The Patient Driven Payment Model (PDPM)

Navigating from Volume to Value in the SNF Setting

Speaker & Disclosures

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Training Objectives

1. Define PDPM.
2. Discuss what did not change.
3. Discuss what did change:
   - ✓ Determining the Case Mix Groups for PDPM
   - ✓ PT/OT's Two Drivers
   - ✓ SLP's Five Drivers
   - ✓ Nursing assessments and related items
4. Define best practices for Medicare A patients moving forward related to:
   - ✓ Functional Outcomes
   - ✓ Interventions
   - ✓ Documentation

PDPM DEFINED

OBJECTIVE 1

How Did We Get Here?

- Current reimbursement system for SNF MCA patients:
  - 90% of payments under the SNF PPS are based primarily on the amount of therapy provided to a patient, regardless of the patient's unique characteristics, needs or goals.
  - Over 60% of covered SNF PPS days billed are in an Ultra High category.
  - The current payment system incentivizes Nursing Home providers to focus on therapy versus the provision of total clinical care and outcomes.
  - Reduces everything about a patient to a single, typically volume-driven, case-mix group regardless of diagnosis.

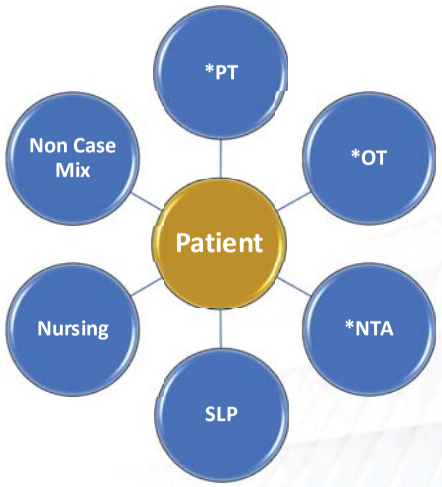
What is the Patient Driven Payment Model?

In July 2018, CMS released the PPS Final Rule.

- PDPM was effective 10/1/2019 for all MCA beneficiaries receiving SNF MCA benefits.
- Replaces PPS/RUGS-IV.
- Focus of the new PDPM model is **not** on the number of therapy minutes provided.
- Instead, residents will be classified based on **patient characteristics** and the focus will be **outcomes**.
- PDPM is a ***case-mix classification model***.

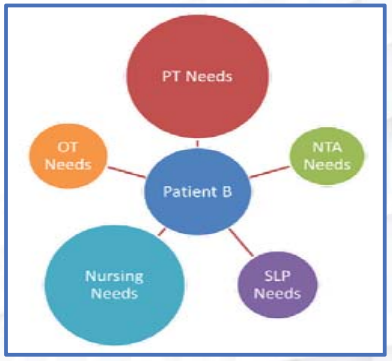
***Quality* vs. *Quantity*!**

What is the Case-Mix Classification Model for PDPM?



- Each patient is classified into a group for each of the 5 case-mix adjusted components.
- Each component utilizes different criteria as the basis for patient classification.
- Non Case-Mix is the base rate.
- All components combine to receive a Facility Total Rate, or *per diem*.

Individualized Case-Mix Indexes



*Each patient's case-mix index and formula total will be different based on the patient's individual clinical care needs.

PDPM Benefits

- PDPM Benefits Include:
  - Enhances payment accuracy → payment dependent on patient-specific clinical characteristics and strengthening incentives for appropriate care.
  - Focuses on verifiable patient characteristics and diagnoses, not amount of therapy delivered.
  - Refocuses care on good clinical practices and treating the unique, individualized needs of the whole patient.
  - Reduces administrative burden on providers (fewer assessments).
  - Budget neutral → better alignment of cost and payment.
  - More case-mix components included in determining payment.

CONSTANTS UNDER PDPM

OBJECTIVE 2

PDPM Did Not Change…

PDPM did not change coverage criteria for skilled care. The regulations for accessing skilled care remain the same.

- The basic Medicare coverage criteria for a patient qualifying for a SNF Part A Benefit has not changed.
  - 3-day hospital admission required.
  - Reasonable and necessary for the treatment of a patient's/resident's particular illness or injury.
  - Services can only be furnished on an inpatient basis.
  - Ordered by a physician.
- A resident must require skilled nursing 7 days a week and/or skilled therapy services 5-7 days a week.
  - Must still follow MD orders.
  - Must still meet **daily** skilled requirement.
  - Reasonable and necessary in terms of duration and quantity.

