## Frequently Asked Questions:

# [On-demand webinar] Oct.1 changes: RAI manual revisions and the Final Rule update

On Aug. 20, 2019, SimpleLTC and Broad River Rehab offered a free webinar with Joel VanEaton from Broad River Rehab. In the webinar, he explained the PDPM RAI manual revisions and the Final Rule updates. This document contains answers for specific questions asked during the webinar.

1. **In terms of the Program integrity piece, what do you think CMS will be monitoring for?**

   CMS will be monitoring for a number of things when PDPM gets here. They will be monitoring for provider behavior that is markedly different under PDPM compared to current behavior. Here is a list of what they have already stated will be in the crosshairs:
   - Reviews will focus on more clearly defined aspects of payment, such as documentation supporting patient diagnoses and assessment coding.
   - Given the increased relevance of a greater set of data elements supporting payment under PDPM, providers should ensure that there is strong documentation and support for the care associated with each PDPM component.
   - CMS will be monitoring therapy service provision under PDPM, as compared to RUG - IV, at the national, regional, state, and facility level.
   - Significant changes in the amount of therapy provided to SNF patients/residents under PDPM, as compared to RUG - IV, or the manner in which it is delivered, may trigger additional program reviews and potential policy changes
   - A major component of CMS' PDPM monitoring strategy is monitoring for consistency in care provision between RUG - IV and PDPM: Therapy intensity, duration, and manner of delivery. Increased utilization of mechanically altered diets. Anomalies in comorbidity coding
   - We plan on monitoring the usage of group and concurrent therapy as well as looking at **clinical outcomes.** If the results of our monitoring efforts indicate substantial non-compliance with the 25 percent limit, we may consider taking additional action in future rulemaking. However, we expect that providers will pay close attention to the warning provided on their validation reports and be aware that we are monitoring their use of group and concurrent therapy as well

2. **Do you think things will change or be different before Oct. 1?**

   There have already been some revisions to the documents on the PDPM Website. The definition of Group therapy and the interruption window have been added. See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html for the documents and https://www.broadriverrehab.com/blog/2019/9/2/cms-updates-the-pdpm-website for a summary.

3. **How does PDPM affect Part B services? Will we be able to continue services with Part B as we do now?**

   PDPM does not affect Part B services. You will be able to continue Part B services as you do now.

4. **During the CMS August training, it was noted that the BIMs should be completed within the first three days. Is this your understanding of that?**
   The BIMS as well as the rest of the interviews will follow the same rules as they do now. From p. C-2 of the RAI Manual v1.17 under Coding Tips, - This interview is conducted during the look-back period of the Assessment Reference Date (ARD) - …within the look-back period (preferably the day before or the day of) the ARD.

5. **Who in the state should we contact regarding regulations proposed or final for the OSA? Is it the state RAI coordinator or is there a central location each state utilizes on state websites?**

   The recently updated FAQ document located at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html indicates at new question 14.15 - I have questions about the OSA. Any questions regarding the OSA should be directed to the relevant state agency governing the state's Medicaid policy issues.

6. **Can you provide clarification regarding staff documentation for section GG? Is it expected that nursing assistants document GG?**

   This is from p. G-10 of the RAI Manual v1.17 under steps for assessment. - Assess the resident's self-care performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the three-day assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period. - Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements. - QUALIFIED CLINICIAN Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.

7. **What if a resident goes to another SNF the 2nd day and then return to the original SNF on day 3. would this still be considered an interrupted stay?**

   No. The FAQ document that may be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html indicates, "CMS defines an "interrupted" SNF stay as one in which a patient is discharged from Part A covered SNF care and subsequently readmitted to Part A covered SNF care **in the same SNF (not a different SNF)** "during the interruption window")."
   **Example 2:** Patient B is admitted to SNF on 11/07/19, admitted to hospital on 11/20/19, and admitted to a different SNF on 11/22/19
   – New stay
   – Assessment Schedule: Reset; stay begins with new 5-day assessment
   – Variable Per Diem: Reset; stay begins on Day 1 of variable per diem schedule
   In other words, each admission to a new SNF constitutes a new stay at that SNF. In your example, it would be a new stay at SNF 2 and a new stay at the original SNF. Regardless if the admissions took place within the interruption window.

