SLP HACK:

any method, skill or information that increases efficiency and treatment!

THE PURPOSE OF THE SLP HACK IS FOR CLINICIANS TO SWAP TIPS, MATERIALS SO WE ALL CAN PROVIDE THE BEST CARE.

PDPM & SPEECH-LANGUAGE PATHOLOGY

It is coming! Effective October 1, 2019, CMS will be implementing a new Medicare Part A payment model called the Patient-Driven Payment Model (PDPM), which will be a change for our setting and for our profession. PDPM shifts the focus of payment from the volume of therapy minutes provided to the patient's condition, complexities, and resulting skilled care needs.

Medicare Guidelines that do not Change

In order for SLP services to be considered reasonable and necessary, the following conditions must be met:

1. Services must meet accepted standards of practice and be a specific and effective treatment for the patient's condition;
2. The services must be of the level of skill and complexity that they can be only safely and effectively performed by a qualified SLP;
3. There must be an expectation that the patient's condition will improve in a reasonable period of time or the services are necessary to establish a safe and effective maintenance program. A maintenance program consists of activities that preserve the patient's present level of function and prevent regression of that function.
4. Patient goals are to be functional, objective and individualized.

A Note about Medical Diagnosis: A qualifying primary medical diagnosis is the chief reason for continued care in a SNF. This diagnosis should be added to an ST evaluation to support medical necessity. Additional medical diagnoses should be added to support the rationale for ST treatment. A medical diagnosis is the etiology that explains a patient's signs and symptoms.

Where can I find a medical diagnosis? Physician orders (if signed in within last 60 days), physician progress notes, admission H&P, discharge summary from hospital, and medical diagnosis list from the facility. A diagnosis can only be assigned based on documentation by the patient's provider, a physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis.

ASPECTS OF PDPM THAT DIRECTLY AFFECT SLPS:

1. **Number of Assessments**: The Initial Medicare Assessment (completed Days 1-8) is an MDS and sets payment for the entire Medicare Part A stay, unless an Interrupted Payment Assessment (IPA) is completed. Gone are rolling windows, COTs, EOTs, and multiple scheduled MDSes.

2. **New Definition of Group Therapy:** "A qualified rehabilitation therapist or therapy assistant treating **2 to 6 patients** at the same time who are performing the same or similar activities." Only a clinician can determine if group therapy is appropriate for a patient, as well as the type of group therapy provided and the size of the group. CMS also reiterated that when group [or concurrent] is used, there must be documentation to justify the medical necessity of those therapy modes. The ST group code to use is CPT 92508;

3. **Group and Concurrent Restrictions**: PDPM restricts the use of group and concurrent therapy to a combined 25% of a patient's total therapy per discipline. There is not a mandate to provide group or concurrent treatment.

4. **Payment**: The SLP case mix group is determined by whether the patient has one or more of the following
    - A swallowing disorder (as determined by coding on Section K of the MDS) and/or
    - A mechanically altered diet (as determined by coding in K0510C2 of the MDS).
    - Acute neurologic condition (as determined by the patient's primary medical diagnosis),
    - Cognitive impairment (as determined by a BIMS score of 12> or staff assessment) and/or
    - An SLP comorbidity related to speech-language or swallowing disorders (see chart).

Aphasia	CVA, TIA, Stroke	TBI	Hemiplegia, hemiparesis	Trach care while a resident	Vent/respirator while a resident
Laryngeal Cancer	ALS	Dysphagia	Aphasia	Oral Cancers	Speech and Language Deficits

A combination of these characteristics produce 12 speech-language pathology case-mix groups that determine payment

How do I know which diagnoses fall into each of the 12 SLP comorbidity categories? CMS released a mapping tool that is a crosswalk from diagnoses to SLP comorbidity category. You must map each diagnoses to see if it maps to an SLP comorbidity. You can find it here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/SNFPPS/PDPM.html

You can also use the app PDPM Mapper!

ASPECTS OF PDPM THAT DIRECTLY AFFECT SLPS: (Continued)

5. **Accountability**: Historical data (e.g., MDS coding, therapy outcomes, ST use of nonspecific ICD-10 codes) was utilized to create the list of SLP comorbidity diagnoses that impact ST case mix groups. It is a limited list. There was simply not enough historical data to support additional diagnoses to be added, such as Parkinson's disease, dementia, MS, voice disorders, etc. The list can and will be (hopefully) modified as CMS refines the payment system and as MDS coding and SLP diagnosis selection become more accurate. It is important for SLPs and SNFs to accurately and comprehensively include the specific diagnoses in our documentation that demonstrate skilled therapy.

6. **Tracking Therapy Services**: The value of the full range of speech-language services will be evidenced by patient outcomes rather than by the volume of therapy minutes provided. Facilities will still be required to track total therapy days and minutes per treatment mode (i.e., individual, group, and concurrent) on the Initial Medicare Assessment and on the Discharge Assessment. Significant changes in operations may be trigger a Medicare Audit. For example, if a facility codes a huge increase in mechanically altered diets, CMS may audit to see if that section of the MDS was coded appropriately because that item is now attached to reimbursement. Trends will be utilized to make changes in the future.

7. **Cognitive Assessment**: A patient's cognition will be assessed via the Brief Interview for Mental Status (BIMS). If a BIMS cannot or is not completed, a resident staff assessment for cognition is done. Social Services usually administers the BIMS. For compliance purposes, it is recommended SLPs not administer the BIMs. It is recommended, however, that the SLP communicate any cognitive impairment identified upon evaluation to the interdisciplinary team.

8. **RNPs**: Restorative/maintenance services can be simultaneously provided along with skilled rehabilitation services. Please contact your DOR for further information about the TOC program.

9. **Preparation**: Know the items that determine the SLP case mix group (see #4) and relay that information to your interdisciplinary team. Each facility varies on how the team will disperse information – find out the process in your facility and relay pertinent information as needed. Continue to provide quality care to your patients. Think outside of the box and start getting creative with your treatment approaches. Begin incorporating group and concurrent treatment when appropriate. Make sure your documentation supports the skilled services you are providing. And remember-the requirements for medically necessity speech, language, and swallow therapy are not changing, just the way we are paid.

*Remember this is a hack (a very simplified and quick version). For additional information, please refer to the **Rehab Synergies Monthly PDPM Webinars on GoToStage**, join PDPM Resources for SLPs on Facebook, or contact Melissa Collier, your DOR, Regional and/or Clinical Liaison.

Resources: https://www.monterotherapyservices.com/articles/medicare-part-a-and-part-b-updates-for-the-snf-setting-new-cms-rules-released, https://leader.pubs.asha.org/doi/full/10.1044/leader.PA.23102018.26