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Eli's Rehab Report

ICD-9 Coding Corner: V Codes Arent Just Accessories

Many coders think of V codes as ICD-9 Codes's equivalent to CPT's add-on codes: They aren't the main event, but they help describe what's going on. In actuality, however, V codes can make or break carrier's reimbursement decisions and can even be used as primary diagnoses.

"It is a common misconception that V codes cannot be listed as primary diagnoses," says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS,** consultant and CPC trainer for A+ Medical Management and Education in Absecon, N.J. "Sometimes the V code is the most accurate choice and should be placed first on the claim."

Problem-Oriented V Codes

Jandroep says that ICD-9 recognizes three types of V codes: problem-oriented, fact-oriented and service-oriented. "The problem-oriented codes are those most likely to be used as primary diagnoses," Jandroep says.

For instance, suppose a patient was exposed to tuberculosis while in rehab following her hip replacement. If the physiatrist performed an examination and testing for TB, the V code would be V01.1 (Contact with or exposure to tuberculosis). The examination is not due to the patient's illness, and she does not have symptoms of TB, but she was exposed to it, so the V code would go first on the claim.

Fact-Oriented V Codes

"The fact-oriented V codes are most often listed as secondary codes," Jandroep advises. "They help round out the story but do not describe the main reason the patient is there."

For instance, suppose a 7-year-old patient presents to your PM&R practice complaining of blurred vision. Her mother explains that the patient has a family history of stroke (436), which each family member had before age 25. The physiatrist examines the patient and orders a CT scan and MRI. Some carriers may reject the claim when submitted only with the blurred vision diagnosis (368.8), stating that the tests were unnecessary in such a young patient. However, if in addition to the diagnosis code for blurred vision you use the "family history of stroke" code (V17.1), you can explain that the visit isn't an expensive substitute for vision screening but is due to the history of the child's family.

Service-Oriented V Codes

Service-oriented V codes are not usually used in private practices because they apply mainly to facility coders, Jandroep says. For instance, V57.21 (Encounter for occupational therapy) might be used in a rehabilitation facility, followed by the reasons for OT, such as lower extremity dysfunction (739.6).

Sometimes it can be difficult to determine whether a V code is necessary. For instance, suppose a patient with sciatica is treated by the physiatrist for two months, and her pain eventually subsides. The doctor asks her to return in six weeks to ensure that the symptoms aren't returning. Is the visit coded with the sciatica diagnosis code (722.10) or the general medical examination code, V70.x?

To make your decision more clear, ask the physiatrist whether he was following up on the patient's chronic pain condition or performing a preventive visit. If the history taken during the visit is related to the sciatica, then you should code an established E/M service (99211-99215) with the sciatica diagnosis. Even though the patient's condition is not now flaring up, you are managing her chronic problem.

V Codes for Preoperative Clearance

In 2001, CMS instructed all local Medicare carriers to accept V codes to indicate medical necessity for preoperative clearance, but many carriers still deny claims with V72.83 (Other specified preoperative examination) listed as the primary diagnosis. Physiatrists often use this code when evaluating patients who are about to undergo hip replacements and other surgeries. If your carrier is still routinely denying these claims, be sure to appeal the denials because many payers have yet to update their systems appropriately.

When V codes are used for preoperative clearance, you should also list the appropriate code for the condition(s) that prompted surgery, along with any other diagnoses present. For instance, if you perform a preoperative evaluation for a stroke patient who is receiving a hip replacement due to osteoarthritis, the claim should be coded as V72.83, 715.15, 436.