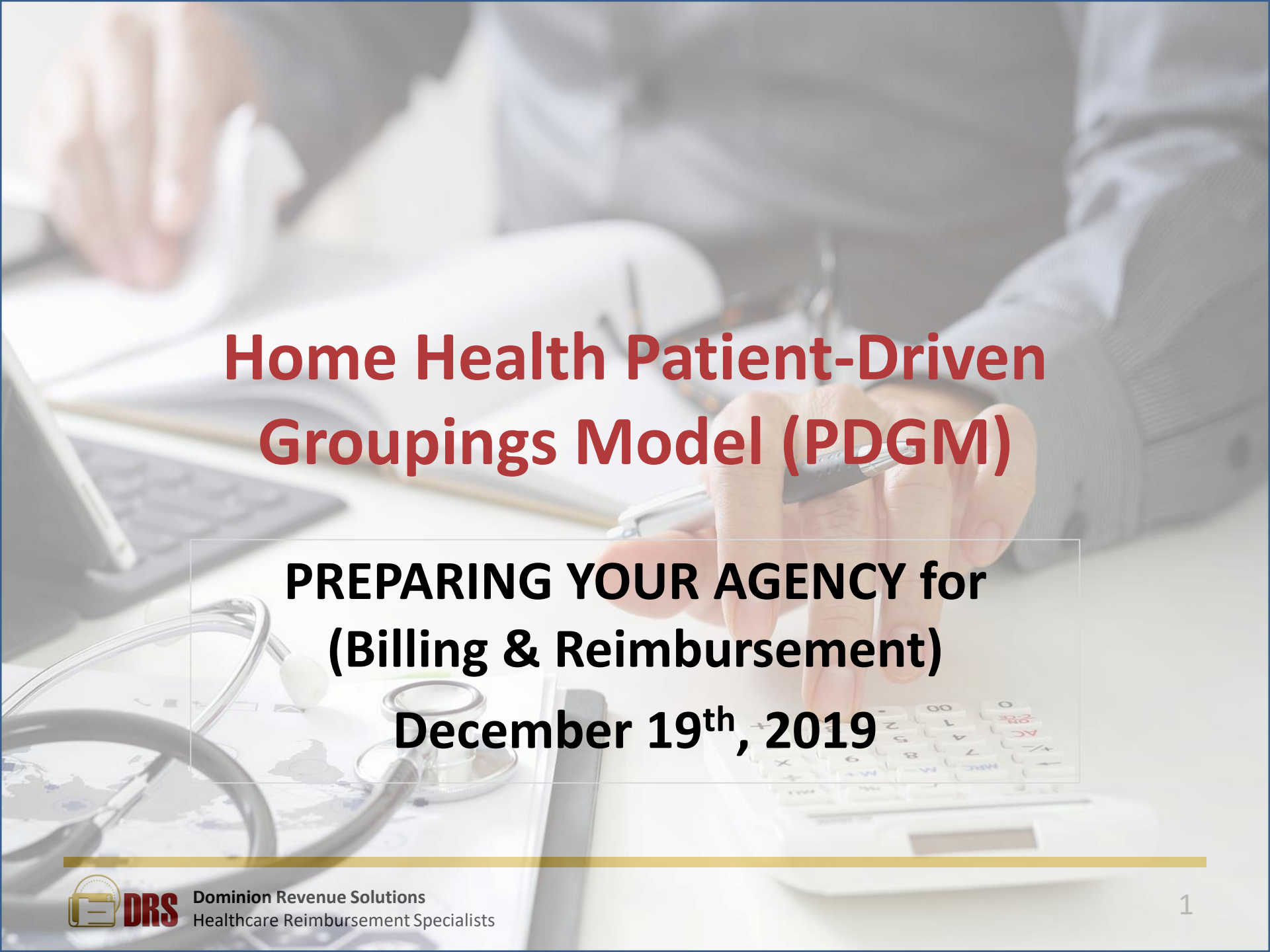


Home Health Patient-Driven Groupings Model (PDGM)

