

FREQUENTLY ASKED QUESTIONS:

PDPM demystified: What you need to know about the new payment model

In July 2018, [SimpleLTC](#), in conjunction with [Seagrove Rehab Partners](#), offered one of our most popular webinar training series ever, with over 2,000 people attending the two training sessions. (You can watch them [here](#) on-demand.)

Based on the hundreds of questions asked during the webinars, our presenter, Mark McDavid, has prepared this follow-up FAQ document to further aid in preparing for the new Patient-Driven Payment Model (PDPM).

DISCLAIMER: All information is offered in good faith and in hopes it may be useful in preparing for regulatory change. However, we cannot guarantee the information to be 100% accurate, up to date, or suitable for any specific purpose. When in doubt, please verify the information provided here with relevant regulatory entities (e.g., CMS).

1. Is RCS-1 no longer going to be implemented or does PDPM replace it?

PDPM will be the law of the land come October 1, 2019. RCS-1 was a precursor to the PDPM model and is no longer on the table.

2. Regarding ADL/functional score, it appears that in some cases the case mix is lower for residents needing more assistance and therefore a lower payment for higher acuity. Is this correct?

You are correct. Based on CMS' review of claims data, patients who had increased ADL/CNA assistance received less therapy overall and, thus, cost less to care for. Therefore, CMS designed the PDPM model to reflect that.

3. Are IPAs for improvements as well as declines?

Both. Think of the IPA much like you think of the Significant Change in MDS 3.0/RUGs IV.

4. Are the clinical categories descriptive so we know which category a patient falls into? Or are there gray areas? Who decides the category they fall into, therapy or MDS?

There is a CMS spreadsheet that is a crosswalk from ICD-10 codes to the clinical categories for PT/OT and SLP. The reason for skilled stay will be the ICD-10 code that MDS uses in I8000 and this ICD-10 will put the patient in the various clinical categories.

5. Are there going to be CAAs still?

To my understanding, yes.

6. Are the IPAs going to have CAAs like the sig changes do now?

At this point I assume so.

7. Are we going to continue doing the initial OBRA assessments or just the 5D?

Understand the OBRA is not changing. We will still log admission assessments, quarterly assessments and annual assessments. If the OBRA and PPS assessment schedules overlap, then you may combine them as you do today.

8. Are we limited to how many IPAs we are allowed complete during the skilled stay?

No.

9. Can a patient fall into two categories if appropriate?

As discussed in the webinar, the ICD-10 spreadsheet that CMS published shows which ICD-10 codes fall into which clinical category. There will be times where one ICD-10 maps to two different clinical categories. In those cases, the presence of a surgical procedure will be the determinant as to which category the patient will be classified in to. Section J2000 will be completed to fully classify the patient into one clinical category or another.

10. Can Rehab Tech/Rehab Aides be utilized for delivering rehab treatment with PDPM? How about use of students?

As it stands today, the RAI rules for tech/student usage are not changing. Techs/aides cannot be used. Students may be used but not treating at the same time as their supervisor is treating a patient.

11. Can you be more specific about how therapy contracts may not work as they have in the past?

Most therapy contracts are currently written to pay the contractor based on a RUG IV rehab RUG. This RUG is based on a volume of therapy being provided. The more therapy that is provided the higher the RUG and the more the contractor gets paid. Under PDPM, the volume of therapy does not determine payment. There will be no RUG scores and a volume of therapy will not be linked to the various clinical categories. Therefore, the contract providers will have to come up with a new way to get paid for Part A service.

12. Can you clarify the changes to the use of IDC-10 codes?

ICD-10 codes will be used at I8000 to identify the primary reason for the skilled stay and to identify other diagnoses that will impact some of the PDPM components. Section J2000 will be used to capture the procedure that occurred in the hospital (if the resident had surgery) to correctly place the patient in the PT and OT Clinical Category.

13. With the new PDPM, we will no longer code ADLs like we currently do in Section G and instead it will be replaced with Section GG from the admission performance assessment. Can you clarify this?

