

Internal Medicine Coding Alert

3 FAQs Help You Achieve Diagnosis

Don't limit yourself to just one ICD-9 code

If you don't know what differentiates an acute condition from a chronic one, or how many diagnosis codes you can report, you could find yourself assigning the wrong code. Check out the following three frequently asked questions to get quick tips to help your ICD-9 coding.

How Many Diagnosis Codes Are 'Too Many'?

Question 1: Our internist treated a patient with diabetes, but he was actually seeing the patient to treat a complication of the diabetes, which was nephropathy. During his evaluation, the physician also noted that the patient has joint inflammation. Should we report the kidney complication only, or several of the ICD-9 codes?

Answer: Normally, the primary diagnosis code that you list on your claim should represent the main reason for the encounter, or the condition with the highest risk of morbidity/mortality that the physician is addressing at the visit. However, the situation changes when you are dealing with a condition like diabetes.

According to Section 1.A.6 of the ICD-9-CM Official Guidelines for Coding and Reporting, "Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-9-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation.

"Should a patient have more than one manifestation of diabetes, more than one code from category 250 may be used with as many manifestation codes as are needed to fully describe the patient's complete diabetic condition," the Guidelines state.

Therefore, you should first report 250.4x (Diabetes with renal manifestations). Remember to add a fifth digit to reflect the type of diabetes the patient has.

Your secondary code should represent the specific renal manifestation. In most cases, you will report 581.81 (Nephrotic syndrome in diseases classified elsewhere).

Because the internist documented joint inflammation, you should also report the appropriate code describing that condition (716.9x).

Although the insurer's computer will only scan the first, main diagnosis code listed, it is a good idea to list all of the codes that apply. That way, if the payer challenges a claim, you can help your appeal by having already sent the insurer all the applicable diagnoses on record for the patient.

Do Injury Codes Apply to Pain?

Question 2: I'm looking for the coding guidelines that describe when I can report an acute injury ICD-9 code rather than a chronic injury code. We see patients for generalized pain (not necessarily a recent injury) and aren't sure what to code. Would you help?

Answer: In coding some conditions, such as kidney disease (585.x), it can be simple to determine when the patient's condition is chronic, because the diagnosis codes differ based on the patient's lab results. However, coding for pain can

be more tricky.

For example, suppose your patient presents with shoulder pain that she says she has had for the past nine months, which came on slowly. You consider code 840.4 (Sprains and strains of shoulder and upper arm; rotator cuff [capsule]), but it is from the "injury" chapter of the ICD-9 guidebook. In this case, the patient didn't have an injury-- instead she had nine months of pain.

Therefore, you should avoid 840.4 and select another code based on the rest of the internist's documentation of her condition, such as 719.41 (Pain in joint; shoulder region), for example, if the patient had pain that was otherwise unspecified.

Why: An acute injury is sudden and severe. A chronic condition is a longer developing syndrome, persistent, continuing, or recurring, but may have been caused by an acute injury, says **Susan Vogelberger, CPC, CPC-H, CMBS**, owner and president of Healthcare Consulting and Coding Education in Boardman, Ohio.

By definition, a patient could have both--a chronic condition resulting from an acute injury, Vogelberger says. "The American Hospital Association's official Inpatient and Outpatient Coding Rules state, 'If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the alphabetical index at the same indentation level, code both and sequence the acute (subacute) code first.' They are, of course, referring to the ICD-9-CM alphabetical index," she says.

Many practices use the "three months or longer" guideline for coding chronic pain conditions versus acute problems. "A definitive guideline has not been addressed by CMS, although they have identified coverage of electrical stimulation for chronic wounds as 'longer than one month,' " Vogelberger says.

CDC Loosely Uses '3-Month' Guideline

In black and white: Although not all payers or physicians follow this guideline, the Centers for Disease Control's National Center for Health Statistics publishes the following definition of an acute condition in its National Health Interview Survey:

"An acute condition is a type of illness or injury that ordinarily lasts less than three months, was first noticed less than three months before the reference date of the interview, and was serious enough to have had an impact on behavior."

Bottom line: Leave the determination of acute versus chronic up to the physician. If an ICD-9 or CPT code forces you to differentiate between whether the patient's condition is acute or chronic, show both descriptors to the internist and ask him to decide.

Do Chronic Conditions Increase E/M Level?

Question 3: The 1997 audit guidelines state that I can reach an extended history by updating the status of at least three chronic or inactive conditions. Our physician likes to refer to this information in both the history of present illness (HPI) section of the note as well as the assessment section of the note. Do you think this is a good idea?

Answer: Although some physicians reference the illnesses in the assessment section of the medical decision-making (MDM) section, some choose to also discuss the illnesses in the HPI notes as well. However, many coding consultants discourage physicians from documenting the illnesses in two separate sections unless you specifically address that issue at the visit.

"I would recommend not counting this twice (once in HPI and again in MDM)," says **Bruce Rappoport, MD, CPC**, a board-certified internist who works with physicians on compliance, documentation, coding and quality issues for Rachlin, Cohen & Holtz LLP, a Fort Lauderdale, Fla.-based accounting firm with healthcare expertise. "If you use this as an element of HPI and it isn't being documented as part of the medical necessity I would not count this additionally as part of the MDM," he says.

If the physician does address the chronic condition, the documentation should be distinct for HPI and MDM. More than likely, however, these conditions are not the focus or being addressed in the visit.

Using the 1997 guidelines may help you report higher-level services for patients who have chronic conditions, such as diabetes and asthma.

Unlike the 1995 version, the 1997 history elements don't require the four elements of HPI for an extended level of HPI because you can use the status of three or more chronic conditions. Therefore, the 1997 guidelines may allow you to report a higher-level E/M code for encounters that involve periodic prescription renewals without the internist having to go into as much detail.

Don't Mix and Match 1995 and 1997 Guidelines

Be careful: You can only use the 1995 or 1997 guidelines individually, but you cannot pick and choose aspects from both sets of guidelines to achieve a higher E/M level. Select one set of guidelines (either 1995 or 1997) and stick with them.

Example: A patient who has controlled type I diabetes (250.01, Diabetes mellitus without mention of complication; type I [juvenile type], not stated as uncontrolled), controlled asthma (493.01, Extrinsic asthma; with status asthmaticus) and hypertensive heart disease (402.00, Hypertensive heart disease; malignant; without heart failure) presents for a follow-up of his diabetes and asthma.

After an appropriate exam, the internist renews the patient's prescription and notes:

- diabetes--active, stable
- asthma--active, stable
- hypertensive heart disease--active, stable.

Because the physician indicates the status of at least three chronic or inactive conditions, using the 1997 guidelines you may report an extended HPI. When combined with an appropriate review of systems and past, family, and social history, the extended HPI may result in a detailed history.

If the physician performs either a detailed examination or moderate-complexity medical decision-making, you may report the encounter with 99214 (Office or other outpatient visit for the evaluation and management of an established patient ...).

Remember: Medical necessity should ultimately drive the visit's history and examination.