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Home Health Patient-Driven Groupings Model (PDGM)

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Disclaimer

The information provided in this presentation is current as of February 1, 2020. Any changes or new information in this presentation are provided in articles with publication dates after February 1, 2020, posted on our website at www.PalmettoGBA.com/HHH

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Agenda

- ✓ Overview of the Patient-Driven Groupings Model (PDGM)
- ✓ PDGM vs. Current PPS
- ✓ 30-Day Periods
- ✓ Requests for Anticipated Payment (RAPs)
- ✓ Billing and Claims Overview
- ✓ New Occurrence Codes
- ✓ PDGM and the Review Choice Demonstration

PDGM Overview

- Effective: January 1, 2020
  - For initial certifications and recertifications that start after the effective date
- PDGM is a new payment model for the Home Health Prospective Payment System (HH PPS)
  - Relies on clinical characteristics and other patient information to place home health periods of care into meaningful payment categories, and
  - Eliminates the use of therapy service thresholds

PDGM Overview

- Implementation of a change in the unit of home health payment from a 60-day episode to a 30-day period
- Case-mix adjusted payment groups
  - HH PPS has 153 possible case-mix adjusted payment groups
  - PDGM has 432 possible case-mix adjusted payment groups

PDGM Overview

- PDGM is designed to be:
  - Budget-neutral;
  - Better align payments with patient needs; and
  - Ensure that clinically complex patients have adequate access to care
- Medicare Advantage Plans will be under no obligation to adopt a payment methodology that is similar to PDGM

PDGM Overview

- Low Utilization Payment Adjustment (LUPA) thresholds will be:
  - Variable
  - Applied to 30-day payment periods
  - Range from two to six visits based on the case-mix

PDGM Overview

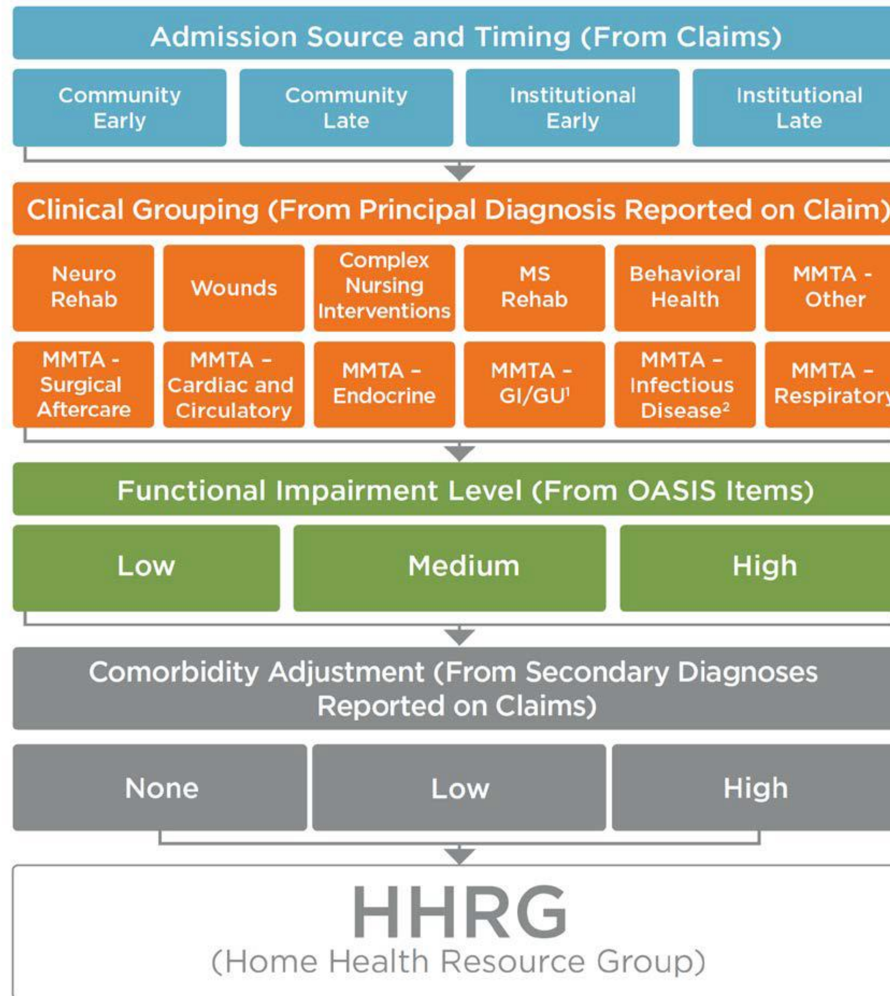
- PDGM is intended to be complementary to other CMS initiatives:
  - Value-Based Purchasing Program
  - Review Choice Demonstration (RCD)
- Home Care Resource Group (HHRG) calculations that originate from the SOC or recertification OASIS will pertain to all 30-day payment periods within each 60-day episode

