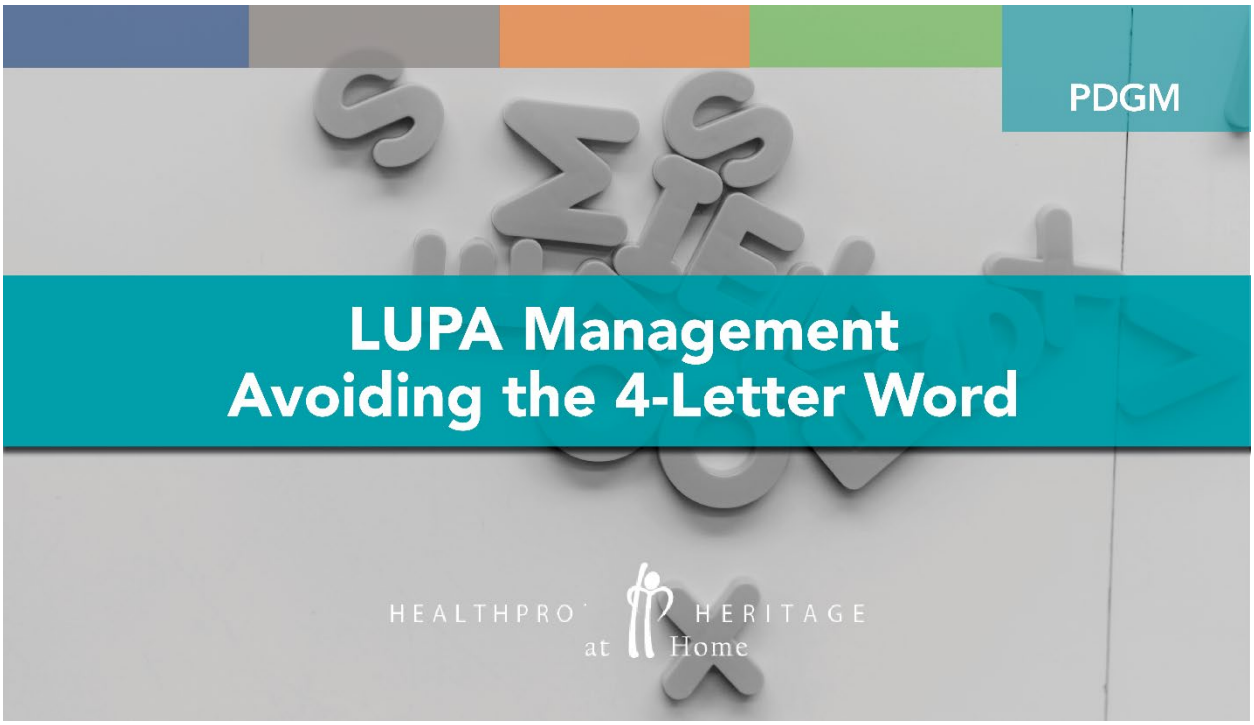

LUPA (Low Utilization Payment Adjustment), the 4 letter word that we have all been trying to avoid under the current PPS system. Just when we thought we had it under control, CMS has decided to add a whole other level of complexity with PDGM. The challenge to managing LUPA's under PDGM will be two-fold; a "moving LUPA" for each 30-day payment, and the need to meticulously manage visits within each of those 30-day windows to avoid that LUPA.

In order to determine the patient specific LUPA threshold, you will need to know the following 5 factors:

1. **Episode timing –** "Early" or "Late": Only the first 30-day episode would qualify as "early" with all other subsequent episodes qualifying as "late."
2. **Admission Source –** "Institutional" or "Community": The 30-day period would be classified as "institutional" if the patient had an acute or post-acute stay within 14 days of the start of care.
3. **Clinical Grouping –** Depending on principal diagnosis, patients would be assigned to 1 of 12 major clinical groups.
4. **Functional Level –** Relies solely on the OASIS codes to designate a patient's level into either "low impairment," "medium impairment," or "high impairment."
5. **Comorbidity Adjustment –** "no adjustment" (none of the 11 comorbidity diagnoses), "low adjustment" (1 qualifying comorbidity), or "high adjustment" (2+ qualifiers)

Once these 5 factors have been determined, a LUPA threshold ranging from 2-6 visits will apply to each 30-day payment episode. Remember, a LUPA occurs when there is one less visit than the pre-determined threshold and the LUPA threshold can vary from one 30-day payment period to the next.

So, now that you have accurately determined what the LUPA threshold hold will be for that particular 30-day payment period, what can you do to ensure that those thresholds are being met?

- Communicate patient specific LUPA thresholds to your entire interdisciplinary team. Medicare has not changed the practice of counting all billable visits towards the reimbursement threshold. Therefore, all team members need to be aware of what this number is.
- Communicate with your patients to avoid potential scheduling conflicts with physician appointments, personal appointments, etc., that could result in a missed visit.
- Train your staff to always attempt to re-schedule visits or have a plan in place where other clinicians are available to make up visits with a patient.
- Be cautious when tapering visits during the second 30-day payment episode. The practice of tapering visits could inadvertently lead to a potential LUPA.
- Ask HealthPRO how using our *Care Pathways to Success* will help your agency to avoid LUPAs through care planning based on the clinical characteristics of each patient.

As we march forward in patient reform, agencies need to remember that almost all LUPA's are preventable and avoidable under PDGM. However, as the management of LUPA episodes has always been a challenge under PPS, it just gets more complex under PDGM. The key is for agencies to continue to deliver efficient OASIS coding practices and strategically manage all of their episodes efficiently. As the home health agencies case management will remain pivotal under PDGM, there will also be a need for daily consistent interdisciplinary collaboration and communication to avoid LUPA's. Clinical pathway development by HealthPRO® Heritage can assist you with that future endeavor.