Medicare 101

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Draft MDS 3.0 Item Set 1.20.1
Draft MDS 3.0 Matrix 1.20.1

MDS Updates 2025

Major Changes to Item Set(s)
Retire: A1250 Transportation
Add: O0390 Therapy Service
(15 minutes a day 1 or more days in last 7 days)
Retire: O0400
PT/OT/SLP/Psychological/Recreational & Restorative minutes
Add Section R Health-Related Social Needs
Living Situation, Food, Utilities, Transportation

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What is Medicare?

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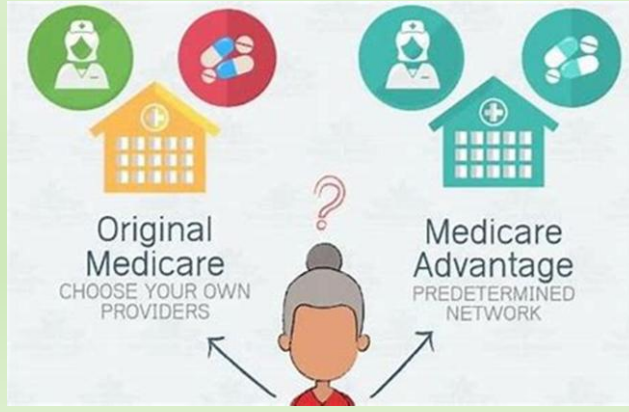
Types of Medicare Plans

Medicare Part A: covers inpatient/ hospital care.
Medicare Part B: covers outpatient/ medical care.
Medicare Part C (Medicare Advantage): A private insurance product that combines part A & B with additional benefits.
Medicare Part D: Provides prescription drug coverage.

Medicare Cost Plans: A type of health plan (private insurance company with federal contract) that includes both part A & B coverage. Only available in 11 states (2020)



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Medicare Eligibility

65 years of age or older and eligible for Social Security or Railroad benefits

65 year old spouse of someone eligible

Disabled and collecting Social Security or Railroad Retirement benefits for 24 months (5 month wait period)

Medicare Eligibility

Received continuous dialysis for permanent kidney failure (3 month waiting period)*

Receiving a kidney transplant*

Individuals with ALS

*any age

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Enrollment

Automatic for many Medicare eligible beneficiaries

Others should apply 3 months prior to age 65 or 4 months after

Part A is premium free
Part B premium based

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Medicare Part A & B Late Enrollment Penalty

Part A

Pay 10% extra if you don't buy Part A when first eligible.

Pay higher premium each month for twice the number of years you could have signed up for Part A (but did not).

Part B

Pay 10% each year you could have signed up for Part B but did'nt.
Penalty is added to the beneficiary's monthly Part B premium.
Penalty is paid for as long as you have Part B.
Generally, a beneficiary does not have to pay a penalty if they qualify for a working,l Enrollment Period. To qualify, you (or your spouse) must still be working and you must have health coverage based on that job.

https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/what-does-medicare-cost

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Medicare Part D Late Enrollment Penalty

Don't join a Medicare drug plan when you first get Medicare,

AND

go 63 days or more without creditable drug coverage (coverage that is similar in value to Part D).

Pay an extra 1% for each month (12% a year) you could have signed up for Part D and did not.
Penalty is added to the monthly premium.
Pay penalty for as long as you have Part D coverage even if you change plans.
You won't have to pay a penalty if you have a creditable drug coverage or if you qualify for Extra Help.

Effective Date

Medicare becomes effective, if enrolled, the 1st day of the month in which beneficiary turns 65

If birthday falls on 1st of the month, benefit begins 1st of previous month

Medicare Open Enrollment

October 15, 2025 and ends December 7, 2025
Effective January 1, 2026
During this time people can review coverage options such as traditional Medicare, Medicare Advantage and Part D RX drug plan.
People with Medicare should look at their coverage choices annually and decide on the best options to meet their needs.

1-800-Medicare or Medicare.gov

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Medicare Savings Programs

A program for low-income seniors and adults with disabilities may qualify to receive financial assistance from the Medicare Savings Programs (MSPs).

Helps people access healthcare a reduce cost. Helps pay Medicare premiums, Medicare deductibles, coinsurance and copayments if they meet eligibility.

It allows people to spend money on other vital needs, including food, housing, or transportation.

Qualified Medicare Beneficiary (QMB) Program
Specified Low-Income Medicare Beneficiary (SLMB)
Qualifying Individual (QI) Program
Qualitied Disabled & working individual (QDWI) Program

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Medicare Savings Programs

Qualified Medicare Beneficiary (QMB) Program- helps pay for Part A premiums, Part B premiums, deductibles, coinsurance, and copayments for services & items Medicare covers).

Qualified Medicare Beneficiary (QMB) Program		
Situation	Monthly income limit	Resource limit
Individual	1,275	9,439
Married Couple	1,724	14,130

Medicare providers aren't allowed to bill you for services and items Medicare covers, including deductibles, coinsurance, and copayments. What should I do if I get a bill?
You may get a bill for a small Medicaid copayment, if one applies.
You'll also get Extra Help paying for your prescription drugs. You'll pay no more than $11.20 in 2024 for each drug covered by your Medicare drug plan.

https://www.medicare.gov/basics/costs/help/medicare-savings-programs

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Medicare Savings Programs

Specified Low-Income Medicare Beneficiary (SLMB) Program helps pay for Part B premiums (Must have Part A & Part B to quality)

Specified Low- Income Medicare Beneficiary (SLMB) Program		
Situation		
Individual	1,526	9,430
Married Couple	2,064	14,130

If you qualify for the SLMB Program:

You'll also get Extra Help paying for your prescription drugs.
You'll pay no more than $11.20 in 2024 for each drug your Medicare drug plan covers.

Medicare Savings Programs

Qualifying Individual (QI) Program- helps pay for Part B premiums (must have Part A & Part B to quality).

Qualifying Individual (QI) Program		
Situation		
Individual	1,715	9,430
Married Couple	2,320	14,130

If you qualify for the QI program:

You must apply every year to stay in the QI Program.
States approve applications on a first-come, first-served basis – priority is given to people who got QI benefits the previous year.
You'll also get Extra Help paying for your prescription drugs. You'll pay no more than $11.20 in 2024 for each drug your Medicare drug plan covers
QI is only available for people who don't qualify for any other Medicaid coverage or benefits, but you may qualify for help from another Medicare Savings Program.

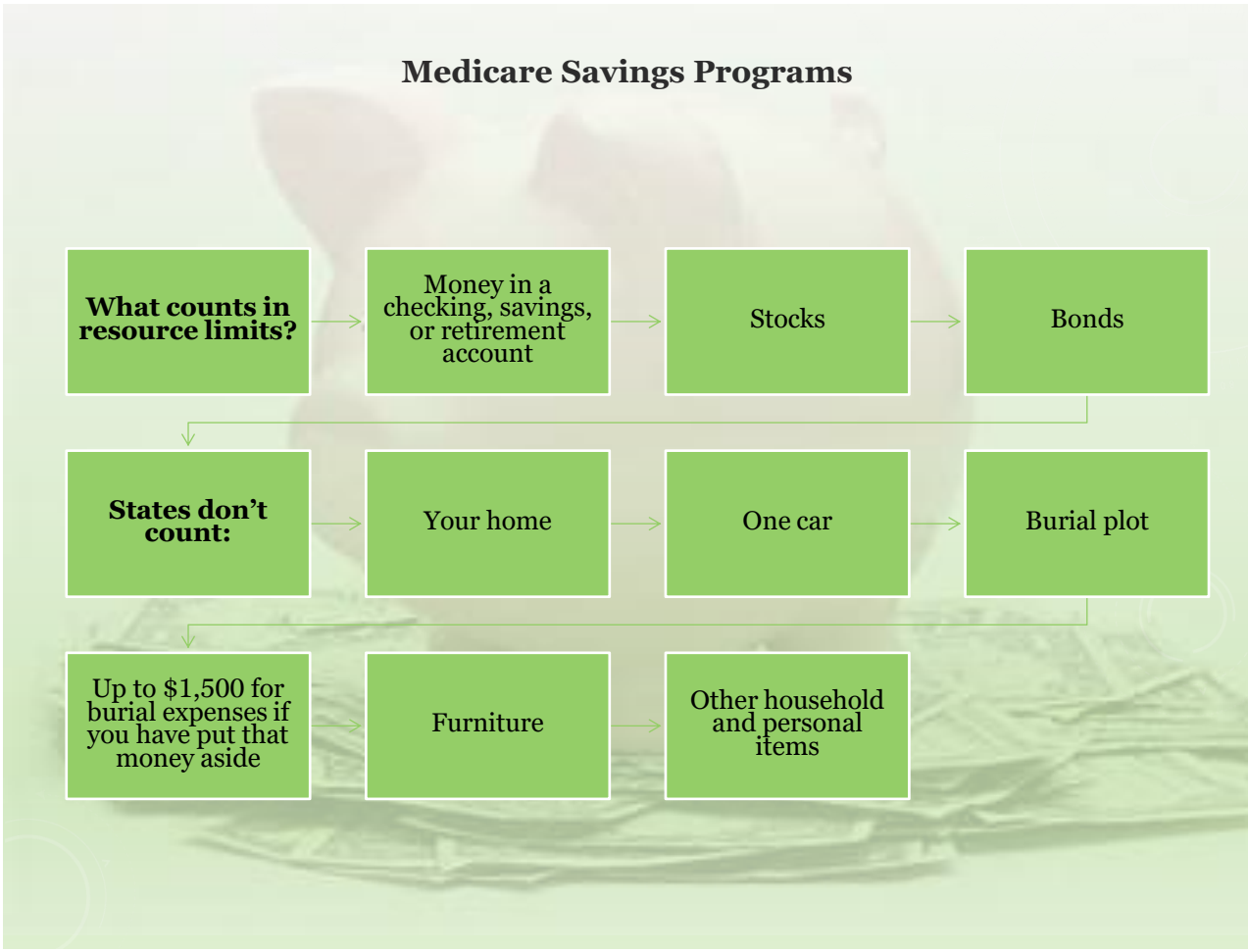
Medicare Savings Programs

Qualitied Disabled & working individual (QDWI) Program- helps pay for Part A premiums only.

Qualified Disabled & Working Individual (QDWI) Program		
Situation		
Individual	5,105	4,000
Married Couple	6,899	6,000

https://www.medicare.gov/basics/costs/help/medicare-savings-programs

Medicare Savings Programs



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Medicare Saving Program New 2025

$2,000 cap

All Medicare plans will include a $2,000 cap on what beneficiaries pay out-of-pocket for prescription drugs covered by your plan.

If the beneficiary's quality for one of the three main Medicare Savings Programs (MSPs), your Medicare Part B monthly premium will no longer be deducted from their Social Security check, and you will automatically get extra help for Part D prescription drug cost.

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Part A Coverage

Inpatient hospital care

Inpatient SNF care

Hospice Care

Home Health Services

Inpatient care in a religious nonmedical health care institution (religious beliefs prohibit conventional & unconventional medical care)

Definitions

Coinsurance is a percentage of your medical and drug costs you may be required to pay as your share of costs for medical services or supplies.

Copayment is a specific dollar amount you may be required to pay as your share of the cost for medical services or supplies (for example, a $10 copay for a healthcare provider visit).

Deductible is the amount you pay for medical services or prescription drugs in a plan year before your plan begins to pay for benefits.

Premium is the amount you are required to pay each month to Medicare or your private insurer for your healthcare coverage.

Accepting Assignment is when the provider accepts the Medicare-approved amount as full payment.

Part A Cost in 2025

2025 Premium free if beneficiary or spouse paid Medicare taxes for at least ten years (40 quarters) while working (99% of beneficiaries)

If beneficiary is not eligible for Premium free Part A monthly premium may be purchased.

https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/what-does-medicare-cost

https://www.cms.gov/newsroom/fact-sheets/2025-medicare-parts-b-premiums-and-deductibles

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Part A Cost Hospital 2025

$1,676 deductible and no co-insurance for days 1-60 each benefit period

$419 for days 61-90 coinsurance

$838 days 91-and beyond (150 days) coinsurance called "lifetime reserve days" up to 60 days over beneficiary lifetime.

After day 150 is the beneficiaries' responsibility

20% of the Medicare approved amount for mental health you get from providers while you're a hospital inpatient.

Inpatient mental health care in a psychiatric hospital limited to 190 days in a lifetime.

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Part A Deductible/Co-insurance

	2022	2023	2024	2025
Inpatient Hospital Deductible	$1,556	$1,600	$1,632	1,676
Daily coinsurance for 61-90 day	$389	$400	$408	$419
Daily coinsurance for lifetime reserve days	$778	$800	$816	$838
SNF coinsurance daily (days 21-100)	$194.50	$200.00	$204	$209.50

Costs | Medicare

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PART A COST – SNF 2025

$0 for first **20 days** each benefit period
$209.50 for days 21 -100 each benefit period
All costs for each day after day 100 in a benefit period

May have other insurance to pay deductible
- Medigap
- Dual Eligible: Medicaid

SNF Care Coverage (medicare.gov)

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Part A SNF coverage

Medicare-covered services in a skilled nursing facility include, but aren't limited to:

A semi-private room (a room you share with other patients)
Meals
Skilled nursing care
*Physical therapy
*Occupational therapy
*Speech-language pathology services
Medical social services
Medications
Medical supplies and equipment used in the facility
Ambulance transportation (when other transportation endangers your health) to the nearest supplier of needed services that aren't available at the SNF.
Dietary counseling

*if needed to meet your health goal

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Home Health Part A Cost 2025

$0 for home health care services
20% of Medicare approved amount for DME

Eligibility: part-time or intermittent skilled services and are “homebound”
Homebound means trouble leaving home without help because of injury or illness, cannot leave home because it is not recommended because of a condition, or it is a major effort to leave.

Medicare A &B home health covers:

Part time/intermittent skilled nursing care,
PT/OT/ST,
Medical Social Services,
Part-Time/intermittent home health aide care- if receiving the skilled nurse or therapy at the same time.
Injectable OP drugs for women,
DME & medical supplies for use at home.

Does not pay for:

24 hour care,
meals,
homemaker services that are not related to the POC
custodial/personal care.

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Hospice Part A Cost 2025

$0 for hospice care

Copayment of up to $5 per Rx for outpatient RX drugs for pain and symptom mgt.

Copayment of 5% of the Medicare approved amount for inpatient respite care
No copayment when general inpatient or respite care.

Medicare does not pay for room & board when receiving hospice care at home or another facility such as a SNF

Certification of less than 6 months to live or less
IDT to have a written POC that meets the patient's need

Medicare payment makes daily payments based on 4 levels:
Routine home care, Continuous home care, Inpatient respite care, or Generally inpatient care.

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Part B Deductible & Coinsurance 2025

Premium $185.00
Deductible $257
Coinsurance 20% (if accepts assignment)
Lab $0 (for covered labs)

Beneficiaries whose full Medicare coverage Ended 36 months after a kidney transplant and do not have other insurance can elect To continue Part B coverage of immunosuppressive drugs by paying a premium.

Immunosuppressive drug premium is $110.40

Pay 20% of the cost for each Medicare-covered service or item after deductible is paid.

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2025 FULL Part B Coverage

Full Part B Coverage 2025

Beneficiaries file individual tax with modified adjusted gross income	File jointly with modified adjusted gross income	Income-related monthly adjustment amount	Total Monthly Premium Amount
</or= $106,000	</or= $212,000	$0	$185.00
>$106.00 & </or = $133,000	>$212,000 & </or = $266,000	$74.00	$259.00
>$133,000 & </or = $167,000	>$266,000 & </or = $334,000	$185.70	$370.00
>$167,000 & </or = $200,000	>$334,000 & </or = $400,000	$295.90	$480.90
>$200,000 & < $500,000	>$400,000 & < $750,000	$406.90	$591.90
>/or= $500,000	>/or= $750,000	$443.90	$628.90

Full Part B Coverage 2025

Married/lived with spouse at anytime during year, but file separate tax returns with modified adjusted gross income.	Income-related Monthly Adjustment Amount	Total Monthly Premium Amount
</= $106,000	$0	$185.70
> $106,000 &/< $394,000	$406.90	$591.90
>/= $394,000	$443.90	$628.90

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2025 Part B Immunosuppressive Drug Coverage Only

Part B Immunosuppressive Drug Coverage Only 2025			
Beneficiaries file individual tax with modified adjusted gross income	File jointly with modified adjusted gross income	Income-related monthly adjustment amount	Total Monthly Premium Amount
</or= $106,000	</or= $212,000	$0	$110.40
>$106.00 & </or = $133,000	>$212,000 & </or = $266,000	$73.60	$184.00
>$133,000 & </or = $167,000	>$266,000 & </or = $334,000	$184.10	$294.50
>$167,000 & </or = $200,000	>$334,000 & </or = $400,000	$294.50	$404.90
>$200,000 & < $500,000	>$400,000 & < $750,000	$404.90	$404.90
>/or= $500,000	>/or= $750,000	$441.70	$515.30

Married/lived with spouse at anytime during year, but file separate tax returns with modified adjusted gross income.	Income-related Monthly Adjustment Amount	Total Monthly Premium Amount
</= $106,000	$0	$110.40
> $106,000 &/< $394,000	$404.90	$515.30
>/= $394,000	$441.70	$552.10

2025 Medicare Part D Income-Related Monthly Adjustment Amounts

Medicare Part D Income-Related Monthly Adjustment Amounts 2025		
Beneficiaries file individual tax with modified adjusted gross income	File jointly with modified adjusted gross income	Income-related monthly adjustment amount
</or= $106,000	</or= $212,000	$0
>$106.00 & </or = $133,000	>$212,000 & </or = $266,000	$13.70
>$133,000 & </or = $167,000	>$266,000 & </or = $334,000	$35.30
>$167,000 & </or = $200,000	>$334,000 & </or = $400,000	$57.00
>$200,000 & < $500,000	>$400,000 & < $750,000	$78.60
>/or= $500,000	>/or= $750,000	$85.80

Married/lived with spouse at anytime during year, but file separate tax returns with modified adjusted gross income.	Income-related Monthly Adjustment Amount
</= $106,000	$0
> $106,000 &/< $394,000	$78.60
>/= $394,000	$85.80

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Medicare Part B

Physicians' services;

Home Health Care;

Services and supplies, including drugs and biologicals which cannot be self-administered, furnished incidental to physicians' services;

Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;

X-ray therapy, radium therapy and radioactive isotope therapy;

Surgical dressings, and splints, casts and other devices used for fractures and dislocations;

Durable medical equipment;

Prosthetic devices;

Braces, trusses, artificial limbs and eyes;

Ambulance services;

Some outpatient and ambulatory surgical services;

Some outpatient hospital services;

Some physical therapy services

*Clinical research

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Medicare Part B

Some occupational therapy;

Some outpatient speech therapy;

Comprehensive outpatient rehabilitation facility services;

Rural health clinic services;

Institutional and home dialysis services, supplies and equipment;

Ambulatory surgical center services;

Antigens and blood clotting factors;

Qualified psychologist services;

Therapeutic shoes for patients with severe diabetic foot disease;

Influenza, Pneumococcal, and Hepatitis B vaccine;

Some mammography screening; Some pap smear screening, breast exams, and pelvic exams;

Some other preventive services including colorectal cancer screening, Diabetes training tests, bone mass measurements, and prostate cancer screening.

