Medicare Part A
SNF Payment Reform

Prepare & Deliver
(Pray & Motivate)

The Final Countdown to PDPM

September 26, 2019

www.zhealthcare.com
(877) SNF-2001

Guiding SNFs through complex payment reform for over 25 years
PDPM is Nigh...

- PDPM is simply a new Revenue Delivery System and just one component of a systemic shift away from FFS/utilization-driven reimbursement models
- Medicare coverage policies do not change
- Where should we be?
  - Expectations based on your Patient Profile
  - Revised Admission & UR processes
  - Prepared for "collateral impact"
  - Systems for measuring performance
  - Ancillary and support partners integrated
  - Compliance plan adjusted
<table>
<thead>
<tr>
<th>Old</th>
<th>New</th>
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<tbody>
<tr>
<td>PPS: RUGs</td>
<td>PPS: PDPM</td>
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<tr>
<td>FFS / Cost-Based</td>
<td>Managed Care / Price-Based</td>
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<tr>
<td>Per Diem</td>
<td>Case Management / Episodic</td>
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<td>“Pass-Though”</td>
<td>Outlier / Replacement Rev</td>
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<td>Utilization Model</td>
<td>Quality (Value) / Shared Risk</td>
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<td>Beneficiary Choice</td>
<td>Narrow Networks</td>
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<td>Manual / Paper</td>
<td>Interoperability / Analytics</td>
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<tr>
<td>National Industry</td>
<td>Local Market Dynamics</td>
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</table>
PDPM Perspectives

- SNF Owners & Operators
- Clinicians
- Lenders
- Vendors
- Financial Managers
- APMs
- Hospital TCUs
- Case Managers
- Patients
Phases of a Budget-Neutral System Change

Old system mastered
New system introduced
Panic & Acceptance
Strategy & Planning
New system implemented
Early adapters succeed
Recalibration to the mean
New system mastered
If this slide is new to you, seek immediate medical attention!!!
You should be thinking in "Future Tense"
PDPM: Beyond Reimbursement

It’s all connected...

- Budgets & Financing
- Therapy Operations
- Nursing Burden
- Liability
- Data Profile
- Vendor Contracting

- Value Proposition
- Managed Care
- Compliance Plan
- Technology
- Medicaid CMI / Cost Report
What’s Old is New Again...

- Clinical Eligibility ("RCE")
- Nursing skill
- "Human nature"
- Technical Eligibility
- 60-day rule

- "Medicare Nurse"
- Respiratory Therapy
- Hospital-Based SNFs
- Ancillary charge detail
Clinical Eligibility: 
Back to Basics

Skilled Therapy: 
5 days / week

Skilled Nursing
7 days / week

Technical eligibility: 
Related to Hospital; 
30 & 60-day rules

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Medicare Benefit Policy Manual
Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Table of Contents
(Rev. 249, 11-02-18)

30 - Skilled Nursing Facility Level of Care - General
(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3132, SNF-214

Care in a SNF is covered if all of the following four factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;

- The patient requires these skilled services on a daily basis (see §30.6); and

- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7.)

- The services delivered are reasonable and necessary for the treatment of a patient’s illness or injury, i.e., are consistent with the nature and severity of the individual’s illness or injury, the individual’s particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.
Long-Term Financial Impact

- Medicare budgeting
- Variability & Impact
- History Lessons
- 1999 Cost-Based to PPS
- 2011 RUG-IV Transition
- PDPM year 1?
- PDPM year 2, 3, 4...?
- Medicaid Cost-Based / CMI
Gravity of PDPM

Knowledge v. Understanding

• Near universal support
• Ripple effect on operations
• New opportunities & risks
• Wrinkle in Space-Time

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<th>Unweighted PPD $ range</th>
<th>Highest: CKAA1*</th>
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<td>Lowest: Default</td>
<td>$367</td>
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Know the Key Reimbursement Drivers

(there really arent that many)
Changes in Provider Behavior (Capture Patterns)

MDS / RUG sensitivity without Therapy distortion:

<table>
<thead>
<tr>
<th>Service / Condition</th>
<th>PDPM</th>
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<tbody>
<tr>
<td>RUG without Therapy</td>
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<tr>
<td>Restorative Nursing</td>
<td>$129.22</td>
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<tr>
<td>Hemi Dx, Oxygen, etc.</td>
<td>$141.93</td>
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<tr>
<td>Respiratory Therapy</td>
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<tr>
<td>Depression</td>
<td>$237.26</td>
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</table>

2020 Urban, Unweighted Rates

Same resident, different score; Higher payment, lower Therapy cost
<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>SCORE</th>
<th>Days 1 - 3</th>
<th>Days 4 - 20</th>
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<tbody>
<tr>
<td>PT / OT Component</td>
<td>TK</td>
<td>$179.43</td>
<td>$179.43</td>
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<td>Medical Mgt., 10-23</td>
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<td>$237.26</td>
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<tr>
<td>AIDS D No</td>
<td>HBC2</td>
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**PDPM Composite Rate**

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<th>$1,032.69</th>
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</table>

- IV Medications
- Respiratory Therapy
- PHQ>9
- Aphasia
- SD & MAD
- Impaired Cognition
- Other Minor NTAs

Urban Unweighted
Compare to RUG-IV RUB = $631.42
Respiratory Therapy

- Nursing Case-Mix Group
- Respiratory Therapist, RN – state guidelines
- Start day 1/2 with ARD day 7/8
- Special Care High
- Qualifying conditions
- "Lock & Drop"
- Compliance
Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Respiratory care (respiratory therapy) is defined as those services prescribed by a physician or a non-physician practitioner for the assessment and diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function.

