Vacuum the RUGs! Medicaid CMI Transition to PDPM

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Objectives

- Gain a Comprehensive Understanding of the PDPM CMI Methodology for Your Respective State
- Delve into the nuances of the Patient-Driven Payment Model (PDPM) and its Case Mix Index (CMI) methodology specific to New England states.
- Understand how it impacts reimbursement and care delivery, enabling you to align your facility's practices with state requirements effectively.
- Master Practical Strategies to Accurately Reflect Patient Acuity in Documentation
- Achieve Compliance with CMI Capture and Prepare for Audit-Readiness

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Medicaid PDPM Methodology

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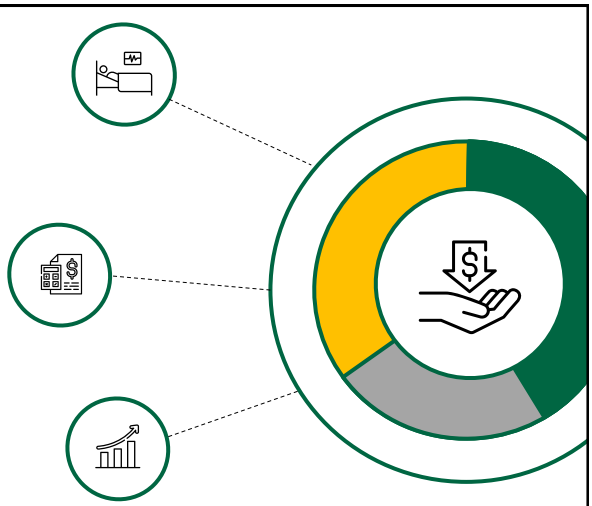
Mastering CMI Ensures Long-term Success

- **Accurate CMI Reflects Resident Acuity:** Higher Medicaid CMI indicates higher resident acuity, ensuring appropriate reimbursement.
- **Resource Allocation:** Proper PDPM capture ensures adequate reimbursement, impacting staffing, training, and specialized services crucial for the Quality Five-Star rating.
- **Survey Outcomes:** Quality care from accurate CMI and PDPM capture results in fewer deficiencies during state inspections, positively impacting the Five-Star rating.
- **Staffing Levels:** Adequate reimbursement through proper CMI and PDPM capture supports better staffing ratios, crucial for high-quality care and resident satisfaction.



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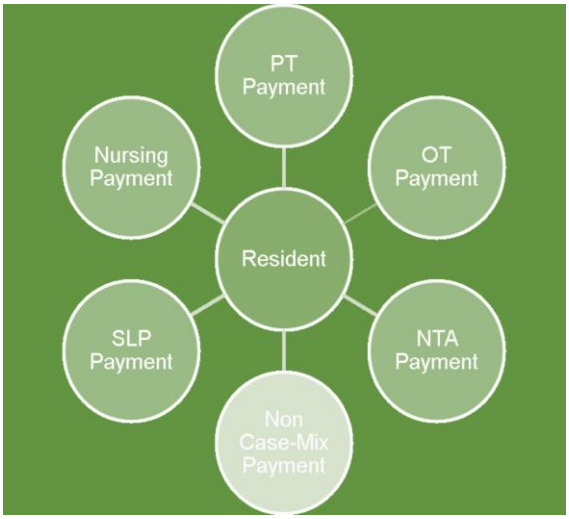
PDPM OVERVIEW

Rate Methodology

- Base Rate + CMI
- CMI dependent on resident classification assigned
  - **Nursing**
  - PT
  - OT
  - SLP
  - NTA
- ICD-10 Impact
- Functional Score (GG) Impact



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

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Neighboring States Methodology

