Medicare Part A SNF Payment Reform

Prepare & Deliver (Pray & Motivate)

The Final Countdown to PDPM

September 26, 2019

ZIMMET HEALTHCARE SERVICES GROUP, LLC

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

Next Generation Terminology

Old	New
PPS: RUGs	PPS: PDPM
FFS / Cost-Based	Managed Care / Price-Based
Per Diem	Case Management / Episodic
“Pass-Though”	Outlier / Replacement Rev
Utilization Model	Quality (Value) / Shared Risk
Beneficiary Choice	Narrow Networks
Manual / Paper	Interoperability / Analytics
National Industry	Local Market Dynamics

PDPM Perspectives

SNF Owners & Operators

Hospital TCUs

PATIENTS

Clinicians

APMs

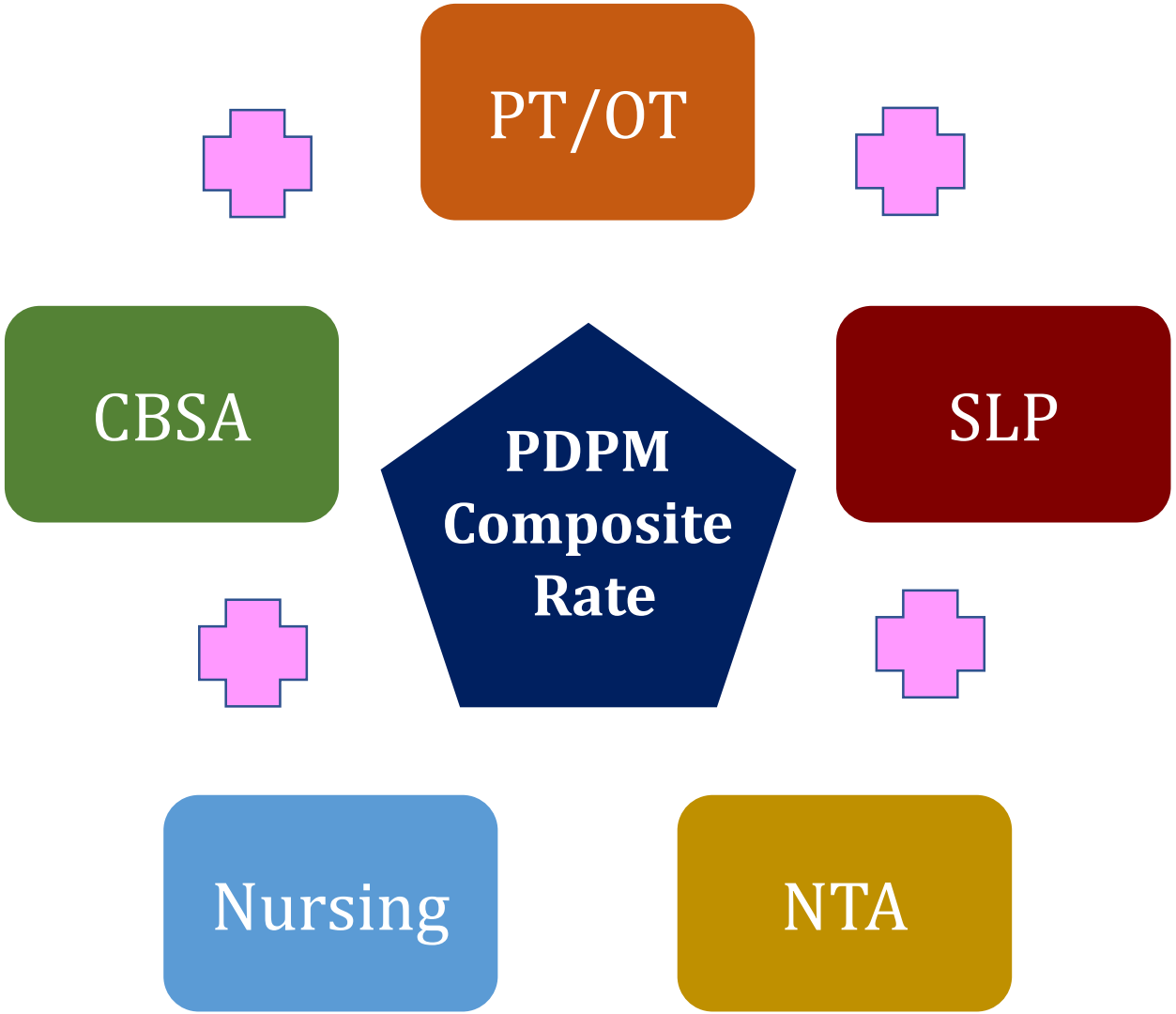
Financial Managers

Lenders

Vendors

Case Managers

Phases of a Budget-Neutral System Change



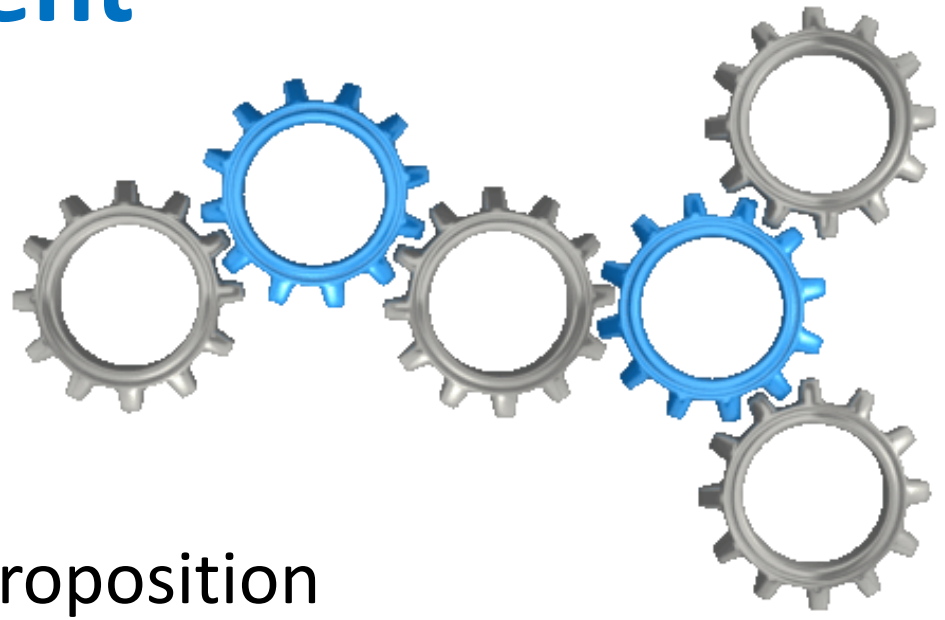
If this slide is new to you, seek immediate medical attention!!!

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

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.

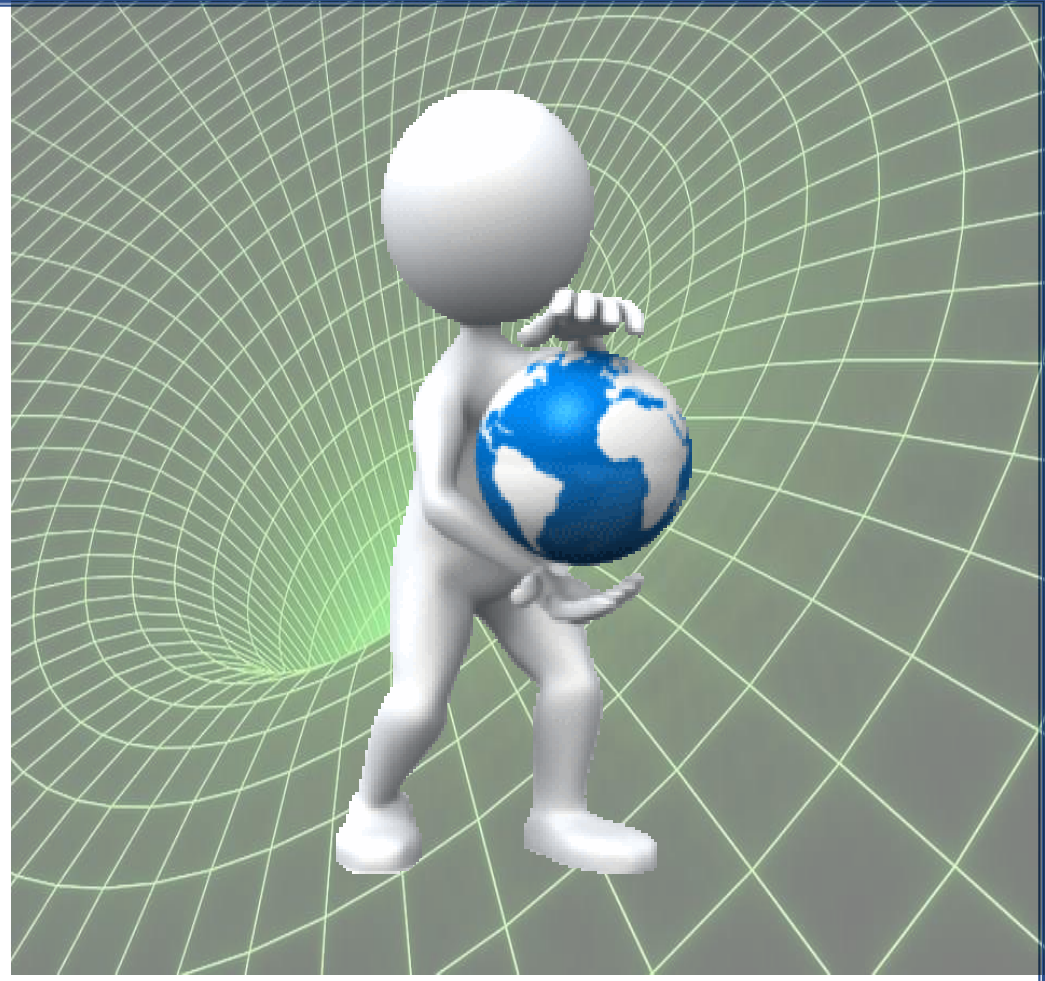
Long-Term Financial Impact

- 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



Unweighted PPD $ range	Highest:	CKAA1*	$1,680
	Lowest:	Default	$367

Know the Key Reimbursement Drivers

(there really arent that many)

Changes in Provider Behavior (Capture Patterns)

MDS / RUG sensitivity without Therapy distortion:

2020 Urban,
Unweighted Rates

	PDPM	Service / Condition
• PBC1 =	$119.69	RUG without Therapy
• PBC2 =	$129.22	Restorative Nursing
• CBC1 =	$141.93	Hemi Dx, Oxygen, etc.
• HBC1 =	$197.01	Respiratory Therapy
• HBC2 =	$237.26	Depression

Same resident, different score;
Higher payment, lower Therapy cost

PDPM Composite Rate		$1,032.69	$738.62
COMPONENT	SCORE	Days 1 - 3	Days 4 - 20
PT / OT Component		$179.43	$179.43
Medical Mgt.;10-23	TK		
SLP Component		$80.06	$80.06
Any Two, Both, SI	SI		
Nursing Component		$237.26	$237.26
AIDS D No	HBC2		
NTA Component		$441.10	$147.03
Points: 7	NC		
Non-Case Mix Component		$94.84	$94.84

- 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
- Physician orders
- “Lock & Drop”
- Compliance

MEDICARE PART A SNF PDPM Nursing Case Mix Group Component

PDPM CATEGORY *with corresponding MDS Section*						Function Score: GG	Secondary End Split	RUG	CMI
SPECIAL CARE HIGH (any one of these is a qualifier)									
Comatose (fully dep)	B0100	Fever with one of:	J1550A	Parenteral/IV feedings	K0510A	0 - 5	Depression	HDE2	2.40
Septicemia	I2100	Pneumonia	I2000	Respiratory Tx, 7 days	O0400D	0 - 5		HDE1	1.99
Diabetes with:	I2900	Vomiting	J1550B	COPD with:	I6200	6 - 14	Depression	HBC2	2.24
Daily insulin inj. &	N0300A	Feeding Tube	K0510B	Shortness of breath when lying flat	J1100C	6 - 14		HBC1	1.86
Insulin order change	N0350B	Weight loss	K0300	Quad as prim. (GG <12)	I5100	*Depression = MDS Section D PHQ*			

ZIMMET HEALTHCARE SERVICES GROUP, LLC

CMS Manual System, Pub 100-20, One Time Notification, Transmittal 477, dated April 24, 2009, Change Request 6338

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.