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Medicare Part B Mental Health (Outpatient) coverage

One depression screening per year. You must get the screening in a primary care doctor's office or primary care clinic that can provide follow-up treatment and referrals.

Individual and group psychotherapy with doctors (or with certain other Medicare-enrolled licensed professionals, as the state where you get the services allows).

Family counseling, if the main purpose is to help with your treatment.

Testing to find out if you're getting the services you need and if your current treatment is helping you. Psychiatric evaluation.

Medication management.

Certain prescription drugs that aren't usually "self administered" (drugs you would normally take on your own), like some injections.

Diagnostic tests.

Partial hospitalization.

Intensive outpatient program services.

Mental health services you get as part of substance use disorder treatment.

A one-time "Welcome to Medicare" preventive visit. This visit includes a review of your possible risk factors for depression.

A yearly "Wellness" visit. Talk to your doctor or other health care provider about changes in your mental health since your last visit

https://www.medicare.gov/coverage/mental-health-care-outpatient

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Mental health care (intensive outpatient program services)

Once-weekly therapy or counseling and inpatient psychiatric care. More rigorous than the doctor's or therapist's office and may include group and individual therapy sessions.

Must participate in at least 9 hours of services per week.

Setting: hospital, community mental health center, Federally qualified health center or rural health clinic.

Pay % of Medicare-approved amount

After Part B deductible, pay coinsurance for each day of intensive outpatient program service in hospital or community mental health center.

Part B coverage

Insulin Pump
If the insulin pump is covered under the DME benefit:
Insulin for the pump cannot be more than $35 monthly
If it is a 3 month supply- cannot be more than $35 dollars a month or $105 for 3 months
Part B deductible won't apply

Continuous Glucose Monitors
To qualify for a continuous glucose monitor you must:
Have diabetes mellitus.
Take insulin or have a history of problems with low blood sugar.
Have a prescription for testing supplies and instructions on how often to test your blood glucose.
Have been trained (or had your caregiver trained) to use a continuous glucose monitor as prescribed by your doctor.
•Make routine in-person or Medicare-approved telehealth visits with your doctor.

What Part B covers | Medicare

Medicare Part B Exclusions

Services which are not reasonable or necessary;

Custodial care/Long-term care;

Personal comfort items and services;

Care which does not meaningfully contribute to the treatment of illness, injury, or a malformed body member;

Prescription drugs which do not require administration by a physician;

Routine physical checkups;

Eyeglasses or contact lenses in most cases

Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses;

Hearing aids and examinations for hearing aids;

Immunizations except for influenza, pneumococcal and hepatitis B vaccine;

Cosmetic surgery;

Most dental services/ dentures;

Routine foot care;

Acupuncture

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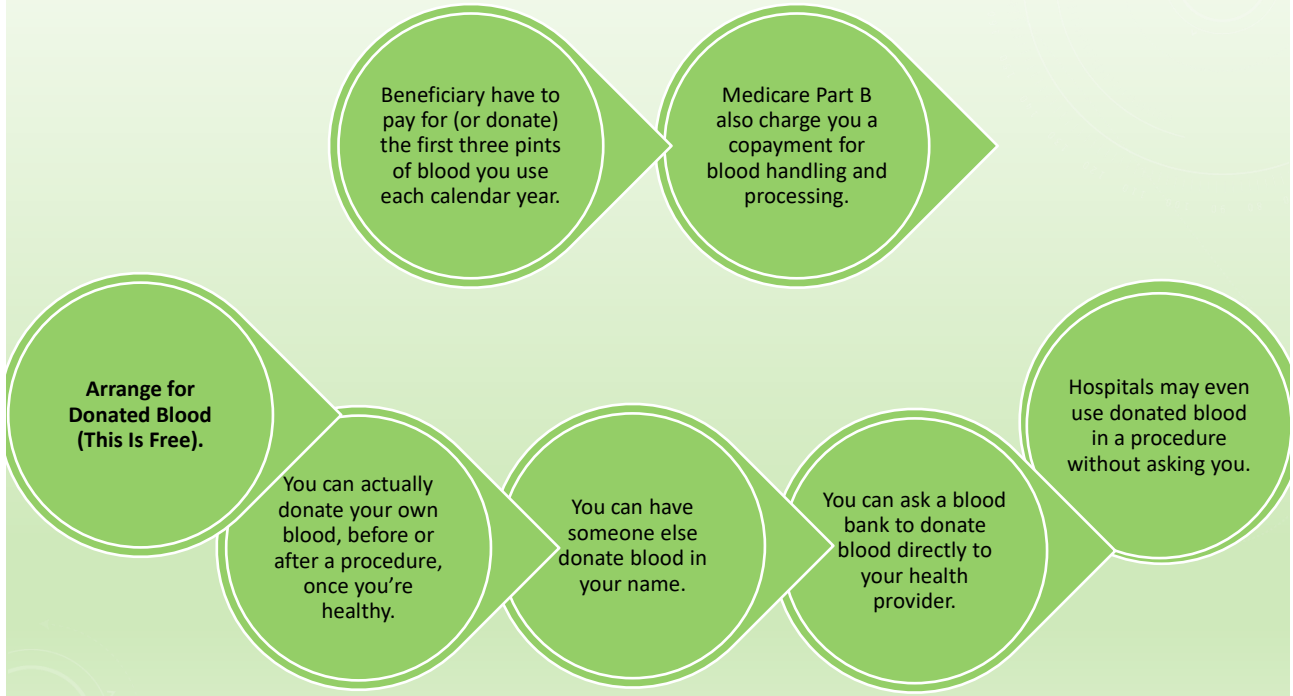
Blood Products and Medicare Coverage



https://www.medicare.gov/coverage/blood

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Hospital Stay

Count day of hospital admission

Do not count day of discharge

Must be inpatient status, not observation

Day of hospital discharge must occur after effective date of Medicare

Verify hospital status

https://wayback.archive-it.org/2744/20111028043116/https://www.cms.gov/mlnmattersarticles/2004mma/itemdetail.asp?itemid=CMS051325

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Observation Stays

Does NOT count towards the 3-day qualifying stay

What does that mean to the Beneficiary?

Per-service line

The total copayment for all outpatient services may exceed the inpatient hospital deductible.

Why Observation Stays??????

A primary motivation for hospitals' increasing use of observation status has been concern about the Recovery Audit Contractor (RAC) program. If the RAC or another Medicare reviewer determines that a patient has been incorrectly classified as an inpatient, the hospital is denied reimbursement for most services provided to the patient, even though the services were medically necessary and coverable by Medicare.

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Psychiatric Stays

Skilled observation and assessment may also be required for patients whose primary condition and needs are psychiatric in nature or for patients who, in addition to their physical problems, have a secondary psychiatric diagnosis. These patients may exhibit acute psychological symptoms such as depression, anxiety or agitation, which require skilled observation and assessment such as observing for indications of suicidal or hostile behavior. However, these conditions often require considerably more specialized, sophisticated nursing techniques and physician attention than is available in most participating SNFs.

(SNFs that are primarily engaged in treating psychiatric disorders are precluded by law from participating in Medicare.) Therefore, these cases must be carefully documented.

Medicare Benefit Policy Manual
Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance Page 9 & 30

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SNF Medicare A (PPS) Criteria

Technical

Enrolled and days available
3-day qualifying hospital stay
Admission w/in 30 days (deferred treatment exception)

Skilled Need

Need and receives medically necessary skilled care on a daily basis – nursing or rehabilitation
Practical matter requires services as inpatient
Condition treated during hospital stay or arose while receiving SNF care

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What is Covered?

Skilled nursing care, skilled rehabilitation services and other goods and services.

PDPM does not change what is covered under the SNF Part A benefit, or what is not covered.

Must be a skilled service, daily basis, and be reasonable and necessary for the treatment of resident's particular illness or injury, based on the individual’s particular medical needs, and accepted standards of medical practice.

Medicare A Skilling Criteria

Services provided by a skilled professional, ordered by MD and care began while in the hospital

The resident requires these **skilled services on a daily basis**

As a practical matter, considering economy & efficiency, the daily skilled services can be **provided only on an inpatient basis in a SNF**

Services must be **reasonable and necessary**

Skilled Care Qualifier

- Reasonable and necessary
- Services are reasonable in regard to duration and quantity
- Keep in mind the Prior Level of Function

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Daily

Combination of Rehab/Nursing services required 7 days per week

Skilled rehab services provided 5 days/week meets the daily requirement definition

For restorative nursing, it is expected to be provided at least 6 days/week

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Practical Matter

Daily skilled can be provided only in a SNF if they are not available on an outpatient basis or transportation would be:

An excessive physical hardship
Less economical
Less efficient or effective than

https://www.cms.gov/sites/default/files/repo-new/29/SNFSpellIllnesschrt.pdf

Presumption of Coverage

Treatment continuation that was initiated during the hospital stay

Skilled level of care will be required at a pre-determined time frame

Resident begins care within that time frame

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html

Presumption of Coverage

Under Presumption of Coverage, only applies to Medicare A.

PDPM classifiers on the 5 day include:

Nursing: Extensive Services, Special Care High, Special Care Low, Clinically Complex categories.

PT/OT: TA, TB, TC, TD, TE TF, TG, TJ, TK, TN, TO

SLP: SC,SE, SF, SH, SI, SJ, SK, SL

NTA: uppermost 12+comorbidity group.

If a resident meets any of these 4 PDPM related criteria, they qualify for presumption of coverage.

Medical Predictability

Skilled services are normally initiated within 30 days after discharge from an inpatient hospital stay.

When specific criteria is met, an elapsed period of more than 30 days is permitted when the patient's condition makes it medically inappropriate to begin an active course of treatment in an SNF immediately after hospital discharge.

This exception applies only when the SNF care constitutes a continuation of care provided in the hospital and is applicable only when the treatment for a particular condition indicates that a covered level of SNF care will be required within a pre-determinable time frame.

Medical Predictability

To qualify for this exception it must be medically predictable **at the time of hospital discharge** that a covered level of SNF care will be required within a predictable period of time for the treatment of a condition for which hospital care was received and the patient must begin receiving such care within that time frame.

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Medical Predictability Documentation Example

It is medically predictable (in accordance with Pub 100-2, Chapter 8, 20.2.2.1) at the time of hospital discharge that a skilled level of nursing facility care will be required within a predictable period of time for the proper continuation of treatment for _____ with surgical repair initiated during the hospital stay and the patient will begin receiving such care within that time frame of _____ after hospital discharge, when weight bearing can be tolerated due to the medical predictability of the skilled therapy services needed for a fracture of this nature.

Benefit Period

Begins with initial qualifying hospital stay

Ends after 60 consecutive days facility free or stays in SNF & does not receive skilled services

New benefit period starts with new 3-day hospital stay

No limits on new benefit periods

Not related to: calendar year, diagnosis or exhaustion of benefits

Benefit Period End

At least 60 consecutive days in which the resident had no inpatient hospital admission

At least 60 consecutive days without receiving a skilled level of care in a SNF

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Benefit Period

60 days in non-certified bed does not end benefit period if resident remains at skilled level of care

Hospital stay for “new” or different diagnosis does not begin new benefit period

Once beneficiary uses up 100 part A days no more SNF benefits are available until one benefit period ends and resident qualifies for a new benefit period

Benefit Period

Home Health has no bearing on the benefit period

"Old" vs. "new" tube feeding is not a deciding factor as long as not in a skilled setting (ALF, Home)

Diagnosis is not deciding factor

Part B services 5x/wk does impact benefit periods. Less than 5 days does **not** impact benefit period

How Does CMS Know About Benefit Periods?

Claims sent to CMS by Billing determine if the resident is skilled or not

- No pay claims

Check the common working file or C-Span or C-Snap
Usually done by corporate, billing office, etc.

Somebody in the building MUST be checking this file

Common Working File

Is not always accurate

- Updated based on claims reviewed
- CWF information is just one piece of the "puzzle"
- Should be checked more than once! At least every 2-4 weeks for entire stay
- Need to conduct Prior Stay Investigation

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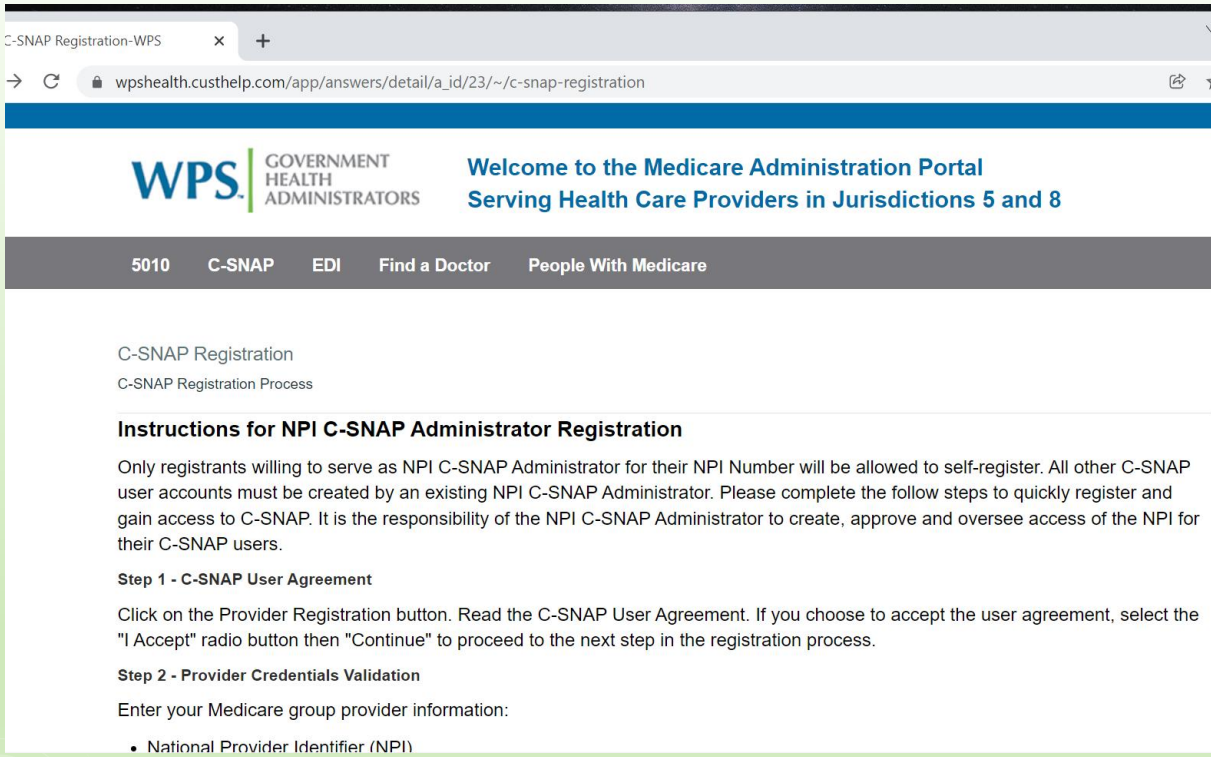
C-SNAP Registration-WPS
wpshealth.custhelp.com/app/answers/detail/a_id/23/~/c-snap-registration
WPS GOVERNMENT HEALTH ADMINISTRATORS
Welcome to the Medicare Administration Portal
Serving Health Care Providers in Jurisdictions 5 and 8
5010 C-SNAP EDI Find a Doctor People With Medicare
C-SNAP Registration
C-SNAP Registration Process
Instructions for NPI C-SNAP Administrator Registration
Only registrants willing to serve as NPI C-SNAP Administrator for their NPI Number will be allowed to self-register. All other C-SNAP user accounts must be created by an existing NPI C-SNAP Administrator. Please complete the follow steps to quickly register and gain access to C-SNAP. It is the responsibility of the NPI C-SNAP Administrator to create, approve and oversee access of the NPI for their C-SNAP users.
Step 1 - C-SNAP User Agreement
Click on the Provider Registration button. Read the C-SNAP User Agreement. If you choose to accept the user agreement, select the "I Accept" radio button then "Continue" to proceed to the next step in the registration process.
Step 2 - Provider Credentials Validation
Enter your Medicare group provider information:
National Provider Identifier (NPI)

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Inpatient Acute Rehabilitation

The patient's physician certifies that inpatient hospitalization for rehabilitation is medically necessary; and

The patient requires a **relatively intense**, **multidisciplinary** rehabilitation program; and

The rehabilitation program is provided by a **coordinated**, multidisciplinary **team**; and

The goal of the rehabilitation program is to upgrade the patient's ability to function as independently as possible; and

The care is provided in a Medicare certified facility which has 24 hour a day availability of a physician.

The care must be reasonable and necessary and not actually available at a lower level of care

Medicare Hospital Days are billed while in Acute Rehab

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CONSOLIDATED BILLING

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SNF Consolidated Billing

Latest Website:

https://www.cms.gov/medicare/coding-billing/skilled-nursing-facility-snf-consolidated-billing

https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update

https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/consolidated-billing

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Outpatient Exclusions

Major Category	Services	Included or Excluded	Place of Service Exclusions	Other
Beyond the Scope of a SNF	Computerized tomography (CT) scans, Cardiac Catheterization, Magnetic resonance imaging (MRI), Radiation Therapy, Angiography, Lymphatic, Venous, and Related Procedures, Outpatient Surgery & Related Procedures, Emergency (ER) services, Medically necessary ambulance for services within this list, Services directly related to services within this list, Additional Surgery HCPCS	Excluded from Consolidated Billing (although outpatient surgery under I.F listed as inclusions on list of HCPCS/CPT codes)	Only excluded if provided at Hospital or Critical Access Hospital (CAH)	Outpatient surgery listed as inclusions on the list of HCPCS/CPT codes. Related services with same line item date of service as ER Revenue Code (045X) also excluded (append -ET modifier for related services provided on subsequent date(s)).Ambulance service excluded when associated with services in Major Category I.A-E and G or renal dialysis facility (RDF) services to patients with End Stage Renal Disease (ESRD).

