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 2011

Principal ICD-9-CM Diagnosis Within MDC[1]	Principal ICD-9-CM Codes	Persons Served [2]		Visits		Total Charges in Thousands	Visit Charges			Program Payments		
		Number in Thousands	Percent	Number in Thousands	Per Person Served		Amount in Thousands	Per Visit	Per Person Served	Amount in Thousands	Per Visit	Per Person Served[3]
Total All Diagnoses[4]	---	3,464	100.0	123,249	36	$18,894,146	$18,473,688	$150	$5,333	$18,362,264	$149	$5,357
Total Leading Diagnoses[5]	---	2,060	59.5	59,868	29	8,901,880	8,692,078	145	4,220	7,954,128	133	3,920
Infectious and Parasitic Diseases (MDC 1)	001-139	25	0.7	514	21	80,964	79,744	155	3,231	66,946	130	2,790
Neoplasms (MDC 2)	140-239	110	3.2	2,245	20	355,678	344,272	153	3,130	344,161	153	3,164
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	22	0.6	409	18	65,443	63,286	155	2,862	64,524	158	2,946
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	376	10.8	17,653	47	2,505,014	2,472,606	140	6,583	1,930,495	109	5,244
Diabetes Mellitus	250	341	9.8	16,887	50	2,392,311	2,361,645	140	6,935	1,818,814	108	5,454
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	11	0.3	186	16	28,609	28,073	151	2,446	29,154	157	2,554
Diseases of the Blood and Blood Forming Organs (MDC 4)	280-289	62	1.8	1,636	26	218,560	215,390	132	3,485	225,955	138	3,677
Other Deficiency Anemias	281	33	1.0	1,020	31	127,503	125,643	123	3,803	135,203	133	4,109
Other and Unspecified Anemias	285	20	0.6	412	21	60,990	60,127	146	3,040	61,624	150	3,138
Coagulation Defects	286	1	(6)	39	27	5,499	5,416	139	3,684	4,681	120	3,221
Mental Disorders (MDC 5)	290-319	94	2.7	2,742	29	415,023	413,245	151	4,407	313,656	114	3,539
Schizophrenic Disorders	295	11	0.3	463	44	65,966	65,755	142	6,186	37,634	81	4,195
Affective Psychoses	296	13	0.4	388	30	58,913	58,753	152	4,507	42,454	110	3,540
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	163	4.7	5,048	31	763,687	750,926	149	4,609	711,622	141	4,457
Parkinson's Disease	332	36	1.0	1,219	34	185,251	183,257	150	5,077	187,317	154	5,263

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 2011

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	987	28.5	28,578	29	$4,365,739	$4,287,894	$150	$4,345	$4,104,465	$144	$4,222
Essential Hypertension	401	300	8.7	7,537	25	1,097,637	1,089,670	145	3,629	1,047,905	139	3,570
Hypertensive Heart Disease	402	42	1.2	1,041	25	153,481	152,338	146	3,660	158,737	152	3,845
Acute Myocardial Infarction	410	20	0.6	338	17	53,777	53,423	158	2,723	51,661	153	2,648
Other Acute and Subacute Forms of Ischemic Heart Disease	411	3	0.1	47	18	6,895	6,851	147	2,705	6,499	139	2,606
Angina Pectoris	413	4	0.1	84	19	11,949	11,878	141	2,646	11,287	134	2,554
Other Forms of Chronic Ischemic Heart Disease	414	69	2.0	1,506	22	226,834	225,177	149	3,284	200,910	133	2,991
Cardiac Dysrhythmias	427	92	2.7	2,001	22	311,361	299,458	150	3,247	285,452	143	3,127
Heart Failure	428	260	7.5	6,562	25	1,006,079	994,250	152	3,821	932,972	142	3,618
Transient Cerebral Ischemia	435	5	0.1	104	21	15,522	15,413	148	3,092	15,203	146	3,084
Acute but Ill-Defined Cerebrovascular Disease	436	3	0.1	85	33	11,559	11,488	136	4,446	11,444	135	4,576
Other Peripheral Vascular Disease	443	13	0.4	325	25	48,853	46,579	143	3,643	42,825	132	3,383
Diseases of the Respiratory System (MDC 8)	460-519	324	9.3	7,258	22	1,109,487	1,095,519	151	3,385	1,096,335	151	3,418
Pneumonia, Organism Unspecified	486	67	1.9	1,087	16	174,222	172,585	159	2,574	174,138	160	2,611
Chronic Airway Obstruction, not Elsewhere Classified	496	36	1.0	839	23	122,038	120,645	144	3,352	109,067	130	3,091
Diseases of the Digestive System (MDC 9)	520-579	88	2.5	1,594	18	249,566	243,694	153	2,772	246,068	154	2,822
Diseases of the Genitourinary System (MDC 10)	580-629	105	3.0	2,098	20	317,285	309,174	147	2,937	304,788	145	2,918
Other Disorders of Urethra and Urinary Tract	599	69	2.0	1,250	18	191,643	187,443	150	2,702	191,093	153	2,768
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	229	6.6	7,515	33	1,234,019	1,123,550	150	4,904	1,002,525	133	4,404
Other Cellulitis and Abscess	682	67	1.9	1,421	21	236,552	222,424	157	3,319	204,986	144	3,078
Chronic Ulcer of Skin	707	154	4.4	5,790	38	950,323	856,153	148	5,571	757,428	131	4,959

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 2011

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	Amount 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	445	12.9	11,612	26	$1,703,723	$1,687,380	$145	$3,788	$1,926,705	$166	$4,377
Rheumatoid Arthritis and Other Inflammatory Polyarthropathies	714	19	0.5	572	30	81,058	80,198	140	4,236	82,611	145	4,428
Osteoarthrosis and Allied Disorders	715	138	4.0	3,333	24	475,090	472,227	142	3,425	549,849	165	4,046
Other and Unspecified Arthropathies	716	35	1.0	884	25	122,897	121,803	138	3,469	134,774	152	3,875
Other and Unspecified Disorders of Back	724	57	1.7	1,173	20	172,170	171,374	146	2,985	212,231	181	3,749
Other Disorders of Bone and Cartilage	733	12	0.3	442	37	59,581	58,978	134	4,919	47,012	106	4,005
Congenital Anomalies (MDC 14)	740-759	3	0.1	69	25	10,356	9,949	145	3,678	8,855	129	3,416
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	236	6.8	5,104	22	788,380	779,918	153	3,298	824,121	161	3,519
General Symptoms	780	58	1.7	1,139	20	176,733	175,620	154	3,054	171,607	151	3,023
Symptoms Involving Urinary System	788	15	0.4	339	23	54,131	51,686	153	3,515	44,260	131	3,040
Injury and Poisoning (MDC 17)	800-999	215	6.2	5,654	26	917,638	870,102	154	4,038	784,360	139	3,668
Fracture of Neck of Femur	820	2	0.1	49	24	7,137	7,085	143	3,475	7,774	157	3,848
Open Wound of Other and Unspecified Sites, Except Limbs	879	5	0.2	159	29	24,592	23,075	145	4,230	19,860	125	3,676
Open Wound of Knee, Leg (Except Thigh), and Ankle	891	28	0.8	738	27	119,284	112,302	152	4,065	101,140	137	3,677
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01-V91	1,233	35.6	23,927	19	3,858,339	3,789,657	158	3,074	4,470,650	187	3,650

[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.

[6]Less than 0.05 percent.

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 Standard Analytical Files; data development by the Office of Information Products and Data Analytics.