Optum

2025 coding guidelines included

Expert

ICD-10-CM Expert for Home Health and Hospice

The complete official code set

Codes valid from October 1, 2024 through September 30, 2025

2025

optumcoding.com

Contents

How to Use ICD-10-CM Expert for Home Health and Hospice 2025

Introduction

ICD-10-CM Expert for Home Health and Hospice: The Complete Official Code Set is your definitive coding resource, combining the work of the National Center for Health Statistics (NCHS), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and Optum experts to provide the information you need for coding accuracy.

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), is an adaptation of ICD-10, copyrighted by the World Health Organization (WHO). The development and maintenance of this clinical modification (CM) is the responsibility of the NCHS as authorized by WHO. Any new concepts added to ICD-10-CM are based on an established update process through the collaboration of WHO's Update and Revision Committee and the ICD-10-CM Coordination and Maintenance Committee.

In addition to the ICD-10-CM classification, other official government source information has been included in this manual. Depending on the source, updates to information may be annual or quarterly. This manual provides the most current information that was available at the time of publication. For updates to the source documents that may have occurred after this manual was published, please refer to the following:

- **NCHS, International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)**

  https://www.cms.gov/medicare/icd-10/2024-icd-10-cm

- **CMS Integrated Outpatient Code Editor (IOCE), version 24.2**

  https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html

- **CMS Home Health Patient-Driven Groupings Model (PDGM)**

  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html

- **CMS Hospice Quality Reporting Requirements**

  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Regulations-and-Notices

- **AHA Coding Clinics**

  https://www.codingclinicadvisor.com/

The official NCHS ICD-10-CM classification includes three main sections: the guidelines, the indexes, and the tabular list, all of which make up the bulk of this coding manual. To complement the classification, Optum's coding experts have incorporated Medicare-related coding edits and proprietary features, such as supplementary notations, coding tools, and appendixes, into a comprehensive and easy-to-use reference. This publication is organized as follows:

What's New for 2025

This section provides a high-level overview of the code changes made for fiscal 2024. The list of codes provided identify new, revised, and deleted codes. Asterisked codes identify prior midyear changes that were made to the classification, effective April 1, 2023. All changes are based on official addendum, provided by the NCHS.

Conversion Table

The conversion table was developed by NCHS to help facilitate data retrieval as new codes are added to the ICD-10-CM classification. This table provides a crosswalk from each fiscal 2024 new code to the equivalent code(s) assigned, prior to October 1, 2023, for that diagnosis or condition. Asterisked codes identify prior midyear additions, effective April 1, 2023. For the full conversion table, refer to the Conversion Table zip file at https://www.cms.gov/medicare/icd-10/2024-icd-10-cm.

10 Steps to Correct Coding

This step-by-step tutorial walks the coder through the process of finding the correct code — from locating the code in the official indexes to verifying the code in the tabular section — while following applicable conventions, guidelines, and instructional notes. Specific examples are provided with detailed explanations of each coding step along with advice for proper sequencing.

Official ICD-10-CM Guidelines for Coding and Reporting

This section provides the full official conventions and guidelines regulating the appropriate assignment and reporting of ICD-10-CM codes. These conventions and guidelines are published by the U.S. Department of Health and Human Services (DHHS) and approved by the cooperating parties (American Health Information Management Association [AHIMA], NCHS, Centers for Disease Control and Prevention [CDC], and the American Hospital Association [AHA]).

Indexes

Index to Diseases and Injuries

The Index to Diseases and Injuries is arranged in alphabetic order by terms specific to a disease, condition, illness, injury, eponym, or abbreviation as well as terms that describe circumstances other than a disease or injury that may require attention from a health care professional.

Neoplasm Table

The Neoplasm Table is arranged in alphabetic order by anatomical site. Codes are then listed in individual columns based upon the histological behavior (malignant, in situ, benign, uncertain, or unspecified) of the neoplasm.

Table of Drugs and Chemicals

The Table of Drugs and Chemicals is arranged in alphabetic order by the specific drug or chemical name. Codes are listed in individual columns based upon the associated intent (poisoning, adverse effect, or underdosing). Drugs with an asterisk identify substances added to the table by Optum subject matter experts.

External Causes Index

The External Causes Index is arranged in alphabetic order by main terms that describe the cause, the intent, the place of occurrence, the activity, and the status of the patient at the time the injury occurred or health condition arose.

Revised Text

The revised text ▶◀ "bow ties" alert the user to changes in official notations for the current year. Revised text may include the following:

- A change in a current parenthetical description
- A change in the code(s) associated with a current parenthetical note
- A change in how a current parenthetical note is classified (e.g., an Excludes 1 note that changed to an Excludes 2 note)
- Addition of a new parenthetical note(s) to a code

Deleted Text

~~Strikethrough~~ on official notations indicate a deletion from the classification for the current year.

Optum Notations

AHA Coding Clinic Citations

Coding Clinics are official American Hospital Association (AHA) publications that provide coding advice specific to ICD-10-CM and ICD-10-PCS.

Coding Clinic citations included in this manual are current up to the second quarter of 2023.

These citations identify the year, quarter, and page number of one or more *Coding Clinic* publications that may have coding advice relevant to a particular code or group of codes. With the most current citation listed first, these notations are preceded by the symbol **AHA:** and appear in purple type.

I15.1 Hypertension secondary to other renal disorders
AHA: 2016, 3Q, 22

Definitions

Definitions explain a specific term, condition, or disease process in layman's terms. These notations are preceded by the symbol **DEF:** and appear in purple type.

√5th **M51.4 Schmorl's nodes**
DEF: Irregular bone defect in the margin of the vertebral body that causes herniation into the end plate of the vertebral body.

Coding Tips

The tips in the tabular list offer coding advice that is not readily available within the ICD-10-CM classification. It may relate official coding guidelines, indexing nuances, or advice from *AHA's Coding Clinic for ICD-10-CM/PCS*. These notations are preceded by the symbol **TIP:** and appear in brown type.

√5th **B97.2 Coronavirus as the cause of diseases classified elsewhere**
TIP: Do not report a code from this subcategory for COVID-19, refer to U07.1.

Icons

Note: The following icons are placed to the left of the code.

Changes to ICD-10-CM codes since the last published edition of this manual are highlighted in two ways:

The following green icons identify new or revised codes effective April 1, 2024:

● **New Code — Midyear**

▲ **Revised Code — Midyear**

The following black icons identify new or revised codes effective October 1, 2024:

● **New Code**

▲ **Revised Code**

☑ **Additional Characters Required**

√4th This symbol indicates that the code requires a 4th character.

√5th This symbol indicates that the code requires a 5th character.

√6th This symbol indicates that the code requires a 6th character.

√7th This symbol indicates that the code requires a 7th character.

√5th **H60.3 Other infective otitis externa**
√6th **H60.31 Diffuse otitis externa**
H60.311 Diffuse otitis externa, right ear
H60.312 Diffuse otitis externa, left ear
H60.313 Diffuse otitis externa, bilateral
H60.319 Diffuse otitis externa, unspecified ear RP

√x7th **Placeholder Alert**

This symbol indicates that the code requires a 7th character following the placeholder "X". Codes with fewer than six characters that require a 7th character must contain placeholder "X" to fill in the empty character(s).

√x7th **T16.1 Foreign body in right ear**

Most icons in this manual, placed at the end of the code description, include official edits from the following sources:

- Integrated Outpatient Code Editor (IOCE) quarterly files
- Home health prospective payment system (HH PPS)

In most instances, FY 2024 data from the above sources were not available at the time this book was printed. In an effort to make available the most current source information, Optum has provided a document identifying FY 2024 changes to edit designations for ICD-10-CM codes. Edit changes identified in this document may include:

- Age
- Sex
- Manifestation
- Unacceptable principal diagnosis
- HH comorbidity high
- HH comorbidity low
- HH return to provider

This document can be accessed at the following:

https://www.optumcoding.com/ProductUpdates/
Title: "2025 ICD-10-CM HH/Hospice Edit Changes"
Password: XXXXXX

10 Steps to Correct Coding

Follow the 10 steps below to correctly code encounters for health care services.