8. **For the stairs, if we have 3 steps in the building and the resident goes up and down multiple times, can that count for 12 steps or does it have to be 12 consecutive steps?**
   Yes

9. **You mentioned CMS expect the UB-04 would match the diagnosis list of the MDS, but I thought they aren't ready to track that yet. Can you please clarify?**

   What I intended to convey was what the FAQ document at is indicating related to the principal diagnosis. Question 1.8 asks, "Is it required that the principal diagnosis on the SNF claim match the primary diagnosis coded in item I0020B? Answer: While we expect that these diagnoses should match, there is no claims edit that will enforce such a requirement. My opinion, (no instruction in the RAI Manual) is also that if an ICD-10 code is used on the MDS to support any part of the PDPM grouper that determines reimbursement, it should also be on the UB-04. Similarly, if any of the diagnoses checked off in section II contribute to payment under PDPM, there should be a supporting ICD-10 code on the UB-04, also my opinion.

10. **Who is qualified to complete the cognitive interview or BIMs?**

    I believe that the person conducting the BIMS should be a qualified clinician such as a nurse, This is not stated in the RAI but the RAI Manual is clear in the instructions related to the Confusion Assessment Method (CAM), which assess for indicators of delirium, "**Steps for Assessment** 1. Observe resident behavior during the **BIMS** items (C0200-C0400) for the signs and symptoms of delirium." And that DELIRIUM is a mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations. I believe it is CMS' expectation that a clinically competent person should be conducting both of these assessments.

11. **if the state assessment will not be allowed for managed care, what assessment will we use to get a RUG score?** My understanding is that individual software products will need to accommodate this by allowing access to RUG IV PPS types of assessments.

12. **Will we continue to be able to combine the Discharge/Medicare PPS Discharge?**

    Yes. See page 2-44 of v1.17 of the RAI Manual where it states, "If the End Date of the Most Recent Medicare Stay (A2400C) occurs on the day of or one day before the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and **may be combined**."

13. **Can you define major surgical procedure? See page J-38 of v1.17 of the RAI Manual:**

    Coding Tips
    • Generally, major surgery for item J2100 refers to a procedure that meets the following criteria:
    1. the resident was an inpatient in an acute care hospital for at least one day in the 30 days prior to admission to the skilled nursing facility (SNF), and
    2. the surgery carried some degree of risk to the resident's life or the potential for severe disability.

14. **For managed care, how will those assessments change regarding PDPM? How will PDPM affect Medicare Advantage Plans?**

    It will be up to the individual plan. The FAQ document which may be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html addresses this in question 11.11.

    For patients utilizing Medicare Advantage plans, the MA plans themselves will decide whether they will incorporate any aspects of PDPM into their payment system.

15. **Does the IPA pay start on the day of the ARD?**

    Yes. Page 2-45 of v1.17 of the RAI Manual indicates that the IPA, "Sets payment for remainder of the stay beginning on the ARD."

16. **Is there a way to receive the data from the quality reporting program?**

    Yes. Individual facility data may be accessed on Nursing Home Compare and in the reports section of the CASPER reporting system.

**17. Where can we find the labor and non-labor portion of the rate?**

It can be found on page 39738 the final rule which can be accessed at https://www.govinfo.gov/content/pkg/FR-2019-08-07/pdf/2019-16485.pdf For FY 2020 the Labor-Related Relative Importance Factor is 0.709 and the Non-Labor portion is 0.291.

**18. Please clarify what H.I.P.P.S. stand for?**

**H**ealth **I**nsurance **P**rospective **P**ayment **S**ystem.

**19. If septicemia resolved in acute care and resident is no longer on ABT upon admission to SNF but suffered ADL decline due to septicemia, can you still code it as an active Septicemia on the MDS for primary clinical dx and category?**

It would be interesting to know what the medical record showed in this case as to the full diagnosis list for this resident. I am concerned that the guidelines would prevent this from the following guidelines. First, from p I-2 regarding the dx category and code at I0020 and I0020B, "Include the primary medical condition coded in this item in Section I: Active Diagnoses in the last 7 days." That said, it is clear that for a diagnosis to be considered active, it must meet all of the criteria on page I-7 including, "Do not include conditions that have been resolved…".

