



# Home Health Patient-Driven Groupings Model: Operational Issues Call


Moderated by: Hazeline Roulac  
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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections you may disconnect at this time. I will now turn the call over to Hazeline Roulac. Thank you, you may begin.

## Announcements & Introduction

Hazeline Roulac: Thank you, Dorothy. I am Hazeline Roulac from the Provider Communications Group here at CMS, and I'm your moderator today. I would like to welcome you to this Medicare Learning Network call on Home Health Patient-Driven Groupings Model Operational Issues. During this call, our subject matter expert will provide information to help your agency prepare to implement billing changes for the Patient-Driven Groupings -- Groups Model on January 1st, 2020. CMS will use the PDGM to reimburse Home Health Agencies for providing Home Health services under Medicare Fee-For-Service.

Topics covered during this presentation include billing and claims processing overview, how OASIS data will be used in the claims system, reporting new occurrence codes, period timing and admission source scenarios, and transitions scenarios. After the presentation, we will open the phone lines to take your questions.

Before we start, you received a link to the presentation in your confirmation email. The presentation is available at the following URL [go.cms.gov/npc](https://go.cms.gov/npc). Again, that URL is [go.cms.gov/npc](https://go.cms.gov/npc). Today's event is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the question and answer session. If you have inquiries, please email [press@cms.hhs.gov](mailto:press@cms.hhs.gov), that's [press@cms.hhs.gov](mailto:press@cms.hhs.gov).

Our subject matter expert for today is Wil Gehne, Technical Advisor in the Provider Billing Group Division of Institutional Claims Processing, and I will now turn the call over to Wil.

## Presentation

Wil Gehne: Thanks, Hazeline. Hello, and thanks for joining us. As Hazeline mentioned, my name is Wil Gehne and I work in the Center for Medicare's Provider Billing Group, where we write billing instructions for Home Health Care providers and claims processing requirements for Medicare contractors. The Division of Institutional Claims Processing does this specifically for providers like hospitals, Skilled Nursing Facilities and HHAs.

I've been writing Home Health instructions since I started with Medicare in 1998, including the original Home Health PPS implementation and 2008 PPS case mix refinements. Today, I'm very pleased to be able to talk with you about the implementation of the next step in Home Health payment policy, the PDGM.

Turning to slide 2, this slide simply a reference to acronyms that appear in the presentation. I've tried to avoid using acronyms too far away from their definition, so please refer back to this slide if you need to.

## Billing and Claims Processing Overview

Slide 3. Today's presentation breaks out in 7 parts. I'll start with more general operational descriptions and get more details as we go along, ending with a discussion of specific scenarios. At the top of each section, you'll see this agenda slide again, indicating the current section and red text. First up is an overview of how billing and claims processing will change under the PDGM.

Slide 4. This is our second National Provider Call about the PDGM, so I'm not going to review any of the policy changes for the new payment model. If you need a refresher on any of that information, the slides and transcript of the February 12th call are still available on the CMS website. Today, I'll focus on operational changes, beginning with the claims process before and after PDGM.

You'll see that many familiar processes are remaining the same, but this comparison provides an opportunity to call out important changes that Home Health Agencies will need to make from January. It also allows me to explain some ways Medicare claims processing systems will change.

While, these changes occur behind the scenes, it'll be helpful for agencies to understand them. I hope to make changes a bit less mysterious.

Slide 5. So, let's start with the before picture. Today, the process begins with the Home Health Agency completing the patient's OASIS. They submit the assessment to the QIES system and also run the OASIS data through Grouper program in their billing software or in the CMS-provided jHAVEN tool. The Grouper produces a payment group for an episode of care in the form of HIPPS code.

The agency submits that HIPPS code on their RAP and receives a split percentage payment. After they provide up to 60 days of home care, they submit a claim for the 60-day episode with the HIPPS code that matches the RAP, and with line item detailing all the services they provide, all familiar steps to you I'm sure.

Slide 6. Also familiar is the current claims process. Medicare systems make the appropriate 60% or 50% payment on the RAP using the submitted HIPPS code as the basis for payment. Then when the claim is received, Medicare systems query QIES to find the associate OASIS assessment for the episode. If the assessment isn't found, the claim is returned. So, the provider has an opportunity to correct the matching information on the claim for the assessment.

When the assessment is found, Medicare systems compare the HIPPS code submitted on the claim with HIPPS code calculated by the official CMS Grouper in the QIES system. If it's different, the OASIS-calculated HIPPS code is used for payment. The Home Health Agency can see this code in Medicare systems in the field labeled RETURN-HIPPS 1.

Later in processing, Medicare systems also check whether the number of therapy services provided in the episode could change the HIPPS code. They also verify the episode sequence information, that is, whether the claim is in earlier or later episode. If either of these checks require further revision of the HIPPS code, the agency sees the final HIPPS code in a field in our systems labeled APC-HIPPS.



Slide 7. Okay, so how things change starting in January. The next few slides run through the process again, this time calling out the PDGM changes in bold texts.

The billing system still begins with the Home Health Agency completing an OASIS and submitting it to the quality system. In January, QIES system will be replaced by the modernized web-based iQIES. The transition to iQIES is not a requirement of the PDGM, but it is happening at the same time.

One significant change is that the agency now has the option to use Grouper software to predict the HIPPS code for payment, but that is not required. The agency can submit any valid HIPPS code on their RAP, knowing that Medicare systems will determine the final HIPPS code for payment on their final claim. If the agency chooses to use Grouper software, they should note that both OASIS and claims data input are now required by the Grouper.

The next step is very similar to the current process. The Home Health Agency submits the HIPPS code on their RAP and receives a split percentage payment. Then they provide services for 30 days before submitting a claim. Like today, the HIPPS code on the claim must match the RAP. This data element remains important to pair up the claim with the corresponding RAP in our systems. There're also some new codes that will be required on Home Health claims under the PDGM, I'll detail those in later section.


Slide 8. Turning to the claims process, the initial steps remain familiar. First, Medicare systems make a split percentage payment on the RAP then when the claim is received, it's matched to the OASIS assessment. If the assessment can't be found, the claim will still be returned. When a matching OASIS is found, though, Medicare's claims process will be quite different.

The iQIES will send the OASIS data to the claim system for the 8 items that are used in PDGM case-mix scoring. This OASIS data will be stored on a new screen in the claim system that I'll show you shortly. Then Medicare systems will combine those OASIS items with claims data that's used in PDGM scoring, such as the diagnosis codes, whether a claim is for the first period of care, and whether there's an inpatient discharge in the 14 days before the from day.

All this information will be sent to the official CMS Grouper that will now be running in the claims system. This is a major change, one that I'm excited about.

It never makes common sense for payment grouping to occur in the quality system and now it'll be happening in the payment system where it belongs. The Grouper in the claims system to calculate the HIPPS code and replace the code submitted by the Home Health Agency in the HCPCS field of the claim. This is another significant change with PDGM. In the past the provider submitted code was always retained in the HCPCS field. But, since grouping the period of care is now optional for the provider, their HIPPS code will be replaced.

