New Home Care PPS Brings Major Changes

by Michelle Dougherty, RHIA

The home care industry will undergo a significant shift in reimbursement methodology when HCFA implements a new prospective payment system (PPS) for Medicare claims on October 1, 2000. Under the new system, a Medicare beneficiary receiving covered home care services will be reimbursed for a 60-day episode of care based on the Home Health Resource Group (HHRG) classification system. The 80 different HHRG categories and related payments are based on the severity of the patient's clinical needs, functional needs, and the services utilized as reported on the OASIS (Oasis and Assessment Information Set). OASIS is a standardized data set completed for Medicare beneficiaries and transmitted electronically by a home health agency to the state and the Health Care Financing Administration (HCFA). Following is a look at the specifics for the new PPS:

Episode of Payment

The per-episode payment will cover all home care services and nonroutine medical supplies delivered to the patient during a 60-day period. There is no limit to the number of 60-day episodes patients may receive as long as they continue to meet Medicare coverage criteria. The 60-day period coincides with the completion schedule for OASIS and the physician plan of care and certification (HCFA form 485). Once OASIS is completed electronically, a grouper program reviews responses to select questions and an HHRG is established. For the OASIS questions impacting payment, see "Home Health Resource Group Case-Mix Classification Decision Tree Logic" in the July 3, 2000, *Federal Register*.[1]

To stem potential problems with providing minimal or negligible care, a low utilization payment adjustment (LUPA) will be applied when an agency provides four or fewer visits in an episode. Under a LUPA, the agency will be reimbursed for each visit rather than for a full 60-day episode.

The home care prospective payment system also provides a mechanism for reclassification into a new HHRG when the patient has a significant change in condition. A new OASIS is completed when there is an unexpected decline or improvement.

Consolidated Billing

Under the home care PPS, the agency is reimbursed with one lump sum to cover all expenses incurred for a Medicare beneficiary. The per-episode payment covers the following types of services during the 60-day period: all skilled nursing visits, home health aide visits, therapy services (physical therapy, occupational therapy, and speech pathology), medical social services, and non-routine medical supplies. Durable medical equipment (DME) was specifically excluded from the per-episode payment because those expenses are billed separately and will be reimbursed under the DME fee schedule.

The July 3, 2000, *Federal Register* includes a list of 178 HCPCS codes showing the nonroutine medical supplies used in developing the PPS rates. The list provides a guide to the nonroutine medical supplies to be covered under the per-episode payment. Even if the supplies are not related to the condition qualifying the patient for Medicare, the home care agency must pay for it out of the per-episode payment.

OASIS Data and PPS Grouper Criteria

The HHRG is a six-position alpha-numeric code that represents a severity level in three domains: clinical severity, functional status, and service utilization. A score is assigned for each domain based on the response to select OASIS questions. The case-mix classification decision tree logic breaks down each domain, the OASIS questions, and the number of points per response. The points are totaled for each domain and assigned a score. The score from each domain is combined for the HHRG. For example: C1F4S2 (clinical = low; functional = max; service = moderate).

HHRG Scoring

	Score	Points	Severity
Clinical Domain	C0	0-7	minimal severity
	C1	8-19	low severity
	C2	20-40	moderate severity
	C3	41+	high severity
Functional Domain	F0	0-2	minimal severity
	F1	3-15	low severity
	F2	16-23	moderate severity
	F3	24-29	high severity
	F4	30+	maximum severity
Service Utilization Domain	S0	0-2	minimum utilization
	S1	3	low utilization
	S2	4-6	moderate utilization
	S3	7	high utilization

ICD-9-CM Diagnosis Reporting

The reporting of ICD-9-CM diagnosis codes on OASIS directly affects the HHRG and payment level under home care PPS. Certain orthopedic, neurologic, diabetis mellitus, burn, and trauma diagnosis codes affect the scoring in the clinical domain. To influence payment, the diagnosis must meet the criteria to be reported on OASIS as a primary diagnosis. There are some diagnoses influencing the HHRG that cannot be reported as primary according to official coding guidelines. Instead, those diagnoses are to be reported in the first line of the secondary diagnosis section with the appropriate underlying condition reported as primary.

A New Role for HIM Professionals

The majority of home care agencies have not hired HIM professionals to manage their systems and assure proper reporting of ICD-9-CM codes. The OASIS coordinator/RN often assigns the ICD-9-CM code when filling out the data set. There are significant compliance risks for an agency, particularly "upcoding," if the quality and accuracy of coded data does not improve. As coding becomes more of an industry focus, there will be an increase in opportunities for HIM professionals to work in home care, provide consultation services, or conduct in-services and training. As a result of the PPS, HIM professionals' expertise will be recognized in home care.

Note

1. Home Health Resource Group Case-Mix Classification Decision Tree Logic available online at www.access.gpo.gov/su_docs/fedreg/a000703c.html, page 41194.

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