Guiding the Way

Partnering for Success in the Patient Driven Payment Model (PDPM)

SNF Provider Review
July 2020

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PDPM | Changing the Course of Patient-Centered Care

Program Started October 1

Largest Change to SNF Prospective Payment System Since Inception

PDPM is still Considered a Positive Change from RUGs Based Payment Methodology

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Agenda:

Review of the naviHealth Clinical Model

Aligning on Definitions

Request for CMG Level Changes

CMG to HIPPS Code Conversion

MDS Discussion

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Review of naviHealth Clinical Model

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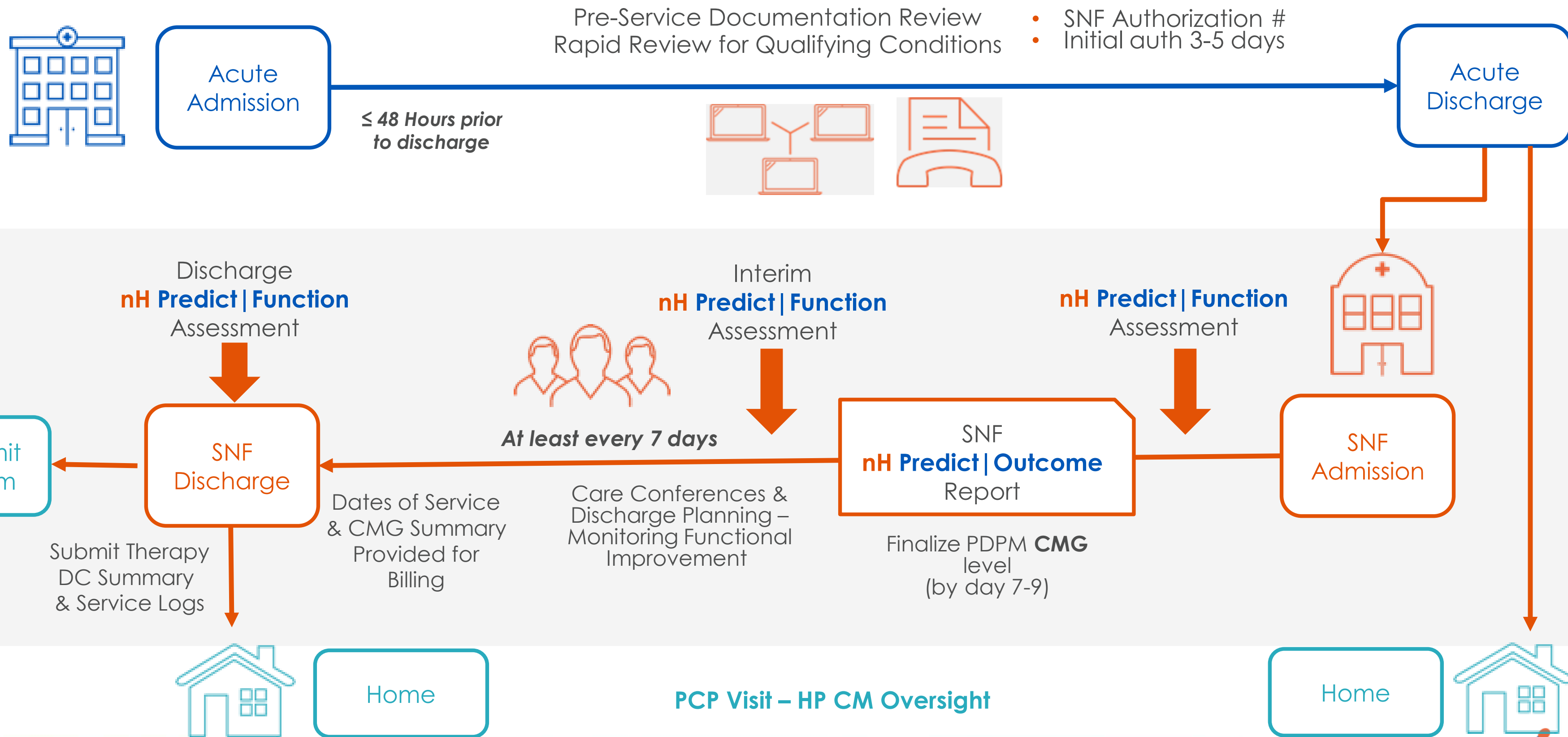
nH Predict: Best Practice Workflow



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Aligning on Definitions

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Aligning on Definitions

Active Diagnosis[1]:

- *"Physician documented diagnoses in the last 60-days that have a **direct relationship** to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death during the 7-day look back period.*
- *This does not include conditions that have **been resolved**, do not affect the resident's current status, or **do not drive the reside plan of care** during the 7 day look back period as these would be considered inactive diagnoses"*

Utilization Management (UM)[2]:

- *"The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provision of the applicable health benefits plan….."*

Types of UM:

Prospective:

Conducted at the onset of treatment, aka Prior Auth., the review is completed before care is rendered in order to eliminate or reduce unnecessary services. May have the impact of reducing care previously recommended by a provider

Concurrent:

Proactive reviews performed during the course of treatment or episode of care. Activities such as: Care Coordination, Discharge Planning, and Care Transitioning. Concurrent review may have an impact of reducing unnecessary services or reducing an existing episode of care

Retrospective:

Reviews conducted after the service has been complete. Assesses the appropriateness of the procedure, setting and timing in accordance with specified criteria. Such reviews often relate to payment and may result in a denial. Financial risk for a retrospective denial is often borne by the provider

1 CMS RAI Manual https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html
2 https://www.apta.org/WhatIsUM/

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Request for CMG Level Change

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Requesting a CMG Level Reassessment

Provider May Request Change in Primary Dx or Any of the Four CMG Groups

- Requests for changes in CMG level occur after admission to SNF
- Supportive clinical documentation is sent to naviHealth Care Coordinator
- Documentation is reviewed for:
  - Presence
  - Relevance
  - Active state
  - Medical/treatment intervention required in SNF
- MD review is possible:
  - M.D. makes final determination
  - CMG level determination is not a denial of SNF skilled services
  - naviHealth goal – deliver to SNF the final CMG determination within 48 hours of SNF request

Requests for CMG level changes should be made as soon as practical
No later than patient’s discharge date

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PT/OT CMG Level Change Request

- Generally seeing strong alignment on determining the primary Dx.
- naviHealth is not dependent upon the provider’s completion of section GG
- The interpretation of “usual performance” may be subjective
- naviHealth uses PT/OT/ST evaluations to determine functional level on admission
- Requests for Change in PT/OT CMG will be considered – based on clinical documentation in the medical record

CMS RAI Version 3.0 Manual pg. 37 GG-10; https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

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Speech, Nursing & NTA CMG Level Change Request

Determining and Confirming Clinical Conditions:

Beyond Presence of In order to capture a clinical condition that condition must be:

- Active
- Relevant
- Appropriate Medical/Clinical Treatment Plan

Sufficient supportive clinical documentation must be provided

- Most recent H&P
- Transfer Documents
- Physician Progress Notes
- Discharge Summary
- Nursing Assessment
- Nursing Care Plan
- Medication Sheets
- Doctor's Orders
- Consults
- Diagnostic Reports

Provide to Care Coordinator as soon as practical

- If there is a clinical condition that is active and relevant to the treatment needs of the patient – it should be identified, assessed, and documented well before the completion of the MDS
- Prior to patient discharge

Requests for reassessment of CMG level change may require physician review

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CMG to HIPPS Conversion

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CMG Level

- Clinical Level of Care
- Two to Four Alpha/Numeric Characters for each of the 4 CMGs
- Clinical language spoken between the clinicians overseeing the care of the patient

CMG & DOS Summary provided at time NOMNC delivered

HIPPS Code

- Used to inform Reimbursement Rate
- One Alpha Character for each of the 4 CMGs and
- One Numeric Character for MDS Assessment Type
- Financial language spoken between business office and health plan

MEMBER JOURNEY

HIPPS Code Generation Process

CMG Level (naviHealth authorized) + Assessment Type = HIPPS Code

Example:

Authorized by naviHealth SICC

Approved CMG Level

PT/OT Case Mix Group: TN
SLP Case Mix Group: SH
Nursing Case Mix Group: CBC2
NTA Case Mix Group: NC

Corresponding HIPPS Code

N	H	N	C	

5th HIPPS code is Assessment Type

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MDS

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MDS Assessment OBRA vs. PPS

- Identifying resident care problems – informing care plan – OBRA Admission Assessment – Required
- Determine reimbursement rate for Medicare Part A FFS Beneficiaries – PPS 5-day Assessment
- The Benefits of the OBRA Required Admission Assessment
  - Fewer sections to complete
  - More lead time to complete
  - Section GG is not required
  - Eliminates the focus on 'matching' the MDS to the care authorized or vice versa
  - Eliminates the need to override the MDS generated level of care
  - Level of care authorized recorded on UB04
  - High degree of confidence in Health Plan Eligibility File
  - Does not eliminate the request to reassess CMG process

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MDS: Coding Considerations

MDS Section	Code	Identifies
A0310A	01	OBRA Required Assessment
A0310B	99	Assessment is NOT PPS Related
A2400A	0	Resident is NOT in a Medicare Part A Covered Stay

Use Caution and Care

- Coding a Medicare Advantage Organization member as a Medicare Part A member on A2400A is in conflict to the RAI manual instructions
- Submitting assessments marked as PPS to CMS when a facility is not seeking payment for a Medicare part A stay may be considered a violation of HIPAA's minimum necessary standard[1]

1. https://qtso.cms.gov/system/files/qtso/20141021_VendorQ%26A_1-15_Consolidatedv1.pdf

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For Additional Information

Visit the naviHealth PDPM Resource Page to access:

- Important Documents
- Links to Industry News

- To schedule a local training on naviHealth payment and PDPM, please contact your naviHealth Provider Relations Manager

http://navihealth.com/partners/pdpm/resources/

The Patient Driven Payment Model (PDPM) - Information and Resources for Provider Partners

PDPM begins October 1, 2019 and represents the largest change to the Skilled Nursing Facility (SNF) Prospective Payment System since its inception. The information and resources on this page are designed to help our provider partners understand the changes that will occur as the result of moving away from RUG-IV.

Scroll down for information and resources to get you started

Resources

We've pulled together the most important and relevant documentation to make things as easy as possible for you and your team.

Presentation: Partnering for Success in the Patient Driven Payment Model (PDPM)

Clinical Documentation Submission Requirements - Preservice Only

Clinical Documentation Submission Requirements - SNF

CMS Facts Sheet, FAQs and Training

Fax Cover Sheet (SNF)

Frequently Asked Questions for SNFs

Frequently Asked Questions for Hospitals

HIPPS Coding Crosswalk

HIPPS Code Process Memo

HIPPS Coding Provider Education

Minimum Data Set (MDS) Overview for Providers

Patient Driven Payment Model - Acute Provider Overview

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