Skilled Documentation to Support PDPM

Co-Presented by:
Terry Raser, RN, RAC-CT, DNS-CT, QCP
PANAC Board Member
Kay P. Hashagen, PT, MBA, RAC-CT
Senior Consultant
Contact Hours

• 1.5 Contact hours will be awarded for this continuing nursing education activity. Criteria for successful completion include attendance for the entire event and submission of the evaluation form.

• The Pennsylvania Association of Nurse Assessment Coordinators Planning Committee has determined there are no conflicts of interest of the planning committee or the speakers in the presentation of this program.

• This nursing continuing professional development activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation. (OBN-001-91)
Your Presenters

Terry Raser, RN, RAC-CT, DNS-CT, QCP
PANAC Board Member

Kay P. Hashagen, PT, MBA, RAC-CT
LW Consulting, Inc.
Senior Consultant
About

Terry Raser, RN, RAC-CT, DNS-CT, QCP
Terry has more than 39 years of experience in the healthcare industry. As a consultant for 19 years, she dedicates her career to compliance, quality improvement, MDS education and improvement in the long-term care nursing profession. Terry provides RNAC support and education and performs audits to assist facilities with regulatory compliance and survey performance. She has PDPM expertise as well as Pennsylvania and Maryland Medicaid Case-Mix expertise. She has been training skilled nursing staff on PDPM and Medicare Basics.

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

• Demonstrate an understanding of the regulations in the MBPM Chapter 8, for both nursing and therapy, to meet Medicare Part A requirements and how documentation must support these requirements.

• Know how to analyze nursing and therapy documentation to identify if it meets coding on the MDS and skilled requirements.

• Identify systems to facilitate proper coding and support CMS regulations.
SNF Documentation Challenges

#1 reason for Medicare Dollar Loss (Repayment) is “Ineffective Documentation”

Focus Areas:
- Re-educating staff
- Painting a picture
- Supporting the MDS and skilled care
- Supporting Diagnosis
Reimbursable MDS Sections for PDPM

- BIMS- Brief Interview for Mental Status
- PHQ-9 Patient Healthcare Questionnaire
- Section GG Functional Abilities
- Section I- Diagnosis
- Section J- Surgical Procedures
- Section K- Dietary
- Section M- Skin and Wounds
- Section O- Special Treatments and Procedures, and Restorative Nursing Program
PDPM Documentation Team

- **Support MDS Items**
  - We don’t know what we don’t know
  - Nursing Education
- **What are the Medicare regulations?**
  - Nursing Education
- **Cost of Not Documenting Skilled Services**
  - Nursing Education
  - Physician Education
  - Social Service
  - *Dietary
  - *Therapy
  - *Restorative Nursing
Supportive Documentation for PDPM
## PDPM Snapshot

<table>
<thead>
<tr>
<th></th>
<th>PT Base Rate</th>
<th>PT CMI</th>
<th>VPD Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$</strong> PT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>$</strong> OT</td>
<td>OT Base Rate</td>
<td>OT CMI</td>
<td>VPD Adjustment Factor</td>
</tr>
<tr>
<td><strong>$</strong> SLP</td>
<td>SLP Base Rate</td>
<td>SLP CMI</td>
<td></td>
</tr>
<tr>
<td><strong>$</strong> NTA</td>
<td>NTA Base Rate</td>
<td>NTA CMI</td>
<td>VPD Adjustment Factor</td>
</tr>
<tr>
<td><strong>$</strong> Nursing</td>
<td>Nursing Base Rate</td>
<td>Nursing CMI</td>
<td>18% Nursing Adjustment Factor (Only for Patients with AIDS)</td>
</tr>
<tr>
<td><strong>$</strong> Non-Case-Mix</td>
<td>Non-Case-Mix Base Rate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PT & OT Components: PDPM

- PDPM
  - Two classifications are used to obtain patient characteristics for PT and OT components under PDPM:
    - Clinical Category - Primary Diagnosis
    - Functional Status - Section GG
  - No therapy minutes required
The physician’s role in documentation of the primary diagnosis

**WHAT IS THE REASON FOR THE SNF ADMISSION?**

- This is the question that drives the choice of the primary diagnosis code
  - The code will be entered into the MDS in Item “I0020B”
  
  ![](image)

The reason for the hospitalization may not be the reason for the SNF admission!
Discussion about Primary Diagnosis

- Physician documented reason for SNF admission
- Physician list the primary diagnosis first
- Physician(s) educated on PDPM
- Comorbidity diagnoses documented by a physician
# PDPM Clinical Categories for PT and OT