Step 1: Identify the reason for the visit or encounter (i.e., a sign, symptom, diagnosis and/or condition).

The medical record documentation should accurately reflect the patient's condition, using terminology that includes specific diagnoses and symptoms or clearly states the reasons for the encounter.

Choosing the main term that best describes the reason chiefly responsible for the service provided is the most important step in coding. If symptoms are present and documented but a definitive diagnosis has not yet been determined, code the symptoms. *For outpatient cases, do not code conditions that are referred to as "rule out," "suspected," "probable," or "questionable."* Diagnoses often are not established at the time of the initial encounter/visit and may require two or more visits to be established. Code only what is documented in the available outpatient records and only to the highest degree of certainty known at the time of the patient's visit. For inpatient medical records, uncertain diagnoses may be reported if documented at the time of discharge.

Step 2: After selecting the reason for the encounter, consult the alphabetic index.

The most critical rule is to begin code selection in the alphabetic index. Never turn first to the tabular list. The index provides cross-references, essential and nonessential modifiers, and other instructional notations that may not be found in the tabular list.

Step 3: Locate the main term entry.

The alphabetic index lists conditions, which may be expressed as nouns or eponyms, with critical use of adjectives. Some conditions known by several names have multiple main entries. Reasons for encounters may be located under general terms such as admission, encounter, and examination. Other general terms such as history, status (post), or presence (of) can be used to locate other factors influencing health.

Step 4: Scan subterm entries.

Scan the subterm entries, as appropriate, being sure to review continued lines and additional subterms that may appear in the next column or on the next page. Shaded vertical guidelines in the index indicate the indentation level for each subterm in relation to the main terms.

Step 5: Pay close attention to index instructions.

- Parentheses ( ) enclose nonessential modifiers, terms that are supplementary words or explanatory information that may or may not appear in the diagnostic statement and do not affect code selection.
- Brackets [ ] enclose manifestation codes that can be used only as secondary codes to the underlying condition code immediately preceding it. If used, manifestation codes must be reported with the appropriate etiology codes.
- Default codes are listed next to the main term and represent the condition most commonly associated with the main term or the unspecified code for the main term.
- "*See*" cross-references, identified by italicized type and "code by" cross-references indicate that another term *must be referenced* to locate the correct code.
- "*See also*" cross-references, identified by italicized type, provide alternative terms that may be useful to look up but *are not mandatory*.
- "Omit code" cross-references identify instances when a code is not applicable depending on the condition being coded.
- "With" subterms are listed out of alphabetic order and identify a presumed causal relationship between the two conditions they link.
- "Due to" subterms identify a relationship between the two conditions they link.
- "NEC," abbreviation for "not elsewhere classified," follows some main terms or subterms and indicates that there is no specific code for the condition even though the medical documentation may be very specific.
- "NOS," abbreviation for "not otherwise specified," follows some main terms or subterms and is the equivalent of unspecified; NOS signifies that the information in the medical record is insufficient for assigning a more specific code.
- *Following* references help coders locate alphanumeric codes that are out of sequence in the tabular section.
- Check-additional-character symbols flag codes that require additional characters to make the code valid; the characters available to complete the code should be verified in the tabular section.

Step 6: Choose a potential code and locate it in the tabular list.

To prevent coding errors, always use both the alphabetic index (to identify a code) and the tabular list (to verify a code), as the index does not include the important instructional notes found in the tabular list. An added benefit of using the tabular list, which groups like things together, is that while looking at one code in the list, a coder might see a more specific one that would have been missed had the coder relied solely on the alphabetic index. Additionally, many of the codes require a fourth, fifth, sixth, or seventh character to be valid, and many of these characters can be found only in the tabular list.

Step 7: Read all instructional material in the tabular section.

The coder must follow any Includes, Excludes 1 and Excludes 2 notes, and other instructional notes, such as "Code first" and "Use additional code," listed in the tabular list for the chapter, category, subcategory, and subclassification levels of code selection that direct the coder to use a different or additional code. Any codes in the tabular range A00.0–T88.9, Z00–Z99.8, and U00.U85 may be used to identify the diagnostic reason for the encounter. The tabular list encompasses many codes describing disease and injury classifications (e.g., infectious and parasitic diseases, neoplasms, symptoms, nervous and circulatory system, etc.).

Codes that describe symptoms and signs, as opposed to definitive diagnoses, should be reported when an established diagnosis has not been made (confirmed) by the physician. Chapter 18 of the ICD-10-CM code book, "Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified" (codes R00–R99), contains many, but not all, codes for symptoms.

ICD-10-CM classifies encounters with health care providers for circumstances other than a disease or injury in chapter 21, "Factors Influencing Health Status and Contact with Health Services" (codes Z00–Z99). Circumstances other than a disease or injury often are recorded as chiefly responsible for the encounter.

A code is invalid if it does not include the full number of characters (greatest level of specificity) required. Codes in ICD-10-CM can contain from three to seven alphanumeric characters. A three-character code is to be used only if the category is not further subdivided into four-, five-, six-, or seven-character codes. Placeholder character X is used as part of an alphanumeric code to allow for future expansion and as a placeholder for empty characters in a code that requires a seventh character but has no fourth, fifth, or sixth character. Note that certain categories require seventh characters that apply to all codes in that category. Always check the category level for applicable seventh characters for that category.

Disorder — *continued*
- binocular — *continued*
  - movement — *continued*
    - convergence
      - excess H51.12
      - insufficiency H51.11
    - internuclear ophthalmoplegia — *see* Ophthalmoplegia, internuclear
    - palsy of conjugate gaze H51.Ø
    - specified type NEC H51.8
  - vision NEC — *see* Disorder, vision, binocular
- bipolar (I) seasonal) (type I) F31.9
  - and related due to a known physiological condition
    - with
      - manic features FØ6.33
      - manic- or hypomanic-like episodes FØ6.33
      - mixed features FØ6.34
  - current (or most recent) episode
    - depressed F31.9
      - with psychotic features F31.5
      - without psychotic features F31.3Ø
        - mild F31.31
        - moderate F31.32
        - severe (without psychotic features) F31.4
          - with psychotic features F31.5
    - hypomanic F31.Ø
    - manic F31.9
      - with psychotic features F31.2
      - without psychotic features F31.1Ø
        - mild F31.11
        - moderate F31.12
        - severe (without psychotic features) F31.13
          - with psychotic features F31.2
    - mixed F31.6Ø
      - mild F31.61
      - moderate F31.62
      - severe (without psychotic features) F31.63
        - with psychotic features F31.64
    - severe depression (without psychotic features) F31.4
      - with psychotic features F31.5
  - II (type 2) F31.81
  - in remission (currently) F31.7Ø
    - in full remission
      - most recent episode
        - depressed F31.76
        - hypomanic F31.72
        - manic F31.74
        - mixed F31.78
    - in partial remission
      - most recent episode
        - depressed F31.75
        - hypomanic F31.71
        - manic F31.73
        - mixed F31.77
  - organic FØ6.3Ø
  - single manic episode F30.9
    - mild F3Ø.11
    - moderate F3Ø.12
    - severe (without psychotic symptoms) F3Ø.13
      - with psychotic symptoms F3Ø.2
  - specified NEC F31.89
- bladder N32.9
  - functional NEC N31.9
  - in schistosomiasis B65.Ø *[N33]*
  - specified NEC N32.89
- bleeding D68.9
- blood D75.9
  - in congenital early syphilis A5Ø.Ø9 *[D77]*
- body dysmorphic F45.22
- bone M89.9
  - continuity M84.9
    - specified type NEC M84.8Ø
      - ankle M84.87- ☑
      - fibula M84.86- ☑
      - foot M84.87- ☑
      - hand M84.84- ☑
      - humerus M84.82- ☑
      - neck M84.88
      - pelvis M84.859
      - radius M84.83- ☑
      - rib M84.88
      - shoulder M84.81- ☑
      - skull M84.88
      - thigh M84.85- ☑
      - tibia M84.86- ☑
      - ulna M84.83- ☑

