REX

Laboratory Bulletin

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Updates and Information from Rex Pathology Laboratory

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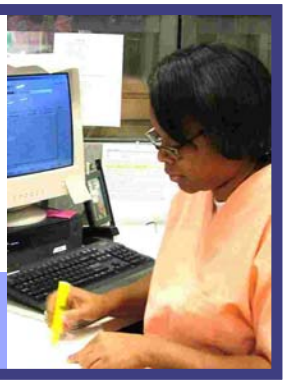


Coding and Compliance Issues
Dealing wth the Hassles

(Editor's Note: This invited review is intended to update physicians of the importance of accurate coding for laboratory and other outpatient tests. Incorrect or incomplete coding delays patient care and creates frustration for service providers, patients, and physician office staff. David White is the Compliance and Billing Specialist for Rex Outreach Laboratory. He is a Certified Procedural Coder (CPC) with the American Academy of Professional Coders (AAPC) and has been in the coding profession for approximately ten years. David has coding experience in both a hospital and physician practice setting. He is actively involved in the hospital's compliance program.)

Beginning April 1, 1989, the Centers for Medicare and Medicaid Services (CMS) required the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes to be reported on all Medicare claims. Third party payers are also requiring that the claims include ICD-9-CM codes. Additionally, diagnostic coding is to be coded at the highest level of specificity for the encounter to reflect symptoms, signs, abnormal test results or other reasons for the service billed.

Who is Required to Use ICD-9-CM?

All physicians are required to report ICD-9-CM diagnosis codes. Physicians included in this mandate are:

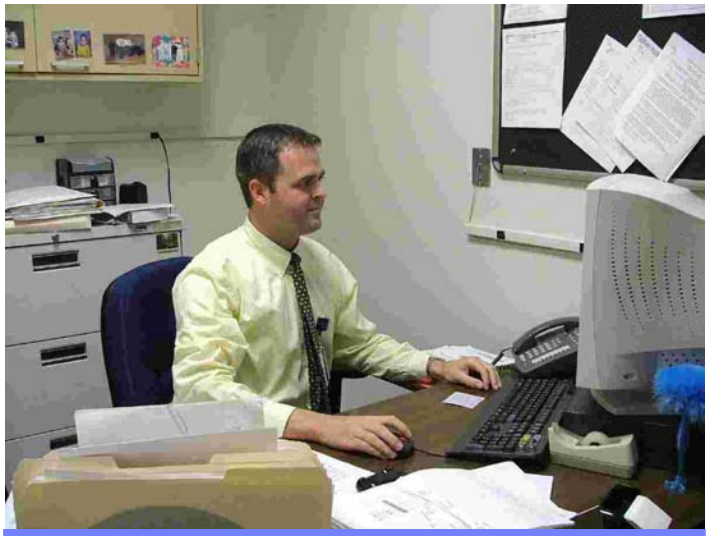
- Doctors of Medicine
- Doctors of Osteopathy
- Doctors of Dental Surgery
- Doctors of Dental Medicine
- Doctors of Podiatry
- Doctors of Optometry
- Doctors of Chiropractic

Non-physician practitioners are also required to report ICD-9-CM diagnosis codes. Non-physician practitioners include:

- Certified Registered Nurse Anesthetist
- Certified Registered Nurse Practitioner
- Clinical Nurse Specialist
- Clinial Psychologist
- Physician Assistant

How ICD-9-CM is Set Up

ICD-9-CM is based on a system originally developed by the World Health Organization to classify morbidity and mortality for statistical purposes, to index hospital records and operations, and to store and retrieve data. The full ICD-9-CM system consists of three volumes. For Medicare and third party payer purposes, physicians should only use the first two volumes. Volume One contains a tabular listing of diseases primarily defined by body system. Volume Two contains an alphabetical index of diseases, conditions, and diagnostic terms used in referencing the tabular listings. The third volume of ICD-9-CM contains procedure codes and is not to be used. The third volume is used primarily for hospital inpatient services. Physician practices should continue to report the procedures using Physicians' Current Procedural Terminology 4th Edition (CPT-4).



David White, Compliance and Billing Specialist at Rex Outreach Laboratory

The portion of ICD-9-CM to be used by physicians consists of codes within two general ranges:

- Numeric codes (001.0 to 999.9) that are broken down into 17 classifications of diseases and injuries including infectious and parasitic diseases; neoplasms; diseases defined by body system; congenital anomalies; symptoms, signs and ill-defined conditions; and injury and poisoning;
- V codes (V01.0 to V84.8) that describe circumstances of a patient visit for reasons other than disease or injury. You can use V codes when reporting preventive medical treatment, physician exams, post-operative follow up, physical therapy, x-rays, lab tests, etc.

