

# Documentation Requirements for PDPM



**Advantage**

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# Objectives

1. Identify 3 differences between RUG-IV and PDPM reimbursement.
2. Understand the PDPM payment drivers.
3. Learn the components of each of the 5 case-mix groups in PDPM.
4. Understand the importance of IDT communication for MDS completion, ICD-10 coding, and supporting documentation.

# PDPM – Patient Driven Payment Model

DEPARTMENT OF HEALTH AND HUMAN  
SERVICES Centers for Medicare & Medicaid  
Services

42 CFR Parts 411, 413, and 424

[CMS–1696–F]

RIN 0938–AT24

Medicare Program; Prospective Payment  
System and Consolidated Billing for Skilled  
Nursing Facilities (SNF) Final Rule for FY  
2019, SNF Value-Based Purchasing Program,  
and SNF Quality Reporting Program

AGENCY: Centers for Medicare & Medicaid  
Services (CMS), HHS. ACTION: Final rule.

D. Improving Patient Outcomes and Reducing  
Burden Through Meaningful Measures

- ▶ The Meaningful Measures Framework has the following objectives:
  - ▶ **Patient-centered** and meaningful to patients
  - ▶ **Outcome-based**
  - ▶ Minimize the level of burden for health care providers
  - ▶ Address measure needs for population based payment through alternative payment models
  - ▶ Align across programs and/or with other payers

# RUG-IV vs. PDPM

## Payment Classification

### RUG-IV

- ▶ Service/quantity-based metrics classify patients into one of 66 RUGs based on 2 case mix components:
  - ▶ Therapy
  - ▶ Nursing
- ▶ Highest index wins
- ▶ Therapy minutes drive
- ▶ Rates constant if utilization constant

### PDPM

- ▶ Patients classified into 5 case mix components based on Dx and functional characteristics:
  - ▶ PT
  - ▶ OT
  - ▶ SLP
  - ▶ Nursing
  - ▶ NTA
- ▶ Incentivizes lower therapy utilization
- ▶ PT/OT and NTA rates adjusted

# RUG-IV vs. PDPM MDS Assessments

## RUG-IV

- ▶ 5 scheduled assessments:
  - ▶ 5-Day
  - ▶ 14-Day
  - ▶ 30-Day
  - ▶ 60-Day
  - ▶ 90-Day
- ▶ 5 unscheduled assessments
  - ▶ OMRA
  - ▶ COT
  - ▶ EOT / SOT
  - ▶ Sig Change
  - ▶ PPS Discharge

## PDPM

- ▶ 1 scheduled assessment
  - ▶ 5-Day
- ▶ 2 unscheduled assessments
  - ▶ PPS Discharge
  - ▶ IPA

# RUG-IV vs. PDPM Therapy Minutes

## RUG-IV

- ▶ Every assessment reports the last 7 days of therapy minutes and treatment days.
- ▶ Group and concurrent are financially discouraged.

## PDPM

- ▶ Modified Section O on Discharge Assessment only per discipline:
  - ▶ Start date
  - ▶ Stop date
  - ▶ Individual minutes
  - ▶ Group minutes
  - ▶ Concurrent minutes
  - ▶ Treatment days
- ▶ CMS still “watching” this data
- ▶ Group and concurrent more financially beneficial

# RUG-IV vs. PDPM

## Functional Assessment

### RUG-IV

- ▶ Section G
- ▶ Based on 4 late loss ADLs:
  - ▶ Bed mobility
  - ▶ Transfers
  - ▶ Toileting
  - ▶ Eating

### PDPM

- ▶ Section GG
- ▶ Based on 10 functional areas:
  - ▶ Eating
  - ▶ Oral hygiene
  - ▶ Toileting hygiene
  - ▶ Sit to lying
  - ▶ Lying to sitting on side of bed
  - ▶ Sit to stand
  - ▶ Chair/bed to chair transfer
  - ▶ Toilet transfer
  - ▶ Walk 50 feet with 2 turns
  - ▶ Walk 150 feet



# RUG-IV vs. PDPM

## Payment Categories

### RUG-IV

- ▶ 66 RUG Groups:
  - ▶ Extensive Plus Rehab (9)
  - ▶ Rehab (14)
  - ▶ Extensive Services (3)
  - ▶ Special Care High (8)
  - ▶ Special Care Low (8)
  - ▶ Clinical Complex (10)
  - ▶ Behavioral Sx/Cog Sx (4)
  - ▶ Reduced Physical Functioning (10)

### PDPM

- ▶ 28,800 unique combinations:
  - ▶ PT and OT: 16 classifications
  - ▶ SLP: 12 classifications
  - ▶ Nursing: 25 classifications
  - ▶ NTA: 6 classifications

# PDPM – Patient Driven Payment Model

- ▶ Effective date October 1, 2019
- ▶ Total Replacement of RUG-IV
- ▶ Budget Neutral
- ▶ Index Combining vs Index Maximizing
- ▶ Minimizing therapy delivery incentives
- ▶ MDS Assessments
- ▶ Functional Score Calculations

