Codify
BY AAPC

OASIS Alert

Diagnosis Coding: Clear Up Confusing Diagnoses With These Basic Coding Steps

Decoding this tricky op note can be a whiz with the right tools.

If you can't distinguish your patients' principal diagnoses from their secondary ones, your coding -- and your OASIS efforts -- will be the ones to suffer.

Selecting the correct principal and secondary diagnoses is essential for accurate coding. **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C**, consultant and principal of **Selman-Holman & Associates** in Denton, Texas offers the following sample coding scenario to illustrate this point.

Scenario: A patient is admitted to home care three weeks after a myocardial infarction. He has continuing symptoms. The op record states that there was 98 percent obstruction in two vessels and that the patient underwent a coronary artery bypass graft (CABG). The wounds are healing well, and orders are to leave the bypass incision and the leg incision open to air.

The patient also has hypertension (HTN) that is currently well-controlled and gastroesophageal re-flux disease (GERD). His history includes a below-knee amputation (BKA) two years ago due to diabetic peripheral angiopathy and a cholecystectomy last year for gall stones.

His diabetes is currently controlled with diet. He will have nursing, physical therapy (PT) for strengthening and gait training, and occupational therapy (OT) for energy conservation techniques and activities of daily living (ADLs). The focus of care is the myocardial infarction, along with aftercare for the CABG.

Code for this patient with the following codes, says Selman-Holman:

M0230a: 410.92 (Acute myocardial infarction; unspecified site; subsequent episode of care);

M0240b: V58.73 (Aftercare following surgery for circulatory conditions, NEC);

M0240c: 414.00 (Coronary atherosclerosis; of unspecified type of vessel, native of graft);

M0240d: 250.70 (Diabetes with peripheal circulatory disorder; type II or unspecified type, not stated as uncontrolled);

M0240e: 443.81 (Peripheral angiopathy in diseases classified elsewhere);

M0240f: 530.81 (Esophageal reflux); and

Other pertinent diagnoses: 401.9 (Essential hypertension; unspecified), V49.75 (Lower limb amputation status; below knee);

Rationale: When there are multiple diagnoses that describe the primary reason for care, the assessing clinician can just choose one. In this case, Selman-Holman selected the MI as primary, but the aftercare could have been chosen as the primary diagnosis alternately, she says.

CAD is still present after a CABG because those vessels containing the plaque are bypassed and not removed. So the CAD is still an existing condition and is obviously related to the plan of care (POC) for this patient.

The other conditions are co-morbidities as long as they reflect the seriousness of the patient's condition (not to be

confused with the severity index), Selman-Holman says. You can list these co-morbidities in any order. The diabetes along with the peripheral angiopathy will obviously impact the care even though at this time the diabetes is controlled.

GERD has the potential to impact the care. For example, if the patient is non-compliant with his medications (including pain medications), his nutrition suffers because of the GERD, or the patient has the potential to confuse the pain of GERD for angina or vice versa, then it will impact the care, Selman-Holman says. That potential should be documented in the record.

Other pertinent diagnoses include two conditions that, according to the guidelines, should always be coded, so be sure to add the codes for the HTN and amputation. The chole-lithiasis that the patient had in the past is historical information and not pertinent to the POC, so you wouldn't code for that.

Remember: Even though OASIS only has six slots (M0230a-M0240f), the home health agency Conditions of Participation re-quire that you code all pertinent diagnoses on the POC, and the claim form includes nine diagnoses slots plus another for an E code, Selman-Holman notes.