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Overview of the Patient-Driven Groupings Model

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PROVIDER TYPES AFFECTED

This special edition MLN Matters® article is intended for physicians that order home health services.

PROVIDER ACTION NEEDED

This article provides information on the implementation of the new Home Health Prospective Payment System (HH PPS) case-mix adjustment methodology named the Patient-Driven Groupings Model (PDGM). The PDGM will be implemented for home health periods of care starting on and after January 1, 2020.

BACKGROUND

Medicare home health services are available to eligible Medicare beneficiaries. To be eligible for Medicare home health services, a physician must certify that a patient:

1. Is confined to the home;
2. Needs skilled services (intermittent skilled nursing, physical therapy, speech-language pathology services, or a continuing need for occupational therapy after the need for skilled nursing, physical therapy and/or speech language pathology services have ceased);
3. Is under the care of a physician;
4. Receives services under a plan of care established and reviewed by a physician; and
5. Had a face-to-face encounter with a physician or allowed non-physician practitioner.

Section 1814(a) and Section 1835(a) of the Act specify that an individual is considered "confined to the home" (homebound) if the following two criteria are met:

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First Criteria One of the following must be met:	Second Criteria Both of the following must be met:
1. Because of illness or injury, the individual needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence.	1. There must exist a normal inability to leave home.
2. Have a condition such that leaving his or her home is medically contraindicated.	2. Leaving home must require a considerable and taxing effort.

The aged person who does not often travel from home because of frailty and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet the above conditions.

The patient may be considered homebound (that is, confined to the home) if absences from the home are:

- Infrequent;
- For periods of relatively short duration;
- For the need to receive health care treatment;
- For religious services;
- To attend adult daycare programs; or
- For other unique or infrequent events (for example, funeral, graduation, trip to the barber).

More information on certifying for Medicare home health services can be found in the MLN Matters® article SE1436, Certifying Patients for the Medicare Home Health Benefit at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1436.pdf.

Medicare covered home health services include:

- Skilled nursing (SN) care (other than solely venipuncture for the purposes of obtaining a blood sample) on part-time or intermittent basis;
- Home health aides on a part-time or intermittent basis;
- Physical therapy (PT);
- Occupational therapy (OT);
- Speech-language pathology (SLP);
- Medical social services;
- Routine & non-routine medical supplies (for example, catheters, catheter care supplies, ostomy bags, and ostomy care supplies);
- Durable Medical Equipment (paid separately from the home health prospective payment);
- Injectable osteoporosis drugs (reimbursed on a reasonable cost basis and the patient must meet certain criteria); and

- Negative pressure wound therapy using disposable devices.

Changes to Home Health Payment

Since October 2000, Home Health Agencies (HHAs) have been paid under a Home Health Prospective Payment System (HH PPS) for 60-day episodes of care that include all covered home health services. The 60-day payment amount is adjusted for case-mix and area wage differences. The case-mix adjustment under this system included: a clinical dimension; a functional dimension; and a service dimension, in which payment would increase if certain thresholds of therapy visits were met.

The Bipartisan Budget Act of 2018 (BBA of 2018) includes several requirements for home health payment reform, effective January 1, 2020. These requirements include the elimination of the use of therapy thresholds for case-mix adjustment and a change from a 60-day unit of payment to a 30-day unit of payment. The mandated home health payment reform resulted in the Patient-Driven Groupings Model, or PDGM. The PDGM removes the current incentive to overprovide therapy, and instead, is designed to focus more heavily on clinical characteristics and other patient information to better align Medicare payments with patients' care needs.

The Importance of Diagnosis Reporting and Physician Documentation under the PDGM

Under the Medicare home health benefit, the patient must be under the care of a physician and must be receiving home health services under a plan of care established and periodically reviewed by a physician. Physicians play an important role in the provision of home health services and HHAs rely on documentation from the certifying physician (and/or the acute/post-acute care facility) to confirm home health eligibility, substantiate diagnoses that are populated on the home health claim and factor into the payment amount, and to help demonstrate the medical necessity of the home health services provided.

The principal diagnosis code on the home health claim will assign the home health period of care to a clinical group that explains the primary reason the patient is receiving home health services. For example, if the reported principal diagnosis is a "stage 2 pressure ulcer of the left heel", the home health period of care would be assigned to the "wound" clinical group, meaning the primary reason for home health services is for wound care. Payment varies between each of the clinical groups to account for the differences in resource use associated with the primary reason for home health care.

