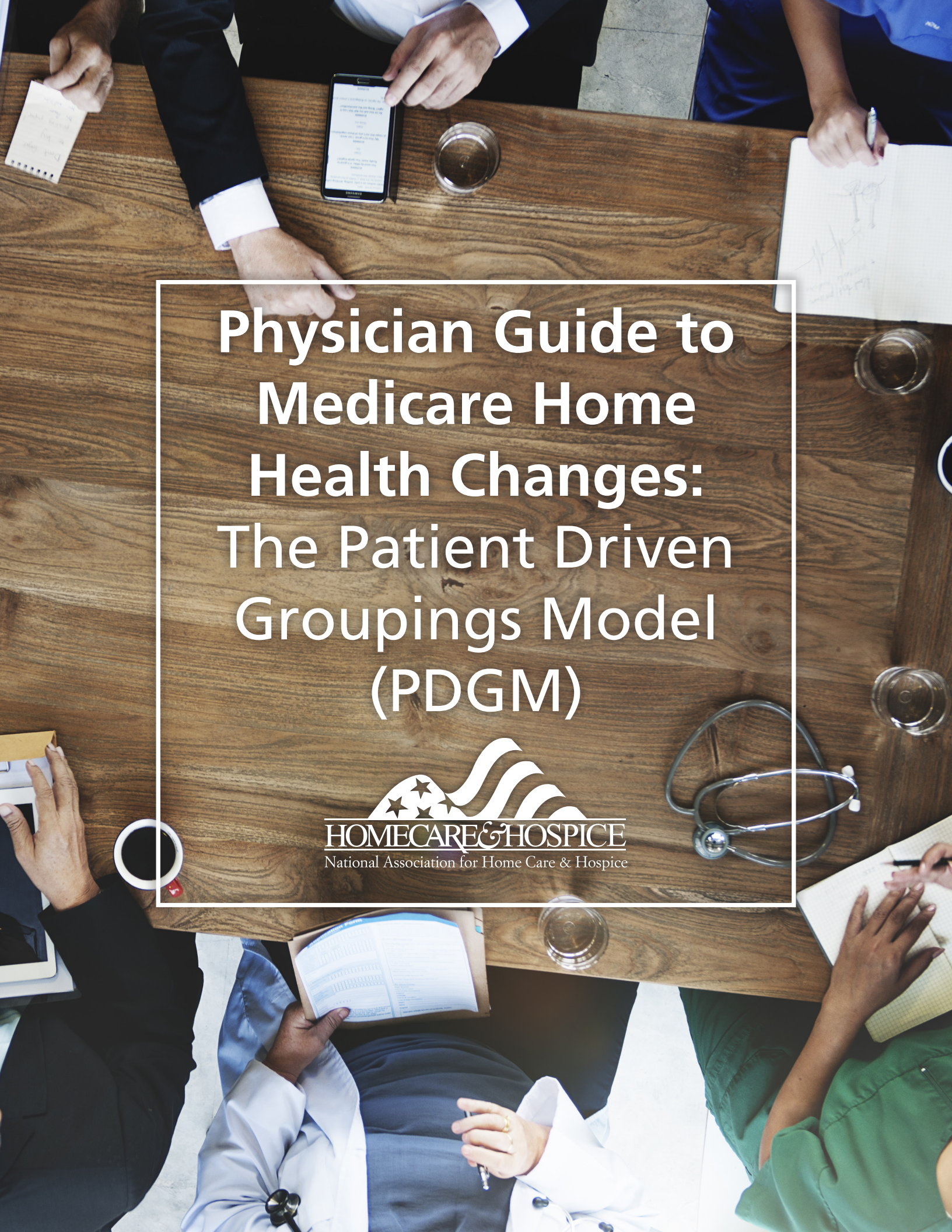


# Physician Guide to Medicare Home Health Changes: The Patient Driven Groupings Model (PDGM)

HOMECARE & HOSPICE
National Association for Home Care & Hospice

## The Patient Driven Groupings Model (PDGM) — Overview

The PDGM is a new payment model for Medicare certified home health agencies (HHAs). The billing cycle for home health agencies under PDGM will be for 30 day periods rather than 60 days. The model is a case mix model that groups patients for payment purposes into categories based on certain patient characteristics. Case mix payment groups are generated using variables from five general categories:

