PDPM REIMBURSEMENT OPPORTUNITIES WITH A COVID 19 DIAGNOSIS

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TODAY'S PRESENTERS

TONYA D'AGOSTINO, RN
MDS Consultant

Tonya has worked in Long Term Care for 24 years and has worked in the MDS/Reimbursement arena since 2008. Tonya managed the reimbursement department for an 88-bed transitional care program at a 5-star, 368 bed facility and was responsible for successfully transitioning her IDT to PDPM in 2019. Additionally, Tonya has provided consulting services through various consulting and has assisted facilities with maximizing reimbursement, ensuring accurate MDS completion, on-boarding and training of new MDSC's, IDT education relevant to RAI and Medicare processes, Quality Measure improvement, implementation of triple check reviews and stand up/Medicare rounds and assisting resident's with successful navigation through the 3rd level ALJ appeals process following unfavorable QIO determinations.

JILL EVE, RN, RAC-CTA
MDS Consultant

Jill has over 20 years experience working in skilled nursing facilities and over 15 years of MDS and clinical reimbursement experience. Over the last 5 years she has developed an interest in MDS consulting and education, specializing in MDS Coordinator training, PDPM reimbursement and NYS CMI.

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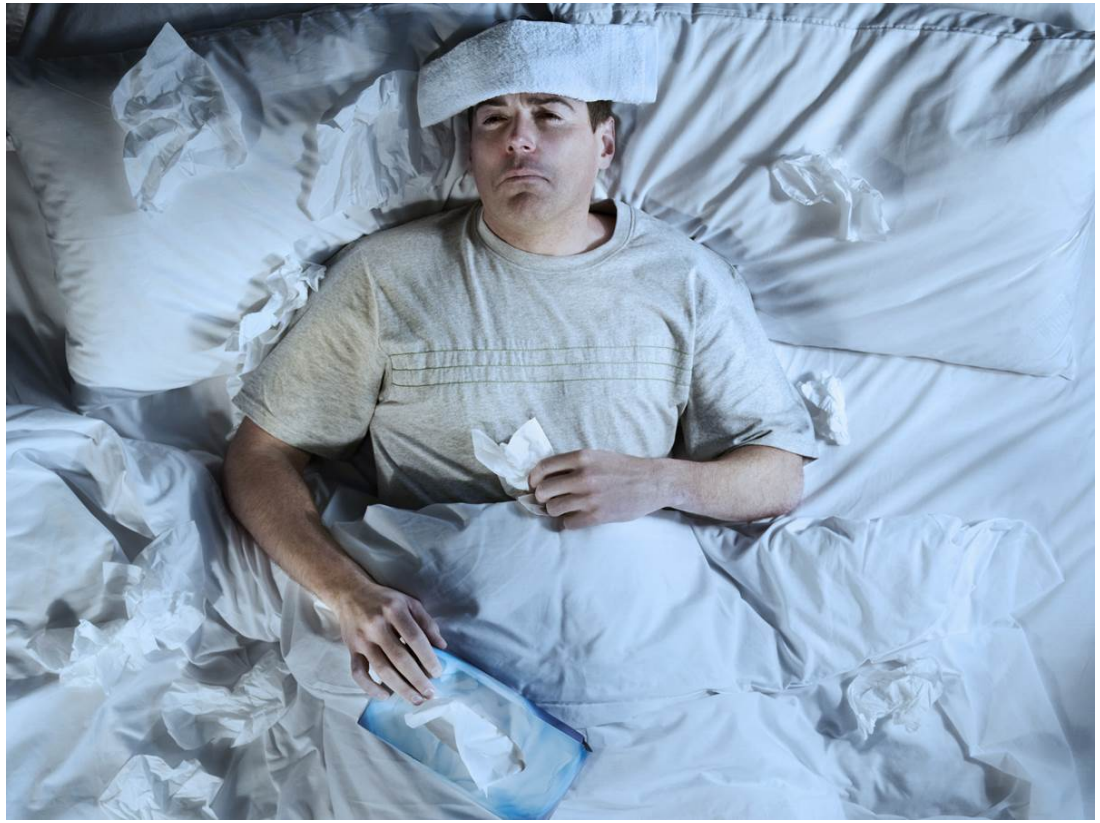
COMMONALITIES OF COVID INFECTED INDIVIDUALS REQUIRING HOSPITALIZATION AND SUBSEQUENT SNF CARE

