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INSIDE THIS ISSUE

Five PDPM pointers and reimbursement opportunities you may have missed

The Patient-Driven Payment Model (PDPM) has so many nuances that can impact reimbursement that it is near impossible for SNFs to consider and capitalize on them all.

BALTC asked leading experts to share some of the lesser-known payment opportunities and challenges in PDPM. Check your processes and procedures to ensure you're taking advantage of or protecting against the following aspects of PDPM.

1: Capture reimbursement for physician utilization review

In RUG-IV and now PDPM, SNFs receive the majority of their payments from Medicare prospectively. However, filing a cost report also leads to reimbursement for a few specific items, including the Medicare utilization review.

"Many SNF providers do not know that if they have a physician who participates in their Medicare utilization review, they can get reimbursed for the Medicare portion of the cost of that," says **Lisa Trundy-Whitten CPA, FHFMA, CPC-A,** a principal for the healthcare and not-for-profit practice groups with the accounting firm, BerryDunn.

This is a reimbursement opportunity for SNFs, who may consider involving physicians in the Medicare utilization review meetings once PDPM goes into effect.

"Because reimbursement will be based on clinical characteristics, there will need to be more participation from providers to determine the primary diagnoses and comorbidities for residents," Trundy-Whitten says.

To ensure correct reimbursement, SNFs will need to ensure that they have documentation that the providers participated in the meetings and a process for ensuring that data pulls over into the cost report.

2. Submit accurate claims when interrupted stays occur

The introduction of the interrupted stay policy (ISP) is one of the biggest changes billers will have to contend with in PDPM, says **Rosana Benbow, RN, CCM, CIC, DNS-CT, RAC-CT**.

The ISP states that when a SNF discharges and readmits a patient within three consecutive calendar days or less, the SNF should consider the readmission a continuation of the previous Medicare Part A-covered stay, Benbow explains.

"The ISP applies anytime they have a three-day gap in their Medicare coverage. This could be because they're in the hospital, they've changed payers, or even a leave of absence," Benbow says.

A discharge home for less than three days also meets the interrupted stay criteria.

Because it is a continuation of the stay, providers resume the assessment schedule and variable per diem schedule from the point just prior to the discharge. SNFs are not required to perform or submit a new 5-day assessment for patients who are subject to the ISP, says Mary Jo Wilson, client engagement specialist and consultant with SNF-Solutions, LLC.

Billing specialists must be aware of and consider the ISP's requirements when calculating beneficiary days.

"Instead of a one-day skip period, a resident can actually be in the hospital for up to three days and they can bill those days as skip days," Wilson says.

Additionally, billers need to understand how to submit claims if a patient returns to the SNF in the interruption window and the MDS/RAI coordinator determines that an interim payment assessment (IPA) is needed.

IPAs allow SNFs to capture the clinical conditions associated with the reasons for the patient's hospital or interrupted stay. The IPA can change all five case mix groups, so the MDS coordinator and billers should evaluate how the IPA will impact the overall daily rate before performing one.

Billers should submit one continued claim with the HCPCS codes generated by the current 5-day assessment. Billers should indicate that the hospital days or interrupted days are non-covered skip days by using revenue codes 0220, 0180, and ZZZZ0. This also requires billers to use span code 74 and dates of service to cover the skip days, Wilson says.

However, keep in mind that the ISP only applies if the resident leaves and returns to the same facility. It does not apply if the resident transfers in from another facility. When the SNF receives a transfer, the clinical team must complete a new 5-day assessment and billers must generate and submit a new claim, Wilson says.

3. Get reimbursed for hospital-administered total parenteral nutrition (TPN)

In PDPM, TPN will impact the non-therapy ancillary (NTA) case-mix component, not just the nursing component which was the only category linked to TPN reimbursement in RUG-IV, says Benbow.

If the resident receives TPN while in the SNF, you will see higher NTA and nursing scores for that patient. The resident will either meet the criteria for TPN High Intensity or Low Intensity. According to Medicare, use Section K0710A2 to determine the resident's level. The criteria are:

- High intensity: If the proportion of total calories the resident received through TPN was 51% or more while a resident
- Low intensity: If the proportion of total calories the resident received through TPN was 26-50% and average fluid intake per day by IV or tube feeding was 501 cc per day or more while a resident

SNFs will continue to receive reimbursement under the nursing component for TPN administered in the hospital. Section K is a 7-day look back, which can include the hospital stay. Including the TPN in Section K can increase the patient's nursing score, which can result in a much higher nursing component case-mix grouping and bump the SNF's reimbursement for these patients.

