OASIS ITEM

(M1020/1022/1024) Diagnoses, Symptom Control, 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). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 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 M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group. Do not assign symptom control ratings for V- or E-codes.

Code each row according to the following directions for each column:

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;

Rate the degree of symptom control for 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

Note that in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). Refer to Appendix D for additional instruction related to the coding of M1024.

Column 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.

(Continued on next page)

OASIS ITEM (M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses (cont'd)

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Assigning or Coding Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 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).
Description	ICD-9-C M / Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
(M1020) Primary Diagnosis a. _____	**(V-codes are allowed)** a. (__ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)
(M1022) Other Diagnoses b. _____	**(V- or E-codes are allowed)** b. (__ __ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** b._____ (__ __ __ . __ __)	**(V- or E-codes NOT allowed)** b._____ (__ __ __ . __ __)
c. _____	c. (__ __ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	c._____ (__ __ __ . __ __)	c._____ (__ __ __ . __ __)
d. _____	d. (__ __ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	d._____ (__ __ __ . __ __)	d._____ (__ __ __ . __ __)
e. _____	e. (__ __ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	e._____ (__ __ __ . __ __)	e._____ (__ __ __ . __ __)
f. _____	f. (__ __ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	f._____ (__ __ __ . __ __)	f._____ (__ __ __ . __ __)

ITEM INTENT

The intent of this item is to accurately code each diagnosis in compliance with Medicare's rules and regulations for coverage and payment. CMS expects HHAs to understand each patient's specific clinical status before selecting and assigning each diagnosis. Each patient's overall medical condition and care needs must be comprehensively assessed **BEFORE** the HHA Identifies and assigns each diagnosis for which the patient is receiving home care. Each diagnosis (other than an E-code) must comply with the "Criteria for OASIS Diagnosis Reporting." (See Appendix D – if a patient has a resolved condition that has no impact on the patient's current plan of care, then the condition does not meet the criteria for a home health diagnosis and should not be coded.) The primary diagnosis (M1020) should be the diagnosis most related to the patient's current plan of care, the most acute diagnosis and, therefore, the chief reason for providing home care.

Secondary diagnoses in M1022 are defined as "all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care." In general, M1022 should include not only conditions actively addressed in the patient's plan of care but also any co-morbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself. Ensure that the secondary diagnoses assigned to M1022 are listed in the order to best reflect the seriousness of the patient's condition and justify the disciplines and services provided. Agencies should avoid listing diagnoses that are of mere historical interest and without impact on patient progress or outcome. 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 language pathology) are used in judging the relevancy of a diagnosis to the plan of care and to the OASIS.

ITEM INTENT (cont'd for OASIS Items M1020/1022/1024)

The order that secondary diagnoses are entered should be determined by the degree that they impact the patient's health and need for home health care, rather than the degree of symptom control. For example, if a patient is receiving home health care for Type 2 diabetes that is "controlled with difficulty," this diagnosis would be listed above a diagnosis of a fungal infection of a toenail that is receiving treatment, even if the fungal infection is "poorly controlled."

A case-mix diagnosis (Column 3) is a diagnosis that gives a patient a score for Medicare Home Health PPS case-mix group assignment. A case mix diagnosis may be the primary diagnosis, "other" diagnosis, or a manifestation associated with a primary or other diagnosis. Each diagnosis listed in M1020 and M1022 should be supported by the patient's medical record documentation (i.e., the patient's Plan of Care is in compliance with 42 CFR 484.18(a)). The list of case mix diagnosis codes is included in the HH PPS Grouper documentation available on the CMS web site (see Chapter 5 of this manual for a link to this website).

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS

- V-codes may be entered in row "a" of Column 2 (item M1020); V-codes and E-codes may be entered in the other rows in Column 2 (item M1022). CMS expects HHAs to avoid assigning excessive V-codes to the OASIS. V-codes are less specific to the clinical condition of the patient than are numeric diagnosis codes. In the home health setting, V-codes are appropriately assigned to M1020 and M1022 when a patient with a resolving disease or injury requires specific aftercare of that disease or injury (i.e., surgical aftercare or aftercare for rehabilitation).
- V-codes and E-codes <u>may not</u> be entered in optional Columns 3 or 4 as these columns pertain to the Medicare PPS case mix diagnosis only.
- In optional Columns 3 and 4, complete only if a V-code is assigned under certain circumstances to column 2 in place of a case mix diagnosis. (Refer to below and Appendix D, Section D (4)).
- To prevent the loss of case mix points when an underlying case mix diagnosis is associated with the primary V-code diagnosis, HHAs should code the numeric case mix code to the primary diagnosis line (a) of M1024 when the following conditions apply: (1) the primary diagnosis (M1020) is a V-code; (2) the V-code displaces a numeric diagnosis that is a case mix diagnosis, and (3) the numeric case mix diagnosis is contained within one of the following three HH PPS diagnosis groups and to comply with ICD-9-CM coding guidelines, the secondary diagnosis, if needed to support the primary V-code diagnosis, (if appropriate for ICD-9-CM reporting in the home health setting), is reported in M1022 sequenced immediately following the V-code. The three HH PPS diagnosis groups are:
  - Diabetes
  - Skin 1-Traumatic Wounds, burns, and post-operative complications
  - Neuro 1-Brain disorders and paralysis
- ICD-9-CM coding guidelines stipulate that the acute fracture code is only to be used for the initial, acute episode of care, which is why the acute fracture code is no longer appropriate once the patient has been discharged from the hospital to home health care. In this scenario, if a V-code replaces the fracture code in either M1020 or M1022, the HHA can code the acute fracture code in the corresponding occurrence of M1024.
- Complete Columns 1 and 2 from top to bottom, leaving any blank entries at the bottom.
- In Columns 3 and 4 (optional), there may be blank entries in any row. When code(s) are entered in Columns 3 and 4 (optional), ensure that they are placed in the row that shows the corresponding V-code.
- No surgical codes – list the underlying diagnosis.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Items M1020/1022/1024)

Assessment strategies: **M1020/M1022: Primary and Other Diagnoses**

- Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician.
- Review current medications and other treatment approaches. Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician.
- The current ICD-9-CM guidelines should be followed in coding these items.
- Assessing degree of symptom control includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities. Assess the patient to determine if symptoms are controlled by current treatments. Clarify which diagnoses/symptoms have been poorly controlled in the recent past.

Assessment strategies: **M1024: Case Mix Diagnoses (OPTIONAL)**

- Select the code(s) that would have been reported as the primary diagnosis under the OASIS-B1 (8/2000) instructions.
- No surgical codes —list the underlying diagnosis.
- V-codes cannot be used in case mix group assignment. If a provider reports a V-code in M1020/1022 in place of a case mix diagnosis, the provider has the option of reporting the case mix diagnosis in M1024.
- If the case mix diagnosis requires multiple diagnoses under ICD-9-CM coding guidelines, enter these codes in Columns 3 and 4 (e.g., if coded as a combination of an etiology and a manifestation code, the etiology code should be entered in Column 3 and the manifestation code should be entered in Column 4).

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Physician orders
- Referral information
- Current medication list
- The current ICD-9-CM code book should be the source for coding
- See Appendix D for further guidance on assigning and coding diagnoses in M1020/M1022
- For degree of symptom control, data sources may include patient/caregiver interview, physician, physical assessment, and review of past health history.