



Monday, October 14, 2019 3:15 PM

401 Understanding Diagnosis Coding in PDGM for Compliance and Optimum Financial Performance

A stylized illustration of a city skyline with various buildings in shades of orange, yellow, and grey, and green trees in the foreground. The background is a light blue sky.

Understanding Diagnosis Coding in PDGM for Compliance and Optimum Financial Performance

The art of life is a constant
readjustment to our surroundings. -

-

Kakuzo Okakura

TABLE OF CONTENTS

Explain the Impact of Coding under PGDM

Evaluate the specificity requirements of coding under PDGM

What your agency should be doing now to prepare for coding under PDGM

© 2019 5 Star Consultants, LLC

3

PDGM – Payment Groupings Overview\

- CY 2019 Home Health final rule, PDGM will be implemented for 30-day periods of care starting on or after January 1, 2020
 - PDGM uses 30-day periods as a basis for payment.
 - 30-day periods are categorized into 432 case-mix groups for the purposes of adjusting payment in PDGM.

© 2019 5 Star Consultants, LLC

4

PDGM - Subgroups

- 30-day periods are placed into different subgroups for each of the following categories:
 - Admission source (two subgroups):
 - Community or
 - Institutional admission source
 - Timing of the 30-day period (two subgroups):
 - Early (first 30-day period) or
 - Late (every subsequent payment period after the first period)

5

PDGM - Subgroups

- Clinical Grouping - Twelve groups based on Primary diagnosis:
 - Musculoskeletal Rehabilitation
 - Neuro/Stroke Rehabilitation
 - Wounds
 - Behavioral Health Care
 - Complex Nursing Interventions
 - MMTA - Surgical Aftercare
 - MMTA - Cardiac and Circulatory
 - MMTA - Endocrine
 - MMTA - Gastrointestinal Tract and Genitourinary System
 - MMTA - Infectious Disease, Neoplasms, and Blood-Forming Diseases
 - MMTA - Respiratory
 - MMTA - Other

Note: MMTA = Medication Management, Teaching, Assessment

6

PDGM - Subgroups

- Functional Impairment Level (three subgroups)
- Low, Medium, or High-based on the OASIS responses to:
 - M1800 - grooming
 - M1810 - upper body dressing
 - M1820 - lower body dressing
 - M1830 - bathing
 - M1840 - toilet transferring
 - M1850 - transferring
 - M1860 - ambulation/locomotion
 - M1033 - hospitalization risk - *excluding responses 8-reports exhaustion, 9-risk(s) not listed in 1-8, and 10-none of the above

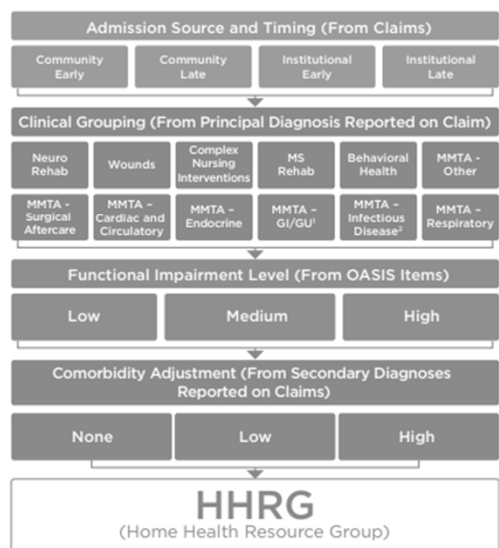
7

PDGM - Subgroups

- Comorbidity Adjustment
 - From Secondary Diagnosis Reported on Claims
 - None
 - Low
 - High

8

Patient-Driven Groupings Model (PDGM)



9

PDGM Coding Impacts

10

Coding Impact on PDGM Groupings Model

- 2 of the 5 categories are based on the diagnoses coding
 - Clinical Grouping
 - From Principal Diagnosis Reported on Claim
 - Comorbidity Adjustment
 - From Secondary Diagnoses Reported on Claim
- Clinical Group Coding
 - Key component of determining payment in PDGM is the 30-day period's clinical group assignment
 - Based on the principal diagnosis code for the patient as reported by the HHA on the home health claim.