**20. Is the matching in relation to the "admit dx" and the "Principal (or final) diagnosis on the UB04?**

This is in relation to the Primary diagnosis coded at item I0020B and the principle on the UB-04. See question 9 above.

**21. On J2810, would we not code surgeries on the prostate or removal of prostate in this area?**

Here is the actual item from the current data set. It clearly indicates that prostate surgery would be coded at J2800.

| | Genitourinary Surgery |
|---|---|
| ☐ | J2800. **Involving male or female organs** (such as prostate, testes, ovaries, uterus, vagina, external genitalia) |
| ☐ | J2810. **Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of nephrostomies or urostomies) |
| ☐ | J2899. **Other major genitourinary surgery** |

**22. Can you share the spreadsheet you have for intrep stay?**

Yes. Please contact me personally at the email provided in the power point presentation.

23. **For Interrupted Stay, if the initial diagnosis was fx hip and hospital readmission for Pneumonia, would you change the primary reason for skill services to Pneumonia? if within three days? Outside three days?**

    If Pneumonia meets the following criteria from p. I-2 of v1.17 of the RAI Manual, then Yes, inside or outside 3 days. "Indicate the resident's primary medical condition category that **best describes the primary reason for the Medicare Part A stay**."

24. **For Interrupted stay, do we complete the DC OBRA and entry when they come back? Does the 24 hours rule apply to DC OBRA for MCA?**

    OBRA rules still apply, these do not change with PDPM so discharge assessments and reentry tracking forms must still be completed according to those guidelines found in chapter 2 of the RAI Manual. LOA definitions still apply as well, see page 2-13 of v1.17 of the RAI Manual.

25. **Is a planned readmission considered in readmission rate?**

    See page 5 of the following https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/Downloads/SNFRM-TechReportSupp-2019-.pdf The comprehensive document should be taken into account, however, on page 5 it states, "The SNFRM uses a modified version of CMS's Planned Readmissions Algorithm4 to identify readmissions that are classified as planned and should therefore not be counted as readmissions." The Planned Readmission Algorithm that is referred to below can be found on page 20 of this document.

    "Planned readmissions are not counted against facilities because they are not indicative of poor quality of care. A planned readmission is defined as any non-acute readmission in which one of a set of typically planned procedures or diagnoses occurred. The Planned Readmission Algorithm is based on two main principles:
    1. Some diagnoses and procedures should always be considered planned.
    2. A separate, larger group of procedures should also be considered planned except in the presence of a disqualifying diagnosis. That is, if any of the procedures in this group occurs in conjunction with a diagnosis that disqualifies a readmission from being considered planned, the readmission will be considered unplanned. The rationale is that the readmission would likely have been necessitated by the acute diagnosis even if the planned procedure was not performed."

    "Unless a readmission meets the algorithm's definition of planned, it is considered unplanned and counted in the numerator of the measure calculation. Note that admissions for acute illness or for complications of care are classified as unplanned."

**26. Can you have any Mapping or tools that can used for documentation improvement and supported under PDPM coding?**

There are a number of tools available from different providers. We have some tools that I would be happy to provide. Please contact me via the email that was provided in the power point presentation.

**27. What about recent surgery in section J within 100 days?**

Item J2000 remains on the PDPM PPS data set but does not have an effect on reimbursement under PDPM.

**28. Can SLP still use R13 on POC as a treatment code (a specific code that identifies phase of swallow ST will treat) even though it will be a RTP?**

Yes, however, there will need to be a diagnosis code selected at I0020B as the primary diagnosis code that maps to one of the 10 clinical categories in order for a HIPPS code to be generated for PT, OT and SLP. This will need to match the principal diagnosis on the claim.

