

# Patient-Driven Groupings Model

## Frequently Asked Questions

### The Basics of PDGM Questions:

#### **1. What is the timing for Institutional versus Community?**

To receive the higher reimbursement for being an “Institutional” referral, the patient must have been discharged from a facility in the 14 days preceding an admission, or from an acute hospital in the 14 days preceding subsequent 30-day payment periods. This will be determined by claim information compiled by CMS.

Due to Axxess’ direct connection to the Medicare Common Working File, agencies can view claims data at Intake when eligibility is verified to determine if a patient is institutional or community.

#### **2. What types of facilities are considered as “Institutional” referrals?**

For the purposes of the initial home health admission, the qualifying facilities include inpatient acute care hospitals, inpatient psychiatric facilities (IPF), skilled nursing facilities (SNF), inpatient rehabilitation facilities (IRF), or long-term care hospital (LTCH). The referral source is determined by claim information rather than an OASIS response.

For the purposes of determining institutional vs. community referral source, when a patient is being resumed to care by a home health agency following transfer to a facility, only those with an inpatient acute care hospital stay in the preceding 14 days will qualify as institutional.

#### **3. Can you speak to some examples of “Institutional/Late”? For example, how would it be classified if a patient went from the hospital to a SNF, then to the home health agency?**

In this scenario, the key piece of information would be the length of stay at the SNF. For this to be classified as an institutional referral, the agency would need to complete the ROC within 14 days from the time that the patient was an inpatient at the acute care hospital. If more than 14 days lapse, it would become a community referral.

As we shared in the previous response, following a transfer and hospitalization the only facility considered as an institution is the acute care hospital.

Additionally, in this scenario CMS has stated that agencies should discharge patients who are transferred to facilities other than acute care hospitals when the patient is not expected to return home with a home health referral. From the October 2019 OASIS Quarterly Q&As: “In the event that a patient had a qualifying hospital admission and was expected to return to your agency, you would complete RFA 6 – Transferred to an inpatient facility – not discharged from agency. If the patient was not expected to return to your agency after this inpatient facility stay, you would complete RFA 7- Transfer to an inpatient facility- patient discharged from agency.

However, if the patient required post-acute care in a SNF, IRF, LTCH or IPF prior to returning for home health services, CMS expects the home health agency to discharge the patient by completing the internal agency discharge paperwork and then to readmit the patient with a new Start of Care. This will allow appropriate admission status assignment for PDGM. There is no need to update or change the transfer OASIS to reflect this discharge.

If a home health patient is admitted directly to a SNF, IRF, LTCH or IPF for a qualifying stay (stays as an inpatient for 24 hours or longer for reasons other than diagnostic testing), you would complete RFA 7 – Transfer to an inpatient facility – patient discharged from agency, then readmit the patient with a new Start of Care if they were referred for further home health services.

**4. What would the second 30 days be considered for episode timing and referral source if the patient comes from a hospital in the prior 14 days?**

This would be an example of “Institutional Late.” The “Institutional” component comes from the fact that the patient was discharged from the hospital in the preceding 14 days, and it would be “Late” because it is not the first 30-day billing period.

**5. Is there a difference in payment if a patient falls into a Community versus Institutional category?**

Yes. Patients categorized as “Community” referrals (meaning they were not discharged from an institution in the 14 days prior to the billing period), are reimbursed at a lower rate than those classified as “Institutional” referrals.

Axxess customers can easily see reimbursement for both 30-day periods by using the PDGM Analysis tool. In addition to showing reimbursement this tool will display LUPA thresholds for each of the 30-day billing periods.

PPS (Ends December 31, 2019)		PDGM (Effective January 1, 2020)		
\$2,277.81		\$3,838.14		
Episode Information (60 Days)			First 30 Days	Second 30 Days
Case-Mix Weight	0.7298	Case-Mix Weight	1.1759	1.0367
Timing	Early Episode	Timing	Early	Late
Clinical	High	Clinical Grouping	MMTA Other	MMTA Other
Functional	Moderate	Functional Level	Low	Low
Therapy Visits	N/A	Admission Source	Institutional	Institutional
HHRG	C3F2S1	Comorbidity Adjustment	None	None
HIPPS	1CGKW	HIPPS	2AA11	4AA11
		LUPA Threshold	3	3
		Payment Amount	\$2,039.80	\$1,798.34

**6. Is Early or Late specific to my agency or does that include care provided by other agencies?**

If a home health claim from the same or another HHA is found within the 60 days before the “from” date of the payment period, the Medicare payment system will automatically regroup the claim as “late.”

**7. Please talk about reimbursement if a patient is seen by one agency and discharged prior to day 30, but 10 days later (in the second 30-day period) the patient is re-opened by a different agency.**

If a home health claim from the same or another HHA is found within the 60 days before the “from” date of the payment period, the Medicare payment system will automatically regroup the claim as “late.”

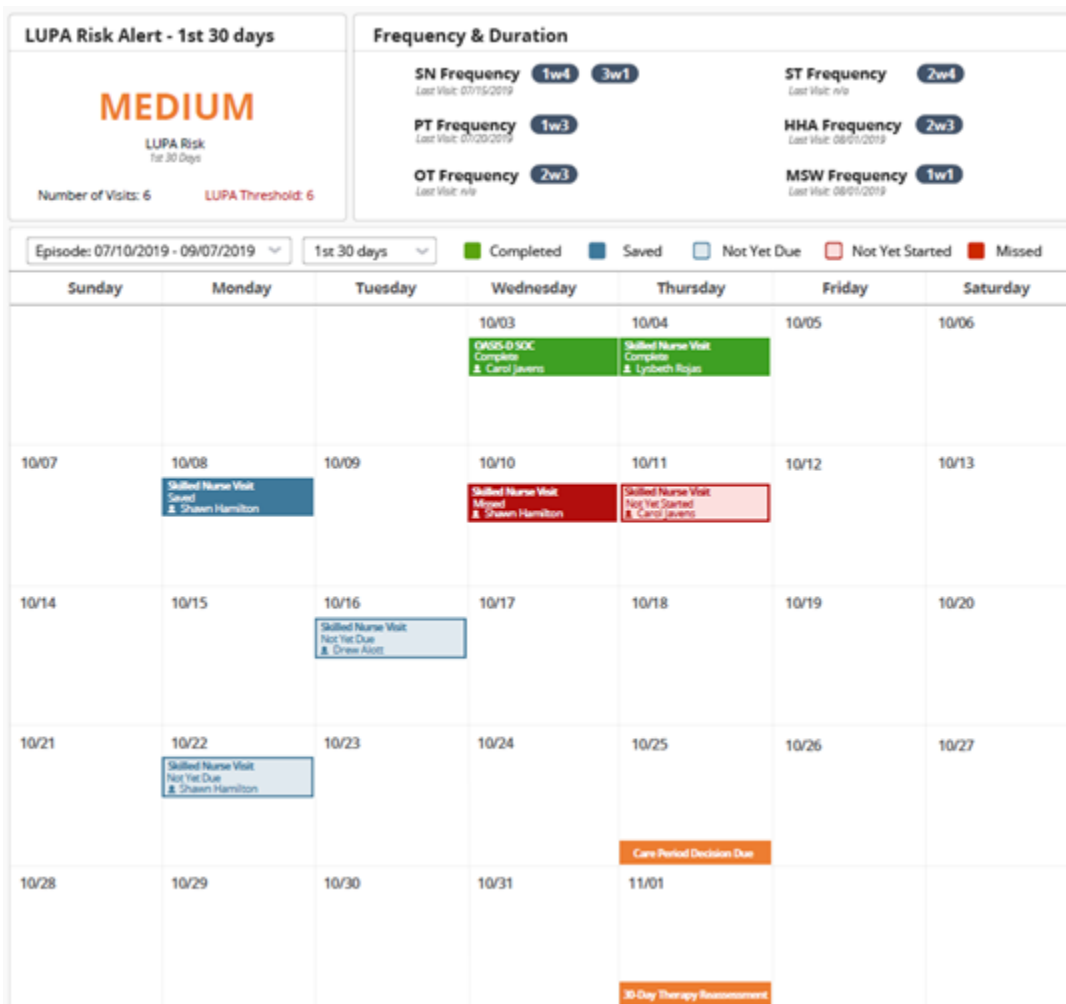
**8. When you refer to the LUPA threshold ranging from 2 to 6 for a payment period, is that the number of visits that we need for full payment or is one greater than that number?**

Providing the number of visits indicated will generate full payment for the 30-day period. Payment periods barely meeting the LUPA threshold are often targeted for review such as ADRs; therefore, agencies should be confident that the care provided was skilled, reasonable and necessary, and that documentation is audit-proof.

