ACHC U®
EDUCATIONAL RESOURCES

HOME HEALTH

ICD-10 CODING IMPACT UNDER PDGM

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5 STAR CONSULTANTS
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It is not the strongest or the most intelligent who will survive but those who can best manage change.

Charles Darwin

OBJECTIVES

- Explain the Impact of Coding under PGDM
- Evaluate the specificity requirements of coding under PDGM
- Clarify what an "Unacceptable Diagnosis" is and actions to resolve a "UD"

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PDGM – PAYMENT GROUPINGS OVERVIEW

- CY 2019 Home Health final rule, PDGM was 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.

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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)

PDGM – SUBGROUPS CLINICAL GROUPING – 12 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

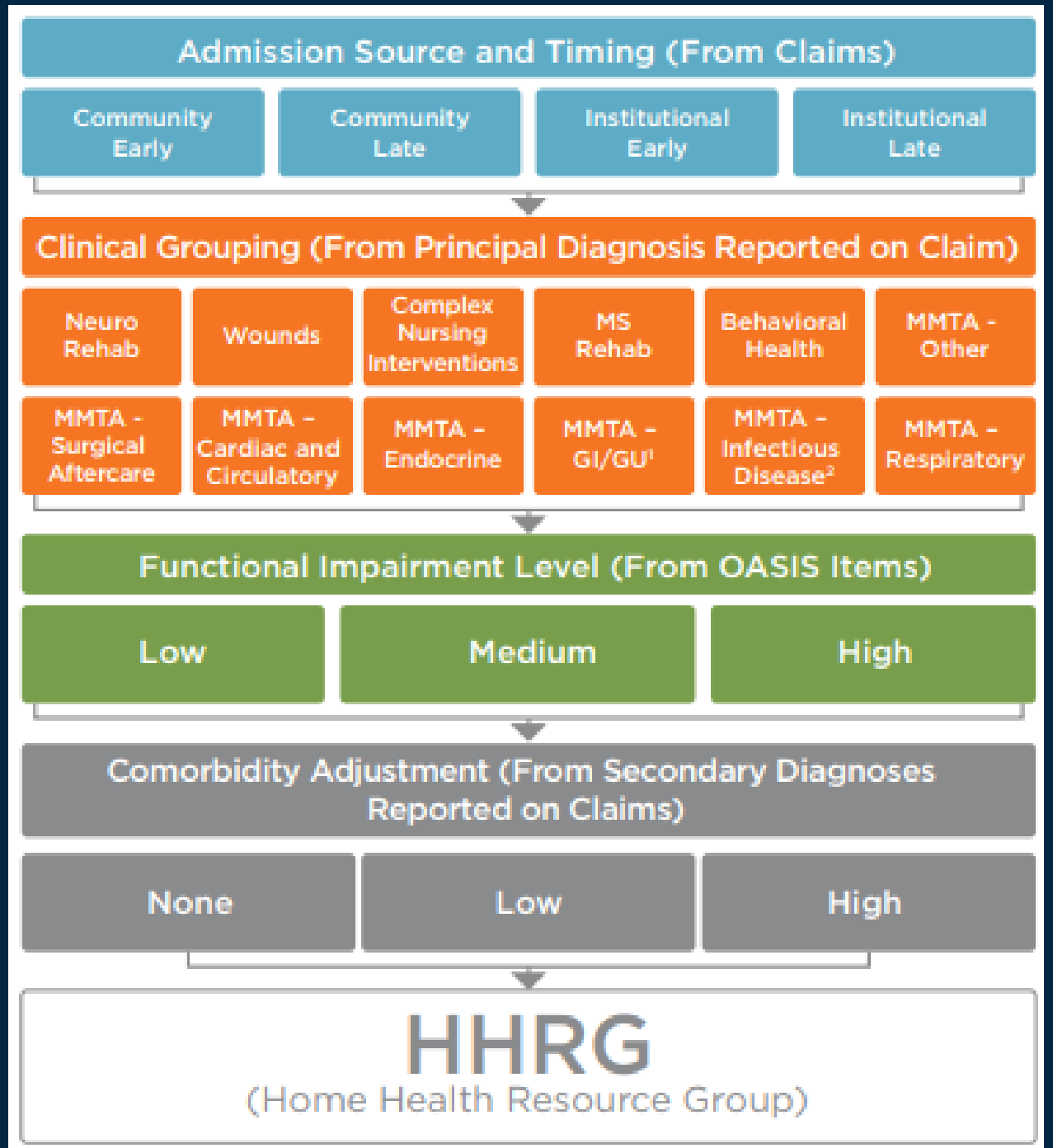
PDGM – SUBGROUPS FUNCTIONAL IMPAIRMENT LEVEL (3 SUBGROUPS)

- 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

PDGM – SUBGROUPS COMORBIDITY ADJUSTMENT

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

PATIENT-DRIVEN GROUPINGS MODEL (PDGM)



ACHC EDUCATIONAL RESOURCES

PDGM
CODING IMPACTS

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.

