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Ms. Hillary A. Loeffler
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Dear Ms. Loeffler:

This letter is respectfully submitted to the Centers for Medicare & Medicaid Services (CMS) by the Patient Driven Groupings Model (PDGM) Workgroup for your consideration when finalizing the rules and guidance related to the assignment of ICD-10 codes as primary for the purposes of placement in a clinical grouping, as well as when addressing other diagnosis-coding-related concerns.

The PDGM Workgroup is an ad hoc committee of home health industry stakeholders working with the National Association of Home Care and Hospice (NAHC) to ensure that the transition from the Home Health Prospective Payment System (HH PPS) to PDGM does not have a deleterious impact on home health agencies.

The Workgroup includes among its members nationally known home health coding and OASIS experts, who are practitioners and have vast experience teaching coding conventions and guidelines, as well as official guidance governing OASIS completion. Also represented in the group are industry-leading home health financial analysts. Every member of the Workgroup is well versed in the requirements for participation in the Medicare program, and share a deep commitment to ensuring agencies understand and comply with those regulations.

We support CMS's efforts to put the patient at the center of care decisions while managing costs to preserve the Medicare fund for future beneficiaries. And, we applaud efforts to promote value over volume, and to reign in overuse of therapy. However, after a thorough analysis of the PDGM final rule (CMS-1689-FC) the Workgroup has some concerns about its implementation, particularly as it pertains to the correct use of ICD-10 codes under PDGM.

There are several overarching concerns and some open questions that if not resolved may result in agencies being unnecessarily penalized through lower episode payments. We know that is not CMS intent. Therefore, we include in this presentation of our concerns recommended remedies that increase the likelihood of correct coding on first submission. Correct coding will result in episode payments that accurately reflect the severity of the patient's condition and the level of skilled services required to meet the patient's goals. Correct coding on first submission will reduce the number of claims returned to providers, which will save agencies and the Medicare Administrative Contractors (MACs) time and money and will result in better budget management for the entire program. Further, correct coding will ensure that CMS accurately captures population health data that will facilitate CMS making needed changes to PDGM over time based on patient characteristics, rather than nominal change.

Primary codes and the clinical groupings

Since calculation of an episode payment begins with the selection of a valid primary code that has been assigned to one of 12 clinical groupings, the PDGM Workgroup endeavored to determine if the clinical grouping into which a primary code is placed accurately reflects how a home health episode would be managed.

To complete that analysis, the group extracted a 2017 CMS list of all ICD-10 codes placed in the primary position by home health agencies. Focusing on the top 400 codes currently used as primary, the group then searched the clinical grouping into which each code would be placed under PDGM to determine if the placement was a logical choice for home health given the skilled care that would be provided, and resources consumed. Further, the group considered current coding conventions and guidelines and any guidance provided in the PDGM Final Rule.

The group learned from that exercise that some ICD-10 codes that would apply to home health and in compliance with current conventions and guidelines should, in fact, be in a clinical grouping other than the grouping into which they currently are placed.

The PDGM workgroup makes the following observations and recommendations regarding specific codes and, in some cases, regarding groups of codes. The codes of concern are listed in the order of placement in the top 400 ICD-10 codes most commonly used in 2017 merely as a means of organizing the material not to suggest an order of priority.

Specific codes:

E11.9 Type 2 diabetes mellitus without complications. Currently in MMTA_OTHER, Workgroup members suggest that E11.9 should be in MMTA_ENDO with the explanation that typically when a patient has a primary diagnosis of E11.9 it is because they are newly diagnosed and, as a result, will need a higher level of teaching and care, even though they may not be exhibiting any complications of the diabetes yet.

It also was observed by the group that E11.9 makes up a portion of reasons for re-certification, and perhaps CMS is signaling that Type 2 diabetes alone is not reason for re-certification, that there would be some complication or other reason for the home health service. This is an opportunity to provide agencies with education to ensure proper coding.