Yes, ADL scores will no longer be used to determine payment/end split. Under PDPM, Section GG will be used to determine a function score for PT/OT and for Nursing. This Function score will help determine the case mix classification group for PT, OT, and Nursing payments.

14. Can you have more than one Interim payment during the entire SNF admission? Is there a limit to this?

Yes. At this time there is no defined limit to the number of IPAs that may occur during a patient's stay.

15. Could it work that a company pay therapy by the minute provided instead of the category?

Yes, that is possible. Prior to PPS, many contractors were paid based on therapist hours on site. Essentially, the facility paid the contractor X dollars for every hour the therapists were in the building. The issue I see with this model is that the contractor is incented to provide more hours of therapy, but the facility is not paid any more money based on the increased number of therapy hours. The incentives for the facility and the contractor are not aligned.

16. Do you expect that therapy will enter values into section GG instead of the MDSC?

I would not recommend that your therapists enter Section GG values into the MDS. Section GG is designed to be a collaborative between nursing and therapy. Allowing your therapists to enter the values does not allow for collaboration between nursing and therapy.

17. Do you think that Managed Care Part A will adopt this model as well? What will be the Managed Care response to this new model?

That is unclear at this time. That said, we have seen managed care companies adopt Medicare policies before and that may be the case here. Until that time, the facility will continue to have to manage the managed care patients under levels (if that is how your managed care contracts read currently).

18. Does this new way of score only relevant for Med A? Med B?

This only impacts Med A. Med B will continue to be paid under the Medicare Physician Fee Schedule based on the units of therapy provided.

19. I understand there will be no more 14 days, 30 days, and 60 days. Is that correct?

Correct. The only MDS assessments relevant to Part A will be the 5-day, IPA, and Discharge Assessment.

20. Group minutes and concurrent will be combined up to 25% of the total Mins during a patient's entire stay (as opposed to current system of 7-day lookback). Is that correct?

Yes, the group and concurrent calculation will be based on the patient's entire stay. The PPS Discharge Assessment (NPE) will not capture minutes in a 7-day look-back.

21. Have the criteria for an IPA been established?

At this time, CMS is leaving the criteria for when an IPA is to be completed up to each facility. That may change in the future and certain criteria established, but that was not specified in the Final Rule.

22. How critical is it going to be for the SNF to use exactly the same ICD 10 codes as the hospital? Will hospitals be mandated to include those codes in the clinical?

During the SNF ODF on 8/2/2018, John Kane made it clear that the hospital admitting diagnosis may or may not be the same as the SNF diagnosis. In other words, the reason the patient was admitted to the hospital may be resolved, but the residual effects of that hospital stay may be why we are seeing them in the SNF. It is our responsibility to code the admitting reason for the SNF stay.

23. How do you determine the function score 1-4?

I assume that this is for the Function Scores. If so, the slides on the Function Scores show that a 05 or 06 on Section GG would equate to a 4 for that Section GG item. A 04 would equate to a 3 for the Function Score calculation. A 03 to a 2, a 02 to a 1, and a 01, 07, 09, or 88 to a 0 for Function Score calculation purposes.

24. How many IPAs will we be able to do after 5Day assessment? Is there a limit?

There is no limit.

25. I am confused as to how PT/OT can have the same case-mix group, but a different CMI for each. How is it decided if the OT or the PT CMI is used, or are they added together?

PT and OT will have the same Case-Mix group, but the Case-Mix score will be different based on Table 21. For example, the PT and OT Case Mix group of T1 will have a PT Case Mix score of 1.13 and an OT Case Mix score of 1.17. Both the Case Mix scores will be used – one for the PT portion of the per diem and the other for the OT portion of the per diem.

26. I know Medicare Advantage plans have the choice as how they pay providers, but when the MDS and RAI changes with the PDPM do you think the MA plans that currently pay FFS will continue to pay FFS under the new PDPM?

That is a bit unknown. Those that currently pay based on RUGs will likely follow suit and pay based on PDPM, but we will have to wait and see.

27. If a resident goes to the hospital and does not have the 3 midnights but stayed for 2 days instead, what is the payment adjusted to?

