304. PDGM – Clinical-Episode Management

FINANCIAL MANAGEMENT CONFERENCE & EXPO

HOMECARE & HOSPICE
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Financial Managers Association

PDGM Clinical Episode Management

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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**

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Learning Objectives

- Discuss necessary modifications to the intake and referral process under PDGM
- Explain the relevance of timely OASIS review, coding completion and clinician documentation under PDGM
- Identify strategies for improved physician interaction to ensure timely 30-day billing
- Recognize the complexity of determining LUPA thresholds under PDGM
- Discuss the relevance of front-loading, missed visits and refusals of care and services to LUPA prevention
- Explain scheduling strategies to prevent missed visits
- Discuss strategies to improve patient buy-in and adherence to the home health plan of care
- Examine clinical management responsibilities related to LUPA prevention
- Outline strategic planning for implementation of clinical episode management best practices within the agency

PPS vs PDGM Overview

PPS	PDGM
60-day billing period within a 60-day episode	30-day billing period within a 60-day episode
Timing (early first two 60-day periods, late third or later 60-day periods)	Timing (early first 30-day period, late all subsequent 30-day periods)
No referral source impact	Referral source (community or institutional source) based on claims data
Therapy drives reimbursement	Therapy does not drive reimbursement
RAP and Final	RAP and Final (considering eliminating RAP in the future)
No comorbidity adjustment	Comorbidity adjustment (none, low (one), high (two or more))
153 payment groups	432 payment groups
Clinical level from OASIS assessment (low, medium, or high)	Clinical grouping (12 clinical groups from primary Dx)
Functional level from OASIS assessment (low, medium, or high)	Functional level from OASIS assessment (low, medium, or high)

Referral Source PPS vs PDGM

PPS

- No impact to reimbursement based on referral source
- Timeliness of care standard per CoPs within 48 hours of referral date or on the physician-ordered SOC/ROC date
- Delays in care impact:
  - Patient
  - Home health compare
  - STAR ratings
  - Value Based Purchasing

PDGM

- Based on the health care setting used in the 14-days prior to home health admission per Medicare claim's data
- Timeliness of care standard per CoPs within 48 hours of referral date or on the physician-ordered SOC/ROC date
- Delays in care impact:
  - Patient
  - Home health compare
  - STAR ratings
  - Value Based Purchasing
  - Reimbursement*

Intake and Referral under PDGM

- More specificity needed for accurate diagnosis coding to:
  - Prevent RTP
  - Identify comorbidities
  - Ensure accurate reimbursement
- Successful coding will depend on accurate referrals and knowledgeable liaisons and intake staff, supported further by clinician assessment
- Educate liaisons and intake in:
  - Unacceptable primary diagnosis codes (Questionable Encounters) under PDGM
  - Specificity needed for coding accuracy (i.e. location of wound or fracture)
  - Adequate information necessary to support:
    - Reason for home health services
    - Homebound status
    - Diagnosis coding
  - Role in initial risk-stratification for patient
  - Timely (same day) communication from intake department to team schedulers to ensure compliance with timeliness of care and improve accuracy of reimbursement

Coding PPS vs PDGM

PPS

- Top 6 diagnosis codes on the claim impact reimbursement
  - Case-mix points system
  - Not all ICD-10 diagnosis codes receive case-mix points, although the diagnoses may still be coded and accepted on the home health claim
- Up to 24 additional diagnosis may be coded, but do not impact reimbursement
- Top 6 diagnosis on claim must match OASIS

PDGM

- Primary diagnosis maps to clinical grouping
  - Clinical grouping system
  - Not all ICD-10 diagnosis codes will map to a clinical grouping. If coded, these will result in RTP and delay in reimbursement
- Up to 24 additional diagnosis may be coded and have the potential to result in a comorbidity adjustment
  - Based on clinical subgroups and clinical subgroups interactions determined by CMS
  - May increase reimbursement by up to 20%
- Diagnoses on claim do not, necessarily, have to match OASIS

Finding A Diagnosis

- Some things to keep in mind:
- Symptoms are not likely to be ok. You need the underlying diagnosis
- Verify the diagnosis is accepted before finishing your processing of the referral
- Use the most specific laterality and location supported in the record
- One of the diagnoses should be the primary reason for home health care
- Probe to determine alternative diagnoses to the non-allowable diagnoses

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Finding an Alternative Diagnosis

Diagnosis not fitting into a clinical grouping	How to approach
M62.81 Muscle Weakness	Ask for the reason the patient is presenting with muscle weakness. Did the patient have surgery or an injury? If so, the aftercare of the surgery or the injury may be a more appropriate diagnosis
M54.5 Low back pain or M54.9 Back pain, unspecified	Ask for the reason patient is presenting with low back pain. For example, does the patient have a chronic condition like spinal stenosis or a back injury. The chronic condition may be more appropriate reason for referral. Is chronic pain a more appropriate reason for referral?
R13.10 Dysphagia, unspecified	Ask for reason patient is now presenting with dysphagia. For example, does the patient have a chronic condition, like a stroke, that has resulted in the dysphagia. If so, the chronic condition may be the more appropriate reason for referral

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Finding an Alternative Diagnosis

Diagnosis not fitting into a clinical grouping	How to approach
Rheumatoid Arthritis, unspecified	Ask the referral source to identify the rheumatoid factor or the specified type (juvenile or idiopathic) and ask the referral source to specify single or multiple locations.
Polyneuropathy	Ask the referral source for the reason the patient is now presenting with polyneuropathy. For example, does the patient have a chronic condition, like diabetes, that has resulted in the polyneuropathy. If so the chronic condition may be the correct diagnosis. Or the referral source may need to specify the exact type of neuropathy (ex idiopathic).
Retention of Urine, unspecified	Ask the referral source the reason the patient is presenting with urine retention. For example, does the patient have a chronic condition like BPH that has resulted in urine retention. Use that diagnosis instead.

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Documentation under PDGM

- Two 30-day episodes each with a RAP and Final claim under PDGM* (*New agencies certified after 1/1/2019 will not receive RAP payments)
- Home health regulations specify that all physician orders, POC, and F2F be signed prior to final billing
- Review of agency processes and procedures is needed to ensure timely processing of RAP and Final claims under PDGM

Documentation under PDGM

Review for timely billing should include:

- Current days to RAP vs PDGM goal for days to RAP
  - Factors influencing the days to RAP
    - Delays in clinician documentation
      - What is agency protocol for documentation turn-around time (TAT)?
      - Clinician accountability-ensure process is clear and being followed
    - Delays in OASIS & Coding review
      - Who is performing OASIS & Coding review-in-house vs outsourced?
      - What is the current TAT vs expected TAT?
      - Process for follow up when expected TAT is not being met-ensure process is in place whether review is being done in-house or being outsourced

Documentation under PDGM

- Current number of days to Final bill vs goal for days to Final under PDGM
  - Factors influencing days to Final
    - Delays in clinician documentation
      - What is agency protocol for documentation turn-around time (TAT)?
      - Clinician accountability-ensure process is clear and being followed
    - Delays in OASIS review
      - Who is performing OASIS (SOC/ROC/Recert/DC) review-in-house vs outsourced?
      - What is the current TAT vs expected TAT?
      - Process for follow up when expected TAT is not being met-ensure process is in place whether review is being done in-house or being outsourced
    - Delayed receipt of signed physician's orders
    - Delayed receipt of completed, signed F2F documents
      - Are there specific guidelines in place for follow up on physician's orders and F2F? Are these guidelines being followed?
      - Is there adequate staffing to support timely processing and follow up on outstanding orders?

Clinician Accountability
Setting the Stage for Episode Management

- Worth a **deep dive** now, given impact to:
  - Assessment and POC documentation **competence**
  - Clinical outcomes achieved and VBP, market positioning
  - Clinician retention and direct expense
  - Revenue cycle and success under PDGM
- Make no assumptions related to field-based competence/standardization of work-process
- Accountability is actively LED:
  - Clarify expectations
  - Provide skills/training/process to meet expectations
  - **Establish method to monitor and measure adherence to expected process**
  - Hold individuals accountable

Clinical Manager Responsibilities

- Strong clinical leadership is essential to success under PDGM
- Clinical managers will need to ensure follow through with established policies, processes and procedures including agency-adopted best practice strategies for episode management and prevention of avoidable LUPA
- Per the CoPs, Clinical managers are responsible for oversight of all patient care services & personnel which must include the following:
  - Making patient and personnel assignments
  - Coordinating patient care
  - Coordinating referrals
  - Assuring that patients are assessed
  - Oversight of the development, implementation and updates to the plan of care

Clinical Manager Responsibilities

- Clinical managers must be aware of scheduling issues including missed visits and gaps in care
  - Missed visits reports should be run within the agency's EMR to aid in follow through with clinician accountability to rescheduling of missed visits
- Clinical managers must *participate* in development, implementation and updates to the POC
  - SOC hand-off, Interdisciplinary team and individual case conferencing should be utilized to ensure oversight of the POC, appropriate implementation and changes to the POC including:
    - Front-loading
    - Tapering of visits
    - Identification of service needs

Clinical Episode Management
Best Practice Strategy

Many Options – One Clear Theme

Best Practice
Utilization Management

- Right discipline
- Right intervention
- Right frequency
- Right time
- Right technology

Care plan based on acuity, risk, best practice and patient goals

Intelligent Care Management

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Intelligent Care Management

- Competence in Assessment and POC documentation build the foundation for care planning:
  - Risk-stratified:
    - Optimal use of predictive analytics
    - Competent OASIS/comprehensive assessment
    - History hospitalizations/ Patient self-rating of health
  - Goal-directed:
    - IDT clear goals – visualization of patient at DC
    - Patient-centered goals, motivating patient/caregiver involvement in plan of care

Intelligent Care Management

- Guide and control care planning – teaching and implementing evidence based best practice to reduce high risk and lose wasted, unfocused, or unnecessary visits:
  - Varying options – internal and outsourced:
    - Care Manager, combined with Clinical Manager
    - Optimal clinical modeling provides ongoing education to clinicians, enhancing their confidence and competence in planning best practice care
  - Best practice approach is dynamic – **know your sources of guidance**, it will pay you back
  - Leverage collaboration between QAPI, Education and Clinical Operations – CoP and PDGM-friendly
  - Align care planning approach with health-literate, patient teaching tools - impacting the social determinants of health
  - Integrate advancing technology – (RPM, telehealth, sensors, robotics, avatars, etc.)
- Add methodology to monitor utilization of visits, by discipline, by Clinical Grouper
- Evaluate the impact to acute care hospitalization rates, patient satisfaction and margin
- As you study your data, learn what individual, team and agency behaviors 'move' the metrics of utilization toward your desired direction

Build Patient Engagement

Patient engagement facilitates buy-in to the home health plan of care resulting in improved adherence as well as involvement in the plan of care

- Teach staff strategies for patient engagement:
  - **Best practice** introduction and use of point of care documentation
  - Identification of patient-stated/patient-centric goal(s) of care
    - Shifts the focus to what is important to the patient rather than what is important to the clinician or agency. WHAT MATTERS MOST to them?
  - Use of communication strategies such as:
    - Motivational interviewing: "You said that you know wearing your oxygen makes you feel less tired, but you find wearing your oxygen to be a nuisance. How is wearing your oxygen a nuisance? What would make wearing your oxygen less of a nuisance?"
    - Open-ended questions: "How has…"; "Tell me…"
    - Active listening
    - Reflection: "It sounds like…"
    - Summarization: "What I heard you say is…"
- Educate staff in use of the patient-stated goal as a motivator
  - E.g. How can therapy help the patient move closer to achieving their goal(s)?
  - Active use of patient-centered goal in dialogue within visit - building adherence to plan of care – motivating language/interviewing

LUPA Thresholds: From Simple to Complex

PPS-LUPA

- 4 or fewer visits in a 60-day period
- Paid per the visit

PDGM-LUPA

- LUPA thresholds within each 30-day period of the 60-day episode
- LUPA thresholds based on payment group - 432 different payment groups
- LUPA thresholds are the 10th percentile in payment group or 2, whichever is higher (Range from 2-6 visits)
- Paid by the visit for visits less than the threshold (for example: a '4 visit LUPA threshold' means reimbursement by the visit if below 4 visits)
- 8.1% downward Behavioral Adjustment assumption- assumes that providers will change behavior to avoid LUPA episodes
- CMS estimates expects LUPA rates to remain stable around the current national average of 8.6% under PDGM
  - Consulting firms with access to national Medicare claims data for all home health providers, forecast that the national LUPA average will actually increase to between 13% and 14% under PDGM

LUPA Threshold by HHRG

Visit Threshold	HHRGs	%
2	94	22%
3	128	30%
4	137	32%
5	63	15%
6	10	2%

LUPA Threshold by Clinical Group

Clinical Group	2	3	4	5	6
Behavioral Health	12	9	15		
Complex	16	13	6	1	
MMTA - Cardiac	6	9	17	4	
MMTA - Endocrine	4	14	13	5	
MMTA - GI/GU	9	12	13	2	
MMTA - Infectious	10	21	5		
MMTA - Other	5	11	10	10	
MMTA - Respiratory	9	8	16	3	
MMTA - Surgical Aftercare	9	10	12	5	
MS Rehab	7	3	8	12	6
Neuro	6	5	9	12	4
Wound	1	13	13	9	
Grand Total	**94**	**128**	**137**	**63**	**10**

Preventing Avoidable LUPAs

- What can you do to be proactive?
  - Use CMS' LDS (Limited Data Set) to identify the Clinical Groupings at highest risk for LUPA within your agency
    - https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/index.html
  - Review active patient charts that fall within the at risk Clinical Groupings to identify trends in care management
  - Develop and implement an action plan for prevention of avoidable LUPA episodes

Preventing Avoidable LUPAs

- Implement episode management best practices including:
  - Front-loading
  - Rescheduling missed visits
  - Strategies to decrease refusals of care
- Front-loading-the gold standard in reducing avoidable re-hospitalizations
  - Used by 64% of home health agencies that were the most successful at reducing hospitalizations
  - Should be a multi-disciplinary and well-coordinated approach to ensure the most efficient care delivery and prevent refusals of services
- Rescheduling missed visits to meet the physician ordered POC
  - Under PDGM, LUPAs are based on a 30-day period, gaps in care lead to a much greater potential for LUPA due to the shorter 30-day period
  - Ensure patients and caregivers participate in the development of the POC, including visit frequency and are aware of the expectation for rescheduling any missed visits
  - Educate staff in expectation for rescheduling missed visits to prevent gaps in care
  - Have staff schedule weekly visits for the earlier part of the week to allow room for rescheduling of any missed visits
  - Have managers run missed visits reports within the EMR daily and share with schedulers to ensure missed visits are rescheduled timely

Preventing Avoidable LUPAs

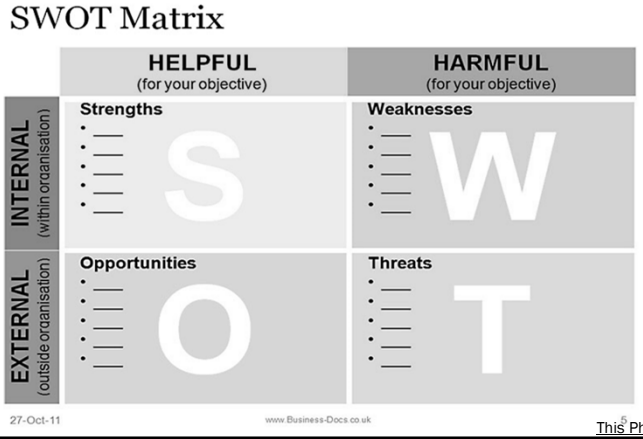
- Strategies to decrease refusals of care
  - Use of scripting to guide the clinician conversation in favor of identified service needs
    - Rather than this: "Would you like me to have the therapist come out?"
    - State this: "I noticed that you were a bit unsteady on your feet and were holding onto the couch to steady yourself, I am going to have the therapist come out to show you some ways to remain safe and steady and prevent you from having any falls."
  - Manager follow up with patients having multiple missed visits in a row or patients requesting discharge prior to meeting the POC goals
    - Helps to identify satisfaction issues, scheduling issues and may lead to recovery of services
  - Engage the patient in their care

Timely Billing: Strategies for Success

- Educate liaisons and marketing personnel in PDGM changes and importance of obtaining accurate, specific referral information prior to SOC
- Develop a plan with liaisons and marketing personnel for providing education to referral sources on PDGM
- Develop a one-page PDGM fact sheet for common referring providers, to include education on:
  - Increased diagnosis specificity expected by CMS
  - Non-covered diagnosis-suggest providing a list of the most common non-covered diagnosis codes under PDGM (e.g. Muscle Weakness, other abnormalities of gait & mobility, Low Back Pain)
  - Increased frequency of billing under PDGM (two 30-day periods)
  - Regulation restricting agencies from submitting a final claim without all physician's orders and F2F signed and received
- Develop a check-list for intake and referral staff which includes essential elements necessary for accurate diagnosis coding and timely billing under PDGM

Strategic Planning

- Perform a SWOT analysis focused on clinical episode management



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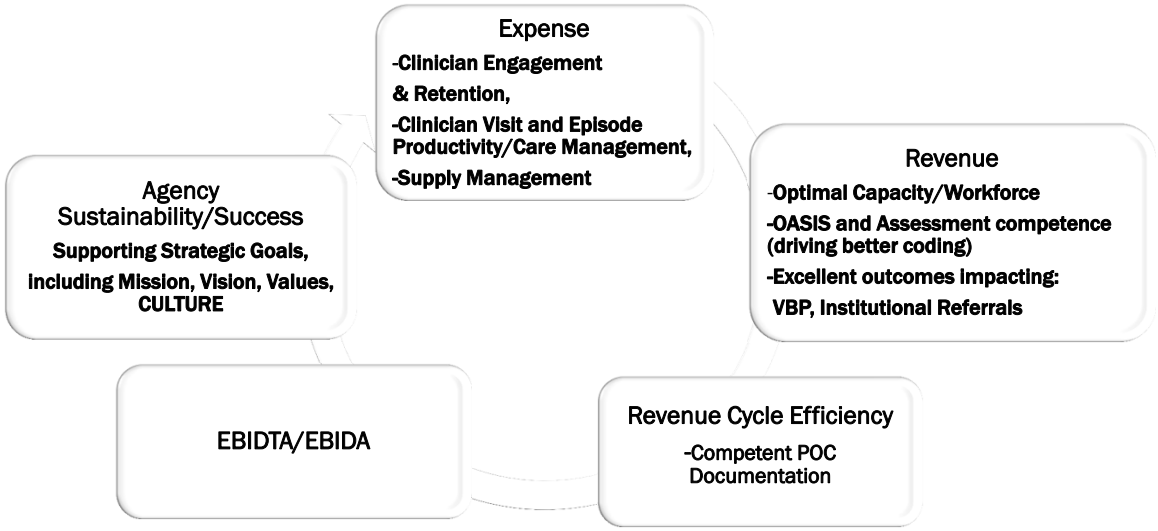
Strategic Planning

- Focus should be based on management of episodes within the PDGM environment with consideration given to:
  - Two 30-day periods within one 60-day episode
  - Shorter and more frequent billing periods
  - No change to OASIS requirements, however possibility of need for SCIC in subsequent 30-day period
  - Increased importance of accurate primary and secondary diagnosis coding
  - Increased importance of collaboration and coordination of care for efficient care delivery
- Develop an action plan for implementation of best practice episode management strategies based on the opportunities, weaknesses and threats identified
- Planning should address agency structure in support of necessary function under PDGM

Clinical Manager Impact on PDGM Success



Look in an Organizational Mirror Now

- Plan to Assure:
  - Quality Assurance and Performance Improvement – studying and guiding our view of key data and how to best move the metrics
  - Education for care planning which 'sticks' and does not grow obsolete
  - Clinical Management which supports increased supervision of the field and key practice competencies
  - Best practice episode management strategies yielding episode productivity (Care Management)
  - Collaborative processes within the agency which yield an engaged and competent workforce
  - Metric review and performance improvement processes

Plan Now to Succeed Under PDGM!

Questions?

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