Home Health ICD-9/ICD-10 Alert

PAY FOR PERFORMANCE: EXPECT CODING SCRUTINY UNDER P4P DEMO

PPS changes in 2008 add urgency to your coding accuracy.

Home health agencies in the seven states participating in the pay for performance demonstration project will want to pay special attention to coding's effect on risk adjustment--but all HHAs could benefit from understanding how it works.

In the P4P demonstration project beginning Jan. 1, rewards will go to the agencies with the best outcomes as compared to all other agencies. But looking at the outcomes of specific high-risk categories of patients is still under discussion, says senior consultant **Judy Adams, RN, BSN, HCS-D, COS-C**, with Charlotte, NC-based **LarsonAllen.** "If demo agencies code patients to the highest degree of specificity and as completely and accurately as possible, they will be prepared for whatever analysis, sub-grouping or risk analysis P4P ultimately uses," she adds.

Background: The **Centers for Medicaid & Medicare Services** has named the seven states selected for the two-year P4P demo project: Alabama, California, Connecticut, Georgia, Illinois, Massachusetts and Tennessee. CMS will solicit HHAs from these states to participate voluntarily in the demo. CMS' contractor, **Abt Associates,** will divide participating agencies into a control group not operating under P4P and a "treatment" group, eligible for P4P financial rewards, Abt's **Henry Goldberg** explained in an Oct. 9 session at the **National Association for Home Care & Hospice's** annual meeting in Denver.

Coding Affects Risk Adjustment

Under the prospective payment system update for 2008, CMS allows coders to use V codes in all six reported diagnoses--the primary diagnosis and the top five secondary or other diagnoses. But V codes do not contribute to risk adjustment for outcomes, Adams warns. Risk adjustment determines which agencies CMS compares your agency's outcomes with, she explains.

How it works: Risk adjustment looks at patient characteristics--including prior and current diagnoses and co-morbidities--as well as risk factors most closely associated with specific outcome measures. This process helps ensure a fairer comparison of outcomes between agencies by looking at an agency's patient mix. It helps minimize effects on outcomes that are not under an agency's control.

Example: An agency's patient mix clearly would affect the agency's outcomes on the measure "Improvement in Ambulation/Locomotion." Agency A may have a high concentration of patients with 438.82 (Late effects of CVA with dysphagia) along with 781.2 (Abnormality of gait) while in Agency B most of the patients with a diagnosis code of 781.2 also have the diagnosis V54.81 (Aftercare following joint replacement). Agency B would have a patient population more likely to improve in ambulation when compared with Agency A. Risk adjustment allows a fairer comparison of these agencies' outcomes.

Do Your Part With Sequencing

A coder can help improve an agency's outcomes. Carefully weigh the sequencing of V codes, Adams advises. Place the V code at the bottom of the list unless coding guidelines say you can list the V code only as a primary diagnosis or the V code is the primary reason for home health care, she reminds coders.

Expert advice: Follow official coding rules and guidelines and include V codes that are necessary to clearly define the patient's situation, but use your judgment about where to place the V code, Adams says. By placing the V codes at the bottom of the list, the agency can reserve the top six diagnosis spots for those codes that will add to risk adjustment as well as reimbursement.

Note: For detailed V code information, sign up for Adams' Nov. 27 Eli-sponsored audioconference "Tackling V57.1 and Other Common Coding Dilemmas," at www.audioeducator.com/industry_conference.php?id=640. Use code "10%OFFHHA" for a 10 percent discount.