I87.2	Venous insufficiency (chronic) (peripheral). Currently in MMTA_CARDIAC, should be in WOUND grouping. I87.2 is the most commonly used code to indicate a stasis ulcer. Furthermore, the Coding Clinic has just confirmed that venous insufficiency in a diabetic would be assumed a diabetic peripheral angiopathy, making E11.51 first listed prior to I87.2 and the ulcer. This would place the E11.51 into a WOUND grouping instead of the MMTA-Endo grouping. This logic applies in the case of atherosclerosis of the extremities with ulceration. In the diabetic, atherosclerosis is assumed related and is coded after E11.5-.
T81.89XD	Other complications of procedures, NEC, subs. Currently in MMTA_OTHER. The Workgroup believes this code belongs in WOUND. This code is used for non-healing or slow-healing surgical wounds and as a result the grouping should reflect the higher level of teaching and care. This code should not be used when the non- or slow-healing wound is a result of infection or dehiscence. The code should not be a commonly used code. The Workgroup agreed that there is an opportunity for clinical education within agencies.
M06.9	Rheumatoid arthritis, unspecified. Currently not in a clinical grouping. Coding experts agreed that it should be in MS_REHAB with the guidance that agencies should query the physician for more specific information; however, in a home health setting treatment is designed to deal with mobility issues related to multiple affected joints, not one particular joint.
M19.90	Unspecified osteoarthritis, unspecified site. Currently not in a clinical grouping. No disagreement in the group, but opportunity to educate agencies about the need to query the physician for greater specificity
Z48.817 (Z48.810 – Z48.817, Z48.3	Encounter for surgical aftercare following surgery on the skin, subcutaneously. Currently In MMTA_AFTER. Experts suggest WOUND but are seeking clarification from CMS as to how agencies are to indicate that an aftercare patient requires wound care. All surgical aftercare codes indicate the patient has had a procedure of some kind, most commonly with interruption of the integument. Many of these wounds require wound care; however, some need only observation and assessment. Considering that placement of the surgical dressing code (Z48.01) as primary is inappropriate, how will agencies receive the higher reimbursement needed for these surgical wounds? Is it possible that the aftercare code combined with the dressing change code as a comorbidity will place the patient in the WOUND group?
T81.4-XD	Infection following a procedure, subsequent encounter. Currently in MMTA_INFECT. Group recommends WOUND as this set of codes (T81.41xD to T81.44xD) is used to indicate a resolving surgical wound infection. The clinical grouping should not include T81.40xA, as this code does not reflect a wound infection.
T81.4-XA	Infection following a procedure, initial encounter. MMTA_INFECT. Group recommends WOUND as this set of codes (T81.41xA to T81.44xA) indicates active treatment of an

infected surgical wound. The clinical grouper should not include T81.40xA, as this code does not reflect a wound infection.

R13.1- Dysphagia codes are not in a clinical grouping currently. Experts recommend MMTA_NEURO REHAB for all R13.1- codes. Reason for recommendation is that dysphagia can be a sequela of another condition such as head trauma, in which case the official coding guideline instructions are to code dysphagia as primary, followed by the code for the trauma with 7th character S. (This guidance applies to all R13.- codes.)

M81.0 Age-related osteoporosis without current pathological fracture. Currently In MMTA_REHAB. Experts suggest MMTA-OTHER. As there is no fracture, the care being given likely is skilled nursing.

Code groups:

I codes (Diseases of the circulatory system), this discussion focused on whether the patient was being treated for an ulcer as well as the cardiac condition. If treating an ulcer, the circulatory code is a combination code that identifies not only the circulatory condition but also a current ulcer, therefore should be placed in the WOUND grouping instead of MMTA-CARDIAC. If no ulcer is present, the circulatory code describes only the circulatory condition and does not identify a current ulcer, therefore should remain in MMTA-CARDIAC

- I87.313 Chronic venous hypertension with ulcer of bi-lateral lower extremity currently is in MMTA-CARDIAC, should be in WOUND
- I87.332 Chronic venous hypertension with ulcer and inflammation of lower extremity is currently in MMTA-CARDIAC, should be in WOUND
- I87.331 Chronic venous hypertension with ulcer and inflammation of right lower extremity is currently in MMTA-CARDIAC, should be in WOUND

T codes (Injury, poisoning and certain other consequences of external causes), as in the discussion around I codes, the mitigating factor for requesting a new clinical grouping was the presence or need to treat a wound.

