Part B Insider (Multispecialty) Coding Alert

DIAGNOSIS CODING: CMN Doesn't Need to Justify Diagnosis Code, CMS Says

You may still be in the dark as to which ICD9 Codes to put on a claim, especially in cases where Medicare now requires a four- or five-digit code. But at least you won't find yourself dinged for clashing with the code on your certificates of medical necessity.

It doesn't matter if the ICD-9 on your claims matches the one on your physician order or CMN, as long as you can back it up, the Centers for Medicare & Medicaid Services said in program memo B-03-028 released April 18. There should be evidence in the patient's medical record to support using that code, and the diagnosis code should support coverage for the item you're supplying.

You also don't need to obtain a new CMN for an existing patient if the CMN doesn't contain the most specific ICD-9 code, CMS confirms. Obviously if the patient's condition or order changes, then you'll need to obtain a new CMN in any case.

"CMS understands that physicians may not always provide suppliers of DMEPOS with the most specific diagnosis code, and may provide only a narrative description," the agency admits. If the physician leaves you without a clue, there are a few places you can hunt down the correct code, the agency adds, including:

coding books and resources

contact with physicians or other professionals

documentation contained in the patient's medical record

verbally from the patient's physician or other clinician.

Each line on your claims should contain a valid diagnosis code, and electronic claims will be bounced back to the supplier through front-end edits, whether they're assigned or unassigned. "These claims do not get in the front door," CMS insists.

Also, you should make sure the ICD-9 codes you submit are valid and not defunct or fictional. Claims with invalid codes will slingshot back to you at top speed unless the durable medical equipment regional carriers are already developing unassigned claims with invalid ICD-9s prior to denial.

Paper claims also require a valid ICD-9 code if the local medical review policy requires one.

The Health Insurance Portability and Accountability Act requires a complete diagnosis code on each claim unless it's a so-called "taxi claim" with no diagnosis. Essentially, CMS explains, a three-digit ICD-9 isn't acceptable if a four-digit code provides more detail. And a four-digit code isn't acceptable if a five-digit code would provide more information as well.