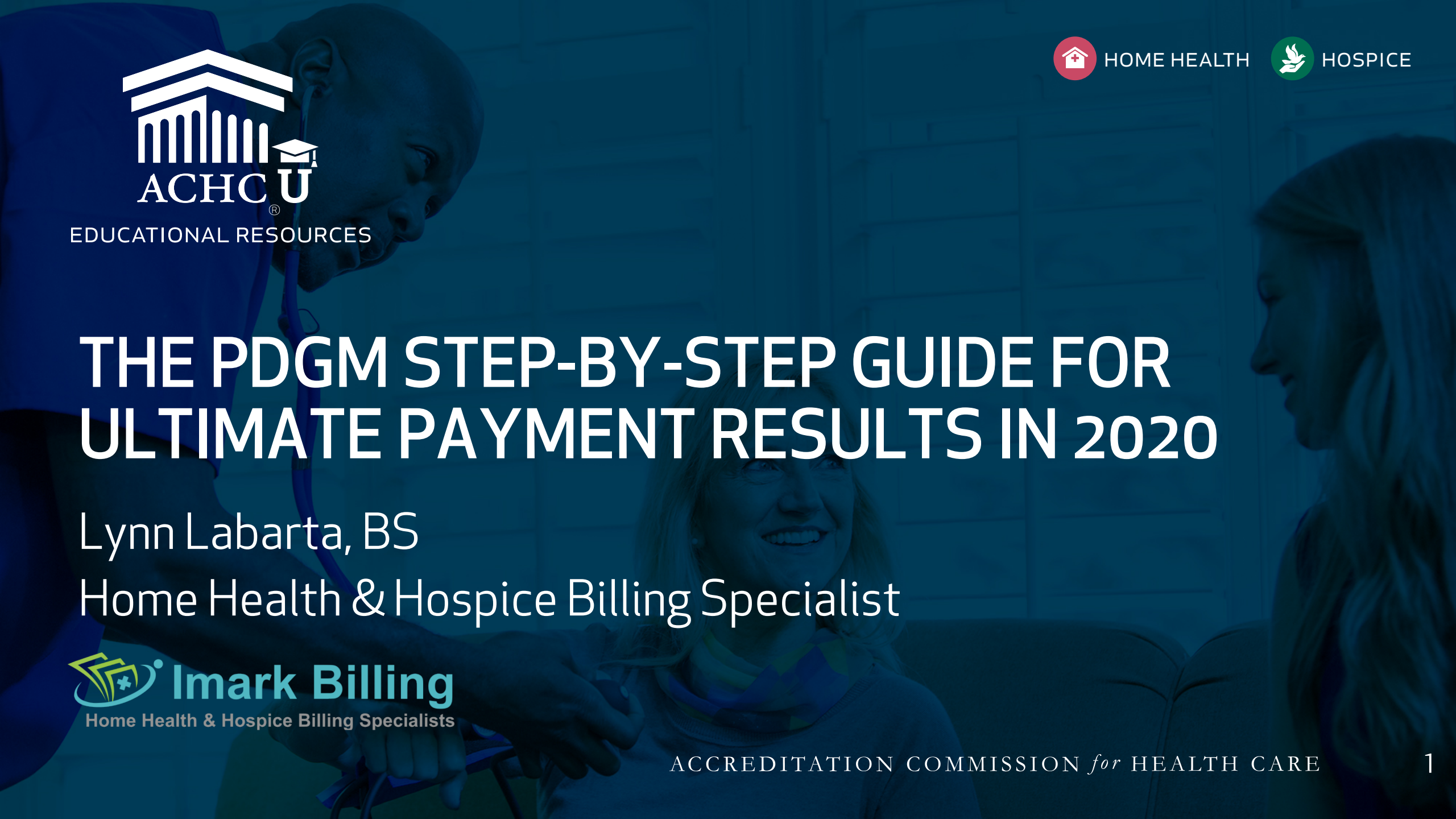

ACHC U®
EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE

THE PDGM STEP-BY-STEP GUIDE FOR ULTIMATE PAYMENT RESULTS IN 2020

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LEARNING OBJECTIVES

- Changes under PDGM vs. current PPS model
- What has not changed with PDGM
- Detailed breakdown of PDGM
- New billing process with PDGM
- Recommendations for transitioning into PDGM
- How your HHA falls under PDGM
- New changes within the proposed rule for 2020 released in July 2019

PATIENT-DRIVEN GROUPINGS MODEL (PDGM)