<table>
<thead>
<tr>
<th>PDPM Clinical Categories</th>
<th>PT &amp; OT Clinical Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>Major Joint Replacement or Spinal Surgery</td>
</tr>
<tr>
<td>Acute Neurologic</td>
<td>Non-Orthopedic Surgery &amp; Acute Neurologic</td>
</tr>
<tr>
<td>Non-Orthopedic Surgery</td>
<td></td>
</tr>
<tr>
<td>Non-Surgical Orthopedic/Musculoskeletal</td>
<td>Other Orthopedic</td>
</tr>
<tr>
<td>Orthopedic - Surgical Extremities Not Major Joint</td>
<td></td>
</tr>
<tr>
<td>Medical Management</td>
<td>Medical Management</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Pulmonary</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular &amp; Coagulations</td>
<td></td>
</tr>
<tr>
<td>Acute Infections</td>
<td></td>
</tr>
</tbody>
</table>
Physician Documentation

- Day 1-8 physician documentation imperative
  - 5-day MDS pays the entire Medicare A stay!
- H&P, Progress note, Consults, Hospital Records
- Diagnosis must be specific - laterality, anatomical area
- Unspecified codes - most are RTP
- Educate to why it is important
Physician Documented Diagnosis

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

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

- Left Fractured Hip - Readmitted 09/23/2019

Note Text: MC Charting-- Resident S/P Left hip Fx. Resident is alert oriented to self only disoriented to time & place. OOB this am with ext of 2 assist. WBAT. Continues to have hallucinations noted to be reaching for things in the air that were not there. Very sleepy through out the day as resident was awake most of last shift. Attended skilled therapy for a short time. Staff propels resident in w/c. Silver dsg in place to left hip, no see through drainage noted. No redness or obvious indications of infection. Does have pitting edema to lower ext. Fluids encouraged. Appetite remains poor. Cont/Incont bladder.

Note Text: resident noted through the shift to at nurses station. resident approx 0430am resident toileted then went to bed with out issue. Resident had some complaints of mild LFT hip pain. Resident administered PRN Tylenol. Resident settled down and went to sleep approx 0500. Continue to monitor

Note Text: Readmission
Resident was out to hospital 9/19/19-9/32/19 dx- L hip fx. Weight is 124.3#,9/26, no weight loss since readmission. Diet is NAS, mechanical soft, thin liquids and intake is variable. She is able to feed herself with supervision. Supplementin place, Medpass 120ml BID. Skin- no pressure areas.
Monitor weekly weights.
Mr. Jones requires skilled care for his pneumonia.
No complaints offered. Slept well during the night.
Requires assist of 1 for ADLs.
Oxygen via nasal cannula 2L., wheezing as times.
Receives PT and OT.
Mr. Jones requires skilled care for his pneumonia.

His respiration are labored with an expiratory wheeze and rales bilaterally. O2 saturation is 94% on 2L of O2 via nasal cannula. Lips and nailbeds are pink. The head of bed is elevated 45 degrees. Resident expressed shortness of breath on exertion during am care. BP 146/84, P88, R20. Will continue to monitor. IV antibiotic continues as ordered.

Resident continues to receive PT and OT daily for strengthening but has difficulty due to SOB on exertion and tires easily.
PT/OT Component- Functional Status Section GG

- Supported by nursing and therapy
- Days 1-3 on admission/readmission (if out > 3 days)
  - Interrupted stay or New stay
- Interim Payment Assessment (IPA)
  - ARD plus 2 days prior
- PPS Discharge
  - PPS DC date plus 2 days prior
- Comprehensive (NC) and Quarterlies (NQ)
  - New October 1st for some states
### Section GG Importance

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

<table>
<thead>
<tr>
<th>Clinical Category</th>
<th>PT &amp; OT Function Score</th>
<th>PT &amp; OT Case Mix Group</th>
<th>PT CMI</th>
<th>OT CMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>0-5</td>
<td>TA</td>
<td>1.53</td>
<td>1.49</td>
</tr>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>6-9</td>
<td>TB</td>
<td>1.69</td>
<td>1.63</td>
</tr>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>10-23</td>
<td>TC</td>
<td>1.88</td>
<td>1.68</td>
</tr>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>24</td>
<td>TD</td>
<td>1.92</td>
<td>1.53</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>0-5</td>
<td>TE</td>
<td>1.42</td>
<td>1.41</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>6-9</td>
<td>TF</td>
<td>1.61</td>
<td>1.59</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>10-23</td>
<td>TG</td>
<td>1.67</td>
<td>1.64</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>24</td>
<td>TH</td>
<td>1.16</td>
<td>1.15</td>
</tr>
<tr>
<td>Medical Management</td>
<td>0-5</td>
<td>TI</td>
<td>1.13</td>
<td>1.17</td>
</tr>
<tr>
<td>Medical Management</td>
<td>6-9</td>
<td>TJ</td>
<td>1.42</td>
<td>1.44</td>
</tr>
<tr>
<td>Medical Management</td>
<td>10-23</td>
<td>TK</td>
<td>1.52</td>
<td>1.54</td>
</tr>
<tr>
<td>Medical Management</td>
<td>24</td>
<td>TL</td>
<td>1.09</td>
<td>1.11</td>
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<tr>
<td>Non-Orthopedic Surgery and Acute Neurologic</td>
<td>0-5</td>
<td>TM</td>
<td>1.27</td>
<td>1.30</td>
</tr>
<tr>
<td>Non-Orthopedic Surgery and Acute Neurologic</td>
<td>6-9</td>
<td>TN</td>
<td>1.48</td>
<td>1.49</td>
</tr>
<tr>
<td>Non-Orthopedic Surgery and Acute Neurologic</td>
<td>10-23</td>
<td>TO</td>
<td>1.55</td>
<td>1.55</td>
</tr>
<tr>
<td>Non-Orthopedic Surgery and Acute Neurologic</td>
<td>24</td>
<td>TP</td>
<td>1.08</td>
<td>1.09</td>
</tr>
</tbody>
</table>
Section GG Documentation Resources