The 7-day look back is measured by the assessment reference date (ARD) counting back 7 days, including the ARD. At times, it may benefit SNFs to use an earlier day in the stay.

SNFs risk missing out on reimbursement dollars associated with TPN if they do not gather complete documentation from the hospital during the pre-admissions process.

"Because we're now able to count back from the hospital administration of the TPN, admissions needs to gather that information so that we can set the reference date early enough to capture that hospital TPN," Benbow says.

4. Get to know the return to provider (RTP) codes

CMS identifies certain ICD-10-CM codes that will automatically trigger an RTP error if submitted on the MDS or claim. ICD-10-CM codes listed on CMS's RTP list are not specific enough to map to a PDPM clinical category, so CMS will kick them back for nonpayment, says **Maureen McCarthy, RN, BS RAC-MT, QCP-MT, DNS-MT, RAC-MTA,** president and CEO of Celtic Consulting.

The RTP list includes many primary diagnoses accepted in the RUG-IV system, including:

- Muscle weakness
- Falls
- Unspecified diagnoses
- Failure to thrive
- Dehydration
- Unsteady gait/Abnormal gait/Difficulty walking
- Debility
- General weakness

Including RTP codes on MDSs and claims will cause delays in reimbursement and could ultimately lead to no reimbursement if you admit a patient who does not have a condition that maps to a PDPM clinical category, McCarthy says.

"In RUG-IV, we could cover patients with these conditions by providing therapy to get them to that skilled-level of care. But now, you do not have that safety net. Those diagnoses do not cross over to PDPM. If you have an RTP condition listed as the reason why you're skilling them, you will not get a case-mix grouping and the patient will not be covered," McCarthy says.

Consider admission staff as your first line of defense in guarding against patients with RTP conditions as their primary diagnosis. Savvy SNFs will screen for these conditions during the pre-admission process.

"If you have one open bed and three referrals, admission staff should look at the diagnosis codes provided in the admission documentation and compare it to the RTP list. You should choose the patient that you can cover—whose conditions are not on the RTP list," McCarthy says.

MDS coordinators should also know the codes that will trigger an RTP and avoid including them on the MDS. If the MDS sees an RTP, it may also be a sign that the clinical documentation is not strong enough to support a more accurate and higher-paying code. The MDS coordinator can go back to the clinical team and get a more accurate diagnosis that CMS will reimburse, McCarthy explains.

Billers are the SNF's last line of defense. During the triple check, the biller should confirm that the primary diagnosis listed does not appear on the RTP list, McCarthy says.

5. Prepare for a bumpy ride

Business office staff, MDS coordinators, and administration should expect technical issues when they submit MDSs and claims to Medicare or to other payers who have adjusted their systems for PDPM, McCarthy says.

"We saw this in 2010 when we went from MDS 2.0 to MDS 3.0. In some states, we couldn't even submit MDSs at all. They were being rejected,' McCarthy says. "There are probably going to be problems, and you're not just going to be able to push one button and be done."

In anticipation of technical problems, do not wait until the last minute to submit MDSs or claims. Give yourself extra time to troubleshoot any issues so that you're not late in submitting the MDS or claims.

Proper preparation can ward off major cashflow issues for the SNF.

"It can cause huge problems. For example, administrators may need to request interim rate relief because they can't make payroll because they cannot get their Medicare money," McCarthy says.

MDS coordinators and billers should also check their software for accuracy during the first several months that PDPM is in effect, says **Jennifer LaBay, RN, RAC-MT, RAC-MTA,CRC,** a MDS and policy consultant with Triad Health Care.

"Most of the bigger integrated software systems have a sequencing component or a list of diagnoses managed by the clinical team that carries over to the bill. Double check that information flows over correctly," LaBay says.

In PDPM, ICD-10 codes take on an entirely new level of importance for reimbursement. The interdisciplinary team (IDT) must ensure that the codes not only accurately reflect the patient's conditions but are sequenced properly.

