BUSINESS SOLUTIONS
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PATIENT CARE

Patient-Driven Payment Model (PDPM) – Compliance Tool Kit

Version 1.0

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Questions about the contents of this PDPM Academy publication may be directed to pdpm@ahca.org.

For additional information about AHCA visit www.ahcancal.org.

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Best Regards,

Mike Cheek

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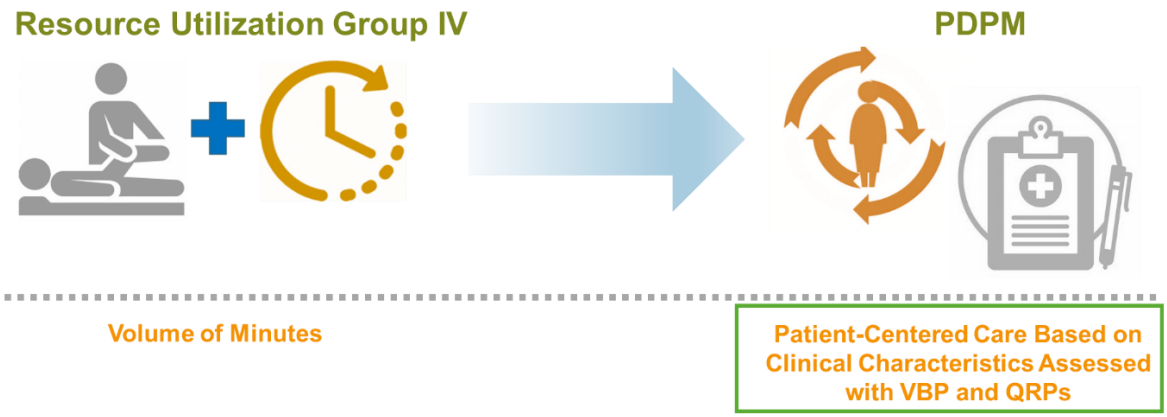
Overview

The Centers for Medicare & Medicaid Services (CMS) fundamentally changed how Skilled Nursing Facilities (SNFs) must operate through implementation of the Patient-Driven Payment Model (PDPM). CMS' core intent with PDPM is "*[t]o better ensure that resident care decisions appropriately reflect each resident's actual care needs, we believe it is important to remove, to the extent possible, service-based metrics from the SNF PPS and derive payment from verifiable resident characteristics*…." (83 FR 39185). CMS views the PDPM as part of their broader shift from volume to value by eliminating the RUGs service-based metric, therapy minutes. See Figure 1, below.

To further support moving from service-based metrics to value and outcomes, CMS created new components with layers of classification steps to ensure services are as tailored to patient needs, or characteristics, as possible. Such classification into now five service components (physical therapy, occupational therapy, speech language pathology, nursing and non-therapy ancillaries) offers SNFs considerably more latitude to design plans of care and potentially be more adequately and accurately reimbursed.

Figure 1. PDPM Fundamental Shift



CMS also wanted to reduce SNF administrative burden. In the Agency's view, they accomplished the reduction in administrative burden by eliminating the current Minimum Data Set (MDS) assessment schedule and Other Medicare Related Assessments (OMRA).

Combined Impact on Compliance

More patient-centered care plan design and reduction in administrative burden are positive steps. However, the new level of complexity of classification, needed level of documentation and the absence of required, regular check-ins via the RUGs IV assessment schedule heightens SNF risk of being out of compliance. Examples include errors in now far more detailed classification and coding for Case Mix Group (CMG) assignment, which vary by component, and no structure for regular care plan updates. In essence, CMS has created an environment in which the onus is on SNFs to develop policies and procedures to provide structure, oversight and ongoing monitoring of information collection for accurate coding, care

plan design using five individually designed components with a strong emphasis on ensuring patient voice. As with CMS' Medicaid approach, it would appear the same three elements (flexibility, transparency, and accountability) apply to Medicare payment systems as well. See Figure 2, below.

Figure 2. CMS Payment Framework

Framework Element	PDPM Impact
Flexibility	• PDPM eliminates the RUGs MDS, as well as OMRA, schedules offers more operational flexibility by freeing up staff time for more direct care coordination or care • PDPM components, while numerous, allow providers to tailor services and related payments to patient needs and care design in a more targeted manner than RUGs IV
Transparency	• CMS "expects primary diagnosis on the SNF claim match the primary diagnosis coded in item I0020B" … while no hard edits will be in place on 10/1/19 CMS will be monitoring[1] • MDS Section GG Functional Items for Physical and Occupational Therapy and Nursing classification overlap except for two items – Oral Hygiene and Walking • In addition to the Section GG items, above, CMS will have more clinical data to assess the appropriateness of care based on clinical characteristics which must be supported by medical documentation
Accountability	• "The new assessment schedule reduces provider burden while still providing enough data to accurately monitor provider behavior, changes in patient condition, and outcomes [emphasis added] via the 5-day assessment, IPA assessments, and discharge assessments[2]" • "[CMS] agrees with commenters that quality and outcomes measures (like those in the SNF Quality Reporting Program) would be a positive way to evaluate the efficacy of therapy provision, and we will take this into consideration for future policy development[3]"

As such, a SNF PDPM Compliance Plan will need to include more internal policy and procedure development, clear oversight responsibility assignment, and monitoring than under RUGs.

Model Approach to Compliance Plan Development

In the sections below, AHCA offers a general framework for a PDPM Compliance Strategy and a template for developing compliance approaches to specific PDPM elements. This document is not intended to be exhaustive, rather, is it intended to provide SNFs with a starting point for developing their own compliance plans. Additionally, the Association will release a Version 2.0 later in 2019 before the October 1, 2019 implementation date.

[1] CMS PDPM FAQ Document dated February 14, 2019. FAQ #1.8.
[2] CMS PDPM FAQ Document dated February 14, 2019, FAQ #13.11.
[3] 83 FR 39236.