Monitoring is defined as the periodic checking of the equipment in actual use to ascertain proper functioning; real time tracking the individual's condition to assure that he/she is receiving effective respiratory therapy services; and periodic evaluation of the patient's progress in improvement of function.

Respiratory care (respiratory therapy) services may include but are not limited to the following:

- application techniques to support oxygenation and ventilation in an acute illness (e.g., establish/maintain artificial airway, ventilatory therapy, precise delivery of oxygen concentrations, aid in removal of secretions from pulmonary tree)
- therapeutic use/monitoring of medicinal gases, pharmacologically active mists and aerosols, and equipment (e.g., resuscitators, ventilators)
- bronchial hygiene therapy (e.g., deep breathing, coughing exercises, IPPB, postural drainage, chest percussion/vibration, and nasotracheal/endotracheal suctioning)
- diagnostic tests for evaluation by a physician (e.g., pulmonary function test, spirometry, and blood gas analyses)
- pulmonary rehabilitation techniques (e.g., exercise conditioning, breathing retraining, and patient education regarding management of patient’s respiratory problems) and periodic assessment of the patient for the effectiveness of respiratory therapy services.

The above services may be performed by respiratory therapists, physical therapists, nurses, and other qualified personnel as described by relevant state practice acts. Documentation in the medical record must clearly support the need for respiratory therapy services to be separately reimbursed.

Respiratory care (respiratory therapy) services can be considered reasonable and necessary for the diagnosis and treatment of a specific illness or injury. The service provided must be consistent with the severity of the patient's documented illness and must be reasonable in terms of modality, amount, frequency, and duration of treatment. The treatment must be generally accepted by the professional community as safe and effective for the purpose used, and recognized standards of care should not be violated.

There must be a specific written order by the physician for all respiratory care (respiratory therapy) services.

749 explicitly supported ICD-10 codes

Codes that DO NOT Support Med Nec: = 0

Local Coverage Determination (LCD):
Respiratory Care (Respiratory Therapy) (L34149)

Your Rehab Department Should be Ready to Roll...
Therapy Considerations

- In-House v. Outsource v. “Hybrid”
- Mgt. Support, Compliance, Shared Risk, Value-add
- Efficiencies (Concurrent & Group)
- Clinical Competencies
- Staffing
- Cost Certainty
- Nursing Burden
- RNP / Activity Extensions
- Benchmarking & Outcomes
PDPM Therapy Contract Terms

- PDPM upsets CTC-SNF incentive-alignment
  - Goals: Min. $ conflict, add value, share risk, cost certainty
- Never Event: Pricing on % of PT/OT/ST rate
  - Inverse GG $ (PT/OT)
  - PT/OT category $ variability; SLP profiles
  - Preferred structure: Fixed PPD subject to reconciliation
- Target based on historical
- Indemnity
- Managed Care & ISNP considerations
“Gestalt” Therapy:

Branded, adjunct, coordinated programs; may also include non-traditional modalities: Chiropractic, massage, acupuncture.

Goal: cost-effective, improved outcomes & patient satisfaction.
Therapy: Efficiency & Benchmarking

Total Therapy Costs

Facility Scorecard:
- 28.5% lower than the national average
- 16.9% lower than the state average
- 14.6% lower than the regional average
- 6% lower than the county average

CORE Analytics
www.zcoreanalytics.com
Outsourcing & “Micro-Outsourcing”

- Therapy, billing, compliance, cost reporting have long been commonly outsourced SNF services
- Remote access has created new possibilities
- “Boutique” services specific to a single $ driver
- Fees often PPD
- Capture ratios benchmarked to calculate ROI from baseline
- Compliance concerns (addressed later)
Emerging PDPM Micro-Outsourcing “Solutions”

- Respiratory Therapy (management)
- Depression / Cognition
- Dietary / Nutrition
- Diagnosis Coding
- Case Management
- Admission & IPA monitoring
- Appeals Management
Transition & October “Assess-athon”

- No phase-in: RUG-IV ends 9/30/19 – PDPM billing begins 10/1/19
- IPA with ARD no later than 10/7/19 required for all Part A patients in-house 9/30/19; otherwise late penalties apply
- 10/1/19 = Day 1 of VPDA schedule, even if stay began earlier
- Assessment burden modeling
- Treatment and documentation protocols fully operational by 9/25

**WHAT DOES THIS MEAN FOR CMI??**
• **Transition: No transition, phase-in or hold harmless period**
  - RUG-IV billing ends 9/30/19 – PDPM billing begins 10/1/19
  - IPA with ARD no later than 10/7/19 required for all Part A patients in-house 9/30/19; otherwise late penalties apply.
  - 10/1/19 = Day 1 of VPDA schedule, even if stay began earlier.

• **CMI:**
  - Strategies will differ by state
    - Full-house or Medicaid only?
    - Medicare “Discharge” assessments used for CMI?
    - RUG-IV considerations for PDPM
Systems should be in place to manage (the $$$) Initial & Interim Assessments
Arbitrage

noun: arbitrage
1. the simultaneous buying and selling of securities, currency, or commodities in different markets or in derivative forms in order to take advantage of differing prices for the same asset.
   "profitable arbitrage opportunities"

verb: arbitrage; 3rd person present: arbitraging; past tense: arbitraged; past participle: arbitraged; gerund or present participle: arbitraging
1. buy and sell assets using arbitrage.
   "much of the short selling was being done by people who were arbitraging between the bond and the equity market"

Origin
LATIN
arbitrari

arbitrer
give
judgement

arbitrage
late Middle English

arbitrate

late Middle English (originally denoting the exercise of individual judgement): from French, from arbitrer 'give judgement', from Latin arbitri (see arbitrate). The current sense dates from the late 19th century.
To IPA or Not to IPA