© 2019 5 Star Consultants, LLC 11

PDGM Clinical Groups

TABLE 6: PDGM CLINICAL GROUPS

CLINICAL GROUP	PRIMARY REASON FOR HOME HEALTH ENCOUNTER IS TO PROVIDE:
Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
Wounds - Post-Op Wound Aftercare and Skin/ Non-Surgical Wound Care	Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcers burns and other lesions
Behavioral Health Care	Assessment, treatment and evaluation of psychiatric and substance abuse conditions
Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions including IV, TPN, enteral, nutrition, ventilator, and ostomies
Medication Management, Teaching and Assessment (MMTA)	
MMTA –Surgical Aftercare	Assessment, evaluation, teaching, and medication management for Surgical Aftercare
MMTA – Cardiac/Circulatory	Assessment, evaluation, teaching, and medication management for Cardiac or other circulatory related conditions
MMTA – Endocrine	Assessment, evaluation, teaching, and medication management for Endocrine related conditions
MMTA – GI/GU	Assessment, evaluation, teaching, and medication management for Gastrointestinal or Genitourinary related condition
MMTA – Infectious Disease/Neoplasms/ Blood-forming Diseases	Assessment, evaluation, teaching, and medication management for conditions related to Infectious diseases/Neoplasms/ Blood-forming Diseases
MMTA –Respiratory	Assessment, evaluation, teaching, and medication management for Respiratory related conditions
MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules

12

PDGM - Comorbidity Coding

- OASIS only allows HHAs to designate 1 primary diagnosis and 5 secondary diagnoses, however, the home health claim allows HHAs to designate 1 principal diagnosis and 24 secondary diagnoses.
- All 24 secondary diagnoses can impact reimbursement
- The comorbidity adjustment in PDGM can increase payment by up to 20 percent.

13

PDGM - Comorbidity Coding

- 30-day periods of care can receive a comorbidity adjustment under the following circumstances:
 - No comorbidity adjustment:
 - No secondary diagnoses exist, or none meet the criteria for a low or high comorbidity adjustment
 - Low comorbidity adjustment:
 - There is a secondary diagnosis on the HH-specific comorbidity subgroup list that is associated with higher resource use.
 - High comorbidity adjustment:
 - 2 or more secondary diagnoses on the HH-specific comorbidity subgroup interaction list that are associated with higher resource use when both are reported together compared to if they were reported separately.
 - The two diagnoses may interact with one another, resulting in higher resource use.

14

PDGM - Comorbidity Adjustment

- Only one comorbidity adjustment is permitted
 - A 30-day period of care can receive only one low comorbidity adjustment or one high comorbidity adjustment
 - Regardless of the number of secondary diagnoses or high comorbidity subgroup interactions reported on the claim
 - The highest level will be assigned

© 2019 5 Star Consultants, LLC

15

PDGM - Comorbidity Adjustment

- 12 comorbidity subgroups receive the low comorbidity adjustment
- 34 comorbidity subgroup interactions receive the high comorbidity adjustment, as noted in the tables on the following slides

© 2019 5 Star Consultants, LLC

16

PDGM -Low Comorbidity Adjustment Subgroups

TABLE 10: LOW COMORBIDITY ADJUSTMENT SUBGROUPS FOR CY 2020

Comorbidity Subgroup	Description
Cerebral 4	Includes sequelae of cerebral vascular diseases
Circulatory 10	Includes varicose veins with ulceration
Circulatory 9	Includes acute and chronic embolisms and thrombosis
Heart 10	Includes cardiac dysrhythmias
Heart 11	Includes heart failure
Neoplasms 1	Includes oral cancers
Neuro 10	Includes peripheral and polyneuropathies
Neuro 5	Includes Parkinson's disease
Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia
Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers

Source: CY 2018 Medicare claims data for episodes ending on or before December 31, 2018.

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules

17

PDGM - High Comorbidity Adjustment Interaction Subgroups

TABLE 11: HIGH COMORBIDITY ADJUSTMENT INTERACTION SUBGROUPS FOR CY 2020

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description	Comorbidity Subgroup	Description
1	Behavioral 2	Includes depression and bipolar disorder	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
2	Cerebral 4	Includes sequelae of cerebral vascular diseases	Circulatory 4	Includes hypertensive chronic kidney disease
3	Cerebral 4	Includes sequelae of cerebral vascular diseases	Heart 11	Includes heart failure
4	Cerebral 4	Includes sequelae of cerebral vascular diseases	Neuro 10	Includes peripheral and polyneuropathies
5	Circulatory 4	Includes hypertensive chronic kidney disease	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
6	Circulatory 4	Includes hypertensive chronic kidney disease	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
7	Circulatory 4	Includes hypertensive chronic kidney disease	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
8	Circulatory 7	Includes atherosclerosis	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
9	Endocrine 3	Includes diabetes with complications	Neuro 5	Includes Parkinson's disease
10	Endocrine 3	Includes diabetes with complications	Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia
11	Endocrine 3	Includes diabetes with complications	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
12	Endocrine 3	Includes diabetes with complications	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules

18

PDGM - High Comorbidity Adjustment Interaction Subgroups

TABLE 11: HIGH COMORBIDITY ADJUSTMENT INTERACTION SUBGROUPS FOR CY 2020

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description	Comorbidity Subgroup	Description
13	Heart 10	Includes cardiac dysrhythmias	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
14	Heart 10	Includes cardiac dysrhythmias	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
15	Heart 11	Includes heart failure	Neuro 10	Includes peripheral and polyneuropathies
16	Heart 11	Includes heart failure	Neuro 5	Includes Parkinson's disease
17	Heart 11	Includes heart failure	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
18	Heart 11	Includes heart failure	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
19	Heart 11	Includes heart failure	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
20	Heart 12	Includes other heart diseases	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
21	Heart 12	Includes other heart diseases	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules

19

PDGM - High Comorbidity Adjustment Interaction Subgroups

TABLE 11: HIGH COMORBIDITY ADJUSTMENT INTERACTION SUBGROUPS FOR CY 2020

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description	Comorbidity Subgroup	Description
22	Neuro 10	Includes peripheral and polyneuropathies	Neuro 5	Includes Parkinson's disease
23	Neuro 10	Includes peripheral and polyneuropathies	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
24	Neuro 3	Includes dementia	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
25	Neuro 3	Includes dementia	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
26	Neuro 5	Includes Parkinson's disease	Renal 3	Includes nephrogenic diabetes insipidus
27	Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia	Renal 3	Includes nephrogenic diabetes insipidus

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules

20

PDGM - High Comorbidity Adjustment Interaction Subgroups

TABLE 11: HIGH COMORBIDITY ADJUSTMENT INTERACTION SUBGROUPS FOR CY 2020

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description	Comorbidity Subgroup	Description
28	Renal 1	Includes chronic kidney disease and ESRD	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
29	Renal 1	Includes chronic kidney disease and ESRD	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
30	Renal 3	Includes nephrogenic diabetes insipidus	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
31	Resp 5	Includes COPD and asthma	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
32	Resp 5	Includes COPD and asthma	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
33	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
34	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers

Reference: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules

21

PDGM - Comorbidity Adjustment Example

- **Low comorbidity adjustment**
- **Example**
 - Secondary diagnosis of I50.9 Heart failure, unspecified
 - No additional comorbid diagnoses on the claim that fall into a Low or High Comorbidity Subgroup
 - I50.9 falls into Low Comorbidity Subgroup - Heart 11

© 2019 5 Star Consultants, LLC

22

PDGM - Comorbidity Adjustment Example

- **High comorbidity adjustment**
- Example
 - I50.32 Chronic diastolic (congestive) heart failure-Comorbidity Group Heart 11 and G20 Parkinson's disease- Comorbidity Group Neuro 5
 - Both of these diagnoses when reported on the same claim fall within one of the 34 high comorbidity adjustment interaction subgroups -16

© 2019 5 Star Consultants, LLC

23

Low Comorbidity – Coding Scenario

- Referral from the hospital for Mr. Smith after he was admitted for a wound to his right calf
- Per the physician documentation, the patient has stasis dermatitis and developed a stasis ulcer to the right calf that currently has the fat layer exposed.
- The patient also has a diagnosis of hypertension
- The referral is for wound care twice a week.

Question

- How would you code the Primary and Secondary Diagnoses based on the above scenario?

© 2019 5 Star Consultants, LLC

24

Low Comorbidity – Coding Scenario – Answer

- Primary Diagnosis:
 - I87.2 Venous insufficiency (chronic) (peripheral) - MMTA-CARDIAC
 - This diagnosis is primary per coding guidelines- the associated underlying condition is coded first followed by the appropriate L97 code
- Secondary Diagnoses:
 - L97.212 Non-pressure chronic ulcer of right calf with fat layer exposed – Comorbidity Subgroup Skin 3
 - I10 Essential (primary) hypertension – No Comorbidity Subgroup
- Low Comorbidity Adjustment - there is a reported secondary diagnosis, L97.212, that falls within one of the HH specific individual comorbidity subgroups - Skin 3

