

Patient Driven Payment Method (PDPM) Overview

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The Most Important Takeaway

- Accuracy with Diagnosis and Conditions Coding on Initial Medicare Assessment (5-day) is Critical
 - For most Part A stays, reimbursement for the entire stay is based on the Medicare 5-day assessment
 - ***Success under PDPM requires a thorough, complete and accurate assessment early in the stay***

PDPM Components and Drivers

- **PT** – Primary Reason for SNF Stay, Recent Surgery, Function Score
- **OT** – Primary Reason for SNF Stay, Recent Surgery, Function Score
- **SLP** – Acute Neuro, SLP Comorbidities, Cognition, Swallowing Symptoms, Mechanically Altered Diet
- **Nursing** – RUG IV Clinical Qualifiers, PHQ-9, Function Score, Restorative Nursing
- **Non-therapy Ancillaries (NTAs)** – Diagnoses and Conditions
- **Non-case-mix component** – flat amount that is the same for each resident

PDPM Components and Drivers – Understand Information Sources

- **PT** – I0020B, J2100 – J5000, GG0130 – GG0170
- **OT** – I0020B, J2100 – J5000, GG0130 – GG0170
- **SLP** – I0020B, MDS check box items and I8000, BIMS, K01000, K01510C
- **Nursing** – MDS check box items, GG0130 – GG0170, PHQ-9©,
- **Non-therapy Ancillaries (NTAs)** – MDS check box items, I8000
- Different components under PDPM look at different MDS items, you may need to code the same diagnosis or condition in more than one place to get credit in each component

PDPM Components and Drivers - Example

- For an admission with Acute Respiratory Failure with Hypoxia
 - I0020B = J96.01 to get the correct PT and OT score
 - J96.01 maps to Medical Management
 - I6300 = checked to get the correct Nursing score
 - Respiratory Failure with oxygen while a resident = Special Care Low
 - I8000 = J96.01 to get the correct NTA score
 - Cardio-respiratory failure/shock = 1 NTA point

Self Care and Mobility: Section GG and the Function Score

PT and OT Components – Function Score

- 2nd Tier: Functional score based on certain GG items
 - Eating
 - Oral hygiene
 - Toileting hygiene
 - Average of:
 - Sit to lying
 - Lying to sitting on side of bed
 - Average of:
 - Sit to stand
 - Chair/bed-to-chair transfer
 - Toilet transfer
 - Average of:
 - Walk 50 feet w/2 turns
 - Walk 150 feet
- Scoring Assignment
 - 4: set up or independent
 - 3: supervision or touching assist
 - 2: partial/moderate assist
 - 1: substantial/maximal assist
 - 0: dependent, refused, n/a
- Functional Categories
 - 0-5
 - 6-9
 - 10-23
 - 24
 - Which pays the most varies by clinical category

Nursing Component – Function Score

- 2nd Tier: GG based function score
 - Eating
 - Toileting Hygiene
 - Average of:
 - Sit to lying
 - Lying to sitting on side of the bed
 - Average of:
 - Sit to stand
 - Chair/bed-to-chair transfer
 - Toilet transfer
- Scoring Assignment
 - 4: set up or independent
 - 3: supervision or touching assist
 - 2: partial/moderate assist
 - 1: substantial/maximal assist
 - 0: dependent, refused, n/a
- Functional Categories
 - 0-5 (highest rate)
 - 6-14
 - 15-16 (lowest rate)

Function Scores Issues

- There are two separate function scores under PDPM
- What is the “best” score is different for PT/OT and Nursing
- Function Scores are the opposite of what we’re used to with RUGs
 - The most independent people have the highest function scores
 - The most dependent people* have the lowest scores

Section GG Coding Hints

- Capture resident's "Usual Performance" over the observation period
 - On the initial assessment, the observation period is the first three days of the SNF stay or until initiating therapeutic interventions
 - On the PPS Part A discharge Assessment, the observation period is the last three days of the part A stay
 - On the IPA, the observation period is the ARD plus two days prior
- Coding should reflect a collaboration between therapy and nursing
- If the resident requires the assistance of two helpers, code "dependent"
- Partial/moderate assistance vs. substantial/maximal assistance
- Coding should be based on an actual assessment, not what you think the resident is capable of

