PDGM: Coding In Depth

September 12, 2019

Melinda A. Gaboury, COS-C, CEO, Healthcare Provider Solutions, Inc.
Sharon M. Litwin, RN, BSHS, MHA, HCS-D, Senior Managing Partner, 5 Star Consultants, LLC

Commercial Support provided by:

Webinar content was developed by the Home Care & Hospice Financial Managers Association (HHFMA), a NAHC affiliate.

Benefits of HHFMA membership ($100) include:

- Networking with peers
- Monthly industry update calls (including benchmarking of key metrics)
- Educational programs
- Access to exclusive HHFMA Listserv addressing industry concerns
- And more…

For more information, visit hhfma.org or call 202-547-7424.

 3

Objectives

Explain the impact of coding under PGDM

Evaluate the specificity requirements of coding under PDGM

What your agency should be doing now to prepare for coding under PDGM

 4

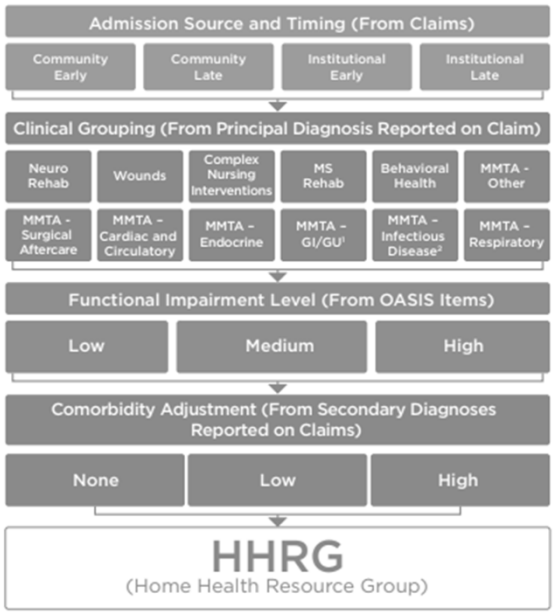
Patient-Driven Groupings Model (PDGM)

- **432 payment groups** – increased from 216 groups originally proposed
- Episode timing: "early" or "late"
- Admission source: Community or Institutional
- Clinical grouping: **12 sub-groups** (primary diagnosis)
- Functional level: 3 groups – Low, Medium or High
- Comorbidity adjustment: None, Low or High (secondary diagnoses)

Patient-Driven Groupings Model (PDGM)

PDGM makes no changes to the 60-day clinical episode certification

- SOC/Recert (Follow-Up)
- 60-day Plan of Care
- Recertification visit within the last 5 days prior to the beginning of the Recertification Episode
- Face to Face Requirements remain



Patient-Driven Groupings Model (PDGM)

Patient-Driven Groupings Model (PDGM)

Admission Source & Timing (Claims) - (Community Early, Community Late, Institutional Early or Institutional Late)

- Only the first 30-day period will be considered Early and all others late. Similar to the current PPS model, the payment period could only be considered Early if great than 60 days has passed since the end of a previous period of care.

Patient-Driven Groupings Model (PDGM)

Admission Source & Timing (Claims) - (Community Early, Community Late, Institutional Early or Institutional Late)

- Admission Source will be Community or Institutional – depending on the healthcare setting utilized in the 14 days prior to home health (inpatient acute care hospitalization, skilled nursing facilities, inpatient rehabilitation facility, psychiatric or long term care hospital)
- **IMPORTANT:** A post-acute stay (SNF, Rehab, LTCH, or Psych) in the 14 days prior to a late home health 30-day period would not be classified as an institutional admission unless the patient had been discharged from home health prior to post-acute stay

Patient-Driven Groupings Model (PDGM)

Clinical Grouping (Primary Diagnosis) – FROM THE CLAIM

NEW -- Medication Management, Teaching and Assessment (MMTA)
- MMTA – Surgical Aftercare
- MMTA – Cardiac/Circulatory
- MMTA – Endocrine
- MMTA – GI/GU
- MMTA – Infectious & Blood-forming Diseases/Neoplasms
- MMTA – Respiratory
- MMTA – Other

- Neuro Rehab
- Wounds
- Complex Nursing Interventions
- Musculoskeletal (MS) Rehab
- Behavioral Health

Patient-Driven Groupings Model (PDGM)

Functional Level (OASIS Items) – (Low, Medium, High)

- Anticipates roughly 33% of periods of care will fall into each of the categories.
- M1800-M1860 and M1033 are OASIS-D1 Items proposed for use in determining Functional Level

OASIS Points Table – **July 2019			
Variable	Response Category	Responses	Points
M1800: Grooming	1	2, 3	5
M1810: Current Ability to Dress Upper Body	1	2, 3	6
M1820: Current Ability to Dress Lower Body	1	2	6
	2	3	12
M1830: Bathing	1	2	3
	2	3, 4	12
	3	5, 6	20
M1840: Toilet Transferring	1	2, 3, 4	5
M1850: Transferring	1	1	3
	2	2, 3, 4, 5	6
M1860: Ambulation/Locomotion	1	2	9
	2	3	11
	3	4, 5, 6	23
M1033: Risk of Hospitalization	4 or more items checked	From 1-7	11

