WELCOME

GINA GAMBARO

Director, Marketing &

Business Development

Asking a question is easy!

- About the topic being presented —
  - Click on the **Q&A** icon at the bottom of your screen
  - Type your question & hit Enter
  - Questions will be answered at the program's end, or offline if time runs out
- About technical issues or CE credit —
  - Click on the **Chat** icon at the bottom of your screen
  - Type your question & hit Enter
  - Our team will reply to your question right away

Housekeeping notes

- This webinar is being recorded for on-demand access later, after the series' conclusion
- To earn CE, you must attend the entire session
- **For those sharing a computer**
  - Complete a manual sign-in sheet before the program ends
  - Go to **Chat** to access the link for the sign-in sheet
  - Each participant must complete an evaluation to obtain CE credit
  - Instructions will also be emailed to the program registrant

Specific Operational and Clinical Tasks to Support Quality Services and Accurate Payment

Presented by
Leah Klusch, RN, BSN, FACHCA
Executive Director
The Alliance Training Center
Leahklusch@tatci.com
330-821-7616

Operational Issues

- Data Quality and Data Formulation Policy – Internal Audit results – Documentation of care
- Payment changes – External info requests – Money per day per categories of base rates
- Compliance basics – October 2019 CMS structure – Part A Medicare case documentation
- Building specific issues – Orientation – Training of current staff – Competency documentation – Survey issues related to data formulation and data accuracy

Clinical Issues

- Review Key Statistics October 2019 to October 2020
  - Demographics – Diagnosis
  - Services
  - Partners – record of Services by contractors
- Nursing leadership – Documentation guidelines – EMR formats
- Quality of documentation on the nursing unit
- Leadership for IDT members – Competency documentation
- Impact of data on payment and outcome documentation
- Impact of first 7 days of the stay documentation – Very Important

Key Compliance and Regulatory Issues

- Part A Covered Services – Medicare Benefit Policy Manual Chapter 8
- Provider Agreement requirements for Policies and Documentation
- Technical and Clinical Eligibility
- Certifications - Skilled PDPM Payment Categories
- Documentation of covered services in the medical record – All departments
- Diagnostic coding – CMS Mapping-Complete Active Diagnosis list during the first 7 days

FOCUS OF GOVERNMENTAL AGENCIES

- COMPLIANCE – LINK POLICIES AND PROCESSES TO THE C0VERAGE GUIDELINES
- REGULATORY STRUCTURE OF FEDERAL AND STATE PROGRAMS – MEDICARE AND MEDICAID
- NEW SURVEY TAGS ON MDS REQUIREMENTS – FITS INTO THE CURRENT CMS FOCUS; Multiple Tags
- PAYMENT – WHAT ARE YOU BEING PAID FOR AND THE INTEGRITY OF YOUR SUBSTANTIATING DATA AS WELL AS COMPLIANT ACCURATE BILLING PROCESS?
- NEW ANALYTICS – CMS & GAO REPORTS

Services Under Arrangement

Third-Party Covered Services-Contracted

EX: Therapies

- Provider Responsible for Supervising Arranged Service
  - "As If" services provided by Provider's staff
  - Complete & timely resident/client records
  - Communication with Provider staff and MD
  - Medicare: Medical Necessity Determinations – Utilization Review Minutes
  - Where is the documentation for the permanent medical record?

PART A MEDICARE

- Medicare Provider Agreement must be in place for you to admit and bill for Medicare Benefits in the SNF
- What document tells you the federal rules and coverage guidelines for Part A Medicare?
- Who needs to have the specific guidelines for admission, coverage of services, documentation, and certification?
- MEDICARE BENEFIT POLICY MANUAL – CHAPTER 8 is the reference – the only reference – Who has copies and knows content?
- All claims' denials and audit denials need to be justified from this document – have been for many years
- WHO HAS THIS DOCUMENT IN YOUR CORPORATE COMPLIANCE OFFICE AND ON SITE IN THE FACILITIES WHERE ADMISSION AND COVERAGE DECISIONS ARE MADE?
- YOU MUST DOCUMENT THAT ADMISSIONS & SERVICES ARE COVERED TO THE PART A STANDARD

Medicare Part A Provider Application Agreement

- CMS – 855-A
- Contains provider responsibilities in order to be approved to bill Part A Medicare for services
- Section 15 (page 45) certificates Statement
- I agree to abide by the Medicare laws, regulations and program instructions that apply to this provider. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statue and the Stark law), and on the provider's compliance with all applicable conditions of participation in Medicare.
- I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

Physician Signature Guidelines

- CMS – Medline Fact Sheet ICN MLN 909340 October 2019
- Necessity of Documentation
- Appropriate documentation substantiates the necessity for those services or items given or ordered. Coverage of services by Medicare depends on sufficient documentation to support medical necessity of the service(s). The documentation should give a complete picture of what occurred during the encounter and why services you ordered/gave are necessary.

