PDGM AND CODING

- With the implementation of PDGM, we have moved into a new era of reimbursement.

- Two of the five PDGM subgroups are directly related to coding.

- As we take flight into this journey together, let's take a deep breath and review what we already know and explore what lies ahead...

It's really <u>not</u> rocket science!

OBJECTIVES

- Understand common coding issues under PDGM

- Review issues that can arise

- Scenarios and Case Studies

- Discuss Action Plans/Best Practices

WHAT WE ALREADY KNOW

- Coding Conventions and Guidelines have not changed

- Follow the conventions and guidelines

- First step in accurate coding

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WHAT WE ALREADY KNOW

- Code to what the physician documents.

- Be sure you have documentation or confirmation from the physician of a diagnosis before assigning that diagnosis.

- Query the physician if additional diagnosis information is needed.

- Provide physician/referral source adequate education regarding PDGM.

- Informed source will be more willing to provide needed information.

WHAT WE ALREADY KNOW

- Code to the comprehensive OASIS assessment.

- The comprehensive assessment and plan of care must support the diagnoses.

- ICD–10–CM coding guidelines state that the entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

- Home health providers should have a clear understanding of the patients' diagnoses in order to safely and effectively furnish home health services.

WHAT WE ALREADY KNOW

- Primary diagnosis, the primary reason for home health services, determines the Clinical Group

- The clinical group represents the primary reason for home health services during a 30-day period of care
  - 12 Clinical Groups

- Comorbidity Adjustment
  - From Secondary Diagnoses reported on the claim
    - None, Low, or High

WHAT WE ALREADY KNOW

- 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.

- There are separate instructions for reporting other/secondary diagnoses on the claim, the OASIS instructions, the CoPs, and the interpretive guidelines.
  - The ICD–10–CM coding guidelines define "other" (additional) diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay."

WHAT WE ALREADY KNOW *(CONTINUED)*

- Separate Instructions:
  - The OASIS manual instructions state that "secondary diagnoses are comorbid conditions that exist at the time of the assessment, that are actively addressed in the patient's plan of care, or that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis."
  - The CoPs at § 484.60 state that the home health plan of care must include all "pertinent diagnoses" and the accompanying interpretive guidelines state that this means that all "known diagnoses."

WHAT WE ALREADY KNOW

- There are differences between the various descriptions, however, in the Final Rule CMS states that these instructions essentially describe the same thing:

  - "All of these coding instructions state to include any conditions that exist at the time of home health admission, or that develop during the course of a home health period of care, and *that affect patient care planning*."

  - "Diagnoses should be reported that *affect or potentially affect patient care* (and therefore would be *addressed in the home health plan of care*), even if such care includes observation and assessment (for actual or potential effects), teaching and training, or direct patient care interventions."

TAKE AWAY ON COMORBIDITY/ SECONDARY DIAGNOSIS CODING

- Comorbidity Coding
  - Code all Diagnoses that affect or potentially affect patient care
  - These Diagnoses should typically be addressed in the home health plan of care

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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

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 4	Includes hypertensive heart disease and chronic kidney disease
Circulatory 9	Includes acute and chronic embolisms and thrombosis
Endocrine 2	Includes diabetes with complications
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 (as of July 31, 2019).

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 10	Includes cardiac dysrhythmias
4	Cerebral 4	Includes sequelae of cerebral vascular diseases	Heart 11	Includes heart failure
5	Cerebral 4	Includes sequelae of cerebral vascular diseases	Neuro 10	Includes peripheral and polyneuropathies
6	Circulatory 4	Includes hypertensive chronic kidney disease	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
7	Circulatory 4	Includes hypertensive chronic kidney disease	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
8	Circulatory 4	Includes hypertensive chronic kidney disease	Skin 4	Includes Stages Two Through Four and Unstageable Pressure 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

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

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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
23	Neuro 5	Includes Parkinson's disease	Renal 3	Includes nephrogenic diabetes insipidus
24	Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia	Renal 3	Includes nephrogenic diabetes insipidus
25	Renal 1	Includes Chronic kidney disease and ESRD	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
26	Renal 1	Includes Chronic kidney disease and ESRD	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
27	Renal 3	Includes nephrogenic diabetes insipidus	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
28	Resp 5	Includes COPD and asthma	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
29	Resp 5	Includes COPD and asthma	Skin 4	Includes Stages Two Through Four and Unstageable Pressure ulcers
30	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
31	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

SCENARIO #1 – HOSPITAL REFERRAL TO HH

- Intake received a faxed referral from the hospital discharge planning department for Mr. H asking if your agency will accept the referral.

- Referral documents that the patient was seen in the ER after falling at home in the bathroom. The patient reported that he had been having diarrhea for the past 4 days.