How PDGM Works

Each 30-day period is assigned a Home Health Resource Group based on five case-mix variables:

1. Admission source
2. Timing
3. Clinical Grouping
4. Functional Impairment Level
5. Comorbidity Adjustment

HHRG



30-Day Periods

30-Day Period

- For HH PPS, HHAs are paid for each (up to) 60-day episode of care provided
  - However, more visits tend to occur in the first 30-day period of a 60-day episode of care
- For PDGM, payment is made for each 30-day period, as required by the Bipartisan Budget Act of 2018
- Change the way each period is paid
- No changes to the following:
  - Certification/recertification;
  - Completion of OASIS assessments; or
  - Updates to the patient’s plan of care
- **Note: All of the above will continue to be completed on a 60-day basis.**

30-Day Period Timing Classifications

- Under PPS
  - An “early” episode is defined as the first and second 60 day episodes
  - Contiguous episodes three and beyond defined as “late” episodes
- Under PDGM
  - The first 30 day payment period is considered “early”
  - Every concurrent payment period after the first in considered “late”
  - Early payment periods will be reimbursed at a higher rate than will late payment periods

Requests for Anticipated Payment (RAPs)

Requests for Anticipated Payment (RAPs)

- All HHAs will need to submit a RAP at the beginning of each 30-day period and a final claim at the end of each 30-day period
- Data fields and billing instructions required on a RAP are not changing
- HIPPS may be produced by Grouper software or be any valid HIPPS code
- New occurrence codes for PDGM are **not** reported on RAPs
- Low utilization payment adjustment (LUPA) claims remain an exception (no-RAP LUPAs)

Requests for Anticipated Payment (RAPs)

- HHAs newly enrolled in Medicare on or after January 1, 2019, will not receive split percentage payments beginning CY 2020
- Still need to submit a RAP normally at the beginning of each 30-day period to establish the home health period of care
- These RAPs will be processed but not paid
- No special coding is required on no-pay RAPs
- The provider record at the HHA's MAC will note that no RAP payments apply
- Full payment for each period of care will be made on the final claim

Requests for Anticipated Payment (RAPs)

The 2020 final rule, with comment period, finalized technical regulations correction at regarding split-percentage payments for newly-enrolled HHAs in CY 2020, and finalizes the following additional changes to the split-percentage payment approach.

CMS-1711-FC

Requests for Anticipated Payment (RAPs)

1. A reduction in the up-front amount paid in response to a RAP to 20 percent of the estimated final payment amount for both initial and subsequent 30-day periods of care for CY 2020

CMS-1711-FC

Requests for Anticipated Payment (RAPs)

2. A reduction to the up-front amount paid in response to a RAP to zero percent of the estimated final payment amount for both initial and subsequent 30-day periods of care with a late submission penalty for failure to submit the RAP within five calendar days of the start of care for the first 30-day period within a 60-day certification period and within five calendar days of day 31 for the second, subsequent 30-day period in a 60-day certification period for CY 2021

CMS-1711-FC

Requests for Anticipated Payment (RAPs)

3. The elimination of the split-percentage payment approach entirely in CY 2022, replacing the RAP with a one-time submission of a Notice of Admission (NOA) with a late submission penalty for failure to submit the NOA within five calendar days of the start of care

CMS-1711-FC

Requests for Anticipated Payment (RAPs)

- With PDGM, the RAP payment will be canceled automatically by the Medicare claims processing systems if
- If the claim is not received 60 days after the calculated end date of the period (day 90), or
- 60 days after the paid date of the RAP (whichever is greater)

Billing and Claims Processing Overview

PDGM Billing and Claims Processing Overview

- HHA completes OASIS assessment and submits to the Internet Quality Improvement and Evaluation System (iQIES)
  - iQIES assessment submission functionality for HHAs will not be available until January 1, 2020
- HHA has option to run OASIS and claim data through Grouper program in their billing system to create HIPPS code or submit any valid HIPPS code
- HHA submits HIPPS code on their RAPs

