Post-acute PPS: Changing the Way We Code

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HIM professionals in post-acute care are reinventing their roles to accommodate the new coding demands of a prospective payment system. Here are some of the developments that are creating new interest in coding issues for post-acute settings.

Three major forces -- the prospective payment system, consolidated billing, and compliance -- are changing the way HIM professionals in post-acute settings work.

Generally in post-acute settings, HIM professionals have had little involvement in or knowledge of the billing cycle. But today they may find themselves reinventing their role to accommodate the new coding demands of a prospective payment system. Similarly, employers in post-acute settings are realizing that to attract skilled coders and information managers, they need to offer new or redefined roles that challenge HIM professionals.

The industry faces special challenges in this new era. Diagnosis coding is a fundamental requirement for post-acute settings, but lack of quality and/or accuracy are industrywide problems. Because reimbursement is not directly linked to coding, it has been difficult to convince decision makers of the need for qualified, educated coders or to justify the time, staff, and resources needed for accurate coding. An alarming number of organizations still use untrained staff who lack even a basic understanding of the system, rules, and standards.

In addition, post-acute settings lack official coding guidelines specific to post-acute settings that provide clear, concise standards and reflect how diagnostic information is collected, utilized, and disseminated in these settings. These factors have caused the quality and reliability of coded data to be questioned.

With their particular expertise, HIM professionals have the right tools to help solve some of these problems. To do their jobs better, HIM professionals need to understand the billing cycle, ensure that clinical documentation supports services billed, and provide accurate coding for clinical conditions and services rendered.

They also need to understand the shifts in the payment landscape that are spearheading new interest in coding issues for post-acute settings:

- skilled nursing facilities are in the final stages of implementing a prospective payment system based on the case mix-adjusted RUGs III system
- interim final rules have been published for home care, requiring Outcome and Assessment Information Set (OASIS) data to be collected and transmitted. The Health Care Financing Administration's (HCFA's) goal is to use OASIS data in the development of a reliable case-mix adjusted prospective payment system for home care by October 1, 2000
- HCFA is developing a short-stay Minimum Data Set (MDS-PAC) for use in multiple post-acute settings, possibly as an instrument for future prospective payment systems in rehab units and hospitals

New Reporting Challenges: PPS in Skilled Nursing Facilities

The prospective payment system for Medicare A benefits is based on a case mix-adjusted system known as RUGs III. There are 44 payment levels based on clinical characteristics collected in the Minimum Data Set 2.0 (MDS). An MDS is completed at specified times during a patient's stay to determine Medicare payment.

In skilled nursing facilities (SNFs), the reimbursement level and the ICD-9-CM diagnosis code assigned during a Part A stay are not directly related. But diagnoses and codes are pertinent reference information on both the MDS and the UB-92 claim form.

Reporting Diagnoses and Codes on the MDS

The MDS requires that all active diagnoses be identified. The diagnoses reported on the MDS should have a relationship to the resident's current ADL status, cognitive status, behavior status, medical treatment, or risk of death. These should be conditions that drive the current plan of care and physician's treatment plan. The staff member completing the diagnostic information should be aware of both the patient's diagnoses and Medicare qualifying conditions as well as coding rules for reporting on the MDS.

One section on the MDS collects diagnosis information. Section I (see Exhibit 1) identifies common diseases and infections typical in a long term care setting. The staff member completing this section checks the appropriate boxes. There is no area to record the specific diagnosis code for checked diagnoses. The MDS user's manual provides a description of the types of conditions represented by checking the box and the associated diagnosis code. However, the manual, written in 1995, does not include new or updated code numbers or multiple code numbers for categories that represent more than one condition.

exhibit 1—MDS 2.0, section I

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1. DISEASES **(If none apply, CHECK the NONE OF ABOVE box)**

ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis	v.
Diabetes mellitus	a.	Multiple sclerosis	w.
Hyperthyroidism	b.	Paraplegia	x.
Hypothyroidism	c.	Parkinson's disease	y.
HEART/CIRCULATION		Quadriplegia	z.
Arteriosclerotic heart disease (ASHD)	d.	Seizure disorder	aa.
Cardiac dysrhythmias	e.	Transient ischemic attack (TIA)	bb.
Congestive heart failure	f.	Traumatic brain injury	cc.
Deep vein thrombosis	g.	**PSYCHIATRIC/MOOD**	
Hypertension	h.	Anxiety disorder	dd.
Hypotension	i.	Depression	ee.
Peripheral vascular disease	j.	Manic depression bipolar disease)	ff.
Other cardiovascular disease	k.	Schizophrenia	gg.
MUSCULOSKELETAL		**PULMONARY**	
Arthritis	l.	Asthma	hh.
Hip fracture	m.	Emphysema/COPD	ii.
Missing limb (e.g., amputation)	n.	**SENSORY**	
Osteoporosis	o.	Cataracts	jj.
Pathological bone fracture	p.	Diabetic retinopathy	kk.
NEUROLOGICAL		Glaucoma	ll.
Alzheimer's disease	q.	Macular degeneration	mm.
Aphasia	r.	**OTHER**	
Cerebral palsy	s.	Allergies	nn.
Cerebrovascular accident (stroke)	t.	Anemia	oo.
Dementia other than Alzheimer's disease	u.	Cancer	pp.
		Renal failure	qq.
		NONE OF ABOVE	rr.

2. INFECTIONS **(If none apply, CHECK the NONE OF ABOVE box)**

Antibiotic resistant infection (e.g. Methicillin resistant staph)	a.	Septicemia	g.
Clostridium difficile (c. diff)	b.	Sexually transmitted diseases	h.
Conjunctivitis	c.	Tuberculosis	i.
HIV infection	d.	Urinary tract infection **in last 30 days**	j.
Pneumonia	e.	Viral hepatitis	k.
Respiratory infection	f.	Wound infection	l.
		NONE OF ABOVE	m.

3. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES

a. ____ ____ ____ • ____ ____

b. ____ ____ ____ • ____ ____

c. ____ ____ ____ • ____ ____

d. ____ ____ ____ • ____ ____

e. ____ ____ ____ • ____ ____

Source: http://www.hcfa.gov/medicare/hsqb/mds20/mdssoftw.htm

If a patient has a more specific diagnosis and code number than is listed in the MDS user's manual, the diagnosis and code is recorded in part 3 of Section I. This is a free-text area in which users write in other diagnoses and conditions not included in the checkboxes. Space is provided for up to five additional diagnoses.

Only a handful of diagnoses in the MDS affect RUG classification and payment rate. They are multiple sclerosis, quadriplegia, cerebral palsy, aphasia (with tube feeding), pneumonia, septicemia, diabetes mellitus, and hemiplegia/hemiparesis. The grouper software used by the MDS programs does not look for the appropriate ICD-9-CM code to determine if the criteria was met but at the box checked on the MDS.

Reporting Diagnoses on the UB-92

A claim submitted on a Medicare patient for a Part A stay must report ICD-9-CM diagnosis codes. The principal diagnosis reported is the condition for which the patient was admitted to the SNF and is receiving skilled services and should be one of

the conditions for which the patient received hospital care in the qualifying hospital stay. There are eight additional fields on the UB-92 to report supporting secondary diagnoses. The additional codes reported represent coexisting conditions at the time of admission or which have developed subsequently and affect treatment or length of stay.

Communication between billing, coding, and clinical staff is critical to ensure that active conditions reported on the MDS are coded accurately and relevant diagnoses reported on the UB-92. Not all diagnoses reported on the MDS may be appropriate on the UB-92 (because they do not relate to the reasons for Medicare coverage), but generally those on the billing claim form should also be found on the MDS. Compliance issues in other settings have reinforced the need for consistency between clinical and billing documentation.

