Eli's Rehab Report

Revitalize Your Dx Coding for Fracture Repair Rehab Service

Bury the myth that you cannot report a V code as a primary diagnosis

When a patient presents to your rehab practice after a fracture repair, should you include a fracture diagnosis code on the claim? Use the following example to decide and you can say goodbye to future fracture care denials.

Scenario: A patient presents to an outpatient rehab service (OT or PT) after a hip fracture repair. She complains of hip pain and joint stiffness.

Warning: Before you launch into your ICD-9 book, keep this in mind: You should not report a fracture diagnosis code from the 820 category (Fracture of neck of femur). Depending on the timeframe of the initial injury, your inclusion of the initial fracture code might inadvertently - and inaccurately - indicate to the payer that the patient has a new fracture instead of needing aftercare treatment for the original injury.

Cater to Your Payer

You have two options for your primary diagnosis code.

Option 1: List a rehab V code as your primary diagnosis. For example, in the scenario above, you would list V57.x (Care involving use of rehabilitation procedures), depending on the type of therapy.

Note: For physical therapy services, use **V57.1** (Other physical therapy). For occupational therapy services, you can report V57.21 (Encounter for occupational therapy).

Option 2: Although you can list V57.x as a primary code, many Medicare carriers for Part B services (outpatient) won't recognize these V codes as supporting medical necessity. For these payers, you may need to use the diagnosis code that is the medical reason that requires the therapy services as the primary diagnosis code. These medical-reason codes may include:

1. 719.45 - Pain in joint, pelvic region and thigh
2. 719.55 - Stiffness of joint, not elsewhere classified, pelvic region and thigh
3. 719.7 - Difficulty in walking.

Smart: Identify the diagnoses that your carriers consider medically necessary for fracture rehab services and also determine how many ICD-9 codes each payer will accept. For example, many Medicare carriers will look only at the first code you report, so you may decide to list the diagnosis code for the medical reason first.

Based on the scenario of a patient presenting for rehab post-hip fracture, "I would list both hip pain (719.45) and joint stiffness (719.55) because these problems are what the therapy will treat," says **Ellen Strunk, PT, MS, GCS,** PT clinical consultant at Restore Therapy Services Ltd. in Pelham, Ala.

Seek Secondary Aftercare Codes

Diagnosis coding doesn't stop after you choose the code for your primary slot. If you report V57.x as your primary diagnosis code, you may want to report a symptom code, such as difficulty walking (719.7), as your secondary or

treatment diagnosis, according to **Ann Lambert, Kramer, OTR/L, MHSA, CPC**, an occupational therapist at Beacon Rehab Solutions in Portland, Maine.

If you choose your primary diagnosis code based on option 2, the medical reason for the therapy (such as 719.45, 719.55 and 719.7), you should report the appropriate aftercare V codes as secondary codes to paint the picture of why the patient requires the rehabilitation service.

Under these circumstances, you will most often use V54.x (Other orthopedic aftercare) as your secondary diagnosis code.

Potential secondary V54.x codes for the above scenario include:

4. V54.09 (Other aftercare involving internal fixation device) if the patient had an ORIF of the hip fracture.
5. If the patient had a total joint placed due to the hip fracture, you should use V54.81 (Aftercare following joint replacement) plus V43.64 (Organ or tissue replaced by other means; hip) as the tertiary code. Basically, V43.64 tells the payer this patient has pain in her hip joint, that she's receiving aftercare for a joint placement, and oh, by the way, she underwent hip joint replacement.
6. If the patient underwent no surgical procedure but had a traumatic fracture, you'll use V54.13 (Aftercare for healing traumatic fracture of hip).
7. If the patient underwent no surgical procedure but had a pathologic fracture, you'll use V54.23 (Aftercare for healing pathologic fracture of hip).

FYI: A pathologic fracture occurs when a bone breaks in an area that is weakened by another disease process. Causes of weakened bone include tumors, infection, and certain inherited bone disorders.

Note: The newly released ICD-9 guidelines are at http://www.cdc.gov/nchs/data/icd9/icdguide.pdf.