PDPM in the real world

Solutions & case studies

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Goals for today's webinar

1. Discuss key best practices you can implement now for PDPM
2. Provide real-world tips to avoid losing reimbursement
3. Share info that applies to all facilities (regardless of EHR, company size, etc.)
4. Use data visualization to show how to understand trends

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What we'll cover

- Diagnoses and keys to optimal coding
- Per-diem rates and the MDS
- Avoiding audits
- Real-world PDPM – Sava Senior Care
- Analyzing and optimizing data for PDPM
- Q&A

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Presenters

Amy Phipps

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SimpleLTC

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Case study

Alice Conley

- Age: 62
- Primary diagnosis: End-stage renal disease
- RUG: RUB
- Mood severity: 1
- PHQ-9: No depression
- SimpleLTC frailty index: 39.77 (mid-range)

Active Diagnoses During Stay

R52	Non-billable	Pain, unspecified
D64.9	Medical Management	Anemia, unspecified
R13.12	Non-billable	Dysphagia, oropharyngeal phase
M25.552	Non-billable	Pain in left hip
E78.5	Medical Management	Hyperlipidemia, unspecified
R26.2	Non-billable	Difficulty in walking, not elsewhere classified
I50.9	Cardiovascular and Coagulations	Heart failure, unspecified
J18.9	Pulmonary	Pneumonia, unspecified organism
M81.8	Non-billable	Other osteoporosis without current pathological fracture
I25.9	Cardiovascular and Coagulations	Chronic ischemic heart disease, unspecified
I49.9	Cardiovascular and Coagulations	Cardiac arrhythmia, unspecified
N19	Medical Management	Unspecified kidney failure
E21.2	Medical Management	Other hyperparathyroidism
E08.8	Non-billable	Diabetes due to underlying condition w unsp complications
M62.81	Non-billable	Muscle weakness (generalized)
I10	Non-billable	Essential (primary) hypertension
E16.2	Medical Management	Hypoglycemia, unspecified
E87.5	Medical Management	Hyperkalemia
R62.7	Non-billable	Adult failure to thrive
N18.6	Medical Management	End stage renal disease

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Diagnoses and keys to optimal coding

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What makes a valid primary diagnosis?

- Planning ahead requires **accurately** calculating PDPM rates with today's MDS assessments and comparing to current RUG-IV rates
- It all starts with primary diagnosis – but what does that mean?
  - CMS Clinical Category Crosswalk
    https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPMClinicalCategoryMapping_Final.zip
  - SimpleAnalyzer™ PDPM Diagnoses Explorer – easily search for:
    - Valid Primary Diagnoses and Associated Clinical Categories
    - NTA and SLP Comorbidities
    - Surgical Eligibility Diagnoses