**9. Is the LUPA threshold always 6 visits for Early payment periods and 2 for Late payment periods?**

No, the LUPA threshold ranges between 2 and 6, and is assigned based on the Home Health Resource Grouping per payment period. When completing a SOC, ROC, or Recertification OASIS assessment, our Home Health software will show the LUPA threshold. Often the LUPA threshold will range from 2 to 4, only 8% of the 432 possible HIPPS codes have a LUPA threshold of 5 or 6.

Axxess makes it easy to determine LUPA threshold with the use of the PDGM Analysis tool. The 30-day calendar view will assist agencies in preventing avoidable LUPAS by providing a good visualization of the end of episodes and LUPA alerts.



**10. Does the LUPA threshold visit count include all disciplines, including home health aide and social work visits?**

Yes. Just as is the case under PPS, billable visits made by Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Workers, and Home Health Aides all count toward the LUPA threshold.

**11. Can we use Questionable Encounter diagnoses as secondary diagnosis codes?**

Ungroupable Diagnoses, also known as Questionable Encounter Codes, are allowed to be used as secondary diagnoses when appropriate and necessary, according to ICD-10-CM Official Guidelines and Conventions. However, ungroupable primary diagnosis codes used in secondary diagnosis will not contribute to comorbidity adjustments.

**12. Where can I find resource materials available for ICD-10 codes that will lead to Questionable Encounters and those that can be assigned to Clinical Groups?**

CMS published final ICD-10-CM diagnosis codes grouper lists with the 2020 Home Health Payment Final Rule. Axxess has a wealth of resources available, including [a list of questionable encounter codes available to download](#). These, as well as additional PDGM resources, can be accessed at: [www.axxess.com/pdgm](http://www.axxess.com/pdgm).

**13. Does sequencing of comorbidities determine payment?**

No, the order of the comorbid diagnosis (also called secondary diagnoses) will not affect payment since the entire claim is scrubbed for contributing diagnoses; however, specific comorbidity diagnoses (i.e. codes from certain paired comorbidity categories as outlined by CMS) must occur to create a high comorbidity adjustment.

**14. If I have multiple comorbidity diagnoses on my claim, will I receive the high comorbidity adjustment?**

Not necessarily. Any single diagnosis from the comorbidity categories will generate the low comorbidity adjustment. However, in order to receive the high comorbidity adjustment there must be secondary diagnoses from categories that have been paired together. An example of this would be having a code from the Behavioral 2 subgroup (such as; F31.9 Bipolar disorder, unspecified) along with a diagnosis from the Skin 3 subgroup (such as; I70.233 Atherosclerosis of native arteries of right leg with ulcerations of ankle). These high-comorbidity adjustment pairings represent higher resource utilization based on certain pathophysiologic comorbidities.

**15. Does a ROC on or after January 1, 2020, generate the PDGM changes in payment?**

This depends on the 60-day episode dates (from and to dates). If the ROC occurs January 1, 2020, or after for episodes that start before January 1, 2020, the payment will continue to be paid under home health prospective payment system, and therefore would not impact/adjust payment. In this scenario, PDGM payment would begin at the next episode that begins after January 1, 2020 and would be based on the recertification OASIS or ROC acting as a recert in the 5-day recert window.

However, if the ROC is completed January 1, 2020, or after for episodes beginning January 1 or after, then the ROC may be used to update the functional score for the subsequent 30-day billing period.

**16. How do you manage recerts in the last week of 2019?**

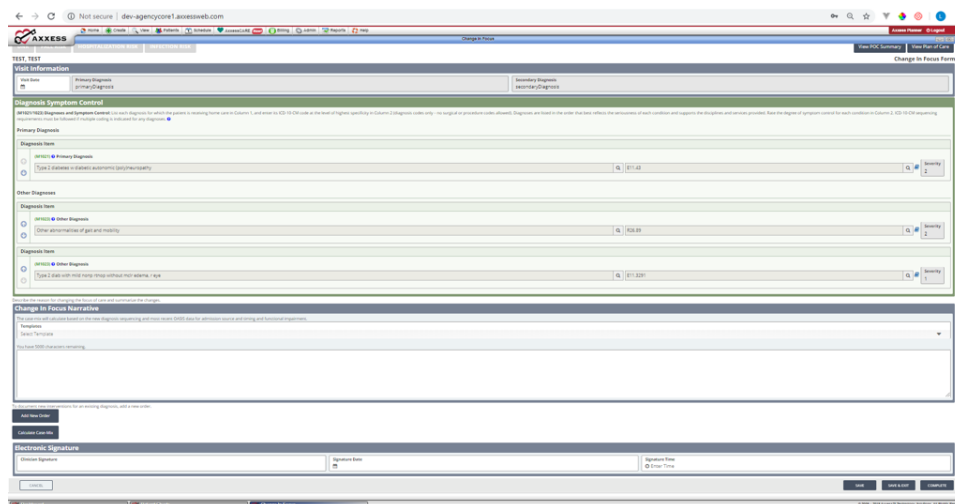
OASIS Recertifications completed in the final five days of 2019, for episodes where the first day of the new certification period is January 1, 2020, or later will be done using the OASIS D-1 format and will need to be completed with an artificial completion date (M0090) of 1/1/2020. These assessments will also need to be submitted to QIES on or after January 1, 2020, rather than in the final five days of December.

OASIS Recertifications completed in the final five days of 2019 for episodes where the new certification period begins prior to January 1, 2020, will continue to be paid under PPS, therefore an OASIS D assessment will be used along with the actual completion date stated in M0090.

**17. On the thirtieth day, is there an assessment /re-assessment necessary to continue into the second 30-day billing period.**

No additional OASIS assessments are required. It would be good agency practice to re-assess the patient and visit plan for the subsequent payment period, but it is not a requirement.

If there is a change in the focus of care (primary diagnosis), Axxess clients would use the Change in Focus Form, which will streamline clinical operations and improve compliance by updating the Care Plan and orders, if needed, through one location. In addition, the new primary diagnosis will flow seamlessly to the billing claim form to ensure maximum reimbursement.



**18. Is the 30-day therapy requalifying evaluation still required?**

Yes. PDGM changes are only impacting billing; all other CMS requirements are unchanged, including the requirements for 30-day therapy re-evaluations.

**19. Do therapists need to continue with reassessments on the 13<sup>th</sup> and 19<sup>th</sup> visit?**

No. The CMS requirements for therapy supervisory visits prior to the 13<sup>th</sup> and 19<sup>th</sup> visit was removed some time ago. The current requirement mandates therapy requalifying visits every 30 days or less while the patient is receiving therapy. The purpose of these visits is to ensure the patient continues to have a skilled need, and the goals and interventions for care remain appropriate. Each therapy discipline involved must perform these 30-day supervisory visits.

**20. How will payment be affected within the PDGM structure to cover cost of wound supplies, which can be costly?**

Due to the high costs associated with caring for wound patients, there is additional reimbursement attributed to the Wound Clinical grouping, as well as to the comorbidity adjustments associated with Skin diagnoses. There will no longer be a separate NRS (non-routine supply) reimbursement. Supply costs will still be reported on the CMS mandated Medicare Cost Report which will be used to determine future rates.

**21. Please explain the 20% RAP.**

For 2020, the RAP will no longer be paid at 60% for a SOC or 50% for subsequent episodes, but rather at 20% of the amount anticipated for the 30-day payment period. RAP submission will still be required, but there will be no RAP payment beginning in 2021.

**22. Is the national standardized patient rate based off individual agency cost reports for 2019 fiscal year? How often is it reviewed?**

The national standardized payment rate is updated annually and is based on figures determined by the federal government based on market baskets. These actuarial numbers are built from many data sources, including Medicare Cost Reports. Although these baskets are not usually updated annually, in most cases an annual forecast error would be applied as deemed necessary to increase or decrease expected rises in the costs of services. National per-visit discipline rates, used for calculation of LUPA payments, are historically updated using data from the Department of Labor. However, CMS has stated that Medicare Cost Report data will be used to calculate these visit costs in the future.

**23. Will hospice care be affected by PDGM?**

No, PDGM is strictly a revamping of the payment system for home health care.

**24. Is telehealth considered a visit?**

No, telehealth is not considered a visit and does not count toward the LUPA threshold.

**25. Can therapy visits extend beyond the first 30-day payment period (e.g. 3W5)?**

Yes, therapy visits can extend beyond the first 30-day payment period. Coverage for skilled, reasonably necessary care has not changed under the PDGM payment system.



### **Regulatory Questions:**

#### **1. What is the Notice of Admission?**

A one-time notice of admission (NOA) would be filed by all home health agencies beginning in 2022 to alert the claims processing system that a beneficiary is under a home health episode of care. This will replace the RAP, which is being phased out (paid at 20% for 2020) and is intended to prevent multiple agencies providing services.

Axxess has streamlined this process and will improve agency compliance with the 2019 Final Rule through the use of the No Pay RAP option, which is already in the home health software. In addition, the No Pay RAP accommodates agencies who were certified in 2019 or later and will not receive RAP payments in 2020.