- Underlying Respiratory Disease
- Obesity
- Cardiac Disease
- Diabetes
- Immunocompromised

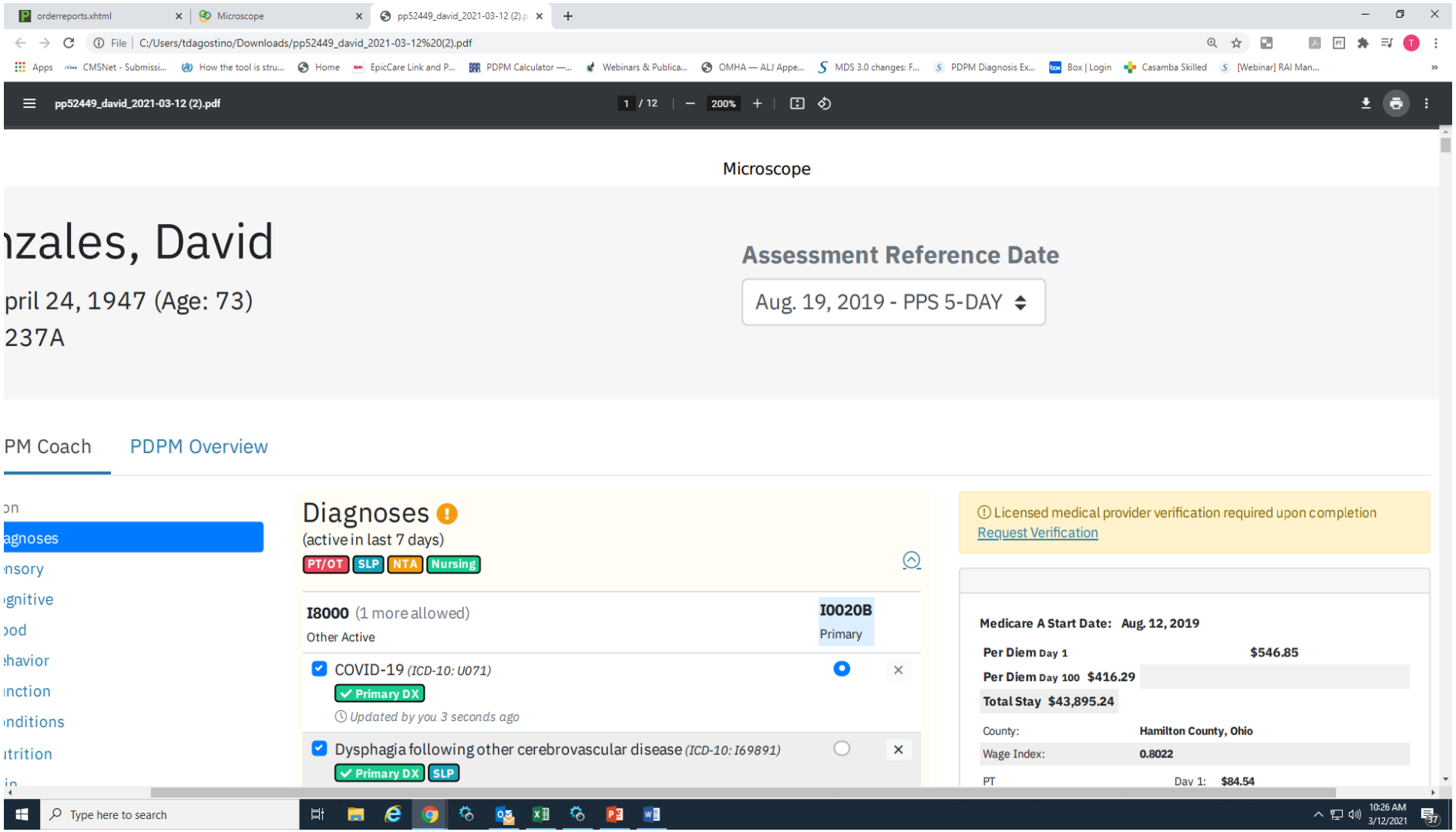


CMG Breakdowns

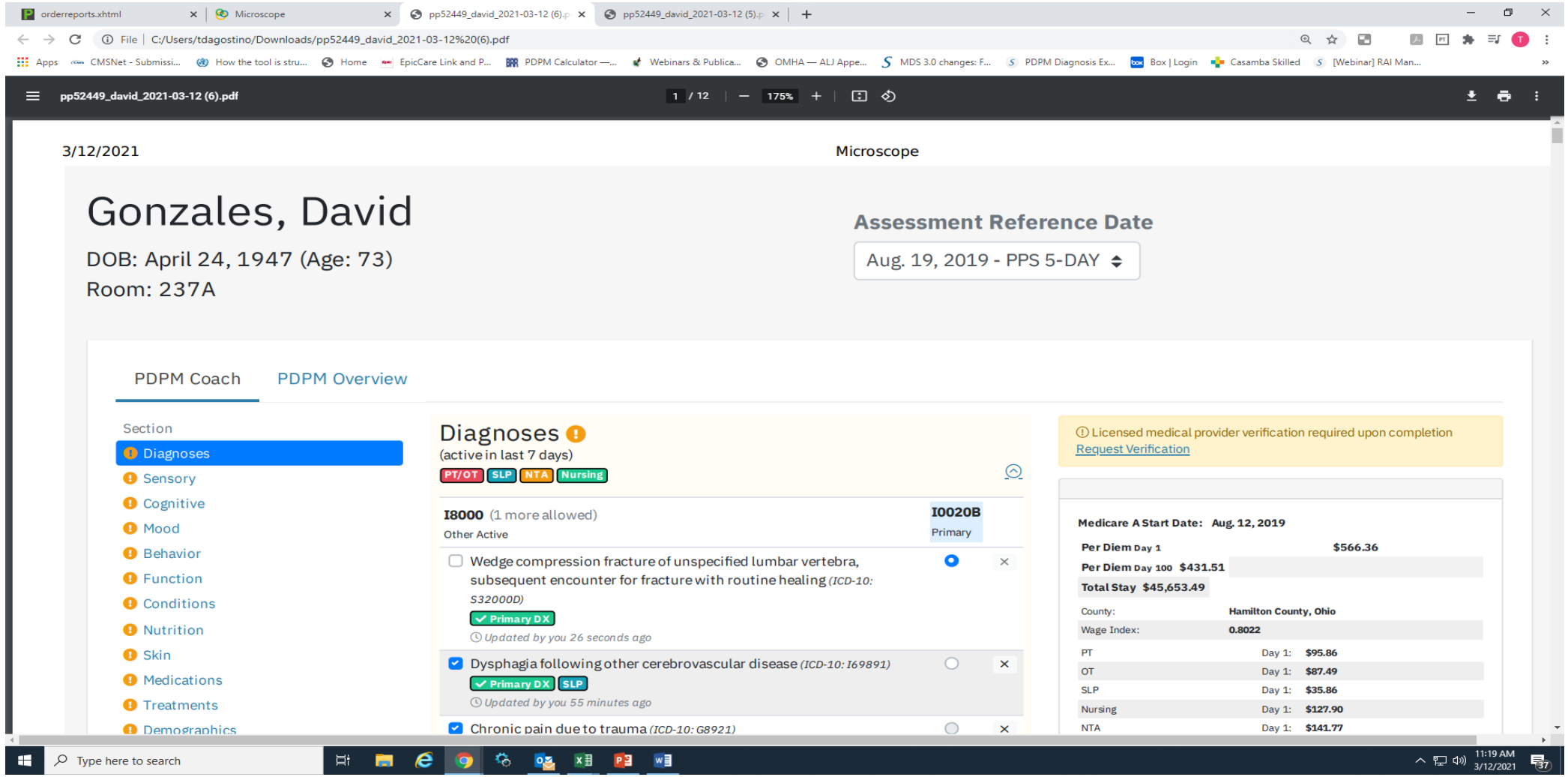
PT/OT CMG

- COVID diagnosis = Medical Management
- May be able to justify other primary diagnosis
  - Was resident hospitalized for reason other than COVID and contracted COVID during hospitalization?
  - Was resident hospitalized for COVID but then treated for something else?
- Ensure accurate/timely functional assessment

