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Internal Medicine Coding Alert

How to Use Diagnosis Codes to Support Hypertension, Diabetes and Anemia Claims

So much attention is paid to CPT codes in regard to billing and reimbursement that it sometimes seems the ICD-9 codes are little more than numerical window dressing on a claim form. However, getting claims paid requires the skillful use of both coding systems.

Think of it this way: CPT codes describe what you do, and ICD-9 codes describe why you do it.

While the amount of money an internist is reimbursed is linked to a claims CPT codes, the ICD-9 codes show the medical necessity of each service by establishing a diagnosis, symptom or complaint. One doesnt work without the other. To illustrate some of the broader concerns regarding ICD-9 coding as they pertain to internists, this article will look at three common disorders: hypertension, diabetes and anemia.

An Additional Digit May Be Required

The basic three-digit code for hypertension in the ICD-9 manual is 401 (essential hypertension), but its prefaced by a red stop-sign marker indicating that an additional digit is required. The choices include: 401.0 (malignant, severe high arterial blood pressure without apparent organic cause); 401.1 (benign, mild elevation in arterial blood pressure without apparent organic cause); and 401.9 (unspecified).

By far the most common symptom for hypertension is high blood pressure, but when an internist or coder checks under high blood pressure in the Index to Diseases section, he or she is referred to 401.9 in the Tabular List.

Thats telling the coder that high blood pressure is the same thing as unspecified hypertension, says Brink. Very often this would be the appropriate code because the patient may not have a history of high blood pressure and the internist feels theres insufficient evidence to warrant coding benign or malignant hypertension. But a lot of physicians wont use this code because they know that 401.9 sometimes doesnt get your claim paid.

Dont Be Too Quick to Code Hypertension

Scott Manaker, MD, a practicing internist at the Hospital of the University of Pennsylvania in Philadelphia, says hes careful not to make the diagnostic leap from high blood pressure to hypertension. One common error is whats called white coat hypertension. This is when the patient is abnormally anxious about seeing the doctor, says Manaker, whos also an adviser to the American College of Physicians/American Society of Internal Medicine panel on coding and reimbursement.

Manaker gives the example of a young man making his first visit to an internist. Hes shown to have high blood pressure with no previous history of hypertension. Its not unusual for someone to have high blood pressure in this circumstance, he says. Before starting to treat a patient for hypertension, internists should make sure that the blood pressure is consistently elevated. Manaker recommends having the patient come back in a week for another blood pressure check.

Manaker contends it would be wrong in this situation to code for hypertension using any of the 401 codes because it isnt clear the patient really has hypertension. He says hes more inclined to code 796.2 (elevated blood pressure reading without diagnosis of hypertension).

Dont Label a Patient Unnecessarily

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Improperly labeling a patient with hypertension may cause problems for future insurance coverage. If coders use any of the 401 codes on a claim, and the patient tries to file for life insurance sometime in the future, the patient is going to be labeled with a diagnosis of hypertension, with all of its life expectancy and insurance complications. Whereas with 796.2, its clear theres no diagnosis of hypertension, and the patient probably wouldnt have to deal with this issue.

Manaker says it may take two or three visits with a patient before he would be comfortable diagnosing hypertension, suggesting that perhaps by the third visit the patients white coat hypertension may have subsided.

However, maybe on the third visit the patients blood pressure is still high and now he needs to be treated with a thiazide, beta blocker or some other medication. In this case, coders should assign a 401-series code. Until then, use code 796.2.

Code to the Highest Level of Specificity

ICD-9 codes may have three to five digits, depending on their category, although few diagnoses have valid three-digit codes. In the category of hypertension, the 401 series demands a fourth digit (i.e., 401.0 [malignant]; 401.1 [benign]; and 401.9 [unspecified]). If, however, a patient with benign hypertension also had benign hypertensive heart disease, coders should report a fifth-digit code, such as 402.10 (hypertensive heart disease, without congestive heart failure) or 402.11 (hypertensive heart disease, with congestive heart failure).

Coders should be careful not to fragment the codes by reporting 401.1 for hypertension and 428.0 for congestive heart failure separately. Both conditions are represented by one code, 402.91 (hypertensive heart disease, unspecified, with congestive heart failure). The general rule of ICD-9 coding is to try and code to the highest level of specificity.

The Rule of 9 in ICD-9 coding mythology maintains that whenever you see a code ending in decimal point 9 its almost always an unspecified code that payers are reluctant to reimburse because they want to see something more definitive.

Diabetes Coding Takes the Fifth

The key to diabetes diagnosis coding is that every diagnosis for diabetes must take a fifth digit. For example, the code for uncontrolled type-I diabetes with ketoacidosis is 250.13. The first three digits represent the diagnostic category; the fourth digit identifies complications associated with diabetes, in this case ketoacidosis; and the fifth digit describes the type of diabetes and its level of control.

There are 10 four-digit codes for diabetes in the ICD-9 Tabular List, and each is prefaced by the red marker indicating that an additional digit is required. To select the fifth digit, coders should refer to the subclassifications box under the initial three-digit description (250) for diabetes mellitus.