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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 – COMORBIDITY CODING

- A comorbidity is defined as a medical condition coexisting in addition to a principal diagnosis.
  - Comorbidity is tied to poorer health outcomes, more complex medical need and management, and a higher level of care
- Comorbidity Coding in PDGM
  - Accounts for differences in resource use based on patient characteristics
  - Uses the presence of home health specific comorbidities as part of the overall case- mix adjustment.
  - Payments adjust based on patient's secondary diagnoses as reported by the HHA on the home health claim.

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PDGM – COMORBIDITY CODING

- A Home Health specific comorbidity list was developed with broad clinical categories used to group comorbidities within PDGM:
  - Heart disease
  - Respiratory disease
  - Circulatory disease
  - Cerebral vascular disease
  - Gastrointestinal disease
  - Neurological conditions
  - Endocrine disease
  - Neoplasms
  - Genitourinary/Renal disease
  - Skin disease
  - Musculoskeletal disease
  - Behavioral health issues (including substance use disorders)
  - Infectious diseases

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PDGM – COMORBIDITY ADJUSTMENT

- These broader categories were further refined into comorbidity subcategories to more accurately capture differences in resource use.
- Thirty-day periods will receive a comorbidity adjustment based on the presence of certain secondary diagnoses reported on home health claims.
- These diagnoses are based on the home health specific list of clinically and statistically significant secondary diagnosis subgroups with similar resource use.

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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.

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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

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PDGM – COMORBIDITY ADJUSTMENT

- Comorbidity Adjustment Increases:
  - No Comorbidity Adjustment to Low Comorbidity Adjustment will increase case mix by 6%
  - Low Comorbidity Adjustment to High Comorbidity Adjustment will increase case mix by 12.95%

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PDGM – COMORBIDITY ADJUSTMENT

- For CY 2020
  - 13 comorbidity subgroups receive the low comorbidity adjustment
  - 31 comorbidity interaction subgroups receive the high comorbidity adjustment
- The finalized CY 2020 low comorbidity adjustment subgroups and the high comorbidity adjustment interaction subgroups including those diagnoses within each of these comorbidity adjustments are posted on the HHA Center webpage as well as on the PDGM webpage.

- https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html

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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

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

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

PDGM – COMORBIDITY ADJUSTMENT

- 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.

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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

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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 31 high comorbidity adjustment interaction subgroups -15

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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?

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LOW COMORBIDITY – ANSWER

- Primary Diagnosis:
  - I87.2 Venous insufficiency (chronic) (peripheral) - WOUND
    - 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

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LOW COMORBIDITY – CODING SCENARIO

- First 30 day period
- Scenario based on:
  - Admission Source – Institutional
  - Timing – Early
  - Clinical Group – WOUND
  - Functional Impairment Level – Low
  - Comorbidity Adjustment - Low
- HIPPS of 2CA21, Case Mix weight of 1.4777, LUPA threshold of 4, Payment $2,375

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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 – WOUND
  - Functional Impairment Level – Low
  - Comorbidity Adjustment - Low
- HIPPS of 3CA21, Case Mix Weight of 0.8915, LUPA threshold of 3, Payment - $1,433

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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?

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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 are 2 or more secondary diagnoses that fall within one or more of the comorbidity interaction subgroups – subgroup 18 - Heart 11/Skin 4

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 1.2943, LUPA threshold of 4, and payment of $2,080

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 0.7081, LUPA threshold of 2, and payment of $1,138

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, and 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?

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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

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HIGH COMORBIDITY – CODING SCENARIO

- This scenario would receive a High Comorbidity adjustment.
- There are 2 or more secondary diagnoses that fall within one or more of the comorbidity interaction subgroups:
  - Subgroup 15 - Heart 11/Neuro 5

As you can see, it is important to list all diagnoses that affect the plan of care.

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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 1.5743, LUPA threshold of 4, and payment of $2,530

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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 0.9881, LUPA threshold of 3, and payment of $1,588

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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"

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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

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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!

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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, for more definitive coding.
  - The agency will then need to review & resubmit the claim with a more appropriate primary diagnosis which does fit into a clinical grouping.

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PDGM – "UNACCEPTED DIAGNOSIS"

- CMS stated that returning a claim for more appropriate or specific coding would not be considered as "up-coding" assuming the documentation clearly supports the need for services.
    - Any changes in the plan of care must be signed and dated by a physician.
    - If a claim is returned for more specific coding, diagnosis on the plan of care should be corrected as well.

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

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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.

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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 *Was added to Clinical Group NEURO-REHAB in final rule!
- 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.

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COMMONLY USED UNACCEPTED DIAGNOSIS CODES

- C34.90 Malignant neoplasm of unspecified part of unspecified bronchus or lung
- I95.9 Hypotension, Unspecified
- 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

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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

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COMMONLY USED UNACCEPTED DIAGNOSIS CODES

- S06.9X9D Unspecified intracranial injury with loss of consciousness of unspecified duration
- S50.11XD Contusion of right forearm, subsequent encounter
- S80.811D Abrasion, right lower leg, subsequent encounter
- Z51.81 Encounter for therapeutic drug level monitoring
- Z51.89 Encounter for other specified aftercare
- Z91.81 History of falling

- 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!

