# OASIS Alert

## Diagnosis Coding :3 STEPS CLEAR YOUR OASIS ATTACHMENT D CONFUSION

**Complete M0246 in only 3 scenarios.**

The **Centers for Medicare & Medicaid Services** has tried to clarify Attachment D errors, but you very likely have lingering questions about how to apply the agency's guidelines. Follow the process below to achieve coding clarity.

**Step 1: Use V codes with care.** The main reason CMS made the Attachment D revisions is because it is unhappy with home care's use of V codes, says **Trish Twombly**, director of coding with **Foundation Management Services** in Denton, Texas.

In the revised Attachment D, CMS warns coders that reporting V codes on the OASIS should be "an assignment of last resort."

This is because "V codes are less specific to the clinical condition of the patient than are numeric diagnosis codes."

CMS hasn't changed the guidelines for assigning V codes in M0230/M0240, but it does remind home care coders that V codes are most appropriately used in M0230 or M0240 "when a patient has a resolving disease or injury that requires specific aftercare of that disease or injury."

**Example:** Common situations when it's appropriate to list a V code include coding for patients who are receiving surgical aftercare or aftercare for rehabilitation, CMS says.

**Step 2: Hold yourself to a higher standard for co-morbidities.** When you list a comorbidity in M0240, CMS expects documentation and support in the clinical record, such as in the plan of care and clinical assessment. You might not have interventions directed at the condition, but CMS expects to see documentation support when it requests a chart.

**Requirement:** Medicare expects documentation to distinguish codes that may describe care from those that are of mere historical interest and do not impact the patient's care or prognosis, says **Lisa Selman-Holman**, coding expert and principle of **Selman-Holman & Associates** in Denton, Texas. Your claim will face downcoding if you don't have documentation that describes the potential impact a diagnosis has on care or prognosis.

Making certain you have thorough documentation before you assign a code has "always been the safe thing to do, but now it's expected when CMS requests to review a chart for medical necessity," Twombly says. "When the chart gets pulled for an edit, it's not the codes that will sink you, it's the documentation.

If your documentation doesn't support the codes you've listed, that's what will trip you up," Twombly says.

**Confusion:** On page four of Attachment D, CMS originally instructed HHAs to "ensure that the diagnosis under consideration is addressed in the home health plan of care and that the diagnosis under consideration affects the patient's responsiveness to treatment and rehabilitative prognosis."

The correct wording is the following: "Ensure that the secondary diagnosis under consideration includes 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," CMS said in a Feb. 12 statement.

**Step 3: Be selective about the codes you place in M0246.** Listing codes in M0246 used to be a frequent

occurrence, but now it should be the exception to the rule, Twombly says.

There are only three instances when you should list a numeric code in M0246:

1. If the V code in M0230 displaces a numeric case mix diagnosis in the Diabetes, Skin 1 (Traumatic wounds, burns, and postoperative complications), or Neuro 1 (Brain disorders and paralysis) diagnosis groups;

2. If you're providing care for a resolved condition; or

3. If you're caring for a healing fracture.

Note: For more information about how Attachment D changes will affect your agency, order a CD or transcript of Twombly's **Eli**-sponsored audioconference HHAs: Get Ready for Major Process Changes at www.audioeducator.com/industry_conference.php?id=1426 or by calling 1-800-508-2582.