

Patient Driven Payment Method

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Outline

- Brief overview of the PDPM payment system compared to the obsolete RUG-IV system
- The specific components of each case mix group
- The influence of Dieticians on each case mix group
- Discuss the “At Risk for Malnutrition”
- The unintended consequences of PDPM
- Things we learned about ourselves after 1 year of PDPM

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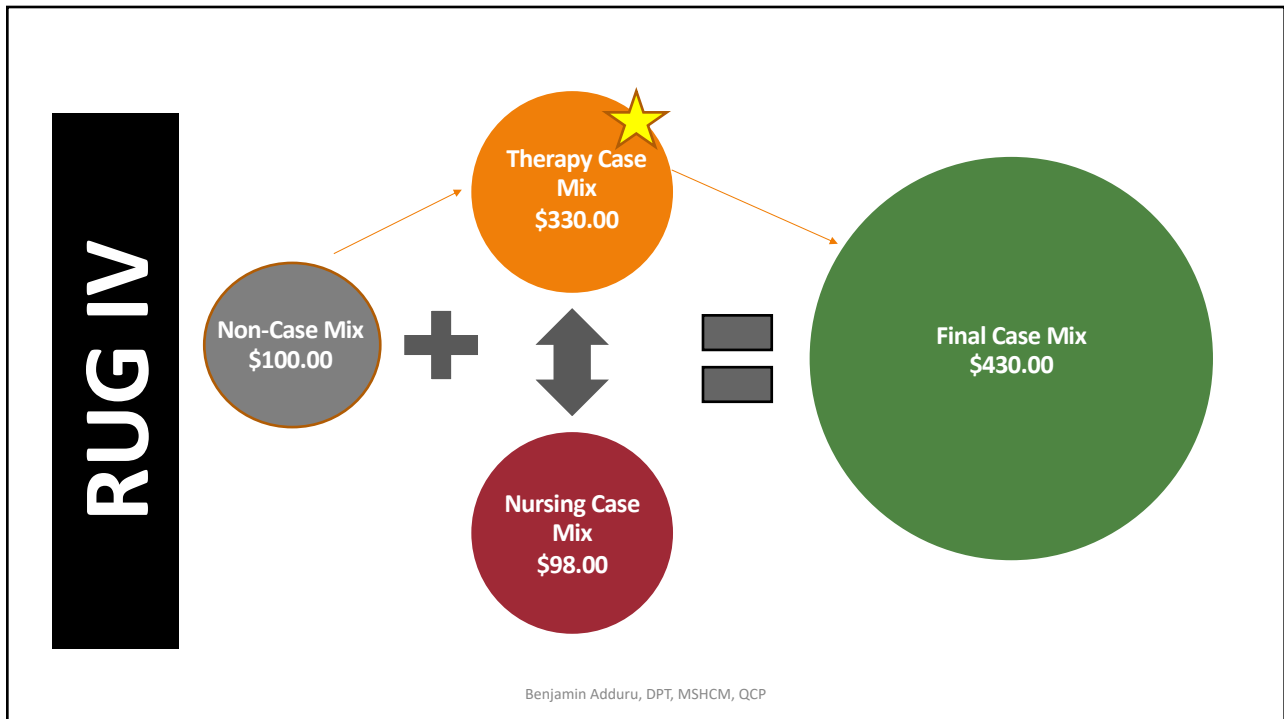
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CMS Intentions on PDPM

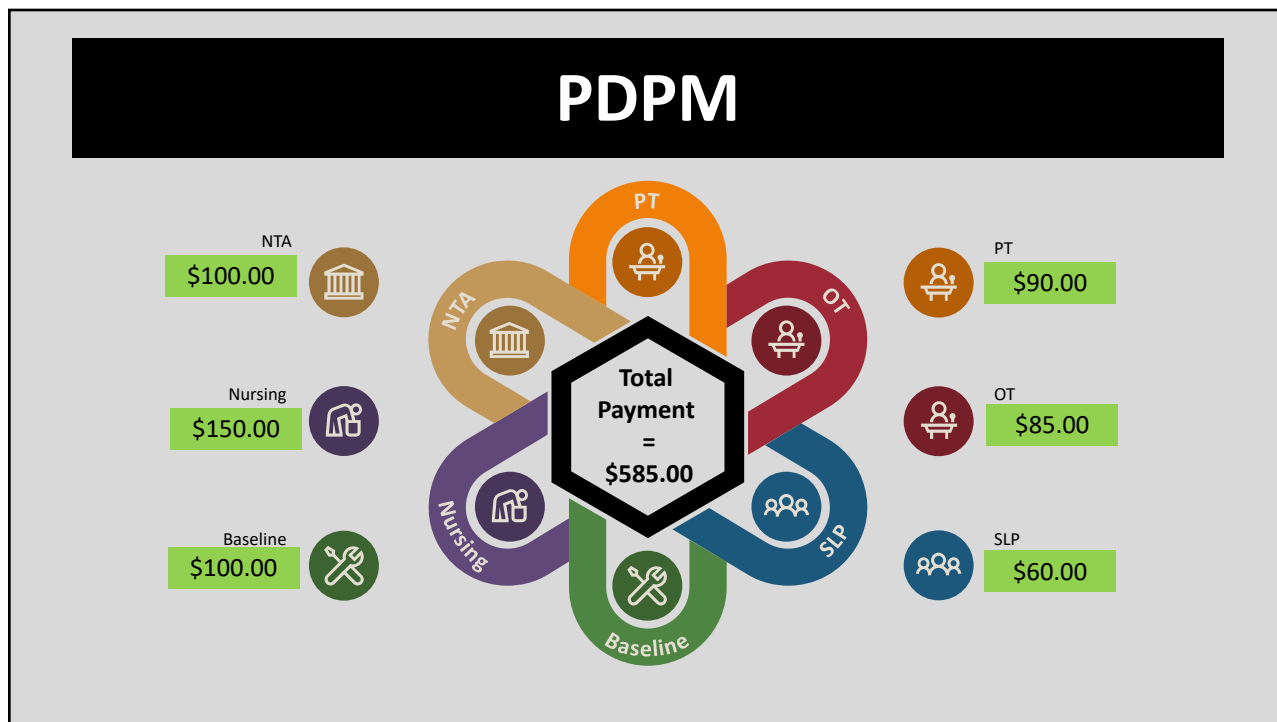
- Improve payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided
- Significantly reduce administrative burden on providers
- Eliminate excessive services that do not affect patient outcomes
- Improves SNF payments to currently underserved beneficiaries without increasing total Medicare payments
- Intended to be Budget Neutral
- *Expand PDPM model to all type of payers