- The PDGM is a new payment model for the Home Health Prospective Payment System (HH PPS) that relies more heavily 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 will take effect January 1, 2020
- PDGM is changing the unit of home health payment from a 60-day episode (under PPS) to a 30-day period

PDGM OVERVIEW: CHANGES

- NO more therapy thresholds
- Episode timing: Early vs. late
- Admission source: Community or institutional
- Clinical Groupings: 12 sub groups based on principal dx
- Functional Levels: 3 groups
- Comorbidity adjustment based on secondary dx
- 432 payment groups
- Lupa: 2-6
- Raps will continue except for newly certified agencies
- Unit of payment is 30 days vs 60 days
- Outliers will continue based on 30 days
- NO NRS separate calculation

PDGM OVERVIEW: WHAT STAYS THE SAME

- Agencies certified BEFORE January 1, 2019, continue to submit RAP and receive split payment
- 60-day timing for certification periods unchanged
- Assessment within 5 days of SOC and no less than last 5 days of every 60 days unchanged
- Plan of Care corresponds with 60-day certification
- OASIS time frames remain unchanged
- COPs (Conditions of Participation) are not changing
- Must have signed orders to bill final claims

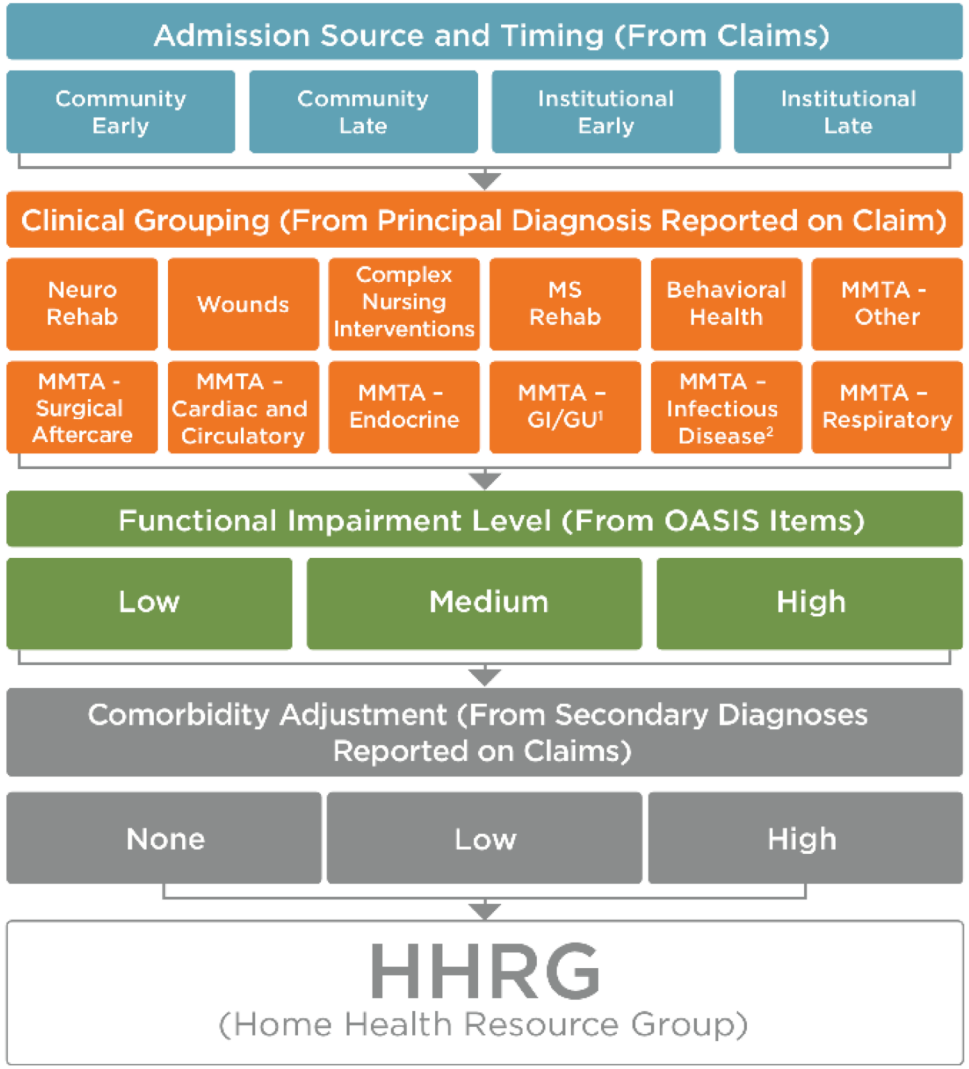
PROPOSED HOME HEALTH RULE 2020

- CMS is proposing to decrease the rap payment amount for existing agencies from the current 60/40 or 50/50 split to a rap payment of 20% of the anticipated 30-day payment

- Significant change proposed since it may result in higher financial impact to agencies in January 2020 under PDGM

HOW IS OUR REIMBURSEMENT DETERMINED UNDER PDGM?

