Home Health PPS Update: Why Accurate Diagnosis Coding is More Important Than Ever

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Practical Tools for Seminar Learning

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The faculty has reported no vested interests or disclosures regarding this presentation.
**Faculty**

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**M. Therese Rode, RHIT, HCS-D**
Ms. Rode is senior coding manager with Inova VNA Home Health in Springfield, VA, where she is responsible for the oversight for the revenue cycle chart audit as well as coding audits. Ms. Rode's 18 years of HIM experience includes coding, privacy, and medical record management. Ms. Rode also authored the home health chapter for AHIMA's *Health Information Management Compliance: Guidelines for Preventing Fraud and Abuse, 4th edition*.

With introduction by:

**Mary St. Pierre, RN, BSM, MGA,** Vice President for Regulatory Affairs with the National Association for Home Care & Hospice where she serves to provide information and guidance about home health issues to providers on clinical, operational, and regulatory issues and represents home health interests before government agencies.
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Introduction

- CMS expansion of case-mix diagnoses
  - Basis
  - Impact
- Importance of accurate diagnosis selection and coding
  - Payment
  - Medical review
  - Future case-mix refinements

Introduction

- Where is CMS?
  - Update Appendix D
  - Sequencing guidance
  - Diagnosis and coding questions
- Considerations
  - Allegations of case-mix creep
  - Social & political implications
Objectives

- Why CMS made changes
- What has changed and what hasn’t
  - New case mix codes
  - New M0 questions
- The supply factor
- Impact on coding
- Basic Guidelines
- Proper sequencing

The Why

- Improve data
- To allow for more specificity
- As coding became more important in HH the coding began to reflect coding guidelines
- HI PAA Claims, Code and Transaction Set, 2003 and the birth of MO245
- No risk adjustment for V-Codes
- V-codes do not reflect severity
The Why

- To eliminate the “old exemption” (reporting 436/434.91)
- To capture co-morbidities that impact resource expenditure and not just primary or 1st secondary
- To prevent “gaming” the system and “case mix coding creep

Changes in Coding Requirements

Case mix codes have been expanded to cover 20 diagnostic categories instead of four

- Blindness
- Blood Disorders
- Neoplasms
- Diabetes
- Dysphagia*
- Gait Abnormality*
- Gastrointestinal
- Heart Disease
- Hypertension
Changes in Coding Requirements

- Neuro 1 – Brain disorders & paralysis
- Neuro 2 – Peripheral neuro disorders
- Neuro 3 – Stroke*
- Neuro 4 – Multiple Sclerosis*
- Ortho 1 – Leg disorders*
- Ortho 2 – Other ortho disorders*
- Psych 1 – Affective & other psychosis, depression
- Psych 2 – Degenerative & other organic psych disorders
- Pulmonary disorders
- Skin 1 – Traumatic wounds, burns & post op complications
- Skin 2 – Ulcers and other skin condition

* Diagnosis will not calculate points without additional specific diagnosis or Functional impairment

Changes in Coding Requirements

- Non-specific codes will have no point value where the specific codes under the same category will be assigned points
  - For example: Reporting 496 COPD will give you no points but reporting 493.20 chronic obstructive asthma with COPD could yield from 2-4 points
- M0245 will be replaced with M0246
- M0246 will allow for reporting multiple case mix codes (both in primary and secondary positions)
Changes in Coding Requirements

- HHRGs expanded from 80 to 153 HHRGs
- Utilization of a 4-equation model
- Diagnosis will have varying point values determined by primary or secondary, combination, episode equation, 22 case mix elements and therapy usage
- Points will be cumulative
  - Primary Diagnosis
  - Primary diagnosis and co-morbidities
    - Points assigned one time only per category

Changes in Coding Requirements

- MO175 is no longer factored into a case weight
  - Still required to report
- SCI C are no longer a billing option
- NRS (non-routine supplies) must be reported and supported
  - LUPAs not included for NRS payment
**Changes in Coding Requirements**

- M0825 is out and M0826 is in
  - Therapy thresholds have been expanded to included rate shifts at 6, 14, 20
  - M0826 MUST be reported even if no therapy is planned (then report 000)

- HH will now be required to report early or late episodes being assessed (M0110)
  - Early episodes = 1st and 2nd
  - Later episodes = 3rd or more

**Changes in Coding Requirements**

- M0826 will be used to determine Service Utilization Severity Level
- 4 equation models will be implemented
  - Equation is determined by episode (early/late) and therapy utilization (6, 14 and 20 visits)
- Regressive payment model for therapy visits beyond the 6, 14, 20 – provides payments for visits between the initial therapy thresholds.
  - Reduces the incentive for HH agencies to perform the magic “10” visits
Changes in Coding Requirements

- PPS system now mandates reporting according to the *Official Guidelines for Coding and Reporting*

- Diagnoses that do not follow the *Official Coding Guidelines for Coding and Reporting* have been eliminated from case mix points
  - Example: 434.9x, 410.91, 436

Changes in Coding Requirements

- The rule stipulates that “the new case mix system avoid, to the fullest extent possible, nonspecific or ambiguous ICD-9-CM codes”
- Codes that “represent general symptomatic complaints in the elderly population and codes that lack consensus for clear diagnostic criteria within the medical community.”