Rex Pathology Associates, P.A.

Stephen V. Chiavetta, MD	(919) 784-3060	Keith V. Nance, MD	(919) 784-3286
Timothy R. Carter, MD	(919) 784-3058	Vincent C. Smith, MD	(919) 784-3056
John D. Benson, MD	(919) 784-3059	Rhonda Humphrey, Practice Manager	(919) 784-3063
John P. Sorge, MD	(919) 784-3062		

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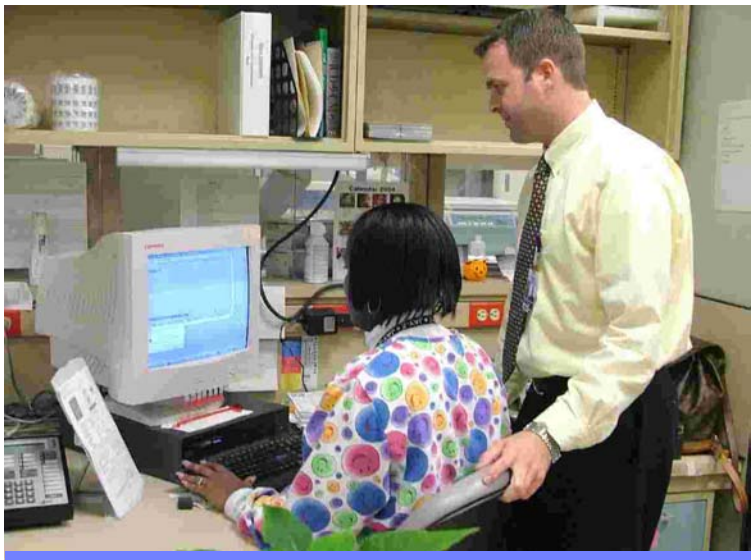
For information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-9-CM Tabular List (Volume 1), see the sections on Conventions Used in the Tabular List and guidance in the use of ICD-9-CM at the beginning of Volume 1. Information about the correct sequence to use in finding a code is described in the Introduction to Volume 2, Diseases: Alphabetic Index. ***The most critical rule involves beginning the search for the correct code assignment through the index, Volume 2. One should never begin searching initially in the Tabular list (Volume 1) as this will lead to coding errors.***



Laboratory Registration Specialist, Annie Thomas and David White. (Laboratory Registration Specialist, Stacey Chestnut is pictured in the header of this month's Laboratory Bulletin.)

In selecting codes to describe the reason for the encounter, the physician will frequently be using codes 001.0 through 999.9. These codes are from the section of ICD-9-CM for the classification of diseases and injuries (e.g. infectious and parasitic diseases; neoplasms; symptoms, signs, and ill-defined conditions, etc.). *Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes if this is the highest level of certainty documented by the physician.*

Guidelines for Coding

ICD-9-CM codes contained in the two-volume set are designed to be used together. Diagnosis coding is a three-step process:

- ***First***, review the medical record and/or encounter form to extract the pertinent written descriptions of the disease or symptoms.
- ***Next***, look up the disease, signs and symptoms, or condition in Volume 2, Diseases Alphabetic Index, and locate the corresponding code.
- ***Finally***, look up the corresponding code in Volume One, Diseases Tabular List and choose the most specific code that accurately describes the patient's condition. Because Volume Two contains many diagnostic terms not used in Volume One and Volume One uses more descriptive terms, it is important to use both volumes when finding the most accurate code. In general, it is best not to code directly from the alphabetic index.

Highest Degree of Specificity

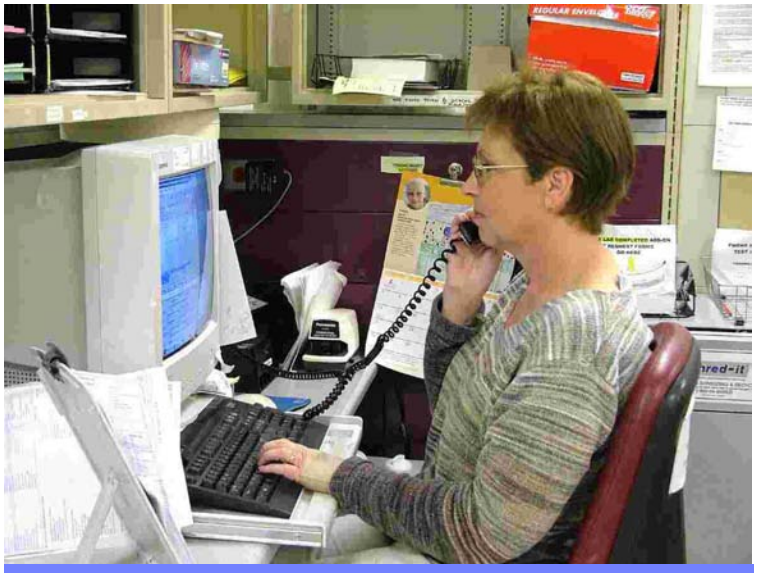
ICD-9-CM is composed of codes with three, four, or five digits. Codes with three digits are included in ICD-9-CM as stand alone codes or as the heading of a category of codes that are further subdivided by the use of fourth or fifth digits, which provide greater specificity. Codes must be used at their highest level of specificity, for example:

- Assign the fifth digit subclassification code for those categories where it exists.
- Assign four digit codes only if there is no fifth digit subclassification for that category, and
- Assign three digit codes only if there are no four digit codes within that code category.

Examples:

- Chronic obstructive pulmonary disease is assigned code 496, chronic airway obstruction, not elsewhere classified. There are no fourth or fifth digits for 496.
- Essential hypertension, 401, has fourth digits that describe the type of hypertension. It would be incorrect to report code category 401 without a fourth digit. Also note that for this code category there is a fourth digit provided to use when no information about the type of hypertension is available (401.9, unspecified site).
- Gastric ulcer, 531 has fourth digits assigned to provide information such as whether there is hemorrhage or perforation. In addition, a fifth digit (0 or 1) is available to describe whether or not there is an obstruction. It would be incorrect to leave off the fifth digit.
- Claims submitted with 3 or 4 digit codes where 4 and 5 digit codes are available will be rejected. It is recognized that a specific diagnosis may not be known at the time of an initial office visit. However, that is not an acceptable reason to submit a 3-digit code when 4 or 5 digits are more appropriate.
- ***Do not code diagnoses documented as "probable," "suspected," "questionable," or "rule out" as if they are established.*** Rather, code the condition(s) to the highest degree of certainty for that encounter such as symptoms,

Laboratory Customer Service Registration Staff



Customer Service Tech., Cathy Parrish talking with a client

signs, abnormal test results, or other reasons for the visit. *Keep in mind that there are no "rule out" codes per se in the ICD-9-CM coding system.* It is important to note that when you use a screening code from the V-code section you should also code signs and symptoms. The reason for doing so is because most health insurance carriers do not provide coverage for routine screening procedures or preventive medicine.

- For surgery, code the diagnosis for which the surgery was performed. If when the claim is filed, the postoperative diagnosis is known to be different from the preoperative diagnosis, select the postoperative diagnosis for coding.
- Code all documented conditions that coexist at the time of the encounter and that require or affect patient care, treatment, or management. Do not code conditions previously treated and no longer existing. Do not code conditions the patient has unless they are the reason for the service. Coding pre-existing conditions that are not being treated may affect medical necessity determinations.
- Physicians are advised to exercise care in coding conditions presently existing, conditions no longer existing, residuals (late effects) of conditions no longer existing and certain postoperative status conditions that require consideration in the management of patient care. *Some physicians will add to the list of conditions currently being treated any previous surgery or conditions that no longer exist to provide easy reference of the patient's history for recapitulation in the ongoing care of the patient. These should not be coded unless they require or affect patient case treatment or management.*

Reporting V Codes

The Supplementary Classification of Factors Influencing Health Status and Contact with Health Services ("V" codes) is provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnoses or problems. For patients who receive only ancillary diagnostic services during an encounter, first report the diagnosis, symptoms or signs for which the services are being performed. Report the appropriate V code for the examination second. Usually V codes should only be reported as a supplementary code and should not be reported as the primary reason or the only reason for the encounter. Diagnostic tests can be reported with a routine diagnosis code (V70.0-V70.9 and V72.0-V72.9). However, when the only diagnosis reported on the claim is one of the previously listed ICD-9 codes, the service will be denied as a routine service. Radiologists and pathologists will use V codes frequently. The following example will assist in reporting V codes:

> *A physician refers a specimen to a pathologist to examine. If at the time the claim is submitted, there is an established diagnosis (e.g., malignant neoplasm, pelvis - 195.3); this diagnosis code should be reported first to describe the reason for the service. The diagnosis code V72.6, laboratory examination, should be reported as a secondary code. If the diagnosis has not been established, the pathologist should report at least one of the signs or symptoms.*

Diagnosis Codes Must be Valid for Date of Service Reported

Effective for claims processed on or after October 1, 2004 the diagnosis that is correlated to the claim line must be valid for the date of service reported.
For example:

- Use of New ICD-9-CM Codes

ICD-9-CM code 790.95 (Elevated C-Reactive Protein) becomes a valid code with the release of the 2005 annual ICD-9-CM update, which is effective October 1, 2004. You may correlate 790.95 for services performed on or after October 1, 2004. If correlated to services performed before October 1, 2004, the service will be denied as the diagnosis reported was not valid at the time the service was performed.

