

Skilled Nursing Facility Patient-Driven Payment Model FAQ

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1. Therapy Plans of Care

1.1. Under PDPM, RUG minutes go away. Who decides how many minutes the patient gets/needs?

The determination of the level of therapy does not change just because the payment model is changing. How much therapy a patient needs/receives should always be determined by health care professionals, with input by the patient. The determination is informed by the findings from the evaluation process. In addition, the basic criteria for a patient qualifying for a SNF Part A benefit has not changed. A resident must require skilled nursing 7 days a week and/or skilled therapy services 5-7 days a week. Therapists must learn to think about clinical approaches separately from this new payment methodology, rather than equate the two. This is a patient-driven payment model.

Now that rehabilitation is not necessarily the driver of payment, physical therapists (PTs) and physical therapist assistants (PTAs) should start talking with their colleagues, peers, and administrators about what volume and dosage of therapy is appropriate. The amount of therapy a patient requires should be based on physical presentation and their needs. Therapists must determine the needs of patients through standardized tests, the tolerance of patients, and the goals of the patients and their families.

1.2. Does the APTA have any standards on dosage per diagnosis categories as a potential guideline?

There are resources on [PTNow](#), and APTA and other stakeholders will continue to build the body of evidence. It is important for the physical therapy profession to look for and identify what is the right amount of therapy that ensures a patient the right outcome.

1.3. Who decides the primary reason for SNF admission?

The primary reason for SNF admission, reflected on the MDS in Item I0020B will determine the case-mix component for PT, OT, and SLP. Further, I0020B should reflect the primary reason the patient is admitted to the facility for all skilled services. Therefore, the facility should not expect the therapist to be 'the one' to determine the primary diagnosis, as the therapist's choice may not completely reflect the reason for the admission. It is important that therapists provide input on the primary admission diagnosis, but the final choice should be a collaborative decision.

1.4. Will patients receive less therapy under PDPM?

It is unclear. CMS is expecting a slight decline in the amount of therapy utilization, but only because they believe there has been an overutilization in therapy due to the financial incentives associated with delivering therapy under the RUG system. Therapists should provide as much therapy as they can substantiate as the right amount of care. The physical therapy profession is evolving, as is the population PTs serve. Whether the amount of therapy is more or less following PDPM implementation is less important than whether it is the right amount at the right time for the right patient. Therapy utilization should be the result of interprofessional team decision-making, be supported clinically, and be well documented.

1.5. Will PDPM pay more for more complex patients?

It is possible. PDPM better accounts for more complex patients. Nursing homes are currently examining whether or not they have expertise in those areas, or, based on the market, whether there is a need for them to expand their service line to be able to care for more of these patients.

2. Group & Concurrent Therapy

2.1. Under PDPM, up to 25% of therapy services can be delivered as group or concurrent therapy. If my SNF has been delivering primarily individual therapy, and we begin to deliver 25% group or concurrent therapy, will my SNF be flagged for audit? With this new limit on group and concurrent therapy, how can my SNF stay fiscally responsible under PDPM?

Before we answer this question let's understand what the difference is in the regulation of RUG IV and PDPM. Under RUG-IV, no more than 25 percent of the therapy services delivered to SNF patients, for each discipline, may be provided in a group therapy setting, while there is no limit on concurrent therapy. Under PDPM CMS is concerned that providers will become incentivized to increase utilization of group and/or concurrent therapy and therefore decrease individualized therapy. Therefore, CMS has imposed a 25 percent maximum on total minutes spent on group and/or concurrent therapy.

The decision to use group and concurrent therapy should be based on patients' needs and clinical presentation. CMS expects to see an increase in group and concurrent therapy delivered to Medicare beneficiaries. However, if a provider went from only providing 1% of group or concurrent therapy to 25% overnight, this likely would be a red flag to CMS. CMS will monitor group and concurrent therapy utilization, and expects utilization to be appropriate, reasonable and necessary. The agency will also be monitoring other important measures of clinical care appropriateness, such as quality measures and re-hospitalization rates. This also implies that documentation for group or concurrent therapy needs to clearly identify that the care is appropriate, reasonable, and necessary.

