

How Will a New Medicare PPS Change CMS Payment Monitoring of Skilled Nursing Facilities?

Joe Greenman / Mark Reagan



Joe Greenman is a shareholder with Lane Powell PC and can be reached at greenmanj@lanepowell.com.



Mark Reagan is the managing shareholder of Hooper, Lundy & Bookman, P.C., and a member of the firm's Fraud & Abuse Practice Group. He can be reached at mreagan@health-law.com.

On October 1, 2019, the Centers for Medicare & Medicaid Services (CMS) implemented the Patient-Driven Payment Model (PDPM) as the Medicare Prospective Payment System (PPS) for Skilled Nursing Facilities (SNFs). PDPM replaces the resource utilization groups (RUGs) system that has been used as the basis for SNF Medicare reimbursement for over 20 years.

PDPM ushers in a fundamental change to SNF case-mix elements of SNF Part A reimbursement and thereby alters the SNF payment system and all other systems that have relied on the RUG-IV system. RUG-IV used service-based metrics to classify patients in an SNF into one of 66 possible groups that include two case-mix indexed components: (1) therapy and (2) nursing. In PDPM, there are five case-mix adjusted components: (1) Physical Therapy (PT); (2) Occupational Therapy (OT); (3) Speech-Language Pathology (SLP); (4) NonTherapy Ancillary (NTA); and (5) Nursing. Each resident is to be classified into one and only one group for each of the five case-mix adjusted components. In other words, each resident is classified into a PT group, an OT group, an SLP group, an NTA group, and a nursing group. For each of the case-mix adjusted components, there are a number of groups to which a resident may be assigned, based on the relevant MDS 3.0 data for that component. There are 16 PT groups, 16 OT groups, 12 SLP groups, 6 NTA groups, and 25 nursing groups. PDPM classifies residents into a separate group for each of the case-mix adjusted components, which each have their own associated case-mix indexes and base rates.

CMS asserts that PDPM will improve payment accuracy and will encourage a more patient-driven care model by addressing each individual resident's unique needs independently. CMS has consistently emphasized that given the more holistic style of care

emphasized under PDPM, program integrity and data monitoring efforts will also be more comprehensive and broader. For program integrity, CMS expects provider risk will be more easily mitigated to the extent that reviews focus on more clearly defined aspects of payment, such as documentation supporting patient diagnoses and assessment coding. Under PDPM, SNF medical record documentation to support MDS and ICD-10 coding that demonstrates medical necessity will be critical to compliance success. We have identified seven discreet issues under PDPM that we expect CMS to focus on with respect to their ongoing program integrity efforts.

CONTINUED APPLICATION OF THE ADMINISTRATIVE PRESUMPTION

A SNF retains responsibility to ensure that its decisions relating to level of care (LOC) are appropriate and timely, including a review to confirm that the services prompting the assignment of one of the designated case-mix classifiers (which, in turn, serves to trigger the administrative presumption) are themselves medically necessary. The administrative presumption is itself rebuttable in those individual cases in which the services actually received by the resident do not meet the basic statutory criterion of being reasonable and necessary to diagnose or treat a beneficiary's condition (according to section 1862(a)(1) of the Act). Accordingly, the presumption would not apply, for example, in those situations in which a resident's assignment to one of the upper groups is itself based on the receipt of services that are subsequently determined to be not reasonable and necessary. CMS has stressed the importance of careful monitoring for changes in each patient's condition to determine the continuing need for Part A SNF benefits after the Assessment Reference Date (ARD) of the five-day assessment.

PDPM does not necessarily change Medicare's basic requirements for

"skilling" a resident; however, due to the change in resident care classifications, the rule specifies the new PDPM categories that will qualify for the presumption of skilled coverage. The new model focuses less on the number of therapy minutes and more on residents' clinical characteristics.

A possible result of expanded case-mix components of payment under PDPM, SNFs should expect that payment and audit criteria will gravitate to evaluating LOC criteria. SNF providers may consider practices to clarify whether resident care is continuously "skilled," and determine whether services are furnished by nursing, the therapies (physical, occupational, or speech), Non-Therapy Ancillary, or a combination, and establish supporting documentation for such determinations, especially in cases where the resident's status does not justify a need for daily therapy services. Under PDPM, the specific amount of therapy provided will no longer be a factor in the payment rates or the administrative level of care presumption determinations. While the basic SNF LOC requirements are not changing, providers should consider preparedness for the renewed focus on resident characteristics for coverage determinations.