STATE	CURRENT METHODOLOGY	FUTURE METHODOLOGY	TIMELINE	DETAILS
CT	RUG IV	PDPM - NURSING (RUG IV-48 GROUPER)	TBD – ANTICIPATED 7/2025	Awaiting confirmation from Meyers + Stauffer/CT on timeline
VT	FROZEN RUG IV RATE WITH PHASED IN PDPM COMPONENT QUARTERLY	PDPM – NURSING (RUG IV-48 GROUPER)	100% PDPM 7/2025	Phased-in approach with additional 25% of PDPM weighted-ness quarter over quarter
MA	PDPM - NURSING (RUG IV 48 GROUPER) WITH MMQ ADD-ONS	NA	EFFECTIVE 10/2023	Add-ons available (see later slide in deck)
ME	RUG IV	PDPM – NURSING (RUG IV-48 GROUPER)	1/2025	
NH	PDPM – NURSING (RUG IV 48 GROUPER)	NA	7/2024	State applied an updated budget adjustment factor (BAF) of 28.76% rather than 25% in July 2024
RI	RUG IV	PDPM – NURSING (RUG IV-48 GROUPER)	10/2025	Considering additional PDPM components– i.e. SLP and NTA

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Medicaid PDPM Classification

- **Will Likely Utilize:**
  - **PDPM Nursing Component:** RUG IV (Compressed) based on Clinical Criteria and certain GG ADLs and other considerations (i.e. Depression, Restorative Programming)
- **Will most likely not currently utilize**
  - **PDPM Non-Therapy Ancillary (NTA) Component**: 50 Diagnosis Groups that reflect conditions that make the care more Complex
  - **PDPM PT/OT Case Mix Group**: Orthopedics, Surgery/Neurological, Medically Complex based on Primary Diagnosis and certain GG ADLs
  - **PDPM Speech:** Cognition (BIMs), Speech Comorbidity, Swallowing Difficulties, Mechanically Altered Diet
- **Will most likely not utilize Therapy Levels of care like other states**

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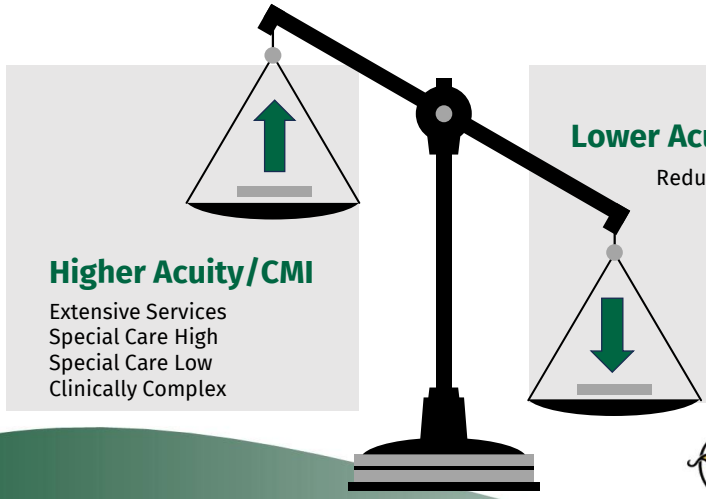
Upper vs Lower Nursing RUG Categories



Higher Acuity/CMI

Extensive Services
Special Care High
Special Care Low
Clinically Complex

Lower Acuity/CMI

Reduced Physical
Function
Behavioral
Cognitive

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CATEGORY III – EXTENSIVE SERVICES All Meet PRESUMPTION					
ADL = 0-14	PDPM Case Mix Group			CMI	HIPPS
☐Tracheostomy care AND ventilator or respirator (while a resident)	ES3	1		3.84	A
☐Tracheostomy care OR ventilator or respirator (while a resident)	ES2	2		2.90	B
☐Infection Isolation (while a resident)	ES1	3		2.77	C
CATEGORY IV – SPECIAL CARE HIGH All Meet PRESUMPTION					
ADL = 0-14	ADL SCORE	END SPLITS	Case Mix Group	CMI	HIPPS
☐Septicemia	0-5	Depression	HDE2 4	2.27	D
☐COPD and SOB when lying flat	0-5	No Depression	HDE1 7	1.88	E
☐Parenteral/IV feedings	6 – 14	Depression	HBC2 5	2.12	F
☐Fever with one of the following:	6 – 14	No Depression	HBC1 9	1.76	G
• Pneumonia • Vomiting • Weight loss • Feeding tube with intake requirements*	*PHQ2-9 Depression criteria is met if the Total Severity Score > 10* ☐Diabetes with both: • daily injections (7 days) • Insulin order changes on 2+ days ☐Quadriplegia and ADL ≤ 11 ☐Comatose and ADL dependent or ADL did not occur				
☐Respiratory therapy = 7 days					

