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

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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 data included in the study. Three to four months of data were analyzed across three communities during the pilot study. And the data reveals that physiatrists can positively impact the PDPM reimbursement by **$58-$72/day** through ICD-10 coding, supportive documentation, and collaboration with the MDS, as seen in Figure 1.

Across all payors, residents seen by physiatry received an increase of $57.95 per day, or an overall increase of **$379,398** across 3 buildings. The physiatry services yielded an average increase of **$34,390** per facility per month during the study time frame. The greatest impact was seen with residents whose payor is traditional Medicare A. These patients saw an average increase of **$71.65**/day.

	IRC Physiatry Patients	Non-Physiatry Patients
All Payors		
Total Days	6547	4503
Total Reimbursement	$4,819,845	$3,054,126
Ave Per Diem Rate	$736.19	$678.24
IRC Impact	**$57.95**	
Med A		
Total Days	5295	3503
Total Reimbursement	$4,053,377	$2,430,580
Ave Per Diem Rate	$765.51	$693.86
IRC Impact	**$71.65**	

Figure 1: PDPM per diem rate impact of residents treated by physiatry versus those not treated by physiatry across all payors and all months.

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 did not receive more reimbursement 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. This demonstrates that the PDPM expertise of the physiatrists is critical, along with the quality of their documentation and their collaboration with the MDS Coordinators, and not merely that physiatry services are provided.

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 5957 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 **$58/day** in PDPM reimbursement, as compared to those residents who were not on the physiatry census. This amounted to **$240,958** increased PDPM reimbursement over 4 months. These results, shown in Figure 2 were achieved with only 2-3 onsite physiatry visits per week in Community A.

Community A	December 2021 – March 2022 without Physiatry	Dec 2021 – March 2022 with Physiatry
Days	1786	4171
Total Revenue	$1,1311,924	$3,304,810
Average Per PDPM Per Diem Rate	$734.56/day	$792.33/day
Impact of Physiatry		+$57.77

Figure 2: 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 physiatry impact was still more than **$5/day** for the Managed Care payors. Additionally, the PDPM Medicare A per diem rates in Community B were increased by over **$12/day** for the patients managed by physiatry services. 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 3. The total physiatry impact on PDPM reimbursement in across the study was **$26,456** for Community B.

Community B	MEDICARE A without Physiatry	MEDICARE A with Physiatry	Managed Care A without Physiatry	Managed Care A with Physiatry
Days	287	711	713	1125
Total Revenue	$189,300	$477,984	$425,206	$676,711
Average Per PDPM Per Diem Rate	$659.58/day	$672.27/day	$596.36/day	$601.52/day
Impact of Physiatry		**+$12.69**		**+$5.16**

Figure 3: Comparison of Medicare A and Managed Care A PDPM per diem rates in Community B for those residents who received physiatry and residents who did not receive physiatry services, from December 2021 through March 2022.

Community C was the smallest community in the pilot study, and has less focus on short term rehabilitation clients than the other communities in the study. However, they also showed the positive impact of the PDPM trained physiatrists. In Community C, an increase of **$10.51** was seen across all payors during the study timeframe. Medicare A patients saw in increase of **$5.27** per day, and Managed Care residents saw an even larger increase of **$15.67** per day, as shown in Figure 4.

Community C	MEDICARE A **without Physiatry**	MEDICARE A **with Physiatry**	**Managed Care A without Physiatry**	**Managed Care A with Physiatry**	**All Payors without Physiatry**	**All Payors withPhysiatry**
Days	1430	413	287	127	1717	540
Total Revenue	$929,356	$270,583	$198,340	$89,757	$1,127,696	$360,340
Average Per PDPM Per Diem Rate	$649.90/day	$655.16/day	$691.08/day	$706.75/day	$656.78/day	$667.30
Impact of Physiatry		**+$5.27**		**+$15.67**		**+$10.51**

Figure 4: Comparison of all payor PDPM per diem rates in Community C for those residents who received physiatry and residents who did not receive physiatry services, from January 2022 through March 2022.

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 4 from all communities, residents who received physiatry services more often achieved a higher NTA Case Mix Group, or CMG, which yielded increased reimbursement. The NTA CMG of A (the highest reimbursing categories) was only achieved for patients treated by physiatry, showing 3% of cases. The next two highest categories were led by physiatry patients, with 5% of the NTA CMG of B, and 12% at C. The difference in daily per diems in this category are shown in Figure 5 for unadjusted Federal and Urban NTA rates. Removing the impact of the wage index in these communities, the per diem rates for residents with an NA are $267/day, and an NB are $209/day and an NC are $152/day. The non-physiatry group achieved increased NTA scores of ND and NE, which yield only $109/day and $79/day respectively. Across all the communities, the actual difference between NTA per diems was an increase of **$28.33/day** on average for patients that were managed by physiatry, with the impact of the wage index removed (which was over 1.3 in some locations).

