OASIS Diagnosis Reporting

Case Examples

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Purpose:

The primary objective of this document is to facilitate diagnosis reporting on the OASIS (effective October 1, 2003). The following case examples are intended to assist home health agencies in understanding correct diagnosis coding practices for Medicare Home health. CMS has summarized these policies within the "OASIS Implementation Manual", Attachment D to Chapter 8, which is located at the following web site.
http://www.cms.hhs.gov/oasis/usermanu.asp
Diagnosis Coding Principles for M0230/M0240 and M0245 (effective 10/01/2003), have been summarized here for your convenience.

<u>M0230</u>

The logic for determining the primary (first listed) diagnosis for M0230 remains unchanged under the Medicare home health perspective payment system (HH PPS). Determine the primary diagnosis based on the condition most related to the current plan of care. The diagnosis may or may not be related to a patient's recent hospital stay but must relate to the services rendered by the home health agency. If more than one diagnosis is treated concurrently, the diagnosis that represents the most acute condition and requires the most intensive services should be entered. Skilled services (skilled nursing, physical, occupational, and speech therapy) are used in judging the relevancy of a diagnosis to the plan of care and to OASIS item M0230.

If a patient is admitted for surgical aftercare, list the relevant medical diagnosis only if it is still applicable. If it is no longer applicable (e.g., the surgery eliminated the disease or the acute phase has ended), then a V code, such as for surgical aftercare, is generally appropriate as the primary diagnosis. The importance of this principle can be seen in the example of hospitalization for the surgical repair of a hip fracture. Coding guidelines stipulate that the acute fracture code may only 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

V codes cannot be used in case mix group assignment. Effective October1, 2003, if a provider reports a V code in M0230 in place of a case mix diagnosis, the provider has the option of reporting the case mix diagnosis in M0245. You must select the code(s) that would have been reported as the primary diagnosis under the original OASIS-B1 (8/2000) instructions that did not allow V codes.

M0240

In general M0240 coding principles are as follows:
- Secondary diagnoses are defined as "all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care of the patient."
- M0240 should include not only conditions actively addressed in the plan of care but also any co-morbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.
- Home Health Agencies should avoid listing diagnoses that are of mere historical interest and without impact on patient progress or outcome.

M0245

M0245 Payment Diagnosis code is an optional OASIS item that home health agencies may use if a V code is selected in M0230, Primary Diagnosis, according to ICD-9-CM coding guidelines. M0245 is intended to facilitate PPS payment operations effective October 1, 2003 when a V code may be required as the primary diagnosis in place of certain diagnosis codes used to determine the PPS case mix group.

(A). Complete M0245 if a V code has been reported in place of a home health PPS case mix diagnosis in M0230. A case mix diagnosis is a primary or first secondary diagnosis that determines the Medicare PPS case mix group. To complete M0245, you must select the code(s) that would have been reported as the primary diagnosis under the OASIS-B1 (8/2000) instructions:

- No surgical codes-list the underlying diagnosis.
- No V codes or E codes-list the relevant medical diagnosis.
- If the patient's primary home care diagnosis is coded as a combination of an etiology and a manifestation code, the etiology code should be entered in M0245 (a) and the manifestation code should be entered in M0245 (b).
- The Final Regulation for home health prospective payment, July 3,2000, includes the case mix diagnoses and is found at this web site: http://www.cms.hhs.gov/providers/hhapps/hhppsfr.asp

(B). Do not complete M0245 if a V code has been reported in place of diagnosis that is **not** a case mix diagnosis.

Please note: In the following case examples the Diagnoses are listed in correct order. The character "x" in a diagnosis code is a placeholder for an additional digit.

Section #1: Completion of M0245 is not indicated

(A): Primary Diagnosis is not a V-code AND not a case-mix diagnosis

Case#1: Diabetes as a secondary diagnosis: Medical hospital discharge with asthma management for a patient with mild dementia and diabetes.

A 72-year-old woman, recently discharged from the hospital after an exacerbation of her extrinsic asthma, was provided at discharge with a nebulizer to improve her medication management. Because she also has a mild senile dementia, skilled nursing services were ordered to teach her and her husband to utilize the nebulizer and to assure medication compliance. She will also be taught to use a home incentive spirometer to monitor her response to the medication. The nurse will also assure compliance with her other medications for hypertension and stable type two diabetes mellitus. Because her asthma medications include an inhaled corticosteroid, the physician asks the nurse to review the patient's logs of blood glucose.

