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. **AFTERCARE SURGERY CIRCULATORY**	(V-codes are allowed) a. (**V58** . **73**) ☐0 ☐1 ☐2 ☐3 ☐4	(V- or E-codes NOT allowed) a. **Diabetes** (**250** . **70**)	(V- or E-codes NOT allowed) a. **ANGIOPATHY** (**443** . **81**)
(M1022) Other Diagnoses b. **DIABETES PERIPHERIAL CIR.**	(V- or E-codes are allowed) b. (**250** **70**) ☐0 ☐1 ☒2 ☐3 ☐4	(V- or E-codes NOT allowed) b. _____ (___ . __)	(V- or E-codes NOT allowed) b. _____ (___ . __)
c. **ANGIOPATHY**	c. (**443** . **81**) ☐0 ☐1 ☐2 ☒3 ☐4	c. _____ (___ . __)	c. _____ (___ . __)
d. **ATTENTION TO SURGICAL DRESSINGS**	d. (**V58** . **31**) ☐0 ☐1 ☐2 ☐3 ☐4	d. _____ (___ . __)	d. _____ (___ . __)
e. **ENCOUNTER FOR THERAPUTIC DRUG**	e. (**V58** . **83**) ☐0 ☐1 ☐2 ☐3 ☐4	e. _____ (___ . __)	e. _____ (___ . __)
f. **LONG TERM USE OF ANTICOAGULANTS**	f. (**V58** **61**) ☐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, M1020 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.

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