PATIENT DRIVEN PAYMENT MODEL
THE BASICS

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WHY THE CHANGE?

CMS, OIG, media and others have identified issues with the current RUG-IV case-mix model:

• Therapy payments under PPS are based primarily on the amount of therapy provided rather than the resident’s overall needs and goals.
• Residents demonstrating different nursing needs/costs often receive the same amount of dollars for nursing services.

PDPM:
• Changes the focus to the resident
• Improves payment accuracy
• Decreases administrative burden on SNF’s
• Reallocates services/payments to underserved Medicare beneficiaries
DIFFERENCES BETWEEN RUG-IV AND PDPM

RUG-IV:
- Two case-mix components:
  - Therapy: based on volume of service provided
  - Nursing: case-mix index doesn’t reflect variations in non-therapy ancillary utilization
- Constant per-diem rate: same from Day 1-Day 100

PDPM:
- Five case-mix “adjusted” components:
  - PT  OT  SLP  Nursing  Non-therapy ancillaries (NTA)
- Variable per-diem adjustment which adjusts over course of SNF stay (details may be found in the Variable Per Diem Schedule available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html))
- PT, OT, NTA components case-mix adjusted per-diem rate is multiplied against a variable per-diem adjustment factor following a schedule of adjustments for each day of the stay
RUG-IV vs. PDPM

- While RUG-IV (left) reduces everything about a patient to a single, typically volume-driven, case-mix group, PDPM (right) focuses on the unique, individualized needs, characteristics, and goals of each patient:
DIFFERENCES BETWEEN RUG-IV AND PDPM
CONTINUE

PDPM:

- Adjustment factor for PT/OT different from NTA due to difference in cost trajectory between PT/OT components and NTA.
- Focus is on the “unique” individual needs or characteristics and goals of each resident
- Improves payment accuracy
- Encourages a “resident-driven” holistic care model
WHAT IS “NOT” CHANGING

• Medicare coverage criteria is not changing: 3 midnight “Admission” hospital stay still required
• Medicare certification/recertification still required
• “Daily” skilled service still required:
  Therapy service 5 days/week
  Nursing skilled service 7 days/week
• NO impact on SNF ABN/NOMNC requirements
• No change in OBRA assessments: Admission, quarterly, annual, significant change

Presumption of coverage must meet one of the following:
  Nursing: Extensive Services, Special Care High/Low, Clinically Complex
  PT/OT groups: TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN or TO
  SLP groups: SC, SE, SF, SH, SI, SJ, SK, SL
  NTA component of 12+ comorbidity groups
So... What “IS” Changing under PDPM?

• PDPM changes the way we look at Medicare referrals and admissions
• Therapy is not the “revenue” driver, it is an expense. Rehab days and minutes no longer impact payment
• Creates a model based on clinical characteristics addressing resident needs
• ICD-10 captured on the MDS will drive clinical classifications impacting reimbursement
• Functional scores, Section GG, will have a significant effect on payment
• Separate component: non-therapy ancillaries (NTA)
• Each resident is classified into each of the 5 components falling into different levels. 23,000 potential payment groups
• MDS schedule changes: Admission 5-day, Interim Payment Assessment (IPA), PPS Discharge assessment, It eliminates 14, 30, 60, 90 day, SOT, COT, EOT assessments. The 5-day has the potential to pay for the entire stay.
• New MDS items: Section I, J, O
MDS CHANGES

• Section I: Primary SNF Diagnosis
  I0020B. ICD-10 code “What is the main reason this person is being admitted to SNF?
  I1300 Ulcerative Colitis, Crohn’s or Inflammatory Bowel Disease diagnosis added to the NP, SP, and IPA
  items sets in order to capture this diagnosis for the NTA comorbidity group score

• Section J: Patient Surgical History
  J2100-J5000. Captures any major surgical procedure that occurred during the inpatient hospital stay
  immediately preceding the SNF admission. These items are used in conjunction with I0020B to classify the
  patients into PT/OT case mix classification groups.

