Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Avoid V Codes And Risk Vaporizing Valuable Green

Fact: V codes can verify medical necessity and validate higher E/M levels

Coders often shun V codes because of some long-standing - and highly inaccurate - coding myths.

The truth: V codes are your keys to documenting chronic conditions or underlying physical or social circumstances that can affect a patient's current health status or treatment.

See if ignoring V codes is locking you out of carrier coffers.

Demystify These Harmful Myths

Myth #1: V codes are only secondary diagnosis codes, like E codes.

"There are times when it's very appropriate to report V codes as a primary code, says **Suzan Hvizdash, BSJ, CPC,** Physician Education Specialist for the **University of Pennsylvania Pittsburg's** department of surgery.

Example: A gastroenterologist sees a patient in his office after a colostomy to check the patient's stoma. You want to report a V code (V55.5, Attention to artificial openings; cystostomy) because attention to the colostomy is the procedure you perform, says Hvizdash.

V codes as primary diagnoses also come into play with Medicare's screening services. Many Medicare-covered screening tests require you to link the main procedure code to a V code. For a list of relevant V codes, see the box "Forget These Screening Codes And Forget Payment From CMS" see the inset box on the next page.

Solution: The V code descriptor will indicate if you may report the code as a primary or secondary diagnosis code with the indicators "PDx" (primary) and "SDx" (secondary). If the code has neither designation, the ICD-9 manual states you may use it as either a primary or secondary diagnosis code.

Myth #2: V codes don't pay anything so there is no reason to use them.

While it's true some V codes are only descriptors that give background information on the patient, the information they provide can help support the complexity or frequency of an E/M code your office reports, or they can support the medical necessity of a claim, such as a chest x-ray or repeated lab tests, says **Jean Acevedo, LHRM, CPC, CHC,** senior consultant with Acevedo Consulting Incorporated in Delray Beach, FL.

Example: A patient taking Celebrex for her arthritis needs to have her liver and kidney functions monitored to make sure the drug is not causing any problems. The patient, who is otherwise healthy, undergoes lab tests every few months to monitor kidney and liver functions.

In this case, a V code that shows the patient is on a drug long term such as V58.64 (Long-term [current] use of non-steroidal anti-inflammatories [NSAID]) will help to substantiate the need for these tests to the patient's insurance carrier. Without it, the tests appear medically unnecessary.

Another example: Let's say a physician sees a patient with diabetes and her blood sugar level is under control and (250.00 - Diabetes mellitus without mention of complication; type II or unspecified type, not stated as uncontrolled). She

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normally only sees her physician every few months but she presents complaining of tingling in her toes and blurry vision.

The physician orders blood tests, changes the patient's medication and performs a level 4 E/M. He refers the patient to a vascular specialist and schedules a follow up visit in two weeks to see how the patient is responding to the medication changes. The patient returns one week later to discuss the findings of the vascular surgeon with the physician.

The physician suspects the patient may be developing diabetic manifestations, but can't be sure until performing diagnostic tests. Under these circumstances, you would report V codes - such as V58.67 (Long term [current] use of insulin) and V12.50 (Unspecified circulatory diseases) - because they help substantiate the higher E/M levels (a diabetic patient is high risk) as well as all of the tests and visits the physician bills the insurance carrier.

Be careful: Do not make the mistake of assigning the diabetic vascular disease code, 250.70, to the patient until the physician confirms this diagnosis and confirms that the vascular symptoms are not due to the patient's diabetes becoming out of control.

History example: A 23-year old female patient discovers a lump in her breast during her monthly at-home breast examination. The physician suspects the lump is a cyst, but the patient has a strong family history of aggressive malignant breast cancer so the physician decides to perform a mammogram. Normally, mammography is not a covered service for such a young patient; however, by reporting V16.3 (Family history of malignant neoplasm; breast) to the carrier, the physician provides evidence of medical necessity to perform the mammogram.

Medicare must: Medicare requires V codes for coverage of certain pharmaceutical prescriptions. For example, if a patient undergoes a kidney transplant because of renal failure and must take immunosuppressive drugs, Medicare requires that the pharmacy report both a) the reason why the patient had the transplant and b) the type of transplant, which you must designate with a V code.

If the pharmacy only reports diagnosis code 585 (Chronic renal failure), it will receive a denial, as it does not explain why the patient requires the immunosuppressive drugs, Hvizdash points out. You must include V42.0 (Organ or tissue replaced by transplant; kidney).

Prove The Myth-Perpetrators Dead Wrong

The value of V codes is nothing new to **Kathy Stuart**, billing manager for **Avalon Medical Group** in Chapel Hill, NC, who uses them on a regular basis. She uses them for PE physicals, counseling and histories, she says. The codes she reports include:

1. V68.0 - Encounters for administrative purposes; issue of medical certificate
2. V58.69 - Long term [current] use of other medications
3. V65.5 - Person with feared complaint in whom no diagnosis was made (also commonly referred to as the "hypochondriac code" by coders).

The most common V code they report? V72.31 (Routine gynecological examination) for the women's wellness exam for Medicare, says Stuart.

Pitfall: Acevedo often sees physicians failing to use V codes on patients whose disease process is no longer active. For example, a female patient whose breast cancer treatment is successful and comes in for a follow-up visit one year after ending treatment receives a diagnosis of breast cancer on the E/M claim form.

Select 'personal history': You should report a diagnosis of V10.3 (Personal history of malignant neoplasm; breast), not 174.5 (Malignant neoplasm of the female breast; lower-outer quadrant), says Acevedo. Mislabeling her as an active cancer patient could affect her ability to get health or life insurance, or affect her treatment by other physicians for other conditions, notes Acevedo.

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Know the threshold: A patient who is cancer free for one year is considered clean, and should have her diagnosis changed to "personal history of cancer."

Vamp Up Your V Code Basics

V codes are supplementary codes you can use in place of ICD-9 codes. ICD-9 classifies V codes into three general categories as follows:

When a person who is not sick encounters the health services for some specific purpose, such as to act as the donor of an organ or tissue, to receive a prophylactic vaccination, or to discuss a disease or injury.

Example: V59.3 - Donors; bone marrow.

When a person with a known disease or injury, whether it is current or resolving, encounters the health care system for a specific treatment of that disease or injury (e.g., dialysis for renal disease, chemotherapy for malignancy, cast change).

Example: V58.81 - Other orthopedic aftercare; aftercare following joint replacement.

When some circumstances or problem is present which influences the patient's health status but is not in itself a current illness or injury

Example: V83.81 - Genetic carrier status; cystic fibrosis gene carrier.

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