**29. Can you clarify which sections have to match in section I and J?**

For items J2300 – J5000 the following is indicated on page J-40 under Steps for Assessment, "Determine whether the surgeries require active care during the SNF stay: Once a recent surgery is identified, it must be determined if the surgery requires active care during the SNF stay. Surgeries requiring active care during the SNF stay are surgeries that have a **direct relationship to the resident's primary SNF diagnosis, as coded in I0020B.**

**30. What does IRF mean?**

**I**npatient **R**ehab **F**acility

**31. When setting up an assessment in A0300a state payment assessment do you answer yes or no for state of Georgia?**

In the FAQ document that may be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html CMS indicates, "Any questions regarding the OSA should be directed to the relevant state agency governing the state's Medicaid policy issues." It is possible that there will be situations in which Georgia will require the Optional State Assessment to be completed. However, each state will make their own decisions regarding its use. Also, see p. A-4 of v1.17 of RAI Manual

**32. Is there more in-depth training on the mapping for section I, for someone with no ICD 10 background?**

I would suggest the AANAC ICD-10 virtual workshop. If you are a member, there is a discount. Here is a link to that resource. https://www.aanac.org/virtual_workshops

**33. In Chapter 3, Section J.... Slide 34 says the resident had major surgery during the inpatient stay that immediately preceded the resident's Part A admission. What happens if the resident leaves the hospital, goes to a LTAC and then comes to a SNF? Does that surgery still count since it did not IMMEDIATELY PRECEDE the SNF stay?**

Question 11.5 in the FAQ document located at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html clarifys this and indicates in relationship to items J2100 – J5000, "These items are used to capture any major surgical procedures that occurred during the inpatient hospital stay that immediately preceded the SNF admission, i.e., the **qualifying hospital stay**." It is the qualifying stay that determines whether surgery is applicable.

**34. Are the Program Integrity focus areas you are reviewing listed in any published document?**

These are mostly in presentations that CMS has done as well as in SNF PPS FY 2020 final rule.

**35. What if the facility is not able to complete the BIMS the day before or the day of the ARD, what does the facility in those instances?**

See p. C-2 of v1.17 of the RAI Manual as well as the FAQ document that can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html Here is what you will find;

**C-2**
**Coding Tips**
• Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
• If the resident needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete

C0700-C1000, Staff Assessment of Mental Status, instead of C0200-C0500, Brief Interview for Mental Status.
• Includes residents who use American Sign Language (ASL).
• If the resident interview was not conducted within the look-back period (**preferably** the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items.
• Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted, but was not done.
• Because a PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM, assessment of resident cognition with the BIMS or Staff Assessment for Mental Status is a requirement for all PPS assessments. As such, only in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS. In this case, the assessor should enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status.

**FAQ Document**

**Q: 5.4 How is the patient classified under PDPM if neither the BIMS nor the CPS staff assessment is completed to determine cognitive level?**
**A:** If neither the BIMS nor the staff assessment is completed, then a patient will be classified under PDPM as if the patient were "cognitively intact." In other words, even if the patient has a cognitive impairment, without the BIMS or staff assessment completed, the cognitive impairment will not be considered as part of the patient's PDPM classification. An IPA may be done to reclassify the patient in such scenarios to capture the cognitive impairment.

36. **If the state assessment will not be allowed for managed care, what assessment will we use to get a RUG score?**

    This will need to be something that you arrange with your software vendor.

37. **If we are a mostly OBRA facility, (don't do a whole lot of skilled) are we generally not affected by PDPM?**

    PDPM affects all Traditional Medicare Part A patients that are in Skilled Nursing Facilities and Swing Beds regardless of volume.

38. **Where can I locate the wage table that has the 100 day rates?**

    The link to the CMS site in the presentation only connects to files with the wage multipliers, not the complete table. That is something that would be supplied by individual vendors. I would be happy to provide you with the tool that I presented. Please contact me via my email supplied in the power point presentation.

39. **I understand if they are a MCR replacement they have to follow MCR rules, but what about the ones that are a level of care? Will there still be an option to pick a 14d, 30d, 60d, 90d?**

    CMS has instructed providers to contact their individual plans to determine what those plans will expect after October 1. If the plan requires RUG scores, then you will need to work that out with your software vendor.

40. **Will the Physician Certifications remain the same with the current guidelines and timeframes?**

    Yes. Nothing changes with the requirements for skilled care coverage at CMS 100-2 Chapter 8 which can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html Details may also be found here https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c04.pdf Remember that you will need to continue the current cert when there is an interrupted stay.