PPS Reform for Home Health
Prepare for 2008!

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The Centers for Medicare and Medicaid Services (CMS) has refined and updated the Home Health Prospective Payment System (HH PPS). The "Home Health Prospective Payment System Refinement and Rate Update for Calendar Year (CY) 2008," was published in the Federal Register on August 29, 2007. Effective January 1, 2008, this Final Rule reflects the ongoing efforts of CMS to improve the efficiency and quality of care provided to Medicare beneficiaries through more accurate payments for services rendered.

As a result of this full-scale reform, home health agencies, paid prospectively for 60-day episodes of care based on a "case mix," will face the most significant changes since Medicare's Prospective Payment System was implemented on October 1, 2000.

The Final Rule can be found in the Federal Register at:
http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1541fc.pdf

The following is a summary of the PPS refinements for 2008:

- To account for the 11.75 percent increase in the case mix, known as the "case mix creep," due to changes not related to home health patients' actual clinical conditions, there will be a reduction of the national standardized 60-day episode payment rate for four years. That reduction will be taken at 2.75 percent per year for three years beginning in CY 2008 and at 2.71 percent for the fourth year. CMS requested comment until October 29, 2007 on one aspect of the Final Rule concerning the fourth year's 2.71 percent reduction to the payment rates. This may result in a change for CY 2011.

- There will be a 3.0 percent increase in the home health market basket for CY 2008. The home health market basket index, which has historically been updated annually, measures inflation in the prices of an appropriate mix of items and services furnished by home health agencies.

- If a home health agency does not submit quality data, the home health market basket increase will be reduced by 2.0 percentage points and the home health agency will only receive a 1.0 percent update for CY 2008.

- This Final Rule adds two new quality measures for a total of 12 measures to be reported by home health agencies in CY 2008:

    - Emergent care for wound infection and deteriorating wound status
    - Improvement in the status of surgical wounds

- The single therapy threshold at 10 visits will be replaced by a three-tiered threshold at 6, 14, and 20 visits.

- There will be a gradual increase in payment between the first and third therapy thresholds as opposed to the current large increase in payment for delivering at least 10 therapy visits in a 60-day episode.

- The single equation model for case mix calculation, with a single set of case mix scores and single therapy threshold, will be replaced by a four-equation case mix model.

- Case mix points will vary under the four-equation case mix model depending on the timing of the episode and the number of therapy visits.

    - Equation 1: Patient is in episode one or two and has 13 or fewer therapy visits.
    - Equation 2: Patient is in episode one or two and has 14 or more therapy visits.
    - Equation 3: Patient is in episode three or higher and has 13 or fewer therapy visits.
    - Equation 4: Patient is in episode three or higher and has 14 or more therapy visits.

- Home health agencies will need to identify “early” episodes (the first or second episode in a sequence of adjacent episodes) and “later” episodes (third or subsequent episodes in a sequence of adjacent episodes), regardless of whether the same home health agency provided care for the entire series of episodes. Adjacent episodes are those that are separated by no more than a 60-day period between episodes.

- A new data element, M0110 Episode Timing, will be added to the OASIS data set to identify “early” and “later” episodes.

- The number of case mix groups will balloon from 80 to 153. Among the 73 additional diagnosis groups that will be worth case mix points in 2008 are cardiac, gastrointestinal, pulmonary, hypertension, cancer, blood disorders, dysphagia, blindness and affective and other psychoses. Also included will be conditions such as infected surgical wounds, abscesses, chronic ulcers, and gangrene.

- Case mix points will be assigned to three V codes. Due to the labor-intensive care associated with caring for patients with a tracheostomy (V55.0), cystostomy (V55.5), and urostomy (V55.6), these V codes will now generate points.

- Case mix points will be garnered for some secondary diagnoses. Nearly all of the diagnosis groups will impact case mix adjustment when placed as the primary or secondary diagnosis.

- Certain combinations of conditions in the same episode will gain case mix points. For example, a patient with dysphagia and a stroke will have the potential of earning 2 or 6 case mix points depending on the episode and the number of therapy visits.

- There will be a complex system for case mix point values. A single diagnosis code will be worth different point values depending on whether it's primary or secondary, used in combination with other diagnoses or specific OASIS data elements, the episode timing ("early" or "later" episode), and the number of therapy visits. For example, case mix points will be earned if a patient's primary or secondary diagnosis is malignant neoplasm of the brain and if M0650 or M0660 (dressing upper or lower body) = 1, 2, or 3. The points will vary (either 2 or 4), depending on the episode and number of therapy visits made. In addition, 3, 5, or 8 points will be given if it's the primary diagnosis, depending on the episode and number of therapy visits.

- Four OASIS data elements will be removed from the case mix calculations:

    - M0175 (discharge from an inpatient facility)
    - M0530 (occurrence of urinary incontinence)
    - M0440 (presence of a lesion or wound)
    - M0610 (behaviors demonstrated at least once a week)

- M0800 (management of injectable medications) will be added to the case mix calculations. If M0800 = 0, 1, or 2, case mix points (1, 2, or 4) will be gained depending on the episode and number of therapy visits.

- The format of M0230/M0240 will be modified to accommodate changes to payment diagnoses.

- M0246 will replace M0245 for payment diagnoses to allow for multiple coding of both primary and secondary diagnoses.

- M0826 will replace M0825 for therapy need. Currently, M0825 is a "yes"/"no" question as to whether or not the projected number of therapy visits for the episode meet the threshold for a Medicare high-therapy case mix group.

M0826 will require the specific number of projected therapy visits for the episode, which affects the particular case mix group for that episode.

- There will be significant changes in coding such as:
    - Acute CVA will no longer be an appropriate diagnosis in home health. Late effects of cerebrovascular disease will be reported for all home health patients who have had an acute stroke with persistent neurologic deficits.
    - Acute myocardial infarction (410.x2) will be worth case mix points only when “2” (subsequent episode of care) is the fifth digit.
- Non-routine supplies (NRS) will be case mix adjusted separately based on 6 severity levels ranging from $14.12 to $551 per episode. Currently, a fixed amount of $49.62 is reimbursed for each episode of care.

These sweeping changes to the Prospective Payment System will bring many opportunities for revenue and error for home health agencies. Understanding the new PPS refinements and how to implement them will be imperative. OASIS and coding accuracy, the key to compliance and reimbursement, will be critical!