HEALTHCARE*first* by ResMed

From Clinical to Coding

PDGM PREP FOR PROS

HEALTHCARE*first* has the answer to managing cost and spending under PDGM.

As managing your agency becomes more challenging, you may be looking for ways to realize cost efficiencies and reduce spending. **Accurate clinical assessment and effective coding practices will be more important than ever under PDGM.**

HEALTHCARE*first* can help you achieve success under PDGM through our coding clinical documentation review and billing services. By managing these tasks for you, we can alleviate some of the administrative burdens that will inevitably come with PDGM, and help you focus on putting your patients first.

In this e-book, we'll discuss how expert coding documentation review and billing services as part of your PDGM preparation strategy can help you succeed.

A brief overview of PDGM

Before we dive into the importance of coding documentation and billing as a prep strategy for PDGM, let's take a brief look into the heart of what PDGM is and how it will impact coding and billing requirements.

PDGM model and HIPPS code construction

The four main domains of PDGM, which make up the 432 different case mix payment groupings (HHRGs), are outlined below:

1. Admission source and timing
2. Clinical grouping
3. Functional impairment level
4. Co-morbidity adjustment factor

The chart below represents how the main dimensions of PDGM construct the HIPPS code. It's important to note that HIPPS codes will no longer be required with OASIS submission. However, HIPPS codes will continue to be submitted on RAPS and final claims.

Position 1	Position 2	Position 3	Position 4	Position 5
Source & Timing	**Clinical Group**	**Functional Level**	**Co-Morbidity**	**Placeholder**
1. Community Early	A. MMTA Other	A. Low	1. None	1.
2. Institutional Early	B. Neuro Rehab	B. Medium	2. Low	
3. Community Late	C. Wounds	C. High	3. High	
4. Institutional Late	D. Complex Nursing			
	E. MS Rehab			
	F. Behavioral Health			
	G. MMTA Surgical			
	H. MMTA Cardiac & Circulatory			
	I. MMTA Endocrine			
	J. MMTA GI/GU			
	K. MMTA Infectious			
	L. MMTA Respiratory			

The submitted HIPPS codes on the RAP are used to pay the split percentage payment, which is proposed to be reduced to 20% upfront in 2020, and completely phased out in 2021. The HIPPS code generated in final claim data is used to adjust or pay the 30-day payment period.

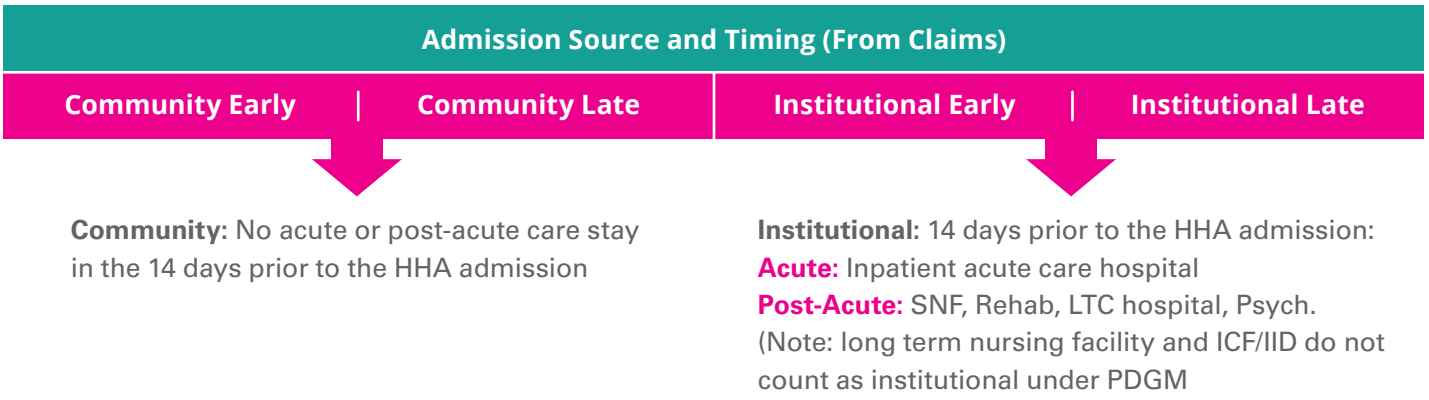
A walk through the PDGM model

With PDGM, care is still provided within a 60-day episode. However, payment is provided in 30-day periods of care.

