Eli's Rehab Report

Your Top-3 ICD-9 Coding Problems Solved

Not identifying treatment diagnoses? Count on undeserved denials

Reporting the correct CPT code for your therapy services is only half the battle for reimbursement--and the other half requires networking with insurance payers and understanding complicating conditions to select the right ICD-9 codes.

Many therapists have a soft spot when it comes to diagnosis coding, and this can hurt payments more than you realize. If the following three ICD-9 coding problems ring a bell, you'll want to pay attention to our simple solutions.

Problem 1: Therapists often confuse the referring physician's medical diagnosis with the therapy treatment diagnosis--and undue denials result.

Solution: Always ask yourself this question: "What is the patient's specific condition or problem I am treating with this therapy service?" You should never assume that the diagnosis on the physician's request form is the relevant diagnosis for the therapy you'll be rendering, says **Sandra Soerries, CPC, CPC-H**, with BKD Consulting in Kansas City, Mo.

For example, therapists treat hemiplegia/hemiparesis (438.2x) and speech deficits (438.1x) for cerebrovascular accident (CVA) patients. But if you see a CVA diagnosis code--such as 434.91 (Cerebral artery occlusion, unspecified, with cerebral infarction)--on the physician's request form and copy it onto your therapy claim as the primary diagnosis, you're coding incorrectly.

Not only does your claim require a therapy treatment ICD-9 code so the carrier will pay it, but you also need to label your patient's condition correctly to avoid future coverage complications.

Wrong way: Suppose a patient requires therapy for gait disturbance (781.2) due to osteoarthritis (715.xx). The physician's request states "evaluate and treat," but it also lists the medical diagnosis of osteoarthritis that the physician has been treating. You have the patient spend 30 minutes performing gait-training exercises, so you report two units of 97116 (Therapeutic procedure, one or more areas, each 15 minutes; gait training [includes stair climbing]). Then you list osteoarthritis code 715.xx as the primary diagnosis to justify the medical necessity of the therapy.

Right way: You should report gait-disturbance code 781.2 as the specific diagnosis you are treating with therapy. Most payers want to see a specific "treatment diagnosis" as the primary ICD-9 code on therapy claims. If you list osteoarthritis as the primary diagnosis, chances are the carrier will deny the claim.

Even if you do receive payment with an incorrect ICD-9 code, you risk problems with reimbursement down the line. Medicare and private carriers and fiscal intermediaries have physical therapy policies that list specific frequency limitations and other coverage guidelines for every diagnosis, and you may find that your patient is eligible for far less coverage than he needs if you're reporting the wrong diagnosis.

Action point: Invest the time and effort to become more familiar with the ICD-9 coding system and the codes for therapy diagnoses you most often treat, says **Ken Mailly, PT**, with **Mailly & Inglett Consulting** in Wayne, N.J.

Problem 2: Unfamiliarity with payers' varying coding policies leads to unnecessary denials.

Solution: Make a habit of calling your payers to follow up on denials and find out for certain which diagnosis codes they require. A common mistake therapy practices make is not having enough communication with payers about how to code, Mailly says.

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Although you should usually follow the standard rule of reporting a treatment diagnosis as primary, there are some payers that instead want a code from the V57.x series (Care involving use of rehabilitation procedures), he says.

Problem 3: Failing to report a secondary diagnosis can weaken your case for a claims appeal.

Solution: Report the physician's medical diagnosis or other relevant diagnoses as secondary ICD-9 codes whenever possible. A secondary diagnosis won't improve your reimbursement, but it may prevent denials and will definitely help explain why some more complicated patients require extra or special services, Mailly says.

Make sure you consider all secondary diagnoses that are pertinent to the treatment diagnosis you've listed as primary, Mailly says. For instance, a physician may have been treating a diabetic patient for osteoarthritis, but he may have failed to list diabetes on the therapy request form because the condition didn't affect his treatment of the patient's osteoarthritis.

If the diabetes complicates your treatment of the patient, however, you should list the appropriate code from the 250.xx series (Diabetes mellitus) as a secondary diagnosis code. You should also list the osteoarthritis.

Secondary Dx Harbors Benefits Down the Road

Many carriers don't have claims-processing systems that even acknowledge a second or third diagnosis code on therapy claims, but that shouldn't stop you.

If you have a complicated patient who exceeds frequency limits on his covered therapy, a secondary ICD-9 code explaining the patient's complication could be the evidence that wins you proper reimbursement.

For example, suppose a carrier allows 10 covered therapy sessions for a patient with gait disturbance, but you are treating a patient who also has a severe cardiac condition. You should report the cardiac condition as a secondary diagnosis on every claim.

When the carrier denies your claim for visit number 11, therefore, you can appeal on the grounds that your patient is more complicated and requires further therapy. The secondary ICD-9 code listed on each of the patient's therapy claims will serve as strong supporting evidence in your appeal, Mailly says.

Watch out: Don't exceed your authority to diagnose, Mailly says. If you want to report a secondary or tertiary diagnosis code, either it has to be one that a PT can select and diagnose within her scope or it has to be documented somewhere else--such as in a physician's past medical history or an op report, he says.

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