PDPM, PDGM, and the Healthcare Practitioner

Amber Heape, CScD, CCC-SLP, CDP, CMDCP
Pruitthealth Therapy Services

State Advocate for Medicare Policy (StAMP) Representative-South Carolina

1

RUG-IV vs. PDPM

	RUG-IV	PDPM
Reimbursement primarily driven by	Therapy minutes provided	Clinically relevant factors (not therapy minutes)
Number of case-mix groupings for nursing	43 Nursing RUGs,	25 Nursing CMGs
Case-mix for therapy	5 major levels of therapy minutes (with or without extensives)	16 CMGs for PT/OT (related to self care, mobility) 12 CMGs for ST (related to 3 elements)
MDS Assessments	5, 14, 30, 60, 90 day; EOT, COT, …….	5 day admission, Interim Payment Assessment (IPA), Discharge Assessment

ST Elements:
- Clinical category
- SLP-related comorbidities
- Presence of cognitive impairment

2

SLP Clinical Components

- Acute Neurological
- Presence of cognitive impairment
- Use of mechanically altered diet
- Presence of dysphagia
- Other SLP-related comorbidities

(Each component area directly contributes to the SLP Case Mix Index Formula)

3

SLP-Related Comorbidities

Aphasia	CVA or TIA
Hemiplegia or Hemiparesis	Apraxia
Traumatic Brain Injury	ALS
Tracheostomy (while resident)	Oral Cancer
Ventilator	Speech & Language Deficits

4

PDPM Cognitive Score

- Brief Interview for Mental Status (BIMS)
  - Alternative for patients who cannot complete BIMS is a staff assessment (Cognitive Performance Scale)

PDPM Cognitive Level	BIMS Score
Cognitively Intact	13-15 **
Mildly Impaired	8-12
Moderately Impaired	0-7
Severely Impaired	-

** This does NOT always mean no deficits in terms of our standardized ST measures!

5

PDGM

Affects Home Health companies, as well as private practitioners who treat patients in their homes.

PDGM payment is based on:

- Source of admission (community or institutional).
- Lower payment for the second 30 days of a 60-day episode.
- Assigned clinical category
- Comorbidities
- Patient's level of function (low, medium, or high).

(Information from www.asha.org)

6

PDGM- Assigned Clinical Category

- Musculoskeletal Rehab (Includes SLP)
- Neuro/ Stroke Rehab (Includes SLP)
- Wound Care
- Complex Nursing Interventions
- Behavioral Health
- Medication Management
- Surgical Aftercare for
  - Cardiac/circulatory
  - Endocrine
  - GI/GU
  - Infectious Disease/Cancer/ Blood diseases
  - Respiratory
  - Other

7

ASHAWIRE

The Patient-Driven Groupings Model: What It Means for Speech-Language Pathologists Working in Home Health

Perspectives of the ASHA Special Interest Groups, Volume: 4, Issue: 6, Pages: 1555-1559, https://doi.org/10.1044/2019_PERSP-19-00037

Characteristics of the patient-driven groupings model. MS = muskuloskelatal; MMTA = medication management, teaching, and assessment; GI= gastrointestinal; OASIS = Outcomes Assessment Information Set.

8

Service Delivery

- Individual
- Group
- Concurrent
- Cotreat

9

Individual Therapy

- 1 therapist: 1 patient
- Still the preferred mode for quality of care
- Tailored to patient needs
- Consistent across payers

***RAI Definition**: The treatment of one resident at a time. The resident is receiving the therapists' or the assistants' *full attention*. Individual minutes do not need to be done consecutively. The total number of individual treatment minutes should be added together for each treatment day. For example, if you saw Mrs. Smith alone for 20 minutes in the morning and went back after lunch and provided another 10 minutes one-on-one, your total individual minutes for the day would be 30.

10

Group Therapy

- 1 therapist: 2-6 patients

***RAI Definition**: Group therapy is defined for Part A as the treatment of two to six residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals.

