Table 7.6

Persons Using Medicare Home Health Agency Services, Visits, Total Charges, Visit Charges, and Program Payments, by Principal Diagnosis Within Major Diagnostic Classifications (MDCs): Calendar Year 2008

Principal ICD-9-CM Diagnosis Within MDC[1]	Principal ICD-9-CM Codes	Persons Served[2]		Visits		Total Charges	Visit Charges			Program Payments		
		Number in Thousands	Percent	Number in Thousands	Per Person Served	in Thousands	Amount in Thousands	Per Visit	Per Person Served	Amount in Thousands	Per Visit	Per Person Served[3]
Total All Diagnoses[4]	---	3,172	100.0	121,005	38	$16,570,487	$16,262,053	$134	$5,127	$16,872,735	$139	$5,361
Total Leading Diagnoses[5]	---	1,813	57.2	64,701	36	8,532,214	8,385,808	130	4,626	7,876,459	122	4,387
Infectious and Parasitic Diseases (MDC 1)	001-139	20	0.6	379	19	52,896	52,129	138	2,645	53,998	143	2,762
Neoplasms (MDC 2)	140-239	110	3.5	2,113	19	303,713	294,761	140	2,691	324,922	154	2,988
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	22	0.7	389	18	55,586	54,399	140	2,480	61,382	158	2,821
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	372	11.7	29,306	79	3,667,653	3,635,636	124	9,775	2,830,386	97	7,707
Diabetes Mellitus	250	341	10.8	28,654	84	3,579,885	3,549,361	124	10,409	2,736,293	95	8,130
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	11	0.4	178	16	25,376	24,809	140	2,168	27,068	152	2,388
Diseases of the Blood and Blood Forming Organs (MDC 4)	280-289	60	1.9	1,623	27	197,095	194,602	120	3,235	211,227	130	3,538
Other Deficiency Anemias	281	30	1.0	959	32	108,427	107,034	112	3,542	115,843	121	3,856
Other and Unspecified Anemias	285	20	0.6	449	22	59,849	59,141	132	2,914	65,272	145	3,244
Coagulation Defects	286	3	0.1	57	21	7,460	7,362	130	2,722	7,375	130	2,754
Mental Disorders (MDC 5)	290-319	68	2.1	1,527	22	206,137	204,986	134	3,019	225,150	147	3,356
Schizophrenic Disorders	295	7	0.2	174	26	23,107	22,985	132	3,423	25,984	149	3,936
Affective Psychoses	296	10	0.3	217	22	30,514	30,391	140	3,052	33,911	156	3,451
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	152	4.8	4,828	32	637,303	628,992	130	4,140	703,071	146	4,686
Parkinson's Disease	332	34	1.1	1,105	32	151,696	150,573	136	4,411	180,237	163	5,328

See footnotes at end of table.

Table 7.6—Continued

Persons Using Medicare Home Health Agency Services, Visits, Total Charges, Visit Charges, and Program Payments, by Principal Diagnosis Within Major Diagnostic Classifications (MDCs): Calendar Year 2008

Principal ICD-9-CM Diagnosis Within MDC[1]	Principal ICD-9-CM Codes	Persons Served[2]		Visits		Total Charges	Visit Charges			Program Payments		
		Number in Thousands	Percent	Number in Thousands	Per Person Served	in Thousands	Amount in Thousands	Per Visit	Per Person Served	Amount in Thousands	Per Visit	Per Person Served[3]
Diseases of the Circulatory System (MDC 7)	390-459	809	25.5	21,370	26	$2,964,613	$2,919,184	$137	$3,607	$3,161,043	$148	$3,938
Essential Hypertension	401	223	7.0	5,099	23	676,036	671,584	132	3,013	751,088	147	3,407
Hypertensive Heart Disease	402	27	0.9	675	25	86,590	86,006	127	3,182	96,037	142	3,612
Acute Myocardial Infarction	410	19	0.6	306	17	44,114	43,861	143	2,364	46,887	153	2,543
Other Acute and Subacute Forms of Ischemic Heart Disease	411	3	0.1	51	16	7,204	7,152	140	2,251	7,781	153	2,460
Angina Pectoris	413	5	0.1	83	18	10,799	10,758	130	2,336	11,329	137	2,479
Other Forms of Chronic Ischemic Heart Disease	414	60	1.9	1,153	19	157,262	156,135	135	2,583	170,356	148	2,840
Cardiac Dysrhythmias	427	72	2.3	1,428	20	197,493	195,546	137	2,700	206,832	145	2,874
Heart Failure	428	212	6.7	4,972	23	688,022	680,985	137	3,218	716,846	144	3,408
Transient Cerebral Ischemia	435	11	0.3	217	20	30,279	30,903	142	2,873	34,349	158	3,216
Acute but Ill-Defined Cerebrovascular Disease	436	6	0.2	177	31	23,486	23,349	132	4,057	25,638	145	4,534
Other Peripheral Vascular Disease	443	12	0.4	301	26	40,965	39,417	131	3,408	39,573	132	3,447
Diseases of the Respiratory System (MDC 8)	460-519	271	8.6	5,735	21	799,884	791,765	138	2,920	858,449	150	3,190
Pneumonia, Organism Unspecified	486	59	1.9	912	15	133,230	132,220	145	2,240	144,292	158	2,460
Chronic Airway Obstruction, not Elsewhere Classified	496	49	1.6	1,069	22	143,941	142,784	134	2,893	145,726	136	2,984
Diseases of the Digestive System (MDC 9)	520-579	74	2.3	1,311	18	185,306	181,138	138	2,446	198,313	151	2,694
Diseases of the Genitourinary System (MDC 10)	580-629	82	2.6	1,617	20	221,614	216,014	134	2,631	230,059	142	2,822
Other Disorders of Urethra and Urinary Tract	599	46	1.4	795	17	110,459	108,368	136	2,367	118,852	149	2,611
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	196	6.2	6,622	34	990,647	914,646	138	4,661	848,893	128	4,357
Other Cellulitis and Abscess	682	54	1.7	1,123	21	172,390	162,326	145	3,033	157,292	140	2,958
Chronic Ulcer of Skin	707	135	4.3	5,255	39	783,245	719,002	137	5,311	661,300	126	4,920

