CODING & PDPM AT THE CROSSROADS

PRESENTED BY:
ALICIA KUNZ, RHIT, QCP, CCS
HEALTH INFORMATION CONSULTANT
ANDERSON HEALTH INFORMATION SYSTEMS

1

Disclaimer

This workshop was developed as a general educational offering and reference for long-term care professionals and is not intended as legal advice nor should it be a substitute for professional advice in any specific situation.

To the best of our knowledge, it reflects current state and federal regulations and practices. The examples used do not represent the employer of the presenter or any preferred electronic health record system or health information technology.

Information contained in this workshop must be considered in light of the individual organization.

2

Objectives – Participants will Identify:

1. **Redirected focus on Coding Processes/System Changes** and impact on quality of care and reimbursement
2. Key on the:
   - Administrative Roles/Responsibilities on the Coding Accuracy
   - Staff roles related to coding – MDS, DON/Direct Care Nursing Staff, Coders & Physicians, IDT, & Therapies
3. Review/Evaluate need for tools used to facilitate and monitor compliance: Coding, Clinical Documentation, Performance Measures, QAPI

3

Where Do We Start?

DON or Administrator meet with Hospitals to establish electronic exchange of Health Information for admissions

CMS EHR Coding Interoperability Initiative – Share info with facility to use when approaching hospitals about data sharing

Handout → HO1_EHR MedicarePromotingInteroperabilityProgram

4

Obtain Acute Hospital Documentation

Acute hospitals with exchange capability **motivated to do** so because:

- Points awarded for sharing data electronically be considered a meaningful **EHR user under the initiative and avoid a negative Medicare 2+% payment adjustment**

5

Obtain Acute Hospital Documentation

Timely and complete transfer of information contributes to decreased rehospitalization rates

Win-Win – the acute care hospital and SNF are both subject to reimbursement penalties related to preventable readmissions within 30 days

Acute documentation diagnoses alert SNF upon admission of conditions defining potentially preventable readmissions

6

Diagnoses – Readmission Risk

Potentially preventable Readmission

- COPD, CHF, C-diff infection
- Dehydration/Gastroenteritis, Electrolyte imbalance
- Bacterial PNA/Aspiration PNA
- Skin/subcutaneous tissue infections
- Influenza
- Acute renal failure
- Arrhythmia, A-fib, Aflutter
- Intestinal impaction and fecal impaction
- Pressure ulcers
- HTN/hypotension
- UTI/kidney infection
- Septicemia
- DM w/ short-term complication

7

Acute Care Transfer Documentation

HIM Consultant/Administrator –

- Set up tracking for completeness of transfer documentation from hospital paper and electronic*
- Acute Care Documentation = Potential for Improved Care and Dollars $$

8

Critical to PDPM

Admission Monitoring – Is Medical Records requesting documentation and following up for Discharge Summaries*? H&P, progress notes, problem lists, labs, diagnostic studies, operative/procedure reports, consults?

Does the ID team have the information early – within the first 72 hours after admission?

Who is leading? Assigned responsibility?

9

Acute Care Transfer Documentation -2

Transfer Documentation Incomplete or hospital not complying with requests?

- Set up tracking/trend for completeness of Transfer Documentation from hospital paper and electronic
- Pinpoint the specific problem hospital and/or documentation that is not available or provided timely
- HIM Consultant identify/evaluate problems – QAPI

10

Getting the Right Diagnosis

Starts prior to admission and continues through the course of the resident's stay

Clinical Documentation Improvement (CDI) process

Physician specificity of Diagnosis to code/bill correctly

- Same as in the acute hospital
- Supporting clinical documentation for each of the diagnoses for accurate coding

11

Physician Documentation Improvement

Administrator/DON –

- Meet with Medical Director re: Clinical Documentation Improvement Program (CDI)
- Schedule Physician Orientation to PDPM and CDI
- See HO2_PhysiciaRoleICD10PDPMImplementation

