



From Quantity to Quality: PDPM's Assessment Schedule

Over the years, the burden associated with the current Medicare required assessment schedule has become “just part of the job.” Staffing of the MDS office is largely driven by Medicare part A census because all residents admitting to a facility for a skilled part A stay will receive a 5 day assessment and depending upon their length of stay may also have a 14-day, 30-day, 60-day, and 90-day assessment. In addition, changes in the delivery of therapy services must be reflected by completing one of four other Medicare required assessments (OMRA) including a start of therapy (SOT), end of therapy (EOT), both start and end of therapy, or a change of therapy (COT) assessment. Finally, facilities must comply with the Federal Omnibus Budget Reconciliation Act (OBRA) required assessment schedule.

CMS has boasted The Patient Driven Payment Model (PDPM) will reduce provider burden by implementing a significantly reduced required assessment schedule outlined as:

5-day Scheduled PPS Assessment | Completed days 1-8 | Covers payment for ALL Part A days

PPS Discharge Assessment | Set as Medicare A stay end date | Does not affect payment.

In addition to all OBRA requirements remaining the same, the Medicare required PPS assessment schedule consists of these two assessments. That's it. CMS does acknowledge that changes in the resident's clinical condition may affect resource use; therefore, they have created an **optional** Medicare assessment:

Interim Payment Assessment (IPA) | Date facility chooses | Payment begins same day as ARD.
(triggering event)

CMS has reiterated the IPA is an **optional** assessment to be initiated at the discretion of the provider. They have not equated it to an OBRA significant change in status (SCSA), as an IPA is a payment assessment and therefore contains only the items sets which affect the clinical classifications of PDPM. It's also important to note the completion of an IPA does not “reset” PDPM's variable per diem calendar.

Remember, the first three days of the Medicare stay will reflect the Non-Therapy Ancillary (NTA) component reimbursed at three times the daily rate. So, while completion of an IPA may reflect changes in the residents functional score, cognitive performance score, swallowing status, clinical categories, or active comorbidities, the IPA should not be used as a form of correction for the 5-day. Therapy and nursing's active involvement from the time of admit will help ensure this accurate coding to capture all appropriate comorbidities.

Accurate, comprehensive coding on the 5-day will be the distinguishing factor in PDPM success. The industry shift from payment based on quantity to the quality of care delivered is easily identified in this new assessment schedule. Facilities should begin evaluating current MDS assessments. Consider whether they paint an accurate picture and reflect all active conditions appropriately. Engage facility partners such as your therapy team to support the MDS team by communicating evaluation findings. Timely and efficient completion of the MDS is necessary, but accuracy and quality **MUST** be recognized as just as important.