See footnotes at end of table.

Table 7.6—Continued

Persons Using Medicare Home Health Agency Services, Visits, Total Charges, Visit Charges, and Program Payments, by Principal Diagnosis Within Major Diagnostic Classifications (MDCs): Calendar Year 2008

Principal ICD-9-CM Diagnosis Within MDC[1]	Principal ICD-9-CM Codes	Persons Served[2]		Visits		Total Charges	Visit Charges			Program Payments		
		Number in Thousands	Percent	Number in Thousands	Per Person Served	in Thousands	Amount in Thousands	Per Visit	Per Person Served	Amount in Thousands	Per Visit	Per Person Served[3]
Diseases of the Musculoskeletal System and Connective Tissue (MDC 13)	710-739	399	12.6	10,934	27	$1,471,282	$1,461,301	$134	$3,660	$1,703,019	$156	$4,309
Rheumatoid Arthritis and Other Inflammatory Polyarthropathies	714	16	0.5	540	33	67,367	66,900	124	4,125	73,826	137	4,612
Osteoarthrosis and Allied Disorders	715	93	2.9	2,200	24	295,002	293,180	133	3,139	361,436	164	3,917
Other and Unspecified Arthropathies	716	60	1.9	1,656	28	212,156	211,118	128	3,532	248,734	150	4,213
Other and Unspecified Disorders of Back	724	50	1.6	1,022	21	142,920	142,214	139	2,860	177,184	173	3,598
Other Disorders of Bone and Cartilage	733	17	0.5	1,104	65	131,918	131,443	119	7,724	91,618	83	5,430
Congenital Anomalies (MDC 14)	740-759	3	0.1	77	25	10,178	9,893	129	3,246	10,078	132	3,393
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	262	8.3	5,489	21	770,369	761,779	139	2,908	911,885	166	3,509
General Symptoms	780	56	1.7	1,028	19	144,868	143,801	140	2,591	162,072	158	2,944
Symptoms Involving Urinary System	788	17	0.5	422	24	54,405	51,558	122	2,981	53,414	127	3,119
Injury and Poisoning (MDC 17)	800-999	208	6.6	5,508	27	815,917	778,293	141	3,746	729,983	133	3,555
Fracture of Neck of Femur	820	4	0.1	104	24	14,502	14,382	138	3,265	16,907	162	3,884
Open Wound of Other and Unspecified Sites, Except Limbs	879	7	0.2	187	28	27,233	25,523	136	3,855	22,152	118	3,444
Open Wound of Knee, Leg (Except Thigh), and Ankle	891	23	0.7	639	28	94,431	89,241	140	3,938	81,572	128	3,634
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01-V82	1,088	34.3	22,562	21	3,275,201	3,216,281	143	2,958	3,871,737	172	3,584

[1]ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification* (Volume 1). Only the first listed or principal diagnosis has been used.

[2]Numbers do not add to total since persons may have more that one principal diagnosis reported for covered HHA services.

[3]Does not reflect beneficiaries who received covered services, but for whom no program payments were reported during the reporting year.

[4]Includes invalid codes not listed separately.

[5]Specific leading diagnostic categories were selected for presentation because of frequency of occurrences or because of special interest.

NOTES: MDCs 11 and 15 were not shown separately (but included in the total), because they were for the most part, not applicable to Medicare beneficiaries. Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Total charges and visit charges are shown for trend purposes only. With the implementation of the home health agency prospective payment system, beginning October 1, 2000, program payments are now associated with episodes and not with individual visits. As a result, program payments may exceed charges.

Changes, as of October 2003, in the medical coding of the ICD-9-CM diagnosis field has resulted in the significant increase in the use of V-codes (Supplementary Classification of Factors Influencing Health Status and Contact with Health Services). That is, V-codes are now being used more frequently in the principal diagnostic field to reflect the fact that the HHA episode is oriented to providing some type of aftercare or rehabilitation service in a post-acute care setting. This is in direct contrast to the acute care setting when the coding of the principal diagnosis is directly related to the underlying condition. Numbers may not add to total because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.