Introduction to PDPM for the Business Office

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The Patient Driven Payment Model (PDPM) is a new case-mix classification system for classifying skilled nursing facility (SNF) patients in a Medicare Part A covered stay into payment groups under the SNF Prospective Payment System. Beginning October 1, 2019, PDPM will replace the current case-mix classification system, the Resource Utilization Group, Version IV (RUG-IV).

PDPM is intended to improve the overall accuracy and appropriateness of SNF payments by classifying patients based on specific, data-driven patient characteristics, while also reducing administrative burden on SNF providers.

The transition between RUG-IV and PDPM will be a "hard" transition, meaning that the two systems will not run concurrently. All days of service on or prior to September 30, 2019 will be billed under RUG-IV and all days of service beginning October 1, 2019 will be billed under PDPM.

PDPM makes no changes as to what constitutes a skilled level of care for coverage Medicare A. There is no change in the requirements for the Notice of Medicare Non-Coverage (NOMNC), Advance Beneficiary Notice (ABN) or denial letter policies.

PDPM rates will be adjusted to reflect the Value-Based Purchasing (VBP) adjustment factor for your facility. A reduction in the market basket adjustment will occur if your facility fails to report data required due to the SNF Quality Reporting Program (QRP).

How PDPM Determines Payment: The PDPM classification methodology utilizes a combination of six payment components to derive payment. Five of the components are case-mix adjusted to cover utilization of SNF resources that vary according to patient characteristics. These groups include Physical Therapy, Occupational Therapy, Speech Language Therapy, Nursing and Non-Therapy Ancillary. There is also an additional non-case-mix adjusted component to address utilization of SNF resources that do not vary by patient.

Different patient characteristics are used to determine a patient's classification into a case-mix group (CMG) within each of the five case-mix adjusted payment components. An adjustment is applied to certain components, which will vary the per diem payment over the course of the stay. This adjustment factor is called the variable per diem (VPD) adjustment. PT, OT and NTA payment components are subject to a VPD adjustment. There are two distinct VPD adjustment schedules and factors; one for both the PT and OT components and one for the NTA component.

For each component, once a patient has been classified into a group, the case-mix index (CMI) for that group is multiplied by the component base rate. Next, that product is multiplied by the applicable per diem adjustment factor to determine the case-mix adjusted payment associated with each of these payment components for each utilization day under PDPM. The payment for each case-mix adjusted components are then added together along with the non-case-mix component payment rate to create a patient's total SNF PPS per diem rate under the PDPM.

PDPM Assessment Schedule: There will 3 SNF PPS assessments under PDPM: the 5-day Assessment, the Interim Payment Assessment (IPA), and the PPS Discharge Assessment. The 5-day assessment and the PPS Discharge Assessment are required. The IPA is optional. It will be completed when the patient has undergone a clinical change that would require a new PPS assessment.

The 5-day Assessment will pay for all covered Part A days until the Part A discharge (except in cases when an IPA is completed). The IPA will pay for all days from the ARD of the IPA through the part A discharge (unless another IPA assessment is completed).

During the changeover from RUG-IV to PDPM, all current SNF patients who were admitted prior to the PDPM effective date (October 1, 2019) must receive a new Interim Payment Assessment (IPA) under the PDPM, even if they were already assessed under RUG-IV. This is required in order to obtain a Health Insurance Prospective Payment System (HIPPS) code for billing purposes.

ICD-10 Coding: There are two ways in which ICD-10 codes will be used under PDPM. First, providers will be required to report on the MDS the patient's primary diagnosis for the SNF stay. Each primary diagnosis is mapped to one of ten PDPM clinical categories, representing groups of similar diagnosis codes, which is then used as part of the patient's classification under the PT, OT, and SLP components.

ICD-10 codes are used to capture additional diagnoses and comorbidities that the patient has. These can factor into the SLP comorbidities for classification of patients under the SLP component. The codes are also used for determination of the NTA comorbidity score that is used to classify patients under the NTA component. The ICD-10 to clinical category mapping that will be used under PDPM is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.

Interrupted Stay Policy: The Interrupted Stay Policy is being introduced alongside the Patient Driven Payment Model. This sets out criteria for determining when Medicare will treat multiple SNF stays occurring in a single Part A benefit period as a single "interrupted" stay, rather than separate stays, for the purposes of the assessment schedule and the variable per diem payment schedule.

When the stay is considered "interrupted" under the Interrupted Stay Policy, both the assessment schedule and the variable per diem payment schedule continue from the point just prior to discharge. When the stay is not considered interrupted, both the assessment schedule and the variable per diem rate reset to Day 1, as it would in a new stay.

An "interrupted" stay is one in which a patient is discharged from Part A SNF care and subsequently readmitted under the following TWO conditions:

- The patient returns to Part A care in the *same* SNF (not a different SNF); *AND:*
- The patient returns within *3 days or less* (the "interruption window")

If both conditions are met, the subsequent stay is considered a continuation of the previous "interrupted" stay. This would mean that the variable per diem schedule continues from the day of the previous discharge. For example, if patient was discharged on Day 7, payment rates resume at Day 7 upon readmission. The assessment schedule continues from the day of the previous discharge. No new 5-day assessment is required. However, an optional IPA may be completed at clinician's discretion

If the patient is readmitted to the same SNF more than 3 consecutive calendar days after discharge, OR in any instance when the patient is *admitted to a different SNF* (regardless of time between stays), then the Interrupted Stay Policy does not apply and the subsequent stay is considered a new stay. This would mean that a new 5-day assessment is required and that the variable per diem schedule resets to Day 1.

Billing for PDPM: Providers will bill for services under PDPM using the Health Insurance Prospective Payment System (HIPPS) code that is generated from assessments with an ARD on or after October 1, 2019. The HIPPS code under PDPM is still a five character code, as under RUG-IV. However, under RUG-IV, the first three characters represent the patient's RUG classification and the last two characters are an assessment indicator (AI) code, to represent the assessment used to generate the patient classification. Under PDPM, the first character of the HIPPS code represents the patient's PT component and OT component classification. The second character represents the patient's SLP component classification. The third character represents the patient's nursing component classification. The fourth character represents the patient's NTA component classification. The fifth character represents the AI code.

The default code under PDPM, which may be used in cases where an assessment is late, is ZZZZZ. The default code under PDPM represents the sum of the lowest per diem rate under each PDPM component, plus the non-case-mix component. In cases where the default code is used, the variable per diem schedule must still be followed.

This overview is based upon information currently available from CMS at the time of publication. For additional details on the Patient Driven Payment Model, please visit the CMS PDPM information page at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.