The Patient-Driven Payment Model (PDPM): Clinical Strategies for Therapists and Assistants

Michael McGregor, PT, DPT, CEEAA
Tammy Faircloth, RN

North Carolina Physical Therapy Association
Fall Conference | October 4, 2019

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Objectives

- Understanding the key components of PDPM and its impact on skilled nursing center reimbursement
- Describe the role of the PT in assessing function and scoring Section GG accurately
- Discuss and collaborate on best practices for optimal inter-professional management of the patient
- Identify effective and efficient clinical strategies, with an emphasis on patient’s outcomes, under PDPM
- Explore and examine opportunities for PT’s to be embraced as leaders in care management of our patients in the skilled nursing center in this new model

PDPM Components

PDPM consists of five case-mix adjusted components, all based on data-driven, stakeholder-vetted patient characteristics:

- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Language

PDPM also includes a "Variable Per Diem (VPD) adjustment" that adjusts the per diem rate over the course of the stay.

PDPM Snapshot

The Patient Driven Payment Model (PDPM), which went into effect October 1, 2019, will improve payments made under the SNF PPS in the following ways:

- Improves payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided
- Significantly reduces administrative burden on providers
- Improves SNF payments to currently underserved beneficiaries without increasing total Medicare payments

Skilled, reasonable and necessary care
- 90 days per week for nursing
- 90 days per week for rehab

Qualifying hospital stay
- 90 midnight stay

Benefit period
- 100 potential SNF days

Spell of wellness
- After 60 days of no need for skilled level of care, a new allocation of 100 SNF days are available

Physician certification of care

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PT & OT Functional Score

The Patient-Driven Payment Model (PDPM) advances CMS’ goal of using standardized assessment items across PAC settings, by using items in Section GG of the MDS as the basis for patient functional assessments. The functional score for the PT & OT components is calculated as the sum of the scores on ten Section GG items in GG013o & GG017o:

- One eating item
- One oral hygiene item
- Two bed mobility items
- One toileting item
- Three transfer items
- Two walking items

PT & OT Functional Score: GG Items

<table>
<thead>
<tr>
<th>Section GG Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>GG0130A1 Eating</td>
<td>0–4</td>
</tr>
<tr>
<td>GG0130B1 Oral Hygiene</td>
<td>0–4</td>
</tr>
<tr>
<td>GG0130C1 Toileting</td>
<td>0–4</td>
</tr>
<tr>
<td>GG0130D1 Sitting (avg. of a bed mobility items)</td>
<td></td>
</tr>
<tr>
<td>GG0130E1 Lying to sitting on side of bed (avg. of a transfer items)</td>
<td>0–4</td>
</tr>
<tr>
<td>GG0130F1 Chair to bed transfer</td>
<td>0–4</td>
</tr>
<tr>
<td>GG0130G1 Toilet transfer</td>
<td>0–4</td>
</tr>
<tr>
<td>GG0130H1 Walk 10 feet with a turn</td>
<td>0–4</td>
</tr>
<tr>
<td>GG0130I1 Walk 10 feet</td>
<td>0–4</td>
</tr>
<tr>
<td>GG0130J1 Walk 10 feet with 2 turns</td>
<td>0–4</td>
</tr>
<tr>
<td>GG0130K1 Walk 10 feet</td>
<td>0–4</td>
</tr>
</tbody>
</table>

PT & OT Functional Score: Item Response Crosswalk

PT & OT Functional Score Construction (NON-WALKING ITEMS)

<table>
<thead>
<tr>
<th>Item Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>01, 05 – Set-up Assistance, Independent</td>
<td>4</td>
</tr>
<tr>
<td>04 – Supervision or touching assistance</td>
<td>3</td>
</tr>
<tr>
<td>03 – Partial/Moderate assistance</td>
<td>2</td>
</tr>
<tr>
<td>02 – Substantial/Maximal assistance</td>
<td>1</td>
</tr>
<tr>
<td>01, 07, 09, 10, 88 – missing – Dependent, Refused, Not applicable, Not attempted due to environmental limitations, Not Attempted due to medical condition or safety concerns</td>
<td>0</td>
</tr>
</tbody>
</table>

PT & OT Functional Score Construction (WALKING ITEMS)

