


Coding for Therapy in PDGM




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Housekeeping: Answering Your Questions




- Please use the **Q&A box** to type in any questions you have today's programming.
- We will gather questions during the presentation and provide Q&A time at the end.



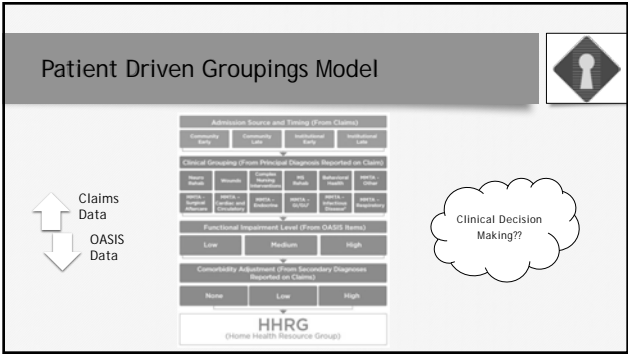
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Objectives



- Identify key elements of the documentation in therapy assessments that support primary group selection in the PDGM
- Identify requirements for inclusion of secondary diagnoses that impact the provision of therapy to capture available comorbidity adjustment in the PDGM
- Document defensibly to support coding and patient centered therapy care plan decisioning in the PDGM

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What Does CMS Say? - PPS 2019 Final Rule

- We disagree that the PDGM diminishes or devalues the clinical importance of therapy. The musculoskeletal and neurological rehabilitation groups under the PDGM recognize the unique needs of patients with musculoskeletal or neurological conditions who require therapy as the primary reason for home health services.
- For the other clinical groups, we note that the 30-day base payment amount includes therapy services, even if the primary reason for home health is not for the provision of therapy. The functional impairment level adjustment in conjunction with the other case-mix adjusters under the PDGM, aligns payment with the costs of providing services, including therapy.

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PDGM Clinical Groupings (M1021)

Clinical Group	The Primary Reason for the Home Health Encounter is to Provide:
Musculoskeletal Rehabilitation	Therapy (physical, occupational or speech) for a musculoskeletal condition
Neuro-Stroke Rehabilitation	Therapy (physical, occupational or speech) for a neurological condition or stroke
Wounds - Post-Op Wound Abrasion and Skin-Non-Surgical Wound Care	Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric conditions
Complex Nursing Interventions	Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies
Medication Management, Teaching and Assessment (MMTA)	
MMTA - Surgical Abstinence	Assessment, evaluation, teaching, and medication management for surgical abstinence
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 conditions
MMTA - Infectious Disease/Neoplasms/Blood-forming Diseases	Assessment, evaluation, teaching, and medication management for conditions related to infectious diseases, neoplasms, and 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

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More About Proper Diagnosis Coding



- Ultimate responsibility for diagnoses rests with the physician
 - This means, that the home health clinician cannot diagnosis a patient with an illness, condition, or disease process.
- However, the reason for hospitalization (or physician office visit, emergent care, etc.), may not be the primary reason for the home health episode of care!
 - The clinical assessment completed on SOC, and all additional discipline evaluations, should provide clear rationale for why the patient is receiving home health care.

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Role of the HH Clinician in Diagnosis Coding



- Sequencing
 - List first code (M1021a), or primary code, as the diagnosis, condition, problem, or other reason for the home health episode
 - Most related to the Plan of Care,
 - Most acute condition, and
 - Requires the most intensive services (chief reason for care)
 - List additional codes (M1023b-f), or secondary codes, that describe any coexisting conditions managed during the episode of care
 - Must be relevant to the care delivered, or
 - Have potential to affect patient's responsiveness to care

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Role of the HH Clinician in Diagnosis Coding



- Coding Chronic Conditions
 - Those treated on an ongoing basis
 - Even if not the focus of care, will always impact the care and should be codes as a pertinent diagnosis
 - Should also be addressed in the Plan of Care
- Select those that best describe the patient's current, active condition under treatment

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Coding the Reason for Therapy Care in PDGM



- Currently in home care, agencies list "therapy diagnoses" when therapy is providing care.
 - There are no "therapy diagnoses" in the ICD code set!
- Therapists commonly list the impairments in body structure/function as the reason/diagnosis driving the provision of therapy
 - Therapists frequently do not list the underlying etiology for the therapy conditions being treated
 - i.e., "muscle weakness" or "gait abnormality"
- How should this be accurately reflected?
 - Should be occurring now, but will affect payment in PDGM!

