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FAQ - December 2019

Frequently asked questions from the webinar

The 2020 Home Health Final Rule

Understanding the new challenges and how to **succeed**

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The 2020 Home Health Final Rule lays out CMS's decisions on a dramatic and sweeping set of changes that will affect home health agencies in 2020 and beyond. The Final Rule updates the payment rates and wage index for home health, finalizes the implementation of the Patient-Driven Groupings Model (PDGM), includes changes to plans of care and the rules for therapy, and much more.

The 2020 Home Health Final Rule will require substantial and rapid action from your agency. Executive management consultant Sharon S. Harder, president of Chicago-based C3 Advisors, LLC, recently presented a free webinar on the Final Rule which is now available for on-demand viewing at get.wellsky.com/2020hhfinalrule.html. In this document, Sharon answers many of the most popular questions asked during the webinar.

Behavioral Adjustment

Q: Is the behavioral adjustment of 4.36% a retroactive payment adjustment that is based on an agency's performance under PDGM?

A: Unfortunately, the behavioral adjustment applies to all agencies irrespective of their performance and operates to reduce the standard payment rate which, after the across-the-board adjustment, now stands at $1,864.03. CMS has applied this adjustment based on an assumption that agencies will respond to the reimbursement changes under PDGM by engaging in upcoding and extending potentially unnecessary visits to avoid LUPAs.

Admission Source

Q: Could you review again for us how Institutional versus Community referrals will work under PDGM?

A: The easiest way to think about Admission Sources is as follows:

If the home health patient can be demonstrated to have been discharged from an inpatient stay within 14 days of the beginning of home health services (the SOC date), the first period of the SOC episode will be classified as an *Institutional Admission Source*. In this case, the inpatient discharge can be from a short-stay acute hospital or a post-acute care provider such as a skilled nursing facility (SNF), an inpatient rehabilitation facility (IRF), a long-term care hospital (LTCH) or an inpatient psychiatric facility (IPF).

For all subsequent, contiguous payment periods following the first period of the SOC, the only type of discharge that would yield an Institutional Admission Source would be from a short-stay acute hospital. If there is no evidence of a qualified inpatient discharge as outlined above, the period would be considered a *Community Payment Period*.

Q: How long does the hospital inpatient stay have to be to be considered an Institutional Admission Source?
A: There is no length of stay requirement as long as the stay is handled by the hospital as an inpatient stay. Observation stays would *not* qualify as Institutional Admission Sources. We note that stays of fewer than two midnights are often observational stays; however, there are some procedures for which the stay may still be short and for which the procedure is listed as inpatient only. Thus, it will be critical for the team to differentiate various types of hospital discharges for applicability to the new home health test.

Q: If we have a patient who is being discharged from a VA hospital to home health, how would you suggest we code the claim?
A: First, if the patient is going to be covered under his or her VA benefits for home health, there is no issue as the VA would be authorizing services and paying the home health claim. It would not come under the purview of PDGM.

On the other hand, if the patient is coming to home health under the auspices of his or her traditional Medicare benefit, the agency would want to be sure to code Occurrence Code 61 on the claim together with the date upon which the patient was discharged from the VA hospital to get credit for the Institutional Admission. Once again, the VA hospital stay must have been an inpatient encounter. The MAC will not be able to locate that claim as it would not be present in the claims data available to the MAC, but the admission would still count as Institutional as long as the agency codes the claim correctly. We also suggest making sure that you get the discharge summary from the VA facility for your records.

We are having trouble understanding when and how a Payment Period would be considered Institutional Late. Can you provide examples?

A: First, for a patient who is transferred during a payment period and then resumed within 14 days of the beginning of the next payment period, the Admission Source for the succeeding payment period would be *Institutional Late*. Remember, that for purposes of the Transfer OASIS and for the Institutional Admission Source, the hospital stay must be an inpatient stay. For an ER visit or an observation stay you would not need a Transfer OASIS and the hospital services would not be eligible for the Institutional classification under home health.

Next, let's assume that your patient was discharged with goals met on day 45 – in other words, on day 15 of the *second* payment period in a home health episode. Two weeks later he is admitted to the hospital for a new condition and discharged three days after that, again to home health. In this case, the new SOC Payment Period would be Late because there are fewer than 60 days that have elapsed between the prior home health DC and the new SOC. And, as long as the patient is being admitted for home health within 14 days of his/her inpatient discharge, the new period would be considered Institutional Late.

Now, for another angle on the same test, let's assume that our patient is transferred to the hospital on day 20 of the first payment period in an episode. The transfer is without a home health discharge. He is discharged from the hospital and resumed on day 32. The next payment period will still be Community Late because the hospital discharge did not occur prior to the start of the next payment period.

Q: If we have a patient who is admitted from the Community and who is hospitalized very shortly after the assessment visit and before other services are provided, should we ignore the admission until the patient comes back from the hospital?
A: No, you should not ignore the admission as I am assuming that the RN who performed the assessment provided skilled teaching

and/or hands-on care during that visit. Thus, the visit was medically necessary with skilled care delivery and is billable. The question here is how the agency should handle the patient Transfer – is it a Transfer with Discharge or Transfer without Discharge? Let's look at an example to illustrate the decision points...

EXAMPLE: Our patient, Mr. Jones, is referred by his physician for teaching and observation due to newly diagnosed heart failure for which new medications have been prescribed along with significant lifestyle changes. The patient is admitted with a primary diagnosis of heart failure. Skilled nursing and a PT evaluation are ordered with the Plan of Care that is expected to go on through two 30-Day Payment Periods.

Mr. Jones's care will come under the MMTA Cardiac Clinical Group and the first payment period will be classified as an Early Community Admission Source. His Functional Impairment level is determined to be medium and there are no coded comorbidities.