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CATEGORY V – SPECIAL CARE LOW All Meet PRESUMPTION

ADL = 0-14

- ☐Respiratory Failure and oxygen
- ☐2+ Stage 2 pressure ulcers with 2+ skin treatments
- ☐Stage 3 or 4 pressure ulcer, or unstageable w/ slough or eschar w/2+ skin treatments
- ☐2+ vascular ulcers with 2+ skin treatments
- ☐Stage 2 pressure ulcer (1) and vascular ulcer (1) w/2+ skin treatments
- ☐Foot infection, diabetic foot ulcer, or other open lesion foot w/ foot dressings
- ☐Radiation therapy while a resident
- ☐Dialysis while a resident

ADL SCORE	END SPLITS	Case Mix Group		CMI	HIPPS
0-5	Depression	LDE2	6	1.97	H
0-5	No Depression	LDE1	10	1.64	I
6 – 14	Depression	LBC2	11	1.63	J
6 – 14	No Depression	LBC1	16	1.35	K

PHQ2-9 Depression criteria is met if the Total Severity Score ≥ 10

- ☐Feeding tube: *(≥51% calories or 26-50% calories & ≥501cc/day)
- ☐Cerebral Palsy and ADL ≤ 11
- ☐Multiple Sclerosis and ADL ≤ 11
- ☐Parkinson's Disease and ADL ≤ 11

CATEGORY VI – CLINICALLY COMPLEX All Meet PRESUMPTION

ADL = 0 - 16

- ☐Those w/Extensive Services, Special Care High or Special Care Low w/ADL 15-16
- ☐Pneumonia
- ☐Hemiplegia/hemiparesis and ADL ≤ 11
- ☐Surgical wounds or open lesion with treatments **
- ☐Burns
- ☐Chemotherapy while a resident
- ☐Oxygen therapy while a resident
- ☐IV medications while a resident
- ☐Transfusions while a resident

ADL SCORE	END SPLITS	Case Mix Group		CMI	HIPPS
0-5	Depression	CDE2	8	1.77	L
0-5	No Depression	CDE1	12	1.53	M
6 – 14	Depression	CBC2	14	1.47	N
6 – 14	No Depression	CBC1	17	1.27	P
15-16	Depression	CA2	20	1.03	O
15-16	No Depression	CA1	23	0.89	Q

PHQ2-9 Depression criteria is met if the Total Severity Score ≥ 10

** Treatments - surgical wound dressing; nonsurgical dressing other than to feet; ointments/meds other than to feet

CATEGORY VII – BEHAVIORAL SYMPTOMS & COGNITIVE PERFORMANCE

ADL = 11 - 16

- ☐Cognitive impairment: BIMS score ≤9; Severely impaired decision-making; or CPS ≥3
- ☐Hallucinations
- ☐Delusions
- ☐Physical behavior symptoms toward others
- ☐Verbal behavioral symptoms toward others
- ☐Other behavioral symptoms not directed toward others
- ☐Rejection of care
- ☐Wandering
- ☐Restorative Nursing Services

ADL SCORE	END SPLITS	Case Mix Group		CMI	HIPPS
11-16	≥2 restorative	BAB2	21	0.98	R
11-16	<2 restorative	BAB1	22	0.94	S

Restorative Nursing Services: 15 mins/day at least 6 days/week
- Urinary &/or Bowel Toileting program *(if both, only count as 1)*
- Passive &/or Active ROM *(if both, only count as 1)*
- Splint or Brace assistance
- Bed Mobility &/or Walking training *(if both, only count as 1)*
- Transfer training
- Dressing &/or grooming training
- Eating &/or swallowing training
- Amputation/prosthesis care
- Communication training

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- Transfer training
- Dressing &/or grooming training
- Eating &/or swallowing training
- Amputation/prosthesis care
- Communication training

CATEGORY VIII – REDUCED PHYSICAL FUNCTION

ADL = 0 - 16

- ☐Behavioral Symptoms and Cognitive Performance with ADL ≤ 11
- ☐Residents who do not meet the conditions in any of the previous categories
- ☐Restorative Nursing Services

