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Internal Medicine Coding Alert

Here's Why the 5th Digit Isn't Always the Key to Accurate ICD-9 Coding

Get the expert tips you need to prevent denials

If you are submitting CPT codes with three-digit diagnosis codes linked to them, you'd better be sure that the claim is correct, because more payers than ever before are demanding accurate ICD-9 coding.

In fact, diagnosis coding is evolving from a choice to a necessity when filing with some carriers - because they are rejecting claims as "medically unnecessary" at a higher rate than they did a few years ago. If you're not taking ICD-9 coding seriously, it's only a matter of time before it affects the practice's bottom line, experts say.

Payers Looking at ICD-9 Codes on Claims

Before sending out a claim with a three-digit diagnosis code, you should double-check the code, says **Victoria Jackson**, owner of Omni Management, which provides practice management services for 15 medical offices in the Los Angeles area. Jackson contends that three-digit diagnosis codes raise the eyebrows of payers because there are very few ICD-9 codes that aren't at least four digits, and all insurance carriers are getting more careful when it comes to diagnosis coding.

"A lot of us didn't pay attention to ICD-9 coding in the past because Medicare was the only carrier that cared if you used the codes," Jackson says. Now, all insurance companies are looking for ICD-9 codes, so coders have to make sure the diagnoses are correctly represented on claims.

No doubt about it, accurate and complete diagnosis coding gets more important each year. And with the Centers for Medicare & Medicaid Services (CMS) demanding immediate implementation of its new ICD-9 codes from now on (see "You Be the Expert" on page 14), it's plain to see that diagnosis coding isn't getting any less urgent.

Read on for advice on how to head off ICD-9 coding troubles before they begin.

Take the 2-Question Test

To ensure accurate ICD-9 reporting, **Margaret Lamb, RHIT, CPC**, coding expert in Great Falls, Mont., asks herself two questions before sending out a claim:
1. Do I have a complete code?
2. Do I have the most specific complete code?

Why are these things important? If the ICD-9 code is not as complete and specific as carrier rules require, the claim may be rejected for lack of medical necessity, Lamb says. You can check that you have the most complete and specific code when looking up the code in the ICD-9 book - if you know what to look for.

Some Conditions Require 5-Digit Diagnosis Codes

There are certain ICD-9 codes that you must carry out to the fifth digit, so you need to know when a fifth digit is required. One of those codes is 250 (Diabetes mellitus).

Example: The FP treats a patient with diabetes. The patient has no complications but does require insulin. If you link 250 to the CPT code, the diagnosis code will be rejected, Lamb says.

Why? You need five digits to reflect complications and insulin dependence, or lack thereof. The code for non-insulin-

dependent diabetes without complications would be 250.01 (Diabetes mellitus without mention of complication; type I [juvenile type], not stated as uncontrolled).

Check Boxes, Then Decide Code Length

"Report the ICD-9 code that provides the highest degree of accuracy and completeness. That 'highest degree' means that you should assign the most precise ICD-9 code that most fully explains the narrative description of the symptom or diagnosis," says **JoAnn Baker, CCS, CPC-H, CPC, CHCC**, an education specialist in East Orange, N.J.
Is this diagnosis code complete? Rely on your ICD-9 manual's instructions to ensure you're listing complete ICD-9 codes. For example, look to the left of the ICD-9 code for noncomplicated diabetes (250.0), and you'll see a box with a check mark and "5th" printed in it. This box indicates that a complete ICD-9 code for this diagnosis must be five digits.

Whenever there is a "5th" box next to an ICD-9 code, it means the most accurate and complete code possible for that diagnosis has five digits - and reporting a code with three or four digits is not acceptable.

2 Steps to Accurate Asthma Coding

In the following two paragraphs, Jackson illustrates how to code as specifically as possible for a patient with asthma.

Step 1: Find the base code for asthma. When you look up asthma in ICD-9 (493), you'll notice a "4th" box beside it, meaning you must carry this diagnosis code to at least the fourth digit.

Step 2: Check four-digit code options. All of the four-digit code options for asthma - 493.0 (Extrinsic asthma), 493.1 (Intrinsic asthma), 493.2 (Chronic obstructive asthma), 493.8 (Other forms of asthma) and 493.9 (Asthma, unspecified) - have "5th" boxes beside them.

Don't ignore the box - it's there for a reason. Asthma coding is "an instance where you should use the fifth digit or you may not get paid," Jackson says.