- The F2F documentation in the referral documents diagnosis M62.81 muscle weakness, R29.6 Frequent falls, and services needed and PT for safely eval and strengthening.

QUESTION:

- Do you accept this referral?

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SCENARIO #1 - ANSWER

- The referral as received does not support the need for home health services, as Muscle Weakness is an Unaccepted Diagnosis as Primary Diagnosis.

- Contact the referral source and explain that the diagnoses provided are not accepted diagnosis under PDGM and ask if they can obtain additional information from the physician as to the *underlying cause of the muscle weakness.*

- Upon request, the referral source faxed additional H&P information which documents that the patient was found to have C-diff and is being treated with antibiotics, was found to have hyponatremia and hypokalemia, both of which are documented as resolved.

SCENARIO #1 – ANSWER *(CONTINUED)*

- Therefore, A04.72 Enterocolitis due to Clostridium difficile, not specified as recurrent, could be the primary diagnosis for home health.

- Query the physician to confirm C-diff as primary and underlying reason for Muscle Weakness and to reflect this diagnosis to support the FTF documents.

- By explaining to the referral source that additional information was needed due to MW unaccepted diagnoses under PDGM, you were able to obtain the needed diagnosis information **before you committed to accepting the patient.**

- Communication with referral sources and physicians is key to ensuring you have the information needed to safely and effectively care for the patient and develop a POC.

- The PT is then able to assess if any nursing services would be recommended to the physician for the C-diff or other issues.

SCENARIO #2 – PHYSICIAN OFFICE REFERRAL

- You receive a referral from the physician office for Mrs. W.

- The referral states the patient family phoned the MD office reporting she fell at home yesterday and went to the emergency room and she is now having difficulty walking.

- The physician requests the nurse make an evaluation to assess the situation.

QUESTION:

- Do you accept this referral?

SCENARIO #2 - POSSIBLE OPTIONS...

- Refuse to make the visit as the only diagnoses received are unacceptable diagnoses.

- Make the visit and phone the physician with update of findings.

- Explain to the physician office that the diagnoses provided are unacceptable diagnoses under PDGM and request additional information, including specific diagnosis information as to the diagnosis that is causing the patient to have difficulty walking.

SCENARIO #2 - ANSWER

A. **Refuse to make the visit as the only diagnoses received are unacceptable diagnoses.**

- This response may cause the physician to hesitate in giving the agency additional referrals.

B. **Make the visit and phone the physician with update of findings.**

- This option could potentially negatively impact your agency. If the physician does not have any additional diagnosis information, the agency would not be able to bill for services.

SCENARIO #2 – ANSWER *(CONTINUED)*

- Explain to the physician office that the diagnoses provided are unacceptable diagnoses under PDGM and request additional information including specific diagnosis information as to the diagnosis that is causing the patient to have difficulty walking.
  - This would be the most appropriate response.
  - The agency is explaining why the additional information is needed, as well as ensuring that the clinician has current diagnosis information to establish a plan of care.

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SCENARIO #2 – ANSWER *(CONTINUED)*

- The HHA should have established processes for referrals that are received without adequate diagnoses information.

- Consistent requests to physician/referral sources for needed diagnosis information will help to improve diagnosis information being received during the referral process.

- Remember EVERY home health agency is requesting specific diagnosis information.

SCENARIO #3 – DR. OFFICE REFERRAL FOR PT

- Dr Stanly's office calls with a referral for physical therapy to see Mrs. Sweet for Ataxia.

- Patient was seen by the doctor yesterday and the office visit note is being faxed with the demographic information.

- The office person who made the phone call does not have any additional information, but states she will fax the note from the office visit.

- When you receive the fax, the office note documents that the physician noted increased ataxia due to her worsening Alzheimer's dementia and she is no longer able to safely leave her home alone.

Question:

- How would you code this episode based on the information provided?

SCENARIO #3 - ANSWER

- Primary Diagnosis

  - G30.9 Alzheimer's disease, unspecified

- Secondary Diagnoses

  - F02.80 Dementia in other diseases classified elsewhere without behavioral disturbance
  - R27.0 Ataxia, unspecified

SCENARIO #3 – ANSWER *(CONTINUED)*

- In this scenario, Alzheimer's disease is coded primary, as the physician documented this is the reason for the patient's worsening ataxia.

- F02.80 Dementia is coded next following the etiology/manifestation convention.

- Ataxia, R27.0, is also coded as a secondary diagnosis, as ICD–10–CM coding guidelines state that codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis.

- In this scenario, the physician office note clearly states the underlying diagnosis causing the patient's ataxia.

- Ensure when reporting to physician at end of admission assessment that you inform that the primary diagnosis will be Alzheimer's based on his notes, coding guidelines and PDGM rules.

