Perception Defies Payment Math

PDPM success requires SNFs to break free from the "therapy-centric" mentality

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The Skilled Nursing Facility ("SNF") Medicare Part A Patient Driven Payment Model ("PDPM") will replace the current RUG-IV system for claims with dates of service effective October 1, 2019. PDPM's defining characteristic relative to RUG-IV is that PDPM is ***non-therapy centric*** with respect to rate setting for SNF services (I know, not exactly "Breaking News" so far).

Disclaimer: for purposes of this discussion, let's assume that every provider delivers superb care, and clinical outcomes are consistent throughout the land. We assume Compliance is prioritized over payment. This is a theoretical reimbursement analysis, not a clinician's guide to post-acute care. Furthermore, contrary to certain opinions, I do not indiscriminately favor in-house therapy over outsourced models – every facility has unique needs. In fact, if I owned a network of SNFs, I would undoubtedly outsource some of my therapy departments, especially as contract pricing has become so competitive and the product improved. Ok?

The complexities of the new system (some obvious, many subtle), have unleashed a coven of PDPM "experts" leading some providers down a path from which some may not recover. Within these pages, I try to illuminate one of the great misconceptions surrounding PDPM: **That PT/OT classification (i.e. primary diagnosis coding in MDS Section I8000 with a possible J2000 surgical qualifier plus therapy function score) is the predominate determinant of PDPM success.**

Note that I am NOT quantifying the newly reimbursement-sensitive diagnoses associated with other Components – only the "Primary reason for SNF stay" codes that determine PT/OT clinical designation.

I recognize that the USA lags 30 other countries in terms of student math proficiency, but **wow, someone must have misplaced a decimal point when PT/OT payment was first explained; or is there reason to suspect deliberate misrepresentation?**

First things first: Where does this "fuzzy math" come from? Anecdotally, we've found most of the "analyses" that include the PT/OT distortion are propagated by contract therapy companies, with added gravitas as PT/OT is typically the first Component discussed in trainings; this fuels the assumption that therapists can directly impact this portion of the Medicare rate. They can't… at least they shouldn't.

Since the onset of the original Prospective Payment System 20 years ago, nurses began ceding control of the SNF "Benefit Period" to their therapy counterparts (whether the department was outsourced or managed in-house). Aggressive therapy programming was relied upon to optimize reimbursement, while therapy technology applications emerged to facilitate documentation and defend against highly subjective third-party audit contractors. For the most part, those days are over.

Nevertheless, this "pre-PDPM" therapy-centric narrative is being perpetuated, and greatly exaggerating the relative Component values within the new system. This mindset must stop. Immediately! These days, many Part A admissions are "clinically" eligible for coverage based on skilled nursing need alone.

Again, this is not an in-house v. outsource issue. "Rehab" remains post-acute care's cognomen regardless of who signs the therapist's paycheck. Educated operators do not need the "***Why therapy is still really, really important under PDPM***" lists that seem obligatory on so many contract therapy websites. Admittedly, I'm not a clinician, but I know nursing remains "really important" under PDPM as well; housekeeping, security and even the business office may still matter too… only time will tell (again, I need that sarcasm font). Why not just be transparent and rename the lists "*Reasons for outsourcing your therapy department under PDPM*." In all seriousness: Despite the fallacy of perception, I've advised many clients to consider outsourcing their therapy departments – PDPM does not change the fact that doing so is the better option for many SNFs – PDPM (as a new "Revenue Delivery System") will change the pricing structures, but not the reality of need.

More Challenges on the Horizon

SNF payment reform is not limited to PDPM, in fact all roads lead to more efficient therapy programs. Specifically in many markets, Institutional Special Needs Plans ("ISNPs") have reduced Medicare Part B therapy billing by over 50% (disclosure: I am heavily vested in the ISNP model). As draconian as that reduction sounds, utilization control is achieved through proactive clinical interventions (and technology) that improve care and INCREASE net income for the SNF (again, a story for another time). All "healthcare reform" initiatives share the same DNA, and the "Double Helix" of SNF Physical and Occupational Therapy will succumb to these same limitations. PDPM is only the beginning.

Despite the obviousness of the truth, the industry has naturally defaulted to the RUG-IV status quo – that Physical and Occupational Therapy will continue to dominate the SNF revenue cycle under PDPM, albeit through diagnosis coding and functional scores for the PT/OT component, as opposed to RUG-IV's arbitrary volume thresholds.

This concept is unequivocally false.

Excluding the static overhead Component, PT/OT is the PDPM payment-array with the least financially variability.

Fact: The PT/OT classification differences are surprisingly financially small, while therapy function scoring that enhances PT/OT revenue more often negatively impacts the associated Nursing Component, resulting in a net loss for the provider!

Bottom line: **Therapy should not be the driving force behind PDPM eligibility and reimbursement management!** This power has been returned to nursing after a generation of perverse incentives endemic to a therapy-centric world. I won't bore you with the equations, but payment rates associated with PT/OT scores were statistically compressed under RUG-IV, as patients "across the acuity spectrum" received 720 minutes of therapy. Knee replacement? 720 minutes. Pneumonia? 720 minutes. You get the idea.