Side 9. Continuing with the claims process, Medicare systems will then use its paid claims history to see whether the HIPPS code determined by claim information is correct; there could easily be cases where Home Health Agency was unaware of a prior Home Health admission or unaware of an inpatient discharge. If Medicare systems see prior claims for these situations, the initial information will be sent back to the Grouper, causing the HIPPS code to be recalculated.



If this happens, the new code will be put on the claim in that APC-HIPPS field, just like when systematic recoding is done today. The RETURN-HIPPS1 field will no longer be used. Another important point about recoding is a number of therapy services is no longer a trigger for it. If a code is placed in the APC-HIPPS field, the Home Health Agency can be sure it relates to information from another claim. That completes the high-level changes for billing and claims processing. If you're a visual person who might want to have a picture of what I just described there are before and after swim lane diagrams in Change Request 11081, please see attachment 2 of that instruction.

## **Request for Anticipated Payment (RAPs)**

Slide 10. Next, let's turn to RAPs under the PDGM.

Slide 11. The biggest change regarding RAPs is that with a 30-day periods to care a RAP will be required every 30 days, rather than every 60, but the content requirements of the RAP are not changing. I already mentioned the Grouper option for RAPs. And while there're new billing codes for PDGM, none of them are required on RAPs.

Today, there is what we call in shorthand a no-RAP LUPA policy that allows Home Health Agencies to forego submitting a RAP if they know in advance that the episode will result in a Low Utilization Payment Adjustment.

This exception doesn't change under PDGM. No RAP is required for LUPA periods of care. But it'll be more challenging to predict when a period of care will result in a LUPA, since the simple threshold for a fewer visits is replaced by a variable threshold.


Slide 12. There is a change in RAP policy regarding newly enrolled Home Health agencies. If an agency was enrolled in the Medicare program on or after January 1st, 2019, the agency will not receive RAP payments. They'll still need to submit RAPs at the beginning of each 30-day period of care in order to establish themselves as the primary HHA who will be billing for services.

Those RAPs will be processed setting up periods of care in Medicare's common working file, but they'll not be paid. This doesn't require any special coding on the RAP. Identifying newly enrolled HHAs will be done by the Medicare Administrative Contractor. Withholding the RAP payment has no effect on the payment calculations for the final claim. Full payment for the period of care will be made on each claim, subject to all normal edits and review processes.

## **How OASIS Data Will Be Used in the Claims System**

Slide 13. Now, I'll expand little more on how OASIS data will be used in the claim system under PDGM.

Slide 14. Earlier, I mentioned how each claim will trigger query to iQIES to find the associated OASIS assessment. Specifically, the system will look back from the claim "From Date" to find the most recent assessment. In today's matching process, a limited number of reasons for assessment or RFA types are used for payment. Today, the start of care assessments or RFA01, follow-up Recertification assessments or RFA04, and Resumption of Care assessments or RFA03, new for the PDGM Other Follow-up assessments, RFA05



will also be used for payment. The OASIS-D1 adds the needed assessment items to the other follow-up assessment to support this change.

Slide 15. When the OASIS with one of these reasons of assessment is found, 8 OASIS items will be sent back to the claims system. They have hospitalization risk item M1033 and the current functional level items, M1800 through 1860. While there are 8 OASIS items, they returned 17 fields of data since M1033 is a mark all that apply item and contain multiple responses. These items will be copied into the claim system and displayed on a new screen in the Fiscal Intermediary Shared System or FISS.

Slide 16. This new screen will look similar to what you see on the slide. I say similar because this is a mock-up; the physical layout of the screen is still being designed, but the basics will not change. The screen will show the OASIS item number and an abbreviated description label. Then, to the right of each item label, you'll see two columns of response information. The first field labeled OA will share the OASIS response that was sent from iQIES.


Once copied to these OA field, the data will never be changed. The fields will be protected, so that neither the Home Health Agency nor the MAC can update them. The second field is labeled MR for medical review. Medical reviewers at the MAC will use these fields to enter corrections when, based on their review of the full medical record, they find OASIS data is not supported.

Today, reviewers enter these changes in a standalone Grouper tool, calculate a new HIPPS code, then manually enter the medical-review-determined HIPPS code on the claim. Under PDGM, they will make their changes in these field labeled MR then release the claim, and the updated OASIS items will go to the Grouper to change the HIPPS code automatically. Access to change the MR field will be limited to reviewers at the MACs, with an audit trail to show the reviewer and the date they entered their responses.

Slide 17. The screen we just looked at is another change in our system that I'm excited about. By recording the OASIS items directly in the claims system, the connection between the assessment and payment becomes much more transparent. There will no longer be a need to look up supporting OASIS items in a separate system, plus Home Health Agencies will have item-by-item information about any changes that occurred during review. Finally, the OASIS items will flow to claims history databases, so there will be less need to combine assessment and claims data in order to study and refine payment system.

Slide 18. Next, I want to briefly touch on the relationship between OASIS corrections and claims adjustments. It's not uncommon for OASIS information to be corrected after it has been initially submitted to the quality system. This may happen after the claim has been submitted. Since OASIS and claims are closely linked under PDGM, I received a number of questions about whether a claim adjustment is required any time an OASIS correction occurs; the answer is no. In many cases, they'll be no need to adjust the claim after an OASIS correction.

Since the 8 functional items are the only OASIS data used by the claims system, corrections to those items are the only corrections that may require claim adjustment. If the Home Health Agency corrects one or more functional items and believes that the change will have an impact on payment, they should submit a claim adjustment to trigger that change in payment.



Slide 19. Now, let's talk about how some OASIS data will not be used. Under the PDGM, OASIS diagnosis code items will not be used for payment grouping. The source of record for payment diagnosis codes will be the claim. This means that the old instruction that OASIS and claim diagnosis codes must match, no longer applies. Typically, the diagnosis codes will match on the first claim in at admission and Start of Care assessment, and for claims corresponding to Recertification assessments. But, second 30-day claims in any 60-day period will not necessarily match in OASIS.

If there're diagnosis code changes during a period of care that is before the From Date of the next period, those coding changes should be reported on the claim for the next period, and will affect the next period's payment. I want to stress the PDGM makes no changes to the OASIS instructions regarding when an Other Follow-up or RFA05 assessment is required. Just like today, you would complete that assessment when the change would be considered a major decline or improvement in a patient's health status, so no change to Home Health Agency's assessment procedures is required.

Under the PDGM, there'll be no edits in Medicare systems to compare claim and OASIS diagnosis code. So, this means there's no need to submit an RFA05 assessment simply to ensure claim and OASIS diagnosis codes match. To do so, it will be an unnecessary administrative burden on Home Health Agencies, because it would have no impact on quality or payment.


### Reporting New Occurrences Code

Slide 20. Earlier, I mentioned there's a new coding requirement on PDGM final claims. Specifically, there're 3 occurrence codes that Home Health Agencies have not used before. So next, we'll look at each of them.

Slide 21. The first new code is Occurrence code 50 which reports the assessment date. This code is required on all PDGM final claims because it's crucial to PDGM processing. Claims will be returned to the provider if this code is missing. The agency will report the assessment completion date, the OASIS item MO90 for the start of care, resumption of care, recertification, or other follow-up assessment that occurred most recently before the claim "From" date. That is, report the MO90 date for the OASIS that should be used to perform the payment grouping. This date, along with the provider number and the beneficiary identifier, will be used by Medicare systems to match the claim to the OASIS, so the accuracy of the date is very important.

