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ABILITY PDPM Series

MDS Changes Under PDPM

A CMS Fact Sheet Overview

CMS aims for clarity in payment model transition

The Centers for Medicare & Medicaid Services (CMS) has put together several helpful resources in an effort to thoroughly communicate the Patient-Driven Payment Model (PDPM) changes that are now upon us.

While some elements of the new payment system may seem a bit mysterious, the agency does have some helpful fact sheets to get skilled nursing facilities (SNFs) through this transition period. Among them is the minimum data set (MDS) changes fact sheet, which was last updated in February 2019.

The changes to MDS under PDPM are significant: several new items have been added, in addition to a streamlined assessment policy and new MDS Item Sets. This flipbook will summarize the key changes outlined in the MDS fact sheet.

Fewer assessments under PDPM

Previously under Resource Utilization Group (RUG) IV, SNFs were required to complete scheduled assessments on or around Days 5, 14, 30, 60, and 90 of a patient's Part A SNF stay. Unscheduled assessments could have been triggered by different events during a patient's stay; for example, when a SNF patient starts or ends therapy, or when there is a change in the patient's status or the volume of therapy received.

Only 3 Prospective Payment System (PPS) assessments

1. 5-Day Assessment
2. Interim Payment Assessment (IPA)
3. PPS Discharge Assessment

The 5-day assessment and the PPS Discharge Assessment are required, says CMS, while the IPA is optional and "will be completed when providers determine that the patient hasundergone a clinical change that would require a new PPS assessment."

Assessing the impact on billing

For late assessments under PDPM, similar to under RUG-IV, the provider will bill the default HIPPS code for the number of days out of compliance and then the 5-day assessment HIPPS code for the remainder of the stay, unless an IPA is completed.

One caveat to this is that the default billing is now assessed prior to the 5-day assessment HIPPS code, in terms of counting days for the variable per diem. For example, the fact sheet notes that if a 5-day assessment is two days late, then Days 1 and 2 of the stay will be calculated using the default HIPPS code and then the 5-day assessment HIPPS code will control payment beginning on Day 3 of the variable per diem schedule.

Two new item sets

CMS has created two new item sets for PDPM:

1

The Interim Payment Assessment has its own IPA item set, which contains payment items and demographic items, as necessary, to attain a billing code under PDPM. Because the IPA is completely optional, there are no late assessment penalties for that assessment.

2

For states using the RUG-IV assessment schedule to calculate case mix groups, **CMS has created an optional assessment** "so that Medicaid payments are not adversely impacted when PDPM is implemented." The optional assessment will remain in place through September 30, 2020.

SNF primary diagnosis

To capture the patient's primary diagnosis, which is used to classify the patient into a PDPM clinical category, **CMS added Item I0020B, which allows providers to report, using an ICD-10 CM code, the patient's primary SNF diagnosis**. The item asks "What is the main reason this person is being admitted to the SNF?" Item 10020B is coded when Item I0020 is coded as any response 1 through 13. Note that item I0020A (under RUG IV) is being retired on the MDS 3.0. Only I0020 and I0020B will be used.

Surgical information

CMS added new items in Section J of the MDS – **Items J2100 to J5000 – in order to capture surgical information that is relevant to classifying SNF patients into a PDPM clinical category**. These are items are used to identify any major surgical procedures that occurred during the inpatient hospital stay immediately preceding the SNF admission, such as the qualifying hospital stay. These items will be used, in conjunction with the diagnosis code captured in I0020B, to classify patients into the PT and OT case-mix classification groups for PDPM.

Discharge therapy items

In order to capture therapy delivery information over the course of a patient's entire Part A stay, CMS added **Items 0425A1 through O0425C5**, which appear in Section O of the MDS. Using a look-back period of the entire PPS stay, providers will report, by each discipline and mode of therapy, the amount of therapy (in minutes) received by the patient. If the total amount of combined Group/Concurrent minutes comprises more than 25 percent of the total amount of therapy for that discipline, a warning message will be issued on the final validation report. (See CMS Gives Fair Warning: Don't Overdo Concurrent and Group Therapy for a review of this new provision in PDPM.)

Interim performance

PDPM advances CMS' goal of using standardized assessment items across payment settings by using items in Section GG of the MDS as the basis for patient functional assessments. On the IPA, GG items are now delivered from a new column "5" that capture the interim performance of the patient. The look-back for this new column is a three-day window preceding and up to the assessment reference date of the IPA.

Key to navigating the transition to PDPM is being well-prepared. Continue to train and educate staff on these significant changes to ensure a smooth adoption of PDPM.