Codify
BY AAPC

MDS Alert

PDPM Deep Dive: Look to HIPPS to Understand Why Diagnosis Code Rankings Matter

HIPPS codes were restructured with the advent of PDPM.

You know that acquiring ICD-10 fluency is a major component of navigating the Patient-Driven Payment Model (PDPM) successfully. But do you know how the Centers for Medicare & Medicaid Services (CMS) determine which diagnoses receive which reimbursement?

You may know that you should sequence ICD-10 diagnosis codes in MDS item I1800 (Additional Active Diagnoses), but if you've ever wondered about the reason, read on.

"The sequencing has to do with prioritizing Non-Therapy Ancillary (NTA) rather than non-reimbursed conditions to ensure appropriate reimbursement for services provided," says **Maureen McCarthy, RN, BS RAC-MT, QCP-MT, DNS-MT, RAC-MTA**, president and CEO of **Celtic Consulting** in Torrington, Connecticut.

Understand Role of Diagnoses

PDPM is centered on provided care specific to each individual resident, including making sure that the resident's health or medical condition necessitates the kind of care that only a nursing facility can provide. So even if the resident has active diagnoses that require medical management, listing certain diagnoses first can lead to reimbursement that more accurately reflects the level of care that resident requires. So, don't list the nail fungus code before diabetes.

"The point of sequencing from a reimbursement standpoint is to make sure all of the diagnoses supporting skilled coverage during the claim period are on the claim," says **Jennifer E. LaBay, RN, RAC-MT, RAC-MTA, CRC**, MDS and policy consultant at **Triad Health Care LLC** in Providence, Rhode Island. "The primary diagnosis on the claim is the main reason why skilled services are required."

However, the other diagnoses - as many as eight - more fully shape CMS' understanding of the resident's health situation and residence in a facility.

"Medicare reviews the top eight secondary diagnoses to determine which diagnoses supported the skilled coverage. This is per Chapter 6 of the Medicare Claims Processing Manual," LaBay says.

ICD-10 Codes Determine HIPPS Codes

The nitty-gritty reasoning underlying ICD-10 code usage on the MDS is so diagnoses are reflected on the facility's claim to Medicare for payment, which utilizes Health Insurance Prospective Payment System (HIPPS) rate codes.

Definition: "Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of [resident] characteristics (or case-mix groups) health insurers use to make payment determinations under several prospective payment systems. Case-mix groups are developed based on research into utilization patterns among various provider types. For the payment systems that use HIPPS codes, clinical assessment data is the basic input," says the CMS Division of Institutional Claims Processing.

However, PDPM has changed the available HIPPS codes. "Under PDPM, the HIPPS code is structured differently. Instead of a three position RUG group, there are five case-mix adjusted rate components," CMS says. "... Under the PDPM, there is a much greater number of valid HIPPS codes, as compared to RUG-IV."

This is mostly helpful as general knowledge and a deeper understanding of how CMS uses the ICD-10 codes to determine payment; the diagnosis codes you list may not make it onto the actual claim.

"The diagnoses on the MDS help create the HIPPS, but those codes on the MDS do not necessarily have to be reflected on the claim. The look back on the MDS is 7 days, but the claim period on the claim could be up to 31 days," LaBay says.

This Diagnosis Affects Payment

Even though, as a general rule, ICD-10 codes won't appear on the claim your facility makes for reimbursement, one diagnosis code can determine reimbursement.

"The only diagnosis on the claim that affects payment is B20 (Human immunodeficiency virus [HIV] disease) which would impact the calculation of the payment for the nursing component and NTA points after the bill is submitted to the Medicare Administrative Contractor (MAC)," LaBay explains.

Worried About Your Coding? Try This

Now that you more fully understand how ICD-10 codes can impact payment, consider putting a system in place to triple-check everything. McCarthy recommends auditing your coding.

McCarthy recommends using these questions to evaluate that the ICD-10 code choices are accurate and appropriate:

- Do all diagnoses agree across various disciplines?
- Are all required codes reported?
- Whose code is it?
- Do the codes reported on the claim coincide with the codes reported by MDS, rehab, or the physician?
- Were any claims denied/returned/suspended?

If you're having problems receiving payment, your claims may be the problem. Implement these steps as part of your code audit process, McCarthy says.

- Monitor appropriateness of diagnosis codes on your claims prior to submission.
- Update triple-check processes to include diagnosis review, if not already included.
- Review of rejected and denied claims for correction.
- Resubmission of corrected claims.