Physiatry Driven Payment Model: Targeting Higher Acuity and Increased PDPM Accuracy Through Physiatry

By Melissa Brown, OTR/L, CDP, CSRS, RAC-CT

Like a phoenix rising, SNF providers are emerging from the devastation of the pandemic. But life after the pandemic and the financial reality of a post-pandemic era are extremely challenging. After having focused for so long on managing the clinical needs patients with COVID-19, sourcing PPE and stabilizing the mental health of the nurses and frontline heroes on their teams, providers have now shifted their focus toward rebuilding the financial stability of their organizations. And with the impact of supplemental government Public Health Emergency (PHE) funds dwindling, SNF Providers are realizing that a renewed concentration on PDPM reimbursement is critical to survival.

Analysis of the COVID Impact on PDPM Rates

After the monumental shift to the new payment model under PDPM, providers had barely 6 months to begin to hone their skills and identify the impact that the payment model shift had on an organization. And because the COVID-19 pandemic has drastically altered coding and PDPM per diem rates, providers are still left wondering what the future looks like. Even in the Fiscal Year (FY) 2022 Skilled Nursing Facility Prospective Payment System Proposed Rule (CMS 1746-P), CMS admitted that the pandemic, "has had a likely impact on SNF PPS utilization data." From the claims data received by the Centers for Medicare and Medicaid Services (CMS), it was identified that the claims only captured a COVID-19 ICD-10 diagnosis code less than 10% of the time. And only 15.6% of skilled claims included the "DR" code, which indicated that the facility had leveraged the 3-day hospital stay waiver, or the 1812(f) waiver. However, many providers were unaware of the DR coding required on these waiver-related claims. And with PCR testing unavailable or taking longer than two weeks to be returned to the SNF provider for most of 2020,

there were countless SNF patient claims that could not include the ICD-10 code for COVID-19, even though the patient was COVID-19 positive.[1] Thus, the CMS claim that the impact of COVID-19 on MDS coding, reimbursement, and PDPM per diem rates was minimal is unfounded and inaccurate.

But one thing is true in every SNF community - improved accuracy of coding and supportive documentation with PDPM can result in increased per diem rates. And by adding PDPM-trained physiatry to a SNF team, and integrating them with the clinical process, transition planning, and the MDS department providers see significantly increased PDPM per diem rates.

Research on Physiatry-Related PDPM Impact

In 2022, Gravity Healthcare Consulting conducted an independent research study into the impact of PDPM-trained physiatrists upon PDPM per diem rates with a variety of Skilled Nursing Providers. With unrestricted access to Integrated Rehabilitation Consultant communities' PDPM HIPPS codes, reimbursement rates, days of Medicare stay, and physiatry census, Gravity independently selected the residents featured in the study. Several months of data were analyzed across two communities during the pilot study. And the data reveals that physiatrists can positively impact the PDPM reimbursement by **$40-$48/day** through ICD-10 coding, supportive documentation, and collaboration with the MDS.

Comparing October 2021 to December 2021 for Community A showed a powerful impact of the PDPM focus in physiatry. Prior to the PDPM training for the physiatrists, the residents who were seen by physiatry in Community A received an average of $30/day less than non-physiatry patients. However, after the physiatrist and physiatry team received PDPM training, in just one month, the community saw an increase of **$71/day** in PDPM per diem reimbursement as compared to prior months.

For the entire study, any stay of three days or less was removed from the analysis due to the 300% NTA bonus on Days 1-3, which would have inaccurately skewed the data. Having removed these super short stays, a total of 1497 PDPM days remained for Community A, including a limited number of residents who were skilled through the COVID-10 Public Health Emergency 1135 Waivers. Comparing 100% of residents who were managed by physiatry versus residents who did not receive physiatry services, the study showed that residents seen by physiatry achieved an additional **$40/day** in PDPM reimbursement, as compared to those residents who were not on the physiatry census. This amounted to **$51,277** increased PDPM reimbursement in just one month. These results, shown in Figure A were achieved with only 2-3 onsite physiatry visits per week in Community A.

Community A	December 2021 without Physiatry	Dec 2021 with Physiatry
Days	229	1268
Total Revenue	$168,845	$986,180
Average Per PDPM Per Diem Rate	$737.31/day	$777.75/day
Impact of Physiatry		**(+$40.44)**

Figure 1: Comparison of PDPM per diem rates in Community A for those residents who received physiatry and residents who did not receive physiatry services.