- Case-mix Variables:
  - Admission
  - Timing: early or late
  - Clinical grouping
  - Functional Level
  - Comorbidity



GROUPING MODEL:ADMISSION SOURCE

- Community –physician office, lower resource use, lower payment
- Institutional – the HHA SOC must be within 14 days of a Inpatient Acute Care Hospital; SNF; Inpatient Rehab Facility (IRF); Inpatient Psychiatric Facility; Long-Term Care Hospital (LTCH) discharge
  - No observation days or ED visits
  - Higher payment due to higher resource use
  - Estimated to be 40% more than a community referral

GROUPING MODEL: ADMISSION SOURCE

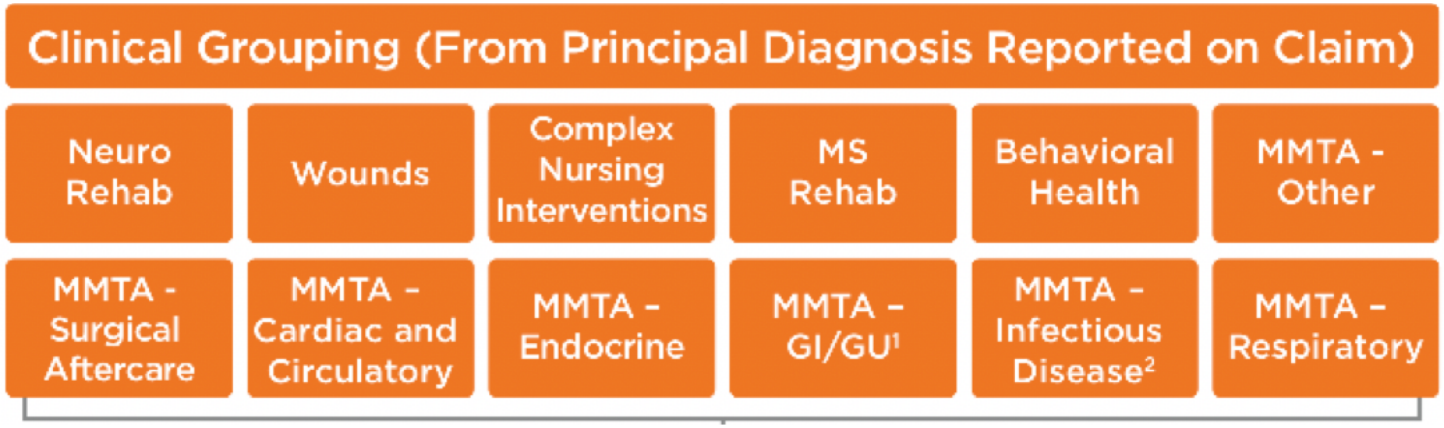
- To determine admission source correctly for each 30-day period of payment:
  - Use a "look back method"
  - Community= NO acute or post acute care in the 14 days prior to the HHA admission
    - (first 30 days; second 30 days of a 60 day episode would be community)
  - Institutional= YES acute or post acute care in the 14 days prior to the HHA admission
    - (first 30 days; second 30 days of a 60 day episode would be community)

GROUPING MODEL: TIMING (EARLY & LATE EPISODE)

- First 30-day period is classified as early
- All subsequent 30-day periods in the sequence (second or later) are classified as late
- If there is a gap of 60 days or more between the end of one 30-day period and the start of the next, then that payment period is considered early again
- Early episode- higher payment
- Late episode- lower payment

GROUPING MODEL: CLINICAL GROUP

- 30-day period is grouped into one of twelve clinical groups based on the patient's principal diagnosis
- Principal diagnosis provides information to describe the primary reason for which patients are receiving home health services
- Diagnosis code must support the need for HH services



GROUPING MODEL: CLINICAL GROUP

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.

