

Executive Summary: Industry Changes are Driving Increased Coding and Financial Complexity

Abstract: Industry changes and influences are now positioning coding as one of the lead drivers of a home health agency's financial success and well-being, thus leading agencies to examine their current coding practices in order to withstand today's regulatory audit climate.



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Industry Changes are Driving Increased Coding and Financial Complexity

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Executive Summary

Coding, now more than ever is at the forefront in today's home health environment. Payor sources once had less concern regarding ICD-9-CM coding as it was not a key indicator of quality outcomes and reimbursement. A clerk or a clinician usually looked up the codes and applied the code that seemed to be the best fit.

Today, that has drastically changed and improper coding usually means an agency is heading toward significant clinical and financial challenges. Audits from any number of groups sanctioned by the OIG, poor surveys, and improper identification of the agency's correct level of care delivery are but a few of the issues an agency can face.

Today, compliant coding means painting the proper portrait of the patient's condition and their needs, the careplan established, and the outcomes expected. ICD-9-CM Coding is now highly complex with accuracy becoming absolutely essential.

Industry Complexity:

In 2008, CMS shifted the focus in home health reimbursement from the negative incentive to the total patient and their needs. One way CMS accomplished this goal was to expand the set of case-mix variables from 80 to 153 case mix groups. In the original PPS, the Home Health Resource Group (HHRG) case-mix model focused on only four categories of case-mix diagnoses; Orthopedic, Diabetic, Neurologic, and Burns/Trauma.

In addition, there are 27 diagnosis groups with hundreds of diagnoses that could be replaced by a V code (The V code is provided to deal with occasions when circumstances other than disease or injury are recorded as "diagnoses" or "problems". The code may be a status code, history code, aftercare visit code, or a follow-up code). Co-morbidities began to influence not only care, but payment also. In addition, changes were made to identification of clinical conditions, primary and secondary diagnoses, as well as manifestation codes.

In 2008, the OASIS M0 questions also interacted with case-mix diagnoses that were related to use of supplies. Coding now had to capture primary and secondary diagnoses with payment linked to specific diagnoses listed in the top six lines, not one line as in previous years. Reimbursement became based upon the entire patient's assessment of needs, not just a single diagnosis. There was increased emphasis on diagnoses sequencing and specificity. As a result, coding became even more complex.

In addition, CMS added a question regarding early versus late episodes and weighted therapy thresholds using three levels. Reimbursement became based on:

- Timing of Episodes
- Therapy Equations and Visits
- Primary and secondary diagnoses in six lines
- M0 questions interacting with CM Diagnosis
- Case Mix Diagnosis now related to use of Supplies
- Some V codes became CM diagnosis

(Source: Federal Register/ Vol72, NO.167/Wednesday, August 29, 2007/Rules and Regulations including Table 2A Case Mix Adjustment, Table 2B Diagnosis Codes, and Table 10B Non-Routine Supplies (NRS) Case Mix Adjustment Model)

What is a Case-Mix Profile?

A profile of each agency was established by CMS, which determined patient needs and diagnostic complexity. This aided CMS in statistical analysis of care trends occurring and patient manifested needs.

- The case-mix report is based upon the mix of patients cared for by an agency. Is one agency caring for sicker patients than another agency?
- It is based on levels of patient acuity, risk, and outcome. The agency is assigned a profile.
- All patients are reviewed by CMS at Start of Care/ Resumption of Care and Recertification. The agency is then ranked against other agencies utilizing the case-mix adjustment model.

What is the Case-Mix Adjustment Model?