ICD-10 Codes that Support Medical Necessity
Group 1 Paragraph: N/A

Group 1 Codes:

ICD-10 Codes	Description
A15.0	Tuberculosis of lung
A15.5	Tuberculosis of larynx, trachea and bronchus
A15.6	Tuberculous pleurisy
A15.7	Primary respiratory tuberculosis
A15.8	Other respiratory tuberculosis
A20.2	Pneumonic plague
A20.7	Septicemic plague
A22.1	Pulmonary anthrax
A31.0	Pulmonary mycobacterial infection
A36.2	Laryngeal diphtheria
A37.00	Whooping cough due to Bordetella pertussis without pneumonia
A37.01	Whooping cough due to Bordetella pertussis with pneumonia
A37.10	Whooping cough due to Bordetella parapertussis without pneumonia
A37.11	Whooping cough due to Bordetella parapertussis with pneumonia

749 explicitly supported ICD-10 codes

Codes that DO NOT Support Med Nec: = 0

noridian
Healthcare Solutions

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

http://bit.ly/ZHSG-RT-LCD

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

ZIMMET HEALTHCARE SERVICES GROUP, LLC

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

Augmented

Formal Therapy

"TherActivities"

RNPs

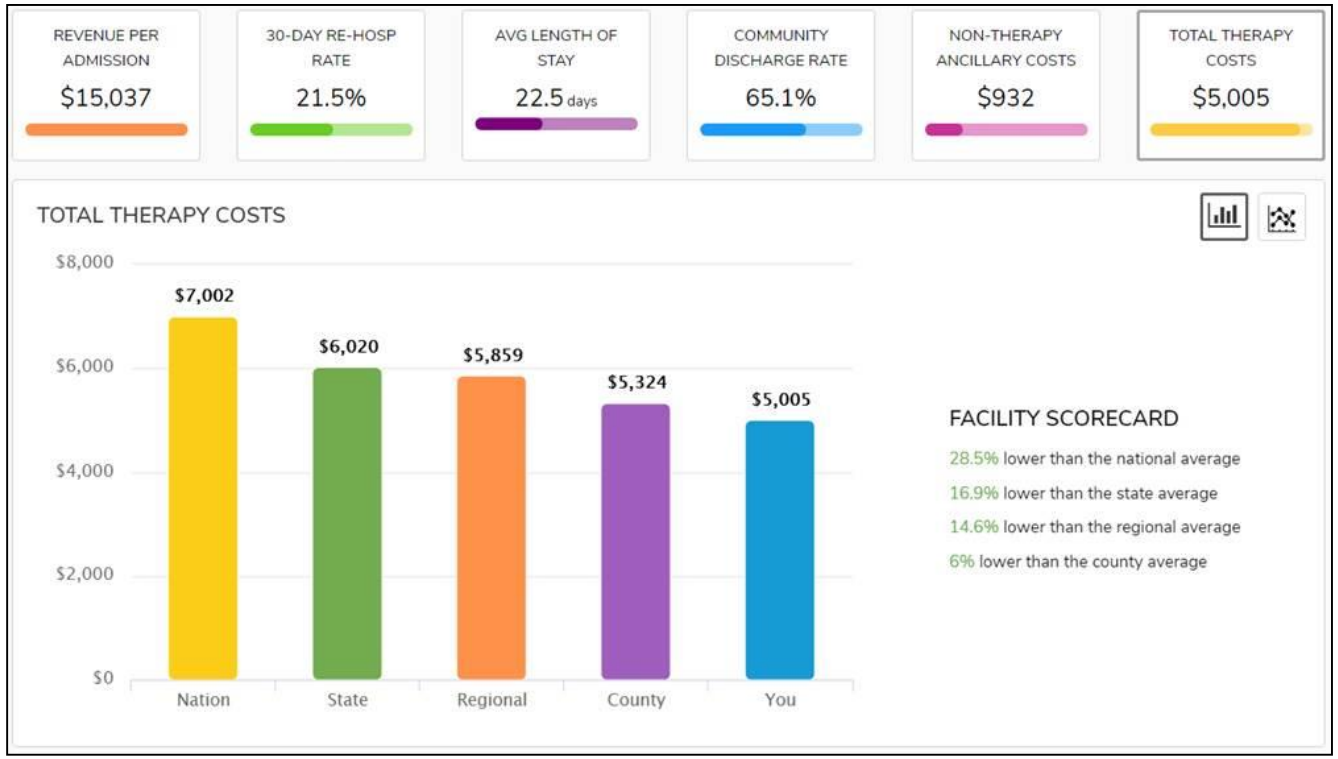
"Gestalt" Therapy:

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

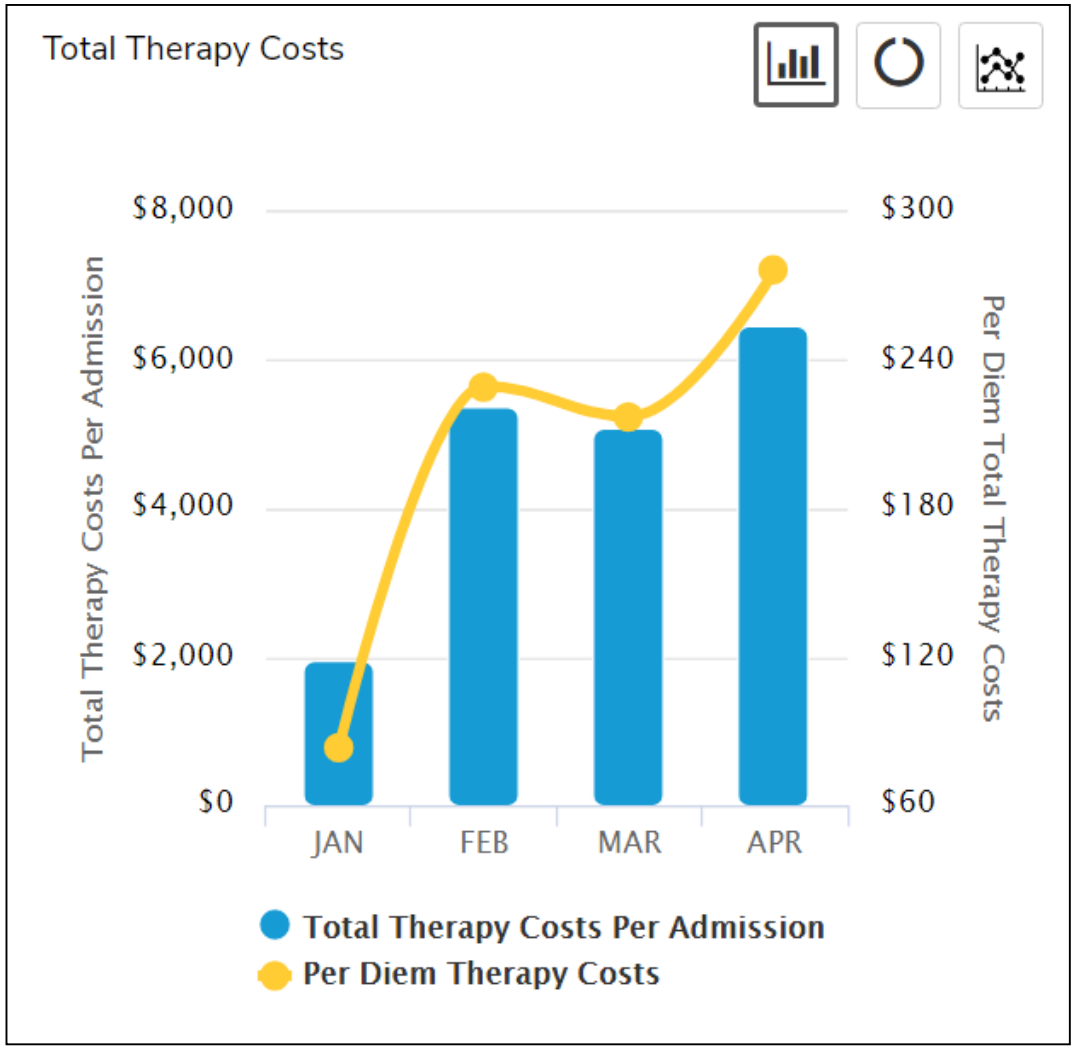
Goal: cost-effective, improved outcomes & patient satisfaction.

Therapy: Efficiency & Benchmarking

ZIMMET HEALTHCARE SERVICES GROUP, LLC



CORE Analytics
www.zcoreanalytics.com



Outsourcing & “Micro-Outsourcing”

ZIMMET HEALTHCARE SERVICES GROUP, LLC

- 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”

ZIMMET HEALTHCARE SERVICES GROUP, LLC

- 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

Dictionary

Search for a word

ar·bi·trage
/ˈärbəˌträZH/

noun

noun: **arbitrage**

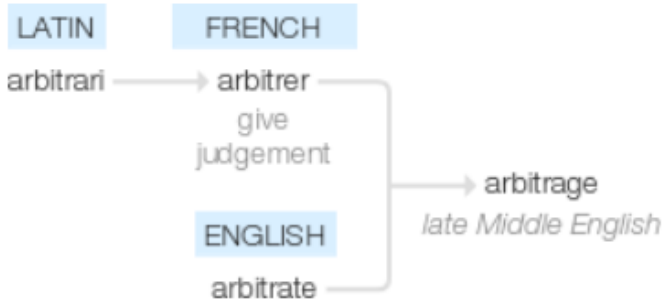
1. the simultaneous buying and selling of securities, currency, or commodities in different markets or in derivative forms in order to take advantage of differing prices for the same asset.
   "profitable arbitrage opportunities"

verb

verb: **arbitrage**; 3rd person present: **arbitrages**; 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

