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Home Health ICD-9/ICD-10 Alert

Case Study: Nail Down When to Code Symptoms Vs. the Disease

Watch for surprises from new Attachment D

If your agency is providing multiple aspects of care, make sure you're not reporting a code that only illustrates one aspect. Know when to report the underlying cause rather than the proximate cause.

Medicare directs coders to list the proximate diagnosis first if you're treating only one aspect of care for an underlying condition such as Parkinson's disease. That way, you don't misrepresent the focus of care. In the past, medical reviews denied points for using the long-term diagnosis as primary, but with PPS Refinements, the majority of the long-term chronic conditions receive the same number of points, regardless of placement in M0230 or M0240.

Exception: Because quadriplegia is in the Neuro 1 case mix category, it earns more points when coded as primary. In that case, the assessment, the plan of care, and the subsequent clinical notes should reflect a care plan with multiple aspects of care directed to the quadriplegia.

On the flip side, you don't want to make the mistake of listing a single aspect of care when your agency is providing care for multiple aspects of care. This could deny your agency case mix points its due when the condition is a Neuro 1 diagnosis.

How This Rule Applies in the Real World

So, what if a client is only receiving physical therapy and the therapist is providing muscle strengthening exercises, gait training, and safety education -- can this be considered care for "multiple aspects of the disease?" In such a case, "can you code the diagnoses instead of the V code for physical therapy?" wonders **Pat Mehmken, RN, MSN,** administrator with Tabitha Home Health Care in Lincoln, Neb.

Scenario: Your new patient's diagnoses at time of referral include: lumbosacral spondylosis, lumbar spinal stenosis, difficulty ambulating, weakness, multiple falls, osteoarthritis, arteriosclerotic heart disease (ASHD), recent pacer insertion, insulin-dependent diabetes mellitus (IDDM), peripheral neuropathy, hypertension, and gastroesophageal reflux disease (GERD). He also has a history of recent falls. Physical therapy was ordered for strength training, gait training, and to improve safety. The patient needs reminding to use his walker for gait stability. He is at high risk for falling. He has chronic back pain and joint aches. Nursing was not ordered.

The therapist rates the client's weakness and difficulty walking as a severity of 3 and the remaining diagnoses as severity of 2.

List V57.X for Therapy-Only

New instruction in Attachment D to Chapter 8 of the OASIS User's Manual changes coding for your therapy-only patients, notes Conetoe, N.C.-based coding and billing specialist **Vonnie Blevins, HCS-D.** If you are admitting the patient only for rehabilitation, you must list V57.X (Care involving use of rehabilitation procedures) as your primary diagnosis. Code for the underlying diagnoses requiring the therapy according to coding guidelines and according to Attachment D. If you were treating the whole disease, then you would list the code for the disease or condition.

For this patient, you would list the following codes:

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- M0240b: 721.3 (Lumbosacral spondylosis without myelopathy);
- M0240c: 724.02 (Spinal stenosis; lumbar region);
- M0240d: 356.9 (Hereditary and idiopathic peripheral neuropathy);
- M0240e: 715.90 (Osteoarthrosis, unspecified whether generalized or localized; site unspecified); and
- M0240f: V15.88 (History of fall).

List V57.1 first because this is a therapy-only case, Blevins says. Follow this with the condition physical therapy is caring for, in this case.

The code for your patient's peripheral neuropathy includes weakness as a symptom, so there's no need to code weakness separately, Blevins says. Coders should not list symptom codes when they have definitive diagnoses, she says.

List 715.90 for osteoarthrosis if the affected joint isn't identified. If multiple joints are affected, use 715.89 (Osteoarthrosis involving, or with mention of more than one site, but not specified as generalized).

Attachment D Update Brings Big Changes

You've probably noticed that the therapy patient in the example above has several diagnoses that aren't in the code list. According to the most recent OASIS instruction from the Centers for Medicare & Medicaid Services, rehab must address all diagnoses on the OASIS in the plan of care. If they aren't in the plan of care, you're instructed not to list them. In this example if the neuropathy isn't documented as a symptom of diabetes, then you wouldn't code for the diabetes or the hypertension unless physical therapy is addressing or monitoring them per the POC, Blevins says.

Clarification: This new direction to code only those diagnoses listed in the plan of care is contradictory to official guidance in AHA Coding Clinic for ICD-9 that states that you should list ICD-9 codes for systemic diseases such as diabetes, hypertension, and coronary artery disease (CAD) even if no active intervention is required, notes **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C,** consultant and principle of Selman-Holman & Associates in Denton Texas. The therapist should be addressing these conditions in a complete care plan.

For example, the therapist should be assessing the blood pressure, the effect of the therapy on blood glucose levels, and the endurance of the patient for the exercises considering the heart disease, Selman-Holman says. GERD could also impact the plan of care in that the patient may not take ordered pain medications because of the GERD, therefore, not be compliant with the home exercise program, and refuse therapy because of the pain.

Although Coding Clinic states that you should code for conditions affecting the care even in the absence of active intervention, if you are going to include the codes, there must be interventions for the conditions under the new Attachment D guidance, Selman-Holman says. (Also note that this new guidance in Attachment D contradicts guidance in Chapter 8 itself.)

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