A second community was also included in the pilot study. Community B had significantly more Managed Care Payors as compared to Community A, and these PDPM scores are often dictated by the Managed Care companies. However, the PDPM Medicare A per diem rates in Community B were increased by over **$48/day** for the patients managed by physiatry services. This part of the analysis included 900 days that also excluded any super short stays less than 4 days in length. The results demonstrate again that the use of PDPM-trained physiatrists can improve the precision of ICD-10 coding and provide the supportive documentation necessary to improve the accuracy of the PDPM per diem rates, as shown in Figure 2. The total physiatry impact on PDPM reimbursement in just one month in Community B was **$43,479.**

	Medicare A PDPM Rates
Non-Physiatry Patient PDPM Rates	$661.22/day
Physiatry Patient PDPM Rates	$709.53/day
Difference	**+$48.31/day**

Figure 2: Comparison of Medicare A PDPM per diem rates in Community B for those residents who received physiatry and residents who did not receive physiatry services.

Impact on PDPM Per Diem Rates Through Physiatry

As part of the study, the results included an analysis of how physiatry impacted the PDPM per diem rates. The results show that impact was seen across all PDPM categories (Physical Therapy, Occupational Therapy, Speech Therapy, Nursing and Non-Therapy Ancillary), but the greatest impact was seen in Non-Therapy Ancillary. As shown in Figure 3 from Community A, residents who received physiatry services more often achieved a higher NTA Case Mix Group, or CMG, which yielded increased reimbursement. NTA CMGs of B and C (two of the highest reimbursing categories) were only achieved for patients treated by physiatry, showing 7% of cases at a B and 23% of cases at a C. The difference in daily per diems in this category are shown in Figure 4 for unadjusted Federal and Urban NTA rates. Community A was in an urban location, so even without the impact of the wage index, the per diem rates for residents with an NB are $209/day and an NC are $152/day. The non-physiatry group achieved increased NTA scores of NE and NF, which yield only $79/day and $59/day respectively. The category of NC was relatively stable between both groups, and a handful of NA days were achieved by the non-physiatry group. In community A the actual difference between NTA per diems was an increase of $18.64/day on average for patients that were managed by physiatry.

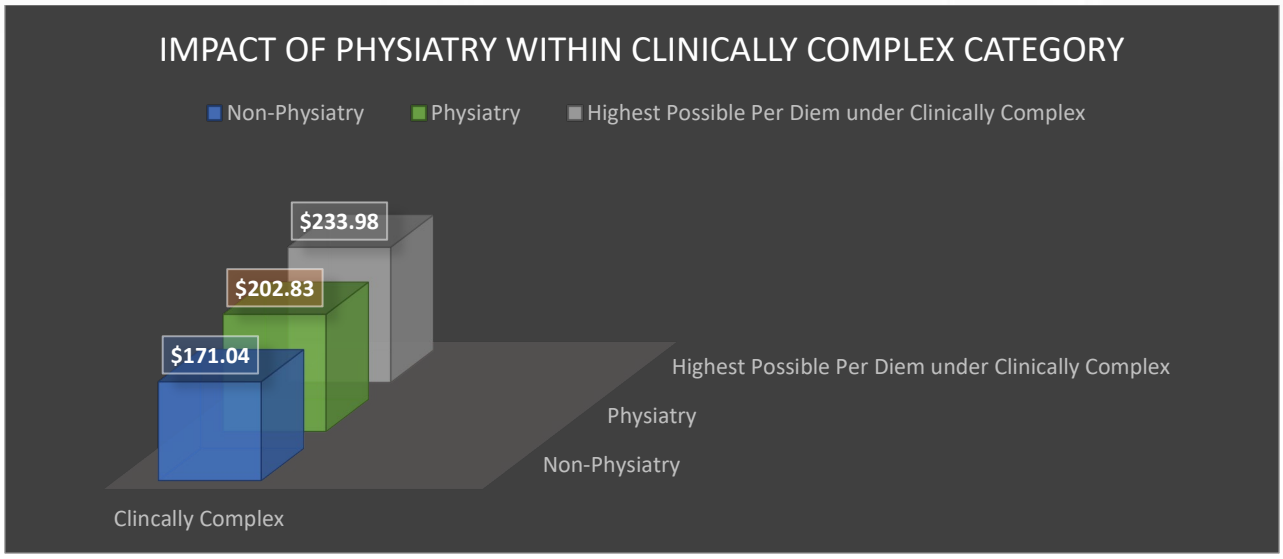

Figure 6: Impact of Physiatry within the Clinically Complex Category.

Reviewing the Medicare A cases from Community B, a higher NTA score was documented for the physiatry group 64% more often. This resulted in an NTA PDPM per diem rate increase of $29.63/day for patients managed by physiatry. The nursing category was also increased under physiatry from $218.91/day for the control group compared to $226.19/day for the physiatry group, netting an increase of $7.28/day. Finally, the PT and OT categories were combined as they always share the same PDPM CMG. Again, physiatry patients saw an increase of $8.06/day for the PT and OT combined PDPM reimbursement. These results see in Community B are shown in Figure 7.