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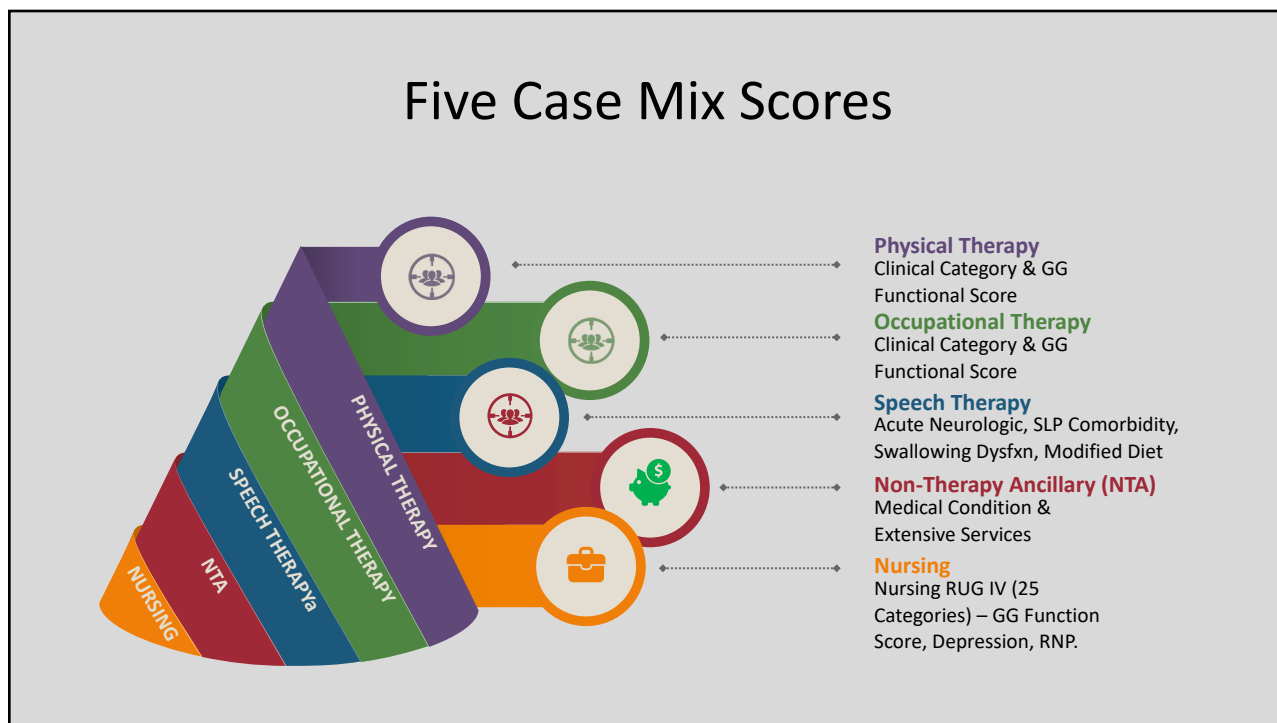
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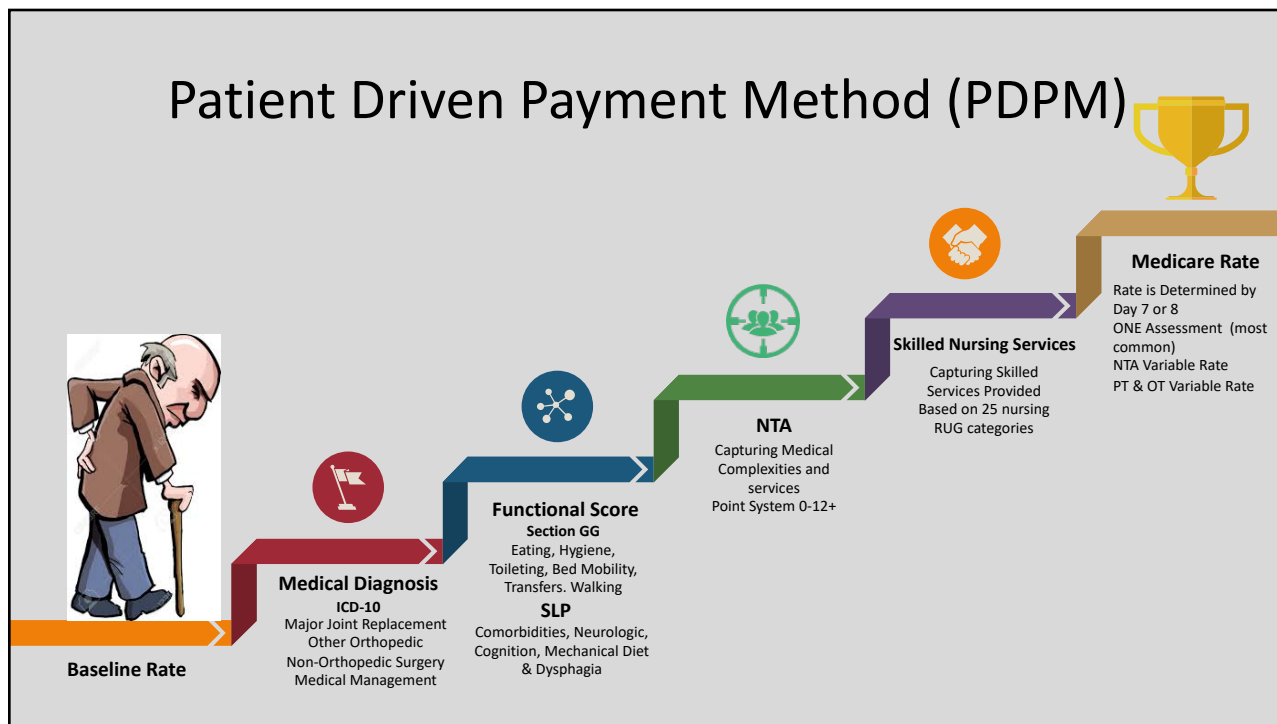
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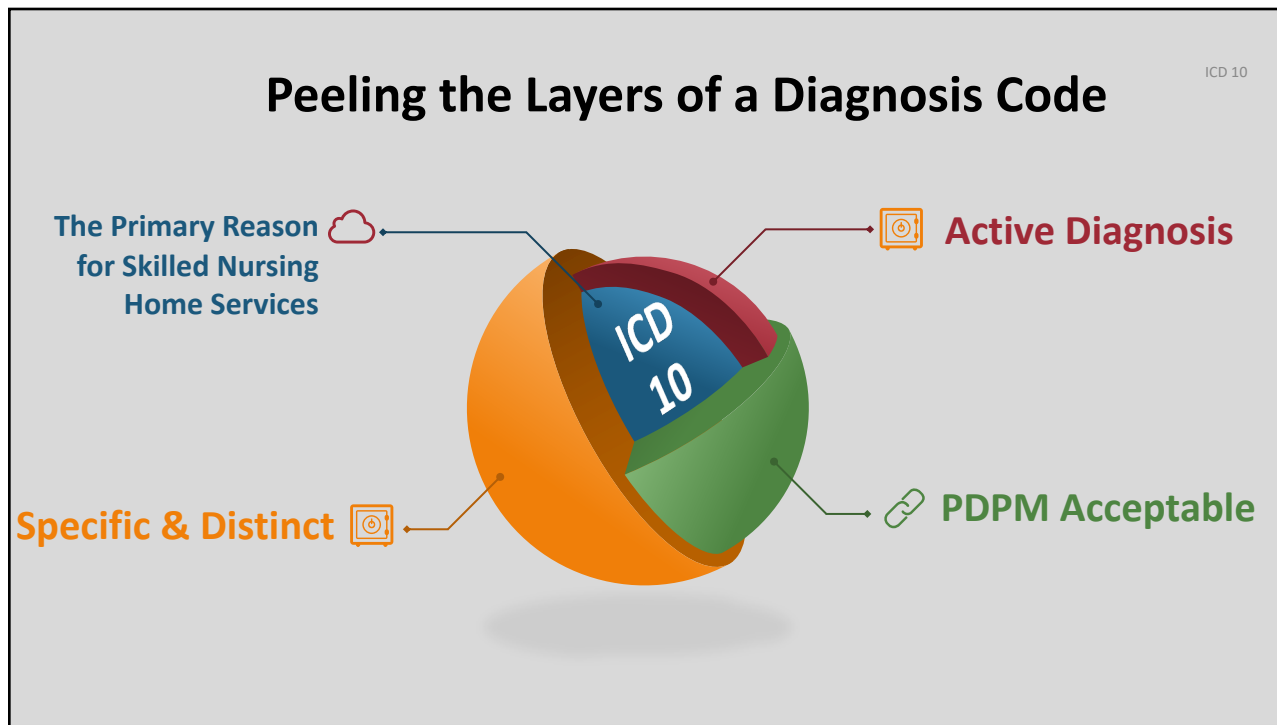
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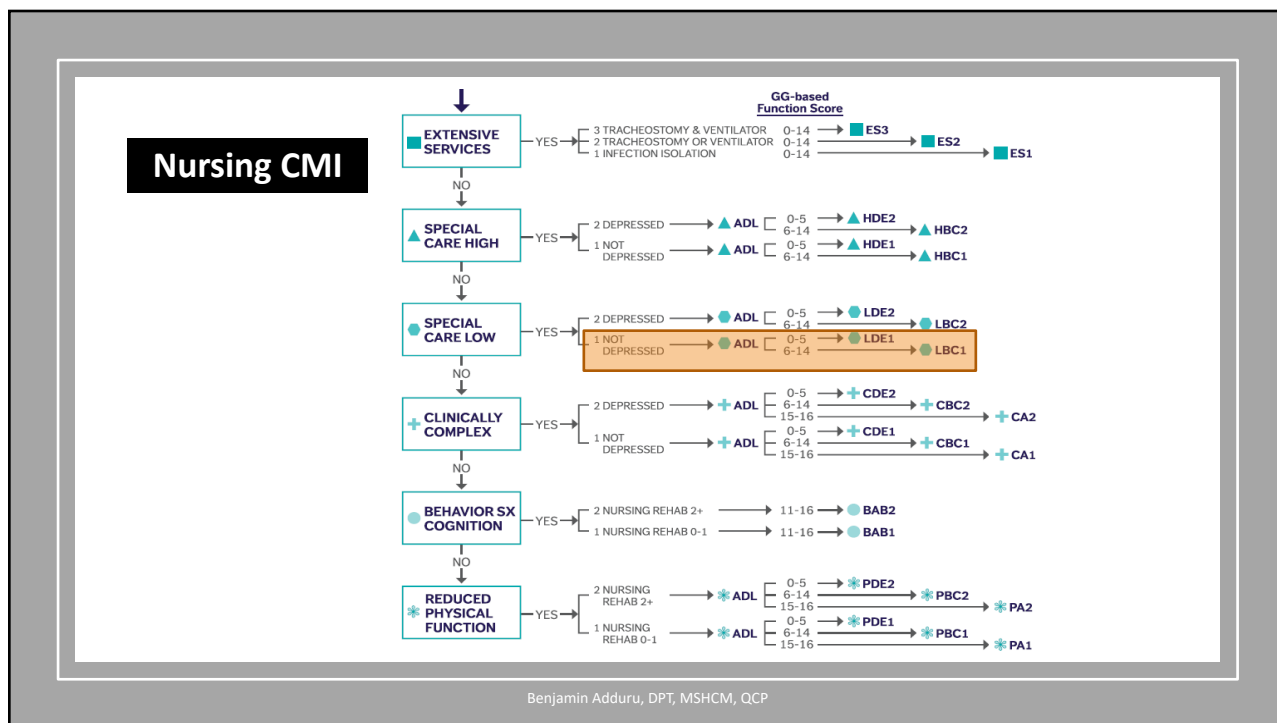


