Patient Driven Payment Model
PDPM – Overview for Compliance

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The Innovator in Healthcare Workforce Solutions and Staffing Services

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Overview and Objectives

Understand the major provisions of the new Medicare Part A SNF PPS PDPM case-mix payment model that the Centers for Medicare and Medicaid Services implemented on October 1, 2019 including but not limited to:

- MDS Changes
- Assessment Changes
- Policy Changes

At the conclusion of this webinar attendee's shall have an understanding of PDPM and be better aligned to begin preparing their organization for the successful transition from RUG-IV to PDPM

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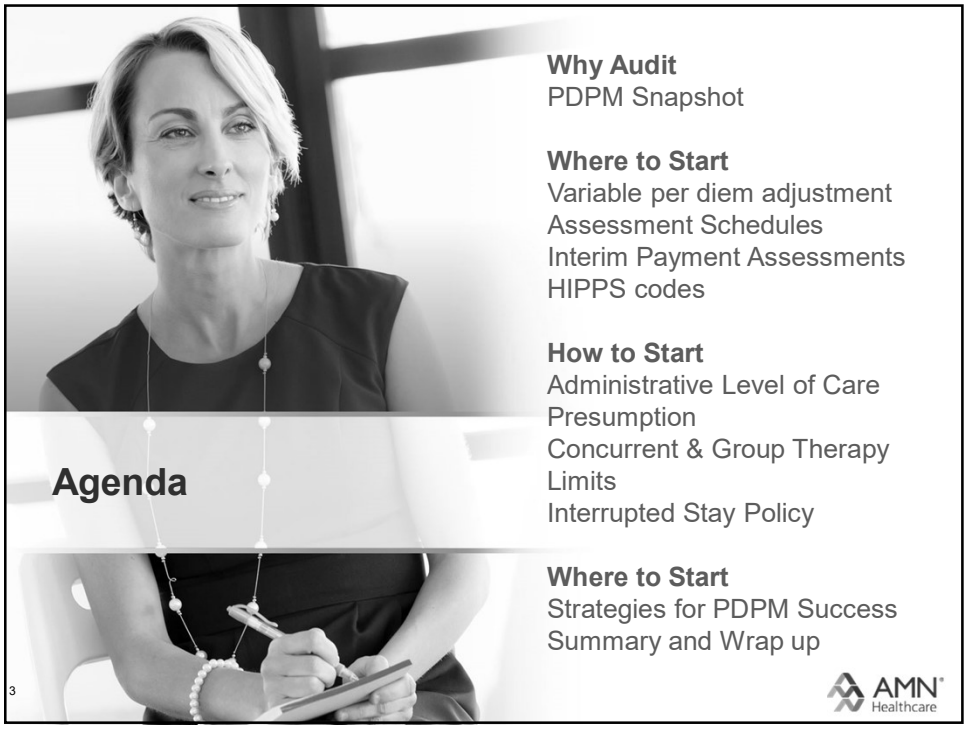

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Why Audit?

Medicare Part A SNF PPS PDPM case-mix payment model was implemented on October 1, 2019

- MDS Changes
- Assessment Changes
- Policy Changes

Evaluation of processes is a constant and we need to continue adapting and altering our processes to ensure coding accuracy and efficiency.

Monitoring and evaluating of data is critical in process improvement, along with the impactful use of the data we obtain.

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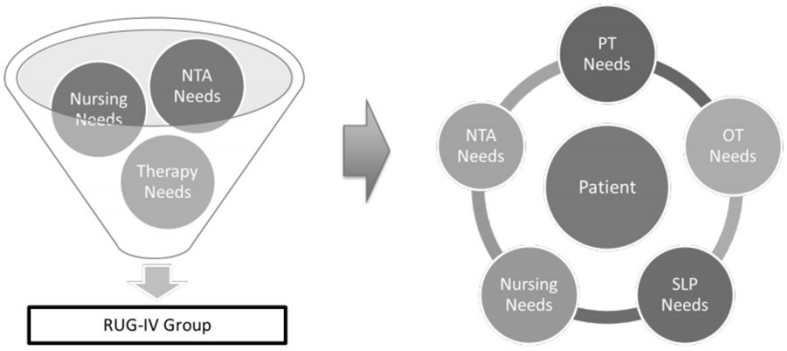
Changing from RUG-IV to PDPM?