ADL SCORE	END SPLITS	Case Mix Group		CMI	HIPPS
0-5	≥2 restorative	PDE2	13	1.48	T
0-5	<2 restorative	PDE1	15	1.39	U
6 – 14	≥2 restorative	PBC2	18	1.15	V
6 – 14	<2 restorative	PBC1	19	1.07	X
15-16	≥2 restorative	PA2	24	0.67	W
15-16	<2 restorative	PA1	25	0.62	Y

Section GG Item	ADL Score
Self-care: Eating	0-4
Self-care: Toileting Hygiene	0-4
Mobility: Sit to lying	0-4 (average of 2 items)
Mobility: Lying to sitting on side of bed	
Mobility: Sit to stand	0-4 (average of 3 items)
Mobility: Chair/bed-to-chair transfer	
Mobility: Toilet transfer	

Response		Score
05, 06	Set-up assistance, Independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 88	Dependent, Refused, N/A, Not Attempted, Resident Cannot Walk*	0

HIV= Add 18% to Nursing Rate

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Case Mix Acuity Comparisons

ES3	A	3.84	LDE1	I	1.72	CA1	Q	0.94
ES2	**B**	2.90	LBC2	**J**	1.63	BAB2	**R**	.98
ES1	**C**	2.77	LBC1	**K**	1.35	BAB1	**S**	.94
HDE2	**D**	2.27	CDE2	**L**	1.77	PDE2	**T**	1.48
HDE1	**E**	1.88	CDE1	**M**	1.53	PDE1	**U**	1.39
HBC2	**F**	2.12	CBC2	**N**	1.47	PBC2	**V**	1.15
HBC1	**G**	1.76	CBC1	**O**	1.27	PBC1	**W**	1.07
LDE2	**H**	1.97	CA2	**P**	1.03	PA2 PA1	**X** **Y**	.67 .62

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ACTIVE DIAGNOSES FOR NURSING RUG CAPTURE: Section I

- The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.

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Reminder - Section I: Active Diagnosis

Active Diagnosis Definition: A physician **documented** diagnosis (Optometrist, nurse practitioner, clinical nurse specialist, or physician assistant, in accordance with the provisions of State licensure laws and Medicare) **in the last 60 days** that have a direct relationship to the resident's current functional status, mood or behavior, medical treatments, nursing monitoring, or risk of death **during the 7-day look-back period**

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Reminder - Section I: Active Diagnosis

- There are two look-back periods for this section:
  1) Diagnosis identification (Step 1) is a 60-day look-back period.
  2) Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period *(except for I2300 UTI, which does not use the 7-day look-back period).*
- Functional limitations – loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis or paralysis.
- Nursing monitoring – clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.)

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Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

	Heart/Circulation
☐	**I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
☐	**I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
☐	**I0700. Hypertension**
☐	**I0800. Orthostatic Hypotension**
☐	**I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**
	Gastrointestinal
☐	**I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**
	Genitourinary
☐	**I1550. Neurogenic**
☐	**I1650. Obstruct**
	Infections
☐	**I1700. Multidrug** **RO)**
☐	**I2000. Pneumonia**
☐	**I2100. Septicemia**
☐	**I2200. Tuberculosis**
☒	**I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**
☐	**I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
☐	**I2500. Wound Infection** (other than foot)
	Metabolic
☐	**I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)

New Guidance for 10/1/2024!

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Section I – Septicemia/Sepsis coding

Item I2100 Septicemia:

New Guidance

- For sepsis to be considered septicemia, there needs to be inflammation due to sepsis and evidence of a microbial process.
- If the medical record reflects inflammation due to sepsis and evidence of a microbial process, code I2100, Septicemia.
- If the medical record does **not** reflect inflammation due to sepsis and evidence of a microbial process, enter the sepsis diagnosis and ICD code in item I8000, Additional Active Diagnoses.

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Functional Performance and Outcomes

Capturing Section GG

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GG Process, Policy & Documentation

- Facilities should refer to RAI Manual, page GG-15, “Steps for Assessment” to ensure accurate completion of Section GG. Here is a key excerpt from that page:
- “Assess the resident’s self-care performance based on direct observation, incorporating resident self-reports 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.”

