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Maximizing Payouts in the Patient-Driven Payment Model

WHY NOW IS THE TIME TO INVEST IN REHAB TECHNOLOGY

CONTENTS

Introduction

Effective October 1, 2019, the Resource Utilization Group Version IV (RUG-IV) is replaced by the Patient-Driven Payment Model, or PDPM, as the case-mix classification system for Skilled Nursing Facility (SNF) patients. While training is underway to make heads or tails of the new classification system, how it will affect day-to-day patient care remains to be seen. In theory, specific data-driven patient characteristics championed by PDPM will improve Medicare reimbursement as well as patient care, while reducing administrative burdens on providers.

If the Office of the Federal Register is correct and facilities experience the estimated savings of more than 183 administrative hours and $12,000 per provider, per year, the growing pains everyone is feeling right now will be worth it. But insightful decision makers understand that PDPM implementation goes beyond checking a compliance box. Acquiring key pieces of rehabilitation technology now will help skilled nursing facilities, and contract therapy groups serving them, overcome key challenges as PDPM goes into effect.

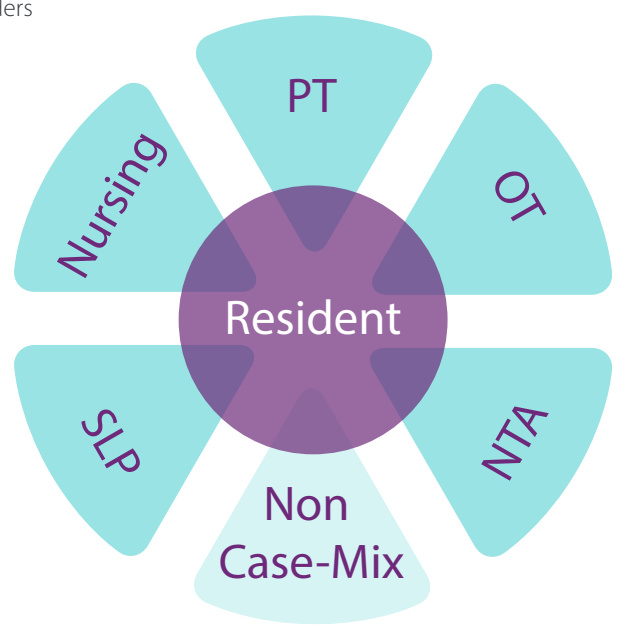
Acquiring key pieces of rehabilitation technology now will help overcome key challenges as PDPM goes into effect.

Just so we are all on the same page...

RUG-IV incentivized providers to categorize all patients in a therapy payment group that used therapy minutes as the basis for Medicare reimbursement. In some cases, providers used this classification to provide therapy services to all patients, whether they needed it or not. Under PDPM, providers use six payment components to arrive at a patient payment group. Five of the six components are based on the particular case, the patient's needs and the services that are available at the SNF. These include:

- Physical therapy (PT)
- Occupational therapy (OT)
- Speech-language pathology (SLP)
- Non-therapy ancillary (NTA) services
- Nursing components
- SNF resources that do not vary from patient to patient

Each patient is assigned a functional score in each component area and from there, a case-mix group (CMG) is assigned and a case-mix index (CMI) is calculated. The CMI is then added to the non-case-mix component rate to arrive at the patient's daily Medicare per diem rate.



What it really means

With pages and pages of frequently asked questions available on the Center for Medicare Services website, it's no wonder many SNF managers and contract therapy groups are scrambling to understand what the new Medicare reimbursement rules really mean in terms of patient care. Therapeutic minutes under RUG-IV were tangible and easy to measure. The new Patient-Driven Payment Model requires a more in-depth initial assessment to determine a patient's needs and case-mix group, but it also rewards SNF providers for treating all aspects of complex cases.

For example, patient Paula is admitted into a SNF after a total hip replacement following a fall. Upon assessment, providers discover that she not only requires physical therapy typical for a post-surgical patient, but also aural rehabilitation for chronic dizziness that caused her fall in the first place. The PDPM model will reward the SNF for treating not only Paula's hip, but also other underlying conditions that may contribute to readmission.

Under PDPM, outcomes-based payment replaces time-based payment

The Challenges

As potentially positive as the new changes are, the new Patient-Driven Payment Model is not without challenges that will begin to emerge with its implementation.

