Under PDPM, CMS has broken the singular nursing component of RUG-IV into two separate components – Nursing and Non-Therapy Ancillary (NTA) – to adeptly account for the wide-ranging variations within the skilled population. This change represents a very different and much-needed approach to efficiently managing patients with higher complexity and/or multiple conditions. It also opens many doors of opportunity for providers and patients alike. For example, providers will now be able to identify specific groups of conditions – and subsequently build specialized care programs recognized by referring hospitals as best practice.

So this all makes sense, and there's nothing to worry about. Right? Not so fast!

While opportunities certainly do exist, there are (as always!) considerable risks as well. In fact, considering all factors associated with PDPM, it's the NTA component that may be the most changeable (positively or negatively) when it comes to reimbursement impact.

When walking the "risk-reward tightrope," HealthPRO® Heritage suggests you consider the following important factors:

50 Comorbid Conditions…1535 Diagnosis Codes…What did we miss?

Yes, you read that correctly. CMS recently provided the updated comorbid conditions and associated diagnosis codes within NTA.

First of all, if you're new to NTA, welcome to the party. The general method for calculation of any NTA category is as follows:

- Points (1-8) are assigned to specific conditions.
- Points are added together for all conditions.
- The higher the total point value, the greater the CMI.

- As reference, NF is the lowest grouper with a score of 0, NA is highest with a score of 12+.

So with more than 1,500 diagnosis codes, it might seem that most patients would be in higher categories. As it turns out, the Acumen Technical Report (2018, p. 100) found that more than 50% of all patient stays fell into the lowest two categories with a score no greater than 2! To add insult to injury, the CMI for these two categories (NF & NE) is less than 1.0.

We all know our patient populations (and we already suspect the culprit here), but it's critical to continually reinforce the need for **COMPLETE and ACCURATE CODING!** To emphasize, consider this angle:

- *With the RUG-IV system*, all patients are under the single nursing component. With an inaccurate diagnosis code here…a completely missed code from the hospital there… payment is essentially the same.
- *Under PDPM*, reimbursement needed to cover costs associated with care provided for these conditions (coded or not) is -- in some ways – essentially a line item association. If there's no code provided, there will be no reimbursement (even when care occurs and costs are incurred).

Best Practices: What does it look like?

In a world where "*best practice*" is more of a catch phrase than an objective measure, PDPM's NTA will prove to be a testing-ground for providers. The following are but a few examples of how establishing proven methods of *best practices* in clinical care leads to opportunities for forward-thinking providers:

21 – Acute and chronic respiratory failure with hypoxia

Establishing an interdisciplinary protocol and education process related to specific care components for patients with a history of respiratory failure, may catch early warning signs of respiratory distress and limit the need for re-hospitalization. Frequency and timeliness of lab results, OT training with energy conservation techniques, and PT gait/cadence training might be examples of interdisciplinary components.

341 – Type 2 diabetes mellitus with severe non-proliferative diabetic retinopathy with macular edema

Don't stop at the Type 2. There's more to this diagnosis. Nursing can conduct timely blood sugar checks, and dietitians can provide education with diet recommendations to manage blood sugars through conservative methods. Therapy should also ensure the patient can safely navigate environments to complete necessary tasks for returning home, and reduce the risk of falls due to low vision.

6 – Ankylosing spondylitis lumbar region

In many cases, lumbar surgery accompanies this condition during the recent admission. Therapy can ensure educationrelated to a home exercise program and use of adaptive equipment and compensatory techniques to facilitate the patient's transition to the next level of care.

We could certainly share 1,532 more examples, but we'll stop there. Bottom line: All clinical avenues must be incorporated to establish effective *best clinical practice*, which, in turn, if appropriately documented and coded, supports optimal reimbursement.

NTA Smarts

HealthPRO® Heritage suggests: First understand your current facility assessment and build an inventory of staff's skills. It'll be important to create a comprehensive checklist, or "work plan" related to the NTA comorbid conditions to assure competencies are in place to be successful (and to help with Survey readiness, too, by the way!) Click here for more tips related to developing a comprehensive "PDPM Checklist."

HealthPRO® Heritage also offers the following perspective: NTA sets us up for implementing a reimbursement strategy that, likewise, should be tied to a multifaceted cost management strategy, inclusive of:

- **Necessary staffing changes** to care for a higher acuity population;
- **Clinical competencies** needed to ensure your staff are prepared;
- **Readmission mitigation strategies** to ensure you don't lose 2% through the back door as NTA is bringing increased revenue through the front door;
- **Strong downstream partners** able to care for the same high acuity residents that you're prepared to admit/care for;
- **A therapy provider capable of offering "complementary nursing programs"** to support your nursing team. Wound care, pain management, Parkinson's level programming are a few examples of how rehab partners can support your interdisciplinary team for success under PDPM. Click here for more on this strategy covered in a recent McKnight's article.
- **A specific blueprint for training, support and change in place by Q1 2019**. Prepare your team to follow a well-designed, actionable plan for Q2 thru Q4 2019 to assure success. Timing is everything!

Parting Thoughts

Beyond simply prepping for PDPM success, providers who work NOW to establish these *best practices* and incorporate these strategies associated with NTA will reap other rewards, too. Consider the advantage of how these changes will also impact Quality Measures, support value-based purchasing practices, and prepare your facility to take on higher acuity residents without increasing risk of hospital readmissions. Win-win-win.

Need more guidance? Or support to execute on these strategies and initiatives? Or, perhaps, you recognize a need to change therapy partners to one that is well-prepared to help you through this transition? Many SNF leaders like you have placed their trust in HealthPRO® Heritage. Whether through our consulting offerings, meet the team here, or our proven approach to therapy management, we've got your back!

Questions and feedback? Contact us: clinicalstrategies@healthpro-heritage.com

PREPARE. EXECUTE. SUCCEED.

HealthPRO® Heritage is a trusted, consultative partner leading the industry in PDPM readiness. Our deliverables: strategy, education, and execution on key clinical competencies that are crucial to PDPM success.

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