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PT & OT CMI	Therapy Functional Score	Case Mix Group	PT Case Mix Index	OT Case Mix Index
Major Joint Replacement/ Spinal Surgery	0 - 5	TA	1.53	1.49
Major Joint Replacement/ Spinal Surgery	6 - 9	TB	1.70	1.63
Major Joint Replacement/ Spinal Surgery	10 - 23	TC	1.88	1.69
Major Joint Replacement/ Spinal Surgery	24	TD	1.92	1.53
Other Orthopedic	0 - 5	TE	1.42	1.41
Other Orthopedic	6 - 9	TF	1.61	1.60
Other Orthopedic	10 - 23	TG	1.67	1.64
Other Orthopedic	24	TH	1.16	1.15
Medical Management	0 - 5	TI	1.13	1.18
Medical Management	6 - 9	TJ	1.42	1.45
Medical Management	10 - 23	TK	1.52	1.54
Medical Management	24	TL	1.09	1.11
Non-Orthopedic Surgery/ Musculoskeletal	0 - 5	TM	1.27	1.30
Non-Orthopedic Surgery/ Musculoskeletal	6 - 9	TN	1.48	1.50
Non-Orthopedic Surgery/ Musculoskeletal	10 - 23	TO	1.55	1.55
Non-Orthopedic Surgery/ Musculoskeletal	24	TP	1.08	1.09