Disorder — *continued*
- bone — *continued*
  - continuity — *continued*
    - specified type — *continued*
      - vertebra M84.88
  - density and structure M85.9
    - cyst — *see also* Cyst, bone, specified type NEC
      - aneurysmal — *see* Cyst, bone, aneurysmal
      - solitary — *see* Cyst, bone, solitary
    - diffuse idiopathic skeletal hyperostosis — *see* Hyperostosis, ankylosing
    - fibrous dysplasia (monostotic) — *see* Dysplasia, fibrous, bone
    - fluorosis — *see* Fluorosis, skeletal
    - hyperostosis of skull M85.2
    - osteitis condensans — *see* Osteitis, condensans
    - specified type NEC M85.8- ☑
      - ankle M85.87- ☑
      - foot M85.87- ☑
      - forearm M85.83- ☑
      - hand M85.84- ☑
      - lower leg M85.86- ☑
      - multiple sites M85.89
      - neck M85.88
      - rib M85.88
      - shoulder M85.81- ☑
      - skull M85.88
      - thigh M85.85- ☑
      - upper arm M85.82- ☑
      - vertebra M85.88
  - development and growth NEC M89.2Ø
    - carpus M89.24- ☑
    - clavicle M89.21- ☑
    - femur M89.25- ☑
    - fibula M89.26- ☑
    - finger M89.24- ☑
    - humerus M89.22- ☑
    - ilium M89.28
    - ischium M89.28
    - metacarpus M89.24- ☑
    - metatarsus M89.27- ☑
    - multiple sites M89.29
    - neck M89.28
    - radius M89.23- ☑
    - rib M89.28
    - scapula M89.21- ☑
    - skull M89.28
    - tarsus M89.27- ☑
    - tibia M89.26- ☑
    - toe M89.27- ☑
    - ulna M89.23- ☑
    - vertebra M89.28
  - specified type NEC M89.8X- ☑
- brachial plexus G54.Ø
- branched-chain amino-acid metabolism E71.2
  - specified NEC E71.19
- breast N64.9
  - agalactia — *see* Agalactia
  - associated with
    - lactation O92.7Ø
      - specified NEC O92.79
    - pregnancy O92.2Ø
      - specified NEC O92.29
    - puerperium O92.2Ø
      - specified NEC O92.29
  - cracked nipple — *see* Cracked nipple
  - galactorrhea — *see* Galactorrhea
  - hypogalactia O92.4
  - lactation disorder NEC O92.79
  - mastitis — *see* Mastitis
  - nipple infection — *see* Infection, nipple
  - retracted nipple — *see* Retraction, nipple
  - specified type NEC N64.89
- Briquet's F45.Ø
- bullous, in diseases classified elsewhere L14
- caffeine use
  - mild
    - with
      - caffeine-induced
        - anxiety disorder F15.18Ø
        - sleep disorder F15.182
  - moderate or severe
    - with
      - caffeine-induced
        - anxiety disorder F15.28Ø
        - sleep disorder F15.282

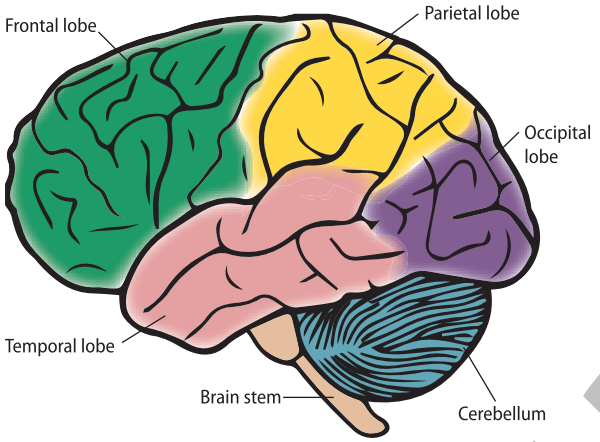
Disorder — *continued*
- cannabis use
  - mild F12.1Ø
    - with
      - cannabis intoxication delirium F12.121
        - with perceptual disturbances F12.122
        - without perceptual disturbances F12.129
      - cannabis-induced
        - anxiety disorder F12.18Ø
        - psychotic disorder F12.159
        - sleep disorder F12.188
    - in remission (early) (sustained) F12.11
  - moderate or severe F12.2Ø
    - with
      - cannabis intoxication
        - with perceptual disturbances F12.222
        - without perceptual disturbances F12.229
      - cannabis-induced
        - anxiety disorder F12.28Ø
        - psychotic disorder F12.259
        - sleep disorder F12.288
        - delirium F12.221
    - in remission (early) (sustained) F12.21
- carbohydrate
  - absorption, intestinal NEC E74.39
  - metabolism (congenital) E74.9
    - specified NEC E74.89
- cardiac, functional I51.89
- carnitine metabolism E71.4Ø
- cartilage M94.9
  - articular NEC — *see* Derangement, joint, articular cartilage
  - chondrocalcinosis — *see* Chondrocalcinosis
  - specified type NEC M94.8X- ☑
    - articular — *see* Derangement, joint, articular cartilage
    - multiple sites M94.8XØ
- catatonia (due to known physiological condition) (with another mental disorder) FØ6.1
- catatonic
  - due to (secondary to) known physiological condition FØ6.1
  - organic FØ6.1
- central auditory processing H93.25
- cervical
  - region NEC M53.82
  - root (nerve) NEC G54.2
- character NOS F6Ø.9
- childhood disintegrative NEC F84.3
- cholesterol and bile acid metabolism E78.7Ø
  - Barth syndrome E78.71
  - other specified E78.79
  - Smith-Lemli-Opitz syndrome E78.72
- choroid H31.9
  - atrophy — *see* Atrophy, choroid
  - degeneration — *see* Degeneration, choroid
  - detachment — *see* Detachment, choroid
  - dystrophy — *see* Dystrophy, choroid
  - hemorrhage — *see* Hemorrhage, choroid
  - rupture — *see* Rupture, choroid
  - scar — *see* Scar, chorioretinal
  - solar retinopathy — *see* Retinopathy, solar
  - specified type NEC H31.8
- ciliary body — *see* Disorder, iris
  - degeneration — *see* Degeneration, ciliary body
- coagulation (factor) — *see also* Defect, coagulation D68.9
  - newborn, transient P61.6
- cocaine use
  - mild F14.1Ø
    - with
      - amphetamine, cocaine, or other stimulant intoxication
        - with perceptual disturbances F14.122
        - without perceptual disturbances F14.129
      - cocaine intoxication delirium F14.121
      - cocaine-induced
        - anxiety disorder F14.18Ø
        - bipolar and related disorder F14.14
        - depressive disorder F14.14
        - obsessive-compulsive and related disorder F14.188
        - psychotic disorder F14.159
        - sexual dysfunction F14.181
        - sleep disorder F14.182
    - in remission (early) (sustained) F14.11
  - moderate or severe F14.2Ø

C69.9 Malignant neoplasm of unspecified site of eye
Malignant neoplasm of eyeball
C69.9Ø Malignant neoplasm of unspecified site of unspecified eye RP
C69.91 Malignant neoplasm of unspecified site of right eye
C69.92 Malignant neoplasm of unspecified site of left eye