*Federal Register/ Vol. 72 No. 167/ Wednesday, August 29, 2007/ Rules and Regulations 49774, 49775*
Changes in Coding Requirements

- Diagnosis Selection will impact Non-Routine Supply Payment
  - 49 categories of diagnosis in combination with clinical OASIS items may contribute to NRS payment in addition to the clinical dimension score
  - NRS payment will be an additional payment added to the case mix calculated reimbursement.
    - Tracheostomy, cystostomy, urostomy, Gangrene, anal fissure, fistula or abscess; cellulitis & abscess; diabetic ulcers; malignant neoplasm of the skin; non-pressure/ non-stasis ulcers; other infection of the skin or subcutaneous tissue; traumatic wounds, operative complications, burns

Changes in Coding Requirements

Non Routine Supplies

- No longer bundled
- Need to be supported by
  - Diagnosis
  - Related M0 questions
    - Example: if 707.0x is reported in M0230 or M0240 then M0450 must identify the pressure ulcer
    - If M0550 is answered 1 or 2 then an ostomy must be reported in M0230 or M0240
  - Reporting the correct diagnosis will impact NRS payment
Changes in Coding Requirements

- Under the new HH PPS system there will be hundreds of diagnoses codes that will impact the Clinical Dimension
  - 3 V-Codes have been added to the case mix diagnosis codes
    - V55.0, Attention to Tracheostomy
    - V55.5, Attention to Cystostomy
    - V55.6 other artificial opening of the urinary tract

New MO Questions That Will Impact the HRRG:

- M0110 - Early or late episode
- M0246 - allows for multiple coding for both primary and secondary diagnosis
- M0826 - number of therapy visits for the episode which will determine where the episode will be grouped
New MO Questions That Will Impact the HRRG:

Clinical Domain

- Diagnosis - MO230/240/246
- Therapies - MO250
- Vision - MO390
- Pain - MO420
- Pressure Ulcers - MO450 & MO460
- Stasis Ulcers - MO476
- Surgical Wounds - MO488
- Dyspnea - MO490
- Bowel Incontinence - MO540
- Ostomy - MO550
- Injectable drugs - MO800*

* New MO question added

Clinical Domain Determinators

- Payments based on broad range of diagnoses reported
  - Both MO230 and MO240 now factor in the equation
  - Coordination is essential between diagnosis and clinical condition reported in the OASIS.
  - Consistency is the basis of payment under the Clinical Domain
New MO Questions That Will Impact the HRRG:

Functional Domain

- Dressing – MO650 or MO660
- Bathing – MO670
- Toileting – MO680
- Transferring – MO690
- Ambulation – MO700

New MO Questions That Will Impact the HRRG:

Service Utilization

- MO826 - point assignments will be based on the total predicted therapy visits
  - Therapy orders must be on the Plan of Care in order to report on the OASIS
SO HOW DO WE CODE IN THE NEW WORLD?

What stayed the same?

- Definition of Primary Diagnosis
  - “The principle diagnosis is the diagnosis most related to the current plan of treatment. It may or may be related to the patient’s most recent hospital stay, but must relate to the service the HHA rendered. If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition and requires the most intensive services.”
  - HIM-11 234.6
What stayed the same?

- Determining Primary Diagnosis
  - What is the purpose of the visit?
  - What patient condition requires the most intensive utilization of services?
  - What diagnosis is utilizing the most resources?
  - Do the ICD-9-CM Official Guidelines for Coding and Reporting direct the coding sequence
    - Etiology and manifestation or late effect coding guidelines
  - It is not about visit counting

What stayed the same?

- Definition of Secondary Diagnosis
  - “Include NOT ONLY conditions actively addressed in the POC 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”
    - Exclude any diagnoses that relate to an earlier episode which have no bearing on this POC
  - The Uniform Hospital Discharge Data Set item 11-b defines other diagnoses as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.”
**What stayed the same?**

- **Determining Secondary Diagnosis**
  - What other conditions are being treated?
  - Is there an additional resolving disease or injury?
    - Is a v-code required?
  - What co-morbidities does the patient’s have that may impact responsiveness to treatment AND rehabilitative prognosis?

**What stayed the same?**

- For reporting purposes the definition for “other diagnoses” is:
  - All conditions that
    - coexisted at the time the POC was established,
    - or which developed subsequently,
    - or that affect the treatment of care
What stayed the same?

CO-MORBIDITIES
- Some co-morbidities should always be reported:
- Impact or have the potential to impact care even if there is no documentation of actively treating
  - Diabetes
  - Hypertension
  - COPD
  - Asthma
  - Chronic diseases - MS, Parkinson’s, LUPUS
  - Alzheimer’s
  - Dementia
  - Blindness
  - PVD
  - CAD
  - Amputation Status
  - History of malignant neoplasm when care is directed at a current neoplasm

What stayed the same?

Diagnosis codes are assigned and sequenced according to the instructions in the ICD-9-CM manual and the ICD-9-CM Official Guidelines for Coding and Reporting.
What stayed the same?

• MO elements are consistent with diagnosis reported
  • If V58.81, Fitting and adjustment of vascular catheter is reported then MO250, patient received IV or Infusion therapy needs to be reported (but now the incentive to do it correctly is points)
  • If 369.xx, Blindness is reported in MO240 have we assessed MO390 correctly?
    • now the incentive to do it correctly = points

What stayed the same?

• MO elements are congruent from one assessment to the next
• MO elements do not contradict each other
• When multi-disciplines are involved input from all disciplines is necessary to accurately assign a score
What stayed the same?

- Coding Guidelines Sources
  - *ICD-9-CM Classification System* incorporates specific conventions/rules in the assignment of codes.
  - *ICD-9-CM Official Guidelines for Coding and Reporting*
    - Rules developed to accompany and compliment the conventions/guidelines in the classification system
  - *Coding Clinic*
    - Quarterly periodical published by the AHA.
    - Provides ongoing guidance
  - *The OASIS Implementation Manual, Chapter 8*

What stayed the same?

- The ICD-9-CM codes reported on the claim form must match (in the same sequence) the diagnosis reported on the OASIS form
- The sequence of the codes is the order that best reflect the seriousness of the patient’s condition and justifies the disciplines and services provided.
- Codes reported in M0245 (M0246) will not appear on the claim unless they are reported in M0240
What stayed the same?