12

Physician Orientation

Involve the Medical Director in the process of engaging the physicians

ORIENT physicians

- Complete and timely diagnoses
- Response for additional diagnostic information to support coding and billing – Use MD Query Process (*as done in Acute Hospitals*)
- Set a goal date to roll out MD awareness and Education Program

13

Physician Orientation_2

Review

- Diagnosis list (on skilled residents) for all current diagnoses
- Specificity of the **principal** and all active diagnoses – i.e.
  - Fractures – traumatic vs. pathologic, laterality, complications
  - Type of diabetes, asthma
  - Pressure ulcer sites, acute vs chronic conditions, etc.

14

Physician Orientation_3

Facility staff will be asking MD to clarify if any diagnoses are conflicting or lacking documentation

MD office billing diagnoses must MATCH the resident chart

15

Physician Documentation Improvement Tools

HIM Consultant can assist to –

- Develop/Adopt Tools for Clinical Documentation Improvement including MD query
- Set up **MD Query Tracking** tools/reporting system
- Support Administrator meet with Medical Director

16

Clinical Documentation Improvement – (CDI) – Best Practices

ADMINISTRATOR/Medical Director have adopted CDI PROCESSES

Focus on **Documentation for PDPM** diagnosis related payment methodology

- Must **reflect patient acuity** which drives reimbursement

Defined SNF Specific CDI program Foster Collaboration between coders and those serving in the role of CDI specialist and MDS coordinator

Provide of the right tools to assist staff and physicians

17

MD Query Process

Provide the practitioner/MD the reason for querying:

- Ask practitioner for clinical interpretation of facts in the medical record
- May be written as a question
- Several choices should always be given, including a choice of "other, please specify", "unable to determine" and "clinically irrelevant" – Check boxes are ok
- Should not sound presumptive, directing, prodding, probing, or as though the practitioner is being led to a diagnosis

18

MD Query Process_2

Obtain query templates for your most common diagnoses to obtain specificity

Query tracking tools

- Are MDS/coders querying MD when lacking a diagnosis or diagnosis in non-specific?
- Are physician's responding to queries?

CDI tip sheets and physician education materials

19

MD Query Process_3

Query methods include:

- Via telephone orders* – must be specific
- Via progress notes
- Use of "query" form
- Printing diagnosis list for MD signature
- E HR system includes option to send notes to the providers with the response included as part of the legal health record *attestation needed

must have supporting MD documentation in chart signed and dated!

System to Track response to queries and trend

20

MD Query Process _4

Many* previously accepted "Unspecified" codes are "Return to Provider" under PDPM

Query the MD to obtain needed information from the provider if:

- specificity is NOT documented or
- there is conflicting/unclear documentation

Coders MUST verify diagnosis codes for complete/accurate codes

Clarified diagnoses must be updated in computer system and print updated diagnosis list

21

Sample MD Query – Atrial Fibrillation

Please clarify resident's Atrial Fibrillation and Flutter diagnosis and check correct one:

____ Paroxysmal atrial fibrillation
____ Chronic atrial fibrillation
____ Atypical atrial flutter/type
____ Unspecified atrial flutter
____ Clinically irrelevant
____ Persistent atrial fibrillation
____ Typical atrial flutter/type
____ Unspecified atrial fibrillation
____ Unable to determine

_____ _____
MD signature **Date**

22

Sample Query – Not just for MDs

LATE EFFECTS/SEQUELA OF NONTRAUMATIC CEREBROVASCULAR DISEASE

***Give to therapy to check appropriate late effects (once they evaluate resident)**

___ Attention & concentration deficit ___ Memory deficit ___ Visuospatial deficit & spatial neglect ___ Psychomotor deficit ___ Frontal lobe & executive function deficit ___ Cognitive social or emotional deficit

