Somebody's Watching You: What are your PDPM, PEPPER, and Facility Risk Areas?

Presenter

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Objectives

- Participants will explain and list the various auditors, their intent, and important steps/systems needed to mitigate risk areas
- Participants will describe specific actions to support documentation in areas of medical necessity, function, LOS and D/C planning
- Participants will be able to describe data analysis of facilities and ways to reduce risk of being an outlier

Who is Watching?

- OIG
- MACs
- RACs
- UPICs

Purpose:

To Monitor, identify, educate, and there by reduce Medicare fraud and waste

The Observer

PDPM Starts Strong, But Backlash Looms

By Danielle Brown *January 5, 2020*

(excerpted from McKnight's Long-Term Care News)

Providers overall saw higher reimbursements under the Patient Driven Payment model than what would have come under the Resource Utilization Group system during its first month of implementation, an initial analysis found.

The PDPM-realized average for skilled nursing facilities was about $615 per day, while it was simulated to be $563 per day under RUG-IV, according to a November analysis by consulting firm Zimmet Healthcare Services Group.

The review found that 91.5% of SNFs were "winners," meaning they enjoyed a positive PDPM impact, while just 8.5% experienced reduced payments.

Zimmet experts said federal regulators are expected to recalibrate rates. They also warned of tougher audits for SNFs, and urged providers to ensure that "everything being captured is being documented" in order to maximize reimbursements.

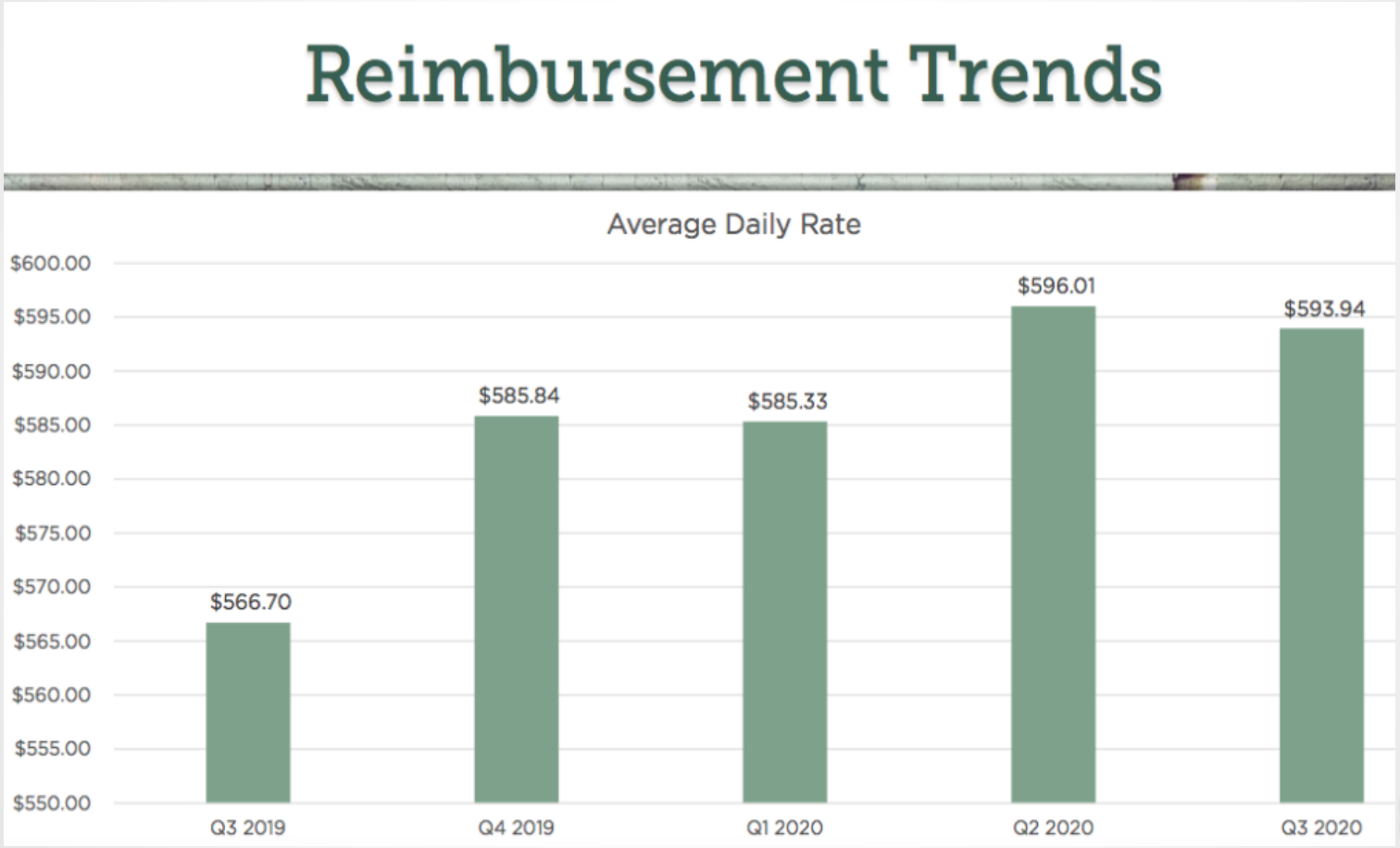
https://www.mcknights.com/print-news/pdpm-starts-strong-but-backlash-looms/

Looking For Trends and Outliers

- CMS goal of PDPM remaining budget neutral compared to RUG system may not be met
- Initial bump with start of PDPM through NTA captures really never went back down to PPS levels:
  - Avg. daily rate Q3 2019 (Pre-PDPM) = 566.70
  - Avg. daily rate Q3 2020 (PDPM) = 593.94 (even during PHE)
  - Difference of 27.24 a day
  - 27.24 x 365 x 10 patients = $99,426 annualized increase in reimbursement potential

https://skillednursingnews.com/2020/10/cms-quiet-on-pdpm-related-enforcement-even-as-rates-rise-but-managed-care-more-prone-to-denials/

Rates PPS vs. PDPM: Skilled Nursing News



The Observer

Rise of Data Could Bring More False Claims Act Cases, CMS Scrutiny to Skilled Nursing

By Alex Spanko *February 26, 2020*

(excerpted from Skilled Nursing News)

Attend any conference geared toward long-term and post-acute health care operators, and you'll hear a common thread: Data is king.

In a landscape defined by value-based payment models such as Medicare Advantage plans and accountable care organizations (ACOs), investing in data analytics has become almost a prerequisite for success.

If a given operator can prove its strength on a variety of key metrics — lower rehospitalization rates, reduced episodic costs — its buildings are more likely to win entrance into hospitals' preferred provider networks, and also potentially attract interest from investors.

But potential partners aren't the only ones looking at that data.

Both the federal government and independent groups have access to an increasing fountain of statistics about nursing home performance and compliance, making the rise of data a double-edged sword for providers worried about attracting the attention of regulators — and potentially facing costly False Claims Act (FCA) cases.

"As claims data and similar information become increasingly available to analytics firms, providers should expect to see more opportunistic FCA cases brought based on data analytics and for traditional relators (such as employees or former employees) to seek to bolster their cases through publicly available reimbursement data," law firm Bass, Berry & Sims noted in its recent recap of 2019 health care fraud and abuse cases. "These cases serve as an important reminder to providers to understand their own data because the government and relators certainly are endeavoring to do so."

https://skillednursingnews.com/2020/02/rise-of-data-could-bring-more-false-claims-act-cases-cms-scrutiny-to-skilled-nursing/

The Observer

In the Face of Crisis, Enforcement Risk Looms for Long-Term Care Providers

By Matt Curley *July 8, 2020*

(excerpted from McKnight's Long-Term Care News)

As long-term care providers brave the most significant public health crisis in our lifetimes, they also may find themselves at the center of an unprecedented increase in enforcement efforts driven by both government regulators and whistleblowers.

