PDPM Playbook

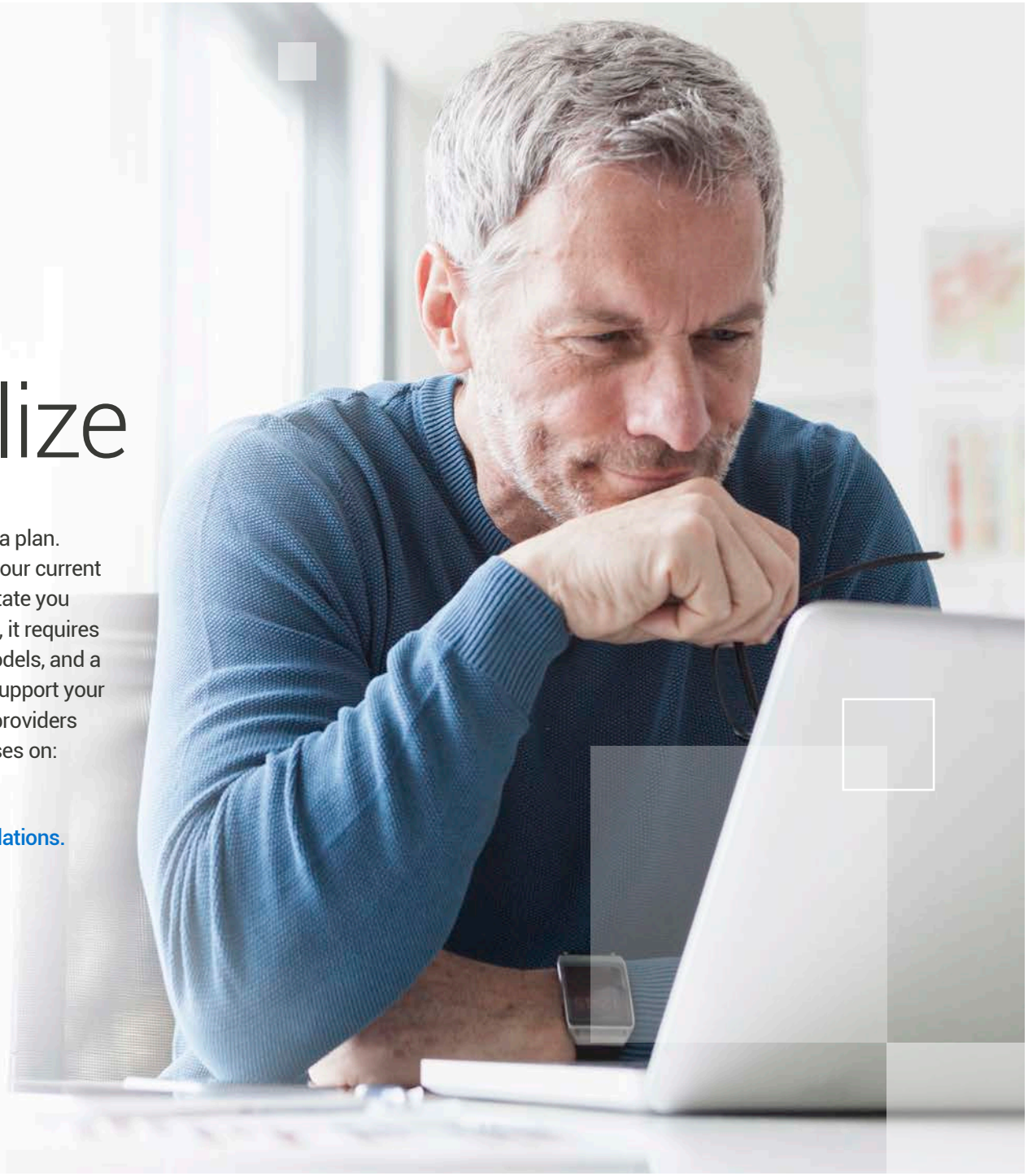
Stage 1: Conceptualize

The first step in your PDPM journey is developing a plan. You can't make changes unless you understand your current state and have a clear understanding of the end state you want to achieve. PDPM is not just a payment shift, it requires a cultural change in care delivery, care delivery models, and a clear understanding of how your technology will support your PDPM journey. To be successful through PDPM, providers will require a change management plan that focuses on:

Optimizing reimbursement.

Addressing their facility's changing resident populations.

Preparing for the impact of the change.



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In the Conceptualize stage of your journey, you should be reviewing the potential impact of PDPM, determine and examine workflows and know what needs to change, understand what education and upskilling staff may need to get you to your end state and understand how referral partners will support you in this transition. You should also initiate any Quality Assurance and Performance Improvement (QAPI) plans to track progress for Requirements of Participation (RoP).

Understand PDPM's Business Impact

The current RUGS payment model incentivizes the volume of therapy minutes provided. PDPM is intended to appropriately reimburse providers for treating the patient specific needs holistically. Understanding the impact of this change on care and billing processes is the key to a successful journey through PDPM.