___ Other S/S involving cognitive functions _____

___ Aphasia ___ Dysphasia ___ Dysarthria ___ Fluency Disorder

___ Other speech and language deficits _____

___ Monoplegia ___ Right side ___ Left side ___ Dominant ___ Non-dominant

___ Hemiplegia/Hemiparesis ___ Right side ___ Left side ___ Dominant ___ Non-dominant

___ Other paralytic syndrome ___ Right side ___ Left side ___ Dominant ___ Non-dominant

___ Apraxia ___ Dysphagia ___ Facial weakness ___ Ataxia

___ Other sequela

23

Sample Query – Not just for MDs

Non-pressure chronic skin ulcer: (Coder queries treatment nurse)

-Site: ___Thigh ___ Calf ___ Ankle
___ Heel/Midfoot ___Other part of foot
___ Other part of lower leg ___ Buttock
___ Back
Skin of other sites (specify) ____

-Symptom: ___Breakdown of the skin ___Fat layer exposed
___ Necrosis of muscle ___ Necrosis of bone
___ With muscle involvement ___ without evidence of necrosis
___ With bone involvement ___ without evidence of necrosis

____ Other specified severity ____ Unable to determine ____ Clinically irrelevant

LN signature Date

24

Documentation Based on Selected Codes

SYSTEMS in place:

1. Staff using **Query Tool** in use to obtain most specific, complete diagnosis to support reimbursement?
2. Medical Records **monitoring Physician Orders**
   - **Complete with diagnosis**, documented in the record by MD
3. **Morning clinical meeting** to discuss new admissions/diagnoses
   - Set the stage for coverage: new admissions/even continued coverage if there is a question regarding the diagnosis and services needed
4. **Coding Performance Measures** in place
   - Diagnosis Added to the Diagnosis List and correctly coded = **$$**

25

Nursing Staff Tools Updated for PDPM

Admission Diagnosis Worksheet

Cue staff to abstract Diagnoses from Hospital and SNF Medical Records for

- **Principal Diagnosis** – must map
- Speech Language Pathology Comorbidities/Non-Therapy Ancillary Comorbidities and related diagnoses = $$ – must map
- Nursing Case Mix Comorbidities = $$

Use Admission Diagnosis Worksheet along with NTA checklist and surgical categories checklist

26

Nursing Staff Tools Updated for PDPM-2

Review and Revise Skilled Documentation Charting Guidelines as needed

Technology – Consider Care Management Software to assist nursing staff in writing skilled documentation to support care and reimbursement that aligns with the MDS

27

Coding driving the dollars

THESE ARE THE RULES

ICD-10 coding edits – Medicare Beneficiary Claims Manual pg. 31

MACs, CERT, Recovery Auditors, and ZPICs shall

- **apply coding guidelines** to services selected for review and **determine that an item/service is correctly coded when it meets all the coding guidelines listed International Classification of Diseases Guidelines (ICD-10) FOR SKILLED NURSING**

28

Skilled Documentation Evaluation – Administrator Informed

Nursing staff

- Medicare Certifications specify which services are being covered **based on qualifying diagnoses**
- No more just checking off PT, OT and Speech on the Medicare Cert (must include specifics of coverage along w/ other qualifying diagnoses)
- Skilled documentation = documented diagnoses = billing
- **All billed diagnoses are linked back to assigned ICD-10 codes**

29

Diagnosis Selection/Coding Compliance – Administrator Informed

Resident's **principal diagnosis** maps into one of ten PDPM clinical categories – ICD-10 codes assigned for Principal Diagnosis listed as "Return to Provider" may result in denied claims

Additional ICD-10 codes capture documented secondary diagnoses and comorbidities = $$

- i.e., HIV/AIDS will result in an 18 percent add-on to the nursing payment component

30

Diagnosis Selection/Coding Compliance – Administrator Informed-2

Correctly coded diagnoses drive the 5-day assessment/sets the payment rate for the entire stay

- **IDT Process required** – No longer driven by therapy minutes, but therapy still a part of coverage
- Staff familiar with/use mapping tools and ICD-10 coding sequencing rules
- System in place to update codes for new or resolved diagnoses after Interrupted Stay and/or Interim Payment Assessment?