Billing and Claims Processing Overview

- HHA provides services for up to 30 days, then submits claim with HIPPS code matching the RAP and detailed service information
- Reporting of service lines remains the same
- Matching HIPPS remains important to pair the claim with the correct RAP

Billing and Claims Processing Overview

- A treatment authorization code is no longer required on every HH claim. This field will only be used when required by the Pre-Claim Review project.
- The OASIS assessment completion date will be required on all claims
  - Report occurrence code 50 and the OASIS item M0090 date
- Two new occurrence codes to support the admission source category of the PDGM (Community vs. Institutional)

Low Utilization Payment Adjustment (LUPA)

- Low Utilization Payment Adjustment (LUPA) thresholds will be variable and will range from two to six visits based on the case-mix
  - Single threshold of four visits used in the existing edit no longer applies
  - The table of LUPA thresholds show the number of visits needed for full payment
    - Examples:
      - 3FC11 has a threshold of two, therefore a LUPA would be one visit
      - 2BB31 has a threshold of six, therefore a LUPA would be five visits or less

New Occurrence Codes

Reporting New Occurrence Codes

- Occurrence code 61 — “Hospital Discharge Date”
  - Reported, but not required, on final claims. Not reported on RAPs.
  - Reported on admission claims **and** continuing claims, if applicable
  - Report the discharge date (“Through” date) of an inpatient hospital admission that ended within 14 days of the “From” date of the HH period of care
  - Claims with hospital discharges within 14 days are grouped into “Institutional” payment groups

Reporting New Occurrence Codes

- Occurrence code 62 — “Other Institutional Discharge Date”
  - Reported, but not required, on final claims. Not reported on RAPs.
  - Reported **only** on admission claims, if applicable
  - Claim “From” and “Admission” date match
  - Report the discharge date (“Through” date) of a skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long term care hospital (LTCH) or inpatient psychiatric facility (IPF) stay that ended within 14 days of the “From” date of the HH period of care
  - Admission claims with other institutional discharges within 14 days are grouped into “Institutional” payment groups

Reporting New Occurrence Codes

- Determining “within 14 days of the ‘From’ date” of the HH claim
  - Include the “From” date, then count back using the day before the “From” date as day 1
  - If “From” date = 1/20/2020, then 1/19/2020 is day 1
  - Counting back from 1/19/2020, the 14-day period is 1/6/2020 –1/19/2020
- Use occurrence codes to report discharge dates in this period
  - LTCH discharge date of 1/6/2020 would be reported on an admission HH claim with occurrence code 62
  - An acute hospital discharge date of 1/20/2020 would be reported with occurrence code 61

Reporting New Occurrence Codes

- Report only one occurrence code 61 or 62 on a claim
- If two inpatient discharges occur during the 14-day window, report the later discharge date
  - Example:
    - HH claim “From” date — 1/20/2020
    - Inpatient hospital discharge date — 1/10/2020 (10 days prior)
    - SNF discharge date — 1/18/2020 (2 days prior)
    - Report occurrence code 62 and 1/18/2020
- Claims with both occurrence code 61 and 62 will be returned
  - Claims with more than one occurrence code will be returned

Reporting New Occurrence Codes

What happens if an HHA is not aware of an institutional discharge when they submit the claim?

- If the inpatient claim has been processed by Medicare before the HH claim is received, Medicare systems will identify it and group the HH claim into an institutional payment group automatically
- If the inpatient claim has not been processed yet when the HH claim is received, Medicare systems will group the HH claim into a community payment group
- When the inpatient claim is processed later, Medicare systems will automatically adjust the paid HH claim and pay it using an institutional payment group instead

Reporting New Occurrence Codes

- Automatic adjustments to change community payment groups to institutional will be identified on the remittance advice:
  - Type of Bill (TOB) 032G
  - Claim adjustment reason code (CARC) 186
  - Remittance advice remark code (RARC) N69
- Institutional payment groups will not be automatically adjusted to community if no inpatient claim is found after the timely filing period closes
  - Inpatient stay may have been in a non-Medicare facility (e.g., Veteran's Administration)
  - Non-Medicare facilities can **only** be identified through occurrence codes

PDGM and the Review Choice Demonstration (RCD)

