Top PDGM Myths

- Busting the myths of today and tomorrow--With CMS guidance!

HCAF 2026 HomeCareCon

McBee and Provider Insights, Inc

Presenters

Lisa Selman-Holman and Annette Lee

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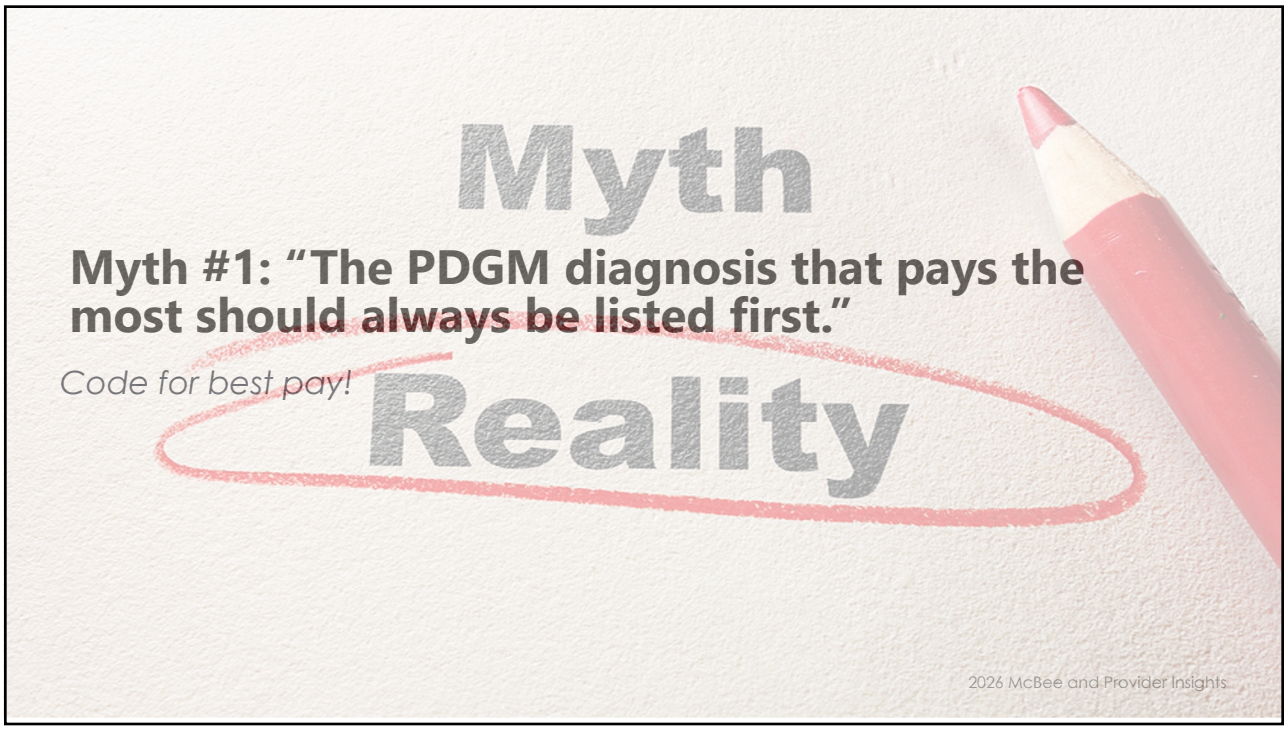

Reality (CMS Guidance):
The **primary diagnosis must reflect the chief reason for home health care**, not reimbursement optimization. CMS explicitly warns against diagnosis sequencing based on payment.

Busted by:

- Medicare Benefit Policy Manual (Ch. 7, §30.2.3)
- Official Coding Guidelines (etiology/manifestation rules still apply)

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Unintentional Consequences

The wound is the primary reason for care and is coded primary. The wound heals on day 25 and no change in primary diagnosis is made to the claim for the second 30 days.

Fact: The claim should reflect the care provided.

"**Clinical Group—As determined by the principal diagnosis reported on home health claims; 30-day periods are assigned to one of 12 clinical groups describing the *primary reason for the home health encounter*.**"

Myth #2: "Functional scoring is 'subjective' and won't be audited."

A tale of an overzealous QA team and audit…

Reality:
CMS uses **claims, OASIS, and medical review data** to recalibrate PDGM functional levels and case-mix weights *every year*. Functional data is absolutely monitored.

Busted by:
- CY Final Rules (ongoing recalibration language)
- HH QRP/OASIS validation audits

✅ Perfect setup for FY 2026 functional level shifts.

This is how bad data becomes bad policy!
California provider audited per NGS for having "High functional" points in the 80th percentile per their PEPPER!

CMS' policy is to *annually recalibrate* the case-mix weights and LUPA thresholds using the most complete utilization data available… [including] the *functional levels* and comorbidity adjustment subgroups."

Final 2026 rule

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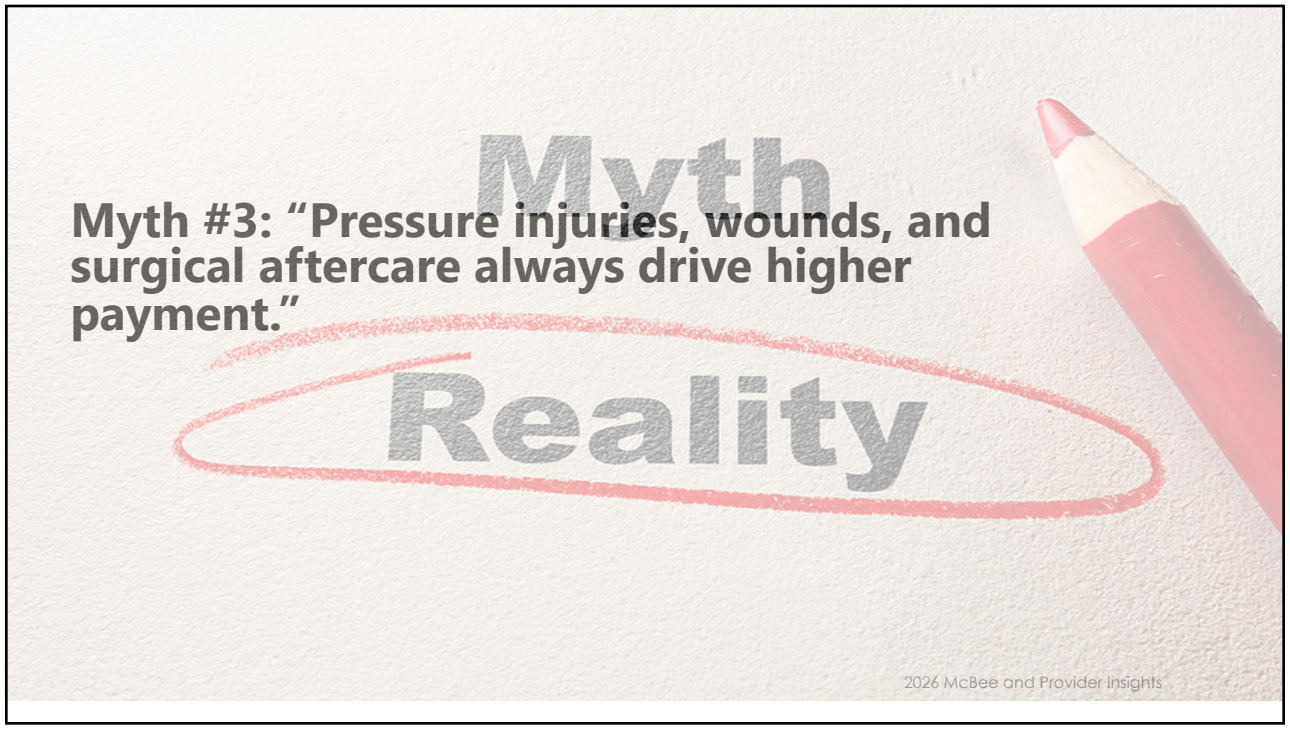


