



Frequently Asked Questions:

[On-demand webinar] PDPM: It's here! The transitional IPA (MDS) and beyond....

On Thursday, Sep. 26, 2019, SimpleLTC, QRM, and Texas Medicaid Coalition offered a [free webinar](#) with PDPM expert Susan Krall PT, RAC-CT, covering strategies heading straight into the transitional IPA MDS assessment and our future world of PDPM. This document contains answers to specific questions asked during the webinar.

Due to the volume of GG questions, please refer to the [RAI manual](#) for additional instructions.

- 1. Can we use BIMS score that was completed prior to IPA but within the 7 day look back?**

New BIMs and PHQ9 interviews will need to be completed within the 7 day look back as well as an interim GG performance score with a window of the ARD date and 2 days prior.

- 2. For section GG, are we supposed to count episodes after the therapy eval and initial treatments?**

Do not include performance that is directly related to the benefits gained in rehab (don't withhold therapy)

- 3. Will a separate RUG IV be needed for residents admitted from 9/23-9/30?**

Yes, the only way to receive payment for Sept dates is to complete an admission assessment, following the current schedule.

- 4. If assessment is scheduled for end of September under RUGs, do they need to be completed by Sept 30th?**

ARD date must not be later than the last day in Sept. You still have the same completion and submission timelines.



5. Will there need to be an assessment for patient's transitioning from RUG-IV to PDPM on 9/30? COT?

If there is a 9/30 COT due – that must be assessed and taken as you would prior to PDPM. All Oct dates of service will be paid based on the Interim IPA MDS Assessment with an ARD of any day 10/1 – 10/7

6. We recently had a change of ownership and were required to discharge all residents at the date of change, and readmitted. Will this have any effect how our IPAs are completed on Oct 1?

Anyone in a skilled bed must have an IPA MDS completed with an ARD date of no later than 10/7 to determine receive Oct payment.

7. Will estimated rehab RUGs levels be an option if patients are admitted to SNF setting late in the month of Sept.?

Sept Rehab RUGs will be handled the same as prior to PDPM implementation. Payment for Oct though will be 100% based on the transitional IPA MDS HIPPS codes eff 10/1/19.

8. Can the Initial Medicare Assessment be combined with an admitting assessment?

Yes, an Initial Medicare Assessment can be combined with the Admission Assessment. The IPA can never be combined with another assessment.

9. Can the transitional IPA be on the day of discharge?

The patient must be in the facility on the ARD date of the transitional IPA.

10. Is DC return anticipated REQUIRED upon DC to hospital as it is an OBRA assessment only if they do not return within 3 days? Or must it be done and a new entry tracker even though they return within 2 days.

Must continue to follow OBRA assessment requirements. It's the PPS assessment that is addressed in the PDPM interrupted stay policy. Also, software vendors have provided guidance on how to code in the software to allow for a continuation at the prior PDPM HIPPS code if the DC turns into an interrupted stay. Definitely helpful to work with your software vendor.



11. If a patient was admitted 9/30/2019, how are you going to schedule a 5-day, admission, and IPA? What will be these assessments ARD?

You'll have to take the RUG level achieved on that one day based on RUG based PPS rules.

12. If a resident DC on day 2nd on admission and return by day three before midnight, can we set the ARD after return?

Address as you would a skip day on setting your ARD date.

13. Can the transitional IPA be on the day of discharge?

The NTA Variable Per Diem (x3 day 1 -3) is applied Oct 1-3 as the VPD begins on 10/1 as if a new admission for this Transition.

14. Do we need 7 day look back requiring new GG (ARD date and 2 days prior) for the required transitional IPAs?

IPA's GG assessment window for gathering usual "interim" performance is always the ARD date and 2 days prior.

15. How should admits on 9/29 or 9/30 be handled?

Same as prior to PDPM initiation. The ARD date however cannot be into Oct. You'll have to have an ARD date on or before 9/30.

16. If we have a discharge within the first 7 days of October, do we do a discharge with an IPA or do we do those separate?

We cannot combine an IPA with any other assessment.

17. Can you provide me your resource document that a NEW BIMS and PHQ-9 is being required for the transitional IPA, even if you have one in the 7-day lookback period?

If there is a BIMS and PHQ9 in the 7 day look back period of the IPA a new one is not required. Thank you for clarifying.



18. Do you know the managed care companies that will follow the PDPM assessment payment?

Sadly, managed care companies' decisions are contract by contract and differs by market so I'm unable to comment on that.

19. If we get a resident on September 27th for example. Do we have to do a 5 day on or before September 30th and then an IPA between Oct 1-7??

