Home Health ICD-9/ICD-10 Alert

Reader Question: Keep Good Documentation when Reporting Muscle Weakness

Question: Our patient has chronic renal failure and was on peritoneal dialysis. She went to the hospital for removal of the PD catheter and insertion of a fistula. We are providing physical therapy for muscle weakness due to the chronic kidney failure and the subsequent surgery. She has a 23-cm incision with 30 staples open to air, but we won't be providing wound care, just assessment of the surgical area. She is also diabetic and her physician says she is in stage IV renal failure, but he can't confirm that diabetes caused the renal failure. How should we code for her?

Michigan subscriber

Answer: Code for this patient as follows:

- **M1020a:** 728.87 (Muscle weakness [generalized]);
- **M1022b:** 585.6 (End stage renal disease);
- **M1022c:** 250.00 (Diabetes mellitus without mention of complication; type II or unspecified type, not stated as uncontrolled); and
- **M1022d:** V45.11 (Renal dialysis status).

Your physical therapist's services to improve strength are the most intensive service you will be providing, so you'll list the patient's muscle weakness as the principle diagnosis. For a patient such as yours with extensive muscle weakness that is not expected to reverse without physical therapy, 728.87 is an appropriate code. But in general, remember that use of this code assumes that the physical therapist is able to:

Document a significant decrease in muscle strength;
Describe the patient's prior and current level of functioning; and
Explain why skilled therapy is required to restore the patient's functioning to a previous level.

Make certain that documentation of the interventions and goals focuses on treatment to improve the patient's strength and includes a list of realistic functional goals that the patient can accomplish as a result of the strengthening. This is a different goal than the maintenance therapy that may be appropriate once the patient has reached maximum rehab potential.

Even though your patient had both a removal of a peritoneal catheter and the insertion of an AV fistula for chronic renal failure, the care of the dialysis catheter is not covered under the home health benefit so you shouldn't code for aftercare. Assessment of the surgical site (which does count as a surgical wound in OASIS item M1340 □ Does this patient have a surgical wound?) is a best practice but is not considered skilled care. Be sure to report any complications to the dialysis center.

Next, list 585.6 to code for the chronic kidney disease, rather than 585.4 (Chronic kidney disease, Stage IV [severe]). Although the physician says the patient has stage-IV chronic kidney disease, the patient requires chronic dialysis, first through the peritoneal dialysis catheter and now via the A-V fistula. Regardless of the stage, the instructions under 585.6 indicate that this is the correct code for chronic kidney disease requiring dialysis.

Follow this with 250.00 for type 2 diabetes, not stated as uncontrolled. You should report this default code because the type wasn't specified and there is no indication that your patient's diabetes is uncontrolled. While about one-third of people with diabetes will develop chronic kidney disease, you can't assume that these two conditions are related.

Codify
BY AAPC