Outpatient Exclusions

Major Category	Services	Included or Excluded	Place of Service Exclusions	Other
ESRD/Hospice	Dialysis, Erythropoietin (EPO), aranesp, other dialysis related services, Hospice care for terminal illness	Excluded from Consolidated Billing	Services under II.A only excluded if provided at a RDF	RDF services **only** excluded if provided to patients with ESRD. Hospice services only excluded if provided to patients who have elected hospice.

Outpatient Exclusions

Major category III

- Specific chemotherapy
- Radioisotope services
- Customized prosthetic devices
- Any Medicare provider with a license but the SNF

Major category IV

- Preventive & screening services

  Mammography, Pneumovac, Hepatitis B and Influenza vaccines, vaccine administration, colorectal screening, prostate cancer screening. Bill to Part B

*Bone Mass measurement is diagnostic not screening so it is bundled into Medicare A PPS payment and subject to consolidated billing.

HCPCS - General Information | CMS

https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS

Best Practices Guidelines | CMS

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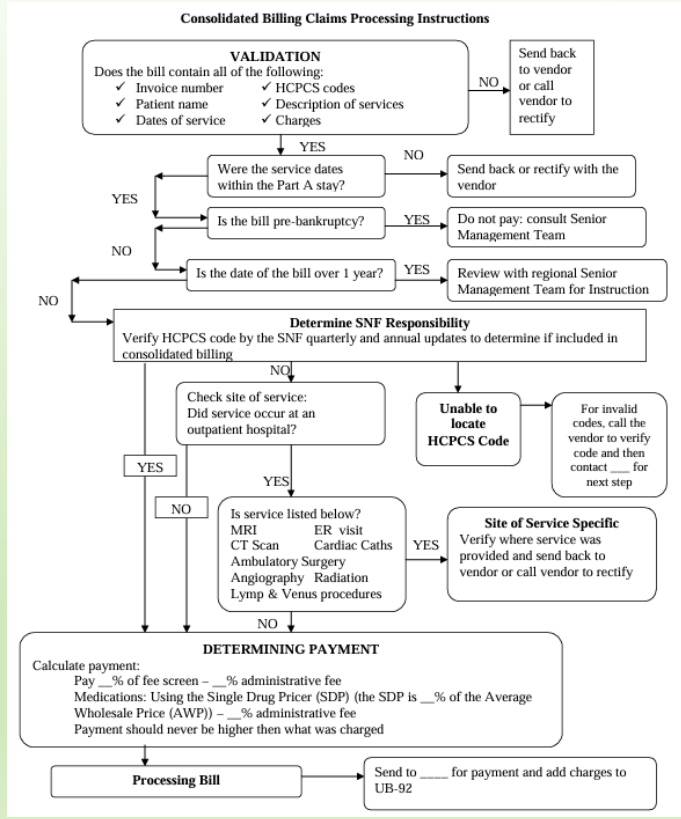
Outpatient Exclusions



https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/downloads/flowchart.pdf

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Therapy

Major Category V

Physical Therapy
Occupational Therapy
Speech Language Pathology

Included in Part A Reimbursement. Can be billed to Part B if not on Medicare A.

General/ Routine Items

DME
Medication
Lab Services
X-rays
Dental Care
Glasses and routine examinations
Hearing aides and examinations
Technical component of lab/diagnostic tests not otherwise excluded

Included in SNF rate/SNF responsible

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Ambulance Inclusions

Travel by ambulance must be the only safe means of transportation available. It is not sufficient that alternative transportation cannot be arranged. **It is necessary to show that the patient's health would have been jeopardized had he or she been transported any other way.**

Non-emergency transportation will only be covered if the ambulance supplier obtains a physician's certification indicating that ambulance transportation is necessary because other means of transportation are medically contraindicated.

The transportation must be provided by a Medicare-certified provider.

Never covers under Part A or B for ambulette, W/C van or litter van.

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Ambulance Service Covered by Medicare: Excluded from CB- Not the facility's responsibility

May be billed under Part B services by the supplier:

Trip from hospital to the SNF for admission

From the SNF to a Medicare-participating hospital or CAH for an inpatient admission.

From a skilled nursing facility after discharge to the beneficiary's home;

From a hospital to a skilled nursing facility;

To or from a hospital based or non-hospital based ESRD facility for dialysis treatment and related services excluded from consolidated billing.

Follows a formal discharge, or other departure from SNF to any destination other than another SNF and beneficiary does not return to that SNF or any other SNF before the following midnight.

To a hospital or CAH and back to the SNF for specific purpose of receiving emergency or other excluded services.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf
Medicare Claims Processing Manual (cms.gov)

SNF Responsible for Ambulance Services in Consolidated Billing

May NOT be billed as Part B services when a resident is in a Part A stay:

Transfers between two SNFs.

To/from a diagnostic or therapeutic site other than a hospital or renal dialysis facility (independent testing), cancer treatment center, radiation therapy center, wound care center, etc.)

Roundtrip to a physician office.

Other Ambulance Important Points

Medicare does not cover wheelchair van transportation.

Medicare usually does not pay for paramedic intercepts.

Medicare will not pay for transportation from the patient's home to the patient's physician office.

In non-emergency situations it is a good idea to ask whether the transportation will be covered *before* taking the trip.

Ambulance Important Points

In a non-emergency situation, if the ambulance provider believes that the transport may be denied coverage by Medicare, the provider must issue an Advance Beneficiary Notice (ABN) to notify the beneficiary of his/her potential financial responsibility for the transport. There are three questions to ask when determining if an ABN is required for an ambulance transport.

If the answer to all of the following is "yes," an ABN should be issued:

Is this service a Medicare-covered ambulance benefit?

AND

Will payment for part or all of this service be denied because it is not reasonable and necessary?

AND

Is the patient stable and the patient non-emergent?

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Ambulance Regulations

Prior Authorization of Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT)

Intent: Prior authorization helps ensure that all relevant clinical or medical documentation requirements are met before services are furnished to beneficiaries and before claims are submitted for payment. It further helps to ensure that payment complies with Medicare documentation, coverage, payment, and coding rules. Prior authorization also allows ambulance suppliers to address coverage issues prior to furnishing services.

Contact Us (wpsgha.com)

https://www.federalregister.gov/documents/2021/08/27/2021-18543/medicare-program-national-expansion-implementation-for-all-remaining-states-and-territories-of-the

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Prior-Authorization-of-Repetitive-Scheduled-Non-Emergent-Ambulance-Transport-

Prior Authorization of Repetitive, Scheduled Non-Emergent Ambulance Transport | CMS

AMBULANCE QUESTIONS

AMBULANCE
CMS REGIONAL OFFICE
CONTACT

KANSAS CITY (VII)
DOUGLAS DAVIS
(816) 426-6553
DOUGLAS.DAVIS@CMS.HHS.GOV
OR
FEEFORSERVICEQUESTIONS@CMS.HHS.GOV

PDPM reimbursement Impact

Nursing Isolation
Restorative Program
Respiratory
Diagnosis

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Nursing Isolation

To qualify for isolation, the patient must:

- Have a physician diagnosis of active infection that is documented
- Be placed in strict isolation and have over and above standard precautions
- They cannot be cohorted or have a roommate
- Must be confined to their room (cannot be moving around the facility)

- Isolation does not have to have occurred during the entire 14 day look back, just at some point during the lookback

- Observe and document disease symptoms every shift
- Include positive lab results in medical record
- Address isolation and include symptom observation and/or monitoring in the care plan

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Restorative Nursing Program

The following criteria for restorative nursing programs must be met in order to code O0500:

Measurable objective and interventions must be documented in the care plan and in the medical record.

Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record.

Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.

A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Restorative nursing does not require a physician's order. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.

This category does not include groups with more than four residents per supervising helper or caregiver.

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What time can be included in Respiratory Therapy?

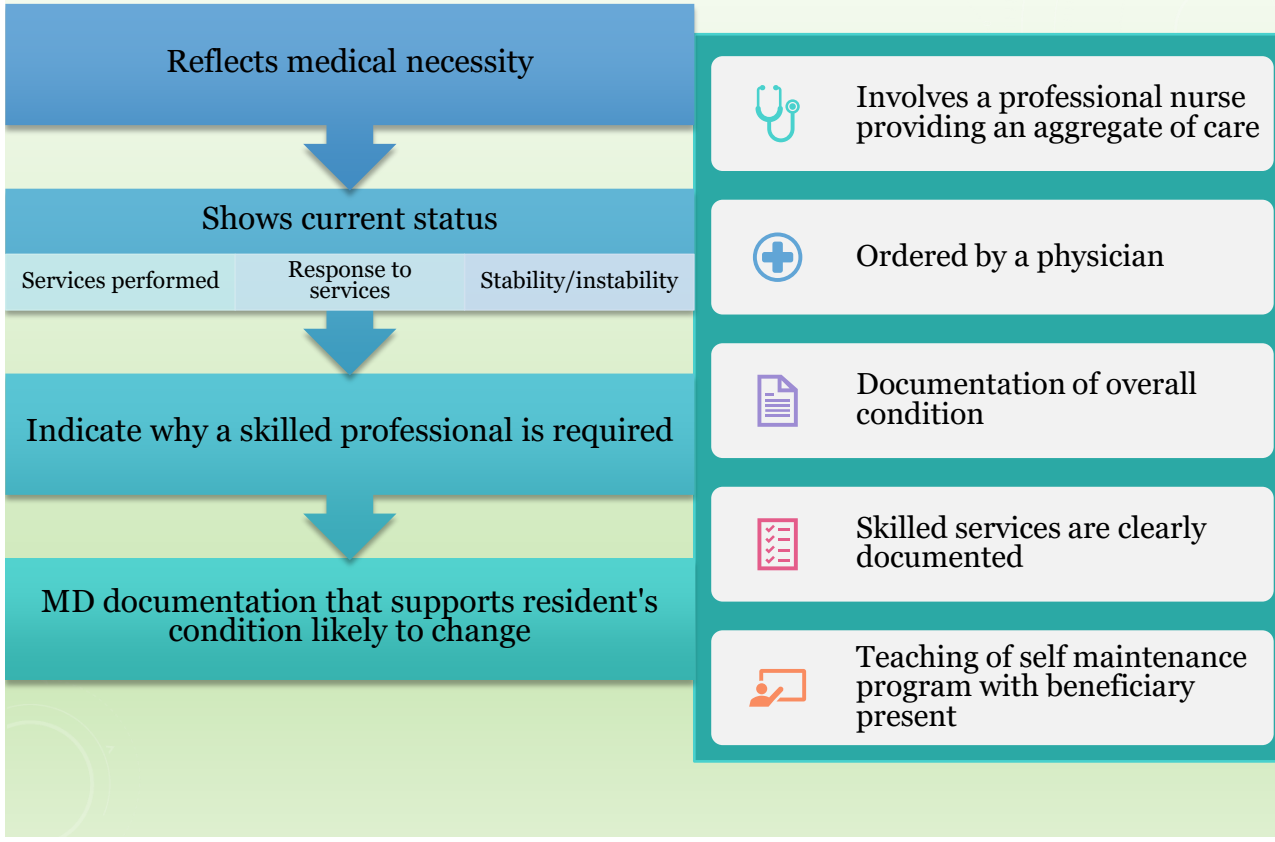
Only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment.

Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS.

Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes.

Documentation must include total minutes for each treatment.

Skilled Nursing



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Documentation must be FLAWLESS

What do we need to be assessing for and do we see it.

Documentation

The skilled services provided.
The response/reaction to the skilled services
Changes in behavior
Future plan of care (rationale for the need for skilled services due to the residents overall medical conditions and experiences)
Complexity of the services

Accurate, specific (avoid vague or subjective description of the resident's care).

Avoid non-skilled language like continue with POC, Resident remains stable, medication as ordered, treatment as ordered, resident tolerate treatment well. Monitoring.

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Skilled Nursing Specific Examples

Management and Evaluation of a Patient Care Plan
Record as a whole clearly establishes that there was a likely potential for serious complications without skilled management

Observation & Assessment of Resident's condition

Teaching and Training Activities

Need more than a "check box" assessment, what does the information/assessment mean

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Skilled Nursing Specific Examples

Management and Evaluation of a Patient Care Plan Record as a whole clearly establishes that there was a likely potential for serious complications without skilled management

New CVA with coumadin (serious complications of possible repeat CVA, excessive bleeding, unstable PT/INR. Interventions.

COPD exacerbation (SOB while laying flat, needs rest periods with ambulation or activities of daily living, new medication monitoring-steriods-inhalers, O2 monitoring, lung sounds, respiratory treatments), Interventions.

Wound with a wound vac (not a daily dressing change)- co-morbidities- Obesity, diabetic, steroid use, delay healing in past. High risk for dehydration, sepsis, hemorrhage, infection, fistula, wound complications, skin interventions, response to care.

Skilled Nursing Specific Examples

Observation & Assessment of Resident's condition

Observing & Assessing new ostomy/ileostomy for complications. Skin condition, output-frequency, contingency etc..

Observing & Assessing for S&S of hyper/hypoglycemia, fingerstick results, and post insulin reactions for a new diabetic. New orders.

Observing & Assessing for a resident who is newly incontinent- developing a toileting program, identifying the "why" for the incontinence, assessing medications that could affect incontinence, skin condition (MASD) due to incontinence. Response to toileting program.

Observing & Assessing post hip surgery, incision line, dressing changes, signs and symptoms of infection, pain, ADL care, safety,

Skilled Nursing Specific Examples

Teaching & Training

- Teaching self-administration of injectable medications or a complex range of medications; Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;
- Teaching self-administration of medical gases to a patient;
- Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;
- Teaching patients how to care for a recent colostomy or ileostomy;
- Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;
- Teaching patients how to care for and maintain central venous lines, such as Hickman catheters;
- Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and
- Teaching patients the proper care of any specialized dressings or skin treatments

Skilled Nursing Documentation

Observation and assessment factors & outcome evident

Identify need to observe/assess high risk or potentially high risk

Daily documentation of situation of high probability of an unstable condition

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Non-Skilling Words

Monitor

Watch

Stable

No problems

No changes

Custodial

Normal

Skilling Words

Observe

Assess

Unstable

Change in condition

Unstable condition

Fluctuating

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Documentation Importance

- MDS Assessments
- Reimbursement
- Quality of care
- Clinical care
- Nursing license

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What Else Should be Documented?

Section 30.2.2.1 of Chapter 8 of the Medicare Benefit Policy Manual states that SNF claims must include sufficient documentation that would allow a reviewer to determine such things as:

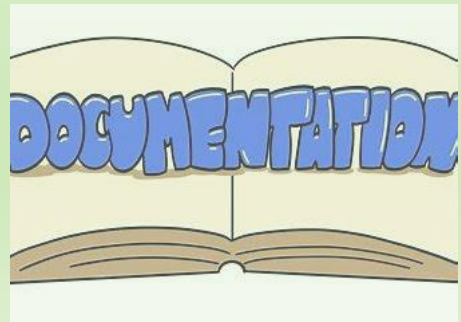
Skilled involvement is required in order for services to be furnished safely and effectively,

The services are reasonable and necessary for the treatment of a patient's/resident's illness or injury, i.e., consistent with…the individual's particular medical needs.

What else should be Documented (cont.)

PDPM does not change these documentation requirements, but rather strengthens the importance of documenting all aspects of a patient's/resident's care, consistent with PDPM's focus on a more holistic care model.

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.



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Physician Documentation

Signed transfer documentation or transfer form

History and Physical

Hospital discharge summary

Physician progress notes, consultation notes

Physician orders

Certs and recerts

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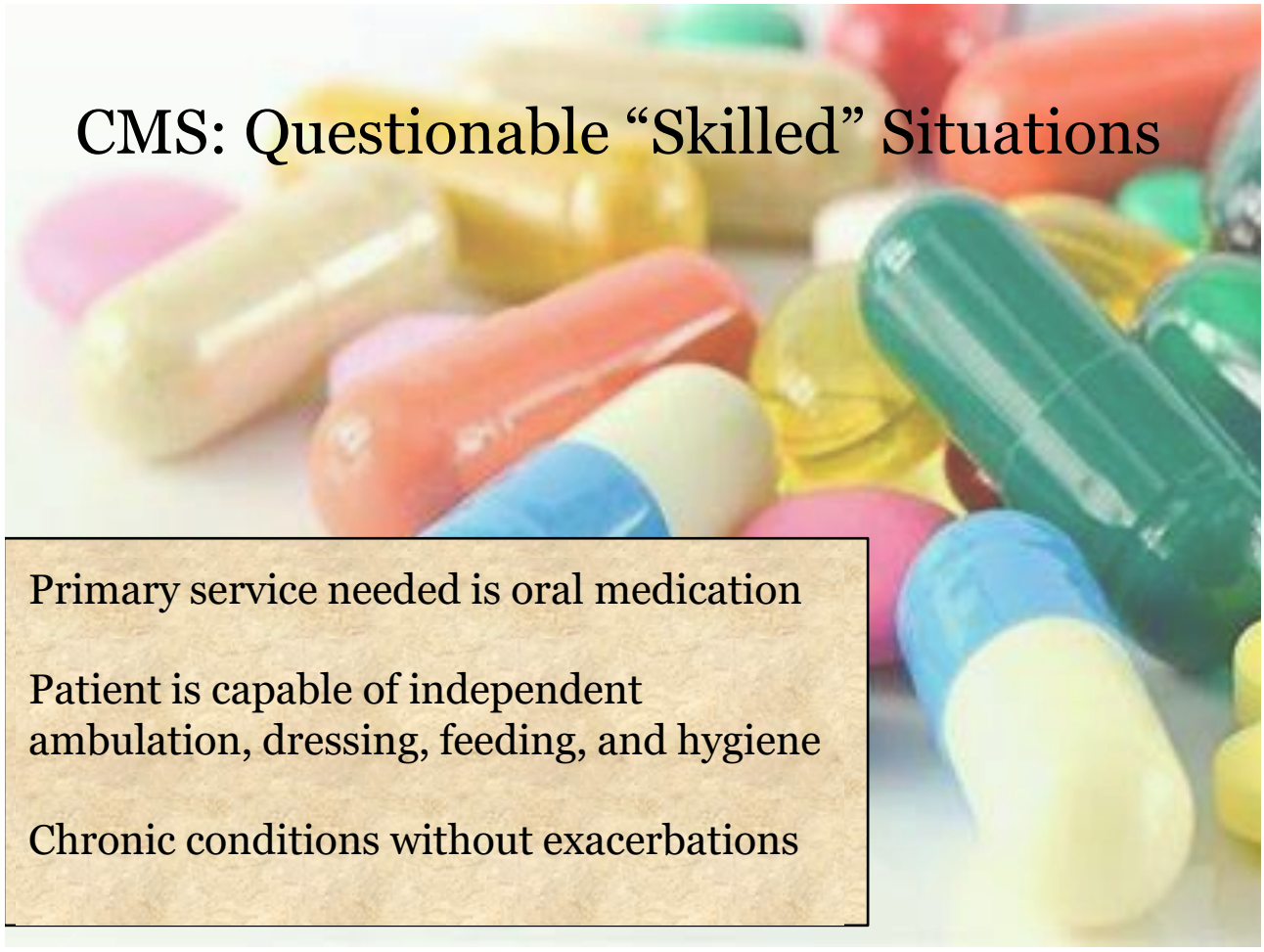