- Patient admitted with Diabetes (with daily insulin injections & order changes) and Wound Infection
- Mechanically Altered Diet & “Sad” upon admission
- After 3 weeks: Function & Mood improve; Mechanically Altered Diet withdrawn; No recent insulin order changes; Infection not resolved - IV meds begin day 21
### Initial Assessment

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>Code / Score</th>
<th>PPD Day 21 - 27</th>
<th>Code / Score</th>
<th>PPD Day 21 - 27</th>
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<tbody>
<tr>
<td><strong>PDPM Composite Rate</strong></td>
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<td>$ 648.91</td>
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### IPA

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*Unweight Urban rates; 2020 Rule*
Absent CMS billing edits, Logic Tests identify “Composite score” combinations that are mutually exclusive, inconsistent or statistically improbable.
UB-04 Reimbursement Logic Tests

- Limited “Billing Edits”
- Rethinking “Triple Check”
- 28,800 component combinations
  - Many are mutually exclusive
- Explicit v. Implicit
- Statistical Probability / False Positives
- “Last line of defense”
- Modifications / Corrections
KDXE1 24

Pharmacy $1xxx
PT $1xxx
OT $1xxx

HIPPS
PT/OT K TK Med Mgt 10 - 23
SLP D SD One, Neither
Nursing X PBC1 6 - 14
NTA E NE 1 - 2
MDS 1 PPS Initial

EXPLICIT
Pneumonia: CBC1

PROBABLE
Aphasia or Cognition (any two?)
Aphasia: M.A.D.; Either

JUSTIFIABLE?
Pneumonia: Resp Tx HBC1
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<th>COMPONENT</th>
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<th>RATE PPD</th>
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**PDPM Composite Rate** $503.78

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<th>RATE PPD</th>
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<td>Medical Mgt.;10-23</td>
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<tr>
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**PDPM Composite Rate** $557.78
<table>
<thead>
<tr>
<th>Resident</th>
<th>Admit Date</th>
<th>Logic Test Trigger(s)</th>
<th>Rate Component</th>
<th>Billed Score</th>
<th>Issue/Explanation</th>
<th>Potential Score</th>
<th>Days</th>
<th>Total</th>
<th>Assessment Type</th>
<th>Resolution</th>
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<tbody>
<tr>
<td>Allen, Michael</td>
<td>10/05/2019</td>
<td>M9701XD</td>
<td>PT / OT</td>
<td>J</td>
<td>Primary dx supports major joint rep / spinal surgery category</td>
<td>B</td>
<td>27</td>
<td>$857</td>
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<td>Elliott, Paige</td>
<td>10/15/2019</td>
<td>E11621. G35</td>
<td>NTA</td>
<td>F</td>
<td>Diabetes and Multiple Sclerosis dx coded (4 NTA points)</td>
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<td>Jones, Richard</td>
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<td>COPD dx reported - review for shortness of breath while lying flat</td>
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<td>Stevens, Wilma</td>
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<td>Nursing</td>
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<td>IPA Initiated</td>
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Default: ZZZZZZ
Anyone else interested in your Reimbursement?
SNF Value-Proposition

- Episodic metrics: Re-hospitalization, ALOS, average PPD
- Alternative Payment Models
  - ACOs, Bundle Conveners: Rate Variation Analysis
- Variable PDPM Episodic Spend within markets
- Incentives for higher acuity (higher Re-H?)
- Medicare Advantage & the ISNP Equation
- “Ultra Short-Term”
- Hospital-based SNFs / TCUs
Technology Considerations

• “Technology Fatigue” & Return on Investment
• IT integration, “scrubbers” and EMR monitoring
• Specific PDPM functionality:
  • Component $ offset issues
  • Initial data capture – IPA monitoring (gross v. net)
  • Support for emerging outsourced models
  • IT integration, “scrubbers,” EMR, billing, vendors...
  • Data Analytics: Referral partner patterns & outcomes
  • Remote Access / Corporate support (multi-facility efficiencies)
Utilization and expense data should be benchmarked by PDPM Component against peers.

Statistically valid UB-04 “Logic Tests” can reveal lost $.

Ancillary (NTA) Expense / Charge data per PDPM category is essential.
### Average Length of Stay By Diagnosis - Last 12 Months

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Average Length of Stay (in Days)</th>
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<tbody>
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<td>Non-Surgical</td>
<td>30</td>
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<tr>
<td>Acute Infect.</td>
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<tr>
<td>Cardiovasc.</td>
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<td>Acute Infect.</td>
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</table>

**ALOS By Diagnosis Group**

- **Length of Stay Total:** 32.7
- **Length of Stay Day Count Total:** 752
- **Length of Stay Resident Count:** 23
Compliance & Potential Audit Focus Areas

- Clinical Eligibility (7 days Nursing, 5 Tx)
- No therapy “levels” to audit – R&N
- Documentation must support all drivers
  - Nursing RUG drivers and “end splits”
  - Speech profiles
  - Function score / Variance from Section G
  - ICD-10 assignment or omission
  - NTA drivers: Medical necessity of administration; active Dx
- IPA policies, trends, consistency and justification
New Compliance Concerns

• New Professionals (& risk) on the Reimbursement team
  • Physicians
  • Medication admin.
  • Primary for skilled care
  • Dietician
  • Respiratory Therapy
  • Depression
  • Active Diagnosis

• PUF data & aberrant billing trends
  • How will they be identified?
  • What will they mean?
  • Will score changes reset Composite?
  • Who is most at risk?
Legal / Liability Issues

• Excess therapy v. rationing
  • Changes in treatment patterns
  • Implications post-discharge

• Indemnity

• “Expected” hours

• 5-Star

• Quality Reporting

• Capture & Care Planning

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Perspective
Rehabbed to Death
Lynn A. Flint, M.D., Daniel J. David, R.N., Ph.D., and Alexander K. Smith, M.D., M.P.H.