Yes, you will have to have an ARD date for that 9/27 admission prior to 10/1 and an IPA MDS must be completed with an ARD date any date 10/1 – 10/7.

20. For the transitional IPA, do we redo the BIMS and PHQ also?

There must be a completed BIMs and PHQ9 in the allowed assessment window lookback period.

21. With an interrupted stay, therapies do not have to re-eval correct if they come back in time?

Correct.

22. Will day 1-3 of the NTA variable be paid regardless if the IPA is any day from 10/1 to 10/7? Since 10/1 uses a look back into September, I am concerned that day 1-3 of the look back is prior to October 1.

Yes, the VPD begins on 10/1 with the first 3 days in Oct benefiting from the triple NTA rate. It also starts as day 1 of the PT/OT VPD that drops 2% every 7 days beginning on day 21 (Oct 21st)

23. Would a discharge MDS would still need to be done even for those resident's that are out of the building less than 3 days? we just don't do a discharge end of PPS stay unless they are going more than 3 days, correct?

A PPS DC is only required if the patient is gone more than 3 midnights. Don't forget the OBRA requirements are still in place.

24. Why does it say to consider my 14-day lookback in setting my ARD when section O does not ask if they had oxygen, transfusions, etc. on the IPA assessment?

This would only apply if the directions on the IPA MDS allow for a 14-day lookback.



25. Are there any items for which the lookback period will change on the Transitional IPA vs the RUG-IV assessments?

Not that I am aware of- please defer to the final RAI manual

26. Did you say that all codes entered in I1800 cannot be RTP?

Only the I0020B that determines the PDPM clinical category has RTP (Return to Provider) in the mapping crosswalk from CMS. If RTP – we will not receive a HIPPS code which is not an option. Must continue to research the primary reason the patient is admitting and work with your medical team to identify the ICD10 code that is applicable and does map.

27. For GG goal care plan - does the therapy plan of care satisfy this or does there need to be a nursing care plan?

The nursing home's Care Plan must address at least one GG goal. The therapy plan of care will not suffice.

28. For IPA, we have to submit a GG for 3 days? The 2 days prior and the ARD date? Or choose one of those 3 dates to submit only 1 GG?

The GG usual performance must be gathered and assessed for the ARD date and 2 days prior following the guidance in the RAI manual for scoring prior to the benefit of intervention. Every GG item must be coded. Only 1 goal is actually required to be established and care planned. But this is the opportunity to establish the priority goals for our patients.

29. How does bed hold policy work for interrupted stay days?

I'll defer to your E.H.R / billing vendors guidance for how to handle bed hold in their system and your administration on how to handle the financial side of a bed hold.

30. Resident returns on Skilled Care for a diagnosis of Aspiration pneumonia but the Chest X-ray does not support that diagnosis by the M.D. can we not use the diagnosis? Resident has Parkinson and dysphasia also.

The physician would need to override and provide the 'active diagnosis' in his documentation for it to be counted on the MDS.



31. For GG, do we only establish 1 goal and dash the rest of the discharge goals?

Goals can be dashed - the requirement is for at least 1 goal to be established with that goal having been care planned by the IDT. However, this is where we can work as a collaborative team to identify our patients prioritized goals we will be focusing on and setting realistic DC goals.

32. Does the Interrupted Stay Policy apply to a patient who Discharges Return Not Anticipated to community then returns to SNF prior to 11:59 on day 3?

Yes, but follow your software vendors guidance on how to accurately work within the system to allow you to do that.

33. Where can you access the tracker?

I can provide what we have created as a very basic transitional tracker upon request. skrall@qrmhealth.com

34. Can the transitional IPA and discharge assessments be scheduled on the same day?

Yes. The IPA cannot be dually coded with any other assessment. But you can have the same ARD dates.

35. If a resident admits on 9/29 and you set 5 day for 9/30, do BIMS and PHQ9 on 9/30, set transitional IPA for 10/3, can you use the 9/30 BIMS and PJQ9 for both assessments?

Yes, if in the lookback window allowed.

36. Do the diagnoses listed in I8000 need to be the ones on the claim too? I know the primary one does but wondering about the other I8000 codes.

Yes, that is best practice.

37. Will you still do a D/C and Reentry just will not do a new Medicare assessment and on the D/C will it be an EOS?

OBRA requirements remain unchanged as well as the Re-entry requirement



- 38. Can an IPA GG assessment be documented the day after the ARD in order to fully capture the usual function of all three days? Our IPA GG assessment includes the statement "usual function during the last three days of the reference period". Or would the assessment need to be completed ON the ARD in order to be documented DURING the reference period?**

Documentation can occur after the ARD date, but the timeframe of the assessment must be the ARD date and 2 days prior – just note that on your documentation of the IDT decision on "usual performance".

