Internal Medicine Coding Alert

Know When to Use V Codes for Follow-Up Visits/Re-checks

As stated in the 1999 ICD-9-CM manual, V codes are codes that represent circumstances other than a disease or injury classifiable to categories 001-999. These diagnosis codes are typically used to indicate screenings, preventive services, exposure to health hazards or a personal history of an illness no longer in evidence. Knowing whether to use a V code as the primary or secondary code will help avoid denial of reimbursement.

An elderly patient presents to the internist complaining of cough, fever and shortness of breath. A physical examination, including a chest x-ray, reveals the patient has pneumonia. A lab culture reveals the presence of streptococcus pneumoniae. The code for the initial visit is reported on the HCFA-1500 form as 481 (pneumococcal pneumonia [streptococcus pneumoniae pneumonia]). The physician prescribes treatment with antibiotics and orders the patient to return in four days for a follow-up visit to check the patients progress. Four days later, the patient comes to the office. A new chest x-ray and exam reveal no presence of pneumonia. How should coders report the medical justification for the second office visit?

Most physician offices would continue reporting the original diagnosis code since the pneumonia is still the reason the patient was seen in the office. The physician needed to ensure that the pneumonia was resolving with treatment.

However, this standard practice runs contrary to guidelines for diagnosis coding published by the Health Care Financing Administration (HCFA), the American Hospital Association (AHA) and in the ICD-9-CM, notes **Kathryn L. Cianciolo,** MA, chair of the American Health Information Management Associations (AHIMA) Society for Clinical Coding and a coding and reimbursement consultant based in Waukesha, Wis.

The way the rules read, you should use a V code for the follow-up visit (e.g., V67.59, follow-up examination following other treatment,other) and then code the condition that is being checked. It doesnt specifically say to code the condition, but that is the only way the payer is going to know what was being followed, she explains.

Payers May Not Recognize V Codes

HCFA does say not to use ICD-9 codes that are no longer applicable, and I am a firm believer in this as well, states **Shelley Perron, CPC,** medical practice coding consultant with Medical Provider Management Co., LLC, in Portland, Maine. Continuing to report conditions that are no longer present or not currently active can lead to problems for the patient as well as the provider, she advises. You should use the V codes for follow-up or the series of codes for history of if the condition that is being followed was a chronic illness. For example, V10.3, personal history of breast cancer.

However, Perron notes, many third-party payers perform CPT-to-ICD-9 edits to ensure that a visit meets medical necessity requirements. And, many of these payers do not recognize V codes.

The insurance companies restrictions are, in essence, causing many coders to be untruthful, believes Perron. How can you code correctly and accurately without using the V codes?

Original Diagnosis May be Applicable

That being said, Perron notes that if the coder feels the original diagnosis reflects the primary reason the patient received treatment on a particular day, then that code should be reported as primary, with the V code reported as secondary.

The ICD-9 code should be used to indicate the reason the patient is being seen, she explains. I definitely believe that V

codes are terrific diagnosis codes to be used when a patient has a history of some illness, is in for follow-up, or is in a pregnant state (V22.0). However, if a numeric code best describes the services, it should be used as primary and the V code as secondary.

Most physician practices would agree with the previous statement and would argue that it justifies reporting the original diagnosis as the primary ICD-9 code for the follow-up visit, says **Jim Stephenson, CPC,** billing manager for Premium Medical Management, a multispecialty group practice in Elyria, Ohio.

The original condition is the reason they are being seen for follow-up, he says. If the medical condition had not resolved, using the same diagnosis would be valid on a follow-up visit. Therefore, it makes little sense to argue a different coding method simply because the condition is found to have resolved with treatment.

The V code can be used as secondary to indicate a follow-up visit, he says. In fact, the 1999 ICD-9-CM tabular list indicates that code V67.9 is a non-specific code and used alone does not reflect enough information to support the visit.

The guidelines published by HCFA and the AHA are meant to guide coders, but, in fact, payer policy may differ. In fact, individual payers and carriers, those that recognize V codes, sometimes request that V codes only be used as secondary codes. Conversely, some specifically state that they want to see a V code as the primary code on follow-up visits and preoperative clearances, Stephenson notes.

Coders might benefit from checking with their payers about their policies for the sequencing of ICD-9 codes for follow-up visits and re-checks.

Perron agrees that the ICD-9 code should specifically indicate the reason for the visit, and the individual circumstances will dictate whether or not a V code or the condition code as a primary code should be used.

Based on the information given in this example, my personal opinion on the diagnosis would be the 481, she says. You want to code for why the patient was presenting at your office. The resolution of the pneumonia is not known until after the exam. However, if the resolution of the pneumonia is known and the physician still wants to see the patient again in order to monitor them, then I would code it a V12.6 (personal history of disease of respiratory system.) This would meet medical necessity for a visit after the pneumonia is known to be resolved. Again, you want to code for the problem that patient is being seen for on that day. They are not being seen for follow-up; they are being seen because of pneumonia.