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Diagnosis Coding: Watch for Revamped Diagnosis Coding Item Intent in OASIS-C1

Old items get new streamlined instruction.

After the ICD-10 transition date moved to 2015, the **Centers for Medicare & Medicaid Services** announced plans to move forward with a modified OASIS-C1. Without the need to accommodate longer, alpha-numeric ICD-10 codes, the OASIS diagnosis items no longer needed an update.

The new interim data set is called the "OASIS-C1/ICD-9" and contains the bulk of the proposed OASIS-C1 changes, except for the following diagnosis-coding items:

- M1010: Inpatient Diagnosis replaces M1011,
- M1016: Diagnosis Requiring Treatment Change instead of M1017, and
- M1020/M1022/M1024: Primary, Other, and Payment Diagnoses in place of M1021/M1023/M1025.

Bottom line: There are no major changes to the old familiar diagnosis coding items. But, the OASIS-C1/ICD-9 does update the item intent for M1020/M1022/M1024. Take note of this streamlined item guidance:

M1020: Primary Diagnosis the intent of this item is to accurately report and code the patient's primary home health diagnosis and document the degree of symptom control for that diagnosis. The patient's primary home health diagnosis is defined as the chief reason the patient is receiving home care and the diagnosis most related to the current home health Plan of Care.

M1022: Secondary Diagnoses the intent of this item is to accurately report and code the patient's secondary home health diagnoses and document the degree of symptom control for each diagnosis. Secondary diagnoses are comorbid conditions that exist at the time of the assessment, that are actively addressed in the patient's Plan of Care, or that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis.

M1024 Payment Diagnosis OPTIONAL: the intent of this item is to allow the reporting of fractures for which the patient is receiving aftercare, when a V-code for aftercare of fracture is reported as a primary or secondary diagnosis in Columns 1 and 2. It also provides the agency with the option of documenting an underlying condition, if a V-code is reported as a primary or secondary diagnosis in Columns 1 and 2, and the underlying condition is no longer active.

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