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RESTORATIVE CARE WITH A PDPM TWIST!

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To Attain and or Maintain

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Restorative Programming Overview

Restorative Programming is a systematic process that builds on positive goals that emphasizes on evaluating each resident individually to determine their current status and the gap of where the resident was able to function prior. A goal of the restorative program is to assist the resident to attain and or maintain their individual highest most practicable level of well being.

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TODAY'S OBJECTIVES

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Objectives

Upon completion of this program participants will be able to:

- Articulate the federal regulations related to restorative care services.
- Brief the intent the role of restorative care holds in the new PDPM payment system.
- Consider the impact of the activities of daily living (ADL) tracking & monitoring to reflect restorative care.
- Discuss key documentation consideration and standards.

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Objectives

Continued Objectives:

- Explain the key elements restorative programming.
- Feature the use of the provided restorative program packet.
- Guide the participants in the use of the program regulations.
- Discuss the role of the care area assessments (CAAs) in the restorative evaluation process.

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Objectives

Continued Objectives:

- Explain the roles and responsibilities of the team related to methods of sharing the functional workload for success.
- Familiarize self with PDPM rules that are pivotal to restorative care and the benefit of integration.

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Federal Regulations

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Federal Regulations

While there are several regulations that may have impact on the care and services your center renders related to restorative programming, today we will focus on:

- F676 - Quality of Life 483.24 (a)(1)(b)(1)(i)-(iii), and
- F688 – Quality of Care 483.25 (c)(1)-(3).

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F 676 Quality of Life

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Quality of Life

F 676 – Quality of Life relates to Activities of Daily Living (ADLs)/Maintain Abilities.

"Quality of Life" An individual's "sense of well-being, level of satisfaction with life and feeling of self-worth and self-esteem. For nursing home residents, this includes a basic sense of satisfaction with oneself, the environment, the care received, the accomplishments of desired goals, and control over one's life."

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Quality of Life

F 676 – Quality of Life relates to Activities of Daily Living (ADLs)/Maintain Abilities.

In 483.24(a) notes that based on the comprehensive assessment of a resident and consistent with the residents needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable.

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Quality of Life

Continued F676

In 483.24(a)(1), a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section….

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Quality of Life

Continued F676

In 483.24(b), Activities of Daily Living (ADL), it notes that the facility must provide care and services in accordance with paragraph (a) for the following ADLs:

- 483.24(b)(1) Hygiene-bathing, dressing, grooming, and oral care,
- 483.24(b)(2) Mobility-transfer and ambulation, including walking,
- 483.24(b)(3) Elimination-toileting,

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Quality of Life-ADLs

Continued F676

- 483.24(b)(4) Dining-eating, including meals and snacks, and
- 483.24(b)(5) Communication, including:
  - (i) Speech,
  - (ii) Language, and
  - (iii) Other functional communication systems.

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Quality of Life-ADLs

- In some cases, residents with dementia may resist the manner in which care is being provided, or attempted, which can be misinterpreted as declination of care.
- In some cases the resident with dementia does not understand what is happening, or may be fearful of unfamiliar staff, or may be anxious or frustrated due to inability to communicate.
- Facility staff are responsible to attempt to identify the underlying cause of the "refusal/declination" of care.

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Quality of Life-ADLs

- Note also that depression is a potential cause of excess disability and, where appropriate, therapeutic interventions should be initiated. Follow up if the resident shows signs/symptoms of depression even if not indicated on his or her MDS.

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Quality of Life-ADLs

- Review: For evaluating a resident's ADLs and determining whether a resident's abilities have declined, improved, or stayed the same within the last twelve months, the following definitions as specified in the State's Resident Assessment Instrument (RAI) Manual are used in reference to the Assessment Reference Date (ARD):
- **Independent** – Resident completed activity with no help or oversight every time during the 7-day look-back period.
- **Supervision** – Oversight, encouragement or cueing provided 3 or more times during the last 7 days.

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Quality of Life-ADLs

- **Limited Assistance** - Resident highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight bearing assistance 3 or more times during the last 7-days.
- **Extensive Assistance** - While resident performed part of activity over the last 7 days, help of following type(s) was provided 3 or more times;
- a. Weight-bearing support provided 3 or more times; or
- b. Full staff performance of activity during part (but not all) of last 7 days.

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Quality of Life-ADLs

- **Total Dependence** - Full staff performance of an activity with no participation by resident for any aspect of the ADL activity. Resident was unwilling or unable to perform any part of the activity over entire 7-day look-back period

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Quality of Life-ADLs

- The facility should:
- Recognize and assess an inability to perform ADLs, or a risk for decline in any ability they have to perform ADLs;
- Develop and implement interventions in accordance with the resident's assessed needs, goals for care, preferences, and recognized standards of practice that address the identified limitations in ability to perform ADLs;
- Monitor and evaluate the resident's response to care plan interventions and treatment; and
- Revise the approaches as appropriate.
- **NOTE**: For concerns related to facility failure to provide care, services, equipment or assistance to a resident with limited mobility, refer to F688, Mobility.

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F 688 Quality of Care

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Quality of Care

F 688 – Quality of Care relates to Increase/Prevent Decrease in ROM/Mobility.

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Quality of Care

F 688 – Quality of Care relates to Increase/Prevent Decrease in ROM/Mobility.

The intent of 483.25(c) is to review the impact of the physical, mental, and/or psychosocial aspects of the resident's ability to maintain, improve or prevent avoidable decline in range of motion and mobility, the surveyor must review the provision of care and services and implementation of interventions under this tag.

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Quality of Care

The intent of this regulation (F688) is to ensure that the facility provides the services, care, and equipment to assure that:

- A resident maintains, and/or improves to his/her highest level of range of motion (ROM) and mobility, unless a reduction is clinically unavoidable; and

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Quality of Care

The intent of this regulation (F688) is to ensure that the facility provides the services, care, and equipment to assure that:

- A resident with limited range of motion and mobility maintains or improves function unless reduced ROM/mobility is unavoidable based on the resident's clinical condition.

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Quality of Care

- Mobility 483.25(c)(1), notes that the facility must ensure that a resident who enters the facility without limited ROM does not experience reduction in ROM unless the resident's clinical condition demonstrates that a reduction in ROM is unavoidable; and

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Quality of Care, Mobility

Continued

- In 483.25(c)(2), it notes that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in ROM.

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Quality of Care, Mobility

Continued

- In 483.25(c)(3), it notes a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.

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Quality of Care: Bowel & Bladder

- §483.25(e) Incontinence.
- §483.25(e)(1) The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

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Quality of Care: Bowel & Bladder

- §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that—
- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
- (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and

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Quality of Care: Bowel & Bladder

- (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.
- §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

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Quality of Care: Bowel & Bladder

- Each resident who is continent of bladder and bowel receives the necessary services and assistance to maintain continence, unless it is clinically not possible.
- Each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal bladder function as possible;
- A resident who is incontinent of bowel is identified, assessed and provided appropriate treatment and services to restore as much normal bowel function as possible;

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Quality of Care: Bowel & Bladder

- An indwelling catheter is not used unless there is valid medical justification for catheterization and the catheter is discontinued as soon as clinically warranted;
- Services are provided to restore or improve normal bladder function to the extent possible, after the removal of the indwelling catheter; and
- A resident, with or without an indwelling catheter, receives the appropriate care and services to prevent urinary tract infections to the extent possible.

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Quality of Care: Bowel & Bladder

- Assessment Considerations:
  1. Prior history of bladder functioning.
  2. Medication review.
  3. Patterns of fluid intake.
  4. Use of urinary tract stimulants or irritants (e.g., frequent caffeine intake).
  5. Pelvic and rectal examination to identify physical features that may directly affect urinary continence.