October 1st 2019 – PRPM Implementation Date – Hard Transition

PDPM focuses on the unique, individualized needs, characteristics and goals of each patient

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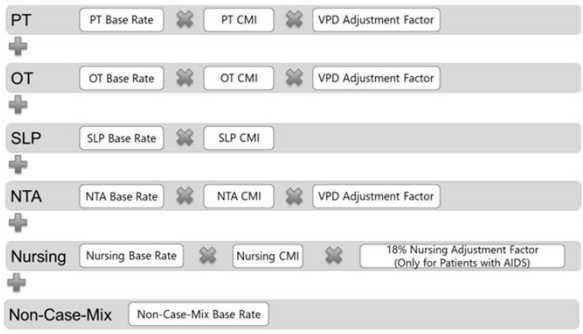
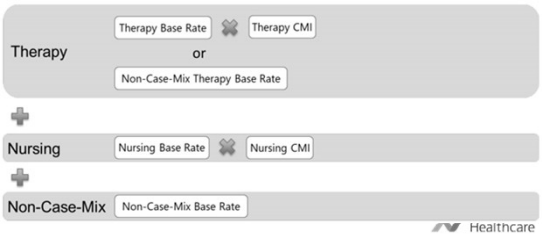
PDPM Snapshot



Providers would bill for services under PDPM using the Health Insurance Prospective Payment System (HIPPS) code that is generated from assessments with an ARD after October 1, 2019.

RUG IV



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Clinical Categories

PDPM Clinical Categories	PT & OT Clinical Categories
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Acute Neurologic	Non-Orthopedic Surgery & Acute Neurologic
Non-Orthopedic Surgery	
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Orthopedic - Surgical Extremities Not Major Joint	
Medical Management	Medical Management
Cancer	
Pulmonary	
Cardiovascular & Coagulations	
Acute Infections	

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SNF Primary Diagnosis Coding for I0020B and Principal Diagnosis for Claim

Section I **Active Diagnoses**

I0020. Indicate the resident's primary medical condition category
Complete only if A0310B = 01 or 08

Enter Code: 1 3

Indicate the resident's primary medical condition category that best describes the primary reason for admission

01. **Stroke**
02. **Non-Traumatic Brain Dysfunction**
03. **Traumatic Brain Dysfunction**
04. **Non-Traumatic Spinal Cord Dysfunction**
05. **Traumatic Spinal Cord Dysfunction**
06. **Progressive Neurological Conditions**
07. **Other Neurological Conditions**
08. **Amputation**
09. **Hip and Knee Replacement**
10. **Fractures and Other Multiple Trauma**
11. **Other Orthopedic Conditions**
12. **Debility, Cardiorespiratory Conditions**
13. **Medically Complex Conditions**

I0020B. ICD Code

C 3 4 . 1 1

CMS expects the diagnosis in I20020B and the primary diagnosis on the SNF claim to match, but there is no claims edit that will enforce such a requirement