- All codes reported on the OASIS (M0230, M0240 and M0245 (MO246)) should be documented on the patient’s Plan of Care in compliance with 42 CFR 484.18(a)
- Points are still scored in the Clinical, Functional, and Service Utilization Domain
- Assigning codes is the clinician’s decision

When to Use a V-Code

Four primary circumstances:
- Person not sick or whose diagnosis is not yet established
- Some problem or circumstance exists that impacts the patient’s health status but is not itself a current injury or illness.
  - Personal history of malignant neoplasm, etc.
- Person with resolving disease or chronic long-term condition encounters the health care system for specific aftercare
- For newborns to indicate birth status
When to Use a V-Code

• Care being rendered is other than a medical diagnosis
  • V53.6 Urinary Device
• If condition no longer exists
  • V10.3 Personal History of Breast CA
• Care is directed to aftercare of a surgical procedure
  • V58.42 Aftercare for surgery of Neoplasm

When to Use a Numeric Diagnosis Code

• Active condition is the focus of care
• A complication is the focus of care
• Exacerbation of a chronic condition
• When the condition was not resolved by they surgery
• Focus of care is the residual of a previous condition
• Focus of care is treatment of a burn or injury
**Basic Guidelines**

**Signs & Symptoms**

- Used when no definitive diagnosis has been established
- Signs & Symptoms that are an integral part of a disease are NOT assigned
- May assign if not associated routinely with a disease process
- May assign if instructed by another code
  - 438.82 instructs the coder to add additional code from category 787.20-787.29

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**Basic Guidelines**

**Acute and Chronic Conditions**

- If the same condition is described as both acute and chronic, unless coding guidelines instruct you to report a combination code
  - Code both
  - **Acute condition is sequenced first**
    - 577.0, Acute Pancreatitis
    - 577.1, Chronic Pancreatitis
  - **Combination code**
    - 491.21, Obstructive chronic bronchitis with acute exacerbation
Basic Guidelines

Late Effects

• Residual effect after the acute phase of an illness or injury has ended
• No time limit on when a late effect can be used
• Residual may occur early on (CVA with Hemi) or months/years later (due to previous injury)
• Generally requires 2 codes
  • Sequence the condition of the late effect first and the late effect code second
    - A patient with a diagnosis of hemiplegia due to polio at age 6 is now 55. 342.90, Hemiplegia, unspecified, and 138, Late effect of acute poliomyelitis

Basic Guidelines

Late Effects (continued)

• Exceptions:
  • If guidelines in the Tabular List instruct to code the late effect followed by the manifestation
    - Scoliosis due to childhood polio, 138 Late effects of acute poliomyelitis, followed by 737.43 Curvature of the spine associated with other condition.
  • The Late effect code has been expanded at the fourth and fifth digit to include the manifestation
    - 438.20, Late Effect, Hemiplegia, unspecified side
Basic Guidelines
Diabetes Mellitus

- Requires 5 digits
- If type is not documented default is type II
- Diabetes (250.xx) is sequenced before the manifestation
- Assign as many codes from category 250 as needed to identify all the associated conditions
  - Diabetic ulcer, lower leg and diabetic peripheral angiopathy: 250.8x, Diabetes w/ other specified manifestations, 707.10
  Ulcer, lower limb and 250.7x, Diabetes with peripheral circulatory disorders, 443.81, Peripheral angiopathy in diseases classified elsewhere
- If two manifestations from the same category are present code both
  - Diabetic retinopathy/ diabetic macular edema, 250.5x, 362.07
  - Diabetic macular edema, 362.01 diabetic retinopathy

Basic Guidelines
Diabetes Mellitus

- Miscellaneous Diabetic Guidelines:
  - Uncontrolled (250.x2 or 250.x3) Physician must document “uncontrolled”
  - Cannot be assumed based on Blood Sugar readings
  - V58.67, Reported only if the patient is Type 2 or unspecified and takes insulin on a regular basis
  - Not reported if Insulin is given temporarily to bring type II patient’s blood sugar under control during an encounter
  - Not reported for Type I diabetic
  - Assumed relationship:
    - If patient is diabetic and has Gangrene or Osteomyelitis ICD-9-CM assumes a correlation between the diabetes and the Gangrene and/or Osteomyelitis unless otherwise specified by the physician.
  - Avoid
    - 250.9x, Diabetes with unspecified complications - AVOID
**Basic Guidelines**

**CVA/ Strokes**

- HIPAA Code and Transaction Set, 2003
- HH exemption versus Official Coding Guidelines
- The exemption is officially rescinded
- “The conditions in categories 430 - 437 identify the cause of the initial onset of an acute stroke and must not be assigned in the home health setting.”
- No longer case mix - out goes 434.9x in comes 438.xx
- Strokes will be reported following the Official Guidelines for Coding and Reporting

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**Welcome - V57.1 as secondary diagnosis (again)**

- Re-instated as secondary diagnosis
- Instructions for use:
  - “Generally for use as first listed only but may be used as additional if patient has more than one encounter on one day or there is more than one reason for the encounter.”
  - Official Guidelines for Coding and Reporting, Effective October 1, 2007, page 74
V57.1

- MO230/ MO240
  - MO246 Report the underlying reason in which therapy is providing care if it is a case mix diagnosis.
  - Why is therapy treating the patient?

Let’s put coding into action!
### M0230/ M0240/ M0246

M0230/240/246 Diagnoses, Severity Index, 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). Rate each condition (Column 2) using the severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) V codes (for M0230 or M0240) or E codes (for M0240 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 M0246 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group.

Code each row as follows:

1. **(Column 1)**: Enter the description of the diagnosis.

