

APPENDIX D – SELECTION AND ASSIGNMENT OF OASIS DIAGNOSIS

A. INTRODUCTION

Appendix D, previously known as Attachment D, was initially published to facilitate the introduction of V-code diagnosis reporting on the OASIS, (see OASIS-B1, 12/2002), effective October 1, 2003. The appendix was designed to clarify HHA implementation of the Official ICD-9-C M Coding Guidelines of 2002. The changes in OASIS diagnosis reporting in 2003 allowed HHAs the ability to assign V-codes to M1020/M1022 and comply with the provisions of the Health Insurance Portability and Accountability Act (HIPAA, Title II).

We are reissuing this document to promote accurate selection and assignment of the patient's diagnosis on the current OASIS-C. This document addresses the OASIS diagnoses items that pertain to the home health episode (i.e., M1020/M1022/M1024 and will clarify CMS' expectations specific to the assignment of V-codes to the OASIS as dictated by the revised ICD-9-C M coding guidelines effective October 2008.

Additionally, with (HH PPS) refinements in January 2010, the HH PPS grouper was revised. If a V-code assigned to M1020/M1022 replaces a case mix diagnosis code, HHAs no longer must always code a numeric diagnosis code in the optional case mix diagnosis M1024. ICD-9-C M coding guidelines state that certain rehabilitation and aftercare V-codes need a secondary diagnosis code in M1022 to describe a resolving condition or sequelae. If the diagnoses codes representing the underlying condition displaced by the V-code are case mix codes, the HH PPS grouper will look to M1022 to award appropriate points.

HHA diagnosis selection and assignment is expected to be performed in compliance with Medicare's rules and regulations for coverage and payment to ensure provider compliance with Section 1862(a)(1)(A) of the Social Security Act. Section 1862(a)(1)(A) excludes provider services from Medicare coverage and payment that are not reasonable and necessary for the patient's diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

B. OASIS INTEGRITY

Appropriate coding practices will ensure the integrity of the home health diagnoses assigned to the OASIS. Due to the nature and significance of accurate HHA diagnosis selection and assignment, CMS expects providers to comply with the following:

- Avoid assigning excessive numbers of V-codes to OASIS M1020 and M1022. CMS expects HHAs to limit the reporting of V-codes on the OASIS. V-codes are less specific to the clinical condition of the patient than are numeric diagnosis codes.
- Limit the number of diagnoses assigned to M1024.
- Avoid the practice of allowing the case mix status of a diagnosis to influence the diagnosis selection process. HHAs are expected to prevent "Coding for Payment" from occurring.
- HHAs are expected to report any indication of fraudulent coding directly to the administrator of the HHA. If appropriate action is not taken, then the clinician is expected to report this activity to the appropriate RHHI hotline and/or to the State Surveyor hotline.

C. COMPREHENSIVE ASSESSMENT MUST PRECEDE DIAGNOSIS CODING

HHAs are expected to understand the patient's specific clinical status before selecting and assigning the diagnosis. Each patient's overall medical condition and care needs must be comprehensively assessed before the HHA selects and assigns the OASIS diagnoses. CMS expects HHAs to complete the patient's comprehensive assessment before assigning the home health diagnoses to M1020/M1022 and M1024 (optional) to the OASIS-C.

D. CRITERIA FOR OASIS DIAGNOSIS REPORTING

1. General Diagnosis Selection Criteria

If a diagnosis under consideration fails to comply with the criteria described below, then the diagnosis is not acceptable and should not be assigned to the OASIS. However, if the diagnosis under consideration complies with the criteria described below, the diagnosis decision process continues to determine if the diagnosis will qualify as the patient's primary or secondary diagnosis.

- HHA clinician/coders are expected to comply with ICD-9-C M coding guidelines when assigning primary and secondary diagnoses to the OASIS items M1020 and M1022. Refer to the *ICD-9-C M Official Guidelines for Coding and Reporting*, which can be found at <http://www.cdc.gov/nchs/datawh/ftp/ftp/cd9/icdguide08.pdf>.
- Code only those diagnoses that are unresolved. If a patient has a resolved condition, which has no impact on the patient's current plan of care, then the condition does not meet the criteria for a home health diagnosis, and should not be coded.
- Code only the relevant medical diagnoses. For example, if a patient is admitted for surgical aftercare (e.g., the surgery eliminated the disease or the acute phase has ended), the acute diagnosis should not be coded in M1020 and M1022. Note: if a V-code is under consideration as diagnosis, refer to Section D.5, Criteria for Coding V-codes as a Diagnosis for additional criteria and coding instructions.
- Code only the diagnoses supported by the patient's medical record documentation (i.e., the home health plan of care and clinical comprehensive assessment). If the diagnosis under consideration is not supported by the patient's medical condition and clinical care needs, then the diagnosis must not be reported on the OASIS.
- Ensure compliance with ICD-9-C M sequencing requirements. If the diagnosis code is not compliant with ICD-9-C M sequencing requirements, then it must not be reported on the OASIS.
- If a condition under consideration calls for multiple diagnosis coding (such as an etiology/manifestation pair), refer to Section D.6, Criteria for Coding Etiology and Manifestation Pairs, for additional criteria and coding instructions.
- Avoid selecting a diagnosis with the following characteristics for assignment to the OASIS:
 - Non-specific or ambiguous diagnosis;
 - Symptom diagnosis (general symptomatic complaint in the elderly population);
 - Diagnosis lacking consensus for clear diagnostic criteria within the medical community;
 - Surgical procedure.

If the diagnosis under consideration meets the above criteria as an acceptable home health diagnosis, continue to analyze the diagnosis to determine if it qualifies as a primary or secondary diagnosis.

2. Primary Diagnosis Selection Criteria (M1020)

The patient's primary diagnosis is defined as the diagnosis most related to the current home health plan of care. The primary diagnosis may or may not relate to the patient's most recent hospital stay, but must relate to the services rendered by the HHA. If more than one diagnosis is treated concurrently, the diagnosis that represents the most acute condition and requires the most intensive services should be assigned to M1020 of the OASIS. If the diagnosis under consideration does not meet the criteria below, it cannot be coded as the primary diagnosis in M1020, and should be considered for coding as a potential secondary diagnosis in M1022.

- Ensure the diagnosis under consideration is acceptable for assignment to the OASIS. The diagnosis meets all criteria listed in Section D.1, General Diagnosis Selection Criteria.
- Ensure that the diagnosis is the one most related to the patient's current plan of care, is the chief reason home care is needed, and is the most acute.
- Ensure that of all the diagnoses under consideration for this patient, this is the diagnosis requiring the most intensive skilled services.
- If the primary diagnosis is a V-code, refer to Section D.5, Criteria for Coding V-codes as a Diagnosis, for additional criteria and coding instructions.
- If the primary diagnosis is a multiple diagnosis situation (such as an etiology/manifestation pair), refer to Section D.6, Criteria for Coding Etiology and Manifestation Pairs, for additional criteria and coding instructions.

3. Secondary Diagnosis Selection Criteria M1022

Secondary diagnoses, or other diagnoses, are defined as all conditions that coexisted with the primary diagnosis at the time the plan of care was established, or which developed subsequently, or affect the treatment or care of the patient.

