# Home Health ICD-9/ICD-10 Alert

## CODING 101: Fifth Digit Shouldn't Be The Last Thing On Your Mind

**Saving time by leaving off that last digit will cost your agency in the end.**

Choose the fifth digit of your ICD-9 codes with care -- and you'll paint the most accurate picture of the care you provide. But a hasty decision could put your claims at risk of delay or denial.

Not coding to the highest level of specificity  almost guarantees claims denials. "ICD-9 coding allows for specificity, and [information] falls through the cracks if not done correctly the first time," says **Robyn Lee** of **Lee-Brooks Consulting** in Chicago.

Avoid this common shortcut: If you "code jam" -- fill in a 0 or 9, to get the fourth or fifth digit -- you  will often change the code's meaning.

Remember that the fourth and fifth digits represent further description of the root code, so by guessing the digit you risk misrepresenting the patient, warns consultant **Christine Twombly** with **Reingruber & Co.** in St. Petersburg, FL.

**Accurate Coding Prevents Claim Problems**

Your goal is to capture the patient's condition(s) as accurately as possible when choosing a code. For example, code 434 indicates occlusion of cerebral arteries. The fourth-digit "0" reports that the occlusion was by a thrombus. The code also requires a fifth digit. A "1" as the fifth digit means that the thrombus that occluded the cerebral arteries resulted in an infarct in the brain. Leaving a required digit off will get your claim returned to provider (RTP).

If you place a "0" as the fifth digit, it may mean open season for medical review. Because 434 is a case mix category and a "0" in the fifth digit means that the patient had a cerebrovascular accident (CVA) without an infarction, you would call into question the appropriateness of the CVA code. A patient without an infarction would not have any residuals of the CVA.

**Another example:** The subcategory 707.0 is used to report a decubitus ulcer. The 707.0 codes require a fifth digit to indicate the location of the decubitus ulcer. The fifth-digit "0" indicates unspecified site, which will get your claim RTP'd, because you're reporting the patient has a decubitus, but your agency doesn't know where it is. The correct five-digit code provides the most complete information about the patient's diagnosis, at the highest level of specificity.

**Shortcuts cost you:** You actually lose time and money in the long run when you try to save time by using general codes, Lee points out. You may get your claims submitted faster, but if they are RTP'd, then you will spend more time searching these claims out and resubmitting them.

**Don't Make These Common Mistakes**

Payers most often reject or question claims for the following reasons:

• Unspecified codes (codes ending in "9");

• Digits added inappropriately as space holders (adding one or two zeros to a three-or four-digit number to make it a five-digit code); and

• Inappropriate primary diagnosis codes (e.g., reporting an acute fracture code when a V code represents the primary reason for home care).

**Communicate With Clinicians**

When clinicians document information correctly, you have a better chance of coding properly. Double-check with clinicians when in doubt about a patient's diagnosis, and let clinicians know exactly what kind of information you need to do your job.

And never code something without documentation to back it up -- even if the proper diagnosis seems obvious to you.

**Warning:** Improper coding can carry some serious repercussions for both the agency and the clinician, especially if the feds choose to interpret mistakes as intentional fraud, notes **Quin Buechner, MS, CPC,** with **ProActive Consultants** in Cumberland, WI.

Among the possibilities are:

• lost reimbursement

• fines

• investigations

• medical review and

• loss of license.