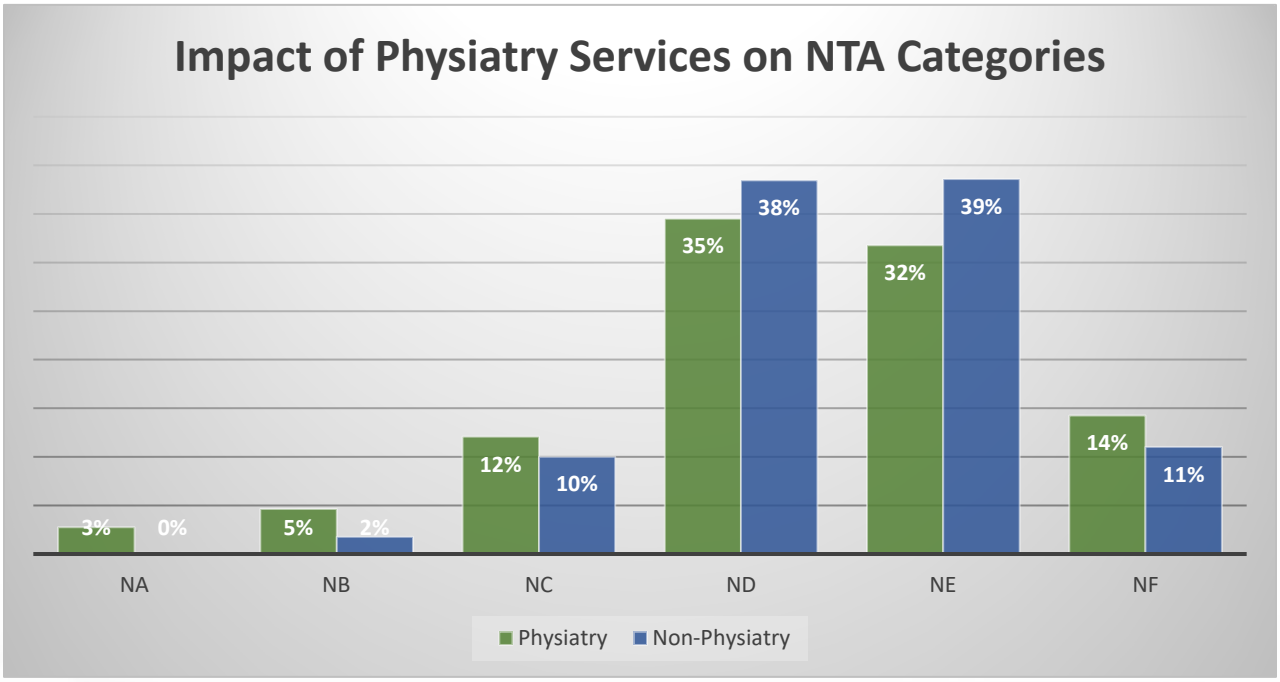


Figure 4: Impact of Physiatry Services on NTA Categories in all Communities.

NTA Component			Daily NTA Urban	Increased NTA Rate on Days 1,2,3	Daily NTA Rural	Increased NTA Rate on Days 1,2,3
NTA Comorbidity Score	NTA Case Mix Group	CMI				
12+	NA	3.24	$267.75	$803.25	$255.83	$767.49
9-11	NB	2.53	$209.08	$627.24	$199.77	$599.31
6-8	NC	1.84	$152.06	$456.18	$145.29	$435.87
3-5	ND	1.33	$109.91	$329.73	$105.02	$315.06
1-2	NE	0.96	$79.33	$237.99	$75.80	$227.40
0	NF	0.72	$59.50	$178.50	$56.85	$170.55

Figure 5: FY 2022 PDPM Rates for NTA Components.[2]

Additionally, the patients who received physiatry evaluations and services were more likely to achieve a higher Nursing CMGs. This was due to the ICD-10 coding provided by the physiatrists, along with supportive documentation that enabled the MDS Coordinators to code clinical indicators that impacted Nursing CMGs. Neither group received a high amount of extensive services CMGs (at 1% and 5%), but the physiatry group achieved 16% more CMGs that were for the second highest Nursing CMG, Special Care High. The Clinically Complex CMG was achieved 4% more often by physiatry than the control group. Both groups yielded 7% at the Behaviors and Cognitive Performance CMG. However, the lowest paying CMG category, Physical Functioning Reduced was captured by non-physiatry patients twice as often, at 20%. The end result, after removing the impact of the wage index, was an increase in the nursing per diems of $8.65 per day achieved by physiatry patients.

