FREE CUSTOMER TRAINING

Welcome to Team TSI's Expert Training

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now a part of SHP

Introductions

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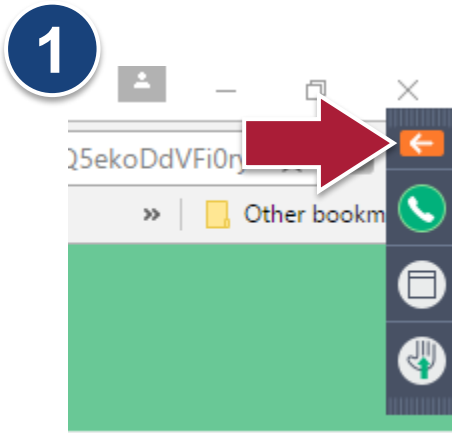
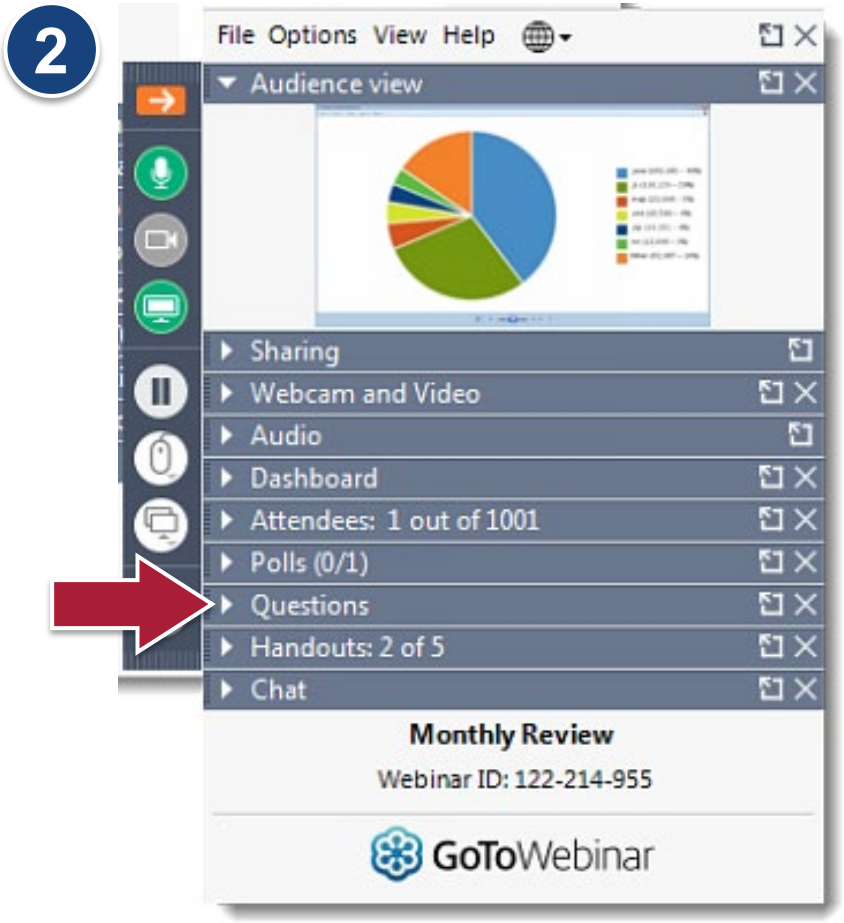
Go To Webinar Audience View