- 39. Can you clarify if a short stay can be used for those residents admitted 9/27 and later (who will not have enough days of therapy for a therapy RUG)?**

Short stays can only be taken if all requirements for short stays are met.

- 40. If we had Medicare A residents during September but all were taken off part A already, do we need to do anything?**

Only those residents on a Med A or PDPM reimbursed Managed Care Plan as of 10/1 will need a transitional IPA completed to determine payment for Oct through DC

- 41. If an optional IPA is submitted in error, and the rate goes down...can the IPA be inactivated?**

Modification rules still apply but best practice is to complete a calculation prior to the decision to take an optional IPA.

- 42. I have a resident whose 1st day of Medicare A is 9/25/19. Can I set the ARD for 10/1/19 for the initial Medicare Assessment and still be reimbursed for RUGs and PDPM? Or do I have to complete the 5 day with ARD 9/30/19, and then do an IPA for ARD 10/1/19**

All ARD dates must be set in Sept. with an IPA ARD date any day 10/1 – 10/7.

- 43. On the DC assessment for those residents who received therapy in September, do we include those minutes too on the DC assessment or is it just the minutes since 10/1?**

DC assessment will include all minutes in the Part A stay (the original Part A date remains throughout the stay).



44. Can RTP ICD10 code be listed in the other dx on the UB04 for therapy treatment codes such as dysphagia R13 codes?

The RTP only pertains to the primary reason for the SNF stay driving the clinical category for I0020B. Other codes for therapy etc can be entered on the UB04. Would want to prioritize I8000 codes that are mapping to SLP co-morbidities and NTA items.

45. Is it okay to complete BIMS at time of therapy evaluation?

As long as the BIMS is completed in the assessment window according to the directions in the RAI manual.

46. What does it mean to have “one section gg goal” and have it care planned?

There are several self-care and mobility GG questions on the MDS. All must be assessed and coded. Then there is a column for goals. The requirement is that at least 1 goal must be coded. We can dash goals. And, the care plan for the patient must include the selected goal(s). The RAI manual outlines the entire process and expectations.

47. Does there need to be documentation on each shift for section GG for the 3 days that are being captured on the MDS or can there be one note documenting the discussions and review of performance that lead to the coding in section GG?

Section GG is coded based on the usual performance in the assessment window as outlined in the RAI manual. This will be a driver of reimbursement and subject to audit. A method of gathering the usual performance is important but documentation of the IDT’s decision on usual performance based on all data gathered is bubbling up as best practice to place in the medical record.

48. When a long-time resident goes out to the hospital and returns skilled, does the I0020B reason for admission have to be the reason the person is skilled or is it the continuing diagnosis the resident was in the facility before going out to the hospital?

From the RAI manual: “Indicate the resident’s primary medical condition category that best describes the primary reason for the Medicare Part A stay; then proceed to I0020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal. • While certain conditions represent acute diagnoses, SNFs should not use acute diagnosis codes in I0020B. Sequelae and other such codes should be used instead.”



- 49. Can you please review Short Stays? I thought that CMS specifically stated that short stays can't be used to get rehab RUG's for patients that will continue a stay into October which means that today (9/26) would be the last day to get a rehab RUG.**

Short Stays can only be used if all criteria are met, you are correct.

- 50. In the process of classifying a resident with a specific Dx S72.001D, as per the ortho discharge Dx – it populated as the PDCC - Non-Surgical Orthopedic, yet the resident had an ORIF. And should have been Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery). How can this be corrected, as this is happening with multiple orthopedic Dx with surgical intervention.**

There are also times when non-surgical procedures map to the surgical category as well. We must follow the CMS ICD10 clinical mapping at this point.

- 51. Regarding section GG, do we get the information from PT/OT and compare with nursing info? Their assessment may differ from nursing?**

Gather from nursing and rehab then determine what the "usual" performance has been for the 3-day assessment window – do not consider performance gained only following intervention.

- 52. Section G and section GG often do not match. Should they?**

They are asking different questions – G: most help needed in a 7 day look back vs GG: "usual" performance capturing the amount of assistance provided by a helper to complete tasks in the 3 day assessment window. In addition, the coding / scoring is inverse. It makes sense they won't match.