1. PDPM Compliance Framework

PDPM Compliance efforts should be integrated into existing Requirements of Participation Compliance Requirements (42 CFR Section 483.85). Core elements to consider are presented in Figure 3, below.

Figure 3. RoP Compliance Requirements

- ✓ Written compliance and quality of care policies and procedures
- ✓ High-level program oversight
- ✓ Sufficient resources and authority to ensure compliance
- ✓ A screening process for positions with discretionary authority
- ✓ Effective communication of compliance standards to staff, contractors, and volunteers
- ✓ Procedures to promote compliance, such as auditing, monitoring, and an anonymous reporting system
- ✓ Consistently enforced disciplinary actions
- ✓ Appropriate response to violations, and prevention of similar future violations
- ✓ An annual review and update of the compliance and ethics program

AHCA recommends PDPM High Risk Compliance Areas be assessed using the format, below on page 7.

2. Ongoing Compliance Plan Update Approach.

Additionally, because PDPM is a new and untested payment system (e.g., CMS did not conduct a demonstration to assess real world impacts), the Agency is highly likely to issue an ongoing array of updates and changes to the payment system and related materials such as RAI Manual, billing, and reporting guidance. Following the Resource Utilization Group Prospective Payment System, sub-regulatory changes were issued regularly and changes to the payment system were made annually. Because of this, the Association also recommends that SNFs develop an ongoing PDPM monitoring process to identify possible new compliance risks, or CMS compliance guidance.

3. Addressing Risk -- Monitoring and Auditing Framework.

On page 25, AHCA offers a model Risk Monitoring and Auditing Framework. Developed by CBSI, an AHCA partner organization, the framework likely a strong starting point for developing a PDPM oversight process in tandem with other SNF programs and policies oversight plans.

Member Input

If you have recommendations for improving AHCA's PDPM compliance resources, please contact the PDPM Academy faculty at pdpm@ahca.org.

Model High Risk Compliance Area Assessment Format

Compliance Area: [INSERT COMPLIANCE AREA NAME]

CMS Citations and Language:

- IDENTIFY AND INSERT CMS REGULATORY LANGUAGE USING AN INTERDISCPLINARY APPROACH (E.G., CLINCAL STAFF, THERAPY STAFFMDS EXPERTS, PAYMENT AND BILLING, COMPLIANCE, AND ADMINISTRATION)

- SEVERAL SOURCES SHOULD BE EXPLORED: FY19 FINAL RULE, RAI MANUAL UPDATE – MAY 2019 (TO BE RELEASED), INTERIM PAYMENT ASSESSMENT ITEMS FORM, 2019 MDS, RoPs

SNF Compliance Strategy (e.g., monitoring, auditing, testing):

Strategy	SNF Lead
Operations	
Statements on how a SNF will operationalize monitoring, auditing and testing	Lead Staff or Bodies
Insert Additional Items	**Insert**
Insert Additional Items	**Insert**
Insert Additional Items	**Insert**
Compliance	
Define specific compliance approach – data, monitoring schedule, correction planning	Lead Staff
Insert Additional Items as Needed	Insert Additional Items as needed

As many rows may be added as needed to flesh out your SNF's approach to each high risk compliance area.

High Risk Compliance Areas

(List Not Exhaustive)

Compliance Area: ICD-10 Coding

CMS Objective: To develop an array of anchor diagnosis which both map to clinical classification groups and offer CMS a line of sight into top tier patient conditions, related needs, and services delivered.

CMS Citations and Language:

Page 39198 of Federal Register "...ICD-10 provides the most accurate coding and diagnosis information on patients…"

Page 39189 of Federal Register: "With regard to the potential consequences of ICD-10 coding errors on RAC audits, as under the current payment system, the information reported to CMS must be accurate. Inaccuracies in the data reported to CMS, or a failure to document the basis for such data, will necessitate the same types of administrative actions as occur today."

Page 39199 of Federal Register "…we believe that one of these reasons prompted transfer to the SNF. This reason would function as the patient's primary diagnosis, as it represents the primary reason for the patient being in the SNF."

Page 39200 of Federal Register "However, CMS recognizes that in many cases, the primary reason for the SNF care may not be the primary reason for the prior inpatient hospital stay." "PDPM requires facilities to code the diagnosis that corresponds most closely to the primary reason for the SNF care…."

SNF Compliance Strategy (e.g., monitoring, auditing, testing):

Strategy	SNF Lead
Operations	
Provide ICD-10 coding training to designated staff. Determine frequency of ongoing ICD-10 education and methods to train necessary new staff as they are on boarded.	TBD
Determine process to obtain source documentation necessary to assign appropriate ICD-10 code related to the primary reason the patient is in the SNF for a Medicare stay.	Interdisciplinary team
Identify person or person(s) who will be responsible for assigning ICD-10 codes	TBD
Compliance	
Review appropriateness and accuracy of ICD-10 codes as part of Triple Check Process	Triple Check Team
Consider external audit of ICD-10 codes as part of compliance plan; appropriate code used with supporting documentation maintained	Compliance team

Compliance Area: Resident Interview(s)

CMS Objective: Care design should be driven by patient goals and needs as well as discussions with the patient and his or her family.

CMS Citations and Language:

Final Rule FR Page 39189: "…PDPM provides a more holistic approach to payment classifications. More specifically, by separately adjusting for the nursing component, which utilizes patient interviews as a major component of patient classification."

RAI 3.0 User Manual (10/1/18 Version) Page 1-11: "The goals of the MDS 3.0 revision are to …increase the resident's voice by introducing more resident interview items."