- T81.89XA Other complications of procedures, NEC, initial encounter currently in MMTA-OTHER should be in WOUND
- T87.89 Other complications of amputation stump currently in MMTA-OTHER should be WOUND, as that is how dehiscence is coded
- T84.53XA Infection/inflammation due to internal right knee prosthetic, initial encounter currently in MMTA-INFECT but should be in WOUND. This should apply to all T84.5- codes as they all indicate infection/inflammation due to prosthetics.
- T87.43 Infection of amputation stump, right lower extremity currently in MMTA-INFECT should be in WOUND

- T87.44 Infection of amputation stump, left lower extremity currently in MMTA-INFECT should be in WOUND (This recommendation also applies to upper extremity amputation complications.)
- T84.5-XD Infection/inflammation reaction due to internal prosthetic, subsequent encounter currently in MMTA-INFECT should be in WOUND

While the experts focused on the second group of 200 codes, the same logic would apply to all I and T codes when wound treatment is required.

R codes (Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified). The coding experts noted that while in the PDGM Final Rule there are no symptom codes placed in any clinical grouping, there are circumstances in which there is no specific diagnosis, but the patient nevertheless needs home care to be safe and to improve. In these instances, R codes should be an appropriate (valid) primary code.

Using those symptom codes that the current coding conventions and guidelines direct to be used as primary to capture the condition of a patient at the start of care (SOC), agencies are complying with CMS guidance but also are correctly capturing data regarding the health and healthcare of the population served by home health. If agencies are compelled to assign a different code as primary to ensure payment for services rendered, they will effectively be skewing the data. The long-term result of which will be inadequate health statistics, which will impact legislative decision-making and research funding.

Below are symptom codes properly used in home health that would be invalid as primary under PDGM. Including:

- R27.0 Ataxia, unspecified
- R00.1 Bradycardia, unspecified
  For example: Certain drugs can cause bradycardia, notably digoxin, propranolol, atenolol, metoprolol (Tropol-XL), sotalol, verapamil (Calan, Isoptin, Verelan) and Ditiazem. If the patient has bradycardia because of a side effect of a drug, the patient may be admitted for observation and assessment and medication teaching. In this case, coding conventions and guidelines dictate that the bradycardia be sequenced first followed by the code to indicate the adverse effect of the certain drug. If the bradycardia was caused by an overdose of the medication, the code for the poisoning of that drug would be sequenced first followed by the bradycardia. The code for the poisonings (overdoses) of drugs are NOT in the clinical grouper either, effectively making this type of patient not eligible for home care. Medication teaching is instrumental in keeping patients out of the emergency departments and avoiding acute hospitalizations, so not including these codes in the clinical grouper is adverse to the ultimate goals set by CMS.
- R41.82 Altered mental status, unspecified
- R13.10 Dysphagia, unspecified
- R42 Example: The patient became dizzy and fell in the bathroom. He had been seen for dizziness in the ER a few days before. He had a complete work-up in the past without a definitive diagnosis found. Patient had a subsequent LINQ device. No arrhythmias. Patient does have carotid stenosis of 75%. There is no definitive diagnosis. The patient has been non-compliant with medications trying to reduce the dizziness himself. The home health agency admits for

multiple falls and medication teaching and calibration. This patient would not be appropriate for home care according to the current Clinical Grouper.

