

Part B Insider (Multispecialty) Coding Alert

Diagnosis Coding: 10 Steps to Ensure ICD-9-CM Coding Compliance

Keep one eye on ICD-9 while looking ahead to ICD-10.

If your practice is focusing heavily on the transition to ICD-10, you're definitely doing the right thing, since there's less than a year left until the new diagnosis coding system takes effect. However, while you're moving forward toward the updated system, you should continue to ensure that you submit clean ICD-9 claims.

The following ten tips can help safeguard your practice against common diagnosis coding pitfalls.

1. Have access to the rules. Coders must have access to and understand the federal, state and private-payer requirements. The only way to defend yourself against payers who may be questioning your diagnosis coding decisions is to show that you followed their requirements. And you can do that only if you know what those requirements are. Be sure to get written documentation of these rules to support your decisions.

You can do this in a variety of ways. First and foremost, you'll want to have the ICD-9-CM Official Guidelines for Coding and Reporting on hand to answer some of your frequently asked question. This 105-page document is a great starting point for searching any diagnosis coding issues and is available on the CMS website at www.cdc.gov/nchs/data/icd9/icdguide10.pdf.

In addition, continue to reference your local coverage decisions (LCDs), in which your MAC will share diagnosis coding information for specific conditions.

2. Always base coding on medical record documentation. Be fanatical about reviewing documentation to be sure the record supports the codes selected. And when you're coding, make sure you have all the patient's documentation in front of you so you can make the proper choices.

For example, if the physician documents retention of urine (788.20) but circles benign prostatic hyperplasia (600.0x) on the superbill instead because he knows the insurer will reimburse you for 600.0x but will deny 788.20, you'd better be sure that benign prostatic hyperplasia is somewhere in the documentation. If not, you cannot report the code and you'll have to default to 788.20, even if it's not going to be payable.

3. Run system reports to discover claims with invalid codes. In cases when new diagnosis codes take effect, you need to find existing patients with codes that are no longer valid and correct the codes. This is less common now that ICD-10 is looming and therefore the ICD-9 code list hasn't been updated frequently, but there are some new and deleted ICD-9 codes each year as new conditions and emerging technology systems arise.

4. Use caution with abbreviated "cheat sheets." Your coding book will help you find the right code, and user-friendly books will make your job much easier. Consulting the alphabetical index, the tabular index and the procedural codes will ensure you comply with coding requirements. Always use both the alphabetical as well as the tabular index when looking for a code.

5. Beware of assumption coding. When a coder sees that a patient is receiving a specific treatment or is on a certain medication, it's tempting to assume that a patient with that medication must have this diagnosis. Then when you review the physician's diagnosis choices, you may be tempted to add the one you just assumed and code it. Don't. First be sure you have a physician's confirmation and adequate documentation for the additional diagnosis.

6. Never alter documentation. Even if the change "sounds better," if you have a question about the documentation, ask the physician before changing anything. If you need to make changes, document the discussion and follow your practice's protocols for correcting information, which includes the physician making an adjustment to the notes and

signing/dating that, based on your specific payer's documented addendum guidelines.

7. Don't bill for services provided by unqualified or unlicensed personnel. Establish procedures to check that everyone has the qualifications they claim to have and that they renew their licenses when needed, or you'll be refunding substantial sums to the government.

8. Assign a knowledgeable coder to review all rejected claims. This review needs to be part of your internal coding practices for any claim rejected for a coding issue. Don't just play around with correcting the codes to get them to go through. In addition to confirming that you're billing correctly, this could prompt some healthy education sessions between you and your practitioners going forward. In some cases, it may be possible that the physicians simply don't realize they are marking incorrect codes.

9. Protect confidentiality of ICD-9 codes. These codes are part of the patient's protected health information (PHI) and thus are protected by the Health Insurance Portability and Accountability Act (HIPAA) privacy provisions. Therefore, you must keep them safe and secure at all times.

10. Don't assume an association for coding purposes when two conditions are listed together in the diagnostic statement. There are certain situations when ICD-9 assumes an association between two diagnoses when a patient has them both. For example, when a patient has a diagnosis of "hypertension with chronic kidney involvement" you can assume a link and code for it as 403.xx (Hypertensive chronic kidney disease).

And when ICD-9 assumes a link, it isn't necessary for the conditions to be listed together in the documentation as they are in the above example. If the patient's diagnoses simply included hypertension and chronic kidney disease (CKD), you would use the 403 code along with the 585 code for CKD.

When ICD-9 doesn't assume a link, you'll need to have physician documentation or verification showing the connection. For example, you can't assume a link when your patient has hypertension and heart disease. The physician would need to indicate "hypertensive heart disease" or "heart disease due to hypertension."

You should remember the official convention of "and" and "with" as well. In ICD-9, "and" does not indicate a connection between the two diagnoses. "With" means the two conditions are associated. "With" can mean one caused another or that the two conditions are associated in some other way.

Do this: If you suspect a relationship between two conditions but cannot find supporting documentation, query the physician for the details. If the physician does not respond, then you should code the conditions separately.