- If the visit note did not document a reason for the ataxia, you would need to query the physician for further information.

- When querying the physician, be sure to document all communication and confirmation of the diagnoses specified.

SCENARIO #4 - PHYSICIAN REFERRAL – PATIENT IS TOO SICK TO GO TO DOCTOR'S OFFICE

- You receive a call from Dr. James, he is requesting you make an evaluation visit to Mrs. V.

- The patient's family just called the physician office stating they think she has the flu, but she is too sick to go to the Dr. Office to be seen.

QUESTION:

- What should you do?

SCENARIO #4 - ANSWER

- Lack of F2F documentation
  - In the scenario, there is a lack of F2F documentation as the patient has not seen the physician for the treatment/diagnosis of the flu.
  - If the patient fails to follow-up with the physician for having the flu, the agency would not receive payment as the patient would not have had a F2F encounter for the reason for home health.

- Your Agency should consider policy for acceptance/non-acceptance of patients without current F2F encounter
  - Accepting a patient without a current F2F puts the agency at risk.

- If agency decides to accept although there is no Face to Face, then what is the patient's home health primary diagnosis?

- This referral doesn't have a specific disease or condition confirmed by the physician.

- Therefore, this would not be an accepted referral for home health without the physician giving more detailed information with an approved home health primary diagnosis.

- For these reasons, best option is to not accept the patient. Use this as a teaching opportunity to the physician's office regarding what an acceptable home health patient is in this era of HH (this was a classic referral in the *"Old Days"* of HH).

SCENARIO #5 – DR. ORDERING HH SPEECH THERAPY

- You receive a referral from Dr. D for Mr. S.

- Mr. S is a 97 year old man who was seen in the office today for difficulty swallowing.

- Documentation in the MD visit note states, "Per the patient, trouble swallowing has been going on for a couple of months and is progressively getting worse."

- The diagnosis is R13.10 Dysphagia, unspecified. The physician is ordering Speech Therapy for evaluation of the dysphagia.

QUESTION:

- Do you accept this referral?

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SCENARIO #5 - ANSWER

- Yes, the Final Rule (Oct 31, 2019) added 5 R codes for Dysphagia that were assigned to the Neuro Rehab clinical group. CMS determined these diagnosis codes would be acceptable for reporting the primary reason for home health services, including unspecified.
  - R13.10 Dysphagia, unspecified
  - R13.11 Dysphagia, oral phase
  - R13.12 Dysphagia, oropharyngeal phase
  - R13.13 Dysphagia, pharyngeal phase
  - R13.14 Dysphagia, pharyngoesophageal phase
  - R13.19 Dysphagia, Other dysphagia

SCENARIO # 6 – DR. OFFICE WITH UNACCEPTABLE DIAGNOSIS

- Mr. X referred from MD office for PT for muscle weakness. Patient has DM, HTN.

- HH Intake RN contacts MD office nurse & states HH can no longer take primary diagnosis of Muscle Weakness under PDGM. RN asks if the physician thinks that primary diagnosis can be Muscle atrophy or wasting, as CMS has given as an example.

- MD says patient doesn't have Muscle atrophy, that is a different condition. He says Mr. X is elderly, debilitated, prone to falls and needs PT for exercise for strengthening.

- RN asks if agency can use DM as primary diagnosis and send an RN to see Mr. X.

- Physician says yes. States he will change diagnosis on FTF.

SCENARIO # 6 *(CONTINUED)*

- HHA admits patient with primary diagnosis DM- E11.9
- Comorbidity / secondary- Muscle Weakness, HTN, Fall history

QUESTION:

- Does this scenario provide an acceptable solution under PDGM?

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SCENARIO #6 - ANSWER

Answer is NO

- Cannot "lead" the physician to put a primary diagnosis that isn't appropriate in order to admit a patient.

- Mr. X did not have any changed meds; BS stable at 110; no s/s hyper/hypoglycemia, diet managed.

- So DM is not appropriate as a primary diagnosis. The clinical record will not have any documentation showing justification for use of DM as primary diagnosis.

- Result – if there is no acceptable diagnosis that is appropriate for Mr. X primary diagnosis, reason for the home health encounter, then the agency cannot admit Mr. X.

USE OF Z45.2

- February 24, 2020 CMS Clarified use of Z45.2 as primary, first listed secondary code under PDGM.

- Coders can assign Z45.2 (Encounter for adjustment and management of vascular access device) as the principal diagnosis **or** the first listed secondary diagnosis code in order to be placed in the Complex Nursing clinical group.

- If the agency is ONLY doing care of vascular access device, and no other care being provided, then Z45.2 can be assigned as the primary diagnosis.

