Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Brush Up on Your ICD-9 Skills Before the 2007 Codes Hit

Follow these tips and guarantee proper diagnosis coding practices

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 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 four-digit 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,- says **Karen Marsh, RN, MSN**, president of **Kare-Med Consulting** in Jensen Beach, FL. Make sure you review the entire record when determining the specific reasons for the encounter and the conditions the physician treated, she adds.

Pitfall: Just because you have to code to the highest specificity, that doesn't mean you can fill in or assume any information that isn't in the patient's medical record.

Example: When a physician reports -benign prostatic hyperplasia,- or BPH, as the diagnosis for a transurethral resection of the prostate gland (TURP), this diagnosis alone does not clarify which ICD-9 diagnostic code would be most appropriate for the medical necessity for this procedure. Instead, a diagnosis of -BPH with obstruction- (600.01) would be more accurate and the proper diagnosis to be given by the urologist and reported by you. Unfortunately, this diagnosis may or may not be found in the medical record.

Don't Avoid Signs and Symptoms

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

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 urologist 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,- says **Denae M. Merrill, CPC**, coder for **Covenant MSO** in Saginaw, MI. - -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: You should not code a rectal examination of the prostate for suspicion of carcinoma (cancer) as carcinoma using ICD-9 code 185 (Malignant neoplasm of prostate) without a definitive biopsy or tissue diagnosis. In this clinical circumstance, a better ICD-9 diagnostic code would be 796.4 (Other abnormal clinical findings) until a more definitive tissue-proven diagnosis can be made.

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 are often hesitant 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.

Reality: Contrary to what you might have been told in the past, 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.

For example, a Medicare patient presents for a screening prostate-specific antigen test. For payment of HCPCS code G0103 (Prostate cancer screening; prostate specific antigen test [PSA], total), you have to use the diagnosis V76.44 (Special screening for malignant neoplasms; other sites; prostate) per CMS guidelines for this screening benefit.

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 secondary diagnosis, according to ICD-9 instructions.

Example: When an established patient with a history of urinary tract infections visits your office for follow-up care, V13.02 (Personal history of other diseases; urinary [tract] infection) may be the most appropriate diagnosis code for you to assign. Urologists can use V13.02 to help establish medical necessity for evaluation of patients with a past history of a UTI and for the performance of further tests.