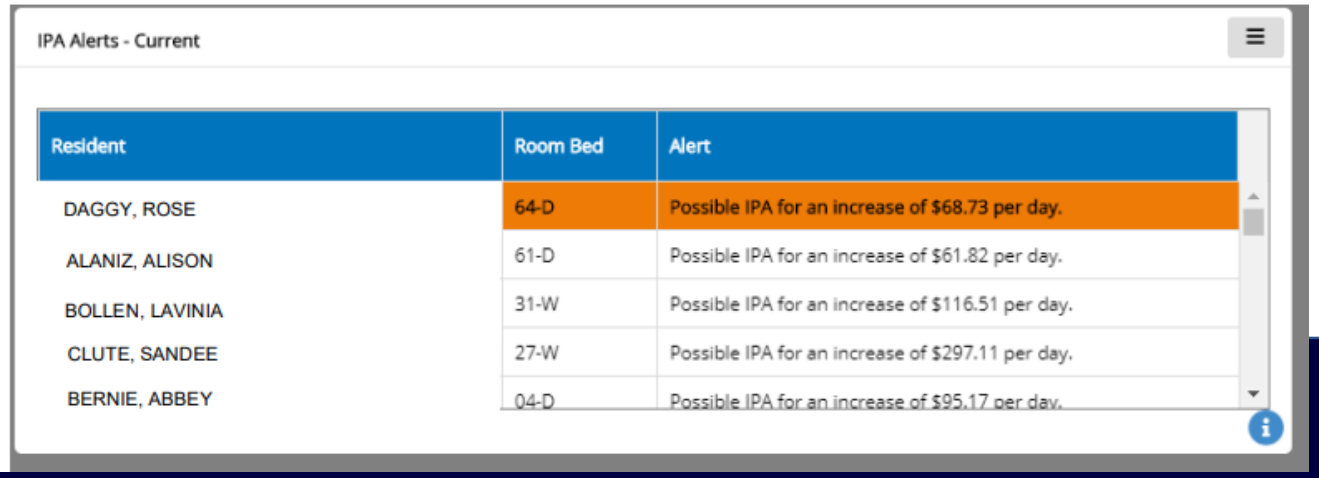


late Middle English (originally denoting the exercise of individual judgement): from French, from *arbitrer* 'give judgement', from Latin *arbitrari* (see arbitrate). The current sense dates from the late 19th century.

Reimbursement Arbitrage

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

PDPM Composite Rate		$ 648.91
COMPONENT	**Code / Score**	***PPD Day 21 - 27***
PT / OT Component		**$ 166.01**
Medical Mgt.; 6-9	**TJ**	
SLP Component		**$ 41.55**
None, Either, SB	**SB**	
Nursing Component		**$ 238.87**
AIDS Dx: No	**HBC2**	
NTA Component		**$ 107.00**
Points: 4	**ND**	
Non-Case Mix Component		**$ 95.48**

IPA

PDPM Composite Rate		$ 634.46
COMPONENT	**Code / Score**	***PPD Day 21 - 27***
PT / OT Component		**$ 177.02**
Medical Mgt.;10-23	**TK**	
SLP Component		**$ 15.52**
None, Neither, SA	**SA**	
Nursing Component		**$ 142.90**
AIDS Dx: No	**CBC1**	
NTA Component		**$ 203.54**
Points: 9	**NB**	
Non-Case Mix Component		**$ 95.48**

Unweight Urban rates; 2020 Rule

Triple-Check

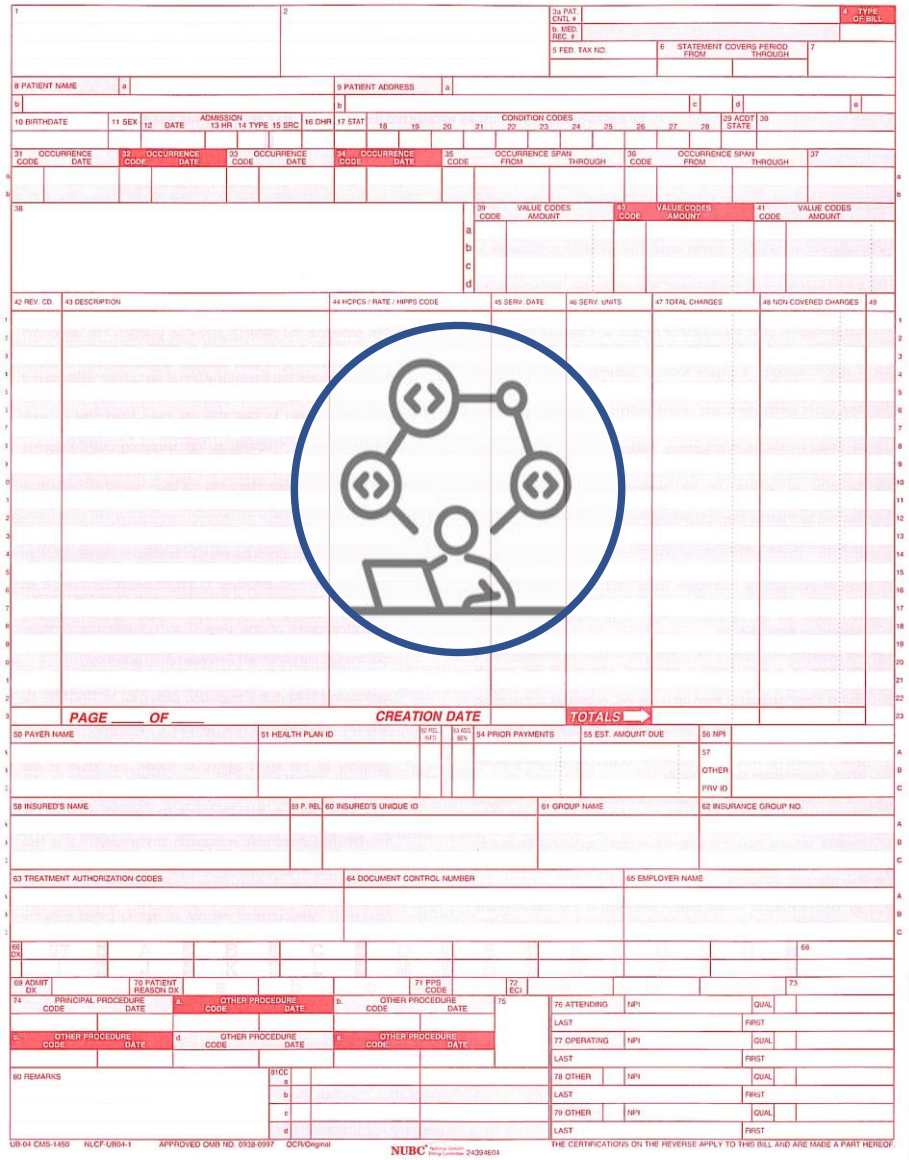
meets

“Logic-Check”