- Section GG Assessment Form
- Therapy Documentation
- Nursing Documentation
- ADL Documentation

- Definitions are different, Retiring G in the future
- How bring utensils to mouth - Eating
- Sit to lying, lying to sitting on the side of the bed
Ineffective Nursing GG Documentation

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

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

- 5 Components support SLP for PDPM.

<table>
<thead>
<tr>
<th>SLP Component</th>
<th>Diagnosis</th>
<th>BIMS</th>
<th>Section K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Neurologic clinical classification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certain SLP related co-morbidities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence of cognitive impairment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence of mechanically altered diet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence of a swallowing disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Speech Language Pathology Component - PDPM

- Physician Documentation

<table>
<thead>
<tr>
<th>MDS Item</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>I4300</td>
<td>Aphasia</td>
</tr>
<tr>
<td>I4500</td>
<td>CVA, TIA, or Stroke</td>
</tr>
<tr>
<td>I4900</td>
<td>Hemiplegia or Hemiparesis</td>
</tr>
<tr>
<td>I5500</td>
<td>Traumatic Brain Injury</td>
</tr>
<tr>
<td>I8000</td>
<td>Laryngeal Cancer</td>
</tr>
<tr>
<td>I8000</td>
<td>Apraxia</td>
</tr>
<tr>
<td>I8000</td>
<td>Dysphagia</td>
</tr>
<tr>
<td>I8000</td>
<td>ALS</td>
</tr>
<tr>
<td>I8000</td>
<td>Oral Cancers</td>
</tr>
<tr>
<td>I8000</td>
<td>Speech and Language Deficits</td>
</tr>
<tr>
<td>O0100E2</td>
<td>Tracheostomy Care While a Resident</td>
</tr>
<tr>
<td>O0100F2</td>
<td>Ventilator or Respirator While a Resident</td>
</tr>
</tbody>
</table>
Cognitive Impairment Component (BIMS)

- PDPM- Speech Component
- Conducted on the ARD or the day before
- Resident Interview
- Rules to Stopping an Interview
- Staff Interview
- Missed Interviews – Considered Cognitively Intact
- Unplanned Discharges – Do Staff Interview
  - Don’t Dash for PPS Assessments
PDPM Cognitive Measure Classification Methodology:

- Cognitive Function Scale for PDPM using the BIMS Resident Interview

<table>
<thead>
<tr>
<th>PDPM Cognitive Level</th>
<th>BIMS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitively Intact</td>
<td>13-15</td>
</tr>
<tr>
<td>Mildly Impaired</td>
<td>8-12</td>
</tr>
<tr>
<td>Moderately Impaired</td>
<td>0-7</td>
</tr>
<tr>
<td>Severely Impaired</td>
<td>-</td>
</tr>
</tbody>
</table>

A score of mildly impaired, moderately impaired or severely impaired will support the PDPM SLP component.
PDPM Cognitive Measure Classification Methodology:

- Cognitive Function Scale for PDPM using the BIMS Staff Interview

<table>
<thead>
<tr>
<th>Staff Assessment Cognitive Scoring</th>
<th>Basic Impairment Count</th>
<th>Severe Impairment Count</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Severe Impairment</strong></td>
<td>Comatose B0100=1 and GG coding dependent or activity did not occur, and Daily Decision Making C1000=3</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Moderate Impairment</strong></td>
<td>NA</td>
<td>2 or 3</td>
</tr>
<tr>
<td><strong>Mild Impairment</strong></td>
<td>NA</td>
<td>1</td>
</tr>
<tr>
<td>Cognitively Intact</td>
<td>NA</td>
<td>0</td>
</tr>
</tbody>
</table>

