



MDS Coordinators

The Super Heroes of PDPM

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Although we do not often see MDS Coordinators working in our nursing communities wearing capes, they are going to be the secret superheroes of each community under PDPM. PDPM, or the Patient Driven Payment Model, is the new PPS system that goes into effect on October 1, 2019. The complex new system, with separate RUGs and per diem rates for Nursing, Non-Therapy Ancillary, Physical Therapy, Occupational Therapy, and Speech Therapy, will require that MDS Coordinators are more proactive than ever. CMS has stated that the reduced number of MDS assessments required under PDPM should reduce MDS-related annual administrative costs by \$12,000 on average

per facility. However, the reality is that MDS Coordinators will need to expand their wings even more than before to oversee new metrics, care provision and documentation to achieve success under the new payment model.

History of the MDS - In A Nut Shell



Dating back to 1991 when the first MDS was initiated, the purpose of the MDS was to monitor and improve the quality of care in nursing facilities. The assessment contains basic resident information, but it has historically placed little weight on the actual delivery of services by the nursing department. In 1998, Medicare and several state

Medicaid programs began using MDS data to classify residents into Resource Utilization Groups (RUGs) which reflect residents' care needs and resource needs. These RUGS groups are used to calculate nursing home reimbursements under prospective payment systems. In 1999, CMS started requiring surveyors to use MDS-based QIs to guide their nursing home evaluations forcing the accuracy of the MDS to become a priority. In turn, the MDS Coordinator role gained its significance. Then in 2010, the MDS 3.0 was implemented which included major changes from the 2.0 version. Its intent was to give residents a "voice" by using resident and staff interviews and to improve clinical relevance, accuracy, efficiency. The workload of the MDS Coordinator grew immensely. This posed some concern that these standardized procedures would require more staff time and training to implement than many nursing homes could reasonably provide. With each change, the role of the MDS Coordinator evolved and expanded and they have become one of the most vital players of the administrative team. MDS Coordinators continue to be held accountable for compliance and accuracy, and the financial and clinical impact of their assessments.

The New Role of MDS Coordinators Under PDPM

Every October providers hold their breath as CMS releases new updates to their payment structure. Following shortly thereafter, the RAI (Resident Assessment Instrument) Manual is released and MDS coordinators brace for new challenges



and shifts in the EMR and tracking systems to achieve success under ever-changing metrics. However, 2019 will be an unprecedented year of challenges that MDS departments and skilled nursing facilities will face. MDS Coordinators are already feeling the pressure and stress that will go hand-in-hand with the transition to PDPM.

Although PDPM is considered to be a more simplified payment model compared to RUGs-IV and is supposed to decrease the administrative burden that PPS carries, it is still yet another uphill climb for MDS Coordinators to conquer. The focus of reimbursement will shift from therapy to a combination of therapy and nursing. Along with this shift, MDS Coordinators will be forced to change their mindset on reimbursement from a focus on the amount of rehab minutes a resident is receiving to the presence of skilled services for all disciplines and the required supportive documentation. This redistributed payment will now include the interdisciplinary team in the reimbursement structure of Medicare. Every department will be, in some way, directly tied to Medicare payment - therapy will no longer be the driver in the majority of reimbursement. Nursing will be responsible to steer the direction of clinical acuity by completing detailed assessments, proactively providing all indicated nursing services and ensuring the supportive nursing documentation is present. This is further compounded by the errors that arise when the Electronic Medical Record (EMR) automatically populated data into the MDS, which may be incorrect or noncompliant, despite facility education and auditing. Unfortunately, this weighs heavily on the MDS Coordinators as they have to scour through resident's medical records searching for the documentation to support the current status, changes in status and progression of goals.

Brewing Up A New IPA Assessment



The good news is that every MDS assessment for skilled residents, other than the 5 day/admission assessment and the discharge assessment, is going away with PDPM. The 14-day, 30-day, 60-day, 90-day, COT, EOT, etc. assessments will no longer need to be completed. This anticipated reduction in the number of MDS assessments is the foundation for the projected “savings” in administrative

costs that CMS predicts. However, the key component for all communities will be the new Interim Payment Assessment, or IPA. With the new IPA assessment, identifying changes in resident’s status is vital as it directly impacts the accuracy of reimbursement over the resident’s stay.