Other codes discussed by the group with recommendations:

- Z48.01 – Encounter for change or removal of surgical wound dressing is in WOUND grouping now, experts suggest it not be a valid primary code, as clinicians would not be in the home just for a dressing change but might be doing aftercare and teaching about wound care, medications and disease process. The code would be more appropriately used as a secondary diagnosis identifying those patients who require dressing changes in addition to other interventions and when listed as a secondary diagnosis, would trigger a co-morbidity adjustment reflective of the complexity of the wound care. The Z codes for wound care are not included in the comorbidity adjustments. This recommendation includes Z48.00 (encounter for change or removal of non-surgical wound dressing.
- I69.9- This subcategory includes sequela of unspecified cerebral vascular disease. (I69.9- codes are for sequela of unspecified cerebral vascular disease and would be used correctly in very limited circumstances. This is an opportunity to educate agencies as to the correct codes.)

- Not Elsewhere Classified (NEC) codes. It appears that in some instances NEC codes are treated as a diagnosis code with a lack of specificity. The NEC codes represent specific clinical diagnoses in which a specific diagnosis code classification does not exist. An example would be M62.838, which is "other muscle spasm." This diagnosis code compasses all other types of muscle spasms that are not included in the two muscle spasm codes which are M62.830, muscle spasm of the back and M62.831, muscle spasm of the calf. Both M62.830 and M62.831 fall into the MS-Rehab grouping for PDGM. An example of the absence of this code in an appropriate clinical grouping occurred with a patient who presented with a diagnosis of lower back pain due to muscle spasm of the gluteus minimus. In this instance the patient does have a specific clinical diagnosis responsible for the lower back pain, but due to the classification the clinical diagnosis falls into a NEC code.

Muscle weakness, generalized

- M62.81, Muscle weakness, generalized is not a valid primary code under PDGM. The Workgroup suggests this is problematic, as there are scenarios in which patients are seen in the home for muscle weakness when the underlying etiology is unknown. Use of this code as primary has been the topic of much discussion within the industry, as it is in the top-10 ICD-10 codes currently used by home health as primary.

  The Workgroup agrees that M62.81 should not be a default code for all patient scenarios in which muscle weakness is present. Agencies should make every effort to query the referring physician to learn about the cause of the muscle weakness. However, the solution is not to advise agencies to use Muscle Atrophy, as that is an entirely different diagnosis. Agencies cannot code muscle atrophy without physician verification and to advise agencies to code muscle atrophy instead is not in compliance with coding guidelines.

  The PDGM Workgroup encourages CMS consider the following:

M62.81 is identified as a diagnostic code to support Medical Necessity for Home Health therapy services by CGS and Palmetto within their local coverage determination. While we agree that M62.81 as a primary diagnosis code is lacking in description, we disagree that this diagnosis would not be deemed medically necessary. When evaluating the assignation of a diagnosis code at the point of care in home health, the coding specialist must consider the available documentation.

Prior to the movement to ICD-10, generalized muscle weakness was often a diagnosis that warranted therapy only, and the primary diagnostic code assigned would be V57.1, care involving other physical therapy. The generalized muscle weakness code would be used as a secondary diagnosis to describe the need for physical therapy. In ICD-10 V57.1 was removed and instruction was provided to code the diagnosis that described the reason for the therapy services. This left, in some instances, M62.81.

Generalized weakness is a clinical diagnosis used by physicians to describe the patient's condition. This diagnosis is used in the absence of additional information that would better describe the patient's condition or the absence of additional testing to identify the underlying reason for the patient's generalized muscle weakness.

Muscle weakness is a common complaint among patients presenting to family physicians (Saguil, 2005). The diagnosis first begins with distinguishing muscle weakness from fatigue or asthenia. Once this has been established, the physician then begins to determine via neurological survey and objective testing any patterns that would narrow down the need for further testing as the complaint of "muscle weakness" is a condition that can be caused by infectious process, neurologic, endocrine, inflammatory, rheumatologic, genetic, metabolic, electrolyte-induced or drug induced reasons (Saguil, 2005).

