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An in-depth look at how reimbursement is calculated under PDPM

WHITE PAPER

Under the current SNF prospective payment system (PPS), RUG-IV, staff mostly rely on computer software to calculate reimbursement rates without understanding the RUG rate components. While many staff contribute to the minimum data set (MDS), they're not able to explain how assessments convert to a dollar amount. On October 1, 2019, the new Patient-Driven Payment Model (PDPM) will replace RUG-IV. Staff will continue to rely on computer software to convert MDS assessment data to calculate reimbursement rates but it is important to understand the rate calculation methodology to identify opportunities to maximize reimbursement and to accurately project revenue.

The structure

PDPM separately identifies and adjusts five case-mix rate components, then combines these together with the non-case-mix component to form the full SNF PPS per diem rate for that resident. Case-mix adjusted rate components are as follows:

- PT – adjusted based on Function Score
- OT – adjusted based on Function Score
- SLP – adjusted based on the following:
  - Cognitive level;
  - SLP-related comorbidities;
  - Presence of an acute neurological condition; and/or
  - Presence of a swallowing disorder/mechanically-altered diet
- Nursing component – adjusted based on the following:
  - Function Score;
  - Depression; and/or
  - Restorative Services
- Non-therapy ancillary (NTA) component – adjusted based on comorbidity count

Start with the per diem base rate

How do we actually assign dollar amounts to each group in PDPM? Refer to tables 12 and 13 in the final rule (included below). The final rule, published in early August each year, tells us what the per diem amounts are for each of the rate components.

TABLE 12: FY 2019 PDPM Unadjusted Federal Rate Per Diem—Urban[1]

Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case-Mix
Per Diem Amount	$103.46	$78.05	$59.33	$55.23	$22.15	$92.63

TABLE 13: FY 2019 PDPM Unadjusted Federal Rate Per Diem--Rural

Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case-Mix
Per Diem Amount	$98.83	$74.56	$67.63	$62.11	$27.90	$94.34

If you look at table 12, for example, the FY 2019 urban per diem rates for each of the case-mix adjusted amounts and the non-case-mix adjusted amounts are provided. Each of these (except for the non-case-mix component, which will not be adjusted) will fluctuate depending on each resident's characteristics as reported in the MDS assessment, and categorization into the appropriate group within each of the five applicable case-mix adjusted rate components listed below:

- 16 PT groups
- 16 OT groups
- 12 SLP groups
- 25 nursing groups
- 6 NTA groups

Note that the final rule provides distinct rates for urban and rural rates according to your facility's geographic location.

The key to reimbursement: Principle admitting diagnosis

When assigning reimbursement under PDPM, everything will hinge on the principle admitting diagnosis, which is documented using ICD-10 coding. Admissions staff, especially those without a clinical background, should team up with the MDS coordinator and other clinical staff members to ensure the correct principle diagnosis is assigned.

Providers have to be very careful that the principle admitting diagnosis is specific to the SNF stay. This will require pinpointing the reason why the admitting resident's three-night qualifying stay in the hospital led to his or her current Medicare SNF stay. In some cases, for example, a resident may be in the hospital for a joint replacement. However, a joint replacement would not be an appropriate diagnosis to explain the SNF stay because the SNF isn't performing the joint replacement, but rather is providing the aftercare, such as physical and occupational therapy.

Based on the principal diagnosis code, the resident will be categorized into one of ten PDPM clinical categories using the first line in MDS item I8000 (item I0020, as needed) to report the ICD-10 code that represents the primary reason for the resident's Part A SNF stay.

The 10 clinical categories are listed in Table 14 of the final rule and are as follows:

- Major Joint Replacement or Spinal Surgery
- Non-Surgical Orthopedic/Musculoskeletal
- Orthopedic Surgery (Except Major Joint Replacement for Spinal Surgery)
- Acute Infections
- Medical Management
- Cancer
- Pulmonary
- Cardiovascular and Coagulations
- Acute Neurologic
- Non-Orthopedic Surgery

CMS chose these ten categories as a result of looking at claims data to determine the most common reasons for SNF admissions. They then created the SNF PDPM Clinical Category Mapping tool, which can be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html. The mapping tool can help facilities determine the most appropriate clinical category for common ICD-10 codes.

