Are You PDPM Ready? Best Practices for Success

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The Medicare Patient Driven Payment Model (PDPM) is finally here. Proactive skilled nursing facilities (SNFs) have been preparing for this sea change for months, adapting processes and procedures to align with the new model. It represents a huge shift in our reimbursement focus from therapy to patients’ clinical characteristics and skilled services rendered, or perfect sense as, over time, the role of SNFs has evolved from rehabilitation to subacute care for medically complex patients.

PDPM certainly delivers on the promise for more clinically aligned reimbursement. However, the documentation burden shifts to SNFs to ensure adequate and commensurate reimbursement for the care they provide to medically complex patients. The entire SNF team, including the medical director and staff, needs to participate in managing the documentation that PDPM requires.

These best practices outline how medical directors and medical staff can help.

1. Admission and the Initial MDS Assessment

WHAT: Timeliness. The initial Minimum Data Set (MDS) assessment (to be completed between days one and eight) is the prime driver of reimbursement under PDPM. Therefore, accurate and comprehensive documentation of patient characteristics in the initial MDS assessment, at the earliest, is of paramount importance.

WHY: SNF patients are at their sickest upon discharge from hospitals because they are being treated for acute illnesses, often requiring expensive medications and extensive nursing care and rehabilitation. The initial MDS assessment needs to happen as early as possible — perhaps within 48 hours — to capture the patient’s higher acuity and utilization of resources upon admission. An initial MDS assessment completed later in the window may not capture the acuity from the tail end of the hospital stay using the seven-day look back (that is available for some categories) in PDPM. Accurate documentation of patient acuity is vital due to the higher Non-Therapy Ancillary (NTA) Case Mix Index (CMI) that is usually afforded to intravenous (IV) therapy, expensive medications and supplies, and nursing care. The cost of a missed opportunity is especially impactful as the NTA payments for the first three days of a SNF stay are multiplied by a factor of three.

WHAT: Accuracy. Without an accurate capture of patient characteristics, SNF reimbursement will suffer under PDPM. A thorough review of hospital and outpatient records performed by a clinical practitioner who can verify and edit (if necessary) the ICD-10 diagnoses codes for each patient goes a long way toward ensuring accuracy and relevance, and establishing medical necessity for services.

WHY: Medicare reimburses physicians for the additional time spent reviewing this information during the initial visit with a SNF patient, and SNFs should insist on and facilitate the early completion of these initial visits. If nonphysician practitioners spend time reviewing and recording orders, these prolonged visits are reimbursed based on medical necessity. Any administrative time spent by medical directors in this process, especially with patients who are not theirs to follow, needs to be factored into their monthly stipend.

WHAT: Relevance. Of particular importance is the process of choosing an ICD-10 code for the primary diagnosis for SNF admission because this maps into a clinical category that drives reimbursement. The correct choice should answer the question “Why is the patient here?”

WHY: Special attention should be given to identifying acute neurological diagnoses, depression, dysphagia, altered diet, and cognitive deficits because they significantly affect CMI under therapy categories.

2. SNF Stay and the Interim Payment Assessment

WHAT: Change of condition. The interim payment assessment (IPA) might not have a profound impact on reimbursement because it does not reset the variable per diem adjustment schedule for therapy and NTA, unless the patient’s clinical condition becomes more acute during the SNF stay.

WHY: In such scenarios when IV infusions, expensive medications, additional nursing care and equipment, or more intense therapy services are needed to optimize care, an IPA likely will bring in higher reimbursements, commensurate with the escalation in care. Each facility may wish to define a threshold increase in per diem reimbursement that will trigger an IPA. A designated clinician (e.g., MDS clinician or director of nursing) would assume ownership of the PDPM process to continually track changes in patient characteristics and functional status (section GG) to initiate IPAs when the time is right. Several electronic therapy and pharmacy systems — Casamba for therapy and pharmacy, Optima, Point Click Care, Care Team and GPM, to name a few — can integrate with electronic MDS records and trigger alerts when an IPA might be appropriate.