Compliance and CDI opportunity

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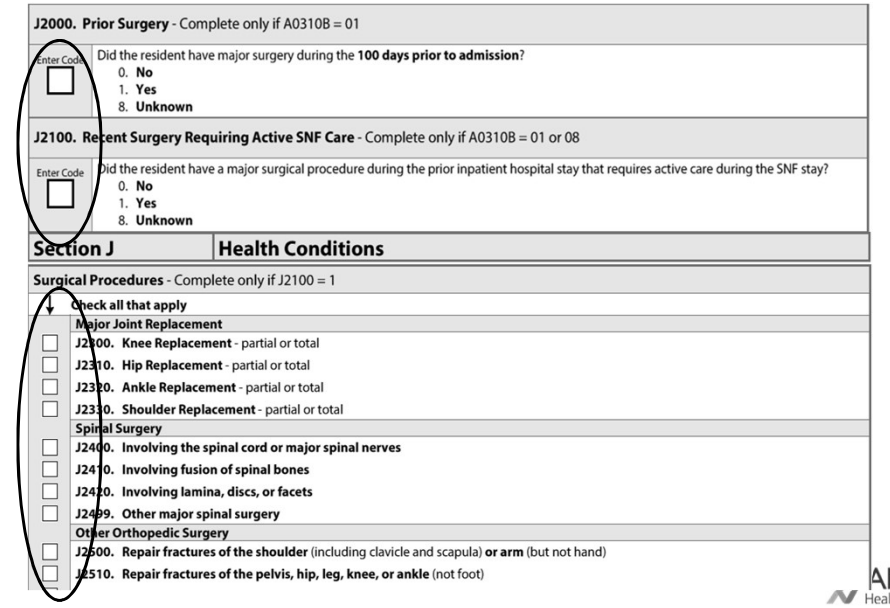
Patient Surgical History



J2000. Prior Surgery - Complete only if A0310B = 01

Enter Code ☐ Did the resident have major surgery during the **100 days prior to admission**?
0. **No**
1. **Yes**
8. **Unknown**

J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or 08

Enter Code ☐ Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?
0. **No**
1. **Yes**
8. **Unknown**

Section J **Health Conditions**

Surgical Procedures - Complete only if J2100 = 1

Check all that apply

Major Joint Replacement
- ☐ **J2000. Knee Replacement** - partial or total
- ☐ **J2310. Hip Replacement** - partial or total
- ☐ **J2320. Ankle Replacement** - partial or total
- ☐ **J2330. Shoulder Replacement** - partial or total

Spinal Surgery
- ☐ **J2400. Involving the spinal cord or major spinal nerves**
- ☐ **J2410. Involving fusion of spinal bones**
- ☐ **J2420. Involving lamina, discs, or facets**
- ☐ **J2499. Other major spinal surgery**

Other Orthopedic Surgery
- ☐ **J2500. Repair fractures of the shoulder** (including clavicle and scapula) **or arm** (but not hand)
- ☐ **J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle** (not foot)

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Differences between G and GG scoring methodologies?

- GG-based functional score is reversed from the methodology used for the section G-based functional score
  - Section G, increasing score means increasing dependence
  - Section GG, increasing score means increasing **independence**
- ADL score used under RUG-IV, which exhibits a linear relationship between increasing dependence and increasing payment
  - RUG-IV, increasing dependence, within a given RUG category, translates to higher payment
  - PDPM, no direct relationship between increasing dependence and increasing payment
- GG offers standardized and more comprehensive measures of functional status and therapy needs

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SLP Component

For the SLP component, PDPM uses a number of different patient characteristics that were predictive of increased SLP costs:

- Acute Neurologic clinical classification
- Certain SLP-related comorbidities
- Presence of cognitive impairment
- Use of a mechanically-altered diet
- Presence of swallowing disorder

SLP Comorbidities	
Aphasia	Laryngeal Cancer
CVA,TIA, or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy (while Resident)	Oral Cancers
Ventilator (while Resident)	Speech & Language Deficits

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Nursing Component

PDPM utilizes the same basic nursing classification structure as RUG-IV, with certain modifications:

- Function score based on Section GG of the MDS 3.0
- Collapsed functional groups, reducing the number of nursing groups from 43 to 25

