THERAPY MANAGEMENT, INC.

BEACON CONSULTING

Building a Championship

PDPM Team

Accurate Reimbursement
Through Intentional Teamwork

Presented by Therapy Management, Inc. & Beacon Consulting

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Today's Game Plan

1

Understanding the Field

PDPM structure, case-mix components, and assessment strategy

2

Your Team's Game Plan

The PDPM Huddle — who's on the field and what to review

3

From Practice to Game Day

Case studies, live demonstration, and actionable takeaways

“Failure to plan is planning to fail. Nowhere is this more true than in managing PDPM case-mix.”

SECTION 1 OF 3

Understanding the Field

PDPM Review

PDPM Structure | Case-Mix Components | Assessment Strategy

What Is PDPM?

Patient-Driven Payment Model

- Uses MDS resident data to predict expected daily cost of care
- CMS analyzed historical SNF claims to identify which clinical characteristics drive spending
- Payment adjusts over the length of stay via variable per diem

PDPM in Numbers

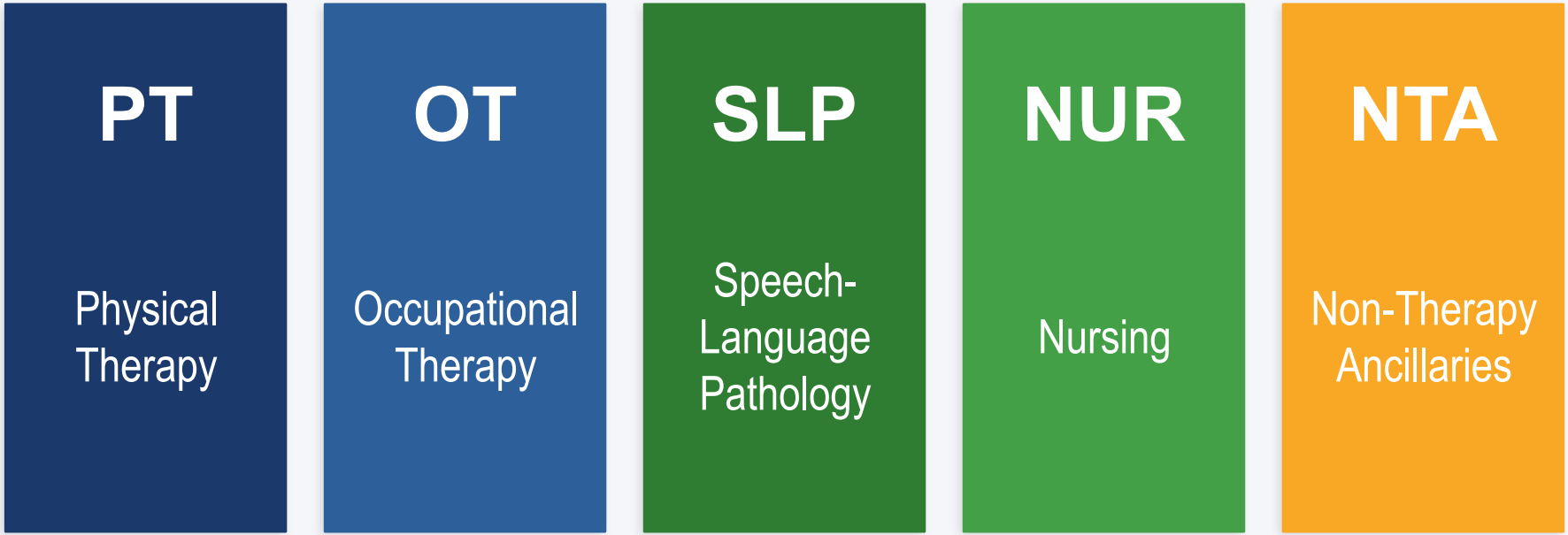
6
Payment Components

5
Case-Mix Adjusted

70,000+
ICD-10 Codes Mapped

1
Non-Case-Mix Component

The Five Case-Mix Adjusted Components



+ One Non-Case-Mix Adjusted Component covering SNF resource utilization that does not vary by patient

PT/OT CMG: Key Drivers

Primary Diagnosis	Prior Surgery	Therapy Function Score
Maps to one of 4 Clinical Categories	**Major surgery may trigger a surgical upgrade**	**GG score: 0 (dependent) to 24 (independent)**
Return to Provider codes pay nothing.	Upgrade when major surgery is accurately coded on the MDS.	Calculated from GG self-care & mobility items

The 4 PDPM Clinical Categories — PT/OT

Major Joint Replacement or Spinal Surgery
Highest paying PT/OT category — requires accurate diagnosis AND surgical coding

