OASIS Alert

Prospective Payment System: Home Care Providers Give CMS an Earful Over M1024 Changes

Proposed update could reduce payment by an average of $200 per episode.

CMS asked for comments on the 2013 home health prospective payment system proposed rule, and the home health industry responded with passion. Publicly submitted comments showed that one hot-button issue centers around proposed changes to M1024 -- Payment diagnoses.

In the rule published in the July 13 Federal Register, the **Centers for Medicare & Medicaid Services** revealed plans to alter the home health PPS grouper logic behind M1024 in two ways:

1. Restricting M1024 for use with fracture codes alone. "We propose to restrict M1024 to only permit fracture (V-code) diagnoses codes which according to ICD-9-CM coding guidelines cannot be reported in a home health setting as a primary or secondary diagnosis. To further ensure compliance with proper coding guidelines, we propose to pair the fracture codes (V-code) with appropriate diagnosis codes and only when these pairings appear in the primary and payment diagnosis fields will the grouper award points," CMS says in the proposed rule.

2. Changing logic to award maximum points for Diabetes, Skin 1, or Neuro 1 when listed in M1022b. "Currently, when a code from the Diabetes, Skin 1 or Neuro 1 group is submitted in the primary diagnosis position (M1020) the diagnosis code may score additional points. In situations where ICD"9 coding guidelines have required a V-code to be submitted in the M1020 position, HHAs have been instructed to report the etiology code in the payment diagnosis field (M1024) and receive equivalent scoring. Specifically, we are proposing a revision in HHRG logic to permit equivalent scoring when the Diabetes, Skin 1 or Neuro 1 codes are submitted immediately following the V-code in the M1020 position without requiring utilization of the payment diagnosis field," CMS explains.

CMS's comment period on the rule closed Sept. 5, and many of the 130+ commenters expressed concern about the unfairness of these changes.

"With out the ability to code medically relevant diagnosis in M1024, the home health industry faces a large decrease in reimbursement as well as not being able to fully communicate and express the conditions and ailments that are being treated in the home," said commenter **Patricia Antonelli** of N.Y.

"This does a severe disservice to all the patients we care for as well as our staff," Antonelli continues. "Without the proper funds, quality of patient care has no choice but to suffer. No one is getting rich from home healthcare. Major cuts have already been made. The healthcare industry as a whole cannot survive and sustain itself through a monetary starvation like the one being proposed by CMS."

The "CMS proposal to 'enhance' the HH PPS Grouper will inappropriately eliminate assignment of case-mix points to the majority of diagnosis codes that are replaced by V codes, and limit the ability to report all Diabetes, Neuro1 and Skin1 codes in the limited spaces at M1020 and 1022," the **National Association for Home Care & Hospice** said in its comments on the proposed rule.

"This recommendation uses the flawed Attachment D guidance as its basis, resulting in disallowance of payment for many of the diagnoses identified by **Abt Associates** in its analysis of home health claims from the first years of PPS as having an impact on resource utilization," NAHC continues.

Watch for Falling Reimbursement

The proposed changes will have a negative impact on reimbursement, especially when it comes to resolved conditions, warn many commenters. "If implemented as written, we believe there is going to be a significant case mix decrease with unintended consequences for patients," says **Nick Dobrzelecki,** CEO of **Daymarck Home Healthcare Coding** in Bismarck, N.D.

For example: A home health agency caring for a status post-mastectomy patient who is not receiving additional treatment for cancer would typically list an aftercare code in M1020/M1022 and the Breast Neoplasm code in M1024, Dobrzelecki says. "This would add case mix points and non-routine supply points to the episode." But based on the proposal, agencies would receive significantly less reimbursement for such patients "who require substantial and costly medical supplies," he says.

"The proposed change will have a material, negative impact on case mix weights and payments for home health services," NAHC warns. Based on information from more than 300 home health agencies about the effect of the proposed change to grouper logic on clinical scores, the association concludes that "this change will reduce payment of affected episodes by an average of $200 per episode. This would result from the lowering of Clinical scores from C3 to C2 and from C2 to C1."

For example: A first episode low therapy patient admitted to home health for post operative care following surgical resolution of an intestinal obstruction (ICD-9 code 560) who also has a surgical wound would receive 4, rather than 6, case-mix points in the clinical domain. This would result in a C1, rather than a C2 severity level score, NAHC points out.

Resolved Conditions Lose Out

The practice of using M1024 to report resolved conditions that are "replaced" by a V code in M1020/M1022 will be a thing of the past if the proposal isn't changed.

"CMS seems to be imposing edits that would exclude certain V-coding for payments for conditions that are resolved (often by surgery) prior to home health admission but which require additional care in the home health setting as the patient recovers," the **Visiting Nurse Associations of America** says in its comments. "CMS indicates that its proposed edits are intended to eliminate inappropriate coding. However ... necessary and proper coding rules that have appropriately driven payment are being eliminated."

"Many Neuro1 and Skin1 conditions are treated by surgery, thus these diagnoses must be replaced with V codes in the primary and secondary fields (e.g. neoplasm of the brain, rupture of an artery, etc.)," NAHC points out. "We believe CMS is incorrect in stating: 'Specifically, we are proposing a revision in HHRG logic to permit equivalent scoring when the Diabetes, Skin1 or Neuro1 codes are submitted immediately following the V code in the M1020 position without requiring utilization of the payment diagnosis field.'"

"The proposed change in M1024 ... would put all homecare agencies at an unfair disadvantage," Texas-based Providence Home Care says in its comments. "We deliver care to many clients who suffered illnesses that affect them. These illnesses may no longer be present but the client still requires care for the resulting condition. We expend time, money and energy to make sure these clients do not return to the hospital and we deserve to be compensated for the care we deliver."

Timeline: CMS expects to issue the 2013 home health PPS final rule in early November.

Note: The 2013 PPS proposed rule is at www.gpo.gov/fdsys/pkg/FR-2012-07-13/pdf/2012-16836.pdf.