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Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: Late Effects Codes Could Be the Key to Reimbursement

5 strategies keep complications out and reimbursement in.

With ICD-10 delayed yet another year, it may be a good time to polish your ICD-9 late effects coding skills. Not only will this help improve your reimbursement when addressing and treating late effects, but it will also teach you these coding conventions that you'll have to know under ICD-10 as well. Fortunately, recognizing late effects can be simple when you use the following five easy strategies that can support your physician's services more accurately, and therefore increase the odds that you collect your full fee.

1. No Time Limits for Late Effects

Late effects are the long-term effects of an injury or illness after the acute phase is over. For example, a patient may have a vertebral fracture and continue to have pain years after the fracture heals. Some late effects present early, while others might only become apparent months or years later. Based on ICD-9 guidelines, there are no time limits for reporting and treating late effects.

The ICD-9 manual provides a separate subsection (905-909.9) describing "late effects of injuries, poisonings, toxic effects, and other external causes." Depending on your specialty, late effects that your practice commonly sees may include 905.0-905.9 (Late effect of musculoskeletal and connective tissue injuries), 907.0-907.9 (Late effects of injuries to the nervous system) or 908.6 (Late effect of certain complications of trauma), for example.

Late effects tell the whole story of a patient's condition, and they present a much clearer picture to the carrier of why a physician may choose to treat a patient in a particular way. Specifically, late effects codes link what is going on with the patient now with what happened in the past. Like E codes for external causes of injury and poisoning, late effects codes provide a more complete picture of the reason for treatment and can be very helpful in getting payment for patients who are injured in an auto accident or in workers' compensation claims.

Certain specialties may see these conditions more than others, such as rehab practices that treat patients with residual problems from spinal cord injuries, traumatic brain injuries, orthopedic injuries as well as conditions such as cerebral vascular accident (CVA).

2. Use Keywords to Detect Late Effect

To determine if a condition is a late effect, you should look for keywords in the physician's documentation. Such keywords might include the following:

- due to - such as "pain in right hip due to fracture last year"
- following - such as "personality changes following a brain injury in 2011"
- as a result of - such as "hemiplegia as a result of CVA"
- residual effect - such as "arthritis that is a residual effect of previous hip fracture."

Heads-up: Don't confuse late effects with complications. A complication is essentially not a part of a patient's disease, condition or problem. A complication is typically associated with a difficulty or problem that occurs with a specific procedure (996.xx) and not the sequelae due to the original disease or injury.

3. Assign Secondary Diagnoses

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When you evaluate late effects of an acute injury, you'll report two separate diagnosis codes. "The condition or nature of the late effect is sequenced first. The late effect code is sequenced second," according to section 12 of the Official ICD-9-CM Guidelines for Coding and Reporting.

For example: A patient fractures his tibia in a fall. Several months later, the patient develops numbness in the foot and continues to have pain in the knee. She visits the physician for testing and treatment. The physician's documentation indicates that these symptoms are due to the past tibia injury.

In this case, you should first report the knee joint pain (719.46, Pain in joint, lower leg) and numbness (782.0 Disturbance of skin sensation) and then code the late effect (905.4, Late effect of fracture of lower extremities).

4. Follow Other Rules for Stroke Coding

There are exceptions to the sequencing rules above, unfortunately. "Exceptions to the [sequencing] guidelines are those instances where the late effect code has been expanded (at the fourth and fifth-digit levels) to include the manifestation(s) or the classification instructs otherwise," the Official Guidelines state. "The code for the acute phase of an illness or injury that led to the late effect is never used with a code for the late effect."

For example, coding for CVA patients deviates from the general rule on coding late effects. When reporting late effects of a stroke, you need not report both the condition's cause and the residual effect. Rather, you should use a single ICD-9 code to describe CVA late effects, because there are codes specifically assigned to the most common late effects of CVA.

Codes describing late effects of stroke appear in a separate section of the ICD-9 manual (438). These codes, such as 438.11 (Late effects of cerebrovascular disease; aphasia) and 438.21 (... hemiplegia affecting dominant side), describe both the residual condition and the cause of the condition.

Example 1: A patient is concerned about continued arm paralysis three months after a CVA and consults with your physician. You should report the late effect as the primary diagnosis. Therefore, you should report 438.30 (... monoplegia of upper limb affecting unspecified side) as the primary diagnosis.

Example 2: However, if the physician admits the patient for treatment of another CVA (new diagnosis), you should report the current CVA first (the 436 category), followed by any appropriate late effects code(s) (such as 438.30). This identifies those deficits that relate to the present CVA and from pre-existing conditions.

"Codes from category 438 may be assigned on a health care record with codes from 430-437, if the patient has a current cerebrovascular accident (CVA) and deficits from an old CVA," the Guidelines note.

Example 3: If the patient has no residual problems from the first CVA, you may report V12.59 (Personal history of other diseases of circulatory system; not elsewhere classified) as the secondary diagnosis.

5. Describe Unnamed CVA Conditions

Two codes in the 438 series require you to add a secondary code because they are nonspecific and you need another code to be as specific as possible.

The first is 438.89 (Other late effects of cerebrovascular disease). When ICD-9 does not list the patient's residual condition, use this along with a second code to provide further detail. For a patient who has urinary incontinence due to CVA, you should report 438.89 followed by 596.59 (Other functional disorder of bladder) and 788.39 (Other urinary incontinence).

The second code in this category is 438.5x (... other paralytic syndrome). ICD-9 may not specify the patient's paralytic syndrome in the 438 series, so you might use 438.5x and another code, such as 344.00-344.09 (Quadriplegia and quadriparesis), to indicate the type of the patient's paralysis.

Note: You can find the official ICD-9-CM Guidelines for Coding and Reporting at

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www.cdc.gov/nchs/data/icd/icd9cm_guidelines_2011.pdf. This was last updated in 2011.

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