New Horizons: Consolidated Billing and HCPCS Coding

A new requirement of the PPS that directly impacts the coder is the requirement for HCPCS codes to be reported for Medicare Part B consolidated billing. In consolidated billing, all Part B services provided to a SNF patient must be billed by the skilled facility on one bundled bill (the UB-92) rather than separate bills from the vendors.

Currently, this requirement is only partially implemented. Part B services provided to a patient covered by Medicare Part A must be billed by the SNF rather than the vendor of those services. (The original intent of the Balanced Budget Act of 1997 was to require the SNF to bill all Part B services provided to any resident in the facility even if not covered by Medicare Part A. This requirement has been indefinitely delayed as HCFA and the intermediaries address necessary information system upgrades related to Y2K issues.)

Services that must be billed by a SNF under consolidated billing include:

- therapy (PT, OT, SLP)
- medical supplies
- orthotics and prosthetics, including adjustments and repairs
- lab services
- diagnostic and radiology services
- hemophilia clotting factors
- incident-to services including nonexempt outpatient services provided by a hospital, physician office, ambulatory surgery center, etc.
- ambulance services in certain situations

One requirement for Part B consolidated billing that did survive the delay is a SNF's responsibility to bill under its Medicare provider number all Part B therapy services rendered to residents. A second change, implemented in January 1999, is the requirement for line item billing, in which all Part B therapy services to be billed are listed on the UB-92 as a separate line by CPT code and date of service.

Once the full realm of consolidated billing is implemented for all Part B services, every item will need an assigned HCPCS code. The HCPCS coding system is new to most nursing facilities. As a result, coding accuracy will be a significant concern in the future, as SNFs must ensure that all services billed were rendered and were medically necessary. Most have relied on the vendor of the service to identify the appropriate code on their invoice, but in the future, HIM professionals should establish a system to review or audit all (or a sampling of) invoices to determine the accuracy of the codes assigned before they are billed.

OASIS and More: Home Care

Just like skilled nursing facilities, home care ICD-9-CM codes do not drive Medicare payments, but are a required field on the UB-92 and a reference for qualifying diagnoses and conditions. Diagnosis information and codes are collected and reported on three main HCFA-mandated documents:

1. *HCFA 485 -- Home Health Certification and Plan of Treatment.* On admission and every 62 days, a HCFA-mandated form known as the 485 (plan of care) is completed and signed by the physician. The plan of care form mandates the following ICD-9-CM information: principal diagnosis and code, surgical procedure and code, and other pertinent diagnoses and codes. Payment is not determined based on the codes assigned, but the information should

relate to the need for home care services

2. *OASIS -- Outcome and Assessment Information Set.* The OASIS data set requires clinical, demographic, and diagnosis information to be collected and reported at specific intervals during a patient's home care episode. The OASIS data set is completed with the start or resumption of care, every two months, upon transfer to an inpatient facility, and upon discharge. The data set is transmitted to the state and then to HCFA on a monthly basis.

   OASIS information collected includes medical diagnoses for those conditions for which the patient is receiving home care services or which have caused a change in the medical or treatment regime. Unfortunately, only the first three digits of the diagnosis code are required to be reported, although it is possible for an agency to report the full code on the form. Surgical and V code information may not be submitted. The collection of only three-digit ICD-9-CM diagnosis codes is a significant concern, since the information from OASIS is intended to assist HCFA with the implementation of a prospective payment system for home care. The prohibition against use of V codes is also a concern because V codes are often necessary to accurately describe the patient's current healthcare status and the care being provided in the home care setting.

3. *UB-92.* Principal and supporting secondary diagnoses that relate to the reason for Medicare coverage for a Part A stay or Part B service are to be reported on the UB-92 Medicare billing form. The same principles that apply to skilled nursing facilities also apply to home care. Diagnoses reported on the UB-92 must justify Medicare coverage and must be consistent with diagnoses reported in the OASIS data set.

