Another Look at Home Care PPS

In the October 2000 Journal of AHIMA, we outlined the new home health care prospective payment system (PPS).1 Coding professionals working with home health providers have learned new terms and additional guidelines for reporting. However, confusion remains concerning code assignments, because some of the reporting rules differ from those of other settings.

What is an HHRG?

Since October 1, 2000, a Medicare beneficiary receiving covered home care services is reimbursed for a 60-day episode of care based on the Home Health Resource Group (HHRG) classification system. The HHRG is a six-position alphanumeric code that represents a severity level in three domains:

- clinical severity
- functional status
- service utilization

Selected ICD-9-CM diagnosis codes may affect reimbursement, so as with the hospital outpatient PPS, coding accuracy and completeness are critical. All diagnoses should be assigned according to ICD-9-CM coding rules, based on the available documentation, and sequenced according to the explanation given under the reporting requirements in the July 3, 2000, Federal Register.2

Episode-based Payment

While a hospital outpatient prospective payment is based on the visit comprising the unit of care, home health services are reimbursed per episode of care. As a result, the claim usually includes more than one date of service. The per-episode home health payment covers all home care services and non-routine medical supplies delivered to the patient during a 60-day period. HCPCS codes may be used for reporting these non-routine supplies for tracking purposes, but no additional payment is available. A description of all of the required data elements on the HCFA Form 485 is detailed in Medicare Program Memorandum A-00-71.3

Once the required OASIS data set is completed electronically, a grouper program reviews responses to selected questions and assigns the HHRG. To allow for patients who have a significant change in condition, there is a mechanism for revision of the HHRG to adjust reimbursement. A new OASIS data set is completed when there is an unexpected decline or improvement in the patient's situation.

Consolidated Billing

The per-episode payment covers most related services that may have been reported or billed separately under the cost-based system. These services may be rendered directly by the agency or provided "under arrangement" with others, such as contracting for physician or speech therapy. The following types of services during the 60-day period may not be reported separately by another provider, because they are included in a home care episode:

- skilled nursing visits
- home health aide visits
- all therapy services (including physical therapy, occupational therapy, and speech pathology)
- medical social services, and non-routine medical supplies

Covered durable medical equipment (DME) was specifically excluded from the per-episode payment. Any DME expenses are reported with the appropriate HCPCS Level II code, billed separately, and will be reimbursed under the DME fee schedule.

The July 3, 2000, Federal Register includes a list of 178 HCPCS codes that indicate the non-routine medical supplies used in developing the PPS rates. Even if these supplies are not related to the condition that qualifies the beneficiary for home care services, the items are paid under the episode of care and do not generate extra reimbursement.

ICD-9-CM Diagnosis Reporting

The fundamental reason for reporting diagnoses codes within OASIS is to provide an updated, accurate picture of the patient's health status. Coders should report the diagnoses and conditions that relate to the patient's current plan of care and treatment and require the most intensive home health services. The diagnosis may or may not relate to the preceding hospital stay. Anything that has been resolved or no longer affects the care plan should not be included. Do not report any E codes or procedure codes for home health services. Although only a three-digit code is required for reporting, the full code is recommended to maintain data consistency.

According to the Official Coding Guidelines, some diagnoses affecting the HHRG cannot be reported as primary diagnoses.4 Those diagnoses are to be reported in the first line of the secondary diagnosis section with the appropriate underlying condition reported as the principal diagnosis. ICD-9-CM guidelines for home health reporting are the same as for other healthcare providers.

Principal Diagnosis

Program Memorandum A-00-71 defines the principal diagnosis as "the diagnosis most related to the current plan of care. The diagnosis may or may not be related to the patient's most recent hospital stay, but must relate to the services rendered by the home health agency (HHA). If more than one diagnosis is treated concurrently, the diagnosis that represents the most acute condition and requires the most intensive services should be entered. The ICD-9-CM guidelines dictate that certain specific principal diagnoses are only to be used when a specific secondary diagnosis is present."

The principal diagnosis must match the diagnosis reported on the physician certified plan of care, the OASIS, and the UB-92 form. In addition, V codes are not acceptable as either principal or first secondary diagnoses but could be reported in item 21, Orders for Discipline and Treatments. The ICD-9-CM coding guidelines should be followed in assigning an appropriate V code for this field.

Coding Examples 1-3

A Medicare beneficiary was surgically treated for a subtrochanteric fracture (code 820.22) with an admission to a home care agency for rehabilitation services (V57.1). The HHA uses 820.22 as the primary diagnosis and may enter V57.1 in field 21.

A patient is immediate post bowel resection for adenocarcinoma of the descending colon (code 153.2) with exteriorization of the colon. Admission to home care is ordered for surgical follow up and instruction in care of the colostomy (V55.3). Even though code V55.3 is more specific to the nature of the proposed service, the HHA must assign code 153.2 as the principal diagnosis (item 11) but may assign code V55.3 in field 21.

A patient has uncontrolled type I diabetes, is legally blind due to diabetic retinopathy, and has congestive heart failure (peripheral vascular disease due to the diabetes). Skilled nursing services provided by the HHA include wound care to a diabetic ulcer of the foot, performing diabetic care and teaching, and monitoring the medication regimen. In this case, ICD-9-CM guidelines require that the diabetes code be reported as the principal diagnosis (250.83) followed by codes 707.15, 250.73, 443.81, 250.53, 362.01, 428.0, and 369.4. Although the diabetic ulcer is the focus of the plan of care, the diabetes code is sequenced first because of the ICD-9-CM guidelines. It is important to confirm with the physician that the ulcer is due to diabetes rather than arteriosclerotic peripheral vascular disease before making this code selection if the documentation is not clear.