SCENARIO #7 - SEPSIS, IV ANTIBIOTICS

- You receive a referral from the hospital for Mr. Neon, who was admitted with sepsis, UTI due to E Coli.

- Pt had PICC line placed and is being discharged home with IV antibiotics for 5 additional days.

How would you code this patient?

SCENARIO #7 - SEPSIS, IV ANTIBIOTICS

- *This is how coding would have been prior to PDGM:*

- Primary Diagnosis A41.9 Sepsis, unspecified organism
  - Clinical Group- *MMTA Infection*

- N39.0 Urinary tract infection, site not specified

- B96.20 Unspecified E Coli

- **Z45.2 Encounter for adjustment and management of vascular access device**

- Z79.2 Long term (current) use of antibiotics

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SCENARIO #7 – SEPSIS, IV ANTIBIOTICS

- In a case where the patient is receiving an IV antibiotic for sepsis, per coding guidelines sepsis should be coded 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.

Now clarified/confirmed by CMS.

SCENARIO #7 - SEPSIS, IV ANTIBIOTICS

- *Correct coding under PDGM*

- Primary Diagnosis A41.9 Sepsis, unspecified organism
  - Clinical Group- *Complex Nursing Interventions*

- **Z45.2 Encounter for adjustment and management of vascular access device**

- N39.0 Urinary tract infection, site not specified

- B96.20 Unspecified E Coli

- Z79.2 Long term (current) use of antibiotics

SCENARIO # 8 - CHANGE IN 30-DAY

- Mrs. J admitted for post op abdominal surgery wound care. Has DM and COPD.

- Primary Diagnosis- Z48.815 Encounter for surgical aftercare following surgery on the digestive system. Clinical Group- MMTA Surgical Aftercare

- Goal for POC is wound to heal in 4 weeks.

- Goals and interventions on POC for DM and COPD, as well as post-op abdominal surgery and wound.

- Week 4 wound is healed. However, blood sugars have been over parameters. Pt not following ADA diet. MD orders new meds and dietician.

- Wound healing is what was planned at SOC.

- Patient not discharged, however, as DM requires interventions, education, and visits.

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SCENARIO # 8 - CHANGE IN 30-DAY *(CONTINUED)*

- Day 28 visit, patient still has elevated blood sugar, physician requests continued visits.

- 2nd 30 day – will have a new primary diagnosis of DM. Physician's order obtained for primary diagnosis change. Primary Diagnosis of DM- E11.9, put on the claim, to change the clinical grouping to MMTA- Endocrine.

- Follow up OASIS not done for SCIC / change in primary diagnosis because wound healing was expected on POC. And DM was already being cared for on POC interventions and goals.

- CMS did not make it mandatory for OASIS follow up to be done for diagnosis changes at 2nd 30-day period; it is up to agency to decide if OASIS follow will be done or not.

- Per CoP's, 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.

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SCENARIO # 9 - 30-DAY CHANGE

- Patient admitted with exacerbation COPD J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation, Clinical Group MMTA - Respiratory

- Patient falls day 25 – ER, injury-severe laceration lower leg, no hospitalization

- OASIS RFA #5 follow-up other completed by RN.

- Physical therapy ordered, RN to do wound care daily x 7, then 3 x week.

- 2ND 30 DAY
  - Primary diagnosis changed to laceration left leg- S81.812D - Clinical Group Wound- as this is the diagnosis requiring the most intensive services.

SCENARIO #10 - CLINICAL RECORD REVIEW OF PATIENT IN 2ND EPISODE OF CARE

- Pt Primary Diagnosis- CHF at SOC and 2nd episode.

- Patient has Nursing and Physical Therapy.

- Documentation - lack of skilled need for HH nursing.

- Auditor asks RN case manager why they are still seeing the patient.

- RN says if don't continue HH the pt will go downhill & will end up with exacerbation.

- Although this is true, Medicare HH does not allow for this long term care to maintain a patient once skilled needs are met.

- Many ADR denials for this type of scenario for lack of skilled need.

- But…

SCENARIO #10 - CLINICAL RECORD REVIEW OF PATIENT IN 2ND EPISODE OF CARE *(CONTINUED)*

- Physical Therapy hadn't recertified the patient.

- Patient has debilitating condition of M06.09 Rheumatoid Arthritis without rheumatoid factor, multiple sites, Clinical Group MS Rehab.

- If physician agrees, PT could stay in under maintenance therapy, even though goals for improvement have been met, in order to prevent decline.

- Issues: Knowledge deficit of skilled need; Therapists opportunities for maintenance therapy.

SCENARIO #11 – PRIMARY DIAGNOSIS EFFECTS ON COMORBIDITY ADJUSTMENT

Referral 1:

Pt with diagnosis of exacerbation diastolic CHF, also has HTN and stage 2 pressure ulcer to coccyx.

