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As New SNF Payment System Takes Effect, CMS Will Monitor Changes in Therapy, Coding

By Nina Youngstrom

Starting Oct. 1, per diem payments to skilled nursing facilities (SNFs) will be more generous on the first few days of a Medicare beneficiary's stay, and then drop as the stay continues. That's one of the changes under the Patient Driven Payment Model (PDPM), the radical new SNF prospective payment system, which replaces resource utilization groups (RUG-IV). Because SNFs will receive higher per diem payments in the earliest days of the patient stay, there is always the possibility for gaming the system, and CMS will be watching.

"The front-loading of the per diem makes sense from a financial standpoint because beneficiaries require more resources in the beginning, but from a compliance perspective, it flips the incentive," said Regina Alexander, senior consultant at VantagePoint HealthCare Advisors in Hampden, Connecticut. Compliance officers will have to keep an eye out for manipulation of the per diems, with SNFs rushing patients out the door as reimbursement wanes or encouraging interrupted stays because the SNF stay starts over if beneficiaries are gone for more than three days.

The PDPM is the most significant overhaul of the SNF PPS since its inception in 1997, she said. It ends the dominance of physical, occupational and speech therapy in payment. Instead, payment will be driven by patient characteristics and resource needs. "The contribution of skilled nursing is recognized in the new model. Therapy no longer rules the roost," Alexander said Sept. 11 at a Health Care Compliance Association webinar.

CMS has high hopes for PDPM. "It improves payment accuracy by focusing on the patient and their needs rather than the services provided, and reduces administrative burden and reallocates the payments," said John Kane, CMS SNF team lead, at SNF quality reporting training in May.

But there will be new kinds of compliance risks. SNFs have to pay more attention to precise ICD-10 coding of principal and secondary diagnoses. "ICD-10-CM codes were not utilized under RUGs as a direct impact on reimbursement," Alexander said. "Under RUG-IV, most SNFs report a primary diagnosis code that's related to the therapy delivery or therapy care plan because of the payment model emphasizing the intensity of the therapy plan and therapy minutes as a driver of payment." That will soon be history. Coding will matter very much under PDPM and needs to be accurate, she explained.

CMS: Therapy Is Still Important

CMS will be monitoring all aspects of the PDPM, including therapy, even if they don't drive payments to the same extent, Kane said. "Therapy is very important under PDPM the same way nursing is extraordinarily important," he said. The before and after will be big in CMS's program integrity strategy. It will compare how much therapy SNFs provided before PDPM took effect versus after, as well as the types of diagnoses SNFs coded then and now and the outcomes "as a result of any change we see in view of other monitoring data," Kane explained.

CMS also reduced the number of required patient assessments to one (two others are optional). That relieves administrative burden, but could make SNFs vulnerable to fraud allegations if they suddenly stop assessing

patients' therapy needs and drastically reduce their therapy overnight because the reimbursement methodology changed, Alexander said.

"So many things are changing," she noted. "It is risky whenever incentives change with a payment model. There is more regulatory scrutiny. Program integrity resources will be focused on anyone who isn't behaving."

Five Factors Will Now Drive Payments

PDPM has a new classification model for Part A SNF services, Alexander said. It's still a case adjusted payment, and nothing about the minimum data set (MDS) changed, but it's all more balanced, and MDS coding drives payment. The five factors are physical therapy, occupational therapy, speech language pathology, the nursing base rate, and non-therapy ancillaries (NTAs). "They come together to establish the daily payments," Alexander said. It is related, however, to the RUG-IV. "All we have done is taken two case mix components—therapy and nursing—and broken them into constituent components," Kane said. "Nursing is nursing, and NTA…is mostly drugs, and therapy is three disciplines."

With this shift, the documentation and coding of diagnoses move to center stage. "There is a direct relationship between the code assignment and payment categories," Alexander said. Of the five service-related components that determine PDPM grouping—PT, OT, SLP, NTA and nursing—accurate and specific ICD-10 diagnosis codes are necessary for four components; the comorbidity diagnoses reported in MDS item I8000 will affect NTA calculations.The primary diagnosis code recorded in MDS item I0020B should reflect the reason for admission. Some primary diagnosis codes will map to a different clinical category from the default clinical grouping depending on the patient's prior inpatient procedure history as reported in section J of the MDS.

Some popular RUG-IV primary diagnosis codes will trigger a rejection and be returned to the provider (RTP'd) under PDPM when reported as primary in section 10020B on the MDS. They include muscle weakness (M62.81), encounter for other specified aftercare (Z51.89), encounter for other specified surgical aftercare (Z48.89), repeated falls (R29.6), functional quadriplegia (R53.2) and adult failure to thrive (R62.7).

"While the primary diagnosis represents the primary reason that the patient was admitted to the SNF and needs skilled care, which may or may not be the same reason that the patient was admitted during the qualifying hospital stay, the primary diagnosis should be associated with a condition that was treated during the qualifying hospital stay," Alexander said. That can be a comorbid condition exacerbated during the hospital stay or a residual effect of the acute condition.

CMS Will Watch For Effect on Outcomes

With PDPM, there are now three patient assessments, but only one is required. Within five days of admission, a physician has to complete the initial assessment. The other two are the interim payment assessment and PPS discharge assessment, but CMS won't ding SNFs if they're not completed, Kane said.

That's quite a departure from RUG-IV, which required five assessments ("Cheat Sheet: SNF Assessments in RUG-IV versus PDPM," *RMC* 28, no. 33). "However, the initial assessment is high stakes. It has to be accurate," Alexander said. There also will be subtler compliance risks around assessments. SNFs have the option to do interim payment assessments, but they must have a rationale and solid clinical policies to mitigate the risk. For example, if the patient is brought to the emergency room for exacerbation of a chronic condition and returned to the SNF the next day, there may be a good reason for an interim payment assessment. "From a compliance standpoint, you want to see if they did interim assessments consistently—for example, because the patient is doing a lot worse or a lot better, rather than randomly or in an effort to reset the PDPM grouping to a higher level," she said.

The changes in reimbursement for PT, OT and SLP also open up SNFs to scrutiny. Under PDPM, no more than 25% of the therapy received by patients during their stay may be concurrent or group, Kane said. "CMS will monitor group and concurrent therapy through a new item in the PPS discharge assessment. If they exceed it, SNFs will receive a warning in the final validation report," he said. "If we see it pop up for a lot of your patients, that will trigger something."

Kane also cautioned that CMS will be watching for SNF fluctuations in the minutes patients spend in therapy now that it doesn't drive payment. "If we see therapy services are coming down or group therapy is going up because of experimenting with different models of care, but quality outcomes are maintained, that's fine," he said. What's more worrisome is a SNF that reduces therapy to 100 minutes a week for every patient whose quality outcomes "are going into the tank. That is a facility that will draw our ire."

Another compliance risk stems from the MDS. There are 188 auditable item fields under PDPM, much more than the 20 with the rehabilitation RUGs. In other words, there will be 188 items associated with assigning a patient to the five components (PT, OT, SLP, nursing and NTAs), Alexander said. ICD-10 codes are required for the first four components, and comorbidities affect NTA payment. What does all this mean? Diagnosis codes should be accurate and supported by clinical documentation, something all providers should be doing anyway.

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