PT and OT Component Issues

PT and OT Components – 16 Payment Groups

- 1st Tier: Diagnosis that represents the primary reason for the SNF stay
 - Major Joint Replacement or Spinal Surgery
 - Other Orthopedic
 - Non-surgical orthopedic/musculoskeletal
 - Ortho surgery except major joint or spinal surgery
 - Medical Management
 - Medical Management
 - Acute infection
 - Cancer
 - Pulmonary
 - Cardiovascular and coagulations
 - Non-Orthopedic Surgery and Acute Neurologic
 - Non-orthopedic surgery
 - Acute Neurologic

PT/OT Classification Groups & Case-Mix Weights

Clinical Category	GG Function Score	PT & OT Case-Mix Group	PT CMI	OT CMI
Major Joint Replacement or Spinal Surgery	0-5	TA	1.49	1.45
	6-9	TB	1.65	1.59
	10-23	TC	1.83	1.64
	24	TD	1.87	1.49
Other Orthopedic	0-5	TE	1.38	1.37
	6-9	TF	1.57	1.56
	10-23	TG	1.62	1.60
	24	TH	1.13	1.12
Medical Management	0-5	TI	1.10	1.15
	6-9	TJ	1.38	1.41
	10-23	TK	1.48	1.50
	24	TL	1.06	1.08
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.24	1.26
	6-9	TN	1.44	1.46
	10-23	TO	1.51	1.51
	24	TP	1.05	1.06

SLP Component Issues

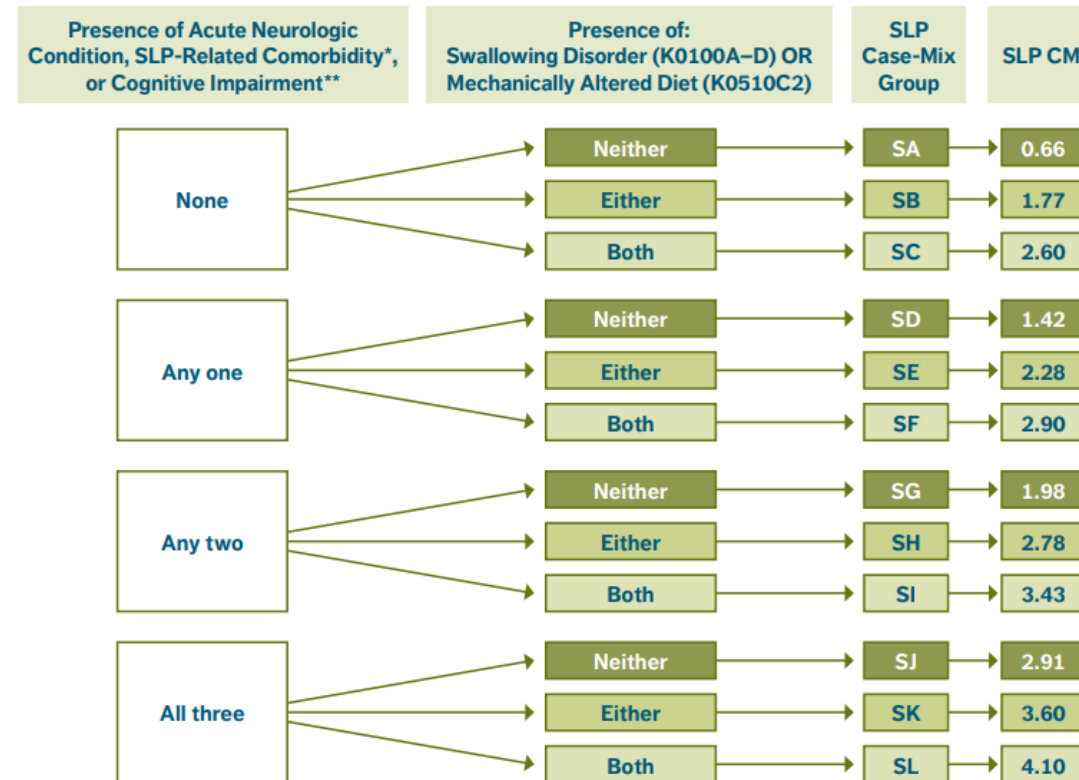
SLP Component – 12 Payment Groups

- 1st Tier: Presence of neurologic condition, SLP-related comorbidity or cognitive impairment:
 - None (lowest rate)
 - Any one
 - Any two
 - All three (highest rate)
- SLP-related comorbidity: CVA, TIA or stroke; Hemiplegia or hemiparesis; TBI; Trach; Vent; *Laryngeal cancer; Apraxia, dysphagia, ALS, oral cancers, speech and language deficits (italicized = 18000)*
- Cognitive impairment: based on BIMS or CPS

