

MNT PROVIDER

Your source for practice management news

Special
EDITION

INSIDE THIS ISSUE:

- New Patient-Driven Payment Model coming to skilled nursing facilities in October! 1
- Trends in RDN knowledge and patterns of coding, billing and payment 1
- Spotlight on malnutrition 4
- Question Corner 5



Increase professional visibility with the NPI.

See page 6 for details.

eat right Academy of Nutrition and Dietetics

www.eatrightpro.org/resources/news-center/in-practice/mnt-provider

New Patient-Driven Payment Model coming to skilled nursing facilities in October!

Effective October 1, 2019, the largest change to skilled nursing facility (SNF) payment in 20 years will take place with the implementation of Medicare’s new Patient-Driven Payment Model (PDPM). The PDPM encourages a more patient-driven care model by addressing each individual resident’s unique needs. The PDPM also offers registered dietitian nutritionists (RDNs) and nutrition and dietetic technicians, registered (NDTRs) an opportunity to impact payment to support staffing to provide the care needed to residents.

With a focus on quality versus quantity and outcomes as a main priority, the PDPM will replace the Resource Utilization Groups, version IV (RUG-IV) model, reducing administrative burdens on providers and strengthening incentives for appropriate care. Medicare payments under



the current SNF Prospective Payment System (PPS) are based primarily on the amount of therapy provided to a resident, regardless of the resident’s unique characteristics, needs, or goals. Under the new PDPM, Medicare will no longer reimburse providers for the volume of services provided, rather payment will be made based on the resources required to provide services for a resident’s condition and level of function.

See **PDPM**, page 2

Trends in RDN knowledge and patterns of coding, billing and payment

Every five years since 2008, the Academy of Nutrition and Dietetics has surveyed registered dietitian nutritionists (RDNs) providing medical nutrition therapy (MNT) in ambulatory care settings to learn about their knowledge and patterns of coding, billing and payment for their services. Results of the survey demonstrated that registered dietitian nutritionists’ (RDNs) knowledge of billing and coding has remained static and very low, especially among RDNs not in supervisory roles or private practice.

The most recent iteration of this survey was conducted in 2018. Responses from the 2018, 2013,

and 2008 surveys were examined to determine the level of change in RDNs’ knowledge of billing code use and reimbursement patterns over time. Since 2013, a dramatic increase in the reported proportion of reimbursement from private/commercial health insurance plans was noted, potentially as a result of the Affordable Care Act. Also reported over the span of the surveys was an increase in MNT services provided to patients with multiple conditions. Alarming, the results also indicated that most RDNs are not aware of the impact on coding and billing practices in a changing healthcare environment.

See **Coding**, page 4

Resident assessment and classification

Each SNF resident receiving Medicare Part A-Level care must be assessed by completing the Minimum Data Set (MDS) assessment to determine diagnoses, treatment, and functional status. The MDS will continue to be used as the foundation for care planning under the PDPM, however, only two to three assessments will be required instead of the five required under the RUG-IV. MDS assessments are also used to map the resident to the appropriate PDPM clinical category, generate Health Insurance Prospective Payment System codes and determine payment for the stay.

Determining payment

The PDPM classification methodology utilizes a combination of six payment components to derive payment. Under the PDPM methodology, the current RUG-IV two case-mix adjustment components (therapy and nursing) will be replaced by a combination of the following five case-mix components to determine payment:

- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology
- Nursing
- Non-Therapy Ancillary (NTA)

An additional sixth non-case-mix adjusted component addressing utilization of SNF resources that do not vary by patient is also taken into account.

Unlike the RUG-IV model, where a resident's classification into a single group determines the case-mix indexes and per diem rates for all case-mix adjusted components, the PDPM classifies residents into a separate group for each of the five case-mix adjusted components. The resident must be classified into one, and only one, group for each of the five case-mix adjusted components based on the relevant MDS data for that component. The payment for each case-mix

adjusted components are then added together along with the non-case-mix component payment rate to create a patient's total SNF PPS per diem rate.

RDN impact on payment: Non-Therapy Ancillary Component

Classification of the NTA component is based on the presence of certain comorbidities, such as malnutrition and obesity, or the use of certain extensive services, such as parenteral feeding. The presence of these conditions and extensive services is reported by providers on the MDS, with some of these conditions being identified by ICD-10-CM codes.