Three therapy disciplines: New opportunities for optimizing revenue

Once you've assigned the resident to one of the ten clinical categories, determine whether the resident has a need for PT, OT, and/or speech language pathology (SLP).

Under PDPM, residents will no longer just fall into a general therapy category; facilities will now have to determine which discipline(s) of therapy the resident needs, and then look further into each discipline to determine if there are any opportunities to receive case-mix adjustments or additional bumps in reimbursement. If the resident meets all three disciplines, you'll have three opportunities to optimize revenue with three separate rate components.

Determine the PT/OT rate

The ten PDPM clinical categories are collapsed into four PT/OT categories. (Keep in mind that PT and OT are two separate rate components that will need to be added together at the end, even though the methodology for computing them is the same for both.) Based on the resident's clinical category, the facility will narrow down which collapsed PT/OT category the resident should fall under (table 15).

TABLE 15: Collapsed Clinical Categories for PT and OT Classification

PDPM Clinical Category	Collapsed PT and OT Clinical Category
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Non-Orthopedic Surgery	Non-Orthopedic Surgery and Acute Neurologic
Acute Neurologic	
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	
Medical Management	Medical Management
Acute Infections	
Cancer	
Pulmonary	
Cardiovascular and Coagulations	

Adjust the PT/OT rate

To case-mix adjust the rate for PT and OT, you'll compute the new function score that CMS created based on Section GG's items (Table 18.) Facilities should expect changes to this section, and for the MDS to require more from our therapists as opposed to RUG-IV, which depended on input from CNAs to Section G.

Each MDS line item in Table 18 will impact reimbursement for PT and OT based on scoring methodology in the right hand column.

TABLE 18: Section GG Items Included in PT and OT Functional Measure

Section GG Item		Score
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	

Calculate the resident's function score using the following Table 18 to determine the Function Score for the following:

- Eating Admission Performance (GG0130A1) Toileting Hygiene
- Admission Performance (GG0130C1)
- Sit to Lying Admission Performance (GG0170B1)
- Lying to Sitting on Side of Bed Admission Performance (GG0170C1)
- Sit to Stand Admission Performance (GG0170D1)
- Chair/Bed-to-Chair Transfer Admission Performance (GG0170E1)
- Toilet Transfer Admission Performance (GG0170F1)
- Second, calculate the average score for the two bed mobility items and the three transfer items as follows:
- Average the scores for Sit to Lying and Lying to Sitting on Side of Bed
- Average the scores for Sit to Stand, Chair/Bed-to-Chair and Toilet Transfer
- Calculate the sum of the following scores:
- The two averages above (Average Bed Mobility Score and Average Transfer Score)

- Eating Function Score
- Toileting Hygiene Function Score

Assign case-mix group and apply case-mix index for total PT/OT rate components

Table 21 in the final rule shows which PT/OT case-mix group and which PT/OT case-mix index will be assigned for each clinical category based on the different Section GG function scores. The last two columns in the table show the case-mix index that will be used to adjust the PT/OT per diem rate component amounts.

TABLE 21: PT and OT Case-mix Classification Groups

Clinical Category	Section GG Function Score	PT OT Case-Mix Group	PT Case-Mix Index	OT Case-Mix Index
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.49
Major Joint Replacement or Spinal Surgery	6-9	TB	1.69	1.63
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88	1.68
Major Joint Replacement or Spinal Surgery	24	TD	1.92	1.53
Other Orthopedic	0-5	TE	1.42	1.41
Other Orthopedic	6-9	TF	1.61	1.59
Other Orthopedic	10-23	TG	1.67	1.64
Other Orthopedic	24	TH	1.16	1.15
Medical Management	0-5	TI	1.13	1.17
Medical Management	6-9	TJ	1.42	1.44
Medical Management	10-23	TK	1.52	1.54
Medical Management	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27	1.30
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48	1.49
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08	1.09

For example, if a resident staying in an urban facility is admitted to the SNF for Major Joint Replacement with a function score of 4 needing PT, his or her PT rate component would be determined by multiplying the base rate for an urban facility ($59.33) by the PT case-mix index for group TA ($1.53) to create the following equation: $59.33 x 1.53 = $90.77.