In OASIS, there are three domains:

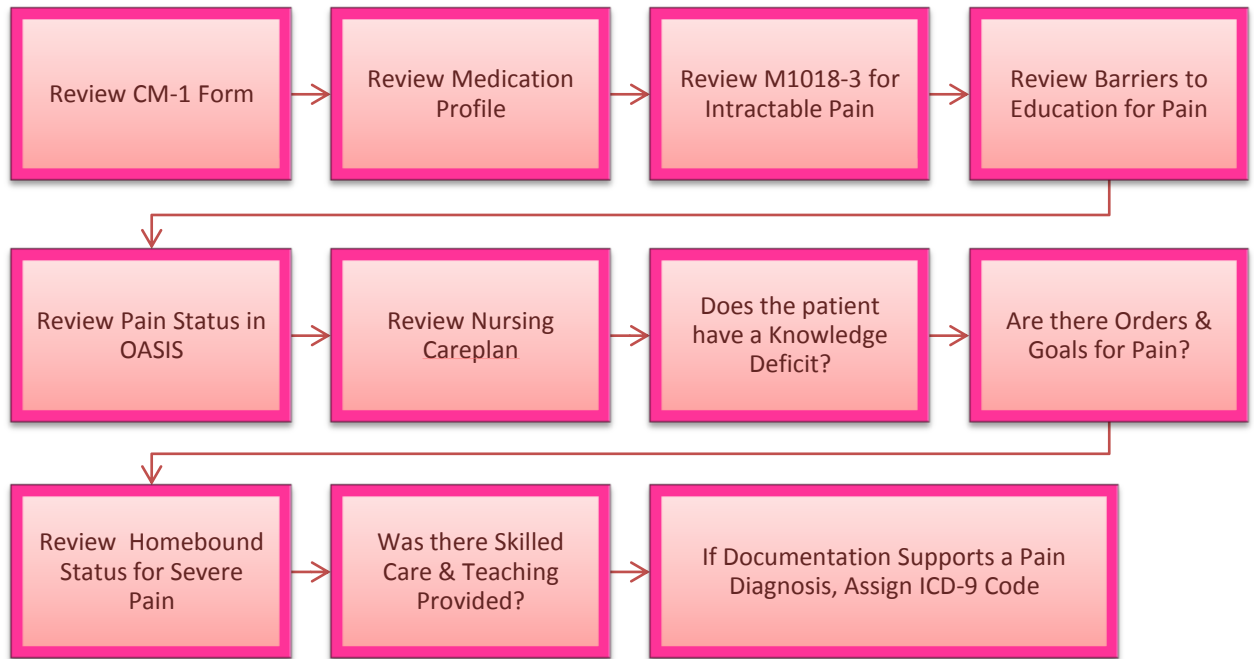
- Clinical Domain (Federal Register/ Vol 72 Table A Lines 1-45)
The clinician determines the patient's plan of care and how much the agency will receive in payment to deliver that care. CMS is looking for congruence. Do you have congruence between assessment, plan, and codes?
M1220, M1222, and M1224- Diagnoses codes are included in risk factors. No E codes and 35 V codes are risk factors. They are included along with symptom control to assist in determining patient improvement likelihood. It is imperative that there is an understanding by the coder of the impact of codes on risk adjustment. The understanding of codes on risk adjustment impacts reimbursement.
M1030 Therapies
M1200 Vision
M1242 Pain All M questions must be reviewed methodically. See Insert #1 PAIN

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MATRIX :

Illustration of Documentation and Coding Review Process for Pain and Its Effect on the Clinical Domain.



M1308 and M1324 Pressure Ulcers

M1334 Stasis Ulcers

M1342 Surgical Wounds

M1400 Dyspnea

M1630 Bowel Incontinence

M1630 Ostomy

M2030 Injectable Drugs

The above M codes account for C1, C2, C3

- Functional Status (Federal Register/Vol 72, Table 2A Lines 46-51)

M1810 Dressing Upper Body

M1820 Dressing Lower Body

M1830 Bathing

M1840 Toileting

M1850 Transferring

M1860 Ambulation

The above M questions account for F1, F2, and F3

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- Service Utilization Domain by Visits (Not a part of the Treatment Authorization Code but is necessary to determine the equation of the claim)
 There are three therapy thresholds: 6, 14, and 20 visits and graduated payment increases with therapy utilization reflect the following equations:
 Equations
 Early and late episodes 0-13 visits: 6, 7-9, 10, and 11-13 visits
 Early and late episodes 14-18 therapy visits: 14-15, 16-17, and 18-19 visits
 Early and late episodes 20+ therapy visits

The above M questions account for S1, S2, S3, S4, and S5

	Equation 1	Equation 2	Equation 3	Equation 4
S1	0-5	14-15	0-5	14-15
S2	6	16-17	6	16-17
S3	7-9	18-19	7-9	18-19
S4	10		10	
S5	11-13		11-13	

The Much Discussed HIPPS Code

This data is required to complete a HIPPS Code. Health Insurance Perspective Payment System (HIPPS) rate codes represent specific patient characteristics (or case-mix groups) on which payment determinations are made. The HIPPS Code has five positions.

