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

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

(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.

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

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

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

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

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

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

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 *they were* 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.

  - 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.

Calculation of PDPM Cognitive Level

The PDPM cognitive level is utilized in the SLP payment component of PDPM. One of four PDPM cognitive performance levels is assigned based on the Brief Interview for Mental Status (BIMS) or the Staff Assessment for Mental Status for the PDPM cognitive level. If neither the BIMS nor the staff assessment for the PDPM cognitive level is complete, then the resident will be classified as if the resident is cognitively intact.

STEP #1

Determine the resident's BIMS Summary Score on the MDS 3.0 based on the resident interview. Instructions for completing the BIMS are in Chapter 3, Section C. The BIMS involves the following items:

C0200 Repetition of three words
C0300 Temporal orientation
C0400 Recall

Item C0500 provides a BIMS Summary Score that ranges from 00 to 15. If the resident interview is not successful, then the BIMS Summary Score will equal 99.

Calculate the resident's PDPM cognitive level using the following mapping:

Table 6: Calculation of PDPM Level from BIMS

PDPM Cognitive Level	BIMS Score
Cognitively Intact	13-15
Mildly Impaired	8-12
Moderately Impaired	0-7
Severely Impaired	-

PDPM Cognitive Level: _____

If the resident's Summary Score is 99 (resident interview not successful) or the Summary Score is blank (resident interview not attempted and skipped) or the Summary Score has a dash value (not assessed), then proceed to Step #2 to use the Staff Assessment for Mental Status for the PDPM cognitive level.

STEP #2

If the resident's Summary Score is 99 or the Summary Score is blank or has a dash value, then determine the resident's cognitive status based on the Staff Assessment for Mental Status for the PDPM cognitive level using the following steps:

A) The resident classifies as severely impaired if one of the following conditions exists:

a. Comatose (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). *It should be noted that, in the case of an IPA, the items used for calculation of the resident's PDPM functional score are the Interim Performance items (GG0XXXX5), rather than the Admission Performance items (GG0XXXX1). For example, rather than GG0130B1, which is used on the 5-Day to assess the resident's Oral Hygiene Admission Performance, the IPA uses item GG0130B5 in order to measure the resident's Oral Hygiene Interim Performance.*

b. Severely impaired cognitive skills for daily decision making (C1000 = 3).

B) If the resident is not severely impaired based on Step A, then determine the resident's Basic Impairment Count and Severe Impairment Count.

For each of the conditions below that applies, add one to the Basic Impairment Count.

a. In Cognitive Skills for Daily Decision Making, the resident has modified independence or is moderately impaired (C1000 = 1 or 2).

b. In Makes Self Understood, the resident is usually understood, sometimes understood, or rarely/never understood (B0700 = 1, 2, or 3).

c. Based on the Staff Assessment for Mental Status, the resident has a memory problem (C0700 = 1).

Sum a., b., and c. to get the Basic Impairment Count: _____

For each of the conditions below that applies, add one to the Severe Impairment Count.

a. In Cognitive Skills for Daily Decision Making, the resident is moderately impaired (C1000 = 2).

b. In Makes Self Understood, the resident is sometimes understood or rarely/never understood (B0700 = 2 or 3).

Sum a. and b. to get the Severe Impairment Count: _____

C) The resident classifies as moderately impaired if the Severe Impairment Count is 1 or 2 and the Basic Impairment Count is 2 or 3.

D) The resident classifies as mildly impaired if the Basic Impairment Count is 1 and the Severe Impairment Count is 0, 1, or 2, or if the Basic Impairment Count is 2 or 3 and the Severe Impairment Count is 0.

E) The resident classifies as cognitively intact if both the Severe Impairment Count and Basic Impairment Count are 0.

PDPM Cognitive Level: _____

PDPM Payment Component: PT

STEP #1

Determine the resident's primary diagnosis clinical category using the ICD-10-CM code recorded in MDS item I0020B. To do so, refer to the PDPM Clinical Categories to ICD-10 Diagnosis Codes mapping (available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html), which maps a resident's primary diagnosis as recorded in MDS item I0020B to the 10 PDPM primary diagnosis clinical categories.

I0020B diagnosis: _____

Default primary diagnosis clinical category: _____

Some ICD-10-CM codes can map to a different clinical category from the default depending on a resident's prior inpatient procedure history. For these codes, a resident may be categorized into a surgical clinical category if the resident received a surgical procedure during the prior inpatient stay that relates to the primary reason for the Part A SNF stay as indicated by item J2100. If the PDPM clinical category mapping indicates that the resident's primary diagnosis code is eligible for one of the two orthopedic surgery categories (major joint replacement or spinal surgery, and orthopedic surgery (except major joint replacement or spinal surgery)), then proceed to Step 1A; if eligible for the non-orthopedic surgery category, then proceed to Step 1C. Otherwise, proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1A

Determine whether the resident received a major joint replacement or spinal surgery during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2300, J2310, J2320, J2330, J2400, J2410, or J2420 was performed during the prior inpatient stay, then the resident is categorized into the major joint replacement or spinal surgery clinical category. If none of these procedures was performed, the resident did not receive major joint replacement or spinal surgery during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Major Joint Replacement or Spinal Surgery? (Yes/No) _____

If the resident received Major Joint Replacement or Spinal Surgery, then the primary diagnosis clinical category is Major Joint Replacement or Spinal Surgery. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment. Otherwise, proceed to Step 1B.

STEP #1B

Determine whether the resident received orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2500, J2510, J2520, or J2530 was performed during the prior inpatient stay, then the resident is categorized into the Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) clinical category. If none of these procedures was performed, the resident did not receive orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)? (Yes/No) _____

If the resident received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery), then the primary diagnosis clinical category is Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery). Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1C

Determine whether the resident received a significant non-orthopedic surgical procedure during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2600, J2610, J2620, J2700, J2710, J2800, J2810, J2900, J2910, J2920, J2930, or J2940 was performed during the prior inpatient stay, then the resident is categorized into the non-orthopedic surgery clinical category. If none of these procedures was performed, the resident did not receive a significant non-orthopedic surgical procedure during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Significant Non-Orthopedic Surgical Procedure? (Yes/No) _____

If the resident received a significant Non-Orthopedic Surgical Procedure, then the primary diagnosis clinical category is Non-Orthopedic Surgery. Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1D

To finalize the primary diagnosis clinical category assignment, if the resident is not eligible for a different clinical category from the default, then select the default clinical category assigned to the primary diagnosis as recorded in MDS item I0020B in Step 1. If the resident is eligible for a different clinical category from the default, select the eligible surgical clinical category as determined in Steps 1A, 1B, or 1C.