- a. If a diagnosis meets the general diagnosis criteria for assignment on the OASIS, but does not meet the criteria for coding as a primary diagnosis, the HHA must consider whether the diagnosis can be coded as a secondary diagnosis in M1022 under ICD-9-C M guidelines. For example, certain V-codes may not be eligible for assignment as a secondary diagnosis. If the diagnosis does not meet the criteria for primary diagnosis, and does not comply with ICD-9-C M requirements as a secondary diagnosis, the diagnosis cannot be coded on the OASIS. Otherwise, if a diagnosis meets the general diagnosis criteria for assignment on the OASIS, but does not meet the criteria for a primary diagnosis, the diagnosis must be coded as a secondary diagnosis in M1022. If the secondary diagnosis is a V-code, or is part of an etiology/manifestation pair, additional coding criteria must be followed (refer to Section D.5, Criteria for Coding V-codes as a Diagnosis, and Section D.6, Criteria for Coding Etiology and Manifestation Pairs, for additional criteria and coding instructions associated with etiology/manifestation pair coding).
- b. Additionally, the following criteria apply to all diagnoses under consideration as a secondary diagnosis:
 - Ensure that the secondary diagnosis under consideration includes not only conditions actively addressed in the patient's home health plan of care but also any comorbidity

affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.

- Ensure that the secondary diagnoses assigned to the OASIS are listed in the order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided.
- When the secondary diagnosis assigned to M1022 is a V-code, then it is appropriate to report the numeric diagnosis that the V-code is replacing. HHAs must usually report the numeric diagnosis that is being replaced by the V-code as a secondary diagnosis in M1022 also. Refer to Section D.5, Criteria for Coding V-codes as a Diagnosis, for a more thorough discussion concerning V-codes.
- If a secondary diagnosis under consideration is part of a multiple diagnosis situation (such as an etiology/manifestation pair), both codes must be reported in M1022, coding first the etiology code followed by the manifestation code. Refer to Section D.6, Criteria for Coding Etiology and Manifestation Pairs, for additional criteria and coding instructions.

4. Coding Optional Case Mix Diagnosis M1024

a. History of M0245

OASIS instructions from the inception of HH PPS in October 2000 until October 2003 did not permit HHAs to assign V-codes to the primary or secondary diagnoses (M1020/M1022). During that time, HH PPS grouper software was structured to award points only for the patient's primary diagnosis in M1020, or the first secondary diagnosis in M1022 in certain situations. To comply with the HIPAA Act of 1996, which required OASIS to become compliant with ICD-9-C M coding guidelines, the OASIS instructions were changed to allow HHAs the ability to assign V-codes to M1020 and M1022, effective Oct. 1, 2003. To ensure that HH PPS grouper software awarded the appropriate points to an assessment when a V-code was coded in M1020, a new field was added to the OASIS, M0245. Clinicians were instructed to code a numeric diagnosis code in M0245 if the V-code assigned to M1020 was used "in place of" a case mix diagnosis code. If the V-code replaced a case mix diagnosis that was part of an etiology/manifestation pair then clinicians were instructed to code both the etiology code and the manifestation code in M0245.

b. Protocol for M1024

Effective January 2008, the structure for the OASIS diagnosis section changed, and M0246 replaced M0245. Additionally, effective with the January 2008 HH case mix refinements, the HH PPS grouper was revised.

HHAs no longer must always code a numeric diagnosis code in M1024 if a V-code assigned to M1020/M1022 replaces a case mix diagnosis code. The reason is that ICD-9-C M coding guidelines state that certain rehabilitation and aftercare V-codes need a secondary diagnosis code in M1022 to describe a resolving condition or sequelae. In some cases, such underlying or associated diagnoses are case mix codes representing the underlying condition displaced by the V-code. In these cases, the HH PPS grouper will look to M1022 to award appropriate points. HHAs optionally may code M1024 when a V-code in M1020/M1022 replaces a numeric case mix code. However, CMS expects that HHA coding of M1024 will be infrequent, limited to the scenarios described in Section D.4.c, *M1024 Coding to prevent loss of case mix points*, and to those scenarios where the V-code is displacing a case mix diagnosis that is inappropriate to report as an underlying or associated code in M1022

Additional information on case mix diagnoses can be found in the Diagnosis Tables, located in the “Downloads” section of the HH PPS web site.

http://www.cms.hhs.gov/HomeHealthPPS/05_CaseMixGrouperSoftware.asp#TopOfPage

c. M1024 coding to prevent loss of case mix points

To prevent the loss of case mix points when an underlying case mix diagnosis is associated with the primary V-code diagnosis, HHAs should code the numeric diagnosis case mix code to the primary diagnosis line (a) of M1024 when the following three conditions apply:

- 1) The primary diagnosis M1020 is a V-code
- 2) The V-code displaces a numeric diagnosis that is a case mix diagnosis
- 3) The numeric case mix diagnosis is contained within one of the following three HH PPS diagnosis groups:
 - Diabetes
 - Skin 1-Traumatic wounds, burns, and post-operative complications
 - Neuro 1-Brain Disorders and Paralysis.

Note: In the situation above, to comply with ICD-9-C M coding guidelines, ensure that a secondary diagnosis--if needed to support the primary, V-code diagnosis and if appropriate for ICD-9-C M reporting in the home health setting--is reported in M1022 sequenced immediately following the V-code.

Additionally, ICD-9-C M coding guidelines stipulate that the acute fracture code only may be used for the initial, acute episode of care, which is why the acute fracture code is no longer appropriate once the patient has been discharged from the hospital to home health care. In this scenario, if a V-code replaces the fracture code in either M1020 or M1022, the HHA can code the acute fracture code in the corresponding occurrence of M1024.

d. General criteria for M1024 diagnoses coding

The following are general criteria required for assigning a diagnosis to M1024:

- Code M1024 if a V-code is reported in M1020 or M1022 and the V-code is replacing a case mix diagnosis that is inappropriate to report as an underlying or associated code in M1022.
- Surgical codes must not be assigned to M1024. Instead, assign the underlying diagnosis to M1020 or M1022 only if the surgery did not eliminate the disease or the acute phase of the disease has not ended.
- E-codes must not be assigned to M1024. Instead, code the relevant medical diagnosis in M1020.
- V-codes must not be assigned to M1024.

5. Criteria for Coding V-codes

CMS expects HHAs to avoid assigning excessive V-codes to the OASIS. V-code reporting on the OASIS became effective in October 2003 in compliance with HIPAA; however, V-codes are less specific to the clinical condition of the patient than are numeric diagnosis codes. The logic for determining V-code assignment to OASIS M1020/M1022 remains unchanged with the CY 2008 HH PPS final rule with comment period (located at <http://edocket.access.gpo.gov/2007/pdf/07-4184.pdf>).

In the home health setting, V-codes are appropriately assigned to M1020 or M1022 when a patient with a resolving disease or injury requires specific aftercare of that disease or injury (e.g., surgical aftercare or aftercare for rehabilitation).

Sometimes in the home health setting, reporting of V-codes in either M1020 or M1022 requires reporting of the replaced numeric case mix diagnosis in M1022 also. The reason is that certain aftercare and rehabilitation V-code categories require an underlying or associated diagnosis to be coded in order to describe the resolving condition or sequelae. In some circumstances, the condition will be a case mix diagnosis; other times, reporting of a V-code in M1020 or M1022 does not require reporting of an underlying or associated diagnosis. Refer to ICD-9-C M coding guidance for a complete discussion of V-code reporting.

Examples:

- The code category V57, Care involving use of rehabilitation procedures, requires the use of an additional numeric code following the V-code to identify the patient's underlying or associated condition. Refer to Case Scenario #1 in Section F, Case Scenarios, for a more detailed example.
- In other V-code situations such as surgical aftercare V-codes, it is not appropriate to code a secondary numeric diagnosis code in M1022. If the acute diagnosis is no longer applicable (e.g., the surgery eliminated the disease or the acute phase has ended, or the acute code is a fracture code), then no numeric code should be coded in M1022.

HHAs are expected to understand each of the following V-code limitations and consider a V-code assignment to the OASIS as an “assignment of last resort.” Additional, specific criteria for assigning V-codes are as listed below. Further information related to coding can be found in the ICD-9-C M Official Guidelines for Coding and Reporting at <http://www.cdc.gov/nchs/datawh/ftp/ftp9icd9/icdguide08.pdf>.