#### **2. Is the penalty for RAPs not submitted within five days going into place in 2020, or just for the NOA not being submitted within five days in 2021?**

For 2020, agencies who are newly certified in 2019 will submit RAPs but will receive no payment. Agencies who were certified prior to 2019 will submit RAPs and will receive 20% of the 30-day period payment. In 2021, all agencies will submit RAPs but will receive 0% payment for these RAPs.

There will be a non-timely submission reduction in payment amount tied to late RAP submission in 2021. This penalty will be assessed when the RAP is not submitted within five calendar days from the start of care or within five calendar days of day 31 of subsequent payment periods. This penalty will be a reduction equal to 1/30<sup>th</sup> of the 30-day period amount for each day from the Start of Care until the no-pay RAP is submitted.

Lastly, in 2022, CMS will completely phase out RAPs and will instead implement a Notice of Admission (NOA) which must be filed within five days of admission. Penalties will also be assessed if the NOA is filed later than 5 days after the SOC.

#### **3. Is Notice of Admission scheduled to begin in 2020 or 2021? What is it and how is it done?**

As part of the RAP phase-out plan, the Notice of Admission (NOA) is scheduled for implementation in 2022 and will establish the beneficiary's agency of record, which is currently established by the filing of a RAP by the home health agency.

**4. How long will agencies have to file an NOA (Notice of Admission) when this is implemented? What will happen if it is late?**

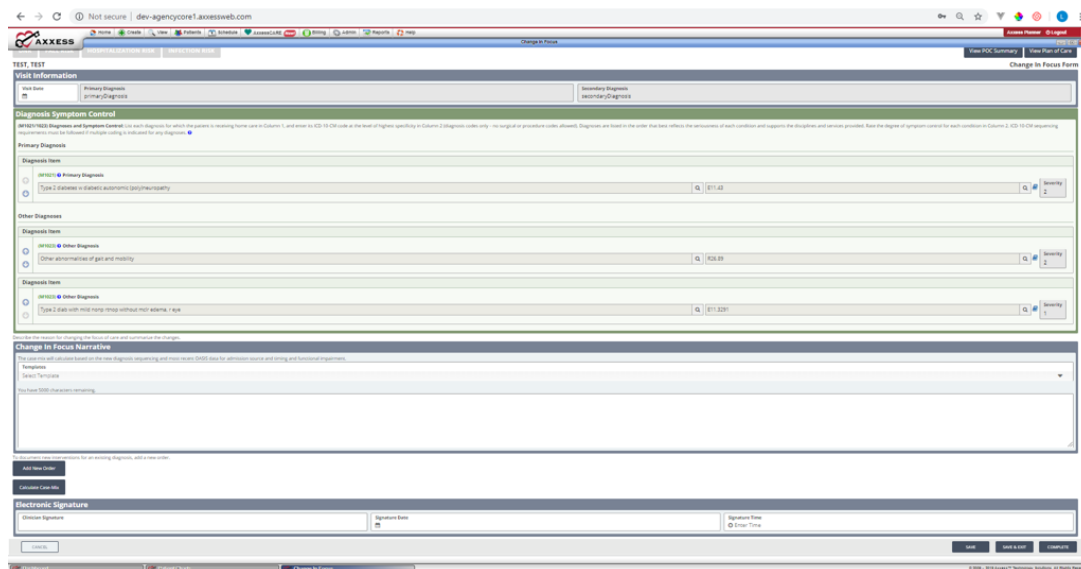
Beginning in 2022, filing of the NOA will be required within five days of admission. If the NOA is filed after this required time, the agency will be penalized an amount equivalent to 1/30<sup>th</sup> of the 30-day payment per each day it was late. For example, if the NOA is not filed until day 7, the agency will not receive payment for the first 6 days.

**5. How do you manage recerts?**

Recertification of 60-day OASIS episodes will not change under PDGM. PDGM is a change in the payment system, but OASIS and Conditions of Participation are not affected. Recertifications will stay on the same 60-day cycles while pay periods change to 30-day periods.

Should there be a change in the patient's focus of care between the first 30-day period and the second 30-day payment period, and no ROC or SCIC OASIS Assessment was required, the agency should have processes in place to communicate this change to the billing department and to update the coding on the claim for accurate reimbursement.

A change of Focus Form is available in the Axxess software to streamline this process and grow revenue. This form is used when the focus of care primary diagnosis changes from the first 30 days to the second 30 days. The new/changed diagnoses will automatically flow to the billing claim form. Although the 60-day OASIS remain the same it is strongly recommended that agencies use this form if they change diagnoses after a 30-day billing period not associated with a SCIC or Recert.

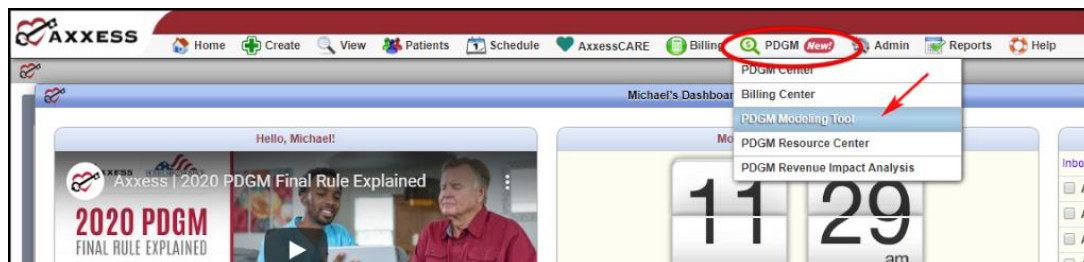


## 6. Do you have resource files where we can review the 432 groups?

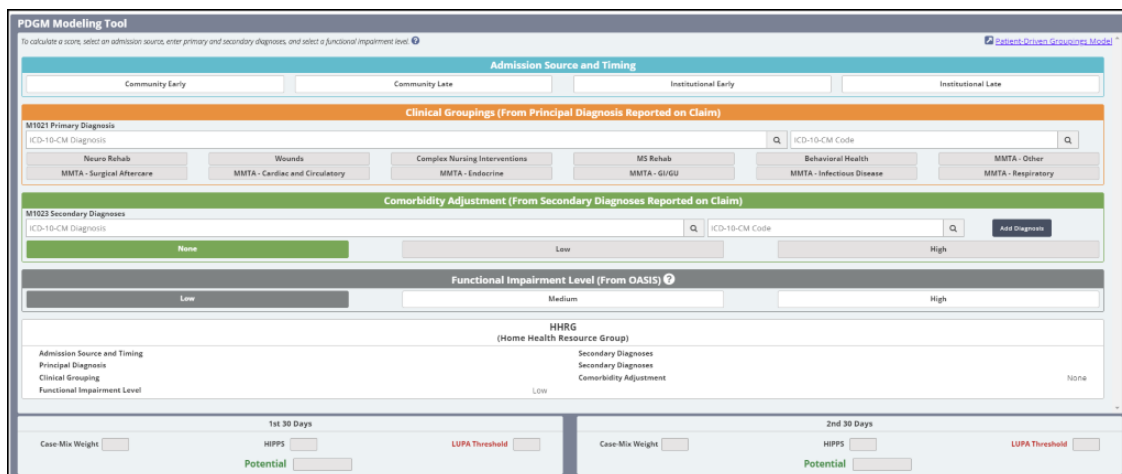
CMS has information available for PDGM at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html>

Axxess' home health software provides a PDGM modeling tool which allows you to envision the PDGM impact for specific scenarios. From your dashboard, select PDGM, then PDGM Modeling Tool.



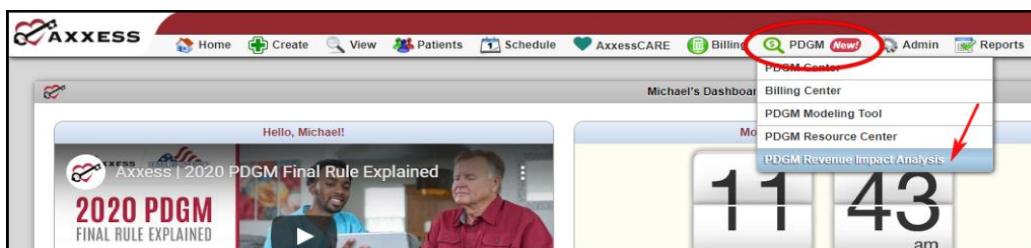
This will lead you to the Modeling Tool, which allows you to input your information to model which of the 432 groups the patient would be assigned to, as well as the case-mix weight and LUPA thresholds.



Axxess also has a wealth of additional PDGM resources that can be accessed at: [www.axxess.com/pdgm](http://www.axxess.com/pdgm).