A wave of new initiatives and pronouncements by the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG) and the U.S. Department of Justice (DOJ) have placed providers on notice that scrutiny of their operations, the appropriateness of their receipt of government funds, and reimbursement for the services that they provide will intensify in the coming months and years.

The significant operational difficulties and tragic outcomes experienced by a number of long-term care providers have been well-documented. Providers have faced extraordinary staffing challenges, critical supply shortages, and a lack of adequate testing for COVID-19, even as they have stood on the front lines of our nation's healthcare system. Rightly or wrongly, providers' actions in the face of the current crisis may very well be judged with the benefit of hindsight. Systemic breakdowns within nursing facilities will be the subject of much second-guessing as to the appropriateness of staffing, the adequacy of training, and the availability of supplies, notwithstanding this challenging environment.

In the midst of this crisis, government regulators have made clear that scrutiny of long-term care facilities is intensifying:

- DOJ announced its National Nursing Home Initiative in furtherance of its previously-announced Elder Justice Initiative and forecasted increased civil and criminal enforcement efforts focused on nursing homes where grossly substandard care to residents has been provided.

https://www.mcknights.com/print-news/pdpm-starts-strong-but-backlash-looms/

The Observer

CMS Resumes RAC Audits, Other Medical Review Activities

By Jacqueline LaPointe *August 5, 2020*

(excerpted from REV Cycle Intelligence)

RAC audits and other medical review activities put on pause because of COVID-19 restarted August 3rd to the dismay of hospitals still struggling with the pandemic.

CMS recently resumed medical review activities, including pre- and post-payment reviews conducted by Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs), which were paused earlier this year due to the COVID-19 public health emergency.

According to the American Hospital Association (AHA), CMS ended the suspension of most Medicare fee-for-service medical reviews on August 3rd despite HHS Secretary Alex Azar extending the COVID-19 public health emergency late last month.

CMS said it will resume Medicare payment audits and other medical review activities regardless of the status of the public health emergency, AHA said.

Dig Deeper

- **OIG to Audit $50B in Coronovirus Relief Funds Given to Providers**
- **One-Third of Providers Believe Payer Audits Are a Burden**
- **Recover Audit Contractor Reform Eases Provider Burden, CMS Says**

But the audits could take away from hospitals' COVID-19 response efforts, the leading hospital group told CMS Administrator Seema Verma in a July 29th letter calling for the continued suspension of medical review activities.

"The AHA is deeply concerned about CMS's decision to resume these burdensome audits during a pandemic," the group wrote. "COVID-19 cases continue to increase and the number of hospitalizations is now on par with those in April.

https://revcycleintelligence.com/news/cms-resumes-rac-audits-other-medical-review-activities

CMS Compliance Program

Medicare Fee-for-Service Compliance Programs

Medical Review & Education

Recovery Auditing

Prior Authorization and Pre-Claim Review

Outreach & Education

Improving Provider Experience

Measuring Effectiveness

Identification

- CMS implemented the Comprehensive Error Rate Testing (CERT) program to measure rate of improper payments in the Medicare Fee-for-Service (FFS) program. This sets the standard to measure effectiveness of the compliance program.
- CMS and contractors analyze error rate data and develop Error Rate
- Reduction plans to reduce improper payments
- Corrective actions include:
  - Refining error rate measurement processes
  - Improving system edits
  - Updating coverage policies and manuals
  - Conducting provider education efforts

CERT

- Error Rate for 2020

$410.81	total expenditures
6.27%	improper payment rate
$25.74	improper payment amount

- CERT findings can be appealed. Findings showed that insufficient documentation accounted for **75.3%** of the SNF improper payments. A major source of insufficient documentation errors is due to missing certification and recertification statements in whole or in part (that is, required elements are missing).

- Include CERT Check with bi-monthly triple check or other auditing program.

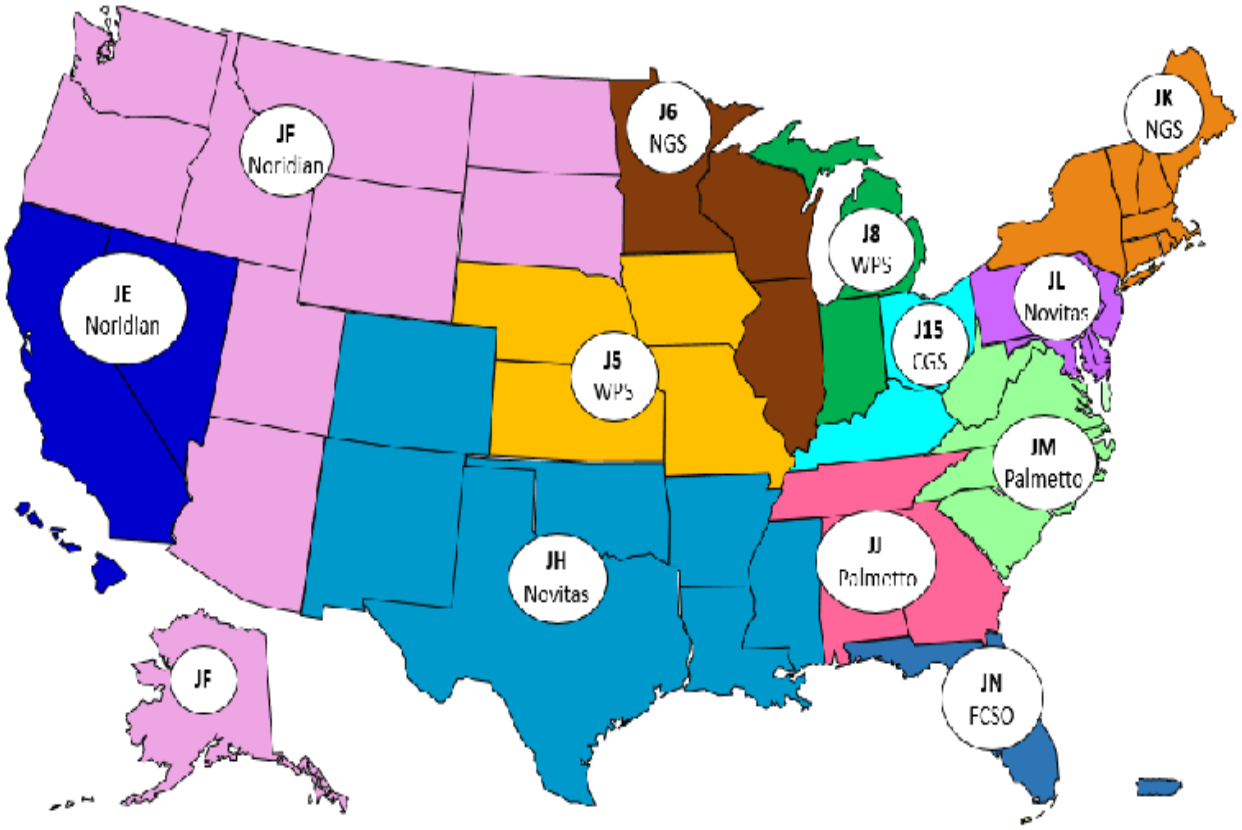
The MACs

A Medicare Administrative Contractor (MAC) is a private health care insurer awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or a durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS)beneficiaries.

- CMS relies on a network of MACs to serve as the primary contact between the Medicare FFS program and enrolled health care providers.
- MACs are multi-state, regional contractors responsible for administering both Medicare Part A and Medicare Part B claims.
- MACs perform many activities including:

  - Process Medicare FFS claims
  - Make and account for Medicare FFS payments
  - Enroll providers in the Medicare FFS program
  - Handle provider reimbursement services and audit institutional provider cost reports
  - Handle redetermination requests (1st stage appeals process)
  - Respond to provider inquiries
  - Educate providers about Medicare FFS billing requirements
  - Establish local coverage determinations (LCD's)
  - Review medical records for selected claims
  - Coordinate with CMS and other FFS contractors

A/B MAC Jurisdictions
as of December 2020



CMS Compliance Program

- TPE – **Target, Probe and Educate** – Run through the MACs
- Most providers will never need TPE. TPE is intended to increase accuracy in very specific areas.
- MACs use data analysis to identify providers and suppliers who have high claim error rates or unusual billing practices, and items and services that have high national error rates and are a financial risk to Medicare.

