Home Health ICD-9/ICD-10 Alert

Prospective Payment System: Industry Responds to Case Mix Diagnosis Code Cuts

Will your reimbursement suffer under these proposed changes?

You're probably already reeling from the many diagnosis coding-related changes you've dealt with recently, let alone preparing for the ICD-10 transition. Now there are case mix changes on the horizon and they're not likely to have a positive impact on your reimbursement. See what the industry has to say about the latest proposed changes.

The proposal: The **Centers for Medicare & Medicaid Services** and its coding and PPS grouper contractors "identified two categories of codes, made up of 170 ICD□9□CM diagnosis codes, which we are proposing to remove from the HH PPS Grouper, effective January 1, 2014," CMS explains in the home health prospective payment system proposed rule published in the July 3 Federal Register. "The inclusion of these diagnosis codes in the grouper was producing inaccurate overpayments," CMS maintains in the rule. Removing the codes from the grouper brings down the case mix average in 2012 from 1.3517 to 1.3417.

First category: In this far larger category, CMS wants to ax codes that are "'too acute,' meaning that this condition could not be appropriately cared for in a HH setting," the agency explains in the rule. CMS believes the codes "likely reflect conditions the patient had prior to the HH admission (for example, while being treated in a hospital setting)" and "the condition progressed to a less acute state, or is completely resolved for the patient to be cared for in the home setting."

Second category: CMS proposes to cut codes for conditions that "would not require HH intervention, would not impact the HH plan of care (POC), or would not result in additional resource use when providing HH services to the patient," it says.

Make Any Changes Budget Neutral

Dropping the codes from the case mix system is far from budget neutral, commenters noted.

This coding change will strip $1.25 billion from Medicare home health spending over the next 10 years, says the **National Association for Home Care & Hospice** in its comment letter on the proposed rule. The eliminations will reduce spending by $100 million in 2014 alone, says the **Home Care Association of New York State** in its comments.

But CMS doesn't make any change to PPS reimbursement rates to make up for the change, commenters note.

California-based health system **Dignity Health** "encourages CMS to reapply savings incurred by the coding update in a budget neutral way and reapportion the affected revenue to other HH PPS rate factors," it says in its comment letter.

Multiple commenters were concerned that CMS furnished no details of its analysis or data to support the change. "Your proposed rule provides no clinical data to support your assertions that these conditions should not be treated in a home health setting," the **Wound Ostomy and Continence Nurses Society** says in its letter.

"The selection of these ICD-9 codes seems to be without any data analysis or review of clinical literature regarding whether or not all of these diagnoses should be eliminated as not appropriate for home health care," the **Texas Association for Home Care & Hospice** admonishes in its letter to CMS.

Eliminating Certain Codes Could Lead To More Rehospitalizations

In many cases, the code eliminations are unwarranted and CMS should not go through with them, multiple commenters argued.

"Elimination of some of the ICD-9 codes for home care is not appropriate and does not reflect the complexity and acuity levels of home care patients today," maintains **Pat West** of **Pioneer Home Health** in Bishop, Calif. "Home health agencies must receive adequate reimbursement to care for these complex patients in order to keep them at home and reduce unnecessary and expensive re-hospitalizations," West says in a comment letter.

"We have serious concerns that your proposed rule lacks a complete understanding of how these conditions are treated post-operatively," the WOCN says. "In our experience these conditions are, in fact, treated appropriately in the HH setting and we are concerned that by eliminating the codes from HH PPS grouper we might see a higher risk of readmission to the acute care setting due to complications from the lack of treatment to these conditions."

Home health agencies will continue receiving referrals for patients with the codes slated for elimination, "and will continue caring for them in the home environment," says the **Illinois Home Care & Hospice Council**. "How will we get paid for caring for these individuals care that often helps to prevent subsequent use of much higher cost services?"

Coding Confusion Persists

In addition to the economic impact, this change highlights an ongoing problem with diagnosis coding and Medicare reimbursement. "This proposal reflects an ongoing conflict within CMS over how coding for home health episodes should be implemented," IHHC says in its letter. "Sometimes managing the symptoms of underlying conditions is critical to helping a Medicare beneficiary in his or her transition from inpatient care to the home. In other cases, providing home care to address the symptoms of a new problem of an acute exacerbation of a chronic condition is critical to preventing the need for inpatient care."

Restricting diagnoses for the home health setting may result in patients being bumped to higher cost care, "when lower cost care in the patient's preferred setting can achieve the same or a better outcome," the trade group says. "This is particularly true given the nosocomial infection rates in hospitals and nursing homes, and the potential impact contraction of these maladies can have on elderly patients."

CMS needs to steer a steady course for coding. "Repeated changes in direction related to diagnosis coding have characterized CMS' approach to this payment system since its inception," IHHC notes. "CMS must work to resolve the ongoing contradiction in its approach to selecting codes for reimbursement under the HHPPS."

Bottom line: "If coding conventions require providers to identify the underlying condition then we should not be prevented from doing so for conditions that are legitimately addressed in the home setting a category of conditions that has grown significantly in past years and will continue to grow," the trade group maintains.

Timeline: It will still be a few weeks before home health agencies know which codes will be dropped from the case mix list. Thanks to the government shutdown, CMS has pushed back the publication date for the home health prospective payment final rule, which it usually releases in late October or early November.

"We intend to issue the final rules on or before November 27, 2013, generally to be effective on January 1, 2014," CMS says in a notice.

Note: See a list of all 170 codes slated for case mix elimination in the rule on pp. 7-9 of the PDF at www.gpo.gov/fdsys/pkg/FR-2013-07-03/pdf/2013-15766.pdf.