Patient Driven Payment Model (PDPM)

New Reimbursement, New Challenges for SNF Providers

Lance Hill, OTR/L, RAC-CT®
Executive Vice President of SNF Operations
Dir. of Regulatory and Clinical Compliance
email: lhill@therapyctr.com

October 2018

This article will address 4 components of PDPM: 1- A brief overview of the PDPM payment model; **2**- New challenges impacting nursing, **3**- Therapy: Debunking myths and therapy's role in PDPM; and finally **4**- What we can do now to begin preparing for change.

Part 3

Debunking Myths and Therapy's Role in PDPM

Therapy under the PDPM model will likely see a drastic change. While the treatment techniques provided to patients will remain mostly unchanged, how therapy is delivered will. Remember PPS rewarded or incentivized Providers for delivering more therapy services. One of the primary drivers for change to the PDPM model surrounds CMS's worry of possible fraud, waste and abuse. CMS believed that increased financial rewards from higher therapy RUG levels at times took precedence over patient need. To combat this, PDPM is outcomes driven, removes much of the incentive to provide more therapy and instead relies on patient condition and functional scores as the primary drivers of reimbursement.

Does that mean that you will no longer need therapy in your facility? The answer is NO! CMS has explicitly stated that under PDPM the expectation is that the patient will not see significant changes in the delivery of services. The expectation that patient outcomes will either remain at the same level or even improve is central to CMS's decision to switch from PPS. What this means is that if a patient is receiving therapy at a Rehab Very High Level or 500 minimum minutes per week, then the expectation is that under PDPM, a level of therapy care will need to be delivered that will yield the same or better outcomes than under the PPS RV category. Section O of the MDS will also receive modifications and will be the instrument CMS uses to insure that the delivery of therapy care does not suffer under PDPM. The new Section O on the Discharge MDS will track therapy start date, therapy end date, minutes of therapy provided (Individual + Group + Concurrent) by discipline and how many total days by discipline the patient receive each therapy service. CMS has made it clear in the final rule that they will monitor the provision of therapy and expects that there will not be a significant decline in minutes provided.

CMS has stated that if they see a significant decline in provided therapy minutes, they could use this as justification to reduce payments in future years. It is not recommended to have a radical shift in therapy delivery.

One of the areas that CMS has included in the PDPM model is that will impact the delivery of therapy is to make concurrent and group therapy less restrictive than it currently is under PPS. Both group and concurrent therapy are allowed under PPS however, benefits for clinician's to use these treatment categories is either nil or actually increases their risk of denial. With PDPM, group and concurrent therapies will see a comeback to a maximum of 25% of the

patient's *overall treatment minutes*. This will need to be monitored carefully by your rehab team; going over the 25% threshold will result in payment denials. RUG levels will go away and will be replaced with 3 case mix silos. One for OT, one for PT and another for ST.

As opposed to the 41 specific rehab RUG's under PPS, there will now be hundreds of possible case mix combinations. Like nursing, coding accuracy will be a critical component to maximizing reimbursement and balancing the level of care that each patient needs.

How We Can Prepare Now

Although PDPM is a year away, there are definite item that we can work on today to prepare for October, 2019. Establishing processes and investment in education today will pay huge dividends when PDPM is implemented. Where to start?

ICD 10 Coding Accuracy: **[Importance- CRITICAL]** Coding accuracy can determine success or failure in PDPM. Unlike PPS where more care equaled more reimbursement, PDPM starts with the patient being categorized into a Medical Classification based on ICD 10 coding. Missing key ICD 10 codes can result in a patient being incorrectly categorized resulting in decreased payment. Certain comorbidities also give financial benefits if present so it is essential that these are captured on ADMISSION. Remember that the number of required assessments will decrease and CMS has stated that IPA's or Interim Patient Assessments should not be used to correct mistakes. Collecting accurate and complete data on admission is essential when managing the bottom line on Part A patients.

One of the major challenges that a SNF Provider faces is information on admission. It is highly recommended that education begins now. Having dialog with hospitals, discharge planners and most importantly physicians and educating on the importance of detailed and accurate coding will not only save countless headaches but will position you to be highly successful under the PDPM payment model.

Physician Education: **[Importance- CRITICAL]** Even though this was just mentioned, physicians will be essential to your success under PDPM and their importance cannot be stated enough. Incomplete, vague, or incorrect coding will cost you valuable reimbursement dollars. Success under PDPM starts with proper classification into one of the 10 Clinical Categories. Having physicians onboard, educated and fully understanding the value of correct coding will position you to best succeed under the new payment model.

Care Team Education: **[Importance- VITAL]** Building systems in preparation of PDPM will ensure a smooth and easy transition. In order for this to happen however, all members of the Care Team must know their new roles and educate themselves to expectations. Your MDS Coordinator as relayed earlier holds a very important role to facilitate accurate information to the MDS. The information transmitted on the MDS will be vital in ensuring that you are paid for the services provided but also ensuring that you stay paid. Communication between Therapists, Nursing, Social Services, Dietary and CNA's needs to be cultivated. Missed information can lead to missed items on the MDS translating into missed revenue. Section GG is another vital area of importance. It is recommended that education be provided on how to properly code GG. The MDS Coordinator will need to be well versed in Section GG as they will be the person to make the final determination as to what is the patient's "Usual". Good communication between all members of the care team will help insure that the MDS is accurate on submission.

This concludes Part 2 of the PDPM article. Stay tuned for Part 3: Therapy: Debunking Myths and Therapy's Role in PDPM
Read this article online here, www.therapyctr.com/pdpm2018_part3/