<table>
<thead>
<tr>
<th>Item Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>05, 06 – Set-up Assistance, Independent</td>
<td>4</td>
</tr>
<tr>
<td>04 – Supervision or touching assistance</td>
<td>3</td>
</tr>
<tr>
<td>03 – Partial/Moderate assistance</td>
<td>2</td>
</tr>
<tr>
<td>02 – Substantial/Maximal assistance</td>
<td>1</td>
</tr>
<tr>
<td>01, 07, 09, 10, 88 – Dependent, Refused, Not applicable, Not attempted due to environmental limitations, Not Attempted due to medical condition or safety concerns, Resident Cannot Walk (coded based on response to GG0130 &amp; GG0170, Walk 10 feet)</td>
<td>0</td>
</tr>
</tbody>
</table>

PT & OT Case-Mix Classification Groups

<table>
<thead>
<tr>
<th>Clinical Category</th>
<th>PT &amp; OT Function Score</th>
<th>PT/OT Case-Mix Group</th>
<th>PT Case-Mix Index</th>
<th>OT Case-Mix Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Orthopedics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Orthopedic Surgery and Acute Neurologic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Variable Per Diem Adjustment

The Social Security Act requires the SNF PPS to pay on a per diem basis.

Constant per diem rates do not accurately track changes in resource utilization throughout the stay, and may allocate too few resources for providers at beginning of stay.

To account more accurately for the variability in patient costs over the course of a stay, under PDPM, an adjustment factor is applied for certain components and changes the per diem rate over the course of the stay.

For the PT & OT components, the case-mix adjusted per diem rate is multiplied against the variable per diem adjustment factor, following a schedule of adjustments for each day of the patient’s stay.

SLP Components: PDPM

Under PDPM, patient characteristics will be used to predict the therapy costs associated with a given patient, rather than rely on service use.

For the SLP component, a number of different patient characteristics are used:
- Acute Neurologic clinical classification
- Certain SLP-related comorbidities
- Presence of cognitive impairment
- Use of a mechanically-altered diet
- Presence of s/s of potential swallowing disorder

Variable Per Diem Adjustment Schedules PT & OT Components

<table>
<thead>
<tr>
<th>Day in Stay</th>
<th>Adjustment Factor</th>
<th>Day in Stay</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-20</td>
<td>1.00</td>
<td>61-69</td>
<td>0.86</td>
</tr>
<tr>
<td>21-47</td>
<td>0.98</td>
<td>70-76</td>
<td>0.84</td>
</tr>
<tr>
<td>48-54</td>
<td>0.96</td>
<td>77-83</td>
<td>0.82</td>
</tr>
<tr>
<td>55-61</td>
<td>0.94</td>
<td>84-90</td>
<td>0.80</td>
</tr>
<tr>
<td>62-68</td>
<td>0.92</td>
<td>91-97</td>
<td>0.78</td>
</tr>
<tr>
<td>69-75</td>
<td>0.90</td>
<td>98-100</td>
<td>0.76</td>
</tr>
<tr>
<td>76-82</td>
<td>0.88</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SLP-Related Comorbidities

Twelve SLP comorbidities were identified as predictive of higher SLP costs:
- Conditions and services combined into a single SLP-related comorbidity flag
- Patient qualifies if any of the conditions/services is present
- A mapping between ICD-10 codes and the SLP comorbidities is available from CMS

Acute Neurologic is determined using the primary clinical category:
- The same as the PT and OT components

The primary clinical categories are mapped to either Acute Neurologic or Non-Neurologic for the first-tier SLP determination

SLP-Related Comorbidities

<table>
<thead>
<tr>
<th>SLP Comorbidities</th>
<th>MOS Item</th>
<th>SLP Comorbidities</th>
<th>MOS Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aphasia</td>
<td>14900</td>
<td>Laryngeal Cancer</td>
<td>18000</td>
</tr>
<tr>
<td>CVA, TIA or Stroke</td>
<td>14990</td>
<td>Apraxia</td>
<td>18000</td>
</tr>
<tr>
<td>Hemiplegia or Hemiparesis</td>
<td>14990</td>
<td>Dysphagia, Neurologic</td>
<td>18000</td>
</tr>
<tr>
<td>Tracheostomy (With or Without a Resident)</td>
<td>14990</td>
<td>Tracheostomy, ALS</td>
<td>18000</td>
</tr>
<tr>
<td>Ventilator</td>
<td>14990</td>
<td>Speech &amp; Language Deficits</td>
<td>18000</td>
</tr>
<tr>
<td>Other</td>
<td>14990</td>
<td>Other</td>
<td>18000</td>
</tr>
</tbody>
</table>
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October 2019

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PDPM

Cognitive Scoring

A patient’s cognitive status is assessed in the same way as under RUG-IV (via the BIMS or staff assessment).