It starts at intake: Admission source and timing

Payment periods will be placed into a timing category of early or late. An early payment period is the first 30-day payment period at start of care, with at least 60 days between prior and new episodes. All other payment periods are considered late.

It is important to have an upfront process at the point of clinical intake to verify the period timing. It's not as simple as considering a start of care as an early period of care. If the patient was on service with another home health agency within the 60 days prior to admission to your agency, it will be considered a late episode. Additionally, there are no changes in the rules for partial payment episodes. If you discharge a patient and readmit them within the original 60-day episode of care, the first 30-day payment period of the new start of care 60-day episode will be considered a late payment period.



Verifying the admission source

In order for a payment period to be classified as institutional, which receives a higher payment than community, there must be an institutional stay within the 14 days prior to the admission, or an acute care hospitalization within the 14 days prior to a subsequent or later period of care.

Agencies need to give thought to the following: Start looking at processes within your clinical intake system to accurately capture and validate the patient's admission source. Think about how to acquire the admission source data. CMS recommends using the discharge summary from the discharging facility.

Communication and validated admission source and timing information from clinical intake to the admitting clinician will be a critical part of your referral-to-admission process under PDGM. For late 30-day payment periods, it will also be crucial to identify your process to obtain and validate a qualifying acute hospital stay that occurs mid-episode within the 14 days prior to the start of a 30-day late payment period.

Clinical grouping: Clinical/coding considerations

Coding will have a significant impact on payment under the PDGM, as two of the dimensions that construct the HIPPS code are related to the patient diagnoses, which are the clinical grouping and comorbidity adjustment.

The primary diagnosis on the claim will determine which of the 12 clinical groups the periods of care will fall under. The ICD-10 code selected must accurately describe, to the highest specificity, the principle reason the patient is receiving home health services. CMS has mapped well over 43,000 ICD-10 codes out of 68,000 to the clinical groupings that will be considered as valid primary diagnoses for home health; all other diagnoses will not be considered valid and identified as questionable encounters.

Clinical Group	Primary reason for home health encounter is to provide:
Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
Wounds - Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcer burns and other lesions
Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions
Behavioral Health Care	Assessment, treatment and evaluation of psychiatric and substance abuse conditions
Medication Management, Teaching and Assessment (MMTA) • MMTA - Surgical Aftercare • MMTA - Cardiac/Circulatory • MMTA - Endocrine • MMTA - GI/GU • MMTA - Infectious Disease/ Neoplasms/Blood-forming Diseases • MMTA - Respiratory • MMTA - Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching, and assessment.

Potential challenges that can be avoided

QUESTIONABLE ENCOUNTERS: Using a questionable encounter will result in the claim being returned to the agency for code adjustment. This can mean payment delays and red flags for auditors, which could cause potential longer-term consequences.

REFERRAL SOURCE DOCUMENTATION: Historically, agencies have difficulties getting documentation from referral sources that support the need for skilled home health services. Code suffix to referral source documents often lack the level of specificity needed in PDGM to properly assign a valid primary code.

PDGM VS. CURRENT GUIDELINES: Home health coding experts have identified numerous instances where the PDGM final rule guidance conflicts with current coding convention and guidelines, such as the use of certain CMS identified non-valid, or questionable encounter codes, which may be appropriate for primary assignment under the current ICD-10 coding conventions and guidelines.

QUESTIONABLE PRIMARY DIAGNOSIS: Historically, admitting clinicians have often struggled with identifying the principal reason for home health services when selecting the primary diagnosis, particularly in complex cases with multiple disciplines providing care.

It's critical for your agency to take steps now to identify which questionable encounter codes you may have commonly been using, and design stronger referral-to-admission processes to help gather more detailed information that will promote accurate identification of the appropriate primary code, to the highest level of specificity.

