

PDPM Update: Seven Months into PDPM... Where Do We Stand?

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Learning Objectives

Identify and understand:

1. The importance of accurate section GG coding
2. Decision making regarding Interim Payment Assessments
3. How your facility is selecting the correct primary medical condition

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PDPM basics

- First payment model change in 20 years
- Greater account for resident characteristics over services delivered
- Better alignment between SNF PPS payments and resource use
- Therapy delivery no longer the anchor for payment
- Applies to Traditional Medicare only

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Why the change from RUG-IV?

- Over 90 percent of covered SNF PPS days are billed using one of the 23 Rehabilitation RUGs
- Over 60 percent of covered SNF PPS days billed using one of the three Ultra-High Rehabilitation RUGs

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Why the change from RUG-IV?

- Only a resident's therapy minutes and Activities of Daily Living (ADL) score to determine the appropriate payment for all aspects of a resident's care
- Utilizing only these two components may not derive much from the resident's characteristics, but is solely focused on the type and amount of care that a facility decides to provide to a resident

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PPS vs PDPM components

PPS

- Therapy (case-mixed)
- Nursing (case-mixed)
- Non-case mix therapy
- Non-case mix

PDPM

- Physical therapy
- Occupational therapy
- Speech-language pathology
- Nursing
- Non-therapy ancillary services (NTAS)
- Non-case mix

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PDPM and MDS



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Impact on MDS scheduling

- PDPM requires only two to three assessments for Part A stay: admission (5-day); discharge; potentially Interim Payment Assessment (IPA)
- Five-day assessment used to classify patient for entire stay unless IPA is needed
- Eliminated 14, 30, 60, and 90-day scheduled assessments
- Eliminated OMRA's (SOT, COT, EOT) or unscheduled assessments

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Impact on MDS scheduling

- Five-day PPS
 - ARD range days one through eight
 - Covers all payment days until the End of MCR Stay MDS completed or the IPA is completed
 - May be combined with OBRA assessments
- Interim Payment Assessment (IPA)
 - ARD no later than 14 days after change in resident's first tier classification criteria is identified
 - Covers payment from the ARD through the End of MCR Stay MDS (unless another IPA is completed)
 - Cannot be combined with any other assessments
- End of MCR Stay assessment
 - ARD equals the date listed in A2400C

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Section GG Functional Assessment

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Section GG impact on Case Mix

Section GG Self-Care and Mobility items, impacts three of the five PDPM case mix components including PT, OT, and Nursing

- Provider is allowed up to three days, Medicare Start Date (A2400B), and the following two days to assess for the resident's usual performance

USUAL PERFORMANCE

- A resident's functional status can be impacted by the environment or situations encountered at the facility
- Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status
- If the resident's functional status varies, record the resident's usual ability to perform each activity
- Do not record the resident's best performance and do not record the resident's worst performance, but rather the resident's usual performance

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Section GG impact on Case Mix

- Assess the resident's self-care performance based on direct observation, *incorporating* resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the three-day assessment period
- CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period
- The admission functional assessment, when possible, should be conducted prior to the *resident* benefitting from treatment interventions in order to *reflect the resident's* true *admission* baseline functional status
 - If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted
 - Treatment should not be withheld in order to conduct the functional assessment

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Section GG impact on Case Mix

What is the provider's best practice in obtaining the functional assessment data?

- **STNA/CNA documentation?**
- Nursing documentation?
- Therapy evaluations?

Utilizing the STNA/CNA ADL documentation over the first three days of the stay

- The assessment of the 24 self-care and mobility items are based on very specific, and at times, multi-step tests
- Unless your STNA/CNAs have been specifically trained and can distinguish between standard ADL care and section GG function assessment, use caution when relying on this documentation
- Have you witnessed the STNA/CNAs actually performing these functional assessments, or could the STNA/CNAs be trying to answer the questions based on daily care provided to everyone?

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Section GG impact on Case Mix

What is the provider's best practice in obtaining the functional assessment data?

