

Important Information for Physicians about Diagnosis Codes and Billing

From the Medical Review Board of ESRD Network #15

As you know, every visit by a patient to the office or the hospital is followed by a submission of the charges for services rendered. Every charge should include a CPT code identifying the type of procedure or visit, and an ICD-9 code referring to a specific diagnosis (or set of diagnoses).

Billing data may be the sole data source used by CMS and their contractors to determine the quality of care you are providing to your patients. Frequently the only information extracted from your billing (the HCFA 1500 or its electronic equivalent) is the principle diagnosis. Because of this, it is very important that your billing includes ALL applicable diagnoses that were addressed during an individual visit. Charge statements that are complete and detailed insure that *all* the work you do is captured by the system; this allows more complete validation of the charge submitted as well as accurate remittance of your expected payment.

We urge all physicians and practitioners to ensure that billing for each individual visit indicates *every* applicable diagnosis. Precise coding leads to more accurate perceptions of the complexity of your patients' conditions and the care you are providing. Coding your more complex patient cases with multiple diagnoses that you address during a visit does NOT constitute "padding" your claim – so long as the work was done and documented. Rather, it represents correct, best-practice coding, and should be a part of your regular practice.

To recap:

- Be sure that EVERY applicable diagnosis is included on each billing statement.
- Leaving out diagnostic codes from your charges may cause incorrect interpretation of the quality of care you are providing and of your practice patterns.
- Medicare allows listing all diagnoses that you addressed during a visit; it is intended that you charge for all work that you do. Don't let your care be undervalued!

For your convenience, the common codes for Chronic Kidney Disease are listed below.

| Stage | Description | GFR (ml/min) ² | ICD-9 Codes |
|-------|--|---------------------------|-------------|
| | Increased risk for CKD | > 90 | |
| 1 | Kidney damage with normal or increased GFR | ≥ 90 | 585.1 |
| 2 | Kidney damage with mildly decreased GFR | 60-89 | 585.2 |
| 3 | Moderately decreased GFR | 30-59 | 585.3 |
| 4 | Severely decreased GFR | 15-29 | 585.4 |
| 5 | Kidney failure | < 15 | 585.5 |