What does coding look like now for cases with therapy?

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Questionable Codes in PDGM



Diagnosis Code	Description	Primary Diagnosis Category	Questionable Encounters	% SOC with Questionable Encounter
M62.81	Muscle weakness	MS/Connective Tissue	115,322	25.9%
R26.89	Oth Abn of Gait & Mob	Symptoms/III defined conditions	27,994	6.3%
R26.81	Unsteadiness on Feet	Symptoms/III defined conditions	17,513	3.9%
R29.6	Repeated falls	Symptoms/III defined conditions	16,226	3.6%
R53.1	Weakness	Symptoms/III defined conditions	16,146	3.6%
R26.9	Unspec Abn of Gt & mob	Symptoms/III defined conditions	14,120	3.2%
R26.2	Difficulty in walking	Symptoms/III defined conditions	9,796	2.2%
M19.91	Primary OA, unspec	MS/Connective Tissue	7,216	1.6%
M19.90	Unspec OA, unspec site	MS/Connective Tissue	6,526	1.6%
M06.9	Rheum arthr, unspec	MS/Connective Tissue	6,526	1.6%

Source: Strategic Healthcare Partners, Santa Barbara California

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Most profitable Diagnosis 2018- Not allowed Under PDGM



ICD-10 code	Avg margin per standard episode	Avg SNV per episode	Avg therapy per episode	Avg costs per episode	Avg reimbursement per episode	Acceptable under PDGM	Clinical group PDGM
2. R26.81- unsteadiness on feet	33.4%	1.8	12.2	\$2,609	\$3,765	No	NA
4. M62.81- Muscle weakness	25.3%	3.8	13.0	\$2,814	\$3,650	No	NA
5. M29.6 (Repeated falls)	24.2%	4.1	13.3	\$2,821	\$3,627	No	NA
9. R53.1 (Weakness)	21.9%	4.4	12.0	\$2,773	\$3,438	No	NA

Source: Ability Network-Minneapolis, MN

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Example: Capturing Traditional "Therapy" Codes in PDGM



- 87 yo female patient is referred for HH services by PCP due to recent falls "due to gait abnormality and muscle weakness."

PMHx: diastolic HF, HTN, COPD, osteoporosis, OA

SHx: Patient resides in private 2-story residence with supportive family residing 2-towns away (60 minute drive); patient able to complete ADLs, basic IADLs; relies on family for transportation to medical appointments and weekly grocery shopping

Reason for Referral: Patient has had recent bout of PNA (resolved 2 weeks ago) but is not returning to PLOF; fell carrying laundry from upstairs bedroom down 5 steps to main floor laundry room and unable to get up (called daughter who called 911; refused hospitalization)

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Example: Capturing Traditional "Therapy" Codes in PDGM



• Admitting Clinician Narrative Note:

• Patient is a motivated, yet anxious 87yo female with recent falls on her attempts to return to PLOF in ADLs/IADLs post 5 week period of decline related to a non-hospitalizing bout of pneumonia. Patient demonstrates impaired peripheral muscle strength and aerobic capacity related to recent illness, reduced activity level over a 30+ day period, in addition to her long-standing chronic comorbidities of diastolic HF and COPD. She is a (+) fall risk and has impaired mobility status, with compromised ability to walk at speeds and distances required for safely entering the community. She reports feeling she is "only 50%" of her "normal self" of 2 months ago. Patient goal is to resume her prior level of functioning (PLOF) with a reduction of falls, fall risk, and fear of falling. She would like to resume her weekly outings with family without feeling "exhausted" and requiring a 2-hour nap upon her return home.