Do not assume that the software sequenced the codes properly. The IDT should review and confirm the sequencing during regular Medicare meetings and during the triple check to ensure that the codes are correct, LaBay says. ■

A tale of two reimbursement models

Juggling PDPM and managed care billing

Preparing for and implementing the new Patient-Driven Payment Model (PDPM) was a momentous task for the skilled nursing industry. However, in many ways, the transition is not complete.

"CMS does not require Medicare Advantage Plans (Medicare Part C plans) and other managed care plans to adopt the new payment model at this time," says **Stacy Baker, OTR/L, CHC, RAC-CT,** director of audit services for Proactive Medical Review & Consulting, LLC.

Medicare Part-C plans can determine their own timelines for transitioning to PDPM. In the meantime, they will continue to pay SNFs based on Resource Utilization Group (RUG) levels or negotiated rates.

Now that PDPM is in effect, that leaves billing specialists and clinical staff to juggle the clinical and reimbursement requirements for both the PDPM and RUG-IV systems, Baker explains.

In fact, even though the industry has recently focused largely on the transition to PDPM, national data indicate SNF billers may submit the majority of their claims using RUG-IV, depending on the number of Medicare Part-C patients they care for and their payer mix trends.

"More consumers are electing one of these plans. Back in 2010, 25% of those eligible elected a Medicare Advantage Plan. Now that's grown to 34%, Baker says.

Additionally, accounting firm Plante Moran published a benchmarking report earlier this year looking at payer mix trends. Medicare makes up only 15% of SNFs' payer mix whereas Medicaid represents 54%, and other payor sources account for 31%.

"We're going to have to have our RUG-IV hats on, and we're going to have to have our PDPM hats on. With these two payment models and the various state Medicaid reimbursement rules, everyone will have to clearly understand the requirements to get reimbursed for services provided," Baker says.

Although billing specialists are adept at managing the requirements of different payers, operating in multiple reimbursement systems and keeping up with Medicare Advantage Plan's gradual transitions into PDPM opens SNFs up to financial risk, says Stefanie Corbett, DHA, post-acute regulatory specialists for HCPro, Inc.

For billing specialists, keeping the SNF's cashflow healthy will require careful tracking of which payers are paying based on negotiated levels, PDPM or RUG-IV categories, Corbett says.

As providers juggle residents covered by Medicare Part-A and RUG-IV, billing specialists will play a vital role in making the team aware of residents' payer type, ensuring a thorough triple check process, and mitigating the risk for improper payments.

Understand what is at risk

It will be critical for billers to communicate residents' exact payers to the interdisciplinary team (IDT). MDS coordinators and the IDT will also have to manage the disparate financial inducements offered by PDPM and RUG-IV. Medicare Advantage Plans that reimburse based on RUG-IV will continue to financially incentivize SNFs for providing therapy to patients, says **Robin Hillier, CPA, STNA, LNHA, RAC-MT,** president of RLH Consulting.

Meanwhile, in PDPM, CMS has shifted away from therapy minutes. Instead, the clinical characteristics and acuity of patients drives PDPM payment.

"If MDS nurses and therapists are unclear about a resident's payor, they could miss therapy targets critical to payment under RUGs, or they could fail to capture clinical information critical to payment under PDPM," says Hillier.

Mismanaging residents will not only result in the loss of reimbursement dollars, but it also causes denials, Baker says. Medicare Advantage Plans and Medicare will deny payment if providers do not have the proper documentation in place. This is complicated as each payer's requirements differ as do the requirements for RUG-IV vs. PDPM, Baker says.

Know your payment arrangements

Navigating between the requirements for different payers will not be easy.

"This is especially going to be a headache for billers because they will have to know how to bill each of the Medicare Part-C plans in addition to Medicare Part A and B, Medicaid, managed care, and private pay. If you are preparing a claim under the retired payment model and not the newly introduced model or under the terms of a revised Medicare Part-C plan that has been updated since the implementation of PDPM, you will not be reimbursed," Corbett says.

Avoid confusion by reviewing and understanding the terms of your facility's agreements with each managed care organization, Corbett says. In addition to listing payment rates for services provided to Medicare Part-C beneficiaries, these contracts outline how billers submit claims to the Medicare Advantage Plan and reimbursement terms.