Primary diagnosis clinical category: _____

STEP #2

Next, determine the resident's PT clinical category based on the mapping shown below.

Table 7: PT Clinical Category

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

PT Clinical Category: _____

STEP #3

Calculate the resident's Function Score for PT payment. Use the following table to determine the Function Score for Eating Admission Performance (GG0130A1), Oral Hygiene Admission Performance (GG0130B1), 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), and Toilet Transfer Admission Performance (GG0170F1).

It should be noted that, in the case of an IPA, the items used for calculation of the resident's PDPM functional score are the Interim Performance items (GG0XXXX5), rather than the Admission Performance items (GG0XXXX1). For example, rather than GG0130B1, which is used on the 5-Day to assess the resident's Oral Hygiene Admission Performance, the IPA uses item GG0130B5 in order to measure the resident's Oral Hygiene Interim Performance.

Determine if the resident can walk using item GG0170I1. If the resident cannot walk 10 feet (GG0170I1 = 07, 09, 10, or 88), then the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) is 0. If the resident can walk (GG0170I1 = 06, 05, 04, 03, 02, 01), then determine the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) using the following table.

Table 8: Function Score for PT Payment

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

Enter the Function Score for each item:

Eating

Eating Function Score: _____

Oral Hygiene

Oral Hygiene Function Score: _____

Toileting Hygiene

Toileting Hygiene Function Score: _____

Bed Mobility

Sit to Lying Function Score: _____

Lying to Sitting on Side of Bed Function Score: _____

Transfer

Sit to Stand Function Score: _____

Chair/Bed-to-Chair Function Score: _____

Toilet Transfer Function Score: _____

Walking

Walk 50 Feet with Two Turns Function Score: _____

Walk 150 Feet Function Score: _____

The next step is to calculate the average function scores for the two bed mobility items, the three transfer items, and the two walking items as follows. For the Average Bed Mobility Function Score, calculate the sum of the Function Scores for Sit to Lying and Lying to Sitting on Side of Bed and divide this sum by 2. For the Average Transfer Function Score, calculate the sum of the Function Scores for Sit to Stand, Chair/Bed-to-Chair, and Toilet Transfer, and

divide this sum by 3. For the Average Walking Function Score, calculate the sum of the Function Scores for Walk 50 Feet with Two Turns and Walk 150 Feet, and divide this sum by 2. Enter the Average Bed Mobility, Average Transfer Function, and Average Walking Function Scores below.

Average Bed Mobility Function Score: _____

Average Transfer Function Score: _____

Average Walking Function Score: _____

Calculate the sum of the following Function Scores: Eating Function Score, Oral Hygiene Function Score, Toileting Hygiene Function Score, Average Bed Mobility Function Score, Average Transfer Function Score, and Average Walking Function Score. Finally, round this sum to the nearest integer. This is the **PDPM Function Score for PT Payment**. The PDPM Function Score for PT Payment ranges from 0 through 24.

PT FUNCTION SCORE: _____

STEP #4

Using the responses from Steps 2 and 3 above, determine the resident's PT group using the table below.

Table 9: PT Case-Mix Groups

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

PDPM PT Classification: _____

PDPM Payment Component: OT

***Note: The steps for calculating the resident's PDPM classification for the OT component follow the same logic used for calculating the resident's PDPM classification for the PT component, described above.**

STEP #1

Determine the resident's primary diagnosis clinical category using the ICD-10-CM code recorded in MDS item I0020B. To do so, refer to the PDPM Clinical Categories to ICD-10 Diagnosis Codes mapping (available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html), which maps a resident's primary diagnosis as recorded in MDS item I0020B to the 10 PDPM primary diagnosis clinical categories.

I0020B diagnosis: _____

Default primary diagnosis clinical category: _____

Some ICD-10-CM codes can map to a different clinical category from the default depending on a resident's prior inpatient procedure history. For these codes, a resident may be categorized into a surgical clinical category if the resident received a surgical procedure during the prior inpatient stay that relates to the primary reason for the Part A SNF stay as indicated by item J2100. If the PDPM clinical category mapping indicates that the resident's primary diagnosis code is eligible for one of the two orthopedic surgery categories (major joint replacement or spinal surgery, and orthopedic surgery (except major joint replacement or spinal surgery)), then proceed to Step 1A; if eligible for the non-orthopedic surgery category, then proceed to Step 1C. Otherwise, proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1A

Determine whether the resident received a major joint replacement or spinal surgery during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2300, J2310, J2320, J2330, J2400, J2410, or J2420 was performed during the prior inpatient stay, then the resident is categorized into the major joint replacement or spinal surgery clinical category. If none of these procedures was performed, the resident did not receive major joint replacement or spinal surgery during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Major Joint Replacement or Spinal Surgery? (Yes/No) _____

If the resident received Major Joint Replacement or Spinal Surgery, then the primary diagnosis clinical category is Major Joint Replacement or Spinal Surgery. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment. Otherwise, proceed to Step 1B.

STEP #1B

Determine whether the resident received orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2500, J2510, J2520, or J2530 was performed during the prior inpatient stay, then the resident is categorized into the Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) clinical category. If none of these procedures was performed, the resident did not receive orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)? (Yes/No) _____

If the resident received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery), then the primary diagnosis clinical category is Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery). Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1C

Determine whether the resident received a significant non-orthopedic surgical procedure during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2600, J2610, J2620, J2700, J2710, J2800, J2810, J2900, J2910, J2920, J2930, or J2940 was performed during the prior inpatient stay, then the resident is categorized into the non-orthopedic surgery clinical category. If none of these procedures was performed, the resident did not receive a significant non-orthopedic surgical procedure during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Significant Non-Orthopedic Surgical Procedure? (Yes/No) _____

If the resident received a significant Non-Orthopedic Surgical Procedure, then the primary diagnosis clinical category is Non-Orthopedic Surgery. Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1D

To finalize the primary diagnosis clinical category assignment, if the resident is not eligible for a different clinical category from the default, then select the default clinical category assigned to the primary diagnosis as recorded in MDS item I0020B in Step 1. If the resident is eligible for a different clinical category from the default, select the eligible surgical clinical category as determined in Steps 1A, 1B, or 1C.