Other Orthopedic
Fractures, dislocations, and other musculoskeletal conditions

Medical Management
Non-surgical medical conditions driving skilled PT/OT need

Non-Orthopedic Surgery & Acute Neurologic
Includes stroke, TBI, and non-orthopedic surgical procedures

🏈 COMMON FUMBLE — PRIMARY DIAGNOSIS CODING

Wrong ICD-10 Code = Wrong Clinical Category

Result: $500 revenue loss for the facility on a single admission

⚠️ INCORRECT CODE

ICD-10-CM Code	ICD-10-CM Code Description	Default Clinical Category
M17.11	Unilateral primary osteoarthritis, right knee	Non-Surgical Orthopedic/Musculoskeletal

⬇⬇⬇⬇ Correct the code to ⬇⬇⬇⬇

✅ CORRECT CODE

ICD-10-CM Code	ICD-10-CM Code Description	Default Clinical Category
Z47.1	Aftercare following joint replacement surgery	Major Joint Replacement or Spinal Surgery

PT/OT CMG: Key Drivers

Primary Diagnosis	Prior Surgery	Therapy Function Score
Maps to one of 4 Clinical Categories	**Major surgery may trigger a surgical upgrade**	**GG score: 0 (dependent) to 24 (independent)**
Return to Provider codes pay nothing.	Upgrade when major surgery is accurately coded on the MDS.	Calculated from GG self-care & mobility items

MISSED SURGICAL UPGRADE — ICD-10 SPECIFICITY FUMBLE

Coding to the Wrong Level of Specificity

Result: $16–$25/day difference in PT/OT per diem — surgical upgrade missed

⚠ REPORTED THIS — Insufficient Specificity

ICD-10-CM Code Description	Default Clinical Category	Resident Had a Major Procedure during the Prior Inpatient Stay that Impacts the SNF Care Plan?
Unspecified fracture of right femur, subsequent encounter for closed fracture with routine healing	Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	N/A

⬇⬇⬇⬇ Should have coded to ⬇⬇⬇⬇

✅ CORRECT CODE — Supported by Documentation

ICD-10-CM Code	ICD-10-CM Code Description	Default Clinical Category	Resident Had a Major Procedure during the Prior Inpatient Stay that Impacts the SNF Care Plan?
S72.001D	Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing	Non-Surgical Orthopedic/Musculoskeletal	May be Eligible for One of the Two Orthopedic Surgery Categories

PT/OT CMG: Key Drivers

Primary Diagnosis	Prior Surgery	Therapy Function Score
Maps to one of 4 Clinical Categories	**Major surgery may trigger a surgical upgrade**	**GG score: 0 (dependent) to 24 (independent)**
Return to Provider codes pay nothing.	Upgrade when major surgery is accurately coded on the MDS.	Calculated from GG self-care & mobility items

Therapy Function Score: Section GG

- Usual performance — not best performance — is what's coded
- **This is an IDT responsibility, not therapy alone**

Score Range 0 — 24
06 — Independent
05 — Setup Help Only
04 — Supervision/Touching Assistance
03 — Partial/Moderate Assistance
02 — Substantial/Maximal Assistance
01 — Dependent

SLP CMG: Key Drivers

1. **Primary Diagnosis**
   Acute Neurologic conditions drive SLP classification
2. **Active SLP Comorbidities**
   Documented conditions that support SLP medical necessity
3. **Impaired Cognition**
   BIMS score from Section C — IDT coordination critical
4. **Swallowing Disorder Indicators**
   Coughing, choking, holding food in mouth, complaints of difficulty swallowing
5. **Mechanically Altered Diet**
   Coded in Section K — dietary must communicate SLP findings

COMMONLY DROPPED PASS — SLP CMG CODING

Missed SLP Revenue: $15–$90/Day

FUMBLE 1: Incorrect ICD-10 Coding	Acute Neurologic diagnoses drive SLP classification. Incorrect or missing primary code costs $15–$90/day for the entire Medicare stay.
FUMBLE 2: Insufficient Swallowing Disorder Documentation	Swallowing indicators must be assessed and documented by ALL team members, not SLP alone.
FUMBLE 3: IDT Communication Breakdown	Lack of clear communication between **SLP and Dietician/CDM** results in miscoding of Section K, directly impacting the SLP CMG.

SCENARIO

SLP Case Discussion

The Resident

80 y/o post-stroke. Acute CVA (Acute Neurologic). Aspiration pneumonia history. BIMS = 9.

The Questions

Who catches the swallowing indicators? Who codes Section K — and when?

The Impact

Miss the diagnosis or the diet texture, and the SLP CMG drops.

Discussion:

Walk through who communicates what — and when — for this resident.