Grace Period Exception
Effective for dates of service on and after October 1, 2004, 90-day grace periods will no longer apply to the annual ICD-9-CM updates.

Diagnosis Claims Linkage

Physicians may report a maximum of four unique diagnosis codes per claim when billing for their professional services on a HCFA-1500. In addition, for each line of service, the physician must indicate which one of the reported diagnosis codes relates to the service(s) reported on that line Of the diagnosis codes reported, the physician must select only the primary diagnosis which best describes the reason for the procedure. The hospital may report a maximum of nine unique diagnosis codes per claim when billing for the technical services. Code linkage is very important for medical necessity purposes. **Failure to provide a diagnosis that is medically necessary will result in a claim denial.**

Any line of service reported on an assigned claim, which is not correlated, to a primary diagnosis code will be rejected. Nonassigned claims will be delayed pending contact with the billing physician to obtain clarification.

Commonly Asked Questions

Listed within this section are frequently asked questions regarding diagnosis coding.

Q. How can I obtain the most current ICD-9-CM?
A. You may purchase a paper version of the ICD-9 Coding by contacting Practice Management Information Corporation (PMIC) or the American Medical Association (AMA)

Q. If I should not code using a `rule out' diagnosis, what code should I use?
A. *Providers should not code a disease or condition unless there is a definitive diagnosis. If tests are performed to rule out a diagnosis and the diagnosis is not established when the claim is submitted, you should only code the chief complaint or signs and symptoms related to the `rule out' or `possible' diagnosis.*

Q. Our physician practice uses coding "cheat sheets" to make coding faster… especially the common codes. Is this appropriate?
A. *Coding "cheat sheets" are a useful tool only if they are maintained and kept up to date. Please keep in mind that coding changes do go into effect every October 1st. Therefore, be sure to update your "cheat sheets" annually.*

Q. What about computer programs that assist in assigning ICD-9 codes for particular laboratory tests?
A. The following companies do have computer programs/software that will help you assign ICD-9 codes:

1. *Encoder Pro (Publisher is Ingenix)*
2. *Code Manager (Publisher is the American Medical Association)*

Q. What does Rex Laboratory do when we send specimens or patients for lab work w/o the necessary codes? (Why is it in our best interests to code properly in the first place?)
A. Rex Laboratory's registration system will not allow our Registrars to enter incorrect diagnoses. Our system is set up with the most up-to-date diagnosis information based on the current ICD-9-CM manual. Therefore, our system will not accept a diagnosis code that is not coded to the highest level of specificity and will not accept an account that does not contain a diagnosis code.

In the event that the diagnosis or sign and symptom are not provided, one of our Registrars will contact your facility. To prevent multiple telephone calls, we ask that you be very specific in your diagnosis description and/or provide us with a diagnosis code (coded to the highest level of specificity) on each laboratory requisition. By doing so, you will 1) receive fewer telephone calls from Rex Laboratory, 2) allow us to register a patient in a timely manner, 3) prevent any coding denials, both on our end as well as your end. Remember that if you submit an incorrect code and/or one not coded to the highest level of specificity, more than likely the claim will be rejected by the carrier. This will also prevent denials for the physician's practice.

Q. When we have multiple diagnosis codes, are we suppose to list them in any particular order?
A. There is a certain order to coding diagnosis codes. First, there are manifestation codes that are used only to code a manifestation of an underlying disease. You must first code the underlying disease. Second, there are secondary diagnosis codes ("V" codes) that may only be used as additional codes, not as first listed codes.Third, there are primary diagnosis codes ("V" codes), which are only acceptable as first listed codes. Your ICD-9-CM manual will typically show you which code may be used as a primary, secondary, etc. Versions of an ICD-9-CM manual will include color-coding to alert the user to special coding situations or conditions that require additional attention. The use of color-coding is found in the Tabular List of Volume 1.

Q. What future developments in ICD-9 coding are in the works?
A. The World Health Organization is in the process of converting ICD-9-CM to ICD-10-CM. No implementation date has been set thus far; however, information will be released in the near future. To read more about ICD-10-CM, please refer to www.cdc.gov/nchs/about/major/dvs/icd10des.htm

Q. What if I have questions about coding for certain laboratory tests?
A. Rex Laboratory is committed to providing you and all your patients with the highest standards of service in the industry. Therefore, if you have any specific questions about coding for certain Outreach laboratory tests, we encourage you to contact our Billing Department at (919) 784-3318 or (919) 784-6125.

David White
Compliance and Billing Specialist
Rex Laboratory