Will they or won't they? Manage care plans diverge on PDPM adoption plans

The Patient-Driven Payment Model (PDPM) is in effect for all Medicare Part A residents. However, CMS does not require Medicare Advantage Plans (Medicare Part-C plans) to reimburse SNFs based on the new payment model. As such each plan will determine when and if they will adopt PDPM.

Billers will need to be aware of when Medicare Advantage Plans will switch systems but should expect each plan to be on a different timeline as they weigh the pros and cons of making the switch.

Although many managed care plans have already announced their intent to transition to PDPM this year along with Medicare Part A, some Medicare Advantage Plans will wait and see how PDPM goes before making a decision about changing their payment methodology, says Robin Hillier, CPA, STNA, LNHA, RAC-MT, president of RLH Consulting.

Reasons for sticking with RUG-IV will vary, but some Medicare Part-C plans may prefer to continue using a levels-based system because it is less administratively complex, Hillier says.

Of course, Medicare Part-C plans will also consider the impact switching to PDPM may have on their bottom lines.

"There's the possibility for higher reimbursement under PDPM and a levels approach is more predictable and has a payment cap," Hillier says.

Conversely, managed care organizations and Medicaid have traditionally followed Medicare's lead on payment methodology and will likely align their rate calculations with PDPM with time, says Stefanie Corbett, DBA, post-acute regulatory specialist for HCPro, Inc.

In addition to aligning on rates, putting similar processes in place for billing creates consistency in practices across all commercial insurers. This ultimately makes submitting and paying out claims easier, say Corbett.

"If I were a managed care organization, I would be looking over time, ways to develop alignment because the last thing you want is for facility not to know how to bill. That creates a headache, not just the facility but also for the managed care organization," Corbett says.

Unfortunately for billers, there's really no predicting what Medicare Advantage Plans will do or when. The best advice is to monitor communications from these plans and establish connections at each organization that you can call and speak with if you have questions, Corbett says.

Billers should know the ins and outs of these agreements. "When you understand the terms of your agreements with those providers, then you can mitigate risk for collection issues with Medicare Part C because the agreements will tell you exactly what they require, which is especially important as Medicare Advantage Plan convert to PDPM," Corbett says.

If you have not done so already, check with each Medicare Advantage Plan to confirm whether they want you to bill using negotiated rates, the RUG-IV or PDPM model. If they will continue to pay under RUG-IV, ask them to share their timeline for converting to PDPM, says **Jennifer Matoushek, MBA/HCM, CPC,** senior consultant with LW Consulting Inc.

Knowing the PDPM transition plan mitigates financial risk by ensuring your billing office is prepared to submit the correct information on the claims during the correct billing cycle. Otherwise, you will receive a denial, Matoushek explains.

Additionally, billing specialists should confirm when their facilities will renew their payment arrangements with each Medicare Advantage Plan.

"Many SNFs and Medicare Part-C plans renegotiate their rates in September or October when Medicare adjusts their rates or in January," Matoushek says.

Reviewing and noting updates to these agreements ensures that billers are informed of any new claim submission or payment protocols—not just those related to PDPM. Billing specialists can then update their processes accordingly, Corbett says.

Implement triple check for all payers

Submitting a clean claim really begins with your month-end triple check process. It may be tempting not to perform triple checks on claims submitted to Medicare Advantage Plans because nothing has changed in the RUG-IV system, but IDTs must recall the original intent of triple checks: To ensure clean claims, no matter the payment model.

"I'm often surprised by how many facilities only perform the triple check for claims going to traditional Medicare payers. You should apply the same process to your managed care claims, too," Baker says.

Triple checks are an industry best practice. Every facility should have a triple check process in place where key personnel come together to review and validate the information on the claim.

"During the triple check, billers should verify all information that supports Medicare Advantage plan claims as well as claims billed to any other payor," Hillier says.

For Medicare Advantage Plans that have not switched to PDPM, the triple check should confirm therapy delivery and minutes.

Know the common reasons for Medicare Part-C denials

Managed care post pay reviews are at an exponential high, and they just keep coming, Baker says. As such, it's critical for billers to know the common reasons for denials so that they can protect their payments.