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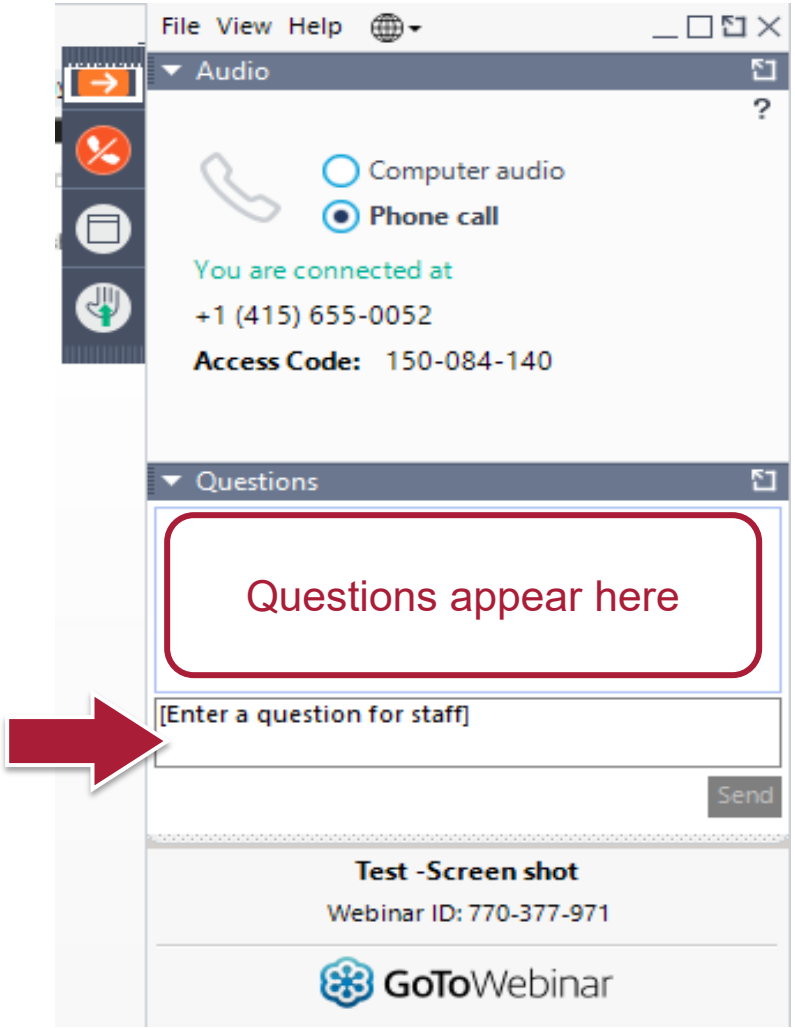
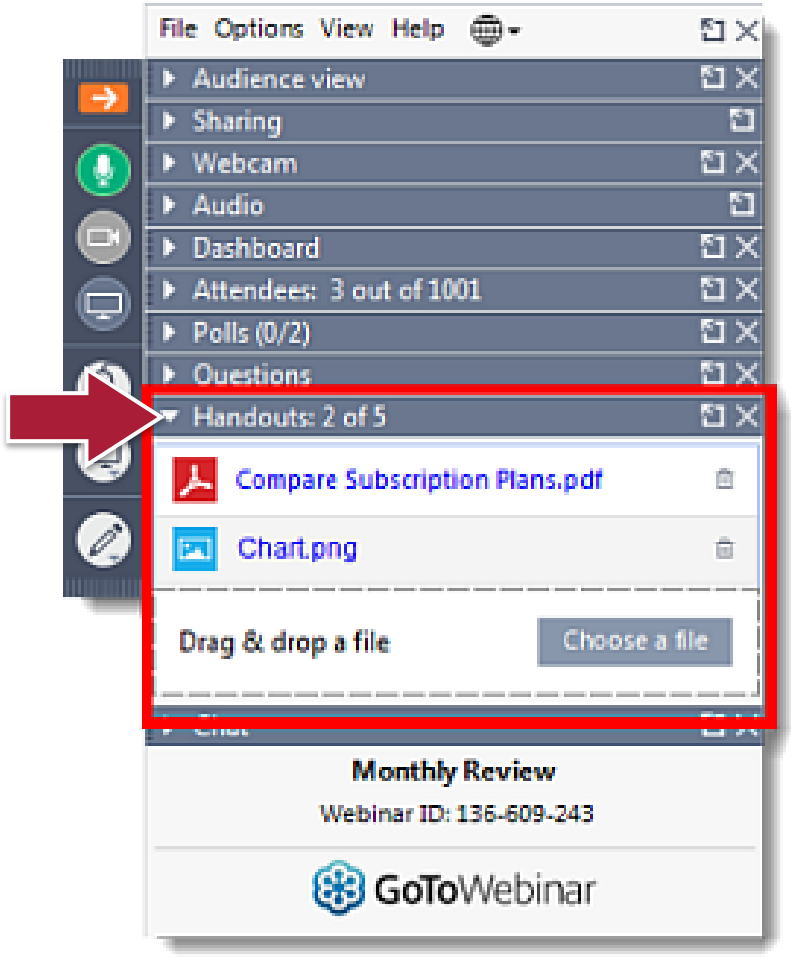
Where to ask Questions



To Retrieve/Download Handouts



FREE CUSTOMER TRAINING

Effective PDPM Huddle Tips

POLARIS GROUP™
Strategic solutions for health care

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PDPM Processes

MDS Coordinator

MDS Coordinator Role is central to success

- Meeting Participation and Leadership
  - Admissions/Re-admissions
  - Daily Stand-Up
  - Daily PDPM Huddle
  - Weekly Medicare Meeting
  - Monthly Triple Check

Pre-Admissions

- Admissions could have a screening tool to better collect information on resident related to Diagnosis, NTA qualifiers, and SLP qualifiers.
- Will attempt to know more about resident to help with accuracy of care needs and coding of MDS.
- See sample Pre-screening tool