C7Ø Malignant neoplasm of meninges
C7Ø.Ø Malignant neoplasm of cerebral meninges
C7Ø.1 Malignant neoplasm of spinal meninges
C7Ø.9 Malignant neoplasm of meninges, unspecified

C71 Malignant neoplasm of brain
EXCLUDES 1 *malignant neoplasm of cranial nerves (C72.2-C72.5)*
retrobulbar malignant neoplasm (C69.6-)

Lobes of the Brain



C71.Ø Malignant neoplasm of cerebrum, except lobes and ventricles
Malignant neoplasm of supratentorial NOS
C71.1 Malignant neoplasm of frontal lobe
C71.2 Malignant neoplasm of temporal lobe
C71.3 Malignant neoplasm of parietal lobe
C71.4 Malignant neoplasm of occipital lobe
C71.5 Malignant neoplasm of cerebral ventricle
EXCLUDES 1 *malignant neoplasm of fourth cerebral ventricle (C71.7)*
C71.6 Malignant neoplasm of cerebellum
C71.7 Malignant neoplasm of brain stem
Malignant neoplasm of fourth cerebral ventricle
Infratentorial malignant neoplasm NOS
C71.8 Malignant neoplasm of overlapping sites of brain
C71.9 Malignant neoplasm of brain, unspecified
AHA: 2014,3Q,3

C72 Malignant neoplasm of spinal cord, cranial nerves and other parts of central nervous system
EXCLUDES 1 *malignant neoplasm of meninges (C7Ø.-)*
malignant neoplasm of peripheral nerves and autonomic nervous system (C47.-)
C72.Ø Malignant neoplasm of spinal cord
C72.1 Malignant neoplasm of cauda equina
C72.2 Malignant neoplasm of olfactory nerve
Malignant neoplasm of olfactory bulb
C72.2Ø Malignant neoplasm of unspecified olfactory nerve RP
C72.21 Malignant neoplasm of right olfactory nerve
C72.22 Malignant neoplasm of left olfactory nerve
C72.3 Malignant neoplasm of optic nerve
C72.3Ø Malignant neoplasm of unspecified optic nerve RP
C72.31 Malignant neoplasm of right optic nerve
C72.32 Malignant neoplasm of left optic nerve
C72.4 Malignant neoplasm of acoustic nerve
C72.4Ø Malignant neoplasm of unspecified acoustic nerve RP
C72.41 Malignant neoplasm of right acoustic nerve
C72.42 Malignant neoplasm of left acoustic nerve
C72.5 Malignant neoplasm of other and unspecified cranial nerves
C72.5Ø Malignant neoplasm of unspecified cranial nerve RP
Malignant neoplasm of cranial nerve NOS
C72.59 Malignant neoplasm of other cranial nerves
C72.9 Malignant neoplasm of central nervous system, unspecified
Malignant neoplasm of unspecified site of central nervous system
Malignant neoplasm of nervous system NOS

Malignant neoplasms of thyroid and other endocrine glands (C73-C75)

C73 Malignant neoplasm of thyroid gland
Use additional code to identify any functional activity

C74 Malignant neoplasm of adrenal gland
C74.Ø Malignant neoplasm of cortex of adrenal gland
C74.ØØ Malignant neoplasm of cortex of unspecified adrenal gland
C74.Ø1 Malignant neoplasm of cortex of right adrenal gland
C74.Ø2 Malignant neoplasm of cortex of left adrenal gland
C74.1 Malignant neoplasm of medulla of adrenal gland
C74.1Ø Malignant neoplasm of medulla of unspecified adrenal gland RP
C74.11 Malignant neoplasm of medulla of right adrenal gland
C74.12 Malignant neoplasm of medulla of left adrenal gland
C74.9 Malignant neoplasm of unspecified part of adrenal gland
C74.9Ø Malignant neoplasm of unspecified part of unspecified adrenal gland RP
C74.91 Malignant neoplasm of unspecified part of right adrenal gland
C74.92 Malignant neoplasm of unspecified part of left adrenal gland

C75 Malignant neoplasm of other endocrine glands and related structures
EXCLUDES 1 *malignant carcinoid tumors (C7A.Ø-)*
malignant neoplasm of adrenal gland (C74.-)
malignant neoplasm of endocrine pancreas (C25.4)
malignant neoplasm of islets of Langerhans (C25.4)
malignant neoplasm of ovary (C56.-)
malignant neoplasm of testis (C62.-)
malignant neoplasm of thymus (C37)
malignant neoplasm of thyroid gland (C73)
malignant neuroendocrine tumors (C7A.-)
C75.Ø Malignant neoplasm of parathyroid gland
C75.1 Malignant neoplasm of pituitary gland
C75.2 Malignant neoplasm of craniopharyngeal duct
C75.3 Malignant neoplasm of pineal gland
C75.4 Malignant neoplasm of carotid body
C75.5 Malignant neoplasm of aortic body and other paraganglia
C75.8 Malignant neoplasm with pluriglandular involvement, unspecified
C75.9 Malignant neoplasm of endocrine gland, unspecified

Malignant neuroendocrine tumors (C7A)

C7A Malignant neuroendocrine tumors
Code also any associated multiple endocrine neoplasia [MEN] syndromes (E31.2-)
Use additional code to identify any associated endocrine syndrome, such as:
carcinoid syndrome (E34.Ø)
EXCLUDES 2 *malignant pancreatic islet cell tumors (C25.4)*
Merkel cell carcinoma (C4A.-)
AHA: 2019,3Q,7
DEF: Tumors comprised of cells that are capable of producing hormonal syndromes in which the normal hormonal balance required to support body system function is adversely affected.

C7A.Ø Malignant carcinoid tumors
AHA: 2019,3Q,7
DEF: Specific type of slow-growing neuroendocrine tumors. Carcinoid tumors occur most commonly in the hormone producing cells of the gastrointestinal tracts and can also occur in the pancreas, testes, ovaries, or lungs.
C7A.ØØ Malignant carcinoid tumor of unspecified site RP

Chapter 5. Mental, Behavioral and Neurodevelopmental Disorders (F01-F99)

INCLUDES disorders of psychological development

EXCLUDES 2 *symptoms, signs and abnormal clinical laboratory findings, not elsewhere classified (RØØ-R99)*

This chapter contains the following blocks:

F01-F09 Mental disorders due to known physiological conditions
F10-F19 Mental and behavioral disorders due to psychoactive substance use
F20-F29 Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
F30-F39 Mood [affective] disorders
F40-F48 Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
F50-F59 Behavioral syndromes associated with physiological disturbances and physical factors
F60-F69 Disorders of adult personality and behavior
F70-F79 Intellectual disabilities
F80-F89 Pervasive and specific developmental disorders
F90-F98 Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99 Unspecified mental disorder

Mental disorders due to known physiological conditions (F01-F09)

NOTE This block comprises a range of mental disorders grouped together on the basis of their having in common a demonstrable etiology in cerebral disease, brain injury, or other insult leading to cerebral dysfunction. The dysfunction may be primary, as in diseases, injuries, and insults that affect the brain directly and selectively; or secondary, as in systemic diseases and disorders that attack the brain only as one of the multiple organs or systems of the body that are involved.

F01 Vascular dementia

Vascular dementia as a result of infarction of the brain due to vascular disease, including hypertensive cerebrovascular disease.

INCLUDES arteriosclerotic dementia
major neurocognitive disorder due to vascular disease
multi-infarct dementia

Code first the underlying physiological condition or sequelae of cerebrovascular disease.