Primary diagnosis clinical category: _____

STEP #2

Next, determine the resident's OT clinical category based on the mapping shown below.

Table 10: OT Clinical Category

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

OT Clinical Category: _____

STEP #3

Calculate the resident's Function Score for OT payment. Use the following table to determine the Function Score for Eating Admission Performance (GG0130A1), Oral Hygiene Admission Performance (GG0130B1), 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), and Toilet Transfer Admission Performance (GG0170F1).

It should be noted that, in the case of an IPA, the items used for calculation of the resident's PDPM functional score are the Interim Performance items (GG0XXXX5), rather than the Admission Performance items (GG0XXXX1). For example, rather than GG0130B1, which is used on the 5-Day to assess the resident's Oral Hygiene Admission Performance, the IPA uses item GG0130B5 in order to measure the resident's Oral Hygiene Interim Performance.

Determine if the resident can walk using item GG0170I1. If the resident cannot walk 10 feet (GG0170I1 = 07, 09, 10, or 88), then the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) is 0. If the resident can walk (GG0170I1 = 06, 05, 04, 03, 02, 01), then determine the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) using the following table.

Table 11: Function Score for OT Payment

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

Enter the Function Score for each item:

Eating

Eating Function Score: _____

Oral Hygiene

Oral Hygiene Function Score: _____

Toileting Hygiene

Toileting Hygiene Function Score: _____

Bed Mobility

Sit to Lying Function Score: _____

Lying to Sitting on Side of Bed Function Score: _____

Transfer

Sit to Stand Function Score: _____

Chair/Bed-to-Chair Function Score: _____

Toilet Transfer Function Score: _____

Walking

Walk 50 Feet with Two Turns Function Score: _____

Walk 150 Feet Function Score: _____

The next step is to calculate the average function scores for the two bed mobility items, the three transfer items, and the two walking items as follows. For the Average Bed Mobility Function Score, calculate the sum of the Function Scores for Sit to Lying and Lying to Sitting on Side of Bed and divide this sum by 2. For the Average Transfer Function Score, calculate the sum of the Function Scores for Sit to Stand, Chair/Bed-to-Chair, and Toilet Transfer, and

divide this sum by 3. For the Average Walking Function Score, calculate the sum of the Function Scores for Walk 50 Feet with Two Turns and Walk 150 Feet, and divide this sum by 2. Enter the Average Bed Mobility, Average Transfer Function, and Average Walking Function Scores below.

Average Bed Mobility Function Score: _____

Average Transfer Function Score: _____

Average Walking Function Score: _____

Calculate the sum of the following Function Scores: Eating Function Score, Oral Hygiene Function Score, Toileting Hygiene Function Score, Average Bed Mobility Function Score, Average Transfer Function Score, and Average Walking Function Score. Finally, round this sum to the nearest integer. This is the **PDPM Function Score for OT Payment**. The PDPM Function Score for OT Payment ranges from 0 through 24.

OT FUNCTION SCORE: _____

STEP #4

Using the responses from Steps 2 and 3 above, determine the resident's OT group using the table below.

Table 12: OT Case-Mix Groups

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

PDPM OT Classification: _____

PDPM Payment Component: SLP

***Note: The primary diagnosis clinical category used for the SLP component is the same as the clinical category used for the PT and OT components.**

STEP #1

Determine the resident's primary diagnosis clinical category using the ICD-10-CM code recorded in MDS item I0020B. To do so, refer to the PDPM Clinical Categories to ICD-10 Diagnosis Codes mapping (available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html), which maps a resident's primary diagnosis as recorded in MDS item I0020B to the 10 PDPM primary diagnosis clinical categories.

I0020B diagnosis: _____

Default primary diagnosis clinical category: _____

Some ICD-10-CM codes can map to a different clinical category from the default depending on a resident's prior inpatient procedure history. For these codes, a resident may be categorized into a surgical clinical category if the resident received a surgical procedure during the prior inpatient stay that relates to the primary reason for the Part A SNF stay as indicated by item J2100. If the PDPM clinical category mapping indicates that the resident's primary diagnosis code is eligible for one of the two orthopedic surgery categories (major joint replacement or spinal surgery, and orthopedic surgery (except major joint replacement or spinal surgery)), then proceed to Step 1A; if eligible for the non-orthopedic surgery category, then proceed to Step 1C. Otherwise, proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1A

Determine whether the resident received a major joint replacement or spinal surgery during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2300, J2310, J2320, J2330, J2400, J2410, or J2420 was performed during the prior inpatient stay, then the resident is categorized into the major joint replacement or spinal surgery clinical category. If none of these procedures was performed, the resident did not receive major joint replacement or spinal surgery during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Major Joint Replacement or Spinal Surgery? (Yes/No) _____

If the resident received Major Joint Replacement or Spinal Surgery, then the primary diagnosis clinical category is Major Joint Replacement or Spinal Surgery. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment. Otherwise, proceed to Step 1B.

STEP #1B

Determine whether the resident received orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2500, J2510, J2520, or J2530 was performed during the prior inpatient stay, then the resident is categorized into the Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) clinical category. If none of these procedures was performed, the resident did not receive orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)? (Yes/No) _____

If the resident received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery), then the primary diagnosis clinical category is Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery). Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1C

Determine whether the resident received a significant non-orthopedic surgical procedure during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2600, J2610, J2620, J2700, J2710, J2800, J2810, J2900, J2910, J2920, J2930, or J2940 was performed during the prior inpatient stay, then the resident is categorized into the non-orthopedic surgery clinical category. If none of these procedures was performed, the resident did not receive a significant non-orthopedic surgical procedure during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Significant Non-Orthopedic Surgical Procedure? (Yes/No) _____

If the resident received a significant Non-Orthopedic Surgical Procedure, then the primary diagnosis clinical category is Non-Orthopedic Surgery. Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1D

To finalize the primary diagnosis clinical category assignment, if the resident is not eligible for a different clinical category from the default, then select the default clinical category assigned to the primary diagnosis as recorded in MDS item I0020B in Step 1. If the resident is eligible for a different clinical category from the default, select the eligible surgical clinical category as determined in Steps 1A, 1B, or 1C.