For the first Payment Period, Mr. Jones's HHRG is set at 1HB11 with a case mix weight of 1.1179. For purposes of illustration, our wage index is 1.00. The expected payment for the first 30-Day Period would be $2,083.80. Because we expect Mr. Jones to be on service well into the second Payment Period of the episode, we conclude that the second Period will be Community Late with no change in either the Functional Impairment level or comorbidity level. The expected HHRG for the second period will be 3HB11 with a case-mix weight of .7118 with expected full reimbursement to be $1,326.82. Thus, the clinical team projects our episode with two Payment Periods to be reimbursed at $3,410.62.

Alas, Mr. Jones suffers a serious fall with injury at home two days after the SOC as he was ambulating to his mailbox without an assistive device. He goes to the ER and is admitted to the hospital as an inpatient. He is discharged five days later with a diagnosed shoulder fracture and facial lacerations but no other apparent after-effects of the injury.

Here are two different scenarios that could play out here...

Scenario 1:

Mr. Jones is resumed on day eight of the first Payment Period. The PT eval, which had been delayed due to the Transfer is rescheduled and the assessing clinician now suggests OT for Mr. Jones due to new upper extremity issues related to the new fracture. The diagnoses coding on the ROC is changed to reflect the addition of treatment for the fracture which becomes primary with heart failure as a new secondary diagnosis.

The diagnoses that drive the payment for the first period are unchanged; however, the Resumption of Care influences a change in the Clinical Group from MMTA Cardiac to MS Rehab for the second payment period. There is also a change in Functional deficit due to the UE injury. Mr. Jones's heart failure also now contributes to a single comorbidity, but the second period is still Community Late because the inpatient discharge occurred more than 14 days before the beginning of the second period. The revised reimbursement for the second Payment Period is now based on a case mix of .9911 and is calculated as $1,847.44. Total reimbursement for the two periods is now moved to $3,931.24 for a gain of $520.62.

Scenario 2:

As Mr. Jones enters the hospital the agency is uncertain as to whether he will return for home health or, perhaps, be referred for inpatient rehab care. The agency discharges Mr. Jones as of Day 3 of the initial Payment Period after only one RN visit. The episode/period is a LUPA and is reimbursed at $276.17.

As it turns out, upon his hospital discharge Mr. Jones is referred back to home health. The agency readmits Mr. Jones within 48 hours of his discharge. Fewer than 60 days have elapsed since Mr. Jones's earlier home health discharge, so the new SOC begins as a *Late Institutional Payment Period*.

For the second episode, Mr. Jones's primary diagnosis related to the new fracture puts him in the MS Rehab Clinical group. His functional impairment is now scored as high due to the loss of ADL function. He has a single comorbidity of continuing heart failure that drives the comorbidity add-on. And, as noted, the initial period will be Late Institutional with the second period in the episode being *Late Community*.

For the first Payment Period in the second episode, the agency will be paid on the basis of a case-mix rate of 1.4386 (4EC21) in the amount of $2,681.59. The second period will be reimbursed at a case-mix rate of .9911 (3EC21) in the amount of $1,847.44. Total reimbursement for Mr. Jones's subsequent episode after the Transfer with Discharge is $4,529.03. There is a loss on the first episode, due to the LUPA, of $3,655.07; however, that is mitigated by the payment on the second episode which produces an overall gain of $873.96.

Q: If a patient is in the middle of the second 30-Day Payment Period and is transferred with a subsequent Resumption of Care before the end of the period, how will that work for billing in terms of whether the period is considered an Institutional or Community Admission Source?
A: In this scenario, where we have a patient in the second Payment Period, the question becomes one of whether the patient will be recertified for another episode. The classification affecting the second payment period will be unchanged because the discharge and resumption did not precede the period. However, if the patient is recertified and if the hospital discharge following the transfer is within 14 days of the start of the recertification, the first period of the succeeding episode would be classified as Institutional. Otherwise, if the hospital discharge occurred more than 14 days prior to the start of the recertification, the Admission Source would still be *Community*.

Q: If a patient has joint replacement surgery as an outpatient and goes home the same day, would that be considered a Community Admission Source? Would this change if the surgery setting is an Ambulatory Surgery Center?
A: Yes, in both instances, the Admission Source would be *Community*.