© 2019 5 Star Consultants, LLC

25

Low Comorbidity – Coding Scenario First 30-Day Period

- First 30-day period
- Scenario based on:
 - Admission Source – Institutional
 - Timing – Early
 - Clinical Group – MMTA-CARDIAC
 - Functional Impairment Level – Low
 - Comorbidity Adjustment - Low
- HIPPS of 2HA21, Case Mix weight of 1.2138, LUPA threshold of 4, Payment \$2,536

© 2019 5 Star Consultants, LLC

26

Low Comorbidity – Coding Scenario Second 30-Day Period

- Second 30-day period with no changes in diagnoses
- Scenario based on:
 - Admission Source – Community
 - Timing – Late
 - Clinical Group – MMTA-CARDIAC
 - Functional Impairment Level – Low
 - Comorbidity Adjustment - Low
- HIPPS of 3HA21, Case Mix Weight of 0.6277, LUPA threshold of 2, Payment - \$1,311

© 2019 5 Star Consultants, LLC

27

High Comorbidity - Coding Scenario

- Mrs. Adams was discharged from the hospital, where she was newly diagnosed with acute exacerbation of diastolic CHF. While hospitalized, she was noted to have a Stage 2 pressure ulcer to her coccyx.
- She has history of hypertension.
- Physician referred to home health to monitor cardiac status and BP, teach disease process CHF, and wound care to pressure ulcer

Question

- How would you code the Primary and Secondary Diagnoses based on the above scenario?

© 2019 5 Star Consultants, LLC

28

High Comorbidity Coding Scenario - Answer

- Primary Diagnosis:
 - I11.0 Hypertensive heart disease with heart failure – Clinical Group MMTA-CARDIAC
- Secondary Diagnoses:
 - I50.31 Acute diastolic (congestive) heart failure - Comorbidity Subgroup Heart 11
 - L89.152 Pressure ulcer of sacral region, stage 2 - Comorbidity Subgroup Skin 4
- High Comorbidity adjustment - there 2 or more secondary diagnoses that fall within one or more of the comorbidity interaction subgroups – subgroup 19 - Heart 11/Skin 4

29

High Comorbidity – Coding Scenario First 30-Day Period

- First 30-day period
- Scenario based on:
 - Admission Source – Institutional
 - Timing – Early
 - Clinical Group – MMTA-CARDIAC
 - Functional Impairment Level – Low
 - Comorbidity Adjustment – High
- HIPPS of 2HA31, case mix weight of 1.3389, LUPA threshold of 4, and payment of \$2,797

30

High Comorbidity – Coding Scenario Second 30-Day Period

- Second 30-day period with no diagnoses changes
- Scenario based on:
 - Admission Source – Community
 - Timing – Late
 - Clinical Group – MMTA-CARDIAC
 - Functional Impairment Level – Low
 - Comorbidity Adjustment – High
- HIPPS of 3HA31, case mix weight of 0.7528, LUPA threshold of 3, and payment of \$1,573

31

High Comorbidity - Coding Scenario

- Mr. Jones is seen in physician office after being discharged from the hospital 2 days ago, where he was treated for exacerbation of COPD and elevated BP.
- He continues to take decreasing doses of prednisone. BP elevated at physician appointment and physician increased dose of Lisinopril.
- Patient complained of pain on his bottom when sitting- found to have Stage 2 pressure ulcer of the coccyx.
- He has history of CHF, Atrial Fib, Parkinson's Disease, & he is taking Coumadin.
- Physician referred to HH- wound care to pressure ulcer 3x/week, monitor resp status, monitor BP, response to med change & ordered PT/INR.

Question

- How would you code the Primary and Secondary Diagnoses based on the above scenario?

32

© 2019 5 Star Consultants, LLC

High Comorbidity Coding Scenario - Answer

- Primary Diagnosis:
 - L89.152 Pressure ulcer of sacral region, stage 2- Clinical Group WOUND
 - This diagnosis is primary as it requires the most intensive skilled service
- Secondary Diagnoses:
 - J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation- Comorbidity Subgroup Resp 5
 - I11.0 Hypertensive heart disease with heart failure - Comorbidity Subgroup Heart 11
 - I50.9 Heart failure, unspecified - Comorbidity Subgroup Heart 11
 - I48.91 Unspecified atrial fibrillation - Comorbidity Subgroup Heart 10
 - G20 Parkinson's Disease - Comorbidity Subgroup Neuro 5
 - Z51.81 Encounter for therapeutic drug level monitoring - Not in Clinical Grouping
 - Z79.01 Long term (current) use of anticoagulants - Not in Clinical Grouping