I suppose it feels "familiar" to accept PT/OT classification as the primary imperative under PDPM – just substitute the applicable diagnosis for minutes. And while every dollar counts, SNFs must understand the NET financial behavior of PDPM Component interactions before making decisions that are presented without context.

For example, a therapy PDPM "expert" may focus on a code that distinguishes the Major Joint category from Other Orthopedic. Take a typical resident with a GG score of 9; how much would such a ghastly coding mistake impact a SNF's finances … $100 a day, $200 a day, more??? Not quite. Using unadjusted urban rates, this coding travesty would reduce the PDPM rate by roughly $7 (that is seven dollars) per day upon admission (and decrease to about $5 by day 100).

Moreover, Section GG's inverse relationship between the PT/OT and Nursing Components essentially mitigates the value of therapy coding to an even greater extent. With a competent therapist running the PT/OT Component, perhaps they astutely (and compliantly) manage to capture a function score of six for a Major Joint patient when a score of five was anticipated.

Kudos to them for generating an additional $17 a day… for the PT/OT Component. Our problem here is that breaching this function threshold impacts the Nursing Component as well… in the opposite direction. A typical Nursing score of LDE1 becomes LBC1 and the associated Nursing rate drops $30 per day. **That talented therapist just reduced your overall Medicare revenue by $13 a day!** Moral of the story? Pay close attention to your therapy contract pricing – it will get tricky.

The Big Picture

Do NOT mistake this for a "plug," as I hardly know her, but Martha Schram, president and CEO of Aegis and newly elected president of NASL, made some excellent observations during an interview with Maggie Flynn published in Skilled Nursing News. While I don't agree with everything she said (shocker), some of her comments like this one were spot on:

"It's not just therapy anymore, so [they] really need to bring into the fold – and this is good for the patient – that increased collaborative effort between rehab and the facility. Whether or not you're in-house or outsourced, that level is going to need to go up."

Irrespective of the outsource – in-house question, make sure nursing and therapy are on the same page or revenue will suffer, both for the initial MDS and any Interim Payment Assessments that may follow.

This juxtaposition among Components just scratches the surface of what we call "**Financial Composite Behavior**"… *Strange things are afoot at the Circle K* (if you don't recognize that movie quote, you are either much younger or more mature than I am… probably both).

Back to the Coding Math

The PT/OT Component simply lacks the rate sensitivity (in both diagnosis code/clinical category assignment and GG score) to make much of a difference under PDPM. Come October 2019, interests are realigned as the dollars (and management) shift to the Components representing the real money – Nursing RUGs and Non-Therapy Ancillaries.

Comparatively, simply capturing Depression can have 8x the rate impact of a PT/OT coding mishap. Respiratory therapy (not vents or traches, but general treatments most SNFs already provide) will, in aggregate, far exceed the dollars associated with PT/OT coding. The Nursing Component list goes on and on with such financial revelations.

Regarding Speech: Tertiary diagnoses, cognition and dietary factors create more potential revenue variability than PT/OT coding. Back to the math: excluding the GG anomaly score of 24, grossly inaccurate diagnosis coding (and the resulting PT/OT clinical category) has a maximum day one difference of about $41 a day. More than twice as much is at risk within the SLP component in terms of reimbursement-sensitivity.

SLP is not getting the attention it deserves because, while an actual ST can facilitate compliant capture, most of the rate variation DOES NOT REQUIRE A THERAPIST! PDPM invites new players to the reimbursement party (e.g. dieticians, psychologists, Social Services) and therefore does not fit neatly within the context of our PT/OT therapy-centric conditioning. *I have so much more to say about the SLP Component… I just can't seem to get the words out.*

From a theoretical reimbursement perspective, having a ST involved carries far greater resonance than a PT or OT. I'm going to repeat the key phrase there so I don't get harassed more than usual: "**from a theoretical reimbursement perspective**."

It's my job to model these scenarios, not treat patients (refer to paragraph two, page one to revisit that disclaimer).

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Non-therapy ancillaries will often represent the greatest variability of all PDPM Components – combined (for a few days at least). NTAs & IPAs are the most interesting management challenges providers will face under PDPM. To be honest, that's where all the action is, and I'll get to it eventually. But *inspiration is not like waiting for a bus, there's no schedule*; and a proper "deep-dive" into NTA/IPA land requires some serious inspiration to explain properly.

So why are so many therapists (aka spontaneous PDPM experts) driving the new system's storyline, featuring the PT/OT Component? Because we continue to exist in a **therapy-centric world**.

SNFs must free themselves of this mindset and embrace the opportunities ahead. We remain confident that most well-prepared (and managed) providers will flourish under PDPM. This is not an opinion – it's simply math.

We hope you enjoyed Thanksgiving – wishing you a wonderful holiday season.

Check our conclusions on ZHSG's PDPM Rate Simulator. Visit www.zhealthcare.com & call (877) SNF-2001 for a complimentary access code.