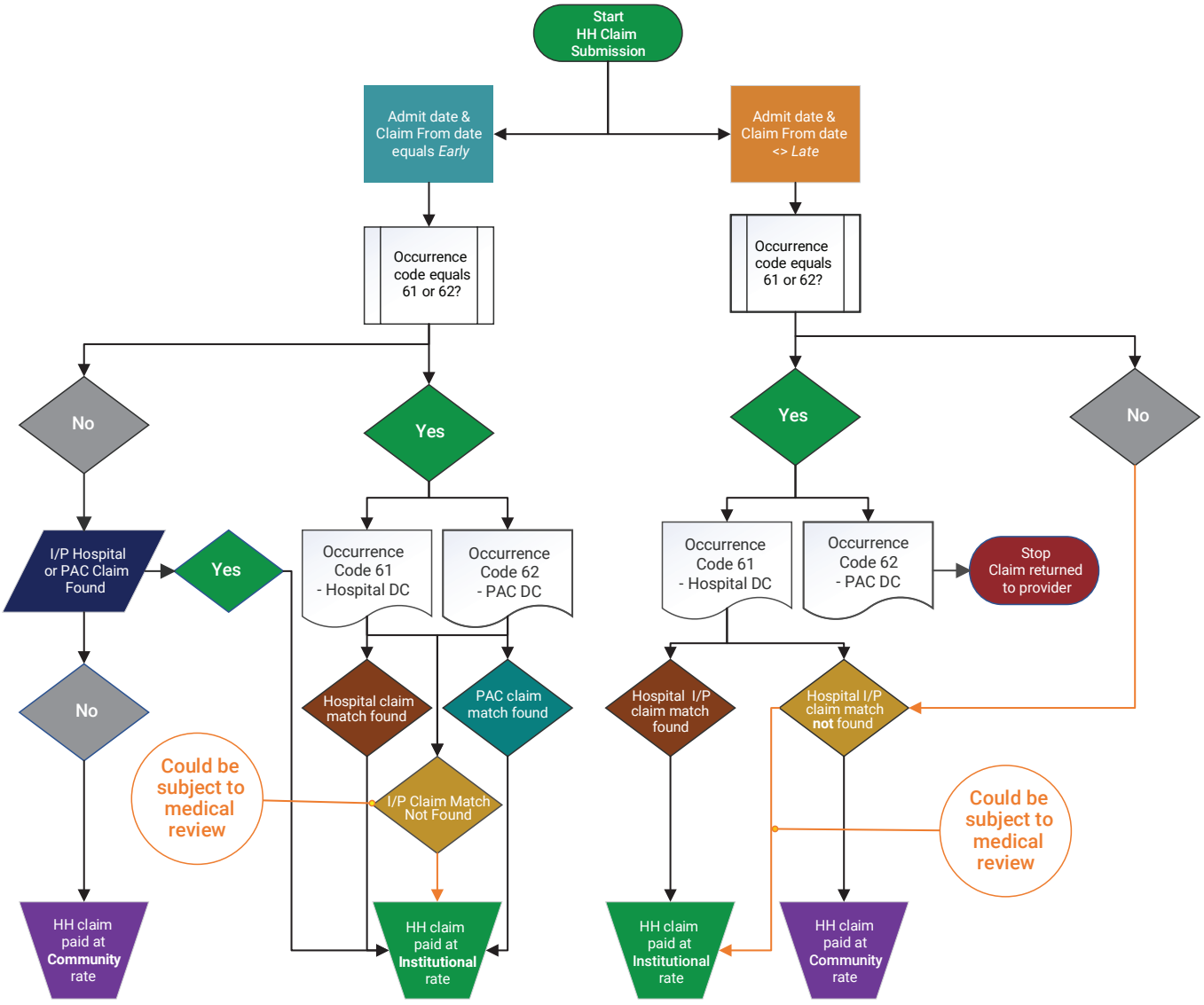
Q: What dates are used in connection with Occurrence Codes 61 or 62 on the claim?
A: In each case, the date associated with the Occurrence Code is the discharge date from the inpatient setting.

Q: How will the billing and payment processes actually work related to evaluation by the MAC of whether the Admission Source is or isn't Institutional. Should we always include the Occurrence Code on the claim or is it even worthwhile to do so since the MAC has to look for the inpatient claim anyway?
A: As long as it is clear from the intake documentation that the team gathers that the patient was truly discharged from an inpatient stay within the 14-day timeframe, your default process should be to include the applicable Occurrence Code and the inpatient discharge date on your claim. Here's why...

CMS has said in earlier rulemaking that the agency would be entitled to the Institutional payment increase even if the hospital or PAC provider, for one reason or another, either does not submit a claim for the inpatient services or is not reimbursed for the service. Moreover, CMS has clearly acknowledged the

fact that not all inpatient services will be paid under traditional Medicare for a variety of reasons including beneficiary elected coverage changes. So, the best bet for you is to establish a process through which the qualifying inpatient stay is first verified and then coded on the claim to ensure capture of the payment.

From the webinar slides, here is a larger and more readable version of the process flow that illustrates the process:



Q: Is the designation of an institutional discharge something that our compliance review team should be concerned about next year?
A: Anything that drives a portion of the payment under PDGM will have compliance implications next year so, yes, the compliance committee should be concerned about this and it would be appropriate to add some review protocols to your in-house compliance audits to review Admission Source designations included with claims against the backup documentation that can be found in the record to ensure compliance.

Functional Impairment Scores

Q: Will the Functional Impairment Score be adjusted based on submission of a Follow-Up/SCIC assessment?
A: Possibly. If the change represents a patient improvement, then it is possible that the Functional Impairment Score will be lower or, alternatively, if the patient change represents a significant decline or an event that causes a change in the focus or intensity of care, the functional deficit might go up.

Generally, the score will remain unchanged from the first payment period in an episode to the second unless there is an ROC or a Follow-Up assessment conducted during the episode that operates to change the point accumulation prior to the start of the subsequent payment period.

Q: Are the Functional Impairment scores designed to predict the need for therapy services? For example, if my patient has a Low Functional Deficit score, does that mean that we should not be providing therapy?
A: The Functional Impairment scores are *not* meant to be proxies for the inclusion (or lack thereof) of therapy services. While there will no longer be a payment adjustment for the volume of therapy visits, we must be clear that there will still be a need for therapy services for patients with functional deficits that can be reversed or stabilized through the provision of therapy services and this will apply to all Clinical Groups.

OASIS

Q: I am still not clear on the OASIS time points. Will we have to complete a new OASIS for every 30-day payment period?
A: No. You will complete the SOC OASIS at the beginning of care and recertification OASIS thereafter every 60 days. One way to think of it is that the payment periods fit inside our traditional episodes.

Q: I was under the impression that our OASIS must be submitted within 30 days, not five. Where did this new requirement come from?
A: You are correct that the submission timeframe is within 30 days; however, the completion timeframe for the assessment is five. This is not a new requirement, but it becomes more important now that it will be measured based on the claim From Date and the OASIS M0090 Date as depicted in conjunction with Occurrence Code 50.

Q: If CMS already knows the submission date for every OASIS, why do we have to include another Occurrence Code on the claim with the submission date?
A: Occurrence Code 50 is accompanied by the OASIS completion date which is the value in M0090. This is quite different from the date on which the OASIS is transmitted.

Q: Regarding the M0090 date, is the five-day window based on calendar or business days?
A: The Conditions of Participation, as shown at 42 CFR 484.55(b) set the standard completion timeframe as five calendar days.

Q: Regarding the day count for the M0090 date, if the patient was assessed by an RN on January 1 and a PT saw the patient on January 5, what date would I use for M0090?
A: It depends. If the SN completed their evaluation of the patient and did not collaborate with the PT as to the findings from the second evaluation, the M0090 date would be January 1. However, if collaboration *did* occur as the therapist completed the evaluation visit, the completion date would be noted by the RN as January 5.