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CY 2020 FINAL RULE – R CODES THAT CAN BE USED FOR PRIMARY DIAGNOSIS

- In the final rule, CMS agreed that the R-codes to describe dysphagia would be acceptable for reporting the primary reason for home health services.
- These codes were assigned to the Neuro Rehab clinical group
  - 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 Other dysphagia

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
- Get this specific information at Intake to prevent time lags from querying at or after admission.

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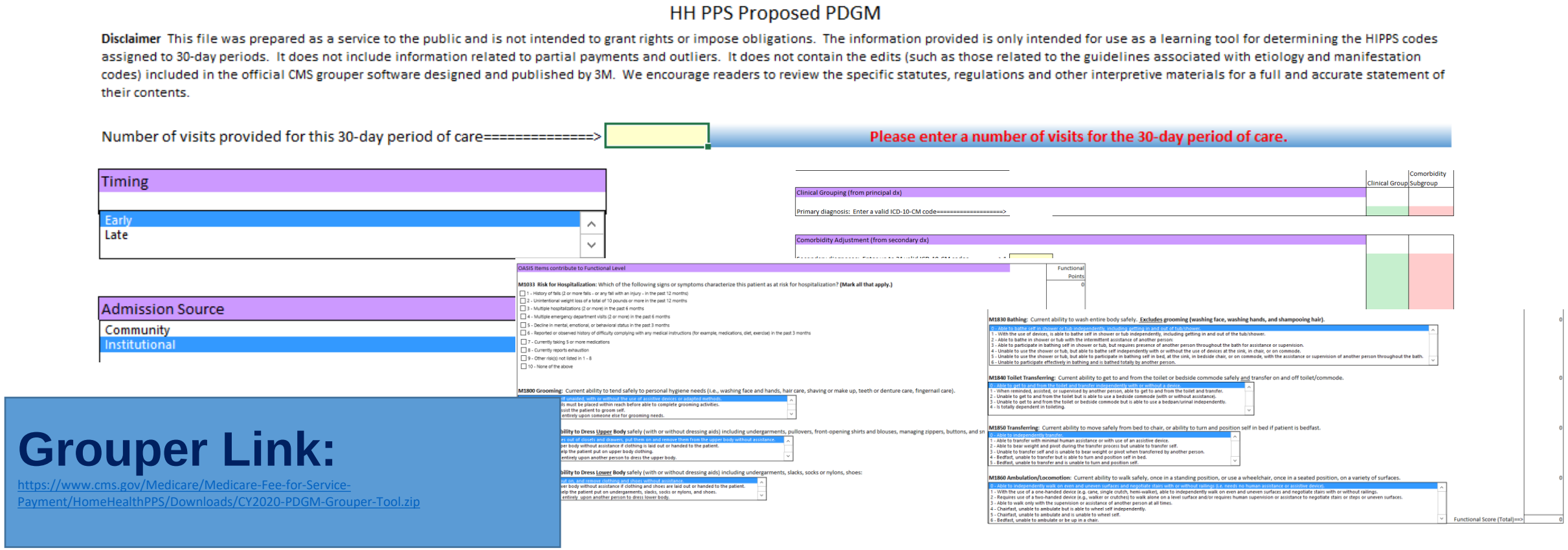
PDGM
GROUPER TOOL

CMS INTERACTIVE GROUPER TOOL

- Use this tool to obtain HIPPS code/case mix weight



Grouper Link:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/CY2020-PDGM-Grouper-Tool.zip

CMS INTERACTIVE GROUPER TOOL

- Clinical Grouping and Comorbidity Adjustment

			Clinical Group	Comorbidity Subgroup
Clinical Grouping (from principal dx)				
Primary diagnosis: Enter a valid ICD-10-CM code==========>	i87.2	Venous insufficiency (chronic) (peripheral)	WOUND	None
Comorbidity Adjustment (from secondary dx)				
Secondary diagnoses: Enter up to 24 valid ICD-10-CM codes==========>	I97.212	Non-pressure chronic ulcer of right calf w fat layer exposed	WOUND	Skin 3
2.	i10	Essential (primary) hypertension	MMTA_CARDIAC	
3.				
4.				
5.				
6.				

CMS INTERACTIVE GROUPER TOOL

- Clinical Grouping and Comorbidity Adjustment – Unaccepted Diagnosis as Primary

			Clinical Group	Comorbidity Subgroup
Clinical Grouping (from principal dx)				
Primary diagnosis: Enter a valid ICD-10-CM code=========>	M62.81	Not found in Clinical Grouping classification	None	None
Comorbidity Adjustment (from secondary dx)				
Secondary diagnoses: Enter up to 24 valid ICD-10-CM codes=========>	R26.9	Not found in Clinical Grouping Classification		
2.	I11.0	Hypertensive heart disease with heart failure	MMTA_CARDIAC	Heart 11
3.	I50.9	Heart failure, unspecified	MMTA_CARDIAC	Heart 11
4.				
5.				