TPE Fact Sheet

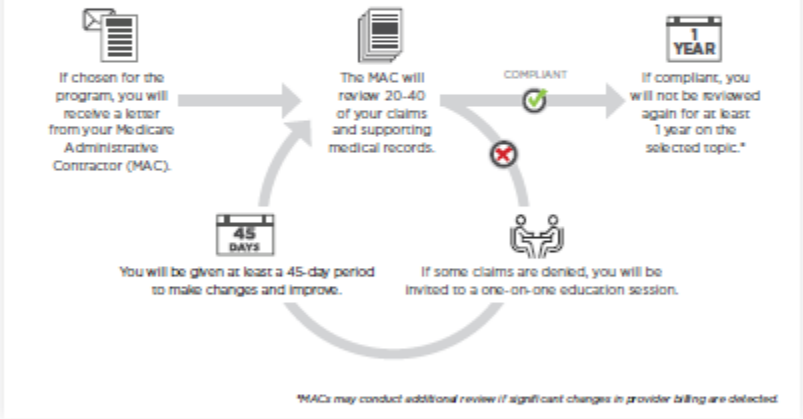
IMPROVING THE MEDICARE CLAIMS REVIEW PROCESS

The Targeted Probe and Educate (TPE) program includes one-on-one help to reduce claim errors and denials.

When Medicare claims are submitted accurately, everyone benefits.

Most providers and suppliers will never need TPE. The process is only used with those who have high denial rates or unusual billing practices. If you are chosen for the program, the goal is to help you quickly improve. Often, simple errors – like missing a signature – are to blame. The process is designed to identify common errors in your submissions and help you correct them.

HOW DOES IT WORK?



*MACs may conduct additional review if significant changes in provider billing are detected.

WHAT IF MY ACCURACY STILL DOESN'T IMPROVE?

This should not be a concern for most providers and suppliers. The majority of those that have participated in the TPE process increased the accuracy of their claims. However, any who fail to improve after 3 rounds of TPE will be referred to CMS for next steps.

WHAT ARE SOME COMMON CLAIM ERRORS?

- The signature of the certifying physician was not included
- Encounter notes did not support all elements of eligibility
- Documentation does not meet medical necessity
- Missing or incomplete initial certifications or recertification

CMS

The RACs

- RACs are CMS's Recovery Audit Contractors

  - Mission: Identify and correct Medicare and Medicaid improper payments through the efficient detection and collection of overpayments made on claims provided to Medicare and Medicaid beneficiaries, to identify underpayments to providers, and to provide information that allows CMS to implement actions that will prevent future improper payments.

  - CMS oversees several different Recovery Audit Programs, such as those for Medicare FFS, Part C, and Part D. States oversee their own Medicaid Recovery Audit Programs in accordance with federal guidelines set by CMS.

Changes to the RACs

- Numerous complaints about the RAC program have been lodged. Providers found the audits time-consuming, necessitating high administrative expenses, and often requiring lengthy appeals.

- Recent efforts by CMS have been made to reduce complaints. These changes include the following:
  - RACs are now accountable for performance by requiring them to maintain a 95% accuracy score. RACs that fail to maintain this rate will receive a progressive reduction in the number of claims they are allowed to review.
  - RACs will maintain an overturn rate of less than 10%. Failure to maintain such a rate, will also result in a progressive reduction in the number of claims the RAC can review.
  - RACs will not receive a contingency fee until after the second level of appeal is exhausted. Previously, RACs were paid immediately upon denial and recoupment of the claim. This delay in payment helps assure providers that the RAC's decision was correct before they are paid.

The RACs

- Previously, RACs could select a certain type of claim to audit. Now, they must audit proportionately to the types of claims a provider submits.

- Instead of treating all providers the same, RACs will conduct fewer audits for providers with low claims denial rates.

- Providers now have more time to submit additional documentation before needing to repay a claim. This 30-day discussion period, after an improper payment is identified, means that providers do not have to choose between initiating a discussion and filing an appeal. CMS expects this will continue to reduce the number of appeals.

Additional RAC Information

CMS will consider allowing Recovery Auditors to use extrapolation to estimate overpayment amounts for:

- Providers who maintain a high denial rate for an extended time period
- Providers who have excessively high denial rates for a shorter time period
- Providers with a moderate denial rate, whose improper payments equal a significantly high overpayment dollar amount

RAC Approved Issues List (SNF)

- SNF Medical Necessity and Documentation Requirements – Stay must meet coverage criteria (Complex Review)
- Untimed Therapy Excessive units (Automated Review)
- SNF Facility Consolidated Billing – outpatient services not separately payable (Automated Review)

Types of RAC Reviews

Automated Review

- Improper payment is obvious
- Claim determination is made immediately

Complex Review

- Claim is likely to contain errors
- RAC requests medical records from the provider to further review the claims
- Claim Determination is made upon review

Clinical Focus

Medical Necessity – Outside of technical issues, most frequently denied clinical reason

Defined:

- "Be safe and effective;
- Have a duration and frequency that are appropriate based on standard practices for the diagnosis or treatment;
- Meet the medical needs of the patient; and
- Require a therapist's skill."

Clinical Focus – Collaboration to Ensure Medical Necessity

PDPM PATIENT FAST TRACK

Patient Name: _____
Admission Date: _____
5 Day ARD: _____
Discharge Plan: _____
Reason for Skilled Stay: _____
ICD-10 Code: _____ Clinical Category
Maps to: _____

Section GG
Therapy Score _____ Nursing Score _____

SLP Comorbidities present? ☐Yes* ☐No **Confirm diagnosis per MD/ST*

List: _____ ICD Code: _____

Cognitive Impairment:

Noted per BIMS Score ☐Yes ☐No **OR** Staff Assessment Score ☐Yes ☐No
Chewing/Swallowing Disorder confirmed through Section K ☐Yes ☐No
Mechanically Altered Diet ☐Yes ☐No

Non-Therapy Ancillary Conditions Present:

List: _____ Points: _____ Nursing RUG: _____

Estimated LOS: ☐greater than 30 days ☐less than 30 days

Click link below for Clinical Category Mapping Crosswalk:
http://www.embracepremier.com/wp-content/uploads/2019/07/PDPM_Clinical_Category_Mapping.zip

Crosswalk from MDS to SLP *(including the description/guidance from the RAI for each item)*

Resident Name: _____
Assessment Reference Date: _____

K0100. Swallowing Disorder Signs and symptoms of possible swallowing disorder.		
↓ Check all that apply		Date Noted
	A. Loss of liquids/solids from mouth when eating or drinking	
	B. Holding food in mouth/cheeks or residual food in mouth after meals	
	C. Coughing or chocking during meals or when swallowing medications	
	D. Complaints of difficulty or pain with swallowing	
	Z. None of the above	

K0100A Loss of liquids/solids from mouth when eating or drinking
When the resident has food or liquid in his or her mouth, the food or liquid dribbles down chin or falls out of the mouth.
Oral prep or oral impairment issue with root cause secondary to reduced labial (lips) or lingual (tongue) strength or range of motion (ROM). Reduced labial (lip) seal or closure. Bilateral or unilateral facial droop or apparent loss of muscle tone.

K0100B Holding food in mouth/cheeks or residual food in mouth after meals
Holding food in mouth or cheeks for prolonged periods of time (sometimes labeled pocketing) or food left in mouth because resident failed to empty mouth completely.
Oral prep or oral impairment issue with root cause secondary to sensory impairment, reduced lingual range of motion, and/or reduced base of tongue retraction. Oral or buccal (cheek) pocketing of food/liquids.