OASIS Diagnosis Reporting Requirements:
M0230 (a), 493.00, extrinsic asthma:
 M0240 (b), 290.0, senile dementia, uncomplicated; M0240 (c): 250.00, diabetes mellitus without mention of complication; M0240 (d): 401.9 essential hypertension, unspecified. There is no need to complete M0245, because the patient's primary diagnosis, (493.00, extrinsic asthma), is not a V-code and is not a case mix diagnosis.

Discussion: Fifth digit of asthma code signifies with/without mention of status asthmaticus or acute exacerbation. The senile dementia precedes the other chronic conditions in the secondary diagnosis listing, because it more strongly influences the overall treatment plan. Diabetes is present and responsible for glucose-and medication-monitoring activities, but it is not the main reason for home health care and so it is listed as a secondary diagnosis lower down in the list.

Case #2: Diabetic patient with stasis ulcer

The patient is a 72-year-old female with chronic stasis ulcer of the leg, but she also has 3 diabetic toe ulcers at this time. Patient has chronic lower extremity edema, CHF, HTN. She has daily caregivers through the Medicaid program. The nurse is seeing her 3 times per week to change leg dressings (using Polymem and covering with stretch bandage), monitor/adjust medications, teach medication management, and teach caregivers to provide low sodium diet, keep leg elevated. The nurse hopes to teach a neighbor to change the dressing at least once per week. Physical therapy is ordered every other week for exercise, transfer training, and gait training. Patient ambulates minimally, only with close assist and walker. She needs assistance with all ADLs.

OASIS Diagnosis Reporting Requirements:
M0230 (a) 454.0, stasis ulcer of the leg;
M0240 (b) 250.80, diabetes with other specified manifestations;
M0240 (c) 707.15, diabetic ulcer of toe;
M0240 (d) 428.0 congestive heart failure;
M0240 (e) 401.9 hypertension
M0240 (f) V57.1, physical therapy
There is no need to complete M0245, because the patient's primary diagnosis, (454.0, stasis ulcer of the leg), is not a V-code AND is not a case mix diagnosis.

Discussion: The most intensive skilled service is provided to the leg dressing related to the stasis ulcer. The stasis ulcer is the appropriate principal/primary diagnosis rather than diabetic ulcer, since the documentation indicates she has a stasis ulcer. The diabetic toe ulcers are reported using the coding sequence 250.80, 707.15. Edema would not be coded and reported because it is integral to CHF. ICD-9-CM coding guidelines indicate that conditions integral to a diagnosis are not coded separately. The CHF and HTN are mentioned as secondary diagnoses because they contribute to the need for medication and physical therapy.

(B): Primary Diagnosis is a V code which does not replace a case mix diagnosis.

Breast Cancer Surgery Patient:

A 66-year-old left-handed woman is discharged from the hospital three days after a right modified radical mastectomy for breast cancer. Her only medications are oral tamoxifen and pain medications. Skilled nursing is prescribed for management of the surgical wound, which has a surgical drain not scheduled to be removed for several days. The patient lives alone and has residual dysfunction of her left arm due to monoplegia after a stroke. The nurse will also supervise the patient's performance of the exercises ordered to improve her shoulder range of motion on the affected side and to monitor for the development of lymphedema in her arm.

OASIS Diagnosis Reporting Requirements:
M0230 (a) V58.42, Aftercare Following Surgery for Neoplasm
M0240 (b) 174.9, malignant neoplasm of female breast, unspecified
M0240 (c) 438.31, late effects of cerebrovascular disease, monoplegia of upper limb
M0240 (d) V58.3, attention to surgical dressings and sutures
There is no need to complete M0245 because the patient's primary diagnosis,
(V 58.42, Aftercare Following Surgery for Neoplasm), is a V code which is not
replacing a case mix diagnosis.