CMS: Questionable “Skilled” Situations

Primary service needed is oral medication

Patient is capable of independent ambulation, dressing, feeding, and hygiene

Chronic conditions without exacerbations

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Skilled Nursing Examples

IV or IM injections and IV feedings

Enteral feeding at least 26 percent of daily calories and provides at least 501 cc of fluid daily

Naso-pharyngeal & trach suctioning

Insertion, sterile irrigation and replacement of suprapubic catheters

Skilled Nursing Examples

Application of dressing (Depends on the wound type: example not a skin tear or MASD)

Treatment of PU stage III or worse or widespread skin disorder

Rehab Nursing procedures related to teaching and adaptive aspects such as bowel and bladder training

Initial phase of administration of medical gases

Colostomy care with teaching

Prior Level of Function

Good documentation on their abilities prior to admission
    Look at Section GG

What is it going to take for them to go home

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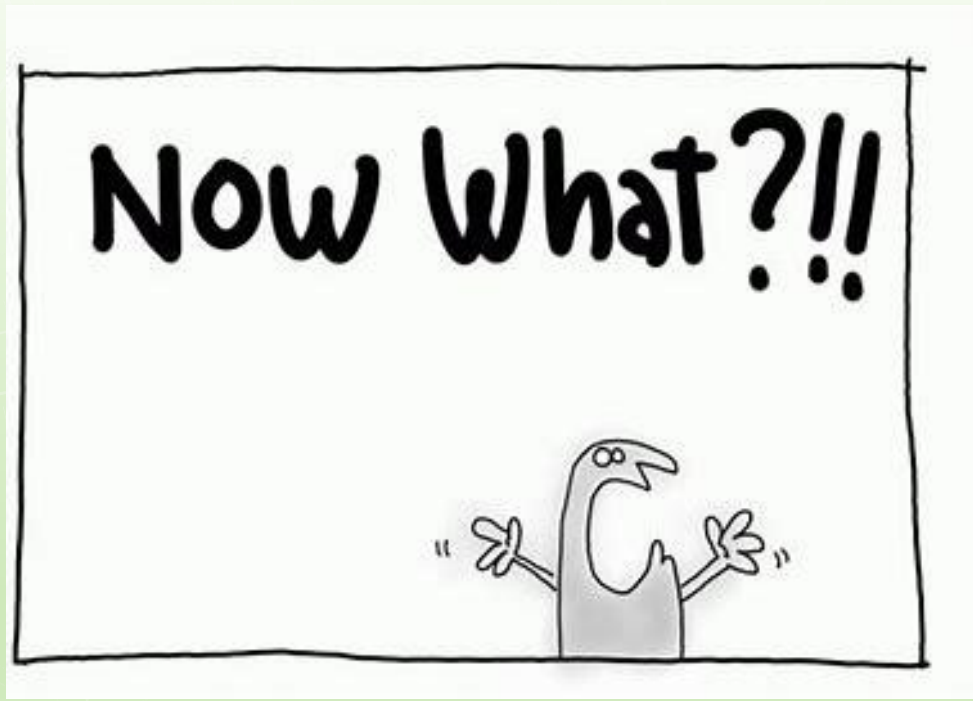
MDS and Therapy

If during the lookback period therapy treatment minutes are provided it belongs on the MDS at O0400.

It is not asking if it is Part A or Part B therapy minutes but was therapy provided as ordered by the physician.

O0425 is when Medicare A PPS Services ends- PART A only



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Referrals

Pre-Admission/Admission Process
- Respond quickly-others want the same resident

- Verify Insurance coverage(s)
  - Medicare vs. Managed Care
  - Medicare as a Secondary Payer (MSP)
  - Benefit periods – days available

- Verify Technical eligibility Requirements
  - 3 day Hospital stay
  - 30 Day Transfer Requirement
  - Daily Skilled Coverage

- Anticipate Clinical Needs
  - Consolidated Billing
  - Staff Competencies

Verify Benefit Eligibility

Medicare (FFS)

Benefit days remaining
- Prior used days
- Full benefit period

Prior stay investigation

3 day qualifying stay

Daily Skilled need

Presumption of coverage/ MSP

Medicare Advantage

3 day qualifying hospital stay required??

Prior authorization?

Daily/Weekly updates?

Payment requirements
- SNF PPS
- Levels
- Contractual Rate

Has beneficiary started disenrollment process

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Technical Eligibility

3 day Qualifying Stay:

Need to verify date of admission with Business office/Admitting Dept

Ensure resident “inpatient” status

Count day of admission, not date of discharge

May not be required for Medicare Advantage Plan OR under a Bundled Payment Agreement

Common Working File

Prior stay Investigation

No:
Full 100 day benefit

Yes:
- Within last 60 days
  - No new benefit period
  - Any leftover days??

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Medicare as a Secondary Payer

Current law and regulations require that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items

https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html

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Assessing/ Anticipating Clinical Needs

Review carefully hospital documentation

Determine if any special equipment and supplies required

Does clinical record indicate any need for further treatments/diagnostics that will be needed on an outpatient basis?

- Where performed?
- Transportation requirements?
- SNF responsibility or excluded

Review Medications

- IV's
- High cost medications

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Admitting the Resident

Communicate Admission and special needs to appropriate staff

Communicate with family Medicare coverage requirements related to coverage of UP TO 100 days

- If covered for rehab, strongly enforce need for participation to continue coverage

If any doubt related to Medicare eligibility treat as Medicare until questions resolved

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Physician Certifications

Certification – time of admission or soon thereafter
- Affirms resident meets SNF level of care definition

Re-certification – documents continued need for skilled SNF care
- 1st no later than 14th day
- Subsequent no later than 30-day intervals after 1st

Initial and 1st may be signed at same time
Based on Signature dates not on MDS dates

Physician Certification and Recertification Form

Resident Name _____ Health Insurance Card Number _____

Initial CERTIFICATION of resident at time of admission.

Admission Date _____

I certify that post-hospital SNF services as a practical matter are required to be given on an inpatient basis because of the above-named resident's need for daily skilled nursing care and/or daily skilled rehabilitation services on a continuing basis for the condition(s) for which he/she was receiving hospital services prior to his/her transfer to the SNF.

Signature of Physician _____ Date _____

First RECERTIFICATION of SNF inpatient care following the initial certification on or before the 14th day after admission.

Date _____

I certify that continued SNF inpatient care is necessary for the following reason(s):

_____

I estimate that the additional period of SNF inpatient care will be ___ days (or weeks). Plans for post-SNF care are:
☐ Home health agency ☐ Office care ☐ Other (specify) _____

Continued SNF care is for the same condition for which the resident received inpatient hospital services? ☐ Yes ☐ No

Signature of Physician _____ Date _____

Second RECERTIFICATION of SNF inpatient care on or before the 30th day following the first recertification.

Date _____

I certify that continued SNF inpatient care is necessary for the following reason(s):

_____

I estimate that the additional period of SNF inpatient care will be ___ days (or weeks). Plans for post-SNF care are:
☐ Home health agency ☐ Office care ☐ Other (specify) _____

Continued SNF care is for the same condition for which the resident received inpatient hospital services? ☐ Yes ☐ No

Signature of Physician _____ Date _____

Third RECERTIFICATION of SNF inpatient care on or before the 30th day following the second recertification.

Date _____

I certify that continued SNF inpatient care is necessary for the following reason(s):

_____

I estimate that the additional period of SNF inpatient care will be ___ days (or weeks). Plans for post-SNF care are:
☐ Home health agency ☐ Office care ☐ Other (specify) _____

Continued SNF care is for the same condition for which the resident received inpatient hospital services? ☐ Yes ☐ No

Signature of Physician _____ Date _____

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Certifications

(Rev. 1, 09-11-02) Medicare General Information, Eligibility, and Entitlement. Chapter 4

The recertification statement must contain an adequate written record of the reasons for the continued need for extended care services, the estimated period of time required for the patient to remain in the facility, and any plans, where appropriate, for home care. The recertification statement made by the physician does not have to include this entire statement if, for example, all of the required information is in fact included in progress note. In such a case, the physician's statement could indicate that the individual's medical record contains the required information and that continued post hospital extended care services are medically necessary. A statement reciting only that continued extended care services are medically necessary is not, in and of itself, sufficient.

Certification Statement Required Criteria

The certification must clearly contain the following information:

The individual needs skilled nursing care (furnished directly by or requiring the supervision of skilled nursing personnel) and/or other skilled rehabilitation services

Services are required daily

Services can only be provided in a SNF or swing-bed hospital on an inpatient basis

Services are for an ongoing condition for which the individual received inpatient care in a hospital, or for a new condition that arose while the individual was receiving care in the SNF or swing-bed hospital for a condition for which he or she received inpatient care in a participating or qualified hospital

A dated signature of the certifying physician or NPP

Delayed Certifications

CMS expects timely certs/recerts, but will honor delayed cert/recert if for example it is an isolated oversight.

Must have an explanation for the delay and any medical or other evidence explaining the delay.

Facility can determine format or statement.

https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/ge101c04.pdf

Certifications

Must clearly indicate that post hospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled care on a continuing basis for any of the conditions for which he/she were receiving inpatient hospital services.

Do not list of the skilled services to be provided: describe the medical and or functional problems requiring skilled service

Daily Nursing- IV antibiotics for pneumonia

Daily PT OT and ST therapeutic activities, therapeutic ADL retraining, gait training for muscle wasting/weakness and communication problems related to CVA

Daily Nursing Observation and Assessment post hip fracture with daily dressing changes, wound assessment, risk for decline due to diabetes, decline in mobility, delayed healing history.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c04.pdf

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Tips

When MDS schedule restarts, Cert schedule restarts

Certs strengthen the case for SNF

Don't pre-date for the MD

Don't have a practice of MD signing blank forms and filling out later

Involve MD in the process from beginning to end

The MD can bill for completing the documentation

SNF PPS Criteria

PDPM assignment
does not mean
skilled care criteria are met

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Regulations

483.20(j) Penalty for Falsification
(1) Under Medicare and Medicaid, an individual who willfully and knowingly–

–(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

–(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

Common types of Medicare and Medicaid audits include:

Targeted Probe & Educate (TPE) Program audits.
Comprehensive Error Rate Testing (CERT) audits.
Recovery Audit Contractor (RAC) Audits
Unified Program Integrity Contractor (UPIC) Audits

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Medicare Audits

Medicare contractor will request documentation:

- To support the HIPPS code billed
- Documentation to support look-back period under review
- Documentation to support MDS even if it falls outside requested billing period
- Documentation to the claim period billed
- Supportive documentation to support the MDS going back 30 days prior to the ARD

Documentation can include:

- hospital d/c summary, transfer forms, orders, progress notes, care plans, nursing/therapy notes, treatment, flow charts, vitals, weights, MAR/TAR

Clinical documentation can include:

- POS, MAR, TAR, medical dx, rehab dx, past medical history, progress notes (need to include response to treatments-physical/mental, labs, positive tests and other documentation to support need for skilled services

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf

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Recovery Audit Contractor

Purpose: Identify and correct Medicare improper payment

Complex and automated post payment reviews.

- Complex- Individual reviews medical record- Additional Documentation Request (IDR)
- Automated- System level review

9/9/24
Untimed Therapy Excessive Units
SNF Consolidated Billing for Therapies; Unbundling-Auto
Facility Duplicate Claims- Auto
SNF Consolidated Billing Part B- Auto
SNF Consolidated Billing Part B Use of Modifier 26, Professional Component- Auto
Transthoracic Echocardiography; Medical Necessity & Documentation Requirements- Complex
Ambulatory Surgical Center Billed During a Covered Part A SNF: Unbundling- Auto
Outpatient Therapy Services During Home Health: Unbunding-Auto
SNF with PDPM: Medical necessity and Documentation Requirements-Complex
SNF Consolidated Billing for Ambulance Transports: Unbundling-Auto

https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medicare-fee-service-recovery-audit-program

Targeted Probe and Education (TPE)

(Rare)

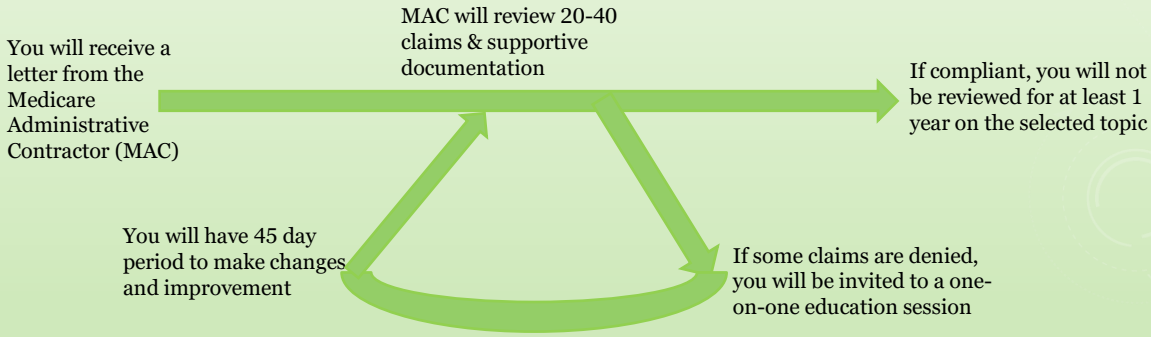
Looks for providers and suppliers who have high claim error rates or unusual billing practices

AND

Items and services that have high national error rates and are a financial risk to Medicare.

Providers whose claims are compliant with Medicare policy won't be chosen for this type of claim review.

Notified by the MAC through a "Notice of Review" letter. At end of review receive a "Final Results Letter".



If the home fails to improve after 3 rounds of educational sessions, they are referred to CMS.

This may include 100% prepay review, extrapolation, referral to an Recovery Auditor or other action.

https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/targeted-probe-and-educate-tpe

CMS 5 Claim Probe & Education Review

Part of the CMS Program Integrity Initiative

Effort to lower the SNF improper payment rate to assist SNFs in understanding how to bill appropriately under PDPM.

SNFs will then be offered education to address any errors identified, helping them avoid future claim denials and adjustments. Review result letters will detail the denial rationales for each claim.

Only 1 round of reviews instead of the standard of 1-3 rounds.

Dats of service under review after October 1, 2019- no COVID-19 diagnosis.

https://www.cms.gov/files/document/mm13164-skilled-nursing-facility-probe-and-educate-review.pdf

https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/skilled-nursing-facility-5-claim-probe-and-educate-review

Unified Program Integrity Contractor (UPIC) Audits

Medicare Fee-for-Service (FFS) and Medicaid programs.
UPICs are responsible for identifying and **protecting against fraud, waste, and abuse** using both pre-payment medical reviews and post-payment audits.

Referrals from MACs, CMS, OIG, Beneficiaries, Providers, suppliers, Medicaid Fraud Unit etc.

First sign-Site visit or documentation request.

Specific records- if 10 medical record request- may just be a probe. If more than 10- more significant.

Comprehensive Error Rate Testing (CERT)

The CERT audit is a post-payment audit for Medicare Part A, Part B, and DMEPOS claims that CMS uses to estimate Medicare FFS improper payments.

Review a random sample of Medicare FFS claims.

From that sample, CMS determines the estimated improper payment rate.

The CERT reviewers categorize improper payment claims into categories if underpayments or overpayments are found.

These categories include the following:

- Insufficient documentation supporting the claim.
- Incorrect coding.
- Lack of medical necessity (as determined by Medicare program requirements).
- No documentation.
- Other.

The CERT will notify the MAC in all cases of improper payment, which may recoup any overpayments.

Providers may appeal adverse audit results.

Most Common Claim Errors

The signature of the certifying physician is not included

Missing or incomplete initial certifications or recertifications

Documentation does not meet the medical necessity

Encounter notes did not support all elements of eligibility

Not providing supportive documentation for the MDS coding (look-back periods)

Not providing supporting documentation for the different components of PDPM (HIPPS code) that is being billed

Section GG coding

Other: Isolation, Respiratory, Restorative

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PDPM

The **Patient Driven Payment Model (PDPM),** effective October 1, 2019, improves payments made under the SNF PPS in the following ways:

Improves payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided

Significantly reduces administrative burden on providers
Improves SNF payments to currently underserved beneficiaries without increasing total Medicare payments

PDPM: Patient Driven Payment Model

MDS assessments are used to classify patients into payment categories

Moves away from intensity driven model of payment to characteristic need driven model of payment

PDPM is ***ONLY*** in place for traditional Medicare Part A

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Daily Rate Covers

Routine costs: regular room, dietary, nursing services, minor medical supplies, social services, psychiatric social services and the use of certain facilities and equipment for which a separate charge is not made.

Ancillary costs: costs for specialized services, such as therapy, drugs, and laboratory series, that are directly identifiable for individual residents.

Capital related costs: costs of land, building, equipment, and the interest incurred in financing the acquisition of such items.