MMTA - Surgical Aftercare	**Low**	**0-37**
	Medium	**38-51**
	High	**52+**
MMTA - Cardiac and Circulatory	**Low**	**0-35**
	Medium	**36-51**
	High	**52+**
MMTA - Endocrine	**Low**	**0-35**
	Medium	**36-51**
	High	**52+**
MMTA - Gastrointestinal tract and Genitourinary system	**Low**	**0-40**
	Medium	**41-54**
	High	**55+**
MMTA - Infectious Disease, Neoplasms, and Blood-Forming Diseases	**Low**	**0-35**
	Medium	**36-51**
	High	**52+**
MMTA - Respiratory	**Low**	**0-37**
	Medium	**38-51**
	High	**52+**
MMTA - Other	**Low**	**0-32**
	Medium	**33-49**
	High	**50+**

 13

Behavioral Health	**Low**	**0-35**
	Medium	**36-52**
	High	**53+**
Complex Nursing Interventions	**Low**	**0-38**
	Medium	**39-57**
	High	**58+**
Musculoskeletal Rehabilitation	**Low**	**0-38**
	Medium	**39-51**
	High	**52+**
Neuro Rehabilitation	**Low**	**0-44**
	Medium	**45-59**
	High	**60+**
Wound	**Low**	**0-41**
	Medium	**42-60**
	High	**61+**

 14

Patient Driven Groupings Model (PDGM)

Secondary Diagnoses – FROM THE CLAIM

- **No comorbidity adjustment**
- **Low comorbidity adjustment:** There is a reported secondary diagnosis that falls within one of the home-health specific individual comorbidity subgroups associated with higher resource use, or;
- **High comorbidity adjustment:** There are two or more secondary diagnoses reported that fall within the same comorbidity subgroup interaction that are associated with higher resource use.

Claims Processing

- When final claims are processed for payment the Medicare MAC will take the information from the claim, CWF and OASIS to group patients into one of the 432 case mix groups and pay the claim based on the HIPPS code that results!
- Imperative that agencies request information from software vendors regarding where the diagnoses codes will be extracted from in the EMR.
- Imperative that we understand each 30-day payment period stands alone

PDGM
CODING IMPACTS

Coding Impact on PDGM

2 of the 5 categories are based on the diagnoses coding

- Clinical Grouping
  - –From Principal Diagnosis Reported on Claim
- Comorbidity Adjustment
  - –From Secondary Diagnoses Reported on Claim

PDGM - Clinical Group Coding

Clinical Group Coding

- Key component of determining payment in PDGM is the 30-day period's clinical group assignment
  - Based on the principal diagnosis code for the patient as reported by the HHA on the home health claim.

PDGM Clinical Groups

TABLE 6: PDGM CLINICAL GROUPS

CLINICAL GROUP	PRIMARY REASON FOR HOME HEALTH ENCOUNTER IS TO PROVIDE:
Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
Wounds - Post-Op Wound Aftercare and Skin/ Non-Surgical Wound Care	Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcers burns and other lesions
Behavioral Health Care	Assessment, treatment and evaluation of psychiatric and substance abuse conditions
Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions including IV, TPN, enteral, nutrition, ventilator, and ostomies
Medication Management, Teaching and Assessment (MMTA)	
MMTA –Surgical Aftercare	Assessment, evaluation, teaching, and medication management for Surgical Aftercare
MMTA – Cardiac/Circulatory	Assessment, evaluation, teaching, and medication management for Cardiac or other circulatory related conditions
MMTA – Endocrine	Assessment, evaluation, teaching, and medication management for Endocrine related conditions
MMTA – GI/GU	Assessment, evaluation, teaching, and medication management for Gastrointestinal or Genitourinary related condition
MMTA – Infectious Disease/Neoplasms/ Blood-forming Diseases	Assessment, evaluation, teaching, and medication management for conditions related to Infectious diseases/Neoplasms/ Blood-forming Diseases
MMTA –Respiratory	Assessment, evaluation, teaching, and medication management for Respiratory related conditions
MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules

PDGM - Comorbidity Coding

- A comorbidity is defined as a medical condition coexisting in addition to a principal diagnosis.
  - Comorbidity is tied to poorer health outcomes, more complex medical need and management, and a higher level of care
- Comorbidity Coding in PDGM
  - Accounts for differences in resource use based on patient characteristics
  - Uses the presence of home health specific comorbidities as part of the overall case- mix adjustment.
  - Payments adjust based on patient's secondary diagnoses as reported by the HHA on the home health claim.

PDGM - Comorbidity Coding

- OASIS only allows HHAs to designate 1 primary diagnosis and 5 secondary diagnoses, however, the home health claim allows HHAs to designate 1 principal diagnosis and 24 secondary diagnoses.
- All 24 secondary diagnoses can impact reimbursement
- The comorbidity adjustment in PDGM can increase payment by up to 20 percent.

PDGM - Comorbidity Coding

- A Home Health-specific comorbidity list was developed with broad clinical categories used to group comorbidities within PDGM
  - Heart disease
  - Respiratory disease
  - Circulatory disease
  - Cerebral vascular disease
  - Gastrointestinal disease
  - Neurological conditions
  - Endocrine disease
  - Neoplasms
  - Genitourinary/Renal disease
  - Skin disease
  - Musculoskeletal disease
  - Behavioral health issues (including substance use disorders)
  - Infectious diseases

PDGM - Comorbidity Coding

- 30-day periods of care can receive a comorbidity adjustment under the following circumstances:
  - **No comorbidity adjustment:**
    - No secondary diagnoses exist or none meet the criteria for a low or high comorbidity adjustment
  - **Low comorbidity adjustment:**
    - There is a secondary diagnosis on the HH-specific comorbidity subgroup list that is associated with higher resource use.
  - **High comorbidity adjustment:**
    - 2 or more secondary diagnoses on the HH-specific comorbidity subgroup interaction list that are associated with higher resource use when both are reported together compared to if they were reported separately.
      - The two diagnoses may interact with one another, resulting in higher resource use.

PDGM - Comorbidity Adjustment

- Only one comorbidity adjustment is permitted
  - A 30-day period of care can receive only one low comorbidity adjustment or one high comorbidity adjustment
    - Regardless of the number of secondary diagnoses or high comorbidity subgroup interactions reported on the claim
  - The highest level will be assigned

PDGM - Comorbidity Adjustment

- 12 comorbidity subgroups receive the low comorbidity adjustment
- 34 comorbidity subgroup interactions receive the high comorbidity adjustment, as noted in the tables on the following slides

PDGM - Low Comorbidity Adjustment Subgroups

TABLE 10: LOW COMORBIDITY ADJUSTMENT SUBGROUPS FOR CY 2020

Comorbidity Subgroup	Description
Cerebral 4	Includes sequelae of cerebral vascular diseases
Circulatory 10	Includes varicose veins with ulceration
Circulatory 9	Includes acute and chronic embolisms and thrombosis
Heart 10	Includes cardiac dysrhythmias
Heart 11	Includes heart failure
Neoplasms 1	Includes oral cancers
Neuro 10	Includes peripheral and polyneuropathies
Neuro 5	Includes Parkinson's disease
Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia
Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers

Source: CY 2018 Medicare claims data for episodes ending on or before December 31, 2018.

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules

PDGM - High Comorbidity Adjustment Interaction Subgroups

TABLE 11: HIGH COMORBIDITY ADJUSTMENT INTERACTION SUBGROUPS FOR CY 2020

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description	Comorbidity Subgroup	Description
1	Behavioral 2	Includes depression and bipolar disorder	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
2	Cerebral 4	Includes sequelae of cerebral vascular diseases	Circulatory 4	Includes hypertensive chronic kidney disease
3	Cerebral 4	Includes sequelae of cerebral vascular diseases	Heart 11	Includes heart failure
4	Cerebral 4	Includes sequelae of cerebral vascular diseases	Neuro 10	Includes peripheral and polyneuropathies
5	Circulatory 4	Includes hypertensive chronic kidney disease	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
6	Circulatory 4	Includes hypertensive chronic kidney disease	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
7	Circulatory 4	Includes hypertensive chronic kidney disease	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
8	Circulatory 7	Includes atherosclerosis	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
9	Endocrine 3	Includes diabetes with complications	Neuro 5	Includes Parkinson's disease
10	Endocrine 3	Includes diabetes with complications	Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia
11	Endocrine 3	Includes diabetes with complications	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
12	Endocrine 3	Includes diabetes with complications	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules

PDGM - High Comorbidity Adjustment Interaction Subgroups

TABLE 11: HIGH COMORBIDITY ADJUSTMENT INTERACTION SUBGROUPS FOR CY 2020

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description	Comorbidity Subgroup	Description
13	Heart 10	Includes cardiac dysrhythmias	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
14	Heart 10	Includes cardiac dysrhythmias	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
15	Heart 11	Includes heart failure	Neuro 10	Includes peripheral and polyneuropathies
16	Heart 11	Includes heart failure	Neuro 5	Includes Parkinson's disease
17	Heart 11	Includes heart failure	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
18	Heart 11	Includes heart failure	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
19	Heart 11	Includes heart failure	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
20	Heart 12	Includes other heart diseases	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
21	Heart 12	Includes other heart diseases	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules

PDGM - High Comorbidity Adjustment Interaction Subgroups

TABLE 11: HIGH COMORBIDITY ADJUSTMENT INTERACTION SUBGROUPS FOR CY 2020

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description	Comorbidity Subgroup	Description
22	Neuro 10	Includes peripheral and polyneuropathies	Neuro 5	Includes Parkinson's disease
23	Neuro 10	Includes peripheral and polyneuropathies	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
24	Neuro 3	Includes dementia	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
25	Neuro 3	Includes dementia	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
26	Neuro 5	Includes Parkinson's disease	Renal 3	Includes nephrogenic diabetes insipidus
27	Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia	Renal 3	Includes nephrogenic diabetes insipidus

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules

PDGM - High Comorbidity Adjustment Interaction Subgroups

TABLE 11: HIGH COMORBIDITY ADJUSTMENT INTERACTION SUBGROUPS FOR CY 2020

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description	Comorbidity Subgroup	Description
28	Renal 1	Includes chronic kidney disease and ESRD	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
29	Renal 1	Includes chronic kidney disease and ESRD	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
30	Renal 3	Includes nephrogenic diabetes insipidus	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
31	Resp 5	Includes COPD and asthma	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
32	Resp 5	Includes COPD and asthma	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
33	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
34	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules

PDGM - Comorbidity Adjustment Example

Low Comorbidity Adjustment

Example

- Secondary diagnosis of I50.9 Heart failure, unspecified
- No additional comorbid diagnoses on the claim that fall into a Low or High Comorbidity Subgroup
- 150.9 falls into Low Comorbidity Subgroup - Heart 11

PDGM - Comorbidity Adjustment Example

High comorbidity adjustment

Example

- I50.32 Chronic diastolic (congestive) heart failure-Comorbidity Group Heart 11 ***and*** G20 Parkinson's disease- Comorbidity Group Neuro 5
  - Both of these diagnoses when reported on the same claim fall within one of the 34 high comorbidity adjustment interaction subgroups -16

Low Comorbidity - Coding Scenario

- Referral from the hospital for Mr. Smith after he was admitted for a wound to his right calf
- Per the physician documentation, the patient has stasis dermatitis and developed a stasis ulcer to the right calf that currently has the fat layer exposed.
- The patient also has a diagnosis of hypertension
- The referral is for wound care twice a week.

