

PT Component and OT Component*

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

Scoring Response for Section GG Items		Score
05, 06	Set-up assistance, independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 10, 88, [-]	Dependent, refused, not attempted, resident does not walk**	0

Section GG items		Score
GG0130A1	Self-care: Eating	0-4
GG0130B1	Self-care: Oral hygiene	0-4
GG0130C1	Self-care: Toileting hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4
GG0170C1	Mobility: Lying to sitting on side of bed	(avg. of 2 bed mobility items)
GG0170D1	Mobility: Sit to stand	0-4
GG0170E1	Mobility: Chair/bed-to-chair transfer	(avg. of 3 transfer items)
GG0170F1	Mobility: Toilet transfer	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0-4 (avg. of 2 walking items)
GG0170K1	Mobility: Walk 150 feet	

***PT Component and OT Component:**
PT and OT components will always result in the same case-mix group; however, the PT and OT case-mix indices/payment levels differ.

If a resident is coded as not attempted (07, 09, 10, or 88) for **GG0170I1 (Walk 10 feet)**, then walking items for GG0170J1 (Walk 50 feet with 2 turns) and GG0170K1 (Walk 150 feet) will be scored as zero points.

NOTE: This document is intended to aid members in their review of the Patient-Driven Payment Model. Resources: FY 2019 SNF PPS Final Rulemaking, CMS Fact sheet: PDPM Patient Classification, and CMS draft PDPM Calculation Worksheet for SNFs. AANAC has made every attempt to ensure the accuracy and reliability of the information provided. AANAC does not accept any responsibility or liability for the accuracy, content, and completeness of the information.

SLP Component

Presence of Acute Neurologic Condition, SLP-Related Comorbidity*, or Cognitive Impairment**	Presence of: Swallowing Disorder (K0100A-D) OR Mechanically Altered Diet (K0510C2)	SLP Case-Mix Group	SLP CMI Case-Mix Group
None	Neither	SA	0.68
	Either	SB	1.82
	Both	SC	2.66
Any one	Neither	SD	1.46
	Either	SE	2.33
	Both	SF	2.97
Any two	Neither	SG	2.04
	Either	SH	2.85
	Both	SI	3.51
All three	Neither	SJ	2.98
	Either	SK	3.69
	Both	SL	4.19

