Patient Driven Payment Model (PDPM)

New Reimbursement, New Challenges for SNF Providers

Lance Hill, OTR/L, RAC-CT®
Executive Vice President of SNF Operations
Dir. of Regulatory and Clinical Compliance
email: lhill@therapyctr.com

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The full contents of this article address 4 components of PDPM: 1- A brief overview of the PDPM payment model; **2**- New challenges impacting nursing, **3**- Therapy: Debunking myths and therapy's role in PDPM; and finally **4**- What we can do now to begin preparing for change.

Part Two

New Challenges Impacting Nursing

Under PDPM, not everything will be or look new. Carrying over from PPS will be the 25 RUG IV nursing RUG classifications currently in use.

- Extensive Services
- Special Care High and Special Care Low
- Clinically Complex
- Behavioral & Cognitive Performance
- Reduced Physical Function

These categories will be adjusted by 3 factors:

- Level of Restorative services provided
- Depression indicators as defined in the RAI manual
- Section GG!

*** It is important to note here that Section GG has been revised and will replace Section G on MDS's under the PDPM model of care.

MDS accuracy is and continues to be critical under PPS but even more attention to detail will be required under PDPM. To be successful under PDPM, your MDS team needs to be educated to capture the patient's condition and to actively recognize significant changes in patient condition should they arise. Active care is key.

The Good, Bad and Ugly

The Good: Required or Scheduled MDS assessments will decrease from a minimum of 5 in a 100 day stay to 1 (completed at the beginning of care).

The Bad: Unlike PPS where if the patient received and classified in a therapy RUG, the strength of support and justification of skilled nursing services was not as important due to therapy's involvement, under the PDPM this will change. Because PDPM takes into account 5 silos of care, each silo must support and justify the services and care delivered in order to qualify for reimbursement. This means that Nursing will need to support and justify the skilled nursing services being delivered and cannot rely on therapy involvement to support the rate. This is also true of therapy. OT must independently support OT services, PT, PT services and ST, ST services. If any of the silos do not adequately justify the level of services provided, that silo will have a negative impact on patient's overall reimbursement.

The Ugly: Section GG and I8000. As mentioned in the introduction, Section GG will replace Section G on the MDS under PDPM. The definitions surrounding Section GG remain the same but new item sets have been added and one category deleted. Here the care team is looking to capture the patient's "Usual" performance in the first 72 hours of care and in the final 72 hours of care on planned discharges. Although many of the item set questions seem therapy related, do not fall into the trap of thinking that therapy should be the only ones answering these questions. The questions are geared for the entire Care Team and the key to remember here is "Usual". Yes therapy should have input but should not be the sole source of data. How does the patient "Usually" perform each task? Often time's therapy will see the patient in a much better light during the first 72 hours compared to the patient usual, so their data should rarely be used as the data to be input on the MDS. At time of discharge how the patient performs in therapy should be more indicative of what the final MDS data records.

So why is it important to be wary of sole use of therapy data on the initial Section GG MDS? The short answer is **outcomes**. PDPM is geared to reward patient outcomes. CMS has been moving to value based purchasing for the past 15+ years and outcomes is key. If your MDS data reports a more independent patient as the usual, your final outcomes will not reflect the true level of care you have provided. This could result in audit scrutiny from MAC's, RAC's and ZPIC's to name a few.

I8000 Active Diagnosis is a field that under PDPM will require careful attention to detail. Education and training now is critical. As mentioned previously, PDPM begins with the Part A patient being classified into a clinical category based on the diagnosis codes appearing in I8000. Not capturing accurate or detailed medical diagnoses will affect your reimbursement. The impact can be compounded if the patient has a missed diagnosis that would qualify for additional reimbursement based on the approved Comorbidities List established inside the PDPM Framework. It is critical that the entire care teams, including physicians are well versed in proper and accurate coding.

This concludes Part 2 of the PDPM article.

Stay tuned for Part 3: Therapy: Debunking Myths and Therapy's Role in PDPM

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