Internal Medicine Coding Alert

READER QUESTION: Make the Most of Diagnosis Options

Question: I know we have to list the code for the patient's primary diagnosis on the claim form, but there are spaces for several additional ICD-9 codes. Exactly how many codes should we list?

Wisconsin Subscriber

Answer: Listing only one code on the CMS-1500 form is not always sufficient. Although the CMS-1500 allows you to report four diagnosis codes, coders and billers often only list one.

This strategy is a major mistake because you need the other codes to fully clarify why the patient is receiving the level of care that the internist is billing. Without this information, you could easily find yourself looking at a denied claim.

For example: Your internist performs a preoperative examination and consultation for a patient with COPD and degenerative joint disease prior to her surgery for hip replacement. The surgeon asks the internist to clear the patient for surgery and to give his recommendations for preoperative, intraoperative, and postoperative care. In this case, you can report V72.82 (Special investigations and examinations; preoperative respiratory examination) as the primary reason for the consultation because that is the reason that the internist is really seeing the patient.

Then, report the comorbid condition(s) requiring clearance by the internist, such as 496 (Chronic obstructive pulmonary disease NOS) in this case. You should also add the reason for the surgery, 715.9x (Osteoarthrosis, unspecified whether generalized or localized) in this case.