PDPM Did Not Change…

PDPM did not change the overall patient identification, assessment, and treatment processes in the SNF setting.

- Medicare values the evaluating therapist's clinical judgement for standards of care.
- Medicare values the therapeutic process, based on the therapist's ability to:
  - Identify changes in function, or *functional deficits.*
  - Assess to identify the underlying causes, or *underlying impairments.*
  - Identify what the patient needs to be able to do for a safe discharge to the next level of care/PLOF.
  - Establish a reasonable treatment plan that can be executed daily via the treating clinician through the *short-term goals* and corresponding *CPTs.*
  - Measure outcomes often, advance goals, and plan for discharge.

RUGS-IV ⟶ PDPM

RUGS-IV MODEL

- Payment is primarily determined by the number of therapy minutes delivered in a reporting period.
- Does not fully consider the wide range of clinical characteristics that influence the burden of care and relative use of resources in the SNF.
- Therapy focus.

PDPM MODEL

- Removed therapy minutes as the basis for payment.
- Fully considers the wide range of clinical characteristics that influence the burden of care and relative use of resources in the SNF.
- Multidisciplinary focus.
- Outcome Driven.

CHANGES UNDER PDPM

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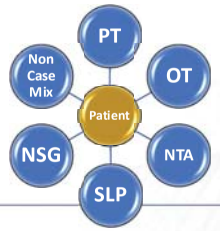
OBJECTIVE 3: DETERMINING THE CASE MIX GROUPS FOR PDPM

RUGS-IV ⟶ PDPM

RUGs System	PDPM	
Therapy & Therapy Non-Case Mix	PT	16
	OT	16
	SLP	12
Nursing	Non-Therapy Ancillary ("NTA")	6
	Nursing	25
Non-Case Mix	Non-Case Mix	1



Each resident will be classified individually into a PT, OT, SLP, Nursing & NTA category regardless of whether they are on therapy caseload or have any specific NTA needs. The PDPM groups are not linked.

Case Mix Classification System

PT & OT Components

Primary Drivers of Classification:

- MDS I0020B primary ICD-10 reason for the skilled stay (Principal Diagnosis)/surgical procedure ⟶ classify into one of four PT/OT Clinical Categories.

  Four (4) PT/OT Clinical Categories:

  1. Major Joint Replacement or Spinal Surgery
  2. Non-Orthopedic Surgery and Acute Neurologic
  3. Other Orthopedic
  4. Medical Management

- Function Score (MDS Section GG)

Once the 2 primary drivers are determined, a CMG/CMI is established.

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PT/OT Classification: Functional Score

- Calculated based on 10 Section GG items → 1 eating, 1 oral hygiene, 1 toileting, 2 bed mobility, 3 transfer, and 2 walking.
- Based on the resident's usual performance at the start of the SNF PPS stay and at discharge.
- Completed with input from nursing staff and/or therapy professionals; the assessment is based upon direct observation, patient self-report and direct care staff reports.
- Bed mobility, transfer and walking scores are averaged, then summed with the scores for eating, toileting and oral hygiene.
- Total summed score will range between 0 - 24. Automatically calculated by the MDS; therapists will not calculate the final MDS Section GG functional score.

Section GG Item	Functional Score Range
GG0130A1 – Self-care: Eating	0 – 4
GG0130B1 – Self-care: Oral Hygiene	0 – 4
GG0130C1 – Self-care: Toileting Hygiene	0 – 4
GG0170B1 – Mobility: Sit to Lying	0 – 4 (average of 2 items)
GG0170C1 – Mobility: Lying to Sitting on side of bed	
GG0170D1 – Mobility: Sit to Stand	0 – 4 (average of 3 items)
GG0170E1 – Mobility: Chair/bed-to-chair transfer	
GG0170F1 – Mobility: Toilet Transfer	
GG0170J1 – Mobility: Walk 50 feet with 2 turns	0 – 4 (average of 2 items)
GG0170K1 – Mobility: Walk 150 feet	