- STNA/CNA documentation?
- **Nursing documentation?**
- Therapy evaluations?
- Has the nursing staff been trained on the delivery of the section GG Functional Assessment items?
- Are they simply asking the STNA/CNA their opinion of the items?
- Are they trying to respond to all GG items or just a subset?

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Section GG impact on Case Mix

What is the provider's best practice in obtaining the functional assessment data?

- STNA/CNA documentation?
- Nursing documentation?
- **Therapy evaluations?**

Pulling the information off the therapy evaluation

- Simply allowing the information from a PT or OT evaluation to auto populate section GG does provide an IDT approach to this assessment
 - Also, this would only be two individuals (PT/OT) opinions to the "usual performance" for the resident in these Functional areas
- Depending on which day of stay and what time of day these evaluations are performed could have a significant impact to the picture obtained of the resident, therefore misrepresenting the "usual performance"

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PT and OT

- Four major clinical categories
 - Major joint replacement or spinal surgery
 - Non-orthopedic surgery & acute neurologic
 - Other orthopedic
 - Medical management
- Section GG item scores on 4-point scale (0-5, 6-9, 10-23, 24)
 - Self-care: eating
 - Self-care: oral hygiene
 - Self-care: toileting hygiene
 - Mobility: average of sit to lying, lying to sitting on side of bed
 - **Average of the two items**
 - Mobility: average of sit to stand, chair/bed-to-chair transfer, toilet transfer
 - **Average of the three items**
 - Mobility: average of walk 50 feet with two turns, walk 150 feet
 - **Average of the two items**

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PT and OT Function Score

Self-care, mobility, and walking items

- MDS coded as:
 - 05, 06 (4 points)
 - Set-up, Independent
 - 04 (3 points)
 - Supervision or touching assistance
 - 03 (2 points)
 - Partial/moderate assistance
 - 02 (1 point)
 - Substantial/maximal assistance
 - 01, 07, 09, 88, 10, (-) (0 points)
 - Dependent, refused, N/A, Not Attempted (medical/safety), Not Attempted (environmental), dash

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Section GG impact on Case Mix

Clinical Category	GG Function Score	PT and OT Case-Mix Group	PT CMI	OT CMI
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.49
	6-9	TB	1.70	1.63
	10-23	TC	1.88	1.69
	24	TD	1.92	1.53
Other Orthopedic	0-5	TE	1.42	1.41
	6-9	TF	1.61	1.60
	10-23	TG	1.67	1.64
	24	TH	1.16	1.15
Medical Management	0-5	TI	1.13	1.18
	6-9	TJ	1.42	1.45
	10-23	TK	1.52	1.54
	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27	1.30
	6-9	TN	1.48	1.50
	10-23	TO	1.55	1.55
	24	TP	1.08	1.09

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Nursing Case Mix

Section GG will be utilized to determine the Function Score (same scale used for PT/OT Function Score)

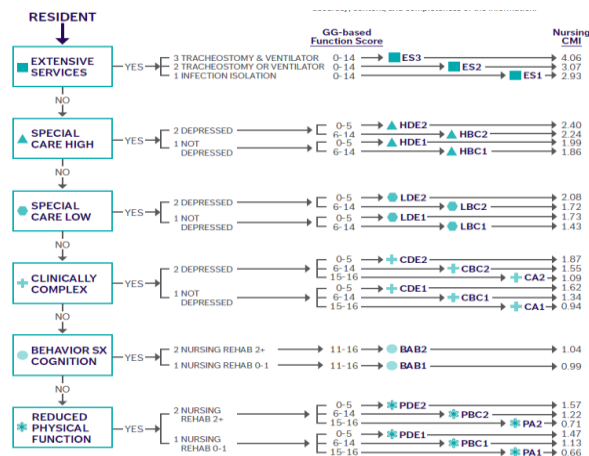
- Looks at:
 - Self-care eating and toilet hygiene
 - Mobility sit to lying, lying to sitting on side of bed
 - Mobility sit to stand
 - Mobility chair/bed-to-chair transfer
 - Mobility toilet transfer