A score of mildly impaired, moderately impaired or severely impaired will support the PDPM SLP component
Mechanically Altered Diet Component- PDPM

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

- Ask the resident
- Interview staff members
- Observe the resident during meals or medication pass
- Review documentation in the medical record
## SLP Component: Payment Groups

<table>
<thead>
<tr>
<th>Presence of Acute Neurologic Condition, SLP Related Comorbidity, or Cognitive Impairment</th>
<th>Mechanically Altered Diet or Swallowing Disorder</th>
<th>SLP Case Mix Group</th>
<th>SLP Case Mix Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Neither</td>
<td>SA</td>
<td>0.68</td>
</tr>
<tr>
<td>None</td>
<td>Either</td>
<td>SB</td>
<td>1.82</td>
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<tr>
<td>None</td>
<td>Both</td>
<td>SC</td>
<td>2.66</td>
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<tr>
<td>Any one</td>
<td>Neither</td>
<td>SD</td>
<td>1.46</td>
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<tr>
<td>Any one</td>
<td>Either</td>
<td>SE</td>
<td>2.33</td>
</tr>
<tr>
<td>Any one</td>
<td>Both</td>
<td>SF</td>
<td>2.97</td>
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<tr>
<td>Any two</td>
<td>Neither</td>
<td>SG</td>
<td>2.04</td>
</tr>
<tr>
<td>Any two</td>
<td>Either</td>
<td>SH</td>
<td>2.85</td>
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<tr>
<td>Any two</td>
<td>Both</td>
<td>SI</td>
<td>3.51</td>
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<tr>
<td>All three</td>
<td>Neither</td>
<td>SJ</td>
<td>2.98</td>
</tr>
<tr>
<td>All three</td>
<td>Either</td>
<td>SK</td>
<td>3.69</td>
</tr>
<tr>
<td>All three</td>
<td>Both</td>
<td>SL</td>
<td>4.19</td>
</tr>
</tbody>
</table>
Nursing Component- PDPM

- Extensive Services
- Special Care High
- Special Care Low
- Clinically Complex
- Behavior/Cognitive
- Reduced Physical Function
## Nursing Components

<table>
<thead>
<tr>
<th>RUG-IV Nursing RUG</th>
<th>Extensive Services</th>
<th>Clinical Conditions</th>
<th>Depression</th>
<th>Restorative Nursing Services</th>
<th>Function Score</th>
<th>CMG</th>
<th>CMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>ES3</td>
<td>Tracheostomy &amp; Ventilator</td>
<td></td>
<td></td>
<td>0-14 ES3</td>
<td>4.04</td>
<td></td>
<td></td>
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<tr>
<td>ES2</td>
<td>Tracheostomy or Ventilator</td>
<td></td>
<td></td>
<td>0-14 ES2</td>
<td>3.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ES1</td>
<td>Infection Isolation</td>
<td></td>
<td></td>
<td>0-14 ES1</td>
<td>2.91</td>
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</tr>
<tr>
<td>HE2/HD2</td>
<td>Serious medical conditions e.g. comatose, septicemia, respiratory therapy</td>
<td>Yes</td>
<td>0-5</td>
<td>HDE2</td>
<td>2.39</td>
<td></td>
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<tr>
<td>HE1/HD1</td>
<td>Serious medical conditions e.g. comatose, septicemia, respiratory therapy</td>
<td>No</td>
<td>0-5</td>
<td>HDE1</td>
<td>1.99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HC2/HB2</td>
<td>Serious medical conditions e.g. comatose, septicemia, respiratory therapy</td>
<td>Yes</td>
<td>6-14</td>
<td>HBC2</td>
<td>2.23</td>
<td></td>
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</tr>
<tr>
<td>HC1/HB1</td>
<td>Serious medical conditions e.g. comatose, septicemia, respiratory therapy</td>
<td>No</td>
<td>6-14</td>
<td>HBC1</td>
<td>1.85</td>
<td></td>
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</tr>
</tbody>
</table>
Nursing Component

- Extensive Services
  - Ventilator, respirator
  - Trach
  - Infection Isolation

- Special Care-High
  - Comatose
  - Septicemia
  - Quadriplegia
  - Diabetes with injections
  - Parenteral/IV Feeding
  - COPD w/ SOB lying flat
  - Fever w/PNA, Vomiting
  - tube feed or wt. loss
  - Respiratory Therapy
Nursing Components

