Codify
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Eli's Rehab Report

ICD-9 Coding Corner: Place Your Diagnosis Codes in the Right Order

Many PM&R patients have multiple problems like the workers' compensation patient with back and neck pain requiring more than one definitive diagnosis. But if you keep the reason for the visit at the front of your list of diagnosis codes, your claims will be processed more smoothly.

Because CMS' oft-used HCFA 1500 form allows coders to list up to four diagnosis codes on Medicare claims, coders are able to specify the reason for the visit, underlying problems, causes of accidents, signs, symptoms, and factors influencing a patient's health status.

According to the Official ICD-9-CM Guidelines for Coding and Reporting, developed by the Public Health Service and CMS, "the circumstances of the encounter govern the selection of the principal diagnosis."

Laureen Jandroep, OTR, CPC, CCS-P CPC-H, **CCS,** consultant and CPC trainer for A+ Medical Management and Education in Absecon, N.J., offers an example. Suppose a patient sees the physiatrist for treatment of her lateral epicondylitis (**ICD-9 726.32**), which stemmed from a tennis injury. Later that afternoon, she presents to the physical therapist for neuromuscular reeducation of movement (97112) to treat her vertigo (780.4). The physiatrist would report his visit with 726.32, while the therapist would report 780.4, even though they saw the same patient on the same day.

Always remember that "E" codes (external causes of injury and poisoning) should never be listed as primary diagnoses, Jandroep cautions. Always append the E codes to the code describing the patient's condition.

Example 1: MS Patient in a Car Crash

Dan Cooley, coding consultant at Washington Medical Consultants in Baltimore, offers this example: A patient with MS (340) presents with pain in her cervical spinal area (723.1) and pain in her low back (724.2) following a car crash in which she was the driver (E812.0).

"The acute problem was pain from the accident, so the neck and back pain should go first, then the MS must be listed because it will play into the physician's medical decision-making, and finally the E code, because they always go last," Jandroep says. "Between the cervical and low back pain, choose the condition that required the most attention." In this case, the patient's cervical spine was more affected than her low back.

Therefore, this claim would be coded as follows:
723.1
724.2
340
E812.0.

Example 2: Suspected Sciatica,History of Arthritis

Also common, Cooley says, is the patient who arrives with a specific complaint or family history that causes the physician to immediately suspect a certain condition. For instance, a patient complains of chronic left leg pain in her muscles (729.5) and her hip joint (719.45). After an exam, the physiatrist suspects sciatica (724.3), but because the patient also has a family history of arthritis (V17.7) the physiatrist calls for further testing.

"You can't code the sciatica, because it is a suspected diagnosis, not a definitive one," Jandroep says. (For more on why suspected diagnoses cannot be reported, see our article "Don't Let Diagnosis Coding Be the Ignored Sibling of the Coding

World" in the July issue of Physical Medicine and Rehab Coding Alert.) "The V code would go last because it wasn't the reason for the visit, but it supports the level of medical decision-making." Therefore, the leg or hip pain should be listed first, depending on which site was more seriously affecting the patient (in this case, the leg pain was the more serious of the two).

The claim should be coded as follows:
729.5
719.45
V17.7.

Example 3: Post-Polio Syndrome

Cooley says that late effects from a previous illness often cause coding dilemmas. For instance, a patient presenting for her rehab session had polio (045.21) as a child, which has caused gait abnormalities (781.2). In addition, she now has post-polio syndrome, causing muscle weakness (728.9) and pain in her knee joints (719.46).

"Gait abnormalities would go first, since that is the reason for therapy," Jandroep says, "followed by muscle weakness and knee pain, then the late effect code for the polio [138]. You can't use 045.21 because that reflects a current case of polio, which is not the case here."

Therefore, this claim should be coded as follows:
781.2
728.9
719.46
138.

If you are coding a claim with several diagnoses and are unsure which should be listed first, always consult with the physician to determine the reason for the patient's visit and the conditions most seriously affecting the patient.