RAI 3.0 User Manual (10/1/18 Version) Appendix D: "All residents capable of any communication should be asked to provide information regarding what they consider to be most important facets of their lives. There are several MDS 3.0 sections that require direct interview of the resident as the primary source of information. Staff should actively seek information from the resident…"

42 CFR 483.21 (10/1/18 Edition) Comprehensive Person-Centered Care Planning

SNF Compliance Strategy (e.g., monitoring, auditing, testing):

Strategy	SNF Lead
Operations	
Train personnel responsible for conducting resident interviews for MDS purposes	TBD
Develop policy and procedures to assure occurrence of and accountability for the resident interview process at each assessment	TBD
Develop and implement monitoring strategy to assure adherence to policy	TBD
Assure timely, complete and accurate documentation of resident interview data	TBD
Compliance	
Develop and implement Audit Tool to consider both Output and Outcome Measures 1. Example Output Measure – Did personnel complete resident interview per policy? 2. Example Outcome Measure – Was effective Care Plan created based upon information obtained during the resident interview(s)?	Compliance Dept.
Document and Report Audit findings to Operations Team and Senior Leadership	Compliance Officer

Compliance Area: Diagnosis- Admission and Subsequent Changes

CMS Objective: Method of monitoring system design expectation of "stable patient characteristics."

CMS Citations and Language:

MM 11152: The only required assessments under PDPM that would produce a HIPPS code would be the 5-day PPS assessment, which follows the same schedule as under the current SNF PPS, and an Interim Payment Assessment (IPA), which may be completed at any point during a PPS stay.

Final Rule FR page 39197: We proposed to categorize a resident into a PDPM clinical category using item I0020B on the MDS 3.0. We stated in the proposed rule (83 FR 21043) that providers would use the first line in item I8000 to report the ICD–10–CM code that represents the primary reason for the resident's Part A SNF stay. We further stated that this code would be mapped to one of the ten clinical categories provided in Table 14 of the proposed rule (set forth at Table 14 of this final rule).

Final Rule FR page 39234: It is our expectation that the optional nature of the IPA will allow facilities to capture all of these changes as they occur during a SNF stay. Facilities will determine when IPAs should be completed, and we expect them to pay special attention to clinical and functional changes. It should be noted that, even absent an IPA requirement, we expect SNFs to constantly evaluate, capture, document and treat clinical and functional changes that occur in patients throughout a SNF stay.

SNF Compliance Strategy (e.g., monitoring, auditing, testing):

Strategy	SNF Lead
Operations	
5-day PPS Assessment: Clinical Category, Functional Assessment, Cognitive Assessment • Responsibility -Determine who will have responsibility for diagnosis coding and clinical mapping (i.e., MDS coordinator, clinical billing liaison) • Education and training -Provide initial and ongoing training for individuals responsible for diagnosis coding and clinical mapping, functional assessment, and cognitive status • Policies and procedures- Develop needed policies and procedures, including but not limited to -Communication with hospital and access of appropriate documentation, including but not limited to inpatient surgical procedural information -Determination of reason for SNF admission ("What prompted reason for transfer?"), correct diagnosis code, surgical procedure category subitem within Item J2000, and accurate clinical mapping, and documentation -Accurate assessment of functional items in MDS Section GG	

Strategy	SNF Lead
-Accurate use of Cognitive Function Scale and cognitive assessment • Monitoring -Develop method to monitor documentation, medical necessity/accuracy, and provide corrective feedback for those responsible for +coding and clinical mapping +GG Functional items +cognitive assessment -Care planning team meetings	
Interim Payment Assessment (IPA)	
• Establish policies and procedures for when an optional IPA is warranted, including requiring a change in at least one of the patient's first tier classification system that is not expected to return to original clinical status within a 14-day period. • Other than determining when to pursue IPA, all other components of 5-day PPS Assessment apply.	
Compliance	
• Education- Ensure appropriate staff training on the various elements of the 5-day PPS Assessment and when to pursue an IPA • Policies and procedures- Ensure operations has adequate policies for all elements of 5-day PPS Assessment and IPA • Monitoring and Auditing- -Confirm that operations is monitoring diagnosis coding and clinical mapping, functional and cognitive assessments, and IPA performance -Conduct auditing of diagnosis coding, functional and cognitive assessments, IPA performance, and discharge assessments -For any noted deficits, work with operations to develop Corrective Action Plan -Review survey findings and review deficiencies related to areas including, but not limited to resident assessments, care plans, abuse and neglect, transfer or discharge, resident rights, and staffing -Conduct follow up audit of areas with noted deficiencies -Consider occasional use of outside expert/firm to conduct coding, documentation, and medical necessity audits	

Compliance Area: Daily Skilled Care Coverage and Documentation

CMS Objective: Assure each Medicare Part A resident in the skilled nursing facility meets the SNF coverage criteria that includes the daily need for "Skilled" care after a medically appropriate qualifying hospital stay.

CMS Citations and Language:

[42CFR 424.20(a)(1)(i)] The individual needs are needed on a daily basis skilled nursing care (furnished directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services that, as a practical matter, can only be provided in an SNF or a swing-bed hospital on an inpatient basis, and the SNF care is or was needed for a condition for which the individual received inpatient care in a participating hospital or a qualified hospital, as defined in § 409.3 of this chapter, or for a new condition that arose while the individual was receiving care in the SNF or swing-bed hospital for a condition for which he or she received inpatient care in a participating or qualified hospital; or

Editor's note: Aside from CMS mentioning that Medicare coverage criteria remains in place there is increased risk for daily care because the PDPM is not tied to therapy minutes. Under PPS, 90% of Medicare days were in the ultra-high or very high rehab categories. These required therapy five days a week and therefore generally met the daily skilled care requirement. Under PDPM therapy delivery should be based on the patient's clinical needs thus increasing the possibility of therapy less than five days per week. Future RAC audits may include documentation of skilled need.

SNF Compliance Strategy (e.g., monitoring, auditing, testing):

Strategy	SNF Lead
Operations	
Training Medicare nurses regarding Medicare coverage and documentation requirements	TBD
Conduct weekly Medicare meetings using sound policies and procedures	TBD
Assure reason for skilled care as outlined on the MDS, UB-04 and Physician re-certification tell a consistent story of why the resident needs post-acute Medicare coverage	TBD
Compliance	
Review and advise on PDPM related changes to organizational policies that may be at increased risk due to changes in therapy deliver	Compliance Officer
Review minutes from Medicare meetings	Compliance Officer
Conduct sample chart audits to assure daily documentation is sufficient to support skilled care.	Compliance Officer

Compliance Area: Resource Underutilization

CMS Objective: PDPM, as a case-mix classification system, is intended to classify SNF patients for purposes of reimbursement based on the resource utilization associated with treating those patients. CMS expects the payment system to change, not the patients. The Agency will be monitoring for substantial services changes and will look for supporting medical documentation monitored.