K0100C Coughing or choking during meals or when swallowing medication
The resident may cough or gag, turn red, have more labored breathing, or have difficulty speaking when eating, drinking, or taking medications. The resident may frequently complain of food or medications "going down the wrong way".
Increased cause for instrumental assessment, however, coughing alone does not always indicate aspiration is a risk or has occurred. Nursing documentation must support coughing with medication. SLP documentation may evidence other laryngeal impairment that may accompany a coughing or choking episode, such as reduced laryngeal elevation and/or wet vocal quality – indicating possible aspiration risk.

K0100D Complaints of difficulty or pain with swallowing
Resident may refuse food because it is painful or difficult to swallow.
Often related to esophageal phase. Consider additionally if you are seeing this complaint where root cause due to GERD or other GI impairment. SLP documentation supports complaints of pain or food/fluid being "stuck" in throat during swallow. Wet vocal quality, multiple swallows with one bite/sip, or facial grimacing during swallow may also indicate difficulty or pain with swallow.

Reminder of RAC ADR Limits

- Limit is one-half of one percent of the provider's total number of paid claims for a previous 12-month period. That baseline annual ADR limit is divided by 8 (number of 45 day cycles in a 12-month period)

  Example:

  Provider billed 22,530 claims in 12 months

  Baseline ADR limit would be 22,530 x 0.005 =112.65

  ADR cycle limit is 112.65/8 = 14.08

  RAC may request 14 ADRs per 45-day cycle

- Error rates are calculated after three 45-day cycles. The error rate is used to readjust you ADR limit for the next 3 day cycles.

Error Adjusted RAC ADR Limits

Denial Rate (Range)	Adjusted ADR Limit (% of Total Paid Claims)
91 – 100%	5.0% (Baseline x 10)
71 – 90%	4.0% (Baseline x 8)
51 – 70%	3.0% (Baseline x 6)
36 – 50%	1.5% (Baseline x 3)
21 – 35%	1.0% (Baseline x 2)
10 – 20%	0.5% (Baseline x 1)
4 – 9%	0.25% (Baseline x ½)
0 – 3%	No reviews for next 3 (45-day) review cycles

Office of Inspector General- OIG

- The mission of the OIG as mandated by the Inspector General Act (Public Law 95-452, as amended), **is to protect the integrity of HHS's programs, as well as the well-being of the beneficiaries of those programs.**

- **OIG holds accountable** those who bill HHS programs **also identifies opportunities to improve the economy, efficiency, and effectiveness of HHS programs.**

- OIG reports both to the Secretary of HHS and to the United States Congress about **program and management problems and recommendations to correct them**. OIG's work is carried out by regional offices nationwide that perform audits, investigations, inspections and other mission-related functions.

Fraud and Abuse Oversight

A key component of OIG's mission is to **detect and root out fraud in Federal health care programs, including Medicare and Medicaid**

OIG's efforts to curb fraud, would include:

- Conducting criminal, civil, and administrative **investigations of fraud and misconduct** related to HHS programs, operations, and beneficiaries.
- **Using state-of-the-art tools and technology in investigations and audits imposing program exclusions and civil monetary penalties**
- **Negotiating global settlements** in cases arising under the civil False Claims Act, **developing and monitoring corporate integrity agreements, and developing compliance program guidance.**

OIG Work Plan

- The OIG Work Plan sets forth various projects including **OIG audits and evaluations that are underway or planned** to be addressed during the fiscal year and beyond by OIG's Office of Audit Services and Office of Evaluation and Inspections.

- Projects listed in the **Work Plan span the department and include the Centers for Medicare & Medicaid Services (CMS), public health agencies such as the Centers for Disease Control and Prevention (CDC) and National Institutes of Health (NIH), and others.**

OIG Work Plan- SNFs

Most of these recommendations/audits are for 2021/2022

- Review how surveys were conducted in regard to complaints and infection control
- Facility initiated discharges completed according to regulation
- Use and reporting of PRF (CARES ACT Provider Relief FUND) done according to requirements
- Medicare Telehealth Services under Part B and Medicaid were rendered without patterns of integrity risks

OIG Work Plan- SNFs

- Review if Nursing Home Compare data is compliant with Health, Fire and Emergency Management deficiencies
- Overview of facilities infection control and emergency management policies and procedures during PHE to control spread of COVID, reporting accuracy and the characteristics of a facility that has high incidence of COVID
- Prevalence of psychotropic drug use and the CMPs/penalties given to NHs
- Up-coding by MAO (Medicare Advantage Organizations) for higher reimbursement amounts

OIG Work Plan -SNFs

- Accuracy of nursing staffing levels on CMS PBJ and, in turn, improve the quality of care of residents
- KX modifier adhere to Federal requirements and payments for ST outpatient services are appropriate
- Accuracy of Part B payments in NH and do the facilities have compliance and control over the care their residents receive
- Sufficiency of Documentation to support DX on claims- Risk Adjusted Data
- Review oversight by state and CMS of the use of Medicaid Waivers in the NH

The UPICs

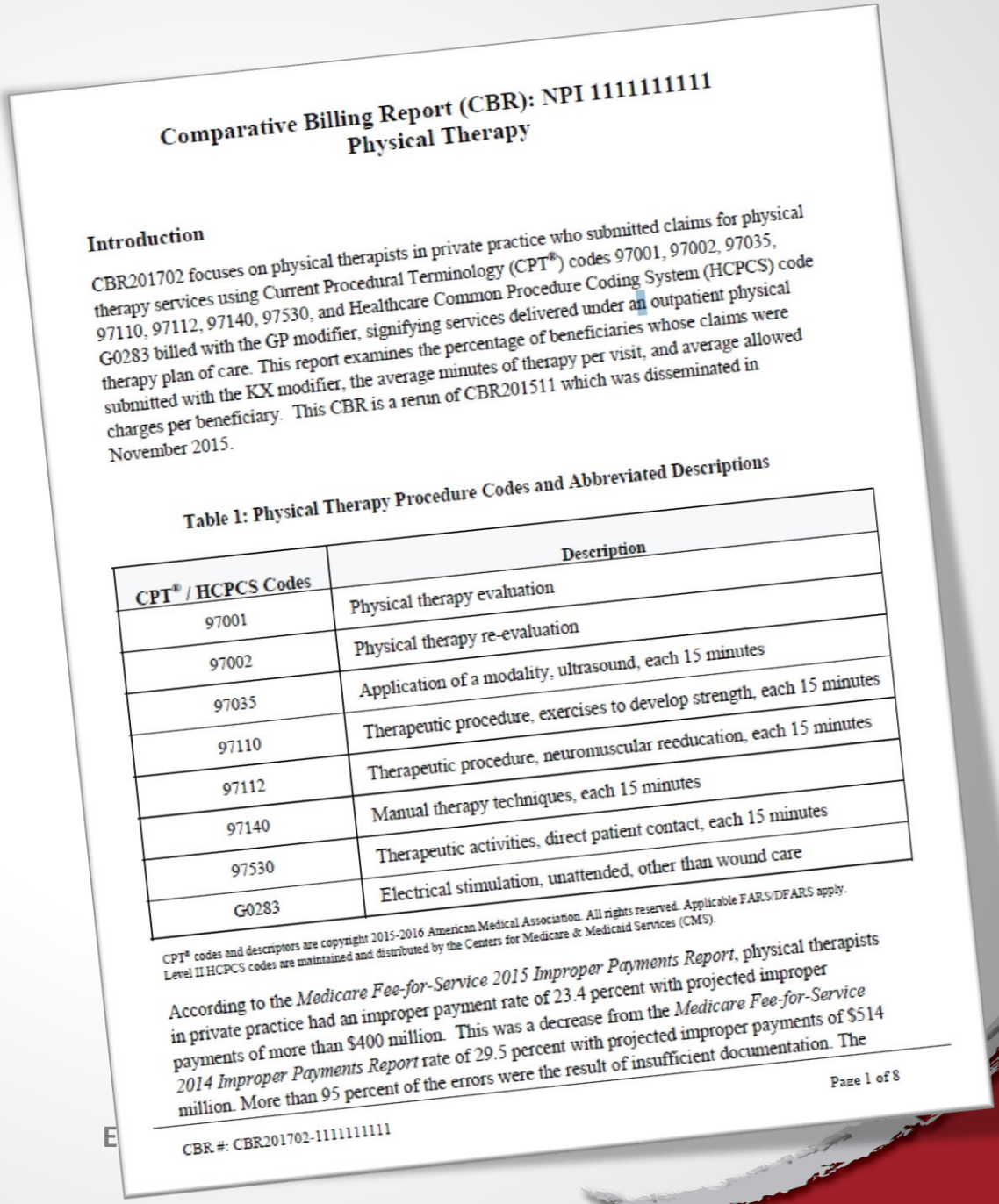
- The Unified Program Integrity Contractors (UPICs) perform fraud, waste & abuse detection, deterrence, and prevention activities for Medicare and Medicaid claims processed in the US.
- The UPICs perform integrity related activities associated with Medicare Parts A, B, DME, HH and Hospice, Medicaid, and the Medicare-Medicaid data match program (Medi-Medi).
- The UPIC contracts operate in 5 separate geographical jurisdictions in the US and combine and integrate functions previously performed by the Zone Program Integrity Contractor (ZPIC), Program Safeguard Contractor (PSC) and Medicaid Integrity Contractor (MIC) contracts.
- UPICs like other contractors will use extrapolation
- Pennsylvania UPIC – SafeGuard Services