# PDPM -- Payment Drivers

## ▶ PT / OT

- ▶ ICD-10 (primary reason for SNF care)
- ▶ GG (functional status on admission)
- ▶ Variable rates after day 20

## ▶ ST

- ▶ ICD-10 (primary reason for SNF care)
- ▶ Cognitive Status
- ▶ Dysphagia or mechanically altered diet
- ▶ Additional SLP-related comorbidities
- ▶ Fixed rates

## ▶ Nursing

- ▶ Hierarchical assignment based on clinical info related to SNF stay
- ▶ Functional Status
- ▶ High functioning residents drop to next level
- ▶ Need for extensive services
- ▶ Depression
- ▶ RNP
- ▶ Fixed rates

## ▶ NTA

- ▶ Top 50 comorbidities
- ▶ Rate changes after day 3

# PDPM – PT/OT Case Mix Classification Groups (16 Total)

| Clinical Category                      | GG Function Score | PT/OT Case Mix Group | PT CMI | OT CMI |
|--|-------------------|----------------------|--------|--------|
| Major Jt Replacement or Spinal Surgery | 0 to 5            | TA                   | 1.53   | 1.49   |
|  | 6 to 9            | TB                   | 1.69   | 1.63   |
|  | 10 to 23          | TC                   | 1.88   | 1.68   |
|  | 24                | TD                   | 1.92   | 1.53   |
| Other Orthopedic                       | 0 to 5            | TE                   | 1.42   | 1.41   |
|  | 6 to 9            | TF                   | 1.61   | 1.59   |
|  | 10 to 23          | TG                   | 1.67   | 1.64   |
|  | 24                | TH                   | 1.16   | 1.15   |
| Medical Management                     | 0 to 5            | TI                   | 1.13   | 1.17   |
|  | 6 to 9            | TJ                   | 1.42   | 1.44   |
|  | 10 to 23          | TK                   | 1.52   | 1.54   |
|  | 24                | TL                   | 1.09   | 1.11   |
| Non-Ortho Surgery & Acute Neuro        | 0 to 5            | TM                   | 1.27   | 1.3    |
|  | 6 to 9            | TN                   | 1.48   | 1.49   |
|  | 10 to 23          | TO                   | 1.55   | 1.55   |
|  | 24                | TP                   | 1.08   | 1.09   |

# PDPM – SLP Case Mix Groups (12 Total)

| <b>Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment</b> | <b>Mechanically Altered Diet or Swallowing Disorder</b> | <b>SLP Case Mix Group</b> | <b>CMI</b> |
|---|---|---------------------------|------------|
| None  | Neither   | SA                        | 0.68       |
| None  | Either  | SB                        | 1.82       |
| None  | Both  | SC                        | 2.66       |
| Any one   | Neither   | SD                        | 1.46       |
| Any one   | Either  | SE                        | 2.33       |
| Any one   | Both  | SF                        | 2.97       |
| Any two   | Neither   | SG                        | 2.04       |
| Any two   | Either  | SH                        | 2.85       |
| Any two   | Both  | SI                        | 3.51       |
| All three   | Neither   | SJ                        | 2.98       |
| All three   | Either  | SK                        | 3.69       |
| All three   | Both  | SL                        | 4.19       |

# PDPM – Some takeaway points

- ▶ More dependent functional score does NOT always mean more \$\$
- ▶ Cognitively impaired diagnosis yields higher reimbursement (even coded as mild)
- ▶ Even when no ST needs yields \$\$
- ▶ Highest ST reimbursement = cog impairment + swallowing disorder + mechanically altered diet
- ▶ Should code 2 person assist as dependent

# PDPM – Hierarchical Approach

## Nursing classification

- ▶ Extensive Service
  - ▶ Extensive Services
  - ▶ Special Care High
  - ▶ Special Care Low
  - ▶ Clinically Complex
  - ▶ Behavioral Symptoms and Cognitive Performance
  - ▶ Reduced Physical Function

# PDPM – Nursing Case Mix Classification Groups (25 Total)

| Nursing Category  | GG Function Score | Nursing Case Mix Group | Depressed | Restorative Nursing |
|-------------------|-------------------|------------------------|-----------|---------------------|
| Extensive Service | <14               | ES3                    | N/A       | N/A                 |
|                   | <14               | ES2                    | N/A       | N/A                 |
|                   | <14               | ES1                    | N/A       | N/A                 |
| Special Care High | 0 - 5             | HDE2                   | Yes       | N/A                 |
|                   | 0 - 5             | HDE1                   | No        | N/A                 |
|                   | 6 - 14            | HBC2                   | Yes       | N/A                 |
|                   | 6 - 14            | HBC1                   | No        | N/A                 |
|                   | 0 - 5             | LDE2                   | Yes       | N/A                 |
| Special Care Low  | 0 - 5             | LDE1                   | No        | N/A                 |
|                   | 6 - 14            | LBC2                   | Yes       | N/A                 |
|                   | 6 - 14            | LBC1                   | No        | N/A                 |

