



## PDGM: Is Your Revenue Cycle Prepared?

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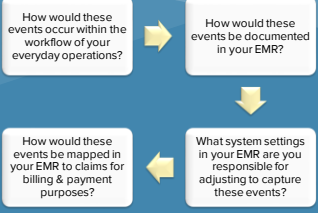
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### Guiding Thoughts for Today



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**30-Day Payment Periods**



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<u>PPS</u>	<u>PDGM</u>
<ul style="list-style-type: none"><li>▶ 60-day episodes for both documentation &amp; payment purposes</li><li>▶ Applies to all episodes beginning in 2019</li></ul>	<ul style="list-style-type: none"><li>▶ 60-day episodes for documentation purposes</li><li>▶ 30-day periods for payment purposes</li><li>▶ Applies to all episodes beginning in 2020<ul style="list-style-type: none"><li>↳ SOCs &amp; recertifications</li></ul></li></ul>



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**National Standard Payment Rate**



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PPS	PDGM
<ul style="list-style-type: none"> <li>National standard 60-day episode payment rate</li> <li>NRS payment add-on per 60-day episode based on OASIS assessment</li> <li>Transition rate for episodes beginning in 2019 &amp; ending in 2020</li> <li>2% penalty for lack of OASIS or HHCAHPS submissions can apply</li> <li>2% sequestration reduction applies</li> </ul>	<ul style="list-style-type: none"> <li>National standard 30-day period payment rate</li> <li><b>\$1,864 final rate</b>, after application of 4.36% reduction for behavior adjustments</li> <li>2% penalty for lack of OASIS or HHCAHPS submissions can apply</li> <li>2% sequestration reduction applies</li> </ul>

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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 <i>(after reduction for behavior adjustments)</i>

\*Before any application of rural payment add-on

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## PDGM Payment Elements

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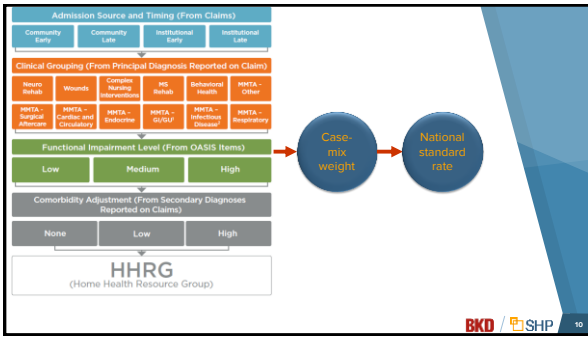
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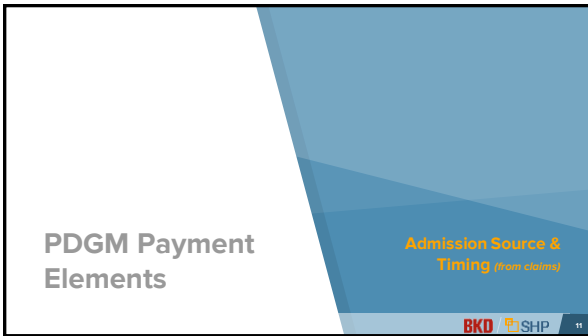
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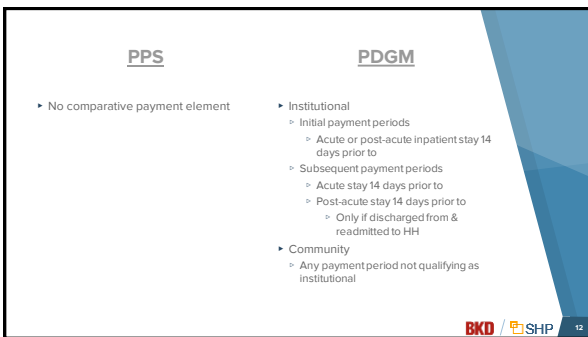
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<u>PPS</u>	<u>PDGM</u>
<ul style="list-style-type: none"><li>▶ Early<ul style="list-style-type: none"><li>▷ 60-day episodes one &amp; two</li></ul></li><li>▶ Late<ul style="list-style-type: none"><li>▷ All third &amp; later 60-day episodes</li></ul></li></ul>	<ul style="list-style-type: none"><li>▶ Early<ul style="list-style-type: none"><li>▷ Initial admission 30-day payment period</li></ul></li><li>▶ Late<ul style="list-style-type: none"><li>▷ All subsequent 30-day payment periods</li></ul></li></ul>

