Part B Insider (Multispecialty) Coding Alert

ICD-9 CODING: Stop Asking 'Which Diagnosis Code Will Get My Claim Paid?'

Instead, code directly from the medical record.

Medical coders face a lot of questions each day in the course of their work, but one question you should not be asking is "which diagnosis code should I put on this claim if I want to collect?"

When the Insider solicited subscribers' questions last week, the overwhelming majority asked questions such as, "We performed xyz procedure -- can you tell me which diagnosis codes we can report to Medicare to get this claim paid?"

But this type of ICD-9 coding is backward, experts say. Instead, you should be coding based on the documentation -- not based on which codes your MAC will reimburse.

"I do not feel that we as coders should be coding based on getting the claim paid," says **Michelle Jubeck, CPC, CEMC, CPMA,** coding compliance analyst with Monroe Clinic in Monroe, Wis.Jubeck points to the ICD-9-CM guidelines, which state, "The entire record should be reviewed to determine the specific reason for the encounter and conditions treated."

Keep in mind: "It is illegal to just assign an ICD-9 code that will get your claim paid -- you have to report the codes documented in the record," says **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CENTC, CHCC,** president of CRN Healthcare Solutions in Tinton Falls, N.J. Any diagnosis that you report on a claim must be clearly documented in the patient's chart -- not selected because it's a covered diagnosis.

ABN use: "If you want to know what will justify the medical necessity of the service the physician performed so you know when to get an advance beneficiary notice (ABN) signed, you need to look at your local coverage decisions (LCDs)," Cobuzzi says.

Tip: In some cases, an LCD will list a very general or unspecified diagnosis code as being payable, whereas your physician has documented a more specific diagnosis which isn't in the LCD. "In these cases, you should still report the documented diagnosis, but if the MAC denies the claim, appeal it by saying 'If the unspecified code is payable, then why isn't the more specific condition considered medically necessary?'" Cobuzzi advises.

Bottom line: "We need to have a good rapport with our physicians -- let them know that documentation (accurate and complete) begins and ends with them," Jubeck says.