

MEDICARE SKILLED THERAPY UNDER PDPM

ISSUE ALERT

BACKGROUND

What is PDPM? The Patient Driven Payment Model (PDPM) is the latest payment system for Medicare-covered nursing home care. PDPM creates a new set of [financial incentives](#) for nursing homes when deciding whom to admit, what type of care to provide, and when to discharge a nursing home resident. Unfortunately, one of the biggest concerns surrounding PDPM's implementation is the risk it poses to residents in need of skilled therapy.

How Does PDPM Affect Therapy? The Centers for Medicare & Medicaid Services (CMS) indicates in the 2018 [final rule's impact analysis](#) that nursing homes have a greater financial incentive under the new payment system to provide little to no therapy to residents. Making matters worse, PDPM allows nursing homes to provide 25 percent of a resident's total therapy regime, by discipline, in group and/concurrent therapy settings *without* any penalty for exceeding that percentage. As a result, residents may experience both less therapy overall and less individualized therapy in particular under the new payment system.

How Have Nursing Homes Responded? Within days of PDPM's implementation, reports began to validate concerns about its effects on therapy. For example, Modern Healthcare [reported](#), "[s]killed-nursing chains have terminated or 'transitioned' many of their therapists. Those who remain have been asked to boost their productivity and quickly cycle through patients as well as increase their use of group and concurrent therapy rather than one-on-one sessions."

Where Does CMS Stand? While PDPM changes Medicare reimbursement, it does not change Medicare coverage and eligibility criteria. In [FAQs](#), CMS specifically states that "PDPM does not change the care needs of SNF patients, which should be the primary driver of care decisions, including the type, duration, and intensity of skilled therapies, made on behalf of SNF patients." ***Thus, therapy decisions must still be based on clinical standards and judgment related to individual care needs.***

RESIDENTS' RIGHTS

Introduction. While therapy decisions must be based on the individualized care needs of residents, the financial incentives emphasize the need for increased vigilance in ensuring residents receive skilled therapy. Following are standards of care we have identified as being potentially useful when challenging a nursing home's decision not to provide, or provide little, skilled therapy to a resident.

Care Planning. Federal law requires nursing homes to provide residents with services that help them attain and maintain their highest practicable physical, mental, and psychosocial well-being in accordance with their written plan of care. 42 U.S.C. § 1395i-3(b)(2). Resident care plans must be person-centered and prepared with the participation, to the extent practicable, of the resident, family members, or legal representative. Federal regulations expand on these requirements and include (1) the right to participate in establishing expected goals and outcomes of care, including the type, amount, frequency, and duration of care; and (2) the right to receive the services in the care plan. 42 C.F.R. § 483.10(c)(2).

Baseline Care Plan. Federal regulations require nursing homes to develop and implement a baseline care plan with 48 hours of a resident's admission. 42 C.F.R. § 483.21(a). The baseline care plan must include the minimum information necessary to properly care for a resident, including person-centered information related to therapy services.

Note: A more comprehensive care plan must be developed within 21 days of a resident's admission; however, PDPM financially incentivizes nursing homes to discharge residents within 15 days of admission. Therefore, some residents may never have a comprehensive care plan in place. Residents should make sure that a baseline care plan is implemented quickly and addresses their therapy needs.

Skilled Therapy. Federal regulations specify that nursing homes must provide skilled therapy services to residents, including physical therapy, occupational therapy, and speech language pathology, as required by the care plan. 42 C.F.R. § 483.65(a)(1)-(2). CMS's Interpretive Guidance for this standard notes that these therapies are specialized because they "are provided based on each resident's individual assessed rehabilitative needs based on their comprehensive plan of care and can only be performed by or under the supervision of qualified personnel."

MAINTENANCE THERAPY

Introduction. PDPM's effect on skilled therapy, combined with the financial incentive to discharge residents sooner, likely mean residents in need of ongoing maintenance therapy will face the biggest challenges under the new payment system. Following is key information about a court-approved settlement agreement that confirms Medicare coverage of maintenance programs.

Jimmo Settlement Agreement. The settlement agreement in [*Jimmo v. Sebelius*](#) required CMS to confirm that Medicare coverage depends on an individual's need for skilled nursing and/or therapy, **not** on his or her potential for improvement. As a result, residents in a Medicare-covered nursing home stay can receive skilled therapy to maintain their condition or to slow or prevent further decline. The *Jimmo* Settlement pertains to all Medicare beneficiaries nationwide, regardless of whether a resident has traditional Medicare or Medicare Advantage.

Medicare Appeals. A nursing home's decision to terminate Medicare-covered skilled therapy is appealable. Nursing homes are required to give residents the Notice of Medicare Non-Coverage (NOMNC) **TWO** days before the termination of skilled care. The NOMNC has instructions for requesting a redetermination and beginning the appeals process. In addition to identifying why skilled therapy is still medically necessary, residents or their representatives should use the *Jimmo* Settlement to educate providers, contractors, and administrative law judges about Medicare's coverage of maintenance therapy. For more information about Medicare appeals in light of the *Jimmo* Settlement, please see the [Center for Medicare Advocacy's Checklist Toolkit](#).

CONCLUSION

Residents in a Medicare-covered nursing home stay are entitled to skilled therapy services. Federal law and regulations give residents the right to participate in their care planning and request individualized therapy services. Nursing homes must provide therapy services to residents that are medically necessary and part of their care plans, including maintenance therapy. Although PDPM has created new financial incentives for nursing homes, resident care must still be based on clinical standards and judgments.