11

Group Therapy

- For SNFs: Group and concurrent may total no more than 25% of the total treatment time per episode of care for patients with Medicare part A
  - 2-6 patients in a SNF setting

  **Always check your LCD to see if the MAC has any other stipulations
- For IRFs: restrictions on maximum percentage are not currently in place.
  - 2-6 patients in a IRF setting

  **Documentation must include-
  - Reason for group and that it is part of an individualized POC
  - Demonstrate that group therapy was provided based on the clinical needs of the patient
  - Describe goals and outcomes

12

Can Group Therapy be Done with MCB?

- Yes!
- Medicare Benefit Policy Manual, Chapter 15:
  - **Group Therapy Services.** Contractors pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) provided simultaneously to two or more individuals by a practitioner as group therapy services. The individuals can be, but need not be, performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.

  ***RAI Manual:** For Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment. For all other payers, follow Medicare Part A instructions.

13

Concurrent Therapy

- 1 therapist: 2 patients
- Medicare Part A and Ins only (Not part B)

RAI Definition**: The treatment of 2 residents at the same time. These residents are ***not performing the same or similar activities. Both of these residents are in line of sight of the treating therapist or assistant. The 2 residents ***do not*** need to have the same insurance.

14

Cotreatment

- 2 therapists from different disciplines: 1 patient

RAI Manual:

- For Part A: When two clinicians (therapists or therapy assistants), each from a different discipline, treat one resident at the same time with different treatments, both disciplines may code the treatment session in full.
  - For example, if two therapists (from different disciplines) were conducting a group treatment session, the group must be comprised of two to six participants who were doing the same or similar activities in each discipline.
  - The decision to co-treat should be made on a case by case basis and the need for cotreatment should be well documented for each patient. Because co-treatment is appropriate for specific clinical circumstances and would not be suitable for all residents, its use should be limited.
- For Part B: Therapists, or therapy assistants, working together as a "team" to treat one or more patients cannot each bill separately for the same or different service provided at the same time to the same patient. CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same patient(s).
  - Where a physical and occupational therapist both provide services to one patient at the same time, only one therapist can bill for the entire service or the PT and OT can divide the service units. For example, a PT and an OT work together for 30 minutes with one patient on transfer activities. The PT and OT could each bill one unit of 97530. Alternatively, the 2 units of 97530 could be billed by either the PT or the OT, but not both.

15

Speech/Language/Cognitive Communication Codes

- 92521- Evaluation of speech fluency (e.g.., stuttering, cluttering)
- 92522- Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
- 92523- Evaluation of speech production (e.g., articulation, phonological process, apraxia, dysarthria); **WITH** evaluation of language comprehension and expression (e.g., receptive and expressive language)
  - If you do not include a speech component to the evaluation, you must use a -52 modifier
  - For Cognitive Linguistic disorders, BCRS, SLUMS, MOCA are examples of tests you would use for 92523
- 92507- Treatment of speech, language, voice, communication, and/or auditory processing disorder- (Individual, Concurrent, or Cotreat)
- 92508- Treatment of speech, language, voice, communication, and/or auditory processing disorder- Group

16

Cognitive Performance Coding

- 96125-Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.
  - Subtests of standardized tests may be used if the subtests themselves are standardized.
  - If the time is less than 31 minutes, you would need to apply the -52 modifier.
  - Some FIs only allow this code if decline is due to an acute neurological event (CVA, TBI)

G0515 deleted. Instead:

- 97129- Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity, direct (one-on-one) patient contact; initial 15 minutes (Report 97129 only once per day)
- 97130- each additional 15 minutes (list separately in addition to code for primary procedure)

***You cannot bill these treatment codes on the same day as 92507 or 92508

17

Dysphagia Coding

- 92610- Evaluation of oral and pharyngeal swallowing function
- 92526- Treatment of swallowing and dysfunctional or oral function for feeding
- 97150- Group Therapeutic Procedures (Only Palmetto accepts currently!)
- 92611- Videofluoroscopic Swallow Study
  - 74230 is the Radiologist's CPT code
- 92612- Flexible fiberoptic endoscopic evaluation of swallowing (FEES)
  - IF an external company is providing FEES, billing may look like this:
    - During a FEES, the external FEES provider bills this CPT code for time that the scope is placed and video running.
    - The facility SLP present can bill for the remaining time, interpretation, and counseling the patient on FEES results. (using the dysphagia evaluation or treatment code- according to which is occurring.)

18