 1 2 3 4 5

Position 1 = Equations (1,2,3,4,5)

Position 2 = Clinical Domain (C1, C2, or C3) converted to A, B, or C

Position 3 = Functional Domain (F1, F2, or F3) converted to F, G, or H

Position 4 = Service Domain (S1, S2, S3,S4, or S5) converted to K, L, M, or P

Position 5 = Non Routine Supplies (S, T, U, V, W, or X) converted to 1, 2, 3, 4, 5, or 6

As seen, the HIPPS code will have five digit/letter coding positions. The first position will always begin with a number. It will identify the grouping according to M0110; 1 if early episode and low therapy; 2 if early episode and 14-19 therapy visits; etc. Positions 2-4 reported will have a letter that will represent the scores of the clinical, functional, and service domains.

Position 5 will have a letter or number depending on the severity of diagnosis and the supplies provided or not provided.

The value of the OASIS M0 items will be different for each equation. An equation includes the combining of OASIS questions and OASIS and diagnoses as well as the number of therapy visits and the episode timing. Since 2008, many diagnoses can now be deemed primary or secondary.

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There can be a combination of M0 items and diagnoses. Functional domain items have not changed, but the service utilization domain is now based **entirely on therapy**.

Do the Supplies Link to the Diagnostic Codes?

If the ICD-9-CM coding has an incorrect primary diagnosis or secondary diagnoses and are incorrectly sequenced, non routine supply codes and reimbursement will also be incorrect.

Severity Level Supplies Not Included on Claim	Severity Level Supplies Included on Claim	Points	Payment
1	S	0	\$14.39
2	T	1-14	\$51.96
3	U	15-27	\$142.48
4	V	28-48	\$211.69
5	W	49-98	\$326.43
6	X	99+	\$561.42

CMS has had specific goals: more precise payment for non routine supplies (NRS)

- They have unbundled the NRS reimbursement
- NRS calculated on:
 - OASIS combinations
 - Selected case-mix diagnoses in M1020, M1022, and M1024
 - Diagnoses must be included for any conditions which the agency supplies NRS
 - The clinician must have accurately described healing of surgical wounds
 - Seven of the twenty two case-mix categories have codes that allow supply points

What about the points? What difference does it make? Points can make a significant difference in dollars and audit risk. Let us say an agency clinician (expert in their clinical specialty) has identified a patient with two diagnoses that will require equal clinical attention. The clinician is not usually an expert in coding and may not have kept totally apprised of the average 600 coding changes annually. (S)he may not be aware that the ICD-9 CM code chosen could have significant impact upon reimbursement and the diagnosis placement position may also impact supply reimbursement points. That could mean a difference of nearly \$200.00 per episode, merely in supply dollars.

Why Did CMS Change the Focus?

The 2008 changes were the first revisions since 2000. Why the change? To predict resource allocation based on case-mix was the response. CMS had found that earlier episodes use fewer resources than later episodes. From 2003 – 2007, CMS identified trends and noted there was continued growth in case-mix diagnoses, however there were:

- Decreased visits per episode
- Decreased wound care cases
- Decreased home health aide usage

Changes were needed because CMS recognized that one diagnosis could no longer adequately portray the patient's condition and their needs. With this recognition of numerous diagnoses and the complexity of coding (as seen above), coding guidelines, and coding sequencing, CMS was prompted to modify their rule re coding and allow a professional coder to assist the home health clinician.

Home health services, in the continuum of care, is unlike the acute/inpatient and physician office visit coding. The latter coding is completed after the diagnoses and the diagnostic procedures have been completed. The DRG payment is then determined. This is retrospective coding.