Pre-admission Screening Tool

PRE-ADMISSION SCREENING – Resident characteristics/Diagnosis	
DIAGNOSIS	**YES**
Hospital reason for Admission:	
Other Diagnosis Available: List:	
• CVA/TIA/Stroke	
• Diabetes	
• Traumatic Brain Injury	
• ALS	
• Respiratory Failure	
• Oral Cancers	
• MDRO	
• Asthma/COPD/Chronic Lung disease	
• MS	

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Pre-admission Screening Tool

PRE-ADMISSION SCREENING – Resident characteristics/Diagnosis	
SPECIAL CARE HIGH	**YES**
1. Coma	
2. Quadriplegia	
3. Vomiting	
4. Respiratory Therapy	
5. Parenteral/IV Feedings	
Purpose for Nutrition/Hydration? Yes/No	
SPECIAL CARE LOW	**YES**
1. Tube feeding	
2. Pressure ulcer Stage 4 or 3	
3. Other Pressure Ulcers	
4. Venous/Arterial Ulcers	
5. Foot infection/diabetic foot ulcer/open lesions	
6. Radiation Treatments	
7.. Dialysis	
CLINICALLY COMPLEX	**YES**
1. Surgical wounds or open lesions	
2. Burns	
3. Chemotherapy	
4. IV medications	
5. Oxygen	
6. Transfusions	
SLP or NTA QUALIFIERS	**YES**
1. Aphasia	
2. Hemiplegia	
3. Mechanically Altered Diet	
4. Swallowing Disorder	
5. [illegible]	
6. Wound Infection	

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Daily Stand-up

- Admissions scheduled this week, with status on admissions for today, tomorrow and the next day.
  - Transferring Hospital or current location (home, ALF, hosp., etc.)
  - Room assignment
  - Estimated time of arrival
  - Attending physician
  - Supplies or other related equipment needs

Daily Stand-up

- Planned discharges from Medicare or Managed Care within next 2-3 days
- Deaths
- Review changes in condition/24-hour report.
- Review all new incidents/accidents.
- Review other management issues as desired by the management team.
- Updates by each department head.

PDPM Huddle

PDPM Huddle Members

- MDS Coordinator (Leads the Meeting?)
- Therapy Team Leader
- Social Services
- Billing
- Others, as desired such as dietary

Overall Function

- MDSC or other leader:
  - Responsible for IDT communication and coordination
  - Provide oversight to IDT to ensure timely and accurate coding.
  - Coordinates the assessment
  - Monitors for IPA Criteria
  - Monitors Skilled Services Documentation

PDPM Huddle

- PDPM Huddle is held as frequently as needed based on Part A admissions/Census
  - Preparation: All staff come prepared to discuss each Part A resident
    - Access to Medical Record/MDS/EMR reports with change in condition/GG
    - Therapy progress
    - PDPM Check List

PDPM Huddle 5-Day MDS Observation Window

1. New Admissions - Objective first 8 days:
   - Payer Source – Medicare/MCO
   - Primary Reason for Admission Discussion
   - Other care needs/comorbidities
   - ARD set – Data Gathering
   - Care coordination/care planning
   - Skilled Services focus
   - Discharge Plan

Day of Admission – Starts Data Gathering

1. New Admission continued:
   - Medicare Part A-anticipated admissions discussed
   - Team notification
   - Resident's orders evaluated
   - Resident assessed

Day of Admission – Starts Data Gathering

1. New Admission continued:
   - The Admission nurse/MDS Coordinator (MDSC) responsible to communicate information to team.
   - The MDSC opens MDS
   - Diagnoses Identification and Coding

Physician Role: The Diagnoses

1. New Admission continued:
   - Will need physician help to ensure all diagnoses are identified with supporting documentation.
   - Diagnoses must be identified and clarified prior to completion of the 5-day MDS.
     - Identify resident characteristics.
     - Identify and ensure documentation of all diagnoses that apply and may impact payment.

Therapy Responsibilities During Data Gathering

1. New Admission continued:
   - Timely and complete physician orders to evaluate and treat.
   - Physician signature on Plan of Treatment if policy.
   - Obtain a clarification orders s
   - Facility has a therapy team leader. This is a key person communicates with IDT or MDSC.
   - Participates in PDPM Huddle
     - Provides Therapy Minutes for 5-day MDS
     - Contributes to Primary Reason for Admission
     - Participates in care coordination and discharge planning.

Social Services Role During Data Gathering

1. New Admission continued:

- Typically responsible for completion of BIMS and Mood Interviews.
- Primary responsibility to work with resident and family related to discharge planning and coordinate with the IDT weekly at the Medicare meeting.
- Ensure notices are provided as required.

