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CHAPTER 6: MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM (SNF PPS)

6.1 Background

The Balanced Budget Act of 1997 included the implementation of a Prospective Payment System (PPS) for skilled nursing facilities (SNFs) and hospitals with a swing bed agreement, consolidated billing, and a number of related changes. The PPS system replaced the retrospective cost-based system for SNFs under Part A of the program (**Federal Register** Vol. 63, No. 91, May 12, 1998, Final Rule). Effective with cost reporting periods beginning on or after July 1, 2002, SNF-level services furnished in rural swing bed hospitals are paid based on the SNF PPS instead of the previous, cost-related method (**Federal Register** Vol. 66, No. 147, July 31, 2001, Final Rule). However, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 included an exemption of critical access hospital swing beds from the SNF PPS.

The SNF PPS is the culmination of substantial research efforts beginning as early as the 1970s that focus on the areas of nursing home payment and quality. In addition, it is based on a foundation of knowledge and work by a number of States that developed and implemented similar case-mix payment methodologies for their Medicaid nursing home payment systems.

The current focus in the development of the Federal payment system (i.e., PPS) for nursing home care is based on recognizing the differences among residents, particularly in the utilization of resources. Some residents require total assistance with their activities of daily living (ADLs) and have complex nursing care needs. Other residents may require less assistance with ADLs but may require rehabilitation or restorative nursing services. The recognition of these differences is the premise of a case-mix system. Reimbursement levels differ based on the resource needs of the residents. Residents with heavy care needs require more staff resources and payment levels should be higher than for those residents with less intensive care needs. In a case-mix adjusted payment system, the amount of reimbursement to the nursing home is based on the resource intensity of the resident as measured by items on the Minimum Data Set (MDS). Case-mix reimbursement has become a widely adopted method for financing nursing home care. The case-mix approach serves as the basis for the PPS for skilled nursing facilities and swing bed hospitals and is increasingly being used by States for Medicaid reimbursement for nursing homes.

6.2 Using the MDS in the Medicare Prospective Payment System

The MDS assessment data is used to calculate the resident's Patient Driven Payment Model (PDPM) classification necessary for payment. The MDS contains extensive information on the resident's nursing and therapy needs, ADL status, cognitive status, behavioral problems, and medical diagnoses. This information is used to define PDPM case-mix adjusted groups, within

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which a hierarchy exists that assigns case-mix weights that capture differences in the relative resources used for treating different types of residents.

Over half of the State Medicaid programs also use the MDS for their case-mix payment systems. The Resource Utilization Group, Version IV (RUG-IV) system replaced the Resource Utilization Group, Version III (RUG-III) system for Medicare starting on October 1, 2010. Starting October 1, 2019, PDPM replaced the RUG-IV system. However, State Medicaid agencies have the option to use the RUG-III, RUG-IV, or PDPM classification systems. CMS also makes available for the States alternative RUG-IV classification systems with 66, 57, or 48 groups with varying numbers of Rehabilitation groups (similar to the RUG-III 53, 44, and 34 groups). States have the option of selecting the system (RUG-III or RUG-IV) with the number of Rehabilitation groups that better suits their Medicaid long-term care population. State Medicaid programs always have the option to develop nursing home reimbursement systems that meet their specific program goals. The decision to implement a certain classification system for Medicaid is a State decision. Please contact your State Medicaid agency if you have questions about your State Medicaid reimbursement system.

6.3 Patient Driven Payment Model (PDPM)

PDPM adjusts payment for each major element of a resident's SNF care, specifically for physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), nursing, and non-therapy ancillaries (NTA). In section 6.6 below, we provide a PDPM calculation worksheet. This calculation worksheet was developed in order to provide clinical staff with a better understanding of how PDPM works. The worksheet translates the standard software code into plain language to assist staff in understanding the logic behind the classification system.