| Nursing Category          | GG Function Score | Nursing Case Mix Group | Depressed | Restorative Nursing |
|---------------------------|-------------------|------------------------|-----------|---------------------|
| Clinically Complex        | 0 - 5             | CDE2                   | Yes       | N/A                 |
|                           | 0 - 5             | CDE1                   | No        | N/A                 |
|                           | 6 - 14            | CBC2                   | Yes       | N/A                 |
|                           | 15 - 16           | CA2                    | Yes       | N/A                 |
|                           | 6 - 14            | CBC1                   | No        | N/A                 |
|                           | 15 - 16           | CA1                    | No        | N/A                 |
| Behavior and Cognition    | 11 - 16           | BAB2                   | N/A       | 2 or more           |
|                           | 11 - 16           | BAB1                   | N/A       | 0 or 1              |
| Reduced Physical Function | 0 - 5             | PDE2                   | N/A       | 2 or more           |
|                           | 0 - 5             | PDE1                   | N/A       | 0 - 1               |
|                           | 6 - 14            | PBC2                   | N/A       | 2 or more           |
|                           | 15 - 16           | PA2                    | N/A       | 2 or more           |
|                           | 6 - 14            | PBC1                   | N/A       | 0 - 1               |
|                           | 15 - 16           | PA1                    | N/A       | 0 - 1               |



# PDPM – Nursing Case Mix Classification Groups with CMI

| Nursing Case-mix Groups | CMI  | Nursing Case-mix Groups | CMI  |
|-------------------------|------|-------------------------|------|
| ES3                     | 4.04 | CBC2                    | 1.54 |
| ES2                     | 3.06 | CA2                     | 1.08 |
| ES1                     | 2.91 | CBC1                    | 1.34 |
| HDE2                    | 2.39 | CA1                     | 0.94 |
| HDE1                    | 1.99 | BAB2                    | 1.04 |
| HBC2                    | 2.23 | BAB1                    | 0.99 |
| HBC1                    | 1.85 | PDE2                    | 1.57 |
| LDE2                    | 2.07 | PDE1                    | 1.47 |
| LDE1                    | 1.72 | PBC2                    | 1.21 |
| LBC2                    | 1.71 | PA2                     | 0.7  |
| LBC1                    | 1.43 | PBC1                    | 1.13 |
| CDE2                    | 1.86 | PA1                     | 0.66 |
| CDE1                    | 1.62 |                         |      |

# PDPM – NTA

- ▶ NTA Comorbidity Score
  - ▶ 50 conditions and extensive services associated with increased NTA costs
  - ▶ MDS Sections H, I, K, M, O
  - ▶ Examples: AIDS/HIV, IV meds, organ transplant, wound infection, narcolepsy, morbid obesity, cirrhosis
- ▶ See CMS [Fact Sheet: NTA Comorbidity Score](#)

# PDPM – NTA

| NTA CMG Score | NTA CMG | CMI  | Rate Days 1-3 | Rate Days 4-100 |
|---------------|---------|------|---------------|-----------------|
| 12+           | NA      | 3.25 | \$760.98      | \$253.66        |
| 9-11          | NB      | 2.53 | \$592.40      | \$197.47        |
| 6-8           | NC      | 1.85 | \$433.17      | \$144.39        |
| 3-5           | ND      | 1.34 | \$313.77      | \$104.59        |
| 1-2           | NE      | 0.96 | \$224.79      | \$74.93         |
| 0             | NF      | 0.72 | \$168.60      | \$56.20         |

# PDPM – Interim Payment Assessment (IPA)

- ▶ Optional assessment: Facilities will be able to determine when IPAs will be completed for their patients to address potential changes in clinical status and what criteria should be used to decide when an IPA would be necessary.
- ▶ We will seek additional stakeholder input on this issue of criteria for completion.
- ▶ An IPA will not stop or change the variable per diem adjustment.
- ▶ The ARD for the IPA will be the date the facility chooses to complete the assessment relative to the triggering event that causes a facility to choose to complete the IPA. Payment based on the IPA will begin the same day as the ARD.
- ▶ The IPA will not be susceptible to assessment penalties, given the optional nature of the assessment.
- ▶ An IPA can be completed any time and as often as needed but will need to complete Section GG again