- V-codes may be used as the primary or secondary diagnosis unless ICD-9-C M coding guidelines stipulate otherwise. OASIS V-code assignment is governed by the *ICD-9-C M Official Guidelines for Coding and Reporting*.
- A single V-code could be related to various underlying or associated numeric codes, each of which describes a specific different clinical condition.
- HHAs are expected to report the accurate underlying diagnosis in M1022, as stipulated in the *ICD-9-C M Official Guidelines for Coding and Reporting*, to support the assignment of certain V-codes.
- If the patient has an acute condition relevant to the plan of care, continue to report the code for the acute condition. V-codes are intended to deal with circumstances other than a disease or injury, or recorded as a diagnosis or problem.

- If there is a complication of medical or surgical care, such as infection or wound dehiscence, select a code specific to either complication rather than a V-code. For example, codes for surgical complications are available within Chapter 17, Injury and Poisoning, of the ICD-9-C M Coding Manual.

6. Criteria for Coding Etiology and Manifestation Pairs

In certain cases, ICD-9-C M guidelines require more than one code to report a condition. The use of two codes in such a prescribed way is referred to as “mandatory multiple coding,” “dual classification,” “dual coding,” or “mandatory dual coding.” One specific example of such mandatory dual coding is termed “etiology/manifestation conventions” and involves the reporting of both a disease and one of its manifestations. The ICD-9-C M manual clearly identifies the instances where etiology/manifestation coding is required in the “Tabular List of Diseases” (see Volume One of the ICD-9-C M manual) and in the “Alphabetic Index to Diseases and Injuries” (see Volume Two of the ICD-9-C M manual). Criteria associated with etiology/manifestation pairs coding are listed below:

- The etiology code is the underlying disease and must be sequenced first, before the code for a related manifestation.
- When a diagnosis is under consideration as an etiology diagnosis, the HHA is expected to ensure that a valid manifestation code is sequenced immediately following the assignment of the etiology code.
- The manifestation diagnosis is the relevant condition caused by the underlying disease. It is never assigned as the patient’s primary diagnosis.
- Additional instructions referencing manifestation and etiology diagnoses in the ICD-9-C M coding manual include:
 - 1) In the Alphabetic Index of the ICD-9-C M Manual, both conditions are listed together with the etiology code listed first and the manifestation code listed second [and in slanted brackets].
 - 2) In the Tabular Index of the ICD-9-C M Manual, the manifestation code may be listed in italics.

An example: How to Code Diabetes Mellitus:

- The ICD-9-C M Official Guidelines for Coding and Reporting, effective October 1, 2008, issued the following sequencing guidance specific to the most commonly used multiple coding situation, Diabetes Mellitus. The codes for Diabetes Mellitus are located under category 250. The diabetes codes and the secondary codes that correspond to them are paired codes that follow the etiology/manifestation convention of the classification. Several codes under category 250 have an instruction note to “use additional code” to identify manifestation. The diabetes code should be sequenced first followed by the manifestation code.
- There are some codes that include the associated condition within the diabetes code, for example, 250.1, Diabetes with ketoacidosis and 250.2 Diabetes with hyperosmolarity. An additional code is not required for these codes.

- Should a patient have more than one manifestation of diabetes, more than one code from category 250 may be used with as many manifestation codes as are needed to fully describe the patient's complete diabetic condition.

E. FLOW CHARTS

1. Purpose of Flow Charts

In these flow charts, each chart is designed to assist HHA clinicians and coders to identify information required to complete each step of the diagnosis selection criteria. The charts should be utilized to analyze the process of assigning a diagnosis to the OASIS. The following flow charts are contained in this section:

Chart A: General Selection and Assignment of the HH Diagnosis

Chart B: Selection and Assignment of the Primary Diagnosis

Chart C: Selection and Assignment of the Secondary Diagnosis

2. Selection & Assignment of the HH Diagnosis

Chart A provides a visual representation of the logical process related to the selection and assignment of all home health diagnoses. This chart identifies a starting point for the decisions that must be made before HHA clinicians and coders are permitted to proceed and it serves to explain how decisions related to the patient's diagnosis will conclude. Please note that Chart A is the official starting point for Chart B and Chart C.

3. M1024 Discussion

The flow charts were designed to concentrate on the selection of the patient's primary and secondary diagnosis and assignment to the OASIS. For reasons discussed in Section D.4, Coding Optional Case Mix Diagnosis, M1024 is an optional payment item that is expected to have limited utilization by HHAs. Refer to the HH PPS Payment Rule if the M1020 Aftercare V-code assignment will result in a loss of points due to compliance with ICD-9-C M Coding Guidelines (see Section D.4.c, M1024 coding to prevent loss of case mix points of this document for further detail).

Chart A - Home Health Correct Coding Protocol: General Selection and Assignment of HH Diagnoses

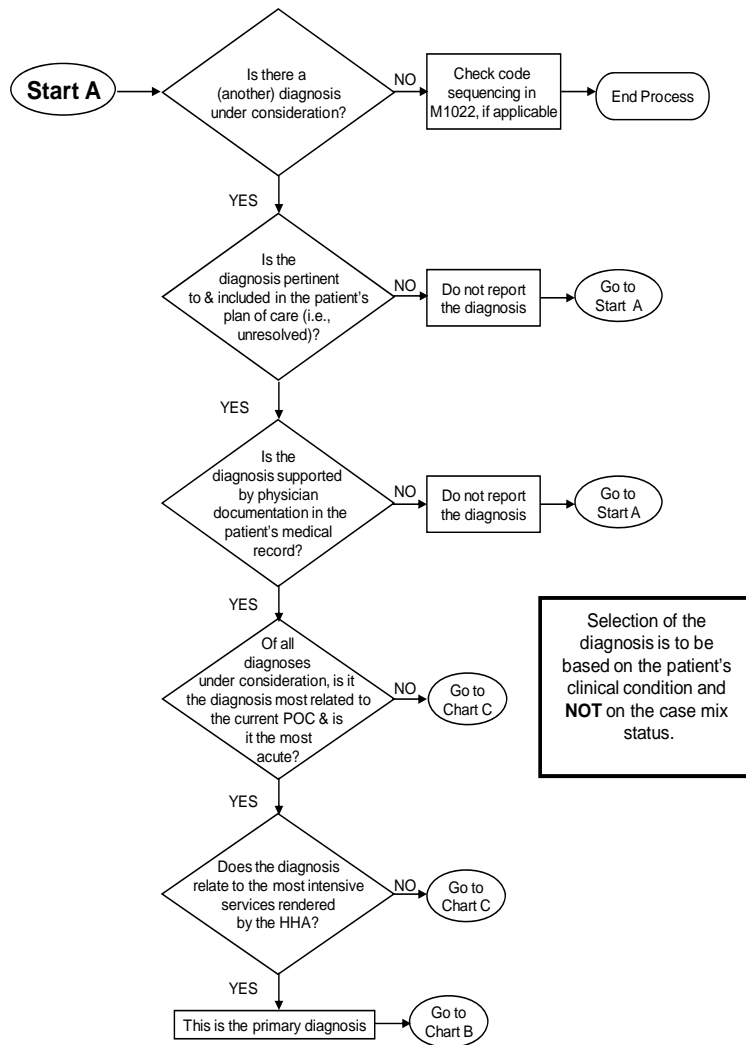


Chart A - Home Health Correct Coding Protocol: General Selection and Assignment of HH Diagnoses is a flowchart used to identify the proper primary or secondary diagnosis codes. The flowchart is a series of questions with “Yes” and “No” responses along with actions associated with each response.

