Internal Medicine Coding Alert

Want to Boost Your ICD-9 Coding Accuracy? 5 strategies for optimal ICD-9 coding

Internal medicine coders who want to assign the most accurate procedure codes know they need at least one crucial element to complete their jobs: the most specific CD-9 codes available for a condition. Follow this expert advice to learn and follow the correct guidelines for choosing and submitting diagnosis codes.

1. Know carrier ICD-9 guidelines. Internal medicine coders must know federal, state and private-payer diagnosis reporting requirements, says **Glenn Littenberg, MD, FACP**, a member of the AMA CPT editorial panel in Pasadena, Calif. If you demonstrate to payers that you followed their requirements, you can defend yourself when they look askance at your decisions. Obtain written rule documentation to safeguard your decisions.

For instance, you should be aware that beginning Oct. 1, all paper and electronic claims that you submit to Medicare carriers must contain a valid diagnosis code, except for claims submitted by ambulance suppliers, according to a June 6 CMS program memorandum (PM) B-03-045.

The PM states, "Carriers must return as unprocessable paper and electronic claims that do not contain a valid diagnosis code ..." CMS also forbids carriers from "placing invalid or valid" diagnosis codes on claims for practices. (To read the PM, go to the CMS Web site www.cms.gov/manuals/pm_trans/B03045.pdf.)

You should submit ICD-9 codes that provide the highest degree of accuracy and completeness. This means that your internist should assign the most precise ICD-9 code to an internal medicine service. You cannot justify a service with a fourth-digit diagnosis code when carriers require a more specific fifth-digit code to describe the patient's condition.

For example, after Jan. 1, your internist lists the old 790.2 (Abnormal glucose), and omits the appropriate fifth digit: 790.21 (Impaired fasting glucose), 790.22 (Impaired glucose tolerance test [oral]), or 790.29 (Other abnormal glucose). In this case, your Medicare carrier would most likely deny your claim, says **Kathy Pride, CPC, CCS-P**, a coding consultant for QuadraMed in Port St. Lucie, Fla.

You should know your local medical review policies to ensure that you don't submit an unacceptable diagnosis code that will not prove medical necessity for procedures. Insurers cover some services based on the presence of certain diagnoses that identify medically necessary reasons for providing the service. If you don't supply these covered diagnoses along with the services, your carrier will deny your claim as not medically necessary, says **Jean Acevedo, CPC, LHRM**, senior consultant, Acevedo Consulting Inc., Delray Beach, Fla.

Let's say your carrier is Noridian Administrative Services of Fargo, N.D. Your internist excises a benign, 0.3-cm lesion from a patient's face. You report the procedure as 11400 (Excision, benign lesion including margins, except skin tag [unless listed elsewhere], trunk, arms or legs; excised diameter 0.5 cm or less) and list 686.1 (Pyogenic granuloma) as the diagnosis. Following Noridian's LMRP, 686.1 is a "medically necessary" reason for performing the lesion excision.

If, however, you attempted to justify 11400 with 686.9 (Unspecified local infection of skin and subcutaneous tissue), which Noridian doesn't list as an acceptable diagnosis code, the carrier would probably reject your claim on the basis of an incorrect ICD-9 code.

But if your LMRP doesn't list your internist's diagnosis, you would still submit the claim with your physician's actual diagnosis. For example, if your LMRP didn't list 686.1, you would have the patient complete an ABN (advance beneficiary notice). Then you could append modifier -GA (Waiver of liability statement on file) to 11400. So if your carrier denies the

claim, you can charge the patient, Acevedo says.

You can obtain information about coverage and medical necessity through your LMRP at the Web site http://www.cms.hhs.gov/coverage/LMRP_contractors_index.asp. Also, remember that carriers don't attach a policy to every service, but when they do, you want to be familiar with the requirements, Acevedo explains.

2. Always base coding on medical record documentation. You should be vigilant about reviewing documentation to ensure that records support the diagnosis codes you're reporting, Littenberg says. Remember, however, that only internists should select diagnosis codes for claims unless you are a certified professional coder (CPC) and your physician has given you the responsibility to abstract the records.

3. Run system reports to discover claims with invalid codes. Make sure you keep up with the latest ICD-9 changes, Acevedo says. CMS and other carriers will reject your claims if you have not implemented the coding changes.

For example, as of Oct. 1, CMS will delete V04.8 (Need for prophylactic vaccination and inoculation against certain viral diseases; influenza) and replace it with V04.81 (Need for prophylactic vaccination and inoculation, influenza), V04.82 (... respiratory synctial virus [RSV]) and V04.89 (... other viral diseases). Medicare provides you with a deadline of Jan. 1, 2004, to stop using V04.8. And if you submit any V04.8 claims after Jan. 1 instead of V04.8x, you'll face denials from Medicare for omitting the fifth digit.

You cannot alter existing ICD-9 coding or documentation to match coding updates, Pride says.

4. Avoid defaulting to the "unspecified" code. When your internist provides you with a code that requires a fourth or fifth digit, don't default to an unspecified code. For example, your physician reports a patient's condition as 250 (Diabetes mellitus), and you insert the digit that represents "unspecified" - which may not justify medical necessity in payers' eyes. For example, you use 250.90 (... with unspecified complication; type II ... not stated as uncontrolled) and do not seek out the most appropriate, specific condition, such as 250.01 (... without mention of complication; type I [insulin dependent type] [IDDM] [juvenile type], not stated as uncontrolled) or 250.23 (... with hyperosmolarity; type I [insulin dependent type] [IDDM] [juvenile type], uncontrolled]).

5. Don't code on assumption. If you see that your internist performs a specific treatment on a patient or prescribes a certain medication, you may assume that a patient with that medication must have a certain diagnosis, Acevedo says. Then when you review your internist's diagnosis choices, you may want to substitute them for your own choices. Suppose your internist treats a patient for allergies. Your physician reports the condition as 477.9 (Allergic rhinitis; cause unspecified). But you worry that the diagnosis doesn't accurately report the patient's condition, so you list 477.0 (... due to pollen) instead.

Don't. Coders should base their decisions on existing documentation. Review the patient's symptoms and the possible code selection with your internist both to describe appropriately the patient's true condition and to educate your physician on the choices the ICD-9 book offers.

Also, you shouldn't base codes on assumptions even to rule out possible and suspected conditions when your internist has not definitively diagnosed the condition. If you assign a specific diagnosis based on assumption, it could potentially lead to diagnosing a patient with a condition he or she doesn't have, which may result in the loss of insurance coverage or an increase in premiums.