PDGM and RCD

- When PDGM starts, HHAs in the Pre-Claim Review (PCR) option will need to submit a PCR for each 30-day period
- A provider can select the subsequent episode/period option and submit two or more 30-day billing periods at the same time
  - In eServices, you can select a subsequent episode(s) once you complete all the tasks for episode/period
  - For subsequent episodes/periods, you will need to enter the episode/period start and end dates, the type of bill, HCPCS codes and upload the POC, if changed, or refer back to the POC (Task 3) for episode/period 1

PDGM and RCD

- When more than one period is submitted in a PCR request, two or more Unique Tracking Numbers (UTNs) will be generated, one for each 30-day period
- HHAs need to ensure they place the correct UTN on the corresponding 30-day billing period claim to avoid the claim being returned

PDGM and RCD

- HHAs in the Postpayment Review option will receive an Additional Documentation Request (ADR) for each 30-day period
- HHAs in Choice 4, Selective Postpayment Review and Choice 5, Spot Check Review will have an increase of reviews due to the 30 day periods

Summary

- PDGM took effect for initial certifications and recertifications on January 1, 2020
- PDGM is a new payment model for the Home Health Prospective Payment System (HH PPS) that changes the unit of home health payment from a **60-day episode** to a **30-day period**
  - OASIS, certification/recertification and plan of care still based on 60 days
- Low Utilization Payment Adjustment (LUPA) thresholds have changed from 4 or less visits to a variable range based on the case-mix assigned to the period
- Period timing under PDGM classifies the first 30-day period as “early” and every subsequent period as “late”
- RAPs must be submitted for every 30-day period
- HHAs who enrolled in Medicare on or after 1/1/2019 will not receive RAP payment, though billing the RAP is still required
  - HHAs eligible for RAP payment will receive 20% of the estimated period payment
  - Full payment for the period will be made based on the HIPPS code assigned to the final claim

Summary

- The HH criteria is the same:
  - All services must have been provided to the beneficiary for the billing period
  - Physician must have signed the plan of care and all orders
  - Face-to-face encounter must be complete
  - OASIS must be submitted and accepted in iQIES
- RAP and claim HIPPS code must match to reconcile the period
- Occurrence code 50, with the OASIS assessment completion date, must be reported on claim
- Occurrence code 61 **or** 62 should be reported when there is an inpatient admission within 14 days of the “From” date of a home health period of care

Agenda

- ✓ Admission Source and Timing
- ✓ Clinical Groups
- ✓ Functional Impairment Levels
- ✓ Comorbidity Group
- ✓ Case-Mix Weights
- ✓ Other Adjustments
- ✓ How OASIS Data Will be Used and Diagnosis Information
- ✓ CMS Resources
- ✓ Palmetto GBA Resources
- ✓ Question and Answer

Admission Source and Timing

Admission Source and Timing

- Each 30-day period is grouped by Admission Source and Timing
  - Institutional vs. Community
  - Early vs. Late

Admission Source

- Institutional — admission within 14 days of the "From" date of the home health claim
  - Acute — inpatient care hospitals, or
  - Post-acute — skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long-term care hospital (LTCH), or inpatient psychiatric facility (IPF)
- Community — no acute or post-acute care admission within 14 days of the "From" date of the home health claim

Timing

- Definition of sequence, or subsequent, claims has not changed:
  - Periods considered sequential when there are no more than 60 days between the end of one period and the start of the next period
- Early Period — the first 30-day period in a sequence of home health periods
- Late Period — the second and later 30-day periods in a sequence of home health periods

Admission Source and Timing

- Late 30-day periods always classified as community admission unless there is an acute hospitalization 14 days prior to the late home health 30-day period
  - HHAs have the option whether or not to discharge the patient if the patient is hospitalized for a short period of time
- A post-acute stay 14 days prior to a late home health 30-day period would not be classified as an institutional admission unless the patient had been discharged from home health prior to post-acute stay
- Information from Medicare systems during claims processing will automatically assign admission source and timing categories
- HHAs have the option to include an occurrence code (61 or 62) on the claim to identify an institutional admission source

Clinical Groups

Clinical Groups

Clinical Grouping (From Principal Diagnosis Reported on Claim)					
Neuro Rehab	Wounds	Complex Nursing Interventions	MS Rehab	Behavioral Health	MMTA - Other
MMTA - Surgical Aftercare	MMTA - Cardiac and Circulatory	MMTA - Endocrine	MMTA - GI/GU[1]	MMTA - Infectious Disease[2]	MMTA - Respiratory