<table>
<thead>
<tr>
<th>RUG-IV Nursing RUG</th>
<th>Extensive Services</th>
<th>Clinical Conditions</th>
<th>Depression</th>
<th>Restorative Nursing Services</th>
<th>Function Score</th>
<th>CMG</th>
<th>CMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>LE2/LD2</td>
<td></td>
<td>Serious medical conditions e.g. radiation therapy or dialysis</td>
<td>Yes</td>
<td></td>
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<td>LDE2</td>
<td>2.07</td>
</tr>
<tr>
<td>LE1/LD1</td>
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<td>Serious medical conditions e.g. radiation therapy or dialysis</td>
<td>No</td>
<td></td>
<td>0-5</td>
<td>LDE1</td>
<td>1.72</td>
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<tr>
<td>LC2/LB2</td>
<td></td>
<td>Serious medical conditions e.g. radiation therapy or dialysis</td>
<td>Yes</td>
<td></td>
<td>6-14</td>
<td>LBC2</td>
<td>1.71</td>
</tr>
<tr>
<td>LC1/LB1</td>
<td></td>
<td>Serious medical conditions e.g. radiation therapy or dialysis</td>
<td>No</td>
<td></td>
<td>6-14</td>
<td>LBC1</td>
<td>1.43</td>
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<tr>
<td>CE2/CD2</td>
<td></td>
<td>Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns</td>
<td>Yes</td>
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<td>0-5</td>
<td>CDE2</td>
<td>1.86</td>
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<td>CE1/CD1</td>
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<td>Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns</td>
<td>No</td>
<td></td>
<td>0-5</td>
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<td>CC2/CB2</td>
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<td>Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns</td>
<td>Yes</td>
<td></td>
<td>6-14</td>
<td>CBC2</td>
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<td>CA2</td>
<td></td>
<td>Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns</td>
<td>Yes</td>
<td></td>
<td>15-16</td>
<td>CA2</td>
<td>1.08</td>
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Nursing Component

- Special Care-Low
  - Cerebral Palsy, MS, Parkinson's
  - 2 or more Stage 2 Plus, stage 3 or 4, venous, arterial
  - Feeding Tube, Oxygen, Respiratory failure
  - Foot infection, Diabetic foot ulcer, open foot lesion
  - Radiation
  - Dialysis
Nursing Component

- Clinically Complex
  - Pneumonia
  - Hemiplegia/paresis
  - Burns
  - Chemo
  - Oxygen
  - IV Medication
  - Transfusions
# Nursing Components

<table>
<thead>
<tr>
<th>RUG-IV Nursing RUG</th>
<th>Extensive Services</th>
<th>Clinical Conditions</th>
<th>Depression</th>
<th>Restorative Nursing Services</th>
<th>Function Score</th>
<th>CMG</th>
<th>CMI</th>
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<td>CC1/CB1</td>
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<td>6-14 CBC1</td>
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Nursing Components

- Behavior/Cognitive
  - Hallucinations
  - Delusions
  - Verbal Abuse
  - Physical Abuse
- Reduced Physical Function
  - Catch All Category

- Hierarchical Structure
NTA Component

- **NTA classification**
  - Based on the presence of certain comorbidities or use of certain extensive services

- **Co-morbidities and extensive services for NTA classification**
  - Derived from a variety of MDS sources
  - Some co-morbidities identified by ICD-10-CM codes reported in MDS Item I8000

- **HIV/AIDS reported on the SNF claim, likewise, to RUG-IV**
  - 8 points awarded for this one diagnosis

- **CMS lists 50 diagnosis codes and conditions**

- **Maximum allowable = 12 points**
## NTA Comorbidities

<table>
<thead>
<tr>
<th>Condition/Extensive Service</th>
<th>MDS Item</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>N/A (SNF claim)</td>
<td>8</td>
</tr>
<tr>
<td>Parenteral IV Feeding: Level High</td>
<td>K0510A2, K0710A2</td>
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<tr>
<td>Special Treatments/Programs: Intravenous Medication Post-admit</td>
<td>O0100H2</td>
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<tr>
<td>Special Treatments/Programs: Ventilator or Respirator Post-admit</td>
<td>O0100F2</td>
<td>4</td>
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<tr>
<td>Parenteral IV Feeding: Level Low</td>
<td>K0510A2, K0710A2, K0710B2</td>
<td>3</td>
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<tr>
<td>Lung Transplant Status</td>
<td>I8000</td>
<td>3</td>
</tr>
<tr>
<td>Special Treatments/Programs: Transfusion Post-admit Code</td>
<td>O010012</td>
<td>2</td>
</tr>
<tr>
<td>Major Organ Transplant Status, Except Lung</td>
<td>I8000</td>
<td>2</td>
</tr>
<tr>
<td>Active Diagnoses: Multiple Sclerosis Code</td>
<td>I5200</td>
<td>2</td>
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<tr>
<td>Opportunistic Infections</td>
<td>I8000</td>
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<td>Active Diagnoses: Asthma COPD Chronic Lung Disease Code</td>
<td>I6200</td>
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<tr>
<td>Bone/Joint/Muscle Infections/Necrosis - Except: Aseptic Necrosis</td>
<td>I8000</td>
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<td>Chronic Myeloid Leukemia</td>
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<tr>
<td>Wound Infection Code</td>
<td>I2500</td>
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<tr>
<td>Active Diagnoses: Diabetes Mellitus (DM) Code</td>
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### NTA Comorbidities