Nursing CMG: Key Drivers

Classification Factors

- Nursing Function Score
- Depression Score (PHQ)
- Restorative Nursing Count

Key Principle:

Residents are always classified into the highest applicable group.

The 6 Nursing Groups

1. Extensive Services
2. Special Care High
3. Special Care Low
4. Clinically Complex
5. Behavioral Symptoms & Cognitive Performance
6. Reduced Physical Function

NTA CMG: Non-Therapy Ancillaries

We don't get paid for diagnoses.
We get paid for the CARE associated with the diagnosis.

NTA classification is driven by:

Conditions	Extensive Services
Diagnoses and clinical conditions that require ancillary services (pharmacy, lab, supplies)	IV meds, IV fluids, tracheostomy, ventilator, isolation— document and order each one

NTA Variable Per Diem

Weighted more heavily in the first 3 days — when ancillary costs are highest. Day 1 documentation matters.

Required PPS Assessments

5-Day Assessment (Payment)

ARD Window:
Days 1–8 of the Medicare Part A stay

- Adjust ARD within the window to capture IVF, status changes, or new documentation
- Avoid one-size-fits-all ARD scheduling — every resident is different

Part A PPS Discharge (Quality Reporting)

Completed at end of Medicare Part A.

Optimal ARD scheduling is one of the highest-impact actions for accurate reimbursement.

The IPA: Your Secret Weapon

Interim Payment Assessment

✓ Optional — but strategically critical

✓ Complete when new diagnoses or services INCREASE the CMG(s)

✓ More support for residents = more reimbursement. That's the IPA.

! No routine IPAs = #1 sign of a broken PDPM oversight process

! The huddle exists to catch IPA opportunities. That's why it matters.

SECTION 2 OF 3

Your Team's Game Plan

The PDPM Huddle

Who's on the Field | What to Review | Why It Matters

What Is the PDPM Huddle?

Align the team. Get PDPM right. Protect revenue.

Two Critical Huddle Functions:

Admission Projection

Ensure each new admit is coded right from Day 1

→ Identify missing documentation
→ Set expected CMG

Ongoing IPA Review

Catch changes across the caseload

→ New conditions or services
→ Trigger IPAs when needed

Who Should Be On the Field?

Nursing

DON / Unit Managers

Social Services

Cognition, Mood, Behaviors

Dietary

Nutrition, Swallowing

Therapy

PT, OT, SLP

MDS Coordinator

Subject-Matter Expert

Physician Services

Documentation accuracy

Administrator

Removes barriers

Nursing: Conditions That Impact Payment

Chronic Conditions

- Diabetes Mellitus
- Chronic lung diseases (COPD, asthma)
- Parkinson's disease
- Respiratory failure
- Multiple Sclerosis
- Morbid obesity

Infections

- Pneumonia
- Foot infections
- Wound infections
- MDROs
- Opportunistic infections

Wounds & Skin

- Pressure ulcers (stage matters!)
- Venous ulcers
- Burns
- Diabetic foot ulcers
- Surgical wounds

Wound Classification: Why It Matters

Not all wounds are equal — and neither are their CMG implications.

Stage 3, 4, or Unstageable — Higher Payment

- Full-thickness tissue loss
- Special Care Low nursing group

Often miscoded as Stage 2 = costly miss

Stage 2 Pressure Ulcer — Lower Payment

- Partial thickness skin loss
- Clinically Complex nursing group

Document wounds separately

The huddle is where these distinctions get caught before the MDS is submitted.

Nursing: Extensive Services

These services must be actively ordered and documented — not just assumed:

Oxygen Therapy
Defensive documentation required – orders in place, routine documentation

Ostomy Care
Active orders for care and documentation to support

Isolation
Orders and documentation to support in place

Tracheostomy Care
Skilled care documentation essential

IV Medications
Most common NTA driver — accurate to the day

IV Fluids / Hypodermoclysis
Often missed — ensure indication is noted

Enteral Tube Feeding
Goal-directed orders with nutrition support documentation

Dialysis
Ensure documentation supports as received — impacts nursing CMG

Nursing: What Documentation Is Needed?

GG Functional Performance	Physician Orders	Nursing Assessments
IDT responsibility — not therapy only	Indications must be clearly stated	How you document determines how you get paid

Documentation Pitfalls to Raise in the Huddle:

⚠ Combining separate wounds into one

⚠ Orders without indications

⚠ Partial thickness wounds vs. full thickness pressure injuries

Social Services & Dietary: Huddle Roles

👥 Social Services

Cognition — BIMS (Section C)

Depression — PHQ (Section D)

Behaviors & Mood (Section E)

🍽 Dietary

Diet Order (Section K)

Swallowing Disorder Indicators

BMI & Malnutrition Risk

Therapy's Role in the Huddle

Function Score Projection

Share GG findings with IDT – collaborative, not a solo calculation.