AHA: 2022,4Q,14-15

F01.5 Vascular dementia, unspecified severity

F01.50 Vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety RP CH A
Major neurocognitive disorder due to vascular disease NOS
Vascular dementia NOS
AHA: 2021,2Q,4

F01.51 Vascular dementia, unspecified severity, with behavioral disturbance

F01.511 Vascular dementia, unspecified severity, with agitation RP CH A
Major neurocognitive disorder due to vascular disease, unspecified severity, with aberrant motor behavior such as restlessness, rocking, pacing, or exit-seeking
Major neurocognitive disorder due to vascular disease, unspecified severity, with verbal or physical behaviors such as profanity, shouting, threatening, anger, aggression, combativeness, or violence
Vascular dementia, unspecified severity, with aberrant motor behavior such as restlessness, rocking, pacing, or exit-seeking
Vascular dementia, unspecified severity, with verbal or physical behaviors such as profanity, shouting, threatening, anger, aggression, combativeness, or violence

F01.518 Vascular dementia, unspecified severity, with other behavioral disturbance RP CH A
Major neurocognitive disorder due to vascular disease, unspecified severity, with behavioral disturbances such as sleep disturbance, social disinhibition, or sexual disinhibition
Vascular dementia, unspecified severity, with behavioral disturbances such as sleep disturbance, social disinhibition, or sexual disinhibition
Use additional code, if applicable, to identify wandering in vascular dementia (Z91.83)

F01.52 Vascular dementia, unspecified severity, with psychotic disturbance RP CH A

Major neurocognitive disorder due to vascular disease, unspecified severity, with psychotic disturbance such as hallucinations, paranoia, suspiciousness, or delusional state
Vascular dementia, unspecified severity, with psychotic disturbance such as hallucinations, paranoia, suspiciousness, or delusional state

F01.53 Vascular dementia, unspecified severity, with mood disturbance RP CH A

Major neurocognitive disorder due to vascular disease, unspecified severity, with mood disturbance such as depression, apathy, or anhedonia
Vascular dementia, unspecified severity, with mood disturbance such as depression, apathy, or anhedonia

F01.54 Vascular dementia, unspecified severity, with anxiety RP CH A

Major neurocognitive disorder due to vascular disease, unspecified severity, with anxiety

F01.A Vascular dementia, mild

EXCLUDES 1 *mild neurocognitive disorder due to known physiological condition with or without behavioral disturbance (FØ6.7-)*

F01.A0 Vascular dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety RP CH A

Major neurocognitive disorder due to vascular disease, mild, NOS
Vascular dementia, mild, NOS

F01.A1 Vascular dementia, mild, with behavioral disturbance

F01.A11 Vascular dementia, mild, with agitation RP CH A
Major neurocognitive disorder due to vascular disease, mild, with aberrant motor behavior such as restlessness, rocking, pacing, or exit-seeking
Major neurocognitive disorder due to vascular disease, mild, with verbal or physical behaviors such as profanity, shouting, threatening, anger, aggression, combativeness, or violence
Vascular dementia, mild, with aberrant motor behavior such as restlessness, rocking, pacing, or exit-seeking
Vascular dementia, mild, with verbal or physical behaviors such as profanity, shouting, threatening, anger, aggression, combativeness, or violence

Chapter 13. Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)

NOTE Use an external cause code following the code for the musculoskeletal condition, if applicable, to identify the cause of the musculoskeletal condition

EXCLUDES 2 *arthropathic psoriasis (L40.5-)*
certain conditions originating in the perinatal period (P04-P96)
certain infectious and parasitic diseases (A00-B99)
compartment syndrome (traumatic) (T79.A-)
complications of pregnancy, childbirth and the puerperium (O00-O9A)
congenital malformations, deformations, and chromosomal abnormalities (Q00-Q99)
endocrine, nutritional and metabolic diseases (E00-E88)
injury, poisoning and certain other consequences of external causes (S00-T88)
neoplasms (C00-D49)
symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94)

This chapter contains the following blocks:

M00-M02 Infectious arthropathies
M04 Autoinflammatory syndromes
M05-M14 Inflammatory polyarthropathies
M15-M19 Osteoarthritis
M20-M25 Other joint disorders
M26-M27 Dentofacial anomalies [including malocclusion] and other disorders of jaw
M30-M36 Systemic connective tissue disorders
M40-M43 Deforming dorsopathies
M45-M49 Spondylopathies
M50-M54 Other dorsopathies
M60-M63 Disorders of muscles
M65-M67 Disorders of synovium and tendon
M70-M79 Other soft tissue disorders
M80-M85 Disorders of bone density and structure
M86-M90 Other osteopathies
M91-M94 Chondropathies
M95 Other disorders of the musculoskeletal system and connective tissue
M96 Intraoperative and postprocedural complications and disorders of musculoskeletal system, not elsewhere classified
M97 Periprosthetic fracture around internal prosthetic joint
M99 Biomechanical lesions, not elsewhere classified

ARTHROPATHIES (M00-M25)

INCLUDES disorders affecting predominantly peripheral (limb) joints

Infectious arthropathies (M00-M02)

NOTE This block comprises arthropathies due to microbiological agents. Distinction is made between the following types of etiological relationship:

a) direct infection of joint, where organisms invade synovial tissue and microbial antigen is present in the joint;

b) indirect infection, which may be of two types: a reactive arthropathy, where microbial infection of the body is established but neither organisms nor antigens can be identified in the joint, and a postinfective arthropathy, where microbial antigen is present but recovery of an organism is inconstant and evidence of local multiplication is lacking.

AHA: 2019,3Q,16

M00 Pyogenic arthritis

EXCLUDES 2 *infection and inflammatory reaction due to internal joint prosthesis (T84.5-)*

AHA: 2022,1Q,31

DEF: Pyogenic: Relating to or involving pus production, often referred to as suppurative or purulent.

M00.0 Staphylococcal arthritis and polyarthritis

Use additional code (B95.61-B95.8) to identify bacterial agent

M00.00 Staphylococcal arthritis, unspecified joint RP

M00.01 Staphylococcal arthritis, shoulder
M00.011 Staphylococcal arthritis, right shoulder
M00.012 Staphylococcal arthritis, left shoulder
M00.019 Staphylococcal arthritis, unspecified shoulder RP

M00.02 Staphylococcal arthritis, elbow
M00.021 Staphylococcal arthritis, right elbow
M00.022 Staphylococcal arthritis, left elbow
M00.029 Staphylococcal arthritis, unspecified elbow RP

M00.03 Staphylococcal arthritis, wrist
Staphylococcal arthritis of carpal bones
M00.031 Staphylococcal arthritis, right wrist
M00.032 Staphylococcal arthritis, left wrist
M00.039 Staphylococcal arthritis, unspecified wrist RP

M00.04 Staphylococcal arthritis, hand
Staphylococcal arthritis of metacarpus and phalanges
M00.041 Staphylococcal arthritis, right hand
M00.042 Staphylococcal arthritis, left hand
M00.049 Staphylococcal arthritis, unspecified hand RP

M00.05 Staphylococcal arthritis, hip
M00.051 Staphylococcal arthritis, right hip
M00.052 Staphylococcal arthritis, left hip
M00.059 Staphylococcal arthritis, unspecified hip RP

M00.06 Staphylococcal arthritis, knee
M00.061 Staphylococcal arthritis, right knee
M00.062 Staphylococcal arthritis, left knee
M00.069 Staphylococcal arthritis, unspecified knee RP

M00.07 Staphylococcal arthritis, ankle and foot
Staphylococcal arthritis, tarsus, metatarsus and phalanges
M00.071 Staphylococcal arthritis, right ankle and foot
M00.072 Staphylococcal arthritis, left ankle and foot
M00.079 Staphylococcal arthritis, unspecified ankle and foot RP