- Each 30-day period grouped by primary reason for home health care
  - Intended to reflect primary reason for services
  - Based on the principal diagnosis reported on the claim
  - Twelve total groups in PDGM case-mix

12 Clinical Groups

Clinical Group	Description	Main reason for HH encounter is to provide:
1	Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
2	Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
3	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
4	Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions (e.g., ostomies, TPN)
5	Behavioral Health Care	Assessment, treatment and evaluation of psychiatric and substance abuse conditions

12 Clinical Groups

Clinical Group	Description	Main reason for HH encounter is to provide:
6-12	**Medication Management, Teaching and Assessment (MMTA)** 6. MMTA-Surgical Aftercare 7. MMTA-Cardiac/Circulatory 8. MMTA-Endocrine 9. MMTA-GI/GU 10. MMTA-Infectious Disease/Neoplasms/ Blood-forming Diseases 11. MMTA-Respiratory 12. MMTA-Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previous groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching and assessment.

ICD-10 Codes
Determine Clinical Group

- 30-day period assigned to clinical group based on principal diagnosis code on the claim
- Average resource use of all 30-day periods within a clinical group varies across clinical groups and differences reflected in payment
- If a diagnosis code is used that does not fall into a clinical group (e.g., dental codes or other uncovered/invalid codes), claim is returned to the provider for more definitive coding
- Additional adjustments made for other health conditions

Functional Impairment Levels

Functional Impairment Levels

- Grouped into Low, Medium, or High based on OASIS items
  - Determined based on OASIS responses to:
    - M1800 (grooming)
    - M1810 (ability to dress upper body)
    - M1820 (ability to dress lower body)
    - M1830 (bathing)
    - M1840 (toilet transferring)
    - M1850 (transferring)
    - M1860 (ambulation/locomotion)
    - M1032 (hospitalization risk)

Functional Impairment Levels

- PDGM uses responses to seven (7) OASIS items associated with functions and 1 for hospitalization risk
- Similar to current system which uses OASIS items for functional domains
- Additional OASIS items under PDGM
  - (Not currently used) to establish impairment level: grooming and risk for hospitalization
- Responses to each element of the OASIS items will be assigned points and drive the categorization of functional impairment

Functional Impairment Levels and Associated Points

Clinical Group	Level of Impairment	Points (2017 Data)
Behavioral Health	Low	0-36
	Medium	37-52
	High	53+
Complex Nursing Interventions	Low	0-38
	Medium	39-58
	High	59+
Musculoskeletal Rehabilitation	Low	0-38
	Medium	39-52*
	High	53+
Neuro Rehabilitation	Low	0-44
	Medium	45-60
	High	61+
Wound	Low	0-42
	Medium	43-61
	High	62+
MMTA - Surgical Aftercare	Low	0-24
	Medium	25-37
	High	38+

Comorbidity Group

Comorbidity Adjustment

- The comorbidity adjustment category is based on the presence of secondary diagnoses on the 30-day period claim
- No comorbidity adjustment
- Low comorbidity adjustment
- High comorbidity adjustment

Comorbidity Adjustment

- The principal HHA-reported diagnosis determines the PDGM clinical group
- Secondary diagnoses also impact resource use and should be taken into account
- A comorbidity is defined as a medical condition coexisting in addition to a principal diagnosis
  - Comorbidity is tied to poorer health outcomes, more complex medical need and management, and higher care costs

Comorbidities Specific to Home Health

- 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

Comorbidities Specific to Home Health

- Home health 30-day periods of care can receive a comorbidity adjustment under the following circumstances:
- Low comorbidity adjustment: there is a reported secondary diagnosis that is associated with higher resource use
- High comorbidity adjustment: there are two or more secondary diagnoses that are associated with higher resource use when both are reported together compared to if they were reported separately, i.e., the two diagnoses may interact with one another resulting in higher resource use
- No comorbidity adjustment: there is no reported secondary diagnosis that falls in either the low or high comorbidity adjustment

Low Comorbidity Adjustment Subgroups

TABLE 10: LOW COMORBIDITY ADJUSTMENT SUBGROUPS FOR CY 2020

Comorbidity Subgroup	Description
Cerebral 4	Includes sequelae of cerebral vascular diseases
Circulatory 10	Includes varicose veins with ulceration
Circulatory 4	Includes hypertensive heart disease and chronic kidney disease
Circulatory 9	Includes acute and chronic embolisms and thrombosis
Endocrine 2	Includes diabetes with complications
Heart 11	Includes heart failure
Neoplasms 1	Includes oral cancers
Neuro 10	Includes peripheral and polyneuropathies
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

Source: CY 2018 Medicare claims data for episodes ending on or before December 31, 2018 (as of July 31, 2019).

