PDGM
(PATIENT DRIVEN GROUPINGS MODEL)
-
CODING & OASIS

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Position #1 Source & Timing	Position #2 Clinical Group	Position #3 Functional Level	Position #4 Co-Morbidity	Position #5 Placeholder
Community Early	1 MMTA_OTHER	A Low	A None	1 1
Institutional Early	2 Neuro Rehab	B Medium	B Low	2
Community Late	3 Wounds	C High	C High	3
Institutional Late	4 Complex Nursing	D		
	MS Rehab	E		
	Behavioral Health	F		
	MMTA - Surgical Aftercare	G		
	MMTA - Cardiac	H		
	MMTA - Endocrine	I		
	MMTA - GI/GU	J		
	MMTA - Infectious	K		
	MMTA - Respiratory	L		

TABLE 1: PDGM CLINICAL GROUPS

CLINICAL GROUP	PRIMARY REASON FOR HOME HEALTH ENCOUNTER IS TO PROVIDE:
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
Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions
Behavioral Health Care	Assessment, treatment and evaluation of psychiatric and sub-stance abuse conditions
Medication Management, Teaching and Assessment (MMTA) • MMTA –Surgical Aftercare • MMTA – Cardiac/Circulatory • MMTA – Endocrine • MMTA – GI/GU • MMTA – Infectious Disease/Neoplasms/ Blood-forming Diseases • MMTA –Respiratory • MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching, and assessment.

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UNSPECIFIED/SYMPTOM CODING

- CMS expects more specific codes to be used
- Most code descriptions with “unspecified” not going to work as primary under PDGM
- CMS expects clinicians to investigate the cause of symptom codes, obtain provider confirmation and assign that code

Muscle Weakness (M62.81)

- CMS has expressed their concern with this code for many years
- Has been in the top 5 primary diagnoses over the past several years
- CMS believes muscle wasting and atrophy codes would be more appropriate – more specific
- Can be used as a secondary diagnosis, but will not be accepted as primary under PDGM

Changes in Primary Diagnosis

- If the diagnoses change between the first and the second 30-day periods, the claim for the second 30-day period would reflect the new diagnosis
- CMS has stated that there must be documentation to support a change in diagnoses from one 30-day period to the next.
- Coding changes, at a minimum, require a signed physician order.
- IF there are changes in the functional status of the patient there would definitely need to be an Other Follow-up OASIS Assessment to be completed and connected to the second 30-day claim

PATIENT DRIVEN GROUPINGS MODEL (PDGM)

- **Low comorbidity adjustment:** There is a reported secondary diagnosis that falls within one of the home-health specific individual comorbidity subgroups associated with higher resource use, or;

  5.97% increase in case-mix from No to Low

- **High comorbidity adjustment:** There are two or more secondary diagnoses reported that fall within the same comorbidity subgroup interaction that are associated with higher resource use.

  12.5% increase in case-mix from Low to High

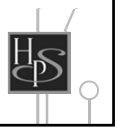
Comorbidity Adjustment

- No Comorbidity Adjustment
- Low Comorbidity Adjustment
  - One or more of 12 subgroups met
  - Consists of one dx from subgroup
- High Comorbidity Adjustment
  - One or more of 34 subgroup interactions met
  - Consist of one dx from two different subgroup

COMORBIDITY ADJUSTMENT

Home Health Specific comorbidity list was developed with broad clinical categories used to group comorbidities.

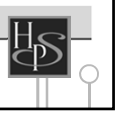
- Heart disease
- Respiratory disease
- Circulatory disease
- Cerebral vascular disease
- Gastrointestinal disease
- Neurological conditions
- Endocrine disease
- Neoplasms
- Genitourinary/Renal disease
- Skin disease
- Musculoskeletal disease
- Behavioral health issues (including substance use disorders)
- Infectious diseases



LOW COMORBIDITY ADJUSTMENT

As shown in the CY 2019 HH PPS Final Rule (83 FR 56487)

Comorbidity Subgroup	Description	
Cerebral 4	Includes sequelae of cerebral vascular diseases	
Circulatory 10	Includes varicose veins with ulceration	
Circulatory 9	Includes acute and chronic embolisms and thrombosis	
Heart 10	Includes cardiac dysrhythmias	
Heart 11	Includes heart failure	
Neoplasms 1	Includes oral cancers	
Neuro 10	Includes peripheral and polyneuropathies	
Neuro 11	Includes diabetic retinopathy and other blindness	ELIMINATED IN THE PROPOSED RULE 2020
Neuro 5	Includes Parkinson's disease	
Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia	
Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis	
Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers	
Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers	