When the patient returns to the same facility after only two midnights then the per diem will be based on the next PPS day. For example, if the patient left the facility on the afternoon of day 21 and returned two days later, the payment would pick back up on day 21 (keep in mind day 20 was the last covered day) and the NTA component would be multiplied by 1 and the PT and OT components would be multiplied by .98 based on the Variable Adjustment Factors. If the patient had stayed that third midnight at the hospital they would return to the facility on day 1 and have a NTA multiplier of 3 and a PT and OT multiplier of 1. Keep in mind that the patient would not have a new benefit period and would therefore not have 100 days to use.

28. If a resident meets max potential prior to their 100 days and remains in the facility or goes home and it is later determined that they need therapy/SNF services again does the cycle start over or continues with the 2% decrease with the days remaining?

If the patient is discharged from Part A in the facility or are discharged from the facility and is off Part A PPS for 3 consecutive midnights, when you bring them back in the facility the adjustment factor will be reset and the NTA will be x3 and the PT/OT will be 100%.

29. If the PT & OT components are already included in payment, what incentives the providers would have to offer those therapy services?

Obviously, if you are not offering enough PT and OT, then the patients will not improve as quickly as if they had that service or may not improve at all. There is a customer service piece to consider (if the patient is there for therapy they may be very unhappy if they are not getting it) as well as your outcome measures and the 5-star rating (which has a PT staffing component).

30. If there is a large change when readmitted from hospital and not a 3-midnight stay, can you do an IPA?

Yes, that is one example of when an IPA would be indicated, in my opinion.

31. I'm an SLP and I've heard fears voiced about not being able to "pick up" someone under this new model. Can you clarify?

I understand your concern, however, patients will still have needs and the providers that are not allowing therapy to provide services will, over time, become chosen less often by the patient. Additionally, their outcome measure will likely suffer which will impact their VBP and QRP scores.

32. Is Section O on the 5-day and IPA MDS's or just the D/C MDS?

That is unclear at this time. I am assuming that it will be on the 5-day and Discharge Assessment. We will have to wait for RAI draft language in early 2019 to know more.

33. Is Texas going to change for Medicaid or not?

We do not know.

34. Is the 25% group/concurrent combined or individually allocated. For example, 25% group and 25% group. That would total 50% caseload mix chance of group and concurrent.

It is combined. Only 25% of total minutes can be provided in the group OR concurrent mode. In other words, at least 75% of the minutes provided to a patient will be provided in the individual mode.

35. Is the IPA replacing the SCSA?

Yes.

36. Is there a date that we should expect to see at least a draft version for these updates to the MDS RAI Manual?

We usually see that in January or February before the October of implementation.

37. Is there only one IPA during the complete skilled stay regardless of how many days of stay?

Answered above.

38. Is this for short stay patient only (Skilled Stay)? How will this affect Long Term Custodial?

Yes, this is for PPS patients. The long-term patients will continue to get OBRA assessments.

39. Is X3 of NA for the 3 disciplines?

No, it is a 3-times multiple. So, take the 78.05 x 3 (that equals 224.78) and that would be the NTA payment for days 1, 2, and 3. Of course the numbers presented in the webinar are federal base rate numbers and not multiplied by your wage index adjustment.

40. If the patient discharges to the hospital and is gone longer than 3 days, will another 5-day MDS need to be completed?

Yes.

41. On page 83 of the final rule it states that all OBRA assessments will still be required. PDPM will not affect the OBRA requirements. Does that mean that if a skilled patient meets all the requirements for a Sig change assessment, then we will still be required to complete this OBRA assessment, but it will not impact PPS payment?

Yes.

42. Can you explain when you would do an IPA assessment?

This is left up to the discretion of each facility.

43. So how will this affect those that are on managed care that is currently using RUGs for payment?

Answered above.

44. Is the IPA is like a COT?

Yes, in that it is an assessment, but the IPA is not predicated on a changing volume of therapy minutes, rather it would be predicated on the changing condition of the patient.