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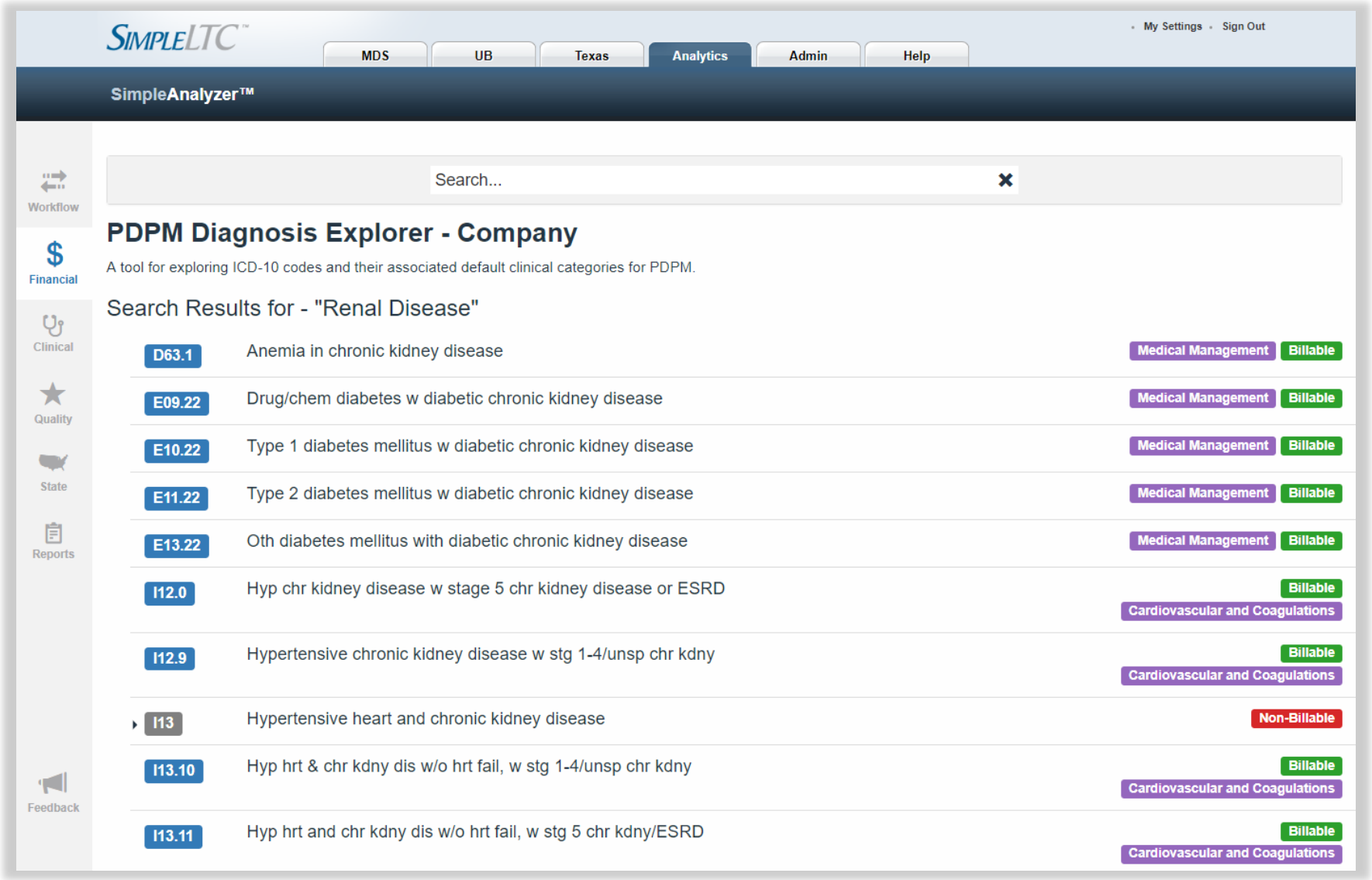
What makes a valid primary diagnosis?



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What makes a valid primary diagnosis?

- Clinical categories by highest per-diem rate **potential**
  - Major Joint Replacement or Spinal Surgery
  - Orthopedic Surgery
  - Non-Orthopedic Surgery
  - Non-Surgical Orthopedic/Musculoskeletal
  - Acute Neurologic
  - Acute Infections
  - Cancer
  - Cardiovascular and Coagulations
  - Pulmonary
  - Medical Management

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Temporarily use I8000A before Oct. 1

- To calculate PDPM case-mix groups (CMG) now, every MDS must have a standardized field for the primary diagnosis
- In your EHR, make sure primary diagnoses are recorded in MDS field **I8000A**
- *After* Oct. 1, primary diagnosis will be recorded in field **I0020B** and only valid primary diagnoses will be accepted by CMS
- Consider modifying previously submitted 5-day PPS assessments to include primary diagnoses for accurate PDPM forecasting