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Updated MDS Definition "Usual Performance"

- "A resident's functional status can be impacted by the environment or situations encountered at the facility. **Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status.** If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance."

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Impact ADL Function Score

- Functional Score Range of 0-16 (Dependent to Independent)
- Impacts all categories in 1 or more of the following ways:
  - ADL Split for all except Extensive Services
  - Extensive, Special Care High and Special care Low require 14 and Below
  - Clinical Category Qualifier of 11 and below with CP, MS, Parkinson's or Hemiparesis
  - Clinical Category Qualifier of 11 and above Behavioral/Cognitive

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Functional Assessment Areas Impacting Nursing PDPM

It is critical that GG data collection is truly an Interdisciplinary Team effort – relies on accuracy of portraying the "USUAL PERFORMANCE"

GG Item
GG0170B1 Bed Mobility: Sit to lying
GG0170C1 Bed Mobility: Lying to sitting
GG0130A1 Eating
GG0130C1 Toileting hygiene
GG0170D1Transfer:Sit to stand
GG0170E1 Transfer: Chair/bed-to-chair transfer
GG0170F1 Transfer: Toilet transfer

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Functional Assessment Areas impacting Nursing PDPM

1. Admission Performance ↓ Enter Codes in Boxes ↓	2. Discharge Goal	
0 4		A. **Roll left and right:** The ability to roll from lying on b bed.
0 3		B. **Sit to lying:** The ability to move from sitting on side
0 3		C. **Lying to sitting on side of bed:** The ability to move feet flat on the floor, and with no back support.
8 8		D. **Sit to stand:** The ability to come to a standing positi bed.
0 3		E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or
0 3		F. **Toilet transfer:** The ability to get on and off a toilet or commode.

1. Admission Performance ↓ Enter Codes in Boxes ↓	2. Discharge Goal	
0 5		A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the m once the meal is placed before the resident.
0 4		B. **Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if app remove dentures into and from the mouth, and manage denture soaking and
0 3		C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes be bowel movement. If managing an ostomy, include wiping the opening but nc

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Admission Performance	Points Assigned
6 Independent/ 5 Set-UP/Clean-UP Assist	4
4 Supervision/. Touching Assistance	3
3 Partial/Moderate Assist	2
2 Substantial Maximal Assist	1
1 Dependent/2 Assist	0
7,9,10,88 Not Attempted (Any Reason)	0

- PDPM- Lower Functional (ADL) Score= Higher Level of Care

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Additional Considerations for Nursing Component

Depression Capture and Restorative Programming

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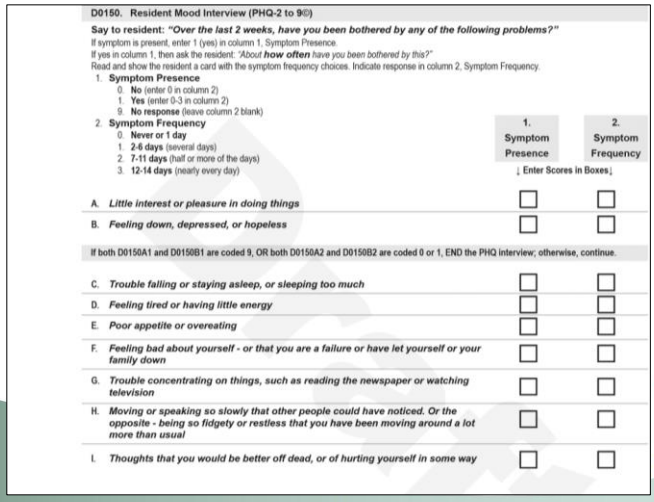
Depression Scoring: Special Care and Clinically Complex (PHQ 2-9)

- Extensive has NO additional considerations such as Depression scoring/RNP
- Mood Score on PHQ-2-9 **10+** for:
  - Special Care High
  - Special Care Low
  - Clinically Complex