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	Restorative Nursing Services	Function Score	CMG	CMI
ES3	Tracheostomy & Ventilator				0-14	ES3	4.04
ES2	Tracheostomy or Ventilator				0-14	ES2	3.06
ES1	Infection Isolation				0-14	ES1	2.91
HE2/HD2		Serious medical conditions e.g. comatose, septicemia, respiratory therapy	Yes		0-5	HDE2	2.39
HE1/HD1		Serious medical conditions e.g. comatose, septicemia, respiratory therapy	No		0-5	HDE1	1.99
HC2/HB2		Serious medical conditions e.g. comatose, septicemia, respiratory therapy	Yes		6-14	HBC2	2.23
HC1/HB1		Serious medical conditions e.g. comatose, septicemia, respiratory therapy	No		6-14	HBC1	1.85

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NTA Component

NTA classification is based on the presence of certain comorbidities or use of certain extensive services

- Comorbidity score is a weighted count of comorbidities:
- Comorbidities associated with high increases in NTA costs grouped into various point tiers
- Points assigned for each additional comorbidity present, with more points awarded for higher-cost tiers

- Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) is reported on the SNF claim, in the same manner as under RUG-IV

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Where to Start?

https://www.grouphomeriches.com

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What is the variable per diem adjustment?

Variable Per Diem Adjustment Factors and Schedule – PT and OT

Medicare Payment Days	Adjustment Factor
1-20	1.00
21-27	0.98
28-34	0.96
35-41	0.94
42-48	0.92
49-55	0.90
56-62	0.88
63-69	0.86
70-76	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

Variable Per Diem Adjustment Factors and Schedule – NTA

Medicare Payment Days	Adjustment Factor
1-3	3.0
4-100	1.0

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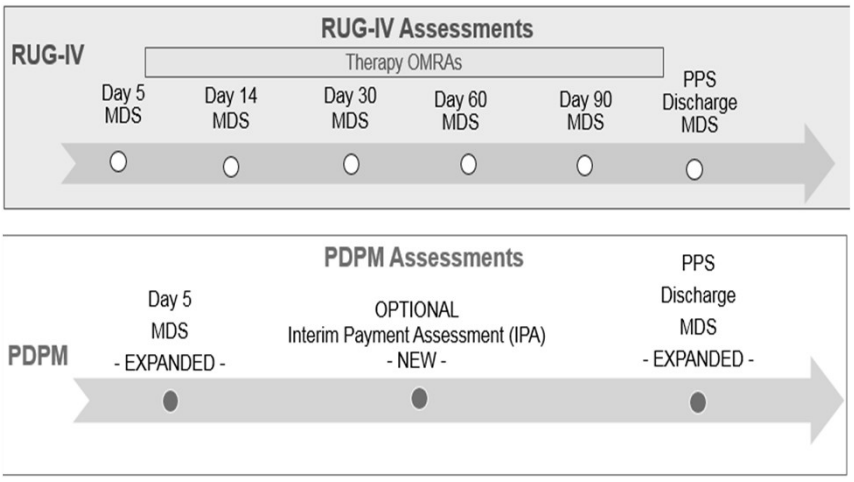
Assessment Schedules



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Assessment Schedules

Medicare MDS Assessment Schedule Type	Assessment Reference Date (ARD)	Applicable Standard Medicare Payment Days
5 – Day PPS Assessment	Days 1-8	All covered Part A days until Part A discharge or an IPA is completed
Interim Payment Assessment (IPA)	Optional Assessment (ARD determined by provider policy)	ARD of the IPA through Part A discharge or another IPA is completed
PPS Discharge Assessment	PPS Discharge Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A

Grace days will not be eliminated and will now be folded into the standard days considered as options for the ARD

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Interim Payment Assessments

CMS has not defined the criteria for IPA, **but:**

"…it is necessary for SNFs to continually monitor the clinical status of each and every patient in the facility regularly regardless of payment or assessment requirements and we believe that there should be a mechanism in place that would allow facilities to do this…"

"...Facilities will be able to determine when IPAs will be completed for their patients to address potential changes is (sic) clinical status and what criteria should be used to decide when an IPA is necessary."