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Section GG impact on Case Mix



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Interim Payment Assessment (IPA)

*"We continue to believe that 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" (emphasis added). At the same time, in making the IPA optional, we recognized "... that providers may be best situated, as in the case of the Significant Change in Status Assessment, to determine when a change has occurred that should be reported through the IPA." (84 FR 39233) We believe this discussion clearly establishes the IPA as one of the vehicles that the SNF can utilize in the course of carrying out its ongoing patient monitoring responsibilities."*

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IPA

OPTIONAL

- Utilized when patient has change of condition that affects payment
- Resets patient classification and payment as of the ARD, but not tapering (tapering continues)
- Uses the IPA item set (questions that impact any one of the five PDPM components)
- Adds column 5 to section GG to capture GG Functional level in 11 areas of self-care and mobility

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IPA

The IPA comes down to some simple questions:

- If I complete the IPA, will my daily rate increase?
- Will it increase to a level that is worth completing this MDS
- Is the predicted length of stay following the IPA worth completing this MDS?

Keep in mind the preceding questions as well as the staff time and energy to complete the IPA (GG, BIMS, PHQ-9 also) before the IDT makes the final decision

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IPA

If even one of the five Case Mix adjusted PDPM components changes, you should complete an IPA?

- The decision to complete an IPA or not will be a very case by case decision at your facility
- Five separate and distinct Case Mix adjust PDPM components
- Having one increase in its Case Mix doesn't mean that the other four have also
- You could have one increase, three stay the same, and one decrease
 - The overall daily rate may get worse or better in this situation, based on the individual resident acuity that is captured on the MDS

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IPA

If the resident is discontinued off the therapy case load and they will be skilled for nursing only, should an IPA be completed?

- The optional IPA is not to be confused with the prior EOT MDS that was needed when a resident under a Rehab RUG ends rehab services and continues under a nursing skilled service
- Therapy ending services wouldn't typically be an IPA trigger, but the acuity picture of the resident may warrant an IPA investigation

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IPA

If the resident meets the criteria for a SCSA, should you also combine it with an IPA?

- The SCSA has very specific criteria for when to complete and not complete, outlined in chapter 2 of the RAI's user manual
- The IPA is a strictly optional assessment for Medicare residents and is to be utilized to capture an increase in the daily PDPM rate
- The IPA cannot be combined with any other assessment

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Primary Clinical Category Selection

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Primary Clinical

Focuses on the primary clinical reason selected at I0020/I0020B and J2100 (prior surgery)

- Enter the ICD-10 code, including the decimal, of the primary diagnosis of the SNF patient
- “We understand that SNF patients have many complex needs and may suffer from a number of different conditions, but a diagnosis coded in I0020B should represent the primary or main reason that person is being admitted”
- This primary SNF diagnosis “may or may not be the same reason that the patient was admitted to the qualifying hospital stay,” pointed out officials. “In other words, there is no necessary reason that the primary SNF diagnosis must match the primary hospital diagnosis from the prior hospital stay”

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I0020. Indicate the resident's primary medical condition category	
Complete only if A0310B = 01 or 08	
Enter Code	Indicate the resident's primary medical condition category that best describes the primary reason for admission
<input type="text"/>	01. Stroke
<input type="text"/>	02. Non-Traumatic Brain Dysfunction
<input type="text"/>	03. Traumatic Brain Dysfunction
<input type="text"/>	04. Non-Traumatic Spinal Cord Dysfunction
<input type="text"/>	05. Traumatic Spinal Cord Dysfunction
<input type="text"/>	06. Progressive Neurological Conditions
<input type="text"/>	07. Other Neurological Conditions
<input type="text"/>	08. Amputation
<input type="text"/>	09. Hip and Knee Replacement
<input type="text"/>	10. Fractures and Other Multiple Trauma
<input type="text"/>	11. Other Orthopedic Conditions
<input type="text"/>	12. Debility, Cardiorespiratory Conditions
<input type="text"/>	13. Medically Complex Conditions
I0020B. ICD Code	
<input type="text"/>	<input type="text"/>

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Clinical crosswalk example

ICD-10-CM Code	Description	Default Clinical Category	Resident Had a Major Procedure during the Prior Inpatient Stay that Impacts the SNF Care Plan?
H5941	Inflammation (infection) of postprocedural bleb, stage 1	Medical Management	N/A
H5942	Inflammation (infection) of postprocedural bleb, stage 2	Medical Management	N/A
H5943	Inflammation (infection) of postprocedural bleb, stage 3	Medical Management	N/A
H59811	Chororetinal scars after surgery for detachment, right eye	Return to Provider	N/A
H59812	Chororetinal scars after surgery for detachment, left eye	Return to Provider	N/A
H59813	Chororetinal scars after surgery for detachment, bilateral	Return to Provider	N/A
H59819	Chororetinal scars after surgery for detachment, unspecified eye	Return to Provider	N/A
H5988	Other intraoperative complications of eye and adnexa, not elsewhere classified	Return to Provider	N/A
H5989	Other postprocedural complications and disorders of eye and adnexa, not elsewhere classified	Return to Provider	N/A
H6000	Abscess of external ear, unspecified ear	Return to Provider	N/A
H6001	Abscess of right external ear	Return to Provider	N/A
H6002	Abscess of left external ear	Return to Provider	N/A
H6003	Abscess of external ear, bilateral	Return to Provider	N/A
H6010	Cellulitis of external ear, unspecified ear	Return to Provider	N/A
H6011	Cellulitis of right external ear	Acute Infections	N/A
H6012	Cellulitis of left external ear	Acute Infections	N/A
H6013	Cellulitis of external ear, bilateral	Acute Infections	N/A
H6020	Malignant otitis externa, unspecified ear	Return to Provider	N/A
H6021	Malignant otitis externa, right ear	Return to Provider	N/A

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J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or 08	
Enter Code <input type="checkbox"/>	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

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Clinical Crosswalk Example

I2599	Other forms of chronic ischemic heart disease	Cardiovascular and Coagulations	NA
I259	Chronic ischemic heart disease, unspecified	Cardiovascular and Coagulations	NA
I2601	Septic pulmonary embolism with acute cor pulmonale	Return to Provider	NA
I2602	Saddle embolus of pulmonary artery with acute cor pulmonale	Cardiovascular and Coagulations	May be Eligible for the Non-Orthopedic Surgery Category
I2609	Other pulmonary embolism with acute cor pulmonale	Cardiovascular and Coagulations	May be Eligible for the Non-Orthopedic Surgery Category
I2690	Septic pulmonary embolism without acute cor pulmonale	Return to Provider	NA
I2692	Saddle embolus of pulmonary artery without acute cor pulmonale	Cardiovascular and Coagulations	May be Eligible for the Non-Orthopedic Surgery Category
I2693	Single subsegmental pulmonary embolism without acute cor pulmonale	Cardiovascular and Coagulations	May be Eligible for the Non-Orthopedic Surgery Category
I2694	Multiple subsegmental pulmonary emboli without acute cor pulmonale	Cardiovascular and Coagulations	May be Eligible for the Non-Orthopedic Surgery Category
I2699	Other pulmonary embolism without acute cor pulmonale	Cardiovascular and Coagulations	May be Eligible for the Non-Orthopedic Surgery Category
I270	Primary pulmonary hypertension	Cardiovascular and Coagulations	NA
I271	Kyphoscoliotic heart disease	Cardiovascular and Coagulations	NA
I2720	Pulmonary hypertension, unspecified	Cardiovascular and Coagulations	NA

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J2100 Recent Surgery Requiring Active SNF Care

Generally, major surgery for item J2100 refers to a procedure that meets the following criteria:

1. The resident was an inpatient in an acute care hospital for at least one day in the 30 days prior to admission to the skilled nursing facility (SNF), and
2. The surgery carried some degree of risk to the resident's life or the potential for severe disability.

- Surgeries requiring active care during the SNF stay are surgeries that have a direct relationship to the resident's primary SNF diagnosis, as coded in I0020B
- Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered surgeries that do not require active care during the SNF stay

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J2100 Recent Surgery Requiring Active SNF Care

Recent surgery during an Interrupted Stay

- The resident returns to the same SNF for skilled services related to the total knee replacement after being in the hospital for two midnights, qualifying as an interrupted stay
 - No new 5-day MDS is required for an interrupted stay because it is a continuation of the previous SNF stay
 - If the SNF chooses to complete an Interim Payment Assessment (IPA) for this resident, J2100 will still be coded 'yes,' and the total knee replacement from the three-day qualifying hospital stay will still be captured in J2300
 - If the facility chooses not to complete an IPA, payment will continue to be based off the existing 5-day assessment that captured that total knee replacement

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J2100 Recent Surgery Requiring Active SNF Care

Recent surgery during a New Stay

- The resident returns to the same SNF for skilled services related to the total knee replacement after being in the hospital for three midnights
 - This resident has had an intervening three-day hospital stay
 - The hospital stay when the resident had the total knee replacement is no longer the immediately preceding inpatient stay, so it should not be coded on the new 5-day MDS even though the resident is still receiving skilled services related to the total knee replacement
 - J2100 would be coded 2 (no), and no surgical procedures would be captured in J2300 – J2500 on the 5-day MDS for this resident who had monitoring and cardiac assessment in the immediately preceding three-day qualifying hospital stay
 - Page J-37 in chapter 3 of the RAI User's Manual clarifies the J2100 question:
 - This item identifies whether the resident had major surgery during the inpatient stay that **immediately preceded the resident's Part A admission**. A recent history of major surgery can affect a resident's recovery

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J2100 Recent Surgery Requiring Active SNF Care

Recent surgery during a New Stay

- Officials with the Centers for Medicare & Medicaid Services reaffirmed this interpretation of the coding instructions during the September 19 Skilled Nursing Facility/Long-term Care Open Door Forum: “If you have a hospital stay that happens in the interim that would create a new stay, then that hospital stay becomes the stay from which you would draw your responses for [J2100 – J5000],” they said
- MDS item A2400B (Start Date of Most Recent Medicare Stay) can serve as a guide for determining which inpatient hospital stay qualifies for J2100 – J5000, advised officials: “The date in A2400 provides a pretty good sense of when the Part A stay began, and then the hospital stay which occurred prior to that Medicare start date is the one we are looking at. That might provide a good way of trying to understand the intent in terms of what hospital stay should be considered for that”

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Surgical Procedures - Complete only if J2100 = 1	
↓	Check all that apply
Major Joint Replacement	
<input type="checkbox"/>	J2300. Knee Replacement - partial or total
<input type="checkbox"/>	J2310. Hip Replacement - partial or total
<input type="checkbox"/>	J2320. Ankle Replacement - partial or total
<input type="checkbox"/>	J2330. Shoulder Replacement - partial or total
Spinal Surgery	
<input type="checkbox"/>	J2400. Involving the spinal cord or major spinal nerves
<input type="checkbox"/>	J2410. Involving fusion of spinal bones
<input type="checkbox"/>	J2420. Involving lamina, discs, or facets
<input type="checkbox"/>	J2499. Other major spinal surgery
Other Orthopedic Surgery	
<input type="checkbox"/>	J2500. Repair fractures of the shoulder (including clavicle and scapula) or arm (but not hand)
<input type="checkbox"/>	J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle (not foot)
<input type="checkbox"/>	J2520. Repair but not replace joints
<input type="checkbox"/>	J2530. Repair other bones (such as hand, foot, jaw)
<input type="checkbox"/>	J2599. Other major orthopedic surgery

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<input type="checkbox"/>	Neurological Surgery
<input type="checkbox"/>	J2600. Involving the brain, surrounding tissue or blood vessels (excludes skull and skin but includes cranial nerves)
<input type="checkbox"/>	J2610. Involving the peripheral or autonomic nervous system - open or percutaneous
<input type="checkbox"/>	J2620. Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices
<input type="checkbox"/>	J2699. Other major neurological surgery
<input type="checkbox"/>	Cardiopulmonary Surgery
<input type="checkbox"/>	J2700. Involving the heart or major blood vessels - open or percutaneous procedures
<input type="checkbox"/>	J2710. Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords - open or endoscopic
<input type="checkbox"/>	J2799. Other major cardiopulmonary surgery
<input type="checkbox"/>	Genitourinary Surgery
<input type="checkbox"/>	J2800. Involving male or female organs (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
<input type="checkbox"/>	J2810. Involving the kidneys, ureters, adrenal glands, or bladder - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
<input type="checkbox"/>	J2899. Other major genitourinary surgery
<input type="checkbox"/>	Other Major Surgery
<input type="checkbox"/>	J2900. Involving tendons, ligaments, or muscles
<input type="checkbox"/>	J2910. Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
<input type="checkbox"/>	J2920. Involving the endocrine organs (such as thyroid, parathyroid), neck, lymph nodes, or thymus - open
<input type="checkbox"/>	J2930. Involving the breast
<input type="checkbox"/>	J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant
<input type="checkbox"/>	J5000. Other major surgery not listed above

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PDPM ICD-10, SLP Comorbidity and NTA Crosswalk

Updated 03-31-2020

*Copy and paste the link below to go directly to the Zip file

<https://www.cms.gov/files/zip/fy-2020-pdpm-icd-10-mappings.zip>

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PT/OT/ST Case-Mix

10 PDPM primary clinical categories	4 corresponding PT/OT collapsed categories	2 corresponding SLP collapsed categories
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery	Non-Neurologic
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic	Non-Neurologic
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Other Orthopedic	Non-Neurologic
Acute Infections	Medical Management	Non-Neurologic
Medical Management	Medical Management	Non-Neurologic
Cancer	Medical Management	Non-Neurologic
Pulmonary	Medical Management	Non-Neurologic
Cardiovascular and Coagulations	Medical Management	Non-Neurologic
Acute Neurologic	Non-Orthopedic Surgery and Acute Neurologic	Acute Neurologic
Non-Orthopedic Surgery	Non-Orthopedic Surgery and Acute Neurologic	Non-Neurologic

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ST Case-Mix (3 characteristics)

1. Clinical Category

- Focuses on the primary clinical reason being “Acute Neurologic” or “Non-Neurologic”
 - Focuses on the primary clinical reason selected at I0020/I0020B

2. Swallowing disorder or mechanically-altered diet

- Increased provider cost for either of the above and more if both are present
- Classification can be “either”, “neither”, or “both”
- Identified in K0100A-D (swallowing disorder) and K510C2 (mechanically-altered diet)

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ST Case-Mix (3 characteristics)

3. Cognitive status or SLP related comorbidity present

- Aphasia
- CVA, TIA, or Stroke
- Hemiplegia or Hemiparesis
- TBI
- Tracheostomy care (while a resident)
- Vent/Respirator (while a resident)
- Laryngeal cancer
- Apraxia
- Dysphagia
- ALS
- Oral Cancers
- Speech and language deficits

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Operational Summary

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Summary

- Mindset of “driving LOS” is not financially responsible
- Accurate coding of covariates, GG, and ICD-10s is critical to accuracy on the MDS and then to accurate and maximal payment for entire stay
- Decreased MDS volume for Traditional MCR does not automatically equate to a reduction in MDS staff
- Therapy utilization no longer driving the RUG calculation does not automatically equate to a reduction in therapy staff

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Summary

What PDPM does not change:

- Medicare coverage criteria
- Physician Certs
- OBRA MDS requirements
- Completion and submission timing requirements
- Modification/Inactivation process
- NOMNC/ABN requirements

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Thank You

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References

- Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, October 2019
- CMS- Patient-Driven Payment Model: Frequently Asked Questions (FAQs), last revised 4-4-19