ICD-10-PCS CODING REQUIREMENTS COULD CREATE COMPLIANCE RISKS BECAUSE OF SNFs' LIMITED EXPERTISE IN USING ICD CODES

SNFs will need to be far more fluent and consistent with the assessment and coding demands of PDPM. As the lynchpin for reimbursement under the RUGs system was the need for and use of rehabilitation, there has not been the same need for assessment that PDPM will demand. Similarly, while ICD-10 coding has been part of the RUGs system, it has not been nearly as important to payment as it will be under PDPM. Hence, it is imperative for

SNFs to identify and properly document the ICD-10 codes that best reflect the patient's reason for Skilled Medicare Coverage upon admission to the SNF.

With regard to the potential consequences of ICD-10 coding errors on RAC audits, as under the current payment system, the information reported to CMS must be accurate. Inaccuracies in the data reported to CMS, or a failure to document the basis for such data, will necessitate the same types of administrative actions as occur today.

SNF staff will need to ensure competencies in reviewing the hospital or transfer records with the interdisciplinary team to determine the reason that skilled care is required. There are three outcomes of ICD-10 selection: 1) Return to Provider, 2) Resolved in Hospital, or 3) Reason for Skilled Care. SNFs will now use the CMS PDPM ICD-10 CM mapping tool to assure the diagnosis identified is not in the "Return to Provider" category. Finally, it is crucial that SNFs verify that the UB-04, the MDS, and the ICD-10 codes match.

Consistent operationalization of the above tasks will ensure appropriateness of diagnosis codes on SNF claims prior to submission. SNFs should monitor that all diagnoses agree across various disciplines with the required codes reported. Quality assurance and auditing tasks will include: review of rejected and denied claims for correction, resubmission of corrected claims, and verification that codes reported on the claim coincide with the codes reported by MDS, rehab, or the physician.

SLP COMPLEXITY

Now that PDPM has taken effect, speech therapy plays a greater role in a resident's overall care plan than under the previous RUGs system. Even as RUGs have removed any financial incentive to log as many therapy hours as possible, speech services—along with physical and occupational

therapy—will have a direct impact on how skilled nursing providers can prove solid outcomes and maximize their total reimbursements.

Speech therapy includes more than just communication, such as the treatment of swallowing disorders and patients who require mechanically altered diets. Identifying those needs and meeting them with appropriate therapy will determine an SNF's eventual reimbursement dollars, and if a speech therapist isn't involved in the initial assessment and collection of the MDS information, the financial implications could be significant, with the daily rate for speech-language pathology potentially varying from \$16 to more than \$100 depending on the accurate identification of swallowing and altered diet needs. Using mechanically altered diets can lead to an increase in the daily rate in the speech and language pathology (SLP) case mix under PDPM, but if facilities record a large jump, it could signal to CMS that the dietary changes were motivated by financial gain rather than patient need.

SNFs should ensure that the speech services are being provided for a swallowing deficit by accounting for why a given patient has received orders for their specific diet. Moreover, SNFs must ensure that the mechanically altered diets are used for residents with a true swallowing deficit, as opposed to a lack of dentures or other similar routine examples.

With regard to the SLP case-mix component, CMS has noted that it plans to monitor specifically for any increases in the use of mechanically altered diet among the SNF population that may suggest that beneficiaries are being prescribed such a diet based on facility financial considerations, rather than for clinical need. CMS may also be watching for an overuse of cognitive impairment as a payment classifier. Depression represents one of these newly reimbursement-sensitive conditions.

