Eli's Rehab Report

ICD-9 Coding Corner: Forget That Fifth Digit? Expect Denials

Practices that omit a required fifth digit on **ICD-9 Codes** , such as those for arthritis (715.00-716.99), should anticipate claim denials, delays and rejections

Not all ICD-9 codes have fifth digits associated with them. Some - for instance, stroke (436) - have only three digits. Most diagnosis codes, however, use a fourth digit to denote the subcategory of a condition. For example, the code group 722 denotes intervertebral disc disorders. Group 722.7 is used for intervertebral disk disorder with myelopathy. And to specify further where the disorder originated, ICD-9 requires coders to assign a fifth digit: 722.70 for unspecified regions, **ICD-9 722.71** for cervical, 722.72 for thoracic, and 722.73 for the lumbar region.

Include Fifth Digit on Superbill

Some practices tend to chronically overlook the required fifth digit, often due to faulty superbill layouts. "We printed up our superbills with the arthritis codes all listed, including the fifth digits," says **Rhonda Merrill,** coding manager at PM&R Associates, a three-physiatrist practice with two offices in south Florida. "That way, the physicians just have to circle the correct site (such as 715.11 for osteoarthritis of the shoulder), and the code is right there. But our intervertebral disk disorder section of the superbill just has 722.0-722.9, and we were submitting the claims that way. The claims kept getting bounced back to us, and by the time we realized what we were doing wrong, we had at least 15 claims we had to resubmit."

Merrill advises practices that don't have enough room on their superbills to list every last fifth digit to place a line after codes that require a fifth digit. For instance, the codes would be listed as 722.1__, 722.3__, and so on. "Then the person sending in the claims would be reminded to look up the appropriate digit to put on the diagnosis code."

Don't Purposely Withhold Digits

Certain procedures, such as Synvisc injections (J7320, Hylan G-F 20, 16 mg, for intra-articular injection), are only payable for patients with specific conditions. In the case of Synvisc, Medicare will only reimburse claims for patients with osteoarthritis of the knee (715.16, 715.26, 715.36 and 715.96) and, therefore, that fifth-digit designation of "6" (denoting the knee) is crucial.

Some practices perform Synvisc injections on patients' shoulders as well, and ask the patient to sign an advance beneficiary notice (ABN) ahead of time to demonstrate that Medicare will deny the claim. This is the correct way to code visits specifically for Synvisc injections to the shoulders.

However, some practices are "creatively coding" by combining a patient's knee and shoulder injection visits and reporting two units of the injection (20610*, Arthro-centesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]) but only submitting the ICD-9 code for the knee arthritis and not for the shoulder. These practices defend their actions but suggesting that the knee was addressed, so withholding the shoulder diagnosis is not lying.

However, says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS,** consultant and CPC trainer for A+ Medical Management and Education in Absecon, N.J., "Good coding dictates that you code all of the diagnoses addressed at that visit."

In addition, Jandroep says, billing a second unit of the injection and withholding the shoulder diagnosis is fraudulent because Medicare would be reimbursing a second injection, but only because they believed the second injection was

related to the shoulder arthritis.

Jandroep recommends billing each injection on a separate line item and linking the first injection to the knee diagnosis and the second injection to the shoulder. "I'd also append modifier -59 (Distinct procedural service) to the second injection to indicate that it was separate and not a duplicate."

Therefore, the claim would read as follows:
(see above chart)

The shoulder injection will be denied, but it is correct coding to always report every service your practice performs. Be sure to advise the patient ahead of time that the shoulder injection will be denied, and maintain an ABN on file for the patient. And, modifier -GA (Wavier of liability statement on file) should be appended to 20610 (as noted above) to show the carrier that the patient signed an ABN specifically for the shoulder injection and that he or she is willing to pay separately for it.