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

MLN Matters Number: MM11527 | Related Change Request (CR) Number: 11527
Related CR Release Date: November 8, 2019 | Effective Date: January 1, 2020
Related CR Transmittal Number: R4452CP | Implementation Date: December 11, 2019

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for Home Health Agencies (HHAs) submitting claims to Home Health & Hospice Medicare Administrative Contractors (HH&H MACs) for services to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11527 informs Medicare contractors about the revisions to additional sections of Chapter 10 of the Medicare Claims Processing Manual to support implementation of the Home Health (HH) Patient-Driven Groupings Model (PDGM). Make sure that your billing staffs are aware of these changes.

BACKGROUND

In the Calendar Year (CY) 2019 final HH Prospective Payment System (PPS) Rate Update final rule, the Centers for Medicare & Medicaid Services (CMS) finalized an alternative case-mix methodology now called the PDGM, which includes payment reform requirements as set forth in the Bipartisan Budget Act (BBA) of 2018. These payment reform requirements will be implemented in CY 2020. The manual instructions in CR 11527 are revised to conform to the final policies of the PDGM.

CR 11527 further implements the policies of the PDGM, as described in the CY 2019 HH final rule and as required by Section 51001 of the BBA of 2018. For the complete policy, see the final rule and CRs 11081, 11272 and 11395.

Note: You can review the articles related to these CRs at the following locations:

- **MM11081**: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm11081.pdf

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- **MM11272**: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm11272.pdf
- **MM11395**: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm11395.pdf

Also, the relevant manual sections are attached to CR 11527.

The following summarizes the manual changes:

1. Inpatient Stays Spanning the End of a 30-day Period

Discharge should be made at the end of the 60-day certification period in all cases if the beneficiary has not returned to the HHA. If the beneficiary returns to HH after an inpatient stay that spans the end of the certification period, Medicare requires a new start of care assessment and a Request for anticipated Payment (RAP) and claim with a new admission date.

For services after January 1, 2020, discharge is not required if the beneficiary has an inpatient stay that spans the end of the first 30-day period of care in a certification period. The HHA should submit the RAP and claim for the period following the discharge as if the 30-day periods were contiguous – submit a From date of day 31, even though it falls during the inpatient stay and the first visit date that occurs after the hospital discharge. Medicare systems will allow the HH claim to overlap the inpatient claim for dates in which there are no HH visits.

2. Periods of Care with No Visits Expected - Service Date on Requests for Anticipated Payment (RAPs)

On RAPs for initial periods of care, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode/period. For subsequent periods of care, the HHA reports on the 0023 revenue code the date of the first visit provided during the episode/period, regardless of whether the visit was covered or non-covered.

The one exception to reporting a visit date on the 0023 revenue code of the RAP is when no visits are expected during a 30-day period of care. For instance, if the beneficiary's plan of care requires that the beneficiary is seen every 6 weeks and there is a recertification, the beneficiary might receive no visits in the first 30-day period following the recertification. In this case, the HHA should submit a RAP for all 30-day periods, but only submit claims for 30-day periods in which visits were delivered.

If no visits are expected during an upcoming 30-day period, the HHA should submit the RAP with the first day of the period of care as the service date on the 0023 line. The RAP for a period with no visit will ensure the HHA remains recorded on Medicare's Common Working File (CWF) system as the primary HHA for the beneficiary and will ensure that HH consolidated billing is enforced. If no visits are provided, the RAP will later be auto-cancelled to recover the payment.

ADDITIONAL INFORMATION

The official instruction, CR 11527, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4452CP.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
November 12, 2019	Initial article released.