© 2019 5 Star Consultants, LLC

33

High Comorbidity – Coding Scenario

- This scenario would receive a High Comorbidity adjustment - there 2 or more secondary diagnoses that fall within one or more of the comorbidity interaction subgroups – subgroup 16 - Heart 11/Neuro 5
 - As you can see, it is important to list all diagnoses that affect the plan of care

© 2019 5 Star Consultants, LLC

34

High Comorbidity – Coding Scenario First 30- Day Period

- First 30-day period
- Scenario based on:
 - Admission Source – Institutional
 - Timing – Early
 - Clinical Group – Wound
 - Functional Impairment Level – Low
 - Comorbidity Adjustment – High
- HIPPS of 2CA31, case mix weight of 1.5865, LUPA threshold of 4, and payment of \$3,314

© 2019 5 Star Consultants, LLC

35

High Comorbidity – Coding Scenario Second 30-Day Period

- Second 30-day period with no diagnoses changes
- This scenario based on:
 - Admission Source – Community
 - Timing – Late
 - Clinical Group – Wound
 - Functional Impairment Level – Low
 - Comorbidity Adjustment – High
- HIPPS of 3CA31, case mix weight of 1.0005, LUPA threshold of 3, and payment of \$2,090

© 2019 5 Star Consultants, LLC

36

PDGM – Comorbidity Coding

- ICD – 10 Coding Guidelines require reporting of all secondary (additional) diagnoses that affect the plan of care
- New Language "Secondary diagnoses are only to be reported if they are conditions that affect patient in terms of requiring clinical evaluation; therapeutic treatment; diagnostic procedures; extended length of hospital stay; or increased nursing care and/or monitoring"
 - Previous language "potentially affect the patient's care"
- New Language "We do not expect that HHAs would report comorbid conditions that are not being addressed in the individualized plan of care"

© 2019 5 Star Consultants, LLC

37

PDGM – Comorbidity Coding- Sequencing

- Place diagnoses in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services in accordance with the ICD -10 Coding Guidelines
- Be sure to Sequence of codes following ICD guidelines for reporting: Manifestation codes, 'Code First', Excludes 1 Notes
- Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD guidelines.

Reference: CMS Transmittal 4312, dated, May 23, 2019

© 2019 5 Star Consultants, LLC

38

PDGM – Comorbidity Coding

- Case-mix variables in PDGM work in tandem to
 - Account for the complexity of patient care needs
 - Make payment for home health services accordingly
- Follow Coding Guidelines and code to what the physician documents and the OASIS assessment indicates is appropriate!

PDGM “Unaccepted Diagnosis”

PDGM - "Unaccepted Diagnosis"

- Based on the primary diagnosis, each 30-day period will be placed into one of the 12 clinical groupings
- If the primary diagnosis does not fit into one of the 12 clinical groups in the payment model, this is considered an "Unaccepted Diagnosis"
- These were formerly called, "Questionable Encounters"
 - Keep in mind that "UD" or "QE" means a patient's diagnosis isn't appropriate for a Medicare Home Health encounter!

41

© 2019 5 Star Consultants, LLC

PDGM - "Unaccepted Diagnosis"

- Submission of an "Unaccepted Diagnosis"
 - If a claim is submitted with a primary diagnosis that doesn't fit into one of the 12 clinical groupings, the claim will be sent back to the agency as an "RTP"- Return to Provider.
 - The agency will then need to review & resubmit the claim with a more appropriate primary diagnosis which does fit into a clinical grouping.

42

© 2019 5 Star Consultants, LLC

PDGM - "Unaccepted Diagnosis"

- Complete list of ICD–10–CM codes and their assigned clinical groupings is found on the CMS HHA Center web page - <https://www.cms.gov/center/provider-type/home-health-agency-hha-center.html>
 - Become familiar with codes that would be used to group 30- day periods of care into the 12 clinical groupings
 - Number of returned claims should be minimal
 - Avoid listing codes as the principal diagnosis code on the claim that are known "unaccepted diagnosis"
 - Diagnoses that will not be allowed as a primary diagnosis for Medicare under PDGM may be allowed as primary diagnoses for other insurances.

43

© 2019 5 Star Consultants, LLC

5 Star Consultants Unaccepted Diagnosis Top 10 Codes

- M62.81 Muscle Weakness (Generalized)
- M54.5 Low back pain
- R26.81 Unsteadiness on Feet
- R26.89 Other abnormalities of gait and mobility
- R53.1 Weakness
- G62.9 Polyneuropathy, unspecified
- R29.6 Repeated falls
- R13.10 Dysphagia, unspecified
- R42 Dizziness and giddiness
- M19.90 Unspecified osteoarthritis, unspecified site

Codes in RED are codes are also in the top unaccepted codes found industry wide.

