Spring 2021 PACAH Conference

The Ins and Outs of What We Learned the First Year of PDPM

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Your Presenters

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About

Jennifer Matoushek, MBA/HCM, CPC
Jennifer Matoushek is a senior consultant with more than ten years of healthcare industry experience. She is versatile, bringing structured thinking, analytical skills, and database solutions to clients in acute, primary care, and post-acute settings. Before joining LW Consulting, Jennifer worked at Select Medical Corporation as a patient account representative, where she was responsible for outpatient physical therapy billing and collections. Jennifer's effective communication among internal team members and clients enables her to cultivate positive relationships. Simultaneously, her focused and detail-oriented approach is key to the successful implementation of improved processes.

Kay P. Hashagen, PT, MBA, RAC-CT
Kay is a seasoned Senior Consultant for LW Consulting, Inc. with more than thirty-five years of healthcare industry experience, specializing in geriatric rehabilitation in skilled nursing and outpatient rehabilitation across the continuum of care. She has a proven record of accomplishing excellent customer service, managing operations with strong performance metrics, and developing creative programs while maintaining appropriate compliance monitoring for Medicare and regulatory requirements. She regularly joins the nurses to teach about the MDS components and how therapy and nursing should work together for optimal performance. Over the past several years she has presented on "The F-309 Tag Related to Dementia and the Importance of a Collaborative Nursing and Therapy Approach," "Improving Your 5-Star CMS Rating," "Critical Therapy Performance Indicators," "Nursing and Therapy Collaboration for Quality Measures and CMI," and "Optimizing Your EHR to Support Clinical Care." Kay has also conducted many webinars related to therapy documentation to meet CMS requirements.

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Objectives:

- **Learn** — Participants will learn how to analyze errors and identify systems to improve outcomes with coding and documentation.
- **Know** — Attendees will know the common root causes of errors from the first year of PDPM and the potential impact of common errors.
- **Understand** — Participants will understand common billing mistakes from the first year of PDPM, including the use of the COVID-19 waiver.

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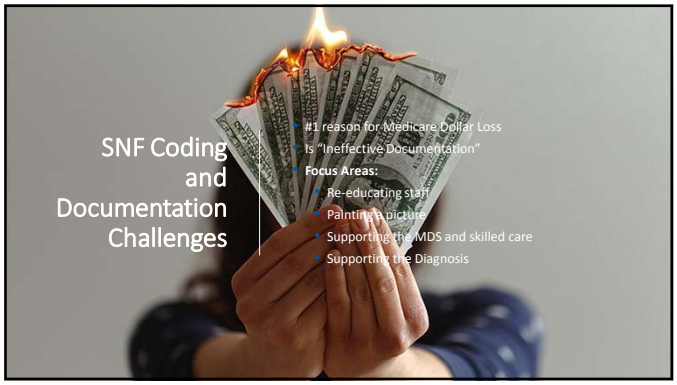

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Reimbursable MDS Sections for PDPM

- Section C-BIMS- Brief Interview for Mental Status
- Section D- PHQ-9 Patient Healthcare Questionnaire
- Section E- Behaviors
- Section GG- Functional Abilities
- Section I- Diagnosis
- Section J- Surgical Procedures
- Section K- Swallowing and Dietary
- Section M- Skin and Wounds
- Section O- Special Treatments and Procedures, Respiratory, and Restorative Nursing Program

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What impact does therapy have?

- Therapy may support the need for daily skilled care.
- The PEPPER Report 2021 now defines Section GG Function Scores between 10-23 and 24 as indicators of "HIGH UTILIZATION" of therapy
- The SNF Proposed Rule is looking at the minutes of therapy and the modes of therapy provided comparing statistics from pre-PDPM to post-PDPM

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PDPM First Year Root Causes for Errors all Engagements

- Section GG coding was the most prevalent error.
- The timeliness of the BIMS interviews.
- Diagnosis coding was the third highest root cause for NTA, nursing and SLP
- Swallowing issues were not routinely recognized by MDS coders.
- Primary diagnosis coding was inaccurate
- Special treatment errors were a result of isolation coding and IV medications.