Each of the 50 comorbidities used under PDPM for NTA classification is assigned a certain number of points, between one and eight, based on its relative costliness. Comorbidities associated with high increases in NTA costs are grouped together and awarded higher points. To determine the resident's NTA comorbidity score, a provider would identify all comorbidities for which a resident would qualify and then add the points for each comorbidity. The resulting sum represents the patient's NTA comorbidity score, which is then used to classify the patient into an NTA case-mix classification group.

Table 1. NTA Case-Mix Classification Groups

NTA Score Range	NTA Case-Mix Group	NTA Case-Mix Index
12+	NA	3.24
9-11	NB	2.53
6-8	NC	1.84
3-5	ND	1.33
1-2	NE	0.96

Each case-mix group is associated with case-mix index number which used to calculate payment rates. (table 1) The higher the index, the greater the payment. The conditions

and the number of points associated with each condition can be found by downloading the NTA comorbidity score fact sheet, available at: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFFPS/Downloads/PDPM_Fact_Sheet_NTAComorbidityScoring_v2_508.pdf

The PDPM recognizes several aspects of nutrition co-morbidities in the NTA which are included in the MDS. Clinical documentation of conditions such as diabetes mellitus, morbid obesity, and malnutrition add points to the NTA score range which can impact the case mix index and potentially increase per diem payment. Residents requiring parenteral or tube feeding can add up to seven points to an NTA score. (table 2)

Table 2. Sample NTA Scoring

NTA Score Range	NTA Case-Mix Group
Parenteral IV Feeding	Level High: 7 points
Parenteral IV Feeding	Level Low: 3 points
Morbid Obesity	1 point
Feeding Tube	1 point
Active Diagnoses: Malnutrition Code	1 point
Diabetes Mellitus	2 points

RDN impact on payment: Speech Language Pathology Component

The speech-language pathology (SLP) component uses the patient's PDPM clinical category, cognitive function, the presence of an SLP related comorbidity, and the presence of a swallowing disorder or a mechanically altered diet to assign a resident to a SLP case-mix classification group. Similar to the NTA component, each

See **PDPM**, page 3

Spotlight on malnutrition

Throughout the month of September, the Academy has focused a spotlight on malnutrition to increase awareness and underscore the crucial role that registered dietitian nutritionists (RDNs) and nutrition and dietetic technicians, registered (NTDRs) play in prevention and treatment of malnutrition for pediatrics, adult and senior populations, and special populations and global malnutrition. In a continued effort to address this important issue, the Academy joined the American Society for Enteral and Parenteral Nutrition (ASPEN), the American Society for Nutrition, and the Association of Clinical Documentation Improvement Specialists in urging the Centers for Medicare & Medicaid Services (CMS) to add malnutrition electronic clinical quality measures (eCQMs) to the meaningful measure set of both the Inpatient and Long Term Care Hospital Quality Reporting Programs under Medicare. To read the Academy's CMS's proposed adoption of malnutrition eCQMs visit: www.eatrightpro.org/news-center/on-the-pulse-of-public-policy/

regulatory-comments/comments-cms-proposed-adoption-malnutrition-ecqms. The Academy is also working with an external groups to get malnutrition eCQMs included in a registry for reporting purposes under various quality payment programs such as MIPS. At the same time, the Academy has been collaborating with ASPEN and the Association of Clinical Documentation Integrity Specialists to resolve the denial issues for hospital claims with a diagnosis of severe malnutrition. Earlier this year, the Academy requested that CMS delay finalization of reclassification of malnutrition diagnostic codes for hospital payment under the inpatient prospective payment system, noting the upgrading and downgrading of codes, as proposed, poses some concern and warrants further review. A copy of the letter to CMS, including rationale for the request, can be viewed at: www.eatrightpro.org/news-center/on-the-pulse-of-public-policy/regulatory-comments/academy-urges-cms-to-delay-finalization-of-reclassification-of-malnutrition-diagnostic-codes



The Academy is committed to ongoing engagement in multi-stakeholder efforts to address and recognize the valuable role RDNs and NDTRs play in providing a low-risk, low-cost solution to managing chronic illnesses in adult patients. Academy members can help spread the word about malnutrition during September and beyond, using the Academy's 2019 Spotlight on Malnutrition Social Media Toolkit available at: thesocialpresskit.com/spotlight-on-malnutrition-month. To access a list of evidence-based tools and resources RDNs and NDTRs can use to help assess, document, diagnosis and treat malnutrition in a variety of practice settings, visit: www.eatrightpro.org/practice/practice-resources/malnutrition.