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Example: Capturing Traditional "Therapy" Codes in PDGM



Common current ICD-10 coding now:

OASIS item	ICD-10 Code
M1021(a)	M62.81 - generalized muscle weakness
M1023(b)	R26.89 - other abnormalities of gait and mobility
M1023(c)	I11.0 - HTN heart disease w/HF
M1023(d)	I50.30 - unspecified diastolic HF
M1023(e)	J44.9 - COPD, unspecified
M1023(f)	M81.0 - age-related osteoporosis w/o current pathological fracture
Add'l Dx	M19.90 - unspecified OA, unspecified site

Possible ICD-10 coding with supportive documentation:

OASIS item	ICD-10 Code
M1021(a)	I11.0 - HTN heart disease w/HF
M1023(b)	I50.30 - unspecified diastolic HF
M1023(c)	J44.9 - COPD, unspecified
M1023(d)	M81.0 - age-related osteoporosis w/o current pathological fracture
M1023(e)	M15.0 - Primary generalized (osteo) arthritis
M1023(f)	Z91.81 - History of falling
Add'l Dx	Z60.2 - Problems related to living alone

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Example: Capturing Traditional "Therapy" Codes in PDGM

- Current therapy coding (per 2020 Proposed Rule)
 - Source: CMS current version PDGM Grouper Tool
 - Result: Primary diagnosis of M62.81 falls into "questionable episode," not a PDGM grouping

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Example: Capturing Traditional "Therapy" Codes in PDGM

- Coding therapy in PDGM (per 2020 Proposed Rule)
 - Source: CMS current version PDGM Grouper Tool
 - Primary diagnosis of I11.0 falls into MMTA-cardiac group; NO comorbidity adjustment

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Capturing Traditional "Therapy" Codes in PDGM

Documentation "DO's"


- Document the underlying etiology of the impairment in body structure/function
- Use objective, standardized tests & measures with age/gender normative data
 - Incorporate qualitative assessments that are patient-specific
- Tie impairment(s) to specific functional deficits of the patient
- Use prior level or "normal" functional status of patient as baseline

Documentation "DON'Ts"

- Document resultant impairments as the actual condition or diagnosis
 - i.e., gait abnormality and LE weakness in a patient with DM2 w/neuropathy, LOPS
 - i.e., reduced strength and endurance in patient recently hospitalized with acute on chronic HF
- Use non-specific, non-measurable statements
 - i.e., "reduced household mobility status" or "severely poor endurance" or "slow walking speed"

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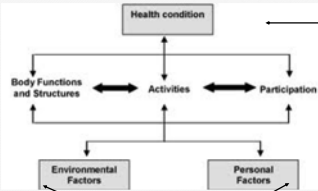
Care Planning in PDGM



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Capturing Patient Uniqueness

- The International Classification of Functioning, Disability and Health (ICF Model)



Diseases, disorders, conditions

Contextual Factors



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Determining Patient Needs


Intrinsic

Disease Process(es)

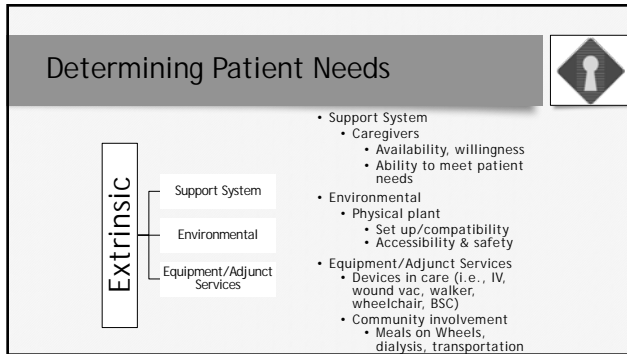
Knowledge Deficits

Functional/Safety

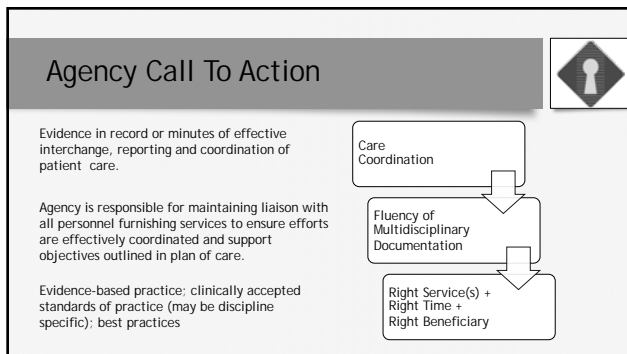
- Disease Process(es)
 - Acuity & Severity
 - Comorbidities
 - Level of independence with management
- Knowledge Deficits
 - Current condition(s)
 - Medications
 - Care procedures
- Functional/Safety
 - Mobility
 - Self care/ADLs