2. **(Column 2)**:
   - Enter the ICD-9-CM code for the diagnosis described in Column 1;
   - Rate the severity of 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

3. **(OPTIONAL)** If a V code reported in any row in Column 2 is reported in place of a case mix diagnosis, list the appropriate case mix diagnosis (the description and the ICD-9-CM code) in the same row in Column 3. Otherwise, leave Column 3 blank in that row.

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-CM coding guidelines, enter the diagnosis descriptions and the ICD-9-CM 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-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.
**M0230/ M0240/ M0246**

<table>
<thead>
<tr>
<th>(M0230) Primary Diagnosis &amp; (M0240) Other Diagnoses</th>
<th>(M0246) Case Mix Diagnoses (OPTIONAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Description</td>
<td>(2) ICD-9-CM and severity rating for each condition</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(M0230) Primary Diagnosis</th>
<th>Description/ICD-9-CM</th>
<th>(M0240) Other Diagnoses</th>
<th>Description/ICD-9-CM</th>
<th>(M0246) Case Mix Diagnoses</th>
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<td>(V or E codes NOT allowed)</td>
<td>(V or E codes NOT allowed)</td>
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<td>b.</td>
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<td>(V or E codes are allowed)</td>
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<tr>
<td>c.</td>
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<td>(V or E codes are allowed)</td>
<td>(V or E codes are allowed)</td>
<td>(V or E codes are allowed)</td>
</tr>
</tbody>
</table>

**Determining Diagnosis Points**

- Table 2B to determine whether or not the diagnosis selected is a case mix diagnosis (If “Yes” then):
- Table 2A to determine if it meets conditions to acquire points
  - Although points are additive, points can only be received from the same line item one time
  - You will need to know the response to OASIS items M0110 and M0826
Determining Diagnosis Points (continued)

- Table 3 - Severity Group Definitions - The 4 equation Model
- Table 9 - Relative weights for NRS
- Table 10B - Diagnosis Included in the Diagnostic Categories for NRS Case-Mix Adjustment
- Table 10A - NRS Case-Mix Adjustment Variables and Scores
- Table 5 - Case-Mix Groups, Average Cost, Case-Mix Weight (link in Resources)

Duplicate Listing of Diagnosis

- Diagnosis may be listed in both 230/240 and in 246 per OASIS instructions
  - “If a V code is reported in place of a case mix diagnosis, then optional item M0246 Payment Diagnoses (Columns 3 and 4) may be completed.
  - A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group.”
    - OASIS Implementation Manual/Attachment B/p8.44
**Diabetes with Manifestations**

Patient admitted to home care with uncontrolled Type II diabetes and diminished visual acuity due to diabetic retinopathy; with multiple diabetic ulcers foot (heel, midfoot, toes) for which nursing is providing wound monitoring and dressing changes three times per week; patient is on long-term insulin.

**Diabetes with Manifestations**

*continued*

**BEFORE 1-1-08**

- **MO230** 250.82 Type II diabetes with other specified manifestation
- **MO240b** 707.14 Diabetic ulcer of heel and midfoot
- **MO240c** 250.52 Diabetes with ophthalmic manifestations
- **MO240d** 362.05 Moderate nonproliferative diabetic retinopathy
- **MO240e** V58.67 Long-term (current) use of insulin
- **MO240f** V58.30 Dressing changes (non-surgical)
- **MO245** N/A No V-Code in MO230
## Diabetes with Manifestations

### AFTER 1-1-08

<table>
<thead>
<tr>
<th>Primary Diagnosis &amp; Other Diagnoses</th>
<th>Case Mix Diagnosis (OPTIONAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
</tr>
<tr>
<td>ICD-9-CM and severity rating for each condition</td>
<td>Complete only if a V code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a complication code)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9-CM</th>
<th>Severity Rating</th>
<th>Description</th>
<th>ICD-9-CM</th>
<th>Severity Rating</th>
</tr>
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<tbody>
<tr>
<td>a. DM, type II, uncontrolled with other specified manifestation</td>
<td>(250.82)</td>
<td></td>
<td>(V or E codes NOT allowed)</td>
<td>a.</td>
<td>__________________</td>
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<tr>
<td>b. Diabetic ulcer of heel and midfoot</td>
<td>(707.14)</td>
<td></td>
<td>(V or E codes NOT allowed)</td>
<td>b.</td>
<td>__________________</td>
</tr>
<tr>
<td>c. DM, type II, with ophthalmologic manifestations</td>
<td>(250.82)</td>
<td></td>
<td>(V or E codes NOT allowed)</td>
<td>c.</td>
<td>__________________</td>
</tr>
<tr>
<td>d. Moderate nonproliferative diabetic retinopathy</td>
<td>(262.05)</td>
<td></td>
<td>(V or E codes NOT allowed)</td>
<td>d.</td>
<td>__________________</td>
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<tr>
<td>e. Long-term (current) use of insulin</td>
<td>(V58.67)</td>
<td></td>
<td>(V or E codes NOT allowed)</td>
<td>e.</td>
<td>__________________</td>
</tr>
<tr>
<td>f. Admission for dressing changes (nonsurgical)</td>
<td>(V58.30)</td>
<td></td>
<td>(V or E codes NOT allowed)</td>
<td>f.</td>
<td>__________________</td>
</tr>
<tr>
<td>g. Diabetes mellitus, type II, uncontrolled, with other specified manifestations</td>
<td>(250.82)</td>
<td></td>
<td>(V or E codes NOT allowed)</td>
<td>g.</td>
<td>__________________</td>
</tr>
<tr>
<td>h. Diabetic ulcer of heel and midfoot</td>
<td>(707.14)</td>
<td></td>
<td>(V or E codes NOT allowed)</td>
<td>h.</td>
<td>__________________</td>
</tr>
</tbody>
</table>

(see document in appendix)