<table>
<thead>
<tr>
<th>Condition/Extensive Service</th>
<th>MDS Item</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endocarditis</td>
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<tr>
<td>Immune Disorders</td>
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<td>1</td>
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<tr>
<td>End-Stage Liver Disease</td>
<td>I8000</td>
<td>1</td>
</tr>
<tr>
<td>Other Foot Skin Problems: Diabetic Foot Ulcer Code</td>
<td>M1040B</td>
<td>1</td>
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<tr>
<td>Narcolepsy and Cataplexy</td>
<td>I8000</td>
<td>1</td>
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<tr>
<td>Cystic Fibrosis</td>
<td>I8000</td>
<td>1</td>
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<tr>
<td>Special Treatments/Programs: Tracheostomy Care Post-admit Code</td>
<td>O0100E2</td>
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<tr>
<td>Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code</td>
<td>I1700</td>
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<tr>
<td>Special Treatments/Programs: Isolation Post-admit Code</td>
<td>O0100M2</td>
<td>1</td>
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<tr>
<td>Specified Hereditary Metabolic/Immune Disorders</td>
<td>I8000</td>
<td>1</td>
</tr>
<tr>
<td>Morbid Obesity</td>
<td>I8000</td>
<td>1</td>
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<tr>
<td>Special Treatments/Programs: Radiation Post-admit Code</td>
<td>O0100B2</td>
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<tr>
<td>Stage 4 Unhealed Pressure Ulcer Currently Present</td>
<td>M0300D1</td>
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<tr>
<td>Psoriatic Arthropathy and Systemic Sclerosis</td>
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<td>1</td>
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<tr>
<td>Chronic Pancreatitis</td>
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### NTA Comorbidities

<table>
<thead>
<tr>
<th>Condition/Extensive Service</th>
<th>MDS Item</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proliferative Diabetic Retinopathy and Vitreous Hemorrhage</td>
<td>I8000</td>
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<tr>
<td>Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code</td>
<td>M1040A, M1040C</td>
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<tr>
<td>Complications of Specified Implanted Device or Graft</td>
<td>I8000</td>
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<tr>
<td>Bladder and Bowel Appliances: Intermittent Catheterization</td>
<td>H0100D</td>
<td>1</td>
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<tr>
<td>Inflammatory Bowel Disease</td>
<td>I1300</td>
<td>1</td>
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<tr>
<td>Aseptic Necrosis of Bone</td>
<td>I8000</td>
<td>1</td>
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<tr>
<td>Special Treatments/Programs: Suctioning Post-admit Code</td>
<td>O0100D2</td>
<td>1</td>
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<tr>
<td>Cardio-Respiratory Failure and Shock</td>
<td>I8000</td>
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<tr>
<td>Myelodysplastic Syndromes and Myelofibrosis</td>
<td>I8000</td>
<td>1</td>
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<tr>
<td>Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory</td>
<td>I8000</td>
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<tr>
<td>Spondylolisthesis</td>
<td>I8000</td>
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<tr>
<td>Diabetic Retinopathy - Except: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage</td>
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<td>Nutritional Approaches While a Resident: Feeding Tube</td>
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<td>Severe Skin Burn or Condition</td>
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<td>Intractable Epilepsy</td>
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<td>Active Diagnoses: Malnutrition Code</td>
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<tr>
<td>Disorders of Immunity - Except: RxCC97: Immune Disorders</td>
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<tr>
<td>Cirrhosis of Liver</td>
<td>I8000</td>
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<tr>
<td>Bladder and Bowel Appliances: Ostomy</td>
<td>H0100C</td>
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<tr>
<td>Respiratory Arrest</td>
<td>I8000</td>
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<tr>
<td>Pulmonary Fibrosis and Other Chronic Lung Disorders</td>
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## NTA Component: Payment Groups

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<thead>
<tr>
<th>NTA Score Range</th>
<th>NTA Case Mix Group</th>
<th>NTA Case Mix Index</th>
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<td>12+</td>
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<td>9-11</td>
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<td>NE</td>
<td>0.96</td>
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<tr>
<td>0</td>
<td>NF</td>
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Skilled Documentation
30.2.2 - Principles for Determining Whether a Service is Skilled

- First Understand What a Skilled Service is.
  - *If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service.*

- Second Determine the Skilled Service(s)
  - Nurses won’t document if they don’t know the Skilled Service.

