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Part B Insider (Multispecialty) Coding Alert

Icd-9 Coding: Master Diagnosis Coding in 3 Easy Steps

Hint: Medical necessity is not necessarily a top priority in selecting a code

If your diagnosis coding fails to support medical necessity for the services you provide, carriers can deny claims outright or may require repayment at a later date. Even when a procedure or service is medically necessary and appropriate, faulty ICD-9 coding can derail the claim.

Today we've got three tips to help you ace diagnosis coding.

1. Think Accuracy First, Medical Necessity Second. You should always strive to report ICD-9 codes that accurately and completely describe the patient's condition as supported by your documentation.

You shouldn't code "rule out," "suspected," "probable," or "questionable" diagnoses. If you don't have a definitive diagnosis, "look for any signs or symptoms that the patient has been having," says **Denae M. Merrill, CPC,** coder for **Covenant MSO** in Saginaw, Mich.

And never assume that a diagnosis applies or select a code based on your memory of the encounter. Be sure that there is sufficient information in the encounter note to support any ICD-9 codes you assign.

The second goal of successful diagnosis coding is to establish medical necessity for any services and procedures the patient receives. Medicare sets the standard for all payers by defining medical necessity as "those services or items reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member."

Check off your list: Medicare further qualifies "reasonable and necessary" to mean that a service or procedure is safe and effective, and not experimental or investigational.

The procedure must also be appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:

• furnished in accordance with accepted standards of medical practice to diagnose or treat the patient's condition, or to improve function of a malformed body member

• furnished in a setting appropriate to the patient's medical needs

• ordered and furnished by qualified personnel

• one that meets, but does not exceed, the patient's medical need

• at least as beneficial as an existing and available medically appropriate alternative.

Important: Only report a diagnosis supported by documentation. You should never assign an ICD-9 code merely for the purpose of achieving payment by falsely claiming medical necessity. This is fraudulent, which can result in serious financial and criminal consequences.

2. Use as Many Codes as Needed -- and Be Specific. You should always report diagnoses as specifically as possible. Therefore, you must use four- or five-digit codes when they are available. You should never report a category (three-digit) or subcategory (four-digit) code when ICD-9 lists more specific codes under those headings.

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In addition, with the documentation as your guide, you should report as many diagnosis codes as you need to establish medical necessity for the services you're billing. Medicare guidelines now allow up to eight ICD-9 codes on a claim.

Watch for: Many software billing packages allow only one diagnosis per procedure. If you are debating which diagnosis to use for a certain procedure, use the one that best relates to your chief complaint.

3. Begin Your Search in the Index. The introduction to the ICD-9 manual provides a good summary of "10 Steps to Correct Coding." Follow these steps as a guide when selecting diagnosis codes.

Most importantly, begin your code search by first consulting the alphabetic index (Volume 2), which is arranged by condition. When you have narrowed your search using the index, cross-reference the codes using the tabular (Volume 1) listings, and read the precise definition of your tentative code selection. Often, the tabular listing will provide additional information to help you pinpoint the exact codes you need.

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