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Nursing CMI

Step Three: SPECIAL CARE HIGH

Resident must have NFS of 14 or less. If resident meets criteria for Special Care High & has NFS of 15-16, the resident will classify as Clinically Complex.

2. Evaluate for signs/symptoms of depression: PHQ-9/OV score of 10 or more indicates sx/sx of depression

1. Determine if the resident meets criteria for ONE of the following:

- Comatose and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170D1, GG0170D1, GG0170E1, and GG0170F1, all e
 - Septicemia
 - Diabetes **with both** of the following:
Insulin injections for all 7 days **AND** Insulin on or more days
 - Quadriplegia with NFS <= 11
 - Chronic obstructive pulmonary disease **AND** shortness of breath when lying flat
- Fever **AND** one of the following: Pneumonia, Vomiting, Weight loss or Feeding tube*
 - Parenteral/IV feedings
 - Respiratory therapy for all 7 days



Nursing Functional Score

ASK

The Dietitian

SX/SX of Depression

Yes
No
Yes
No

Case Mix Group

HDE2
HDE1
HBC2
HBC1

If the resident **DOES NOT** qualify for the Special Care High category, proceed to Step 4: Special Care Low

*Tube feeding classification requirements:
(1) K0710A3 is 51% or more of total calories OR
(2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.

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SLP CMI

Presence of Acute Neurologic Category, Speech Related Co-Morbidities , Cognitive Impairment	Mechanically Altered Diet/ Swallowing Disorder	Case Mix Group	SLP Case Mix Index
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.67
Any One	Neither	SD	1.46
Any One	Either	SE	2.34
Any One	Both	SF	2.98
Any Two	Neither	SG	2.04
Any Two	Either	SH	2.86
Any Two	Both	SI	3.53
All Three	Neither	SJ	2.99
All Three	Either	SK	3.70
All Three	Both	SL	4.21



ASK

The Dietitian

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Mechanically Altered Diet

C. Mechanically Altered Diet

Check if Present	MECHANICAL DIET	MDS Item
	MECHANICALLY ALTERED DIET	K0510C2
	NA	

- Identify solids or liquids that “alter the texture or consistency of food to facilitate oral intake”
- Includes thickened liquids
- Includes PO even if not primary method of intake (e.g. “Tube feed plus 4 oz pureed 2x/day”)

D. Swallowing Disorder (check all that apply)

Check	K0100 : SWALLOW DISORDER	MDS Item
	A. Loss of liquids from the mouth	K0100A
	B. Holding food in mouth/cheeks or residual food in mouth after meals	K0100B
	C. Coughing or choking during meals or swallowing meds	K0100C
	D. Complaints of difficulty or pain w/ swallowing	K0100D
	Z. NONE of the Above	K0100Z

- Document any of A-D if they occurred even once in 7-day lookback
- Interview nursing staff
- SLP may perform swallow eval to ID
- Pain from dentures while eating may be applicable for item D.
- Use Swallowing Impairment checklist and EAT10 as applicable

SUMMARY (check all that apply)

___ Neuro Dx ___ SLP Co-morbidity ___ Mechanically Altered Diet ___ Swallow Disorder ___ NONE

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Condition/Extensive Service	MDS Item	Points
HIV/AIDs	N/A (SNF Claim)	8
Section H		
Ostomy	H0100C	1
Intermittent Catheterization	H0100D	1
Section I		
Diabetes Mellitus	I2900	2
Asthma, COPD, Chronic Lung Disease DX	I6200	2
Wound Infection Coded	I2500	2
Anti-Drug Resistant Organism (MDRO) Coded	I1700	1
Morbid Obesity	I8000	1
Malnutrition Coded	I5600	1
Bone/Joint/Muscle Infections/ Necrosis (except Aseptic Necrosis of Bone)	I8000	2
Multiple Sclerosis	I5200	2
Cardio-Respiratory Failure and Shock	I8000	1
Cirrhosis of Liver	I8000	1
Diabetic Retinopathy (Except for Proliferative Diabetic Retinopathy and Vitreous Hemorrhage)	I8000	1
Inflammatory Bowel Disease		
Chronic Pancreatitis		
End-Stage Liver Disease		
Intractable Epilepsy		
Respiratory Arrest		
Pulmonary Fibrosis and Other Lung Disorders		
Complications of Specified Implanted Device or Lung Transplant Status		
Major Organ Transplant Status (except Lung)		
Chronic Myeloid Leukemia		
Myelodysplastic Syndromes and Myelofibrosis		
Endocarditis	I8000	1
Opportunistic Infections	I8000	2
Immune Disorders	I8000	1
Specified Hereditary Metabolic/ Immune Disorders	I8000	1
Disorders of Immunity (Except RxCC97)	I8000	1
Psoriatic Arthropathy and Systemic Sclerosis	I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, Inflammatory Spondylopathies	I8000	1