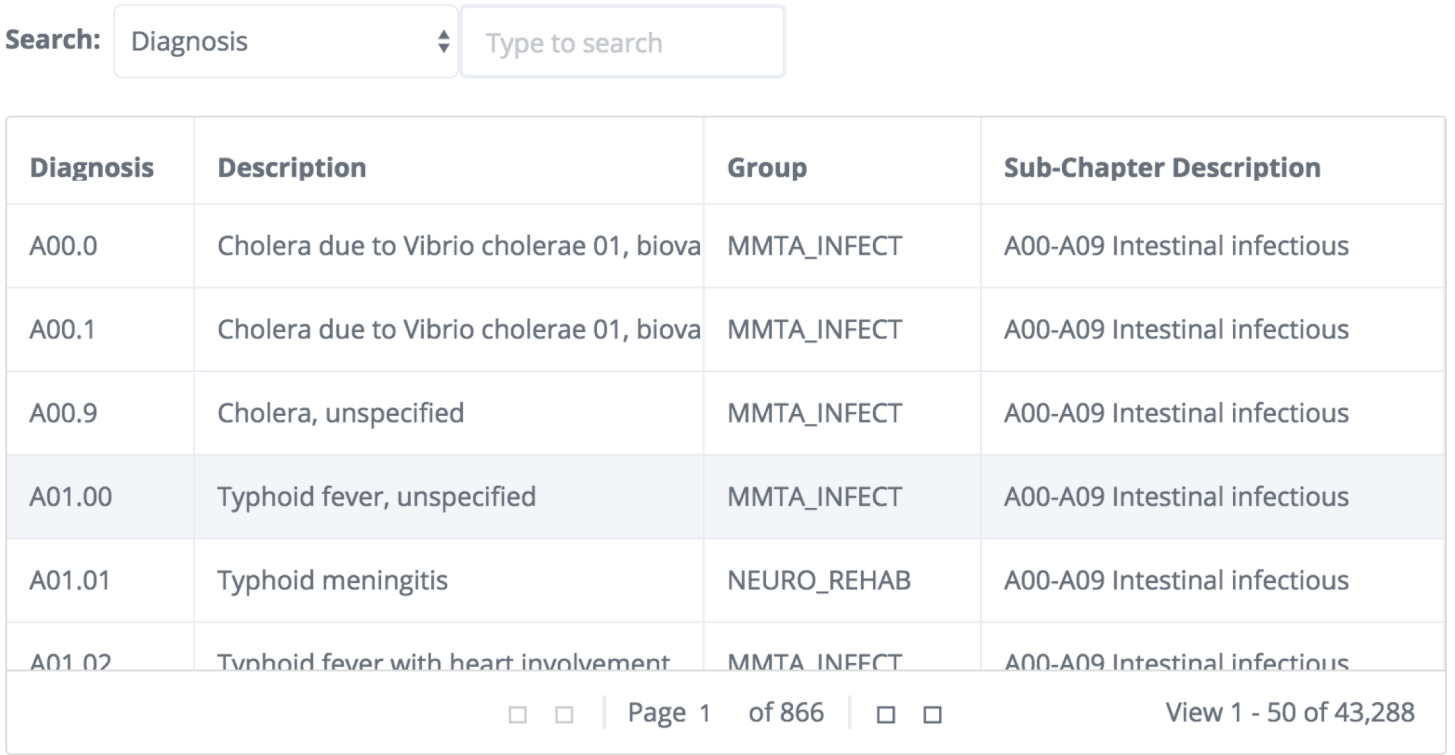
GROUPING MODEL: CLINICAL GROUP

Clinical	Primary Reason for HH Encounter:
Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) -Mostly therapy only cases but still can have nursing if needed
Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) -Mostly therapy only cases but still can have nursing if needed
Wounds - Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Higher paying group, but keep in mind will have much higher resource use and supplies are included
Behavioral Health Care	Lowest paying group, psych conditions
Complex Nursing Interventions	Including IV, TPN, enteral nutrition, ventilator, and ostomies ...maybe a higher paying group
MMTA – Surgical Aftercare	About 50% or more of these cases can fall into this group
MMTA – Cardiac/Circulatory	
MMTA – Endocrine	
MMTA – GI/GU	
MMTA – Infectious Disease/Neoplasms/Blood-forming Diseases	
MMTA – Respiratory	
MMTA – Other	

GROUPING MODEL: CLINICAL GROUP

- PDGM uses the primary dx code for the clinical groups
- Currently under PPS the 6 dx slots OASIS
- List of all 42,000+ PDGM dx codes look-up tool on our website
- Claim will be returned to provider if correct dx code not used from list
- Secondary diagnosis codes will be used in a comorbidity adjustment