SLP

As a result of the varying types of SLP services provided to residents in a SNF and a wide array of resident needs, under PDPM, greater clinical complexity will result in greater reimbursement.

The case-mix adjustments for SLP services are as follows:

- Payment category will be assigned based on any combination/none of the following:
  - Cognitive impairment
  - Presence of acute neurologic condition
  - SLP-related comorbidity
- Then any combination of the following:
  - Mechanically-altered diet
  - Swallowing disorder

Determine the SLP clinical category

If the resident needs SLP services, you will assign one of ten SLP primary diagnosis clinical categories to the resident using ICD-10 codes recorded in MDS item I8000 to indicate whether the resident has an acute neurologic condition. (The primary diagnosis clinical category should match the primary diagnosis clinical category chosen for the PT and OT components.) The following table shows which SLP categories indicate an acute neurologic condition.

TABLE A: Determining If Acute Neurologic Condition is Present

Primary Diagnosis Clinical Category	SLP Clinical Category
Major Joint Replacement or Spinal Surgery	Non-Neurologic
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Non-Neurologic
Non-Orthopedic Surgery	Non-Neurologic
Acute Infections	Non-Neurologic
Cardiovascular and Coagulations	Non-Neurologic
Pulmonary	Non-Neurologic
Non-Surgical Orthopedic/Musculoskeletal	Non-Neurologic
Acute Neurologic	Acute Neurologic
Cancer	Non-Neurologic
Medical Management	Non-Neurologic

Does the resident have one or more SLP-related comorbidity(ies)?

Next, determine whether the resident has any SLP-related comorbidities. The following table includes MDS items that will be used to identify comorbidities for the SLP rate component. If any of these items is indicated as present, the resident has a SLP-related comorbidity.

TABLE B: SLP-Related Comorbidities

MDS Item	Description
I4300	Aphasia
I4500	CVA, TIA, or Stroke
I4900	Hemiplegia or Hemiparesis
I5500	Traumatic Brain Injury
I8000	Laryngeal Cancer
I8000	Apraxia
I8000	Dysphagia
I8000	ALS
I8000	Oral Cancers
I8000	Speech and Language Deficits
O0100E2	Tracheostomy Care While a Resident
O0100F2	Ventilator or Respirator While a Resident

Table 10 in the PDPM Calculation Worksheet provides a mapping tool for ICD-10 codes to SLP-related comorbidities.

Determine whether the resident has a cognitive impairment

A new cognitive function score will be used for the application of a case-mix adjustment for the SLP rate component if the resident has a cognitive impairment (mildly, moderately, or severely impaired). The cognitive function score is based on the Brief Interview for Mental Status (BIMS) and the Cognitive Performance Scale (CPS) scoring methodology.

Social workers usually complete the cognitive function tests as part of the current MDS process. That process will remain the same, although the scoring methodology has been revised, as shown below in Table 20.

TABLE 20: PDPM Cognitive Measure Classification Methodology

Cognitive Level	BIMS Score	CPS Score
Cognitively Intact	13-15	0
Mildly Impaired	8-12	1-2
Moderately Impaired	0-7	3-4
Severely Impaired	-	5-6

If the PDPM cognitive level is cognitively intact, then the resident does not have a cognitive impairment. Otherwise, if the resident is assessed as mildly, moderately, or severely impaired, then the resident classifies as cognitively impaired.

SLP case-mix groups

Take the following steps to determine the resident's SLP case-mix group:

1. Determine how many of the following conditions are present (up to three):
    a. Based on the determinations discussed above, the resident is classified in the Acute Neurologic clinical category.
    b. Based on the determinations discussed above, the resident has one or more SLP-related comorbidities.
    c. Based on the determinations discussed above, the resident has a cognitive impairment
2. Determine whether the resident has a swallowing disorder using item K0100.
3. Determine whether the resident has a mechanically altered diet using item K0510C2.
4. Determine how many of the following conditions are present based on numbers 2 and 3:
    a. The resident has neither a swallowing disorder nor a mechanically altered diet.
    b. The resident has either a swallowing disorder or a mechanically altered diet.
    c. The resident has both a swallowing disorder and a mechanically altered diet.

