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Your PDPM Resource

PDPM: DICTIONARY OF TERMS

Clinical Catalyst

A clinical partner to the DOR and treating clinician responsible for facilitating clinical enhancement. Serves as a resource to enhance overall clinical development, growth and excellence of service delivery within assigned setting. Responsible for maintaining clinical resources, organizing clinical education activities, analysis of clinical metrics and development of clinical goals in conjunction with the DOR.

Clinical Extender

Adjunct personnel who safely and effectively furnish therapeutic practices as an adjunct to therapy services. This would include wellness services, rehab aides, and restorative services. They do not meet the definition of a qualified professional per CMS.

Clinical Leader

A treating clinician enrolled in or completed the Bronze, Silver, Gold, or Platinum level clinical leader program. Utilized as a resource by the Clinical Catalyst/CPS/DOR to perform clinical enhancement activities according to their individual skill set and needs of the building/setting.

Clinically Driven Care Path

Clinically driven care path is a resource tool considering patient specific characteristics such as co-morbidities and complex social histories that may impact the patient. This tool is a resource to evidence based on decisions for care frequency and intensity.

CMI: Case-mix Index

Case mix index (CMI) is a relative value assigned by the diagnosis and functional needs of patients for index codes. PDPM uses case-mix index codes for the PT, OT, SLP, Nursing and NTA components, which are independently determined and then summed-up to create the first five characters of the PDPM case mix group code.

Comprehensive Invoicing

How we bill the customer. This may be defined by minutes, diagnosis, CMI or risk-shared model. This may or may not include adjunct services for extenders or other optional services.

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Extender Minutes

All minutes delivered by a clinical extender. Extender minutes are therapeutic practices that can be safely and effectively furnished by non-qualified professional staff. General exercises to promote overall fitness and flexibility and activities to provide repetitive therapeutic practice or general motivation are included in extender minutes. Extender minutes are not recorded on the MDS as therapy minutes; however, may be recorded as contributing to Restorative minutes on the MDS. Extender minutes may be recorded by Aegis and captured for comprehensive invoicing.

Extender Mix

In addition to qualified professional, this is the combination of all individuals assisting in the care provided to patients. This would be further categorized as Aegis employed extenders and Non-Aegis employed extenders.

Functional Clinical Pathway

Clinical progression tool with functional milestones demonstrating the pathway of progression towards a greater independence from the patient's prospective.

HIPPS: Health Insurance Prospective Payment System

Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made.

ICD-10-CM: International Classification of Diseases, Tenth Revision, Clinical Modification

A system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures.

IPA: Interim Payment Assessment

Optional interim payment assessment which is intended to allow SNFs to reclassify patients into a new payment category based on changes in condition.

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Master Clinician

Practicing therapists and therapist assistants who have received advanced training in special clinical areas. While Master Clinicians adhere to the job standards for the position to which they were hired, additional criteria must be met to qualify for and participate in this program.

The Master Clinician works closely with the Clinical Services department and the Area VPs to improve the quality of clinical services. This is accomplished by answering questions from other clinicians, participating in and leading conference calls, hands-on training and demonstration.

Medicare Advantage Plan (Part C)

A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits. Medicare Advantage Plans include:

- Health Maintenance Organizations
- Preferred Provider Organizations
- Private Fee-for-Service Plans
- Special Needs Plans
- Medicare Medical Savings Account Plans

Medicare Special Needs Plan (SNP)

A special type of Medicare Advantage Plan (Part C) that provides more focused and specialized health care for specific groups of people, like those who have both Medicare and Medicaid, who live in a nursing home, or have certain chronic medical conditions.

MDS: Minimum Data Set

The Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. Care Area Assessments (CAAs) are part of this process, and provide the foundation upon which a resident's individual care plan is formulated. MDS assessments are completed for all residents in certified nursing homes, regardless of source of payment for the individual resident.

NTA: Non-Therapy Ancillary

Component of PDPM case mix index that captures reimbursement for resident comorbidities and special treatments.

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OSA: Optional State Assessment

Assessment used by providers to report on Medicaid-covered stays, per requirements set forth by their state. Allows providers in states using RUG-III or RUG-IV models as the basis for Medicaid payment to do so until September 30, 2020, at which point CMS support for legacy payment models will end.

