Patient-Driven Groupings Model (PDGM) Grouping Tool Help Document

Disclaimer: This file was prepared as a service to the public and is not intended to grant rights or impose obligations. The information provided is only intended for use as a learning tool for determining the HIPPS codes assigned to 30-day periods. It is not intended to be used to determine partial payments or outliers. It is not intended to take the place of the official CMS grouper software designed by 3M. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

The purpose of the grouping tool Excel file is to help users understand how the payment grouping parameters, which are part of the PDGM, would be used to determine case-mix assignments that are part of the payment calculation under the Home Health Prospective Payment System (HH PPS)., Upon implementation of the PDGM in CY 2020, CMS will provide official grouper software, developed under contract with 3M.

For more information regarding the PDGM, please refer to the "CY 2019 Home Health Prospective Payment System Rate Update and Final CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy; and Training Requirements for Surveyors of National Accrediting Organizations" final rule (CMS-1689-FC).located at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html. The following steps explain how to navigate the PDGM grouping tool:

1. **Timing of the 30-Day Period**.

From the list, the user can choose from two options: Early or Late. Click on either choice to select.

2. **Admission Source**

From the list, the user can choose from two options: Community or Institutional. Click on either choice to select.

3. **Clinical Grouping (based on the principal diagnosis reported on the claim).**

The user enters the principal diagnosis code reported on the home health claim. Entry of the principal diagnosis code determines the assigned clinical group (Wound, Neuro Rehab, Musculoskeletal Rehab, Complex Nursing Interventions, Behavioral Health, or Medication Management, Teaching, Assessment (MMTA-Other or one of six MMTA subgroups: Surgical Aftercare; Cardiac and Circulatory; Endocrine; GI/GU[1]; Infectious Disease[2]; Respiratory) for the 30-day period of care. The clinical group explains the primary reason the individual is receiving home health services. A list of ICD-10-CM codes that correspond to the 12 clinical groups can be found in the "ICD10 DXs" tab in the Excel file.

4. **Comorbidity Adjustment.**

The user can enter up to twenty-four secondary diagnosis codes that are used to determine if a comorbidity exists relative to the primary diagnosis entered previously. If one of the reported secondary diagnosis codes is identified in the subcategories on the home health specific comorbidity list (Comorbidity-Low tab in the Excel file), the period of care would receive a low comorbidity payment adjustment. If the user enters at least two secondary diagnosis which interact with the primary diagnosis (Comorbidity-High tab in Excel file) then the period of care receive a high comorbidity adjustment.

[1] Gastrointestinal/Genitourinary System

[2] The Infectious Disease subgroup also includes diagnoses related to neoplasms and blood-forming diseases.

5. **OASIS Items-Functional Level.**

Responses to various OASIS items are used to determine the functional level for the 30-day period of care. The user would check the appropriate check boxes for OASIS item M1033 Risk of Hospitalization. The remainder of the user inputs in this section utilize list boxes from which the user selects the appropriate responses to the following OASIS items: M1800 Grooming, M1810 Current Ability to Dress Upper Body, M1820 Current Ability to Dress Lower Body, M1830 Bathing, M1840 Toilet Transferring, M1850 Transferring, and M1860 Ambulation/Locomotion.

The user inputs for these four sections of the grouping tool determine the Home Health Resource Group (HHRG). On Medicare claims, these HHRGs are represented as Health Insurance Prospective Payment System (HIPPS) codes, which correlate to the case-mix weights for the 30-day periods of care. The Excel file displays the HIPPS code (on cell C113) that results from the user inputs to the admission source and timing, principal diagnosis code, secondary diagnosis codes (comorbidities), and responses to the pertinent OASIS items associated with functional level. If the user's entry in cell C4 (number of visits) does not warrant a low utilization payment adjustment (LUPA), then the case-mix weight associated with the HIPPS code is displayed (on cell C114 in the Excel file).

Users who have questions or need help using the Excel and .csv files should contact CMS by e-mailing HomeHealthPolicy@cms.hhs.gov. As a reminder, the finalized policies that are the basis for this grouping tool should be reviewed in the "CY 2019 Home Health Prospective Payment System Rate Update and Final CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting

Requirements; and Home Infusion Therapy; and Training Requirements for Surveyors of National Accrediting Organizations" final rule (CMS-1689-FC).