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



ZIMMET HEALTHCARE SERVICES GROUP, LLC

Patient Name

Facility

Hospital Stay

Revenue Code

Days / Units

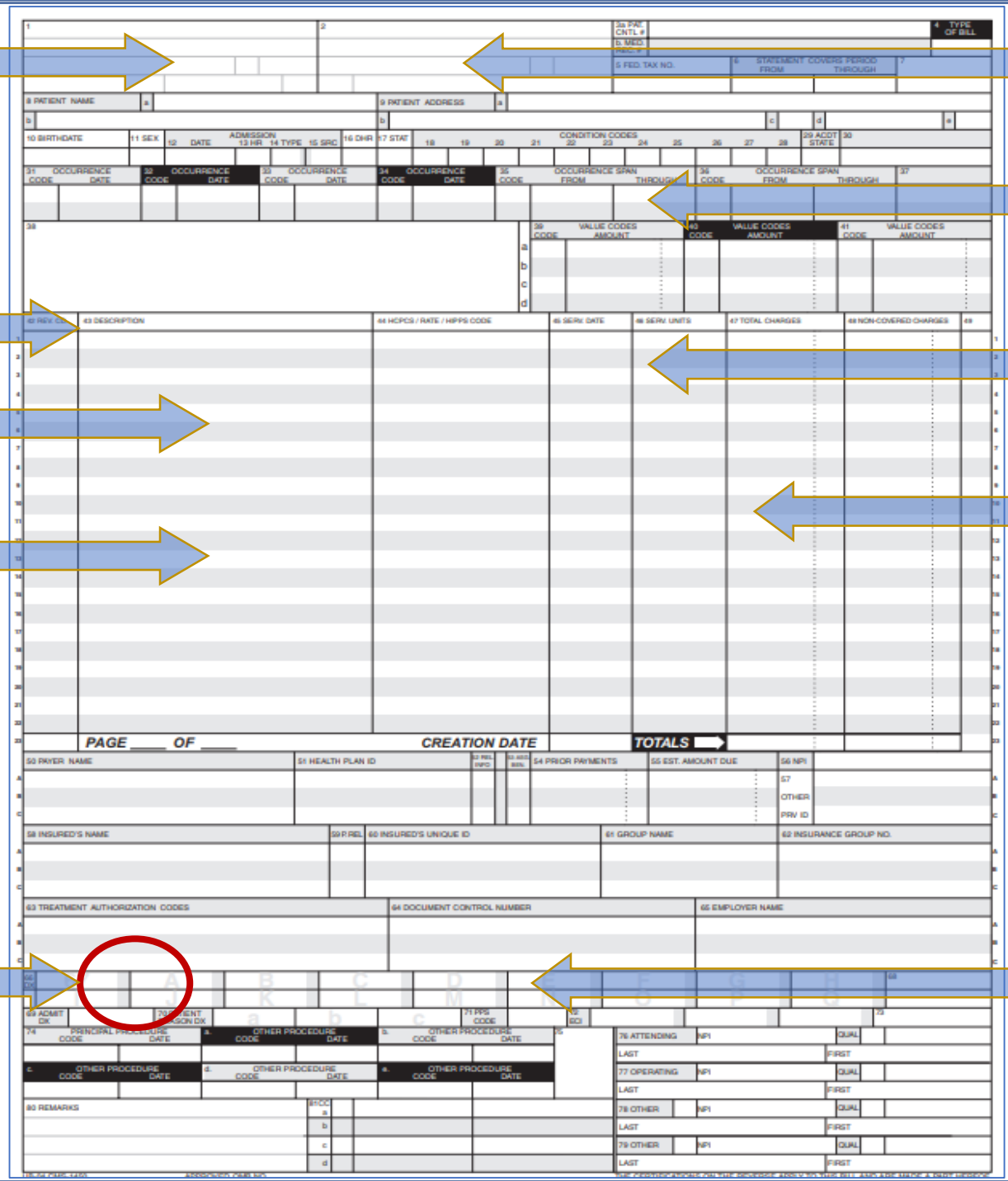
HIPPS Code

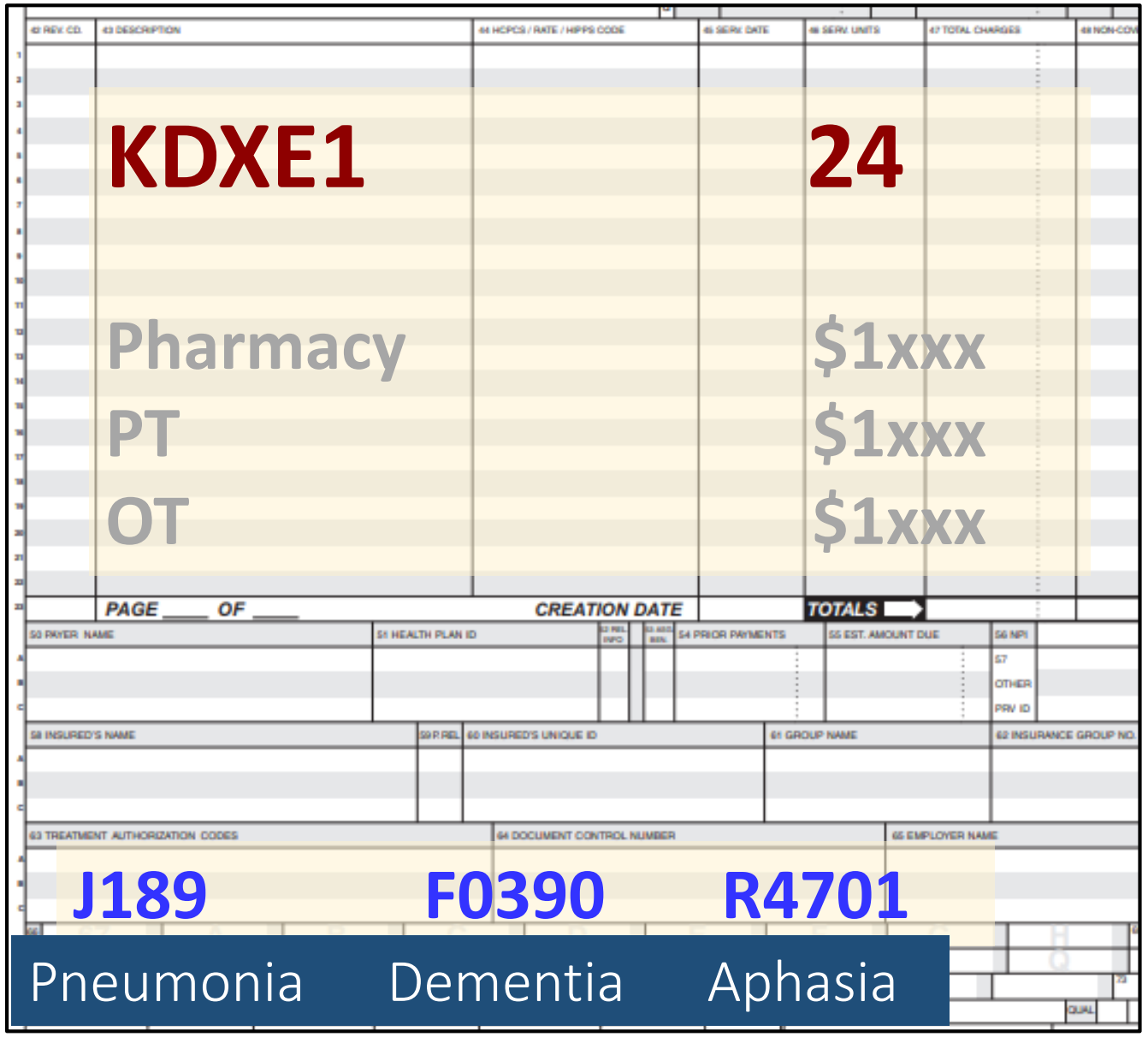
Charges

Ancillaries

Admit Dx

Secondary Dx





	HIPPS	Case Mix Group	
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

ZIMMET HEALTHCARE SERVICES GROUP, LLC

PDPM Composite Rate			$503.78
COMPONENT	**SCORE**	**DAY**	**RATE PPD**
PT / OT Component			**$179.43**
Medical Mgt.;10-23	TK	1 - 20	
SLP Component			**$33.11**
Any One, Neither, SD	SD		
Nursing Component			**$119.69**
AIDS Dx: No	PBC1		
NTA Component			**$76.71**
Points: 1	NE	4 - 100	
Non-Case Mix Component			**$94.84**

PDPM Composite Rate			$557.78
COMPONENT	**SCORE**	**DAY**	**RATE PPD**
PT / OT Component			**$179.43**
Medical Mgt.;10-23	TK	1 - 20	
SLP Component			**$64.86**
Any Two, Either, SH	SH		
Nursing Component			**$141.93**
AIDS Dx: No	CBC1		
NTA Component			**$76.71**
Points: 1	NE	4 - 100	
Non-Case Mix Component			**$94.84**

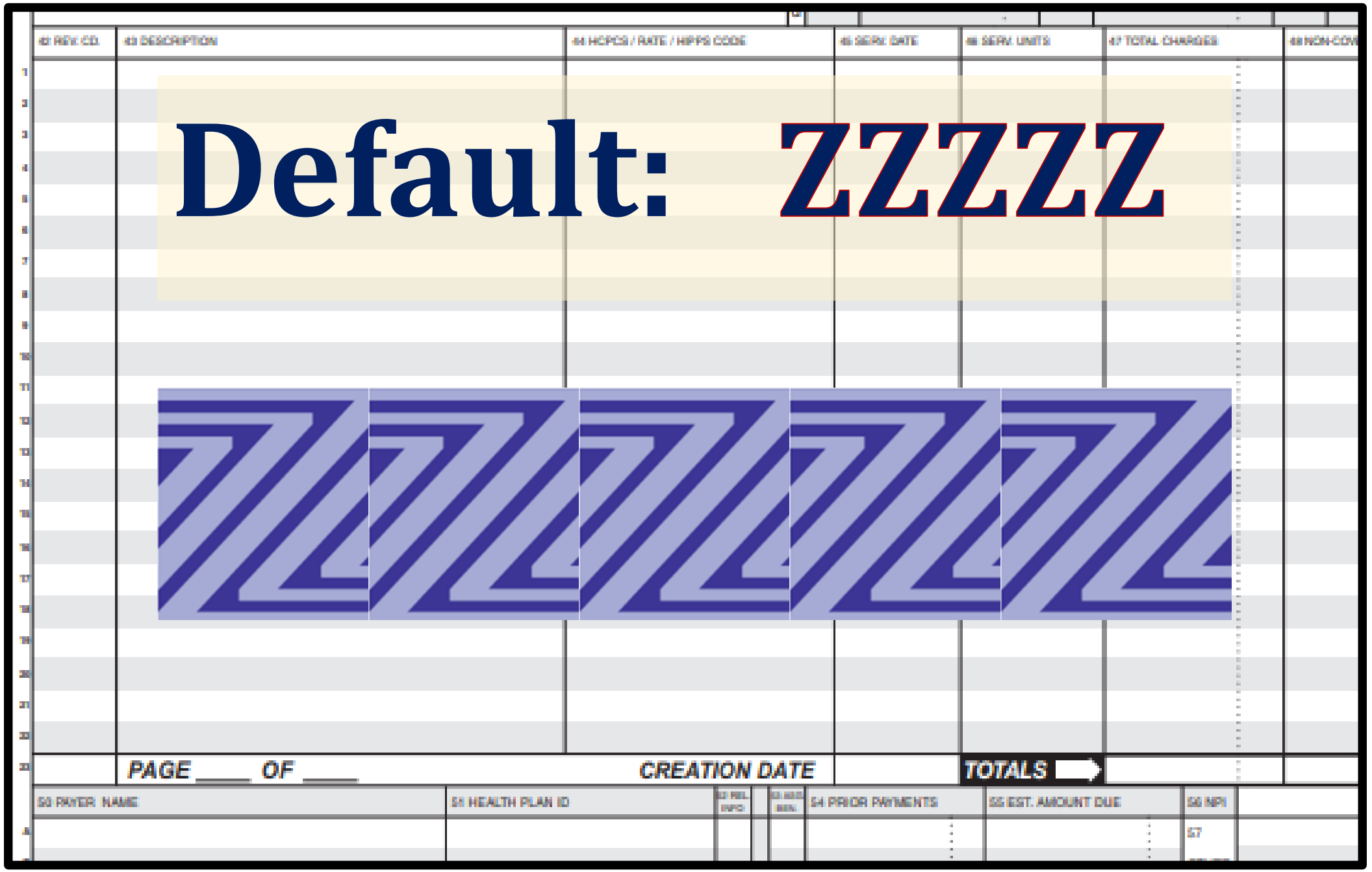
ZIMMET HEALTHCARE SERVICES GROUP, LLC

Date Range: 10/01/2019 to 10/31/2019

Probability: High 7 Medium 1 Low 4

Resident	Admit Date	Logic Test Trigger(s)	Rate Component	Billed Score	Issue/Explanation	Potential Score	Days	Total	Assessment Type	Resolution
Allen, Michael	10/05/2019	M9701XD	PT / OT	J	Primary dx supports major joint rep / spinal surgery category	B	27	$857	5-day	Issue Corrected
Ellen, Paige	10/15/2019	E11621, G35	NTA	F	Diabetes and Multiple Sclerosis dx coded (4 NTA points)	D	15	$1,218	5-day	Issue Corrected
Jones, Richard	10/01/2019	J441, J449	Nursing	X	COPD dx reported - review for shortness of breath while lying flat	G	31	$2,759	5-day	IPA Initiated
Klein, Matthew	10/02/2019	F039, R1310	SLP	A	Dementia and Dysphagia dx coded	H	30	$1,710	5-day	Issue Corrected
Stevens, Wilma	10/20/2019	IV Medications	Nursing	Y	IV Medications reported	Q	12	$420	5-day	Issue Corrected
Stevens, Wilma	10/20/2019	IV Medications	NTA	E	IV Medications reported	D	12	$633	IPA	IPA Initiated

CORE analytics


42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COV
Default:
ZZZZZ
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57

Anyone else *interested* in your Reimbursement?