• Section O: Discharge Therapy Items
  O425A1-O425C5 A reporting of the entire stay look back for each discipline, mode of therapy, and amount
  of therapy (in minutes)

• Section GG: Interim Performance
  On the IPA, GG items will be derived from a new column “5” which will capture interim performance with a
  “three-day window preceding and up to the ARD look back period”
# Components Overview

- **Patient Classifications** are used for each component:

<table>
<thead>
<tr>
<th>Component</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT</td>
<td>Clinical Category, Functional Score</td>
</tr>
<tr>
<td>OT</td>
<td>Clinical Category, Functional Score</td>
</tr>
<tr>
<td>SLP</td>
<td>Presence of Acute Neurological Condition, SLP-related Comorbidity or Cognitive Impairment, Mechanically-altered Diet, Swallowing Disorder</td>
</tr>
<tr>
<td>NTA</td>
<td>NTA Conditions/Comorbidities Score</td>
</tr>
<tr>
<td>Nursing</td>
<td>Clinical conditions/Needs, Functional Score</td>
</tr>
</tbody>
</table>

(Section GG)
For PT/OT the Clinical Categories are decreased to 4:

- Major Joint Replacement or Spinal Surgery
- Non-orthopedic Surgery and Acute Neurologic
- Other Orthopedic
- Medical Management: default category for conditions such as Pneumonia, UTI, Cardiac
- Diagnosis

PDPM advances CMS’ goal of using standardized assessment items across payment settings using items in Section GG of the MDS as the basis for patient functional assessments.
Case-mix has 2 primary elements used to determine classification:

- Clinical Category for SNF stay I0020B
- Functional Status: Score derived from 10 items in Section GG, 3 from GG0130, 7 from GG0170
  - 2 bed mobility items
  - 3 transfer items
  - 1 eating item
  - 1 toileting item
  - 1 oral hygiene item
  - 2 walking items

The higher the number, the more independent the resident

The lower the number, the more dependent the resident

- 16 case-mix groups each
 COMPONENTS OVERVIEW

SLP

SLP has 3 elements:
• Clinical category for SNF stay: Acute Neurologic or Non-neurologic
• Presence of Swallowing Disorder and/or Mechanically-Altered Diet (Section K)
• Cognitive Status (BIMS) and/or Presence of an SLP-related comorbidity

SLP has 12 comorbidities under PDPM:
• SLP comorbidity tag combines conditions and services
• Only presence of one of the following is required to qualify:

  | Aphasia | Laryngeal Cancer | Oral Cancers |
  | CVA, TIA or Stroke | Apraxia | Speech & Language Deficits |
  | Hemiplegia or Hemiparesis | Dysphagia | Tracheostomy (while resident) |
  | Traumatic Brain Injury | ALS | Ventilator (While resident) |
Components Overview
Nursing

Same RUG-IV Major Categories:
• Extensive Services
• Special Care High
• Special Care Low
• Clinically Complex
• Behavior Symptoms & Cognitive Impairment
• Reduced Physical Function (if the resident doesn’t qualify on one of other 5, score here)
• 25 case-mix groups

Nursing Functional Score MDS Section GG Functional Abilities and Goals:
• Assessed during the first 3 days of admission
• Documents “usual performance”
• Functional score ranges from 0 (dependent) to 16 (independent)
• **Note:** Nursing component will increase by 18% for residents with HIV/AIDS, 8 points into NTA count, B20 must be on SNF claim (UB04)
Components Overview
Non-Therapy Ancillaries (NTA)

Ancillaries case-mix group includes medical resources, medical supplies, medications, labs and respiratory services. This is where you may front load expensive medications, wound care supplies, etc.

Comorbidity score is a weighted count of comorbidities:
• Points are assigned for each additional comorbidity present with more points awarded at higher cost tiers
• Comorbidities and extensive services for NTA classifications are derived from a variety of MDS sources, with some from item I8000
• HIV/AIDS remains a SNF claim reported adjustment (8 points)
• Calculated based on points assigned for 50 MDS items
• Every point counts!!!!!
Data sources include:
HIV/AIDS-SNF claim
Bowel/bladder application-H0100C, H0100D ostomy, catheterization
Parenteral/IV tube fed-Section K
Ulcers, foot skin problems-Section M
Special treatments/ext. services-Section O IV meds, trach, vent, suctioning, transfusion, infection
Diagnosis-Section I 6 specific diagnosis
Additional active Dx.–Item I8000 28 specific diagnosis
**VARIABLE PAYMENT ADJUSTMENTS (VRB)**

