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White paper

What every home health agency should know about the Patient Driven Groupings Model: A three-part series

Part II - Digging deeper: small but significant PDGM details

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About the author

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As with nearly every major rule change, the basics are just the tip of the iceberg and PDGM is certainly no exception. There is complexity that will require study and thought, there are a few subtle nuances that will influence payments and it seems as though there are exceptions everywhere. In this installment of the PDGM series, we'll explore some of those areas to get a deeper and more thorough understanding of what lies ahead.

30-Day Payment Periods

As the plan stands now, PDGM Payment Periods will apply to services that begin on or after January 1, 2020.

As CMS analyzed episode characteristics it became clear that there is a difference in resource use between the first half of a 60-day episode and the last half with far more resource deployment in the early days of service. And, about a third of all episodes during 2017 concluded within 30 days. The average length of all episodes is about 45 days.

Five key things to know about payment periods

1. Assuming that the agency is qualified to submit a RAP (meaning that the agency is Medicare certified prior to January 1, 2019), the interim payments will continue. The billing sequence will be to submit the RAP for payment followed by submission of the Final Claim attributable to the 30-Day Payment Period. Thus, for every episode that goes on for more than 30 days, there will be two sets of claim submissions (a RAP and a Final Claim for each Payment Period) and two sets of payments (the RAP payment and the Final adjustment for each Payment Period).

2. Visit volume will not matter for purposes of calculating payments except when it comes to Payment Periods that have low-utilization, or LUPA, adjustments or, at the other end of the spectrum, Outlier adjustments. For these, services will be paid on a visit by visit basis, much as they are paid now.

PDGM LUPA Thresholds in Excess of the PPS LUPA Visit Level					
Timing	**Admission Source**	**Clinical Group**	**Functional Impairment**	**Comorbidity Level**	**LUPA Threshold**
Early	Institutional	Complex Nursing	Medium	Interactive	5
Early	Community	MMTA Cardiac	Medium	None	5
Early	Community	MMTA Cardiac	Medium	Interactive	5
Early	Community	MMTA Cardiac	High	None	5
Early	Institutional	MMTA Cardiac	Medium	Interactive	5
Early	Community	MMTA Endocrine	Medium	None	5
Early	Community	MMTA Endocrine	Medium	Low	5
Early	Community	MMTA Endocrine	Medium	Interactive	5
Early	Community	MMTA Endocrine	High	None	5
Early	Community	MMTA Endocrine	High	Low	5
Early	Community	MMTA GI/GU	Medium	Interactive	5
Early	Institutional	MMTA GI/GU	Medium	Interactive	5
Early	Community	MMTA Other	Medium	None	5
Early	Community	MMTA Other	Medium	Low	5
Early	Community	MMTA Other	Medium	Interactive	5
Early	Community	MMTA Other	High	None	5
Early	Community	MMTA Other	High	Low	5
Early	Community	MMTA Other	High	Interactive	5
Early	Institutional	MMTA Other	Medium	Low	5
Early	Institutional	MMTA Other	Medium	Interactive	5
Early	Institutional	MMTA Other	High	Low	5
Early	Institutional	MMTA Other	High	Interactive	5
Early	Community	MMTA Respiratory	Medium	Interactive	5
Early	Community	MMTA Respiratory	High	Interactive	5
Early	Institutional	MMTA Respiratory	Medium	Interactive	5
Early	Community	MMTA Surgical Aftercare	Medium	Interactive	5
Early	Institutional	MMTA Surgical Aftercare	Medium	Low	5
Early	Institutional	MMTA Surgical Aftercare	Medium	Interactive	5
Early	Institutional	MMTA Surgical Aftercare	High	Low	5
Early	Institutional	MMTA Surgical Aftercare	High	Interactive	5
Early	Community	MS Rehab	Low	None	5
Early	Community	MS Rehab	Low	Low	5
Early	Community	MS Rehab	Low	Interactive	5
Early	Community	MS Rehab	Medium	None	5
Early	Community	MS Rehab	Medium	Low	5
Early	Community	MS Rehab	Medium	Interactive	5
Early	Community	MS Rehab	High	None	5
Early	Community	MS Rehab	High	Low	5
Early	Community	MS Rehab	High	Interactive	5
Early	Institutional	MS Rehab	Low	None	5
Early	Institutional	MS Rehab	Low	Low	5
Early	Institutional	MS Rehab	Low	Interactive	5
Early	Institutional	MS Rehab	Medium	None	6
Early	Institutional	MS Rehab	Medium	Low	6
Early	Institutional	MS Rehab	Medium	Interactive	6
Early	Institutional	MS Rehab	High	None	6
Early	Institutional	MS Rehab	High	Low	6
Early	Institutional	MS Rehab	High	Interactive	6

