OASIS Alert

Diagnosis Coding: GET READY FOR DIAGNOSIS CODING CHANGES EFFECTIVE JANUARY 1

Watch for V code overuse, CMS warns.

In the chaos of preparing for OASIS C, don't forget to focus some of your training on coding. Beginning Jan. 1, the old familiar OASIS items M0230, M0240, and M0246 will be renumbered and new instructions added.

The good news: There are very few changes in OASIS C from the current OASIS B-1 with regard to the diagnosis codes, beyond the renumbering, says **Judy Adams**, president and CEO of **Adams Home Care Consulting** in Chapel Hill, N.C.

Now, instead of reporting your principal diagnosis in M0240, you'll report it in M1020. You'll enter secondary diagnoses in M1022 and when it's appropriate to list an optional payment diagnosis, you'll place it in M1024.

Choose Secondary Diagnoses With Care

While the form structure hasn't changed much, OASIS C does offer some new advice for selecting accurate diagnosis codes. Secondary diagnoses should be "listed in the order to best reflect the seriousness of the patient's condition and justify the disciplines and services provided," the **Centers for Medicare & Medicaid Services** advises.

A renewed focus on proper sequencing may be behind the instruction to enter diagnoses in order "determined by the degree that they impact the patient's health and need for home healthcare, rather than the degree of symptom control."

CMS illustrates: If you are providing care for a patient with type 2 diabetes that is "controlled with difficulty" and a "poorly controlled" fungal toenail infection, you would sequence the diabetes first because the diabetes has a greater impact on the patient's health and need for home care, CMS says. You'll also want to make certain the diagnoses you report are pertinent to the care your agency is providing and aren't just conditions the patient may have had during his hospital stay. CMS will look at the skilled services your agency provides and how they are used to address your patients' diagnoses to judge whether you are reporting the right diagnosis codes. If you're reporting diagnoses that aren't linked to services you are providing, you could face added scrutiny.

Play it safe: Make sure all the comorbidities you list as secondary diagnoses are addressed in the plan of care, says **Lisa Selman-Holman**, consultant and principal of **Selman-Holman & Associates** and **CoDR -- Coding Done Right** in Denton, Texas.

Diagnosis coding guidance for home health states that you should code any condition that will impact the plan of care or rehabilitation prognosis, even if the condition requires no home health treatment itself. CMS still expects any condition you list to be documented on the comprehensive assessment and on the plan of care, however.

You may simply need to assess some diagnoses so that any complications are noted early and interventions can take place, Selman-Holman says. A goal may be to recognize complications of comorbidities and intervene in a timely manner.

Here's the Latest Word on V Codes

CMS still seems concerned with the number of V codes home health agencies report -- "... avoid assigning excessive V codes to the OASIS." Numeric diagnosis codes provide greater specificity than V codes, CMS emphasizes.

You can still report V codes as principal and secondary diagnosis codes in M1020 and M1022 when "a patient with a

resolving disease or injury requires specific aftercare of that disease or injury." For example, you would report a V code when providing aftercare for surgery.

Confusion over when to list the case mix code underlying a V code in M0246 ran rampant when CMS added this "payment diagnosis" column to the OASIS form. As M0246 makes way for M1024, CMS takes the opportunity to include clarification.

Requirement: With OASIS C, if you list a V code as the primary diagnosis in M1020, you can report the numeric case mix code that underlies the V code in the primary diagnosis line (a) of M1024, but only if one of the following conditions is met:

1. The V code replaces a numeric case mix diagnosis, and the numeric case mix diagnosis falls in the Diabetes, Skin 1-Traumatic wounds, burns, and post-operative complications, or Neuro 1-Brain disorders and paralysis PPS diagnosis groups.

2. The case mix diagnosis is resolved, so you cannot place it in M1024.

3. The case mix diagnosis is a fracture (traumatic or pathological) because coding guidelines restrict the fracture codes to settings providing active treatment; therefore, fracture codes cannot appear in M1020 or M1022.

No more severity rating:With OASIS C, CMS changes "severity rating" to "symptom control" -- a much better term for the intent, notes Adams. But there's no need to report symptom control for V codes even though you may have assigned a severity index to V codes in the past.

Fracture coding tip: Coding guidelines reserve the acute fracture code for use during the initial, acute episode of care, CMS says in the OASIS instruction. This is why the acute fracture code is no longer appropriate once the patient has been discharged from the hospital to home health care.

If you're coding for such a patient and a V code replaces the fracture code in either M1020 or M1022, you can list the acute fracture code in the corresponding spot of M1024.