Outcomes Over Therapy Minutes

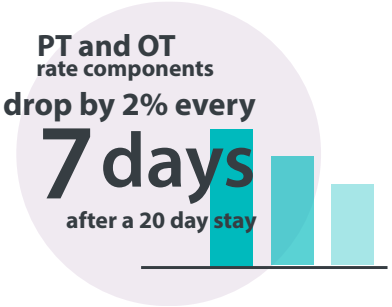
Under the new payment model, outcomes-based payment replaces time-based payment. CMS has emphasized that PDPM is a reimbursement change, not a quality of care change. However, just like therapy practice shifted when the RUGs system went into effect, facilities will want to be prepared to shift with PDPM. The key to avoiding a CMS flag will be tying any changes in care to what is clinically appropriate for the individual patient for a better outcome. SNFs and therapy groups that are not equipped to efficiently drive functional outcomes through standardized, evidence-based practice may miss out on large revenue opportunities.

Faster Return-to-Function

One of the biggest changes under PDPM is the variable per-diem adjustment. Physical and occupational therapy rate components drop by two percent every seven days, after a 20-day stay while the non-therapy ancillary component declines after three days, by 67 percent until discharge. Of course, PDPM's emphasis on shorter stays is in line with recent trends across the country.

CMS's 2019 introduction of separate short- and long-term stay star ratings came with the statement, *"While every nursing home resident has their own individual needs and goals, the overarching goal of the short-stay residents is typically aimed at improving their health status, so they can return to their previous setting."*

The 20-day variable per-diem adjustment for PT, OT and non-ancillary components is designed to keep facilities from delaying the discharge of short-term patients, but adds a definitive target timeline to therapy services. While need for a positive outcome will (as it should) ultimately determine a patient's length of stay, making functional gains quickly will be the challenge for the therapy team.



The need for proving need, progress and outcome with objective documentation will only grow under PDPM.

More Group and Concurrent Billing

With therapeutic minutes out of the picture, the focus in many organizations will likely shift to creating positive outcomes, in less time. PDPM provides a slight increase in reimbursement on group and concurrent therapy, capped at 25% of a patient's total amount of care. SNFs who will successfully capitalize on group and concurrent therapy will need to have appropriate safety practices in place to ensure sessions are significantly contributing to outcomes.

It is important to add that CMS will be taking note of sudden spikes in group and concurrent therapy. The key to avoiding a red flag will be tying group and concurrent therapy to a functional goal.

Meeting the Challenges Head-On with Rehabilitation Technology

With such large-scale change on the horizon, many facilities are reluctant to invest large amounts of capital into their facilities. However, investing in the right rehab technology will provide SNF care groups with tools to help them maximize payouts under PDPM:

- Better functional outcomes
- Earlier mobilization
- Safer group/concurrent therapy
- Objective documentation

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Better Functional Outcomes

With PDPM shifting the therapy focus to functional outcomes in less time, SNFs and contract therapy groups may need to assess the role rehabilitation devices play in achieving those goals. More passive rehab equipment such as upper body cycles and stationary bikes may pull less weight under the patient-driven model, while elliptical trainers that support a more natural, functional movement may be more valuable for driving those desired therapy gains. Making sure therapy staff is sufficiently equipped with the right tools to serve their caseload will help in achieving more functional outcomes across the board.

Equipment that suits more than one purpose and enhances the recovery process is key to getting the most out of your investment. For example, new technology has motorized the stand-assist device while combining it with a walk-assist device that allows a patient to remain in one harness system as they stand up from sitting and begin to walk.

Earlier Mobilization

Time and again, studies have shown that early mobilization programs positively affect patient outcomes, regardless of the patient's age and prior mobility level. Since therapeutic minutes are no longer the standard for Medicare reimbursement, the challenge becomes getting patients ambulatory earlier in their treatment protocol. Equipment designed for safe patient handling & mobility (SPHM) has multiple benefits that not only help prevent fall-related injuries during therapy, but also drive functional goals.

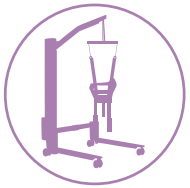
Less independent, more complex patients, which stand to generate substantial payouts under the patient-driven model, may particularly benefit from using a track and harness system or similar ambulation aid. Patients experience safer mobilization as PTs and OTs work toward returning them to their prior level of function.