Better targets payments under SNF PPS to reflect cost trends

- 2 different variable payment adjustments:
  
  **PT/OT component:** 2% decrease in original rate every 7 days beginning on day 21

<table>
<thead>
<tr>
<th>Payment days</th>
<th>Adjustment factor</th>
</tr>
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<tbody>
<tr>
<td>1-20</td>
<td>1.0</td>
</tr>
<tr>
<td>21-27</td>
<td>0.98</td>
</tr>
<tr>
<td>28-34</td>
<td>0.96...</td>
</tr>
<tr>
<td>98-100</td>
<td>0.76</td>
</tr>
</tbody>
</table>

- Non-therapy ancillary adjustments
  
  Days 1-3 adjustment factor of 3.0 meaning you get $3x$ the rate for the first 3 days
  
  Days 4-100 adjustment factor of 1.0
ICD-10 Coding

- Replaced ICD-9 codes in October, 2015
- Expanded number of codes from 13,000 to 70,000+
- Expanded from a 4-digit to a 6-digit code to allow for more specificity
- Clinical categories are assigned based on primary diagnosis for the SNF stay
- New MDS item I0020B is used to “map” to one of the PDPM clinical categories
- Section J (Surgical Procedures) is used to further adjust clinical classifications, if applicable (must occur during the current hospital stay)

**Note:** Under the cms.gov PDPM resources is a PDPM ICD-10 mapping tool (revision 8/30/19)
ICD-10 Coding Coding Accuracy

Step by step to coding accurately:

• Identify the reason for admission to SNF-diagnosis/condition, sign/symptoms
• Once the reason is identified, consult the alphabetical index in the book before verifying the code selection in the tabular section
• Locate the main term entry
• Read cross-reference listed with the main term or sub-term
• Review entries for modifiers
• Interpret abbreviations, cross-references, default codes, additional character and brackets
• Chose a potential code and locate in the tabular list
• Determine whether the code is at the highest level of specificity
• Assign the code-discuss with the IDT, look to see if it maps versus “Return to Provider”
• Sequence codes correctly, primary, moving downward
Section GG
Functional Scoring

• Differences between RUG-IV and PDPM:
  Reversed scoring between RUG-IV and PDPM
    RUG-IV Section G-higher score indicates increased dependence
    PDPM Section GG-higher score indicates increased independence

• Payment differences related to function:
  RUG-IV payments increase with dependence within given RUG
  PDPM no direct relationship between increased dependence and increased payments
  For PT & OT component, payment for 3 clinical categories is lower for the most & least dependent residents

• PDPM uses the same basic structure as RUG-IV except:
  Section GG functional scoring
  Functional groups decreased from 43 to 25
• 10/1/18 General Clarifications: Apply to both GG0130 (self care) and GG0170 (mobility)

Steps for Assessment: CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period.

Defined: “Qualified Clinician”: Healthcare professionals practicing within their scope of practice and consistent with Federal, state and local law regulations.

• Important because:

Nursing and therapy utilize a different language

Therapy ratings may not reflect the resident’s “usual performance” as the resident may respond differently in therapy than on the nursing unit.
SECTION GG
FUNCTIONAL SCORING

• **Usual Performance GG-9:**

  Resident’s functional status may be affected by the environment or activities within the facility. Functional status should be observed in different locations and circumstances to provide a more comprehensive assessment. If the resident’s functional status varies, record his/her usual ability to perform the individual activity. Don’t record the best or worst performance but the **usual** performance.
**PT & OT Functional Score: GG Items**

- Section GG items included in the PT & OT Functional Score:

<table>
<thead>
<tr>
<th>Section GG Item</th>
<th>Functional Score Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>GG0130A1 – Self-care: Eating</td>
<td>0 – 4</td>
</tr>
<tr>
<td>GG0130B1 – Self-care: Oral Hygiene</td>
<td>0 – 4</td>
</tr>
<tr>
<td>GG0130C1 – Self-care: Toileting Hygiene</td>
<td>0 – 4</td>
</tr>
<tr>
<td>GG0170B1 – Mobility: Sit to Lying</td>
<td>0 – 4</td>
</tr>
<tr>
<td>GG0170C1 – Mobility: Lying to Sitting on side of bed</td>
<td>(average of 2 items)</td>
</tr>
<tr>
<td>GG0170D1 – Mobility: Sit to Stand</td>
<td>0 – 4</td>
</tr>
<tr>
<td>GG0170E1 – Mobility: Chair/bed-to-chair transfer</td>
<td>0 – 4</td>
</tr>
<tr>
<td>GG0170F1 – Mobility: Toilet Transfer</td>
<td>(average of 3 items)</td>
</tr>
<tr>
<td>GG0170J1 – Mobility: Walk 50 feet with 2 turns</td>
<td>0 – 4</td>
</tr>
<tr>
<td>GG0170K1 – Mobility: Walk 150 feet</td>
<td>(average of 2 items)</td>
</tr>
</tbody>
</table>
Nursing Functional Score: GG Items

- Section GG items included in the Nursing Functional Score:

<table>
<thead>
<tr>
<th>Section GG Item</th>
<th>Functional Score Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>GG0130A1 – Self-care: Eating</td>
<td>0 – 4</td>
</tr>
<tr>
<td>GG0130C1 – Self-care: Toileting Hygiene</td>
<td>0 – 4</td>
</tr>
<tr>
<td>GG0170B1 – Mobility: Sit to Lying</td>
<td>0 – 4</td>
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</tr>
<tr>
<td>GG0170F1 – Mobility: Toilet Transfer</td>
<td>0 – 4</td>
</tr>
</tbody>
</table>
MDS Items

New items:
- I0020B-SNF Primary Diagnosis (replaces I0020A)
- J2100-J5000-Patient Surgical History
- O0425A1-O045C5-Discharge Therapy items
- Section GG: New column 5 for use with IPA assessments

Items affecting payment:
- Primary diagnosis (new item I0020B)
- Recent/past surgical procedures (new item J2100-J5000)
- Function scores
- Cognition-BIMS
- Depression/mood-PHQ9
- Speech comorbidities
- Swallowing difficulties/modified diets - Section K
- Special conditions/services (NTA component)
MDS Items

- MDS sections utilized by PDPM:
  - Section B - Hearing, Speech and Vision
  - Section C - Cognitive Patterns
  - Section H - Bladder and Bowel
  - Section I - Active Diagnosis
  - Section GG - Functional Ability
  - Section J - Health Conditions
  - Section K - Swallowing/Nutritional Status
  - Section M - Skin Conditions
  - Section O - Special Treatments
Assessment Changes

- Admission/5 day:
  ARD 1-8 days
  Covers entire stay unless IPA completed

- Interim Payment Assessment (IPA): **OPTIONAL**
  ARD no later than 14 days after change in first tier classification
  Pays from ARD until discharge except if another IPA completed
  Does not change the variable payment schedule

- PPS Discharge Assessment:
  ARD equals end date of the most recent stay (A2400C)
  Not used for payment purposes
  Section O therapy days/minutes
3 Day Interruption Window

- The count starts the calendar day of discharge (first non-covered day) and includes the 2 immediately following calendar days, ending at 1159 of the third consecutive non-covered day.
- It allows the combination of multiple stays into a single stay in cases where the resident discharge and readmission occurs within the prescribed window.
- It applies to instances when the resident physically leaves the facility but also cases when the resident remains but is discharged from a Medicare A covered stay.
- Billing criteria is similar to LOA (see billing manual).
  - Occurrence span code 74 with from/through dates of leave.
  - Value code 81 for number of non-covered days.
  - Revenue code 0180 for non-covered revenue.
• Based on responses on the MDS the residents are classified into payment groups which are billed using a 5-character HIPPS code.

• In order to accommodate the new payment groups, the PDPM HIPPS algorithm is revised as follows:
  Character 1: PT/OT payment group
  Character 2: SLP payment group
  Character 3: Nursing payment group
  Character 4: NTA payment group
  Character 5: Assessment indicator

• Default code will change to ZZZZZ
How Do I Get Started?