- For purposes of classification, scoring the patient’s cognitive status is based on the Cognitive Function Scale (CFS), which is able to provide consistent scoring across the BIMS and staff assessment.
- Role of PT and cognitive screening

NTA Component

The NTA classification is based on the presence of certain comorbidities or use of certain extensive services resulting in an overall score.

This comorbidity score is a weighted count of comorbidities and/or services:
  - Comorbidities/services associated with high increases in NTA costs grouped into various point tiers
  - Points assigned for each additional comorbidity/service present, with more points awarded for higher-costs

Nursing Component: PDPM

Under PDPM, Nursing is separated from the NTA component into a separate, specific Nursing component.

The Nursing classification uses the same basic structure as under RUG-IV, including:
  - Extensive services
  - Certain clinical conditions
  - Presence of depression
  - RNPs
  - Function

MDS-Related Changes Under PDPM

The assessment schedule under PDPM is significantly more streamlined and simple to understand than under RUG-IV.

The Assessment Schedule

Both RUG-IV and PDPM utilize the MDS 3.0 as the basis for patient assessment and classification.

RUG-IV includes both scheduled and unscheduled assessments with a variety of rules governing timing, interaction among assessments, combining assessments, etc.:
  - Frequent assessments are necessary, due to the focus of RUG-IV on such highly variable characteristics as service utilization

PDPM PPS Assessment Schedule

<table>
<thead>
<tr>
<th>PPS Assessment</th>
<th>ARD Window</th>
<th>Payment Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-day</td>
<td>Days 1-8</td>
<td>All covered Part A days until Part A discharge (unless IPA is completed)</td>
</tr>
<tr>
<td>IPA</td>
<td>Optional</td>
<td>ARD through Part A discharge (unless another IPA completed)</td>
</tr>
<tr>
<td>Part A PPS Discharge</td>
<td>Date in A2400C or day after when combined with OBRA Discharge</td>
<td>N/A</td>
</tr>
</tbody>
</table>

PDPM PPS Assessment Schedule
Clinical Strategies for Therapists and Assistants

The Patient-Driven Payment Model (PDPM):

New MDS Item Sets*

- **Optional State Assessment (OSA)**
  - Solely to be used by providers to report on Medicaid-covered stays, per requirements set forth by their state
  - Allows providers in states using RUG-III or RUG-IV models as the basis for Medicaid payment
  - There is presently no timeline for retiring the OSA
  - States need time to collect data to consider a transition to PDPM
  - CMS will evaluate the ongoing need for the OSA in consultation with the states

* 4 items sets will be retired as of 10/1: NO, NOO, NS, & NSD
** Cannot be combined with any another assessment type

New MDS Items

New & Revised MDS Items: I0020B

**NEW SNF Primary Diagnosis**

- Item I0020B (New Item 5-day & IPA)
  - This item is for providers to report, using an ICD-10-CM code, the patient’s primary SNF diagnosis
  - “What is the main reason this person is being admitted to the SNF?”
  - Coded when I0020 is coded as any response 2–13
  - Beginning 10/1, no longer should you code the primary diagnosis in I8000A as this will be captured in I0020B

New & Revised MDS Items: J2100-J5000

**Patient Surgical History**

- Items J2100–J5000 (New Items 5-day & IPA)
  - These items are used to capture any major surgical procedures that occurred during the inpatient hospital stay that immediately preceded the SNF admission (i.e. the qualifying hospital stay)
  - “Major surgery” for J2100 is defined the same as J2000:
    - The resident was inpatient in an acute care hospital for at least one day in the 30 days prior to admission to the SNF and
    - The surgery carried some degree of risk to the resident’s life or the potential for severe disability

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**New & Revised MDS Items: O0425**

**NEW Discharge Therapy Collection Items only on the Part A PPS Discharge (A0310H=1)**

- Items O0425A1 – O0425C5
- Look-back: The entire PPS stay
- Code for each discipline the amount of therapy (in minutes) received by the patient
- If the total amount of group/concurrent minutes exceeds a new cap under PDPM, a warning is issued on the final validation report