D0150. Resident Mood Interview (PHQ-2 to 9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: *"About **how often** have you been bothered by this?"*
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**
   - 0. **No** (enter 0 in column 2)
   - 1. **Yes** (enter 0-3 in column 2)
   - 9. **No response** (leave column 2 blank)
2. **Symptom Frequency**
   - 0. **Never or 1 day**
   - 1. **2-6 days** (several days)
   - 2. **7-11 days** (half or more of the days)
   - 3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	☐
B. *Feeling down, depressed, or hopeless*	☐	☐
If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue.		
C. *Trouble falling or staying asleep, or sleeping too much*	☐	☐
D. *Feeling tired or having little energy*	☐	☐
E. *Poor appetite or overeating*	☐	☐
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*	☐	☐
G. *Trouble concentrating on things, such as reading the newspaper or watching television*	☐	☐
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual*	☐	☐
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*	☐	☐

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Capturing Depression & Case Mix Groupings

- HDE2- $127.68 X 2.27 = $289.83
- HDE1- $127.68 X 1.88 = $240.04
- Difference **-$49.79**
- **Missing depression score of 10 or more**

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Restorative Nursing Program Objectives

- Improve function
- Assist in returning to prior level of function
- Progressive – build toward higher levels of function through time (reach goal, then set new goal until highest function met)
- Maintain function
- Preventative – Avoid complications; Slow decline in function

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Reduced Physical & Cognitive/Behavioral RNP Considerations

- Measurable objective and interventions must be documented in the care plan and in the medical record
- Evidence of periodic evaluation by the licensed nurse
- Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- A nurse must supervise the activities in a restorative nursing program.
  - This item **does not** include procedures or techniques carried out by or under the direction of qualified therapists

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Initiating Restorative Nursing Programs

A resident may be started on a restorative nursing program when:

- He or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or
- When restorative needs arise during the course of a longer-term stay, or
- In conjunction with formalized rehabilitation therapy, or
- A resident is discharged from formalized PT, OT, or SLP rehabilitation therapy and restorative services would assist the resident in carry-over of therapeutic training.

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Reduced Physical & Cognitive/Behavior: RNP Considerations

- Restorative Nursing 6 Days per a week 2 Areas Restorative nursing services:
  - ❖*H0200 C / H0500 - Scheduled toileting plan
  - ❖*O0500 A, B - passive and/or active ROM*
  - ❖• O0500 C - splint or brace assistance
  - ❖*O0500 D, F - bed mobility and/or walking training *
  - ❖• O0500 E - transfer training
  - ❖• O0500 G - dressing or grooming training
  - ❖• O0500 H - eating or swallowing training
  - ❖• O0500 I - amputation/prosthesis care
  - ❖• O0500 J - communication training

* These count as only one even if both are provided.

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Resident Benefits of Restorative Nursing

- Promotes Improved Quality of Life
  - Independence within capabilities
  - A sense of purpose with improved self-esteem/mood
  - Increased social interaction
  - Residents are generally healthier with less incidences of complications
- Increases length-of-stay but decreases rehospitalizations
- Good patient care/Good customer service!

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Facility Benefits of Restorative Nursing

- Nursing driven program rather than therapy driven
- Decreases caregiver workload & costs of providing care
- Assists in managing Quality Measures and promoting safety
- Can delay discharge to master therapy strategies before going home alone, to reduce rehospitalizations, increase successful discharges
  - Impacts SNFQRP, SNFVBP, and 5-Star QMs
- RNPs are a skilled services under the Medicare Part A benefit *if at least TWO services and at least 15 mins/day over 6-7 days per week*
- Provides a strategy for ACOs and bundle programs to identify residents at risk of rehospitalization

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Planning for RNP

- Restorative nursing does not require a physician's order but is good practice
- Set up a system to identify those residents who would benefit from RNP
- Identify Program Coordinator
- Train staff in RNP practices (nurses and aides)
- Ensure skills competency of staff at routine intervals

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Restorative Nursing Program Requirements

- Resident specific, short-term goals documented in care plan & medical record
- Must be provided at least 15 minutes over 24 hours-not required to be all at one time
- Aides document the number of minutes/day of each intervention provided
- Periodic licensed nurse note on progress or cosign nurse aide progress note
- No more than 4 participants in a RNP program
- Update goals periodically

