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# **Diagnosis** Coding and Medical Necessity: Rules and Reimbursement

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#### Introduction

The origins of using diagnosis codes in hospitals and other healthcare settings goes back to the early 1950s when the US Public Health Service and the Veterans Administration extended the concept of using the International Classification of Diseases to hospital indexing of medical record storage and retrieval. However, the linkage of diagnosis codes to the concept of medical necessity did not occur until 1965 when Title XVIII and IX were added to the Social Security Act, the Medicare and Medicaid programs. The foundation of the Medicare and Medicaid programs is the concept of medical necessity and thus, the importance of diagnosis coding was elevated beyond a mere indexing of data.

The focus of my presentation is on how the bond between diagnosis coding and medical necessity impacts reimbursement of healthcare services. The presentation will explore the various rules in place for diagnosis coding and its importance in supporting the medical necessity of the services performed. The intent of this paper is to provide background information regarding the *International Classification of Diseases* and a discussion of the importance of medical necessity to the Medicare and Medicaid programs.

## **Background Information Regarding ICD-9-CM Coding**

In 1968, the US Public Health Service published a product, the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States*. This publication became commonly known as ICDA-8, and, beginning in 1968, it served as the basis for coding diagnostic data for both official morbidity and mortality statistics in the US. The current *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* is based on the official version of the World Health Organization's Ninth Revision, Internal Classification of Diseases (ICD-9).

The term "clinical" is used to emphasize the modification's intent: to serve as a useful tool to classify morbidity data for indexing medical records, medical care review, and ambulatory and other medical care programs, as well as for basic health statistics. To describe the clinical picture of the patient, the codes must be more precise than those needed only for statistical groups and trend analysis. In January 1979, ICD-9-CM was made the single classification system intended primarily for use in the US.

Physicians have been required by law to submit diagnosis codes for Medicare reimbursement since the passage of the Medicare Catastrophic Coverage Act of 1988. This Act requires physician offices to include the appropriate diagnosis codes when billing for services provided to Medicare or Medicaid beneficiaries on or after April 1, 1989. At that time, the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) designated ICD-9-CM as the coding system that physicians must use.

CMS considers *Coding Clinic*, published quarterly by the American Hospital Association, to be the official source for coding guidelines. Hospitals should follow the *Coding Clinic* guidelines to assure accuracy in ICD-9-CM coding and DRG assignment. Obviously, the guidelines are far too lengthy to include here, but every hospital, physician practice, and other healthcare organization should maintain current versions of the guidelines applicable to their healthcare system. For example, the *Coding Clinic* defines certain terms as follows:

**Principal Procedure** is the diagnosis that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If two procedures appear to meet this definition, then the one most related to the principal diagnosis should be selected as the principal procedure.

**Significant Procedure** is a significant procedure as defined by the Uniform Hospital Discharge Data Set--one that is surgical in nature, carries a procedural or anesthetic risk or requires specialized training.

**Documentation** means the documentation that must be present in the medical record to substantiate a procedure was medically necessary and that it was performed. A procedure should not be coded from the title of a procedure; the narrative description of the procedure needs to be read and the correct codes need to be determined based on the narrative description. Procedures that are integral to another procedure are not coded separately, for example, the closure.<sup>2</sup>

General guidelines, coding conventions, and chapter-specific guidelines apply to all healthcare settings. Coding sequencing instructions in Volumes I, II, and III of ICD-9-CM take precedence over any guidelines. Each year, major additions and changes to the coding guidelines are published by the cooperating parties and are effective on October first of that year. The *Coding Clinic* purpose is to assist users in coding and reporting accurately when the ICD-9 manual itself does not provide clear direction.

The official guidelines have four sections. They may be generally described as:

- General coding guidelines
- Guidelines for reporting *principal diagnosis for inpatient* services
- Guidelines for reporting additional diagnosis codes for inpatient services
- Coding guidelines for outpatient services

The major distinctions between inpatient and outpatient reporting are:

- Definitions for principal versus "first listed" diagnosis codes
- The ability to code or not code "rule out" diagnoses
- More common application of V codes and signs/symptoms coding for outpatient services

The proper ICD-9-CM code is the highest level of detail according to the number of digits available. That is, if a code can be described by a four-digit code rather than a three-digit code, then the four-digit code should be selected; similarly, if a five-digit code is available, that code would represent the highest level of detail and should be selected. Codes that are not specified to the highest order possible are considered truncated and may result in a claim denial.

