Chapter 5:
Master HHRGs, PDGM and HIPPS

The PDGM model allows Medicare to pay agencies a predetermined rate for each 30-day payment period. These payment rates are based on the patient characteristics, admission source and timing, coding and OASIS. Other determining factors include adjustment for the market basket pricing based on geographical area for delivered services. Low utilization payment adjustments (LUPAs) for each 30-day payment period will be specific to the HIPPS score for each patient. LUPA thresholds range from two to six visits for that HIPPS score.

Intro to HHRGs and HIPPS

CMS calculates the 30-day payment for agencies under PDGM in 2024 will be $2,038.13 if they submit their OASIS related quality data. If the agencies do not submit their OASIS for quality data, they will receive a base rate of $1,998.56 for a 30-day period.

OASIS submission is a condition for payment

In 2012, the HHS Office of Inspector General (OIG) submitted a report entitled "Limited Oversight of Home Health Agency OASIS Data." In that report, the OIG identified 6% of agencies that had not reported OASIS data. This, the OIG said, represented more than $1 billion in payments by Medicare that should not have occurred. The OIG also found that only 199 agencies had actually incurred the 2% reduction from 2007 through 2010. All of this, the OIG said, indicated "CMS did not ensure the accuracy or completeness of OASIS data and did not validate states' processes for monitoring submitted OASIS data.

Effective April 3, 2017, CMS began denying claims when OASIS assessment is not found in the Quality Improvement and Evaluation System (QIES). CMS indicates "If the OASIS assessment is not found in the QIES upon receipt of a final claim for an HH episode and the receipt date of the claim is more than 30 days after the assessment completion date, Medicare systems will deny the HH claim. (While the regulation requires the assessment to be submitted within 30 days, the initial implementation of this edit will allow 40 days.)"

On Oct. 12, 2017, CMS issued a temporary solution to alleviate some of the denials.

Until matching errors are corrected, Medicare systems will put home health claims without a corresponding OASIS assessment into a return to provider (RTP) status. If Medicare returns a claim with reason code 37253, agencies should resubmit the claim following the completion of one of these actions:

1. Update the MBI (Medicare Beneficiary Identifier) so it matches on the OASIS assessment and current claim information.
2. Fix the assessment completion date with Occurrence code 50 on the claim to match the OASIS assessment.

3. Resubmit for denial using condition code 21 and Type of Bill 320 if the assessment wasn't submitted.

The following information will be used to find the OASIS to check against the claim, so agencies should double-check this information prior to submission.

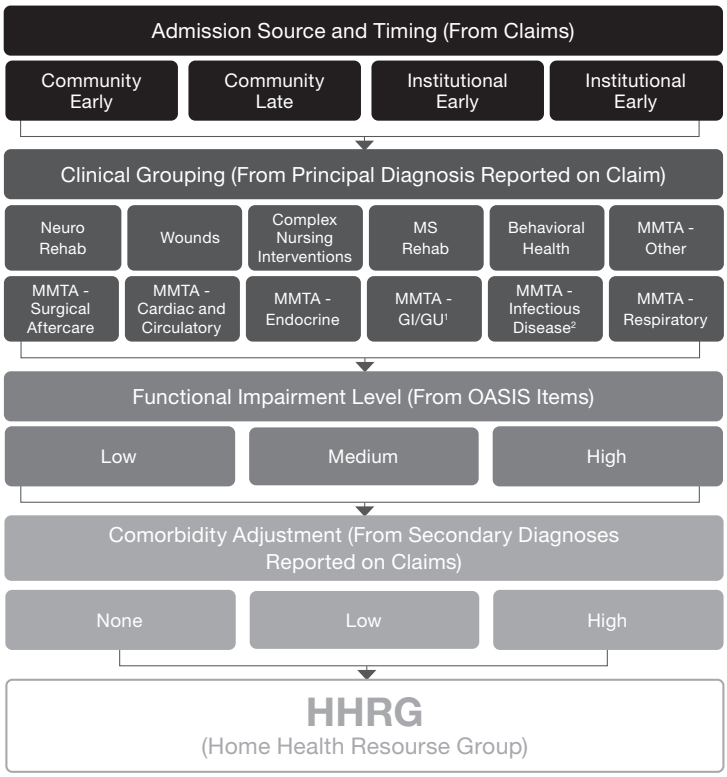
- HHA CMS Certification Number (OASIS item M0010)
- Beneficiary Medicare Number (OASIS item M0063)
- Assessment Completion Date (OASIS item M0090)
- Reason for Assessment (OASIS Item M0100) equal to 01 (SOC), 03 (ROC), 04 (Recertification) or 05 (Other-FollowUp)

It will be vital that billers track and verify the transmittal and acceptance of every OASIS assessment within that 30-day timeframe before it bills the final claim. Otherwise, the agency may not be paid.

More to note on the PPS and PDGM

The home health PPS payment system used the OASIS assessment information and the claims system to make a payment calculation. It established case-mix adjusted payments for each patient's 60-day episode of care. Under PDGM, we continue this 60-day episode of care, or quality episode, but billing is broken down into two 30-day payment periods. If a patient is still eligible for care after the end of the first 60-day quality episode, a second quality episode can begin. There are no limits to the number of episodes a patient who remains eligible for the home health benefit can receive — as long as the patient continues to have a need for skilled, intermittent home health care that is medically necessary.

Under PDGM, the 432 case-mix groups, Home Health Resource Groups (HHRGs), are determined by the following characteristics: The admission source of the patient, the timing of the episode, the principle clinical grouping, functional level or limitations and the comorbidity adjustments. Under PDGM these characteristics will determine the first four characters of the HIPPS code, and the fifth character will be a 1 as a placeholder. So under PDGM, a HHRG code is the same as the HIPPS code without a 5th digit of 1.



[1] Gastrointestinal tract/Genitourinary system

[2] The infectious disease category also includes diagnoses related to neoplasms and blood-forming diseases

Source: *Centers for Medicare & Medicaid Services Medicare Learning Network.*

New model increases number of HHRGs

Under PDGM, there are 432 home HHRGs. That's far more than what was proposed under HHGM (144) and what existed under PPS (153).

CMS credits the increase in HHRGs to a change in comorbidity adjustments CMS had originally proposed to provide an adjustment if the patient had a comorbidity. But in PDGM, CMS will have three levels in the comorbidity case-mix adjustment: no comorbidity adjustment, low comorbidity adjustment and high comorbidity adjustment.

Validate HIPPS code on the claim

Previously, CMS had instructed Medicare contractors to create an interface between the Fiscal Intermediary Standard System (FISS) and the iQIES, so contractors were unable to directly validate the submitted HIPPS codes(s) against the associated assessment.

Effective Jan. 1, 2015, OASIS assessment data was to be submitted to CMS via the national OASIS Assessment Submission and Processing (ASAP) system. With the implementation of the OASIS ASAP system, agencies no longer submit OASIS assessment data to CMS via state databases. Effective January 2020, OASIS is now transmitted to Internet Quality Improvement and Evaluation System (iQIES).