31

Diagnosis Selection/Coding Compliance – Administrator Informed-3

How will you check compliance?

- Ongoing performance evaluation and quality monitoring
- Computer system alerts used and/or CMS PDPM Mapping Tools –
  - Clinical Category for Primary Diagnosis/Return to Provider
  - NTA mapping tool
  - SLP Comorbidities mapping tool

32

Diagnosis Selection/Coding Compliance – Administrator Informed-4

Checking compliance (continued)

- Coding performance measures evaluation for correct assignment/sequencing of diagnoses/codes
- Identify issues now and produce a plan – Your plan is complete --- right?

Coding for PDPM should be happening now!

33

Coding Skill Competencies – Admin Informed_5

Training for **ICD-10 coders** – staff who code regularly and backup coders
- Medical Records
- MDS

Establish Performance Measures/competencies to evaluate coding skills, accurate billing practices

Begin **regular review** using coding performance measures by HIM Consultant – should have TOOLS to assist! **Trend results** – Report to Administrator – **Performance Metrics – Part of your QAA and future Compliance Plan**

Ongoing education based on identified areas of need/risk – coding updates

Establish **QAPI** for areas of non-compliance

34

How Will I Know I'm in Compliance?

Administrative Information System

What **you** were paid = what was billed?

No ADRs
- MACS $$ paid as billed

NO ZPICS

THE RULES ARE MET BY REGULAR REPORTING/QUALITY MONITORING RESULTS

35

Unresolved Issues…Admin. Informed

Is staff aware of the Conflict between instructions for coding in the RAI Manual v17.0 and the official ICD-10 Coding Guidelines?

MAY BE A CHALLENGE FOR FACILITY – PLAN AND UPDATE

Code may map on the mapping tool and in your computer system but are not correct codes for use in the SNF!

Computer system changes and tools designed to assist with selection of codes still need the human touch to review for correct application based on coding and reimbursement rules

36

ICD-10 Coding Changes Ahead…

ICD-10 Coding for ***2020*** (Books ready for use on October 1, 2019)
Released by CMS **June 21, 2019** Updates to the 2020 Coding

- **71932** codes in icd10cm_**2019**
- **72184** codes in icd10cm_**2020**
- **273 additions – 21 deletions**
- http://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-CM.html
- Includes revised codes for E. coli, added codes for fractures, and much more

CMS Answers to unresolved mapping issues?

- Incorrect mapping of acute care codes as acceptable principal diagnosis

37

Coding Staff/Systems

Coding training completed for PDPM for:

- Coders, backup coders ✓
- MDs ✓
- Clinical staff who assign and sequence diagnoses ✓

TIME TO EVAULATE PERFORMANCE

Post-training competency evaluations
Targeted re-training based on results of evaluations and coding reviews

38

Coding Evaluation Tools

ICD-10 Coding Quality Performance Measures – Performed by Health Information Consultant at prescribed intervals

- Reports to Administrator
- Follow-up training provided as needed
- Focus training/re-training on most common errors and
- Errors that affect reimbursement

39

Coding Performance Measures

1. Principal diagnosis correctly selected/Clinical Category Maps N0 = return to provider* Medicare $$$
2. Principal diagnosis correctly coded, as specified by Physician
3. Top 10 secondary diagnoses correctly coded, included all skilled diagnoses. Medicare/Case Mix $
4. Top 10 diagnoses correctly sequenced, based on coding guidelines
5. NTA/SLP Comorbidities – all coded correctly New focus for PDPM Case Mix $
6. NTA/SLP Comorbidities – all sequenced correctly

40

Coding Performance Measures_2

7. Therapy treatment diagnoses coded and in computer timely (7 days)
8. Therapy evaluations reflect correct medical condition diagnoses.
   Even though therapy will no longer be the main driver of reimbursement – accurate therapy code must still be accurate – Principal Medical Dx. on eval must match code on dx. list and MDS
9. Aftercare codes assigned correctly, based on coding guidelines. Aftercare codes are not used in conjunction with codes with a seventh character extension for the episode of care (Fractures, Injuries) Updated codes for fractures in 2020