Several other common coding problem areas that may be confusing for physicians and facility coders are:

- The use of E codes. In the past, coders were advised by various payers not to use E codes. Worker's compensation and auto insurers usually require these codes because they provide more detailed information regarding the cause of an accident resulting in an injury. Coders should report E codes when the circumstances warrant it.
- The assignment of a "first listed" diagnosis in the outpatient setting. Often facility coders who are accustomed to applying inpatient coding guidelines for first listed and additional diagnosis code selections have a difficult time adapting to the diagnosis coding requirements for an outpatient setting. The outpatient coding guidelines state that, "For ambulatory surgery, code the diagnosis for which the surgery was performed. If the post-operative diagnosis is known to be different from the pre-operative diagnosis at the time the diagnosis is confirmed, select the post-operative diagnosis for coding since it is most definitive." 

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- Coders fail to be as specific in their coding as the documentation supports. They select a generic or unlisted diagnosis when a more specific detailed one is available. This may be the result of relying exclusively on the diagnosis codes that are preprinted on an encounter form or another form. Often the forms are not updated to reflect additions, deletions, and description changes that occur at least once a year. The most applicable and specific diagnostic code must be selected when physicians are ordering diagnostic services (clinical diagnostic labs, radiology, and medicine diagnostic services).
- Diagnostic services are often subject to payment limitations based on medical
  necessity. The failure to provide the most applicable diagnoses may result in the
  service being denied. Physician practices as well as facilities should ensure that they
  have procedures in place to verify questionable and/or vague diagnosis codes. In
  addition, they need to tie in the diagnosis data to the completion of an Advance
  Beneficiary Notice (ABN) when the medical necessity is questionable and the
  patient is a Medicare beneficiary.
- Preventive services diagnosis coding also may present a unique challenge to coders.
   Medicare does not typically cover "preventive" services except under specific criteria and frequency limitations. Thus, it is important to report the applicable diagnosis codes to receive payment for medically necessary preventive services.

- When a psychiatric diagnosis is listed as the primary diagnosis for a Medicare
  patient, the services provided may be reduced as a result of the Outpatient Mental
  Health Treatment Limitation. Psychiatric diagnoses should be coded when they
  apply, but, if a medically indicated condition other than a psychiatric diagnosis is
  more appropriate, it should be coded first.
- Coders should assure that services requiring modifiers are properly supported with applicable diagnosis codes. For example, attaching of a "59" modifier to identify a separately excised lesion may require a separate diagnosis code for each excision and/or specimen obtained since the lesions may vary in tissue type. Providing distinct diagnoses for both services will support the necessity for performing and billing both services.

Selecting the correct diagnosis code based on the documentation requires an excellent understanding of the coding guidelines and good cooperation of the physician to provide a detailed description of why he/she provided certain services.

## Background Information Regarding Medical Necessity

"Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services- (1)(A) which, except for items and services described in the succeeding subparagraph, are not reasonable and necessary for the diagnosis and treatment of illness or injury to improve the functioning of a malformed body member."

—Social Security Act Chapter XVIII, Section 1862(a) (1)

Some services that are covered under the Medicare program may be limited in coverage due to certain diagnoses, frequency parameters, etc. For example, the payment for a vitamin B-12 injection is limited to diagnoses such as pernicious anemia, gastrointestinal disorder, neuropathies, etc. Therefore, if the criteria are not met, the service will be denied. A procedure may be denied as not reasonable and necessary if it is considered investigational, experimental, or of questionable usefulness. A service may be denied as not reasonable and necessary if it is done more frequently than CMS' policy guidelines specify. When a facility or physician practice is aware of a situation, which Medicare may deny, and they give the Medicare beneficiary an ABN prior to the service and the service is denied, the full charge may be collected from the patient.

Medical necessity denials occur as a result of a National Coverage Determination (NCD) or a Local Coverage Determination (LCD). Between December 2003 and December 2005, Medicare carriers and fiscal intermediaries (FI) are converting their Local Medicare Review Policies (LMRPs) to LCDs.