Primary diagnosis clinical category: _____

STEP #2

Next, determine the resident's SLP clinical category based on the mapping shown below.

Table 13: SLP Clinical Category

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

SLP Clinical Category: _____

STEP #3

Determine whether the resident has one or more SLP-related comorbidities. To do so, examine the services and conditions in the table below. If any of these items is indicated as present, the resident has an SLP-related comorbidity. For conditions and services that are recorded in item I8000 of the MDS, check if the corresponding ICD-10-CM codes are coded in item I8000 using the mapping available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.

Table 14: 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
O01*I*0E*1b*	Tracheostomy Care While a Resident
O01*I*0F*1b*	*Invasive Mechanical* Ventilator or Respirator While a Resident

Presence of one or more SLP-related comorbidities? (Yes/No) _____

STEP #4

Determine whether the resident has a cognitive impairment. Calculate the resident's PDPM cognitive level, as described previously. 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.

Presence of Cognitive Impairment? (Yes/No) _____

STEP #5

Determine how many of the following conditions are present:

a. Based on Step 2, the resident is classified in the Acute Neurologic clinical category.

b. Based on Step 3, the resident has one or more SLP-related comorbidities.

c. Based on Step 4, the resident has a cognitive impairment.

Number of conditions present: _____

STEP #6

Determine whether the resident has a swallowing disorder using item K0100. If any of the conditions indicated in items K0100A through K0100D is present, then the resident has *a* swallowing disorder. If none of these conditions is present, the resident does not have a swallowing disorder for purposes of this calculation.

Presence of Swallowing Disorder? (Yes/No) _____

STEP #7

Determine whether the resident has a mechanically altered diet. If K05*2*0C*3* (mechanically altered diet while a resident) is checked, then the resident has a mechanically altered diet.

Presence of Mechanically Altered Diet? (Yes/No) _____

STEP #8

Determine how many of the following conditions are present based on Steps 6 and 7:

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.

Presence of Mechanically Altered Diet or Swallowing Disorder? (Neither/Either/Both): _____

STEP #9

Determine the resident's SLP group using the responses from Steps 1-8 and the table below.

Table 15: SLP Case-Mix Groups

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

PDPM SLP Classification: _____

PDPM Payment Component: NTA

STEP #1

Determine whether resident has one or more NTA-related comorbidities.

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

   Resident has HIV/AIDS? (Yes/No) _____

2. 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 K05*2*0A*3*. 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.

   Presence of Parenteral/IV Feeding – High Intensity? (Yes/No) _____

   Presence of Parenteral/IV Feeding – Low Intensity? (Yes/No) _____

3. Determine whether the resident has any additional NTA-related comorbidities. To do this, examine the conditions and services in the table below, of which all except HIV/AIDS are recorded on the MDS. HIV/AIDS is recorded on the SNF claim. For conditions and services that are recorded in item I8000 of the MDS, check if the corresponding ICD-10-CM codes are coded in item I8000 using the mapping available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.

Table 16: NTA Comorbidity Score Calculation

Condition/Extensive Service	MDS Item	Points
HIV/AIDS	N/A (SNF claim)	8
Parenteral IV Feeding: Level High	K0520A3, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	O0110H1b	5
Special Treatments/Programs: *Invasive Mechanical* Ventilator or Respirator Post-admit Code	O0110F1b	4
Parenteral IV Feeding: Level Low	K0520A3, K0710A2, K0710B2	3
Lung Transplant Status	I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	O0110I1b	2
Major Organ Transplant Status, Except Lung	I8000	2
Active Diagnoses: Multiple Sclerosis Code	I5200	2
Opportunistic Infections	I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	I6200	2
Bone/Joint/Muscle Infections/Necrosis - Except: Aseptic Necrosis of Bone	I8000	2
Chronic Myeloid Leukemia	I8000	2
Wound Infection Code	I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	I2900	2
Endocarditis	I8000	1
Immune Disorders	I8000	1
End-Stage Liver Disease	I8000	1
Narcolepsy and Cataplexy	I8000	1
Cystic Fibrosis	I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	O0110E1b	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	I1700	1
Special Treatments/Programs: Isolation Post-admit Code	O0110M1b	1
Specified Hereditary Metabolic/Immune Disorders	I8000	1
Morbid Obesity	I8000	1
Special Treatments/Programs: Radiation Post-admit Code	O0110B1b	1
Stage 4 Unhealed Pressure Ulcer Currently Present[1]	M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	I8000	1
Chronic Pancreatitis	I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1

Condition/Extensive Service	MDS Item	Points
Other Foot Skin Problems: Foot Infection Code, Diabetic Foot Ulcer Code, Other Open Lesion on Foot Code	M1040A, M1040B, M1040C	1
Complications of Specified Implanted Device or Graft	I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	H0100D	1
Inflammatory Bowel Disease	I1300	1
Aseptic Necrosis of Bone	I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	O011*1*0D*1b*	1
Cardio-Respiratory Failure and Shock	I8000	1
Myelodysplastic Syndromes and Myelofibrosis	I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	I8000	1
Diabetic Retinopathy - Except: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Nutritional Approaches While a Resident: Feeding Tube	K05*2*0B*3*	1
Severe Skin Burn or Condition	I8000	1
Intractable Epilepsy	I8000	1
Active Diagnoses: Malnutrition Code	I5600	1
Disorders of Immunity - Except: RxCC97: Immune Disorders	I8000	1
Cirrhosis of Liver	I8000	1
Bladder and Bowel Appliances: Ostomy	H0100C	1
Respiratory Arrest	I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	I8000	1

[1] If the number of Stage 4 Unhealed Pressure Ulcers is recorded as greater than 0, it will add one point to the NTA comorbidity score calculation. Only the presence, not the count, of Stage 4 Unhealed Pressure Ulcers affects the PDPM NTA comorbidity score calculation.

