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Non-Therapy Ancillary (NTA) Services – At a Glance

The Patient-Driven Payment Model (PDPM) takes effect on October 1, 2019 and represents a significantly different approach to reimbursement for care in Skilled Nursing Facilities (SNFs).

Perhaps the most "transformative" component relates to Non-Therapy Ancillary (NTA) Services. CMS felt that certain residents, especially those who were more "medically complex," were being under-represented in skilled care reimbursement. Therefore, they separated NTA conditions and services from all other nursing-related services so that they could be accounted for more accurately and completely when determining per-diem payments.

The NTA component of PDPM attempts to capture and quantify the extent to which SNF residents are medically complex. To do so, it identifies 50 different **conditions** and **services** that are most often related to medical complexity. One of these (HIV/AIDS) is captured on the SNF claim. All of the other conditions and services are captured via coding entries on the MDS.

The 49 of the 50 conditions and services that come from the MDS occur in sections H, K, M, O and I. The grouper software will essentially search these particular sections of the MDS looking for very specific ICD-10 and procedural coding that will indicate that a resident has a particular condition or needs a certain service. Failure to use the correct coding will result in a facility not getting reimbursed for services that they are providing.

Some examples of "conditions" that are captured for NTA classification include: Diabetic Foot Ulcer, COPD, Morbid Obesity, Diabetes Mellitus and Inflammatory Bowel Disease.

Some examples of "services" that are captured for NTA classification include: IV Medication, Radiation, Suctioning, Infection Isolation and Feeding Tube.

One very unique aspect of how payment for the NTA component is calculated relates to the situation a particular resident is in regarding their progress during their stay. In the first three days of the stay, the NTA contribution towards the per-diem payment is **tripled** to reflect the "up-front" nature of costs related to provision of service for medically complex residents. Essentially, this was CMS' method for capturing the more intensive costs associated with equipment, supplies, training, and staff time in the first three days of the stay.

Some of the 50 NTA conditions and services (about ¼ of them) are weighted more heavily, receiving from two to eight points towards their eventual "Comorbidity Score." The rest of the conditions and services only count for one point. However, even one additional point represents additional complexity of services that will have a measurable impact on the per-diem reimbursement.

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Because the conditions and services represented in the NTA component are captured in so many separate sections of the MDS, communication and collaboration between care team members is vital to ensure all relevant items are captured.

The opportunity to be properly reimbursed for services related to the high levels of medical complexity of SNF residents is truly one of the most revolutionary aspects of the new PDPM payment system. In order to receive sufficient and fair reimbursement, facilities will need to capture all complexities using correct coding. This will be necessary on the Admission Assessment, as well as any potential Interim Payment Assessments (IPA) if the resident's condition or needs change throughout the stay.

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