Home health coding is prospective coding. It is based upon assessment, care planned, and the diagnoses sequenced. This is a unique coding experience because, home health is the only health care setting requiring **coding assigned prior to care** delivered based upon an OASIS integrated assessment while adhering to coding guidelines, coding convention, and adequate diagnoses coding documentation support. This coding requires experienced coding expertise. The OIG expects accurate compliant coding.

From the OIG Workplan:

- “Accuracy of coding and claims for Medicare HHRGs:

We will review Medicare claims submitted by HHAs to determine the extent in which the HHRG billing codes that are used in determining payments of home health agencies are accurate and supported by documentation in the medical record. The Social Security Act 1895, governs the payment basis and reimbursement for claims submitted by HHAs including a case-mix adjustment using HHRGs. Medicare pays for home health episodes based on a PPS that categorizes beneficiaries into groups, referred to as HHRGs. Each HHRG has an assigned weight that affects the payment rate. **We will assess the accuracy of HHRG assignment and identify patterns of coding by HHAs.” (OIG Workplan, 2009).**

Refining the assessment to allow for improved coding and outcomes lead to the refinement of the OASIS tool and ultimately, to OASIS C.

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2010 and OASIS-C

- OASIS- B had only outcome measures. OASIS-C moved to process measures.

Though not mandated, it was clear that CMS was interested in not only outcomes, but process measures. They are interested in the plan that supports the interventions needed based upon the OASIS integrated assessment. CMS is interested in how the clinician, ie. the agency, plans to achieve the expected outcomes. Ultimately, process measures and best practices have become a focus in the industry. More than just data; the agency needs to determine what they will do about the patient data collected? CMS is promoting evidence-based care practices.

The conditions targeted by the new OASIS-C process measures were those with the huge costs attached: diabetes, heart failure, pressure ulcers. Prevention oriented situations: falls and depression became a focus because of their link to increased hospital readmissions. The agencies were encouraged to look at how they will prevent conditions such as falls. Prevention is a must focus.

From a national health policy perspective, CMS anticipates the process measures will promote the use of best practices across the home health industry. They wanted to move to validated standards and practices. New changes always bring opportunities:

Opportunities for more refined payment for care are available. Compliant coding is vital to describe the diagnoses to support the care proposed and ultimately, the visits made.

Opportunities are available to present a portrait of patients' needs through expert coding.

What Else is Expected of an Expert Coding Team?

In 2008, the 5 reasons for ADR denial included:

1. Downcoding due to inaccurate primary diagnosis. It is believed, in the industry, that many coders attempt an ultra conservative approach that drives them to inaccurate coding; misrepresenting the patient's true condition. It can become a compliance issue for at least three reasons:
 - a) The Coding is inaccurate and not congruent with Coding Guidelines and can incur audit alerts.
 - b) The Coding presents a patient with lesser need, thus the agency is more likely to meet or exceed outcomes. This erroneously under identifies the true picture of the patient. Outcomes that can impact P4P in the future could be impacted.
 - c) The agency is not being appropriately paid for care and financial expenses incurred.
2. Therapy visits not medically necessary are thus disallowed.
3. None or poor documentation for medical necessity.
4. Skilled observation initially identified need, then, subsequently, no progress documented.

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5. Timeliness with ADR response.

The coding team experts are expected to be certain there is appropriate documentation for all diagnoses assigned. If medical necessity is not clearly documented, visits and /or the episode payment can be denied. A proper documentation process must exist to discern coding specificity and be certain medical necessity is identified.

Documentation Requirements have become Complex and Vital

Documentation requirements have become complex and specific in order to justify not only Conditions of Participation substantiation but meet Coding Guidelines. An example includes Wound Care Coverage which must have specific physician orders for one or all of the following:

- Instruction/teaching on the wound care
- Performance of the specific wound care
- Assessment as to wound site progress/complications

NOTE: Documentation must include type of wound with size, depth, drainage, odor, color, skin condition, with specific interventions provided as ordered by the physician.