PREPARING YOUR AGENCY for (Billing & Reimbursement)

December 19th, 2019

Introductions, Roles and Credentials

Blessing C Jonas –CEO Dominion Revenue Solutions, LLC

Blessing C Jonas

- Founder of Dominion Revenue Solutions
- Over 20 Years in Healthcare
- Clinical, Information Technology, Revenue Cycle Management, Finance, Accounting & Managed Care
- Hospital & Home Health Experience
- Certified Managed Care Specialist (HFMA)
- Established HHRS 2014
- Renamed DRS in 2016
- Integrity, Precisions, Reliability & Relationship

AGENDA

- Overview of the Patient-Driven Groupings Model (PDGM)
- Major Changes (Front-End & Billing Department)
- 30-Day Billing Periods
- Requests for Anticipated Payment (RAPs)
- New Occurrence Codes
- Final Claim Submission

Overview of PDGM

- PDGM is a new payment model for the Home Health Prospective Payment System (HH PPS) that Relies more 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, for initial certifications and recertifications that start after 1/1/2020.
  - *For 60-day episodes that begin on or before December 31, 2019, and span January 1, 2020, the payment will be the calendar year (CY) national, standardized 60-day episode payment amount.*

PDGM IS BUDGET NEUTRAL

- PDGM will not increase or decrease the overall Medicare expenditure. So the goal is to better align payments with patient needs, and to ensure that clinically complex patients have access to care.

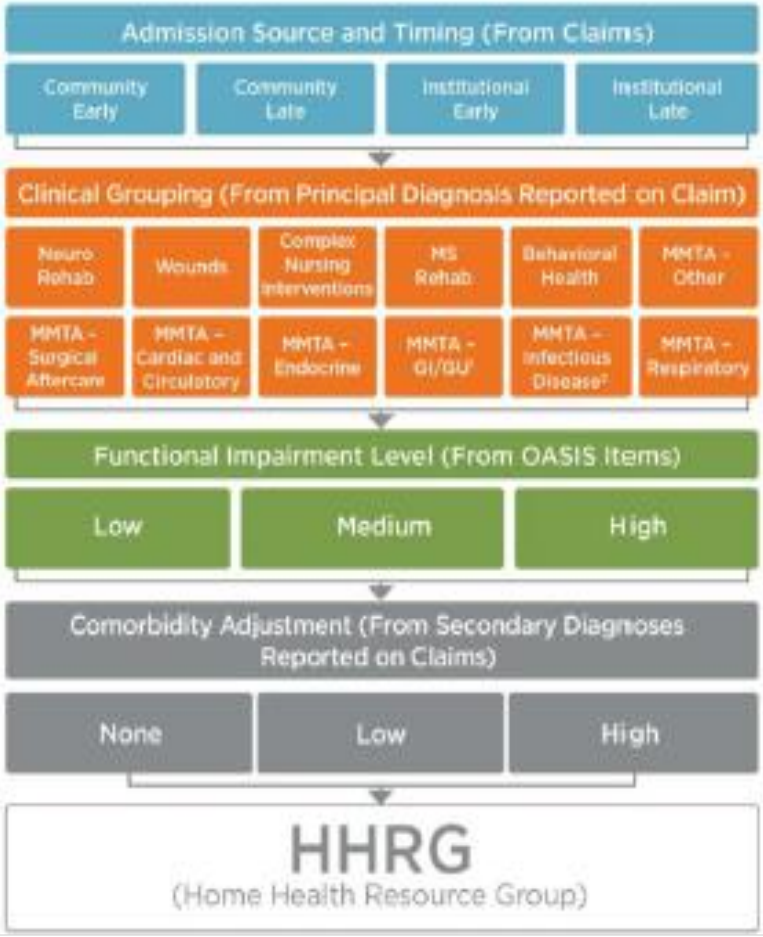
PDGM - Major Changes

- Case-Mix Adjusted Payment Groups
- Billing Periods from 60 days to 30 days
- New Occurrence Codes
- Low Utilization Payment Adjustment (LUPA) Thresholds
- PDGM and the Review Choice Demonstration