- Look at your referral and admission processes: what information do you receive from the transferring facility? How easily can you obtain additional information to support a diagnosis and/or ICD-10 code?
- What does your nursing admission documentation look like? Does it include accurate wound assessments, IV therapy documentation and more?
- Who is responsible for completion of Section GG in the first 3 days of admission? How are you going to ensure completion and accuracy?
- What is the system of communication between nursing and therapy? What is your process for tracking therapy days and minutes needed to complete a discharge assessment?
- Who is responsible for ICD-10 coding? Do you have a second Champion with coding knowledge? Do they have knowledge of “mapping”? How do they get to the mapping site? Do they know how to sequence properly?
How Do I Get Started?

- Do you have a Restorative Nursing Program? Are the number of programs and minutes the resident receives accurately documented? Is the documentation consistent?
- What are your CNA’s documenting about care delivery? Is it accurate or are they just going through the motions?
- What education have you or will you be providing for your staff: MDS Coordinator(s), Business Office Manager, Therapists, Nurses, CNA’s, Social Services, Activities, Dietician?
- Are you able to identify best practices and develop “care paths” for specific resident conditions?
- **Is your MDS Coordinator pulled to work the floor? Will he/she be allowed uninterrupted time to complete the CRITICAL 5 day/Admission assessment?**
- Do you have a triple check process? If no, why not? If yes, have you revised the process to reflect the changes?
- Is your software vendor ready?
How Do We Get There?

- **Start preparing today!!! October 1, 2019 is just around the corner!!!**
- Identify processes impacted by PDPM
- Talk with your therapy provider-contract revision
- Sharpen ICD-10 coding skills
- Implement programs to improve your capture of functional skills-Accuracy is Key!!!
- Establish or build up your restorative program
- Review documentation: BIMS/PHQ9, Section K, Section GG, nursing documentation, physician documentation
- Look at staff competencies and provide needed education
- Look at length of stay management
- Get with your referral sources to identify which residents are difficult to place
Transitioning to PDPM

Prepare to transition from RUG-IV to PDPM:

- RUG-IV billing **ends** 9/30/19: must have an ARD prior to 10/1/19 to bill for September

PDPM begins 10/1/19:

- To establish PDPM payment a 1x “transitional” IPA with an ARD no later than 10/7/19 needs completed for the transition. Every resident currently on Medicare Part A on 9/30/19 will need this “transitional” IPA with an ARD of 10/1-10/7/19
- 10/1/19 will be **day 1** under the PDPM variable payment regardless of what day of the stay the resident is in
- If an IPA is completed with an ARD of 10/8/19 for it will be considered late and the default penalty for days out of compliance will apply
RESOURCES

- CMS Patient Driven Payment Model Website:
  https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/SNFPPS/PDPM.html

- PDPM Implementation and policy PDPM@cms.hhs.gov

- Patient Driven Payment Model (PDPM) Ron Orth, RN, CMAC, CHC Relias

- Patient Driven Payment Model (PDPM) Prepare for Success BKD CPA’s and Advisors
QUESTIONS

???????
For the SLP component, PDPM uses a number of different patient characteristics that were predictive of increased SLP costs:

- Acute Neurologic clinical classification
- Certain SLP-related comorbidities
- Presence of cognitive impairment
- Use of a mechanically-altered diet
- Presence of swallowing disorder
12 SLP comorbidities were identified as predictive of higher SLP costs

FYI’s…

- Conditions and services combined into a single SLP-related comorbidity flag
- Patient qualifies if any of the conditions/services is present
- A mapping between ICD-10 codes and the SLP comorbidities is available on the PDPM webpage

How is it calculated?

- Presence of condition(s)
- Comorbidities
- Score on the BIMS of the MDS
- Mechanically-altered diet
- Swallowing disorder
### 12 Qualifying Speech Language Pathology Conditions and Comorbidities

<table>
<thead>
<tr>
<th>Condition</th>
<th>Comorbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aphasia</td>
<td>Laryngeal Cancer</td>
</tr>
<tr>
<td>CVA, TIA, or Stroke</td>
<td>ALS</td>
</tr>
<tr>
<td>Apraxia</td>
<td>Tracheostomy (while Resident)</td>
</tr>
<tr>
<td>Hemiplegia or Hemiparesis</td>
<td>Oral Cancers</td>
</tr>
<tr>
<td>Dysphagia</td>
<td>Ventilator (while Resident)</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td>Speech &amp; Language Deficit</td>
</tr>
</tbody>
</table>

