

Strategically preparing for upcoming changes in current payment models:

ICD-10 with PDGM and PDPM

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Health agencies are ramping up for changes imposed by CMS for CY 2019. The final rule for 2019 delivers some of the most sweeping changes to CMS since the 1990s. Patient Driven Grouping Model (PDGM) for home health agencies and Patient Driven Payment Model (PDPM) for skilled nursing facilities will replace the current payment models for both entities respectively.

Both models move from therapy-based delivery to more patient-centric, patient-focused care. How agencies interact with their main collection instrument, Outcomes Assessment Information Set (OASIS) for home health and Minimum Data Set (MDS) for skilled nursing, will require specific data items, more consideration given to clinical groupings and more specificity to both primary and secondary diagnoses. And for the skilled nursing side, add procedural codes to the mix. In a nutshell, ICD-10-CM (Clinical Modification) and ICD-10-PCS (Procedure Coding System) become very important.

The implementation date is Oct. 1, 2019 for skilled nursing and Jan. 1, 2020 for Home Health. That's a good amount of time for agencies to start socializing and utilizing diagnosis and procedural codes more strategically in preparation for the upcoming changes.

The new rule does introduce stringent ICD-10-CM/PCS coding expectations, which will require strategic approaches. Start communicating and planning now. Below are some talking points going forward. Let's break down each entity.

PDGM and ICD-10 in home health

So, what has changed for home health? Other than the annual coding updates on Oct. 1, 2019, how we apply diagnosis codes with the new clinical groupings is where the difference lies. Originally proposed as six clinical groups, the new rule CY 2019 uses 12 new clinical groupings. The expansion to the following 12 will aid in better documenting patient-specific needs for skilled nursing and/or therapy. These groupings are designed to capture the most common types of home care provided and more accurately align payments with the cost of providing that care. *(See the following page for the list of the 12 PDGM clinical groups.)*

PDGM Clinical Groups¹

- Musculoskeletal Rehabilitation
- Behavioral Health Care (including Substance Use Disorder)
- Neuro/Stroke Rehabilitation
- Complex Nursing Interventions
- Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care
- Medication Management, Teaching, and Assessment (MMTA) – Surgical Aftercare
- Medication Management, Teaching, and Assessment – Cardiac/Circulatory
- Medication Management, Teaching, and Assessment – Endocrine
- Medication Management, Teaching, and Assessment – GI/GU
- Medication Management, Teaching, and Assessment – Infectious Disease/Neoplasms/Blood-Forming Disease
- Medication Management, Teaching, and Assessment – Respiratory
- Medication Management, Teaching, and Assessment – Other

Home health primary diagnosis

For home health coding, we want to code based on the condition most affecting the resource use, the main reason for home health services and the main goal of PDGM. This condition becomes the primary diagnosis and may be independent of the most recent hospital stay.

Coding guidelines and the new home health clinical groups may sometimes collide. Coding foundations stress the importance that certain codes are listed first (Code First) where an underlying condition is present, but that condition may not be appropriate for home health based on clinical grouping. The Code First note provides sequencing instructions. “Codes may appear independently of each other or to designate certain etiology/manifestation paired codes. The instructions signal the coder that an additional code should be reported to provide a more complete picture of that diagnosis.”² An example for primary diagnosis is Parkinson’s disease must be listed prior to dementia if both are listed on the claim.

Also ask, “What is involved to manage the diagnosis at home?” This data would support the resource used in home health and thus the primary diagnosis. Consider an infection of a Below Knee Amputation (BKA) that would only require antibiotic treatment versus management of necrosis of tissue that requires debridement and subsequent wound care for proper healing to occur. Necrosis of a BKA denotes wound care. To meet the new wound care grouping, the diagnosis must reflect a break in skin integrity, which in turn involves wound care and therefore, skilled nursing. A diagnosis simply indicating infection does not necessitate wound care.

Now, let’s turn to secondary diagnoses.

¹ Center for Medicare & Medicaid Services (2019), CY 2019 Final Rule HPPPS, page 2, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/HomeHealthPPS/Downloads/Overview-of-the-Patient-Driven-Groupings-Model.pdf>

² Center for Medicare & Medicaid Services (2019), ICD-10-CM, page 10, <https://www.cms.gov/Medicare/Coding/ICD10/2019-ICD-10-CM.html>

Home health secondary diagnoses and comorbidity

The secondary diagnoses are those coexisting conditions actively addressed in the plan of care. This may include comorbid conditions with the potential to affect responsiveness to treatment and rehabilitative prognosis, even if not the focus of home health treatment itself, as well as potential to impact the skilled services provided by a home health agency.

