HHA Prospective Payment System Changes

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Several changes to the prospective payment system went into effect at the start of 2013, including coding changes affecting the M1024 Rule.

Reimbursement for home healthcare agencies (HHA) was converted to a prospective payment system by the Centers for Medicare and Medicaid Services (CMS) in October 2000. The conversion was designed to promote efficiency and help prevent waste and abuse within the home healthcare payment system. In the prospective payment system, HHAs are paid a predetermined base payment that may vary for each 60-day episode of care depending on the patient's severity of illness and home health needs. Reimbursed services include aide visits, skilled nursing visits, supplies, medical social service, and therapy.

Prospective Payment System Primer

Key provisions of the prospective payment include:

- Medicare will reimburse HHAs for each 60-day episode of care as long as the patient remains eligible and the services are medically necessary.
- Beneficiaries who have greater home healthcare needs will warrant higher payment rates to their HHAs.
- National payment rates will be used for reimbursement that range from $1,100 to $5,900 for each 60-day episode of service. Payment is determined by the intensity of care provided. Data documented from patient assessments will be used to support payment rates. Payment rates are also adjusted by area wage differences.
- In cases where the patient's care results in unusually high home healthcare costs, outlier payments will be made for a portion of the cost amount beyond the set threshold.
- CMS will pay 60 percent of the initial episode payment up front when a HHA first accepts a new Medicare patient in order to streamline the approval process and ensure adequate payment. HHAs will receive the remaining 40 percent of payment at the end of that initial episode of care. The episodes of care that follow will be paid based on equally divided payments between the beginning and the end of those episodes of care.
- Patients who have a significant change in their condition during an episode of care will have an adjustment made to their payment rate.
- HHAs will get a partial episode payment for a beneficiary-elected transfer or a discharge and return to the same agency that warrants a new clock for payment. When a new 60-day episode begins, the original 60-day payment is proportionally adjusted to reflect the time the beneficiary remained under the agency's care before the intervening event.
- HHAs and suppliers will be paid separately for durable medical equipment if it is medically necessary.
- CMS will perform extensive reviews to assess errors or trends within this new payment system as well as ensure the quality of patient care is maintained.

Outcome and Assessment Information Set

Home healthcare data is collected on the Outcome and Assessment Information Set (OASIS) form, which is part of the uniform data set. OASIS is a group of data elements that represent core items in a comprehensive assessment for an adult home care patient. The data elements form the basis of patient outcome measurements used for outcome-based quality improvement.

CMS requires OASIS data collection by a qualified clinician as part of the comprehensive assessment at state of care, resumption of care, follow-up, transfer to inpatient facility with or without discharge, discharge to community, and death at home. Encoding of OASIS data items must be complete to accurately compute the information necessary for billing a Medicare patient under the prospective payment system.

Example of the New M1024 Rule

Documentation scenario

Patient was admitted to home health care following a fall that resulted in a hip fracture. The patient is now status post ORIF. While in the hospital, he suffered a small bowel obstruction requiring bowel resection. A skilled care nurse is assigned dressing changes to the patient's hip and abdomen.

Pre-January 1, 2013 coding

- M1020- V54.13 Aftercare traumatic hip fracture
- M1022- V58.75 Aftercare GI surgery
- M1022- V58.31 Attention surgical dressings
- M1022- V15.88 History of falls
- M1024- 820.8 Hip fracture
- M1024- 560.9 Bowel obstruction (1-6 additional clinical points)

Post-January 1, 2013 coding

- M1020- V54.13 Aftercare traumatic hip fracture
- M1022- V58.75 Aftercare GI surgery
- M1022- V58.31 Attention surgical dressings
- M1022- V15.88 History of falls
- M1024- 820.8 Hip fracture
- M1024- (BLANK)

Prospective Payment Changes

While there were several changes to the Department of Health and Human Services' prospective payment system, there is one particular change that impacts coding. Medicare's final rule for the CY 2013 prospective payment system limits the use of M1024 codes to only one instance for payment diagnoses.

The only diagnoses permitted in M1024 will be fracture codes. In the past, M1024 has been utilized to support the reason for aftercare codes and also to capture points for resolved conditions that would otherwise be lost. By only capturing fractures in M1024, there will be times that points will be lost for the resolved conditions that can no longer be placed in that OASIS field. Small bowel obstruction, cholecystitis, osteoarthritis, and abscesses that have been resolved through surgery are some of the diagnoses that will no longer be captured for reimbursement following the new rule.

In the post-January 1, 2013 coding example shown in the sidebar, there will be no points for the bowel obstruction, which would normally have been 1-6 additional clinical points based on the case-mix categories. This is an example of how the new M1024 rule may impact reimbursement.

There are some diagnoses that are resolved by surgery, but this is not always the case. Examples of these unresolved diagnoses include cancer, spinal stenosis, and spondylosis. These types of diagnoses should be coded as active unless documentation states the condition is resolved. This coding method will reduce case-mix point loss while still following coding guidelines.

The Home Health Prospective Payment System final rule is available for review at www.cms.gov.

Reference

Abraham, Prinny R. *Documentation and Reimbursement for Home Care and Hospice Programs*. Chicago, IL: AHIMA Press, 2001.

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