General directions for Chart A

1. Selection of the diagnosis is to be based on the patient’s clinical condition and NOT on the case mix status.

Start A

Question 1: Is there a (another) diagnosis under consideration?

If no, check the code sequencing in M1022, if applicable, and end process.

If yes, go to Question 2.

Question 2: Is the diagnosis pertinent to and included in the patient’s plan of care (i.e., unresolved)?

If no, do not report the diagnosis and return to Start A.

If yes, go to Question 3.

Question 3: Is the diagnosis supported by physician documentation in the patient’s medical record?

If no, do not report the diagnosis and return to Start A.

If yes, go to Question 4.

Question 4: Of all diagnoses under consideration, is it the diagnosis most related to the current POC and is it the most acute?

If no, go to Chart C.

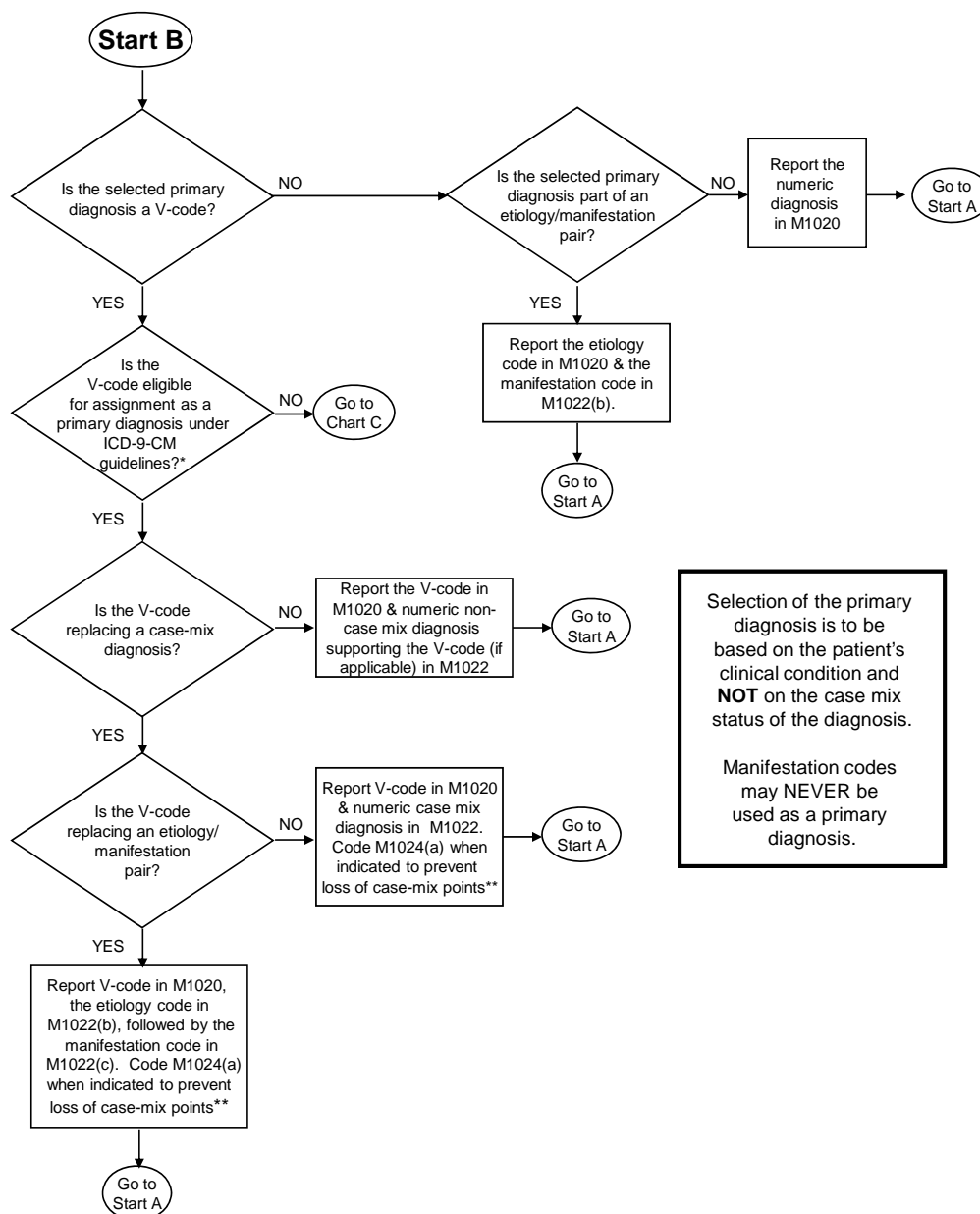
If yes, go to Question 5.

Question 5: Does the diagnosis relate to the most intensive services rendered by the HHA?

If no, go to Chart C.

If yes, this is the primary diagnosis and go to Chart B.

Chart B - Home Health Correct Coding Protocol: Selection and Assignment of the Primary Diagnosis



* See V-code Table in the "ICD-9-C M Official Guidelines for Coding and Reporting" at <http://www.cdc.gov/nchs/dataawh/ftp/ftp9/ftp9.htm>

** Refer to M1024 coding to prevent loss of case-mix points if the M1020 Aftercare V-code assignment will result in a loss of points due to compliance with ICD-9-C M Coding Guidelines (see Section D4(c) of this document for further detail).

Chart B - Home Health Correct Coding Protocol: Selection and Assignment of Primary Diagnosis is a flowchart used to select the proper primary diagnosis code, i.e., a V-code or an ICD-9-C M code that is not a V-code. The flowchart is a series of questions with “Yes” and “No” responses along with actions associated with each response.

General directions for Chart B

1. Selection of the primary diagnosis is to be based on the patient’s clinical condition and NOT on the case mix status of the diagnosis.
2. Manifestation codes may NEVER be used as a primary diagnosis.

Start B

Question 1: Is the selected primary diagnosis a V-code?

If no, answer Follow-up Question: Is the selected primary diagnosis part of an etiology or manifestation pair?

If no, report the numeric diagnosis in M1020 and return to Start A.

If yes, report the etiology code in M1020, report the manifestation code in M1022(b), and return to Start A.

If the answer to Question 1 “Is the selected primary diagnosis a V-code?” was “yes,” then go Question 2.

Question 2: Is the V-code eligible for assignment as a primary diagnosis under ICD-9-C M guidelines? (See V-code Table in the ICD-9-C M Official Guidelines for Coding and Reporting at <http://www.cdc.gov/nchs/datawh/ftpserve/ftp/cd9/ftp/cd9.htm>.)

If no, go to Chart C.

If yes, go to Question 3.

Question 3: Is the V-code replacing a case-mix diagnosis?

If no, report the V-code in M1020, report the numeric non-case mix diagnosis support the V-code (if applicable) in M1022, and return to Start A.

