Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: Beef Up Your Diagnosis Know-How for Medical Necessity

Keep these guides in mind to help prove your case.

With payers tightening the reins on reimbursement, establishing medical necessity for your doctor's services can be one of your biggest coding challenges. Follow our real-world tips for choosing the best diagnosis to establish the need for anesthesia and help keep your reimbursement intact.

Study the Patient's Circumstances

Medicare defines "medical necessity" as services or items reasonable or necessary to diagnose or treat an illness or injury, or to improve the functioning of a malformed body member. Payers consider each case individually to determine if the treatment method is reasonable and necessary. Circumstances that help establish medical necessity for anesthesia can include:

• Medical conditions such as cancer, epilepsy, or seizure disorders.

• A danger of airway compromise because of sleep apnea.

• A history of being combative or the onset of diminished ability to comprehend what's happening.

• The need to establish and maintain the surgical field, such as coronary catheterization when the patient needs to be lightly sedated because of his participation during the procedure.

• The patient's age.

For example: A physician is performing a magnetic resonance imaging (MRI) test on a child. Because the patient must sit still in order to complete the scan, anesthesia is necessary. In addition, this kind of example applies to adult patients who are mentally handicapped, psychotic, or unable to sit still because of pain or a physical condition. Without anesthesia, they would not be able to complete the exam or procedure.

V code help: ICD-9 2010 introduced a new code that can help you explain some of these cases. V15.80 (Personal history of failed moderate sedation) can help support medical necessity for anesthesia services because moderate sedation didn't work in the past. In effect, V15.80 tells the payer that an anesthesiologist was needed because the surgeon tried using moderate sedation in the past or for another procedure but was unsuccessful.

Old and new: Pay attention to the patient's current condition versus her history, and select the appropriate diagnosis codes. "One of the problems I often see is that coders will assign current diagnosis codes when the diagnosis is listed under the patient's history, such as coronary artery disease," says **Kelly Dennis, MBA, ACSAN, CANPC, CHCA, CPC, CPC-I,** owner of Perfect Office Solutions in Leesburg, Fla.

Caution: Even if a service is reasonable and necessary, payers might limit or deny your claim if your physician provides the service more often than allowed under a coverage policy or more than what usually is accepted as the standard of practice. Double-check your payer's policy to ensure you're not overstepping its limits.

Match the Diagnosis and Procedure

Some payers have lists of approved diagnoses for procedures and those lists can be rather extensive.

Submitting a diagnosis for a procedure that isn't on the payer's list can send your claim straight to denial. For example, diagnoses that can support medical necessity for monitored anesthesia care (MAC) during endoscopy can include:

• 250.00-250.03 -Diabetes mellitus without mention of complication

• 278.01 -Morbid obesity

• 401.9 -Essential hypertension; unspecified

• 997.00 -Nervous system complications, unspecified.

Check your physician's documentation for any medical conditions or reasons supporting the need for anesthesia. If more than one diagnosis code applies, include all on your claim instead of singling out one. Dennis advises also including the reason for surgery on your claim, but check with your payer before taking that step.

"If you need additional codes to explain the patient's physical status or the use of anesthesia, they're usually secondary," Dennis says. "However, I have seen a few carriers who specify that the additional codes to explain use of anesthesia may be reported as primary diagnoses over the reason for surgery."

Pitfall: Only use the diagnosis codes that match your physician's documentation. If you choose codes just to get paid, you're setting yourself up for compliance issues.

Check ICD-9's Symbols

The colorful dots, triangles, and other symbols in ICD-9 aren't just there to look pretty they instruct you how to report certain diagnoses correctly. Pay special attention to the symbol or mark that defines "not first-listed diagnosis." You'll find this designation on codes such as 357.2 (Polyneuropathy in diabetes). "Give the symptoms or a more precise diagnosis," advises **Jann Lienhard, CPC,** a coder in New Jersey. For example, you might include a diagnosis such as 250.6x (Diabetes with neurological manifestations) in conjunction with 357.2.

Warning: Even if the diagnosis applies to your case, the payer could deny your claim if you report it as primary instead of secondary.

Watch for: Some coding mistakes can be a slip of the finger. If you receive a diagnosis-based denial, double-check your claim against the physician's record. Even if you intended to submit the correct code, you might have filed a claim with a typo. If the diagnosis you submitted was correct but isn't on the payer's approved list, talk with your physician. A secondary diagnosis he documented might work just as well and turn the denial into acceptance.

6 Questions to Ask Yourself About Medical Necessity

Let these answers help keep your diagnosis coding on track. When you're trying to get to the bottom of a diagnosis-based denial, start moving in the right direction by asking yourself these questions that Dennis recommends:

1. Is the diagnosis code valid for the date of service billed?

2. Is the diagnosis code limited to being reported as a secondary diagnosis only?

3. Is the diagnosis coded to the highest specificity?

4. Is additional information and/or diagnosis codes necessary?

5. Is the payer denying "unspecified" diagnosis codes?

6. Is the diagnosis code appropriate for the gender and age?