High Comorbidity Adjustment Subgroups

TABLE 11: HIGH COMORBIDITY ADJUSTMENT INTERACTION SUBGROUPS FOR CY 2020

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description	Comorbidity Subgroup	Description
1	Behavioral 2	Includes depression and bipolar disorder	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
2	Cerebral 4	Includes sequelae of cerebral vascular diseases	Circulatory 4	Includes hypertensive chronic kidney disease
3	Cerebral 4	Includes sequelae of cerebral vascular diseases	Heart 10	Includes
4	Cerebral 4	Includes sequelae of cerebral vascular diseases	Heart 11	Includes heart failure
5	Cerebral 4	Includes sequelae of cerebral vascular diseases	Neuro 10	Includes peripheral and polyneuropathies
6	Circulatory 4	Includes hypertensive chronic kidney disease	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
7	Circulatory 4	Include hypertensive chronic kidney disease	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
8	Circulatory 4	Include hypertensive chronic kidney disease	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
9	Endocrine 3	Includes diabetes with complications	Neuro 5	Includes Parkinson's disease
10	Endocrine 3	Includes diabetes with complications	Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia
11	Endocrine 3	Includes diabetes with complications	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
12	Endocrine 3	Includes diabetes with complications	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
13	Heart 10	Includes cardiac dysrhythmias	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
14	Heart 11	Includes heart failure	Neuro 10	Includes peripheral and polyneuropathies
15	Heart 11	Includes heart failure	Neuro 5	Includes Parkinson's disease
16	Heart 11	Includes heart failure	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
17	Heart 11	Includes heart failure	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
18	Heart 11	Includes heart failure	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
19	Heart 12	Includes other heart diseases	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
20	Heart 12	Includes other heart diseases	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
21	Neuro 10	Includes peripheral and polyneuropathies	Neuro 5	Includes Parkinson's disease
22	Neuro 3	Includes dementias	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
23	Neuro 5	Includes Parkinson's disease	Renal 3	Includes nephrogenic diabetes insipidus
24	Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia	Renal 3	Includes nephrogenic diabetes insipidus
25	Renal 1	Includes Chronic kidney disease and ESRD	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
26	Renal 1	Includes Chronic kidney disease and ESRD	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
27	Renal 3	Includes nephrogenic diabetes insipidus	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
28	Resp 5	Includes COPD and asthma	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
29	Resp 5	Includes COPD and asthma	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
30	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
31	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

Source: CY 2018 Medicare claims data for episodes ending on or before December 31, 2018 (as of July 31, 2019).

Case-Mix Weights

Case-Mix: HIPPS Codes

How HIPPS codes are assigned to each case-mix constructed under PDGM:

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

Case-Mix Weights

- PDGM assigns separate payment weights to periods for patients with similar characteristics and needs:
- Each 30-day period assigned into one of 432 case-mix groups
- The average resource use for each case-mix dictates the assigned case-mix weight where resource use is the estimated cost of visits recorded on the claim together with non-routine supply (NRS) costs
- Cost calculation uses home health Medicare cost reporting and claims data in a Cost Per Minute + NRS formula (CPM+NRS)
- New case-mix weights are used to adjust the HH base payment amount; higher resource need periods are assigned higher case-mix weights and thereby receive more payment
- Annual recalibration of the PDGM case-mix weights to reflect the most recent utilization data available at time of rulemaking

Other Adjustments

Low Utilization Payment Adjustment (LUPA)

- Payments for 30-day periods with a low number of visits are not case-mix adjusted, but instead paid on a per-visit basis using the national per-visit rates.
- Each of the 432 different PDGM payment groups has a threshold that determines if the 30-day period receives a LUPA
  - For each payment group, the 10th percentile value of visits is used to create a payment group specific LUPA threshold with a minimum threshold of at least two for each group (range is 2–6 visits in a 30-day period)
  - LUPA thresholds for each of the 432 case-mix groups can be found in Table 16 in the CY 2020 HH PPS Final Rule and on the CMS HHA Center page

