# Home Health ICD-9/ICD-10 Alert

## CODING 101: LAST BUT NOT LEAST: DON'T SACRIFICE ACCURACY WITH THE FIFTH DIGIT

Taking the lazy way out with the last digit can cost your agency time and money.

If you don't take the time to make certain you're selecting the most accurate fifth digit up front, you're likely to wind up with delayed or denied claims. Accurate ICD-9 coding depends on coding the highest level of specificity and taking the time to find the right fifth digit will help you meet the mark every time.

Avoid This Seemingly Easy Fix

It can be tempting to simply fill in a 0 or 9 when you're uncertain about the correct fifth digit, but doing so changes the code's meaning. A "0" in the last digit often indicates an unspecified condition -- meaning the medical record doesn't provide enough information to allow you to select a more specific code. On the other hand, reporting a "9" for the lastdigit can indicate that the patient's condition was specified in the medical record, but there is no ICD-9 code to report the diagnosis. Listing the fifth digit 9 indicates an "other specified" condition.

Guess what? The fifth digit provides further description of the root code. Guessing which digit to list risks misrepresenting the patient. Look to your coding book for guidance, says **Matt Santangelo, RN, BSN, COS-C, HCS-D,** with FirstLantic Healthcare in Fort Lauderdale, Fla. There, you'll find hints as to when to use a "9" or "0" in the fifth digit, he says.

Coding example #1: Your patient has osteoarthrosis of the knees and the hips and you will be providing physical therapy for strengthening, gait training, fall precautions and pain management. You will also provide skilled nursing to instruct, teach and administer IV antibiotics to treat acute osteomyeltitis of the left hand and an infected stage II pressure ulcer of the coccyx with methicillin resistant Staphyloccocus aureus (MRSA).

Without paying careful attention to fifth digit selection, you could wind up with the following inaccurate list of codes for this patient:

• 715.89 (Osteoarthrosis involving, or with mention of more than one site, but not specified as generalized; multiple sites)

• 730.28 (Unspecifed osteomyelitis; other specified sites)

• 707.05 (Pressure ulcer; buttock)

• 707.20 (Pressure ulcer, unspecified stage)

• 041.10 (Staphylococcus, unspecifed)

• V58.82 (Fitting and adjustment of non-vascular catheter NEC)

• V58.69 (Long-term [current] use of other medications)

These are all good codes, but they don't represent the correct specificity for the conditions you are treating so they are incorrect in this case, says **Vonnie Blevins, HCS-D,** with Houston-based Excellence Healthcare. Instead, Blevins suggests the following codes for this patient:

• 715.96 (Osteoarthrosis, unspecified whether generalized or localized; lower leg)

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• 715.95 (Osteoarthrosis, unspecified whether generalized or localized; pelvic region and thigh)

• 730.04 (Acute osteomyelitis; hand)

• 707.03 (Pressure ulcer; lower back)

• 041.12 (Methicillin resistant Staphyloccocus aureus)

• 707.22 (Pressure ulcer, stage II)

• V58.81 (Fitting and adjustment of vascular catheter)

• V58.62 (Long-term [current] use of antibiotics)

Impact: Osteoarthrosis code 715.89 won't earn you any case mix points, but 715.96 and 715.95 will, because in this case you are providing IV/infusion so you've met the requirements for receiving case mix points for Ortho 2 diagnoses, Blevins says. Plus, if you know the specific sites you should code the separately to the highest specificity.

Accurately coding acute osteomyelitis with 730.04 can also earn case points.

Aside from the loss of case mix points, sloppy coding can inaccurately represent the care you provide.The ICD-9 manual indicates that 707.03 is the correct code for a pressure ulcer of the coccyx, Blevins says. And because you know this pressure ulcer is stage II, the right staging code to report is 707.22. ICD-9 coding guidelines also require you to list the organism causing an infection if it's known, so you should add 041.12 for MRSA.

Coding to the highest specificity possible completes the full diagnostic picture, earns the highest reimbursement available, and prevents denied claims, Blevins says.

Coding example #2: Frequently, when coding for a patient who has coronary artery disease (CAD), the medical record doesn't include any details about which artery is affected, Santangelo says. This is a case when it is appropriate to use a "0" for the fifth digit because the artery is unspecified -- your code is 414.00 (Coronary atherosclerosis of unspecified type of vessel, native or graft).

However, if the medical record does specify that the CAD is in a native coronary artery, then you should report that detail by listing 414.01 (Coronary atherosclerosis of native coronary artery), Santangelosays. This indicates that the patient's CAD isn't in an artery grafted during a bypass.

Coding example #3: You turn to subcategory 707.0x (Pressure ulcer) to report a patient's decubitus ulcer. The fifth digit for this series indicates the ulcer's location. If you list fifth-digit "0"(Unspecified site), prepare to have the claim returned to provider (RTPed). Why? You're reporting a patient with a decubitus ulcer, but you're also indicating that your agency doesn't know where the ulcer is. The correct five-digit code provides the most complete information about your patient's diagnosis at the highest level of specificity.

Communicate With Clinicians

Best practice: Double check with your clinicians when you're not sure about a patient's diagnosis. If your clinicians document the information correctly, you'll have a better chance of coding properly. Let your clinicians know exactly what kind of information you need to be able to do your job correctly.

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

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