Coding, from page 1

Nor are they aware of the impact of newer practice settings and care delivery models on billing and reimbursement for MNT services.

Billing and coding are integral to the healthcare revenue cycle processes. They are the processes which translate a patient encounter into the languages used for claims submission and reimbursement. A fundamental knowledge of coding and billing can ensure RDNs get paid for services delivered, increase visibility of RDN provided service to payers, enhance the revenue cycle to help practices remain open and deliver needed care to patients, and better secure the future of dietetics practice.

RDNs need to understand and be held accountable for the business side of MNT practice and their value proposition in today's health care environment. RDNs providing MNT services in a fee-for-service environment need a working knowledge of coding and billing to ensure all potential revenue streams are being maximized, even if someone else is managing the billing. In fact, all RDNs, regardless of area of practice or practice setting, should understand where their salary comes from. Utilizing the survey results to identify where and how colleagues have been successful, RDNs can maximizing opportunities for service provision and revenue potential in today's

health care environment.

To learn more about the survey and results, read the article, Trends in Registered Dietitian Nutritionists' Knowledge and Patterns of Coding, Billing, and Payment, recently published in the Journal of the Academy of Nutrition and Dietetics, available at: [https://jandonline.org/article/S2212-2672\(19\)30467-8/fulltext](https://jandonline.org/article/S2212-2672(19)30467-8/fulltext). For more information on coding, billing and payment for nutrition services, visit: www.eatrightpro.org/payment. For a list of CPT and G codes for RDNs, visit: www.eatrightpro.org/payment/coding-and-billing/diagnosis-and-procedure-codes/cpt-and-g-codes-for-rdns.

Question Corner



Q: What does the color coding in the list of Healthcare Provider Taxonomy Codes (HPTC) represent?

A: The National Uniform Claim Committee (NUCC) maintains the HPTC codes set for standardized classification of health care providers to categorize the type, classification, and/or specialization of health care providers. When applying for or updating a National Provider Identifier or NPI, a health care provider should select the HPTC(s) that most closely describes the provider's type. The NUCC updates the code set twice per year with changes effective April 1 and October 1. The changes to the code set may include the addition of a new code and/or addition of definitions to existing codes. Revisions made since the last release are identifiable by color code as follows:

- New items - green
- Modified items - orange
- Inactive items - red
- No change - black

The NUCC generally posts updates to the code set three months prior to the effective date. The most recent code changes will not be effective until October 1, 2019. To learn more about specialist taxonomy codes applicable to registered dietitian nutritionists, visit: www.eatright-pro.org/payment/getting-started/becoming-a-provider/obtaining-an-npi-or-ein. To learn more about the HPTCs October 2019 Code set update, visit: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM11418.pdf. A full list of taxonomy codes can be viewed at: nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/

code-lookup-mainmenu-50.

Q: How will ICD-10 codes be used under Patient Driven Payment Model (PDPM)?

A: Providers are required to report the patient's primary diagnosis for the skilled nursing facility (SNF) stay on the minimum data set (MDS) using the ICD-10 codes. Each primary diagnosis is mapped to one of ten PDPM clinical categories, representing groups of similar diagnosis codes, which is then used as part of the patient's classification under the physical therapy, occupational therapy and speech language pathology (SLP) components. ICD-10 codes are also used to capture additional diagnoses and comorbidities that the patient has, which can further factor into the SLP component. ICD-10 codes also impact the comorbidity score used to classify patients under the Non-Therapy Ancillary (NTA) component. For a mapping of comorbidities included in the PDPM NTA component to ICD-10-CM Codes, visit: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPDS/Downloads/PDPM_ICD10_Mappings_FY2020_20190724.zip.

Q: Are the rates for rural and urban providers different under PDPM?

A: Yes, PDPM has different base rates for urban and rural providers, which means that the case-mix adjusted rates for urban and rural providers will also be different.

Q: What is the variable per diem adjustment under the PDPM?

A: The Balanced Budget Act of 1997 mandates the implementation of a per diem for all costs related to the services furnished to

beneficiaries under Part A of the Medicare program in a SNF, meaning that there is a payment rate associated with each day of the patient's SNF stay. Under PDPM, an adjustment is applied to certain components under the PDPM that varies the daily payment over the course of the stay. This adjustment factor is called the variable per diem (VPD) adjustment.

