Physical Therapy in a Patient-Driven Groupings Model

Diana (Dee) Kornetti, PT, MA, HCS-D, HCS-C

Presentation Objectives

- Upon completion of this educational session, participants will be able to:
  - Determine key elements for inclusion in home health therapy in a patient-driven groupings model (PDGM)
  - Interpret current literature related to the value of therapy in post-hospitalization care of patients receiving home health care
  - Demonstrate defensible documentation to support home health therapy services in PDGM
Housekeeping

- Please feel free to ask questions throughout the presentation.
- Time will be provided at the end of the course for Q&A.

Where are you in your PDGM journey?
Professional Responsibility

* Practice Act
* Standards of Practice
* Code of Ethics

Professional Licensure

Payer Source Requirements

Regulatory Agencies

The Journey from FFS to PDGM
An Historical Perspective of Home Health Therapy & Payment
What Has Spurred the Movement Away From Fee-For-Service Care?

Fee-for-service (FFS) is a payment model where medical services are unbundled and paid for separately. In health care, FFS provides an opportunity that incentivizes providers to deliver in quantity rather than quality.

Since 2015, HHS has been moving Medicare away from FFS, toward payment for quality, patient-centered care through alternative payment models.

- 85% of all Medicare FFS payment tied to quality or value by end of 2016 → 90% by end of 2018
- 30% of Medicare payments tied to quality or value through APMs by end of 2016 → 50% by end of 2018
CMS Strategies Driving Change

Wheel Invented: Alternative Payment Models (APM)

- Accountable Care Organizations
  - NextGen ACOs (Medicare/Private)
  - Private ACO

- Bundled Payments (Medicare/Private)
  - BPCI, BPCI-A, CJR, Oncology Care Model

- Primary Care Transformation
  - CPC+, Transforming Clinical Practice Initiative

- Other CMMI initiatives
  - Initiatives to accelerate development/testing and speed adoption

- Value Based Purchasing / Pay for Performance (Medicare/Private)

- Medicare Advantage Programs

- Population Health

IMPACT Act of 2014

Package patients to hospital or post-acute facility
Optimize patient pathways, care length of stay
Minimize patient readmissions
What is important to APMs?

- Quality and Performance
- Reducing total cost of care
- Reducing readmissions/complications
- Partners who share their goals

IMPACT Act: A Deeper Dive

Improving Medicare Post-Acute Care Transformation Act

- IMPACT Act signed into law
- Payment = Blend of unified PAC PPS and current PPS relative weights over two years. (MedPAC Recommendation, March 2018)
- Change from 60-day to 30-day episode of care. Therapy thresholds are removed from case mix adjustment. (MedPAC Recommendation, March 2018)
- Unified PAC PPS Begins with three year transition. (MedPAC Recommendation, June 2018)
IMPACT Act: A Deeper Dive

Three Pillars of CMS Payment Reform

- Patient Empowerment
- Innovation
- Competition

Historical Perspective


- The Medicare HH benefit is ill-defined
- HH payment should not be based on the number of therapy visits
  - Payments based on therapy thresholds creates financial incentives that distract agencies from focusing on patient characteristics when setting plans of care.
  - Trend of notable shifts away from non-therapy visits.
- HH payment should be determined by patient characteristics

- CMS PDGM Webinar
- Tuesday, February 12, 2019
CMS Rationale for Revision of Payment Methodology

“The improved structure of this proposed case-mix system would move Medicare towards a more value-based payment system that puts the unique care needs of the patient first while also reducing the administrative burden associated with the HH PPS.”

Centers for Medicare and Medicaid, CMS proposed 2019 and 2020 payment and policy changes, July 2, 2018

The Patient-Driven Groupings Model (PDGM)

- Better align payment with patient needs
- Increase access to home health care for vulnerable patients associated with lower margins
- Address payment incentives in current system
- Allow patient characteristics to better inform payment
“The current payment system may discourage agencies from serving patient with complex or poorly controlled chronic conditions which may require a larger number of nursing visits rather than therapy.”

Study found episodes with no SN services were 30% more profitable than those with SN services


Payment Refinement in Home Health

<table>
<thead>
<tr>
<th></th>
<th>Pre PPS</th>
<th>Initial PPS</th>
<th>Revised PPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Therapy Use</td>
<td>Overall</td>
<td>Increases</td>
<td>Increases</td>
</tr>
<tr>
<td>Overall</td>
<td>&lt; 10</td>
<td>10 - 13</td>
<td>14+ / 20+</td>
</tr>
</tbody>
</table>
PDGM: The Path that Data Built

Do you know what your data is saying?

Quick Facts

- Data does not provide link between patient diagnoses and specific discipline
- Data does not provide link between patient presentation and service intensity/duration
- Data does not provide link between service volume and outcome

<table>
<thead>
<tr>
<th>State</th>
<th>% Spending</th>
<th>% Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dist. Columbia</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>Hawaii</td>
<td>73</td>
<td>0</td>
</tr>
<tr>
<td>N. Dakota</td>
<td>60</td>
<td>1</td>
</tr>
<tr>
<td>Montana</td>
<td>70</td>
<td>0</td>
</tr>
<tr>
<td>Alaska</td>
<td>67</td>
<td>2</td>
</tr>
<tr>
<td>S. Dakota</td>
<td>68</td>
<td>7</td>
</tr>
</tbody>
</table>

Quality score values may appear in fractional groups because of rounding.

Spending Indicator Note: Spending estimates are based on claims for home health care incurred by Medicare eligible beneficiaries within 60 months of Medicare enrollment. Payments were then adjusted to account for regional wage differences. Total spending per beneficiary is not necessarily the sum of spending in other settings of care.
Key Take-Aways

- Data that looks like fraudulent, wasteful and abusive is more easily discoverable within a system that is more robust and sensitive
- Early identification is available through multiple channels – to remediate behavior
- External scrutiny puts tremendous administrative and financial burden on HHAs

“Get it right the first time, that’s the main thing” – Billy Joel

Introduction to PDGM

A Primer for Home Health Clinicians
### Structure of the Home Health PDGM

<table>
<thead>
<tr>
<th>Source &amp; Timing</th>
<th>Clinical Grouping</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDGM</td>
<td></td>
</tr>
</tbody>
</table>

#### Admission Source and Timing (From Claims)
- Community Early
- Community Late
- Institutional Early
- Institutional Late

#### Clinical Grouping (From Principal Diagnosis Reported on Claim)
- MMTA
- Neuro Rehab
- Wounds
- Complex Nursing Interventions
- MS Rehab
- Behavioral Health

#### Functional Level (From OASIS Items)
- Low
- Medium
- High

#### Comorbidity Adjustment (From Secondary Diagnoses Reported on Claims)
- None
- Low
- High

**HHRG**  
(Home Health Resource Group)

Under the Patient Driven Groupings Model, a 30-day period is grouped into one (and only one) subcategory under each larger colored category. A 30-day period’s combination of subcategories places the 30-day period into one of 216 different payment groups.
**Claims Data Element**

- Admission source:
  - Depends on healthcare setting utilized 14 days prior to home health
  - Institutional:
    - Any acute or post-acute care stay 14 days prior to home health SOC
    - SNF, IRF, LTAC, IPF
    - Does NOT include ER visits or OBS stays
  - Community:
    - No acute or PAC stay within 14 days prior to episode
  - Will be database, not claims driven

**OASIS Data Element**

- Functional status reflects an individual’s ability to carry out activities of daily living (ADLs) and to participate in various life situations and in society
- Research shows correlation between function and hospital readmissions & overall cost of care
- Each 30 days period would be place into one of three functional levels.
  - Low = lower functional needs therefore lower cost
  - High = higher needs and cost.
  - Unknown how new OASIS-D GG functional items will effect.
Primary Diagnosis

ICD-10 Codes Used to Determine Clinical Group

- 30-day period assigned to clinical group based on principal diagnosis code on the claim
- The average resource use of all 30-day periods within a clinical group varies across clinical groups and the payment reflects those differences
- **If a diagnosis code is used that does not fall into a clinical group (e.g., dental codes or other uncovered/invalid codes), claim is returned to the provider for more definitive coding**
- Additional adjustments made for other health conditions
Comorbidity Adjustment (From Secondary Diagnoses Reported on Claims)

<table>
<thead>
<tr>
<th>None</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
</table>

- Comorbidity adjustment based on secondary diagnosis
- Will look at all secondary diagnosis on the claim (up to 24) versus the 5 secondary diagnosis listed on the OASIS
- Can receive a payment for low adjustment or high adjustment but not both
- Will receive only one low or high comorbidity adjustment regardless of the number of reported diagnosis
- Adjustment is the same across the low as well as the high adjustment subgroups
- Co-morbid diagnosis that are within the same ICD10 block of codes as the primary diagnosis are excluded from consideration as a qualifying comorbid adjustment diagnosis
- Can increase payment up to 20%

Secondary Diagnoses

Co-morbid diagnosis that are within the same ICD10 block of codes as the primary diagnosis are excluded from consideration as a qualifying comorbid adjustment diagnosis
- Can increase payment up to 20%

Co-morbidity Body System Categories

- Heart disease
- Respiratory disease
- Circulatory disease & Blood disorders
- Cerebral Vascular disease
- GI disease
- Neurological disease
- Endocrine disease
- Neoplasms
- GU & Renal disease
- Skin disease
- Musculoskeletal disease/injury
- Behavioral health
- Infectious disease
A Little More about Proper Diagnosis Coding

- **Ultimate responsibility for diagnoses rests with the physician**
  - This means, that the home health clinician cannot diagnosis a patient with an illness, condition, or disease process.
  - However, the reason for hospitalization (or physician office visit, emergent care, etc.), may not be the primary reason for the home health episode of care!
  - The clinical assessment completed on SOC, and all additional discipline evaluations, should provide clear rationale for why the patient is receiving home health care.

Role of the HH Clinician in Diagnosis Coding

- **Sequencing**
  - List first code (M1021a), or primary code, as the diagnosis, condition, problem, or other reason for the home health episode
    - Most related to the Plan of Care,
    - Most acute condition, and
    - Requires the most intensive services (chief reason for care)
  - List additional codes (M1023b-f), or secondary codes, that describe any coexisting conditions managed during the episode of care
    - Must be relevant to the care delivered, or
    - Have potential to affect patient’s responsiveness to care
Role of the HH Clinician in Diagnosis Coding

- Coding Chronic Conditions
  - Those treated on an ongoing basis
  - Even if not the focus of care, will always impact the care and should be codes as a pertinent diagnosis
  - Should also be addressed in the Plan of Care

- Select those that best describe the patient’s current, active condition under treatment

Coding the Reason for Therapy Care in PDGM

- Currently in home care, agencies list “therapy diagnoses” when therapy is providing care.
  - *There are no “therapy diagnoses” in the ICD code set!*

- Therapists commonly list the impairments in body structure/function as the reason/diagnosis driving the provision of therapy
  - *Therapists frequently do not list the underlying etiology for the therapy conditions being treated*
  - i.e., “muscle weakness” or “gait abnormality”

- How should this be accurately reflected?
  - *Should be occurring now, but will affect payment in PDGM!*
Capturing Traditional “Therapy” Codes in PDGM

**Documentation “DO’s”**
- Document the underlying etiology of the impairment in body structure/function
- Use objective, standardized tests & measures with age/gender normative data
  - Incorporate qualitative assessments that are patient-specific
- Tie impairment(s) to specific functional deficits of the patient
- Use prior level or "normal" functional status of patient as baseline

**Documentation “DON’Ts”**
- Document resultant impairments as the actual condition or diagnosis
  - i.e., gait abnormality and LE weakness in a patient with DM2 w/neuropathy, LOPS
  - i.e., reduced strength and endurance in patient recently hospitalized with acute on chronic HF
- Use non-specific, non-measurable statements
  - i.e., “reduced household mobility status” or “severely poor endurance” or “slow walking speed”

The Behavioral Adjustments

**BEHAVIORAL ADJUSTMENT ASSUMPTIONS – PROPOSED 2020**

<table>
<thead>
<tr>
<th>Assumption</th>
<th>30-Day Standard Amt</th>
<th>Percent Change from None</th>
<th>FDL Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Behavior Adjustment</td>
<td>$1,907.11</td>
<td>-</td>
<td>.56</td>
</tr>
<tr>
<td>LUPA Threshold – 1/3 of LUPAs 1-2 visits away from threshold get extra visits for full payment</td>
<td>$1,871.67</td>
<td>-1.86%</td>
<td>.59</td>
</tr>
<tr>
<td>Clinical Group Coding – among available diagnoses, the one leading to the highest payment group will be used as primary</td>
<td>$1,794.42</td>
<td>-5.91%</td>
<td>.60</td>
</tr>
<tr>
<td>Comorbidity Coding – availability of more diagnosis codes on the claim increases opportunity for comorbidity adjustments</td>
<td>$1,900.05</td>
<td>-3.37%</td>
<td>.56</td>
</tr>
<tr>
<td>LUPA + Clinical Group + Comorbidity Coding</td>
<td>$1,754.37</td>
<td>-8.01%</td>
<td>.63</td>
</tr>
</tbody>
</table>

*Set in 2019 at 6.42% and now raised to 8.01%*
CMS Behavioral Assumptions

- Home health agencies will alter their behavior under PDGM and will:
  1. Put the highest paying diagnosis as the primary diagnosis to increase reimbursement.
  2. Make more use of extended diagnostic coding to maximize opportunity for the comorbidity adjustment.
  3. Will add visits for payment periods that are close to the LUPA ranges to ensure full payment.

- Reality check – CMS has not used behavioral adjustments in any other health care setting, including SNFs under PDPM, as a prospective tool for controlling cost.

Major Changes from PPS to PDGM

<table>
<thead>
<tr>
<th>HH PPS</th>
<th>PDGM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Score: low, medium, high</td>
<td>Assigned to 1 of 6 Clinical Groups</td>
</tr>
<tr>
<td>Functional Scores</td>
<td>Combine OASIS responses. Low, medium and high</td>
</tr>
<tr>
<td>Therapy Visits</td>
<td>Number of therapy visits/thresholds will have no impact on case mix weight</td>
</tr>
<tr>
<td>153 payment HHRGs</td>
<td>216 payment HHRGs</td>
</tr>
<tr>
<td>NRS</td>
<td>Non-Routine Supply utilization cost already determined in CMW</td>
</tr>
<tr>
<td>LUPAs</td>
<td>LUPA thresholds will vary depending upon assigned payment group</td>
</tr>
</tbody>
</table>
Anticipated Reimbursement in PDGM

![Ave. Reimbursement by Clinical Group](chart.png)

Source: 2017 Claims Data

### HIPPS Codes w/Highest Case Mix Weight Under PDGM

<table>
<thead>
<tr>
<th>HIPPS</th>
<th>Clinical Group and Functional Level</th>
<th>Timing and admission source</th>
<th>Comorbidity adjustment</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>2CC31</td>
<td>Wound-High</td>
<td>Early-Institutional</td>
<td>2</td>
<td>1.8646</td>
</tr>
<tr>
<td>2BC21</td>
<td>Neuro-High</td>
<td>Early-institutional</td>
<td>2</td>
<td>1.8216</td>
</tr>
<tr>
<td>2IC31</td>
<td>MMTA-Endocrine-high</td>
<td>Early-institutional</td>
<td>2</td>
<td>1.7546</td>
</tr>
<tr>
<td>2CB31</td>
<td>Wound-Medium</td>
<td>Early-institutional</td>
<td>2</td>
<td>1.7404</td>
</tr>
<tr>
<td>2CC21</td>
<td>Wound-High</td>
<td>Early-institutional</td>
<td>1</td>
<td>1.7351</td>
</tr>
<tr>
<td>4CC31</td>
<td>Wound-High</td>
<td>Late-Institutional</td>
<td>2</td>
<td>1.7263</td>
</tr>
<tr>
<td>2BB31</td>
<td>Neuro-Medium</td>
<td>Early-institutional</td>
<td>2</td>
<td>1.7170</td>
</tr>
<tr>
<td>2EC31</td>
<td>MS Rehab-High</td>
<td>Early-Institutional</td>
<td>2</td>
<td>1.7085</td>
</tr>
<tr>
<td>2BC21</td>
<td>Neuro-High</td>
<td>Early-Institutional</td>
<td>1</td>
<td>1.6921</td>
</tr>
<tr>
<td>1CC31</td>
<td>Wound-high</td>
<td>Early-community</td>
<td>2</td>
<td>1.6880</td>
</tr>
<tr>
<td>4BC31</td>
<td>Neuro-High</td>
<td>Late-institutional</td>
<td>2</td>
<td>1.6833</td>
</tr>
<tr>
<td>2CC11</td>
<td>Wound-high</td>
<td>Early-institutional</td>
<td>0</td>
<td>1.6751</td>
</tr>
</tbody>
</table>

Source: Proposed Rule 2020
### Questionable Episode Diagnosis Codes

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
<th>Primary Diagnosis Category</th>
<th>Questionable Encounters</th>
<th>% of SOC with Questionable Encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>M62.81</td>
<td>Muscle weakness</td>
<td>MS/Connective tissue</td>
<td>115,322</td>
<td>25.9%</td>
</tr>
<tr>
<td>R26.89</td>
<td>Other abnormalities of gait and mobility</td>
<td>Symptoms and ill defined conditions</td>
<td>27,994</td>
<td>6.3%</td>
</tr>
<tr>
<td>R26.81</td>
<td>Unsteadiness on feet</td>
<td>Symptoms and ill defined conditions</td>
<td>17,513</td>
<td>3.9%</td>
</tr>
<tr>
<td>R29.6</td>
<td>Repeated falls</td>
<td>Symptoms and ill defined conditions</td>
<td>16,226</td>
<td>3.6%</td>
</tr>
<tr>
<td>R53.1</td>
<td>Weakness</td>
<td>Symptoms and ill defined conditions</td>
<td>16,146</td>
<td>3.6%</td>
</tr>
<tr>
<td>R26.9</td>
<td>Unspecified abnormalities of gait and mobility</td>
<td>Symptoms and ill defined conditions</td>
<td>14,120</td>
<td>3.2%</td>
</tr>
<tr>
<td>R26.2</td>
<td>Difficulty in walking</td>
<td>Symptoms and ill defined conditions</td>
<td>9,796</td>
<td>2.2%</td>
</tr>
<tr>
<td>M19.91</td>
<td>Primary OA, unspecified</td>
<td>MS/Connective tissue</td>
<td>7,216</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

### Most Profitable Diagnosis 2018 – Not Allowed Under PDGM

<table>
<thead>
<tr>
<th>ICD-10 code</th>
<th>Avg margin per standard episode</th>
<th>Avg SNV per episode</th>
<th>Avg therapy per episode</th>
<th>Avg costs per episode</th>
<th>Avg reimbursement per episode</th>
<th>Acceptable under PDGM</th>
<th>Clinical group PDGM</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. R26.81</td>
<td>33.4%</td>
<td>1.8</td>
<td>12.2</td>
<td>$2,609</td>
<td>$3,765</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>4. M62.81</td>
<td>25.3%</td>
<td>3.8</td>
<td>13.0</td>
<td>$2,814</td>
<td>$3,650</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>5. M29.6</td>
<td>24.2%</td>
<td>4.1</td>
<td>13.3</td>
<td>$2,821</td>
<td>$3,627</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>9. R53.1</td>
<td>21.9%</td>
<td>4.4</td>
<td>12.0</td>
<td>$2,773</td>
<td>$3,438</td>
<td>No</td>
<td>NA</td>
</tr>
</tbody>
</table>

Source: Ability Network-Minneapolis, MN
What About Therapy??

- We disagree that the PDGM diminishes or devalues the clinical importance of therapy. The musculoskeletal and neurological rehabilitation groups under the PDGM recognize the unique needs of patients with musculoskeletal or neurological conditions who require therapy as the primary reason for home health services.

- For the other clinical groups, we note that the 30-day base payment amount includes therapy services, even if the primary reason for home health is not for the provision of therapy. The functional impairment level adjustment in conjunction with the other case-mix adjusters under the PDGM, aligns payment with the costs of providing services, including therapy.

CMS, PPS 2019 Final Rule

NAHC Survey Results

How do you anticipate PDGM will impact therapy utilization in your agency?

- Stay the same: 21%
- Decrease more than 10%: 16%
- Decrease less than 10%: 34%
- Unsure: 19%
- Increase: 5%

485 Responses
Preparing for PDGM

Example: Capturing Traditional “Therapy” Codes in PDGM

- 87 yo female patient is referred for HH services by PCP due to recent falls “due to gait abnormality and muscle weakness.”

PMHx: diastolic HF, HTN, COPD, osteoporosis, OA

SHx: Patient resides in private 2-story residence with supportive family residing 2-towns away (60 minute drive); patient able to complete ADLs, basic IADLs; relies on family for transportation to medical appointments and weekly grocery shopping

Reason for Referral: Patient has had recent bout of PNA (resolved 2 weeks ago) but is not returning to PLOF; fell carrying laundry from upstairs bedroom down 5 steps to main floor laundry room and unable to get up (called daughter who called 911; refused hospitalization)
Example: Capturing Traditional “Therapy” Codes in PDGM

- Admitting Clinician Narrative Note:
  - Patient is a motivated, yet anxious 87yo female with recent falls on her attempts to return to PLOF in ADLs/IADLs post 5 week period of decline related to a non-hospitalizing bout of pneumonia. Patient demonstrates impaired peripheral muscle strength and aerobic capacity related to recent illness, reduced activity level over a 30+ day period, in addition to her long-standing chronic comorbidities of diastolic HF and COPD. She is a (+) fall risk and has impaired mobility status, with compromised ability to walk at speeds and distances required for safely entering the community. She reports feeling she is “only 50%” of her “normal self” of 2 months ago. Patient goal is to resume her prior level of functioning (PLOF) with a reduction of falls, fall risk, and fear of falling. She would like to resume her weekly outings with family without feeling “exhausted” and requiring a 2-hour nap upon her return home.

<table>
<thead>
<tr>
<th>OASIS item</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1021(a)</td>
<td>M62.81 - generalized muscle weakness</td>
</tr>
<tr>
<td>M1023(b)</td>
<td>R26.89 – other abnormalities of gait and mobility</td>
</tr>
<tr>
<td>M1023(c)</td>
<td>I11.0 – HTN heart disease w/HF</td>
</tr>
<tr>
<td>M1023(d)</td>
<td>I50.30 – unspecified diastolic HF</td>
</tr>
<tr>
<td>M1023(e)</td>
<td>J44.9 – COPD, unspecified</td>
</tr>
<tr>
<td>M1023(f)</td>
<td>M81.0 – age-related osteoporosis w/o current pathological fracture</td>
</tr>
<tr>
<td>Add’l Dx</td>
<td>M19.90 – unspecified OA, unspecified site</td>
</tr>
</tbody>
</table>

Possible ICD-10 coding with supportive documentation:

<table>
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<td>I11.0 – HTN heart disease w/HF</td>
</tr>
<tr>
<td>M1023(b)</td>
<td>I50.30 – unspecified diastolic HF</td>
</tr>
<tr>
<td>M1023(c)</td>
<td>J44.9 – COPD, unspecified</td>
</tr>
<tr>
<td>M1023(d)</td>
<td>M81.0 – age-related osteoporosis w/o current pathological fracture</td>
</tr>
<tr>
<td>M1023(e)</td>
<td>M15.0 – Primary generalized (osteo) arthritis</td>
</tr>
<tr>
<td>M1023(f)</td>
<td>Z91.81 - History of falling</td>
</tr>
<tr>
<td>Add’l Dx</td>
<td>Z60.2 – Problems related to living alone</td>
</tr>
</tbody>
</table>
Example: Capturing Traditional “Therapy” Codes in PDGM

- Current therapy coding (*per 2020 Proposed Rule*)
  - Source: CMS current version PDGM Grouper Tool
  - Result: Primary diagnosis of M62.81 falls into “questionable episode,” not a PDGM grouping

\[
V = \frac{Q + S}{C}
\]

Moving from Volume → Value
Completing the Paradigm Shift
How Therapy Research Can Inform Us

- Credit for the data to Jason R. Falvey, PT, DPT, PhD
  - Post-Doctoral Fellow
  - Yale University School of Medicine
    - Division of Geriatrics
- Jason.Falvey@Yale.edu

Think Big About Research: Applicability

- Show PT Value
- Reduce readmission rate
- Improve physical function
Demonstrating the Value of Therapy

- Impact on Publicly Reported Outcomes
  - Self-Care, ADLs
  - Mobility/Locomotion
- Reduction in the Use of Higher Cost Centers of Care
  - Urgent, Emergent Care Centers
  - Unplanned Physician Office Visits
  - ED (re-) Hospitalizations
- Positive Patient Experience

HH PT & Reduced Healthcare Costs

Lower readmission rates
Less ADL dependency
More likely to age in place

Improved Function

Lower Cost
Function and Readmission

- Importance of function is **MORE THAN FALLS**
- Function is both a critical outcome for HH PT and a biomarker for hospitalization
- Being able to articulate **WHY** function improves outcomes during and after HH episodes is critical for showing value

Defining Hospital-Associated Deconditioning

- Multi-system decline in function partially avoidable occurrence resulting from prolonged immobility during period(s) of hospitalization
  - Decline in ADL performance
  - Prolonged periods of bed rest/relative inactivity
    - Older adults spend ~83% of hospital stay in bed
    - Older adults spend ~12% of hospital stay in chair

After Hospitalization
Early Recovery Matters!

Research: Did You Know??

- Hospital readmission rates after acute care discharge are 3x higher if physical therapist discharge recommendations are replaced with less intensive interventions.

- Older adults who walk < 4,691 steps per day over the 1st week post discharge are ~6x more likely to be readmitted within 30 days.

Falvey, JR, et al. Role of Physical Therapists in Reducing Hospital Readmissions: Optimizing Outcomes for Older Adults During Care Transitions From Hospital to Community. Phys Ther. 96:8, pp 1125-1134, 2016.
Service Utilization: SN, PT & Function

- Dose-Response Relationship Between HHC Services and Rehospitalization in Older Adults
  - 1/3 of Medicare patients are rehospitalized within 90 days after hospital discharge
  - 90% of these are unplanned events
  - Emerging evidence has shown that, overall, HHC improves physical function and reduces healthcare costs, for which “dosing” of specific HHC services is likely the key


- At the threshold dose of 1 PT or 2 SN visits/week, higher visit intensity significantly reduced the hazard of rehospitalization in these patients by up to 82% for PT
  - The effect of PT on reducing the risk of rehospitalization was more pronounced in patients with low versus high functional limitation
    - Threshold: 1 PT visit/week
    - Risk lowered: up to 82%
  - SN was only effective in reducing the hazard of rehospitalization in the low functional limitation, but not in the high functional limitation group
    - Threshold: 2 SN visits/week
    - Risk lowered: 48%

Take Away?

- Older patients should receive enough HHC services (especially PT and SN) to avoid rehospitalizations with consideration of their functional limitation.
- Compared with nonrehospitalized patients, rehospitalized patients were more likely to have heart failure, COPD, or osteoarthritis; take ≥10 medications; have had a longer hospital stay before HHC admission; and have higher rates of exhaustion, smoking, and functional limitation.

Research: Did You Know??

- Declines in self-reported ADL ability is strongly linked to poor outcomes following hospitalization.
- Older adults who return home with unmet needs for ADL assistance have a 66% increase in the odds of hospital readmission when compared to those whose needs are adequately addressed after discharge.

Falvey, JR, et al. Role of Physical Therapists in Reducing Hospital Readmissions: Optimizing Outcomes for Older Adults During Care Transitions From Hospital to Community. Phys Ther. 96:8, pp 1125-1134, 2016.
Reducing “HAD” with HH Therapies

- Occupational Therapy
  - ADL Coach
- Physical Therapy
  - Mobility Coach

Exercise Prescription: The Issue of Underdosing

- Functional Reserve (def): the capacity for older adults to handle additional stressors or illnesses without loss of independence
- Older adults discharged with poor physical function have 3x the odds of being re-hospitalized within 30 days as compared to:
  - Older adults with medically complex conditions, &
  - Older adults with high physical function
- Most common PAC physical therapists choose low-intensity exercises (“safer”)

Exercise Prescription: Paradigm Shift

- **Focus of Interventions in HAD:**
  - High intensity resistance training
  - Mod to high intensity motor control-based gait, balance, ADLs
  - Mod intensity aerobic training
  - General conditioning activity


Documentation Defensibility in PDGM

Key Elements of the Home Health Medicare Benefit
The Role of Documentation = facilitate determinations for claims involving skilled care. CMS states, the presence of accurate documentation, in and of itself, is not an element of the definition of “skilled” service, it provides a means by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case.

Essential Elements of Documentation

- Clinical Documentation
  - Homebound
  - Skilled
  - Reasonable
  - Necessary
  - Clinician Judgment
  - Care Coordination
  - Patient Centered Care
“ID” Insufficient Documentation: Common Findings

Every Visit

- Homebound status not stated or inferred
- Repetitive documentation across visits
- Care is inconsistent with patient condition(s)
- Services are not integral for recovery or stabilization
- Clinical assessment limited to “pt tol well” phraseology
- Review of multiple disciplines reflect “different” patient
- Cookie cutter care plans

Eligibility Requirements for Home Health

- Eligibility requirements for care under the MEDICARE PART A Home Health Benefit:
  - Confined to the home
  - Physician-approved Plan of Care
  - Under care of Physician
  - Need for Skilled Care
  - Physician Certification (F2F)

- Eligibility for recertification = establish the continuing need for service(s)
Step 1: Presence of Elements
Criteria 1
Either option but not both is required
Criteria 2
Both components are required

Step 2: Content of Elements

Criteria-One

Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence.

Criteria-Two

There must exist a normal inability to leave home.

Defining Homebound Criteria

Operationalize “considerable and taxing effort to leave home” in relation to unique presentation of the patient:
- Example: Documentation of deteriorating O2 saturation with walking distances > ”x” feet
- Example: Increased demonstration of L Trendelenberg in unilateral stance and L foot drag in swing phase of gait cycle when walking > ”x” feet

Operationalize “weakness/muscle weakness” by linking to functional limitations unique to the patient:
- Example: Documentation of reduced aerobic capacity and peripheral muscle strength limiting patient's ability to ascend/descend 12 steps to access bedroom/bathroom consistent with PLOF.
Documentation Queries: “Confined to Home”

- Step 1: Presence of Element
  - Answer the questions:
    - “What aids/assistance does the patient require?”
    - “What is the medical contraindication to going out for care?”

- Step 2: Content of Elements
  - Normal inability to leave home
  - Considerable and taxing effort
  - Answer the questions:
    - “What is the patient’s past “normal ability?”
    - “What currently impedes this ability?”
    - “What is the considerable effort?”
    - “How is taxing measured?”

Documentation: Need for Skilled Care

- Skill
  - proficiency, facility, or dexterity that is acquired or developed through training or experience; an art, trade, or technique
- Reasonable
  - governed by or being in accordance with reason or sound thinking; not excessive or extreme
- Necessary
  - Absolutely essential; needed to achieve a certain result or effect; requisite

Skilled Services (ref): HH Benefit Policy Manual, Chapter 7, 40.1 - Skilled Nursing Care, 40.2 – Skilled Therapy Services
Documentation Queries: “Need for Skilled Care”

Section 40.2 – Skilled Services
Must require the skills of a qualified nurse/therapist and must be reasonable and necessary for the treatment of the patient’s illness or injury. Coverage does not turn on the presence or absence of an individual’s potential for improvement, but rather on the beneficiary’s need for skilled care.

Answer the question:
“What is the deficiency or impairment the patient has?”

Answer the question:
“What care can only be provided by a skilled clinician due to its inherent complexity?”

Answer the question:
“Why can’t a lay person carry out this education or intervention?”

Documentation: Reasonable & Necessary

**Skill**
- Proficiency, facility, or dexterity that is acquired or developed through training or experience; an art, trade, or technique.

**Reasonable**
- Governed by or being in accordance with reason or sound thinking; not excessive or extreme.

**Necessary**
- Absolutely essential; needed to achieve a certain result or effect; requisite.

The amount makes sense

The care is indispensable

Skill Services (ref): HH Benefit Policy Manual, Chapter 7, 40.1 - Skilled Nursing Care; 40.2 - Skilled Therapy Services.
A patient’s overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed ("reasonable and necessary"). Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.

Answer the question:
“What are the evidence-based interventions that are appropriate to provide the patient?”

Answer the question:
“What education/training deficits exist that need to be addressed?”

Answer the question:
“Why are these interventions and education required? Why is the expected result for the patient?”

**Definition:** the conclusion or enlightened opinion at which a clinician arrives following a process of observation, reflection and analysis of observable or available information or data

- Margot Phaneuf, R.N., Ph.D. 12/17/2008
Complete Individual Assessments

- Social Determinants of Health
- Review of Medical History
  - Co-morbidities, medications
- Measurement of Physical Functioning
  - Self-care/ADLs
  - IADLs
  - Muscle Strength
  - Aerobic Capacity/Endurance
  - Gait
  - Balance/Balance Confidence
- Assessment of Mental Functioning
  - Cognition
  - Associated Disorders
- Assessment of Physical Environment and Social Support

Identifying/Determining Outcomes

- What does the patient, their family and caregiver(s) want to achieve with your services?
- What is required for either (a) return to prior level or (b) stabilization of this patient to reduce the likelihood of non-related disease process deterioration or decline?
Sample SBAR Admission Note

Situation
"Patient referred for home health services due to...."

Background
"Recently discharged from ACH following CABG; PMHx includes ...

Assessment
"Objective findings show risk for re-hosp. due to (+) fall risk, need for med. Instruction, lack of family support...."

Recommendation
"Admitting clinician recommends SN for.... and therapy to evaluate for...."

Conditions for Coverage of Therapy Services

Skills of a qualified therapist are needed to restore function

Patient's condition requires a qualified therapist to design or establish a maintenance program

Skills of a qualified therapist are required to perform maintenance therapy

Restorative Maintenance Maintenance
Making a Decision

Therapy Assessment

Return to PLOF?

Need Skilled Intervention?

Restorative Therapy

At Optimal Level?

Need Skilled Intervention?

Maintenance Therapy

Medicare Billing Manual

- Limits on Goals????

“Any ‘rules of thumb’ that would declare a claim not covered solely on the basis of elements, such as lack of restoration potential, ability to walk a certain number of feet, or degree of stability, is unacceptable without individual review of all pertinent facts to determine if coverage may be justified. Medical denial decisions must be based on a detailed and thorough analysis of the beneficiary’s total condition and individual need for care.”
Goal Statements

- **Specific**: achievement of client specific learning or accomplished task
- **Measurable**: level of assistance, results of tests and measures, frequency and duration of symptoms self-management and monitoring
- **Attainable**: reasonable
- **Relevant**: how does it improve or stabilize health condition, activity or participation
- **Time bound**: by when do you expect the goal to be achieved

Capturing Patient Uniqueness

- Health condition
  - Body Functions and Structures
  - Activities
  - Participation

  - Environmental Factors
  - Personal Factors

  Contextual Factors:
  - Diseases, disorders, conditions
What Can You Do?