Table 23 demonstrates which SLP case-mix group and case-mix index will be assigned to each clinical category based on the whether the resident has an acute neurologic condition, a SLP-related comorbidity, cognitive impairment, mechanically-altered diet or swallowing disorder. The last column in the table shows the case-mix index that will be used to adjust the SLP per diem rate component amount.

TABLE 23: SLP Case-Mix Classification

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group	SLP Case-Mix Index
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.66
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97
Any two	Neither	SG	2.04
Any two	Either	SH	2.85
Any two	Both	SI	3.51
All three	Neither	SJ	2.98
All three	Either	SK	3.69
All three	Both	SL	4.19

Determine the adjustments for non-therapy ancillary (NTA) rate component

The NTA category will be the easiest to calculate and compute. This will be based on a comorbidity score which is determined by whether or not the resident meets the criteria for an HIV/AIDS and/or Parental/IV feeding modifiers, as well as taking a weighted, count methodology to account for fifty high-acuity conditions.

First, determine whether the resident has HIV/AIDS. HIV/AIDS is not reported in the MDS but is recorded on the SNF claim (ICD-10-CM code B20).

Next, determine whether the resident meets the criteria for the comorbidity: "Parenteral/IV Feeding – High Intensity" or the comorbidity: "Parenteral/IV Feeding – Low Intensity." To do so, first determine if the resident received parenteral/IV feeding during the last 7 days while a resident of the SNF using item K0510A2. If the resident did not receive parenteral/IV feeding during the last 7 days while a resident, then the resident does not meet the criteria for Parenteral/IV Feeding – High Intensity or Parenteral/IV Feeding – Low Intensity.

If the resident did receive parenteral/IV feeding during the last 7 days while a resident, then use item K0710A to determine if the proportion of total calories the resident received through parenteral or tube feeding was 51% or more while a resident (K0710A2 = 3). If K0710A2 =3 then the resident meets the criteria for Parenteral/IV Feeding – High Intensity. If the proportion of total calories the resident received through parenteral or tube feeding was 26-50% (K0710A2 = 2) and average fluid intake per day by IV or tube feeding

was 501 cc per day or more while a resident (K0710B2 = 2), then the resident qualifies for Parenteral/IV Feeding – Low Intensity.

Lastly, determine whether the resident has any additional NTA-related comorbidities. To do this, examine the conditions and services in Table 12 of the PDPM calculation worksheet, of which all except HIV/AIDS are recorded in the MDS. For conditions and services that are recorded in Section I8000 of the MDS, check if the corresponding ICD-10-CM codes are coded in Section I8000 using the mapping tools available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

The NTA case-mix groups can be found below in Table 28 from the final rule. The last column in the table shows the case-mix index that will be used to adjust the NTA per diem rate component amount (found in Tables 12 and 13).

TABLE 28: NTA Case-Mix Classification Groups

NTA Score Range	NTA Case-Mix Group	NTA Case-Mix Index
12+	NA	3.25
9-11	NB	2.53
6-8	NC	1.85
3-5	ND	1.34
1-2	NE	0.96
0	NF	0.72

Determine the nursing rate component

To determine the nursing rate component, first calculate the resident's function score using the following table to determine the Function Score for the following:

- Eating Admission Performance (GG0130A1) Toileting Hygiene Admission Performance (GG0130C1)
- Sit to Lying Admission Performance (GG0170B1)
- Lying to Sitting on Side of Bed Admission Performance (GG0170C1)
- Sit to Stand Admission Performance (GG0170D1)
- Chair/Bed-to-Chair Transfer Admission Performance (GG0170E1)
- Toilet Transfer Admission Performance (GG0170F1)

Second, calculate the average score for the two bed mobility items and the three transfer items as follows:

- Average the scores for Sit to Lying and Lying to Sitting on Side of Bed
- Average the scores for Sit to Stand, Chair/Bed-to-Chair and Toilet Transfer

Calculate the sum of the following scores:

- The two averages above (Average Bed Mobility Score and Average Transfer Score)
- Eating Function Score
- Toileting Hygiene Function Score

Finally, round this sum to the nearest integer. This is the PDPM Function Score for nursing payment. The PDPM Function Score for nursing payment ranges from 0 through 16.