44

© 2019 5 Star Consultants, LLC

Commonly Used Unaccepted Diagnosis Codes

- L03.90 Cellulitis, unspecified
- L89.--9 Pressure ulcer with unspecified stage
- L98.9 Disorder of the skin and subcutaneous tissue, unspecified
- M06.9 Rheumatoid arthritis, unspecified
 - Alternative code-M06.89-Other specified rheumatoid arthritis, multiple sites
- M25.551 Pain in right hip
- M25.552 Pain in left hip
- M25.651 Pain in right knee
- M25.652 Pain in left knee

© 2019 5 Star Consultants, LLC

45

Commonly Used Unaccepted Diagnosis Codes

- M48.00 Spinal stenosis, site unspecified
- M54.30 Sciatica, unspecified side
- M62.50 Muscle wasting and atrophy, not elsewhere classified, unspecified site
 - Code for muscle wasting must include site to be accepted as a primary diagnosis
- R26.0 Ataxic gait
- R27.8 Other lack of coordination
- R33.9 Retention of urine, unspecified
- R55 Syncope and collapse
- R25.9 Unspecified convulsions
- S06.9X9D Unspecified intracranial injury with loss of consciousness of unspecified duration
- Z48.89 Encounter for other specified surgical aftercare
- Z51.81 Encounter for therapeutic drug level monitoring
- Z51.89 Encounter for other specified aftercare
- Z91.81 History of falling

© 2019 5 Star Consultants, LLC

46

Commonly Used Unaccepted Diagnosis Codes

- Many codes that end with the character "9" are unaccepted diagnosis codes as these codes indicate unspecified sites, or unspecified diseases
- **Remember** - Unacceptable Diagnoses Can be Secondary Diagnoses!

47

© 2019 5 Star Consultants, LLC

Resolving an Unaccepted Diagnosis Code

- Review documentation thoroughly to see if specific disease information is included
- Query the physician for:
 - Specific disease information
 - Underlying cause of a symptom
 - Condition causing, for example, Muscle Weakness
- The clinician can determine the site of an issue, such as a wound, and verify/confirm the information with the physician
- Communication, Communication, Communication!

48

© 2019 5 Star Consultants, LLC

PDGM Coding Specificity

49

Coding Specificity:

- Most specific code that describes a medical disease, condition, or injury should be selected.
- “Unspecified” codes are used when there is lack of information about location or severity of medical conditions in the medical record.
- BUT.....you are to use a precise code whenever more specific codes are available.
- If additional information regarding the diagnosis is needed, follow-up with the referring provider in order to ensure the Plan of Care (POC) is sufficient in meeting the needs of the patient.

© 2019 5 Star Consultants, LLC

50

Coding Specificity:

- Many of the codes that indicate pain or contractures as the primary diagnosis, ex: M54.5, Low back pain or M62.422, Contracture of muscle, right hand, is site specific, but doesn't indicate the cause of the pain or contracture.
- CMS expects a more definitive diagnosis indicating the cause of the pain or contracture, as the reason for the skilled care, in order to appropriately group the home health period.

Reference: Federal Register/Vol. 83, No. 219/Tuesday, November 13, 2018/Rules and Regulations

© 2019 5 Star Consultants, LLC

51

CMS - Coding Specificity: Muscle Weakness

- M62.81, "Muscle weakness, generalized" is extremely vague, therefore, will not be accepted as a Primary Diagnosis under PDGM
 - "Generalized muscle weakness, while obviously a common condition among recently hospitalized patients, does not clearly support a rationale for skilled services and does not lend itself to a comprehensive plan of care."

© 2019 5 Star Consultants, LLC

52

CMS - Coding Specificity: Muscle Weakness

- 2008 HH PPS final rule, CMS- “Muscle Weakness (generalized)” is a nonspecific condition that represents general symptomatic complaints in the elderly population.
- CMS stated that inclusion of this code “would threaten to move the case-mix model away from a foundation of reliable and meaningful diagnosis codes that are appropriate for home care” (72 FR 49774).

© 2019 5 Star Consultants, LLC

53

Coding Specificity: Use of R Codes

- R codes- that describe signs and symptoms, as opposed to diagnoses- are Unacceptable Diagnoses as principal diagnosis codes
- Use of symptoms, signs, abnormal clinical & lab findings make it difficult to meet the requirements of an individualized plan of care (CoPs).
- Clinically, it is important for HH clinicians to have a clearer understanding of the patients’ diagnoses in order to safely and effectively furnish home health services.

