Internal Medicine Coding Alert

Educate Your Internists On Aftercare's New Requirement

ICD-9 2007 lets you break out dressing change, suture removal

Your summer coding education program will put your practice on the fast track to avoiding denials if you teach staff how to use three essential new aftercare codes.

Pinpoint Post-Op Care With Expanded V58.3 Series

If you yearn for aftercare specificity, ICD-9 2007 answers your call with three new V58.3x codes. Now, the designation "attention to surgical dressings and sutures" is a catchall for dressing changes and suture removal. When the new codes become effective Oct. 1, you'll be able to specify three aftercare types.

Catch: You'll have to add a flag to your system that V58.3 is no longer valid this fall. The encounter code will require a fourth-digit to indicate an encounter for:

• nonsurgical wound dressing change or removal, V58.30

• surgical wound dressing change or removal, V58.31

• suture removal, V58.32.

Hopefully, having a specific suture removal code will help practices get paid for 99211-99212 (Office or other outpatient visit for the evaluation and management of an established patient ...), says **Victoria S. Jackson,** practice management consultant with JCM Inc. in California. Payers may still require you to report the injury code (such as 883.0, Open wound of finger[s]; without mention of complication) as a secondary diagnosis to tie the original billing to the postoperative care, she says.

Action: If the internist didn't perform the original laceration repair, code the suture removal with an E/M code and, starting Oct. 1, V58.32. In Jackson's office, the physician always checks the wound before the nurse performs the removal. "So we use 99212."

Error averted: Do not separately bill the suture removal with an E/M code if the internist placed the sutures. In this case, the laceration repair includes the postoperative care of removing the sutures.

Tip: To track nonbillable work, code follow-up visits with 99024 (Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason[s] related to the original procedure) and either V58.32 for suture removal or V58.30-V58.31 for dressing change.

Code Family History to Further Support Scope

The 2007 update also gives you more codes for a family history of digestive disorders. This October, you can use a fifth digit on V18.5 to indicate that a patient has a family history of colonic polyps (V18.51) or other digestive disorders (V18.59).

A family history differs from a personal history in that the patient's family, not the patient, has had the disorder, says **Jeffrey F. Linzer Sr., MD, FAAP, FACEP,** associate medical director for compliance and business affairs at EPG in Egleston, Ga. These codes are useful because often a patient has a test, such as a colonoscopy, or study only because of

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a family history of disease.

Warning: When billing Medicare, make sure to use V18.51 and V18.59 as secondary diagnoses. CMS proposed adding the codes to its "Unacceptable Principal Diagnosis" edit, according to the Federal Register, April 25, 2006. Check with your FI to see if it accepts these guidelines.

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