CASE MIX DIAGNOSIS LOOK UP TOOL



https://imarkbilling.com/tools/pdgm-icd-lookup/

GROUPING MODEL: FUNCTIONAL IMPAIRMENT LEVEL

- The PDGM designates a functional impairment level for each 30-day period based on the answers to certain OASIS items
- The more impaired the patient is, the higher the score
- The higher the level of impairment, the higher the resource use

GROUPING MODEL: FUNCTIONAL IMPAIRMENT LEVEL FROM THE OASIS

VARIABLE #	DESCRIPTION
M1800	Grooming
M1810	Current ability to dress upper body safely
M1820	Current ability to dress lower body safely
M1830	Bathing
M1840	Toilet transferring
M1850	Transferring
M1860	Ambulation and locomotion
M1033	Risk for hospitalization

GROUPING MODEL: FUNCTIONAL IMPAIRMENT LEVEL

- The more dependent the patient is, the higher the Oasis Points=higher payment
- 33% of periods of care will fall into each of the categories (low, medium, high)
- Low level impairment = responses for the OASIS items that are associated with the lowest resource use
- High level impairment = responses on the OASIS items that are associated with the highest resource use
- Low to Medium approx. $270 increase in payment
- Medium to High approx. $190 increase in payment

GROUPING MODEL: FUNCTIONAL IMPAIRMENT LEVEL

- OASIS Accuracy continues to be critical
- OASIS completed by professionals that possess strong assessment skills required to document a detailed "picture" of the patient
- Should not be an interview; must observe and assess
- Functional Levels driven by the OASIS– impact payment
  - Low, Medium, High
  - If the OASIS is not completed correctly and thoroughly, an underpayment may result

GROUPING MODEL: FUNCTIONAL IMPAIRMENT LEVEL

- When completed correctly the OASIS represents patient information that is submitted to CMS - Quality Outcomes
- The OASIS must be audited by a qualified experienced individual prior to submission to ensure correct reimbursement

OASIS SUBMISSION

- All Oasis still need to be transmitted before the final is billed
- Oasis data must be transmitted to CMS, otherwise a 2% rate reduction will be imposed

GROUPING MODEL: COMORBITITIES

- Comorbidity adjustment is taken from the presence of a secondary dx reported on the CLAIM Form
- NONE, LOW, HIGH adjustment for each 30-day episode
- 24 slots on claim form for dx comorbidities opportunity

GROUPING MODEL: COMORBITITIES

- Low Comorbidity Adjustment= A secondary diagnosis that falls into one comorbidity adjustment subgroup
- High Comorbidity Adjustment= Two or more secondary diagnoses that fall within the same comorbidity subgroup interaction
  - 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. That is, the two diagnoses may interact with one another, resulting in higher resource use
- None= No secondary diagnosis that falls into a comorbidity adjustment subgroup

GROUPING MODEL: COMORBITITIES

- Individual subgroups for comorbidity adjustment = Specific dx codes that are grouped specific subgroups (categories) that CMS has considered for a comorbidity adjustment
- List of dx codes that drive comorbidity
- 13 categories

GROUPING MODEL: COMORBITITIES

Comorbidity subgroups	Description
Cerebral4	Includes sequelae of cerebrovascular diseases
Circulatory10	Includes varicose veins with ulceration
Circulatory9	Includes acute and chronic embolisms and thrombosis
Heart10	Chronic atrial fibrillation
Heart11	Includes heart failure
Neoplasms1	Malignant neoplasm
Neuro10	Includes diabetic neuropathies
Neuro11	Includes diabetic retinopathy and other blindness
Neuro5	Parkinson's disease
Neuro7	Includes hemiplegia, paraplegia, and quadriplegia
Skin1	Includes cutaneous abscess, cellulitis, and lymphangitis
Skin3	Include diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
Skin4	Includes stages Two-Four and unstageable pressure ulcers by site

COMORBIDITIES LOOK UP TOOL

- https://imarkbilling.com/tools/pdgm-comorbidity-adjustment/

Comorbidity Subgroup Chart

Comorbidity Subgroups
Cerebral4
Circulatory10
Circulatory9
Heart10
Heart11
Neoplasm1
Neuro10
Neuro11
Neuro11
Neuro5
Neuro7
Skin1
Skin3
Skin4

Search: ICD-10 Code | Type to search

ICD-10 Code	Comorbidity Group	Description	Sub-Chapter Description
A04.7	infectious1	Enterocolitis due to Clostridium difficile	A00-A09 Intestinal infectious
A04.71	infectious1	Enterocolitis due to clostridium difficile,	A00-A09 Intestinal infectious
A04.72	infectious1	Enterocolitis due to clostridium difficile,	A00-A09 Intestinal infectious
A22.1	Resp2	Pulmonary anthrax	A20-A28 Certain zoonotic bacte
A37.01	Resp2	Whooping cough due to Bordetella pertu	A30-A49 Other bacterial diseas
A37.11	Resp2	Whooping cough due to Bordetella para	A30-A49 Other bacterial diseas