SLP Component

- 2nd Tier: Presence of swallowing disorder or mechanically altered diet
 - Neither (lowest rate)
 - Either
 - Both (highest rate)
- NOTE: Functional Score from GG does not impact this component
- NOTE: MDS coding of these two items is often not accurate in my experience

SLP Classification Groups & Case-Mix Weights



*** SLP-Related Comorbidities:**
 Aphasia (I4300); CVA, TIA, or Stroke (I4500); Hemiplegia or Hemiparesis (I4900); TBI (I5500); Tracheostomy (O0100E2); Ventilator (O0100F2); Laryngeal Cancer, Apraxia, Dysphagia, ALS, Oral Cancers, Speech and Language Deficits (I8000)

**** Cognitive Impairment:**
 The PDPM cognitive level is based on the Brief Interview for Mental Status (BIMS) or the PDPM staff assessment for mental status. See the CMS PDPM Calculation worksheet in chapter 6 of the RAI User's Manual.

SLP Component Considerations

- 1st tier assignment: Acute Neurologic, SLP comorbidities, cognitive impairment
 - Acute Neurologic primary reason for SNF stay pays lower PT and OT components, but increases SLP component
 - SLP Comorbidities
 - some are “check box” items, others need specific ICD10 codes entered into I8000
 - CMS PDPM website ICD10 file has the specific ICD10 codes that qualify (example – dysphagia only r/t cerebrovascular events)
 - See discussion of the BIMS score in the interview section later

SLP Component Considerations

- 2nd tier assignment:
 - Signs and symptoms of a **potential** swallowing disorder (see next slides)
 - Mechanically altered diet – CMS is monitoring increased use of mechanically altered diets, be sure the need is well documented

SLP Discussion: K0100 – Swallowing Symptoms

- **K0100A, loss of liquids/solids from mouth when eating or drinking.** When the resident has food or liquid in his or her mouth, the food or liquid dribbles down chin or falls out of the mouth.
- **K0100B, holding food in mouth/cheeks or residual food in mouth after meals.** Holding food in mouth or cheeks for prolonged periods of time (sometimes labeled pocketing) or food left in mouth because resident failed to empty mouth completely.
- **K0100C, coughing or choking during meals or when swallowing medications.** The resident may cough or gag, turn red, have more labored breathing, or have difficulty speaking when eating, drinking, or taking medications. The resident may frequently complain of food or medications “going down the wrong way.”
- **K0100D, complaints of difficulty or pain with swallowing.** Resident may refuse food because it is painful or difficult to swallow.
- **K0100Z, none of the above:** if none of the K0100A through K0100D signs or symptoms were present during the look-back

NTA Component Issues

Non-therapy Ancillary (NTA) Component – 6 Payment Groups

- 50 conditions and services qualify for point values of 1, 2, 3, 4, 5, 7 or 8 points (most are 1 point)

- NA: 12 or higher 3.15
- NB: 9-11 2.46
- NC: 6-8 1.79
- ND: 3-5 1.29
- NE: 1-2 0.93
- NF: 0 0.70

NTA Component Considerations

- Review NTA Diagnoses and Conditions Checklist
- Note the source of each item – where on the MDS is it pulled from?
- Review item specific coding instructions

NTA Component Sources

Section H: Bladder and Bowel

- Intermittent Catheterization
 - H0100D
 - Assigned 1 point
- Ostomy
 - H0100C
 - Assigned 1 point

Section K: Nutritional Status

- Feeding Tube
 - K0510B2 (while a resident)
 - Assigned 1 point
- Parenteral IV Feeding
 - K0510A2
 - Assigned 7 or 3 points

Section M: Skin Conditions

- Diabetic Foot Ulcer
 - M1040B
 - Assigned 1 point
- Stage 4 Pressure Ulcer
 - M0300D1
 - Assigned 1 point
- Foot Infection **or** Other open lesion on the foot
 - M1040A or M1040C
 - Assigned 1 point