### Aftercare Following Joint Replacement - Knee

Patient is being admitted to home health following a left total knee replacement due to osteoarthritis, localized, of the left knee. Orders for skilled nursing and physical therapy. Patient will also be receiving skilled nursing visits weekly for dressing changes as well as monitoring of his postoperative pain, which is not yet under control. Physical therapy is also ordered to treat his abnormal gait.
**Aftercare Following Joint Replacement - Knee** (continued)

**BEFORE 1-1-08**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>ICD-9-CM</th>
<th>Severity Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>MO230</td>
<td>Aftercare following joint replacement</td>
<td>V54.81</td>
<td></td>
</tr>
<tr>
<td>MO240b</td>
<td>Artificial joint knee</td>
<td>V43.65</td>
<td></td>
</tr>
<tr>
<td>MO240c</td>
<td>Abnormality of gait</td>
<td>781.2</td>
<td></td>
</tr>
<tr>
<td>MO240d</td>
<td>Other acute postoperative pain</td>
<td>338.18</td>
<td></td>
</tr>
<tr>
<td>MO240e</td>
<td>Encounter for change or removal of Surgical Wound Dressings</td>
<td>V58.31</td>
<td></td>
</tr>
<tr>
<td>MO245</td>
<td>Abnormality of Gait</td>
<td>781.2</td>
<td></td>
</tr>
</tbody>
</table>

59

**AFTER 1-1-08**

**Primary Diagnosis & Other Diagnoses**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>ICD-9-CM</th>
<th>Severity Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>MO230</td>
<td>Aftercare following joint replacement</td>
<td>V54.81</td>
<td></td>
</tr>
<tr>
<td>MO240b</td>
<td>Artificial joint knee</td>
<td>V43.65</td>
<td></td>
</tr>
<tr>
<td>MO240c</td>
<td>Abnormality of gait</td>
<td>781.2</td>
<td></td>
</tr>
<tr>
<td>MO240d</td>
<td>Other acute postoperative pain</td>
<td>338.18</td>
<td></td>
</tr>
<tr>
<td>MO240e</td>
<td>Encounter for change or removal of Surgical Wound Dressings</td>
<td>V58.31</td>
<td></td>
</tr>
<tr>
<td>MO245</td>
<td>Abnormality of Gait</td>
<td>781.2</td>
<td></td>
</tr>
</tbody>
</table>

59

(see document in appendix)
Attention to Colostomy

Patient is being admitted to the agency following hospitalization and surgery for CA of colon with new colostomy. Pathology report states residual carcinoma in wound edges and patient will receive chemotherapy as an outpatient for this problem. SN 3xwk for colostomy care teaching and assess med compliance.

Attention to Colostomy (continued)

BEFORE 1-1-08

MO230 V55.3 Attention to Artificial openings - Instruction & care of colostomy

MO240b V58.42 Aftercare following surgery for neoplasm

MO240c 153.9 Malignant neoplasm of colon

MO245 N/A because not a case-mix diagnosis
Attention to Colostomy

AFTER 1-1-08

<table>
<thead>
<tr>
<th>(M0230) Primary Diagnosis &amp; (M0240) Other Diagnoses</th>
<th>(M0246) Case Mix Diagnoses (OPTIONAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Description ICD-9-CM and severity rating for each condition</td>
<td>(2)</td>
</tr>
<tr>
<td><strong>(M0230) Primary Diagnosis</strong></td>
<td></td>
</tr>
<tr>
<td>a. Attention to colostomy</td>
<td>(V codes are allowed)</td>
</tr>
<tr>
<td></td>
<td>V55.3</td>
</tr>
<tr>
<td>b. Aftercare following surgery for neoplasm</td>
<td>(V or E codes are allowed)</td>
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<tr>
<td></td>
<td>V58.42</td>
</tr>
<tr>
<td>c. Malignant neoplasm of the colon</td>
<td>(V or E codes are allowed)</td>
</tr>
<tr>
<td></td>
<td>153.9</td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td></td>
</tr>
</tbody>
</table>

(see document in appendix)

CVA with Dysphagia

Patient is being admitted to home care following hospitalization and treatment for an acute stroke with resultant left-sided hemiparesis and dysphagia. Patient has decubitus ulcer, right ankle for which nursing has been ordered to do dressing changes. Orders for skilled nursing, physical therapy, and occupational therapy. OT has been ordered to help with swallowing and PT for gait training (each 3x/wk). Skilled nursing for dressing changes 2x/wk.
### CVA with Dysphagia

#### BEFORE 1-1-08

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>M0230</td>
<td>V57.89 Admission for multiple therapies</td>
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<tr>
<td>M0240a</td>
<td>787.20 Dysphagia</td>
</tr>
<tr>
<td>M0240b</td>
<td>342.90 Hemiplegia affecting unspecified side as a late effect of cerebrovascular disease</td>
</tr>
<tr>
<td>M0240c</td>
<td>781.2 Abnormal Gait</td>
</tr>
<tr>
<td>M0240d</td>
<td>707.06 Decubitus ulcer, right ankle</td>
</tr>
<tr>
<td>M0245a</td>
<td>434.91 Unspecified acute CVA</td>
</tr>
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</table>

#### AFTER 1-1-08

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>M0230</td>
<td>Admission for multiple therapies</td>
</tr>
<tr>
<td>M0240b</td>
<td>Hemiplegia affecting unspecified side as a late effect of cerebrovascular disease</td>
</tr>
<tr>
<td>M0240c</td>
<td>Abnormal Gait</td>
</tr>
<tr>
<td>M0245a</td>
<td>Decubitus ulcer, right ankle</td>
</tr>
</tbody>
</table>

### CVA with Dysphagia

(see document in appendix)
Conclusion

- Coding Rules have not changed
- Coding accuracy is crucial - it’s all about portraying the patients accurately
- Certified Coders will become a critical component of a HHA’s team
- Following the ICD-9-CM Official Guidelines for Coding and Reporting will help to achieve accurate data
- CMS is requiring more specificity