Rehabilitation Facilities and Long Term Care Hospitals

In its report to Congress on the Medicare Payment Policy, the Medicare Payment Advisory Commission (MedPAC) indicated that HCFA is moving toward more uniform payment policies across post-acute settings. The intent is to design a system that is conceptually similar to the per diem prospective payment system recently implemented for SNFs, but to use the new Minimum Data Set-Post-Acute Care (MDS-PAC) in rehabilitation facilities and long term hospitals. At this time, HCFA is sponsoring a study to collect patient assessment information using the MDS-PAC and staff time measurements to create payment weights for a prospective payment system.

The diagnosis section of the MDS-PAC is an expanded version of the MDS 2.0 completed by skilled nursing facilities. Three questions on the MDS-PAC relate to diagnoses -- a check-box format for diseases and infections and a free-text area for up to six additional diagnoses and codes. (See Exhibit 2)

exhibit 2—MDS-PAC, section H—diagnoses

Code:
[Blank] Not present
1. Primary diagnosis/diagnoses for current stay
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment
4. Diagnosis present not being treated or monitored, but has relationship to current ADL status, cognitive status, mood or behavior status, or risk of death

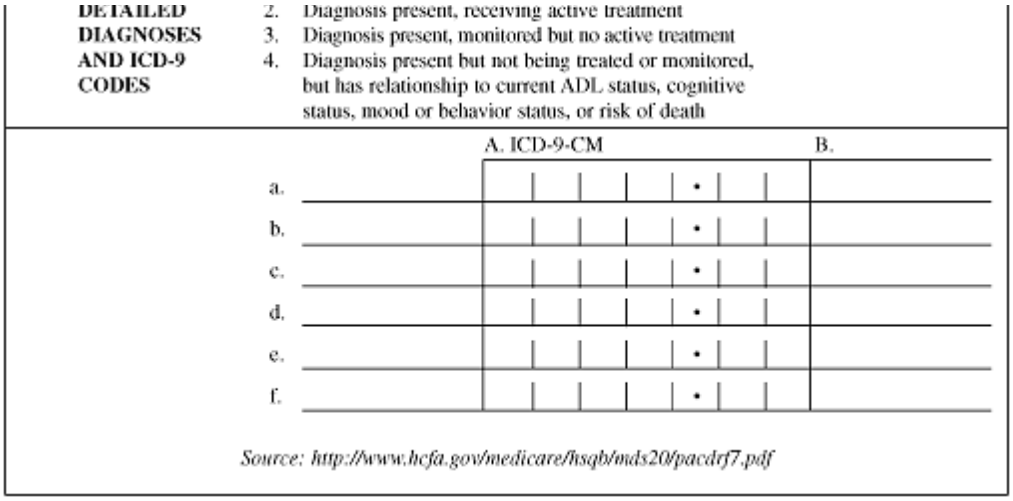
(If no diseases, check NONE OF ABOVE Item H1, bn)