CMS INTERACTIVE GROUPER TOOL

- Clinical Grouping and Comorbidity Adjustment – R13.10 Dysphagia Code as Primary

			Clinical Group	Comorbidity Subgroup
Clinical Grouping (from principal dx)				
Primary diagnosis: Enter a valid ICD-10-CM code==========>	R13.10	Dysphagia, unspecified	NEURO_REHAB	None
Comorbidity Adjustment (from secondary dx)				
Secondary diagnoses: Enter up to 24 valid ICD-10-CM codes=========>	i12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	MMTA_CARDIAC	Circulatory 4
2.	n18.2	Chronic kidney disease, stage 2 (mild)	MMTA_GI_GU	Renal 1
3.	i48.0	Paroxysmal atrial fibrillation	MMTA_CARDIAC	Heart 10
4.	z51.81	Not found in Clinical Grouping Classification		
5.	z79.01	Not found in Clinical Grouping Classification		
6.				
7.				

PDGM
CODING SPECIFICITY

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.

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CODING SPECIFICITY

- Many of the codes that indicate pain or contractures as the primary diagnosis:
  - Example:
    - M54.5, Low back pain or
    - M62.422, Contracture of muscle, right hand
- Are site specific, but don'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

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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."
- 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).

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CMS – CODING SPECIFICITY: MUSCLE WEAKNESS

- "Clinical record documentation must describe how the course of therapy treatment for the patient's illness/ injury is in accordance with accepted professional standards of clinical practice."
- "Without an identified cause of muscle weakness, it would be questionable that the course of therapy treatment meets these professional standards."
- "A more appropriate code would be one of the muscle wasting & atrophy codes as grouped into the musculoskeletal group, which indicate the reason for the generalized muscle weakness & provide more clarity for the necessity of skilled services." (72 FR 49774).

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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.

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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.

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CODING SPECIFICITY: USE OF R CODES

- Alternative R Code Examples:
  - Weakness following hospitalization for CHF
    - Confirm with the physician that weakness is due to CHF
      - Code I50.9 Heart failure, unspecified
  - Repeated falls with history of Parkinson's Disease
    - Confirm with the physician that falls are due to Parkinson's Disease
      - Code G20 Parkinson's Disease
  - Difficulty with ambulation history of Stroke with right hemiparesis
    - Confirm with the physician that ambulation difficulty is due to Stroke/hemiparesis
      - Code I69.351 Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side

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CODING SPECIFICITY: USE OF R CODES

- Alternative R Code Examples:
  - Dizziness with fall resulting hospitalization
    - Confirm with physician if reason for dizziness/fall was identified in hospital
      - Physician confirms orthostatic hypotension I95.1
  - Ataxia with history of Parkinson's Disease
    - Confirm with the physician that ataxia is due to Parkinson's Disease
      - Code G20 Parkinson's Disease

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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.

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CODING SPECIFICITY: USE OF S AND T CODES

Example:

- S52.301D Unspecified fracture of shaft of right radius, subsequent encounter for closed fracture with routine healing
  - This is an Accepted Primary Diagnosis under PDGM- the fracture is unspecified, but the site is specified (right radius).
- S52.309D Unspecified fracture of shaft of unspecified radius, subsequent encounter for closed fracture with routine healing
  - This is an Unaccepted Diagnosis under PDGM as the site of the fracture is not specified.

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CODING SPECIFICITY: USE OF S AND T CODES

Example:

- S81.801D Unspecified open wound, right lower leg, subsequent encounter
  - This is an Accepted Primary Diagnosis under PDGM- the wound is unspecified, but the site is specified (right lower leg).
- S81.809D Unspecified open wound, unspecified lower leg, subsequent encounter
  - This is an Unaccepted Diagnosis under PDGM as the laterality of the wound is not specified.

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CODING SPECIFICITY: USE OF S AND T CODES

Example:

- T84.033D Mechanical loosening of internal left knee prosthetic joint, subsequent encounter
  - This is an Accepted Primary Diagnosis under PDGM- the site of the internal knee prosthetic joint is specified (left knee)
- T84.039D Mechanical loosening of unspecified internal prosthetic joint, subsequent encounter
  - This is an Unaccepted Diagnosis under PDGM as the internal prosthetic joint is not specified

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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.

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CODING SPECIFICITY: USE OF Z CODES

- Z codes may be used as primary diagnosis
  - Z43.0 Encounter for attention to tracheostomy – COMPLEX Nursing Interventions
  - Z43.1 Encounter for attention to gastrostomy – COMPLEX Nursing Interventions
  - Z43. 3 Encounter for attention to colostomy – COMPLEX Nursing Interventions
  - Z43.5 Encounter for attention to cystostomy – COMPLEX Nursing Interventions
  - 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
  - Z47.33 Aftercare following explanation of knee joint prosthesis– MS_REHAB

CODING SPECIFICITY: USE OF Z CODES

- Z codes may be used as primary diagnosis - Continued
  - Z47.89 Encounter for other orthopedic aftercare– MS_REHAB
  - Z48.00 Encounter for change or removal of nonsurgical wound dressings – WOUND
  - Z48.01 Encounter for change or removal of surgical wound dressings – WOUND
  - Z48.22 Encounter for aftercare following kidney transplant – MMTA_AFTER
  - Z48.3 Aftercare following surgery for neoplasm – MMTA_AFTER
  - Z48.812 Encounter for surgical aftercare following surgery on the circulatory system – MMTA_AFTER
  - Z48.815 Encounter for surgical aftercare following surgery on the digestive system – MMTA_AFTER
  - Z99.11 Dependence on respirator [ventilator] status – COMPLEX Nursing Interventions

