CMS Hosts PDGM National Provider Call On Claims Submission & Processing

On Wednesday, August 21, 2019, CMS hosted a National Provider Call titled: Home Health Patient-Driven Groupings Model: Operational Issues, presented by Wil Gehne, Technical Advisor, CMS Division of Institutional Claims Processing. During the call, Mr. Gehne discussed claims submission and processing under the Patient-Driven Groupings Model (PDGM) and reviewed several scenarios regarding timing (early vs. late), admission source (institutional vs. community), and the transition from the current home health (HH) prospective payment system (PPS) to PDGM in January, 2020.

Claim Submission

Under PDGM, home health agencies (HHAs) will submit OASIS assessments to the new internet Quality Improvement and Evaluation System (iQIES). The HHA has the *option* to run the OASIS and claim through a Grouper program in their own billing system to create a HIPPS code or they may submit *any valid health insurance prospective payment system (HIPPS) code.* This is a change from current practice/requirements where the HHA runs the OASIS data through a Grouper in their billing system to determine the payment group (HIPPS code). The PDGM HIPPS code generated from the agency Grouper, or any valid HIPPS code, is submitted on the agency's Request for Anticipated Payment (RAP), and Medicare makes the split percentage payment based on the submitted HIPPS code on the RAP.

At the end of the 30-day payment period, the HHA submits the claim with the same HIPPS code that was submitted on the RAP. Once received, Medicare systems will query the OASIS in iQIES to look for the answers to the eight OASIS functional items used in PDGM case-mix scoring. If found, the answers are returned to the claims system and stored in a new screen on the claim record. The Medicare system combines these OASIS items and claims data and sends it to the Grouper, which now resides in the Payment system and not the Quality system. The Grouper-produced HIPPS code *replaces* the submitted HIPPS code and is used for payment.

Requests for Anticipated Payment (RAPs)

All HHAs will need to submit a RAP at the beginning of each 30-day period and a final claim at the end of each 30-day period. "Newly-enrolled agencies," that is, HHAs certified after January 1, 2019, will not receive a split percentage payment based on the submitted RAP in 2020 (i.e., it is a no-pay RAP). The data fields and billing instructions required on the RAP are not changing, and as noted above, the HIPPS code on the RAP may be produced by agency Grouper software or be any valid HIPPS code. The new occurrence codes for PDGM (50, 61, 62) are *not* reported on RAPs. No special coding is required on no-pay RAPs submitted by newly-enrolled agencies. In the Q&A session at the end of the presentation, Mr. Gehne clarified that a change of ownership, or CHOW, does not impact the definition of a "newly-enrolled" HHA, which is

determined by the date the agency provider transaction access number (PTAN) was established.

The OASIS and the Claim

OASIS information may be corrected by an HHA after they have submitted their claim to Medicare. Only the eight functional items are used by the claims system, so claims only need to be adjusted if these items are corrected and the HHA believes the changes would impact payment.

If diagnosis codes change during a period of care, the coding changes should be reflected on the claim on the next period. An "other follow-up" OASIS assessment would need to be completed only when a change would be considered a major decline or improvement in the patient's status. The "old" (current) instructions stating that the diagnosis on the claim and the OASIS must match will go away with PDGM. There will be no edits in the Medicare system comparing diagnosis codes on the claim and the OASIS.

New Occurrence Codes

There are three new occurrence codes to support the transition to PDGM:

Occurrence Code 50 – "Assessment Date"

- This code is required on all final claims, not RAPs.
- This date will be used to match the claim to the OASIS record in iQIES.
- If occurrence code 50 is missing, the claim will be returned.
- Report the assessment completion date (M0090) for the SOC, ROC, recertification, or other follow-up OASIS that occurred most recently before the claim "From" date.
- A mismatch between occurrence code 50 and M0090 will result in a returned claim.

Occurrence Code 61 – "Hospital Discharge Date"

- This code is reported, but not required, on final claims. It is not reported on RAPs.
- It is reported on admission claims AND continuing claims, if applicable.
- Report the discharge date ("Through" date) of an inpatient hospital admission that ended within 14 days of the "From" date of the HH period of care.
- Indicates an "institutional" admission for the period of care.

Occurrence Code 62 – "Other Institutional Discharge Date"

- This code is reported, but not required, on final claims. It is not reported on RAPs.
- It is reported ONLY on admission claims, if applicable (the claim "From" and "Admission" dates match).

- Report the discharge date ("Through" date) of a skilled nursing facility (SNF), inpatient rehab facility (IRF), long-term care hospital (LTCH), or inpatient psychiatric facility (IPF) stay that ended within 14 days of the "From" date of the HH period of care.
- Indicates an "institutional" admission for the period of care.

HHAs may report ONLY ONE occurrence code 61 or 62 on a claim. If two inpatient discharges occur within the 14-day window, report the later discharge date and corresponding occurrence code. If an HHA is not aware of an institutional discharge when the claim is filed, and therefore an occurrence code is not reported, CMS will group the claim into a community admission group. If an inpatient claim is processed later, Medicare systems will automatically adjust the paid HH claim and pay it as an institutional admission instead.

Institutional payment groups (i.e., those identified by occurrence code 61 or 62 on the claim) will not automatically be adjusted to a community admission if no inpatient claim is found in the Medicare system after the timely filing period. An inpatient stay in a non-Medicare facility (e.g., the VA) can only be identified by an occurrence code.

Period Timing

Medicare secondary payer (MSP) episodes are counted to determine early vs. late, while Medicare Advantage period are not counted in determination of period timing.

Transition to PDGM

Payment for 60-day episodes that being on or before December 31, 2019, and end on or after January 1, 2020, will be paid via the CY 2020 national, standardized 60-day episode payment amount. HH periods of care that being on or after January 1, 2020, will be paid via the CY 2020 national, standardized 30-day period payment amount. Recertification for HH services, updates to the comprehensive assessment, and updates to the HH plan of care will continue on a 60-day basis.

The implementation date for PDGM in Medicare instructions is January 6, 2020. If RAPs or claims with a PDGM HIPPS code are submitted between January 1 and January 6, 2020, they will be held by the Medicare Administrative Contractor (MAC) and released for processing after the January 6 implementation date to prevent them being returned in error.

The Q & A Session

- CMS representatives emphasized that Medicare Advantage can "do what they want" with respect to migrating to PDGM or paying for HH services in another way.
- Swing bed stays in a critical access hospital (CAH) are considered "post-acute" or "Other Institutional" stays for purposes of classifying the admission source.

- Non-Medicare inpatient stays will only be able to be indicated or identified via occurrence codes 61 or 62, as CMS has no way to validate this information in its systems.
- CMS has no plans for any “large scale recovery” process related to using occurrence codes 61 and 62 if the information cannot be validated by a claim, whether because it was a “non-Medicare stay” or because the inpatient claim was not filed timely.

Access the presentation slides, transcript, and call recording **here**.

Change Request (CR) 11081 summarizing the comparison of claim processing under the current (2019) HH PPS and under PDGM can be accessed **here**.