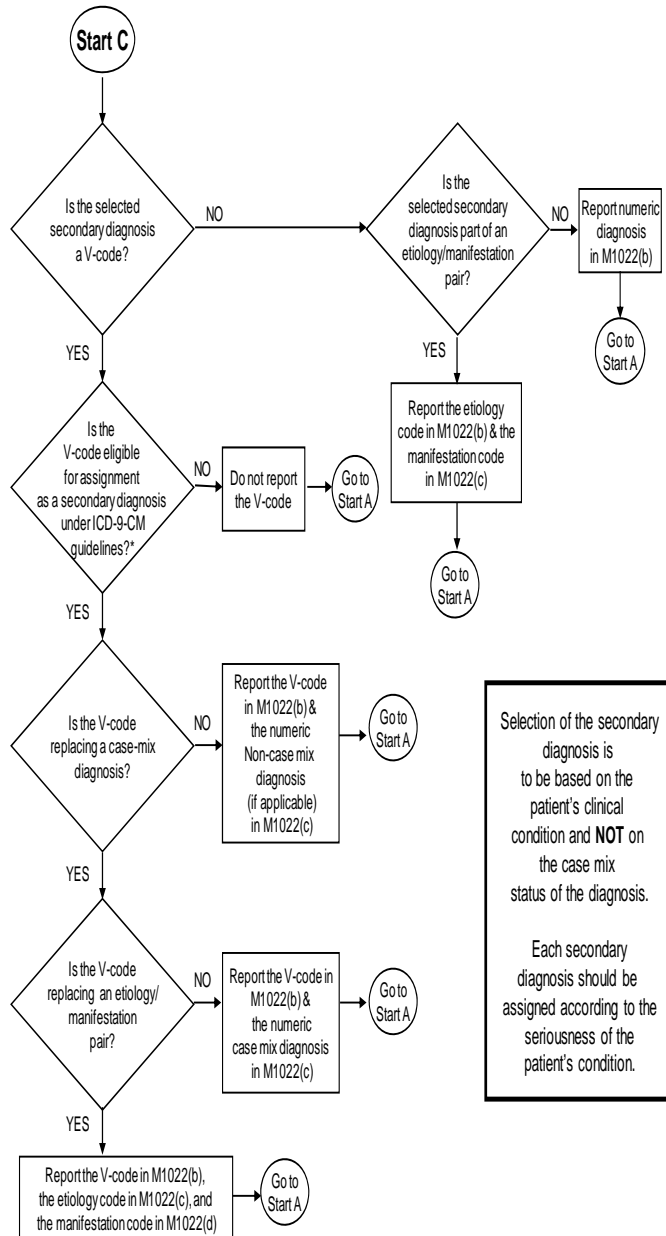
If yes, go to Question 4.

Question 4: Is the V-code replacing an etiology or manifestation pair?

If no, report V-code in M1020 and numeric case mix diagnosis in M1022. Code M1024(a) when indicated to prevent loss of case-mix points. (Refer to M1024 coding to prevent loss of case-mix points if the M1020 Aftercare V-code assignment will result in a loss of points due to compliance with ICD-9-C M Coding Guidelines, see Section D4(c) of this document for further detail.) Return to Start A.

If yes, report V-code in M1020, report the etiology code in M1022(b), report the manifestation code in M1022(c). Code M1024(a) when indicated to prevent loss of case-mix points. (Refer to M1024 coding to prevent loss of case-mix points if the M1020 Aftercare V-code assignment will result in a loss of points due to compliance with ICD-9-C M Coding Guidelines, see Section D4(c) of this document for further detail.) Return to Start A.

Chart C - Home Health Correct Coding Protocol: Selection and Assignment of the Secondary Diagnosis



* See V-code Table in the "ICD-9-C M Official Guidelines for Coding and Reporting" at <http://www.cdc.gov/nchs/datawh/ftp/ftp/cd9/ftp/cd9.htm>

Chart C - Home Health Correct Coding Protocol: Selection and Assignment of the Secondary Diagnosis is a flowchart used to select the proper secondary diagnosis code, i.e., a V-code or an ICD-9-C M code that is not a V-code. The flowchart is a series of questions with “Yes” and “No” responses along with actions associated with each response.

General directions for Chart C

1. Selection of the primary diagnosis is to be based on the patient’s clinical condition and NOT on the case mix status of the diagnosis.
2. Each secondary diagnosis should be assigned according to the seriousness of the patient’s condition.

Start C

Question 1: Is the selected secondary diagnosis a V-code?

If no, answer Follow-up Question: Is the selected secondary diagnosis part of an etiology or manifestation pair?

If no, report the numeric diagnosis in M1022(b) and return to Start A.

If yes, report the etiology code in M1022(b), report the manifestation code in M1022(c), and return to Start A.

If the answer to Question 1 “Is the selected secondary diagnosis a V-code?” was “yes,” then go Question 2.

Question 2: Is the V-code eligible for assignment as a secondary diagnosis under ICD-9-C M guidelines? (See V-code Table in the ICD-9-C M Official Guidelines for Coding and Reporting at <http://www.cdc.gov/nchs/datawh/ftp/ftp9icd9/ftp9icd9.htm>.)

If no, do not report the V-code and return to Start A.

If yes, go to Question 3.

Question 3: Is the V-code replacing a case-mix diagnosis?

If no, report the V-code in M1022(b), report the numeric non-case mix diagnosis (if applicable in M1022(c), and return to Start A.

If yes, go to Question 4.

Question 4: Is the V-code replacing an etiology or manifestation pair?

If no, report the V-code in M1022(b), report the numeric case mix diagnosis in M1022(c), and return to Start A.

If yes, report the V-code in M1022(b), report the etiology code in M1022(c), and report the manifestation code in M1022(d). Return to Start A.

F. CASE SCENARIOS

1. Purpose and Design

The purpose of this section is to provide case scenario examples of the guidance given in previous sections of this attachment. HHAs are responsible for consistently accurate diagnosis reporting to ensure compliance with Medicare's rules and regulations for coverage and payment. Section 1862(a)(1)(A) of the Social Security Act excludes from Medicare coverage and payment provider services that are not reasonable and necessary for the patient's diagnosis.

Each Case Scenario includes the following subsections:

- M1020/M1022 Discussion/Assignment: Implements guidance provided within Section D of this attachment.
- M1024 Discussion: Throughout this subsection, Tables 2A and 2B are tables located in the HH PPS Final Rule with Comment, dated August 29, 2007 (see CMS-1541-FC in the Federal Register or <http://www.cms.hhs.gov/HomeHealthPPS/HPPSRN/itemdetail.asp?filterType=dual.%20keyword&filterValue=1541&filterByDID=0&sortByDID=4&sortOrder=ascending&itemID=CM S1202451&intNumPerPage=10>)
- OASIS Coding: Instruction is provided specific to the line and column assignment for each diagnosis assigned to M1020/M1022/M1024.

Case Scenario #1: V-code used to Designate Specific Aftercare.

An 85-year-old independent female sustained a left hip fracture resulting in a hospital stay for an open reduction with internal fixation. Following her discharge from the hospital, she was admitted to a skilled nursing facility (SNF). She is scheduled to be discharged from the SNF to her home where she will receive home health skilled therapy services. Her physician ordered non-weight bearing activity to her left lower extremity with supervised pivot transfers and contact guard assist in and out of bed.

Skilled Nursing: The HHA did not receive an order from the patient's physician to provide skilled nursing services. The initial assessment visit by the HHA did NOT identify a skilled nursing need.

Therapy Need: The physician ordered physical therapy (PT) for gait evaluation/training and strengthening exercises three times per week for four weeks. The patient's ambulation is limited due to the non-weight bearing status of her left leg. This is her first episode of home health care. Twelve therapy visits are ordered by her physician for this episode of care.

M1020 Discussion/Assignment

Code V57.1, Other physical therapy, is selected as the patient's primary diagnosis and assigned to M1020. The rehabilitation code V57.1, Other physical therapy, qualifies as the patient's primary diagnosis because the focus of the patient's current home health plan of care is to provide rehabilitation through therapeutic physical therapy.

Specific Coding Considerations:

- Coding guidelines for V57 instructs the HHA to use an additional code to identify the patient's underlying condition. Code 781.2, Abnormality of gait, is identified as the patient's underlying condition.
- Codes under category V57 are expected to be assigned as a primary diagnosis unless there are multiple reasons for the patient's admission (not applicable to this scenario).

M1022 Discussion/Assignment

Abnormality of gait, code 781.2, is selected as the secondary diagnosis and assigned to M1022. This diagnosis most accurately describes the patient's current condition and supports the patient's need for PT services.

