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Q & A: Identifying and preventing UTIs in Long-Term Care

Urinary tract infections (UTIs) account for 20% of infections reported in long-term care facilities according to the Centers for Disease Control (CDC).

UTIs are in the top five of infections reported at LTCFs, after bacterial pneumonia, diarrheal diseases, and antibiotic staph infections.

Identifying UTIs in elderly patients can be challenging as many UTI symptoms such as incontinence, burning during urination, and pelvic pain mimic symptoms that are often attributed to aging.

Not only does failure to prevent or properly diagnose UTIs affect patient care, but it also affects quality measures related to the SNF Value-Based Purchasing Program as well as referrals made by Medicare Advantage plans.
Earlier this year, Jennifer Maina, BSN, RN, DON, director of nursing for Larksfield Place Health Care Center in Wichita, Kansas, hosted a webinar and shared her experiences on guiding members of her staff to identifying a UTI and employing prevention methods.

The following Q & A occurred after the webinar and was lightly edited for quality.

**Question:** Are cranberry capsules useful in UTI prevention?

**Maina:** A randomized clinical trial was done around 2016 and showed no difference of incidence of bacterial compared to when using cranberry capsules vs. a placebo, however, cranberry juice provides hydration and calories, so it’s not going to hurt, but it hasn’t been proven to reduce the risk of UTIs.

**Question:** Can you describe your experience with antibiotic stewardship in your facility? What have you found works for your staff?

**Maina:** One of the most important pieces is educating the physicians about when antibiotics are appropriate vs. when they are not; because at the end of the day, it’s the physician who orders the prescription. Facilities often obtain a urine analysis (UA) unnecessarily, causing increased cost to the resident or facility. Once the UA is done, the physician often treats the lab rather than the resident. It is important to know your surveillance criteria/protocol and consistently apply the criteria, even when making the decision to obtain a UA.

Don’t be afraid to tell the physician that the patient doesn’t meet the criteria for an antibiotic treatment. Engaging the staff, educating the nurses, and educating the families on the harm that antibiotics can actually do well will only benefit the patient.

**Question:** Are follow-up urinary analysis recommended?

**Maina:** A UA should only be done if a resident meets the criteria. Remember to treat the resident, not the lab. Some key facts about antibiotic stewardship include:

- Never perform random UAs (including urine dipsticks) or screen for urinary tract infections. It is an unnecessary expense and often physicians will treat asymptomatic bacteriuria.
- Never start an antibiotic for a UTI without having the culture and sensitivity (C&S) results, unless septicemia is in question.
- As part of surveillance, ensure the proper antibiotic is ordered and that the antibiotic is sensitive on the C&S report.

**Question:** What are your thoughts on the silver tip catheter?

**Maina:** One of the most important pieces is educating the physicians about when antibiotics are appropriate vs. when they are not; because at the end of the day, it’s the physician who orders the prescription. Facilities often obtain a urine analysis (UA) unnecessarily, causing increased cost to the resident or facility. Once the UA is done, the physician often treats the lab rather than the resident. It is important to know your surveillance criteria/protocol and consistently apply the criteria, even when making the decision to obtain a UA.

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Maina: A randomized clinical trial with 745 participants was completed on silver impregnated urinary catheters. It failed to demonstrate the efficacy of silver in prevention of CA-SUTI. It also showed a significantly increased incidence of bacteriuria (bacteria that should not be treated with antibiotics). The Association for Professionals in Infection Control and Epidemiology’s (APIC) recommendation is to avoid most silver lined devices.

See Figures 1 and 2 from the CDC’s Long-term Care Facility Component Urinary Tract Infection, released in January 2019, for criteria for defining UTIs in patients without an indwelling urinary catheter as well as patients who may have a UTI with an indwelling urinary catheter.

EDITOR’S NOTE:
For more information on UTIs, check out the on-demand version of the webinar Identifying and Preventing UTIs in Long-Term Care on hcmarketplace.com.

