HOMECARE & HOSPICE
National Association for Home Care & Hospice

HHFMA PDGM Global Overview Webinar

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Presented by

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We acknowledge Commercial Support provided by:

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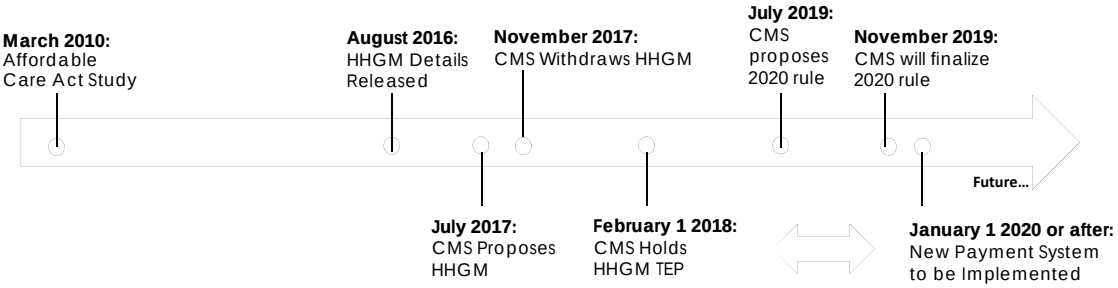
PDGM Global Overview Objectives

- Provide brief history and goal of PDGM model.
- Describe each of the components of the PDGM model and their potential impact on providers.
- Review objectives of future PDGM webinars (interdisciplinary, documentation/coding, operations, referral sources, and EMR readiness).

The History of PDGM

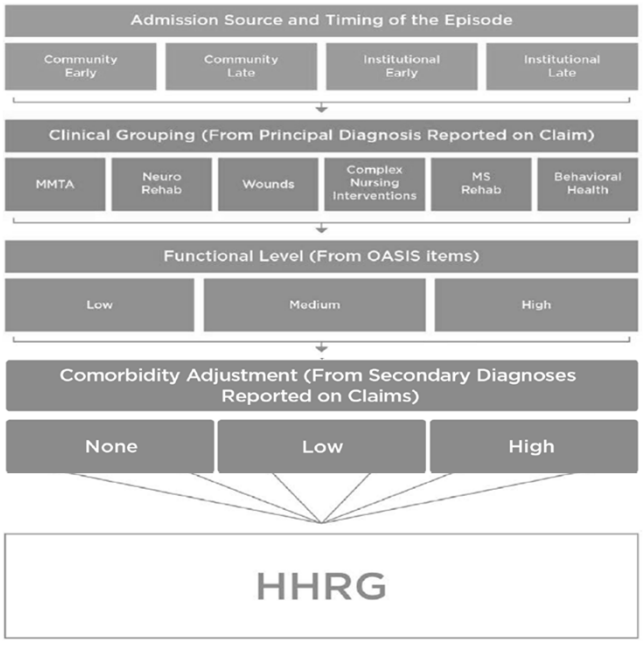


- Looking at the Process of Reimbursement Rules Changes
- Industry Response – An Alternative to HHGM

PDGM Key Elements

- HHPPS will be replaced by PDGM which will be the most significant change in home care in 20 years.
- Payment will rely on clinical characteristics and be more patient focused.
  - —Two 30-day billing cycles within on 60 day episode
  - —Elimination of therapy as a reimbursement driver
  - —New methodology for LUPA determination

Patient-Driven Groupings Model Elements



Other Key PDGM Elements

- RAPs (Request for Anticipated Payments)
  - Newly enrolled HHAs as of 1/1/19 will file RAP but are exempt from receiving RAP payments
  - Early episode RAP split 60/40 and late episode RAP split 50/50
- PEPs (Partial Episode Payments)
- Outliers based on 30 day unit of payment
- LUPAs have variable thresholds based on HIPPS code –
  - LUPA rates are paid for one less than the threshold listed
  - Thresholds ranges from 2 visits – 6 visits