Calculating CMI: PT/OT

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	1.70	1.63
	10-23	TC	1.88	1.69
	24	TD	1.92	1.53
Other Orthopedic	0-5	TE	1.42	1.41
	6-9	TF	1.61	1.60
	10-23	TG	1.67	1.64
	24	TH	1.16	1.15
Medical Management	0-5	TI	1.13	1.18
	6-9	TJ	1.42	1.45
	10-23	TK	1.52	1.54
	24	TL	1.09	1.11
Non-Orthopedic Surgery & Acute Neurologic	0-5	TM	1.27	1.30
	6-9	TN	1.48	1.50
	10-23	TO	1.55	1.55
	24	TP	1.08	1.09

STEP 1:
Classify in a Clinical Category (ICD-10)

STEP 2:
Determine Section GG Fx Score

STEP 3:
Assign Case Mix Group & Corresponding CMI

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SLP Classification Components

5 Characteristics Determine the SLP Case-Mix Classification

1) Acute Neurologic or Non-Neurologic Classification
   - Dependent on if the patient is classified into the Acute Neurologic PDPM category via the principal diagnosis/surgery or not.
2) Presence of Certain SLP-Related Comorbidities
3) Presence of Cognitive Impairment
   - Any level of cognitive impairment (mild or above) qualifies for classification.
   - Either a BIMS score or CPS score is necessary to classify the patient for this aspect of the SLP component. This is administered and determined by MDS or Social Services.
4) Use of a Mechanically-Altered Diet
5) Presence of a Swallowing Disorder

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SLP Classification: SLP-Related Comorbidities

- CMS identified 12 SLP-related comorbidities directly related to increased SLP costs.
  - The patient qualifies for having an SLP-related comorbidity if *any* ***one*** of the 12 conditions is recorded as being present (MDS Sections I & O).
  - Mapping of ICD-10 codes to SLP comorbidities → utilizes diagnosis coding to capture SLP related comorbidities.
  - SLPs should include accepted comorbidities on their clarification orders if present.
    - Examples – Presence of apraxia, dysphagia, speech & language deficits, aphasia.

SLP Comorbidities	
Aphasia	Laryngeal Cancer
CVA,TIA, or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy (while Resident)	Oral Cancers
Ventilator (while Resident)	Speech & Language Deficits

SLP ICD-10 Comorbidity Crosswalk Example

SLP Comorbidity Description	ICD-10-CM Code	ICD-10-CM Code Description
Speech and Language Deficits	I69.020	Aphasia following nontraumatic subarachnoid hemorrhage
Speech and Language Deficits	I69.021	Dysphasia following nontraumatic subarachnoid hemorrhage
Speech and Language Deficits	I69.022	Dysarthria following nontraumatic subarachnoid hemorrhage
Speech and Language Deficits	I69.023	Fluency disorder following nontraumatic subarachnoid hemorrhage
Speech and Language Deficits	I69.028	Other speech and language deficits following nontraumatic subarachnoid hemorrhage
Speech and Language Deficits	I69.120	Aphasia following nontraumatic intracerebral hemorrhage
Speech and Language Deficits	I69.121	Dysphasia following nontraumatic intracerebral hemorrhage
Dysphagia	I69.091	Dysphagia following nontraumatic subarachnoid hemorrhage
Dysphagia	I69.191	Dysphagia following nontraumatic intracerebral hemorrhage
Dysphagia	I69.291	Dysphagia following other nontraumatic intracranial hemorrhage
Dysphagia	I69.391	Dysphagia following cerebral infarction
Dysphagia	I69.891	Dysphagia following other cerebrovascular disease
Dysphagia	I69.991	Dysphagia following unspecified cerebrovascular disease
Apraxia	I69.090	Apraxia following nontraumatic subarachnoid hemorrhage
Apraxia	I69.190	Apraxia following nontraumatic intracerebral hemorrhage
Apraxia	I69.290	Apraxia following other nontraumatic intracranial hemorrhage
Apraxia	I69.390	Apraxia following cerebral infarction
Apraxia	I69.890	Apraxia following other cerebrovascular disease
Apraxia	I69.990	Apraxia following unspecified cerebrovascular disease
ALS	G12.21	Amyotrophic lateral sclerosis

Resource: SLP ICD-10 Comorbidity Crosswalk

SLP ICD-10 Comorbidity Example

Case Example:

- New admission presents with difficulty in receptive language, orientation, short-term memory, and swallowing post-CVA.

- Tx Dx Coding Options:
  - R41.8 *Cognitive Communication Deficit* and R13.12 *Dysphagia, Oropharyngeal Phase*

CONSULT THE COMORBIDITY MAP

  - Speech & Language Option?
  - Dysphagia Option?