Nine steps for developing a business case for UTI prevention

Step 1: Identify the senior leader who will be the champion for UTI prevention and make the case to the executive team.
Step 2: Create a multidisciplinary team of department leaders and frontline staff who will support the mission and goals and work to engage other staff.
Step 3: Propose how the requested resources will address and improve current UTI prevention efforts and how the return on investment will be measured.
Step 4: Outline the costs associated with the requested resources. If necessary, include a budget that details costs for salaries, supplies, equipment, education and training, and any other related expenses.
Step 5: Show the current rate of UTIs and define the reduction goal.
Step 6: Show the average cost of one UTI and the total annual cost of all UTIs identified within the organization in the past 12 months.
Step 7: Demonstrate how reduction in the UTIs rate would lead to direct savings.
Step 8: Demonstrate other potential measurable outcomes, including reduced length of stay and UTI rates.
Step 9: Describe any additional benefits the requested resources will have on resident safety, resident satisfaction, staff satisfaction, and organizational safety culture.
Figure 1: Criteria for Defining Non-Catheter Associated Symptomatic Urinary Tract Infection (SUTI):

Resident without an indwelling catheter (Meets criteria 1 OR 2 OR 3):

**SUTI – Criteria 1**

**Either** of the following:
1. Acute dysuria
2. Acute pain, swelling, or tenderness of the testes, epididymis or prostate

**OR**

**SUTI – Criteria 2**

**Either** of the following:
1. Fever\(^a\)
2. Leukocytosis\(^b\)

**AND**

**ONE or more** of the following:
1. Costovertebral angle pain or tenderness
2. New or marked increase in suprapubic tenderness
3. Gross hematuria
4. New or marked increase in incontinence
5. New or marked increase in urgency
6. New or marked increase in frequency

**OR**

**SUTI – Criteria 3**

**TWO or more** of the following:
1. Costovertebral angle pain or tenderness
2. New or marked increase in suprapubic tenderness
3. Gross hematuria
4. New or marked increase in incontinence
5. New or marked increase in urgency
6. New or marked increase in frequency

**Either** of the following:

1. Specimen collected from clean catch voided urine and positive culture with no more than 2 species of microorganisms, at least one of which is a bacterium of \( \geq 10^5 \text{ CFU/ml} \)
2. Specimen collected from in/out straight catheter and positive culture with no more than 2 species of microorganisms, at least one of which is a bacterium of \( \geq 10^5 \text{ CFU/ml} \)

**NOTE:** Yeast and other microorganisms, which are not bacteria, are not acceptable UTI pathogens

\(^a\) Fever: Single temperature \( \geq 37.8^\circ C (>100^\circ F) \), or \( > 37.2^\circ C (>99^\circ F) \) on repeated occasions, or an increase of \( > 1.1^\circ C (>2^\circ F) \) over baseline

\(^b\) Leukocytosis: \( > 14,000 \text{ cells/mm}^3 \), or Left shift (> 6% or 1,500 bands/mm)

Updated January, 2019

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Source: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
Figure 2: Criteria for Defining Catheter Associated Symptomatic Urinary Tract Infection (CA-SUTI)

**Resident with an indwelling urinary catheter:**

**ONE or more** of the following:
- Fever
- Rigors
- New onset hypotension, with no alternate noninfectious cause
- New onset confusion/functional decline with no alternate diagnosis **AND** Leukocytosis
- New costovertebral angle pain or tenderness
- New or marked increase in suprapubic tenderness
- Acute pain, swelling or tenderness of the testes, epididymis or prostate
- Purulent discharge from around the catheter

**AND**

**Any** of the following:

*If urinary catheter removed within last 2 calendar days:*
1. Specimen collected from clean catch voided urine and positive culture with no more than 2 species of microorganisms, at least one of which is a bacterium of \( \geq 10^6 \) CFU/ml
2. Specimen collected from in/out straight catheter and positive culture with no more than 2 species of microorganisms, at least one of which is a bacterium of \( \geq 10^6 \) CFU/ml

*If urinary catheter in place:*
3. Specimen collected from indwelling catheter and positive culture with no more than 2 species of microorganisms, at least one of which is a bacterium of \( \geq 10^5 \) CFU/ml