Dietary Role During Data Gathering

1. New Admission continued:
   - Perform observations and data gathering for assigned sections of MDS.
     - Observe resident / Interview staff
     - Perform assessment and documentation-
     - Assist with identification of NTA and co-morbidities
     - Considers documentation of therapy - SLP
     - Ensure orders/diagnosis are supported
     - Ensure care plan addresses issues and supported

PDPM Huddle – Finalize 5-day MDS

2. Around day 10

- Finalize Primary Reason for Admission
- Finalize Section I - Diagnosis and treatment codes
  - Compare with medical diagnoses list - match
- Review all MDS items for completeness and accuracy to finalize MDS prior to submission
- Section J coding

PDPM Huddle

3. Review Readmissions:

- Interrupted Stay Readmission:
  - Returned within 2 midnights or less
  - Review admission care needs and determine if IPA is warranted
  - Set ARD for IPA if needed and communicate to team
  - Primary Reason for Admission Discussion/new additional Diagnoses?
  - Other Care needs/comorbidities/Care coordination/care planning
  - Skilled Services focus
  - Discharge Plan

IPA Situations – Interrupted Stay –Same Stay with Leave of Absence

1. Transferred to Hospital: Inpatient stay
2. Transferred to Hospital: ER/Observation/Inpatient stay
3. Discharged off Part A and from SNF, then readmitted
4. Discharged off Part A but remains in facility under different payer source.
5. Elected Hospice or Lower Level of care, then resumed Part A.

1. Transferred to Inpatient Stay:

- Determine if change in primary reason for admit
- Review Major Surgery Coding Section J
- Review for new orders/diagnoses/comorbidity
- New physician certification is not required

2. Transferred to ER/Observation Stay:

- Determine if change in primary reason for admit
- Review for new orders which impact PDPM
- Review for new orders/diagnoses/comorbidity
- New physician certification is not required as continuation of stay with LOA days

3. Discharged off Part A and from SNF, then readmitted

- Obtain all new orders and diagnoses
- Determine if change in primary reason for admit.
- Remember must ensure qualifies for Part A stay.
- A new Admission Assessment must be completed

4. Discharged off Part A but remains in facility under different payer source.

- Since a LOC change, NOMNC/SNFABN were issued.
  - Primary reason for admission
  - Remember must ensure qualifies for Part A stay.
- FYI – remember no PPS Discharge assessment is done with this scenario.

5. Elected Hospice then changed their mind:

- IPA likely not required.
- Ensure qualifies for Part A Services related to qualifying stay or complication.
- Continuation of stay with LOA days
- No notices were issued but consider a new Physician Certification and orders for skilled services

Other Considerations

- If transferred and re-admitted within 2 midnights or less during the 8-day observation period of the 5-day MDS.
  - Consider whether to combine 5-day MDS with the Discharge Assessment moving ARD to the day of discharge.
  - For very short stays, consider completing Discharge Assessment, then complete 5-day MDS with original ARD to allow for more days for data gathering.

If off Part A three (3) midnights or more it is a PPS Discharge

START OVER!

New 5-day MDS

New Physician Certification

New Variable Rate Count

PDPM Huddle

1. Review Readmissions continued:
   - Readmission after off Part A three midnights or more:
     - Finalize Discharge Assessment with a Medicare End date.
     - Review admission care needs and begin 8-day observation period for 5-day MDS
     - Primary Reason for Admission Discussion/new additional Diagnoses?
     - Other Care needs/comorbidities/Care coordination/care planning
     - Skilled Services focus
     - Discharge Plan

PDPM Huddle

2. Continued Stay Review: discuss each Part A weekly which leads into Medicare Weekly Meeting
   - Monitor for change in condition which could trigger an IPA
   - Current HIPPS – CMGs
   - Therapy threshold report
   - EMR reports on changes/GG
   - Review Care Coordination/Care Plan
   - Skilled Documentation supports skilled service
   - Discharge Plan progress and LCD if known

IPA During a Part A Stay

Consider scenarios without an Interrupted Stay/Leave of Absence

General Considerations

- IDT will monitor for triggers of an IPA during course of Part A Stay during PDPM Huddle.
- Suggest review be at a minimum weekly to ensure no significant clinical changes are missed
  - 24-hour report – new orders
  - Changes in condition/decline/complications
  - New orders
  - Physician documents a new diagnosis which impacts care planning/orders

General Considerations

- It is not recommended to complete an IPA for expected improvement during the course of the Part A stay.
  - For example, expected improvement in ADLs, which results in a change in Function Score impacting PT & OT components of rate.
  - Rational: Approach consistently, you would not complete an IPA for other expected improvements:
  - D/C Mechanically Altered Diet
  - D/C IV feeding
  - Swallowing problems improve
  - SOB while lying flat improves

What Might Trigger an IPA during the course of a Part A Stay

- How about new NTA and/or Nursing Qualifiers which impact both:
- Feeding Tube indicates a decline
  - Feeding Tube increases NTA only one point.
  - Feeding Tube may increase Nursing CMG to Special Care High (with fever) or Special Care Low

What Might Trigger an IPA during the course of a Part A Stay

- Parenteral/Enteral Feeding started? Likely there is a significant clinical change or complication which arose during SNF stay.
  - Parenteral/Enteral Feeding would add 7 points or 3 points depending on Calories.
  - Would likely increase NTA CMG
  - Could change Nursing CMG to Special Care High

What Might Trigger an IPA during the course of a Part A Stay

- Regarding SLP Component:
  - Additional Comorbidity does not change CMG.
  - Start Mechanical Altered Diet; support underlying clinical change.
  - New Swallowing Problem documented, support clinical change.
  - Always update Care Plan, and ensure documentation supports change.

