

Does Your Home Health Agency Effectively Provide Wound Care with the Patient Driven Groupings Model (PDGM)?



How to Effectively Manage Wound Care and PDGM
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Home Health Agencies (HHAs) started 2020 with a significant change from the Home Health Prospective Payment System (HH PPS) to the Patient-Driven Groupings Model (PDGM). PDGM affects patients receiving home health services who have Medicare as their primary insurance. As PDGM approaches the six-month milestone following implementation, agencies have identified trends and areas of the payment model that have had an overall negative impact. Managing patients who require wound care continues to be challenging for HHAs. The challenges consist of determining appropriate wound treatments, medical supplies, visit utilization, and clinician efficiency while producing a viable profit margin. The objective of this white paper is to provide a general overview of PDGM and the best practices for managing PDGM with a focus on wound care.

PDGM changes the unit of payment from 60-day episodes of care to 30-day periods of care and eliminates the therapy thresholds used in determining home health payment. The previous HH PPS payment model utilized 153 case-mix adjusted Home Health Resource Group (HHRG) payments for a 60-day episode payment based on severity levels. PDGM consists of 432 case-mix adjusted HHRG payments for a 30-day period based on five groups. Thirty-six of the 432 case-mix adjusted HHRG payments consist of wound clinical groups. The wound clinical groups pay a high pay rate for each 30-day period of care. Therefore, PDGM reimbursements favor HHAs who can efficiently manage wound care cases.

The five groups that determine one of the 432 case-mix adjusted groups for a 30-day period are:

- Admission Source (Institutional or Community)
- Timing (Early/Late)
- Clinical Grouping (Principal Diagnosis on Claim)
- Functional Impairment Level (OASIS items)
- Comorbidity Adjustment (Secondary Diagnoses on Claim)

The admission source had no impact on payment implications with the previous payment model. The admission source with PDGM has two categories: institutional or community. A payment period is an institutional category when a patient has had a stay in an acute care hospital, skilled nursing facility, inpatient rehab facility, long-term acute care hospital, or inpatient psychiatric facility within the last 14 days prior to the patient's admission to home health. A community category occurs from any other referral source besides what is in an institutional category. PDGM payment is consistently lower when a period of payment is a community category. HHAs have been focusing on developing relationships with referral sources that are in the institutional category due to the increased associated payment.

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"A consistent trend of patients requiring home health are those who were in an institutional setting due to requiring wound care."

The timing group consists of two levels: early or late. A payment period is early only for the initial admission 30-day payment period. All subsequent payment periods after the 30-day payment period are categorized as late. Reimbursement decreases significantly when a patient transitions to a late episode, which is all 30-day payment periods following the initial 30-day payment period. Data from the first quarter of PDGM displayed a large number of claims categorized as institutional – early. However, this is largely due to the implementation of PDGM in Q1. The second quarter through the end of 2020 will provide more relevant data related to each group that comprises the case-mix.

Under PDGM, agencies can document up to twenty diagnosis codes, which is a significant change from the previous payment model that only recognized six diagnosis codes. Since the implementation of PDGM, higher volumes of diagnosis codes are appearing on claims. This creates a clearer picture of the patient's medical history that is relevant to the home health plan of care. It increases the interdisciplinary team's ability to provide a plan of care that is achievable and specifically meets the patient's individual goals. The ability to document additional diagnosis codes could trigger either a low or high comorbidity adjustment, which increases the case-mix. It is considerably important for agencies to capture all pertinent diagnoses due to the impact it has on the overall case-mix and developing an appropriate, individualized plan of care.

One of the five groups that affects the reimbursement for each home health 30-day pay period is the Clinical Grouping. The Clinical Grouping has twelve clinical categories utilized per the patient's primary diagnosis.

PDGM 30-Day Period of Care Clinical Groupings:

- MMTA Other (Medication Management, Teaching, and Assessment)
- Neuro Rehab (Neuro/Stroke Rehabilitation)
- Wounds
- Complex Nursing Intervention
- MS Rehab (Musculoskeletal Rehabilitation)
- Behavioral Health
- MMTA Surgical Aftercare (Medication Management, Teaching, and Assessment - Surgical Aftercare)
- MMTA Cardiac and Circulatory (Medication Management, Teaching, and Assessment - Cardiac and Circulatory)
- MMTA Endocrine (Medication Management, Teaching, and Assessment - Endocrine)
- MMTA GI/GU (Medication Management, Teaching, and Assessment - Gastrointestinal Tract and Genitourinary System)
- MMTA Infectious Disease (Medication Management, Teaching, and Assessment - Infectious Disease)
- MMTA Respiratory (Medication Management, Teaching, and Assessment - Respiratory)

"Per CMS data, the Wound Clinical Grouping is one of the highest paid categories of the twelve Clinical Groupings."

