Section GG & PDPM (Patient-Driven Payment Model): A Financial Analysis

By Melissa Keiter, RN, RAC-CT, DNS-CT, DON
and Melissa Sabo, OTR/L, CDP, CSRS

Care providers agree that Section GG is a true interdisciplinary assessment and is therefore a better indicator of the resident's actual level of independence and need for nursing and therapy care (as compared to Section G). In response to provider comments and concerns that the Resident Classification System (RCS-1) was too complex, CMS requested that Acumen reexamine the number and complexity of the proposed RUG scores. Acumen reviewed their own research and determined that when they substituted Section GG for Section G, they could remove cognition as a factor for PT and OT RUG scores because the Section GG scoring more accurately aligned with costs regardless of cognition. Thus, the PT and OT RUG scores were simplified and reduced. For Nursing, Section GG allowed for fewer categories due to insignificant variability in cost associated with similar ADL scores. This shift of utilizing Section GG instead of Section G for determining the PDPM per diem rate for PT, OT and Nursing streamlines the number of possible RUG scores and advances the prospective payment system's precision. However, because Section GG plays a vital role in reimbursement under PDPM, accuracy is critical. Understanding how Section GG impacts the RUG scores/CMIs, the per diem rates and the overall reimbursement is essential with effective management of PDPM. Providers should focus on training team members how to accurately code Section GG to receive the most appropriate reimbursement based upon resident characteristics.

157 Baltimore Street, Suite 200, Cumberland MD 21502
© 2017 Gravity Healthcare Consulting & CareVentures, Inc.
gravityhealthcareconsulting.com

GRAVITY
HEALTHCARE•CONSULTING

One of the biggest challenges CMS faced with trying to make the transition from Section G to Section GG for PDPM was due to the fact that there is not a direct correlation between the two systems - they are fundamentally different. However, Acumen determined the best possible correlation and mapped it to Section GG for the analysis. (Refer to table 1 for mapping of section GG to section G provided by Acumen.) One of the clearest differences that is immediately apparent is that Section G and GG are scored oppositely of each other; Section GG offers a higher score for more independence with ADLs and mobility and Section G offers a lower score for more independence with the late-loss ADLs.

Table 1

Section GG Response	Section G Response
01 Dependent	4 Total Dependence
02 Substantial/maximal assistance	3 Extensive Assistance
03 Partial/moderate assistance	3 Extensive Assistance
04 Supervision or touching assistance	1 Supervision / 2 Limited Assistance
05 Setup or clean-up assistance	No equivalent response
06 Independent	0 Independent
07 Resident refused	8 Activity Did Not Occur
09 Not applicable	8 Activity Did Not Occur
88 Not attempted due to medical condition or safety concerns	8 Activity Did Not Occur

Table 1: Mapping of Section G to Section GG in the Acumen Technical Expert Panel report on PDPM.

In RUGs-IV, the ADL score is captured only by scoring the four late-loss ADLs. Under PDPM, Section GG includes additional functional categories beyond the four late-loss ADLs and thus expands the system's ADL scoring foundation. This expansion is due, in part, to provider and advocate comments that both the late-loss ADLs and the restricted Section GG metrics under RUGs-IV for SNFs did not accurately represent the progress made by residents in therapy or the entire scope of necessary skills to return to the next level of care.

© 2017 Gravity Healthcare Consulting & CareVentures, Inc.

Another key benefit of the shift from Section G to Section GG is that CMS could collapse and simplify the Nursing RUG categories in PDPM. Specifically, the Special Care High, Special Care Low, Clinically Complex, and Reduced Physical Function classification groups (RUGs beginning with H, L, C, or P), for nursing groups that were otherwise defined with the same clinical traits (for example, extensive services, medical conditions, depression, restorative nursing services received), were combined by ADL scores. Again, because of the improved accuracy of Section GG, Acumen found that the costs associated with care were more closely aligned with Section GG scoring. Thus, the following pairs of second characters were combined due to the insignificant difference in cost per diem: E with D and C with B.