SNF Value-Proposition

ZIMMET HEALTHCARE SERVICES GROUP, LLC

- 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

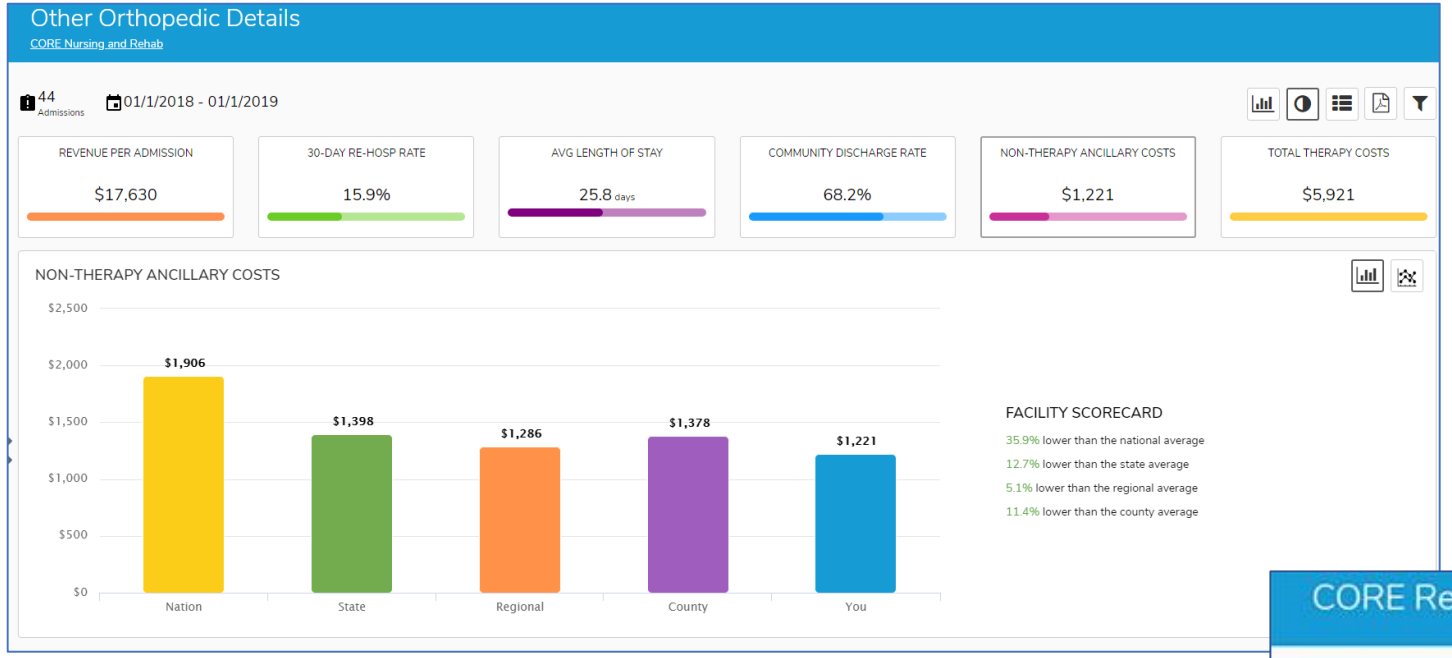
ZIMMET HEALTHCARE SERVICES GROUP, LLC

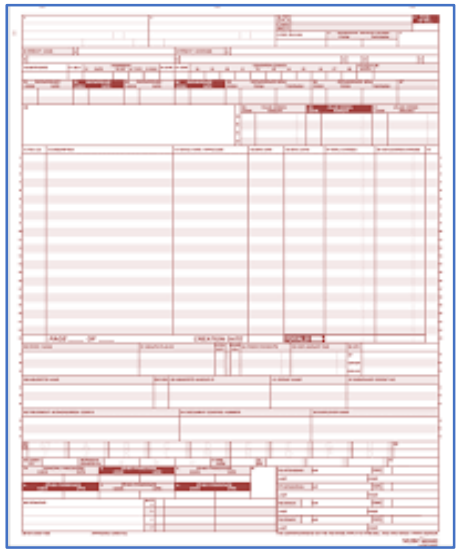
- "Technology Fatigue" & Return on Investment
- IT integration, "scrubbers" and EMR monitoring
- Specific PDPM functionality:
  - Component $ offset issues
  - Initial data capture – IPA monitoring (gross v. net)
  - Support for emerging outsourced models
  - IT integration, "scrubbers," EMR, billing,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

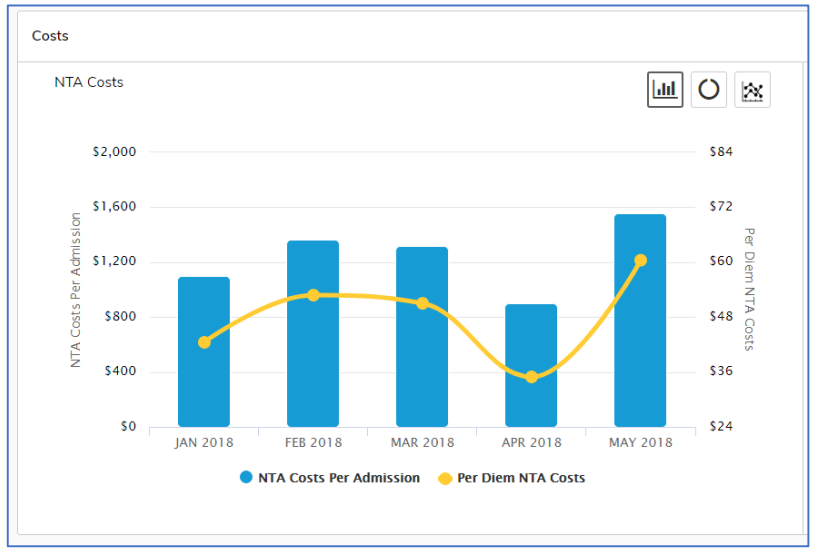
Utilization and expense data should be benchmarked by PDPM Component against peers

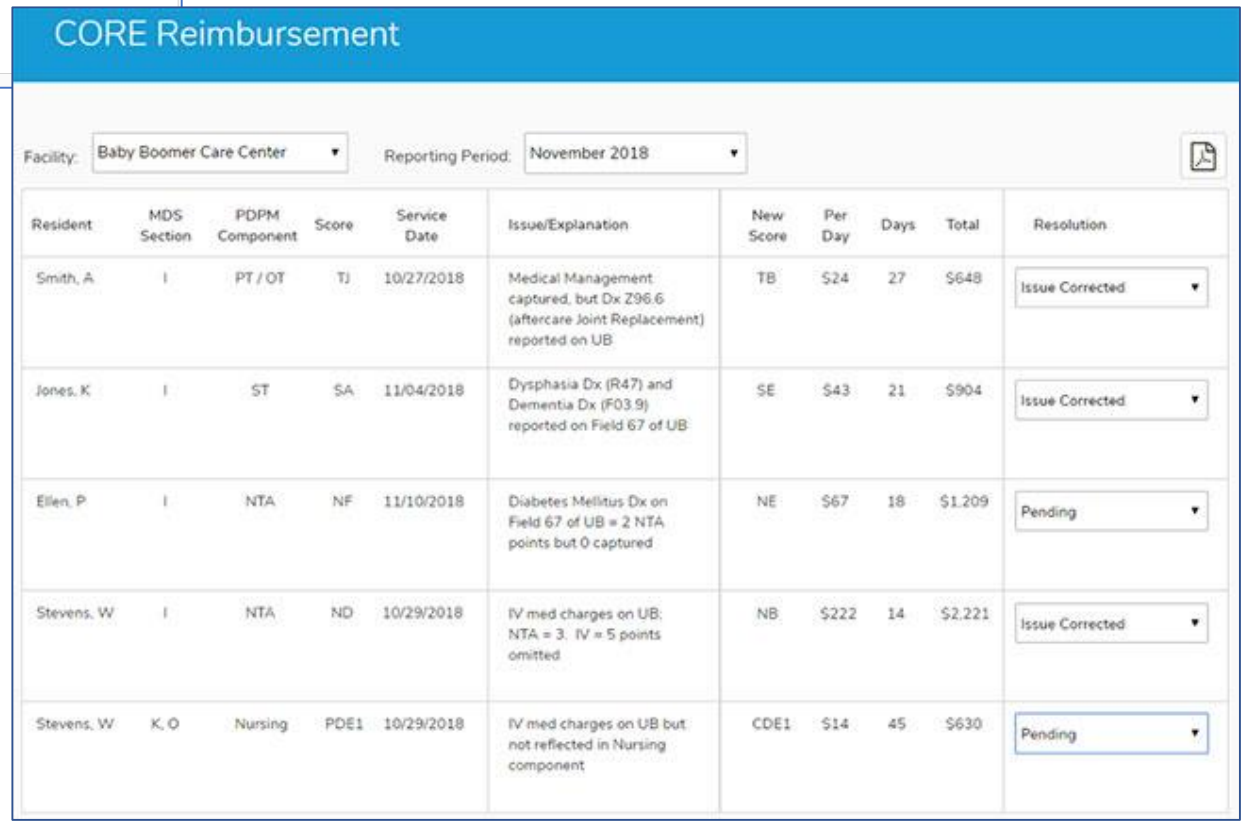
Statistically valid UB-04 "Logic Tests" can reveal lost $

Ancillary (NTA) Expense / Charge data per PDPM category is essential









Resident	MDS Section	PDPM Component	Score	Service Date	Issue/Explanation	New Score	Per Day	Days	Total	Resolution
Smith, A	I	PT / OT	TJ	10/27/2018	Medical Management captured, but Dx Z96.6 (aftercare Joint Replacement) reported on UB	TB	$24	27	$648	Issue Corrected
Jones, K	I	ST	SA	11/04/2018	Dysphasia Dx (R47) and Dementia Dx (F03.9) reported on Field 67 of UB	SE	$43	21	$904	Issue Corrected
Ellen, P	I	NTA	NF	11/10/2018	Diabetes Mellitus Dx on Field 67 of UB = 2 NTA points but 0 captured	NE	$67	18	$1,209	Pending
Stevens, W	I	NTA	ND	10/29/2018	IV med charges on UB: NTA = 3. IV = 5 points omitted	NB	$222	14	$2,221	Issue Corrected
Stevens, W	K, O	Nursing	PDE1	10/29/2018	IV med charges on UB but not reflected in Nursing component	CDE1	$14	45	$630	Pending

Financial Reports

FILTER | Demo Facility A | BACK TO REPORTS MENU

Filter

As Of Date: 10/08/2019

Facility: Demo Facility A

Unit: Select

Payer: Select

APPLY

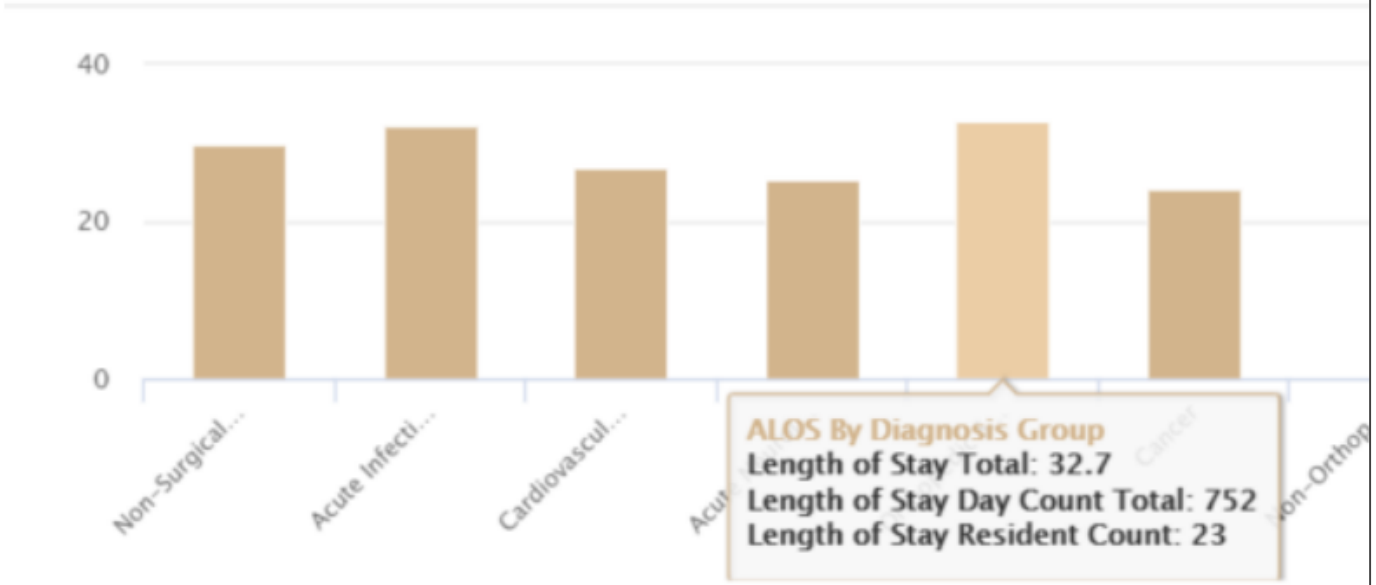
PDPM Complete — Detail Date: 09/05/2019 — Search

