The Role of Therapy under the Home Health Patient-Driven Groupings Model (PDGM)

MLN Matters Number: SE20005  Related Change Request (CR) Number: N/A
Article Release Date: August 20, 2021  Effective Date: January 1, 2020
Related CR Transmittal Number: N/A  Implementation Date: January 1, 2020

We revised this article to update the web links. All other information is unchanged

Provider Types Affected

This special edition MLN Matters article is for home health agencies (HHAs) that furnish therapy services (physical therapy, occupational therapy, and speech-language pathology therapy) under a physician-established Medicare home health plan of care.

What You Need to Know

This article provides information on the continuing role of therapy under the newly implemented home health prospective payment system (HH PPS) case-mix adjustment methodology, named the Patient-Driven Groupings Model (PDGM), for home health periods of care starting on and after January 1, 2020.

Background

The Bipartisan Budget Act of 2018 (BBA of 2018) included 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 is designed to emphasize clinical characteristics and other patient information to better align Medicare payments with patients' care needs.

Has Home Health Eligibility and Coverage Changed Under the PDGM?

No. While there has been a change to the case-mix adjustment methodology and the unit of payment beginning in CY 2020, eligibility criteria and coverage for Medicare home health services remain unchanged. That is, as long as the individual meets the criteria for home health services as described in the regulations at 42 CFR 409.42, the individual can receive Medicare home health services, including therapy services.
Payment under the HH PPS continues to be a bundled payment meant to cover all home health services as described at 42 CFR 409.44; including nursing, medical supplies, home health aides, and therapy services. Under the PDGM, the national, standardized 30-day payment amount is adjusted to account for patient characteristics and other information; including the principal diagnosis, secondary diagnoses, and functional impairment level, as described in the “Overview of the Patient-Driven Groupings Model” MLN Matters Article (SE19027, https://www.cms.gov/files/document/se19027.pdf).

**The Continued Role of Therapy Under the PDGM**

The need for therapy services under PDGM remains unchanged. Therapy provision should be determined by the individual needs of the patient without restriction or limitation on the types of disciplines provided or the frequency or duration of visits. The number of needed visits to achieve the goals outlined on the plan of care is determined through the therapist's assessment of the patient in collaboration with the physician responsible for the home health plan of care. The home health Conditions of Participation (CoPs) (42 CFR 484.60) require that each patient must receive an individualized written plan of care. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s); the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care, and the patient and caregiver education and training. All services must be furnished in accordance with physician orders and accepted standards of practice. Therefore, the visit patterns of therapists should not be altered without consultation and agreement from the physician responsible for the home health plan of care. Any changes to the frequency or duration of therapy visits must be in accordance with the home health CoPs at 42 CFR 484.60.

Additionally, beneficiaries must receive proper written notice in advance of the HHA reducing or terminating on-going care in accordance with the home health CoPs regarding patient rights at 42 CFR 484.50. These rights also include that the patient must be advised of the name, address, and telephone number of the Quality Improvement Organization (QIO) in the beneficiary’s service area if the beneficiary has a complaint about the quality of care he/she has received, or if the beneficiary needs to appeal a health care provider’s decision to discontinue services.

Even though therapy thresholds are no longer a factor in adjusting home health payment, there are two clinical groups under the PDGM where the primary reason for home health services is for therapy (musculoskeletal rehabilitation and neuro/stroke rehabilitation). Furthermore, therapy should be provided regardless of the clinical group when included under the plan of care. While the principal diagnosis helps define the primary reason for home health services, it does not in any way direct what services should be included in the plan of care. Additionally, there is no improvement standard under the Medicare home health benefit and therapy services can be provided for restorative or maintenance purposes. The physician who establishes and periodically reviews the home health plan of care must determine the therapy the patient needs regardless of the patient’s diagnoses or PDGM clinical group.

Therapists play an instrumental role in assessing and documenting patients’ functional
impairments. This information is captured through responses to OASIS items measuring functional ability, including walking, dressing and bathing and assists therapists in developing an individualized home health therapy plan of care in collaboration with the certifying physician. A comprehensive assessment conducted by a skilled therapist can help to ensure that patient needs are identified, an individualized therapy plan of care is established, therapy services are provided, and goals of care are met.

Finally, the quality scores on Home Health Compare incorporate the use of therapy services in patient outcomes. Home Health Compare is a website for patients and their families where they can compare HHAs to help them choose a quality HHA that has the skilled home health services they need. In addition to general information about HHAs, Home Health Compare includes information on:

- **Services** offered (like nursing care, physical therapy, occupational therapy, speech therapy, medical/social services, and home health aide services)
- A **Quality of Patient Care star rating** that summarizes selected information about the performance of each home health agency compared to other agencies
- Information about each home health agency’s quality of care (quality measures) and information from patients about experiences with the home health agency (patient survey results)

Therefore, high quality therapy services with a focus on patient outcomes can help HHAs achieve higher patient satisfaction and higher quality scores.

Utilizing educational resources such as MLN Matters ® Articles, Home Health Open Door Forums, the Medicare Benefit Policy Manual (chapter 7), the home health Conditions of Participation found at 42 CFR Part 484, and the accompanying interpretative guidelines in the State Operations Manual, can help HHAs fully understand the requirements under the Medicare home health benefit and provide opportunities to ask questions. Therapists can also contact their respective state licensing boards for information on scope of practice, and their industry associations for information and guidance on accepted standards of care.

Listed in the “Resources” section below are CMS and association resources and links HHAs and therapists can access to help them stay informed and engaged to ensure that Medicare beneficiaries receive all reasonable and necessary home health therapy services.
Resources:


HHA Center Webpage: [https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html](https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html)

PDGM Webpage: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html)

JIMMO Settlement Page: [https://www.cms.gov/Center/Special-Topic/Jimmo-Center](https://www.cms.gov/Center/Special-Topic/Jimmo-Center)


Quality Improvement Organizations (QIOs): [https://live-qio.pantheonsite.io/](https://live-qio.pantheonsite.io/)

American Physical Therapy Association (APTA): [https://www.apta.org/](https://www.apta.org/)

American Occupational Therapy Association (AOTA): [https://www.aota.org/](https://www.aota.org/)

American Speech-Language-Hearing Association (ASHA): [https://www.asha.org/](https://www.asha.org/)

More Information

If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).
### Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 20, 2021</td>
<td>We revised this article to update the web links. All other information is unchanged</td>
</tr>
<tr>
<td>February 10, 2020</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**Disclaimer**: Paid for by the Department of Health & Human Services. This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2019 American Medical Association. All rights reserved.

Copyright © 2013-2020, the American Hospital Association, Chicago, Illinois. Reproduced by CMS with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.