| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-20 One-Time Notification | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 2270** | **Date: March 13, 2019** |
| | **Change Request 11152** |

**Transmittal 2252, dated February 8, 2019, is being rescinded and replaced by Transmittal 2270, dated, March 13, 2019 to remove Business Requirements (BRs) 11152.2 and 11152.3 and to revise BR 11152.4.3. All other information remains the same.**

**SUBJECT: Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)**

**I. SUMMARY OF CHANGES:** This Change Request will implement the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM).

**EFFECTIVE DATE: October 1, 2019**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: July 1, 2019 - CWF and FISS Coding and Testing in July 2019; July 1, 2019 - CWF Implementation in July; October 1, 2019 - Pricer Updates and Continue Testing**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| N/A | N/A |

**III. FUNDING:**
**For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**One Time Notification**

# Attachment - One-Time Notification

| Pub. 100-20 | Transmittal: 2270 | Date: March 13, 2019 | Change Request: 11152 |
|---|---|---|---|

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**SUBJECT: Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)**

**EFFECTIVE DATE: October 1, 2019**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: July 1, 2019 - CWF Implementation in July; July 1, 2019 - CWF and FISS Coding and Testing in July 2019; October 1, 2019 - Pricer Updates and Continue Testing**

## I. GENERAL INFORMATION

**A. Background:** This Change Request (CR) is for implementation of the changes to the Skilled Nursing Facility (SNF) Prospective Payment System (PPS), specifically implementing changes required for the Patient Driven Payment Model (PDPM). These changes were finalized in the FY 2019 SNF PPS Final Rule (83 FR 39162) and are effective October 1, 2019. This Change Request (CR) is applicable to the Fiscal Intermediary Shared System (FISS) and the Common Working File (CWF). SNFs billing on Type of Bill (TOB) 21X and hospital swing bed providers billing on TOB 18X (subject to SNF PPS), will be subject to these requirements.

Currently, under the SNF PPS, revenue code 0022 indicates that this claim is being paid under the SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different Health Insurance Prospective Payment System (HIPPS) Rate Code(s) and assessment periods. The HCPCS/Rates field must contain a 5-digit "HIPPS Code". Currently, the first three positions of the code contain the Resource Utilization Group (RUG) group, and the last two positions of the code contain a 2-digit assessment indicator (AI) code.

**B. Policy:** Under PDPM, the HIPPS code is structured differently, as a result of there being five case-mix adjusted rate components under the revised model. The first position represents the Physical and Occupational Therapy case-mix group. The second position represents the Speech-Language Pathology case-mix group. The third character represents the nursing case-mix group. The fourth character represents the Non-Therapy Ancillary case-mix group. The fifth character represents the AI code. CMS would note that this also affects the number of potentially valid HIPPS codes under PDPM, as compared to RUG-IV.

The PPS assessment schedule under PDPM is also significantly different from that used under the current case-mix classification system, the Resource Utilization Group, Version IV (RUG-IV) model. The only required assessments under PDPM that would produce a HIPPS code would be the 5-day PPS assessment, which follows the same schedule as under the current SNF PPS, and an Interim Payment Assessment (IPA), which may be completed at any point during a PPS stay.

Additionally, under PDPM, SNF PPS payments will be reduced according to a prescribed schedule, referred to as the variable per diem adjustment. Under the current SNF PPS, all days within any given RUG during a covered stay are paid at the same per diem rate. Under PDPM, however, the per diem rate for a given day of the SNF PPS stay may be different from the prior day, depending on an adjustment factor that may be applied against the SNF PPS rate connected with the HIPPS code. Moreover, the variable per diem schedule applies only to the PT, OT, and NTA components of the per diem rate, with different schedules for the PT/OT components than for the NTA component. More details on this may be found in Table 30 of the FY 2019 SNF PPS Final Rule (83 FR 39228). A similar adjustment exists under the Inpatient Psychiatric

Facility (IPF) PPS.

PDPM also includes an interrupted stay policy, similar to that which exists in the Inpatient Rehabilitation Facility (IRF) PPS and the Inpatient PPS (IPPS). Specifically, if a patient in a covered Part A SNF stay is discharged from the SNF but returns to the same SNF no more than three consecutive calendar days after having been discharged, then this would be considered a continuation of the same SNF stay. In such cases, no new patient assessments are required and the variable per diem adjustment is not reset. If the patient returns to the same SNF after the 3-day window, or returns to a different SNF, then this would be considered a new PPS stay. The interrupted stay would be recorded on the claim in the same manner as is done for the IRF PPS and IPPS.

As under the current SNF PPS, patients with a “B20” code on the SNF claim, meaning the patient has AIDS/HIV, receive an adjustment factor for their PPS rate. Under PDPM, the adjustment factor is different from that used under the current SNF PPS. Rather than a 128 percent adjustment for the entire PPS per diem rate, the adjustment under PDPM is an increase of 18 percent in the nursing component of the per diem rate and a reclassification under the NTA component to a higher rate category.

