Alternate Health Care Facilities and Coding Guidelines

Alternate health care settings require reporting of codes for insurance and reimbursement purposes, such as:

- Behavioral health care facilities
- Hospice inpatient care facilities
- Long-term care facilities (LTCFs)

Coding guidelines for alternate health care settings were established by the Centers for Medicare & Medicaid Services to include:

- Long-term care coding guidelines
- Home health care coding guidelines
- Hospice outpatient care coding guidelines

Behavioral Health Care Facilities

Behavioral health care includes mental health (or psychiatric) services that are provided in health care settings that range from least restrictive (e.g., outpatient weekly psychotherapy) to most restrictive (e.g., year-round residential treatment). The types of inpatient behavioral health care settings include:

- **Behavioral health crisis services**: Provides short-term, usually fewer than 15 days, crisis intervention and treatment; patients receive 24-hour-per-day supervision.

- **Behavioral health residential treatment facility**: Seriously disturbed patients receive intensive and comprehensive psychiatric treatment on a long-term basis.

- **Behavioral health respite care**: Care is provided by specially trained individuals at a setting other than the patient’s home to offer relief and rest to primary caregivers.

- **Chemical dependency program**: Provides 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting. Treatment services usually include drug and alcohol detoxification, withdrawal management, chemical dependency and substance abuse treatment programs, and individual needs and medical assessments.

- **Developmentally disabled/mentally retarded facilities**: Sometimes categorized as an intermediate care facility, or ICF, these facilities provide residential care and day programming, including academic training, clinical and technical assistance, health care services, and diagnosis and evaluation of individuals with developmental disabilities.

- **Psychiatric hospital treatment**: Patients receive comprehensive psychiatric treatment on an inpatient basis in a hospital, and the length of treatment varies.
Hospice Inpatient Care Facilities

Hospice care provides comprehensive medical and supportive social, emotional, and spiritual care to terminally ill patients and their families; and it is often provided by a Medicare-approved public agency or private company. All age groups, including children, adults, and the elderly, are eligible for hospice care during their final stages of life. Most hospice patients have cancer, although a growing number of hospice patients have end-stage heart, lung, kidney, neurological, or liver disease; HIV/AIDS; stroke; Alzheimer’s disease; or other conditions. The hospice team consists of doctors, nurses, social workers, clergy, and volunteers who coordinate an individualized plan of care for each patient and family. Hospice care allows every person and family to participate fully in the final stages of life.

The goal of hospice is palliative (interdisciplinary pain control and symptom management) rather than curative (therapeutic). Hospice palliative care includes all care for which the primary goal of treatment is providing comfort rather than curing a person with advanced disease that is life-limiting and refractory to disease-modifying treatment; this includes providing bereavement (grief) counseling services to the patient’s family. Hospice and palliative care collectively represent a continuum of comfort-oriented and supportive services provided in home, community, or inpatient settings for people in the advanced stages of an incurable disease. Although most hospice care is provided in the home (e.g., hospice home health care), patients are also eligible to receive respite care on an inpatient basis at a hospital or a hospice facility. Respite care offers relief and rest to primary caregivers, and it includes the following:

- Caring for patients who do not have a primary caregiver or whose caregiver is unable to manage the patient at home
- Controlling and managing pain and other symptoms (e.g., nausea, seizures, respiratory distress, complicated wound dressings)
- Managing acute psychosocial crises that result in an inability to care for the patient at home
- Teaching home care skills to patients and/or caregivers to prepare for discharge to the home or to an extended care facility

Medicare authorizes hospice as “periods of care,” and a hospice patient is eligible for two 90-day periods followed by an unlimited number of 60-day periods. At the beginning of each period of care, the hospice medical director or another hospice physician recertifies the patient as terminally ill so hospice care can continue. A period of care starts the day the patient begins to receive hospice care, and it ends when the 90-day or 60-day period ends. A patient can receive hospice care as long as his or her doctor and the hospice medical director or another hospice physician certifies that the patient is terminally ill and probably has six months or less to live if the disease runs its normal course. If the patient lives longer than six months, the patient still receives hospice care as long as the hospice medical director or another hospice physician recertifies that the patient is terminally ill.

**EXAMPLE:** Mrs. Jones has terminal cancer, and she had received hospice care for two 90-day periods of care when her cancer went into remission. At the start of her 60-day period of care, Mrs. Jones and her physician decided that, due to her remission, she wouldn’t need to return to hospice care at that time. Mrs. Jones’ doctor told her that if she becomes eligible for hospice services in the future, she can be recertified and return to hospice care.

Long-Term Care Facilities (LTCFs)

Long-term care facilities (LTCFs) provide a variety of nursing, rehabilitative, and social services for people who need ongoing assistance. Lengths of stay typically average greater than 30 days (and in some facilities, the LOS is years). While most residents of LTCFs are elderly, young people also need long-term care during an extended illness or after an accident. LTCFs provide a range of services including custodial, intermediate, rehabilitative, and skilled nursing care.
Alternate Health Care Facilities and Coding Guidelines

**Adult day care** provides care and supervision in a structured environment to seniors with physical or mental limitations. Most centers are located in assisted living facilities, churches, freestanding facilities, hospitals, or nursing facilities (NFs). Some centers specialize in caring for those with certain diseases, such as Alzheimer’s disease. Adult day care staff members usually include an activity director, a nurse, and a social worker and depend on volunteers to run many activities.

An **assisted living facility** (ALF) is a combination of housing and supportive services including personal care (e.g., bathing) and household management (e.g., meals) for seniors. Assisted living residents pay monthly rent and additional fees for services they require. An ALF is not a nursing facility (NF), and it is not designed for people who need serious medical care. An ALF is intended for adults who need some help with activities such as housecleaning, meals, bathing, dressing, or medication reminders and would like the security of having assistance available on a 24-hour basis in a residential environment. While dementia care facilities and Alzheimer treatment facilities have many of the same characteristics as ALFs, there is more extensive monitoring of residents and day-to-day care. Often, these facilities are associated with assisted living facilities, usually as a separate building or unit, and cost is higher than for assisted living (but lower than for nursing facility care).

