**Pocket Coding Adviser**

# Diagnosis Coding Part I: Best Practices

Effective diagnostic coding is crucial to your practice. While CPT codes drive revenue, diagnosis (ICD9) codes establish the medical necessity for CPT codes reported and specify the complexity of the work involved. Improper ICD9 coding can result in claims being delayed, down-coded, or denied. In addition, the ICD9 data submitted on your claims is gathered by third-party payers and forms a "profile" of your practice. This data is used both for comparison with your peers and for the physician rating programs recently implemented by larger insurers. By making accurate diagnosis coding a priority in your practice, you can ensure that you will receive the revenue—and the rating—you deserve.

## TIPS

**Replace your manual every year.** October 1 is the effective date for new/revised/deleted codes. Make sure that charge sheets and "cheat" sheets are reviewed and updated annuall as well. Don't rely on generic, pre-printed charge sheets; be certain that all codes listed are customized to *your* practice.

**Use both volumes.** Proper use of the ICD9 manual requires both Volumes 1 and 2 for looking up codes. Relying only on the Volume 2 Index will lead to errors in code assignment and denied claims. Be sure to read and follow any notes, guidelines, and exclusions listed in the Volume 1 Tabular List; they may direct you to use different or additional codes. Always code to the highest specificity: a fourth or fifth digit may be required. A truncated code means a denied claim.

Remember that "Rule out," "Suspected," and "Probable" diagnoses are *not reportable* in the office or outpatient setting. ICD9 does not contain codes for these terms. If no diagnosis has been established, report complaints or signs/symptoms as the reason for the visit or tests ordered.

Charge sheets should be designed in a way that allows you to link and sequence a maximum of four ICD9 codes to *each* CPT service provided and for tests ordered at the encounter. This is crucial when the visit involves multiple diagnoses, procedures, and tests. Do not rely on billing staff—or payers—to figure out which code goes with what. Errors and denials will inevitably result. The extra moment it takes to get it right will improve your revenue cycle and eliminate costly denials for you and your patients.

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March 2008 02M07280