6.4 Relationship between the Assessment and the Claim

The SNF PPS establishes a schedule of PPS assessments. The 5-Day assessment is the only required PPS assessment that is used to support PPS reimbursement. However, as described in Chapter 2, Section 2.9, an optional assessment, the Interim Payment Assessment (IPA), may be used to reclassify the resident into a new PDPM classification, and would also affect the associated payment rate. See Chapter 2 of this manual for greater detail on assessment types and requirements.

Numerous situations exist that impact the relationship between the assessment and the claim above and beyond the information provided in this chapter. It is the responsibility of the provider to ensure that claims submitted to Medicare are accurate and meet all Medicare requirements.

For example, if a resident's status does not meet the criteria for Medicare Part A SNF coverage, the provider is not to bill Medicare for any non-covered days. The assignment of a PDPM classification is not an indication that the requirements for a SNF Part A stay have been met. Once the resident no longer requires skilled services, the provider must not bill Medicare for days that are not covered. Therefore, the following information is not to be considered all-inclusive and definitive. Refer to the **Medicare Claims Processing Manual**, Chapter 6

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(<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf>), for detailed claims processing requirements and policies.

The SNF claim must include two data items derived from the MDS assessment:

Assessment Reference Date (ARD)

The ARD must be reported on the SNF claim. CMS has developed internal mechanisms to link the MDS assessment and the claims processing system.

Health Insurance Prospective Payment System (HIPPS) Code

Each SNF claim contains a five-position HIPPS code for the purpose of billing Part A covered days to the Medicare Administrative Contractor (MAC). The HIPPS code consists of a series of codes representing the resident's PDPM classification and the Assessment Indicator (AI) as described below. CMS provides standard software and logic for HIPPS code calculation.

PDPM Classification

The first four positions of the HIPPS code contain the PDPM classification codes for each PDPM component to be billed for Medicare reimbursement. The PDPM classification is calculated from the MDS assessment clinical data. See Section 6.6 for calculation details on each PDPM group. CMS provides standard software, development tools, and logic for PDPM calculation. CMS software, or private software developed with the CMS data specifications, is used to encode and transmit the MDS assessment data and automatically calculates the resident's PDPM classification. CMS edits and validates the PDPM classification code of transmitted MDS assessments. Skilled nursing facilities are not permitted to submit Medicare Part A claims until the assessments have been accepted into the CMS database, and they must use the PDPM classification code as validated by CMS when bills are filed, except in cases in which the facility must bill the default code (ZZZZZ). See Section 6.8 for details.

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Table 1. First Character: PT/OT Component

Clinical Category	Section GG Function Score	PT/OT Case-Mix Group	HIPPS Character
Major Joint Replacement or Spinal Surgery	0-5	TA	A
Major Joint Replacement or Spinal Surgery	6-9	TB	B
Major Joint Replacement or Spinal Surgery	10-23	TC	C
Major Joint Replacement or Spinal Surgery	24	TD	D
Other Orthopedic	0-5	TE	E
Other Orthopedic	6-9	TF	F
Other Orthopedic	10-23	TG	G
Other Orthopedic	24	TH	H
Medical Management	0-5	TI	I
Medical Management	6-9	TJ	J
Medical Management	10-23	TK	K
Medical Management	24	TL	L
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	M
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	N
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	O
Non-Orthopedic Surgery and Acute Neurologic	24	TP	P

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Table 2. Second Character: SLP Component

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group	HIPPS Character
None	Neither	SA	A
None	Either	SB	B
None	Both	SC	C
Any one	Neither	SD	D
Any one	Either	SE	E
Any one	Both	SF	F
Any two	Neither	SG	G
Any two	Either	SH	H
Any two	Both	SI	I
All three	Neither	SJ	J
All three	Either	SK	K
All three	Both	SL	L

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Table 3. Third Character: Nursing Component