M00.08 Staphylococcal arthritis, vertebrae
M00.09 Staphylococcal polyarthritis

M00.1 Pneumococcal arthritis and polyarthritis

M00.10 Pneumococcal arthritis, unspecified joint RP

M00.11 Pneumococcal arthritis, shoulder
M00.111 Pneumococcal arthritis, right shoulder
M00.112 Pneumococcal arthritis, left shoulder
M00.119 Pneumococcal arthritis, unspecified shoulder RP

M00.12 Pneumococcal arthritis, elbow
M00.121 Pneumococcal arthritis, right elbow
M00.122 Pneumococcal arthritis, left elbow
M00.129 Pneumococcal arthritis, unspecified elbow RP

M00.13 Pneumococcal arthritis, wrist
Pneumococcal arthritis of carpal bones
M00.131 Pneumococcal arthritis, right wrist
M00.132 Pneumococcal arthritis, left wrist
M00.139 Pneumococcal arthritis, unspecified wrist RP

M00.14 Pneumococcal arthritis, hand
Pneumococcal arthritis of metacarpus and phalanges
M00.141 Pneumococcal arthritis, right hand
M00.142 Pneumococcal arthritis, left hand
M00.149 Pneumococcal arthritis, unspecified hand RP

M00.15 Pneumococcal arthritis, hip
M00.151 Pneumococcal arthritis, right hip
M00.152 Pneumococcal arthritis, left hip
M00.159 Pneumococcal arthritis, unspecified hip RP

M00.16 Pneumococcal arthritis, knee
M00.161 Pneumococcal arthritis, right knee
M00.162 Pneumococcal arthritis, left knee
M00.169 Pneumococcal arthritis, unspecified knee RP

M00.17 Pneumococcal arthritis, ankle and foot
Pneumococcal arthritis, tarsus, metatarsus and phalanges
M00.171 Pneumococcal arthritis, right ankle and foot
M00.172 Pneumococcal arthritis, left ankle and foot
M00.179 Pneumococcal arthritis, unspecified ankle and foot RP

M00.18 Pneumococcal arthritis, vertebrae
M00.19 Pneumococcal polyarthritis

Chapter 21. Factors Influencing Health Status and Contact with Health Services (Z00–Z99)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

Note: The chapter-specific guidelines provide additional information about the use of Z codes for specified encounters.

a. Use of Z Codes in any healthcare setting

Z codes are for use in any healthcare setting. Z codes may be used as either a first-listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter. Certain Z codes may only be used as first-listed or principal diagnosis.

Patient with middle lobe lung cancer admitted for observation and discontinuation of chemotherapy

Z51.11 Encounter for antineoplastic chemotherapy

C34.2 Malignant neoplasm of middle lobe, bronchus or lung

Explanation: A Z code can be used as first-listed in this situation based on guidelines in this chapter as well as chapter 2, "Neoplasms."

b. Z Codes indicate a reason for an encounter or provide additional information about a patient encounter

Z codes are not procedure codes. A corresponding procedure code must accompany a Z code to describe any procedure performed.

c. Categories of Z Codes

1) Contact/exposure

Category Z20 indicates contact with, and suspected exposure to, communicable diseases. These codes are for patients who are suspected to have been exposed to a disease by close personal contact with an infected individual or are in an area where a disease is epidemic.

Category Z77, Other contact with and (suspected) exposures hazardous to health, indicates contact with and suspected exposures hazardous to health.

Contact/exposure codes may be used as a first-listed code to explain an encounter for testing, or, more commonly, as a secondary code to identify a potential risk.

2) Inoculations and vaccinations

Code Z23 is for encounters for inoculations and vaccinations. It indicates that a patient is being seen to receive a prophylactic inoculation against a disease. Procedure codes are required to identify the actual administration of the injection and the type(s) of immunizations given. Code Z23 may be used as a secondary code if the inoculation is given as a routine part of preventive health care, such as a well-baby visit.

3) Status

Status codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition.

A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code. For example, code Z94.1, Heart transplant status, should not be used with a code from subcategory T86.2, Complications of heart transplant. The status code does not provide additional information. The complication code indicates that the patient is a heart transplant patient.

For encounters for weaning from a mechanical ventilator, assign a code from subcategory J96.1, Chronic respiratory failure, followed by code Z99.11, Dependence on respirator [ventilator] status.

The status Z codes/categories are:

Z14 Genetic carrier

Genetic carrier status indicates that a person carries a gene, associated with a particular disease, which may be passed to offspring who may develop that disease. The person does not have the disease and is not at risk of developing the disease.

Z15 Genetic susceptibility to disease

Genetic susceptibility indicates that a person has a gene that increases the risk of that person developing the disease.

Codes from category Z15 should not be used as principal or first-listed codes. If the patient has the condition to which he/she is susceptible, and that condition is the reason for the encounter, the code for the current condition should be sequenced first. If the patient is being seen for follow-up after completed treatment for this condition, and the condition no longer exists, a follow-up code should be sequenced first, followed by the appropriate personal history and genetic susceptibility codes. If the purpose of the encounter is genetic counseling associated with procreative management, code Z31.5, Encounter for genetic counseling, should be assigned as the first-listed code, followed by a code from category Z15. Additional codes should be assigned for any applicable family or personal history.

Z16 Resistance to antimicrobial drugs

This code indicates that a patient has a condition that is resistant to antimicrobial drug treatment. Sequence the infection code first.

Z17 Estrogen receptor status

Z18 Retained foreign body fragments

Z19 Hormone sensitivity malignancy status

Z21 Asymptomatic HIV infection status

This code indicates that a patient has tested positive for HIV but has manifested no signs or symptoms of the disease.

Z22 Carrier of infectious disease

Carrier status indicates that a person harbors the specific organisms of a disease without manifest symptoms and is capable of transmitting the infection.

Z28.3 Underimmunization status

See Section I.B.14. for underimmunization documentation by clinicians other than the patient's provider.

Z33.1 Pregnant state, incidental

This code is a secondary code only for use when the pregnancy is in no way complicating the reason for visit. Otherwise, a code from the obstetric chapter is required.

Z66 Do not resuscitate

This code may be used when it is documented by the provider that a patient is on do not resuscitate status at any time during the stay.

Z67 Blood type

Z68 Body mass index (BMI)

BMI codes should only be assigned when there is an associated, reportable diagnosis (such as obesity). Do not assign BMI codes during pregnancy.

See Section I.B.14. for BMI documentation by clinicians other than the patient's provider.

Z74.01 Bed confinement status

Z76.82 Awaiting organ transplant status

Z78 Other specified health status

Code Z78.1, Physical restraint status, may be used when it is documented by the provider that a patient has been put in restraints during the current encounter. Please note that this code should not be reported when it is documented by the provider that a patient is temporarily restrained during a procedure.

Z79 Long-term (current) drug therapy

Codes from this category indicate a patient's continuous use of a prescribed drug (including such things as aspirin therapy) for the long-term treatment of a condition or for prophylactic use. It is not for use for patients who have addictions to drugs. This subcategory is not for use of medications for detoxification or maintenance programs to prevent withdrawal symptoms (e.g., methadone maintenance for opiate dependence). Assign the appropriate code for the drug use, abuse or dependence instead.

Assign a code from Z79 if the patient is receiving a medication for an extended period as a prophylactic measure (such as for the prevention of deep vein thrombosis) or as treatment of a chronic condition (such as arthritis) or a disease requiring a lengthy course of treatment (such as cancer). Do not assign a code from

Appendix D: Qualifications for Medicare Coverage of Home Health Services

The criteria that must be met by the patient to qualify for Medicare coverage of home health services are specified in the following sections of the Medicare Benefit Policy Manual (Pub. 100-02), Chapter 7 - Home Health Services.