– CMS-1696-F pp. 230-231

1. Define your facility's IPA criteria
2. Develop a systematic, regular check-in to facilitate and communicate monitoring for changes
3. Apply criteria consistently
4. Periodically audit

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What does the HIPPS code represent under PDPM?

The HIPPS code under PDPM is still a five character code:

- Character 1: PT/OT Payment Group
- Character 2: SLP Payment Group
- Character 3: Nursing Payment Group
- Character 4: NTA Payment Group
- Character 5: Assessment Indicator

SNF billing practices related to the use of the HIPPS code and revenue codes remain the same under PDPM.

The default code under PDPM, which may be used in cases where an assessment is late, is ZZZZZ

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PDPM payment code

All providers will be required to complete an IPA with an ARD no later than October 7, 2019 for all SNF Part A patients.

October 1, 2019 will be considered Day 1 of the variable per diem schedule under PDPM, even if the patient began their stay prior to October 1, 2019.

Any “transitional IPAs” with an ARD after October 7, 2019 will be considered late and the late assessment penalty would apply.

The HIPPS code derived from the transitional IPA should be used to bill for dates of service beginning October 1, 2019.

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How to Start?

Your auditing plan should be:

Specific to your organization

Designed to address current needs

What type of audit is being performed?

Retrospective (Random or focused)? Concurrent?

What education do you want to deliver?

What elements do you want to capture in the audit?

How can you maximize the audit findings to support education?

Without a focus on education you are working blind. A consistent ongoing auditing plan should be a part of your overall strategy

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How to Start?

Negative perceptions and fear can easily set in among the team when they imagine an auditor pointing over their shoulders and scrutinizing their accuracy.

Negativity leads to defensiveness, internal sabotage, and disregard for audit findings.

Have a discussion prior to the audit clearly outlining the objective with your team

Audits are to help! Not penalize...

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Administrative Level of Care Presumption under the PDPM

Assigned one of the designated, more intensive case-mix classifiers on the initial five-day Medicare-required assessment

Automatically classified as meeting the SNF level of care definition up to and including the assessment reference date (ARD) for that assessment

Not assigned one of the designated case-mix classifiers

- not automatically classified as either meeting or not meeting the definition
- receives an individual level of care determination using the existing administrative criteria

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Concurrent & Group Therapy Limits

Under RUG-IV, no more than 25% of the therapy services delivered to SNF patients, for each discipline, may be provided in a group therapy setting, while there is no limit on concurrent therapy

- Concurrent Therapy: One therapist with two patients doing different activities
- Group Therapy: One therapist with four patients doing the same or similar activities

PDPM - combined limit both concurrent and group therapy to be no more than 25% of the therapy received by SNF patients, for each therapy discipline

If the total number of concurrent and group minutes, combined, comprises more than 25% of the total therapy minutes provided to the patient, for any therapy discipline, then the **provider will receive a warning message on their final validation report**

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Reporting Therapy

Report, by each discipline and mode of therapy, the amount of therapy (in minutes) received by the patient.

Interrupted stay

Report the amount of therapy furnished the patient since the beginning of the Part A stay, including all parts of an interrupted stay.

Example:

- *Patient's Part A stay began on November 1, 2019 and ended on December 31, 2019, with two interrupted stay occurrences during this period, then all therapies since November 1, 2019 would be coded on the discharge assessment completed with an ARD of December 31, 2019.*

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Concurrent & Group Therapy Limits

- Therapy services are only to be reported on SNF PPS discharge MDS
- The following PT/OT/SLP service delivery items are to be reported separately by discipline
  - Start and end dates
  - Total treatment days during entire stay
  - Total individual 1:1 therapy minutes during entire stay
  - Total concurrent therapy minutes during entire stay
  - Total group therapy minutes during entire stay

- There is a 25% limit on the total amount of concurrent and or group therapy permitted per stay within each discipline
  - CMS will issue a non-fatal warning edit on validation report if limit surpassed
  - CMS will monitor and flag providers for audits, and revise policy if abused