These characters correspond to ADL score bins of 15 to 16 (E) and 11 to 14 (D) as well as 6 to 10 (C) and 2 to 5 (B), respectively. For example, HE2 and HD2 under RUGs-IV, which are both in the Special Care High group and both indicate the presence of depression, are collapsed into a single nursing case-mix group in PDPM. Similarly, PC1 and PB1 (Reduced Physical Function and 0 to 1 restorative nursing services) also are combined into a single nursing case-mix group. In the Behavioral and Cognitive Performance classification group (RUGs beginning with B), for RUGs that are otherwise defined by the same number of restorative nursing services (0 to1 or 2 or more), PDPM combines RUGs with the second character B and A, which correspond to contiguous ADL score bins 2 to 5 and 0 to 1, respectively. In other words, BB2 and BA2 are combined into a single nursing group, and BB1 and BA1 are also combined into a single nursing group. (Refer to table 2.) The end result is an approximately two-thirds reduction in the total number of nursing RUGs of PDPM, thus streamlining the MDS process and reimbursement variation to providers.

© 2017 Gravity Healthcare Consulting & CareVentures, Inc.

Table 2

Nursing RUG	Nursing GG-based Function Score	# of Stays	% of Stays	Avg. WWST
ES3	0-14	5,465	0.3%	420
ES2	0-14	11,029	0.6%	318
ES1	0-14	20,089	1.1%	303
HDE2	0-5	6,545	0.3%	249
HDE1	0-5	73,030	3.8%	207
HBC2	6-14	10,921	0.6%	231
HBC1	6-14	167,801	8.8%	192
LDE2	0-5	7,204	0.4%	215
LDE1	0-5	109,783	5.8%	179
LBC2	6-14	8,434	0.4%	178
LBC1	6-14	183,343	9.7%	148
CDE2	0-5	7,229	0.4%	194
CDE1	0-5	114,140	6.0%	168
CBC2	6-14	17,239	0.9%	160
CA2	15-16	1,945	0.1%	113
CBC1	6-14	466,468	24.6%	138
CA1	15-16	48,848	2.6%	98
BAB2	11-16	1,009	0.1%	108
BAB1	11-16	61,572	3.2%	102
PDE2	0-5	2,021	0.1%	163
PDE1	0-5	88,186	4.6%	153
PBC2	6-14	5,506	0.3%	125
PA2	15-16	289	0.0%	73
PBC1	6-14	421,387	22.2%	115
PA1	15-16	28,320	1.5%	69

Table 2: List of all nursing RUGs in PDPM.

A critical takeaway in the scoring of Section GG in PDPM, as compared to Section G in RUGs IV scoring, lies within the analysis of the per diem rates for nursing, physical therapy and occupational therapy. In RUGs-IV, the more assistance a resident needed would result in a higher Section G score and that would translate into an increased CMI and per diem rate. **However, under PDPM, a higher level of independence results in a higher functional score resulting in an increased per diem rate (except for some diagnoses with a functional score of 24 which would correlate with a resident who is completely independent).** Note the parabolic relationship between the cost per day and the section GG score. (Refer to Table 3.) This helps us to understand why CMS focused the highest amount of reimbursement and resources to those in the highest to middle range for Section GG scores.

© 2017 Gravity Healthcare Consulting & CareVentures, Inc.

