

Chapter 12

Section 9

Home Health Benefit Coverage And Reimbursement - Under The Patient-Driven Groupings Model (PDGM)

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1.0 APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network Home Health Agencies (HHAs) effective January 1, 2020. However, alternative network reimbursement methodologies are permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0 DESCRIPTION

Implementation of the PDGM under TRICARE's Home Health Agency Prospective Payment System (HHA PPS) for services beginning on or after January 1, 2020.

3.0 POLICY

3.1 Statutory Background

3.1.1 Under Title 10, United States Code (USC), Section 1079(i)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under the TRICARE program, "shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare." Section 701 of the National Defense Authorization Act for Fiscal Year 2007 (NDAA FY 2007) (Public Law 107-107) (December 28, 2001), added a new Section 10 USC 1074j, establishing a comprehensive, part-time or intermittent home health care benefit to be provided in the manner and under the conditions described in Section 1861(m) of the Social Security Act (SSA) (42 USC 1395x(m)).

3.1.2 In the Calendar Year (CY) 2019 HH PPS Rate Update final rule (CMS-1689-FC), the Centers for Medicare and Medicaid Services (CMS) finalized an alternative case-mix methodology now called the PDGM which includes the payment reform requirements mandated in section 51001 of the Bipartisan Budget Act of 2018 (BBA of 2018), for home health services beginning on or after January 1, 2020. This rule also finalized a change in the unit of payment from 60-day episodes of care to 30-day periods of care, and the elimination of therapy thresholds for use in determining home health payment, as required by section 51001 of the BBA of 2018. Based upon the statutory provisions in the paragraph

3.1.1, DHA adopts Medicare's benefit structure and PPS for reimbursing HHAs that are currently in effect under the Medicare program.

3.2 Reimbursement

3.2.1 Effective for periods of care on or after January 1, 2020, the original HHA PPS case-mix system is replaced with a new case-mix classification model known as PDGM. Under the PDGM, a case-mix adjusted payment for a 30 day period of care is made using one of 432 unique case-mix groups which are called Home Health Resources Groups (HHRGs). These HHRGs are represented as Health Insurance Prospective Payment System (HIPPS) codes. The PDGM assigns the 30-day period of care into one of 432 case-mix groups based upon the following five components:

- Timing: The first 30-day period of care is an early period of care. The second or later 30-day period of care is a late period of care;
- Admission Source: Admissions sources are either community or institutional. If the patient was referred to home health from the community or an acute or post-acute care referral source (inpatient, skilled nursing, inpatient rehabilitation facility, long term care hospital, inpatient psychiatric facility) in the 14 days prior to the HH admission;
- Clinical Group: The primary reason the patient requires home care, represented by 12 distinct clinical groups as determined by the principal diagnosis reported on the home health claim;
- Functional Impairment Level: The patient's functional impairment level is based upon eight Outcome and Assessment Information Sets (OASIS) items for activities of daily living, the 30-day period of care shall be put into one of three functional levels low, medium or high; and
- Comorbidity Adjustment: If the patient has certain comorbid conditions/secondary diagnoses reported on the home health claim, the 30-day period of care shall receive a no, low, or high comorbidity adjustment.

3.2.2 The new case-mix model, PDGM, for the HHA PPS shall apply to HHAs in all 50 states, District of Columbia, Puerto Rico, U.S. Virgin Islands, and Guam.

3.2.3 Reimbursement shall follow Medicare's methodology, and revenue code 023 shall continue to be present for all HHA PPS TRICARE Encounter Data (TEDs) in addition to all other revenue code information pertinent to the treatment. See the TRICARE Systems Manual (TSM), [Chapter 2, Addendum H](#) for a list of valid revenue codes. In addition, under the TRICARE HHA PPS all HH TEDs shall be coded with Special Rate Code **V** Medicare Reimbursement Rate or Special Rate Code **D** for a Discount Rate Agreement.

3.3 Composition Of HIPPS Codes Under The PDGM

3.3.1 The distinct five-position, alphanumeric HH HIPPS codes are created as follows:

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- First Position - A numeric value representing a combination of the referral source (community or institutional) and the period timing (early or late).
- Second and Third Positions - Represents the clinical and functional domains of the HHRG coding system.
- Fourth Position - Represents the co-morbidity category that applies to the patient.
- Fifth Position - A placeholder for future use, required only because the field used to report HIPPS codes requires five positions.

