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ABILITY PDPM Series

The New Assessment Process Under PDPM

Number of assessments are declining, but not your responsibilities

Casual observers might be led to think the government's new nursing home payment system is easing up on documentation – that age-old bane of nurses and billing departments. After all, the Centers for Medicare & Medicaid Services (CMS) does promise that the new Patient-Driven Payment Model (PDPM), which is now in effect, streamlines the arduous (though vital) process of assessments.

But that is, as they say, an over-simplification.

True, PDPM has shifted payment incentives away from billable therapy hours and toward general treatment of the patients' overall health issues. This means your caregivers are accountable for treating each and every resident holistically, and with good clinical practices.

While the actual number of assessments is dropping, what your staff does in preparing those assessments can have more serious consequences than ever for your reimbursement – and stress levels.

CMS asserts its new system is designed to reduce the administrative burden, but the new rules are placing greater pressures than ever on your staff – including nurses and assessment coordinators. Top-down in your organization, everyone will quickly come to have a newfound respect for the importance of having good information and being accurate.

Resident days up to Sept. 30, 2019, were paid under the previous resource utilization group (known as "RUG IV") method. As of October 1, it became a whole new ball game. No transition.

How have assessment rules changed?

Medicare and Medicaid programs have long relied on the resident assessment instrument (RAI) of the minimum data set (MDS) – the tool all nursing homes use to determine residents' function capabilities. The RAI-MDS is the blueprint for all care plans.

The changes to MDS significantly alter the rules around the assessment process, outlining the clinical information used to determine case-mix payment rates and how therapy services are reported, according to the American Health Care Association (AHCA).

These changes impact all aspects of SNF operations including front office, billing, resident assessment, and care planning and delivery processes, according to AHCA.

Here's a brief look at those changes:

- A streamlined assessment schedule. Under RUG IV, SNFs were required to complete scheduled assessments at least five times – beginning on day five through day 90 of a resident's stay, as well as for specific "events" like therapy. Under PDPM, only three assessments are required: the old five-day assessment, an optional "interim payment assessment" (IPA), and a PPS Discharge Assessment.
- New MDS sets and "items," including two new sets for the IPA and an Optional State Assessment (OSA). New MDS items under PDPM include sections for a primary SNF diagnosis, surgical history and tracking interim performance. Other payment-specific MDS items include sections for swallowing disorders and other speech-related services, ulcerative colitis, Crohn's and inflammatory bowel disease.

> **"These changes will impact all aspects of SNF operations."**
> —American Health Care Association

What's most important for your operation?

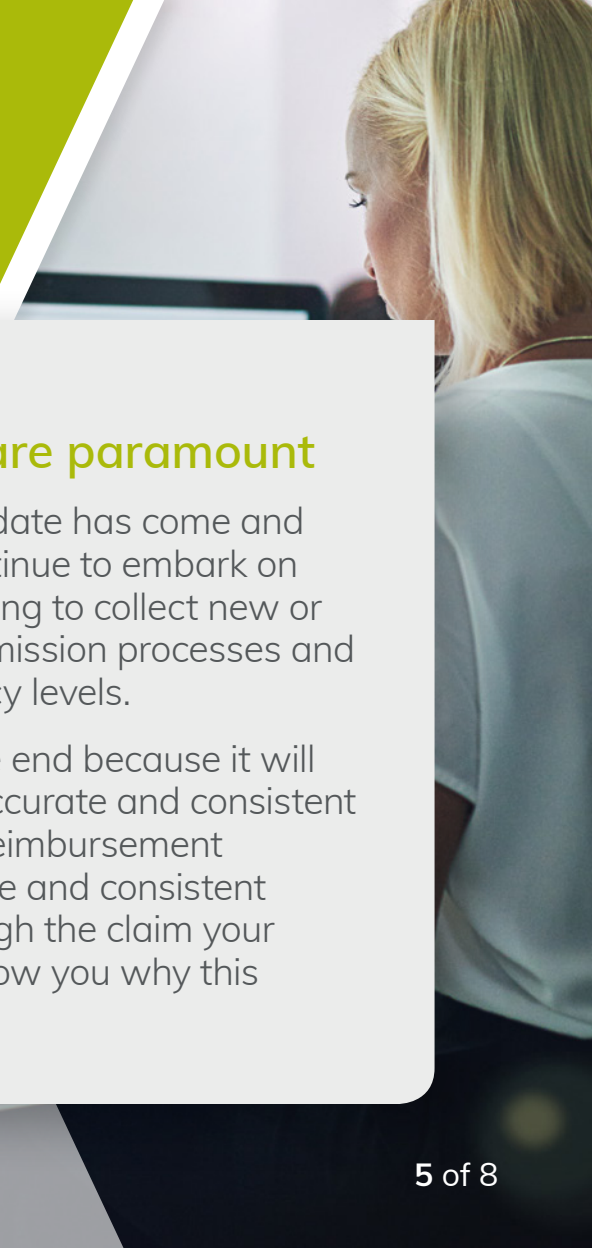
That initial assessment on day 5 is critical