Key Points: PDGM/LUPAs

- LUPA thresholds range between 2-6 visits under PDGM
- PDGM LUPA 'speak' is that you will be paid by the visit for visits less than the threshold (EX: A '4 visit LUPA' means reimbursement by the visit if 3 visits or less)
- LUPA thresholds vary based on clinical grouping and episode timing
- Clinical Groupings with highest LUPA % are in complex nursing, MS Rehab and in Wounds clinical groupings(2nd 30-day period)
- LUPA thresholds will be evaluated annually by CMS

60 Day Care Episode
VERSUS
30 Day Unit of Payment

- What will be **different**?
  - Bill 60 day episode in two 30 day increments
  - Two RAPs and Two Final Claims Submitted
  - All PDGM Elements derived from final claim except functional scoring which comes from OASIS
- What stays the **same**?
  - Orders for 60 days
  - POC for 60 days
  - Responsible to keep patients out of hospital and ED for 60 days
  - OASIS Timepoints
  - 5 Star Ratings/VBP reflect changes between SOC/ROC and Discharge

PDGM HIPPS CODE

Each character of the Health Insurance Prospective Payment System (HIPPS) is associated with the PDGM elements.

HIPPS Code	
1st position (Source & Timing)	2
2nd position (Clinical Group)	A
3rd position (Functional Level)	C
4th position (Comorbidity)	1
5th position (Placeholder)	1
HIPPS Code	2AC11
Case-mix weight	1.4415

PDGM: Operational Success HIPPS Code Structure

Position #1		Position #2		Position #3 Functional Level		Position #4		Position #5	
Source & Timing		Clinical Group				Co-Morbidity		Placeholder	
Community Early	1	MMTA – Other	A	Low	A	No	1		1
		Neuro Rehab	B						
Institutional Early	2	Wounds	C	Medium	B	Low	2		
		Complex Nursing	D						
Community Late	3	MS Rehab	E	High	C	High	3		
		Behavioral	F						
Institutional Late	4	MMTA – Surgical Aftercare	G						
		MMTA – Cardiac	H						
		MMTA – Endocrine	I						
		MMTA – GI/GU	J						
		MMTA – Infectious	K						
		MMTA - Respiratory	L						

RAPs Under PDGM

- Must be in "paid" status before corresponding claim can be billed & paid
  - Subject to auto-cancellation & payment recoupment by MAC when corresponding claim is not successfully received timely
    - 60 days from end date of 30-day payment period, or
    - 60 days from date RAP is paid,
    - Whichever date is greater

Claims Under PDGM

- Required for each 30-day payment period
  - Not required to be billed sequentially
    - Required to have corresponding RAP in "paid" status
  - Paid full claim amount less recoupment of RAP payment
  - Subject to payment recoding & adjustments, *if applicable*
- All payment periods subject to same billing requirements as PPS claims
- Claims for SOC or Recert 30 day payment periods subject ot OASIS validation
- Pending CMS guidance re: claims for subsequent 30 day payment periods

PDGM Revenue Cycle Operational Issues

- Data collection timing
  - Admission source & timing data collection required for each 30-day payment period
  - Diagnosis coding requirements for billing transactions
- Documentation management
  - POC remains applicable for 60-day episode vs. 30-day payment period while interim orders may apply to only one 30-day payment period
  - Visit & NRS documentation confirmation required for billing each 30-day payment period vs. 60-day episode

ADMISSION SOURCE & TIMING

Facts: Admission Source & Timing

- Industry history reveals more resource/costs for patient admitted from facility
- Facility includes:
  LTAC, SNF, IRF IPF, Hospital
- Includes facility stay within 14 days prior to home health admission
- Patients discharged from institutional setting require more time to get back to functional level
- Industry history reveals more resource/costs for patient during the first 30 days of the episode
- Related to front loading and prevention of re-hospitalization
- All other 30 day periods are considered 'late' unless a 60 day gap exists between episodes