Ms. P. was an 87-year-old woman with moderate dementia who lived alone in an apartment before being admitted to the hospital with pneumonia. During her hospitalization, she became deconditioned and could no longer walk without assistance. Friends and family were unable to provide the amount of help she needed to live safely at home, so she was transitioned to a nursing home for post-acute care, paid for by Medicare. She then developed diarrhea, however, and was readmitted to the hospital with a *Clostridium difficile* infection. She was transferred back to the nursing home for more rehabilitation, only to develop delirium, which led to a fall and a readmission. Shortly after Ms. P.’s third transfer to the nursing home, the 100 days of skilled nursing facility—based post-acute care covered by Medicare ended. She continued to need help with...
“In the middle of every difficulty lies opportunity”

- Albert Einstein
Your Behavior Today Will Impact Your Tomorrow

- Changes in MDS coding practices
- Over/Under coding of key payment/regulatory drivers
- Significant cut/change in therapy practices
- Over or no use of IPA
- Vendors: Under Arrangement and Under Agreement
Medical Review and Data Monitoring (cont. 1)

- Given the more holistic style of care emphasized under PDPM, program integrity and data monitoring efforts will also be more comprehensive and broad.

- For program integrity, we expect provider risk will be more easily mitigated to the extent that reviews focus on more clearly defined aspects of payment, such as documentation supporting patient diagnoses and assessment coding.
  - If the provider codes that the patient’s/resident’s primary diagnosis is a major joint replacement, then the reviewer should be able to verify that the patient/resident received a major joint replacement.
PDPM Workflow Process

**Pre-Admission**
- Receive Referral from Hospital. Request Hospital Documentation.
- Hospital Documentation to RN for Review.
- RN Reviews Documentation andMakes Recommendation to Admit or Deny Admission. RN Notifies Admissions Director of Determination.
- Admissions Director Communicates Decision to Hospital. If Approved, Admissions Director will Notify Facility Personnel.

**IF ADMITTED**

**Admission Basic Documentation**
- RN Completes Facility Defined Admission Assessments.
- Facility Nurse Coordinates with Physician to Obtain Initial Medical Orders.
- RN Begins 48-Hour Baseline Care Plan to be Completed by Day 2.
- Therapy Screens and/or Evals Completed by Day 3.
- If Patient Not Deemed Appropriate by Therapy, RN may begin Restorative Program, as appropriate.

**Admission MDS Workflow**
- MDS Coordinator Opens 5-Day MDS.
- Facility Clinical Personnel Begins Assessing & Documenting Section GG usual performance.
- MDS Coordinator Reviews Dx and ICD-10 Coding by End of Day 6.
- MDS Coordinator will Assure that all MDS Interviews are Completed On/Or before the ARD Date.
- MDS Coordinator will Certify that MDS is Completed, Locked, and Submitted 14 Days after the ARD.
Preadmission Items

- Hospital Medical Record (ID, ENT, Ortho, Neuro, LOS, etc.)
- Hospital Diagnoses vs Post Acute Skilled Care
- IV Fluid Administration Record
  - Capture for Nursing Component (Special Care High)
- Cognition, Moods, Nutrition
Review of All Medicare Admissions by day 3/4 of Medicare stay to “set” ARD, review doc./assessments completed by IDT
  - Determine the PDPM Component Scores:
    - PT/OT Component (TA-TP)
    - SLP Component (SA-SL)
    - Nursing RUG (ES3-PA1)
    - NTA Component (NA-NF)

- Documentation of diagnoses, treatments, monitoring and evidence of Daily Skilled Care Services
Postadmission Assessments

- Interdisciplinary team assessments
- MD History & Physical
- Nursing admission assessment
- Social Service/Psychology assessments
- Speech language pathology screen/evaluation
- Dietary assessments
- Therapy Department assessments
ICD 10 Coding
Section I Coding

- Item I0020 (indicate the resident’s primary medical condition category
  - No direct impact on patient classification under PDPM.
- Serve as a gateway question to reach the I002B
  - The ICD-10 Clinical Category Crosswalk will convert the ICD-10 code captured in I0020B into one of the 10 PDPM primary clinical categories
- Not all diagnoses are considered valid primary diagnoses for the SNF stay,” Invalid primary diagnoses are listed as “return to provider” in the ICD-10 Clinical Category Crosswalk
*Note that decimals are not used in the ICD-10 codes on the Mapping Tools*
PT/OT Component

- Selecting Primary Dx (Section I)
  - Surgical Procedures driving care
  - Capture of Acute Neurologic diagnosis when appropriate
  - Use of CMS Clinical Mapping Tool to code primary

- Capture and Coding of Section GG first 3 days
  - Collaboration between Nursing & Therapy
  - Score/code for Oral Hygiene and Walking Section GG
Section GG

Days 1-3, Collaborative and Significant for Quality Measures
# Section GG Function Score

## Section GG Items Included in PT & OT Functional Measure

<table>
<thead>
<tr>
<th>Section GG Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>GG0130A1 Self-care: Eating</td>
<td>0 - 4</td>
</tr>
<tr>
<td>GG0130B1 Self-care: Oral Hygiene</td>
<td>0 - 4</td>
</tr>
<tr>
<td>GG0130C1 Self-care: Toileting Hygiene</td>
<td>0 - 4</td>
</tr>
<tr>
<td>GG0170B1 Mobility: Sit to lying</td>
<td>0 - 4 (average of 2 items)</td>
</tr>
<tr>
<td>GG0170C1 Mobility: Lying to sitting on side of bed</td>
<td>0 - 4 (average of 2 items)</td>
</tr>
<tr>
<td>GG0170D1 Mobility: Sit to stand</td>
<td>0 - 4 (average of 2 items)</td>
</tr>
<tr>
<td>GG0170E1 Mobility: Chair / bed-to-chair transfer</td>
<td>0 - 4 (average of 3 items)</td>
</tr>
<tr>
<td>GG0170F1 Mobility: Toilet transfer</td>
<td></td>
</tr>
<tr>
<td>GG0170J1 Mobility: Walk 50 feet with 2 turns</td>
<td>0 - 4 (average of 2 items)</td>
</tr>
<tr>
<td>GG0170K1 Mobility: Walk 150 feet</td>
<td></td>
</tr>
</tbody>
</table>

