

December 2004

## **Important Notice for Providers Using ICD-9-CM Codes to Bill Health Partners/Senior Partners**

### **BACKGROUND**

Effective June 1, 1989 the Medicare Catastrophic Coverage Act of 1988 (PL 100-330) required health care providers to use appropriate diagnostic coding using the *International Classification of Diseases, 9<sup>th</sup> Revision, Clinical Modification* (ICD-9-CM). ICD-9-CM codes at their highest level of specificity must be included on all claims reported through the CMS programs. Pennsylvania's Department of Public Welfare, Office of Medical Assistance also requires all claims be reported using the ICD-9-CM classification and at the highest level of specificity. Senior Partners and Health Partners, as respective Medicare and Medicaid contracted Managed Care Program Participants, are bound by and adhere to this coding requirement.

### **ACTION REQUIRED BY PROVIDERS**

Providers are reminded, ICD-9-CM (diagnosis) codes must be documented at their highest level of specificity:

- Assign a three-digit code only if there are no four-digit codes within the coding category;
- Assign a four-digit code only if there is no fifth digit sub-classification for the category;
- Assign a fifth digit sub-classification code for those categories where it exists.

Chronic diseases treated on an on-going basis should be coded and reported as many times as the patient receives treatment and care for the condition.

**Providers should code all conditions that coexist at the time of the visit that affect patient care, treatment or management.** Do not code conditions

that were previously treated and no longer exist. However, history codes (V10 – V19) may be used as secondary codes if the historical condition has an impact on current care or influences treatment.

List as many ICD-9-CM codes as exist.

E codes are considered supplemental to ICD-9-CM codes, and are never to be recorded as a principal (first listed) diagnosis or stand as a solo code.

V codes may be used as either the primary or secondary code depending on the circumstances. (Certain V codes may only be listed in the first position; others only as secondary codes.) An ICD-9-CM code should follow any V code placed in the primary position to define the reason for which the service was performed.

## **IMPACT**

Claims filed with three- and four-digit ICD-9-CM diagnosis codes where four- and five-digit codes are available, are considered invalid and **will cause claims to be denied** for:

**BG** – “Non-covered diagnosis”

**GS** – “Invalid diagnosis”

**M64, M76, MA63, MA65** – HIPAA compliant Health Care Claim Remark Codes all indicating “Missing/incomplete/invalid diagnosis or condition”

**47** – HIPAA compliant Health Care Claim Adjustment Reason Code, “This diagnosis is not covered, missing or invalid.”

It is important that all additional conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, or increased monitoring be reported. This data is extremely helpful in studying clinical outcomes and managing care provided by multiple providers.

## **REFERENCES**

***International Classification of Diseases, 9<sup>th</sup> Revision, Clinical Modification, Sixth Edition***, 2004, Practice Management Information Corporation [PMIC], Los Angeles, CA.

**PROMISE™ Provider Handbooks and Billing Guides**,  
<http://www.dpw.state.pa.us/omap/provinf/omapprovhb.asp>