Physician Signature Guidelines

- Documentation Supporting Medical Necessity must be complete, legible, and include, at a minimum:
  - Identity of person giving the service(s)
  - Date of service
  - Patient's signs and symptoms
  - Date of the services rendered and items furnished
  - Indication of where the services were given
  - Signed orders for services and the clinical rationale for the orders
  - Rationale for the level of care given
  - Intensity, frequency, duration, and scope of services
  - Legible signature of the person rendering the service and the physician ordering and approving treatment plans (if signature is not legible, include a signature log showing name in print and signature)

- USE THE MEDICARE BENEFIT POLICY MANUAL (CHAPTER 8) FOR ORIENTATION, INSERVICES, DOCUMENTATION GUIDELINES, COVERAGE DECISIONS, AND CERTIFICATION RULES
- DOCUMENT THE SECTIONS OF CHAPTER 8 IN YOUR DOCUMENTATION NOTES OR UTILIZATION MINUTES TO CONFIRM COVERAGE
- NONE OF THE MEDICARE PART A REQUIREMENTS CHANGE WITH PDPM

Essential Review MBPM – Chapter 8

- Updated 10-04-2019 – Important
- Section 20.1 Three-Day Prior Hospitalization (Pages 8 & 9)
- Section 30 Skilled Nursing Facility Level of Care (Pages 18 & 19)
- Section 30.2.1 Skilled Services Defined (Pages 22 & 23)
- Section 30.2.2.1 Documentation to Support Skilled Care Determinations (Pages 25, 26, 27)
- Section 30.2.3.3 Teaching and Training Activities (Pages 30, 31, 32)
- Section 30.3 Direct Skilled Nursing Services (Pages 32, 33)

Essential Review MBPM – Chapter 8, continued

- Section 30.4.1 Skilled Physical Therapy (Pages 34, 35)
- Section 30.5 Non-Skilled Supportive on Personal Care Services (Pages 38 & 39)
- Section 40 Physician Certification and Recertification (Pages 44)
- Section 40.1 Who May Sign the Certification or Recertification for Extended Care Services (Page 45)
- Section 70.4 Services Furnished Under Arrangements with Provider (Page 54)

Name_____

Admission Date_____

Admission Primary Diagnosis_____

M.B.P.M. Section 30 Skilled Nursing Facility Level of Care – General

Care in a SNF is covered if all of the following four factors are met:

_____The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see 30.2-30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;

____The patient requires these skilled services on a daily basis (see 30.6); and

____As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See 30.7)

____The services must be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

RAI Manual References to SNF PPS Eligibility Criteria

- RAI Manual – October 2019 – Chapter 6 – Pages 6-10 & 6-11
- **Technical Eligibility Requirements**

  The beneficiary must meet the following criteria:
  - Beneficiary is enrolled in Medicare Part A and has days available to use.
  - There has been a 3-day prior qualifying hospital stay (ie, three midnights)
  - Admission for SNF-level services is within 30 days of discharge from an acute care stay or within 30 days of discharge from a SNF level of care

RAI Manual References to SNF PPS Eligibility Criteria continued

- **Clinical Eligibility Requirements**

  A beneficiary is eligible for SNF extended care if all of the following requirements are met:

  - The beneficiary has a need for and receives medically necessary skilled care on a daily basis, which is provided by or under the direct supervision of skilled nursing or rehabilitation professionals.
  - As a practical matter, these skilled services can only be provided in an SNF.
  - The services provided must be for a condition:
    - for which the resident was treated during the qualifying hospital stay, or
    - that arose while the resident was in the SNF for treatment of a condition for which he or she was previously treated in a hospital.

RAI Manual References to SNF PPS Eligibility Criteria continued

- **Physician Certification**
  The attending physician or a physician on the staff of the SNF who has knowledge of the case—or a nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS) who does not have a direct or indirect employment relationship with the facility but who is working in collaboration with the physician—must certify and then periodically recertify the need for extended care services in the skilled nursing facility
  - **Certifications** are required at the time of admission or as soon thereafter as is reasonable and practicable (42 CFR 424.20). The initial certification
    - affirms, per the required content found in 42 CFR 424.20, that the resident meets the existing SNF level of care definition, or
    - validates via written statement that the resident's assignment to one of the upper PDPM groups (defined below) is correct