- 53. Does section GG need to be entered on day 3 or day 4 of stay?**

The importance is the gathering of data during the correct assessment window. Completion of GG on the MDS follows completion rules. Best practice due to the urgency of knowing the GG score is that a GG huddle be held on day 4 with the IDT documenting their decision on 'usual' performance.



54. Are nurses expected to walk residents to capture a GG score on the crosswalk?

The question is asking whether the patient can walk 10' – if so, how much assistance is provided by the helper to walk 50' with 2 turns or 150' – it doesn't specify who is walking in the RAI – however, if not walking with nursing – the question is why not – is it due to medical safety? We are not to include the level of assistance following the benefit of intervention.

55. Regarding section GG, is it true that the data collection for GG should be completed prior to therapy services beginning for the resident?

The performance captured should be taken prior to the patient's gains following intervention

56. Can we have a link to the CMS PHQ9 and BIMS videos?

Included in an earlier response. Can also search for BIMS Interview on YouTube.

57. What is the best way to code a discharge goal on Section GG? Is it best to code what we realistically feel like the resident is going to achieve? Is it wrong to have a goal of independent even if they weren't at that level before?

Code what we realistically believe the resident can and needs to achieve for a safe transition so the entire IDT can work towards that or those goal(s). Of course, we have to take into consideration market pressures for length of stay such as bundles and ACO's.

58. For the transitional IPA, does this have to have day 1 of the assessment period as October 1st? For example: a resident admitted on September 26th, will I need to schedule a transitional IPA with start of reference period October 1st as the ARD for admission/5day is October 2nd?

The ARD must be any day 10/1 – 10/7. The look back window of 7 days can go back into Sept.

59. Where can we get a mapping tool?

CMS website: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/pdpm.html>



- 60. Can a transitional IPA be scheduled the same ARD as a discharge assessment? Ex. Patient admitted on 9/19/19 and is planned to go home on 10/4/19.**

The ARD must be a date when the patient is a resident.

- 61. Do we have to discharge residents on skilled therapy by Oct 1st or should we just do an IPA and continue them on Med A?**

Do not DC on 10/1 – just complete the IPA and continue Med A – this will change the reimbursement eff 10/1.

- 62. Your slides reference a new goal on the IPA, but I do not see a place to collect and record this data on the IPA MDS. Can you clarify?**

Section GG on the IPA is merely a gathering of the interim GG 'usual performance'. Thank you for clarifying.

- 63. Do we have skip days with PDPM?**

Skip days are replaced by the Interrupted Stay Policy.

- 64. What PPS assessment should we open for residents who have admitted 9/23 – 9/30? A 5-day assessment or an Admission/5-day assessment?**

Follow the MDS schedule in place prior to the 10/1 transition. You could dually code the 5 day and Admission assessment.

- 65. Would having to crush medications qualify as a swallowing order?**

The question would be to find out why the meds are crushed. Is it due to pain with swallowing?

- 66. Regarding re-education and training and documentation, is this at the staff level or the resident?**

Staff level; Re-education of the team members completing assessments / interviewing

- 67. If a resident transfer to hospital on 9/30/2019, what assessments should we do for RUG and PDPM?**

PDPM rules do not apply until 10/1. Follow the assessments as you would prior to PDPM. The Interrupted stay would not apply in Sept.



68. Should we do an IPA assessment if there are changes in section GG as they are working with rehab?

It is an Optional Assessment as determined by the provider. Would need to be thoroughly assessed.

69. If someone goes to the hospital for less than 3 days, do they need a new therapy evaluation?

No

70. Our MDS will do the IPA on the 7th of October. When do therapy complete BIMS/PHQ9?

That is up to each building – but they must be completed within the assessment window.

71. For PDPM, who does the discharged goal for section gg?

Should be an IDT process following state and federal guidelines

72. What affect does the 30-day Medicare rule have on VPD if reskilled due to Change of condition while in window and not requiring hospitalization?

VPD starts on day 1 of each Med A Part A stay. The RAI manual has several specific examples.

73. Where does it state that depression is PHQ 9 of 10 or more?

The RAI manual outlines the nursing component depression criteria is met with a PHQ9 score of = or > 10 but not 99.

“The resident qualifies as depressed for PDPM classification in either of the two following cases: The D0300 Total Severity Score is greater than or equal to 10 but not 99, or The D0600 Total Severity Score is greater than or equal to 10”

74. Do we have 14-days to complete the assessments that are opened under Rug IV?

The completion and submission dates have not changed with PDPM.



75. Can you explain please when a resident has an LCD for Med but stays in the facility and is picked back up under Med A, how do you do the interrupted stay. Is their LCD, the first of the 3 day?

