Part B Insider (Multispecialty) Coding Alert

ICD-9 CODING: 2 Scenarios Help You Find the Right ICD-9 Code When the Physician Doesn't Provide It

Tip: Don't choose a code based on the coverage decision

Physicians do it every day--they hand their coders a chart without an ICD-9 code, leaving the coder to discern a diagnosis code. Some-times selecting the right code is easy--but other times, the coder is left scratching her head.

Use these two quick scenarios that can help you sort out this common problem.

Get to the Root of the Problem

Example 1: The physician performs a subsequent hospital visit, but does not provide an ICD-9 code for the encounter. The physician dictates the initial hospital visit and the discharge summary, but feels that his coder can look at the discharge summary and chose the first of several diagnoses to use for the subsequent hospital visits. The coder, however, doesn't know whether to choose the admitting diagnosis or the patient's most recent status.

The challenge: -Subsequent hospital care includes reviewing the medical record and the results of diagnostic studies and changes in the patient's status, (that is, changes in history, physical condition and response to management) since the last assessment by the physician,- says **JoAnn Baker, CCS, CPC-H, CPC, CHCC**, a coding analyst with **CodeRyte.**

When the physician reviews the medical record and the diagnostic study results, the diagnosis or the patient's status may change from day to day. So choosing a diagnosis from the admitting or discharge summary list may result in either over- or undercoding the E/M level depending on the medical decision-making, Baker says.

Talk to the Physician

Solution: Ask the physician to document the appropriate diagnosis on each subsequent visit for the encounter. -Good documentation for subsequent care day services (diagnosis--interval history and exam when appropriate) serves two very important functions,- Baker says. -It ensures clinical documentation that is accurate and precise, clearly outlines the patient's condition to any other providers or ancillary staff involved in the patient's care, and provides excellent supporting documentation for leveling E/M.-

Don't Code Based on What Pays

Scenario 2: A physician orders a radiology service, but fails to write an ICD-9 code on the claim. The coder calls her co-worker who works closely with the patient's insurance carrier and asks, -Which ICD-9 code gets this procedure paid?-

Error: Unfortunately, this scenario is not particularly uncommon. But coding from the coverage decision is never a good idea. You should select a diagnosis code based on the patient's condition, and not what the payer says it will accept.

-One of the biggest problems for radiology/lab practices is to get a complete accurate history of the patient you are seeing,- says **Kim French, CIC**, of **Crouse Radiology Associates** in Syracuse, N.Y.

Research on the Front End

-The norm is that you receive just basic information, sometimes one or two words on a diagnosis or clinical symptom that reflect the big picture and not necessarily pertinent to that specific test. And because Medicare has lists with very specific payable conditions, they don't always match up,- she says.

Solution: -We try to do our research on the front end rather than waiting for a denial, and I can tell you from my experience that when you delve further into a patient's medical record, you most often find there is documentation that a payable code exists and that is the real reason for the study,- French says.

If the patient's diagnosis is not payable, however, you should still report it, even if it might lead to a denial. After all, correct coding dictates that you place the most accurate ICD-9 code on the claim, regardless of whether it will lead to a denial.