



STRATEGIC HEALTHCARE PROGRAMS

PDGM: Is Your Revenue Cycle Prepared?



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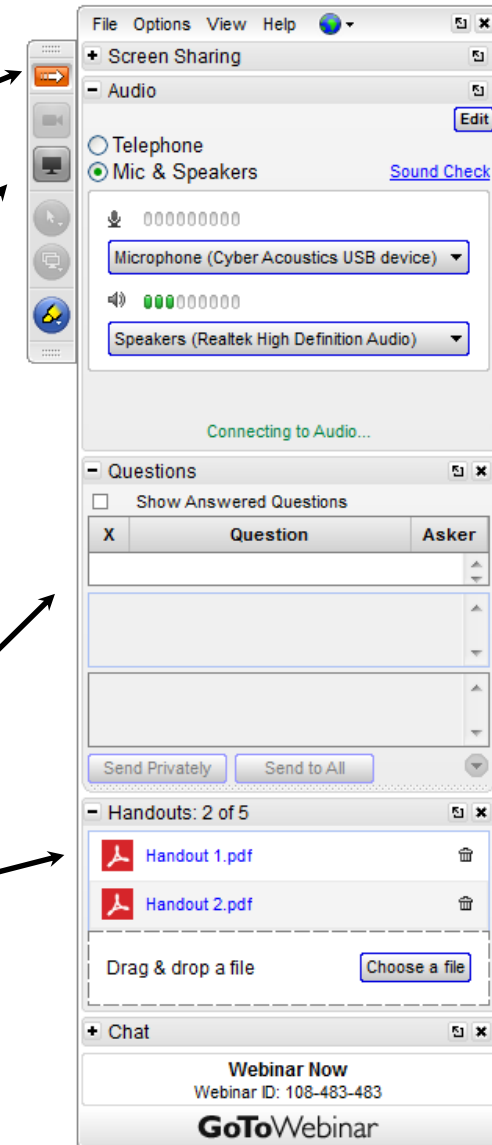
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How would these events occur within the workflow of your everyday operations?



How would these events be documented in your EMR?



How would these events be mapped in your EMR to claims for billing & payment purposes?



What system settings in your EMR are you responsible for adjusting to capture these events?

Guiding Thoughts for Today

30-Day Payment Periods

PPS

- ▶ 60-day episodes for both documentation & payment purposes
- ▶ Applies to all episodes beginning in 2019

PDGM

- ▶ 60-day episodes for documentation purposes
- ▶ 30-day periods for payment purposes
- ▶ Applies to all episodes beginning in 2020
 - ▷ SOC & recertifications

National Standard Payment Rate

PPS

- ▶ National standard 60-day episode payment rate
- ▶ NRS payment add-on per 60-day episode based on OASIS assessment
- ▶ Transition rate for episodes beginning in 2019 & ending in 2020
- ▶ 2% penalty for lack of OASIS or HHCAHPS submissions can apply
- ▶ 2% sequestration reduction applies

PDGM

- ▶ National standard 30-day period payment rate
 - ▷ **\$1,864 final rate**, after application of 4.36% reduction for behavior adjustments
- ▶ 2% penalty for lack of OASIS or HHCAHPS submissions can apply
- ▶ 2% sequestration reduction applies