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Interrupted Stay Policy

PDPM, & variable per diem adjustment, there is a potential incentive for providers to discharge SNF patients from a covered Part A stay and then readmit the patient in order to reset the VPD clock

- Represents a significant risk to patient care
- **To mitigate, PDPM includes an interrupted stay policy**

Interrupted Stay Policy - effective concurrent with implementation of PDPM

CMS defines an "interrupted" SNF stay as one in which a patient is discharged from Part A covered SNF care and subsequently readmitted to Part A covered SNF care **in the same SNF** (not a different SNF) within 3 days or less after the discharge

Interruption window is a 3-day period, starting with the calendar day of discharge and including the 2 immediately following calendar days, ending at midnight

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Interrupted Stay

If both conditions are met, the subsequent stay is considered a continuation of the previous "interrupted" stay for the purposes of both the variable per diem schedule and the assessment schedule

The assessment schedule continues from the day of the previous discharge. No new 5-day assessment is required upon the subsequent readmission

Readmitted to the same SNF more than 3 consecutive calendar days after discharge, OR in any instance when the patient is admitted to a different SNF, then the Interrupted Stay Policy does not apply and the subsequent stay is considered a new stay.

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Interrupted Stay Policy Examples

***Example 1*:**

Patient A is admitted to SNF on 11/07/19, admitted to hospital on 11/20/19, and admitted to a different SNF on 11/22/19

- New stay
- Assessment Schedule: Reset; stay begins with new 5-day assessment
- Variable Per Diem: Reset; stay begins on Day 1 of variable per diem schedule

***Example 2*:**

Patient B is admitted to SNF on 11/07/19, admitted to hospital on 11/20/19, and returns to the same SNF on 11/22/19

- Continuation of previous stay
- Assessment Schedule: No PPS assessments required, IPA optional
- Variable Per Diem: Continues from Day 14 (Day of Discharge)

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Interrupted Stay

Patient is discharged from a SNF and readmitted to the same SNF 4 or more consecutive calendar days after the discharge, or is immediately transferred to another SNF	Subsequent stay is a considered a new stay for SNF PPS purposes • A 5-Day assessment is required • The variable per-diem payment schedule is reset to day 1 • CMS will be monitoring this policy for potential future revisions
Patient is discharged from a SNF and readmitted to the same SNF no more than 3 consecutive calendar days after the discharge	Subsequent stay is considered a continuation of the prior stay for SNF PPS purposes • Payment schedule continues based on most recent assessment (5-Day or IPA) that occurred prior to the discharge • Variable per-diem payment schedule continues from the point just prior to discharge (e.g. last day was day 10 – first day back is day 11) • An optional IPA assessment could be completed upon the return to change the resident-s PDPM case mix rate but this does not reset variable per-diem payment schedule to day 1

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Where to start? The findings

Variation can be the enemy of quality in auditing

Consider multiple auditors on one project…

Add R40.241-glascow coma scale of 15 documented in the ED and H&P -refer *Guideline Section I.C.18.e. Coma scale can be used in conjunction with traumatic brain injury codes--assign coma scale total score when only the total score is documented;* Add R11.2 pt had nausea and vomiting noted on progress note and D/C; Add S50.0812A abrasions noted on forearm on H&P; Revise the PDX to S43.102A-the pt is admitted with AC joint separation and ulna fracture--the pt did have a concussion but that was not the reason for admission or the focus of the treatment refer to *Guideline Section I.C.19.b--code the most serious injury as determined by the provider and the focus of treatment is sequenced first*--in this scenario the ulna fracture and the ac joint separation pt was admitted for both are treated equally-either one can be the pdx--the AC joint dislocation optimizes the DRG refer to *Guideline Section II C Two or more diagnoses that equally meet the definition for principal diagnosis states when the two or more diagnosis equally meet the criteria for principal as determined by the circumstances of admission, diagnostic workup, and or therapy provided and the index and tabular does not provide sequencing direction either of the diagnosis may be sequenced first* --this changes the DRG; Add 0KC80ZZ-extirpation of foreign body form upper arm muscle--foreign body material was removed from the arm--noted in the op report

add I44.7 -left bundle branch block noted on anesthesia report-monitored;add Z85.72-pt has history of lymphoma had chemo; add B245ZZ4-TEE was performed

