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PATIENT-DRIVEN GROUPINGS MODEL
WHAT WE'VE LEARNED & WHAT'S TO COME

PDGM
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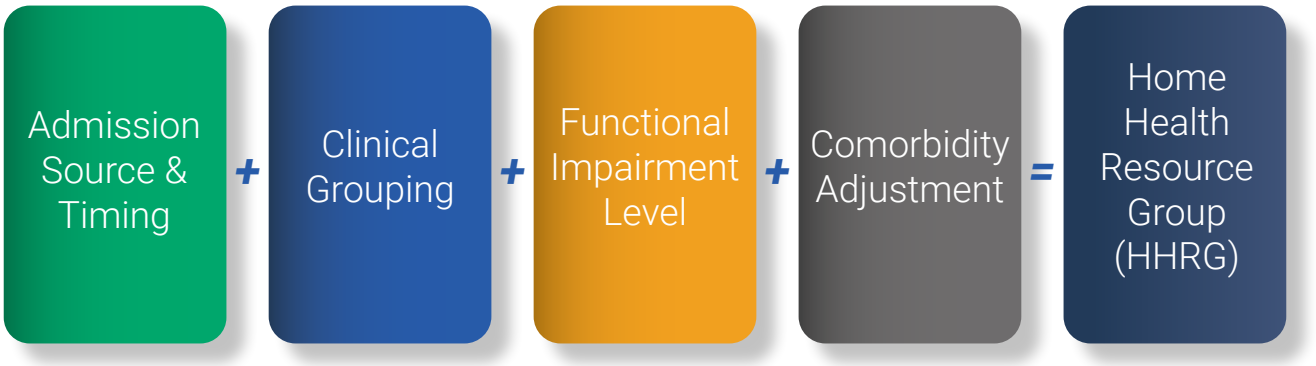
The Patient-Driven Groupings Model, or PDGM, went into effect January 1, 2020. It included several changes to how home health agencies were paid under PPS. CMS says that PDGM "removes the current incentive to overprovide therapy, and instead, is designed to focus more heavily on clinical characteristics and other patient information to better align Medicare payments with patients' care needs."

Home Health Billing Changes Under PDGM

Major changes to home health billing included:

- The elimination of therapy volume as a payment determinant.
- Cutting payment periods in half, from 60-day episodes to 30-day periods of care.
- Categorization of 30-day periods into a payment category or Home Health Resource Group (HHRG) based on 432 case-mix groups that are determined by a combination of admission source and timing, clinical grouping, functional impairment level, and comorbidity adjustment.
- New LUPA (Low Utilization Payment Adjustment) thresholds that vary by HHRG, based on the 30-day period of care.



LOOKING BACK

LESSONS LEARNED

While it's too soon to know the true impact PDGM will have on home health agencies, there are several insights that can be gained during these first severl months post-implementation.

Many agencies were prepared.

Let's start with the good news. There were a lot of home health agencies that were well prepared for PDGM. Agencies that developed (and are continuing to follow) a solid PDGM strategy are experiencing fewer problems than agencies who did not. They are learning to address any issues as they occur and are adapting quickly.

Documentation is key.

From the very beginning, revenue cycle management experts have been touting the value of patient-centered documentation under PDGM. Post implementation, documentation has proven to be of major importance. Agencies that document with the right amount of specificity, appropriately answer all OASIS questions, accurately document primary and secondary diagnoses, and ensure that the OASIS and other assessment items are consistent and coordinated are successful. Those that do all of this in a timely manner are even more successful.

Avoid using unacceptable dignoses codes.

Under PDGM, there are several primary diagnoses codes that don't fall into one of the 12 clinical groupings used for payment determination. These have been deemed unacceptable diagnoses. CMS states that these are too vague and they don't provide enough information to support the need for home health services. Claims that have unacceptable primary diagnoses will be "returned to provider" (RTP) because CMS cannot assign the 30-day period to a clinical group for payment.