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	HIPPS Character
ES3	Tracheostomy & Ventilator	-	-	-	0-14	ES3	A
ES2	Tracheostomy or Ventilator	-	-	-	0-14	ES2	B
ES1	Infection	-	-	-	0-14	ES1	C
HE2/HD2	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	Yes	-	0-5	HDE2	D
HE1/HD1	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	No	-	0-5	HDE1	E
HC2/HB2	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	Yes	-	6-14	HBC2	F
HC1/HB1	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	No	-	6-14	HBC1	G
LE2/LD2	-	Serious medical conditions e.g., radiation therapy or dialysis	Yes	-	0-5	LDE2	H
LE1/LD1	-	Serious medical conditions e.g., radiation therapy or dialysis	No	-	0-5	LDE1	I
LC2/LB2	-	Serious medical conditions e.g., radiation therapy or dialysis	Yes	-	6-14	LBC2	J

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RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	HIPPS Character
LC1/LB1	-	Serious medical conditions e.g., radiation therapy or dialysis	No	-	6-14	LBC1	K
CE2/CD2	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	Yes	-	0-5	CDE2	L
CE1/CD1	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	No	-	0-5	CDE1	M
CC2/CB2	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	Yes	-	6-14	CBC2	N
CA2	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	Yes	-	15-16	CA2	O
CC1/CB1	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	No	-	6-14	CBC1	P
CA1	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	No	-	15-16	CA1	Q
BB2/BA2	-	Behavioral or cognitive symptoms	-	2 or more	11-16	BAB2	R
BB1/BA1	-	Behavioral or cognitive symptoms	-	0-1	11-16	BAB1	S
PE2/PD2	-	Assistance with daily living and general supervision	-	2 or more	0-5	PDE2	T

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RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	HIPPS Character
PE1/PD1	-	Assistance with daily living and general supervision	-	0-1	0-5	PDE1	U
PC2/PB2	-	Assistance with daily living and general supervision	-	2 or more	6-14	PBC2	V
PA2	-	Assistance with daily living and general supervision	-	2 or more	15-16	PA2	W
PC1/PB1	-	Assistance with daily living and general supervision	-	0-1	6-14	PBC1	X
PA1	-	Assistance with daily living and general supervision	-	0-1	15-16	PA1	Y

Table 4. Fourth Character: NTA Component

NTA Score Range	NTA Case-Mix Group	HIPPS Character
12+	NA	A
9-11	NB	B
6-8	NC	C
3-5	ND	D
1-2	NE	E
0	NF	F

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The PDPM HIPPS code is recorded on the MDS 3.0 in item Z0100A (Medicare Part A HIPPS code). The HIPPS code included on the SNF claim depends on the specific type of assessment involved (as described below).

The HIPPS code in item Z0100A is validated by CMS when the assessment is submitted. If the submitted code is incorrect, the validation report will include a warning giving the correct code; the facility must enter this correct code in the HIPPS code item on the bill.

The provider must ensure that all PPS assessment requirements are met. When the provider fails to meet the PPS assessment requirements, such as when the assessment is late (as evidenced by a late ARD), the provider may be required to bill the default code. In these situations, the provider is responsible to ensure that the default code and not the PDPM classification-based HIPPS code validated by CMS in item Z0100A is billed for the applicable number of days. See Section 6.8 of this chapter for greater detail.

AI Code

The last position of the HIPPS code represents the AI, identifying the assessment type. The AI coding system indicates the different types of assessments that define different PPS payment periods and is based on the coding of item A0310B. CMS provides standard software, development tools, and logic for AI code calculation. CMS software, or private software developed with the CMS tools, automatically calculates the AI code. The AI code is validated by CMS when the assessment is submitted. If the submitted AI code is incorrect on the assessment, the validation report will include a warning and provide the correct code. The facility must enter this correct AI code in the HIPPS code item on the bill. The code consists of one digit, which is defined below. In situations when the provider is to bill the default code, the AI provided on the validation report is to be used along with the default code, ZZZZZ, on the SNF claim.