POSITION #1	POSITION #2	POSITION #3	POSITION #4	POSITION #5
SOURCE & TIMING	CLINICAL GROUP	FUNCTIONAL LEVEL	CO-MORBIDITY	PLACEHOLDER
1 - Community Early	A - Medial Management, Teaching and Assessment (MMTA) Other	A - Low	1 - None	1
2 - Institutional Late	B - Neuro Rehab	B - Medium	2 - Low	
3 - Community Late	C - Wounds	C - High	3 - High	
4 - Institutional Late	D - Complex Nursing Interv.			
	E - MS Rehab			
	F - Behavioral Health			
	G - MMTA Surgical Aftercare			
	H - MMTA Cardiac & Circulatory			
	I - MMTA Endocrine			
	J - MMTA GI/GU			
	K - MMTA Infectious Disease			
	L - MMTA Respiratory			

3.3.2 Using this structure, a second period for a patient with a hospital inpatient stay during the period (institutional late), in the Wounds group, high functional severity and no co-morbidity shall be coded **4CC11**. HIPPS codes shall continue to be reported with revenue code 0023.

3.4 Unit of Payment

3.4.1 The episode or period of care is the unit of payment for HHA PPS. The episode/period of care payment is specific to one individual homebound beneficiary. It shall pay all TRICARE covered home health services for the patient's care, including routine and non-routine supplies (NRS) used by that beneficiary during the episode/period of care, with the exception of those services described in Section 2. A beneficiary may be covered for an unlimited number of non-overlapping episodes or periods of care.

3.4.2 For episodes beginning before January 1, 2020, the duration of a single full-length episode is 60 days. Episodes may be shorter than 60 days. For home health services that start on or before December 31, 2019, and end on or after January 1, 2020, episodes that span into 2020, the payment of unit shall be the CY 2020 national, standardized 60-day episode payment amount, and shall be case-

mix adjusted using the CY 2019 HHA PPS case-mix weights as posted on the CMS HHA Center website at <https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html>.

- For such 60-day episodes, that are not classified as Low Utilization Payment Adjustment (LUPA) episodes, which span into CY 2020, the latest the 60-day episode payment amount shall cover is an episode ending on February 28, 2020. If there is a continued need for home health services at the end of the 60-day episode, any subsequent periods of care shall be reimbursed at the 30-day national, standardized payment amount, and adjusted using the appropriate CY PDGM case-mix weight.

3.4.3 For periods of care beginning on or after January 1, 2020, the duration of a period is 30 days. Periods of care may be shorter than 30 days. Effective for periods of care beginning on or after January 1, 2020, the payment of unit shall be the CY 2020 national, standardized 30-day payment amount.

3.4.4 Under the PDGM, there are no changes to the certification/recertification, completion of OASIS assessments, or updates to the patient's plan of care, all of which shall continue on a 60-day basis

3.5 Split Percentage Payments And Requests For Anticipated Payments (RAPs)

3.5.1 HHAs certified for participation in Medicare on or after January 1, 2019, shall be responsible for no longer submitting split-percentage or RAP payments. HHAs that are certified for participation in Medicare effective on or after January 1, 2019, shall still be required to submit a "no pay" RAP at the beginning of care to establish the home health period of care, as well as, every 30 days thereafter upon implementation of the PDGM.

3.5.2 Existing HHAs, meaning those that certified for participation in Medicare prior to January 1, 2019, shall continue to receive RAP payments upon implementation of the PDGM. For split percentage payments to be made, existing HHAs shall submit a RAP at the beginning of each 30-day period of care. For 30-day periods of care beginning on or after January 1, 2020, the upfront split percentage payment shall be 20 percent for each 30-day period. Additionally, contractors are not required to verify if the date the HHA certified for participation with Medicare was before or after January 1, 2019.

3.5.3 The percentage payment for the RAP shall be based upon the HIPPS code as submitted. Upon receipt of the corresponding claim, grouping to determine the HIPPS code used for final payment of the period of care shall occur at HHAs.

3.5.4 With the removal of RAP payments starting in CY 2021, the upfront split percentage payment shall be zero percent for 30-day periods of care beginning on or after January 1, 2021.

3.5.5 HHAs shall submit RAPs in accordance with the policies and instructions set forth in the CMS Internet-Only Manuals (IOM) Publication #100-04, Medicare Claims Processing Manual (CPM), Chapter 10, Section 40.1.