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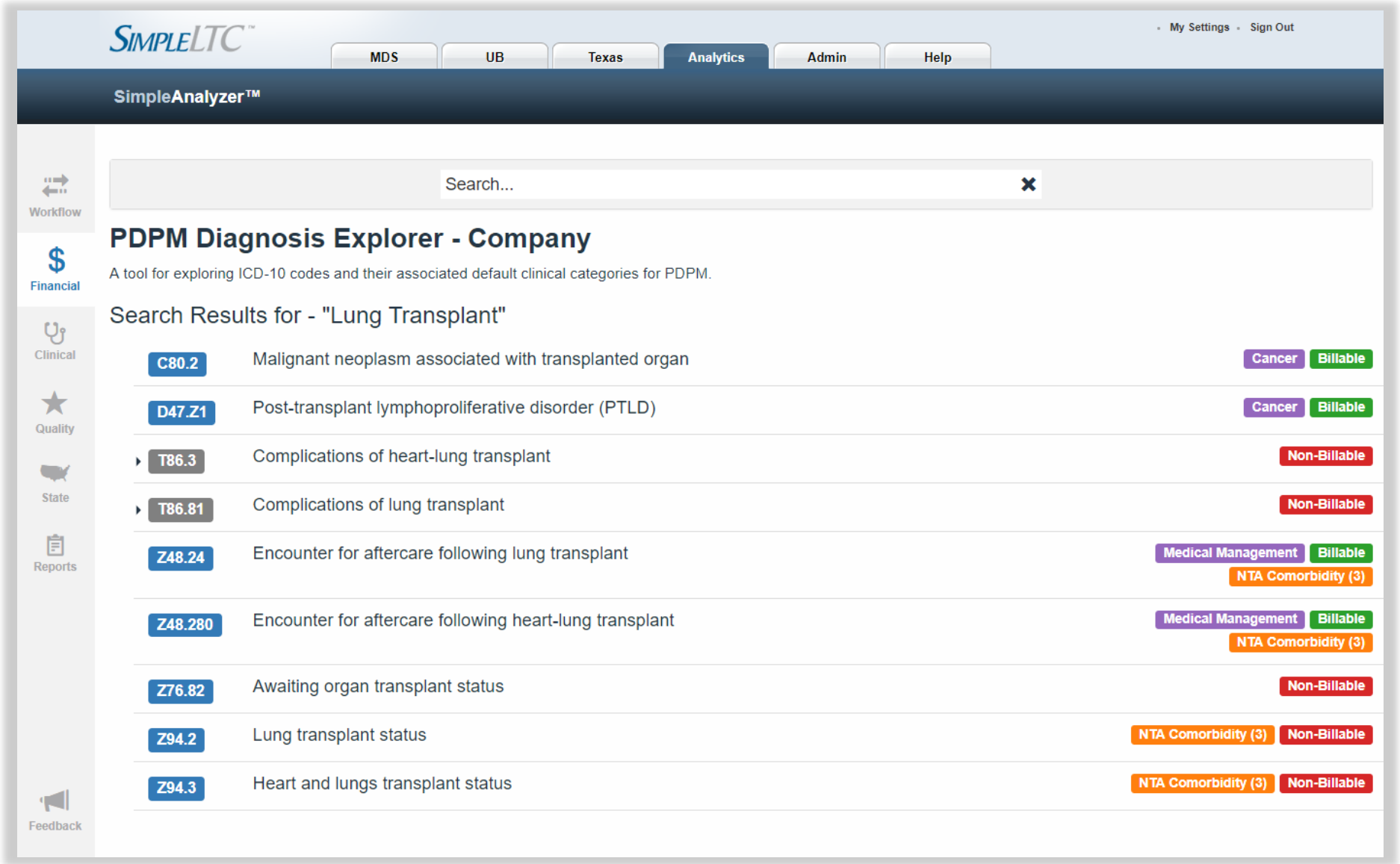
Don’t leave out active diagnoses

- Non-primary diagnoses are still very important
  - Especially for NTA, SLP and Nursing categories
- Don’t skip any I0100–I7900 fields
  - And include any relevant NTA/SLP comorbidities in I8000(B-J)

Don't leave out active diagnoses



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Diagnoses: Key takeaways

- Primary diagnosis **must** be valid
- Associated default clinical category heavily impacts a resident's base per-diem rate
- Other active diagnoses are still very important for optimizing reimbursement rates
- Not a Return to Provider (RTP) diagnosis
- Start educating staff on PDPM relevant diagnoses now

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Live poll

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Per-diem rates and the MDS

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Anatomy of the PDPM per-diem rate