RAI Manual References to SNF PPS Eligibility Criteria, continued

- **Physician Certification, continued**
  - Those nursing groups encompassed by the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories;
  - 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; and
  - The NTA component's uppermost (12+) comorbidity group
- **Re-certifications** are used to document the continued need for skilled extended care services
  - The first re-certification is required no later than the 14th day of the SNF stay
  - Subsequent re-certifications are required at no later than 30-day intervals after the date of the first re-certification
  - The initial certification and first re-certification may be signed at the same time

Management Approaches

- Document competencies with regulatory requirements
- Develop relationships with acute care, pharmacy, service contractors (NP groups) to promote accurate timely information at admission
- Identify the efficiency, competency and accuracy of the data formulation process. Orientation & Onboarding Process
- Determine nursing & therapy teams' clinical competencies when completing assessments and plans for treating specific diagnostic groups
- Develop care team awareness of diagnostic and treatment data impacting PDPM payment groups as well as increased focus on timelines
- Look for changes in work patterns, assignments and communication within the IDT.

The Change to PDPM Is Complex

- This is a new process – does not build on PPS
- Start with the MDS data formulation process
- Your assessment process should be documented in policy and procedure documents for use with orientation and training programs
- The MDS manager needs to direct the process and be able to show efficiency, accuracy, timeliness of transmissions, audit activity to show reproducibility of data in the medical record and the use of analytics when possible, to identify coding and key-stroke errors
- All IDT members that code the MDS must have complete updated instructions from the current RAI Manual and training when necessary (October 2019)
- Utilization Review process must be adopted to review the HIPPS codes for payment levels

COMPLIANCE AUDITS - ESSENTIAL

- ARE YOU ACTIVE WITH AUDITS:
  - ADMISSION CRITERIA – DOCUMENTATION IN THE CHART – WHY WAS THIS PERSON ADMITTED UNDER Part A?
  - Admission primary diagnosis – very important – MDS & Billing MUST MATCH! – New Risks with PDPM
  - Certification documents – signed and dated on time – original documents must be available if outside audit is done; no cert, no payment
  - Treatment records, orders and documentation of interventions for skilled nursing or skilled therapy – specific documentation – resident specific plans & interventions are required
  - Outcomes and documentation of changes in coverage
  - This is the facility responsibility – not the therapy contractor – The facility owns the record
  - Document the audits and outcomes as well as actions to improve compliance. If the contractor is auditing, you need copies of audits and results

Impact on Current Process

- Begin with understanding of current data collection processes - October 1, 2019, RAI Manual Changes https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html
- Evaluate data formulation policies and procedures for compliance & staff competency.
- Educate all IDT members on structure of the PDPM payment process, data base content impacting the payment process and the impact of H.I.P.P.S. codes
- Evaluate the case management process at the time of admission to evaluate accuracy of diagnostic info, treatments, interventions and services necessary to care for the elder
- Review the facility history of compliance with assessment transmissions & validation as well as late assessments. CASPER Reports
- Begin review of (RUG IV) utilization review process to establish criteria focused on PDPM data requirements and outcome documentation
- Review content of utilization review meetings and storage of meeting minutes

Evaluate Data Formulation Process – Very Important!

- Operational leadership to review data formulation and documentation process
- Structure of interdisciplinary documentation to meet reproducibility standards
- Focus on the first 7 days of the stay for documentation of care, observations and interview activity
- Reference structure of definitions, timing and content of assessments in RAI Manual –October 2019 Manual Updates
- Document responsibility for data coding, timing of data collection and accuracy certification (Section Z)
- Staff coding into the MDS data base should be given directions for the data items and a copy of the attestation statements – Section Z400

Today

- ADR requests are beginning to be processed on some Part A Medicare claims from 2019
- Managed Care companies are sending out ADR's and processing denials related to
  - Section GG
  - Parenteral/IV feeding
  - Medical Diagnosis
  - Malnutrition
  - Speech-Language Pathology (SLP) Case Mix
- Each Category of denials is citing a lack of documentation to support Section GG documentation
- Denial notice language: "Unable to support documentation, requested records do not identify the clinician completing the assessment and completion date
- The documentation provided does not support coding of all Section GG payment items during the first 3 days

Regulatory Compliance with Assessment Tags 636-641-642

- Reproducibility of all data in the Medical Record
- Big issue today is Section GG data that is supported by tracking, etc, during the first 3 and last 3 days of the stay
- Section GG produces the Functional Performance Score for all Part A cases and impacts payment levels in PT, OT, and Nursing Case Mix Index group
- Data collection tools or electronic process to support all coding
- Reproducibility of all data is required in the medical record during the assessment reference period

Selected Quotes from Regulatory Tags Defining the MDS 3.0 Process

F Tag 636 483.20 Resident Assessment

- The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity
- (XVIII) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts
- Utilization Guidelines provide instructions for when and how to use the RAI; the Utilization Guidelines are also known as the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual
- The facility is expected to use resident observation and communication as the primary source of information when completing the RAI; in addition to record review, direct observation and communication with the resident
- Does the facility have a system in place to assure assessments are conducted in accordance with the specified timeframes for each resident?

