Home Health PPS Update

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*by **Ida K. Blevins,** RHIA*

The long-anticipated update to the Home Health Prospective Payment System (PPS), released in the August 29, 2007, *Federal Register,* goes into effect January 1, 2008. The final rule encompasses a wide range of changes for home health agencies.

An Overview of the Final Rule

The Centers for Medicare and Medicaid Services (CMS) studied a sample of claims from 2001 to 2004 (and later for 2005, as well) to refine elements including the case-mix model, OASIS scoring, and nonroutine medical supplies. In addition, CMS reevaluated certain "reason for assessment" time points as they relate to significant changes in condition (SCICs), low utilization payment adjustments (LUPAs), outliers, and partial episode payments.

As a result of the analysis, CMS:

- Eliminated the SCIC adjustment.
- Changed the case-mix regression model to therapy thresholds of 6, 14, and 20 visits, with a gradual increase in payment between the first and third threshold. The rule outlines four equation models for weight calculation. It allows scores to vary by episode type and with classification of episodes as follows:
    - Early episodes (first and second) with 0 to 13 therapy visits
    - Early episodes (first and second) with 14 or more therapy visits
    - Later episodes (third and greater) with 0 to 13 therapy visits
    - Later episodes (third and greater) with 14 or more therapy visits
- Created M0110 to identify early and later episodes.
- Included M0826, which replaces M0825 in identifying the number of projected therapy visits per episode.
- Replaced M0245 with M0246 and allowed for multiple coding for both primary and secondary diagnoses.
- Allowed reimbursement for nonroutine supplies for supply payment separated from base rate and added to episode rate based on severity levels, with a range in payments from a low of $14.12 to a high of $551, and severity levels supported by selection of appropriate ICD-9-CM codes.
- Increased LUPA payments an additional $87.93 if they occur as the sole episode or the first of a sequence of adjacent episodes.
- Increased the number of quality data reporting measures from 10 to 12.

The CMS analysis also revealed an increase in case mix over time, or "case-mix creep." This rise in case mix appeared to be unrelated to changes in patient characteristics; the changes were thought to be related to changes in how agencies coded (or scored) the OASIS data collection document.

The final rule addresses this creep by providing a 10.96 percent rate reduction over four years: reductions of 2.75 percent for 2008 through 2010 and 2.71 percent in 2011.

Significant Case-Mix Changes

The changes to the case-mix adjustment model are significant. The new rule increases the number of home health resource groups (HRGs) from 80 to 153 payment scenarios. ICD-9-CM codes for primary and secondary diagnoses partially determine an agency's appropriate HRG. Prior to 2008, four categories of diagnoses affected case mix: diabetes, neurologic, orthopedic, and certain burns and trauma codes.

Case-mix diagnoses have been dramatically expanded to include diagnoses and combinations of diagnoses and certain OASIS item scores:

- Blindness and low vision
- Blood disorders
- Cancer and selected benign neoplasms
- Diabetes
- Dysphagia
- Gait abnormality
- Gastrointestinal disorders
- Heart disease
- Hypertension
- Neuro 1—brain disorders and paralysis
- Neuro 2—peripheral neurologic disorders
- Neuro 3—stroke
- Neuro 4—MS
- Ortho 1—leg disorders
- Ortho 2—other orthopedic disorders
- Psych 1—affective and other psychoses, depression
- Psych 2—degenerative and other organic psychiatric disorders
- Pulmonary disorders
- Skin 1—traumatic wounds, burns, postoperative complications
- Skin 2—ulcers and other skin conditions
- Tracheostomy care
- Urostomy/Cystostomy care

Example from the OASIS-B1 1/2008

OASIS ITEM
M0230/240/246 Diagnoses, Severity Index, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Rate each condition (Column 2) using the severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) V codes (for M0230 or M0240) or E codes (for M0240 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V code is reported in place of a case mix diagnosis, then optional item M0246 Payment Diagnoses (Columns 3 and 4) may be completed. A case-mix diagnosis is a diagnosis that determines the Medicare PPS case-mix group. Code each row according to the following directions for each column: Column 1: Enter the description of the diagnosis. Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1; rate the severity of the condition listed in Column 1 using the following scale: 0 - Asymptomatic, no treatment needed at this time 1 - Symptoms well controlled with current therapy 2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring 3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring 4 - Symptoms poorly controlled; history of re-hospitalization Column 3: (Optional) If a V code reported in any row in Column 2 is reported in place of a case-mix diagnosis, list the appropriate case-mix diagnosis (the description and the ICD-9-CM code) in the same row in Column 3. Otherwise, leave Column 3 blank in that row. Column 4: (Optional) If a V code in Column 2 is reported in place of a case-mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines, enter the diagnosis descriptions and the ICD-9-CM codes in the same row in Columns 3 and 4. For example, if the case-mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave column 4 blank in that row.