POTENTIAL FOR THE UNDERUTILIZATION OF SERVICES: VARIABLE PER DIEM ADJUSTMENTS AND THE “TAPERING” OF PAYMENTS

In examining costs over an SNF stay for the purposes of PDPM, CMS determined that for certain categories of services, notably physical therapy (PT), occupational therapy (OT), and non-therapy ancillary (NTA)¹ services, costs declined over the course of the stay. Based on the claim submission schedule and variations during the month when a stay began, CMS estimated resource use for specific days. As a result, CMS developed the PDPM system so that the PT and OT case-mix components would decrease from their initial levels at admission by 2 percent at Day 21 of the stay and 2 percent lower for each week thereafter. This is the “tapering” element of PDPM.

NTA resource utilization, however, exhibited a somewhat different pattern from the other case-mix components. For example, CMS found that NTA costs were very high at the beginning of the stay, drop rapidly after the first 3 days, and remain relatively stable from the fourth day of the stay. CMS stated that starting on Day 4 of a stay, the per diem costs drop to roughly one-third of the per diem costs in the initial 3 days. CMS explained that this suggests that many NTA services are provided in the first few days of an SNF stay. Therefore, CMS set the NTA adjustment factor at 300 percent of the established NTA component rate for Days 1 through 3 to reflect the extremely high initial costs, then reducing it to 100 percent (two thirds lower than the initial level) for subsequent days.

In contrast to PT, OT, and NTA, CMS was unable to assess potential changes in the level of nursing costs over a resident's stay, in particular because nursing charges are not separately identifiable in SNF claims, and nursing minutes are

not reported on the MDS assessments; however, stakeholders (industry representatives and clinicians) at multiple TEPs indicated that nursing costs tend to remain relatively constant over the course of a resident's stay. As a result, the nursing case-mix component will stay constant over the case of a resident's stay for the nursing case-mix component.²

As the rate of per diem reimbursement will decline over the course of the resident's stay under PDPM, there would appear to be financial disincentives to longer lengths of stay. As a result, CMS will be monitoring SNFs to identify whether beneficiaries experience inappropriate early discharge or provision of fewer services. CMS will also be scrutinizing any conduct on significant downturns in the provisions of therapy to address concerns expressed regarding “stinting” on these services. Accordingly, many of the compliance concerns with PDPM in this area will largely focus on the potential underutilization rather than the overutilization of services.

INTERIM PAYMENT ASSESSMENT

Under PDPM, a resident that undergoes a significant change in condition that would alter his or her assessment upon admission may have an additional assessment known as an Interim Payment Assessment (IPA). It is optional for SNFs whether to have an IPA performed or at what stage to do so. In some instances, an IPA may produce a higher per diem reimbursement rate for the SNF than is currently in place. In other circumstances, the rate may be lower. At no time, however, will any of the “tapering” of the various case mix groups be “reset” by virtue of an IPA.

While CMS has left it to SNFs to determine whether and/or when IPAs will be undertaken, CMS nevertheless expects that SNFs will pay special attention to clinical and functional changes experienced by its residents. In fact, regardless

of the opportunity to conduct an IPA, CMS expects SNFs to constantly evaluate, capture, document, and treat clinical and functional changes that occur throughout an SNF stay.

As the performance of an IPA can produce a higher reimbursement rate, CMS will be monitoring SNF practices to determine if their optional IPAs were reasonable and necessary. As a result, SNFs will need to carefully consider policies and procedures for the use of IPAs for residents and the criteria to be used. As a result, the criteria should largely be neutral and avoid the appearance that IPAs are undertaken only in situations where per diem reimbursement is likely to increase.

CMS THERAPY OVERSIGHT TO CONTINUE

Under PDPM, CMS's stated objective is to ensure that SNF residents receive the majority of therapy services on an individual basis. To achieve this objective, CMS adopted in rule the requirement that concurrent and group therapy combined is limited to no more than 25 percent of an SNF resident's therapy minutes by discipline. In combination, this limit would ensure that at least 75 percent of a resident's therapy minutes are provided on an individual basis. CMS stated that because the change in how therapy services would be used to classify residents under PDPM gives rise to the concern that providers may begin to utilize more group and concurrent therapy due to financial considerations, CMS set a combined 25 percent limit on concurrent therapy and group therapy for each discipline of therapy provided.