1. DISEASES	**ENDOCRINE**		ae. Alzheimer's disease	
	a. Diabetes mellitus		af. Dementia other than Alzheimer's disease	
	b. Hyperthyroidism		ag. Aphasia or Apraxia	
	c. Hypothyroidism		ah. Cerebral palsy	
	HEART/CIRCULATION		ai. Guillain-Barré	
	d. Cardiac arrhythmias		aj. Hemiplegia/hemiparesis	
	e. Congestive heart failure		ak. Multiple sclerosis	
	f. Coronary Artery Disease (CAD)		al. Other congenital neurological disorders	
	g. Deep vein thrombosis		am. Parkinson's disease	
	h. Hypertension		an. Quadriplegia	
	i. Hypotension		ao. Seizure disorder	
	j. Peripheral vascular disease (arteries)		ap. Spinal cord dysfunction-non-traumatic	
	k. Post-acute MI (within 30 days)		aq. Spinal cord dysfunction-traumatic	
	l. Post heart surgery (e.g. valve, CABG)		ar. Stroke (CVA)	
	m. Pulmonary embolism		as. Transient ischemic attack (TIA)	
	n. Pulmonary failure		at. Traumatic brain injury	
	o. Other cardiovascular disease		**PSYCHIATRIC/MOOD**	
	MUSCULOSKELETAL		au Anxiety disorder	
	p. Amputated limb (lower extremity)		av. Bipolar disorder	
	q. Amputated limb (upper extremity)		aw. Depression	
	r. Fracture-hip, arthroplastic replacement		ax. Personality disorder	
	s. Fracture-hip, no surgical replacement		ay. Schizophrenia	
	t. Fracture-hip, pinned		az. Other psychiatric disorder	
	u. Fracture-lower extremity		**PULMONARY**	
	v. Fracture-pathological bone		ba. Asthma	
	w. Fracture(s)-other		bb. COPD	
	x. Osteoarthritis		bc. Emphysema	
	y. Osteoporosis		**SENSORY**	
	z. Post surgery-orthopedic, elective hip		bd. Cataracts	
	aa. Post surgery-orthopedic, knee		be. Glaucoma	
	ab. Post surgery-orthopedic, other		bf. Macular degeneration	
	ac. Rheumatoid arthritis		**OTHER**	
	NEUROLOGICAL		bg. Cancer-known metastasis	
	ad. ALS (Amyotrophic lateral sclerosis)		bh. Cancer-no known metastasis	
			bi. Major multiple trauma	
			bj. Post organ transplant	
			bk. Post surgery-non-orthopedic, non-cardiac	
			bl. Renal failure	
			bm. Shock (septic, cardiogenic)	
			bn. *NONE OF ABOVE*	bn

2. INFECTIONS	**Code:** *[Blank]* Not present 1. Primary diagnosis/diagnoses for current stay 2. Diagnosis present, receiving active treatment 3. Diagnosis present, monitored but no active treatment **(If no infections, check NONE OF ABOVE Item H2, m)**	

a. Antibiotic resistant infection (e.g., methicillin resistant staph, VRE)		g. Osteomyelitis	
b. Clostridum difficile		h. Septicemia	
c. Hepatitis		i. Staphylococcus infection (other than item "a" above)	
d. HIV/AIDS		j. Tuberculosis (active)	
e. Infection of the foot-e.g. cellulitis, purulent drainage		k. Urinary tract infection	
f. Pneumonia		l. Wound infection	
		m. *NONE OF ABOVE*	m

3. **OTHER CURRENT OR MORE**	**A. Code ICD-9-CM diagnosis code:** **B. CODE:** 1. Primary diagnosis/diagnoses for current stay	



DETAILED DIAGNOSES AND ICD-9 CODES	2. Diagnosis present, receiving active treatment 3. Diagnosis present, monitored but no active treatment 4. Diagnosis present but not being treated or monitored, but has relationship to current ADL status, cognitive status, mood or behavior status, or risk of death		
		A. ICD-9-CM	B.
	a.	.	
	b.	.	
	c.	.	
	d.	.	
	e.	.	
	f.	.	

Source: http://www.hcfa.gov/medicare/hsqb/mds20/pacdrf7.pdf

The diagnosis check boxes are expanded from the MDS 2.0 to include conditions found in a rehab facility. In addition, each diagnosis checked or written is assigned a relationship:

- primary diagnosis
- diagnosis present and actively treated
- diagnosis present and monitored with no active treatment
- diagnosis present that only affects the ADL, cognitive, mood/behavior status, or risk of death

The accuracy of diagnostic information submitted on the MDS-PAC will be critical in the development of the prospective payment system.