3.6 LUPA

3.6.1 For periods of care beginning on or after January 1, 2020, if an HHA provides fewer than the threshold of visits specified for the period's HHRG, they shall be paid a standardized per visit payment instead of a payment for a 30- day period of care. This payment adjustment is called a LUPA. Under PDGM each of the 432 case-mix groups has a visit threshold ranging from two to six visits to determine whether the period of care meets the LUPA threshold.

3.6.2 Under PDGM, if the LUPA threshold is met, the 30-day period of care shall be reimbursed at the full 30-day national, standardized payment amount listed in [Addendum C \(CY 2020\), Figure 12.C.2020-3](#). For periods of care that do not meet the LUPA visit threshold, reimbursement shall be at the appropriate CY per-visit payment amount. For example: If the LUPA visit threshold is three, and a period of care has two or less visits, it shall be classified as a LUPA and reimbursed at the per-visit amount. If the visit is three or more, then it shall not be classified as a LUPA and reimbursement shall be the full 30-day payment amount. Therefore, periods of care with one visit are considered LUPA claims, and also reimbursed at the per-visit payment amount.

3.6.3 The HH pricer software, which is used to process all HHA PPS claims and operates as a call module within the contractors' claims processing system, maintains national standard visit rate tables that shall be used in outlier and LUPA determinations. The contractors shall process and pay LUPA claims based upon the guidance and methodologies set forth in the Medicare CPM, Chapter 10 "Home Health Agency Billing".

3.7 Benefits And Condition Of Coverage

3.7.1 To qualify for home health benefits, a beneficiary must meet the following requirements:

- Be confined to the home;
- Under the care of a physician;
- Receiving services under a plan of care established and periodically reviewed by a physician; and
- Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or
- Have a continuing need for occupational therapy.

3.7.2 For HHA services to be covered, the individualized plan of care shall specify the services necessary to meet the patient-specific needs identified in the comprehensive assessment. In addition, the plan of care shall include the identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in the CMS IOM Publication # 100-02, Medicare Benefit Policy Manual, Chapter 7 "Home Health Services", that establish the need for such services. All care provided shall be in accordance with the plan of care.

3.7.3 All requirements outlined in [Sections 1](#) and [2](#) shall continue to apply to periods of care beginning on or after January 1, 2020.

3.8 Consolidated Billing

3.8.1 Section 1842 (b)(6)(F) of the Social Security Act requires Consolidated Billing (CB) of all Medicare home health services while a beneficiary is under a home health plan of care authorized by a physician. DHA will follow Medicare's policy and law concerning CB which requires that only the primary HHA overseeing the plan bills for services under the home health benefit, with the exception of DME and therapy services provided by physicians.

3.8.2 The contractors shall continue to follow all CB instructions described in [Section 2](#).

3.9 Preauthorization

The contractor's authorization process (including data entering screens) shall be used in designating primary provider status and maintaining and updating the episode information/history of each beneficiary. The managed care authorization system shall be used in lieu of Medicare's remote access inquiry system. All requirements outlined in Section 5 shall apply to periods of care beginning on or after January 1, 2020.

3.10 OASIS

3.10.1 HHAs shall still be responsible for the collection and encoding of OASIS data (OASIS is the clinical data set that currently shall be completed by HHAs for patient assessment), in accordance with [Section 3](#). This information provides a mechanism for objectively measuring facility performance and quality. It is also used to support the HHA PPS (i.e., generate the HIPPS code and claim-OASIS matching key output required on the CMS 1450 UB-04 claim form for pricing).

3.10.2 Since TRICARE contractors shall not have the capability to incorporate the HH Grouper logic (which uses OASIS data from the CMS quality data repository to assign a HIPPS code) into their claims processing system, HHAs shall continue to include the HIPPS code on claims by inputting OASIS data through a Grouper program in their billing software or in the CMS-provided Java-based Home Assessment Validation and Entry (jHAVEN) tool. The jHAVEN software package contains a Grouper module that generates a HIPPS code for a particular 60-day episode or 30-day period of care based upon the beneficiary's condition, functional status and expected resource consumption. Updated versions of this software package may be downloaded from the CMS web site at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HAVEN.html>.