CMS Citations and Language:

Final Rule FR Page 39184: "… [CMS has] a great deal of concern that by separating payment from the actual provision of services…beneficiaries would be vulnerable to underutilization."

Final Rule FR Page 39186: "… with regard to the potential impact of PDPM [that SNF providers could stint on care, most notably therapy services] or provide fewer services to patients, and that such providers will be overcompensated for care that is not being delivered, [CMS] plans to monitor closely service utilization, payment, and quality trends which may change as a result of implementing PDPM." "… [CMS] may take further action, which may include administrative action against providers…and/or proposing changes in policy." "[CMS] will also continue to work with the HHS OIG should any specific provider behavior be identified which may justify a referral for additional action."

42 CFR 483.21 (10/1/18 Edition) Comprehensive Person-Centered Care Planning; 42 CFR 483.24 Quality of Life; 42 CFR 483.25 Quality of Care; 42 CFR 483.40 Behavioral Health Services (These regulations require that each SNF resident receive, and the SNF must provide, the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.)

SNF Compliance Strategy (e.g., monitoring, auditing, testing):

Strategy	SNF Lead
Operations	
Assure SNF care delivery practices and care decision-making processes continue to meet regulatory requirements	TBD
Assure timely, complete and accurate documentation of resident assessments	TBD
Monitor vendor practices for potential PDPM related "stinting" of care/services	TBD
Compliance	
Review and advise on PDPM related changes to organizational policies that may trigger CMS scrutiny regarding SNF "overcompensation" or "stinting"	Compliance Officer
Review and advise on new vendor contracts or proposed amendments to current vendor contracts that are related to PDPM implementation	Compliance Officer/Legal Dept.
Provide education to the board, senior managers, SNF personnel or vendors about the organization's compliance risks associated with PDPM	Compliance Dept.
Consider post-PDPM implementation audits of high risk areas related to care/service delivery to identify trends that might suggest "overcompensation" or "stinting" could be occurring	Compliance Dept.

Compliance Area: Interrupted Stay Policy

CMS Objective: CMS explained that application of the variable per diem adjustment is of particular concern because providers may consider discharging a resident and then readmitting the resident shortly thereafter to reset the resident's variable per diem adjustment schedule and maximize the payment rates for that resident. CMS stated in the proposed rule (83 FR 21068) that, given the potential harm which may be caused to the resident if discharged inappropriately, and other concerns outlined previously in this section and in the proposed rule, CMS discussed in last year's FY 2018 ANPRM the possibility of adopting an interrupted stay policy under the SNF PPS in conjunction with the implementation of the RCS-I case-mix model.

CMS Citations and Language:

We proposed to implement an interrupted stay policy as part of the SNF PPS, effective beginning FY 2020 in conjunction with the proposed implementation of the SNF PDPM. Specifically, in cases where a resident is discharged from a SNF and returns to the same SNF by 12:00 am at the end of the third day of the interruption window (as defined below), we proposed treating the resident's stay as a continuation of the previous stay for purposes of both resident classification and the variable per diem adjustment schedule. In cases where the resident's absence from the SNF exceeds this 3-day interruption window (as defined below), or in any case where the resident is readmitted to a different SNF, we proposed treating the readmission as a new stay, in which the resident would receive a new 5-day assessment upon admission and the variable per diem adjustment schedule for that resident would reset to Day 1.

We stated in the proposed rule (83 FR 21068 through 21069) that, consistent with the existing interrupted stay policies for the IRF and IPF settings, we would define the interruption window as the 3-day period starting with the calendar day of discharge and additionally including the 2 immediately following calendar days. We stated that for the purposes of the interrupted stay policy, the source of the readmission would not be relevant. That is, the beneficiary may be readmitted from the community, from an intervening hospital stay, or from a different kind of facility, and the interrupted stay policy would operate in the same manner. We explained that the only relevant factors in determining if the interrupted stay policy would apply are the number of days between the resident's discharge from a SNF and subsequent readmission to a SNF, and whether the resident is readmitted to the same or a different SNF.

…We acknowledged that this could lead to patterns of inappropriate discharges and readmissions that could be inconsistent with the intent of this policy; for example, we stated we would be concerned about patients in SNF A consistently being admitted to SNF B to the exclusion of other SNFs in the area. We explained that should we discover such behavior, we would flag these facilities for additional scrutiny and review and consider potential policy changes in future rulemaking.

…We also noted that we believe that frequent SNF readmissions may be indicative of poor quality care being provided by the SNF. Given this belief, we stated we plan to monitor the use

of this policy closely to identify those facilities whose beneficiaries experience frequent readmission, particularly facilities where the readmissions occur just outside the 3-day window used as part of the proposed interrupted stay policy. We stated that should we discover such behavior, we would flag these facilities for additional scrutiny and review and consider potential policy changes in future rulemaking.