PPS episodes ending prior to 01/01/20 paid based on 2019 PPS rates

Rate Paid for PPS Episodes Ending Prior to 01/01/20*

\$3,154.27

PPS episodes ending on or after 01/01/20 paid based on 2020 PPS transition rates

Rate Paid for PPS Episodes Ending On or After 01/01/20*

\$3,220.79

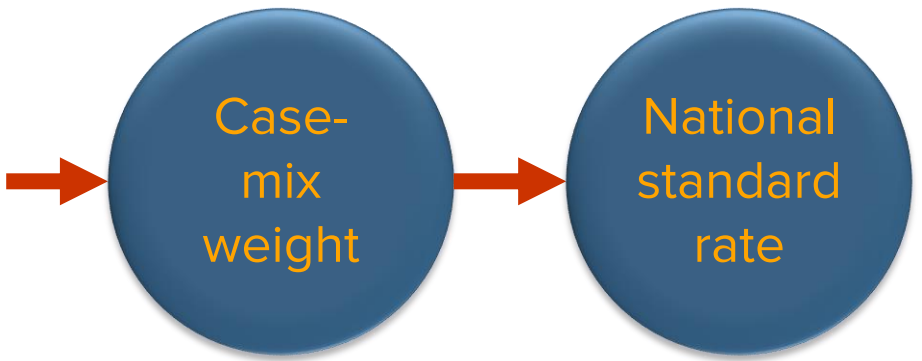
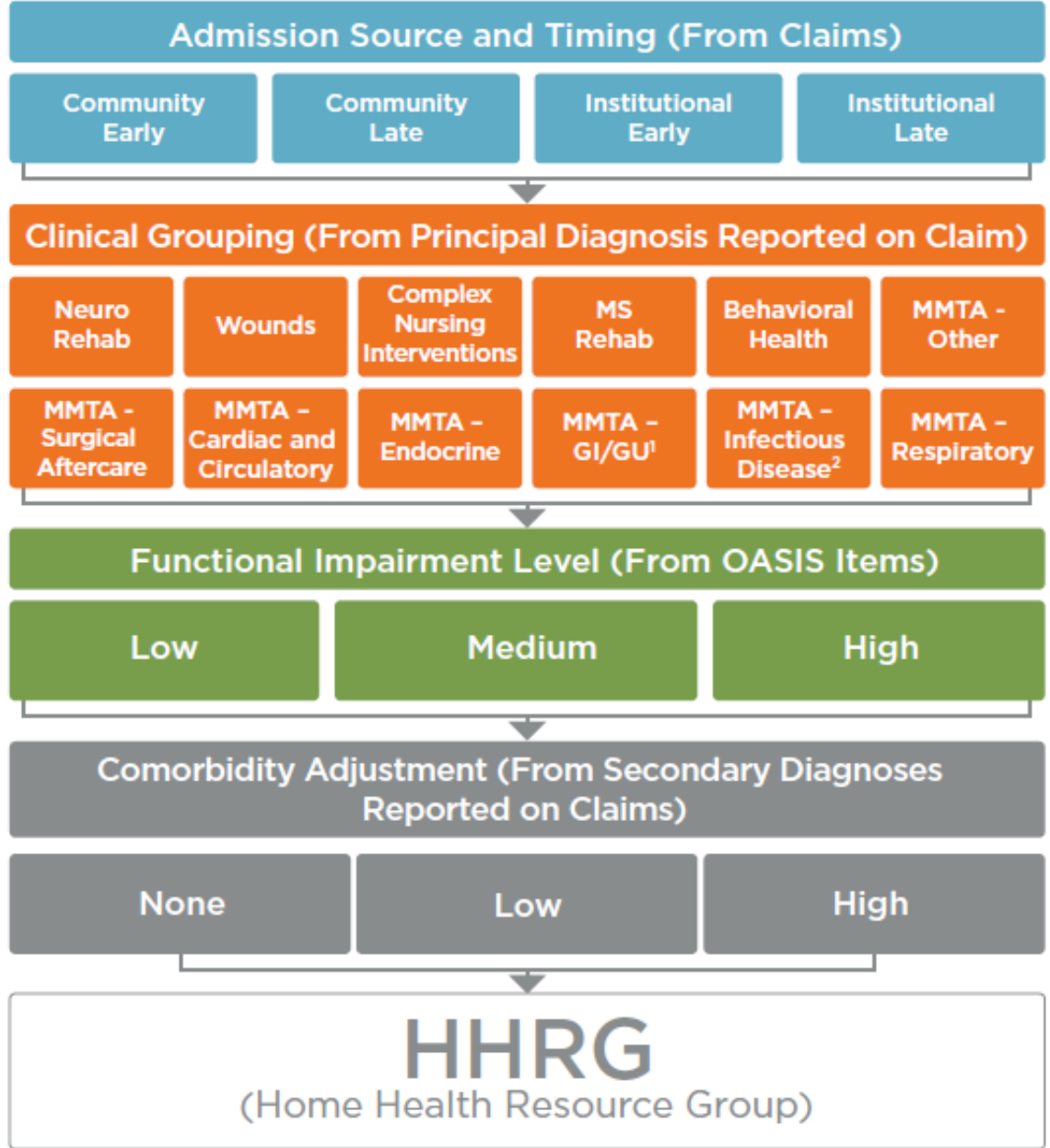
SOCs or recertifications beginning on or after 01/01/20 paid based on PDGM rates

Rate Paid for PDGM Periods Beginning On or After 01/01/20*

\$1,864.03
(after reduction for behavior adjustments)

**Before any application of rural payment add-on*

PDGM Payment Elements



PDGM Payment Elements

**Admission Source &
Timing** *(from claims)*

PPS

- ▶ No comparative payment element

PDGM

- ▶ Institutional
 - ▷ Initial payment periods
 - ▷ Acute or post-acute inpatient stay 14 days prior to
 - ▷ Subsequent payment periods
 - ▷ Acute stay 14 days prior to
 - ▷ Post-acute stay 14 days prior to
 - ▷ Only if discharged from & readmitted to HH
- ▶ Community
 - ▷ Any payment period not qualifying as institutional

PPS

- ▶ Early
 - ▷ 60-day episodes one & two
- ▶ Late
 - ▷ All third & later 60-day episodes

PDGM

- ▶ Early
 - ▷ Initial admission 30-day payment period
- ▶ Late
 - ▷ All subsequent 30-day payment periods

PDGM Payment Elements

Clinical Grouping
(from claims)

PPS

- ▶ 13 payment weighted OASIS questions for each 60-day episode
 - ▷ SOC
 - ▷ Recertification
 - ▷ ROC, if used as recertification OASIS

PDGM

- ▶ 12 clinical groupings based on primary diagnosis billed on claim for each 30-day payment period
 - ▷ Per SOC & recertification OASIS
 - ▷ Per updates in clinical documentation reflecting changes & communication/coordination with certifying physician

PDGM Payment Elements

**Functional Impairment
Level** *(from OASIS)*

PPS

- ▶ Six payment weighted OASIS questions for each 60-day episode
 - ▷ M1810 current ability to dress upper body
 - ▷ M1820 current ability to dress lower body
 - ▷ M1830 bathing
 - ▷ M1840 toilet transferring
 - ▷ M1850 transferring
 - ▷ M1860 ambulation/locomotion