Resident: Daggy, Rose (10012019) — **Unit:** Two A **Room Bed:** 207-A

Admit Date: 10/01/2019 — **Payer:** Medicare A

Section	MDS Item	Condition/Description	Date Found	Location Found	Notes
Section C	C0700	Staff Assessment Memory	10/3/2019	Mapped UDA	Proposed MDS Answer: Memory problem
	C1000	Skills for Descision Making	10/3/2019	Mapped UDA	Proposed MDS Answer: Moderately Impaired
Section E	E0200A	Physical Behavior towards others	10/2/2019	Keyword	Cursing - Received Mrs. Daggy alert and oriented to person only. She refused am meds x3 attempts. During am care she was Cursing and ***hitting staff***. Her behavior was redirected when care stopped. F/C patent and intact draining amber colored urine.
	E0200B	Verbal Behavior towards others	10/2/2019	Keyword	Cursing - Received Mrs. Daggy alert and oriented to person only. She refused am meds x3 attempts. During am care she was ***Cursing*** and hitting staff. Her behavior was redirected when care stopped. F/C patent and intact draining amber colored urine.
Section I	I6200	Asthma, COPD, Chronic	10/1/2019	Resident Diagnosis	J44.9
	I6300	Respiratory Failure	10/1/2019	Resident Diagnosis	J96.21
	I8000	Active Diagnoses	10/1/2019	Resident Diagnosis	J96.21 - Acute and chronic respiratory failure with hypoxia NTA - Cardio-Respiratory Failure and Shock
Section K	K0510C2	Mechanically Altered Diet	10/1/2019	Mapped UDA	
Section N	N0350A	Insulin Injections	10/1/2019	Pharmacy Order	NovoLOG FlexPen Solution Pen-injector 100 UNIT/ML Insulin Aspart
Section O	O0100C2	Oxygen Therapy	10/1/2019	Keyword	Oxygen - Received patient in bed, observed to be breathing evenly and unlabored with ***Oxygen*** 2 L continuous. Pt had no signs of pain or discomfort, administered all due meds which was tolerated well. Safety precaution in place with bed at lowest position, 2 side rails up and call light is within reach.
	O0100H2	IV Medications	10/1/2019	Pharmacy Order	Venofer Solution 100 MG/100ML Iron Sucrose 200mg = 200ml anemia
	O0100I2	Transfusion	10/1/2019	Other Order	Transfuse 1 unit PRBC ASAP for decreasing hgb
	O0100M2	Isolation	10/3/2019	Keyword	Isolation - Dr. Anderson aware of UA/CS. No new orders given. Per MD, continue ***Isolation*** .
	O0400D2	Respiratory Therapy for 7 days	10/1/2019	Keyword	Nebulizer - Hydroxide)Give 30 ml by mouth every 24 hours as needed for ConstipationIpratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML1 vial inhale orally via

Average Length of Stay By Diagnosis - Last 12 Months



Real Time MEDICAL SYSTEMS

Compliance & Potential Audit Focus Areas

ZIMMET HEALTHCARE SERVICES GROUP, LLC

- 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

ZIMMET HEALTHCARE SERVICES GROUP, LLC

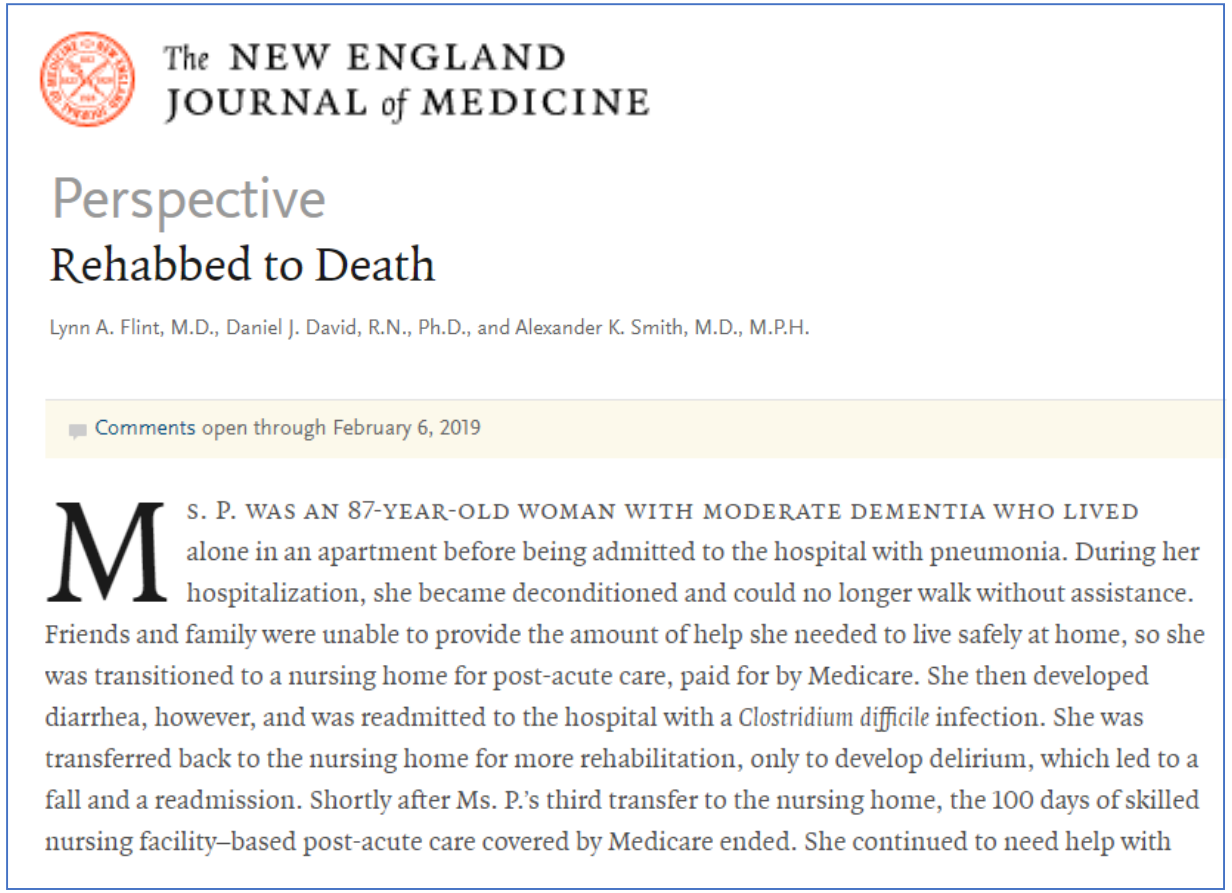
- New Professionals (& risk) on the Reimbursement team
  - Physicians
  - Medication admin.
  - Primary for skilled care
  - Dietician
  - Respiratory Therapy
  - Depression
  - Active Diagnosis

- 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

ZIMMET HEALTHCARE SERVICES GROUP, LLC

- Excess therapy v. rationing
  - Changes in treatment patterns
  - Implications post-discharge
- Indemnity
- “Expected” hours
- 5-Star
- Quality Reporting
- Capture & Care Planning



The NEW ENGLAND JOURNAL of MEDICINE

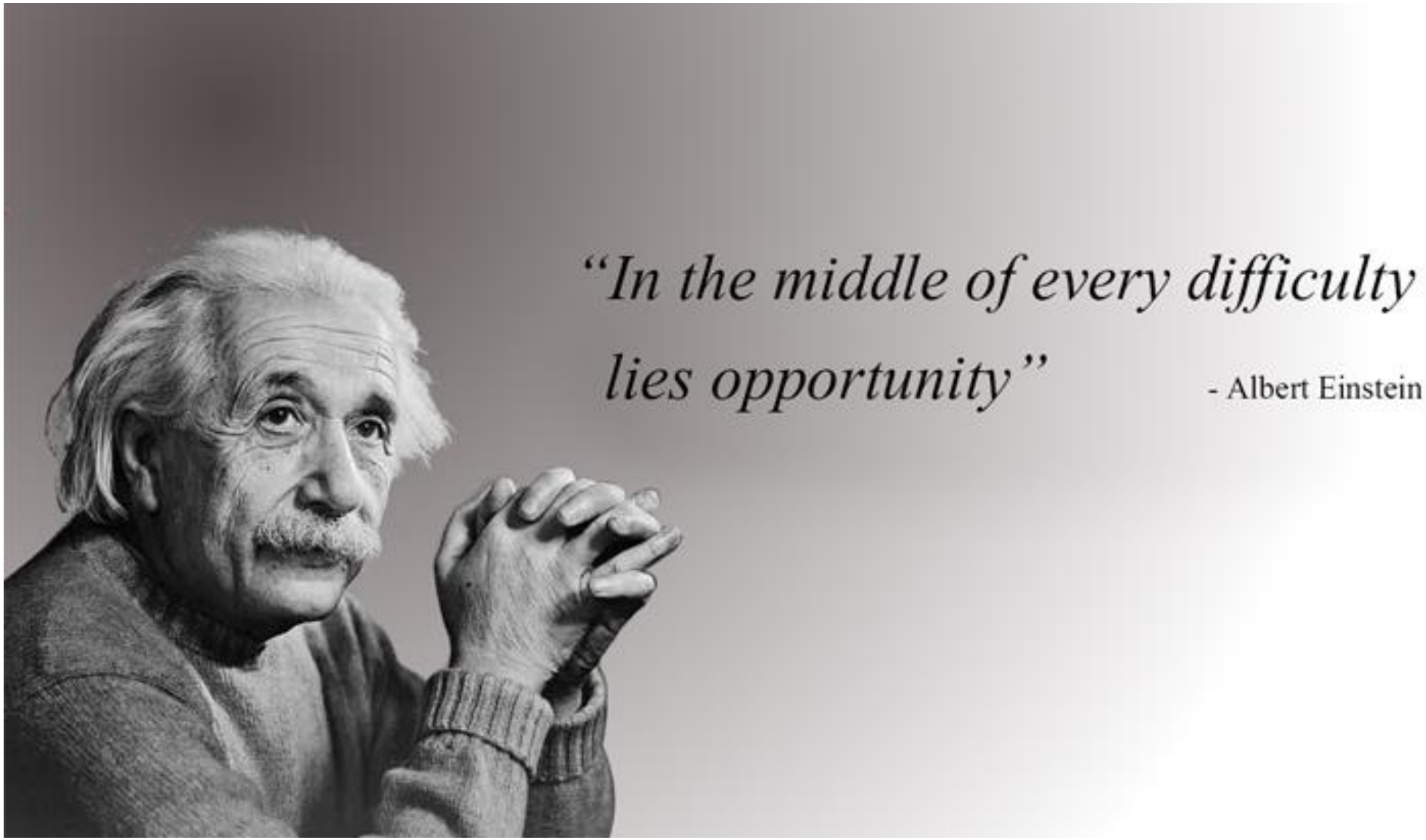
Perspective

Rehabbed to Death

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

Comments open through February 6, 2019

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.

