Codify
BY AAPC

Eli's Rehab Report

Reader Questions: List 2 ICD-9 Codes for 2 Diagnoses

Question: A therapist in our practice was told that we could use only one diagnosis code per modality code that we report. Is this correct?

Georgia Subscriber

Answer: No, this isn't totally accurate. Insurers normally expect physical therapy practices to be as specific as possible in their diagnosis coding, so be sure to include in box 21 of the CMS-1500 form all applicable ICD-9 codes on your claims. Some payers, however, do restrict the number of diagnoses that you can link to a specific line item in box 24E of the form.

The payer's computer systems will often perceive the first diagnosis you link in 24E as the primary reason for the service, so watch your charge entry to make sure you link up diagnoses correctly to specific line items for your physiatry services.

For instance, you perform therapeutic exercises (97110) to treat a patient who has difficulty walking due to osteoarthritis of the left knee and also to treat joint pain due to tendinitis of the left wrist. You should report 719.7 (Difficulty in walking) as the primary diagnosis for the services treating the knee problem, and link 719.43 (Pain in joint; forearm) to the therapy modalities provided to treat the wrist pain.

If your insurer prefers secondary diagnoses as well, you can also include 715.16 (Osteoarthrosis, localized, primary; lower leg) and 726.4 (Enthesopathy of wrist and carpus), but only list these after your primary diagnoses of 719.7 and 719.43.

You Be the Coder and Reader Questions were reviewed by **Marvel Hammer, RN, CPC, CCS-P, CHCO**, owner of MJH Consulting in Denver.