Question

How would you code the Primary and Secondary Diagnoses based on the above scenario?

Low Comorbidity - Coding Scenario - Answer

- **Primary Diagnosis:**
  - I87.2 Venous insufficiency (chronic) (peripheral) - MMTA-CARDIAC
    - This diagnosis is primary per coding guidelines- the associated underlying condition is coded first followed by the appropriate L97 code
- **Secondary Diagnoses:**
  - L97.212 Non-pressure chronic ulcer of right calf with fat layer exposed – Comorbidity Subgroup Skin 3
  - I10 Essential (primary) hypertension – No Comorbidity Subgroup
- **Low Comorbidity Adjustment** - there is a reported secondary diagnosis, L87.212, that falls within one of the HH specific individual comorbidity subgroups - Skin 3

Low Comorbidity - Coding Scenario First 30 Day Period

- First 30 day period
- Scenario based on:
  - Admission Source – Institutional
  - Timing – Early
  - Clinical Group – MMTA-CARDIAC
  - Functional Impairment Level – Low
  - Comorbidity Adjustment - Low
- HIPPS of 2HA21, Case Mix weight of 1.2138, LUPA threshold of 4, Payment $2,536

Low Comorbidity - Coding Scenario Second 30 Day Period

- Second 30 day period with no changes in diagnoses
- Scenario based on:
  - Admission Source – Community
  - Timing – Late
  - Clinical Group – MMTA-CARDIAC
  - Functional Impairment Level – Low
  - Comorbidity Adjustment - Low
- HIPPS of 3HA21, Case Mix Weight of 0.6277, LUPA threshold of 2, Payment - $1,311

High Comorbidity - Coding Scenario

- Mrs. Adams was discharged from the hospital, where she was newly diagnosed with acute exacerbation of diastolic CHF. While hospitalized, she was noted to have a Stage 2 pressure ulcer to her coccyx.
- She has history of hypertension.
- Physician referred to home health to monitor cardiac status and BP, teach disease process CHF, and wound care to pressure ulcer

Question

How would you code the Primary and Secondary Diagnoses based on the above scenario?

High Comorbidity Coding Scenario - Answer

- **Primary Diagnosis:**
  - I11.0 Hypertensive heart disease with heart failure – Clinical Group MMTA-CARDIAC
- **Secondary Diagnoses:**
  - I50.31 Acute diastolic (congestive) heart failure - Comorbidity Subgroup Heart 11
  - L89.152 Pressure ulcer of sacral region, stage 2 - Comorbidity Subgroup Skin 4
- **High Comorbidity adjustment** - there 2 or more secondary diagnoses that fall within one or more of the comorbidity interaction subgroups – subgroup 19 - Heart 11/Skin 4

High Comorbidity - Coding Scenario First 30 Day Period

- First 30 day period
- Scenario based on:
  - Admission Source – Institutional
  - Timing – Early
  - Clinical Group – MMTA-CARDIAC
  - Functional Impairment Level – Low
  - Comorbidity Adjustment – High
- HIPPS of 2HA31, case mix weight of 1.3389, LUPA threshold of 4, and payment of $2,797

High Comorbidity - Coding Scenario Second 30 Day Period

- Second 30 day period with no diagnoses changes
- Scenario based on:
  - Admission Source – Community
  - Timing – Late
  - Clinical Group – MMTA-CARDIAC
  - Functional Impairment Level – Low
  - Comorbidity Adjustment – High
- HIPPS of 3HA31, case mix weight of 0.7528, LUPA threshold of 3, and payment of $1,573

High Comorbidity - Coding Scenario

- Mr. Jones is seen in physician office after being discharged from the hospital 2 days ago, where he was treated for exacerbation of COPD and elevated BP.
- He continues to take decreasing doses of prednisone. BP elevated at physician appointment and physician increased dose of Lisinopril.
- Patient complained of pain on his bottom when sitting- found to have Stage 2 pressure ulcer of the coccyx.
- He has history of CHF, Atrial Fib, Parkinson's Disease, & he is taking Coumadin.
- Physician referred to HH- wound care to pressure ulcer 3x/week, monitor resp status, monitor BP, response to med change & ordered PT/INR.

Question
How would you code the Primary and Secondary Diagnoses based on the above scenario?