Refer to the **Medicare Claims Processing Manual**, Chapter 6, for detailed claims processing requirements and policies.

The AI code identifies the assessment used to establish the per diem payment rate for the standard PPS payment periods. These assessments are the 5-Day assessment and Interim Payment Assessment. Table 5 displays the AI code for each of the PPS assessment types and the standard payment period for each assessment type.

Table 5. Assessment Indicator Table

AI Code	Assessment Type (abbreviation)	Standard Payment Period
0	Interim Payment Assessment	See Chapter 2, Section 2.9
1	5-Day	Entire Part A Stay

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6.5 SNF PPS Eligibility Criteria

Under SNF PPS, beneficiaries must meet the established eligibility requirements for a Part A SNF-level stay. These requirements are summarized in this section. Refer to the **Medicare General Information, Eligibility, and Entitlement Manual**, Chapter 1 (Pub. 100-1), and the **Medicare Benefit Policy Manual**, Chapter 8 (Pub. 100-2), for detailed SNF coverage requirements and policies.

Technical Eligibility Requirements

The beneficiary must meet the following criteria:

- Beneficiary is enrolled in Medicare Part A and has days available to use.
- There has been a three-day prior qualifying hospital stay (i.e., three midnights).
- Admission for SNF-level services is within 30 days of discharge from an acute care stay or within 30 days of discharge from a SNF level of care.

Clinical Eligibility Requirements

A beneficiary is eligible for SNF extended care if all of the following requirements are met:

- The beneficiary has a need for and receives medically necessary skilled care on a daily basis, which is provided by or under the direct supervision of skilled nursing or rehabilitation professionals.
- As a practical matter, these skilled services can only be provided in an SNF.
- The services provided must be for a condition:
 - for which the resident was treated during the qualifying hospital stay, or
 - that arose while the resident was in the SNF for treatment of a condition for which he or she was previously treated in a hospital.

Physician Certification

The attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case—or a nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS) who does not have a direct or indirect employment relationship with the facility but who is working in collaboration with the physician—must certify and then periodically recertify the need for extended care services in the skilled nursing facility.

- **Certifications** are required at the time of admission or as soon thereafter as is reasonable and practicable (42 CFR 424.20). The initial certification
 - affirms, per the required content found in 42 CFR 424.20, that the resident meets the existing SNF level of care definition, or
 - validates via written statement that the resident's assignment to one of the upper PDPM groups (defined below) is correct.

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- Those nursing groups encompassed by the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories;
- PT and OT groups TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO;
- SLP groups SC, SE, SF, SH, SI, SJ, SK, and SL; and
- The NTA component's uppermost (12+) comorbidity group.
- **Re-certifications** are used to document the continued need for skilled extended care services.
 - The first re-certification is required no later than the 14th day of the SNF stay.
 - Subsequent re-certifications are required at no later than 30-day intervals after the date of the first re-certification.
 - The initial certification and first re-certification may be signed at the same time.

6.6 PDPM Calculation Worksheet for SNFs

In the PDPM, there are five case-mix adjusted components: PT, OT, SLP, NTA, and Nursing. Each resident is to be classified into one and only one group for each of the five case-mix adjusted components. In other words, each resident is classified into a PT group, an OT group, an SLP group, an NTA group, and a nursing group. For each of the case-mix adjusted components, there are a number of groups to which a resident may be assigned, based on the relevant MDS 3.0 data for that component. There are 16 PT groups, 16 OT groups, 12 SLP groups, 6 NTA groups, and 25 nursing groups.

PDPM classifies residents into a separate group for each of the case-mix adjusted components, each of which has its own associated case-mix indexes and base rates. Additionally, PDPM applies variable per diem payment adjustments to three components, PT, OT, and NTA, to account for changes in resource use over a stay. The adjusted PT, OT, and NTA per diem rates are then added together with the unadjusted SLP and nursing component rates and the non-case-mix component to determine the full per diem rate for a given resident.