



Patient Driven Payment Model (PDPM):

Why Restorative Matters for SKILLED Residents

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Restorative Nursing has been a vital component of successfully individualizing resident care and preventing avoidable issues such as decline in functional independence, wounds and contractures. But Restorative Nursing Programs are moving to the forefront under the Patient Driven Payment Model, or PDPM, especially for skilled residents. Under PDPM, providers will be able to capture reimbursement for approximately half of skilled residents if restorative nursing is captured on the

MDS. It will be vital for facilities to implement restorative nursing services on Day 1 of the resident's admission when clinically indicated. The 5-day SNF PPS scheduled assessment in PDPM will impact overall reimbursement throughout the entire stay, unless a resident experiences clinical changes and an IPA (Interim Payment Assessment) is completed to capture the change(s). Educating the nursing team on the importance of conducting a thorough assessment of each resident upon admission and identifying their clinical indicators for Restorative will play a major role in under the PDPM system.

The objectives of the white paper are to review how the Restorative Nursing services will impact reimbursement and care in PDPM and the role nursing and the interdisciplinary team play in

exercising best practices for capturing resident-specific characteristics on the MDS starting of the day of admission and continuing throughout the entire stay. The structure under PDPM also allows providers to rethink the provision of certain services that were traditionally considered “therapy-only”. This transition will also help providers to avoid some of the common denials in recent years for therapy services that, per CMS or other insurances, did not require the skilled services of a therapist. These services are often being denied, “because the documentation submitted did not support that the ongoing physical, occupational or speech therapy services were reasonable and necessary”.

The focus and goal of restorative nursing remains unchanged as providers transition from RUGs-IV to PDPM. Restorative Nursing Programs (RNPs) actively focus on achieving and maintaining a residents optimal physical, psychosocial and mental well-being while promoting their ability to adjust and adapt to living as independently and safely as possible. Increasing self-esteem, promoting improvement in function, minimizing deterioration and encouraging a resident to concentrate on areas of strength rather than weakness are all benefits to restorative nursing programs. Secondary benefits also include wound prevention and management, contracture prevention and management, fall risk reduction, improvements with incontinence and many more. Per the RAI (Resident Assessment Instrument) Manual:

- *Restorative nursing program refers to nursing interventions that promote the resident’s ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.*
- *A resident may be started on a restorative nursing program when he or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy.*

For as many benefits as there are to have a successful RNP, there are even more detriments to not having a robust RNP in place. Among the most prominent of these is the risk for avoidable declines. F-tag deficiency F684, can be cited when the requirements of § 483.25 are not met. Per the State Operations Manual, or SOM:

§ 483.25 Quality of care

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents’ choices...

The SOM further clarifies that, "Highest practicable physical, mental, and psychosocial well-being' is defined as the highest possible level of functioning and well-being, limited by the individual's recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental or psychosocial needs of the individual."



The reason that Restorative services will have a new impact under PDPM is that nursing RUGs are reimbursed in their own category separate from therapy. This means that RNPs that are accurately captured by nursing are reimbursable even when therapy is occurring concurrently. The key to understanding how this reimbursement can be accurately captured is that both therapy and Restorative Nursing cannot be doing the same activity or working on the same goals at the same time. For example, if OT is providing ROM (range of motion) to the arms and putting a splint on the arms daily, then restorative cannot also be capturing either ROM or splinting to the arms. However, if PT is exercising the legs and Restorative is completing upper body ROM, these could both be reimbursable because the programs, elements and goals are different between the two disciplines. In another example, if PT is ambulating the resident long distances in the hallway using a cane and Restorative Nursing is doing short distance ambulation in the room using a walker, these programs would not both be reimbursable at the same time. This is because both programs, though they have varying distances, locations and assistive devices, are working on the same goal of maintaining or increasing independence with ambulation. However, if for example, OT is working on upper body and lower body ADLs with a resident while there is an RNP for ambulation to and from

the dining room for all meals daily, these two programs could be reimbursable because they are distinct and separate. The clinical judgement of the therapists and the Restorative Nursing Supervisor will be critical to avoid unapproved overlaps in the delivery of service and to provide substantive documentation to demonstrate the need for RNPs concurrently with therapy services. Some states may have even more restrictions of detailed explanations about which programs can occur concurrently, so providers should review these regulations and guidelines for further clarification.



