COMMONLY USED DIAGNOSES BUT
"UNACCEPTABLE" TO CMS MEDICARE

ICD10 CM Code	Description	
M62.81	**Muscle weakness (generalized)**	MOST COMMON
R29.6	**Repeated falls**	
R00.1	**Bradycardia unspecified**	
R26.0	**Ataxic gait**	
R25.1	**Paralytic gait**	
R26.2	**Difficulty walking not otherwise classified**	
R26.81	**Unsteadiness on feet**	
R26.89	**Other abnormalities of gait and mobility**	
R56.9	**Unspecified convulsions**	
Z91.81	**History of falls**	
C34.10	Malignant neoplasm of upper lobe, unspecified bronchus or lung	
C34.30	Malignant neoplasm of lower lobe, unspecified bronchus or lung	
C56.9	Malignant neoplasm of unspecified ovary	
C65.9	Malignant neoplasm of unspecified renal pelvis	
I69.30	Unspecified sequelae of cerebral infarction	
I70.239	Atherosclerosis of native arteries of right leg with ulceration of unspecified site	
I70.249	Atherosclerosis of native arteries of left leg with ulceration of unspecified site	
I25.2	Old myocardial infarction	
I95.9	Hypotension, unspecified	

For more information, please call:

888.842.4663

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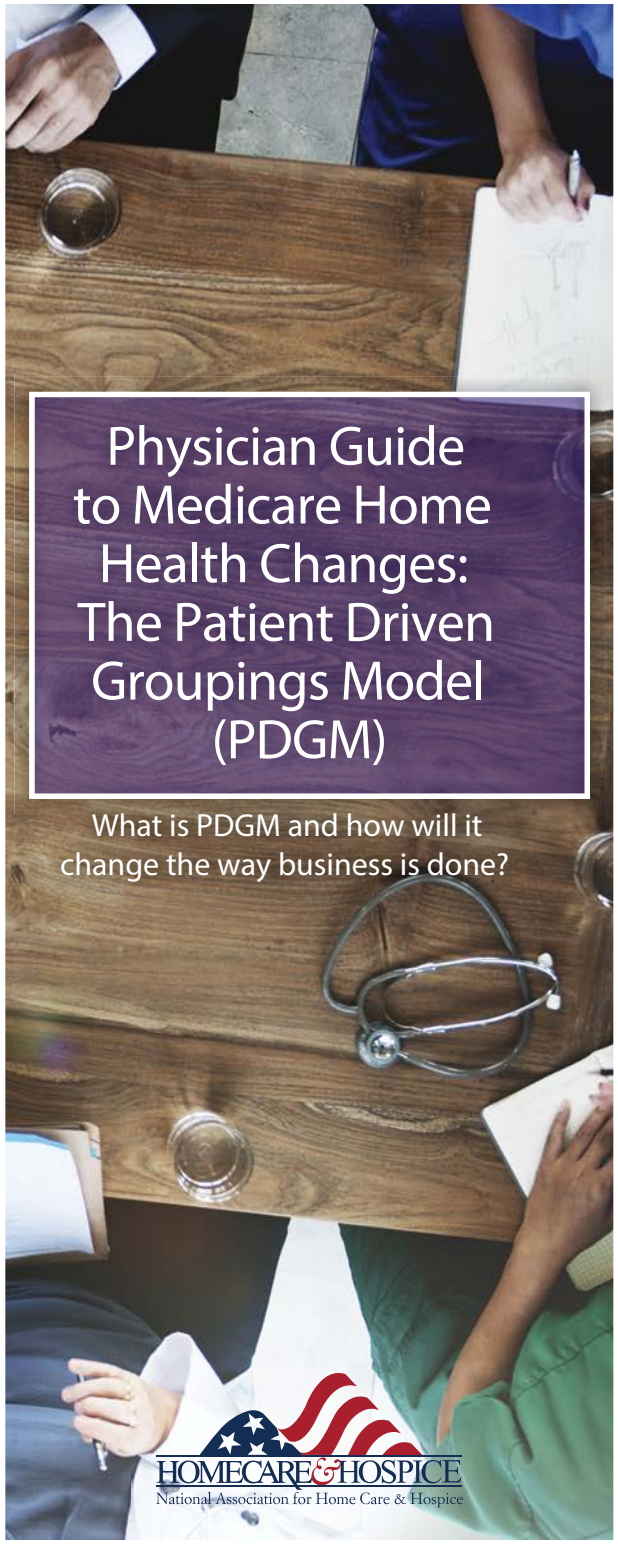

Physician Guide to Medicare Home Health Changes: The Patient Driven Groupings Model (PDGM)

What is PDGM and how will it change the way business is done?

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What is the PDGM?

The PDGM is a new payment model for Medicare-certified home health agencies. The billing cycle for home health agencies under PDGM will be for 30 day periods rather than 60 days. The model is a case mix model. Case mix groups are generated using variables from five general categories:

- Admission source
  - institutional – has had an inpatient stay within 14 days of admission to home health services
  - community – no inpatient stay within 14 days of admission to home health services
- Timing of the period – first in a series of 30 day periods = "early", or second and later 30 day periods = "late"
- Clinical grouping – based on the primary diagnosis from twelve diagnostic categories
- Functional grouping – based on certain assessment items from a standardized assessment tool that are further categorized as high, medium, or low
- Comorbidities – (secondary diagnoses) or a combination of diagnoses associated with high resource use. These are further categorized into none, high, or low

The combination of all these criteria yields 432 payment groups, as compared to 153 payment groups from the old model, making the model more complex but also more accurate in determining resource use. The amount of therapy a patient receives does not directly impact reimbursement and all services and supplies are bundled under a single payment for the 30 day period.

How will PDGM change your interactions with the home health agencies?

1. Home health agencies bill for the care they provide in 30 day units and must have all physician orders and certification completed and signed prior to submitting each claim.

   Agencies may be contacting your office more frequently and soon after admission in order to obtain any outstanding orders that require signature.

2. The PDGM model does not change the requirement for a face-to-face (F2F) encounter as part of the home health certification.

   Agencies may be contacting your office more frequently and soon after admission for a F2F encounter note that is related to the primary reason for home health services.

3. The model relies heavily on the billed diagnoses, and agencies will no longer be permitted to submit a claim if the primary diagnosis is what is referred to as an "unacceptable" diagnosis for home health services (see commonly used "unacceptable" diagnoses chart).

   RULES OF THUMB:
   - Codes ending in "9" are no longer accepted because they are unspecified codes.
   - Codes beginning with "R" are no longer accepted because they are symptom codes of an underlying diagnosis.

   Agencies may be contacting you with requests for additional information if a patient is referred to home health with an "unacceptable" primary diagnosis.

   Agencies will work with you to develop an acceptable diagnosis if the medical record supports a more appropriate diagnosis.

4. Under PDGM, CMS expects the agency to discharge a patient and readmit to home health whenever a patient is transferred to a post-acute care facility (i.e. skilled nursing facility, inpatient rehabilitation facility, long term care hospital, inpatient psychiatric facility). This could occur with a direct admission to post-acute care or a post-acute care stay after an acute care stay.

   The agency may contact your office to request a new plan of care and certification for home health services more frequently. The agency may be contacting you for new orders even if the plan of care has not changed.

For more information about the impact on physicians of the new home health PDGM model as well as other home health topics, please visit www.nahc.org . See the rotating announcements on the main page of the website.