Internal Medicine Coding Alert

READER QUESTIONS: Is 719.xx Putting You in Hot Water?

Question: I pulled several of our fracture stabilization charts and noted that they all contain a diagnosis of pain. Could this be a problem?

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Answer: Absolutely. Auditing experts list using the same diagnosis for similar encounters as a red flag that indicates a major problem.

Real-world coding: One auditor found that a practice used the same ICD-9 code for ankle pain (719.47, Other and unspecified disorders of joint; pain in joint; ankle and foot) with every ankle-related visit.

On average, the office was billing $600 per visit (such as 99214, Office visit for the evaluation and management of an established patient ...), and some visits were as high as $1,200 for the E/M visit plus supplies (for instance, S8451, Splint, prefabricated, wrist or ankle).

In many cases, the patient probably had a fracture (such as 824.8, Fracture of ankle; unspecified, closed) instead of simple ankle pain (719.47), but the diagnosis code did not reflect that. If you're using a superbill, it may attach ICD-9 codes in random order, but the coder has to make sure the most important code goes first. Also verify that you're listing the definitive diagnosis (meaning fracture) as primary, not the chief complaint (pain).

Bottom line: Diagnosis coding determines the medical necessity for what's being done. If ICD-9 codes don't support the CPT codes, take a closer look at your claims.