Case-mix adjusted payment groups

- HH PPS has 153 possible case-mix adjusted payment groups
- PDGM has 432 possible case-mix adjusted payment groups

HOW HHRGs are DERIVED



How the Patient-Driven Groupings Model Works

- **Five main case-mix variables—**

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

- A 30-day period is grouped into **one** subcategory in each color category
- This results in **432 possible case-mix adjusted payment groups** into which a 30-day period can be placed:
  (2*2*12*3*3 = 432 HHRGs)

[1] Gastrointestinal tract/Genitourinary system
[2] The infectious disease category also includes diagnoses related to neoplasms and blood-forming diseases

Current HH PPS - ADMISSION TIMING

- **Early episode of care** - First two 60-day episodes in a sequence of adjacent covered episodes.
- **Late episode of care** – Third episode and beyond in a sequence of adjacent covered episodes.

PDGM ADMISSION TIMING

- Timing of the 30-day period (Two Subgroups):
  Early or Late
- The First 30-Day Period is considered EARLY, every other 30-Day Period is considered LATE.
- Exception for Early Episode:
  - A gap of more than 60 days between the end of one period and the start of another.
  - Episode #1 - 1/1/2020 through 1/30/2020 – Early
    60 DAYS GAP (Feb & March)
  - Episode #2 - 4/1/2020 through 4/30/2020 - Early

PDGM ADMISSION SOURCE

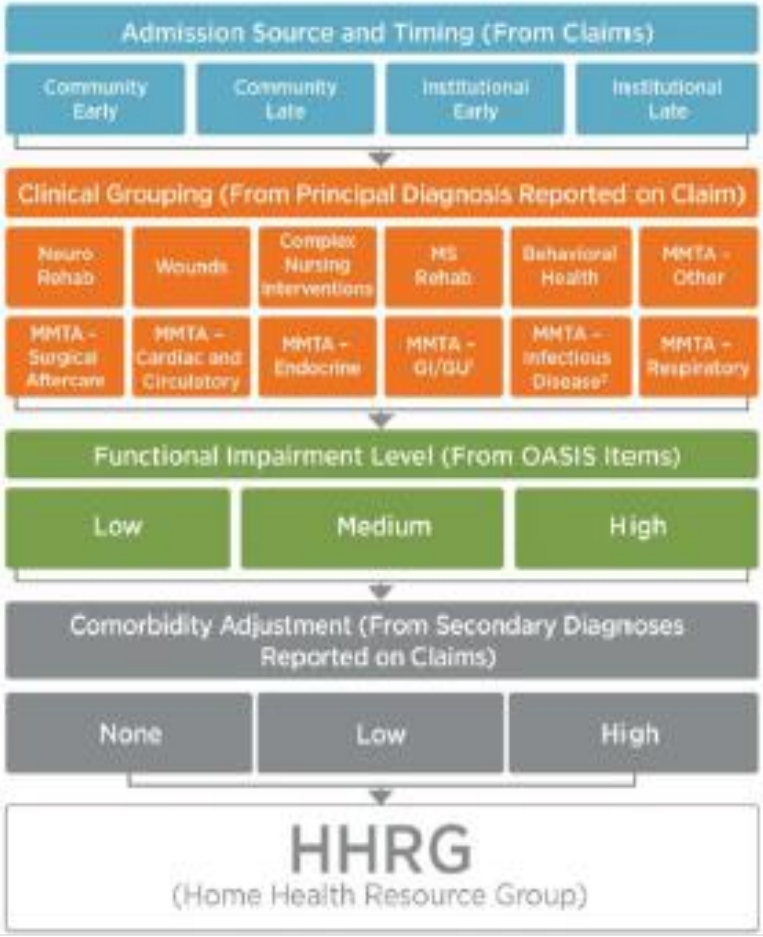
- Admission Source (Two Subgroups):
  Community or Institutional
- Institutional - Any acute or post-acute care in the 14 days prior to the Home Health admission
- Community - No acute or post-acute care in the 14 days prior to the HH admission.