# PDPM – Interrupted Stay Policy

- ▶ If resident is discharged from a SNF and returns to the same SNF by 12:00 a.m. at the end of the third day of the interruption window, the resident's stay will be a continuation of the previous stay for purposes of both resident classification and the variable per diem adjustment schedule.
- ▶ If resident's absence from the SNF exceeds this 3-day interruption window , or in any case where the resident is readmitted to a different SNF, the readmission will be treated as a new stay, in which the resident would receive a new 5-day assessment upon admission and the variable per diem adjustment schedule for that resident would reset to Day 1.
- ▶ Source of readmission not relevant, except, if readmission is to a different SNF.
- ▶ If for SNF to SNF transfer, new SNF does PPS 5 day and variable payment schedule starts over.
- ▶ See CMS [Fact Sheet: Interrupted Stay](#) for examples

# MDS items requiring documentation

- ▶ Strong Nursing documentation / care planning is imperative to support eligibility and protect reimbursement
- ▶ Start now
  - ▶ Learning
  - ▶ Supporting each other

# MDS items requiring documentation

- ▶ Section GG
- ▶ Functional scoring
- ▶ RNP
- ▶ Cognition
- ▶ Depression
- ▶ Wounds
- ▶ Bowel / Bladder
- ▶ 24h Medicare A Nurses Note
  - ▶ Reasonable and necessary
- ▶ 48-hour care plan meeting

# MDS items requiring documentation

- ▶ Section G – CAN ADL documentation
- ▶ Team Review
  - ▶ Diagnosis Coding
  - ▶ External documentation
  - ▶ ICD-10 assignment
- ▶ Clinical Eligibility
  - ▶ No therapy “levels” to audit
  - ▶ Reasonable and necessary
- ▶ Speech Variables
- ▶ Dietary / Nutrition
  - ▶ IV use (while a resident)



# We continue to discuss section GG

- ▶ Do the residents change their functional ability in therapy versus when they are on the units
  - ▶ Yes, they do behave differently functionally and section GG is a way of documenting that behavior difference
- ▶ Do you have a Professional Nursing Form to capture section GG?
  - ▶ Discussion on process of section GG
    - ▶ Nursing GG form
    - ▶ Usual Performance Documentation Form
    - ▶ Compare the Nursing GG form with the functional Assessment scores from therapy
      - ▶ Decide as a team what the usual performance should be coded

# PDPM – PT & OT Function Score

## Functional Areas

- ▶ Score:
  - ▶ Eating
  - ▶ Oral Hygiene
  - ▶ Toileting Hygiene
  - ▶ Bed Mobility: Average of 2 items
  - ▶ Transfer: Average of 3 items
  - ▶ Walking: Average of 2 items
- ▶ Add the scores and round to nearest integer
- ▶ Missing value in a GG required item will be scored a 0
- ▶ Total score will be 0-24
- ▶ Same calculation for PT and OT

## PT/OT Function Scoring

| <b>Admission Score (Column 1) GG</b>                           | <b>Function Score</b> |
|--|-----------------------|
| Independent / Set Up (05 or 06)                                | 4                     |
| Supervision or Touching Assistance (04)                        | 3                     |
| Partial / Moderate Assistance (03)                             | 2                     |
| Substantial / Maximal Assistance (02)                          | 1                     |
| Dependent / Refused / N/A / Not Attempted (01, 07, 09, 10, 88) | 0                     |

# PDPM – Nursing Function Score

## Functional Areas

### ▶ Score:

- ▶ Eating
- ▶ Toileting Hygiene
- ▶ Sit to Lying
- ▶ Lying to Sitting on Side of Bed
- ▶ Sit to Stand
- ▶ Chair/bed-to-chair Transfer
- ▶ Toilet Transfer

| <b>Admission Score (Column 1) GG</b>                           | <b>Function Score</b> |
|--|-----------------------|
| Independent / Set Up (05 or 06)                                | 4                     |
| Supervision or Touching Assistance (04)                        | 3                     |
| Partial / Moderate Assistance (03)                             | 2                     |
| Substantial / Maximal Assistance (02)                          | 1                     |
| Dependent / Refused / N/A / Not Attempted (01, 07, 09, 10, 88) | 0                     |

### ▶ Average the scores for:

- ▶ Refer to next slide

### ▶ Missing value in a GG required item will be scored a 0 (no dashes as this will decrease 2% of refunded money)

### ▶ Total score will be 0-16

# PDPM – Nursing Function Score

## Functional Areas (Average Score)

- ▶ Mobility items
  - ▶  $(\text{Sit to Lying} + \text{Lying to Sitting on side of bed})/2$
- ▶ Transfer Items
  - ▶  $(\text{Sit to stand} + \text{Chair/bed-to-chair} + \text{Toilet Transfer})/3$
- ▶ Add Eating + Toileting + Average Bed Mobility + Average Transfer
- ▶ Round this score to the nearest integer to get your Function Score

# Restorative Nursing Programs (RNP) (end split)

- ▶ Nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible
- ▶ Restorative nursing programs affect resident quality of life by allowing the resident to be as independent as possible
- ▶ Care must be taken to assure that documentation justifies the necessity of the Restorative programs provided.
- ▶ Periodic documentation by the Restorative Nurse ( recommend with every OBRA assessment – including 5-day even if not combined with an OBRA assessment)
- ▶ Justification for treatment would include objective evidence or a clinically supportable statement that includes:
  - ▶ Functional limitations and complicating factors
  - ▶ Safety issues
  - ▶ Functional focus areas of treatment describing complexity of services
  - ▶ Prognosis / anticipated outcomes
  - ▶ Consequences if services are not delivered