Medicare Benefit Policy Manual- Chapter 8
30.2.2.1 Documentation to Support Skilled Services

- An 81-year-old woman who is aphasic and confused, suffers from hemiplegia, congestive heart failure, and atrial fibrillation, has suffered a cerebrovascular accident, is incontinent, has a Stage 1 decubitus ulcer, and is unable to communicate and make her needs known.
  - No specific service provided is skilled,
  - The patient’s condition requires daily skilled nursing involvement to manage a plan for the total care needed,
  - To observe the patient’s progress, and
  - To evaluate the need for changes in the treatment plan.

- The medical condition of the patient must be described
- Must be documented to support the goals for the patient and the need for skilled nursing services.
Skilled Documentation

- Documentation needs to allow a reviewer to determine whether:
  - Services furnished safely and effectively
  - Services are reasonable and necessary
  - Documentation supports duration and quantity
Skilled Documentation

- Documentation should include the following
  - The individual’s medical assessment including areas that are relevant to the services provided to the individual
  - The skilled services provided and the individuals response to these services
  - The continued need for these services based on the individual’s response to the plan
  - The influencing and complicating factors related to the individual’s illness or injuries
  - The complexity of the service to be performed
Skilled Documentation

- When documenting a skilled service it is important to include communication between team members:
  - The individual’s medical condition
  - Development of a plan with measurable goals for the skilled stay
  - Changes in the plan of care
  - The individual’s progress toward goals
  - Training provided to the individual and caregivers
Skilled Documentation

- The clinical record should be specific and descriptive to the skilled care of the individual
- Avoid general statements that do not support the care provided
The following examples does not sufficiently describe the reaction of the patient to his/her skilled care:

- Patient tolerated treatment well
- Activities of Daily Living (ADLs) need assist of one
- Continue with plan of care
- Patient remains stable
- Continue to encourage fluids
- All needs anticipated by staff
- Safety measures in place
Documentation Skilled or Not?

- Documentation supports the removal of a Foley catheter with notation that individual will be encouraged to void every two hours.
- The next dated shift documentation does not address voiding.
- Further documentation supports “voiding pattern every 2 hours for 3 days” with no further documentation.
- The next note states “up to BR with 380 cc clear yellow urine. 39 cc after void on bladder scan. No abdominal discomfort upon palpation.”
Skilled Nursing Care

Tips for documenting to support specific diagnosis codes or symptoms

1. Know the primary diagnosis
2. Document on the skilled nursing assessments that take place on a daily basis
3. Capture skilled treatments that are performed and monitored on a daily basis
4. Always try to paint the picture of what skilled care is being provided to the patient based on the patient’s diagnosis
Daily Skilled Documentation Guidelines

- Pneumonia/Pulmonary Diseases
  - Vital signs
  - Lung Assessments
  - Cough
  - Shortness of breath/endurance level
  - Use of supplemental oxygen/oxygen saturation results
  - Skin color
  - Use of accessory muscles
  - Medications and responses to these medications
  - Lab results
Daily Skilled Documentation Guidelines

- Pneumonia/Pulmonary Diseases:
  - Skilled nursing required for daily nursing observation for signs of exacerbation of COPD. Vital Signs- BP-132/80, Pulse 86, Respirations 20. Lung sounds clear. No cough. Resident continues to be short of breath with exertion from bed/chair to dining room. Requires O2 at 2 L via nasal cannula continuously. HOB elevated secondary to resident’s experiencing SOB while lying flat.
Daily Skilled Documentation Guidelines

- Hip or Knee Replacement/Fracture of Hip
  - Level of pain/response to pain medications
  - Surgical site condition
  - Staples and sutures
  - Any hip precautions
  - Circulation or sensation assessment
  - Use of Continuous Passive Motion (CPM) if ordered/response
  - Weight bearing status and ability to maintain it
  - Use of anticoagulants/adverse reactions
  - Lab results
Hip or Knee Replacement/Fracture of Hip More Specific Documentation

- Patient received from therapy. New pain medication administered 30 minutes prior to therapy was effective today. Patient rates pain at 0/10 at this time. Incision at left hip is intact and well approximated with 19 staples. Redness noted at incision. Slight yellow serous drainage. Nurse Practitioner to visit this afternoon. Skilled nursing assessments required daily to assess for complications related to hip replacement surgery.
Daily Skilled Documentation Guidelines

- Anticoagulation Therapy
  - Medication administered
  - Signs or symptoms of bleeding
  - Lab results
  - Pain
  - Pallor or cyanosis
  - Education to individual or caregiver and response
  - New orders
Daily Skilled Documentation Guidelines