\( \text{CA-SUTI} \)

*Fever can be used to meet SUTI criteria even if the resident has another possible cause for the fever (for example, pneumonia)*
*Fever: Single temperature \( \geq 37.8\,^\circ\text{C} (=100\,^\circ\text{F}), \text{or} \geq 37.2\,^\circ\text{C} (=99\,^\circ\text{F}) \text{on repeated occasions, or an increase of} >1.1\,^\circ\text{C} (>2\,^\circ\text{F}) \text{over baseline})*
*Leukocytosis: >14,000 cells/mm³ or Left shift (>6% or 1,500 bands/mm³)*

Source: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
Putting the person in the care plan

This article has been excerpted from MDS Care Plans: A Person-Centered, Interdisciplinary Approach to Care, Second Edition, published earlier this year. Visit our marketplace to learn more.

Person-centered care is an idealistic approach to resident care that became common around 1985. It was designed to allow people with developmental disabilities to have a voice in their lives and to facilitate self-determination. By the late 1990s, the concept had filtered into other areas of healthcare.

Person-centered planning was developed in an effort to offer people who request and receive human services the opportunity to describe and define the characteristics of and conditions in life that make their present and future desirable. It also offers to those who deliver these services an opportunity to learn and grow alongside the person who is at the core of the planning process, and it aims to influence how the systems that support such services respond to the requests and desires of their primary customers. Overall, person-centered planning was created to remove the artificial boundaries between our communities to make room for every one of our neighbors every day (Kendrick, 2000).

Person centeredness is about being with people intentionally. It demands a personal commitment to engaging conscious awareness of and self-reflection about the relationship between what we are thinking, what we are feeling, and what we are actually doing. Note that not everyone needs or benefits from a person-centered planning process, and such a process should never be initiated without a commitment from the key stakeholders, including service systems, to honor the process, take action, and follow through on agreements. Essential lifestyle plans are developed through a process of asking and listening. The best essential lifestyle plans reflect the balance between competing desires, needs, choice, and safety. Remember, too, that a plan is not the same as an outcome (Cornell University, n.d.).

Simply declaring that we are person-centered does not make us so in our care-planning efforts. Person-centered care is an empathic, common-sense approach to personalizing care and de-institutionalizing the nursing facilities environment. The irony is that mandates have driven facilities into a very structured, system-centered approach to care in order to remain in compliance while also requiring flexibility and system changes using the Minimum Data Set 3.0 and the care area assessments (CAA) to center our attention on individual needs.

System-centered services rarely accommodate person-centered services or preferences (e.g., rising times, bed times, meal times, bath times, activities, etc.). In the person-centered model, however, the resident is in control. For example, if the person likes coffee upon rising each day (and rising on his or her schedule and not on the facility’s) and prefers to have only toast rather than a complete breakfast prescribed by the dietitian, adjustments should be made to accommodate that individual. Obviously, when you consider the number of residents who have individual preferences, it’s clear that current systems will require many adaptations to provide such accommodations. Facilities using a neighborhood care model have been innovators in this regard, experimenting with ways to improve responsiveness to individuals with good results.

We continue to modify our systems for better outcomes and a more idealistic care model; it is a continuous process of change. Trial and error will eventually evolve into the person-/comfort-centered care model. As nursing facilities continue converting systems to a setting that predominantly caters to individual needs and desires, it is vital that the care plan become the bridge making it happen. It’s the map to our destination.

Person-centered care isn’t about generating new forms or increasing workload. It is intended to shift the emphasis away from a paper-oriented process of care delivery. In the not-too-distant past, one concept for person-centered care plans was to create “I” care plans. The idea of these plans is to improve communication with staff members about who the person is, to have staff members become more familiar with the resident, and to remind them that the resident is more than a room number or a diagnosis, thereby improving the quality of care they received. Although the concept was great, however, the method was awkward.
The stated goals for using “I” plans are really no different than the those for any care plan format. The concept certainly prompted additional discussion about giving the resident a voice, and the “I” plans attempt do this quite literally, with care plans written in the first person. However, care planning is not about format: It is a process rather than a physical item. It is a means to an end, rather than an end in itself. Person-centered care is more than delivering care or giving care plans a title; it is about being conscious of the person—the actual human being—who is receiving the care.