Episode Timing and Referral Source

Episode Timing	Percent of Periods
EARLY	35.5%
LATE	64.5%

Referral Source	Percent of Periods
Institutional	22.2%
Community	77.8%

Source: McBee – 2017 Claims Data

Average Payments by Admission Source

Community vs. Institutional	Average Full Period Payment
Institutional	$2,260.65
Community	$1,545.51

Source: McBee – 2017 Claims Data

Admission Source & Timing Examples

Example #1

SOC December 1st, discharged from SNF November 28th; LOS 47 days:

First 30 day period=institutional early
Second 30 day period=community late

Example #2

1st SOC August 28th, discharged from IPF August 10th, discharged from HH October 15th; LOS 49 days; 2nd SOC December 15th; LOS 28 days

First 30 day period=community early
Second 30 day period=community late
Third 30 day period=community early

Payment Impact: 1st 30 Day vs. 2nd 30 Day Period

Primary Dx Infection of amputation stump, right lower extremity

Early & Institution – $2,112.75

- 11 Visits
- Clinical Grouping = MMTA Infection
- Low Comorbidity
- Functional Score of 41

Late & Community – $1,146.40

- 11 Visits
- Clinical Grouping = MMTA Infection
- Low Comorbidity
- Functional Score of 41

Admission Source & Timing Considerations

- Know your admission source trends for past 6 months
- Know your timing trends for PDGM related to past 6 months data
- Revenue will be less for late 30 day units of payment
- Revenue will be less for patients from the community
- Consider intake re-design

CLINICAL GROUPINGS & ACCEPTABLE CODES

PDGM Clinical Groupings

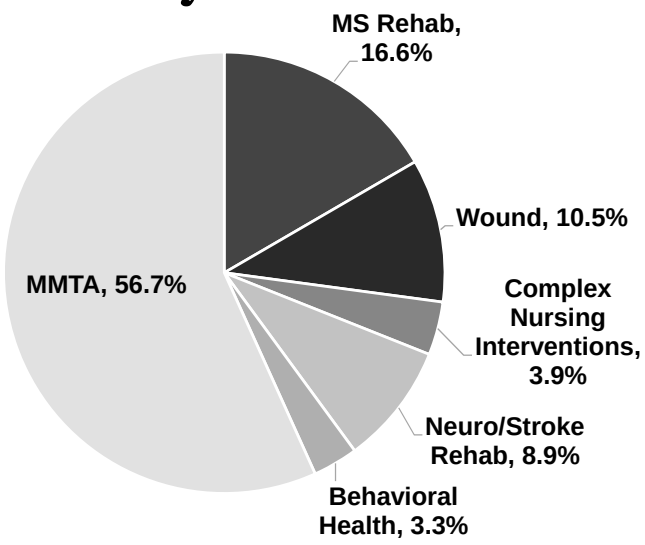
Clinical Groups	The Primary Reason for the Home Health Encounter is to Provide:
Musculoskeletal Rehabilitation	Therapy (physical, occupational or speech) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (physical, occupational or speech) for a neurological condition or stroke
Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric conditions
Complex Nursing Interventions	Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies
Medication Management, Teaching and Assessment (MMTA)	
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

Clinical Groupings

Primary Diagnosis

- MMTA is expected to include the largest number of 30-day episodes
- Episode periods that can't be assigned to a clinical group because the primary diagnosis code was:
  - Non-specific;
  - Unlikely to have required skilled home health care; or
  - Indicative of a diagnosis that was too acute for home health care
- Claims containing periods that are assigned a diagnosis that does not map to a clinical group will be rejected and returned to provider for more definitive coding

Historical Breakdown by Clinical Grouping



Source: CMS.gov

PDGM Clinical Groupings Facts

- Therapy Visits no longer major driver for reimbursement
- Focus on functionally improving our patients remains
- Wound care now top paying clinical grouping
- Clinically Complex Care now clinical grouping

Impact of Coding in PDGM

- Two of five elements that calculate PDGM payment are based on diagnosis coding:
  - Clinical Groupings
  - Co-morbidities
- Coding is based off the claim versus OASIS
- Diagnoses on the POC needs to match the claim
- May collect up to 24 codes reflective of the primary diagnosis and any co-morbid conditions