Additionally, coders must be aware of some situations that are unique to home health care. For example, code 436 (Acute, but ill-defined, cerebrovascular disease) is assigned for any post cerebrovascular accident (CVA) patient with residual conditions as a principal diagnosis. However, this contradicts the Official Coding Guidelines, which suggest a code from the 438 series. But because the PPS system was built to reimburse the agency for services related to an acute CVA rather than late effects, the HHA would not obtain the proper reimbursement if it reported codes in the 438.xx range. So, for a patient discharged to

HHA following a hospital stay for an acute CVA, code 436 should be reported. At the time of publication, HCFA has not provided any clarification on how long the CVA is to be considered "acute" before a code in the 438.xx range would be appropriately reported for a home health patient.

Another common error in home health coding is incorrectly assigning a code from the 800 range for an "open wound" when the patient is receiving post-surgical wound care. The proper code to assign is a V code. However, because V codes cannot be used as the principal diagnosis in the home health PPS system, the HHA should report the underlying condition, which necessitated the surgery.

Coding Example 4

A bilateral amputee patient requires home health care following a cholecystectomy with cholangiogram and T-tube insertion. The HHA is providing surgical wound care to include dressing changes and management of the tube. The diagnosis at the time of surgery was chronic cholecystitis with choledocholithiasis. For home health reporting, the principal diagnosis is 574.4. There would be no additional secondary diagnoses to report on the OASIS data set, since choledocholithiasis (with cholecystitis) is also the underlying reason for the T-tube. The V codes may be reported in secondary position on the 485 and UB-92 form would be V58.3 (dressing changes), V58.49 (aftercare), and V49.70 (amputation status).

Payer Reporting Policy

When a payer has a policy that clearly conflicts with Official Coding Guidelines, it is important to obtain and follow the written policy of that payer. In the home health PPS, written documentation in the Federal Register and the HCFA program memorandum directs agencies to code in a different manner than other settings. Coding professionals must be aware of the unique coding rules and follow them consistently to minimize payment problems.

According to Health Information Management Compliance: A Model Program for Healthcare Organizations, "due to the reliance of the home health prospective payment system on OASIS data, it is imperative that measures be taken to ensure that the OASIS data are complete and accurate. Because OASIS links the patient's clinical status to payment, accurate data are needed to ensure that home health agencies are reimbursed appropriately."5

Want to Know More?

The frequently asked questions (FAQ) section on AHIMA's Web site provides coding scenarios, resources, rationale, and more for the home health PPS. Go to http://www.ahima.org/faqs/index.html and select "coding."

- HCFA has created an electronic mailbox for provider billing questions regarding the home health PPS. If you have unanswered questions after reviewing instructions and available resources, you may submit them to HHPPSQUESTIONS@hcfa.gov. Questions received in this mailbox will be answered in the order received.
- HCFA's home health PPS quick reference guide is available at http://www.hcfa.gov/medlearn/refhha.htm.
- Audio Seminar: "Home Care PPS: ICD-9-CM Coding Is No OASIS." Available for purchase through Ingenix at (800) 632-0123. Product no. Z367. AHIMA member price: $129.95

HCFA Addresses Glitches

In addition to questions about diagnosis reporting, selected billing glitches in the system have required adjustment early in the implementation process. For example, in early December, based on input from HHA providers and trade associations, HCFA learned that many agencies did not prepare their billing systems to reflect Medicare's instruction that the claim "through" date must match the latest line item date of service. As a result, many claims were returned to providers for correction. The HHAs

found that this instruction conflicted with their clinical documentation practices, which allowed them to record a discharge date that is later than the last visit to the beneficiary. Due to this feedback, HCFA has re-evaluated the need for this billing instruction and has determined that the instruction can be removed, along with the edits in Medicare systems that enforce it.

Forecast for HIM

The HIM professional or coding professional working for a home health agency should track and report any coding or billing issues to improve services. When possible, work with payers to clarify any variances required concerning Official Coding Guidelines application.

As coding across the continuum of care becomes an industry focus, there will be an increase in opportunities for HIM professionals to work in HHAs, provide consultation services, or conduct in-services and training on code reporting, billing and reimbursement. As a result of PPS, the expertise of HIM practitioners is beginning to be recognized in home health care. u

Notes

1. The complete Home Care PPS Final Rule is available at http://www.hcfa.gov/medicare/hhppsfr4.htm.

2. The July 3, 2000, Federal Register is available at http://www.access.gpo.gov/su_docs/fedreg/a000703c.htmll.

3. Medicare Program Memorandum A-00-71 is available at http://www.hfa.gov/pubforms/transmit/A0071.pdf.

4. The ICD-9-CM Official Coding Guidelines are available at http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm.

5. Prophet, Sue. Health Information Management Compliance: A Model Program for Healthcare Organizations. Chicago, IL: AHIMA, 2000. Available at http://www.ahima.org.

Prepared by

Karen Youmans, MPA, RHIA, CCS, Rita Scichilone, MHSA, RHIA, CCS, CCS-P, and Michelle Dougherty, RHIA

Karen Youmans *(karen.youmans@ahima.org) is an AHIMA coding practice manager,* ***Rita Scichilone*** *(rita.scichilone@ahima.org) is AHIMA's director of coding products and services, and* ***Michelle Dougherty*** *(michelle.dougherty@ahima.org) is an AHIMA practice manager.*

Article citation:
Youmans, Karen, Rita Scichilone, and Michelle Dougherty. "Another Look at Home Health PPS." *Journal of AHIMA* 72, no.2 (2001): 76-78.