**Section GG: Functional Abilities and Goals**

Although this section is only required for Medicare assessments, it has very specific rules related to the plan of care. The Impact Act of 2014 drives the addition of this section as well as several other questions on the MDS. The quality measures from this area address that the area has been assessed and care planned for goals identified.

**Care planning implications**

Prior level of Function: Self care, Indoor mobility/Ambulation, Stairs, and Functional Cognition

Assess these areas to identify where potential for rehabilitation is present by comparing prior level of function (just before current illness or condition) to resident-identified goals and by tracking progress during their stay. Throughout the stay, also consider areas that may not improve, and work with the resident and family to adjust the plan of care. Psychosocial and mood concerns may contribute to progress and also can be affected by poor progress.

**GG0130: Selfcare; GG0170: Mobility**

These areas are assessed for performance and goals during the initial Medicare assessment and for performance upon discharge. They also may be updated with any interim payment assessments during a Medicare stay. The care plan, however, should continue to be updated any time the goals change during the Medicare stay.

Consider resident-identified goals for performance and any changes to health status that may limit rehabilitation or prevent achieving goals. Also consider comorbid factors such as cognitive impairments and impaired healing due to other disease processes.

Are there structural or social barriers to achieving goals (e.g., a CVA resident who will not be able to climb stairs in their two-story home, residents with dementia who lack family support, etc.?? Are there social programs that can be used to help overcome these potential barriers? In many instances, it is important to identify such barriers and initiate referrals early to allow for safe discharge planning.

In a world of regulations and processes that demand attending to the resident voice and resident preferences, we must step up to the challenge by shifting our focuses, increasing the time we spend gathering histories and habits, and truly moving our “systems” world to focus on what would result in satisfied customers (both resident and family members). When we take the time to identify how the resident prefers to have their care provided, at what times, and the extent to which they want to participate in certain activities, we honor them by honoring those choices and allow them satisfaction in their care. This approach truly embraces the concept behind person-centered care planning.

“Person-centered planning begins when people decide to listen carefully and in ways that can strengthen the voice of people who have been or are at risk of being silenced.”


The philosophy of person-centered plans intends to honor and respect the voice of the resident, in whatever manner that may be documented and deciphered by others who are in the distinct role of providing care and support. Shifting emphasis from the mechanics of care plans and delivery to actually honoring the uniqueness of the human being who needs our assistance will herald the next evolution of nursing facilities. As always, the road will be full of challenges as surveyors, facilities operators, staff members, significant others, and those for whom we are charged with caring shift into this alternative, idealistic universe.

Create a simple mission statement like “listen, learn, and connect,” and couple it with a vision statement that encompasses what it means to lay a foundation for the culture change that is sure to come. Create a vision for your organization: What does person-centered care look like when it is achieved? How will you blend and promote standards of care for health conditions, potential risk, and an individual’s functional status while promoting the quality of life for each person in your care? What will the positive impact be for all stakeholders? Vision is the source of new models and a new structure. It creates a picture in the present moment that directs us toward the future. Empower people to act in service of that vision, and remove obstacles to change—one at a time.

At the end of this article you’ll find a sample care plan for Section GG.
### Functional Abilities and Goals

