HAS/MyUnity Essentials

PDGM Billing

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Purpose

This document highlights the billing changes in HAS for Medicare and Medicare Advantage payers switching from PPS to PDGM billing for periods on or after 1/1/2020.

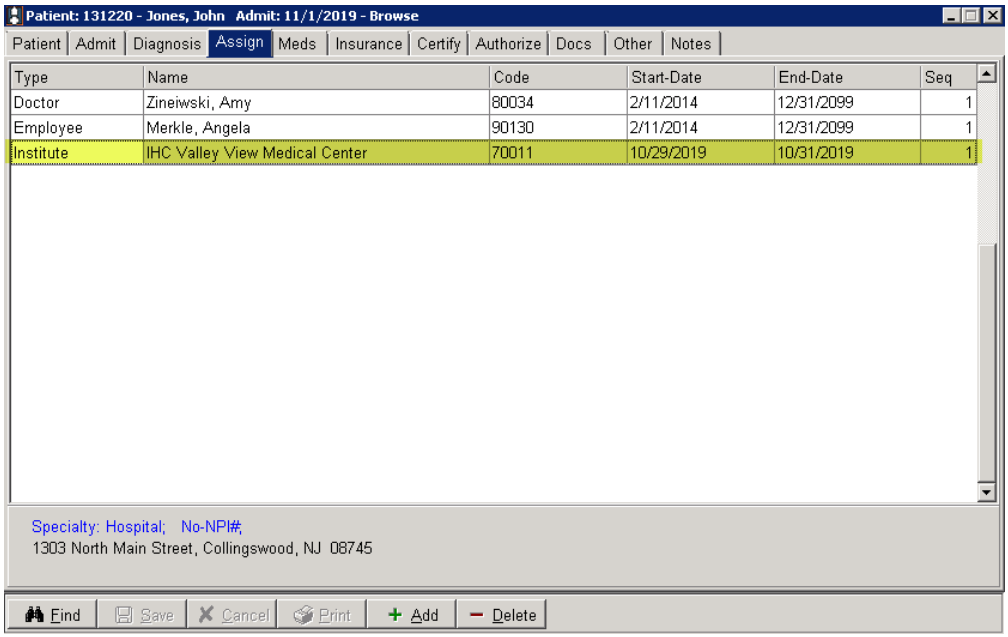
What to Know

- Certification/Recertification periods and requirements remain at 60-days.
- Billing of 60-day episodes replaced with billing of 30-day periods.
- HIPPS coding stems from 5 case-mix variables instead of being tied to only OASIS.
- Only the first 30-day period (the SOC period 1) is considered Early.
- Medicare will regroup the HIPPS based on Final claim diagnoses submitted on the claim, as well as for Admission Source and Timing based on their records and for functional score based on matching OASIS found in iQIES using Occurrence Code 50 - M0090 date from Final claim.
- Accurate diagnosis coding is essential. The primary must reflect the primary reason for Home Health services and controls the clinical grouping score of the HIPPS. Secondary diagnoses affect co-morbidity scoring.
- LUPA threshold now falls within a range of 2-6 visits (actual threshold based on the HIPPS).
- PEPs and Outliers still apply.
- Therapy up-coding and down-coding adjustments no longer apply.
- New Occurrence Code 50 and optional Occurrence Code 61 or 62 reporting on Final claims.
- HAS scores the PDGM HIPPS for billing when the Billing Pre-Audit is run, but any valid HIPPS code can be submitted on the RAP and Final.
- HIPPS code submitted on RAP and Final claim must still match.
- RAP payment lowered to 20% of estimated final payment for initial and subsequent periods.
- A no-pay RAP must still be submitted even if no visits supplied within a 30-day period (no special claim output requirements).
- Medicare Advantage payers are not required to follow PDGM billing rules. (Contact your MA payers for guidance on their billing requirements for CY 2020).
- RAP takeback will occur if the final claim isn't received 90 days after the period start date or 60 days after the RAP paid date, whichever is later.

Patient Institute Stays

Patient Institute Stays are entered into the Location of Care section of the Patient Profile in Clinical and post to the Patient file Assign tab in Billing. Be sure to check the Clinical Integration Log to ensure the information is posting successfully and address any Failure or Decline messages (**Note**: the Type drop-down must be set to Location of Care).

If the patient was in an acute or post-acute facility within the 14 days prior to the start of the 30-day period of care, the Institute information should be entered into the DeVero Patient Profile and will export to HAS. To view the information in HAS, go to **Patient > Admit/Maintain** and select the patient. Click on the **Assign** tab to view the Institute information.



The End-Date and Specialty type are used in determining the Admission Source for HIPPS scoring and whether Occurrence Code 61- Hospital Discharge Date or Occurrence Code 62 - Other Institutional Discharge Date are needed on the Final claim.

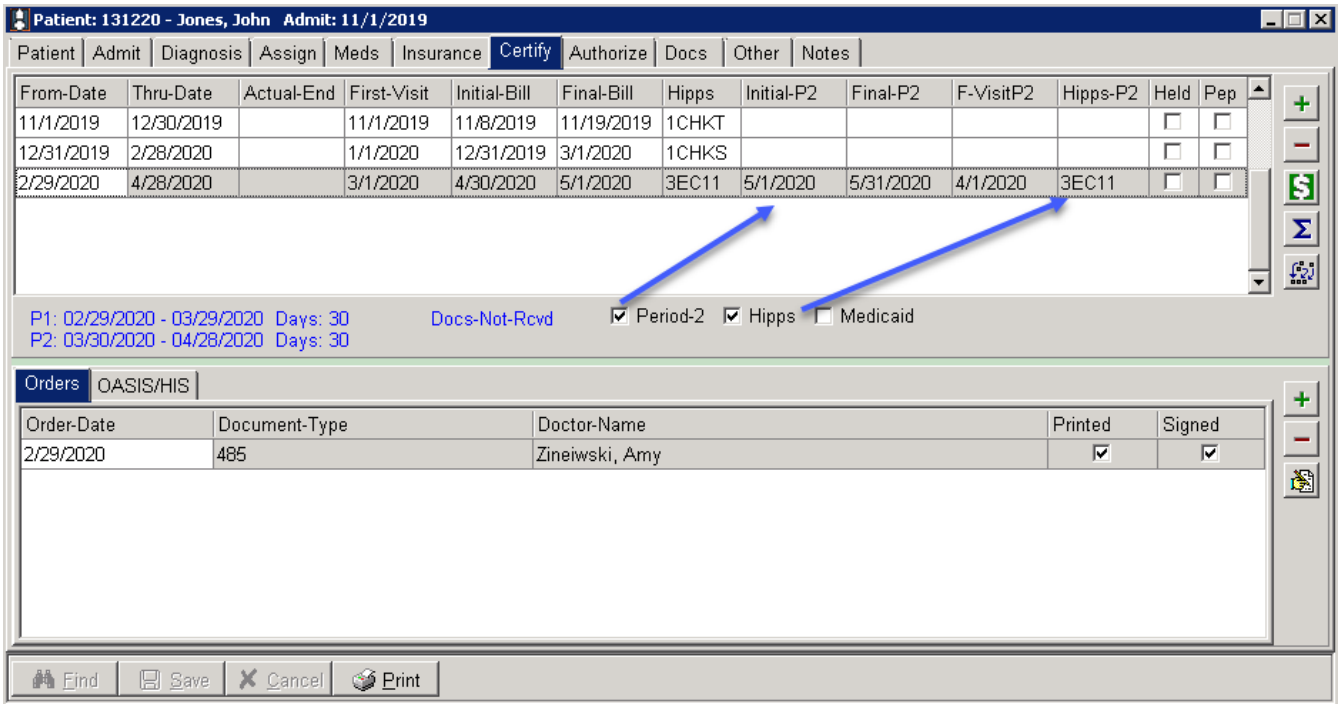
Billing Process

The billing process follows the same steps (Billing Pre-Audit, Audit, claims), with the difference of billing a RAP and Final every 30 days within each 60-day episode. If your agency is not accustomed to running the Billing Pre-Audit first, that step is now required in order to generate the PDGM HIPPS.

The **Patient** file **Certify** tab has been updated to include options to display both RAP and Final bill dates and HIPPS for each 30-day period within the cert.

Period-2: when checked, displays columns for Initial-P2 (RAP Bill Date for period 2), Final-P2 (Final Bill Date for period 2), and F-VisitP2 (First Billable visit date on file when period 2 RAP billed).

HIPPS: when checked, displays columns for grouped HIPPS and HIPPS-P2 for periods 1 & 2 respectively.



Occurrence Codes

No option set changes are needed to accommodate the reporting of Occurrence Codes 50, 61 or 62. The codes will pull to Final claims for PDGM periods starting on or after 1/1/20 based on OASIS and Institute information present in the patient file. If the patient was in more than one facility, only the last gets reported on the claim. Only Occurrence Code 61 or 62 is reported on a claim, not both.

Occurrence Code 50

- The OASIS M0090 date is required on PDGM Final claims with Occurrence Code 50.
- The most recent OASIS RFA 1, 3, 4, or 5 performed prior to the period start is reported with an Occurrence Code 50 and M0090 date. CMS uses this information to locate the OASIS in iQIES.
- M0090 used to be reported in the Authorization Number field of the RAP and Final as part of the OASIS Claim Key but a claim key is no longer reported on PDGM claims.
- Not reported on the RAP.

Occurrence Code 61

- Reporting of Occurrence Code 61 with the patient's acute stay Discharge Date on the Final claim is optional (but recommended).
- If the patient has a Hospital facility type in their Patient file Assign tab within 14 days prior to the start of the claim 'From' date, Occurrence Code 61 with institute End-Date will pull to the Final claim.
- Reported on admission and subsequent period claims.
- Not reported on the RAP.

Occurrence Code 62

- Reporting of Occurrence Code 62 with the patient's post-acute stay Discharge Date on the Final claim is optional (but recommended).

- If the patient has one of the following facility types in their Patient file Assign tab within 14 days prior to the start of the claim 'From' date, Occurrence Code 62 with institute End-Date will pull to the Final claim.
    - Skilled nursing facility (SNF)
    - Inpatient rehabilitation facility (IRF)
    - Long term care hospital (LTCH)
    - Inpatient psychiatric facility (IPF)
- Reported only on admission period claims but not subsequent period claims.
- Not reported on the RAP.

LUPA

Low Utilization Payment Adjustments (LUPAs) now fall within a range of 2 – 6 visits based on the period case mix score.

The **Stats > PPS Activity** report, has a **LUPA Threshold** option that can be used when run for Open or Closed Period Visit report types. A LUPA +/- column will display how many visits over or under the threshold you're at for the period. Periods not yet Final billed will be included on the Open report and periods that have been Final billed will be included on the Closed Period report (Note, on prior versions the Open report only included periods RAP billed). Your DeVero site must be configured to send unverified visits to HAS for accurate LUPA Threshold reporting.

The threshold per period is also included in the **Stats > Period Overview** report.

Periods of Care with No Visits Expected

A RAP must still be submitted for periods in which no billable visit will be provided, such as in the instance where the patient is only seen monthly. A Final claim does not get submitted for these periods, per Medicare requirements. This only applies to situations where the patient remains on service and hasn't been discharged by the agency. The purpose of this is to retain the agency as primary for the patient in the CWF and to enforce consolidated billing requirements. Medicare will pay the RAP, but because no Final claim is submitted, they will later auto-cancel the RAP and recoup payment. In these scenarios, the 0023 HIPPS line on the RAP will be the period start date.

To allow for this in Billing for periods *after* the SOC period, two options are possible:

1. In **File > File Maintenance > System Settings**, on the **Reporting** tab, the **Days to RAP** count can be changed from '0' to '1' to allow the Billing Pre-Audit and Audit to generate for a period without a billable visit. The Billing Pre-audit must then be run for only for the specified patient(s) for which the situation applies. Once done, the setting can be change back to '0' so the edit checks are turned back on to hold the RAP from processing until a billable visit is done for the rest of the patient population.
2. In lieu of changing the above setting, a billable visit can be entered in Charge > Enter/Maintain, which will prevent the Billing Pre-Audit Failure for "No valid charge found." Once the Billing Pre-Audit and Billing Audit are run and posted, the billable visit can be deleted from Charge > Enter/Maintain.

After the RAP Billing Audit is posted, a RAP should be generated to Medicare under Billing > Electronic Claims. When the period comes to an end, the Billing Pre-Audit will generate for the Final with no special intervention needed. The Final Billing Audit should be posted as usual. When running

Billing > Electronic Claims for the Final, the patient will appear with an exception message “Negative-Charges, No-Charges, or No-Units Found.” This failure does not need to be addressed since the Final does not get submitted to Medicare for no-visit periods.

If an unanticipated billable visit occurs in the period after the no-visit RAP was submitted to Medicare, cancel that RAP in DDE and un-bill and re-post the RAP audit with the billable visit prior to posting the Final for that period.

Case-Mix (HIPPS) Scoring in HAS

The case-mix is generated for periods when the Billing Pre-Audit report is run. Below is a breakdown of the main variables and where they are read from in HAS. Position 5 of the HIPPS is a placeholder and always has a value of ‘1’.

Admission source: Community or Institutional

Reads from the **Patient** file **Assign** tab for the Institute type (comes down from DeVero Patient Profile under Location of Care). Patients with an Institute End Date (their Inpatient Discharge Date) within 14 days of the period start date are considered Institutional. All others are scored as Community.

The Institute **Specialty** also comes down from DeVero and can be viewed in HAS on the **Patient** file **Assign** tab.

Timing: Early or Late

The first 30-day period (the SOC period 1) is calculated as Early, all other periods are Late. The “Late” box can be checked on the **Patient** file **Admit** tab in HAS to manually override this when needed.

Admission Source and Timing combined make up the first position of the PDGM HIPPS:

1 = Early Timing, Community Admission Source
2 = Early Timing, Institute Admission Source
3 = Late Timing, Community Admission Source
4 = Late Timing, Institute Admission Source

Clinical grouping: A through L

The Clinical Grouping comes from the primary diagnosis (or rarely from the first secondary diagnosis, such as with Z452 which replaces the primary diagnosis in the scoring if used as the first secondary diagnosis code). The diagnosis is read from the most recent **Plan of Care** on file (Patient file Certify tab) prior to the period start date. Clinical groupings can be viewed on the **Patient** file **Diagnosis** tab for the most recent Plan of Care diagnoses or on the **Stats > Period Overview** report.

Possible Values:

A = MMTA_Other
B = Neuro Rehab
C = Wounds
D = Complex Nursing
E = MS Rehab
F = Behavioral Health
G = MMTA – Surgical Aftercare
H = MMTA – Cardiac
I = MMTA – Endocrine
J = MMTA – GI/GU
K = MMTA – Infectious
L = MMTA – Respiratory

Functional impairment level: Low (A), Medium (B), High (C)

The responses for certain OASIS questions are assigned points and the range of scores are classified as either low, medium, or high dependent upon the Clinical Group. HAS calculates the Functional Impairment score based on OASIS M00 questions for the most recent RFA 1, 3, 4 or 5 on file in the **Patient** file **Certify,** OASIS/HIS tab prior to the period start. Questions used in the scoring are:

M1033 - Risk for Hospitalization
M1800 - Grooming
M1810 - Current ability to dress upper body safely
M1820 - Current ability to dress lower body safely
M1830 - Bathing
M1840 - Toilet transferring
M1850 - Transferring
M1860 - Ambulation and locomotion

Possible Values:
A = Low
B = Medium
C = High

Comorbidity adjustment: None (1), Low (2), High (3)

Based on secondary diagnoses and read from the most recent **Plan of Care** on file (Patient file Certify tab) prior to the period start date. Clinical groupings can be viewed on the **Patient** file **Diagnosis** tab or on the **Stats > Period Overview** report.

Possible Values:
1 = None
2 = Low
3 = High

OASIS

OASIS D1 assessments should be used for periods beginning on or after 1/1/2020, even for patients recertified in the last 5 days of 2019 for periods starting in 2020.

Note: there is a waiver for the M0090 Assessment Completed Date rule for patients being recertified in the last 5 days of 2019 for periods starting in 2020. Per CMS,

“Instructions for RFA 4 Recertification Assessments

To allow for the 5-day recertification window for episodes of continuous care that begin 1/1/2020 through 1/5/2020, there may be cases where the RFA 4 - Recertification assessment is completed in the last five days of 2019. In these cases, CMS is temporarily waiving the requirement that HHAs enter the actual OASIS completion date in M0090, and instead enter the M0090 date of 1/1/2020. HHAs should be aware that in the event they attempt to submit the RFA 4 - Recertification assessment with an artificial M0090 date of 1/1/2020 prior to 1/1/2020, they will receive a fatal error preventing the transmission of the assessment. Therefore, HHAs should not transmit these assessments until

1/1/2020."

Guidance can be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual

Also, register for the new iQIES system by 12/23/2019 to avoid delayed payments.

"Please note that failure to obtain access to iQIES by December 23rd will impact your agencies' ability to submit assessment data needed for claims matching purposes after January 1, 2020. Claims that cannot be matched to assessments will be returned to the HHA, delaying Medicare payment."

https://www.cms.gov/files/document/SE19025

The recommendation is to create an OASIS Submission file at the end of the year with a Through Date of 12/26/2019 so all Locked and ready for export assessments up to that date will be included for transmission to the State to avoid late submissions. On or after 1/1/2020, create the OASIS Export file following standard procedures.

Medicare Advantage Payers

The Insurance file under **File > File Maintenance > Entity** now has a field on the 'Insurance' tab for the **PDGM effective date**. The date defaults to 1/1/2020 and is available for payers set to PPS Billing with a Payer Type of 2- Medicare HMO/Managed.

Contact your Medicare Advantage payers to determine what their billing requirements will be for claims 1/1/20 and after. Change the PDGM date in your insurance file for any payer who will not be billing PDGM for claim periods starting January 1st (cannot be greater than 1/1/2021). Billing of PPS HIPPS codes in HAS can be done through 12/31/2020.

Once PDGM billing has been posted, this date cannot be changed without un-billing and inactivating all PDGM claims for that payer. For 2020 Medicare Advantage claims, we recommend initially only posting the billing audit for a small batch of patients. Agencies should confirm these claims have been accepted by the payer prior to posting any additional 2020 audits.

MBI Numbers

Although not part of the Final Rule changes, be sure to update your patients' Medicare contract number to the their new MBI prior to submitting claims 1/1/2020, regardless of dates of service. Failure to do so will cause claims to reject (crossover claims are an exception). Electronic claims will return a 277 rejection for Claim Status Code 164 "Entity's contract/member number" if the HIC is submitted instead of the MBI.

https://www.cgsmedicare.com/hhh/pubs/news/2019/1019/cope14553.html

Medicare Implementation Date

For PDGM RAPs and Finals submitted between 1/1/2020 and 1/5/2020, MACs will hold the claims for processing until their implementation date of 1/6/2020. They'll be released for processing by the MAC after that date. Expect delayed payment for claims submitted within that date range as a result.