- In addition to the Z codes listed, there are several others- Check in ICD 10 diagnosis list

PDGM & CODING GUIDELINES

PDGM & CODING GUIDELINES

- The importance of consistent, complete medical documentation cannot be overemphasized.
  - Without such documentation, accurate diagnosis coding cannot be achieved.
  - 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.
- If there is a question as to what the appropriate principal (or secondary) diagnosis should be, the HHA should query the certifying physician who is responsible for establishing the home health plan of care.

PDGM & CODING GUIDELINES – PRIMARY CODING

- In accordance with ICD-10-CM coding guidelines, the principal diagnosis reported is that "condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- For purposes of home health care admission, this would be the diagnosis chiefly responsible for home health services.
- Because of the home health requirements that the individual receiving home health services must be certified for such services and must have had a face-to-face encounter related to the primary reason for home health care, CMS believes that by the time an individual is admitted to home health, the patient has been seen by other health care providers and a diagnosis has been established.
- ICD-10- CM coding guidelines state that codes for symptoms, signs, and ill-defined conditions are not to be used as the principal diagnosis when a related definitive diagnosis has been established.

PDGM & CODING GUIDELINES

ICD-10-CM coding guidelines state:

- 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, such as signs and symptoms associated with complex syndromes.
- The definitive diagnosis should be sequenced before the symptom code.
- Signs or symptoms that are associated routinely with a disease process should not be assigned as secondary codes, unless otherwise instructed by the classification.
- CMS expects that HHAs would report the principal and secondary diagnoses that affect the home health plan of care and justify the need for home health services.

CODING GUIDELINES/OASIS INSTRUCTIONS/COPS

- 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."
- 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".
- CMS recognizes that there could be a perceived difference between the various descriptions, but 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.

PDGM
PRIMARY DIAGNOSIS CODING CHANGES

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.

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PDGM – PRIMARY DIAGNOSIS CHANGES

- Typically, the codes will match between the 1st 30-day claim & the start of care assessment & claims corresponding to recertification assessments.
- 2nd 30-day claims in any 60-day period will not necessarily match the OASIS assessment.

NOTE: Per CMS, 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.

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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.
- PDGM ***does not*** change the OASIS timepoint requirements!
  - Continue to collect OASIS data at the appropriate timepoints as you have been

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CY 2020 FINAL RULE - COMMENTER RECOMMENDATIONS AND CMS RESPONSES FOR SPECIFIC CLINICAL GROUP CHANGES

CY 2020 CLINICAL GROUP CHANGES

Table 12: Commenter Recommendations and CMS Responses for Specific Clinical Group Changes

ICD-10-CM Diagnosis Code	Code Description	Current Clinical Group	Commenter Recommended Clinical Group	CMS Response	Finalized Clinical Group
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy w/o gangrene	MMTA-Endo	Commenters recommended assigning to the Wound group as they stated that venous insufficiency in a patient with diabetes is assumed to be a diabetic angiopathy.	We disagree with this recommendation because these two conditions are not synonymous. However, we will continue to examine reported diagnosis codes, and the associated resource use to determine if any future changes to coding assignments are warranted.	MMTA-Endo
E11.9	Type 2 diabetes mellitus without complications	MMTA-Other	Commenters recommended assigning to MMTA-Endo as they stated that if listed this diagnosis code was primary, this would mean that the patient is newly diagnosed.	We agree with commenters that this code should be grouped under the MMTA-Endo group. Furthermore, to be clinically consistent, we will also move E10.9, E11.9, and E13.9 to MMTA-Endo as well.	MMTA-Endo
I87.2	Venous Insufficiency (chronic/peripheral)	MMTA-Cardiac	Commenters recommended assigning to the Wound group.	We agree with commenters that this should be grouped under Wound as the ICD-10 Index entry for Ulcer, Stasis (venous) lists I87.2 as the appropriate diagnosis code to report.	Wound

CY 2020 CLINICAL GROUP CHANGES

Table 12: Commenter Recommendations and CMS Responses for Specific Clinical Group Changes

ICD-10-CM Diagnosis Code	Code Description	Current Clinical Group	Commenter Recommended Clinical Group	CMS Response	Finalized Clinical Group
I87.311 I87.312 I87.313 I87.331 I87.332 I87.333	Chronic venous hypertension w ulcer of right low extremity Chronic venous hypertension w ulcer of left low extremity Chronic venous hypertension w ulcer of bilateral low extremity Chronic venous hypertension w ulcer and inflammation of r low extremity Chronic venous hypertension w ulcer and inflammation of l low extremity Chronic venous hypertension w ulcer and inflammation of bilateral low extremity	MMTA-Cardiac	Commenters recommended assigning to the Wound group because of the code description.	We agree with commenters that this should be grouped under the Wound group given the ulcer is included in the code description.	Wound
J95.01 J95.02 J95.03 J95.04 J95.09	Hemorrhage from tracheostomy stoma Infection of tracheostomy stoma Malfunction of tracheostomy stoma Tracheo-esophageal fistula following tracheostomy Other tracheostomy complication	MMTA-Resp	Commenters recommended that all complications of ostomies be included in the Complex group.	We agree with commenters that this should be grouped under the Complex Nursing Interventions group as other ostomy complication codes are included in the Complex Nursing Interventions group.	Complex