The IPA can be triggered when one of five things changes with the resident during the skilled stay enough to impact payment. Figure 1 shows the five IPA triggers under PDPM.

First Tier Classifications

- PT and OT: **Diagnosis group**
- ST: **Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment**
- NSG: **RUG score**
- NTA: **Conditions or Extensive Services**

Figure 1: First tier classifications in PDPM.

While there may be additional clarification in future RAI Manuals, what CMS is instructing at this point is that IPAs be conducted when indicated to reflect the most accurate documentation (and thus reimbursement) at any point. Providers have considered only completing IPAs when the payment would increase. However, CMS has cautioned that providers must be accurate and complete

IPAs when clinically indicated, even though there is currently no penalty for a missed IPA.

The actual day-to-day strategy for IPAs remains unclear at this point and future clarification is expected in the Final Rule for SNFs, which will be released in the summer of 2019. But, we do know that CMS expects, at the very least, that we complete IPAs within 14 days of the noticed change. What is compelling to consider, however, is how the MDS Superhero can adjust the operations and work flow in the MDS department to take advantage of IPAs as quickly as possible when the opportunity presents itself. Under RUGS-IV, only the discharge of therapy (for a resident who remains skilled for nursing) or change in therapy minutes at the COT check point is enough to trigger a COT assessment. Under PDPM, because any of the 5 first tier classifications can be an indicator for an IPA, MDS coordinators will need to develop systems of tracking and identifying the changes as quickly as possible. And MDS Coordinators will not be able to do it alone. The entire interdisciplinary team will need to keep alert to all of the key metrics (and not just those that affect one aspect of payment) and report them in a timely manner. The altered payment associated with an IPA will begin on the day of the ARD, so a proactive and timely response to resident changes can allow a community to receive the most accurate reimbursement on the first day of the noted change.

Stand Up to PDPM



Morning and/or afternoon daily “stand up” meetings will need to flow differently under PDPM. Because a new, wider range of items impact payment, every one in every department will need to be watching out for and quickly reporting key changes.

For example, everyone on the team should report any:

- Changes in reports of pain
- Increases/declines in independence (especially when enough to impact nursing rug through section gg scores)
- New or discontinued iv's
- New diagnosis or change in primary diagnosis (MDS item i8000a)

- New or discontinued antibiotic orders/infections
- New, worsening or improved diabetic foot ulcers
- New, worsening or improved pressure ulcers
- New transfusion orders
- New or discontinued mechanically altered diet
- New multi-resistance drug organism
- New, changed or discharged restorative nursing programs (including residents who did not receive at least 2 programs, for 15 minutes each day, for 6 days in the look back period)
- New or resolved swallowing disorders, new diagnosis of dysphagia
- Changes in resident mood/behavior
- New psychoactive medications/diagnosis
- Change in resident cognitive status

The Team of PDPM Superheroes



It is challenging to look forward to PDPM as we consider how to accomplish these tasks and who is going to be accountable to ensure compliance in these new areas of importance. MDS Coordinators know they will be responsible for continuing to promote accuracy of documentation and reimbursement, commensurate with the levels of care provided.

Providers should look for ways to spread out the tasks and oversight of the many new metrics that will need to be followed closely under PDPM. Consider assigning a Restorative Nurse to oversee the program and attend morning meeting daily. Ask Social Services to take the lead on gathering information about changes in depression and cognition and reporting those daily. Assign a key nurse, with exceptional clinical skills, to oversee all wounds and bring those reports to the morning meeting every day. Include therapy in the clinical discussions and encourage therapy associates to communicate all changes with the resident as promptly as possible. Encourage all team members to voice their ideas and observations rather than leaving it up to the MDS Coordinator to decide herself. As Michael Jordan said, "Talent wins games, but teamwork and intelligence win championships." Surround your MDS Super Hero with the strength

and proactiveness of the entire interdisciplinary team, and they can be an unstoppable superhero team under PDPM.

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