- **Admission source**
  - institutional (has had an inpatient stay within 14 days of admission to home health services)
  - community (no inpatient stay within 14 days of admission to home health services)
- **Timing of the period** (first in a series of 30 day periods = "early", second and later 30 day periods = "late")
- **Clinical grouping** based on the primary diagnosis from twelve diagnostic categories (see chart below)

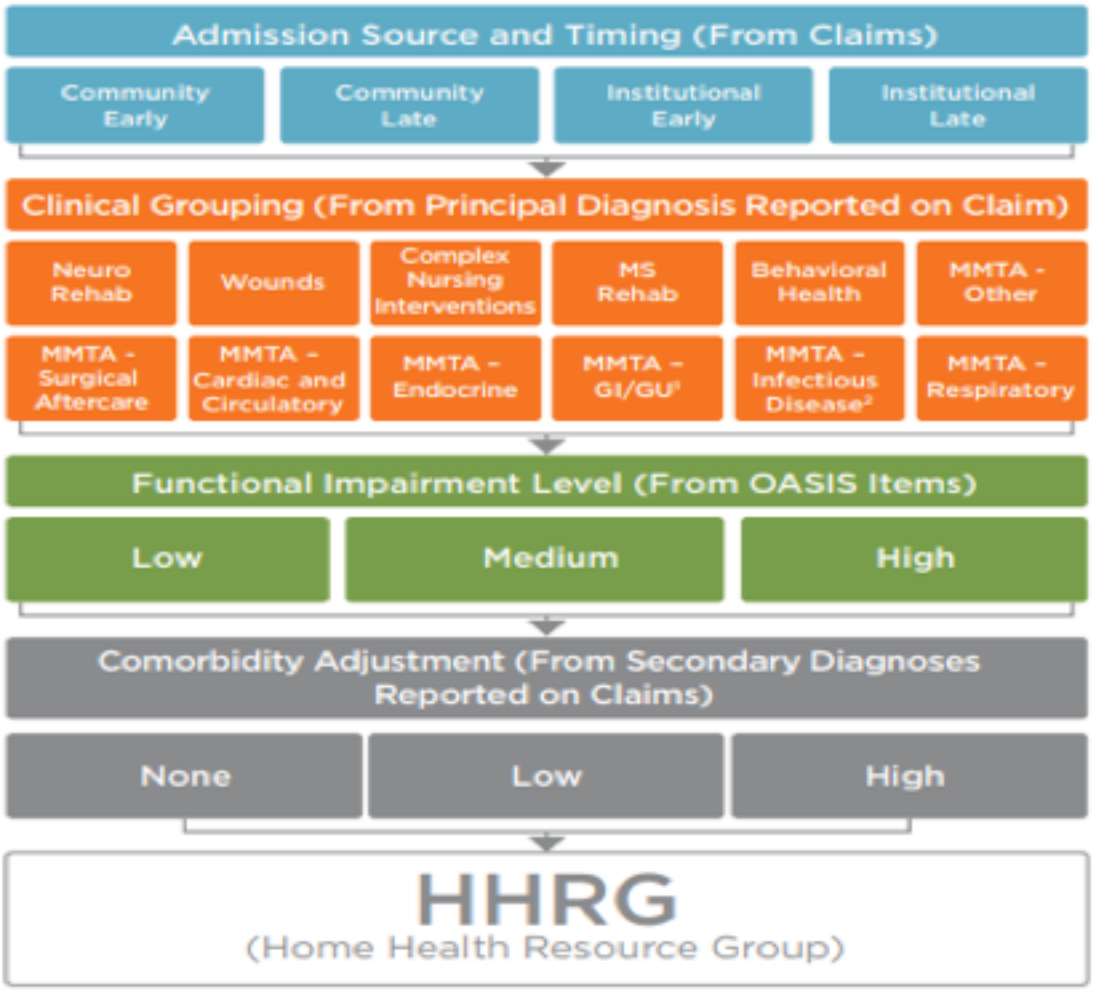
| Clinical Groups | The Primary Reason for Home Health Services |
|---|---|
| Musculoskeletal rehabilitation | Therapy (PT, OT, SLP)for a musculoskeletal condition |
| Neuro/stroke rehabilitation | Therapy (PT, OT, SLP) for a neurological or stroke condition |
| Wounds: post-op wound aftercare and skin/ non-Surgical wound care | Assessment, treatment& evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns and other lesions. |
| Behavior health care | Assessment, treatment & evaluation of psychiatric and substance abuse conditions |
| Complex nursing Interventions | Assessment treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies |
| Medication and Management, Teaching and Assessment (MMTA). | This clinical group is subdivided into six additional clinical groups |
| MMTA (Surgical aftercare) | Assessment, evaluation, teaching, and medication management for surgical after care |
| MMTA (Cardiac/circulatory) | Assessment, evaluation, teaching, and medication management for cardiac and other circulatory related conditions |
| MMTA (Endocrine) | Assessment, evaluation, teaching, and medication management for endocrine related conditions |
| MMTA (GI/GU) | Assessment, evaluation, teaching, and medication management of gastrointestinal or genitourinary related conditions |
| MMTA (Infectious diseases/ neoplasms/blood forming diseases) | Assessment, evaluation, teaching, and medication management for conditions related to infectious diseases. neoplasms, and blood forming diseases |
| MMTA (Respiratory) | Assessment, evaluation, teaching and medication management for respiratory related conditions |
| MMTA (Other) | Assessment. evaluation, teaching and medication management for a variety of medical and surgical conditions not previous classified |