PDPM Adjustments

Resident characteristics: Diagnoses, functional assessment, comorbidities, extensive services and conditions determine which case mix groups the residents will achieve

- Federal base PT, OT, SLP, Nursing, Non therapy ancillary (NTA) and Non case mix rate

Facility urban verses rural status

Area labor costs

Labor costs

HIV/AIDS Add On: Additional 18% of the nursing component and receives eight points under the NTA component. Documentation is the Medicare claim: B20

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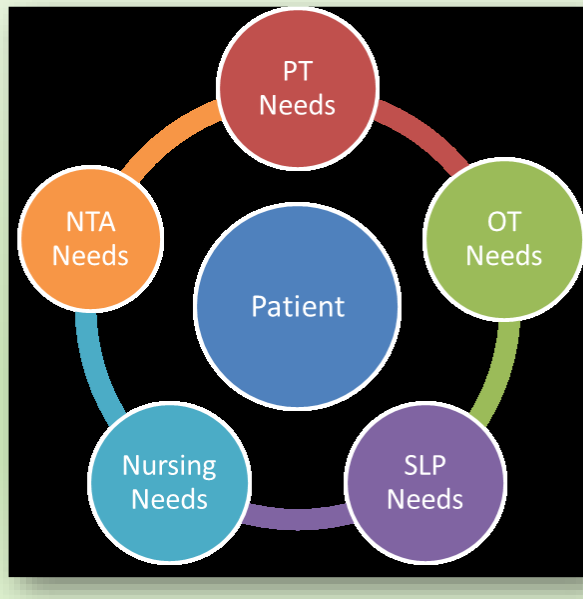
PDPM

Case-Mix Criteria Overview

PDPM consists of five case-mix adjusted components, all based on data-driven, stakeholder-vetted patient characteristics:



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GG Methodology

Scoring methodology:

Under Section GG, increasing score means increasing independence

Non-linear relationship to payment:

Under PDPM, there is not a direct relationship between increasing dependence and increasing payment

PDPM SNAPSHOT

PT Base Rate X PT CMI X VPD Adjustment Factor

+

OT Base Rate X OT CMI X VPD Adjustment Factor

+

SLP Base Rate X SLP CMI

+

NTA Base Rate X NTA CMI X VPD Adjustment Factor

+

Nursing Base Rate X Nursing CMI X 18% Adjustment Factor for AIDS/HIV

+

Non-Case-Mix Base Rate

Total PDPM Rate

Character 1: PT/OT
Character 2: SLP
Character 3: Nursing
Character 4: NTA
Character 5: Assessment Indicator

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Variable Per Diem Adjustment

The Social Security Act requires the SNF PPS to pay on a per-diem basis

Constant per diem rates do not accurately track changes in resource utilization throughout the stay and may allocate too few resources for providers at beginning of stay

To account more accurately for the variability in patient costs over the course of a stay, under PDPM, an adjustment factor is applied (for certain components).

For the PT, OT, and NTA components, the case-mix adjusted per diem rate is multiplied against the variable per diem adjustment factor, following a schedule of adjustments for each day of the patient's stay.

NTA variable will be weighted 3x higher in the first 3 days of the stay. PT/OT, after day 20, this component's reimbursement is reduced by 2% every 7 days.

PDPM Components & Adjustments

Component	Case Mix Adjusted	Variable Per Diem adjustment
Physical therapy	X	X
Occupational therapy	X	X
Speech-language pathology	X	
Nursing	X	
Non-therapy ancillary	X	X
Non case mix		

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Patient Classifications

Under PDPM, each patient is classified into a group for each of the five case-mix adjusted components: PT, OT, SLP, Nursing and NTA

Each component utilizes different criteria as the basis for patient classification:

PT: Clinical Category, Functional Score
OT: Clinical Category, Functional Score
SLP: Presence of Acute Neurologic Condition, SLP-related Comorbidity or Cognitive Impairment, Mechanically-altered Diet, Swallowing Disorder
Nursing: Multiple Categories
NTA (Non Therapy Ancillary): NTA Comorbidity Score

PT/OT Component Overview

Case-mix has 2 primary elements used to determine classification:

1. Clinical Category for SNF stay: I0020B

2. Functional Status: Score derived from 10 items in Section GG

Primary Medical Condition

I0020. Indicate the resident's primary medical condition category
Complete only if A0310B = 01 or 08

Enter Code

Indicate the resident's primary medical condition category that best describes the primary reason for admission

01. **Stroke**
02. **Non-Traumatic Brain Dysfunction**
03. **Traumatic Brain Dysfunction**
04. **Non-Traumatic Spinal Cord Dysfunction**
05. **Traumatic Spinal Cord Dysfunction**
06. **Progressive Neurological Conditions**
07. **Other Neurological Conditions**
08. **Amputation**
09. **Hip and Knee Replacement**
10. **Fractures and Other Multiple Trauma**
11. **Other Orthopedic Conditions**
12. **Debility, Cardiorespiratory Conditions**
13. **Medically Complex Conditions**

I0020B. ICD Code

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Coding Instructions

Code 01, Stroke, Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease.

Code 02, Non-Traumatic Brain Dysfunction, Examples include Alzheimer's disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, anoxic brain damage.

Code 03, Traumatic Brain Dysfunction, Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion.

Code 04, Non-Traumatic Spinal Cord Dysfunction, Examples include spondylosis with myelopathy, transverse myelitis, spinal cord lesion due to spinal stenosis, and spinal cord lesion due to dissection of aorta.

Code 05, Traumatic Spinal Cord Dysfunction, Examples include paraplegia and quadriplegia following trauma.

Code 06, Progressive Neurological Conditions, Examples include multiple sclerosis and Parkinson's disease.

Code 07, Other Neurological Conditions, Examples include cerebral palsy, polyneuropathy, and myasthenia gravis.

Coding Instructions

Code 08, Amputation, An example is acquired absence of limb.

Code 09, Hip and Knee Replacement, An example is total knee replacement. If hip replacement is secondary to hip fracture, code as fracture.

Code 10, Fractures and Other Multiple Trauma, Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula.

Code 11, Other Orthopedic Conditions, An example is unspecified disorders of joint.

Code 12, Debility, Cardiorespiratory Conditions, Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue.

Code 13, Medically Complex Conditions, Examples include diabetes, pneumonia, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance.

PT/OT Component Overview ICD-10

I0020 Indicate the resident's primary medical condition category

I0020B ICD Code (must match with ICD 10 mapping)

Residents are first classified into a clinical category based on the primary diagnosis and that will be broken down further into 4 categories to influence PT/OT case mix component (using ICD-10 code):

- Major joint replacement or spinal surgery
- Other orthopedic
- Medical management
- Non-orthopedic surgery and acute neurologic

PT/OT Functional Status

Pulled from items in Section GG:

- 2 bed mobility items
- 1 eating item
- 1 oral hygiene item
- 3 transfer items
- 1 toileting item
- 2 walking items

Items are scored based on dependence.
The **higher** the number, the more **independent** the resident
The **lower** the number, the more **dependent** the resident

PT & OT Functional Score Crosswalk (Walking Items)

Item Response	Score
05, 06 –Set-up Assistance, Independent	4
04 –Supervision or touching assistance	3
03–Partial/Moderate assistance	2
02-Substantial/Maximal assistance	1
01,07, 09, 10, 88, missing –Dependent, Refused, Not applicable, Not attempted due to environmental limitations, Not Attempted due to medical condition or safety concerns, Resident Cannot Walk (Coded based on response to GG0170)	0

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Section GG Items Included in PT and OT Functional Score

Item	Description	Score Range
GG0130A1	Self-care: Eating	0-4
GG0130B1	Self-care: Oral Hygiene	0-4
GG0130C1	Self-care: Toileting Hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4 (average of 2 items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4 (average of 3 items)
GG0170E1	Mobility: Chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0-4 (average of 2 items)
GG0170K1	Mobility: Walk 150 feet	

Admission or Interim Performance (Column 1 or 5)=	Function Score =
05, 06	4
04	3
03	2
02	1
01,07,09. 10, 88, missing	0

Function Score for PT Payment

ADL self-care/Mobility Activity	Performance	Functional Score	Functional score tally
Eating: independent	06	4	**4**
Oral Hygiene: Set up only	05	4	**4**
Toileting Hygiene: moderate assistance	03	2	**2**
Sit to Lying: Max assist	02	1	1+1=2 Average of two items 2/2=**1**
Lying to Sitting: Max Assist	02	1	
Sit to Stand: Max Assist	02	1	1+1+1=3 Average of 3 items 3/3=**1**
Chair/Bed to chair Transfer: max assist	02	1	
Toileting Transfer: Max assist	02	1	
Walking 50 Feet with 2 turns: Max assist with 2 assistants	01	0	
Walking 150 feet: 88: (not attempted due to medical condition or safety concerns)	88	0	
TOTAL			**12**

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PT/OT Component: Payment Groups

Clinical Category	PT & OT Function Score	PT & OT Case Mix Group
Major Joint Replacement or Spinal Surgery	0-5	TA
Major Joint Replacement or Spinal Surgery	6-9	TB
Major Joint Replacement or Spinal Surgery	10-23	TC
Major Joint Replacement or Spinal Surgery	24	TD
Other Orthopedic	0-5	TE
Other Orthopedic	6-9	TF
Other Orthopedic	10-23	TG
Other Orthopedic	24	TH
Medical Management	0-5	TI
Medical Management	6-9	TJ
Medical Management	10-23	TK
Medical Management	24	TL
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO
Non-Orthopedic Surgery and Acute Neurologic	24	TP

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate
A	1.45	$121.08	1.41	$108.13
B	1.61	$134.44	1.54	$118.10
C	1.78	$148.63	1.60	$122.70
D	1.81	$151.14	1.45	$111.20
E	1.34	$111.89	1.33	$102.00
F	1.52	$126.92	1.51	$115.80
G	1.58	$131.93	1.55	$118.87
H	1.10	$91.85	1.09	$83.59
I	1.07	$89.35	1.12	$85.89
J	1.34	$111.89	1.37	$105.07
K	1.44	$120.24	1.46	$111.97
L	1.03	$86.01	1.05	$80.52
M	1.20	$100.20	1.23	$94.33
N	1.40	$116.90	1.42	$108.90
O	1.47	$122.75	1.47	$112.73
P	1.02	$85.17	1.03	$78.99
Q	-	-	-	-
R	-	-	-	-
S	-	-	-	-
T	-	-	-	-
U	-	-	-	-
V	-	-	-	-
W	-	-	-	-
X	-	-	-	-
Y	-	-	-	-

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Concurrent and Group Therapy Limits

Under PDPM, we use a combined limit *both* concurrent and group therapy to be no more than 25 percent of the therapy received by SNF patients/residents, for each therapy discipline.

Compliance with the concurrent/group therapy limit will be monitored by new items on the PPS Discharge Assessment:

Providers will report the number of minutes, per mode and per discipline, for the entirety of the PPS stay.

If the total number of concurrent and group minutes, combined, comprises more than 25 percent of the total therapy minutes provided to the patient/resident, for any therapy discipline, then the provider will receive a warning message on their final validation report.

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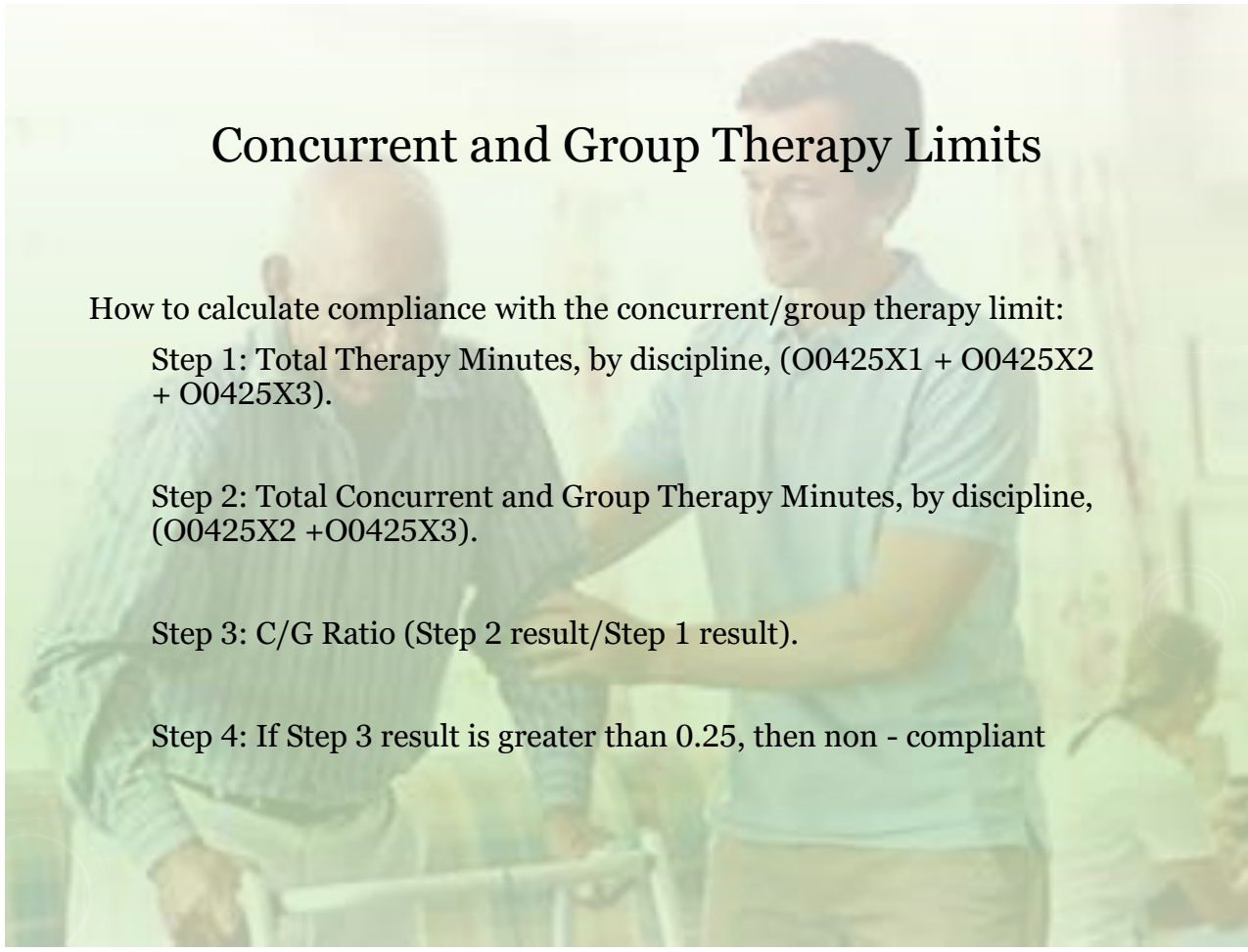

Concurrent and Group Therapy Limits

How to calculate compliance with the concurrent/group therapy limit:

Step 1: Total Therapy Minutes, by discipline, (O0425X1 + O0425X2 + O0425X3).

Step 2: Total Concurrent and Group Therapy Minutes, by discipline, (O0425X2 +O0425X3).

Step 3: C/G Ratio (Step 2 result/Step 1 result).

Step 4: If Step 3 result is greater than 0.25, then non - compliant

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Speech- Language Pathology Component

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SLP Component

SLP category is influenced by:

1. Primary clinical category (neurologic and non-neurologic) and other diagnoses listed under this item set as co-morbidities.

2. Plus conditions captured in Section K for swallowing disorders and mechanically altered diets.

3. As well as cognitive impairment derived from BIMS score.

SLP Component

Resident characteristics that are predictive of increased SLP costs:

- Acute Neurologic clinical classification
- Certain SLP-related comorbidities
- Presence of cognitive impairment
- Use of a mechanically-altered diet
- Presence of swallowing disorder

SLP- Related Comorbidities

SLP COMORBIDITIES	
Aphasia	Laryngeal Cancer
CVA,TIA, or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy (while Resident)	Oral Cancers
Ventilator (while Resident)	Speech & Language Deficits

Twelve SLP comorbidities were identified as predictive of higher SLP costs:

Conditions and services combined into a single SLP-related comorbidity flag

Patient qualifies if any of the conditions/services is present

A mapping between ICD-10 codes and the SLP comorbidities is available on the PDPM webpage

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PDPM Cognitive Scoring

Under PDPM, a patient's cognitive status is assessed using the Brief Interview for Mental Status (BIMS):

In cases where the BIMS cannot be completed, providers are required to perform a staff assessment for mental status
The Cognitive Performance Scale (CPS) is then used to score the patient's cognitive status based on the results of the staff assessment

RAI page 6-12 &13

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SLP Component: Payment Groups

Presence of Acute Neurologic Condition, SLP Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case Mix Group
None	Neither	SA
None	Either	SB
None	Both	SC
Any one	Neither	SD
Any one	Either	SE
Any one	Both	SF
Any two	Neither	SG
Any two	Either	SH
Any two	Both	SI
All three	Neither	SJ
All three	Either	SK
All three	Both	SL

PDPM Group	SLP CMI	SLP Rate
A	0.64	$22.05
B	1.72	$59.27
C	2.52	$86.84
D	1.38	$47.55
E	2.21	$76.16
F	2.82	$97.18
G	1.93	$66.51
H	2.7	$93.04
I	3.34	$115.10
J	2.83	$97.52
K	3.50	$120.61
L	3.98	$137.15
M	-	-
N	-	-
O	-	-
P	-	-
Q	-	-
R	-	-
S	-	-
T	-	-
U	-	-
V	-	-
W	-	-
X	-	-
Y	-	-

Nursing Component

PDPM utilizes basic nursing classification structure:

Function score based on Section GG of the MDS 3.0

25 functional nursing groups

Nursing Component

Uses Section GG functional scoring

25 Functional groups

Presence of cognitive impairment increases the nursing component

Presence of depression (indicated by score on PHQ-9), increases weight of nursing component

Presence of behaviors increases the nursing component

PDPM Reimbursement for HIV/AIDS

As PDPM was developed, the rate components were specifically designed to account accurately and appropriately for the increased cost of AIDS - related care, as determined through research.

PDPM addresses costs for this subpopulation in two ways:

- Assigns those patients/residents with AIDS the highest point value (8 points) of any condition or service for purposes of classification under its NTA component.
- An 18% add - on to the PDPM nursing component.

PDPM Reimbursement for HIV/AIDS

AIDS diagnosis continues to be identified through the SNF's entry of International Statistical Classification of Diseases and Related Health Problems - 10 Clinical Modification (ICD - 10 - CM) code B20 on the SNF claim.

Providers may report AIDS diagnoses on the MDS, as permitted by their state laws, but only the presence of this diagnosis on the claim is sufficient for the patient's/resident's per diem rate to be adjusted accordingly.

In Missouri it is placed on the claim but also can be placed on the MDS, but for billing/PDPM purposes, it has to be on the claim to obtain additional reimbursement.