No-RAP LUPA

- Advance knowledge of LUPA for 30-day period
- HHA chooses to not submit RAP
- Claim may be adjusted later if visits are added that exceed LUPA threshold
  - Remember to submit RAP before adjusting claim

Partial Payment Adjustment

- Payments adjusted if a beneficiary transfers from one home health agency to another or is discharged and readmitted to the same agency within 30 days of the original 30-day period start date
- The case-mix adjusted payment for 30-day periods of that type is pro-rated based on the length of the 30-day period ending in transfer or discharge and readmission, resulting in a partial period payment

Transfers

- Same transfer process should be followed under PDGM:
- Receiving agency coordinates with initial HHA
  - Contact and coordinate transfer date
  - Document communications between agencies
  - Submit RAP indicating transfer (condition code 47)
- Transferring agency submits discharge claim showing transfer status “06” — this claim will receive the partial payment adjustment due to the shortened period

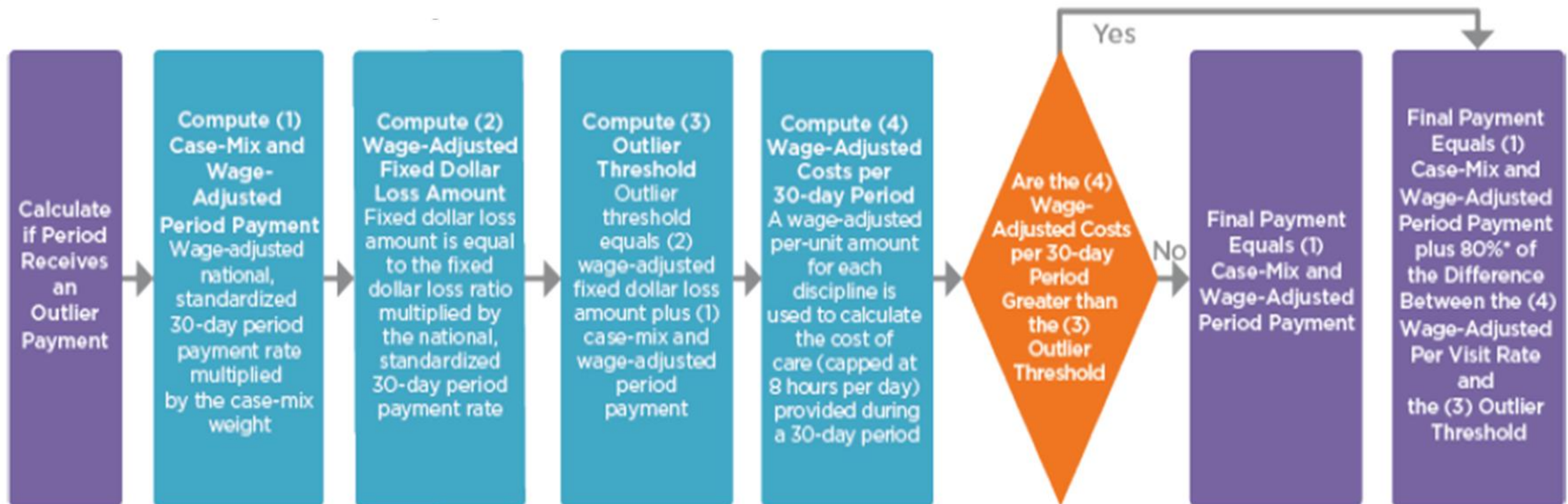
Discharge and Readmission

- Patient discharged before end of 30-day period and same agency readmits in the same 30 days
- Prorated first period – this is the claim with the partial payment adjustment (billed with “06” patient status code)
- New 30-day period begins based on readmission RAP date

Outlier Payment

- Periods that have estimated costs of care (the wage-adjusted costs) that exceed a specific outlier threshold receive an outlier payment to cover a portion of the high costs associated with that 30-day period
- The approach to calculating the outlier payment is the same as the approach used in the current system

Outlier Calculation



How OASIS Data Will Be Used and Diagnosis Reporting

OASIS Data

- OASIS used in determining HIPPS is based on the one most recently completed:
- Medicare system looks back from the claim “From” date for most recent assessment
- Start of Care assessment use for determining functional impairment level for first and second 30-day periods of new home health admission
- Follow-up Recertification assessment used for third and fourth 30-day periods
- Resumption of Care or Other Follow-up assessments may be used for second or later 30-day period