# Restorative Nursing Programs (RNP) (end split)

- ▶ 2 restorative programs
  - ▶ 6 out of 7 days for at least 15 minutes over the last 7 days
  - ▶ Do you have delegated restorative CAN's
    - ▶ If not, what measures are taken to insure the restorative programs are being completed
  - ▶ Do your CAN's need training to insure that RNP's are performed and documented correctly?
    - ▶ Now is the time to reach out to your therapy company for training on competency and documentation of RNP's

# Cognition (end split)

- ▶ Document the systems of Cognitive Loss
  - ▶ Cognitive Loss: Describe severity of cognitive loss and accurately describe current level of orientation (i.e. person, place, time) as well as area of deficit (i.e. short term or long term memory affected)
  - ▶ BIMS – standardized form
    - ▶ Who should be completing this form
    - ▶ More money if you do BIMS correctly
- ▶ This is a good time to discuss the cognitive abilities/depressive symptoms of the resident, prior to the PHQ being completed.
  - ▶ Who completes the PHQ
  - ▶ Has the resident developed a comfortable relationship with the evaluator, enough that the resident is likely to give accurate information
    - ▶ If not, what is your plan B (another evaluator that the comfort level has been established)

# PDPM – Presence of Cognitive Impairment – BIMS/CPS

| <b>PDPM Cognitive Level</b> | <b>BIMS Score</b> | <b>CPS Score</b> |
|-----------------------------|-------------------|------------------|
| Cognitively Intact          | 13-15             | 0                |
| Mildly Impaired             | 8-12              | 1-2              |
| Moderately Impaired         | 0-7               | 3-4              |
| Severely Impaired           |                   | 5-6              |



# Depression (end split)

- ▶ Document the symptoms of depression
  - ▶ Signs of Depression
    - ▶ Describe accurately any signs of depression displayed to include but not limited to:
      - ▶ Negative statements made, repetitive questions, calling out, persistent anger, self depreciation, unrealistic fears, repetitive non-health related complaints, unpleasant mood in morning, insomnia or change in usual sleep pattern, sad/anxious appearance, crying/tearfulness, repetitive physical movements, withdrawn from activities and social interaction

# Depression (end split)

- ▶ Document the symptoms of behavior / hallucinations or delusions
  - ▶ Behavior Symptoms Present: Describe skilled nursing interventions to establish resident safety upon observance of the following behaviors: Wandering halls oblivious to safety, verbally abusive towards others, physically abusive towards others, socially inappropriate behavior or resistance to care.
  - ▶ Hallucinations or Delusions Present: Describe all skilled nursing interventions implemented to assist resident cope with any hallucination or delusions and include skilled nursing observations regarding same

# Wounds

- ▶ Describe condition of wound
- ▶ Describe response to current treatments
- ▶ Describe nursing interventions used to prevent further ulcer development
- ▶ Describe skilled nursing interventions used to aid in wound healing
- ▶ Describe consumption amounts of meals and fluids provided
- ▶ Describe overall skin condition including poor skin turgor, bruises, rashes, cyanosis, redness, edema or other abnormality
- ▶ Document any interventions implemented r/t abnormal lab values (i.e. low H&H, low serum albumin, low Fe+ levels, etc.)
- ▶ Describe dietary interventions implemented such as increased vitamin C and protein foods offered
- ▶ At least weekly, describe in detail wound measurements, locations and response to treatments. This will insure documentation is available in case of a IPA

# Bowel / Bladder

- ▶ Include in the 24 hour Nursing Notes or on a form which includes bowel / bladder
  - ▶ H0100C – Ostomy (including urostomy, ileostomy, and colostomy)
  - ▶ H0100D – Intermittent catheterization

# What to include in a Skilled Care Nurses Note (required every 24 hours)

- ▶ Substantiate daily skilled care provided (reasonable and necessary):
  - ▶ Provide detailed descriptions and assessment of patient condition including causative factors and/or risk factors
  - ▶ Record treatments, therapies and resident response
  - ▶ Analyze potential outcomes or consequences of care provided
  - ▶ Include evaluation of resident's response to the plan
  - ▶ Document evidence of physician and responsible party notification
  - ▶ Include communication between disciplines
  - ▶ Coordinate continuity of care

# Example of a Skilled Note:

4/8/19- Resident is A&O x 3, able to make needs known. VSS 98.6, 82, 22, 140/68. Lungs with crackles in bilateral lower lobes, O2 SAT 92% on 2 LPM, capillary refill <1 sec, no cough noted, receiving IV antibiotics for Pneumonia. Ceftin IV infused via pump as ordered via LUE PICC without difficulties. No redness or inflammation at insertion site pre or post infusion. Transfers with extensive assist of 2 staff member from bed to w/c. Requires staff assistance to propel self on unit, reminders given to lock brakes before exiting chair. BS + in all 4 quads, continent of B&B, requires assistance of staff member with clothing management. Receiving therapy for muscle strengthening, WC management, ambulation and energy conservation. Able to perform grooming after set up at bathroom sink, able to ambulate in room with WW and assist of 1 staff member, gait is unsteady at this time; educated resident on taking frequent breaks from tasks to decrease SOB. Therapy is being received 5x weekly.