Nursing Functional Score Crosswalk (Non-walking items)

Item Response	Score
05, 06 –Set-up Assistance, Independent	4
04 –Supervision or touching assistance	3
03–Partial/Moderate assistance	2
02–Substantial/Maximal assistance	1
01,07, 09, 10, 88, missing –Dependent, Refused, Not applicable, Not attempted due to environmental limitations, Not Attempted due to medical condition or safety concerns	0

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Nursing Function Score: GG Items

Section GG Item	Functional Score Range
GG0130A1 –Self care: Eating	0-4
GG0130C1–Self-care: Toileting Hygiene	0–4
GG0170B1–Mobility: Sit to Lying GG0170C1 –Mobility: Lying to Sitting on side of bed	0 –4 (average of 2 items)
GG0170D1 –Mobility: Sit to Stand GG0170E1 –Mobility: Chair/bed-to-chair transfer GG0170F1–Mobility: Toilet Transfer	0–4 (average of 3 items)

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Nursing Component: Payment Groups

PDPM Nursing Component: Extensive Services
Extensive Services included tracheostomy, and/or ventilator or respirator, or infection isolation
Clinical Conditions None
Depression None
Restorative Nursing Services None
Function Score 0-14
CMG ES3, ES2, ES1

Extensive Service Conditions	PDPM Nursing Classification	HIPPS Code
Tracheostomy care AND ventilator/respirator	ES3	A
Tracheostomy care OR ventilator/respirator	ES2	B
Isolation or quarantine for active infectious disease (without tracheostomy care, without ventilator/respirator)	ES1	C

Nursing CMG	Nursing CMI	Nursing Rate
ES3	3.84	$468.44
ES2	2.90	$353.77
ES1	2.77	$337.91

Function score of 15-16 would be clinically complex

Nursing Component: Payment Groups

PDPM Nursing Component:
Extensive Services included Serious Medical Conditions
Clinical Conditions:
Comatose,
Septicemia,
DM with daily injections (7days) & insulin order changes 2+days
Quadriplegia
COPD & SOB when lying flat
Fever with (1 of the following) Pneumonia/vomiting/wt loss/feeding tube with intake requirements
Parenteral/IV feedings
Respiratory therapy (daily)
Depression Yes or No
Restorative Nursing Services None
Function Score 0-14
CMG HDE2, HDE1, HBC2, HBC1

Nursing Function Score	Depressed?	PDPM Nursing Classification	HIPPS
0 to 5	Yes	HDE2	D
0 to 5	No	HDE1	E
6 to 14	Yes	HBC2	F
6 to 14	No	HBC1	G

HDE2	2.27	$276.92	1.26	$115.96
HDE1	1.88	$229.34	0.91	$83.75
HBC2	2.12	$258.62	0.68	$62.58
HBC1	1.76	$214.70	-	-

Nursing Component: Payment Groups

PDPM Nursing Component:
Extensive Services included Conditions requiring complex medical care
Clinical Conditions:

- Cerebral Palsy
- Multiple Sclerosis
- Parkinson's Disease
- Respiratory failure & Oxygen therapy
- Feeding tube with intake requirements
- 2+ Stage 2 PU with 2+ skin treatments
- Stage 3 or 4 PU or unstageable with slough or eschar with 2+ skin treatments
- 2+ venous/arterial ulcers with 2+ skin treatments
- Stage 2 PU (1) and venous/arterial ulcer (1) with 2+ skin treatments
- Foot infection, diabetic foot ulcer, or other open lesion of foot with dressing
- Radiation therapy while a resident
- Dialysis while a resident

Depression Yes or No
Restorative Nursing Services None
Function Score 0-14
CMG LDE2, LDE1, LBC2, LBC1

Nursing Function Score	Depressed?	PDPM Nursing Classification	HIPPS
0 to 5	Yes	LDE2	H
0 to 5	No	LDE1	I
6 to 14	Yes	LBC2	J
6 to 14	No	LBC1	K

LDE2	1.97	$240.32
LDE1	1.64	$200.06
LBC2	1.63	$198.84
LBC1	1.35	$164.69

Nursing Component: Payment Groups

Tube Feeding classification requirements:

51% or more of total calories
OR
26%-50% of total calories and 501cc or more per day fluid enteral intake in the last 7 days

Skin Treatments include:

Pressure relieving chair and/or bed (count as 1 even if both are present)
Turning/repositioning
Nutrition or hydration intervention
Pressure ulcer care
Application of dressings (not to feet)
Application of ointment (not to feet)

Nursing Component: Payment Groups

PDPM Nursing Component:
Extensive Services included Conditions requiring Complex Medical Care
Clinical Conditions:

Pneumonia
Hemiplegia/hemiparesis with Nursing Function Score <=11
Open lesions (other than ulcers, rashes, and cuts) with any selected skin treatments* or surgical wounds
Burns
Chemotherapy while a patient
Oxygen while a patient
IV Medications while a patient
Transfusions while a patient

Depression Yes or No
Restorative Nursing Services None
Function Score 0-16
CMG CDE2, CDE1,CBC2,CA2,CBC1,CA1

Nursing Function Score	Depressed?	PDPM Nursing Classification	HIPPS
0 to 5	Yes	CDE2	L
0 to 5	No	CDE1	M
6 to 14	Yes	CBC2	N
15 to 16	Yes	CA2	O
6 to 14	No	CBC1	P
15-16	No	CA1	Q

*Selected Skin Tx: Surgical wound care, Application of nonsurgical dressing (other than feet), Application of ointment/medications (other than feet).

CDE2	1.77	$215.92
CDE1	1.53	$186.64
CBC2	1.47	$179.33
CA2	1.03	$125.65
CBC1	1.27	$154.93
CA1	0.89	$108.57

Nursing Component: Payment Groups

PDPM Nursing Component:
Extensive Services included Behavioral Symptoms & Cognitive Performance
Clinical Conditions:

PDPM Nursing Functional Score is >11
Cognitive impairment (BIMS </= 9) per staff interview
Staff assessment (one of three conditions):

1. Coma & completely dependent or activity did not occur at
   GG0130 Self Care-Eating & Toileting hygiene
   GG0170 Mobility-Sit to lying, lying to sitting, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer & toilet transfer.

2. Severely impaired cognitive skills for daily decision making

3. (Two or more of the following impairments)
   Usually, sometimes or rarely/never understood, Short-term memory problem, impaired cognitive skills for daily decision making AND
   (One or both of the severe impairments)
   Sometimes or rarely/never makes self understood, Moderately or severely impaired cognitive skills for daily decision making

Continue next page

Nursing Component: Payment Groups

PDPM Nursing Component:
Extensive Services included Behavioral Symptoms & Cognitive Performance CONTINUED
Clinical Conditions:

Hallucinations
Delusions
Physical behavioral symptoms directed towards others (behavior occurred 4-6 days or daily)
Verbal behavioral symptoms directed towards others (behavior occurred 4-6 days or daily)
Rejections of care (behavior occurred 4-6 days or daily)
Wandering ((behavior occurred 4-6 days or daily)

Depression No
Restorative Nursing Services YES
Function Score 11-16
PDPM Nursing Function Score is <11 skip to Reduced Physical Function Category
CMG BAB2 BAB1

Nursing Function Score	Restorative Nursing	PDPM Nursing Classification	HIPPS
11 to 16	2 or more	BAB2	R
11 to 16	0 or 1	BAB1	S

BAB2	0.98	$119.55
BAB1	0.94	$114.67

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Nursing Component: Payment Groups

PDPM Nursing Component:
Extensive Services included Assistance with daily living and general supervision
Clinical Conditions:

Any resident that does not meet the conditions of the previous categories. Also includes those who meet criteria for Behavioral Symptoms & Cognitive Performance category but have a PDPM Nursing Function of less than 11.

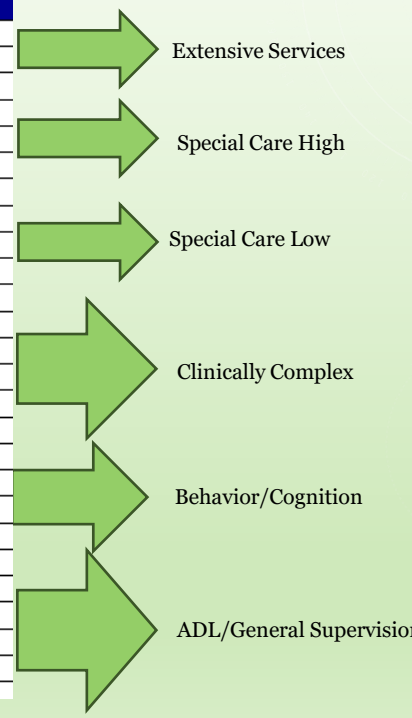
Depression No
Restorative Nursing Services YES
Function Score 0-16
CMG PDE2,PDE1,PBC2, PA2,PBC1,PA1

Nursing Function Score	Restorative Nursing	PDPM Nursing Classification	HIPPS
0 to 5	2 or more	PDPE2	T
0 to 5	0 or 1	PDE1	U
6 to 14	2 or more	PBC2	V
15 to 16	2 or more	PA2	W
6 to 14	0 or 1	PBC1	X
15-16	0 or 1	PA1	Y

PDE2	1.48	$180.55
PDE1	1.39	$169.57
PBC2	1.15	$140.29
PA2	0.67	$81.73
PBC1	1.07	$130.53
PA1	0.62	$75.63

Nursing Component: Payment Groups

PDPM Group	Nursing CMG	Nursing CMI	Nursing Rate
A	ES3	3.84	$468.44
B	ES2	2.90	$353.77
C	ES1	2.77	$337.91
D	HDE2	2.27	$276.92
E	HDE1	1.88	$229.34
F	HBC2	2.12	$258.62
G	HBC1	1.76	$214.70
H	LDE2	1.97	$240.32
I	LDE1	1.64	$200.06
J	LBC2	1.63	$198.84
K	LBC1	1.35	$164.69
L	CDE2	1.77	$215.92
M	CDE1	1.53	$186.64
N	CBC2	1.47	$179.33
O	CA2	1.03	$125.65
P	CBC1	1.27	$154.93
Q	CA1	0.89	$108.57
R	BAB2	0.98	$119.55
S	BAB1	0.94	$114.67
T	PDE2	1.48	$180.55
U	PDE1	1.39	$169.57
V	PBC2	1.15	$140.29
W	PA2	0.67	$81.73
X	PBC1	1.07	$130.53
Y	PA1	0.62	$75.63



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NTA Component

NTA classification is based on the presence of certain comorbidities or use of certain extensive services

We considered various options to incorporate comorbidities into payment:

- Total number of comorbidities is linked to NTA costs, but a simple count of conditions overlooks differences in relative costliness
- A tier system accounts for differences in relative costliness but does not account for the number of comorbidities

Comorbidity score is a weighted count of comorbidities:

- Comorbidities associated with high increases in NTA costs grouped into various point tiers
- Points assigned for each additional comorbidity present, with more points awarded for higher-cost tiers

Non-Therapy Ancillary (NTA) Component

Based on points assigned for 50 MDS items including diagnoses or extensive services to account for complex medical conditions and co-morbidities.

This variable will be weighted 3x higher in the first 3 days of the stay.
Points are assigned based on conditions

i.e. Diabetes Mellitus is 2 points, stage 4 pressure ulcer 1 point, IV medication 5 points.

The higher the total number of points, the increased value of this component.

Non-Therapy Ancillary (NTA) Component

Comorbidities and extensive services for NTA classification are derived from a variety of MDS sources, with some comorbidities identified by ICD-10-CM codes reported in Item I8000

A mapping between ICD-10-CM codes and NTA comorbidities

Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) is reported on the SNF claim

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NTA Component: Condition Listing

Condition/Extensive Service	Source	Points
HIV/AIDS	SNF Claim	8
Parenteral Intravenous (IV) Feeding: Level High	MDS Item K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	MDS Item O0100F2	4
Parenteral IV feeding: Level Low	MDS Item K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	MDS Item I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0100I2	2
Major Organ Transplant Status, Except Lung	MDS Item I8000	2
Multiple Sclerosis Code	MDS Item I5200	2
Opportunistic Infections	MDS Item I8000	2
Asthma Chronic obstructive pulmonary disease(COPD) Chronic Lung Disease Code	MDS Item I6200	2
Bone/Joint/Muscle Infections/Necrosis -Except Aseptic Necrosis of Bone	MDS Item I8000	2
Chronic Myeloid Leukemia	MDS Item I8000	2
Wound Infection Code	MDS Item I2500	2
Diabetes Mellitus (DM) Code	MDS Item I2900	2

NTA Component: Condition Listing

Condition/ Extensive Service	Source	Points
Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End-Stage Liver Disease	MDS Item I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	MDS Item M1040B	1
Narcolepsy and Cataplexy	MDS Item I8000	1
Cystic Fibrosis	MDS Item I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	MDS Item O0100E2	1
Multi-Drug Resistant Organism (MDRO) Code	MDS Item I1700	1
Special Treatments/Programs: Isolation Post-admit Code	MDS Item O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	MDS Item I8000	1
Morbid Obesity	MDS Item I8000	1
Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1
Highest Stage of Unhealed Pressure Ulcer -Stage 4	MDS Item M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1
Chronic Pancreatitis	MDS Item I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1

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NTA Component: Condition Listing

Condition/Extensive Service	Source	Points
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	MDS Item M1040A, M1040B, M1040C	1
Complications of Specified Implanted Device or Graft	MDS Item I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	MDS Item H0100D	1
Inflammatory Bowel Disease	MDS Item I1300	1
Aseptic Necrosis of Bone	MDS Item I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	MDS Item O0100D2	1
Cardio-Respiratory Failure and Shock	MDS Item I8000	1
Myelodysplastic Syndromes and Myelofibrosis	MDS Item I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	MDS Item I8000	1
Diabetic Retinopathy -Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Nutritional Approaches While a Resident: Feeding Tube	MDS Item K0510B2	1
Severe Skin Burn or Condition	MDS Item I8000	1
Intractable Epilepsy	MDS Item I8000	1
Malnutrition Code	MDS Item I5600	1

NTA Component: Condition Listing

Condition/Extensive Service	Source	Points
Disorders of Immunity -Except : RxCC97: Immune Disorders	MDS Item I8000	1
Cirrhosis of Liver	MDS Item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS Item H0100C	1
Respiratory Arrest	MDS Item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS Item I8000	1

Condition/Extensive Service	Source	Points
HIV/AIDS	SNF Claim	8
Parenteral IV Feeding: Level High	MDS Item K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	MDS Item O0100F2	4
Parenteral IV feeding: Level Low	MDS Item K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	MDS Item I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0100I2	2
Major Organ Transplant Status, Except Lung	MDS Item I8000	2
Active Diagnoses: Multiple Sclerosis Code	MDS Item I5200	2
Opportunistic Infections	MDS Item I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	MDS Item I6200	2
Bone/Joint/Muscle Infections/Necrosis - Except Aseptic Necrosis of Bone	MDS Item I8000	2
Chronic Myeloid Leukemia	MDS Item I8000	2
Wound Infection Code	MDS Item I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	MDS Item I2900	2
Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End-Stage Liver Disease	MDS Item I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	MDS Item M1040B	1
Narcolepsy and Cataplexy	MDS Item I8000	1
Cystic Fibrosis	MDS Item I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	MDS Item O0100E2	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	MDS Item I1700	1
Special Treatments/Programs: Isolation Post-admit Code	MDS Item O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	MDS Item I8000	1
Morbid Obesity	MDS Item I8000	1
Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1
Highest Stage of Unhealed Pressure Ulcer - Stage 4	MDS Item M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_NTAComorbidityScoring_v2_508.pdf

NTA Component Payment Groups

NTA Score Range	NTA Case Mix Group
12+	NA
9 –11	NB
6 –8	NC
3 –5	ND
1 –2	NE
0	NF

A	3.06	$281.61
B	2.39	$219.95
C	1.74	$160.13
D	1.26	$115.96
E	0.91	$83.75
F	0.68	$62.58

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PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—URBAN

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.45	$106.21	1.41	$96.13	0.64	$17.50	ES3	3.84	$490.29	3.06	$294.77
B	1.61	$117.93	1.54	$105.00	1.72	$47.04	ES2	2.90	$370.27	2.39	$230.23
C	1.78	$130.39	1.60	$109.09	2.52	$68.92	ES1	2.77	$353.67	1.74	$167.61
D	1.81	$132.58	1.45	$98.86	1.38	$37.74	HDE2	2.27	$289.83	1.26	$121.38
E	1.34	$98.16	1.33	$90.68	2.21	$60.44	HDE1	1.88	$240.04	0.91	$87.66
F	1.52	$111.34	1.51	$102.95	2.82	$77.13	HBC2	2.12	$270.68	0.68	$65.50
G	1.58	$115.74	1.55	$105.68	1.93	$52.79	HBC1	1.76	$224.72	-	-
H	1.10	$80.58	1.09	$74.32	2.7	$73.85	LDE2	1.97	$251.53	-	-
I	1.07	$78.38	1.12	$76.36	3.34	$91.35	LDE1	1.64	$209.40	-	-
J	1.34	$98.16	1.37	$93.41	2.83	$77.40	LBC2	1.63	$208.12	-	-
K	1.44	$105.48	1.46	$99.54	3.50	$95.73	LBC1	1.35	$172.37	-	-
L	1.03	$75.45	1.05	$71.59	3.98	$108.85	CDE2	1.77	$225.99	-	-
M	1.20	$87.90	1.23	$83.86	-	-	CDE1	1.53	$195.35	-	-
N	1.40	$102.55	1.42	$96.82	-	-	CBC2	1.47	$187.69	-	-
O	1.47	$107.68	1.47	$100.22	-	-	CA2	1.03	$131.51	-	-
P	1.02	$74.72	1.03	$70.23	-	-	CBC1	1.27	$162.15	-	-
Q	-	-	-	-	-	-	CA1	0.89	$113.64	-	-
R	-	-	-	-	-	-	BAB2	0.98	$125.13	-	-
S	-	-	-	-	-	-	BAB1	0.94	$120.02	-	-
T	-	-	-	-	-	-	PDE2	1.48	$188.97	-	-
U	-	-	-	-	-	-	PDE1	1.39	$177.48	-	-
V	-	-	-	-	-	-	PBC2	1.15	$146.83	-	-
W	-	-	-	-	-	-	PA2	0.67	$85.55	-	-
X	-	-	-	-	-	-	PBC1	1.07	$136.62	-	-
Y	-	-	-	-	-	-	PA1	0.62	$79.16	-	-

https://www.mhanet.com/mhaimages/issue%20briefs/08-02-2024%20Final%20FY%202025%20SNF.pdf

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PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—RURAL

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.45	$121.08	1.41	$108.13	0.64	$22.05	ES3	3.84	$468.44	3.06	$281.61
B	1.61	$134.44	1.54	$118.10	1.72	$59.27	ES2	2.90	$353.77	2.39	$219.95
C	1.78	$148.63	1.60	$122.70	2.52	$86.84	ES1	2.77	$337.91	1.74	$160.13
D	1.81	$151.14	1.45	$111.20	1.38	$47.55	HDE2	2.27	$276.92	1.26	$115.96
E	1.34	$111.89	1.33	$102.00	2.21	$76.16	HDE1	1.88	$229.34	0.91	$83.75
F	1.52	$126.92	1.51	$115.80	2.82	$97.18	HBC2	2.12	$258.62	0.68	$62.58
G	1.58	$131.93	1.55	$118.87	1.93	$66.51	HBC1	1.76	$214.70	-	-
H	1.10	$91.85	1.09	$83.59	2.7	$93.04	LDE2	1.97	$240.32	-	-
I	1.07	$89.35	1.12	$85.89	3.34	$115.10	LDE1	1.64	$200.06	-	-
J	1.34	$111.89	1.37	$105.07	2.83	$97.52	LBC2	1.63	$198.84	-	-
K	1.44	$120.24	1.46	$111.97	3.50	$120.61	LBC1	1.35	$164.69	-	-
L	1.03	$86.01	1.05	$80.52	3.98	$137.15	CDE2	1.77	$215.92	-	-
M	1.20	$100.20	1.23	$94.33	-	-	CDE1	1.53	$186.64	-	-
N	1.40	$116.90	1.42	$108.90	-	-	CBC2	1.47	$179.33	-	-
O	1.47	$122.75	1.47	$112.73	-	-	CA2	1.03	$125.65	-	-
P	1.02	$85.17	1.03	$78.99	-	-	CBC1	1.27	$154.93	-	-
Q	-	-	-	-	-	-	CA1	0.89	$108.57	-	-
R	-	-	-	-	-	-	BAB2	0.98	$119.55	-	-
S	-	-	-	-	-	-	BAB1	0.94	$114.67	-	-
T	-	-	-	-	-	-	PDE2	1.48	$180.55	-	-
U	-	-	-	-	-	-	PDE1	1.39	$169.57	-	-
V	-	-	-	-	-	-	PBC2	1.15	$140.29	-	-
W	-	-	-	-	-	-	PA2	0.67	$81.73	-	-
X	-	-	-	-	-	-	PBC1	1.07	$130.53	-	-
Y	-	-	-	-	-	-	PA1	0.62	$75.63	-	-

How Does it All Add Up?