Comparative Billing Reports

- 2018 - CMS combined the CBR and the Program for Evaluating Payment Pattern Electronic Reports (PEPPER) programs into one contract.

- 2019 RELI Group and its partners—TMF Health Quality Institute and CGS—began producing CBRs and PEPPERs.

Comparative Billing Report Example



Comparative Billing Report (CBR): NPI 1111111111
Physical Therapy

Introduction

CBR201702 focuses on physical therapists in private practice who submitted claims for physical therapy services using Current Procedural Terminology (CPT®) codes 97001, 97002, 97035, 97110, 97112, 97140, 97530, and Healthcare Common Procedure Coding System (HCPCS) code G0283 billed with the GP modifier, signifying services delivered under an outpatient physical therapy plan of care. This report examines the percentage of beneficiaries whose claims were submitted with the KX modifier, the average minutes of therapy per visit, and average allowed charges per beneficiary. This CBR is a rerun of CBR201511 which was disseminated in November 2015.

Table 1: Physical Therapy Procedure Codes and Abbreviated Descriptions

CPT® / HCPCS Codes	Description
97001	Physical therapy evaluation
97002	Physical therapy re-evaluation
97035	Application of a modality, ultrasound, each 15 minutes
97110	Therapeutic procedure, exercises to develop strength, each 15 minutes
97112	Therapeutic procedure, neuromuscular reeducation, each 15 minutes
97140	Manual therapy techniques, each 15 minutes
97530	Therapeutic activities, direct patient contact, each 15 minutes
G0283	Electrical stimulation, unattended, other than wound care

According to the *Medicare Fee-for-Service 2015 Improper Payments Report*, physical therapists in private practice had an improper payment rate of 23.4 percent with projected improper payments of more than $400 million. This was a decrease from the *Medicare Fee-for-Service 2014 Improper Payments Report* rate of 29.5 percent with projected improper payments of $514 million. More than 95 percent of the errors were the result of insufficient documentation. The

Usefulness of the CBR

Value to CMS

- Supports the integrity of claims submission
- Summarizes claims data
- Provides an educational resource for possible improvement by providing coding guidelines information

Value to Providers

- Reflects providers' billing patterns as compared to their peers
- Provides specific coding guidelines and billing information
- Informs providers whose billing patterns differ from those of their peers

PEPPER REPORTS Version 2019

- Summarizes statistics for three federal fiscal years:
  - 2017
  - 2018
  - 2019
- Statistics for all time periods are refreshed with each release.
- The oldest fiscal year rolls off as the new one is added.

SNF Improper Payment Risks

- As of Oct. 1, 2019, SNFs are reimbursed through PDPM. Previously, SNFs were reimbursed through the SNF prospective payment system, based on RUGs. Several SNF PEPPER target areas were designed to report on payment vulnerabilities specific to the RUGs.

- The Q4FY19 release still includes these target areas. The following target areas will be phased out for the FY2020 release (anticipated in April 2021):
  - Therapy RUGs with High ADL
  - Non-therapy RUGs with High ADL
  - Change of Therapy Assessment
  - Ultra High Therapy RUGs

SNF Improper Payment Risks

The new target area, 3- to 5-Day Readmissions, was identified through a review of the PDPM and in coordination with CMS subject matter experts. Moving forward, additional target areas may be identified to reflect other potential vulnerabilities related to the PDPM.

SNF Target Areas

3- to 5-Day Readmissions (new as of Q4FY19 release)	N: count of readmissions within three to five calendar days (four to six consecutive days) to the same SNF for the same beneficiary (identified using the Health Insurance Claim number) during an episode that ends during the report period D: count of all claims associated with SNF episodes ending during the report period, excluding patient discharge status code 20 (expired)

The Intent of the New Measure

TARGET AREA	SUGGESTED INTERVENTIONS IF AT/ABOVE 80TH PERCENTILE	SUGGESTED INTERVENTIONS IF AT/BELOW 20TH PERCENTILE
3- to 5-Day Readmissions	This could indicate that patients are being discharged prematurely or that patients are being readmitted after the interrupted stay threshold, thereby resetting the variable per diem adjustment. A sample of readmission cases should be reviewed to identify the appropriateness of admission, discharge, quality of care, post-discharge care, and billing errors. The facility is encouraged to generate data profiles for readmissions to its facility within three to five consecutive calendar days. Suggested data elements to include in these profiles are as follows: patient identifier, date of admission, date of discharge, patient discharge status code, and principal and secondary diagnoses.	Not applicable.

Appendix 3: How Readmissions Are Identified

These example scenarios are included to help providers understand how readmissions are identified and counted in PEPPER.

Scenario 1: A beneficiary returns to the SNF after three complete non-covered SNF Medicare Part A days. This scenario would be counted as a 3- to 5-Day Readmission in PEPPER.

- 2/1/20: Admitted to SNF for Medicare Part A care.
- 2/8/20: Discharged from SNF and admitted to a hospital (anytime between midnight and 11:59 p.m.). This is the first non-covered day.
- 2/9/20: Remains in hospital. This is the second non-covered day.
- 2/10/20: Remains in hospital. This is the third non-covered day.
- 2/11/20: Readmitted to SNF for Medicare Part A care (anytime between midnight and 11:59 p.m.). This is the first day outside the three-day interruption window. The SNF PPS treats this as a new stay with a required five-day PPS assessment; the variable payment rate schedule starts on day 1.

Appendix 3: How Readmissions Are Identified

Scenario 2: A beneficiary returns to the SNF during the third non-covered SNF day. This scenario would not be counted as a 3- to 5-Day Readmission in PEPPER.

- 2/1/20: Admitted to SNF for Medicare Part A care.
- 2/8/20: Discharged from SNF and admitted to a hospital (anytime between midnight and 11:59 p.m.). This is the first non-covered day.
- 2/9/20: Remains in hospital. This is the second non-covered day.
- 2/10/20: Readmitted to SNF for Medicare Part A care (anytime between midnight and 11:59 p.m.). This is the last day of the three-day period that begins on the first non-covered day following a SNF stay covered by Medicare Part A. The SNF PPS would treat this as an interrupted stay; this day would be considered covered because there is not a complete period of three consecutive non-covered days.