Specific Coding Considerations: The patient's acute hip fracture, code 820.8, Unspecified part of neck of femur, closed fracture, should not be assigned as a home health diagnosis to M1020/M1022. Acute fracture codes, according to ICD-9-C M Coding Guidelines, must be used only for the patient's initial, acute episode of care. In case scenario #1, the patient's treatment is directed at rehabilitation following hip fracture and surgery. The physical therapy services ordered by the patient's physician are not treating the fracture but rather the gait abnormality, which occurred as a result of the fracture.

M1024 Discussion

Primary diagnosis: Other physical therapy, code V57.1, could potentially be considered to replace code 781.2, Abnormality of gait; however, it is not an option in this case because of the patient's clinical status. Code 781.2 does not qualify as a case mix diagnosis and M1024 (optional) is blank.

Secondary Diagnosis: Abnormality of gait, 781.2, does not qualify as a case mix diagnosis because the patient in this scenario does not have a pressure ulcer (clinical interaction required in line item 19 of Table 2A is NOT present in this scenario). Note: To qualify as a case mix diagnosis, the diagnosis must be listed in Table 2B and meet the criteria stipulated in Table 2A. Acute hip fracture, code 820.8, is contained in the "Ortho-1-Leg Disorders" diagnosis group in Table 2B however this diagnosis does not qualify as a case mix diagnosis because the patient in this scenario does not have a pressure ulcer and is not receiving intravenous, parenteral nutrition or enteral nutrition therapy at home, (clinical interactions required in line items 19 and 20 of Table 2A).

OASIS Coding

Primary Diagnosis:	M1020a	Column 1, Other Physical Therapy
	M1020a	Column 2, V57.1
Secondary Diagnosis:	M1022b	Column 1, Abnormality of Gait
	M1022b	Column 2, 781.2
Optional Payment Diagnosis	M1024a	Column 3, is blank
Optional Payment Diagnosis	M1024b	Column 3, is blank

(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare P P S case mix group. Do not assign symptom control ratings for V- or E-codes.

Code each row according to the following directions for each column:

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 using the following scale:

0 - Asymptomatic, no treatment needed at this time

1 - Symptoms well controlled with current therapy

2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring

3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring

4 - Symptoms poorly controlled; history of re-hospitalizations

Note that in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Case Mix Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete only if the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-C M / Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
(M1020) Primary Diagnosis	(V-codes are allowed)	(V- or E-codes NOT allowed)	(V- or E-codes NOT allowed)
a. <u>Other physical therapy</u>	a. (<u> V 5 7 </u> . <u> 1 </u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	a. _____ (_____ . _____)	a. _____ (_____ . _____)
(M1022) Other Diagnoses	(V- or E-codes are allowed)	(V- or E-codes NOT allowed)	(V- or E-codes NOT allowed)
b. <u>Abnormality of gait</u>	b. (<u> 7 8 1 </u> . <u> 2 </u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	b. _____ (_____ . _____)	b. _____ (_____ . _____)
c. _____	c. (_____ . _____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	c. _____ (_____ . _____)	c. _____ (_____ . _____)
d. _____	d. (_____ . _____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	d. _____ (_____ . _____)	d. _____ (_____ . _____)
e. _____	e. (_____ . _____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	e. _____ (_____ . _____)	e. _____ (_____ . _____)
f. _____	f. (_____ . _____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	f. _____ (_____ . _____)	f. _____ (_____ . _____)

Case Scenario #2: Multidisciplinary Case Involving Total Hip Replacement

An 83-year-old female is admitted by the HHA following discharge from the hospital. The patient is seven days status post left total hip replacement due to osteoarthritis in both hips. She developed a mildly exudated wound infection (*Staph. aureus*) of her surgical incision and was discharged from the hospital with IV antibiotics. This is the patient's initial episode of home health care.

Skilled Nursing Need: The patient's physician ordered daily skilled nursing visits for three weeks to treat her infected left hip surgical wound. The specific skilled nursing services ordered by the physician include the following:

- monitor the wound for signs and symptoms of infection;
- administer IV antibiotics daily for 21 days; and
- teach the patient's daughter to perform IV administration and wound care.

Therapy Need: The patient's physician ordered physical therapy services for gait training and strengthening exercises two times a week for four weeks. Ambulation is limited due to non-weight-bearing status of her left lower extremity. The patient can perform supervised pivot transfers with contact guard assistance in and out of bed. Her daughter will be staying with her until her mobility improves.

M1020 Discussion/Assignment

This is a multidisciplinary case directed at providing post-op care following a total hip replacement. Code 998.59, Other post-operative infection, is selected as the patient's primary diagnosis and assigned to M1020. The surgical wound infection represents the most acute condition and requires the most intensive skilled services.

M1022 Discussion/Assignment

Code 041.11, Methicillin susceptible staphylococcus aureus in conditions classified elsewhere and of unspecified site; V54.81, Aftercare following joint replacement; V43.64, Hip joint replaced; 715.35, Osteoarthritis, localized, not specified whether primary or secondary, pelvic region and thigh; and 781.2, Abnormality of Gait are selected as the patient's secondary diagnoses. Each diagnosis is assigned to the OASIS in the order that reflects the seriousness of the patient's condition and to justify the disciplines and services provided (see Section D.3, Secondary Diagnosis Criteria, of this attachment).

M1022b - 041.11, Methicillin susceptible staphylococcus aureus in conditions classified elsewhere and of unspecified site, is assigned as the first diagnosis in M1022. Coding guidelines for ICD-9-C M code 998.59, which is the primary diagnosis, requires assignment of an additional code to identify the infection.

M1022c - V54.81, Aftercare following joint replacement, is assigned as the second diagnosis in M1022. ICD-9-C M coding guidelines require an additional code to identify the joint replacement site, left hip V43.64.

M1022d - V43.64, Hip joint replaced, is the additional "Status V-Code" required per ICD-9-C M coding guidelines to identify the joint replacement site of the V54.81 Aftercare code. It is the third diagnosis assigned to M1022.

M1022e - 715.35, Osteoarthritis, localized, not specified whether primary or secondary, pelvic region and thigh, is assigned as the fourth secondary diagnosis in M1022.
M1022f - 781.2, Abnormality of gait is assigned as the fifth secondary diagnosis in M1022.

M1024 Discussion

Primary diagnosis: Other post-operative Infection, code 998.59, qualifies as a case mix diagnosis based on the clinical status of the patient. Note: M1024a, column 3 is blank because a V-code is not replacing the case mix diagnosis. The Grouper will identify the diagnosis assigned to M1020 as a point bearing diagnosis qualifying for case mix points.

Secondary Diagnoses: Osteoarthritis, localized, not specified whether primary or secondary, pelvic region and thigh, code 715.35, qualifies as a case mix diagnosis based on the clinical status of the patient. Although code V54.81, Aftercare following joint replacement, could replace case mix diagnosis code 715.35, and 715.35 could be coded to M1024 (optional), this is not the preferred way to code. It is preferable for osteoarthritis to be assigned to M1022 rather than M1024 because osteoarthritis is an ongoing condition of the patient. Note: M1024c, column 3 is blank, the Grouper will identify diagnoses assigned to M1022 that qualify for case mix points.

Code 781.2, Abnormality of gait, does not qualify as a case mix diagnosis. To qualify as a case mix diagnosis, the diagnosis must be listed in Table 2B and meet the criteria stipulated in Table 2A. Code 781.2, Abnormality of gait, does not qualify as a case mix diagnosis because the patient in this scenario does not have a pressure ulcer (clinical interaction required in line item 19 of Table 2A is NOT present in this scenario).