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Restorative Nursing Basics

- Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services.
  - These minutes described above DO NOT meet the criteria for rehabilitative therapy under Section O400 (PT/OT/ST minutes) and must only be coded as restorative nursing rather than skilled therapy.
- Although therapists may participate, members of the nursing staff are still responsible for overall coordination & supervision of restorative nursing programs

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Restorative Nursing Specifics

- Establish responsibility for monitoring documentation for completeness.
- Set up system to capture minutes daily
  - Current software may have program or add to current ADL flow sheet
- Set up a schedule to review & update goals
- Need 6 of 7 days of participation to qualify for MDS coding
- Set up as a daily program to allow 1 day for ‘miss’

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Compliance Considerations

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Audit Preparedness

- An audit may consist of a review of the **MDS sections that support the nursing payment grouper** of the PDPM score
- Nursing facilities will need to provide all clinical documentation **that supports these sections**
- **All documentation** contained within a medical record (paper and/or electronic) is subject to review and must be readily available at time of audit
- MDS assessments must be completed and submitted in accordance with CMS RAI guidelines
- Significant change MDS assessments **must meet criteria** as written in the CMS RAI User Manual
- Documentation within the medical record **must support the coding of the MDS and the resulting PDPM** score
- Supporting documentation used for coding the MDS may be corrected only by the original writer

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Documentation Review on Audit

- The medical record, in its entirety, may be subject to review during the audit and must be made readily available upon request at the time of the audit
- The medical record must support the coding of the MDS assessment and the resulting Nursing Payment Grouper Category, with particular focus on the questions in the MDS assessment that factor into the Nursing Payment Grouper as outlined in Chapter 6 of the RAI Manual

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Documentation Review on Audit

At a minimum, the following documentation can be reviewed during an audit:

- Care Plans
- Physician's orders/progress notes/History and Physical (H&P)
- Medical Administration Records (MAR)/Treatment Authorization Request (TAR)
- All assessments (respiratory, ulcers/wounds)
- Nurses' notes/clinicians' notes/MDS notes
- Occupational Therapy (OT)/Physical Therapy (PT) /Speech Language Pathologist (SLP) documentation
- Nursing Restorative notes
- Dietician notes/assessment
- Mental Health Specialist notes, Social Service notes
- Certified Nursing Assistant (CNA) documentation

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Common Compliance Pitfalls – Avoid These Mistakes!

- Infections (Septicemia, Pneumonia) does not meet the RAI Manual criteria of Active Diagnosis in the last 7 Days
- Physician documentation to support active diagnosis (Hemiparesis, Quadriplegia, COPD…) in the last 60 Days
  - Copy forward MDS
  - Resolved diagnosis
- Respiratory therapy does not meet the criteria in Appendix A and Section O criteria
- Isolation not supported (requesting census to support no roommate)
  - Common on admission combined with Medicare-Ensure all MDS Staff are educated

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Common Pitfalls – Lower 8 Categories

- MDS Section E behavior coded without supportive documentation by nursing and or CNA flowsheets
  - Loss will also result in loss of the resident specific behavior add-on if BAB1/2 qualification were certain behaviors
  - Delusions, Hallucinations and BIMs score <=9 will qualify for BAB1/2 but not the resident Specific Behavior Add-On
- Delusions and hallucination not supported in the look-back period
- PHQ 2-9 and/or BIMS not completed timely

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Be Confident in Your Coding: Documentation Matters

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Supportive Documentation – Common Areas of Opportunity

K0510A
Parenteral / IV Feeding - Special Care High

Does require:
• Documentation that includes any and all nutrition and hydration received by the resident in the last 7 days either at the nursing home, at the hospital, or as an outpatient or an inpatient, provided the documentation supports the need for nutrition or hydration.

Does include:
• IV fluids or hyperalimentation, including TPN, administered continuously or intermittently.
• IV fluids running at KVO (keep vein open).
• IV fluids contained in IV piggybacks.
• Hypodermoclysis and sub-q ports in hydration therapy.
• IV fluids administered for the purpose of "prevention" of dehydration if specifically documented for nutrition and/or hydration.