PDGM

- ▶ Eight payment weighted questions from most recently completed OASIS assessment
 - ▷ M1033 risk of hospitalization
 - ▷ M1800 grooming
 - ▷ M1810 current ability to dress upper body
 - ▷ M1820 current ability to dress lower body
 - ▷ M1830 bathing
 - ▷ M1840 toilet transferring
 - ▷ M1850 transferring
 - ▷ M1860 ambulation/locomotion

PDGM Payment Elements

**Comorbidity
Adjustment** *(from OASIS)*

PPS

- ▶ No comparative payment element

PDGM

- ▶ Based on other diagnoses billed on claim
 - ▷ No adjustment
 - ▷ No other diagnosis on claim from qualifying comorbidity subgroups
 - ▷ Low adjustment
 - ▷ Other diagnosis on claim from one of 13 comorbidity subgroups
 - ▷ High adjustments
 - ▷ Two or more other diagnoses on claim from one of 31 comorbidity subgroup interactions

Case-Mix Weights

PPS

- ▶ 153 possible case-mix weights for each 60-day episode
 - ▷ 0.4691 low
 - ▷ 2.0228 high
- ▶ Correspond to HIPPS codes

PDGM

- ▶ 432 possible case-mix weights for each 30-day payment period
 - ▷ 0.5057 low
 - ▷ 1.8430 high
- ▶ Correspond to HIPPS codes

LUPAs

PPS

- ▶ Per-visit payment applied to any 60-day episode with less than five total visits
- ▶ LUPA add-on conditionally applied

PDGM

- ▶ Per-visit payment applied to any 30-day period with total visits ranging from less than two to less than six
 - ▷ LUPA threshold unique to each case-mix weight
- ▷ LUPA add-on conditionally applied

RAPs

PPS

- ▶ Required for each 60-day episode
- ▶ Paid based on submitted HIPPS code

PDGM

- ▶ Required for each 30-day period
 - ▷ Two required for each payment period in one 60-day episode
- ▶ Paid based on submitted HIPPS code
 - ▷ Phased out by 2022
 - ▷ Replaced by NOA billing transaction

Effective January 1, 2020	Effective January 1, 2021	Effective January 1, 2022
<ul style="list-style-type: none"> Agencies Medicare certified prior to 2019 <ul style="list-style-type: none"> Bill RAPs for each payment period Paid 20% on all RAPs 	<ul style="list-style-type: none"> All agencies bill “no pay” RAPs for all payment periods <ul style="list-style-type: none"> Must be billed within 5 days or payment penalty applies 	<ul style="list-style-type: none"> All agencies bill NOA for SOC payment period only <ul style="list-style-type: none"> Must be billed within 5 days or payment penalty applies
<ul style="list-style-type: none"> Agencies Medicare certified in 2019 or after <ul style="list-style-type: none"> Bill “no pay” RAPs for all payment periods 	<ul style="list-style-type: none"> “No pay” RAP billing requirements revised 	

PPS

- ▶ Subject to payment recoupment when matching final claim not received timely
 - ▷ 120 days from episode start date, or
 - ▷ 60 days from RAP payment date
 - ▷ Which ever date is latest
 - ▷ Recoupments monitored by MACs

PDGM

- ▶ Subject to payment recoupment when matching final claim not received timely
 - ▷ 90 days from episode start date, or
 - ▷ 60 days from RAP payment date
 - ▷ Which ever date is latest
 - ▷ Recoupments monitored by MACs

PPS

- ▶ Key billing requirements
 - ▷ OASIS, POC & first billable visit occurring during 60-day episode must be completed prior to billing RAP
 - ▷ Diagnosis codes must match OASIS

PDGM

- ▶ Key billing requirements
 - ▷ Initial 30-day payment periods
 - ▷ Same requirements for OASIS, POC & first billable visit
 - ▷ Diagnosis codes would typically match OASIS
 - ▷ Subsequent 30-day payment periods
 - ▷ First billable visit occurring during period must be completed
 - ▷ Changes to diagnosis codes must be documented
 - ▷ No new OASIS *required*

Final Claims

PPS

- ▶ Required for each 60-day episode
- ▶ Claim paid in full based on submitted HIPPS code & OASIS matching string
- ▶ Subject to payment adjustments
 - ▷ LUPA & LUPA add-on
 - ▷ PEP
 - ▷ Outlier

PDGM

- ▶ Required for each 30-day period
 - ▷ Two required for each payment period in one 60-day episode
- ▶ Claim paid in full according to Medicare claims processing system calculated HIPPS code based on claims & OASIS data
- ▶ Subject to payment adjustments
 - ▷ LUPA & LUPA add-on
 - ▷ PEP
 - ▷ Outlier

PPS

- ▶ Key billing requirements
 - ▷ OASIS must be received by QIES
 - ▷ All physician orders must be signed & dated
 - ▷ Physician FTF encounter documentation
 - ▷ POC & all other orders
 - ▷ Diagnosis codes must match OASIS & RAP

PDGM

- ▶ Key billing requirements
 - ▷ OASIS must be received by iQIES
 - ▷ Initial 30-day payment periods
 - ▷ Same requirements for OASIS & physician orders
 - ▷ Diagnosis codes match OASIS & RAP
 - ▷ Subsequent 30-day payment periods
 - ▷ Same requirements for physician orders
 - ▷ Changes to diagnosis codes must be documented
 - ▷ New OASIS might have been completed