## PT / OT Function Score Construction

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>05, 06</td>
<td>Set-up assistance, Independent</td>
</tr>
<tr>
<td>04</td>
<td>Supervision or touching assistance</td>
</tr>
<tr>
<td>03</td>
<td>Partial / moderate assistance</td>
</tr>
<tr>
<td>02</td>
<td>Substantial / maximal assistance</td>
</tr>
<tr>
<td>01, 07, 09, 88</td>
<td>Dependent, Refused, N/A, Not Attempted</td>
</tr>
<tr>
<td>01, 07, 09, 88</td>
<td>Walking items only: Dependent, Refused, N/A, Not Attempted, Resident Cannot Walk*</td>
</tr>
</tbody>
</table>

* Coded based on response to GG0170H1 (Does the resident walk?)
## PDPM – GG Offset

<table>
<thead>
<tr>
<th>Section GG Item</th>
<th>Coding</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>GG0130A1 Self Care:</td>
<td>Eating</td>
<td>4</td>
</tr>
<tr>
<td>GG0130B1 Self Care:</td>
<td>Oral Hygiene</td>
<td>4*</td>
</tr>
<tr>
<td>GG0130C1 Self Care:</td>
<td>Toileting Hygiene</td>
<td>Refused</td>
</tr>
<tr>
<td>GG0170B1 Mobility:</td>
<td>Sit to lying</td>
<td></td>
</tr>
<tr>
<td>GG0170C1 Mobility:</td>
<td>Lying to sitting on side of bed</td>
<td></td>
</tr>
<tr>
<td>GG0170D1 Mobility:</td>
<td>Sit to stand</td>
<td></td>
</tr>
<tr>
<td>GG0170E1 Mobility:</td>
<td>Chair/bed-to-chair transfer</td>
<td></td>
</tr>
<tr>
<td>GG0170F1 Mobility:</td>
<td>Toilet transfer</td>
<td></td>
</tr>
<tr>
<td>GG0170J1 Mobility:</td>
<td>Walk 50 feet with 2 turns</td>
<td></td>
</tr>
<tr>
<td>GG0170K1 Mobility:</td>
<td>Walk 150 feet</td>
<td></td>
</tr>
</tbody>
</table>

**PT/OT Function Score:** 12

**Nursing Function Score:** 6

TK: $175.23

CBC1: $138.64

Total: $313.87
## PDPM – The Good

<table>
<thead>
<tr>
<th>Section GG Item</th>
<th>Coding</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>GG0130A1 Self Care: Eating</td>
<td>Supervision</td>
<td>3</td>
</tr>
<tr>
<td>GG0130B1 Self Care: Oral Hygiene</td>
<td>Set-up</td>
<td>4*</td>
</tr>
<tr>
<td>GG0130C1 Self Care: Toileting Hygiene</td>
<td>Refused</td>
<td>0</td>
</tr>
<tr>
<td>GG0170B1 Mobility: Sit to lying Lying to sitting on side of bed</td>
<td>Sub/Max Assist</td>
<td>1</td>
</tr>
<tr>
<td>GG0170C1 Mobility: Lying to sitting on side of bed</td>
<td>Sub/Max Assist</td>
<td>1</td>
</tr>
<tr>
<td>GG0170D1 Mobility: Sit to stand Chair/bed-to-chair transfer Toilet transfer</td>
<td>Sub/Max Assist</td>
<td>1</td>
</tr>
<tr>
<td>GG0170E1 Mobility: Chair/bed-to-chair transfer</td>
<td>Sub/Max Assist</td>
<td>1</td>
</tr>
<tr>
<td>GG0170F1 Mobility: Refused</td>
<td>Sub/Max Assist</td>
<td>1</td>
</tr>
<tr>
<td>GG0170J1 Mobility: Walk 50 feet with 2 turns Walk 150 feet</td>
<td>Partial/Mod Assist</td>
<td>2*</td>
</tr>
<tr>
<td>GG0170K1 Mobility: Walk 150 feet</td>
<td>Partial/Mod Assist</td>
<td>2*</td>
</tr>
</tbody>
</table>

**PT/OT Function Score: 11**

**Nursing Function Score: 5**

**TK: $175.23**

**CBC1: $167.60**

**Total: $342.83**
## PDPM – The Bad

<table>
<thead>
<tr>
<th>Section GG Item</th>
<th>Coding</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>GG0130A1 Self Care:</td>
<td>Eating</td>
<td>4</td>
</tr>
<tr>
<td>GG0130B1 Self Care:</td>
<td>Oral Hygiene</td>
<td>0*</td>
</tr>
<tr>
<td>GG0130C1 Self Care:</td>
<td>Toileting Hygiene</td>
<td>0</td>
</tr>
<tr>
<td>GG0170B1 Mobility:</td>
<td>Sit to lying</td>
<td>1</td>
</tr>
<tr>
<td>GG0170C1 Mobility:</td>
<td>Lying to sitting on side of bed</td>
<td>1</td>
</tr>
<tr>
<td>GG0170D1 Mobility:</td>
<td>Sit to stand</td>
<td>1</td>
</tr>
<tr>
<td>GG0170E1 Mobility:</td>
<td>Chair/bed-to-chair transfer</td>
<td></td>
</tr>
<tr>
<td>GG0170F1 Mobility:</td>
<td>Toilet transfer</td>
<td></td>
</tr>
<tr>
<td>GG0170J1 Mobility:</td>
<td>Walk 50 feet with 2 turns</td>
<td></td>
</tr>
<tr>
<td>GG0170K1 Mobility:</td>
<td>Walk 150 feet</td>
<td></td>
</tr>
</tbody>
</table>