**Board and care homes** (or boarding homes) are group living arrangements designed to meet the needs of people who cannot live independently, but who do not require nursing facility services. These homes offer a wider range of services than assisted living facilities, and most provide help with activities of daily living (ADL) (e.g., eating, walking, bathing, toileting, etc.). In some cases, private long-term care insurance and medical assistance programs will help pay for board and care home services.

A **Continuing Care Retirement Community** (CCRC) provides different levels of care based on the residents’ need—from independent living apartments to skilled nursing care in an affiliated nursing facility (NF). Residents move from one setting to another based on their needs, but continue to remain a part of their CCRC community. Many CCRCs require a large down payment prior to admission, and they bill on a monthly basis.

An **Intermediate care facility** (ICF) provides the developmentally disabled with medical care and supervision, nursing services, occupational and physical therapies, activity programs, educational and recreational services, and psychological services. ICFS also provide assistance with activities of daily living (ADL), including meals, housekeeping, and assistance with personal care and medications. ICFs are state-licensed and federally certified, which allows them to receive reimbursement from Medicare and Medicaid. Licensure confirms that health care facilities have met minimum standards of services and quality in compliance with state law and regulations. Federal certification measures the ability of health care facilities to deliver care that is safe and adequate in accordance with federal law and regulation.

Long-term care hospitals (LTCHs) are defined in the Medicare law as “hospitals that have an average inpatient LOS greater than 25 days.” They typically provide extended medical and rehabilitative care (e.g., comprehensive rehabilitation, cancer treatment) for patients who are clinically complex and may suffer from multiple acute or chronic conditions.

A **residential care facility** (RCF) provides nonmedical custodial care, which can be provided in a single family residence, in a retirement residence, or in any appropriate care facility including a nursing home. RCFs are not allowed to provide skilled services (e.g., injections, colostomy care); but they can provide assistance with activities of daily living (ADL), which include bathing, dressing, eating, toileting, and walking. This type of care is called custodial care because there is no health care component and because the care may be provided by those without medical skills or training. (Medicare does not reimburse the RCF level of care.)

A **skilled nursing facility** (SNF) (or nursing facility, NF) provides medically necessary care to inpatients on a daily basis that is performed by or under the supervision of skilled medical personnel. SNFs provide IV therapy, rehabilitation (e.g., physical therapy, speech therapy), and wound care services. Patients are often transferred from acute care facilities to the SNF if they need continuing medical care and are not well enough to return home or they cannot tolerate the requirements of a rehabilitation facility. After receiving care in the SNR, a patient may be transferred to a rehabilitation facility or home. (Medicare pays for up to 100 days of skilled nursing care in a SNF during a benefit period, but there are special eligibility requirements.)
A long-term care rehabilitation facility provides services to patients who have experienced a recent decline in function, often due to a stroke or a head or spinal cord injury. Intensive medical rehabilitation is provided by specially trained health care professionals; and these facilities can be located in an ACF or NF, or they can be freestanding. Patients must be willing and able to tolerate their rehabilitation treatment plan, and they must make progress to remain in this type of facility. Patients are transferred to rehabilitation care from acute, post-acute, or skilled care or from home.

Long-Term Care Coding Guidelines

Long-term care coding guidelines developed and approved by the cooperating parties in conjunction with the Editorial Advisory Board for Coding Clinic standardize the process of data collection for long-term care and assist the coder in assigning and reporting codes. According to Coding Clinic, diagnoses documented in long-term care patient records are dynamic, are dependent upon many factors, and have a longer time frame than an acute care hospital stay. ICD-9-CM (or ICD-10-CM) codes are assigned to diagnoses upon admission; concurrently as diagnoses arise; and at the time of discharge, transfer, or expiration of the resident. ICD-9-CM (or ICD-10-CM) codes for other diagnoses present (e.g., chronic conditions) that affect the resident’s continued care are also assigned.

UHDDS definitions have been expanded to include all nonoutpatient settings (e.g., acute care, home health, nursing facilities, rehabilitation facilities, short-term care, long-term care, and psychiatric hospitals). This includes the UHDDS definition of principal diagnosis: “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.” For long-term care facilities, that definition is expanded to include “or continued residence in the nursing facility.”

EXAMPLE 1: A patient is admitted from an acute care hospital to a LTCF due to the residual effects of a cerebrovascular accident (CVA). Assign a code from category 438, late effects of cerebrovascular disease.

EXAMPLE 2: A patient is transferred to a LTCF for physical therapy following acute care hospitalization for treatment of an acute pelvic fracture. Assign code V57.1 (Other physical therapy) as the first-listed code and assign code V54.89 (Other orthopedic aftercare) as an additional diagnosis code. Do not assign a code to the acute pelvic fracture because it was treated during the acute care hospitalization.

EXAMPLE 3: A LTCF resident develops a UTI due to E. coli, which is treated and resolved during his stay. Assign codes 599.0 (Urinary tract infection, site unspecified) and 041.4 (E. coli infection) because this diagnosis is considered part of the resident’s active problem list until the infection is resolved. Once resolved, do not assign a code for the condition.

EXAMPLE 4: A resident returns to the LTCF following acute care hospitalization for pneumonia. The hospital physician’s orders state, “continue intravenous antibiotics for three days,” and “repeat chest x-ray to determine status of the pneumonia.” Assign a code for the pneumonia. If the physician does not identify a causal organism (e.g., staphylococcus, streptococcus, pseudomonas), assign code 486 (Pneumonia, organism unspecified) until the condition is resolved, after which the condition is no longer coded and reported.

(Permission to reuse explanation and examples above granted by the American Hospital Association.)

Note:

Do not confuse LTCFs (e.g., SNFs) with LTACHs. Residents of LTCFs have lengths of stay of months and years, while LTACH lengths of stay average 25 days (or more).

Reporting Diagnoses and Procedures/Services

NFs report ICD-9-CM (or ICD-10-CM) diagnosis codes for residents on the UB-04 and as part of the MDS (Figure 1) on an RAI as required by the SNF PPS. Frequency of reporting codes is as follows:

- Admission or readmission of resident (When a resident of the NF is admitted, readmitted, or transferred from an acute care hospital stay, the record is reviewed and ICD-9-CM or ICD-10-CM codes are assigned to diagnoses.)
Quarterly, per the MDS schedule (Each NF resident’s record is reviewed at least quarterly each year to coincide with the reporting of MDS data.)