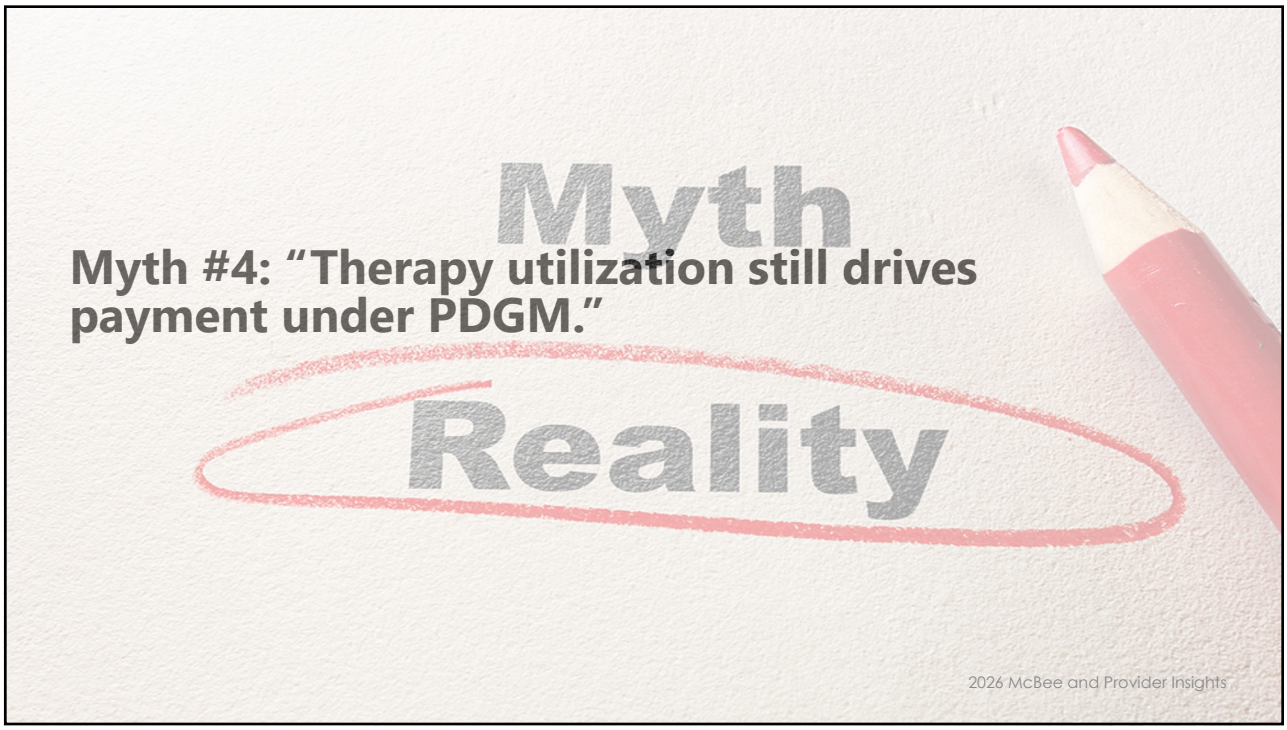
Reality:
Only **specific codes, groupings, and severity combinations** increase case-mix weight. Many commonly used wound codes fall into **lower-paying clinical groups** or are not part of the grouper.

Busted by:

- PDGM Grouper logic
- CMS case-mix weight tables

Final CY 2026 (with comparisons) Clinical Group Threshold

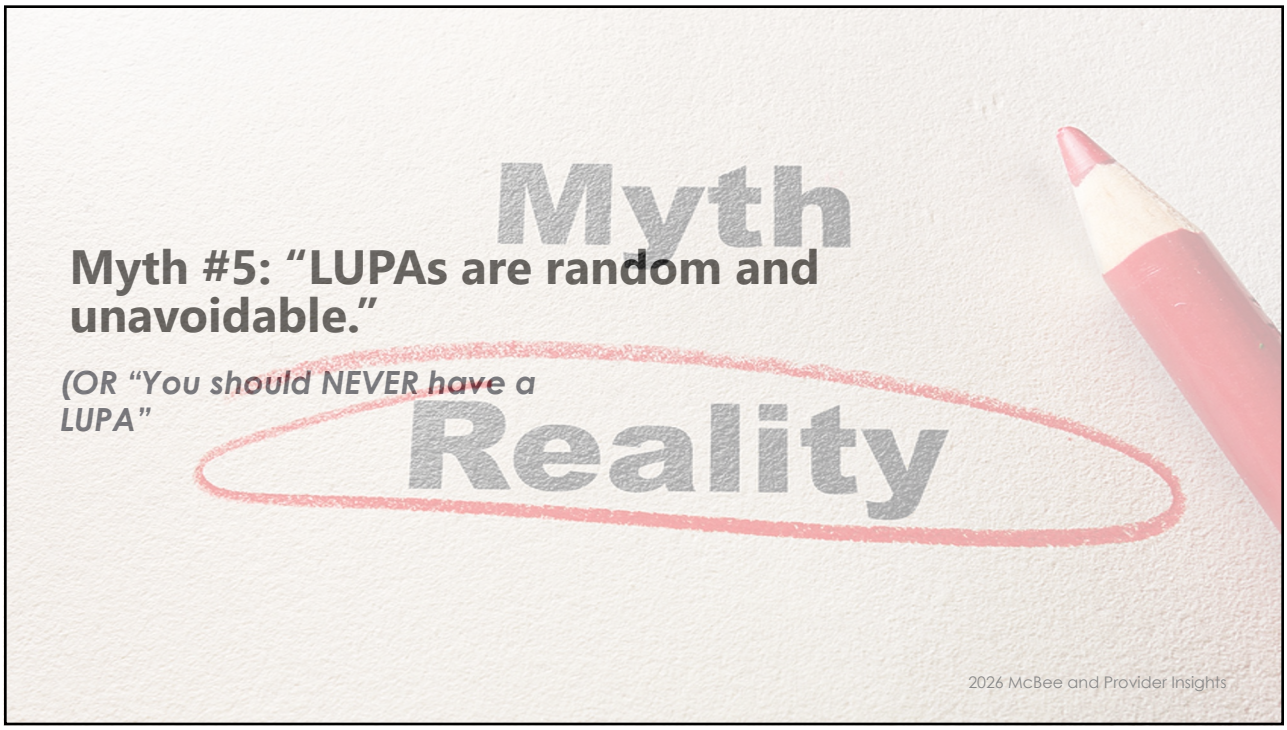
Clinical Group	Low 2025	Low 2026	Med 2025	Med 2026	Diff	High 2025	High 2026	Diff
MS Rehab	0-29	0-31	30-43	32-45	+2	44+	46+	+2
Neuro Rehab	0-33	0-34	34-49	35-52	+1	50+	53+	+3
Wound	0-32	0-33	33-48	34-52	+1	49+	53+	+4
Complex Nursing	0-29	0-31	30-52	32-54	+2	53+	55+	+2
Behavioral Health	0-28	0-31	29-44	32-46	+3	45+	47+	+2
MMTA Aftercare	0-27	0-30	28-40	31-42	+3	41+	43+	+2
MMTA Cardiac	0-27	0-28	28-40	29-43	+1	41+	44+	+3
MMTA Endocrine	0-27	0-27	28-40	28-41	+0	41+	42+	+1
MMTA GI/GU	0-32	0-34	33-47	35-48	+2	48+	49+	+1
MMTA Infection	0-31	0-32	32-44	33-46	+1	45+	47+	+2
MMTA Respiratory	0-32	0-33	33-44	34-46	+1	45+	47+	+2
MMTA Other	0-28	0-30	29-43	31-45	+2	44+	46+	+2



