Home Health ICD-9/ICD-10 Alert

READER QUESTIONS

Break M0245 Fracture Code Confusion

Question: How do we meet the criteria that the OASIS, the 485 and the bill are supposed to match when we're coding for a patient whose primary problem is a fracture? We put the healing fracture V code in M0230 and the acute fracture code in M0245. Our software won't allow the code in M0245 to print to the 485. Can we also put the acute fracture code in M0240, so it will transfer to the 485?

Answer: Your question addresses several issues:

First, the code in M0245 is not directly reported in any field of the claim form, according to the **Centers for Medicare & Medicaid Services**. The way to get the M0245 code in locator 21 is to simply type it in with your orders. For example, if you code 808.8 (Fracture of pelvis; Unspecified, closed) in M0245, then in locator 21 you could type "M0245 = 808.8." Or you could state in your orders "aftercare to traumatic fracture 808.8."

Second, the code in M0230 goes in locator 11 of the plan of care and in field locator 67 on the UB-92. The codes in M0240 go in locator 13 of the POC and in field locators 68-75 on the UB-92. But the code in M0245 doesn't go in locator 13 or on the UB-92. That means it doesn't have to match anything.

Finally, if coding guidelines require you to report the codes in M0245 as secondary diagnoses, you can repeat them in M0240, CMS instructs in the Medicare Claims Processing Manual. But it is a violation of coding rules to use the acute fracture codes outside of the acute setting, so you don't repeat them in M0240.

Get A Leg Up On Knee Replacement Aftercare Coding

Question: We often admit patients post knee replacement. Usually the nurse makes four or five visits to monitor the incision and change dressings. The PT goes in a dozen times or so for gait training. Do we code V57.1 (Other physical therapy) as primary or do we use V54.81 (Aftercare following joint replacement) as primary?

Answer: Code V54.81 as primary. In this case both therapy and nursing are providing aftercare for the joint replacement, so that is the most intense service. Enter the diagnosis that represents the most acute condition and requires the most intensive services, according to the HIM 11. You would still place 781.2(Abnormality of gait) in M0245 for payment.

Don't Always Code Prior Procedures

Question: When we admit a patient who had bypass surgery in the past, but the current episode is not directly related to the previous surgery, do we use a status code to indicate the prior history, such as coronary artery bypass graft or femoral-popliteal bypass graft?

Answer: For informational purposes, you may use status codes such as V45.81 (Aortocoronary bypass status) or V45.89 (Other postprocedural status) for a femoral-popliteal bypass graft, if the fact that the patient had the bypass impacts your plan of care.

Consider The Essential Issue - Proximate Cause

Question: The nurse goes in monthly to change the urinary catheter for a Medicare patient who is an incomplete quadriplegic with diabetes. We were thinking we'd code as follows: M0230 - V53.6 (Urinary devices), M0240 - 344.0x (Quadriplegia and quadriparesis), 250.00 (Diabetes mellitus, without mention of complications, Type II or unspecified type, not stated a uncontrolled) and M0245 - 596.54 (Neurogenic bladder, NOS). Is that correct?

Answer: Code V53.6 in M0230. The next diagnosis would be neurogenic bladder (596.54), then quadriplegia (344.0x) and then diabetes (250.00). Don't put neurogenic bladder in M0245, - it isn't a case mix code.

Caution: Don't be tempted to code quadriplegia (344.0x) directly after V53.6 and then put 344.0x in M0245 for the 20 extra case mix points. Instead, you must look at the proximate diagnosis - the closest reason you are there - which, in this case, is neurogenic bladder.