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PDGM
It All Starts Here: Referrals and Intake

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v1.0

PDGM

It All Starts Here: Referrals and Intake

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Today's Objectives

Understand what you and your intake, liaison and sales staff need to know now about the PDGM structure related to admission and timing.

Understand how to improve the working relationship between your clinical, intake and sales teams.

Identify the steps to take now to change your referral source mix.

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It's a Changing World!

In a world of change…
there is no standing still!

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Patient Driven Groupings Model (PDGM) Goals

- Better align payment with costs
- Increase access to vulnerable patients associated with lower margins
- Address payment incentives in current system, i.e. eliminate impact of therapy volume on payment
- Place patients into clinically meaningful payment categories
- Effective January 1, 2020

Used with Permission: Abt Associates, Medicare Home Health Prospective Payment System: Case Mix Methodology Refinements: Overview of Home Health Grouping Model. November 18, 2016.
HHS. CMS. Medicare and Medicaid Programs: CY 2019 Home Health Prospective Payment System Rate Update and Proposed CY 2020 Case-Mix Adjustment Methodology Refinements; Home health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements. Final Rule.

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30-Day Unit of Payment

- 30-day period = days 1-30 of a current 60-day episode where "day 1" is the current 60-day episode's *From Date*. Second period is days 31 and above.
- CMS will calculate a proposed, national, standardized 30-day payment amount. Would propose the actual 30-day payment amount in the CY 2020 HH PPS proposed rule.
- Going forward will calculate payment amount by updating the preceding year by the HH payment update percentage.

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PDGM Case Mix Weight Structure

- Admission Source and Timing
- Clinical Grouping
- Comorbidity Adjustment
- OASIS Items-Functional Level

An episode is grouped into one (and only one) subcategory under each category. An episode's combination of subcategories groups the episode into one of 432 different payment groups.

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Patient Driven Groupings Model

1 Admission Source and Timing
- Community Early
- Community Late
- Institutional Early
- Institutional Late

3 Functional Level
- Low
- Medium
- High

2 Clinical Group
- Neuro Rehab
- Wounds
- Complex Nursing Interventions
- MS Rehab
- Behavioral Health
- MMTA - Surgical Aftercare
- MMTA - Cardiac/Circulatory
- MMTA - Endocrine
- MMTA - GI/GU
- MMTA - Infectious Disease/ Neoplasms/Blood-Forming Disease
- MMTA – Respiratory
- MMTA - Other

4 Comorbidity
- None
- Low
- High

= HHRG 432

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Admission Source

•Uses a 14 day "look-back" period

•Community: no acute or post-acute care in the 14 days prior to the HH admission (30 day periods; second 30 days of a 60 day episode is assigned community)

•Institutional: acute or post-acute (SNF, inpatient rehab facility, long term care hospital, psychiatric inpatient) care in the 14 days prior to the HH admission

Medicare claims processing system would check for presence of an acute/post-acute Medicare claim occurring within 14 days of the HH admission on an ongoing basis.

Manual Occurrence Codes will be allowed

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Average Resource Use by Admission Source

Admission Source	Average Resource Use	Number of Periods	25th Percentile	Median	75th Percentile
Institutional	$2,171.00	2,215,971 (25.7%)	$1,246.05	$1,920.06	$2,791.91
Community	$1,363.11	6,408,805 (74.3%)	$570.26	$1,062.05	$1,817.75
Total	$1,570.68	8,624,776 (100%)	$679.12	$1,272.18	$2,117.47

Source: Department of Health and Human Services. Centers for Medicare & Medicaid Services. CMS-1689-P. CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements. Proposed Rule. Filed July 2, 2018.

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Average Revenue Community and Institution

Admission Source	Percent of 30-Day Periods	PDGM Payment/Period
Community Early	13.38%	$2,135
Community Late	60.60%	$1,400
Institutional Early	19.31%	$2,419
Institutional Late	6.72%	$2,221

Source: Fazzi Business Intelligence Division

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Timing

•Only the first 30-day period in a sequence of periods be defined as early and all other subsequent 30-day periods would be considered late.

•First episodes are those where the beneficiary has not had home health in the 60-days prior to the start of the first episode.

To identify the first 30-day period in a sequence, Medicare claims processing system would verify that the claims "From date" and "Admission date" match.

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Clinical Groupings

- Each 30-day period of care will be assigned to one of twelve groups based on the reported principal diagnosis.
- Diagnosis code must support the need for HH services.
- Secondary diagnosis codes would then be used to case-mix adjust the period further through additional elements of the model, such as the comorbidity adjustment.