With regard to transition between the current SNF PPS and PDPM, we anticipate a hard transition between the two systems, such that days paid under RUG-IV would stop on September 30, 2019 and days would be paid under PDPM beginning October 1, 2019.

All other adjustment factors, such as adjustments for geographic variation in wage costs, remain the same under PDPM as under the current SNF PPS.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 11152.1 | The Medicare contractor shall modify its existing edits of occurrence code 50 to ensure that there is an occurrence code 50 and date to correspond with each 0022 line on the claim.<br><br>Note: The edits shall no longer consider the assessment indicator of the HIPPS code. | | | | | X | | | | |
| 11152.2 | The Medicare contractor shall assign a new edit for SNF (TOB 21x) and swing bed claims (TOB 18x) with a statement covers period to date greater than 10/01/19. Claims with discharge dates = 10/01/19 are excluded from this. | | | | | X | | | | |
| 11152.2.1 | The Medicare contractor shall return to the provider (RTP) claims assigned the edit created under BR 11152.2 | X | | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | D M E M A C | Shared-System Maintainers | | | | Other |
| | | A | B | H H H | | F I S S | M C S | V M S | C W F | |
| 11152.3 | The Medicare contractor shall no longer require therapy services to be present on SNF/Swing bed claims with statement covers thru dates greater than 10/01/19.<br><br>Note: Claims with discharges on 10/1/19 are not included. | | | | | X | | | | |
| 11152.4 | The Medicare contractor shall create a new edit (that may be over ridden) , for the SNF interrupted stay policy. Shall not allowi an interrupted stay of more than 3 days, based on Date of Service (DOS) for a SNF. | X | | | | | | | X | |
| 11152.4.1 | The Medicare contractor shall return to the provider (RTP) claims assigned the edit created under BR 11152.4. | X | | | | X | | | | |
| 11152.4.2 | The Medicare contractor shall create a new IUR associated with the new edit created under BR 11152.4. | | | | | | | | X | |
| 11152.4.3 | The Medicare contractor shall adjust the claim identified in the IUR created under 11152.4.2 | | | | | X | | | | |
| 11152.5 | The Medicare contractor shall create a new edit, (that may be over ridden) , not to allow discharge between same SNF if stay between two stays for same provider is less than 3 days, based on Date of Service (DOS).for a SNF. | X | | | | | | | X | |
| 11152.5.1 | The Medicare contractor shall return to the provider (RTP) claims assigned the edit created under BR 11152.5. | X | | | | X | | | | |
| 11152.5.2 | This business requirement has been deleted. | | | | | | | | X | |
| 11152.5.3 | This business requirement has been deleted. | | | | | X | | | | |
| 11152.6 | The Medicare contractor shall implement a new SNF PRICER effective for statement covers thru dates on or after 10/01/19. | | | | | X | | | | |
| 11152.6.1 | The Medicare contractor shall revise the SNF PRICER record layout as shown in Attachment 1. | | | | | X | | | | SNF Pricer |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 11152.6.1.1 | The Medicare contractor shall calculate the prior days value to pass into the SNF PRICER when pricing the current claim as follows: Add the cost report days on all claims paid under the same admission as the claim being priced. | | | | | X | | | | |
| 11152.6.2 | The PRICER shall count 10/01/19 as day one for its calculation on admissions prior 10/01/19. | | | | | | | | | SNF Pricer |
| 11152.6.3 | The Medicare contractor shall assign a new edit to the claim if at least one of the previously processed claims is offline | | | | | X | | | | |
| 11152.6.4 | The Medicare contractor shall manually retrieve the offline claims based on the edit assigned in BR 11152.6.3.<br><br>**NOTE:** The volume is expected to be very low | X | | | | | | | | |
| 11152.7 | The Medicare contractor shall install and test a version of the SNF PRICER. | X | | | | X | | | | STC |
| 11152.7.1 | The Medicare contractor shall receive the BETA version of Pricer for October (with logic changes and FY 2019 rates ) on or about June 1st. | | | | | X | | | | STC |
| 11152.8 | The Medicare contractor shall no longer calculate the total VBP for the line for claims with thru dates greater than 10/01/19. The Medicare contractor shall continue to use the current calculation for claims with thru dates on or before 10/01/19.<br><br>Note: Claims with discharges on 10/01/19 will use the FY 19 PRICER and not price under PDPM. | | | | | X | | | | |
| 11152.8.1 | The Medicare contractor shall no longer multiply the payment amount returned by the Pricer by the units on the line. | | | | | X | | | | |
| 11152.8.2 | The Medicare contractor shall move the VBP amount returned from the SNF PRICER to the same VBP amount line item field on the FISS claim record. | | | | | X | | | | |
| 11152.8.3 | The Medicare contractor shall continue to total the amounts in the VBP field on the claim record and move the total to the value code QV. | | | | | X | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| 11152.9 | MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter. | X | | | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements:** N/A