STEP #2

Calculate the resident's total NTA score using the table above. To calculate the total NTA score, sum the points corresponding to each condition or service present. If none of these conditions or services is present, the resident's score is 0.

NTA Score: _____

STEP #3

Determine the resident's NTA group using the table below.

Table 17: NTA Case-Mix Groups

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

PDPM NTA Classification: _____

PDPM Payment Component: Nursing

STEP #1

Calculate the resident's Function Score for nursing payment. Use the following table to determine the Function Score for 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), and Toilet Transfer Admission Performance (GG0170F1).

Table 18: Function Score for Nursing Payment

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

Enter the Function Score for each item:

Eating

Eating Function Score: _____

Toileting Hygiene

Toileting Hygiene Function Score: _____

Bed Mobility

Sit to Lying Function Score: _____

Lying to Sitting on Side of Bed Function Score: _____

Transfer

Sit to Stand Function Score: _____

Chair/Bed-to-Chair Function Score: _____

Toilet Transfer Function Score: _____

Next, 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.[1] Average the scores for Sit to Stand, Chair/Bed-to-Chair and Toilet Transfer.[2] Enter the average bed mobility and transfer scores below.

Average Bed Mobility Function Score: _____

Average Transfer Function Score: _____

Calculate the sum of the following scores: Eating Function Score, Toileting Hygiene Function Score, Average Bed Mobility Score, and Average Transfer 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.

PDPM NURSING FUNCTION SCORE: _____

STEP #2

Determine the resident's nursing case-mix group using the hierarchical classification below. Nursing classification under PDPM employs the hierarchical classification method. Hierarchical classification is used in some payment systems, in staffing analysis, and in many research projects. In the hierarchical approach, start at the top and work down through the PDPM nursing classification model steps discussed below; the assigned classification is the first group for which the resident qualifies. In other words, start with the Extensive Services groups at the top of the PDPM nursing classification model. Then go down through the groups in hierarchical order: Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavioral Symptoms and Cognitive Performance, and Reduced Physical Function. When you find the first of the 25 individual PDPM nursing groups for which the resident qualifies, assign that group as the PDPM nursing classification.

[1] Calculate the sum of the Function Scores for Sit to Lying and Lying to Sitting on Side of Bed. Divide this sum by 2. This is the Average Bed Mobility Function Score.

[2] Calculate the sum of the Function Scores for Sit to Stand, Chair/Bed-to-Chair, and Toilet Transfer. Divide by 3. This is the Average Transfer Function Score.

CATEGORY: EXTENSIVE SERVICES

The classification groups in this category are based on various services provided. Use the following instructions to begin the calculation:

STEP #1

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

O01*I*0E*1b*	Tracheostomy care while a resident
O01*I*0F*1b*	*Invasive mechanical v*entilator or respirator while a resident
O01*I*0M*1b*	Isolation or quarantine for active infectious disease while a resident

If the resident does not receive one of these treatments or services, skip to the Special Care High Category now.

STEP #2

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, *they* classif*y* in the Extensive Services category. **Move to Step #3. If the resident's PDPM Nursing Function Score is 15 or 16, *they* classif*y* as Clinically Complex. Skip to the Clinically Complex Category, Step #2.**

STEP #3

The resident classifies in the Extensive Services category according to the following chart:

Extensive Service Conditions	PDPM Nursing Classification
Tracheostomy care* **and** ventilator/respirator*	ES3
Tracheostomy care* **or** ventilator/respirator*	ES2
Isolation or quarantine for active infectious disease* **without** tracheostomy care* **without** ventilator/respirator*	ES1

*while a resident

PDPM Nursing Classification: _____

If the resident does not classify in the Extensive Services Category, proceed to the Special Care High Category.

CATEGORY: SPECIAL CARE HIGH

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP #1

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

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) K05*2*0B*2* or K05*2*0B*3* Feeding tube*
K05*2*0A*2* or K05*2*0A*3*	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 the resident does not have one of these conditions, skip to the Special Care Low Category now.

STEP #2

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, *they* classif*y* as Special Care High. **Move to Step #3. If the resident's PDPM Nursing Function Score is 15 or 16, *they* classif*y* as Clinically Complex. Skip to the Clinically Complex Category, Step #2.**

STEP #3

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 Patient Mood Interview (PHQ-2 to 9©) or the Staff Assessment of Patient Mood (PHQ-9-OV©). Instructions for completing the PHQ-2 to 9© are in Chapter 3, Section D. *Item D0100 is a gateway question to determine when the Patient Mood Interview (D0100 is coded 1, Yes) or the Staff Assessment of Patient Mood is to be conducted (D0100 is coded 0, No).* Refer to Appendix E for cases in which the PHQ-2 to 9© or PHQ-9-OV© is complete but all questions are not answered. For the PHQ-2 to 9©, if either D0150A2 or D0150B2 is coded 2 or 3, continue asking the questions below, otherwise end the PHQ interview. *Assessors should proceed to D0700, Social Isolation in the case of resident refusal or unwillingness to participate.* The following items comprise the PHQ-2 to 9© and PHQ-9-OV© for the Patient and Staff assessments, respectively:

Resident	Staff	Description
D0150A	D0500A	Little interest or pleasure in doing things
D0150B	D0500B	Feeling down, depressed, or hopeless
D0150C	D0500C	Trouble falling or staying asleep, or sleeping too much
D0150D	D0500D	Feeling tired or having little energy
D0150E	D0500E	Poor appetite or overeating
D0150F	D0500F	Feeling bad about yourself - or that you are a failure or have let yourself down or your family down
D0150G	D0500G	Trouble concentrating on things, such as reading the newspaper or watching television
D0150H	D0500H	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
D0150I	D0500I	Thoughts that you would be better off dead, or of hurting yourself in some way
-	D0500J	Being short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at item D0160 and for the staff assessment at item D0600. The resident qualifies as depressed for PDPM classification in either of the two following cases:

The D0160 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.