F Tag 641 483.20(g) Accuracy of Assessments

- The assessment must accurately reflect the resident's status
- Intent 483.20g – To assure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline
- Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment
- The assessment must represent an accurate picture of the resident's status during the observation period of the MDS. The Observation Period (also known as the Look-Back period) is the time period over which the resident's condition or status is captured by the MDS assessment and ends at 11:59 PM on the day of the Assessment Reference Date (ARD)
- When the MDS is completed, only those occurrences during the observation period will be captured on the assessment; in other words, if it did not occur during the observation period, it is not coded on the MDS
- Based on your total review of the resident, observations, interviews and record reviews, does each portion of the MDS assessment accurately reflect the resident's status as of the Assessment Reference Date?
- Is there evidence that the health professionals who assessed the resident had the skills and qualifications to conduct the assessment?

F Tag 642 483.20 (H) (I) Coordination & Certification

- A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals
- A registered nurse must sign and certify that the assessment is completed
- Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment
- Penalty for falsification
  - 483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly --
    - (i) Certifies a material and false statement in a res ident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or
    - (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment

F Tag 642 483.20 (H) (I) Coordination & Certification

- **Backdating Completion Dates** -Backdating completion dates is not acceptable -- note that recording the actual date of completion is not considered backdating (for example, if an MDS was completed electronically and a hard copy was printed two days later, writing the date the MDS was completed on the hard copy is not considered backdating)
- A pattern within a nursing home of clinical documentation or of MDS assessment or reporting practices that result in higher Resource Utilization Group (RUG) scores, untriggering Care Area Assessments (CAAs) or unflagging Quality Measures (QMs), where the information does not accurately reflect the resident's status, may be indicative of payment fraud or attempts to avoid reporting negative quality measures
- When such patterns or practices are noticed, they should be reported by the State Agency to the Regional Office and Medicaid Fraud Control Unit
- Are the appropriate certifications in place, including the RN Coordinator's certification of completion of an MDS assessment or Correction Request, and the certification of individual assessors of the accuracy and completion of the portion(s) of the assessment or tracking record completed?

What Team Members Need to Know

- Essential to have each team member be competent with the new definitions and data formulation for each section or item on the MDS 3.0. – October 2019 Update
- Tag 641 in the current regulatory process states, “Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.” The assessment must represent an accurate picture of the resident’s status during the assessment reference period
- Has your facility implemented all the definitional and data formulation changes in the October 2019 update? The PDPM program builds on those guidelines and definitions to establish per day payment rate

Data Formulation Policy and Procedure

- Important Part of Compliant Operations
- Begins with Regulatory Structure – TAGs
- Responsible parties – Job descriptions – Competency evaluations – Regulatory resources
- Section by Section coding responsibility and timelines for data collection
- Structure of data base software programs – Training - Audits
- Passwords – documentation and assignment- Central operational document
- Timelines for assessment completion, transmission and validation – Review CASPER Reports
- Audit program and reporting – Have a format for Part A Medicare Case audits – Document results

Management Approaches

- Document competencies with regulatory requirements
- Develop relationships with acute care, pharmacy, service contractors (NP groups) to promote accurate timely information at admission
- Identify the efficiency, competency and accuracy of the data formulation process Orientation & Onboarding Process
- Determine nursing & therapy teams' clinical competencies when completing assessments and plans for treating specific diagnostic groups
- Develop care team awareness of diagnostic and treatment data impacting PDPM payment groups as well as increased focus on timelines
- Look for changes in work patterns, assignments and communication within the IDT

PDPM Snapshot

PT	PT Base Rate	✖	PT CMI	✖	VPD Adjustment Factor
✚					
OT	OT Base Rate	✖	OT CMI	✖	VPD Adjustment Factor
✚					
SLP	SLP Base Rate	✖	SLP CMI		
✚					
NTA	NTA Base Rate	✖	NTA CMI	✖	VPD Adjustment Factor
✚					
Nursing	Nursing Base Rate	✖	Nursing CMI	✖	18% Nursing Adjustment Factor (Only for Patients with AIDS)
✚					
Non-Case-Mix	Non-Case-Mix Base Rate				