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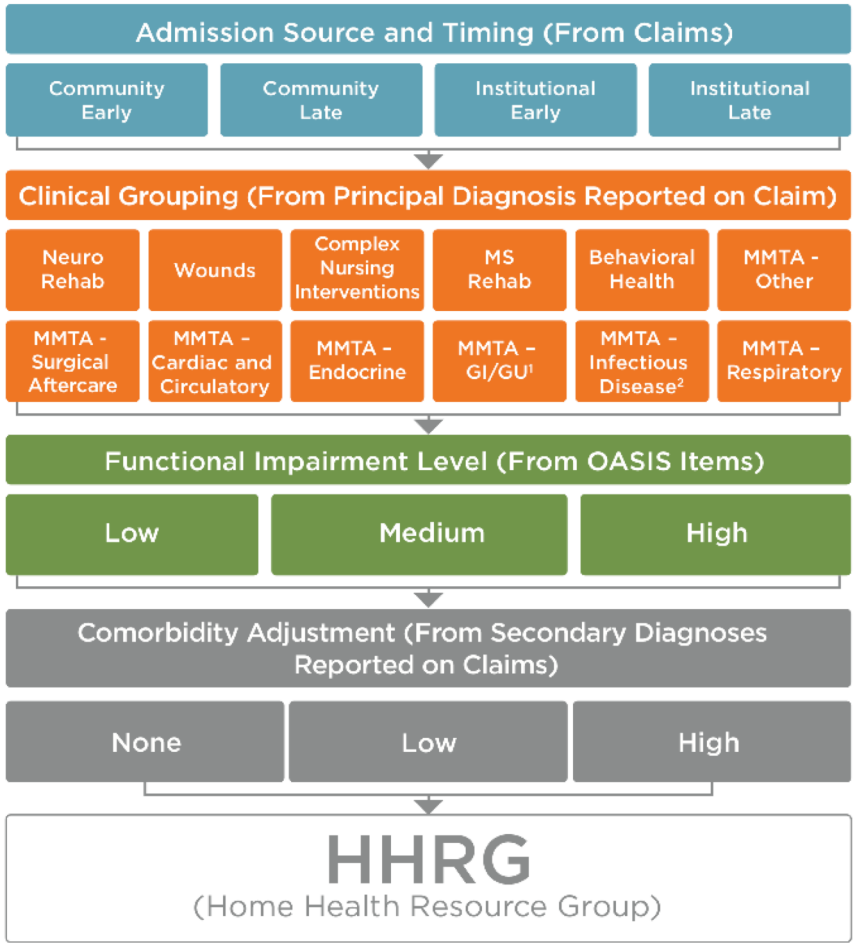
GROUPING MODEL: COMORBITITIES

- Medicare expects that about 80% of 30-day payment periods will have NO comorbidity adjustment
- Low/High adjustments are expected to increase your payment approx. 20%
- Clinicians need to put all diagnoses on claim or in the software that can affect the plan of care (not just Oasis)
- 24 secondary dx codes must be entered into your home health software or on claim, if not using software
- Ask referring physicians for H+P in order to get all of the diagnoses needed to code
- Do chart reviews in facilities, if possible
- Secondary dx coding needs to be clinically appropriate

STRUCTURE OF THE PATIENT-DRIVEN GROUPINGS MODEL

- 432 case mix groups (categories of payment) into which your case can fall
- 30-day unit of payment rate from CMS is $1,791.73



CASE MIX HIPPS CODES
HIPPS CODES UNDER PDGM

Position 1	Position 2	Position 3	Position 4	Position 5
Timing/admission	Clinical group	Functional level	Comorbidity adjustment	Static placeholder
1 - Early/community 2 - Early/institutional 3 - Late/community 4 - Late/institutional	A - MMTA other B - Neuro/stroke C - Wound D - Complex nursing E - MS rehab F - Behavioral health G - MMTA - surgical H - MMTA - cardiac I - MMTA - endocrine J - MMTA - GI/GU K - MMTA - infectious L - MMTA - respiratory	A - Low B - Medium C - high	1 - None 2 - Low 3 - High	1

- Example hipps: 1AB11= $$$

EPISODE EXCEPTIONS

- LUPA
- PEP
- Outliers

LUPA- PDGM (LOW UTILIZATION PAYMENT ADJUSTMENT)

- LUPA thresholds will vary for a 30-day period depending on the payment group to which it is assigned
- LUPA thresholds range from 2-6 visits

LUPA- PDGM (LOW UTILIZATION PAYMENT ADJUSTMENT)

- In PDGM, in order for an agency to know if the claim is going to be a Lupa, they need to know the Hipps code from the OASIS and then use Imark's look up tool on our website to see how many visits would be considered a Lupa for that particular claim.