Q: How many MDS assessments are there under PDPM?

A: There are three assessments under PDPM, the 5-day assessment, the interim payment assessment (IPA), and the discharge assessment.

Q: Which MDS assessments are required and which are optional?

A: The 5-day assessment and the discharge assessment are required. The IPA is optional and is completed when providers determine that the patient has undergone a clinical change requiring a new assessment. For a list of frequently asked questions and answers addressing the PDPM, visit: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPDS/Downloads/PDPM_FAQ_Final_v5.zip

See **Question Corner**, page 6

Questions?

Do you have a question for the Question Corner?

E-mail your question to reimburse@eatright.org to have it answered in an upcoming issue of the *MNT Provider*.

The National Provider Identifier

All registered dietitian nutritionists and nutrition and dietetics technicians, registered should have an individual National Provider Identifier (NPI) regardless of work environment, employment status, or whether claims are submitted to payers. NPIs are needed to demonstrate a viable workforce to external stakeholders, including the government and private payers. Additionally, NPIs are used increasingly to match providers to data such as in health care claims and they may be tied to provider notes in electronic health records. Obtaining an NPI is quick and easy and can help increase the visibility of the profession. To learn more about the NPI, or to find out how to obtain an NPI, visit: www.eatrightpro.org/payment/getting-started/becoming-a-provider-obtaining-an-npi-or-ein.



Question Corner, from page 5

Q: Where can I learn more about calculating points under the PDPM?

A: To learn more about how a resident is classified for payment purposes and how per diem payment is calculated under PDPM, see the PDPM Calculation Worksheet, available at: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF_PDPM_Classification_Walkthrough_20190208_508.pdf

Q: To whom should I direct questions about PDPM and Medicare Advantage?

A: Any questions regarding the impact of PDPM on Medicare Advantage (MA) plans should be directed to MA plan sponsors.

Q: If we need to do a 5-day MDS in September to get paid under RUG-IV, will we need to do another assessment in October to get paid correctly during the transition?

A: Yes, since the RUG-IV system will end on September 30th and the PDPM system begin on 10/1,

it will be necessary to establish a RUG-IV category to bill for days prior to 10/1 and a PDPM HIPPS code to bill 10/1 and after. To receive a PDPM HIPPS code that can be used for billing beginning October 1, 2019, all providers will be required to complete an IPA with an assessment reference date no later than October 7, 2019 for all SNF Part A patients. October 1, 2019 will be considered Day 1 of the variable per diem schedule under PDPM, even if the patient began their stay prior to October 1, 2019. To learn more, about transition billing, visit: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_FAQ_Final_v2_508.pdf.

Q: What is the Interrupted Stay Policy?

A: The Interrupted Stay Policy is a component of the SNF PDPM payment policy that sets out criteria for determining when Medicare will treat multiple SNF stays occurring in a single Part A benefit period as a single "interrupted" stay, rather than separate stays, for the

purposes of the assessment schedule and the variable per diem payment schedule. To learn when is a stay considered "interrupted" and how the policy affect the assessment schedule and variable per diem, visit: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_FAQ_Final_v2_508.pdf.

Q: How will the interrupted stay policy affect the assessment schedule and variable per diem?

A: When the stay is considered "interrupted" under the Interrupted Stay Policy, both the assessment schedule and the variable per diem payment schedule continue from the point just prior to discharge. When the stay is not considered interrupted, both the assessment schedule and the variable per diem rate reset to Day 1, as it would in a new stay. For more information about the Interrupted Stay Policy, download the PDPM interrupted stay fact sheet, available at: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_InterruptedStay_Final.pdf.

MNT Provider (ISSN: 1540-370X) is published monthly for members of the Academy of Nutrition and Dietetics; 120 South Riverside Plaza; Chicago, IL 60606-6995. Telephone: 312/899-0040 Editor: Mara Bujnowski, MAEd, RD, Nutrition Services Coverage.

No article or statement appearing herein may be reproduced in any form without written permission from the publisher. Opinions expressed here do not necessarily reflect the views of the Academy. Advice is general, and readers should seek professional counsel for legal, ethical and business concerns. © 2019 Academy of Nutrition and Dietetics.

 Academy of Nutrition and Dietetics