Challenges and Projections Related to PDPM in 2024

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Kay is a seasoned Senior Consultant for LW Consulting, Inc. with more than thirty-five years of healthcare industry experience, specializing in geriatric rehabilitation in skilled nursing and outpatient rehabilitation across the continuum of care.

She has a proven record of accomplishing excellent customer service, managing operations with strong performance metrics, and developing creative programs while maintaining appropriate compliance monitoring for Medicare and regulatory requirements. She regularly joins the nurses to teach about the MDS components and how therapy and nursing should work together for optimal performance.

Kay presented at the HCCA National Conference in April of 2023, and LifeSpan in the Fall of 2023. She has conducted webinars to meet CMS requirements regarding MDS changes and has extensive experience providing individualized training to physicians and staff to reinforce audit findings.

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Objectives

- Outline root causes of increased scrutiny for PDPM to help listeners know why CMS is doing what they are doing
- Discuss projections for CMS review the remainder of the year
- Visit recommendations for internal monitoring to minimize the impact of CMS reviews

What is PDPM?

- Patient Driven Payment Model
- Reimbursement for Medicare Part A
- Replaced the RUG IV PPS based reimbursement
- Initiated October 1, 2019

AUDITS, AUDITS, and MORE AUDITS

Starting in 2023 and continuing into 2024, CMS is performing audits on Medicare Part A claims.

Ultimate Reason for Audits

- Recoup Medicare dollars
- Ensure documentation supports requirements in the regulations
  - Medicare Benefit Policy Manual (MBPM)
  - Medicare Program Integrity Manual (MPIM)
  - Medicare Claims Processing Manual

Why the increase in audits?

- Impact of COVID
  - Medicare Part A-
    - Removal of the 3-Day Qualifying Hospital Stay (QHS)
    - Allowed “skill in place” during the PHE
  - Medicare Part B- no audits during the PHE

More Reasons for the increase in audits…

- Changes in error rates for PDPM
  - The CERT program projected an improper payment rate of 15.1% for SNF services in 2022, up from 7.79% in 2021.

- Cracking down on medical necessity and reasonable and necessary skilled care
  - LOS impact

Increased Scrutiny by CMS Common Audit Types

- TPE audits = Targeted Probe and Educate
  - Completed by the MAC
- SPE audits = Skilled Nursing Facility 5-Claim Probe and Educate Review
  - Completed by the MAC

Increased Scrutiny by CMS Common Audit Types

- SMRC audits = Supplemental Medical Review Contractor
  - Noridian Healthcare Solutions is the SMRC
- RAC audits = Recovery Audit Program
  - Performant Recovery, Inc. or Cotiviti, LLC are the RAC auditors

Increased Scrutiny by CMS Common Audit Types

- CERT = Comprehensive Error Rate Testing
  - Completed by your MAC
- UPIC audits = Unified Program Integrity Contractor
  - Program Safeguard Contractor (PSC)

Summary of Medical Review Types

Review Entity	Pre-Pay	Post-Pay
MAC – Medicare Administrative Contractors	X	X
SMRC – Supplemental Medical Review Contractor	X	X
RAC – Recovery Audit Contractors		X
CERT – Comprehensive Error Rate Testing		X
UPIC – Unified Program Integrity Contractors (formerly ZPIC/PSC and MIC)	X	X

Changes in Error Rates Under PDPM

How bad was the improper payment?

- The projected improper payment amount for SNF services during the 2023 report period was $4.8 billion, resulting in an improper payment rate of 13.8 percent.
- CMS is concerned about the error rate
  - Any error is counted regardless of the financial impact
  - i.e. An error in coding that does NOT change the HIPPS coding is still counted as an error!