Resident Qualifies as Depressed Yes _____ No _____

STEP #4

Select the Special Care High classification based on the PDPM Nursing Function Score and the presence or absence of depression according to this table:

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	HDE2
0-5	No	HDE1
6-14	Yes	HBC2
6-14	No	HBC1

PDPM Nursing Classification: _____

CATEGORY: SPECIAL CARE LOW

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP #1

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

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, O01*1*0C*1b*	Respiratory failure and oxygen therapy while a resident
K05*2*0B*2* or K05*2*0B*3*	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 *or any unstageable pressure ulcer due to slough and/or eschar* 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
O01*1*0B*1b*	Radiation treatment while a resident
O01*1*0J*1b*	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 *program*
M1200D Nutrition or hydration intervention
M1200E Pressure ulcer*/injury* care
M1200G Application of *nonsurgical* dressings (not to feet)
M1200H Application of ointments*/medications* (not to feet)
#Count as one treatment even if both provided

If the resident does not have one of these conditions, skip to the Clinically Complex Category now.

STEP #2

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, they classify as Special Care Low. **Move to Step #3. If the resident's PDPM Nursing Function Score is 15 or 16, they classify as Clinically Complex. Skip to the Clinically Complex Category, Step #2.**

STEP #3

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care Low category. Residents with signs and symptoms of depression are identified by the Patient Mood Interview (PHQ-2 to 9©) or the Staff Assessment of Patient Mood (PHQ-9-OV©). Instructions for completing the PHQ-2 to 9© are in Chapter 3, Section D. *Item D0100 is a gateway question to determine when the Patient Mood Interview (D0100 is coded 1, Yes) or the Staff Assessment of Patient Mood is to be conducted (D0100 is coded 0, No).* Refer to Appendix E for cases in which the PHQ-2 to 9© or PHQ-9-OV© is complete but all questions are not answered. For the PHQ-2 to 9©, if either D0150A2 or D0150B2 is coded 2 or 3, continue asking the questions below, otherwise end the PHQ interview. *Assessors should proceed to D0700, Social Isolation in the case of resident refusal or unwillingness to participate.* The following items comprise the PHQ-2 to 9© and PHQ-9-OV© for the Patient and Staff assessments, respectively:

Resident	Staff	Description
D0150A	D0500A	Little interest or pleasure in doing things
D0150B	D0500B	Feeling down, depressed, or hopeless
D0150C	D0500C	Trouble falling or staying asleep, or sleeping too much
D0150D	D0500D	Feeling tired or having little energy
D0150E	D0500E	Poor appetite or overeating
D0150F	D0500F	Feeling bad about yourself - or that you are a failure or have let yourself down or your family down
D0150G	D0500G	Trouble concentrating on things, such as reading the newspaper or watching television
D0150H	D0500H	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
D0150I	D0500I	Thoughts that you would be better off dead, or of hurting yourself in some way
-	D0500J	Being short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at item D0160 and for the staff assessment at item D0600. The resident qualifies as depressed for PDPM classification in either of the two following cases:

The D0160 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.

Resident Qualifies as Depressed Yes _____ No _____

STEP #4

Select the Special Care Low classification based on the PDPM Nursing Function Score and the presence or absence of depression according to this table:

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	LDE2
0-5	No	LDE1
6-14	Yes	LBC2
6-14	No	LBC1

PDPM Nursing Classification: _____

CATEGORY: CLINICALLY COMPLEX

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP #1

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

Table 19: Clinically Complex Conditions or 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) or surgical wounds with any selected skin treatments*
M1040F	Burns (second or third degree)
O0110A1b	Chemotherapy while a resident
O0110C1b	Oxygen therapy while a resident
O0110H1b	IV Medications while a resident
O0110I1b	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)

If the resident does not have one of these conditions, skip to the Behavioral Symptoms and Cognitive Performance Category now.

STEP #2

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Clinically Complex category. Residents with signs and symptoms of depression are identified by the Patient Mood Interview (PHQ-2 to 9©) or the Staff Assessment of Patient Mood (PHQ-9-OV©). Instructions for completing the PHQ-2 to 9© are in Chapter 3, Section D. *Item D0100 is a gateway question to determine when the Patient Mood Interview (D0100 is coded 1, Yes) or the Staff Assessment of Patient Mood is to be conducted (D0100 is coded 0, No).* Refer to Appendix E for cases in which the PHQ-2 to 9© or PHQ-9-OV© is complete but all questions are not answered. For the PHQ-2 to 9©, if either D0150A2 or D0150B2 is coded 2 or 3, continue asking the questions below, otherwise end the PHQ interview. *Assessors should proceed to D0700, Social Isolation in the case of resident refusal or unwillingness to participate.* The following items comprise the PHQ-2 to 9© and PHQ-9-OV© for the Patient and Staff assessments, respectively:

Resident	Staff	Description
D0*15*0A	D0500A	Little interest or pleasure in doing things
D0*15*0B	D0500B	Feeling down, depressed, or hopeless
D0*15*0C	D0500C	Trouble falling or staying asleep, *or* sleeping too much
D0*15*0D	D0500D	Feeling tired or having little energy
D0*15*0E	D0500E	Poor appetite or overeating
D0*15*0F	D0500F	Feeling bad about yourself - or that you are a failure or have let yourself down or your family down
D0*15*0G	D0500G	Trouble concentrating on things, such as reading the newspaper or watching television
D0*15*0H	D0500H	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
D0*15*0I	D0500I	Thoughts that you would be better off dead, or of hurting yourself in some way
-	D0500J	Being short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at item D0*16*0 and for the staff assessment at item D0600. A higher Total Severity Score is associated with more symptoms of depression. For the resident interview, a Total Severity Score of 99 indicates that the interview was not successful.

The resident qualifies as depressed for PDPM classification in either of the two following cases:

The D0*16*0 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.

Resident Qualifies as Depressed Yes _____ No _____

STEP #3

Select the Clinically Complex classification based on the PDPM Nursing Function Score and the presence or absence of depression according to this table:

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	CDE2
0-5	No	CDE1
6-14	Yes	CBC2
15-16	Yes	CA2
6-14	No	CBC1
15-16	No	CA1

PDPM Nursing Classification: _____

CATEGORY: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

Classification in this category is based on the presence of certain behavioral symptoms or the resident's cognitive performance. Use the following instructions:

STEP #1

Determine the resident's PDPM Nursing Function Score. If the resident's PDPM Nursing Function Score is 11 or greater, go to Step #2.

