Scenario 17

Your patient has diabetes with acute osteomyelitis of the right foot. The patient is receiving IV Vancomycin and skilled nursing for wound care, IV administration of antibiotics and to draw labs, peak and trough.

Primary and Secondary Diagnosis	M1024 Case-Mix Diagnoses 3	4
M1020a 250.80		
M1022b 731.8		
M1022c 730.07		
M1022d V58.81		
M1022e V58.83		
M1022f V58.62		

250.80, Diabetes mellitus with other manifestations 3

731.8, Other bone involvement 13

730.07, Acute Osteomyelitis of the foot 13

V58.81, Fitting and adjustment of vascular catheter V

V58.83, Medication monitoring V

V58.62, Long-term use of antibiotics V

This is an excellent example of where giving thought to sequencing can greatly affect the way you code. Acute diseases, in this case diabetes and the osteomyelitis that has resulted from it, should trump V codes in sequencing. The skilled nursing is there because of the disease.

V58.83 is a code to carefully watch in home health. Although there isn't a guideline restriction, it should not be used primary since it indicates blood draws to monitor medications. The code should always be used in tandem with a V58.6x code to identify the category of drug being monitored, and cannot be used just for medication management. Medication management is not skilled care by itself, although it can be used when assessing the effectiveness of a medication through labs.

Osteomyelitis is an assumed manifestation of diabetes unless otherwise stated in the record, and it requires three codes. Often forgotten is the bone involvement code, 731.8. Read coding instructions in the Tabular List to guide you.

Since there is no designation for the type of diabetes nor a statement from the physician that the diabetes is uncontrolled, 250.80 is used.

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Combination codes

Q How do we know when to assign two codes versus a combination code for a disease?

Answer: The use of combination codes (single codes used to classify two diagnoses or a diagnosis with an associated secondary process or manifestation) or a diagnosis with an associated complication, is governed by a general coding guideline.

Combination codes are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.

Part of the Official Coding Guidelines tells you to always start your coding at the Alphabetic Index, then go to the Tabular List to verify your code. If you think you know the code and you start in the Tabular List, you may be missing important combination information.

Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs. Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.

Practice: Let's look up pneumonia caused by *Staph aureus*. If you incorrectly search the Tabular first for pneumonia, you may find code 486 (Pneumonia, organism unspecified). If you look around more you may see pneumonia in whooping cough (484.3) and pneumonia in anthrax (484.5), but you may not find a code specific for Staph aureus pneumonia, so you stick with 486.

If you had started in the Alphabetic Index as the General Coding Guidelines (Section I.B) require and looked up "Pneumonia," you would have seen several columns of options for pneumonia coding. This pneumonia is due to *Staph aureus*. You can search for those terms and come to 482.41. Only then would you have gone to the Tabular and verified that was the code you should assign.

Searching the Alphabetic Index, and understanding how it is categorized, leads you to the best code, which you can then verify (or look again for a better code) in the Tabular.

Also watch for *Use additional code* notes or *Code first underlying disease* … these should help you see if you need another code. Always read category instructions and includes or excludes notes for more guidance.

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Disease-specific diagnosis coding

Sequencing

Q How is sequencing decided?

Answer: The determination of the primary and secondary diagnoses must be completed by the assessing clinician, in conjunction with the physician.

Sequencing of other or secondary diagnoses must be based on the seriousness of the diagnoses as they relate to the Plan of Care and the skilled services to be provided. Because the seriousness can be based on many clinical factors, the assessing clinicians' judgement and the development of the POC are key components. There is not an "easy" formula for sequencing.

A clinician or coder should ask:

- Why are we seeing this patient?
- What diagnosis is the focus of care?
- What other diagnoses affect/impact this patient's care?
- What other diagnoses may impact the healing or recovery of the primary diagnosis?
- What medications is this patient taking for acute/chronic conditions?
- What therapies is this patient receiving (i.e., IV therapy, oxygen, renal dialysis), and for what reason?
- What co-morbid conditions should be monitored, evaluated, or treated as part of this patient's POC?

Diagnoses should not be sequenced based on symptom control ratings, per OASIS-C guidance for M1020 and M1022.

Q How can we sequence correctly?

Answer: Sequencing is part art, so even the best coders/clinicians can disagree on certain sequencing issues. In general, these steps will help you sequence:

1. Choose the principal (primary) diagnosis – the diagnosis most related to the current plan of treatment. It must always be related to the services your agency provides.

Don't: Base your choice on which discipline has the most visits.

2. Understand how to code secondary diagnoses. These "other" diagnoses include all conditions that coexisted at the time the Plan of Care was established, those that developed subsequently, or those that affect the treatment of care. If the

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