PDGM LUPA Thresholds in Excess of the PPS LUPA Visit Level					
Timing	**Admission Source**	**Clinical Group**	**Functional Impairment**	**Comorbidity Level**	**LUPA Threshold**
Early	Community	Neuro	Low	Low	5
Early	Community	Neuro	Medium	None	5
Early	Community	Neuro	Medium	Low	5
Early	Community	Neuro	Medium	Interactive	6
Early	Community	Neuro	High	Low	5
Early	Community	Neuro	High	Interactive	5
Early	Institutional	Neuro	Low	None	5
Early	Institutional	Neuro	Low	Low	5
Early	Institutional	Neuro	Low	Interactive	5
Early	Institutional	Neuro	Medium	None	6
Early	Institutional	Neuro	Medium	Low	6
Early	Institutional	Neuro	Medium	Interactive	6
Early	Institutional	Neuro	High	None	5
Early	Institutional	Neuro	High	Low	5
Early	Institutional	Neuro	High	Interactive	5
Late	Institutional	Neuro	Medium	Interactive	5
Early	Community	Wound	Low	None	5
Early	Community	Wound	Medium	None	5
Early	Community	Wound	Medium	Low	5
Early	Community	Wound	Medium	Interactive	5
Early	Community	Wound	High	Low	5
Early	Institutional	Wound	Medium	None	5
Early	Institutional	Wound	Medium	Low	5
Early	Institutional	Wound	Medium	Interactive	5
Early	Institutional	Wound	High	Low	5

3. Billing requirements will not change under PDGM. That means that the OASIS that drives the payment calculation must be complete and exported. As well, Plans of Care, certifications, supplemental orders and any other documentation requiring a signature must be in hand and appropriately signed and dated by the relevant parties prior to billing for services in any 30-Day Payment Period. This will mean that the revenue cycle team will need to focus on greater efficiency with respect to billing timeframes to ensure sufficient cash flow for operations.

4. The first 30-Day Payment Period will be classified as Early. All others in a contiguous series will be considered Late Payment Periods. The key point with respect to Early versus Late periods is that the 60-day gap following a home health discharge still applies to the timing classification. Thus, if a patient is discharged from the agency and returns for a new SOC within 60-days of his/her discharge, the new episode would begin with a Late, rather than Early, Payment Period.

5. Comprehensive assessments with OASIS data will continue to apply to 60-day episodic periods or two 30-Day Payment Periods. It is anticipated that the diagnosis coding that drives the assignment of the Clinical Grouping from the first period in an episode to the second will not change. If the agency must change the patient's primary diagnosis at some point, it appears that there will be an obligation to accompany the change with a follow-up assessment that memorializes the fluctuation in patient condition leading to the coding change. The coding change would only take effect in the second of the two Payment Periods; however, as the initial Clinical Grouping will not be subject to change in the midst of a Payment Period.

In a situation when there is a change in patient condition, not only will a follow-up assessment need to be completed, it is also expected that the agency would obtain a physician order that effectuates the update to the Plan of Care.