# PDPM - Communication

Early IDT Meeting to determine: (recommend during 48-hour discharge meeting for all Medicare A Residents)

- ▶ Data details from hospital DC summary
- ▶ ICD-10 codes
  - ▶ All diagnoses that will be represented on the MDS (active dx). Starting with the admission / primary dx for all Medicare A admits.
  - ▶ This is a good time to recognize that the admitting dx is specific enough, and if not, search for the information you need.
  - ▶ Query the physician to add the full dx so it can be coded and placed on the MDS
    - ▶ Are there diagnoses that affect payment which are evident in the resident but the diagnosis needs to be added (i.e. hemiparesis, dysphagia, obesity, etc.)

# PDPM – Communication, cont.

- ▶ Other MDS data that impacts payment / case-mix groups
- ▶ DC date
- ▶ DC destination
- ▶ Case-Mix Groups
- ▶ Treatment / Interventions
  - ▶ Person-centered functional goals – Nursing and Therapy
  - ▶ This is a good time to evaluate section GG. It may be possible to complete a usual performance evaluation or form at this time.
  - ▶ This is a good time to discuss the cognitive abilities / depressive symptoms of the resident, prior to the BIMS being completed.

\*\* PDPM is not just a game of coding, it is a collective strategy for patient success



# PDPM – SLP Case Mix Speech Variables

- ▶ Relevant Components:
  - ▶ Presence of Acute Neurological Condition - Section I (I8000)
  - ▶ SLP Related Comorbidities
  - ▶ Cognitive Impairment
  - ▶ Mechanical Altered Diet or Swallowing Disorder

# Que Physician on observations of possible swallowing diagnosis

- ▶ Dietician needs to document in progress notes any of the following:
  - ▶ K0100A – Loss of liquids/solids from mouth when eating or drinking
  - ▶ K0100B – Holding food in mouth/cheeks or residual food in mouth after meals
  - ▶ K0100C – Coughing or choking during meals or when swallowing medications
  - ▶ K0100D – Complaints of difficulty or pain with swallowing
- ▶ Inform the physician so a diagnosis can be obtained

# PDPM – SLP Related Comorbidities

| <b>Description</b>                  | <b>MDS Item</b> |
|-------------------------------------|-----------------|
| Aphasia                             | I4300           |
| CVA, TIA, or Stroke                 | I4500           |
| Hemiplegia or Hemiparesis           | I4900           |
| Traumatic Brain Injury              | I5500           |
| Laryngeal Cancer                    | I8000           |
| Apraxia                             | I8000           |
| Dysphagia                           | I8000           |
| ALS                                 | I8000           |
| Oral Cancers                        | I8000           |
| Speech and Language Deficits        | I8000           |
| Trach Care While a Resident         | O0100E2         |
| Vent or Respirator While a Resident | O0100F2         |

# PDPM – Swallowing Disorder / Mechanically Altered Diet

- ▶ Swallowing Disorder: K0100A-D
  - ▶ A. Loss of liquids from mouth 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 difficult or pain with swallowing
- ▶ Nutritional Approaches: K0510
  - ▶ Mechanically altered diet- require change in texture of food or liquids (e.g. pureed food, thickened liquids).

# IV use

- ▶ Does your facility except IV's from the hospital
  - ▶ Now would be a good time to start
  - ▶ Increases payment
- ▶ We need to capture the IV to receive payment
  - ▶ Document in the 24 hour skilled nurses note
  - ▶ Place as much information about the IV on the care plan

# PDPM – Care Plans

- ▶ Comprehensive Person-Centered Care Plan
  - ▶ CMS expects improved Care Plans with more regular IDT communication
  - ▶ Patient goals and needs should be driving the Care Plan
  - ▶ Care Plans should include discussions with the patient and his/her family

# Section G (CNA ADL documentation)

- ▶ Is there accurate coding of section G by the CNAs
  - ▶ There is a lot of discussion regarding section GG but where are we on CNA ADL coding?
  - ▶ When the resident comes off of Medicare A, we still need to go to the 44 grouper for a CMI RUG category
  - ▶ Continue to support and educate your CNAs on their accurate coding – seek out consulting to educate and support your staff educator

# Now is the time to put systems in place and seek out consulting to begin educating on documentation

- ▶ Put a PDPM team together – headed by your Nurse Assessment Coordinator Team
- ▶ Discuss investigation team to review casefile to insure diagnosis for PDPM are represented
  - ▶ Review external documentation from hospital
  - ▶ Do we need to ask for more documentation?
- ▶ Discuss plan B for all interviews – who is the best person to complete the interview
- ▶ What is your GG plan for Nursing to complete
- ▶ Review the CMS fact sheet to aid in documentation



# **When do we start this process? TODAY!!**

All process should be streamlined, procedures in place, and all documentation flowing easily prior to 9/25/19 when we need to have everything in place for those IPAs that need to be completed 10/1/19 to 10/7/19 for all Medicare A residents on 9/30/19.

