PDPM Success – The Components, Documentation, and Reducing Audit Risk

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Disclaimers

The most current MDS 3.0 RAI Manual and CMS memos supersede all content presented within and should be consulted.

The MDS RAI Manual V1.17 effective October 2019 and V1.17.1R Errata effective October 1, 2021, were used for this presentation.

Reference links are provided at the end of the slides

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Today's Objectives

- Review the requirements for Medicare Part A skilled care
- Identify best practices in PDPM workflow
- Discuss the multi-disciplinary approach to PDPM success
- Effectively document the skilled care being provided to support the UB-04 HIPPS code
- Recognize the common MDS coding errors compromising reimbursement under PDPM
- Apply supporting documentation strategies across multiple payor sources, including managed care partners

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Back to Basics

Skilled Therapy:
5 days per week

Skilled Nursing:
7 days per week

Medicare Benefit Policy Manual
Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Table of Contents
(Rev. 261; Issued: 10-04-19)

30 - Skilled Nursing Facility Level of Care - General
(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3132, SNF-214

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 delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are 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.

If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered. For example, payment for a SNF level of care could not be made if a patient needs an intermittent rather than daily skilled service.

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Definition of Skilled Care

- Skilled nursing and/or skilled rehabilitation services are services that:
  - Are ordered by a physician
  - Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and
  - Must be provided directly by, or under the general supervision of, these skilled nursing or skilled rehabilitation personnel in order to assure the safety of the patient and to achieve the medically desired result.

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What is Considered a Skilled Service?

- Inherently complex services that can only be performed by skilled personnel and provided on a daily basis
- Rehabilitation therapy – key issue is whether the skills of a professional therapist are required
  - Is it possible to return (partially or in full) to a prior level of functioning?
  - Can the resident be expected to demonstrate "improvement" in a reasonable period?

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Reasonable and Necessary

- Medicare Program Integrity Manual Chapter 13 – Local Coverage Determinations
- Reasonable and Necessary criteria
  - Safe and effective
  - Not experimental or investigational (with certain exceptions)
  - Appropriate, including duration and frequency that is considered appropriate for the item or service in terms of whether it is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member
    - Furnished in a setting appropriate to the patient's medical needs and condition
    - Ordered and furnished by qualified personnel
    - One that meets, but does not exceed, the patient's medical needs
    - At least as beneficial as an existing and available medically appropriate alternative

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Technical Coverage Requirements

- For a SNF admission to be covered under Part A, the resident must:
  - Be enrolled in Medicare Part A with available benefit days
  - Have had a prior qualifying hospital stay (QHS) for at least 3 consecutive calendar days
  - Meet the 30-day transfer requirement
  - Hospital stay must be medically necessary
  - Social admissions (nobody to care for patient, or hospital admission for SNF placement) do not meet QHS requirements
  - Observation stay and ER time do not count
  - Medicare-covered SNF stay must be for a condition treated during the QHS or for a condition that arose while on a Medicare-covered stay in the hospital **OR**
  - Meet the requirements for the PHE waiver*
    - * while in effect per the Dept. of Health and Human Services https://aspr.hhs.gov/legal/PHE/Pages/COVID19-14Jan2022.aspx

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Physician Certification and Recertification of Extended Care Services

Skilled care in an SNF is covered only if a physician (or physician extender who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician) certifies as follows:

- Initial certification
  - At the time of admission, or as soon thereafter as is reasonable and practicable
  - Must certify that the services are being provided for a condition for which the patient received inpatient hospital services
- Recertifications
  - On or before the 14th day of the stay
  - No later than 30 days from the prior recertification

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Physician Certification and Recertification of Extended Care Services

- Certification and Recertification must include the required elements as per Chapter 4 of the CMS Manual
- There is no requirement for a specific "certification form," as long as the approach adopted by the facility fulfills the certification and recertification requirements.
- Refer to Chapter 4 of the Medicare General Information, Eligibility, and Entitlement Manual

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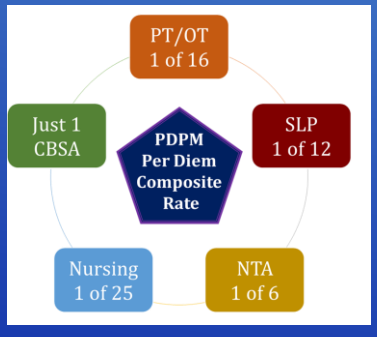
PDPM Components – Review



- 6 distinct (4 variable) rate components:
- Physical Therapy
- Occupational Therapy

} Combined as one rate

- Speech Language Pathology
- Nursing
- Non-therapy Ancillaries
- Overhead / Non-Case-Mix Adjusted (1 static rate)