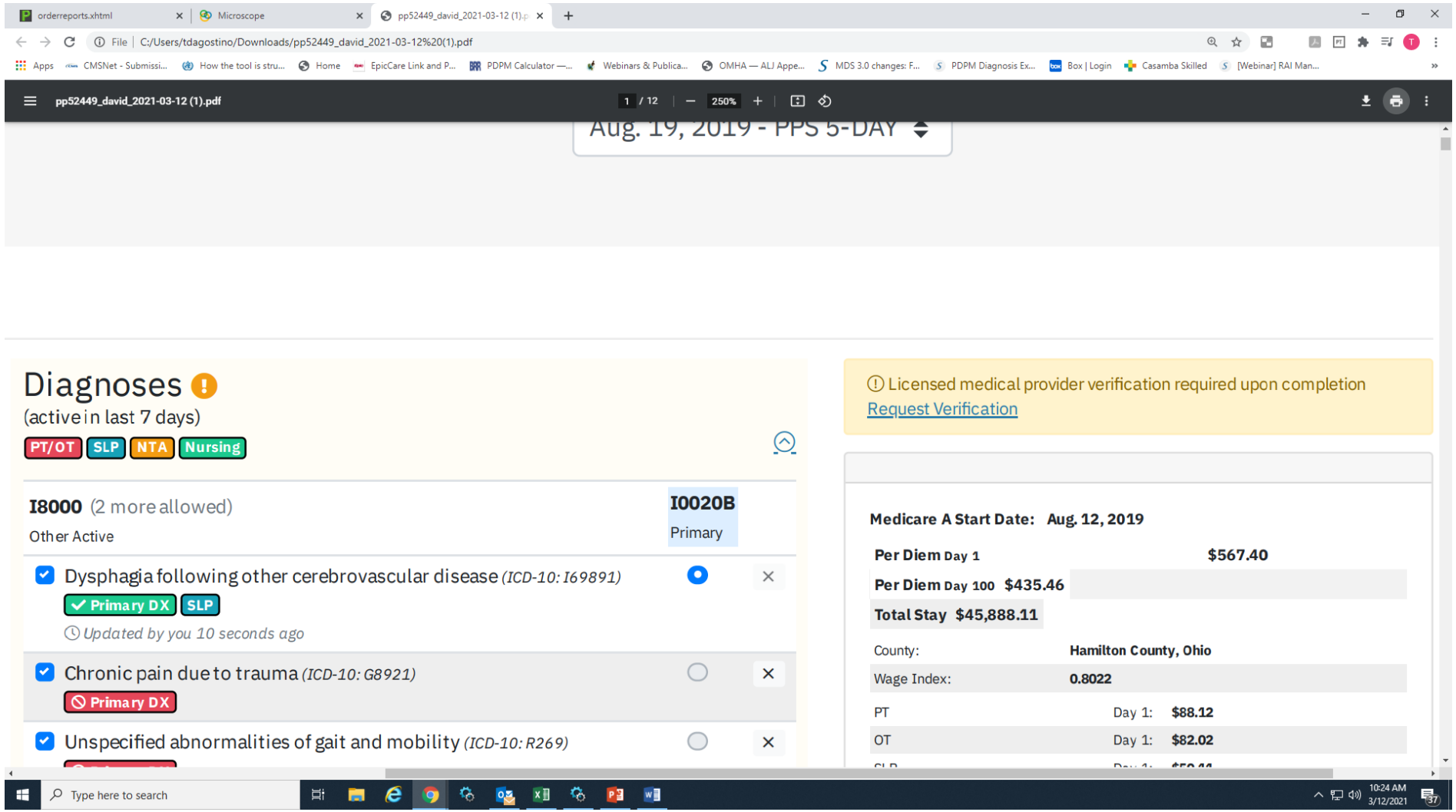
COVID (Medical Management Primary)