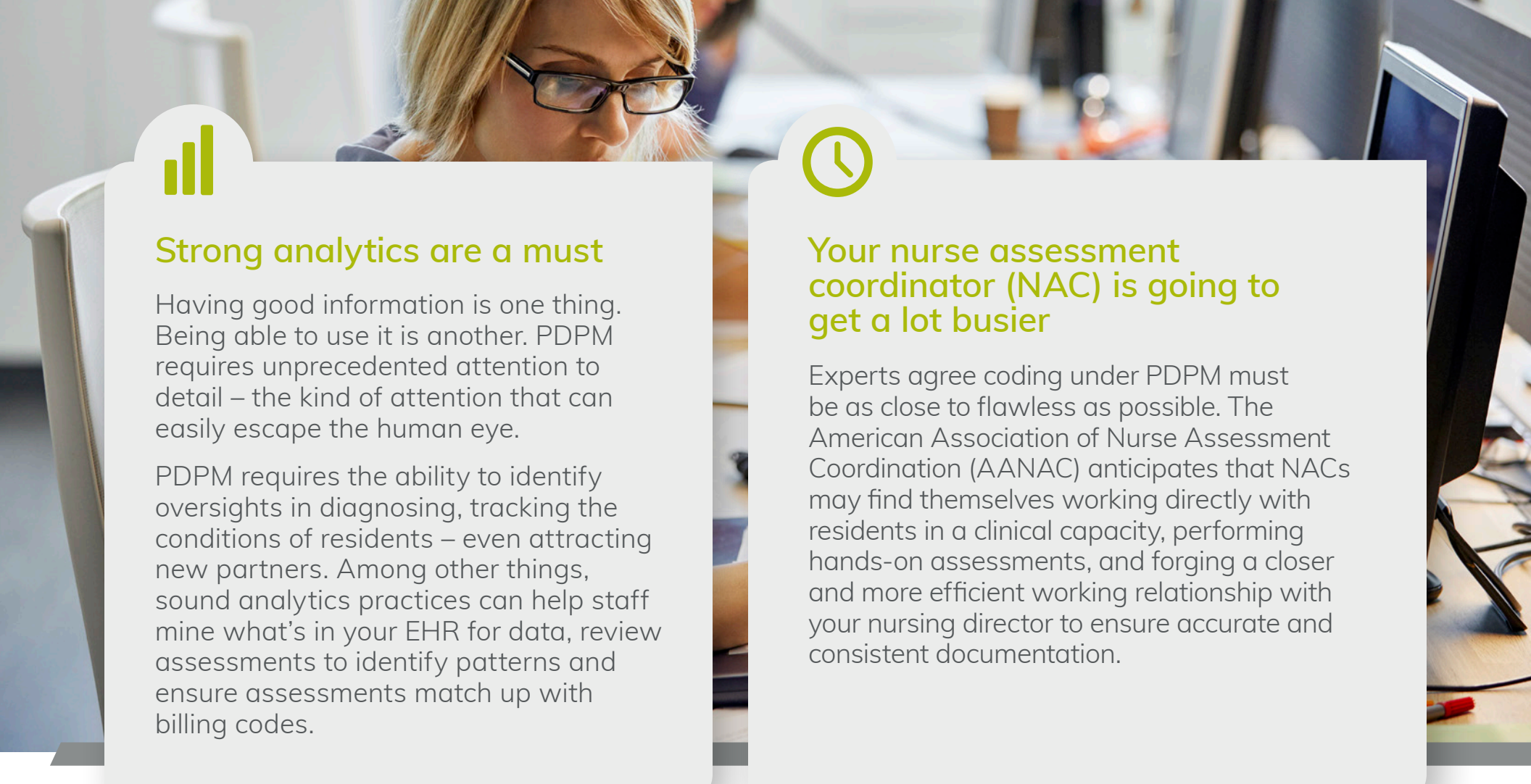
The accuracy of that assessment will directly determine your facility's reimbursement rate. Get it wrong and you're stuck with it for a while – even possibly for the resident's entire stay. Experts advise assessing your facility's readiness, including ICD-10 MDS coding capability and the health of your clinical documentation practices.

Accuracy and consistency are paramount

Now that the Oct. 1 implementation date has come and gone, it's crucial that your facility continue to embark on PDPM training, decide how you're going to collect new or different information, review your admission processes and get a handle on your staff competency levels.

This exercise will pay dividends in the end because it will demonstrate the absolute need for accurate and consistent information across your clinical and reimbursement documentation. This includes accurate and consistent coding – from the assessments through the claim your billing department prepares. We'll show you why this important down below.





Strong analytics are a must

Having good information is one thing. Being able to use it is another. PDPM requires unprecedented attention to detail – the kind of attention that can easily escape the human eye.

PDPM requires the ability to identify oversights in diagnosing, tracking the conditions of residents – even attracting new partners. Among other things, sound analytics practices can help staff mine what's in your EHR for data, review assessments to identify patterns and ensure assessments match up with billing codes.

Your nurse assessment coordinator (NAC) is going to get a lot busier

Experts agree coding under PDPM must be as close to flawless as possible. The American Association of Nurse Assessment Coordination (AANAC) anticipates that NACs may find themselves working directly with residents in a clinical capacity, performing hands-on assessments, and forging a closer and more efficient working relationship with your nursing director to ensure accurate and consistent documentation.

The consequences of getting it wrong

- Get your day-five assessment right the first time or risk having to live with a lower reimbursement rate the entire time that resident is in your facility. According to AANAC, the IPA “will be the only tool providers have to increase the per-diem rate once it’s set by the five-day PPS MDS.”
- Inaccuracy in assessments and their corresponding coding claim discrepancies can expose your facility to the scrutiny of recovery audit contractors. This could lead to RAC audits, inspections, and survey deficiencies, which can be devastating and long-lasting. The clinical documentation in your EHR must synch with your MDS.

Tips and pointers

- Review your documentation. Ensure assessments match up with the information the MDS coder placed on your claim.
- Ensuring absolute accuracy on all assessments and related documentation is a must. Having to resubmit claims is not only time-consuming and impedes cash flow, but it could raise red flags with payers down the road.
- Identify errors and inconsistencies to ensure you're not missing opportunities for additional diagnoses. This not only will help inoculate your facility from fraud, but also help avoid leaving tens of thousands of dollars of legitimate reimbursement on the table.

While the number of assessments under PDPM has decreased, the responsibilities of your staff have not. Most important, accuracy and better analytics are key to success, so ensure your very first assessment is error-free.

Find out how ABILITY can help you successfully navigate PDPM

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