What Might Trigger an IPA during the course of a Part A Stay

- Caution: Keep in mind whenever an IPA is completed the Function Score is re-calculated.

PDPM Huddle

5. PDPM Check List Form:

- Form design
- Prior to finalizing review qualifiers
- The form can be used at any time to review qualifiers to ensure any new qualifiers are identified and coded; or to trigger an IPA.

PDPM Check List Form

PDPM Huddle Check List for 5-day MDS Accuracy or Trigger for IPA **Resident:** **Admit Date:** **5-day MDS ARD:** **HIPPS:**		
Change in Condition: Triggers IPA? Yes/No IPA ARD:		
Discharge/Meets Interrupted Stay upon readmit: Trigger IPA Yes/No		
SKILLED SERVICES IDENTIFIED and DOCUMENTATION	**YES**	**IPA Check**
Skilled Services documented		
DIAGNOSES – ICD-10 Mapping. **MDS MATCHES Medical Diagnosis List**	**YES/Coded**	**IPA Check**
Primary Reason for Admission:		
CVA/TIA/Stroke		
Diabetes		
Pneumonia		
Traumatic Brain Injury		
Aphasia		
ALS		
Oral Cancers		
MDRO		
Inflammatory Bowel Disease (NTA)		
HIV/AIDS		

PDPM Check List Form

FUNCTION SCORE	**Change/Impact?**	**IPA Check**
Coding on MDS is supported and explained in Medical Record for 5-day MDS/End of stay		
Review of daily documentation Nursing and Therapy – no change in Function Score to trigger an IPA See Function Score Sheet for detail if indicated		
Therapy Minutes: Total Minutes for last 7 days	**YES/Coded**	**IPA Check**
Group Minutes within Cap for PT		
Group Minutes within Cap for OT		
Group Minutes within Cap for ST		
Concurrent Minutes within Cap for PT		
Concurrent Minutes within Cap for OT		
Concurrent Minutes within Cap for ST		
Treatment Diagnosis:		
BIMS and MOOD INTERVIEWS	**YES/Coded**	**IPA Check**
BIMS INTERVIEW completed/staff observations supported		
MOOD INTERVIEW completed/Staff Observations supported		
EXTENSIVE	**YES/Coded**	**IPA Check**
1. Tracheostomy Care while a resident (NTA)		
2. Ventilator/Respirator Treatment while a resident (NTA)		
3. **Isolation/Quarantine** for active infectious disease while a resident **(NTA)**		

PDPM Check List Form

SPECIAL CARE HIGH	YES/Coded	IPA Check
1. Coma/GG Coding		
2. Septicemia		
3. **Diabetes** with daily injections and Insulin order changes **(NTA)**		
4. Quadriplegia with Nursing Function Score <=11		
5. **COPD** and shortness of breath when lying flat **(NTA)**		
6. Fever w/ pneumonia or vomiting or weight loss or tube feeding		
7. **Parenteral/IV Feedings (while a resident or at admission last 7 days) (NTA)**		
8. Respiratory Therapy – daily over the last 7 days or since admission if less than 7 days in the facility.		
SPECIAL CARE LOW	YES/Coded	IPA Check
1. Cerebral Palsy with Nursing Function Score <=11		
2. **Multiple Sclerosis** with Nursing Function Score <=11 **(NTA)**		
3. Parkinson's disease with Nursing Function Score <=11		
4. Respiratory Failure (I6300) with oxygen therapy while a resident		
5. Tube feeding (NTA)		
6. Two or more Stage 2 pressure ulcers with two or more treatments		
7. A Stage 3 or **4 (NTA)** pressure ulcer with two or more treatments		
8. 2+Venous/Arterial ulcers with two or more treatments		
9. 1 stage 2 and 1 Venous/Arterial with two or more treatments		
10. **Foot infection/diabetic foot ulcer/open lesions (NTA)**		
11. **Radiation Treatments while a resident (NTA)**		
12. Dialysis while a resident		
CLINICALLY COMPLEX	YES/Coded	IPA Check
1. Pneumonia		
2. Hemiplegia with Nursing Function Score <=11		
3. Surgical wounds or open lesions with one of the following; wound care or skin treatments		
4. Burns		
5. Chemotherapy while a resident		
6. **IV medications while a resident (NTA)**		

PDPM Huddle

- The PDPM Huddle is essential needed for success
  - An effective PDPM Huddle with team input to ensure MDS is accurate for all Items impacting PDPM PRIOR to submission is key.
  - Check of Interrupted Stay re-admissions for IPA.
  - Monitoring for significant clinical decline for an IPA trigger during course of Part A stay.

