Part B Insider (Multispecialty) Coding Alert

Diagnosis Coding: Your Top 5 Diagnosis Coding Questions Answered

Hint: Documentation will reveal appropriate 'Welcome to Medicare' Dx code.

Although your practice is most likely gearing up for the ICD-10 transition, you probably still have diagnosis coding questions that can't wait until 2014--or beyond--before you get answers. Today we've gathered five of the most pressing diagnosis coding questions that our readers have submitted, and we've got the solutions that can help you keep reimbursement flowing.

Don't Armchair Diagnose Patients

Question 1: If the physician hasn't indicated ECG results in his final diagnosis, should I code the findings? The doctor wrote a complete interpretation on the strip. He says "yes," because usually he has another diagnosis to justify the ECG.

Answer 1: For you to report positive findings from the ECG, the physician must document the findings as a final diagnosis. Choosing a diagnosis based on the patient's test results -- even when that diagnosis seems obvious-- is inappropriate and possibly fraudulent coding. CMS describes its guidelines for this issue in Transmittal AB-01-144 in which the agency states that a physician must confirm a diagnosis based on the test results.

Here's why: The physician may indicate that the ECG indicates an arrhythmia--but if you base your coding on that statement and report an ICD-9 code for unspecified arrhythmia, you may not be accurate. The doctor may actually have diagnosed the patient with a specific condition, such as Wolff-Parkinson-White syndrome, which would be the correct diagnosis code to report.

This CMS transmittal goes on to say that if the test results are normal or nondiagnostic, you should code the signs or symptoms that prompted the test -- in other words, the indications. Similarly, the ICD-9 coding guidelines for diagnostic testing instruct you not to "interpret" what a study says, but rather to rely on the physician's stated diagnosis. If the ECG findings seem like an important component of the case -- and may play a role in substantiating the medical necessity for the visit-- you should query the physician regarding the diagnosis.

'V' Codes Can Be Primary, But May Not Be Payable

Question 2: Can we use 'V' codes as primary diagnoses?

Answer 2: Yes, you can use the 'V' codes as primary diagnoses, but whether or not you will collect reimbursement for these claims is a different story.

V codes are often the answer in difficult-to-code scenarios but the challenge is determining which V codes payers will accept and which they will not. Often, payer edits are not published anywhere, and all coders and billers can do is to glean the list of payable and non-payable V codes from their claim experience.

For example: Florida Medicaid considers some "history of" V codes payable, even as a primary diagnosis, and these codes may help to support the medical necessity of the claim. If a patient presents with no symptoms at all and has a history of cardiac disease, and the patient does have some sort of cardiac exam and/or work-up, then the coder can use V12.50, Personal History of Unspecified Circulatory Disease to support the medical necessity of the claim.

In addition, this personal history code could also be used with other diagnosis codes on the claim. However, this same payer will not pay for a claim with many of the follow-up V codes, such as V67.9, (Unspecified follow-up examination).

Drawback: Unfortunately, the screening or follow-up V codes are typically not payable diagnoses for Medicare carriers.

On the other hand, if the screening or follow-up V code is absolutely the only diagnosis code that can be pulled from the chart documentation, then the coder may have no choice but to submit the V code that will result in a denial and then appeal perhaps with a copy of the medical record.

Get docs on board: Emphasize to your physician the importance of documenting all presenting complaints and signs and symptoms in the context of avoiding unnecessary denials. Many times, the physician may not be familiar with ICD-9 and what diagnoses are and are not available to coders and how they ultimately impact claim payments.

Look to Documentation--Not LCD--for WTM Dx Code

Question 3: Which diagnosis code should be reported with the Welcome to Medicare (WTM) exam and the annual wellness visit (AWV)?

Answer 3: CMS does not dictate which ICD-9 code should be linked to the WTM exam code (G0402, Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment). Instead, you should select the most applicable diagnosis code from your physician's documentation.

"An example of diagnosis codes that could be included on the WTM claim are V70.0 (Routine general medical examination at a health care facility), V70.3 (Other general medical examination for administrative purposes), or V70.9 (Unspecified general medical examination)," said CMS's **Kathleen Kersell** during a March 28 CMS call. "These all could be considered acceptable diagnosis codes, as well as any other valid, appropriate diagnosis codes," she said.

As for the AWV, "There are no specific ICD-9 diagnosis codes that are required for the annual wellness visit," said CMS's **Thomas Dorsey** during the same March 28 forum. He noted that V70.0, V70.3, and V70.9 are being accepted by MACs for the AWV visits as well.

Determine How Many Dx Codes to Report

Question 4: Our doctor treated a patient with diabetes, but he was actually seeing the patient to treat a complication of the diabetes, diabetic neuropathy. During his evaluation, the physician also noted that the patient had joint inflammation. Should we report the neuropathy complication only, or several of the ICD-9 codes?

Answer 4: Normally, the primary diagnosis code that you list on your claim should represent the main reason for the encounter, or the condition with the highest risk of morbidity/mortality that the physician addresses during the visit. The situation changes, however, when you deal with a condition like diabetes.

According to Section 1.A.6 of the ICD-9-CM Official Guidelines for Coding and Reporting, "Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-9-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation."

The Guidelines continue, explaining that you may report more than one code from category 250 to "fully describe the patient's complete diabetic condition" if the patient has "more than one manifestation of diabetes."

Therefore, you should first report 250.6x (Diabetes with neurological manifestations) on the claim. Remember to add a fifth digit to reflect the type of diabetes the patient has.

Your secondary code should represent the specific neurological manifestation. In most cases, you will report 357.2 (Polyneuropathy in diabetes).Because the doctor documented that the patient also has joint inflammation, you should report the appropriate code describing that condition (716.9x, Arthropathy, unspecified).

Although the insurer's computer will scan only the first, main diagnosis code that you list, you should list all of the codes that apply. That way, if the payer challenges a claim, you can help your appeal by having already sent the insurer all the patient's applicable diagnoses on record.

Know When Injury Codes Are Best

Question 5: I'm looking for the coding guidelines that describe when I can report an acute injury ICD-9 code rather than a chronic injury code. We see patients for generalized pain (not necessarily a recent injury) and aren't sure what to code.

Answer 5: In coding some conditions, such as kidney disease (585.x), it can be simple to determine when the patient's condition is chronic, because the diagnosis codes differ based on the patient's lab results. However, coding for pain can be more tricky.

For example, suppose your patient presents with shoulder pain that she says she has had for the past nine months, which came on slowly. You consider code 840.4 (Sprains and strains of shoulder and upper arm; rotator cuff [capsule]), but it is from the "injury" chapter of the ICD-9 guidebook. In this case, the patient didn't have an injury-- instead she had nine months of pain.

Therefore, you should avoid 840.4 and select another code based on the rest of the doctor's documentation of her condition, such as 719.41 (Pain in joint; shoulder region), for example, if the patient had pain that was otherwise unspecified.

Why: An acute injury is sudden and severe. A chronic condition is a longer developing syndrome, persistent, continuing, or recurring, but may have been caused by an acute injury.

By definition, a patient could have both--a chronic condition resulting from an acute injury. The American Hospital Association's official Inpatient and Outpatient Coding Rules state, "If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the alphabetical index at the same indentation level, code both and sequence the acute (subacute) code first." They are referring to the ICD-9-CM alphabetical index.