Items Impacting CMI Levels

- PT Base Rate is impacted by Diagnosis Category and FPS to identify CMI
- OT Base Rate is impacted by Diagnosis Category and FPS to identify CMI
- SLP base rate is impacted by Acute Neurologic Diagnosis BIMS, Speech Covariates, Swallowing issue and Mechanically altered diet to identify CMI
- NTA Base Rate is determined by number of points from listed qualifiers
- Nursing Base Rate is determined by RUG IV qualifiers, Mood Severity Score and FPS to identify CMI
- Non-Case Mix Base rate is predetermined $ urban or rural
- All qualifiers are MDS 3.0 items except for the HIV AIDS Diagnosis

PDPM Model – MDS Drivers by Section

- **B** Hearing, Speech, and Vision – SLP / Nursing
- **C** Cognitive Patterns – SLP / Nursing
- **D** Mood – Nursing
- **E** Behavior – Nursing
- **GG** Functional Abilities and Goals – PT / OT / Nursing
- **H** Bladder and Bowel – Nursing / NTA
- **I** Active Diagnoses – PT/OT/SLP /Nursing / NTA
- **J** Health Conditions – PT/OT/SLP/Nursing
- **K** Swallowing/Nutritional Status-SLP / Nursing / NTA
- **M** Skin Conditions – Nursing / NTA
- **N** Medications – Nursing
- **O** Special Treatments, Procedures and Programs (all while a resident) – SLP / Nursing / NTA

Relationship Between the Assessment and the Claim

- Internal & External audit activity
- Data from the 5-day Comprehensive Assessment or the IPA creates the payment rate.
- “It is the responsibility of the provider to ensure that claims submitted to Medicare are accurate”
- SNF claim must contain the ARD of the Assessment and the HIPPS code – 5 positions Code reported on Section – Z – 100 on the MDS 3.0.

Coding Instructions for Z0100A, Medicare Part A HIPPS Code

- Typically, the software data entry product will calculate this value
- The HIPPS code is a Skilled Nursing Facility (SNF) Part A *five-position* billing code*; the first four positions represent the PDPM case mix version code and the fifth is an assessment type indicator*. For information on HIPPS, access:

  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html
- Note that the *version code* included in this HIPPS code takes into account all MDS items used in the *PDPM* logic and is the "normal" group since the classification considers the rehabilitation therapy received
- This HIPPS code is used for Medicare SNF Part A billing by the provider; sets the base rate on all claims
- Left-justify the 5-character HIPPS code; the extra two spaces are supplied for future use, if necessary

HIPPS Code Pathway to PDPM Payment

- Health Insurance Prospective Payment System Code (HIPPS)
- Payment charts with HIPPS codes
- Characters indicate payment qualifiers and rates (urban or rural)
- All payment indicators come from validated MDS 3.0 data base
- Creates a specific data base to audit accuracy of MDS assessment
- To audit start with the HIPPS code and trace qualifiers back to Medical Record during the assessment reference period
- HIPPS Code specifics Chapter 6 of the RAI Manual

MDS 3.0 Data Set Content for PDPM

- Total change in data items contributing to payment rates
- Dramatic increase in the # of MDS items impacting payment rates
- 5 specific components for each elder specific payment rate
- Quality of coding on MDS directly impacts payment rates – October 2018 and October 2019 RAI manual updates
- Functional Performance Score from Section GG items impacts PT, OT and Nursing Rates
- Therapy delivery will NOT impact payment at all!
- BIMS score required to Validate MDS for PDPM
- Mood score of 10 points or more has significant impact on Nursing Component
- Measurements – Ht & Wt, Fever, Pressure Ulcers, etc
- Comorbidities – Very important Section I – 8000 coding

Purpose of HIPPS Code Audits

- Consolidation of Data from MDS 3.0 data base into payment codes
- HIPPS Code produces payment per elder for claim
- HIPPS Code can trace back into the MDS and to the record for reproducible documentation
- Discover staff competency and front-line documentation deficiencies
- Look for patterns of non covered PDPM payment groups – This is new!