NTA Component Sources

Section O: Special Treatments, Procedures, and Programs

- IV Medication
 - O0100H2 (while a resident)
 - Assigned 5 points
- Ventilator or Respirator
 - O0100F2 (while a resident)
 - Assigned 4 points
- Transfusion
 - O0100I2 (while a resident)
 - Assigned 2 points
- Radiation
 - O0100B2 (while a resident)
 - Assigned 1 point
- Suctioning
 - O0100D2 (while a resident)
 - Assigned 1 point
- Tracheostomy Care
 - O0100E2 (while a resident)
 - Assigned 1 point
- Isolation
 - O0100M2 (while a resident)
 - Assigned 1 point

NTA Component Sources

Section I: Active Diagnoses (I0100-I7900)

- Wound Infection
 - I2500
 - Assigned 2 points
- Diabetes Mellitus
 - I2900
 - Assigned 2 points
- Multiple Sclerosis
 - I5200
 - Assigned 2 points
- Asthma, COPD, Chronic Lung Disease
 - I6200
 - Assigned 2 points
- Inflammatory Bowel Disease
 - I1300
 - Assigned 1 point
- Multi-Drug Resistant Organism (MDRO)
 - I1700
 - Assigned 1 point
- Malnutrition
 - I5600
 - Assigned 1 point

NTA Component Sources

Section I: Additional Active Diagnoses (I8000)

- Lung Transplant Status
 - Assigned 3 points
- Major Organ Transplant Status, Except Lung
 - Assigned 2 points
- Opportunistic Infections
 - Assigned 2 points
- Bone/Joint/Muscle Infections/Necrosis – except Aseptic Necrosis of Bone
 - Assigned 2 points
- Chronic Myeloid Leukemia
 - Assigned 2 points
- Endocarditis
 - Assigned 1 point
- Immune Disorders
 - Assigned 1 point
- End-Stage Liver Disease
 - Assigned 1 point
- Narcolepsy and Cataplexy
 - Assigned 1 point
- Cystic Fibrosis
 - Assigned 1 point
- Specified Hereditary Metabolic/Immune Disorders
 - Assigned 1 point

NTA Component Sources

Section I: Additional Active Diagnoses (I8000) (each 1 point)

- Morbid Obesity
- Psoriatic Arthropathy and Systemic Sclerosis
- Chronic Pancreatitis
- Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
- Complications of Specified Implanted Device or Graft
- Aseptic Necrosis of Bone
- Cardio-Respiratory Failure and Shock
- Myelodysplastic Syndromes and Myelofibrosis
- Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies
- Diabetic Retinopathy (Except Proliferative)
- Severe Skin Burn or Condition
- Intractable Epilepsy
- Disorders of Immunity – Except Immune Disorders
- Cirrhosis of Liver
- Respiratory Arrest
- Pulmonary Fibrosis and Other Chronic Lung Disorders

Recap: NTA Component Items >1 Point

High Point Items

- HIV/AIDS (claim) 8
- Parenteral/IV – High 7
- IV Meds 5
- Vent/respirator 4
- Parenteral/IV – Low 3
- Lung transplant (I8000) 3

2 Point items

- transfusion
- organ transplant, except lung (I8000)
- MS
- opportunistic infections (I8000)
- asthma - COPD - lung disease
- necrosis, except aseptic necrosis of bone (I8000)
- chronic myeloid leukemia (I8000)
- wound infection
- diabetes mellitus

NTA Component – Nutrition Related Items

- Ulcerative Colitis, Crohn's Disease or Inflammatory Bowel Disease I1300 = Checked (1 point)
- Diabetes Mellitus I2900 = Checked (2 points)
- Malnutrition I5600 = Checked (1 point)
- Feeding Tube K0510B2 = Checked (1 point)
- Parenteral/IV Feeding (Level High) K0510A2 = Checked AND K0710A2=3 (7 points)
- Parenteral/IV Feeding (Level Low) K0510A2 = Checked AND K0710A2 = 2 AND K0710B2 = 2 (3 points)
- Morbid Obesity I8000 A-J= appropriate ICD (1 point)

Morbid Obesity

- Morbid Obesity Diagnoses that are considered “Morbid Obesity” for the NTA Component
 - E6601 Morbid (severe) obesity due to excess calories
 - BMI 35-40 AND experiencing obesity related health conditions such as high blood pressure or diabetes
 - E6602 Morbid (severe) obesity with alveolar hypoventilation
 - Z6841 Body mass index (BMI) 40.0-44.9, adult
 - Z6842 Body mass index (BMI) 45.0-49.9, adult
 - Z6843 Body mass index (BMI) 50-59.9 , adult
 - Z6844 Body mass index (BMI) 60.0-69.9, adult
 - Z6845 Body mass index (BMI) 70 or greater, adult

