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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 4 Tips Improve Your Respiratory Diagnosis Coding

Ensure payment with these ICD-9 coding strategies Are you up to speed on 2004's new and revised asthma and bronchitis ICD-9 codes? If not, your physician could be losing deserved reimbursement. Follow four tips offered by coding experts to boost your ICD9 coding accuracy. Medicare focused on asthma for many of its updates because asthma is a high-profile condition for patients, physicians and payers, says **Anthony M. Marinelli, MD, FCCP**, chairman of the American Thoracic Society's Clinical Practice Committee. CMS and other carriers may use the data from ICD-9 reports to adjust payments or develop quality guidelines. That's why your practice should be as accurate as possible when you report diagnosis codes to avoid potential fraud or abuse, he adds. **1. Specify the Asthma Problem, Not Symptoms** CMS made your asthma-related diagnosis coding easier in 2004 by introducing ICD-9 codes 493.81 (Exercise-induced bronchospasm) and 493.82 (Cough-variant asthma), which allow you to specify the asthma problem, instead of relying on the patient's signs and symptoms. The codes went into effect on Oct.1, but CMS gave practices until Jan.1 to update their systems and begin using the codes. "One of the primary reasons for developing new codes and updating/revising current diagnosis codes is to improve the specificity of diagnosis coding," says **Mary Mulholland, BSN, RN, CPC**, a reimbursement analyst for the office of clinical documentation at the University of Pennsylvania's department of medicine in Philadelphia. As physicians identify new conditions, or new features of existing conditions, Medicare must also develop new diagnosis codes, she adds. **2. Watch Out for Signs and Symptoms Coding** Having 493.81 and 493.82 means that your physician's documentation can medically justify with more specificity his or her asthma treatment procedures. But that also means if you are still using signs and symptoms coding, your insurer may deny your claims or the coding practice could trigger an audit, Mulholland says. "When selecting the primary diagnosis code, the coder should first report the ICD-9 diagnosis that most accurately identifies the patient's medical condition," Mulholland says. Coders may also report any additional signs and symptoms, which the physician documents in the medical record, if they contribute to the doctor's services, she adds. **Example:** When a patient presents with chronic cough (786.2) and shortness of breath (786.05), your internist may test for cough-variant asthma. Suppose the physician tests the patient with bronchodilators (94640, Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes [e.g., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device]) and diagnoses the patient with cough-variant asthma. In this situation, you would bill 94640 for the bronchodilator treatment, and link ICD-9 code 493.82 to 94640. Make sure the physician's documentation specifies cough-variant asthma, not only the signs and symptoms (786.2, 786.05). Prior to this year, you could have used 786.2 and 786.05 to justify billing 94640, but now Medicare and most private insurers require 493.82, which is the most specific code. **3. Don't Forget the New Bronchitis Descriptors** To ensure that you are accurately coding obstructive chronic bronchitis, you should look for patients' specific levels of exacerbation in your physician's medical documentation, coding experts say. **News:** This year, CMS offers revised descriptors for 491.20 (Obstructive chronic bronchitis; without exacerbation) and 491.21 (... with [acute] exacerbation) to help you more specifically determine a patient's level of exacerbation. Let's say your physician performs an E/M service on a patient with cough (786.2) and painful respiration (786.52). The physician diagnoses the patient with obstructive chronic bronchitis, without exacerbation, and prescribes antibiotics. To get paid for this visit, you should report the appropriate E/M code (for example, 99203, Office or other outpatient visit for the E/M of a new patient ...), and link ICD-9 code 491.20 to the E/M. Coders should use 491.21 only when the physician specifically identifies that the patient has acute exacerbation, Mulholland says. **Best bet:** Remember that 491.20 now represents "without exacerbation," which is a phrase you should look for in the documentation. Previously, the physician had to provide the less specific diagnosis of "without mention of acute exacerbation." The new descriptors mean your physician must specify if the patient doesn't have exacerbation to justify code 491.20. And if the documentation doesn't support the diagnosis code, your insurer may deny your claim. **4. Use New V Codes for Inoculations** You will need to report a five-digit diagnosis code when patients need inoculations for compromised immune systems. Codes V04.81 (Need for prophylactic vaccination and inoculation against certain viral diseases; influenza), V04.82 (... respiratory syncytial virus [RSV]) and V04.89 (... other viral diseases) replace V04.8 (Need for prophylactic vaccination and inoculation against certain viral diseases, influenza). **Watch for:** The physician should use V04.81, V04.82 and V04.89 only for vaccinations, Marinelli says. For example, if

your physician vaccinated a patient vulnerable to influenza (487.x), you would report G0008 (Administration of influenza virus vaccine ...) for Medicare patients, or 90471 (Immunization administration [includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections]; one vaccine [single or combination vaccine/toxoid]) for most private insurers. You would link the diagnosis V04.81 to the procedure. Medicare may have added V04.81-V04.89 to separate these inoculation codes from other routine vaccinations, such as hepatitis A (Medicare covers hepatitis B), which CMS and other carriers may not cover.