If you only use a four-digit code, the payers going to deny it because its a non-specific code, says **Catherine Brink, CPC,** president of Healthcare Resource Management, in Spring Lake, N.J. Most coders know that diabetes requires a fifth digit but many physicians dont. If the code comes from the internist without a fifth digit, the coder should take the documentation back to the internist and get clarification on what type of diabetes is being treated.

A Change in Condition = Diagnosis Code Change

Another thing to watch for with diabetes coding is when the patients condition changes. For example, if a patient has, for many years, been diagnosed 250.01 (diabetes mellitus without mention of complication, type I, insulin dependent juvenile, not stated as uncontrolled) and then goes on kidney dialysis, the diagnosis code should change to reflect that. In this case, the best code to use is 250.43 (diabetes with renal manifestations, type 1, insulin dependent juvenile, uncontrolled).

Be Specific When Coding for Anemia

As with hypertension diagnosis coding, coding for anemia generally deals with four-digit codes, and many of them are

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non-specific. An unspecified anemia code may be fine if its the second or third diagnosis on a claim. It can be helpful if its being used to paint a picture of whats wrong with a patient, why they have a number of complicated medical problems and why youre billing a level-four or -five service, Manaker says.

But he warns that internists may run into claim denials if they use an unspecified anemia code to justify medical necessity for a procedure. Weve had terrible trouble getting colonoscopies paid because physicians have been using unspecified anemia codes. Theyll code 281.9 [unspecified deficiency anemia] or 280.9 [iron deficiency anemia, unspecified], and really what it should be is 280.0 [... secondary to blood loss], Manaker says.

For example, if a patient has positive fecal occult blood tests or lower gastrointestinal bleeding, a colon-oscopy will be performed to look for colon carcinoma. The medical necessity for the colonoscopy is going to be gastrointestinal bleeding or iron deficiency anemia secondary to blood loss, 280.0.

Customize the Encounter Form

Brink says a good encounter form is the key to clearing up misunderstandings between internists and coders. For diagnosing diabetes, its much better to have a form that leaves a blank for the fifth digit (e.g., 250.0_). This tells the internist that he or she must fill in the fifth digit.

If a practice tends to have many diabetes patients, consideration should be given to listing all the diabetes codes with a blank for the fifth digit on the encounter form. Brink says most practice management software allows encounter forms to be customized and recommends each practice regularly review its needs and alter its encounter form to suit those needs.

Manaker also reiterates the importance of up-to-date encounter forms to help ensure correct ICD-9 coding. Weve got 40 different practice sites [at the Hospital of the University of Pennsylvania], and each one has a different encounter form based on the most commonly used diagnosis codes. Practices need to evaluate their encounter forms every year, take a look at what new codes are out, which may reflect on the patients in their practice, what codes are being removed or what codes are being further subdivided. If youve got a code that youre never using, get it off in favor of a code thats more relevant to your patients.

How to Use the ICD-9 Manual

Its important that internists and coders are clear on the correct use of their ICD-9 manual. Although the order is sometimes inverted, normally the front half of the manual (or Volume 1 if its split into two volumes) contains the alphabetic Index to Diseases, while the back half (or Volume 2) contains the Tabular List, a numerical listing of all available codes, followed by two supplementary classifications comprised of V codes and E codes, and then five appendices lettered A to E.

One of the most common errors, according to **Catherine A. Brink, CMM, CPC,** president of Healthcare Resource Management Inc., a physician practice management consulting firm in Spring Lake, N.J., is that many internists and coders look only as far as the Index to Diseases and then take the code directly from there. They never cross-reference it with the Tabular List where it really gives a more complete and accurate definition, Brink says. Thats where the excludes this and includes that descriptions are found, and if you dont look there, a lot of times that leads to incorrect coding.

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Prioritize Your Diagnoses

When theres more than one ICD-9 code on the encounter form, its vital that internists prioritize the diagnoses because thats how theyre going to get listed when the coder enters the data on the encounter form and sends in the claim.

Manaker says, many internists tell me they dont write down three or four diagnoses because coders tell them that Medicare only looks at one diagnosis code anyway. Thats probably true, but what happens if you have to appeal a denial? What happens if a carrier denies your high-level E/M service because it doesnt think there is medical necessity and they want to downcode the claim based on the incorrect diagnosis code? Thats when your second, third and fourth diagnosis codes are going to support that claim.

Combining all the disorders explored in this article, Brink cites the example of a male patient who has insulin-dependent diabetes with renal manifestations and whos also diagnosed with malignant hypertension and iron-deficient anemia. His treatment is ongoing, so the visit is coded with a 99214 (office or other outpatient visit for the evaluation and management of an established patient, which requires a detailed history and examination and medical decision-making of moderate complexity). The carrier looks at the first diagnosis code, (250.43, insulin-dependent diabetes with renal manifestations) and denies it based on lack of specificity. This is when you need to list all the diagnoses codes and prioritize them based on the main reason the patient is being treated and then the other co-existing conditions. The extended documentation could really be your salvation in a claim denial.

Manaker feels internists generally require an attitude adjustment with regard to ICD-9 coding. Sadly, Id say their interest is somewhere between slim and zero. Internists dont recognize that to avoid the hassle they need to really learn and understand ICD-9 coding, embrace it and use it to their advantage.

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