OASIS Alert

Take a Closer Look at these Diagnoses On the PPS Chopping Block

Say goodbye to a slew of resolved conditions and hello to less detailed reporting.

The changes the **Centers for Medicare & Medicaid Services** suggests making to the home health PPS grouper logic could have far-reaching consequences, commenters to the proposed rule point out.

The proposed change "will deprive home health agencies of case-mix points, and thus payment, for care to patients whose conditions are resolved by surgery and/or other medical means, despite the fact that these diagnoses were determined to impact resource use," the **National Association for Home Care & Hospice** says in its comments on the proposed rule. These conditions include the majority of gastrointestinal conditions, cancers, and orthopedic conditions treated by surgery, as well as resolved infections that require post-acute care in the home (e.g., meningitis).

"Home health, by the nature of the setting, frequently provides aftercare to patients following surgery or other treatment that 'resolves' the underlying diagnosis," says commenter **Judy Adams, RN, BSN, HCS-D, HCS-O,** with **Adams Home Care Consulting** in Chapel Hill, N.C.

Background: Starting in 2003, home health agencies began reporting V codes in compliance with HIPAA requirements to describe aftercare situations, Adams points out. In the same year, agencies began reporting the underlying diagnosis responsible for the aftercare in the payment diagnosis slot, then M0245, now M1024, she explains.

"With the expansion of the OASIS in 2008, the list of case mix codes for home health was expanded to include a large number of diagnoses that are typically seen only as the underlying reason for the aftercare," Adams says. "Removing the ability to list these diagnoses in M1024, to receive the associated payment, will significantly lower the reimbursement to HHAs to care for patients that require the associated aftercare."

If CMS moves forward with the proposed changes to the grouper logic, NAHC points out that a number of diagnoses that impact resource utilization will no longer be eligible for reporting at M1024. Diagnoses that could be affected include ICD-9 categories:

- 140-199 (Neoplasms)
- 213-234 (Benign neoplasms and carcinoma in situ)
- 320-326 (Inflammatory diseases of the central nervous system)
- 414 (Other forms of chronic ischemic heart disease)
- 440 (Atherosclerosis)
- 530-562 (Diseases of esophagus, stomach, and duodenum, appendicitis, hernia of abdominal cavity, noninfectious enteritis and colitis, and other diseases of intestines), 564-567 and 569 (Other diseases of intestines and peritoneum)
- 570 (Acute and subacute necrosis of liver) 574-577 (Cholelithiasis, Other disorders of gallbladder, other disorders of biliary tract, and diseases of pancreas)
- 685 (Pilonidal cyst)
- 707 (Chronic ulcer of skin)
- 711 (Arthtropathy associated with infections)
- 713 (Arthropathy associated with other disorders classified elsewhere)
- 715 (Osteoarthrosis and allied disorders)
- 716 (Other and unspecified arthropathies)
- 720-724 (Dorsopathies)
- 726 (Peripheral enthesopathies and allied syndromes)
- 727 (Other disorders of synovium, tendon, and bursa)

- 730 (Osteomyelitis, periostitis, and other infections involving bone)
- 731 (Osteitis deformans and osteopathies associated with other disorders classified elsewhere)
- 733 (Other disorders of bone and cartilage)
- 741 (Spina bifida)
- 785 (Symptoms involving cardiovascular system)
- 831-838 (Dislocation)

Don't miss: "Not only will this proposed change to the grouper impact case-mix scores and payment for episodes, but will also affect non-routine supply payments," NAHC says.

Still More Problems

If all this isn't enough, NAHC also notes that the proposed rule seems to indicate that case-mix points will no longer be available for fractures when a fracture is not a primary diagnosis. "If that is the result of this proposal, payment will be inappropriately reduced."

"Diagnoses must be sequenced based on the intensity of services for comorbidities. Often a person comes to the attention of the healthcare system after sustaining a fracture. However, once discharged to the community, a coexisting medical condition may initially require more intensive home care services than the fracture, or an 'aftercare of fracture' code may be required by coding rules, thus causing the fracture to be reported as a secondary diagnosis," NAHC says.

Another loss: "Prohibiting reporting of diagnoses that require V codes in the primary and secondary fields in OASIS M1024 will eliminate the only avenue for capturing important public health and health planning data sources about underlying medical conditions that require post-acute home health services," NAHC points out.

For example: "Every patient requiring post-surgical care will be identified with the same V code diagnosis when the causative condition was removed," NAHC notes. "Therefore, all patients seen in home health for post operative care after removal of a benign tumor, a malignancy, a gastrointestinal or genitourinary disorder, or a gangrenous limb, or services needed to address post-acute meningitis sequela, will all be identified with the primary diagnosis of V58 (Encounters for other and unspecified procedures for aftercare)."