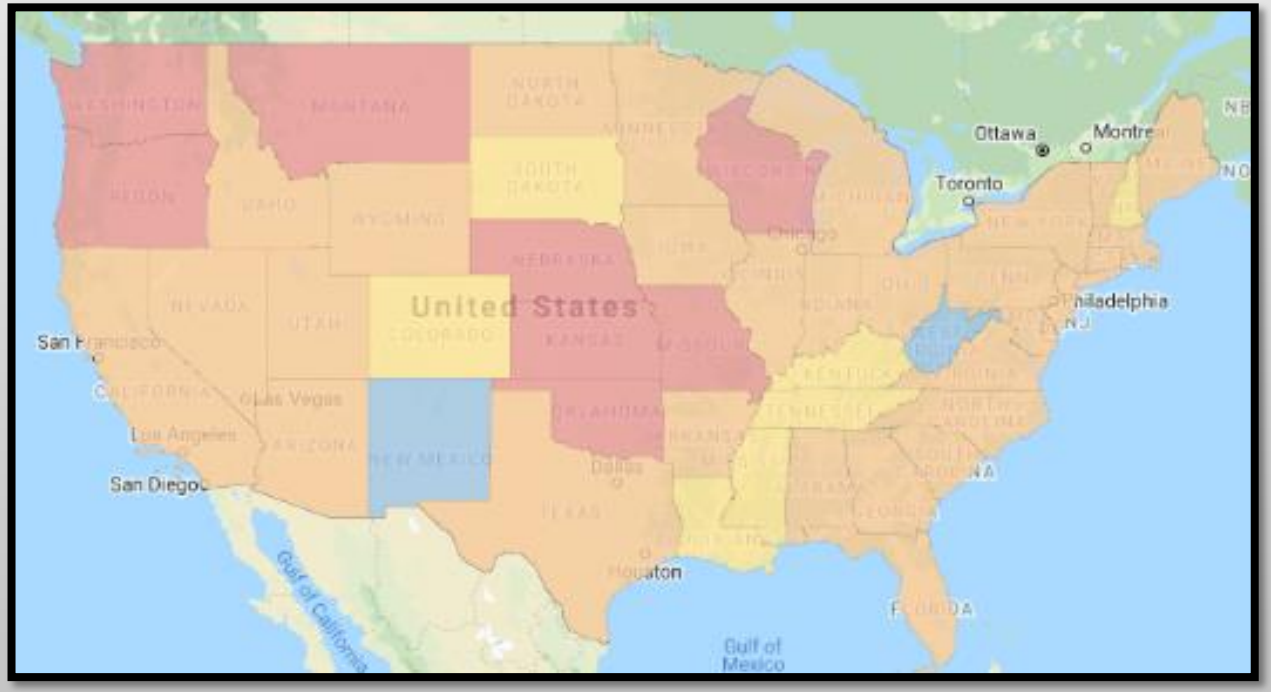
CMS Recommended PEPPER Strategies

- Do not panic
  - Outlier status does not necessarily mean that compliance issues exist
  - Review of report and response to issues should be part of compliance plan

- If you are an "outlier," determine why that may be.
  - Do the statistics reflect your operation? Specialized programs/services? Patient population? Referral sources?

- Verify by:
  - Sampling claims and reviewing documentation in the medical record and Minimum Data Set (MDS).
  - Reviewing the claim. Was it coded and billed appropriately, based upon documentation in medical record and MDS?
  - Ensure you are following best practices, even if you are not an outlier.

SNF PEPPER Retrievals – PEPPER Resources Portal



Percent of SNFs that accessed PEPPER in the state:

- 80-100%
- 60-79%
- 40-59%
- 20-39%
- 0-19%

https://pepper.cbrpepper.org/Training-Resources/Skilled-Nursing-Facilities/PEPPER-Portal-Retrieval-Map

Audit and Payment Implications for Accuracy of Section GG

Section GG

- Vital role in level of reimbursement to facility for both PDPM and Medicaid patients (grab data at different time points)
- Accuracy and management of Section GG important
- Code according to resident characteristics to get most appropriate reimbursement
- Scored differently than Section G so all staff must be trained consistently (higher score for more independence = GG, Section G opposite)
- More function is scored under Section GG rather than just late loss ADLs as with Section G
- Scoring of GG should not be solely the responsibility of rehab
  - GG is a measure of Usual Performance
  - Therapy is not always treating or SLP might be only one treating at discharge

Section GG

- Staff and MDS must realize that scoring a “0” in areas will result in zero value in the calculation of per diem rate. Inaccurate scoring can cost you!
- As in the past, OIG and MACs will be auditing Section GG and documentation especially now it is directly tied to reimbursement.
- If you do not have accurate documentation to support how you scored Section GG then denials and recoupment can occur.
- New hire orientation and annual re-training is a must with Section GG, accurate documentation and understanding PDPM.

Section GG

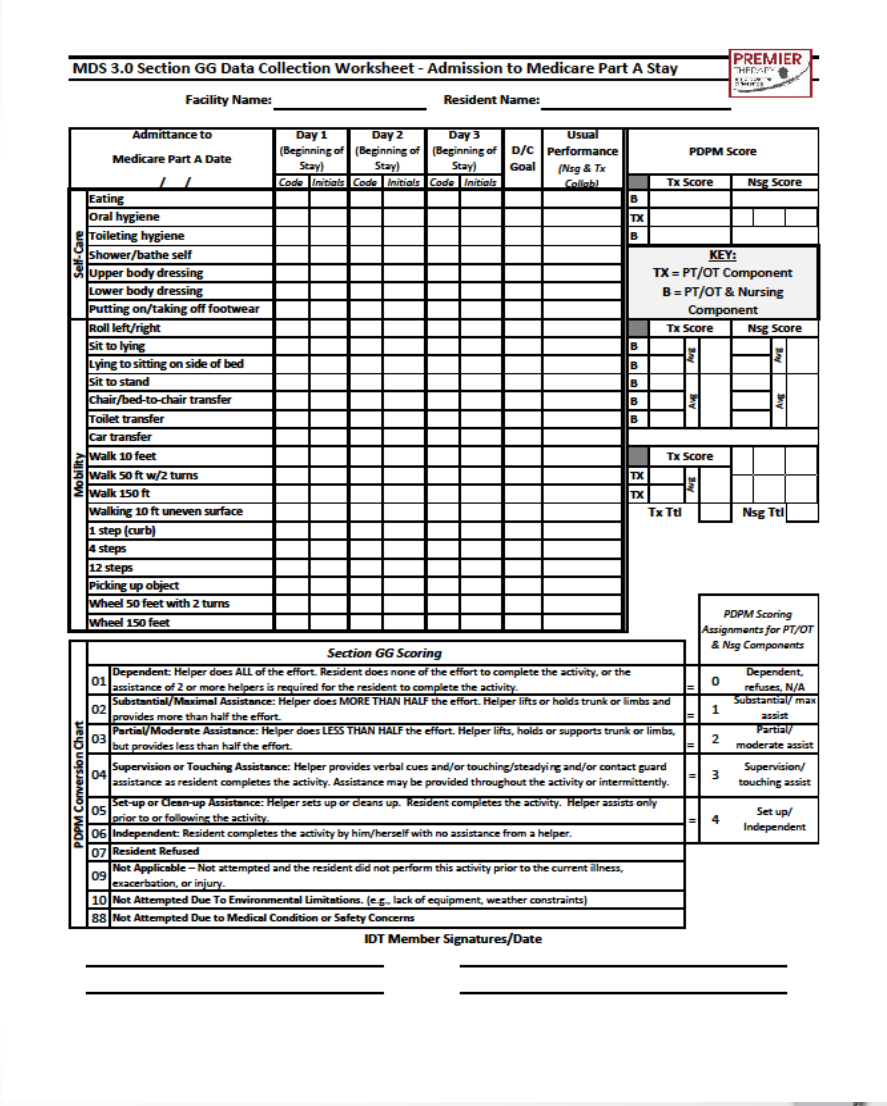
- Expectation that Section GG shows improvement with intervention from admission to discharge
  - Review patient progress in UR – Ensure carryover extends to floor
  - Should see a change in medical record that will be reflected in GG scoring at discharge
- Medical Necessity drives LOS
  - IDT documentation during UR is critical since scheduled PPS (PDPM) care plan meetings are significantly reduced from PPS (RUG)
  - Also what formalized process exists to assess for potential IPA
- Improvement in Section GG can support Medical Necessity
- Should start if have not already: auditing Section GG to documentation

