Codify
BY AAPC

Optometry Coding & Billing Alert

Master Optometry Diagnosis Coding in 3 Easy Steps

Hint: Medical necessity is not necessarily top priority

If your diagnosis coding fails to support medical necessity for the services and procedures provided, carriers can deny claims outright or may require repayment (along with additional fines or even fraud investigations) at a later date. Even when a procedure or service is medically necessary and appropriate, faulty ICD-9 coding can derail the claim.

Here are three tips to help you ace diagnosis coding.

1. Think Accuracy First, Medical Necessity Second

In all cases, you should strive to report ICD-9 codes that accurately and completely describe the patient's condition as supported by your documentation.

You shouldn't code "rule out," "suspected," "probable" or "questionable" diagnoses. If you don't have a definitive diagnosis, "look for any signs or symptoms that the patient has been having," says **Denae M. Merrill, CPC,** coder for Covenant MSO in Saginaw, Mich.

And never assume that a diagnosis applies or code based on your memory of the encounter. Be sure that there is sufficient information in the encounter note to support any ICD-9 codes you assign.

Details matter: In the same vein, always be sure that you report a diagnosis to the highest available and supportable specificity level. Including fourth and fifth digits, when available, to any ICD-9 codes you report is incredibly important for both proper coding and timely payment.

The second goal of successful diagnosis coding is to establish medical necessity for any services and procedures the patient receives. Medicare sets the standard for all payers by defining medical necessity as "those services or items reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member."

Check off your list: Medicare further qualifies "reasonable and necessary" to mean that a service or procedure meets the following:

- safe and effective

- not experimental or investigational and

- appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:

-furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition, or to improve the function of a malformed body member
-furnished in a setting appropriate to the patient's medical needs and condition
-ordered and furnished by qualified personnel
-one that meets, but does not exceed, the patient's medical need and
-at least as beneficial as an existing and available medically appropriate alternative.

Many payers will establish guidelines that state explicitly which diagnosis codes they will accept to establish medical necessity for a given CPT or HCPCS procedural code, and you can find these codes in the payers- local coverage

determinations (LCDs) for various procedures.

You must always observe diagnosis coding's first rule: Only report a diagnosis supported by documentation. You should never assign an ICD-9 code merely for the purpose of achieving payment by falsely claiming medical necessity. This is fraudulent, which can result in serious financial and criminal consequences, and can harm patient outcomes.

2. Use as Many Codes as Needed -- and Be Specific

You should always report diagnoses as specifically as possible. Therefore, you must use four- or five-digit codes when they are available.

You should never report a category (three-digit) or subcategory (four-digit) code when ICD-9 lists more specific codes under those headings.

In addition, with the documentation as your guide, you should report as many diagnosis codes as you need to establish medical necessity for the services you-re billing. Medicare guidelines now allow up to eight ICD-9 codes on a claim.

Watch for: Many software billing packages allow only one diagnosis per procedure. For most procedures with most carriers, one diagnosis is all that you need. If you are debating which diagnosis to use for a certain procedure, use the one that best relates to your chief complaint. For any claim, your diagnosis and your chief complaint go hand in hand.

Certain carriers may require multiple diagnoses for specific procedures, the most common of which is visual fields for a patient on Plaquenil or other high-risk medication. A few carriers require V58.69 (Long-term [current] use of other medications) and the code for the systemic disease being treated. But most carriers will accept V58.69 alone. Your records and interpretation and report (I&R) should include the disease and the medication the patient is taking to justify the visual field.

3. Begin Your Search in the Index

The introduction to the ICD-9 manual provides a good summary of "10 Steps to Correct Coding," and you should follow these steps as a guide when selecting diagnosis codes.

The most important of these steps is to begin your code search by first consulting the alphabetic index (Volume 2), which is arranged by condition. When you have narrowed your search using the index, cross-reference the codes using the tabular (Volume 1) listings, and read the precise definition of your tentative code selection. Often, the tabular listing will provide additional information that will help you pinpoint the exact codes you need.

Example: You need to find a diagnosis for wet age-related macular degeneration (AMD). Check the ICD-9 index under "Degeneration, macula," which gives a "general" code of 362.50. Looking down the list of subentries, you find "wet," which points to 362.52.

Next, find 362.52 in the tabular listing. Under this code, ICD-9 gives the descriptor "Exudative senile macular degeneration" and provides a further definition, "Leakage in macular blood vessels with loss of visual acuity." Code 362.52 is the right code for this condition, says **Diane McVinney, CPC,** billing manager at the Jones Eye Institute at the University of Arkansas for Medical Sciences in Little Rock.

The general code 362.50 (Macular degeneration [senile], unspecified) is not correct because you should use an "unspecified" code only if the documentation doesn't supply you with enough information to report a more accurate code.