# PDPM – Therapy Updates

- ▶ Therapy Treatment Minutes Guidelines:
  - ▶ Group and Concurrent Therapy combined is capped at no more than 25% of total therapy minutes per discipline
  - ▶ 75% of therapy minutes must be individual
- ▶ CMS will continue to monitor if therapy is reasonable and necessary
- ▶ CMS expects no decrease in therapy minutes compared to RUG-IV intensities
- ▶ For example, if a resident received 800 minutes of physical therapy, no more than 200 minutes of this therapy could be provided on a concurrent or group basis.
- ▶ Group and concurrent therapy should not be utilized to satisfy therapist or resident schedules, and all group and concurrent therapy should be well documented in a specific way to demonstrate why they are the most appropriate mode for the resident and reasonable and necessary for his or her individual condition.
- ▶ Items added to PPS Discharge Assessment.....

# PDPM – Therapy Minutes Reporting

- ▶ PPS Discharge Assessment to include modified Section O
- ▶ Per Discipline:
  - ▶ Start Date
  - ▶ Stop Date
  - ▶ Total Individual Minutes
  - ▶ Total Concurrent Minutes
  - ▶ Total Group Minutes
  - ▶ Total Treatment Days
- ▶ \*\*CMS will likely use therapy utilization data with Section GG (outcomes) for further rate adjustments.

# PDPM – Therapy Documentation

- ▶ Chapter 8 of the MBPM Definition of Skilled Services – no change
  - ▶ Skilled involvement for services to be provided safely and effectively
  - ▶ Reasonable and necessary
  - ▶ Frequency and duration
- ▶ Therapy Documentation Requirements
  - ▶ History & physical exam
  - ▶ Skilled services provided
  - ▶ Patient's response
  - ▶ Plan of care
  - ▶ Detailed rationale describing need for skilled services and consequences if services not provided
  - ▶ Complexity of services provided
  - ▶ Any other pertinent patient characteristics

# PDPM – Therapy Documentation

- ▶ What makes this service skilled? What are the consequences if not provided?
- ▶ Person-centered functional goals
- ▶ Function-based vs. Impairment-based treatment
- ▶ Therapeutic exercise vs. RNP
- ▶ Outcomes / Tests & Measures

# PDPM – Therapy Documentation

## Modes of Therapy

- ▶ Concurrent Therapy: one therapist with two patients doing different activities
- ▶ Group Therapy: one therapist with four patients doing the same / similar activities
- ▶ Combined 25% limit per discipline on PDPM DC Assessment
  - ▶ CMS will issue a warning on validation report if limit surpassed

# PDPM – Therapy Documentation

- ▶ Therapy documentation must support the mode of therapy billed and describe the clinical rationale and goals for the use of the different modes utilized.
- ▶ Specific considerations when establishing Group Therapy as part of skilled intervention:
  - ▶ State the purpose of the group activity
  - ▶ State how the group activity relates to the patient's goals established on the POC
  - ▶ Include the number of patients in the group
  - ▶ Focus on the skilled intervention that reflects the skills of a therapist
- ▶ Consider Group Therapy schedules, staffing, space and equipment requirements
- ▶ Design the group activity to meet the individual needs / goals of each patient participating

# PDPM – Operational Strategies

- ▶ Admissions
  - ▶ ICD-10 coding info from hospital
  - ▶ Documentation packet from hospital
- ▶ MDS Team
  - ▶ MDS item updates
  - ▶ MBPM – no change
- ▶ Nursing & Therapy
  - ▶ Evidence-based Clinical Pathways
  - ▶ Skill set – more clinically complex patients
  - ▶ CMS targeting pneumonia, dehydration, CHF, UTI, skin ulcers, cellulitis, COPD, and asthma (80.3% of SNF rehospitalizations)



# PDPM – Operational Strategies

- ▶ Documentation
  - ▶ Nursing, therapy, physician, ICD-10 coding
  - ▶ E&T and auditing
- ▶ Auditing / Compliance
  - ▶ ICD-10 coding → PDPM Clinical Categories
    - ▶ NTA, SLP co-morbidities, surgical codes
  - ▶ 5-day MDS vs. 14-day MDS
  - ▶ Section GG
- ▶ Restorative Nursing Programs
  - ▶ Enhance or complement skilled therapy services

