Know the Facts!

PATIENT DRIVEN PAYMENT MODEL

Understanding the Myths and Realities of PDPM

Since October 1, 2019, skilled nursing facilities (SNFs) have been paid under a payment system known as the **Patient Driven Payment Model (PDPM)**. This system transitioned Medicare from fee-for-service to a value-based payment dependent on patients' clinical characteristics, such as diagnosis and comorbidities. This fundamentally shifted the way SNFs were paid for therapy services, changing from payment based on minutes of therapy provided to payment based on what types of services the patient may need, such as speech-language pathology services. When effectively engaged by SNFs, speech-language pathologists (SLPs) can help ensure compliance with Medicare regulations and support accurate reimbursement for their services.

When you're told "Medicare doesn't pay for that," here are the facts.

If SNFs have appropriately implemented PDPM, SLPs should be empowered to identify and treat patients who need their clinically necessary services rather than count the minutes of therapy provided to each patient. SNFs that state that SLPs are being laid off because of PDPM are not being transparent about the rationale for terminating therapists. SNFs that utilize SLPs to accurately and comprehensively code and document for speech, language, swallowing, voice, and cognitive impairments are more likely to receive payment for the services they deliver and avoid payment penalties under quality reporting or for survey and certification violations.

Under Resource Utilization Group-Version 4 (RUG-IV), payment was driven by the minutes of therapy provided. Some SNFs manipulated treatment time to maximize reimbursement. Under PDPM, some SNFs may establish administrative mandates to provide as little therapy as possible to maximize profit. But administrative mandates are not Medicare requirements—they are set by the SNF administration or contract therapy company. Medicare does not limit evaluations or treatment session amounts, frequencies, or durations. If an administrator takes action to limit any of these variables, **SLPs can reinforce their ethical obligation** (www.asha.org/medicare-snf/) to provide therapy based on the skilled, clinical needs of the patient.

Productivity standards are an industry-developed mechanism to maintain profitability and manage staff. They are not a payment policy. ASHA opposes productivity standards that compromise quality patient care and ethical service delivery. Standards do not typically include all activities required for patient care and may not support realistic practice. This undervalues the importance of strong documentation and high-quality care for patients. These important clinical and administrative tasks protect SNFs from negative post-payment audit findings. ASHA has developed **productivity resources** (https://www.asha.org/slp/productivity/)for our members to help them advocate for improvements to these standards with their employers.

Under PDPM, group and concurrent therapy are restricted to 25% of a patient's total episode of care, per therapy discipline. The use of group and concurrent therapy should always be clinically appropriate for the patient and part of an individualized plan of care. Administrative mandates to provide a certain percentage (e.g., 10%) of group and/or concurrent therapy for every patient regardless of need are inappropriate, unethical, and a violation of Medicare policy.

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Medicare does not dictate who can provide therapy.

Each facility determines how to use therapy clinicians in compliance with state licensing laws. If an administrator states that Medicare no longer allows you to perform certain types of services, it's not accurate. It is likely a facility-based decision, not a Medicare mandate. For example, Medicare does not dictate that cognition or swallowing services can only be provided by occupational therapists or SLPs.

Medicare does not require mandatory evaluations for every patient.

A brief assessment or screening can help you determine if a full evaluation is warranted. The SLP's clinical judgment and the needs of the patient remain paramount in the decision-making process. Administrative policies that mandate an evaluation and at least one treatment are inappropriate, unethical, and fraudulent when not clinically necessary.

Medicare has not changed the definition of skill that triggers coverage in SNFs.

Care in a SNF is covered under Medicare Part A if the following four factors are met:

- the patient requires skilled nursing services or skilled rehabilitation services (i.e., services that must be performed by or under the supervision of professional or technical personnel [see §§30.2 - 30.4]; that are ordered by a physician and the services are rendered for a condition which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF;
- the patient requires these skilled services daily (see §30.6);
- as a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF (see §30.7.); and
- the services delivered are reasonable and necessary for the treatment of a patient's illness or injury (i.e., they are consistent with the nature and severity of the individual's illness or injury, the individual's medical needs, and accepted standards of medical practice). The services must also be reasonable in terms of duration and quantity.

Medicare has not replaced clinical judgment and professional standards of practice with SNF-developed administrative mandates.

Clinicians can **advocate for appropriate clinical services** (www.asha.org/slp/healthcare/navigating-workplace-challenges-in-health-care/) with their employer. The need for clinical judgment and corporate compliance reporting remains your professional obligation. Administrative mandates that run counter to the clinical needs of the patient are inappropriate and unethical and are considered Medicare fraud.

[1]The American Occupational Therapy Association, American Physical Therapy Association, & American Speech-Language-Hearing Association. (n.d.). *Consensus Statement on Clinical Judgment in Health Care Settings AOTA, APTA, ASHA*. www.asha.org/uploadedfiles/aota-apta-asha-consensus-statement.pdf

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Learn more about PDPM:
www.asha.org/Practice/reimbursement/medicare/Medicare-Skilled-Nursing-Facility-Prospective-Payment-System/

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