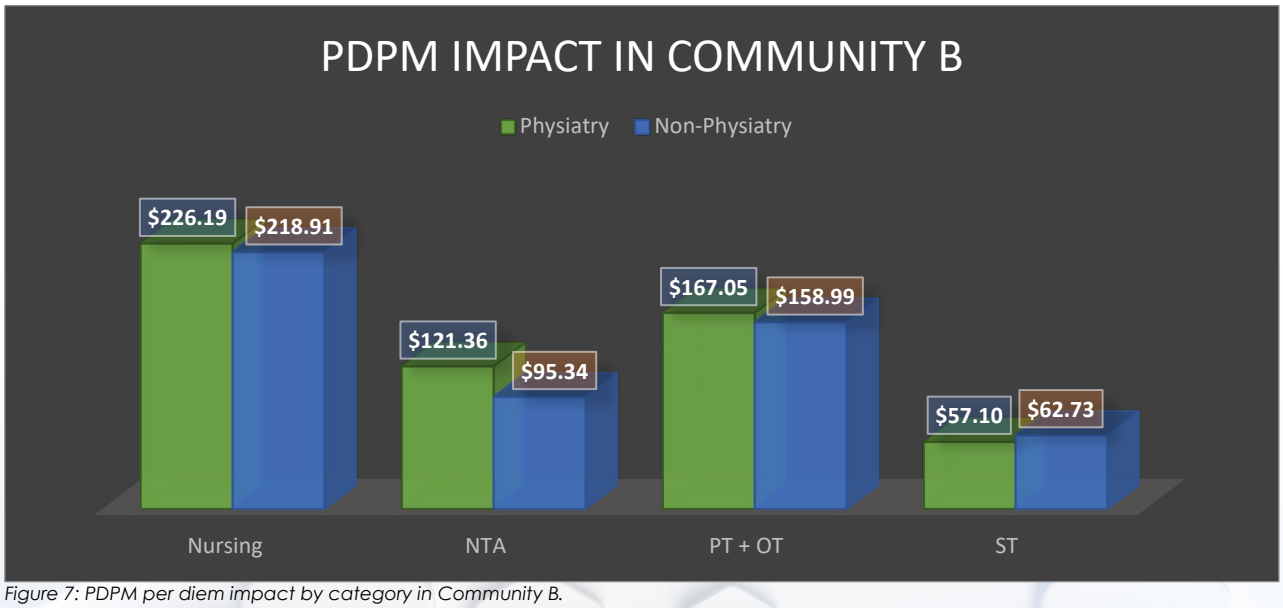

Figure 7: PDPM per diem impact by category in Community B.

PDPM Success

While few can doubt the positive clinical impact of partnering with exceptional physiatrists to provide additional layers of clinical oversight and insight, the supportive documentation and clinical expertise of PDPM-trained physiatrist teams can positively impact the accuracy of PDPM rates. As this study showed, in multiple communities and across multiple months, the skilled services and particular focus of documentation provided by physiatry yielded and increase in PDPM per diem rates of $40-$48/day. This was achieved across PDPM categories, impacting NTA and Nursing CMGs most significantly. A critical element to this success was the streamlined and consistent communication from the physiatry team to the MDS Coordinators, and specialized PDPM training received by the physiatrists in this study.

As physiatry services are not considered part of consolidated billing, the physiatry services can be provided by a vendor partner for no increased cost to the skilled nursing provider. To rise from the ashes of the pandemic, skilled nursing providers need to leverage every solution that improves the clinical approach along with the accuracy of PDPM per diems. From being able to accept and effectively manage patients with a higher acuity to improving the accuracy of PDPM-related supportive documentation, the results of this study demonstrate that physiatry can be a critical component toward achieving PDPM success.

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Melissa Brown

Chief Operating Officer
Gravity Healthcare Consulting

About the Author

Melissa Brown is the Chief Operating Officer with Gravity Healthcare Consulting. An Occupational Therapist with over 20 years of experience across the health care spectrum, Melissa, specializes in skilled nursing and long-term care settings. A self-described "PDPM Nerd" Melissa has studied over 4,000 pages of regulations and guidance from CMS to supply providers with key strategies and analysis for success under the payment model, while always striving for excellence in care. She has served as a clinical liaison and compliance officer for several rehabilitation services companies and is the host of the Gravity Healthcare Hacks Podcast. She specializes in strategizing through regulatory changes and burdens to help communities provide outstanding clinical care while achieving operational success.

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