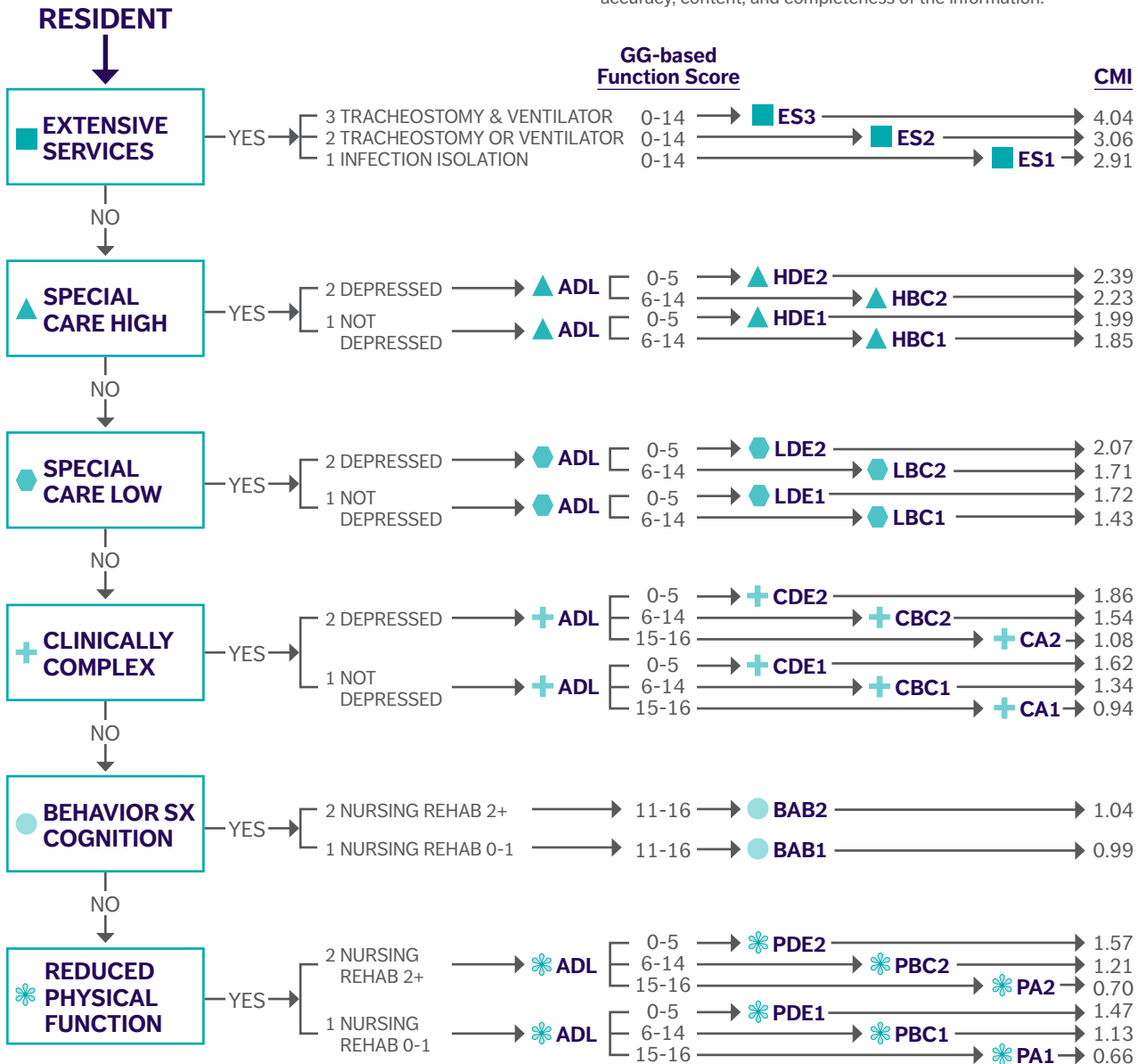
*** SLP-Related Comorbidities:**
Aphasia (I4300); CVA, TIA, or Stroke (I4500); Hemiplegia or Hemiparesis (I4900); TBI (I5500); Tracheostomy (O0100E2); Ventilator (I0100F2); Laryngeal Cancer, Apraxia, Dysphagia, ALS, Oral Cancers, Speech and Language Deficits (I8000)

**** Cognitive Impairment:**
The PDPM cognitive level is based on the Brief Interview for Mental Status (BIMS) or staff assessment. See the PDPM calculation [worksheet](#) provided by CMS for details.

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Nursing Component*

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Scoring Response for Section GG Items		Score
05, 06	Set-up assistance, independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 10, 88, [-]	Dependent, refused, not attempted	0

***Nursing Component:**
See the CMS PDPM calculation [worksheet](#) for inclusion criteria for each nursing classification.

Section GG items		Score
GG0130A1	Self-care: Eating	0-4
GG0130C1	Self-care: Toileting hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4 (avg. of 2 bed mobility items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4 (avg. of 3 transfer items)
GG0170E1	Mobility: Chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	

Medicare Part A: Skilled or Not?

No. 1 Technical Requirements

- ☐ 3 consecutive calendar days (**midnights**) (count the day of admission, but not the day of discharge from acute in-patient hospital)
 - Days in observation, ER, or non-acute swing bed use, are not counted
 - If not admitted directly from acute in-patient hospital, may meet **Thirty-Day Transfer Rule**
- ☐ Resident has days remaining **OR** has achieved a 60-day wellness period



No. 2 Validation of Skilled Level of Care

***Must meet all 4 items below** (see also **Presumption of Coverage**)

- ☐ Resident requires skilled nursing services or skilled rehabilitation services that are:
 - Ordered by a physician
 - Performed by or under the supervision of professional or technical personnel
 - Rendered for a condition for which the resident received inpatient hospital services or a condition that arose while receiving care in a SNF for a condition for which the resident received inpatient hospital services
- ☐ Resident requires skilled services on a daily basis. Daily skilled is defined as: 7 days per week for skilled nursing services
AND/OR
 - 5 days per week for skilled therapy
- ☐ As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF
- ☐ Services delivered are reasonable and necessary for treatment of resident's illness or injury



Thirty-day Transfer Rule (Meets Any 1 to Qualify)

- ☐ Resident may utilize Medicare SNF benefits if admitted to the SNF within 30 days of a qualifying hospital stay (day of discharge from the hospital is NOT counted in the 30 days)
- ☐ Resident may utilize Medicare SNF benefits if readmits to a SNF within 30 days of the last covered skilled day (day of discharge is counted)
- ☐ Resident that ends skilled coverage without discharging from the SNF may utilize Medicare benefits if skilled care arose within 30 days of last covered skilled day

