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Part B Insider (Multispecialty) Coding Alert

Coding Quiz Answers: Find Out Whether Your 2011 ICD-9 Coding Skills Pass Muster

After you calculate your score, consider studying any diagnosis coding areas where you struggled.

Do you feel like you aced our 2011 ICD-9 coding quiz on page xx? Check out the following answers and determine whether you're a pro.

Answer 1: B. In the past, you may have reported A, C, or D for this diagnosis, because the ICD-9 manual did not include a specific code for spinal stenosis of the lumbar region with neurogenic claudication. However, you must now report 724.03 for this diagnosis, because it most accurately describes the condition. Your physician may perform diagnostic neuromuscular electrodiagnostic tests to determine whether the symptoms in a patient's extremities can be classified as neurogenic claudication due to stenosis. These may include electromyography (EMG, 95860-95872) nerve conduction studies (NCS, 95900-95904), or H-reflex tests (95934).

If neurogenic claudication is not found, you may still resort to reporting other ICD-9 codes; however, if claudication is confirmed, you'll benefit from 724.03.

Answer 2: False. When a V code is your only option, report it as the primary diagnosis. If you think that you should never report V codes (found near the back of the ICD-9 manual) as primary diagnosis codes, think again.

Although it used to be difficult to collect reimbursement from some insurance companies when you reported only V codes, many are coming around. Some new V codes you may use include V85.41 (Body mass index 40.0-44.9, adult), V91.01 (Twin gestation, monochorionic/monoamniotic [one placenta, one amniotic sac]), and V90.10 (Retained metal fragments, unspecified).

Answer 3: C. New code 560.32 (Fecal impaction) may help you support colonoscopy and sigmoidoscopy procedures for commercial payers. It's unclear at this point whether Medicare contractors will add this as an acceptable diagnosis in their local coverage determinations (LCDs).

How it works: Just because you have these new codes to use doesn't mean you're suddenly going to get paid by payers who didn't pay you before. In the past, even with 560.39 (Other impaction of the intestine), some payers did not view the diagnosis as proof of medical necessity for the procedure.

Answer 4: True. You should use E codes to describe external causes of injuries or accidents. You should never bill E codes as your primary code, and you should always list the E codes last. It may be necessary to assign more than one E code to fully explain each cause.

ICD-9 2011 includes new code E000.2 (Volunteer activity) and revised code E017.0 (Roller coaster riding).

Answer 5: To justify medical necessity for 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes), you should report the following diagnoses:

- 410.11 (Acute myocardial infarction; of other anterior wall; initial episode of care) to represent the patient's myocardial infarction
- 970.81 (Poisoning by cocaine), a new code for 2011, to represent the patient's cocaine poisoning
- 401.9 (Essential hypertension; unspecified) to represent the patient's hypertension.

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