Admission sources

It is important to understand what CMS really means by the term "Admission Source." Traditionally, a home health admission is a single event that occurs at the start of a home health stay that could go on for a single episode or several, concurrent 60-day episodes. All home health admissions are memorialized by a Start of Care (SOC) assessment. When it comes to PDGM, however, the Admission Source category is established at the beginning of each Payment Period, or every 30 days, and is predicated on the patient's whereabouts in the 14-day span leading up to the first day of the Payment Period. Thus, in a full 60-day episode with two Payment Periods, there will be two opportunities to establish the PDGM Admission Source and, they can be different from one period to the next. In reality, the term "Admission Source" as it is used in connection with PDGM more aptly applies to the patient's medical history and place(s) of service, if any, in the 14 days prior to each Payment Period.

Patients who receive inpatient care in a facility setting such as an acute care hospital, skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long-term care hospital (LTCH) or an inpatient psychiatric hospital and who are discharged within 14-days of a home health SOC and first Payment Period will be considered Institutional Admissions. All other patients who do not meet the inpatient stay requirement would be classified as Community Admissions at the Start of Care.

Most often, a second Payment Period in any SOC episode would be construed as a Community Admission irrespective of how the prior Payment Period was classified. The same would be true for recertifications and the Payment Periods associated subsequent episodes. There is an exceptions to this axiom, though.

Five key things to know about admission sources

1. Institutional Admissions can pertain to stays that are paid by traditional Medicare or another payer.

2. Patients who receive outpatient services including surgical procedures, even if they are provided within an inpatient facility, would not come under the Institutional Admission definition.

   Observation services will not be eligible for the Institutional Admission category even though the services are typically rendered in a hospital setting. A relevant example is the practice of some hospitals to keep joint replacement patients for one to two days in observation status, discharging them to home health thereafter. If the patient was not hospitalized as an inpatient following the surgical procedure, the home health admission would be considered a Community Admission rather than an Institutional Admission.

   It will be important to fully understand the distinctions that will influence classification of patients in advance of each Payment Period.

3. Home health patients in a second or subsequent Payment Period will always be classified as Community Admissions for purposes of the Payment Period unless there is an acute inpatient hospitalization in the 14 days prior to the start of the subsequent Payment Period. These would be home health transfers without discharge from the agency's care followed by a Resumption of Care in that 14-day timeframe. In such cases, the subsequent Payment Period would qualify as an Institutional Admission for purposes of calculating the case-mix.

   It is important to note that a post-acute stay occurring in the midst of a subsequent Payment Period -- for example one in a SNF, IRF, or LTCH -- would not be classified as an Institutional Admission in advance of a subsequent Payment Period unless the patient was discharged from the home health episode commensurate with the transfer and readmitted to home health with a new SOC. The start of a new home health episode could qualify as an Institutional Admission if the 14-day requirement is met.

The key takeaway, here, is that coding of the Transfer OASIS becomes important. If a patient is transferred and enters a post-acute facility before home health services are reinstituted and the RFA on the Transfer OASIS was 06, when the patient comes back to home health he/she would be classified as a Community Admission. On the other hand, if the Transfer OASIS RFA is 07, indicating a discharge from the agency, the continuation of the patient's home health services would be considered a new SOC and the Institutional Admission source would apply.

4. Agencies will be able to use new Occurrence Codes to signify that a Payment Period follows a qualified inpatient discharge. Inclusion of the Occurrence Code on the home health claim will not be required when the inpatient stay is paid by Medicare; however, for inpatient stays attributable to any other payer source the Occurrence Code must be present to qualify the payment based on the Institutional Admission criteria.

   Medicare systems will confirm the status based on an examination of Medicare claims data as home health Final Claims are submitted for payment. Conversely, when a Medicare claim is submitted following an acute inpatient or post-acute stay, Medicare systems will also backtrack to check for a prior home health claim with a Community Admission source and, if found, will adjust the home health claim accordingly. All of this will be limited to the 12-month timely filing window, however.

   The confirmation of Admission Source designations is purely a claims-based exercise and, even though OASIS data includes information about prior inpatient stays, it will not be used to establish or confirm Admission Source classifications.

5. During medical review of a claim that relies on an Institutional Admission classification, if no acute or post-acute claim can be located in Medicare claims data and no documentation is offered by the agency to confirm the inpatient stay, Medicare will revert the coding to signify a Community Admission and will adjust any prior payment made to correct for the overpayment based on the Institutional Admission Source coding. The key takeaway is that providers will be well-served to obtain documentation of any prior inpatient stray that is being relied upon to establish an Institutional Admission Source for purposes of payment.

Clinical groupings

Each of the 12 Clinical Groups will be assigned based on each patient's primary diagnosis. CMS has identified over 43,000 ICD-10 codes that are assigned to one of the following 12 groups. Notably, in both 2016 and 2017 one in five claims had generalized, non-specific coding that prevented assignment to a Clinical Group which suggests that coding improvements will be an important component of the 2019 preparatory work undertaken by many agencies.

PDGM CLINICAL GROUPS	
Clinical Group	**Primary Reason for Home Health Care**
Musculoskeletal Rehab	Therapy (physical, occupational or speech) for a musculoskeletal condition.
Neuro/Stroke Rehab	Therapy (physical, occupational or speech) for a neurological condition or stroke.
Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcers, burns and other lesions.
Behavioral Health Care	Assessment, treatment and evaluation of psychiatric conditions.
Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions including IV, TPN, enteral nutrition, ventilator and ostomies.

PDGM CLINICAL GROUPS	
Clinical Group	**Primary Reason for Home Health Care**
Medication Management, Teaching and Assessment (MMTA)	
MMTA – Surgical Aftercare	Assessment, evaluation, teaching and medication management for surgical aftercare.
MMTA – Cardiac/Circulatory	Assessment, evaluation, teaching and medication management for cardiac or other circulatory related conditions.
MMTA – Endocrine	Assessment, evaluation, teaching and medication management for endocrine related conditions.
MMTA – GI/GU	Assessment, evaluation, teaching and medication management for gastrointestinal or genitourinary related conditions.
MMTA – Infectious Disease/Neoplasms/Blood-forming Diseases	Assessment, evaluation, teaching and medication management for conditions related to infectious disease, neoplasms, and blood forming diseases.
MMTA – Respiratory	Assessment, evaluation, teaching and medication management for respiratory related conditions.
MMTA - Other	Assessment, evaluation, teaching and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups.

Five key things to know about clinical groups

1. In response to industry concerns that the MMTA Clinical Group was a 'catch-all' category, the grouping was segmented into six specific and one non-specific subgrouping. CMS notes, however, that the case-mixes associated with the diagnoses in each of the expanded groups has not changed.

2. Diagnostic coding and attention to appropriate diagnostic sequencing will be of paramount importance as PDGM is implemented. In an analysis of 2016 and 2017 data, CMS notes that approximately one in five claims was accompanied by a primary diagnosis code that was not descriptive of a medical disease, condition or injury. Rather, a fifth of all claims were predicated on symptomatic or generalized codes that will not yield a Clinical Grouping assignment under PDGM. Each claim must have a recognized primary ICD-10 code from the 'approved' list of 43,000 codes in order to be eligible for reimbursement. Indeed, without a valid primary diagnosis, the case-mix cannot be calculated.

3. There are no "R" Codes in the list of approved PDGM diagnoses. CMS notes that while such codes are recognized for the reporting of signs, symptoms and less well-defined conditions, they do not lend themselves to establishment of a specific, focused Plan of Care. An R Code that is often used is R26.89; abnormality of gait; however, this code does not portray the underlying condition that is causing the abnormality. Coding teams should keep in mind that CMS is looking for that underlying disease code that is the causation of the patient's skilled need.

4. CMS notes the following with respect to coding; agencies will be well served to begin implementing these principles if there are any questions around the sufficiency of coding between now and January 2020.

    - By the time patients are referred for home health services, it is expected that definitive coding can be performed to ensure accuracy and specificity of Clinical Groupings.
    - Clinicians should not be in the habit of using "unspecified" codes when they can identify the side or site of the patient's condition that warrants home health. In other words, laterality needs to be coded.
    - If additional information is needed by the agency to establish a definitive and specific primary

diagnosis, CMS expects agencies to follow up with the physician to ensure that the Plan of Care is established in a way that meets the needs of the patient and establishes clear medical necessity.

5. Case mixes cannot be adjusted in a single period. If there is a change in the patient's condition that would warrant reassignment of the principal diagnosis and; hence, the Clinical Grouping, a new assessment must be submitted to reflect the change. CMS has made it clear that this will be a claim matching requirement.

Functional impairment levels

Functional Impairment Levels are drawn from the associated OASIS for each Payment Period. Levels are classified as Low, Medium or High. In essence, Low Impairment suggests a higher level of function and High Impairment, conversely, is indicative of a lower level of functional ability. CMS expects that PDGM Payment Periods will be evenly distributed among the three levels of Functional Impairment.

Two Key Things to Know About Functional Impairment Scoring

1. There will be eight OASIS ADL categories that will drive Functional Impairment scores under PDGM; M1800 (Grooming), M1810 (Current Ability to Dress Upper Body), M1820 (Current Ability to Dress Lower Body, M1830 (Bathing), M1840 (Toilet Transferring), M1850 (Transferring), M1860 (Ambulation/Locomotion), and M1032 (Risk of Hospitalization). Depending on the response to each element, points will be awarded and will drive the categorization of functional impairment. The table below shows the point counts for each OASIS Item and response based on CMS' analysis of 2017 data. It is important to keep in mind that Functional Impairment point values could be subject to change by the time PDGM is implemented.

OASIS POINTS FOR FUNCTIONAL IMPAIRMENT SCORING

(BASED ON 2017 DATA)

Response		0	1	2	3	4	5	6
OASIS Item	OASIS Topic	CM Points	CM Points	CM Points	CM Points	CM Points	CM Points	CM Points
M1800	Grooming	-	-	4	4			
M1810	Upper Body Dressing	-	-	6	6			
M1820	Lower Body Dressing	-	-	5	11			
M1830	Bathing	-	-	3	13	13	21	21
M1840	Toilet Transferring	-	-	4	4	4		
M1850	Transferring	-	4	8	8	8	8	
M1860	Ambulation	-	-	10	12	24	24	24
M1032	Hospitalization Risk	4 or more items checked = 11 points						

2. Functional Impairment Point Ranges will determine the impairment level by Clinical Grouping as shown below. Points shown are based on 2017 data and could be subject to change by the time PDGM is implemented.

FUNCTIONAL LEVELS BY CLINICAL GROUP

(BASED ON 2017 DATA)

Clinical Group	Impairment Level	Points	Clinical Group	Impairment Level	Points
Behavioral Health	Low	0-36	MMTA – Cardiac and Circulatory	Low	0-36
	Medium	37-52		Medium	37-52
	High	53+		High	53+
Complex Nursing Interventions	Low	0-38	MMTA – Endocrine	Low	0-51
	Medium	39-58		Medium	52-67
	High	59+		High	68+

FUNCTIONAL LEVELS BY CLINICAL GROUP (BASED ON 2017 DATA)					
Clinical Group	**Impairment Level**	**Points**	**Clinical Group**	**Impairment Level**	**Points**
Musculoskeletal Rehabilitation	Low	0-38	MMTA Gastrointestinal and Genitourinary Systems	Low	0-27
	Medium	39-52		Medium	28-44
	High	53+		High	45+
Neuro/Stroke Rehabilitation	Low	0-44	MMTA – Infection Disease, Neoplasms, and Blood-Forming Diseases	Low	0-32
	Medium	45-60		Medium	33-49
	High	61+		High	50+
Wounds	Low	0-42	MMTA – Respiratory	Low	0-29
	Medium	43-61		Medium	30-43
	High	62+		High	44+
MMTA – Surgical Aftercare	Low	0-24	MMTA - Other	Low	0-32
	Medium	25-37		Medium	33-48
	High	38+		High	49+

Comorbidity Adjustments

There will be three levels of Comorbidity Adjustments – No Adjustment, Low Adjustment or High/Interactive Adjustment. Comorbidities that count toward adjustments will be those that CMS considers to be home health specific conditions. There will be 13 Low Comorbidity Adjustment possibilities under PDGM and 34 interactive groups that will add comorbidity adjustments. Comorbidity adjustments will be calculated by the MAC at the time of payment based on the diagnoses presented on the Final Claim. It will be important to make sure that all relevant diagnoses are not only coded but present on the final claim submission.

Five Key Things to Know About PDGM Comorbidity Adjustments

1. Comorbidity adjustments are intended to reward agencies for cases where resource use is above the median when taking into consideration a patient's attributes other than those addressed by the primary diagnosis.

2. Low Comorbidity Adjustment Subgroups rely on a single comorbid diagnosis based on data included on the Final Claim. There are 11 possibilities.

LOW COMORBIDITY ADJUSTMENT SUBGROUPS	
Comorbidity Subgroup	**Description**
Cerebral 4	Includes sequelae of cerebral vascular diseases
Circulatory 10	Includes varicose veins and ulceration
Circulatory 9	Includes acute and chronic embolisms and thrombosis
Heart 10	Includes cardiac dysrhythmias
Heart 11	Includes heart failure
Neoplasms 1	Includes oral cancers
Neuro 10	Includes peripheral and polyneuropathies
Neuro 11	Includes diabetic retinopathy and other blindness

LOW COMORBIDITY ADJUSTMENT SUBGROUPS	
Comorbidity Subgroup	**Description**
Neuro 5	Includes Parkinson's Disease
Neuro 7	Includes hemiplegia, paraplegia and quadriplegia
Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
Skin 3	Includes diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
Skin 4	Includes Stage Two through Four and Unstageable pressure ulcers

3. There are 34 interaction groups that will be used to establish high Comorbidity Adjustments. Once again, interaction groups will be based on diagnoses listed on the Final Claim.

HIGH COMORBIDITY ADJUSTMENT INTERACTION SUBGROUPS				
Comorbidity Subgroup Interaction	**Comorbidity Subgroup**	**Description**	**Comorbidity Subgroup**	**Description**
1	Behavioral 2	Includes depression and bipolar disorder	Skin 3	Includes diseases of arteries, arterioles, ad capillaries with ulceration and non-pressure, chronic ulcers
2	Cerebral 4	Includes sequelae of cerebral vascular diseases	Circulatory 4	Includes hypertensive chronic kidney disease
3	Cerebral 4	Includes sequelae of cerebral vascular diseases	Heart 10	Includes cardia dysrhythmias
4	Cerebral 4	Includes sequelae of cerebral vascular diseases	Heart 11	Includes heart failure
5	Cerebral 4	Includes sequelae of cerebral vascular diseases	Neuro 10	Includes peripheral and polyneuropathies
6	Circulatory 10	Includes varicose veins with ulceration	Endocrine 3	Includes diabetes with complications
7	Circulatory 10	Includes varicose veins with ulceration	Heart 11	Includes heart failure
8	Circulatory 4	Includes hypertensive chronic kidney disease	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
9	Circulatory 4	Includes hypertensive chronic kidney disease	Skin 3	Includes diseases of arteries, arterioles, ad capillaries with ulceration and non-pressure chronic ulcers
10	Circulatory 4	Includes hypertensive chronic kidney disease	Skin 4	Includes Stages Two through Four and Unstageable Pressure Ulcers
11	Circulatory 7	Includes atherosclerosis	Skin 3	Includes diseases of arteries, arterioles, ad capillaries with ulceration and non-pressure chronic ulcers
12	Endocrine 3	Includes diabetes with complications	Neuro 5	Includes Parkinson's Disease
13	Endocrine 3	Includes diabetes with complications	Neuro 7	Includes hemiplegia, paraplegia and quadriplegia