Comorbidity coding becomes more important with CY2019 as PDGM further adjusts payments based on the patient's secondary diagnoses as reported on the claim. Also, the order of the diagnoses plays an important role as they support determining clinical group and comorbidity adjustment.

Recent expansion of ICD-10-CM makes it possible for agencies to more accurately and specifically code conditions present in home health. With that said, the OASIS allows for only one designated primary diagnosis (M1021) and five secondary diagnoses (M1023). The home health claim (837I institutional claim – electronic version of the paper UB-04) allows for reporting up to 24 secondary diagnoses. Since coding guidelines require reporting of all secondary diagnoses to establish a complete picture for the plan of care, it is expected that these additional diagnoses may also be reported on the claim. Considering all four components of PDGM:

1) admission source and time, 2) clinical groups, 3) functional level, and 4) comorbidity; there is the potential that PDGM will increase payments by up to 20 percent. Secondary diagnoses become very important.

PDPM and ICD-10 in skilled nursing

The goal of PDPM is to address the patient's unique care needs while improving payment accuracy. The focus must be on the patient and ultimately quality outcomes. So, what has changed for skilled nursing? There is an abundance of information to be consumed and the devil is in the details. Here, we focus on a high-level summary of case-mix components, clinical categories and the importance of correct diagnoses.

The skilled nursing case-mix model, Resource Utilization Groups, Version IV (RUG-IV), looked to the amount of therapy and non-therapy ancillary utilization as opposed to the patient's specific clinical needs. The case-mix index was derived from the volume of therapy services provided and the nursing components. RUG-IV payment model influenced rehab practices. The new model, PDPM, has five case-mix adjusted components used to describe the patient characteristic and needs for care and one component for facilities. Nursing practices will now influence the payment model. The PDPM components are:

PDPM Case Mix Components³

- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Language Pathology (SLP)
- Non-Therapy Ancillary (NTA)
- Nursing
- Non-Case Mix (facility)

³ Center for Medicare & Medicaid Services (2019), CY 2019 Final Rule SNPPS, page 5, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNPPS/Downloads/PDPM-101_Final.pdf

Unlike home health, skilled nursing becomes more involved where the case-mix components and comorbidity diagnoses intersect, which are very specific with the SLP and NTA services. More on this topic later.

PDPM clinical categories

In addition to changing the case-mix components, PDPM also has new clinical categories. Like home health, these clinical categories and how ICD-10-CM codes are used in the electronic record, as well as in the MDS, become crucial for reimbursement. Below are the groupings:

PDPM clinical categories⁴

- Major Joint Replacement or Spinal Surgery
- Cancer
- Non-Surgical Orthopedic/Musculoskeletal
- Orthopedic Surgery (Except Major Joint Re-placement of Spinal Surgery)
- Cardiovascular and Coagulations
- Acute Infections
- Acute Neurologic
- Medical Management
- Non-Orthopedic Surgery
- Pulmonary

Skilled nursing primary diagnosis

With skilled nursing, diagnoses are captured a little differently. While coding guidelines always apply when completing accurate diagnosis coding, skilled nursing uses the MDS item Section I: Active Diagnoses to meet compliance. The Section I intent is to “code diseases that have a direct relationship to the resident’s current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death.”⁵ Item I0020 captures the “resident’s primary medical condition category”, not the specific resident diagnoses.⁶

The MDS item I0020 stores the resident’s primary medical condition category that best describes the primary reason for admission. If the medical condition falls under Code 14-Other Medical Conditions, the MDS coder is directed to I0020A and instructed to code a specific ICD-10-CM code with decimal for the primary diagnosis for the skilled nursing facility (SNF) stay. Note this is the diagnoses for the skilled nursing visit, not the diagnoses for the previous or most recent hospital stay. They can be different.

This primary diagnosis (I0020A) is then mapped back to one of the 10 new PDPM clinical categories listed above. It is then used as part of the classification or PT, OT or SLP. Additionally, this clinical classification may be adjusted based on if there is documentation of a surgical procedure occurring in the prior inpatient stay. Surgical procedure coding information is documented in Section J of the MDS.

⁴ Center for Medicare & Medicaid Services (2019), CY 2019 Final Rule SNPPS, page 11, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNPPPS/Downloads/PDPM-101_Final.pdf

⁵ Center for Medicare & Medicaid Services (2018), MDS 3.0 RAI Manual, page I-1, Section I, <https://downloads.cms.gov/files/1-MDS-30-RAI-Manual-v1-16-October-1-2018.pdf>

⁶ *ibid.*

This mapping was a major effort and CMS provides an extensive ICD-10 Clinical Category Crosswalk⁷ tool to help navigate and determine the correct primary diagnosis code to the appropriate clinical grouping. This mapping also will help to prevent a Return To Provider (RTP) status if the code is not correct.