- **PT/OT Function Score:** 6
- **Nursing Function Score:** 6
- **TK:** $163.78
- **CBC1:** $138.64
- **Total:** $302.42
SLP Component

- Acute Neuro Dx or Other
- Timing and interview skills for BIMS (Section C)
  - Who is responsible?
- Assessment of Swallowing & Chewing Disorders Section K100
- Documentation of SLP Related Comorbidities
Cognitive Impairment and the SLP Component

- PDPM Cognitive Score based on **Cognitive Function Scale (CFS)** which combines BIMS and CPS into one scale used to compare the cog. function across all patients
- Triggered by any level on CFS except Cognitively Intact
- PDPM Classification requires all items be completed.
- Either BIMS or CPS necessary to classify under the SLP component

<table>
<thead>
<tr>
<th>Cognitive Level</th>
<th>BIMS Score</th>
<th>CPS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitively Intact</td>
<td>13 - 15</td>
<td>0</td>
</tr>
<tr>
<td>Mildly Impaired</td>
<td>8 - 12</td>
<td>1 - 2</td>
</tr>
<tr>
<td>Moderately Impaired</td>
<td>0 - 7</td>
<td>3 - 4</td>
</tr>
<tr>
<td>Severely Impaired</td>
<td>-</td>
<td>5 - 6</td>
</tr>
</tbody>
</table>
Cognitive Impairment

Proper Identification of cognitive impairment (CI) is key to clinical and financial success.
What Does the Professional Literature Suggest?

- CI higher risk of death in hospital, longer ALOS, as well as outcomes such as delirium, falls, dehydration, reduction in nutritional status, etc.
  - Int J Geriatr Psychiatry. 2018 Sep; 33(9): 1177–1197

- ER use significantly increases with dementia
  - JAMDA 17 (2016) 541-546
  - Dementia severity does not have a significant influence on ED utilization or rate of admission to the hospital

- Severe sepsis in hospitalization proxy for CI, shorter survival
  - Study points to goals upon admission
  - Society of Critical Care Medicine and Wolters Kluwer Health, Inc
Section K0100 – Swallowing Disorder

Any swallowing problem noted in the ARD 7-day look-back period should be captured here in section K0100

Refer to:

- Nursing notes
- Speech Therapist Notes
- Patient, family or caregiver information
- Hospital records
Section K0150 – Nutritional Approaches

A mechanically altered diet is specifically prepared to alter the texture or consistency of food to facilitate intake.

Examples include:
- Soft solids
- Pureed foods
- Ground meat
- Thickened liquids
Nursing Component

- Review of all current Dx requiring care, medications, treatments, monitoring
  - Documentation of SOB while lying flat (Special Care High with COPD)
  - Skin treatments and conditions
  - Documentation to support capture of Respiratory Therapy treatments
  - Timing of interview and capture of Signs of Depression
**PDPM CATEGORY**

*with corresponding MDS Section*

<table>
<thead>
<tr>
<th>EXTENSIVE SERVICES</th>
<th>Function Score: GG</th>
<th>Secondary End Split</th>
<th>RUG</th>
<th>CMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracheostomy care O0100E</td>
<td>----- AND -----</td>
<td>Ventilator / Respirator O0100F</td>
<td>0 - 14</td>
<td>Not Used</td>
</tr>
<tr>
<td>Tracheostomy care O0100E</td>
<td>----- OR -----</td>
<td>Ventilator / Respirator O0100F</td>
<td>0 - 14</td>
<td>Not Used</td>
</tr>
<tr>
<td>Isolation for active infectious disease O0100M</td>
<td></td>
<td></td>
<td>0 - 14</td>
<td>Not Used</td>
</tr>
</tbody>
</table>