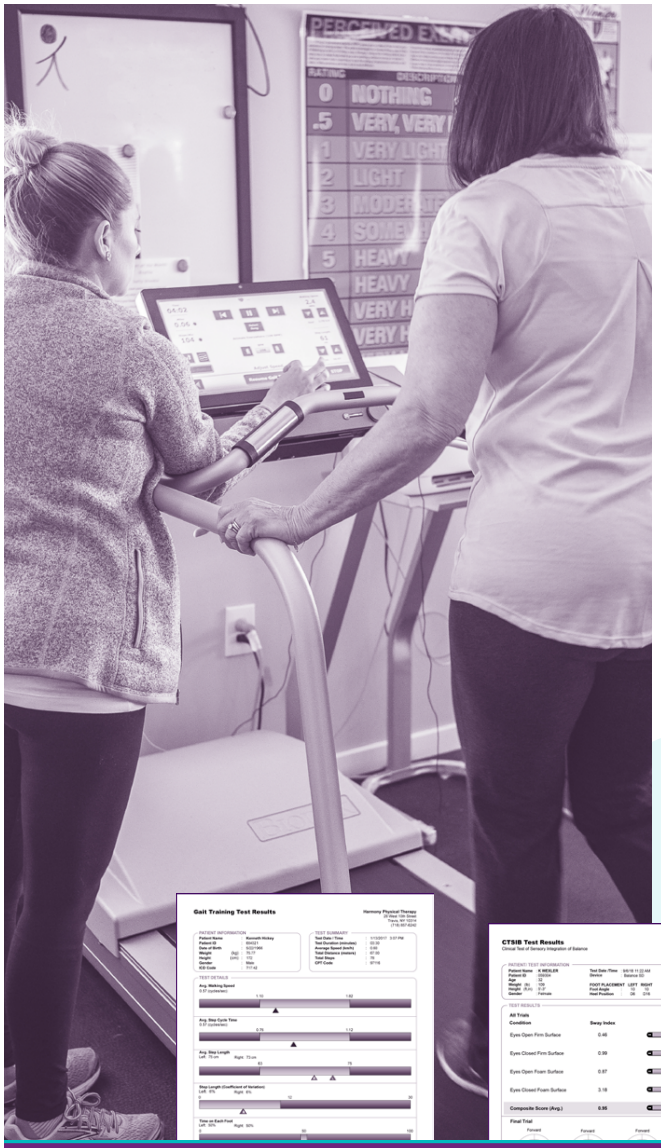
Equipment that suits more than one purpose and enhances the recovery process is key to getting the most out of your investment.

Safer Group/Concurrent Therapy

Under PDPM, SNFs that are able to keep the length of stay around 20 days will receive the highest reimbursement rates for PT, OT and SLP. If they can maintain their census at those levels, they will continue to be paid at those rates. In order to provide therapy efficiently and affect change in less than three weeks, rehabilitation technology may offer a significant advantage for providing therapy services in groups.

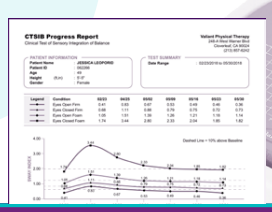
If PDPM inadvertently places a high priority on group and concurrent therapy, supported ambulation systems and mobility assistance devices allow multiple patients to work on PT and OT goals with minimal hands-on therapist involvement. Once patients are connected to these systems, they may work safely on their own to increase strength, balance and mobility. Therapists are free to move from one patient to the next, instructing and encouraging, knowing each patient is safe from a fall.





Objective Documentation

With changes to the ICD-10 codes and the way data is managed and communicated under the PDPM, fast, easy-to-acquire documentation is vital to the reimbursement process. Here is where investment in gait trainers and balance devices featuring data reporting tools will pay back dividends. These tools can be used during the initial 5-day assessment that will determine a patient's case-mix group and case-mix index. They can also provide important data during treatment and rehabilitation to measure success throughout a patient's stay at a SNF. Armed with quantifiable data, setting treatment goals, measuring progress and even requesting more inpatient days or making referrals to outpatient facilities becomes easier.



Conclusion

The changes that will come with PDPM will ultimately shape the way skilled nursing facilities provide care to their patients. As is the case with all regulatory, systemic change, the differentiating factor will be whether a skilled nursing facility reacts to regulatory changes or is proactive in determining their own destiny. Utilizing rehabilitation technology to their advantage can provide a SNF with additional revenue streams, help achieve shorter stays without compromising care, drive functional outcomes quickly and effectively, and give therapists the documentation they need to remain compliant with new reporting requirements. This simple investment can ultimately shape the way facilities operate while achieving their ultimate goal — helping patients receive the care they need to live their best lives.

With more than 60 years of service, Biodex Medical Systems, Inc. provides innovative technology solutions and support to medical and wellness facilities on a global scale.

To explore devices that will help you meet the challenges of PDPM, contact us.

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