Dynamic Chiropractic

BILLING / FEES / INSURANCE

Know Your Billing Codes

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Q: I am getting denials stating my diagnosis is truncated or incomplete. What does this mean?

A: Realize that the majority, if not all, of these denials are not because there are new codes, but because codes billed are being scrutinized more carefully for accuracy. The *ICD-9-CM* (*International Classification of Diseases 9th Revision - Clinical Modificatio*) contains all the diagnoses currently billable under all insurance claims. These codes contain three, four or five digits. In order for the diagnosis to be complete and accepted, it must contain all the necessary digits. Due to the implementation of HIPAA, insurers are relying more on electronic examination of billing, and are required to reject claims not containing accurate codes. Consequently, if the diagnosis is incomplete, it is rejected. You must verify all of your current diagnoses, particularly if you diagnose using a list that has not been verified by the doctor or staff, that it is complete to the highest level.

An example of the coding variety of digits would be flat foot, which is coded 734 (a three-digit only code) with no additional digits needed to be complete. Cervical spine strain/sprain is 847.0 (a four-digit code) with no additional digits needed to be complete. However, wrist strain/sprain requires five digits to be complete, and is coded 842.00 (wrist sprain/strain, unspecified site), 842.01 (wrist strain/sprain, carpal joint), 842.02 (wrist strain/sprain, radiocarpal joint) or 842.09 (wrist strain/sprain, other) - meaning you can identify the region, but it is not listed above, such as radioulnar joint - distal.

Prior to HIPAA implementation, an incomplete diagnosis code may have been routinely accepted because the reviewer could ascertain what the code was ultimately for. For example, many offices would bill migraine headaches as 346.0; although it requires a fifth digit to be complete, it would be accepted and claim processed. Now when 346.0 is billed, the claim is rejected for incorrect and/or invalid diagnosis. Many offices are at a loss, as they have billed the code in the past and were never aware it was incorrect, but now, when it is not accepted, they do not know what to do. (By the way, 346.00 is for a classical migraine without mention of intractable pain, while 346.01 is a classical migraine with mention of intractable pain.)

Therefore, it is imperative that if your office is not coding from a diagnosis code book and is only using a "cheat sheet" for diagnosis, the sheet must be verified. All of the codes on the sheet must be correct for the number of digits and the level of specificity. For instance, although shoulder strain/sprain uses only a four-digit code, it has 10 possibilities from 840.0 to 840.9, depending on the specific shoulder structure. Disc displacement of the cervical spine is coded 722.0 (a four-digit code) while 722.10 is used for lumbar spine and 722.11 for thoracic spine; both are five-digit codes.

It is recommended that you have a complete and current (published annually) code book of the *ICD-9* codes for reference. There is an edition of the book that not only contains the diagnosis codes and descriptions, but also has definitions of many of them. This version is referred to as the *ICD-9 Professional Edition* (volumes 1 and 2). There is also a free Web site, www.flashcode.com, where you can check an ICD-9 code for specificity.

Again, I recommend that you have a complete book. Once you have a chance to look at all of the varied possibilities of *ICD-9* codes, you may be able to find codes that are a more accurate description of a patient's condition and may lead to increased levels of allowed care.

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