- MD has ordered SN visits 3 x week to monitor cardiac status, response to med changes, wound care is 2 x week

▪ Primary I11.0, Secondary- I50.9 & L89.152 – results in a **high comorbidity adjustment**- *Comorbidity Subgroup interaction #17 Heart 11 and Skin 3*

SCENARIO #11 – PRIMARY DIAGNOSIS EFFECTS ON COMORBIDITY ADJUSTMENT

Referral 2:

Pt with diagnosis of stage 2 pressure ulcer to coccyx, also has Dx of HTN and CHF.

- MD ordered SN visits 2 x week for wound care.

- Primary L89.152, Secondary- I11.0 & I50.9- results in a **low comorbidity adjustment-** Both I11.0 &I50.9 are in the comorbidity subgroup Heart 11

***Primary diagnosis is not factored into the comorbidity adjustment

SCENARIO #12 – MISSING DISCHARGE SUMMARY

- Referral Scenario 1: Mrs. Z referred to HH for post op care after having gallbladder removed.
- Only information given is that patient is debilitated, weak, has difficulty walking and lives alone.
- HHA admits and codes : Z48.815 Encounter for surgical aftercare following surgery on the digestive system.
- Clinical group : MMTA Surgical Aftercare
- Comorbidity – None -No secondary diagnoses are in the comorbidity groups for low or high
  - R53.81 Debility
  - R53.1 Weakness
  - R26.2 Difficulty Walking
  - Z60.2 Lives Alone

SCENARIO #12 –NO COMORBIDITY – CODING SCENARIO – FIRST 30 DAY PERIOD

- This scenario based on:
  - Admission Source – Institutional
  - Timing – Early
  - Clinical Group – MMTA Surgical Aftercare
  - Functional Impairment Level – High
  - Comorbidity Adjustment – None

- HIPPS of 2GC11, case mix weight of 1.4027, LUPA threshold of 5, and payment of $2,254.53

SCENARIO #12 – MISSING DISCHARGE SUMMARY

- **Referral Scenario 2:** Mrs. Z referred to HH for post op care after having gallbladder removed. In the hospital EMR, there is documentation in Discharge summary that patient has these diagnoses: HTN, CHF, COPD
  - HHA admits and codes : Z48.815 Encounter for surgical aftercare following surgery on the digestive system
  - Clinical group : MMTA Surgical Aftercare
  - Comorbidity – Low
    - **I11.0 Hypertensive heart disease w/heart failure**
    - **I50.9 Heart Failure unspecified**
    - J44.9 COPD unspecified
    - R53.81 Debility
    - R53.1 Weakness
    - R26.2 Difficulty Walking
    - Z60.2 Lives Alone

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SCENARIO #12 –LOW COMORBIDITY – CODING SCENARIO – FIRST 30 DAY PERIOD

- This scenario based on:
  - Admission Source – Institutional
  - Timing – Early
  - Clinical Group – MMTA Surgical Aftercare
  - Functional Impairment Level – High
  - Comorbidity Adjustment – Low
    - I11.0 Hypertensive heart disease w/heart failure & I50.9 Heart failure unspecified are both in the low comorbidity subgroup Heart 11
- HIPPS of 2GC21, case mix weight of 1.4535, LUPA threshold of 5, and payment of $2336.18

SCENARIO #12 – ADDITIONAL CLINICAL INFORMATION CONFIRMED AT SOC VISIT

- **Referral Scenario 3:** Mrs. Z referred to HH for post op care after having gallbladder removed. In the hospital EMR, there is documentation in Discharge summary that patient has HTN, CHF, COPD. During the SOC visit, the SN notes that the patient has a wound on her left ankle.

- RN calls the PCP- confirms that the patient has a chronic ulcer due to venous insufficiency and receives orders for wound care to be done 2 x week.

SCENARIO #12 – ADDITIONAL CLINICAL INFORMATION CONFIRMED AT SOC VISIT *(CONTINUED)*

- Referral scenario 3
- HHA admits and codes : Z48.815 Encounter for surgical aftercare following surgery on the digestive system
- Clinical group : MMTA Surgical Aftercare
- Comorbidity – High
  - I87.2 Venous insufficiency (chronic) (peripheral)
  - L97.322 Non-pressure ulcer of left ankle w/fat layer exposed
  - I11.0 Hypertensive heart disease with heart failure
  - I50.9 Heart Failure unspecified
  - J44.9 COPD unspecified
  - R53.81 Debility
  - R53.1 Weakness
  - R26.2 Difficulty Walking
  - Z60.2 Lives Alone

