Part B Insider (Multispecialty) Coding Alert

ICD-10: 10 Steps Ensure ICD-10-CM Coding Compliance

You've made the transition to the new diagnosis coding system—now make sure you're compliant.

Practices have been so careful about creating their ICD-10 transition plans that they may have been focusing on the big picture—so now it's time to scrutinize the details of the new diagnosis coding system.

The following ten tips can help safeguard your practice against common diagnosis coding pitfalls under ICD-10.

1. Don't Rely Solely on Shortcut 'Cheat Sheets.' Your coding book will help you find the right code, and user-friendly books will make your job much easier. And although shortcut "cheat sheets" can be extremely helpful for your practice, don't stop there when you find the right code group for your patient's condition. 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.

For example: Suppose your patient has a laceration of the eyelid. You quickly flip to the index of your ICD-10 manual and find "Laceration, eyelid" connected to code S01.11 for lacerations without a foreign body or S01.12 when a foreign body is present. If you simply put one of these codes on your shortcut sheet—or worse yet, on a claim—you will be facing denials. Why? Because these codes are followed with a check mark icon, which means that an additional character is required.

The only way to code the eyelid laceration properly is to flip to the tabular list in the back of the ICD-10 manual. Under the listing for S01.11 (Laceration without foreign body of eyelid and periocular area), you'll find three subsequent entries referring to the right eye (S01.121), the left eye (S01.122) or unspecified eye (S01.129). The same options are available for the S01.12 series. This illustrates how essential it is to use not just your cheat sheets but also each section of the ICD-10 manual.

2. Keep All of the Rules Nearby. Coders and billers 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-10-CM Official Guidelines for Coding and Reporting on hand to answer some of your frequently-asked questions. This 115-page document is a great starting point for searching any diagnosis coding issues and you can find it on the CMS website at www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf. The guidelines offer both general diagnosis coding information on issues such as sequencing, as well as specific information applicable only to certain diagnoses. For instance, the guidelines advise coding non-healing burns as "acute burns," and to default to code E11.- (Type 2 diabetes mellitus) if the doctor doesn't document the type of diabetes in the patient's medical record.

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

3. Review medical record documentation before selecting a code. Be fanatical about reviewing documentation to

be sure the record supports the codes that you or your doctor have selected. And when you're coding, make sure you have all of the patient's documentation in front of you so you can make the proper choices.

For example, if the physician documents retention of urine (R33.9) but circles "enlarged prostate" (N40.0) on the superbill instead because he knows the insurer will reimburse you for N40.0 but will deny R33.9, you'd better be sure that documentation of the patient's enlarged prostate is somewhere in the patient encounter notes. If not, you cannot report the code and you'll have to default to R33.9, even if it's not going to be payable.

4. Execute system reports to find claims with invalid codes. Because the ICD-9 coding system was active very recently, it's quite possible that your practitioners are still assigning diagnoses from memory without thinking about it—and those could now be outdated. Search through your systems periodically to ensure that only active diagnosis codes are listed on your claims.

5. Don't base diagnosis on assumptions. 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 a specific diagnosis. Then when you review the physician's diagnosis choices, you may be tempted to add the one you just assumed and code it—but you must avoid doing this. First be sure you have a physician's confirmation and adequate documentation for the additional diagnosis.

6. N**ever change the documentation.** Even if your adjustment "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 and your state'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 conditions treated by unqualified or unlicensed personnel. Establish procedures to check that everyone has the qualifications they must have to treat certain diagnoses. For instance, even if your medical assistant says she performed subcutaneous injections for allergies at her last practice, it's best to check your state laws to make sure she is licensed to do so in your office as well.

8. Assign a specific staff member 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 diagnosis codes to get them to go through to appeals. 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 diagnosis codes.

9. Protect confidentiality of ICD-10 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-10 assumes an association between two diagnoses when a patient has them both. For example, when a patient has a diagnosis of "hypertensive chronic kidney disease" you can code for it as I12.9 (Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease). However, if the doctor separately documents hypertension in one part of the chart and kidney issues in another part of the chart, you can't assume that I12.9 is the right code.

You should remember the official convention of "and" and "with" as well. In ICD-10, "and" does not necessarily indicate a connection between the two diagnoses. "With" means the two conditions are associated.

Do this: If you suspect a relationship between two conditions but cannot find supporting documentation, query the physician for the details.