If the PDPM Nursing Function Score is less than 11, skip to the Reduced Physical Function Category now.

STEP #2

If the resident interview using the Brief Interview for Mental Status (BIMS) was not conducted (indicated by a value of "0" for item C0100), skip the remainder of this step and proceed to Step #3 to check staff assessment for cognitive impairment.

Determine the resident's cognitive status based on resident interview using the BIMS. Instructions for completing the BIMS are in Chapter 3, Section C. The BIMS items involve the following:

C0200	Repetition of three words
C0300	Temporal orientation
C0400	Recall

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 interview is not successful, then the BIMS Summary Score will equal 99.

If the resident's Summary Score is less than or equal to 9, *they* classif*y* in the Behavioral Symptoms and Cognitive Performance category. Skip to Step #5.

If the resident's Summary Score is greater than 9 but not 99, proceed to Step #4 to check behavioral symptoms.

If the resident's Summary Score is 99 (resident interview not successful) or the Summary Score is blank (resident interview not attempted and skipped) or the Summary Score has a dash value (not assessed), proceed to Step #3 to check staff assessment for cognitive impairment.

STEP #3

Determine the resident's cognitive status based on the staff assessment rather than on resident interview.

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: B0700 >= 2 Sometimes or rarely/never makes self understood C1000 >= 2 Moderately or severely impaired cognitive skills for daily decision making

If the resident meets one of the three above conditions, then *they* classify in Behavioral Symptoms and Cognitive Performance. Skip to Step #5. If *they* do not meet any of the three conditions, proceed to Step #4.

STEP #4

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)

If the resident presents with one of the symptoms above, then *they* classify in Behavioral Symptoms and Cognitive Performance. Proceed to Step #5. If *they* do not present with behavioral symptoms, skip to the Reduced Physical Function Category.

STEP #5

Determine Restorative Nursing Count

Count 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

Restorative Nursing Count: _____

STEP #6

Select the final PDPM Classification by using the total PDPM Nursing Function Score and the Restorative Nursing Count.

Nursing Function Score	Restorative Nursing Count	PDPM Nursing Classification
11-16	2 or more	BAB2
11-16	0 or 1	BAB1

PDPM Nursing Classification: _____

CATEGORY: REDUCED PHYSICAL FUNCTION

STEP #1

Residents who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the Behavioral Symptoms and Cognitive Performance category but have a PDPM Nursing Function Score less than 11, are placed in this category.

STEP #2

Determine Restorative Nursing Count

Count 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

Restorative Nursing Count: _____

STEP #3

Select the PDPM Classification by using the PDPM Nursing Function Score and the Restorative Nursing Count.

Nursing Function Score	Restorative Nursing Count	PDPM Nursing Classification
0-5	2 or more	PDE2
0-5	0 or 1	PDE1
6-14	2 or more	PBC2
15-16	2 or more	PA2
6-14	0 or 1	PBC1
15-16	0 or 1	PA1

PDPM Nursing Classification: _____

Calculation of Variable Per Diem Payment Adjustment

PDPM incorporates variable per diem payment adjustments to account for changes in resource use over the course of a stay for three payment components: PT, OT, and NTA. To calculate the per diem rate for these components, multiply the component base rate by the case-mix index associated with the resident's case-mix group and the adjustment factor based on the day of the stay, as shown in the following equation:

Component Per Diem Payment = Component Base Rate x Resident Group CMI x Component Adjustment Factor

The adjustment factors for the PT and OT components can be found in the table below.

Table 20: PT and OT Variable Per Diem Adjustment Factors

Day in Stay	PT and OT 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 adjustment factors for the NTA component can be found in the table below.

Table 21: NTA Variable Per Diem Adjustment Factors

Day in Stay	NTA Adjustment Factor
1-3	3.00
4-100	1.00

Calculation of Total Case-Mix Adjusted PDPM Per Diem Rate

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:

*Total Case-Mix Adjusted Per Diem Payment = (PT Component Per Diem Rate * PT Variable Per Diem Adjustment Factor) + (OT Component Per Diem Rate * OT Variable Per Diem Adjustment Factor) + SLP Component Per Diem Rate + (NTA Component Per Diem Rate * NTA Variable Per Diem Adjustment Factor) + Nursing Component Per Diem Rate + Non-Case-Mix Component Per Diem Rate*

6.7 SNF PPS Policies

Requirements and policies for SNF PPS are described in greater detail in Chapter 8 of the **Medicare Benefit Policy Manual** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08*pdf*.pdf). There are some situations that the SNF may encounter that may impact Medicare Part A SNF coverage for a resident, affect the PPS assessment schedule, or impact the reimbursement received by the SNF.

Delay in Requiring and Receiving Skilled Services (30-Day Transfer)

There are instances in which the resident does not require SNF level of care services when initially admitted to the SNF. When the resident requires and receives SNF level of care services within 30 days from the hospital discharge, Day 1 for the PPS assessment schedule is the day on which SNF level of care services begin. For example, if a resident is discharged from the hospital on August 1 and the SNF determines on August 30 that the resident requires skilled service for a condition that was treated during the qualifying hospital stay, then the SNF would start the PPS assessment schedule with a 5-Day PPS assessment, with August 30 as Day 1 for scheduling purposes. However, if the resident requires and receives a SNF level of care 31 or more days after the hospital discharge, the resident does not qualify for a SNF Part A stay (see Medical Appropriateness Exception below).

Medical Appropriateness Exception (Deferred Treatment)

An elapsed period of more than 30 days is permitted for starting SNF Part A services when a resident's condition makes it inappropriate to begin an active course of treatment in a SNF immediately after a qualifying hospital stay discharge. It is applicable only where, under accepted medical practice, the established pattern of treatment for a particular condition indicates that a covered level of SNF care will be required within a predeterminable time frame, and it is medically predictable at the time of hospital discharge that the resident will require SNF level of care within a predetermined time period (for more detailed information see Chapter 8 of the **Medicare Benefit Policy Manual**). For example, a resident is admitted to the SNF after a qualifying hospital stay for an open reduction and internal fixation of a hip. It is determined upon hospital discharge that the resident is not ready for weight-bearing activity but will most likely be ready in 4-6 weeks. The physician writes an order to start therapy when the resident is able to tolerate weight bearing. Once the resident is able to start therapy, the Medicare Part A stay begins, and the 5-Day assessment will be performed. Day 1 of the stay will be the first day on which the resident starts therapy services.

Interrupted Stay

An "interrupted" SNF stay is defined as one in which a resident is discharged from SNF care and subsequently readmitted to the same SNF (not a different SNF) within 3 days or less after the discharge (the "interruption window").

The interruption window is a 3-day period, starting with the calendar day of Part A discharge and including the 2 immediately following calendar days, ending at midnight. In other words, the resident must return to the same SNF by 11:59 p.m. at the end of the third calendar day. The

interruption window begins on the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered stay.

If both conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A stay for the purposes of both the variable per diem schedule and the assessment schedule. The variable per diem schedule continues from the day of the previous discharge. For example, if the resident was discharged on Day 7, payment rates resume at Day 7 upon readmission. The assessment schedule also continues from the day of the previous discharge. Thus, no new 5-Day assessment is required upon the subsequent readmission, although the optional IPA may be completed at clinician's discretion.

If a resident is readmitted to the same SNF more than 3 consecutive calendar days after discharge, OR in any instance when the resident is admitted to a different SNF (regardless of the length of time between stays), then the Interrupted Stay Policy does not apply, and the subsequent stay is considered a new stay. In such cases, the variable per diem schedule resets to Day 1 payment rates, and the assessment schedule also resets to Day 1, necessitating the completion of a new 5-Day assessment.

Example 1: *Resident* A is admitted to the SNF on 11/07/19. *They are* admitted to a hospital on 11/20/19. *They* return to the same SNF on 11/25/19. Because *Resident* A is readmitted to the same SNF more than three calendar days after discharge, this would be considered a new stay. The assessment schedule would be reset to Day 1, beginning with a new 5-Day assessment, and the variable per diem schedule would begin from Day 1.

Example 2: *Resident* B is admitted to the SNF on 11/07/19. *They are* admitted to the hospital on 11/20/19. *They are* admitted to a different SNF on 11/22/19. Because *Resident* B is admitted to a different SNF, this would be considered a new stay. The assessment schedule would be reset, beginning with a new 5-Day assessment, and the variable per diem schedule would begin from Day 1.

Example 3: *Resident* C is admitted to the SNF on 11/07/19. *They are* admitted to a hospital on 11/20/19. *They* return to the same SNF on 11/22/19. Because *Resident* C is admitted to the same SNF within three days from the point of discharge, this would be considered a continuation of the previous stay. No 5-Day assessment would be required upon readmission, though the IPA would be an option. Additionally, the variable per diem would continue from Day 14 (Day of Discharge).

Resident Discharged from Part A Skilled Services and Returns to SNF Part A Skilled Level Services

In the situation in which a resident is discharged from SNF Medicare Part A services and later requires SNF Part A skilled level of care services, and it is not an instance of an interrupted stay (as described above), the resident may be eligible for Medicare Part A SNF coverage if the following criteria are met:

1. Less than 30 days have elapsed since the last day on which SNF level of care services were required and received,

2. SNF-level services required by the resident are for a condition that was treated during the qualifying hospital stay or for a condition that arose while receiving care in the SNF for a condition for which the beneficiary was previously treated in the hospital,
3. Services must be reasonable and necessary,
4. Services can only be provided on an inpatient basis,
5. Resident must require and receive the services on a daily basis, and
6. Resident has remaining days in the SNF benefit period.

For greater detail, refer to the **Medicare Benefit Policy Manual**, Chapter 8.

6.8 Non-compliance with the SNF PPS Assessment Schedule

To receive payment under the SNF PPS, the SNF must complete scheduled and unscheduled assessments as described in Chapter 2.

According to 42 CFR 413.343, an assessment that does not have an ARD within the prescribed ARD window will be paid at the default rate for the number of days the ARD is out of compliance. Frequent late assessment scheduling practices or missing assessments may result in additional review. The default rate (ZZZZZ) takes the place of the otherwise applicable Federal rate. It is equal to the sum of the rate paid for the case-mix group reflecting the lowest acuity level under each PDPM component, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

Late Assessment

If the SNF fails to set the ARD within the defined ARD window for a PPS assessment, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the day the error was identified.

The SNF will bill the default rate for the number of days that the assessment is out of compliance. This is equal to the number of days between the day following the last day of the available ARD window and the late ARD (including the late ARD). **The SNF would then bill the Health Insurance Prospective Payment System (HIPPS) code established by the late assessment for the remaining period of time that the assessment would have controlled payment.** For example, a 5-Day assessment with an ARD of Day 11 is out of compliance for 3 days and therefore would be paid at the default rate for Days 1 through 3 and the HIPPS code from the late 5-Day assessment for the remainder of the Part A stay, unless an IPA is completed. In the case of a late assessment, the variable per diem schedule still begins on Day 1 of the stay and not with the late assessment ARD and default billing will be assessed prior to billing based on the late 5-Day assessment.

Missed Assessment

If the SNF fails to set the ARD of a PPS assessment prior to the end of the last day of the ARD window, and the resident is no longer a SNF Part A resident, and as a result a PPS assessment does not exist in *i*QIES for the payment period, the provider may not usually bill for days when an assessment does not exist in *i*QIES. When a PPS assessment does not exist in *i*QIES, there is not a HIPPS code the provider may bill. In order to bill for Medicare SNF Part A services, the provider must submit a valid PPS assessment that is accepted into *i*QIES. The provider must bill the HIPPS code that is verified by the system. If the resident was already discharged from Medicare Part A when this is discovered, a PPS assessment may not be performed.

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

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

ARD Outside the Medicare Part A SNF Benefit

A SNF may not use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for a PPS assessment. For example, the resident returns to the SNF on December 11 following a hospital stay, requires and receives SNF skilled services (and meets all other required coverage criteria), and has 3 days left in *their* SNF benefit period. The SNF must set the ARD for the PPS assessment on December 11, 12, or 13 to bill for the HIPPS code associated with the assessment.