SCENARIO #12 –HIGH COMORBIDITY – CODING SCENARIO – FIRST 30 DAY PERIOD

- Comorbidity Subgroup Interaction **#17 –**
  - L97.322 Non-pressure ulcer of left ankle w/fat layer exposed- comorbidity subgroup Skin 3,
  - I11.0 Hypertensive heart disease with heart failure, I50.9 Heart failure unspecified- both comorbidity subgroup Heart 11,
- Comorbidity Subgroup Interaction **#28 –**
  - L97.322 Non-pressure ulcer of left ankle w/fat layer exposed-comorbidity subgroup Skin 3
  - J44.9 COPD unspecified-comorbidity subgroup Resp 5

SCENARIO #12 –HIGH COMORBIDITY – CODING SCENARIO – FIRST 30 DAY PERIOD

- This scenario based on:
  - Admission Source – Institutional
  - Timing – Early
  - Clinical Group – MMTA Surgical Aftercare
  - Functional Impairment Level – High
  - Comorbidity Adjustment – High
- HIPPS of 2GC31, case mix weight of 1.5501, LUPA threshold of 5, and payment of $2491.44

SCENARIO #13 – UNSPECIFIED FRACTURE LATERALITY

- You receive a referral from the ER for a patient who fell and fractured humerus. Patient is not being admitted to the hospital.

- Primary Diagnosis- S42.301D- Unspecified fracture of shaft of humerus, unspecified arm, subsequent encounter for fracture with routine healing
  - This code is not an acceptable code and therefore cannot be used as a primary diagnosis

SCENARIO #13 – UNSPECIFIED FRACTURE LATERALITY- CLARIFIED AT REFERRAL

- You receive a referral from the ER for a patient who fell and fractured Humerus, patient is not being admitted to the hospital. You confirm with the physician that it is the patient's right humerus that has been fractured.

- Primary Diagnosis- S42.309D- Unspecified fracture of shaft of humerus, right arm, subsequent encounter for fracture with routine healing.
  - This code is acceptable code and can be used as a primary diagnosis.
  - Even though the type of fracture is unspecified, the laterality is specified.

SCENARIO #14 – CODING SEQUENCING

- Referral from hospital for Mr. C, who has been hospitalized for 2 weeks. He was initially admitted for amputation of his left great toe due to diabetic ulcer with gangrene.

- He subsequently developed a UTI, which was treated with IV abx and has resolved.

- He was also noted to have AKI, hypokalemia, and hyponatremia which were treated and have resolved.

- He has a history of PVD, HTN, CHF, CKD 3, Atrial Fib, h/o prostate cancer, BPH, urinary incontinence, and he lives alone.

- The surgical amputation site is healing well. The physician has ordered SN for wound care to surgical site and PT for evaluation, gait training and safety.

How would you code this patient?

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SCENARIO #14 – CODING SEQUENCING

- You would not code DM ulcer with gangrene as the ulcer and gangrene were resolved by the amputation.

- You would not code the UTI, AKI, hypokalemia or hyponatremia as they are resolved.

- You would code the patient's pertinent medical diagnosis that may affect the POC.

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SCENARIO #14 – CODING SEQUENCING

- Z47.81 Encounter for orthopedic aftercare following surgical amputation

- Z89.412 Acquired absence of left great toe

- E11.51 Type 2 DM with diabetic peripheral angiopathy without gangrene

- E11.22 Type 2 DM with diabetic chronic kidney disease

- **I13.0 Hypertensive heart and chronic kidney disease with heart failure and stage 1-4 CKD**

- **I50.9 Heart failure unspecified**

- N18.3 Chronic kidney disease, stage 3

- I48.91 Unspecified Atrial Fib

- N40.1 Benign prostatic hyperplasia with lower urinary tract symptoms

- R32 Unspecified urinary incontinence

- Z60.2 Problems related to living alone

- Z86.31 h/o diabetic ulcer

- Z87.440 Personal history of UTI

- Z85.46 Personal history of malignant neoplasm of prostate

- Z79.01 Current (long term) use of anticoagulant

SCENARIO #14 –LOW COMORBIDITY – CODING SCENARIO – FIRST 30 DAY PERIOD

- I13.0 is in comorbidity subgroup Circulatory 4

- I50.9 is in subgroup Heart 11

- DM diagnoses are in group Endocrine 3 which is not in one of the 13 comorbidity subgroups

- A fib is in group Heart 10 which is not in one of the 13 comorbidity subgroups

- BPH is in group Renal 3 which is not in one of the 13 comorbidity subgroups

- None of the Z codes are in a comorbidity subgroup

- This combination of diagnoses does not have any Comorbidity Subgroup Interactions, therefore no High Comorbidity adjustment