Discussion:
Part A: Appropriate Primary and Secondary Diagnosis
The most intensive skilled service that is being provided to this patient is the skilled
home health treatment activity for the care of her surgical wound. Since the specific
focus of care for this patient is the result of the patient's recent surgery for breast
cancer, the patient's primary diagnosis is, V58.42, Aftercare following Surgery for
Neoplasm. ICD-9-CM coding guidelines stipulate that code V58.42 is sequenced
before the malignancy code, if the focus of care is aftercare which it is in this case.
Therefore, 174.9, malignant neoplasm of the female breast unspecified is the patient's
secondary diagnosis. Since code 174.9 is not a case mix diagnosis, M0245 does not
need to be completed, as a V code is not replacing a case mix diagnosis. In addition,
the breast cancer is not resolved, as evidenced by the tamoxifen treatment.
Part B: Selection of the appropriate code for the neoplasm
 The diagnosis of neoplasm will vary depending on the patient's type of neoplasm,
(i.e., ICD-9-CM code of 217 would be indicated if the neoplasm was determined to
be benign).
Part C: Selection of the order of placement for the remaining diagnoses.
 The diagnoses which follow will vary depending on the conditions that coexist at the
time the Patient's Plan of Care is established, or which have developed subsequently,
or that affect the treatment of care. These diagnoses are listed on the Plan of Care in
order to best reflect the seriousness of the patient's condition and to justify the
disciplines and services provided. The diagnosis responsible for the patient's
inability to perform the wound care, late effect of CVD, is reflected as a secondary
diagnosis. The patient may not necessarily have a physical inability to perform the
wound care, (i.e. if she is incapable of performing the procedure due to a learning
deficit or a refusal this requires documentation of the skilled nurse's attempts to teach
and the result of the teaching.) The fifth digit for late effects signifies dominant/non-
dominant/non-specified side.

Section #2: Completion of M0245 is indicated

Case #1: Diabetes with Postoperative Aftercare (provided by AHIMA)

A 64-year-old female was discharged from the hospital after undergoing a
surgical amputation of the right foot due to diabetic osteomyelitis. The patient

has type 11 diabetes. She was admitted to Home Health Care for wound care consisting of assessment for signs and symptoms of a wound infection, instruct patient and patient's husband on wound care, and dressing changes. She will also receive physical therapy to improve her gait.

OASIS Diagnosis Reporting Requirements:
M0230 (a), V58.78, Aftercare Following Surgery of the Musculoskeletal System, Not Elsewhere Classified.
M0240 (b), 250.80, Diabetes with Other Specified Manifestations
M0240(c), 731.8, Other Bone Involvement in Diseases Classified Elsewhere.
M0240 (d), 781.2, abnormality of gait
M0240 (e), V57.1, Physical Therapy
M0240 (f), V58.3, Attention to Surgical Dressings and Sutures.
There is a need to complete M0245 because V58.78, is a V code which is replacing a case mix diagnosis (250.80). In this case, the case mix diagnosis, diabetic osteomyelitis, requires multiple coding (250.80 and 731.8).
M0245 (a) 250.80 Diabetes with Other Specified Manifestations
M0245 (b) 731.8, Other Bone Involvement in Diseases Classified Elsewhere.

Discussion: As you can see from this example Diabetic Osteomyelitis is at the root of the patient's current problem which is the loss of the patient 's right foot by amputation. Diabetic Osteomyelitis is not a direct cause of the treatment need so it is not the primary diagnosis. The primary diagnosis which is associated with the most intensive skilled service provided to this patient is V58.78, Aftercare Following Surgery of the Musculoskeletal System.
Since an aftercare V-code is replacing a case mix diagnosis the agency would be expected to complete M0245 with the case mix diagnosis which in this case requires multiple coding (250.80, Diabetes with Other Specified Manifestations and 731.8, Other Bone Involvement in Diseases Classified Elsewhere).
Therefore, because the case mix diagnosis requires a manifestation code, the home health agency is expected to complete both M0245 (a) and M0245 (b) as stated above.

Case #2: Hip Fracture
 An 85-year-old female fell in her home, sustaining a left hip fracture. An open reduction with internal fixation was performed seven days ago. The patient was discharged home where her sister now cares for her. The patient is non-weight bearing on left lower extremity but can perform supervised pivot transfers with contact guard assist in and out of bed. The physician orders the agency to provide physical therapy for gait training and exercise three times per week for four weeks.

OASIS Diagnosis Reporting Requirements
M0230 (a), V57.1 physical therapy
M0240 (b), 781.2 abnormality of gait

M0240 (c), V54.13, aftercare for healing traumatic fracture of hip
There is a need to complete M0245 because the patient's primary diagnosis is a
V-code, (V57.1), which replaces a case mix diagnosis.
M0245 (a), 781.2, abnormality of gait

Discussion:
The most intensive skilled service that is being provided to this patient is the
skilled physical therapy services for gait training. V-57.1, physical therapy is
selected as this patient's primary diagnosis because her treatment is directed at
rehabilitation following her hip fracture and surgery. Coding guidelines stipulate
that the acute fracture code may only be used for the initial, acute episode of care.
The acute fracture code is no longer appropriate once the patient has been
discharged from the hospital to home health care. Abnormality of gait (781.2) was
selected as the first secondary diagnosis because it accurately describes this
patient's current condition and her need for therapy (technically, she no longer
has a hip fracture, which was resolved by the hospital surgical treatment) and
because the physician specified gait training.