Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach : Keep Chronic Pain Denials at Bay With Surefire Diagnosis Tips

Be careful not to put words in your physicians mouth, or risk audit woes.

Imagine your physician treats a chronic pain patient, but during the visit your physician isnt able to uncover a definitive diagnosis. While you know that altering or guessing a diagnosis to ensure payment is wrong, there are codes you can choose from to handle the situation. Heres what you need to know.

Interpret Docs Docs for Help

Specificity in diagnosis coding is always important, but it is increasingly vital because third-party payers are establishing more stringent coverage criteria for therapies and procedures and are using automated edits to deny claims based on the lack of a covered diagnosis, says **Mary H.McDermott, MBA, CPC,** with Johns Hopkins University in Baltimore.

Using a non-specific diagnosis code, which may be close but not exact, may mean you will not be paid for a service due to a Medicare Local Coverage Decision [LCD] or a third-party medical policy, McDermott explains. Or it may mean you are paid in error for a service for which there would be no coverage if you had used the right diagnosis.

Both of these scenarios are problematic. Well show you how to use the most specific diagnosis appropriate for the patient and make sure it is well-documented in the medical record.

Dx Assumptions Bring Painful Lessons

Imagine Patient A complaining of severe, chronic pain in the right side of his back. The pain began about 10 months ago. Your pain management specialist performs an examination and then provides two trigger point injections in the right lumbar multifidus muscle for pain relief. However, his chart notes reveal only the patient has back pain.

You receive this chart and note your physician performed trigger point injections on other patients in the past, using one unit (because trigger point injection coding is based on the number of separate muscles injected and not the quantity of injections performed) of 20552 (Injection[s]; single or multiple trigger point[s], 1 or 2 muscle[s]). Lets say the most recent injections performed on the other patients backs were for myofascial pain.

In the absence of a more specific diagnosis, should you assume Patient A also has myofascial pain,and report 20552 with a diagnosis of 729.1 (Myalgia and myositis,unspecified)?

Correct answer: No.Assumptions are not sufficient for coding compliance. If your physician did not specifically note myofascial pain or myalgia and you use one of those codes, you could find yourself in trouble in the event of a payer audit. Such errors are exactly the kind of thing that auditors keep an eye out for,says **Laureen Jandroep, OTR,CPC, CPC-H,** senior instructor for www.CodingCertification.Org, an online coding certification training center in Galloway, N.J.

Is back pain (724.5) the same thing as myalgia (729.1)? No. The patients generic back pain symptom may be due to many different conditions, which could include muscular causes. The myalgia diagnosis is usually a covered ICD-9 code for trigger point injections but back pain typically is not. The coder cant just pick myalgia because it is close and is on the approved list, Jandroep says. If the patient does not have an actual diagnosis listed as acceptable on the LCD, you cannot substitute one to get paid.

Study your LCD: Some payers will accept 724.5 (Backache,unspecified) for trigger point injections, so be sure to study your payer coverage policies carefully before determining if the diagnosisfits within the payers rules. You have to be as

specific as you can,Jandroep says.

This may mean that your physician performs services that are not ultimately going to be reimbursed or [he] may need to more accurately document the medical reason for performing the service.

Before Coding for Pain, Watch for Prior Conditions

Your physician should document (and you should code) prior conditions contributing to current complaints if they affect the management of the current condition.

For example, prior trauma,such as a previously broken bone,can cause patients to experience back or neck pain, McDermott says. If a patients pain stems from a previous condition, that diagnosis can also be coded to justify pain management procedures.

Depending on the situation,there may be V codes or late-effect codes that you may use in addition to the current complaint that show a late effect or a personal history of trauma. For example, in a scenario where chronic neck pain was present due to a prior traumatic vertebral fracture -- at C6, for instance -- you could code this using all of the following:

" 338.21 -- Chronic pain due to trauma

" 723.1 -- Cervicalgia

" 905.1 -- Late effect of fracture of spine and trunk without mention of spinal cord lesion.

Or you could code this as 338.21, 723.1, and V15.51(Personal history of injury-healed traumatic fracture).

If the fracture was a pathologic fracture, the coding might be different. For example, you might use 338.29 (Other chronic pain) and V13.51 (Personal history of pathologic fracture) in addition to 723.1. Code 338.29 is appropriate (instead of 338.21) because a pathologic fracture is not considered due to trauma.

The key to the correct coding of these contributory conditions is making sure they are appropriately documented in the medical record. Its essential that your provider is aware of how important this information is to justify medical necessity.

Tip: Remember that the ICD-9 official guidelines instruct coders that Signs and symptoms that are associated routinely with a disease process should not be assigned additional codes, unless otherwise instructed by the classification.