HIGH COMORBIDITY ADJUSTMENT INTERACTION SUBGROUPS				
Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description	Comorbidity Subgroup	Description
14	Endocrine 3	Includes diabetes with complications	Skin 3	Includes diseases of arteries, arterioles, ad capillaries with ulceration and non-pressure chronic ulcers
15	Endocrine 3	Includes diabetes with complications	Skin 4	Includes Stages Two through Four and Unstageable Pressure Ulcers
16	Heart 10	Includes cardiac dysrhythmias	Skin 4	Includes Stages Two through Four and Unstageable Pressure Ulcers
17	Heart 11	Includes heart failure	Neuro 10	Includes peripheral and polyneuropathies
18	Heart 11	Includes heart failure	Neuro 5	Includes Parkinson's Disease
19	Heart 11	Includes heart failure	Skin 3	Includes diseases of arteries, arterioles, ad capillaries with ulceration and non-pressure chronic ulcers
20	Heart 11	Includes heart failure	Skin 4	Includes Stages Two through Four and Unstageable Pressure Ulcers
21	Heart 12	Includes other heart diseases	Skin 3	Includes diseases of arteries, arterioles, ad capillaries with ulceration and non-pressure chronic ulcers
22	Heart 12	Includes other heart diseases	Skin 4	Includes Stages Two through Four and Unstageable Pressure Ulcers
23	Neuro 10	Includes peripheral and polyneuropathies	Neuro 5	Includes Parkinson's Disease
24	Neuro 3	Includes dementias	Skin 3	Includes diseases of arteries, arterioles, ad capillaries with ulceration and non-pressure chronic ulcers
25	Neuro 3	Includes dementias	Skin 4	Includes Stages Two through Four and Unstageable Pressure Ulcers
26	Neuro 5	Includes Parkinson's Disease	Renal 3	Includes nephrogenic diabetes and insipidus
27	Neuro 7	Includes hemiplegia, paraplegia and quadriplegia	Renal 3	Includes nephrogenic diabetes and insipidus
28	Renal 1	Includes chronic kidney disease and ESRD	Skin 3	Includes diseases of arteries, arterioles, ad capillaries with ulceration and non-pressure chronic ulcers
29	Renal 1	Includes chronic kidney disease and ESRD	Skin 4	Includes Stages Two through Four and Unstageable Pressure Ulcers
30	Renal 3	Includes nephrogenic diabetes and insipidus	Skin 4	Includes Stages Two through Four and Unstageable Pressure Ulcers
31	Respiratory 5	Includes COPD and asthma	Skin 3	Includes diseases of arteries, arterioles, ad capillaries with ulceration and non-pressure chronic ulcers
32	Respiratory 5	Includes COPD and asthma	Skin 4	Includes Stages Two through Four and Unstageable Pressure Ulcers
33	Skin 1	Includes cutaneous abscess, cellulitis and lymphangitis	Skin 3	Includes diseases of arteries, arterioles, ad capillaries with ulceration and non-pressure chronic ulcers
34	Skin 3	Includes diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers	Skin 4	Includes Stages Two through Four and Unstageable Pressure Ulcers

4. Only one adjustment will be made per Payment Period irrespective of how many might apply.

5. It is expected that about 40% of all Payment Periods will receive a Low or High Comorbidity Adjustment. Comorbidity classifications, like case-mix weights, will be recalibrated annually and the list of applicable comorbidities and interactions could also be amended with additions and/or deletions.

The key takeaway:

Take it one step at a time

The structure of PDGM is complex. I will creep out to the edge of the limb and predict that it will become ***even more so*** as questions are raised and factored into the mix of how reimbursement for services will actually happen. Because of the inherent complexity, not to mention the initial unfamiliarity with some of the underlying methods of PDGM, the best way to approach an understanding of the program is piece by piece; one step at a time. Only then will we be able to fully understand and plan for all of the working parts that will operate to change things in the future.

The next, and final, installment in our PDGM series will focus on the things your agency can begin working on now to ensure full readiness and to enhance your ability to address the additional changes that are sure to come in the 2020 Home Health Final Rule, as PDGM is "perfected" (I use the term loosely) and readied for launch.

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