Home health agencies who had a lot of unacceptable codes in the past must be sure they're not using them under PDGM. Take a close look at claims and be sure that unacceptable diagnoses aren't being used. The most common codes include symptom codes and unspecified codes. Continue to train intake staff on collecting more specific information up front and consider providing a checklist to make data collection easier and more accurate.

Examine your therapy strategy.

Under PDGM, therapy volume is no longer a reimbursement determinant. For many agencies that have relied on a therapy-driven care model, there could be a decline in revenue. A recent study by Home Health Care News stated that 52% of home health providers see PDGM forcing a decrease in therapy utilization.

While PDGM attempts to address over-utilization of therapy, it's important that you don't drastically reduce or even cut therapy out altogether. If that happens, you could raise a red flag to CMS. The best thing to do is to examine your therapy strategy, taking a restrained approach to possible reductions. Remember that you're still being reimbursed for therapy services and you can't decline therapy when it's in the plan of care.

Ongoing education is critical.

You've likely spent a good amount of time training your staff to be ready for PDGM. But the training can't stop now. CMS will continue to update, refine, and provide education about PDGM. Just because we're past the "go live" date, it doesn't mean that the hard work is over. Now is not the time to let your guard down.

Take a close look at how your intake, clinical, coding, and billing teams are doing. Is everyone successfully managing their part? Do you see instances where help is needed? Encourage multi-disciplinary communication. Spend time talking about your patients, including the care that is being provided and how that care is being documented, coded, and billed.

If your staff is struggling, look to establishing vendor partnerships that can help alleviate some of the burden. One type of vendor to consider is a third-party coding and billing company like HealthRev Partners. It will have the skill, expertise, and bandwidth available to ensure accurate and timely submission of claims, so you're paid everything you're owed under PDGM.

LOOKING AHEAD

THE FUTURE OF HOME HEALTH

While it's too soon to know the true impact PDGM will have on home health agencies, there are several insights that can be gained during these first few months of implementation.

There will be more mergers and acquisitions.

As home health agencies start to feel the impact of PDGM on their cash flow, it's inevitable that many will be looking to consolidate with competitors, or even sell their businesses. Providers who have successfully navigated PDGM and are seeing positive returns from the updated payment model will actively seek agencies who were not as prepared for PDGM and are suffering from its effects.

Referral and intake processes need optimization refinement.

While having the right referral sources has always been important to home health, it's even more critical under PDGM. Successful agencies should diversify their referral sources to ensure the right mix of community and institutional referrals.

The number of RCM partnerships will increase.

PDGM requires an abundance of knowledge, time, effort, and staff. Many home health agencies are taking a "wait and see" stance when it comes to coding and billing. They're managing their revenue cycle internally to find out if it's something they can handle. However, as they begin to cycle through reimbursements, many will seek out third party partners to supplement their efforts.

Revenue cycle management organizations like HealthRev Partners can relieve some of the administrative burden of PDGM through expert coding, billing, and billing recovery services. Since revenue cycle management is all we do, we're able to focus solely on maximizing reimbursements and getting you what you're owed.

Agencies will get "back to the basics."

The goal of PDGM is to shift from a volume-focused billing model to one that rewards quality and value for the patient. As agencies continue to work through this new model, they'll be taking a closer look at the mission of home care – to provide high-quality, thoughtful, and appropriate care that ensures the best possible patient outcomes. Many will find that to do so, they'll need to get back to the basics and focus on providing good old-fashioned patient care.

INSPIRING POSSIBILITIES

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HealthRev Partners **inspires possibilities** for home health and hospice agencies across the nation through high quality, personalized revenue cycle management services and consulting enabled by the latest technology. Our innovative, scalable solutions accelerate cash flow, spark continuous growth and reinvestment, and provide peace of mind, allowing you to focus on advancing your mission to provide exceptional care and touch more lives.

To learn more about how we can help you succeed under PDGM, contact us today at 866.774.8943 or connect@healthrevpartners.com.

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