Condition/Extensive Service	MDS Item	Points
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Aseptic Necrosis of Bone	I8000	1
Severe Skin Burn or Condition	I8000	1
Narcolepsy & Cataplexy	I8000	1
Cystic Fibrosis	I8000	1
Section K		
Feeding Tube (while a resident)	K0510B2	1
Parenteral IV Feeding: Level High	K0510A2	7
	K0710A2	
Parenteral IV Feeding: Level Low	K0510A2	3
	K0710A2	
	K0170B2	
Section M		
Highest Stage of Unhealed Pressure Ulcer- Stage 4	M0300X1	1
Diabetic Foot Ulcer Coded	M1040B	1
Foot Infection Coded or Other Open Lesion to Foot Coded	M1040A	1
	M1040B	
	M1040C	
	O0100H2	5
	O0100M2	1
	O0100E2	1
	O0100D2	1
	O0100I2	2
	O0100B2	1
	O0100F2	4

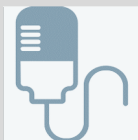
ASK

The Dietitian

NTA Score Range	NTA Case Mix Group	NTA Case Mix Index
12+	NA	3.24
9-11	NB	2.53
6-8	NC	1.84
3-5	ND	1.33
1-2	NE	0.96
0	NF	0.72

Determine NTA Case Mix

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Parenteral Feeding

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B

	1. While NOT a Resident	2. While a Resident	3. During Entire 7 Days
1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the <i>last 7 days</i> . Only enter a code in 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 <i>while a resident</i> of this facility and within the <i>last 7 days</i>			
3. During Entire 7 Days Performed during the entire <i>last 7 days</i>			
	↓ Enter Codes ↓		
A. Proportion of total calories the resident received through parenteral or tube feeding			
1. 25% or less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. 26-50%			
3. 51% or more			
B. Average fluid intake per day by IV or tube feeding			
1. 500 cc/day or less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. 501 cc/day or more			

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Parenteral Feeding

- Presence of parenteral/IV feedings at K0510A while a resident % of artificial intake at K0710A while a resident.
 - HIGH: In order to qualify, the resident must receive 51% or more of total calories by artificial route. (7 NTA Points)
 - LOW: If the resident receives 26–50% and 501cc/day at K0710A and K0710B, then the resident would qualify for low-intensity parenteral/IV feedings for three points. (3 NTA Points)
 - Accurate calculation by the dietitian during the seven-day look-back period is required.
1. Review the intake records to determine actual intake through parenteral/IV or tube-feeding routes
 2. Calculate the portion of total calories received through artificial routes, requiring a calculation of total calories by mouth and artificial route.

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Parenteral Feeding

- Parenteral/IV feeding—The following fluids may be included when there is supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need.
- This supporting documentation should be noted in the resident's medical record according to State and/or internal facility policy:
 - IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
 - IV fluids running at KVO (Keep Vein Open)
 - IV fluids contained in IV Piggybacks
 - Hypodermoclysis and subcutaneous ports in hydration therapy
 - IV fluids can be coded in K0510A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record.

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Malnutrition or at Risk for Malnutrition

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Possible Risks for Malnutrition in the Nursing Home

- Body weight of less than 100 pounds
- 5% or more weight loss in one month (not intended)
- 10% or more weight loss in six months (not intended)
- Presence of pressure sores
- Nutrition received by tube feeding
- History of malnutrition
- Laboratory values indicative of malnutrition or dehydration
- Depression
- Limited mobility and needing assistance to eat
- Poor communication
- Medication side effects (ex. dry mouth)
- Teeth problems
- Restricted diet
- Poor eating habits and decreased intake at meals
- Chewing and swallowing problems
- Mental impairment

<https://sweeneylawfirm.com/content/malnutrition>

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Prevalence of Malnutrition Risk and the Impact of Nutrition Risk on Hospital Outcomes

- Analysis included data from 9959 adult patients from 601 wards. The overall prevalence of malnutrition risk (MST score ≥ 2) was 32.7%. On nutrition Day, **32.1%** of patients ate a quarter of their meal or less. Hospital mortality hazard ratio was **3.24** (95% CI: [1.73, 6.07]; P -value < 0.001) for patients eating a quarter compared with those who ate all their meal and increased to **5.99** (95% CI: [3.03, 11.84]; P -value < 0.0001) for patients eating nothing despite being allowed to eat.
- This study provides the most robust estimate of malnutrition risk in U.S. hospitalized patients to date, finding that approximately **1 in 3 are at risk**. Additionally, patients who have diminished meal intake experience **increased mortality risk**. These results highlight the ongoing issue of malnutrition in the hospital setting.

Journal of Parenteral and Enteral Nutrition
<https://onlinelibrary.wiley.com/doi/abs/10.1002/jpen.1499>

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47 – 62% at risk of malnutrition in LTC

In a recent systematic literature review that used the Mini Nutrition Assessment as a parameter, risk of malnutrition was observed in 47% to 62% of older adults in LTC.⁴⁰ A separate literature review identified leading modifiable risk factors of malnutrition (weight loss, low body mass index [BMI; calculated as kg/m²], and poor nutrition) in LTC, including depression, poor food/fluid intake, and impaired function, such as dependence on others for eating, impaired mobility, and insufficient staffing.⁴¹ Additional facility-associated factors that lead to poor oral intake include poor food delivery systems, timing of menu selection vs service, difficulty opening foods/beverages and handling dishes, and unappetizing food on overly restrictive therapeutic diets.²²