- A stasis ulcer with a status of early/partial granulation adds two points to the Home Health Resource Group (HHRG). A “not healing” status adds 11 points. Auditors will look for the specific documentation to support each. The clinicians must have congruence with this descriptor and answers of other M questions. No or poor documentation increase risk of disallowance of payment.
- In addition, an early/partial granulation adds 25 supply points and not healing adds 36 points. Congruence in answers and plans is essential to have accuracy and deter audits.

Note: Inadequate venous circulation to the affected area must be clearly documented in order to code properly. Coding without the proper documentation means increased risk for take-backs. Expert coders know to monitor for these documentation to diagnoses needs.

Therapy is Under Scrutiny. Documentation must be Detailed.

The Coding team must review the treatment plan and it must:

- Relate to the exact diagnosis that has required therapy intervention.
- Identify visit frequency and duration and look for reasonableness.
- Identify the present and prior functional level of the patient.
- State specifically the procedures, treatments, and/or exercises to be performed.

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- Clearly list the reasonable goals to be achieved.
- Specify the rehabilitation potential.
- Specify the discharge plan.
If the coders are not continually updated as to regulation changes, coding requirements, and coding analytics, they might miss a crucial therapy plan element.

Documentation must be Objective and Specific

- If 781.2 Abnormality of Gait is used to justify PT care, PT **needs specific documentation to support gait and balance and strength** e.g. TUG or Tinetti Test Tools. Gait training should be specific with objective measurement progress. The gait should be described specifically and graphically; ataxic, spastic, staggers with increase in ambulation of ___ feet this day. Lack of documentation specifics means the coding team must request more detail.
- If 719.7- Difficulty in walking is coded, the therapist should be clear that this is **due to e.g. degenerative and chronic joint disease**. This code is used for e.g. gait deficiencies due to lower extremity joint stiffness or effusion. If this is not documented the visit is at risk as is the plan. The coding team must request documentation, if it exists, to support the diagnosis.
- If muscle weakness 728.87 is coded, **there should be manual muscle strength tests** indicating weakness. The therapeutic plan should have specific exercises and goals related to the weakness. NOTE: Absence of a specific exercise plan can jeopardize visit payments.
- The following diagnoses codes require **VERY specific plans of care to substantiate need** as they are case-mix diagnoses. Once named case-mixes, these diagnoses were more frequently used and are now closely reviewed. They include:
 - Low Vision
 - GERD
 - Depression
 - Alzheimers Disease

Know that the above diagnoses generate alerts for review.

How frequently are these diagnoses affixed in your agency?

Is the documentation adequate?

Does the documentation support a focus of care for these diagnoses?