The following are some of the denials Baker most commonly sees:

- Therapy minutes documentation. Therapy minutes will continue to generate denials for those managed care plans that stick with the RUG-IV payment model, Baker says. Medicare Advantage Plans frequently deny payment due to a lack of daily therapy documentation. There is room for error in this two-payment situation because Medicare rules do not require therapists to write a daily treatment note but most managed care plans do require that. It will be critical for billers to ensure MDS coordinators know if a resident is a Medicare Part-C beneficiary that requires this documentation, Baker says.

  However, therapy minutes will not be a concern from the technical review or denial standpoint for those plans that switch to PDPM, Baker says.

- Nursing documentation. Inadequate or incomplete nursing documentation can also cause a denial, especially if a patient has a severe condition that requires extensive nursing services, such as isolation. In that case, the Medicare Advantage Plan will want to see very technical documentation showing the patient is in a private room, lab documentation, etc.

Modifier-59. Managed care plans also do not like to see Modifier -59. They traditionally do not accept services billed together on the same date and will issue a technical denial. They tend to prefer that providers bill for each distinct service using the appropriate CPT code, Baker says.

- Certifications and recertifications. SNFs often receive denials from Medicare Part-C because they do not have the physician certifications and recertifications documented.

  "Many facilities I work with do not think Medicare Advantage Plans require those certifications, but most do," Baker says.

- Prevent denials by applying your process for obtaining physician certifications and recertifications for Medicare beneficiaries to managed care beneficiaries. ■

Updated RAI Manual includes more details and guidance on PDPM

Many providers were relieved when CMS released the mid-year draft of the MDS 3.0 Resident Assessment Instrument (RAI) Manual v1.17 on May 20.

"An advance copy of the RAI Manual v1.17 was published in May so that providers and software developers can become familiar with the changes and prepare for the implementation of PDPM," says Stefanie Corbett, DHA, postacute regulatory specialist for HCPro, a Simplify Compliance brand.

Although the early release of the RAI Manual v1.17 gives providers additional time to read, digest, and operationalize the changes, CMS encourages providers to check the RAI Manual website "shortly prior to October 1 for a final posting that may contain additional updates."

Although subject to revision, this new version of the RAI Manual includes changes to the MDS that are necessary for the transition to PDPM, such as more information about the new PPS assessment schedule, new MDS item set changes, and how to calculate PDPM per diem rates, Corbett says.

"Billers have been waiting to hear how any updates will impact billing operations. They may be relieved to hear that billing processes will not change with PDPM," Corbett says.

With that in mind, the 1,299-page RAI Manual v1.17 contains a lot of valuable information for billers. Although PDPM will not change a lot of their daily activities, they should understand the impact the new payment model will have on billing and reimbursement. BALTC's experts highlight the top takeaways.

New HIPPS codes

The MDS 3.0 RAI Manual update provides additional information on the new HIPPS codes introduced with PDPM.

"Billers must become familiar with the new HIPPS codes because the current ones under RUG-IV will be discontinued. Any claims for services occurring on or after October 1 must use the new HIPPS codes that coincide with the new resident classification system," Corbett says.

The new HIPPS codes still contain five characters, but CMS modified the codes to correspond with the five PDPM case-mix adjusted components, says Kim Cusson, CCS, CPC, a consultant with Crowe Healthcare Risk Consulting, LLC.

This is a big change from RUG-IV where the HIPPS code classified patients into one payment group, Cusson adds.

The characters in the PDPM HIPPS codes represent the following payment groups:

- First character: Patient's physical therapy (PT) and occupational therapy (OT) payment group
- Second character: Speech-language pathology payment group
- Third character: Nursing payment group
- Fourth character: Non-therapy ancillary (NTA) payment group

- Fifth character: The assessment used to classify the patient

Because PT and OT use the same process for component classification, they will fall into the same payment group.

Although the meaning of each character changes under PDPM, the process for obtaining the HIPPS code from MDS validation reports and inputting the code in the claim is not changing, Corbett says.

Billers should also be aware that the RAI Manual includes an update to the default HIPPS code.

"The new HIPPS code for the default rate is ZZZZZ rather than AAA00," Corbett says. However, the process for billing late assessments and penalties for noncompliance remains the same.