The PDPM nursing classification categories that will be financially impacted by providing Restorative Services include: Behavioral Symptoms/Cognitive Performance and Reduced Physical Function, which are nursing RUGs under PDPM that begin with B or P. For RNPs to have a financial impact on facility reimbursement, a resident must have 2 or more restorative programs, supplied 6 days per week each and for 15 minutes daily minimum for each program. The

medical record must include the supportive documentation for these RNPs to be considered a skilled service. Under Medicare, RNPs can be considered a skilled service if documentation is present to support progress toward the outlined goal and if it includes minutes provided and the initials or signature of the caregiver providing the RNP. SNFs must work diligently with educating and training of staff on the significance of restorative nursing and also conduct routine monitoring and auditing of the programs to ensure compliance is being followed and the criteria is being met. A licensed nurse must also document regular supervision of and reevaluation/adjustment of the RNPs (recommended at least monthly). Especially now that RNPs can be reimbursable concurrently with therapy for skilled residents, providers can expect that the Office of Inspector General (OIG) and MAC auditors from CMS will be auditing RNPs for complete documentation and clinical justification.

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1	Range of Motion (Passive)
2	Range of Motion (Active)
3	Splint or Brace Assistance
4	Bed Mobility
5	Transfers
6	Walking/Ambulation
7	Dressing and/or Grooming
8	Eating and/or Swallowing
9	Amputation/Prosthesis care
10	Communication
11	Urinary Toileting Program
12	Bowel Program

Figure 1: Approved list of Restorative Nursing Programs from the RAI manual.

Under PDPM, in order to capture the RNPs for the 5-day admission assessment, programs will need to be initiated on Day 1, 2 or 3 of the stay to allow enough time for the required 6 days of RNPs to be provided by day 8. For ARDs set on Day 8, RNPs will only count for the 7-day look back period that starts on Day 2. This can create challenges for providers to determine which programs could effectively be captured by Restorative that do not overlap with those functional items that need to be addressed by therapy. One obvious choice for

many residents will be ROM or exercise. For many years, CMS and the various therapy practice boards have been encouraging therapists to move away from the “biomechanical” aspects of therapy (such as exercise and ROM) and transition the therapy to functional tasks whenever possible. While there will always be some cases that require the skilled interventions of the therapist to provide exercise, such as a resident with a new stroke with hemiplegia or a resident with a shoulder fracture who is allowed only pendulum shoulder exercises, many of the therapy exercises that have been traditionally provided to SNF residents could be effectively provided through an RNP. Again, it is important to remember that there cannot be any concurrent overlap between Therapy and Restorative, e.g. OT cannot be completing arm exercises when Restorative is being captured for arm exercises or ROM.

Another restorative program that providers can consider is a bowel and/or bladder program. Per the RAI Manual, “3 days” of observation should be completed prior to the start of the bowel and/or bladder restorative program. This is to provide documentation of the toileting schedule and continent/incontinent status so that the supervising nurse can accurately evaluate, create, and care plan the toileting program regularly. So, in order to capture the bowel and/or bladder RNPs, providers would need to initiate the observation and documentation of the toileting patterns on Days 1,2 and 3 and then initiate the toileting RNP half way through Day 3 so that the minimum 15 minutes of the toileting RNP could be captured on Day 3. This will provide enough days in the look back period for the admission assessment set on Day 8 to allow for the bowel and/or bladder program to be captured on the MDS for potential reimbursement.

In Figure 1 below is a sample taken from the RAI manual the clearly shows that several RNPs when provided together will only count as one program each. These are:

1. Bowel RNP with Bladder RNP
2. Active ROM with Passive ROM
3. Bed mobility and walking (ambulation)

STEP # 5

Determine Restorative Nursing Count

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A,B**	Passive and/or active ROM
O0500C	Splint or brace assistance
O0500D,F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Restorative Nursing Count _____

Figure 1: Restorative Nursing Count from RAI Manual

These programs, even if they are documented as 2 distinct programs and 30 minutes of services provided, can only be counted as one program. CMS has indicated that this is because these programs have too much overlap and often one service is required when the other is required. Furthermore, it is difficult to separate out when one program begins and the other ends. While we may not all agree with their clinical reasoning, this is how CMS has structured the RUGs and thus we must operate within these confines.



As PDPM redefines the reimbursement structure for SNFs, especially for therapy, there may be many shifts that occur in the provision of therapy services for skilled residents. The legitimate new deficits that a resident demonstrates should continue to be addressed by therapy and will require the skilled services of a therapists. However, under PDPM because the payment structure is so different, it is more likely that SNF residents may not require two or

three therapy disciplines upon admission. In these rarer cases, where perhaps only one discipline is indicated from admission, RNPs can be indicated for the other functional aspects not being addressed through therapy. For example, a resident requires PT to address bed mobility, transfers and ambulation but is at her baseline for ADLs and other OT areas. PT evaluates the resident upon admission and begins treatment but OT screens the resident and does not determine any indicators for OT treatment upon admission. An ADL RNP could be initiated to help the resident maintain the current level of ADL independence until transferring to the next level of care. Coordination between therapy and the Restorative Supervisor will be key upon the resident's admission to proactively plan for and provide the beneficial RNPs in a timely manner so that they can be captured on the MDS for reimbursement.