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**PDGM Payment Elements**

**Clinical Grouping**  
*(from claims)*

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<u>PPS</u>	<u>PDGM</u>
<ul style="list-style-type: none"><li>▶ 13 payment weighted OASIS questions for each 60-day episode<ul style="list-style-type: none"><li>▷ SOC</li><li>▷ Recertification</li><li>▷ ROC, if used as recertification OASIS</li></ul></li></ul>	<ul style="list-style-type: none"><li>▶ 12 clinical groupings based on primary diagnosis billed on claim for each 30-day payment period<ul style="list-style-type: none"><li>▷ Per SOC &amp; recertification OASIS</li><li>▷ Per updates in clinical documentation reflecting changes &amp; communication/coordination with certifying physician</li></ul></li></ul>

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**PDGM Payment Elements**

Functional Impairment Level (from OASIS)

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<u>PPS</u>	<u>PDGM</u>
<ul style="list-style-type: none"><li>▶ Six payment weighted OASIS questions for each 60-day episode<ul style="list-style-type: none"><li>▶ M1810 current ability to dress upper body</li><li>▶ M1820 current ability to dress lower body</li><li>▶ M1830 bathing</li><li>▶ M1840 toilet transferring</li><li>▶ M1850 transferring</li><li>▶ M1860 ambulation/locomotion</li></ul></li></ul>	<ul style="list-style-type: none"><li>▶ Eight payment weighted questions from most recently completed OASIS assessment<ul style="list-style-type: none"><li>▶ M1033 risk of hospitalization</li><li>▶ M1800 grooming</li><li>▶ M1810 current ability to dress upper body</li><li>▶ M1820 current ability to dress lower body</li><li>▶ M1830 bathing</li><li>▶ M1840 toilet transferring</li><li>▶ M1850 transferring</li><li>▶ M1860 ambulation/locomotion</li></ul></li></ul>

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**PDGM Payment Elements**

Comorbidity Adjustment (from OASIS)

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<u>PPS</u>	<u>PDGM</u>
<ul style="list-style-type: none"><li>▶ No comparative payment element</li></ul>	<ul style="list-style-type: none"><li>▶ Based on other diagnoses billed on claim<ul style="list-style-type: none"><li>▶ No adjustment<ul style="list-style-type: none"><li>▶ No other diagnosis on claim from qualifying comorbidity subgroups</li></ul></li><li>▶ Low adjustment<ul style="list-style-type: none"><li>▶ Other diagnosis on claim from one of 13 comorbidity subgroups</li></ul></li><li>▶ High adjustments<ul style="list-style-type: none"><li>▶ Two or more other diagnoses on claim from one of 31 comorbidity subgroup interactions</li></ul></li></ul></li></ul>

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## Case-Mix Weights

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<u>PPS</u>	<u>PDGM</u>
<ul style="list-style-type: none"><li>▶ 153 possible case-mix weights for each 60-day episode<ul style="list-style-type: none"><li>▶ 0.4691 low</li><li>▶ 2.0228 high</li></ul></li><li>▶ Correspond to HIPPS codes</li></ul>	<ul style="list-style-type: none"><li>▶ 432 possible case-mix weights for each 30-day payment period<ul style="list-style-type: none"><li>▶ 0.5057 low</li><li>▶ 1.8430 high</li></ul></li><li>▶ Correspond to HIPPS codes</li></ul>

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LUPAs



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<b>PPS</b>	<b>PDGM</b>
<ul style="list-style-type: none"><li>▶ Per-visit payment applied to any 60-day episode with less than five total visits</li><li>▶ LUPA add-on conditionally applied</li></ul>	<ul style="list-style-type: none"><li>▶ Per-visit payment applied to any 30-day period with total visits ranging from less than two to less than six<ul style="list-style-type: none"><li>▷ LUPA threshold unique to each case-mix weight</li></ul></li><li>▷ LUPA add-on conditionally applied</li></ul>