- Urinary conditions/Urinary Tract Infections
  - Urine color, clarity or odor
  - Burning or pain with urination
  - Frequency or urgency
  - Change incontinence
  - Other pain
  - Lab results
  - Medications administered and the individual’s response
  - Catheters
  - Dialysis
Nursing Documentation for Training

- 30.2.3.3 - Teaching and Training Activities
- Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services.
Example of Teaching and Training

- Teaching self-administration of injectable medications or a complex range of medications;
- Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;
- Teaching self-administration of medical gases to a patient;
- Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;
- Teaching patients how to care for a recent colostomy or ileostomy
Documentation for Teaching and Training

- The documentation must describe all efforts that have been made to educate the patient/caregiver,
- The resident’s responses to the training.
- Can the resident demonstrate back the training provided.
- The medical record should also describe the reason for the failure of any educational attempts, if applicable.
Under PDPM, since the patient diagnosis will be supporting the reimbursement of the CMI for PT, OT and Nursing, BOTH therapy and nursing must demonstrate that skilled care, related to the diagnosis for the reimbursement is still necessary.

If nursing documentation does not support skilled care for the diagnosis CMS might say

- Why didn’t you discharge the patient off Part A services?
Skilled Therapy Focus
Therapy Requirements to Support Skill

- MBPM §30.2.1 - Skilled Services Defined
  - Furnished pursuant to physician orders
  - Require the skills of qualified technical or professional health personnel
  - Skilled care may be necessary
    - to improve a patient’s current condition,
    - to maintain the patient’s current condition, or
    - to prevent or slow further deterioration of the patient’s condition.
Care in a SNF is covered if all the following are met:

- The patient requires skilled nursing services or skilled rehabilitation services
- The patient requires these skilled services **on a daily basis**
- The daily skilled services can be provided only on an inpatient basis in a SNF
- The services delivered are reasonable and necessary for the treatment of a patient’s illness or injury
How is “daily” basis defined for therapy?

- A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the “daily basis” requirement when they need and receive those services on at least 5 days a week.
- If therapy services are provided less than 5 days a week, the “daily” requirement would not be met.
- Note: if therapy doesn’t meet skilling criteria, nursing must...
Considerations for Therapy Delivery

- Coverage criteria unchanged for intensity
- Patient care needs is the focus
- Medical Necessity
  - Type
  - Duration
  - Intensity
  - Skill

PDPM is a reimbursement model change, not a clinical change
Reduction in Therapy?

- Underutilization concerns
- CMS is watching
Ramifications and Risks Under PDPM

- Therapy intensity will no longer be used for reimbursement
- Documentation must support reasonable and necessary care and demonstrate outcomes
- CMS will be monitoring changes in intensity
- Administrators will want to see demonstration of outcomes to justify ongoing therapy
Therapy Metrics
Therapy Metrics

- Therapy Intensity
- Frequency of Services
- Modes
- Discipline Involvement
The evaluating therapists should provide input regarding the appropriate clinical minutes the patient can benefit from.

If the evaluating therapist determines the care needs based on the resident needs, the intensity of therapy should remain like that under RUGS.
Frequency is times per week
Are the therapists developing plans of care for 5x per week to meet skilled requirements?
Are they providing the plan frequency?

NOTE: audits often reveal less therapy than the plan
✓ A common tactic is 5x BETWEEN OT and PT
The modes of therapy provided, as outlined by CMS include:

- Individual
- Group
- Co-treatment
- Concurrent

CMS originally stated that delivery of therapy should remain mostly individual, with a cap of 25% concurrent and group per discipline.

Covid has certainly helped this metric!
Your staff mix of Therapists and licensed Therapist Assistants should be monitored.

Especially if you have contract therapy, you should know that your Therapist-Assistant requirements are being met.

- Supervisory visits are being documented
- Progress notes are completed and signed timely
- Goals are updated to demonstrate progress
PDPM Therapy Metrics

- Monitoring of therapy utilization
  - PDPM compared to current/historical RUGs IV PPS

- Performance changes
  - Therapy outcomes
  - Length of Stay
  - Diagnosis coding supported by therapy documentation
  - Documentation supports modes
Specific Therapy Documentation Risks

- Resident is mostly “skilled” for rehab...yet frequency is less than 5x/week.
- Coding of minutes includes refusals or non-skilled repetitive walking and/or exercise (that could be done by restorative)
- Documentation does not support reasonable and necessary care, no progress, extended LOS
Systems to Support Defensible Documentation

- Utilize the entire IDT to review documentation looking for skill, painting the picture and key words
- READ the documentation, really...
- Use your Triple Check meeting as a time to catch documentation and coding errors
- Have baseline knowledge regarding root causes of errors in your building
  - External audits
Thanks for your attention!

Please submit to Kay.Hashagen@lw-consult.com
Or call (410) 207-8338