## 7. Can you provide directions to the PDGM Impact Study?

The PDGM Revenue Impact Analysis tool is available to agencies using Axxess' home health software. From your Dashboard, select PDGM, then PDGM Revenue Impact Analysis.



The resulting analysis will use your historical OASIS and visit information to display the impact that PDGM would have on your agency if no changes are made. This can be set to study the past 3 calendar years.

**PDGM Revenue Impact Analysis**

Branch: Location 2 Year: 2019 Last Updated on 1st November, 2019

Payer: Medicare Includes expected payment amount for episodes ending within the selected time period.

PDGM Impact Summary	Number of Affected Episodes	Percent of PPS Episodes	PPS Billed Revenue	Percent of PPS Revenue	PDGM Projected Revenue	Gain/Loss	Percent of Change in Revenue
Questionable Encounter Code (Non-Reimbursable Under PDGM)	10	6.8%	\$15,037	5.4%	\$0	(\$15,037)	-100.0%
Full Episode Pay for DC in 30 Days	8	5.4%	\$13,902	5.0%	\$13,344	(\$558)	-4.0%
Episode Includes 30-Day LUPA Rule	23	15.0%	\$17,176	6.2%	\$19,969	\$2,793	16.3%
Full Pay for 60 Days	103	70.1%	\$226,310	82.0%	\$277,060	\$50,750	22.4%
<b>Total</b>	<b>144</b>	<b>100.0%</b>	<b>\$272,425</b>	<b>100.0%</b>	<b>\$310,403</b>	<b>\$37,978</b>	<b>13.9%</b>

PDGM Clinical Groupings	Number of Diagnoses	PPS Billed Revenue	Percent of PPS Revenue	PDGM Projected Revenue	Gain/Loss	Percent Change
Neuro/Stroke Rehabilitation	4	\$8,129	2.9%	\$11,966	\$3,837	47.2%
Musculoskeletal Rehabilitation	2	\$847	0.3%	\$1,126	\$279	33.0%
Wounds - Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	3	\$3,671	1.3%	\$5,441	\$1,770	48.2%
Complex Nursing Interventions	0	\$0	0.0%	\$0	\$0	0.0%
Behavioral Health Care	0	\$0	0.0%	\$0	\$0	0.0%
Medical Management, Teaching, and Assessment - Cardiac	61	\$116,530	42.8%	\$144,109	\$27,579	23.7%
Medical Management, Teaching, and Assessment - Endo	7	\$12,506	4.6%	\$18,515	\$6,010	48.1%
Medical Management, Teaching, and Assessment - GI/GU	0	\$0	0.0%	\$0	\$0	0.0%

CMS produced a much less specific analysis of how agencies would be impacted by PDGM. That data can be accessed here:

<https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html>. It can also be found on the Axxess PDGM Resource Page: [www.axxess.com/pdgm](http://www.axxess.com/pdgm)

#### 8. Can you provide a link to show diagnoses and corresponding thresholds?

30-day payment period LUPA levels are determined by the combined HHRG score, including referral source and timing, clinical grouping, functional deficit, and co-morbidity adjustment, rather than diagnosis. A zip file of the LUPA thresholds for the 432 distinct HHRG scores can be downloaded here:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html>

#### 9. Can you provide a link to the Questionable Encounter Codes?

CMS has information available for PDGM at

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html>.

Axxess also has a wealth of resources, including a list of the most commonly used Questionable Encounter Codes, as well as the list of all of the Questionable Encounter Codes. These resources can be accessed for download from:

[www.axxess.com/pdgm](http://www.axxess.com/pdgm).

Additionally, starting at the point of Intake and continued throughout Axxess' home health software, the attempted use of a primary diagnosis code that would result in a Questionable Encounter will trigger an alert.

Patient Diagnosis

(M1021) Primary Diagnosis\*

Questionable Encounter Code Entered

This diagnosis is a questionable encounter code and will not calculate a grouper payment under PDGM. Contact the physician to obtain a more definitive primary diagnosis that is payable under PDGM.

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**10. Is the tool for PDGM in the home health software a reliable resource to determine a patient's LUPA threshold for each billing period?**

Yes. The tools within Axxess' home health software are accurate and up-to-date with Final Rule modifications.

**11. How are we going to satisfy PDGM and RCD/PCR when a face-to-face encounter states a diagnosis such as muscle weakness?**

In CMS' home health final rule, it is stated that, "The Home Health Agency should query the certifying physician who is responsible for establishing the home health plan of care." CMS went on to state that in regard to symptom codes that are excluded from the PDGM groupers, "We believe that by the time the individual is admitted to home health, the patient has been seen by other health care providers and a diagnosis has been established."

Again, CMS recommends querying the physician or provider for the underlying medical diagnosis causing the symptoms so that the plan of care and treatment is specific to that disease process.

**12. Do we get paid for telehealth visits?**

Medicare currently does not reimburse for telehealth visits. The cost of telehealth or telemonitoring is an allowed reportable cost for the Medicare Cost Report. In some states, such as Texas, Medicaid does provide reimbursement

**13. Is there a timeframe for how early a ROC or SCIC can be done in the 30-day episode to capture Clinical and Functional changes?**

CMS will use the OASIS with the latest M0090 date in the prior billing period to calculate the functional level for the next 30-day period, whether that is a SOC, ROC or SCIC. Clinical category changes (i.e. the primary and secondary diagnoses) will come from claims data submitted by the agency. Therefore, the OASIS should be exported before the final bill is sent for processing so that the functional score can be calculated from the most recent OASIS Assessment. Agencies should have processes in place to notify the billing department when coding changes need to take place on the second 30-day billing claim. In Axxess, the agency can use the “Change in Focus” form to update diagnoses and this updated information will then flow to the claim.

**14. Is EVV part of PDGM? Is EVV currently required for Medicare patients?**

EVV is not part of PDGM. It is not currently required for Medicare patients.

**15. Is recertifying patients for multiple 60-day episodes a red flag under PDGM?**

The Medicare requirements for home health benefit eligibility have not changed under PDGM, (which is a change to the payment system). There is no limit on the number of episodes of care if the patient meets eligibility requirements for ‘confined to home’ and ‘reasonable and necessary skilled services’ are met, per the Medicare Benefit Policy Manual, Publication 100-2, Chapter 7.

**16. What are the recommendations regarding RCD?**

Review Choice Demonstration (RCD) for Home Health Services will give providers in the demonstration states an *initial choice of three options*:

- Pre-Claim Review (PCR)
- Post-Payment Review
- Minimal Post-Payment Review with a 25 percent payment reduction for all home health services

Once the home health agency’s full affirmation rate or claim approval rate is 90% or greater for a minimum of 10 claims or requests for the 6-month period, they may choose one of the subsequent review options:

- Start or continue participating in PCR for another six-month period
- Selective post-payment review of a statistically valid random sample (SVRS) of claims every six months, for the remainder of the demonstration; or

- No review, other than a spot check of five percent of their claims every six months to ensure continued compliance

Although not required, agencies are highly encouraged to submit both 30-day payment periods for review at the same time. Once approved, the agency will have a Unique Tracking Number (UTN) for each of the 30-day billing periods. These UTNs will need to be added to the appropriate final claim for processing.

**Updates to RCD:** <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Choice-Demonstration/Review-Choice-Demonstration-for-Home-Health-Services.html>

**17. Can NPs and PAs certify patients for home health and perform the face-to-face visit?**

Mid-level providers, including nurse practitioners and physicians' assistants, can perform the face-to-face visit in collaboration with the physician. However, the physician is the only one who can certify the patient's eligibility for home health.

**18. Do face-to-face and primary diagnosis need to match?**

Yes, the face-to-face encounter documentation from the clinical encounter must be for the same reason as the primary reason for home health care. See MLN Matters SE 1436 for complete certification requirements, which included face-to-face encounter information.

**19. Do all disciplines need to be started within 5 days?**

It is recommended best practice for all assessing disciplines to assess the patient within the assessment period, which for Starts of Care, is 5 days from Start of Care date. This allows for collaboration between skilled disciplines for OASIS scoring as allowed by OASIS and CoP Guidance, as well as coordination of the patient's individualized plan of care. Therapy evaluations done within this 5-day window in Axxess' home health software will flow to the comprehensive plan of care, which means the agency will not have multiple orders awaiting signature.

**20. How will a SCIC be reported to CMS? Our FIM is Palmetto.**

Agency policy will determine when a patient qualified for OASIS RFA-5 Other Follow Up, which is the type used when a Significant Change in Condition is identified per Conditions of Participation definition. This OASIS type must be completed within 48 hours of the discovery of the significant change and is then exported per OASIS guidelines.



- 21. Can you clarify about having a different primary diagnosis on the second 30-day period? Do we need to get that diagnosis approved by the doctor and supported by the face-to-face document? Can we use that diagnosis on the Recert if it is not approved by the doctor?**

Official Guidelines and Conventions are the rules that apply to diagnosis coding. These rules state that the primary diagnosis should be the primary reason for care for the encounter period. These rules also state that resolved conditions are not to be coded/included on the claim. Therefore, if the primary focus of care in the first 30-day period resolves or is different from the second 30-day period, the agency should update the coding and/or sequencing of diagnoses for the second 30-day period.

All diagnoses used on the claim must be supported by physician documentation.

#### **Billing/Financial Questions:**

- 1. Do secondary diagnosis codes need to be listed in a specific order for the purposes of the comorbidity adjustment?**

No, the ordering of the secondary diagnoses does not impact comorbidity adjustment. It is also important to note that the comorbidity does not change based upon the Clinical Grouping.

- 2. Who determines “Early” versus “Late”? Is the agency responsible, or does it come from CMS? If the agency is inaccurate, will CMS correct it?**

Episode timing of early or late will be determined based on the number of subsequent billable payment episodes that have occurred without a 60-day break in care. This will ultimately be based on CMS claims data, and while agencies may classify the patient as early on the RAP, CMS will adjust based on claims data, if needed.

While CMS will no longer use M0110 to influence payment under PDGM, other payers may be using this data in their PPS-like payment model. In such cases, agencies should follow instructions from individual payors directing data collection by patient. Agencies may code M0110 Episode Timing with NA – Not Applicable for assessments where the data is not required for the patient’s payer (including all Medicare FFS assessments).

To streamline operation, Axxess clients have a direct connection to the Medicare Common Working File. At Intake, agencies can run Medicare eligibility and view claims data to view claims that would indicate whether the patient will fall in early vs. late category.

**3. How do you recommend we handle a situation where the face-to-face does not match the primary diagnosis on the claim?**

In instances where the encounter documentation used to fulfill the face-to-face encounter requirement does not identify the same primary reason for home health care as the admitting clinician's determined primary reason for care, the agency staff would need to coordinate with the referral source to update this information, either through a subsequent visit with the physician in charge, or as an addendum to the clinical note as dictated by agency policy.

**4. How will the RAP be calculated without the OASIS?**

RAPs will be based on the HIPPS code as submitted by the agency. Axxess' home health software will calculate this based on the information provided by the agency. This is different than how the final claim will be calculated, as CMS requires the MACs to verify the HIPPS code being paid by using a combination of the OASIS data on file in the QIES system (for the functional status), eligibility information and claims data. The OASIS must be submitted timely and on file when the final is billed to receive a final claim payment.

**5. Is there such a thing as a no-RAP LUPA?**

No-RAP LUPAs will remain in PDGM but will be applied to each 30-day billing period.

**6. How long will it take for the 20% RAP to be paid and the 80% Final for each 30-day billing period?**

RAPs are not considered to be a claim, so they are not subject to the 14-day Medicare claim payment floor. Medicare Fiscal Intermediaries should continue to process both RAPs and claims in the normal timeframes from submission date.

However, agencies can expect a delay early in the transition to PDGM from PPS, as evidenced by PDPM transition (in Skilled Nursing Facilities October 2019) information reported to date.

**7. For Recerts, what will happen with the RAP on LUPA patients?**

Agency process will dictate whether the agency will bill a no-payment RAP for known LUPA episodes versus submitting RAPs for payment as usual. If a RAP payment is received and the payment period becomes a LUPA period, CMS will adjust payment with the Final Claim as needed. If the RAP payment was more than the LUPA payment rate, the agency will show a recoupment of the difference in payment on the Remittance Advice.

**8. Describe auto cancellation and resubmission of claims process of claims per 30- day PDGM billing.**

The RAP cancellation process will remain the same for PDGM. If a Final has not been submitted within 60 days from the end of the 30-day billing period or 60 days from the time the RAP was paid, it will be automatically cancelled by Medicare.

**9. How can you bill two 30-day episodes at the same time?**

PDGM will have two independent 30-day billing periods, each with its own RAP and Final that can be billed as soon as the billing requirements have been met. If the first billing period and second period billing requirements are met at the same time, then both claims can be billed. There is no condition that they must be billed sequentially.

**10. After 30 days, do we need to submit a new RAP? If yes, what documents are needed for the second 30-day RAP?**

Yes, a RAP is required for each 30-day billing period and each billing period will keep the same current requirements. To bill a RAP, the OASIS must be completed, the plan of care must have been sent to the physician, and a first billable visit must have been completed. These requirements will be the same for the first and second 30-day payment periods.

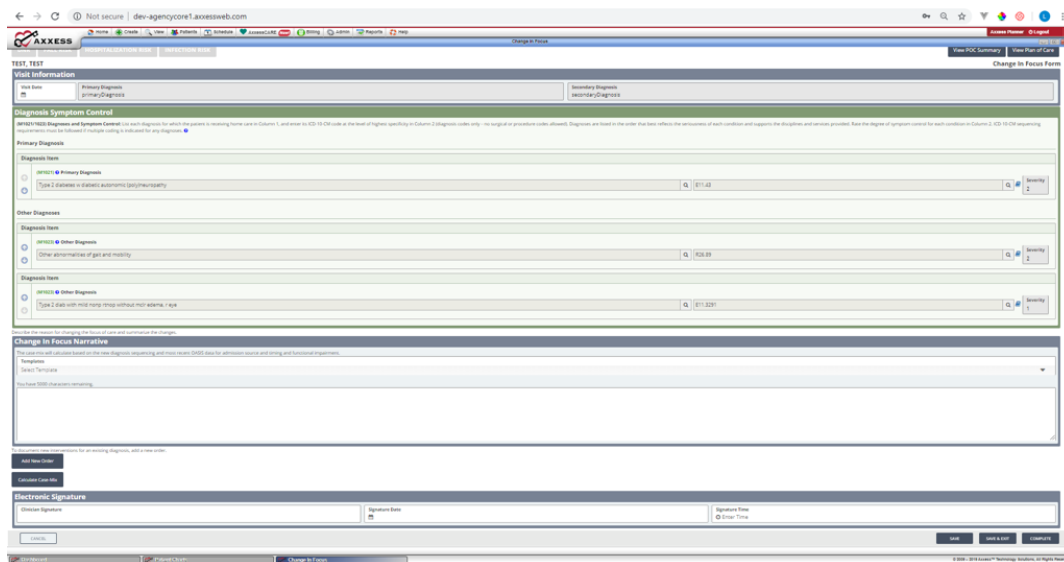
**11. Will the UTN for RCD be the same for both 30-day billing periods?**

Under RCD's Pre-Claim Review option, agencies will submit supporting documentation for each PDGM 30-day period and will receive a Unique Tracking Number (UTN) for each of these 30-day periods. The UTN will NOT be the same for both periods.

**12. If diagnosis codes change within a 30-day period, how would you change those codes in the final claim without doing another OASIS or another plan of care?**

Should a patient's focus of care change in the second 30-day period, the home health agency will need to change the primary diagnosis, and possibly the secondary diagnoses, on the claim. Unlike current requirements, the OASIS, plan of care, and the claim will not be required to match under PDGM. Therefore, no OASIS is required to be performed just to ensure the diagnoses match across these documents. No new plan of care is required before the recertification cycle as long as interventions and goals are covered on the original plan of care or supplemental orders.

Axxess has streamlined operations for its clients through the Change of Focus form. This form will help agencies improve compliance as it provides easy access to update goals and the plan of care. In addition, it will increase revenue by allowing the new primary diagnosis to flow directly to the billing claim form.



**13. If a patient is discharged before the end of the 60-day episode and before the LUPA threshold has been met, will agencies be paid?**

Yes, just as we are accustomed to under PPS, the agency will be paid for LUPAs for either or both 30-day payment periods at an adjusted rate reflective of how many visits have been provided.

**14. Is it mandatory to bill at the new 30-day payment period mark? Or could you wait if you wanted and bill the entire 60 days at the end of the episode?**

You are required to submit claims in 30-day increments, but there is not a requirement for you to bill every 30 days. If an agency chooses, they may bill at the end of the 60 days but will still be required to bill 2 RAPs and 2 Finals.

**15. Can we bill insurance for telehealth?**

Medicare does not provide reimbursement for telemonitoring; however, some state Medicaid plans (for example Texas) do provide reimbursement for telemonitoring. Agencies will need to check with individual plans to determine if telemonitoring is a covered benefit.

**16. What is the FISS System? How is this related to recent hospitalizations?**

The Fiscal Intermediary Standard System (FISS) is the standard Medicare Part A claims processing system. It allows you to enter, correct, adjust, or cancel your Medicare billing transactions. The FISS System will be checked by CMS for recent hospital stays that may adjust final claim payment for home health payments under PDGM.

**17. Will there be a reduction of payment if a patient is readmitted in fewer than 60 days?**

Partial Episode Payment, or PEP, rules will remain the same under PDGM. However, rather than considering the 60-day OASIS certification period, they will occur based on 30-day billing periods.

**18. How will orders be affected in PDGM?**

In order to file a final 30-day claim at the end of each billing cycle, all orders must be signed and back to the agency. Orders management will be a crucial piece of successful PDGM management.

Axxess has streamlined orders management through the Physician's Portal within the home health software, as well as an integration partnership with WorldView.

**19. Will all physician's orders need to be signed to be able to bill the 30-day period?**

Yes. All physician's orders, including plans of care, must be signed prior to billing the final claim.

**20. Will there be any change in the billing of outlier patients?**

Outlier payment calculations will still be based on high cost periods and will be applied to 30-day payment periods rather than 60-day episodes.

**21. How will CMS implement the 4.36% behavioral adjustment?**

The 2020 National Standardized Payment Rates have been adjusted like any annual increases or decreases.

### Operations Questions:

- 1. Please explain how patient recertifications are handled in the final few days of 2019. Are they reimbursed under PPS or PDGM?**

Recertification OASIS completed between December 27-31, 2019, for episodes beginning January 1, 2020, or after will be completed on OASIS D-1 and will require an artificial date of 01/01/2020 in M0090. These OASIS (with artificial date of 01/01/2020) should not be exported until on or after January 1, 2020.

Recertifications completed between December 27-30, 2019 for an episode beginning prior to January 1, 2020, will continue to be paid under home health Prospective Payment System (PPS), and will be completed using OASIS D with the ACTUAL date of completion stated in M0090.

- 2. Will there be new OASIS requirements beginning January 1, 2020?**

Yes, OASIS D-1 will be used for episode dates beginning on or after January 1, 2020. To satisfy the needs of PDGM, additional items were added to the Recertification (M1033 Risk for Hospitalization and M1800 Grooming) while responses to items used for PPS have been made optional.

- 3. Where are we going to send the NOA?**

The requirements for the Notice of Admission will not begin until 2022. CMS has not yet announced how the NOA will be processed.

- 4. With the heavy presence of home health in assisted living (AL) communities (many using home health aides and nursing to supplement their own staff) and with most AL being Late/Community referrals, what impact will PDGM have on these communities and how should they be preparing?**

Home health service eligibility requirements have not changed because of PDGM. Agencies should provide medically necessary, outcomes-focused care based on the patient's needs. Late/Community referrals may focus on ongoing disease processes and chronic comorbid conditions, so focusing on industry best practices for managing these types of patients, including practicing to the top of professional licenses and coordinating care with agency and assisted living communities should be top of mind.

## 5. How do we predict the impact of PDGM on our agency?

Agencies would be wise to use claims data in the form of an impact analysis to analyze their greatest potential impacts. This data can be used to predict the areas in which policies should be refined as well as opportunities for improvement and success. CMS provides historical information on their website. More information can be found for related questions in the Regulatory section of the FAQs.

Axxess clients may use the PDGM Impact Analysis tool located under the PDGM tab above their Dashboard to predict the impact of PDGM on their agency.

PDGM Impact Summary	Number of Affected Episodes	Percent of PPS Episodes	PPS Billed Revenue	Percent of PPS Revenue	PDGM Projected Revenue	Gain/Loss	Percent of Change in Revenue
Questionable Encounter Code (Non-Reimbursable Under PDGM)	17	7.3%	\$45,229	7.2%	\$0	(\$45,229)	-100.0%
Full Episode Pay for DC in 30 Days	11	4.7%	\$22,363	3.5%	\$22,057	(\$306)	-1.4%
Episode Includes 30-Day LUPA Rule	7	3.0%	\$8,882	1.4%	\$9,959	\$1,078	12.1%
Full Pay for 60 Days	197	84.9%	\$554,809	87.9%	\$644,353	\$89,544	16.1%
<b>Total</b>	<b>232</b>	<b>100.0%</b>	<b>\$631,361</b>	<b>100.0%</b>	<b>\$676,369</b>	<b>\$45,007</b>	<b>7.1%</b>

PDGM Clinical Groupings	Number of Diagnoses	PPS Billed Revenue	Percent of PPS Revenue	PDGM Projected Revenue	Gain/Loss	Percent Change
Neuro/Stroke Rehabilitation	22	\$60,855	9.6%	\$78,694	\$18,839	29.7%
Musculoskeletal Rehabilitation	36	\$113,890	18.0%	\$122,811	\$8,921	7.8%
Wounds - Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	9	\$27,674	4.4%	\$32,431	\$4,757	17.2%
Complex Nursing Interventions	0	\$0	0.0%	\$0	\$0	0.0%
Behavioral Health Care	0	\$0	0.0%	\$0	\$0	0.0%
Medical Management, Teaching, and Assessment - Cardiac	53	\$134,069	21.2%	\$151,796	\$17,727	13.2%
Medical Management, Teaching, and Assessment - Endo	17	\$42,296	6.7%	\$52,100	\$9,804	23.2%
Medical Management, Teaching, and Assessment - GI/GU	2	\$4,613	0.7%	\$5,616	\$1,003	26.1%
Medical Management, Teaching, and Assessment - Infectious Dx	6	\$23,234	3.7%	\$26,546	\$3,312	14.3%
Medical Management, Teaching, and Assessment - Respiratory	11	\$28,226	4.5%	\$34,830	\$6,604	23.4%
Medical Management, Teaching, and Assessment - Surgical Aftercare	0	\$0	0.0%	\$0	\$0	0.0%
Medical Management, Teaching, and Assessment - Other	59	\$151,475	24.0%	\$174,330	\$22,855	15.1%

## 6. Is maintenance therapy payable under PDGM?

Yes. Where clinically appropriate, therapy services may provide maintenance therapy under the home health benefit. According to the Final Rule that was recently released, Physical Therapy Assistants (PTAs) and Occupational Therapy Assistants (OTAs) may now provide maintenance therapy visits as well. Maintenance therapy is not documented or billed any differently, rather it is the practice of continuing to provide therapy services for patients in order to keep patients and their caregivers safe, and to slow the process of decline. Maintenance therapy can be used with a wide variety of chronic illnesses, for example, Parkinson's Disease and Multiple Sclerosis, where the likelihood of a patient making measurable improvements is limited.

Axxess clients can ensure compliance and protect revenue using the Axxess tools below when documenting and planning care using maintenance therapy as a skill.

## Plan of Care Therapy Service Orders

- ☐ Need for Restorative Therapy Services
- ☒ Need for Maintenance Therapy Services
  - ☐ Need for physical therapy maintenance therapy:
  - ☐ Need for occupational therapy maintenance therapy:
  - ☐ Need for speech therapy maintenance therapy:
- ☐ Therapy Evaluation Performed; No Further Visits Required

## Plan of Care Therapy Service Orders

- ☐ Need for Restorative Therapy Services
- ☒ Need for Maintenance Therapy Services
  - ☒ Need for physical therapy maintenance therapy:
    - ☒ Physical therapist assessed patient and determined skilled need exists to develop plan of care:
 

Physical Therapist assessed patient and determined skilled need exists to develop plan of care to maintain functional status or to prevent or slow further deterioration in function. POC developed with patient/caregiver involvement to be countersigned by physician. PT to recognize and intervene to minimize complications; notify physician immediately of any potential problems that indicate decline to functional status or impediments to desired goals.
- ☐ Additional Orders: Select Template

Visit Information  
Physical Assessment  
Therapy Tool Box  
Summary of Care  
**Plan of Care**

ST Assessment/Evaluation Note | Dr. Arine

Frequency:   
Frequency Description  
Enter Frequency Description

### Plan of Care Therapy Service Orders

- ☐ Need for Restorative Therapy Services
- ☒ Need for Maintenance Therapy Services
- ☐ Therapy Evaluation Performed; No Further Visits Required

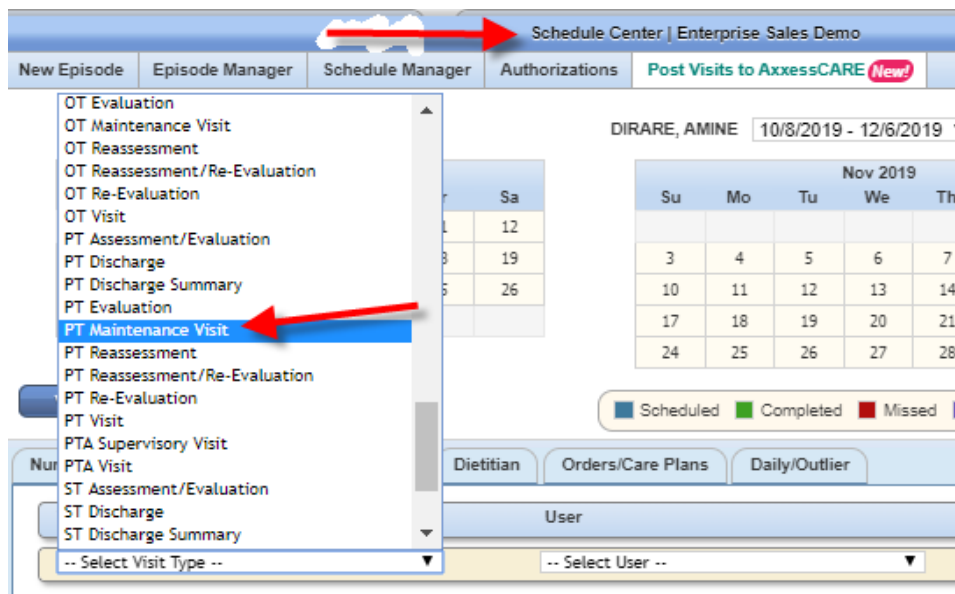
### Append Assessment/Evaluation to Therapy Orders

**Assessment performed within five-day window** - The Plan of Care will automatically flow to the Multi-Discipline Plan of Care when this assessment is completed within five days of the beginning of the episode or within the last five days before the end of the episode.