Scoring of Self-Care and Mobility Items in Section GG Under PDPM

Section GG Item		Score
GG0130A1	Self-care: Eating	0-4
GG0130B1	Self-care: Oral Hygiene	0-4
GG0130C1	Self-care: Toileting Hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4 (average of 2 items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4 (average of 3 items)
GG0170E1	Mobility: Chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0-4 (average of 2 items)
GG0170K1	Mobility: Walk 150 feet	

Paper GG Tracker

- Encourages collaboration between IDT
- Ensures coding is focused on Usual performance



MDS 3.0 Section GG Data Collection Worksheet - Admission to Medicare Part A Stay

PREMIER THERAPY

Facility Name: _____ Resident Name: _____

	Admittance to Medicare Part A Date / /	Day 1 (Beginning of Stay) Code	Day 1 Initials	Day 2 (Beginning of Stay) Code	Day 2 Initials	Day 3 (Beginning of Stay) Code	Day 3 Initials	D/C Goal	Usual Performance (Nsg & Tx Collab)
Self-Care	Eating								
	Oral hygiene								
	Toileting hygiene								
	Shower/bathe self								
	Upper body dressing								
	Lower body dressing								
	Putting on/taking off footwear								
Mobility	Roll left/right								
	Sit to lying								
	Lying to sitting on side of bed								
	Sit to stand								
	Chair/bed-to-chair transfer								
	Toilet transfer								
	Car transfer								
	Walk 10 feet								
	Walk 50 ft w/2 turns								
	Walk 150 ft								
	Walking 10 ft uneven surface								
	1 step (curb)								
	4 steps								
	12 steps								
	Picking up object								
	Wheel 50 feet with 2 turns								
	Wheel 150 feet								

PDPM Score

	Tx Score	Nsg Score
B		
TX		
B		

KEY:
TX = PT/OT Component
B = PT/OT & Nursing Component

	Tx Score	Avg	Nsg Score	Avg
B				
B				
B				
B				
B				

	Tx Score	Avg
TX		
TX		

Tx Ttl _____ Nsg Ttl _____

PDPM Conversion Chart — Section GG Scoring

			PDPM Scoring Assignments for PT/OT & Nsg Components
01	**Dependent:** Helper does ALL of the effort. Resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity.	= 0	Dependent, refuses, N/A
02	**Substantial/Maximal Assistance:** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.	= 1	Substantial/ max assist
03	**Partial/Moderate Assistance:** Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.	= 2	Partial/ moderate assist
04	**Supervision or Touching Assistance:** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity. Assistance may be provided throughout the activity or intermittently.	= 3	Supervision/ touching assist
05	**Set-up or Clean-up Assistance:** Helper sets up or cleans up. Resident completes the activity. Helper assists only prior to or following the activity.	= 4	Set up/ Independent
06	**Independent:** Resident completes the activity by him/herself with no assistance from a helper.		
07	**Resident Refused**		
09	**Not Applicable** – Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.		
10	**Not Attempted Due To Environmental Limitations.** (e.g., lack of equipment, weather constraints)		
88	**Not Attempted Due to Medical Condition or Safety Concerns**		

IDT Member Signatures/Date

_____ _____

_____ _____

LOOK at QRP MDS items for facility performance

Example: SNF Functional Outcome Measure: Discharge Self-Care Score for Skilled Nursing Facility Residents (NQF #2635) (CMS ID: S024.01)45

This measure estimates the percentage of Medicare Part A SNF Stays (Type 1 SNF Stays only) that meet or exceed an expected discharge self-care score.

The Self-Care assessment items used for discharge Self-Care score calculations are:

a) GG0130A3. Eating
b) GG0130B3. Oral hygiene
c) GG0130C3. Toileting hygiene
d) GG0130E3. Shower/bathe self
e) GG0130F3. Upper body dressing
f) GG0130G3. Lower body dressing
g) GG0130H3. Putting on/taking off footwear

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-Measure-Calculations-and-Reporting-Users-Manual-V20.pdf

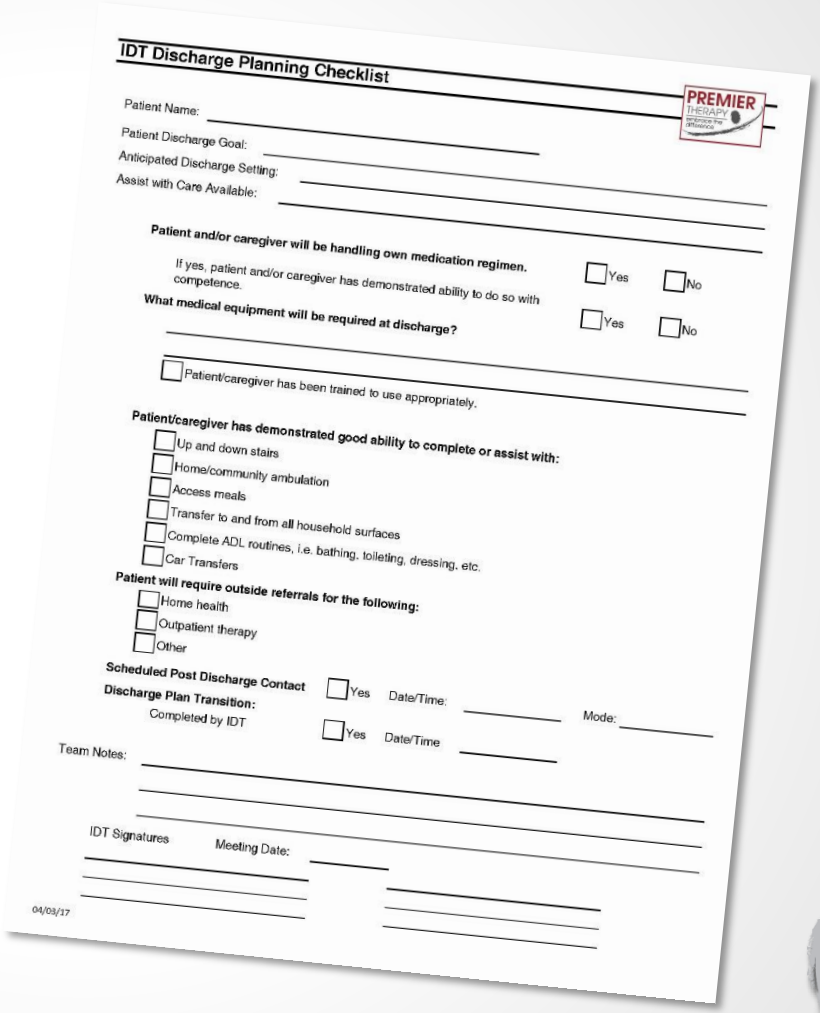
Discharge – LOS - Continued Medical Considerations

- Documentation of Medical Necessity must remain consistent throughout the stay
  - Long LOS (monitored by 2 PEPPER items (20 day and 90 day)) must be audited to ensure on going skill and need
  - The longer the length of stay, the more difficult it is to document skilled need
  - Must focus audit on these residents
    - Plateaus and regression reasons must be evident with supporting continue skilled need documented within IDT documentation

Discharge Planning and Supporting LOS

- Ensure ICD-10 coding paints the true picture of a patient's condition (complexity of a patient can support medical necessity and length of stay)
- Care Planning Discharge Plans
- Early Family Meetings and Planning
- Medication Reconciliation and training prior to discharge
- Home Assessments by Therapy/virtual visits
- Discharge Checklist to make sure all addressed

Discharge Checklist



IDT Discharge Planning Checklist

PREMIER THERAPY

Patient Name: _____

Patient Discharge Goal: _____

Anticipated Discharge Setting: _____

Assist with Care Available: _____

Patient and/or caregiver will be handling own medication regimen. ☐ Yes ☐ No

If yes, patient and/or caregiver has demonstrated ability to do so with competence.

