OASIS Alert

PPS 2013: Brace Yourself: CMS Moves Forward with M1024 Changes

PPS 2013 clarifies and changes resolved condition reporting.

Come Jan. 1, the way you answer M1024 -- Payment diagnoses will change drastically. The good news is the instructions for answering this item will be much easier to follow. The bad news is that thanks to grouper logic changes, your reimbursement may take a hit.

Changes to the grouper logic will encompass three areas:

1. Restrict M1024 to Fractures Only

Starting in 2012, the **Centers for Medicare & Medicaid Services** will modify instructions for the payment diagnosis field to restrict awarding case mix points to aftercare for fracture situations alone. CMS plans to alter the grouper logic to award points only when a V54.1x (Aftercare for healing traumatic fracture) or V54.2x (Aftercare healing pathological fracture) is reported as a primary or secondary diagnosis and paired with a fracture code from the newly released V code/fracture code pairing listing.

This will limit M1024 to using only fracture codes to calculate case mix points, since you can only report acute fracture codes for 'active treatment' under ICD-9-CM rules, says **Judy Adams, RN, BSN, HCS-D, HCS-O,** with **Adams Home Care Consulting** in Chapel Hill, N.C.

However, "historically, home health agencies rarely receive any case mix points from these fracture diagnoses," Adams points out. This is because to receive points, the fracture diagnoses must meet all of the conditions for Ortho 1 or Ortho 2 diagnoses as listed in Table 2b, Case Mix Adjustment Variables and scores, she explains. The conditions required in order to receive case mix points for fracture aftercare are:

Line 19: Primary or other diagnoses = Ortho 1 -- Leg Disorders or Gait Disorders **and** M1324 -- Most problematic pressure ulcer stage = 1,2,3, or 4.

or

Line 20: Primary or other diagnosis = Ortho 1 -- Leg **or** Ortho 2 -- Other orthopedic disorders **and** M1030 -- Therapy at home = 1 (IV/Infusion) or 2 (Parenteral).

Don't miss: This change eliminates the Table of V Codes the grouper may use with columns 3 and 4 of M1024 that has been in place since the Prospective Payment System enhancements in 2008, Adams says. Replacing the old table is a new table pairing V codes V54.1x, or V54.2x with fracture codes. (You'll find the new table in the final rule, beginning on page 143: www.ofr.gov/OFRUpload/OFRData/2012-26904_PI.pdf.)

2. Watch Coding Changes for DM, Skin 1 and Neuro 1

CMS also plans to move forward with a revision "to score Diabetes, Skin 1 or Neuro 1 diagnosis codes when submitted immediately following a V code in the primary diagnosis field the same as they are currently scored when a V code is reported in the primary diagnosis field and the supporting diagnosis code is reported in the payment diagnosis field," according to the final rule.

In other words: Diagnoses from these categories that are displaced by a V code in M1020 will receive points only if they are unresolved conditions that you list directly under the V code listed in M1020, Adams explains. According to the final rule, the new algorithm for the grouper will award the higher case mix points currently limited to the M1020 slot when

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you list these diagnosis codes in the first M1022 position immediately following the V code, she says.

3. Say Goodbye to Points for Resolved Conditions

Once the 2013 PPS changes go into effect, you will no longer earn case mix points for any case mix diagnoses/conditions that are resolved by surgery or are no longer current, Adams says. As of Jan. 1, CMS will modify the M1024 rules to allow coders to continue to report "resolved conditions related to the plan of care that may be significant in describing the patient," but the grouper will no longer award any points for diagnoses other than the fracture codes.

This change seems to go against long-held CMS guidance, Adams says. Since 2003, there has been a common understanding that coders could list the underlying reason for surgery or other aftercare in the payment diagnosis slot corresponding to the V code replacing that diagnosis. "In fact, the OASIS directions prior to 2003, before CMS allowed V codes to be used by home health, were specifically to code the underlying reason for the surgery when a patient had surgery or other treatment to treat and correct a diagnosis," she says.

Once CMS began allowing the use of V codes in 2003 to be compliant with HIPAA, the instruction changed to coding the underlying diagnosis/condition in M0246, the newly created payment diagnosis item, to garner case mix points for the underlying diagnosis, Adams says. "Since that time, the same system has been used by home health agencies with no questions or denials from intermediaries for the last 10 years."

In the new rule, CMS calls out HHAs for coding incorrectly and indicates that this is one reason for the M1024 change. "But this situation has never been previously identified to the home health industry," Adams says.

"I believe the mixed messages that CMS has given over the past several years on M1024 have been made more clear without [CMS] taking much of the blame except that [in the final rule] they 'conclude that the guidance (Attachment D) issued did not fully communicate that the reporting of resolved conditions in the payment diagnosis field should be limited.' Not only did the attachment not accurately explain what they wanted, but on national calls, CMS representatives were not clear over the years," maintains **Nick Dobrzelecki**, chief executive officer of **Daymarck Home Healthcare Coding** in Bismarck, N.D.

How Will Your Reimbursement Fare?

CMS claims payment impact will be minimal as a result of these changes, but industry experts think otherwise.

"HHAs will see a significant impact on their reimbursement beginning in January since case mix points from diagnoses replaced by aftercare V codes have been significant in the home health setting," Adams predicts. "In fact, a majority of the home health case mix diagnoses are unlikely to be seen in home health except as the underlying reason for aftercare, thus making a large portion of the case mix diagnoses null and void."

"CMS is obviously looking to correct the +0.0533 increase in case mix from 2007 to 2008 due to the introduction of points for secondary diagnosis codes. CMS should have seen that coming back then and adjusted other formulas to offset this," Dobrzelecki says. CMS doesn't include the loss of case mix points in calculations of the overall case mix reduction because CMS does not feel that these points should have been awarded in the first place, he says.

Bottom line: "The final rule will allow other case mix diagnoses that are displaced by a V code at M1020 or M1022 to be listed in M1024, at the request of providers, to gather any potential risk adjustment credit, but they will not be awarded any case mix points," Adams says.

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