OASIS Data and the Claims System

- OASIS items used to determine the PDGM payment group are returned from iQIES and recorded on the claim record:
  - Items M1033 (Hospitalization Risk), M1800, M1810, M1820, M1830, M1840, M1850, M1860 (current functional levels)
  - 8 items but 17 fields of data in all
- This information will be displayed on a new screen in the Fiscal Intermediary Shared System (FISS)

OASIS Information in FISS

HHAs can see information pulled from OASIS on a new Claim Page 43 (MAP103O):

```
                         QIES/OASIS INFORMATION
                                   USERID XXXXXX__ DT ENTERD XX/XX/XX
M1033-HSTRY-FALL     OA   0 MR 01     M1033-WEIGHT-LOSS    OA   0 MR 01
M1033-MLTPL-HOSPZTN  OA   0 MR 01     M1033-MLTPL-ED-VISIT OA   0 MR 01
M1033-MNTL-BHV-DCLN  OA   X MR XX     M1033-COMPLIANCE     OA   X MR XX
M1033-5PLUS-MDCTN    OA   X MR XX     M1033-CRNT-EXHSTN    OA   X MR XX
M1033-OTHER-RISK     OA   X MR XX     M1033-NONE-ABOVE     OA   X MR XX
M1800-CRNT-GROOMING  OA   X MR XX     M1810-DRESS-UPPER    OA   X MR XX
M1820-DRESS-LOWER    OA   X MR XX     M1830-CRNT-BATHG     OA   X MR XX
M1840-CRNT-TOILTG    OA   X MR XX     M1850-CRNT-TRNSFRNG  OA   X MR XX
M1860-CRNT-AMBLTN    OA   X MR XX
```

OASIS Corrections and Claim Adjustments

- OASIS information may be corrected by an HHA after submitting a claim to Medicare
- No need to adjust claims every time a correction is made
- Only the eight functional items (below) are used by the claims system, so claims only need to be adjusted if these items are corrected and the HHA believes the changes will have an impact on payment
  - M1033, M1800, M1810, M1820, M1830, M1840, M1850, M1860

Diagnosis Reporting

- Diagnoses reported on the claim may not necessarily match the OASIS
- Claims are the source of record for payment diagnosis codes; HHA reports principal diagnosis code and up to 24 additional diagnoses
  - If diagnosis codes change before the “From” date of the next period, coding changes should be reflected on the next period
    - Complete an “other follow-up” (RFA 05) assessment when a change would be considered a major decline or improvement in the patient’s health status
    - No edits in Medicare systems comparing claim and OASIS diagnosis codes
    - No need to complete an RFA 05 just to ensure claim and OASIS coding match

Claim Match with OASIS

- When the 30-day period claim is received Medicare claims system checks iQIES for assessment
- If assessment isn't found, claim is RTP'd with reason code 37253
- If assessment is found, answers to 8 OASIS items are returned and stored on claim record
- Medicare system combines OASIS and claims data and sends to Grouper
- Grouper-produced HIPPS code is used for payment (replaces provider-submitted HIPPS code)

CMS Resources

CMS Resources

- MM11081: Home Health Patient-Driven Groupings Model (PDGM) — Split Implementation
- MM11272: Home Health Patient-Driven Groupings Model (PDGM) — Additional Manual Instructions
- MM11395: Home Health (HH) Patient-Driven Groupings Model (PDGM) — Revised and Additional Manual Instructions
- Centers for Medicare & Medicaid Services Patient-Driven Groupings Model
- Home Health Agency (HHA) Center
  - Overview of the PDGM Model Medicare Learning Network Call external link Presentation, Audio Recording, and Transcript — February 12, 2019
  - Home Health Patient-Driven Groupings Model Operational Issues Call external link Presentation, Presentation Clarification, Audio Recording and Transcript from August 21, 2019

Palmetto GBA Jurisdiction M

- Palmetto GBA PDGM Resource Webpage
- **Website:** www.palmettogba.com/hhh
- **IVR/Customer Service: 855–696–0705**
- Palmetto GBA JM Call Flow
- **eServices Online Provider Portal:** https://www.onlineproviderservices.com/ecx_improvev2/initLogin.do

Thank You for Attending!

- HHH Website: www.palmettogba.com/hhh
- IVR/Customer Service: 855–696–0705
- Palmetto GBA JM Call Flow
- eServices Online Provider Portal