### How do they score on the BIMS?

<table>
<thead>
<tr>
<th>Cognitive Level</th>
<th>BIMS score</th>
<th>CPS score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitively intact</td>
<td>13-15</td>
<td>0</td>
</tr>
<tr>
<td>Mildly impaired</td>
<td>8-12</td>
<td>1-2</td>
</tr>
<tr>
<td>Moderately impaired</td>
<td>0-7</td>
<td>3-4</td>
</tr>
<tr>
<td>Severely impaired</td>
<td>-</td>
<td>5-6</td>
</tr>
</tbody>
</table>
### Presence of Acute Neurologic Condition, SLP Related Comorbidity, or Cognitive Impairment

<table>
<thead>
<tr>
<th>Presence of Acute Neurologic Condition, SLP Related Comorbidity, or Cognitive Impairment</th>
<th>Mechanically Altered Diet or Swallowing Disorder</th>
<th>SLP Case Mix Group</th>
<th>SLP Case Mix Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Neither</td>
<td>SA</td>
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<tr>
<td>Any three</td>
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<td>SL</td>
<td>4.19</td>
</tr>
</tbody>
</table>

### Case Study

**Patient:** Zane White  
**Admitted:** 11/6/2019  
**Dx:** Traumatic Brain Injury from a MVA, some aphasia, HTN, swallowing disorder, right femoral fracture  
**ADLs:** more dependent assist in most circumstances (transfers, mobility, hygiene, toileting, eating)  
**Nursing:** depression, surgical wound to head
<table>
<thead>
<tr>
<th>Discipline</th>
<th>Category</th>
<th>GG Score</th>
<th>Group</th>
<th>CMI</th>
<th>Payment</th>
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</thead>
<tbody>
<tr>
<td>PT</td>
<td>Other Orthopedic</td>
<td>6</td>
<td>TF</td>
<td>1.6070</td>
<td>$84.52</td>
</tr>
<tr>
<td>OT</td>
<td>Other Orthopedic</td>
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<td>TF</td>
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<td>$76.97</td>
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<td>SLP</td>
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<td>$76.17</td>
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<tr>
<td>NTA</td>
<td>Non-neurologic</td>
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<td>SI</td>
<td>0.7203</td>
<td>$41.76</td>
</tr>
<tr>
<td>Nursing</td>
<td>Non-case mix</td>
<td>4</td>
<td>CDE2</td>
<td>1.8648</td>
<td>$143.29</td>
</tr>
<tr>
<td>Total (1-3)</td>
<td>Non-case mix</td>
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<td></td>
<td></td>
<td>$73.35</td>
</tr>
<tr>
<td>Total (4-20)</td>
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<td></td>
<td></td>
<td>$579.57</td>
</tr>
<tr>
<td>Average payment per day (PPD) = $501.62</td>
<td>By day 45, PPD = $483.14</td>
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</table>

By day 45, PPD = $483.14
MDS, Sections B-E

- Section B - Communication (vision, hearing, dental) no changes
- *Remember, this is a GREAT place to help someone’s communication ability through an updated glasses prescription, new or adjusted dentures, hearing aids, pocket-talkers, etc.) CAREPLAN it 😊
- Section C - BIMS: a patient’s cognitive status is assessed in exactly the same way as under RUG-IV (i.e., via the BIMS or staff assessment) *Remember this will impact your PDPM score
- Sections D & E - no changes Use this opportunity to look more closely at behaviors and analyze RCA

Now What?

- You’ve calculated it
- You’ve done your 5-day/admission assessment
- CHART! CHART! CHART!
  - Main dx
  - Comorbidities (that you’ve claimed) that require daily care (e.g., dementia, diabetes, swallowing problems, etc.)
  - Life-skill ADLs (cater to section GG wording rather than typical section G ADLs)
  - Tell the whole story - what you’re doing for them, why they’re here, how they’re improving or declining
  - Care Plan!

REMEMBER - Every story will be different. There’s no place for copycat charting in PDPM.