- **Functional grouping** based on certain assessment items from a standardized assessment tool that are further categorized as high, medium, or low.
- **Comorbidities** (secondary diagnoses) or a combination of diagnoses associated with high resource use. These are further categorized into none, low or high.

The combination of these criteria yields 432 payment groups, as compared to 153 payment groups from the old payment model, making the model more complex but also more accurate in determining resource use. In contrast to the old model, the amount of therapy a patient receives does not directly impact reimbursement. All home health services and supplies are bundled under a single payment for the 30 day period.

The low utilization payment adjustment (LUPA) is made where the number of visits in the 30 day period falls below the case mix specified threshold. The threshold is between 2-6 visits for each of the 432 case mix payment groups. LUPA periods are paid on a per visit basis. The threshold is the minimum number of visits that must be provided in order to receive the full 30 day period payment amount for that payment group.

## HOME HEALTH PDGM PAYMENT GROUP VARIABLES



## How Physicians Will Be Impacted Under PDGM

### PLAN OF CARE/ORDERS

Because the new model reduces the billing cycle for HHAs to 30 day periods agencies will need to have the patient's certification, POC, and all interim orders signed by the physician much sooner than under the previous payment model.

In order to maintain timely billing and adequate cash flow HHAs will be contacting physicians more frequently and sooner after the patient's admission to services than in the past.

Physicians should expect plans of care and verbal orders to be sent for signature within one to two days after their completion. If the documents are not returned within one week, HHAs will be contacting the physician's office. Physicians may also see an increase in visits from agency personnel to obtain signatures on outstanding plans of care/orders.

### FACE TO FACE ENCOUNTER (F2F)

PDGM does not change the certification requirements for home health services. A F2F encounter that is related to the primary reason for home health services will continue to be required in order for HHAs to bill for care. The diagnosis on the encounter note does not need to match the primary diagnosis for home health care but the physician encounter must be related to the reason the patient requires home health services.

Agencies need to obtain physician encounter notes that contain information related to why the patient is receiving home health care.

## Diagnoses

### "UNACCEPTABLE" DIAGNOSIS CODES

Each 30 day period will be placed into one of the 12 clinical groupings based on the primary diagnosis. Not all diagnoses are included in the PDGM. A diagnosis is not assigned to one of the 12 clinical groups in the payment model if it is considered an "unacceptable" diagnosis.

"Unacceptable" diagnoses are those diagnoses that the federal government has determined are not appropriate or Medicare coverage of home health services.

As a rule of thumb, "unacceptable" diagnoses are diagnoses that indicate nonspecific conditions or symptoms, such as, muscle weakness and unsteady gait.