Retraining Staff to Improve Data Accuracy

- Importance of the RAI Manual content for each coded item
- Update staff competencies for October 1, 2019, manual revisions asap
- Retraining? Everyone needs retraining now because of significant coding changes & data use
- Focus on 5-day assessment – first 7 days of the stay – vital importance of accuracy and reproducibility of data
- The entire IDT needs to understand the broad scope of the MDS data base that contributes to the 5 payment categories
- Documented competencies in all areas need to be initiated as soon as possible to increase timelines and accuracy of coding

Medical Review and Data Monitoring – CMS Speaking

- Regardless of the payment model used, ensuring appropriate safeguards for program integrity is always essential
  - Ensuring program integrity can also represent an administrative burden and potential financial risk for providers
- Given the more holistic style of care emphasized under PDPM, program integrity and data monitoring efforts will also be more comprehensive and broad
- For program integrity, we expect provider risk will be more easily mitigated to the extent that reviews focus on more clearly defined aspects of payment, such as documentation supporting patient diagnoses and assessment coding
  - If the provider codes that the patient's/resident's primary diagnosis is a major joint replacement, then the reviewer should be able to verify that the patient/resident received a major joint replacement

MDS Process Management

- Evaluate current leadership and communication to the entire IDT
- MDS manager must be accountable to the Administrator for operational and fiscal issues as well as the DON for clinical issues
- Front line staff and nursing leadership on the unit MUST know definitions and measurements required by the regulations and the current RAI manual
- Assignments for assessment tasks and interviews must include information from the current 2019 RAI manual
- Schedule work in the MDS office will change dramatically and must be discussed – Many new tasks – fewer repeat assessments – increased time to complete assessments

3-Day Hospital Stay Waiver Documentation

- In March of 2020, the CMS Administrator said “SNF care without a 3-day inpatient hospital stay will be covered for beneficiaries who experience dislocations or are otherwise affected by the emergency, such as those who are
  1. Evacuated from a nursing home in the emergency area,
  2. Discharged from a hospital (in the emergency or receiving locations) in order to provide care to more seriously ill patients, or
  3. Need SNF care as a result of the emergency”

3-Day Hospital Stay Waiver Documentation

- Most compliance and billing professionals suggest: To avoid potential denials of waiver cases the IDT should determine and document in the medical record
  1. What the skilled service(s) is/are
  2. How SNF level of care is met
  3. How the skilled stay related to the PHE and
  4. How an inpatient hospital stay would have likely been necessary to manage the condition(s) in absence of the pandemic
- If you use this waiver, documentation is crucial to support that extending the patient's skilled care days is related to the pandemic…If that documentation does not exist, we do suspect that the claim could be denied if reviewed in an audit

Focus on Diagnostic Documentation for all Payment – Start with Section I

- PDPM payment classification begins with “Primary medical condition category” documentation Section I0020
- October 1, 2019, change from 14 categories to 13 categories; all cases have to be put into one of 13 categories listed
- Gateway diagnoses – admission primary – needs to be documented in I-0020B on all PDPM assessments

New MDS Item Section I- 10020: SNF Primary Diagnosis

- To capture the patient's primary diagnosis, which is used to classify the patient into a PDPM clinical category, CMS added item I0200B, which allows providers to report, using an ICD – 10-CM code, the patient's primary SNF diagnosis
- The item will ask "What is the main reason this person is being admitted to the SNF?"
- Item I0200B will be coded when Item I0200 is coded as any response 1-13; this may not necessarily be the same as the hospital primary diagnosis

Section I	Active Diagnoses

I0020. Indicate the resident's primary medical condition category

Complete only if A0310B = 01 or 08

Enter Code ☐☐

Indicate the resident's primary medical condition category that best describes the primary reason for admission

01. Stroke
02. Non-Traumatic Brain Dysfunction
03. Traumatic Brain Dysfunction
04. Non-Traumatic Spinal Cord Dysfunction
05. Traumatic Spinal Cord Dysfunction
06. Progressive Neurological Conditions
07. Other Neurological Conditions
08. Amputation
09. Hip and Knee Replacement
10. Fractures and Other Multiple Trauma
11. Other Orthopedic Conditions
12. Debility, Cardiorespiratory Conditions
13. Medically Complex Conditions

I0020B. ICD Code

☐☐☐☐☐☐☐☐

Importance of Accurate Diagnosis Coding on the 5-day data set

- Admission Primary Diagnosis I0020B – must be CMS acceptable diagnostic code
- Published list of ICD – 10 codes that CMS has determined acceptable for processing PDPM claims
- New terminology – Diagnosis codes not acceptable are identified as Return to Provider or n/a Categories
- Primary Diagnosis
- Additional Active Diagnosis codes- Very important for PDPM calculation
- Section I – RAI Manual guidelines – Very Important
- Comorbidity documentation for Speech – Nursing & NTA payment qualifiers for PDPM
- All MDS managers and others working with Diagnostic coding need to read the entire directions – coding instructions and examples in Section I of chapter 3 of the RAI Manual and have access to CMS Mapping data. Pages I-1 to I-13

- PDPM ICD-10 Mappings:

  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFP.P.S./PDPM.html

Determining the Diagnosis

- Must meet the criteria of the RAI Manual as well as the Coding Guidelines
- Must be considered ‘active’ – diagnosis have a direct relationship to the resident’s current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring or risk of death during the look back period.
- Must be documented in the medical record during the A.R.P. of the 5 day assessment as active by a physician or an extender.
- Primary reason for admission to be documented in I0020A as a check off – used for the SNF Q.R.P.
- Diagnostic code reflecting the reason for admission to be documented in I0020B – used for the PDPM – CMS acceptable ICD-10 code.