45. Will there still be COT checks with therapy every 7 days? What if you have more than one “significant change,” can you do more than one IPA assessment?

No, COTs will no longer occur. You can do as many IPAs as is necessary.

46. With the final rule, they do not appear to include the updates to section GG that go into effect 10-1-2018. Do you think this was an oversight, should we expect them to be added at a later date?

Yes. CMS will be adding to and retiring some Section GG items that impact PDPM as those items are changed in Section GG.

47. So PDPM is saying the more independent, the higher the payment. Is that correct?

Correct. According to CMS’ review of claims data, the more independent patients received more therapy and thus incurred more cost.

48. Although MDSs are decreasing, our QRPs are increasing. I can see the need to maintain the current RAI team, but I can see why CFOs may want to decrease the RAI staff. What is your suggestion for the processes within the community for PDPM and to maintain RAI staff?

As we briefly discussed at the end of the call, I think the RAI team should be your facility experts on QRP and VBP and will be the people in the facility tasked with making sure that those metrics are captured accurately. I agree that many CFOs will see this as an opportunity to reduce MDS staff, but I think the skillset that the MDS coordinators have will be more valuable redirected in the facility vs losing them altogether.

49. The ARD for the 5-day will be the fifth day of resident stay, correct?

The ARD for the 5-day assessment can be any PPS day between days 1 and 8.

50. What about managed care?

We discussed this briefly, but Managed Care may choose to use the PDPM payment model, stick with Levels, or go to something that we have yet seen.

51. What happens if 1 discipline d/cs prior to other disciplines?

Since the PDPM is not based on utilization, the payment will not be impacted by adding or discharging disciplines of therapy. For clinical reason, an IPA may be indicated if the clinical picture of the patient has changed significantly.

52. What is per diem? Per day/per stay?

Per Diem is the rate the Medicare pays per day for each day the resident is in your facility at midnight.

53. When you do the 5-day, are you still combining with an admission assessment also?

As of now, whenever the PPS and OBRA assessments can be combined (based on schedules of each assessment type) then you are allowed to combine them.

54. Why is are more independent patients a higher case-mix index for orthopedic surgery groups?

See response above.

55. Will a significant change MDS still be required if patient meets all the criteria for OBRA assessments? If so, would that significant change MDS effect payment if patient is in a skilled stay?

If you are doing an OBRA Significant Change, you will most likely do a PPS IPA (in my opinion) since the clinical picture of the resident is changing/has changed.

56. Will an overnight ER visit still be handled like a “skip day”?

Yes, skip day rules are not impacted by PDPM.

57. Will CNAs still be required to document ADLs? How does that impact reimbursement under PDPM?

That is unclear at this point. ADLs will no longer be used to calculate the PPS per diem, however Medicaid, Managed Care and some other payers may still require ADLs in order to set payment for those residents.

58. Will there be clear-cut rules of when to do a IPA?

Based on what is in the Final Rule, Medicare is allowing each facility to set rules surrounding when you complete an IPA. I do not think that we will get more specific requirements for an IPA. That said, the draft RAI that comes out in early 2019 will address IPAs and that may help us all have a better understanding of when an IPA can/should be completed.

59. Will these all be transmitted to CMS even if payer is insurance or managed Medicare?

Rules surrounding when to and when not to transmit are not changing based on the Final Rule.

60. Will this affect Medicaid and private pay assessments as well?

Medicaid will determine if/when they transition to PDPM. Medicaid is not likely to transition October 1, 2019. Private pay will likely use PDPM assessments for consistency.

61. With this new system, regarding long-term residents, do we still do Quarterly MDSs and Significant changes MDSs?

Yes, you must still meet all OBRA requirements. OBRA guidelines are not changing based on what we know today.

62. Won't the software companies continue to have this as a formula calculation? The 25% calculation, that is.

Yes, however, the new calculation is 25% for group and concurrent combined. Under RUG IV, group is limited to 25% and concurrent has no limit.

63. You mentioned a likely decrease in need for therapists. What do you think about the need for MDS coordinators/directors?

See responses above.