WHAT: Interdisciplinary collaboration. This is perhaps the most overlooked and yet the most important singular attribute that results in PDPM success for SNFs. Because, like hospitals, SNFs aren’t reimbursed for unnecessary care and services, everyone on the team needs to always be mindful of medical necessity.

WHY: A dollar saved is two dollars earned. It is vital that clinical practitioners initiate the orders to reduce unnecessary utilization, whether it is prescribing, stopping IVs and antibiotics, or reducing therapy minutes. That, along with a timely discharge to a lower-cost care setting, is extremely important in maintaining financial health. The decision needs to be correlated with medical necessity and signed off promptly by the practitioner to avoid potential audits and litigation.

WHAT: Data analytics. In addition to revenue forecasting and timing of IPAs using changing patient characteristics, SNFs should analyze their revenue streams and expenses closely.

WHY: These analyses should look for discrepancies, which, in turn, should trigger a root-cause analysis to identify process errors and areas for improvement.

3. Pharmacy Collaboration

WHAT: Formulary compliance. A robust formulary is invaluable for PDPM success. But even the best formulary cannot deliver cost savings when prescribers do not comply.

WHY: Pharmacy costs are reimbursed under the NTA category, but Medicare does not distinguish, nor account for, cost differences between branded and generic medications. For example, SNFs receive higher reimbursement for patients receiving IV therapy, but branded IV medications may cost more than the entire NTA allowance. Confirming formulary substitutions in a timely manner is essential for realizing cost savings.

WHAT: Deprescribing. Discontinuing the multitude of nonessential medications that routinely accompany patients from the hospital is crucial.

WHY: Deprescribing needs to be embraced — not just for cost containment, but for patient safety.

WHAT: Antibiotic stewardship. Closely managing antibiotics is important for patient safety and cost reduction.

WHY: Antibiotics as a class are expensive, and formulary substitution and timely cessation are imperative. It also affects patient safety by preventing resistance, opportunistic infections, and rehospitalizations.

4. Therapy Collaboration

WHAT: Physical and occupational therapy. It is quite natural that PDPM’s reimbursement curve for nursing services is linearly dependent on frailty. The lower the functional score and cognition, the higher the reimbursement. For physical and occupational therapies, the relationship is bell shaped to allow the patients with the highest potential for improvement to receive more therapy and reimbursement. So there typically comes a time in most patients’ care episodes when their functional scores improve, and they become candidates for greater benefit from physical and/or occupational therapy.

WHY: Capturing patient progress via an IPA could result in better reimbursement for therapy services, which more than offsets the modest decline in nursing CMI that accompanies functional improvement. Because the information captured by the IPA is used to calculate reimbursement for the remainder of the care episode, it is important to gauge whether the relative improvement in therapy and/or nursing CMI is not offset by a potential decline in the NTA score due to expected lower utilization as the patient improves. Careful monitoring of section GG scores on the MDS will help identify the opportunity for a potential IPA. The medical practitioner needs to be closely involved in the initiation, care planning, and cessation of therapy services to streamline and safeguard their efficiency and integrity and lower any legal risks.

WHAT: Speech therapy. Neurological disease, depression, cognitive deficits, dysphagia, tube feeding, or a need for a mechanically altered diet must be carefully documented on MDS.

WHY: Payment for speech therapy can change by a factor of six depending on the patient’s diagnoses and comorbidities, from the least complex CMI to the most. If the listed conditions were not initially present or went unrecognized on admission, an IPA will help improve reimbursement for speech therapy once the clinical documentation supports the change.

PDPM is a welcome change that will allow SNFs to receive reimbursements that more accurately reflect the services provided, and the increased need for accuracy in documentation, interdisciplinary collaboration, and clinical leadership is a great opportunity for quality clinical practitioners and medical directors to enhance and showcase their value in the SNF world.