PPS

- ▶ Key billing requirements
 - ▷ Must report OASIS matching string

PDGM

- ▶ Key billing requirements
 - ▷ New occurrence code to replace OASIS matching string
 - ▷ 50 – OASIS M0090 date
 - ▷ New occurrence codes to report institutional admission source
 - ▷ 61 – hospital discharge date
 - ▷ 62 – SNF, IRF, LTCH or IPF discharge date

PPS

- ▶ Subject to payment validation against OASIS on file in QIES
- ▶ Subject to payment recoding & adjustments

PDGM

- ▶ Subject to new process for payment validation against OASIS in iQIES
- ▶ Subject to payment recoding & adjustments

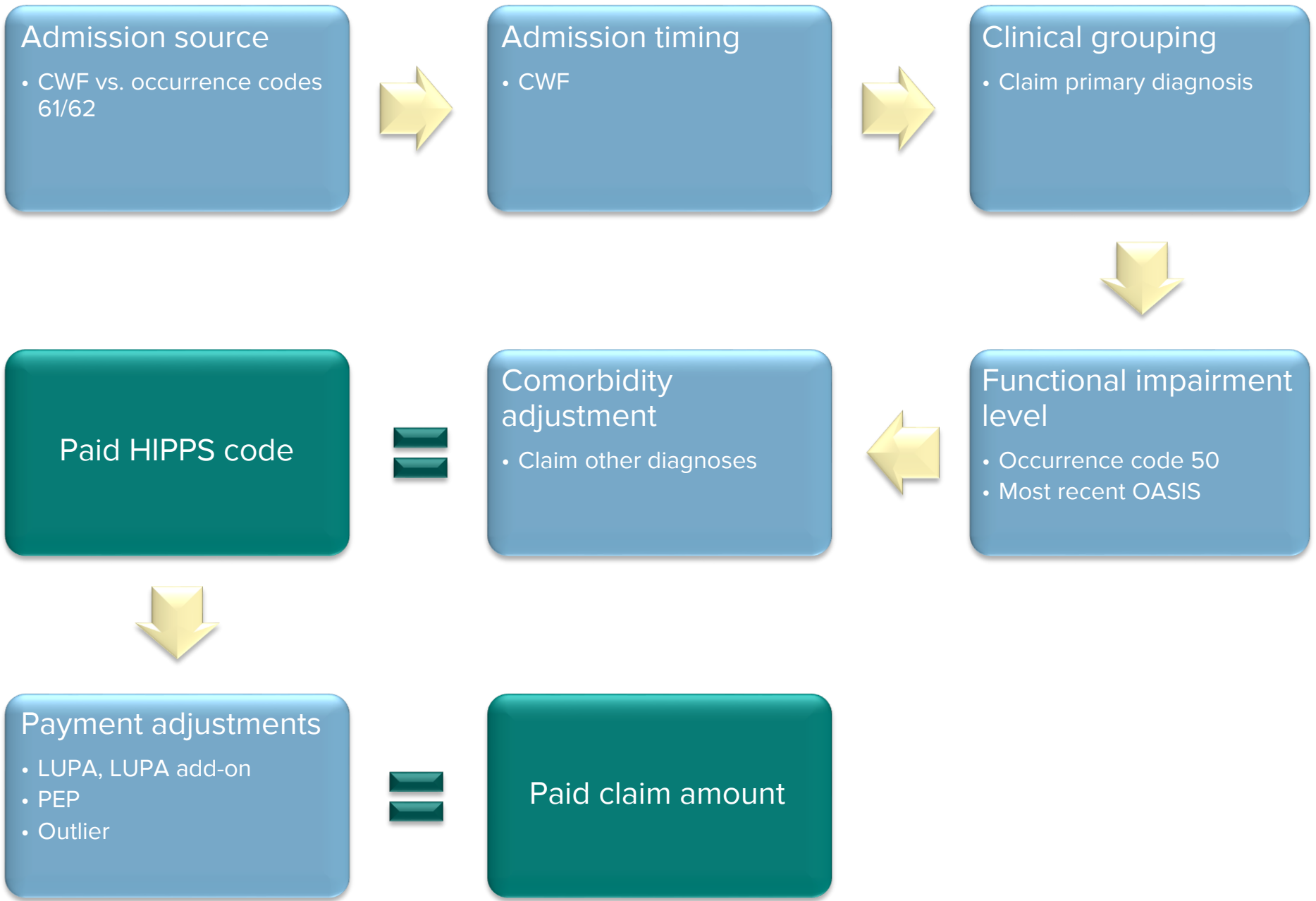
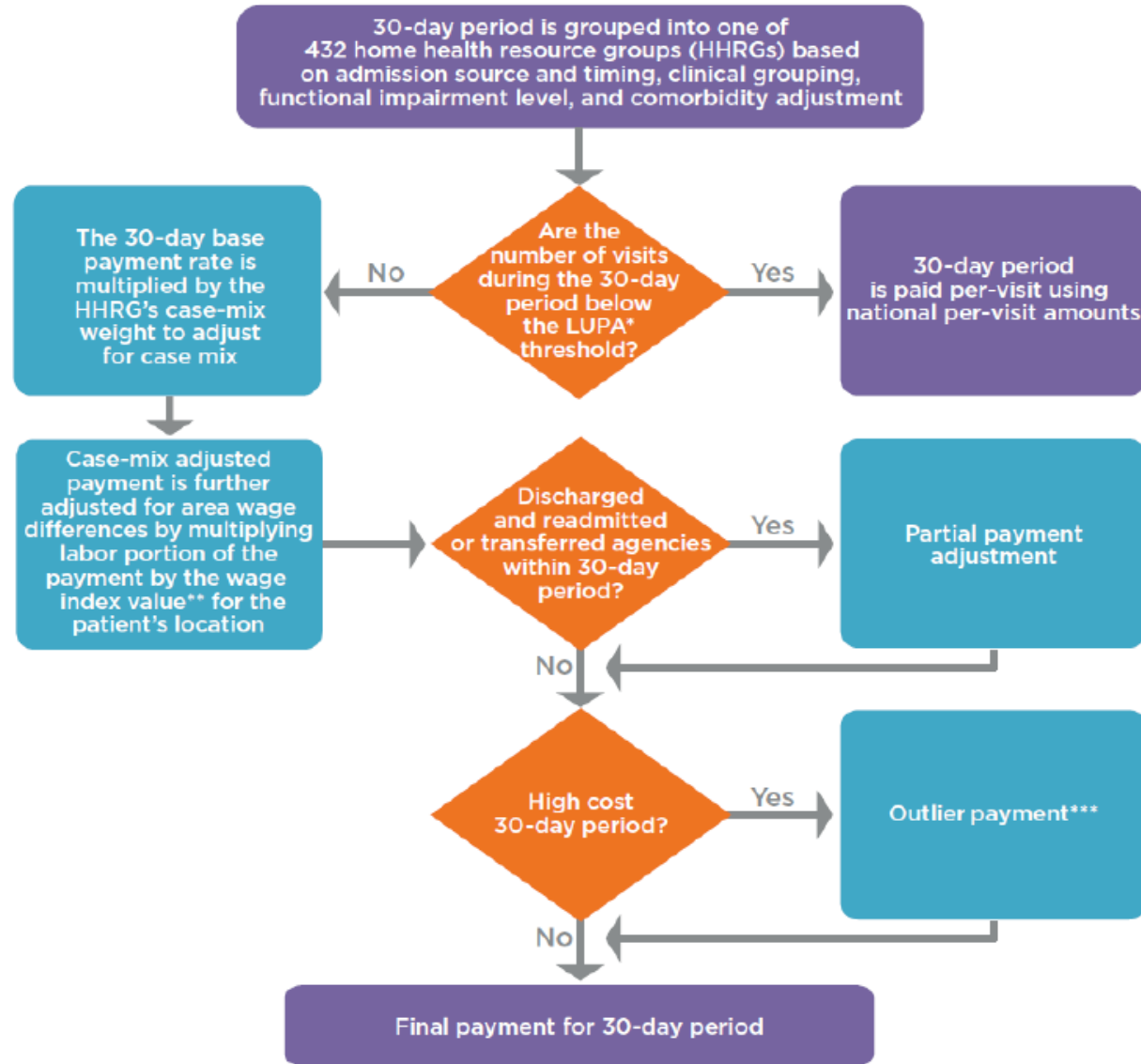