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RAPs



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<u>PPS</u>	<u>PDGM</u>
<ul style="list-style-type: none"> <li>▶ Required for each 60-day episode</li> <li>▶ Paid based on submitted HIPPS code</li> </ul>	<ul style="list-style-type: none"> <li>▶ Required for each 30-day period                             <ul style="list-style-type: none"> <li>▷ Two required for each payment period in one 60-day episode</li> </ul> </li> <li>▶ Paid based on submitted HIPPS code                             <ul style="list-style-type: none"> <li>▷ Phased out by 2022</li> <li>▷ Replaced by NOA billing transaction</li> </ul> </li> </ul>

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

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<u>PPS</u>	<u>PDGM</u>
<ul style="list-style-type: none"> <li>▶ Subject to payment recoupment when matching final claim not received timely                             <ul style="list-style-type: none"> <li>▷ 120 days from episode start date, or</li> <li>▷ 60 days from RAP payment date                                     <ul style="list-style-type: none"> <li>▷ Which ever date is latest</li> </ul> </li> </ul> </li> <li>▶ Recoupments monitored by MACs</li> </ul>	<ul style="list-style-type: none"> <li>▶ Subject to payment recoupment when matching final claim not received timely                             <ul style="list-style-type: none"> <li>▷ 90 days from episode start date, or</li> <li>▷ 60 days from RAP payment date                                     <ul style="list-style-type: none"> <li>▷ Which ever date is latest</li> </ul> </li> </ul> </li> <li>▶ Recoupments monitored by MACs</li> </ul>

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<p style="text-align: center;"><u>PPS</u></p> <ul style="list-style-type: none"> <li>▶ Key billing requirements           <ul style="list-style-type: none"> <li>◦ OASIS, POC &amp; first billable visit occurring during 60-day episode must be completed prior to billing RAP</li> <li>◦ Diagnosis codes must match OASIS</li> </ul> </li> </ul>	<p style="text-align: center;"><u>PDGM</u></p> <ul style="list-style-type: none"> <li>▶ Key billing requirements           <ul style="list-style-type: none"> <li>◦ Initial 30-day payment periods               <ul style="list-style-type: none"> <li>▶ Same requirements for OASIS, POC &amp; first billable visit</li> <li>▶ Diagnosis codes would typically match OASIS</li> </ul> </li> <li>◦ Subsequent 30-day payment periods               <ul style="list-style-type: none"> <li>▶ First billable visit occurring during period must be completed</li> <li>▶ Changes to diagnosis codes must be documented</li> <li>▶ No new OASIS required</li> </ul> </li> </ul> </li> </ul>
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Final Claims

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<p style="text-align: center;"><u>PPS</u></p> <ul style="list-style-type: none"> <li>▶ Required for each 60-day episode</li> <li>▶ Claim paid in full based on submitted HIPPS code &amp; OASIS matching string</li> <li>▶ Subject to payment adjustments           <ul style="list-style-type: none"> <li>◦ LUPA &amp; LUPA add-on</li> <li>◦ PEP</li> <li>◦ Outlier</li> </ul> </li> </ul>	<p style="text-align: center;"><u>PDGM</u></p> <ul style="list-style-type: none"> <li>▶ Required for each 30-day period           <ul style="list-style-type: none"> <li>◦ Two required for each payment period in one 60-day episode</li> </ul> </li> <li>▶ Claim paid in full according to Medicare claims processing system calculated HIPPS code based on claims &amp; OASIS data</li> <li>▶ Subject to payment adjustments           <ul style="list-style-type: none"> <li>◦ LUPA &amp; LUPA add-on</li> <li>◦ PEP</li> <li>◦ Outlier</li> </ul> </li> </ul>
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<u>PPS</u>	<u>PDGM</u>
<ul style="list-style-type: none"> <li>▶ Key billing requirements               <ul style="list-style-type: none"> <li>◦ OASIS must be received by QIES</li> <li>◦ All physician orders must be signed &amp; dated                   <ul style="list-style-type: none"> <li>▶ Physician FTF encounter documentation</li> <li>▶ POC &amp; all other orders</li> </ul> </li> <li>◦ Diagnosis codes must match OASIS &amp; RAP</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▶ Key billing requirements               <ul style="list-style-type: none"> <li>◦ OASIS must be received by iQIES</li> <li>◦ Initial 30-day payment periods                   <ul style="list-style-type: none"> <li>▶ Same requirements for OASIS &amp; physician orders</li> <li>▶ Diagnosis codes match OASIS &amp; RAP</li> </ul> </li> <li>◦ Subsequent 30-day payment periods                   <ul style="list-style-type: none"> <li>▶ Same requirements for physician orders</li> <li>▶ Changes to diagnosis codes must be documented                       <ul style="list-style-type: none"> <li>▶ New OASIS might have been completed</li> </ul> </li> </ul> </li> </ul> </li> </ul>

