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General Surgery Coding Alert

Diagnosis: Put 'Signs and Symptoms' Coding in its Place

Overcome four falsehoods that hamper your reporting.

When you face a case report with no definitive clinical diagnosis, do you find yourself wondering whether or how to report those "current complaints" on the claim?

Let our experts clarify whether the following myths you may have heard about reporting signs and symptoms are true or false, based on official ICD-10-CM coding guidelines.

Myth 1: Never 'List First' a Chapter 18 Code

ICD-10-CM's Chapter 18 is for "Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified."

Despite what you may have heard about not using these codes as a primary diagnosis, the chapter guidelines I.C.18.a state, "codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider."

In other words, Chapter 18 "captures signs and symptoms that are not captured in other chapters and, as such, may be the only information the provider has at the end of the visit if the symptoms are still under investigation and a definitive diagnosis has not been made," explains **Melanie Witt, MA, RN, CPC,** an independent coding expert based in Guadalupita, New Mexico.

For example: Your surgeon consults with a patient referred for possible colonoscopy with biopsy to rule out Crohn's disease based on symptoms of abdominal pain, diarrhea, fever, and loss of appetite. In this case, you would use signs and symptoms such as R10.10 (Upper abdominal pain, unspecified), R19.7 (Diarrhea, unspecified), R50.9 (Fever, unspecified), and R63.0 (Anorexia) as principal diagnoses for this encounter. Later, if the surgeon performs the procedure and receives pathology findings to establish a definitive diagnosis, you would report the final diagnosis.

Myth 2: Never Report Chapter 18 Codes With a Definitive Diagnosis

This myth is only partly incorrect, because, "in some cases, you may be able to report a code from Chapter 18 if the sign or symptom is not normally associated with a definitive diagnosis," says **Chelle Johnson, CPMA, CPC, CPCO, CPPM, CEMC, AAPC Fellow,** billing/credentialing/ auditing/coding coordinator at County of Stanislaus Health Services Agency in Modesto, California.

Per guideline I.C.18.b, you may report a sign and symptom code in addition to a related definitive diagnosis when the sign or symptom "is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes."

Example: Your surgeon performed a hernia repair procedure for a person with a recurring obstructed right femoral hernia and found no evidence of gangrene. Report the diagnosis for the procedure as K41.31 (Unilateral femoral hernia, with obstruction, without gangrene, recurrent).

However, the pre-op complete blood count (CBC) identified abnormal megaloblasts of red blood cells, and the surgeon recommends the patient follow up with his primary care physician to investigate this finding. That means you should also list the appropriate code such as D53.1 (Other megaloblastic anemias, not elsewhere classified), because this sign is not

routinely associated with a femoral hernia.

Myth 3: Use 'Probable' Diagnosis Instead of Chapter 18 Symptoms

One ICD-10-CM guideline, II.H, has probably led to vast confusion about coding a diagnosis that the clinician identifies as "probable," "suspected," "questionable," "ruled out," or with some similar language.

The guideline states, "if the diagnosis documented at the time of discharge is qualified as 'probable,' 'suspected,' 'likely,' 'questionable,' 'possible,' 'still to be ruled out,' 'compatible with,' 'consistent with,' or other similar terms indicating uncertainty, code the condition as if it existed or was established."

Caveat: Guideline II.H goes on to state, "this guideline is applicable only to inpatient admissions to short-term, acute, long-term care, and psychiatric hospitals."

Do this: In most cases, you must look to outpatient guideline IV.H, which states, "Do not code diagnoses documented as 'probable,' 'suspected,' 'questionable,' 'rule out,' 'compatible with,' 'consistent with,' or 'working diagnosis,' or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit."

Myth 4: Only Chapter 18 Includes 'Signs and Symptoms' Codes

This one is completely false. "Some of the body system chapters also include symptoms related to that area," notes Witt. So, it is important not to limit your search for signs and symptoms codes to just one chapter.

Examples: "One code that immediately comes to mind is N63.- (Unspecified lump in breast)," says Johnson. And there are countless others, such as M25.5- (Pain in joint).