Weaving Through the Maze:
PDPM, DRR vs. MRR, Quality Measures
A Case Study

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Learning Objectives

- Understand the impact of timely and accurate ICD-10 and MDS coding related to PDPM
- Recognize the role of pharmacy and the Interdisciplinary team related to drivers of PDPM and Quality Measures
- Distinguish the difference in requirements between DRR and MRR
- Identify critical timing of assessment events from admission to discharge

Resident Profile

- 67 y/o female
- Resided at facility in a Medicare Part A stay with primary diagnosis of Cerebral Infarct then had **hospital readmission on 9/24**
- Had a **Significant Change 5 day** assessment completed on **9/20**
- Admitted to the hospital on 9/24 on day 12 of Medicare stay
- **Readmitted to the facility on 9/28** as a hospital return
  - **Medicare Part A** (traditional Medicare)
  - Also has Community Health Choices **(CHC)**
  - New on return to facility: Receiving IV antibiotics, Tracheostomy care, wound care, and Tube Feeding

MDS Assessment Schedule

Type of Assessment		Timing of Assessments Required
• Discharge to hospital	-	Discharge Return Anticipated/PPS Discharge with ARD 9/24/19
• Readmission	-	Entry Record 9/28/19
• OBRA vs. PDPM requirements	-	Medicare 5 Day ARD 9/30
• Schedule after October 1st	-	PDPM IPA (Interim Payment Assessment) Schedule between 10/1-10/7 Have 14 days to complete from ARD

- Review record for Significant Change

Diagnosis

Diagnosis

- Cerebral Infarct
- Right Hemiparesis
- Right Hemiplegia
- Pneumonia
- Epilepsy
- Aphasia
- Dysphasia
- Depression
- Anxiety
- Diabetes
- Pressure Ulcer (Stage IV) Right Heel

ICD-10

- I69.351 Hemiplegia/Hemiparesis following Cerebral Infarction affect right dominant side/stroke/CVA **(Acute Neurological)**
- J18.9 Pneumonia unspecified organism **(Pulmonary)**
- G40.919 Epilepsy, unspecified intractable without status without status epilepticus **(Medical Management)**
- I69.391 Dysphagia following cerebral infarction/stroke/CVA **(Acute Neurological)**
- I69.320 Aphasia following Cerebral Infarction, CVA **(Acute Neurological)**
- F33.92 Major Depressive Disorder, recurrent unspecified Depression **(Medical Management)**
- F41.9 Anxiety Disorder, unspecified **(Medical Management)**
- F11.9 Type II Diabetes without complication **(Medical Management)**
- L89.614 Stage 4 Pressure Ulcer right heel **(Medical Management)**

Diagnoses

After readmission, this resident was given a diagnosis of **COPD** because she was administered Advair and Spiriva while in the hospital.

HOWEVER, **she does <u>NOT</u> have COPD** – they were administered for the acute pneumonia.

Impact of Proper Diagnoses and Coding

- PDPM
  - Select Primary Diagnosis
    - Physical Therapy, Occupational Therapy and Speech Therapy
    - Must be reason the resident is being skilled
    - Case study resident had Cerebral Infarction, tracheostomy, new tube feeding
      - Most recent hospitalization for pneumonia
      - **WHAT IS THE REASON THIS RESIDENT IS BEING SKILLED?**
  - Non-Therapy Ancillaries (NTA)
    - Diagnosis and MDS coding impacts NTA Category.
      - Achieved by points from MDS coding
        - Diabetes = 2 points
        - Stage 4 Pressure Ulcer = 1 point
        - Tracheotomy = 1 point
        - Tube feeding = 1 point
        - Total 5 points = 3-5 points = Urban rate $106.28 and Rural rate $101.53
          - If one point identified the 6-8 points = $147.03 and Rural rate $140.47

What is the primary diagnosis?