Provider-Related Responsibilities

- Educate IDT on the new system and the need for accurate, complete diagnostic information as well as the timeframe for the 5-day MDS - ARD
- Establish a procedure for querying IDT members when there is insufficient diagnostic information (requires a written policy)
- Determine if the IDT members see the residents within a timely manner for capturing the needed information for the 5-day MDS
- Review current procedure, source, timeliness of obtaining and documenting diagnosis in the medical record
- Review current process, timeliness and accuracy for assigning the ICD-10- diagnostic code included in CMS Mapping
- Develop a written policy on the coding process and responsibilities from pre-admission to Data Set Documentation and transmission

Provider-Related Responsibilities, continued

- Review current codes and clean the lists
- Determine the primary diagnosis as a team and/or team consensus TEAMWORK, COMMUNICATION AND COMPETENCY IS CRITICAL
- Ensure the ENTIRE team is educated to the parameters of PDPM – Admission, Social Services, Nursing staff, Activities, Dietary, Medical Director, Therapy, Administration
- Make sure there is a back-up educated individual in the facility or available by phone for assigning the diagnostic codes at all times.
- Consider incorporating diagnosis review along with the admission drug regiment review – Pharmacy or Consultant Pharmacist
- Evaluate the setting of the Assessment Reference Date (ARD) due to the availability of the diagnostic information
- Determine the diagnosis assignment for an Interim patient Assessment (IPA)

Audit Issues Diagnostic Coding

- Acceptable codes – CMS Mapping
- Primary Dx – Payment Categories – PT – OT – Speech
- Secondary Diagnosis Payment Categories Nursing – NTA
- I-8000 diagnosis Codes – NTA – Very important – 10 open fields
- Where is the diagnosis documented – authorized in the record. (Assessment Reference Period) - Required
- If admission primary is after care – Documentation of procedure in the hospital needs to be documented in the SNF record
- CMS training example

Audit PT & OT

- Audit issues PT and OT
  - Admission Diagnosis Category
  - After Care – Post surgical needs to include documentation of the procedure done during the acute care stay
  - Functional Performance Score level accuracy
  - Section GG coding supporting documentation – Day 1 through Day 3 of the stay
  - Frequently used Diagnosis PT and OT – Keep a list of Diagnosis codes for your facility

SLP PDPM Components

- Cognitive Impairment – BIMS Score of 12 points or less -Section C
- Acute neurologic Diagnosis – Section I
- SLP related Co-morbidities – Section I & Section O
- Mechanically Altered Diet – Section K
- Swallowing Disorder – Section K

SLP Related Comorbidities	
✓ Aphasia	Laryngeal Cancer – I8000
✓ CVA, TIA, or Stroke	Apraxia – I8000
✓ Hemiplegia or Hemiparesis	Dysphagia – I8000
✓ Traumatic Brain Injury	ALS – I8000
✓ Tracheostomy Care*	Oral Cancers – I8000
✓ Vent or Respirator Care *	Speech and Lang Deficits – I8000

Audit SLP

- Identify who collects and codes data related to SLP payment
- Interview documentation and policy - BIMS
- Acute neurologic diagnosis documentation
- Co-morbidities – I8000 codes and check mark codes in other sections
- Mechanically altered diets – documentation in Medical record during the Assessment Reference period
- Swallowing disorder – High value area for payment; First 3 days of the stay for post surgical patients

Nursing PDPM Components

- Mood Severity Score – Section D
- Behaviors, Wandering – Rejection of Care – Section E
- Functional Performance Score – Section GG
- Diagnosis codes – Section I
- SOB, fever – Section J
- Parenteral/IV feedings – Section K
- Pressure Ulcers & Skin Treatments – Section M
- Respiratory Therapy, High Acuity Treatments, Restorative Nursing – Section O

Nursing Functional Performance Scores

- Individual for each nursing category
- Importance of GG coding
- First three days of the stay on the admission assessment– last three days of ARP on IPA and discharge assessment
- Score range O-16, Independent scores 15 & 16 lower nursing categories
- Significant impact on payment – Must be a true representation of first 3 days of the stay
- Education and competency testing are essential