Reality:
PDGM is **not visit- or therapy-driven**. Overutilization creates **margin erosion**, not higher reimbursement, and may trigger medical review concerns.

Busted by:

- PDGM statutory design language
- CMS repeated clarifications post-2020



Reality:
CMS adjusts **LUPA thresholds annually** based on national utilization patterns. Many LUPAs are **predictable and preventable** with front-end planning.

Busted by:

- Annual Final Rule LUPA recalibration
- PDGM national claims data methodology

Example

Add'l PpE Revenue	Add'l Recert Revenue	Add'l LUPA Revenue	Add'l Revenue Opportunity	% Revenue Opportunity
$96,087	$517,396	$78,398	$691,881	16.61%

2025 Data

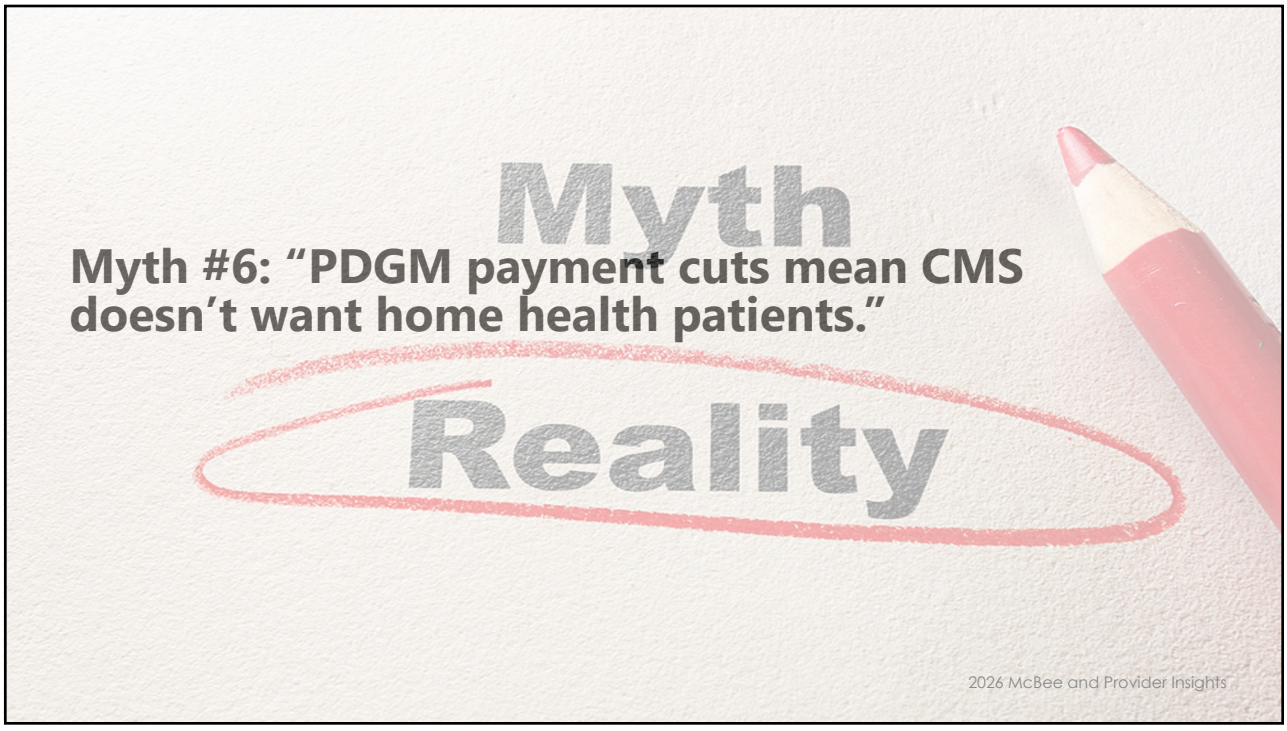
Periods per Episode	1.64
Revenue per Period	$2,330
Revenue per Episode	$3,825
Visits per Period	7.98
Visits per Episode	13.10
Percent Early Periods	38.48%
Average Early Case Mix	1.27
Average Case Mix	1.04
LUPA Rate	8.95%
Percent Outliers	9.17%
Percent Functional Low	44.35%
Percent Functional Medium	27.09%
Percent Functional High	28.56%
Average Wage Index	1.24
Recert Rate	25.53%
Total Revenue 2025	$4,165,836

2026 Data

Periods per Episode	1.64
Revenue per Period	$2,324
Revenue Per Episode	$3,815
Visits per Period	7.98
Visits per Episode	13.10
Percent Early Periods	38.48%
Average Early Case Mix	1.26
Average Case Mix	1.05
LUPA Rate	8.84%
Percent Outliers	9.68%
Percent Functional Low	44.36%
Percent Functional Medium	27.12%
Percent Functional High	28.53%
Average Wage Index	1.23
Recert Rate	25.53%
Total Revenue 2026	$4,154,803

2026 National Data

Periods per Episode	1.68
Revenue per Period	$2,061
Revenue Per Episode	$3,466
Visits per Period	8.01
Visits per Episode	13.47
Percent Early Periods	31.24%
Average Early Case Mix	1.19
Average Case Mix	0.96
LUPA Rate	6.58%
Percent Outliers	8.02%
Percent Functional Low	30.32%
Percent Functional Medium	31.70%
Percent Functional High	37.98%
Average Wage Index	0.99
Recert Rate	38.18%
Total Revenue 2026	$17,754,520,566



Reality:
CMS has repeatedly stated PDGM adjustments are aimed at **budget neutrality** and correcting **behavioral assumptions**, *not denying care*. Coverage criteria have not changed.
Busted by:
•Final Rules (behavioral adjustment narrative)
•Coverage criteria in Ch. 7 remain intact

