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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Don't Ditch the Last Digit - It Helps Deflect Denials

Care in diagnosis coding will maximize your claims success

If you're not taking ICD-9 coding seriously, it's only a matter of time before your mistakes affect your practice's bottom line, experts say.

That's because many carriers are rejecting claims as "medically unnecessary" at a higher rate than they were just a few years ago, which makes proper diagnosis coding more important than ever. "A lot of us didn't pay attention to ICD-9 coding in the past because Medicare was the only carrier that cared if you used the correct codes," says **Victoria Jackson**, owner of **Omni Management**, which provides practice management services for 15 medical offices in the Los Angeles area. Now, all insurance companies are looking for ICD-9 codes, so coders have to make sure the diagnoses are correctly represented on claims.

Look Twice at Claims with Three-Digit Codes

Before sending out a claim with a three-digit diagnosis code, you should double-check the code, says Jackson. Three-digit diagnosis codes raise payers' eyebrows, Jackson contends, because there are very few ICD-9 codes that don't require at least four digits.

Payers realize this fact, and are examining ICD-9 codes to ensure they're appropriately specific. That means a three-digit code won't make the grade if a four- or five-digit code is called for.

Check Boxes, Then Decide Code Length

"Report the ICD-9 code that provides the highest degree of accuracy. That 'highest degree' means that you should assign the most precise ICD-9 code that most fully explains the narrative description of the symptom or diagnosis," says **JoAnn Baker, CCS, CPC-H, CPC, CHCC**, an education specialist in East Orange, NJ.

Strategy for success: To ensure you use the most accurate ICD-9 code every time, **Margaret Lamb, RHIT, CPC**, coding expert in Great Falls, MT, suggests asking two questions before sending out a claim:

1. Do I have a complete code?
2. Do I have the most specific complete code?

Rely on your ICD-9 manual's instructions to ensure you're listing complete ICD-9 codes. Whenever there is a "5th" box next to an ICD-9 code, it means the most accurate and complete code possible for that diagnosis has five digits and reporting a code with three or four digits is not acceptable. For example, look to the left of the ICD-9 code for noncomplicated diabetes (250.0), and you'll see a box with a check mark and "5th" printed in it. This box indicates that a complete ICD-9 code for this diagnosis must be five digits.

Example: The physician treats a patient with diabetes. The patient has no complications but does require insulin. If you link 250 to the CPT code, the diagnosis code will be rejected, Lamb says.

Why? You need five digits to reflect both the complications from diabetes, such as ophthalmic or neurological manifestations, and insulin dependence, or lack thereof. The code for non-insulin-dependent diabetes without complications would be 250.01 (Diabetes mellitus without mention of complication; type I [juvenile type], not stated as

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uncontrolled).

Another example: The 5th digit in abdominal pain (789.0 - Other symptoms involving abdomen and pelvis; abdominal pain) coding is one that coders miss all the time, says **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CHBME**, president of **Cash Flow Solutions, Inc.** in Brick, NJ. With abdominal pain, the 5th digit indicates the quadrant where the pain is located (0 for unspecified, 4 for left lower quadrant, etc.). Note: The 5th digit for 789 only applies to 789.0, 789.3, 789.4, and 789.6.

So when a patient presents with abdominal pain and cramps in her right upper quadrant, you would code 789.01 (...abdominal pain; right upper quadrant).

Key idea: If the ICD-9 code is not as complete and specific as carrier rules require, the claim may be rejected for lack of medical necessity and/or a truncated ICD-9 code, Lamb says.

2 Steps to Accurate Asthma Coding

Denials stemming from incomplete asthma diagnosis codes often leave practices short of breath. Here's how to code the condition correctly every time.

Step 1: Find the base code for asthma. When you look up asthma in ICD-9 (493), you'll notice a "4th" box beside it, meaning you must carry this diagnosis code to at least the fourth digit.

Step 2: Check four-digit code options. All of the four-digit code options for asthma - 493.0 (Ex-trinsic asthma), 493.1 (Intrinsic asthma), 493.2 (Chronic obstructive asthma), 493.8 (Other forms of asthma) and 493.9 (Asthma, unspecified) have "5th" boxes beside them. The 5th digit indicates if the asthma is unspecified (0), with status asthmaticus (1), or with (acute) exacerbation (2) (the exception here is 493.8, which has its own set of 5th digit codes: 493.81 - Exercise induced bronchospasm and 493.82 - Cough variant asthma).

Don't ignore the box - it's there for a reason. Asthma coding is "an instance where you should use the fifth digit or you may not get paid," Jackson says.

Example: An asthma patient experiences an acute exacerbation that requires a nebulizer treatment (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]). In this case, you should link 94640 to 493.x2. Reporting 493.x2 will help the payer understand why the patient needs the treatment, says **Chrissy Letsen, CPC**, billing coordinator with **Metropolitan ENT** in Alexandria, VA. Assigning 493.x0 will incorrectly inform the carrier that the patient's asthma is under control, making a treatment unnecessary.

Don't Stop Short When Selecting Symptoms

When working with diagnosis coding, you must remain up to date with your codes and read though a code listing entirely, or you may find yourself forgetting a 4th or 5th digit.

This past October, ICD-9 added a plethora of new codes, many of which were the result of expanding 4 digits to 5 digits, allowing the specification of conditions that previously went unspecified.

Good news: The increased detail of the codes will help in proving medical necessity for a procedure that a carrier could assume was merely cosmetic, adds **McCoy Rockefeller, CPC**, OMS coding specialist with the **Medical College of Georgia** in Atlanta. By staying current on your codes, you'll be able to code more accurately, increase your chances of proving medical necessity and decrease your chance of a denial.

Be Specific Now to Stay Ahead of the Curve

With the number of codes growing every year, you must keep your superbill updated, says Cobuzzi, who notes that many

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offices have quite a few truncated codes on their bills, causing coders and billers to need to go back to the chart or physician to find out what the 4th or 5th digit should be.

Tip: Add a dash after a code and a space to write (and perhaps a legend) to allow the physician to add the information in a more specific form, or make the superbill double sided, she suggests.

"Doctors have to give the specificity," Cobuzzi says. And they should get used to doing so now, she says, because the ICD-10 of the future is going to be far more demanding than the ICD-9, she warns.

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