Discharge (When the NF resident is discharged or expires, ICD-9-CM or ICD-10-CM codes are assigned to diagnoses for statistical analysis to generate data for the disease index.)

According to the Resident Assessment Instrument User’s Manual published by the CMS, ICD-9-CM (or ICD-10-CM) diagnosis codes reported as part of the MDS should be related to the resident's current ADL status, cognitive (thought process) status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. In general, these are conditions that formulate the resident's current care plan. The diseases and conditions coded and reported require a physician-documented diagnosis in the clinical record, and it is good clinical practice to have the resident's physician provide supporting documentation for any diagnosis. Conditions that have been resolved or that no longer affect the resident's functioning or care plan are not coded and reported.

When submitting the UB-04 claim to a third-party payer, the NF reports ICD-9-CM (or ICD-10-CM) codes for diagnoses. (Some NFs report ICD-9-CM or ICD-10-PCS procedure codes.) Physicians and other providers, such as
as physical therapists, submit a CMS-1500 claim and report ICD-9-CM (or ICD-10-CM) codes for diagnoses and CPT/HCPCS codes for professional services provided to nursing facility residents.

Note:

In some NFs, clinical staff and physicians neglect to update the list of a resident’s “active” diagnoses, and there is a tendency to continue to document “old” diagnoses that are resolved or that are no longer relevant to the resident’s plan of care. One of the Important functions of the MDS assessment is to generate an updated, accurate picture of the resident’s health status.

When a Medicare patient has exhausted his or her Part A coverage (maximum of 100 days), the NF submits a bill to the MAC for Medicare Part B services and it reports ICD-9-CM (or ICD-10-CM) codes for diagnoses and CPT/HCPCS codes for procedures and services. The resident and/or family is responsible for reimbursing the NF for room and board charges unless the resident is eligible for Medicaid or some other health insurance program. Because the patient remains a nursing facility resident (even when ineligible for Medicare Part A), physicians and other providers submit a CMS-1500 claim (to Medicare Part B) and report ICD-9-CM (or ICD-10-CM) codes for diagnoses and CPT/HCPCS codes for professional services provided to nursing facility residents.

Make sure you assign ICD-9-CM (or ICD-10-CM) codes to diseases or infections that have a relationship to the resident’s current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. The resident’s physician is responsible for listing diagnoses in the patient record and for providing supporting documentation for any diagnosis listed. Conditions that have been resolved or that no longer affect the resident’s functioning or care plan are not coded and reported to the MAC. Therefore, it is important that long-term care clinical staff and physicians update the list of a resident’s active diagnoses.

Coding Tip:

- Acute care hospital lengths of stay are shorter, and patients are routinely transferred to LTCFs (e.g., SNFs) before their illness or Injury has completely resolved. If a LTCF resident is being treated for an active condition, assign an ICD-9-CM (or ICD-10-CM) code to that condition. Residents are commonly treated for the residuals or late effects of an illness or Injury, which should be property coded. A late effect is the residual condition that remains after the acute phase of an illness or Injury has ended. Late effects include conditions documented as sequelae of a previous illness or injury. For example, when a patient is admitted to a nursing home due to residual effects of a CVA, assign a code from ICD-9-CM category 438 (Late effects of cerebrovascular disease), or ICD-10-CM category 169 (Sequelae of cerebrovascular disease).
- Late effect and V codes are commonly assigned as the first-listed diagnosis code for LTCF residents. Patients are transferred to LTCFs after the acute phase of an illness or injury has ended because they need continued care and/or therapy (e.g., physical, occupational, and speech therapy). Such care cannot be provided cost effectively by an acute care hospital.
- ICD-9-CM (or ICD-10-CM) codes for chronic conditions are often reported as the first-listed diagnosis for LTCF residents (e.g., senile dementia, CHF).

Coding Uncertain Diagnoses for LTCFs

LTCFs do not assign codes to uncertain diagnoses (e.g., probable, possible, rule out). It is acceptable to assign codes to signs and/or symptoms if a definitive diagnosis has not been established and documented in the patient record. “The official coding guidelines state that ‘diagnoses documented as probable, suspected, likely, questionable, and
possible are to be coded as if they existed.” This guideline is applicable only to short-term, acute, long-term acute care, and psychiatric hospitals.” Because long-term care settings such as nursing homes, rehabilitation facilities, skilled nursing facilities, and home health agencies are not stated in the guidance, do not assign codes to uncertain diagnoses.

**EXAMPLE:** An 84-year-old female nursing facility resident was seen by her physician during a routine visit. The physician documented the following diagnoses: hemiplegia and dysphagia due to previous CVA, confusion and agitation, rule out senile dementia. Assign codes to hemiplegia and dysphagia due to previous CVA, confusion, and agitation. Do not assign a code to “rule out senile dementia” because it is an uncertain diagnosis.

### Skilled Nursing Facility Consolidated Billing

The BBA mandated that payment for the majority of services provided to beneficiaries in a Medicare covered SNF be included in a bundled prospective payment made by the MAC (formerly called the fiscal intermediary) to the SNF. Bundled services are submitted on a **consolidated bill**, and the services cannot be billed separately. Medicare Part A beneficiaries receive care in an SNF (e.g., medical services as well as room and board) until coverage is exhausted; then they are eligible for certain Medicare Part B medical services (not room and board). The consolidated billing requirement results in the SNF submitting one bill for the entire package of care that residents receive during a covered Part A SNF stay. After Part A coverage is exhausted, consolidated bills are submitted to Medicare Part B for physical, occupational, and speech therapy services provided. All other covered SNF services for Medicare Part B beneficiaries are separately billed to and reimbursed by MACs.

A limited number of services are specifically excluded from consolidated billing practices and are, therefore, payable separately. For Medicare beneficiaries in a covered Part A stay, these separately payable services include:

- Certain ambulance services, including ambulance services that transport the beneficiary to the SNF initially, ambulance services that transport the beneficiary from the SNF at the end of the stay (other than in situations involving transfer to another SNF), and round-trip ambulance services furnished during the stay that transport the beneficiary off-site temporarily in order to receive dialysis or to receive certain types of intensive or emergency outpatient hospital services
- Certain chemotherapy administration services
- Certain chemotherapy drugs
- Certain dialysis-related services, including covered ambulance transportation to obtain the dialysis services
- Customized prosthetic devices
- Erythropoietin for certain dialysis patients
- Physician’s professional services
- Radioisotope services

When services are furnished to an SNF resident covered by Medicare Part A and those services are provided by an outside provider, the SNF can no longer unbundle those services and then submit a separate bill to the MAC. Instead, the SNF must furnish the services directly or furnish them through a contracted arrangement with the outside provider. The SNF, rather than the provider of the service, bills Medicare. As a result, the outside provider of the service receives payment from the SNF, not the MAC.

### Home Health Care Coding Guidelines

The CMS developed guidelines entitled *Diagnosis Coding for Medicare Home Health under PPS* to assist HHAs in the assignment of ICD-9-CM (or ICD-10-CM) codes for reimbursement of Medicare home health care services. The guidelines include information about general coding principles, a discussion of coding issues pertinent to
home health, case scenarios for illustration, and frequently asked questions (FAQs) about diagnosis coding. The basis for development of the guidelines is the ICD-9-CM coding manual and the ICD-9-CM Official Guidelines for Coding and Reporting (or the ICD-10-CM coding manual and the ICD-10-CM Official Guidelines for Coding and Reporting).

Note:

Coding questions that HHAs encounter during their clinical practice should be referred to the agency’s Medicare administrative contractor (previously called a carrier or fiscal intermediary).

Diagnosis Coding for Medicare Home Health under PPS

The home health care first-listed diagnosis is based on the condition that is most related to the patient's current plan of care, and it is reported on the UB-04 or CMS-1500 claim and the CMS-485 (Home Health Certification and Plan of Treatment) form (Figure 2).

Note:

The CMS-485 form is no longer mandated, but its content must be captured by the HHA. Some HHAs continue to complete the CMS-485, while others capture the information in another format (e.g., software).

Figure 2  CMS-485 plan of care form and data entry software screen with ICD-9-CM codes. (Permission to reuse CMS-485 form in accordance with CMS Web reuse and linking policy.) (Permission to reuse data entry software screen granted by Future Visions.)
HHAs transmit the OASIS data set to their state for the purpose of OBQI and Outcome-Based Quality Management (OBQM). The OASIS data set is also entered in HAVEN software (Figure 3) (developed by CMS) for the purpose of generating a home health resource group (HHRG), which is assigned a health insurance prospective payment system (HIPPS) code and determines the reimbursement paid to the HHA. ICD-9-CM (or ICD-10-CM) codes for OASIS data set items M0190 (hospital inpatient diagnosis) and M0210 (medical diagnoses) are entered into the HAVEN software, but they are not used for reimbursement purposes under the HHRG payment system. Items M0210 (medical diagnoses), M0230 (first-listed diagnosis), and M0240 (other diagnoses) are entered along with M0245 (payment diagnosis), which is an optional field if a V code is reported in item M0230.

Note:

- Because the Diagnosis Coding for Medicare Home Health under PPS guidelines was published prior to allowing ICD-9-CM V codes (or ICD-10-CM Z codes) to be reported in item M0240 and it does not include appropriate information about assigning and reporting ICD-9-CM V codes (or ICD-10-CM Z codes), make sure you refer to the Diagnostic Coding and Reporting Guidelines for Outpatient Services: Hospital-Based and Physician Office (located in Chapter 6 of your textbook).
- CPT and HCPCS level II national codes are entered on third-party payer health insurance claims to report services if requested by the payer, but they are not captured as part of the OASIS data set.

OASIS Item M0190

When a patient is discharged from a hospital inpatient stay to home health care, **OASIS item M0190** contains the ICD-9-CM (or ICD-10-CM) codes for diagnoses that were actively treated during the inpatient hospital stay. The hospital's discharge planner or the referring physician provides the list of diagnoses that were actively treated.

OASIS Item M0210

**OASIS item M0210** contains the patient's medical diagnoses and ICD-9-CM (or ICD-10-CM) codes. This item identifies the diagnoses that have resulted in a change to the patient's treatment, regimen, health care services received, or medication within the past 14 days. The diagnoses and codes reported in this item can be new diagnoses or an exacerbation to an existing condition. Do not enter ICD-9-CM V codes or E codes (or ICD-10-CM external cause codes or health status codes) in item M0210.

OASIS Item M0230

**OASIS item M0230** contains the first-listed diagnosis and ICD-9-CM (or ICD-10-CM) code. If an ICD-9-CM V code (or ICD-10-CM Z code) for a burn/trauma, diabetic, neurological, or orthopedic case is reported in item M0230, report the case mix diagnosis code in M0245. (Other ICD-9-CM V codes or ICD-10-CM Z codes reported in item M0230 do not require reporting the case mix diagnosis code in M0245.) A case mix diagnosis is the first-listed diagnosis that determines the Medicare PPS case mix group. For home health purposes, the case mix diagnosis is assigned to patients with selected conditions (e.g., burns/trauma, diabetic, neurological, or orthopedic) to generate a case mix group for Medicare PPS case mix adjustment.

Note:

If an ICD-9-CM V code (or ICD-10-CM Z code) is reported in OASIS item M0230 instead of a case mix diagnosis, enter a case mix diagnosis code in OASIS item M0245.
The home health first-listed diagnosis, which is reported in OASIS item M0230, is based on the condition most related to the current plan of care. The first-listed diagnosis may or may not be related to a patient's recent hospital stay; however, it must relate to the services provided by the HHA. If more than one diagnosis is treated concurrently, the diagnosis that represents the most acute condition and that requires the most intensive services should be entered as the first-listed diagnosis in item M0230. Skilled services (e.g., skilled nursing and physical, occupational, and speech therapy) are used in judging the relevancy of a diagnosis to the plan of care and to OASIS item M0230.

**OASIS Item M0240**

OASIS item M0240 contains other diagnoses (secondary diagnoses) and ICD-9-CM (or ICD-10-CM) codes. ICD-9-CM V codes and E codes (or ICD-10-CM health status and external cause codes) can be reported in item M0240. The other diagnoses (or secondary diagnoses) include all conditions that coexisted at the time the home health plan of care was established or that developed subsequently or that affect the treatment or care of the patient.