Utilizes the diagnosis in I0020B to identify the Clinical Category

The resident's Function Score is then identified which then leads to the case mix index (CMI) and the associated weight factor

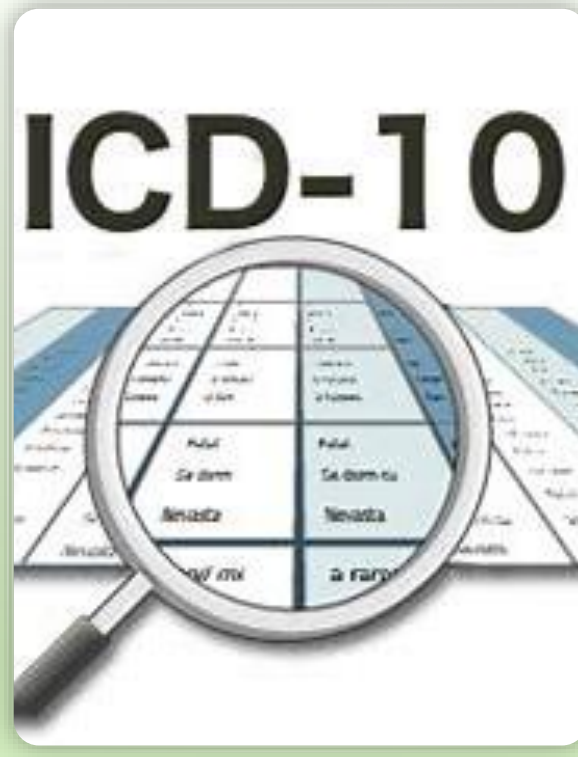
The CMI weight factor is then multiplied times the daily payment for each of the components to identify the final payment for each day

PT/OT note: the CMI weight factor and daily payment rate are different after the 20th day, daily rate decreases by 2% every 7 days

NTA: 3 x's higher the first 3 days

ICD-10 Information

https://www.cms.gov/Medicare/Coding/ICD10/index.html



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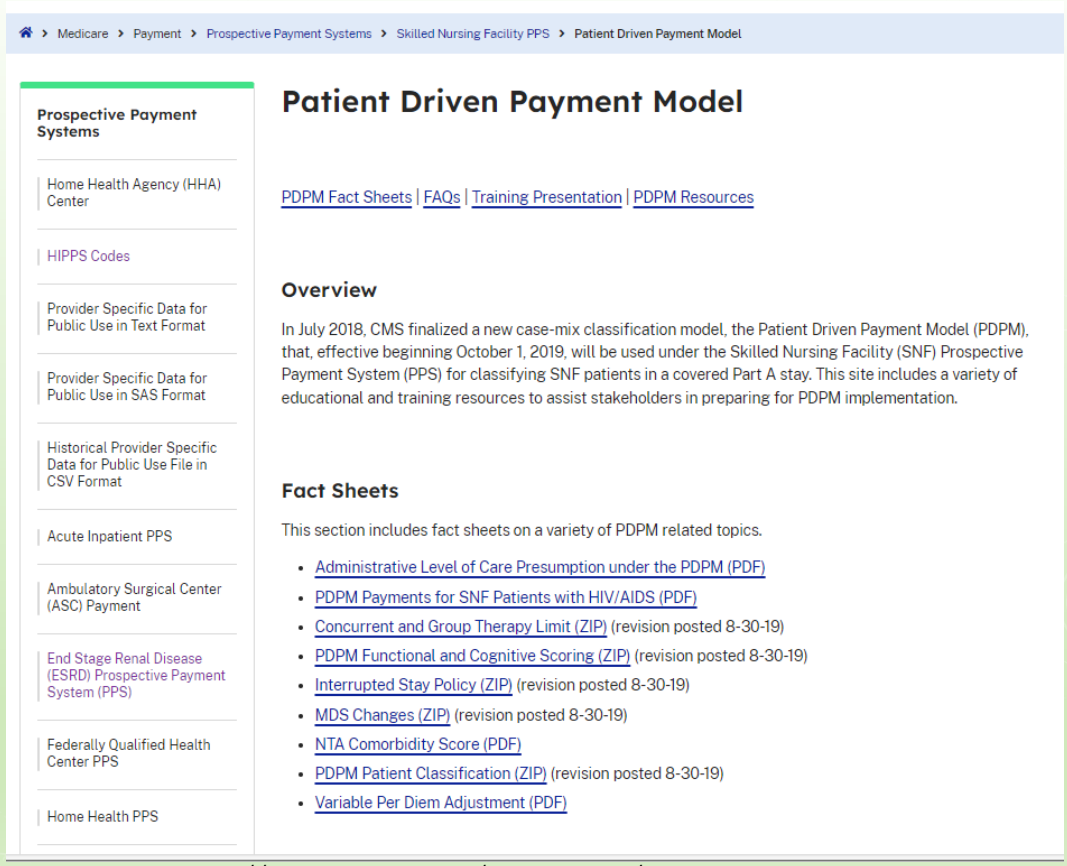
PDPM Clinical Categories

SNF patients are first classified into a clinical category based on the primary diagnosis for the SNF stay

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes, coded on the Minimum Data Set (MDS) in Item I0020B, are mapped to a PDPM clinical category: Clinical classification may be adjusted by a surgical procedure that occurred during the prior inpatient stay, as coded in Section I.

ICD-10 mapping available on the PDPM webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM



HTTPS://WWW.CMS.GOV/MEDICARE/MEDICARE-FEE-FOR-SERVICE-PAYMENT/SNFPPS/PDPM.HTML

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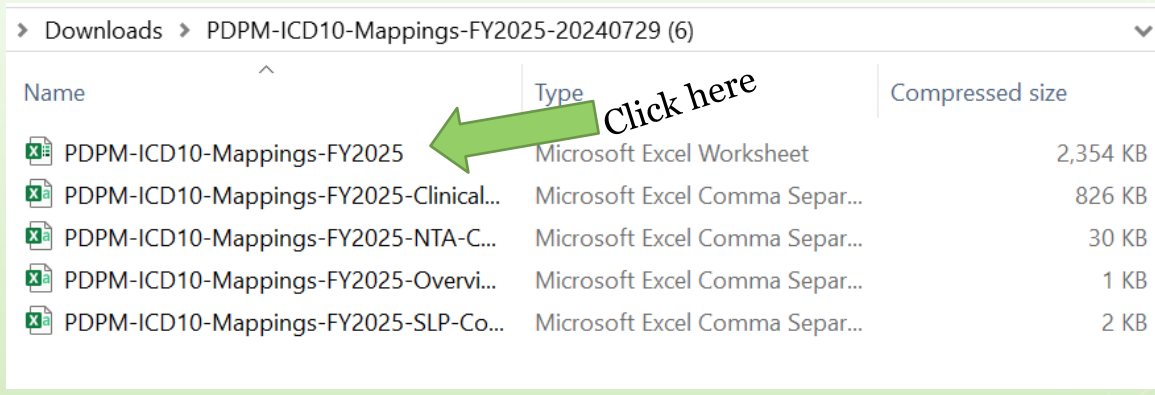
PDPM Resources

This section includes additional resources relevant to PDPM implementation, including various coding crosswalks and classification logic.

- PDPM GROUPER Logic
- FY 2020 PDPM ICD-10 Mappings (ZIP) (revision posted 03-31-2020)
- FY 2021 PDPM ICD-10 Mappings (ZIP) (effective 01-01-2021)
- FY 2022 PDPM ICD-10 Mappings (ZIP) (revision posted 09-27-2021)
- FY 2023 PDPM ICD-10 Mapping (ZIP) (effective 10-01-2022)
- FY 2024 *DRAFT* PDPM ICD-10 Mapping (ZIP) (see FY 2024 SNF PPS Proposed Rule) (revision posted 08-07-2023)
- FY 2024 PDPM ICD-10 Mapping (ZIP) (effective 10-01-2023; revision posted 04-12-2024)
- FY 2025 PDPM ICD-10 Mapping (ZIP) (effective 10-01-2024)

Click here

UTILIZE CMS MAPPING TOOL



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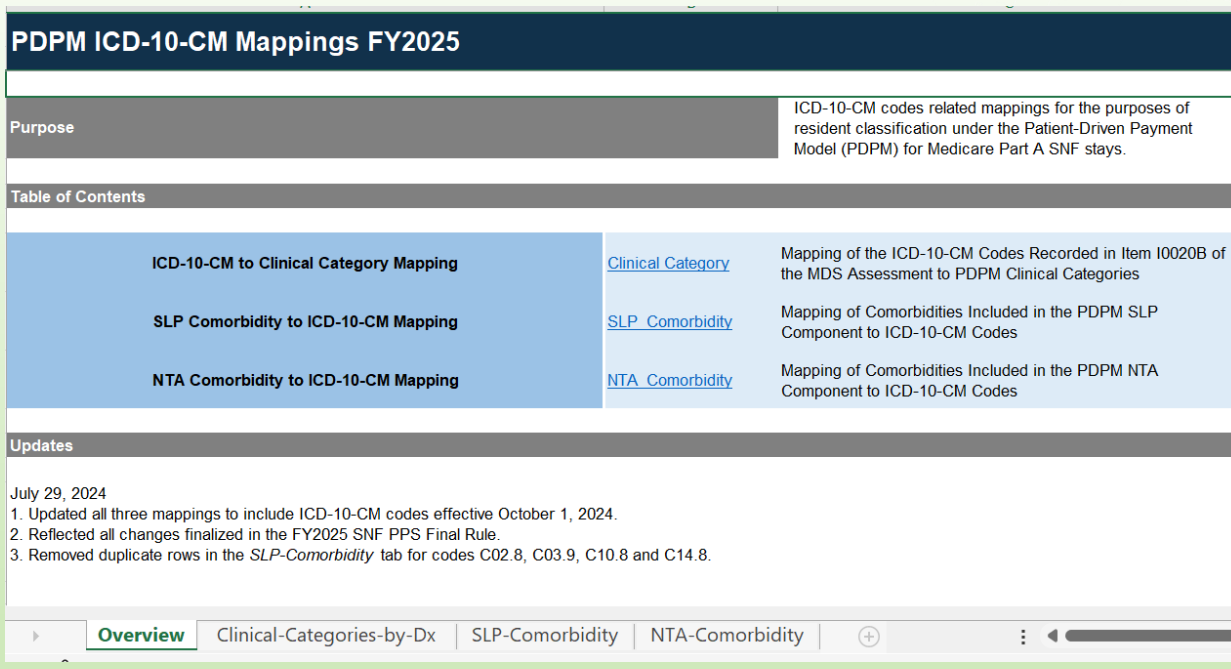

PDPM ICD-10-CM Mappings FY2025

Purpose	ICD-10-CM codes related mappings for the purposes of resident classification under the Patient-Driven Payment Model (PDPM) for Medicare Part A SNF stays.

Table of Contents

ICD-10-CM to Clinical Category Mapping	Clinical Category	Mapping of the ICD-10-CM Codes Recorded in Item I0020B of the MDS Assessment to PDPM Clinical Categories
SLP Comorbidity to ICD-10-CM Mapping	SLP_Comorbidity	Mapping of Comorbidities Included in the PDPM SLP Component to ICD-10-CM Codes
NTA Comorbidity to ICD-10-CM Mapping	NTA_Comorbidity	Mapping of Comorbidities Included in the PDPM NTA Component to ICD-10-CM Codes

Updates

July 29, 2024
1. Updated all three mappings to include ICD-10-CM codes effective October 1, 2024.
2. Reflected all changes finalized in the FY2025 SNF PPS Final Rule.
3. Removed duplicate rows in the *SLP-Comorbidity* tab for codes C02.8, C03.9, C10.8 and C14.8.

Overview | Clinical-Categories-by-Dx | SLP-Comorbidity | NTA-Comorbidity

Click Here

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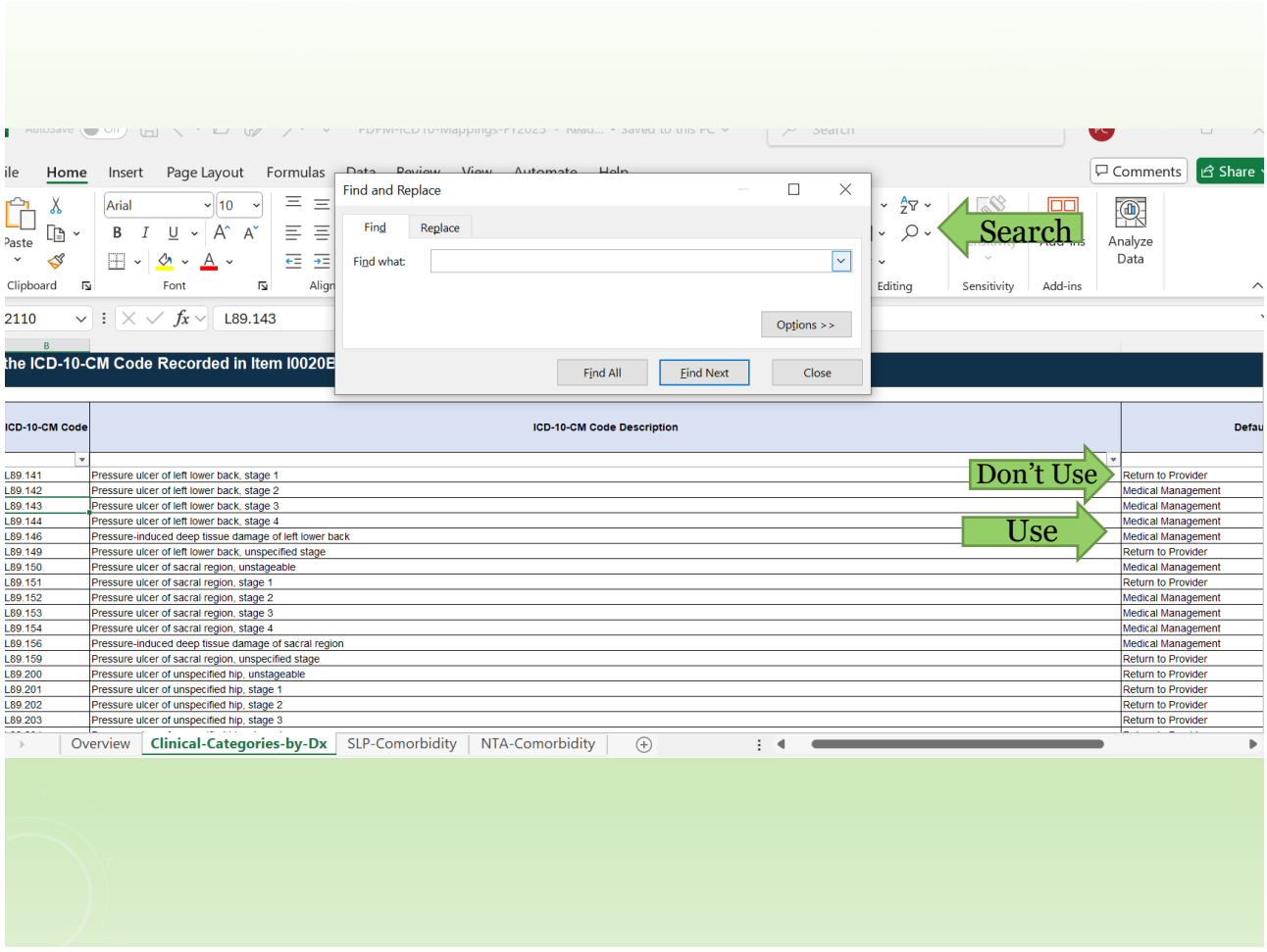
Find and Replace
Find
Replace
Find what:
Options >>
Find All
Find Next
Close
Search
Don't Use
Use
the ICD-10-CM Code Recorded in Item I0020E
ICD-10-CM Code
ICD-10-CM Code Description
L89.141 Pressure ulcer of left lower back, stage 1 — Return to Provider
L89.142 Pressure ulcer of left lower back, stage 2 — Medical Management
L89.143 Pressure ulcer of left lower back, stage 3 — Medical Management
L89.144 Pressure ulcer of left lower back, stage 4 — Medical Management
L89.146 Pressure-induced deep tissue damage of left lower back — Medical Management
L89.149 Pressure ulcer of left lower back, unspecified stage — Return to Provider
L89.150 Pressure ulcer of sacral region, unstageable — Medical Management
L89.151 Pressure ulcer of sacral region, stage 1 — Return to Provider
L89.152 Pressure ulcer of sacral region, stage 2 — Medical Management
L89.153 Pressure ulcer of sacral region, stage 3 — Medical Management
L89.154 Pressure ulcer of sacral region, stage 4 — Medical Management
L89.156 Pressure-induced deep tissue damage of sacral region — Medical Management
L89.159 Pressure ulcer of sacral region, unspecified stage — Return to Provider
L89.200 Pressure ulcer of unspecified hip, unstageable — Return to Provider
L89.201 Pressure ulcer of unspecified hip, stage 1 — Return to Provider
L89.202 Pressure ulcer of unspecified hip, stage 2 — Return to Provider
L89.203 Pressure ulcer of unspecified hip, stage 3 — Return to Provider
Overview
Clinical-Categories-by-Dx
SLP-Comorbidity
NTA-Comorbidity