LUPA- PDGM LOOK UP TOOL

- https://imarkbilling.com/tools/pdgm-lupa-look-up-tool/

Find Your LUPA Threshold

1aa11 | Search

HIPPS 1AA11

Clinical Group and Functional Level	MMTA - Other - Low
Timing and Admission Source	Early - Community
Comorbidity Adjustment	None
Visit Threshold	4

PEP- PARTIAL EPISODE PAYMENTS

- 3 Trigger Event
  - Patient transfers to another HHA
  - Patient is discharged & readmitted to your agency
  - Patient enrolls in a HMO during 30 days

OUTLIER DEFINITION

- Additional payments to the 30-day episode payments for beneficiaries who incur unusually large costs. These outlier payments will be made for episodes whose imputed cost exceeds a threshold amount for each case-mix group.

OUTLIERS: WHAT YOU NEED TO KNOW

- Make sure you document all of the visits you performed during the episode
- Confirm that the visit time IN and time OUT are correct
- No other action is required; portions of the outlier payment will be made at any time

PAYMENTS VS. CERTIFICATION

- Payment work flow *(payment period)*
  - Two 30-day payment periods within a 60-day certification period
- Certification period workflow *(episode)*
  - 60-day timing for certification periods (60-day episodes)
  - Plan of Care corresponds with 60-day certification
  - SOC Oasis covers for 60-day episode
  - Recert OASIS continues if extending initial 60 days

BILLING PROCESS

- When a patient is admitted, a 60-day episode is created (certification episode)
- Billing is done for every 30 days the patient is on service (payment period)
- Bill once at the beginning of the payment period (RAP)
- Bill once at the end of the 30 days or earlier if services are over (FINAL or EOE)

30-DAY UNIT OF PAYMENT

- 30-day payment period = days 1-30 of a current 60-day episode
  - Monthly billing
- Average 30-day unit of payment $1,791.73

BILLING PROCESS: PRE-BILL PROCESS FOR REQUEST FOR ANTICIPATED PAYMENT (RAP)

- To bill a RAP, three criteria must be met:
  - OASIS assessment is complete, locked, export ready or exported
  - A plan of care has been established and sent to the physician
  - First service visit delivered and documented in your homecare software

RAPs

- RAPs should be sent as soon as possible.
  - Goal of 6 to 10 days
- RAP pays 60% of unit payment or 50% for recerts- *ONLY FOR AGENCIES CERTIFIED BEFORE 2019*
- Once a RAP is billed will receive the money within 5-7 days
- Agencies certified After January 1, 2019 will not receive a RAP payment, but RAP still needs to be billed

FINAL

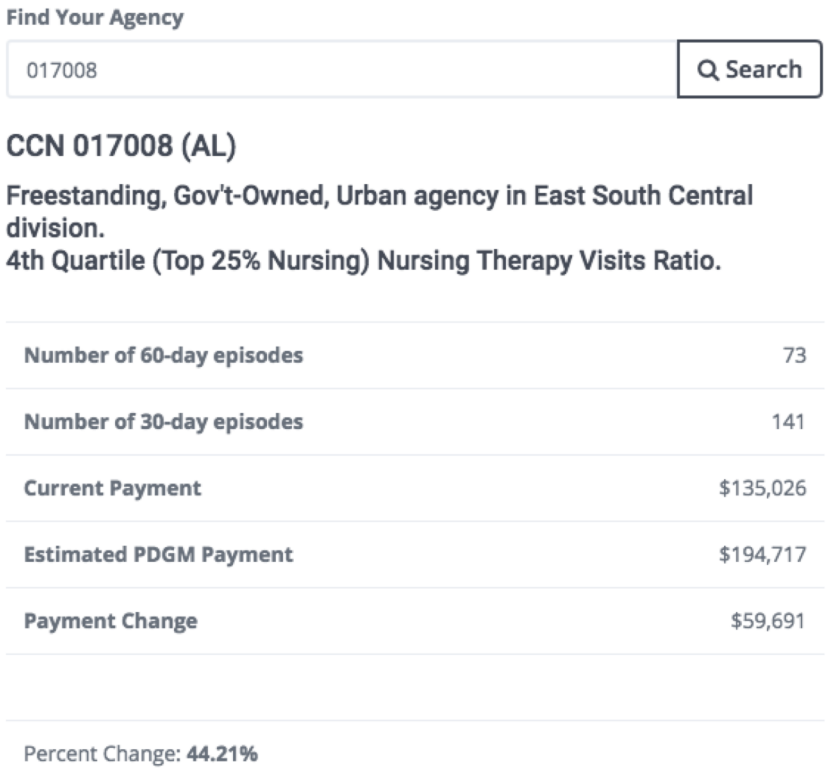
- Before billing final, perform a billing audit to ensure:
  - Orders are signed
  - Discipline and frequency match schedule
  - Pre-bill report matches visits being billed with schedule
  - Face-to-face (only for SOC)