© 2019 5 Star Consultants, LLC

54

Coding Specificity: Use of R Codes

- Coding guidelines- R codes are to be used when no more specific diagnosis can be made.
- By the time the patient is referred to home health and meets the qualifications of eligibility, a more definitive code should exist to substantiate the need for services.
- This may involve calling the referring physician to gather more information.

© 2019 5 Star Consultants, LLC

55

Coding Specificity: Use of S and T Codes

- There are many S and T codes where the fracture and/or injury is unspecified, but the site is specified.
- The site of injury and/or fracture should be identified
- The treatment or intervention would likely not change based on the exact type of injury or fracture.
- Many of these codes are appropriate to group into a clinical group, and are either in the musculoskeletal group or the wounds group.

© 2019 5 Star Consultants, LLC

56

Coding Specificity: Sepsis

- A sepsis diagnosis should be assigned the appropriate code for the underlying systemic infection.
 - These codes will be classified under MMTA—Infectious Disease/Neoplasms/Blood-forming Diseases

NOTE:

- In a case where the patient is receiving an IV antibiotic for sepsis, the HHA is required to code sepsis as the primary diagnosis:
 - The Z code must be listed as the first secondary diagnosis code listed on the claim in order to group the period into the Complex Nursing Interventions group

© 2019 5 Star Consultants, LLC

57

Coding Specificity: Use of Z Codes

- Z codes may be used as primary diagnosis
 - Z45.2 Encounter for adjustment and management of VAD - COMPLEX Nursing Interventions
 - Z46.6 Encounter for fitting and adjustment of urinary device will be grouped into the - COMPLEX Nursing Interventions
 - Z47.1 Aftercare following joint replacement surgery – MS_REHAB
 - Z48.00 Encounter for change or removal of nonsurgical wound dressings – WOUND
 - Z48.812 Encounter for surgical aftercare following surgery on the circulatory system – MMTA_AFTER
- In addition to the Z codes listed, there are several others- Check in ICD 10 diagnosis list

58

PDGM

Primary Diagnosis Coding Changes

59

PDGM – Primary Diagnosis Changes

- If the primary diagnosis changes between the 1st & 2nd 30-day periods, then the claim for the 2nd 30-day period would reflect the new diagnosis
 - Code would not change the claim for the first 30-day period
- Case mix group cannot be adjusted within each 30-day period
- For claim "From" dates on or after January 1, 2020, the ICD-10 code & principle diagnosis used for payment grouping will be from the claim coding rather than the OASIS item.
- The claim and OASIS diagnosis codes will no longer be expected to match in all cases.

© 2019 5 Star Consultants, LLC

60

PDGM – Primary Diagnosis Changes

- Typically, the codes will match between the 1st claim in an admission & the start of care (Reason for Assessment –RFA 01) assessment & claims corresponding to recertification (RFA 04) assessments.
- 2nd 30-day claims in any 60-day period will not necessarily match the OASIS assessment.

NOTE: When diagnosis codes change between one 30-day claim and the next, a change in the diagnoses does not necessarily mean that an “other follow-up” OASIS assessment (RFA 05) would need to be completed just to make the diagnoses match.

61

© 2019 5 Star Consultants, LLC

PDGM – SCIC & Other Follow UP OASIS

- HHA is required to complete an ‘other follow-up’ (RFA 05) assessment when such a change would be considered a major decline or improvement in the patient’s health status.
- If a patient experienced a significant change in condition before the start of a subsequent, contiguous 30-day period, for example due to a fall, in accordance with 484.55(d)(1)(ii), the HHA is required to update the comprehensive assessment.

62

© 2019 5 Star Consultants, LLC

PDGM

How to Prepare

63

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- It is important to implement changes now and not wait until January 1, 2020
- Revise current coding practices
 - Change coding practices now to assure that primary diagnosis codes being used are approved for use as a primary diagnosis under PDGM.
 - All coders should be educated in the list of diagnosis codes in the PDGM Grouper Tool
 - A complete list of ICD–10–CM codes and their assigned clinical groupings is available on the CMS Home Health Agency (HHA) Center web page: <https://www.cms.gov/center/provider-type/home-health-agency-hha-center.html>

64

© 2019 5 Star Consultants, LLC

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- Education for Staff/ Physicians/ Referral sources
 - PDGM coding requirements
 - Specificity needed
 - Codes that may result in an "Unaccepted Diagnosis"
 - » R Codes/symptom codes
 - » Muscle Weakness/Weakness
 - » Falls
 - » Difficulty Ambulating/Balance Issues
 - » "Unspecified" codes
 - Physician follow up for additional diagnoses information if needed

© 2019 5 Star Consultants, LLC

65

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- Consider developing a standardized "request for additional diagnosis information " form for use when additional diagnosis information is needed from the physician
 - The form would include an explanation that due to Medicare coding guidelines, additional documentation for the primary diagnosis is needed
 - Primary Diagnosis
 - Symptom code
 - Specific location
 - Wound etiology
 - Etc.

