Home Health ICD-9/ICD-10 Alert

Coding Coach: Last Digits Help Deflect Denials

Watch out: Payers use your coding shortcuts as a red flag to deny claims.

Many payers are rejecting claims as "medically unnecessary" at a higher rate than they were just a few years ago, which makes proper diagnosis coding more important than ever.

Beware three digit codes: Before sending out a claim with a three-digit diagnosis code, you should double-check the code, says **Victoria Jackson** with Los Angeles-based **Omni Management**. Three-digit diagnosis codes raise payers' eyebrows, Jackson contends, because there are very few ICD-9 codes that don't require at least four digits.

Payers realize this fact, and are examining ICD-9 codes to ensure they're appropriately specific. That means a three-digit code won't make the grade if a four- or five-digit code is called for.

"Report the ICD-9 code that provides the highest degree of accuracy. That 'highest degree' means that you should assign the most precise ICD-9 code that most fully explains the narrative description of the symptom or diagnosis," says **JoAnn Baker,** CCS, CPC-H, CPC, CHCC, an education specialist in East Orange, NJ.

Rely on your ICD-9 manual's instructions to ensure you're listing complete ICD-9 codes. Whenever there is a "5th" box next to an ICD-9 code, it means the most accurate and complete code possible for that diagnosis has five digits and reporting a code with three or four digits is not acceptable.

Example: Look to the left of the ICD-9 code for osteoarthritis (715.0), and you'll see a box with a check mark and "5th" printed in it. This box indicates a complete ICD-9 code for this diagnosis must be five digits. The codes listed below give you the fourth digit and the shaded box above gives you location codes to enter as the fifth digit.

Don't stop short: When working with diagnosis coding, you must remain up to date with your codes and read through a code listing entirely, or you may find yourself forgetting a 4th or 5th digit.

This past October, ICD-9 added a plethora of new codes, many of which were the result of expanding 4 digits to 5 digits, allowing the specification of conditions that previously went unspecified, experts say. This means you must code more carefully than ever to get paid for your agency's efforts.

Key idea: If the ICD-9 code is not as complete and specific as payer rules require, the claim may be rejected for lack of medical necessity and/or a truncated ICD-9 code, says **Margaret Lamb**, RHIT, CPC, coding expert in Great Falls, MT.

Strategy for success: To ensure you use the most accurate ICD-9 code every time, Lamb suggests asking two questions before sending out a claim:

1. Do I have a complete code?

2. Do I have the most specific complete code?