CY 2020 CLINICAL GROUP CHANGES

Table 12: Commenter Recommendations and CMS Responses for Specific Clinical Group Changes

ICD-10-CM Diagnosis Code	Code Description	Current Clinical Group	Commenter Recommended Clinical Group	CMS Response	Finalized Clinical Group
M06.9	Rheumatoid Arthritis, unspecified	Not assigned	Commenters recommended assigning to the MS Rehab clinical group with guidance to query the physician for more specific information. Commenters stated that in the HH setting, treatment is designed to deal with mobility issues related to multiple joints.	We disagree with commenters that this particular code should be included in the MS Rehab group. If the patient has multiple joints affected, M06.89, other specified rheumatoid arthritis, multiple sites would be the appropriate code to report.	Not assigned
M54.5	Low Back Pain	Not assigned	While commenters did not provide a specific clinical group, this diagnosis code was recommended by commenters for inclusion in the clinical group variable.	We believe that the case-mix should system avoid, to the fullest extent possible, non-specific or ambiguous ICD–10–CM codes, codes that represent general symptomatic complaints in the elderly population, and codes that lack consensus for clear diagnostic criteria within the medical community. Given the vagueness of this particular code, we question whether this would necessitate the need for home health services absent more information.	Not assigned

CY 2020 CLINICAL GROUP CHANGES

Table 12: Commenter Recommendations and CMS Responses for Specific Clinical Group Changes

ICD-10-CM Diagnosis Code	Code Description	Current Clinical Group	Commenter Recommended Clinical Group	CMS Response	Finalized Clinical Group
M62.81	Muscle weakness, unspecified	None	Commenters recommended assigning to MS Rehab group. Commenters stated that "it is problematic to exclude this code, as there are scenarios in which the patients are seen in the home for muscle weakness when the underlying etiology is unknown, or when the original condition, causing the weakness is resolved." Commenters added that M62.81 is identified as a diagnostic code to support medical necessity for home health therapy services by the MACs within their local coverage determinations. Some commenters agreed that this diagnosis lacks specificity, but disagreed that this diagnosis would not be deemed medical necessary. A few commenters stated that when evaluating the assignation of a diagnosis code at the point of care in home health, the coding specialist must consider the available documentation.	We disagree with commenters that this code be assigned to the MS Rehab group. See our more detailed response in this final rule with comment period.	Not assigned

CY 2020 CLINICAL GROUP CHANGES

Table 12: Commenter Recommendations and CMS Responses for Specific Clinical Group Changes

ICD-10-CM Diagnosis Code	Code Description	Current Clinical Group	Commenter Recommended Clinical Group	CMS Response	Finalized Clinical Group
M62.838	Other Muscle Spasm	Not assigned	Commenters recommended assigning to the MS Rehab group.	We believe that this diagnosis code does not provide sufficient information to substantiate the need for home health services.	Not assigned
M81.0	Age-related osteoporosis w/o current pathological fracture	MS Rehab	Since there is no fracture, commenters suggested moving to MMTA-Other as the services would likely be nursing.	We agree with this commenter's position. Clinically, if this is reported as the principal diagnosis, the primary reason for home health services would be for MMTA.	MMTA-Other
T81.40X A/D/S	Infection following a procedure, unspecified	MMTA-Infect	Commenters stated that the grouper should not include this code as this code lacks specificity and the default code for an infected surgical wound would be T81.49, Infection following a procedure, other surgical site.	We agree with commenters that there are more specific codes that code be reported to indicate an infected surgical wound.	Not assigned
T81.49X A/D/S	Infection following a procedure, other surgical site	MMTA-Infect	Commenters recommended that this diagnosis should be assigned to the Wound group as T81.49 is used to indicate a resolving surgical wound infection when the physician has not documented the depth of the infection.	We agree with commenters that ICD-10-CM coding instructions under the three character classification for T81.4, states that these codes indicate a wound abscess following a procedure.	Wound

CY 2020 CLINICAL GROUP CHANGES

Table 12: Commenter Recommendations and CMS Responses for Specific Clinical Group Changes

ICD-10-CM Diagnosis Code	Code Description	Current Clinical Group	Commenter Recommended Clinical Group	CMS Response	Finalized Clinical Group
T81.89X A/D/S	Other complications of procedures, NEC	MMTA-Other	Commenters recommended assigning to the Wound group.	We agree with commenters that these codes should be assigned to the Wound group as the Coding Clinic, 2014, 1st qtr. States that ICD-10-CM does not provide a specific code to describe a nonhealing surgical wound so T81.89XX would be the appropriate code to assign. If a postsurgical wound does not heal due to infection, assign code T81.4XX-, Infection following a procedure. If the wound was closed at one time and is no longer closed, it is coded as disruption. In that case, code T81.3-, Disruption of wound, not elsewhere classified, should be assigned.	Wound

