1

Speakers

Joe Eaton – Chief Strategist

Joe Eaton is Broad River Rehab's Chief Strategist. With a passion for problem-solving, he takes great satisfaction in simplifying the complex and creating tools to make complex issues easier to understand. He comes to BRR with 20 years of experience in engineering and business and has written numerous software systems and tools for the healthcare industry from nursing to therapy. Joe specializes in the development of Artificial Intelligence tools (AI) that greatly simplify accuracy and compliance. He takes pride in providing clients with actionable data analytics and is always looking for a challenging new problem to solve.

Renee Kinder – Executive Vice President of Clinical Services

Renee Kinder, MS, CCC-SLP, RAC-CT, is Broad River Rehab's Executive Vice President of Clinical Services. She authors McKnight's Long Term Care News "Rehab Realities", serves as Gerontology Professional Development Manager for the American Speech Language Hearing Association's (ASHA) gerontology special interest group, is a member of the University of Kentucky College of Medicine community faculty, and is an advisor to the American Medical Association's Relative Value Health Care Professionals Advisory Committee (HCPAC).

2

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Course Overview

Understanding Your CMS Claims Data – Methods for Optimizing Medicare MDS Accuracy and Reimbursement | Broad River Rehab

This course will assist the IDT with being able to describe 2019-2022 PDPM data trends from the CMS Research Data Assistance Center (ResDAC) for Virginia as a state, each individual provider/group of homes, and across the nation. Furthermore, speakers will provide guidance on defining key clinical data elements and MDS coding practices related to NTA, Nursing and Rehab in conjunction with immediate impact on reimbursement and financial impacts for communities and explore dynamics of care in the post-acute (PAC) world including clinical decision-making, methods to maintain quality of life and choice based on one's understanding of how their data trends internally.

3

3

Health Care Paradigm Shift

Historical

- Provider centric
- **Incentives for volume**
- Siloed care
- Fee for service

Reforming

Patient centric
Incentives for outcomes
Coordinated care
Value based/ alternative payment

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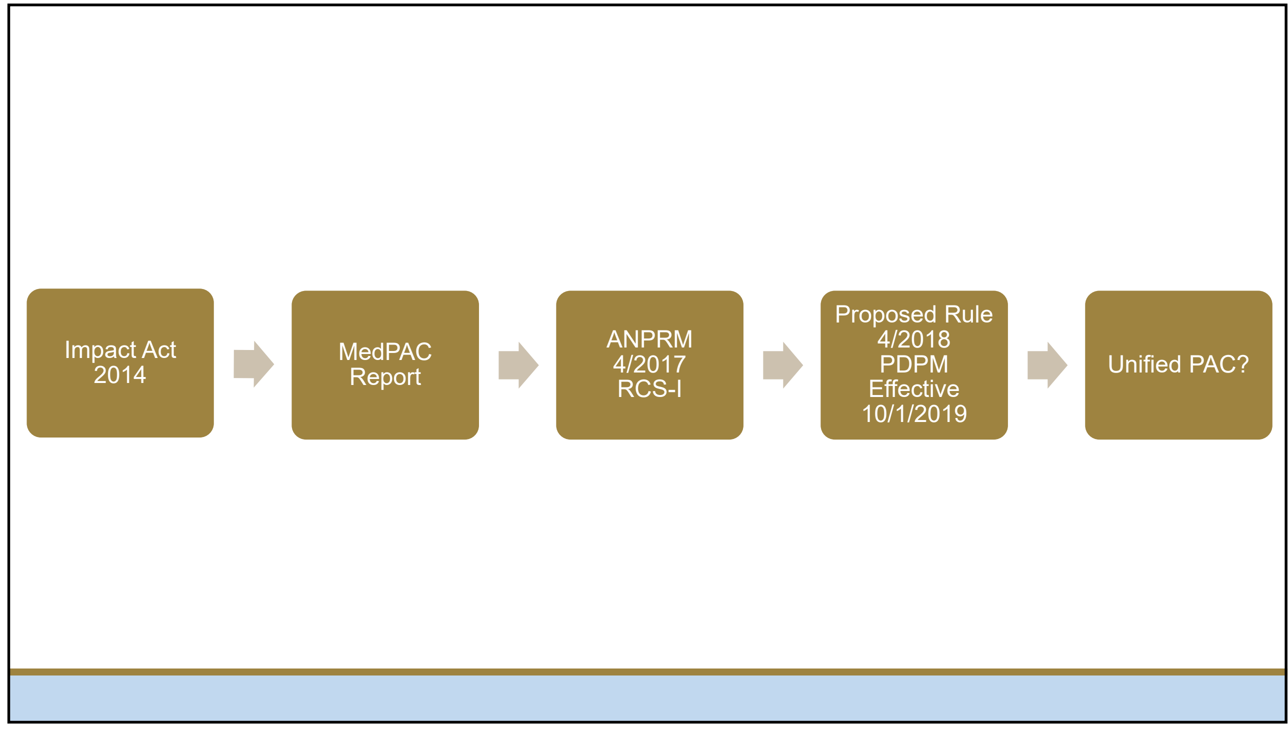

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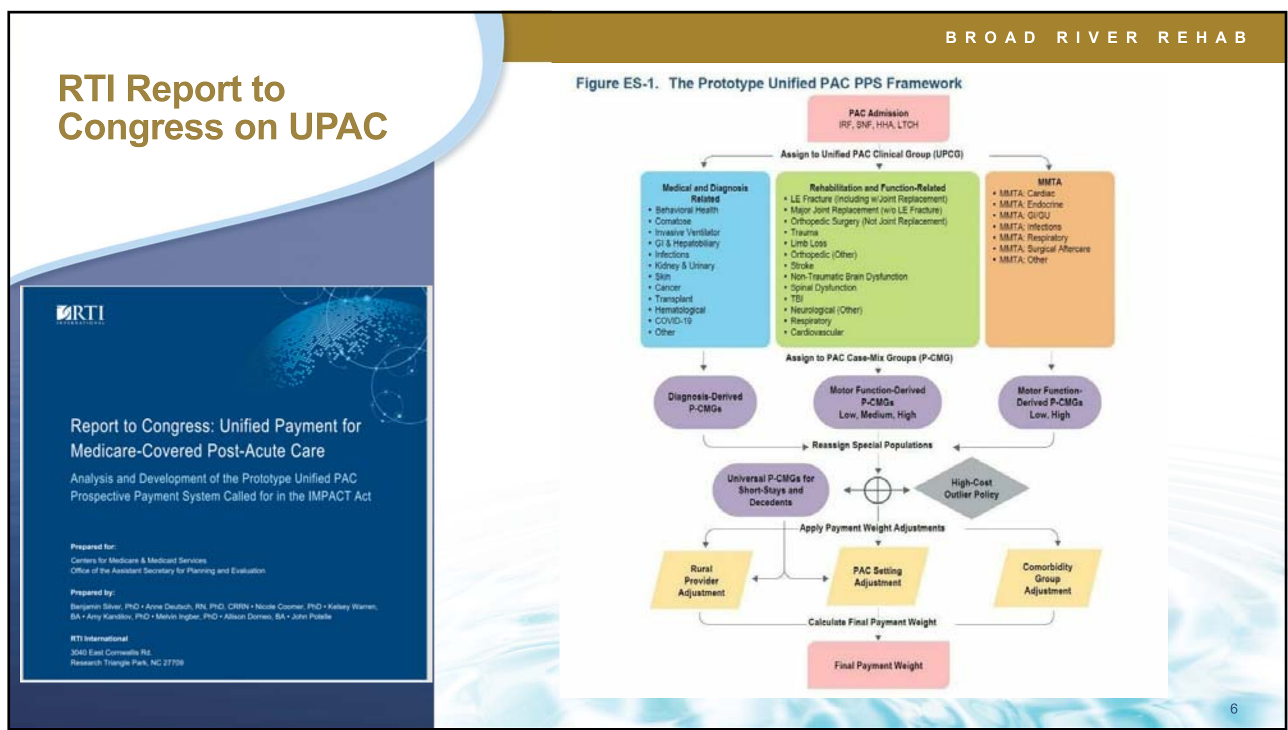

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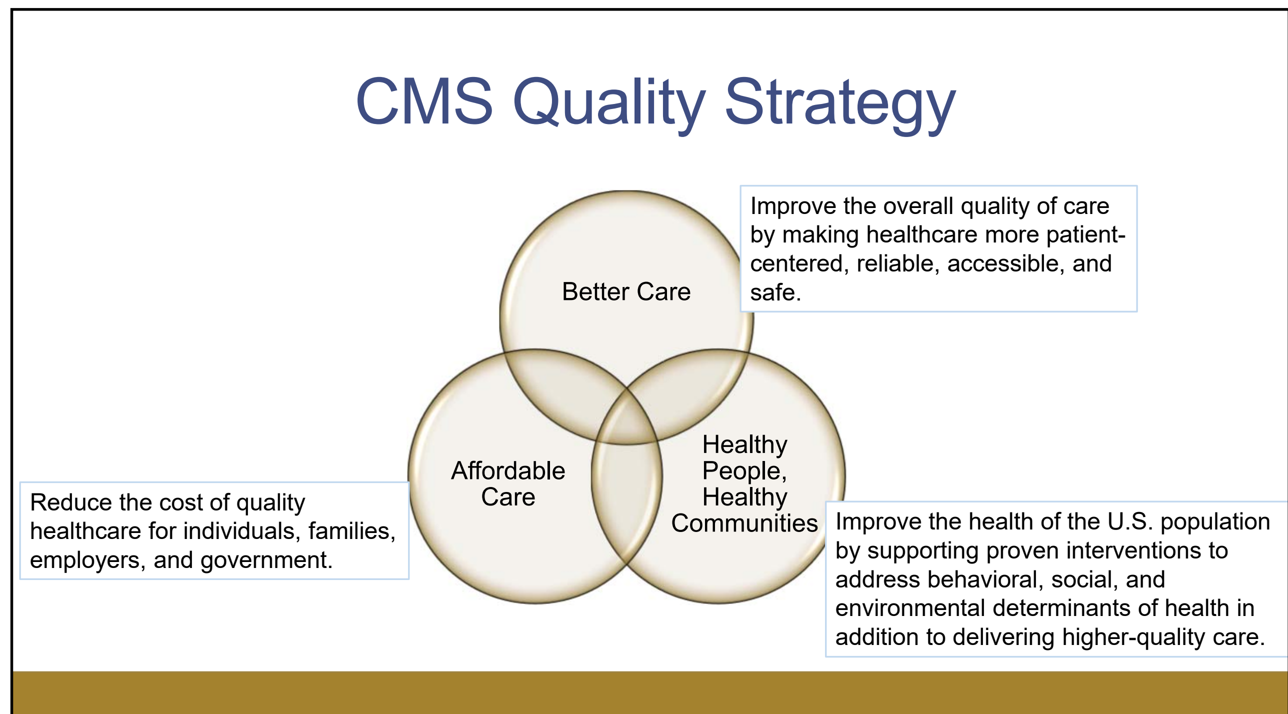

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Challenges in Prior Payment Models

- For skilled nursing facilities and home health agencies, payment was currently driven by the amount and types of services provided (e.g. therapy services)
- Prior prospective payment systems (PPS) don't fit into the new payment environment of value over volume
  - Unified PAC PPS across home health, SNF, IRF, and LTCH
  - Alternative Payment Models (APMs)

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Data Findings in Prior Payment Systems

- Numerous government findings of fraud and abuse by OIG and DOJ
- MedPAC Reports

CMS Findings: SNF

"The two most notable trends… were that the percentage of residents classifying into the Ultra-High therapy category has increased steadily and, of greater concern, that the percentage of residents receiving just enough therapy to surpass the Ultra-High and Very-High therapy thresholds has also increased. {Specifically} ''the percentage of claims-matched MDS assessments in the range of 720 minutes to 739 minutes, which is just enough to surpass the 720- minute threshold for RU groups, has increased from 5 percent in FY 2005 to 33 percent in FY 2013'' and this trend has continued since that time."

PDPM: Major Features

- Group & concurrent therapy limitation
- Need for an accountability mechanism to ensure therapy is delivered when a therapy payment is made
- Revised assessment schedules
- Variable per diem rates for PT, OT, and non-therapy ancillary services; consistent payment across the episode for SLP and Nursing services
- Clinical conditions and comorbidities drive payment

Goals of PDPM

- Based heavily on data analytics
- Derives payment from verifiable patient characteristics.
- Remove service-based metrics (e.g. therapy minutes) as determinant of payment
- Decrease administrative burden
- Reduce the complexity (number of component levels) compared to what was proposed in RCS-1

Under PDPM Skilled Nursing Facility Level of Care Definition Did Not Change

Care in a SNF is covered if all of the following four factors are met:

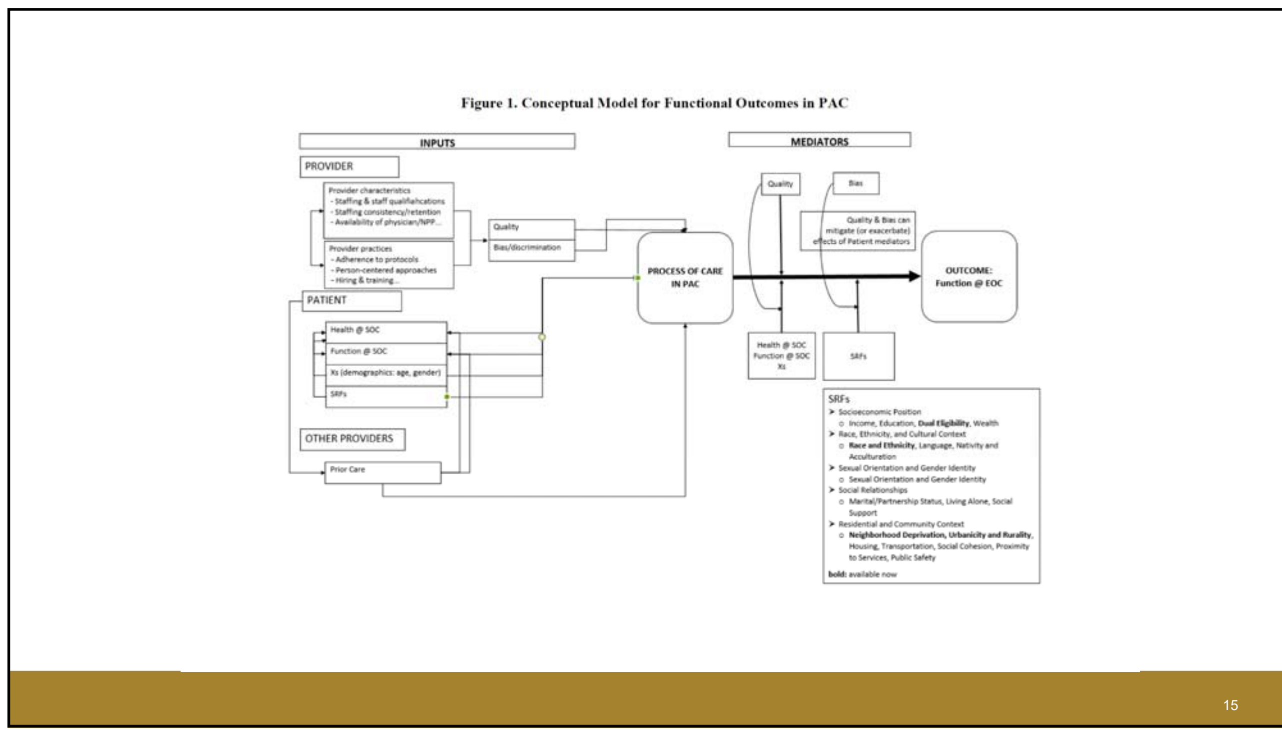
- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;
- The patient requires these skilled services on a daily basis (see §30.6); and
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7.)
- The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

Under PDPM Quality and Survey Expectations Did Not Change

- New Survey Process secondary to Phase II Requirements of Participation went into effect 11.28.2017
- Short and Long Stay Quality Measures are still in place
- Quality Reporting Program
- Value Based Purchasing
- 5 Star Rating System

What about outcomes? Technical Expert Panel (TEP) for Cross-Setting Function Measure Development

- Under this project, the PAC QRP Support team supports CMS in the development and maintenance of quality measures for use in the IRF, LTCH, SNF, and HH QRPs and the Nursing Home Quality Initiative (NHQI).
- These measures are designed to improve care quality and to enable Medicare beneficiaries to make informed choices when selecting a healthcare provider.
- The suite of PAC QRP measures covers several domains relevant to care quality, including function – a dimension of care that is especially salient to each of the PAC settings.
- Over the last decade, CMS has introduced several measures addressing function.
- To ensure these and any newly developed function measures meet CMS program requirements and goals while maintaining high levels of scientific acceptability, the PAC QRP Support team convened a Technical Expert Panel (TEP). The PAC QRP Support team sought guidance on specifications for a cross-setting functional outcome measure to implement across PAC QRPs.



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PAC Outcomes Challenges

- Coding accuracy
  - Accuracy of measures
  - Gaps in coding
  - Involvement of the interdisciplinary team
- Setting variances
  - Skilled Nursing
  - Long Term Care Hospitals
  - Inpatient Rehab
  - Home Health

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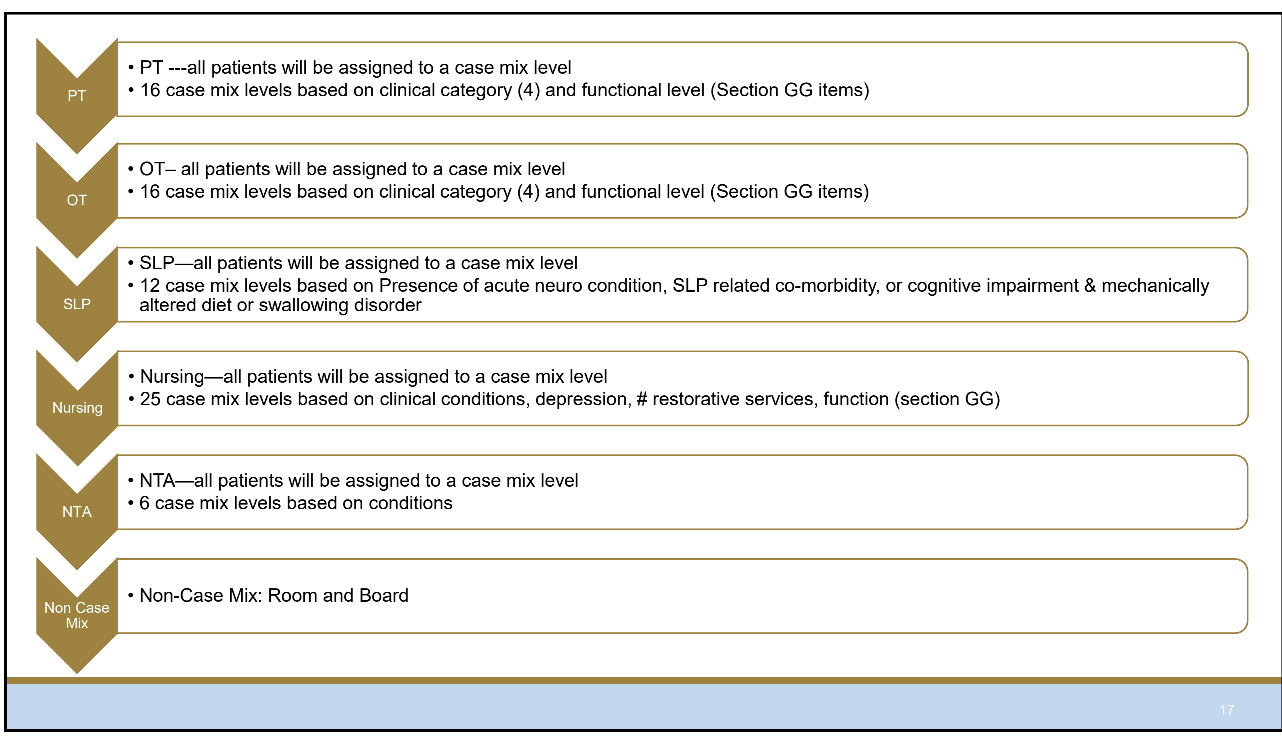

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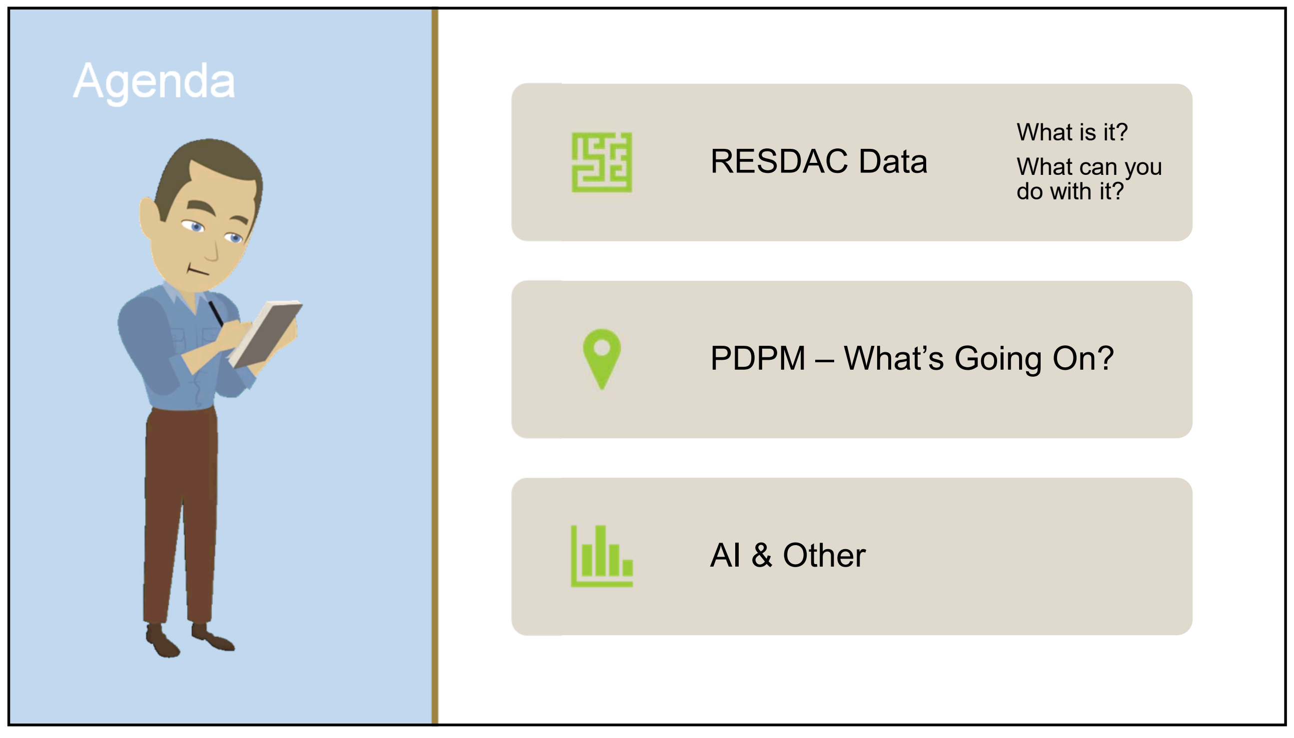

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RESDAC Data

https://resdac.org/

- Medicare and Medicaid data
- Research Identifiable Files (RIF)
- Standard Analytical Files (SAF)
- Medicare Provider Analysis and Review (MEDPAR)
- Much More

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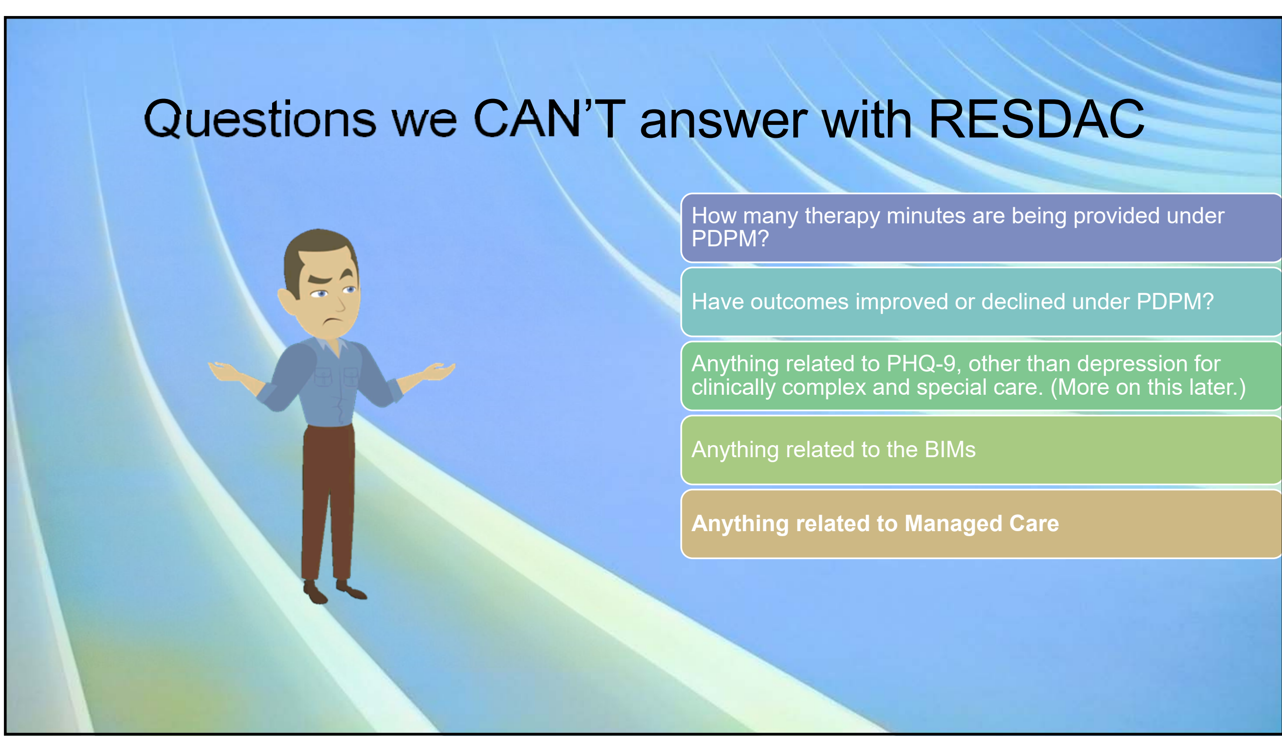

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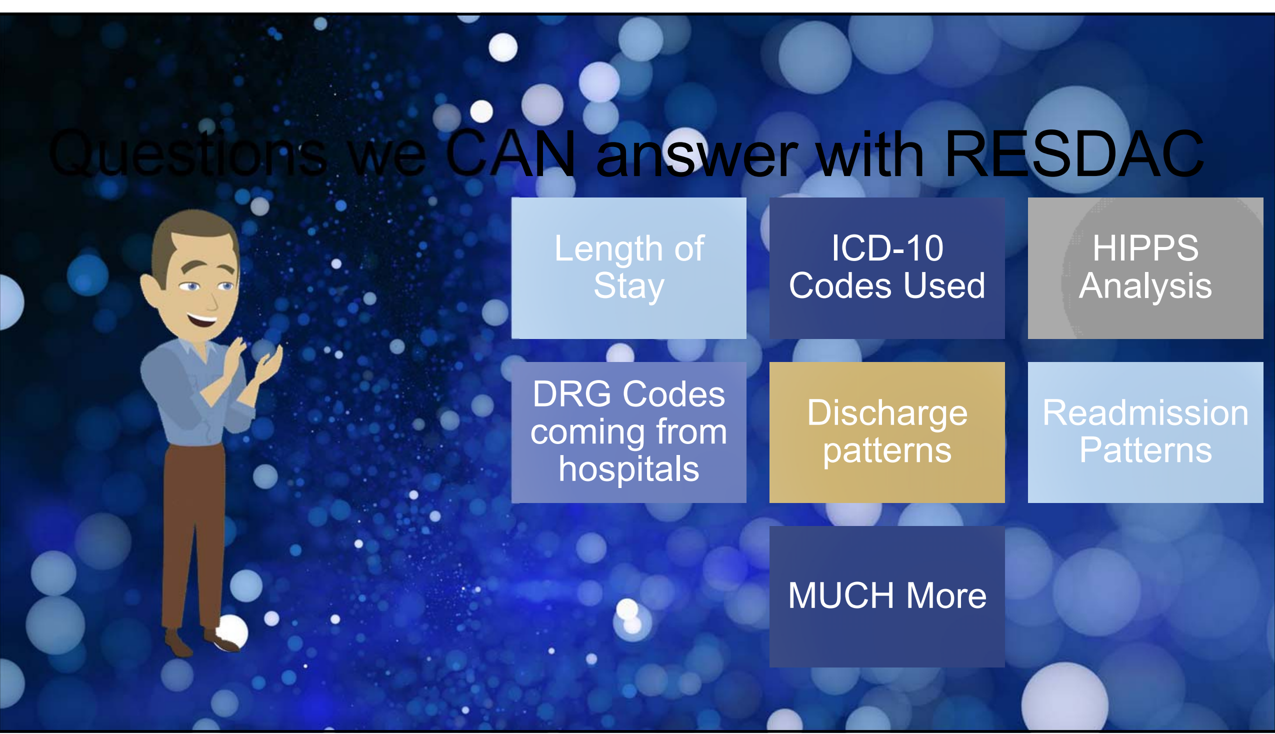

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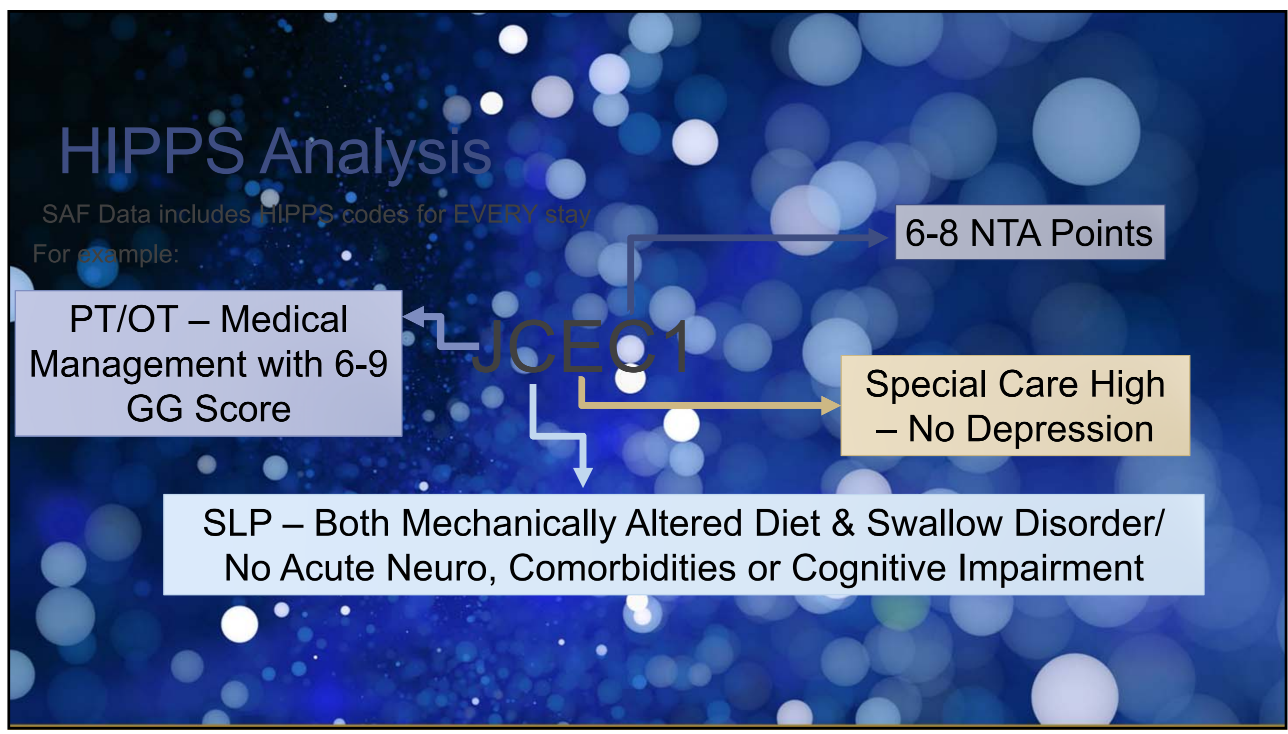

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HIPPS	Discipline	CMI	Pay
J	PT	1.4200	$87.78
	OT	1.4500	$82.32
C	SLP	2.6700	$68.11
E	Nursing	1.9900	$179.73
C	NTA	1.8400	$125.36
Non-Case-Mix			$86.22
Total (1-3)			**$880.25**
Total (4-20)			**$629.52**

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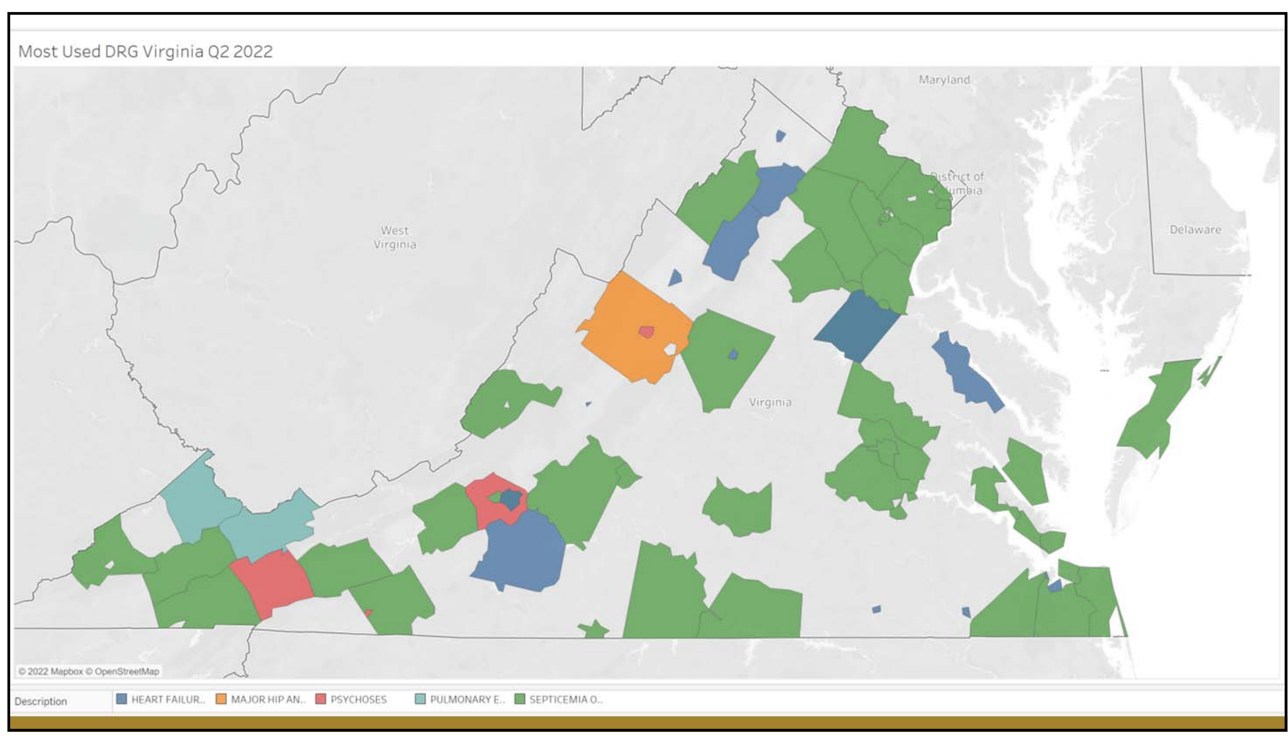

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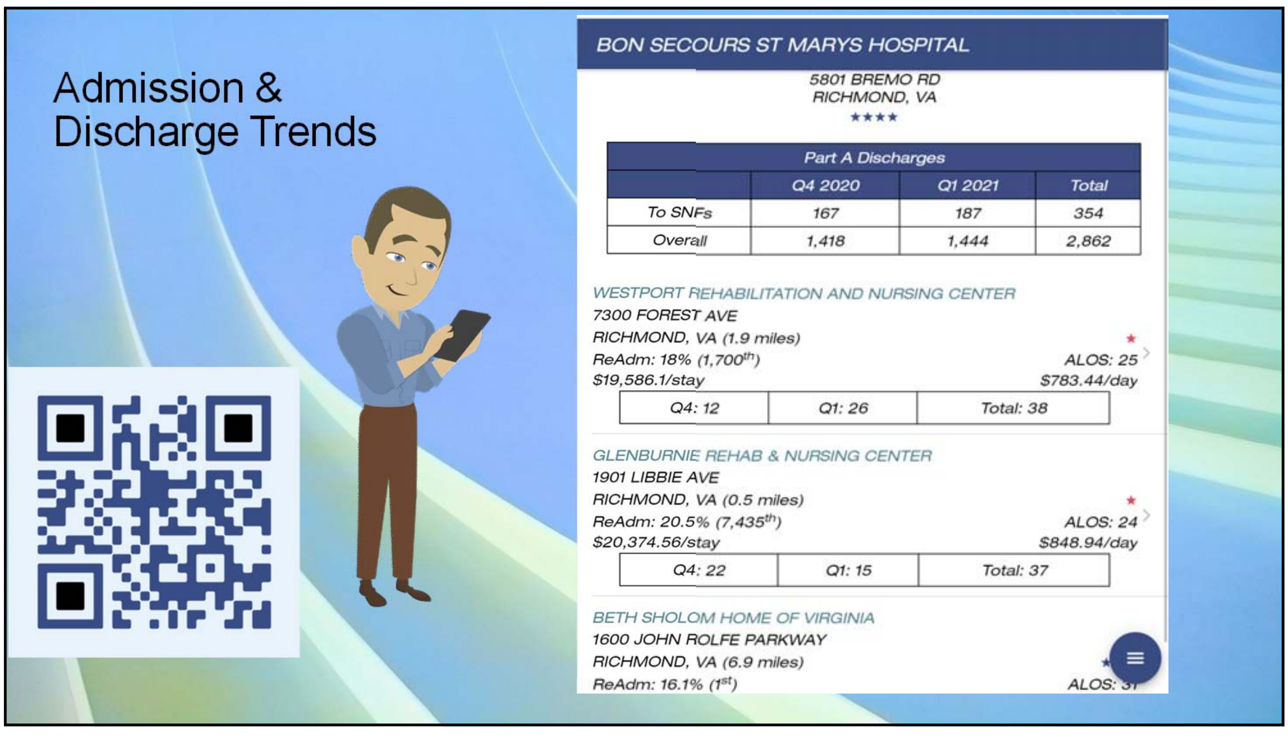

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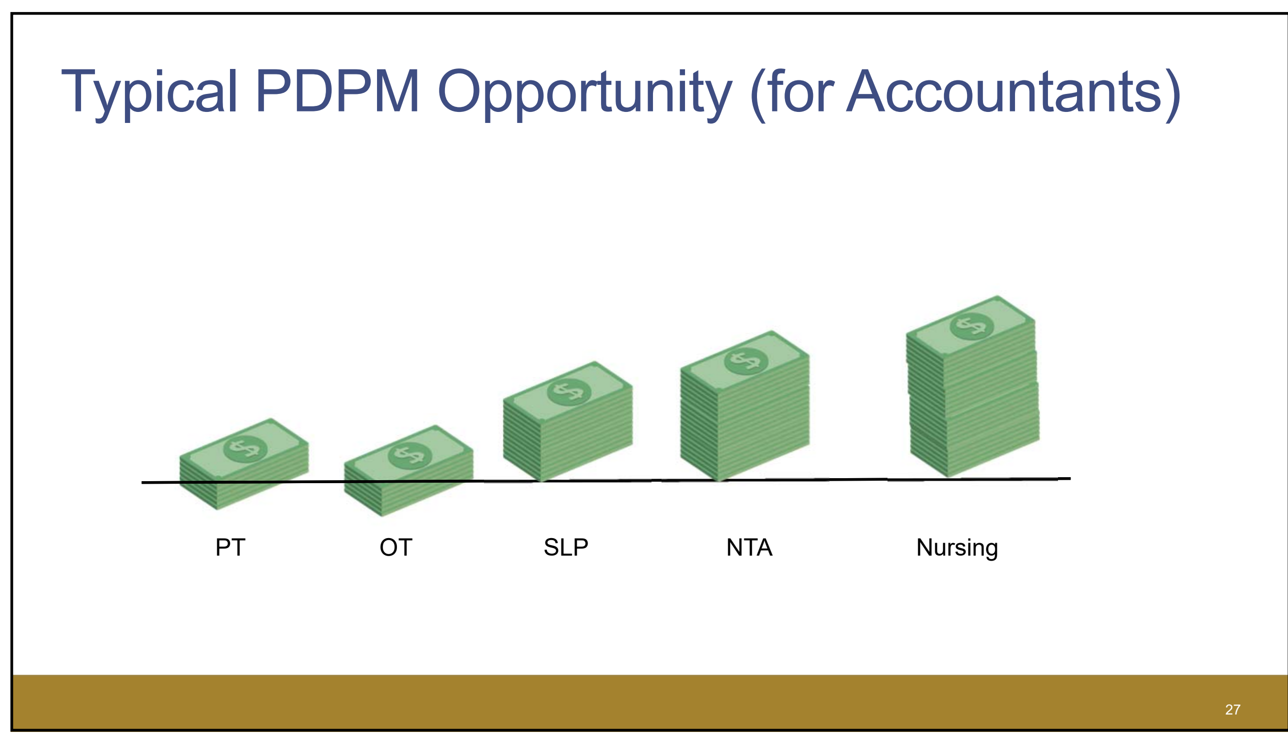

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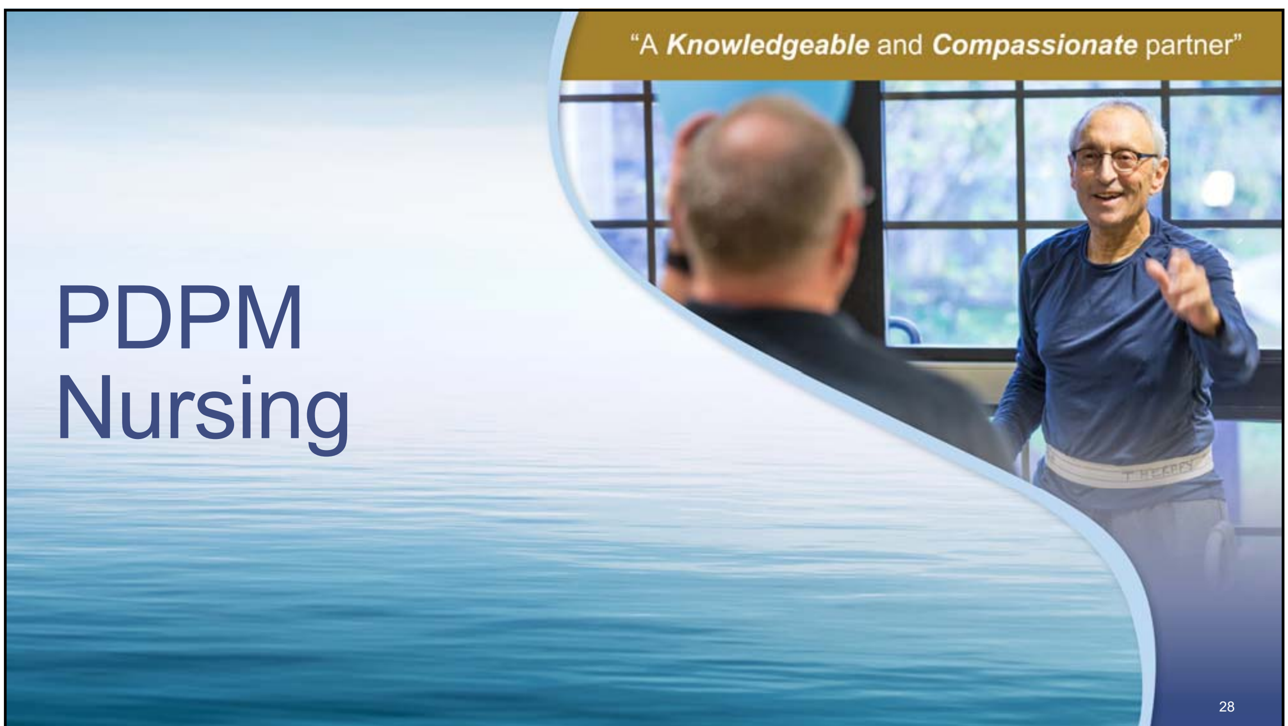

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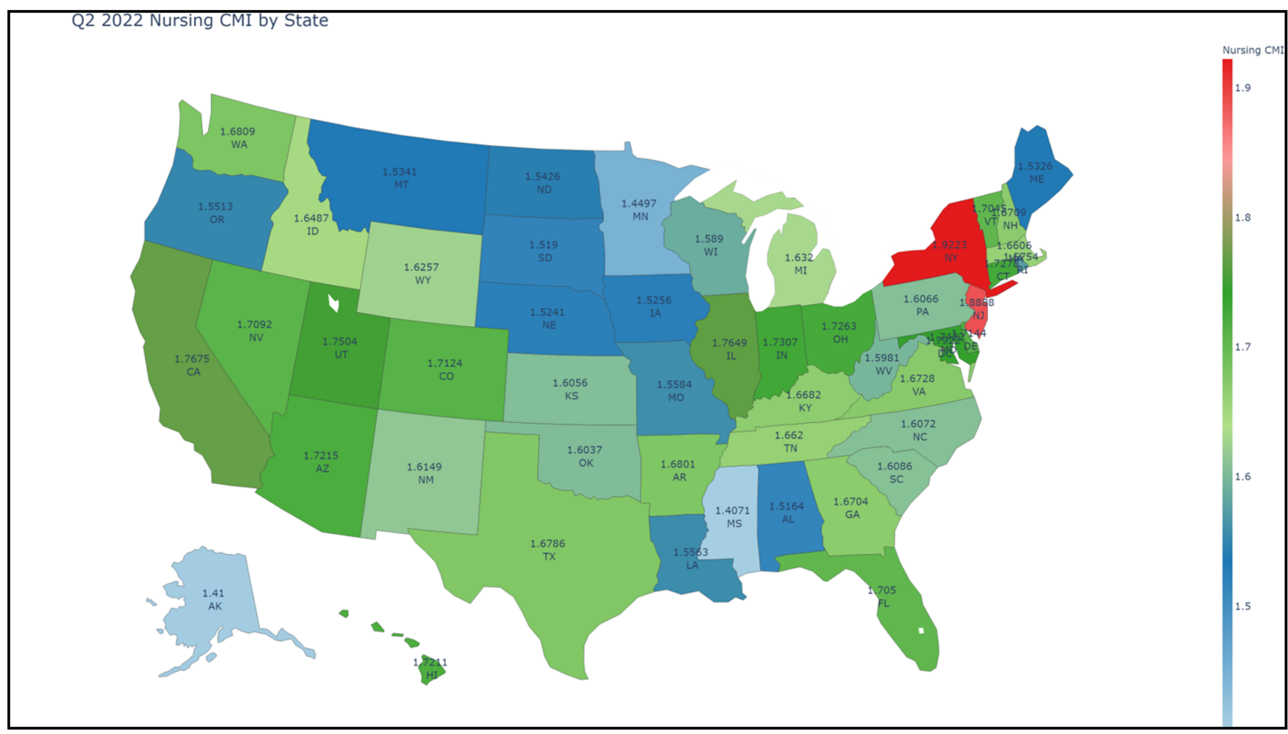

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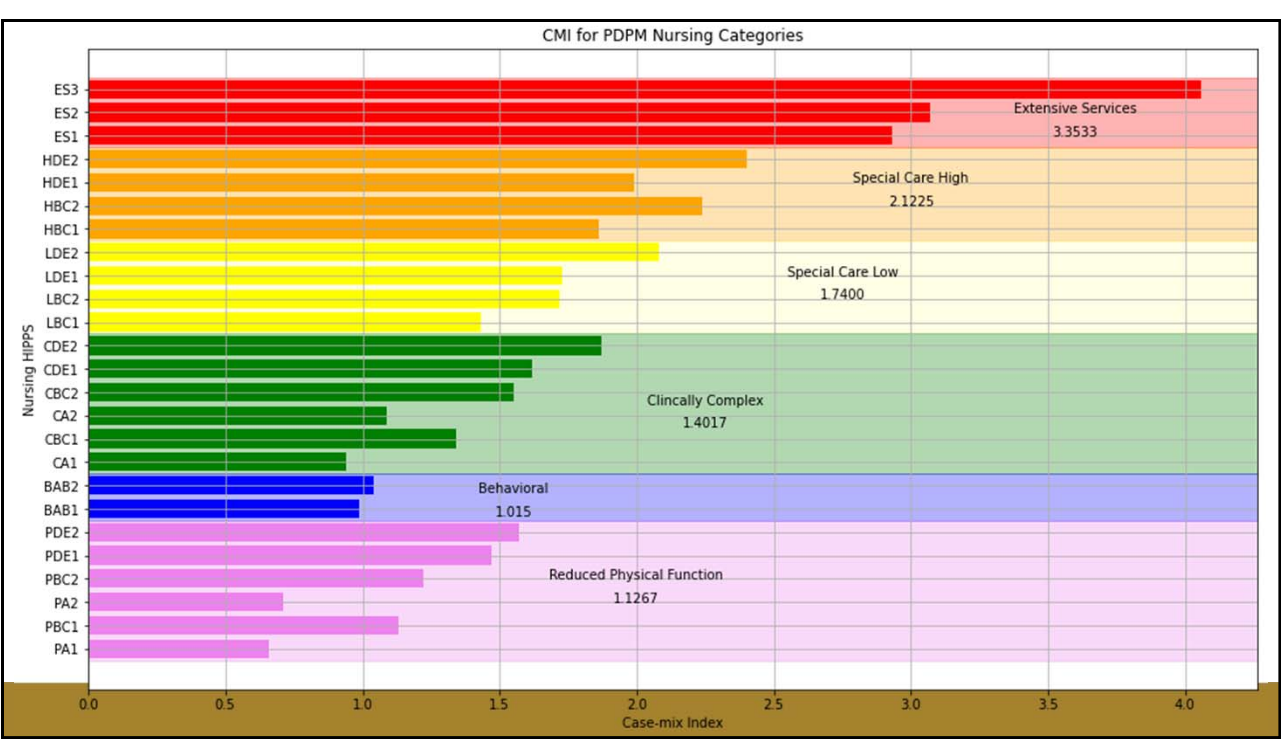

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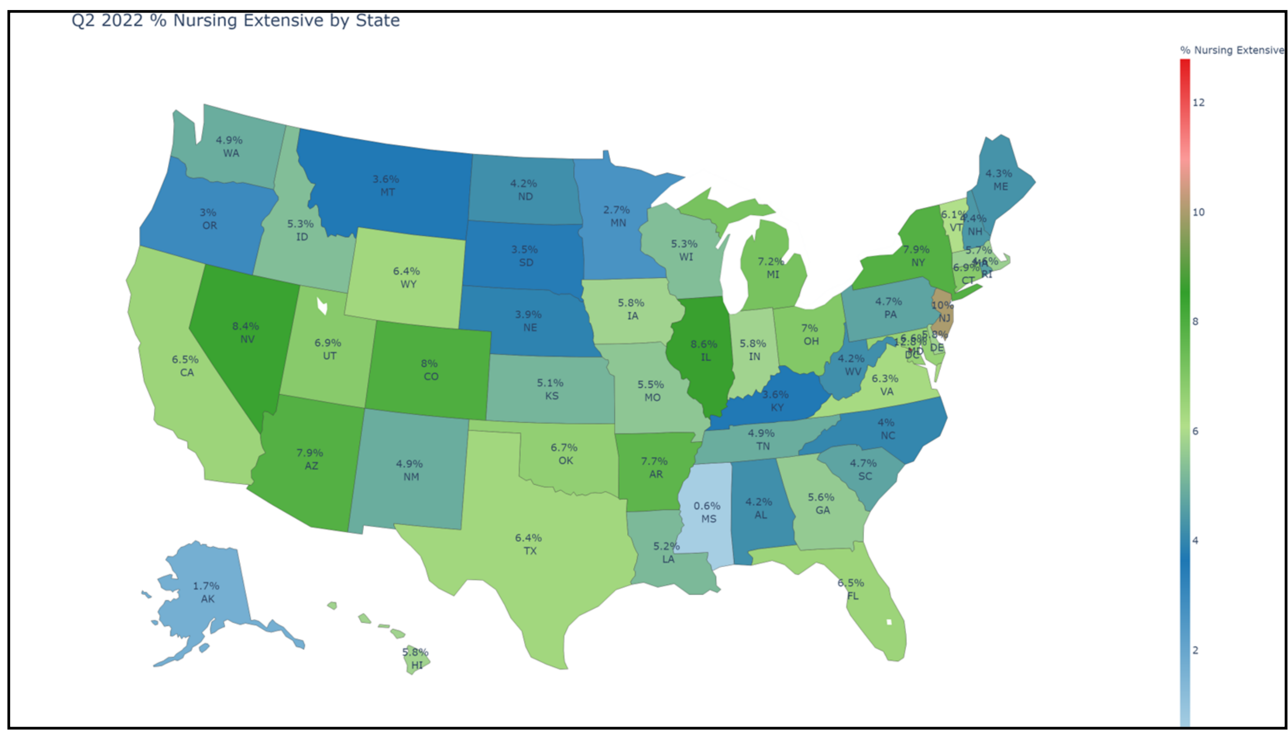

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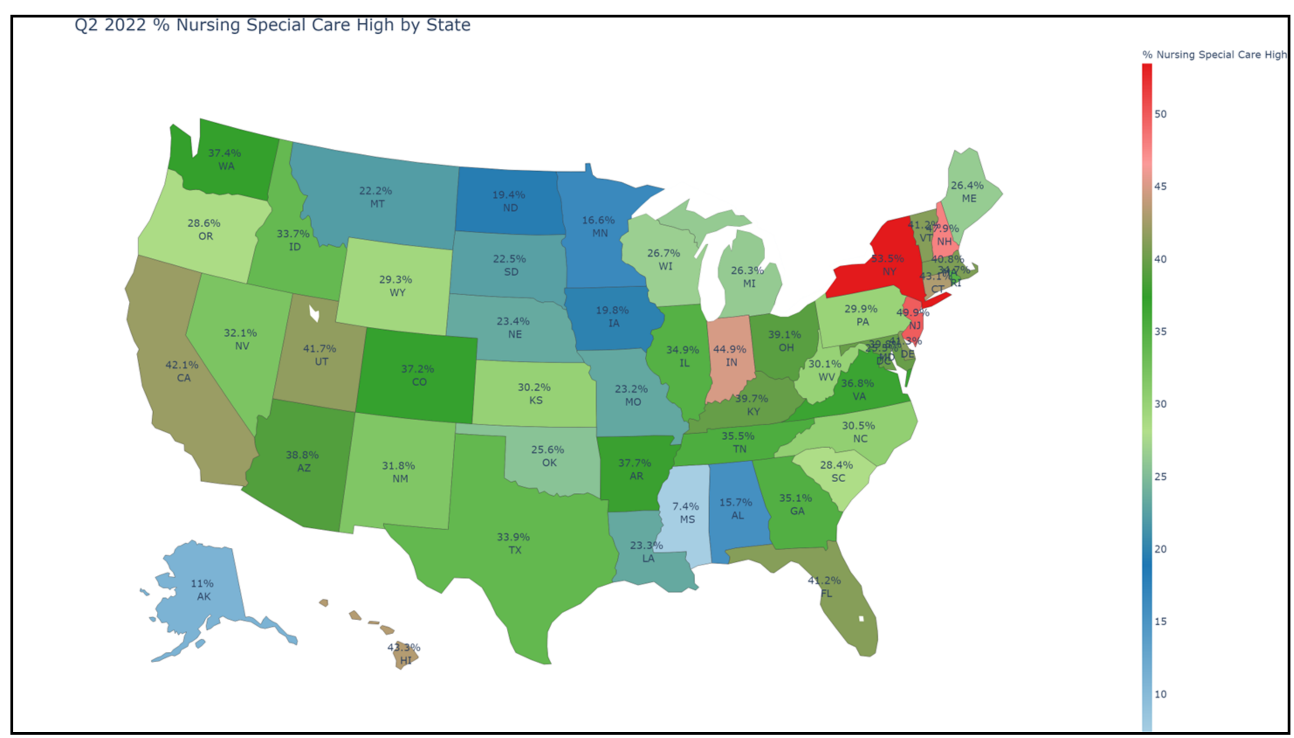

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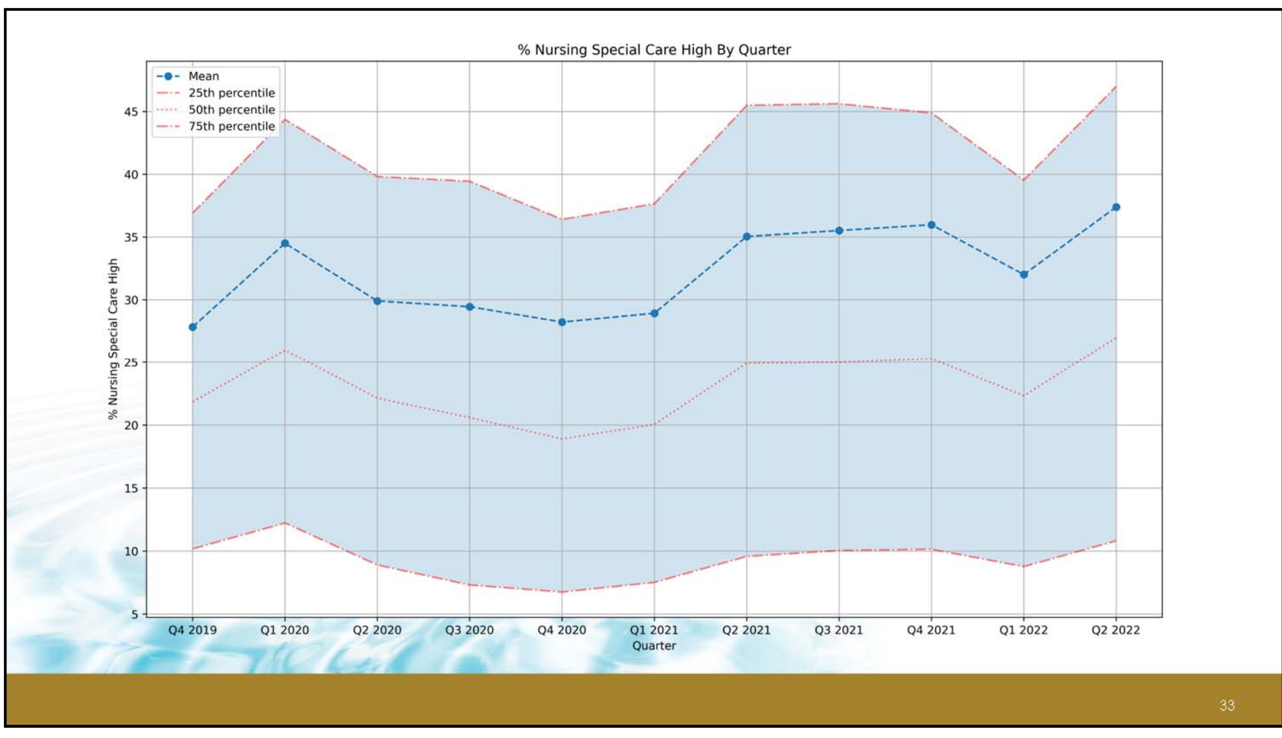

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MDS Frequency Data

- Data for nearly every MDS item
- Free to access
- Aggregated by State

https://www.cms.gov/apps/mds/mds_notemp/mds30FreqStart.asp

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Special Care High

1. **B0100**, Section GG items Comatose and completely dependent or activity did not occur at admission (**GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1**, all equal 01, 09, or 88)
2. **I2100** Septicemia
3. **I2900, N0350A, B** Diabetes with **both** of the following: **N0350A** Insulin injections for all 7 days **and N0350B** Insulin order changes on 2 or more days
4. **I5100**, Quadriplegia **with** GG Nursing Function Score <= 11
5. **I6200** Chronic obstructive pulmonary disease and **J1100C** shortness of breath when lying flat
6. **J1550A**, Fever **and** one of the following; **I2000** Pneumonia **or J1550B** Vomiting **or K0300** Weight loss(1 or 2) **or K0510B1 or K0510B2** Feeding tube *
7. **K0510A1** Parenteral / IV feedings while not a resident **or K0510A2** Parenteral/IV feedings while a resident
8. **O0400D2** Respiratory therapy for all 7 days

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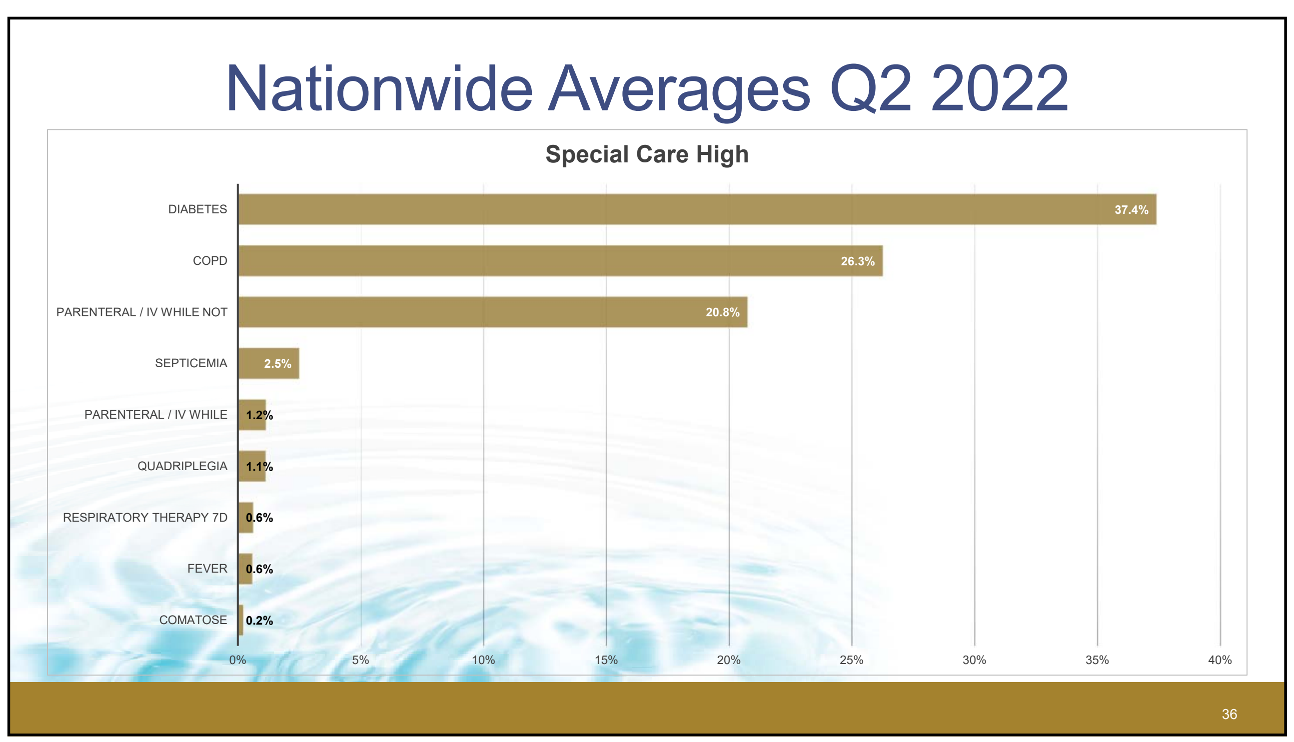
Nationwide Averages Q2 2022



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Special Care High – NY vs the Nation (& VA)

	Criteria	Nation	NY	VA
1	Comatose (B0100)	0.23%	0.26% (14th)	0.24% (16th)
2	Septicemia (I2100)	2.5%	2.5% (21st)	3.05% (11th)
3	Diabetes (I2900), (N0350A, N0350B)	37.4%	36.4% (28th)	38.6% (19th)
4	Quadriplegia (I5100)	1.1%	0.94% (33rd)	1.38% (12th)
5	COPD (I6200), (J1100C)	26.26%	26.27% (18th)	26.0% (23rd)
6	Fever+ (J1550A)	0.60%	0.90% (12th)	0.66% (28th)
7a	Parenteral Feeding (K0510A1 - **NOT** a resident)	20.8%	**31.6% (1st)**	18.7% (23rd)
7b	Parenteral Feeding (K0510A2 - while a resident)	1.15%	**3.38% (2nd)**	1.3% (13th)
8	Respiratory – 7 Days (O0400D2)	4.33%	5.59% (11th)	2.28% (32nd)

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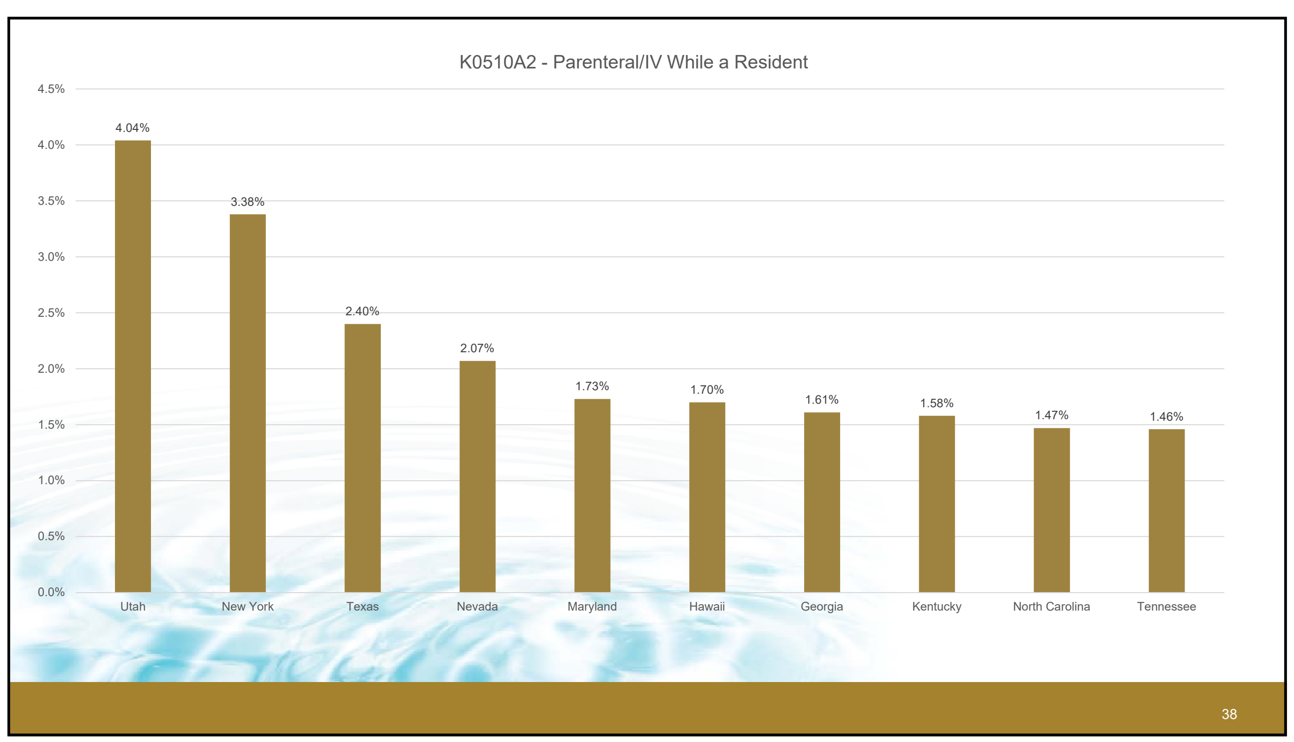

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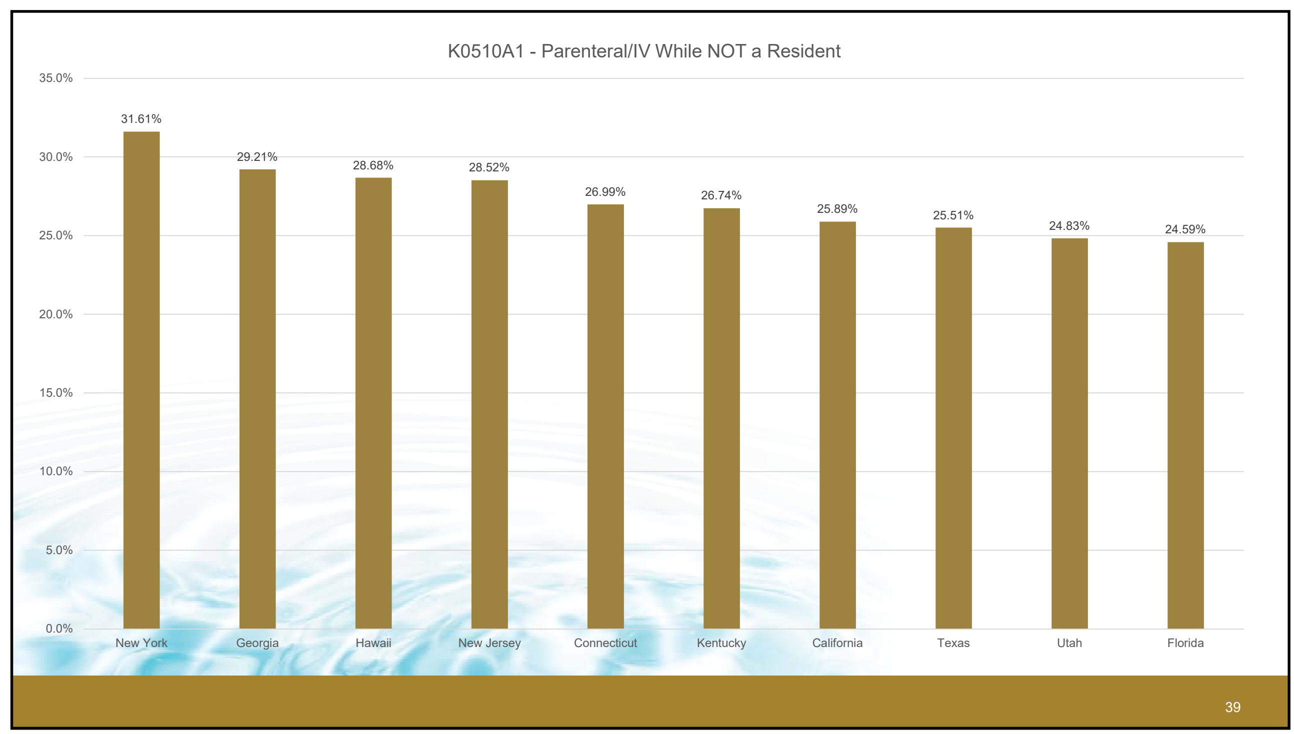

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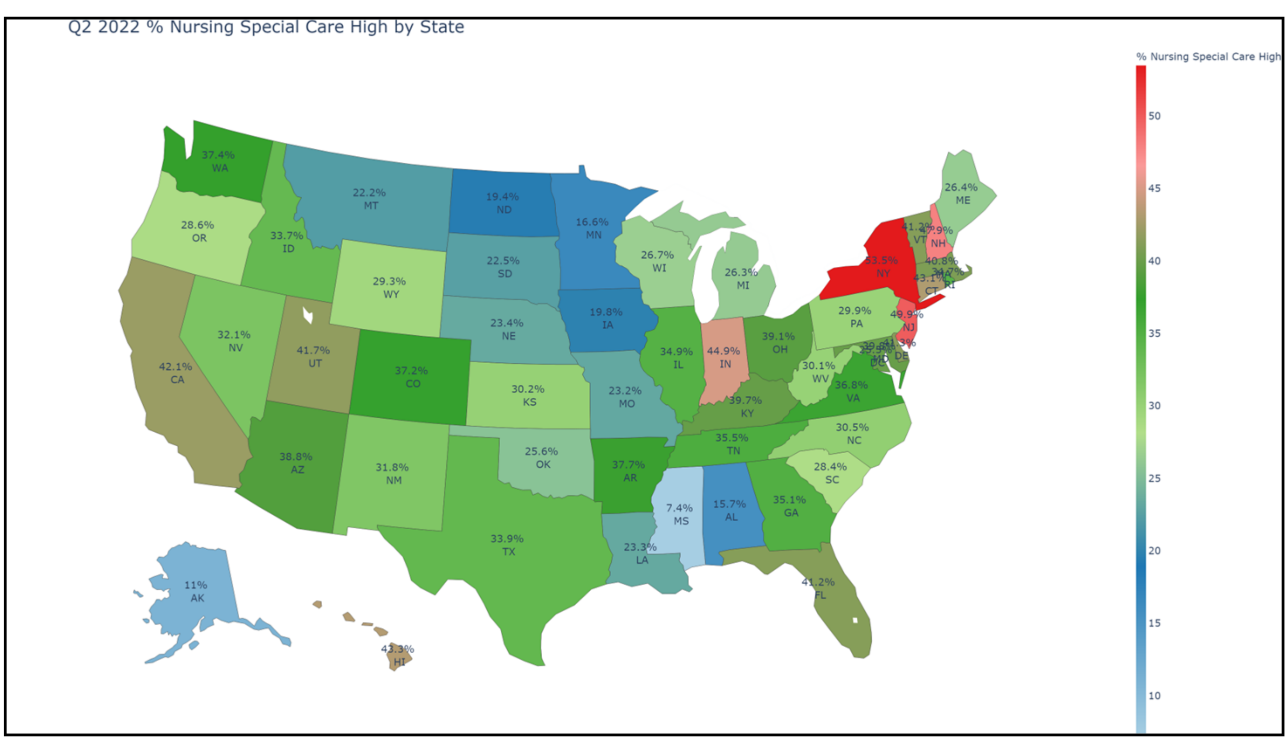

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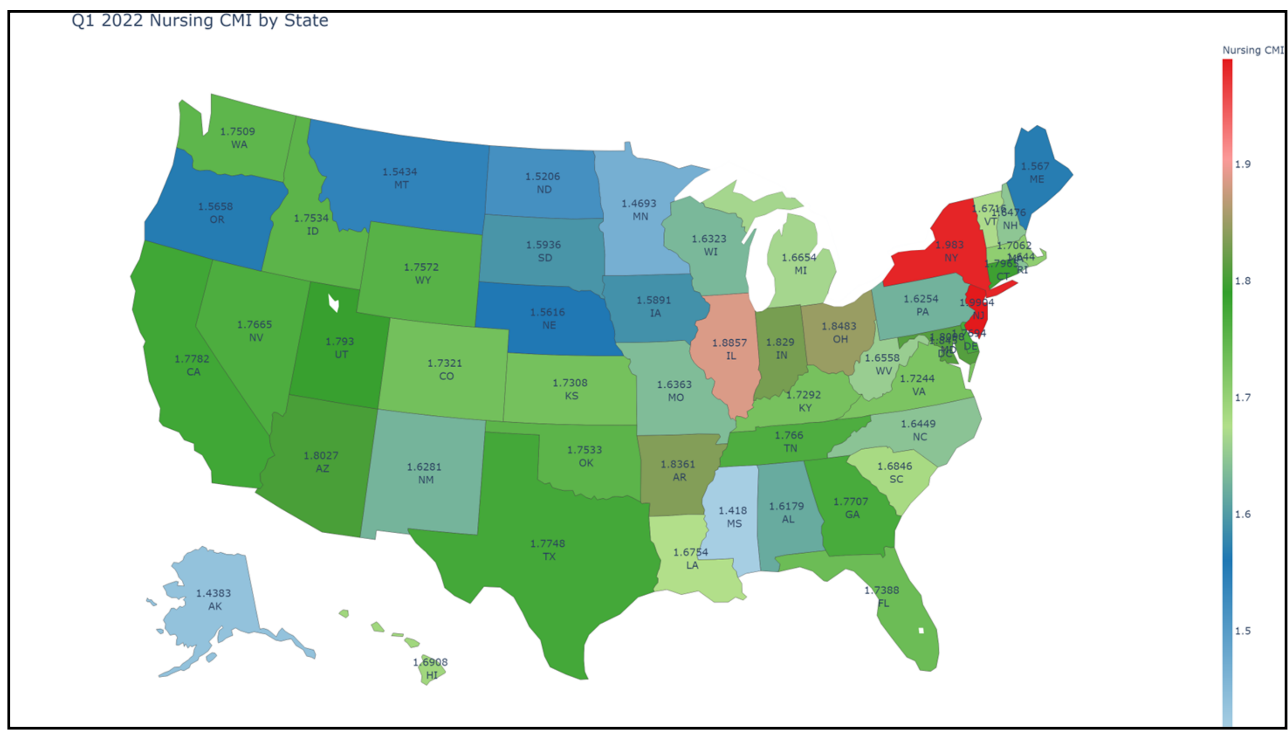

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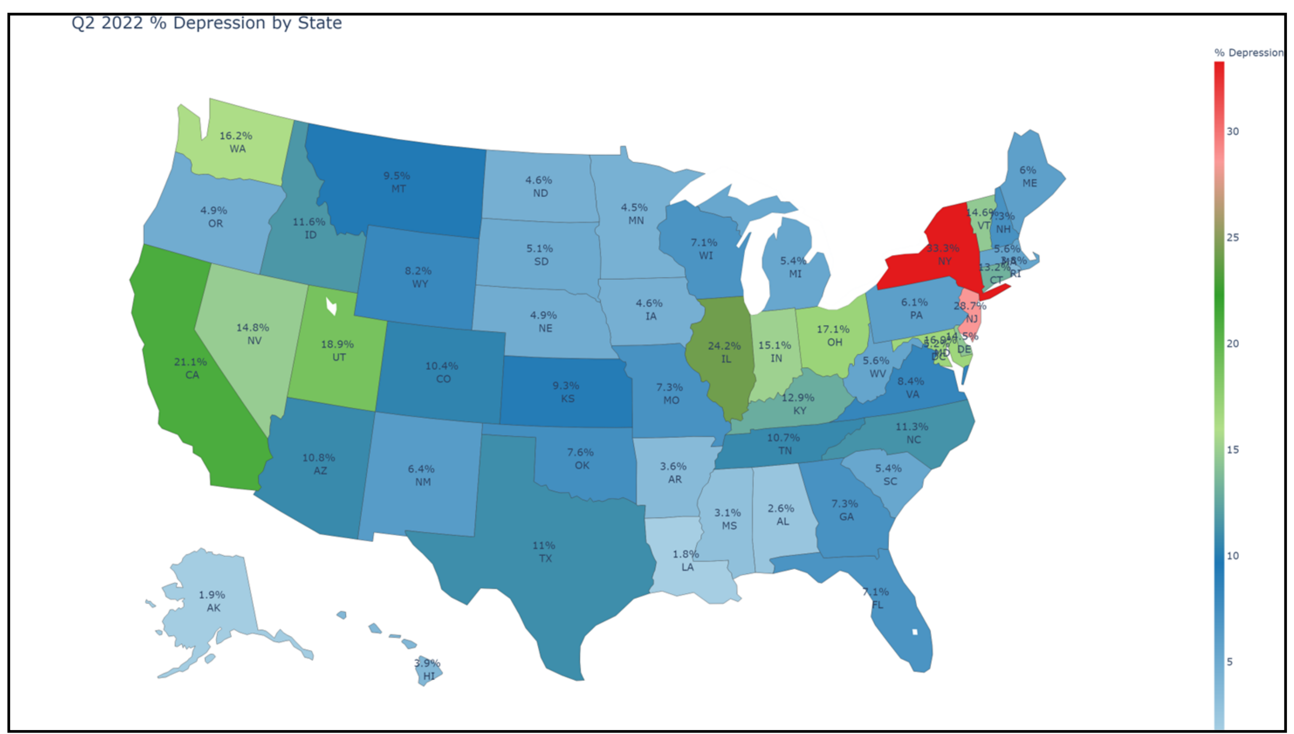

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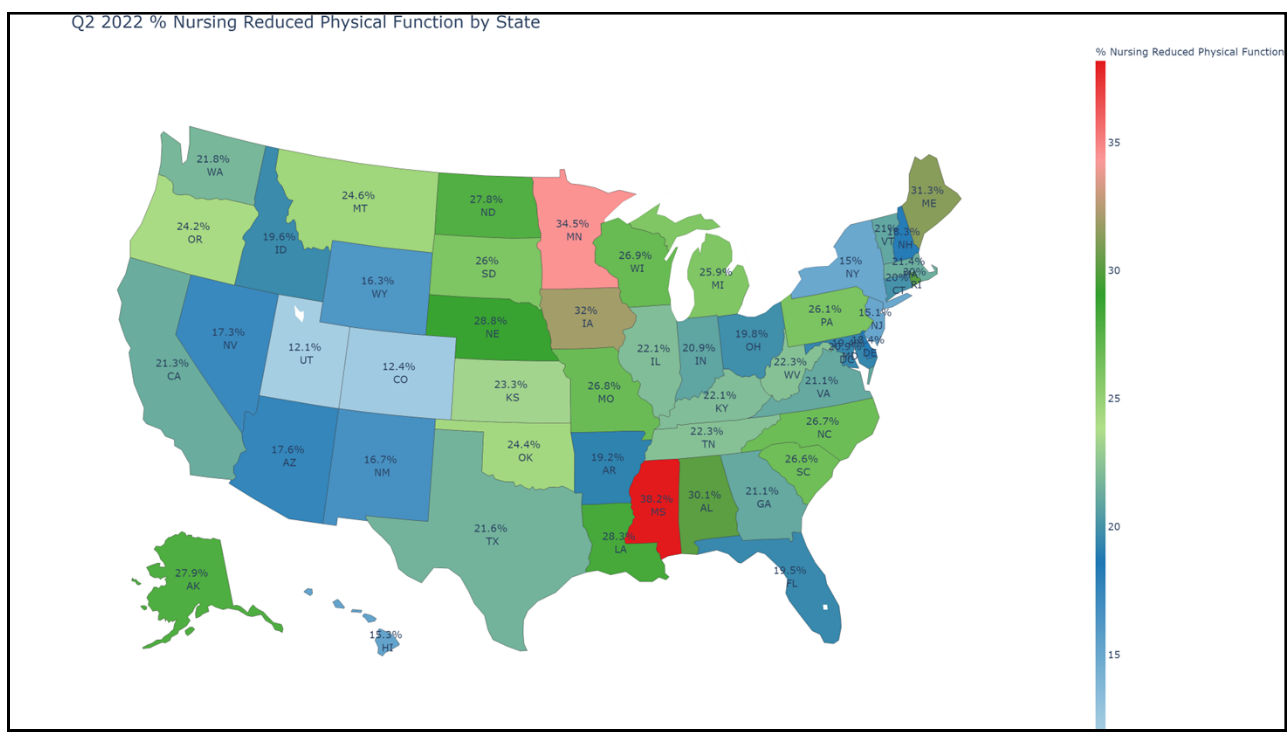

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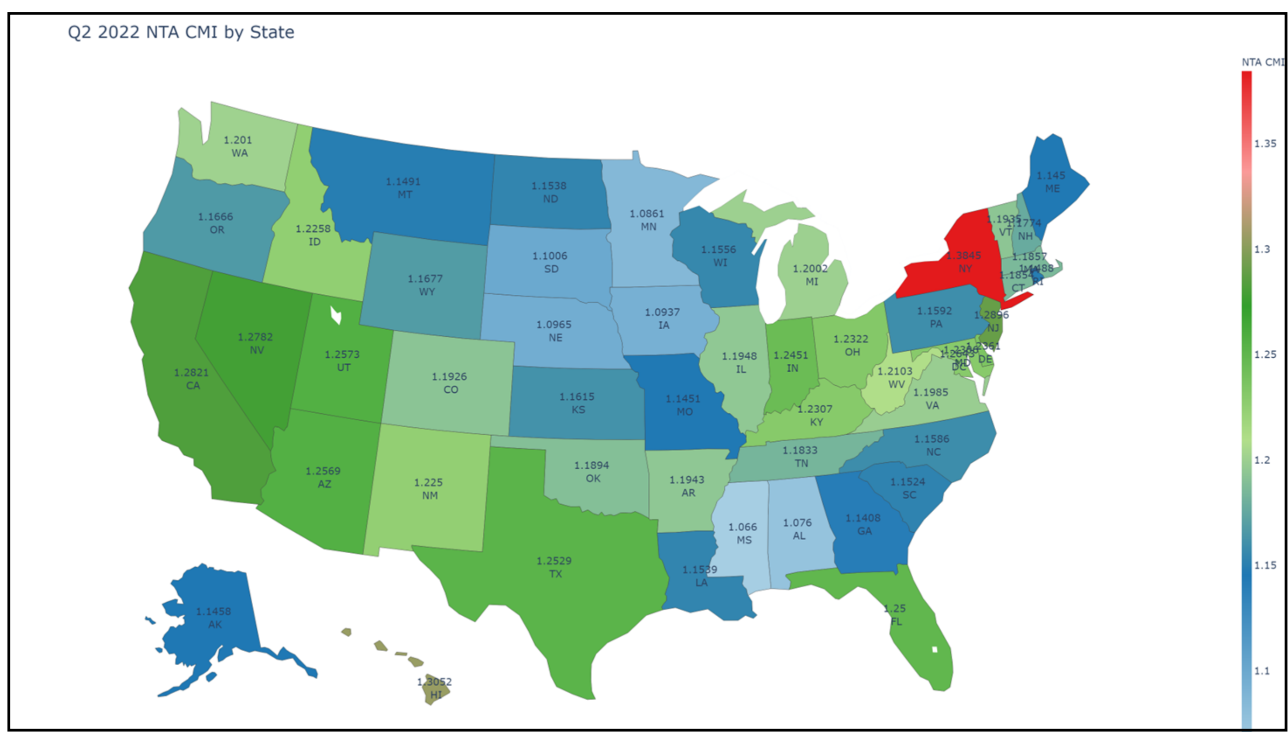

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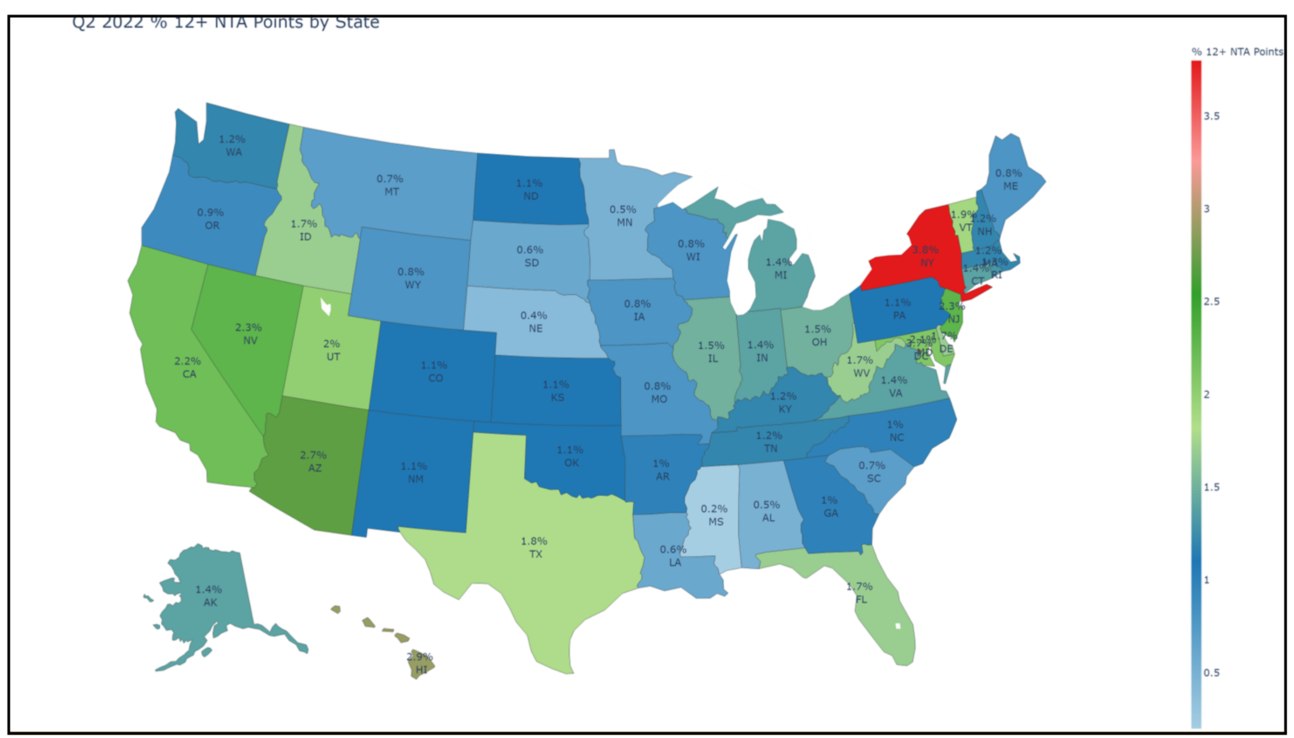

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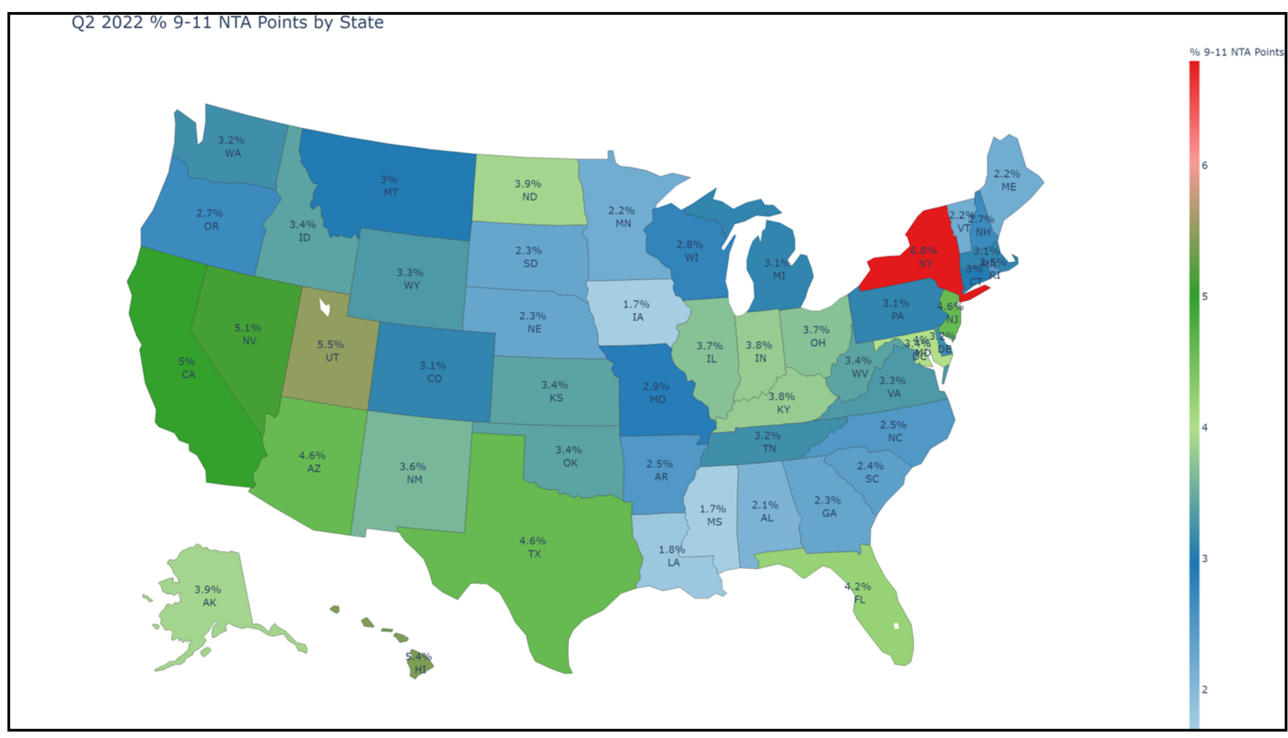

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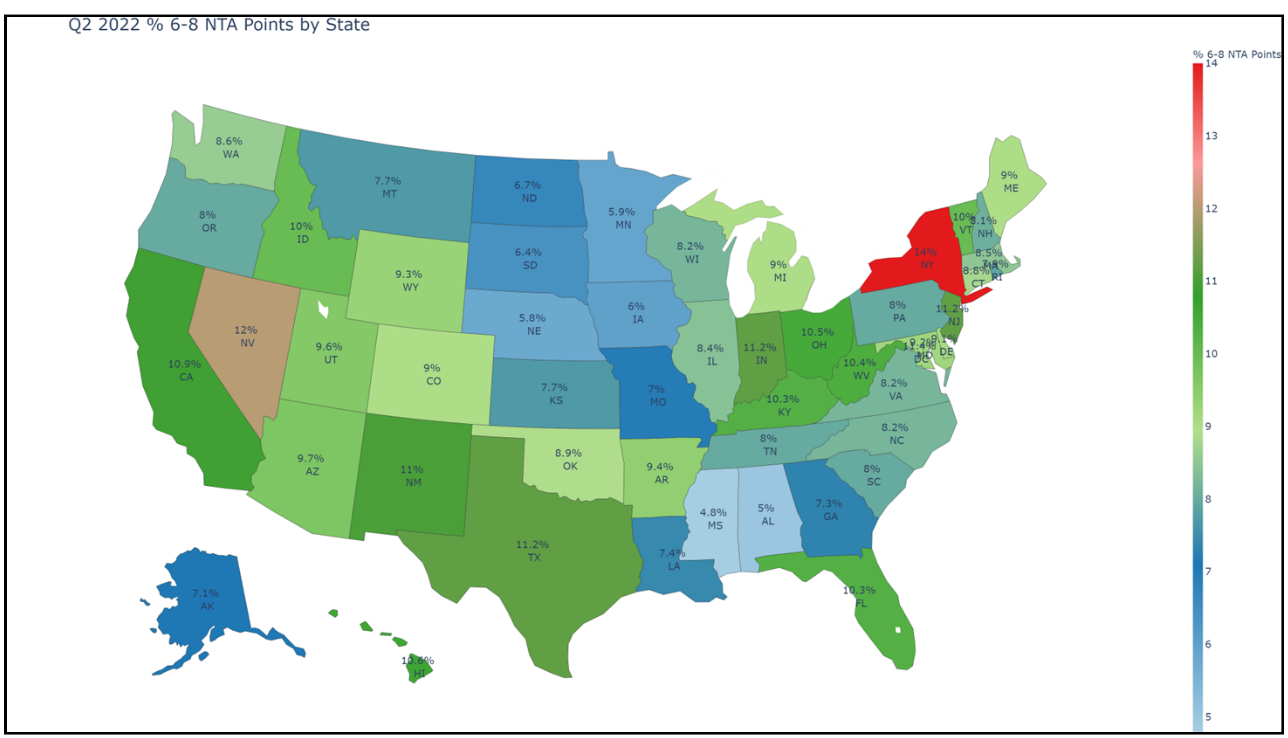

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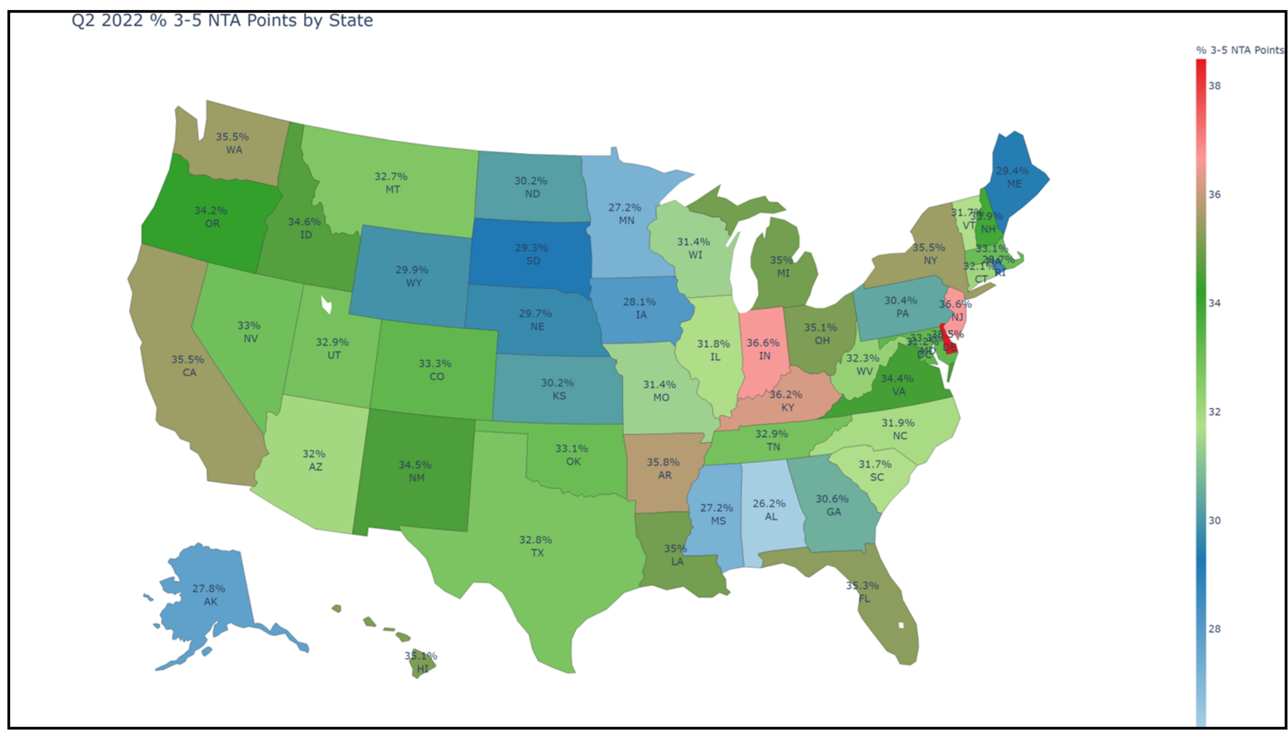

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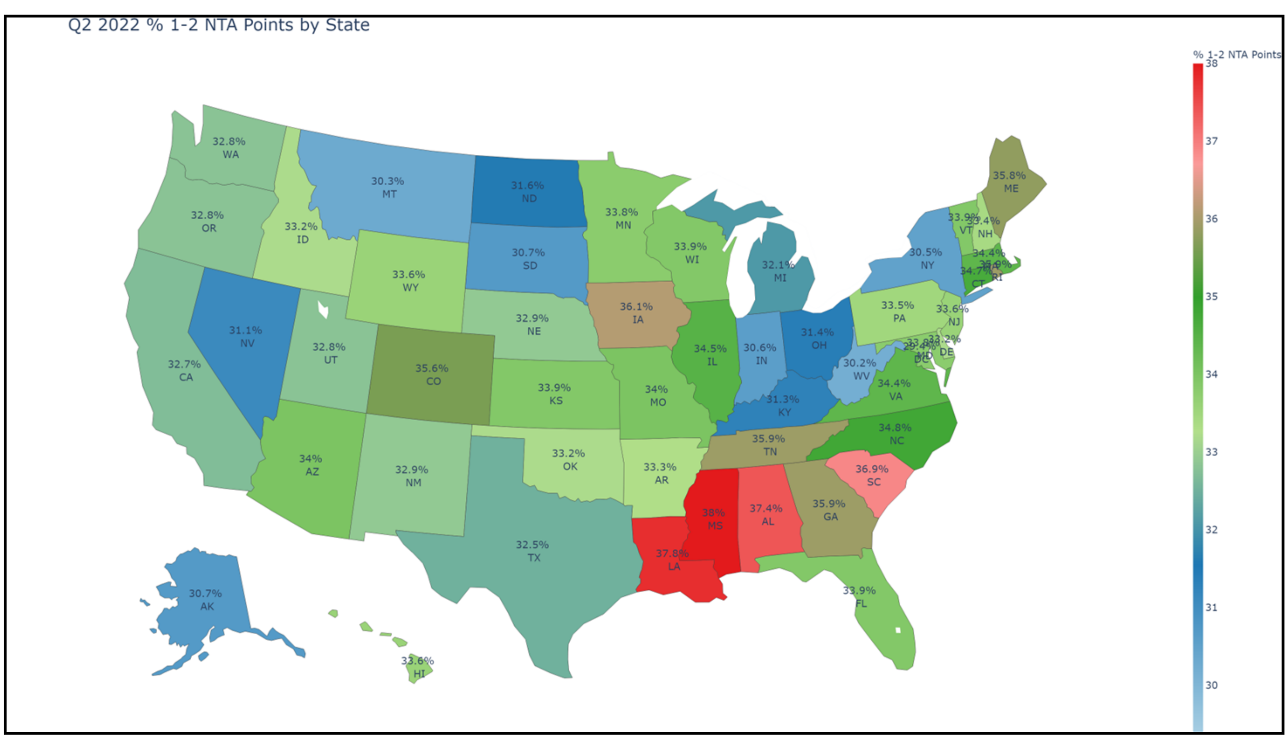

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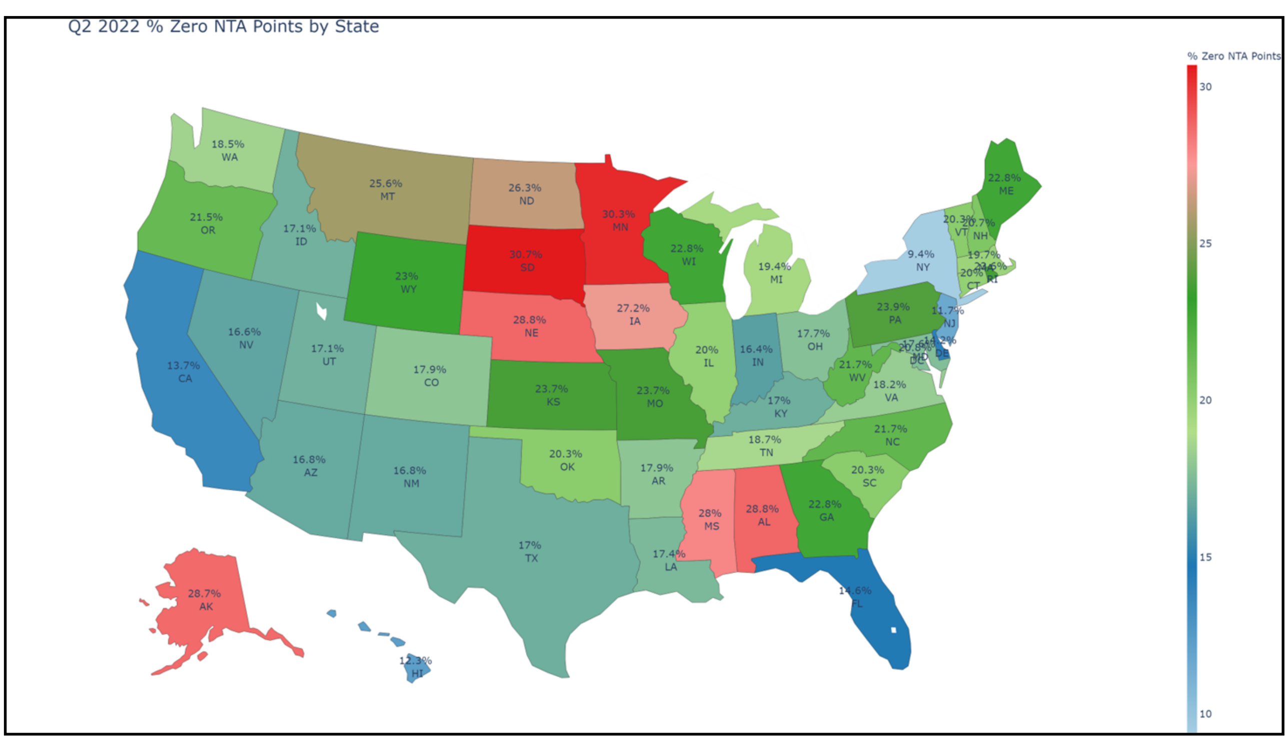

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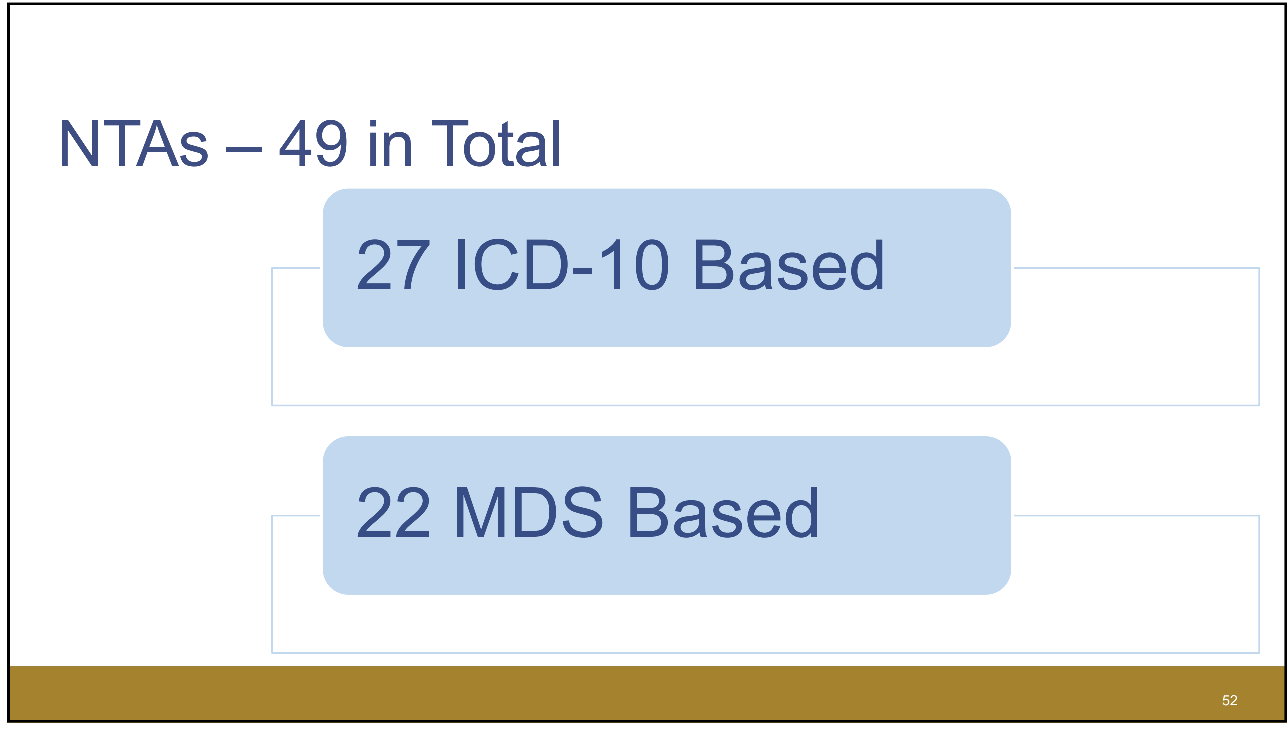

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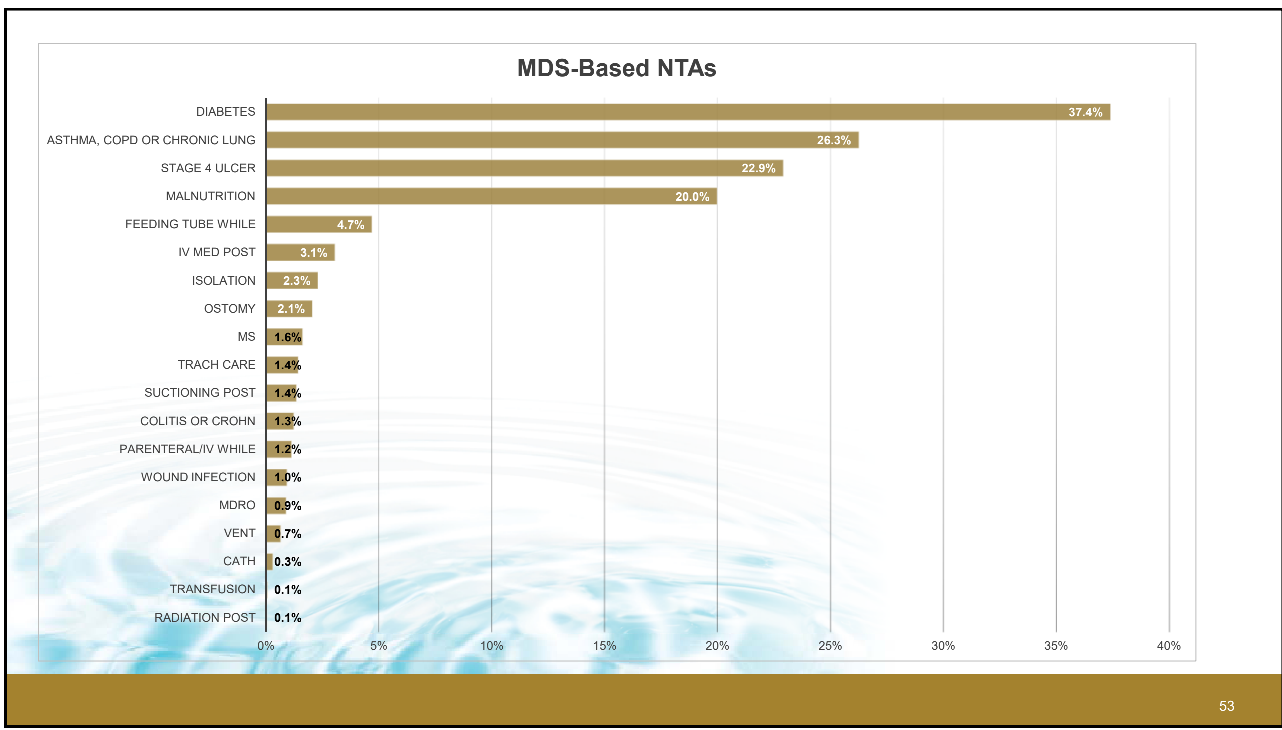

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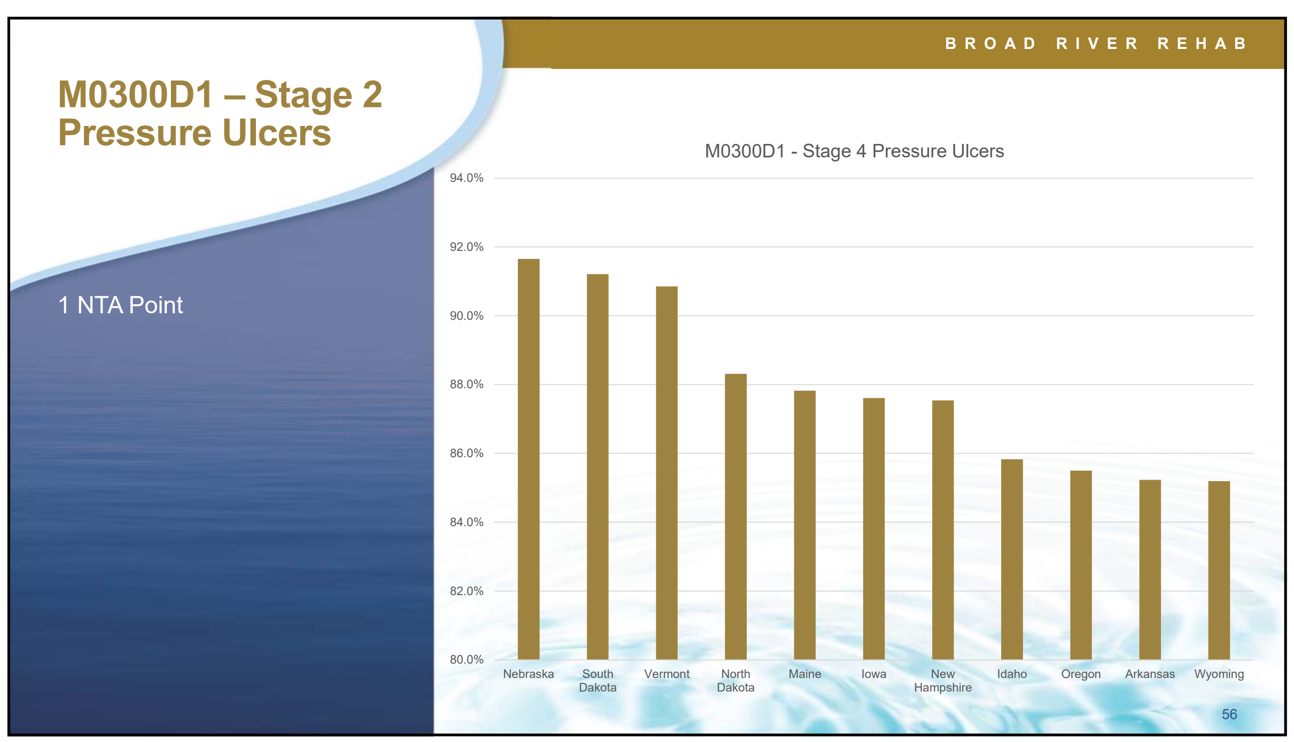

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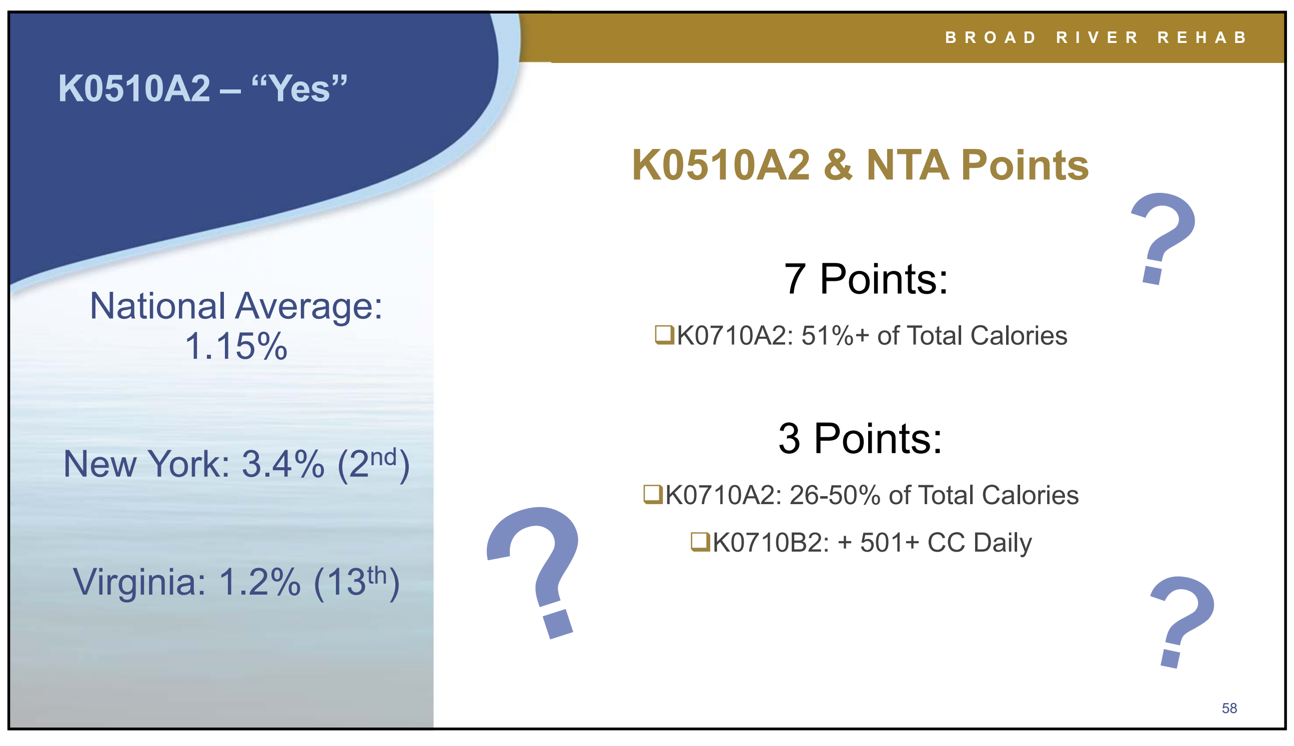

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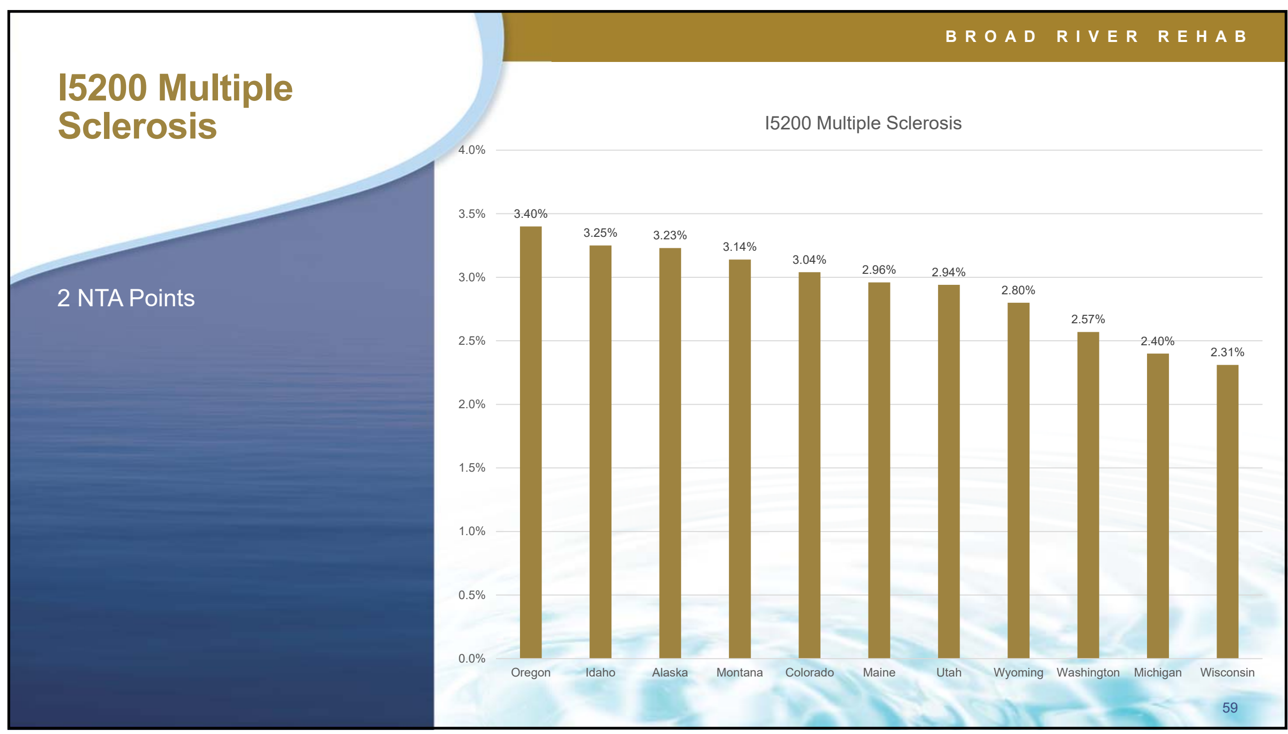

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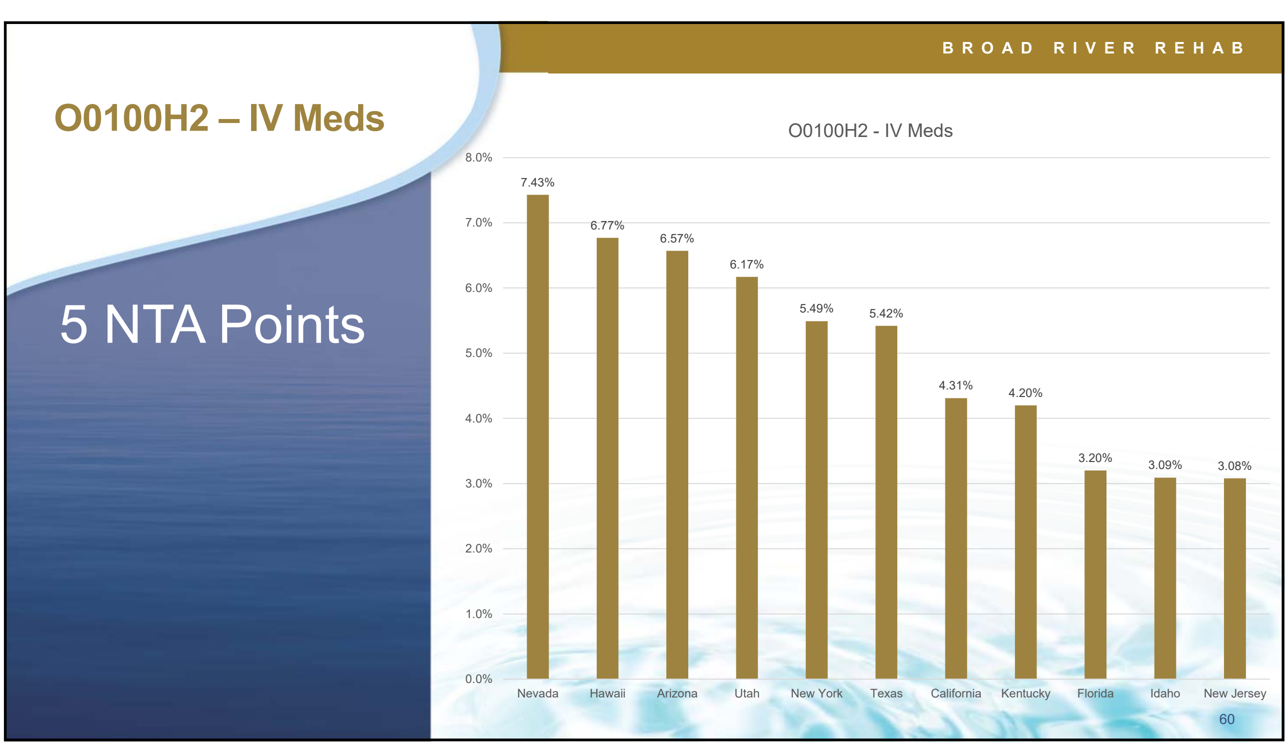

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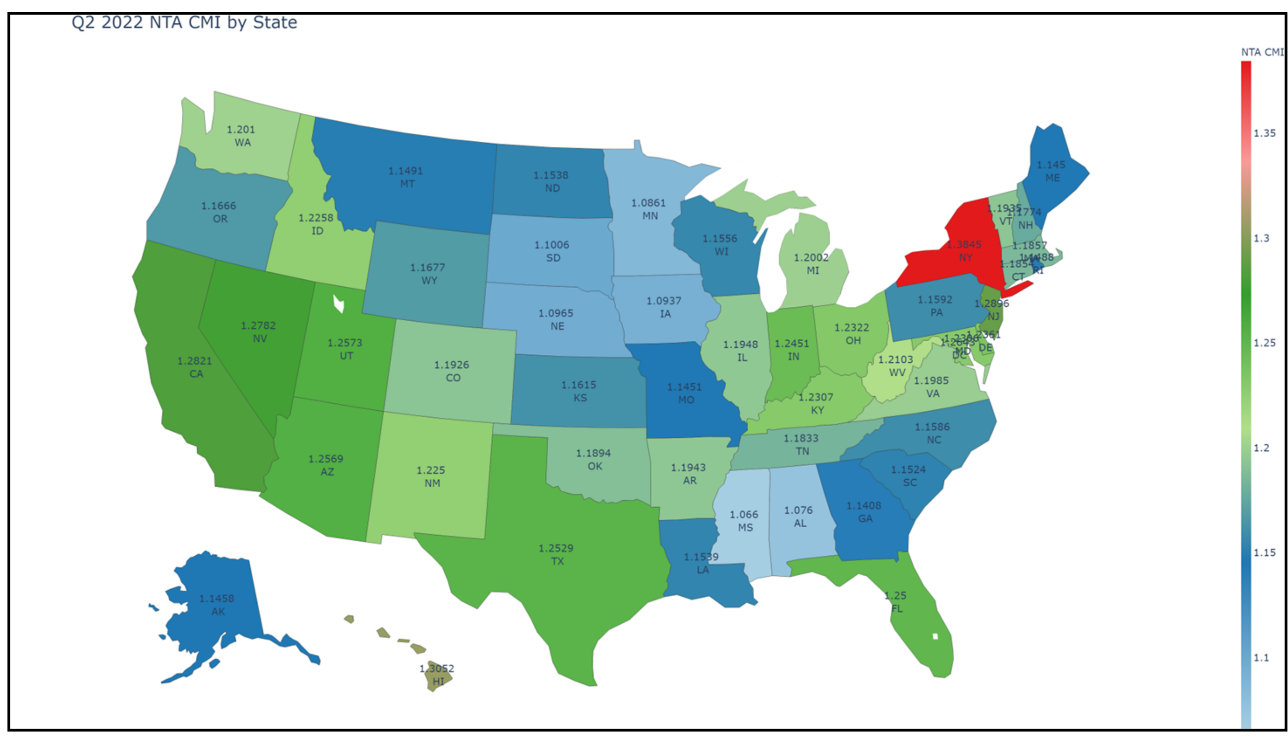

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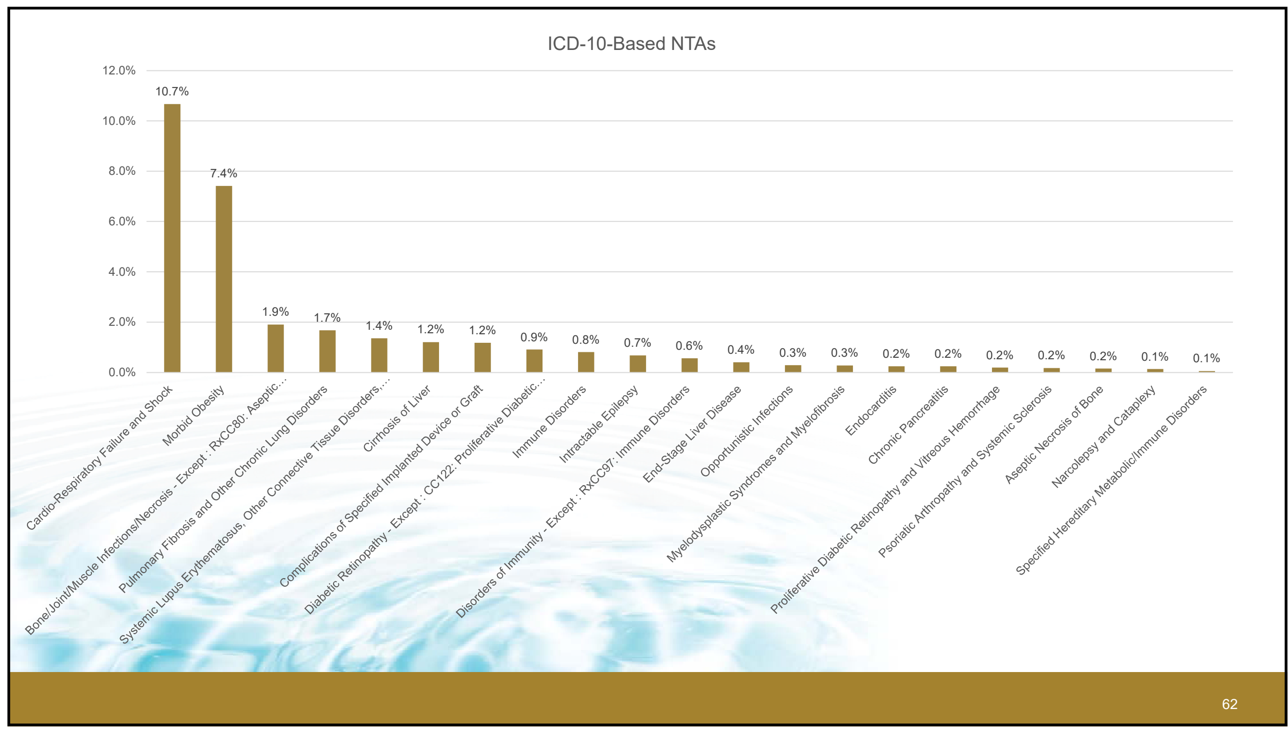

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Top 10 ICD-10 Based NTAs

Cardio-Respiratory Failure and Shock	Morbid Obesity	Bone/Joint/Muscle Infections/Necrosis - Except : RxCC80: Aseptic Necrosis of Bone	Pulmonary Fibrosis and Other Chronic Lung Disorders	Cirrhosis of Liver	Complications of Specified Implanted Device or Graft	Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	Immune Disorders	Disorders of Immunity - Except : RxCC97: Immune Disorders	Diabetic Retinopathy - Except : CC122: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
District of Columbia	Idaho	Guam	New York	Arizona	Vermont	New York	New York	Delaware	Idaho
Utah	Utah	Puerto Rico	New Jersey	Washington	Arizona	North Carolina	Delaware	New Jersey	New Jersey
Idaho	Delaware	District of Columbia	Montana	District of Columbia	New Jersey	North Dakota	California	Connecticut	Connecticut
Nevada	Oregon	Alaska	New Hampshire	Delaware	Washington	Massachusetts	Montana	Massachusetts	Wisconsin
Delaware	Vermont	Montana	Delaware	California	Delaware	Maryland	New Jersey	Utah	West Virginia
New Mexico	Ohio	Arizona	Vermont	New Mexico	Montana	Oklahoma	Massachusetts	Wisconsin	North Dakota
Colorado	Wisconsin	New Jersey	Ohio	Oregon	Oregon	Washington	North Carolina	New York	South Dakota
California	Washington	Maryland	Idaho	Kentucky	Massachusetts	Montana	New Hampshire	New Hampshire	Vermont
11th	15th	27th	15th	23rd	16th	23rd	14th	26th	26th

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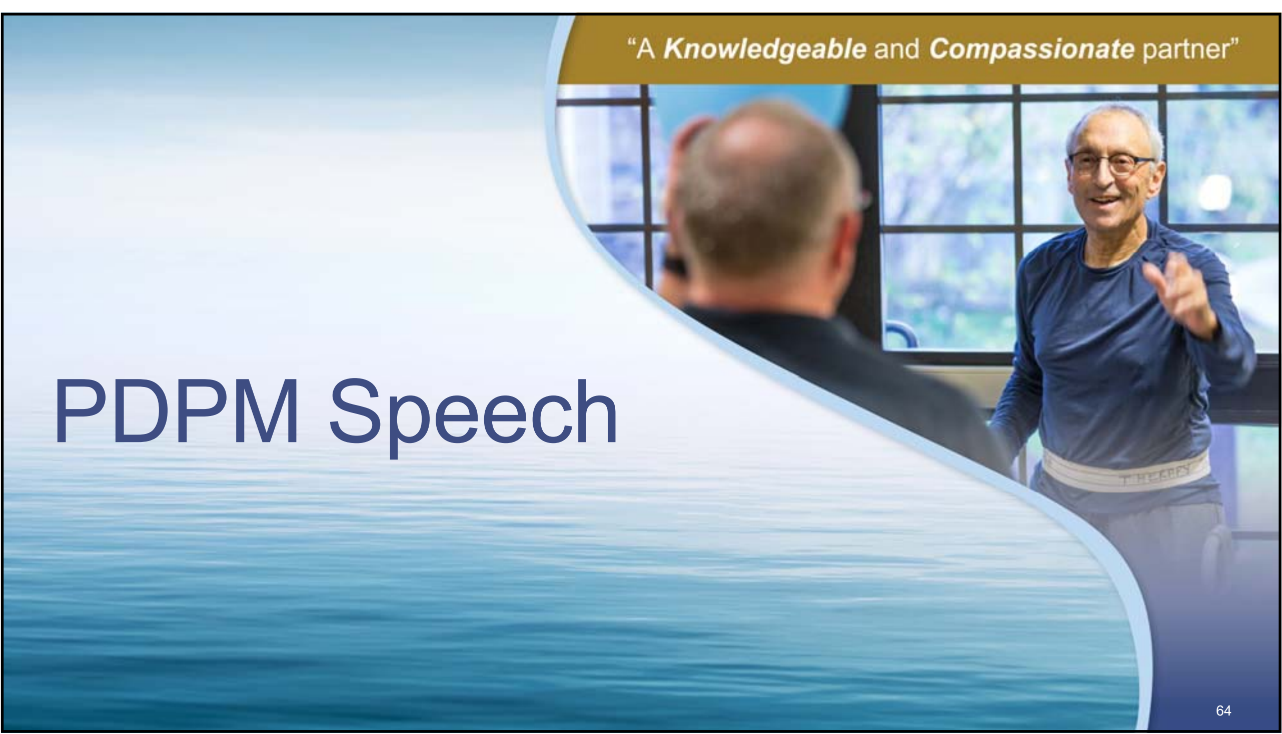

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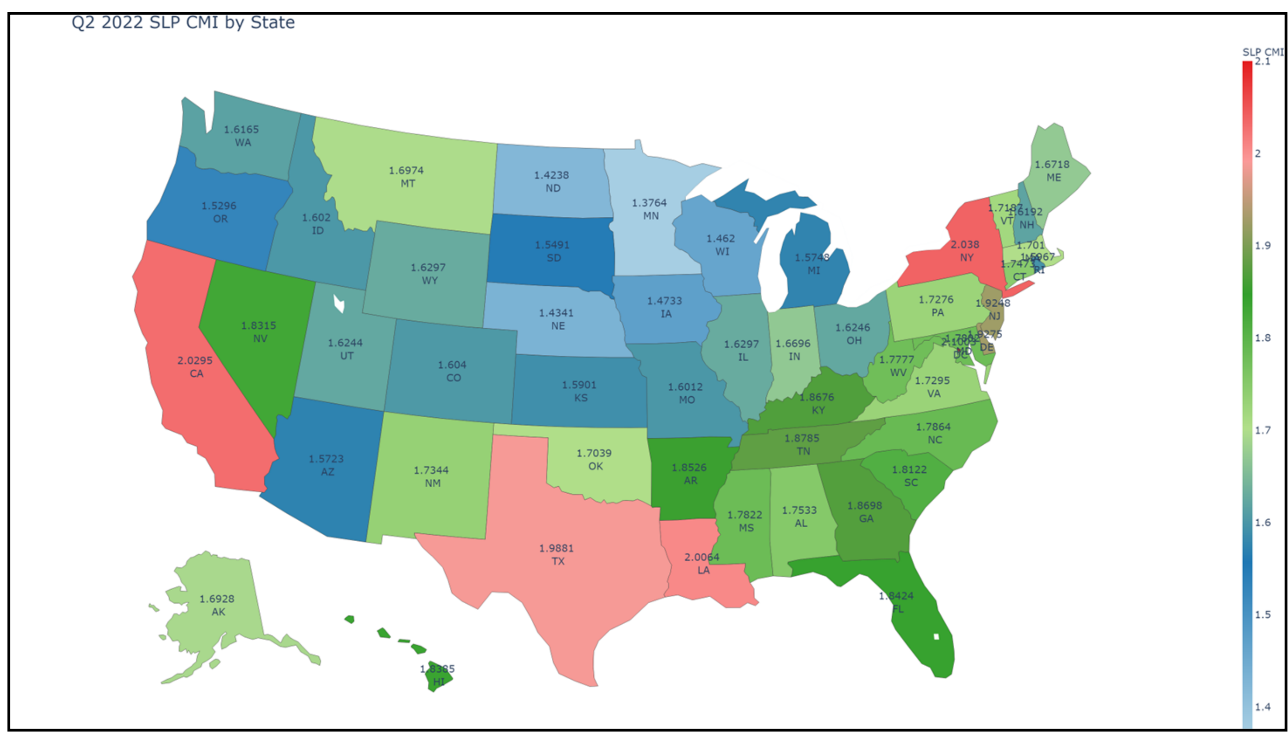

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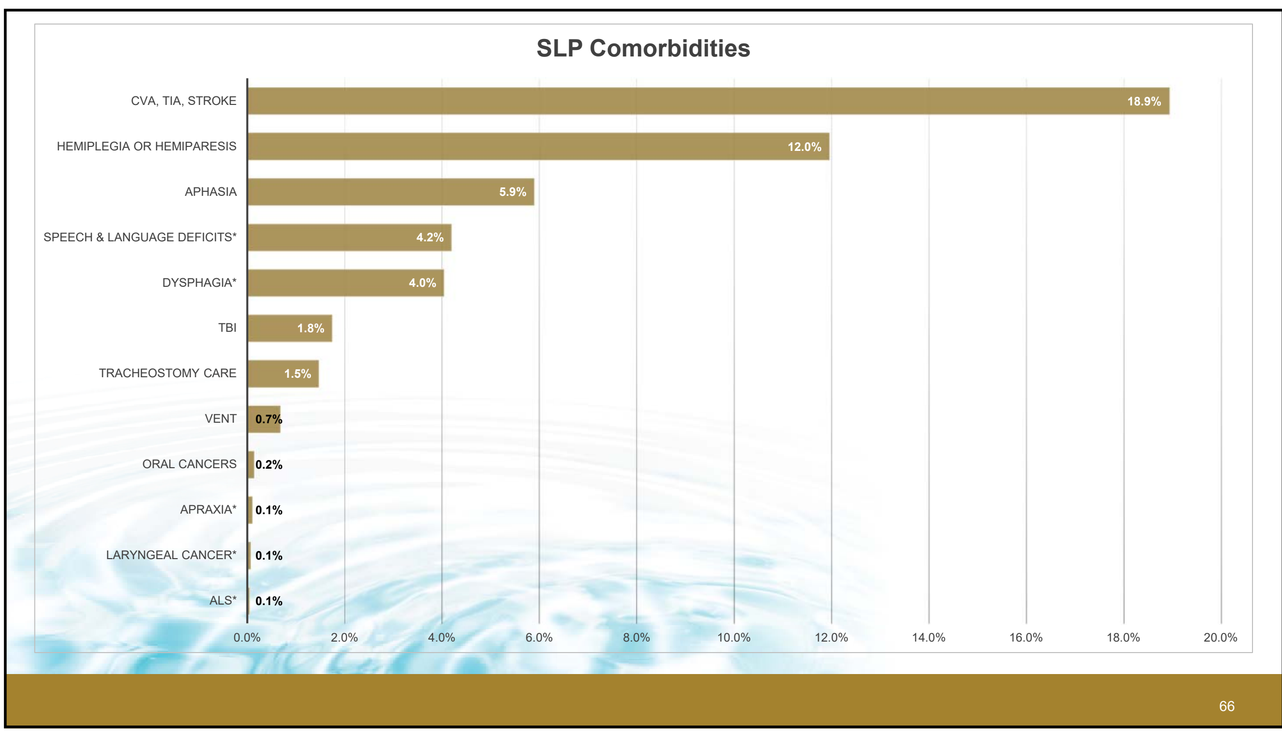

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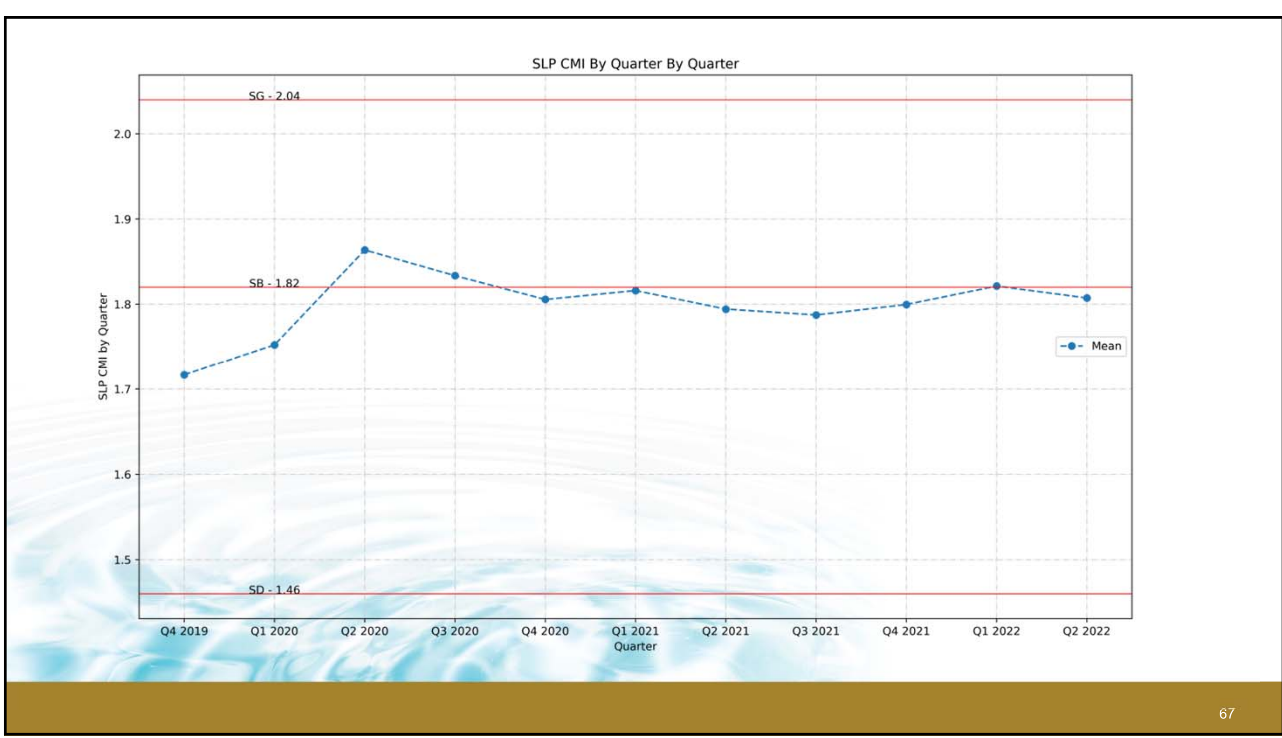

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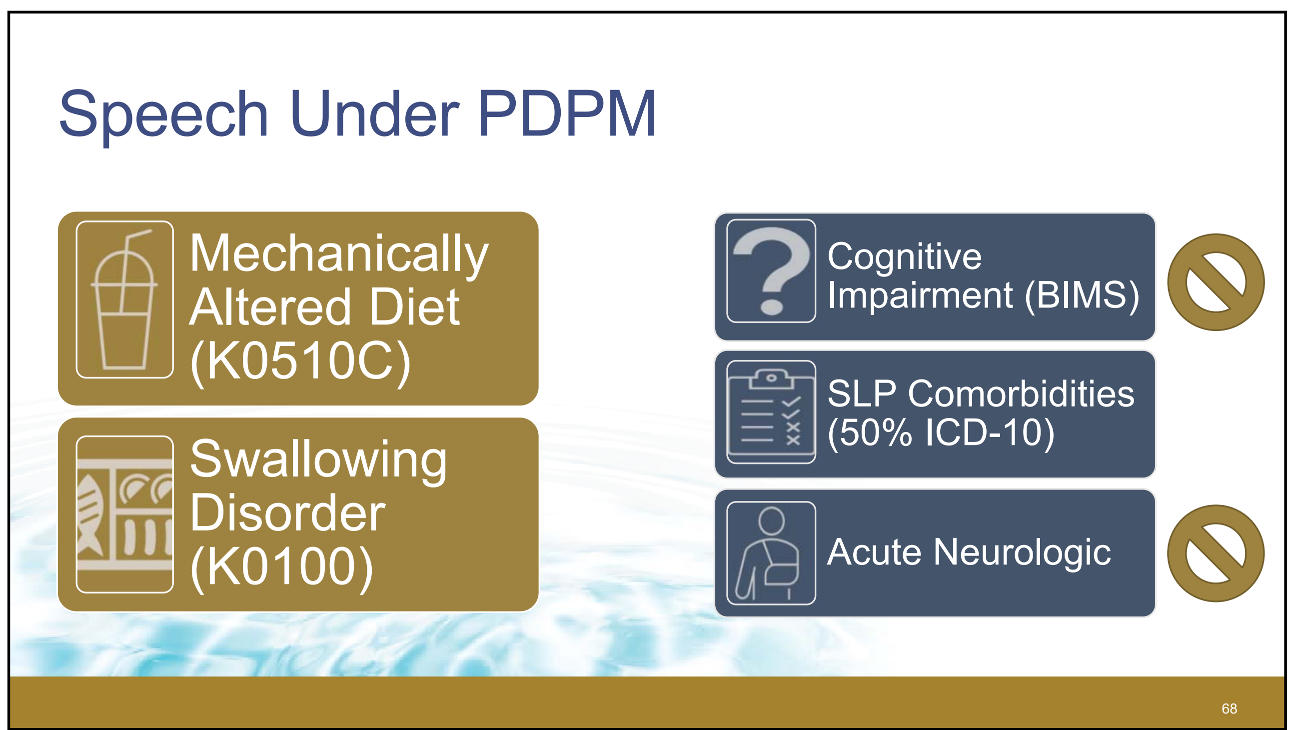

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SLP

	Mech Altered Diet	Swallowing Disorder	Vent	Trach	TBI	Hemiplegia/ Hemiparesis	CVA / TIA / Stroke	Aphasia
California	**42.3% (2nd)**	**10.1% (10th)**	**2.3% (4th)**	**4.5% (3rd)**	2.0% (14th)	14.0% (12th)	17% (27th)	5.0% (32nd)
New York	35% (13th)	**10.7% (5th)**	**1.5% (7th)**	**2.5% (7th)**	2.1% (12th)	11.4% (26th)	**21.5% (10th)**	6.4% (14th)
Texas	34.9% (15th)	9.6% (13th)	0.3% (29th)	1.0% (26th)	1.7% (27th)	12.4% (20th)	**24.8% (3rd)**	**7.7% (6th)**
Louisiana	29% (34th)	9.0% (16th)	0.4% (25th)	1.0% (27th)	1.3% (50th)	**15.8% (5th)**	**24.0% (5th)**	**12.4% (1st)**
New Jersey	33.8% (20th)	**10.6% (8th)**	0.9% (11th)	1.9% (10th)	1.4% (49th)	9.7% (39th)	17.1% (26th)	5.1% (31st)
Virginia	31.7% (29th)	7.7% (31st)	0.5% (19th)	1.1% (21st)	1.7% (28th)	14.0% (13th)	21.6% (8th)	6.7% (11th)
Nation	32.3%	8.2%	0.7%	1.5%	1.8%	12.0%	18.9%	5.9%

SLP Comorbidities (ICD-10)

	ALS	Apraxia	Dysphagia	Laryngeal Cancer	Oral Cancer	Speech & Language Deficits
California	0.11%	0.11%	5.6%	0.05%	0.14%	3.9%
New York	0.05%	0.11%	8.2%	0.06%	0.13%	7.2%
Texas	0.05%	0.16%	5.1%	0.06%	0.09%	5.5%
Louisiana	0.07%	0.44%	6.7%	0.02%	0.04%	9.1%
New Jersey	0.06%	0.09%	3.3%	0.13%	0.25%	3.0%
Virginia	0.10%	0.05%	5.6%	0.05%	0.12%	5.6%

Strategy for Success

- How does my data compare to the state/nation/competitors?
- DIVERSITY of Coding
- Miss LESS

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Joe's PDPM "Red Flags"

1. High Use of Nursing Category 'Reduced Physical Function'
2. High Use of NTA Category 'F'
3. Extreme Utilization of 10-23 in PT/OT
4. Very high Medical Management
5. No Evidence of SLP Programs
6. Zero Percent Depression

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Strategy for Success

There are 2 sides to the ledger!

- Many focus only on reducing cost and do not question whether clinical staff are coding appropriately
- Accuracy leads to reimbursement (that includes depression)
- Are your residents lower acuity than everyone else?
- Are your coding practices different?

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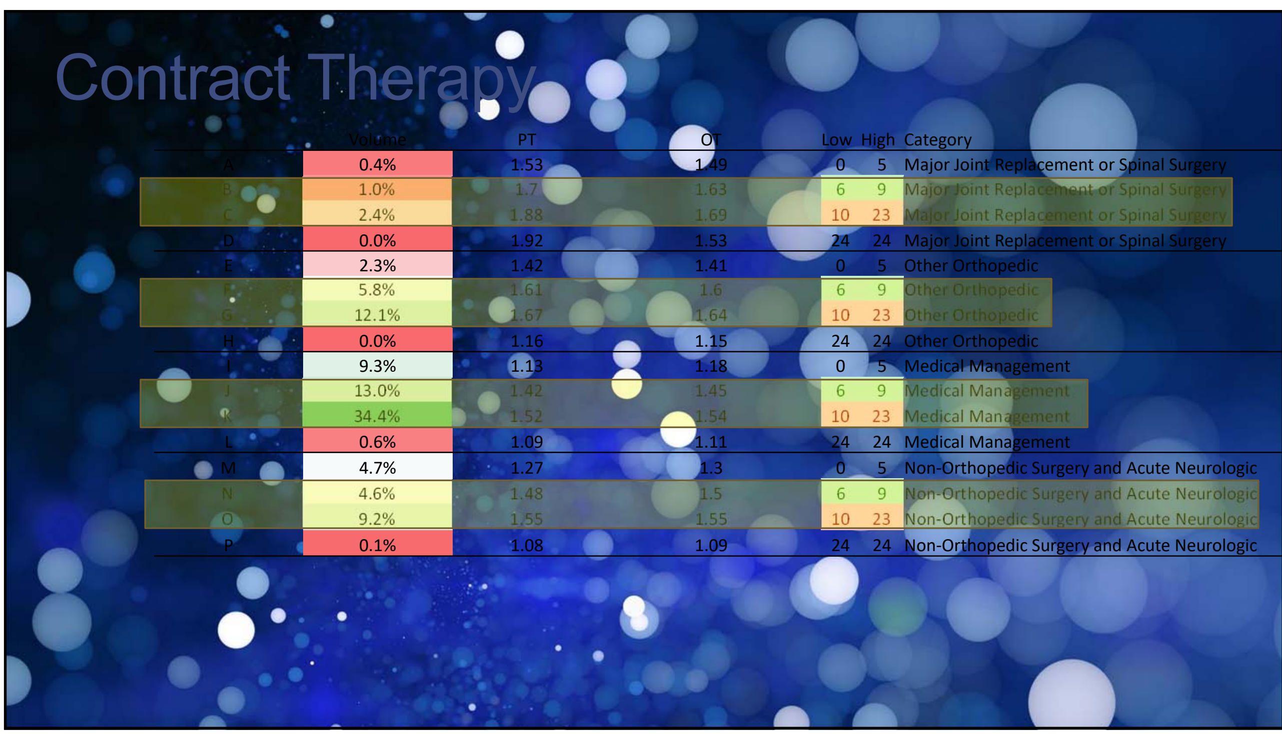

Contract Therapy

	Volume	PT	OT	Low	High	Category
A	0.4%	1.53	1.49	0	5	Major Joint Replacement or Spinal Surgery
B	1.0%	1.7	1.63	6	9	Major Joint Replacement or Spinal Surgery
C	2.4%	1.88	1.69	10	23	Major Joint Replacement or Spinal Surgery
D	0.0%	1.92	1.53	24	24	Major Joint Replacement or Spinal Surgery
E	2.3%	1.42	1.41	0	5	Other Orthopedic
F	5.8%	1.61	1.6	6	9	Other Orthopedic
G	12.1%	1.67	1.64	10	23	Other Orthopedic
H	0.0%	1.16	1.15	24	24	Other Orthopedic
I	9.3%	1.13	1.18	0	5	Medical Management
J	13.0%	1.42	1.45	6	9	Medical Management
K	34.4%	1.52	1.54	10	23	Medical Management
L	0.6%	1.09	1.11	24	24	Medical Management
M	4.7%	1.27	1.3	0	5	Non-Orthopedic Surgery and Acute Neurologic
N	4.6%	1.48	1.5	6	9	Non-Orthopedic Surgery and Acute Neurologic
O	9.2%	1.55	1.55	10	23	Non-Orthopedic Surgery and Acute Neurologic
P	0.1%	1.08	1.09	24	24	Non-Orthopedic Surgery and Acute Neurologic

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Category	Change In PT & OT (Urban – no WI)
Major Joint Replacement or Spinal Surgery	$11.17 + $12.73
Other Orthopedic	$3.72 + $3.46
Medical Management	$6.20 + $5.78
Non-Orthopedic Surgery and Acute Neurologic	$4.34 + $4.04

Average PT/OT Change: $12.28

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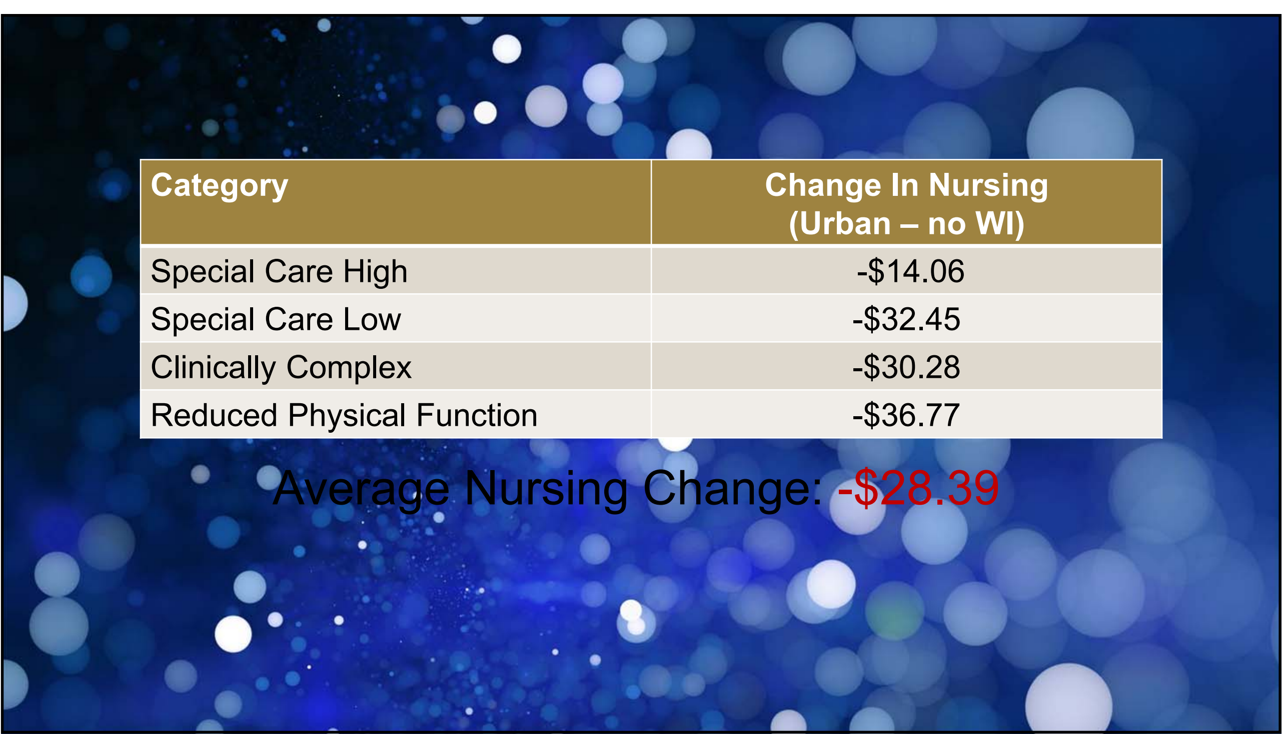

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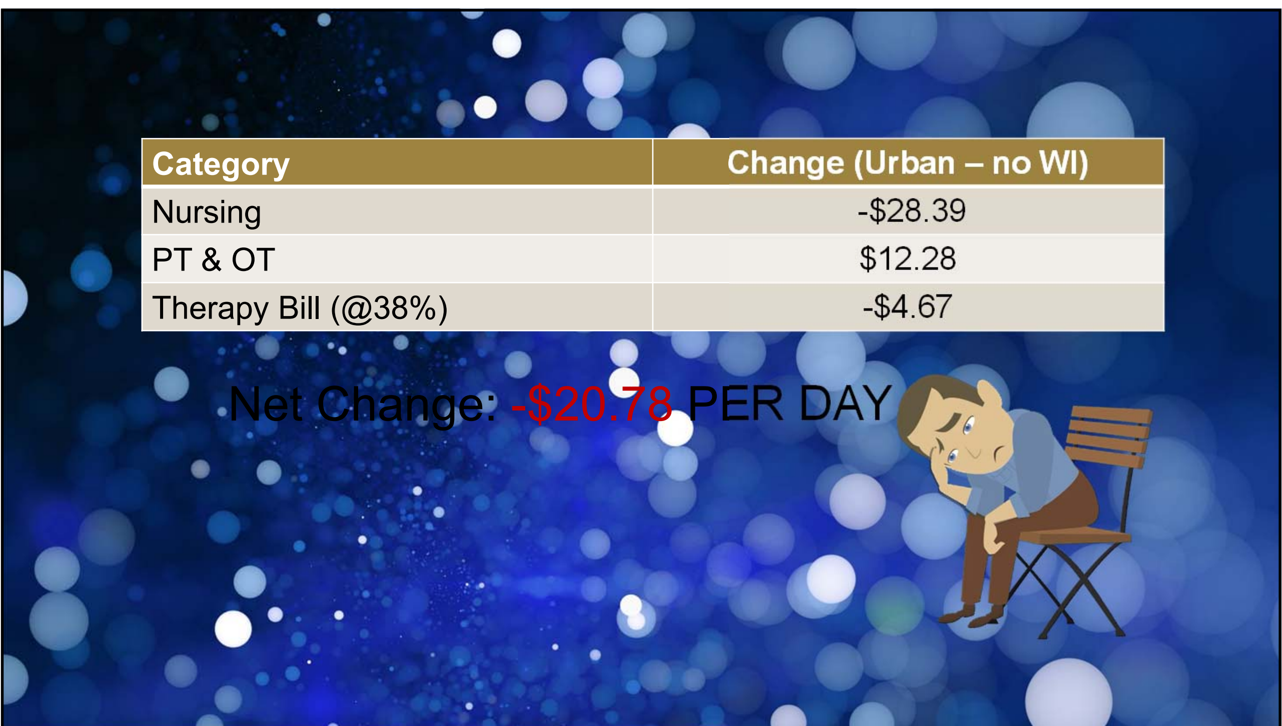

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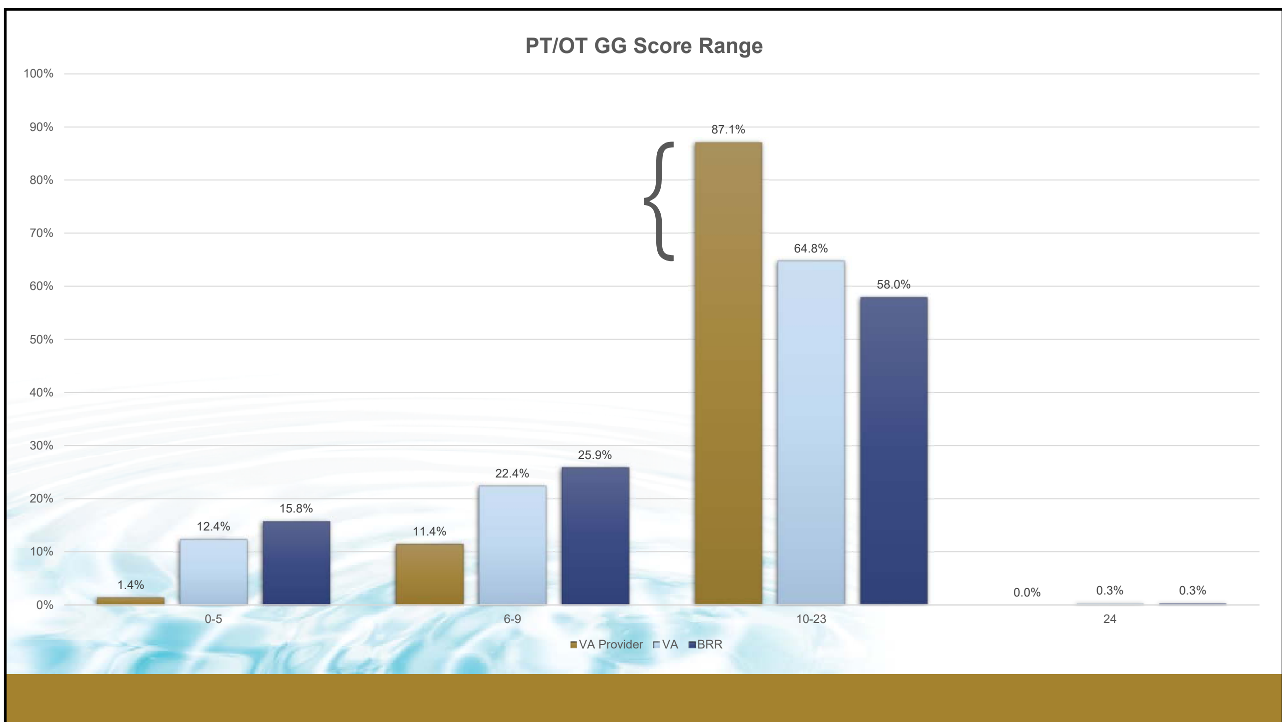

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Contract versus In-House Therapy

You will need to:

- Recruit and maintain PT, OT and SLP. (PTAs and OTAs too)
  - Pay is extremely market-dependent and does NOT following nursing trends
  - Your ratio of therapist to assistant is important
- You will need to manage *very* carefully!
- You will need to manufacture or buy your own tools.
- You will be responsible for all audit activity, including gathering data and defending yourself.
- Educate yourself and your staff. Changes Do. Not. Stop.

"Contract therapy companies make a profit. If I do what they do I can keep that profit."

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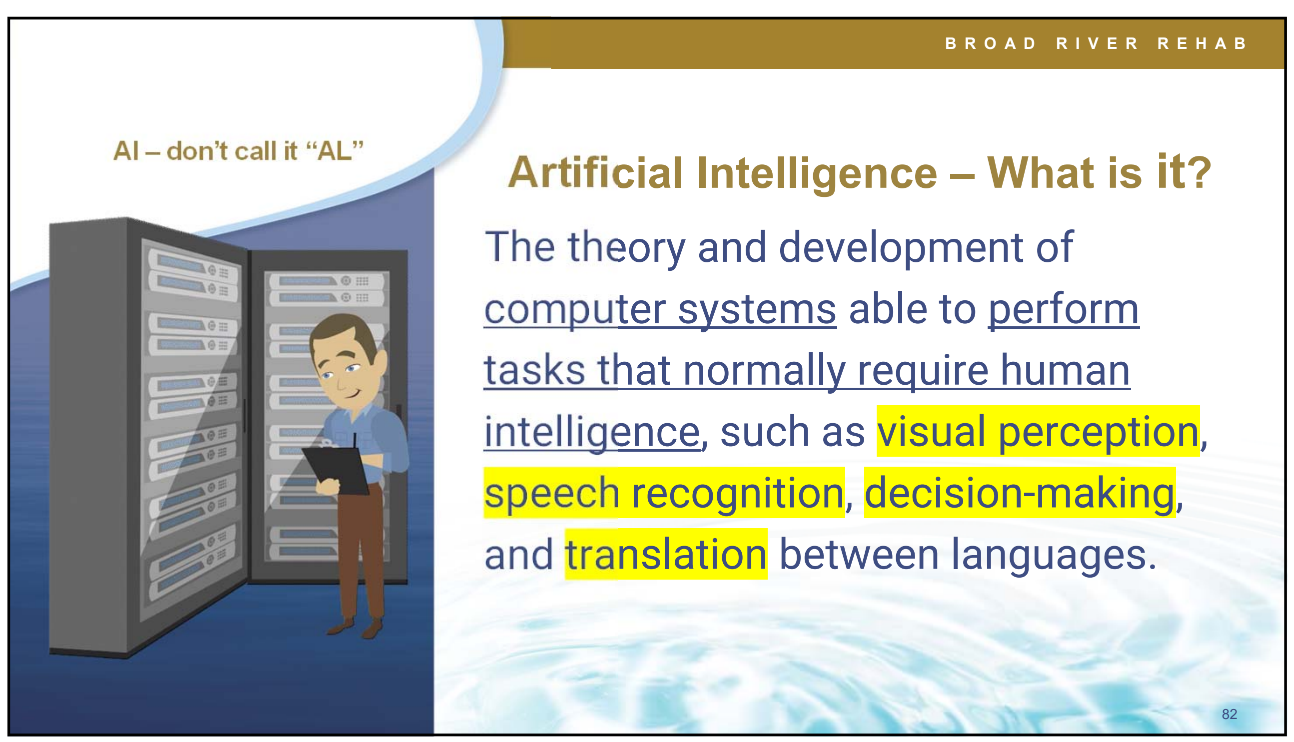

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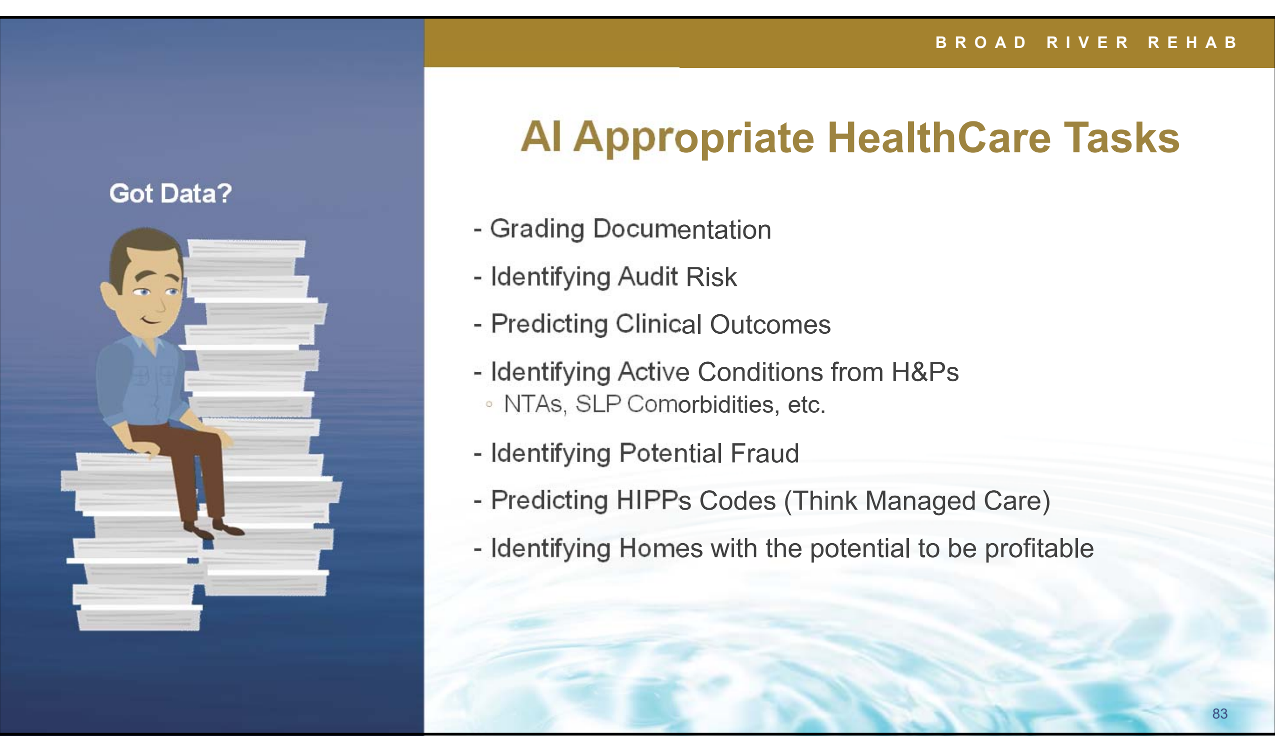

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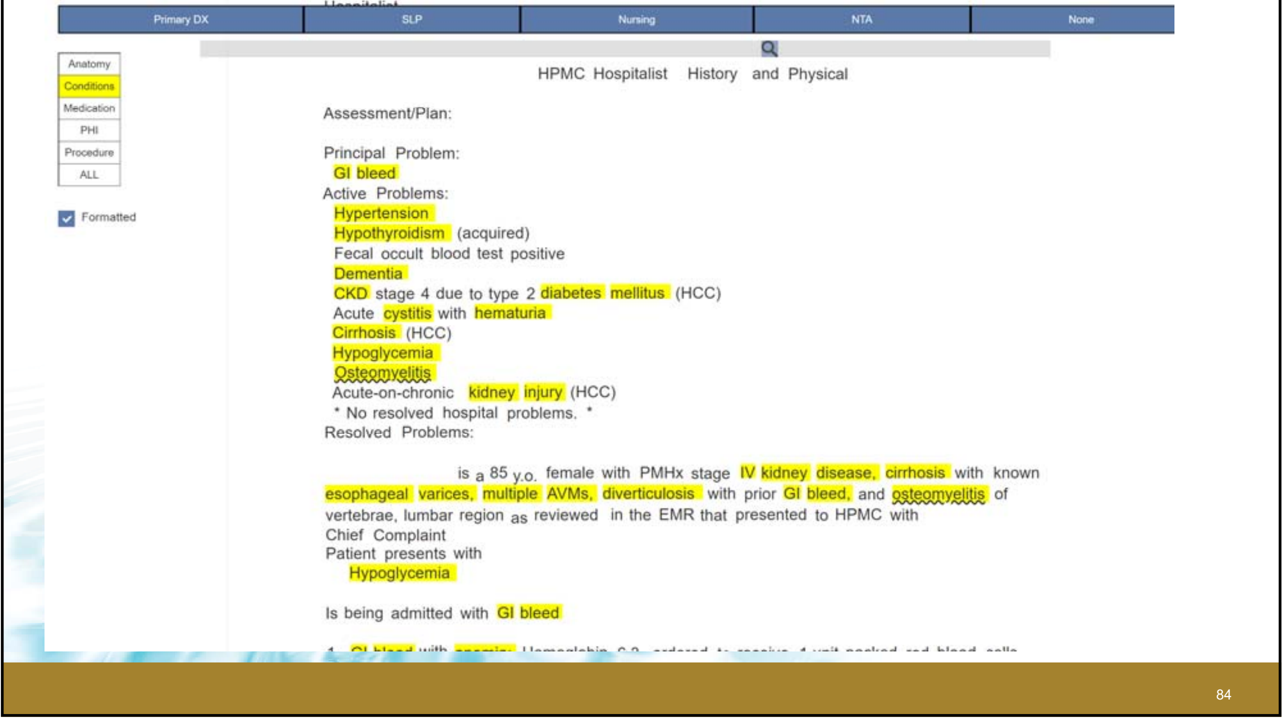

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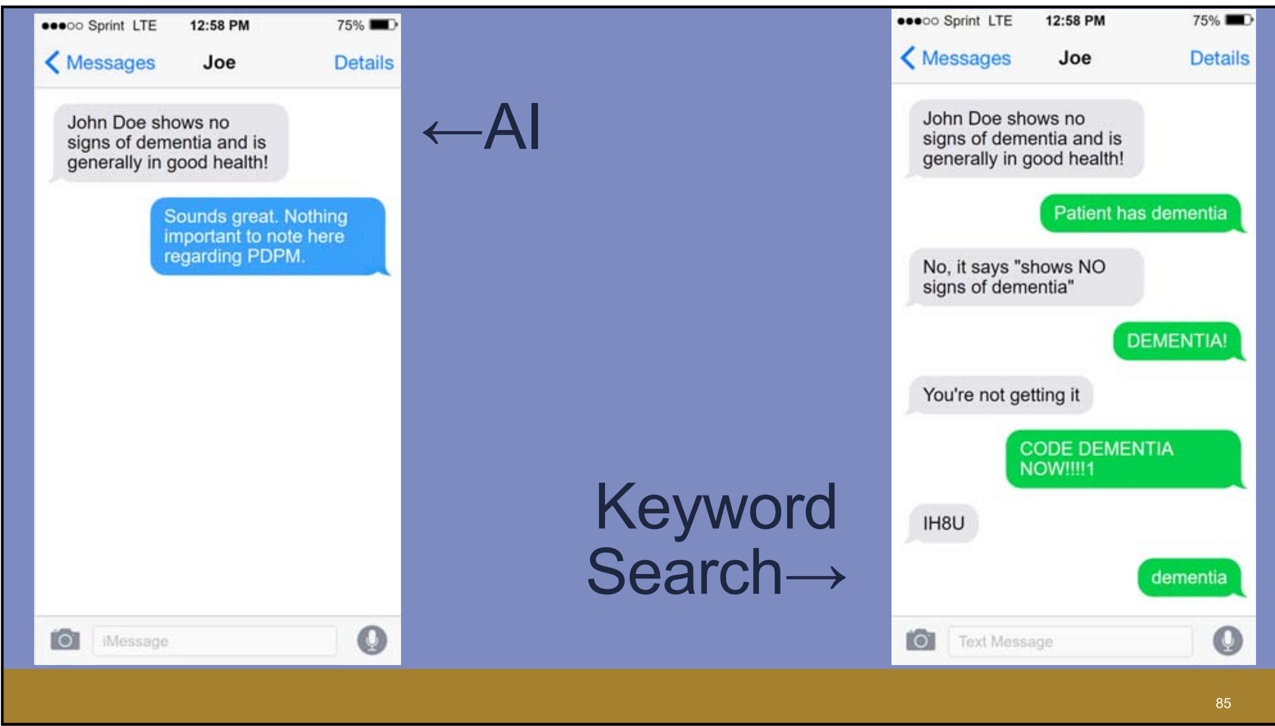

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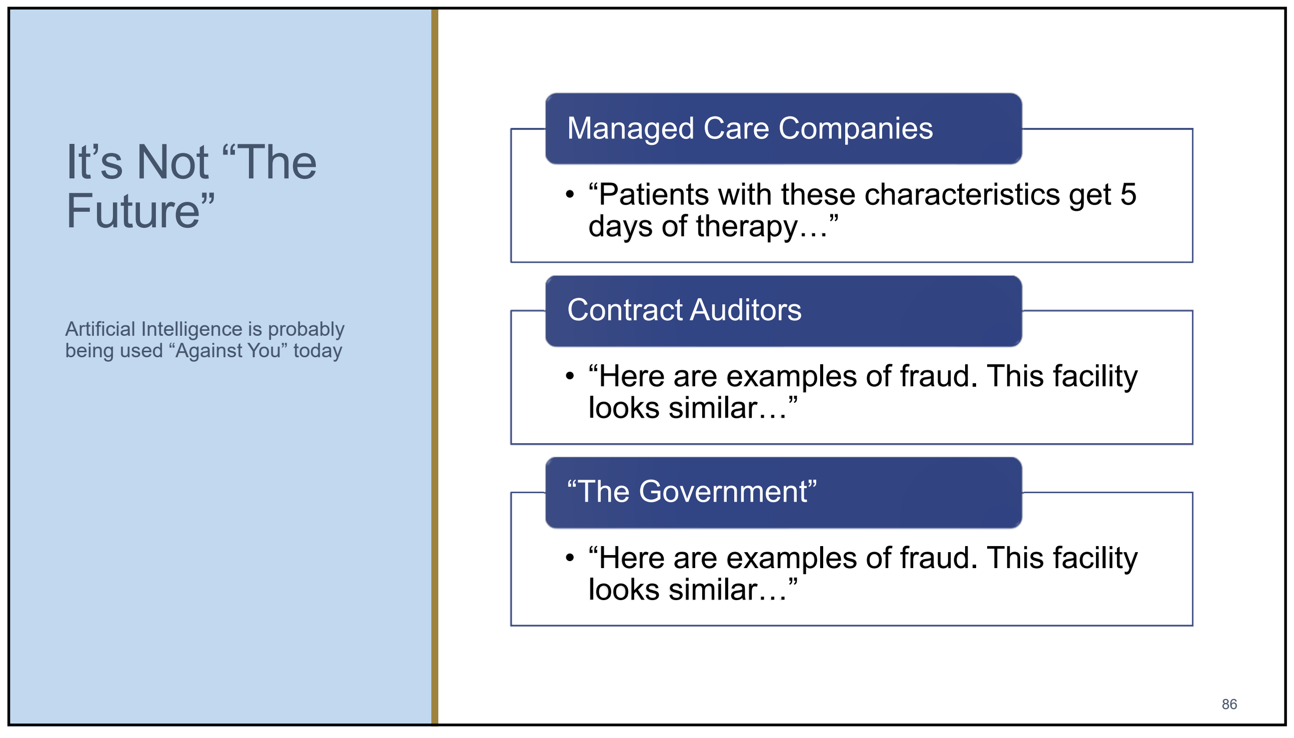

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In Use TODAY

Artificial Intelligence is in use in facilities around you.

DocNav®

- Reads incoming H&Ps with respect to PDPM (Primary DX, NTAs, Nursing & SLP)

DocAudit™

- Reads *EVERY* therapy note, *EVERY* day

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It still isn't easy

A. It still takes a great deal of expertise to develop your own.
B. It requires access to an enormous amount of data. (How much? MORE.)
C. It still requires discipline to use.

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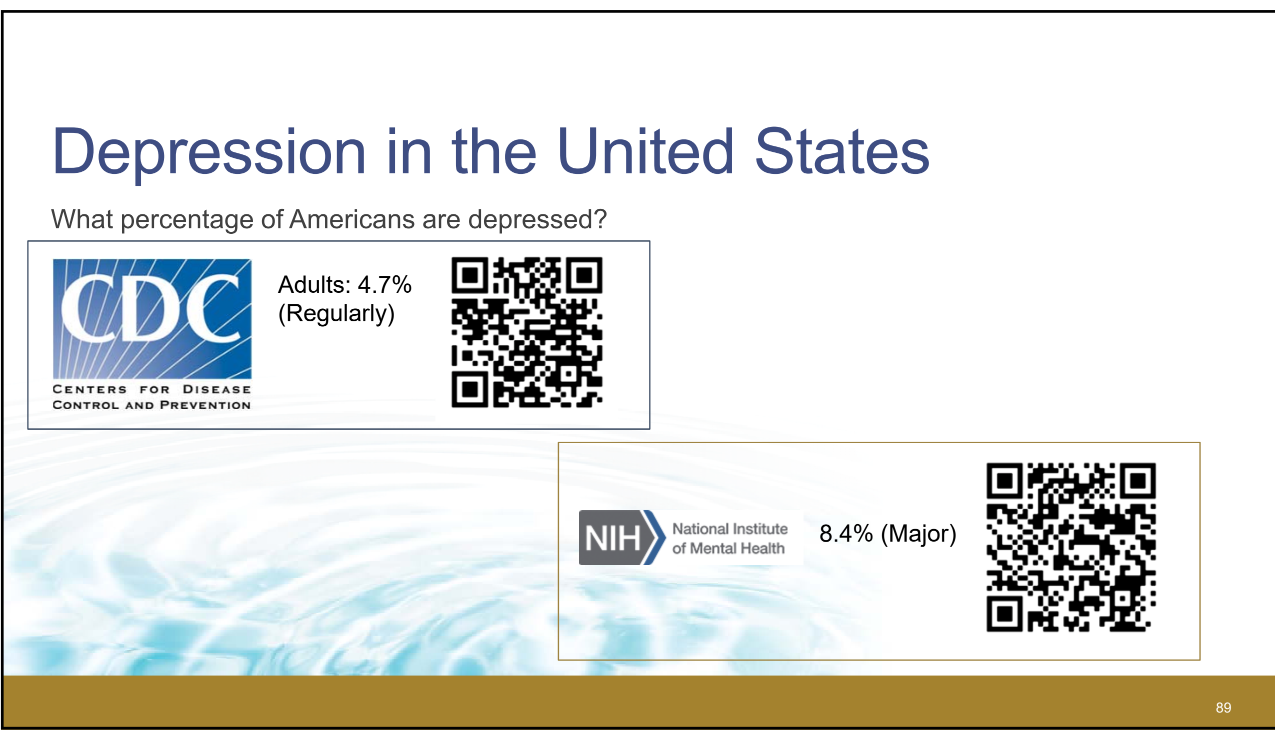

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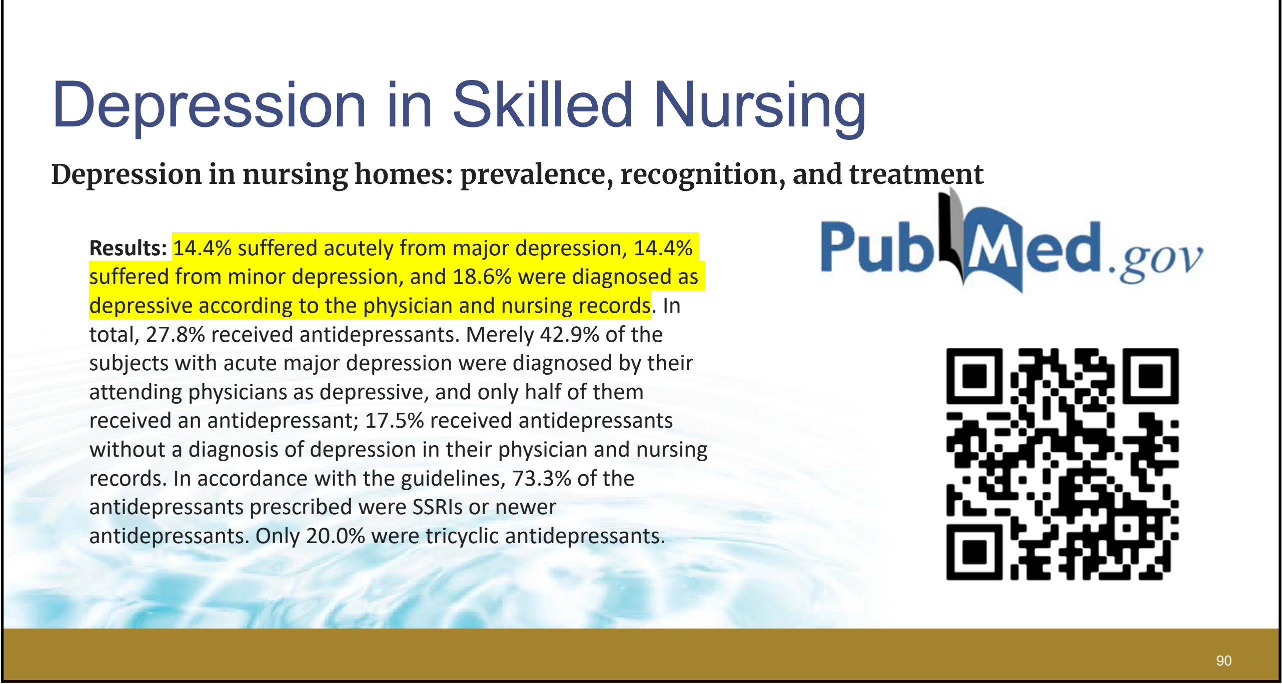

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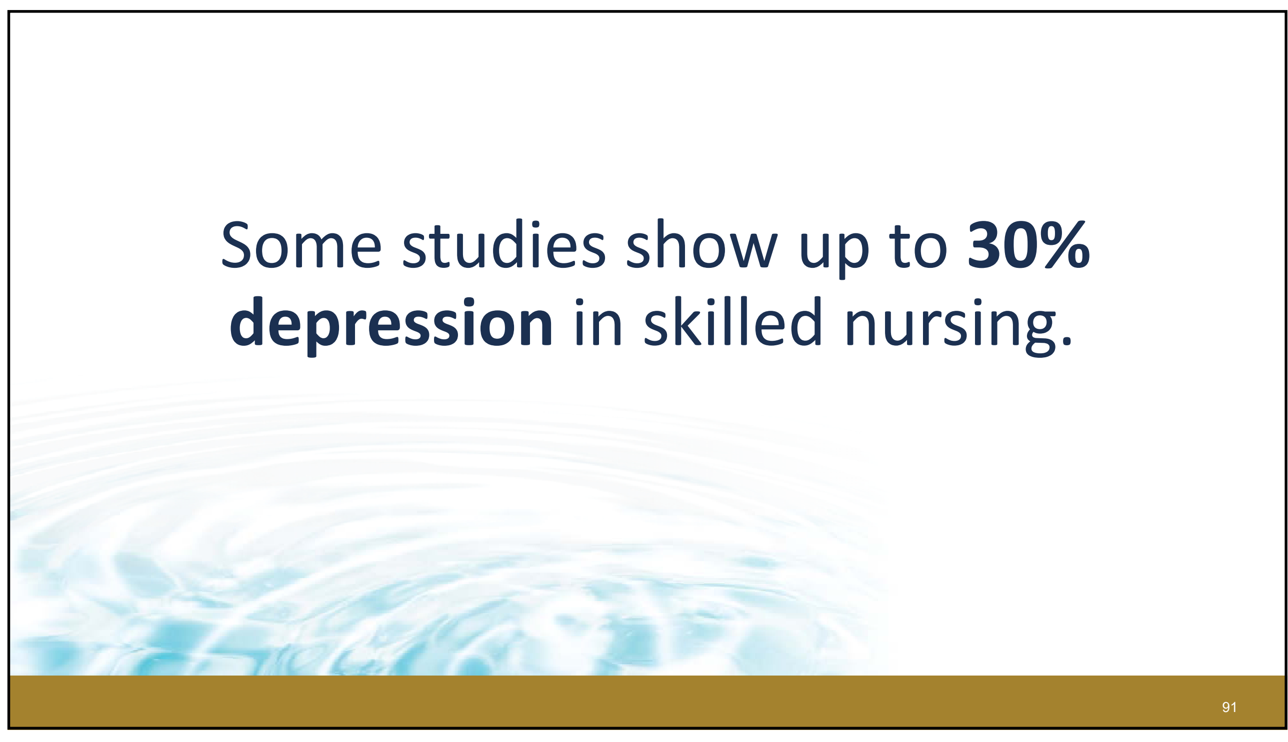

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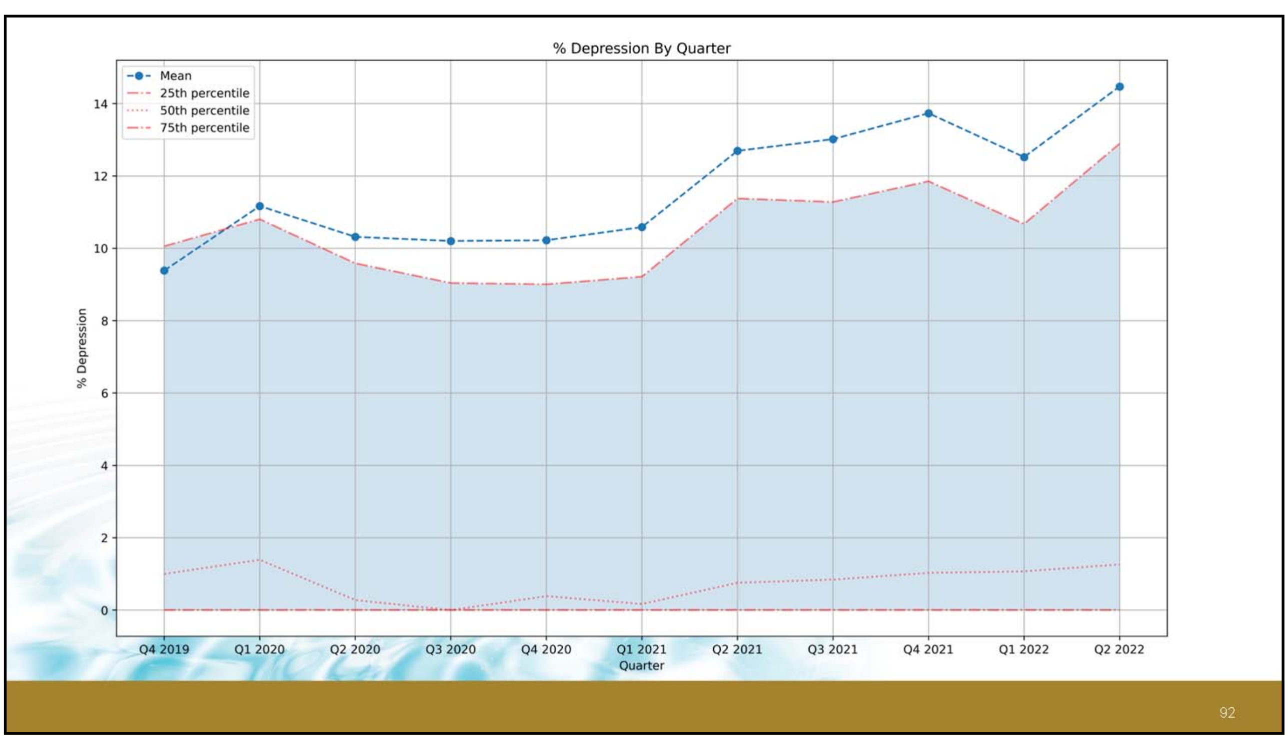

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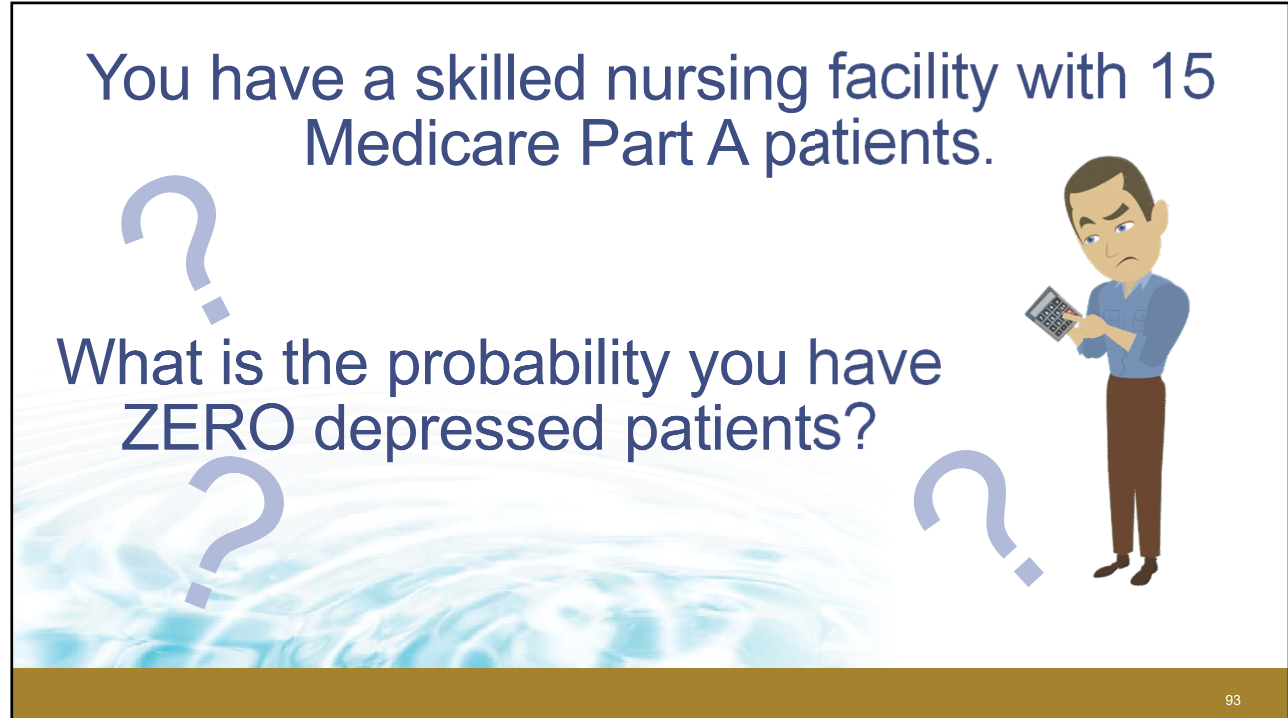

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Probability of ZERO Depression:

$$(1 - 0.2)^{15}$$

That's 3.5% chance.

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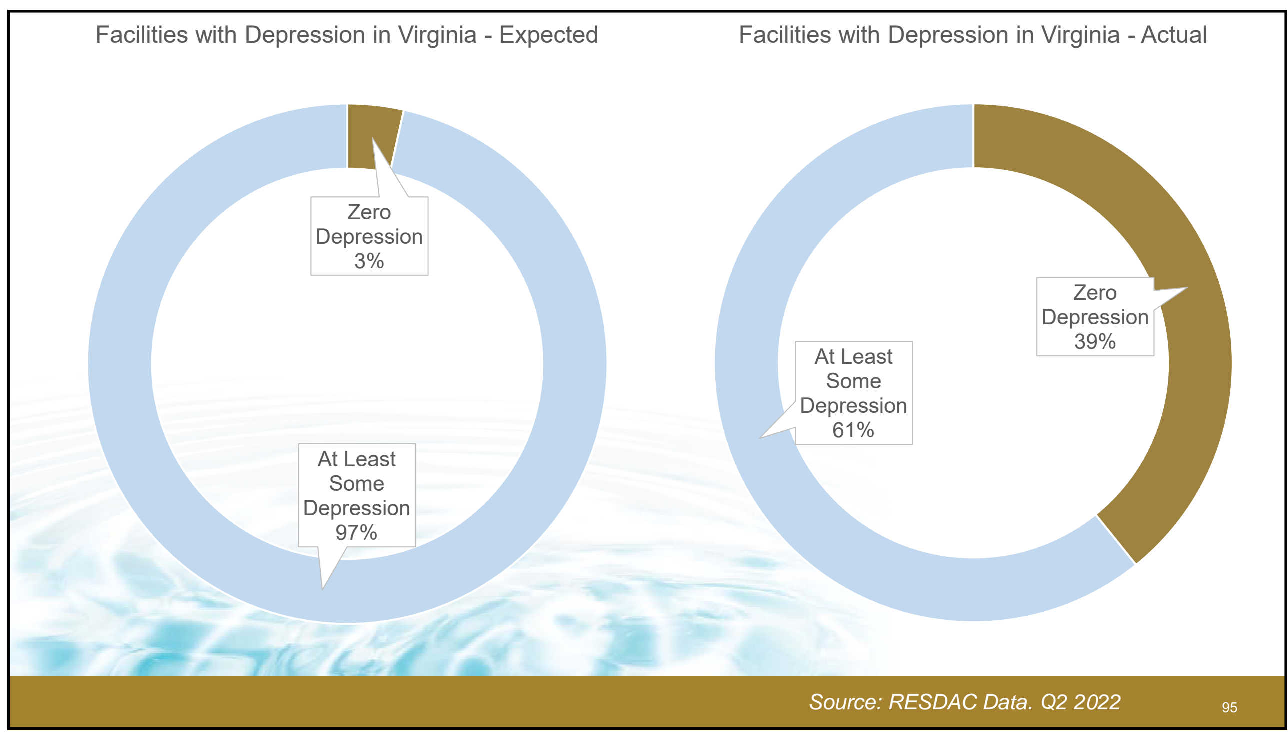

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Reasons we don't code depression

- Empathy: We don't want someone to be depressed.
- Mental illness is not as obvious as other conditions
- Care Area Assessments (CAAs): AKA work
- Poor Training: Do staff know how to fill out the PHQ-9?
- Concern about Quality Measures

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The PHQ-9©

D0200. Resident Mood Interview (PHQ-9©) $$ CATs QMs

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

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

1. Symptom Presence $$ CATs QMs
- 0. **No** (enter 0 in column 2)
- 1. **Yes** (enter 0-3 in column 2)
- 9. **No response** (leave column 2 blank)

2. Symptom Frequency $$ CATs QMs
- 0. **Never or 1 day**
- 1. **2-6 days** (several days)
- 2. **7-11 days** (half or more of the days)
- 3. **12-14 days** (nearly every day)

	1. Symptom Presence $$ CATs QMs	2. Symptom Frequency $$ CATs QMs
	Enter Scores in Boxes	
A. *Little interest or pleasure in doing things* CAA: *7, *10, *N030.02*	☐	☐
B. *Feeling down, depressed, or hopeless* *N030.02*	☐	☐
C. *Trouble falling or staying asleep, or sleeping too much*	☐	☐
D. *Feeling tired or having little energy*	☐	☐
E. *Poor appetite or overeating*	☐	☐
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*	☐	☐
G. *Trouble concentrating on things, such as reading the newspaper or watching television*	☐	☐
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual*	☐	☐
I. *Thoughts that you would be better off dead, or of hurting yourself in some way* CAA: *8	☐	☐

D0300. Total Severity Score $$ CATs QMs

Enter Score ☐☐

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. **CAA: *8, 8, *N030.02***
Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items). **CAA: 8**

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Reasons we should code depression

- Compliance.
- Real empathy is recognizing someone needs help and providing it
- Also: compliance
- Increased CAAs and Quality Measures should be reflective of actual care.

Also:

From	To	From	To	Difference
CA1	CA2	$ 84.90	$ 98.45	$ 13.55
CBC1	CBC2	$ 121.03	$ 139.99	$ 18.97
CDE1	CDE2	$ 146.32	$ 168.89	$ 22.58
LBC1	LBC2	$ 129.15	$ 155.35	$ 26.19
LDE1	LDE2	$ 156.25	$ 187.86	$ 31.61
HBC1	HBC2	$ 167.99	$ 202.31	$ 34.32
HDE1	HDE2	$ 179.73	$ 216.76	$ 37.03
			Average >>	**$ 26.32**

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PDPM Reimbursement Priority List

- ❑ Default Clinical Category
  - ❖ *..the applicable hospital condition need not have been the principal diagnosis that actually precipitated the beneficiary's admission to the hospital, but could be any one of the conditions present during the qualifying hospital stay ~ RAI Manual v 1.17.1 page I-1 and CMS 100-2 Chapter 8, page 8*
  - ❖ *Consider EVERY active diagnosis*
- ❑ *Nursing Category*
  - ❖ *Same as above: Consider all active diagnoses*
- ❑ *Depression*
  - ❖ *Accurately fill out the PHQ-9*

100

100

PDPM Reimbursement Priority List

- ❑ *NTAs*
  - ❖ *Code EVERY valid NTA: Do not stop even if you don't think you'll make the next threshold. You never know what is going to happen*
  - ❖ *You are out of compliance if you don't code an active condition*
  - ❖ *You will treat the condition whether you code it or not. Get reimbursed!*
- ❑ Speech
  - ❖ *Study the comorbidities carefully*
- ❑ *PT & OT*
  - ❖ *If you are contract therapy, think about your contract and whether you have aligned interests*

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Key Points

Know your data!

- Your facility versus the state
- Your state versus the nation

Understand what's at stake

- NTA Point (~$18.60 / point)
- Depression (~$26.32)
- Nursing Changes (~ $20-$70 / day)

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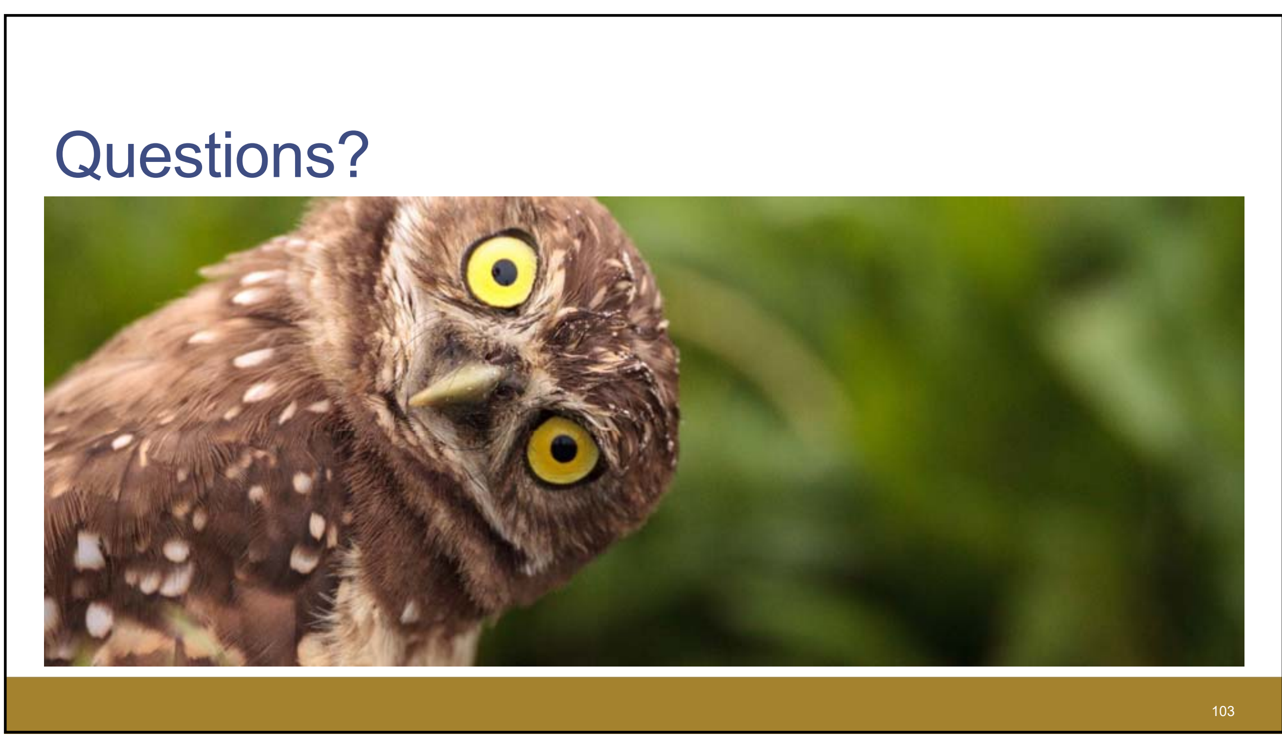
Questions?



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