3 commonly used questionable encounter codes

Based on 2017 data, CMS estimates that 15% of all episodes would not fall into a clinical grouping under PDGM. It is important to note that CMS is associating diagnoses not fitting into a clinical grouping, with conditions not normally associated with skilled need. The majority of these codes that would be considered non-valid and questionable encounter codes under PDGM are symptom codes. This is good news, as there are remedies for this situation.

Coding guidance already dictates that when a symptom is being treated, if the symptom is related to a more specific diagnosis, the more specific diagnosis code should be used. The following examples are three commonly used codes that, if used under PDGM, would not fit into a clinical grouping-and be considered by CMS as a questionable encounter.

1 **MUSCLE WEAKNESS:** Muscle weakness was the most commonly used questionable encounter code in 2017. If the symptom of muscle weakness is being treated as a primary focus of home health services being provided, then more than likely, the primary need is for therapy. There needs to be more investigation into the etiology of the muscle weakness. Look to a patient's history and get confirmation of potential neuromuscular or musculoskeletal conditions, diseases, or injuries.

2 **UNSPECIFIED ABNORMALITIES OF GAIT AND MOBILITY:** Among the 10 most commonly used questionable encounter codes in 2017, gait abnormalities are usually associated with a condition, disease, or deformity, and needs more investigation as to what the etiology of the gait and/or mobility abnormality is. Current coding guidelines clearly state that if the cause of the abnormality of gait is known, the code for the underlying cause should be assigned.

3 **REPEATED FALLS:** Repeated falls are also among the top 10 commonly used questionable encounter codes in 2017. If a patient is referred to home health after incurring repeated falls, something is wrong that is causing the falls, and needs to be investigated and confirmed with a physician.

Comorbidity adjustment factor: Clinical/coding considerations

CMS recognizes that patients with multiple co-morbidities likely require more complex skilled nursing care than the average patient. This will allow for a co-morbidity adjustment under PDGM. There will be low, no, or high co-morbidity adjustment, and the calculation is based on the patient having a reported secondary diagnosis that is included in the low co-morbidity adjustment subgroups, or the patient has two secondary diagnoses that are included within the high co-morbidity adjustment interactions group.

Diagnoses falling into the high co-morbidity subgroup are associated with higher resource use when reported together, as they have the potential to interact with each other. In order to calculate the co-morbidity adjustment, CMS will be extracting the primary diagnosis and all co-morbidities from the claim, which allows for up to 24 secondary diagnoses to be reported.

The final rule for PDGM does not offer any sequencing guidelines for secondary diagnoses. However, it is reasonable to believe that current ICD-10 convention and guidelines should be continued to be followed. When reporting diagnoses on the claim, include only current diagnoses actively addressed in the plan of care or that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis even if not the focus of any home health treatment itself. Exclude resolved diagnoses or those that do not have the potential to impact the skilled services provided by the home health agency, even if they are known/documented diagnoses. Adhere to the ICD-10-CM Official Guidelines for Coding and Reporting when assigning ICD-10-CM diagnosis codes. It will be very important for agencies to ensure that all co-morbidities are accurately captured on the claim, to ensure the episode payment is properly adjusted, as reimbursement could potentially be increased by as much as 20%.

Functional impairment level: OASIS accuracy is essential

Under PDGM, scores for three functional impairment levels – low, medium and high – are derived from answers to the eight OASIS items seen in the chart below.

Table 8: CY 2020 OASIS points for those items associated with increased resource use using a reduced set of OASIS items			
	Responses	**Points (2018)**	**Percent of Periods in 2018 with this Response Category**
M1800: Grooming	0 or 1	0	39.6%
	2 or 3	5	60.4%
M1810: Current Ability to Dress Upper Body	0 or 1	0	37.5%
	2 or 3	6	62.5%
M1820: Current Ability to Dress Lower Body	0 or 1	0	18.1%
	2	6	60.5%
	3	12	21.4%
M1830: Bathing	0 or 1	0	4.6%
	2	3	16.6%
	3 or 4	12	54.0%
	5 or 6	20	24.9%
M1840: Toilet Transferring	0 or 1	0	66.3%
	2, 3 or 4	5	33.7%
M1850: Transferring	0	0	2.5%
	1	3	32.3%
	2, 3, 4 or 5	6	65.2%
M1860: Ambulation/Locomotion	0 or 1	0	6.2%
	2	9	22.6%
	3	11	55.9%
	4, 5 or 6	23	15.3%
M1032: Risk of Hospitalization	Three or fewer items marked (excluding responses 8, 9 or 10)	0	81.2%
	Four or more items marked (excluding responses 8, 9 or 10)	11	18.8%

Source: CY 2018 home health claims and OASIS data.

Please note: Except for grooming and hospitalization risk, all items are currently used in the existing PPS system to determine the functional domain. CMS uses a regression model that determines the relationship between the responses to the listed OASIS items, and average 30-day period resource use. The coefficients from their regression are used to assign points.

Responses that indicate higher functional impairment and higher risk of hospitalization are associated with having larger coefficients, and are therefore assigned higher points. The points are then totaled, and the thresholds are applied to the assigned clinical group – which is split into thirds to determine whether the payment period is assigned a low, medium, or high functional impairment.

OASIS accuracy: Critical for PDGM

OASIS accuracy remains critical under PDGM and will continue to be important for clinicians to use the best practice of direct observation – versus interviewing when assessing the patient's functional abilities and limitations. There are other clinical considerations your agency should be reviewing to prepare for PDGM that include training clinicians on best practice direct observation methods for functional assessment, and assuring interdisciplinary collaboration (when applicable) on functional assessment items.

Under the new PDGM model, the HIPPS code could potentially change in a subsequent 30-day period of care if there are functional impairment level changes in the OASIS items, when a resumption of care or other follow-up assessment is performed prior to the start of the second 30-day payment period. Therefore, your agency needs to assure a strong process is in place for workflow and quality review of changes that occur mid-episode, and prior to the start of each 30-day payment period.

Agencies should also be reviewing their current policies and expectations of when a follow-up assessment should be performed, as well as make sure a process is in place to confirm that OASIS records for time points that occur mid-episode are both submitted and accepted by CMS prior to submitting the second 30-day prior period final claim. CMS will use the latest resumption of care, and/or other follow-up assessments to calculate the HIPPS for the final claim.

- ✓ **Direct observation when assessing functional status**
- ✓ **IDT collaboration on functional items**
- ✓ **Train staff on importance of accurate hospitalization risk assessment**
- ✓ **Potential HIPPs code changes mid-episode:**
  - Acute care hospitalization within 14 days prior to late payment period
  - Changes in patient's functional status/ significant decline or improvement
- ✓ **Assure strong processes for:**
  - Quality review of changes mid-episode/prior to start of late 30-day period
  - Confirmation OASIS records mid-episode are both submitted and accepted prior to submitting second 30-day claim
  - Agency policy/guidelines for when a follow-up assessment is expected to be performed

Pulling it all together: Tips for success

Here are some survival tips to ensure clinicians and agencies will be successful with the transition to PDGM.

✓ **PREPARATION IS KEY:** Establishing solid processes with in-take staff will ease the labor burden with staff and potential impact to reimbursement, once PDGM goes into effect. Provide intake with the tools they need to identify and solve potential hold-ups.

✓ **KNOW THE CODING GUIDELINES:** What is the competency of your coding staff? Come up with a plan to educate referral sources on the top 10 or more questionable encounter codes your agency has identified that won't be acceptable primary diagnoses with PDGM.

✓ **TRAIN ADMISSION STAFF:** Train staff on the importance of the hospitalization risk assessment, and importance of using direct observation to capture an accurate functional assessment of the patient. Demand interdisciplinary collaboration, when applicable, to ensure OASIS accuracy.

✓ **DON'T BLINDLY CUT BACK ON THERAPY:** Determine how to provide therapy effectively for patient care and outcomes, while containing costs. Consider utilizing therapy assistants, telehealth, or remote monitoring, and expect more from your physical therapist.