Q: Do we always have to include Occurrence Code 50 on the claim even if the date is the same as the visit date?
A: Yes. If the Occurrence Code and date are not reported, it is our understanding that the claim will be returned for correction.

Q: Is the M0090 date the date of the visit or the date that the documentation was submitted?

A: M0090 is neither the visit date, per se, nor the submission date. It is intended to be the last day on which the assessing clinician gathered information for the assessment. So, for example, let's say that the RN assesses the patient over two days, the second visit would be the M0090 date as it would represent the last day on which information for the assessment was gathered.

Q: Does the M0090 date apply to RFA 04 or 05?
A: M0090 is required for all assessments including the SOC, Recertifications, Follow-Ups, Transfers, Resumptions of Care, Discharge, and Death at Home.

Q: Please clarify how a SCIC/Follow-Up OASIS affects payment.
A: First, the Follow-Up OASIS may or may not affect payment. It is to be completed within 48-hours of a significant, or material, patient change that could be defined as either an improvement or decline in the patient's condition.

If there is a change in condition and if the assessment is completed prior to the beginning of a second payment period within an episode with a change to the patient primary or secondary diagnoses or functional scoring items (M1800 through M1860), the case mix for the second payment period would likely change resulting in a change in the payment amount.

Q: When we look at the two 30-day payment periods within an episode and under the same Plan of Care, as we reach the second period will the original OASIS govern the case-mix assignment if there has been no SCIC or follow-up assessment?
A: The OASIS that will be used to construct the HIPPS Code and case mix will be the most recent SOC, Recert or Follow-Up Assessment performed prior to the start date of the payment period.

Q: In the future, will we need to include the Treatment Authorization Code on the claim since we aren't being paid based on the therapy thresholds any longer?
A: The Treatment Authorization Code will no longer be used for calculation of the final payment amount as it was under PPS. However, the code also has trailing spaces for the affirmation or non-affirmation of payment under the Review Choice Demonstration at positions 19-32 where the UTN will be entered. So, if your agency is in one of the States where RCD is being implemented, you would still want to ensure that the Treatment Authorization Code and UTN in its entirety is included on the claim.

Q: Our coders are tasked with reviewing the OASIS and making suggestions for changes related to the responses selected by the assessing clinician. How does this affect the M0090 date?
A: First, let's take a look at the OASIS guidance relative to collaboration. It says that *"although one clinician must take responsibility for the comprehensive assessment, collaboration with the patient, caregivers, and other health care personnel, including the physician, pharmacist, and/or other agency staff is appropriate.* ***For items requiring patient assessment, the collaborating healthcare providers must have had direct contact with the patient"*** [emphasis added].

Thus, unless your coders have direct contact with the patient, they would not, technically, be in a position to offer alternative guidance to the assessing clinician on completion of the assessment data. Nonetheless, if they do offer such guidance and if the recommendations are implemented by the assessing clinician, the M0090 date would be the date on which the clinician received the recommendations and altered his/her original answers. And, if that occurs after the 5-day window has closed, the assessment completion would not be timely.

Care Planning and Utilization

Q: I understand your suggestion that we manage visit frequencies over both 30-day periods in an episode, but why would it also be necessary to avoid doubling up on visits by different disciplines on the same day?
A: This goes back to the agency's primary goal for each patient which is to keep him or her out of the hospital. One of the major quality indicators for your agency is the rate of hospitalization and hospital readmission within the first 30 days of care after an inpatient discharge. If disciplines are effectively doubling up on the same days with subsequent gaps of several days when the patient is not seen, your ability to more frequently assess a rising or high-risk patient is diminished. Alternatively, if different clinicians are seeing the patient on individual days and effectively collaborating regarding patient status and care needs, the agency is more apt to identify and address a potential problem before it becomes so significant that the patient must be hospitalized. This is good for the patient and good for the agency.

Q: How will BID frequency patients be affected by PDGM payment periods?
A: Patients who receive two visits per day, for example for insulin injections that they cannot manage themselves and where there is no available caregiver, will most likely have episodes for which the PDGM payment periods will still be calculated as Outliers. The calculation is done based on the duration of the visits and does not change from the methodology used under PPS.

Q: Will it be wise to increase visits in the second 30-day period to avoid the LUPA if the patient's condition warrants the increase and continuation of service?
A: The key issue is what is best for the patient and whether the patient needs the additional skilled intervention. If the patient's condition warrants an increase in service, the patient should receive the care irrespective of whether he/she is in a first or second payment period within an episode.

As the assessment is completed and care planning progresses, the objective will be to continually determine how visit frequencies should be spaced to maximize the benefit to the patient and achieve the desired care outcome. If the patient's needs change or if the patient is not progressing as anticipated, visit frequencies may have to be increased. If a patient's relatively minor wound is healed early and that is all that the agency is there to address, the patient may be ready for an early discharge with a discontinuation of additional planned, and unnecessary, visits. This is nothing new.

For example, when a patient has a limited need for education related to new conditions or medication changes, artificially extending visits into a second 30-day solely to secure a higher rate of reimbursement could backfire in medical review due to the potential for a finding related to lack of medical necessity. On the other hand, if we have therapy visits that could be spread out or, alternatively, front loaded to a lesser degree and then tapered for the benefit of the patient and his/her ability to fully benefit from therapy -- even with fewer total visits – adjusting the visit frequencies might make good clinical sense in terms of an optimal outcome for the patient.

Whatever you do, the visit frequencies should be closely aligned with the patient's skilled need and ability to benefit from the treatment you provide. This will require careful thought on the part of assessing clinicians and case managers next year.

Coding

Q: Many of our physicians will write scripts that direct us to "eval and treat" for muscle weakness, but their progress notes will state that the patient has arthritis or a similar condition. How would we code that?

A: The agency should code the underlying disease as primary and every code that is used should be active and traceable to a diagnosis that has been assigned and documented by a physician who has treated the patient.

Q: If a physician does not have an appropriate diagnosis in the referral order can we just write an order for the physician's signature that establishes our designation of the treatment diagnoses?
A: No. The agency's "treatment diagnoses" must be rooted in documentation that is offered by a physician who has treated the patient. The home health agency is not in the business of establishing new diagnoses for which the patient requires treatment.

Q: Can you provide more information about exactly what a *query process* entails?
A: A query process sets forth the agency's approach to ensuring that coding in each record is accurate, specific and supportive of the agency's claim for reimbursement based, in part, on identified primary and secondary diagnosis coding.

A query process should be used when documentation that is initially offered suffers from weakness due to conflicting information in the record, imprecise information as to the patient's condition, incomplete information regarding the cause of the patient's condition, ambiguous information or inconsistent information.

Queries can take several different forms. They can be structured or open ended. They can be in writing or verbal. They can be electronic (for example, an e-mail or communication note) or they can be on paper.

Whatever form the query takes, it must not be leading, and the documentation should be preserved for the record so that the agency can establish how it came to identify a diagnosis that would influence payment.

In 2016 the Association of Clinical Documentation Improvement Specialists and the American Health Information Management Association published Guidelines for Achieving a Compliant Query Practice. The paper was updated in 2019. I recommend it along with another published by AHCC entitled Establishing an Effective Query Process in the Home Health Setting. The first resource can be found at the following URL: https://acdis.org/resources/guidelines-achieving-compliant-query-practice%E2%80%942019-update

Q: When you are talking about comorbidities, can we assume that a "secondary" diagnosis is the same as a "tertiary" diagnosis?
A: "Tertiary" means third. So, a tertiary diagnosis is any diagnosis that is not the primary or second leading diagnosis. For home health, the most often used term is "secondary" as all diagnosis other than the primary are considered comorbid conditions.

Q: I understand that we can no longer use symptom codes as the primary diagnosis, but can we still use them as a secondary diagnosis code to indicate the type of treatment we will be providing?
A: There is no impediment to using symptom or non-specific codes as secondary diagnoses as long as they are relevant and in keeping with other coding conventions and guidelines.

General Billing

Q: What factors will our MAC take into consideration to recalculate the HIPPS Code that will be used for payment of the claim?
A: *Timing will come from a comparison of the Admission Date on the Claim and the Claim From Date.* If the two match, the timing will be considered Early as long as there has been no prior instance of home health within the 60-day period prior to the Admission Date and SOC. Otherwise, if the two dates are not a match – meaning the Admission Date *precedes* the Claim From Date – the period will be considered Late. Thus, the assigning

of the timing classification depends entirely on the information on the claim.

The Admission Source will be confirmed with inpatient claim data and/or the Occurrence Code on the home health claim.

1. If, the period is associated with a SOC, the Medicare system will look for an associated inpatient claim from a hospital, SNF, IRF, LTCH or inpatient psych facility with a discharge date that is within 14 days of the HH SOC date. If a qualified claim is found, the period will be classified as Institutional.

2. If the period is a second or subsequent, contiguous period in a series, the Medicare system will look only for a hospital inpatient claim and discharge within the 14-day period that immediately precedes the beginning of the home health payment period. If a qualifying hospital claim is found, the home health reimbursement will be calculated using an Institutional case-mix.

3. If the home health claim shows Occurrence Code 61 indicating a prior qualified hospital inpatient stay for any period or Occurrence Code 62 indicating a prior qualified post-acute stay in advance of the SOC date, the claim will be classified and paid using a case-mix associated with an Institutional Admission whether or not the Medicare system locates the corresponding paid or processed inpatient claim in the Medicare claims data. Be aware that second and subsequent payment periods cannot rely upon a PAC claim to establish the institutional Admission Source because, in the event of a transfer to a post-acute facility, the patient would have to be discharged by the home health agency.

The Clinical Group will be derived based on the primary diagnosis that is listed on the claim. For initial periods this will come from the SOC or Recert OASIS; however, under PDGM there will be times when the primary diagnosis could change without the use of a Follow-Up assessment (SCIC). This could be the result of a known and planned change that would occur during an episode. In this case the agency would substitute the 'new' primary diagnosis as the focus of care for the second payment period in the episode. In the case of significant changes in patient condition, the agency would be well advised to use the Follow-Up assessment in which case, the primary diagnosis associated with that assessment should flow to the claim and govern the Clinical Group assignment.

Functional Scoring will come from the most recent associated SOC, Recert, or ROC OASIS. This is the only element of the case-mix calculation that will come from any source other than a claim for reimbursement.

The Comorbidity add-on will be derived from the secondary diagnoses listed on the claim.

Q: Where should the information on the claim come from – the OASIS, the Plan of Care, or both?
A: The information on the claim needs to come from both the comprehensive assessment (which entails more than just the OASIS elements) and the Plan of Care. All three elements of the documentation in the record – the comprehensive assessment, the Plan of Care and the claim – must be consistent.

Q: How will maintenance therapy be billed under PDGM?
A: Maintenance therapy services will be billed by line item (visits) on the claim, just as any therapy visit is billed now. The only difference will be that assistants will be able to provide maintenance therapy once the plan is established by the licensed therapist.

Q: There are specific HCPCS Codes that are used to bill for maintenance therapy by PTs, OTs and SLPs. How will therapy assistant services related to maintenance be billed?

A: CMS did not define new G-Codes for therapy assistants providing maintenance services under the supervision of the licensed therapist even though it did solicit comments as to whether maintenance services need to be differentiated from other therapy service. Nothing further was offered in the Final Rule related to coding changes for therapy services. Thus, we are left with the codes that we have:

G0157	PT Assistant services
G0158	OT Assistant services
G0159	PT Maintenance service
G0160	OT Maintenance service
G0161	SLP Maintenance service

Currently, we have no G-Code for SLP assistants in the home health setting.

Q: Do we need to put Occurrence Codes on the RAPs or just on Final Claims?
A: Occurrence Codes and the associated dates will be required only on Final Claims.

Q: Will all rules regarding use of the three Occurrence Codes (50, 61 and 62) apply if Medicare is the secondary payer?
A: Yes. So, when you are submitting the secondary claim to Medicare, that information needs to be on the claim.

Q: Under Review Choice will we have to submit each of the 30-day periods for review, or just the first one for each episode?
A: Neither the Proposed Rule for 2020 nor the Final Rule addresses this question. So, we have resorted to the Review Choice FAQs and the new RCD Operations Manual (October 19, 2019) for information.

The information published by CMS thus far indicates that the RCD submission must be made based on the episode or, alternatively, it can be for multiple "episodes of care" if it is known at the time that a particular patient will require multiple recertification periods (for example, for a patient with monthly Foley catheter changes that are expected to go on for some time). There is no mention of a requirement to resubmit an affirmation request based on a second PDGM Payment Period within an episode covered by the same assessment and Plan of Care.

Q: Do we still have to bill for supplies under PDGM?
A: With respect to supplies, the only thing that changes under PDGM is that there is no longer an add-on payment for Non-Routine Supplies. It is still appropriate to bill them and there is no indication in the billing manual updates of any change related to billing of supplies. They have never been the subject of a consolidated billing edit.

Q: What is the process for changing the diagnoses codes on the claim for a late period? Is that something that the billing team can do?
A: If there is a patient change such that the codes that are listed on the final claim for the second of two periods covered by the same Plan of Care are different than those listed on the claim for the first period (either by virtue of the codes themselves or the sequencing of the codes), there must be a signed order from the certifying physician that establishes the basis for the change. Remember, any change in the Plan of Care must be accompanied by a signed order.

It would not be appropriate for the billing or revenue cycle team to make the change in the absence of an order from the physician that effectuates the reassignment or rearrangement of the diagnosis codes that pertain to the patient's focus of care.

Q: Can you please explain how the new HIPPS Codes will be structured?
A: The HIPPS Codes under PDGM will be completely different from those that we've grown accustomed to under PPS.

The table on the following page lays out how the HIPPS Code will be constructed.

HIPPS CODES UNDER				
POSITION 1 – ADMISSION SOURCE AND TIMING	**POSITION 2 –** CLINICAL GROUP	**POSITION 3 –** FUNCTIONAL IMPAIRMENT LEVEL	**POSITION 4 –** COMORBIDITY LEVEL	**POSITION 5 -** PLACEHOLDER
1 = Community Early	A = MMTA OTHER	A = LOW	1 = NONE	1
2 = Institutional Early	B = NEURO REHAB	B = MEDIUM	2 = LOW	
3 = Community Late	C = WOUNDS	C = HIGH	3 = HIGH	
4 = Institutional Late	D = COMPLEX NURSING			
	E = MS REHAB			
	F = BEHAVIORAL HEALTH			
	G = MMTA SURG AFTERCARE			
	H = MMTA CARDIAC			
	I = MMTA ENDOCRINE			
	J = MMTA GI/GU			
	K = MMTA INFECTIOUS DISEASE			
	L = MMTA RESPIRATORY			

Q: Do the rules for Outliers change under PDGM?
A: Only to the extent that Outliers will be calculated based on the 30-day payment period rather than on an episode. Otherwise, the formula stays the same and will depend on the visit duration and pro-rated payment for the proportion of 15-minute increments used for each visit.

RAPs

Q: If our agency does not submit a RAP before January 1, 2020 for an episode that began in 2019, will we receive only 20% of the calculated reimbursement amount on that RAP submission?
A: Any episode that begins in 2019 and ends in 2020 will be processed based on transitional rules. Thus, you would receive a RAP payment equal to either 60% of the total HHRG value if the episode is a Start of Care or 50% if the episode represents a recertification. The payment reduction applies only to episodes that are started in 2020 and paid under PDGM rules.

Q: When you say "newly certified agencies" won't be getting RAP payments in 2020, are you referring to agencies for which the initial certification occurred on or after January 1, 2019 or does this also apply to deemed status from accreditation bodies such as CHAP, AAHC or TJC?
A: The ruling applies to the date on which the agency became Medicare certified and has no bearing on deemed status and the date on which that became effective.

Q: We understand the Final Rule to say that if the RAP is not dropped within five days, there would be a penalty for late submission. Is that correct?
A: It is correct for services that begin *on or after January 1, 2021 and through December 31, 2021*.

So, for services that relate to 2021 episodes/ payment periods, the RAP payment is reduced to zero. In other words, even though the RAPs are still required, they will be considered "no-pay" submissions for all providers.

In addition, for the duration of 2021, if the RAP is not submitted within five days of the beginning of the period, payment will be reduced for every day from the start of the period until the RAP is submitted. For example, if our payment period has a case-mix that produces an expected payment of

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$1,800 and we do not submit the RAP until day 11, we would be penalized for 10 days – representing the day count between the start of the period and the date on which the submission is made. Assuming full payment for the period in question would amount to $1,800, our payment would be reduced by $600 ([1,800/30] x 10).

This provision is only in effect for 2021 and does not relate to services in 2020. By 2022, the Notice of Admission requirement becomes effective and the 5-day submission requirement for the NOA will apply only to the first period of the SOC. Thus, the NOA is a one-time submission as of 2022 when RAPs are no longer required.

Q: Does the Plan of Care have to be signed before we send in the RAP?
A: Currently, if the agency is relying on a verbal order to cover services while the physician's signature on the Plan of Care is pending, the POC must have been sent to the physician for signature prior to submitting the RAP.

Beginning in 2021, the rule will be relaxed somewhat and will require only that the agency have the verbal order from the physician to cover the Plan of Care and that the first visit of the episode be completed.

