THERAPY IN PDGM
TIP SHEET FOR SURVIVAL

The PDGM in no way diminishes or devalues the clinical importance of therapy. Physical therapy, occupational therapy, and speech -language pathology services play important roles in quality of outcomes and prevention of such adverse events as falls, hospital readmissions, and emergency room visits. These services also are vital to helping patients remain in their homes. The PDGM's goal is to provide appropriate payment based on identified resource use.

WHEN DOES PATIENT-DRIVEN GROUPINGS MODEL (PDGM) GO INTO EFFECT?

PDGM goes into effect for home health episodes that begin on or after January 1, 2020.

WHAT IS PDGM?

The Patient-Patient Driven Groupings Model is a new payment model for Home Health Prospective Payment System (HH PPS) that relies more heavily on clinical characteristics and other patient data to classify home health periods of care into meaningful payment categories. It also eliminates the use of therapy service thresholds and separate payments for medical supplies.

I HEARD THAT CMS WILL NO LONGER PAY FOR THERAPY. IS THIS TRUE?

Under PDGM, payment will be based on patient characteristics rather than the number of therapy visits. Agencies should continue to provide therapy for patients who require it; payments will be determined by patient characteristics as defined by PDGM.

KEY PROVISIONS

PDGM will use 30-day periods as a basis for payment. These periods are categorized into 1 of 432 case-mix groups for the purposes of adjusting payment.

ADMISSION SOURCE

Two subgroups-Community or Institutional? A 30-day period is classified as "institutional" if an acute or post-acute stay occurred within 14 days of the start of the episode. A period is categorized as "community" if there was not an acute or post-acute care stay in the 14 days prior to the start of the home health period of care.

TIMING

Two subgroups. Is the 30-day period early or late? Only the first 30-day episode qualifies as "early"-all other episodes are considered "late."

CLINICAL GROUPING

Twelve subgroups. Based on the principle diagnosis reported in claims, patients are assigned to 1 of these groups: musculoskeletal rehabilitation; neuro/stroke rehabilitation; wounds; medication management, teaching, or assessment (MMTA)-surgical aftercare; MMTA-car-

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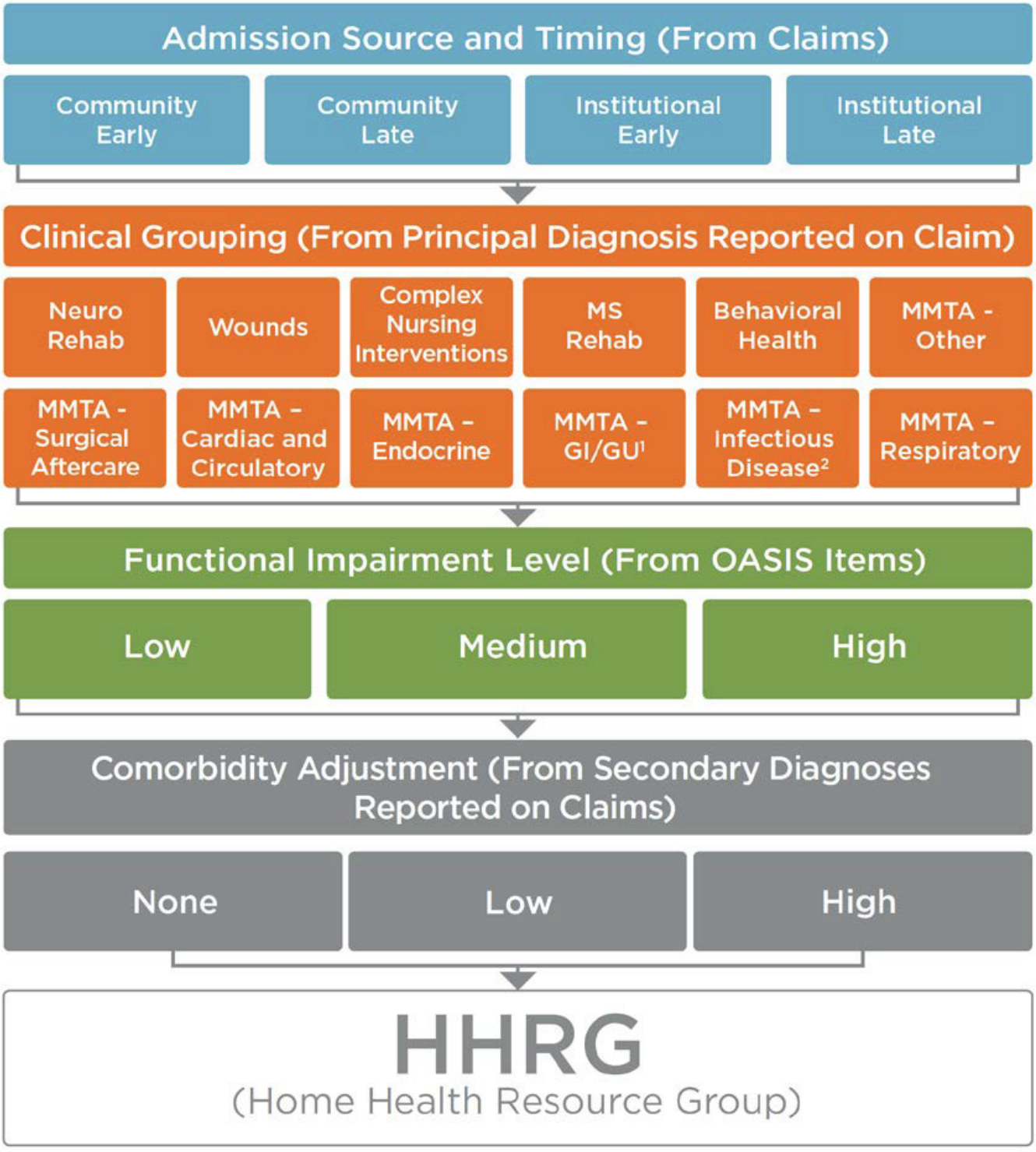
diac and circulatory; MMTA-endocrine; MMTA-gastrointestinal tract and genito-urinary system; MMTA-infectious disease, neoplasms, and blood-forming diseases; MMTA-respiratory; MMTA-other; behavioral health; or complex nursing interventions.

FUNCTIONAL IMPAIRMENT LEVEL

Three subgroups. Is it low, medium, or high, based on certain OASIS items? These items are M1800 (grooming), M1810 (current ability to dress upper body safely), M1820 (current ability to dress lower body safely), M1830 (bathing), M1840 (toilet transferring), M1850 (transferring), M1860 (ambulation and locomotion), and M1033 (risk for hospitalization). CMS determines the relationship between the responses for the listed OASIS items and average 30-day period resource use, and assigns points to a 30-day period. Responses that indicate higher functional impairment and a higher risk of hospitalization are associated with having larger coefficients, and are therefore assigned higher points. The points are then summed, and thresholds are applied to determine whether a 30-day period is assigned a low, medium, or high functional impairment level. Each clinical group is assigned a separate set of thresholds. On average, 30-day periods in the low level have responses for the listed OASIS items that are associated with the lowest resource use. On average, 30-day periods in the high level have responses on the OASIS item that are associated with the highest resource use.

COMORBIDITY ADJUSTMENT

Three subgroups. Based on secondary diagnosis, the adjustment is none, low, or high. A 30-day period of care receives a low comorbidity adjustment if there is a reported secondary diagnosis that is associated with higher resource use. A 30-day period of care receives a high comorbidity adjustment if there are 2 or more secondary diagnoses that are associated with higher resource use when they are reported together, as opposed to reported separately. There is no comorbidity adjustment if no secondary diagnosis exists, or if none meets criteria set forth in the rule.



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CHANGES TO LUPA

Payments for 30-day periods with a low number of visits are not case-mix-adjusted. Rather, they are paid per visit using national per-visit rates. Each of the 432 different PDGM case-mix groups has a threshold that determines if the period receives the LUPA. A 30-day period with a total number of visits below the LUPA threshold is paid per visit rather than at the case-mix adjusted 30-day payment rate. Conversely, a 30-day period with a total number of visits at or above the LUPA threshold is paid at the case-mix adjusted 30-day payment rate rather than per visit.

ACCESS CONCERNS

Although the payment methodology is changing, CMS's coverage of physical therapy is not. The new case-mix system creates payments that more closely reflect patients' actual needs. Combining functional impairment level with a clinical grouping and other patient characteristics will help ensure that payment is accurately aligned with actual patient characteristics and resource needs and costs.

Many patients in home health will continue to require physical, occupational and speech therapy after January 1, 2020, and Medicare will continue to pay for it. CMS reiterated in the final rule that it is the responsibility of the patient's treating physician to determine if and what type of therapy (maintenance or otherwise) the patient needs regardless of the clinical groupings. CMS said it fully expects the ordering physician, in collaboration with the therapist, to develop and follow a plan of care for each home health patient without regard to clinical group. Clinical grouping is not meant to be the sole determinant of the type and extent of therapy that particular patient needs.

WHEN AND HOW CAN I PREPARE FOR PDGM?

Begin now by evaluating your current software and asking how your current technology vendor is planning for PDGM. Will my current software support PDGM? PDGM will force home health agencies to make a number of changes to their internal processes and software vendors must be ready with updated systems.

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PDGM AND CODING

Waiting until the last minute to prepare may put your agency in huge financial trouble when PDGM launches. Coding will have one of the most significant impacts on home health payment in PDGM. The primary diagnosis code on the claim will determine which of 12 clinical groups the episode falls into. There are more than 40,000 codes that are on the acceptable primary list and will drive payment in PDGM. List all diagnoses relevant to the plan of care, not just the six allowed on the OASIS on the home health claim. In addition to assigning one principal diagnosis, you can assign up to 24 secondary diagnoses, and receive a comorbidity adjustment. Understand the questionable encounter codes. There are over 28,000 questionable encounter codes. Failure to use a primary diagnosis code that fits into one of the clinical groups could result in claims getting kicked back to providers. To avoid claims being returned and or denied, take steps now at your agency to identify which questionable encounter codes your agency uses and work to gather more detailed information from your referring providers.

QUESTIONABLE CODE	CODE REPLACEMENT	EXAMPLE
M62.81 Muscle weakness (generalized)	Query for reason for weakness such as musculoskeletal disorder, stroke, brain injury, etc.	Muscle wasting, muscle atrophy. Chronic Fatigue syndrome, Hyponatremia, Hypokalemia, MS non-surgicl fractures, RA, muscle strains, Parkinsons, neuropathy Left/right hemiparesis or hemiplegia Rhabdomyolysis MS, Parkinson's disease, ALS
M1021a…M19.90 Unspecified osteoarthritis, unspecified site	Query for details indicating a specific joint. There has to be a link in the record ensuring that what the clinician recorded actually has been diagnosed or confirmed by the physician.	The more specific code, M19.011 (Primary osteoarthritis, right shoulder), can be assigned instead only if the physician diagnosed osteoarthritis in the right shoulder or if the physician confirms that additional detail in response to a query
R00.1 Bradycardia unspecified	Query for underlying cause of bradycardia	Congenital heart defect, CAD, myocarditis, sleep apnea, lupus, side effect of medications cardiac dysrhythmias Atrial fibrillation Orthostatic hypotension (low BP) CV disease

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QUESTIONABLE CODE	CODE REPLACEMENT	EXAMPLE
R13.1 Dysphagia codes including unspecified and those which describe phases of	Code underlying disease such as Sequela of Cerebrovascular disease rather than this symptom code.	Parkinson's disease, MS, CVA, ataxia Aspiration pneumonia
R26.0 Ataxic gait	Code underlying cause of ataxia rather than this symptom code	MS, Head trauma, stroke, CP, tumors, vitamin deficiency B12 Wernickes disease, cerebellar abscess, cerebellar hemorrhage, Freidrichs ataxia, CVA, meningitis, encephalitis, chicken pox, measles History of Falls Parkinson's disease
R25.1 Paralytic gait	Code underlying cause of paralytic gait rather than this symptom code	Parkinsons CVA R and L hemiparesis
R26.2 Difficulty walking, not elsewhere classified	Code underlying cause of difficulty walking rather than this symptom code	Alzheimer's Disease, myasthenia gravis, amputation, peripheral neuropathy LE Fractures TKR/THR Rhabdomyolysis
R26.81 Unsteadiness on feet	Code underlying cause of unsteadiness rather than this symptom code	Parkinsons, foot drop History of Falls
R26.89 Other abnormalities of gait and mobility	Code underlying cause of abnormality rather than this symptom code	Hemiparesis/hemiplegia Chronic progressive neuro conditions Falls
R26.9 Unspecified abnormalities of gait and mobility	A query for further information by intake, nursing or the coder is needed to determine the underlying cause of the gait is needed. Remember, under PDGM, it is never appropriate to assign the code for a symptom from Chapter 18 as the primary diagnosis. Claims like this will be returned to providers for further specification.	For this example, the gait was caused by arthritis of the right foot. So the primary diagnosis code would be M19.071 (Primary osteoarthritis, right ankle and foot) since osteoarthritis defaults to primary location of where the osteoarthritis is known.
Z48.89 Encounter for other specified surgical aftercare	Query to ensure aftercare versus a complication such as infection, abscess, or dehiscence and use complication code instead if applicable	Aftercare surgery – TKR/THR, ortho MRSA infection after surgery