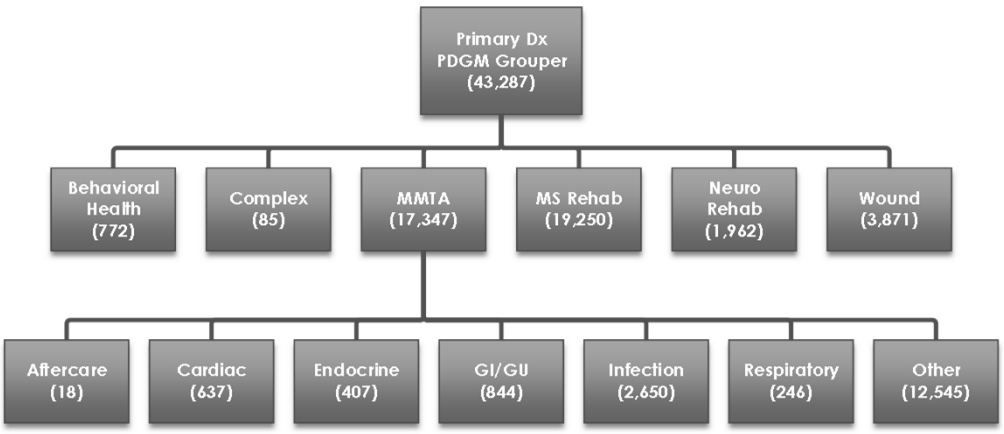
PPS vs PDGM Comparison of Top Diagnosis Codes by Revenue

- Top Diagnosis codes in each PDGM Clinical Group
- PDGM Revenue is lower in 3 of the 6 Groups
- Variance is significant compared to national PPS rates are reimbursed today

Clincal Group	ICD Code	ICD-10 Description	Avg. PPS $	Avg PDGM $	Rev. Change
Wounds	E11.621	Type 2 diabetes mellitus with foot ulcer	$ 2,817	$ 3,695	31.2%
MMTA - Endocrine	E11.65	Type 2 diabetes mellitus with hyperglycemia	$ 2,687	$ 2,877	7.1%
Behavioral Health	F03.90	Unspecified dementia without behavioral disturbance	$ 3,116	$ 2,438	-21.8%
Neuro Rehab	G20.	Parkinson's disease	$ 3,927	$ 3,245	-17.4%
MMTA - Other	I10.	Essential (primary) hypertension	$ 2,764	$ 2,725	-1.4%
MMTA - Cardiac	I11.0	Hypertensive heart disease with heart failure	$ 2,926	$ 2,992	2.2%
MMTA - Respiratory	J44.1	Chronic obstructive pulmonary disease w (acute) exac.	$ 2,902	$ 3,034	4.5%
MMTA - GI/GU	N39.0	Urinary tract infection, site not specified	$ 3,053	$ 2,916	-4.5%
MMTA - Infectious	T81.4XXA	Infection following a procedure, initial encounter	$ 3,074	$ 2,881	-6.3%
Complex Nursing	Z46.6	Encounter for fitting and adjustment of urinary device	$ 2,604	$ 2,805	7.7%
MS Rehab	Z47.1	Aftercare following joint replacement surgery	$ 3,239	$ 2,628	-18.9%
MMTA - Surgical Aftercare	Z48.812	Encntr for surgical aftcr following surgery on the circ sys	$ 2,972	$ 2,927	-1.5%

Source: SHP

Breakout of Acceptable Primary Diagnosis



Unacceptable Primary Diagnosis

- 9 of top 50 primary diagnoses* from 2015 – 2017 are not on the acceptable list

M54.5	Low back pain
M62.81	Muscle weakness (generalized)
R26.2	Difficulty in walking, not elsewhere classified
R26.81	Unsteadiness on feet
R26.89	Other abnormalities of gait and mobility
R26.9	Unspecified abnormalities of gait and mobility
R29.6	Repeated falls
R53.1	Weakness
Z48.89	Encounter for other specified surgical aftercare

