Medicare Home Health Diagnosis Coding

Revised operational ICD-9-CM guidelines have been issued for several aftercare V-codes, effective 12/1/05. A few changes have been made to the V-Code Table in the updated version of the ICD-9-CM Official Guidelines for Coding and Reporting, so this table should be reviewed carefully to identify V-Codes that have moved to a different section within the table. Those codes that have moved are underlined**,** for example, the V57 codes have moved from the "First or Additional" section to the "First Listed Only" section of the V Code Table. This means that the V57 codes may only be reported as a primary diagnosis. ***http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm*** **It is important to note that the general diagnosis coding principles and coding issues specific to M0230/M0240 and M0245 as stipulated in the "*OASIS Implementation Manual*" (Attachment D, Chapter 8) have not changed**.

Selection of Primary Diagnosis:
The logic for determining the primary (first listed) diagnosis remains unchanged under the revised guidelines. Home health providers are expected to continue to 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 HHA. 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.

Selection of Secondary Diagnosis:
The general diagnosis coding principles and coding issues specific to secondary diagnoses or M0240 remains unchanged under the revised guidelines. Secondary diagnoses located in M0240 remain 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." In general, M0240 should include not only conditions actively addressed in the patient's plan of care but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself. Agencies should avoid listing diagnoses that are of mere historical interest and without impact on patient progress or outcome **as well as V-Codes that may only be utilized as primary diagnosis codes.**

V Code General Principles:
The use of V codes is governed by the ICD-9-CM Official Guidelines for Coding and Reporting. Therefore if the patient has an acute condition relevant to the plan of care, continue to report the code for the acute condition. Whether it is listed as a primary or secondary diagnosis depends on the focus of care indicated on the patient's plan of care. V codes are intended to deal with circumstances other than the diseases or injuries classifiable to the main part of the ICD-9-CM codes 001-999). For example, V-codes are recorded as reasons for encounters with a health care provider. V-codes may be used as the primary or secondary diagnoses. It is important to note that the major use of V-codes

in the home health setting occurs when a person with current or resolving disease or injury encounters the health care system for specific aftercare of that disease or injury. If there is a complication of medical or surgical care, such as infection or wound dehiscence, select a code specific to either condition rather than a V-code. For example, codes for surgical complications are available within Chapter 17 of the ICD-9-CM coding guidelines and elsewhere.