Table 3

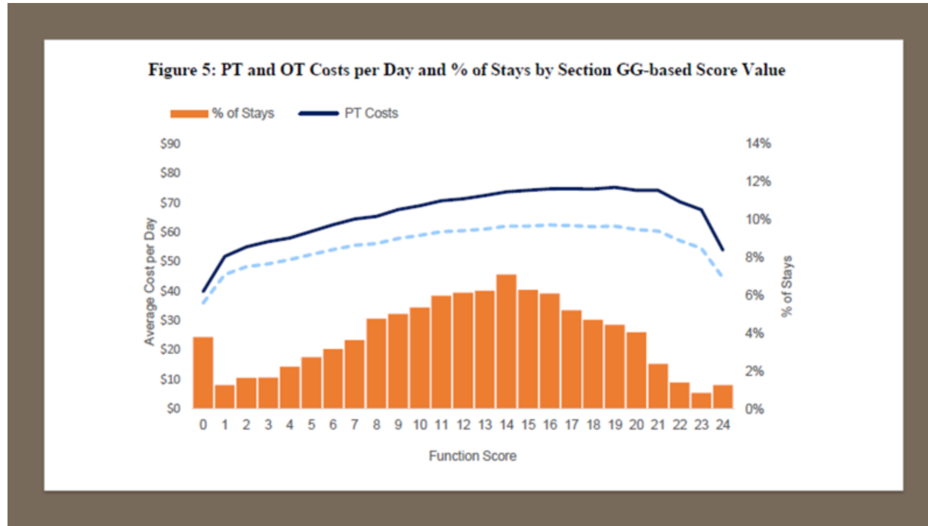

Table 3: PT and OT Costs per Day and % of Stays by Section GG-based Score Value

Another change with PDPM is that Section GG scores some mobility functional areas by averaging more than one mobility item. Averages of the Section GG scores will be used for the two-bed mobility items, the three-transfer items, and the two-walking items. Table 4 shows how the scoring on Section GG is calculated under PDPM and how the averaging of some mobility items will be captured. Thus, the total possible PDPM Section GG score is 0 to 24 points, which establishes the RUG scores for PT, OT and nursing.

Table 4

Section GG Item		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 (average of 2 items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4 (average of 3 items)
GG0170E1	Mobility: Chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0-4 (average of 2 items)
GG0170K1	Mobility: Walk 150 feet	

Table 4: Scoring of Self-Care and Mobility items in Section GG under PDPM.

© 2017 Gravity Healthcare Consulting & CareVentures, Inc.

While PDPM has some similarities to the previously proposed RCS-1 (Resident Classification System, Version 1) and to RUGs-IV, the system overall is significantly improved from RCS-1. RUGs-IV has a total of 66 RUG scores and RCS-1 decreased the nursing RUGs to only 43 scores. PDPM decreases it even further to a total of 25 nursing RUGs/CMIs by combining existing groups. For PDPM, all residents would be classified into one and only one of the 25 nursing case-mix groups. The PDPM nursing indexes are determined based upon whether the resident has certain classification such as:

1. Requiring extensive services
2. Presence of specific clinical conditions
3. Signs and symptoms of depression
4. Provision of restorative nursing services
5. Section GG-based function score

PDPM RUG scores calculate various RUGS for Physical Therapy, Occupational Therapy, Speech Therapy, Nursing and Non-Therapy Ancillary, or NTA Categories. Each individual category is assigned its own independent CMI score and each category thus receives an independent per diem rate. Each of the five separate per diem rates are added together to give one final aggregate per diem rate. (Table 5).

Table 5

Table 5: Calculating CMIs and per diem rates for all categories in PDPM.

Each of the separate RUG categories are calculated differently and a few key points to remember are:

1. PT and OT will receive a 2% reduction in per diem rate starting on day 21 of the stay and reducing an additional 2% every 7 days thereafter.
2. NTA has in increased rate of 300% for the first 3 days of the stay.
3. PT and OT will always have the same RUG score, though the actual per diem rates for each will differ.
4. All categories (except NTA) are based upon the clinical category assigned to each resident, which is pulled from the ICD-10 diagnosis code.

© 2017 Gravity Healthcare Consulting & CareVentures, Inc.