TABLE 18: Section GG Items Included in PT and OT Functional Measure

Section GG Item		Score
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	

Determine nursing case-mix groups

To determine the resident's nursing case-mix groups, use the same method for nursing classification used under RUG-IV. The nursing rate component contains 25 nursing groups in the following categories:

Extensive services

Determine whether the resident is coded for one of the following treatments or services:

- O0100E2 Tracheostomy care while a resident
- O0100F2 Ventilator or respirator while a resident
- O0100M2 Isolation or quarantine for active infectious disease while resident

If at least one of these treatments or services is coded and the resident has a total PDPM Nursing Function Score of 14 or less, he/she classifies in the Extensive Services category.

Special Care High

Determine whether the resident is coded for one of the following conditions or services:

TABLE C: Special Care High Conditions/Services

MDS Items	Descriptions
B0100, Section GG items	Comatose and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1, all equal 01, 09, or 88)
I2100	Septicemia
I2900, N0350A,B	Diabetes with both of the following: Insulin injections (N0350A) for all 7 days Insulin order changes on 2 or more days (N0350B)
I5100, Nursing Function Score	Quadriplegia with Nursing Function Score <= 11
I6200, J1100C	Chronic obstructive pulmonary disease and shortness of breath when lying flat
J1550A, others	Fever and one of the following; I2000 Pneumonia J1550B Vomiting K0300 Weight loss (1 or 2) K0510B1 or K0510B2 Feeding tube*
K0510A1 or K0510A2	Parenteral/IV feedings
O0400D2	Respiratory therapy for all 7 days
*Tube feeding classification requirements: (1) K0710A3 is 51% or more of total calories OR (2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.	

If at least one of the special care conditions above is coded and the resident has a total PDPM Nursing Function Score of 14 or less, he or she classifies as Special Care High.

Next, you will evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care High category. Residents with signs and symptoms of depression are identified by the Resident Mood Interview (PHQ-9©) or the Staff Assessment of Resident Mood

(PHQ-9-OV©). The resident qualifies as depressed for PDPM classification in either of the two following cases:

- The D0300 Total Severity Score is greater than or equal to 10 but not 99, or
- The D0600 Total Severity Score is greater than or equal to 10.

Lastly, select the Special Care High classification based on the PDPM Nursing Function Score and the presence or absence of depression according to Table 26 below.

Special Care Low

Determine whether the resident is coded for one of the following conditions or services:

TABLE D: Special Care Low Conditions/Services

MDS Items	Descriptions
I4400, Nursing Function Score	Cerebral palsy, with Nursing Function Score <=11
I5200, Nursing Function Score	Multiple sclerosis, with Nursing Function Score <=11
I5300, Nursing Function Score	Parkinson's disease, with Nursing Function Score <=11
I6300, O0100C2	Respiratory failure and oxygen therapy while a resident
K0510B1 or K0510B2	Feeding tube*
M0300B1	Two or more stage 2 pressure ulcers with two or more selected skin treatments**
M0300C1, D1, F1	Any stage 3 or 4 pressure ulcer with two or more selected skin treatments**
M1030	Two or more venous/arterial ulcers with two or more selected skin treatments**
M0300B1, M1030	1 stage 2 pressure ulcer and 1 venous/arterial ulcer with 2 or more selected skin treatments**
M1040A,B,C; M1200I	Foot infection, diabetic foot ulcer or other open lesion of foot with application of dressings to the feet
O0100B2	Radiation treatment while a resident
O0100J2	Dialysis treatment while a resident

*Tube feeding classification requirements:
(1) K0710A3 is 51% or more of total calories OR
(2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.

**Selected skin treatments:
M1200A,B# Pressure relieving chair and/or bed M1200C Turning/repositioning
M1200D Nutrition or hydration intervention
M1200E Pressure ulcer care
M1200G Application of dressings (not to feet)
M1200H Application of ointments (not to feet)
#Count as one treatment even if both provided

If at least one of the special care conditions above is coded and the resident has a total PDPM Nursing Function Score of 14 or less, he or she classifies as Special Care Low.

Next, you will evaluate for depression as discussed in above in the Special Care High category.

Lastly, select the Special Care Low classification based on the PDPM Nursing Function Score and the presence or absence of depression (Table 26).