- 5 PDPM categories and their base rates
  - Nursing $103.46 ($98.83 – rural)
  - NTA $78.05 ($74.56 – rural)
  - PT $59.33 ($67.63 – rural)
  - OT $55.23 ($62.11 – rural)
  - SLP $22.15 ($27.90 – rural)
- Non-case-mix $92.63 ($94.34 – rural)
- Multipliers
  - AIDS/HIV diagnosis code (not all states allow coding of these dx on the MDS)
  - First 3 days of stay, multiply NTA rates by 3

- Per-diem reductions over time

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

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Functional scoring and cognitive status

- Section GG will now play a vital role in determining per-diem rates
- Under-reporting or skipping functional status scores in section GG will result in lower reimbursement rates
- Be aware of functional score cut points
  - Remember: Nursing is the opposite of therapy

Nursing	PT/OT
0-5	0-5
6-14	6-9
15-16	10-23
11-16	24

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Functional scoring and cognitive status

- Cognitive impairment and depression will also play a vital role in determining per-diem rates
- Ensure that staff always conduct:
  - BIMS interview or CPS staff assessment (MDS Section C)
  - PHQ-9 mood interview or staff assessment (MDS Section D)
- Begin doing this *now* – don't wait till Oct. 1

Other important MDS sections

- Don't under-report these sections:
  - **Section K** – Swallowing/Nutritional Status
    - Important for both SLP, NTA and Nursing categories
      - Parenteral/IV feedings, mechanically altered diet, swallowing, etc.
  - **Section O** – Special Treatments, Procedures, & Programs
    - SLP/NTA comorbidities and Nursing categorization
  - **Section M** – Skin Conditions
    - NTA comorbidities and Nursing categorization
  - **Section H** – Bladder & Bowel
    - NTA comorbidities

Live poll

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Avoiding audits

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Therapy minutes

- Group and concurrent therapy combined – can't go over 25% of therapy minutes
- "Consistent violation of this limit may result in your facility being flagged for additional medical review." – CMS
- Not tracked in the MDS until Oct. 1 (new Section O fields)
- More details from CMS fact sheets
  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_Template_CGLimit_v5_508.pdf

Expect CMS to be on the lookout for anomalies

- Depression/BIMs scoring
  - Average rate of depressive symptoms of SNF stays is 47.4% https://www.ncbi.nlm.nih.gov/pubmed/20391857
  - Don't overstate depressive symptoms
  - Begin accurately and comprehensively completing Section D PHQ-9 now!
- Speech/language deficit and altered diet
  - What are the current incidence rates in your population?
- Look at QAPI processes now, prep for changes now
- Document, document, document!

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Properly coding

- As of Oct. 1, CMS will not accept MDS with an invalid diagnosis
- Only a licensed clinician can assign a patient diagnosis
- Start properly coding and regularly communicating with physicians and nurse practitioners now
  - Prep them for PDPM and documentation they will be expected to provide

Real-world PDPM: Sava Senior Care

- 4th largest SNF provider in U.S.
- 200+ facilities
- 10,000+ employees
- 23 states

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Analyzing our systems

- Biggest risks identified
  - Coding
  - GG process/accuracy
  - NTA capture
- Case study – opportunities identified
  - Clinical category
    - Medical Management when Cardio/Coagulations available as well as Acute Infections
    - 0-3 avg NTAs captured (4-6 points available)
    - GG – Setup vs partial assistance in documentation

Case study comparison

Alice Conley: Option #1

Do nothing

- Current Results =
  - TK CMG +SD CMG +NF CMG =

    –$83/day diff base rate compared to RUG rate
- Option #1 isn't a great option

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Case study comparison

Alice Conley: Option #2

4 PDPM strategies initiated

1. ICD-10 coding mapping – Are we choosing the best primary DX?
   - All DX codes mapped to a clinical category
   - Choose most appropriate Clinical Category as Primary
2. Institute GG Huddles daily for first 72 hours after admissions with nursing and rehab documenting GG performance
3. Speech involvement in Cognitive Functional performance and evaluation
4. NTA Clinical Morning Meeting Tool and proficiency with NTA

