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OASIS Alert

Diagnosis Coding: Brace Yourself: CMS Cuts 170 Case Mix Codes

Bone up on OASIS accuracy to help soften the blow.

Despite hearty protests from the industry, CMS has slashed 170 diagnosis codes from the prospective payment system case mix calculation for 2014.

Get the Background on the Cuts

Last summer, the Centers for Medicare & Medicaid Services and its coding and PPS grouper contractors identified two categories of codes it wanted to eliminate from the PPS grouper. "The inclusion of these diagnosis codes in the grouper was producing inaccurate overpayments," CMS said in the proposed rule. Removing the codes from the grouper brings down the case mix average in 2012 from 1.3517 to 1.3417.

CMS wanted to ax two categories of codes those that are "too acute" and those that didn't require home health treatment. Category 1 codes are diagnoses that are considered too acute to be treated in the patient's home, says Jennifer Warfield, RN, BSN, HCS-D, COS-C, education director with PPS Plus Software in Biloxi, Miss. These "too acute" codes represented conditions that HHAs could not appropriately care for in a home health setting, the agency said. CMS believed 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."

The smaller list of Category 2 codes should not affect a home health patient's care at home, Warfield says. These codes "would not impact the home health plan of care (POC), or would not result in additional resource use when providing home health services to the patient," the proposed rule said.

For example: ICD-9 code 447.2 (Rupture of artery) would be an emergency situation for which the patient could never be safely cared for at home, Warfield says. In Category 2, the code 530.81 (Esophageal reflux) reflects a condition that does not require home health intervention, would not impact a patient's POC, or would not result in additional resources to care for this patient.

Providers seemed fine with some of the codes getting ditched. A number of the codes "shouldn't have been in there," acknowledges financial expert Pat Laff with Laff Associates in Hilton Head, S.C.

"What bothers me the most are GI codes with hemorrhage or bleeding, says Lisa Selman-Holman, JD, BSN, RN, COS-C, HCS-D, HCS-O, AHIMA Approved ICD-10-CM Trainer/Ambassador of Selman- Holman & Associates, LLC, CoDR Coding Done Right and Code Pro University in Denton, Texas. "If the patient received treatment for the condition in the hospital or even in the ER and then was discharged home, the physician will likely document the hemorrhage or bleeding, for example diverticulitis with bleeding. That is what we have to code since we have to code based on the physician documentation."

No points: "That code has been cut from the case mix list, however the code for diverticulitis without mention of bleeding is still on the case mix list," Selman-Holman says. "The kicker is that the patient with bleeding may still be sent home for skilled nursing for observation and assessment. That patient requires more utilization, but the diagnosis no longer earns points."

Not on the POC? Don't Code It.

"The truth is that some agencies may have been getting case mix points they should not have gotten," says Ann Rambusch, MSN, HCS-D, HCS-O, COS-C, RN, AHIMA Approved ICD-10 Trainer with Rambusch3 Consulting in Georgetown,

Texas.

"The OIG found in an audit reported in March that agencies were coding diagnoses such as GERD (530.81) on the basis of medication the patient was taking or a reference to the condition in physician notes, Rambusch points out.

"The OIG also found that while an agency coded the diagnosis for case mix points, there was rarely any reference to care in the plan of care," Rambusch says. "So the exclusion of GERD (one of eight category 2 diagnoses on the list) from the case mix list isn't surprising. CMS concluded that the condition did not contribute significantly to the use of additional resources and/or did not impact the POC."

Bottom line: "CMS expects that if a diagnosis is significant enough to code (and receive case mix points) then we should be doing something about it," Rambusch cautions.

But commenters protested getting rid of many of the codes. In the "too acute" category, providers and industry reps lobbied to keep codes for GI ulcers and gastritis (531-535), Diverticulitis/diverticulosis (562), Hemorrhage of GI tract (578.9), Post-hemorrhagic anemia (285.1), Peritonitis (567. 21), Peritoneal Abscess (567.22), Liver Abscess (572.0), and Acute pancreatitis (577.0), among others.

In the second category, commenters wanted to keep Restless leg syndrome (333.94), and Sickle cell trait (282.5), they said in letters commenting on the proposed rule.

In the 2014 HH PPS final rule published in the Dec. 2 Federal Register, CMS shoots down commenters' many objections and finalizes the 170 codes' removal from the grouper effective Jan. 1. "The removal of the 170 codes encourages compliance with ICD-9-CM coding guidelines and ensures that conditions that are either too acute to be treated in a home health setting or do not represent the resources assigned to a diagnosis group are removed from assignment to one of our diagnosis groups within the HH PPS Grouper," CMS says. "The removal of these codes is appropriate, either because these conditions cannot be appropriately treated in a home health setting, or because these conditions do not impact the home health plan of care and result in overpayments to HHAs."

"Many of the codes on the list that were classified by CMS as 'acute' conditions, should never have been coded in the home health record based on coding guidelines because the conditions had evolved into a more chronic version of the disease," Rambusch says.

Prepare for Financial Impact

"The double whammy of annual changes plus rebasing will have a huge impact on payment for home health episodes," says Judy Adams, RN, BSN, HCS-D, HCS-O, with Adams Home Care Consulting in Asheville, N.C. "CMS's analysis of the reasons for deleting the 170 case mix diagnoses and their response to comments is pretty complete. Many of those conditions would be appropriate as aftercare codes and not the acute condition codes in the primary and secondary diagnoses."

"CMS set all case-mix weights to 1.00 by applying a reduction factor of 1.3417 to the current weights for each diagnoses group by basing the reduction factor on the average case-mix weight for 2012," Warfield says.

Consider this: "Since all the analysis was on 2012 claims, I wonder how much the use of the payment diagnosis (M1024) had on the number of incorrect codes," Adams says. "In 2012, HHAs were still allowed to code the underlying illness that was replaced by a V code."

Know what You can do

So, what can you do to help mitigate the hit your agency's reimbursement will take as a result of these changes? There are two actions you should take, Adams advises.

1. Follow the Official Coding Guidelines and
2. Be as accurate as possible with OASIS scoring.

"The reductions in reimbursement associated with the rebasing will have a significant impact on home health agencies," Adams predicts. "The number of visits has already been reduced, so the primary action you can take will be to improve accuracy in scoring and improve thoroughness of the assessments to reach the best possible information to base the plan of care on."

Tip: CMS has not made coding these diagnoses off-limits for home health, Rambusch says. "The diagnoses will just be excluded from case mix consideration." But, "these diagnoses must still meet the coding guidelines to be assigned in the record whether they receive case mix points or not."