Find more information about HIPPS codes in the RAI Manual v1.17 under Chapter 2, Section 2.12; Chapter 3, Section Z; Chapter 5, Section 5.4; and Chapter 6, Sections 6.4 and 6.8.

Interrupted stay policy

The RAI Manual v1.17 includes additional information, guidance, and examples relating to the interrupted stay policy (ISP), which is new for facilities with the introduction of PDPM.

"The interrupted stay is one of the biggest changes there is in PDPM," says **Rosanna Benbow, RN, CCM, CIC, DNS-CT, RAC-CT**, owner and consultant of Leading Transitions Post Acute Care and Staffing, LLC.

The ISP combines multiple SNF stays into a single stay in cases where the patient's discharge and readmission occurs within the three-day interruption window, according to CMS.

"If a patient is discharged from the SNF and then readmitted to the same facility within three consecutive calendar days or less after the discharge, the stay is considered a continuation of the previous Medicare Part A covered stay," Cusson says.

Because it is a continuation of the stay, providers resume the assessment schedule and variable per diem schedule from the point just prior to the discharge.

For example, if a resident is discharged on day 23 and is readmitted within the interruption window, the payment rates resume at day 23. Providers do not need to conduct a new five-day assessment.

Residents who qualify for a Part A covered stay still receive their 100 days of SNF services per benefit period. However, billers will need to know how to calculate the interruption window to determine if a readmission is subject to the ISP.

According to CMS, the interruption window is a three-day period that:

- Starts with the calendar day of discharge
- Includes the two immediately following calendar days, ending at midnight

CMS also specifies that the resident must return by 12:00 a.m. at the end of the third calendar day after the discharge.

However, if a patient is readmitted to the same SNF outside of the interruption window (more than three consecutive calendar days after discharge) or is admitted to a different SNF, then the ISP does not apply. Providers would consider this a new stay, and the variable per diem and assessment schedules reset to day 1. Providers must complete a new five-day assessment, CMS says in its Interrupted Stay fact sheet.

"The thought process is that if the resident is readmitted within three days, their condition probably has not changed much, so there's no need to reset the per diem and assessment schedule," Benbow says.

However, if the resident was readmitted to the hospital during the three-day interruption window, providers will want to evaluate whether there was a significant enough change in clinical status to warrant an interim payment assessment (IPA) to adjust reimbursement, Benbow says.

Additionally, CMS says the ISP eliminates an unintended incentive to discharge patients and readmit them in order to reset the variable per diem schedule.

For example, in PDPM, the PT and OT case-mix payment drops 2% every seven days after day 20. The ISP prevents SNFs from discharging a patient who is on day 32 of a Part A covered stay and readmitting the

patient in order to reset the variable per diem schedule, Benbow explains.

Billers can find more information about interrupted stays in the RAI Manual v1.17 under Chapter 2; Chapter 3, Section A; and Chapter 6, Section 6.7.

Chapters 2 and 6

Providers will notice the most significant changes to Chapter 2: Assessments for the RAI and the entirely new Chapter 6: Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS), says Benbow.

"It's basically like they just threw out Chapter 2 and Chapter 6 and started over again because there are so many changes to the Medicare process and schedules and the overall payment classifications," she says.

In fact, the changes to Chapter 2 were so substantial that CMS did not include them on the MDS 3.0 Item Set Change History for October 2019 Version 1.17.1 that outlines major changes.

Chapter 2 provides details on the new PDPM MDS assessments and schedule. According to Corbett, updates include details on the following:

- The item sets in the MDS that will impact reimbursement under PDPM (Chapter 2)
- The new PPS assessment types and the completion deadlines for each

Although CMS completely rewrote this chapter, it did not make any notable changes to the assessment schedule that was first set forth in the final payment rule.

As an overview, PDPM only requires two assessments:

- The five-day assessment, which sets the payment rate for the entire stay (unless an IPA is completed)
- The discharge assessment, which is completed when the resident's covered Part A stay ends but the resident remains in the facility

"The discharge assessment can be combined with OBRA discharge assessment if the Part A stay ends on the same day or before the resident's discharge date," Cusson says.

With CMS only requiring one assessment before discharge, the interdisciplinary team will have to work together to gather information to fully capture the resident's acuity and set the optimal payment rate, Benbow says.