Item M0240 should contain just those conditions that are actively addressed in the plan of care; it should also contain any comorbidity (coexisting condition) that affects the patient's responsiveness to treatment and rehabilitative prognosis even if the condition is not the focus of any home health treatment itself (e.g., hypertension for which the patient takes medication).

**Note:**

Do not report diagnosis codes in item M0230 for conditions that are of mere historical interest (e.g., history of urinary tract infection that has totally resolved) and that do not impact the patient's progress or outcome.
OASIS Item M0245

OASIS item M0245 is an optional item that is completed by HHAs only if a burn/trauma, diabetic, neurological, or orthopedic ICD-9-CM V code (or ICD-10-CM orthopedic Z code) was entered in item M0230. Item M0245 was created to facilitate PPS payment operations. It went into effect on October 1, 2003, when the instructions for OASIS data entry were modified to allow the reporting of a V code as the first-listed diagnosis in item M0230.

Enter a case mix diagnosis code in item M0245 if a burn/trauma, diabetic, neurological, or orthopedic ICD-9-CM V code (or ICD-10-CM orthopedic Z code) was reported in item M0230. The case mix diagnosis determines the Medicare PPS case mix group; and if a burn/trauma, diabetic, neurological, or orthopedic ICD-9-CM V code (or ICD-10-CM orthopedic Z code) is reported in M0230, the case mix diagnosis code must be entered in item M0245 so that the Medicare PPS case mix group can be determined.

Note:

Do not enter ICD-9-CM V or E codes (or ICD-10-CM health status and external cause codes) in item M0245, which is reserved for entry of the case mix diagnosis code if a burn/trauma, diabetic, neurological, or orthopedic ICD-9-CM V code (or ICD-10-CM orthopedic Z code) was entered in item M0230.

If an ICD-9-CM V code (or ICD-10-CM Z code) was entered in item M0230 and the patient's first-listed diagnosis results in the assignment of two codes to indicate the etiology and manifestation of a condition, use both lines in item M0245 to enter the two codes. Enter the etiology code in item M0245(a) and the manifestation code in item M0245(b).

Note:

Do not enter ICD-9-CM V codes or E codes (or ICD-10-CM health status or external cause codes) in OASIS item M0245 because that field is reserved for Medicare PPS case mix diagnosis codes only.

Example: A 67-year-old woman was recently discharged from the hospital after an exacerbation of her extrinsic asthma; and at discharge, she was provided with a nebulizer to improve her medication management. Because she also has a mild senile dementia, home health skilled nursing services were ordered to teach her and her husband how to use the nebulizer and to ensure medication compliance. She was also taught how to use a home incentive spirometer to monitor her response to the medication. The nurse also ensured compliance with her other medications for hypertension and uncomplicated type 2 dependent diabetes mellitus. Because her asthma medications include an inhaled corticosteroid, the physician asked the nurse to review the patient's logs of blood glucose.

<table>
<thead>
<tr>
<th>OASIS Diagnosis Reporting Requirements</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0230: Extrinsic asthma</td>
<td>493.00</td>
<td>J45.909</td>
</tr>
<tr>
<td>M0240: Senile dementia, uncomplicated</td>
<td>290.00</td>
<td>F03</td>
</tr>
<tr>
<td>Type 2 diabetes mellitus, without complication</td>
<td>250.00</td>
<td>E11.9</td>
</tr>
<tr>
<td>Essential hypertension, unspecified</td>
<td>401.9</td>
<td>I10</td>
</tr>
</tbody>
</table>

The code for extrinsic asthma is reported in OASIS item M0230. Multiple codes are reported in item M0240 for senile dementia, type 2 diabetes mellitus, and hypertension. Nothing is reported in item M0245 because the patient's first-listed diagnosis (in item M0230) is not an ICD-9-CM V code (or ICD-10-CM Z code). The senile dementia code precedes other chronic condition codes in item M0240 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; therefore, it is reported as an other (additional) diagnosis lower in the list. Because the nurse ensured that the patient complied with taking all medications, hypertension is coded in item M0240.

When a patient is admitted for surgical aftercare, the relevant medical diagnosis code is reported only if it is still applicable. If the diagnosis is no longer applicable (e.g., because the surgery eliminated the disease or the acute phase of the disease has ended), enter an ICD-9-CM V code (e.g., surgical aftercare) (or ICD-10-CM Z code) as the first-listed diagnosis.

**Note:**

ICD-10-CM aftercare Z codes are reported for aftercare following surgery. The Z codes are not reported for aftercare following injuries; instead, an ICD-10-CM code for the injury is reported with 7th character “D” (subsequent encounter).

**EXAMPLE 1:** A patient is discharged from the hospital to home health care after having undergone surgical repair of a hip fracture. She receives physical therapy in her home three times each week.

<table>
<thead>
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<th>ICD-10-CM</th>
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</thead>
<tbody>
<tr>
<td>M0230: Physical therapy</td>
<td>V57.1</td>
<td>Z47.89</td>
</tr>
<tr>
<td>M0240: Abnormality of gait</td>
<td>781.2</td>
<td>R26.9</td>
</tr>
<tr>
<td>M0245: Abnormality of pit</td>
<td>781.2</td>
<td>R26.9</td>
</tr>
</tbody>
</table>

The code for physical therapy is reported in item M0230 as the first-listed diagnosis, and the code for abnormality of gait is reported in items M0240 and M0245. (A code for hip fracture is not assigned because that condition was surgically treated.) Because an orthopedic ICD-9-CM V code was reported in item M0230, the code for abnormality of gait is repeated in item M0245 as the case (or ICD-10-CM Z Code) mix diagnosis. Because orthopedic care ICD-9-CM V codes (or ICD-10-CM Z codes) cannot be used in the assignment of an HHPPS case mix group, the case mix diagnosis (e.g., abnormality of gait) is reported in OASIS item M0245.

**EXAMPLE 2:** A patient is discharged from the hospital following surgical treatment for lung cancer. The physician documents that the patient will receive chemotherapy for the lung cancer. Home health skilled nursing services are ordered to assess the patient’s compliance with taking chemotherapy medications.