Review the CMS SNF PDPM Provider Specific Impact Analysis.

- The impact file estimates PDPM's financial impact on your facility.
- Are you in the red or black?
- How does the rescoring affect nursing case mix and therapies?
- What would you need to change to achieve your revenue goals in the coming years?

Review your Facility Assessment to determine the resources you require

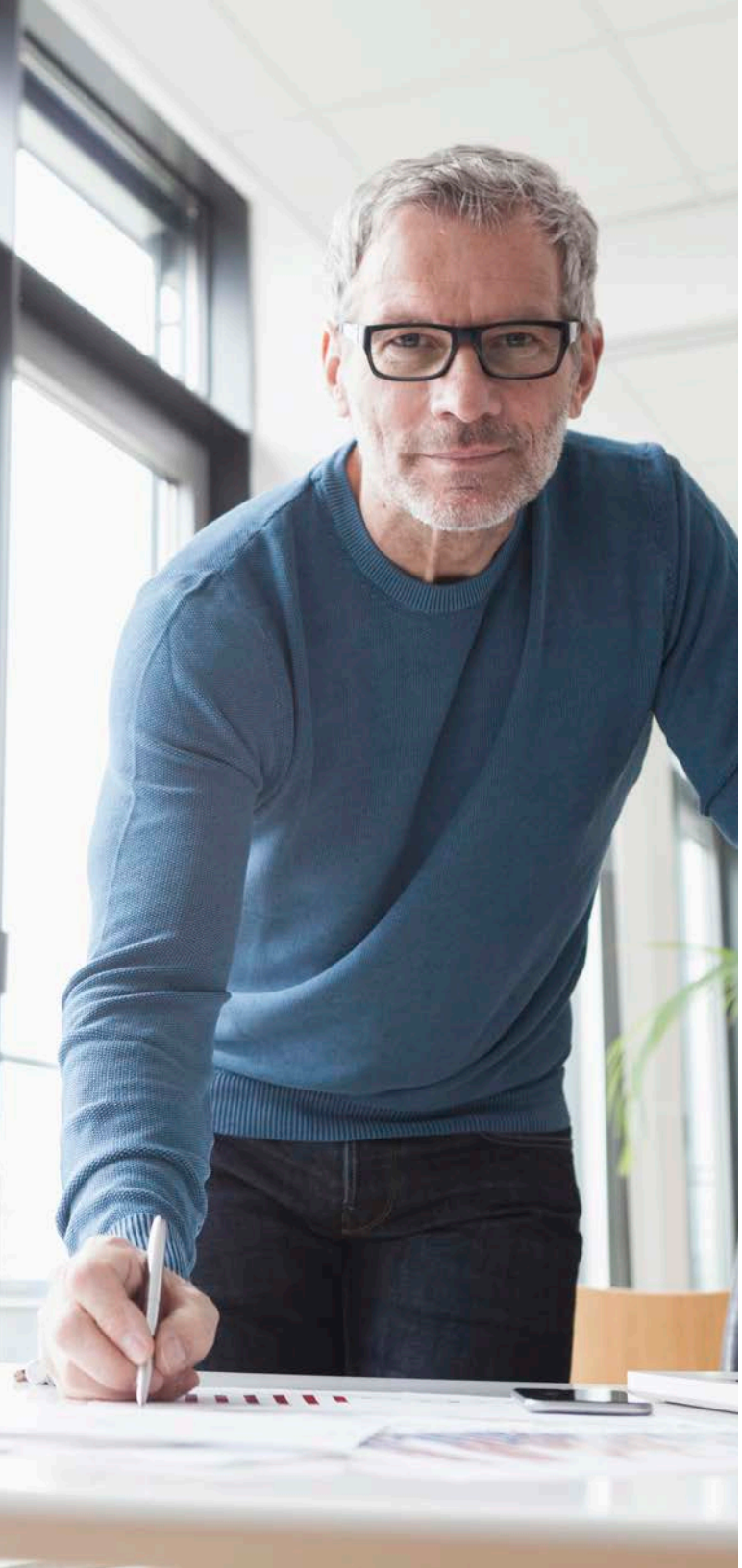
- Will current resident mix support revenue targets?
- What needs to immediately change to reduce risk in the future?
- Does your quality mix include medically complex residents? Under RUGS payment model, these residents may have been challenging to take and ensure you could cover all your costs. Under PDPM, the reimbursement for the care of clinically complex residents is much more attractive.
- Do you need to connect with referral partners to educate them on what referrals are important to you and whether they can help your achieve case mix goals?

Document and review all processes related to MDS management and reimbursement

- Payer identification. PDPM only affects Medicare A, all other payers continue with their dictated practices. Payer source drives the MDS assessment schedule, item set and the completion dates. Getting the payer right is even more important with PDPM. Missed assessments or timing can be costly.
- Problem/Diagnosis list and ranking
- Pre-admission and Admission data collection
- Ongoing assessment, monitoring and observation. What tools are needed to ensure a best practice cadence of assessments to meet skilled nursing standards?
- MDS Coding practices – with focus on section GG
- Skilled documentation across disciplines.
- Triple checks.

Understand the impact of therapy on case mix and revenue.

- CMS has stated that homes that dramatically reduce the use of therapies after implementation will be at greater risk for audits. Do you need to reduce therapy provision to avoid future audits? Dramatic drops in therapy provision for similar characteristics pre and post PDPM are predicted to increase litigation risk as well.
- What is the impact on therapy contracts?
- What are the clinical needs of the rehab clients your serve?



Audit ICD-10 codes for accurate and comprehensive diagnosis coding to ensure adequate resourcing

In PDPM, the ICD-10 code selected will drive reimbursement in OT/PT/NTA and SLP Case Mix Groups. Comprehensive diagnosis coding and ensuring those codes are on the MDS is something that facilities can change now. There must be a clear understanding of how the codes map to clinical categories for payment, and how the decision on which code will support the resources needed to care for the conditions and clinical characteristics of the resident.

Audit ICD-10 codes

- Does the primary diagnosis selected map to a clinical category under PDPM?
- How do current coding practices need to change with PDPM given the Primary Dx effect on Therapies? Is a change in process needed? Is there clear understanding of "Why the resident is here?" What are the true clinical needs of the resident and how is that captured in the record?
- Review the chart – were co-morbidities missed? Focus on the NTA and SLP co-morbidities that drive reimbursement.
- How is the doctor involved in the process? What information does he need to code under PDPM?
- How can technology help expedite communication and improve coding accuracy?
- Is there adequate supportive documentation for the primary and all other diagnosis in the record?

    How are these reflected in the record and where is the documentation routinely found? Does the care plan reflect the clinical needs of the resident as reflected in their diagnosis lists?

Audit Records and Referrals

There is only one chance to get this right – the five-day payment assessment. You don't want to have to be redoing assessments and creating modifications. This means that homes will need to understand what information is needed on admission to comprehensively code that 5-day assessment and what can be collected before admission to expedite the process on admission. You should not only be looking at the tools used to collect the information but also sources – patients and their families are excellent sources of information. You should also examine coding practices between the 5 and 14 day, determine upcoding on the 14 day and how to get the required information in a timelier manner. Oftentimes, detailed surgery information is not available until discharge summaries are completed by the hospital, which could be a week of more after discharge.

Review 5-day MDS for PDPM data gaps

- What information is currently available on admission to code the 5-day? What is missing? How can you get it sooner?
- Do you get the right information soon enough to get into the record to code the 5-day MDS?
- Do you get the right surgical information to code the section J questions affecting the calculation?

Compare 5-day to 14-day PPS assessments and look for information added to the 14-day which was not captured on the 5-day.

- Should it have been captured on the 5-day; if so, why wasn't it?
- Was information missed, not available, or not applicable to the 5-day?
- How often are 5-day MDS modified for missing or incorrect information? Is there a way to improve this number?
- Are there trends which can be addressed to improve modification rates?

You should also examine coding practices between the 5 and 14 day, determine upcoding on the 14 day and how to get the required information in a timelier manner.

Determine staff learning needs to be PDPM competent

Staff will need to understand what is changing and why, so they understand why processes are changing in the home. Your staff need to be competent to care for more potentially medically complex residents, need to understand new presumption of care rules and what changes in documentation are required to support the transition to PDPM. You will need a clear training plan for the upcoming transition.

Identify staff competencies (ROP) needed to care for a changing population (also required for the Facility Assessment).

- What education do your staff need to help the facility be successful with PDPM?

Do you have the right care assessments and content to clearly identify need and the supportive approaches?

- What technology changes do you need to implement to assist with addressing more medically complex residents?

Staff will need to understand what is changing and why. You will need a clear training plan for the upcoming transition.

Conclusion

We understand to be prepared for PDPM you will need to invest not only your time and resources, but also have the right tools to ensure you make a successful transition.

Customer Relationship Manager (CRM)

Pre-admission assessment data can help you select the right resident for your care provisioning levels, and helps plan your staffing needs for more medically complex residents.

Eligibility Verification

On-demand access to a resident's payer information, both at pre-admission and throughout their stay, is critical to ensuring consistent reimbursement flow.

COMS Interactive

Leveraging extensive best practice knowledge and standardized data can help bring consistency to your care delivery and identify areas of reimbursement you might have otherwise missed.

Compliance Analytics

Having visibility into your organization's performance metrics, and support for quality process improvement efforts, can help you optimize your care delivery model to prosper with PDPM.

There's a lot of work ahead, but the good news is we can help.

GET STARTED ON STAGE 1