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Prospective Payment System: Gauge The Impact Proposed PPS Changes Will Have On Your Agency's Bottom Line

Look for secondary diagnoses to gain case mix points.

Say goodbye to your handy case mix diagnosis code cheat sheets if the **Centers for Medicare & Medicaid Services**' proposed refinements to the prospective payment system rule become final.

What's different: The new case mix calculations are more complicated and the link between diagnoses and points isn't as clear cut.

For example: Under the current PPS rule, a diabetes diagnosis as a primary diagnosis brings you 17 case mix points, but the proposed changes drop this to:

• 5 points for episode 1 or 2 with 0-13 therapy visits,

• 11 points for episode 1 or 2 with 14+ therapy visits,

• 2 points for episode 3 + with 0-13 therapy visits or

• 9 points for episode 3 + with 14+ therapy visits.

But the points don't mean the same thing under the proposed changes as they do now, explains **Judy Adams, RN, BSN, HCS-D, COS-C,** with **LarsonAllen** in Charlotte, NC.

Good news: The new case mix calculations add points for secondary diagnoses as well as therapy utilization and whether the episode is early or late in point calculation, Adams says. For example if the diabetes was a secondary diagnosis, you would receive:

• 2 points for episode 1 or 2 with 0-13 therapy visits,

• 4 points for episode 1 or 2 with 14 + therapy visits,

• 1 point for episode 3 + with 0-13 therapy visits or

• 4 points for episode 3 + with 14 + therapy visits.

In the current system, you only get case mix points for a diagnosis if it's the primary focus of care. In the new system, you would get points for primary or secondary diagnoses, although some diagnoses add points only when listed as primary.

Mistake: Coders often misconstrue the term "secondary" as meaning the second ICD-9 code on the list of diagnoses. In actuality, a secondary diagnosis is any diagnosis listed after the primary diagnosis or any code listed in M0240.

Learn The Four Equations

The proposed changes add four equations that affect how many points a particular diagnosis may earn, explains **Mark**

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Sharp with **BKD** in Springfield, MO. They are:

• **Equation 1:** Episode number 1 or 2 with 0-13 therapy visits

• **Equation 2:** Episode number 1 or 2 with 14+ therapy visits

• **Equation 3:** Episode number 3+ with 0-13 therapy visits

• **Equation 4:** Episode number 3+ with 14+ therapy visits

The same diagnosis can score differently across the different equations, Sharp says.

For example: Suppose your patient has a primary diagnosis of cancer which falls under one of the proposed new case mix ICD-9 code categories. You'll earn additional money if your patient falls under the second, third or fourth equation.

But don't expect an additional payment if the patient lands in the first equation. And, the extra reimbursement for a patient in the second or fourth equation (14+ therapy visits) is $500 to $600 -- much greater than the approximately $150 you would earn for a patient under the third equation.

With cancer, you have more extensive resource utilization if you have more therapy utilization, Sharp interprets. Also, the reimbursement distribution implies that resource utilization for these patients doesn't vary much between earlier and later episodes, he says.

Experts warn: The proposed PPS rule refinements will change how people look at diagnoses, Adams predicts. "The grouping isn't as logical as it used to be -- you'll need to look through the tables more. The old system with cheat sheets won't be feasible because it will be even more important to access the notes and tips in the coding manual to be sure you have the correct code," she says.

Predict The Impact On Your Agency

Because the proposed changes to case mix are so complex, it can be difficult to know how they will impact your agency. But one thing you can do if you work with a vendor for benchmarking is look at the case mix data you have for the past year and calculate what your case mix would be under the new guidelines, Adams says.

Strategy: If you don't have a benchmarking vendor, use CMS' toy grouper to enter your OASIS scores for individual patients or simply examine the impact on your agency's most common diagnoses, Adams says.

You can download the toy grouper from www.cms.hhs.gov/center/hha.asp. To see how the changes can impact reimbursement, take a look at the following scenario Adams ran through the toy grouper.

Scenario: Your patient had been in the hospital for gram-negative meningitis and was referred to home health following his hospitalization. There is no further active treatment for the meningitis other than skilled nursing to observe for signs and symptoms of ataxia and convulsions.

For this patient, you would list:

•M0230: V12.42 (Personal of history of infections of the central nervous system);

•M0240: 781.3 (Ataxia NOS);

•M0240: 780.39 (Other convulsions); and

•M0245a: 320.82 (Meningitis due to gram-negative bacteria, not elsewhere classified).

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In 2007, this patient would score C2F1S0 on the OASIS and earn $2084.98 (based on the wage index for Raleigh, NC). But with the proposed changes, in 2008 the same patient would score C1F2S1 on the OASIS and earn only $1,498.15.

Watch for: Monitoring discrepancies be-tween related OASIS answers will become even more important, Sharp says. You'll need to know that a certain score in one area means you should check another area on the OASIS because it could affect your reimbursement.

For example, you'll need to keep a close eye on M0110 (Episode timing) because a particular diagnosis might have more impact on a later episode than on an earlier episode, Sharp says.

The bottom line: Coders will earn their money trying to make sure the right ICD-9 codes are listed and sequenced in proper order and that OASIS is scored correctly, Adams says.

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