SNFs continue to be required to record therapy minutes on the MDS. Providers now complete a new section of the MDS, section O0425, where they report the total amount of therapy, broken down by therapy mode (individual, concurrent, and group) and by therapy discipline (Physical Therapy, Occupational Therapy, Speech-Language Pathology) the patient received during the entire Part A stay.

The look back for these items is the entire SNF Part A stay, starting at Day 1 of the Part A stay and finishing on the last day of the Part A stay. Once reported on the MDS, CMS grouping software will calculate the percentage of group and concurrent therapy, combined, provided to each patient, by discipline, as a percentage of all therapies provided to that patient. If the amount of therapy provided exceeds 25 percent, then this would be deemed as noncompliance.

The FY 2020 PPS final payment rule did not establish a penalty for exceeding the 25 percent combined concurrent and group therapy limit; however, providers will receive a warning edit on their assessment validation report that will inform them that they have exceeded the 25 percent limit. The warning edit will read as follows: "The total number of group and/or concurrent minutes for one or more therapy disciplines exceeds the 25 percent limit on concurrent and group therapy. Consistent violation of this limit may result in providers being flagged for additional medical review." CMS will also monitor therapy provision under PDPM to identify facilities that exceed the limit, in order to determine if additional administrative or policy action would be necessary.

CMS has also stated that it plans to use reported therapy minutes to conduct reviews of changes in the volume and intensity of therapy services provided to SNF residents under PDPM compared to that provided under RUG-IV. Should CMS discover that the amount of therapy under PDPM is distinctly different from the amount of therapy under RUG-IV, CMS will evaluate the potential reasons for this change and consider potential actions, either at the provider or systemic level, to address these issues.

SNF administrators in collaboration with facility therapists (in-house or contract) should adopt policies and procedures to ensure and consistently document medical necessity and clinical appropriateness.

This should include assessing whether concurrent or group therapy is the best for the patient, therapist, and provider and determining whether concurrent or group therapy is appropriate for patients with greater medical complexity who are admitted for skilled rehabilitation. Under PDPM, the use of concurrent and group therapy must include detailed justification in the resident's plan of care.

We expect that CMS will take special note of any changes to therapy utilization levels during the PDPM transition and beyond. Providers should expect CMS to monitor how much change occurs, along with changes in the assessed needs of the patient population. CMS will scrutinize whether changes in the patient population occur as a result of payment incentives continuing to have an impact on resident care decisions.

INTERRUPTED STAY POLICY

In cases where a resident is discharged from an SNF and returns to the same SNF by 12:00 a.m. at the end of the third day of the interruption window (as defined below), PDPM regulations 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. In cases where the resident's absence from the SNF exceeds this three-day interruption window, or in any case where the resident is readmitted to a different SNF, the readmission will be treated as a new stay, in which the resident would receive a new five-day assessment upon admission, and the variable per diem adjustment schedule for that resident would "reset" to Day 1. In that instance, the "tapering" for any applicable case-mix components would not continue. In other words, a new stay for the resident

could produce a higher rate of per diem reimbursement than the previous stay, particularly when the variable case-mix components would "reset."

As a result, CMS will be monitoring SNFs for potential manipulation of the Interrupted Stay Policy, under the belief that frequent SNF readmissions may be indicative of poor quality care being provided by the SNF. CMS will also closely monitor the use of this policy to identify those facilities whose beneficiaries experience frequent readmission, particularly facilities where the readmissions occur just outside the three-day window used as part of the proposed interrupted stay policy. CMS stated that should it discover such behavior, it would flag these facilities for additional scrutiny and review and consider potential policy changes in future rulemaking.

CONCLUSION

It will be a challenge for SNFs to adapt to the demands of the new PDPM methodology regarding assessment and coding. These demands will pose clear program integrity issues as SNFs endeavor to maintain compliance with more robust assessment requirements and coding accuracy. Moreover, the seven issues discussed above will be closely monitored by CMS for program integrity in order to hold SNFs accountable for their compliance with the programmatic elements of the PDPM system.

Endnotes

1. NTA services include many different types of ancillary services but are predominantly comprised of prescription drug costs.
2. CMS determined that speech-language pathology (SLP) costs did not decrease over time. As a result, the SLP case-mix component will not "taper" under PDPM.