**Assessment performed outside five-day window** - The Plan of Care will automatically flow to the Individualized Therapy Plan of Care when this assessment is completed outside the five-day window of a Comprehensive Assessment (i.e., OASIS SOC/Recert).

**Evaluation required for physician signature**  
 If your agency requires the Evaluation and Plan of Care to be signed by the physician, you may select to have the Full Evaluation, or an abbreviated version of the evaluation added to the Plan of Care orders.

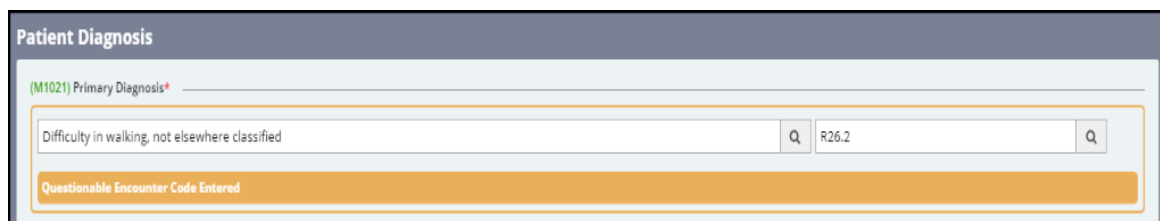




## 7. How can agencies identify and flag QECs?

Axxess' home health software will alert you to primary diagnosis codes that would trigger an Ungroupable Diagnosis or QE. Axxess has a wealth of resources available including a list of commonly used Questionable Encounter Codes available to download. These resources can be accessed at [www.axxess.com/pdgm](http://www.axxess.com/pdgm)

Axxess clients are currently provided a warning at Intake if a QEC is used. Beginning January 1, 2020, the warning will be a hard stop if the patient is a Medicare patient in order to protect the agency's revenue under the new requirements for PDGM reimbursement.



This diagnosis is a questionable encounter code and will not calculate a grouper payment under PDGM. Contact the physician to obtain a more definitive primary diagnosis that is payable under PDGM.

**8. For payment purposes, is it better to keep patients for 60 days or discharge at the end of 30 days?**

Where clinically appropriate, there may be an advantage to an increased length of stay. For example, a PT frequency of 2W4 would concentrate all the visits in to the first 30-day payment period. If it would be beneficial to the patient (e.g. still meet their goals, maintain their safety, and achieve good outcomes), a visit frequency of 2W3 followed by 1W3 may be an alternative to consider. The same mapping and appropriate planning of visits is important for all disciplines.

Axxess clients can see their revenue for both 30-day periods using the PDGM Modeling Tool. In addition, they can see the total operating income by using the Gross Margin Calculator as shown below.

PPS (Ends December 31, 2019)		PDGM (Effective January 1, 2020)		
\$2,277.81		\$3,838.14		
Episode Information (60 Days)			First 30 Days	Second 30 Days
Case-Mix Weight	0.7298	Case-Mix Weight	1.1759	1.0367
Timing	Early Episode	Timing	Early	Late
Clinical	High	Clinical Grouping	MMTA Other	MMTA Other
Functional	Moderate	Functional Level	Low	Low
Therapy Visits	N/A	Admission Source	Institutional	Institutional
HHRG	C3F2S1	Comorbidity Adjustment	None	None
HIPPS	1CGKW	HIPPS	2AA11	4AA11
		LUPA Threshold	3	3
		Payment Amount	\$2,039.80	\$1,798.34

PPS Gross Margin Calculator

OASIS Episode Information

OASIS Start of Care 11/16/2019 for Jenny Interim MRN Inter\_0001, performed by Jonatrice St. Germain RN

Total Therapy Visits (M2200)

000

HHRG

C2F1S1

Timing

Early Episode

Functional

Low

Case-Mix Weight

0.5769

HIPPS

1BFKS

Clinical

Moderate

Non-Routine Supply Level

Level 1 - \$14.84

Episode Payment

\$2497.62

Total Cost

\$528.00

Gross Profit(Loss)

\$1969.62

Gross Margin

78.86%

Cost Modeling

The case-mix rate includes the total number of therapy visits entered via the OASIS M2200. When the number of therapy visits are adjusted up or down, the case-mix rate will be updated when the recalculate button is selected.

SN

8

visits x \$

66

HHA

0

visits x \$

14

MSW

0

visits x \$

100

PT

0

visits x \$

100

OT

0

visits x \$

75

ST

0

visits x \$

60

Wage Index

1.4523

Supplies

0

Recalculate

**9. How does PDGM affect current frequency and duration?**

Where clinically appropriate, there may be an advantage to an increased length of stay. Frequency and Duration of visits should be based on a patient-centered assessment using the professional process, and based on the number of skilled, medically necessary interventions and goals. Agencies are encouraged to use best practices to dictate policies for determining frequency and duration, such as clinical pathways.

**10. Is Medicare going to pay for home health aides in 2020?**

Home Health Aide (along with SN, PT, OT, ST, and MSW) visits remain one of the disciplines covered in the Home Health benefit when reasonable and necessary. Home Health Aide visits also contribute to the LUPA thresholds count.

**11. How many diagnoses should be addressed in the plan of care?**

All diagnoses that are not resolved, and require intervention during the home health episode, or that have the potential to impact the care being provided, should be listed on the Plan of Care. CMS will be able to view up to 24 secondary diagnoses on the claim information for possible comorbidity payment adjustment, and all codes that are listed must be included on the Plan of Care as requiring intervention or having the potential to impact the services being provided.

**12. We are gathering data regarding our clinical groupings, hospitalizations, comorbidities, and functional impairment. How do we coordinate all together with actions we should take?**

It is certainly wise to study your agency's past performance to see where the PDGM payment system offers opportunities to make modifications. Depending on your agency-specific findings, the agency could develop strategies including focused marketing of specialty programs, improved or outsourcing of ICD-10 coding, fall prevention programs, or enhanced OASIS education. If you do not feel as though you have the internal resources, please consider reaching out to clinical consultants or professional services experts.

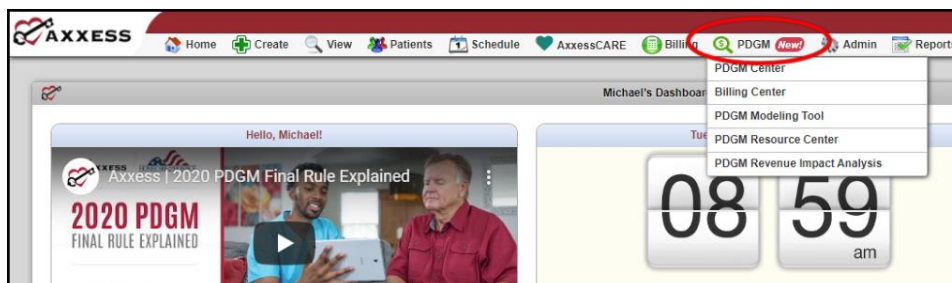
In addition to the multiple PDGM tools provided within the Axxess software, consulting services will be offered through Axxess beginning in 2020. PDGM Agency Operational Playbook is an individualized plan of action for agencies to thrive under PDGM. For more information, email [PDGMquestions@axxess.com](mailto:PDGMquestions@axxess.com).

### 13. Can a WOCN use telehealth to consult on wounds?

Yes. Because of the expansion of the one-clinician rule, WOCNs can use telehealth or telemonitoring to collaborate on OASIS items and consult on appropriate wound care patients. For collaboration, CMS has specified that the collaborating professional must have had patient contact within the timeframe specified. They went on to state that telehealth is considered patient contact in this specific example. This is an efficient use of resources, but remember, telehealth visits are not reimbursable.