Remember to use the CMS recommended two-step process to identify active diagnoses:

- 1) Diagnosis identification is a 60-day look back period to identify disease conditions, which require a physician-documented diagnosis.
- 2) Determine if the diagnosis is active or inactive in the last seven days. If a diagnosis (with exception to a UTI) has been resolved and does not affect the resident's current status or care planning in the 7-day-look back period, it is considered inactive. Do not code.

Skilled nursing secondary diagnoses and comorbidity

In addition to item I0020, the resident may have further active diagnoses that can affect the disease process. These diagnoses categories are recorded in I0100 to I7900. I8000 allows for recording additional diagnoses if the disease or condition is not specifically listed. Correct ICD-10 code in I8000A-J Items become very critical as they are directly tied to reimbursement. Coders would refer to specific ICD-10-CM codes with decimals. This could be secondary diagnoses or a comorbidity.

Comorbidities also become very important specifically with SLP and NTA services. Comorbidities can be predictive of higher costs for SLP and NTS services. There are 12 SLP Comorbidities:

SLP Comorbidities⁸

- Aphasia
- Laryngeal Cancer
- CVA, TIA or Stroke
- Apraxia
- Hemiplegia or Hemiparesis
- Dysphagia
- Traumatic Brain Injury
- ALS
- Tracheostomy (while Resident)
- Oral Cancers
- Ventilator (while Resident)
- Speech & Language Deficits

And for NTA classifications, there are 50 conditions and extended services that are derived from a variety of MDS sources, as well as ICD-10-CM codes reported on I8000. Like the clinical categories, CMS provided an NTA Comorbidity Crosswalk⁹ that will help identify the correct codes. With more than 1,500 comorbidity codes, only one exclusion, B20-HIV/AIDS, will continue to be reported on the claim because some states will not allow for this diagnosis to be coded on the MDS Item I8000. B20 will be reported in the same manner as the RUG-IV model.

⁷ Center for Medicare & Medicaid Services (2019), ICD-10 Clinical Category Crosswalk, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNPPS/PDPM.html>

⁸ Center for Medicare & Medicaid Services (2019), CY 2019 Final Rule SNPPS, page 20, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNPPS/Downloads/PDPM-101_Final.pdf

⁹ Center for Medicare & Medicaid Services (2019), ICD1- NTA Comorbidity Crosswalk, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNPPS/PDPM.html>

“Unspecified” and “Other” codes

For both home health agencies and skilled nursing facilities, the CY 2019 rule is a good reason to give serious review in the use of “Unspecified” and “Other” codes. Our coding guidelines tell us that “the most specific code that describe a medical disease, condition, or injury”¹⁰ should be documented. So why do we have “Unspecified/NOS” or “Other/NEC” diagnosis codes?

The ICD-10 official coding guidelines for “Other” codes state, “Codes titled ‘other’ or ‘other specified’ are for use when the information in the medical record provided detail for which a specific code does not exist.”¹¹ And “Codes titled ‘unspecified’ are for use when the information in the medical record is insufficient to assign a more specific code.”

In some settings these codes may be appropriate; however, by the time a patient is admitted into home health or skilled nursing, that primary diagnosis should be clear; otherwise, the use for resources is ambiguous. If the primary diagnosis is not clear, send a query out to the diagnosing physician for more clarity and/or specificity in a timely manner.

To drive this point home, consider T14.90 – Injury, unspecified. This code does not indicate type or extent of the injury and therefore, fails to support needed skilled resources. However, S72.111D – Displaced fracture of greater trochanter of right femur, clearly supports skilled resource use.

Another popular, but vague primary diagnosis is M62.81-Muscle Weakness, generalized. Just the description itself does not indicate or clearly support skilled services and certainly does not speak to creating a comprehensive plan of care. As coders, we should ask, “What is causing the weakness?” If the diagnosis is not clear, how can treatment be properly initiated? A more specific code, such as muscle-wasting or atrophy would be a more appropriate code that would support skilled nursing. Additionally, both codes fall into the musculoskeletal grouping. These are just a few examples for the primary diagnosis.

We highly encourage you to continue engaging your teams to understand PDGM/PDPM and how the changes will impact diagnosis coding. In the meantime, consider these talking points with your teams, and execute a plan for incorporating strategies soon.

For information and more resources to help you prepare, visit:

www.ntst.com/pdgm

www.ntst.com/pdpm

¹⁰ Center for Medicare & Medicaid Services (2019), ICD-10-CM, page 10, <https://www.cms.gov/Medicare/Coding/ICD10/2019-ICD-10-CM.html>

¹¹ *ibid.*

About Netsmart

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