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FAQ

Frequently asked questions from the webinar

Preparing Your Clinical Team for PDGM

Updated with new info from the 2020 Home Health Final Rule

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PDGM will immediately bring new challenges to your agency in the areas of case management, billing, and timely documentation. Your clinicians are critical to these processes. Is your clinical team fully informed and prepared for PDGM?

Clinicians must understand the rules of PDGM to be effective, frontline members of your team. **Jill Dyer, BSN, RN, HCS-D, HCS-O**, President of J.I.D. Consulting & Coding, recently presented a free webinar which is now available for on-demand viewing at get.wellsky.com/pdgm-clinical-prep.html. In this document, Ms. Dyer answers some of the most popular questions asked during the webinar.

Q: What are the OASIS M-items that contribute to the functional score in PDGM payments?

A: The M-items that contribute to the functional score are the following:

- **M1033** Risk for Hospitalization
- **M1800** Grooming
- **M1810** and **M1820** Upper and Lower Body Dressing
- **M1830** Bathing
- **M1840** Toilet Transferring
- **M1850** Bed Transferring
- **M1860** Ambulation/Locomotion

Q: What is the guidance for responses to M1033 Risk for Hospitalization?

A: At least four of responses 1-7 must be marked to contribute to the functional score in PDGM. The following text in italics is additional guidance on responses to the M1033 Risk for Hospitalization from CMS in the Quarterly OASIS Q&A in October 2019:

"Q: For M1033 Risk for Hospitalization, response 1 - History of falls, does this include witnessed and unwitnessed falls?

A: *Yes, M1033 considers any fall in the last 12 months, with or without an injury, whether witnessed or unwitnessed. Code 1 – History of falls on M1033 if 2 or more falls occurred, or if a single fall resulted in ANY injury. A fall is defined as an unintentional change in position coming to rest on the ground, floor, or the next lower surface (such as a bed or chair). Falls resulting from an overwhelming force and falls resulting from therapeutic balance retraining are considered falls for M1033. Intercepted falls are not considered falls for M1033.*

Q: What types of hospitals are included when counting hospitalizations for M1033 Risk for Hospitalization, Response 3?

A: *Only acute care hospitalizations are included when counting hospitalizations for M1033 Risk for Hospitalization. Inpatient psychiatric hospitalizations and long-term care hospitals (LTCHs) are not included as hospitalizations for M1033.*

Q: Does a patient have to be admitted to an acute care hospital for more than 24 hours and for reasons of more than diagnostic testing to be considered a hospitalization?
A: *Yes, an acute care hospitalization is defined as the patient being admitted for 24 hours or longer to an inpatient acute bed for more than just diagnostic testing. Observation stays are not included as hospitalizations for M1033 Risk for Hospitalization.*

Q: For M1033 Risk of Hospitalization, if my patient is discharged from the acute care hospital in the morning and readmitted to the acute care hospital that same day, is that counted as two acute care hospital admissions?
A: *Yes, if the patient is discharged from an acute care hospital in the morning and readmitted to an acute care hospital that same day and both hospitalizations meet the definition for an acute care hospitalization, that is counted as two hospitalizations. Observation stays are excluded.*

Q: *For M1033 Risk for Hospitalization, response 4 - Multiple Emergency Department Visits – Does this include urgent care centers and walk-in clinics?*
A: *No, response 4 only includes hospital emergency departments, as defined in M2301 Emergent care.*

Q: Please provide any definitions or parameters for M1033 Risk for Hospitalization, response 5 – Decline in Mental, Emotional, or Behavioral Status in the past 3 months?
A: *A decline in mental, emotional, or behavioral status, is considered a change in which the patient, family, caregiver or physician has noted a decline regardless of the cause. A decline may be temporary or permanent. Physician consultation or treatment may or may not have occurred.*

Q: What medications are included in M1033 Risk for Hospitalization, response 7 – Currently Taking 5 or More Medications? Are herbals and oxygen included?
A: *Medications include prescribed and over the counter (OTC) medications, nutritional supplements, vitamins, and homeopathic and herbal products administered by any route. Medications may also include total parenteral nutrition (TPN) and oxygen (as defined in M2001 Drug Regimen Review)."*

Q: Where can I find the diagnoses that fall into each clinical and comorbidity group?

A: There is an interactive grouper tool posted on the CMS.gov web page: https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html (Note that the 2020 Home Health Final Rule included adjustments to the clinical and comorbidity groups. Be certain you go the website listed above for the most up-to-date version.)

This interactive grouper tool will include all of the ICD-10 diagnosis codes used in the PDGM and may be used by home health agencies to generate PDGM case-mix weights for their patient census. When you get to the web page, go to the CY 2020 PDGM grouper tool. It is an Excel

spreadsheet with several tabs. For the list of ICD-10 diagnoses and the categories of clinical groups go to the ICD-10 Dx tab. The ICD-10 diagnoses will be listed along with the clinical group. If the ICD-10 diagnosis is not listed in the clinical group list, it is not acceptable as a primary code and will be returned to provider.

The comorbidity groups are also listed on this Excel speadsheet under *Comorbidities*. The ICD-10 code is listed along with the comorbidity group they are assigned. If none of our secondary diagnoses are found, the comorbidity group will be "None."

Q: Will agencies certified in 2019 be allowed to RAP in 2020?

A: According to the 2020 Final Rule: *"We finalized that newly-enrolled HHAs, that is HHAs certified for participation in Medicare effective on or after January 1, 2019, will not receive split-percentage payments beginning in CY 2020. HHAs that are certified for participation in Medicare effectiveon or after January 1, 2019, will still be required to submit a "no pay" Request for Anticipated Payment (RAP) at the beginning of a period of care in order to establish the home health period of care, as well as every 30 days thereafter. Existing HHAs, meaning those HHAs that are certified for participation in Medicare with effective dates prior to January 1, 2019, would continue to receive split-percentage payments upon implementation of the PDGM and the change to a 30-day unit of payment in CY 2020.*

Q: Can you clarify your statement about discharging a patient when they become admitted as an inpatient?

A: During a 30-day payment period, if a patient is transferred to the hospital without discharge from home health agency and then discharged back to the agency from the hospital within 14 days of the subsequent payment period, the subsequent payment period would be classified as an *institutional payment period*. This rule applies to hospital transfers only.

During a 30-day payment period, if a patient is transferred back to a SNF, IRF, LTCH or other PAC facility, the patient would be considered transferred and discharged. There would be no subsequent payment period unless there is another SOC

Q: Are the SCIC (significant change in condition/care) and follow-up OASIS the same thing?

A: They are the same OASIS. The follow-up OASIS may be completed for a recertification (in the last 5 days of the 60-day clinical episode) or when there is a significant change in condition or care as defined by your agency policy. The questions will be the same for either OASIS. Your response to M0100 will be either *Response 4, Recertification (Follow-up) Reassessment* or *Response 5, Other Follow-up*.

Q: Do we need new physician orders for a SCIC OASIS?

A: If there is a change to the plan of care, you will need updated physician orders. It is likely that if you are completing a SCIC OASIS, there is a change in the plan of care.

Q: Should we schedule a follow-up OASIS at the end of the first 30-day billing period?

A: No, you would not need to schedule an OASIS at the end of the 30-day billing period. However, you should be tracking patients for any change in primary diagnosis/focus of care. If you find there is a change in the primary diagnosis/focus of care, you need a process and policy in place to evaluate the need for a follow-up/SCIC OASIS. Your process should include notification to biller of the change in primary diagnosis or change in case-mix.

Q: How would our biller know if there is a change in the primary diagnosis, functional score, or admission source/timing?

A: This is a process and policy your agency needs to establish. You also need to find out how your EMR will assist you in this transfer of information. You may choose to case conference each patient who is approaching the end of the first 30-day billing period, much like you currently evaluate patients for recertification or discharge at the end of the 60-day clinical episode.

Q: Does PDGM affect Medicare Advantage?

A: Each Medicare Advantage program will make its own decision regarding PDGM. Check with those you are currently under contract with to verify their decision.

Q: Can you explain the LUPA (low utilization payment adjustment) in PDGM?

A: In PDGM, the four-visit threshold we currently have will no longer apply. The LUPA threshold in PDGM will vary depending on your case-mix score. The threshold will range from two to six visits.

Q: Where can we find the interpretative guidance about when to complete a SCIC OASIS?

A: You can find the guidance here: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO18-25-HHA.pdf

Here's part of what it says:

§484.55(d) Standard: Update of the comprehensive assessment.

The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status.

Interpretive Guidelines §484.55(d)

A marked improvement or worsening of a patient's condition, which changes, and was not anticipated in, the patient's plan of care would be considered a "major decline or improvement in the patient's health status" that would warrant update and revision of the comprehensive assessment.

About the author

Jill Dyer, BSN, RN, HCS-D, HCS-O is a senior-level home health executive with more than 30 years of progressive management experience. An accomplished nurse, Jill has fulfilled a wide variety of roles that inform her expertise as an industry consultant, including home health administrator, home health director of nursing, and nurse consultant for home health. Jill is also certified as a Home Care Coding and OASIS Specialist. Through her clinical knowledge as a nurse and extensive management experience, Jill brings a comprehensive and well-rounded perspective to her work as a consultant and educator.