(M0230) Primary Diagnosis & (M0240) Other Diagnoses		(M0246) Case Mix Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
	ICD-9-CM and severity rating for each condition	Complete only if a V code in Column 2 is reported in place of a case mix diagnosis.	Complete only if the V code in Column 2 is reported in place of a case-mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-CM/Severity Rating	Description/ICD-9-CM	Description/ICD-9-CM
(M0230) Primary Diagnosis a.	(V codes are allowed) a. (__ __ __ • __ __) ☐0 ☐1 ☐2 ☐3 ☐4	(V or E codes not allowed) a._____ (__ __ __ • __ __)	(V or E codes not allowed) a._____ (__ __ __ • __ __)
(M0240) Other Diagnoses b.	(V or E codes are allowed) b. (__ __ __ __ • __ __) ☐0 ☐1 ☐2 ☐3 ☐4	(V or E codes not allowed) b._____ (__ __ __ • __ __)	(V or E codes not allowed) b._____ (__ __ __ • __ __)
c.	c. (__ __ __ __ • __ __) ☐0 ☐1 ☐2 ☐3 ☐4	c._____ (__ __ __ • __ __)	c._____ (__ __ __ • __ __)
d.	d. (__ __ __ __ • __ __) ☐0 ☐1 ☐2 ☐3 ☐4	d._____ (__ __ __ • __ __)	d._____ (__ __ __ • __ __)
e.	e. (__ __ __ __ • __ __) ☐0 ☐1 ☐2 ☐3 ☐4	e._____ (__ __ __ • __ __)	e._____ (__ __ __ • __ __)
r.	f. (__ __ __ __ • __ __) ☐0 ☐1 ☐2 ☐3 ☐4	f._____ (__ __ __ • __ __)	f._____ (__ __ __ • __ __)

OASIS, the Outcome and Assessment Information Set, is a group of data elements determined by CMS as core items in an assessment of an adult home care patient. The data also form the basis for measuring outcome-based quality improvement. Additionally, OASIS is fundamental to determining reimbursement in the home health prospective payment system.

The example here illustrates the change in the data set as it relates to item M0246 (case-mix diagnosis), which is comprised of two separate columns, as shown. Column 3 is used to report the case-mix diagnosis code that replaces the V code reported in column 2. Column 4 is used only in situations where a V code is reported in place of a case-mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines (e.g., mandatory etiology and manifestation combination).

ICD-9-CM Code Changes

OASIS item M0245 is deleted and replaced with M0246. These M0 items were created because no points were assigned to V codes; that is, prior to the creation of these M0 items, V codes had no impact on determining case mix and reimbursement.

The change allows the point-bearing case-mix diagnosis to be reported in a manner that doesn't negatively affect reimbursement. The final rule for the 2008 Home Health PPS (and the replacement of M0245 with M0246) extends this concept to secondary as well as primary diagnoses.

The rationale for assigning primary and secondary diagnoses (M0230 and M0240, respectively) remains essentially unchanged. Identification of the primary diagnosis is based on the condition most related to the current plan of care, the diagnosis related to the services being rendered by the home health agency, and the diagnosis that represents the most acute condition and requires the most intensive skilled services.

M0240 is reserved for secondary diagnoses. By definition, secondary/other diagnoses include:

- All conditions that coexist at the time the plan of care is established
- All conditions that develop subsequently
- All conditions that affect the treatment or care

In addition to conditions actively addressed in the plan of care, secondary/other diagnoses include 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 itself.

Coding professionals should avoid reporting diagnoses that are merely historically interesting and do not affect patient progress, outcome, or plan of care.

M0246 (case-mix diagnosis) is comprised of two separate columns, as shown in the table on the preceding page. Column 3 is used to report the case-mix diagnosis code that replaces the V code reported in column 2. Column 4 is used only in situations where a V code is reported in place of a case-mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines (e.g., mandatory etiology and manifestation combination).

Although the final rule has been published and distributed, it is important that coding professionals regularly check the CMS Web site for updates. CMS also offers updates via free mailings. The last refinement of the rule was published in the November 30, 2007, Federal Register (volume 72, number 230).

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