Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Anesthesia Providers Shouldn't Ignore V Codes

Build your diagnosis codes by starting with subterms.

Thinking that V code diagnoses might not apply to your provider is a mistake no anesthesia coder should make. Follow these tips to successful V code selection and find better ways to get your claims paid.

Subterms Guide You to the Best Diagnosis

V codes can add details to your claim that help the payer better understand the situation. That additional information and specificity can possibly boost your reimbursement, experts say.

Example: Let's assume you're coding for a patient who underwent prophylactic organ removal of an ovary. You have several steps to take before reaching the best diagnosis code, beginning with the very basic terms:

1. Search for the term "Admission" in the ICD-9 index.
2. Beneath the term "Admission," reference the subterm "for."
3. Follow your choices to the subterm "prophylactic."
4. Beneath "prophylactic," look for "organ removal."
5. Under "organ removal," end at "ovary," which designates code V50.42.
6. Look up V50.42 in ICD-9's tabular section, which gives you "Prophylactic organ removal; ovary." Check the entry for additional instructions or coding guidelines.

The surgeon and anesthesiologist can each submit their claims with V50.42 as the primary diagnosis and V16.41 (Family history of malignant neoplasm; ovary) as the secondary diagnosis if the patient's background includes such history.

Caution: Payer guidelines can differ on insurers' use or acceptance of certain V codes, so check your payers' policies before submitting claims, advises **Kelly Dennis, MBA, ACS-AN, CANPC, CHCA, CPC, CPC-I**, owner of Perfect Office Solutions in Leesburg, Fla.

Tip: Periodically review the ICD-9-CM Official Guidelines for Coding and Reporting (visit www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf)to be sure you're following the most updated coding conventions.

Match V Codes With Correct Procedures

Reporting the correct diagnosis for a procedure is just as important as correctly coding the procedure.

Remember: Some procedures have a list of approved diagnoses. For example, Cahaba has a local coverage determination (LCD) for continuous peripheral nerve blocks (codes 64416, 64446, 64448, and 64449). Diagnoses that Cahaba states support medical necessity and therefore will pay for include 338.11 (Acute pain due to trauma)-338.19 (Other acute pain), 350.1 (Trigeminal neuralgia), 723.1 (Cervicalgia), V58.43 (Aftercare following surgery for injury and trauma), and others.

If the payer doesn't agree that your reported diagnosis supports the procedure's medical necessity (by being an approved diagnosis), the payer could deny your claim.

In your coding, watch out for these common diagnosis mistakes:

- Not updating a pain management patient's diagnosis for example, administering an epidural with a vague diagnosis such as "back pain" instead of something more specific like 724.03 (Spinal stenosis, lumbar region, with neurogenic claudication).
- Due to lack of provider documentation, reporting an unspecified spinal region diagnosis code for example,721.90 (Spondylosis of unspecified site; without myelopathy).
- An incorrect diagnosis for post-op pain management.
- Not reporting a code from the 338 (Pain, not elsewhere classified) series when appropriate.

Potential trap: Many payers have specific guidelines for the diagnoses they consider acceptable for postoperative pain management.

Example: A payer may list only three diagnoses to justify 01996 (Daily hospital management of epidural or subarachnoid continuous drug administration) and epidural codes 62310-62319. The payer may accept 338.11 (Acute pain due to trauma), 338.12 (Acute post-thoracotomy pain), and 338.18 (Other acute postoperative pain).

Tip: Always verify your payer's post-op pain management policy before submitting the claim.

Check Your Spelling and Numbers

Some mistakes can be a simple matter of keying the wrong diagnosis. If you receive a diagnosis-based denial, double check that you didn't submit a claim with a typo or inadvertently transpose numbers.

If the diagnosis you submitted was correct but isn't on the payer's list, talk with your physician. A secondary diagnosis he documented might work just as well.