Weekly Medicare Meeting

Medicare Meetings: Part A Reviews

- Attendees may include but not be limited to:
  - MDS Coordinator
  - Medicare Coordinator
  - DON
  - Billing Office Coordinator
  - Therapy Team Leader
  - Therapists
  - Nursing Unit Manager
  - Physician

Weekly Medicare Meeting

Medicare Meetings: Part A Reviews

- Communication to update all team members:
  - Primary Reason for Admission – New Admission
  - Changes in condition/characteristics impacting PDPM components
  - Benefit days available
  - Tapering day count

Weekly Medicare Meeting

Medicare Meetings: Part A Reviews

- Communication to update all team members:
  - Skilled services being given
  - Physician certification compliance
  - Patient progress toward goals (include status)
  - Anticipated skilled services – nursing and therapy
  - Discharge plans and anticipated Last Covered day and discharge date
  - Patients that continue to be skilled after benefits exhaust
  - Consider weekly IDT note supporting need for skilled services

Medicare Weekly Meeting

Weekly Medicare Review - Part A

Resident Name: Date of Review:

Admit Date	Benefit Day	Variable Rate Day	5 Day HIPPS Mod	IPA triggered?	IPA ARD	Certification Compliance	Last Covered day	Discharge Date

Diagnoses on MDS

Primary Reason for Adm.		Other	
Treatment Diag		Other	
Other Diag		Other	

Medicare Weekly Meeting

Current Status & Problem List
Medical/Medication
Nutritional
Functional
Cognitive/mood/psy chosocial:

Skilled Nursing Services:
Function Score Coding check
Management & Evaluation of Patient Care Plan:
Observation & Assessment of Patient's Condition:
Teaching & Training Activities:
Direct Skilled Nursing Services:
Restorative:

Skilled Therapy Services		
Minutes within Thresholds?		
PT	**OT**	**ST**
Reason for continued Rx:	Reason for continued Rx:	Reason for continued Rx:

Billing Communication

- The MDS software may be electronically linked to the billing software or information is available from a PDPM report.
- Review Validation reports weekly or at a minimum monthly at PDPM Triple Check.
- Ensure EMR system supports the ICD-10 codes on MDS are communicated to claims and/or Medical Diagnosis list and then to claims.

PDPM Triple Check

- **PDPM Triple Check:**
  - Comparing Record to Claim
  - Ensure Principal and Admitting diagnoses match Primary Reason for Admission I0020B code
  - Ensure other diagnoses on claim are supported on MDS
  - Review other qualifiers for payment to include on Claim

Why Triple Check?

- The Triple Check QA meeting is the final “check” of the claim prior to submission.
- Ensure Medicare is billed accurately and timely.
- The triple check process “validates the information on the UB-04 is accurate” prior to billing.
- All allowable incurred costs the facility has acquired are billed under the Medicare program.
- Verification and cross-check review of the Medicare claim by the interdisciplinary team.

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PDPM Triple Check

- Triple Check Audit examples:
  - Part A Audit Tool

  or
  - Medicare Check List form

PDPM Triple Check

MEDICARE PART A UB-04 TRIPLE CHECK (Claim Sequence: I= Initial claim, O=ongoing claim, D=Discharge claim)

Resident Name: _____ **Admit Date:** _____ **Date Completed:** _____ **Discharge Date:** _____

