Codify
BY AAPC

Eli's Rehab Report

ICD-9 Coding Corner: Dont Let Diagnosis Coding Be the Ignored Sibling

Although PM&R coders are often very focused on precise CPT coding, what they don't realize is that ICD-9 coding can be even more important than CPT coding because the diagnosis establishes medical necessity for the services rendered.

Physical medicine and rehab coders are in a unique situation: They use codes not only from CPT's PM&R section but also from the orthopedic, anesthesia, neurology, surgery and radiology sections, among others. Therefore, it's no wonder that many PM&R billers spend most of their time sifting through various CPT Codes to assign to physiatry claims. Unfortunately, this often leaves diagnosis codes as the ignored sibling of the coding world.

With this new column, we aim to advise PM&R practices on the best ways to avoid ICD-9 coding errors, focusing on a different aspect of diagnosis coding each month. Following is a breakdown of just why ICD-9 codes are so important.

"Most medical practices believe that the procedure code determines reimbursement," says **Randall Karpf,** owner of East Billing, a medical reimbursement consulting firm in East Hartford, Conn. "That's true to a certain extent, but the carrier is only going to pay the claim if they know that the patient's condition warranted the procedure. If your diagnosis codes are accurate and substantiate medical necessity, great. If not, your claims could get held up because the insurer requests records and notes. Or, they might just deny the claims."

One of the most common diagnosis coding errors is that a required fourth or fifth digit is missing from the ICD-9 code and, therefore, the claim is not coded as specifically as possible.

"Most payers require diagnoses to be coded to the highest level of specificity," says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H**, **CCS,** consultant and CPC trainer for A+ Medical Management and Education in Absecon, N.J. "If charts are audited and this has not been done, the practice can be fined, or money might have to be paid back. If it looks like you're picking approved diagnoses from those listed on an LMRP (versus what the patient actually has), you could even be accused of fraud."

What frustrates many practices is the way that payers pick and choose which ICD-9 codes are payable for certain procedures, and the list differs from one carrier to the next. For instance, Nationwide Medicare, the provider for West Virginia and Ohio, lists 13 payable diagnoses for Botox type A (J0585) injections, including multiple sclerosis (MS, 340) and infantile cerebral palsy (CP, 343.0-343.9). However, Florida's carrier, First Coast Service Options, lists only nine diagnoses that support medical necessity and does not include MS or infantile CP.

Of course, your practice can always appeal a denial and attempt to prove medical necessity on your own, but the fact is that many claims sink or swim based on the ICD-9 code.

In addition, Karpf says, practices must be sure to add any fourth or fifth digits as required. "Many of our clients will send us their explanations of benefits and say, 'Can you tell me why this claim was rejected?' We look at it and immediately see that they sent in an incomplete ICD-9 code. It's often overlooked but can cause a lot of denials."

For instance, osteoarthritis is coded as 715.0 through 715.9 to denote the type of arthritis present, e.g., localized, generalized, etc. But claims for these conditions must include a fifth digit indicating the site affected, such as "1" for the shoulder or "6" for the lower leg. Therefore, a patient with localized primary osteoarthritis of the hip would be coded as 715.15.

Jandroep also warns practices to avoid coding diagnoses based on suspected illnesses. It's not correct coding, and it could hurt the patient in the future. "If a patient is assigned a code for a disease he or she does not have, it could affect

CPT® 2023 American Medical Association. All rights reserved.

their ability to get life or disability insurance," she says.

For example, a physician may think a patient has MS and sends her for tests. The office staff codes the claim with the diagnosis code for MS, but the tests subsequently reveal that the patient has complicated migraines instead. Several years later, the patient applies for life insurance and is quoted astronomical rates and can't figure out why. "What she doesn't know is that the insurance company got records from the physician's office and sees that she was billed as having MS."

Next month: How placing your diagnosis codes in the correct order can speed the claims process and cut down on denials.

CPT® 2023 American Medical Association. All rights reserved.