Clinically Complex

Determine whether the resident is coded for **one** of the conditions or services in the following table:

TABLE E: Clinically Complex Conditions/Services

MDS Item	Condition or Service
I2000	Pneumonia
I4900, Nursing Function Score	Hemiplegia/hemiparesis with Nursing Function Score <= 11
M1040D,E	Open lesions (other than ulcers, rashes, and cuts) with any selected skin treatment* or surgical wounds
M1040F	Burns
O0100A2	Chemotherapy while a resident
O0100C2	Oxygen Therapy while a resident
O0100H2	IV Medications while a resident
O01400I2	Transfusions while a resident

**Selected Skin Treatments: M1200F Surgical wound care, M1200G Application of nonsurgical dressing (other than to feet), M1200H Application of ointments/medications (other than to feet)*

Next, you will evaluate for depression as discussed in above in the Special Care High category.

Lastly, elect the Clinically Complex classification based on the PDPM Nursing Function Score and the presence or absence of depression according to Table 26.

Behavioral Symptoms & Cognitive Performance

Determine the resident's PDPM Nursing Function Score. If the resident's PDPM Nursing Function Score is 11 or greater, then determine the resident's cognitive status based on resident interview using the BIMS. Item C0500 provides a BIMS Summary Score for these items and indicates the resident's cognitive performance, with a score of 15 indicating the best cognitive performance and 0 indicating the worst performance. If the resident's Summary Score is less than or equal to 9, he or she classifies in the Behavioral Symptoms and Cognitive Performance category.

If the resident interview using the Brief Interview for Mental Status (BIMS) was not conducted (indicated by a value of "0" for Item C0100), then determine the resident's cognitive status based on the staff assessment rather than on resident interview.

Next, check if one of the three following conditions exists:

1. B0100—Coma (B0100 = 1) and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88)
2. C1000—Severely impaired cognitive skills for daily decision making (C1000 = 3)

3. B0700, C0700, C1000—Two or more of the following impairment indicators are present:
   - B0700 > 0 Usually, sometimes, or rarely/never understood
   - C0700 = 1 Short-term memory problem
   - C1000 > 0 Impaired cognitive skills for daily decision making

and

One or more of the following severe impairment indicators are present:

a. B0700 >= 2 Sometimes or rarely/never makes self understood

b. C1000 >= 2 Moderately or severely impaired cognitive skills for daily decision making

If the resident presents with one of the symptoms above, then he or she classifies in Behavioral Symptoms and Cognitive Performance. If he or she does not present with behavioral symptoms, skip to the Reduced Physical Function Category. Next, you will determine whether the resident presents with one of the following behavioral symptoms:

- E0100A—Hallucinations
- E0100B—Delusions
- E0200A—Physical behavioral symptoms directed toward others (2 or 3)
- E0200B—Verbal behavioral symptoms directed toward others (2 or 3)
- E0200C—Other behavioral symptoms not directed toward others (2 or 3)
- E0800—Rejection of care (2 or 3)
- E0900—Wandering (2 or 3)

The next step is to determine the Restorative Nursing Count by counting the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

- H0200C, H0500**—Urinary toileting program and/or bowel toileting program
- O0500A,B**—Passive and/or active range of motion
- O0500C—Splint or brace assistance
- O0500D,F**—Bed mobility and/or walking training
- O0500E—Transfer training
- O0500G—Dressing and/or grooming training
- O0500H—Eating and/or swallowing training
- O0500I—Amputation/prostheses care
- O0500J—Communication training

**Count as one service even if both provided

Lastly, Select the final PDPM Classification by using the total PDPM Nursing Function Score and the Restorative Nursing Count found below in Table 26 from the final rule.

Reduced Physical Function

First, determine the Restorative Nursing Count as discussed in the Behavioral Symptoms & Cognitive Performance category then select the PDPM Classification by using the Nursing Function Score and the Restorative Nursing Count according to Table 26 from the final rule below.

The nursing case-mix groups can be found in Table 26 in the final rule. The last column in the table shows the case-mix index that will be used to adjust the nursing per diem rate component amount (found in Tables 12 and 13).