Communicating and Linking Diagnosis Code to Services Billed

One of the most significant compliance problems identified as a result of the federal government's fraud and abuse initiative is the lack of medical necessity documentation for services billed to Medicare. Because the UB-92 form is not set up to directly link a service to the appropriate ICD-9-CM code, a good rule of thumb may be to review the billing claim before submission to determine that every service billed has an associated diagnosis code referenced on the bottom of the UB-92. This effort may help to prevent future problems and integrate necessary safeguards to ensure that all services rendered are linked to a code that identifies the medical necessity.

Under the RUGs III system, a coder assigns a diagnosis code that supports services qualifying a resident for Medicare. For example, if therapy qualifies the patient for Medicare and the RUG III class assigned, the underlying reason or diagnosis that justifies therapy should be reported on both the MDS and UB-92.

Two issues can commonly result in clinical and billing documentation inconsistencies:

- The billing staff should not automatically transfer diagnoses from the admission record or preadmission record to the UB-92 unless they have been confirmed by the clinical and coding staff. The diagnoses on these documents may not be the Medicare qualifying condition or in the correct sequence. The clinical staff making Medicare continued coverage decisions must communicate the revised diagnoses to update the UB-92 as the primary qualifying condition changes over the course of a Medicare stay. This ensures that the reason for coverage is consistent with the ICD-9-CM diagnosis code

- Codes should not be submitted on the UB-92 if they are assigned directly from a computerized ICD-9-CM library that is not updated yearly. Trained coders should verify the diagnosis codes assigned to ensure they are correct

Continuing Challenges: Documentation

As in any healthcare setting, the medical record and physician documentation must substantiate the diagnosis code assigned. Post-acute settings face a number of challenges in obtaining appropriate documentation. The most significant problem is lack of access to the physician to review and discuss diagnoses and conditions. Most codes are assigned according to hospital

documentation, physician orders, and physician progress notes, which may result in so-called "nonspecific" ICD-9-CM codes. Staff must rely on telephone orders or infrequent physician visits (every 30 to 60 days) to obtain the necessary supporting documentation.

Automation Pitfalls

The clinical software programs used in many post-acute settings have limited ICD-9-CM coding capabilities, although this is changing as new products appear. Many programs include a library of code numbers and short descriptions but lack the "encoder" functionality that includes coding logic and rules. Common pitfalls of coding libraries used in post-acute settings include:

- Software programs often do not include the entire library of diagnosis codes with descriptions and inclusion and exclusion notes. A user must look for the description and number that is the closest match rather than referring to the code book for an accurate code assignment

- Many vendors do not provide annual updates to their library (although this, too, is changing with new clinical software and consumer demand). Because the amount of code numbers changing each year can be overwhelming, staff may not take the time to review the new codes, compare them to the database, and update the ICD-9-CM library

- Many software programs allow the user to choose a code that is invalid. For example, if there is a code with a fifth digit, the software doesn't prevent the user from choosing a four-digit code

Facilities and agencies can minimize coding errors when using the ICD-9-CM library by recognizing its limitations and establishing procedures that ensure coding accuracy.

Data Collection across the Post-acute Care Continuum

MedPAC has recommended to Congress that a fundamental set of information should be collected across all post-acute care settings to identify where differences and overlaps in patients occur and to compare costs and payments across provider types. The commission believes that a core set of common data about patients in all post-acute settings would considerably improve the ability to monitor and make policy decisions about post-acute care.[1]

As data collection in post-acute care becomes more systematic, diagnostic information will play a critical role in the formation and reevaluation of prospective payment systems. When the information collected does not meet the highest standards of specificity, this is a matter of concern.

HIM professionals must strive to ensure that the information we submit is accurate and complete. In addition, we must work to recruit HIM professionals in post-acute settings and begin to educate the industry about the importance of ICD-9-CM coding for policy decisions in the future. All of these things are within our reach.

Note

1. Medicare Payment Advisory Commission. "Report to the Congress: Medicare Payment Policy." Washington, DC: 1999, p. 82.

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