**Resident**

<table>
<thead>
<tr>
<th>Problem/Need</th>
<th>Related to:</th>
<th>Risks/Challenges</th>
<th>Goals</th>
<th>Interactions and approaches</th>
<th>Disc.</th>
<th>Target date</th>
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<td>❑ CVA</td>
<td>❑ Confusion</td>
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<td>❑ Therapy screening/treatment</td>
<td>PT/OT</td>
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<td></td>
<td>❑ Fracture</td>
<td>❑ Limited ROM</td>
<td>Eating</td>
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<td></td>
<td>❑ Weakness</td>
<td>❑ Confusion</td>
<td>Oral hygiene</td>
<td>❑ Restorative nursing</td>
<td>N</td>
<td></td>
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<td></td>
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<td>❑ Encourage resident to be more independent</td>
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<td>❑ Confusion</td>
<td>Roll left/right</td>
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<td>All</td>
<td></td>
</tr>
<tr>
<td></td>
<td>❑ ________</td>
<td>❑ Confusion</td>
<td>Sitting to lying</td>
<td>❑</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>❑ Confusion</td>
<td>Lying to sitting (bed)</td>
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<td>All</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>❑ Confusion</td>
<td>Sit to stand</td>
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<td>All</td>
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<tr>
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<td>❑ Confusion</td>
<td>Chair to bed transfer</td>
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<td></td>
</tr>
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<td>Toilet transfer</td>
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<td></td>
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<td>All</td>
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</table>
Something replaced, something new, and something removed

Changes to therapy reporting and reimbursement that affect billers

Three changes happened recently for therapists that billers should know about: Medicare’s outpatient therapy cap was repealed and the therapy threshold was lowered; new modifiers for therapy assistants were added; and the requirement for functional limitations reporting was removed.

Understanding the therapy thresholds

Therapy financial limitations on Medicare-covered Part B therapy services were first initiated by the Balanced Budget Act of 1997 and were implemented in 1999, known as the therapy cap. The limitations were placed on moratorium and implemented again for a short time in 2003 before once again being placed on moratorium. Then, with the Tax Relief and Health Care Act of 2006, caps on outpatient therapy services were established again and the amounts changed annually. Since that time, therapy caps limited the amount of coverage available for beneficiaries receiving Part B therapy.

“You had to jump through hoops to get paid if services exceeded the cap,” says Mark McDavid, OTR, RAC-CT, CHC, founder of Seagrove Rehab Partners.

On February 9, 2018, the Bipartisan Budget Act (BBA) of 2018 was signed into law. This law permanently repealed Medicare’s outpatient therapy cap. This law allows providers to treat clients above a set dollar amount as long as they meet certain requirements. “We felt like this was a huge win for the industry. Then at the eleventh hour the congressional leaders who were putting together the legislation added in the reimbursement reduction for therapy assistants as an offset for the increased cost of repealing the cap. They also changed the threshold for manual medical review,” says McDavid.

The 2019 Medicare Physician Fee Schedule lists the therapy thresholds as $2,040 for combined physical therapy (PT) and speech-language pathology (SLP) services and $2,040 for occupational therapy (OT) services. The BBA also retains the targeted medical review threshold of $3,000 for combined PT and SLP services and $3,000 for OT services. The Centers for Medicare & Medicaid Services (CMS) is charged with implementing these thresholds. These thresholds can be accessed at www.cms.gov/Medicare/Billing/TherapyServices/index.html. There will continue to be a combined threshold for PT and SLP and a separate threshold for OT.

New modifiers for therapy assistants

In 2022, reimbursement for PT assistants (PTA) and certified OT assistants (COTA) will be reduced. This change to reimbursement will require other changes to claims processing, including a means of designating the appropriate provider.

The BBA requires payment for services furnished in whole or in part by a therapy assistant at 85% of the applicable Part B payment amount for the service effective January 1, 2022.

In order to implement this payment reduction, the law requires two new modifiers:

- -CQ—To be used for reporting outpatient PT services furnished in whole or in part by a PTA
- -CO—To be used to report outpatient OT services furnished in whole or in part by an OTA

CMS clarified that to qualify as “in part,” the assistant must provide more than 10% of the reported therapy service. “We’re still not clear what this means. If an OTA provides services for three units and the OT provides services for one unit, does that entire treatment get reduced by 15% or just the three units that the assistant provided? We don’t know,” says McDavid.

This requirement is being finalized in a de minimis (too minor to merit consideration) standard in which CMS clarifies the definition of services furnished “in part” to mean more than 10% of the services being furnished, as
opposed to their previous definition, which allowed for any minute of a therapeutic service furnished by a PTA or OTA to be considered “in part.” These modifiers will be used alongside the existing therapy modifiers to report all PT, OT, and SLP (i.e., -GP, -GO, and -GN) and are to be appended on the same line of service as the respective PT or OT modifiers.