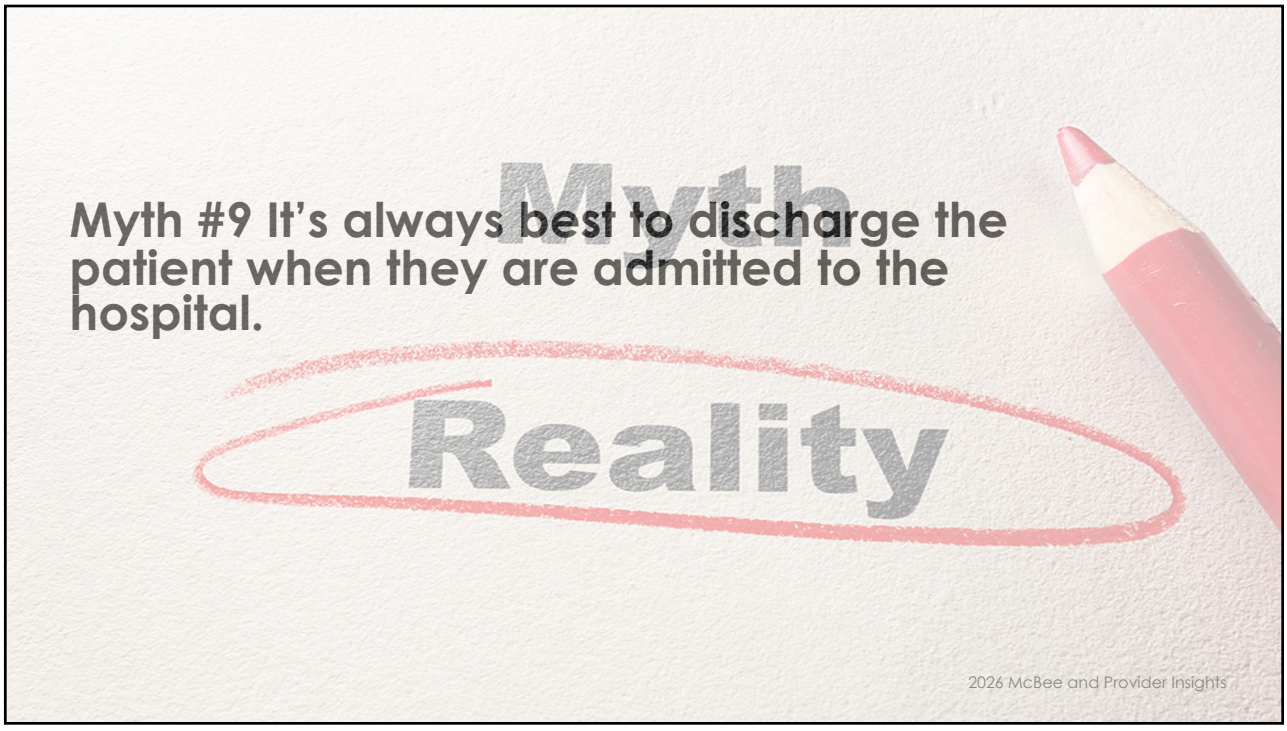
Reality:
Only **certain combinations** qualify, and many diagnoses agencies assume are "high value" no longer produce additional case-mix weight — especially after recalibration.

Busted by:
- PDGM comorbidity subgroup tables
- Annual CMS recalibration methodology

✅ Strong segue to FY 2026 PDGM Grouper updates.

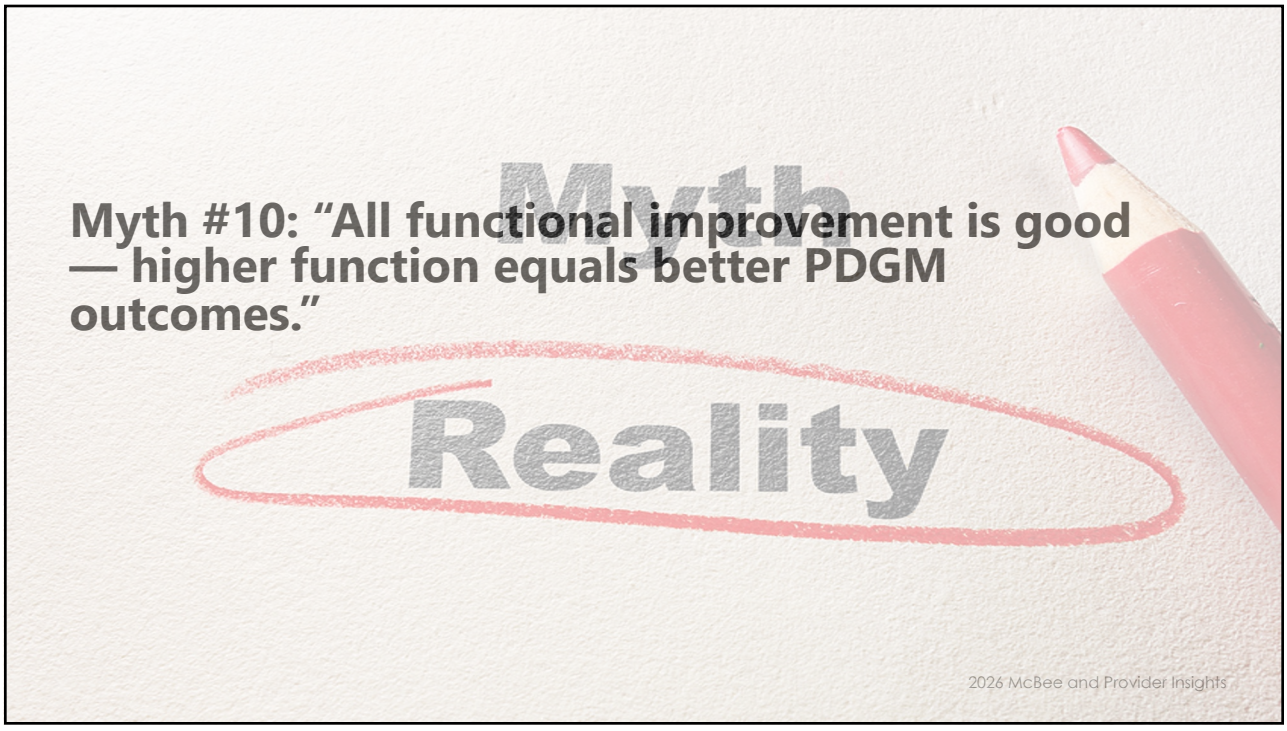
Reality:
PDGM pays by **30-day payment periods**, not per visit or per episode. Premature discharges increase exposure to **partial payment adjustments (PPAs)**, lost value in planned care, and increased rehospitalization risk.

Busted by:
- PDGM payment structure guidance (PEP)
- PPS claims processing rules



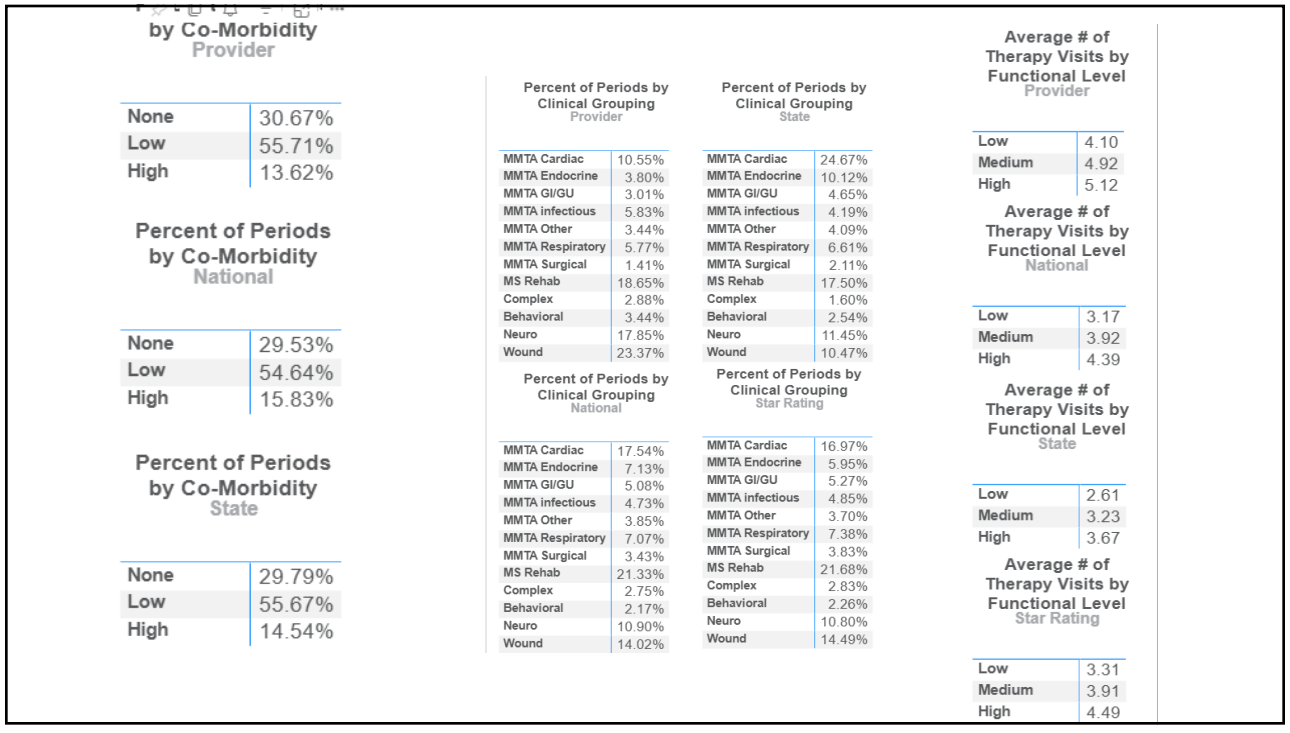
Reality:
CMS encourages a ROC and this is allowed (clarified in the October 2019 Q&As right before PDGM went into effect- and consistent ever since) even when the patient goes into a PAC stay
The HHA MUST do a new SOC if the inpatient stay bridged into another 60-day certification period
-- Let's discuss: Impact of institutional payment (hospital vs PAC prior to SOC and during care) and the PEP risks

Busted by:
- PDGM payment structure guidance (PEP)
- PPS claims processing rules



Reality:
Improved function may benefit **quality outcomes**, but **functional scoring directly affects case-mix weight**. Inaccurate or unsupported scoring — either too high *or too low* — creates **compliance risk** and case-mix distortion.

Busted by:
- PDGM functional impairment methodology
- HH QRP OASIS accuracy standards



by Co-Morbidity
Provider

None	30.67%
Low	55.71%
High	13.62%

Percent of Periods by Co-Morbidity
National

None	29.53%
Low	54.64%
High	15.83%

Percent of Periods by Co-Morbidity
State

None	29.79%
Low	55.67%
High	14.54%

Percent of Periods by Clinical Grouping
Provider

MMTA Cardiac	10.55%
MMTA Endocrine	3.80%
MMTA GI/GU	3.01%
MMTA infectious	5.83%
MMTA Other	3.44%
MMTA Respiratory	5.77%
MMTA Surgical	1.41%
MS Rehab	18.65%
Complex	2.88%
Behavioral	3.44%
Neuro	17.85%
Wound	23.37%

Percent of Periods by Clinical Grouping
State

MMTA Cardiac	24.67%
MMTA Endocrine	10.12%
MMTA GI/GU	4.65%
MMTA infectious	4.19%
MMTA Other	4.09%
MMTA Respiratory	6.61%
MMTA Surgical	2.11%
MS Rehab	17.50%
Complex	1.60%
Behavioral	2.54%
Neuro	11.45%
Wound	10.47%

Percent of Periods by Clinical Grouping
National

MMTA Cardiac	17.54%
MMTA Endocrine	7.13%
MMTA GI/GU	5.08%
MMTA infectious	4.73%
MMTA Other	3.85%
MMTA Respiratory	7.07%
MMTA Surgical	3.43%
MS Rehab	21.33%
Complex	2.75%
Behavioral	2.17%
Neuro	10.90%
Wound	14.02%

Percent of Periods by Clinical Grouping
Star Rating

MMTA Cardiac	16.97%
MMTA Endocrine	5.95%
MMTA GI/GU	5.27%
MMTA infectious	4.85%
MMTA Other	3.70%
MMTA Respiratory	7.38%
MMTA Surgical	3.83%
MS Rehab	21.68%
Complex	2.83%
Behavioral	2.26%
Neuro	10.80%
Wound	14.49%

Average # of Therapy Visits by Functional Level
Provider

Low	4.10
Medium	4.92
High	5.12

Average # of Therapy Visits by Functional Level
National

Low	3.17
Medium	3.92
High	4.39

Average # of Therapy Visits by Functional Level
State

Low	2.61
Medium	3.23
High	3.67

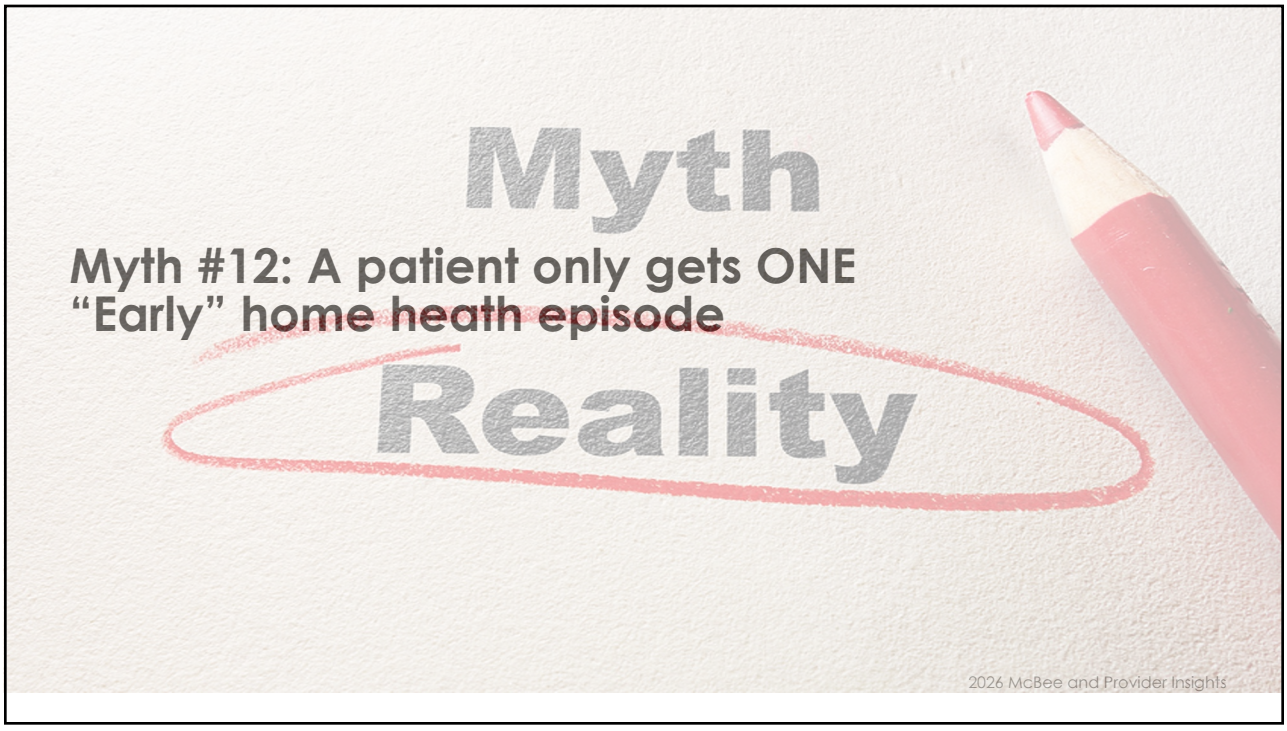
Average # of Therapy Visits by Functional Level
Star Rating