Typically, codes ending in "9" are not accepted because they are unspecified conditions and codes beginning with "R" are not accepted because they are symptoms of an underlying diagnosis. Following are commonly used "unacceptable" diagnoses.

| ICD10 CM Code | Description | Fix Needed |
|---|---|---|
| C34.10 | Malignant neoplasm of upper lobe, unspecified bronchus or lung | Identify which lung is impacted |
| C34.30 | Malignant neoplasm of lower lobe, unspecified bronchus or lung | Identify which lung is impacted |
| C56.9 | Malignant neoplasm of unspecified ovary | Identify which ovary is impacted |
| C65.9 | Malignant neoplasm of specified renal pelvis | Identify which kidney is impacted |
| I69.30 | Unspecified sequelae of cerebral infarction | Identify the impact or deficits following the cerebral infarct |
| I70.239 | Atherosclerosis of native arteries of right leg with ulceration of unspecified site | Identify the location of the ulcerations |
| I70.249 | Atherosclerosis of native arteries of left leg with ulceration of unspecified site | Identify the location of the ulcerations |
| I25.2 | Old myocardial infarction | Identify underlying condition such as coronary artery disease. |
| I95.9 | Hypotension, unspecified | Identify underlying cause of hypotension |
| M62.81 | Muscle weakness (generalized) | Provide reason for weakness such as musculoskeletal disorder, stroke, etc. |
| M54.5 | Low back pain | Identify the underlying cause of the back pain i |
| R29.6 | Repeated falls | Identify the disease process or condition causing the falls |
| R00.1 | Bradycardia unspecified | Identify the underlying cause of bradycardia |
| R26.0 | Ataxic gait | Identify underlying cause of ataxia |
| R25.1 | Paralytic gait | Identify underlying cause of paralytic gait |
| R26.2 | Difficulty walking not otherwise classified | Identify underlying cause for difficulty walking |
| R26.81 | Unsteadiness on feet | Identify underlying cause of unsteadiness |
| R26.89 | Other abnormalities of gait and mobility | Identify underlying cause of gait abnormality |
| R56.9 | Unspecified convulsions | Identify the disease or condition causing convulsions |
| Z91.81 | History of falls | Identify an underlying reason for the falls |

If the HHA submits a claim with a primary diagnosis that is an "unacceptable" diagnosis the claim will be sent back to the agency to review and resubmit with an allowed diagnosis. All diagnoses must be established by the physician and supported by the physician's documentation. If the physician cannot provide any additional information to assign an acceptable diagnosis, the agency will not be able to bill for services.

If a referral to the home health agency includes an "unacceptable" primary diagnosis, the agency will contact the physician upon referral for additional information. If the HHA is unable to obtain information to support an acceptable diagnosis, it may not be able to admit the patient. If the patient has been admitted to the HHA, it may have to discharge patient.

HHAs will work with physicians to develop an acceptable diagnosis if the medical record supports a more appropriate diagnosis. For example, confirming which side of the body is impacted for those conditions that require identifying laterality or determining the underlying condition for frequent falls for which the agency could appropriately intervene.

## COMORBID DIAGNOSES

Several individual secondary diagnoses and combinations of secondary diagnoses contribute to the payment groups under PDGM, However, similar to the primary diagnosis, the physician documentation will need to support any diagnosis an agency reports on the claim for services.
HHAs may need to contact physicians for additional information and consultation if they believe the patient has other diagnoses that should be reported for which there is no documentation from the physician.

## MORE FREQUENT DISCHARGES AND READMISSIONS

PDGM is designed to encourage, and the federal regulators instruct, agencies to discharge a patient and readmit to home health when ever a patient is transferred to a post-acute care facility (i.e. skilled nursing facility, inpatient rehabilitation facility, long term care hospitals and Inpatient psychiatric facility). This could occur with a direct admission to post-acute care or a post-acute care stay after an acute care stay.

This means that the HHA agency will need to submit new plans of care and certifications for home health services more frequently for such patients. The agency may be contacting you for new orders even if the plan of care has not changed.

For more information about the impact on physicians of the new home health PDGM model as well as other home health topics, please go to www.nahc.org