<table>
<thead>
<tr>
<th>OASIS Diagnosis Reporting Requirements:</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0230: Aftercare following surgery for neoplasm, right lung</td>
<td>V58.42</td>
<td>Z48.813</td>
</tr>
<tr>
<td>M0240: Lung cancer, right</td>
<td>162.9</td>
<td>C34.91</td>
</tr>
</tbody>
</table>

The HHA reports the code for “aftercare following surgery for neoplasm” in OASIS item M0230 as the first-listed diagnosis because the nurse is monitoring the patient’s compliance with taking chemotherapy medications. The secondary diagnosis code for lung cancer is reported in item M0240 because the physician documented that the patient is receiving chemotherapy for the cancer, which still exists (even though the patient underwent surgical treatment). In this case, because ICD-9-CM code V58.42 (or ICD-10-CM Z48.813) is not a burn/trauma, diabetic, neurological, or orthopedic ICD-9-CM V code (or ICD-10-CM Z code), OASIS item M0245 remains blank. Do not report ICD-9-CM code 162.9 or ICD-10-CM code C34.91 (lung cancer) in item M0245.
Entering ICD-9-CM (or ICD-10-CM) Codes on Claims and Care Plans

The ICD-9-CM (or ICD-10-CM) code for the first-listed diagnosis is entered in:

- Form locator 67 of the UB-04 claim.
- Block 21a of the CMS-1500 claim.
- Form locator 11 of the CMS-485 form.
- The appropriate OASIS data set screen of HHPPS grouper software.

ICD-9-CM (or ICD-10-CM) codes for other (additional) diagnoses are entered in:

- Form locators 67A-67Q of the UB-04 claim.
- Block 21b-d of the CMS-1500 claim.
- Form locator 13 of the CMS-485 form.
- The appropriate OASIS data set screen of HHPPS grouper software.

The ICD-9-CM (or ICD-10-PCS) code for a surgical procedure is entered in form locator 12 of the CMS-485 form if the procedure performed was relevant to the plan of care. (If a surgical procedure was not performed, NA is entered in form locator 12.)

Health insurance prospective payment system (HIPPS) rate codes are entered in form locator 44 of the UB-04. When the OASIS data set for a home health agency patient is entered into grouper software, the HHRG is determined and the HIPPS rate code is generated. (HIPPS rate codes represent specific patient characteristics, or a case mix, on which Medicare payment determinations are made. HIPPS codes are used in association with special revenue codes reported in form locator 42 of the UB-04 claim. In certain circumstances, multiple HIPPS codes may appear on separate lines of a single claim.)

Tips for Accurate Home Health Care Coding

Physicians who are not employees of the HHA and who provide professional services (e.g., evaluation and management) submit a CMS-1500 claim to obtain reimbursement.
patient’s responsiveness to HHA treatment and/or rehabilitative prognosis even if the condition is not the focus of any home health treatment. Avoid reporting diagnoses that are of historical interest and that do not impact the patient’s progress or outcome.

After the HHA determines the first-listed diagnosis and other diagnoses, ICD-9-CM (or ICD-10-CM) codes are assigned and reported on the UB-04 or CMS-1500 claim and on the CMS-485 form. Rules for assigning codes are based on OASIS data set requirements and ICD-9-CM (or ICD-10-CM) guidelines. If requirements and guidelines conflict regarding the assignment of an ICD-9-M (or ICD-10-CM) code, use the OASIS requirements to assign the code because the home health prospective payment system (HHPPS) case mix system was developed using the OASIS diagnosis requirements and violations might cause rejections by state agencies.

1. Completely classify certain conditions by assigning separate codes to the underlying etiology and multiple body system manifestation due to the underlying etiology.

   **EXAMPLE:** The first-listed diagnosis for a home care patient is “polyneuropathy in uremia.” ICD-9-CM Index to Diseases main term polyneuropathy contains the indented subterm in uremia and lists two codes: 585.9 [357.4]. Upon verifying the codes in the ICD-9-CM tabular list, report 585.9 for the diagnosis “chronic renal failure” and 357.4 for the “polyneuropathy.” In the ICD-10-CM Index to Diseases and injuries, main term polyneuropathy contains the indented subterm in uremia and lists two codes: N18.9 [G63]. Upon verifying the codes in the ICD-10-CM tabular list, report N18.9 for the uremia and G63 for the polyneuropathy.

   • The code in brackets is a manifestation of the disease “uremia,” and it is always sequenced second on an insurance claim.

   • The ICD-9-CM tabular list entry for code 357.4 says “Polyneuropathy in other diseases classified elsewhere” and it is followed by the instruction “Code first underlying disease, as:” along with examples of possible underlying conditions (e.g., uremia). (Italics are used in the ICD-9-CM coding manual for disease manifestation tabular list entries.)

   • The ICD-10-CM tabular list entry for code G63 says “Polyneuropathy in diseases classified elsewhere,” and it is followed by the instruction to “Code first underlying disease, such as:” along with examples of possible underlying conditions. Although code G63 is not italicized in the ICD-10-CM index, the code and its description are italicized in the ICD-10-CM tabular list, which indicates that G63 is a manifestation code and is sequenced second.

   This is an example of multiple coding for a single diagnosis, and the HHA must report both ICD-9-CM or ICD-10-CM codes in the appropriate sequence to indicate the etiology and the manifestation of the disease.

2. Locate the body part or site affected by a problem when assigning an ICD-9-CM (or ICD-10-CM) code to musculoskeletal conditions. Agencies should become familiar with the details of a case to avoid assigning “site unspecified” codes. Assigning nonspecific codes limits the usefulness of data submitted by HHAs, which are used for research into improving case mix measurement and other policy issues.

3. Patients recently discharged from the hospital after a cerebrovascular accident (CVA) (stroke) often receive rehabilitation services from an HHA. Limit the assignment of ICD-9-CM code 436 (CVA) (or ICD-10-CM 163.9) to the period of time during which an HHA patient continues to improve under rehabilitation therapy. (Some payers prefer that ICD-9-CM code 434.91 or ICD-10-CM code 163.50 be reported instead of code 436.) Once the HHA patient’s recovery has reached a plateau, assign an ICD-9-CM code from category 438 (late effects of cerebrovascular disease). If an HHA patient has been discharged from care because goals have been met, but later (or ICD-10-CM sequelae codes, such as hemiparesis, aphasia, and so on) returns for a problem related to the stroke, assign an ICD-9-CM code from category 438 (or ICD-10-CM codes for sequelae).
Many coding questions in home health are concerned with what causal chain leads to the patient’s current condition and treatment and where in the causal chain the home health diagnosis assignment should focus. Medicare instructions indicate that agencies must focus on the diagnoses that directly explain the need for home care.