Low	3.31
Medium	3.91
High	4.49

	Low	Medium	High
MMTA Cardiac	$ 2,006.31	$ 2,205.49	$ 2,423.78
MMTA Endocrine	$ 2,607.43	$ 2,697.06	$ 2,860.06
MMTA GI/GU	$ 1,994.02	$ 2,207.02	$ 2,423.78
MMTA Infectious	$ 2,043.09	$ 2,226.53	$ 2,530.84
MMTA Other	$ 2,042.08	$ 2,222.20	$ 2,423.94
MMTA Respiratory	$ 2,025.67	$ 2,234.23	$ 2,446.92
MMTA Surgical Aftercare	$ 2,024.75	$ 2,240.55	$ 2,517.68
Behavioral Health	$ 1,948.61	$ 2,218.33	$ 2,379.76
Complex	$ 2,001.53	$ 2,291.96	$ 2,224.65
MS Rehab	$ 2,094.71	$ 2,269.85	$ 2,541.90
Neuro	$ 2,279.07	$ 2,484.46	$ 2,779.55
Wound	$ 2,903.33	$ 3,066.35	$ 3,342.10
	$ 2,164.22	$ 2,363.67	$ 2,574.58

CMS Claims Processing Manual

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c10.pdf



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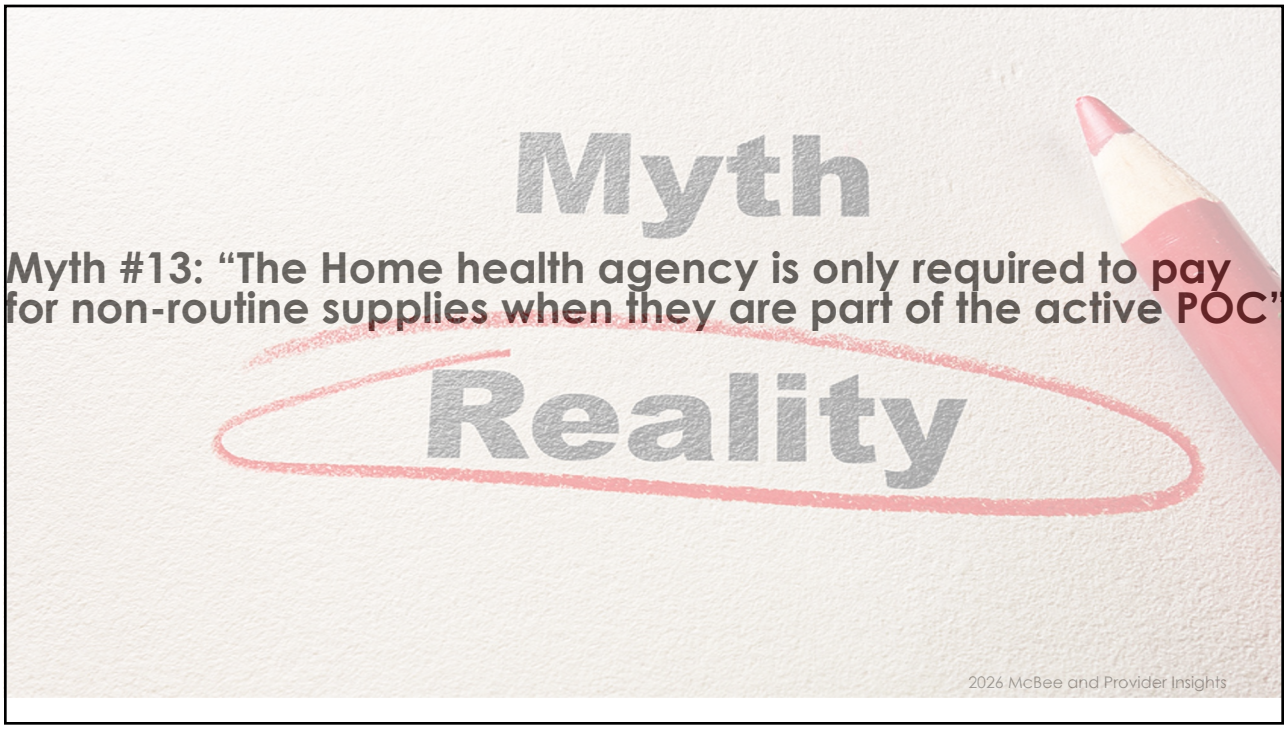