HIGH COMORBIDITY ADJUSTMENT SUBGROUPS

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description (Includes)	Comorbidity Subgroup	Description (includes)
1	behavioral2	depression & bipolar disorders	skin3	Diseases of arteries, arterioles, capillaries with ulceration & non-pressure, chronic ulcers
2	Cerebral4	sequelae of cerebral vascular diseases	Circulatory4	Hypertensive chronic kidney disease
3	Cerebral4	sequelae of cerebral vascular diseases	Heart11	heart failure
4	Cerebral4	sequelae of cerebral vascular diseases	Neuro10	Peripheral & polyneuropathies
5	Circulatory4	Hypertensive chronic kidney disease	skin1	Cutaneous abscess, cellulitis, lymphangitis
6	Circulatory4	Hypertensive chronic kidney disease	skin3	Diseases of arteries, arterioles, capillaries with ulceration & non-pressure, chronic ulcers
7	Circulatory4	Hypertensive chronic kidney disease	skin4	Stages 2, 3, 4 pressure ulcers & unstageable
8	Circulatory7	atherosclerosis	skin3	Diseases of arteries, arterioles, capillaries with ulceration & non-pressure, chronic ulcers
9	Endrocrine3	Diabetes with complications	Neuro5	Parkinson's disease

HIGH COMORBIDITY ADJUSTMENT SUBGROUPS

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description (Includes)	Comorbidity Subgroup	Description (includes)
10	Endrocrine3	Diabetes with complications	Neuro7	Hemiplagia, paraplegia, quadriplegia
11	Endrocrine3	Diabetes with complications	skin1	Cutaneous abscess, cellulitis, lymphangitis
12	Endrocrine3	Diabetes with complications	skin3	Diseases of arteries, arterioles, capillaries with ulceration & non-pressure, chronic ulcers
13	Heart10	Cardiac dysrhythmias	skin3	Diseases of arteries, arterioles, capillaries with ulceration & non-pressure, chronic ulcers
14	Heart10	Cardiac dysrhythmias	skin4	Stages 2, 3, 4 pressure ulcers & unstageable
15	Heart11	heart failure	Neuro10	Peripheral & polyneuropathies
16	Heart11	heart failure	Neuro5	Parkinson's disease
17	Heart11	heart failure	skin1	Cutaneous abscess, cellulitis, lymphangitis
18	Heart11	heart failure	skin3	Diseases of arteries, arterioles, capillaries with ulceration & non-pressure, chronic ulcers

HIGH COMORBIDITY ADJUSTMENT SUBGROUPS

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description (Includes)	Comorbidity Subgroup	Description (includes)
19	Heart11	heart failure	skin4	Stages 2, 3, 4 pressure ulcers & unstageable
20	Heart12	Other heart diseases	skin3	Diseases of arteries, arterioles, capillaries with ulceration & non-pressure, chronic ulcers
21	Heart12	Other heart diseases	skin4	Stages 2, 3, 4 pressure ulcers & unstageable
22	Neuro10	Peripheral & polyneuropathies	Neuro5	Parkinson's disease
23	Neuro10	Peripheral & polyneuropathies	skin3	Diseases of arteries, arterioles, capillaries with ulceration & non-pressure, chronic ulcers
24	Neuro3	dementias	Skin3	Diseases of arteries, arterioles, capillaries with ulceration & non-pressure, chronic ulcers
25	Neuro3	dementias	skin4	Stages 2, 3, 4 pressure ulcers & unstageable
26	Neuro5	Parkinson's disease	renal3	Nephrogenic diabetes insipidus

HIGH COMORBIDITY ADJUSTMENT SUBGROUPS

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description (Includes)	Comorbidity Subgroup	Description (includes)
27	Neuro7	Hemiplagia, paraplegia, quadriplegia	renal3	Nephrogenic diabetes insipidus
28	renal1	Chronic kidney disease & ESRD	Skin3	Diseases of arteries, arterioles, capillaries with ulceration & non-pressure, chronic ulcers
29	renal1	Chronic kidney disease & ESRD	skin4	Stages 2, 3, 4 pressure ulcers & unstageable
30	renal3	Nephrogenic diabetes insipidus	skin4	Stages 2, 3, 4 pressure ulcers & unstageable
31	Resp5	COPD & asthma	Skin3	Diseases of arteries, arterioles, capillaries with ulceration & non-pressure, chronic ulcers
32	Resp5	COPD & asthma	skin4	Stages 2, 3, 4 pressure ulcers & unstageable
33	skin1	Cutaneous abscess, cellulitis, lymphangitis	Skin3	Diseases of arteries, arterioles, capillaries with ulceration & non-pressure, chronic ulcers
34	skin3	Diseases of arteries, arterioles, capillaries with ulceration & non-pressure, chronic ulcers	skin4	Stages 2, 3, 4 pressure ulcers & unstageable