Note: Must validate skilled level of care

Presumption of Coverage May be Used Through the ARD of the 5-day MDS if:

- ☐ PDPM classification falls into any one of the following case-mix groups:
Nursing Groups: Extensive Services, Special Care High, Special Care Low, and Clinically Complex
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
NTA Group: NA
AND
- ☐ Resident is admitted/readmitted directly to the SNF after a qualifying hospital stay
OR
- ☐ Resident was on Medicare in the SNF, was re-hospitalized, and

Presumption of Coverage Does Not Apply When:

- ☐ Resident is admitted/readmitted under the thirty-day transfer rule
- ☐ The ARD of the 5-day is set late (e.g., greater than day 8)
- ☐ PDPM Classification does not fall into one of the designated case-mix groups
Individual determination of skilled level of care must be completed



Effective Oct. 1, 2019

For more information:

<https://www.cms.gov/Medicare/Fee-for-Service-Payment/SNFPPS/PDPM.html>



Determining Skilled Nursing Services (Direct or Indirect)

Key Highlights from the Medicare Benefit Policy Manual—Chapter 8

DIRECT SKILLED NURSING SERVICES

Some examples of direct skilled nursing services [include]:

- Intravenous or intramuscular injections and intravenous feeding;
- Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day;
- Naso-pharyngeal and tracheotomy aspiration;
- Insertion, sterile irrigation, and replacement of suprapubic catheters;
- Application of dressings involving prescription medications and aseptic techniques (see §30.5 for exception);
- Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder (see §30.5 for exception);
- Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to evaluate the [resident's] progress adequately (see §30.5 for exception);
- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training programs;
- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy; and
- Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the [resident's] medical record. [§30.3]

INDIRECT SKILLED NURSING SERVICES

The documentation in the medical record as a whole is essential for determination of indirect skilled nursing services and must illustrate the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of skilled nursing personnel to promote the [resident's] recovery and medical safety in view of the [resident's] overall condition. [§30.2.3.1]

- **1. Management and Evaluation of a [Resident] Care Plan**—The development, management, and evaluation of a [resident] care plan, based on the physician's orders and supporting documentation, constitute skilled nursing services when, in terms of the [resident's] physical or mental condition, these services require the involvement of skilled nursing personnel to meet the [resident's] medical needs, promote recovery, and ensure medical safety.
- **2. Observation and Assessment of [Resident's] Condition**—Observation and assessment are skilled services when the likelihood of change in a [resident's] condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the [resident's] need for possible modification of treatment or initiation of additional medical procedures, until the [resident's] condition is essentially stabilized.
- **3. Teaching and Training Activities**—Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a [resident] how to manage their treatment regimen, would constitute skilled services.

Disclaimer: AANAC has made every attempt to ensure the accuracy and reliability of the information provided. AANAC does not accept any responsibility or liability for the accuracy, content, and completeness of the information. Skilled Nursing Facilities are responsible to review and understand the Medicare benefit policy manual before making coverage decisions.

For more information: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102C08.pdf>

PDPM Case-Mix Group Conversion to HIPPS Characters



PT/OT Payment Group	SLP Payment Group	Nursing Payment Group	NTA Payment Group	HIPPS Character
TA	SA	ES3	NA	A
TB	SB	ES2	NB	B
TC	SC	ES1	NC	C
TD	SD	HDE2	ND	D
TE	SE	HDE1	NE	E
TF	SF	HBC2	NF	F
TG	SG	HBC1		G
TH	SH	LDE2		H
TI	SI	LDE1		I
TJ	SJ	LBC2		J
TK	SK	LBC1		K
TL	SL	CDE2		L
TM		CDE1		M
TN		CBC2		N
TO		CA2		O
TP		CBC1		P
		CA1		Q
		BAB2		R
		BAB1		S
		PDE2		T
		PDE1		U
		PBC2		V
		PA2		W
		PBC1		X
		PA1		Y

Assessment Type	HIPPS Character
IPA	0
PPS 5-day	1
OBRA assessment (not coded as a PPS assessment)	6

1st character	PT and OT payment group
2nd character	SLP payment group
3rd character	Nursing payment group
4th character	NTA payment group
5th character	Assessment Indicator