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Questionable Encounters

Episodes that can't be assigned to a clinical group. The primary code was:

- Too vague
- Related to a non-home health covered service
- Manifestation code
- Unlikely to require skilled, home health care
- Too acute

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Coding Tips from Fazzi's Coding QI Team

Common Coding Practices to Avoid:

Unspecified codes: Injury site NOS, Muscle Weakness

Coding Etiology before Manifestation codes: Foot ulcer, diabetes

Symptom codes as primary: Rash

Inappropriate acute conditions: Acute renal failure

Diagnoses not supporting need for homecare

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PDGM Clinical Groups

Clinical Group	Primary Reason for HH Encounter:
Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
Wounds - Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcers, burns and other lesions
Behavioral Health Care	Assessment, treatment and evaluation of psychiatric conditions
Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies

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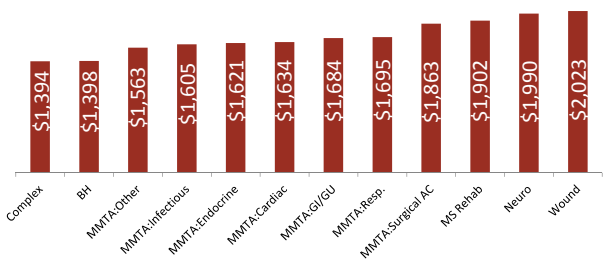
PDGM Clinical Groups, *Continued*

Clinical Group	Primary Reason for HH Encounter:
MMTA – Surgical Aftercare	Assessment, evaluation, teaching, and medication management for surgical aftercare
MMTA – Cardiac/Circulatory	Assessment, evaluation, teaching, and medication management for cardiac or other circulatory related conditions
MMTA – Endocrine	Assessment, evaluation, teaching, and medication management for endocrine related conditions
MMTA – GI/GU	Assessment, evaluation, teaching, and medication management for gastrointestinal or genitourinary related conditions
MMTA – Infectious Disease/Neoplasms/Blood-forming Diseases	Assessment, evaluation, teaching and medication management for conditions related to infectious diseases, neoplasms, and blood-forming diseases
MMTA – Respiratory	Assessment, evaluation, teaching and medication management for respiratory related conditions
MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups

Revenue by Clinical Group



Source: Fazzi Business Intelligence Division

It's a Team Effort

- There are implications for renewed emphasis on accuracy in information about diagnoses, coding, prior acute care and post acute stays, OASIS and more
- It all starts in Intake
- But in reality-- it is a team effort!

A Delicate Balance

The Golden Dilemma of Intake:

How do I satisfy the clinician by getting the information they want and not torment the referral source?

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A Delicate Balance – A Few Thoughts

- The referral source only knows what they know.
- If the referral source says they don't have any other information, don't keep asking.
- Don't make them feel bad about not having information.
- Are there alternative ways to obtain information - hospital records, faxing face sheets?
- You'll never know until you get into the patient home.

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Is Intake "Off the Hook"?

The answer is: NO!

The reality is--

- It is important to prepare your intake staff as well as your clinicians and managers to understand the information that is required and the importance of accuracy
- Intake must pursue efforts to gather accurate information
- Clinical staff must verify any staff provided by intake staff and utilize the patient, family and communication with the physician to gather information needed.
- Intake must utilize all resources to get as much information as they can with special emphasis on identifying the following physician.

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CLARITY ON INFORMATION

Admission Source

Admission source is not the same as the source of the referral. Admission source is determined by whether the patient was in an acute care, post acute care or inpatient psychiatric hospital in the past 14 days.

Referral Source vs Admission Source:

If patient's family calls the agency to ask for services, that would be the referral source. If the patient was in the hospital or SNF etc in the past 14 days prior to admission it would still be "institutional" for purposes of admission source.

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DIAGNOSES

- The primary diagnosis code is a determinant of clinical group.
- Intake should not take sole responsibility for determining the primary diagnosis.
- Intake should make an effort to gather all relevant diagnoses of the patient.
- The clinician should determine the primary diagnosis which substantiates the need for home health care after assessing the patient.
- Caution: Do not rely solely on the coding done by Intake. Final codes should be applied after the clinician visit. If intake does code the diagnoses, codes should be checked and revised after the first visit.

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ADMISSION SOURCE AND MARKETING/SALES

- Institutional admission sources will provide higher payment
- If you currently have a high percentage of referrals on patients who have not been hospitalized or in a SNF you may want to consider starting to diversify your referral sources.

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INCREASING INSTITUTIONAL REFERRALS

#1 Rule

Do not assume that because the hospital has a home health agency that you cannot get referrals from the hospital.

What we *do* know:

Most hospital affiliated or hospital based agencies do not receive all the referrals from the hospital they are related to.

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WHAT YOU NEED TO KNOW

- The needs of the hospital: readmission rates, special programs, patient origin
- What you're good at; what's your distinctive competence
  - ✓ hospitalization rates
  - ✓ time from referral to admission
  - ✓ availability of therapy
  - ✓ liaison services
  - ✓ special programs
- Data: back up your claims!

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GETTING THE BUSINESS

- Act from strength
- Identify who you know who knows or can influence the decision makers

(understand the political structure of the organization– discharge planner/senior management– nursing, finance, etc)

an employee of your agency?

someone who knows an influencer in the hospital?

- Approach the hospital's home health agency
- Approach a vendor that you have in common
- Utilize a report on a current patient to go to see the hospital discharge planner

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Other Considerations

- Who is calling on your institutional referral sources?
- Do they have sales skills and knowledge of the agency
- Are they a match between their position in the organization and the person they are calling on?

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Best Practice Recommendations

- Educate the entire team
- Clarify intake's role in gathering information; Clarify clinical's role
- Identify opportunities for building referrals from SNFs and Hospitals. Assess the skills of your sales team. Develop a plan to present your agency to SNFs and hospitals.

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Controlling Your Future

"The best way to predict the future is to create it."

- Peter Drucker

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