Does NOT include:
• IV medications.
• IV fluids used to reconstitute and/or dilute meds.
• IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay.
• IV fluids administered solely as flushes.
• IV fluids administered in conjunction with chemotherapy or dialysis.

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Supportive Documentation – Common Areas of Opportunity

O0400D2
Respiratory Therapy Days - Special Care High

Documentation Needed:
• Only medically necessary therapies that occurred after admission/readmission to the facility that were: 1) Ordered by a physician (or other licensed professional as allowed by state law) based on a qualified therapist's assessment and treatment plan
2) Documented in the resident's medical record
3) Care planned and periodically evaluated to ensure the resident receives needed therapies and that treatment plans are effective

• Therapy services may occur inside or outside the facility (Minimum of 15 min/day)
• Documentation of minutes that the respiratory therapist or respiratory nurse spends with the resident conducting the actual respiratory therapy treatment including the set-up and removal of treatment equipment.
• Associated initials/signature(s) on a daily basis to support the total number of minutes of respiratory therapy provided.
• Respiratory evaluation during the observation period by a respiratory therapist or a trained respiratory nurse.
• A respiratory nurse must be proficient in the modalities provided

Does include:
• Coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc.

Does NOT include:
• Metered-dose and/or dry powder inhalers.
• Self-administered/unsupervised treatments

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Supportive Documentation – Common Areas of Opportunity

O0500A-J
Restorative Nursing Program Days - Behavioral Cognitive + Reduced Physical Function

Does require:
• Documentation of actual direct minutes and initials/signature on a daily/shift/occurrence basis for each restorative program.
• Each program must be individualized to the resident's needs, planned, monitored, evaluated, and documented.
• Time must be provided separately for each restorative program.
• Documentation must include the five criteria to meet the definition of a restorative nursing program:
1. Measurable objectives and interventions must be documented in the care plan and in the medical record; and
2. Evaluation of the program by a licensed nurse. (*For the case mix review, reassess progress, goals and duration/frequency of each program within the observation period.*); and
3. Staff trained in the proper techniques; and
4. Supervised by licensed nurse; and
5. No more than 4 residents per supervising helper or caregiver.

• Documentation for splint or brace assistance must include an assessment of the skin and circulation under the device within the observation period.

Does include:
• An evaluation of the program written by a CNA and co-signed by a licensed nurse once the purpose and objectives of treatment have been established. (Contingent on state rules)

Does NOT include:
• Requirement for physician order.
• Procedures or techniques carried out by or under the direction of qualified therapists.
• For both active and passive range of motion movement by a resident that is incidental to care does not count as part of a formal restorative nursing program.
• Treatment for less than 15 direct minutes per day.

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Quality Oversight

- Educate staff on documentation expectations and monitor patterns/accuracy
- Review CMS reports for resident-level triggers
- Monitor MDS and other reporting for trends and accuracy including items for risk-adjustment
- Ensure Nursing, MDS, and Medical leadership collaborate
- Ensure facility's have a back up plan who are well-informed in quality and reporting

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Shoot for the Stars: Quality Measure Impact

- **Restorative Nursing Program Impact**
  - Long-stay QMs
    - Falls w/ Major Injury, Pressure Sores, ADL need, Ability to Move Independently
  - Short Stay PDPM residents
    - Section GG Coding/Discharge Functional Status
    - Financial considerations of lower Nursing categories
- **Survey Readiness**
- **Staffing**
  - Retention
  - Training
  - Compensation
- **Real-time monitoring of documentation, MDS capture + QM impact**

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Wrap-Up and Takeaways

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Questions Worth Asking

- Interview strategy + outlined process – particularly PHQ 2-9?
- Do we/should we have a Restorative Nursing Program in place?
  - Impact on the lower-level Nursing RUGS – what is the ROI for your facility?
  - Consider Quality impact as well
- Do we have a Medicaid CMI standing meeting?
  - Who is participating?
  - What is the standing agenda?
  - How are changes effectively communicated?
- Process for resolving old/inactive ICD-10 codes?
- ADR and Denials Processes – are these working well?
- Does our documentation reflect the care provided?

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Questions?

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