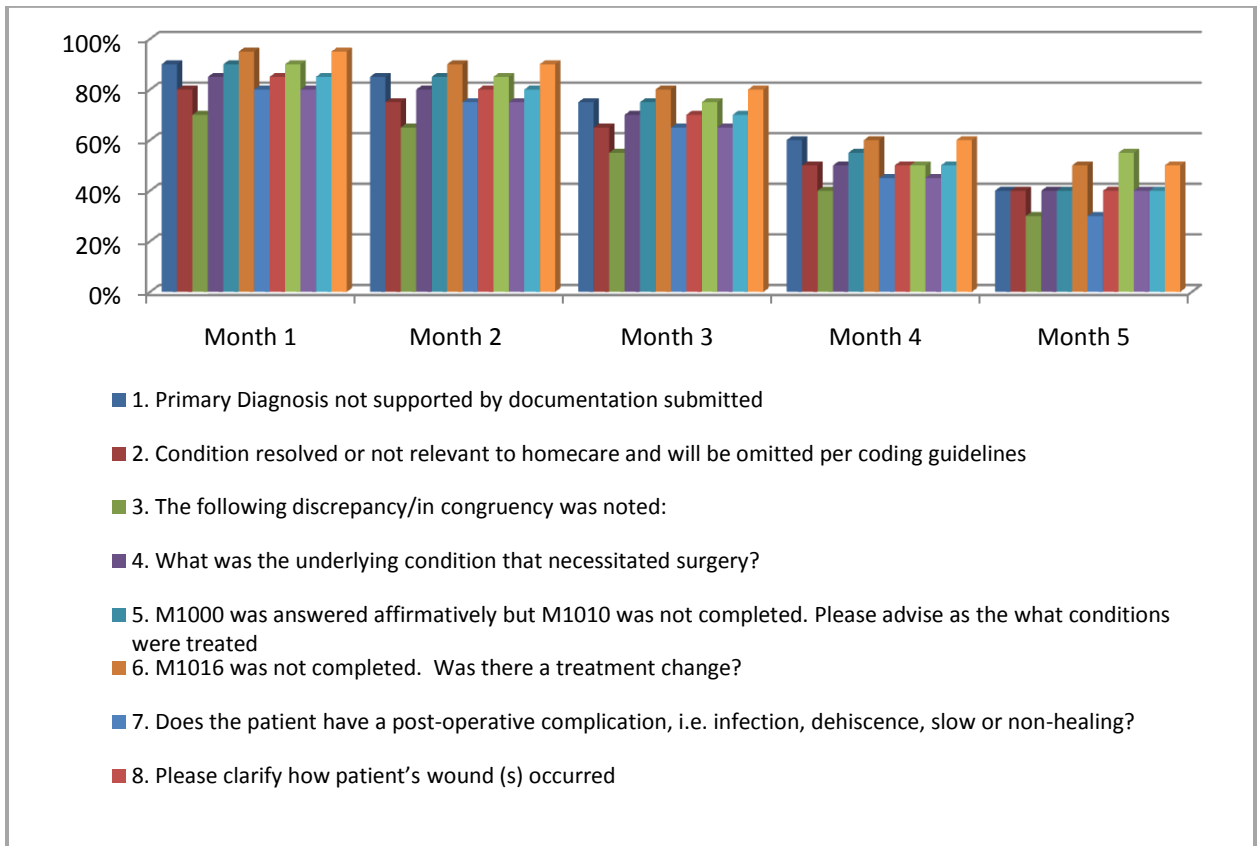
How do you track and trend supportive documentation, or lack thereof?

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Do you have an education program in place for clinicians?

Graph of Documentation Errors: Coding Queries, Education, and Trending



Expert Coding Also Includes Monitoring MAC Edits

There are specific Medicare MAC edits that should be monitored. For instance, at a recertification, the coding team should flag any case that meets the criteria of Edit 5023T which targets:

- Claims with an initial episode 60 days and a recertification proposed for 60 days
- Hypertension as a Primary Diagnosis
- 5-10 Skilled Nursing Visits

This 5HMED Edit has a risk for denial of 98%. The coding team needs to alert the clinical team. Does yours?

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The Value of Compliant Coding is Peace of Mind and Proper Payment

There are the RACs, MACs, MICs, PSCs, Z-PICs, and the HEAT, to name a few of the auditing groups.

- RACs- Recovery Audit Contractors are contingency motivated recovery audit contractors (retrospective focus) focused on Medicare and now directed toward Medicaid. (Federal Register, Vol 75, 11/10, 2010). Medicare Prescription Drug, Improvement, and Modernization Act (MMA) and Tax Relief and Health Care Act of 2006 (TRHCA) section 306 gave the Center for Medicare and Medicaid (CMS) authority to make **Recovery Audit Contractors (RACs)** a permanent nationwide program and the establishment of the nationwide Program Safeguard Contractors (PSCs) to fight fraud with data analysis.
- MACs- Medicare Administrative Contractors can impose “severe administrative action” such as up to 100% prepayment review, payment suspension, and use of statistical sampling for overpayment estimation of claims (current and prospective focus). Medicare Administrative Contractors will replace fiscal intermediaries. In January 2009, CMS announced the awarding of the final MAC contracts to a total of 15 companies. Each has a jurisdiction. MACs have been transitioning in and replacing the Regional Home Health Intermediaries (RHHIs). The MACs can act closely with the RACs. Of the 15 MACS, 4 will service only DME claims. CMS has assigned agencies that provide Home Health AND Hospice to four “specialty” MACs (6,11,14,15). Auditing claims and making coverage determinations more quickly is the ultimate goal.
- CERTs- described as the “QI for MACs” looking at claims payment accuracy. Comprehensive Error Rate Testing. Their primary responsibility is to evaluate the FIs/MACs as to having made correct claim payment decisions. From 1996 to 2002, the OIG designed a sampling method that estimated only a national Fee for Service paid claims error rate (the % of dollars that FIs and Quality Improvement Organizations, QIOs) erroneously allowed to be paid.
- MICs- described as the MACs of Medicaid. MICs (Medicaid Integrity Contractors) are expected to complete four program integrity activities:
 1. Review provider actions
 2. Audit claims
 3. Identify overpayments
 4. Educate providers, managed care providers, beneficiaries, and others with respect to payment integrity and quality of care.

