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Home Health Patient-Driven Groupings Model FAQ

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1. PDGM Categories – Where does PT fit?

1.1 There are concerns that patient populations that need therapy services but that do not fall exclusively into 1 of the 2 rehabilitation clinical groupings will receive less therapy. Is it a strategy to code more patients to ensure they are categorized into a "rehabilitation" grouping?

No, PTs must code appropriately. Under PDGM, just because someone is not in the musculoskeletal rehabilitation or neurological rehabilitation clinical groupings does not mean they are not eligible to receive rehabilitation. If patients in Medication Management, Teaching, and Assessment (MMTA), complex nursing, behavioral health, or wounds grouping have rehabilitation needs, then agencies and their therapy professionals must satisfy those needs. Rehabilitation services are not confined to the neurological rehabilitation and musculoskeletal rehabilitation groupings. There is a myth that the patient in 1 of the other 4 clinical groupings will not need rehabilitation. However, rehabilitation needs are not driven by clinical grouping. There are many types of patients who may need rehabilitation services, and the clinical groupings should not preclude anyone from accessing rehabilitation.

There will be many agencies that do not understand this, so therapy professionals must inform the agencies about the right way to reimburse.

CMS reiterated this same sentiment during a February 12, 2019 PDGM webinar, stating: "While there are clinical groups where the primary reason for home health services is for therapy, and others where the primary reason for home health is for nursing, these groups reflect the primary reason for home health services during the period of care - but not the only reason. Home health remains a multi-disciplinary benefit, and payment is bundled to cover all necessary services identified on the individualized home health plan of care. So, for example, if a period of care is grouped under the complex nursing interventions group because the primary reason the patient needs home health services is for nursing care, therapy services could also be provided if those therapy services are reasonable and necessary and ordered on a Home Health plan of care." (See: https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2019-02-12-PDGM-Transcript.pdf).

2. Concerns Related to Reduction in Therapy

2.1 Some agencies are assuming that therapy services will have to be reduced for the agency to remain "sustainable" when therapy is no longer reimbursed separately. What suggestions do you have for therapists working in an environment where management is operating from that assumption?

Treatment must always be connected to medical necessity. Patients that require rehabilitation are entitled to it. Not providing this rehabilitation is inappropriate and may be reportable. Physical therapists must be open, honest, and transparent in leadership and as rehabilitation professionals. The idea that home health agencies (HHAs) are only paid for rehabilitation if X number of visits are provided is a myth. The right message for rehabilitation staff is that rehabilitation services will always be necessary when the patient's condition warrants it because such services benefit patients.

Clinicians that drive value will always be needed, creating high satisfaction in patients and families. However, health care is a business, and HHAs may try to be innovative and meet patient needs in various ways, but they need to ensure that they achieve good outcomes. Real innovation will lead to better outcomes, and PDGM creates an opportunity for rehabilitation professions to focus on these areas.

2.2 How should PTs respond if they are told their visits are limited based on the expected payment?

The benefit is not changing: when an HHA accepts a patient, it accepts responsibility to provide the services the patient needs. Therapists should use their clinical judgment to determine the appropriate number of visits. The patient's characteristics should be driving what the patient is receiving. If clinically inappropriate visit limits are being established, please reach out to advocacy@apta.org, so APTA can share such feedback with CMS.

2.3 Has CMS articulated how and what may be monitored related to therapy utilization?

CMS expects the ordering physician in conjunction with the therapist to develop the plan of care. CMS is somewhat relying on the physician plan of care to ensure patients are getting the appropriate amount of therapy. CMS also has indicated it will monitor utilization under PDGM by looking at service units on the claim, changes in quality metric outcomes, and changes in Home Health Compare scoring.

2.4 Will PDGM reduce the impact that therapy may have in home health, since therapy will not be "driving" reimbursement as compared to how it is today?

How care is paid for may be different, but it is important for PTs and PTAs to remind agencies, patients, and colleagues of the value therapists bring to patient quality of life.

3. Productivity in Home Health

3.1 Productivity has been such a major driver of therapy behaviors and measure of financial success. Will the focus of this measure change in the future and if so, what might therapists expect?

Productivity as an operational metric for all staff will not change. Ensuring agencies have a productive, efficient, and effective workforce is vital to the agency remaining in business and extending services to the patients who need them. Measuring specific productivity of therapy as a financial measure may change because there is no incremental revenue from it, and that is for the better. There is need for a reimbursement system focused on clinical characteristics of the patient's specific issues, not striving to achieve a certain level of reimbursement under the system. Rehabilitation professionals should take a proactive approach to ensuring agencies have a focus on the right metrics as PDGM is implemented.

4. Therapy Plans of Care

4.1 Should therapists anticipate front-loading of visits for increased ability for intensity and appropriate dosing per evidenced based practice to continue to occur?

Yes, and it will continue to occur. This is one of the reasons why CMS changed the 60 day unit of payment to 30 days; the majority of visits were completed in the first 30 days of the episode. Additionally, research and evidence-based practice is lining up rapidly, and is driving the need for front-loaded care. Rehabilitation professionals are being asked to keep patients out of the hospital, which may necessitate more visits at the front part of the episode. This often necessitates additional visits at the initial part of the episode.

5. Outlier Policy

5.1 What is the outlier payment? Does an outlier payment help to cover the costs of a high-cost episode? What determines the outlier threshold?

Outlier patients will be reimbursed the same way under PDGM as they were under the previous system. An example of a high-cost episode might be a lymphedema patient. Professionals should model a lymphedema patient and whether their case-mix grouping offsets the cost of care using CMS's grouper tool, which can be found here: https://www.cms.gov/center/provider-type/home-health-agency-hha-center.html

6. Coding under PDGM

6.1 What is the importance of coding under PDGM?

The primary diagnosis will be used to determine the clinical grouping which patients are assigned to. Physical therapists (PTs) who have shied away from clinical taxonomy should fully embrace coding. PTs should be responsible for body structure and body impairments that are derived from the health conditions and should be more responsible for identifying the primary condition that is driving reimbursement for that condition for that 30-day period. Additionally, in PDGM there is a new construct called the "questionable encounter." CMS believes these ICD-10 codes are not appropriate to reflect a primary diagnosis. This will impact rehabilitation professionals, as codes typically used by therapists, such as abnormality of gait, are designated as a questionable encounter, and claims will not proceed with these codes. PTs will need to educate themselves on these questionable encounter codes.

6.2 What are "common therapy diagnoses" currently on home health claims and what is their use under PDGM? For example, "generalized muscle weakness" (M62.81)?

Claims using codes that CMS categorize as "questionable encounters" will be rejected. So, for example, if M62.81 is used, it will get rejected. Therapy professionals must think about what they are treating and why, which will require collecting as much information from the referral source as possible and asking more questions.

Rehabilitation professionals have shied away from ICD-10 coding, but it is critical that the comprehensive assessment collects enough information so that the agency's coders can make a correct determination. Moreover, ICD-10 Official Guidance and Reporting requires physician documentation. For example, while a PT can stage a pressure ulcer, the physician has to document the wound as a pressure (vs. diabetic, for example) ulcer.

6.3 A patient is referred to home care for PT services to address weakness and history of recent falls. A review of medical history reveals hypertension with congestive heart failure and diabetes with neuropathy. Would an Oasis reviewer/coder be able to ask the start of care clinician to clarify if congestive heart failure or the diabetes would be the primary reason for causing the weakness? Or, should that primary diagnosis for home care be obtained from the physician at the time the start of care clinician calls for verbal orders?

This is a real scenario in this new model. The physician will have to be the one that clarifies the etiology for what is driving the reason for home care. The reviewer may connect with the start of care clinician, to say – I'm reviewing your information, help me understand what is the primary reason for home care? And what is the etiology of the condition? Is the heart failure creating such a problem with muscle oxygenation…?

It would be great to get to a point where all PTs are able to answer these questions. The physician would then confirm, based on the documentation the PTs have collected.

7. Effects of PDGM on Other Payer Sources

7.1 Will the Home Health Value-Based Purchasing (VBP) be implemented in other states in the future?

Yes, it is expected that VBP will be expanded to other states in the future.

7.2 Will PDGM drive referrals toward Medicare Part B home visits as it relates to physical therapy?

PDGM changes should not drive patients to outpatient therapy. PDGM is a payment structure, not a benefit. The Medicare home health benefit is not changing. If a patient is homebound and satisfies other coverage criteria, the patient should receive home health services.

8. Value and Physical Therapy

8.1 What are strategies for therapists to demonstrate their value?

Practice at the top of your license; be a total and complete clinician. Therapists should demonstrate that they are willing to:

- Supervise PTAs;
- Perform medication management;

- Perform an OASIS admission assessment; and
- Assess vital signs and ADLs.

Driving value means taking extra steps to keep patients out of the hospital or ER while ensuring patients are highly satisfied with services they are receiving.

Therapists also should focus on:

- Tracking data and showing outcomes. Therapists should focus on a few metrics, not all home health compare metrics, because they aren't all equal;
- Insure you are responsible for utilization of resources. Make every visit count;
- Successful discharge to community;
- Acute care hospitalization rates;
- Patient satisfaction (HCAHPS). Claims based metrics and metrics where families provide feedback are crucial;
- How they determine number of visits;
- The effectiveness of their exercises;
- Connecting with upstream providers, e.g. find out what goals the patient achieved in the Hospital/IRF/SNF and what goal areas remain;
- Discharge planning and aligning the plan of care with the patient's goals;
- How individualized the plan of care should be;
- Section GG functional status, especially since all 4 PAC settings are collecting Section GG, and CMS will be using the data to look at what's happening to a beneficiary across the care setting; and
- Advocating for patients and coordinating with other health care professionals.

8.2 What does PDGM expect of rehabilitation professionals?

PDGM expects rehabilitation professionals will continue to deliver high quality therapy services that are reasonable and necessary. It is expecting such professionals will continue to drive value. Therefore, rehabilitation professionals need to constantly evaluate how they are driving value and what they can do to improve. Individuals need to continue to ask questions about technical aspects of the rule change, and how it will impact agencies and patients. Rehabilitation professionals should proactively reach out to CMS with any questions and concerns.