High Comorbidity Coding Scenario - Answer

- Primary Diagnosis:
  - L89.152 Pressure ulcer of sacral region, stage 2- Clinical Group WOUND
    - This diagnosis is primary as it requires the most intensive skilled service
- Secondary Diagnoses:
  - J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation- Comorbidity Subgroup Resp 5
  - **I11.0 Hypertensive heart disease with heart failure - Comorbidity Subgroup Heart 11**
  - I50.9 Heart failure, unspecified - Comorbidity Subgroup Heart 11
  - I48.91 Unspecified atrial fibrillation - Comorbidity Subgroup Heart 10
  - **G20 Parkinson's Disease - Comorbidity Subgroup Neuro 5**
  - Z51.81 Encounter for therapeutic drug level monitoring - Not in Clinical Grouping
  - Z79.01 Long term (current) use of anticoagulants - Not in Clinical Grouping

High Comorbidity - Coding Scenario

- This scenario would receive a High Comorbidity adjustment - there 2 or more secondary diagnoses that fall within one or more of the comorbidity interaction subgroups – **subgroup 16 - Heart 11/Neuro 5**
  - As you can see, it is important to list all diagnoses that affect the plan of care

High Comorbidity - Coding Scenario First 30 Day Period

- First 30 day period
- Scenario based on:
  - Admission Source – Institutional
  - Timing – Early
  - Clinical Group – Wound
  - Functional Impairment Level – Low
  - Comorbidity Adjustment – High
- HIPPS of 2CA31, case mix weight of 1.5865, LUPA threshold of 4, and payment of $3,314

High Comorbidity - Coding Scenario Second 30 Day Period

- Second 30 day period with no diagnoses changes
- This scenario based on:
  - Admission Source – Community
  - Timing – Late
  - Clinical Group – Wound
  - Functional Impairment Level – Low
  - Comorbidity Adjustment – High
- HIPPS of 3CA31, case mix weight of 1.0005, LUPA threshold of 3, and payment of $2,090

PDGM - Comorbidity Coding

- ICD – 10 Coding Guidelines require reporting of all secondary (additional) diagnoses that affect the plan of care
- New Language "Secondary diagnoses are only to be reported if they are conditions that affect patient in terms of requiring clinical evaluation; therapeutic treatment; diagnostic procedures; extended length of hospital stay; or increased nursing care and/or monitoring"
  - Previous language "potentially affect the patient's care"
- New Language "We do not expect that HHAs would report comorbid conditions that are not being addressed in the individualized plan of care"

PDGM - Comorbidity Coding- Sequencing

- Place diagnoses in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services in accordance with the ICD -10 Coding Guidelines
- Be sure to Sequence of codes following ICD guidelines for reporting: Manifestation codes, 'Code First', Excludes 1 Notes
- Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD guidelines.

Reference: CMS Transmittal 4312, dated, May 23, 2019

PDGM - Comorbidity Coding

- Case-mix variables in PDGM work in tandem to
  - Account for the complexity of patient care needs
  - Make payment for home health services accordingly
- Follow Coding Guidelines and code to what the physician documents and the OASIS assessment indicates is appropriate!

PDGM
UNACCEPTED DIAGNOSIS

PDGM - "Unaccepted Diagnosis"

- Based on the primary diagnosis, each 30 day period will be placed into one of the 12 clinical groupings
- If the primary diagnosis does not fit into one of the 12 clinical groups in the payment model, this is considered an "Unaccepted Diagnosis"
- These were formerly called, "Questionable Encounters"
  - Keep in mind that "UD" or "QE" means a patient's diagnosis isn't appropriate for a Medicare Home Health encounter!

PDGM - "Unaccepted Diagnosis"

- Significance of an "Unaccepted Diagnosis"
  - If a claim is submitted with a primary diagnosis that doesn't fit into one of the 12 clinical groupings, the claim will be sent back to the agency as an "RTP"- Return to Provider.
  - The agency will then need to review & resubmit the claim with a more appropriate primary diagnosis which does fit into a clinical grouping.

PDGM - "Unaccepted Diagnosis"

- CMS stated that returning a claim for more appropriate or specific coding would not be considered as "up-coding" assuming the documentation clearly supports the need for services.
  - Any changes in the plan of care must be signed and dated by a physician.
  - If a claim is returned for more specific coding, diagnosis on the plan of care should be corrected as well

Reference: Federal Register/Vol. 83, No. 219/Tuesday, November 13, 2018/Rules and Regulations

PDGM - "Unaccepted Diagnosis"

- Complete list of ICD–10–CM codes and their assigned clinical groupings is found on the CMS HHA Center web page-
- https://www.cms.gov/center/provider-type/home-health-agency-hha-center.html
  - Become familiar with codes that would be used to group 30- day periods of care into the 12 clinical groupings
  - Number of returned claims should be minimal
    - Avoid listing codes as the principal diagnosis code on the claim that are known "unaccepted diagnosis"

Diagnoses that will not be allowed as a primary diagnosis for Medicare under PDGM *may* be allowed as primary diagnoses for other insurances.

Unaccepted Diagnosis Top 10 Codes

- M62.81 Muscle Weakness (Generalized)
- M54.5 Low back pain
- R26.81 Unsteadiness on Feet
- R26.89 Other abnormalities of gait and mobility
- R53.1 Weakness
- G62.9 Polyneuropathy, unspecified
- R29.6 Repeated falls
- R13.10 Dysphagia, unspecified
- R42 Dizziness and giddiness
- M19.90 Unspecified osteoarthritis, unspecified site

Codes in RED are codes are also in the top questionable codes found industry wide.