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<u>PPS</u>	<u>PDGM</u>
<ul style="list-style-type: none"> <li>▶ Key billing requirements               <ul style="list-style-type: none"> <li>◦ Must report OASIS matching string</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▶ Key billing requirements               <ul style="list-style-type: none"> <li>◦ New occurrence code to replace OASIS matching string                   <ul style="list-style-type: none"> <li>▶ 50 – OASIS M0090 date</li> </ul> </li> <li>◦ New occurrence codes to report institutional admission source                   <ul style="list-style-type: none"> <li>▶ 61 – hospital discharge date</li> <li>▶ 62 – SNF, IRF, LTCH or IPF discharge date</li> </ul> </li> </ul> </li> </ul>

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<u>PPS</u>	<u>PDGM</u>
<ul style="list-style-type: none"> <li>▶ Subject to payment validation against OASIS on file in QIES</li> <li>▶ Subject to payment recoding &amp; adjustments</li> </ul>	<ul style="list-style-type: none"> <li>▶ Subject to new process for payment validation against OASIS in iQIES</li> <li>▶ Subject to payment recoding &amp; adjustments</li> </ul>

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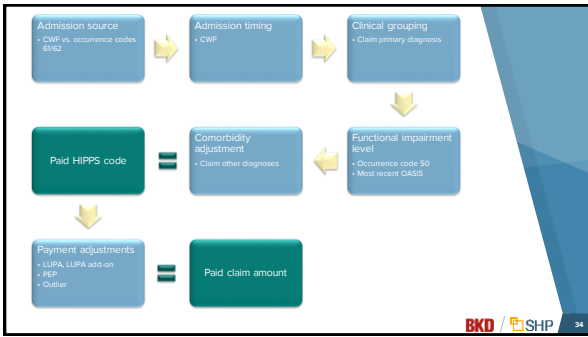
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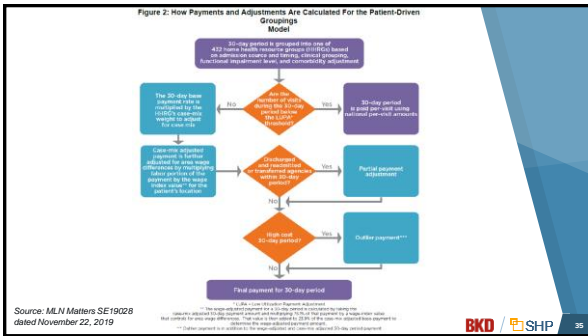
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Position 1 Admission Source & Timing	Position 2 Clinical Grouping	Position 3 Functional Impairment	Position 4 Comorbidity Adjustment	Position 5 Unassigned
1 Community, early	A MMTA – Other	A Low	1 No adjustment	1 (unassigned)
2 Institutional, early	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			

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Cash Flow

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- January – 15% decrease
- February – 30% decrease
- March – Rebound
- April – New normal

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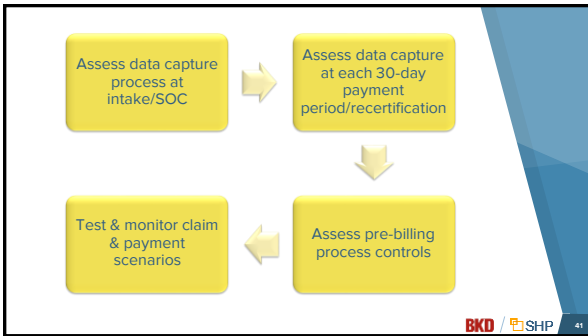
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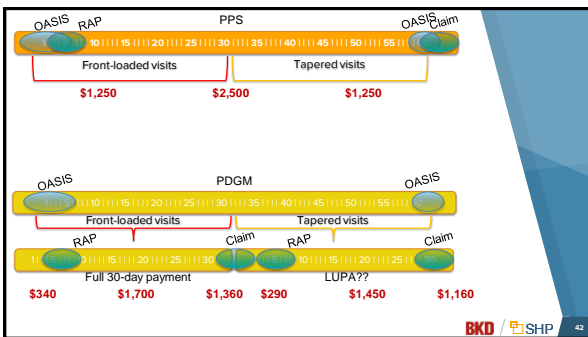
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### Scenario 1 – Admission Source