Conclusion

- System is more complex, but more accurately connects the impact of disease and resources utilized
- Allows for a more accurate portrayal of the patient
- Diagnosis reported must be supported by
  - The OASIS Assessment
  - Documentation contained in the medical record
- What we report today will impact any further refinement of HH PPS tomorrow
Resources

- **ICD-9-CM Official Guidelines for Coding and Reporting**

- **OASIS Implementation Manual**

- **Federal Register, CMS, August 29, 2007**
  - [http://www.access.gpo.gov/su_docs/fedreg/a070829c.html](http://www.access.gpo.gov/su_docs/fedreg/a070829c.html)

- **CMS Claims Processing Manual, Chapter 10**
  - Pub. 100-04

Useful Links Related to Coding

- **ICD-9-CM Diagnostic Coding for Long-Term Care and Home Care**, Charlotte Lefert, RHIA, and Ida Blevins, RHIA, AHIMA publication
  - [http://www.ahima.org/](http://www.ahima.org/)

- **HIM-11 (site no longer available)**
  - [http://www.cms.hhs.gov/manuals/11_hha/HH00.asp](http://www.cms.hhs.gov/manuals/11_hha/HH00.asp)

- **WOCN Guidance on OASIS Skin & Wound M0 Items**
Useful Links Related to Coding

- Pressure Ulcer Advisory Panel Info
  - http://www.npuap.org/pr2.htm

- CMS’s Home Health Information Resource for Medicare
  - http://www.cms.hhs.gov/providers/hha/

- Updated ICD-9-CM Codes for 10-2007

Useful Links Related to Coding

- CMS Web-based coding training

- Coding Clinic for ICD-9-CM
  - Submitting a coding question to the Central Office

- Home Health PPS Tables
  - http://www.cms.hhs.gov/HomeHealthPPS/05_CaseMixGrouperSoftware.asp
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www.AHIMA.org

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or sign on to MyAHIMA
AHIMA Member ID number and password required – for members only

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Personal Page then under Community Discussions
you will be able to:

NAHC Members may address questions for the NAHC
listserv to mts@nahc.org
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Diagnosis vs. V Code Coding Tool............................................................45
AHIMA Standards of Ethical Coding ..........................................................46
CE Certificate Instructions........................................................................47
Diabetes with Manifestations

Patient admitted to home care with uncontrolled Type II diabetes and diminished visual acuity due to diabetic retinopathy; with multiple diabetic ulcers foot (heel, midfoot, toes) for which nursing is providing wound monitoring and dressing changes three times per week; patient is on long-term insulin

PRIOR TO 1-1-08

<table>
<thead>
<tr>
<th>Code</th>
<th>ICD-9-CM</th>
<th>Diagnosis Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MO230</td>
<td>250.82</td>
<td>Type II diabetes with other specified manifestation</td>
</tr>
<tr>
<td>MO240b</td>
<td>707.14</td>
<td>Diabetic ulcer of heel and midfoot</td>
</tr>
<tr>
<td>MO240c</td>
<td>250.52</td>
<td>Diabetes with ophthalmic manifestations</td>
</tr>
<tr>
<td>MO240d</td>
<td>362.05</td>
<td>Moderate nonproliferative diabetic retinopathy</td>
</tr>
<tr>
<td>MO240e</td>
<td>V58.67</td>
<td>Long-term (current) use of insulin</td>
</tr>
<tr>
<td>M0240f</td>
<td>V58.30</td>
<td>Dressing changes (non-surgical)</td>
</tr>
<tr>
<td>MO245</td>
<td>N/A</td>
<td>No V-Code in MO230</td>
</tr>
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</table>

AFTER 1-1-08

<table>
<thead>
<tr>
<th>(M0230) Primary Diagnosis &amp; (M0240) Other Diagnoses</th>
<th>(M0246) Case Mix Diagnoses (OPTIONAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Description</td>
<td>(2) ICD-9-CM / Severity Rating</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(M0246) Case Mix Diagnoses (OPTIONAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete only if a V code in Column 2 is reported in place of a case mix diagnosis (e.g., a manifestation code).</td>
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</table>

<table>
<thead>
<tr>
<th>(M0230) Primary Diagnosis</th>
<th>(V codes are allowed)</th>
<th>(V or E codes NOT allowed)</th>
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</thead>
<tbody>
<tr>
<td>a. DM, type II, uncontrolled with other specified manifestation</td>
<td>(250.82)</td>
<td>a.</td>
</tr>
<tr>
<td>b. Diabetic ulcer of heel and midfoot</td>
<td>(707.14)</td>
<td>b.</td>
</tr>
<tr>
<td>c. DM, type II, with ophthalmologic manifestations</td>
<td>(250.52)</td>
<td>c.</td>
</tr>
<tr>
<td>d. Moderate nonproliferative diabetic retinopathy</td>
<td>(362.05)</td>
<td>d.</td>
</tr>
<tr>
<td>e. Long-term (current) use of insulin</td>
<td>(V58.67)</td>
<td>e.</td>
</tr>
<tr>
<td>f. Admission for dressing changes (nonsurgical)</td>
<td>(V58.30)</td>
<td>f.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(M0240) Other Diagnoses</th>
<th>(V or E codes are allowed)</th>
<th>(V or E codes NOT allowed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. DM, type II, uncontrolled with other specified manifestation</td>
<td>(250.82)</td>
<td>a.</td>
</tr>
<tr>
<td>b. Diabetic ulcer of heel and midfoot</td>
<td>(707.14)</td>
<td>b.</td>
</tr>
<tr>
<td>c. DM, type II, with ophthalmologic manifestations</td>
<td>(250.52)</td>
<td>c.</td>
</tr>
<tr>
<td>d. Moderate nonproliferative diabetic retinopathy</td>
<td>(362.05)</td>
<td>d.</td>
</tr>
<tr>
<td>e. Long-term (current) use of insulin</td>
<td>(V58.67)</td>
<td>e.</td>
</tr>
<tr>
<td>f. Admission for dressing changes (nonsurgical)</td>
<td>(V58.30)</td>
<td>f.</td>
</tr>
</tbody>
</table>
Aftercare following Joint Replacement - Knee

Patient is being admitted to home health following a left total knee replacement due to osteoarthritis, localized, of the left knee. Orders for skilled nursing and physical therapy. Patient will also be receiving skilled nursing visits weekly for dressing changes as well as monitoring of his postoperative pain, which is not yet under control. Physical therapy is also ordered to treat his abnormal gait.

