

DIAGNOSIS CODING: USING THE MOST SPECIFIC CODE AVAILABLE

By Melissa Romanelli

Don't Let Improper Coding Slow Down Your Practice

- *Codes become more specific; don't be left behind.*
- *Codes become more specific; don't let unnecessary mistakes slow down your practice.*

It has always been the standard that diagnosis codes should be documented on a claims to the highest level of specificity. Recently, insurance companies have begun to more stringently enforce this guideline.

This means that you can no longer use just the 4 digit code (XXX.X) if a fifth digit code exists (XXX.XX). So, for example, you can no longer bill for a patient with Rotator Cuff Syndrome using code 726.1, you must use one of the more specific codes that are available (726.11, 726.12 or 729.19). Another example, if you have a patient with an affective personality disorder, you can no longer use code 301.1, there are four more specific codes that fall under that diagnosis header, and you must select from one of those codes.

Additionally, the use of general codes such as "Other Unspecified Back Disorders" (724.9) will routinely be rejected.

Every office should have access to an ICD-9 code book. There are quick coders available for most specialties that allow you to focus on just the codes that will be used in your practice. If you do not have access to a code book, your billing professionals can help you to develop a list that applies to your practice and your patients. Your billing professional is also available if you have questions about selecting the most specific code available.