MALNUTRITION IN OLDER ADULTS

Malnutrition, also known as undernutrition, is most simply defined as any nutritional imbalance.³⁶ The Academy provides a more detailed definition: "Inadequate intake of protein and/or energy over prolonged periods of time resulting in loss of fat stores and/or muscle stores, including starvation-related malnutrition, chronic disease or condition-related malnutrition and acute disease or injury-related malnutrition."³⁷ Malnutrition can occur along a continuum from non-severe to severe, and UWL can occur at any point along that continuum. It can be categorized in three ways: starvation-related malnutrition, chronic disease-related malnutrition, and acute disease or injury-related malnutrition.^{38,39} The criteria used to identify malnutrition has changed in recent years; it can be diagnosed based on several key indicators, as outlined in Figure 2.³⁹

[https://jandonline.org/article/S2212-2672\(18\)30154-0/pdf](https://jandonline.org/article/S2212-2672(18)30154-0/pdf)

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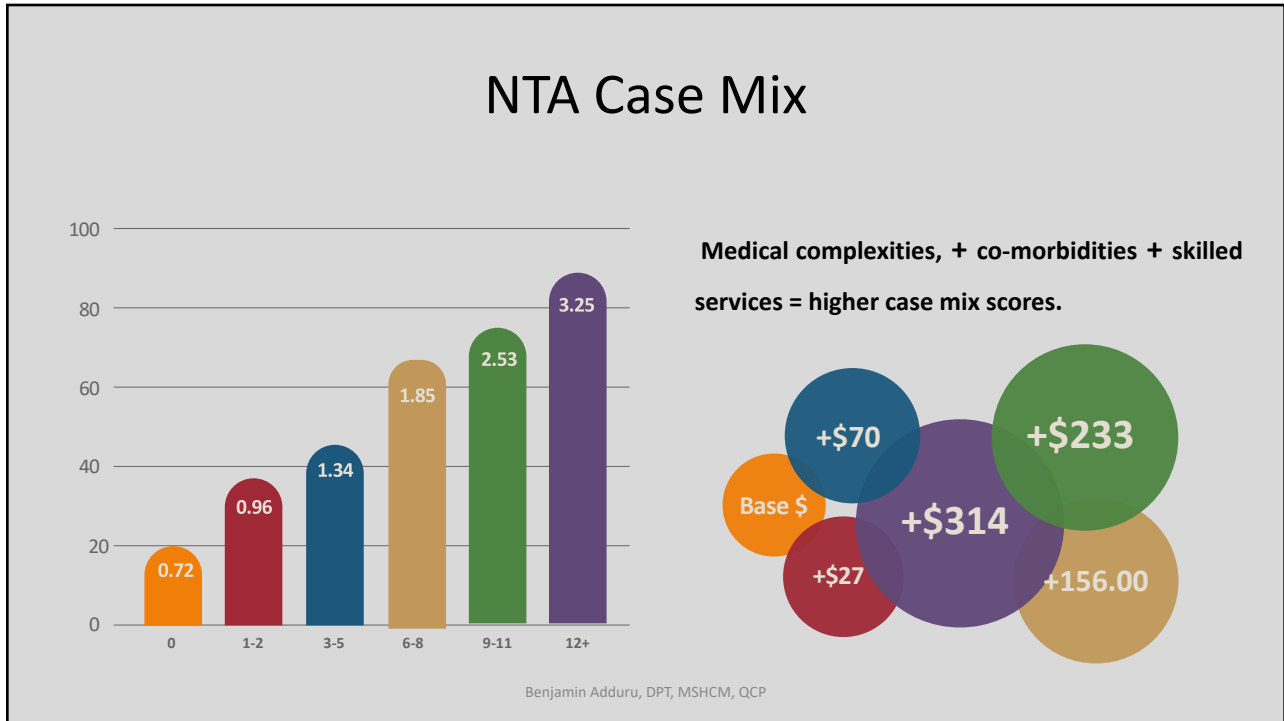