TABLE 26: Nursing Indexes under PDPM Classification Model

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	Nursing Case-Mix Index
ES3	Tracheostomy & Ventilator	-	-	-	0-14	ES3	4.04
ES2	Tracheostomy or Ventilator	-	-	-	0-14	ES2	3.06
ES1	Infection	-	-	-	0-14	ES1	2.91
HE2/HD2	-	Serious medical conditions e.g. comatose, septicemia, respiratory therapy	Yes	-	0-5	HDE2	2.39
HE1/HD1	-	Serious medical conditions e.g. comatose, septicemia, respiratory therapy	No	-	0-5	HDE1	1.99
HC2/HB2	-	Serious medical conditions e.g. comatose, septicemia, respiratory therapy	Yes	-	6-14	HBC2	2.23
HC1/HB1	-	Serious medical conditions e.g. comatose, septicemia, respiratory therapy	No	-	6-14	HBC1	1.85
LE2/LD2	-	Serious medical conditions e.g. radiation therapy or dialysis	Yes	-	0-5	LDE2	2.07
LE1/LD1	-	Serious medical conditions e.g. radiation therapy or dialysis	No	-	0-5	LDE1	1.72
LC2/LB2	-	Serious medical conditions e.g. radiation therapy or dialysis	Yes	-	6-14	LBC2	1.71
LC1/LB1	-	Serious medical conditions e.g. radiation therapy or dialysis	No	-	6-14	LBC1	1.43
CE2/CD2	-	Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	Yes	-	0-5	CDE2	1.86
CE1/CD1	-	Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	No	-	0-5	CDE1	1.62
CC2/CB2	-	Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	Yes	-	6-14	CBC2	1.54
CA2	-	Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	Yes	-	15-16	CA2	1.08
CC1/CB1	-	Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	No	-	6-14	CBC1	1.34

TABLE 26: Nursing Indexes under PDPM Classification Model (cont.)

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	Nursing Case-Mix Index
BB2/BA2	-	Behavioral or cognitive symptoms	-	2 or more	11-16	BAB2	1.04
BB1/BA1	-	Behavioral or cognitive symptoms	-	0-1	11-16	BAB1	0.99
PE2/PD2	-	Assistance with daily	-	2 or more	0-5	PDE2	1.57
RUG-IV Nursing RUG	**Extensive Services**	**Clinical Conditions**	**Depression**	**# of Restorative Nursing Services**	**GG-based Function Score**	**PDPM Nursing Case-Mix Group**	**Nursing Case-Mix Index**
		living and general supervision					
PE1/PD1	-	Assistance with daily living and general supervision	-	0-1	0-5	PDE1	1.47
PC2/PB2	-	Assistance with daily living and general supervision	-	2 or more	6-14	PBC2	1.21
PA2	-	Assistance with daily living and general supervision	-	2 or more	15-16	PA2	0.70
PC1/PB1	-	Assistance with daily living and general supervision	-	0-1	6-14	PBC1	1.13
PA1	-	Assistance with daily living and general supervision	-	0-1	15-16	PA1	0.66

Calculate the total PDPM case-mix adjusted per diem rate

Adjustment Factor

The total case-mix adjusted per diem payment will decrease with time. According to the resident's length of stay during the 100-day benefit period, an adjustment factor is applied to the PT/OT and NTA rate components.

After the 20th day of a resident's stay, the PT/OT rate components will decrease by 2% every 7 days according to Table 30.

TABLE 30: Variable Per-diem Adjustment Factors and Schedule – PT and OT

Medicare Payment Days	Adjustment Factor
1-20	1.00
21-27	0.98
28-34	0.96
35-41	0.94
42-48	0.92
49-55	0.90
56-62	0.88
63-69	0.86
70-76	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

The NTA rate component will pay at 300% for the first 3 days of a resident's stay and then be reduced by 2/3rds on each day for days 4-100 according to Table 31.

TABLE 31: Variable Per-diem Adjustment Factors and Schedule – NTA

Medicare Payment Days	Adjustment Factor
1-3	3.0
4-100	1.0

Putting it all together

The total case-mix adjusted PDPM per diem rate equals the sum of each of the five case-mix adjusted components and the non-case-mix adjusted rate component. To calculate the total case-mix adjusted per-diem rate, add all component per diem rates calculated in prior steps together, along with the non-case-mix rate component, as shown in the following equation: