How Home Health Billing Will Change Under PDGM

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Billing Under PDGM

- Patient Driven Grouping Model (PDGM) method of Medicare reimbursement is effective from 01/01/2020.
- Many basic elements of current Medicare claims submission and processing, such as RAP & EOE, will remain the same. The key differences and some important changes are outlined below.
- Episode definition remains the same. There are two types of episode:
  - (1) Admission episode, or the Start of Care episode begins on new admission of a patient, and
  - (2) Follow-up episodes / re-cert episodes are all subsequent episodes of care in a sequence of episodes.
- The following presentation looks at how HHA claims submission and Medicare claims processing will change as a result of PDGM, under 7 different scenarios.

Claims Submissions and Processing

	UNDER CURRENT SYSTEM	UNDER PDGM
1	HHAs complete OASIS and submit to Quality Improvement & Evaluation System (QIES)	HHA completes OASIS assessment and submits to **iQIES** system
2	HHAs determine HIPPS code from the OASIS data using the vendor software or grouper software	**HHAs have the option to generate HIPPS code from OASIS data using Grouper software or submit claim with any valid HIPPS code**
3	HHAs submit RAP and receive split percentage payments -50% on re-cert, 60% on start of care	HHAs submit RAP and receive split percentage payments -50% on re-cert, 60% on start of care
4	HHAs provides services for 60 days or up to the discharge date, whichever is earlier, and then submit the final claim with HIPPS code matching the RAP and detailed line items of service information	HHAs provides services for **30** days or up to the discharge date, whichever is earlier, and then submit the final claim with HIPPS code matching the RAP and detailed line items of service information **and new coding requirements**

Claims Submissions and Processing

	UNDER CURRENT SYSTEM	UNDER PDGM
5	When the claim is received, Medicare systems query the OASIS in QIES • If an assessment is not found, the claim is returned to the provider • Compare the submitted HIPPS code with the code calculated by the Grouper in QIES • If the OASIS-calculated HIPPS code is different, it is used for payment. • If the number of therapy visits, as reflected on the claim requires revision on OASIS, such revision is made on the Medicare Pricer Program to recalculate the HIPPS code and the payment is accordingly adjusted.	When the claim is received, Medicare systems query the OASIS in **iQIES** • If an assessment is not found, the claim is returned to the provider • **If found, answers to 8 OASIS items used in PDGM case-mix scoring are returned to the claims system and stored on the claim record.** • **Medicare systems combine OASIS items and claims data (period timing, inpatient discharge, diagnoses) and send to Grouper program.** • **Grouper-produced HIPPS code replaces the submitted HIPPS code and issued for payment** • **Number of therapy visits no longer require results in recoding**

Claims Submissions and Processing

	UNDER CURRENT SYSTEM	UNDER PDGM
6	Not applicable	If Medicare claims history indicates period sequence is incorrect or HHA was not aware of inpatient discharge information, the corrected information is sent back to the Grouper and the HIPPS code is recalculated
7	Not applicable	If Medicare claims history does not indicate inpatient discharge date within last 14 days, and the OASIS information include such information, the OASIS information will be used in grouper to calculate the HIPPS code

RAP Processing

- No difference exists between RAP processing under current system and under PDGM.
- All agencies are required to submit RAP at the beginning of the 30 day period.
- New occurrence codes (*discussed later*) under PDGM are not reported on RAP.
- Low utilization payment adjustment (LUPA) claims remain an exception (no-RAP claim).

OASIS Data in PDGM Claims

OASIS assessment used in determining the HIPPS code is the most recent time point:

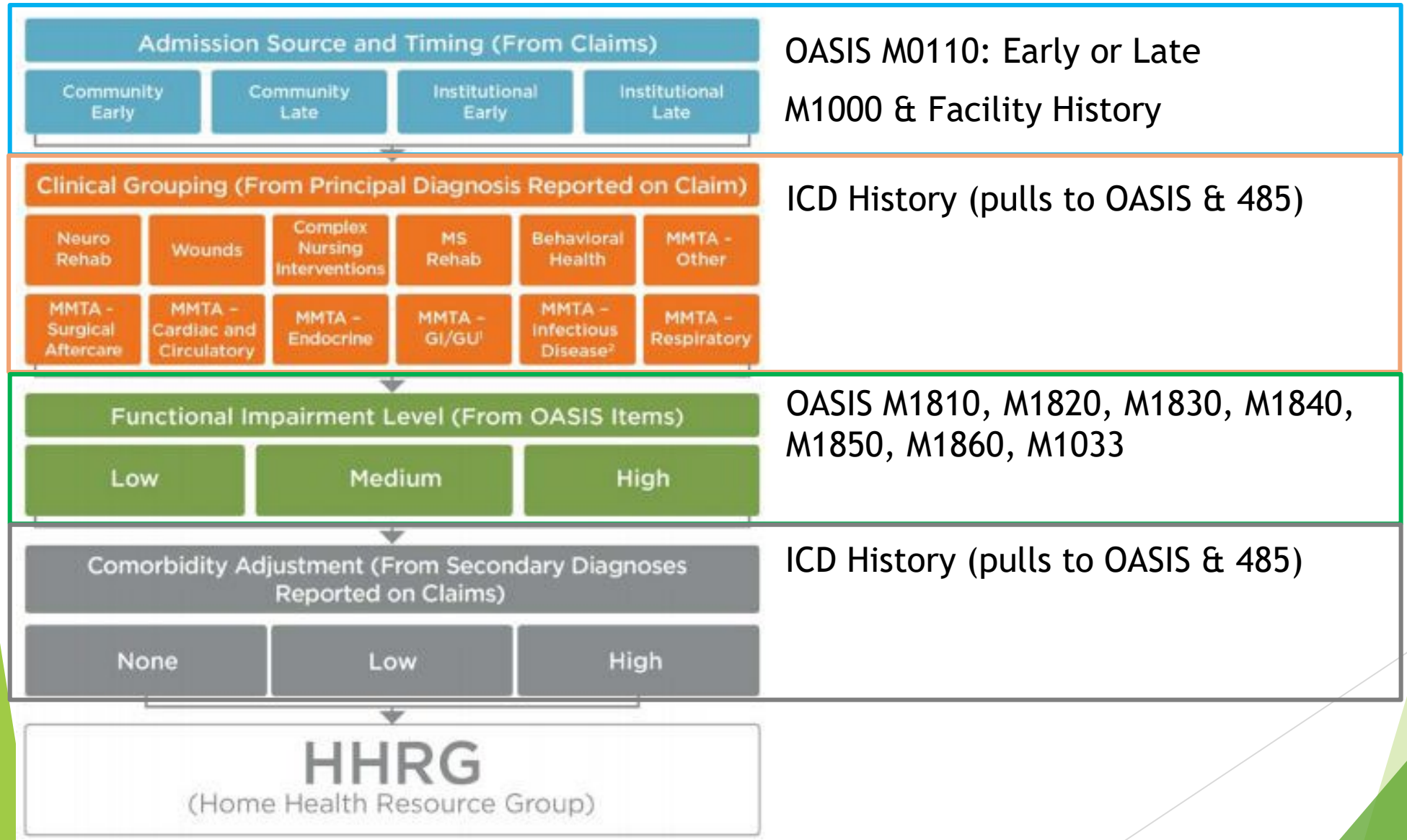
The system will look back from the claim's "**From Date**" for the most recent OASIS assessment.

- Start of Care (SOC) assessment (RFA 01) used for determining the functional impairment level for both the first and second 30-day periods of a new home health admission.
- Follow-up Recertification assessment (RFA 04) used for third and fourth 30-day periods.
- Resumption of Care (ROC – RFA 03) or Other Follow-up (RFA 05) assessments may be used for the second (or later) 30-day period.

OASIS Data in PDGM Claims

- 8 Functional level data in OASIS (MO1033, MO1800-MO1860) are used to calculate the HIPPS code.
- OASIS information may be corrected by an HHA after they have submitted their claim to Medicare.
- No need to adjust claims every time a correction is made.
- Only the 8 functional items are used by the claims system, so claims only need to be adjusted if these items are corrected and the HHA believes the changes will have an impact on payment.

HIPPS Code Calculation



OASIS Data in PDGM Claims

- Under PDGM, **claims are the source of record for payment diagnosis codes, not OASIS.**
- If diagnosis codes change during a period of care (before the "From" date of the next period), the coding changes should be reflected on the claim on the next period.
- Complete an 'other follow-up' (RFA 05) assessment when a change would be considered a major decline or improvement in the patient's health status.
- No edits in Medicare systems comparing claim and OASIS diagnosis codes.
- No need to complete an RFA 05 just to ensure claim and OASIS coding match.

New Occurrence Codes

The following occurrence codes are new to the Medicare billing and applicable only under PDGM system:

- **Occurrence code 50: Assessment completion date**
- Required on all final claims, not on RAPs.
- If this code is missing, the claim will be returned.
- Report the assessment completion date (OASIS item M0090) for the start of care, resumption of care, recertification or other follow-up OASIS that occurred most recently before the claim “From” date.
- This date will be used to match to the OASIS record in iQIES.
- ***For recertification episodes starting from 01/01/20 through 01/05/20, if the OASIS completion date is December 2019 (5 days prior), use 01/01/20 as MOO90 date (one time exception). Transmit the OASIS on or after 01/01/20.***

New Occurrence Codes

- Two new occurrence codes to support the admission source category of the PDGM (Community vs. Institutional)
- **Occurrence code 61 – "Hospital Discharge Date"**
- Reported, ***but not required***, on final claims. Not reported on RAPs.
- Reported on admission claims ***AND continuing claims***, if applicable.
- Report the discharge date ("Through" date) of an inpatient hospital admission that ended within 14 days of the "From" date of the HH period of care. Swing bed hospitals and outpatient admission do not count towards inpatient stay.
- Claims with hospital discharges within 14 days are grouped into "Institutional" payment groups.
- Treatment authorization codes are no longer required on the claims.

New Occurrence Codes

- Occurrence code 62 – “Other Institutional Discharge Date”
- Reported, ***but not required***, on final claims.
- Not reported on RAPs.
- Reported ***ONLY on admission(SOC) claims***, if applicable.
- Claim “From” & “Admission” date match.
- Report the discharge date (“Through” date) of a skilled nursing facility (SNF),inpatient rehabilitation facility (IRF), long term care hospital (LTCH) or inpatient psychiatric facility (IPF) stay that ended within 14 days of the “From” date of the HH period of care.
- Admission claims with other institutional discharges within 14 days are grouped into “Institutional” payment groups.

New Occurrence Codes

Determining "within 14 days of the 'From' date" of the HH claim:

- Include the 'From' date, count back using the day before the 'From' date as day 1.
- If 'From' date = 1/20/2020, then 1/19/2020 is day 1. Counting back from 1/19/2020, the 14 day period is 1/6/2020 – 01/19/2020.
- Any post acute discharge from 01/06/2020 up to 01/20/2020 will have occurrence codes either 61 or 62.

New Occurrence Codes

- Report ***only one*** occurrence code 61 or 62 on a claim.
- If two inpatient discharges occur during the 14 day window, report the later discharge date. Example:
  - HH claim “From” date – 1/20/2020
  - Inpatient hospital discharge date – 1/10/2020 (10 days prior)
  - SNF discharge date – 1/18/2020 (2 days prior
  - Report occurrence code 62 and 1/18/2020.
- Claims with both occurrence code 61 and 62 will be rejected.

New Occurrence Codes

What happens if an HHA is not aware of an institutional discharge when they submit the claim?

- If the inpatient claim has been processed by Medicare before the HH claim is received, Medicare systems will identify it and group the HH claim into an institutional payment group automatically.
- If the inpatient claim has not been processed yet when the HH claim is received, Medicare systems will group the HH claim into a community payment group.
- When the inpatient claim is processed later, Medicare systems will automatically adjust the paid HH claim and pay it using an institutional payment group instead.
- If HHA submits Institutional claim (occurrences 61 or 62) and Medicare claims processing system does not contain any information about an inpatient claim after the timely filing period closes, Medicare will not automatically adjust the HH claim to community. This is because:
- Inpatient stay may have been in a non-Medicare facility (e.g., Veteran's Administration)
- Non-Medicare facilities can ONLY be identified through occurrence codes.

Episode Timing

- Each character of the HIPPS code is associated with PDGM variables:
  - Position #1: Timing and Admission Source
  - Position #2: Clinical Grouping
  - Position #3: Functional Impairment Level
  - Position #4: Comorbidity Adjustment
  - Position #5: Placeholder
- Example 1 HIPPS Code: 2DC21
  = Early-Institutional/Complex Nursing/High Functional Impairment/ One(Low) Comorbidity Adjustment
- Example 2 HIPPS Code: 3BB31
  = Late-Community/Neuro/Medium Functional Impairment/More than one(High) Comorbidity Adjustment

Episode Timing

Period timing reflected by two pairs of values in the first position of the HIPPS code:

- **Early**
  - 1 – Community Early
  - 2 - Institutional Early
- **Late**
  - 3 – Community Late
  - 4 – Institutional Late

“Institutional” and “Community” were discussed before under “Occurrence codes”

Episode Timing

- "Early" episode of care under PDGM are limited to the first 30-day period in a *sequence** of HH periods of care. All subsequent episodes of care are "Late".
- **Sequence - periods with no more than 60 days between the end of one cert period and the start of the next cert period (no change from current definition)*. Sequence of care can be by same agency or multiple agencies as long as there no more than 60 days gap between one episode of care and the start of the next episode of care.
- Patient transferred from HHA1 to HHA2 will always be **Late** episode for HHA2. Once there is a gap of more than 60 days between the last discharge and next admission, the sequence of care will be **Early** for the first 30-day billing period of new admission

Episode Timing

Example 1, Beneficiary is:

- Admitted to HHA1: 01/15/2020
- Discharged by HHA1: 02/10/2020
- 1/5 to 2/10 claim processed: 03/05/2020

- Re-admitted by HHA1: 04/05/2020
- Claim for 01/15 period paid as “Early”
- ***On all Early claims “From” and “Admission” dates must match (04/05) but the period of care starts within 60 days of the last HH discharge***
- Period starting 04/05/2020 is grouped as a “Late” period of care, because number of days between the last discharge (02/10/2020) and current admission (04/05/2020) is less than 60 days.
- ***On all Late claims “From” and “Admission” dates may or may not match.***

Episode Timing

- If a HH makes error on HIPPS code that begins with 1 or 2 when there was another HH within the last 60 days, Medicare systems will automatically regroup the claim and pay using the corresponding HIPPS code that begins with 3 or 4 instead.
- If the prior HH claim has not been yet been processed by Medicare, the claim will initially pay as an “Early” period of care:
  - When the prior HH claim is processed later, Medicare systems will automatically adjust the paid HH claim and pay it using a “Late” payment group instead.
  - “Late” periods will also be recoded to “Early” if no prior claims are found

Episode Timing: MSP

Medicare Secondary Payer (MSP)

Example 2, Beneficiary is:

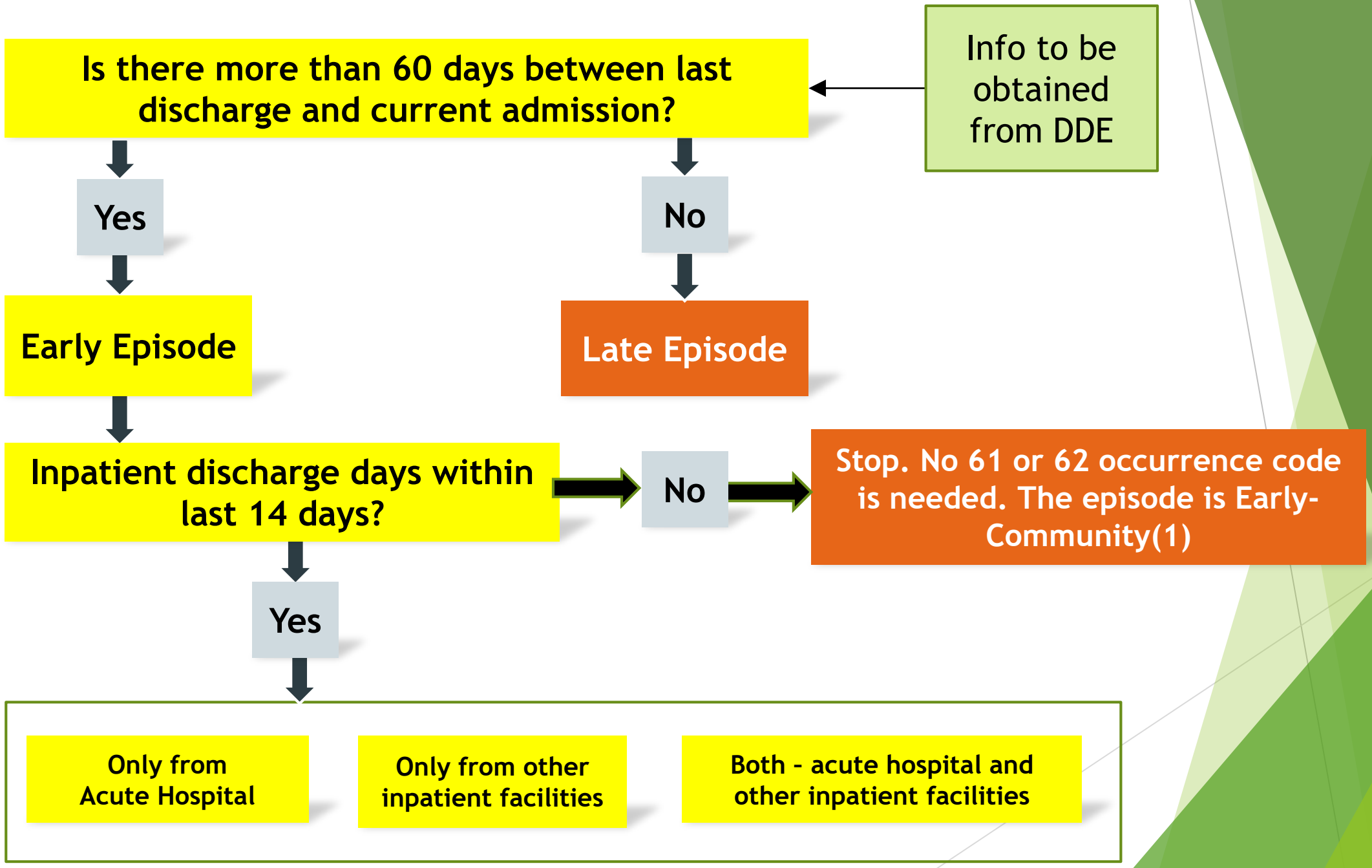
- Admitted to HHA as MSP: 03/01/2020
- MSP claim for period 1: 03/01/2020 – 03/30/2020
- Payer changes to Medicare Primary: 03/31/2020
- Medicare primary claim, period 2:03/31/2020 – 04/29/2020
- MSP periods are counted to determine Early or Late 03/01 period uses “Early” HIPPS code when calculating MSP payment
- 03/31 period uses “Late” HIPPS code when calculating Medicare primary payment

Episode Timing

However, period of timing under Medicare Advance Program (Part C) does **NOT** count towards determining Early or Late episode.

For example:

- Admitted to HHA as MA: 03/01/2020
- MA claim for period 1: 03/01/2020 – 03/31/2020
- Payer changes to Medicare Primary: 04/01/2020
- Medicare primary claim, period 2: 04/01/2020 – 04/30/2020
- HHA should use the 04/01 period as “Early” HIPPS code when calculating Medicare primary payment


Is there more than 60 days between last discharge and current admission?
Info to be obtained from DDE
Yes
No
Early Episode
Late Episode
Inpatient discharge days within last 14 days?
No
Stop. No 61 or 62 occurrence code is needed. The episode is Early-Community(1)
Yes
Only from Acute Hospital
Only from other inpatient facilities
Both - acute hospital and other inpatient facilities

Admission Source Scenario

Example 1: Admission to HHA after two inpatient stays

The beneficiary:

- Has inpatient hospital stay: 02/01/2020 – 02/04/2020
- Has SNF stay: 02/05/2020 – 02/12/2020
- Is admitted to HH period of care: 02/14/2020

- Report occurrence code 62, both discharges are within 14 days of the HH admission date, but the SNF is most recent institutional discharge
- 02/14 period is grouped as Early/Institutional
- HIPPS code starts with 2

Admission Source Scenario

Example 2: Resumption of HH after Inpatient Stays.