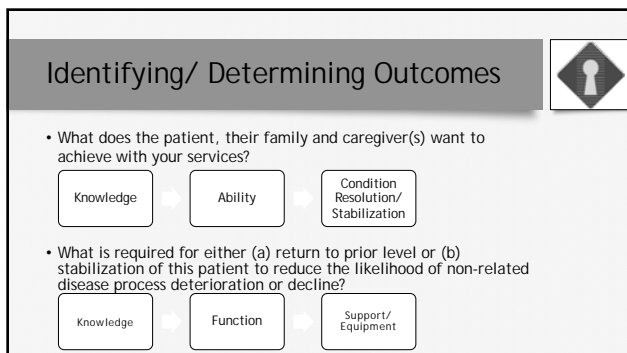
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SIMPLICITY: Risk for Hospitalization

What are the key elements a patient with HF needs to focus on to prevent re-hospitalization?

What roles does each clinician play in these identified risks?

- SN
- PT
- OT
- HHA

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One Beneficiary - One Plan of Care: CHF

SN	PT	OT
<ul style="list-style-type: none"> • Education on self mgmt of s/s of fluid overload • Role of medications on cardiac pathophysiology 	<ul style="list-style-type: none"> • Able to safely and accurately complete daily weights / getting on & off scale • Development and instruction in aerobic exercise program 	<ul style="list-style-type: none"> • Energy conservation during completion of ADLs • Pacing strategies during completion of IADLs

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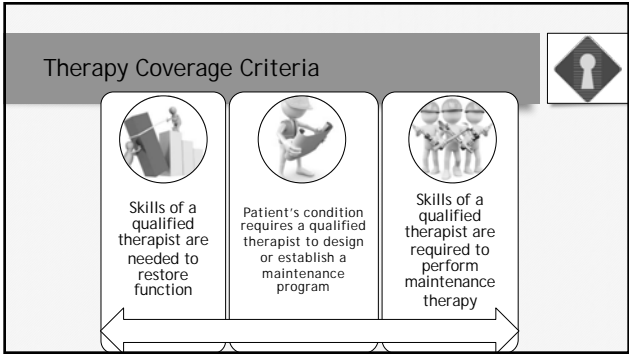
Operationalize Collaboration Care Planning & Delivery

• Example: Activity Monitoring with cardiopulmonary clients

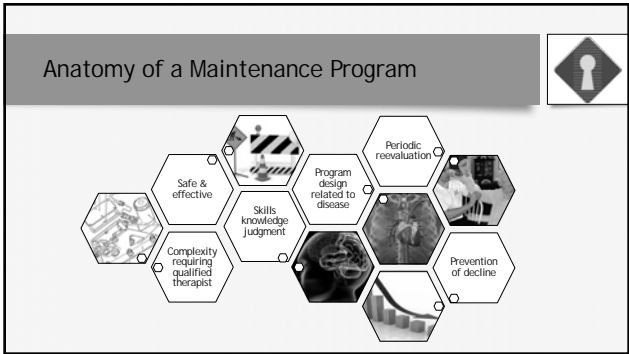
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graph LR
    SN[SN: Disease acuity/severity, Mgmt of signs/symptoms, Medication use/purpose/side effects, Dietary restrictions] --> PT[PT: Pre-/post-vitals support modification from aerobic to strengthening exercises, Teach how to rate perceived exertion]
    PT --> OT[OT: Increased compensatory strategies with self-care activities, Reinforce strengthening program]
    OT --> HHA[HHA: Provide increased assistance with bathing, Monitor self-perceived exertion during assisted ADLs]
  
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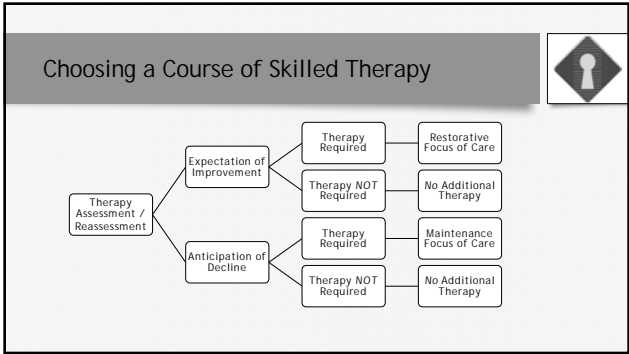
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Stop the Pendulum Swing

Pre PPS
therapy
utilization



Current
PPS therapy
utilization

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Appropriate Therapy Utilization

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Answering
Your
Questions




Thank You!







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