Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach 3 Ways to Do Diagnosis Coding Right

Signs and symptoms may sometimes be your best choice.

Choosing the right CPT procedure code is the first step to ensure your physicians get paid for the work they do, but if you fail to attach the correct diagnosis code, you may be in jeopardy of receiving denials.

Follow these expert recommendations to ensure you're properly coding patients' signs, symptoms and diagnoses.

Watch for 4th- and 5th-Digit Requirements

Correct coding requires that you code as specifically as possible.

That means your physician should assign the most precise ICD-9 code to a service. You cannot justify a service with a fourdigit diagnosis code when carriers or ICD-9 requires a more specific five-digit code to describe the patient's condition. Using the fourth or fifth digit when it is required -- or just when you do have that information -- is an important concept to follow. Make sure you review the entire record when determining the specific reasons for the encounter and the conditions the physician treated.

Pitfall: Don't assume what isn't in the medical record.

Example: If you are coding for deep vein thrombosis (DVT), you cannot simply report 453.4 because four digits alone don't make for a complete diagnosis. Instead, you must specify a fifth digit of 0 (for DVT of unspecified vessels of lower extremity), 1 (for DVT of proximal lower extremity) or 2 (for DVT of distal lower extremity).

Tip: If the medical record does not allow you to code to the required level of specificity, check with the reporting physician for guidance.

Call on Signs and Symptoms

When your physician provides a confirmed diagnosis, you should always code that diagnosis instead of the presenting signs and symptoms. If the physician cannot document a definitive diagnosis, however, report the patient's signs and symptoms to support medical necessity for services the physician provides.

Avoid "rule outs": ICD-9 coding guidelines state that you should not report "rule-out" diagnoses in the outpatient setting. You'll avoid labeling the patient with an unconfirmed diagnosis, and by coding the presenting signs and symptoms, your surgeon will still get paid for his services, even if he cannot establish a definitive diagnosis. Look to see if the physician has given the patient a definitive diagnosis. "Rule out," "suspected," "probable," or "questionable" are not codable. If there is no definitive diagnosis given, look for any signs or symptoms that the patient has been having.

Example: The surgeon sees a patient in the emergency department (ED) with a very high fever and suspects that she had sepsis.

Correct coding in this instance depends on available documentation. If the surgeon stated that the diagnosis was sepsis, report the relevant code (for example, 038.8, Septicemia; other specified septicemias). If the physician stated that he was attempting to "rule out" sepsis, you should report the signs and symptoms (for example, 780.6, General symptoms; fever).

Again: CMS outpatient services guidelines explicitly state that practices should not use the condition being ruled out as the diagnoses. Instead, "code the condition(s) to the highest degree of certainty for that encounter/visit such as

symptoms, signs, abnormal test results ..."

Pointer: Talk to your physicians about how important it is to be accurate with their terms. Tell the physician that if he can come to a definite conclusion about the patient's diagnosis, he needs to state this in his dictation so you may choose the best code.

Use V Codes When Applicable

Coders often hesitate to report V codes, but sometimes they may be the most accurate descriptors of the reason for the patient's condition. Actually, you should use V codes to provide additional clinical information to an insurer, whether it's Medicare or a private carrier.

Most coders believe that V codes are only appropriate as secondary codes, but the reality is that you may -- and, on occasion, should -- report V codes as a primary diagnosis. In some instances, a V code may even be the only way to be paid for a service.

Example: A Medicare patient presents for a screening colonoscopy. To indicate high risk factors for this patient and therefore justify medical necessity for the test, you may chose from a number of V codes as primary diagnoses, such as V10.05 (Personal history of malignant neoplasm; gastrointestinal tract; large intestine), V12.72 (Personal history of certain other diseases; diseases of digestive system; colonic polyps) and V16.0 (Family history of malignant neoplasm; gastrointestinal tract), among others.

Tip: Many versions of the ICD-9 manual will indicate whether you can report a V code as a primary or secondary diagnosis using the indicators "PDx" (primary) and "SDx" (secondary) next to the code descriptor. If the code has neither a "PDx" nor an "SDx" designation, you may use that V code as either a primary or a secondary diagnosis, according to ICD-9 instructions.