201. Revenue Cycle Management
Session 201
Revenue Cycle Management

Continuing Education

The planners and presenters of this activity disclose no relevant relationships with any commercial entity pertaining to the content.

- Nurse attendees may earn a maximum of 15.5 contact hours
- Accountant attendees can earn up to 18.9 CPEs

Accreditation Statement
NAHC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.
NAHC is [also] approved by the California Board of Registered Nursing, provider #10810.

Commercial Support provided by Brightree, Excel Health Group, Healthcare Provider Solutions, and Simione Healthcare Consultants.
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PPS vs PDGM
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Institutional vs. Community
• Only the 1st 30-day period will be considered “Institutional”
  – All subsequent periods to be considered “Community”

Determination made by looking back at 14 days prior to admission to look for institutional stay

<table>
<thead>
<tr>
<th>Community vs. Institutional</th>
<th>Average Full Period Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional</td>
<td>$2,260.65</td>
</tr>
<tr>
<td>Community</td>
<td>$1,545.51</td>
</tr>
</tbody>
</table>

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Early vs. Late Determination
• Currently, an episode is considered early for the first 120 days of care
  – Must be more than 60 days between end of one period & start of another period

– PDGM changes this to 30 day billing periods
  • Only the first claim is early, not the first two episodes
  • 34% average reduction in reimbursement for early / late change

<table>
<thead>
<tr>
<th>Early vs. Late</th>
<th>Average Full Period Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>EARLY</td>
<td>$2,147.39</td>
</tr>
<tr>
<td>LATE</td>
<td>$1,428.37</td>
</tr>
</tbody>
</table>
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For billing purposes, PDGM will keep the RAP/Final billing methodology

- RAP Billing
  -- OASIS Completion/QA, receipt of verbal orders
    - PDGM RAP 2 in most cases will use the same OASIS as PDGM RAP 1 leading to quicker billing timeline

- Billing requirements remain the same for final claim:
  - Completed and successfully transmitted OASIS assessment
  - Compliant face-to-face certification
  - Signed and dated orders
  - Signed and dated plan of care
  -- Timely receipt of visits and supply information

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60 DAY EPISODE

<table>
<thead>
<tr>
<th>OASIS</th>
<th>OASIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1......5.........10...........15.........20.........25.........30.........35.........40.........45.........50.........55.........60.........70</td>
<td>Front-loaded visits  Tapered visits</td>
</tr>
</tbody>
</table>

Orders management

SOC or recertification 30-day payment period  Subsequent 30-day payment period, if applicable

1...........5.........10.........15.........20.........25.........30  1...........5.........10.........15.........20.........25.........30

Between day 5-11=Bill RAP for initial 30 day period  Between day 1-10=Bill final Claim for Initial 30 day period
Between day 5-11= Bill RAP for subsequent 30 day period  After 60th day, 61-74=Bill final Claim for subsequent 30 day period
Required for each 30-day payment period vs. every 60 day episode
- No payment for HHAs Medicare certified in 2019 or thereafter
  • HHAs required to submit “no-pay” RAPs
    Could potentially be phased out pending future rulemaking
- RAPs possibly eventually replaced by a Notice of Admission (NOA) billing transaction
- SOC or recertification payment periods
  • Same as current PPS requirements
- Subsequent payment periods
  • First billable visit has been completed
- Must be in “paid” status before corresponding final claim can be billed & paid
- Subject to auto-cancellation & payment recoupment by MAC, as in PPS
Final Claims

• Required for each 30-day payment period
  – Not required to be billed sequentially

• Required to have corresponding RAP in “paid” status
  – Subject to 14-day payment floor
  – Paid full claim amount less recoupment of RAP payment
  – Subject to payment recoding & adjustments, if applicable
  – OASIS validation

• Claims for, SOC or recertification, 30-day payment periods subject to OASIS validation
  – Same requirements as current PPS claims

Payment Recoding

**Episode Timing**

• Claim payments to be automatically recoded for early or late status based on paid claims history on Medicare CWF
  – Payment period timing
    1=Early
    2=Late

**Admission source**

• Claim payments to be automatically recoded for community or institutional status based on paid claims history on Medicare CWF
  1=Community Early
  2=Community Late
  3=Institutional Early
  4=Institutional Late
Payment Adjustments

- **LUPAs & add-on**
  - Paid same methodology as PPS but LUPA threshold applied to each separate Group case-mix specific 30-day payment period (CMS expects to see a lot more LUPAs in the 2nd 30 day period)

- **PEPs**
  - Paid same methodology as PPS but prorated over 30-day payment period; are now called Partial Payment Adjustments

- **Outliers**
  - Paid same methodology as PPS but outlier cost & threshold measured over 30-day period

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NRS
Non Routine Supplies
Changes in NRS Payments

• Currently, non-routine supplies (NRS) are paid separately from the HHRG payment, based on a case-mix model that calculates 6 different levels of payment from $14.62 to $570.62 (FY 2019 rates)
• Under PDGM, NRS payments will be paid prospectively, but combined with the overall resource. PDGM payment includes NRS in methodology
• NRS cost is generated by taking NRS charges on claims and converting them to costs using a NRS cost-to-charge ratio that is specific to each HHA
• NRS is factored into the average resource use; NRS costs are reflected in the average resource use that establishes the case-mix weights (Cost per Minute + NRS)

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Changes in NRS Payments

• Patient Grouping most likely to require high NRS
  • Wound and Complex Nursing
    • These groups comprise 14% of all 30 day periods of care • 47% of all NRS charges fall into these groups
• LUPA payment includes NRS reimbursement in per visit cost
• Agencies need to ensure that supply cost is included on claims
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Payment Impact:
1st 30 day period vs. 2nd 30 day
Primary Dx Infection of amputation stump, right lower extremity
• Early & Institution – $2,112.75
  • 11 Visits
  • Clinical Grouping = MMTA Infection
  • Low Comorbidity
  • Functional Score of 41
• Late & Community – $1,146.40
  • 11 Visits
  • Clinical Grouping = MMTA Infection
  • Low Comorbidity
  • Functional Score of 41

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<table>
<thead>
<tr>
<th>Type</th>
<th>Start Date</th>
<th>End Date</th>
<th>Bill Date</th>
<th>Paid Date</th>
<th>Total Days To Pay</th>
<th>$$$</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPS Claim = $3,300</td>
<td>Day 1</td>
<td>Day 1</td>
<td>Day 7</td>
<td>Day 14</td>
<td>14</td>
<td>$1,980</td>
</tr>
<tr>
<td>PPS Rap</td>
<td>Day 1</td>
<td>Day 60</td>
<td>Day 67</td>
<td>Day 81</td>
<td>81</td>
<td>$1,320</td>
</tr>
<tr>
<td>PDGM 1st Period Claim = $1,900</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDGM RAP1</td>
<td>Day 1</td>
<td>Day 1</td>
<td>Day 7</td>
<td>Day 14</td>
<td>14</td>
<td>$1,140</td>
</tr>
<tr>
<td>PDGM FC 1</td>
<td>Day 1</td>
<td>Day 30</td>
<td>Day 14</td>
<td>Day 58</td>
<td>58</td>
<td>$760</td>
</tr>
<tr>
<td>PDGM 2nd Period Claim = $1,400</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDGM RAP2</td>
<td>Day 31</td>
<td>Day 31</td>
<td>Day 34</td>
<td>Day 41</td>
<td>11</td>
<td>$700</td>
</tr>
<tr>
<td>PDGM FC 2</td>
<td>Day 31</td>
<td>Day 60</td>
<td>Day 67</td>
<td>Day 81</td>
<td>51</td>
<td>$700</td>
</tr>
</tbody>
</table>
# Session 201
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## 60 DAY EPISODE

<table>
<thead>
<tr>
<th>Front-loaded visits</th>
<th>Tapered visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>OASIS</td>
<td>OASIS</td>
</tr>
<tr>
<td>1........5.........10........15........20........25........30........35........40........45........50........55........60........70</td>
<td></td>
</tr>
</tbody>
</table>

**Orders management**

- SOC or recertification 30-day payment period
  - Between day 5-11=Bill RAP for initial 30 day period
  - After 60th day, 61-74=Bill final Claim for subsequent 30 day period

- Subsequent 30-day payment period, if applicable
  - Between day 1-10=Bill final Claim for Initial 30 day period
  - Between day 5-11= Bill RAP for subsequent 30 day period

**Next.................**
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Downstream Effect from Intake
• It All Starts at Intake
  – Correct Determinations to Prevent Billing/Revenue Issues:
    Early vs. Late Period
    Community vs. Institutional
    Coding—Homecare Primary Diagnosis and all comorbidities
    Paperwork correct & complete

Keys to Success
• Tools to Improve Efficiency
  – EMR feature functionality
  – Utilization of a Document Management Systems
  – Increase e-Referrals
  – Establish referral checklist to streamline

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• Personnel demands
  – Additional billing & payment posting transactions due to shorter payment periods of only 30-days vs. 60-days
  – More time spent on seeing if claims were PAID correctly and not just be happy because the claim was paid
  – More claims adjustments performed due to late notes and cash flow

• Cash flow issues
  – Smaller, more frequent RAP & claim payments
  – No RAP payments for HHAs Medicare certified in 2019 & thereafter

• Additional issues created for payment posting functions
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- Is your biller to capacity?
- Is it time to hire an additional biller?
- Is your software helping or hurting this new process?
- What are your billers’ ‘other’ current job duties?
- Claims volume will double, but not your $$$$
- HH agencies are comfortable & relaxed in regard to getting doctor orders back because we’ve always had 2 months to get orders
- Orders Management
  - We need new goals/processes, like orders back in a week

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2020 Proposed Rule
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**PDGM Tools**

- [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)

  - CY2019 HH PPS Wage Index [ZIP, 105KB]
  - CY2019 HH PPS Proposed Case-Mix-Weights [ZIP, 13KB]
  - PDGM Grouper Tool [ZIP, 1MB]
  - CY 2019 through CY 2022 Rural Add-on Payments: Analysis and Designations [ZIP, 479KB]
  - PDGM Weights and LUPA Thresholds [ZIP, 30KB]
  - PDGM Agency-Level Impacts, Estimated for CY 2019 [ZIP, 1MB]
  - Summary of the Home Health Technical Expert Panel Meeting [PDF, 1MB]

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Thank you!

For questions, please feel free to reach out to me:

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CMS Targeted Probe & Educate

• CMS expansion on Probe & Educate is for Home Health and Hospice and will be effective 10/1/2017. This is referred to as Targeted Probe & Educate (TPE). This review will include targeted medical review and education along with an option for potential elevated action, up to and including referral to other Medicare contractors including the Zone Program Integrity Contractor (ZPIC), Unified Program Integrity Contractor (UPIC), Recovery Audit Contractor (RAC), etc.

• The goal of TPE is to reduce/prevent improper payments. The purpose of this expansion is to reduce appeals, decrease provider burden, and improve the medical review and education process.
CMS Targeted Probe & Educate

- All MAC medical record reviews are replaced with three rounds of pre-payment or post-payment TPE. If the provider's error rate remains high upon completion of the first round, then the provider is retained for the second and, potentially, a third round of review.
- Providers with a continued high error rate after three rounds of TPE will be referred to CMS for additional action.
CMS Targeted Probe & Educate

- MAC will select the topics for review based upon existing data analysis procedures.
- The claim sample size for each round of probe review is limited to a minimum of 20 and a maximum of 40 claims.
- TPE processes include provider specific education that will focus on improving specific issues without allowing other problems to develop along with an opportunity for the provider to ask questions. Education will be offered after each round of 20 to 40 claims reviewed.

### HOME HEALTH EDITS

<table>
<thead>
<tr>
<th>Review Topic</th>
<th>Description</th>
<th>Review Type</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Eligibility and Medical Necessity</td>
<td>This edit selects providers who submitted home health claims with errors as identified in HH probe and educate round 2.</td>
<td>Targeted Probe and Educate Prepayment Review</td>
<td>Active</td>
</tr>
<tr>
<td>LOS with Hypertension</td>
<td>This edit selects home health claims for providers who submitted diagnosis Hypertension and a length of stay greater than 120 days.</td>
<td>Targeted Probe and Educate Prepayment Review</td>
<td>Active</td>
</tr>
<tr>
<td>No response to ADR</td>
<td>This edit selects providers who fail to respond to ADRs (additional documentation requests)</td>
<td>Targeted Probe and Educate Prepayment Review</td>
<td>Active</td>
</tr>
</tbody>
</table>

CGS Home Health Edits Active for TPE
CMS Targeted Probe & Educate

• Tips for Success
  ▪ Providers targeted for TPE will receive a notification letter about the upcoming review and additional development requests (ADRs) will be used for the specific claims selected for review.
  ▪ Providers should ensure that medical records are submitted promptly upon request.

CMS Targeted Probe & Educate

▪ Provider nonresponse to medical records requests will count as an error. PGBA stated this will warrant a ZPIC referral
▪ MACs may conduct a "related claim review" of services related to a denied claim and such reviews may be conducted outside of the TPE process.
▪ The TPE process does not replace or change appeal rights.
CMS Targeted Probe & Educate

- **RECEIPT OF DOCUMENTATION** – When your documentation has been received the claim is moved from status/location S B6001 to S M50MR for review. Providers can monitor the S M50MR status/location in FISS, to verify that their documentation has been received. Confirmation of receipt is also provided when using to submit your documentation.

- **REVIEW OF DOCUMENTATION** – A nurse reviewer will examine the medical records submitted to ensure the technical components (OASIS, certifications, election statement, etc.) are met, and that medical necessity is supported. MAC has 30 days from the date the documentation is received to review the documentation, and make a payment determination. For demand denials (condition code 20), MAC has 60 days from the date the documentation is received to review the documentation.

CMS Targeted Probe & Educate

- Provider nonresponse to medical records requests will count as an error.
- MACs may conduct a "related claim review" of services related to a denied claim and such reviews may be conducted outside of the TPE process.
- The TPE process does not replace or change appeal rights.
Results from CGS

Home Health
Probes completed October 1, 2018 – December 31, 2018
Eligibility and Medical Necessity edit 5A000

<table>
<thead>
<tr>
<th>Results</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probes Completed</td>
<td>55</td>
</tr>
<tr>
<td>Providers Compliant after Round 1 Completion</td>
<td>2</td>
</tr>
<tr>
<td>Providers Non-compliant after Round 1 Completion (advancing to Round 2)</td>
<td>53</td>
</tr>
<tr>
<td>Providers with Non-Responses to ADR’s for Round 1</td>
<td>14</td>
</tr>
</tbody>
</table>
RISK

Home Health Risk Category

Risk Category is defined based on end of round provider error rate. The categories are defined as:

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>0-25%</td>
</tr>
<tr>
<td>Moderate</td>
<td>26-50%</td>
</tr>
<tr>
<td>Significant</td>
<td>51-100%</td>
</tr>
</tbody>
</table>

![Home Health Risk Category Pie Chart]

Top Denial Reasons

Top Denial Reasons October 1, 2018 – December 31, 2018

1. Face-to-Face missing/incomplete/untimely
2. Initial certification invalid
3. Medical records were not received
4. Plan of care missing/invalid
5. Therapy visits not medically necessary
Top Denial Reasons

- **FTF Documentation Denials** accounted for approximately 27% of the total Targeted Probe and Educate denials.
  - Certifying physician did not document the date of the FTF encounter
    - CGS Home Health Physician Certification Web page
  - Community physician was not identified when a physician who would not be following the patient after discharge signed the certification
  - Required elements for initial certification (initial plan of care, initial certification, initial encounter documentation) were not submitted for recertification
  
  Refer to the CGS Home Health Coverage Guidelines Web page for a variety of resources on the home health FTF encounter.

- **Initial certification invalid** accounted for approximately 12% of the total Targeted Probe and Educate denials.

Refer to the CGS Home Health Physician Certification Web page for documentation tips and access to the Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7).

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Top Denial Reasons

- **Medical records were not received** accounted for approximately 10% of the total Targeted Probe and Educate denials.

Refer to the CGS Medical Review Additional Development Request (ADR) Process Web page for information to ensure that necessary steps are taken to submit documentation timely.

- **Plan of care missing/invalid** accounted for approximately 8% of the total Targeted Probe and Educate denials.

Refer to the CGS Physician Orders, Plan of Care and Certification and Home Health Missing/Incomplete/Untimely Plan of Care or Certification [PDF] Web pages for documentation tips and access to the Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7).

- **Documentation did not support medical necessity of therapy services** accounted for approximately 8% of the total Targeted Probe and Educate denials.

Refer to the CGS Physical Therapy Web page for documentation tips, access to the Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7) therapy information and the Local Coverage Determination for physical therapy services.
**Home Health PEPPER**

P Program for  
E Evaluating  
P Payment  
P Patterns  
E Electronic  
R Report

**Target Areas**

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Target Area Definition</th>
</tr>
</thead>
</table>
| **Average Case Mix**        | **Numerator (N):** sum of case mix weight for all episodes paid to the HHA during the report period, excluding LUPAs (identified by Part A NCH HHA LUPA code) and PEPs (identified as patient discharge status code equal to ‘06’).  
                           | **Denominator (D):** count of episodes paid to the HHA during the report period, excluding LUPAs and PEPs                                                   |
| **Average Number of Episodes** | **N:** count of episodes paid to the HHA                                                                                                                   |
|                              | **D:** count of unique beneficiaries served by the HHA                                                                                                     |
|                              | Note: reported as a rate, not a percent                                                                                                                     |
Target Areas

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Target Area Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episodes with 5 or 6 Visits</td>
<td>( N ): count of episodes with 5 or 6 visits paid to the HHA ( D ): count of episodes paid to the HHA</td>
</tr>
<tr>
<td>Non-LUPA Payments</td>
<td>( N ): count of episodes paid to the HHA that did not have a LUPA payment ( D ): count of episodes paid to the HHA</td>
</tr>
<tr>
<td>High Therapy Utilization Episodes</td>
<td>( N ): count of episodes with 20+ therapy visits paid to the HHA (first digit of HHRG equal to ‘5’) ( D ): count of episodes paid to the HHA</td>
</tr>
<tr>
<td>Outlier Payments</td>
<td>( N ): dollar amount of outlier payments (identified by the amount where Value Code equal to ‘17’) for episodes paid to the HHA ( D ): dollar amount of total payments for episodes paid to the HHA</td>
</tr>
</tbody>
</table>

The Compare Targets Report displays statistics for target areas that have reportable data (11+ target count) in the most recent time period. Percentiles indicate how a home health agency's target area percent/rate compares to the target area percent/rates for all home health agencies in the respective comparison group. For example, if a home health agency's national percentile (see below) is 80.0, 80% of the home health agencies in the nation have a lower percent/rate value than that home health agency. The home health agency's Medicare Administrative Contractor (MAC) jurisdiction percentile and the state percentile values (if displayed) should be interpreted in the same manner. Percentiles at or above the 80th percentile for any target area indicate that the home health agency may be at a higher risk for improper Medicare payments. The greater the percentile value, in particular the national and/or jurisdiction percentile, the greater consideration should be given to that target area.

<table>
<thead>
<tr>
<th>Target</th>
<th>Description</th>
<th>Target Count/Amount</th>
<th>Percent/Rate</th>
<th>Home Health Agency National %ile</th>
<th>Home Health Agency Jurisdiction %ile</th>
<th>Home Health Agency State %ile</th>
<th>Sum of Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Case Mix</td>
<td>Proportion of the sum of case mix weight for all episodes paid to the HHA during the report period, excluding LUPAs and PEPs, to the count of episodes paid to the HHA during the report period, excluding LUPAs and PEPs</td>
<td>296</td>
<td>1.14</td>
<td>77.1</td>
<td>78.0</td>
<td>74.0</td>
<td>Not Calculated</td>
</tr>
<tr>
<td>Average Number of Episodes</td>
<td>Proportion of the count of episodes paid to the HHA during the report period, to the count of unique beneficiaries served by the HHA during the report period</td>
<td>284</td>
<td>1.30</td>
<td>13.9</td>
<td>7.6</td>
<td>10.6</td>
<td>$753,471</td>
</tr>
<tr>
<td>Non-LUPA Payments</td>
<td>Proportion of the count of episodes paid to the HHA that did not have a LUPA payment during the report period, to the count of episodes paid to the HHA during the report period</td>
<td>264</td>
<td>93.0%</td>
<td>44.9</td>
<td>34.8</td>
<td>81.7</td>
<td>$747,540</td>
</tr>
<tr>
<td>High Therapy Utilization Episodes</td>
<td>Proportion of the count of episodes with 20+ therapy visits paid to the HHA during the report period (first digit of HHRG equal to ‘5’), to the count of episodes paid to the HHA during the report period</td>
<td>22</td>
<td>7.7%</td>
<td>51.6</td>
<td>49.0</td>
<td>44.2</td>
<td>$111,702</td>
</tr>
</tbody>
</table>
Home Health Agency PEPPER

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Rates over time resulting in greater risk of improper Medicare payments
- Your Target Rate (first row in the table below) is above the national 90th percentile

### Average Case Mix

| Date Range           | Target Rate | Home Health Agency | Total 30th Percentile | Total 90th Percentile | Total All
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/13 – 12/31/13</td>
<td>1.20</td>
<td>1.20</td>
<td>1.20</td>
<td>1.20</td>
<td></td>
</tr>
<tr>
<td>1/1/14 – 12/31/14</td>
<td>1.22</td>
<td>1.22</td>
<td>1.22</td>
<td>1.22</td>
<td></td>
</tr>
<tr>
<td>1/1/15 – 12/31/15</td>
<td>1.30</td>
<td>1.30</td>
<td>1.30</td>
<td>1.30</td>
<td></td>
</tr>
</tbody>
</table>

### Comparative Data

<table>
<thead>
<tr>
<th>Category</th>
<th>National 90th Percentile</th>
<th>Jurisdiction 90th Percentile</th>
<th>State 90th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1.20</td>
<td>1.20</td>
<td>1.20</td>
</tr>
</tbody>
</table>

Note: HHSC case mix weights changed (decreased) in CY 2014 from CY 2013

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Home Health Agency PEPPER

Top Diagnoses

Home Health Agency Top Diagnoses, Most Recent Calendar Year

In Descending Order by Total Episodes

<table>
<thead>
<tr>
<th>CCS Diagnosis Categories</th>
<th>Total Episodes</th>
<th>Proportion of Episodes to Total</th>
<th>Number of Visits for CCS</th>
<th>Average Visits for CCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other aftercare</td>
<td>59</td>
<td>20.8%</td>
<td>1,079</td>
<td>18.3</td>
</tr>
<tr>
<td>Chronic ulcer of skin</td>
<td>23</td>
<td>8.1%</td>
<td>493</td>
<td>21.4</td>
</tr>
<tr>
<td>Congestive heart failure; nonhypertensive</td>
<td>23</td>
<td>8.1%</td>
<td>347</td>
<td>15.1</td>
</tr>
<tr>
<td>Rehabilitation care; fitting of prostheses; and adjustment of device</td>
<td>22</td>
<td>7.8%</td>
<td>343</td>
<td>15.6</td>
</tr>
<tr>
<td>Other connective tissue disease</td>
<td>15</td>
<td>5.3%</td>
<td>349</td>
<td>23.3</td>
</tr>
<tr>
<td>Late effects of cerebrovascular disease</td>
<td>12</td>
<td>4.2%</td>
<td>200</td>
<td>16.7</td>
</tr>
<tr>
<td>Diabetes mellitus without complication</td>
<td>11</td>
<td>3.9%</td>
<td>151</td>
<td>13.7</td>
</tr>
</tbody>
</table>
Thank You for Attending!

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