Commonly Used Unaccepted Diagnosis Codes

- E08.-- codes for Diabetes due to underlying conditions
- I25.2 Old myocardial infarction
- I95.9 Hypotension, unspecified
- C34.90 Malignant neoplasm of unspecified part of unspecified bronchus or lung
- C50.919 Malignant neoplasm of unspecified site of unspecified female breast
- I69.30 Unspecified sequelae of cerebral infarction
- I70.239 Atherosclerosis of native arteries of right leg with ulceration of unspecified site
- I70.249 Atherosclerosis of native arteries of left leg with ulceration of unspecified site

Commonly Used Unaccepted Diagnosis Codes

- L03.90 Cellulitis, unspecified
- L89.--9 Pressure ulcer with unspecified stage
- L98.9 Disorder of the skin and subcutaneous tissue, unspecified
- M06.9 Rheumatoid arthritis, unspecified
  - Alternative code-M06.89-Other specified rheumatoid arthritis, multiple sites
- M25.551 Pain in right hip
- M25.552 Pain in left hip
- M25.651 Pain in right knee
- M25.652 Pain in left knee

Commonly Used Unaccepted Diagnosis Codes

- M48.00 Spinal stenosis, site unspecified
- M54.30 Sciatica, unspecified side
- M62.50 Muscle wasting and atrophy, not elsewhere classified, unspecified site
  - Code for muscle wasting must include site to be accepted as a primary diagnosis
- R26.0 Ataxic gait
- R27.8 Other lack of coordination
- R33.9 Retention of urine, unspecified
- R55 Syncope and collapse
- R25.9 Unspecified convulsions

Commonly Used Unaccepted Diagnosis Codes

- S06.9X9D Unspecified intracranial injury with loss of consciousness of unspecified duration
- Z48.89 Encounter for other specified surgical aftercare
- Z51.81 Encounter for therapeutic drug level monitoring
- Z51.89 Encounter for other specified aftercare
- Z91.81 History of falling

- Many codes that end with the character "9" are unaccepted diagnosis codes as these codes indicate unspecified sites, or unspecified diseases
- Remember - Unacceptable Diagnoses Can be Secondary Diagnoses!

Resolving an Unaccepted Diagnosis Code

- Review documentation thoroughly to see if specific disease information is included
- Query the physician for:
  - Specific disease information
  - Underlying cause of a symptom
    - Condition causing, for example, Muscle Weakness
- The clinician can determine the site of an issue, such as a wound, and verify/confirm the information with the physician
- **Communication, Communication, Communication!**

PDGM

CODING SPECIFICITY

Coding Specificity:

- Most specific code that describes a medical disease, condition, or injury should be selected.
- "Unspecified" codes are used when there is lack of information about location or severity of medical conditions in the medical record.
- BUT……you are to use a precise code whenever more specific codes are available.
- If additional information regarding the diagnosis is needed, follow-up with the referring provider in order to ensure the Plan of Care (POC) is sufficient in meeting the needs of the patient.

Coding Specificity:

- Many of the codes that indicate pain or contractures as the primary diagnosis, ex: M54.5, Low back pain or M62.422, Contracture of muscle, right hand, is site specific, but doesn't indicate the cause of the pain or contracture.
- CMS expects a more definitive diagnosis indicating the cause of the pain or contracture, as the reason for the skilled care, in order to appropriately group the home health period.

Reference: Federal Register/Vol. 83, No. 219/Tuesday, November 13, 2018/Rules and Regulations

CMS - Coding Specificity: Muscle Weakness

- M62.81, "Muscle weakness, generalized" is extremely vague, therefore, will not be accepted as a Primary Diagnosis under PDGM
  - "Generalized muscle weakness, while obviously a common condition among recently hospitalized patients, does not clearly support a rationale for skilled services and does not lend itself to a comprehensive plan of care."

CMS - Coding Specificity: Muscle Weakness

- 2008 HH PPS final rule, CMS- "Muscle Weakness (generalized)" is a nonspecific condition that represents general symptomatic complaints in the elderly population.
- CMS stated that inclusion of this code "would threaten to move the case-mix model away from a foundation of reliable and meaningful diagnosis codes that are appropriate for home care" (72 FR 49774).

CMS - Coding Specificity: Muscle Weakness

- Clinical record documentation must describe how the course of therapy treatment for the patient's illness/ injury is in accordance with accepted professional standards of clinical practice."
- Without an identified cause of muscle weakness, it would be questionable that the course of therapy treatment meets these professional standards.
- "A more appropriate code would be one of the muscle wasting & atrophy codes as grouped into the musculoskeletal group, which indicate the reason for the generalized muscle weakness & provide more clarity for the necessity of skilled services."

Coding Specificity: Use of R Codes

- R codes- that describe signs and symptoms, as opposed to diagnoses- are Unacceptable Diagnoses as principal diagnosis codes
- Use of symptoms, signs, abnormal clinical & lab findings make it difficult to meet the requirements of an individualized plan of care (CoPs).
- Clinically, it is important for HH clinicians to have a clearer understanding of the patients' diagnoses in order to safely and effectively furnish home health services.

Coding Specificity: Use of R Codes

- Coding guidelines- R codes are to be used when no more specific diagnosis can be made.
- By the time the patient is referred to home health and meets the qualifications of eligibility, a more definitive code should exist to substantiate the need for services.
- This may involve calling the referring physician to gather more information.

Coding Specificity: Use of S and T Codes

- There are many S and T codes where the fracture and/or injury is unspecified, but the site is specified.
- The site of injury and/or fracture should be identified
- The treatment or intervention would likely not change based on the exact type of injury or fracture.
- Many of these codes are appropriate to group into a clinical group, and are either in the musculoskeletal group or the wounds group.