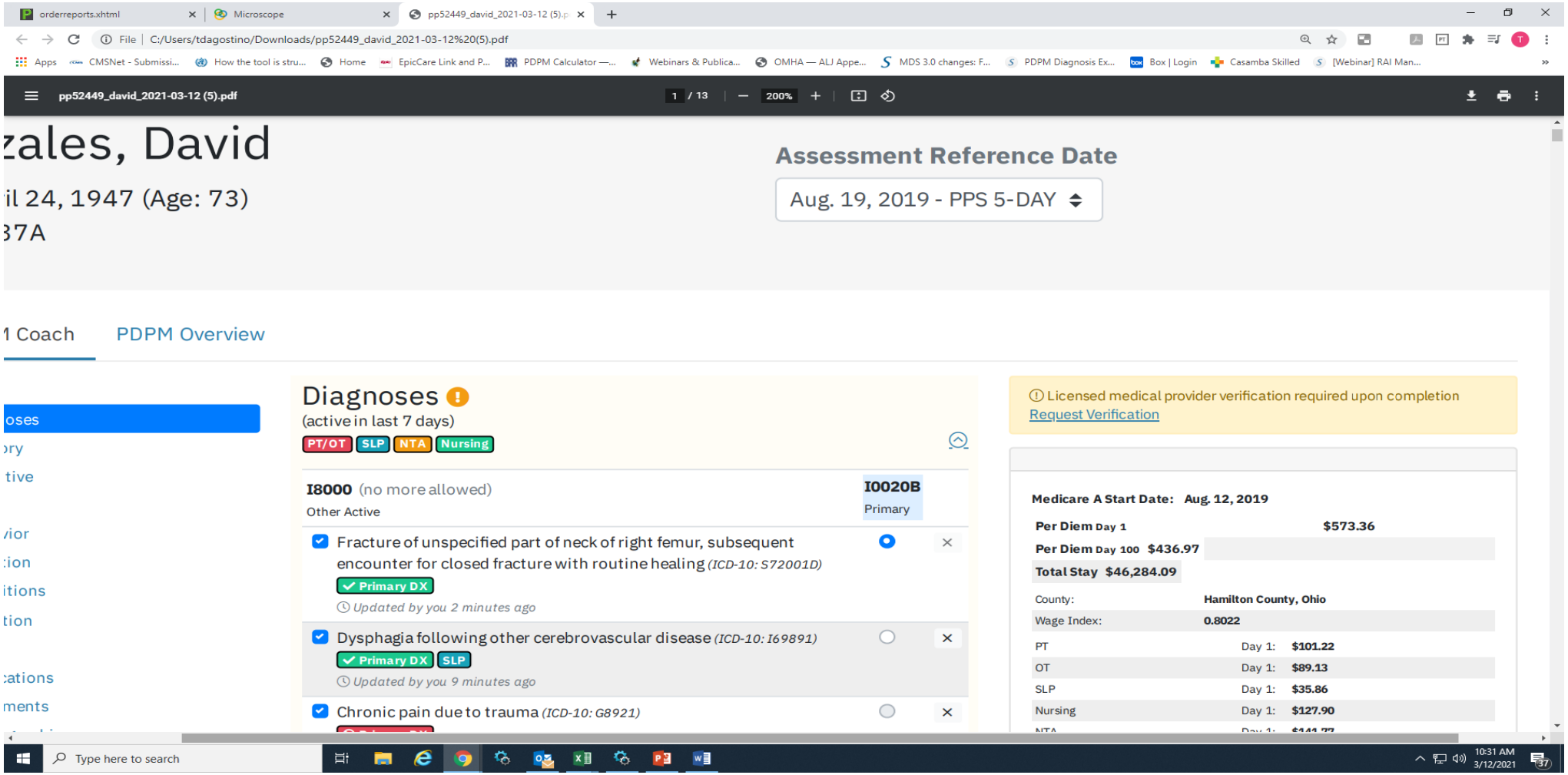
Other Ortho Primary



Acute Neuro Primary



Major Joint/Spinal Surgery Primary



SLP CMG

- Presence of acute neurological condition = no
  - ? Encephalopathy
  - CVA/Stroke while in hospital
- SLP Comorbidities
  - CVA/Stoke/TIA
  - Hemi
  - TBI
  - Tracheostomy Care
  - Vent or respirator Care
  - Laryngeal Cancer
  - Apraxia
  - Dysphagia
  - ALS
  - Oral Cancers
  - Speech and Language Deficits
- Cognitive Impairment
  - BIMS less than 13
  - CPS score 1-6
- Presence of Swallowing Disorder
  - Residents treated for PNA/post intubation may have residual swallowing disorders
- Mechanically Altered Diet

All residents should be referred to SLP for evaluation upon admission/readmission

NURSING CMG

What will it be?

Extensive Services

There is no exception from the RAI guidelines for COVID residents to code isolation

Any of the following while a resident

- Ventilator/Respirator
- Trach care
- Isolation
  - ✓ *The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.*
  - ✓ *Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.*
  - ✓ *The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and **not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.***
  - ✓ *The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).*

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Special Care High

- **IVF while or while not a resident**
  - ✓ Thoroughly review hospital records
  - ✓ If setting ARD early in stay – communicate with team to ensure timely interviews and assessments
