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White paper

Getting ready for change with PDGM:

areas to address now

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About the author

Sharon S. Harder has over three decades of executive management experience in the health care industry. She has served in financial and operational leadership roles in a variety of health care organizations ranging from a major health care professional association to large post-acute health care providers. 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 health care marketplace.

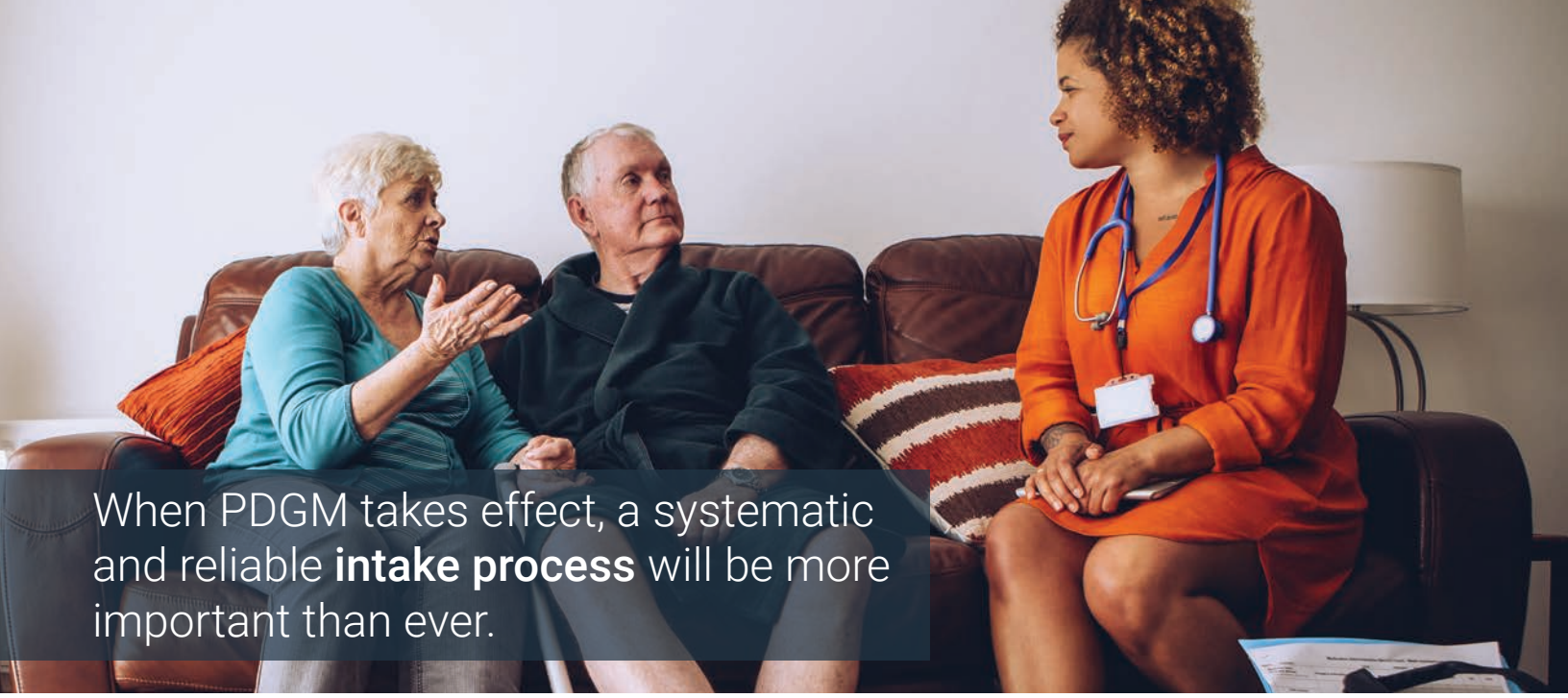
As the saying goes, “things may come to those who wait, but only the things left by those who hustle.”

