



Home Health (HH) Patient-Driven Groupings Model (PDGM) – Additional Manual Instructions

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Related Change Request (CR) Number: 11272

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Effective Date: Claim “From” dates on or
after January 1, 2020

Related CR Transmittal Number: R4312CP

Implementation Date: August 7, 2019

Note: We revised this article on August 26, 2019, to provide a link to MLN Article [MM11395](#). That article is based on CR11395 which revises additional sections of the Medicare Claims Processing Manual, Chapter 10, to support the implementation of the Home Health (HH) PDGM and creates new sections to describe the HH PDGM Grouper program. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters Article is for physicians and Home Health Agencies (HHAs) billing Medicare Administrative Contractors (MACs) for Home Health services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11272 revises additional sections in Chapter 10 of the Medicare Claims Processing Manual to support the implementation of the Home Health (HH) Patient-Driven Groupings Model (PDGM). Make sure your billing staffs are aware of these revisions.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) finalized an alternative case-mix method now called the Patient-Driven Groupings Model (PDGM), which includes the payment reform requirements set forth in the Bipartisan Budget Act of 2018 (BBA). CMS discussed this model in the Calendar Year (CY) 2019 final Home Health (HH) Prospective Payment System Rate Update final rule. CMS will implement this in CY 2020, effective for claims with From dates on or after January 1, 2020.

CR 11272 revises manual instructions to conform to the final policies of the PDGM. It also

further implements the policies of the PDGM, as the CY 2019 HH final rule describes and as Section 51001 of the BBA requires. The complete policy is available in MM11081 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11081.pdf>.

The revised Manual sections are part of CR11272. One manual change is that episode is also now a period of care. HHAs should note the following instructions in the revised Medicare Claims Processing Manual, Chapter 10, Section 40.2:

- HH PPS claims must report a 0023 revenue code line on which the first four positions of the HIPPS code match the code submitted on the RAP. This HIPPS code is used to match the claim to the corresponding RAP that was previously paid. After this match is completed, grouping to determine the HIPPS code used for final payment of the period of care will occur in Medicare systems. At that time, the submitted HIPPS code on the claim will be replaced with the system-calculated code.
- Principal Diagnosis Code
 - **For claim “From” dates before January 1, 2020**, the ICD code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).
 - **For claim “From” dates on or after January 1, 2020**, the ICD code and principle diagnosis used for payment grouping will be claim coding rather than the OASIS item. As a result, the claim and OASIS diagnosis codes will no longer be expected to match in all cases.
 - Typically, the codes will match between the first claim in an admission and the start of care (Reason for Assessment –RFA 01) assessment and claims corresponding to recertification (RFA 04) assessments. Second 30-day claims in any 60-day period will not necessarily match the OASIS assessment. When diagnosis codes change between one 30-day claim and the next, there is no requirement for the HHA to complete another follow-up (RFA 05) assessment to ensure that diagnosis coding on the claim matches to the assessment.
- Other Diagnosis Codes
 - **For claim “From” dates before January 1, 2020**, the other diagnoses and ICD codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses).
 - **For claim “From” dates on or after January 1, 2020**, claim and OASIS diagnosis codes may vary as described under Principal Diagnosis.

Note: The above instructions from Chapter 10, Section 40.2 pertaining to principal diagnosis code and other diagnosis codes also apply to RAPs, as the revised Chapter 10, Section 40.1 indicates.

HHAs may also want to review the revised Sections 70.3 (Decision Logic Used by the Pricer on RAPs) and 70.4 (Decision Logic Used by the Pricer on Claims). These revised sections are part of the manual revision that is attached to CR 11272.

Also, CMS added guidance for HHAs in case the MAC returns a claim because there is no

corresponding OASIS assessment in Medicare's systems related to the claim. In such cases, the HHA may correct any errors in the OASIS or claim information to ensure a match and then re-submit the claim. If there was no error and the HHA determines the claim did not meet the condition of payment, the HHA may bill for denial using the following coding:

- Type of Bill (TOB) 0320 indicating the expectation of a full denial for the billing period
- Occurrence span code 77 with span dates matching the From/Through dates of the claim, indicating the HHA's acknowledgment of liability for the billing period
- Condition code D2, indicating that the HHA is changing the billing for the Health Insurance Prospective Payment System (HIPPS) code to non-covered.

Do not use condition code 21 in these instances, since it would result in inappropriate beneficiary liability.

The MACs will use the following remittance advice messages and associated codes when processing billings for denial under this policy. This Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) combination is compliant with Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Business Scenario Three.

- Group Code: CO
- CARC: 272
- RARC: N211

ADDITIONAL INFORMATION

The official instruction, CR 11272, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4312CP.pdf>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

DOCUMENT HISTORY

Date of Change	Description
August 26, 2019	We revised this article to provide a link to MLN Article MM11395 . That article is based on CR11395 which revises additional sections of the Medicare Claims Processing Manual, Chapter 10, to support the implementation of the Home Health (HH) PDGM and creates new sections to describe the HH PDGM Grouper program.
May 24, 2019	We revised the article to reflect the revised CR 11272 issued on May 23. CMS revised the CR to show that the new diagnosis instructions added to section 40.2 (HH claims) also apply to section 40.1 (RAPs) and we revised the article accordingly. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.
May 3, 2019	Initial article released.

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