	Correct Yes/No	Items/Areas Reviewed	By	Source Record	UB04 Locator #	Claim	Required Action/ Person Responsible	Done Yes/No
1		Resident's NAME and health insurance, MBI NUMBER match HETS, Medicare Card, DOB, CO-INSURANCE DAYS verified.	MC/ BOM	Common Working File (CWF)(HETS)	8, 60, 10, 40	I		
2		Medicare Secondary Payer questions asked/form completed	BOM	Admission Folder	52	I		
3		Assignment of Benefits signed and dated	BOM	Admission Folder	53	I		
4		Type of Bill correct – start through end of care -211, first claim - 212, continuing claim - 213, discharge claim – 214	BOM	UB04	4	I, O, D		
5		DATES OF SERVICE correct - From and through dates on UB-04 are correct	MC	Nurses Notes	6	I		
6		Correct ADMISSION date	MC	Chart	12	I		
7		Correct hospital QUALIFYING STAY dates-verified by hospital medical records department (If qualifying stay is more than 30 days from admit date, condition code 57 is present and 30-day transfer requirement is met)	MC	Hospital notes, HPN	35	I, O, D		
8		Accurate Census Days (covered days (value code 80) LOA/non covered days (value code 81) are present and match room and board days, rev code 110, 120 or 180-General, 183-Theraputic, 185-NH Hospitalization)	BOM	Census Report	6, 44	I, O, D		
9		Co-insurance Days (value code 82) and co-insurance amount (value code 09) correct per HETS	BOM	UB04	39, 40 or 41	I, O, D		
10		Accurate PATIENT STATUS (01, 02, 04, 06, 07, 20, 30, 51, 70, etc.)	BOM	Medical Record/UB04	17	I, O, D		
11		If skilled care ending, occurrence code 22 present with last covered day. (order to discharge from skilled care present)	BOM	UB04	31	D		
12		If applicable, correct **SNF notices (SNFABN/NOMNC)** issued (if patient status is 01, 04, 22, 06 due to skilled level of care no longer required, form(s) must be timely).	BOM	Medical Record		D		
13		Physician Certification/Re-Certification (signed, dated and have skilled services listed, estimated length of stay, post SNF discharge plan, does stay relate to acute care stay)	MC	Medical Record		I, O, D		
14		MDS (signed as completed by an RN)	MDSC	MDS		I, O, D		
		Type 5 day or IPA						
		ARD (within window for MDS) (Occurrence code 50 with ARD in FL 31–34 on UB04)	MDSC	MDS	31-34	I, O, D		
		ADL Section G and GG (supported by medical record)	MDSC	MDS				
		NTA component supported by medical record	MDSC	MDS				

Medicare Part A Checklist

MEDICARE PART A CHECKLIST

Basic Information:
___ Resident Name matches MBI, Medical record, MDS
___ DOB, Gender correct
___ Medicare Secondary Payer questions asked
___ Assignment of Benefits signed and dated

Date Information:
___ Dates of service correct
___ Admission Date
___ Hospital stay dates
___ Discharge Date
___ Dropped LOC date

Physician's Orders:
___ Phys order for skilled services
___ Phys telephone orders, signed, dated
___ Therapy Treatment Orders
___PT ___OT ___SLP
___ Clarification orders
___PT ___OT ___SLP

Physicians Certification:
___ Initial cert signed timely
___ Complete/signed/dated
___ Recertification on or before day 14 (signed, dated)

MDS:
___ Signed as completed by RN within 14 days of ARD
___ ADL section G and GG supported by medical record
___ Nursing component Case Mix supported by medical record
___ NTA component supported by medical record
___ SLP co morbidities supported by medical record
___ Completed within ARD window
___ Medicare start and end dates correct
___Therapy information correct

Therapy:
___ Therapy minutes accurate (match MDS)
___PT ___OT ___SLP
___ Evaluation complete signed by phys, credentialed by therapist
___PT ___OT ___SLP
___ Weekly Summaries/progress towards goals
___PT ___OT ___SLP
___ Group and Concurrent minutes are not more than 25% if total therapy minutes
___ CQ (PTA) or CO (COTA) documentation provided as needed

Diagnosis:
___Principal Diagnosis accurate for this benefit period (MDS section I0020B)
___Admission Diagnosis accurate (MDS section I0020
___Therapy Diagnosis accurate (MDS section I0020

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Compliance Issues under PDPM

Compliance

What could MAC/RAC Auditors look for?

- MDS coding items impacting a CMG for one or more components of the rate will be audited for supporting documentation.
- If coding is not supported, will adjust the CMG for one or more components of a rate.
  - Incorrect Primary diagnosis
    - Does not support need for Part A stay
    - Not related to qualifying stay

Compliance

What could MAC/RAC Auditors look for?

- Incorrect coding on MDS Section I – not supported
  - Section I8000 diagnosis not supported
- Diagnoses on claim not supported in EMR and MDS
- Documentation does not support function score
  - Will they really adjust just a function Score? It would impact three components but in different ways so maybe not an area of focus?

Medical Review Language

Documentation supports the coding on MDS and the medical necessity of services on the MDS.

- Excerpts of interest:
  - "Each MDS represents the patient's clinical status based on an Assessment Reference Date (ARD) and established look-back periods for the covered days associated with that MDS. Medicare expects to pay at the rate based on the most recent clinical assessment (i.e., MDS), for all covered days associated with that MDS. Medical review decisions are based on documentation provided to support the coding and medical necessity of services recorded on the MDS for the claim period billed. Medicare contractors focus on the unique, individualized needs, characteristics and goals of each patient, in conjunction with CMS payment policies, to determine the appropriateness of the case-mix classifier billed."

Medical Review Language

- Excerpts of interest:
  - "Services are Reasonable and Necessary--Determine whether the services are reasonable and necessary under §1862(a)(1)(A) of the Act. When making reasonable and necessary determinations, contractors shall determine whether the services indicated on the MDS were rendered and were reasonable and necessary for the beneficiary's condition as reflected by medical record documentation. If the reviewer determines that none of the services provided were reasonable and necessary or that none of the services billed were supported by the medical record as having been provided, the Medicare contractor shall deny the claim in full."

