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V Codes and E Codes Are Helpful Tools to Support Medical Necessity of Your ED Claims

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When it comes to supporting the medical necessity of your ED claims, V codes and E codes should be an ICD-9 tool that you pull often from your coding toolbox. They can often paint a much clearer picture of that ED patient visit than just the main Tabular List of Diseases. The ED patient visit picture can often be muddied with non-specific diagnosis coding, making it almost impossible to ascertain just from the ICD-9 codes exactly what brought the patient to the ED for this encounter. A clear picture of the encounter must be painted by the diagnostic coding for the payors to agree with the medical necessity of the ED visit and to ultimately pay the claim.

ICD-9 CM includes the V code and E code sections as "Supplementary Classifications" to the main Tabular List of Diseases. V codes are defined by ICD-9 as "Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01-V91)." Some V codes may be used as the principal diagnosis, others may only be used as secondary codes, and some can be used as either, depending on the circumstances. The rules for sequencing of V codes are different for the outpatient setting than they are for the inpatient setting. V codes can be invaluable in supporting the medical necessity of the claim and thereby avoiding inappropriate claim denials.

V codes can be particularly relevant in the ED place of service because many ED patients present to the ED without clear disease processes. Many present without any disease process, but need various health care services, such as to rule out infectious disease after a possible exposure or for observation after a motor vehicle accident or even for a screening examination prior to admission to another facility. As all ED coders know, these can become one of the most frustrating diagnosis coding scenarios. V codes are often the answer in these difficult-to-code scenarios. Many payors do except V codes as diagnosis codes on claims. The difficult part to ascertain is which they will accept and which they will note. Often these payor edits are not published anywhere, and all coders and billers can do is to glean the list of payable and non-payable V codes from their claim experience.

For example, Florida Medicaid does consider some "history of" V codes payable, even as a primary diagnosis and these codes may help to support the medical necessity of the claim. If a patient presents with no symptoms at all and has a history of cardiac disease, and the patient does have some sort of cardiac exam and/or work-up, then the coder can use V12.50, *Personal History of Unspecified Circulatory Disease* to support the medical necessity of the claim. In addition, this personal history code could also be used when there are other diagnosis codes coded on the claim if it is needed. However, this same payor will not pay for a claim with many of the follow-up V codes,

such as V67.9, *Unspecified follow-up examination.* Unfortunately often times the screening or follow-up V codes are not payable diagnosis for payors. However, if the screening or follow-up V code is absolutely the only diagnosis code that can be pulled from the chart documentation, then the coder may have no choice but to submit the V code that will result in a denial and then appeal the denial.

Physician education is a helpful tool to remedy some of these denials by emphasizing to the physician the importance of documenting all presenting complaints and signs and symptoms in the context of avoiding unnecessary denials. Many times, the physician may not be familiar with ICD-9 and what diagnosis are and are not available to coders.

Injuries are one of the top groups of diagnosis for which patients present to the ED. E codes are used to provide additional data and information on injury and poisoning cases. E codes are "Supplementary Classification of External Causes of Injury and Poisoning (E000-E999)". So like V codes, E codes are also considered supplementary codes to the main tabular section in ICD-9. Unlike V codes, E codes are never to be used as the primary diagnosis. E codes can provide additional information on where the injury happened, how it happened, what the patient was doing when it happened, whether it was accidental, unintentional or intentional and the place that it occurred. With all that added detail, it is easy to see how E codes can help to more fully describe the circumstances of the ED visit and to further support the medical necessity of the claim. For example, if a child has a final diagnosis of a fairly simple injury, such as ICD-9 code 914.0, *Superficial injury of the hand, abrasion or friction burn without mention of infection*, and an ED E/M level 99284 is coded, it is understandable that a payor may question or even deny that claim initially. However, when E codes are added that further explain the circumstances of the injury, such as E884.0 *Fall from playground equipment*, the payor may not deny or request records on the case because they can better see the medical necessity of a Level 99284 History, Exam and Medical Decision Making was necessary to rule out more severe injuries for the child. Workers Compensation Carriers do usually want or even require E codes on their claims. Conversely, some payors do not want E codes on their claims and may even deny claims when submitted with E codes (most likely because their systems just have not been updated to accept E codes). Research must be done on an individual payor basis to determine which payors accept or require E codes and which do not accept them at all.

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