ZIMMET HEALTHCARE
SERVICES GROUP, LLC

2019

PDPM Workflow Process

Pre-Admission

Receive Referral from Hospital.
Request Hospital Documentation.

Hospital Documentation
to RN for Review.

RN Reviews Documentation and
Makes 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.

→ Section GG to be Completed by End of Day 3.

MDS Coordinator Reviews Dx and
ICD-10 Coding by End of Day 6.

→ MDS Coordinator will Work with IDT Team to Assure that Any Dx Identified but not in the Record are Put in the Record.

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

PDPM Huddle

- 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

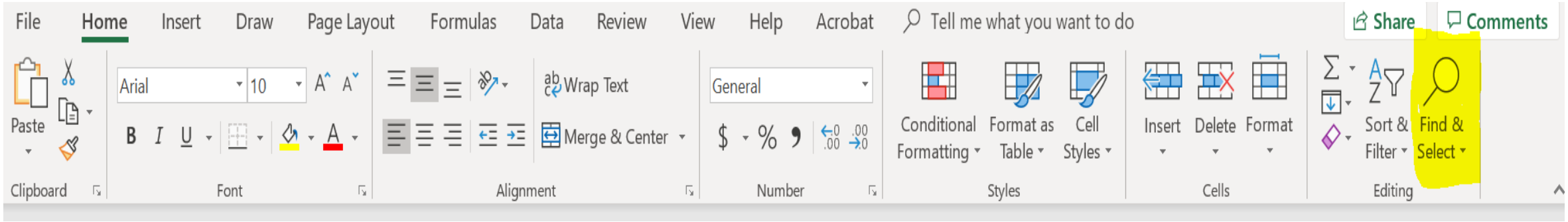
ICD 10 Coding

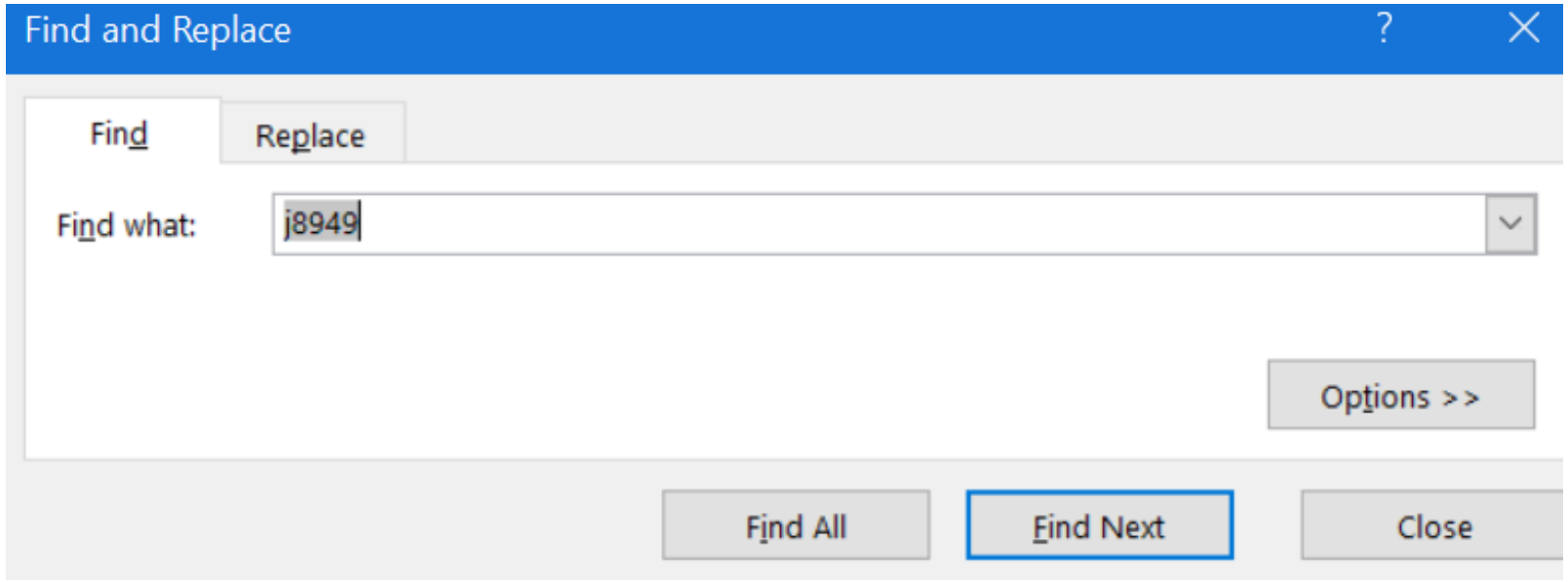
Section I Coding

- 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

Searching the CMS Mapping Tools

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

PT / OT Function Score Construction		
Response		**Score**
05, 06	Set-up assistance, Independent	4
04	Supervision or touching assistance	3
03	Partial / moderate assistance	2
02	Substantial / maximal assistance	1
01, 07, 09, 88	Dependent, Refused, N/A, Not Attempted	0
01, 07, 09, 88	Walking items only: Dependent, Refused, N/A, Not Attempted, Resident Cannot Walk*	0

**Coded based on response to GG0170H1 (Does the resident walk?)*

PDPM – GG Offset

Section GG Item		Coding	Score
GG0130A1 Self Care:	Eating	Set-up	4
GG0130B1 Self Care:	Oral Hygiene	Set-up	4*
GG0130C1 Self Care:	Toileting Hygiene	Refused	0
GG0170B1 Mobility: GG0170C1 Mobility:	Sit to lying Lying to sitting on side of bed	Sub/Max Assist Sub/Max Assist	1
GG0170D1 Mobility: GG0170E1 Mobility: GG0170F1 Mobility:	Sit to stand Chair/bed-to-chair transfer Toilet transfer	Sub/Max Assist Sub/Max Assist Refused	1
GG0170J1 Mobility: GG0170K1 Mobility:	Walk 50 feet with 2 turns Walk 150 feet	Partial/Mod Assist Partial/Mod Assist	2*
PT/OT Function Score: 12		Nursing Function Score: 6	
TK: $175.23		CBC1: $138.64	
		Total: $313.87	

PDPM – The Good

Section GG Item		Coding	Score
GG0130A1 Self Care:	Eating	Supervision	3
GG0130B1 Self Care:	Oral Hygiene	Set-up	4*
GG0130C1 Self Care:	Toileting Hygiene	Refused	0
GG0170B1 Mobility: GG0170C1 Mobility:	Sit to lying Lying to sitting on side of bed	Sub/Max Assist Sub/Max Assist	1
GG0170D1 Mobility: GG0170E1 Mobility: GG0170F1 Mobility:	Sit to stand Chair/bed-to-chair transfer Toilet transfer	Sub/Max Assist Sub/Max Assist Refused	1
GG0170J1 Mobility: GG0170K1 Mobility:	Walk 50 feet with 2 turns Walk 150 feet	Partial/Mod Assist Partial/Mod Assist	2*
PT/OT Function Score: 11		Nursing Function Score: 5	
TK: $175.23		CBC1: $167.60	
		Total: $342.83	

PDPM – The Bad

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

PDPM Cognitive Measure Classification Methodology		
Cognitive Level	**BIMS Score**	**CPS Score**
Cogntively Intact	13 - 15	0
Mildly Impaired	8 - 12	1 - 2
Moderately Impaired	0 - 7	3 - 4
Severely Imparied	-	5 - 6

Cognitive Impairment

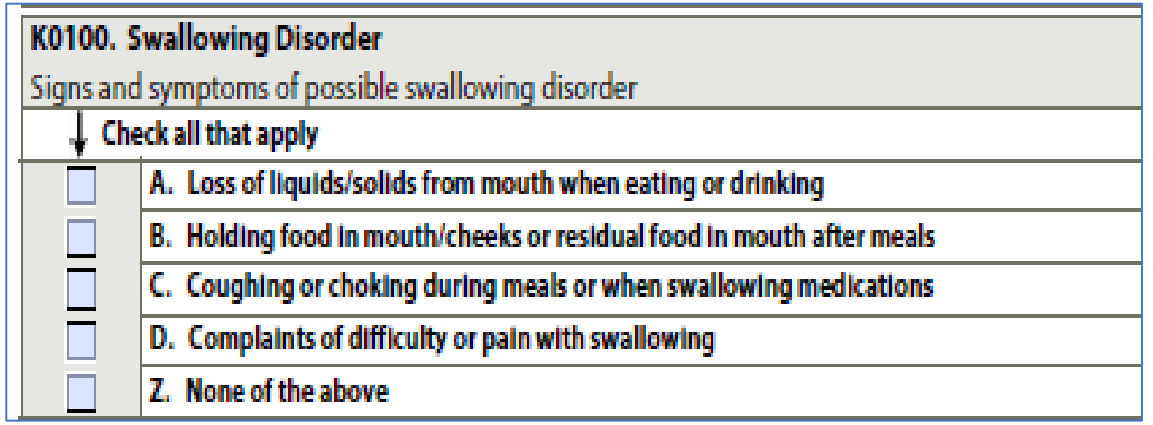
Proper Identification of cognitive impairment (CI) is key to clinical and financial success

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



K0100. Swallowing Disorder Signs and symptoms of possible swallowing disorder	
Check all that apply	
☐	A. Loss of liquids/solids from mouth when eating or drinking
☐	B. Holding food in mouth/cheeks or residual food in mouth after meals
☐	C. Coughing or choking during meals or when swallowing medications
☐	D. Complaints of difficulty or pain with swallowing
☐	Z. None of the above

Refer to:

- Nursing notes
- Speech Therapist Notes
- Patient, family or caregiver information
- Hospital records

ZIMMET HEALTHCARE SERVICES GROUP, LLC

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

K0510. Nutritional Approaches

Check all of the following nutritional approaches that were performed during the last **7 days**

	1. While NOT a Resident	2. While a Resident
1. While NOT a Resident Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank **2. While a Resident** Performed ***while a resident*** of this facility and within the ***last 7 days***	↓ Check all that apply ↓	
A. Parenteral/IV feeding	☐	☐
B. Feeding tube - nasogastric or abdominal (PEG)	☐	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)		☒
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)		☐
Z. None of the above	☐	☐

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*						Function Score: GG	Secondary End Split	RUG	CMI
EXTENSIVE SERVICES								*Urban Set*	
Tracheostomy care	O0100E	----- *AND* -----		Ventilator / Respirator	O0100F	0 - 14	Not Used	ES3	4.06
Tracheostomy care	O0100E	----- *OR* -----		Ventilator / Respirator	O0100F	0 - 14	Not Used	ES2	3.07
Isolation for active infectious disease	O0100M					0 - 14	Not Used	ES1	2.93
SPECIAL CARE HIGH (any one of these is a qualifier)									
Comatose (fully dep)	B0100	Fever with one of:	J1550A	Parenteral/IV feedings	K0510A	0 - 5	Depression	HDE2	2.40
Septicemia	I2100	Pneumonia	I2000	Respiratory Tx, 7 days	O0400D	0 - 5		HDE1	1.99
Diabetes with:	I2900	Vomiting	J1550B	COPD with:	I6200	6 - 14	Depression	HBC2	2.24
Daily insulin inj. &	N0300A	Feeding Tube	K0510B	Shortness of breath when lying flat	J1100C	6 - 14		HBC1	1.86
Insulin order change	N0350B	Weight loss	K0300	Quad as prim. (GG <12)	I5100	***Depression = MDS Section D PHQ***			

