# Revolutionary Payment Changes Prompt Skilled Nursing Facilities to Eye CDI Programs



By Lisa A. Eramo, MA

While clinical documentation hasn't exactly been a strength in many of today's financially strapped skilled nursing facilities (SNFs), this may soon change as SNFs shift to a new payment methodology—the Patient-Driven Payment Model (PDPM)—in which these facilities are paid based primarily on each patient's unique medical complexity. The biggest change? Level of assistance with activities of daily living (ADL) and number (and type) of therapy minutes per week have minimal impact on reimbursement under the PDPM. Specificity of ICD-10-CM diagnosis codes is what matters most, and those codes are based entirely on clinical documentation. This is leading many SNFs to turn to clinical documentation improvement (CDI) programs in order to rehab their documentation in advance of the upcoming reimbursement changes.

"We definitely see an opportunity to increase our focus on documentation now that SNFs are going to a diagnosis-related payment methodology," says Monica Baggio Tormey, BS, RHIA, CHP, CHC, CHRC, chief compliance officer and director of HIM/privacy officer at Spaulding Rehab Network, who plans to launch a formal CDI program in its 123-bed SNF this fall.

Spaulding implemented a CDI program in its long-term care hospital (LTCH) in 2011 and a similar program in its inpatient rehab facilities (IRF) in 2015 primarily to ensure that documentation reflects patient acuity and drives accurate reimbursement. Baggio Tormey sees the PDPM as an opportunity to accomplish these same goals in the SNF realm.

However, as with all SNFs, Spaulding must address many challenges before it can proceed with formalizing a CDI program. For example, who will perform the CDI function, and what additional training is necessary? How will individuals in the CDI role pose and track queries to physicians? On what areas of documentation should a SNF CDI program focus?

Experts say the shift to PDPM is garnering attention from SNF administrators, many of whom want to ensure that the documentation recorded by the interdisciplinary team is consistent with the MDS assessment to support accurate coding. A primary concern is that payers will scrutinize diagnosis codes and potentially deny SNF services once PDPM goes into effect. The Centers for Medicare and Medicaid Services provided the following reason for moving to the PDPM:

> "Under RUG-IV, most patients are classified into a therapy payment group, which uses primarily the volume of therapy services provided to the patient as the basis for payment classification. This creates an incentive for SNF providers to furnish therapy to SNF patients regardless of the patient's unique characteristics, goals, or needs. PDPM eliminates this incentive and improves the overall accuracy and appropriateness of SNF payments by classifying patients into payment groups based on specific, data-driven patient characteristics, while simultaneously reducing administrative burden on SNF providers."

"CDI will potentially explode into the SNFs because they're going to need this knowledge. There's certainly an opportunity for these programs," says Deanna Peterson, MHA, RHIA, CHPS, LNHA, vice president of health consulting services at First Class Solutions, LLC, based in in Maryland Heights, MO. None of her SNF clients have formal CDI programs, but they've already expressed interest in how to prepare documentation-wise for the monumental shift to PDPM.

### Three Best Practices for CDI in SNFs

1. Define SNF-specific CDI program goals and metrics. Acute care goals and metrics may not translate directly to SNF programs because of the uniqueness of the workflow and MDS assessment that drives payment.

2. Foster collaboration between coders (or individuals performing the coding function), those serving in the role of CDI specialist (or individuals trained to obtain documentation specificity), and MDS coordinators.
3. Obtain buy-in from SNF medical directors who can take the lead on physician communications.

## Seven High-Impact Areas of CDI in SNFs

Under PDPM, the stakes are high. Documentation to support ICD-10-CM diagnosis codes, medical necessity, and more is of the utmost importance. Seven areas in which CDI can have an impact are:

1. Clarify specificity of all diagnoses, including the primary diagnosis (why the resident is receiving skilled services) and any comorbidities that exist on admission and/or develop throughout the duration of the resident's stay.
2. Develop query templates, query tracking tools, CDI tip sheets, physician education materials, and more.
3. Ensure that nursing documentation supports medical necessity of 24/7 skilled nursing care as well as all information reported on the MDS assessment.
4. Identify any major surgical procedures that occurred during the inpatient hospital stay that immediately preceded the SNF admission.
5. Obtain copies of physician progress notes, which can be omitted from the transfer/admission process.
6. Obtain copies of the complete hospital record, especially the hospital discharge summary, operative report (when relevant), and interfacility transfer report. These records can also be omitted during the transfer/admission process, though in many cases a unit clerk would help assist the CDI specialist with obtaining both physician progress notes and the complete hospital record.
7. Work with acute care hospitals to clarify the date of the preceding hospital admission.

## Overcoming CDI Challenges in SNFs

Widespread adoption of CDI in today's SNFs would represent a significant departure from the status quo. Although SNFs generally provide some nursing education regarding documentation requirements, these efforts don't typically extend to physicians, and there isn't usually a formal (and compliant) process for querying providers, Peterson says.

To date, there are many reasons why CDI programs haven't extended into the SNF setting. First, many SNFs don't currently employ certified HIM professionals, nor is HIM typically a dedicated role or department, says Carol Young, a recently retired HIM professional who has extensive experience working in skilled nursing facilities and helped AHIMA develop SNF CDI tip sheets. Young says the quality of medical record documentation is usually a low priority because staff tasked with managing records are also responsible for feeding residents, coordinating transportation and supplies, creating staff schedules, and more.

Another challenge is that physicians aren't employed directly by the SNF. "This requires a very different engagement strategy than on the acute care side," says Staci LePage, RHIT, senior consultant at Anderson Health Information Systems in Santa Ana, CA. Medical directors must play a key role in raising physician awareness and explaining the purpose of the queries, she adds.