A mismatch between the Occurrence code 50 date day and the MO90 date will result in the claim being returned to the provider for correction. On claims today, the MO90 date is encoded in the treatment authorization code field. Since the days of moving to Occurrence code 50 and the other components for the treatment authorization code are no longer needed under the PDGM. The treatment authorization code is no longer required on all Home Health final claims. For those stays participating in the review choice demonstration, the unique tracking number or UTN will still be reported in the treatment authorization code field.

Slide 22. Also new for PDGM are two occurrence codes that indicate whether a claim falls into a community or institutional payment group. The first code is Occurrence code 61, defined as "Hospital Discharge Date". Like the Occurrence code 50, this code is not reported on RAPs, but unlike Occurrence code 50, is not required on all claims since many Home Health claims are community admissions and the code would not apply.



Home Health Agencies should report the discharge date from an inpatient hospital that falls within 14 days from the date of a Home Health period of care. Note that this code can be reported on admission claims and any continuing claims in a sequence of periods; it is only used to report the acute care hospital claims, not other types of inpatient stays. If this code is present on a claim, Medicare systems will use it as a trigger to group the period into an institutional payment group.

Slide 23. The other new code is Occurrence code 62, defined as “Other Institutional Discharge Date”. It’s reported in a fashion similar to Occurrence code 61 with one significant exception. This code is only reported on admission claims, that is, it should only be reported where the claim from and admission date match.

When present on admission claim, Medicare systems will use the code as a trigger to group the period into an Institutional payment group. But, what does other mean, if there’s four types of inpatient discharge dates, discharges from a Skilled Nursing Facility or SNF, an Inpatient Rehab Facility or IRF, a Long-Term Care Hospital or LTCH, sometimes pronounced LTAC, and an Inpatient Psychiatric Facility IPF. It’s important to note that outpatient hospital stays including observations stays and ER visits are not reported using either occurrence code.

Slide 24. The instructions for both codes refer to within 14 days of the from date but how exactly of this period determined. You include the “From” date then count back using the day before the “From” date as day one. So, in a simple example, if the “From” date is January 20th then January 19th is day one coming back from January 19th, the 14-day period is January 6th through January 19th.


If an inpatient discharge date falls on any date in that period or on the admission date itself, it’s eligible to be reported on the claim. For instance, if an LTCH discharge date 01/06 occurred before Home Health admission on 01/20, the Home Health Agency will report occurrence code 62 and the 01/06 date on the admission claim or if in an acute hospital discharge occurred on 01/20, the agency report that date with the Occurrence code 61.

Slide 25. Only one of these occurrence codes should be reported on a single claim. But, it’s very possible for two inpatient discharges to occur during the 14-day period. If this happens, report the later discharge date. Using a January 20th of Home Health admission date, again, if a beneficiary is discharged from an acute care hospital on January 10th which is 10 days prior, then admitted to a SNF and discharged from the SNF on January 18th 2 days prior, report the SNF discharge date. So, this claim would report Occurrence code 62 with the date of January 18th. This is important because claims with 2 of these occurrence codes, whether both 61 and 62, or duplicates of either code, will be returned to the provider for correction.

Slide 26. Now, you report these new occurrence codes when you’re aware of an inpatient discharge, say when you received a discharge summary from a hospital discharge planner, but in practice it doesn’t always work that way. You may admit a beneficiary that you believe as a community admission, and patient or caregiver doesn’t mention hospitalization from, say, 12 days ago.

What happens then? The answer depends on whether the hospital or other facility has already billed Medicare. If Medicare has received the inpatient claim, Medicare systems will identify during processing and group the claim into an institutional payment group based on a claims history information. If the inpatient facility is not





billed yet, that is, if both Medicare and the Home Health Agency don't know about the inpatient discharge, the claim will be paid using a community payment group.

But, when the inpatient claim comes in later during the time filing period, Medicare systems will automatically adjust the paid Home Health claim and pay using an institutional payment group instead. The difference in the payment will be reflected on the Home Health Agency's next Medicare remittance advice.

Slide 27. You'll know this happen because the claims will be identified on the remittance advice using distinct coding. The adjustment will be identified by Type of Bill 032G which represents a common working file-initiated adjustment, CARC 186 which indicates a level of care change adjustment, and RARC N69 which means prospective payment system code change by the claims processing system.

Now in certain cases, Medicare may never learn about the inpatient stay during the timely filing period. Automatic adjustments can only be triggered by Medicare processing the inpatient claim. If the beneficiary was in a non-Medicare facility, say, VA hospital, Medicare will never receive that claim. So, stays in non-Medicare facilities can only be identified for payment through the Home Health Agency submitting the appropriate occurrence codes.

## Period Timing Scenarios

Slide 28. Along the way of discussing the new codes, we've looked at a few simple examples. Now, I'd like to spend the rest of the presentation on billing scenarios that can get a little more complicated. Let's start with period timing scenarios.


Slide 29. To talk about period of care timing, it helps to first review the new HIPPS coding structure. The slide will look familiar to folks who joined our 1st National Provider Call back in February. Since, we're implementing a new grouping system, the set of HIPPS codes that represent payment groups will be completely replaced.

Like today, each character of HIPPS code is associated with the payment variable, but those variables are changing. Today, position 1 reports timing and the therapy threshold. Under PDGM, it will report timing and admission source. Today, position 2 reports a clinical severity level under PDGM, it'll be the clinical grouping for the patient.

The content of position 3 is not changing here. It remains the functional impairment level. But, there's a significant change in position 4. Today, we're it reports to service level. Under PDGM, it will carry the comorbidity adjustment. Position 5 is just a placeholder. The field of care and HIPPS code requires 5 positions, the value in that field will always be 1.

So, to apply this to an example, say the HIPPS code 2DC21, 2 represents an "Early" institutional period of care, D means the patient is in a complex nursing group, C means the functional impairment level is high and 2 in the 4th position represents the low comorbidity adjustment.

Slide 30. This means from a claims processing perspective, when we talk about period of timing, we're talking about the 1st position of HIPPS code.



Codes beginning with 1 or 2 are “Early” periods of care, 3 or four are “Late”. It sounds pretty straightforward, but a number of factors can affect whether a period of care is grouped into code beginning 1 or 2.

Turning to slide 31. One straightforward part is the definition of “Early”. An “Early” period is the first 30-day period in a sequence of related period. This definition of sequence is not changed into the PDGM, but still defined as periods with no more than a 60-day gap in home care. On the face of the claim, identifying “Early” is also straightforward. The claim where the “From” and “Admission” dates match can be an “Early” period of care, it can be, but it isn't always, so that's where things get a little more complicated.

When a claim is initially sent to the Grouper program, these admission claims will be grouped as “Early”, but that isn't the end of the process. Medicare systems will look at claims history data to find any information that could change the grouping.


Slide 32. If Home Health claim is found within 60 days of the “From” date of claim with an “Early” HIPPS code, Medicare systems will automatically regroup the claim to a late HIPPS code that is change the first position of HIPPS code to 3 or 4. If the prior Home Health claim is not in our claims history yet, the claim will pay as “Early”, but similar to the process for inpatient discharges when a prior claim is received, this will trigger an automatic adjustment, and the same remittance advice coding will be used on these adjustments. Just like episode sequence editing today, “Late” periods will also be recoded to “Early” if no prior claim has been processed.