Skilled Nursing Facility CERT Reports

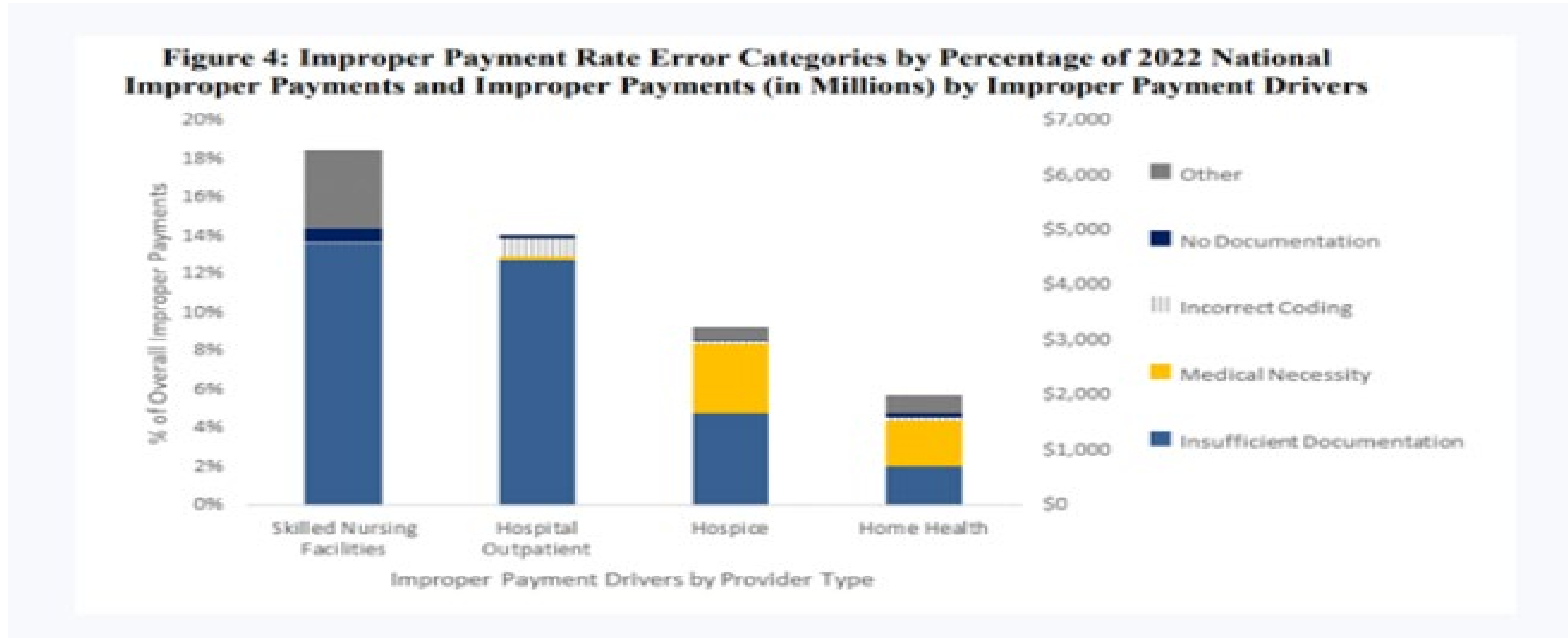
Top Root Causes for Skilled Nursing Facility	Error Category	Sample Claim Count **
HIPPS level changed based on documentation submitted*	Insufficient Documentation	195
Case Mix Group (CMG) component documentation – Missing	Insufficient Documentation	147
Physician's Certification/Recertification – Inadequate	Insufficient Documentation	85
Order – Missing	Insufficient Documentation	74
Nursing home records – Missing	Insufficient Documentation	62
Signature log to support a clear identity of an illegible signature – Missing	Insufficient Documentation	51
Physician's Certification/Recertification – Missing	Insufficient Documentation	39
Order – Inadequate	Insufficient Documentation	36
Physical/Occupational/Speech Therapy – Plan of care – Missing	Insufficient Documentation	26
HIPPS/RUG level in the repository does not match the RUG level billed	Other	18

* Root causes frequently associated with partial improper payments are identified.

** The root cause and error category with the highest sample claim count may not correspond with the top error category of improper payments for the drivers.

Source: 2023_medicare_fee-for-service_supplemental_improper_payment_data.pdf

Improper Payment Rate Errors-AHCA NACL



https://www.ahcancal.org/News-and-Communications/Blog/Pages/CMS-Initiates-National-SNF-5-Claim-Probe-and-Educate-Review.aspx

How do errors in PDPM compare with errors under the old RUG IV PPS based system?

- Under the RUG based system the most common error was therapy intensity not supported as reasonable or necessary.

- Rehab Ultra High was billed; however, documentation supported a lower RUG level

- OR skilled services were not supported, and the Length of Stay (LOS) was reduced.