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Admission Workflow

- Pre-admission: Information from hospital
  - Admission decisions
- On Admission: Assessment information, H & P
  - Determination of skilled care needs
  - Gathering/documenting of MDS items

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Team Huddle

- By Day 2: Clinical Team meeting
- Open MDS assessment – communication with the clinical team
- Provision of care and services
- On-going assessment & documentation by clinical team

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Primary Diagnosis Coding

- The ICD-10 Clinical Category Crosswalk will convert the ICD-10 code captured in I0020B into one of the 10 PDPM primary clinical categories
- Not all diagnoses are considered valid primary diagnoses for the SNF stay. Invalid primary diagnoses are listed as “return to provider” in the ICD-10 Clinical Category Crosswalk
- Clinical category may change depending on the presence of a surgical procedure from MDS section J during the immediately preceding hospital stay
- May or may not be the same as the primary diagnosis from the hospital stay

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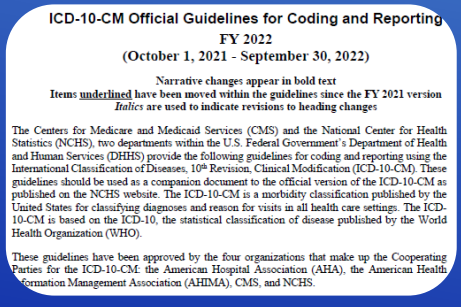
Primary Diagnosis Coding

- May not necessarily be the highest paying diagnosis
- Orthopedic surgery, fractures and Section J
- ICD-10-CM coding rules apply
  - Use ICD-10-CM Official Guidelines for Coding and Reporting for the correct fiscal year – always begins October 1
  - Do not use online/internet searches
  - Smartphone apps
  - Google
  - Cheat sheets



ICD-10-CM Official Guidelines for Coding and Reporting
FY 2022
(October 1, 2021 - September 30, 2022)

Narrative changes appear in bold text
Items underlined have been moved within the guidelines since the FY 2021 version
***Italics* are used to indicate revisions to heading changes**

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

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Primary Diagnosis Coding

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

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Diagnosis Coding for PDPM

- MDS Section I – diagnoses and conditions impact the following areas:
  - PT/OT clinical category classification
  - SLP clinical category classification
  - SLP-related comorbidities
  - Nursing categories
  - Non-therapy Ancillaries

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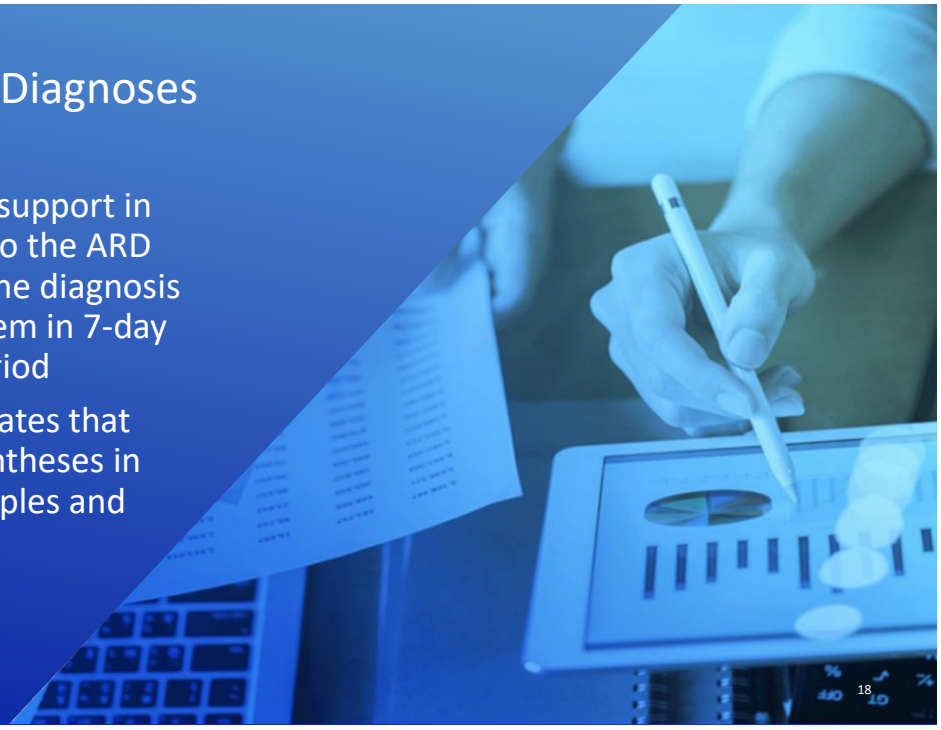
Other Section I Diagnoses