BIMS Contribution

Share cognition observations from sessions to inform Section C coding

Swallowing Indicators

Coughing, choking, wet voice, complaints of difficulty swallowing - tell dietary before Section K is coded.

Diagnosis Validation

Flag new clinical observations to MDS coordinator - Parkinson's, new weakness, cognitive changes.

The MDS Coordinator =

The Quarterback

Subject-Matter Expert

Maps every data point to a CMG — the coding authority.

Puts the Puzzle Together

Translates IDT input into defensible MDS coding.

Leads the Huddle Conversation

Forecasts CMGs in real time. Catches gaps before MDS closes.

Guides IPA Decisions

Knows when new conditions warrant an IPA.

Physician Services & Administrative Support

Physician Services

Three non-negotiables:

- Link documentation to reimbursement
- Efficient, timely query process
- Document the diagnosis list

Administrator

Three ways to do it:

- Protect the huddle
- Right people in the room
- Follow through on doc gaps

THE BOTTOM LINE

Why Structured Huddles Matter

- ⚔ Maximizes reimbursement by catching IPA opportunities before the window closes
- ⚔ Ensures accurate CMG projection from Day 1 — preventing revenue leakage
- ⚔ Aligns all disciplines on each resident's clinical picture before MDS coding
- 🛡 Identifies documentation gaps that could trigger denials or audit risk
- 🛡 Creates a defensible record of interdisciplinary clinical decision-making
- 🛡 Ensures the facility takes credit for care it is already providing

SECTION 3 OF 3

From Practice to Game Day

Case Studies & Demonstration

Real Results | Live Demonstration | Actionable Takeaways

Case Study Results: Before & After Structured Huddles

Rate comparisons represent 3–6 month windows before and after implementing structured PDPM huddles.

Center #1	Center #2	Center #3
BEFORE	BEFORE	BEFORE
$573.91	$577.03	$599.1
AFTER	AFTER	AFTER
$653.1	$622.12	$636.7
↑ 13% increase	↑ 7.8% increase	↑ 6.2% increase

Case Scenario: Project the HIPPS Code

Resident admitted post-hospitalization:
Femur fracture, status post surgical intervention.

PT/OT	Primary: femur fracture, s/p surgery. Therapy function score: 10.
SLP	Hemiplegia (2/2 CVA). BIMS score 10. Mechanical soft diet
Nursing	Nursing function score: 7. COPD + continuous O2 (ATC) + routine nebulizer treatments.
NTA	Adult failure to thrive. Poor oral intake. MNA: at risk for malnutrition. Active diabetes mellitus.

HIPPS CODE PROJECTION — WITHOUT HUDDLE

Projecting the Case-Mix Groups

PT/OT CMG
Right femur fracture (other ortho) + Function Score 10

TG

SLP CMG
SLP-related Comorbidity + BIMS 10 + Mech Soft Diet

SH

Nursing CMG
Special Care High: COPD + Function Score 7 + oxygen use/hemiplegia

CBC1

NTA CMG
COPD + DM

ND

HIPPS CODE PROJECTION — WITH HUDDLE

Projecting the Case-Mix Groups

PT/OT CMG
*Right femur fracture (other ortho) + ***Surgical Upgrade*** + Function Score 10*

TC

SLP CMG
*SLP-related Comorbidity + BIMS 10 + Mech Soft Diet + ***swallowing indicators****

SI

Nursing CMG
*Special Care High: COPD + ***SOB while lying flat*** + Function Score 7*

HBC1

NTA CMG
*COPD + DM + ***risk of malnutrition*** + ***chronic resp failure****

NC

Potential Loss Revenue

PDPM huddles align the team to verify documentation and coding in real time, ensuring accurate, compliant PDPM rates.

WITHOUT HUDDLE	WITH HUDDLE
Daily Rate (Days 1 – 3): $851.91 Daily Rate (Days 4 – 20): $612.13	Daily Rate (Days 1 – 3): $1,128.7 Daily Rate (Days 4 – 20): $797.58

Daily Difference: $276.79 (Days 1 – 3)
Daily Difference: $185.45 (Days 4 – 20)

Huddles promote critical thinking and the right questions across the team—everyone plays a role in ensuring accurate, compliant PDPM rates.

Actionable Takeaways

1. Audit your PDPM Huddle — right team, IPAs captured?
2. Review IPA frequency — gaps = revenue lost.
3. Optimize ARD scheduling — not one-size-fits-all.
4. Assess physician documentation and query efficiency.
5. Train your IDT on GG scoring — nursing must be involved.
6. **We’re not asking you to change how you care for residents — just to take credit for it.**

Thank You!

Questions & Discussion

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