At this point the physician, as a steward of Medicare dollars, is left to decide if further testing should be pursued or if treatment to alleviate the symptoms and/or maintain the patient's current functional status is warranted. Given that the treatment of the initial complaint, regardless of the causation, includes strengthening, the physician will refer the patient to home health with the diagnosis of generalized muscle weakness. If the physician suspects the underlying cause and is considering pursuing additional testing, the conventions governing the ICD-10 CM classification require that the agency code the confirmed diagnosis which would be generalized muscle weakness, M62.81.

The concern is that the referral of patients whose principal complaint is generalized muscle weakness will continue and the agency will contact the physician to obtain additional information or a "better" diagnosis. This is problematic as the data will then be skewed to diagnoses that are generalized and fail to capture the patient's true needs. A 2012 study on musculoskeletal disorders indicates that a higher incidence of Idiopathic Inflammatory myopathies was found in historical review than reported (Somyer-Tomic, Amato, Fernandes, 2012).

The authors cite miscoding as one of the reasons for the lack of data accuracy. The citing of this research is important as generalized muscle weakness is the first clinical diagnosis used to describe the symptoms of a myopathy in absence of further testing to definitively identify the underlying cause. In our limited study of 109,178 assessments we found that generalized muscle weakness comprised 17.96% of diagnoses coded that were classified as Questionable.

This is problematic for several reasons. First, it represents a volume of Medicare beneficiaries who currently receive services that they may not be entitled to under PDGM. Generalized muscle weakness represents the initial symptoms that the physician may choose to treat prior to pursuing further testing. Second, the patient will still require treatment for the symptom of generalized muscle weakness which may result in the Coding Specialist or home health clinician identifying a diagnosis such as Congestive Heart Failure as the underlying cause, when in fact the patient may have a myopathy which will continue to go undiagnosed and untreated beyond the underlying symptomology.

Origin of unique code for muscle weakness

Before 2002, under the ICD-9 Classification System muscle weakness was indexed to 728.9, Unspecified disorder of muscle, ligament and fascia. In that year, the American Academy of Neurology presented three proposals for ICD-9 changes; among them was a request for a unique code for muscle weakness. The argument was that 728.9 did not allow the identification of muscle weakness, and that when conducting neurodiagnostic testing such as electromyography, nerve conduction studies and their derivatives there was no adequate code to explain the reason for the test or its finding, namely, muscle weakness. In that year, the ICD-9-CM Coordination and Maintenance Committee added 728.87, Muscle Weakness.

Outstanding questions

In completing its analysis of the use of ICD-10 codes as primary and their clinical groupings placement, the group raised several questions for which it is seeking answers from CMS:

(1) **Non-Routine Supplies:** The PDGM Final Rule is not specific about how non-routine supplies will be calculated and seeks clarification from CMS as to whether the same data elements will be used as in previous years. If so, there are codes missing from the current list that should be added to ensure proper NRS reimbursement.

(2) Risk-adjustment

Similarly, the PDGM Final Rule is unclear if risk-adjustment will be calculated using the same predictive models as in previous years. Again, if so, there are some codes missing from the current list.

(3) Comorbidity Adjustment: The list of diagnoses for comorbidity adjustment stops at the R Codes. The Workgroup questions why there is no further comorbidity adjustment for traumas, postoperative complications and the Z codes. Examples: Z codes for attention to ostomies may not be appropriately coded as primary in some situations but should still provide some adjustment for the acuity of the patient. The codes for wound care could also be appropriately used for comorbidity adjustment as they are not appropriate as primary. The code for fitting and adjustment of a vascular catheter is not appropriate as primary for patients receiving IV care for an acute condition.

(1) Also, attached for your review is an analysis of the financial impact of the Workgroup's recommendations to place certain codes into a different clinical grouping in accord with current coding conventions and guidelines, home health practices and anticipated resource use. (Data analyzed was from 2017.) In completing the analysis, it was discovered that in a significant number of instances a code assigned to one clinical grouping was also placed in a different clinical grouping. Using code E11.9 as an example, for the period analyzed there were 165,302 patient periods. 163,594 of those periods were assigned to MMTA-OTHER, but 1,708 were assigned to COMPLEX NURSING. In fact, in every case where a code is assigned to a different clinical grouping, it is assigned to COMPLEX NURSING. The Workgroup is seeking clarification and asks CMS to review the analysis and guide us through the rationale so that we can share with other industry stakeholders.