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PDPM Coding Issues Encountered in all 2020 Audits

- Primary diagnosis did not accurately represent the reason for Medicare Coverage.
- Additional diagnosis were not documented by physician or were not active diagnosis.
- Nursing documentation to support skilled in place was not strong and did not support the claim in some cases.
- Isolation was coded, but did not meet the regulatory requirements (especially related to COVID)

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Audit Red Flags

- Exposure to COVID and positive diagnosis alone will not qualify for skilled services.
- Diagnosis, symptoms monitoring play a key role in determining if Medicare Coverage is appropriate.
- The length of Medicare coverage will depend on the resident's condition, CDC recommendations and skilled services provided.

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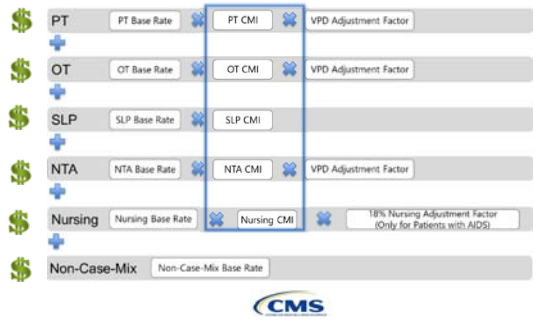
PDPM Snapshot



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PT & OT Components: PDPM

- PDPM
  - Two classifications are used to obtain patient characteristics for PT and OT components under PDPM:
    - Clinical Category- Primary Diagnosis
    - Functional Status- Section GG
- No therapy minutes required

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Diagnosis

- Primary diagnosis did not support reason for skilled care in all cases.
- All diagnosis were not captured in Section I related to SLP and NTA.
- All diagnosis were not captured in I8000.

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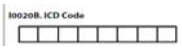
The physician's role in documentation of the primary diagnosis

WHAT IS THE REASON FOR THE SNF ADMISSION?

- This is the question that drives the choice of the primary diagnosis code
  - The code will be entered into the MDS in Item "I0020B"



The reason for the hospitalization may not be the reason for the SNF admission!

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Discussion about Primary Diagnosis

- Physician documented reason for SNF admission
- Physician list the primary diagnosis first
- Physician(s) educated on PDPM
- Comorbidity diagnoses documented by a physician

Days 1-8

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PDPM Clinical Categories for PT and OT

PDPM Clinical Categories	PT & OT Clinical Categories
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Acute Neurologic	Non-Orthopedic Surgery & Acute Neurologic
Non-Orthopedic Surgery	
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Orthopedic - Surgical Extremities Not Major Joint	
Medical Management	Medical Management
Cancer	
Pulmonary	
Cardiovascular & Coagulations	
Acute Infections	

CMS

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Muscle Weakness (M62.81) vs Muscle Atrophy (M62.59)

Choice of a code can significantly change reimbursement

- M62.81 codes to RTP = no reimbursement
- M62.59 codes to Other Orthopedic
- Using a medical diagnosis from the hospitalization would probably track to Medical Management
- If the patient had Function Scores in the 10-23 range, in the Rural Rate category, for PT Category, here are the financial impacts:
  - RTP = $0
  - Other Orthopedic = $115.65
  - Medical Management = $105.26

Make sure your documentation clearly supports the choice of your code.

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Physician Documented Diagnosis

- Must be documented to code
  - 60-day lookback physician documented diagnosis
  - 7-day active diagnosis lookback
- Progress notes must support the primary diagnosis
- Progress notes must support skilled service(s)

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Nursing & Therapy Documentation of the Primary Diagnosis

- Know the Primary Diagnosis
- Document the skilled condition
- State the primary diagnosis in progress notes
- Document the need and reason for skilled care
- Document the part of the body affected by the condition
- Current condition and discharge needs

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PT/OT Component- Functional Status Section GG

- Supported by nursing and therapy
- Days 1-3 on admission/readmission
- Interim Payment Assessment (IPA)
  - ARD plus 2 days prior
- PPS Discharge
  - PPD DC date plus 2 days prior

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Section GG Importance

Clinical Category	PT & OT Function Score	PT & OT Case Mix Group	PT CMI	OT
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.
Major Joint Replacement or Spinal Surgery	6-9	TB	1.69	1.
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88	1.
Major Joint Replacement or Spinal Surgery	24	TD	1.92	1.
Other Orthopedic	0-5	TE	1.42	1.
Other Orthopedic	6-9	TF	1.61	1.
Other Orthopedic	10-23	TG	1.67	1.
Other Orthopedic	24	TH	1.16	1.
Medical Management	0-5	TI	1.13	1.
Medical Management	6-9	TJ	1.42	1.
Medical Management	10-23	TK	1.52	1.
Medical Management	24	TL	1.09	1.
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27	1.
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48	1.
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55	1.
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08	1.