Figure 2: How Payments and Adjustments Are Calculated For the Patient-Driven Groupings Model



Source: MLN Matters SE19028 dated November 22, 2019

* LUPA = Low Utilization Payment Adjustment
 ** The wage-adjusted payment for a 30-day period is calculated by taking the case-mix adjusted 30-day payment amount and multiplying 76.1% of that payment by a wage-index value that controls for area wage differences. That value is then added to 23.9% of the case-mix adjusted base-payment to determine the wage-adjusted payment amount.
 *** Outlier payment is in addition to the wage-adjusted and case-mix adjusted 30-day period payment

HIPPS Codes

Position 1 Admission Source & Timing		Position 2 Clinical Grouping		Position 3 Functional Impairment		Position 4 Comorbidity Adjustment		Position 5 Unassigned
1	Community, early	A	MMTA – Other	A	Low	1	No adjustment	1 (unassigned)
2	Institutional, early	B	Neuro rehab	B	Medium	2	Low adjustment	
3	Community, late	C	Wounds	C	High	3	High adjustment	
4	Institutional, late	D	Complex nursing					
		E	MS rehab					
		F	Behavioral health					
		G	MMTA – Surgical aftercare					
		H	MMTA – Cardiac					
		I	MMTA – Endocrine					
		J	MMAT – GI/GU					
		K	MMTA – Infectious disease					
		L	MMTA - Respiratory					

