PDPM

CMS Holds the Line
On the Definition of Skilled Requirements

The more things change the more things stay the same.

CMS has been very clear that in order to receive Medicare Part A reimbursement under PDPM, the following will still hold true:

A resident must require skilled nursing services or skilled rehabilitation services (see §§30.2 – 30.4) on a daily basis (see §30.6); and can be provided only on an inpatient basis in a SNF (See §30.7). Also, services delivered are reasonable and necessary and are consistent with medical needs, accepted standards of practice as well as the nature/severity of the illness or injury.

Why is this important?

CMS is committed to sending a clear message: reimbursement will be based on each resident's unique *clinical characteristics* and need for skilled nursing and/or therapy interventions – rather than our current (and somewhat arbitrary) RUG-IV system. In other words, while CMS has reinforced that payment under PDPM will truly be resident-specific, the underlying definition of "skilled need" absolutely must continue to be met. This drives home "The more things change the more they stay the same" concept and begs the question….

How can SNFs achieve (and protect!) optimal reimbursement under PDPM?

Success under PDPM will require many SNFs to make important changes in "*the ways we've always done things around here*."

Today – Under RUG-IV, therapy utilization is the primary driver of reimbursement.

Tomorrow – Under PDPM, reimbursement will be based on a more balanced, clinical representation of all skilled nursing, therapy, and ancillary services provided to the resident.

Also important – Documentation of skilled nursing need has always been required to support the coverage of skilled care under Medicare Part A, but the burden of proof under the new system will rest with the entire interdisciplinary team. True collaboration and consistent communication among all IDT members will be necessary to recognize/document/validate the accurate and thorough clinical profile of each resident. IDT teams must ask important questions such as:

- Does your daily nursing documentation support skill to the point it would stand a Medicare audit WITHOUT therapy?
- Does the MDS paint an accurate picture of the resident's unique clinical characteristics that support the presence of skilled nursing, therapy, and other ancillary services?
- Does the resident's clinical record not only support and validate the data outlined on the completed MDS assessments, but also paint a clear picture of the skilled need for those services, as clearly and consistently defined by CMS?

HealthPRO® Heritage advocates for "collaborative documentation practices" where it makes sense. For instance, for therapy and nursing to work together to complete Section GG; and Dietary to work closely with speech therapy to complete Section K.

The implications for a less than perfect execution on this important competency will result in lost reimbursement opportunity. Moreover, SNFs should be concerned that discrepancies between the medical record and the MDS would trigger audit activity and result in penalties.

Therapy = Skilled

When PDPM system was first unveiled, some skeptics predicted that therapy services would become irrelevant or even considered a cost center. Cooler heads prevail today, and the industry recognizes how important therapy continues to be under PDPM. The need for therapy services must be present in order for a resident to be considered skilled under Part A, and therapeutic interventions – based on clinical need – will be absolutely necessary to drive positive outcomes for residents.

In fact, NOW is an optimal time for SNFs to evaluate (and possibly redefine) their expectations of their therapy partners. After all, for the last 20 years of RUGS-IV, therapy has become very skilled at defining the processes to drive reimbursement. The tables have turned with PDPM, and IDT (especially nursing!) will rise to the occasion. How can the experience/expertise of your therapy team be leveraged with the IDT in support of assuring skilled interventions are prescribed, delivered and accurately documented?

SNF Leaders: Ask yourself these important questions!

- Are processes in place for my team to communicate/collaborate effectively? Are they receiving education/training related to how to take documentation practices to the next level?
- Is my MDS well-supported (receiving education/training) to recognize whether skilled services are accurately documented and captured?

- Am I satisfied with our medical team's process re: the certification of Medicare skill? Is the documentation and level of detail satisfactory? What changes need to be made with documentation practices NOW to align with PDPM expectations?
- What quality assurance stopgaps are in place to facilitate and validate that what is captured by my clinical team translates into optimal reimbursement rates? (HINT: Ask your EMR about whether automated features of your system can serve to prompt MDS for coding practices that influence optimal/accurate reimbursement rates.)
- Can therapy offer support that extends beyond providing just traditional rehab services? Should SNFs rely on their therapy partners to offer more strategic solutions and innovative tools to ensure success under PDPM?

Prepare. Execute. Succeed.

With less than 10 months until the transition, perhaps your team would benefit from the support of our PDPM experts? HealthPRO® Heritage is a trusted, consultative partner leading the industry in PDPM readiness. Our deliverables: strategy, education, and execution on key clinical competencies that are crucial to PDPM success.