Slide 33. So, let's look at a specific example, in this case the discharge and readmission. Beneficiary admitted to HHA1 on January 15th and then discharged on February 10th. The claim for that period is processed on March 5th and paid as an “Early” episode and paid as an “Early” period of care. Then the patient is readmitted to HHA1 on April 5th. The from and admission dates will match on the claim for the period starting April 5th, but Medicare claim systems will identify the prior period and group period of care as “Late”.

Slide 34. Example 2 uses the same dates, but the only difference being that the beneficiary is admitted to a different Home Health Agency on April 5th. The result is the same because HHA2 period of care starts within 60 days of the prior Home Health services. Their admission claim will be grouped as a “Late” period of care.

Slide 35. Some agencies and software vendors have asked me about how Medicare secondary payer or MSP claims effect period timing. Example 3 shows this. The beneficiary is admitted as MSP on March 1 and receives a 30-day period of care. Then at the start of their second period of care, the beneficiary's coverage changes, and Medicare becomes the primary payer. MSP periods count the same as Medicare primary periods. So, in this case, Medicare systems will use an “Early” HIPPS code as the basis for calculating an MSP payment on the March 1 claim. And then use the “Late” HIPPS code as the basis for calculating Medicare's primary payment on the March 31 claim.

Slide 36. Medicare Advantage or MA periods of care are different, however. Example 4 uses the same dates as example 3, but here the first period is covered by an MA plan. Then at the start of the second period of care the beneficiary's coverage changes to original Medicare. MA periods of care are not counted when determining the period timing under the PDGM. So, in this case, the March 1 period of care will be billed to the MA plan. Then, the Home Health Agency would submit the March 31 period to original Medicare, showing March 31 as



the admission date. The admission date and from date would match and the period would be grouped as “Early” HIPPS code.

Slide 37. Next, let's look at some scenarios involving in admission source, Community versus Institutional. Slide 38. I've talked about how Home Health Agencies report inpatient discharges using Occurrence code 61 or 62. Remember, only one of these codes should appear in any claim. It's also important to note that like diagnosis codes, claim information is the source of record for determining admission source. OASIS item M1000 reports similar information, but will not be used by Medicare systems under the PDGM. As a result, it's not necessary to correct a submitted OASIS if agency learns of an inpatient discharge after the OASIS was submitted. The discharge only needs to be reported on the claim. If you're hearing a theme, you're right. Medicare wants to avoid creating administrative burden from OASIS submissions just to make the claim and OASIS match.


Slide 39. Back to scenarios. In example 5, the admission to Home Health follows two inpatient stays. the beneficiary is discharged from the hospital on February 4th then admitted to a SNF from February 5th through 12th. The beneficiary is admitted to Home Health on February 14th. Both inpatient discharge dates are within 14 days of the Home Health admission date, but the SNF discharge is the most recent. So, the Home Health Agency would report the SNF discharge date February 12th using the occurrence code 62. This will result in the February 14 period of care being grouped as “Early Institutional”; the HIPPS code will start with 2.

Slide 40. Example 6 looks at a Resumption of Care after inpatient stays. In this example, the beneficiary is admitted to Home Health first on January 15th then they have the hospital and SNF stays before resuming Home Health on February 11th to complete their first period of care. In this example, the second period of care starts February 14. The claim for the first period of care beginning January 15th would be paid as “Early Community”. The claim for the second period of care beginning February 14th would report Occurrence code 61 and the hospital discharge date February 2nd. The difference in this case is that while the SNF discharge is more recent, occurrence code 62 is only reported on admission claims. The “From” and admission dates on the February 14th claim would not match, so the hospital discharge date is reported instead. The claim would be grouped as “Late Institutional” with the HIPPS code that starts with 4.

Slide 41. Now for our next two scenarios, let's focus on Other Institutional Stays alone. Example 7 considers a discharge and readmission with an Other Institutional stay occurring during the gap in Home Health services. Beneficiary is discharged from Home Health period of care on March 20th. They receive services in an inpatient psychiatric facility and discharged on March 27<sup>th</sup>, then readmitted to Home Health starting on March 31st.

In this case, there is an Other Institutional Stay within 14 days and the March 31 claim is an admission claim. So, the claim would report Occurrence code 62 with an IPF discharge date of March 27th. The claim will be grouped as “Late Institutional” with the HIPPS code that starts with 4.

Slide 42. Now, let's contrast that with the scenario where the Other Institutional Stay occurs during the period of care. In example 8, the beneficiary is admitted to Home Health on March 20th then has an inpatient rehab stay during the period of care from March 27th to April 9th. The next day April 10th, the beneficiary resumes Home Health care.



The second Home Health period of care starts on April 19th. The Home Health Agency would not report the IRF discharge date on the claim for the April 19th period of care. It's not an admission claim, and only acute hospital discharges are reported on continuing period to care. The April 19th claim would be grouped as "Late Community", with the HIPPS code that starts with 3.

Slide 43. Now, let's look at one more admission source of scenario. In example 9, the beneficiary is in the hospital, but is not admitted; instead, they're under observation until February 3rd. On February 4th, the beneficiary is admitted to Home Health care. In this case, Occurrence code 61 would not be reported; observation stays are not considered inpatient discharges for PDGM payment purposes. The claim will be grouped as "Early Community" with the HIPPS code that starts with 1. Finally, let's talk a little bit about the transition to the PDGM.

### Transition Scenarios

Slide 45. One crucial question for any implementation is how will the cut over work. In this case, for 60-day episodes that begins on or before December 31st, 2019 and span January 1, 2020, the payment will be the calendar year 2020 national standardized 60-day episode payment amount. For Home Health periods of care that begin on or after January 1st, 2020, the unit of payment will be calendar year 2020 standardized 30-day payment amount. The key date as well the claim "From" date is January 1st or later.

Just a reminder, even there was shifting from 60-day episodes to 30-day periods, the recertification of Home Health services, updates to comprehensive assessment, and Home Health plan of care continue on a 60-day basis.

Slide 46. So, if the basic transition policy is that PDGM applies based on from dates on or after January 1st, 2020, does that mean that all first periods of care starting after January 1st will be grouped as "Early"? The answer showed in example 10 is no. If the beneficiary is admitted on December 12, 2019, their Home Health PPS 60-day episode of care will extend to February 12, 2020. Then the first PDGM period of care will begin on February 13th. All PDGM policies will apply to the period of care starting February 13th. This means the period will be grouped as "Late" because the "Admission" and "From" dates on the claim would not match. The admission date would be December 15th, 2019.

Slide 47. We've also received some questions about how the transition could affect Medicare system's ability to match claims to OASIS. In cases where a beneficiary starts a period of care on or near the January 1st transition date, the assessment completion date could fall before the transition. I've shown in example 11, this will not present a problem. The beneficiary ends the 60-day Home Health PPS episode on December 31<sup>st</sup>, and begin the PDGM period of care on January 1st.