There is more than a kernel of truth there for home health agencies contemplating the onslaught of post-acute Medicare payment reform.

With PDGM looming, it is an absolute fact that there is no time to lose in getting ready. Procrastination is guaranteed to deliver only one outcome – an operational and financial test that may be difficult to survive. As the most sweeping reimbursement change to be presented to home health providers in more than two decades, PDGM will require significant preparation, and the work that needs to be done cannot be accomplished overnight. So, the time to start preparing for PDGM was “yesterday.” If your agency missed that target, the second-best time is “now.”

There are five key operational areas that every agency management team should carefully evaluate, and if necessary, refine, to handle the operational and financial changes that will be imposed by PDGM. Not every agency will have the same array of strengths and weaknesses when it comes to evaluating their level of PDGM preparedness. As a result, the analysis of where work needs to be prioritized in each agency needs to be objective, thorough, and imminent.

This paper explores the **five areas** you should concentrate on now.



When PDGM takes effect, a systematic and reliable **intake process** will be more important than ever.

1) Intake

The intake process has always been a critical element of any agency's success. But when PDGM takes effect, a systematic and reliable intake process will be more important than ever. In addition to gathering information about a patient's eligibility for service, it will be important for the intake team to capture and disseminate other pieces of key information to the clinical and revenue cycle teams to facilitate their work.

There are five questions that must be answered with each new patient admission under PDGM.

1. Where is the patient coming from? An inpatient stay, or through a physician referral without an inpatient encounter within 14 days of the SOC?
2. Has the patient had a timely and qualified Face-to-Face encounter that can be used to establish eligibility for service?
3. What is the patient's expected primary diagnosis and skilled need?
4. Has the patient been seen or treated by another home health agency and discharged? And if so, should we plan for a partial episode payment (PEP) adjustment?
5. Can our agency obtain enough medical history for the patient to correctly assign the most specific diagnosis possible to support the care we plan to deliver?

Using an intake checklist which sets forth ***1)*** *the minimum documentation that the team should work to gather* and ***2)*** *the questions that must be answered as a prelude to accepting a patient for service* will help to eliminate gaps and streamline the process.

The method of gathering pertinent documentation should focus on the following:

- **The referral**
  The referral will ideally come with an order and information about the patient's skilled need. This helps to establish the patient's [projected] primary diagnosis, recent medical history, and overall physical condition, as well as skilled need. It helps the clinical team understand the basic interventions and visit volume that will most likely be required to produce the expected outcome of care.
- **Face-to-Face encounter documentation**
  Whether an inpatient encounter or a physician's progress note, this documentation is important for linking the precipitating health encounter to the focus of planned home health services. Remember, there must be an identifiable relationship between the two. The encounter must have occurred within the 120-day timeframe ending no more than 30 days after the Start of Care (SOC). Face-to-Face requirements do not change with PDGM and in those in states where Review Choice Demonstration (RCD) will be

implemented, the encounter documentation will be required to obtain an affirmation of payment. Agencies that do not regularly acquire the Face-to-Face encounter documentation as a part of the intake process are simply challenging fate when it comes to medical review.

- **Admission source documentation**
  The Inpatient Discharge Summary – or other documentation to demonstrate that a patient is coming from a true inpatient stay – should be an intake requirement each time the agency expects to claim credit for an initial "Institutional" payment period.

  This could be a skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), or long-term care hospital (LTCH) discharge summary or progress note, or it could be other evidence that the patient was being cared for in an inpatient psychiatric setting. Remember that, for patients who are coming from a short-stay hospital encounter, it will be important to validate the stay as a true inpatient stay and not one related to outpatient observation, an emergency department visit, or other outpatient services.

  Remember, too, that some hospital procedures are no longer considered "inpatient only," including Total Knee Arthroplasty procedures which can now be performed on an outpatient basis. Because this could impact reimbursement levels under PDGM, it will be important to get it right the first time and have the backup documentation to support the agency's final claim related to any qualifying inpatient stay.

- The bottom line is this – if your agency intends to classify the SOC or a payment period following a Resumption of Care as an "institutional" source for payment purposes, your record should contain documentation of that fact. In the future, and in the event of an ADR or medical review after 2020, it will be necessary to produce the documentation that supports the agency's claim.

- **Patient medical history documentation**
  This information should be used to facilitate accurate and complete diagnostic coding of

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the record and must be gathered at the time of admission. Coding will drive reimbursement under PDGM. As a result, coding accuracy will be exceptionally important. Thus, in addition to the discharge summary, inpatient H&P, or physician encounter, the intake team should endeavor to get as much of the patient's pertinent, recent medical history as possible to make coding easier, as specific as possible, and correct.

- **Eligibility and information that may be available from the Common Working File (CWF)**
  A patient's previous home health stays could influence the agency's final reimbursement based on application of PEP rules.

A well thought-out intake process will go a long way toward ensuring success under PDGM, and intake process improvements can be identified and implemented right now.

2) Diagnostic coding

Diagnoses have long impacted reimbursement, although in recent years, under prospective payment, diagnosis codes that could be used to elevate case mix have been slowly eliminated. All that will change with PDGM, as the primary diagnosis code will drive the Clinical Group assignment, and secondary codes could contribute to comorbidity payment additions. To keep things interesting under PDGM, only about 60% of all ICD-10 codes will be considered applicable as home health primary diagnoses, and many symptom codes or unspecified codes frequently used in the past will not yield a Clinical Group assignment. Because of this, accurate coding the first time around will be very important; every agency's coding practices will be under increased scrutiny as PDGM becomes reality. The following guidelines should be confirmed as the drivers of each agency's coding process going forward:

- Diagnosis codes should be sequenced so that they are listed based on the significance of each condition for which the patient will receive home health services. All pertinent, active diagnoses should be assigned. Resolved diagnoses should not be listed.
- Diagnoses should be derived from physician documentation concerning the treatment of the patient or, alternatively, verified by the physician prior to being applied.
- Basic coding conventions must be followed.
  - *Not Elsewhere Classified* (NEC) should be used only for specific disease entities for which no term exists.
  - *Unspecified codes* should only be used when information in the record is insufficient to allow more specificity.
  - *Etiology/manifestation codes* are used only to describe causal effect of the underlying condition.
  - *Sequelae codes* are used when the patient's condition is related to the after-effect of an event or disease.
  - Where applicable, *laterality* should always be coded even if laterality has been omitted from other coding in the patient's history.
- Coding should still match across the OASIS, the plan of care, and the claim. Remember that CMS will use claims to derive coding that will be used to calculate both the Clinical Group and comorbidity adjustment, if any.

- **There are five codes that your agency should stop using as primary diagnoses as soon as possible:**
  M62.81 *Muscle Weakness (generalized)*
  R26.89 *Abnormality of gait and mobility*
  M54.5 *Low back pain*
  R26.81 *Unsteadiness on feet*
  R53.1 *Weakness*

Coding must also be timely, because the coding on the plan of care essentially establishes the focus of care and planned service interventions. If coding is not specific, or is inapplicable, claims could be exposed to denial in review due to a disconnect between the coding on the plan of care and the

services that were delivered to the patient. For this reason, coding must be timely and accurate as a prelude to finalizing the plan of care.

3) Care planning:
utilization, scheduling, and productivity

Under PDGM, the management of care planning and clinical processes will also take on more significance. As episodic payments are reduced to 30-day payment periods with case-mix reductions in second and subsequent "late" periods, it will be important for the clinical team to plan care that will yield the desired patient outcomes within the confines of expected reimbursement. It won't always be easy.

- Proactive management of the care planning process, especially related to planned disciplines, visit counts, and frequencies, will be critically important. Over-utilization will result in higher direct costs and erosion of margins on care. Under-utilization could result in compromised patient outcomes. An imbalance of visits between an initial and subsequent payment period under the same POC could result in only a portion of expected reimbursement or increased LUPA exposure. Striking an effective balance will be essential.

- Because of the way in which the payment periods have been structured, agencies will be well-served to continue modified 'front-loading' of visits to stabilize the patient early on, followed by tapering visits into the next payment period to also assure continuity of reimbursement.

  To illustrate the point, an analysis of CMS claims data from 2017 showed that approximately one in four PPS episodes went on for a duration of 30 days or less. Under PDGM, those patients treated in the same way for the same periods of time would yield about 23% less in overall reimbursement, so this is an issue worth investigating in terms of your agency's patient population and care planning norms.

- The following table shows the most prevalent diagnosis codes associated with short PPS episodes that would translate to single payment periods, along with the average projected reimbursement loss (based on a single PPS episode) under PDGM:

Z47.1	Aftercare following joint replacement surgery	avg -28%
Z48.812	Surgical aftercare following circulatory system surgery	avg -19%
I11.0	Hypertensive heart disease w/ heart failure	avg -19%
J44.1	COPD with (acute) exacerbation	avg -18%
Z47.89	Encounter for other orthopedic aftercare	avg -23%

- LUPA avoidance, when possible, will also be important given the variable LUPA thresholds of between two and six visits. Five Clinical Groups are more likely than others to generate a LUPA in a second, late payment period. As with single payment periods, it will be useful to evaluate your agency's patient mix to determine the degree to which your patients may be concentrated in the following categories with higher LUPA exposure:

  - Complex Nursing
  - Wounds
  - MMTA GI/GU
  - MMTA Infectious Disease
  - MMTA Surgical Aftercare

- OASIS accuracy will be important as OASIS responses related to ADLs (M1800, M1810, M1820, M1830, M1840, M1850, and M1860) will be aggregated to influence payment levels.

- In addition, most agencies that have not used follow-up assessments in recent years will want to re-examine their processes for when and how these interim assessments can and should be used. This will be important for securing accurate reimbursement related to patient changes that occur in the midst of a plan of care where diagnoses that drive reimbursement may need to change from the initial care plan payment period to the following one.

Timely documentation will be even more crucial due to the cash flow implications of PDGM

CMS has recently made it clear that not all coding changes from one payment period to the next will require a follow-up assessment. In our view, the rule of thumb should be that any change in a patient's condition that would result in a coding modification that would increase the case-mix and reimbursement should be accompanied by an assessment that lays out the details and rationale for the coding change.

4) Documentation management

While there are no new documentation requirements related to the conditions of payment under PDGM, documentation management – and the timeliness of documentation – will be exceptionally important.

To bill the RAP, the plan of care must have been documented by a recorded verbal order from the physician and sent to the physician for signature prior to submitting the RAP. When billing the Final Claim for the 30-day period, the RAP must be in a paid status and the plan of care together with all interim orders pertaining to any date within the 30-day period must be signed and dated by the physician. The OASIS must have been submitted and accepted.

Documentation that does not have to be in hand to bill, but which we recommend be secured at the outset of services, includes the Face-to-Face encounter documentation and the backup from the inpatient facility if the payment period is being billed as an Institutional billing period. In review, and as a part of the Review Choice Demonstration (RCD), the Face-to-Face encounter documentation must be presented. CMS may also require agencies in the RCD states to produce the inpatient backup after January of 2020, although this has not been confirmed by CMS.

Most agencies do not get documentation back within acceptable timeframes following the close of an episode. Timeliness will be even more crucial due to the cash flow implications of PDGM. As a result, Plans of Care should be sent to physicians for signature within five days of the start of the 60-day period to which each applies. Orders should be sent for signature on the day they are received, and both should be the subject of regular weekly follow ups with

certifying or authorizing physicians.

If your agency is one that is not able to release final claims for more than 10 days following the close of each PPS episode, this is an area that should be addressed and corrected. And don't forget to analyze documentation delays in terms of the physicians who may be most often responsible. Work with those physicians and their staff members first to ensure better turnaround once PDGM gets here.

5) Revenue cycle

Under PDGM, revenue cycle processes will be among the most challenging for many agencies. With the dissection of 60-day PPS episodes into 30-day PDGM payment periods, the workload for Medicare billers will essentially double. Adding to the challenge will be the fact that most, if not all, payers other than traditional Medicare, will stick with their current reimbursement methodologies. Cash flow is sure to be disrupted and there is a very real possibility of hiccups within the systems used to process Medicare claims in connection with the transition to PDGM. All of this adds up to a significant challenge for revenue cycle managers and staff.

As the revenue cycle sits at the very end of the process, it is here where systemic inefficiencies related to intake and clinical processes will be manifested. If the intake process does not result in the acquisition of documentation required to substantiate billing, the revenue cycle and cash flow from patient services will be affected. If the clinical team fails to effectively manage service volume and visit frequencies, LUPAs and reimbursement reductions will be a certainty – not to mention higher direct costs as a proportion of net reimbursement. Thus, managing the revenue cycle as PDGM becomes reality will be both important and challenging.

On the other hand, if more efficiency can be woven into the documentation management process and if attention is paid to preservation of margins through utilization controls, the revenue cycle will be easier. The key will be preparation.

It has been estimated that all agencies will experience cash flow disruptions in the first two to three months of 2020 as PDGM gains momentum. The underlying reasons could be many but the end result for most agencies will be the same – a need for belt tightening, careful and aggressive receivables management, and cash conservation. Five steps that can be taken now to mitigate the depth of any initial cash flow problems posed by PDGM include the following:

1. All agencies should establish a realistic budget that is focused on expanding other sources of revenue through contract opportunities with other payers or expansion into related services/ business lines, controlling operating and capital expenditures and preserving cash reserves.

2. Arrangements with contract providers, such as therapy companies, should be reviewed and visit volume for contract therapists should be carefully controlled as a part of the agency's approach to care planning and case management. Under PDGM, therapy services will continue to be important, but our approach to volume of service must change.

3. Monitoring of services and receivables on behalf of other payers, including Medicaid and Medicare Advantage plans, will be important. Many agencies with growing Medicare Advantage portfolios actually end up, in effect, subsidizing the services to patients of these plans with the more timely cash flow generated from traditional Medicare patients. Under PDGM this will be much more difficult to do and, as a result, arrangements with non-Medicare payers may have to be reviewed. In essence, PDGM becomes a balancing act not only with respect to services provided to traditional Medicare patients, but also between Medicare and other payers with different service authorization requirements and payment timelines.

4. Timely and accurate financial reporting will be crucial to track results of operations, projected cash inflow, disbursement obligations and turnover of receivables.

5. Some agencies may want to give consideration to financing alternatives. Banks and other commercial lenders will often be willing to enter into credit arrangements that are secured by an agency's receivables. Borrowing generally cannot exceed a certain percentage of receivables that

are 90 days old or less. The agency must be creditworthy and must be able to produce regular and reliable reporting of the results of operations as well as the detailed borrowing base calculations. Since most credit arrangements take at least 60 to 90 days to secure, starting now may be a good idea if this is in keeping with your agency's overall financial plan.

The key takeaway

PDGM is coming, and any thought that CMS might postpone payment reform again should be re-evaluated. The wheels have begun to turn. Billing and claims processing instructions have been delivered to the MACs. Recent proposed rulemaking related to SNFs demonstrates that CMS is moving forward with payment reform in other post-acute venues. And, we believe, that CMS will move forward with PDGM next year as planned. Home health teams need to get ready.

The five most critical areas of preparation are intake, diagnostic coding, care management, documentation management, and revenue cycle management. Work on these areas now by identifying strengths and weaknesses that must be addressed to ensure success under PDGM.

Good luck! And, with this wish for good luck, remember the words of Thomas Jefferson – *"I'm a great believer in luck, and I find the harder I work the more I have of it!"*

So, let's get to work!

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