SNFs also frequently rely on documentation that's outside of their four walls—particularly the hospital record and physician progress notes. The hospital record, for example, could drive the entire SNF payment if the physician doesn't see the resident by the eighth day of the SNF stay (the day when the MDS assessment is due), Peterson says.

"Hospitals are just beginning to give SNFs access to their systems," LePage says. "Some hospitals were reluctant to do this unless they had a good relationship with the SNF and sent them a lot of patients."

Likewise, physician progress notes help SNFs identify specific diagnoses and comorbidities that affect payment under the PDPM. However, physicians frequently document these notes in the hospital electronic health record (EHR) system or their own EHR. Copies may not be available to the SNF, making it difficult for SNF providers to obtain a complete clinical picture of each resident and thus bill correctly.

A final challenge for SNFs looking to implement CDI programs is that some SNFs don't have an EHR. This means CDI in these organizations is likely a manual and time-consuming process, Baggio Tormey says. "If you don't have an electronic

medical record, this change for SNFs is going to result in some facilities having financial challenges," she says. "There's a lot of pressure to figure out how they're going to survive in this very new world. Therapy isn't the primary driver of revenue anymore."

### Five Facts About the PDPM

Check out these important facts about the new payment model that will revolutionize the way in which SNFs are reimbursed.

1. Takes effect October 1, 2019.
2. Replaces the current case-mix classification system, the Resource Utilization Group, Version IV (RUG-IV).
3. Determines payment through a combination of six payment components, five of which are case-mix adjusted. The case-mix adjusted components include speech therapy, occupational therapy, physical therapy, nontherapy ancillary services, and nursing. The non-case-mix adjusted component covers utilization of SNF resources that do not vary according to patient characteristics.
4. Prioritizes clinically-relevant factors (i.e., individual resident conditions as represented by ICD-10-CM diagnosis codes) to determine base rates and case-mix indices.
5. Includes an optional Interim Payment Assessment (IPA) that allows providers to report a change in a resident's PDPM classification.

To learn more about PDPM, visit www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.

## Emerging Opportunities for HIM Professionals

As SNF administrators consider the feasibility of CDI programs, they must first address the question of who will perform the CDI function. Spaulding Rehab Network hopes that MDS coordinators can take on some of the tasks. "MDS nurses work so closely with attending physicians. They already have that relationship established. Adding CDI to these conversations shouldn't be a heavy lift at all," Baggio Tormey says.

Others agree. "The MDS nurse interviews the resident to complete the MDS assessment, and they really know what's going on with the resident and what treatment they're receiving," Peterson says. "They're in an ideal position to be able to identify documentation opportunities."

Changes under PDPM also reduce the number of assessments that MDS coordinators are required to perform. This could allow them to invest time into CDI instead, LePage says. That's what Baggio Tormey hopes will happen. If it ends up being too much for the SNF's MDS coordinators to handle, she plans to recruit a CDI professional to serve in a dedicated CDI specialist role.

Experts agree that regardless of who serves in the role of CDI specialist, this individual must work in tandem with a certified coder. "PDPM is pushing everyone down the path of having a certified coder assigning codes. Your acuity—and now your revenue—all ties into ICD-10 diagnosis codes," says Baggio Tormey, adding that Spaulding uses a centralized team of certified post-acute coders who code all SNF services. Peterson agrees. "Even the facilities that can't afford to invest in a certified coder right now may start to look for one just because there's such a risk," she says.

Large post-acute care networks are already beginning to create formal HIM departments, and smaller facilities likely won't be too far behind, Peterson says. "There absolutely is a need for dedicated HIM personnel in long-term care. Facilities have been reluctant to invest in these roles unless they have a reason, and I think that PDPM is that reason," she adds.

Experts agree that if larger SNFs begin to recruit HIM professionals to serve in a dedicated CDI capacity, these individuals will likely report to corporate-level HIM directors or chief financial officers. In smaller facilities, HIM may report to the SNF administrator or director of nursing.

## Developing a Physician Query Workflow

Physicians should have access to the SNF's EHR so they can clarify diagnoses on admission when they write and sign orders, says Rhonda Anderson, RHIA, QCP, president at Anderson Health Information Services. Worst case scenario is that the facility uses a paper-based method to query physicians (i.e., creating physical mailboxes into which queries are placed or faxing queries to physician offices).

Here's how Spaulding Rehab Network plans to address the CDI workflow. Certified coders review all documentation to assign one or more diagnosis codes on admission. Coders then work with MDS nurses to obtain any necessary specificity. When appropriate, MDS nurses send physician queries through an internal inbox in the EHR. Once physicians answer the query the response becomes part of the patient's record, and coders update the diagnosis code when needed. All of this happens within the first five days of the resident's stay, Baggio Tormey says.

This is the opposite of CDI workflow in most acute care hospitals, where a CDI specialist uses an encoder to assign a working DRG that's subsequently validated by a coder. Because coders reporting SNF services play such an important role in terms of assigning the initial diagnosis, they must receive in-depth training on the PDPM, something that Spaulding plans to provide this summer, she adds.

## Demonstrating Return on Investment

There are many ways in which CDI specialists can have an impact in SNFs, most importantly by ensuring that documentation supports the MDS assessment that's used to determine payment. For example, they can identify and address documentation discrepancies like in the following scenario: MDS says the resident needs extensive assist with two staff members for toileting and bed mobility, but the nursing narrative says the resident is independent in terms of ADLs.

Another area of impact is capturing all comorbid conditions that directly affect payment and ensuring documentation supports code assignment. "If a SNF is going to even consider a formal CDI program, they're going to have to see a return on investment," Peterson says. "More than any other provider setting, skilled nursing facilities are dealing with very minimal resources. Their reimbursement structure is not as profitable as it is in the acute care world."

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