QUESTIONABLE CODE	CODE REPLACEMENT	EXAMPLE
R56.9 Unspecified convulsions	Query for disease process causing convulsions	TBI, seizure disorder
R29.6 Repeated falls	Code the disease process or complication causing falls instead	If a further query was made, documentation would show that the fall was caused by Meniere's disease in both ears. A more accurate code for this patient example would be Meniere's disease, bilateral H81.03. While the patient is being treated for the aftereffects of the fall, there is something that caused the fall, and that should be documented in the record and coded as primary Hypotension, dementia, UTI, Anemia, dehydration, medication side effects, vertigo, visual disorders, syncope, epilepsy, alcohol related disorders MS, CVA, Parkinsons, neuropathy, foot drop Hypoglycemia UTI Neuromuscular diseases
Z91.81 History of falls	Code the disease process or complication causing falls instead	Low vision, Cataracts, glaucoma, foot conditions, joint deformity, Arthritis MS, CVA, Parkinsons, neuropathy, foot drop UTI, acute infections
E08. - codes: EXAMPLE E08.21 Diabetes due to underlying condition with diabetic neuropathy	Follow official Coding Guidance: Code first the underlying condition, such as Cushing's Syndrome or Cystic Fibrosis	Mass, tumors (ex. adrenal glands)
I25.2 Old myocardial infarction	This includes all MI's with acute onset more than four weeks ago. If patient is still having symptoms, query and use underlying condition code such as coronary artery disease	CAD, chest pain, shortness of breath Decrease in activity tolerance
I95.9 Hypotension, unspecified	Query to determine underlying cause of hypotension	Orthostatic hypotension
CODES ENDING IN "9" Multiple codes are excluded that end with the character "9". These codes indicate unspecified sites, or unspecified diseases	Query the provider for specific disease information. Remember, visiting clinicians can determine the site of the issue (L or R) and verify information with the provider. All diagnosis information must be supported by provider or facility documentation.	Provide stages of diseases Specify locations and types of diseases

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QUESTIONABLE CODE	CODE REPLACEMENT	EXAMPLE
C34.10 Malignant neoplasm of upper lobe, unspecified bronchus or lung	Review clinician documentation to locate which lung is affected and/or query provider to confirm location	Specify locations
C34.30 Malignant neoplasm of lower lobe, unspecified bronchus or lung	Review clinician documentation to locate which lung is affected and/or query provider to confirm location	Specify locations
C56.9 Malignant neoplasm of unspecified ovary	Review clinician documentation to locate which ovary is affected and/or query provider to confirm location	Specify locations
C65.9 Malignant neoplasm of unspecified renal pelvis	Review clinician documentation to locate which renal pelvis is affected and/or query provider to confirm location	Specify locations
G03.9 Meningitis, unspecified	Query provider to determine type of meningitis	Specify type of bacteria
I69.30 Unspecified sequelae of cerebral infarction	Query assessing clinician(s) for types and locations of sequela(e) and/or query provider to confirm findings or types	Difficult in speech/swallowing (aphasia, dysphagia) Cognitive impairment
I70.239 Atherosclerosis of native arteries of right leg with ulceration of unspecified site	Query clinician for location on leg and/or query provider for location of ulceration(s)	DM 1 with diabetic ulcer of R leg PVD, PAD
I70.249 Atherosclerosis of native arteries of left leg with ulceration of unspecified site	Query clinician for location on leg and/or query provider for location of ulceration(s)	Same as above
Z51.89 Encounter for other specified aftercare	Code the condition for which rehabilitation services are ordered or provided	Right femoral fracture; surgical aftercare codes

KEY TAKEAWAYS

CMS emphasized in the final rule that the PDGM does not limit or prohibit provision of therapy services in home health, nor does it reduce the overall base rate of home health payment. The agency intends to monitor the impact of all case-mix adjustments in the PDGM to determine if they are causing any changes in utilization especially as they relate to the provision of therapy. This includes monitoring therapy visits reported on home health claims.