OASIS Coding

Primary Diagnosis:	M1020a	Column 1, Other postoperative Infection
	M1020a	Column 2, 998.59
Secondary Diagnosis:	M1022b	Column 1, Methicillin susceptible staphylococcus aureus in conditions classified elsewhere and of unspecified site
	M1022b	Column 2, 041.11
Secondary Diagnosis:	M1022c	Column 1, Aftercare following joint replacement
	M1022c	Column 2, V54.81
Secondary Diagnosis:	M1022d	Column 1, Hip joint replaced
	M1022d	Column 2, V43.64
Secondary Diagnosis:	M1022e	Column 1, Osteoarthritis, localized, not specified whether primary or secondary, pelvic region and thigh
	M1022e	Column 2, 715.35
Secondary Diagnosis:	M1022f	Column 1, Abnormality of Gait
	M1022f	Column 2, 781.2
Optional Payment Diagnosis	M1024a-f	Column 3, is blank

(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare P P S case mix group. Do not assign symptom control ratings for V- or E-codes.

Code each row according to the following directions for each column:

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 using the following scale:

0 - Asymptomatic, no treatment needed at this time

1 - Symptoms well controlled with current therapy

2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring

3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring

4 - Symptoms poorly controlled; history of re-hospitalizations

Note that in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Case Mix Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete only if the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-CM / Symptom Control Rating	Description/ ICD-9-CM	Description/ ICD-9-CM
(M1020) Primary Diagnosis a. <u>Other post-operative infection</u>	(V-codes are allowed) a. (<u> 9 9 8 . 5 9 </u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4	(V- or E-codes NOT allowed) a. _____ (_____ . _____)	(V- or E-codes NOT allowed) a. _____ (_____ . _____)
(M1022) Other Diagnoses b. <u>Methicillin susceptible Staph. Aureus</u>	(V- or E-codes are allowed) b. (<u> 0 4 1 . 1 1 </u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4	(V- or E-codes NOT allowed) b. _____ (_____ . _____)	(V- or E-codes NOT allowed) b. _____ (_____ . _____)
c. <u>Aftercare following joint replacement</u>	c. (<u> V 5 4 . 8 1 </u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	c. _____ (_____ . _____)	c. _____ (_____ . _____)
d. <u>Hip Joint replaced</u>	d. (<u> V 4 3 . 6 4 </u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	d. _____ (_____ . _____)	d. _____ (_____ . _____)
e. <u>Osteoarthritis, localized, not spec. whether primary or secondary, pelvic region & thigh</u>	e. (<u> 7 1 5 . 3 5 </u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	e. _____ (_____ . _____)	e. _____ (_____ . _____)
f. <u>Abnormality of gait</u>	f. (<u> 7 8 1 . 2 </u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	f. _____ (_____ . _____)	f. _____ (_____ . _____)

Case Scenario #3: Malignant Neoplasm of the Breast

A 66-year-old left-handed, left dominant woman who lives alone is discharged from the hospital three days after a right, modified radical mastectomy for breast cancer. The patient has a right surgical breast wound and lymphedema of the right arm. She also has residual weakness of her left arm, due to H/O stroke. The patient is unable to care for her breast wound. Her medications include Tamoxifen for estrogen receptor positive breast cancer chemotherapy and pain medications. Her physician reports that the patient's breast cancer is not resolved and the surgical drain is scheduled to be removed in several days.

Skilled Nursing Need: The patient's physician ordered skilled nursing visits daily for 10 days until the surgical drain is removed, then three times a week for four weeks to provide surgical wound care and supervision of the exercises ordered to improve her right shoulder range of motion and to monitor her arm lymphedema.

Skilled Therapy Need: Skilled therapy services are not required or ordered by the patient's physician. The nurse will supervise the patient's performance of the exercises ordered to improve her shoulder range of motion on the affected side.

M1020 Discussion/Assignment

V58.42, Aftercare following surgery for neoplasm, is selected as the primary diagnosis and assigned to M1020. The skilled nursing services rendered by the HHA to care for the patient's surgical wound and monitor the wound for signs and symptoms of infection is the chief reason for providing home care. ICD-9-C M Coding Guidelines require the use of an additional aftercare code in conjunction with code V58.42 to fully identify the reason for the aftercare services. Therefore, code V58.31, Encounter for change or removal of surgical wound dressing, is assigned as the first secondary diagnosis.

M1022 Discussion/Assignment

Code V58.31, Encounter for change or removal of surgical wound dressing; Code 174.9, Malignant neoplasm of breast (female), unspecified; V86.0, Estrogen receptor positive status; Code 457.0, Post-mastectomy lymphedema syndrome and Code 438.31, Monoplegia of upper limb affecting dominant side, are selected as the patient's secondary diagnoses. Each diagnosis is assigned to the OASIS in the order that reflects the seriousness of the patient's condition and to justify the services provided, (see Section D.3, Secondary Diagnosis Selection Criteria, of this attachment).

M1022b - Code V58.31, Encounter for change or removal of surgical wound dressing is coded as the first secondary diagnosis in M1022. The assignment of this code complies with ICD-9-C M coding guidelines and identifies the skilled nursing wound care services provided to the patient.

M1022c - Code 174.9, Malignant neoplasm of breast (female) unspecified, is coded as the second diagnosis in M1022. Note: It is preferable for code 174.9 to be coded as a secondary diagnosis because malignant cancer is an ongoing condition that justifies/supports the assignment of V58.42 and V58.31. ICD-9-C M coding guidelines require the use of an additional code to identify the estrogen receptor status when assigning code 174.9.

M1022d - Code V86.0, Estrogen receptor positive status, is coded as the third diagnosis in M1022 in compliance with ICD-9-C M coding guidelines.

M1022e - Code 457.0, Post mastectomy lymphedema syndrome, is coded as the fourth diagnosis in M1022. Lymphedema is actively addressed in the patient's plan of care and affects her responsiveness to treatment and rehabilitative prognosis.

M1022f - Code 438.31, Monoplegia of upper limb affecting dominant side, is coded as the fifth diagnosis in M1022. This condition is a residual dysfunction of her left arm (the patient's dominant side), due to a stroke that occurred one year ago. Code 438.31, is a co-morbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis.

M1024 Discussion

Primary Diagnosis: M1024a, Column 3 is blank. Although code V58.42, Aftercare following surgery for neoplasm, could replace case mix diagnosis code 174.9, Malignant Neoplasm of breast (female) unspecified, and 174.9 could be coded to M1024a, Column 3, this is not the preferred way to code this case. It is preferable for code 174.9 to be assigned as a secondary diagnosis rather than coded to M1024a, Column 3, because the malignant cancer is an ongoing condition.

Secondary Diagnoses: Code 174.9, Malignant neoplasm breast (female), unspecified, qualifies as a case mix diagnosis. Note: M1024c, Column 3, is blank; the Grouper will identify diagnoses assigned to M1022 that qualify for case mix points.

Code 457.0, Post mastectomy lymphedema syndrome does not qualify as a case mix diagnosis.

Code 438.31, Monoplegia of upper limb affecting dominant side, qualifies as a case mix diagnosis, M1024f, Column 3, is blank, the Grouper will identify diagnoses assigned to M1022 that qualify for case mix points.

OASIS Coding

Primary Diagnosis:	M1020a	Column 1, Aftercare Following Surgery for Neoplasm
	M1020a	Column 2, V58.42
Secondary Diagnosis:	M1022b	Column 1, Encounter for change or removal of surgical wound dressing
	M1022b	Column 2, V58.31
Secondary Diagnosis:	M1022c	Column 1, Malignant neoplasm breast (female), unspecified
	M1022c	Column 2, 174.9
Secondary Diagnosis:	M1022d	Column 1, Estrogen receptor positive status
	M1022d	Column 2, V86.0
Secondary Diagnosis:	M1022e	Column 1, Post mastectomy lymphedema syndrome
	M1022e	Column 2, 457.0
Secondary Diagnosis:	M1022f	Column 1, Monoplegia of upper limb affecting dominant side
	M1022f	Column 2, 438.31
Optional Payment Diagnosis	M1024a-f	Column 3, is blank

(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare P P S case mix group. Do not assign symptom control ratings for V- or E-codes.