**New & Revised MDS Items: Section GG**

**Section GG Functional Items – Interim Performance**

- On the IPA, a new column “g” will capture the interim performance of the patient
  - Only includes those items needed for calculating Function Scores for PT, OT, and Nursing
- Look-back: The three-day window leading up to and including the ARD of the IPA (ARD and the 2 calendar days prior to the ARD)
  - Example: ARD 10/7
  - Section GG IPA Assessment Period: 10/5 – 10/7

**Concurrent & Group Therapy Limits**

**Under PDPM, there will be a combined limit of both concurrent and group therapy to be no more than 25% of the therapy received by SNF patients, for each therapy discipline.**

**Compliance** will be monitored by new items on the Part A PPS Discharge MDS: O0425.

- Providers will report the number of minutes, per mode and per discipline, for the entirety of the PPS stay

**Changes to Therapy**

**Concurrent & Group Therapy Limits**

There will be no penalty for exceeding the combined concurrent and group limit.

Providers will receive a warning edit on their MDS validation report that will inform them that they have exceeded the 25% limit.

The warning will read:

The total number of group and/or concurrent minutes for one or more therapy disciplines exceed the 25 percent limit on concurrent and group therapy. Consistent violation of this limit may result in your facility being flagged for additional medical review.
The Patient-Driven Payment Model (PDPM):
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**Documentation**

Section 30.2.2.1 of Chapter 8 of the Medicare Benefit Policy Manual states that SNF claims must include sufficient documentation that would allow a reviewer to determine:
- Skilled involvement is required in order for services to be furnished safely and effectively
- The services are reasonable and necessary for the treatment of a patient's/resident's illness or injury (i.e., consistent with the individual's particular medical needs)
- The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals

**PDPM** does not change documentation requirements, but rather strengthens the importance of documenting all aspects of a patient's care, consistent with PDPM's focus on a more holistic care model.

*Given* the increased relevance of a greater set of data elements supporting payment under PDPM, providers should ensure that there is strong documentation and support for the care associated with each PDPM component.

**The Needs of the Patient**

While **PDPM changes how patients** are classified into payment groups, PDPM does not change what SNF patients need, their goals, or the unique characteristics of each patient/resident that should drive care planning.

**CMS notes** that what a patient needs as of September 30th and nothing changes clinically with the patient, will be the same needs as of October 1st.
- CMS will monitor for significant shifts in care provision between RUG-IV and PDPM
- Significant changes by a facility may draw scrutiny from CMS

**Care Management Under PDPM**

**Care Management**

**Purpose of Regulatory Reform**
- Meaningful Measures (improve outcomes for patients, their families, and health care providers while reducing burden and costs for clinicians)

**What is Care Management?**

The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.

Care management is a promising team-based, patient-centered approach "designed to assist patients and their support systems in managing medical conditions more effectively." It also encompasses those care coordination activities needed to help manage chronic illness.
The Patient-Driven Payment Model (PDPM): Clinical Strategies for Therapists and Assistants

Value Based Care Delivery

- **Approach to care** that is focused on insuring that all care is delivered based on the analysis of its overall contribution to an outcome that is meaningful to the patient and family.
  - Results in optimal wellness, functional performance, chronic disease management and risk management

- **Patient-Centered Comprehensive Assessments**
  - Focused assessments
  - Evidenced based practice, standardized tests and measures
  - Early ID of the next level in the continuum of care

Care Management: Following Screen

- **What is our role in this delivery as PT’s and PTA’s?**

  - Are we, as a team, able to identify interdisciplinary functional deficits?
    - Is it effective and efficient?
    - Consider role of all disciplines (PT/OT/ST)

  - Are we addressing all identified functional deficits?
    - How can the DOR impact this?

  - Ongoing screening process

Comprehensive Assessments

- **Key Questions**
  - Where is the patient going and with whom?
  - What does the patient need to get there?

- **Care Coordination**
  - Ongoing coordination among the inter-professional care team that maximizes the patient's benefits from treatment
  - Eliminates duplication of services

Evidence-Based Practice

- **Includes** the integration of best available research, clinical expertise, and patient values and circumstances related to patient and client management, practice management, and health policy decision-making.

- **Components**
  - Best available evidence
  - Clinician's knowledge and skills
  - Patient's wants and needs
Clinical Practice Guidelines

Clinical practice guidelines (CPGs) enable PTs and PTAs to understand the state of the evidence as it stands. They are key to decreasing unwarranted variations in practice, decreasing the knowledge translation gap, and optimizing movement.