Malnutrition

- Facilities should have a policy for assessing malnutrition or *at risk for malnutrition* on admission
 - Example, from ASPEN: BMI < 18.5, chronic disease, increased metabolic requirements, altered diets or diet schedules, inadequate nutrition intake, weight loss 5% in 30 days, 10% or 10 pounds in 6 months
- Requires a physician diagnosis, which could be prompted by the nutrition professional's assessment and recommendation
- Nutrition review should happen early in the stay to capture Dr agreement/diagnosis for malnutrition, risk for malnutrition, morbid obesity or other nutrition services related diagnoses by ARD

IV Fluids: NTA vs. Nursing Component

- For the NTA component, the parenteral or IV must be delivered while the person was a resident of the facility in order to receive credit
- **For the nursing component, you receive credit for parenteral or IV's administered in the last seven days, regardless of if they were administered while the person was a resident or not**

NTA Component Considerations – Section I

- What makes a diagnosis active
 - Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death **during the 7-day look-back period**
 - Planning for Care - This section identifies active diseases and infections that **drive the current plan of care.**
 - Remember when looking at the last seven days you can include days prior to admission to this SNF, depending on your ARD
- One of my most common findings have been diagnoses that weren't coded as being active that I think could have been
- Prioritizing I8000

Nursing Component Issues

Nursing Component – 25 Payment Groups

- 1st Tier:

- Extensive services
- Special care high
- Special care low
- Clinically complex
- Behavior symptoms/cognition
- Reduced physical function

- 2nd Tier:

- Function Score
- PHQ9 Score
- Restorative Nursing

Extensive Services

- Residents satisfying the following two conditions:
 - Having a function score of 14 or lower.
 - While a resident, receiving:
 - tracheostomy care,
 - ventilator/respirator, and/or
 - infection isolation.
 - P O-6: examples of when the isolation criteria would NOT apply include UTIs, encapsulated pneumonia and wound infections
 - See next slide for coding criteria

- Trach AND Vent ES3 A 3.95
- Trach OR Vent ES2 B 2.99
- Isolation ES1 C 2.85

Isolation Requirements and MDS Coding

- RAI User's Manual, page O-5 states: Code for "single room isolation" only when **all of the following conditions** are met:
 - 1. The resident **has active infection** with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission
 - 2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect
 - 3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in a room alone **and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation**
 - 4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g., rehabilitation, activities, dining, etc.)

Special Care High

- Residents satisfying the following two conditions:
 - Having a function score of 14 or lower.
 - Receiving any of the following:
 - comatose,
 - septicemia,
 - diabetes with daily insulin injections and insulin order changes on at least 2 days,
 - quadriplegia with function score of 11 or lower
 - Asthma, COPD or other chronic lung disease, with shortness of breath when lying flat
 - fever with pneumonia, vomiting, weight loss, or tube feeding*
 - parenteral/IV feeding, or
 - respiratory therapy 7 out of the last 7 days.

Coding IV Fluids as Nutritional Approaches in K0510 and K0710

- May be coded:
 - IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
 - IV fluids running at KVO (Keep Vein Open)
 - IV fluids contained in IV Piggybacks
 - Hypodermoclysis and subcutaneous ports in hydration therapy
 - IV fluids can be coded in K0510A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record.

Coding IV Fluids as Nutritional Approaches in K0510 and K0710

- May not be coded:
 - IV fluids used to reconstitute and/or dilute medications for IV administration.
 - IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay.
- There must be a documented nutrition or hydration need in order to code any nutritional approaches

Special Care High

HDE2 D 2.33
HDE1 E 1.94
HBC2 F 2.18
HBC1 G 1.81

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	HDE2
0-5	No	HDE1
6-14	Yes	HBC2
6-14	No	HBC1

Special Care Low

- Residents satisfying the following two conditions:
 - Having a function score of 14 or lower
 - Receiving any of the following:
 - cerebral palsy with function score of 11 or lower,
 - multiple sclerosis with function score of 11 or lower,
 - Parkinson's disease with function score of 11 or lower,
 - respiratory failure and oxygen therapy while a resident,
 - tube feeding,*
 - ulcer treatment with two or more ulcers including venous ulcers, arterial ulcers or stage II or higher pressure ulcers,
 - ulcer treatment with any stage III or IV pressure ulcer,
 - foot infections or wounds with application of dressing,
 - radiation therapy while a resident, or
 - dialysis while a resident.