2.2. Will group therapy minutes be divided under PDPM?

No. Group therapy minutes will not be divided under PDPM. Under PDPM, because there is no dollar value assigned to it, they will not be allocated or divided. For example, if PTs spend 60 minutes with 4 patients, they will report 60 minutes for each patient, and a full 60 minutes will be counted towards the 25% limit of group+concurrent therapy

3. Functional Status and Section GG

3.1. Currently, a therapist fills out Section GG in our SNF. Will a therapist continue to do so?

CMS has indicated that the level or score of any item within Section GG should be the "usual performance" prior to any treatment intervention. In addition, successful collaboration among the interdisciplinary team is best to identify this score. Now that Section GG directly relates to payment for PT, OT, and nursing components, there will be more attention to what is included for each item in Section GG. If the scores chosen do not reflect the documentation in the chart, that could be a problem for providers.

Additionally, while therapists may be better suited to answering some GG items, others may be more appropriately answered by nursing. So there should always be collaboration among the patient's care team. Finally, recognize that if therapists are currently completing Section GG as part of their therapy evaluations or outcome modules, they may continue to do so. However, they also need to recognize that these scores might or might not be the same score that is placed on the MDS.

4. Medicare Advantage under PDPM

4.1. How will PDPM affect Medicare Advantage (MA) patients?

Some MA plans may change their payment models to mirror PDPM. Others may not change their payment models in relation to the changes. However, because they are private plans, MA plans currently take a wide variety of forms, with some already approximating the structure of PDPM, using patient characteristics rather than service utilization as the basis for payment. CMS will work with stakeholders, including private plans, to ensure adequate education and resources are available for all parties.

In addition to MA plans, state Medicaid programs are going to have to consider what payment model they will operate under in the future. Currently, all states are using some version of the RUG to determine the Medicaid reimbursement rate for SNF residents. However, CMS announced that they will not continue to support the RUG software after 10/1/2020. This puts pressure on states to determine how they will establish the Medicaid daily rate. It will be interesting to see whether they utilize PDPM or shift to a per diem model of some kind.

5. Restorative Nursing Programs

5.1. Will restorative nursing replace therapy services?

Maintaining independence with activities of daily living (ADLs) is critical, and restorative nursing is an important part of a program to maintain functional skills. That said, restorative nursing will not replace therapy services. There are opportunities for skilled therapy and restorative nursing to work together. PDPM gives therapists an opportunity to look at how restorative nursing and therapy services may be coordinated to improve patient outcomes and increase satisfaction.

6. Preparation for PDPM

6.1. How will therapy evaluations need to change?

PTs practicing at the top of their licenses will hopefully not change how they complete their evaluations. Ideally they are already using standardized tests involving the patient/family in the goal setting process, exploring discharge plans from the time of evaluation, assessing patient activity tolerance for intensity, and performing a complete evaluation.

6.2. Are there any tools to help a PT self-assess readiness for the PDPM changes?

The APTA Academy of Geriatric Physical Therapy is working on a self-assessment tool –stay tuned! However, PTs can start assessing their readiness for PDPM changes by doing one or more of the following:

- Assess how good they are at writing exercise prescriptions. PTs are good at writing plans of care. However, by writing out exercise prescriptions and therapeutic activity prescriptions, PTs can increase their ability to effectively deliver care;
- Increase communication and collaborating skills;
- Collaborate with nursing and help to refine diagnoses;
- Identify patient characteristics that affect a person's rate of recovery;
- Enhance predictive capabilities in terms of dosing through objective tests and standardized measures;
- Setting specific targets that incorporate the goals of patients and caregivers provide better benchmarks of care; and
- Use objective tests and standardized measures to become skilled predictors and prognosticators around appropriate dosing.

6.3. When should PTs begin trial assessments or engage in other mechanisms to help ensure the PDPM transition process is seamless?