SNF Compliance Strategy (e.g., monitoring, auditing, testing):

Strategy	SNF Lead
Operations	
Develop policies and procedures and training to guide compliance with CMS interrupted stay policies.	Senior Leadership in consultation with MDS/RAI subject matter expert
Train personnel responsible for admission, discharge, completion of MDS and management on the policy including CMS's objectives.	RAI Training Lead
Assure SNF care delivery practices and care decision-making processes are based on medical necessity and appropriate business relationships.	Administrator/ Director of Nursing
Develop and implement monitoring strategy and procedures to assure adherence to policy: • Monitor compliance with policy regarding completion of assessments as required. • Monitor interrupted stay frequency. • Monitor location of re-admission. • Audit center if interrupted stay is frequently used and/or location of re-admission is frequently to the same center and/or assessments are not completed as required. • Implement corrective actions as needed.	Administrator/ Director of Nursing
Compliance	
Review and advise on PDPM-related policies and training.	Compliance Officer
Review and advise on monitoring strategy to assure adherence to policy.	Compliance Department
Test adherence to monitoring and auditing procedures. Document and report findings and corrective actions to leadership.	Compliance Department

Compliance Area: Interim Payment Assessment (IPA)

CMS Objective: The IPA is optional and will be completed when providers determine that the patient has undergone a clinical change that would require a new PPS assessment. The IPA ARD, completion and transmission requirements for the IPA are:

- The ARD (Item A2300) may be set for any day of the SNF PPS stay, beyond the ARD of the 5-Day assessment
- The IPA must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days)
- The IPA authorizes payment for remainder of the PPS stay, beginning on the ARD
- The IPA must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days)

CMS Citations and Language:

83 FR 39232 … PDPM relies on stable characteristics that we do not expect to change significantly over the course of the stay. Therefore, additional SNF PPS payment assessments would not necessarily capture different data throughout the stay. Additionally, the OBRA assessment schedule will remain the same and those assessments would provide needed information and data for surveyors and research purposes. Moreover, if clinical characteristics do change, we would expect facilities to elect the option (as discussed further below) to complete the IPA to track these changes. We appreciate the recommendation to revise the assessment period and ARD to align more closely with other PAC providers in order to implement standardized patient data elements required by the IMPACT Act. We believe that many of the policies being finalized as part of PDPM serve to improve alignment with other PAC settings such as the utilization of functional measures similar to those in IRFs, and the interrupted stay policy which is similar to the IRF and IPF policies, and we hope to continue to improve this alignment in future refinements. As such, we may consider these in future.

83 FR 39282… In section V.D. of this final rule, we discuss that while we proposed to require SNFs to reclassify residents under the PDPM using the Interim Payment Assessment (IPA) if certain criteria are met, we have decided in this final rule to make this assessment optional, thereby leaving completion of this assessment at the discretion of the individual provider.

SNF Compliance Strategy (e.g., monitoring, auditing, testing):

Strategy	SNF Lead
Operations	
Develop policy for setting the ARD date and Lookback Period	Compliance Officer, Chief Clinical Officer
Define payment dates – IPA ARD through Part A Discharge in policy	Chief Clinical Officer
Define Criteria for Triggering Event (Example: Results in a payment change in either one component or overall payment and the change(s) are such that the resident would not be expected to return to his or her original clinical status within a 14 day -period	Chief Clinical Officer

Strategy	SNF Lead
Assessment approach – During daily morning reviews, Care Team should discuss any changes identified which would require and IPA: • New Clincal Category • SLP-Related Comorbitities • Improvement or decline in Section GG Functional Abilities • Patient Surgical History – Surgical Procedure History • Conditions/Extensive Services • Depression Indicators • Improvement or decline of Cognitive Status	Chief Clinical Officer, Triple Check Team
Compliance (documentation and oversight)	
If a triggering event is identified, the team decision must be documented in the Progress Notes	Triple Check Team
MDS Coordinator to set the IPA ARD at the point when it is identified	MDS Coordinator Compliance Officer
IDT to complete Section GG Functional abilities based on direct observation, resident's self-report, and reports from qualified clinicians, care staff, or family	IDT Compliance Officer
Patient interviews to be completed on or before the day of ARD	MDS Coordinator Compliance Officer

Compliance Area: Upcoding

CMS Objective: PDPM, as a case-mix classification system, includes an array of patient characteristics, which vary by component and are used to classify patients into case mix groups (CMGs) and related Case Mix Indices. Table 1, below, provides a quick reference guide. While, CMS specifically has identified certain component classification items for monitoring, as discussed in the introduction, PDPM by nature of the system's intentional flexibility to deliver more patient centered care, creates substantial new risk areas. In this section we highlight specific classification items CMS notes in the Final Rule and cross reference to other related compliance areas – ICD-10, Section GG and Therapy Modalities.

Table 1. PDPM Patient Classification Characteristics by Component Quick Reference Chart

Component	Classification Element	Classification Element	Classification Element	Classification Element
Physical Therapy (PT) and Occupational Therapy (OT)	**Primary Diagnosis Clinical** - Major Joint Replacement of Spinal Surgery - Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) - Medical Management - Non-Orthopedic Surgery - Acute Neurologic	**Clinical Category** - Major Joint Replacement or Spinal Surgery - Other Orthopedic - Medical Management - Non-Orthopedic Surgery and Acute Neurologic **Section J Surgical Modifier**		**Functional Score Based on Section GG:** Eating Oral Hygiene Toilet Hygiene **Bed Mobility** *(average score)* - Sit to Lying - Lying to Sitting on Side of Bed **Transfers** *(average score)* - Sit to Stand - Chair/Bed-to-Chair Transfer - Toilet Transfer **Waling** *(average score)* - Walk 50 Feet with Two Turns - Walk 150 Feet

Component	Classification Element	Classification Element	Classification Element	Classification Element
Speech Language Pathology	**SLP Level 1 Case Mix Factors** - Acute Neurologic - Cognitive Impairment - SLP Comorbidity	**SLP Level 2 Case Mix Factors** - Swallowing Disorder - Mechanically Altered Diet		
Nursing	**Hierarchical Assessment** - Extensive Services - Special High Care - Special Low Care - Clinically Complex - Behavioral & Cognitive - Assistance with daily living and general supervision	**Depression (Yes or No) for:** ~~- Extensive Services~~ - Special High Care - Special Low Care - Clinically Complex - Behavioral & Cognitive - Assistance with daily living and general supervision	**Number of Restorative Services -- Ranges between 0-2 for only:** - Behavioral & Cognitive - Assistance with daily living and general supervision	**Section GG Function Scores (same as PT/OT scores less two items – see below)** Eating ~~Oral Hygiene~~ (not included) Toilet Hygiene **Bed Mobility** *(average score)* - Sit to Lying - Lying to Sitting on Side of Bed **Transfers** *(average score)* - Sit to Stand - Chair/Bed-to-Chair Transfer - Toilet Transfer ~~**Waling** *(average score)*~~ ~~- Walk 50 Feet with Two Turns~~ ~~Walk 150 Feet~~ (not included)