© 2019 5 Star Consultants, LLC

66

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- EMR
 - Diagnosis coding- will the software allow for secondary diagnosis selection, beyond the five allowable on the OASIS assessment?
 - Functional Impairment Level-OASIS-check for inconsistencies?
 - Admission source and timing?
 - Will the software estimate HHRG placement and communicate the related LUPA visit threshold?
 - Order Tracking?
 - Billing and Claims Management?

© 2019 5 Star Consultants, LLC

67

What Should Your Agency Be Doing Now To Prepare For Coding Under PDGM

- Coding / OASIS Review
- Consider having coding certified/experienced RN's reviewing the physician information, OASIS Comprehensive Assessment, and Plan of Care
- Experts to identify Primary Diagnosis that is approved and most accurate for the Patient
- Communicate to assessing clinician and/or Clinical Manager proactively to query physician for more specific diagnoses
- Ensure consistencies between OASIS, Plan of Care and physician information including Face to Face

© 2019 5 Star Consultants, LLC

68

Intake Tips

Referral Checklist

69

ACT

Accuracy – important to have accurate and complete referral information

Communication is KEY – communicate with your Intake / referral sources

Train – Train and educate your staff regarding the requirements under PDGM

© 2019 5 Star Consultants, LLC

70

Intake Tips

Important:

- Referral Source – where the referral came from
- Admission Source –institutional or community. NEW PDGM
 - Institutional source - has a 14-day admission lookback (acute care and post-acute care)
 - Community source – no 14-day prior admission
- Timing - NEW PDGM
 - First 30-day period – EARLY
 - All subsequent 30-day periods - LATE

© 2019 5 Star Consultants, LLC

71

Intake Tips - continued

- Diagnosis Coding
 - Gather as much specific documentation as you can at intake.
 - Unspecified codes – unaccepted primary code*
 - Symptom codes – unaccepted primary code*
- Unaccepted ICD 10 codes (previously called questionable encounter codes) – codes that are not grouped for home health reimbursement – cannot be used as a primary diagnosis.

© 2019 5 Star Consultants, LLC

72

Intake Referral Checklist Form

- Admission Source
 - Admission Source – Community / Institutional (acute care, post-acute care or inpatient psychiatric hospital in the past 14-days.).
 - Has patient received home health services from any agency in the last 30-days
 - Has the patient been discharged from a post-acute (SNF/rehab) in the last 30-days
 - Admission 14-day lookback (referral source documentation / Medicare Common working file) for all referrals
- Episode Timing (use Medicare common working file if needed)
- Documentation
 - Face to Face Encounter documentation
 - Detailed documentation supporting medical necessity/need for home health services/homebound status

73

Intake Referral Checklist Form - continued

- Diagnosis
 - Gather as much specific documentation as you can at intake.
 - Detailed diagnosis-specific documentation
 - Symptom Codes –need to query physician and/or referral source
 - Unspecified Codes -need to query physician and/or referral source
 - Be knowledgeable of unaccepted ICD 10 codes
 - May need to contact MD for additional documentation for diagnosis
- Reports
 - H&P
 - Acute and Post-Acute discharge summary reports
 - Any other reports

74

Conclusion

- Implement coding training now
 - Have certified, experienced coders!
- Identify the unaccepted diagnoses you have currently and the root cause behind them
- Educate referral sources and physicians
 - Need Specifics!
- Review your agency processes from intake to discharge to identify any changes needed in workflow
- Preparation is vital to having a smooth transition into PDGM beginning January 1, 2020!

© 2019 5 Star Consultants, LLC

75

Thank You!

Sharon M. Litwin, RN, BSHS, MHA, HCS-D

Senior Managing Partner

5 Star Consultants, LLC

slitwin@5starconsultants.net

Contact Us at:

1-866-428-4040

www.5starconsultants.net

You can find us on Facebook and LinkedIn



Come Visit Us at Booth 733

76