Coding Specificity: Sepsis

- A sepsis diagnosis should be assigned the appropriate code for the underlying systemic infection.
  - These codes will be classified under MMTA—Infectious Disease/Neoplasms/Blood-forming Diseases

NOTE:

In a case where the patient is receiving an IV antibiotic for sepsis, the HHA is required to code sepsis as the primary diagnosis:

- The Z code must be listed as the first secondary diagnosis code listed on the claim in order to group the period into the Complex Nursing Interventions group

Coding Specificity: Use of Z Codes

- Z codes may be used as primary diagnosis
  - Z45.2 Encounter for adjustment and management of VAD - COMPLEX Nursing Interventions
  - Z46.6 Encounter for fitting and adjustment of urinary device will be grouped into the - COMPLEX Nursing Interventions
  - Z47.1 Aftercare following joint replacement surgery – MS_REHAB
  - Z48.00 Encounter for change or removal of nonsurgical wound dressings – WOUND
  - Z48.812 Encounter for surgical aftercare following surgery on the circulatory system – MMTA_AFTER
- In addition to the Z codes listed, there are several others- **Check in ICD 10 diagnosis list**

PDGM
PRIMARY DIAGNOSIS CODING CHANGES

PDGM - Primary Diagnosis Changes

- If the primary diagnosis *changes* between the 1st & 2nd 30-day periods, then the claim for the 2nd 30-day period would reflect the new diagnosis
  - Code would not change the claim for the first 30-day period
- Case mix group cannot be adjusted within each 30-day period
- For claim "From" dates on or after January 1, 2020, the ICD10 code & principle diagnosis used for payment grouping will be from the claim coding rather than the OASIS item.
- The claim and OASIS diagnosis codes will no longer be expected to match in all cases.

PDGM - Primary Diagnosis Changes

- Typically, the codes will match between the 1st claim in an admission & the start of care (Reason for Assessment –RFA 01) assessment & claims corresponding to recertification (RFA 04) assessments.
- 2nd- 30-day claims in any 60-day period will not necessarily match the OASIS assessment.

NOTE: When diagnosis codes change between one 30-day claim and the next, a change in the diagnoses does not necessarily mean that an "other follow-up" OASIS assessment (RFA 05) would need to be completed just to make the diagnoses match.

PDGM - SCIC & Other Follow UP OASIS

- HHA ***is required*** to complete an 'other follow-up' (RFA 05) assessment ***when such a change would be considered a major decline or improvement in the patient's health status***.

- If a patient experienced a ***significant change in condition*** before the start of a subsequent, contiguous 30-day period, for example due to a fall, in accordance with 484.55(d)(1)(ii), the HHA is required to update the comprehensive assessment.

PDGM – Plan of Care (POC)

- CoPs §484.60 - the individualized POC must specify the care & services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care.

- Individualized POC will need to reflect the primary and secondary diagnoses
  - Responsible disciplines must be documented
  - Interventions/Plan for Primary and Secondary diagnoses
  - Outcomes/Goals need to be measurable
  - Accuracy of the Plan of Care

Tying PDGM, Coding Guidelines & CoPs Together!

Precise coding allows for more meaningful analysis of home health resource use and ensures that patients are receiving appropriate home health services as identified on an individualized plan of care.

PDGM
HOW TO PREPARE

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- It is important to implement changes now and not wait until January 1, 2020
- Revise current coding practices
  - Change coding practices now to assure that primary diagnosis codes being used are approved for use as a primary diagnosis under PDGM.
  - All coders should be educated in the list of diagnosis codes in the PDGM Grouper Tool
  - A complete list of ICD–10–CM codes and their assigned clinical groupings is available on the CMS Home Health Agency (HHA) Center web page: https://www.cms.gov/center/provider-type/home-health-agency-hha-center.html

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- Staff Education
  - Intake
    - Ensure that Referral information includes specific diagnoses information
      - Provide training for Intake staff on common diagnosis that are not acceptable as primary diagnosis and may result in an "Unaccepted Diagnosis"
        - » R Codes/Symptom codes
        - » M62.81 Muscle Weakness
        - » M19.90 Unspecified osteoarthritis, unspecified site
        - » C34.90 Malignant neoplasm of unspecified part of unspecified bronchus or lung
        - » M06.9 Rheumatoid arthritis, unspecified
        - » "Unspecified" codes

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- Staff Education
  - Intake
    - Consider Development/refinement of Referral Checklist which includes pertinent data for PDGM:
      - » Referral Source for Community vs. Institutional
      - » Primary diagnosis for home care
      - » Secondary diagnoses/Comorbidities
        - Query if diagnoses are not specific
      - » Documentation supports ordered services

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- Staff Education
  - Intake
    - Consider Development/refinement of Referral Checklist which includes pertinent data for PDGM: (continued)
      - F2F encounter documentation that is consistent with Primary Diagnosis
      - Regulations state the Face to Face must be related to the primary reason the patient requires home health services
        - » States "related to" not "exact"

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- Staff Education
  - Clinicians
    - Educate staff in the importance of following up with the physician to obtain additional diagnoses information if needed
    - Ensure confirmation/clarification of specific diagnoses is documented in the clinical record

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- Staff Education
  - Plan of Care Development
    - Review Current Processes
    - Implement an interdisciplinary team approach
      - Teams with all disciplines assigned & communicate after initial assessments
    - Implement monitoring for compliance – QAPI

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- Physician Education
  - Educate physicians on need for specific information on referral
    - Codes that may result in an "Unaccepted Diagnosis"
      - » R Codes/symptom codes
      - » Muscle Weakness/Weakness
      - » Falls
      - » Difficulty Ambulating
      - » Balance Issues
      - » "Unspecified" codes

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- Physician Education
  - Consider developing a standardized request for additional diagnosis information form
    - The form would include an explanation that due to Medicare coding guidelines, additional documentation for the primary diagnosis is needed
      - » Primary Diagnosis
      - » Symptom code
      - » Specific location
      - » Wound etiology
      - » Etc.