Cash Flow

January – 15% decrease

February – 30% decrease

March – Rebound

April – New normal

Billing Scenarios

Assess data capture process at intake/SOC



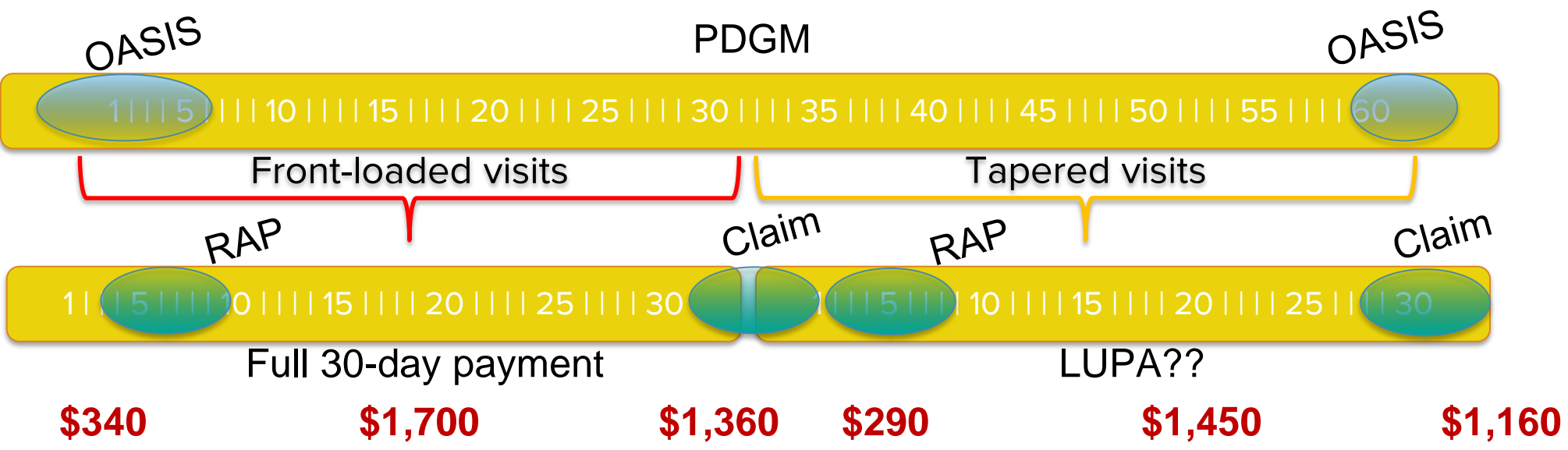
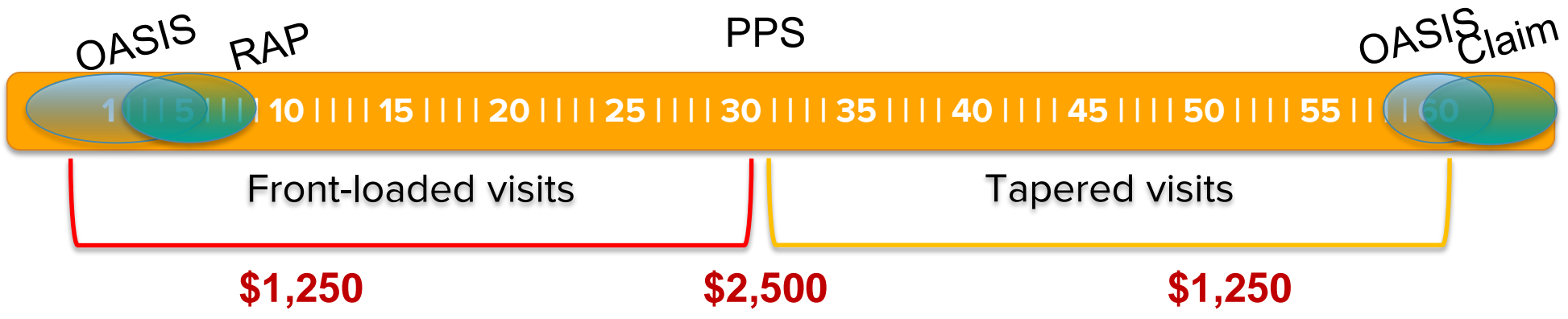
Assess data capture at each 30-day payment period/recertification



Test & monitor claim & payment scenarios



Assess pre-billing process controls



Scenario 1 – Admission Source

Scenario

Patient admitted to HH 01/01/20
with no prior inpatient stays

Patient admitted to emergency
room 01/28/20

Patient discharged home from
observation stay 01/29/20

Observation stays
not qualified as
institutional

Payment period
01/01/20 grouped as
community

Payment period
01/31/20 grouped as
community

Scenario 2 – Admission Source

Scenario

Patient admitted to HH 01/01/20 with no prior inpatient stays

Patient admitted to hospital 01/20/20 & discharged to SNF 01/23/20

Patient returns to HH 01/30/20 after discharge from SNF 01/28/20

Payment period 01/01/20 grouped as community

HH discharged as of 01/23/20 due to SNF admission

Payment period 01/30/20 grouped as institutional

Report occurrence code “62” with date 01/28/20

Scenario 3 – Admission Timing

Scenario

Patient admitted to HH 11/17/19 with MA plan as primary

Patient reverts to original Medicare as primary effective 01/01/20

Prior HH services covered under MA are not considered

Payment period 01/01/20 grouped as early

Scenario 4 – Clinical Grouping

Scenario

Patient admitted to HH 01/01/20 with wound care as primary focus of care

By 01/31/19 wound has healed as expected & focus of care shifts to address patient's deconditioned state

Clinical grouping for payment period 01/01/20 is Wounds

Shift in focus of care was not due to significant change in condition

Clinical grouping for payment period 01/31/20 is MS Rehab

Scenario 5 – Functional Impairment Level

Scenario

Patient admitted to HH 01/01/20 with functional impairment grouping of “3” on SOC OASIS