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Case study outcome

Alice Conley: Option #2

- **Results**
  - TK – Medical Management or Coagulation or Pulmonary were all the same
- **GG for PT/OT at 14 and Nursing 10**
  - Assessed walking due to prior ability and no fracture or contraindication (originally not assessed) along with several GG items at setup and documentation showing Max – GG HUDDLE caught and corrected
- **Speech**
  - SH CMG from original SD CMG – Dysphagia in DX but no altered diet or swallowing issues noted
  - BIM from 15 – no issues to 9 – mild – check documentation and ensure BIMs is being accurately completed to reflect resident's function
- **NTA points from 2 – 6**
  - Obesity and Heart/Pulmonary concerns added points with the DM
- **Rate change**
  - From **$524/base** to **$623/base** – (RUG was $631)

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Corporate operational changes

- **Admissions**
  - Screening Process and data gathering prior to admissions – NTA Awareness
- **Morning Meeting NTA Tool**
  - Highlighted and organized by most common DX WE see in our facilities – prioritized
- **GG Huddles**
  - Initiating GG review for first 3 days of Admission
- **Who is conducting BIMs?**
  - Can Speech Therapy take on this role?
  - What are we missing when cognitive deficits are not identified?
- **Primary diagnoses**
  - No transmissions that don't map to ICD-10 primary starting June 15
  - District-level audit tools incorporating Clinical Category pieces to standard audit process

What we're doing NOW to prepare

- **PDPM Countdown Calendar**
  - Utilizing industry recommendations coupled with our specific Risk/Opportunity areas
  - Homework and QAPI Plan: Facility, District, Division and Company-wide
- **IPA Go-Live Plan**
  - 3,000 Medicare needing IPAs within first 7 days of October
  - "All Hands On Deck" (no vacations Sep. 15-Oct. 15)
- **PDPM Hotline**
  - Division team management for 24/7 support of field
- **PDPM Steering Committee and Training Team**
  - All IDT members meet monthly with Training development in April
  - Onsite 6-week roadshow for field teams beginning in August

Analyzing and preparing data for PDPM

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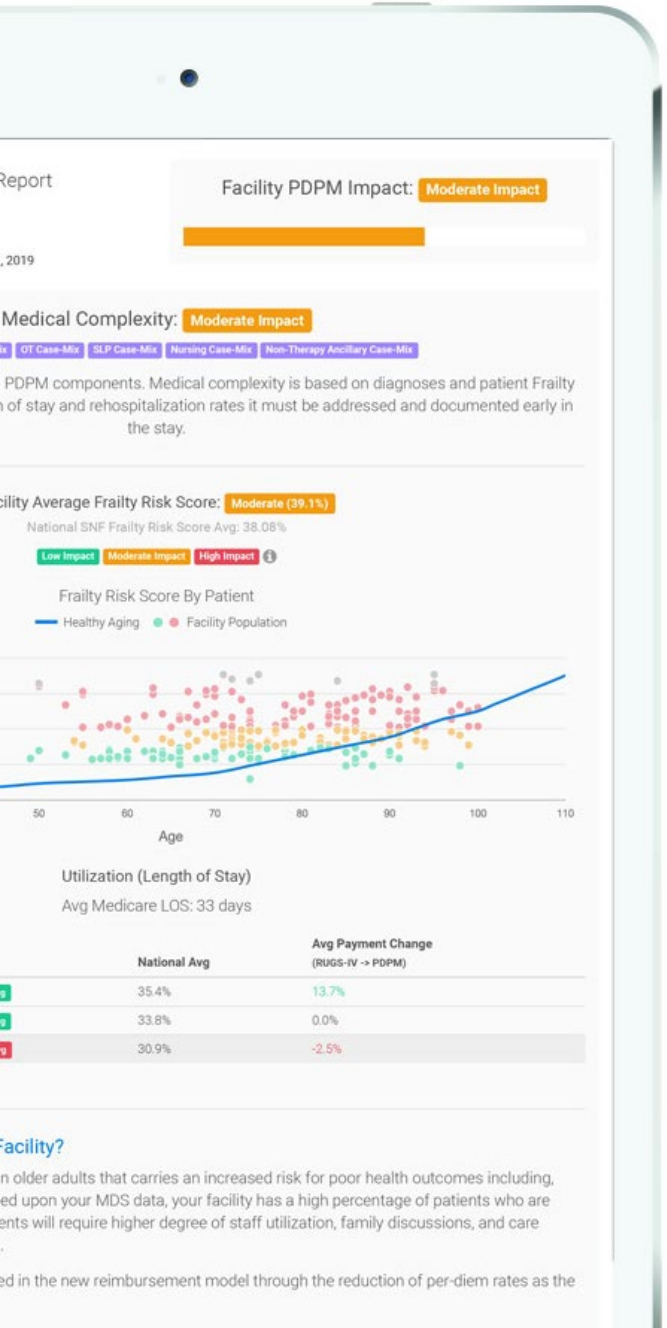