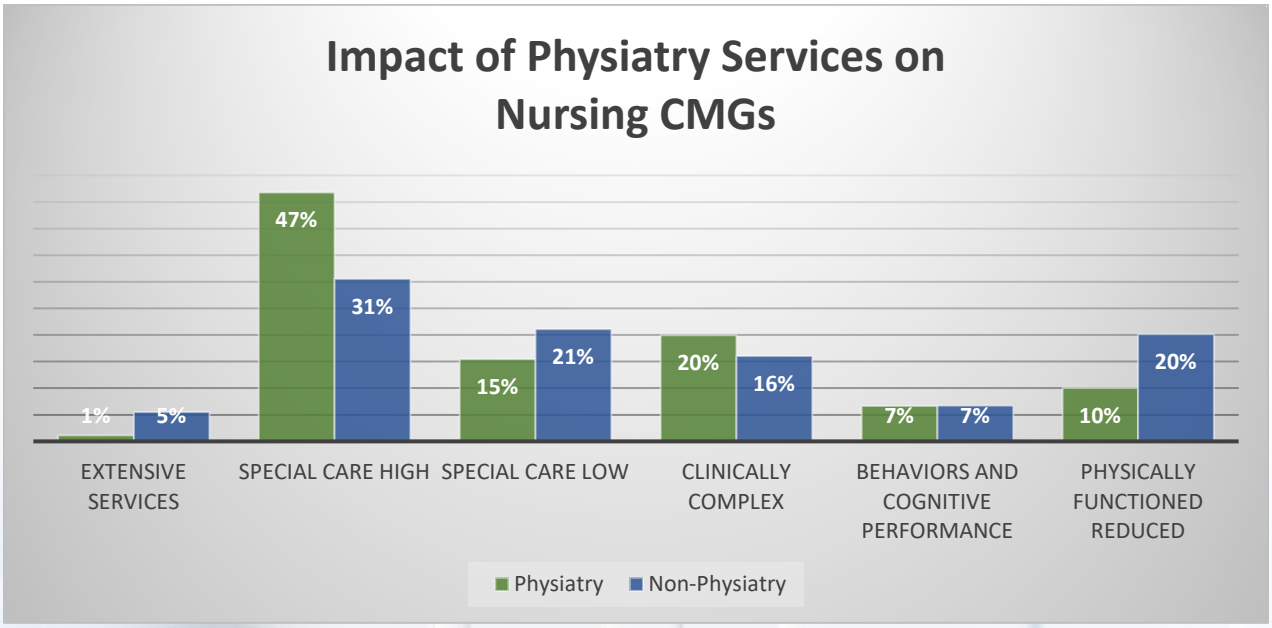


Figure 6: Impact of Physiatry Services on Nursing CMGs across all communities.

Reviewing all of the CMG categories across payors and including all buildings, a higher ST score was obtained with the physiatry group as seen in Figure 8. This resulted in an increase of **$5.24** per day in ST reimbursement for those residents seen by physiatry services. The PT and OT group was not positively impacted by physiatry services, but this is likely due to the fact that these categories have the least opportunity to be impacted by the care and the documentation of the physiatrist.

