

2019 CALTCM Summit for Excellence



**Patient Driven Payment Model (PDPM):  
Engage Your Medical Director, Or Die!**

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@Wassdoc

 2019

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**Disclosure Statement**

Editorial Board, The Merck Manual

Board Member, Wish of a Lifetime Foundation

Board Member, Foundation For Health In Aging

President, California Association of Long Term Care Medicine (CALTCM)

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**Patient-Driven Payment Model (PDPM)**

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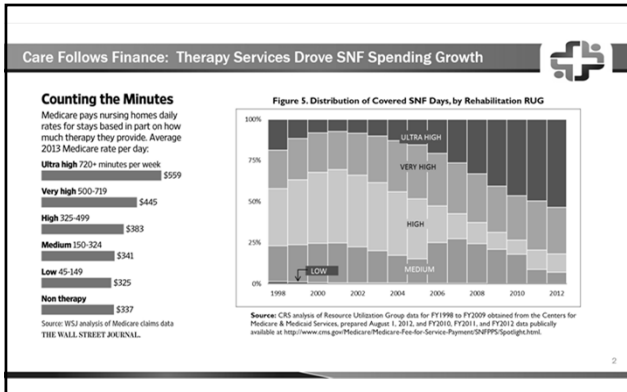
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## Game Changing Differences

- RUG IV
  - 80% dependent on Level/ hours of therapy
  - 10% dependent on ADLs
  - 10% dependent on geographic location
  - Total MDS items: 20
- PDPM:
  - Driven by **primary clinical diagnosis + co-morbidities** based on **ICD-10 codes**
  - Modified by cognitive, functional status assessments
  - Modified by LOS
  - Total MDS items: 161

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## Drivers of Patient Outcomes?

- Chicken and egg?
- Minutes of therapy?
  - Reimbursement, not evidence-based
- Nursing needs?
- Actuary's dream?
- SNF's nightmare?

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## Clinician's Impact in PDPM

- Payment linked to patient condition(s) on admission
- New category, NTA ( non-therapy ancillary), depends on patient co-morbidities and therapy
- Modify payment of 3 categories during stay if acuity changes
  - Reimbursement decreases over time unless there are documented changes in condition.




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## Admission Note Documentation is Essential

- Establish Primary Diagnosis
- Primary admitting Diagnosis may be different than inpatient diagnosis.
- Important to note any surgery done during proceeding inpatient stay
- Specific codes (not general codes) justify SNF
- Completed within first 5 days




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## PDPM Primary Diagnosis Clinical Categories based on Physician Documented ICD-10 codes

### Surgical Categories

- MJR or Spinal
- Other Ortho Surgical
- Non-Ortho Surgical
- Non-Surgical Ortho

### Medical Categories

- Medical Management
- Acute Infections
- Cancer
- Pulmonary
- CV and Coagulations
- Acute Neurologic




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## Role of Medical Director

- Need to oversee attending physicians in facility
- ICD-10 Expertise and Guidance
- Great opportunity for education
- That's only the tip of the iceberg!




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## Role of Medical Director

- Geriatrics expertise is critical
- Clinical acumen is necessary to achieve beneficial outcomes
- Medical director is the clinical leader in the facility!
- Let the games begin!




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### Non-Therapy Ancillary Conditions/Services

Condition/Extensive Service	Points
HIV/AIDS	6
Parenteral IV Feeding: Level High	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	5
Special Treatments/Programs: Ventilator Post-admit Code	4
Parenteral IV Feeding: Level Low	3
Lung Transplant Status	3
Special Treatments/Programs: Transfusion Post-admit Code	2
Major Organ Transplant Status: Except Lung	2
Active Diagnosis: Multiple Sclerosis Code	2
Opportunistic Infections	2
Active Diagnosis: Asthma: COPD: Chronic Lung Disease Code	2
Bone/Joint/Muscle Infection/Necrosis - Except: Aseptic Necrosis of Bone	2
Chronic Myeloid Leukemia	2
Wound Infection Code	2
Active Diagnosis: Diabetes Mellitus (DM) Code	2
Endocarditis	1
Immune Disorders	1
End Stage Liver Disease	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	1
Epilepsy and Cataplexy	1
Cystic Fibrosis	1
Special Treatments/Programs: Tracheostomy Post-admit Code	1
Active Diagnosis: Multi-Drug Resistant Organism (MDRO) Code	1
Special Treatments/Programs: Isolation Post-admit Code	1
Specified Hereditary Metabolic/Immune Disorders	1

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### Non-Therapy Ancillary Conditions/Services

Condition/Extensive Service	Points
Morbid Obesity	1
Special Treatments/Programs: Radiation Post-admit Code	1
Highest Stage of Unhealed Pressure Ulcer - Stage 4	1
Posterior Arthropathy and Systemic Sclerosis	1
Chronic Pancreatitis	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	1
Complications of Specified Implanted Device or Graft	1
Barter and Bowel Appliances: Intermittent catheterization	1
Inflammatory Bowel Disease	1
Aseptic Necrosis of Bone	1
Special Treatments/Programs: Suturing Post-admit Code	1
Cardio-Respiratory Failure and Shock	1
Myelodysplastic Syndromes and Myelofibrosis	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	1
Diabetic Retinopathy - Except - Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	1
Nutritional Approaches While a Resident: Feeding Tube	1
Severe Skin Burn or Condition	1
Intractable Epilepsy	1
Active Diagnosis: Malnutrition Code	1
Disorders of Immunity - Except - HIV/AIDS Immune Disorders	1
Orchitis of Uter	1
Barter and Bowel Appliances: Ostomy	1
Respiratory Arrest	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	1