SCENARIO #14 –LOW COMORBIDITY – CODING SCENARIO – FIRST 30 DAY PERIOD

- This scenario based on:
  - Admission Source – Institutional
  - Timing – Early
  - Clinical Group –MS Rehab
  - Functional Impairment Level – High
  - Comorbidity Adjustment – Low
- HIPPS of 2EC21, case mix weight of 1.5773, LUPA threshold of 6, and payment of $2535.16

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PHYSICIAN EDUCATION - NAHC PDGM PHYSICIAN TOOLKIT

- https://www.nahc.org/meetings-education/pdgm/

NAHC PDGM PHYSICIAN TOOLKIT

- https://www.nahc.org/wp-content/uploads/2019/12/PDGM_PhysiciansToolkit_Brochure.pdf

- https://www.nahc.org/wp-content/uploads/2019/12/PDGM_PhysiciansToolkit_Brochure_Panels.pdf

NAHC PDGM PHYSICIAN TOOLKIT

Unacceptable Diagnoses for Medicare Home Health Care

The complete unacceptable diagnoses list for Medicare home health care is 620 pages and contains to more than 29,000 ICD 10- diagnoses code and descriptions. Many of the diagnoses on the list would never be listed as a primary diagnosis for home health patients from a clinical perspective.

The list might be helpful to determine if a particular diagnosis will not be accepted for Medicare home health patients under PDGM.

https://www.nahc.org/wp-content/uploads/2019/12/PDGM_Unacceptable-Diagnoses-for-Medicare-Home-Health-Care.pdf

	Diagnosis decription	ClinicalGroup
A1810	Tuberculosis of genitourinary system, unspecified	NA
A289	Zoonotic bacterial disease, unspecified	NA
A4901	Methicillin suscep staph infection, unsp site	NA
A4902	Methicillin resis staph infection, unsp site	NA
A491	Streptococcal infection, unspecified site	NA
A492	Hemophilus influenzae infection, unspecified site	NA
A493	Mycoplasma infection, unspecified site	NA
A498	Other bacterial infections of unspecified site	NA
A499	Bacterial infection, unspecified	NA
A64	Unspecified sexually transmitted disease	NA
B03	Smallpox	NA

EDUCATIONAL RESOURCES

NAHC PDGM PHYSICIAN TOOLKIT

- https://www.nahc.org/wp-content/uploads/2019/12/PDGM_PhysiciansToolkit_Guide.

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https://vimeo.com/378042670
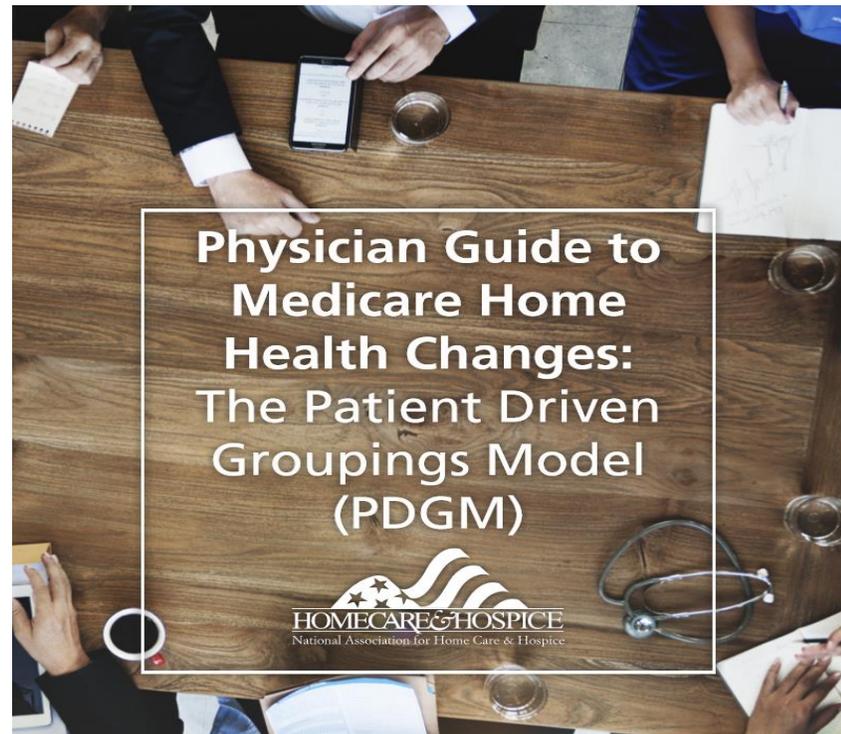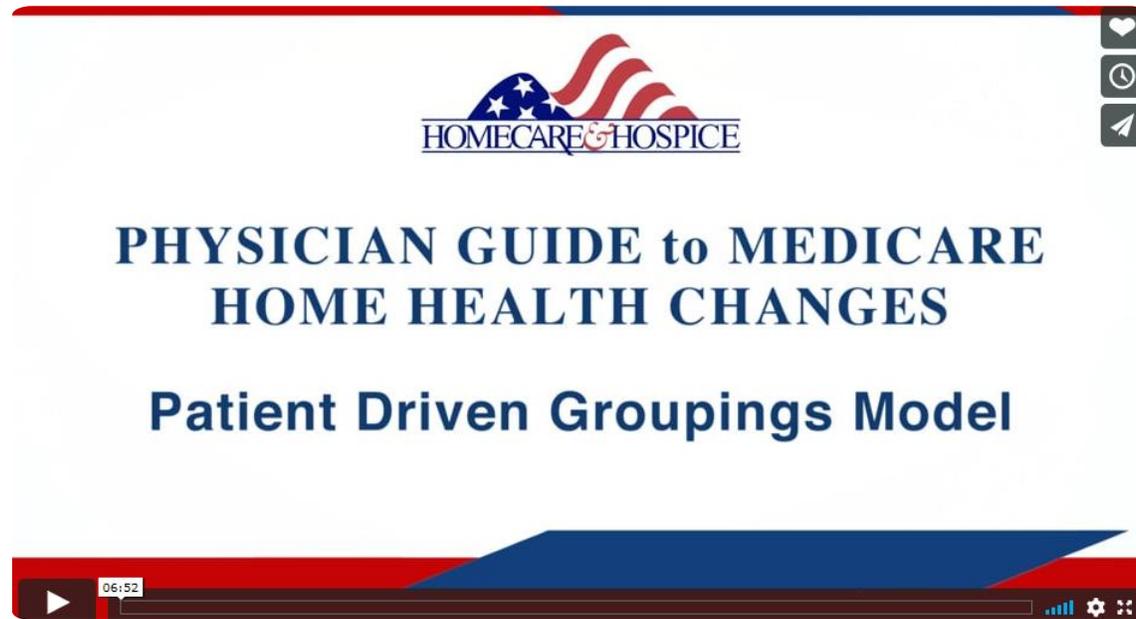
REFERRAL SOURCE EDUCATION