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

**Section B: All other recommendations and supporting information:** N/A

## V. CONTACTS

**Pre-Implementation Contact(s):** Valeri Ritter, 410-786-8652 or valeri.ritter@cms.hhs.gov

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

## VI. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**ATTACHMENTS: 1**

The SNF Pricer input/output file will be remain 300 bytes in length. The required data and format are shown below.
*The changes to the FY2020 SNF Input record layout are specified below in red.*

| File Position | Format | Title | Description |
|---|---|---|---|
| 1-4 | X(4) | MSA | Input item: The metropolitan statistical area (MSA) code. Medicare claims processing systems pull this code from field 13 of the provider specific file. |
| 5-9 | X(5) | CBSA | Input item: Core-Based Statistical Area |
| 10 | X | SPEC-WI-IND | Input item (if applicable) :Special Wage Index Indicator<br>Valid Values: **Y** (yes) or **N** (no) |
| 11-16 | X(6) | SPEC-WI | Input item (if applicable): Special Wage Index |
| 17-21 | X(5) | HIPPS-CODE | Input Item: Health Insurance Prospective Payment System Code – Medicare claims processing systems must copy the HIPPS code reported by the provider on each 0022 revenue code line |
| 22-29 | 9(8) | FROM-DATE | Input item: The statement covers period "from" date, copied from the claim form. Date format must be CCYYMMDD. |
| 30-37 | 9(8) | THRU-DATE | Input item: The statement covers period "through" date, copied from the claim form. Date format must be CCYYMMDD. |
| 38 | X | SNF-FED-BLEND | Input Item: Effective October 1, 2017, MACs shall populate the FED PPS BLEND IND field in the PSF with a "1" to indicate the SNF did not meet the quality reporting requirements.<br><br>Input item: Code for the blend ratio between federal and facility rates. For SNFs on PPS effective for cost reporting periods beginning on or after 7/1/98. Medicare claims processing systems pull this code from field 19 of the provider specific file.<br><br>**Transition Codes:**<br>Facility % Federal %<br>**1** 75 25 (1st year) |

| File Position | Format | Title | Description |
|---|---|---|---|
| | | | **2** 50 50 (2$^{nd}$ year)<br>**3** 25 75 (3$^{rd}$ year)<br>**4** 0 100 (full fed rate)<br>**NOTE**: All facilities have been paid at the full federal rate since FY 2002. |
| 39-45 | 9(05)V9(02) | SNF-FACILITY RATE | Input item: Rate based on each SNF's historical costs (from (from A/B MAC (A) audited cost reports) including exception payments.<br>**NOTE**: All facilities have been paid at the full federal rate since FY 2002. |
| 46-52 | X(7) | SNF-PRIN-DIAG-CODE | Input item: The principle diagnosis code, copied from the claim form. Must be three to seven positions left justified with no decimal points. |
| 53-59 | X(7) | SNF-OTHER-DIAG-CODE2 | Input item: Additional Diagnosis Code, copied from the claim form, if present, must be three to seven positions left justified with no decimal points. |
| 60-220 | Defined above | Additional Diagnosis data | Input item: Up to twenty-three additional diagnosis codes accepted from claim. Copied from the claim form. Must be three to seven positions left justified with no decimal points. |
| 221-228 | 9(06)V9(02) | SNF-PAYMENT RATE | *Output Item: The Calculated TOTAL amount received by the SNF based on the days received.*<br><br>*Effective FY 2018, this amount reflects VBP adjustment.*<br><br>***NOTE:** Effective October 1, 2019, the previously calculated RUG per diem rate will be replaced by the PDPM Calculated TOTAL amount received by the SNF.* |
| 229-230 | 9(2) | SNF-RTC | Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.<br>Payment return code:<br>00 RUG III group rate returned<br><br>Error return codes:<br>20 Bad RUG code<br>30 Bad MSA code<br>40 Thru date < July 1,1998 or Invalid<br>50 Invalid federal blend for that Year |

| File Position | Format | Title | Description |
|---|---|---|---|
| | | | 60 Invalid federal blend<br>61 Federal blend = 0 and SNF Thru date < January 1, 2000<br>70 Invalid VBP Multiplier |
| 231-242 | S9V9(11) | VBP-MULTIPLIER | Input item: Medicare systems move this information from field 52 of the provider specific file. |
| 243-250 | S9(06)V9(02) | VBP-PAY-DIFF | Output item: The *total* SNF VBP adjustment amount, determined by subtracting the SNF VBP adjustment total payment from the SNF PPS payment that would otherwise apply to the *line.* Added to the claim as a value code QV amount.<br><br>***NOTE:*** *Effective October 1, 2019, the previously calculated VBP difference per day will be replaced by the TOTAL VBP difference amount.* |
| *251-252* | *9(02)* | *SNF-PDPM-UNITS* | *Input item: The number of service units reported by the SNF on the revenue code 0022 line that is being priced.* |
| *253-255* | *9(03)* | *SNF-PDPM-PRIOR-DAYS* | *Input item: When pricing the first revenue code 0022 line on a claim, this is the number of prior SNF days identified by FISS from claims history. On later dated revenue code 0022 lines, this is the days from claims history plus any units from any earlier dated 0022 lines.* |
| *256-300* | *X(45)* | *FILLER* | *Blank* |