The beneficiary:

- Is admitted to HH: 01/15/2020
- Has inpatient hospital stay: 02/01/2020 – 02/04/2020
- Has SNF stay: 02/05/2020 – 02/10/2020
- Is admitted to HH period of care: 02/14/2020

- Report occurrence code 61, hospital stay is within 14 days of 2nd period
- SNF is most recent institutional discharge**, but occurrence code 62 is only** reported on **admission** claims.
- 02/14 period is grouped as Late/Institutional
- HIPPS code starts with 4

Admission Source Scenario

Example 3: Discharge and readmission with other institutional stay

The beneficiary:

- Is discharged from HH: 03/20/2020
- Is discharged from IPF: 03/27/2020
- Is admitted to HH period of care: 03/31/2020

- The readmission is a Late period since no 60 day gap in services between last discharge and this admission occurred. Occurrence code 62 should be reported on this Late period of care.
- The 3/31 period of care is an admission episode("From" and "Admission" dates will match), so reporting other institutional discharge dates applies
- The 3/31 period will be grouped as Late/Institutional
- HIPPS code starts with 4

Admission Source Scenario

Example 4: Other institutional stay during period

The beneficiary:

- Is admitted to HH period of care: 03/20/2020
- Has an IRF stay: 03/27/2020 – 04/09/202
- Resumes care at HH: 04/10/2020
- Re-cert episode begins 04/19/2020

- Even though there is an inpatient stay within last 14 days of re-cert episode, occurrence code 62 does not apply to the 04/19 period, because it is not an Admission or start of care episode.
- The 04/19 period would be grouped as Late/Community
- HIPPS code starts with 3

Admission Source Scenario

Example 5: Admission after observation stay.

The beneficiary:

- Is under observation in a hospital: 02/01/2020 - 02/03/2020
- Is admitted to HH for episode of care: 02/04/2020

- Occurrence code 61 does not apply, since the patient was not admitted to the inpatient hospital
- 02/04 episode pf care is grouped as Early/Community
- HIPPS code starts with 1

CMS Data Sources for Claim Processing

- As mentioned earlier, HHAs do not need to calculate the HIPPS code. They need to submit claims with any valid HIPPS code, not necessarily correct HIPPS code. ***Medicare Grouper software will calculate the HIPPS code and process the claims accordingly***:
- There are three sources from where Medicare Grouper software will pick data and calculate the HIPPS code. Its important to understand the sources so correct information is submitted to Medicare by the HHAs.
- The following table (next page) summarizes these sources

CMS Data Sources for Claim Processing

HIPPS code Data position	Description	OASIS submitted	Medicare Claims History	HHA claims (UB 04)	Remarks
1	Timing	M0110	Yes	No	If data exists, Medicare claims history record will supersede OASIS submitted data.
1	Admission Source	M1000 & M1005	Yes	No	If data exists, Medicare claims history record will supersede OASIS submitted data
2	Clinical Grouping	M1021 (Primary Diagnosis)	No	Yes	
3	Functional Impairment	M1800 to M1860, & M1033	No	No	
4	Comorbidity factor	No	No	Yes	From the list of secondary diagnosis on UB04

Other Factors

- For episodes started before 01/01/2020 but ended after 01/01/2020, old standardized 60-day episode payment will apply with rates updated for 2020.
- For episodes started after 01/01/2020, new standardized 30-day episode payment will apply with 2020 rates.
- If an episode begins on 01/02/2020, and recertification OASIS is done on 12/31/2020, M0090 (OASIS completion date) should be reported as 01/01/2020, per one-time OASIS D-1 instructions.
- HIPPS code on RAP and EOE claims do not have to match under PDGM.

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