The Impact of Errors under PDPM

- Although the error rate is higher, the dollar amount is reduced
- In LWCI statistics, the percent of overpayments = the percent of underpayments
- Reason for lower dollar impact
  - Miscoding in SLP and NTA cause underpayments
  - Average of each claim was less than $500.00 per claim

LWCI Statistics from PDPM Audits in 2023

Payment Error Percent	Overpayment Percentage	Underpayment Percentage	Total Overpayments	Total Underpayments
44%	11%	11%	$31,768.23	$15,045.62

- Note: The overpayment percentage = the underpayment percentage BUT, the dollar amount for overpayments exceeded the underpayment amount

LWCI Root Causes from PDPM Audits in 2023

Root Cause	Overall Percent
Malnutrition Diagnosis Not Documented by Physician	14%
Active Diagnosis Coding Inaccurate (NTA and SLP)	13%
Section GG Coding Not Supported by Documentation	10%
Special Treatment are Not Properly Coded	5%
Shortness of Breath Coding Not Supported by Documentation	5%
BIMS Conducted after ARD; Resident Scored as Cognitively Intact	4%
Primary Diagnosis Inaccurate	4%
Payment Received is Inaccurate (Noncovered Days Billed on UB-04 or Admission Date Wrong)	3%
Depression Not Properly Coded	3%
MDS Not Properly Billed on UB-04	1%
Daily Skilled Services are not Documented	1%
Swallowing Disorder or Nutritional Approached Not Properly Coded	1%
Mechanically Altered Diet Not Supported by Documentation	1%
Physician Orders Not Present Before Treatment	1%

5 Claim SPE Audit Impact and Risk

- The audits are Pre-Pay unless you request financial hardship and post-payment reviews
- Errors are BOTH underpayments or overpayments
- If you have 20% error rate on the 5 records, you may be placed on a focused review
- Missing documentation is the most common root cause of errors

Top Trending Errors on SPE audits

- Documentation did not support the required certifications or recertifications for the SNF stay.
- Documentation did not support that the SNF services were reasonable and necessary.
- Documentation submitted did not support that skilled services were provided at a frequency to meet the definition of daily.
- The HIPPS was recoded to reflect MDS changes supported by the documentation submitted.

How does the SPE compare to a traditional TPE?

- The traditional TPE audit is a series of 3 strikes before you are “out”, or on “focused review.”
- The first request is usually related to verification that the documentation supports the coding and billing.
- After the first review, your team will receive “training” by CMS.
- Then a 2nd and 3rd round will be requested.
- There is time for improvement with the traditional TPE.

With the SPE there is ONE request for 5 records

FOCUS: Schizophrenia Audits

- CMS Memo QSO-23-05-NH dated 1/18/2023

- Adjusting Quality Measure Ratings: audits of **schizophrenia coding in the MDS** and, based upon the results, adjust the Nursing Home Care Compare quality measure star ratings for facilities whose audits reveal inaccurate coding.

  - Posting Citations Under Dispute: CMS will now display citations under informal dispute on the Nursing Home Care Compare website.

Operational Issues with Schizophrenia Audits

- Once the CMS request for audit is received you have only 48 hours to accept the audit, OR to decline and submit a Plan of Correction
- If you do not pass the audit, your Star Rating drops to a "1"
- CMS learns of coding of schizophrenia through the MDS Coding of item I, 6000

Risk Related to Operational Changes in the MDS

- CMS implemented a new MDS effective October 1, 2023
- Section G, Functional Status is removed and replaced by Section GG Functional Abilities and Goals
- Changes with Section A, B, Q that may impact Quality Surveys
- Changes in Sections K and O may impact coding and documentation

Projections for CMS Review into 2024

Continued SNF 5-Claim Probe and Educate (SPE) audits

- Based on the original transmittal the SNF 5-Claim reviews will commence on June 5th, 2023, for one year.

- SPE audits should continue until June 4, 2024 based on this original information.

Note: SPE will not be concurrent with TPE – however, may progress from SPE to TPE.

NEW Initiatives Based on Results of SPE Audits

- CMS has NOT yet published any updates on the results of the SPE audits thus far.
- Expectations based on internal communications with clients across the country is that CMS will definitely be following up with more impactful reviews.
- There have been no Corporate Integrity Agreements for SNF since October 2019 when RUG IV changed to PDPM.