Comorbidity Adjustment

- Only one comorbidity adjustment allowed
- Highest level will be assigned
- It is important to continue to follow coding guidelines and assign appropriate diagnosis in order to provide CMS data for analysis in the future
- Ensure codes are updated within the 30-day payment periods to ensure capture of proper case-mix group

Additional Considerations

- Claims with unacceptable primary diagnoses will be returned to the provider (RTP or T-Status) and not considered a denial
- T-Status claims can be recoded with more appropriate code as long as there is appropriate supporting provider documentation
- EMRs should be telling you the codes are not acceptable before the claim is submitted for payment
- Coding guidelines still must be followed

ACCURATE OASIS-D1

- The only items that will affect the case-mix calculation under PDGM is the ADL Section (M1800-M1860) & Risk for Hospitalization (M1033)
- OASIS-D1will go into effect January 1, 2020
  - Had to add M1800 – Grooming & M1033 – Risk for Hospitalization to the FollowUp OASIS
  - Many items are now "optional" on the FollowUp as they do not affect any calculations for reimbursement

ACCURATE OASIS-D1

- There are very specific updated instructions for completing and transmitting Follow-Up/Recertification OASIS for patients that will be recertified during the last few days of 2019 and the recertification episode will begin January 1, 2020 and later under the new PDGM.
- When the recertification is completed within the last 5 days of 2019, CMS will temporarily waive the requirement that HHAs enter the actual OASIS "Date the Assessment Is Completed" date in M0090. Instead, agencies are required to enter the M0090 date as 1/1/2020. The agency must wait to transmit the OASIS until 1/1/2020, or there will be a fatal error.

ACCURATE OASIS-D1

Transition Recertification Example:

- Start of Care date: November 3, 2019
- Recertification assessment (using OASIS-D1 Follow-Up (RF4)) is completed on December 29, 2019 (the episode is to begin January 2, 2020)
- Report artificial M0090 date of 1/1/2020
- Submit the OASIS to the ASAP database 1/1/2020 or later

OASIS-D1 ITEMS

Functional Status

- M1800 – Grooming
- M1810 – Dressing Upper Body
- M1820 – Dressing Lower Body
- M1830 – Bathing
- M1840 – Toilet Transferring
- M1850 - Transferring
- M1860 – Ambulation
- M1033 – Risk for Hospitalization

OASIS Points Table – July 2019

Variable	Response Category	Responses	Points
M1800: Grooming	1	2, 3	5
M1810: Current Ability to Dress Upper Body	1	2, 3	6
M1820: Current Ability to Dress Lower Body	1	2	6
	2	3	12
M1830: Bathing	1	2	3
	2	3, 4	12
	3	5, 6	20
M1840: Toilet Transferring	1	2, 3, 4	5
M1850: Transferring	1	1	3
	2	2, 3, 4, 5	6
M1860: Ambulation/Locomotion	1	2	9
	2	3	11
	3	4, 5, 6	23
M1033: Risk of Hospitalization	4 or more items checked	From 1-7	11

ACCURATE OASIS-D1

- Interdisciplinary collaboration huge for accurate OASIS D especially for accurate functional assessment
- Observation is the BEST method for accuracy

BEST PRACTICES:

- Comprehensive ADL (OASIS) Assessment education program developed by therapists (PT & OT) for RNs with return demonstration
- Discipline-neutral (RN, PT, ST, OT) **competence in OASIS assessment process**

ACCURATE OASIS-D1

- Assessing ADLs in isolation does not capture accurate performance within the patient's daily routine
  - e.g., assessing patient with COPD for showering in a 'dry run' does not capture the effects of standing 20 minutes in warm moist air
  - e.g., assessing cardiac and respiratory patients in any ADLs will look different depending on the time of day, possibly affecting MMTA groupings

ACCURATE OASIS-D1

- Unless prevented by state regulation, "Therapy Only" patients should be admitted by a PT/ST with comprehensive assessment and OASIS completed by a therapist.
- Even if your therapists don't collect OASIS data on therapy only cases, assure ALL therapists are trained in OASIS item specific guidance to contribute through collaboration
- Even if the GG items don't affect payment, consistency with OASIS is noted in medical review

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