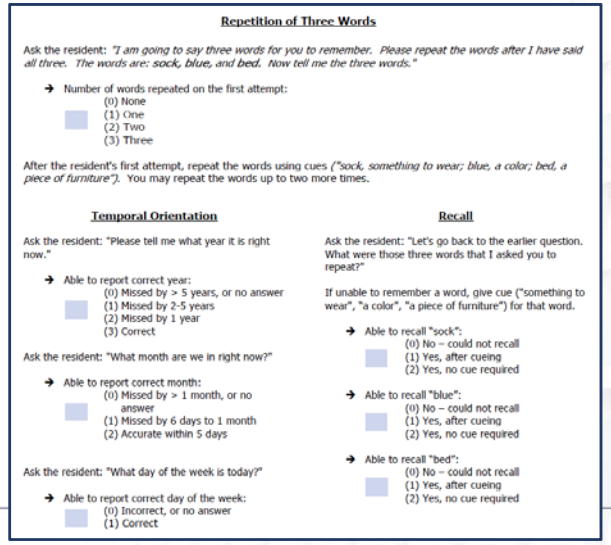
- Clarification Order example:
  ST Clarification: Skilled ST at 5x/week x 4 weeks to address other speech and language deficits and dysphagia following a cerebral infarction via speech/language tx, dysphagia tx, group tx for dysphagia and speech/language as indicated, and pt/caregiver education.

SLP Classification: Cognitive Impairment

- Either a BIMS score or CPS score is required on the MDS to qualify a patient under the SLP component of "presence of a cognitive impairment".
- The BIMS/Staff Assessment is completed by nursing or social services.
  - Any degree of cognitive impairment contributes to the SLP Component.
  - SLPs should always thoroughly document cognitive impairments of any level as a part of their comprehensive evaluation.

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

SLP Classification: Cognitive Impairment



Repetition of Three Words

Ask the resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words."*

→ Number of words repeated on the first attempt:
(0) None
(1) One
(2) Two
(3) Three

After the resident's first attempt, repeat the words using cues *("sock, something to wear; blue, a color; bed, a piece of furniture")*. You may repeat the words up to two more times.

Temporal Orientation

Ask the resident: "Please tell me what year it is right now."

→ Able to report correct year:
(0) Missed by > 5 years, or no answer
(1) Missed by 2-5 years
(2) Missed by 1 year
(3) Correct

Ask the resident: "What month are we in right now?"

→ Able to report correct month:
(0) Missed by > 1 month, or no answer
(1) Missed by 6 days to 1 month
(2) Accurate within 5 days

Ask the resident: "What day of the week is today?"

→ Able to report correct day of the week:
(0) Incorrect, or no answer
(1) Correct

Recall

Ask the resident: "Let's go back to the earlier question. What were those three words that I asked you to repeat?"

If unable to remember a word, give cue ("something to wear", "a color", "a piece of furniture") for that word.

→ Able to recall "sock":
(0) No – could not recall
(1) Yes, after cueing
(2) Yes, no cue required

→ Able to recall "blue":
(0) No – could not recall
(1) Yes, after cueing
(2) Yes, no cue required

→ Able to recall "bed":
(0) No – could not recall
(1) Yes, after cueing
(2) Yes, no cue required

SLP Classification: Diet & Swallowing Disorder

- Presence of Swallowing Disorder.
  - Does not require that the resident actually have a diagnosed swallowing disorder; only the presence of signs & symptoms of a possible swallowing disorder.

Section K	Swallowing/Nutritional Status
K0100. Swallowing Disorder Signs and symptoms of possible swallowing disorder	
↓ Check all that apply	
☐	A. Loss of liquids/solids from mouth when eating or drinking
☐	B. Holding food in mouth/cheeks or residual food in mouth after meals
☐	C. Coughing or choking during meals or when swallowing medications
☐	D. Complaints of difficulty or pain with swallowing
☐	Z. None of the above

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SLP Classification: Diet & Swallowing Disorder

K0510: Nutritional Approaches

K0510. Nutritional Approaches Check all of the following nutritional approaches that were performed during the last 7 days	1. While NOT a Resident	2. While a Resident
1. While NOT a Resident Performed *while NOT a resident* of this facility and within the *last 7 days*. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank 2. While a Resident Performed *while a resident* of this facility and within the *last 7 days*	↓ Check all that apply ↓	
A. Parenteral/IV feeding	☐	☐
B. Feeding tube - nasogastric or abdominal (PEG)	☐	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)		☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)		☐
Z. None of the above	☐	☐

RAI Manual:

- Use of a Mechanically-Altered Diet.
  "A diet specifically prepared to alter the texture or consistency of food or liquids to facilitate oral intake".