Table 6

PT	OT	SLP	Nursing	NTA
• Primary reason for SNF care (diagnosis) • Functional Status	• Primary reason for SNF care (diagnosis) • Functional Status	• Primary reason for SNF care (diagnosis) • Cognitive status • Presence of swallowing disorder or mechanically altered diet • Other SLP-related comorbidities	• Clinical information from SNF stay • Functional Status • Extensive services provided • Presence of depression • Restorative Nursing services provided	• Comorbidities present • Extensive services provided
• Day of the stay (variable per diem adjustment	• Day of the stay (variable per diem adjustment			• Day of the stay (variable per diem adjustment

Table 6: Determinants of Payment in PDPM

A critical feature to understand about the Section GG scoring under PDPM is that facilities will be penalized for any score of "0". A score of "0" is achieved when any element in Section GG is coded as: Resident refused (07), Not applicable (08), Not attempted due to safety or medical concerns (88), and Dependent (01). These scores can be considered "danger zones" and miscoding elements with these "zero-value" codes will result in reduced and inaccurate per diem rates for PT, OT and nursing. These codes are often misused and they are rarely used when scored correctly, per CMS's description. It is imperative to make sure RNACs and MDS Coordinators, CNAs/GNAs, and nursing team members understand how and when to appropriately use these codes. (Refer to Table 7.)

For example, the "Not Applicable" is often misunderstood and miscoded. Consider a resident who is currently non-ambulatory upon admission due to a non-weightbearing status of the right lower extremity because of a Stage IV heel wound. This resident would be miscoded as "Not Applicable" for ambulation and transfers, even though the resident is unable to complete those transfers upon admission. The mobility items from Section GG would be applicable to this resident as they are something the resident will likely resume and/or will at least attempt to resume once the weight bearing status is upgraded. An example of an appropriate coding of "Not Applicable" could be a bilateral, above-knee amputee who is unable to wear prosthetics and has not ambulated for 20 years. For this resident, "Not Applicable" could be an appropriate code for the ambulation mobility items on Section GG.

© 2017 Gravity Healthcare Consulting & CareVentures, Inc.

Table 7

S – Not attempted due to safety concerns: You were unable to assess this or determine it from other documentation or nursing report, or you were unable to infer from the other data you gathered. Example: Res with new DVT to RLE on bedrest and unable to safely attempt transfers and ambulation.

N – Not Applicable: This should only be used if the resident will not ever attempt this activity again and it could not ever (now or in the future) be the resident's goal. This should NOT be used because it was not attempted or because it is not directly part of the plan of care. Instead, infer from your clinical judgement and NSG report to determine these levels. You should assume that your interventions have the potential to positively affect other aspects of independence even if you are not directly addressing them and the CARE tool is designed to help you take credit for this associated increase in function.

A – Attempted but not completed: This would rarely be an appropriate code to use, and rather you should try to infer the data, collect it from NSG, or attempt to complete the task later in the evaluation day.

P – Patient Refused: To be used only if the resident refuses and you cannot infer through clinical data or from nursing report. However, if the resident is refusing because of being afraid or doubting their ability, then they should be scored as DEPENDENT instead.

Table 7: Explanation of S-N-A-P codes in Section GG (based upon the CARE Tool).

Providers need to be proactive in preparing for this shift of focus on to Section GG. If past performance is any indication, it is very likely that the Office of Inspector General (OIG) and/or Medicare Administrative Contractors (MACs) will be auditing Section GG for accuracy and supportive documentation now that it is directly tied to reimbursement under PDPM. Providers with inaccurate Section GG coding could see denials, recoupment and fines. **Education for CNAs and nursing team members, as well as therapy and staff educators, will be critical in the preparation for PDPM.** Providers should also consider standardized training during the orientation process and at annual retraining for all staff who could potentially contribute to Section GG data under PDPM.

PDPM is truly a paradigm shift from previous Prospective Payment Systems (PPS). The scoring and payment structure is based upon resident characteristics rather than the volume of services provided. However, CMS is confident that PDPM should be budget neutral and, from their perspective, should yield approximately the same payments to providers overall as RUGs-IV.