Chapter 2 also includes information on how to schedule the IPA. The IPA is an optional and unscheduled assessment that providers can complete when a patient experiences a change in condition. An IPA will update the patient's PDPM classification, but it will not reset the variable per diem rate, Cusson explains.

IPAs are brand-new to PDPM, and facilities will have to determine how the interdisciplinary team will identify patients for an IPA.

Chapter 6 explains how the MDS impacts reimbursement under the SNF PPS.

"Billers may find Chapter 6 of the RAI Manual resourceful for explaining the prospective payment system under PDPM and an explanation of how MDS assessments relate to the claim," Corbett says.

Section 6.6: PDPM Calculation Worksheet for SNFs walks providers through how to calculate the PDPM rate. Calculate per diem rates by adding the five case-mix rate components to the non-case-mix rate component.

Interim payment assessment (IPA) quick reference

- The assessment reference date (ARD) (item A2300) may be set for any day of the SNF PPS stay, beyond the ARD of the five-day assessment. The IPA must be completed (item Z0500B) within 14 days after the ARD (ARD + 14 days).
- The IPA authorizes payment for remainder of the PPS stay, beginning on the ARD.
- The IPA must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (item Z0500B) (completion + 14 days).
- The ARD for an IPA may not precede that of the five-day assessment.
- The IPA may not be combined with any other assessments (PPS or OBRA).

Source: CMS.

Case-mix adjustments are applied according to individual resident characteristics captured in the MDS (e.g., diagnoses, functional abilities, comorbidities, extensive services), Corbett explains.

"A new and important step in calculating per diem rates is the application of the variable per diem adjustment, an automatic adjustment factor for the PT, OT, and NTA rate components," she says.

Although most facilities have software systems that will calculate the rate, billers should understand the principles driving PDPM reimbursement.

"Technology is a big help and will eliminate the need to manually calculate per diem rates. However, it is always good to know how rates are calculated so that you will have an understanding of how the claim links to the MDS and medical record documentation," Corbett says.

MDS changes

In PDPM, MDS coding drives reimbursement to an extent that providers have never seen before. Complete and accurate MDSs will be the lynchpin of success.

That's why Chapter 3: Overview to the Item-by-Item Guide to the MDS is a must-read for MDS coordinators. It provides comprehensive coding instructions and details the changes to all sections of the MDS.

Billers should review the information pertaining to Section Z: Assessment Administration, which provides an overview of Z0100, which generates the HIPPS code (p. Z-1 of the RAI Manual).

This chapter is lengthy, but you can find a summary of changes on CMS' MDS 3.0 Item Set Change History for October 2019. This document is included in the ZIP file along with the RAI Manual v1.17 on CMS' website. ■

Tips for SNFs

Appointing an infection preventionist in your SNF

Infection is the leading cause of morbidity and mortality among nursing home residents in the United States. According to CMS, between 1.6 million and 3.8 million infections occur each year in SNFs, with almost 388,000 deaths attributed to infections. SNF leadership have a responsibility to stem the infection rate at their facilities.

SNF residents are often susceptible to illness and infection, so minimizing the transfer of preventable infections has become an increasing priority, says Brian Garavaglia, PhD, in his book, Infection Control: How to Implement an Effective Approach for Long-Term Care. "Eliminating unneeded hospitalizations due to preventable infections helps to minimize runaway costs that are found in our healthcare system, and controlling the transmission of pathogenic agents to already sick and frail individuals can prevent these individuals from needlessly becoming more ill or even dying," says Garavaglia. "Finally, a strong infection control program saves money for the healthcare facility on the operational level and provides for a more functional resident population, as well as a healthier workforce."

Because of the prevalence of infections, SNFs are required by CMS to have an infection preventionist (IP) on staff to diminish the risk of infections. An IP is defined by CMS in the proposed rule, Medicare and Medicaid Programs; Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency and Transparency (CMS-3347-P), as a person that:

- Has primary professional training in one of the following: epidemiology, microbiology, medical technology. or a related field
- Is qualified for the role through education, training, certification, or experience
- Has completed specialized training in infection prevention and control
- Works at least part-time at the facility
- Is a member of the SNF's quality assessment and assurance committee

An IP is currently required to be on-site "part-time," but "part-time could be interpreted in various ways

and could result in confusion," admits CMS. IPs currently spend a median of 8.5 hours at a facility per week, according to the Washington Health Care Association. Because of the ambiguous definition of part-time, CMS has amended the requirement to say that a trained IP must be on-site frequently enough to meet infection prevention and control program (IPCP) objectives, come November 28 when Phase III Requirements of Participation (RoP) take effect.