Irene Henrich, Director of Quality and Compliance for Flagship Rehabilitation notes, "The role of restorative nursing with PDPM will be more intertwined with skilled therapy services more than ever. Restorative will have a direct impact on quality outcomes as the restorative staff/team will have to effectively carry out programs established by therapy for residents who are skilled under their Medicare A benefits even beyond the direct provision of skilled therapy. Caseload mixes are going to be more diverse to win under PDPM and restorative programs and teams will be charged with keeping these residents functioning at their highest level alongside therapy and beyond."

Some health care providers believe that it isn't feasible to carry out a strong RNP because of the regulations required to meet the criteria to capture the RNP services provided. However, what most health care providers fail to realize is that many of the services may already be provided but the documentation is either inadequate or missing to comply with RNP requirements outlined in the RAI User's Manual. This is when educating and training the nursing team becomes paramount. Nursing associates must be able to recognize when a resident will benefit from RNP and must be diligent to document the RNP services provided. Facilities adopting a culture that focuses on the benefits of restorative nursing services will secure a strong foundation to optimize resident care.

Many organizations are considering various options to implement or increase a structured, formalized and effective Restorative Nursing Program under PDPM, which may include using a contract rehab provider to supplement and manage the RNPs. Chelsea Boyle, COO of Flagship Rehabilitation and COO of Anchor Rehabilitation states, "A well-managed RNP has always been at the center of outstanding long-term care programs. But RNPs are going to take a new precedence for skilled residents under PDPM. Ultimately, RNPs are going to be a key with PDPM because they will promote increased resident outcomes, stimulate improved quality of life, and support additional reimbursement. Our recommendation to our customers is that they add robust restorative programs that are pro-actively managed for

skilled residents, as well as long term care residents, to engage the residents to achieve exceptional outcomes and ignite their recovery.”

The RAI Manual further clarifies the appropriateness of using therapy personnel for providing restorative nursing programs because, “Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies). The therapist’s time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.”



Providers may see increased benefits to this formalized “contract restorative nursing programs” through the contract rehab suppliers because the therapists already function as consultants to the RNPs, and are well aware of the indications, contraindications and opportunities for RNPs. Furthermore, therapists have historically provided many of the programs that may transition to RNPs under PDPM, such as ROM and exercise, so the therapists are best qualified to provide or

oversee these services to short term skilled residents. Additionally, because the therapy industry has shifted and admission day therapy evaluations are more common, the therapists are able to assess for, plan and implement Restorative Services on Day 1. The 5-day ARD, which is allowed to be set on Days 1-8 in PDPM, will pay for the entire skilled stay, so again RNPs must be started on either Day 1, Day 2 or Day 3 of the stay in order to capture it on the admission MDS for a minimum of 6 days each of 2 RNPs. Finally, providers may find this as the best option moving into PDPM as it may not require any additional staffing for the RNP programs that will need to be expanded to include skilled residents as well. Some of the skilled RNP services should continue to be provided by the dedicated Level II Restorative Nursing Aides (RNAs) or the Level III CNA/GNAs as they can easily be weaved into the current workflow of the nursing team (e.g. ADLs or Walk-to-Dine). But some programs that would require significantly more nursing resources to perform, such as exercise and ROM, may be instead provided or overseen by rehab team members.

CMS has contributed numerous resources and conducted extensive research in the development of PDPM. Healthcare entities and payment systems are continuing to evolve with a focus on providing person-centered care that has supporting documentation reflective of the services required to support the needs and care of every person. The therapy industry is shifting toward a “almost all function” approach in the provision of services, which is reshaping the expectations and delivery of therapy in all communities.

With the proposed PDPM, providers will have to be diligent performing assessments, documenting accurately, and providing appropriate services starting on admission day. This will help providers to supply residents with high quality care that is reflective of an individualized plan of care focused on appropriate length of stay and optimal outcomes. The reimbursement provided by CMS via the proposed PDPM would utilize data captured on the 5-day assessment to provide payment for services provided by the SNF throughout the resident’s entire stay. Interdisciplinary team communication and documentation are integral components to whether a SNF will successfully transition to PDPM. Providers must be proactive and prepared to transition when the time arrives.

Gravity Healthcare Consulting offers comprehensive Restorative Nursing Program support including:

1. RNP Manual with required policies and procedures
2. Restorative audits to determine accuracy of reimbursement and presence of supportive documentation
3. Onsite, in-depth Restorative Module training including competencies and pre/post-test
4. Restorative Video Module training and training manual for ongoing new hire and annual re-training
5. Restorative experts to assist your team with implementation of a successful RNP

References

1. RAI User’s Manual, Revised October 2017; <https://downloads.cms.gov/files/1-MDS-30-RAI-Manual-v115R-October-1-2017-R.pdf>
2. State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Revised November 2017; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf