

Chapter 2

Revenue Cycle Operations

Intake and PDGM

In addition to changes in clinical operations, PDGM has changed how agencies operate within revenue cycle operations. Specifically, the areas of intake, document management and billing have been greatly impacted under PDGM. The accuracy, completeness and efficiency for each of these areas is paramount for agency success.

For intake, obtaining as much accurate information as possible at the time of referral is key for several reasons. It will:

1. Facilitate the accuracy and completeness of the coding of the patient.
2. Promote efficient billing. The identification of the correct physician completing necessary face-to-face requirements and physician signing orders is key in obtaining both billing requirements timely, which subsequently impacts timely billing.

For document management, the added importance under PDGM comes with the billing interval. Agencies bill in 30-day increments. This makes document management and specifically orders tracking much more important under PDGM to promote timely billing.

For billing, the volume of bills makes claim submission and A/R management more important to monitor and manage. Cash flow is also impacted under PDGM, with average claims being lower dollar, on average, than PPS claims.

Intake plays a key role

Intake takes on a crucial role under PDGM. Completeness and accuracy within the intake function impact several areas of revenue cycle operations. Below are the specific areas within PDGM that are impacted by intake.

- **Coding** — Complete and accurate coding has new meaning in PDGM due to its impact on two components with the HHRG — the Clinical Grouping and the Comorbidity Adjustment. Intake plays a role in coding by gathering as much information regarding patient history and reason for home care as possible. This information includes the history and physical, medication profile and physician narrative.
- **LUPAs** — The information gathered by intake and the clinician's completed OASIS will dictate what HIPPS code/HHRG is generated. That HIPPS/HHRG will subsequently determine the LUPA threshold for the 30-day period of care. If intake inaccurately completes the referral by not capturing the correct source or timing, it could result in the agency managing to the incorrect LUPA threshold.
- **Document management** — Obtaining signed physician orders and required face-to-face documentation is more important under PDGM with the billing timeframe reduced from every 60 days to every 30 days. The further the delay in obtaining signed orders, the longer the time to submit final claims and subsequent extended time to receive reimbursement. One of the keys to obtaining signed orders timely is correctly identifying which physician should be signing the orders from the start of care.
- **Revenue recognition** — Accurate identification of source and timing will impact the HHRG and subsequently Medicare revenue.
- **Billing** — The timing of billing could be impacted by intake. Not identifying the correct physician to sign orders could lead to delays in final claim billing. Additionally, incorrect identification of the correct source and timing would result in inaccurate expected reimbursement.

Community vs. institutional

One of the keys for success in PDGM within intake is education. One specific area that is important to educate intake staff is community versus institutional referral source. CMS includes **inpatient psychiatric facility (IPF)** stays in the institutional category for PDGM.

However, despite some stakeholders asking for **observation stays** to be considered institutional under PDGM, CMS has decided to keep those stays in the community admission category. CMS also believes **ambulatory surgery centers** don't meet the definition of institutional, nor does discharge from hospice care.

CMS has designated institutional admissions as 30-day periods for beneficiaries with any inpatient acute care hospitalizations, IPF stays, inpatient rehabilitation facility stays, skilled nursing facility stays, inpatient rehabilitation facility stays or long-term care hospital stays within the 14 days prior to a home health admission.

The category also includes patients who had an acute care hospital stay during a prior 30-day period of care and within 14 days prior to the subsequent, contiguous 30-day period of care and for which the patient wasn't discharged from home health and readmitted.

Questionable encounter codes

Intake staff also should be trained to gather more information about patients referred to home health with muscle weakness, abnormalities of gait, osteoarthritis and/or dysphagia.

Under PDGM failure to use a primary diagnosis code that fits into one of the 12 clinical groups could result in claims getting kicked back to providers.

If that happens, it also would mean payment delays and potential red flags for auditors. The red flags would come because if claims are sent back to the agency and then resubmitted with a new primary diagnosis code, it may appear to auditors that the agency isn't confirming the diagnoses with the physician but recoding to resubmit quickly.

M62.81 (Muscle weakness (generalized)), R26.89 (Other abnormalities of gait and mobility), M19.91 (Primary osteoarthritis, unspecified site) and R13.10 (Primary osteoarthritis, unspecified site) are among the 20 most common questionable encounter codes under PDGM, according to 2019 analysis from Strategic Healthcare Programs (SHP) in Santa Barbara, Calif.

To avoid these issues, take steps to identify which questionable encounter codes your agency uses and work to gather more detailed information that will lead to more specific, acceptable codes instead.

PDGM and intake Q&A

Below are answer to common questions about PDGM and intake answered by Sue Payne, vice president and chief clinical officer for The Corridor Group of Overland Park, Kan.

Q: Many patients at my agency have a primary diagnosis of M62.81 (Muscle weakness, generalized). Could you explain what intake should do with this?

A: Since that's not acceptable as a primary diagnosis under PDGM, that is a code that I would begin to address now. Your organization should try to minimize the use of muscle weakness as we know CMS doesn't like that it is a top code we are using in home health. At intake with these patients, you're trying to understand why the patients are having muscle weakness. That is going to require you reaching out to speak with the physician, trying to research more in the documentation so you can get a better handle on why the patient has muscle weakness.

Q: We have a number of patients with a primary diagnosis of unspecified abnormality of gait, which is an unacceptable primary diagnosis under PDGM. How can intake help us avoid this as a primary diagnosis?

A: Intake could say to the referral source, “Does the patient have any neuropathy? Does the patient have osteoarthritis or fractures? Is there anything you could share with me about the patient’s history that is leading her to have abnormality of gait?” Those are the types of questions that we are going to have to script and ask our intake staff and/or liaisons to be able to ask of referral sources.

Q: We’ve always had non-clinicians handle intake at our agency. Should we stop using those employees under PDGM?

A: No. I recommend you continue with utilizing non-clinicians in intake. You need to provide the right amount of training for them. That’s something you can do now by providing competency training on the face-to-face encounter review, sharing a sample tool with some examples of the types of codes that will be not acceptable, so they can begin to identify some of those and understand how and when to query. And don’t forget to connect them to the ‘why,’ Don’t just give them the task. Explain to them how important they are upstream in the process, how they make decisions that ultimately determine operations and billing outcomes downstream. Connecting the dots for your intake team is important. Do you want to add somebody clinical to intake if you don’t currently have a clinician on the team? Maybe. There’s an 80/20 rule or a 90/10 rule where the non-clinical staff can handle most of the review of the referral and determination when to query, but they get stuck on 10% to 20% of the review. Then they can rely on that clinical person to assist them during those times.

Q: When we’re hiring a new intake employee, what are some qualities we should look for that will help us under PDGM?

A: Their customer service ability. Someone who can ask a question — and it might be a hard question — but the person being asked feels comfortable with how they’re being asked. Intake should be able to avoid upsetting referral sources, which requires finesse. That was important with PPS, but it will be even more important with PDGM because of the increased need for querying. The other thing to look for is their attention to detail to be able to learn what would be a non-specific or symptom code and what might not be the best quality face-to-face encounter information. So you need someone that’s interested enough in the detail and that’s able to discern some of that through review of referral information. During the interview process, providing test questions or sample scenarios could be very helpful. And you are assessing these skills. Behavioral questions are also great as you identify the right team for intake.

Is intake staff getting the basics?

From meeting certification requirements to preventing missed visits, timely and efficient intake begins with the basics.

Intake staff must first be sure to get the correct name, address and phone number for the patient. An alternate number for a family member is also a good idea. Basic demographic information can save schedulers days on the phone trying to make contact. It can also prevent clinicians from wasting time and miles on multiple “drive-by” attempts to catch someone at home.

It’s also important to identify an emergency contact as well as if the patient has a representative. This information helps with care and discharge instruction and is required as part of the revised Home Health Conditions of Participation (CoPs) [§484.55(c)(6) and §484.55(c)(7)]. Documentation of any advanced directives is also required by CoPs, as is identifying the patient’s primary language. The primary language is also helpful in providing care.

Intake also should identify the referral source and episode timing identified. Both are essential for reimbursement under PDGM. Institutional sources may generate higher reimbursement, but historical data show they are also associated with higher resource use than community sources.