Ensure you have a standard policy for auditors to apply when documenting recommendations in an audit to promote consistency in approach and documentation of findings

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Where to start? The findings

Respect the team/provider by following:

- Basic rules of grammar
- Punctuation
- Spelling

Focus of the audit should be education

Formulate recommendations to reflect this focus

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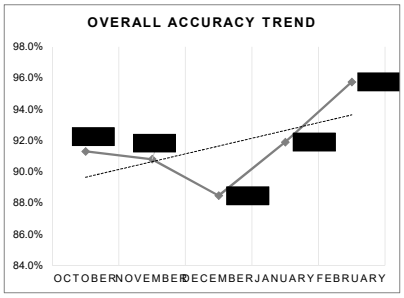
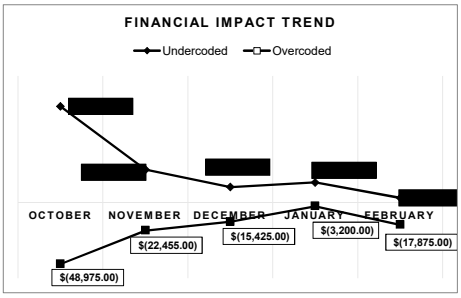
Standardized terminology

Financial impact and accuracy can easily be calculated from a manual spreadsheet and can provide valuable data to management in identifying areas of risk.

This information is most useful trended over time





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Strategies for PDPM Success

Data comes from the Minimum Data Set (MDS)

Most folks have MDS accuracy incorporated in to their Quality Assurance Performance Improvement (QAPI) programs

- Foundation for care planning process
- Source document for Quality Measures
- Drives Five-Star outcomes, Quality Reporting Programs and Nursing Home Compare information
- Current reimbursement is derived from it

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Strategies for PDPM Success

1. Daily skilled service needs to be clear in the Medical Record

2. Increased focus on Section GG
   Needs to be completed or separate penalty
   Section G for Case Mix states

Ensure the primary diagnosis is correctly entered in I8000A. Be sure to do this for every resident and make this a standard practice

3. Documentation to support
   Surgery in prior hospital stay
   ICD-10 code for primary reason in the SNF

4. Documentation of swallowing difficulties/mechanically altered diets in the Medical Record

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Strategies for PDPM Success

5. Therapy documentation still needs to cover days, minutes and need for skilled services
   - Tracking of the new 25% combined limit on group and concurrent therapy
6. Identification of change in condition
   - Determining whether an Interim Payment Assessment (IPA) is appropriate

Implemented November 28th, 2019 (Phase 3)

The facility takes reasonable steps to achieve compliance with the programs standards, policies, and procedures. Such steps include, but are not limited to, utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under the Act.

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Summary

1. PDPM remains a per-diem payment model but components have changed

2. PDPM Adds Variable Per-Diem Payment Adjustments
3. Patient Characteristics Represented by MDS Items Drive Payment
4. Fewer Assessments Required Under PDPM, streamlined schedule
5. New Policies/Revised Policies – Interrupted Stay, HIV/AIDS, Therapy
6. New and revised MDS components – GG, G, J etc.

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Wrap Up

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Links and References

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.

Fact Sheets

This section includes fact sheets on a variety of PDPM related topics.

- Administrative Level of Care Presumption under the PDPM
- PDPM Payments for SNF Patients with HIV/AIDS
- Concurrent and Group Therapy Limit
- PDPM Functional and Cognitive Scoring
- Interrupted Stay Policy
- MDS Changes
- NTA Comorbidity Score
- PDPM Patient Classification
- Variable Per Diem Adjustment

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