- Functional Score 6-9
- Primary diagnosis
  - 69.351 Hemiplegia/Hemiparesis following Cerebral Infarction affect right dominant side/stroke/CVA (Acute Neurological)
    - PT/OT component Non-Orthopedic Surgery and Acute Neurologic
    - Urban Rate $174.74 unadjusted rate/day
    - Rural Rate $197.89 unadjusted rate/day
  - Acute Neurological also will place them in Speech component

    Speech co-morbidity only requires one condition however, resident has Hemiplegia, dysphagia/aphasia (if not using therapy treatment code) CVA and trach care.
  - J18.9 Pneumonia unspecified organism (Pulmonary)
    - PT/OT component Medical Management
    - Urban Rate $168.27 unadjusted rate/day
    - Rural Rate $190.56 unadjusted rate/day

  - **What is this resident being skilled for?** Team decision!

Medication Profile

- **Cefepime I.V.** cost (and need for IV access)
  - Cefepime 2gm IV every 8 hours x 10 days (pneumonia)
  - Days 1-3 in hospital; days 4-10 in facility – **cost of 7 days approx. $700**
  - 4th gen cephalosporin; may not be a great candidate for oral conversion if true hospital-acquired pneumonia, but need for IV administration of other meds should be considered
  - A detailed evaluation of hospital course and HPI should be performed to ensure that proper ID protocols were performed when IV antibiotic agent was selected

Medication Profile

- **Sliding Scale Novolog** started in hospital (taken off of Metformin and Humulin-N)
  - **Cost per vial of Novolog - $300/vial** and cost associated with glucose testing and increased nursing time
  - Started in hospital as part of glycemic protocol; Humulin-N and Metformin were discontinued due to temporary NPO status and poor glucose control

Medication Profile

Protonix (PPI) started in hospital for prophylaxis

- Cost of Protonix granules - **$115/week**
- Are there any clinical indicators that there is still a need?

Santyl to stage-IV right heel ulcer

- **Cost per 30gm tube - $300 (**multiple tubes necessary for continued treatment)
- Are there other effective treatments that could be utilized?

Medication Profile

Cost associated with inappropriately continuing treatment for the **inaccurate COPD diagnosis**

Financial consideration

Ethical consideration

Medication Profile

PRN Ativan being used for crying

- Cost associated with therapy the drug is negligible
- **Incorrect diagnosis** listed for use (anxiety would be correct with crying possibly used for behavior monitoring)
- **PRN psychotropic** subject to recent mega-rule regulation

What's wrong with this scenario?

Medication Profile

Zyprexa

- **Cost** associated with therapy **negligible**
- Patient started on Zyprexa in hospital due to acute agitation and possible delirium which resolved after antibiotic treatment started
- **Continued in skilled care with diagnosis of <u>"antipsychotic"</u>**

What's wrong in this scenario?

Inappropriate use reflects directly in short-term quality measures

Medication Profile

DVT prevention with **Lovenox**

- Enoxaparin (Lovenox) 40mg sub-Q daily indefinitely; **cost of therapy - $120/wk**
- Evaluation of medical need for prophylaxis must be continually weighed
- Converting to oral agent (Eliquis, Xarelto) does not offer great cost savings of medication, but reduces administration burden.
- While cheaper, Warfarin is likely not more cost effective due to increased need for labwork

Medication Profile

MRR

- 1974 – Medicare requirement that every patient residing in a skilled nursing center receive **a monthly review of their medication profile by a licensed pharmacist**
- The regulation has expanded to include review of all patient profiles once a month, after admission or readmission, and for any major change in condition (no requirement for time frame is specified)
- CMS definition of MRR is essentially synonymous with DRR for SNFs

DRR

- Defined in the IMPACT Act of 2014
- Includes medication reconciliation and general review of drug regimen to **address and prevent "clinically significant" or "potentially significant"** medication issues (i.e. major drug interactions, drug allergies, obvious therapeutic duplications or omissions, ineffective or unnecessary therapy, adverse drug reactions)