If the patient leaves the Part A stay and remains in the facility but is no longer receiving skilled care and ends up back in a Med A covered stay within the 3 midnights this meets qualifications for an Interrupted Stay.

76. Do the MDS and the UB-04 coding have to match?

Should include I0020B and all I8000 codes captured that are mapping to SLP co-morbidities and NTAs.

77. Do we still use Jraven to submit the IPA to CMS?

PDPM did not change the submission process for assessments.

78. Where is the reference to indicate that an IPA HIPPS code position 5 is a 0?

From CMS' PDPM Presentation: The 5th position is the Assessment Indicator. 0 is an IPA, 1 is a PPS 5 day and 6 is an OBRA assessment not coded as a PPS assessment

79. If you have a long-term resident who is admitted to the hospital then readmitted to facility under Medicare A, would you have to use the dx of why they are long term in your facility as their primary dx?

We are to use the primary reason they are needing SNF care following the hospital stay.

80. Does the diagnosis need to be cross walked to PDPM before transitional IPA?

We had an opportunity to get a head start on our patients transitioning on 10/1 to identify the primary reason for the SNF stay, conditions and co-morbidities for SNF and NTA and crosswalk to make certain we had granular specific diagnosis that would map within the crosswalk.

81. In a case of an interrupted stay – will the chart be kept open? Currently charts are closed with each transfer to an acute hospital.

Work with software vendors on how to best manage the charts.



82. For section GG, do you suggest having more than one goal?

I would have more than 1 to more accurately identify patient specific goals that we will be working towards for a safe transition.

83. We are swing bed facility. The patient only stays for 4 days, do we only do a default payment since we are not supposed to combine assessments of initial and discharge assessments?

The IPA cannot be combined with another assessment, but you can combine an initial and DC assessment

84. Resident that is currently on med A PPS and transition to PDPM, do we transfer the GG assessment from PPS to PDPM?

IPA requires an interim GG score be gathered based on interim GG performance ARD day and 2 days prior.

85. Are the GG questions on MDS changing?

Refer to the RAI manual and MDS with the eff date of 10/1 for clarification of GG questions.

86. Can you explain the 7-day look back? When would this look back begin?

The ARD date is day 7 of a look back window.

87. Do you have a good Pre-admission audit tool or resource that would be good to utilize?

There are several available. We have created one as well.

88. If they admit with joint replacement and go to hospital for over 3 days for another condition when they come back, can you use the joint replacement as primary?

If completing a new Initial Medicare Assessment, you would need to identify the primary reason for the SNF stay.

89. If a resident goes on an interruptive stay for 2 nights, do we still do the discharge OMRA MDS?

OBRA assessment requirements remain in place.



RAI Manual Reference

Due to the multiple GG questions, please refer to the [RAI manual](#) for full instructions. I pulled the below guidance out of the RAI manual to help clarify the majority of questions:

Assess the resident's self-care performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the three-day assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period. For Section GG, the admission assessment period is the first three days of the Part A stay starting with the date in A2400B, the Start of Most Recent Medicare Stay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment). For the Interim Payment Assessment (A0310B=08), the assessment period for Section GG is the last 3 days (i.e., the ARD and two days prior). 2. Residents should be allowed to perform activities as independently as possible, as long as they are safe. 3. For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, "helper" does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration such as hospice staff, nursing/certified nursing assistant students, etc.

Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, consider only facility staff when scoring according to the amount of assistance provided. 4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity. 5. The admission functional assessment, when possible, should be conducted prior to the resident benefitting from treatment interventions in order to reflect the resident's true admission baseline functional status. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment. 6. Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.



Reminders for IPA

- The IPA can NOT be combined with any other assessment
- The ARD date can be any day Oct 1-7
- The look back window can include days in September
- OBRA assessments are still required (could open an IPA and an OBRA Admission Assessment for a Sept Admission at the same time with the same ARD dates)
- New "Interim GG" scores are required – assessing the usual performance from the ARD date and 2 days prior
- BIMs and PHQ9 Assessments are required in this IPA look back window
- All conditions, diagnosis and co-morbidities must be active during the assessment window with documentation and diagnosis to support capturing
- There are still 14 days to complete and 14 days to submit the IPA and other MDS' under PDPM (Initial Medicare Assessment and DC Assessment)
- Skilled Service must still meet Medicare Part A Requirements

- Nursing:

- Evidence of skilled nursing care on 7/7 days in look back window

Or

- Therapy:

- Evidence of skilled therapy delivered on 5/7 days in look back window