BEFORE 1-1-08

MO230 – V54.81 Aftercare following joint replacement
MO240b – V43.65 Artificial joint knee
MO240c – 781.2 Abnormality of gait
MO240d - 338.18 Other acute postoperative pain
MO240e – V58.31 Encounter for change or removal of Surgical Wound Dressings

MO245 – 781.2 Abnormality of Gait

AFTER 1-1-08

<table>
<thead>
<tr>
<th>(M0230) Primary Diagnosis &amp; (M0240) Other Diagnoses</th>
<th>(M0240) Case Mix Diagnoses (OPTIONAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 1</td>
<td>Column 2</td>
</tr>
<tr>
<td>Description</td>
<td>ICD-9-CM and severity rating for each condition</td>
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<td>(V codes are allowed)</td>
<td>(V or E codes NOT allowed)</td>
</tr>
<tr>
<td>(M0230) Primary Diagnosis</td>
<td>(V or E codes NOT allowed)</td>
</tr>
<tr>
<td>a. Aftercare following joint replacement</td>
<td>a. Osteoarthritis, localized, left knee</td>
</tr>
<tr>
<td>b. Artificial joint knee</td>
<td>b. Abnormal gait</td>
</tr>
<tr>
<td>c. Abnormality of gait</td>
<td>c. Abnormal gait</td>
</tr>
<tr>
<td>d. Other acute postoperative pain</td>
<td>d. Encounter for change or removal of Surgical Wound Dressings</td>
</tr>
<tr>
<td>e. Encounter for change or removal of Surgical Wound Dressings</td>
<td></td>
</tr>
<tr>
<td>f. Encounter for Physical therapy</td>
<td>f. Abnormal gait</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Column 3</th>
<th>Column 4</th>
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<tbody>
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<td>(V or E codes NOT allowed)</td>
<td>(V or E codes NOT allowed)</td>
</tr>
<tr>
<td>(V or E codes NOT allowed)</td>
<td>(V or E codes NOT allowed)</td>
</tr>
</tbody>
</table>

Complete only if a V code in Column 2 is reported 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).

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).
## Attention to Colostomy

Patient is being admitted to the agency following hospitalization and surgery for CA of colon with new colostomy. Pathology report states residual carcinoma in wound edges and patient will receive chemotherapy as an outpatient for this problem. SN 3xwk for colostomy care teaching and assess med compliance.

- **MO230** V55.3  Attention to Artificial openings – Instruction & care of colostomy
- **MO240b** V58.42 Aftercare following surgery for neoplasm
- **MO240c** 153.9 Malignant neoplasm of colon
- **MO245** N/A because not a case-mix diagnosis

<table>
<thead>
<tr>
<th>(M0230) Primary Diagnosis &amp; (M0240) Other Diagnoses</th>
<th>(M0246) Case Mix Diagnoses (OPTIONAL)</th>
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<td>(1) (2)</td>
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<tr>
<td>Description</td>
<td>ICD-9-CM and severity rating for each condition</td>
</tr>
<tr>
<td><strong>(M0230) Primary Diagnosis</strong></td>
<td></td>
</tr>
<tr>
<td>a. Attention to colostomy</td>
<td>V55.3</td>
</tr>
<tr>
<td></td>
<td>(0 1 2 3 4)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(M0240) Other Diagnoses</strong></td>
<td></td>
</tr>
<tr>
<td>b. Aftercare following surgery for neoplasm</td>
<td>(V or E codes are allowed) b. (V58.42)</td>
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<td>(0 1 2 3 4)</td>
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<tr>
<td>c. Malignant neoplasm of the colon</td>
<td>(153.9)</td>
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<tr>
<td></td>
<td>(0 1 2 3 4)</td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0 1 2 3 4)</td>
</tr>
<tr>
<td>e.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0 1 2 3 4)</td>
</tr>
<tr>
<td>f.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0 1 2 3 4)</td>
</tr>
</tbody>
</table>
Patient is being admitted to home care following hospitalization and treatment for an acute stroke with resultant left-sided hemiparesis and dysphagia. Patient has decubitus ulcer, right ankle for which nursing has been ordered to do dressing changes. Orders for skilled nursing, physical therapy, and occupational therapy. OT has been ordered to help with swallowing and PT for gait training (each 3x /wk). Skilled nursing for dressing changes 2x /wk.