4. Except when assigning ICD-9-CM (or ICD-10-CM) codes for multiple or manifestation coding, do not assign a code for the cause of a patient’s health problems if a more proximate (immediate) diagnosis is available.

**EXAMPLE:** Each of the diagnostic statements below contains two conditions. The underlined condition is the reason for providing HHA services, and it is reported as the first-listed diagnosis. Any other condition is an underlying condition, and it is reported as an other (additional) diagnosis.

- **Abnormality of gait** in a recent amputee who had gangrene due to diabetes
- **Neurogenic bladder** in a stable multiple sclerosis patient
- **Radiculitis** in a stable multiple sclerosis patient
- **Raynaud’s syndrome** in a patient with systemic lupus erythematosus
- **Stroke** in a patient with cerebral arteriosclerosis

5. Whenever possible, HHAs should avoid reporting ICD-9-CM Chapter 16 (or ICD-10-CM Chapter 18) signs and symptoms codes as the first-listed diagnosis except in the following circumstances:

- A definitive diagnosis has not been established.
- Reporting a sign/symptom code avoids using an outdated diagnosis associated with the recent hospitalization.
- Reporting some other diagnosis would portray the case inaccurately in terms of the Home Health Agency Manual instructions.

a. OASIS restrictions sometimes require HHAs to report a diagnosis that no longer strictly applies to the plan of care. In this situation, the HHA may find that a sign or symptom code more accurately portrays the primary reason for home care; reporting the sign or symptom code is a better choice than reporting an inapplicable diagnosis.

**EXAMPLE 1:** REPORTING SIGN/SYMPTOM CODE INSTEAD OF DEFINITIVE DIAGNOSIS: Report “shortness of breath” when an infirm, elderly patient is admitted for supportive care after hospitalization for pneumonia. By the time the patient receives home care services, the pneumonia may no longer be a current diagnosis and may not be the reason for home care (although it is certainly part of the patient’s recent medical history). Thus, to avoid reporting a code for a condition that has resolved, assigning a symptom code may be the best choice.

**EXAMPLE 2:** REPORTING EITHER A DIAGNOSIS OR A SYMPTOM TO AVOID REPORTING AN OUTDATED DIAGNOSIS CODE THAT IS ASSOCIATED WITH A RECENT HOSPITALIZATION: When a status-post laminectomy patient receives physical therapy home care services, the HHA is not required to report a symptom code if the diagnosis assigned satisfies the OASIS instruction to report the condition underlying the surgery. For status-post laminectomy, the OASIS instruction is met if the indication for the laminectomy (e.g., spinal stenosis) is reported. However, OASIS instructions do not prevent the HHA from reporting a more current diagnosis, such as one that describes the primary reason for home care, in the case of status-post laminectomy, the HHA may report a symptom code such as “paresthesia” if it best describes the primary reason for home care.

b. If a patient receives HHA services for just one aspect of a chronic condition and ICD-9-CM (or ICD-10-CM) does not contain a code that explicitly incorporates the aspect treated, a sign/symptom code may be reported as the primary reason for home care. Although ICD-9-CM (or ICD-10-CM) guidelines stipulate that sign/symptom codes should be reported when a related, definitive diagnosis has not been established, for HHA coding, assigning a sign/symptom code satisfies the Home Health Agency Manual requirement for the primary reason for care.
EXAMPLE: REPORTING A SYMPTOM WHEN THE DEFINITIVE DIAGNOSIS DOES NOT INCLUDE AN ASPECT OF THE CONDITION: An Alzheimer’s patient and his family have been receiving home care due to the patient’s deteriorating neurological status, which requires medication teaching, patient and caregiver education, safety assessment, and activities of daily living (ADL) training. The first-listed diagnosis for this case is Alzheimer’s disease.

Once the HHA treatment goals have been met, the Alzheimer’s patient is discharged. The patient is readmitted soon thereafter due to dysphagia, and his primary care physician has ordered a feeding tube. In this case, the Alzheimer’s disease is no longer the primary reason for treatment; the focus is on setting the patient up with a feeding tube. Therefore, an ICD-9-CM (or ICD-10-CM) symptom code for dysphagia is reported.

c. Reporting sign/symptom codes as other diagnoses is a common HHA practice and is entirely appropriate when the code describes an important aspect of the patient’s condition, provided the following two conditions are met:

- The sign/symptom code is not used instead of a definitive diagnosis, classifiable elsewhere in ICD-9-CM (or ICD-10-CM) (e.g., abnormal sputum should not be reported instead of bronchitis if the plan of care is to address the patient’s bronchitis).
- The sign/symptom code reported should not be an essential part of the definitive diagnosis it is intended to support (e.g., edema is integral to the diagnosis of congestive heart failure; therefore, do not report a code for edema in addition to a code for congestive heart failure).

6. Effective October 1, 2003, HHAs were permitted to report ICD-9-CM V codes as first-listed and other (additional) diagnosis codes. (The list of ICD-10-CM Z codes that can be reported as the principal diagnosis or the first-listed diagnosis is extremely limited, unlike ICD-9-CM’s V codes. Refer to Appendix II in your textbook for the list of Z codes that can be reported as principal diagnosis or first-listed diagnosis.)