There are certain diagnoses that are vague, unspecified, or not allowed to be reported as a principal diagnosis by ICD-10 coding guidelines that will not be assigned into a clinical group. If a home health claim is submitted with a principal diagnosis that would not be assigned to a clinical group under the PDGM, the claim would be returned to the HHA for more definitive diagnosis coding. The top 5 diagnoses reported on home health claims that would not be assigned to a clinical group are:

- M62.81, Muscle weakness, generalized
- R26.89 Other abnormalities of gait and mobility
- M54.5, Low back pain
- R26.81, Unsteadiness on feet
- R53.1, Weakness

For example, if a patient has been referred to home health with a principal diagnosis of “muscle weakness, generalized” (M62.81), this would not be assigned to a clinical group because this is a vague code that does not clearly support a rationale for skilled services. If the underlying etiology of the generalized muscle weakness is unknown by the time a home health referral is made, a more definitive principal diagnosis is warranted in order to justify the need for skilled services and appropriate treatment. Further, if the original condition is resolved, but the resulting muscle weakness persists as a result of the known original diagnosis, we anticipate that a more specific code exists that accounts for why the muscle weakness is on-going, such as muscle wasting or atrophy. So, if M62.561, “muscle wasting and atrophy of the right lower leg” is reported as the principal diagnosis, the home health period of care would be assigned to the “Musculoskeletal Rehab” clinical group, meaning the primary reason for home health services is for therapy.

Additionally, if reported as a principal diagnosis, most symptom diagnoses will not be assigned to a clinical group under the PDGM. Clinically, it is important for HHAs to have a clear understanding of the patients’ diagnoses in order to safely and effectively furnish home health services. Interventions and treatment aimed at mitigating signs and symptoms of a condition may vary depending on the cause. For example, if a patient has been referred to home health with a diagnosis of ‘‘other abnormalities of gait and mobility’’ (R26.89), it is important for the home health clinician to know what is precipitating the abnormality. For instance, a plan of care for a gait abnormality related to a neurological diagnosis (such as Parkinson’s disease, G20) is likely to be different from a plan of care for a gait abnormality due to a fracture or injury (such as a fracture of the head and neck of femur, S72.0).

There are other, more specific ICD-10-CM diagnosis codes that could be used as the principal diagnosis instead of symptom codes to ensure that a home health period of care is accurately assigned to the appropriate clinical group reflecting the patient’s home health care needs. Symptom codes can be reported as secondary diagnoses, as appropriate, to more fully explain patient characteristics.

Reported secondary diagnoses (that is, comorbidities) also factor into the case-mix adjustment methodology under the HH PPS. For example, if there is a reported secondary diagnosis of “heart failure,” home health payment is increased for the period of care to account for the additional resource needs associated with this condition. Additionally, HHAs can report up to 24 secondary diagnoses that may be eligible for additional payment under the PDGM.

Complete, accurate, and specific diagnosis reporting by physicians, along with clinical documentation supporting all diagnoses, is important to make sure that patient characteristics are fully captured under the PDGM. However, this does not mean that the certifying physician would be required to perform additional diagnostic testing solely to certify a patient for home health services or establish a home health plan of care. Complete and comprehensive documentation of the patient’s diagnoses and other clinical conditions by the physician will help to ensure that such diagnoses support medical necessity and Medicare payment aligns with your patient’s home health resource needs.

30-Day Periods of Care under the PDGM:

While the unit of payment for home health services will be a 30-day period starting on January

1, 2020; there are no changes to timeframes for re-certifying eligibility and reviewing the home health plan of care, both of which still need to occur every 60-days (or in the case of updates to the plan of care, more often as the patient's condition warrants). Physicians are separately paid by Medicare for certification and recertification for home health services.

Because the unit of payment is now 30-days, instead of 60-days, HHAs may have more frequent contact with the certifying physician to communicate any changes in the patient's condition to ensure that home health payment is adjusted to account for those changes. Furthermore, the certification and the home health plan of care must be signed timely by the certifying physician because HHAs will submit a final claim with each 30-day period of care and need this important signed documentation in order to bill for home health services.

Home health services are not limited to a single 30-day period of care. An individual can continue to receive home health services for subsequent 30-day periods as long as the individual continues to meet home health eligibility criteria.

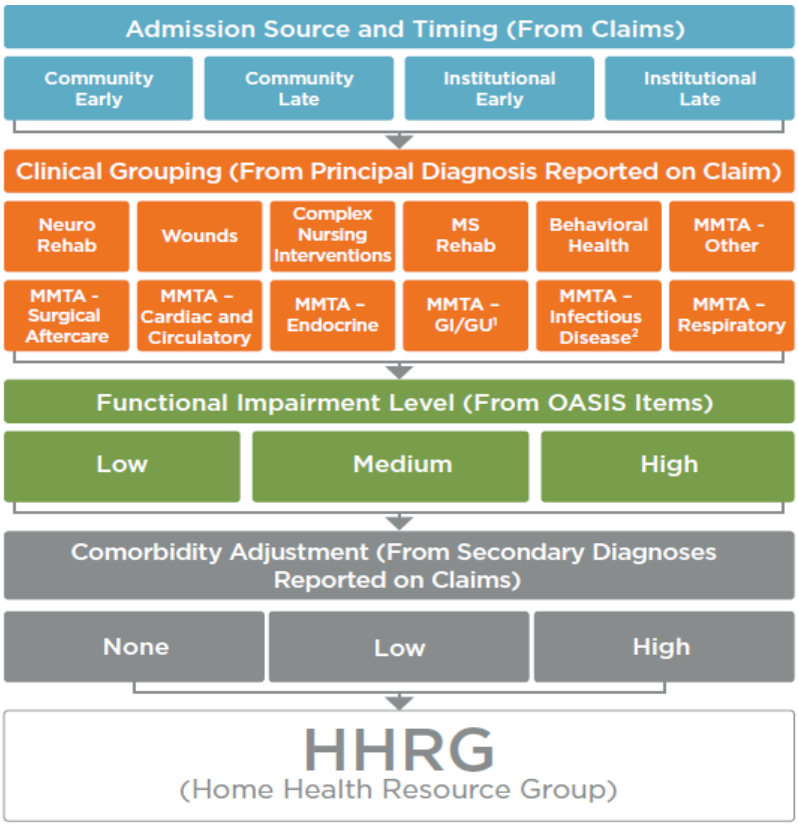
Overview of the Patient-Driven Groupings Model:

Figure 1 below provides an overview of how 30-day periods are categorized into 432 case-mix groups for the purposes of adjusting payment under the PDGM. In particular, 30-day periods are placed into different subgroups for each of the following broad categories:

- **Admission source** (two subgroups): community or institutional admission source
- **Timing of the 30-day period** (two subgroups): early or late
- **Clinical grouping** (twelve subgroups): musculoskeletal rehabilitation; neuro/stroke rehabilitation; wounds; Medication Management, Teaching, and Assessment (MMTA) - surgical aftercare; MMTA - cardiac and circulatory; MMTA - endocrine; MMTA - gastrointestinal tract and genitourinary system; MMTA - infectious disease, neoplasms, and blood-forming diseases; MMTA - respiratory; MMTA- other; behavioral health; or complex nursing interventions
- **Functional impairment level** (three subgroups): low, medium, or high
- **Comorbidity adjustment** (three subgroups): none, low, or high based on secondary diagnoses.

In total, there are 2*2*12*3*3 = 432 possible case-mix adjusted payment groups.

Figure 1: Structure of the Patient-Driven Groupings Model



Under the Patient-Driven Groupings Model, a 30-day period is grouped into one (and only one) subcategory under each larger colored category. A 30-day period's combination of subcategories places the 30-day period into one of 432 different payment groups.

1 Gastrointestinal tract/Genitourinary system
2 The infectious disease category also includes diagnoses related to neoplasms and blood-forming diseases

Admission Source:

Under the PDGM, each 30-day period is classified into one of two admission source categories – community or institutional – depending on what healthcare setting was utilized in the 14 days prior to home health admission. Late 30-day periods are always classified as a community admission unless there was an acute inpatient hospital stay in the 14 days prior to the late home health 30-day period. A post-acute stay in the 14 days prior to a late home health 30-day period would not be classified as an institutional admission unless the patient had been discharged from home health prior to a post-acute stay.

Timing of the 30-Day Period:

Under the PDGM, the first 30-day period is classified as early. All subsequent 30-day periods (second or later) in a sequence of 30-day periods are classified as late. A sequence of 30-day periods continues until there is a gap of at least 60-days between the end of one 30-day period

and the start of the next. When there is a gap of at least 60-days, the subsequent 30-day period is classified as being the first 30-day period of a new sequence (and therefore, is labeled as early).

Clinical Groups:

Under the PDGM, each 30-day period is grouped into one of twelve clinical groups based on the patient's principal diagnosis as reported on home health claims. The reported principal diagnosis provides information to describe the primary reason for which patients are receiving home health services under the Medicare home health benefit. Table 1 below describes the twelve clinical groups. These groups are designed to capture the most common types of care that Home Health Agencies (HHAs) provide.

Table 1: PDGM Clinical Groups

Clinical Groups	The Primary Reason for the Home Health Encounter is to Provide:
Musculoskeletal Rehabilitation	Therapy (physical, occupational or speech) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (physical, occupational or speech) for a neurological condition or stroke
Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric conditions, including substance use disorder
Complex Nursing Interventions	Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies

Clinical Groups	The Primary Reason for the Home Health Encounter is to Provide:
Medication Management, Teaching and Assessment (MMTA)-- • **MMTA –Surgical Aftercare** • **MMTA – Cardiac/Circulatory** • **MMTA – Endocrine** • **MMTA – GI/GU** • **MMTA – ID/Neoplasms/ Blood Diseases** • **MMTA –Respiratory** • **MMTA – Other**	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching, and assessment.

While there are clinical groups where the primary reason for home health services is for therapy (for example, Musculoskeletal Rehabilitation) and other clinical groups where the primary reason for home health services is for nursing (for example, Complex Nursing Interventions), these groups represent the primary reason for home health services during a 30-day period of care, but not the only reason for home health care. Home health remains a multidisciplinary benefit and payment is bundled to cover all necessary services identified on the individualized home health plan of care.

Functional Impairment Level:

The PDGM designates a functional impairment level for each 30-day period based on responses to the OASIS items in Table 2 below:

Table 2: OASIS Items Used for Functional Impairment Level in the PDGM

Item #	Description
M1033	Risk for Hospitalization
M1800	Grooming
M1810	Current ability to dress upper body safely
M1820	Current ability to dress lower body safely
M1830	Bathing
M1840	Toilet transferring

Item #	Description
M1850	Transferring
M1860	Ambulation and locomotion

Responses that indicate higher functional impairment and a higher risk of hospitalization are associated with higher resource use and are therefore assigned higher points. These points are then summed, and thresholds are applied to determine whether a 30-day period is assigned a low, medium, or high functional impairment level.

Comorbidity Adjustment:

The PDGM includes a comorbidity adjustment category based on the presence of certain secondary diagnoses (for example, congestive heart failure) associated with increased resource use. Depending on a patient's secondary diagnoses, a 30-day period may receive no comorbidity adjustment, a low comorbidity adjustment, or a high comorbidity adjustment. Home health 30-day periods of care can receive a comorbidity adjustment under the following circumstances:

- ***Low comorbidity adjustment:*** There is a reported secondary diagnosis that is associated with higher resource use, or;
- ***High comorbidity adjustment:*** There are two or more secondary diagnoses that are associated with higher resource use when both are reported together compared to if they were reported separately. That is, the two diagnoses may interact with one another, resulting in higher resource use.
- ***No comorbidity adjustment:*** A 30-day period would receive no comorbidity adjustment if no secondary diagnoses exist or none meet the criteria for a low or high comorbidity adjustment.

With the implementation of the PDGM in CY 2020, the physician continues to play an invaluable role in making sure that needed home health services are provided to eligible Medicare beneficiaries through accurate, specific diagnosis reporting, developing a patient-specific home health plan of care identifying all services and disciplines to provide care, and communicating with home health agencies in a timely-fashion to ensure that all Medicare requirements are met.

RESOURCES

HHA Center Webpage at: https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html

PDGM Webpage at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html

Medicare Benefit Policy Manual, Chapter 7, Home Health Services at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

MLN Matters® article SE1436, "Certifying Patients for the Medicare Home Health Benefit"

at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1436.pdf

DOCUMENT HISTORY

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November 22, 2019	Initial article released.