- Supports reimbursement for PT/OT and Nursing components
- Functional Score

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Section GG

- Section GG coding should accurately represent the resident's usual performance of the activity, NOT the most dependent.
- Nursing and therapy documentation must support Section GG starting on the day of admission, and days 2 and 3.
- The documentation must clearly establish the date it was completed.
- If IDT recommends coding other than what the documentation shows, a clarifying note must explain the coding used.
- Percentage of claims with errors overall is 68%

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Section GG Documentation Resources

- Section GG Abilities and Goals Assessment Form
- Therapy Documentation
- Nursing Documentation

Do NOT use ADL Documentation in Section G

- Task definitions are different
- Coding formats are different

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Note Text: Resident new admit day 2. resident alert and oriented pleasant and cooperative with all care. Took meds without difficulty. VSS. Resident 1 assist with transfers and care. Resident denied any pain/discomfort this shift.

Ineffective Nursing GG Documentation

- Resident requires contact guard of 1 assist with sit to stand and bed to chair transfers or
- Resident requires moderate assistance of 1 person with sit to stand and bed to chair transfers or
- Resident requires maximal assistance of 1 person with sit to stand and bed to chair transfers

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Speech Language Pathology Component-PDPM

5 Components support SLP for PDPM.

SLP Component	
Acute Neurologic clinical classification	Diagnosis
Certain SLP related co-morbidities	Diagnosis
Presence of cognitive impairment	BIMS
Presence of mechanically altered diet	Section K
Presence of a swallowing disorder	Section K

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Speech Language Pathology Component-PDPM

- Physician Documentation

MDS Item	Description
I4300	Aphasia
I4500	CVA, TIA, or Stroke
I4900	Hemiplegia or Hemiparesis
I5500	Traumatic Brain Injury
I8000	Laryngeal Cancer
I8000	Apraxia
I8000	Dysphagia
I8000	ALS
I8000	Oral Cancers
I8000	Speech and Language Deficits
O0100E2	Tracheostomy Care While a Resident
O0100F2	Ventilator or Respirator While a Resident

Diagnosis

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Cognitive Impairment Component (BIMS)

- PDPM- Speech Component
- Conducted on the ARD or the day before
- Resident Interview
- Rules to Stopping an Interview
- Staff Interview
- Missed Interviews – Considered Cognitively Intact
- Unplanned Discharges – Do Staff Interview
  - Don't Dash the MDS

Affects Reimbursement

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BIMS Scoring Issue

- CMS FAQ 5.4 How is the patient classified under PDPM if neither the BIMS nor the CPS staff assessment is completed to determine cognitive level?
  - If neither the BIMS nor the staff assessment is completed, then a patient will be classified under PDPM as if the patient were "cognitively intact." In other words, even if the patient has a cognitive impairment, without the BIMS or staff assessment completed, the cognitive impairment will not be considered as part of the patient's PDPM classification. An IPA may be done to reclassify the patient in such scenarios to capture the cognitive impairment.
- The software programs do not score the resident as indicated in the CMS FAQs. If the BIMS is correctly dashed, the software programs use Step #2 of PDPM Calculation Worksheet to determine the Cognitive Score.
- LWCI will score the resident as cognitively intact if a BIM is not completed timely.

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Mechanically Altered Diet Component- PDPM

- Order from physician
- Documentation from dietician and nursing
  - Reason for diet
  - Resident's response to diet
  - Improvement on diet or lack of
  - Weight on diet
  - Does diet affect activity participation and socialization?

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Swallowing Disorder Component- PDPM

- Ask the resident
- Interview staff members
- Observe the resident during meals or medication pass
- Review documentation in the medical record

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SLP Component: Payment Groups

Tier 1: Presence of Acute Neurologic Condition, SLP Related Comorbidity, or Cognitive Impairment	Tier 2: Mechanically Altered Diet or Swallowing Disorder	SLP Case Mix Group	SLP Case Mix Index
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.66
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97
Any two	Neither	SG	2.04
Any two	Either	SH	2.85
Any two	Both	SI	3.51
All three	Neither	SJ	2.98
All three	Either	SK	3.69
All three	Both	SL	4.19

CMS

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Nursing Component- PDPM

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Examples of critical nursing documentation

- SOB lying flat
- Isolation
- Diabetes and insulin orders and injections
- COPD documented and supported
- Oxygen use
- Wounds and wound treatments

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Isolation was coded, but did not meet the regulatory requirements (especially related to COVID)

- The resident has active infection
- Precautions are over and above standard precautions.
- The resident is in a room alone because of active infection and cannot have a roommate.
- The resident must remain in his/her room.