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- Education for Referral sources
  - Basic education on PDGM
    - Understand coding requirements
    - Specificity needed
      - Codes that may result in an "Unaccepted Diagnosis"
        - » R Codes/symptom codes
        - » Muscle Weakness/Weakness
        - » Falls
        - » Difficulty Ambulating
        - » Balance Issues
        - » "Unspecified" codes

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- EMR
  - Diagnosis coding- will the software allow for secondary diagnosis selection, beyond the five allowable on the OASIS assessment?
  - Functional Impairment Level-OASIS-check for inconsistencies?
  - Admission source and timing?
  - Will the software estimate HHRG placement and communicate the related LUPA visit threshold?
  - Order Tracking?
  - Billing and Claims Management?

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- Coding / OASIS Review
- Consider having coding certified/experienced RN's reviewing the physician information, OASIS Comprehensive Assessment, and Plan of Care
- Experts to identify Primary Diagnosis that is approved and most accurate for the Patient
- Communicate to assessing clinician and/or Clinical Manager proactively to query physician for more specific diagnoses
- Ensure consistencies between OASIS, Plan of Care and physician information including Face to Face

SAMPLE INATKE TIPS

REFERRAL CHECKLIST FORM

PDGM - What Do I Need to Do?

Accuracy – important to have accurate and complete referral information

Communication is KEY – communicate with your Intake / referral sources

Train – Train and educate your staff regarding the requirements under PDGM

Intake Tips

- Educate and train your intake staff for the PDGM requirements
- Educate your billing staff on episode timing and admission source and the importance of the common working file
- Talk with your EMR to ensure that your system will be updated for January 1, 2020
- Update your intake forms if using paper tools
- Communicate with your referral sources so that they understand why you will need additional information at intake
- Identify your referral sources that have limited referral information.
- Review your intake processes and staff responsibilities
- Review and streamline your processes

Intake Tips

- Your intake is the front line communication for referral sources
- These tips will benefit both your agency and referral sources to create a good working relationship
- Everyone is busy and does not want "added" work, so an educated referral source will have the needed information and eliminate frustration
- Remember…..ALL Home Health Agencies will be asking Referral Sources for the same items under PDGM

Intake Tips

Important:

- Referral Source – where the referral came from
- Admission Source –institutional or community - ***NEW PDGM***
  - Institutional source - has a 14-day admission lookback (acute care and post-acute care)
  - Community source – no 14-day prior admission
- Timing - ***NEW PDGM***
  - First 30 day period – EARLY
  - All subsequent 30 day periods - LATE
- Diagnosis Coding
  - Gather as much specific documentation as you can at intake.
  - Unspecified codes – unaccepted primary code*
  - Symptom codes – unaccepted primary code*
- Unaccepted ICD 10 codes (previously called questionable encounter codes) – codes that are not grouped for home health reimbursement – cannot be used as a primary diagnosis

Intake Referral Checklist Form

- Admission Source
  - Admission Source – Community / Institutional (acute care, post-acute care or inpatient psychiatric hospital in the past 14 days.).
  - Has patient received home health services from any agency in the last 30 days
  - Has the patient been discharged from a post-acute (SNF/rehab) in the last 30 days
  - Admission 14-day lookback (referral source documentation / Medicare Common working file) for all referrals
- Episode Timing (use Medicare common working file if needed)
- Documentation
  - Face to Face Encounter documentation
  - Detailed documentation supporting medical necessity/need for home health services/homebound status
- Diagnosis
  - Gather as much specific documentation as you can at intake.
  - Detailed diagnosis-specific documentation
    - Symptom Codes –need to query physician and/or referral source
    - Unspecified Codes - need to query physician and/or referral source
  - Be knowledgeable of unaccepted ICD 10 codes
  - May need to contact MD for additional documentation for diagnosis
- Reports
  - H&P
  - Acute and Post-Acute discharge summary reports
  - Any other reports

Conclusion

- Implement coding training now
  - Have certified, experienced coders!
- Identify the unaccepted diagnoses you have currently and the root causes behind them
- Educate referral sources and physician groups
  - Need Specifics!
- Review your Agency processes from intake to discharge to identify any changes needed in work flow
- Preparation is vital to having a smooth transition into PDGM beginning January 1, 2020!

Questions

Upcoming Events

2019 Home Care and Hospice Conference and Expo

October 13-15, 2019 | Seattle, WA

seattle2019.NAHC.org

Upcoming Webinars

PDGM: Billing In Depth

Thursday, September 26, 2019 | 2:00-4:00 PM EDT

Private Duty: Current Trends in Regulatory and Legal Issues

Thursday, October 24, 2019 | 2:00-3:30 PM EDT

 99

Contact Information

Melinda A. Gaboury, COS-C
Chief Executive Officer
Healthcare Provider Solutions, Inc.
mgaboury@healthcareprovidersolutions.com
615-399-7499

Sharon M. Litwin, RN, BSHS, MHA, HCS-D
Senior Managing Partner
5 Star Consultants, LLC
slitwin@5starconsultants.net
1-866-428-4040

 100

HOMECARE & HOSPICE
National Association for Home Care & Hospice

Commercial Support provided by:

YOUR FUNDING TREE