3.11 Maternity And Children Under 18

3.11.1 The abbreviated assessment located in [Addendum B](#) shall be conducted for eligible TRICARE beneficiaries who are under the age of eighteen or receiving maternity care from a Medicare certified HHA. This shall require the manual completion and scoring of a HHRG Worksheet for pricing and payment under the PDGM. OASIS assessments are not required for authorized care in non-Medicare certified HHAs that qualify for corporate services provider status under TRICARE (e.g., those

HHAs specializing solely in the treatment of beneficiaries under the age of 18 or receiving maternity care).

3.11.2 If a Medicare-certified HHA is not available within the service area, the contractor may authorize care in a non-Medicare certified HHA that qualifies for corporate services provider status under the TRICARE Program (refer to the TRICARE Policy Manual (TPM), [Chapter 11, Section 12.1](#), for the specific qualifying criteria for granting corporate services provider status under the TRICARE Program.)

3.12 Medical Review Requirements

The contractors shall continue to use and adhere to the medical review requirements as outlined in [Section 8](#).

3.13 HHA PPS Claims With Inpatient Claim Types

3.13.1 Beneficiaries cannot be institutionalized and receive home health care simultaneously. The contractors shall reject an HHA claim, if it finds dates of service on the HH claim that falls within the dates of an inpatient, SNF or swing bed claim (not including the dates of admission and discharge and the dates of any leave of absence). The HHA shall submit a new claim removing any dates of service within the inpatient stay that were billed in error.

3.13.2 If the HHA claim is received first and the inpatient hospital, SNF or swing bed claim comes in later, but contains dates of service duplicating dates of service on the HHA claim, the contractors shall adjust the previously paid HHA claim to non-cover the duplicated dates of service.

3.14 NRS

Effective January 1, 2020, the NRS payment amounts apply to only those 60-day episodes that begin on or before December 31, 2019, but span the implementation of the PDGM and the 30-day unit of payment on January 1, 2020 (ending on February 28, 2020). Under the PDGM, NRS payments are included in the 30-day base payment rate.

3.15 Data And Pricer

3.15.1 The data elements required to submit a claim will no longer be updated in Chapter 12. With the exception of Corporate Service Providers (CSPs), the contractors shall reject an HHA claim that is missing any of the required data elements listed in the Medicare CPM, Chapter 10, Section 40.2. These claims shall be processed according to the rules described in Section 40.2.

3.15.2 All HHA claims shall run through the Medicare HH Pricer software and shall be reimbursed based upon calculations made by the Pricer which operates as a call module within contractors' systems, as is the current process. The HH Pricer makes all reimbursement calculations, including percentage payments on RAPs, claim payments for full Episodes or Periods of Care, and all payment adjustments, including LUPAs, Partial Episode Payment adjustments, significant change in condition adjustments, and outlier payments. Contractors' systems shall send an input record to the Pricer for all claims with covered visits, and the Pricer will send the output record back to the contractors' system.

3.15.3 The data, input/output record layout, and decision logic provided in [Section 7](#) will no longer be updated, beginning January 1, 2020. The contractors shall format the interface with the Medicare HH Pricer according to the record layout in the Medicare CPM, Chapter 10, Section 70.2, and shall ensure that RAPs and claims are calculated by the Pricer according to the logic described in Chapter 10, Sections 70.3 and 70.4 of the Medicare CPM.

3.15.4 Rate and weight information used by the Medicare HH Pricer is usually updated annually. Updates occur each January, to reflect the fact that HHA PPS rates are effective for a calendar year. Updates may also occur at other points in the year when required by CMS legislation and are published in the Federal Register. Listings of federal regulations and notices for fiscal years and calendar years are available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html>.

3.15.5 The contractors shall install the latest Medicare HH Pricer software from CMS' website: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/HH.html> and replace the existing HH Pricer with the updated HH Pricer within 10 calendar days of download. Contractors shall maintain the last version of the HH Pricer software for each prior fiscal year and the most recent quarterly release.

3.15.6 PDGM Case-Mix Weights and LUPA Thresholds are available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html>.

3.15.7 The current version of the OASIS data set is available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-Data-Sets.html>.

3.15.8 Information related to the use and maintenance of the HIPPS code set is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html>.

Note: CMS may periodically renumber or reorganize information within their CPM; contractors shall use the most up-to-date version and applicable chapters and sections of the CPM. DHA will update this chapter with the correct CPM chapter and section reference and web address as soon as practicable.

4.0 EFFECTIVE DATE

January 1, 2020, for reimbursement of home health services under the PDGM.

- END -