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Skilled Documentation: Nursing Care

Tips for documenting to support specific diagnosis codes or symptoms

- Know the primary diagnosis
- Document on the skilled nursing assessments that take place on a daily basis
- Capture skilled treatments that are performed and monitored on a daily basis
- Always try to paint the picture of what skilled care is being provided to the patient based on the patient's diagnosis

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NTA Component

- NTA classification
  - Based on the presence of certain comorbidities or use of certain extensive services
- Co-morbidities and extensive services for NTA classification
  - Derived from a variety of MDS sources
  - Some co-morbidities identified by ICD-10-CM codes reported in MDS Item I8000
- HIV/AIDS reported on the SNF claim, likewise, to RUG-IV
  - 8 points awarded for this one diagnosis
- CMS lists 50 diagnosis codes and conditions
- Maximum allowable = 12 points

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NTA Component: Payment Groups

NTA Score Range	NTA Case Mix Group	NTA Case Mix Index
12+	NA	3.25
9-11	NB	2.53
6-8	NC	1.85
3-5	ND	1.34
1-2	NE	0.96
0	NF	0.72

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Eligibility Focus Areas

- Three-day qualifying stay and use of CMS Waiver.
- Signed Admission orders.
- Documentation to Support daily skilled services.
- Medicare coverage under presumption of coverage.

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Medicare Coverage Criteria

- MBPM Chapter 8, §30.2.1
- Care in a SNF is covered if 4 conditions are met:
  1. Services must be performed by a qualified provider under orders by the physician [for a condition related to the hospital stay].
  2. Requires 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 are reasonable and necessary for the patient's specific needs supported by standards of practice.

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Presumption of Coverage

- Beneficiaries who are "correctly assigned to one of the designated case-mix classifiers on the initial 5-day, Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date on the 5-day Medicare required assessment".
- The presence of any of the following classifiers will qualify a resident for the administrative presumption that the SNF level of care requirements have been met under PDPM:
  - Nursing case-mix groups: Extensive Services, Special Care High, Special Care Low, and Clinically Complex
  - PT and OT groups: TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO
  - SLP groups: SC, SE, SF, SH, SI, SJ, SK, and SL
  - NTA Group: NA

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CMS Waivers

CMS waivers are in effect, with a retroactive effective date of March 1, 2020, through the end of the emergency declaration.

1 Mar. 2020

21 Jan. 2021

CMS waivers were last renewed on January 21, 2021 and continue to be effective.

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CMS Waivers – 3-Day Hospital Stay

1. Using the waiver authority under Section 1812(f) of the Social Security Act, CMS waived the requirement for a 3-Day Prior Hospitalization in order to furnish Medicare Part A services without a qualifying hospital stay (QHS).
   - A COVID-19 diagnosis is not required.

2. CMS allowed beneficiaries to obtain an additional 100-day benefit period without a 60-day break in spell of illness (Benefit-Period waiver) if certain conditions are met.
   - Authorizes a one-time renewal of benefits for an additional 100 days.
     - Without interrupting a current stay (i.e., PHE prevents completion of care at day 100 and care continues day 101 and beyond).
     - After an interruption of skilled level of care following expiration of initial 100-day benefit period but not completion of 60-day break in spell-of-illness (same or different SNF).
   - Applies only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances.

3. Requirement for a 3-day prior hospitalization for coverage of a SNF stay is waived
   - Resident must meet MBPM guidelines.

4. Does not extend benefit period for residents with tube feeding requirements.

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Billing Reminders

- Modified MDS Not Properly Billed on UB-04
- Requires system to verify that subsequent bills will have the corrected HIPPS coding
  - Triple Check
  - Communication with Business Office
  - Verify HIPPS coding

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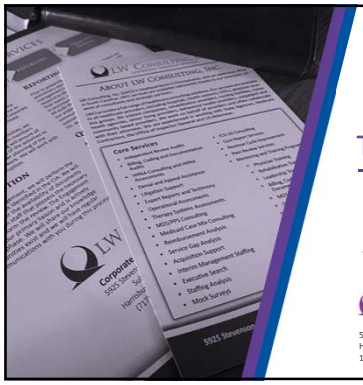

Thank You!

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