- Require physician support in the 60 days prior to the ARD ***AND*** support for the diagnosis as a current problem in 7-day ARD look-back period
- The RAI Manual states that diagnoses in parentheses in Section I are examples and not all-inclusive



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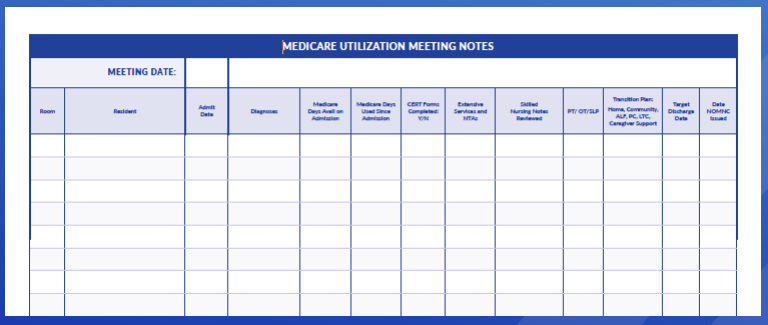
Utilization Review Meetings



MEDICARE UTILIZATION MEETING NOTES

MEETING DATE:

Room	Resident	Admit Date	Diagnoses	Medicare Days Avail on Admission	Medicare Days Used Since Admission	CERT Forms Completed: Y/N	Extensive Services and NTAs	Skilled Nursing Notes Reviewed	PT/ OT/SLP	Transition Plan: Home, Community, ALF, PC, LTC, Caregiver Support	Target Discharge Date	Date NOMNC Issued

- Review of Residents
  - Medicare Part A
  - Managed Care
  - Medicaid
- Team Discussion
  - Progress in Rehab
  - Discharge Planning
  - Barriers to Progress

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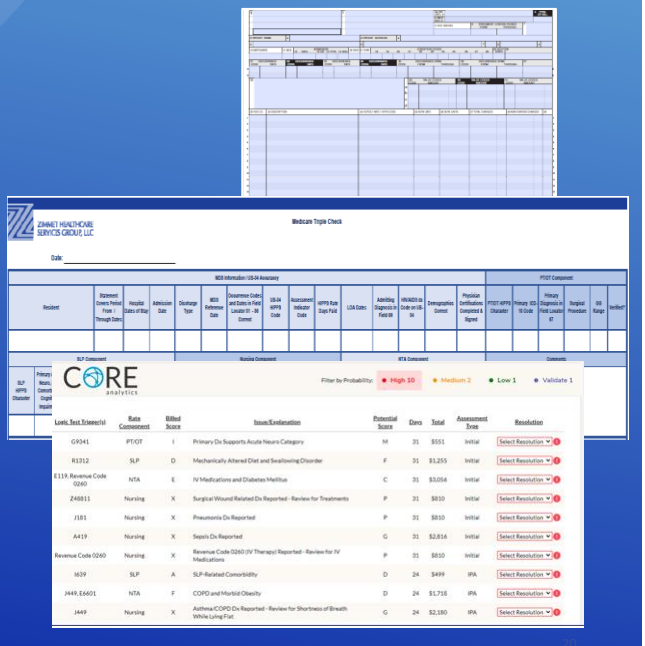
Triple / Quadruple Check

- Ensure billing accuracy and compliance
- IDT to provide checks and balances
  - Business/Billing Office Manager
  - MDS Coordinator(s)
  - Representative from Rehabilitation Therapy
- All PPS MDS assessments complete, signed, submitted, and accepted
- DOCUMENTATION
- UB-04s available - accurate
- Review of reimbursement-sensitive items
- Medicare compliance / clinical eligibility
  - Physician certifications



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Documentation

- Substantiate daily skilled care provided:
  - Provide detailed descriptions and assessment of patient condition including causative factors and/or risk factors
  - Record treatments, therapies and resident response
  - Analyze potential outcomes or consequences of care provided
  - Include evaluation of resident's response to the plan
  - Document evidence of physician and responsible party notifications
  - Include communication between disciplines
  - Coordinate continuity of care

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Supportive vs. Non-Supportive Nursing Documentation

Supportive:

- "Assessed for"
- "Monitored for"
- "Improvement in"
- "Deterioration in"
- Objective facts
- Subjective observations

Non-Supportive:

- "OOB to chair"
- "Ambulating ad lib"
- "To smoking room"
- "Out on pass"
- "VSS"
- "No complaints"
- "Stable"

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Medicare Operational Expectations

- 30.2.2.1 Documentation to Support Skilled Care Determinations
  - Although the presence of appropriate documentation is not, in and of itself, an element of the definition of a "skilled" service, such documentation serves as the means by which a provider would be able to establish and a contractor would be able to confirm that skilled care is, in fact, needed and received in a given case.
  - It is expected that the documentation in the patient's medical record will reflect the need for the skilled services provided.

