Part B Insider (Multispecialty) Coding Alert

PART B REVENUE BOOSTER: Brush Up on Your ICD-9 Know-How With 3 Tips

Confused about fifth digits or V codes? Look no further.

Insurers base your reimbursement on whether your claims show medical necessity -- and you cant demonstrate that without accurate diagnosis codes. Refresh your ICD-9 coding skills with three tips that make ICD-9 coding a breeze.

Tip 1: Forget that fifth digit and forget reimbursement. If you omit a required fifth digit when submitting ICD-9 codes, such as those for arthritis (715.00-716.99), you can anticipate claim denials, delays, and potential payer rejections.

The purpose of the fifth digit is to allow the physician to provide greater detail, and when required it must be billed in order to facilitate reimbursement, says **Susan Vogelberger, CPC, CPC-H, CPC-I,CMBS, CCP-P,** president of Healthcare Consulting & Coding Education, LLC in Boardman, Ohio. A code is invalid if it has not been coded to the full number of digits required.

Fifth digits add additional information to the code, Vogelberger says, such as the location of anatomy for arthritis codes or the percentage of body surface with third-degree burns.

Best practice: If youve dealt with denials due to missing fifth digits, you should print the applicable ICD-9 codes, including the fifth digits, right on your superbill. For instance, you could include all of the carpal bone fracture codes, including the fifth digits, right on your superbill. If you dont have enough room on your superbill to list every last fifth digit, you should place a line or symbol after codes that require a fifth digit.

For example: Suppose you want to offer the physician the option of circling an upper end closed humerus fracture, but you want to remind him that a fifth digit is required.

Solution: In one of my offices, we denote 812.0* and in my other office we denote 812.0X, says **Marlene Gould** with Verity Orthopedics and Spine Surgery in Orlando, Fla. This way, the person sending in the claims would be reminded to look up the appropriate digit to put on the diagnosis code.

Tip 2: When a V code is your only option, report it as the primary diagnosis. If you think that you should never report V codes (found near the back of the ICD-9 manual) as primary diagnosis codes, think again.

Practices can use V codes for primary diagnoses under certain circumstances. Although it used to be difficult to collect reimbursement from some carriers when you reported only V codes, many are coming around.

Example: If a patient returns for follow-up care after a fracture, it is incorrect to report the fracture code again, because once it has been reduced and casted or splinted, it is no longer considered a fracture. Therefore, you should report a V code instead, such as V54.12 (Aftercare for healing traumatic fracture of lower arm).

Tip 3: When you have a workers comp case, append an E code. Suppose a patient falls off of scaffolding at his construction job and fractures two metacarpal bones and three phalanges. Your hand surgeon sees the patient, and you report 817.0 (Multiple fractures of hand bones; closed) for the fractures, but the patients workers comp insurer denies the charge. Why? Because you forgot to add the appropriate E code to describe how the work-related diagnosis occurred.

You should use E codes to describe external causes of injuries or accidents. You should never bill E codes as your primary code, and you should list the E codes last. It may be necessary to assign more than one E code to fully explain each

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cause.

In the example above, the coder should report 817.0, followed by E881.1 (Fall from scaffolding) and E849.3 (Place of occurrence; industrial place and premises).

Dont forget: Workers comp laws vary from state to state, so you should ask the insurer for its guidelines and requirements before you bill.

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