- **Have that necessary conversation with the clinician**
  - Look for use of objective, standardized tests & measures
  - Facilitate development of an agency “toolkit” of objective measures; teach/train with skills lab component to ensure standardization in tool administration (validity of findings)

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**Example: Interdisciplinary Collaboration in PDGM**

- **77 yo male patient is referred for HH services following 4-day hospitalization for exacerbation of HF.** Patient referred for nursing, PT and OT services for disease process management, medication training, ADL and mobility interventions.
  - **PMHx**: chronic diastolic HF, HTN, hyperlipidemia, osteoarthritis
  - **SHx**: Patient resides in private 2-story residence alone with supportive family residing 2 towns away (approx. 60 miles). Patient was independent with basic ADLs (bathing, dressing) and IADLs (light meal prep), but relies on weekly family assistance with housekeeping, laundry, and trips into community for social and medical events
  - **Reason for Referral**: Patient was admitted to hospital through ED where he was seen following a 30-day period of gradual decline (self reported) and progressively worsening shortness of breath (SOB). Patient fell at home, was unable to get up and called 911 for assistance.
Anticipated Reimbursement in PDGM

Source: 2017 Claims Data

Prevalence of Diagnosed Heart Disease Among Medicare Beneficiaries
Chronic Disease Management in Home Health

- Movement from a volume-based (PPS) to a value-based (PDGM) system of care in the post-acute space will require assessment of current data, with a critical eye to:
  - Improving processes and efficiencies
  - Evaluating service utilization decision rationale
  - Assessment of outcomes and their financial impact

Source: HF Hospitalization Rate per 2,000 Medicare Beneficiaries, 65+, All Races/Ethnicities, Both Genders, 2014-2016.
www.nccd.cdc.gov
PDGM = End of “Silos of Care”

Considerations for Therapy Client Mgmt in PDGM

Thorough evaluation of the patient’s functional status
- Physiological/Functional
- Disease process knowledge
- Social/Environmental

Interdisciplinary care coordination
- Ensure eligibility under benefit
- Goal setting
- Expected outcomes

DC to self management
- Education
- Self-management training
- Maintenance program
Social Determinants of Health

- Health & health care utilization are impacted by social, economic and environmental factors.
- Unmet needs may increase a person’s:
  - Risk of developing chronic conditions,
  - Reduced ability to manage these conditions,
  - Cost of health care, and
  - Use of avoidable health care.
- Failure to triage for unmet health-related social needs can lead to increased health risks, chronic disease burden and possibly disability.

CONCEPT: One Beneficiary – One Plan of Care

- Reducing Re-hospitalization: M1033: Risk for Hospitalizations
- Improving Function: M1860: Ambulation/Locomotion, M1830: Bathing
- Reducing Falls: M1910, Home safety assessment
- Managing Medications: M2020: Managing of Oral Medications
• What are the key elements a patient with heart failure need to focus on to prevent hospitalizations?
• What role does each clinical discipline play in these risks?
  • SN
  • PT
  • OT
  • HHA

**Example:** Activity Monitoring with cardiopulmonary clients

**SN**
- Disease acuity/severity
- Mgmt of signs/symptoms
- Medication use/purpose/side effects
- Dietary restrictions

**PT**
- Pre-/post-vitals support modification from aerobic to strengthening exercises
- Teach how to rate perceived exertion

**OT**
- Increased compensatory strategies with self-care activities
- Reinforce strengthening program

**HHA**
- Provide increased assistance with bathing
- Monitor self-perceived exertion during assisted ADLs
In Summary . . .

Determining Current State of Therapy

- Frequency and Duration
- Tests and Measures
- Patient Specific Interventions
- Relevant Goal Setting
- OASIS / Coding
- Maintenance Therapy
Reinforcing Clinical Focus on Value / Outcome

- Documentation Queries:
  - Does documented care reflect impact of care toward desired outcome(s)?
  - Do goal statements reflect anticipated functional impact of improvement in/stabilization of impairments?
  - Are risk areas identified on admission remediated/resolved through provision of care?

- Clinical Utilization Decisions:
  - Are documented impairments quantified using objective measurement?
  - Are frequency/duration decisions supported by data interpretation + clinical judgment + contextual factors unique to the patient?
  - Are expected outcomes of care coordinated between all members of the patient’s care team?

Therapists: Thinking Beyond Visit #s

- ADD VALUE
  - Become better patient managers
  - Ensure holistic care
  - Optimize cost effectiveness
  - Monitor and ensure patient progress
  - Collaborate
  - Proactive readmission reduction
Demonstrating the Value of Therapy

- Impact on Publicly Reported Outcomes
  - Self-Care, ADLs
  - Mobility/Locomotion
- Reduction in the Use of Higher Cost Centers of Care
  - Urgent, Emergent Care Centers
  - Unplanned Physician Office Visits
  - ED, (re-) Hospitalizations
- Positive Patient Experience

Quality Care
Patient Centered
Reduced Cost

Thank You!

Kornetti & Krafft HEALTH CARE SOLUTIONS
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