Access on the APTA website: https://www.apta.org/EvidenceResearch/EBPTools/CPGs/

Care Management: Following Evaluation

Guiding Topics
- Barriers for safe transition
  - Is the patient at risk for re-hospitalization, falls, medication management, etc.?
- Training needs
  - Who needs training?
  - What cues/prompts will need communicated?
- Specific areas of treatment focus
- Section GG

Care Management: Dosing

Guiding Topics
- Treatment time needed to reach discharge disposition/day
  - Variations in treatment days
- Anticipated length of service
- Aspects of POC that can be transitioned or supported by to care extenders
- Modes that can be utilized to facilitate safe transition
- Documentation

Determining Therapy Treatment Progression

Dosing refers to the frequency, intensity, and duration of therapy services.
- Decisions regarding type and intensity of interventions are developed in collaboration with the client and must be reasonable under accepted standards of practice
- We should not consume resources that don’t produce a meaningful result or based on changes in the patient's condition, response to therapy and treatment focus

Intensity, Duration & Treatment Design

It is the responsibility of the primary therapist to determine the duration of each therapy session, considering the patient's diagnoses, conditions and goals.

Abbreviated or extended sessions are based on clinical needs of the patient.

Unique clinical considerations may impact tolerance and intensity (WB and other precautions).

Determining the duration of the episode of care is based on the time needed to ensure a safe and sustainable transition to the next level of care.
Clinical Reasoning in Determining Therapy Treatment Prescription

Are interventions rooted in evidenced based practice and accepted standards of practice?

Is there a duplication of service delivery?

During ongoing clinical reviews, is the patient meeting targeted outcomes?

How can alternative modes of therapy be utilized to promote patient engagement, treatment objectives and reinforcement of skill attainment?

What can be done outside of the therapy session to promote carryover, reinforce skills and encourage optimal engagement and self efficacy?

Treatment Session Design

Goal: To optimize the benefits of skilled therapy and maximize patient safety and self efficacy by integrating all appropriate modes of therapy.

- Conditions or diagnosis specific
  - Pain management
  - Cardiovascular impairments
  - Dementia
  - Orthopedic

Transition Planning

Goal: To integrate appropriate activities and programs in the current setting beyond the skilled therapy session, and engaging patient in a feasible post transition continuum plan to achieve and sustain positive outcomes.

- Leverage other resources (RNP) as an adjunct to skilled therapy
- Engage patient and caregivers early to maximize function and carryover
- Begin patient/caregiver training ASAP and initiate the HEP
- Engage the community partners and all community based resources

Care Management: Rehab Clinical Meeting

Guiding Topics

- Review discharge plan
- Problem solving ongoing and/or new barriers
- Modifications to POC based on progress or lack thereof
- Top of license practice
- Status of education to care extenders
- Reassessment of dosage

Meaningful Outcomes

- Patient/family/caregiver education
- Barriers to discharge
- Functional limitations and impairments
- Home assessment, as indicated
- Transitional needs and services

Care Management: Prior to Discharge

Have we addressed all aspects of care including:

- Patient/family/caregiver education
- Barriers to discharge
- Functional limitations and impairments
- Home assessment, as indicated
- Transitional needs and services
In Summary

Key Questions for Sustainable Practice

Referrals
• What is your current interdisciplinary screening process?
• Are your evaluating therapists using objective screening tools?

Comprehensive Assessments
• What is the discharge disposition/next level of care for the patient?
• Are all staff trained in utilizing the right tests and measures?
• Does your evaluation support?
  • Are you engaging the patient and the caregiver?

Care Management
• Are you providing the most effective care for the lowest cost?
• Are you utilizing modes of care to support patient outcomes?
• What parts of the plan of care requires the unique skills of a therapist?

Treatment Progression
• Are the goals progressing throughout the POC? If not, are we modifying as applicable?
• Are we identifying barriers and making necessary referrals?
• Is their effective communication between all members of the team?

Sustainable Health Outcomes
• Are we achieving positive outcomes?
• Does the patient having the resources needed to transition safely?

Questions?

References

APTA Clinical Practice Guidelines.
https://www.apta.org/EvidenceResearch/EBPTools/CNgradPTA/  
CMS Meaningful Measures Framework.
POMI Frequently Asked Questions Document. Available at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html  
POMI/ICD-10-Mappings. Available at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html  
POMI website
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html  
https://healthforum.brandeis.edu/research/pdfs/CareManagementPrincetonConference.pdf