Home Health ICD-9/ICD-10 Alert

Reader Question: Be Accurate With Exacerbation Dates

Question: Should we note exacerbation of a diagnosis when the condition is noted in the medical record but no care is ordered? For example, what if it's noted that the patient has joint pain but there are no injections or other interventions ordered? Or for a diabetic patient, what if the nursing notes indicate that blood sugar reached 350 a couple of times during the 60-day episode, but there was no medication change or other care ordered?

-- California Subscriber

Answer: There is little guidance on the onset and exacerbation dates. The "O" and "E" dates are not mandated by Medicare but are recommended by the regional home health intermediaries (RHHIs). These dates are used to indicate that there is a fluctuating condition that requires skilled care. When there is no date of onset or exacerbation documented, the need for initiation or continuation of home health services may be in doubt.

The terms are defined as follows:

O = Onset of a new diagnosis

E = Exacerbation or a recurrence of a pre-existing or chronic condition that requires a change in the current plan of care.

Many folks use an onset date the same as the start of care (SOC) date or an exacerbation date every recertification, but this isn't appropriate. The RHHI is looking for real changes in the condition of the patient. The plan of care should always reflect the clinical record and vice versa. Surveyors have given deficiencies based on "unreal" onset and exacerbation dates.