Component	Classification Element	Classification Element	Classification Element	Classification Element
Non-Therapy Ancillaries	NTA Component Points from MDS Checklist	- Medical Documentation and Physician Orders Needed - ICD-10-CM Code List		

CMS Citations and Language:

Physical Therapy & Occupational Therapy

- See Therapy Modalities Discussion on page 22
- See Section GG Discussion on page 21

Speech Language Pathology

- 83 FR Page 39214: "We note that we do plan to monitor specifically for any increases in the use of mechanically altered diet among the SNF population that may suggest that beneficiaries are being prescribed such a diet based on facility financial considerations, rather than for clinical need."

- 83 FR 39213: "… we found that cognitive impairment is a relevant characteristic in predicting SLP resource utilization and costs. However, we understand the concern regarding the potential for providers to overutilize SLP services in certain instances and will monitor the use of SLP services under PDPM to identify any potential consequences of using this payment classifier as part of the SLP component.

Nursing

- CMS will monitor for accuracy and/or evidence of gaming with Depression
- Alignment of Section GG item scores between PT/OT and Nursing Function

SNF Compliance Strategy (e.g., monitoring, auditing, testing):

Strategy	SNF Lead
Operations	
Ability to rapidly collect information from hospitals to improve accuracy of SNF clinicians' primary diagnosis for SNF care as well as to inform component classification	Chief Clinical Officer, Admissions, MDS Coordinator

Strategy	SNF Lead
Capacity to maintain and update clinical information to document 5-Day Assessment Case Mix Group classifications	Chief Clinical Officer, Admissions, MDS Coordinator
Process for updating clinical record when an IPA is conducted	Chief Clinical Officer, Admissions, MDS Coordinator
Compliance	
Regular review of case file samples to ensure documentation is present to support classification	Compliance Officer
Assessment of change of primary diagnosis from admission on 5-Day to discharge	Compliance Officer, MDS Coordinator
Monitoring system to ensure MDS Discharge information matches ICD-10 claims coding, use of interrupted stay, and possibly IPA	Compliance Officer, Billing

Compliance Area: Functional Status -- Section GG

CMS Objective: PDPM, as a case-mix classification system, is intended to classify SNF patients for purposes of reimbursement based on the resource utilization associated with treating those patients. Section GG drives payment in three of the five clinical components of PDPM. In addition, CMS is increasing focused on Section GG for quality reporting metrics.

CMS Citations and Language:

MM 11152: The only required assessments under PDPM that would produce a HIPPS code would be the 5-day PPS assessment, which follows the same schedule as under the current SNF PPS, and an Interim Payment Assessment (IPA), which may be completed at any point during a PPS stay.

Final Rule FR page 39206: We are finalizing our proposals relating to the use of the section GG items as the basis for determining the patient's PDPM functional score and for classifying the patient under PDPM PT and OT components, with modifications.

MDS Manual October 1, 2018; Assess the resident's self-care performance based on direct observation, as well as the resident's self-report and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the three-day assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period. For Section GG, the admission assessment period is the first three days of the Part A stay starting with the date in A2400B, the Start of Most Recent Medicare Stay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment).

SNF Compliance Strategy (e.g., monitoring, auditing, testing):

Strategy	SNF Lead
Operations	
Assure coding for section GG is based on an interdisciplinary review of the resident's functional status	TBD
Assure timely, complete and accurate documentation of resident assessments	TBD
Conduct timely and effective IDT based care planning that leads to accurate capture of functional status	TBD
Compliance	
Review provider policies and procedures relating to the use of concurrent and group therapy	Compliance Officer
Conduct annual chart audits that include the review of Section GG related to Functional Status.	Compliance Officer
Develop and implement Audit Tool to assure the coding policy is being followed and that a sample of charts are audited.	Compliance Officer
Correlate and report finding	Compliance Officer

Compliance Area: Therapy Modalities

CMS Objective: To deliver the appropriate amount of therapy to each resident based on the clinical needs of the resident and in accordance with the resident's care plan. And, to assure that no more than 25% of therapy minutes by discipline is delivered using group and concurrent therapy.

CMS Citations and Language:

Final Rule FR Page 39184: "… [CMS has] a great deal of concern that by separating payment from the actual provision of services…beneficiaries would be vulnerable to underutilization."

Final Rule FR Page 39186: "… with regard to the potential impact of PDPM [that SNF providers could stint on care, most notably therapy services] or provide fewer services to patients, and that such providers will be overcompensated for care that is not being delivered, [CMS] plans to monitor closely service utilization, payment, and quality trends which may change as a result of implementing PDPM." "… [CMS] may take further action, which may include administrative action against providers…and/or proposing changes in policy." "[CMS] will also continue to work with the HHS OIG should any specific provider behavior be identified which may justify a referral for additional action."

Final Rule FR Page 39231: SNFs are required to report the amount of therapy provided to a resident over the course of the stay or by which we may monitor that they are in compliance with the proposed 25 percent group and concurrent therapy limit as described in section V.F. of the proposed rule. Therefore, for these reasons, under the proposed PDPM, we proposed to require that SNFs continue to complete the PPS Discharge Assessment,

SNF Compliance Strategy (e.g., monitoring, auditing, testing):

Strategy	SNF Lead
Operations	
Assure Resident care plans are developed that incorporate an the appropriate therapy modalities based on the needs of each individual resident.	TBD
Assure timely, complete and accurate documentation group and concurrent therapy minutes.	TBD
Review the MDS transmission reports to identity MDS errors including the overutilization of concurrent and group minutes.	TBD
Compliance	
Review provider policies and procedures relating to the use of concurrent and group therapy	Compliance Officer
Conduct annual chart audits that include the review of Section O related to group and concurrent therapy	Compliance Officer
Review sample of MDS transmission reports for MDS related errors	Compliance Officer
Consider post-PDPM implementation audits of high risk areas related to care/service delivery to identify trends that might suggest "overcompensation" or "stinting" could be occurring	Compliance Dept.