Understanding trends and CMI

- Use data visualization tools to predict/analyze trends and population CMI leading up to PDPM
- Leverage patient profiling and preadmission screening
  - Patient Pattern, etc.

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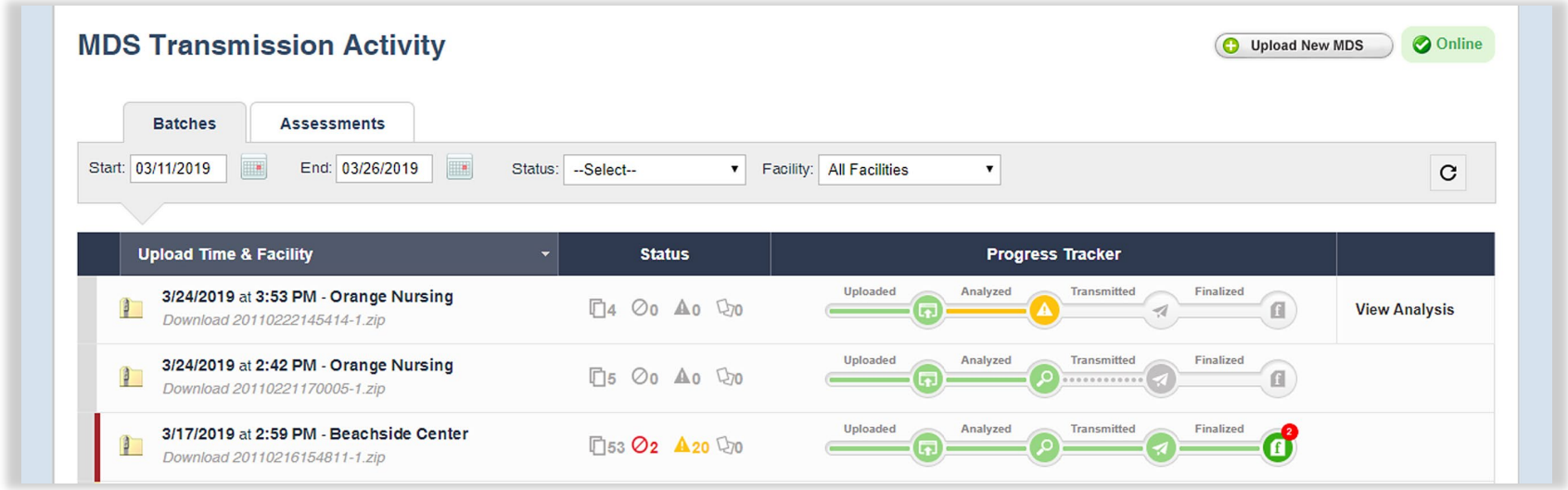
PDPM preparation using analytics

- Preadmission scrubbing is vital



- Use analyzer flags/pre-transmission rules (by Oct. 1) – for example:
  - Check for I8000A primary diagnosis code (begin May-June at latest)
  - Mechanically altered diet, verify if there is a swallowing problem
  - Section GG coding one point from next category
  - COPD diagnosis, verify shortness of breath while lying flat
  - Etc.