WHAT AFFECTS THE CASHFLOW!

ADMISSION SOURCE / TIMING

- Admission Source and Timing Information will be derived from the claims for reimbursement.
- The information is reported with the new Occurrence Codes 61 and 62, CMS has made these optional.
- *Recommendation: Include in claim*
- *Intake and Marketing Consultants to obtain hospitalization dates from referral sources.*
- *Intake Staff must identify admission source and timing on intake forms.*
- DRS has incorporated admission source and timing into our pre-billing QA process.
- We recommend using the occurrence codes 61 and 62 even though its optional. (We will discuss occurrence codes later).

HOW HHRGs are DERIVED



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PRINICPAL DIAGNOSIS

- Current Home Health PPS
  - ICD code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).
- PDGM Principal Diagnosis
  - ICD code and principle diagnosis used for payment grouping will be claim coding rather than the OASIS item. As a result, the claim and OASIS diagnosis codes will no longer be expected to match in all cases.

Dx CHANGE between 30-day Claim AND NEXT

- Second 30-day claims in any 60-day period will not necessarily match the OASIS assessment.
- There is no requirement for the HHA to complete another follow-up assessment
- This applies to “other diagnosis” code as well.

COMORBIDITY ADJUSTMENT

- **No comorbidity adjustment:** If your claim does not have reported comorbidities that fall into one of the Comorbidity subcategory chart below, there would be no comorbidity adjustment applied.
- **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.

WHAT AFFECTS THE CASHFLOW!

Dx Codes & COMOBIDY FACTOR

- Principal diagnosis codes will be derived from the claims for reimbursement.
- Secondary diagnosis codes will determine reimbursement for comorbidity adjustment.
- *Intake staff must obtain primary and secondary diagnosis codes from referral sources to the best of their ability.*
- *Clinical staff must keep in mind the comorbidity adjustment as they verify diagnosis codes and sequence with doctor.*
- *DRS has incorporated diagnosis code verification into our pre-billing QA process.* Use this comorbidity tool from CMS to determine if a specific comorbidity dx code falls into the Comorbidity subcategory chart for CMS to consider a comorbidity adjustment which would increase your payment.
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools

Billing Period Changes

Billing Period Changes

- Currently we have 60 days Episode
  - Certification/Recertification in 60days
  - OASIS once in 60 days
  - Billing Period in 60 days (2 claims in episode)
- PDGM will have 60 days Episode
  - Certification/Recertification in 60 days
  - OASIS once in 60 days
  - Billing Period in 30days (4 claims in episode)

30 Day Period

- For the PDGM, payment is made for each 30-day period
- Each 30-Day Period – Has a RAP & FINAL Payment.
- No changes to the requirements for certs and recerts assessments.

30 Day Period

- Under PPS –
  - 1st 60 days episode – “Early”
  - 2nd 60 days episode – “Early”
  - 3rd and Others – “Late”
- PDGM
  - 1st 30 days period – “Early”
  - All Other 30 days periods – “Late”
  - “Early” periods will reimburse higher.

RAP Changes

RAP Cancelations

- Currently RAPs cancel after 120 days from start of care.
- With PDGM:
  - 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)
- There are changes to RAP payments from CY 2020 to CY 2022

Requests for Anticipated Payment (RAPs) CY 2020

- Each 30 Days Period
  - Submit a RAP claim
  - Submit a FINAL claim
  - RAP may be exempted for LUPA episodes.
- Required Data Fields
  - Date fields are not changing
  - Valid HIPPS Codes will still be generated
  - Reporting of service lines remains the same
  - A treatment authorization code is no longer required.

  .