PDGM Workgroup and NAHC's Policy Position on "matching" diagnosis codes

The Centers for Medicare & Medicaid Services (CMS) has had a long-standing policy that requires the principle diagnosis and other diagnoses on home health claims "match" the diagnoses and sequencing as reported on the Outcome and Assessment Information Set (OASIS).

In the updates to chapter 10 of the Medicare Claims Processing Manual (Change Request (CR) 11272), section 40.1 and 40.2, CMS clarified that effective with the implementation of the PDGM, a principle diagnosis on the claim might not match the principle diagnosis on the OASIS in all cases. When the diagnosis changes from the first 30-day period to the second 30-day period there may not be an associated OASIS assessment and therefore a diagnosis on the second 30-day period claim would not be expected to match the diagnosis on an OASIS. The revised instructions relax the requirement for the diagnosis matching criteria in instances when a diagnosis changes between two 30-day periods.

Although the instructions are appropriate for the principle diagnosis, there remains concern with the expectation that the diagnoses on the RAP and the claim match all the diagnoses on the OASIS, other than the above exclusion, regarding the reporting of "other" diagnoses. Since home health agencies must follow separate instructions for reporting diagnoses on the claim and reporting diagnoses on the OASIS, it is possible for "other" diagnoses on the claim to not match the diagnoses on the OASIS in all instances.

ICD-10 Guidelines

"All conditions that coexist at the time of admission, that develop subsequently, or <u>that affect</u> the treatment received and/or the length of stay."

OASIS Manual

"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 <u>that have the potential to affect</u> the patient's responsiveness to treatment and rehabilitative prognosis."

CMS' policy that the diagnoses on the claim "match" the diagnoses as listed on the OASIS conflicts with the ICD-10 diagnoses reporting guidance. The ICD-10 reporting requirements restricts listing on the claim any diagnosis that has a "potential" to impact the treatment plan. ICD-10 instructions permit only diagnoses that have an actual impact on the treatment plan to be reported on the claim.

Further complicating matters, CMS has different instructions for reporting diagnoses on the home health plan of care (POC) than for reporting diagnoses on the OASIS and the claim.

CoPs

The regulation at §484.60(a)(2) requires that all pertinent diagnoses be included in the POC. CMS, in their guidance document for this regulation, defines pertinent diagnoses to "mean all known diagnoses." This is a very different instruction than listing diagnoses that have either an actual impact or potential impact on the treatment plan. The varying instructions make it possible for the POC to have more diagnoses than the OASIS and the OASIS and the POC to have more diagnoses than the claim.

Recommendation:

The Workgroup respectfully suggests that CMS

- Modify sections 40.1 and 40.2, chapter 10, Medicare Claims Processing Manual for "Other Diagnosis Codes" by maintaining instructions to report diagnoses in accord with the Official ICD-10 Guidelines for Coding and Reporting and eliminate the last sentence that reads:

"For claim "From" dates on or after January 1, 2020, claim and OASIS diagnosis codes may vary as described under Principal Diagnosis".

PDGM Workgroup appreciates CMS' consideration

Members of the PDGM Workgroup appreciate that the preceding list of questions, concerns and recommendations is substantial and will require review by CMS. Members will make themselves available to CMS for conference calls or in-person meetings should there be a need.

Again, members of the group support CMS' efforts to put the patient at the center of care decisions while managing costs to preserve the Medicare fund for future beneficiaries. And, we applaud efforts to promote value over volume, and to reign in overuse of therapy. However, after a thorough analysis of the PDGM final rule (CMS-1689-FC) the Workgroup has some concerns about its implementation, particularly as it pertains to the correct use of ICD-10 codes under PDGM.

Because members of the group are committed to fully complying with Medicare regulations, we respectfully ask that these issues be addressed.

Thank you for your consideration.

Sincerely,

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