CY 2020 CLINICAL GROUP CHANGES

Table 12: Commenter Recommendations and CMS Responses for Specific Clinical Group Changes

ICD-10-CM Diagnosis Code	Code Description	Current Clinical Group	Commenter Recommended Clinical Group	CMS Response	Finalized Clinical Group
T84.51XX T84.52XX T84.53XX T84.54XX T84.59XX T84.610X T84.611X T84.612X T84.613X T84.614X T84.615X T84.620X T84.621X T84.622X T84.623X T84.624X T84.625X T84.63XX T84.69XX T84.7XXX	Infection and inflammatory reaction d/t internal joint prosthesis (hip, knee, humerus, radius, femur, tibia, spine, other)	MMTA-Infect	Commenters recommended reassigning to the Wound or MS Rehab. Commenters stated that these patients are usually on long-term antibiotics, often require wound care, and many require removal of their prosthesis and subsequently require therapy.	While we agree that patients with these diagnosis codes reported as principal may require various home health services, we note that these listed diagnoses codes could be present in the absence of an open wound. We consulted with coding experts who state that there are other codes that should be reported in the event of a wound that results from a complication of an internal joint prosthesis including, T8131XD Disruption of external operation (surgical) wound, not elsewhere classified, subsequent encounter We will monitor the resource use associated with these codes to determine if any future changes to coding assignments are warranted.	MMTA-Infect

CY 2020 CLINICAL GROUP CHANGES

Table 12: Commenter Recommendations and CMS Responses for Specific Clinical Group Changes

ICD-10-CM Diagnosis Code	Code Description	Current Clinical Group	Commenter Recommended Clinical Group	CMS Response	Finalized Clinical Group
T87.41 T87.42 T87.43	Infection of amputation stump, right upper extremity Infection of amputation stump, left upper extremity Infection of amputation stump, right lower extremity	MMTA-Infect	Commenters recommended assigning to the Wound group, stating that these complications of amputations generally require wound care.	It is possible for there to be an infection in the absence of an open wound. If there is an open wound, and the primary reason for home health care is for wound care, we would expect that the code for the wound would be reported as principal. We consulted with coding specialists who state that in the event of a wound at the amputation site, the first listed diagnosis would be dependent on the circumstances of the encounter. There are other codes that could be used to describe a wound at the amputation stump depending on the cause, and documented cause-effect relationship. However, we will continue to examine reported diagnosis codes, and the associated resource use to determine if any future changes to coding assignments are warranted.	MMTA-Infect

CY 2020 CLINICAL GROUP CHANGES

Table 12: Commenter Recommendations and CMS Responses for Specific Clinical Group Changes

ICD-10-CM Diagnosis Code	Code Description	Current Clinical Group	Commenter Recommended Clinical Group	CMS Response	Finalized Clinical Group
Z48.01	Encounter for change or removal of surgical wound dressing	Wound	Commenters stated that this should not be reported as a principal diagnosis for clinical grouping because the clinician would not be in the home just for a dressing change but is likely doing other aftercare and teaching.	Z48.01 is an aftercare code and the coding instructions state that aftercare codes are generally first listed to explain the specific reason for the encounter. Coding instructions also state that aftercare codes should be used in conjunction with other aftercare codes or diagnosis codes to provide better detail on the specifics of an aftercare encounter visit. For example, if the primary reason for the home health period of care is to provide wound care to a surgical wound site following CABG surgery, the HHA could report Z48.01, encounter for change or removal of surgical wound dressing as the principal diagnosis, and Z48.812, Encounter for surgical aftercare on the circulatory system (another aftercare code), to identify the body system requiring aftercare. There is no sequencing guideline provided for these aftercare codes other than they can be reported in conjunction with other aftercare codes. The HHA should report the primary reason for the home health encounter (which in this scenario would be for wound care, even though the clinician can also be providing teaching about the patient's condition).	Wound

CY 2020 CLINICAL GROUP CHANGES

Table 12: Commenter Recommendations and CMS Responses for Specific Clinical Group Changes