Program Integrity efforts target Medicare and Medicaid Individually as well as Medi-Medi. MICs are not paid by contingency fee but fee for service. However, their performance will determine if contracts are renewed. Renewal of MIC contract is based on successful performance.

- Z-PICs- Zone Program Integrity Contractors' primary goal is to identify cases of fraud, develop the investigation, and refer to the OIG. Bill Dombi, Chief Legal Representative for NAHC stated (4/20/2010), "If an agency receives a Z-PIC letter, they should just call their legal counsel." The Z-PICs act with the Department of Justice and FBI as the investigators when fraud is very strongly thought to have been found.

ZPICs will perform Medicare Program integrity functions for CMS. Each MAC will interact with one ZPIC to handle fraud and abuse issues within their jurisdictions. ZPICs are seen to consolidate work of present CMS Program Safeguard Contractors (PSCs) and Medicare Drug Integrity Contractors (MEDICs). ZPICs are divided into 7 zones.

- HEAT- Healthcare Fraud and Enforcement Action Team- This is the more aggressive investigator of essentially DME and Home Health. Using state of the art technology to expand the CMS Medicaid provider audit program, they are an expansion of DOJ/CMS/HHS Inspector General Medical Strike forces initially assigned to Baton Rouge, Brooklyn, Detroit, Houston, LA, Miami-Dade, and Tampa Bay. The leadership of this program meets directly with top anti-fraud leaders in Congress, Law enforcement, and the Private sector.

NOTE: Fiscal Intermediaries reviewing denials May 28, 2008- October 31, 2009 identified lack of medical necessity and homebound status unsupported in the medical record. In addition, ADRs were not received in a timely manner.

Proper clinical and billing coding demands proper supportive documentation. When the process is compliant, there is peace of mind. When compliance is in jeopardy, the agency may be in jeopardy.

The future of home health will not be easier. It will continue to become complex. On the coding horizon is ICD-10.

What are the Differences between ICD-9-CM and ICD-10-CM?

ICD-9-CM	ICD-10-CM
17 chapters and V and E code chapters	21 chapters- V and E codes in disease chapters
13,000 disease codes plus V and E codes	68,000 disease codes, including V and E codes
3,000 procedure codes in Volume 3	87,000 procedures codes in ICD-10-PCS
3-5 digits in disease codes	3-7 digits in disease codes
Essentially numeric system	Alphanumeric system
Codes usually do not indicate timing encounter	Codes specify initial and subsequent encounters
No differentiation between left/right	Differentiates between the right and left
	Expertise in anatomy, physiology, and diagnostics will be a must.

Summary

Today, leaders are realizing that they cannot afford to have one or two coders driving the financial health of the agency. Furthermore, leaders know they must rely on the fact that codes are coded compliantly, thus solidifying that billed revenues remain retained revenues and will withstand audit scrutiny. The home health agency of tomorrow will require clinical specialists in specific disease metrics, strong financial and operational leadership with vision, and a strong team of third party coding experts whose only focus is Compliant Coding.

Coding summarizes the clinical picture and plan of care for the patient. Improper coding, whether upcoding or downcoding places an agency at risk. Smart documentation coupled with coding expertise means reduced risk, peace of mind, and retention of dollars deserved. Now, that paints a picture of a healthy agency and a healthy future.