Patient Driven Payment Model
PDPM – Overview for Compliance

Laura Pait, RHIA, CDIP, CCS
Vice President, Workforce and Advisory Solutions

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The Innovator in Healthcare Workforce Solutions and Staffing Services

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
Why Audit?

PDPM Snapshot

Where to Start
Variable per diem adjustment
Assessment Schedules
Interim Payment Assessments
HIPPS codes

How to Start
Administrative Level of Care
Presumption
Concurrent & Group Therapy
Limits
Interrupted Stay Policy

Agenda

Where to Start
Strategies for PDPM Success
Summary and Wrap up

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.
Changing from RUG-IV to PDPM?

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

October 1st 2019 – PRPM Implementation Date – Hard Transition

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.
Clinical Categories

<table>
<thead>
<tr>
<th>PDPM Clinical Categories</th>
<th>PT &amp; OT Clinical Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>Major Joint Replacement or Spinal Surgery</td>
</tr>
<tr>
<td>Acute Neurologic</td>
<td>Non-Orthopedic Surgery &amp; Acute Neurologic</td>
</tr>
<tr>
<td>Non-Orthopedic Surgery</td>
<td>Other Orthopedic</td>
</tr>
<tr>
<td>Non-Surgical Orthopedic/Musculoskeletal</td>
<td>Medical Management</td>
</tr>
<tr>
<td>Orthopedic - Surgical Extremities Not Major Joint</td>
<td></td>
</tr>
<tr>
<td>Medical Management</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Pulmonary</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular &amp; Coagulations</td>
<td></td>
</tr>
<tr>
<td>Acute Infections</td>
<td></td>
</tr>
</tbody>
</table>

SNF Primary Diagnosis Coding for I0020B and Principal Diagnosis for Claim

Section I

<table>
<thead>
<tr>
<th>Active Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>I0020B: Indicate the resident's primary medical condition category</td>
</tr>
<tr>
<td>Complete only if A231 or A366</td>
</tr>
</tbody>
</table>

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
Patient Surgical History

J2000. Prior Surgery - Complete only if A0310B = 01

- 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

- 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

Surgical Procedures - Complete only if J2100 = 1

Check all that apply

- Major Joint Replacement
  - J2100. Knee Replacement - partial or total
  - J2101. Hip Replacement - partial or total
  - J2102. Ankle Replacement - partial or total
  - J2103. Shoulder Replacement - partial or total

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

- Other Orthopedic Surgery
  - J2900. Repair fractures of the shoulder (including clavicle and scapula) of arm (but not hand)
  - J2910. Repair fractures of the pelvic, hip, leg, knee, or ankle (but not foot)

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
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

<table>
<thead>
<tr>
<th>SLP Comorbidities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aphasia</td>
</tr>
<tr>
<td>Laryngeal Cancer</td>
</tr>
<tr>
<td>CVA, TIA, or Stroke</td>
</tr>
<tr>
<td>Apraxia</td>
</tr>
<tr>
<td>Hemiplegia or Hemiparesis</td>
</tr>
<tr>
<td>Dysphagia</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
</tr>
<tr>
<td>ALS</td>
</tr>
<tr>
<td>Tracheostomy (while Resident)</td>
</tr>
<tr>
<td>Oral Cancers</td>
</tr>
<tr>
<td>Ventilator (while Resident)</td>
</tr>
<tr>
<td>Speech &amp; Language Deficits</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>RUG-IV Nursing RUG</th>
<th>Extensive Services</th>
<th>Clinical Conditions</th>
<th>Depression</th>
<th>Restorative Nursing Services</th>
<th>Function Score</th>
<th>CMG</th>
<th>CMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>ES3</td>
<td>Tracheostomy &amp; Ventilator</td>
<td>Serious medical conditions e.g. coma, sepsis, respiratory therapy</td>
<td>Yes</td>
<td>ES3</td>
<td>0-14</td>
<td>ES3</td>
<td>4.04</td>
</tr>
<tr>
<td>ES2</td>
<td>Tracheostomy or Ventilator</td>
<td>Serious medical conditions e.g. coma, sepsis, respiratory therapy</td>
<td>No</td>
<td>ES2</td>
<td>0-14</td>
<td>ES2</td>
<td>3.06</td>
</tr>
<tr>
<td>ES1</td>
<td>Infection Isolation</td>
<td>Serious medical conditions e.g. coma, sepsis, respiratory therapy</td>
<td>Yes</td>
<td>ES1</td>
<td>0-14</td>
<td>ES1</td>
<td>2.91</td>
</tr>
<tr>
<td>HE2/HO2</td>
<td></td>
<td>Serious medical conditions e.g. coma, sepsis, respiratory therapy</td>
<td>Yes</td>
<td>HE2/HO2</td>
<td>0-5</td>
<td>HCE2</td>
<td>2.39</td>
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<tr>
<td>HE1/HO1</td>
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<td>Serious medical conditions e.g. coma, sepsis, respiratory therapy</td>
<td>No</td>
<td>HE1/HO1</td>
<td>0-5</td>
<td>HCE1</td>
<td>1.99</td>
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<tr>
<td>H1/HO2</td>
<td></td>
<td>Serious medical conditions e.g. coma, sepsis, respiratory therapy</td>
<td>Yes</td>
<td>H1/HO2</td>
<td>6-14</td>
<td>HBC2</td>
<td>2.23</td>
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<tr>
<td>H1/HO1</td>
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<td>Serious medical conditions e.g. coma, sepsis, respiratory therapy</td>
<td>No</td>
<td>H1/HO1</td>
<td>6-14</td>
<td>HBC1</td>
<td>1.85</td>
</tr>
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</table>

AMN Healthcare
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

Where to Start?

https://www.groupomniches.com
What is the variable per diem adjustment?

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

Assessment Schedules

RUG-IV

<table>
<thead>
<tr>
<th>Day 5 MDS</th>
<th>Day 14 MDS</th>
<th>Day 30 MDS</th>
<th>Day 60 MDS</th>
<th>Day 90 MDS</th>
<th>PPS Discharge MDS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RUG-IV Assessments

- Therapy OMRA

PDPM

<table>
<thead>
<tr>
<th>Day 5 MDS - EXPANDED -</th>
<th>OPTIONAL Interim Payment Assessment (IPA) - NEW -</th>
<th>PPS Discharge MDS - EXPANDED -</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PDPM Assessments

- PPS
**Assessment Schedules**

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

**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
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.

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.
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.

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...
**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

**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**
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.

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
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

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.
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)
Where to start? The findings

Variation can be the enemy of quality in auditing
Consider multiple auditors on one project…

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.

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
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.

![Graphs showing Overall Accuracy and Financial Impact Trends]

Strategies for PDPM Success

Data comes from the Minimum Data Set (MDS)

Most folks have MDS accuracy incorporated into 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
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

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

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.
Summary

1. PDPM remains a per-diem payment model but components have changed
   
   **RUGs**
   - Therapy
   - Non-Case-Mix Therapy
   - Nursing
   - Non-Case-Mix

   **PDPM**
   - PT
   - OT
   - SLP
   - Nursing
   - NAC
   - Non-Case-Mix

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
6. New and revised MDS components – GG, G, J etc.

Wrap Up

It’s a journey...  
PDPM!

- Ask Questions
  - This is easy!
  - Ok, getting better
  - I’ve got this
  - This is tough, but ok
  - I will never get this!
  - Who designed this system anyway????
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

Q&A