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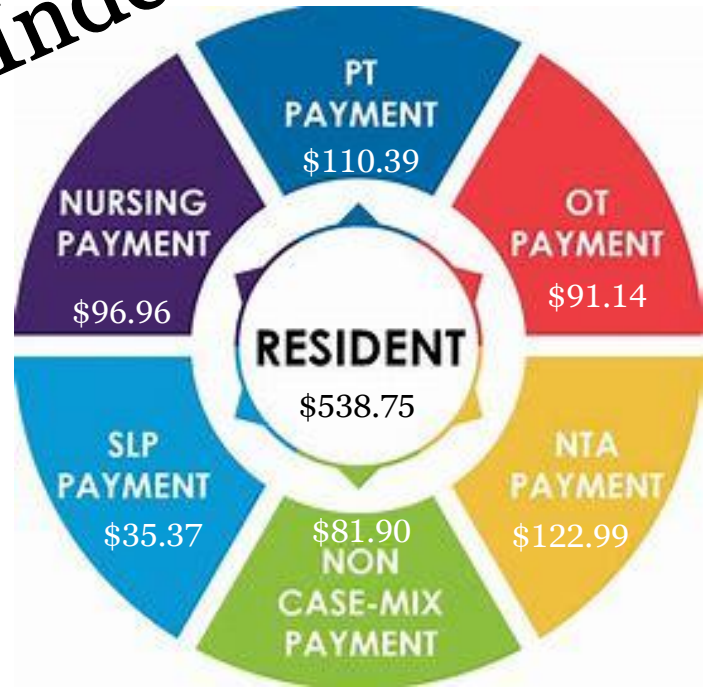
Determine PDPM Case Mix Index



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PDPM HIPPS Coding

Based on responses on the MDS, patients are classified into payment groups, which are billed using a 5-character HIPPS code

In order to accommodate the payment groups, the PDPM HIPPS algorithm is as follows:

Character 1: PT/OT Payment Group
Character 2: SLP Payment Group
Character 3: Nursing Payment Group
Character 4: NTA Payment Group
Character 5: Assessment Indicator

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PDPM HIPPS Grids

PDPM HIPPS CODE METHODOLOGY
Character 1- PT/OT Payment Group
Character 2- SLP Payment Group
Character 3- Nursing Payment Group
Character 4- NTA Payment Group

ASSESSMENT TYPE	HIPPS CHARACTER
IPA	0
5 Day	1
OBRA	6

PT/OT	SLP	NTA	HIPPS
TA	SA	NA	A
TB	SB	NB	B
TC	SC	NC	C
TD	SD	ND	D
TE	SE	NE	E
TF	SF	NF	F
TG	SG		G
TH	SH		H
TI	SI		I
TJ	SJ		J
TK	SK		K
TL	SL		L
TM	SM		M
TN	SN		N
TO	SO		O
TP	SP		P

NURSING GROUP	HIPPS
ES3	A
ES2	B
ES1	C
HDE2	D
HDE1	E
HBC2	F
HBC1	G
LDE2	H
LDE1	I
LBC2	J
LBC1	K
CDE2	L
CDE1	M
CBC2	N
CA2	O
CBC1	P
CA1	Q
BAB2	R
BAB1	S
PDE2	T
PDE1	U
PBC2	V
PA2	W
PBC1	X
PA1	Y

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HIPPS CODE WORKSHEET

Example 1

PT/OT: TH
SLP: SG
Nursing: CBC2
NTA: NA
Assessment: 5 day

HIPPS_____

Example 2

PT/OT: TA
SLP: SC
Nursing: ES3
NTA: NF
Assessment: IPA

HIPPS_____

Example 3

PT/OT: TP
SLP: SL
Nursing: PBC2
NTA: NB
Assessment: OBRA

HIPPS_____

RAI Special Situations Impacting Reimbursement

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Special Services

Leave of absence

Beneficiary leaves for certain excluded services

LOA and Schedule Issues

Leave of Absence

- Temporary home visit of at least one night; or
- Therapeutic leave of at least one night; or
- Hospital observation stay less than 24 hours and the hospital does not admit the resident.

Will have reimbursement implications- non-billable for the day was not in the facility.

For example, if a resident leaves a SNF at 6 p.m. on Wednesday, which is Day 27 of the resident's stay, and returns to the SNF on Thursday at 9 a.m., then Wednesday becomes a non - billable day and Thursday becomes Day 27 of the resident's stay.

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Midnight Rule

Day preceding the midnight on which the beneficiary was absent from the facility, facility can not bill for that day

Less then 24 hours in hospital, not admitted then a LOA

Medicare “clock” is altered but clinical assessments remain the same

Upon return, may need a significant change

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Avoid Scheduling Issues

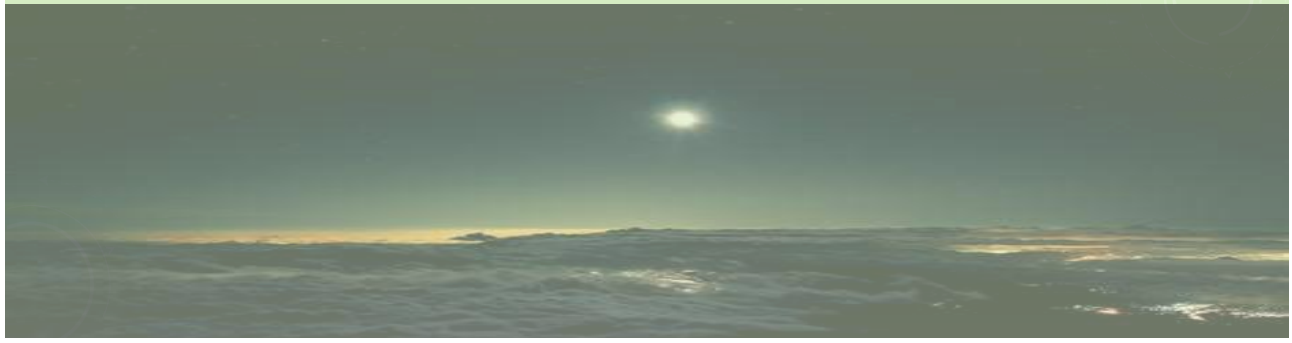
Open 5 day assessment with ARD between day 1-8 ASAP once in the facility.

Resident expires before or on the eighth day of the SNF stay.

Complete the 5 day assessment as completely as possible. Submit to CMS. If none submitted then bill the default rate.

Resident is sent to an acute care facility, NOT in SNF over midnight (but less than 24 hours) and is NOT admitted to the acute care facility. A new 5 day assessment is not required. Consider an IPA if appropriate.

Payment implications: The day preceeding the midnight on which the resident was absent from the nursing home is NOT covered under Part A due to the "midnight rule".



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Medicare A Assessments

Required for reimbursement under Medicare Part A

Must meet OBRA requirements also

When combining Medicare and OBRA assessments:

All requirements for both are met*

Discharges

Discharge Reporting

- OBRA Discharge return not anticipated
- OBRA Discharge return anticipated
- PPS Discharge

Part A PPS Discharge is completed when a resident's Medicare Part A stay ends, but the resident remains in the facility. (Item A0310H)

PPS Discharge can be combined with an OBRA discharge as long as the OBRA discharge occurs on the day of or one day after the end date of Medicare

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Medicare Schedule for Reimbursement Purposes

Entry

Admission Assessment (Clinical)/ 5 day Assessment (Reimbursement)

SNF part A PPS Discharge Assessment

OBRA Discharge: Discharge Return Anticipated/ Discharge Return NOT Anticipated

Reentry upon returning

Start Medicare assessments again with a new Medicare 5 day unless it is a "interrupted stay"

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What is an Interrupted Stay?

An interrupted stay only pertains to Medicare A residents only.
When a Medicare A resident returns to the same SNF and resumes Medicare A services within the 3 day interruption window.

Example 1:
Resident is Medicare A, is out of the facility 3 days or less (day of discharge is day 1). Returns to the same SNF under Medicare A services. The resident returned within the "interruption window".
A discharge return anticipated would be done on the day of discharge, and entry tracking form on the day return to the facility and NO new 5 day is completed. An IPA may be completed if deemed appropriate.

Example 2:

Same scenario but the resident is out past day 3, then it is not an interrupted stay. A discharge return anticipated combined with a Medicare Part A PPS discharge assessment, an entry would be done on the day the resident returned and a new 5 day assessment would be required to pick up payment when the resident returned.

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Discharge from Medicare A Skilled Services

Resident Discharged from Part A Skilled Services Is Not Physically Discharged from the Skilled Nursing Facility

> If they remain in a Medicare and/or Medicaid certified bed with another payer source, the facility must continue with the OBRA schedule from the beneficiary's original date of admission (item A1900) and must also complete a Part A PPS Discharge assessment.

Keep in mind, that the OBRA schedule is not altered based on the discharge from Medicare Part A.

Reminder- if the resident is placed back on Medicare A within 3 days of being taken off Medicare A (day of discharge off Med A is day 1) then it would qualify as an interrupted stay and a new 5 day is not warranted.

Interim Payment Assessment (IPA)
Optional

This assessment may be completed to capture changes in the resident's status and condition

The ARD for an IPA may not precede that of the 5 Day assessment.

May **NOT** be combined with any other assessments (PPS or OBRA).

ARD may be set for any day of the SNF PPS stay, beyond the ARD of the 5 Day.

Authorizes payment for remainder of the PPS stay, beginning on the ARD.

Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).

Must be submitted 14 days after completion (Item Z0500B) (completion + 14 days).

Why is the discharge type and return in 30 days so important?

Medicare A resident discharge return anticipated and returns within 30 day- an entry tracking form would be completed, then you would continue with your OBRA assessment as previously scheduled. If greater then 3 days then a new 5 day assessment would also be required for reimbursement purposes. If less than 3 days- then a new 5 day assessment would not be required if it qualifies for an interrupted stay.

Medicare A resident discharge return anticipated and does not return in 30 days- an entry tracking form would be completed, then a new Admission assessment and new 5 day assessment would need to be completed.

Medicare A resident discharge return anticipated and does not or does return within 30 days- an entry tracking form would be completed, then an Admission assessment would be required and a new 5 day assessment would be required.

Moving the ARD

The ARD can be changed only during the “window”

If a resident is discharged prior to the ARD it can be “moved” to the day of discharged if done prior to the 14th day after discharge, otherwise it is considered a missed MDS.

If no ARD was “set” prior to discharge then there is **no** MDS that can be adjusted.

Non-Compliance with PPS Assessment Schedule

Frequent late assessment scheduling practices or missed assessments may result in additional review.

The default rate takes the place of the otherwise applicable Federal rate.

This rate is equal to the rate paid for the Health Insurance Prospective Payment System (HIPPS) code reflecting the lowest acuity level for each PDPM component, and be lower than the Medicare rate payable if the SNF had submitted an assessment on time.

Late PPS Assessments

The SNF will bill the default rate for the number of days that the assessment is out of compliance.

This is equal to the number of days between the day following the last day of the available ARD window and the late ARD (including the late ARD).

The SNF would then bill the HIPPS code established by the late assessment for the remainder of the SNF stay, unless the SNF chooses to complete an IPA.

Missed Assessment

If the SNF fails to set the ARD of a 5-Day assessment prior to the end of the last day of the ARD window, and the resident was already discharged from Medicare Part A when this error is discovered, the provider cannot complete an assessment for SNF PPS purposes, and the days cannot be billed to Part A.

No backdating of an ARD is allowed.

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Missed Assessment

However, there are instances when the SNF may bill the default code when a PPS assessment does not exist in the QIES ASAP system. These exceptions are:

1. The stay is less than 8 days within a spell of illness,
2. The SNF is notified on an untimely basis of or is unaware of a Medicare Secondary Payer denial,
3. The SNF is notified on an untimely basis of a beneficiary's enrollment in Medicare Part A,
4. The SNF is notified on an untimely basis of the revocation of a payment ban,
5. The beneficiary requests a demand bill, or
6. The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage plan.

HIPPS Coding- Default Billing

There may be instances in which providers may bill the "default" rate on a SNF claim

- The default rate refers to the lowest possible per diem rate.

The default code under PDPM is ZZZZZ

IF you are late, or missed setting the ARD for a PPS assessment it WILL impact survey, reimbursement

IF you are late or missed completing an OBRA assessment it may impact you with survey, but it will not impact you financially under Medicare Part A reimbursement.

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Assessment Completion Late

- Impacts Care Plan Meeting/ Process
- Facility Stress
- Job dissatisfaction
- Survey implications

Reason for Late Assessments

Being pulled to the floor

Job responsibility including other “job duties”, IP-Antibiotic Stewardship program, GDR program, Auditing, Restorative Nurse duties, etc.....

Not organized, unable to prioritize, unable to focus

Not trained in all areas needed for success

Medical Review and Data Monitoring

Regardless of the payment model used, ensuring appropriate safeguards for program integrity is always essential.

- Ensuring program integrity can also represent an administrative burden and potential financial risk for providers.

Consider an external auditor to review a random sample of MDS forms, the related medical records, and the claims to confirm the accuracy and completeness of the required Medicare Part A components.

- May need to consider a review under attorney-client privilege to keep such activities confidential and protected.

Protection Processes

Check the claims before submitting for reimbursement:

- Triple Check Process
- Monitor the expedited review process
- Are the right letters being delivered?
- Are they timely?
- Monitor Medicare & Medicaid Audits
- PEPPER Reports https://pepper.cbrpepper.org/

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Payment/ Quality Alignment

CMS measures the quality of care provided to SNF patients/residents in a variety of ways:

- SNF Quality Reporting Program.
- SNF Value Based Purchasing.
- Nursing Home Compare Star Ratings.

Value driven care is, by definition, a balance between care quality and care cost:

- High - value, efficient providers are those who are able to deliver high quality care for low cost.

Unchanged Policies under PDPM

Basic administrative processes under SNF PPS.

Wage index calculations.

Payment and policy associated with therapy evaluations.

Denial notice policies, Advance Beneficiary Notices (ABNs), Notices of Medicare Non - Coverage (NOMNCs).

Student supervision policies.

What is a MDS Coordinator?

What role does that person play in the facility?

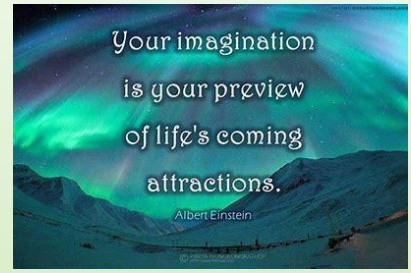
MDS Coordinator: Leader vs. Manager

Leaders show the way, while Managers pave the way through day-to-day problem solving. A person who is a good leader of people may not be good at managing resources. A good manager may have the skills to organize the workload and accomplish tasks but may be able to build teams and envision strategies to advance the department.

Five Traits

Mindset:

Believes in the mission, the plans, and believes in his/herself They feel called to do the task



Imagination:

Thinks big

Focus:

Looks intently and with total focus. Possess a clearly identified goal

Integrity:

A great leader will keep his word, will not compromise

Courage:

Will stand up, stand out, and stand strong Great leaders stand up and take action. They choose not to be average

Successful Managers

Organized, focused and wizards at time management

Manages resources to deliver the best care possible while meeting tight deadlines

Analyzes data, set resolution, addressing concerns and complaints.

Leadership and Management Comparison

	Leadership	Management
Motto	Do the right thing	Do things right
Challenge	Change	Continuity
Focus	Purpose	Structures & procedures
Time frame	Future	Present
Methods	Strategy	Schedule
Questions	Why?	Who, what, when, where, how?
Outcomes	Journeys	Destinations
Human	Potential	Performance
Source: Bennis & Nanus 1997		

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MDS Coordinator's Role

Without the MDS, facilities and care givers:

Would not know the unique care that each resident needs & deserves

Would not know the resident's preferences for care

Would not know the potential life-threatening events that could occur

Surveys would be a disaster

The facility would not have any income

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REFERENCES

http://cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp
- MDS 3.0 manual
- Training material
- Technical information

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs
- Medicare Benefit Policy Manual
- Medicare Claims processing

Medicare Benefit Manual Billing
http://www.cms.gov/manuals/downloads/clm104c06.pdf
https://www.wpsgha.com
- Understanding the major categories of exclusion from consolidated billing
- Medicare Payment Scheduler
- Spell of Illness Chart

RESOURCES

https://www.wpsgha.com
- Understanding the major categories of exclusion from consolidated billing
- Medicare Payment Scheduler
- Spell of Illness Chart

http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html
http://www.medicareadvocacy.org
http://www.medicare.gov/publications/pubs/pdf/11435.pdf

PDPM website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

For questions related to PDPM implementation and policy: PDPM@cms.hhs.gov

For questions related to the OSA: OSAMedicaidinfo@cms.hhs.gov

CNA information https://health.mo.gov/safety/cnaregistry/index.php.

https://www.medicare.org/medicare-part-a/

SNF Consolidated Billing | CMS
Historical Questions & Answers on SNF Consolidated Billing (cms.gov)

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RESOURCES

For more information: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html

Medicare Administrative Contractor (MAC). Wisconsin Physician Services (WPS) is the MAC for SNFs in Missouri, meaning this is who will process your Medicare claims. Their customer services number is 866-518-3285 and you must have your SNFs NPI and last 5 digits of the Tax Identification Number (TIN) when you call.

FFS SNF ABN | CMS

MLN article regarding spell of illness information:
https://www.cms.gov/sites/default/files/repo-new/29/SNFSpellIllnesschrt.pdf

RESOURCES

Medicare Rates

https://www.mhanet.com/mhaimages/issue%20briefs/08-02-2024%20Final%20FY%202025%20SNF.pdf

CMS-8080-N: https://www.federalregister.gov/public-inspection/2022-21180/medicare-program-calendar-year-2023-inpatient-hospital-deductible-and-hospital-and-extended-care
CMS-8081-N:https://www.federalregister.gov/public-inspection/2022-21176/medicare-program-cy-2023-part-a-premiums-for-the-uninsured-aged-and-for-certain-disabled-individuals
CMS-8082-N:https://www.federalregister.gov/public-inspection/2022-21090/medicare-program-medicare-part-b-monthly-actuarial-rates-premium-rates-and-annual-deductible

https://cmsnationaltrainingprogram.cms.gov/sites/default/files/shared/2025_Medicare%20Amounts_508%20FINAL_0.pdf

Hospice
Hospice Care Coverage (medicare.gov)

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QIPMO: www.nursinghomehelp.org

Jessica Mueller Senior Program/QIPMO Project Support Coordinator:
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MLN mlnmonursing.org
MANHA mlnha.org
Leading Age leadingagemissouri.org