# PDPM – Takeaways

- ▶ ICD-10 coding specificity / accuracy
  - ▶ Be familiar with diagnosis tables for clinical categories, surgery procedure codes, SLP comorbidities, NTAs
- ▶ ADL coding (and nursing / therapy documentation)
- ▶ RNPs (importance of starting day one)
- ▶ Functional Outcomes Tracking / Auditing (CARE / Section GG)
- ▶ Cognitive impairment scoring (BIMS) on MDS (and nursing / therapy documentation)

# PDPM – Takeaways

- ▶ Clinical pathways / protocols per diagnostic category (or per PT, OT, ST case mix component scores) – Care Intensity projections
- ▶ Clinically appropriate use of / return of group and concurrent modes of therapy treatment \*\* See CMS [Fact Sheet: Concurrent and Group Therapy Limit](#)
- ▶ When to do an IPA
- ▶ New therapy contract pricing models
- ▶ Data analytics / PDPM projections
  - ▶ ALOS per dx category
  - ▶ Functional outcomes (CARE/GG) per dx category
  - ▶ Hospital readmit rates per dx category
  - ▶ Analyze areas of opportunity (ICD-10 coding, RNP, cog, speech therapy, etc.)

# PDPM – A Step Toward Unified PAC Payment System?

- ▶ MedPAC exploring a unified Medicare payment model for all PAC providers
  - ▶ Premise setting payment based on patient characteristics
  - ▶ Instead of site of care
- ▶ Steps are currently being taken on timeframes to unify PAC payments
- ▶ Common requirements for all four PAC settings have been identified
- ▶ Moving to reduce variation in PAC spending
- ▶ MedPAC2016 Industry Facts
  - ▶ 15,000 SNFs \$29.1 billion for 2.3 million stays (\$12,650 / stay)
  - ▶ 12,000 HHA received \$18.1 billion for 6.5 million stays (\$2780 / stay)

# Patient Classification Example

Consider two patients with the following characteristics (CMS):

| Patient Characteristics   | Patient A    | Patient B               |
|---------------------------|--------------|-------------------------|
| Therapy Received          | Yes          | Yes                     |
| Therapy Minutes           | 730          | 730                     |
| Extensive Services        | No           | No                      |
| ADL Score                 | 9            | 9                       |
| Clinical Category         | Acute Neuro  | Major Joint Replacement |
| PT & OT Functional Score  | 10           | 10                      |
| Nursing Functional Score  | 7            | 7                       |
| Cognitive Impairment      | Moderate     | Intact                  |
| Swallowing Disorder       | No           | No                      |
| Mechanically Altered Diet | Yes          | No                      |
| SLP Comorbidity           | No           | No                      |
| Comorbidities             | IV Meds & DM | Chronic Pancreatitis    |
| Other Conditions          | Dialysis     | Septicemia              |
| Depression                | No           | Yes                     |

# Patient Classification Example— RUG-IV Classification

- ▶ Both patients would be classified into the same RUG category based on minutes of therapy received, no extensive services, and ADL score →

RUB

# Patient Classification Example— PT & OT Components

- ▶ Patient A is classified into Acute Neurologic with PT and OT Functional Score of 10
  - ▶ PT Case-mix Group = TO; CMI = 1.55
  - ▶ OT Case-mix Group = TO; CMI = 1.55
- ▶ Patient B is classified into Major Joint Replacement/Spinal Surgery with a PT and OT Functional Score of 10
  - ▶ PT Case-mix Group = TC; CMI = 1.88
  - ▶ OT Case-mix Group = TC; CMI = 1.68

# Patient Classification Example— SLP Component

- ▶ Patient A is classified into Acute Neurologic, has moderate cognitive impairment, and is on a mechanically-altered diet
  - ▶ SLP Case-mix Group = SH; CMI = 2.85
- ▶ Patient B is classified into non-neurologic with no SLP-classification related issue
  - ▶ SLP Case-mix Group = SA; CMI = 0.68



# Patient Classification Example— Nursing Component

- ▶ Patient A is receiving dialysis services with PDPM Nursing Functional Score of 7 and is classified into LBC1
  - ▶ CMI = 1.43
- ▶ Patient B has septicemia and PDPM Nursing Functional Score of 7, exhibits signs of depression, and is classified into HBC2
  - ▶ CMI = 2.23

# Patient Classification Example— NTA Component

- ▶ Patient A has an NTA Comorbidity Score of 7 from IV medication (5 points) and diabetes mellitus (2 points)
  - ▶ NTA Case-mix Group = NC; CMI = 1.85
- ▶ Patient B has an NTA Comorbidity Score of 1 from chronic pancreatitis (1 point)
  - ▶ NTA Case-mix Group = NE; CMI = 0.96

# Questions?

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# Is PDPM Your Favorite?

THANK YOU!