What medical equipment will be required at discharge? ☐ Yes ☐ No

_____

☐ Patient/caregiver has been trained to use appropriately.

Patient/caregiver has demonstrated good ability to complete or assist with:

- ☐ Up and down stairs
- ☐ Home/community ambulation
- ☐ Access meals
- ☐ Transfer to and from all household surfaces
- ☐ Complete ADL routines, i.e. bathing, toileting, dressing, etc.
- ☐ Car Transfers

Patient will require outside referrals for the following:

- ☐ Home health
- ☐ Outpatient therapy
- ☐ Other

Scheduled Post Discharge Contact ☐ Yes Date/Time: _____ Mode: _____

Discharge Plan Transition:

Completed by IDT ☐ Yes Date/Time _____

Team Notes: _____

IDT Signatures Meeting Date: _____

04/03/17

Trends and Future Implications – RISK AREAS

- CMS planned for MDS coding to remain the same but did not anticipate that teams would improve their coding skills
- Better communication, collaboration and overall understanding of resident characteristics led to better coding and documentation
- CMS expected that coding for nursing and ST would remain unchanged but that has been proven untrue
- CMS expected daily rates to be impacted more by NTA adjustments and thus weighted case mix to adjust for this but it did not happen

https://skillednursingnews.com/2020/10/cms-quiet-on-pdpm-related-enforcement-even-as-rates-rise-but-managed-care-more-prone-to-denials/

Trends and Future Implications – RISK AREAS

- Swallowing disorders and dietary modifications are being captured at higher rates from 20% of residents to 30% of residents
- CMS stated they would be looking at drastic changes in therapy minutes but no influx of ADRs have been generated yet – may be due to decrease in auditing during COVID- may ramp up after PHE over
- Managed Care (Mostly Humana and UH) still auditing with focus on Section GG and Diagnosis coding
- Coding "Fatigue"- may be reason for decrease in NTA case mix especially would think otherwise with COVID patients- comorbidities often are a factor for institutional care

https://skillednursingnews.com/2020/10/cms-quiet-on-pdpm-related-enforcement-even-as-rates-rise-but-managed-care-more-prone-to-denials/

Trends and Future Implications – RISK AREAS

- Section GG functional score decreased by 6% since beginning of PHE which may be due to difficulty progressing patient that is very sick
- Comparing Q4 2019 to Q2 2020 CASPER information:
  - Loss of Movement was up 55%
  - Loss of Activities of Daily Living up 15%
  - Unexplained Loss of Weight up 65%
  - Could be due to increased isolation and change in staffing patterns with COVID

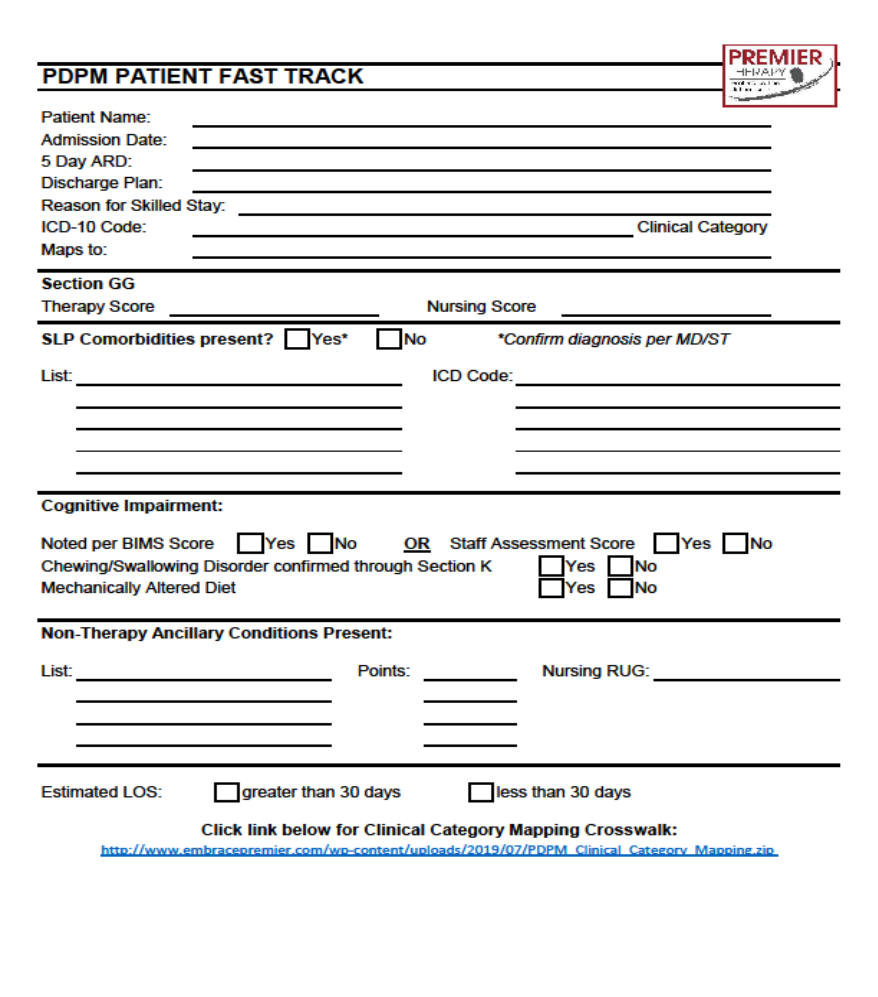
https://skillednursingnews.com/2020/10/cms-quiet-on-pdpm-related-enforcement-even-as-rates-rise-but-managed-care-more-prone-to-denials/

Wrap Up

- Auditors are ramping back up and have money to find
- Data is king – outliers in;
  - Nursing Home Compare
  - Quality Measures – QRP
  - Staffing
  - Survey
  - PEPPER
  - CBR Part B therapy provision
  - Increased Part A stays
  - COVID waivers – make sure meet criteria
  - PDPM Case Mix/Rate

Triple Check Process

Should be completed with scoring of the 5 day, UR, or IPA and reviewed end of month



PDPM PATIENT FAST TRACK

PREMIER THERAPY

Patient Name: _____
Admission Date: _____
5 Day ARD: _____
Discharge Plan: _____
Reason for Skilled Stay: _____
ICD-10 Code: _____ Clinical Category
Maps to: _____

Section GG
Therapy Score _____ Nursing Score _____

SLP Comorbidities present? ☐ Yes* ☐ No **Confirm diagnosis per MD/ST*

List: _____ ICD Code: _____

Cognitive Impairment:

Noted per BIMS Score ☐ Yes ☐ No OR Staff Assessment Score ☐ Yes ☐ No
Chewing/Swallowing Disorder confirmed through Section K ☐ Yes ☐ No
Mechanically Altered Diet ☐ Yes ☐ No

Non-Therapy Ancillary Conditions Present:

List: _____ Points: _____ Nursing RUG: _____

Estimated LOS: ☐ greater than 30 days ☐ less than 30 days

Click link below for Clinical Category Mapping Crosswalk:
http://www.embracepremier.com/wp-content/uploads/2019/07/PDPM_Clinical_Category_Mapping.zip

Resources

https://skillednursingnews.com/2020/10/cms-quiet-on-pdpm-related-enforcement-even-as-rates-rise-but-managed-care-more-prone-to-denials/ Accessed 1-5-21

https://www.harmony-healthcare.com/blog/mds_3.0_revisions_and_pdpm_state_mapping

Resources

1. Skillednursingnews.com/2020/10/cms-quiet-on-pdpm-related-enforcement-even-as-rates-rise-but-managed-care-more-prone-to-denials/ Accessed 1-5-21
2. https://www.harmony-healthcare.com/blog/mds_3.0_revisions_and_pdpm_state_mapping
3. PEPPER Resources (cbrpepper.org)
4. www.medicare.gov/care-compare/
5. www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures
6. www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf