

WOUNDS

A Hidden Gem For Reimbursement Under PDPM

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As providers prepare for and transition into the Patient Driven Payment Model, or PDPM, there are many questions surrounding effective and efficient operations and delivery of care under the new model. With so many aspects of the payment structure shifting significantly, providers need to consider new targets other than therapy minutes to achieve appropriate and adequate reimbursement. While CMS has touted PDPM as a “revenue neutral” payment shift, for the large majority of providers, PDPM equals a reimbursement reduction, unless significant changes are enacted. Some of the key new targets are more obvious, such as capturing Non-Therapy Ancillary (NTA) points, documenting accurate Section GG data, and choosing the correct primary ICD-10 code. However, there are other important aspects of care and documentation that can have a tremendous impact on the accuracy of reimbursement. Wound management, documentation, and treatment are all critical elements for capturing appropriate Nursing RUG levels and NTA RUG levels under PDPM.



“Almost since its inception, the SNF PPS has been criticized for encouraging the provision of unnecessary rehabilitation therapy services and not accurately targeting payments for Non-Therapy Ancillary (NTA) services.”¹ Per CMS, the NTA RUGs were designed to capture “certain comorbidity conditions and extensive services [that] were highly predictive of relative differences in resident NTA costs.”² Wounds are one of the many elements that impact NTA points and can be captured in a few different ways for

the Non-Therapy Ancillary RUGs. Table 1 shows a comprehensive list of the NTA points that can be impacted by residents with a wound. For example, a diabetic foot ulcer, documented on the MDS under item M1040B, results in one (1) NTA point. However, a resident with this diagnosis would also have a diagnosis of diabetes, which yields two (2) additional NTA points. Another NTA point is assigned if the resident has either of these items documented on Section M1040 on the MDS: Foot Infection Code OR Other Open Lesion on Foot Code. The highest stage of pressure ulcer, a Stage IV ulcer, is captured on the MDS in Item M0300X1 and also adds one (1) NTA point. An infection in a wound that is clearly documented in the chart and captured on the MDS in Item I2500 yields 2 additional NTA points.

Table 1: NTA Points for various wound-related conditions:

Condition from NTA Table	MDS Item	NTA points
Diabetic foot ulcer	M1040B	1
Active Diagnosis of Diabetes	M12900	2
Other Ulcers, Wounds, Skin Problems: Other Open Lesion on Foot OR Foot infection	M1040 A or C	1
Stage IV pressure ulcer	M0300X1	1
Wound Infection	I2500	2

For many residents with wounds, there will be a cumulative effect of multiple NTA items adding points (see examples below in Table 2). For example, Resident A who has a diagnosis of diabetes and also has an infected foot wound would receive 5 NTA points for that one wound (diabetic diagnosis, infected wound, diabetic foot ulcer). Resident B with an infected Stage IV buttock wound would receive 3 points for that wound (wound infection and Stage IV wound). Resident C who is diagnosed with a Stage IV pressure wound on the foot would yield 2 NTA points. Providers will need to be diligent in carefully examining the chart and documenting wounds accurately so that all potential NTA points can be accurately captured. Wound rounds are essential for all skilled-care communities and can help to prevent avoidable wounds, which promote improved quality measures. Some of the key quality measures beyond PDPM that effective wound management can impact include: worsening pressure ulcer, reports of moderate to severe pain, ability to move around more independently, rate of hospital readmissions, and rate of successful return to home.

Table 2: Cumulative effect of wound documentation on NTA scoring:

Resident A	NTA Points	Resident B	NTA Points	Resident C	NTA Points
Diabetes	2	Wound Infection	2	Stage IV Wound	1
Diabetic Foot Ulcer	1	Stage IV Wound	1	Foot Wound	1
Wound infection	2				
Total NTA Points:	5		3		4

Additional NTA points do not necessarily guarantee a higher NTA RUG, but often only one additional point may be required to advance to the next RUG level. In Table 3 below, the NTA RUGs, with NTA point scores and daily urban and rural rates, are shown. The increased variable per diem NTA Rate, which is tripled on Days 1, 2 and 3 of the skilled stay, are also included. An examination of these rates shows that on days 4-100 of the skilled stay, the impact of changing from one NTA RUG to the next can impact payment by \$19.08 to \$55.81/day. Over an 18-day average length of stay for skilled residents, this could yield additional revenue in just the NTA per diem rate of between \$457.92 up to \$1,340.16 for one resident who was able to increase the NTA RUG scores due to accurate wound documentation.

NTA Component			Daily NTA Urban	Variable Rate on Days 1,2,3	Daily NTA Rural	Variable Rate on Days 1,2,3
NTA Comorbidity Score	NTA Case Mix Group	CMI				
12+	NA	3.25	\$ 253.65	\$ 760.96	\$ 242.31	\$ 726.93
9-11	NB	2.53	\$ 197.84	\$ 593.53	\$ 189.00	\$ 566.99
6-8	NC	1.85	\$ 144.51	\$ 433.52	\$ 138.05	\$ 414.14
3-5	ND	1.34	\$ 104.54	\$ 313.63	\$ 99.87	\$ 299.61
1-2	NE	0.96	\$ 75.31	\$ 225.93	\$ 71.94	\$ 215.83
0	NF	0.72	\$ 56.22	\$ 168.66	\$ 53.71	\$ 161.12