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## Role of Medical Director

- Today's SNF, under PDPM, is yesterdays hospital
- Admission decision implications
- Acuity and complex care decision making
- Appropriate Staffing decisions
- Potential Liability



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## Role of Medical Director

- Appropriate care and treatment plan
  - Will influence outcomes
- Appropriate medications
  - Costs
  - Outcomes
- Appropriate Deprescribing
- Palliative care considerations



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## Role of Medical Director

- Unintended Consequences
- Acuity > Facility capabilities
- Care decisions driven by reimbursement considerations
- Swallowing Dysfunction Implications




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## SLP: Clinical Category+

### SLP Payment Factors

- Primary Diagnosis
- Acute Neurologic Condition
- SLP Co-morbidities
- Cognitive impairment
- Swallowing disorder
- Mechanically Altered Diet

### SLP Co-morbidities

- CVA, TIA
- Aphasia
- Hemiplegia/ Hemiparesis
- Traumatic Brain Injury
- ALS
- Oral Ca
- Laryngeal CA
- Apraxia
- Dysphagia
- Speech & language Deficits
- Tracheostomy care
- Ventilator




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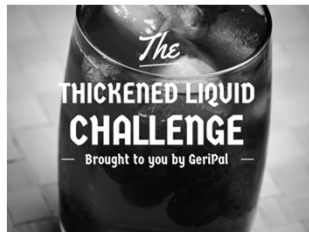
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## Swallowing Dysfunction and Mechanically Altered Diet

- Swallowing dysfunction matters
- Appropriate therapy
- Dietary modifications
- Unintended consequences




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## Swallowing Dysfunction and Mechanically Altered Diet

- Dehydration
- Malnutrition
- Rehospitalizations
- Increased reimbursement could lead to worse outcomes and greater costs




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## Case Presentation

81 yo F with COPD admitted to Hospital for SOB and fever. HPI: 10 days at home with cold symptoms, sputum production and fever, weakness, poor appetite, SOB.  
PMH: COPD, HTN, Diverticulosis, Mild Dementia

Hospital course: Found to be in respiratory distress, BP 90/60, acidotic and admitted to ICU. Placed on BICAP and treated with IV antibiotics. Improved over 7 days. DC to SNF because of generalized weakness.

Med list: includes Albuterol, Atrovent inhaler and steroid taper, Metformin, Metamucil, Rouvastatin, Benazepril, Bactrim

PE: vitals stable, Oriented x 2, wt. 240, Ht. 5'4"  
Lungs: Few wheezes  
Hrt: RRR  
Ext: Lft ankle ulcer 3cm, tender, red, with mild exudate  
Culture: MRSA recovered  
Albumin 2.8




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**Primary Diagnosis COPD: Pulmonary - Medical Management**  
**NTA Co-morbidities: Less Obvious Opportunities**

- 1Pt. Cardio-respiratory shock
- 1Pt. Morbid Obesity
- 2 pt. Active DM
- 1 Pt. Multi-drug resistant organism
- 1 Pt. Diabetic foot ulcer
- 1 Pt. Wound infection
- 1 Pt. Malnutrition

8 Pt. Total; increased NTA CMI 0.96 to 1.85 (\$77.3 vs. \$149.00) =  
\$1445.00 for 14 day stay




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## Important concepts and Diagnosis

- **ICD 10 coding**
  - Major factor in base rate calculation
  - Identify primary dx + co-morbidities
  - Co-morbidities in NTA; SLP
- LOS: first three days
  - 5 day rule
  - NTA 1-3
  - + 20 days
- **Major changes of condition** (Dx and co-morbidities)
  - Acute neuro conditions
  - Preceding surgeries in ACH
- HIV and AIDS
- Diabetes and complications
- COPD/asthma/fibrosis
- Infections: Ortho, resistant organ, opportunistic
- Immune def/connective tissue disorders/IBD
- Morbid obesity/malnutrition
- Psoriatic arthritis
- CML/ myeloplastic disease
- ESLD/ cirrhosis
- Chronic pancreatitis




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## Worse Isn't Better; Better Isn't Worse

- Relationship between functional status and payment is not linear
- Moderate functional decline a/w higher reimbursement
- Focus on most appropriate care!




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## Impact of PDPM

- Proper ICD-10 coding is critical for payment
- Proper evaluation and MDS coding required
- Maximizing payment is **ONLY** the initial step!
- Delivering **EFFECTIVE** care will determine the ultimate results
- Focus **MUST** be on proper clinical approach
- The Geriatrics approach to care is **NECESSARY**!




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## Engaging the Medical Director

- Must have adequate time to participate in leadership role
- Should be engaged in ALL skilled admissions
- Critical role in clinical education for physicians and staff
- MUST have geriatrics competencies
- Ideally, should have CMD



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Questions???

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