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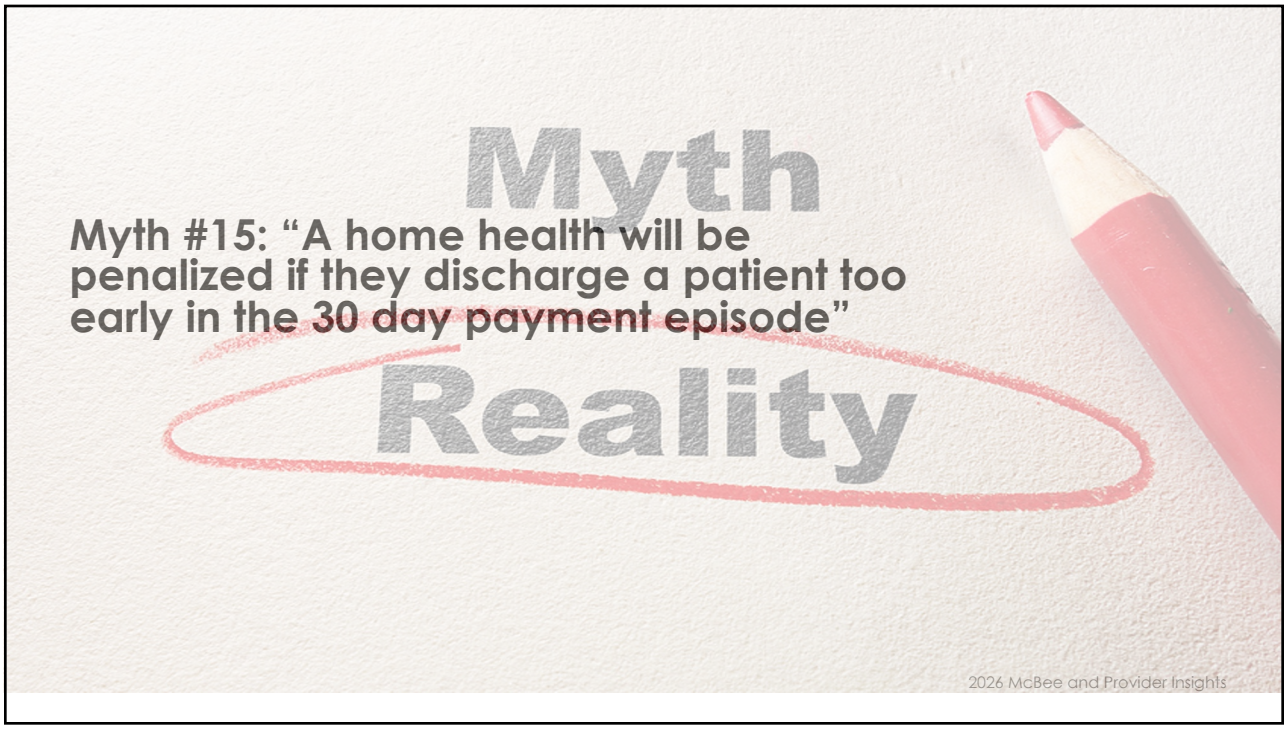

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Myth #16: "An agency will not receive a "PEP" (partial episodic payment) if the patient gets readmitted to another agency- only if the patient gets readmitted to their own agency.

Myth

Reality

CMS Claims Processing Manual

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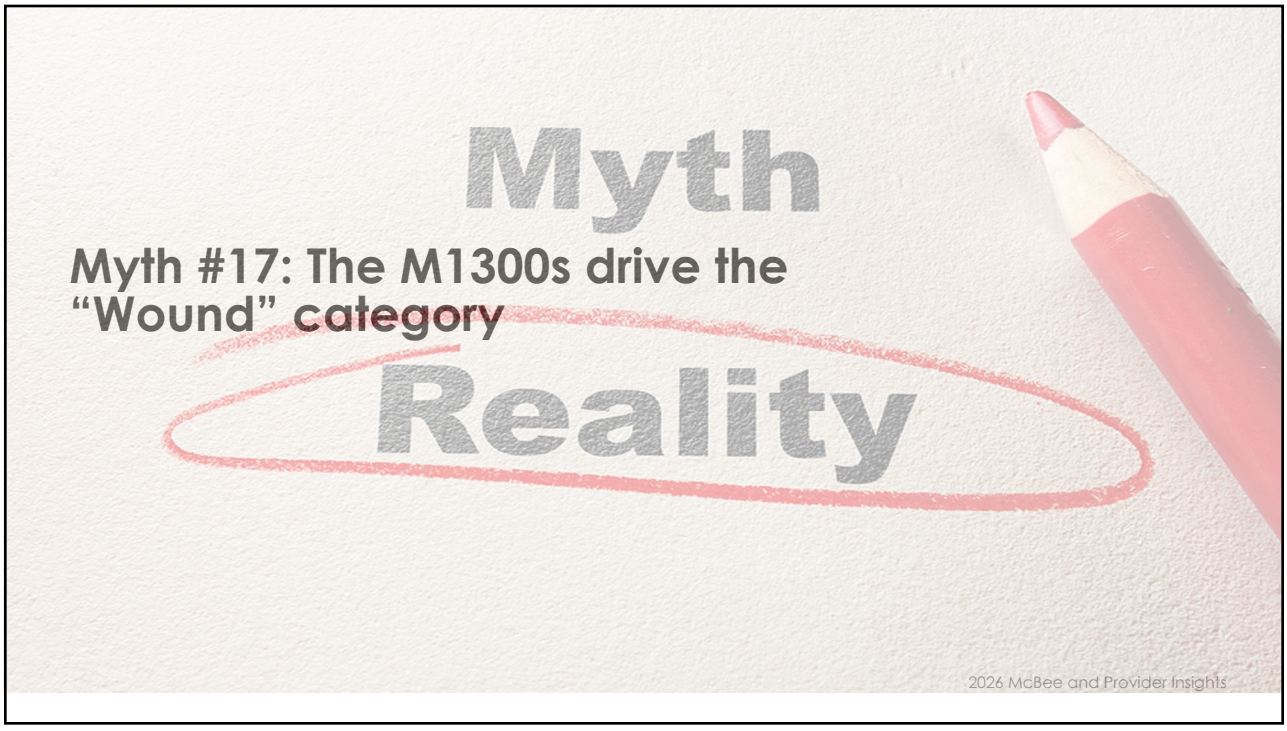

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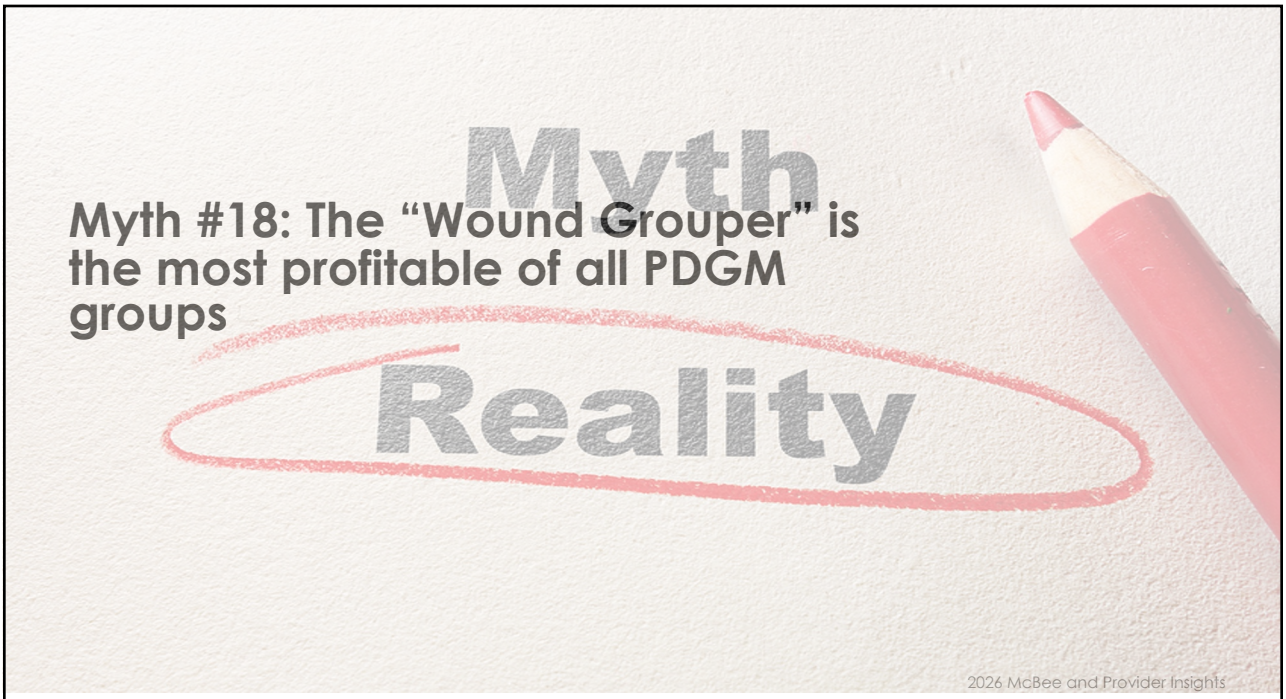
Myth #18: The "Wound Grouper" is the most profitable of all PDGM groups



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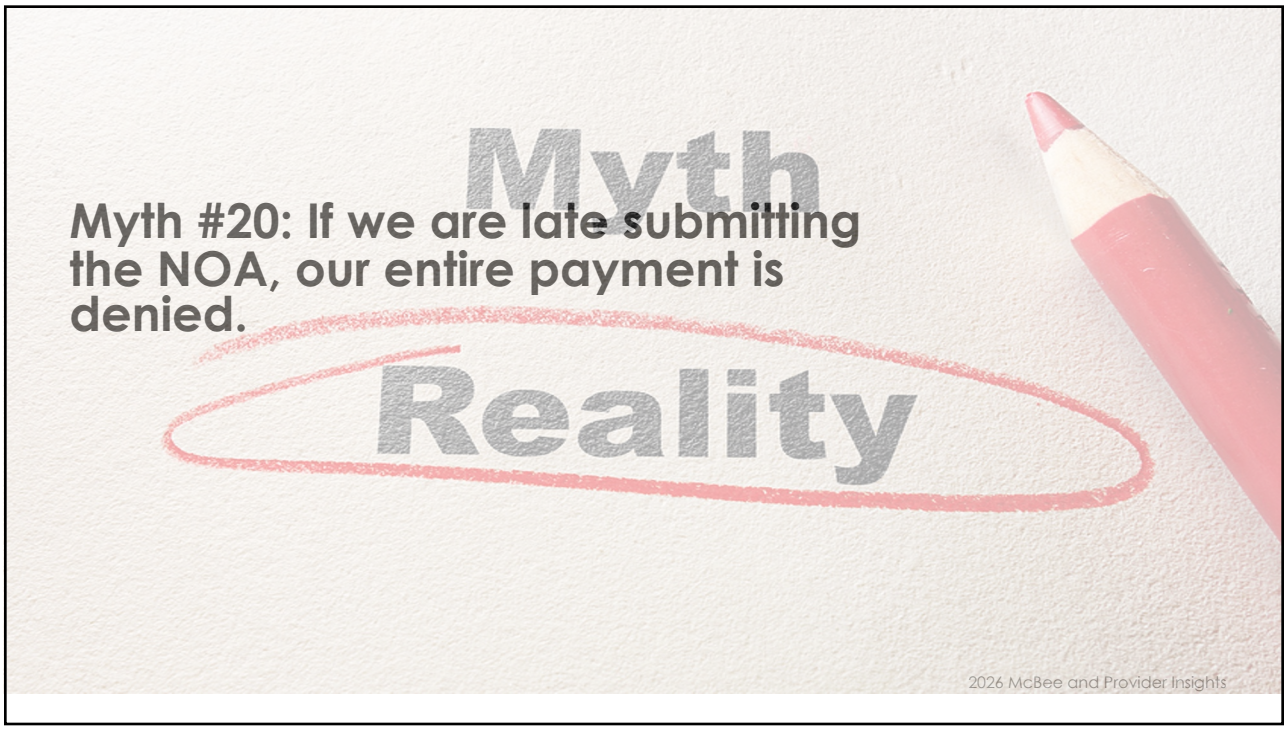

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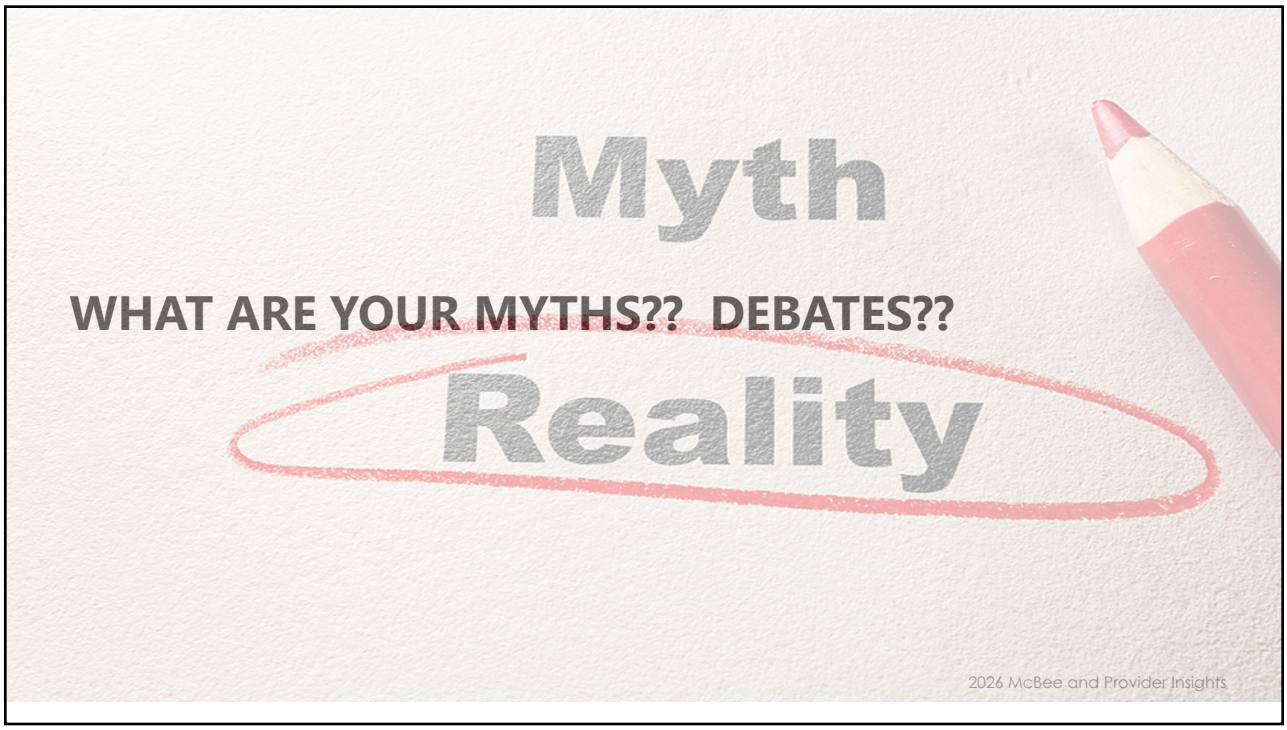
Myth
WHAT ARE YOUR MYTHS?? DEBATES??
Reality
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MYTHBUSTERS
Thank You!
Have a new myth or story to try busting? Reach out to us!
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