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

Cerebral Palsy (GG < 12)	I4400	Pressure Ulcers w/ Tx:		Radiation therapy^	O0100B2	0 - 5	Depression	LDE2	2.08
Multiple Scler (GG < 12)	I5200	> 1 Stage II	M0300B	Resp failure & Oxy Tx^	I6300, O0100C2	0 - 5		LDE1	1.73
Parkinson's (GG < 12)	I5300	Any Stage III/IV	M0300C,D	Dialysis^	O0100J2	6 - 14	Depression	LBC2	1.72
Foot infection	M1040A	2 or more skin Tx w/:	M1200	Diabetic Foot Ulcer	M1040B	6 - 14		LBC1	1.43
Feeding tube *	K0510B	>1 ven/art ulcers; or	M1030	Foot lesions w/ Tx	M1040C; M1200I				
** = calories ≥ 51% or*		1 Stage 2 pres ulcer &	M0300B	*^ = while a resident*					
26-50% & & fluid ≥ 501cc		1 venous/arterial ulcer	M1030	***Depression = MDS Section D PHQ***					

CLINICALLY COMPLEX (any one of these is a qualifier)

Extensive Services, Special Care High or Special Care Low qualifier with GG Function Score = 15 - 16						0 - 5	Depression	CDE2	1.87
Pneumonia	I2000	Chemotherapy^	O0100A2	Burns	M1040F	0 - 5		CDE1	1.62
Hemi-plegia/paresis*	I4900	IV medications^	O0100H2	** = GG score < 12*		6 - 14	Depression	CBC2	1.55
Surgical wounds**	M1040E	Transfusions^	O0100I2	*** = with treatment*		15 - 16	Depression	CA2	1.09
Open lesions**	M1040D	Oxygen therapy^	O0100C2	*^ = while a resident*		6 - 14		CBC1	1.34
				Depression = MDS Section D PHQ		15 - 16		CA1	0.94

BEHAVIORS & COGNITIVE PERFORMANCE								
Cognitive impairment BIMS score ≤ 9 or CPS ≥ 3 OR			*Sections B, C, E*		11 - 16	RNP	BAB2	1.04
Hallucinations or delusions E0100 OR Physical or verbal behavioral sympto			*GG < 11, go to Physical scores*		11 - 16		BAB1	0.99
toward others, Other behavioral symptoms, Rejection of care, or Wandering			E0800, E0900					
PHYSICAL FUNCTION REDUCED								
No other qualifiers; Restorative Nursing Programs (RNPs); 2 or more 6+ days/wk					0 - 5	RNP	PDE2	1.57
Urinary and/or bowel toileting	H0200C, H0500	Walking training		O0500F	0 - 5		PDE1	1.47
Passive and/or Active ROM	O0500 A,B	Dressing and/or grooming training		O0500G	6 - 14	RNP	PBC2	1.22
Splint or brace assistance	O0500C	Eating and/or swallowing training		O0500H	15 - 16	RNP	PA2	0.71
Bed mobility training	O0500D	Amputation/prostheses care		O0500I	6 - 14		PBC1	1.13
Transfer training	O0500E	Communication training		O0500J	15 - 16		PA1	0.66

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 $\geq$ 40, or $\geq 35 + \mathrm{HTN/DM}$)
  - Pulmonary Fibrosis and Other Chronic Lung Disorders

PDPM Assessment Schedule

Medicare MDS Type	Assessment Reference Date	Effective Payment
5-day Scheduled PPS Assessment	Days 1 - 8 ("Grace Days" no longer distinguished)	All covered days until Part A discharge (unless IPA is completed)
Interim Payment Assessment (IPA)	OPTIONAL: No later than 14 days after qualifying change is identified	IPA ARD through Part A discharge (unless another IPA is completed)
PPS Discharge Assessment	End Data of Most Recent Medicare Stay (A2400C) or End Date	N/A

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

Interrupted Stay Policy

Residents discharged from and return to same SNF by 12am of the end of third day of "interruption window",

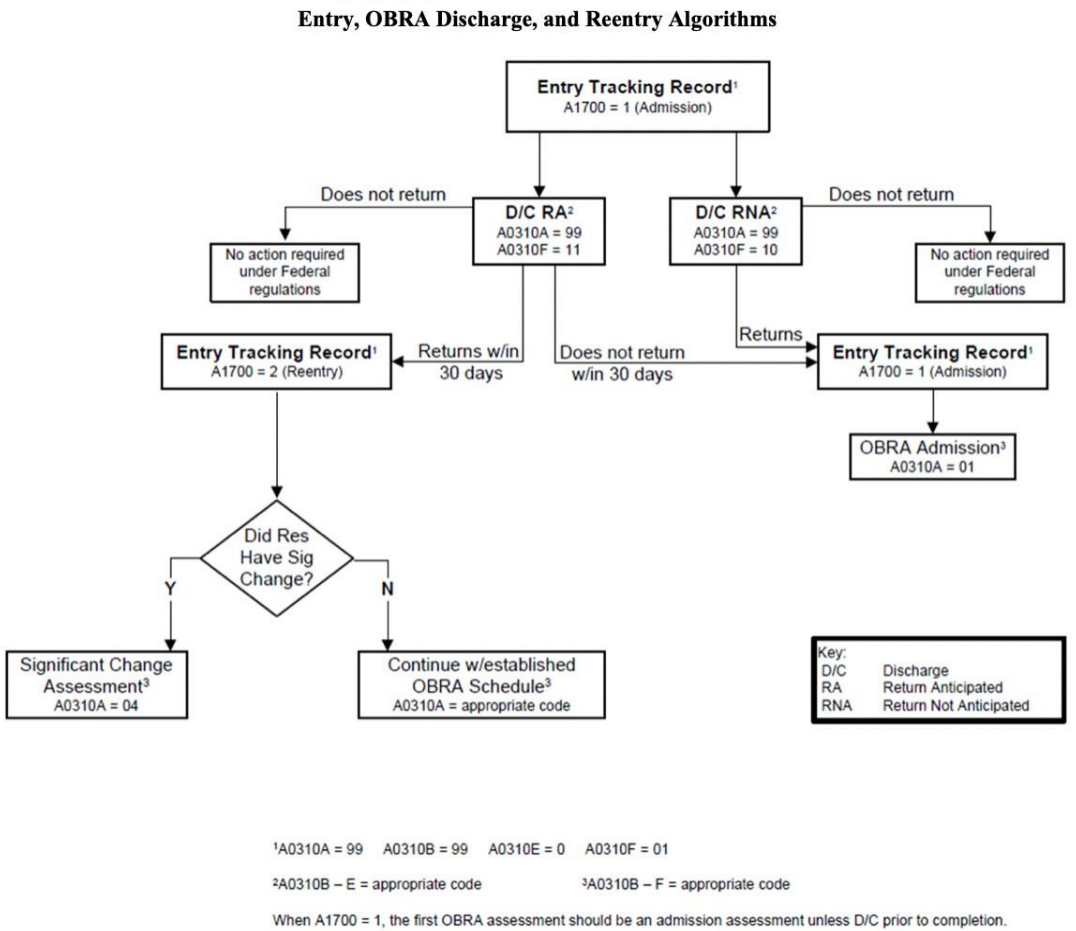
Composite & VPDA continue unchanged

Interim Payment Assessment Management

- 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

- Evaluate / enhance clinical competencies
- Policies and Procedures
- Clinical Pathways

Using EMR technology integration

ZIMMET HEALTHCARE SERVICES GROUP, LLC

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?

September 2019

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

PDPM Transitional IPA Planning

- 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

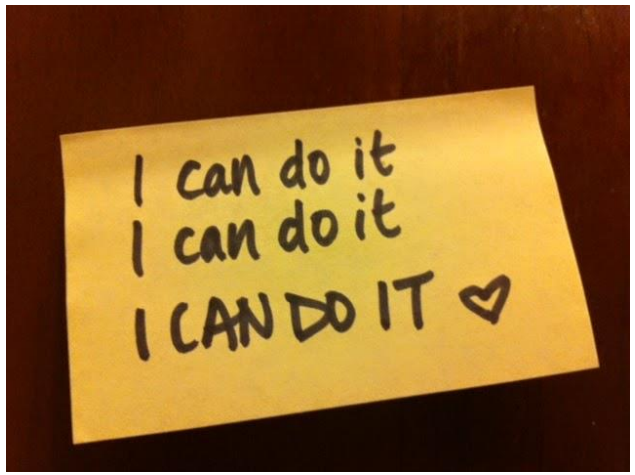
Admission Date	Option 1	Option 2
9/23/19 or earlier	Follow RUG protocols including COT, EOT as appropriate	
9/24/2019	Eval & Treat on Day 1 no therapy on weekend unless needed	Eval & Treat on Day 2 provide therapy on Saturday OR Sunday
9/25/2019	Eval & Treat on Day 1 provide therapy on Saturday OR Sunday	Eval & Treat on Day 2 provide therapy on Saturday AND Sunday
9/26/2019	Must Eval & Treat on day of admission and then consecutively for 4 days (Saturday AND Sunday) for ARD 9/30/19 to capture Rehab RUG	
9/27 - 9/30/19	Provide therapy at PDPM Protocols	

Transitional IPA Planning: What are you trying to capture? Look-back and assessment periods may extend back into September

Transitional IPA ARD	GG Collection Start Date	Earliest BIMS or Cognitive Assessment Completion	Earliest PHQ-9 or Staff Assessment of Mood Completion	IV Fluids Last Administration Date	Pressure Ulcers or Other Skin Issues w/ Treatment	Documentation of Diagnoses	Respiratory Treatments	Restorative Nursing	Earliest Date of MDS Section O Treatments
10/1/19	9/29/19	9/25/19	9/25/19	9/25/19	9/25/19	9/25/19	9/25/19	9/26/19	9/18/19
10/2/19	9/30/19	9/26/19	9/26/19	9/26/19	9/26/19	9/26/19	9/26/19	9/27/19	9/19/19
10/3/19	10/1/19	9/27/19	9/27/19	9/27/19	9/27/19	9/27/19	9/27/19	9/28/19	9/20/19
10/4/19	10/2/19	9/28/19	9/28/19	9/28/19	9/28/19	9/28/19	9/28/19	9/29/19	9/21/19
10/5/19	10/3/19	9/29/19	9/29/19	9/29/19	9/29/19	9/29/19	9/29/19	9/30/19	9/22/19
10/6/19	10/4/19	9/30/19	9/30/19	9/30/19	9/30/19	9/30/19	9/30/19	10/1/19	9/23/19
10/7/19	10/5/19	10/1/19	10/1/19	10/1/19	10/1/19	10/1/19	10/1/19	10/2/19	9/24/19

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
- 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
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.
CORE
analytics
ZIMMET HEALTHCARE
SERVICES GROUP, LLC
Real Time
MEDICAL SYSTEMS

Medicare Part A
SNF Payment Reform

Thank You!!!

The Final Countdown to PDPM

September 18, 2019

ZIMMET HEALTHCARE SERVICES GROUP, LLC

www.zhealthcare.com

(877) SNF-2001

Guiding SNFs through complex payment reform for over 25 years