ICD-10-CM Diagnosis Code	Code Description	Current Clinical Group	Commenter Recommended Clinical Group	CMS Response	Finalized Clinical Group
Z48.810	Encntr for surgical aftercare following surgery on the sense organs	MMTA-After	Commenters recommended that these diagnosis codes be assigned to the Wound group. Commenters stated that all surgical aftercare codes indicate that the patient has had a procedure of some kind, most often with interruption of the skin.	We disagree with commenters that all of these surgical aftercare codes would indicate that the primary reason for home health care would be for wound care. We note that the coding instructions for Z48.81-encounter for aftercare of specific body systems state that these codes are to be used in conjunction with other aftercare codes to fully explain the aftercare encounter. Additionally, if the condition treated should also be coded if still present. Furthermore, we consulted with coding specialists who stated that these encounter for surgical aftercare codes do not specifically indicate the presence of a wound and that there are other codes that would be listed to indicate that the encounter is for wound care.	MMTA-After
Z48.811	Encntr for surgical aftcr fol surgery on the nervous sys	MMTA-After			
Z48.812	Encntr for surgical aftcr following surgery on the circ sys	MMTA-After			
Z48.813	Encntr for surgical aftcr following surgery on the resp sys	MMTA-After			
Z48.814	Encntr for surgical aftcr following surgery on the teeth or oral cavity	Not assigned			
Z48.815	Encntr for surgical aftcr following surgery on the GI system	MMTA-After			
Z48.816	Encounter for surgical aftcr following surgery on the GU sys	MMTA-After			
Z48.817	Encntr for surgical aftcr fol surgery on the skin, subcu	MMTA-After			
Z48.89	Other specified surgical aftercare, NEC	Not assigned	While commenter did not recommend a specific clinical group, it was suggested that this should be included in the clinical group variable.	We agree with the commenter that this diagnosis code would warrant inclusion for MMTA-Aftercare	MMTA-Aftercare

CY 2020 FINAL RULE – REASSIGNED DIAGNOSIS CODES FOR CLINICAL CONSISTENCY

CY 2020 CLINICAL GROUP CHANGES

Table 13: Reassigned Diagnosis Codes for Clinical Consistency

ICD-10-CM Diagnosis Code	Code Description	Current Clinical Group	Finalized Clinical Group	Rationale
C09.1	Malignant neoplasm of tonsillar pillar (anterior)(posterior)	Not assigned	MMTA-Infect	Other similar codes in the code classification are included in MMTA-Infect (for example M09.0, Malignant neoplasm of tonsillar fossa).
C60.0	Malignant neoplasm of prepuce	Not assigned	MMTA-Infect	Other similar codes in the code classification are included in MMTA-Infect (for example, C60.1, Malignant neoplasm of glans penis).
E03.2	Hypothyroidism d/t meds and other exogenous substances	Not assigned	MMTA-Endo	Other similar codes in the code classification are included in MMTA-Endo (for example, E03.1, Congenital hypothyroidism without goiter).
I21.A9	Other myocardial infarction type	Not assigned	MMTA-Cardiac	Other similar codes in the code classification are included in MMTA-Cardiac (for example, I21.A1, myocardial infarction type 2).
I10	Essential hypertension	MMTA-Other	MMTA-Cardiac	To be clinically consistent with other similar diagnoses in the same diagnosis block of codes (I10-I16, hypertensive diseases) assigned to MMTA-Cardiac.

CY 2020 CLINICAL GROUP CHANGES

Table 13: Reassigned Diagnosis Codes for Clinical Consistency

ICD-10-CM Diagnosis Code	Code Description	Current Clinical Group	Finalized Clinical Group	Rationale
I80.291	Phlebitis and thrombophlebitis of deep vessels of r low extremity	Not assigned	MMTA-Cardiac	To be clinically consistent with I80.292 (left lower extremity) and I80.293 (bilateral lower extremities) which are included in MMTA-Cardiac.
M05.711	Rheumatoid arthritis w/rheumatoid factor of R shoulder w/o organ system involvement	Not assigned	MS Rehab	To be clinically consistent with M07.712 (L shoulder) which is included in MS Rehab.
T23.162D	Burn of first degree of back of left hand, subsequent encounter	MS Rehab	MMTA-Other	To be clinically consistent with T23.162A and S which are in MMTA-Other.
T84.89X A/D/S	Other specified complication of internal orthopedic prosthetic devices, implants and grafts	MMTA-Other	Wound	We consulted with coding experts who stated this would be reported if there is a wound associated with an internal prosthetic device.
T87.89	Other complications of amputation stump	MMTA-Other	Wound	We consulted with coding experts who stated this would be reported if there is a wound associated with an amputation stump complication.

PDGM
ARE YOU PREPARED?

ARE YOU PREPARED FOR CODING UNDER PDGM

- PDGM is now effective… Is your agency prepared?
- Monitor coding practices
  - Monitor coding practices to assure that primary diagnosis codes being used are approved for use as a primary diagnosis under PDGM.
  - All coders should have received education on the list of diagnosis codes in the PDGM Grouper Tool.
    - Reinforce education is provided.
  - 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

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ARE YOU PREPARED 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
      - Consistent with Face To Face

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ARE YOU PREPARED 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.

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ARE YOU PREPARED FOR CODING UNDER PDGM

- EMR
  - Diagnosis coding- does your 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?
  - Does your software estimate HHRG placement and communicate the related LUPA visit threshold?
  - Order Tracking?
  - Billing and Claims Management?

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ARE YOU PREPARED 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.

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CONCLUSION

- Monitor coding practices:
  - Have certified, experienced coders!
- Educate referral sources and physicians:
  - Need Specifics!
- Monitor your agency processes from intake to discharge to identify effectiveness of work-flow and promptly identify any areas of concern/ needed changes:
  - Prevent issues from developing into big problems
- Monitoring is key to ensuring a smooth transition into PDGM.

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THANK YOU!

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