  - ✓ Ensure supporting documentation is present
- **Pneumonia**
  - ✓ Monitor for Fever
    - 2.4 degrees higher than baseline
    - 100.4 degrees or higher if baseline not established
- **Respiratory Therapy x7 days**
  - ✓ **Monitor**
  - ✓ **Assess**
  - ✓ **Document**
- **Sepsis**
- **COPD with Shortness of Breath While Lying Flat**
  - Chronic Bronchitis
  - Asbestosis
  - Emphysema
  - Lung Cancer
  - Pulmonary Fibrosis
  - Pulmonary Hypertension
  - Lymphangioleiomyomatosis (LAM)
  - Cystic Fibrosis
  - Chronic Pneumonia
  - Interstitial Lung Disease
    - Sarcoidosis
    - Idiopathic Pulmonary Fibrosis
    - Langerhans Cell
    - Bronchiolitis Obliterans
    - Langerhans Cell Histiocytosis

https://www.womenshealth.gov/a-z-topics/lung-disease
https://www.healthline.com/health/understanding-idiopathic-pulmonary-fibrosis/chronic-lung-diseases-causes-and-risk-factors

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Special Care Low

- Respiratory Failure with O2
  - Query provider
- Skin issues
  - Common due to acute illness with inability to reposition self, poor nutrition, increased incontinence
    - Foot infection
    - Two or more stage II pressure ulcers
    - One or more Stage III, IV or Unstageable Pressure Ulcers
    - 2 or more venous/arterial Ulcers or
    - 1 venous/arterial ulcer and 1 Stage II pressure ulcer
    - Diabetic Foot Ulcer
    - Foot Lesion
- Feeding Tube
  - Swallowing Disorders
  - Loss of appetite
- Dialysis
  - 15% of hospitalized coronavirus patients are experienced AKI leading to CKD with need for Dialysis upon discharge

