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- Call 866-782-6258 (M-F, 8 AM-8 PM ET)
- Email customerservice@PhysicalTherapy.com

HOME HEALTH PDGM: WHAT THERAPISTS NEED TO KNOW NOW

Dee Kornetti PT, MA, HCS-D
Cindy Krafft PT, MS, HCS-O

2

LEARNING OUTCOMES

- Articulate the key elements used to calculate payment in Patient-Driven Groupings Model (PDGM)
- Define the role of therapy in the primary diagnosis driven groups
- Identify opportunities for therapists to quantify value in a PDGM environment

PPS 2017 - HOME HEALTH GROUPING MODEL (HHGM)

- In the CY 2017 proposed rule, CMS described an alternate case-mix model option, the Home Health Groupings Model (HHGM). If implemented, the Home Health Groupings Model could redistribute payments across the range of home health patients, improve payments for specific vulnerable populations, and help address disincentives to provide services to vulnerable populations.
- **HHGM Technical Report:**
  - **https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2017-01-18-Home-Health.html**

BIBA OF 2018 MANDATES

- Go into effect in 2020
- Budget Neutrality
- Behavioral Adjustments
- Stakeholder Participation
- End of Therapy Thresholds
- 30 day Payment "Unit"

Bipartisan Budget Act

30 DAY UNITS

We are finalizing the change in the unit of payment from 60 days to 30 days, effective for 30-day periods of care that start on or after January 1, 2020, as proposed and in accordance with the provisions in the BBA of 2018. In addition, we are finalizing the PDGM, with modification, also effective for 30-day periods of care that start on or after January 1, 2020. We are also finalizing the corresponding regulations text changes as described in section III.F.13 of this final rule with comment period. We will provide responses to more detailed comments regarding the PDGM and the calculation of the 30-day budget neutral payment amount for CY 2020 further in this final rule with comment period.

60 day Episode = 2 Units (30 days) covered by same OASIS

Behavioral Adjustments will proceed

LUPAS = 2 TO 6 VISITS

- ***Final Decision****: We are finalizing our proposal to vary the LUPA threshold for each 30-day period of care depending on the PDGM payment group to which it is assigned. Likewise, we are finalizing that the LUPA thresholds for each PDGM payment group will be re-evaluated every year based on the most current utilization data available.*
- *The LUPA thresholds for the PDGM payment groups with the corresponding HIPPS codes based on CY 2017 home health data are listed in Table 32. Since we propose to implement the PDGM on January 1, 2020, LUPA thresholds for the PDGM payment groups with the corresponding HIPPS codes for CY 2020 will be updated in the CY 2020 HH PPS proposed rule using CY 2018 home health data.*

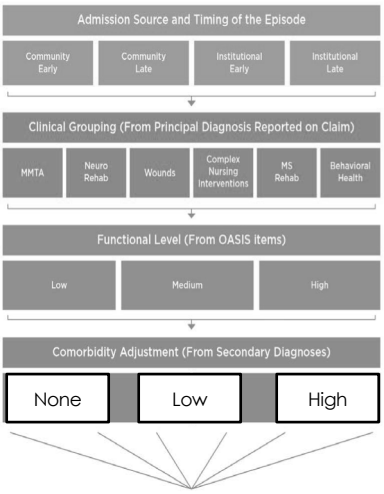
IMPACT ON RAPS

Certified by 12/31/18	Certified after 1/1/19
Submit RAPS	Submit RAPS
Split Payments	NO Split Payments

60/40

50/50

Patient Driven Groupings Model

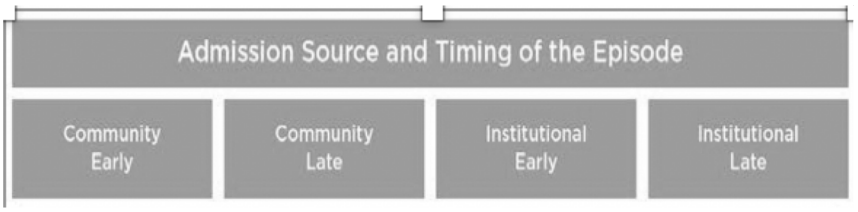


Claims Data

OASIS Data

HHGM ⇨ PDGM

ADMISSION SOURCE / TIMING



Claims Data

CLINICAL GROUPINGS (M1021)

Clinical Groups	The Primary Reason for the Home Health Encounter is to Provide:
Musculoskeletal Rehabilitation	Therapy (physical, occupational or speech) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (physical, occupational or speech) for a neurological condition or stroke
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
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric conditions
Complex Nursing Interventions	Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies
Medication Management, Teaching and Assessment (MMTA)	
MMTA –Surgical Aftercare	Assessment, evaluation, teaching, and medication management for surgical aftercare
MMTA – Cardiac/Circulatory	Assessment, evaluation, teaching, and medication management for cardiac or 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 for gastrointestinal or genitourinary related conditions
MMTA – Infectious Disease/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 classified in one of the previously listed groups

Claims Data

COMORBIDITY ADJUSTMENT (M1023)

- Defined as a medical condition coexisting in addition to the primary diagnosis and tied to worse health outcomes, more complex medical need and management and higher care costs.
- Periods having at least one comorbidity included with the adjustment group will receive an adjustment
- Comorbidity List:
  - https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html

Claims Data

A LITTLE ABOUT PROPER DIAGNOSIS CODING

- **The circumstances for admission govern the selection of a patient's principal diagnosis.**
- According to the Uniform Hospital Discharge Data Set (UHDDS), the primary diagnosis is defines as "***that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care***."
  - Definitions developed to ensure inpatient data elements were reported by hospitals utilizing a standard format (FR Vol. 50, No. 147, pp. 31038-40, July 31, 1985).
  - Since this time, the UHDDS definitions have been expanded to include all non-outpatient settings of care, including home health
  - To achieve this, requires consistent, complete documentation in the medical record

A LITTLE *MORE* ABOUT PROPER DIAGNOSIS CODING

- **General Rules exist for reporting additional (other) diagnoses**
- **Defined by UHDDS as "*all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and./or the length of stay.*"**
- For reporting purposes, the definition for "other diagnoses" is interpreted as "the additional conditions that affect patient care in term of requiring:
  - Clinical Evaluation, or
  - Therapeutic treatment, or
  - Diagnostic procedures, or
  - Extended length of stay, or
  - Increased care and/or monitoring."

A LITTLE *MORE* ABOUT PROPER DIAGNOSIS CODING

- **Ultimate responsibility for diagnoses rests with the physician**
  - This means, that the home health clinician cannot diagnosis a patient with an illness, condition, or disease process.
  - However, the reason for hospitalization (or physician office visit, emergent care, etc.), may not be the primary reason for the home health episode of care!
    - The clinical assessment completed on SOC, and all additional discipline evaluations, should provide clear rationale for why the patient is receiving home health care.

ROLE OF THE HH CLINICIAN IN DIAGNOSIS CODING

- Sequencing
  - List first code (M1021a), or primary code, as the diagnosis, condition, problem, or other reason for the home health episode
    - **Most related to the Plan of Care,**
    - **Most acute condition, *and***
    - **Requires the most intensive services (chief reason for care)**
  - List additional codes (M1023b-f), or secondary codes, that describe any coexisting conditions managed during the episode of care
    - **Must be relevant to the care delivered, or**
    - **Have potential to affect patient's responsiveness to care**

ROLE OF THE HH CLINICIAN IN DIAGNOSIS CODING

- Coding Chronic Conditions
  - Those treated on an ongoing basis
  - Even if not the focus of care, will always impact the care and should be codes as a pertinent diagnosis
  - Should also be addressed in the Plan of Care
- Select those that best describe the patient's current, active condition under treatment

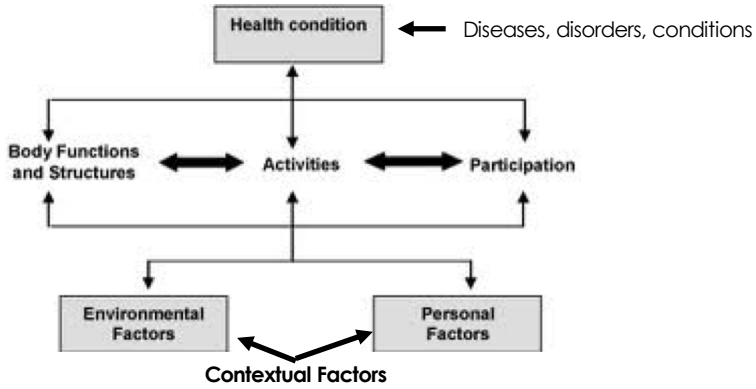
EXAMPLE 1: CODING IN PDGM

- **Reason for Referral**: Patient is referred for HH physical therapy following 3-day hospitalization for acute exacerbation of his chronic combined systolic and diastolic heart failure. On evaluation the patient presents with reduced peripheral muscle strength and impaired balance.
- **PMHx**: Type 2 diabetes with diabetic retinopathy and neuropathy with loss of protective sensation, COPD
- **Contextual Factors**: Resides alone in 2nd floor apartment in an independent senior living building; relies on public transportation for medical appointments, grocery and pharmacy.

CODING THE REASON FOR THERAPY CARE IN PDGM

- Currently in home care, agencies list "therapy diagnoses" when therapy is providing care.
  - ***There are no "therapy diagnoses" in the ICD code set!***
- Therapists commonly list the impairments in body structure/function as the reason/diagnosis driving the provision of therapy
  - ***Therapists frequently do not list the underlying etiology for the therapy conditions being treated***
  - i.e., "muscle weakness" or "gait abnormality"
- How should this be accurately reflected?
  - ***Should be occurring now, but will affect payment in PDGM!***

ICF: A BIOPSYCHOSOCIAL MODEL OF DISABILITY



EXAMPLE 1: CODING IN PDGM

- Primary Diagnosis Code:

Primary Diagnosis	ICD-10 Code	Correct/Incorrect?
A/C systolic & diastolic HF?	I50.43	**CORRECT!**
Muscle weakness?	M62.81	**INCORRECT**

- PDGM: MMTA – Cardiac, *not* MMTA-other, or MS-Rehab
- Comorbidity Adjustment (secondary diagnoses):

Secondary Diagnoses	ICD-10 Code	Low/High Comorbidity Adjustment
Type 2 diabetes or COPD	E11.9, or J44.9	LOW (1 comorbidity)
Type 2 diabetes + COPD	E11.319, E11.42 + J44.9	HIGH (2+ comorbidities)

FUNCTIONAL ITEMS

LOW
MEDIUM
HIGH

- M1800 Grooming
- M1810 Upper Body Dressing
- M1820 Lower Body Dressing
- M1830 Bathing
- M1840 Toilet Transferring
- M1850 Transferring
- M1860 Ambulation
- M1033 Risk of Hospitalization

"When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact."

FUNCTION AND FALL RISK

(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

0 - No multi-factor falls risk assessment conducted.
1 - Yes, and it does not indicate a risk for falls.
2 - Yes, and it indicates a risk for falls.

Fall Risk Assessment Score? ⇨ Need at Least Supervision? ⇨ Intermittent vs Continuous?

GROOMING AND DRESSING

- **Response 0** = Patient is safe and independent completing the task INCLUDING gathering the items needed as part of the task.
- **Response 1** = Patient is safe and independent completing the task IF the needed items are laid out or handed to the patient (Gathering eliminated)
- **Response 2** = In order to be safe completing the task SOMEONE ELSE should be involved (Includes verbal cues and stand by assistance)
- **Response 3** = The patient is unable to participate effectively in the task. (Could be physical and / or cognitive issue)

M1840 TOILET TRANSFERRING

(M1840)	**Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.	
Enter Code ☐	0	Able to get to and from the toilet and transfer independently with or without a device.
	1	When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
	2	Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
	3	Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
	4	Is totally dependent in toileting.

In / Out

On / Off

WHAT ABOUT THERAPY?

- *We disagree that the PDGM diminishes or devalues the clinical importance of therapy. The musculoskeletal and neurological rehabilitation groups under the PDGM recognize the unique needs of patients with musculoskeletal or neurological conditions who require therapy as the primary reason for home health services.*
- *For the other clinical groups, we note that the 30-day base payment amount includes therapy services, even if the primary reason for home health is not for the provision of therapy. The functional impairment level adjustment in conjunction with the other case-mix adjusters under the PDGM, aligns payment with the costs of providing services, including therapy.*

PREPARING FOR PDGM

- OASIS Data Collection ✓
- ICD-10 Coding ✓
- OASIS D Collaboration
- One Beneficiary = One Plan of Care
- Reducing Re-hospitalization
- Maintenance Therapy
- Skilled Management and Evaluation

GG0130 / GG0170: PERFORMANCE ASSESSMENT

Licensed clinicians may assess the patient's performance based on direct observation (preferred) as well as reports from the patient, clinicians, care staff and/or family.

When possible, CMS invites a multidisciplinary approach to patient assessment.

If helper assistance is required because patient's performance is unsafe or of poor quality, Score according to amount of assistance provided.

Patients with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the patient's need for assistance to perform the activity safely.

RECONCILING M AND GG

(M1810)	Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
Enter Code ☐	0 Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1 Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2 Someone must help the patient put on upper body clothing. 3 Patient depends entirely upon another person to dress the upper body.

M

GG

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.

(M1830)	**Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**
Enter Code ☐	0 Able to bathe self in shower or tub independently, including getting in and out of tub/shower. 1 With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. 2 Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. 3 Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 4 Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode. 5 Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person. 6 Unable to participate effectively in bathing and is bathed totally by another person.

M

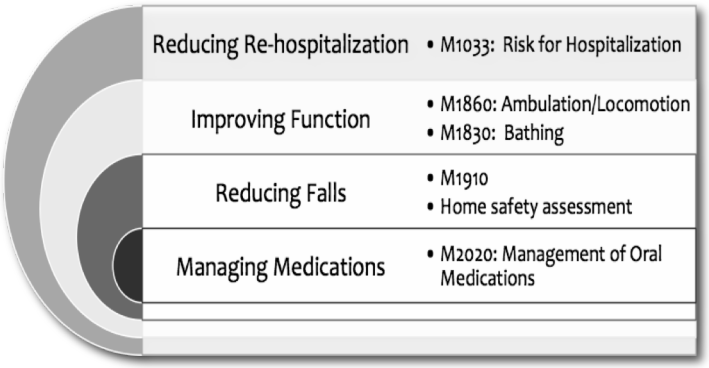
GG

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower

GG0130 / GG0170 – GOALS

- Discharge goal(s) may be coded the same as SOC/ROC performance, higher than SOC/ROC performance or lower than SOC/ROC performance.
- If the SOC/ROC performance of an activity was coded using one of the activity not attempted codes (07, 09, 10 or 88) a discharge goal may be submitted using the 6-point scale if the patient is expected to be able to perform the activity by discharge.
- Licensed clinicians can establish a patient's discharge goal(s) at the time of the SOC/ROC based on the patient's prior medical condition, SOC/ROC assessment, self-care and mobility status, discussions with the patient and family, professional judgment, the profession's practice standards, **expected treatments, patient motivation to improve, anticipated length of stay, and the discharge plan**. Goals should be established as part of the patient's care plan.

ONE BENEFICIARY – ONE PLAN OF CARE



ORAL MED MANAGEMENT

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.

1 - Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart.

2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times

3 - Unable to take medication unless administered by another person. NA - No oral medications prescribed.

REDUCING RE-HOSPITALIZATION

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization?

1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)

2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months

3 - Multiple hospitalizations (2 or more) in the past 6 months

4 - Multiple emergency department visits (2 or more) in the past 6 months

5 - Decline in mental, emotional, or behavioral status in the past 3 months

6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months

7 - Currently taking six or more medications

8 - Currently reports exhaustion

DID YOU KNOW??

- Hospital readmission rates after acute care discharge are 3x higher if physical therapist discharge recommendations are replaced with less intensive interventions.
- Older adults who walk < 4,691 steps per day over the 1st week post discharge are ~6x more likely to be readmitted within 30 days.

Falvey,JR, et.al. Role of Physical Therapists in Reducing Hospital Readmissions: Optimizing Outcomes for Older Adults During Care Transitions From Hospital to Community. Phys Ther. 96:8, pp 1125-1134, 2016.

DID YOU KNOW??

- Declines in self-reported ADL ability is strongly linked to poor outcomes following hospitalization.
- Older adults who return home with unmet needs for ADL assistance have a 66% increase in the odds of hospital readmission when compared to those whose needs are adequately addressed after discharge.

Falvey,JR, et.al. Role of Physical Therapists in Reducing Hospital Readmissions: Optimizing Outcomes for Older Adults During Care Transitions From Hospital to Community. Phys Ther. 96:8, pp 1125-1134, 2016.

DEFINING "HAD"

- Multi-system decline in function partially avoidable occurrence resulting from prolonged immobility during period(s) of hospitalization
  - Decline in ADL performance
  - Prolonged periods of bed rest/relative inactivity
    - Older adults spend ~83% of hospital stay in bed
    - Older adults spend ~12% of hospital stay in chair

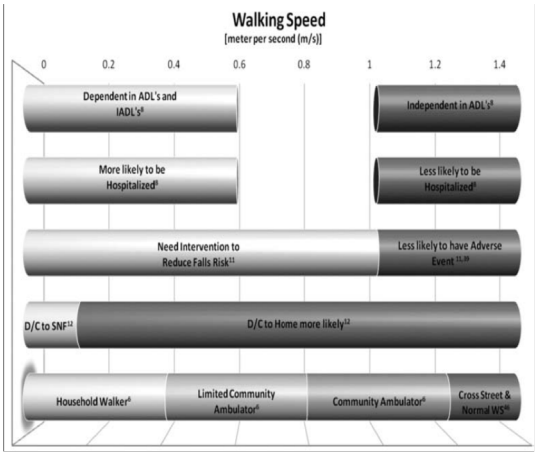
Falvey,JR, et.al. Rethinking Hospital-Associated Deconditiong: Proposed Paradigm Shift. Phys Ther. 95:9, pp 1307-1315, 2015.

REDUCING HAD

Occupational Therapy
- ADL Coach

Physical Therapy
- Mobility Coach

FOCUS ON FUNCTION



Fritz S. and Lusardi M. "Gait Velocity: The 6th Vital Sign" *Journal of Geriatric Physical Therapy Vol. 32:2:09:2-5.*

UNDERDOSING OF EXERCISE IN HAD

- Functional Reserve (def): the capacity for older adults to handle additional stressors or illnesses without loss of independence
- Older adults discharged with poor physical function have 3x the odds of being rehospitalized within 30 days as compared to:
  - Older adults with medically complex conditions, &
  - Older adults with high physical function
- Most common PAC physical therapists choose low-intensity exercises ("safer")

Falvey,JR, et.al. Rethinking Hospital-Associated Deconditiong: Proposed Paradigm Shift. Phys Ther. 95:9, pp 1307-1315, 2015.

FALVEY, ET AL: PARADIGM SHIFT

Current Rehabilitation Hierarchy for Older Adults With HAD

Updated Rehabilitation Hierarchy for Older Adults With HAD

Figure 2.
Current rehabilitation hierarchy for older adults with hospital-associated deconditioning (HAD) and hierarchy of an updated treatment approach for older adults with HAD. RT=resistance training, ADL=activities of daily living, GCAs=general conditioning activities.

<u>Focus of Interventions in HAD</u>:
High intensity resistance training

Mod to high intensity motor control-based gait, balance, ADLs

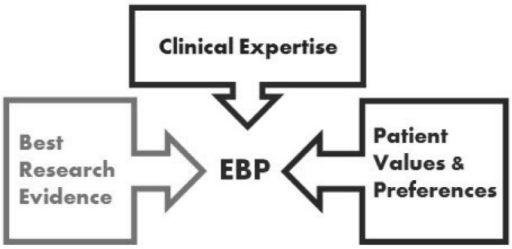
Mod intensity aerobic training

General conditioning activities

Falvey,JR, et.al. Rethinking Hospital-Associated Deconditiong: Proposed Paradigm Shift. Phys Ther. 95:9, pp 1307-1315, 2015.

BEST PRACTICES FOR HOME HEALTH

- Evidence-based care ⟹ "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research."
  – David Sackett



MAINTENANCE THERAPY? MANAGEMENT AND EVALUATION?

CARE REDESIGN AND M&E

- Skilled nursing visits for management and evaluation of a patient's care plan are reasonable and necessary when **underlying conditions or complications require that only a registered nurse can ensure that essential non-skilled care is achieving its purpose.**
- The complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the beneficiary's overall condition.

TIME LIMITATIONS?

- Management and evaluation is **not intended to serve as the primary mechanism for providing long-term care.**
- **However,** there are no time restrictions for carrying out this skill.

M&E CHECKLIST

- ✓ Briefly document the complicating factors resulting in a high potential for complication or for ensuring that **essential non-skilled services** are achieving its purpose to promote the beneficiary's recovery and safety.
- ✓ Skilled management and evaluation involves finding that **recovery and safety cannot be assured** unless the total care, skilled or not, is planned and managed by a registered nurse.
- ✓ Skilled management and evaluation should be a **specific order** when it is the only skilled nursing service rendered.
- ✓ MUST be RNs only – no LPNs

THERAPY COVERAGE CRITERIA

Skills of a qualified therapist are needed to restore function

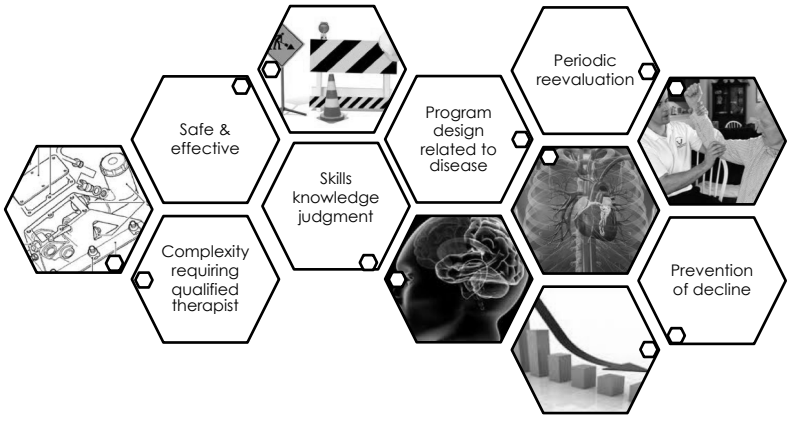
Patient's condition requires a qualified therapist to design or establish a maintenance program

Skills of a qualified therapist are required to perform maintenance therapy

WHAT ABOUT THE CAREGIVER?

- The presence or absence of a caregiver DOES NOT define the intervention provided as "skilled"
- IF someone OTHER THAN a therapist can do the intervention THEN it would NOT be considered "skilled"

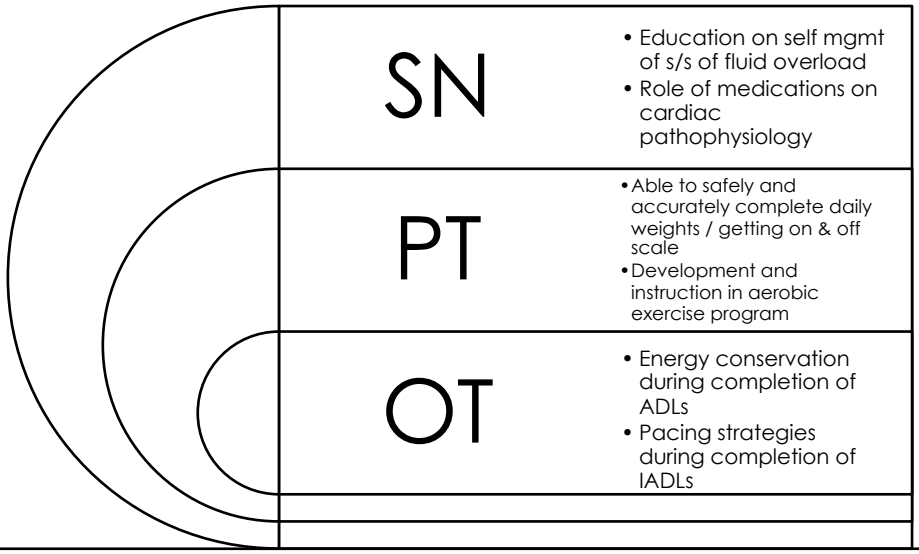
ANATOMY OF A MAINTENANCE PROGRAM



REINFORCING THERAPY'S FOCUS ON VALUE/OUTCOME

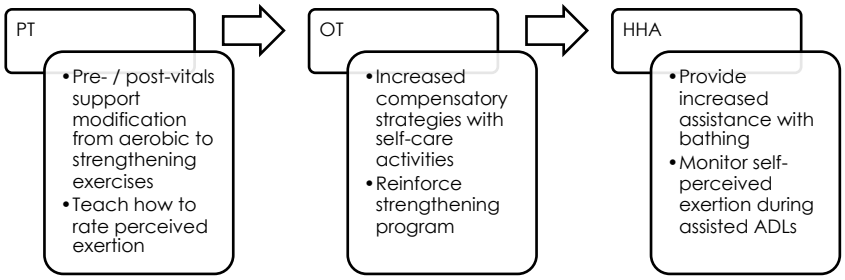
- What are the key elements a patient with HF needs to focus on to ***prevent re-hospitalization***?
- What roles does each clinician play in these identified risks?
  - SN
  - PT
  - OT
  - HHA

REINFORCING THERAPY'S FOCUS ON VALUE/OUTCOME: CHF



REINFORCING THERAPY'S FOCUS ON VALUE/OUTCOME: CARE PLANNING

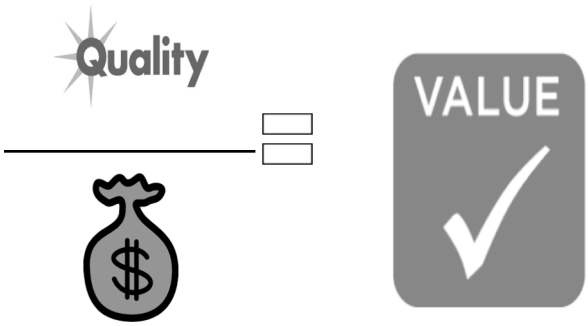
- **Example:** Activity Monitoring with cardiopulmonary clients



REINFORCING THERAPY'S FOCUS ON VALUE/OUTCOME

- ❑ Documentation Queries:
  - ❑ Does documented care reflect impact of care toward desired outcome(s)?
  - ❑ Do goal statements reflect anticipated functional impact of improvement in/stabilization of impairments?
  - ❑ Are risk areas identified on admission remediated/resolved through provision of care?
- ❑ Clinical Utilization Decisions:
  - ❑ Are documented impairments quantified using objective measurement?
  - ❑ Are frequency/duration decisions supported by data interpretation + clinical judgment + contextual factors unique to the patient?
  - ❑ Are expected outcomes of care coordinated between all members of the patient's care team?

HOW TO BUILD A CULTURE OF "VALUE"



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Our Mission:

Empower home health agencies with revenue protection strategies.

Our Core Values:

Innovation / Trust / Integrity

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HEALTH CARE SOLUTIONS
Value Beyond The Visit