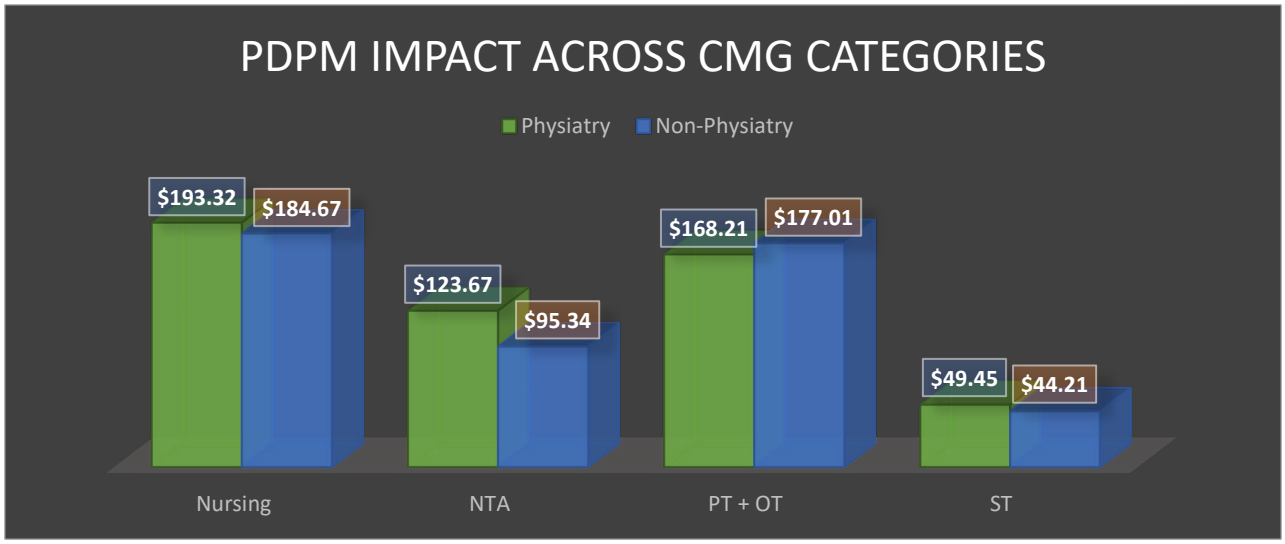
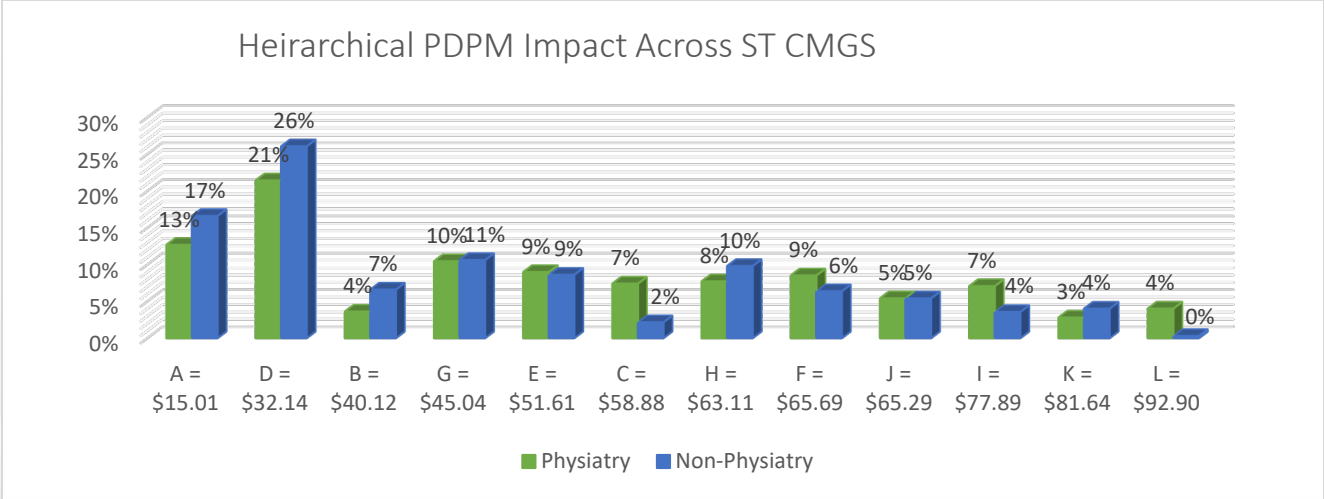


Figure 8: PDPM per diem impact by CMG Category in all communities, with the wage index removed.

Speech Therapy (ST) PDPM reimbursement does not follow a linear path, and thus a CMG of SD actually pays less than the SC CMG. Arranging the CMGs according to a hierarchical reimbursement pattern as seen in Figure 9 shows the positive impact of physiatry services. The two lowest paying ST CMGS of A and D, were captured by the non-physiatry group 4% more and 5% more respectively. These categories yield such low reimbursement that it is often difficult to even provide any Speech Therapy services without taking a loss. However, some of the highest paying ST CMGs of C, F, I and L all were captured by physiatry between 3-5% more often than the non-physiatry group.



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 **$58-$72/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 services and PDPM expertise can be a critical component toward achieving PDPM success.

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About the Author

Melissa Brown is the Chief Operating Officer with Gravity Healthcare Consulting. An Occupational Therapist with over 15 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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