Conditions to be Met for Coverage of Home Health Services

Medicare covers HHA services when the following criteria are met:

1. The person to whom the services are provided is an eligible Medicare beneficiary;
2. The HHA that is providing the services to the beneficiary has in effect a valid agreement to participate in the Medicare program;
3. The beneficiary qualifies for coverage of home health services as described in §30;
4. The services for which payment is claimed are covered as described in §§40 and 50;
5. Medicare is the appropriate payer; and
6. The services for which payment is claimed are not otherwise excluded from payment.

Reasonable and Necessary Services

Background: In enacting the Medicare program, Congress recognized that the physician or allowed practitioner would play an important role in determining utilization of services. The law requires that payment can be made only if a physician or allowed practitioner certifies the need for services and establishes a plan of care. The Secretary is responsible for ensuring that Medicare covers the claimed services, including determining whether they are "reasonable and necessary."

Determination of Coverage: The Medicare contractor's decision on whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS as required by 42 CFR 484.55 or a medical record of the individual patient. Medicare does not deny coverage solely on the basis of the reviewer's general inferences about patients with similar diagnoses or on data related to utilization generally, but bases it upon objective clinical evidence regarding the patient's individual need for care.

Coverage of skilled nursing care or therapy to perform a maintenance program does not turn on presence or absence of a patient's potential for improvement from nursing care or therapy, but rather on the patient's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

Impact of Other Available Caregivers and Other Available Coverage on Medicare Coverage of Home Health Services

Where the Medicare criteria for coverage of home health services are met, patients are entitled by law to coverage of reasonable and necessary home health services. Therefore, a patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services. However, where a family member or other person is or will be providing services that adequately meet the patient's needs, it would not be reasonable and necessary for HHA personnel to furnish such services. Ordinarily it can be presumed that there is no able and willing person in the home to provide the services being rendered by the HHA unless the patient or family indicates otherwise and objects to the provision of the services by the HHA, or unless the HHA has first hand knowledge to the contrary.

Similarly, a patient is entitled to reasonable and necessary Medicare home health services even if the patient would qualify for institutional care (e.g., hospital care or skilled nursing facility care) and Medicare payment should be made for reasonable and necessary home health services where the patient is also receiving supplemental services that do not meet Medicare's definition of skilled nursing care or home health aide services.

Example 1: A patient who lives with an adult daughter and otherwise qualifies for Medicare coverage of home health services, requires the assistance of a home health aide for bathing and assistance with an exercise program to improve endurance. The daughter is unwilling to bathe her elderly father and assist him with the exercise program. Home health aide services would be reasonable and necessary.

Example 2: A patient who is being discharged from a hospital with a diagnosis of osteomyelitis and requires continuation of the I.V. antibiotic therapy that was begun in the hospital was found to meet the criteria for Medicare coverage of skilled nursing facility services. If the patient also meets the qualifying criteria for coverage of home health services, payment may be made for the reasonable and necessary home health services the patient needs, notwithstanding the availability of coverage in a skilled nursing facility.

Example 3: A patient who needs skilled nursing care on an intermittent basis also hires a licensed practical (vocational) nurse to provide nighttime assistance while family members sleep. The care provided by the nurse, as respite to the family members, does not require the skills of a licensed nurse (as defined in §40.1) and therefore has no impact on the beneficiary's eligibility for Medicare payment of home health services even though another third party insurer may pay for that nursing care.

Use of Utilization Screens and "Rules of Thumb"

Medicare recognizes that determinations of whether home health services are reasonable and necessary must be based on an assessment of each beneficiary's individual care needs. Therefore, denial of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms is not appropriate.

Conditions Patient Must Meet to Qualify for Coverage of Home Health Services

To qualify for the Medicare home health benefit a Medicare beneficiary must meet the following requirements:

- Be confined to the home;
- Under the care of a physician or allowed practitioner;
- Receiving services under a plan of care established and periodically reviewed by a physician or allowed practitioner;
- Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or
- Have a continuing need for occupational therapy.

For purposes of benefit eligibility, "intermittent" means skilled nursing care that is either provided or needed on fewer than seven days each week or less than eight hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

A patient must meet each of the criteria specified in this section. Patients who meet each of these criteria are eligible to have payment made on their behalf for services discussed in §§40 and 50.

Confined to the Home

For a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician or allowed practitioner certify in all cases that the patient is confined to his/her home. For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

1. Criterion-One:

   The patient must either:

   - Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence

   OR

   - Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the criterion-one conditions, then the patient must *also* meet two additional requirements defined in criterion two below.

2. Criterion-Two:
   - There must exist a normal inability to leave home; AND
   - Leaving home must require a considerable and taxing effort.

To clarify, in determining whether the patient meets criterion two of the homebound definition, the clinician needs to take into account the illness or injury for which the patient met criterion one and consider the illness or injury in the context of the patient's overall condition. The clinician is not required to include standardized phrases reflecting the patient's condition (e.g., repeating the words "taxing effort to leave the home") in the patient's chart, nor are such phrases sufficient, by themselves, to demonstrate that criterion two has been met. For example, longitudinal clinical information about the patient's health status is typically needed to sufficiently demonstrate a normal inability to leave the home and that leaving home requires a considerable and taxing effort. Such clinical information about the patient's overall health status may include, but is not limited to, such factors as the patient's diagnosis, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, etc.

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.

Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited to furnish adult day-care

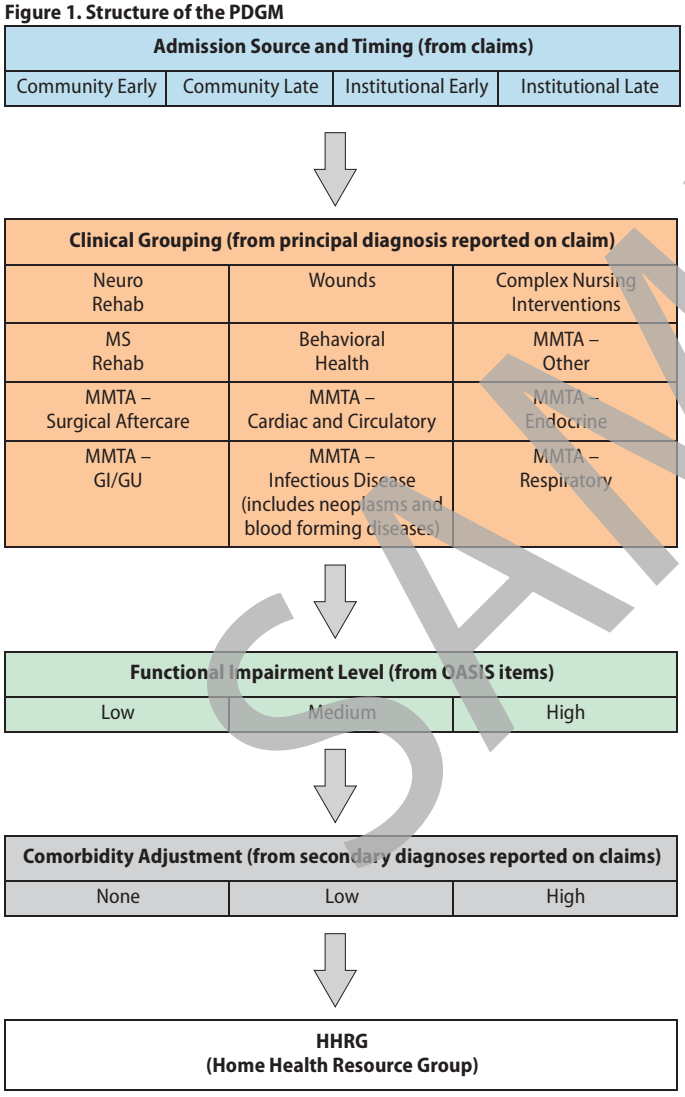
Appendix E: Overview of the Patient-Driven Groupings Model (PDGM)