Special Care Low

LDE2 H 2.02

LDE1 I 1.68

LBC2 J 1.67

LBC1 K 1.39

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	LDE2
0-5	No	LDE1
6-14	Yes	LBC2
6-14	No	LBC1

Clinically Complex

- Residents receiving any of the following:
 - Clinical qualifiers for Extensive, Special Care High or Special Care Low without required function score
 - pneumonia,
 - hemiplegia with function score of 11 or lower,
 - surgical wounds or open lesions with treatment,
 - burns,
 - chemotherapy while a resident,
 - oxygen therapy while a resident,
 - IV medications while a resident, or
 - transfusions while a resident.

Clinically Complex

CDE2 L 1.82
CDE1 M 1.58
CBC2 N 1.51
CBC1 O 1.06
CA2 P 1.30
CA1 Q 0.91

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	CDE2
0-5	No	CDE1
6-14	Yes	CBC2
6-14	No	CBC1
15-16	Yes	CA2
15-16	No	CA1

Behavioral Symptoms and Cognitive Performance

- Residents satisfying the following two conditions:
 - Having a function score of 11 or higher.
 - Having behavioral or cognitive performance symptoms, involving any of the following:
 - difficulty in repeating words, temporal orientation, or recall (score on the Brief Interview for Mental Status ≤ 9),
 - difficulty in making self understood, short term memory, or decision making (score on the Cognitive Performance Scale ≥ 3),
 - hallucinations,
 - delusions,
 - physical behavioral symptoms toward others,
 - verbal behavioral symptoms toward others,
 - other behavioral symptoms,
 - rejection of care, or
 - wandering.

Behavior Symptoms and Cognitive Performance

BAB2 R 1.01

BAB1 S 0.96

<i>Nursing Function Score</i>	<i>Restorative Nursing</i>	<i>PDPM Nursing Classification</i>
11-16	2 or more	BAB2
11-16	0 or 1	BAB1

Reduced Physical Function

- Residents whose needs are primarily for support with activities of daily living and general supervision.
- (Residents who didn't group anywhere else)

Reduced Physical Function

PDE2 T 1,53
PDE1 U 1.43
PBC2 V 1.19
PBC1 X 1.10
PA2 W 0.69
PA1 Y 0.64

Nursing Function Score	Restorative Nursing	PDPM Nursing Classification
0-5	2 or more	PDE2
0-5	0 or 1	PDE1
6-14	2 or more	PBC2
6-14	0 or 1	PBC1
15-16	2 or more	PA2
15-16	0 or 1	PA1

Variable Per Diem Adjustment

NTA Component

- Days 1-3: 300%
- Days 4-100: 100%

PT and OT Components

- Days 1-20 are paid at 100%
- Every seven days thereafter, the rate would decrease by 2%
 - Days 21-27: 98%
 - Days 28-34: 96%
 - Days 35-41: 94%

 - Days 84-90: 80%
 - Days 91-97: 78%
 - Days 98-100: 76%

PDPM Interrupted Stay Policy

Interrupted Stay

- An “interrupted” SNF stay is defined as one in which a resident is discharged from SNF care and subsequently readmitted to the same SNF (not a different SNF) within 3 days or less after the discharge (the “interruption window”).
 - The interruption window is a 3-day period, starting with the calendar day of Part A discharge and including the 2 immediately following calendar days, ending at midnight. In other words, the resident must return to the same SNF by 11:59 p.m. at the end of the third calendar day.
 - The interruption window begins on the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered stay.

Interrupted Stay

- If both conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A stay for the purposes of both the variable per diem schedule and the assessment schedule.
- The variable per diem schedule continues from the day of the previous discharge.
 - For example, if the resident was discharged on Day 7, payment rates resume at Day 7 upon readmission.
 - The assessment schedule also continues from the day of the previous discharge. Thus, no new 5-Day assessment is required upon the subsequent readmission, although the optional IPA may be completed at clinician's discretion.

Interrupted Stay

- If a resident is readmitted to the same SNF more than 3 consecutive calendar days after discharge, OR in any instance when the resident is admitted to a different SNF (regardless of the length of time between stays), then the Interrupted Stay Policy does not apply, and the subsequent stay is considered a new stay.
- In such cases, the variable per diem schedule resets to Day 1 payment rates, and the assessment schedule also resets to Day 1, necessitating the completion of a new 5-Day assessment.

