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OASIS Alert

ICD-9 Coding: Don't Jump to Conclusions with Psych Diagnoses

Avoid edits for Alzheimer's disease.

You can earn additional case mix points for patients diagnosed with psychiatric conditions, but you can also bring unwanted scrutiny to these claims if you're not careful. To safeguard your reimbursement, make sure you aren't coding more than your documentation will support.

Know the Impact

Psychiatric conditions can increase the amount of services needed to care for a patient, says **Judy Adams, RN, BSN, HCS-D, HCS-O,** with **Adams Home Care Consulting** in Chapel Hill, N.C. For example, you may need more time or visits to teach a patient with dementia or depression. Or, you may have to focus on teaching caregivers more than the patient.

Clinicians may also need to employ special techniques to implement the plan of care when the patient has a mental impairment, Adams says. Or the patient may limit his active participation in the treatment plan, resulting in an inability to meet goals or very slow progress. You may need to modify goals to be more realistic even for a patient who is participating in the plan of care to some level. Plus, the impact of psychiatric medications may be significant.

As a result, it's essential to record careful documentation that shows the impact of mental health issues, but also shows material progress in a reasonable time period, Adams says. When diagnoses bring additional case mix points, they also pique the interest of the intermediaries. See the table below for a breakdown of case mix point assignment for certain mental disorders.

Mind the Guidelines

It may seem obvious, but you should never list a diagnosis of dementia or any other psychiatric diagnosis in M1020/M1022 unless you have physician documentation. "This is no different than any other diagnosis, but it's especially important here," Adams says. Having a psychiatric diagnosis in your medical record can have a big impact, she says.

You might be tempted to list a depression diagnosis code based on a positive depression screen in M1730 -- Depression Screening, but that's not appropriate unless the physician confirms the diagnosis. The M1730 response might show that a patient is at high-risk of depression, but that's not the same as being diagnosed with depression, Adams explains.

OASIS item M1730 isn't the only one with which you should tread cautiously. You shouldn't code mental disorders, signs, or symptoms based on responses to any of the OASIS items related to mental disorders, Adams cautions.

You can use OASIS responses as hints and clues to get to an accurate diagnosis, Adams says. But before you list a code for a mental disorder, make sure it's supported by and consistent with the documentation in the medical record and visit notes as well as the responses to OASIS items M1700-M1750. See the table below for a list of these OASIS items related to mental disorders.

Check the POC

When your patient does have a physician-confirmed diagnosis of a mental impairment or disorder, it impacts the plan of care (POC), Adams says. You should code this diagnosis as a co-morbidity on the OASIS and address it in the POC.

Psychiatric conditions can impact how long services take, how well the patient responds, and whether the patient will even allow services to occur, Adams says.

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Any diagnosis you list in M1020/M1022 -- especially if it's a case mix diagnosis -- needs to be documented in the plan of care, Adams says. This is true of psychiatric diagnoses as well.

For example: The POC might include a note that you will monitor the impact of depression on a patient's participation and receptiveness to care. Or you might have a plan to evaluate how the depression is affecting the patient and when it might be appropriate to notify the physician if there's a change. If the patient has medication prescribed to address the psychiatric condition, the notes could indicate that you will monitor the medication and its effectiveness and the patient's medication compliance.

Adding supportive documentation to the POC doesn't take much, Adams says. But you need to be sure to include the diagnoses, any assessment findings that indicate the patient has psychiatric issues, and what changes in the patient's condition will trigger you to contact the physician.

Bottom line: "Medicare did not make us become psychiatric nurses one and all, but we need to recognize how these conditions can impact our care and when to contact the physician if needed," Adams says.

Find the Right Chapter

You'll find the codes for psychiatric disorders in several different chapters of your ICD-9 manual. Each code series has its own considerations, so be certain to read the notes thoroughly and follow the coding guidelines.

Paying attention to the notes in Chapters 5 -- Mental, Behavioral and Neurodevelopmental Disorders and 6 -- Diseases of the Nervous System and Sense Organs is especially important because some codes require multiple coding and/or have sequencing specifics, Adams says.

For example: Coding for Alzheimer's dementia requires you to follow etiology/manifestation coding rules. Many people mistakenly think that Alzheimer's patients routinely have dementia, Adams says. This isn't the case, so your patient's Alzheimer's-induced dementia is coded as a manifestation. To code for a patient with Alzheimer's dementia, you'll list 331.0 (Alzheimer's disease) first, followed by 294.1x (Dementia in conditions classified elsewhere).

Note: You don't need to provide care by a psychiatric nurse in order to code Alzheimer's disease as primary.

If your patient's mental disorder is the result of an injury or medical treatment, you'll turn to Chapter 17 -- Injury and Poisoning to find your code, Adams says. You may also list an E code along with a code for the disorder.

Sometimes you'll turn to Chapter 16 -- Symptoms, Signs, and Ill-Defined Conditions to report the signs or symptoms of mental disorders when there is no documented underlying etiology, Adams says.

Take Care with These Psychiatric Diagnoses

There has been controversy over how to code for depression and anxiety when the documentation indicates that a patient has both conditions, says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C, HCS-O**, consultant and principal of **Selman-Holman & Associates** in Denton, TX.

Should you list 311 (Depressive disorder, not elsewhere classified) and 300.00 (Anxiety state, unspecified) separately? Or do you report the code you'll find in the Alphabetic Index under Anxiety, depression -- 300.4 (Dysthymic disorder)?

If the physician documents depression with anxiety or anxiety with depression, then the correct code is 300.4, Selman-Holman says. However, if the physician documents depression and anxiety, then you should code for the two conditions separately, she says.

Caution: Some psychiatric diagnoses are the subject of special edits by fiscal intermediaries when listed as primary, Adams says. For example, listing dementia, Alzheimer's disease, or memory loss as primary for greater than 60 days will draw scrutiny. When services go on longer than that, often the services aren't supported. "This doesn't mean the patient doesn't have dementia, just that there isn't much we can do to change his condition or improve his status," she says. In other words, the patient doesn't meet the Medicare eligibility criteria for the home care benefit.

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Reasons for continuing with Alzheimer's as the primary diagnosis past the first or second episode may include new medications or teaching of a new caregiver, Selman-Holman says. Generally, teaching the patient is not considered medically necessary.

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