**PRIOR TO 1-1-08**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>M0230</td>
<td>Admission for multiple therapies</td>
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<tr>
<td>M0240a</td>
<td>Dysphagia</td>
</tr>
<tr>
<td>M0240b</td>
<td>Hemiplegia affecting unspecified side as a late effect of cerebrovascular disease</td>
</tr>
<tr>
<td>M0240c</td>
<td>Abnormal Gait</td>
</tr>
<tr>
<td>M0240d</td>
<td>Decubitus ulcer, right ankle</td>
</tr>
<tr>
<td>M0245a</td>
<td>Unspecified acute CVA</td>
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</table>

**AFTER 1-1-08**

<table>
<thead>
<tr>
<th>(M0230) Primary Diagnosis</th>
<th>(M0240) Other Diagnoses</th>
<th>(M0246) Case Mix Diagnoses (OPTIONAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 1</td>
<td>Column 2</td>
<td>Column 3</td>
</tr>
<tr>
<td>Description</td>
<td>ICD-9-CM /</td>
<td>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). Column 4</td>
</tr>
<tr>
<td>(M0230) Primary Diagnosis</td>
<td>(V codes are allowed)</td>
<td>(V or E codes NOT allowed)</td>
</tr>
<tr>
<td>a. Encounter for multiple therapies</td>
<td>(V57.89 )</td>
<td>a. Dysphagia as late effect of cerebrovascular disease (438.41 )</td>
</tr>
<tr>
<td>(M0240) Other Diagnoses</td>
<td>(V or E codes are allowed)</td>
<td>(V or E codes NOT allowed)</td>
</tr>
<tr>
<td>b. Dysphagia as late effect of cerebrovascular disease</td>
<td>(438.41 )</td>
<td></td>
</tr>
<tr>
<td>c. Dysphagia</td>
<td>(787.20 )</td>
<td></td>
</tr>
<tr>
<td>d. Hemiplegia affecting unspecified side as a late effect of CVD</td>
<td>(438.20 )</td>
<td></td>
</tr>
<tr>
<td>e. Abnormal Gait</td>
<td>(781.2)</td>
<td></td>
</tr>
<tr>
<td>f. Decubitus ulcer, right ankle.</td>
<td>(707.06)</td>
<td></td>
</tr>
</tbody>
</table>
**CODING TOOL**

**Medical Diagnosis vs. V Code**

<table>
<thead>
<tr>
<th>Medical Diagnosis</th>
<th>V-Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Identifies the patient’s acute disease, condition, complication, late effect or symptom</td>
</tr>
<tr>
<td><strong>ICD-9-CM Official Guidelines for Coding and Reporting, October 1, 2007</strong></td>
<td>The condition, after study, to be chiefly responsible for occasioning the admission of the patient to home health for care…. All conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of the stay.</td>
</tr>
<tr>
<td><strong>Code</strong></td>
<td>Disease and injury codes are classifiable to the main part of the ICD-9-CM codes 001-999 Report the acute condition if it is the focus of care. (conditions classifiable to the main part of the ICD-9-CM codes 001-999) Code all conditions that coexist at the time of the encounter, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. A diagnosis/symptom code should be used whenever a current, acute, diagnosis is being treated or a sign or symptom in being studied. Medical Diagnosis are (conditions classifiable to the main part of the ICD-9-CM codes 001-999)</td>
</tr>
<tr>
<td><strong>Determination</strong></td>
<td>Is the patient being treated for a current medical condition? Is the patient being treated for a late effect or residual of a previous condition? Is the condition a complication of a previous procedure/condition? Is the patient being treated for a burn? Is the patient being treated for a wound or ulcer? Is the patient being treated for a symptom which is not inherent in a condition reported?</td>
</tr>
<tr>
<td><strong>Key Words</strong></td>
<td>The reported condition (pneumonia, lymphoma, MI, Diabetes) Infection, obstruction, Hypertension Treatment is focused of the disease, injury or condition</td>
</tr>
</tbody>
</table>
Standards of Ethical Coding

In this era of payment based on diagnostic and procedural coding, the professional ethics of health information coding professionals continue to be challenged. A conscientious goal for coding and maintaining a quality database is accurate clinical and statistical data. The following standards of ethical coding, developed by AHIMA's Coding Policy and Strategy Committee and approved by AHIMA's Board of Directors, are offered to guide coding professionals in this process.

1. Coding professionals are expected to support the importance of accurate, complete, and consistent coding practices for the production of quality healthcare data.
2. Coding professionals in all healthcare settings should adhere to the ICD-9-CM (International Classification of Diseases, 9th revision, Clinical Modification) coding conventions, official coding guidelines approved by the Cooperating Parties,* the CPT (Current Procedural Terminology) rules established by the American Medical Association, and any other official coding rules and guidelines established for use with mandated standard code sets. Selection and sequencing of diagnoses and procedures must meet the definitions of required data sets for applicable healthcare settings.
3. Coding professionals should use their skills, their knowledge of currently mandated coding and classification systems, and official resources to select the appropriate diagnostic and procedural codes.
4. Coding professionals should only assign and report codes that are clearly and consistently supported by physician documentation in the health record.
5. Coding professionals should consult physicians for clarification and additional documentation prior to code assignment when there is conflicting or ambiguous data in the health record.
6. Coding professionals should not change codes or the narratives of codes on the billing abstract so that meanings are misrepresented. Diagnoses or procedures should not be inappropriately included or excluded because payment or insurance policy coverage requirements will be affected. When individual payer policies conflict with official coding rules and guidelines, these policies should be obtained in writing whenever possible. Reasonable efforts should be made to educate the payer on proper coding practices in order to influence a change in the payer's policy.
7. Coding professionals, as members of the healthcare team, should assist and educate physicians and other clinicians by advocating proper documentation practices, further specificity, and resequencing or inclusion of diagnoses or procedures when needed to more accurately reflect the acuity, severity, and the occurrence of events.
8. Coding professionals should participate in the development of institutional coding policies and should ensure that coding policies complement, not conflict with, official coding rules and guidelines.
9. Coding professionals should maintain and continually enhance their coding skills, as they have a professional responsibility to stay abreast of changes in codes, coding guidelines, and regulations.
10. Coding professionals should strive for optimal payment to which the facility is legally entitled, remembering that it is unethical and illegal to maximize payment by means that contradict regulatory guidelines.

Revised 12/99

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