Compliance Area: Inappropriately Short Lengths of Stay

CMS Objective: PDPM include variable per diems for physical therapy, optional therapy and non-therapy ancillaries. Variable per diems are intended to better tailor relative resource use of the course of a stay to patients' individuals needs. CMS' does not intend the variable per diem to serve as an incentive to shorten lengths of stay to the degree that patient health, safety, welfare and quality outcomes negatively are impacted.

CMS Citations and Language:

83 FR 39228: "… given the potential payment reduction for long stays, we plan to monitor provider behavior closely to identify facilities whose beneficiaries experience inappropriate early discharge or provision of fewer services."

83 FR 39228: "… as stated above, we do plan to monitor the impact of this [variable per diem] policy [on lengths of stay] and may consider revisions to the policy if there is evidence of adverse trends either systemically or within certain patient populations. "

SNF Compliance Strategy (e.g., monitoring, auditing, testing):

Strategy	SNF Lead
Operations	
Assure SNF care delivery practices and care decision-making processes continue to meet regulatory requirements	TBD
Assure timely, complete and accurate documentation of resident assessments	TBD
Monitor vendor practices for potential PDPM related "stinting" of care/services	TBD
Compliance	
Review and advise on PDPM related changes to organizational policies that may trigger CMS scrutiny regarding SNF "overcompensation" or "stinting"	Compliance Officer
Review and advise on new vendor contracts or proposed amendments to current vendor contracts that are related to PDPM implementation	Compliance Officer/Legal Dept.
Provide education to the board, senior managers, SNF personnel or vendors about the organization's compliance risks associated with PDPM	Compliance Dept.
Consider post-PDPM implementation audits of high risk areas related to care/service delivery to identify trends that might suggest "overcompensation" or "stinting" could be occurring	Compliance Dept.

Addressing Risk Through Monitoring & Auditing Framework

Addressing Risk Through Monitoring & Auditing

Prepared by Bill Ulrich, President/CEO, CBSI

Key Risk Area	Source	Risk Level	Training, Policies Procedures	Monitoring Tool	Auditing Tool	Comments
Quality of Care						
Appropriate use of Psychotropic Drugs	Fed Reg 2008 Page 56838		Policies and procedures that outline best practice	Consultant Pharmacist monthly review for inappropriate use	Pre-Survey	Focus on staff training
Medication Management	Fed Reg 2008 Page 56837		Policy and procedure outline process to accurately acquire, receive, dispense and administer Medications	Consultant Pharmacist monthly review for medication errors	Pre-Survey	Focus on staff training.
Comprehensive Resident Care Plans	Fed Reg 2008 Page 56837		Policy and procedure outline process and involvement of physician and family	Alert charting	Pre-Survey	Monitor F ???
Resident Safety	Fed Reg 2008 Page 56838		Training and Education	Alert charting Hot Line	Pre-Survey	
Excluded individuals & Entities	Fed Reg 2008		Policies and procedure for new hires and	Pre-Employment Screening	OIG Exclusion List	Licensure verification

Key Risk Area	Source	Risk Level	Training, Policies Procedures	Monitoring Tool	Auditing Tool	Comments
			licensure verification			
Low Weekend Staffing	PBJ			Daily Staffing Rpt Complaint Surveys	QIES – Quarterly	Interviews with staff, residents and family.
RN Staffing	Fed Reg 2008			Daily Staffing Rpt Complaint Surveys	QIES – Quarterly	Interviews with staff, residents and family.
Total Staffing	Fed Reg 2008			Daily Staffing Rpt Complaint Surveys	QIES - Quarterly	Interviews with staff, residents and family.
Verbal Mental or Physical Abuse	Fed Reg 2000					
Inappropriate use of physical restraints	Fed Reg 2000					
Accurate Functional Measures	PDPM			MDS Review	Chart Audit	MDS GG Impacts PT, OT, SLP & NRSG
Falls with Major Injury	5 Star / QRP			Alert Charting QIES	Chart Audit	
Incontinence	Fed Reg 2000			QIES	Chart Audit	
High Risk Pressure Ulcers	Fed Reg 2000			QIES	Chart Audit	
Increased Help with ADL	Fed Reg 2000			QIES	Chart Audit	
Mobility Worsened	5 Star / QRP			QIES	Chart Audit	
Moderate to Severe Pain	5 Star / QRP			QIES	Chart Audit	
Rehospitalization	5 Star / QRP			QIES	Chart Audit	

Key Risk Area	Source	Risk Level	Training, Policies Procedures	Monitoring Tool	Auditing Tool	Comments
Patient Drive Payment Model [PDPM]						
Active Diagnosis	PDPM			MDS Review	Chart Audit	MDS I8000 Impacts SLP & NTA
BIMS Interview	PDPM			MDS Review	Chart Audit	MDS C0500 Impacts SLP
Enteral Calories Count	PDPM			MDS Review	Chart Audit	MDS K0710A & B Impacts NTA
HIV / AIDES Diagnosis	PDPM			MDS Review	Chart Audit	Claim Impacts NTA
Mechanically Altered Diet	PDPM			MDS Review	Chart Audit	MDS K0510c Impacts SLP
Mood	PDPM			MDS Review	Chart Audit	MDS D0300
Section I Clinical Conditions	PDPM			MDS Review	Chart Audit	MDS Ixxxx Impacts NRSG & SLP
Surgery in Hospital	PDPM			MDS Review	Chart Audit	MDS Jxxxx Impacts PT & OT
Swallowing Disorder	PDPM			MDS Review	Chart Audit	MDS K0100 Impacts SLP
Vent / Trach	PDPM			MDS Review	Chart Audit	MDS O0100 Impacts NRSG
Wound Staging	PDPM			MDS Review	Chart Audit	MDS M0210B-F Impact NTA
Group and Concurrent Therapy	PDPM			MDS Transmission Report	Chart Audit	
Submission of Accurate Claims						
20 Day episode of Care	Pepper			Medicare Meeting	Chart Audit	