Clinically Complex

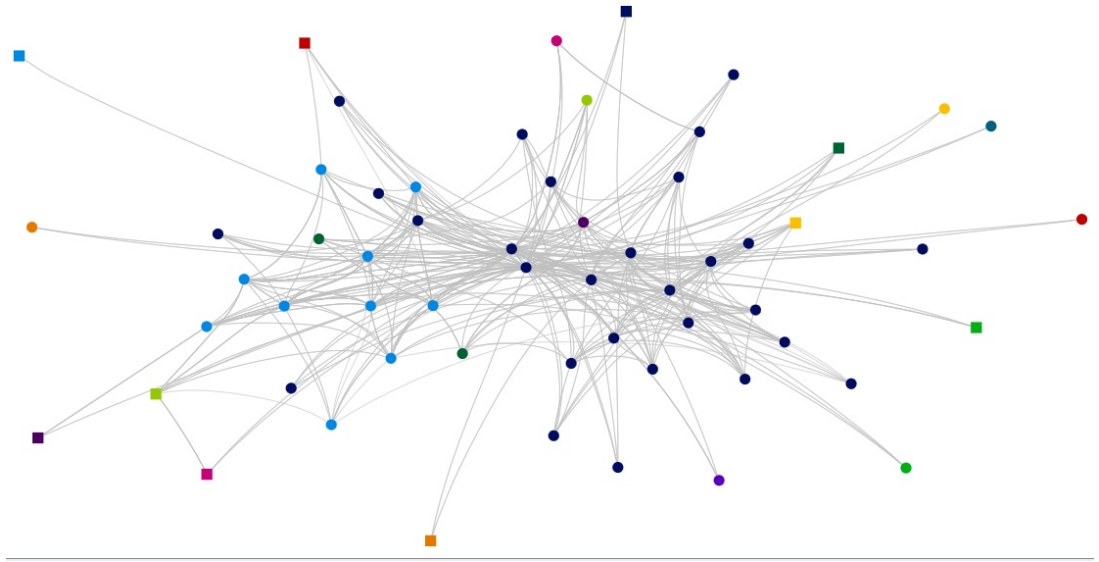
- Pneumonia
- Oxygen therapy
- IV Medications

NTA CMG

Comorbidities affect a person's ability to recover from COVID thus increasing the need for hospitalization and subsequent SNF care

Additionally, many individuals have developed complications from the disease

Many of these commodities and complications map to NTA points and the medical record should be thoroughly reviewed to ensure all appropriate diagnoses have been captured



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Common NTA's Increasing Risk for Complications

- DM
- MS
- Cirrhosis
- COPD
- Pulmonary Fibrosis
- Cystic Fibrosis
- Respiratory Failure
- Chronic Myeloid Leukemia, Immune Disorders
- End Stage Liver Disease
- Radiation/Chemo
- Chronic Pancreatitis
- Myelodysplastic Syndromes and Myelofibrosis

- Malnutrition (actual or at risk for)
  - Registered Dietician should assess and if criteria met, physician should document
- History of Organ Transplant
- HIV/AIDS
  - Diagnosis must be on UB
- Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies
- Morbid Obesity
  - Query Provider if BMI 35 or greater with comorbid conditions

Common NTA's related to COVID Complications

- Tube Feed
- IV Medications
- Isolation
- Trach Care
- Suctioning

- Malnutrition
- Respiratory Failure
- Opportunistic Infections
  - Example: Esophageal candidiasis due to prolonged mechanical ventilation

Determining Active Diagnosis

Diagnosis Identification– documented by provider during last 60-days

- Can be diagnoses found in hospital documentation as long as documented in last 60 days
- Review hospital admission H&P, discharge summaries and problem lists
- Query facility providers if needed to clarify diagnoses

Is Diagnosis Active

- Diagnoses that have a direct relationship to resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk for death during 7-day look back
  - Transfer documents
  - Progress notes
  - History and Physical
  - Discharge Summary
  - Nursing Assessments
  - Care Plans
  - MARS/TARS
  - Doctors orders
  - Consults
  - Diagnostic Reports

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Special Treatments/Procedures

- Only need to be documented once during 7-day or 14-day look-back
  - Admitted with O2 but removed upon admission
  - Only isolated one shift
  - SOB while lying flat only documented once during 7-days
- Resident performing own trach care can still be captured

Summary

- MDS process is a collaboration of entire IDT to capture all diagnoses and care
- Medical record should support MDS coding
- Must be able to prove Functional Assessment (GG) was completed collaboratively and within 3-day window

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PDPM Medicare Reimbursement

Frailty Scoring For Measuring and Managing Resident Risk

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QUESTIONS?

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