Codify
BY AAPC

Eli's Rehab Report

Secure Inpatient Pay Every Time With This ICD-9 Code Sequence

Primary DX should represent why you see the patient, not the underlying condition

Physiatrists who report inpatient rehab visits should emphasize the condition that they are treating, which may not be the same reason that the patient was admitted to the hospital.

Because physiatrists often see patients after surgery, you might be tempted to report the diagnosis that prompted the surgery as your primary ICD-9 code. If you always sequence your diagnosis codes this way, however, you might watch your reimbursement decrease and your denials skyrocket. Why? Because if you see the patient in an inpatient rehab unit the same day the surgeon admits the patient and you both report the same diagnosis codes, your carrier might consider your services medically unnecessary and only reimburse the surgeon.

Remember Why the Physiatrist Saw the Patient

Suppose your physiatrist sees a diabetic patient recovering from total knee arthroplasty (TKA, 27447) for a joint contracture (718.46). The patient is in an inpatient rehabilitation unit and requires daily rehabilitation services including pain management injections and physical therapy. She complains of severe pain in the affected knee.

The coder assigns diabetes (250.xx) as the primary diagnosis because she learned at a seminar that the diabetes ICD-9 code always goes first. She lists the joint contracture as the secondary diagnosis, and the knee pain (719.46) last.

This coder assigned her diagnosis codes incorrectly: Although many coders believe that they should always list diabetes diagnoses first, this is not necessarily
true, particularly for rehab coders, who normally treat diabetes only as an under-
lying condition.

"This is true if the condition is a manifestation of the diabetes, which in this case it is not," says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS**, director and senior instructor for the CRN Institute, an online coding certification training center. "A history of diabetes does not necessarily mean that the diabetes caused the patient's hospitalization."

First List the Reason You Saw the Patient

Because your physiatrist saw the patient specifically to treat the knee pain, you should list **ICD-9 719.46** first.

Many coders, however, are confused by the Official ICD-9-CM Guidelines for Coding and Reporting, developed by the Public Health Service and CMS, which states, "The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as 'that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital
for care.' "

Code Status-Post Surgery Last

You might reason that the patient was admitted to the hospital for the joint contracture and that you should therefore list that diagnosis first. This would apply if you were the admitting physician, "But because the physiatrist is coding for his services, he should report the code for the condition that he treated," Jandroep says.

The physiatrist probably did not see the patient until after the surgeon treated the joint contracture, so you should not report 718.46 as an existing condition.

Instead, you should use a V code to demonstrate to the insurer that the patient is status-post a knee replacement (V43.65, Organ or tissue replaced by other means; joint; knee).

The code sequence for this patient, therefore, would be 719.46, 250.xx, V43.65.

Outpatients Require Similar Sequencing

Fortunately, the Official ICD-9-CM Guidelines are much clearer when it comes to outpatient diagnosis coding. If you see an outpatient, the Guidelines advise, "List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions."

Your outpatient visit would therefore list the same diagnosis codes as your inpatient care, in the same order.

If you're ever confused about which code to assign first in the outpatient setting, "review the documentation to determine the patient's chief complaint - the condition that drove the medical necessity for the service that you provided," says **Sandra Soerries, CPC, CPC-H**, a healthcare reimbursement consultant at RSM McGladrey in Kansas City, Mo.