Beyond NTA, the Nursing PDPM RUGs can also be impacted by the presence of wounds and sufficient documentation in the medical record. With the PDPM Nursing RUGs, CMS wanted to classify: "Residents into non-rehabilitation RUGs to develop a proposed nursing classification that helps ensure nursing payment reflects expected nursing utilization rather than therapy utilization... We believe that classifying the residents in this

manner for payment purposes would capture variation in nursing costs in a more accurate and granular way than relying on the rehabilitation RUG's nursing CMI."² Wounds can be captured for additional revenue if they result in a higher Nursing RUG than would otherwise be obtained. For example, a resident in the "Physical Functioning Reduced" Nursing RUG with a RUG of PBC2 would receive a PDPM CMI of 1.21, which would provide \$125.19 per diem. However, if that same resident developed a Stage III or IV pressure ulcer they would advance to an LBC2 Nursing RUG, with a CMI of 1.71, yielding \$171.92 per day. Over an average 18-day length of stay, this would impact



overall reimbursement by \$841.14. Similarly, if a resident in receiving a "Behaviors and Cognitive Performance" Nursing RUG of BAB1 developed two or more Stage II ulcers, this would also advance their nursing RUG to LBC2. This higher nursing RUG would yield an additional \$74.49 per day, which would provide an additional \$1,430.82 in reimbursement over an 18-day length of stay.

There are times when a wound would not impact payment. For example, if a resident was already skilled in the Special Care Low, Special Care High or Extensive Services RUGs, they are already receiving the same or higher payment regardless of the wounds. However,

providers will want to continue to give accurate wound documentation in the chart and on the MDS. As resident needs and clinical indicators can shift over the course of the stay and even if the wound didn't impact payment upon admission, it may affect reimbursement if an Interim Payment Assessment (IPA) is indicated. Additional wound-based items that can place a resident in the Special Care Low RUG include:

- **2 or more skin treatments with:**
 - 2 or more venous/arterial ulcers
 - 1 Stage II pressure ulcer and 1 venous/arterial ulcer
- **Diabetic foot ulcer**

On the other side, providers must be cautious and ensure that documentation demonstrates evidence to support the NTA RUG and Nursing RUG that are achieved on the MDS. For example, if a wound was communicated as being at a Stage IV in the morning stand-up meeting, but was only documented as a Stage III in the most recent wound documentation, then capturing it as a Stage IV on the MDS could result in a denial of the higher Nursing RUG and NTA RUG. Since wound documentation is now directly tied to actual per diem reimbursement under PDPM, providers can expect that CMS, the OIG and Utilization Review Groups will be closely monitoring the

documentation of wounds for accuracy. Incorrect or missing documentation could result in a denial or request for repayment.

In light of this, some providers may benefit from instituting a standardized approach to wound care and working with a specialty Wound Physician Practice. A dedicated Wound Physician Consultant can coordinate with internal teams and allows for a physician to oversee the treatment and accurate documentation of wounds. Additionally, these specialized physicians are trained in effective surgical debridement techniques, which can both accelerate the healing and also ensure that more accurate staging of the wound is documented. This allows for correct



diagnosis coding and can help achieve the most appropriate reimbursement for that wound. Another benefit to utilizing a Specialized Wound Physician Group is that these physicians have well established, evidenced-based treatment protocols that improve outcomes, reduce wound healing time, and help to prevent the onset of new wounds. A study from Ostomy and Wound Management in September of 2010 showed that Skilled Nursing Communities that used Wound Physicians saw a reduction in rehospitalizations, improved wound healing time by 21 days and cut Medicare expenses by almost 50% for the beneficiary on average.³

As we shift into PDPM, new concerns will become likely targets for the Office of Inspector General and CMS in their ongoing efforts to prevent, detect and reduce fraud. Providers should work diligently to ensure that documentation for all items that contribute to revenue under PDPM is accurate, especially those key items that increase revenue. Since the impact of wound documentation can affect both the nursing and NTA RUGs, providers should look for solutions to promote uniformity of documentation and staging of wounds. Utilizing a Specialized Wound Physician provider could improve the quality and consistency and inter-rater reliability. Appropriate Wound Physicians should have extensive training in proper staging, according to CMS standards, and can provide the supportive documentation and ICD-10 coding required to help your community fight a denial and avoid a deficiency during state survey. Additionally, proper standardized wound documentation can support the correct coding on the MDS, which will yield the most appropriate and accurate per diem rate, consistent with the amount of services that are being provided.

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Under PDPM, therapy will no longer drive reimbursement. Instead, it will supplement the overall per diem rate. CMS completed extensive research to determine the correct resident classifiers, conditions and extensive services that are correlated with increased expenses for the provider and set the Nursing and NTA RUGs accordingly. Providers will need to work closely with their teams and consider supplementing their wound strategy with Specialized Wound Physicians to promote accurate and sufficient reimbursement under PDPM.

References:

1. Government Accountability Office 2002, Government Accountability Office 1999, White et al. 2002; [http://medpac.gov/docs/default-source/reports/chapter-7-skilled-nursingfacility-Medicare-Program;Prospective-Payment-System-and-Consolidated-Billing-for-Skilled-Nursing-Facilities-\(SNF\)-Proposed-Rule-for-FY-2019,-SNF-Value-Based-Purchasing-Program,-and-SNF-Quality-Reporting-Program;https://www.federalregister.gov/public-inspection/current](http://medpac.gov/docs/default-source/reports/chapter-7-skilled-nursingfacility-Medicare-Program;Prospective-Payment-System-and-Consolidated-Billing-for-Skilled-Nursing-Facilities-(SNF)-Proposed-Rule-for-FY-2019,-SNF-Value-Based-Purchasing-Program,-and-SNF-Quality-Reporting-Program;https://www.federalregister.gov/public-inspection/current)
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3. DaVanzo, et. al, A Retrospective Comparison of Clinical Outcomes and Medicare Expenditures in Skilled Nursing Facility Residents with Chronic Wounds, Ostomy and Wound Care, September 2010; <https://vohra-public.s3.amazonaws.com/file/2019/01/04/fQOMmqCuX6D4tmKH0je3nqQzO0sjreCvpPtU06C.pdf>

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