Compliance

What could MAC/RAC Auditors look for?

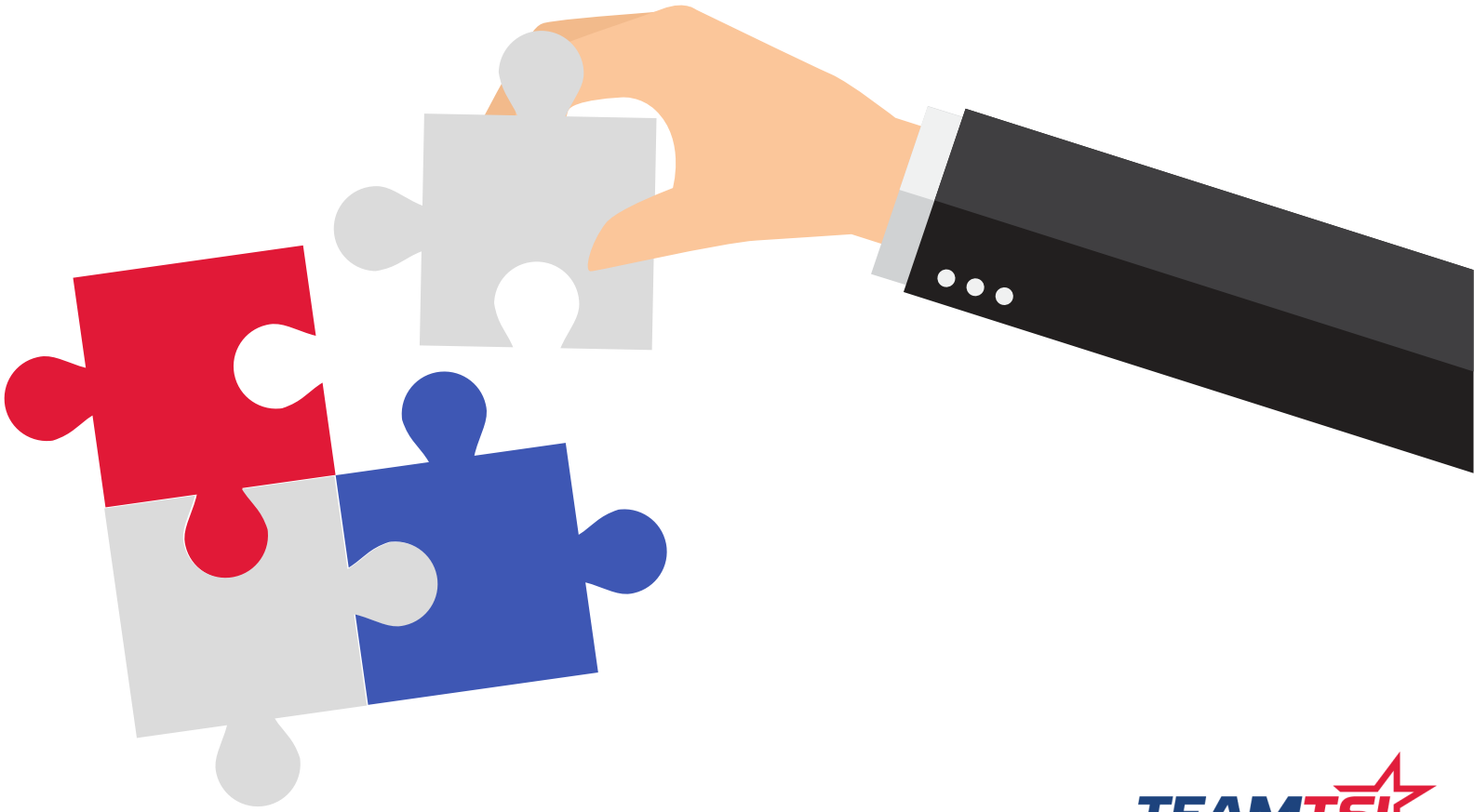
NOT NEW

- Need to support medical necessity of a daily nursing skilled service and/or therapy skilled services 5 days a week remains.
- Need to support practical matter; need to be in Part A bed to receive the skilled service.
  - Not sure this is any different than before?
- Monitoring for abuse/mis-use of IPAs
- Triggered review if pattern of over minute thresholds

Key Strategies

- Effective PDPM Huddle
- Focused QA checks of Section I
- Run First Listed diagnosis in Section I8000 through Mapping to determine clinical category
- Ensure get information as needed regarding surgical procedures from hospital
- Establish GG Observation Assessment process
- Ensure BIMS and Mood Interviews are completed within ARD window

Success is making the pieces fit!



Thank you!

Questions?

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