41

Coding Performance Measures_3

10. Injuries correctly coded, with correct 7th character, based on coding guidelines and chart specificity. Caution Codes with Acute "A" suffix map – Must use appropriate SNF "D" or "S"
11. Non-traumatic head injuries (CVD) correctly coded with I69 code. Common error using I60-63 Acute care only – these map but are not the correct code for SNF
12. If CVD, all residual effects coded.
13. Hypertension correctly coded, per coding guidelines.
14. CHF correctly coded, per chart specificity.

42

Coding Performance Measures -4

15. All DM complications correctly coded, per coding guidelines and chart specificity. NTA $
16. History/Status codes correctly sequenced (not principal diagnosis) Lung, major organ transplant, ESRD status = NTA $
17. Infections coded correctly with causal organisms included (if documented) Documentation from acute hospital needed

43

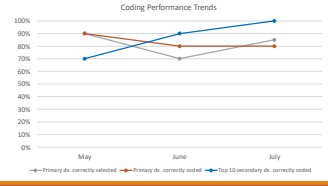
Coding Metrics show the trends

Key areas of non-compliance	May	June	July	August
1. Primary diagnosis correctly selected.	90%	70%	85%	
2. Primary diagnosis correctly coded, as specified.	90%	80%	80%	
3. Top 10 secondary diagnoses correctly coded, included all skilled diagnoses.	70%	90%	100%	
7. Aftercare codes assigned correctly, based on coding guidelines.	67%	75%	85%	
8. Injuries correctly coded, based on coding guidelines and chart specificity.	33%	100%	90%	
13. DM correctly coded, per coding guidelines and chart specificity.	50%	40%	50%	
14. History/Status codes correctly sequenced (not primary diagnosis)	67%	80%	85%	
15. Infections coded correctly with causal organisms included (if documented)	60%	40%	70%	

44

Metrics

How will the information collected inform your next steps in the development of a performance improvement plan?



45

Analysis of Coding Trends

HIM Consultant can assist you to identify causes of errors:

Acute care documentation not available timely or data received not incorporated into the record

- Operative reports not utilized for coding section J Surgery codes **($$)** and possible Section I Diagnosis/Codes
- Labs not available/reviewed for underlying cause of infections = **Incomplete or incorrect code used**
- Discharge Summary from Acute (MD has 14 days to complete) included additional diagnoses not yet coded = incomplete codes/possible conflicting diagnostic information in the record (**legal and billing risk**)

46

Analysis of Coding Trends-2

MD documentation incomplete/Admission H&P not done timely

- Diagnosis list contains unspecified or incomplete diagnoses
- Diagnoses recorded on the SNF H&P are not picked up later and added to the diagnosis list
- MD unaware of changing conditions communicated by nursing that may require an updated diagnosis with supporting documentation

47

Analysis of Coding Trends-3

Clinician's (Nursing/MDS) Diagnosis List incomplete, incorrect, or not completed timely

- Not including applicable codes for the Nursing, NTA case mix, recent surgeries $$
- Not using the Clinical category, NTA mapping tools
- Not forwarding diagnosis list to coder timely
- Not querying MD when more information needed to clarify diagnosis

48

Analysis of Coding Trends-4

IDT not Communicating Regarding Assignment of Diagnosis

- Therapies and Clinical team not meeting regarding assignment of principal diagnosis and therapy diagnosis = Therapy evaluations have incorrect principal diagnosis (not matching Medical Diagnosis List)
- Therapies choosing codes from incomplete list of acceptable therapy diagnosis codes = not choosing diagnosis that most accurately reflects resident's problem/diagnosis (can be a software issue)
- Always using same codes – not person-centered
- Interim Payment Assessment done/Diagnosis List not updated