Mood Severity Score, Impact on Nursing Payment

- Impact Special Care High. Special Care Low, and Clinically Complex Categories
- Most of skilled admissions will be in these categories
- Very big impact on dollars per day
- Know Steps for the Assessment in RAI manual
- Big issues 14-day look back period Chapter 3, Section D pages 1-17
- Scoring is very important
- This test does not diagnose depression
- Back up documentation in the record during the ARP is very important
- Appendix D & E of the RAI manual has important information for completing and scoring Mood interview

Nursing Audit

- FPS – Front line documentation for first 3 days of the stay – accurate calculation
- Diagnosis and treatment coding in the medical record during the ARP – Physician orders and diagnosis authorization
- High acuity treatments – RAI manual definitions
- Mood interview documentation in the medical record is important. Refer to Section D, Appendix D and Appendix E of the RAI manual
- Respiratory therapy – 7 days – Respiratory Nurse definition – documentation – Preventative approach
- Medication - Nurse documentation very important

Non-Therapy Ancillary (NTA) PDPM Components

- Bladder & Bowel – Section H
- Diagnosis – Section I
- Swallowing/Nutritional Status IV's – Section K
- Skin Conditions – Section M
- High Acuity Interventions – Section O

NTA Component: Comorbidity Coding

- Comorbidities and extensive services for NTA classification are derived from a variety of MDS sources, with some comorbidities identified by ICD-10-CM codes reported in Item I8000
- A mapping between ICD-10-CM codes and NTA comorbidities used for NTA classification is available on the PDPM webpage
- One comorbidity Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) is reported on the SNF claim, in the same manner as under RUG-IV:
  - The patient's NTA classification will be adjusted by the appropriate number of points for this condition by the CMS PRICER for patients with HIV/AIDS
  - See NTA Scoring Chart Resource

Documentation for NTA Items

- Must understand MDS Source code determinations from NTA – PDPM Calculation worksheet
- Accurate coding on MDS items from the October 2019 Manual revisions.
- I800 Coding items must be CMS acceptable codes.
- HIV Aids diagnosis – Transfer from Medical Record to Claim form – Does not code on the MDS
- All NTA items need to be substantiated in the medical record before 11:59pm on the ARD of Admission Comprehensive Assessment or the IPA

NTA Audit

- Total NTA points accurate
- Each item must meet definitional and delivery documentation criteria – RAI Manual references.
- All diagnostic codes must be CMS acceptable
- All documentation must be during the ARP of the assessment
- HIV/AIDS must be documented in the medical record and communicated to billing.
- Was historical information from family physician, consultants or family part of the admission conversation.

Data Gathering

- CMS reported that the use of data analytics in the Medicare program has resulted in *millions of dollars* in cost avoidance savings and recoveries
- There are two types:
  - Predictive analytics
  - Data mining
- Predictive analytics can identify fraud and errors before payments are made. For example, this model analyzes historical provider data to see if it matches the pattern of a known scheme
- Data mining can assist in the identification of improper payments after the fact. Data mining involves “the application of database technology and techniques such as statistical modeling to uncover hidden patterns and subtle relationships in data and to infer rules that allow for the prediction of future results”

Management Approaches for Accurate Data Formulation and Coding

- Know the data that creates the various data bases
- Best tool is multi-colored MDS 3.0 document
- IDT Competency is the base line -- Orientation and onboarding policies
- Proof of competency in HR files
- Timelines are very important and MUST be respected
- MDS managers need retraining with PDPM-follow up with policy and procedure updates
- Where are the manuals? -- One paper manual per building
- Audit for accuracy and payment per day
- Monitor public data reporting about your facility for accuracy at Nursing Home Compare -- 5 Star

Resources

— **Medicare Benefit Policy Manual Chapter 8**

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf

— **State Operations Manual** – Regulations

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

— **CMS P.D.P.M. Resources**

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

— **MDS Items Sets for V1.17.2**

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html

— **RAI Manual – October 1, 2019**

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

— **Color coded MDS 3.0** – Med Pass item # CP9100H – JS (09/20) 800-438-8884

Questions?

About CE credit

Administrator credit

This program has been approved for one hour of continuing education by the National Continuing Education Review Services (NCERS) of the National Association of Long-Term Care Administrator Boards (NAB) – Approval #20221015-1-A78426-DL.

Nursing credit

This program has been approved for one clock hour of continuing education credit by The Illinois Board of Nursing, an approved sponsor of continuing education by the Illinois Department of Professional Regulation.

Want more CE after this?

ForumPharmacy.com

Look for our next webinar or visit our website for available on-demand, self-study courses:

October:

Rising Above the Rest: Using Your Brand to Impact Recruitment, Retention & Reputation

THANK YOU!