Right now, PTs need to start thinking now about how they will transition to PDPM. For example:

- Who will decide the primary diagnosis? This should be a team effort. PTs should think about how they will make recommendations for primary diagnosis and how they intend to provide input by the 7th or 8th day;
- How should PTs improve their patient assessments? PTs' evaluations may not change at all. For instance, PTs would not need to change their practice of doing meaningful, standardized tests;
- How can PTs analyze their historical data to determine any reimbursement differences under both models (PDPM and RUG-IV);
- How Section GG is collected; and
- How PTs will plan therapy (i.e., either group or concurrent therapy) and any clinical pathways.

Additionally, it may make sense to begin assessing the SNF's coding accuracy by examining previous patients' MDS forms that have been completed next to the documentation in the chart to consider whether any opportunities for accurate coding were missed. Therapists also could consider conducting full chart reviews to assess what information was transferred and/or missed.

6.4. I was practicing as a therapist back in 1999 when PPS came into the nursing home. Will this one be anything like that time?

No. Therapists were paid on a cost basis prior to 1999, then went to a PPS basis. Because of that, a lot of companies laid off several therapists early in the process, only to subsequently go through a period of rehiring.

PDPM is intended to better align payment with patient characteristics and patient needs and eliminate the connection between therapy utilization and reimbursement. Although the payment methodology is changing, Medicare coverage of physical therapy services is not, and the amount of therapy a patient requires should, as always, be based on physical presentation and a patient's needs.

6.5. What continuing education should PTs and PTAs take to prepare for PDPM?

APTA is partnering with the Home Health Section, AGPT, and HPA the Catalyst to develop tools to help therapists prepare for PDPM, as well as the Home Health Patient-Driven Groupings Model. The changes to both models are similar in a lot of ways. The Sections and APTA are developing tools and information on therapist readiness for PDPM. Note: PTs and PTAs using webinars and podcasts developed by other parties should view these critically, especially with regard to their sources of information.

6.6. How can PTs and PTAs best prepare for this payment model change?

PTs and PTAs should examine how they practice. They can do this by: conducting workflow analysis, identifying opportunities for interprofessional collaboration, proactively address changes in plans of care, determining what discipline specific data is being gathered and how that relates to quality reporting, and understanding the link between care and data being captured by therapists and how that relates to performance under the quality measures.

PTs should follow clinical practice guidelines and develop a common clinical language for their teams. Therapists should also assess their knowledge of different regulatory aspects and their understanding of Medicare Part A, Medicare Part B, Medicare Advantage, and 3rd party payer rules. Finally, therapists can become more involved in managing clinical software to insure it satisfies the clinical and regulatory requirements of therapy.

7. Interim Payment Assessment and Interrupted Stays

7.1. If the facility chooses to complete an Interim Payment Assessment after a 2-day interrupted stay, is it necessary to complete a new therapy evaluation?

Interim Payment Assessment (IPA): CMS has not laid out any specific rules for when the IPA should be completed. They have said it is an optional assessment and the facility will decide when and why to do it.

Interrupted Stay: An interrupted stay occurs when a resident leaves a SNF and returns to the same SNF 1 or more times within the same Medicare Part A benefit period. The PDPM includes variable per diem payment adjusters for the PT, OT, and NTA base rate components, creating the need for a SNF PPS interrupted-stay policy. CMS finalizes the following interrupted-stay policy under the PDPM:

- The variable per diem adjustment is reset whenever a resident is discharged then readmitted to a different SNF (where a new MDS assessment would be required):
- When a resident is discharged from a SNF and returns to the same SNF by 12:00 AM at the end of the third day of the interruption window, CMS will treat the resident's stay as a continuation of the previous stay for purposes of both resident classification and the variable per diem adjustment schedule. A new MDS assessment would not be required, although the SNF could choose to complete an IPA assessment for reclassification if clinically appropriate.
- The resident's PDPM classification will not change from admission for a readmission to the same SNF occurring in 3 or fewer days after discharge.
- When the resident's absence from the SNF exceeds this 3-day interruption window (as defined below), CMS will treat the readmission as a new stay, in which the resident will receive a new 5-day assessment upon admission, and the variable per diem adjustment

schedule for that resident would reset to Day 1. In this case, the facility would complete a SNF PPS Discharge Assessment. The SNF should count the total volume, mode, and type of therapy to report in section O of the MDS for purposes of the discharge assessment when a resident's stay included 1 or more interrupted stays as follows: when a resident is discharged and then readmitted to a SNF in a manner that triggers an interrupted stay under the interrupted stay policy, all therapies that occurred since the admission would be included in section O of the MDS for each discharge assessment.

The Interrupted Stay policy under PDPM can be compared to an End-of-Therapy Resumption under the RUG's system. Today, when a patient is put on 'hold' or has to miss several days of therapy in a row, the facility is required to do an End-of-Therapy OMRA and if therapy is resumed within 5 days, an End-of-Therapy Resumption OMRA. When this policy was first implemented, the question was raised about whether the PT would need to do another evaluation when the EOT Resumption was done. CMS indicated it was the clinician's decision if it was necessary or not, but also to defer to state, local, or facility policy.

Under PDPM, if there is an interrupted stay, and the facility chooses to do an IPA, then it is likely there has been a significant clinical change. Therefore, the PT will be required to understand what that change is, and whether it impacts the PT plan of care.

8. Students

8.1. Are there any changes with students and reimbursement under PDPM?

PDPM makes no changes to the rules for coding minutes as it relates to students. Refer to the RAI manual for how to allocate minutes.

It is expected the RAI manual will be updated and issued in May 2019. Once it is, additional information will be provided.

9. Value and Physical Therapy

9.1. What are practical strategies for PTs and PTAs to demonstrate their value?

They should examine their facilities' quality metrics and their facilities' performance and think about how they impact various metrics, including falls, pain, pressure ulcers, and discharge to community. PTs and PTAs should identify opportunities to collaborate with other care disciplines, improve their communication, and bring value to the entire care team. Therapists and therapist assistants also should consider how they can contribute to their patients' quality of life and overall outcomes.

PDPM presents an opportunity for PTs and PTAs to use their settings as living laboratories, to better understand dosing and the relationship between outcomes and quality measures. They have an opportunity to look at evidence-based practice. PTs and PTAs have an opportunity to participate in a value-based payment model, and they should demonstrate their relevance in such model.

9.2 What does top of license practice look like in SNFs? What are some barriers to top of license practice in these settings?

Top of license practice

Top of license practice reflects the utilization of therapists and therapist assistants' knowledge and skills in a way that maximizes their efficiency and contribution. An analysis of a therapist or assistant's day or week can help identify tasks or activities that could be performed by other members of the team. To the greatest extent possible tasks and activities should be assigned to the most appropriate team member. Appropriate utilization of personnel is critical.

Given that the skills of certain providers are going to be more closely aligned with patient need the use of those resources will need to be responsible and appropriate. Determining what must be done by a therapist and ensuring that only those things that require the skills of a therapist are performed by that individual will ensure responsible stewardship and optimal resource utilization under a payment system that is designed to minimize inappropriate utilization of high cost resources. Top of license practice is just that – responsible stewardship of a resource.

In a SNF, top of license practice would include therapists engaging in only those activities that are unique to their skill and scope including consultation, screening, examination, evaluation, treatment, interdisciplinary care planning, patient and caregiver education, staff education. Activities like equipment management and maintenance, routine exercise classes, routine positioning or transfer activities would not constitute top of license practice.

Barriers

Barriers include:

- Lack of staffing/resources;
- Ineffective maintenance programs or transition programs from skilled care;
- Lack of appreciation of the unique skills of a PT or PTA; and
- Expectation for performance of tasks just because they have always been done by therapy such as wheelchair cleaning or inventory

It is important for therapists to communicate with their team and managers and openly share concerns and feedback.