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Medicare Operational Expectations

- 30.2.2.1 Documentation to Support Skilled Care Determinations
  - The patient's medical record is also expected to provide important communication among all members of the care team regarding the development, course, and outcomes of the skilled observations, assessments, treatment, and training performed.
  - Taken as a whole, then, the documentation in the patient's medical record should illustrate the degree to which the patient is accomplishing the goals as outlined in the care plan. In this way, the documentation will serve to demonstrate why a skilled service is needed.

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Code Pairings – Orthopedic Aftercare – ICD-10 Manual

- ***Surgical Amputation* Example (R AKA)**
  - *Code the orthopedic aftercare **Z47.81** (orthopedic aftercare following surgical amputation)*
  - *This code refers you to specify the limb amputated in the Z89 series)*
    - *In this case, **Z89.611** (acquired absence of right leg above knee)*
- ***Joint Replacement Example* (Left TKR)**
  - Code the orthopedic aftercare **Z47.1** (aftercare following joint replacement surgery)
  - This code refers to you specify the joint replaced in the Z96.6 series
    - In this case, **Z96.652** (presence of artificial joint left knee)

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Surgical Aftercare – Z48.xxx

Z48.81 Encounter for surgical aftercare following surgery on specified body systems

- These codes identify the body system requiring aftercare. They are for use in conjunction with other aftercare codes to fully explain the aftercare encounter. The condition treated should also be coded if still present.

  - ***Excludes1:*** *aftercare for injury- code the injury with 7th character D aftercare following surgery for neoplasm (Z48.3)*
  - ***Excludes2:*** *aftercare following organ transplant (Z48.2-) orthopedic aftercare (Z47.-)*

    - ***Z48.810** Encounter for surgical aftercare - **sense organs***
    - ***Z48.811** Encounter for surgical aftercare - **nervous system***
    - ***Z48.812** Encounter for surgical aftercare - **circulatory system***
    - ***Z48.813** Encounter for surgical aftercare - **respiratory system***
    - ***Z48.814** Encounter for surgical aftercare - **teeth or oral cavity***
    - ***Z48.815** Encounter for surgical aftercare - **digestive system***
    - ***Z48.816** Encounter for surgical aftercare - **genitourinary system***
    - ***Z48.817** Encounter for surgical aftercare - **skin and subcutaneous tissue***

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Diagnosis Shopping

Hemiplegia – via Google Search

Hemiplegia, unspecified affecting left dominant side

G81. 92 is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes. The 2022 edition of ICD-10-CM G81. 92 became effective on October 1, 2021.

G81 Hemiplegia and hemiparesis – ICD-10 Coding Manual - Tabular

G81 Hemiplegia and hemiparesis

Note: This category is to be used only when hemiplegia (complete)(incomplete) is reported without further specification, or is stated to be old or longstanding but of unspecified cause. The category is also for use in multiple coding to identify these types of hemiplegia resulting from any cause.

Excludes1: congenital cerebral palsy (G80.-)
hemiplegia and hemiparesis due to sequela of cerebrovascular disease (I69.05-, I69.15-, I69.25-, I69.35-, I69.85-, I69.95-)

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Diagnosis Shopping continued

CVA (Cerebral Infarction) - Google Search or Hospital Record

Cerebral infarction, unspecified

I63. 9 is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes. The 2022 edition of ICD-10-CM I63. 9 became effective on October 1, 2021.

CVA coding – Sequela – ICD-10 Official Guidelines for Coding and Reporting

Category I69, Sequelae of Cerebrovascular disease (Nontraumatic)
Category I69.xxx is used to indicate conditions classifiable to categories I60-I67 as the causes of sequela. These "late effects" include neurological deficits that persist after initial onset of conditions in I60-167 and may be present from the onset or may arise at any time after the onset.

Examples may include: hemiplegia, aphasia, dysphagia and cognitive deficits, each of which have their own ICD-10 code relative to the type of cerebrovascular event that occurred.

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Coding Errors & Missed Opportunities

Isolation	Asthma, COPD, or Chronic Lung Disease	Foot Infections and Open Lesions on the Foot	BIMS & PHQ-9
Orthopedic issues	Malnutrition/Risk for Malnutrition	Morbid Obesity	Swallowing Problems & Mechanically Altered Diets

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Working with Managed Care Partners

- Review your contracts
- Communicate with the case manager
- Documentation
- Set realistic discharge goals
- MDS completion
- Discharge plans vs. waiting for denial
- Timely provision of NOMNC

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Final Thoughts

- Documentation is Key!
- Not documented is not done!
- Evidence of daily skilled care
- Tell the patient's story
- Active treatment plans
- Patient and caregiver education
- Discharge plans

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References & Resources

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Thank You

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