- "Nutritional approaches that vary from the normal (e.g., mechanically altered food) or that rely on alternative methods (e.g., parenteral/IV or feeding tubes) can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating. "

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Calculating CMI: SLP

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case Mix Group	SLP Case Mix Index
None	Neither	SA	0.68
	Either 1 of the 2	SB	1.82
	Both	SC	2.67
Any 1 of the 3	Neither	SD	1.46
	Either 1 of the 2	SE	2.34
	Both	SF	2.98
Any 2 of the 3	Neither	SG	2.04
	Either 1 of the 2	SH	2.86
	Both	SI	3.53
All 3	Neither	SJ	2.99
	Either 1 of the 2	SK	3.70
	Both	SL	4.21

STEP 1:
Determine presence of Neuro Condition (ICD-10), Comorbidity, Cognitive Impairment.

STEP 2:
Determine presence of Altered Diet, Swallowing Disorder.

STEP 3:
Assign Case Mix Group & corresponding CMI.

Calculating CMI: SLP

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Example:
SNF LTC Resident sent out to hospital with pneumonia. Upon return, presents the following:

- Regular diet, thin liquids
- Complaints of pain when swallowing
- Hx of mild-mod dementia; BIMS of 12

Calculating CMI: SLP

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Example:
STR Admission presents with the following:

- S/P L CVA 1 month prior
- SLP evaluation reveals????

Calculating CMI: SLP

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case Mix Group	SLP Case Mix Index
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Example:
SNF admission for possible LTC. Old CVA with R UE hemiplegia.

- SLP screens. BIMS of 13.
- Dentures don't fit.

CHANGES UNDER PDPM

OBJECTIVE 3: NURSING ASSESSMENTS AND RELATED ITEMS

MDS Assessment Changes Under PDPM

- There are only two required MDS Assessments → Initial Medicare Assessment and Discharge Assessment.
  - No more COTs, SOTs, EOTs, 14, 30, 60, or 90-day assessments.
- One optional assessment – Interim Payment Assessment (IPA).
  - Performed when there is a significant change in condition that would reclassify the patient due to new patient characteristics.
  - If an IPA is warranted, the DOR will communicate this to the evaluating therapists, and a UPOC will be performed with required areas documented.
    - This includes all Section GG, K, and C items as required under Functional Deficits.
  - For patients that are not on therapy caseload, a screening or evaluation may be warranted depending on the reason for the IPA.

PDPM Assessment Schedule

Medicare MDS Assessment Type	Assessment Reference Date	Applicable Standard Medicare Payment Days
Initial Medicare Assessment	Days 1-8	All covered Part A days until Part A discharge (unless an IPA is completed)
Interim Payment Assessment (IPA)	Optional Assessment	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

- ✓ Initial MCR assessment is used to classify patient for the entire stay unless an IPA is completed.
- ✓ Eliminates 14, 30, 60, and 90-day scheduled assessments.
- ✓ Eliminates OMRAs (SOT, COT, EOT) or unscheduled assessments.