Code each row according to the following directions for each column:

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 using the following scale:

0 - Asymptomatic, no treatment needed at this time

1 - Symptoms well controlled with current therapy

2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring

3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring

4 - Symptoms poorly controlled; history of re-hospitalizations

Note that in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Case Mix Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete only if the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-CM / Symptom Control Rating	Description/ ICD-9-CM	Description/ ICD-9-CM
(M1020) Primary Diagnosis a. <u>Aftercare following surgery for neoplasm</u>	(V-codes are allowed) a. (<u>V 5 8 . 4 2</u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(V- or E-codes NOT allowed) a. _____ (____ . ____)	(V- or E-codes NOT allowed) a. _____ (____ . ____)
(M1022) Other Diagnoses b. <u>Encounter for change or removal of surgical wound dressing</u>	(V- or E-codes are allowed) b. (<u>V 5 8 . 3 1</u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4	(V- or E-codes NOT allowed) b. _____ (____ . ____)	(V- or E-codes NOT allowed) b. _____ (____ . ____)
c. <u>Malig Neo. (female) Breast Unspecified</u>	c. (<u>__ 1 7 4 . 9 __</u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4	c. _____ (____ . ____)	c. _____ (____ . ____)
d. <u>Estrogen Receptor Positive</u>	d. (<u>V 8 6 . 0 __</u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4	d. _____ (____ . ____)	d. _____ (____ . ____)
e. <u>Lymphedema syndrome</u>	e. (<u>__ 4 5 7 . 0 __</u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	e. _____ (____ . ____)	e. _____ (____ . ____)
f. <u>Monoplegia of upper limb affecting dominant side</u>	f. (<u>__ 4 3 8 . 3 1</u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	f. _____ (____ . ____)	f. _____ (____ . ____)

Case Scenario #4: Cerebral Contusion

Note: This scenario provides an example of acceptable M1024 documentation. (Refer to Section D.4.c, M1024 coding to prevent loss of case mix points, within this document for additional information.)

A 70-year-old male is admitted to home health following discharge from a three- day hospitalization for cerebral contusion, code 851.02. He accidentally fell at home with brief loss of consciousness, confusion (resolved), and resolving right leg weakness and unsteady gait (dominant side). CT revealed a focal left cortex contusion. The patient received physical therapy and occupational therapy while in the hospital. Although his functional ability is improved, he is unable to ambulate and requires a manual wheelchair for mobility. The patient requires physical therapy to regain his normal gait. His physician orders home health skilled therapy due to residual effects of his intracranial injury, code 907.0, Late effect of intracranial injury without mention of skull fracture.

Skilled Nursing: The HHA did not receive an order from the patient's physician to provide skilled nursing services. The patient's initial comprehensive assessment visit by the HHA did NOT identify a skilled nursing need.

Therapy Need: The patient's physician orders physical therapy for gait evaluation/training and strengthening exercises three times per week for four weeks. The patient is currently wheelchair dependent (chairfast). He is unable to ambulate but he is able to wheel independently in his wheel chair. This is his first episode of home health care.

M1020 Discussion/Assignment

The rehabilitation code V57.1, Other physical therapy, qualifies as the patient's primary diagnosis because the focus of the patient's current home health plan of care is to provide rehabilitation through therapeutic physical therapy.

Specific Coding Considerations:

- Coding guidelines for V57 instructs HHAs to use an additional code to identify the patient's underlying condition. Code, 907.0, Late effect of intracranial injury without mention of skull fracture, is identified as the patient's underlying condition.
- In the home health setting, V-codes are appropriately assigned to M1020 when a patient with a resolving disease or injury requires specific aftercare of that disease or injury.

M1022 Discussion/Assignment

Code 907.0, Late effect of intracranial injury without mention of skull fracture, is identified as the as the first secondary diagnosis because it is the condition that best reflects the seriousness of the patient's condition and justifies the therapy services provided.

Abnormality of gait, code 781.2, is selected as the second diagnosis assigned to M1022. This diagnosis most accurately describes the patient's current condition and supports the patient's need for PT services.

Specific Coding Considerations:

In this case scenario the patient received treatment for his acute condition, cerebral contusion, code 851.02 in the hospital. The patient's cerebral contusion is the cause of his acute injury and Code 907.0, Late effect of intracranial injury without mention of skull fracture is identified as the late effect of the patient's injury. Under ICD-9-CM coding guidelines, the code for the acute phase of an illness or injury that led to the patient's late effect is never used with a code for the late effect. To comply with ICD-9-CM Official Guidelines for Coding and Reporting, code 851.02 must not be assigned as the patient's primary and or secondary diagnosis.

M1024 Discussion

Specific HH PPS payment rules and documentation considerations apply to the primary diagnosis in this scenario.

- The patient's primary diagnosis is a V-code, V57.1, Other physical therapy. The first secondary diagnosis is Code 907.0, Late effect of intracranial injury without mention of skull fracture is a case mix diagnosis contained within the Neuro 1-Brain Disorders and Paralysis Diagnosis Group, (Refer to Section D.4.c of this document, M1024 coding to prevent loss of case mix points for additional information.).
- To qualify as a case mix diagnosis, the diagnosis must be listed in Table 2B and the patient's condition meets the criteria stipulated in Table 2A.

Documentation Guidance: To avoid receiving secondary points for case mix diagnosis code, 907.0, Late effect of intracranial injury without mention of skull fracture, report this code in the case mix section of the OASIS, the primary diagnosis line (a) of M1024.

OASIS Coding

Primary Diagnosis:	M1020a	Column 1, Other Physical Therapy
	M1020a	Column 2, V57.1
Secondary Diagnosis:	M1022b	Column 1, Late effect of intracranial injury without mention of skull fracture.
	M1022b	Column 2, 907.0
Secondary Diagnosis:	M1022c	Column 1, Abnormality of gait
	M1022c	Column 2, 781.2
Optional Payment Diagnosis	M1024a	Column 3, Late effect of intracranial injury without mention of skull fracture 907.0
Optional Payment Diagnosis	M1024b	Column 3, is blank

(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare P P S case mix group. Do not assign symptom control ratings for V- or E-codes.

Code each row according to the following directions for each column:

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 using the following scale:

0 - Asymptomatic, no treatment needed at this time

1 - Symptoms well controlled with current therapy

2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring

3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring

4 - Symptoms poorly controlled; history of re-hospitalizations

Note that in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Case Mix Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete only if the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-CM / Symptom Control Rating	Description / ICD-9-CM	Description / ICD-9-CM
(M1020) Primary Diagnosis a. <u>Other physical therapy</u>	(V-codes are allowed) a. (<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(V- or E-codes NOT allowed) a. <u>Late effect of intracranial injury without mention of skull fracture</u> (<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>)	(V- or E-codes NOT allowed) a. _____ (<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>)
(M1022) Other Diagnoses b. <u>Late effect of intracranial injury without mention of skull fracture</u>	(V- or E-codes are allowed) b. (<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(V- or E-codes NOT allowed) b. _____ (<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>)	(V- or E-codes NOT allowed) b. _____ (<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>)
c. <u>Abnormality of gait</u>	c. (<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	c. _____ (<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>)	c. _____ (<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>)
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e. _____	e. (<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	e. _____ (<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>)	e. _____ (<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>)
f. _____	f. (<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	f. _____ (<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>)	f. _____ (<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>)