PDPM Interrupted Stay Policy

- If the resident discharges from the SNF and returns to the same SNF within 3 midnights
 - Original stay resumes, only reentry tracking is required
 - Remains in the same payment categories (unless an IPA completed)
 - Variable rate adjustment **does not** reset back to day 1
- If the resident returns to the SNF after midnight of the third day
 - Treated like a new stay
 - New 5-day assessment for case mix group assignment
 - Variable rate adjustment **does reset** to day 1

PDPM Rate Calculations

Sample Resident

- PT/ OT CMG = TO (Acute Neurologic, 10-23) CMI = 1.55/1.55
 - Primary reason for the SNF stay = Exacerbation of Parkinson's disease
 - Function Score = 14
- SLP CMG = SH (any two, either) CMI = 2.85
 - Acute neuro due to Parkinson's as primary reason for SF stay
 - Cognitive Impairment (BIMS = 11)
 - Resident documented as coughing while taking meds
- NTA CMG = NC (6-8) CMI = 1.85
 - COPD (2), DM (2), Acute respiratory failure w/hypoxia (1), risk for malnutrition (1)
- Nursing CMG = LBC1 CMI = 1.43
 - Parkinson's disease
 - Function Score = 12
 - PHQ9© = 4

Example Resident – PDPM (Day 1-3)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	66.06	x	1.55	x		x	1.00	=	\$102.39
OT	\$61.49	x	1.55	x		x	1.00	=	\$95.31
SLP	\$24.66	x	2.85	x		x		=	\$70.29
NTA	\$86.88	x	1.85	x		x	3.00	=	\$482.19
Nursing	\$114.15	x	1.43	x	1.00	x		=	\$163.23
Non-Case-Mix Component	\$103.12	x		x		x		=	\$103.12
							Total	=	\$1016.53

Example Resident – PDPM (Day 4-20)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	66.06	x	1.55	x		x	1.00	=	\$102.39
OT	\$61.49	x	1.55	x		x	1.00	=	\$95.31
SLP	\$24.66	x	2.85	x		x		=	\$70.29
NTA	\$86.88	x	1.85	x		x	1.00	=	170.73
Nursing	\$114.15	x	1.43	x	1.00	x		=	\$163.23
Non-Case-Mix Component	\$103.12	x		x		x		=	\$103.12
							Total	=	\$695.07

Example Resident – PDPM (Day 21 -27)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	66.06	x	1.55	x		x	0.98	=	\$100.34
OT	\$61.49	x	1.55	x		x	0.98	=	\$93.39
SLP	\$24.66	x	2.85	x		x		=	\$70.29
NTA	\$86.88	x	1.85	x		x	1.00	=	\$160.73
Nursing	\$114.15	x	1.43	x	1.00	x		=	\$163.23
Non-Case-Mix Component	\$103.12	x		x		x		=	\$103.12
							Total	=	\$691.10

Example Resident – PDPM (Day 28 - 30)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	66.06	x	1.55	x		x	0.96	=	\$98.29
OT	\$61.49	x	1.55	x		x	0.96	=	\$91.49
SLP	\$24.66	x	2.85	x		x		=	\$70.29
NTA	\$86.88	x	1.85	x		x	1.00	=	160.73
Nursing	\$114.15	x	1.43	x	1.00	x		=	\$163.23
Non-Case-Mix Component	\$103.12	x		x		x		=	\$103.12
							Total	=	\$687.25

Example Resident – PDPM 30 Days

Day 1-3	=>	3 days	@	\$1,016.53
Day 4-20	=>	17 days	@	\$695.07
Day 21-27	=>	7 days	@	\$691.10
Day 28-30	=>	3 days	@	\$687.25

Medicare Huddle: PDPM from Start to Finish

- Pre-admission assessment
 - Primary reason for the SNF Stay
 - Surgery?
 - Start NTA capture
- First 24 hours
 - Thorough admission assessments by discipline
 - Start evaluating diagnoses
 - Missing diagnoses? (e.g., morbid obesity)
 - Need more detail? (“unspecified”)
 - Preliminary rate estimate
- Within 72 hours
 - Finalize ARD decision
 - Finalize primary reason for the SNF stay
 - Collaboratively code GG
 - Continue to finalize diagnoses
 - Schedule interviews
 - Preliminary rate estimate
- ARD Review
- Ongoing stay
 - Monitor need for IPA
 - Monitor outcomes progress