HHAs newly enrolled in Medicare on or after January 1, 2019

- 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
  - RAPs will be processed but not paid
  - No special coding is required on no-pay RAPs
  - The provider record at the 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) CY 2021

- Changes for CY 2021
  - No more RAP Payments for both 30 days periods
  - Agency will receive a FINAL claim payment every 30 days
  - Late submission penalty for failure to submit the RAP:
    - First 30 days - within five calendar days of the SOC (Day 1 to Day 5)
    - Second 30 days - 5 calendar days of day 31 (Day 31 to Day 35)

Requests for Anticipated Payment (RAPs) CY 2022

- The elimination of the split-percentage payment approach entirely in CY 2022.
  - RAP replaced with one-time submission of a Notice of Admission (NOA)
  - Late submission penalty for failure to submit the NOA within 5 calendar days of the start of care

There will be a reduction in reimbursement as penalty…similar to Hospice today.

Periods of Care with No Visits Expected

For periods where patient may not receive care within the first four weeks of the episode, a RAP claims should still be submitted to show that patient is under care.

WHAT AFFECTS THE CASHFLOW!

RAP PAYMENTS

- Early payment periods will be reimbursed at a higher rate than will late payment periods.
- RAP payments will be 20% of episode reimbursement for each 30day period.
- Frequent submission of “clean claims” will be key for cashflow.
- New occurrence codes for PDGM are NOT reported on RAP.
- *Increase QA checks on claims to avoid denials and rejections.*
- *Bill claims frequently to sustain cashflow*
- *DRS has increased staffing resources to ensure we keep up with pre-bill QA and claim submission…ultimately to keep the cashflow coming!*
- *If you anticipate that your billing department may be overwhelmed…consider outsourcing some of your billing today.*

New Occurrence Codes
FINAL CLAIMS ONLY

New Occurrence Codes
FINAL CLAIMS ONLY

- OCCURRENCE CODE 50
  - Used to report the OASIS assessment completion date (M0090 date).
  - Claims without occurrence code will be RTP'd.
- OCCURRENCE CODE for Admission Source
  - Two new occurrence codes to support the admission source category of the PDGM (Community vs. Institutional)

New Occurrence Codes
FINAL CLAIMS ONLY

- OCCURRENCE CODE 61
  - "Hospital Discharge Date"
  - Reported, but not required, on final claims.
  - Not reported on RAPs.
  - Claims with hospital discharges within 14 days are grouped into "Institutional" payment groups

New Occurrence Codes
FINAL CLAIMS ONLY

- 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
  - 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 one
- If “From” date = 1/20/2020, then 1/19/2020 is day one 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

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

Reporting New Occurrence Codes AGENCY UNAWARE OF DISCHARGE

- Medicare will still adjust your claim for correct payment at a later date

PDGM OASIS SUBMISSION (iQIES)

- 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

Reporting New Occurrence Codes Payment Adjustment

- 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
  - Non-Medicare facilities can only be identified through occurrence codes

Low Utilization Payment Adjustment (LUPA)

- Low Utilization Payment Adjustment (LUPA) thresholds will be variable, applied to 30-day payment periods, and will range from two to six visits based on the case-mix.

Low Utilization Payment Adjustment (LUPA)

- 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

Partial Payments and Outliers

- A partial payment adjustment will apply if a beneficiary transfers from one HHA to another, or is discharged and readmitted to the same HHA within 30 days of the original 30-day period start date.
- Cases “outside” expected home care experience by involving an unusually high level of services in 30-day periods of care under PDGM, will still receive “outlier” payment.

Medicare Advantage Plans

- Medicare Advantage Plans will be under no obligation to adopt a payment methodology that is similar to PDGM.
- However some of the Medicare Advantage plans may adjust their reimbursement structure to mirror PDGM.

PDGM and the Review Choice Demonstration (RCD)

- RCD will be implemented in the following states in 2020. Texas will begin 3/1/2020.
  - Texas
  - North Carolina
  - Florida

We are here to serve you!

Dominion Revenue Solutions, LLC
Email: blessing@dominionrevenue.com

Blessing C Jonas

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Questions Are Welcome.
THANK YOU!