The Patient-Driven Groupings Model (PDGM) uses 30-day periods as a basis for payment. Figure 1 below provides an overview of how 30-day periods are categorized into 432 case-mix groups for the purposes of adjusting payment in the PDGM. In particular, 30-day periods are placed into different subgroups for each of the following broad categories:

- Admission source (two subgroups): community or institutional admission source
- Timing of the 30-day period (two subgroups): early or late
- Clinical grouping (twelve subgroups): musculoskeletal rehabilitation; neuro/stroke rehabilitation; wounds; medication management, teaching, and assessment (MMTA) — surgical aftercare; MMTA — cardiac and circulatory; MMTA — endocrine; MMTA — gastrointestinal tract and genitourinary system; MMTA — infectious disease, neoplasms, and blood-forming diseases; MMTA — respiratory; MMTA — other; behavioral health; or complex nursing interventions
- Functional impairment level (three subgroups): low, medium, or high
- Comorbidity adjustment (three subgroups): none, low, or high based on secondary diagnoses

In total, there are 2*2*12*3*3 = 432 possible case-mix adjusted payment groups. The remainder of this overview provides more detail on each PDGM grouping category and additional adjustments to payment that are made within the PDGM.

Figure 1. Structure of the PDGM



Under the PDGM, a 30-day period is grouped into one (and only one) subcategory under each larger colored category. A 30-day period's combination of subcategories places the 30-day period into one of 432 different payment groups.

Admission Source

Under the PDGM, each 30-day period is classified into one of two admission source categories — community or institutional — depending on what healthcare setting was utilized in the 14 days prior to home health admission. Late 30-day periods are always classified as a community admission unless there was an acute inpatient hospital stay in the 14 days prior to the late home health 30-day period. A post-acute stay in the 14 days prior to a late home health 30-day period would not be classified as an institutional admission unless the patient had been discharged from home health prior to a post-acute stay.

The Medicare claims processing system will check for the presence of an acute/post-acute Medicare claim for an institutional stay occurring within 14 days of the home health admission on an ongoing basis. However, if the HHA is aware that a beneficiary had a preceding acute/post-acute care stay, HHAs have the option to submit occurrence code 61 (hospital discharge date) or occurrence code 62 (other institutional discharge date) indicating a preceding institutional stay in order to categorize the home health admission as "institutional."

Timing

Under the PDGM, the first 30-day period is classified as early. All subsequent 30-day periods (second or later) in a sequence of 30-day periods are classified as late. A sequence of 30-day periods continues until there is a gap of at least 60-days between the end of one 30-day period and the start of the next. When there is a gap of at least 60-days, the subsequent 30-day period is classified as being the first 30-day period of a new sequence (and therefore, is labeled as early).

HHAs will not have to determine whether a 30-day period is early (the first 30-day period) or late (all adjacent 30-day periods beyond the first 30-day period). CMS will use Medicare claims data and not the Outcome and Assessment Information Set (OASIS) in order to determine if a 30-day period is considered early or late. Information from the Medicare claims system will be used during claims processing to automatically assign the appropriate timing category.

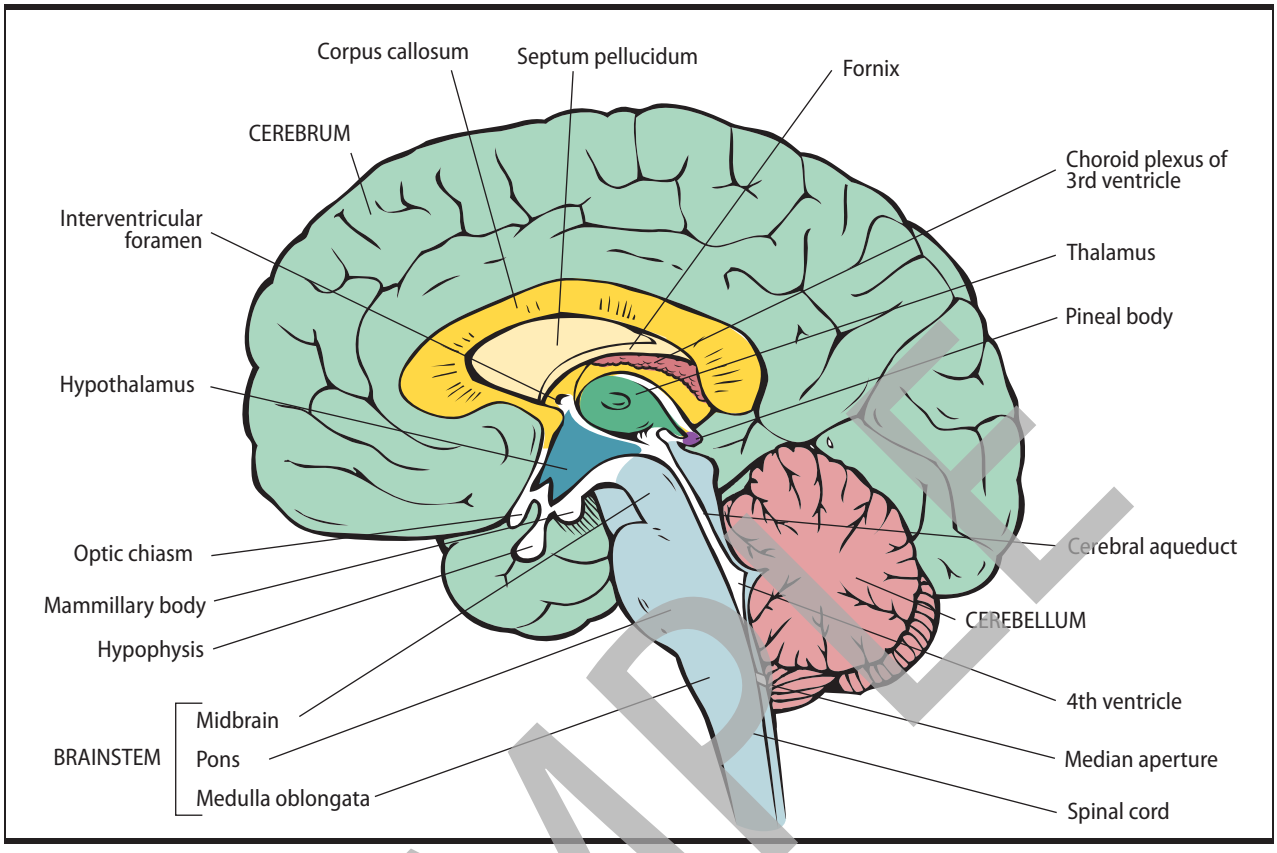
While the unit of payment for home health services will be a 30-day period, all other requirements (that is, certification, recertification, updates to the comprehensive assessment and plan of care) will remain on a 60-day basis. As a result, information obtained from the Outcome and Assessment Information Set (OASIS) used in the PDGM may not change over the two 30-day periods the OASIS covers. However, if a patient experiences a significant change in condition before the start of a subsequent, contiguous 30-day period; for example, due to a fall with injury; a follow-up assessment would be submitted at the start of a second 30-day period to reflect any changes in the patient's condition, including functional abilities, and the second 30-day claim would be grouped into its appropriate case-mix group accordingly.

Clinical Grouping

Under the PDGM, each 30-day period is grouped into one of twelve clinical groups based on the patient's principal diagnosis. The reported principal diagnosis provides information to describe the primary reason for which patients are receiving home health services under the Medicare home health benefit. Table 1 describes the twelve clinical groups. These groups are designed to capture the most common types of care that home health agencies (HHAs) provide.

Chapter 6. Diseases of the Nervous System (GØØ–G99)

Brain



Cranial Nerves