The Medicare Home Health Patient Driven Grouping Model: New Requirements for Home Health Care

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The Medicare Home Health Patient Driven Grouping Model (PDGM), the most significant change to how agencies are reimbursed for home health services in 20 years, takes effect on January 1, 2020. Predicting the financial impact in transitioning to this new model has proved particularly challenging and has raised many concerns across the home health industry. The industry is awash in a sea of comparative data and dire predictions for agencies that fail to prepare adequately for the process. Cash flow disruptions associated with the new coding and claim submission requirements are among those concerns. Here are a few things you should know about PDGM.

How Does PDGM Differ From the Current System?

Under the current Medicare Home Health Prospective Payment System (HH PPS), home health agencies complete an outcome and assessment information set (OASIS) for each patient within five days of starting care. Based on this information set, the proposed treatment is grouped into a Home Health Resource Group and the home health agency submits a Request for Anticipated Payment (RAP) for a 60-day episode. Under HH PPS, physical or occupational therapy is the most significant factor in reimbursement potential per episode, and low utilization adjustments are applied to the final payment for periods with four or fewer visits per 60-day episode.

PDGM makes a number of changes to the current system:

- While the OASIS will still be based on a 60-day episode, claims and payment will now be

based on episodes of 30 days, not 60 days.

- The number of case mix adjusted groups will increase significantly, from 153 to 432, resulting in a requirement of greater precision in setting anticipated payments. These groups are based on episode timing, admission source, clinical grouping (principal diagnosis), functional impairment, and comorbidities.
- If a 30-day period of care involves an unusually large number or a costly mix of visits, the home health agency may be eligible for an additional outlier payment.
- Low utilization payment adjustments will vary by clinical grouping.

Potential Winners and Losers Under PDGM

State-level comparisons of the most recent (2017) HH PPS case mix data from Centers for Medicare and Medicaid (CMS) suggest how overall reimbursement for home health services will decrease under PDGM in some states and rise incrementally in others. These state-level increases and decreases often correlate with corresponding changes for individual home health agencies. The data suggests that overall reimbursement will increase in Connecticut, Massachusetts, New Hampshire and New York, and decrease slightly in Maine and Rhode Island.

Diagnosis Coding Matters More Under PDGM

Under HH PPS, imprecise primary diagnosis codes, inaccurate sequencing, and missing assignment of comorbidity codes on OASIS and the associated claims have not had a significant impact on claim acceptance or reimbursement. In light of this, many home health agencies have understandably deferred investments in training in coding, certification of provider queries, and clinical documentation audits. With the implementation of PDGM, home health agencies should take a fresh look at these investments.

Under PDGM, it is anticipated that CMS will conduct a higher level of scrutiny when reviewing claims. Imprecise or incorrect coding of primary diagnosis and missing or inaccurate secondary diagnoses, may result in an increase in the number of claims returned for recoding, lower reimbursement due to missing out on comorbidity adjustments, and an impact on the case mix score for the episode. Delays in payment caused by the need to recode and resubmit returned claims will result in cash flow disruption. Indeed, some current HH PPS data indicates that up to 60% of Medicare-reimbursed home health episodes are currently billed with a diagnosis code that does not have a clinical grouping under PDGM. If home health agencies need a greater incentive to invest in this area, they should keep in mind that accurate and complete capture of comorbidity diagnoses may

increase overall episode payments by up to 20% under PDGM.

The Importance of Intake and Billing Workflow

The change to a 30-day payment period under PDGM, combined with a likely increase in claims returned to provider due to greater CMS scrutiny, will require home health agencies to redesign their current work processes. The intake and billing teams will need to work together closely to ensure timely completion and submission of the OASIS and RAP because under PDGM, RAPs are subject to recoupment and automatic cancellation if the claim for the payment period is not submitted in a timely fashion.

PDGM requirements will also increase the importance of collaboration between front-end revenue cycle and billing teams to ensure development of a complete patient medical record. Under PDGM, final claims for any 30-day payment period must include signed physician orders, a plan of care, and compliant face-to-face documentation.

Conclusion

The arrival of PDGM is yet another reminder that in the health care industry the only constant is change. The new requirements of PDGM present an opportunity for the home health agencies that anticipate the challenges and invest in training in coding, certification of provider queries, and clinical documentation audits in order to meet the requirements of the new system.

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