The OASIS recertification assessment is completed on December 30th, 2019. The Home Health Agency would report December 30th assessment date in Occurrence code 50 on the PDGM claim. Medicare systems will use that date to find the 2019 assessment and will apply the functional information from that assessment to the claim that starts January 1.



## Resources

Slide 49. Some agencies and their vendors have noticed that while the PDGM is effective based on “From” dates on or after January 1st, the implementation date for Medicare system changes is January 6th. So, what will happen if a RAP claim with the PDGM HIPPS code is submitted before January 6<sup>th</sup>? Those RAPs in claims will be held by your Medicare Administrative Contractor until after January 6<sup>th</sup>, then released for processing. Holding claims like this generally happens with each quarterly Medicare systems release, but typically the hold does not involve RAPs; this year it will. That’s in order to prevent the RAPs with PDGM HIPPS codes from being returned to the provider in error.

Finally, turning to slide 50, I just want to point to you to some PDGM resources that are available for your reference after the call. The primary resource is the PDGM webpage and on that page, you’ll find links to interactive Grouper tool, to spreadsheets indicating case-mix weights, LUPA thresholds, and agency-level impact, and all the materials from our February provider call. If you have questions about the information that you see on that webpage, you can send them to the resource email box shown on the slide HomeHealthPolicy@cms. You can also for all the details refer to last year’s final rule in the Federal Register, and we’ve also published two MLN Matters articles, numbers are 11081 and 11272, about the PDGM.

With that now, I’ll turn it back to Hazeline.

## Question & Answer Session

Hazeline Roulac: Thank you so much, Wil. We will now take your questions. As a reminder, this event is being recorded and transcribed. In an effort to get to as many questions as possible, each caller is limited to one question to allow more participants the opportunity to ask questions please send questions specific to your particular organization to the email address on slide 52, so our staff can do more research.


During this call, preference will be given to general questions applicable to a larger audience and we will be mindful of the time spent on each question. All right Dorothy, we are ready for our first caller.

Operator: To ask a question, press star followed by the number one on your touchtone phone. to remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question, to assure clarity. Once your line is open state your name and organization. Please note, your line will remain open during the time you’re asking your question, so anything you say, or any background noise, will be heard in the conference. If you have more than one question, press star one to get back into the queue and we will address additional questions as time permits. Please hold while we compile the Q and A roster. Please hold while we compile the Q and A roster.

Your first question comes from the line of Amy Smith.

Amy Smith: Hi, good afternoon. It was mentioned in the PowerPoint presentation that newly enrolled agencies will not receive the RAP payment starting in 2020. Is there any clarification for how that impacts a change of ownership, so the PTAN is not new to Medicare, but there is a CHOW in place after January 1, 2020?

Wil Gehne: Okay. You’re saying that the PTAN is not changing in that case?



Unidentified Male on participant line: Correct.

Wil Gehne: Provider number is conveying from the old owner to the new one.

Amy Smith: Correct.

Wil Gehne: Yeah. RAP payments would continue to be made in that case.

Amy Smith: Okay. Thank you.

Operator: Your next question comes from a line of Josh Lamkin.

Josh Lamkin: Hi, Wil. My question is about the process for getting an institutional admission source claim paid if the institutional claim was not submitted in a timely filing period. It sounded like you were saying that the only basis for getting the institutional admission source noted was the submission of the institutional claim within their timely filing period, but then you said that if that wasn't done if the agency submitted the proper occurrence code that they could still get paid for the institutional admission source; "A", did I hear that right? And "B", if I did, could you let us know what the process for doing that would be?

Wil Gehne: Okay. Well, it's the basic point I probably should have stressed this more is that the reporting the inpatient discharge dates is optional for the provider. If a provider knows about the inpatient discharge dates and wants to make sure they receive the institutional payment grouping more promptly, you know, they would report that on their claim, but there's no penalty if you don't do that because if we find the date information about the inpatient discharge date, you know, at any point during the timely filing period, we're going to correct the claim if the provider didn't tell us that the inpatient discharge occurred.

The point I was making in the presentation was that the only time we can't do that is for, say, VA claim where we're not going to get a claim to trigger it. The only the only source for Medicare systems become aware that inpatient discharge happened, is for the provider to put the occurrence code on the claim, or if they find out about the VA stay later, adjust the claim and add the occurrence code to it.

Josh Lamkin: So, there's no verification process for that really, it's just, you can get discovered at some point later in ADR, or any kind of servicing area has to be documented, I guess?

Wil Gehne: Right, I mean, there's any number ways the information could turn up over the course of the 12 months.

Josh Lamkin: Okay, just double checking on that. Thank you.

Wil Gehne: Thank you.

Operator: Your next question comes from the line of Galina Pol-A-Via.

Galina Pol-A-Via: Hi. I was wondering if all these wonderful new codes, this condition code 47 still going to be used?

Wil Gehne: Yes. You still indicate transfer with that, yeah.

Galina Pol-A-Via: Okay, wonderful. That was my question, thank you.

Wil Gehne: Thank you, and let's say generally, you know, if we didn't say something about a code being added or going away, it's staying the same.

Operator: Your next question comes from the line of Sherry Weland.

Sherry Weland: Hi, Wil. I just wanted to check the occurrence code on the RAP, as they are there, the claim will not get denied for that, correct, or the RAP will not get denied for that, correct?

Wil Gehne: That's right. They're valid NUBC codes. They can be submitted at the provider's discretion. We couldn't reject for them being there. They just won't have any impact, they won't be used in processing at all.

Sherry Weland: You'll ignore them?

Wil Gehne: Yes.

Sherry Weland: Okay, just want to make sure, thanks.

Operator: Your next question comes from a line of Steven Scott.

Steven Scott: Good afternoon. I was wondering if you guys have given any direction to the Medicare Advantage plans and how they should or should not adopt PDGM billing?

Kelly Vontran: Hi this is Kelly Vontran from the Division of Home Health and Hospice. Medicare Advantage plans, while they do have to provide the same coverage as original Medicare, they do make their determinations on a plan-by-plan basis on any restrictions or payment; so you know, it really is up to the plan's discretion as to whether or not they will adopt PDGM because PDGM is strictly for Medicare Fee-For-Service.

Hazeline Roulac: Did that answer your question?


Steven Scott: No. Did you guys give any advisements in their reporting to you all with the PDGM groupings?

Kelly Vontran: We have reached out to our Medicare Advantage colleagues, so they are aware as to what education they might be providing that would have to be go to that particular component.

Steven Scott: Okay, thank you.

Operator: Your next question comes from the line of Kim Bradley.

Kim Bradley: Hi. I'm with Weston Care Services, and I am requesting that you repeat once more what the link is to have a on-demand performance of this.



Hazeline Roulac: Yes, thanks for your question. So, the URL is [go.cms.gov/npc](https://go.cms.gov/npc).

Kim Bradley: Thank you very much.

Hazeline Roulac: You're welcome. Thank you.

Operator: Your next question comes from the line of Tina Coleman.

Tina Coleman: I'm sorry, I had my question answered. Thank you.

Operator: Your next question comes from the line of Latisha La-Duff.