Source: SHP

Unspecified/Symptom Codes

- CMS expects whenever possible, the more specific codes to be used
- They see code descriptions with "unspecified" in general not to be valid
- Some unspecified codes are allowed in such cases when the exact types of injury is unknow i.e. fractures
- They do expect home health clinicians to report laterality even if not documented by the provider
- CMS expects clinicians to investigate the cause of symptom codes, obtain provider confirmation and assign that code

Muscle Weakness (M62.81)

- CMS has been citing since 2008 their concern with this code
- Has been in the top 5 primary diagnoses over the past several years
- CMS believes muscle wasting and atrophy codes would be more appropriate
- Need to determine underlying cause for the muscle weakness

Primary Diagnoses Changes in the 2nd 30 Day Period

- If the primary diagnosis changes between the first and the second 30-day periods, then the claim for the second 30-day period would reflect the new diagnosis
- CMS needs to provide guidance on what will be required if the diagnosis does change between contiguous 30 day periods

PDGM FUNCTIONAL LEVELS

PDGM Case Mix Adjustment Model Functional Levels

- Patients are categorized into one of three levels based on the relationship between functional and cognitive status
  - Patients will be classified as either a low, medium or high functional level
  - Anticipated that roughly 33% of periods care will fall into each of the categories
- Classification is based on points accumulated from several OASIS Assessment Functional items:
  - Similar to the functional levels under the HHPPS system
  - With the addition of 2 new categories:
    - M1800: Grooming
    - M1033 Risk of Hospitalization

Functional Levels (cont.)

Functional Item Comparison

Functional OASIS Items	Current Payment System	PDGM
M1800: Grooming	No	**Yes**
M1810: Current ability to dress upper body safely	Yes	Yes
M1820: Current ability to dress lower body safely	Yes	Yes
M1830: Bathing	Yes	Yes
M1840: Toilet Transferring	Yes	Yes
M1850: Transferring	Yes	Yes
M1860: Ambulation/Locomotion	Yes	Yes
M1033: Risk of Hospitalization	No	**Yes**

Functional Level (cont.)
Functional Score-New Consideration

M1800 Grooming:
Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
1 - Grooming utensils must be placed within reach before able to complete grooming activities.
2 - Someone must assist the patient to groom self.
3 - Patient depends entirely upon someone else for grooming needs.

M1033 Risk for Hospitalization:
Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)

- ☐ 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
- ☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- ☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months
- ☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months
- ☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- ☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- ☐ 7 - Currently taking 5 or more medications
- ☐ 8 - Currently reports exhaustion
- ☐ 9 - Other risk(s) not listed in 1 - 8
- ☐ 10 - None of the above

Functional Level (cont.)

- Functional points are awarded based on CMS algorithms from answers provided on the OASIS Assessment functional items and the clinical grouping
- Total score determines whether it is low, med or high functional adjustment
- Risk for hospital (M1033) will only get points if 4 or more of the first 7 items are checked

Functional Level (cont.)

OASIS Scoring

OASIS Points Table

Variable	Response Category	Responses	Points
M1800: Grooming	1	2, 3	4
M1810: Current Ability to Dress Upper Body	1	2, 3	6
M1820: Current Ability to Dress Lower Body	1	2	5
	2	3	11
M1830: Bathing	1	2	3
	2	3, 4	13
	3	5, 6	21
M1840: Toilet Transferring	1	2, 3, 4	4
M1850: Transferring	1	1	4
	2	2, 3, 4, 5	8
M1860: Ambulation/Locomotion	1	2	10
	2	3	12
	3	4, 5, 6	24
M1032: Risk of Hospitalization	4 or more items checked	From 1-7	11

Functional Level (cont.)