**SPECIAL CARE HIGH (any one of these is a qualifier)**

<table>
<thead>
<tr>
<th></th>
<th>Function Score: GG</th>
<th>Secondary End Split</th>
<th>RUG</th>
<th>CMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comatose (fully dep) B0100</td>
<td></td>
<td>Parenteral/IV feedings K0510A</td>
<td>0 - 5</td>
<td>Depression</td>
</tr>
<tr>
<td>Septicemia I2100</td>
<td></td>
<td>Respiratory Tx, 7 days O0400D</td>
<td>0 - 5</td>
<td></td>
</tr>
<tr>
<td>Diabetes with: I2900</td>
<td>Vomiting J1550B</td>
<td>COPD with: I6200</td>
<td>6 - 14</td>
<td>Depression</td>
</tr>
<tr>
<td>Daily insulin inj. &amp; N0300A</td>
<td>Feeding Tube K0510B</td>
<td>Shortness of breath when lying flat J1100C</td>
<td>6 - 14</td>
<td></td>
</tr>
<tr>
<td>Insulin order change N0350B</td>
<td>Weight loss K0300</td>
<td>Quad as prim. (GG &lt;12) I5100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Depression = MDS Section D PHQ*
<table>
<thead>
<tr>
<th>Condition</th>
<th>GG Score</th>
<th>Qualifier Details</th>
<th>MDS Code</th>
<th>Category</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebral Palsy (GG &lt; 12)</td>
<td>I4400</td>
<td>Pressure Ulcers w/ Tx: &gt; 1 Stage II M0300B and Radiation therapy^ O0100B2</td>
<td>0 - 5</td>
<td>Depression</td>
<td>2.08</td>
</tr>
<tr>
<td>Multiple Scler (GG &lt; 12)</td>
<td>I5200</td>
<td>Resp failure &amp; Oxy Tx^ M6300, I61000C2 and Depression LDE1</td>
<td>0 - 5</td>
<td>Depression</td>
<td>1.73</td>
</tr>
<tr>
<td>Parkinson’s (GG &lt; 12)</td>
<td>I5300</td>
<td>Any Stage III/IV M0300C,D and Dialysis^ O0100J2 and Depression LBC2</td>
<td>6 - 14</td>
<td>Depression</td>
<td>1.72</td>
</tr>
<tr>
<td>Foot infection</td>
<td>M1040A</td>
<td>2 or more skin Tx w/: M1200 Diabetic Foot Ulcer M1040B and Depression LBC1</td>
<td>6 - 14</td>
<td>Depression</td>
<td>1.43</td>
</tr>
<tr>
<td>Feeding tube *</td>
<td>K0510B</td>
<td>&gt;1 ven/arterial ulcer &amp; Foot lesions w/ Tx M1030</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>^ = while a resident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>*= calories ≥ 51% or 26-50% &amp; fluid ≥ 501cc</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>** = with treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical wounds**</td>
<td>M1040E</td>
<td>Transfusions^ O0100I2 and Depression CA2</td>
<td>15 - 16</td>
<td>Depression</td>
<td>1.09</td>
</tr>
<tr>
<td>Open lesions**</td>
<td>M1040D</td>
<td>Oxygen therapy^ O0100C2 and Depression CA1</td>
<td>15 - 16</td>
<td>Depression</td>
<td>0.94</td>
</tr>
</tbody>
</table>

**SPECIAL CARE LOW (any one of these is a qualifier)**

**CLINICALLY COMPLEX (any one of these is a qualifier)**
### BEHAVIORS & COGNITIVE PERFORMANCE

<table>
<thead>
<tr>
<th></th>
<th>RNP</th>
<th>BAB1</th>
<th>1.04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive impairment BIMS score ≤ 9 or CPS ≥ 3  OR Sections B, C, E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallucinations or delusions E0100  OR Physical or verbal behavioral symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GG &lt; 11, go to Physical scores</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>toward others, Other behavioral symptoms, Rejection of care, or Wandering</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>RNP</td>
<td>PDE2</td>
<td>1.57</td>
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<tr>
<td>Urinary and/or bowel toileting H0200C, H0500</td>
<td>0 - 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking training</td>
<td>O0500F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Passive and/or Active ROM O0500 A,B</td>
<td>6 - 14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing and/or grooming training O0500G</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Splint or brace assistance O0500C</td>
<td>15 - 16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating and/or swallowing training O0500H</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed mobility training O0500D</td>
<td>6 - 14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amputation/prostheses care O0500I</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer training O0500E</td>
<td>15 - 16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication training O0500J</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PHYSICAL FUNCTION REDUCED

<table>
<thead>
<tr>
<th></th>
<th>RNP</th>
<th>PDE1</th>
<th>1.47</th>
</tr>
</thead>
<tbody>
<tr>
<td>No other qualifiers; Restorative Nursing Programs (RNPs); 2 or more 6+ days/wk</td>
<td>0 - 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary and/or bowel toileting H0200C, H0500</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking training</td>
<td>O0500F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Passive and/or Active ROM O0500 A,B</td>
<td>6 - 14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing and/or grooming training O0500G</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Splint or brace assistance O0500C</td>
<td>15 - 16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating and/or swallowing training O0500H</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed mobility training O0500D</td>
<td>6 - 14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amputation/prostheses care O0500I</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer training O0500E</td>
<td>15 - 16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication training O0500J</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Moods and Signs of Depression

Proper Identification of Moods is key to clinical and financial success
MDS Section D – Mood and PDPM

• Depression has a significant impact on three of the Nursing component RUGs in PDPM:
  • Special Care High / Low
  • Clinically Complex

• D0200 (PHQ-9/Resident Mood Interview) or D0500 (PHQ-9-OV/Staff Assessment of Mood)

• A score of 10 or above triggers the Depression end-split

• Depression end-split under PDPM can be $16–$43.73/day*

* based on unweighted urban rates
What Does the Professional Literature Suggest?

- Testing the PHQ-9 interview and observational versions (PHQ-9 OV) for MDS 3.0
  - PHQ-9 and PHQ-9 OV very high correlations with industry standards, and superior to MDS 2.0
  - J Am Med Dir Assoc. 2012 Sep;13(7):618-25
  - “Nurse Researcher” vs “Reality Nurse”

- Measurement validity of the Patient-Health Questionnaire-9 in US nursing home residents
  - The validity of the PHQ-9 OV should be examined further with a structured psychiatric interview as a stronger criterion standard
  - Int J Geriatr Psychiatry. 2019 May;34(5):700-708
Depression is a Lynchpin to Success

1. Proper assessment and treatment (and documentation) of depression on 5-Day MDS is essential for superior clinical outcomes

2. Caring for depression is costly and challenges many care outcomes

3. Can increase reimbursement by $43 PPD, $870 during the first 20 days
Non-Therapy Ancillary Component

- Review of all consults, diagnoses, labs and treatments
  - Diabetes Mellitus and COPD
  - Capture of Malnutrition (MDS Section I5600)
  - Capture of Acute/Chronic Respiratory Distress Dx Codes
  - Capture of Multi-drug Resistant Organisms (MDS Section I1700)
  - Complication of Implanted Devices (become familiar with this list)
  - Morbid Obesity (BMI ≥ 40, or ≥35 + HTN/DM)
  - Pulmonary Fibrosis and Other Chronic Lung Disorders
Interrupted Stay Policy
Residents discharged from and return to same SNF by 12am of the end of third day of “interruption window”, Composite & VPDA continue unchanged.