Mini Nutritional Assessment MNA

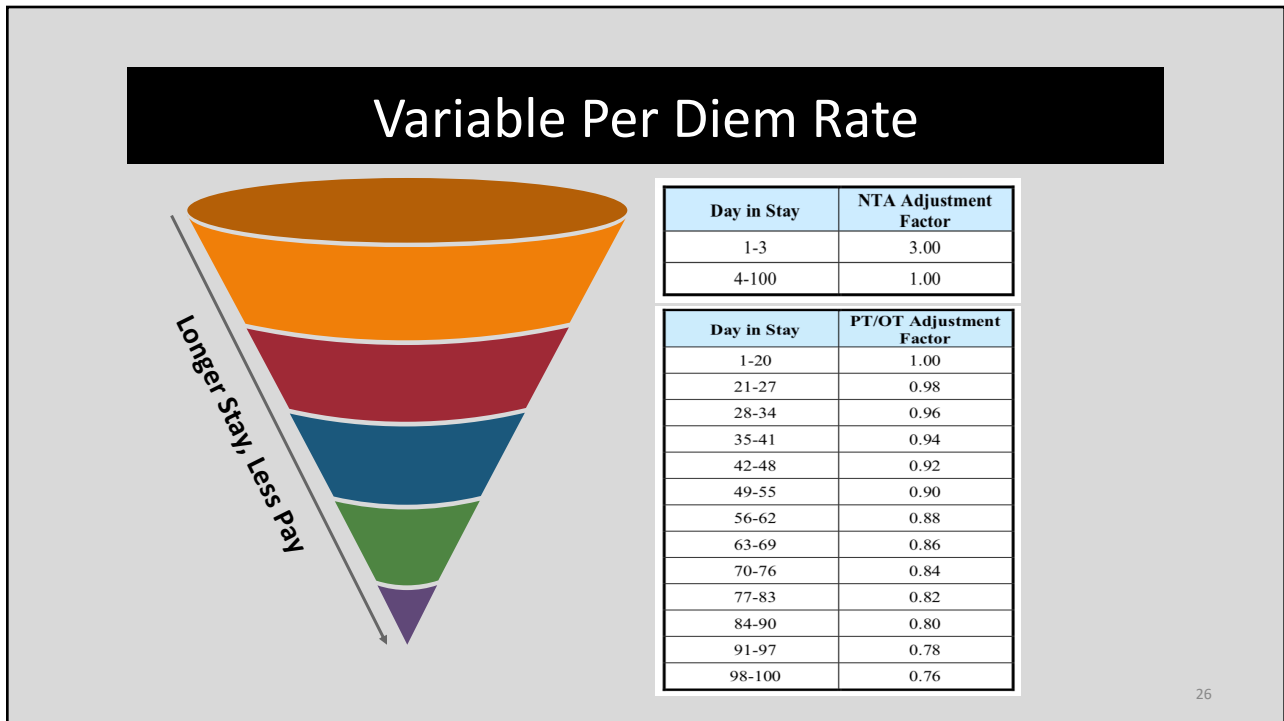
Screening	
A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? 0 = severe decrease in food intake 1 = moderate decrease in food intake 2 = no decrease in food intake	<input type="checkbox"/>
B Weight loss during the last 3 months 0 = weight loss greater than 3 kg (6.6 lbs) 1 = does not know 2 = weight loss between 1 and 3 kg (2.2 and 6.6 lbs) 3 = no weight loss	<input type="checkbox"/>
C Mobility 0 = bed or chair bound 1 = able to get out of bed / chair but does not go out 2 = goes out	<input type="checkbox"/>
D Has suffered psychological stress or acute disease in the past 3 months? 0 = yes 2 = no	<input type="checkbox"/>
E Neuropsychological problems 0 = severe dementia or depression 1 = mild dementia 2 = no psychological problems	<input type="checkbox"/>
F1 Body Mass Index (BMI) (weight in kg) / (height in m)² <input type="checkbox"/> 0 = BMI less than 19 1 = BMI 19 to less than 21 2 = BMI 21 to less than 23 3 = BMI 23 or greater	<input type="checkbox"/>
IF BMI IS NOT AVAILABLE, REPLACE QUESTION F1 WITH QUESTION F2. DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.	
F2 Calf circumference (CC) in cm 0 = CC less than 31 3 = CC 31 or greater	<input type="checkbox"/>
Screening score (max. 14 points)	<input type="checkbox"/> <input type="checkbox"/>
12-14 points: <input type="checkbox"/> Normal nutritional status 8-11 points: <input type="checkbox"/> At risk of malnutrition 0-7 points: <input type="checkbox"/> Malnourished	<input type="button" value="Save"/> <input type="button" value="Print"/> <input type="button" value="Reset"/>

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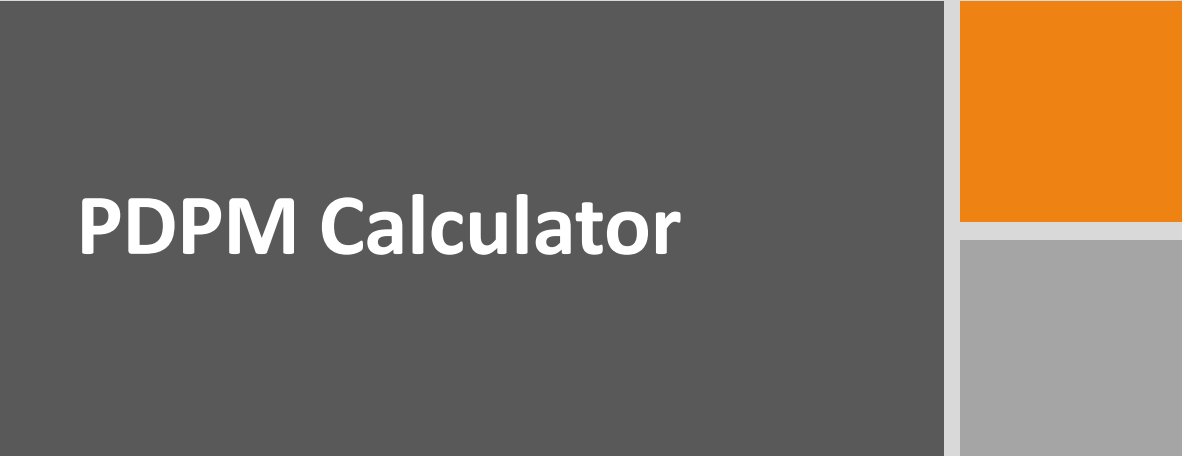
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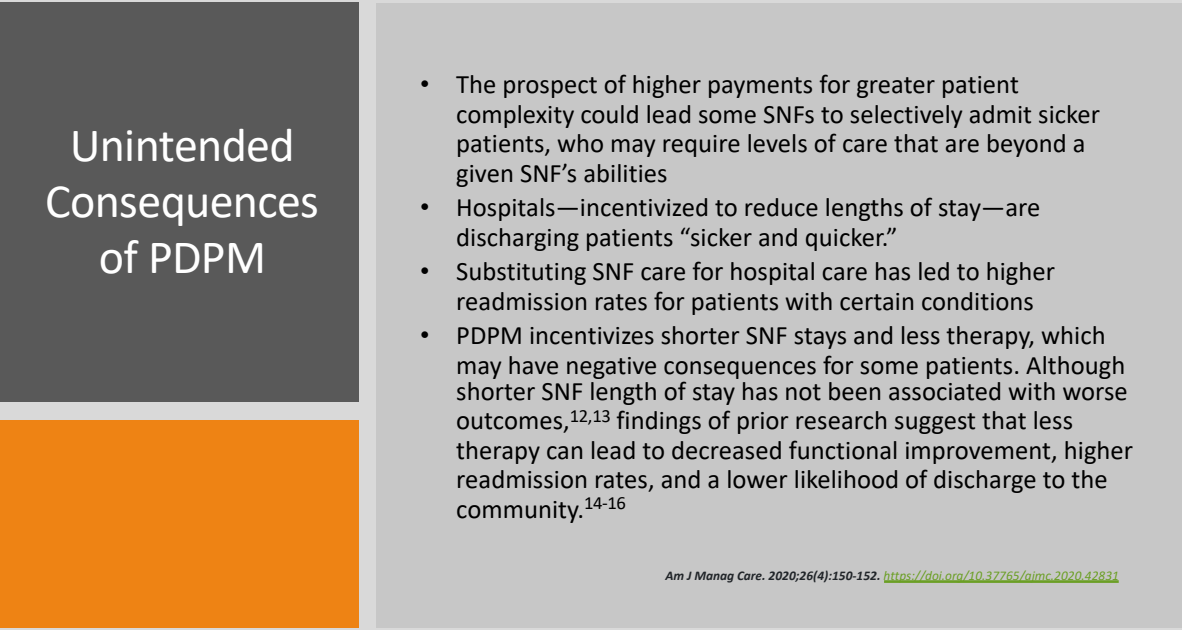
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PDPM Calculator