Modifiers -GP, -GO, and -GN will continue to be in effect, unmodified, as follows:

- **-GP**—services delivered under an outpatient PT POC
- **-GO**—services delivered under an outpatient OT POC
- **-GN**—services delivered under an outpatient SLP POC

CMS anticipates addressing application of the therapy assistant modifiers and the 10% standard more specifically, including their application for various scenarios and types of services, in rule-making for 2020.

“There doesn’t appear to be a repeal coming of the assistant piece, simply because this methodology has been around for two decades in other parts of Medicare payment with physicians and physician assistants. If you look at the way physician assistants are paid, it mirrors this 85%,” says McDavid.

“I think what will happen in 2025 when the payment actually starts to change will be somewhat predicated on what happens in the next year and a half in the staffing market for therapists. I think we’re going to see some therapy volume on the Part A side be reduced because of the Patient-Driven Payment Model. With volume going down, we may also see therapy pay rates be re-diced, and facilities that have had a hard time finding therapists in the past may no longer have that problem,” he says.

McDavid also points out that some nursing home software may need to be updated to accommodate the added modifiers for therapy assistants.

Note that the reduced payment amount for such outpatient therapy services is applicable to payment made to therapists in private practice, as well as payment to providers that submit institutional claims for therapy services such as outpatient hospitals, rehabilitation agencies, SNFs, home health agencies, and comprehensive outpatient rehabilitation facilities. The reduced payment rate for outpatient therapy services when furnished in whole or in part by a therapy assistant is not applicable to outpatient therapy services furnished by critical-access hospitals.

### Removal of functional reporting requirements

The Middle Class Tax Relief and Jobs Act required that data be collected regarding beneficiary function during the course of therapy services. This requirement assisted Medicare in understanding the beneficiary’s condition and outcomes. In the future, the data will be used to improve the therapy payment system.

“The problem with this reporting system was that Medicare didn’t have a mechanism in place for collecting the data,” says McDavid. Instead, Medicare came up with a series of functional limitation items that therapists had to report on at various times throughout the patient’s stay. The way therapists did that was through non-therapy G-codes (CPT® codes) that had no dollars associated with them, but indicated to Medicare the presence of a functional limitation reporting item.

“Medicare was using the billing system to collect outcomes data,” says McDavid, who explains that in some settings, in order for the G-code to go through the system, you had to attach a penny to it. “You wouldn’t get paid the penny—you’d have to write that off—but if you left that penny off, the functional limitation reporting wouldn’t be included on the claim and the claim would be denied.”

Any claims with a date of service before January 1, 2019, filed without these G-codes will not be paid. Effective for dates of service on or after January 1, 2019, HCPCS G-codes and severity modifiers for functional reporting are no longer required on claims for therapy services billed for Medicare Part B.
How VBP, QRP, and Five-Star will be affected by PDPM

Maureen McCarthy, BS, RN, RAC-MT, QCP-MT, DNS-MT, RAC-MTA, President/CEO of Celtic Consulting, advisory board member

With the recent Five-Star Rating System Changes released by the Centers for Medicare & Medicaid (CMS) on March 5, 2019, the agency is one step closer to aligning the skilled nursing facility (SNF) Quality Reporting Program (QRP) and Five-Star Rating System Quality Measures (QM). The changes to the Five-Star Rating System mimic the QRP measures, inclusions, and data points. The Patient Driven Payment Model (PDPM) will likely further align these programs by unifying the minimum data set (MDS) reporting fields. Data collected on the activities of daily living (ADLs) will transition over to Section GG as a resource utilization groups (RUGS) III and IV get phased out of the MDS item sets.

New measures added to quality programs

The Five-Star Rating System program added unstageable pressure ulcers to the pressure ulcer measure, which should further align Five-Star and QRP. Currently, the Five-Star Rating Systems measures your “whole house” by reporting all payer sources and assigning various QMs to both long and short stays, while the SNF QRP program only measures traditional PPS Medicare Part A beneficiaries.