- Can use info from NAHC physician toolkit.

- Meet with each to ensure that they have an understanding of the 'rules' for acceptable primary diagnosis.

- Analyze your referrals- ensure you spend most time with ones that have given higher number of unaccepted diagnosis.

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INTAKE

- Must ensure that the intake process is such that No Unacceptable Diagnoses will go through to admission.

Admitting Clinician

- Ensure thorough knowledge of acceptable diagnosis, skilled need
- Diagnose specifics
- When and how to Query physicians

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CODING DEPARTMENT

- If unaccepted diagnosis, send immediately back to clinical manager.

- Clinical manager addresses for this patient, but also uses to educate and tighten processes to prevent this from occurring.

- Coding ensures all secondary diagnosis that may affect the POC are coded to the highest level of specificity.

- Coder has access to grouper tool in order to see the clinical group, low or high comorbidity adjustment.

- Some EMRs have "grouper like" functionality within their software that can identify clinical groups, low/high comorbidity, functional impairment.

CODING DEPARTMENT - AUDITS

- Whether in house or out-source, audit coders.

- Have expert review assessments as if they have not yet been coded.

- Put codes/rationale on paper identifying the variances.

- Identify missed codes, lack of specificity, upcoding, following coding conventions/guidelines, etc.

- Audit should be at least 20% of each coder to ensure capturing compliance.

CODING DEPARTMENT - AUDITS

- Then for those not demonstrating compliance to coding guidelines, physician documentation and comprehensive oasis

  - Remedial classes

  - One on one education

  - Continue to audit monthly, then quarterly

  - Do trends per coder and per agency

REIMBURSEMENT FROM CODING / OASIS

- Ensure using Grouper or EMR to identify clinical groups, l/h comorbidity, functional impairment, etc.

- Enter primary and secondary diagnosis – good method to identify what each diagnosis fits into.

- Then entering all information see case mix, HIPPS.

- Run reports showing all patients, then by physician, by HH team, etc.

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CONCLUSION

- PDGM requires HHAs to ensure that patients are appropriate to be admitted to Home Health by having an Acceptable Primary Diagnosis.

- If physician doesn't provide an underlying cause for an unacceptable diagnosis and there are no other appropriate diagnoses for home health, then you may not be able to accept a pt.

- Code to highest specificity!

- Code to Coding Guidelines, Physician Documentation & Comprehensive Assess.

- Many Scenarios under PDGM you will find patient by patient!

QUESTIONS?

ACCREDITATION COMMISSION *for* HEALTH CARE

THANK YOU!

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