Variable Per Diem Adjustment
PT/OT & NTA $ decrease as the benefit period progresses (see handout for details)

This is not entire policy – details in support document.
Optional Assessment where SNFs determine when IPAs are completed to address potential changes in clinical status and what criteria should be used to decide when an IPA is appropriate

- The ARD will be within 14 days of the triggering event
- Payment effective date = IPA ARD but will not reset VPDA
- Effective 10/1/19 in conjunction with PDPM implementation
- Requires DAILY monitoring for condition changes
- Remember that Component values may offset others (Net $ Impact)!
Entry/Discharge/Reentry Algorithm

- Entry, OBRA Discharge, and Reentry Algorithm:
  - A0310C and A0310D were removed from the Entry Tracking Record footnote below the diagram.
PDPM: Operational Imperatives

- Target new types of admissions, and take credit for the care we already provide
- MDS: Workload & Staffing & Responsibilities
- Organizational and Care management from Admission to Discharge
- Using EMR technology integration
  - Evaluate / enhance clinical competencies
  - Policies and Procedures
  - Clinical Pathways
Medicare / Assessment Management is a **Team Sport**

- Complex system with diverse players and many moving parts

**Reimbursement management team roles / P&Ps:**

- **Playbook:** Daily Monitoring, Capture & Documentation
- **Most Improved Player:** Admissions
- **Starting New Position:** Therapy
- **Rookies:** RT, Dietary, Psychology, Coder, Social Services
- **Key Returning Veteran:** MDS Coordinator
- **New Coach:** Assessment Compliance Coordinator
- **Offensive / Defensive Strategy:** Critical Thinking!
Evidence of Daily Skilled Care

Care Plan, Orders, Narrative Notes, MAR, TAR
Administrative Presumption of Coverage Under PDPM

- Clinical Eligibility automatically established through the ARD of initial assessment
- The following are designated under the presumption:
  - PT & OT: TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, TO
  - SLP: SC, SE, SF, SH, SI, SJ, SK, SL
  - Nursing: Clinically Complex RUG or higher
  - NTA score: NA (12+)
What About September?
The MDS PPS schedule must be followed with an assessment completed for a RUGs HIPPS rate for ALL days billed in September 2019 including COT, EOT, etc.

A Transitional Interim Payment Assessment (IPA) MUST be completed for an PDPM HIPPS rate for all Medicare Part A patients whose stay began before October 1, 2019 and will have billed days in October – ARD can ONLY be set for 10/1 - /10/7/19 and must be set within this window

Do NOT wait until 10/1/19 to start planning! OBRA Rules MUST be followed for ALL patients
<table>
<thead>
<tr>
<th>Admission Date</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/23/19 or earlier</td>
<td>Follow RUG protocols including COT, EOT as appropriate</td>
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</tr>
<tr>
<td>9/24/2019</td>
<td>Eval &amp; Treat on Day 1</td>
<td>Eval &amp; Treat on Day 2 provide therapy on Saturday OR Sunday</td>
</tr>
<tr>
<td></td>
<td>no therapy on weekend unless needed</td>
<td></td>
</tr>
<tr>
<td>9/25/2019</td>
<td>Eval &amp; Treat on Day 1</td>
<td>Eval &amp; Treat on Day 2 provide therapy on Saturday AND Sunday</td>
</tr>
<tr>
<td></td>
<td>provide therapy on Saturday OR Sunday</td>
<td></td>
</tr>
<tr>
<td>9/26/2019</td>
<td>Must Eval &amp; Treat on day of admission and then consecutively for 4 days (Saturday AND Sunday) for ARD 9/30/19 to capture Rehab RUG</td>
<td></td>
</tr>
<tr>
<td>9/27 - 9/30/19</td>
<td>Provide therapy at PDPM Protocols</td>
<td></td>
</tr>
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</table>
Transitional IPA Planning: What are you trying to capture? Look-back and assessment periods may extend back into September.
<table>
<thead>
<tr>
<th>Transitional IPA AD</th>
<th>GG Collection Start Date</th>
<th>Earliest BIMS or Cognitive Assessment Completion</th>
<th>Earliest PHQ-9 or Staff Assessment of Mood Completion</th>
<th>IV Fluids Last Administration Date</th>
<th>Pressure Ulcers or Other Skin Issues w/ Treatment</th>
<th>Documentation of Diagnoses</th>
<th>Respiratory Treatments</th>
<th>Restorative Nursing</th>
<th>Earliest Date of MDS Section O Treatments</th>
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<tbody>
<tr>
<td>10/1/19</td>
<td>9/29/19</td>
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<td>10/1/19</td>
<td>10/1/19</td>
<td>10/2/19</td>
<td>9/24/19</td>
</tr>
</tbody>
</table>
Final Thoughts on Preparing

- Have your resources ready, ensure consistency!
  - Clinical Eligibility: Chapter 8 of Medicare Benefit Policy Manual
  - [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html)
- Ensure consistency among all team members
  - (Nurses, Physicians, Psychologists, Coders, Dieticians, etc.)
- Manage and benchmark therapy performance
- Get "plugged in" to the greater provider community
- Evaluate performance every day!
- Have backups! No margin for error
PDPM Prime is a comprehensive, intelligence-driven consulting platform designed to ensure accurate reimbursement and maintain compliance under the Patient Driven Payment Model.

Designed by SNF reimbursement-compliance experts with decades of payment system transition experience.
Medicare Part A
SNF Payment Reform

Thank You!!!

The Final Countdown to PDPM

September 18, 2019

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