EXAMPLE: A 75-year-old man is discharged from the hospital after receiving treatment for a right middle cerebral artery thrombotic occlusion. The patient now has nondominant side hemiplegia, for which the patient’s attending physician orders home care services. The following treatment is provided once the patient has returned home: physical and occupational therapy for rehabilitation after his stroke. The following ICD-9-CM codes are assigned:

- 438.22 (Hemiplegia affecting nondominant side, following a stroke)
- V57.1 (Other physical therapy)
- V57.21 (Encounter for occupational therapy)

The following ICD-10-CM code is assigned:

- 169.959 (Hemiplegia affecting nondominant side, following a stroke)

<table>
<thead>
<tr>
<th>OASIS ITEM</th>
<th>DIAGNOSIS</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0230</td>
<td>Physical therapy</td>
<td>V57.1</td>
<td></td>
</tr>
<tr>
<td>M0240</td>
<td>Hemiplegia affecting nondominant side</td>
<td>438.22</td>
<td>169.959</td>
</tr>
<tr>
<td></td>
<td>Occupational therapy</td>
<td>V57.21</td>
<td></td>
</tr>
<tr>
<td>M0245</td>
<td>Hemiplegia affecting nondominant side</td>
<td>438.22</td>
<td>169.959</td>
</tr>
</tbody>
</table>

OASIS item M0230 contains an ICD-9-CM V code for physical therapy. Item M0240 contains codes for other (additional) diagnoses, including hemiplegia affecting the nondominant side and an ICD-9-CM V code for occupational therapy. Item M0245 contains the case mix diagnosis of “hemiplegia affecting nondominant side” because item M0230 contains an ICD-9-CM V code for
a neurological disorder. Because the list of ICD-10-CM Z codes that can be reported as the principal diagnosis or the first-listed diagnosis does not include occupational therapy or physical therapy, items M0230 and M0245 would be left blank. However, ICD-10-CM code 169.959 would be reported in item M0245.

Hospice Outpatient Care Coding Guidelines

Hospice is a special way of caring for people who are terminally ill and for their families. This care includes physical care and counseling. Hospice care is provided by a public agency or private company approved by Medicare. It is for all age groups, including children, adults, and the elderly during their final stages of life. The goal of hospice is to care for the patients and their families, not to cure the patient's illness(es). Hospice CMS-1500 or UB-04 claims should include an IC-09-CM (or ICD-10-CM) code for the terminal illness diagnosis (e.g., cancer), if applicable, in addition to one or more codes that describe the condition(s) resulting in the patient's decline. The following conditions are those most likely to be associated with a patient's decline:

- Abnormal weight loss
- Alteration of consciousness, stupor, or unconsciousness
- Anorexia
- Cachexia (may indicate adult “failure to thrive”)
- Coma
- Debulity, unspecified (may indicate adult “failure to thrive”)
- Decubitus ulcer
- Dysphagia
- Feeding difficulties and mismanagement
- Gangrene
- Hypotension, unspecified
- Incontinence of feces
- Incontinence of urine
- Other abnormal blood chemistry (albumin/cholesterol)
- Other general symptoms
- Persistent vegetative state
- Senility without mention of psychosis
- Shock without mention of trauma

Because no official hospice coding guidelines have been published to assist in the assignment of diagnosis and procedure/service codes, coders should refer to the Diagnostic Coding and Reporting Guidelines for Outpatient Services: Hospital-Based and Physician Office and the Diagnosis Coding for Medicare Home Health under PPS when assigning hospice home health codes. In addition, third-party payers and Medicare administrative contracts can be contacted to request clarification about code assignment. (Hospice inpatient coding was discussed previously in this document.)

CPT and HCPCS level II national codes are reported on the UB-04 or CMS-1500, whichever the hospice uses to request reimbursement from third-party payers. HCPCS level II national codes include G0151 (Physical Therapy), G0152 (Occupational Therapy), G0153 (Speech Pathology), G0154 (Skilled Nursing), G0155 (Social Worker), and G0156 (Home Health Aide). Other procedures reported on the plan of treatment are assigned ICD-9-CM (or ICD-10-PCS) procedure codes.
The first-listed diagnosis is reported on the CMS-1500 or UB-04 claim; and it is the primary cause of the patient’s admission to hospice care, whether inpatient or home-based. A sign or symptom code is reported as the first-listed diagnosis when a definitive diagnosis has not been established and when there are no other diagnoses responsible for the patient’s admission to hospice care.

**Coding Cancer Cases**

For patients diagnosed with cancer who are admitted for hospice care, the primary site of cancer is reported as the first-listed code except when the:

- Primary site of cancer is unknown (report the secondary site of cancer as the first-listed diagnosis along with ICD-9-CM code 199.1 for unknown primary).
- Primary site of cancer has been removed (report the secondary site of cancer along with the appropriate V code to classify history of malignant neoplasm of the site).
- Terminal condition is the result of a secondary site of cancer (not the primary site).

**Assigning ICD-9-CM V (or ICD-10-CM Z) Codes**

Following ICD-9-CM (or ICD-10-CM) coding guidelines for assigning and reporting ICD-9-CM V codes (or ICD-10-CM Z codes) as diagnosis codes allows hospice agencies to capture and report palliative care and psychosocial problems such as economic, family, and housing problems. When palliative care is the primary reason for hospice care, assign a code for “encounter for palliative care.” Make sure you review the hospice record to verify that the health care provider has documented palliative care in the admission note, outpatient progress note, and/or physician orders.

**EXAMPLE:** A hospice patient with advanced dementia receives outpatient palliative care consistent with the expressed primary goal of comfort and then developed a closed fracture of the intertrochanteric section of the femur (hip) after falling. Surgical repair of the fracture was performed with the goal of reducing pain and promoting maximal mobility. The first-listed diagnosis is “closed fracture of the intertrochanteric section of the femur,” and the secondary diagnosis is “palliative care.”

**Inpatient and Outpatient Care for Hospice Patients**

When a hospice patient is admitted to the hospital or seen on an outpatient basis for palliative care, assign an ICD-9-CM (or ICD-10-CM) code to indicate the reason for care (e.g., cancer) and report an ICD-9-CM V code (or ICD-10-CM Z code) as the secondary diagnosis.

**EXAMPLE 1:** A patient is admitted as a hospital inpatient with end-stage lung cancer, for palliative care only. Report a code for “malignant neoplasm of bronchus and lung, unspecified” as the principal diagnosis; then report a code for “encounter for palliative care” as the secondary diagnosis.

**EXAMPLE 2:** A patient with end-stage lung cancer receives treatment for congestive heart failure in the hospital’s outpatient department. Report the “congestive heart failure” code as the first-listed diagnosis; then code the “malignant neoplasm of bronchus and lung, unspecified” and “encounter for palliative care” as secondary diagnoses.

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