Latisha La-Duff: Yes. I'm wanting to clarify the reporting of the Occurrence codes 61 and 62 since the proposed RAC said that they would be using the Medicare claims processing system to identify admission sources. If we reported on our claim and it's later found that the institutional provider did not file a claim for whatever reason, will Medicare go back and adjust those claims for those payments that we received, and if they do, will there be a recourse that we can file or follow through with, so that we can keep the money that we billed for?

Wil Gehne: Thanks. Yes, there won't be any systematic process and we have to wait to prove that the negative, that there was no inpatient hospital claim. We have to wait until the end of the timely filing period, and then perform a look back after that 12 months was over. We don't have a current plan to create any automated look back like that if a case came up in the course of a review, you know, where at prior inpatient stay wasn't substantiated that could be adjusted during the course of that review, and be subjected to the same appeal process as any determination or redetermination. But I think it at this point, we're going to monitor what they've said about what's happening in that regard, and at this point, we don't have a plan for any kind of automated large-scale recovery process for that.

Latisha La-Duff: Okay, thank you.

Operator: Your next question comes from a line of Dave Macke.

Dave Macke: Yes, thank you. On slide 27, you mentioned that the non-Medicare facilities can only be identified through the occurrence code for the institutional payment. So, it is that to understand that it'll strictly rely on whether the claim includes code 61 and 62, there will be no way for CMS to validate that?


Wil Gehne: That is correct.

Dave Macke: Thank you.

Operator: Your next question comes from a line of Grace Hanson.

Grace Hanson: Hello. We just had a very general question. We just wanted to know, as far as the CMS help email, do you happen to know the response time for that when we do send something to the [homehealthpolicy@cms.hhs.gov](mailto:homehealthpolicy@cms.hhs.gov)?





Kelly Vontran: Hi, this is Kelly Vontran again. Unfortunately, I know it has been a little bit on the slower side and as you know, we are making right now, so staff that mans that particular policy mailbox sometimes may have other responsibilities, but we do try to get to them as soon as possible, plus we do have to vet them to make sure that we can answer certain things during the comment period. So, we really do try to get feedback as soon as possible, so we do appreciate any patience that you can afford.

Grace Hanson: Okay. Thank you.

Operator: Your next question comes from a line of Doris Williams.

Doris Williams: Good afternoon. I do Home Health care and I have a lady training us with this new system with the Medicaid transformation. I'm just going to ask the question how does, Medicare does -- when billing for Medicaid, do we have to be approved in the Medicare system?

Wil Gehne: Well, it being -- you're talking about the case where a patient is a Medicare and Medicaid dual eligible?

Doris Williams: Yes.

Wil Gehne: Well then yes, since Medicare is the primary payer, in that situation you would need to bill the Medicare claim in the matter of describes, you know, first, and then submit the claim in the Medicare's remittance advice to Medicaid to see what their secondary payment might be.

Doris Williams: Okay. So, I need to submit the claim first to Medicaid and then --.

Wil Gehne: Medicare.

Doris Williams: Medicare and they also disperse out, if they're the second -- you've sent it out to Medicaid, you'll be at the primary.

Wil Gehne: Right. In the great majority of cases, we'll send the claim forward through the automated coordination of benefits to the Medicaid.


Doris Williams: Okay. So, if they just have Medicaid what would I do in that case, do I still bill to the Medicare systems.

Wil Gehne: No, you just go Medicaid directly.

Doris Williams: Okay, thank you.

Operator: Your next question comes from the line of Lance Lowe.

Lance Lowe: Yeah, I just had a question regarding slide 21 where you talked about the OASIS item M0090, should the date be the same as the start of care date or the date the OASIS was actually close by the clinician after other collaboration has been done?



Wil Gehne: The rules for reporting the M0090 aren't changed by the PDGM, it's when the OASIS is completed, and the specifics behind that are in the OASIS instruction manual. So, you complete the M0090 days the way you normally do and then report that date on the claim in the Occurrence code 50. That helped?

Lance Lowe: Yes, thank you.

Operator: Your next question comes from the line of Michelle Cosman.

Michelle Cosman: Hi. I had a question in regards to the claims hold for 01/01 to 01/05 claim date submissions. Do you anticipate the claims to then be released on 01/06 from what you found for your testing, or is there a soft ETA with that?

Wil Gehne: Yeah. You said the key word the testing, that you know when we'll be ready to release that bill, will depend, generally. We hold them for the 14-day payment floor period, so some date before 01/14.

Michelle Cosman: So, you're holding it for a date prior to one, like between 01/14 and 01/06 or is 01/06 is the actual ETA?

Wil Gehne: I can't say for certain that the claims will be released on 01/06, they may be held for a few days longer and may be held until the complete timely filing period depending on where we are with, you know, issues that we discover late in testing, but any claim with -- and again this only affects claims with 2020 date of service. So, all the claims with date of service for 2019 would process normally, but claims of 2020 date of service, from dates I should say on or after January 1st PDGM claims, you know, will be held from January 1st until a date after January 6th. And the short answer is, it's a date to be determined based on, you know, where we are with the release testing at that moment.

Michelle Cosman: Okay, thank you.

Operator: As a reminder, if your question has been answered and to remove yourself from the queue, press the pound key. Your next question comes from the line of Lesley Spencer.


Lesley Spencer: Hi. I'm just wanted to clarify on slide 27, the claim adjustment reason code, you have listed is 186 and then on slide 32, you mentioned the same Remittance Advice Coding, but it says code is 168. So, I just want to confirm if that's a typo or if it is truly 186 on one scenario and 168 in the other?

Wil Gehne: Thank you for reminding me that I'm the worst proofreader ever. It is a typo and the value should be 186 in both slides.

Lesley Spencer: Okay, thank you.

Operator: Your next question comes from the line of Stephanie Hyte.

Stephanie Hyte: Hi, yes. I was just wondering if the billing in the 60-day period has to be sequential. Will we bill a RAP and then ELE and then a RAP then ELE, can we bill for instance RAP, RAP, ELE, ELE?



Wil Gehne: There's no sequential submission requirement now, and there will not be any sequential submission requirements under PDGM.

Stephanie HYTE: Thank you.

Operator: Your next question comes from a line of Ivy Stuart.

Ivy Stuart: Yes, my question is for patients that are at a critical access hospital in swing bed status. Would you use code 61 or 62?

Wil Gehne: Well, that's a good point. We should clarify that in instructions somewhere, and those patients receiving a SNF level of care, so they'd be identical. So, you would report Occurrence code 62.

Ivy Stuart: Thank you very much.

Operator: Your next question comes from the line of Christina King.

Christina King: Hi. I was wondering for those agencies that are under pre-claim review. Will we be required to submit for every 30-day episode of billing, or will we continue on the 60-day episodes for the clinical side?

Kelly Vontran: Hi. We-- pre-claim reviewers, obviously, under CPI, we don't have anyone here in the room from there, but if you would send that question in, I will make sure to get it to them to clarify to make sure that you know how often that is supposed to be done.

Christina King: Okay thank you.

Operator: Your next question comes from a line of Muhammad Iqbal.


Muhammad Iqbal: Hi. Thank you for taking my call. This is Muhammad. Well, can you please explain the slide 40, because it was little bit confusing to us?

Wil Gehne: Give me a minute while I flip back to it. So, the patient is admitted, then has inpatient hospital stay, then has a SNF stay, and then resumes goes back to Home Healthcare all within the first period of care, and then the second period of care starts on February 14th. The point is that even though the SNF is the most recent inpatient admission, you wouldn't report the SNF stay on that second period of care because it's the other institutional discharge dates only apply to admission claims. And so, since this is the continuing claim, only the inpatient hospital stay could apply as the prior inpatient discharge. So, you would report Occurrence code 61 and the February 4th discharge date.

Muhammad Iqbal: Thank you, Sir.

Wil Gehne: Thank you.

Operator: Your next question comes from the line of Heather Hool.



Heather Hool: I was wondering about the behavioral adjustment. How would that be applied, are they going to, like, lower the 30-day payment amounts by whatever percent they decide, or is that a separate adjustment when the claim processes?

Kelly Vontran: Hi, this is Kelly Vontran again. That is actually something that we discussed in the calendar year 2020 propose rule, so you might want to just take a quick look at that to just to see how that works. That is actually in adjustment to the standardized 30-day period of care. And that does not affect the case-mix adjustment, so with that should that base rate.

Heather Hool: Okay.

Kelly Vontran: And if you want, we are still in the comment period, so you can still submit any comment or question regarding any of the information in the 2020 proposal rule, I believe it's [regulations.gov](https://www.regulations.gov).

Heather Hool: Okay, thank you.

Operator: Your next question comes from a line of Kathleen Watson.

Kathleen Watson: Hi, thanks. I just want to clarify, so if a hospital, say an acute care hospital, did not bill their claim by the time a Home Health Agency billed their RAP and it really should be institutional. There's no way for that RAP to calculate as institutional and correct it, would be either hopefully by the final claim or at some point in the future when the hospital billed, there's no way to get the RAP to pay institutional, is that correct?

Wil Gehne: Right. Well, the RAPs are going to be paid at face value based on whatever the HIPPS code that's submitted is, all of the grouping that I described only applies to the final claim, because for that very reason, because there's not enough time to have all the information that's needed to get it right. So, whatever the percentage payment is based on the HIPPS code that you submit on the RAP, that will be the only thing that determines what your RAP payment is and all the factors that I've described to be applied to the claim.

Kathleen Watson: So, if we grouped it and called institutional, and that's what our HIPPS code said, it would pay based on institution?


Wil Gehne: Right.

Kathleen Watson: Okay. Thank you. Oh, I get it.

Operator: Your next question comes from the line of Naomi Williams.

Naomi Williams: Yes. My name is Naomi and I'm from Dr. Stewarts' Home Care and I have a question regards to the 27 code. I know we're billing through RAP and a lot of times when we bill a RAP, we don't know there's another agency in there until as we bill that first RAP. Let's say we have a scenario where we bill a RAP and other agency bills a RAP, but they discharge before that first 30 days, would we still have ownership of that second 30 days with that RAP when they're final, or do we lose both after the 30-day episodes?

Wil Gehne: I didn't quite follow that. Can you give me that scenario one more time?



Naomi Williams: Yes. Okay, let's say we bill a RAP on 07/01 and later on, you know, we could find out there was another agency that was also seeing the patient that started let's say on 07/02. And they bill their RAP before us, so technically they would have ownership of their episode. So, let's say they discharged the patient on 07/23, would we lose that for that both of the 30-day episodes, or would we still be able to bill for that second RAP and ELE.

Wil Gehne: I'm having a hard time working through that one and can you email us on the presentation, could you shoot me that an email and we can work through that together?

Naomi Williams: Yeah, that's fine.

Wil Gehne: Thank you.

Operator: Your next question comes from the line of Sorita Chestwer.

Sorita Chestwer: Hello. My question is going to join the question of the gentlemen about the Medicare Advantage payment PDGM on PDGM, and I'm going to be more specific talking about the out-of-network Medicare Advantage. So, the regulation says that the out-of-network Medicare Advantage, they have to pay according to PPS. So now, how are we going and that's when they call us when we have referrals for those patients that's what we tell them, according to the requirement, you have to pay PPS according to PPS fee schedule. So, is it going to apply still, or is it going to be the choice of those out-of-network Medicare Advantage payers to say no, I'll pay you according to PDGM fee schedule?

Wil Gehne: The requirement is that the plan is, need to pay that out-of-network people the way original Medicare would pay them. So, they would pay them under...

Sorita Chestwer: Correct.

Wil Gehne: ...PPS today they would pay them under PDGM in all cases in the future.

Sorita Chestwer: All right, fantastic. Thank you very much.


Operator: Your next question comes from the line of Evelyn Debalin.

Evelyn Debalin: Hi, hello. Hi?

Wil Gehne: Hi.

Evelyn Debalin: Yes, hello. Yeah, this is Evelyn from Northern Mariana Island. I have a question regarding the slide 11 about the LUPA. It was only discussed on the RAP. So basically, there is no changes in number of thresholds, it's still 4 or less than 4 basically?

Wil Gehne: Now, the policy has changed. the LUPA threshold is no longer and across the board, you know, 4 visit threshold, and described in detail in the final rule, but it varies by the HIPPS code. So, the threshold for



HIPPS code 1 might be two visits; for HIPPS code 2, it might be one visit; for HIPPS code 3, it might be four visits, so it varies.

Evelyn Debalin: Okay. So, it depends that there's a Grouper on that, but does it'll show the final claim, under RAP if that'll be affected on the first 30 days of the -- I mean if we submitted a RAP, it will now show, it's only like 2 visits.

Wil Gehne: Right. Just like today, the LUPA adjustment is only applied to the claim.

Evelyn Debalin: Yeah on the end of episode.

Wil Gehne: Right.

Evelyn Debalin: Okay, I got it. Thank you.

Operator: Your next question comes from a line of Debbie Pratt.

Debbie Pratt: Yeah. My question is, has there been any consideration for how to handle billing when you have no visit in the first 30 days. For example, we have a fair amount of patients that are only seen every 6 to 8 weeks, so the first 30 days, there is no business to be made or billed for that 30-day episode. It doesn't occur until the second 30-day episode.

Kelly Vontran: I guess my question is that this is a patient that's just newly admitted into Home Health, how the comprehensive assessment --?

Debbie Pratt: This will be recert—this will be a recertification, so we see on admission, we see them 7 weeks later, recertify them and then don't see them again for 7 weeks, so it's the second 30-day episode.


Hazeline Roulac: Bear with just a moment please, thank you.

Kelly Vontran: Could you actually send that one in. I think we talk about that one a little bit more because I understand the type of situation and what you're talking about. So, if you could send that in and I guess Wil said he had his email in the presentation. If you can get that to Wil, we can discuss that a little bit further to make sure that we can provide an answer. And again, I sound like a broken record, you could also submit that same question into [regulations.gov](https://www.regulations.gov) so that we can also formally answer that in the rule if that's a venue in which you might want to see that as well.

Debbie Pratt: Great. Thank you.

Operator: Your next question comes from a line of Alice Halcomb.

Alice Halcomb: Hello. This is Alice. I have a question about paperwork reduction. With, you know, many of our patients that are on service, they may change from like a Medicaid to Medicare or Medicare Advantage to Medicare, would we still need to do a discharge at a new start of care in order to switch those payers?



Kelly Vontran: You're talking about having to discharge and then do an admission OASIS is that what you're trying to --?

Alice Halcomb: Yes, that's what I'm trying to ask. So, if we had a patient who is open to care under Medicare Advantage plan and then they change back to Medicare traditional the next month, typically now we discharged them and readmit them under a new start of care for, you know, the change in insurance. But sometimes we have patients who have Medicaid or Medicaid Advantage and of course, we do OASIS on those patients too and then they switch to a Medicare, that doesn't happen very often, but it does happen. And so, you know, I'm just thinking is there a way to reduce our paperwork burden and having to do a new start of care by using the same OASIS that would be in the QIES system?

Wil Gehne: There's nothing in the PDGM that's changing the OASIS instruction. I think it's been around from the beginning that says any time the patient changes to original Medicare, there needs to be a new start of care assessment. Thank you for raising that.

Alice Halcomb: Yeah, I was just trying to reduce our paperwork, it's a lot of extra work. All right, thank you.

Operator: Your next question comes from a line of Ann Hernandez.

Ann Hernandez: Hi. This is Ann. I would just like to verify for clarification, because of the billing now every 30 days. So, initially let's say we did the RAP and then are we after 30 days, are we doing the recert already that day, or we still continue the same process like after 60 days, you will determine if it's recert or a discharge?

Wil Gehne: The recertification assessment schedule hasn't changed.

Ann Hernandez: So, it's basically just billing then, that is billing change, just like let's say we did a RAP today after 30 days, they will do the billing, and as Home Health we just continue the same process of RAP, I mean our SOC, then recert after 60 days.

Wil Gehne: Yes, that's correct.

Ann Hernandez: Okay, thank you.


Operator: Your next question comes from the line of Barbara Pimble.

Barbara Pimble: Hi. Well, I have question about submitting the OASIS, are exporting the OASIS to the iQIES system. Currently, I believe there's 40 days to match the claim. Are we still going to have that 40 days or will it be 30 days?

Wil Gehne: Okay. You're referring in the claims matching process that we look for -- if an assessment isn't found, we look to see if the date is down 40 days to see if it's past due; that's not changing.

Barbara Pimble: Okay. Thank you.

Operator: Your next question comes from the line of Quentin Sills.



Quentin Sills: Yes. My question actually has to do with slide 12. It stated that Home Health Agencies newly enrolled in Medicare on or after January 1, 2019, we'll not receive the RAP payments. Is that actually 19 or is that supposed to be 2020, just want to verify?

Wil Gehne: 2019 is correct.

Quentin Sills: Thank you.

Operator: Your next question comes from the line of Candy Graham.

Candy Graham: Yes. I want a clarification, please. The gentleman that had asked about the OASIS and the M0090 date, I do know the M0090 date is the date that the OASIS is actually completed, however, I was reading an article that said CMS was going to temporarily waive that requirement that the agency had to enter the actual OASIS date completed and instead they were going to be required to enter the M0090 date as 01/01/20. These are those that occur in the last 5 days of December that we're recerting. So, and then we wait to transmit the OASIS until 01/01/20. Is that correct?

Wil Gehne: We don't have the right staff in the room to verify that, but that sounds about right, but we don't have the OASIS experts here to verify that.

Hazeline Roulac: Can you submit the question to the mailbox on slide 52?

Candy Graham: Yes. we will.

Hazeline Roulac: Thank you so much.

Operator: Your next question comes from the line of Donna Somma.

Donna Somma: Question in reference to partial episode of payments, if a patient is discharged on day 29 of an episode and then readmitted 4 days after the first episode discharge date, how are PEP applied with the new 30-day payment model.


Wil Gehne: On your example, wouldn't be a partial payment because they didn't receive any care within the 30-day period. The logic is essentially the same, just with the date window changing, that partial period adjustment only applies if there are services within the original 30-day period.

Donna Somma: So, the 29th day would not be 29 out of 30 days paid for that episode? Or would have to be within that 30-day? For example, if the patient discharged –

Wil Gehne: If I'm understanding your scenario, they were discharged on day 29 to come back on service on day 35, something like that?

[Crosstalk]





Donna Somma: Yeah. Let's make it maybe a different scenario. Let's say on the 19th day of the original episode and then they readmitted on the day 35 with a new admission.

Wil Gehne: As long as there aren't services that overlap that original 30-day period, the first period would be paid a full payment. It's only a...

[Crosstalk]

Wil Gehne: ... only if admission was on, say, day 28, then a partial payment would be made for the first 15 days of the period.

Donna Somma: Okay. Thank you.

Operator: Your next question comes from the line of Barbara Goodman.

Barbara Goodman: Hi Wil, this is Barbara. I have a question because first of all you've done a wonderful job, but my question got me thinking here, in the current system if a patient's transferred and not discharged at the end of the episode, as it stands, and that first visit in that new episode is a resumption of care. It really should be a start of care or if the HHRG didn't change, it could be the resumption. So, how does that work in the 30-day billing period? So, like, I guess if the patient is transferred at the end of the first 30-days and not discharged, and then they're like, come out, is that going to be a note in the OASIS' continuous episode? Are we looking at continuous episodes or continuous billing period, because that's what's driving the OASIS that's in the current system draw of the payment? It just made me think.

Wil Gehne: I'm struggling with that scenario right now too. Can you send me that in email and we'll get to the bottom of it, and I'll make whatever necessary clarification to the manual thereafter?

Barbara Goodman: Okay. Thank you.

Wil Gehne: Thank you.

Hazeline Roulac: We have time for one more question, Dorothy.

Operator: Your final question comes from the line of Crystal Tyson.

Crystal Tyson: Hi Wil. I had a question about slide 25. On there, it mentioned if you have two inpatient discharges occurred during the 14-day window, you'd report the later discharge date, and I just wanted to get clarification about what that would look like with an early versus the late timing for the admission source?

Wil Gehne: I think that later that in the admission source scenarios, I tried to break out each of those, once it resulted in Early Institutional versus "Late Institutional". So, I'd say go back and review the scenarios later in the presentation, and I know you have my email address, so just write to me for any clarification. I think that's all in the sides now, though, and before I stop, want to first thank Barbara for her kind words before and thank all of you for bearing with me for all this time. I appreciate your attention.

Hazeline Roulac: Crystal?

Crystal Tyson: Thank you.

Hazeline Roulac: Thank you for your question.

### Additional Information

Hazeline Roulac: Okay, so unfortunately that is all the time we have for questions today. If we did not get to your question, you can email it to the email address listed on slide 52. We hope you will take a few moments to evaluate your experience. Please see slide 53 for information on how to evaluate. If you missed any portion of today's call or would like to review again, an audio recording and transcript will be available in about two weeks at [go.cms.gov/npc](https://go.cms.gov/npc). Again, that is [go.cms.gov/npc](https://go.cms.gov/npc).

Again, my name is Hazeline Roulac. I would like to thank our presenters, Wil Gehne, and also thank Kelly Vontran, and also, I would like to thank you, our participants today, for joining us on this Medicare Learning Network event on Home Health Patient-Driven Groupings Model Operational Issues. Have a great day everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.