The SNF VBP program is slated to change its only current measure, to the SNF potentially preventable readmission (PPR) measure, similar to the PPR measure under the SNF QRP. CMS can add only one measure per year to the SNF VBP, per the Final Rule. Currently, the readmission measure (RM) proposed for SNF PPR does not include a post-discharge window, which differentiates it from the SNF QRP RM, but instead measures the window beginning at admission to 30-days past admission.

New lessons under PDPM

The PDPM will likely bring additional changes that providers may not have thought of yet, such as determining skilled care coverage. Many times, once a resident is coming off rehabilitative therapy, their skilled care ends as well. Currently, the nurses who determine whether a resident still meets skilled coverage criteria rely on a rehab end date to determine when skilled care will end. Without that landmark to help navigate the waters, many MDS coordinators may find themselves asking, “When does the resident drop down to a level of unskilled services?” Learning where that “skilled line” is may take some getting used to.

The same learning curve can be expected for some therapists as well. Therapists who are newer to skilled nursing or who have not practiced under the cost-based system may find themselves having to relearn how to estimate the number of minutes a resident should be provided to meet their goals for discharge while not overspending per the SNF QRP’s Medicare Spending per Beneficiary (MSPB) measure. In other words, how many minutes will be considered clinically appropriate or sufficient to achieve the following:

- Meet the resident’s needs
- Help the resident achieve his or her goals for admission
- Most importantly, stay healthy out in the community for at least 30 days

Learning how to provide enough care and services to meet the goals for discharge and making sure those goals are achievable will be a major competency under PDPM for SNF staff.
**New measures for Section GG**

CMS has added four new measures related to Section GG in addition to the performance measures for completion. The original SNF QRP measure for Section GG that began October 1, 2016 is the Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631). Providers received credit for completing this measure if they reported the GG information 80% of the time on 100% of the MDS assessments submitted.

The new measures, which began October 1, 2018 are as follow:

- **Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)**
- **Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)**
- **Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)**
- **Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)**

Even though the measure reads inpatient rehab facility (IRF), this measure is being used for skilled nursing homes. Providers will have to learn how these measures will gauge the success of their outcomes.

**The impact Section GG will have on operations**

Once Section G and other RUG III and IV items have been eliminated from the MDF item sets, many providers may have rehab staff completing Section GG, but may not have considered the impact completion of this section will have for residents who are not on therapy caseload. This is an especially important consideration for those providers who outsource their rehab departments to a therapy vendor. Outcomes from Section GG will impact the SNF QRP program as described above, and this section will also impact PDPM through functional score determination for the physical therapy, occupations therapy, and nursing components of the Medicare fee-for-service rates.

Providers need to consider how Section GG data will be collected, by whom, and within what timeline. Additional considerations should include:

- Who will translate those goals to the resident’s care plan
- How will the direct care staff be made aware of what these goals are
- How will they document the resident’s progress toward the goals on a regular basis during the three-day observation periods both upon admission and again at discharge

In order to provide an accurate picture of the resident, the data for Section GG should encompass more than just what is observed in the rehab gym. The resident’s functional status on the nursing unit should also be considered, especially on the off-shifts where care need is generally heavier. Nursing assistants and unit nurses should have input into the resident’s functional status in order to have a well-rounded picture and an accurate care plan. Since data collection tools and policies and procedures will likely need to be updated as well, providers shouldn’t wait too long to address the Section GG process.

As a whole, PDPM is set to begin October 1, 2019 and Requirement of Participation Phase III will be right on its heels effective November 28, 2019. Unlike when PPS and RUGs were introduced in 1998, this means multiple major changes will be happening at the same time. With this payment system change, there are still many changes that haven’t been mastered, fully implemented, or understood by the industry in general. Even though we are only three months into 2019, it’s gearing up to be quite a busy year. Staying up-to-date on the ever-changing Medicare world will take more effort than it ever has in the past. As Bette Davis once said, “Fasten your seatbelts. It’s going to be a bumpy night.”