MatrixCare by ResMed

PDGM FAQ

PDGM 101: Answering your frequently asked questions

What is MatrixCare doing for PDGM?

- Since the new grouping model was initially proposed in 2017 as a rewrite to the current PPS episodic model, the entire MatrixCare Home Care product group has been studying the changes.
- PDGM was finalized for implementation in 2020 as part of the Home Health Final Rule for 2019 which was released on October 26, 2018.
- There are significant changes agencies will need to make to clinical, financial and operational workflows to be ready for the Jan. 1, 2020 implementation deadline.
- Our team is focusing on the impact of current behavior as it relates to PDGM and OASIS coding. We have also been studying the claims data to better understand the impact of the new rule.
- We have a PDGM customer panel that meets weekly to discuss the organizational and operational changes, and we're taking their feedback as we make changes to our software.
- When CMS releases it's beta grouper in July, we'll implement it and have our PDGM Panel customers test the new operational, clinical, billing, and financial processes. Our PDGM panel customers will test the new operational, clinical, billing and financial processes of the CMS grouper.

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How can MatrixCare help with Admission Source & Timing updates?

- Our system allows intake staff to determine and record whether the patient is admitted from an institution or community.
- Our eReferral process helps you get to the institutional referrals first and makes it easier for your referral sources to send you the patient instead of a competitor provider.
- Automatic Insurance Eligibility Verification within the intake workflow confirms payer information, shows any prior home health episodes and any current certification periods (if another agency has already admitted them).
- Our system will also flow the admission source through to M1000 on the start of care assessment.
- If the intake staff determined that the patient is an institutional admission, our solution automatically adds the appropriate occurrence codes on the final claim to ensure higher levels of reimbursement for you.
- Access to CommonWell in MatrixCare's core software allows visibility into whether a referral has institutional stays within the prior 14 days. Keep in mind that a community referral may have been institutionalized, discharged home and now needs care. Just because the patient didn't come from a hospital referral source doesn't mean they didn't have an institutional stay in the last 14 days; therefore, this full view of the patient's care path is extremely beneficial.

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How can our system help with clinical groupings & diagnoses?

- Our system can flag the principal ICD-10 code if it doesn't map to one of the 12 clinical groupings. This should help agencies avoid periods that don't have the primary diagnosis required to generate a HIPPS code.
- Includes up to 25 diagnoses on the final claim since CMS will validate the diagnoses from the final claim instead of the OASIS.
- Through CommonWell in MatrixCare's core software, organizations are able to see patient history from other channels of care, as it may impact coding of comorbidities.

How will you estimate the reimbursement amount under PDGM?

- We use an internal tool to simulate the CMS Payment Grouper called PPS to PDGM Comparison.
- We display information for the two 30-day payment periods and compare this to what was paid under PPS to show the net change in easy-to-understand colors; red for negative change, green for a positive change.
- The PPS to PDGM Comparison calculator information is available to coders as part of the QA workflow.

How will you help us manage LUPAs?

- We know the LUPA threshold amount for each 30-day period and will display this on the patient calendar.
- We'll schedule alerts that help manage the LUPAs within each 30-day period.

What will change with claim processing?

- We generate the no-pay RAP for new agencies certified after Jan. 1, 2019.
- We add rules to ensure proper sequencing of the RAP and final claim generation and submission within each 30-day payment period.
- Our solution automatically places occurrence code 61 and 62 on the claim when applicable.
- Built-in checks and balances to support the Occurance Code 50 is required on all final claims.

How can we manage our clinical documentation?

- In an effort to help our agencies get their clinical documentation (Plan of Care; Supplemental Orders; F2F) returned in the timeliest fashion possible, we're integrated with Forcura's document tracking system.

What if we use an OASIS Scrubber vendor?

- We continue to work closely with the OASIS analysis tools for those providers who use them for coding assistance: HEALTHCAREfirst, SHP, etc.

What will change with financial reporting and accounting?

- Updates to the revenue recognition method include the current 1/60th method will change to the 1/30th method.
- Updates to financial reports.
- Updates to deferred revenue.

How will you help with clinical documentation?

- Good clinical content drives consistency in care and outcomes and guides nurses through complex care situations.
- You'll easily see the 30-day periods on the patient calendar.

What happens if Medicare Advantage Plans continue to use the PPS episodic model?

- We continue to support PPS Episodic payments for Medicare Advantage Plans that don't adopt PDGM.
- We provide a flexible way to adjust Medicare Advantage Plans to work for PDGM.

How can interoperability benefit me in this new PDGM era?

- Automate the referral process and avoid common errors, saving you time and money in the long run.
- Streamline documentation, especially since PDGM is requiring such an increase and at a more granular level, taking into account comorbidities, functional levels, clinical groupings, and admission sources.
- Increase your institutional referrals through interoperability.

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Get in touch: Do you have a question?
Send us an email at **info@matrixcare.com**
or contact us at **1-866-469-3766.**