Thresholds Based on Clinical Grouping

Clinical Group	Low	Medium	High
Behavioral Health	0-36	37-52	53+
Complex Nursing Interventions	0-38	39-58	59+
Musculoskeletal Rehabilitation	0-38	39-52	53+
Neuro Rehabilitation	0-44	45-60	61+
Wound	0-42	43-61	62+
MMTA - Surgical Aftercare	0-24	25-37	38+
MMTA - Cardiac and Circulatory	0-36	37-52	53+
MMTA - Endocrine	0-51	52-67	68+
MMTA - Gastrointestinal tract and Genitourinary system	0-27	28-44	45+
MMTA - Infectious Disease, Neoplasms, and Blood-Forming Diseases	0-32	33-49	50+
MMTA - Respiratory	0-29	30-43	44+
MMTA - Other	0-32	33-48	49+

PDGM: Interdisciplinary Collaboration

- Interdisciplinary collaboration is key to assure an accurate assessment of the patient's needs so we can provide appropriate care by the appropriate disciplines
  - Interdisciplinary case conferences on new SOC and intervals through out the episode
- Assessment of the patient's ability to perform tasks by direct observation (preferred) as well as reports from the patient, clinicians, care staff, and/or family. Include the task as part of their daily routine and not as an isolated task.
- Education and competency of all disciplines on OASIS D
- Development of interdisciplinary realistic goals for the patient

PDGM Intradisciplinary Care Coordination

- Evaluate the need for remote monitoring to reduce the need for additional skilled visits.
- Identify generalized skill for all disciplines to reinforce at each visit such as medication management.
- Identify unique skills to be provided by a specific discipline.
- Have therapist support daily routines instead of focus on "HEP."
- Consider aides to reinforce daily routines such as transfers, bathing and dressing.

CO-MORBIDITY CODES

Secondary Diagnoses Source of Truth

- Three Instructions:
  - Claim-ICD 10 guidelines
  - OASIS-diagnosis that impacts the POC
  - POC-any known diagnosis per COPs

- *Current Medicare Claims Processing Manual, Chapter 10 will need to change for PDGM:*
- "secondary diagnoses on the claim match the diagnoses on the OASIS as reported in M1022."

PDGM Case Mix Adjustment Model Comorbidity Adjustment

- Patients are categorized into one of three levels based on the presence of secondary diagnoses
  - Up to 24 secondary diagnosis may be included on a home health claim
  - Patient comorbidity classifications are:
    - None: no secondary diagnosis exists or does not meet the criteria for comorbidity adjustment
    - Low: 1 secondary diagnosis that falls within one of the home health specific individual comorbidity subgroups that are associated with higher resource utilization
    - High: 2 or more secondary diagnosis reported within the comorbidity subgroup interaction that are associated with higher resource utilization . Consists of one diagnosis from 2 different sub groups.
  - Comorbidity category can increase PDGM payment up to 20%

Comorbidity Adjustment (cont.)

- Only one comorbidity adjustment is allowed
- Highest level will be assigned
- CMS will continue to monitor for additional levels or subgroups
- Remember coding guidelines must be followed to assign the appropriate diagnosis

Comorbidity Adjustment (cont.)

- The following clinical categories were used to group comorbidities within PDGM:

Heart Disease	Neoplasms
Respiratory Disease	Genitourinary and Renal Disease
Circulatory Disease and Blood Disorders	Skin Disease
Cerebral Vascular Disease	Musculoskeletal Disease or Injury
Gastrointestinal Disease	Behavioral Health (including Substance Use Disorders)
Neurological Disease and Associated Conditions	Infectious Disease
Endocrine Disease	

Upcoming HHFMA PDGM Webinars

5/9: Operations Impact: Referral Source & Intake

5/21: Operations Impact: 30 day periods, LUPAs, Supplies

6/6: Coding/Documentation Review/Revenue Cycle

7/11: Interdisciplinary Considerations

8/15: EMR Readiness

8/16: Clinical Management of PDGM Risks

For more information and to register, visit:
http://www.nahc.org/pdgm-webinars

Upcoming NAHC Events

Financial Management Conference and Expo
July 14-16, 2019 | Chicago, IL
fmc2019.NAHC.org

Home Care and Hospice Conference and Expo
October 13-15, 2019 | Seattle, WA

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