NCDs and LCDs specify the clinical circumstances under which a service is covered (including whether the circumstances are considered reasonable and necessary). Local coverage decisions may vary in number and content from carrier to carrier and FI to FI.

For example, HGSA administrators, a Medicare carrier for Pennsylvania, has 18 policies under the category "surgical services." Trailblazer, a carrier covering several different states, has only seven LCDs under the surgical service category. Arkansas Blue Cross and Blue Shield, who also functions as a Medicare carrier for several states, has only eight policies under this category.

LCDs may be general, or more specific, and provide narrative descriptions of diagnoses that support the medical necessity of a specific service. In some cases, they may have a detailed list of ICD-9-CM codes under which the service will be considered as reasonable and necessary. The best reference for both NCDs and LCDs is the CMS Web site at <a href="https://www.cms.hhs.gov">www.cms.hhs.gov</a>.

Another important section of the Social Security Act is 1842 (a) (2) (B), which requires Medicare carriers and FIs to apply "safeguards against unnecessary utilization of services furnished by providers." The safeguards may entitle prepayment screens, prepayment reviews, and postpayment reviews to identify inappropriate, medically unnecessary, or excessive services and to take actions where questionable practice patterns are found.

Both prepayment and postpayment reviews use the same set of medical policies. In general, claims received by carriers and FIs are processed on the assumption that providers have the integrity to submit correct information on claims. The claim information, however, must be supported by the medical documentation in the provider's file and must be made available upon request to a carrier or an FI.

The key elements of the medical review process are:

- Monitoring patterns of Medicare claim submissions to identify statistical deviations
- Identifying physicians and suppliers whose utilization patterns differ from medically recognized standards, criteria, and peer norms
- Recovering any inappropriate program expenditures resulting from abuse or overutilization of services
- Educating physicians and other healthcare providers to prevent future abuse of program funds
- Recommending administrative sanctions under 1128 (a) and 1826 (d) (2) of the Social Security Act when physicians and other healthcare providers fail to correct their inappropriate practices

CMS requires that before carriers and FIs assign significant resources to examine a provider claim to identify potential problems, that a probe audit be conducted. A probe review will be of a small number of claims and will not exceed 100 claims. Providers will be asked to submit any and all medical documentation applicable to the claims in question.

The probe review results may be classified as minor, moderate, or major. If a minor problem is detected, the carrier or FI will educate the provider on appropriate billing procedures, pursue recoupment of claims paid in error, and may conduct further analysis at a later date to ensure the problem was corrected. If a moderate problem is detected, additional action

may be to place the provider under a prepayment review until they have demonstrated correction of the billing procedures. When a major problem is detected, in addition to a prepayment review, further sampling may be conducted, payment may be suspended, and a referral may be placed to the Benefit Integrity unit for investigation of fraud or abuse.

Fraud is the intentional deception or misrepresentation that an individual knows to be false, and knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. Examples of fraud are:

- Billing for services and supplies that were not provided
- Misrepresenting the diagnosis for a patient to justify the services or equipment furnished
- Altering claim forms to obtain a high payment amount
- Unbundling (exploding) charges or upcoding
- Participating in schemes that involve collusion between a provider and a beneficiary, that result in higher costs or charges to the Medicare program (for example, kickbacks)

The term abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practices. Abuse may directly or indirectly result in unnecessary costs to the program, improper reimbursement, or program reimbursement for services that fail to meet professionally recognized standards of care or which are medically unnecessary. CMS identifies the overutilization of medical and healthcare services, which occurs when a patient receives services that are not medically necessary or reasonable, as the leading type of abuse.

### References

The Social Security Act

Medicare Program Integrity Manual, Chapter 13, Section 1

CMS Web site for NCDs and LCDs

Medicare Claims Processing Manual

ICD-9-CM Official Guidelines for Coding and Reporting, Effective October 1, 2003.

Coding Clinic, American Hospital Association

#### **Endnotes**

- 1. 2004 ICD-9-CM Expert for Physicians, Volumes 1 and 2.
- 2. Coding Clinic, fourth quarter 1990, page 5.

3. 2004 ICD-9-CM Expert for Hospitals.

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