Q: With regard to RAP submissions and the penalty for late submissions after five days in 2021, what happens if we don't know all of the disciplines and visit frequencies within the five-day window?
A: Under the current CoPs, the comprehensive assessment must be complete within five days, and it is the comprehensive assessment that determines the patient's home health needs. So, you should at least know the disciplines and, ideally, what their recommended interventions, goals and visit frequencies will be. If that is not the case now in your agency, I recommend serious attention to the assessment process and timeline. In addition, there are good reasons for making sure that the process is completed within the five-day window for all disciplines because, among other things, this will help the agency to ensure that the functional impairment levels are correctly stated when both nursing and therapy services are contemplated.

Remember, the agency will have to portray the assessment completion date on the claim, so getting this right will be important.

Q: How do we capture all pertinent diagnoses and comorbidities for the RAP if we are unable to get these assessments finished in time? Should we just drop the RAP to avoid the penalty and hope to catch up before sending in the EOE?
A: Respectfully, the assessments need to be finished on time. This is not a new requirement.

Until the assessment is complete, the agency cannot have a fully developed Plan of Care. And without a Plan of Care that is approved by the certifying physician for the purpose of guiding the agency's care delivery, the agency's clinicians should not be visiting the patient.

Work on your processes to ensure that the following things happen to facilitate compliance with this requirement:

- Make sure that the intake team is getting as much information as possible from the physician and/or the inpatient facility related to the patient and his/her course of treatment and diagnoses. This will facilitate timely coding.
- Make sure that the assessing clinicians are completing their assessments on time (within 24 hours) so that the coders can get to them and code the pertinent diagnoses for both the assessment and the claim (remember that the assessment typically won't have room for all 25 diagnosis codes).
- This will enable the agency to formulate the Plan of Care and obtain the physician's verbal order before additional services are provided.
- Make sure that when more than one discipline is contemplated for the care that the other disciplines – particularly the therapists - have a chance to interact with the patient within that initial five-day window so that they can effectively collaborate with the rest of the team relative to care planning and portrayal of findings related to the patient's health status.
-

Q: If clinicians have five days to complete the SOC or Recert OASIS, how can CMS expect that the RAP will be submitted within the same timeframe?
A: The rules are changing a little bit, and this will help. At the time that the RAP submission requirement and penalty takes effect in 2021, all the agency will need to submit the RAP is the verbal order for the SOC/recert period which should be in place quickly and completion of the assessment visit as the prerequisite for sending in the RAP.

Q: What is the timeframe for RAP cancellations under PDGM?
A: The RAP auto cancellation rules have not changed. The RAP will auto cancel upon the later of 60 days from the end of the episode or 60 days from the issuance of the RAP payment. In 2021, as RAP payments cease, RAP auto cancellations will also cease.

Q: What happens if our RAP is cancelled because all of the documentation needed for billing is not in on time? Will we lose all payment under that set of circumstances?
A: No. If the RAP cancels in 2020, you would resubmit the RAP when the documentation required for billing is available followed by submission of the final claim in short succession. This is what you are likely doing now – this is what you will do in 2020.

Q: Please clarify the RAP submission requirement for recertification periods where the patient might not have the first visit within the first five days of the payment period. For example, how would this be handled for a patient with orders for monthly Foley catheter changes when the first visit is not within the first five days of the period?
A: The visit requirement relates only to the first visit of the episode. So, for a second period where, as in your example, the patient might not have a visit within the first five days of the period, it won't matter because the prerequisite for the visit completion relates only to the first visit of the episode.

CMS released MLN Matters 11527 on November 8th and it addresses this topic as well. The article notes that for RAPs associated with initial periods of care, the agency would report on the 0023 revenue code line the date of the first covered visit provided during the episode/period. For subsequent periods of care, the agency would report on the 0023 revenue code line the date of the first visit provided during the episode or period regardless of whether the visit was covered or non-covered.

The one exception to reporting a visit date with the 0023 revenue code of the RAP is when no visits are expected during a 30-day period of care. For instance, if the beneficiary's Plan of Care requires that the beneficiary is seen every six weeks and there is a recertification the beneficiary might receive no visits in the first 30-day period following the recertification. In this case, the agency should submit the RAP for all 30-day periods, but only submit claims for the periods in which visits were performed.

If no visits are expected during an upcoming 30-day period, the agency should submit the RAP with the first day of the period of care as the service date on the 0023 revenue code line. The RAP for a period with no visits will ensure that the agency remains recorded in the CWF as the primary home health provider for the beneficiary and will ensure that consolidated billing rules are enforced. If no visits are provided, the RAP will later be cancelled to recover payment.

Q: How will the RAP submission timeline work for States under Review Choice?
A: CMS has not published any information that would suggest that for States under RCD the RAP submission requirements will be any different from other States.

Discharge Planning

Q: How often do we have to ask the hospital to add our agency to its list of qualified providers?
A: The agency must request to be added to the hospital's list of home health agencies within the service area. The regulation does not indicate how often this should occur, but I'm guessing that it would be good to do so annually. And, that might be a good time to also update the hospital discharge planning team on the agency's most current quality metrics and resource use measures such as hospitalizations or readmission rates.

Q: How will the quality data and measures be presented to the patient at the hospital?
A: The hospital will have an obligation to share quality and resource use information that is "relevant and applicable to the patient's goals of care and treatment preferences." If a patient is not being identified for a home health discharge, the hospital would not share information about its list of available providers.

Q: How does the hospital disclose its financial interest with the patient? For example, we know that some of the hospitals in our area have their own agencies and their liaisons are already inside the hospital meeting with patients prior to discharge.
A: The regulation as revised states that "the hospital, as part of the discharge planning process, must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services and must, when possible, respect the patient's or the patient representative's goals of care and treatment preferences as well as other preferences they express. The hospital must not specify or otherwise limit the qualified providers or suppliers that are available to the patient."

Q: Does the home health data that can be used to establish our agency as a high-quality provider have to be only from Home Health Compare or can we submit additional quality data of our own to the hospital?
A: The data must be relevant but does not have to be limited to the metrics that one would find on Home Health Compare. Thus,

if you have more current information or, for example, additional information that establishes the agency's expertise or skill with certain types of complex patients, there is nothing in the regulations that would preclude you from offering that to the hospital for its use in establishing relevant quality distinctions among providers on its list.