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Shortly after the implementation of PDGM, home health providers had to change their focus from learning how to manage PDGM to the COVID-19 pandemic. As more data is available on PDGM, Home Health Agencies are now voicing their challenges with the new Medicare payment model. One of the biggest challenges is visit utilization. Wounds is one of the twelve Clinical Groupings that is causing a significant challenge for home health providers to appropriately manage visit utilization, while continuing to produce high quality outcomes that reflect a viable profit margin. Wounds can be challenging to manage and cause Home Health Agencies to endure a significant amount of cost in an industry that already produces low profit margins.

What are the best practices for managing a patient who requires home health services for a wound(s)?

Performing case conferences with the home health interdisciplinary team is a best practice for managing patients who are high acuity, at risk for hospitalization, or have a complex diagnosis, such as wounds. Case conferences will promote interdisciplinary team care coordination and collaboration, ongoing updates to the plan of care, and ensure appropriate frequency and duration. There must be documentation of the case conference in each individual patient record to demonstrate that the communication and collaboration has occurred.

Visit utilization has been a challenge with PDGM. HHAs have been developing processes to increase the quality of care provided during each home health visit, instead of centering visits on quantity. The previous payment model incentivized agencies based on the quantity of therapy visits provided. The number of therapy visits utilized to reach a therapy threshold for HH PPS payment model is not relevant to PDGM. The quantity of visits provided during a 30-day period with PDGM has no effect on the case-mix. Therefore, no increased payment. Due to the COVID-19 Pandemic, CMS has released the COVID-19 Emergency Blanket Waivers for Health Care Providers. One of the waivers approved by CMS is usage of telehealth visits for home health. However, HHAs are unable to bill telehealth visits on the claim. The telehealth visits will not count towards achieving the Low Utilization Payment Assessment (LUPA) Threshold. Utilization of telehealth visits is to occur, when appropriate, to supplement in-person visits.

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Home health telehealth visits are beneficial for the following reasons:

- Education on safety in the home and community.
- Medication safety and review of medication schedule.
- Disease process education and teaching for new or exacerbated conditions.
- Observation of functional status.
- To determine if an additional in-person visit would be a beneficial add-on to the current plan of care.

How does an HHA provide high-quality, cost-effective wound care?

Patients who have a wound diagnosis are generally challenging to treat and require, on average, 12- 14 visits per 30-day payment period. Wound care patients require a substantial number of visits, have a long length of stay, and are a significant cost to the HHA. Developing a partnership with reputable wound care physicians has multiple benefits to the patients, caregivers, clinical team, and the HHA. Vohra Wound Physicians is a specialty wound care company that provides virtual and in-person wound care consultations for the post-acute care settings, including home health. Vohra Wound Physicians utilizes user-friendly technology when providing virtual consults that is used by patients, caregivers, and clinicians.

Benefits for HHAs who collaborate with Vohra Wound Physicians:

- Eliminate transportation challenges, safety risks, and the potential exposure to COVID-19 that occurs when a patient leaves their place of residence for physician and wound clinic visits.
- Increase quality of care and clinical outcomes for wounds.
- Appropriately decrease home health length of stay, while achieving high quality outcomes.
- Decrease the cost of non-routine medical supplies.
- Increase revenue due to providing innovative and efficient care, while decreasing unwarranted clinician visits.
- Ability to accept complex patients with chronic wounds and efficiently manage these wounds within a single 30-day episode.
- Increase referrals by marketing proven wound care treatments that produce high-quality clinical outcomes.
- Decrease overall agency cost per 30-day period with PDGM, which translates into increased profit margins.
- Access to wound care education, certifications, and resources for home health clinical leadership and clinicians.
- Utilize Vohra's Wound Care App with Wound Healing Predictor.



There is no cost to an HHA when collaborating with Vohra Wound Physicians for virtual consultations or in-person visits. Vohra's specialists are a proven* benefit to a patient's wound care. Vohra focuses on quality communication and collaboration to achieve the goals of the patients, caregivers, and HHA.

Vohra Wound Physicians is the nation's most trusted wound care solution. Founded in 2000, the company works with nearly 3,000 skilled nursing facilities, educates thousands of medical professionals each year, and uses proven, proprietary technologies to provide superior wound healing to patients at healthcare facilities and their homes. Vohra's committed physicians, long-standing partnerships, innovative technologies and relentless dedication to improving outcomes position them to continue to serve more patients every day.

**To find out how your HHA can collaborate with Vohra Wound Physicians,
contact us at (205) 891-2716 or visit our website at
<https://vohrawoundcare.com/>.**

** According to the Lewin Group Study on Vohra Wound Outcomes by the Ostomy Wound Management Journal, Vohra decreased wound-related hospitalizations by 88%, decreased wound healing times by an average of 21 days, and saved Medicare more than \$19,000 per patient.*