Continued Schizophrenia Audits

- According to CMS, approximately half of the facilities that have been contacted have attested to having erroneous schizophrenia diagnoses and committed to correcting their information.
- For the remaining audited facilities that have erroneous schizophrenia diagnoses – found to have an absence of comprehensive psychiatric evaluations, medical evaluations, and behavioral documentation to support a diagnosis of schizophrenia.

Recommendations for SNF Operators

Best Practices to Minimize the Impact of CMS Reviews

- Internal monitoring systems
- External Audit
- Utilize your EMR vendor and EMR system to support your needs
- Have a system in place to track any requests
- Have a system in place to prepare records
- Utilize your Triple Check Meeting

Internal Monitoring Systems to Review

- Regularly review your MDS documentation
  - Validate MDS coding by review of documentation
  - Multidisciplinary documentation should support Section GG usual performance
  - Presence of hospital records and other documentation prior to admission to the SNF to support MDS coding
  - Consults to support coding of MDS items
  - All active diagnoses have supporting documentation including high risk diagnoses such as schizophrenia
  - Accurate capture of therapy minutes

More Internal Monitoring Systems to Review

- Is the HIPPS Code Supported by Documentation
  - Accuracy of MDS data
  - Analysis of PDPM case-mix groups (CMGs)
  - Validate Medicare regulation compliance
  - Check for weaknesses – i.e., choose the proper ARD, ICD-10-CM capture, overlooked opportunity for an interim payment assessment (IPA)
- Routinely audit and review the quality of the medical record documentation
  - Involve team members in conducting regular audits and reviews of charting to check compliance with Medicare standards.

Secure an External Audit as Part of Your Compliance Plan

- Done by professionals who devote their whole attention to audit guidelines and any recent regulatory changes.
- No need to worry about retaliation that may come from results from audit outcomes from internal review.
- Identify underpayments; money left on the table that can be recouped by completing a modified MDS.
- Identify weaknesses and risk before you get an audit request from the government!

Utilize Your EMR Vendor and EMR System to Support You

- HIPPS analysis
  - PDPM CMG days billed
  - Billing reports
- Check for CMG outliers

  Examples:
  - PT/OT component in the Major joint/Spinal Surgery Clinical Category (1st character HIPPS A, B, C, D)
  - Nursing component in Reduced Physical Functioning category (3rd HIPPS character T, U, V, W, X, Y)

Utilize Your EMR to Support You: Commons Tools (that may need to be requested)

- Section GG Collaborative Tool
- Electronic Certification and Recertification Forms
- Certification includes Diagnosis List (so that when it is signed, the diagnoses are supported by physician signature)
- Print PDF of the medical record

Have a System in Place to Track ADR or Denial Requests

- Educate your team to be ON THE LOOKOUT for requests for records from the MAC or CMS.
  - Know your MAC
  - Know the MAC for the specialized audits
- Be aware that sometimes the notifications come in the mail, but some are online.
- If you miss the request, you will probably miss the filing and you will receive an automatic denial.
- Identify one person and a back up to check for requests daily.

Have a System in Place to Track ADR or Denial Requests

- Establish a systematic log to track each request –
  - Receipt dates
  - What documents are needed to be submitted
  - When the documents must be submitted
  - Maintain a copy of all documents sent
  - Mailed/Sent dates
  - Log communication/conversations with reviewers
  - Review response outcomes

Write a Policy and Procedure on Record Preparation

- Understand and know what documents are requested – i.e., use a checklist
- Develop a facility medical review plan and team in advance
- Triage claims under large volume review
- Review documentation prior to submission
- If needed, provide a claim position statement
- Organize the documentation packet for ease of review – label or provide a cover page for each requested document
- ALWAYS keep a record that the package was submitted

Utilize Your Triple Check Meeting

- The Triple Check Meeting is the LAST place that you can find and fix data prior to the claim going to CMS!
- Use an interdisciplinary approach; each member of the team owns the data that goes on the MDS and claim related to their operational position.
- Actually, VERIFY that the data in the MDS and on the claim is supported and matches.
- Do not release the claim if there are missing items until the errors are fixed.

In Summary:

- CMS is just getting restarted after the retreat related to the Pandemic
- PDPM has not really been tested by CMS audits-wait for the roll up of the SPE audits after June 2024
- Expect the scrutiny to get more intense
- Work smart; utilize your EMR to the fullest
- Hardwire systems and educate your staff

Questions?

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