Q: If the home health agency is discharging a patient to a hospital, do we have to share a list of hospitals that the patient can go to with their quality information?
A: The requirements relating to home health discharges are directed toward post-acute care providers. There is no requirement related to home health transfers with discharge.

Q: Does the discharge planning guidance extend to situations where one agency is transferring a patient to another agency?
A: Yes. In the case of a transfer to another home health provider, the transferring agency must send necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences to the receiving agency. This is intended to ensure a safe and effective transition of care. Likewise, the transferring agency must comply with requests for additional clinical information as may be necessary for treatment of the patient by the receiving organization.

Q: Is there any guidance regarding discharging a patient from home health to a provider that is not Medicare certified?
A: The regulations do not distinguish among potential discharge destinations in terms of whether the receiving agency or facility is or is not Medicare certified.

Q: Does the home health agency have any obligation to share quality data and resource measures about post-acute care facilities to which we discharge patients?
A: Yes. As with the hospital rules, home health agencies are obligated to "assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF or LTCH data on quality and resource use measures that are relevant and applicable to the patient's goals of care and treatment preferences.

Q: How does the discharge planning apply to agencies that have both home health and hospice where the same team follows the patient from one type of care to the next?
A: Freedom choice applies in this situation, too. Hospices are not specifically on the list of identified post-acute destinations following home health, but if you have a patient who wishes to elect hospice and who is appropriate for hospice, the agency would have an obligation to share information about its own program as well as others that may be appropriate for the patient's needs to promote freedom of choice.

Q: How does the discharge preference work for HH discharges when it comes to patients under capitation arrangements? Would we not still be obligated to default to the affiliated agency as opposed to providing patient choice. Would that not cause billing complications?
A: The discharge planning process is not driven by the availability of third-party reimbursement, but it certainly would have a bearing on patient choice I would think. The discharging entity is obligated to abide by the principle of patient choice. But, if there are certain agencies that the hospital knows are contracted with a particular Medicare Advantage plan, that would be information that would be relevant and appropriate to disclose, assuming that the hospital has the information. The same would be true for the home health agency if a patient is going to another post-acute provider.

Q: What are the documentation requirements for a home health discharge? Is this something that would be generated by the case manager or the clinical staff? Can

the discharge planning requirement be addressed by a single document like an order or is it expected to be documented in a series of communication notes in addition to the Plan of Care?
A: First, the home health agency must develop and implement an effective discharge planning process that is geared toward patient preference and discharge goals. For patients who are being transferred to another agency or who are being discharged to a SNF, IRF or LTCH, the agency must also assist patients and their caregivers with the selection of a provider by using and sharing quality and resource use data which is appropriate and relevant to the patient and his/her treatment preferences and goals.

Generally speaking, this is something that would be handled by the clinical team. The new rules do not specify whether the planning process culminates in a single document that is shared with the patient/caregiver or how discharge goals, preferences and plans are otherwise documented and communicated. That is the piece that relates to the agency-specific process that must be defined. The key element here, though, is that the patient and his/her caregivers must be involved in the process and informed about it as it unfolds.

Infusion Services

Q: Do we need to have a new and separate accreditation to provide skilled nursing services to patients receiving infusion services at home?
A: No. The accreditation that is contemplated by the rule is for infusion providers, aka those who are supplying the drugs or biologicals. The provision of skilled nursing services in the home does not require additional accreditation on the part of the home health provider.

Q: Regarding infusion therapy services, does this only apply to a specific list of IV medications? So, if the infusion drug is not on the list, can home health still provide service under the home health benefit (assuming the patient meets the eligibility standard)?
A: Yes. The list of IV medications is limited and does not generally include substances that can be self-administered by more than 50% of the Medicare population as measured by CMS. The medications fall into three categories: Payment Category 1 covers antifungals and antivirals, inotropic and pulmonary hypertension drugs, pain management drugs and chelation drugs. Payment Category 2 includes subcutaneous immunotherapy drugs. Payment Category 3 includes chemotherapy drugs and biologicals. If the infusion drug is not on the list of drugs that are covered for home infusion and is intended to be self-administered, the home health agency would still be able to provide services related to patient education and periodic dressing changes, etc. under the home health benefit.

Quality Reporting

Q: Are the quality measures limited to what is reported on Home Health Compare?
A: No. Home Health Compare reports some but not all of the quality data that is gathered and analyzed.

Q: If our agency is submitting the SOC, Recert and ROC OASIS why do we still have a problem with the 2% payment reduction?
A: The quality submissions rely on data from episodes of care that begin with an SOC or a Resumption and end with a Discharge. So, if your agency only submits the 'front half' of the OASIS assessment picture, that is why you still have to deal with the payment reduction. The best rule of thumb is to submit all of the OASIS not just those that are needed to claims matching under PPS and/or functional scoring under PDGM.

Q: Can you please explain why we are going to have all of these new SPADEs questions on the OASIS and when the new ones take effect?

A: The "why" part of the question relates to the IMPACT Act which, among other things, establishes the need for assessment data that is standardized and comparable across the entire post-acute spectrum. In other words, we are talking about data that is measuring the same things irrespective of where the patient is receiving care.

The new SPADEs elements are the *standardized patient assessment data elements* that are the same across settings. We already have some of them – for example, the GG elements on the OASIS are from this initiative. The next ones will be on the OASIS for 2021 and will be included in quality reporting by 2022. They include measures for the following:

- Cognitive function and mental status
- Special services, treatments, and interventions
- Medical condition and comorbidity data
- Impairment data
- Social determinants of health

About the author

Sharon S. Harder has over three decades of executive management experience in the healthcare industry. She has served in financial and operational leadership roles in a variety of healthcare organizations, ranging from large post-acute healthcare providers to a major healthcare professional association. As president of C3 Advisors, LLC Sharon engages with clients to develop and implement the strategic vision required to improve their profitability and competitive position in the rapidly transforming healthcare marketplace.

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