49

Analysis of Coding Trends-5

Coder (Med Recs/MDS or other clinical staff) errors or not timely

- Coding error (wrong or incomplete code) – more training needed and/or improvement in accuracy needed
- Not getting Diagnosis List from clinicians timely or incomplete Diagnosis List or not updated after an IPA is completed
- Not querying clinicians when more information is needed to determine the accurate code
- Not using the medical record to obtain diagnosis information
- Insufficient number of trained coders

50

Analysis of Coding Trends-6

HIM Consultant can assist you by:

- Providing, analyzing, and summarizing coding trends
- Set coding accuracy performance goals/thresholds
- Draft QAPI

Facility Reports significant trends at QAA

QAPI errors based on frequency, prevalence, or risk

Plan changes… then change!

51

Documentation to Support Coding/Billing

Adapt Admission Diagnosis Coding Worksheet/Related Tools

- Guide clinical staff to **abstract complete diagnostic information** for PDPM
  - Nursing Case Mix
  - Non-Therapy Ancillary Case Mix/Speech Language Pathology Comorbidities
  - Recent Surgical Procedures
  - Principal Diagnosis

What changes may be needed to existing tool?

52

Adapting Tools for PDPM

Admission Diagnosis Worksheets, Medicare Charting Guidelines, computer software to ensure:

- All current/relevant diagnoses captured
- Nursing documentation supports medical necessity as well as information reported on the MDS

53

Interim Payment Assessment (IPA)

Optional – Does not require a readmission – **may affect coding**

Stand alone assessment – cannot be combined with other assessment

Has its own MDS item set

Does NOT reset the variable per diem rate – however, …

May be completed by providers in order to **report a change in the patient's PDPM classification**

Payment Impact: Changes payment beginning on the ARD and continues until the end of the Part A stay or until another IPA is completed

54

Reasons to Do an IPA

New diagnosis of dysphagia and a diet downgrade

New diagnosis of wound infection and long-term IV therapy

New diagnosis of multi-drug resistant organism with long-term IV therapy

New diagnosis of pancreatitis and parental IV feeding

New diagnoses will be coded on the MDS and new diagnoses would be coded and added to the Diagnosis List

There are other reasons that you would do an IPA that may not have an associated diagnosis/code like change in level of functioning

55

Readmission After Interrupted Stay

Coding may be affected:

- There could be new diagnoses to consider
- Review of diagnosis list is needed
- If occurs during a month, do not delete codes, but can add code
- **Remember the IPA is optional**

IDT communication is key to capturing reimbursable diagnoses and subsequent coding

Face Sheets/Diagnosis List must be updated and reflect current diagnoses – Recent survey issue

56

Medicare Coverage Documentation

Review and Revise Skilled Documentation Charting Guidelines

Diagnoses coded supported by documentation in the Medical Record

Medicare Cert/Recert form – Is there space to include all conditions being certified for skilled coverage?

Daily Skilled Charting – E HR charting provides structure that allows for nursing staff to adequately address progress toward goals for covered conditions?

Nursing staff access to Skilled Charting Guidelines to assist with writing complete and descriptive notes related to covered conditions

57

Medicare Coverage Documentation_2

Caution: Structured notes that provide only check boxes may not facilitate documentation that:

"Describes the skilled services that require the involvement of nursing personnel to promote the recovery and or stabilization of the patient's medical condition and safety or illustrate the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of skilled nursing personnel"

58

Medicare Coverage Documentation_3

Technology – Consider Care Management Software to assist nursing staff in writing skilled documentation to support care and reimbursement that aligns with the MDS

Many new PDPM tools on the market in use by facilities, therapies and E HR systems

Beware – not all systems integrate with one another

59

Coding for PDPM is Far Reaching

Diagnosis Selection and coding accuracy affect the MDS/Casper

For example QM – % of Residents who received an Antipsychotic medication

Long Stay measure modified Antipsychotic Medication (Long Stay) measure has been modified w/ addition of new conditions as exclusion criteria:

- Manic Depression, Psychotic Disorder, and Traumatic Brain Injury
- Other excluded diagnoses are Schizophrenia, Tourette's Syndrome, and Huntington's Disease

Incomplete or inaccurate diagnosis selection and coding can directly affect this Quality Measure as well as the QASP

60

Coding for PDPM is Far Reaching -2

Another example is Long Stay Quality Measure % of residents who have/had a catheter inserted and left in their bladder

Excluded diagnoses include:
- Neurogenic Bladder
- Obstructive Uropathy

Covariates:
- Pressure Ulcers Stage 2-4 on prior assessment

Incorrect diagnosis and **coding affects the risk adjusted score on that QM**

61

Analysis of MDS/CASPER

MDS Submitted
- Accurate – I8000 and Medical Diagnosis Sheet match and other diagnoses throughout the MDS (examples those that affect NTA and Speech comorbidities)
- Complete – All relevant diagnoses included
- Timely

Review the Casper for trends that link back to specific diagnoses

62

But What About Managed Care?

Have relied on the facility to provide RUGS-IV levels for their billing –
- What will you do when your software is set up for PDPM?
- Will Managed Care provide their own RUGS levels after October 1st?
- Do they have plans to convert to PDPM system?

CMS will support RUGS-IV for managed care into 2020 but have not specified for how long

63

But What About Managed Care?-2

Government Accountability Office in a letter to HHS Secretary Azar (3/28/19) addressed CMS failures related to diagnostic coding differences between Medicare Advantage and Medicare Fee for Service, including better accounting for beneficiary characteristics and more refined data for determining Medicare Advantage Payments

64

It's In Your Hands

65

Looking ahead…SPADEs

SPADEs = Standardized Patient Assessment Data Elements

CMS must develop, implement, and maintain standardized assessment-based data elements to meet the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, Section 2(a) that impact 4 Post Acute settings

- Home health agencies (HHAs)
- Inpatient rehabilitation facilities (IRFs)
- Long-term care hospitals (LTCHs)
- Skilled nursing facilities (SNFs)

66

SPADEs-2

SNF QRP: Proposed FY 2022 SNF QRP QMs require SPADEs

Begin reporting MDS data for two new QMs proposed for FY 2022 SNF QRP (Transfer of Health Information to Provider–PAC and Transfer of Health Information to Patient–PAC) for residents beginning with October 1, 2020 discharges. Measures specified under the Transfer of Health Information domain are required to use SPADEs, says CMS.

The *Proposed Specifications for SNF QRP Quality Measures and Standardized Patient Assessment Data Elements* and the Change Table for Proposed SNF QRP New and Modified Items – Effective Date: October 1, 2020 include further clarification on SPADEs Requirements.

67

SPADEs-3

Three SPADEs play a central role:

*** FY 2022 proposed Transfer of Health Information to the Provider–PAC**

*** FY 2022 proposed Transfer of Health Information to the Patient–PAC QM**

The calculation of the proposed QM "would be based on the proportion of resident stays with a discharge assessment indicating that a current reconciled medication list was provided to the resident, family, or caregiver at the time of discharge"

*** FY 2020 Discharge to Community–PAC SNF QRP revision**

68

21st Century Cures Act

In short – documentation and billing across the spectrum of care will be monitoring for

Continuity of Diagnoses, Billing, Payment

Interoperability is a large component of having consistent clinical information to support the ICD Code, Current Procedural Terminology Codes (CPT) = equals the diagnosis, applied also to the type of visit, complexity of the visit and documentation by the physicians/PA/NP

69

Conclusions

Management Plan Checklist *(See HO Coding_Admin_ Checklist)*

- Staff trained
- Systems in place
- Tools ready/in use

Evaluation of

- Staff skills/competency
- $$ impact – billing rejections, denied claims due to incorrect/incomplete coding

QAPI Process in place w/ metrics = measurement and progress!

70