PDGM: A Guide for Home Health Referral Sources

Patient-Driven Groupings Model (PDGM) is the new Medicare payment model for home health agencies effective January 1, 2020.

Home Health agencies will continue to serve the same types of patients, but there will be changes in the information requested by these agencies when a patient is referred to home health.

Eligibility: Eligibility requirements have not changed:

- Patient must be homebound due to illness or injury (cannot drive at all)
- Services must be ordered by a physician
- Intermittent skilled services are required by a nurse, physical therapist, or speech language pathologist
- Face to Face encounter must be signed and dated by the ordering physician on or before the plan of treatment is signed.

Episode of care will continue to be 60 days.

Payment period: The payment period will be 30 days, with each episode of care divided into two payment periods. There will be a higher payment for the first 30-day period, and lower payments for subsequent periods.

- Although a new plan of treatment is not required for the second 30-day billing period, there may be a need for physician orders or additional documentation for any new/changed diagnosis for the second billing period, including documentation supporting any institutional stays during the 30-day payment period.

Diagnosis: Specificity of diagnosis is important for accurate payment, as CMS has eliminated most unspecified codes and symptom codes from the payment model.

- There may be requests for the diagnosis which is causing the symptom (such as abnormal gait or generalized weakness).
- Secondary diagnosis will need to be included in documentation, so the agency may request supporting documentation to establish proper payment. CMS will now include up to 25 diagnosis instead of the 6 that were previously considered for reimbursement calculations.

Physician Orders: Orders given to the agency during each 30-day payment period must be signed and dated by the physician prior to the home health submission of the claim to CMS.

Therapy Thresholds: The number of therapy visits will no longer be included in the payment grouping. Payment for therapy visits will be included in payment based on patient's functional limitations and diagnosis.

Institutional Stays: The agency will require accurate information regarding recent institutional admissions (including whether the patient was inpatient status or observation status, because observation status is not counted as an institutional admission for home health).

- Institutional admissions are those who had an acute or post-acute stay within the last 14 days. These will lead to higher reimbursement for the agency.
- Community admissions are those who had no acute or post-acute stay within the last 14 days. These will result in lower reimbursement for the agency.
- Patients admitted to a post-acute inpatient facility while on service with home health will now be discharged from home health and will require a new referral if home health is needed upon discharge from the facility. However, if they are admitted to acute care, their care can be placed on hold and resumed when they return home.