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Unintended Consequences of PDPM

- The prospect of higher payments for greater patient complexity could lead some SNFs to selectively admit sicker patients, who may require levels of care that are beyond a given SNF's abilities
- Hospitals—incentivized to reduce lengths of stay—are discharging patients “sicker and quicker.”
- Substituting SNF care for hospital care has led to higher readmission rates for patients with certain conditions
- PDPM incentivizes shorter SNF stays and less therapy, which may have negative consequences for some patients. Although shorter SNF length of stay has not been associated with worse outcomes,^{12,13} findings of prior research suggest that less therapy can lead to decreased functional improvement, higher readmission rates, and a lower likelihood of discharge to the community.¹⁴⁻¹⁶

Am J Manag Care. 2020;26(4):150-152. <https://doi.org/10.37765/ajmc-2020-42831>

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PDPM is Budget Neutral?

“The illusion of PDPM budget-neutrality is already over. We should enjoy the largesse while it lasts but prepare for the inevitable correction long before 2020’s back-to-school sales are over.” Marc Zimmet

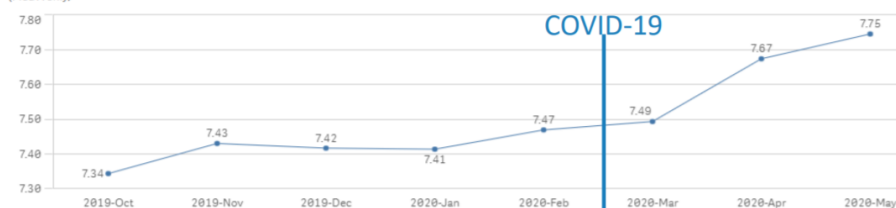
A majority (91.5 percent) of facilities had a higher PDPM rate than they would have achieved under the previous payment structure, Resource Utilization Group (RUG).

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Financial Outcomes

Composite CMI Trend
(Med A only)



Per Diem Trend
(Med A only)



<https://www.claconnect.com/-/media/files/presentations/pdpmimplementation061620.pdf>

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Where do we go from here?

- CMS expanded/expanding the PDPM payment model across all post-acute care providers.
- Other payers including Managed Care HMO's and Medicaid have begun their transition to PDPM
- SNF providers are expecting an adjustment with payment rates to make it truly budget neutral.
- SNF providers must be prepared for close scrutiny to account for the incoming CMS audits from its contractors.
- Traditional Fee for Service Medicare will continue to phase out as HMO's, Bundled Payments, and ACO's will continue to grow and dominate the payment model.

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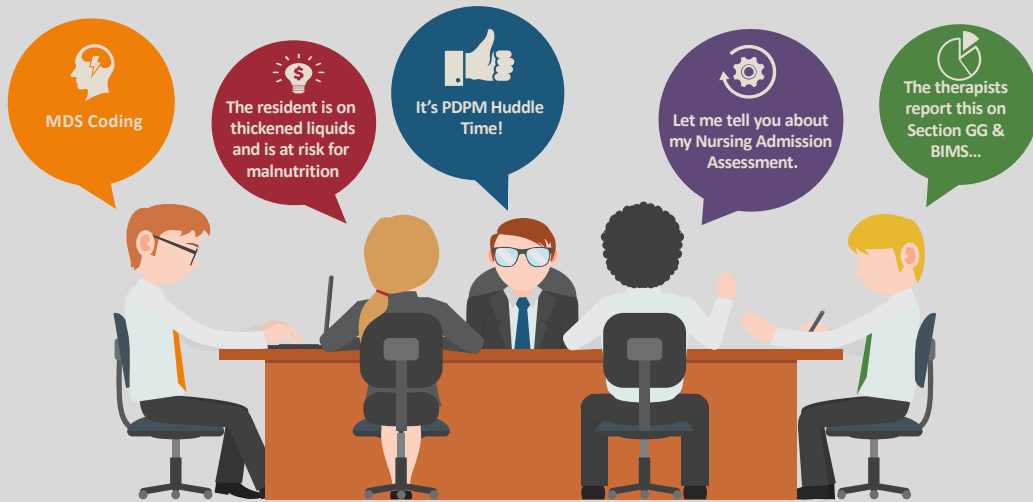
What We Learned About Ourselves

- We need better competencies on ICD-10 Coding
- We need closer hospital partnerships including faster and more robust information exchange
- MDS Coordinators need to be more than just coders but investigative clinicians
- We need to be more sophisticated in clinical documentation to support the resident complexities.
- Identifying complexities created an opportunity to care plan more thoroughly and provide interventions that otherwise may have been missed.
- SNFs need to invest in training to care for higher level medically complex patients.
- Taking shortcuts will result in compliance risk.
- We were not a collaborative IDT as we thought.

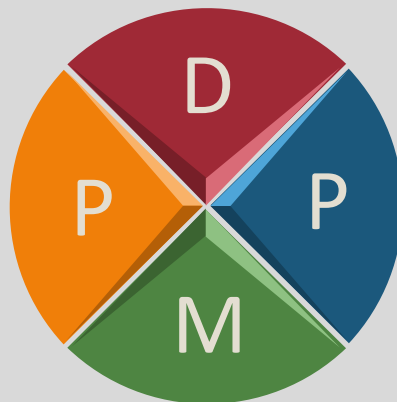
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Collaboration = Better Patient Care



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Patient Driven Payment Method

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