Eli's Rehab Report

For Aftercare, Report New V Codes Instead of Surgical Codes

If your rehab practice performs aftercare following surgery or fracture, do not report the surgery or fracture code as your primary diagnosis. Instead, correct coding dictates that you should select the appropriate V code from ICD-9's "aftercare" section to illustrate your role in the patient's recovery.

The U.S. Department of Health and Human Services (HHS) introduced more than 30 new aftercare V codes in 2003. Although many PM&R practices were grateful for the new codes, just as many were confused about how to use them.

"One of our rehab patients is a diabetic who lives far away from her orthopedic surgeon," says **Tammy Roesner,** billing assistant at Forman Rehab in Illinois. "Because our physiatrist is her rehab physician and saw her in the hospital following her great-toe amputation, he took over her aftercare so she wouldn't have to drive into the city to see the surgeon. We weren't sure whether to report the diagnosis code for the diabetes (250.xx), the toe ulcer (250.7x-250.8x, 707.15), or the aftercare."

Because the surgeon removed the dead tissue, you should not report the toe-ulcer diagnosis. The physiatrist should first report **ICD-9 V54.89** (Other orthopedic aftercare), then V49.71 (Lower limb amputation status, great toe), followed by the diabetes code (250.xx) to denote the underlying condition.

Not All Aftercare Requires Two Codes

A note in ICD-9's "Other aftercare following surgery" section (V58.4x, V58.7x) instructs coders to report these codes with another aftercare code "to fully identify the reason for the aftercare encounter," but many PM&R practices wonder why these codes exist at all if they must piggy-back them onto other V codes. (You need not report a second V code with aftercare codes V50.x-58.3.)

"Two codes may be necessary to tell the insurer the complete story," says **Elisabeth Fulton, CPC,** coding specialist at Orthopaedic Specialists of the Carolinas, a practice with three physiatrists and 14 orthopedists in Winston-Salem, N.C.

For instance, a rehab physician removes a patient's pins following a craniectomy. You should report V54.0 (Aftercare involving removal of fracture plate or other internal fixation device) and V58.72 (Aftercare following surgery of the nervous system, NEC).

Or if the physiatrist adjusts the patient's neuropacemaker following craniectomy, you should report V53.02 (Fitting and adjustment of neuropacemaker [brain] [peripheral nerve] [spinal cord]) and V58.72.

Current Problem Supersedes Aftercare

If you see the patient following craniectomy to manage one aspect of her rehabilitation, such as neck pain, you should report 723.1 (Cervicalgia), followed by the other postsurgical status code (V45.89). "The ICD-9 guidelines read, 'the aftercare V code should not be used if treatment is directed at a current, acute disease or injury,'" Fulton says. Therefore, treating neck pain does not qualify as aftercare.

"There is a very fine line that divides treating a current injury and aftercare," Fulton says. "Coders should look to the physician to decide whether a visit falls into the category of aftercare or treatment of a current injury."

Use Symptom Codes for Deconditioning

Some PM&R practices assign only postsurgical states V codes (V45.xx) when treating patients who decondition following surgery, but you should first report the patient's symptoms. According to the October 1999 Coding Clinic for ICD-9-CM, rehab practices should report "the symptoms of the deconditioning, such as gait disturbance (781.2), weakness (728.9 [for muscle weakness]), etc."

Most Part B carriers agree. The local medical review policies for several Part B carriers, including those in Georgia, Montana, New York, South Carolina, and Wisconsin, state, "When physical medicine and rehabilitation services are performed for beneficiaries who have suffered musculoskeletal or neurological complications secondary to some other disease, use the complication diagnosis, not the underlying condition.

"For example, when patients have become decondi-tioned because of prolonged inactivity in the cardiac care unit, use codes 728.2 (Muscular wasting and disuse atrophy, not elsewhere classified), 799.3 (Debility, unspecified), 799.4 (Cachexia), not the code for the cardiac condition."