Medication Profile

MRR

- Thorough evaluation of the med regimen with the goal of promoting positive outcomes and minimizing adverse events associated with medications.
- Includes preventing, identifying, reporting, and resolving medication-related problems, med errors, or other irregularities.
- All recommendations and consults must be **reported to the attending physician and addressed by said physician or designee within 30 days (additionally must be reviewed by medical director and director of nursing)**

DRR

- Not specific to being performed by a pharmacist - **DRR may be performed by a variety of clinical professionals**
- **Strict reporting** requirement of all clinically or potentially significant medication issues **to physician or designee by midnight of the next calendar day after they are identified (after admission or AT ANY TIME during their stay).**

DRR

- SNF Quality Reporting Program (QRPs)
- Drug Regimen Review conducted with follow-up for identified issues
- Reports the percentage of Medicare Part A SNF Stays at time of admission and timely follow-up with physician occurred each time potential or actual clinically significant medication issues were identified through out stay.
- Data collection began October 1, 2018
- Includes all medication: prescribed, over the counter, herbal, nutritional supplements, vitamins, homeopathic, Oxygen and TPN.

Consider review of new admission records at morning meeting.

Section N2001 on MDS that is completed on Medicare 5 Day

N2001. Drug Regimen Review - Complete only if A0310B = 01

Enter Code [ ]

Did a complete drug regimen review identify potential clinically significant medication issues?

0. **No** - No issues found during review
1. **Yes** - Issues found during review
9. **NA** - Resident is not taking any medications

N2003. Medication Follow-up - Complete only if N2001 =1

Enter Code [ ]

Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/ recommended actions in response to the identified potential clinically significant medication issues?

0. **No**
1. **Yes**

N2005. Medication Intervention - Complete only if A0310H = 1

Enter Code [ ]

Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?

0. **No**
1. **Yes**
9. **NA** - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

PPS Discharge

Section N	Medications

N2005. Medication Intervention - Complete only if A0310H = 1

Enter Code	**Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?** 0. **No** 1. **Yes** 9. **NA** - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

Can you wait for pharmacy to review for DRR?

- Remember guidance states for DRR that **any clinician** can review
- What happens when pharmacy contacts the facility with identified issues?
- What is the follow up with issues that are identified?
- Consider review of new admission records at morning meeting

Therapy and Treatments Ordered

The resident is ordered the following:

- Speech Therapy
- Occupational Therapy
- Respiratory Therapy
- Accuchecks tid
- Continuous tube feeding over 20 hours with Glucerna
- Wound Care
  - Santyl
  - Allevyn

MDS Impact of Treatment Plan PDPM/CHC

- Therapy minutes are not necessary to receive Physical Therapy, Occupational Therapy or Speech Therapy
- Therapy delivery of service is still an important part of discharge planning
- However, Facilities continue to submit the Facility Quarterly CMIs
  - What are your contracts with CHC?
  - If your CHC contract is set with quarterly CMIs then the rate does change based on that quarterly CMI

MDS Impact of Treatment Plan PDPM/CHC

- Treatment plan should not change with implementation of PDPM or CHC.
- PDPM only changes the payment structure for Medicare Part A residents and those Medicare Replacement Plans that are transitioning to PDPM
  - Do you know which ones will be which???
- Quality Reporting Program Measure only on traditional Medicare Part A

Medicare Skilling Reason Unchanged Chapter 8 Medicare Manual

- NO CHANGE IN MEDICARE PART A COVERAGEMEDICARE BENEFIT POLITY MANUAL CHAPTER 8 –COVERAGE OF EXTENDED CARE (SNF) SERVICES

1. Patient requires **skilled nursing** services or **skilled rehabilitation** services
2. The patient requires these skilled services on a **daily basis**
3. The daily skilled services can be provided **only on an inpatient basis in a SNF**
4. The services delivered are **reasonable and necessary** for the treatment of a patient's illness or injury

Other Items to Consider

- Is your software updated for PDPM?
- Is your team aware of October 1 changes?
- Do you know which managed care insurers will be utilizing PDPM vs. RUGs?

Resources

- www.CMS.gov
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html
- MDS-30-RAI-Manual-v117 October-2019
- Medicare Manual Chapter 8