Discharges: Interrupted Stay vs. New Stay

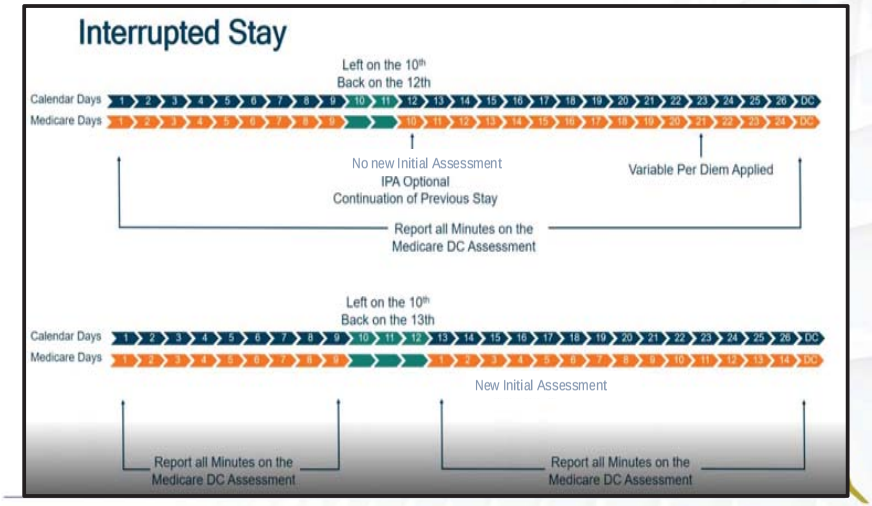
Interrupted Stay

- The patient returns to the *same* SNF (not a different SNF); AND
- The patient returns within 3 days or less (the "interruption window").
  - ✓ A 3-day period, starting with the calendar day of discharge and including the 2 immediately following calendar days, ending at midnight.
- The variable per diem schedule and the assessment schedule continues from the day of the previous discharge.
- No new MDS or Section GG or DC Assessment.
- Optional IPA may be completed at the facility's discretion.
- Optional UPOC.

New Stay

- If readmitted to same SNF greater than 3 consecutive days OR patient admits to different SNF.
- Considered a new MCR stay upon return.
- Variable per diem resets to Day 1.
- Assessment schedule resets to Day 1.
- New Initial MCR Assessment required.
  - ✓ Comprehensive Initial MDS
  - ✓ Section GG
  - ✓ New POC

Interrupted Stay - Example



Group & Concurrent Therapy

Definitions –

- Concurrent Therapy: One therapist treating two patients performing different activities.
- Group Therapy: One therapist treating two to six patients at the same time who are performing the same or similar activities (*new definition for 10/1*).

- CMS recognizes the importance of varied service delivery when clinically appropriate.
- Minutes will no longer be allocated on the MDS, so the division of concurrent (1/2) and group (1/4) is eliminated.

- Under PDPM there is a *combined* limit:
  - ✓ Concurrent AND group therapy to be no more than 25% of the therapy received by SNF patients, for each therapy discipline.
  - ✓ In combination, this limit would ensure that at least 75% of a resident's therapy minutes are provided on an individual basis.

- Compliance with the concurrent/group therapy limit will be monitored on the MDS Discharge Assessment.

PDPM BEST PRACTICES

OBJECTIVE 4

THE IMPORTANCE OF OUTCOMES
INTERVENTION PRACTICES
DOCUMENTATION PRACTICES
TRANSITION REQUIREMENTS

The Importance of Functional Outcomes

- The MDS will be reported to CMS at SOC and EOC only for most patients.
- Therapy elements reported:
  - 10 Section GG Functional Areas for PT, OT
  - Section K (Swallowing) for SLP
  - Section C (Cognitive) for SLP
  - Any applicable Comorbidities for SLP
- Discharge Reporting – Opportunity to show what the patient achieved!
  - Have Section GG Functional Areas improved?
  - Has communication, comorbidities, cognition, dysphagia improved?

The Importance of Functional Outcomes

- Therapy POCs must focus on those required areas as well as deficit areas required to improve for safe discharge.
  - What does the patient need to be able to do to discharge home or to a lesser level of care safely?
- Correct coding of Section GG, K, and C items and comorbidities are critical.

ICD-10 Coding: Therapy

- **For PT/OT/ST, the MDS principal diagnosis code will likely also represent the primary medical diagnosis on the therapy POC.**
  - The condition that is causing the patient's symptoms and the need for therapy should be the principal diagnosis followed by the appropriate therapy treatment code(s).
  - Supportive secondary (and tertiary as applicable) medical diagnoses should be added to the therapy POCs as available from the medical record to support the medical necessity, LOS, and intensity of services.
- **Therapy Treatment Codes:**
  - Selection of treatment diagnoses should be completed after a comprehensive clinical assessment to address the impairments found related to the principal diagnosis.
  - Should indicate the primary area of impairment to be targeted by skilled intervention.
  - There must be a logical relationship between medical diagnoses selected and treatment diagnoses indicated.

Intervention Best Practices

Treatment Planning: Treating Clinicians

- Make every effort to execute the treatment plan daily.
  - ✓ Know the active STGs.
  - ✓ Address each goal daily.
  - ✓ Anything outside of the active STGs should not be addressed.
  - ✓ Document goal addressed, activity used to address it, skill provided, and patient performance as it relates to the goal.