✓ **ENSURE AGENCY POLICY IDENTIFIES WHEN A FOLLOW-UP ASSESSMENT IS INDICATED:** For changes in the first 30-day period of care, consider what will warrant follow-up assessments. CMS expects that the home health agency clinical documentation will also reflect these changes, and any communication or coordination with the certifying physician should be documented.

Admission Source & Timing	Clinical Grouping & Comorbidities	Functional Impairment	Mid-Episode Changes
Strong clinical intake system	Know the Questionable Encounter codes	OASIS accuracy	Review current policy for follow up assessments
Validate admission source and timing	Establish a process to query providers i.e. scripting	Interdisciplinary collaboration	Focus of care changes in the first period
Request DC Summary documentation from facilities	Ensure the principle diagnosis is the reason for care	Coordinate with therapists and capitalize on this resource	Quality review of changes

For more information and tips on PDGM, reference the CMS resources found on the Home Health Agency (HHA) Center website, which can be found at cms.gov.

Common questions from HEALTHCARE*first* clients

Answered by a panel of industry experts, these are some of HEALTHCARE*first*'s most frequently asked questions.

What are the highest priority actions agency leaders should take to prepare for PDGM?

"For us, it was really looking at where we were, in terms of diagnoses. We needed to make sure that we understood the groupings, and that we had the breadth and depth internally, which we did not, to manage the coding, and the amount and intensity of time that it would take to be able to do that."

–Deborah Wesley, RN, BN, MSN, MHA – CEO/VP of Clinical Services Addison County Home Health & Hospice

"I have to agree. The biggest thing is the coding, making sure that primary diagnosis is spot-on. We use the Brightree coders in communicating with the coders. I communicate with the vendors almost on a daily basis, and making sure that we are getting the documentation that we need from our referral sources."

–Denise Tonkin, RN – Director of Nursing, Heritage Visiting Nurses Agency

Why is coding considered to be more important than ever under PDGM?

"As I mentioned before, under PDGM, each 30-day period of care is assigned to one of those 12 clinical groupings. Each of these groupings has its own base payment rate adjustment. It's critical that coding is done to the highest specificity with the diagnosis code that is valid under the PDGM. Those additional secondary diagnoses are also important, as there's a co-morbidity adjustment based on the interaction of certain conditions with others. Adjustment is designed to recognize that more complex care is needed, and thus added to the calculated reimbursement. In order to avoid major reduction of reimbursement, it's important to query those referral sources and figure out, right off the gate, if there's questionable encounters that are being referred to be addressed immediately, so that there are no delays with billing and no red flags to regulatory authorities."

–Leah Fleming, RN, BSN, HCS-D, COS-C – OASIS Review & Coding Specialist, HEALTHCARE*first*

What are some best practices and guidelines for PDGM?

"We really wanted someone that could understand where we were strong, and where we were weak, in terms of our coding. We wanted to have a consistent team, so that they could get to know our team, and really offer that ongoing education, clinician by clinician. That has been very helpful for us, and as we continue to grow, it's really facilitated our learning."

–Deborah Wesley, RN, BN, MSN, MHA – CEO/VP of Clinical Services Addison County Home Health & Hospice

"Internally, for agencies, you're going to really need a strong clinical intake system. Those intake people are really going to need to be provided with information, such as the questionable encounters, that list of diagnoses, so that can be recognized from the time the referral has started. They can also validate admission source and timing. Make sure that any available records can be obtained from the hospital, or the physician's office. Anything that's going to enable OASIS clinicians, coders, to have access to the best, most specific information as possible."

–Leah Fleming, RN, BSN, HCS-D, COS-C – OASIS Review & Coding Specialist, HEALTHCARE*first*

"It starts with intake. It starts with your referral to admission process and flows all the way into back office for billing. It's really about process and workflow. Agencies need to be analyzing their workflow now, and making any needed changes to have their structured, sound systems within their revenue cycle for next year under PDGM. I also would highly recommend that agencies are preparing for an acceleration of their documentation and their billing practices."

–Brandy Shifteh, RN, BHSA, MBA – Regulations Compliance Manager, HEALTHCARE*first*

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