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Quality of Care: Bowel & Bladder

6. Functional & cognitive capabilities that could enhance urinary continence & limitations.
7. Type and frequency of physical assistance necessary.
8. Pertinent diagnosis & developing complications.
9. Tests/studies, assessing resident's readiness for bladder rehabilitation programs.
10. Environmental factors and assistive devices that may restrict or facilitate a resident's ability to access the toilet

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Quality of Care: Bowel & Bladder

- Options for Management of incontinence – behavioral
  1. **"Bladder Rehabilitation/Bladder Retraining**" is a behavioral technique that requires the resident to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void.

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Quality of Care: Bowel & Bladder

2. Pelvic floor muscle rehabilitation - strengthen the voluntary periuretheral and perivaginal muscles that contribute to the closing force of the urethra and the support of the pelvic organs.

- Programs dependent on staff involvement & assistance.
  1. Prompted Voiding
  2. Habit Training/Scheduled Voiding
  3. Intermittent catheterization

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Quality of Care: Bowel & Bladder

4. Medication therapy
5. Use of devices – i.e. pessary, incontinence products

- Fecal Incontinence
  1. Passive incontinence
  2. Urge
  3. Fecal seepage

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Quality of Care: Bowel & Bladder

- Complete "3 days" of observation
- Provide documentation of the toileting schedule and continent/incontinent episodes noted.
- Nurse Manager evaluates, creates, & implement care plan for the toileting program.
- To capture, observation/documentation of the toileting patterns on Days 1,2 and 3.
- Initiate the toileting program half way through Day 3 so that the minimum 15 minutes of the toileting RNP could be captured on Day 3.

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Restorative Qualifying Programs

- 2 programs, 15 minutes each per day and look back period 6 out of 7 days.
- No more than 4 in group sessions

- Areas

1. Walking and/or Bed Mobility
2. Splint and Brace Assistance
3. Range of Motion (PROM, AROM, AAROM)

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Restorative Qualifying Programs

- Areas

4. Transfer Training
5. Communication Training (Cognitive)
6. Dressing and/or Grooming
7. Amputation and Prosthetic Care
8. Eating and Swallowing
9. Toileting: Bowel and/or Bladder

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Key Definitions, 483.25(c)

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Active ROM

Active ROM means the performance of an exercise to move a joint without any assistance or effort of another person to the muscles surrounding the joint.

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Active Assisted ROM

Active Assisted ROM means the use of muscles surrounding the joint to perform the exercise but requires some help from the therapist or equipment (such as a strap). Mobility refers to all types of movement, including walking, movement in a bed, transferring from a bed to chair, all with or without assistance or moving about an area either with or without an appliance (such as a chair, walker, came, crutches, etc.).

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Muscle Atrophy

Muscle Atrophy means the wasting or loss of muscle tissue.

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Range of Motion

ROM means full movement potential of a joint.

Passive ROM means the movement of a joint through the range of motion with no effort from the patient/resident.

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Range of Motion

- The resident's comprehensive assessment should include and measure, as appropriate, a resident's current extent of movement of his/her joints and the identification of limitations, if any and opportunities for improvement.
- The assessment should address:
- Whether the resident had previously received treatment and services for ROM and whether he/she maintained his/her ROM, whether the ROM declined, and why the treatment/services were stopped.
- The assessment should address, for a resident with limited ROM, if he/she is not receiving services, the reason for the services to not be provided.

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Range of Motion

- The resident-specific, comprehensive assessment should identify individual risks which could impact the resident's range of motion including, but not limited to:
- Immobilization (e.g., bedfast, reclining in a chair or remaining seated in a chair/wheelchair);
- Neurological conditions causing functional limitations such as CVA, MS, ALS or Lou Gehrig's disease, Guillain-Barre syndrome, MD**,** or cerebral palsy, etc.**;**

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Range of Motion

- Any condition where movement may result in pain, spasms or loss of movement such as cancer, presence of pressure ulcers, arthritis, gout, late stages of Alzheimer's, contractures, dependence on mechanical ventilation, etc.; or
- Clinical conditions such as immobilized limbs or digits because of injury, fractures, or surgical procedures including amputations.

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Range of Motion

- Comprehensive Assessment of the Resident's Ability
- For movement including to and from the lying position,
- Turning and side to side movement in bed,
- Positioning of the body
- Transfers between surfaces such as to and from bed or chair, standing, and walking.

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Range of Motion

- Any previously received treatment and services for mobility and whether he/she maintained his/her mobility, whether there was a decline, and why the treatment/services were stopped. In addition,
- If he/she is not receiving services, the reason for the services to not be provided.
- Identify individual risks which could impact the resident's mobility including, but not limited to include the risk factors in the above section for range of motion

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Prostheses

- §483.25(j) Prostheses
- The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
- Refer to appropriate sections of the RAI/MDS, as applicable.

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Prostheses

- For residents selected for review, as appropriate:

Is resident able to apply the prosthesis by himself /herself or with some assistance?

1. Are residents wearing their prostheses?
2. Does the prosthesis fit correctly?
3. Is skin/mucous membrane in contact with the prosthesis free of abrasions, wounds, irritation?
4. Is the prosthesis in good condition and functioning as intended?
5. Is the prosthesis in need of repair?

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Dining/Eating

- §483.25(g) Assisted nutrition and hydration.
- Based on a resident's comprehensive assessment, the facility must ensure that a resident—
- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

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Dining/Eating

- §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;
- §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
- F692 Nutrition/Hydration Status Maintenance

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Dining/Eating

- Examples of goals may include, but are not limited to:
- A target weight range.
- Desired fluid intake.
- The management of an underlying medical condition (e.g. diabetes, kidney disease, wound healing, heart failure, or infection.)
- The prevention of unintended weight loss or gain

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Dining/Eating

- Weight stability, rather than weight gain, may sometimes be the most pertinent short-term or long-term objective for the nutritionally at-risk or compromised resident.
- After an acute illness or as part of an advanced or end-stage medical condition, the resident's weight and other nutritional parameters may not return to previous levels and may stabilize at a lower level, sometimes indefinitely.

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Principals of Restorative

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Recommended Principals

We recommend five principals in the development of your program:

- Be proactive
- Encourage activity as lack of weakens individuals
- Stave off further disability or decline
- Focus on ability not disability 'I can' as opposed to 'I cannot'
- Consider the entire person or person centered care

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Think Collaboration

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Considerations for Success

- If restorative nursing is captured on the MDS hand in hand with PDPM, then providers will be able to capture reimbursement.
- Think about preventing decline, restoring functional abilities, & preventing avoidable issues.
- Restorative programs can be started for new admissions if the comprehensive assessment shows the need for nursing services.
- The key is to identify clinical indications suggestive of involving a Restorative program for the resident.

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Considerations for Success

- Focus on the goal of achieving & maintaining a resident's optimal physical, psychosocial, & mental well-being while promoting their ability to adjust & adapt to living independently & safely as possible.

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Considerations for Success

- When is a good time to start a Restorative Program?
- First collaborate closely with Therapy services to identify the resident characteristics that therapy can possibly skill the resident for and nursing services can work with therapy at the same time to meet any resident restorative care needs.
- Restorative can be started:
  - On admission

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Considerations for Success

- Restorative can be started:
  - In collaboration with therapy needs.
  - On admission when a resident is not a candidate for formalized rehabilitation program.
  - When restorative needs occur during a longer stay in the skilled unit.
- Restorative nursing programs can occur concurrently with therapy as long as there is supporting and adequate documentation for need of both services because of the resident's condition.