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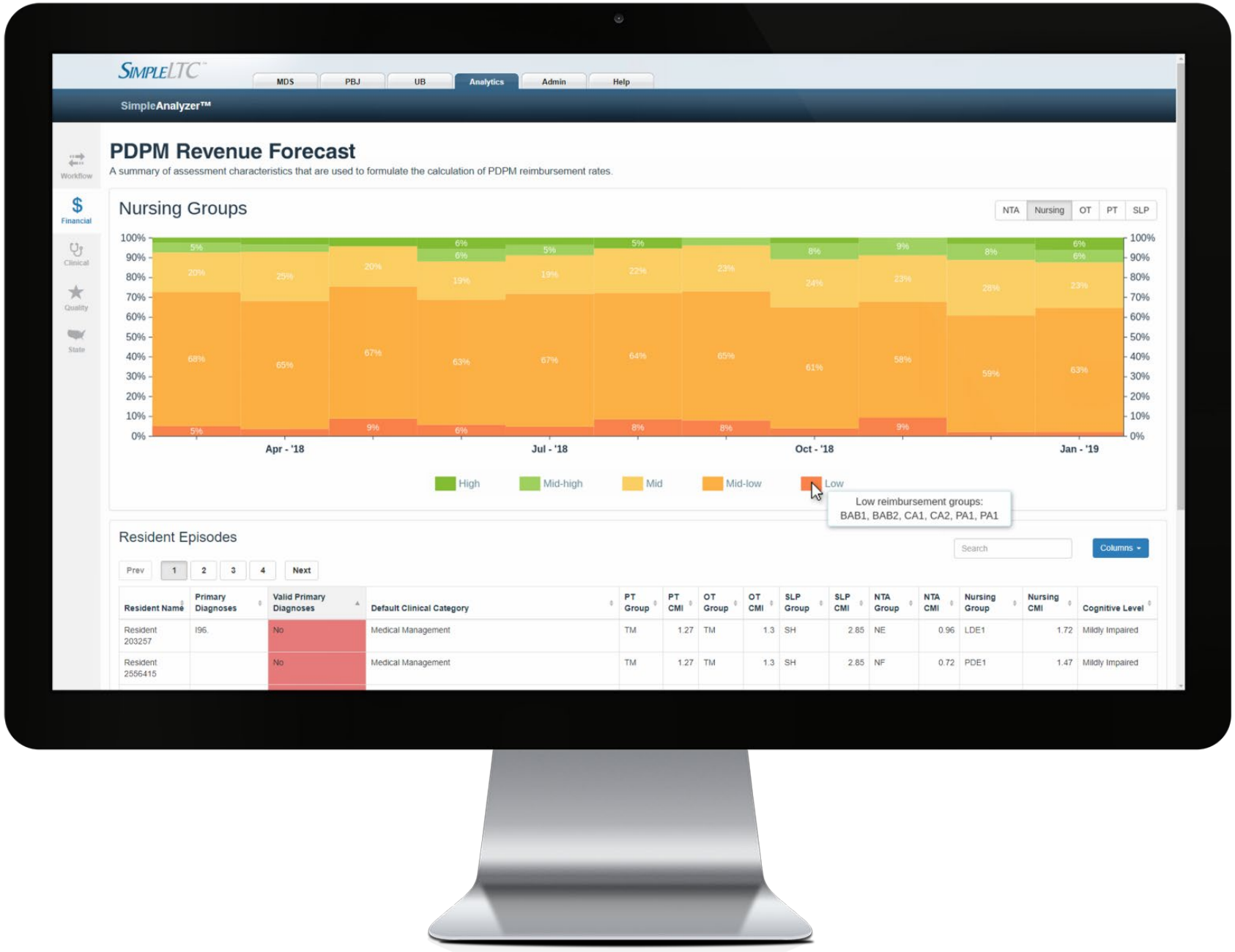

SimpleAnalyzer™

- Forecast PDPM revenue
- Scrub pre-transmission MDS data based on PDPM rules
- Forecast negative trends (diagnoses, frailty and more)
- Improve QMs and Five-Star
- Reduce rehospitalization
- Optimize reimbursement

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Live poll

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Q&A

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Thank you for attending!

Recording and slides available at

simpleltc.com/pdpm

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