ROC OASIS completed 01/29/20 resulted in functional impairment grouping of “2”

Recertification OASIS completed 02/29/20 resulted in functional impairment grouping of “1”

Functional impairment grouping for payment period 01/01/20 is “3” based on SOC OASIS

Functional impairment grouping for payment period 01/31/20 is “2” based on ROC OASIS

Functional impairment grouping for payment period 03/01/20 is “1” based on recertification OASIS

Scenario 6 – Overlapping Inpatient Stay

Scenario

Patient admitted to HH 01/01/20

Patient admitted to hospital
01/29/20

HH care resumed 02/02/20

Inpatient stays can overlap payment periods but not episodes

RAP for payment period 01/01/20 based on SOC

RAP for payment period 01/31/20 billed after care is resumed

Scenario 7 – Low Visit Frequency

Scenario

Patient admitted to HH 01/01/20
for catheter care

Visits were made 01/01/20 &
03/01/20

Patient was discharged 03/10/20

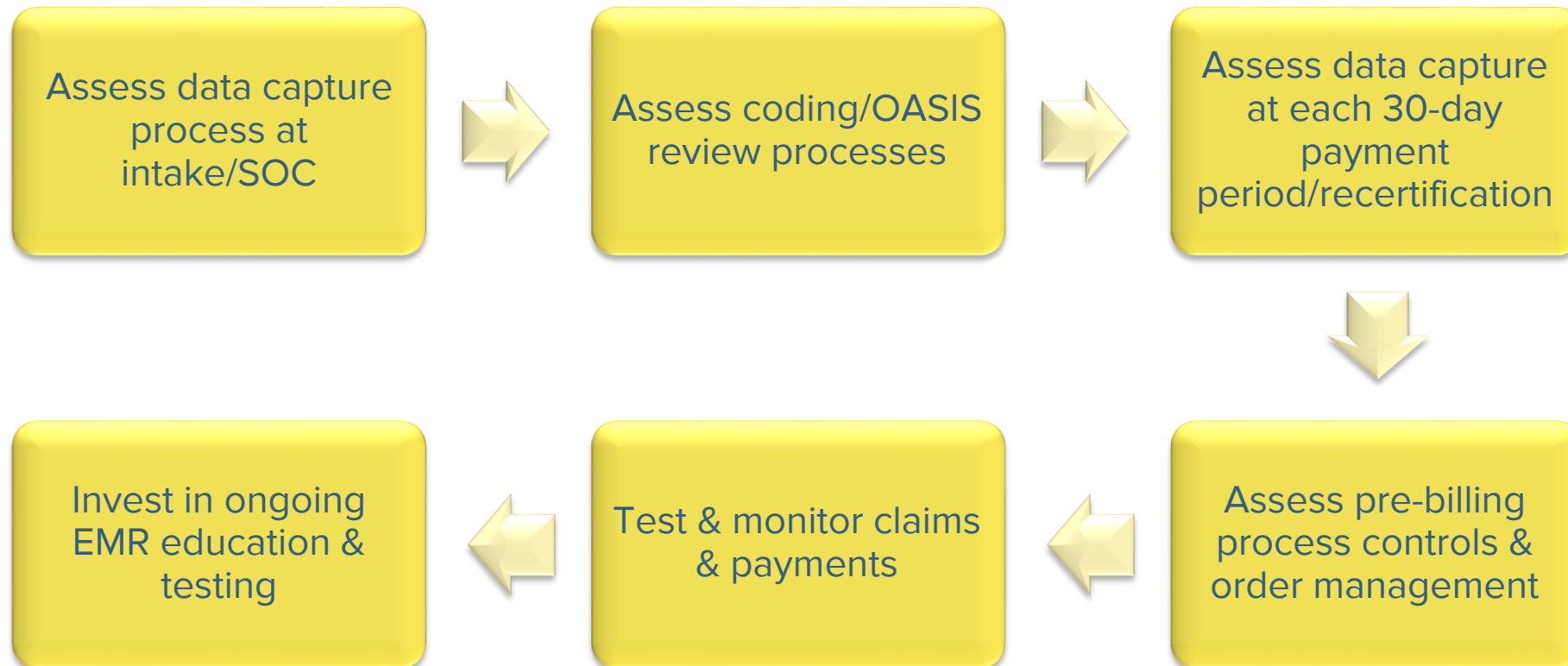
Payment periods with no ordered
visits must have a RAP submitted

RAP & claim billed for payment
period 01/01/20

RAP for payment period 01/31/20
billed, paid & eventually auto
canceled by MAC

RAP & claim billed for payment
period 03/01/20

Revenue Cycle Strategies



PDGM Resources

PDGM Resources

- ▶ 2020 final payment rule
 - ▷ **Federal Register** & attachments dated November 8, 2019
- ▶ Other documents
 - ▷ **Change Request 11272** dated May 23, 2019
 - ▷ MLN presentation dated August 21, 2019
 - ▷ **Change Request 11395** dated August 23, 2019
 - ▷ **Change Request 11527** dated November 8, 2019
 - ▷ **Change Request 11536** dated November 8, 2019
 - ▷ **MLN Matters SE19027** dated November 22, 2019
 - ▷ **MLN Matters SE19028** dated November 22, 2019