PDPM: Patient Driven Payment Model

The Patient-Driven Payment Model (PDPM) is the proposed new Medicare payment rule for skilled nursing facilities. In PDPM, therapy minutes will no longer be the primary driver of reimbursement. PDPM identifies and adjusts five different case-mix components for the varied needs and characteristics of a resident's care and then combines these with a non-case-mix component to determine the full SNF PPS Per Diem rate for that resident. PDPM will be implemented on October 1, 2019.

POD: Problem Oriented Documentation

An approach to patient care documentation that focuses on the patient's specific health problems requiring immediate attention, and the structuring of a cooperative health care plan designed to deliver care to the specified problems.

Programs of All-inclusive Care for the Elderly (PACE)

A special type of health plan that provides all the care and services covered by Medicare and Medicaid as well as additional medically necessary care and services based on your needs as determined by an interdisciplinary team. PACE serves frail older adults who need nursing home services but are capable of living in the community. PACE combines medical, social, and long-term care services and prescription drug coverage.

QRP: Quality Reporting Program

The IMPACT Act of 2014 requires the implementation of specified clinical assessment domains using standardized data elements to be nested within the assessment instruments currently required for submission by LTCH, IRF, SNF, and HHA providers. The Act requires that CMS develop and implement quality measures from five quality measure domains using standardized assessment data. In addition, the Act requires the development and reporting of measures pertaining to resource use, hospitalization, and discharge to the community.

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Restorative Nursing

Restorative interventions that promote the person's ability to adapt and adjust to living as independently and safely as possible and attain maximum functional potential. The restorative nursing program actively focuses on achieving and maintaining optimal physical, mental and psychosocial function. Measurable objectives and interventions must be documented in the care plan and in the clinical record. Evidence of periodic evaluation by a licensed nurse must be present in the clinical record. Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity. These activities are carried out or supervised by members of the nursing staff. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. For Restorative Nursing care plans to qualify for Medicare reimbursement: There must be 2 or more different Restorative activities at least 6 days per week, each practiced for a total of at least 15 minutes during each 24-hour period.

Section GG: Functional Abilities and Goals

Section GG is a section of the MDS that measures functional abilities and goals. It includes items focused on prior function, admission performance, discharge goals, and discharge performance. Functional status is assessed based on the need for assistance when performing self-care and mobility activities. This data reflects the "usual status" of the patient by blending together data from multiple sources. Section GG is completed for traditional Medicare Part A patients.

Service Delivery Mode

The method of delivery for skilled services to a patient. This is defined by CMS as individual, group, and concurrent.

- **Individual services** are provided by one therapist or assistant to one resident at a time.
- **Concurrent therapy** is defined as the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. Concurrent delivery is not recognized as a delivery mode for Part B residents. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident.
- **Group therapy** is defined for ***Part A*** as the treatment of 2-6 residents, regardless of payer source of other participants, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals. Group therapy is defined for ***Part B*** as the simultaneous treatment of 2-6 residents, regardless of payer source of other participants. The individuals can be, but need not be performing the same activity. The therapist or assistant divides their attention between all participants, and are not supervising any other individuals.

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Skilled Minutes

All minutes delivered by PT, OT, SLP, PTA, or COTA, also meeting the definition of skilled therapy per CMS. This will include all evaluation and treatment minutes (individual, group, and concurrent). Excluded minutes will include hot/cold pack.

Staff Mix

The combination of all qualified professionals participating in the delivery of skilled service. This would include PT, PTA, OTR, COTA and SLP.

State Health Insurance Assistance Program (SHIP)

A state program that receives money from the federal government to provide free local health insurance counseling to people with Medicare.

Telemedicine

Medical or other health services given to a patient using a communications system (like a computer, phone, or television) by a practitioner in a location different than the patient's.

Triple Check Process

Monthly review process completed by SNF to audit patients charts to determine the accuracy and compliance of Medicare billing before it is submitted for payment.

VPD: Variable Per Diem

The SNF PPS is required to pay on a "per diem" basis, which means that there is a payment rate associated with each day of the patient's SNF stay. Since its inception, the SNF PPS has used a constant per diem rate, meaning that the payment rate for each day of the stay is the same, as long as the patient stays in the same payment group. However, under PDPM, an adjustment is applied to certain PDPM components that varies the per diem payment over the course of the stay.

VBP: Value Based Purchasing

The SNF VBP Program focuses on better outcomes and rewards skilled nursing facilities with incentive payments for the quality of care they give to people with Medicare, in particular reducing hospital readmissions. The SNF VBP Program moves CMS toward paying providers based on the quality, rather than the quantity, of care they give patients.

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