- Keep in mind Functional Score items and the big picture for each patient →
  - ✓ *What does the patient need to be able to do to safely reach their goals?*
  - ✓ *Does the treatment plan get them there effectively and efficiently?*

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Documentation Best Practices

Evaluating Therapists: New Considerations Under PDPM

- SLP evaluations will have new required assessment areas.
  - These areas are similar to what is currently required, but the verbiage will align with related Section K and C items on the MDS.
    - Example: "Coughing or choking during meals or when swallowing medications" will be a pre-checked area to address.
    - These will be required on the POC, UPOC, and Discharge Summary as PT and OT have for Section GG.

- Certain ICD-10s have been designated as "Return to Provider" codes.
  - These codes are not to be used as the principal medical diagnosis.
  - These are non-specific or unspecific codes, and should be avoided for medical diagnoses.
  - A number of therapy treatment codes are RTP. They can be used, but only as a treatment diagnosis or secondary supportive medical.
  - See: *PDPM Return to Provider* resource.

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Documentation Best Practices

Daily Note Requirements per CPT Code

- The requirements for a skilled daily treatment note do not vary based on payor.

- A skilled daily treatment note must:
  - Define the CPT billed and the minutes spent under the procedure.
  - Relate directly to an active STG and define the corresponding functional outcome of the activity.
  - Define the treatment task or activity provided during the procedure.
  - Define the skilled service performed by the therapist.
  - Define the patient's performance on the treatment task/activity related to the active goal.

→ Do not wait for the weekly progress report to advance a goal or the treatment plan.
→ Have the discussions daily to maximize patient outcomes.
→ Remember the requirements for group treatment documentation –
  → State group task, number of participants in the group in addition to the above required elements.

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Documentation Best Practices

Daily Note Documentation of Skill Example

Define the CPT billed and minutes spent under that procedure.
Example: 97129 – 15 minutes.

Define the treatment task or activity provided during the procedure.
Example Continued: 97129 – 15 minutes. Provided two solutions to problems associated with household safety.

Define patient performance on the treatment task/activity.
Example Continued: 97129 – 15 minutes. The patient verbally provided two solutions to problems associated with household safety on 4/10 opps and on 8/10 opps.

Define the skilled service performed by the therapist.
Example Continued: 97129 – 15 minutes. The patient verbally provided two solutions to problems associated with household safety on 4/10 opps independently and on 8/10 opps when provided with verbal cueing.

Relate directly to an active STG and define the corresponding functional outcome of the activity.
Each treatment task must be linked to an active STG and must aim to show improvement on that STG for improved overall function.

Example Continued: 97129 – 15 minutes. STG #2 r/t problem solving in the home environment addressed. The patient verbally provided two solutions to problems associated with household safety on 4/10 trials independently and on 8/10 trials when provided with verbal cueing.

Documentation Best Practices

Daily Note Priorities Under PDPM

- Daily documentation should additionally capture any changes noted in function or level of impairment – improvement or decline.
  - Think through items pertinent to both therapy and the MDS.
    - Pain
    - Mood/Behavior
    - Cognition
    - Swallowing
    - Transfers
    - Mobility
    - ADLs
- Communicate any changes noted to nursing and the DOR, and document that this was done.
- Daily Measurement is the key for PDPM.
  - Dates matter; each section of the MDS has a different look-back, and your clinical notes can make a difference.
  - Changes communicated and documented will assist in determining the need of further intervention or an IPA.

PDPM Clinician Final Takeaways

- <u>Ensure Evaluations:</u>
  - Are completed timely and are comprehensive.
  - Fully address function.
  - Focus on establishing what needs to be accomplished for a safe discharge, including education and any other discharge planning priorities.
- <u>Ensure Weekly Documentation:</u>
  - Addresses key clinical areas.
  - Documents discharge planning.
- <u>Ensure Daily Documentation:</u>
  - Includes all required skilled components.
  - Focuses on achievement of outcomes, improving UIs, reaching STGs, noting changes.
- <u>Ensure the Discharge Summary:</u>
  - Clearly defines achieved outcomes.
  - Documents training provided for a safe discharge.
  - Is not completed until 3 days post-discharge from the facility to avoid extra documentation if the patient returns before day 3.

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