The IP is able to have other roles and responsibilities within the SNF, but infection prevention must be the employee's primary role, said Stefanie Corbett, DHA, postacute regulatory specialist at HCPro, in the April 3 webinar, "Requirements of Participation: Are You Ready for Phase 3?" which is available for on-demand purchase.

More often than not, IPs do have multiple roles within facilities. In a June 2019 study conducted by the American Journal of Infection Control, "Factors Associated with Infection Preventionist Turnover in Long-Term Care Facilities," researchers surveyed a total of 64 IPs (28.8%) and found that IPs were "performing at least one additional responsibility in addition to their IP role (range 1-4)." This plurality of roles, accompanied with high turnover rate of director of nursing positions, led to a 54.3% turnover rate for IPs, according to the study. Researchers recommend raising awareness and controlling managerial staff turnover to decrease IP turnover rates.

IPCP objectives

While having an IP on-site is a positive step toward preventing infections, that alone isn't enough. "CMS is holding facilities accountable for completing a thorough facility assessment according to § 483.70(e) to develop an IPCP and determine based on their unique needs how much time the infection preventionist devotes to achieve the objectives set forth in the IPCP. The change to the rule introduces confusion around what is to be considered sufficient time. CMS sought suggestions from providers on how to determine that infection preventionists devote sufficient time to IPCP," Corbett tells **PPSA.**

CMS outlines the minimum requirements to meet IPCP objectives in the State Operations Manual as:

- A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases that:
- Covers all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement;
- Is based on the individual facility assessment;
- Follows accepted national standards;
- Written standards, policies and procedures in accordance with §483.80(a)(2);
- A system for recording incidents identified under the IPCP and corrective actions taken by the facility; and
- An antibiotic stewardship program (ASP) (F881)

Training

In order to lighten the burden on SNFs to find and train an IP, there is a free online training for IP certification offered by CMS in tandem with the Centers for Disease Control and Prevention. The curriculum for the course, as outlined by CMS, is:

- IPCP overview
- IP responsibilities
- Quality assessment and performance improvement integration
- Infection surveillance
- Outbreaks
- Principles of standard precautions
- Principles of transmission-based precautions
- Hand hygiene
- Injection safety
- Respiratory hygiene and cough etiquette
- Device (i.e., indwelling urinary and central venous catheters) and wound management
- Point-of-care blood testing

- Reprocessing reusable resident care equipment
- Environmental cleaning
- Water management program
- Linen management
- Preventing respiratory infections
- Tuberculosis prevention
- Occupational health considerations
- Antibiotic stewardship
- Care transitions

The training course takes an estimated 19 hours to complete and counts as CME, CNE, or CEU continuing education credits.

Additionally, the American Health Care Association (AHCA), in tandem with the National Center for Assisted Living (NCAL), offer the Infection Preventionist Specialized Training – IPCO course. The AHCA/NCAL outlines the course's contents as follows:

- A thorough explanation of the impact of infections on the people who live, work at, and visit nursing centers
- Definitions of essential components of an effective IPCP
- Identification and management of common infections
- Strategies to prevent the spread of infections
- Identification and description of the steps necessary for infection surveillance, antibiotic stewardship, and infection investigating, tracking, and reporting
- Successful implementation strategies

SNFs must have employed an IP that has completed mandatory training by the RoP Phase III deadline on November 28. It's also crucial that the IP maintain certification in order to comply with CMS standards and ensure the SNF is eligible for Medicare reimbursement, according to Corbett. The current F-tag for infection control, as outlined by CMS, can be found below:

F-880

§483.80 Infection Control

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

When and to whom possible incidents of communicable disease or infections should be reported;

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Standard and transmission-based precautions to be followed to prevent spread of infections;

When and how isolation should be used for a resident; including but not limited to:

The type and duration of the isolation, depending upon the infectious agent or organism involved, and

A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.

The facility will conduct an annual review of its IPCP and update their program, as necessary. ■

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