Home Care Coding Basics: Potential PPS Changes May Affect Home Care Coding

by Ida Blevins, RHIA

Home health agencies are required to use the ICD-9-CM Official Guidelines for Coding and Reporting for Medicare Outcome and Assessment Information Set (OASIS) reporting for MO230 (principal/primary listed diagnosis) and MO240a–MO240f (secondary/additional diagnoses). The stipulation took effect as a result of mandated HIPAA regulations. According to those HIPAA mandates all healthcare settings must adopt diagnosis codes (Volumes I and II). Volume III (procedure codes) is used for inpatient procedures reported by hospitals.

MO245 (case mix/payment diagnosis code) is also reserved for ICD-9-CM codes. However, in many instances the rules that pertain to this particular OASIS item are outside official ICD-9-CM coding guidance. Guidance that relates to this particular MO item was issued by the Centers for Medicare and Medicaid Services (CMS) in September 2001 and updated in October 2003.

Prior to October 1, 2003, home health agencies were instructed to use the condition that precipitated surgery as the primary diagnosis (because V codes were not permitted as a primary diagnosis in home care reporting prior to that date). If the primary diagnosis fell into either the case-mix or payment code category (e.g., diabetes, neurologic, orthopedic, or burns/trauma), additional points were assigned. Burns and trauma fell into this category because many home care agencies were inappropriately reporting surgery aftercare as open wounds.

After October 1, 2003, as a result of the HIPAA mandates, agencies were allowed to use V codes. Although this presented agencies with the opportunity to more accurately report conditions, this change also presented a potential loss of reimbursement for home health agencies. CMS had to identify how to avoid loss of reimbursement when a V code is used as the primary diagnosis instead of a case-mix or payment diagnosis. Thus, the birth of MO245.

If a V code is used as the primary diagnosis and that code replaces a case-mix code that would have been used prior to October 1, 2003, that case-mix code is placed in MO245 to ensure that the agency captures the reimbursement that is due them, based on the existing Home Health Agencies (HHA) Prospective Payment System (PPS). As it exists today, the HHA PPS uses the primary diagnosis (and second listed diagnosis in the case of required sequencing of certain etiology/manifestation situations), along with other OASIS MO items to determine reimbursement.

The MO items that affect reimbursement are shown in the table [below].

Updates to Home Care Coding

There is movement within the industry to update the HHA PPS by taking complications and comorbidities into consideration when determining case mix (and ultimately the HRG and reimbursement). With this in mind, agencies should be cognizant of the definitions of primary and secondary diagnoses as they relate to home care and code to reflect documentation in the medical record.

The primary diagnosis is the diagnosis most related to the current plan of care. The diagnosis may be related to the patient's most recent hospital stay, but must relate to skilled services being provided by the home health agency.

Secondary diagnoses are defined as "all conditions that coexisted at the time the plan of care was established or which developed subsequently or affect the treatment of care." Coders are instructed to exclude diagnoses that relate to an earlier episode that have no bearing on this plan of care. CMS's coding guidance further clarified this determination by instructing coders to include not only conditions actively addressed in the plan of care but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment.

In the "Active Projects Report—2006 Edition, Studies in Home Health Case Mix," CMS notes that analyses have been directed at performance of the existing adjuster for long-stay patients; feasibility of an adjuster for supply costs; prediction of therapy costs and other approaches to accounting for high-cost therapy users; performance of additional diagnosis groups and comorbidities; miscellaneous refinements of existing diagnosis groups; and time trends in OASIS item coding. This project's primary objective is to further expand the case-mix model used for the HHA PPS and identify new approaches to case-mix adjuster development. It is relatively safe to say that changes to the HHA PPS are inevitable.

In preparation for such a change, agencies should review documentation and pay special attention to the definition of secondary or additional diagnoses. Agencies should also be diligent in including all diagnoses that are considered comorbidities in order to develop a truly reflective case mix.

Recall that prior to October 1, 2003, agencies were not allowed to use V codes and were instructed to use the diagnosis that precipitated the surgery as the primary diagnosis. That, of course, resulted in a database that was flawed, as agencies were often led to report conditions that no longer existed. Agencies are encouraged to truly paint a picture of the patients they are seeing through selecting and reporting ICD-9-CM codes that accurately reflect the severity of illness of the patient and the intensity of services being provided. This focus on complications and comorbidities in development of case mix can provide the home care industry with the first data that is accurate and demonstrative of the patients we see.

MO Items That Affect Reimbursement	
Clinical Severity Domain	
OASIS Item	**Description**
MO230/MO240/MO245 (MO245 is used only when MO230 is a V code and the V code replaces a case-mix diagnosis code)	Primary, secondary (for certain manifestation codes)
MO250	IV Infusion.parenteral/Enteral therapies
MO390	Vision
MO420	Pain
MO440	Wound/Lesion
MO450	Multiple pressure ulcers
MO460	Most problematic pressure ulcer stage
MO476	Stasis ulcer status
MO488	Surgical wound status
MO490	Dyspnea
MO530	Urinary incontinence
MO540	Bowel incontinence
MO550	Ostomy (bowel)
MO610	Behavioral problems
Functional Status Domain	
MO650 (current status) MO660 (current status)	Dressing
MO670 (current status)	Bathing
MO680 (current status)	Toileting
MO690 (current status)	Transferring
MO700 (current status)	Locomotion
Service Utilization Domain	

Variable	Description
MO175 - line 1	No hospital discharge within past 14 days
MO175 - lines 2 or 3	Inpatient rehab/skill nursing facility discharge within past 14 days
MO825	Therapy threshold (expect > or = 10 rehab visits within the episode (includes speech, occupational, and physical therapy)

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