Key Risk Area	Source	Risk Level	Training, Policies Procedures	Monitoring Tool	Auditing Tool	Comments
90+ Day Episode of Care	Pepper			Medicare Meeting	Chart Audit	
Change of Therapy Assessment	Pepper			Medicare Meeting	Chart Audit	
Daily skilled care	Fed Reg 2008			Medicare Meeting	Chart Audit	
Hospital 3 Day Qualifying Stay	OIG 2019			Medicare Meeting	Chart Audit	
Over Utilization of Therapy [Ultra-High Therapy]	Pepper			Medicare Meeting	Chart Audit	
Admission Paperwork [MSP]				Triple Check	Claims Audit	
Ambulance Services	OIG 2019			Triple Check	Claims Audit	
Anti-Supplementation	Fed Reg 2008			Triple Check	Claims Audit	
Hospice – Reserved Bed Placement	Fed Reg 2008					
Non Therapy RUG w/ High ADL	Pepper			Triple Check	Chart Audit	
Over use of Interrupted Stay Policy	PDPM			Triple Check	Claims Audit	
Physician Certification	CERT			Triple Check	Chart Audit	
Proper Reporting of resident case mix	Fed Reg 2008			Triple check	Chart Audit	
Therapy Minutes	OIG Reports			Triple Check	Chart Audit	
Therapy RUGS w/ High ADL	Pepper			Triple Check	Chart Audit	
Billing for items or services not provided or rendered as claimed	Fed Reg 2000			Triple Check	Claims Audit	

Key Risk Area	Source	Risk Level	Training, Policies Procedures	Monitoring Tool	Auditing Tool	Comments
Submitting claims for equipment and medical supplies that are medically unnecessary	Fed Reg 2000			Triple Check	Claims Audit	
Billing the resident privately for items or services that should be included in the per diem rate	Fed Reg 2000			Triple Check	Claims Audit	
Other						
Service Contracts at FMV	Fed Reg 2008			Contract Review	N/A	
Swapping arrangements	Fed Reg 2008			Contract Review	N/A	
Free Goods & Services	Fed Reg 2008			Contract Review	N/A	
Physician Self-Referral	Fed Reg 2008			Contract Review	N/A	
HIPAA Privacy and Security	Fed Reg 2008			Supervisor	HIPAA Audit	
Discretionary Admissions	Fed Reg 2000					

Sources

- OIG Work Plan
- OIG Advisory Opinions
- CMS PDPM Final Rule
- OIG Supplemental Compliance Program for Nursing Facilities; Federal Register September 30, 2008 Page 56832

Auditing and Monitoring Processes

Alert Charting

Alert Charting system for a resident having a change in condition. A change of condition is defined as an improvement or decline in their physical, mental and/or psychosocial status. When a change of condition has been observed, then the nurse will indicate the "change" on the 24-Hour Communication so that all staff is aware that a resident has been placed on "Alert." Many care related issues are first identified by the nurse, Nurse Aide or other care giver. Using an alert charting system helps to monitor overall quality of care.

From a compliance perspective Alert Charting should be reviewed as part of the annual compliance plan. First, assuring that the system is place.

Chart Audit

As part of the compliance program a sample of medical records should be audited on an annual basis to assure accurate and complete documentation.

Claims Audit

As part of the compliance plan a sample of Medicare UB-04s should be audited on an annual basis to assure accurate and complete documentation.

Contract Review

All contract should be reviewed by a competent healthcare attorney prior to contracts being signed.

MDS Review

The MDS is a complex document that not only influences the resident's care plan but also drives payment. With the implementation of PDPM errors on the MDS will yield under payment or overpayment situations.

The purpose of the weekly MDS review is to assure that each MDS is reviewed and accurate prior to transmitting and locking the MDS in the system. Everyone should be aware that the business office cannot bill Medicare until the MDS has been locked. Therefore, there is financial pressure placed on the clinical process to assure it is completed as soon as possible.

The compliance officer should review a sample of notes from the MDS review to assure this process is effective in catching MDS related errors.

MDS Transmission Report

The MDS must be transmitted and accepted by the State database prior to billing Medicare. The MDS report not only shows whether the MDS is transmitted and accepted but also yields MDS related errors. With the implementation of PDPM the MDS transmission report is the best way to identify residents that received more than 25% of therapy minutes using group and concurrent therapy.

From a monitoring perspective the Director of Nursing and / or the Administrator should review the MDS Transmission Report in order to identify any errors.

From an auditing perspective, the compliance officer should review a sampling of MDS transmission reports on an annual basis.

Medicare Meeting

The Medicare meeting takes different forms depending on the provider. Essentially the Medicare meeting is the place where the clinical needs of each Medicare patient are discussed along with the continued need for Medicare skilled services. Best practice is that a comprehensive note be included in the patient's chart identifying the reason for continued skilled coverage.

Pre-Employment Screening

The hiring process should include a robust pre-employment screening process that includes the verification that the potential hire is eligible for employment and is not excluded from employment by the state or federal jurisdiction.

Pre-Survey

Each facility should include a pre-survey process that is conducted by either a regional team or by an outside contractor.

QIES

The QIES system yields a report showing not only the Provider's quality measures but also how the facility performs against state and national data. This information should be reviewed by the Administrator and incorporated into the QAPI process.

Triple Check

Triple check is simply a thorough review by key staff of each UB-04 prior to billing. This process is important to assure each claim is error free and reflects the care delivered to the patient for the time period relevant to the claim.

Questions about the contents of this PDPM Academy publication may be directed to pdpm@ahca.org. For additional information about AHCA visit www.ahcancal.org.