PRE-BILL PROCESS FOR FINAL

- FINAL can be billed on or before 30-day period is over
- Final should be sent as soon as possible
  - Goal of 8 to 12 days
- Once the final is billed, will receive the money within 14 to 30 days

PDGM IMPACT ON YOUR AGENCY

- https://imarkbilling.com/tools/pdgm-impact-lookup/



*this is from 2018 data collected by CMS

PDGM IMPACT ON YOUR AGENCY

Nursing Therapy Ratio	Average Payment 60-day Episode	Average Payment per 60-day, PDGM	Payment Change	Percent Change
1st Quartile (Lowest 25% Nursing)	$3,240.26	$2,919.00	-$321.26	-9%
2nd Quartile	$2,952.24	$2,928.58	-$23.67	-0.80%
3rd Quartile	$2,819.50	$3,001.58	$182.07	6%
4th Quartile (Top 25% Nursing)	$2,605.20	$3,048.29	$443.08	17%

CONCLUSIONS ON PDGM

- Wound and complex cases typically will have higher payment
- Behavioral health, some MMTA, will have lower
- Agencies that are non-profits, and in the Northeast, predicted to have higher payments to their episodes
- Rural agencies and facility-based are expected to fair positively
- Agencies with a higher ratio of nursing will also have an average higher weight
- Agencies with high therapy visits will see a large impact in payment
- Other f/u assessments, if there is a significant change in condition, will be important
  - Consider putting a process in place to evaluate the patient's resource use and condition before the end of the 30-day period, in case a SCIC assessment would need to be done
- Relationships with institutional providers for referrals – 40% more than community referrals
- More into on the billing process will be released towards the end of 2019 and when CMS manuals are updated

TRANSITIONING TO PDGM: WHAT TO DO NOW?

- START by:
  - Using the Imark Billing Look-Up Tool (PDGM Impact look-up) to analyze the impact on your agency
  - Educate office staff and field staff on the new PDGM model
    - Ensure all staff watch this webinar on PDGM
    - Focus on the drivers of reimbursement under PDGM

TRANSITIONING TO PDGM

Referral Sources Review:

- It's predicted that institutional referrals will be paid at a higher rate than community (physician) referrals, approx. 40% more
- Analyze the % of community vs. institutional referrals
- Increase your marketing efforts to Inpatient Acute Care Hospital; SNF; Inpatient Rehab Facility (IRF); Inpatient Psychiatric Facility; Long-Term Care Hospital (LTCH)

TRANSITIONING TO PDGM

Intake/Processing:

- Get familiar with the primary dx look-up tool to ensure your primary dx is listed as a PDGM acceptable reason for home health services https://imarkbilling.com/tools/pdgm-icd-lookup/
- Review current processes to ensure a chart review or History & Physical (H&P) is obtained to capture all secondary diagnoses that could affect the plan of care. There could be an increase in payment of approx. 20% for certain secondary dx.

TRANSITIONING TO PDGM

Case Management:

- Lupa Management https://imarkbilling.com/tools/pdgm-lupa-look-up-tool/
- Determine appropriate visit frequency/resources use according to level of impairment

TRANSITIONING TO PDGM

Timelines:

- Review your current time frames for visit and assessment documentation to be completed
  - Implement action plan to speed documentation completion
- Analyze time frame in which physician orders and F2F documents are received
  - Implement action plan to increase speed in obtaining these documents, since billing will need to be done monthly (30-day periods)
- Review how many days it takes your agency to bill a RAP & Final
  - Implement action plan to speed up billing of claims

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QUESTIONS?

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