The accuracy of coding Section GG is more important than ever as it directly affects the reimbursement rate of PDPM. Table 8 shows a financial scenario of PDPM versus RUGs-IV for an actual resident. Upon auditing the MDS, it was noted that Section GG in the actual MDS appears to be inaccurate and does not match therapy and other supporting documentation resulting in a loss of $8.39 per diem. Also, if the resident could benefit from it, adding restorative nursing upon admission would increase the per diem by $8.71. Another key finding of the audit of this resident was that the incorrect ICD-10 code was used as the primary diagnosis. The accurate coding for after-care of hip replacement changes resident to TC for PT/OT and nursing group to CBCI. This would result in an increase of $99.21 per diem.

© 2017 Gravity Healthcare Consulting & CareVentures, Inc.

Table 8

Comparison of Contract Therapy Scenarios Under PDPM – Hip Replacement (More Independent)

Current RUG IV Score	Current Per Diem Therapy Component of RUG IV	Potential RUG with PDPM	Potential Combined PT, OT, and ST Per Diem Rate	Current Payment to Contract Rehab	Current Facility Margin After Contract Rehab	Proposed Payment to Contract Rehab Under PDPM	Potential Margins for Facility with Contract Rehab Under PDPM	Potential Change Total Provider Reimbursement Under PDPM
RUC	$246.90	TG & SA	$204.72	$102.86	$144.04	(80% of per diem) $163.77	$133.57*	-$90.85
RVC	$169	TG & SA	$204.72	$71.43	$97.57	$163.77	$133.57*	-$1.11

* Will be offset by increased per diem rates for Nursing and Non-Therapy Ancillary

Table 8: Comparison of Contract Therapy Scenarios under PDPM – Hip Replacement (More Independent)

With the proposed PDPM, providers will have to be diligent in performing assessments, documenting accurately, and providing appropriate services starting on day 1 of the resident's admission. This will aid providers in receiving the most accurate reimbursement for all residents while providing high quality care that is reflective of an individualized plan of care focused on appropriate length of stay and optimal outcomes. The reimbursement provided by CMS, via the proposed PDPM, would utilize data captured on the 5-day assessment to provide payment for services given by the SNF throughout the resident's entire stay. The CMIs and per diem rates established on the 5-day admission MDS can only be altered if the resident qualifies for an Interim Payment Assessment, or IPA, so accuracy during the 5-day admission assessment is vital. Interdisciplinary team communication and documentation are integral components of successfully navigating through PDPM. Providers should consider Section GG auditing, Section GG ADL Coding training for all staff that can contribute toward Section GG, implementing a Restorative program for skilled residents as clinically indicated, and improving the ICD-10 coding skills of the MDS Coordinators to promote the strongest accuracy of RUG scores and CMI under PDPM.

© 2017 Gravity Healthcare Consulting & CareVentures, Inc.

About Us:

Gravity Healthcare Consulting is diverse and experienced team of clinicians who are here to serve your healthcare consulting needs. Our team includes seasoned MDS Coordinators and RNACs who are prepared to train your team in accurate Section GG ADL coding. We provide both onsite training as well as remote training or video training materials. Our consultants can complete Section GG audits, along with a variety of other MDS audits, training, materials and support. We also provide interim services for MDS Coordinator/RNACs, DONs and NHAs. Gravity Healthcare also provides a comprehensive onsite Restorative Training Program that includes the Restorative Manual, Pre- and Post-training audits, video module training for future staff and a variety of other Restorative resources. If you have any questions or could benefit from these or any other of our services, please do not hesitate to reach out to Melissa Sabo, Lead Consultant, directly at 240-803-7999 or Msabo@GravityHealthcareConsulting.com.

References

1. Centers for Medicare and Medicaid Services. Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for CY 2019, SNF Value-Based Purchasing Program, SNF Quality Reporting Program. Available April 27, 2018, at https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-09015.pdf
2. Acumen. Skilled Nursing Facilities Patient-Driven Payment Model Technical Report. Available April 27, 2018 at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Technical_Report_508.pdf

© 2017 Gravity Healthcare Consulting & CareVentures, Inc.