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Considerations for Success

- Consider the PDPM Nursing Classification Categories (B & D categories) & its impact on providing Restorative Nursing Services (RNP)

1. Behavior Symptoms/Cognitive Performance
2. Reduced in physical function

- Programs 2/day, 15 minutes/day, at least 6 days a week with specific goals & interventions.
- Supportive documentation showing progress
- Staff training with Licensed Nurse supervision

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Considerations for Success

- Approved list of Restorative Nursing Programs from the RAI manual

1. Range of Motion (Passive)
2. Range of Motion (Active)
3. Splint or Brace Assistance
4. Bed Mobility
5. Transfers
6. Walking/Ambulation
7. Dressing and/or Grooming
8. Eating and/or Swallowing
9. Amputation/Prosthesis care
10. Communication
11. Urinary Toileting Program
12. Bowel Program

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Considerations for Success

- Capture Day 1, 2, 3 (5day assessment)
- With ARD set at day 8, start the program as soon as the remainder of the 3rd day to meet 6 day requirement and 7 days look back.

NOTE: REMEMBER NO OVERLAP OF FUNCTIONAL ITEMS ADDRESSED BY THERAPY.

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Considerations for Success

- RNPs when provided together will only count as one program each. These are:

1. Urinary Toileting Program and/or Bowel Training Program
2. Passive and/or Active ROM
3. Bed mobility and/or walking training

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Considerations for Success

- Some facilities may contract with therapy services to supplement & manage RNPs.
- Nursing is mainly responsible for coordinating the program.
- Nursing can consult with therapy.

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Considerations for Success

Documentation Requirements:
Remember:

- Determine classification base on data completed with MDS assessments. Review by team.
- Guide/checklists to review items on MDS that will help classify residents for collaborative care services.
- Make sure ICD-10-CM codes & co-morbidities are coded.

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Restorative Programming

Includes the clinical process:

- Evaluation
- Develop
- Plan
- Implement
- Re-evaluation

Similar to the resident assessment instrument & process!

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Keys to Successful Programming

Four Keys:

- Be structured, daily routines
- Be consistent, time of day, etc.
- Be communicative, discuss with all for consensus
- Be interdisciplinary, part of the plan of care

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Therapy and Nursing

- Therapy evaluates the resident.
- Therapy coordinates with nursing. Therapy can assist with expertise by providing education, training and teaching competencies.
- Nursing Supervision with restorative program and providing regular evaluations of residents.
- Nursing consults with therapy for any needs the resident may have.

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Role of the MDS

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Role of Minimum Data Set

The MDS, part of the RAI process role includes:

- Help gather definitive resident information (e.g., strengths, weakness, amount of support needed, etc.).
- Measures resident abilities to function regardless of their disease and disability to help individualize and avoid 'one size fits all'.
- Promotes resident focused goal establishment.
- Helps determine resources and services that may be additionally needed to support the resident.

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Role of Care Area Assessments

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Care Area Assessment Role

The care area assessment (CAA) role is to help us focus on specifically triggered items from the MDS to further evaluate the area and gather additional resident specific data.

This will help identify various factors that could interfere with the resident's ability to perform activities of daily living (ADLs) and the reason for the interruption of independence.

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Care Plan Considerations

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Care Plan Role

In the spirit of person centered care, the care plan should be individualized for each individual resident. By using the MDS to gather data and then completing the triggered CAAs to further gain knowledge and continue to deepen the evaluation, we are able to determine if there is a need to:

[ ] proceed or

[ ] not proceed to a plan of care …

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Care Plan Need Statement

Need Statement:

Identification of the gap and how it may become a need, problem, concern, or strength to be addressed.

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Establishment of Goals

Goals:

Determination of goals includes what will happen, as evidenced by ?, and when the goal would be achieved…

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Interventions

Interventions:

To help the resident reach their goal, it is important to have clear concise steps/tasks that are noted to include who (what discipline if the facility staff), will complete what, and when. Additionally communication to whom if there is a concern, change in condition, etc.

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Restorative Program Guide

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Provided Restorative Guide © RBHPs

FHCA sent you a zip file that contains a restorative guide. This is for your use if you like. We encourage you to send us your feedback and any suggested updates. Of course, if your facility is part of a group or chain or corporate structure, thank you in advance for following your organization protocols.

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RBHPs Restorative Nursing Program

Table of Contents:

- ❑ Memorandums of Direction
- ❑ Most pertinent federal regulations
- ❑ Activities of Daily Living RBHPs Form
- ❑ Mobility RBHPs Form
- ❑ Specialized Rehabilitation and Restorative Services RBHPs Form

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RBHPs Restorative Nursing Program

Table of Contents:

- ❑ Restorative Nursing Program Procedure, RBHPs
- ❑ Nursing Rehab/Restorative Program Record, RBHPs
- ❑ Tracking and Trending Bowel/Bladder Form, RBHPs (includes a 3 & 5 day option)
- ❑ Restorative Bowel/Bladder Program Form, RBHPs

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A Restorative Lens for PDPM

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Overview Patient-Driven Payment Model

- Restorative Care has a role in PDPM!
- The PDPM model uses clinical conditions to determine the resident's therapy payment category.
- A major change between PPS and PDPM is that the focus shifts off of delivered minutes of rehab provided to overall clinical management.
- A marriage between clinical, rehab, health information for coding, with operations is needed for success!

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More on PDPM Composition

- Restorative Care and Therapy can be planned for treatment at the same time. We do not have to duplicate services but recognize creating synergies between both disciplines.
- Payments would taper for PT, OT, and NTAS but beginning on different days of the resident's stay.
- The separate PT and OT components begin to taper after day 20. NTAS tapering begins after day 3 of a stay.
- The SLP and Nursing component payments will remain consistent through the length of the Medicare stay.

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More on Composition of PDPM

- Restorative Care will continue to benefit from the use of section G; however, no payment will be from the ADL index score generated from section G as current.

NOTE: Section G is projected to be removed from the MDS on Octoboer 1, 2020.

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More on composition of PDPM

- Skilled nursing categories continue to be determined by the resident's conditions and services through the RUGS IV classification system and will be collapsed to 25 (from 43) categories. Additionally, the ADL index will be based on scoring from section GG of the MDS.
- Physical therapy (PT) and occupational therapy (OT) will use the same scoring methodology based off of section GG.

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Nursing Considerations for PDPM

- Nursing uses depression symptoms and restorative nursing services to further adjust the case mix index score.
- It is common for residents with decrease in mood state to have change in care and restorative care needs.
- Non-therapy ancillary (NTA) services are used to adjust the case mix overall score as well and consist of a score for the number of comorbidities coded on the MDS. There are fifty comorbidity conditions considered for the NTA score.

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Section GG Items Included in the PT and OT Function Measures

Section GG Item		Score
GG0130A1	Self-care: Eating	0-4
GG0310B1	Self-care: Oral Hygiene	0-4
GG0130C1	Self-care: Toileting Hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4 (avg of 2 items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4 (avg of 3 items)
GG0170E1	Mobility: chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0-4 (avg of 2 items)
GG0170K1	Mobility: Walk 150 feet	

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Section GG Items Included in the PT and OT Function Measures

- Note – Bed Mobility, Transfer, and Walking item averages are rounded to determine the functional score.

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PT & OT Case-Mix Classification Groups

Clinical Category	Section GG Function Score	PT OT Case-Mix Group	PT Case-Mix Index	OT Case-Mix Index
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.49
	6-9	TB	1.69	1.63
	10-23	TC	1.88	1.68
	24	TD	1.92	1.53
Other Orthopedic	0-5	TE	1.42	1.41
	6-9	TF	1.61	1.59
	10-23	TG	1.67	1.64
	24	TH	1.16	1.15

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PT & OT Case-Mix Classification Groups

Clinical Category	Section GG Function Score	PT OT Case-Mix Group	PT Case-Mix Index	OT Case-Mix Index
Medical Management	0-5	TI	1.13	1.17
	6-9	Tj	1.42	1.44
	10-23	TK	1.52	1.54
	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27	1.30
	6-9	TN	1.48	1.49
	10-23	TO	1.55	1.55
	24	TP	1.08	1.09

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Cognitive Functional Score (CFS)

- CMS Proposes blending BIMS and CPS to get a CFS score.

PDPM Cognitive Scale (CFS)	BIMS Score	CPS Score
1- Cognitively Intact	13-15	0
2- Mildly Impaired	8-12	1-2
3- Moderately Impaired	0-7	3-4
4- Severely Impaired	-	5-6

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Nursing Case-Mix Classification

- 25 Nursing Indices.
- Will use a modified version of the RUG-IV Nursing Categories
- Reduced the number of Nursing RUGs from 43 to 25.
- Nursing will also use Section GG to capture the Nursing Function Score.
- Section G will still exist just not for payment. It will have a role with restorative care as will section GG.

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Nursing Case-Mix Classification

- Will use the same functional scoring methodology as for the PT and OT component.
- 0-4 point scale.
- Average bed mobility and transfers.

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Section GG items for Nursing

Section GG Item		Score
GG0130A1	Self-care: Eating	0-4
GG0130C1	Self-care: Toileting Hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4 (avg of 2 items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4 (avg of 3 items)
GG0170E1	Mobility: chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	

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Nursing Functional Score Construction

Responses		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	0

More Care Needed

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Section GG items for Nursing

- Note – Bed Mobility and Transfer item averages are rounded to determine the functional score.

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Nursing Case-Mix Classification

Nursing Classification				
Nursing Category	Conditions/Services	Conditions/Services Present	Section GG-Based Function Score	PDPM RUG
Extensive Services	Tracheostomy Care and Ventilator/Respirator	Yes	0-14	ES3
Extensive Services	Tracheostomy Care or Ventilator/Respirator	Yes	0-14	ES2
Extensive Services	Infection Isolation	Yes	0-14	ES1
Special Care High	Depressed	Yes	0-5	HDE2
Special Care High	Depressed	No	0-5	HDE1
Special Care High	Depressed	Yes	6-14	HBC2
Special Care High	Depressed	No	6-14	HBC1
Special Care Low	Depressed	Yes	0-5	LDE2
Special Care Low	Depressed	No	0-5	LDE1
Special Care Low	Depressed	Yes	6-14	LBC2
Special Care Low	Depressed	No	6-14	LBC1
Clinically Complex	Depressed	Yes	0-5	CDE2
Clinically Complex	Depressed	No	0-5	CDE1
Clinically Complex	Depressed	Yes	6-14	CBC2
Clinically Complex	Depressed	Yes	15-16	CA2
Clinically Complex	Depressed	No	6-14	CBC1
Clinically Complex	Depressed	No	15-16	CA1
Behavioral Cognitive Symptoms	Restorative Nursing Services	2 or More	11-16	BAB2
Behavioral Cognitive Symptoms	Restorative Nursing Services	0-1	11-16	BAB1
Reduced Physical Function	Restorative Nursing Services	2 or More	0-5	PDE2
Reduced Physical Function	Restorative Nursing Services	0-1	0-5	PDE1
Reduced Physical Function	Restorative Nursing Services	2 or More	6-14	PBC2
Reduced Physical Function	Restorative Nursing Services	2 or More	15-16	PA2
Reduced Physical Function	Restorative Nursing Services	0-1	6-14	PBC1
Reduced Physical Function	Restorative Nursing Services	0-1	15-16	PA1

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Nursing Case-Mix Classification

Nursing Component		
PDPM Nursing RUG	Function Score	CMI
ES3	0-14	4.04
ES2	0-14	3.06
ES1	0-14	2.91
HDE2	0-5	2.39
HDE1	0-5	1.99
HBC2	6-14	2.23
HBC1	6-14	1.85
LDE2	0-5	2.07
LDE1	0-5	1.72
LBC2	6-14	1.71
LBC1	6-14	1.43
CDE2	0-5	1.86
CDE1	0-5	1.62
CBC2	6-14	1.54
CA2	15-16	1.08
CBC1	6-14	1.34
CA1	15-16	0.94
BAB2	11-16	1.04
BAB1	11-16	0.99
PDE2	0-5	1.57
PDE1	0-5	1.47
PBC2	6-14	1.21
PA2	15-16	0.70
PBC1	6-14	1.13
PA1	15-16	0.66

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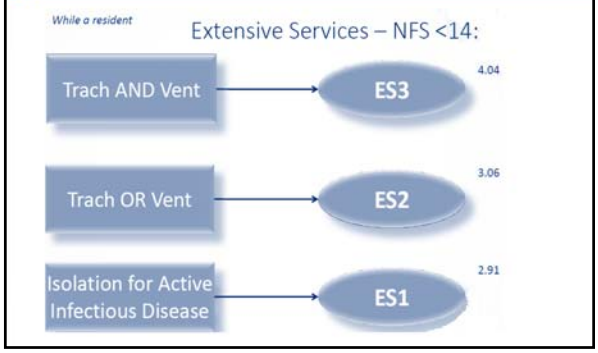
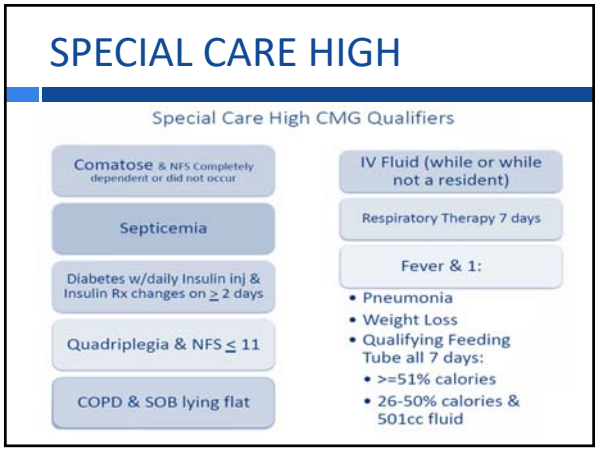
EXTENSIVE SERVICES



106

SPECIAL CARE HIGH



107

SPECIAL CARE HIGH

Nursing Classification				
Nursing Category	Conditions/Services	Conditions/Services Present	Section GG-Based Function Score	PDPM RUG
Special Care High	Depressed	Yes	0-5	HDE2
Special Care High	Depressed	No	0-5	HDE1
Special Care High	Depressed	Yes	6-14	HBX2
Special Care High	Depressed	No	6-14	HBX1

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SPECIAL CARE LOW

- Cerebral Palsy & NFS ≤ 11
- Multiple Sclerosis & NFS ≤ 11
- Parkinson's Disease & NFS ≤ 11
- Qualifying Tube Feeding (entire 7 days)
- Foot Infection, Diabetic foot ulcer, or open lesions on foot w/ dressings to feet.
- Radiation therapy while resident.
- Respiratory Failure and Oxygen therapy while resident.
- Dialysis while resident.

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SPECIAL CARE LOW (CONT'D)

Special Care Low

- >=2 St II PU & >=2 skin treatments
- >=1 St III, IV, or unstageable slough/eschar PU & >=2 skin treatments
- >=2 venous/arterial ulcers & >=2 skin treatments
- 1 St II PU & 1 venous/arterial ulcer & >=2 skin treatments.

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SPECIAL CARE LOW (CONT'D)

Nursing Classification				
Nursing Category	Conditions/Services	Conditions/Services Present	Section GG-Based Function Score	PDPM ROG
Special Care Low	Depressed	Yes	0-5	LDE2
Special Care Low	Depressed	No	0-5	LDE1
Special Care Low	Depressed	Yes	6-14	LDE2
Special Care Low	Depressed	No	6-14	LDE1

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CLINICALLY COMPLEX

Clinically Complex: Any ADL Score
Depression End Split 10 PHQ9/OV

Extensive Services, Special Care High or Low with an ADL score of <2
Pneumonia
Hemiplegia/Hemiparesis and NFS ≤ 11
Surgical wounds or open lesions w/treatment
Burns
Chemotherapy while resident
Oxygen therapy while resident
IV Medications while resident
Transfusions while resident

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CLINICALLY COMPLEX

Nursing Classification				
Nursing Category	Conditions/Services	Conditions/Services Present	Section GG-Based Function Score	PDPM RUG
Clinically Complex	Depressed	Yes	0-5	CDE2
Clinically Complex	Depressed	No	0-5	CDE1
Clinically Complex	Depressed	Yes	6-14	CBC2
Clinically Complex	Depressed	Yes	15-16	CA2
Clinically Complex	Depressed	No	6-14	CBC1
Clinically Complex	Depressed	No	15-16	CA1

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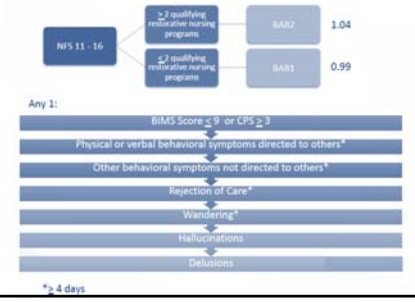
BEHAVIORAL & COGNITIVE

Behavioral Symptoms & Cognitive Performance



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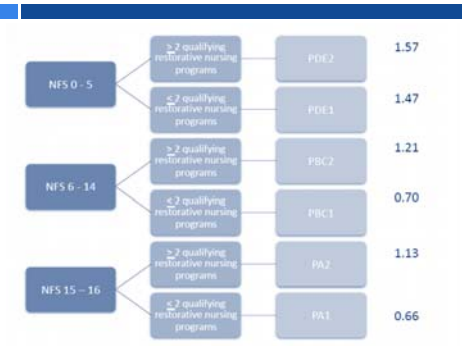
BEHAVIORAL & COGNITIVE

Nursing Classification				
Nursing Category	Conditions/Services	Conditions/Services Present	Section GG-Based Function Score	PDPM RUG
Behavioral Cognitive Symptoms	Restorative Nursing Services	2 or More	11-18	BAB2
Behavioral Cognitive Symptoms	Restorative Nursing Services	0-1	11-18	BAB1

115

REDUCED PHYSICAL FUNCTION



116

REDUCED PHYSICAL FUNCTION

Nursing Classification				
Nursing Category	Conditions/Services	Conditions/Services Present	Section GG-Based Function Score	PDPM RUG
Reduced Physical Function	Restorative Nursing Services	2 or More	0-5	PDE2
Reduced Physical Function	Restorative Nursing Services	0-1	0-5	PDE1
Reduced Physical Function	Restorative Nursing Services	2 or More	6-14	PBC2
Reduced Physical Function	Restorative Nursing Services	2 or More	15-16	PA2
Reduced Physical Function	Restorative Nursing Services	0-1	6-14	PBC1
Reduced Physical Function	Restorative Nursing Services	0-1	15-16	PA1

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Review of the NTA Component & Weighting Calculation related to Comorbidities

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Review of the NTA Component & Weighting Calculation related to Comorbidities

- Under PDPM, the NTA comorbidity score is the result of a weighted count of a patient's comorbidities, rather than using a simple count of comorbidities.
- Rationale: A simple count ignores the difference in relative costliness between different comorbidities.
- Additionally, looking at just the most costly comorbidity would ignore the effect of a patient having multiple comorbidities.

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Review of the NTA Component & Weighting Calculation related to Comorbidities

- To achieve this weighted count, each of the 50 comorbidities used under PDPM for NTA classification is assigned a certain number of points, between one and eight, based on its relative costliness.
- In order to determine the patient's NTA comorbidity score, a provider would identify all comorbidities for which a patient would qualify and then add the points for each comorbidity together.

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Review of the NTA Component & Weighting Calculation related to Comorbidities

- The resulting sum represents the patient's NTA comorbidity score, which is then used to classify the patient into an NTA component classification group.
- The table on the following slides lists each of the comorbidities used as part of determining the patient's NTA comorbidity score, as well as the source of this information and the associated number of points for that comorbidity.

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Review of the NTA Component & Weighting Calculation related to Comorbidities

NTA Component		
NTA Comorbidity Score	NTA Case Mix Group	CMI
12+	NA	3.25
9-11	NB	2.53
6-8	NC	1.85
3-5	ND	1.34
1-2	NE	0.96
0	NF	0.72

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Review of the NTA Component & Weighting Calculation related to Comorbidities

Conditions and Extensive Services Used for NTA Classification

Condition/Extensive Service	Source	Points
HIV/AIDS	SNF Claim	8
Parenteral IV Feeding: Level High	MDS Item K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	MDS Item O0100F2	4
Parenteral IV feeding: Level Low	MDS Item K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	MDS Item I8000	3

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Review of the NTA Component & Weighting Calculation related to Comorbidities

Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0100I2	2
Major Organ Transplant Status, Except Lung	MDS Item I8000	2
Active Diagnoses: Multiple Sclerosis Code	MDS Item I5200	2
Opportunistic Infections	MDS Item I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	MDS Item I6200	2
Bone/Joint/Muscle Infections/Necrosis - Except Aseptic Necrosis of Bone	MDS Item I8000	2
Chronic Myeloid Leukemia	MDS Item I8000	2
Wound Infection Code	MDS Item I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	MDS Item I2900	2

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Review of the NTA Component & Weighting Calculation related to Comorbidities

Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End-Stage Liver Disease	MDS Item I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	MDS Item M1040B	1
Narcolepsy and Cataplexy	MDS Item I8000	1
Cystic Fibrosis	MDS Item I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	MDS Item O0100E2	1

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Review of the NTA Component & Weighting Calculation related to Comorbidities

Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	MDS Item I1700	1
Special Treatments/Programs: Isolation Post-admit Code	MDS Item O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	MDS Item I8000	1
Morbid Obesity	MDS Item I8000	1
Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1
Highest Stage of Unhealed Pressure Ulcer - Stage 4	MDS Item M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1

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Review of the NTA Component & Weighting Calculation related to Comorbidities

Condition/Extensive Service	Source	Points
Chronic Pancreatitis	MDS Item I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	MDS Item M1040A, M1040B, M1040C	1
Complications of Specified Implanted Device or Graft	MDS Item I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	MDS Item H0100D	1
Inflammatory Bowel Disease	MDS Item I1300	1
Aseptic Necrosis of Bone	MDS Item I8000	1

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Review of the NTA Component & Weighting Calculation related to Comorbidities

Special Treatments/Programs: Suctioning Post-admit Code	MDS Item O0100D2	1
Cardio-Respiratory Failure and Shock	MDS Item I8000	1
Myelodysplastic Syndromes and Myelofibrosis	MDS Item I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	MDS Item I8000	1
Diabetic Retinopathy - Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Nutritional Approaches While a Resident: Feeding Tube	MDS Item K0510B2	1
Severe Skin Burn or Condition	MDS Item I8000	1

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Review of the NTA Component & Weighting Calculation related to Comorbidities

Intractable Epilepsy	MDS Item I8000	1
Active Diagnoses: Malnutrition Code	MDS Item I5600	1
Disorders of Immunity - Except : RxCC97: Immune Disorders	MDS Item I8000	1
Cirrhosis of Liver	MDS Item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS Item H0100C	1
Respiratory Arrest	MDS Item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS Item I8000	1

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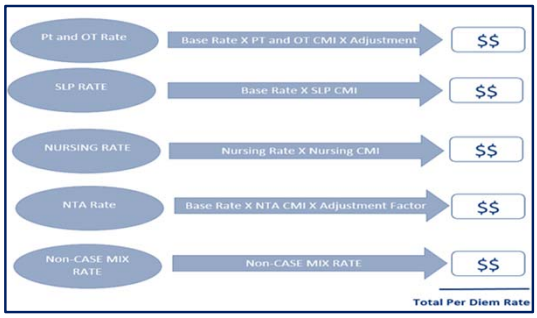
Putting it all together
Daily Per Diem Rate Calculation



130

Variable Per Diem Adjustment Factor

- Adjustment Factor:
- PT and OT: After day 20, drop 2% every 7 days.
- NTA Adjustment Factor:

Medicare Payment Days	Adjustment Factor
1-3	3.0
4-100	1.0

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Putting it all together

- Unadjusted base rates if PDPM had been implemented FY19:

FY 2019 PDPM Unadjusted Federal Rate Per Diem -- Rural						
Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case-Mix
Per Diem Amount	$98.83	$74.56	$67.63	$62.11	$27.90	$94.34
FY 2019 PDPM Unadjusted Federal Rate Per Diem -- Urban						
Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case-Mix
Per Diem Amount	$103.46	$78.05	$59.33	$55.23	$22.15	$92.63

- Note: *Labor cost adjustments will continue under PDPM*

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EXAMPLE TWO – Joint Replacement / Medically Complex

- Patient with multiple comorbidities (joint replacement, dysphagia and mech. altered diet, septicemia, depressed, 0-5 on GG, 12+ on NTA):
- PT and OT case-mix group –TA
- SLP case-mix group –SC
- Nursing PDPM case-mix group –HDE2
- Non-therapy ancillary –NA
- Non case-mix flat rate

133

Updated rules related to the IPA assessment.

- Under PDPM (effective October 1, 2019), there are 3 SNF PPS assessments: the 5-day Assessment, the Interim Payment Assessment (IPA) and the PPS Discharge Assessment.
- The 5-day assessment and the PPS Discharge Assessment are required.
- 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.

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Updated rules related to the IPA assessment.

- The schedule of PPS assessments under PDPM may be found in the table below.
- *Note – The IPA may not be combined with an OBRA Significant Change Assessment.

Medicare MDS assessment schedule type	Assessment reference date	Applicable standard Medicare payment days
5-day PPS Assessment	Days 1-8	All covered Part A days until Part A discharge (unless an IPA is completed).
Interim Payment Assessment (IPA)	The date the facility chooses to complete the IPA relative to the triggering event that causes the facility to choose to complete the IPA.	ARD of the assessment through Part A discharge (unless another IPA assessment is completed).
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A.

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Expected Changes to the MDS

- Update effective January 8, 2019:
- This assessment will be used for transitioning Part A patients from RUG-IV to PDPM on October 1, 2019 for those who were on Part A prior to October 1st.
- The MDS form for the IPA has been "unveiled" and will be included with the training materials for this presentation.

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Transition to PDPM

- There is no transition period between RUG-IV and PDPM.
  - RUG-IV billing ends September 30, 2019.
  - PDPM billing begins October 1, 2019.
- To receive a PDPM HIPPS code that can be used for billing beginning October 1, 2019, all providers will be required to complete an IPA with an ARD no later than October 7, 2019 for all SNF Part A patients.

137

PDPM Interrupted Stays & Restorative

- The payment calendar continues (using adjustment factors) if the resident is discharged from a SNF and returns to the same SNF within 3 midnights.
- If patient is discharged from SNF and readmitted more than 3 consecutive calendar days after discharge, or admitted to a different SNF, then the subsequent stay is considered a new stay.
- Assessment schedule and variable per diem schedule reset to day 1.

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Overview Patient-Driven Payment Model

- The PDPM model uses clinical conditions to determine the resident's therapy payment category.
- A major change between PPS and PDPM is that the focus shifts off of delivered minutes of rehab provided to overall clinical management.
- A marriage between clinical, rehab, health information for coding, with operations is needed for success!

139

PDPM Composition

- PDPM is composed of five case mix adjusted payment components and one non-case mix component:
  - Physical Therapy (PT)
  - Occupational Therapy (OT)
  - Speech Language Pathology (SLP)
  - Nursing
  - Non-Therapy Ancillaries Services (NTAS)
  - Non-Case Mix Component
- (room and board, admin cost, capital-related costs) + wage adjustment

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More on PDPM Composition

- Payments would taper for PT, OT, and NTAS but beginning on different days of the resident's stay.
- The separate PT and OT components begin to taper after day 20. NTAS tapering begins after day 3 of a stay.
- The SLP and Nursing component payments will remain consistent through the length of the Medicare stay.

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More on Composition of PDPM

- Skilled nursing categories continue to be determined by the resident's conditions and services through the RUGS IV classification system and will be collapsed to 25 (from 43) categories. Additionally, the ADL index will be based on scoring from section GG of the MDS.
- Physical therapy (PT) and occupational therapy (OT) will use the same scoring methodology.

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More on PDPM Composition

- Speech and language pathology treatment has a different scoring method.
- PT, OT, and nursing categories use the resident's functional scores from MDS Section GG to adjust case mix.
- All residents would be classified into PT, OT, and SLP classifications regardless of whether they are on therapy case load.

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Nursing Considerations for PDPM

- Nursing uses depression symptoms and restorative nursing services to further adjust the case mix index score.
- Non-therapy ancillary (NTA) services are used to adjust the case mix overall score as well and consist of a score for the number of comorbidities coded on the MDS. There are fifty comorbidity conditions considered for the NTA score.

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PT and OT Components

- PT and OT Case Mix components are calculated in the same manner, but paid separately based on separate case-mix indices.
- Drivers of PT and OT component:
  - Primary reason for skilled stay
    - Utilizes diagnosis codes in conjunction with specified surgical procedures to classify residents into one of four PT and OT clinical categories.
  - Function Score.

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PT and OT Components

- Selection of the primary reason for skilled stay:
  - Determine the resident's primary diagnosis
    - This code will be entered into item I0200B if I0020 is coded as reasons 1-13.
      - Per CMS update on November 19th, this will be a new item added to the MDS for the October 1, 2019 PDPM effective date.
    - Some codes may map to more than one clinical category.

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PT and OT Components

- Selection of the primary reason for skilled stay:
  - Further delineation may be made into a surgical category based on specific procedures that occurred during the inpatient hospitalization.
    - Surgical Procedure Category will be selected under new MDS items J2100 – J5000.
      - These will be check boxes similar to the major condition categories in Section I.

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Review of new MDS Items

Item	Surgical Procedure Category
J2100	Recent Surgery Requiring Active SNF Care
J2300	Knee Replacement - partial or total
J2310	Hip Replacement - partial or total
J2320	Ankle Replacement - partial or total
J2330	Shoulder Replacement - partial or total
J2400	Spinal surgery - spinal cord or major spinal nerves
J2410	Spinal surgery - fusion of spinal bones

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Review of new MDS Items

Item	Surgical Procedure Category
J2420	Spinal surgery - lamina, discs, or facets
J2499	Spinal surgery - other
J2500	Ortho surgery - repair fractures of shoulder or arm
J2510	Ortho surgery - repair fractures of pelvis, hip, leg, knee, or ankle
J2520	Ortho surgery - repair but not replace joints
J2530	Ortho surgery - repair other bones
J2599	Ortho surgery - other

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Review of new MDS Items

J2600	Neuro surgery - brain, surrounding tissue or blood vessels
J2610	Neuro surgery - peripheral and autonomic nervous system - open and percutaneous
J2620	Neuro surgery - insertion or removal of spinal and brain neurostimulators, electrodes, catheters, and CSF drainage devices
J2699	Neuro surgery - Other
J2700	Cardiopulmonary surgery - heart or major blood vessels - open and percutaneous procedures
J2710	Cardiopulmonary surgery - respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords – open and endoscopic
J2799	Cardiopulmonary surgery - Other

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Review of new MDS Items

J2800	Genitourinary surgery - male or female organs
J2810	Genitourinary surgery - the kidneys, ureter, adrenals, and bladder—open, laparoscopic
J2899	Other major genitourinary surgery
J2900	Major surgery - tendons, ligament, or muscles
J2910	Major surgery - the GI tract and abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, spleen—open or laparoscopic
J2920	Major surgery - endocrine organs (such as thyroid, parathyroid), neck, lymph nodes, and thymus—open
J2930	Major surgery - the breast
J2940	Major surgery - repair of deep ulcers, internal brachytherapy, bone marrow, or stem cell harvest or transplant
J5000	Major surgery - Other not listed above

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PT and OT Components

- Selection of the primary reason for skilled stay:
  - Utilizing the primary diagnosis and any surgical procedure, the resident will be categorized into one of the four major clinical categories:
    - Major joint replacement or spinal surgery
    - Other orthopedic
    - Non-orthopedic surgery
    - Medical Management

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PT and OT Components

Major Joint Replacement or Spinal Surgery	
ICD-10-CM Code	**Description**
M970-	Periprosthetic fracture around internal prosthetic hip joint
M971-	Periprosthetic fracture around internal prosthetic knee joint
M973-	Periprosthetic fracture around internal prosthetic shoulder joint
S120-	Unspecified displaced (or nondisplaced) fracture of first cervical vertebra
S22001-	Stable burst fracture of unspecified thoracic vertebra
S32001-	Stable burst fracture of unspecified lumbar vertebra
T84010-	Broken internal right hip prosthesis
T84011-	Broken internal left hip prosthesis
T84012-	Broken internal right knee prosthesis
T84013-	Broken internal left knee prosthesis
Z471	Aftercare following joint replacement surgery

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PT and OT Components

PT and OT Clinical Category	Primary Diagnosis Clinical Category
Major Joint Replacement or Spinal Surgery	• Major Joint Replacement • Spinal Surgery
Other Orthopedic	• Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) • Non-Surgical Orthopedic/Musculoskeletal

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PT and OT Clinical Categories

PT and OT Clinical Category	Primary Diagnosis Clinical Category
Non-Orthopedic Surgery and Acute Neurologic	• Non-Orthopedic Surgery • Acute Neurologic
Medical Management	• Acute Infections • Cardiovascular and Coagulations • Pulmonary • Cancer • Medical Management

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16 PT and OT Case-Mix Groups

Clinical Category	Function Score	PT Case Mix Group	CMI
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53
Major Joint Replacement or Spinal Surgery	6-9	TB	1.69
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88
Major Joint Replacement or Spinal Surgery	24	TD	1.92
Other Orthopedic	0-5	TE	1.42
Other Orthopedic	6-9	TF	1.61
Other Orthopedic	10-23	TG	1.67
Other Orthopedic	24	TH	1.16
Medical Management	0-5	TI	1.13
Medical Management	6-9	TJ	1.42
Medical Management	10-23	TK	1.52
Medical Management	24	TL	1.09
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08

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PT and OT Functional Score

- 10 Section GG items will be used to calculate the PT and OT Function Score. This includes 4 late loss ADLs and 2 early loss ADLs:
  - Two bed mobility items
  - Three transfer items
  - One eating items
  - One toileting item
  - One oral hygiene item
  - Two walking items
- GG has a 6-point scale (with 3 not attempted codes) to calculate a 0-4 point scale for Function Score purposes

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PT and OT Functional Score Construction

Responses		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	0

More Care Needed

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Section GG Items Included in the PT and OT Function Measures

Section GG Item		Score
GG0130A1	Self-care: Eating	0-4
GG0310B1	Self-care: Oral Hygiene	0-4
GG0130C1	Self-care: Toileting Hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4 (avg of 2 items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4 (avg of 3 items)
GG0170E1	Mobility: chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0-4 (avg of 2 items)
GG0170K1	Mobility: Walk 150 feet	

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Section GG Items Included in the PT and OT Function Measures

- Note – Bed Mobility, Transfer, and Walking item averages are rounded to determine the functional score.

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SLP Component

- Five Characteristics that will impact the SLP Component
- Acute Neurologic or Non-Neurologic
- SLP-Related Comorbidity
- Cognitive Impairment
- Mechanically Altered Diet
- Swallowing Disorder

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SLP Component

- The ST Case Mix component utilizes diagnosis codes to classify residents into neurologic or non-neurologic clinical categories.
  - Also utilizes diagnosis coding to capture SLP related comorbidities.
    - Oral Cancers
    - Speech Language Deficits

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SLP Component

- The following comorbidities will be pulled from Section I – Active Conditions of the MDS
- Item I4300. Aphasia
- Item I4500. CVA, TIA, Stroke
- Item I4900. Hemiplegia or Hemiparesis
- Item I5500. Traumatic Brain Injury

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SLP Component

- The following comorbidities will be pulled from Section I – Active Conditions of the MDS
- Item I8000.
  - Laryngeal Cancer
  - Apraxia
  - Dysphagia
  - ALS
  - Oral Cancers
  - Speech and Language Deficits

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SLP-Related Comorbidities

Aphasia	Laryngeal Cancer
CVA, TIA, or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy Care (while a resident)	Oral Cancers
Ventilator or Respirator (while a resident)	Speech and Language Deficits

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SLP Component

Condition	ICD-10-CM Code	Description
Speech and Language Deficits	I69.928	Other speech and language deficits following unspecified cerebrovascular disease
Speech and Language Deficits	I69.920	Aphasia following unspecified cerebrovascular disease
Speech and Language Deficits	I69.921	Dysphasia following unspecified cerebrovascular disease
Speech and Language Deficits	I69.922	Dysarthria following unspecified cerebrovascular disease
Speech and Language Deficits	I69.923	Fluency disorder following unspecified cerebrovascular disease
Speech and Language Deficits	I69.928	Other speech and language deficits following unspecified cerebrovascular disease

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SLP Component

- Additional factors utilized to adjust case mix index calculation
- Mechanically Altered Diet
  - Determined by K0510C2
- Swallowing Disorder
  - Determined by K0100
- Cognitive Impairment
  - Determined by C0500 or C1000

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12 SLP Case-Mix Groups

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case Mix Group	CMI
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.66
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97
Any two	Neither	SG	2.04
Any two	Either	SH	2.85
Any two	Both	SI	3.51
All three	Neither	SJ	2.98
All three	Either	SK	3.69
All three	Both	SL	4.19

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HIV/AIDS add-on

- Due to the significant increase in nursing cost to care for HIV/AIDS patients, the facility will get an 18% increase in the Nursing Component.
- This would be applied based on the presence of ICD-10-CM code B20 on the SNF claim.

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Non Case-Mix Component

- Flat rate.
- Non case-mix adjusted.

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EXAMPLE ONE – Hip Replacement

- Mr. T had a hip replacement and was sent for rehab at our SNF. His case-mix groups are as follows:
- PT and OT case-mix group –TA
- SLP case-mix group –SA
- Nursing PDPM case-mix group –CDE2
- Non-therapy ancillary –NE
- Non case-mix flat rate

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EXAMPLE – Hip Replacement

Case Mix Group	TB	TB	SA	CDE2	NE	
Case Mix Index	1.69	1.63	.68	1.86	.96	
Urban	PT	OT	SLP	NURSING	NTA	Non-Case Mix
Per Diem	$59.33	$55.23	$22.15	$103.46	$78.05 X 3	$92.63
Subtotal	$100.27	$90.02	$15.06	$192.44	$224.78	$92.63

*Note: these rates are not wage index adjusted

DAYS	PER DIEM
1-3	$715.20
4-20	$565.35
21-27	$561.54

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EXAMPLE TWO – Joint Replacement / Medically Complex

- Patient with multiple comorbidities (joint replacement, dysphagia and mech. altered diet, septicemia, depressed, 0-5 on GG, 12+ on NTA):
- PT and OT case-mix group –TA
- SLP case-mix group –SC
- Nursing PDPM case-mix group –HDE2
- Non-therapy ancillary –NA
- Non case-mix flat rate

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EXAMPLE TWO – Joint Replacement / Medically Complex

Case Mix Group	TA	TA	SC	HDE2	NA	
Case Mix Index	1.53	1.49	2.66	2.39	3.25	
Urban	PT	OT	SLP	NURSING	NTA	Non-Case Mix
Per Diem	$59.33	$55.23	$22.15	$103.46	$78.05 X 3	$92.63
Subtotal	$90.77	$82.29	$58.91	$247.26	$760.98	$92.63

*Note: these rates are not wage index adjusted

DAYS	PER DIEM
1-3	$1,332.87
4-20	$825.54
21-27	$822.08

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Transition to PDPM

- October 1, 2019 will be considered Day 1 of the VPD schedule under PDPM, even if the patient began their stay prior to October 1, 2019.
- Any "transitional IPAs" with an ARD after October 7, 2019 will be considered late and relevant penalty for late assessments would apply.

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Presumption of Coverage under PDPM

- If the patient meets **any** of the following four PDPM-related criteria , the patient qualifies for the presumption:

1. Nursing groupers that classify into the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories.

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Presumption of Coverage under PDPM

2. PT and OT groups TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN and TO.
3. SLP groups SC, SE, SF, SH, SI, SJ, SK and SL.
4. The NTA component's uppermost (12+) comorbidity group.

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PDPM Modes of Therapy

- Group and Concurrent Therapy Limits to 25% combined.
- Most services provided on an individual basis.

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PDPM Modes of Therapy

- Group and Concurrent minutes counted in full vs ¼ and ½ respectively.
- CMS will use the Discharge Assessment to monitor Group and Concurrent utilization.
- If a provider exceeds this limitation, a non-fatal warning edit will appear on the validation report after submission to the QIES ASAP system.
- CMS may consider future proposals to address abuses of this policy or flag providers for additional review.

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PDPM Interrupted Stays

- The payment calendar continues (using adjustment factors) if the resident is discharged from a SNF and returns to the same SNF within 3 midnights.
- If patient is discharged from SNF and readmitted more than 3 consecutive calendar days after discharge, or admitted to a different SNF, then the subsequent stay is considered a new stay.
- Assessment schedule and variable per diem schedule reset to day 1.

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PDPM Interrupted Stays

- The readmission source is irrelevant:
- Hospital
- Home
- Other health care facility

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Review of new MDS Items

- New MDS Item Sets: IPA and OSA
- There are two new item sets that have been created as a result of PDPM.
- First, the IPA has its own IPA item set. This item set contains merely payment items and demographic items, as necessary to attain a billing code under PDPM.
- (Note: A draft IPA form for the MDS will be included with this training)

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Review of new MDS Items

- Second, for states that rely on the RUG- III & IV assessment schedule for calculating case mix group for NF patients, CMS has created an optional assessment so that Medicaid payments are not adversely impacted when PDPM is implemented as of October 1, 2019.
- States will have the ability to determine the policy associated with this assessment to meet Medicaid payment needs.

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Review of new MDS Items

- The optional assessment will be in place from October 1, 2019 through September 30, 2020.

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Review of new MDS Items

- New MDS Item: Section I: SNF Primary Diagnosis
- To capture the patient's primary diagnosis, which is used to classify the patient into a PDPM clinical category, CMS added Item I0200B.
- This allows providers to report, using an ICD-10-CM code, the patient's primary SNF diagnosis.

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Review of new MDS Items

- New MDS Item: Section I: SNF Primary Diagnosis
- The item will ask "What is the main reason this person is being admitted to the SNF?"
- Item I0200B will be coded when Item I0020 is coded as any response 1 – 13.

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Review of new MDS Items

- New MDS Items: Section J: Patient Surgical History
- In order to capture surgical information which may be relevant to classifying the patient into a PDPM clinical category, CMS is adding new items in Section J of the MDS.
- These items are Items J2100 – J5000.
- These items are used to capture any major surgical procedures that occurred during the inpatient hospital stay that immediately preceded the SNF admission, i.e., the qualifying hospital stay.

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Review of new MDS Items

- New MDS Items: Section J: Patient Surgical History
- These items will be used, in conjunction with the diagnosis code captured in I0020B, to classify patients into the PT and OT case-mix classification groups for PDPM.
- Similar to the active diagnoses captured in Section I, these Section J items will be in the form of check-boxes.

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Review of new MDS Items

- New MDS Items: Section O: Discharge Therapy Items:
- In order to capture therapy delivery information over the course of a patient's entire Part A stay, as it relates to the concurrent and group therapy limit under PDPM, CMS added Items 0425A1 – O0425C5 which will be added to Section O of the MDS.

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Review of new MDS Items

- New MDS Items: Section O: Discharge Therapy:
- Using a lookback period of the entire PPS stay, providers will report, by each discipline and mode of therapy, the amount of therapy (in minutes) received by the patient.
- If the total amount of Group/Concurrent minutes, combined, comprises more than 25 percent of the total amount of therapy for that discipline, a warning message will be issued on the final validation report.

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Review of new MDS Items

- New MDS Item: Section GG: Interim Performance:
- On the IPA, GG items will be derived from a new column “5”, which will capture the interim performance of the patient.
- The look-back for this new column will be a three day window preceding and up to the ARD of the IPA.

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Review of new MDS Items

- Existing MDS Items Added to PPS Item Sets:
- There are several existing MDS items that are being added to PPS item set as part of PDPM implementation.
- There will be several existing MDS Items added to the “Swing Bed” PPS Assessment.

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Review of new MDS Items

- Existing MDS Items Added to PPS Item Sets:
- A swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide post-hospital SNF care and meets certain requirements.

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Review of new MDS Items

- Existing MDS Items Added to PPS Item Sets:
- Items added to the swing bed PPS assessment are:
  - K0100: Swallowing Disorder,
  - I4300: Active Diagnosis: Aphasia, and
  - O0100D2: Special Treatments, Procedures and Programs: Suctioning, While a Resident.

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Review of new MDS Items

- Existing MDS Items Added to PPS Item Sets:
- Until now, these items have not been part of the Swing Bed PPS Assessment form because they have not been used for payment.
- However, each of these items will now be used to classify swing bed residents under PDPM.

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A Few Closing Comments

- Restorative Care is an important part of your facility programing.
- It is important to assure those that work in restorative are knowledgeable of the resident assessment instrument (RAI) and able to participate in the applicable areas of the MDS and CAAs.
- CMS encourages person centered care using a holistic approach hence the importance of assuring the resident and or their representative is included.
- F676 – is Quality of Life 483.24 (a)(1)(b)(1)(i)-(iii)
- F688 – is Quality of Care 483.25 (c)(1)-(3).

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A Few More Closing Comments

- The PDPM program differs from the PPS program in that rehab minutes are not the defining determination for the RUG rates for those who have had a start of therapy (SOT).
- The PDPM per diem rate will be based upon the sum of six individual components.
- Five of these components are case mix adjusted.
- The PT and OT components have an adjustment factor, which reduces the base rate by 2% for each successive seven day period after day 20.

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Summary – cont'd

- The NTA component has an adjustment factor multiplied by 3.0 for the first three days, then 1.0 thereafter.
- For PDPM purposes only a 5 days PPS and discharge assessments will be required.
- However, an Interim payment assessment (IPA) may be completed to capture significant changes in resident condition during the stay.
- It is recommended to review the requirements of significant change which the IPA is integrated with. This can be found in the RAI Manual, Chapter 2.

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Q & A

Questions???

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