**Scenario**

- Observation stays not qualified as institutional
- Payment period 01/01/20 grouped as community
- Payment period 01/31/20 grouped as community

Observation stays not qualified as institutional

Payment period 01/01/20 grouped as community

Payment period 01/31/20 grouped as community

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### Scenario 2 – Admission Source

**Scenario**

- Payment period 01/01/20 grouped as community
- HH discharged as of 01/29/20 due to SNF admission
- Payment period 01/30/20 grouped as institutional
- Report occurrence code "62" with date 01/28/20

Payment period 01/01/20 grouped as community

HH discharged as of 01/29/20 due to SNF admission

Payment period 01/30/20 grouped as institutional

Report occurrence code "62" with date 01/28/20

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### Scenario 3 – Admission Timing

**Scenario**

- Prior HH services covered under MA are not considered
- Payment period 01/01/20 grouped as early

Prior HH services covered under MA are not considered

Payment period 01/01/20 grouped as early

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### Scenario 4 – Clinical Grouping

**Scenario**

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

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### Scenario 5 – Functional Impairment Level

**Scenario**

- 01/01/20 Patient admitted to HH 01/01/20 with functional impairment grouping of "3" on SOC OASIS
- 01/29/20 ROC OASIS completed 01/29/20 resulted in functional impairment grouping of "2"
- 02/29/20 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 01/01/20 is "1" based on recertification OASIS

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### Scenario 6 – Overlapping Inpatient Stay

**Scenario**

- 01/01/20 Patient admitted to HH 01/01/20
- 01/29/20 Patient admitted to hospital 01/29/20
- 02/02/20 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 01/29/20 based after care is resumed

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### 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 cancelled by MAC
- RAP & claim billed for payment period 03/01/20

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### Revenue Cycle Strategies

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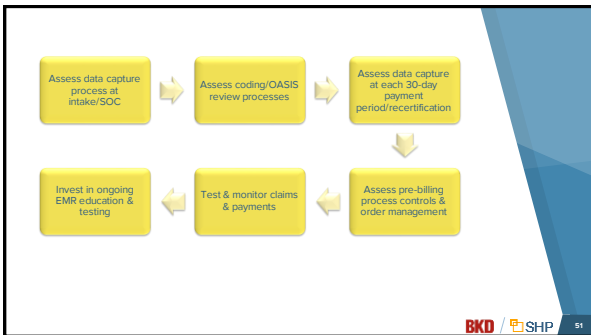
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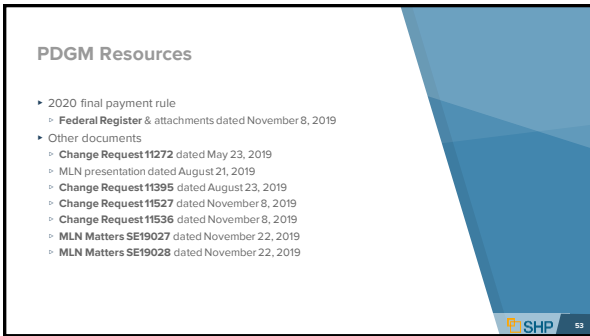
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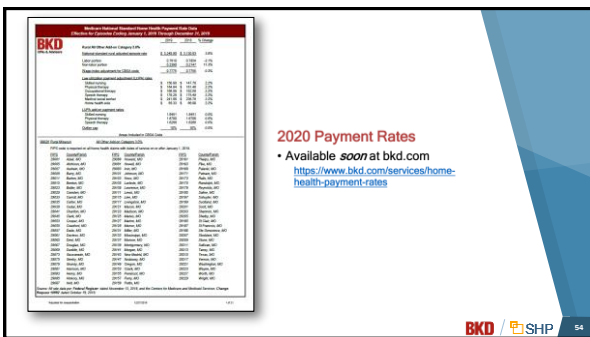
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**Glossary**

- ▶ 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

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**SH<sup>P</sup>**  
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# Questions

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**SH<sup>P</sup>**  
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**Thank you for Attending!**

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