### 14. What are the best reports to use for PDGM?

A deep understanding of how your current practices and processes will be impacted by PDGM will help you identify areas of focus. High on the list of processes to understand is the need to identify coding practices that need to change in order to avoid Questionable Encounters. It is also important to understand the other aspects of PDGM, including how you will be impacted by episodes that have a length of stay of fewer than 30-days, the distribution of patients among the Functional Deficit thresholds, and the impact of comorbidities. Our home health software users currently have easy access to this information and much more in the new PDGM Center.



### 15. What is the impact of community referrals on an agency less than 50?

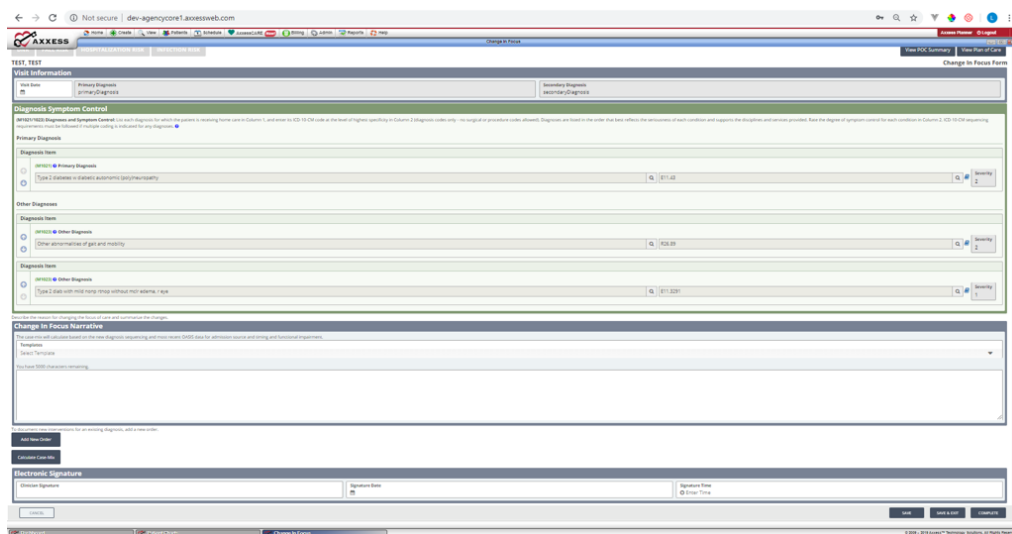
Regardless of size of the agency, there will be a lower reimbursement for patients who have not been in an institution in the preceding 14 days. This adjustment occurs due to data illustrating patients who were recently discharged from a facility are more acutely ill and require additional resources. Because of the lower reimbursement, smaller size agencies may need to adjust by maximizing the efficiency of each visit, assure that they are appropriately scoring the OASIS to receive the appropriate Functional Deficit adjustment, and coding accurately in order to be assigned to the correct Clinical Group for comorbidity adjustments.

### 16. How do we move from one 30-day period to another 30-day period?

There are no requirements to complete additional OASIS or re-certification assessments. Agencies may choose to adopt a policy of re-assessing patients near the 30-day mark to

assure that care should be continued and that the visit plan is appropriate to avoid unnecessary LUPAs.

Axxess clients should use the Change of Focus form pictured below in order to ensure compliance with updating the plan of care and maximize revenue through the automation of changing the primary diagnosis on billing claim forms.



**17. We have discussed PT/OT use, what about speech therapy? Where does ST come in to play in functional scoring? Are these OASIS items based only on motor skills, ADLs, and self-care?**

The OASIS items that are considered for functional scoring are listed below. These items cover a gamut of ADLs, and OASIS guidance mandates that the cognitive abilities of the patient, as well as the physical abilities, must be considered when answering these items. Per OASIS guidance, Speech Therapists can complete OASIS assessments.

The functional impairment portion of PDGM is based on the following OASIS items:

- M1800 – Grooming
- M1800 – Dressing Upper Body
- M1820 – Dressing Lower Body
- M1830 – Bathing
- M1840 – Toilet Transferring
- M1850 – Transferring
- M1860 – Ambulation/Locomotion
- M1033 – Risk for Hospitalization

**18. What considerations for operations would you recommend when the second 30-day billing period's diagnosis changes from the first billing period without OASIS? What should the agency do as it relates to the plan of care, orders, and claim?**

If the agency's software does not have a system to change the clinical grouping, the agency will need to develop manual operations to notify billing when there is a clinical grouping change. The agency should identify in their documentation that the focus of care has changed to the new diagnosis and clinical grouping and explain why. This can be documented in a wide variety of ways to include inclusion on the clinical care note, care coordination note and/or team conference. If orders are already on the existing plan of care for the new clinical grouping, new orders will not be required.

Axxess clients should use the Change of Focus Form pictured and discussed above in question 16.

**19. In the live seminar presentation, it was stated that therapy utilization of 8-10 visits will create a profit margin. Is this 8-10 in a 30- day period or 60-day period?**

The statement made indicated that in many cases the PDGM reimbursement that would be paid over the two combined payment periods (provided that neither payment period becomes a LUPA) is at a similar level to the reimbursement that is currently paid under PPS for a patient receiving 8-10 therapy visits.

**20. Rehab Aides are mentioned multiple times. What are these and are they reimbursable by Medicare?**

"Rehab Aides" is a term coined for the use of Home Health Aides who have received additional training and competency evaluations to perform certain non-skilled rehab care to include assistance with home exercise programs, assessment of environment for safety concerns, assessment of DME equipment for safety concerns, and assistance with ambulation. There are restrictions in many states about Rehab Aides providing hands on rehab care, such as massage or Passive Range of Motion (PROM). These visits would be included and billed as home health aide visits and are therefore reimbursable by Medicare. Practice restrictions may vary on a state by state basis.

**21. What visit frequency would you recommend for therapy under PDGM?**

The best advice is to provide the care that the patient needs to meet their goals, to optimize their safety, and to restore function. Just as is the case with PPS, there will be payment periods where the agency profits and those where there is a loss. Many agencies who have been providing an appropriate level of therapy care will see minimal change in their practices under PDGM. A dramatic reduction in the volume of therapy visits provided will be an indicator to post-payment review entities that an unnecessary

level of therapy was being provided under PPS. There must be a focus on showing quality, measurable outcomes.

**22. At the end of the 30-day episode, does the RN do another recert?**

To continue skilled care, an OASIS Recertification is required every 60 days, but no Recertification is required at the end of the 30-day billing period. It is advisable practice to have a case-conference type meeting near the end of the 30-day payment period to plan visits and to collaborate on continued care.

**23. Do we need to pay for telemonitoring visits?**

Telemonitoring is considered a cost of the agency to do business. It is not reimbursed by Medicare but can be included on the Medicare cost reports. Unless the patient has another source of payment for telemonitoring, the agency would need to pay for this service. Some state Medicaid programs will pay for telemonitoring. For patients who are dual eligible, they can and should bill Medicare for home health services and Medicaid for telemonitoring services simultaneously.

**24. Should agencies call the hospitals on or prior to the weekend to check on discharges?**

Many patients are discharged on the weekend and a suggested best practice would include phone calls to track patients on the weekend.

**25. What are some examples that fall under the complex nursing grouping?**

Some examples would include: Colostomy malfunction (K94.03), Infection of incontinent external stoma of urinary tract (N99.521), Leakage of infusion catheter, sequela (T82.534S), and Encounter for fitting and adjustment of urinary device (Z46.6).

**26. What are some examples that fall under the behavioral health grouping?**

Some examples would include: Unspecified dementia with behavioral disturbance (F03.91), Paranoid schizophrenia (F20.0), Major depressive disorder, recurrent, unspecified (F33.9), and Suicide attempt (T14.91).

**27. If a nurse and therapist perform a visit together, will that impact billing?**

Generally, only one visit is billable at a time (during the same time in/time out) unless medical necessity is proven. Therefore, only one visit would count toward the LUPA threshold.

**28. What are the qualifications of a psych nurse under NGS as intermediary?**

- An RN with a master's degree with a specialty in psychiatric or mental health nursing and licensed in the state where practicing would qualify. The RN must have nursing experience (recommended within the last three years) in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program or other outpatient psychiatric services.
- An RN with a bachelor's degree in nursing and licensed in the state where practicing would qualify. The RN must have one year of recent nursing experience (recommended within the last three years) in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program or other outpatient psychiatric services.
- An RN with a diploma or associate degree in nursing and licensed in the state where practicing would qualify. The RN must have two years of recent nursing experience (recommended within the last three years) in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program or other outpatient psychiatric services.

**29. Does CMS require an OASIS on infusion patients, private pay patients and pro bono patients?**

Any patient who is cared for by an agency under a Medicare license must receive a comprehensive assessment, which according to the Conditions of Participation, includes an OASIS. The only exceptions to the OASIS requirement are those patients who are under the age of 18, maternity patients, or those who require non-medical services only.