Medicare National Standard Home Health Payment Rate Data
Effective for Episodes Ending January 1, 2019 Through December 31, 2019



CPAs & Advisors

	2019	2018	% Change
Rural All Other Add-on Category 3.0%			
National standard rural adjusted episode rate	\$ 3,248.90	\$ 3,130.83	3.8%
Labor portion	0.7810	0.7854	-3.1%
Non-labor portion	0.2390	0.2147	11.3%
Wage-index adjustment for CBSA code	0.7775	0.7755	0.3%
Low utilization payment adjustment (LUPA) rates			
Skilled nursing	\$ 150.90	\$ 147.70	2.2%
Physical therapy	\$ 164.94	\$ 161.46	2.2%
Occupational therapy	\$ 168.08	\$ 162.56	2.2%
Speech therapy	\$ 179.28	\$ 175.49	2.2%
Medical social worker	\$ 241.86	\$ 236.76	2.2%
Home health aide	\$ 68.33	\$ 66.89	2.2%
LUPA add-on payment ratios			
Skilled nursing	1.8451	1.8451	0.0%
Physical therapy	1.6700	1.6700	0.0%
Speech therapy	1.6266	1.6266	0.0%
Outlier cap	10%	10%	0.0%

Areas Included in CBSA Code

99926 Rural Missouri

All Other Add-on Category 3.0%

FIPS code is required on all home health claims with dates of service on or after January 1, 2019.

FIPS	County/Parish	FIPS	County/Parish	FIPS	County/Parish
29001	Adair, MO	29089	Howard, MO	29161	Phelps, MO
29005	Atchison, MO	29091	Howell, MO	29163	Pike, MO
29007	Audrain, MO	29093	Iron, MO	29169	Pulaski, MO
29009	Barry, MO	29101	Johnson, MO	29171	Putnam, MO
29011	Barton, MO	29103	Knox, MO	29173	Rails, MO
29015	Benton, MO	29105	Laclede, MO	29175	Randolph, MO
29023	Butler, MO	29109	Lawrence, MO	29179	Reynolds, MO
29029	Camden, MO	29111	Lewis, MO	29195	Saline, MO
29033	Carroll, MO	29115	Linn, MO	29197	Schuyler, MO
29035	Carter, MO	29117	Livingston, MO	29199	Scotland, MO
29039	Cedar, MO	29121	Macon, MO	29201	Scott, MO
29041	Chariton, MO	29123	Madison, MO	29203	Shannon, MO
29045	Clark, MO	29125	Maries, MO	29205	Shelby, MO
29053	Cooper, MO	29127	Marion, MO	29185	St Clair, MO
29055	Crawford, MO	29129	Mercer, MO	29187	St Francois, MO
29057	Dade, MO	29131	Miller, MO	29186	Ste Genevieve, MO
29061	Daviess, MO	29133	Mississippi, MO	29207	Stoddard, MO
29065	Dent, MO	29137	Monroe, MO	29209	Stone, MO
29067	Douglas, MO	29139	Montgomery, MO	29211	Sullivan, MO
29069	Dunkin, MO	29141	Morgan, MO	29213	Taney, MO
29073	Gasconade, MO	29143	New Madrid, MO	29215	Texas, MO
29075	Gentry, MO	29147	Nodaway, MO	29217	Vernon, MO
29079	Grundy, MO	29149	Oregon, MO	29221	Washington, MO
29081	Harrison, MO	29153	Ozark, MO	29223	Wayne, MO
29083	Henry, MO	29155	Pemiscot, MO	29227	Worth, MO
29085	Hickory, MO	29157	Perry, MO	29229	Wright, MO
29087	Holt, MO	29159	Pettis, MO		

Source: All rate data per Federal Register dated November 13, 2018, and the Centers for Medicare and Medicaid Services Change Request 10992 dated October 19, 2018.

*Adjusted for sequestration

12/27/2018

1 of 21

2020 Payment Rates

- Available *soon* at bkd.com

<https://www.bkd.com/services/home-health-payment-rates>

Glossary

- ▶ CMS Centers for Medicare & Medicaid Services
- ▶ CWF Common working file
- ▶ EMR Electronic medical record
- ▶ FTF Face-to-face
- ▶ HH Home health
- ▶ HHCAHPS Home Health Consumer Assessment of Healthcare Provider & Systems
- ▶ HHRG Home health resource group
- ▶ HIPPS Health insurance prospective payment system
- ▶ IPF Inpatient psychiatric facility
- ▶ IRF Inpatient rehabilitation facility
- ▶ LTCH Long-term care hospital
- ▶ LUPA Low utilization payment adjustment
- ▶ MAC Medicare Administrative Contractor
- ▶ NRS Non-routine supplies
- ▶ NOA Notice of Admission
- ▶ OASIS Outcome & Assessment Information Set
- ▶ PDGM Patient Driven Groupings Model
- ▶ PEP Partial episode payment
- ▶ POC Plan of care
- ▶ QIES Quality Improvement Evaluation System
- ▶ PPS Prospective Payment System
- ▶ RAP Request for anticipated payment
- ▶ ROC Resumption of care
- ▶ SNF Skilled nursing facility
- ▶ SOC Start of care

Questions



STRATEGIC HEALTHCARE PROGRAMS

Thank you for
Attending!



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