Codify
BY AAPC

Internal Medicine Coding Alert

Medicare Settles on Final Diagnosis Coding Guidelines

"Determining whether to code the result of a lab or radiology test or the reason the test was ordered has been a source of controversy among coders for some time," says **Kathy Pride, CPC, CCS-P,** HIM applications specialist with QuadraMed, a national healthcare information technology and consulting firm based in San Rafael, Calif. "Much of the controversy was due to various carriers' having different interpretations of the existing guidelines."

In response, CMS issued a program transmittal to its carriers and fiscal intermediaries that solves this problem. Citing the HIPAA rule that requires the use of ICD-9 and its official coding guidelines, ICD-9-CM Official Guidelines for Coding and Reporting, by Medicare and other payers, CMS states that it agrees with and will follow the existing official guidelines for coding and reporting diagnostic tests. The guidelines are effective Jan. 1, 2002. **Linda Bishop, CPC, CCS,** corporate compliance officer, Pediatric Management Group at Children's Hospital, Los Angeles, provides the following interpretation of these guidelines and examples of their use for coders:

1. Code the definitive diagnosis.

If the interpreting physician confirms a diagnosis, that diagnosis should be reported as primary, not the signs or symptoms that may have prompted the test. If the primary diagnosis does not fully explain the signs and symptoms that prompted the test, the coder may list the signs and symptoms as a secondary diagnosis.

For example, a patient presents with abdominal pain. A CT scan is ordered, and the radiologist interpreting the scan diagnoses an intra-abdominal abscess. The code reported for this test would be 567.2 (Other suppurative peritonitis). In this instance, it is not necessary to code the patient's abdominal pain because it is explained by the definitive diagnosis of intra-abdominal abscess.

In another example, a patient is referred for a chest x-ray because of a cough. The radiologist diagnoses a pulmonary nodule, which he codes as 518.89 (Other diseases of lung, not elsewhere classified). The cough may be coded as a secondary diagnosis (786.2, Cough) because it is not necessarily explained by the pulmonary nodule.

2. Code the signs and symptoms that prompted the the test if the diagnostic test result was normal or did not provide a diagnosis.

Many times a test result is normal or does not allow the interpreting physician to make a diagnosis. In this instance, code only the signs and symptoms that the patient presented with.

For example, a spinal x-ray is performed for back pain. The reading of the x-ray is normal. The proper code for this service would be 724.5 (Backache, unspecified).

Alternatively, a patient presents complaining of chest pain. An EKG is performed and is found to be normal. The patient is sent home with a final diagnosis of suspected gastroesophageal reflux disease. The code for the normal EKG would be the presenting symptom, 786.50 (Chest pain, unspecified). The gastroesophageal reflux disease would not be coded because it has not been confirmed. ICD-9 coding guidelines forbid the coding of unconfirmed diagnoses that are listed as probable, suspected, questionable or rule-out.

3. Code incidental findings as secondary diagnosis.

Often a physician reading a test result will come across an abnormal finding that is unrelated to the reason the test was ordered. These are known as incidental findings. An incidental finding may be coded as a secondary diagnosis, but it

should never be coded as the primary diagnosis.

For example, an abdominal ultrasound is ordered for a patient with jaundice. The physician interpreting the ultrasound does not find any abdominal pathology to explain the patient's jaundice, but he incidentally notes that the patient has an abdominal aneurysm. The primary diagnosis in this case would be the symptom, jaundice (782.4, Jaundice, unspecified, not of newborn), that prompted the ultrasound. The unrelated or incidental finding of the abdominal aortic aneurysm (441.4, Abdominal aneurysm without mention of rupture) would be coded as a secondary diagnosis.

Or, a chest x-ray is ordered because a patient is wheezing. Upon review of the chest x-ray, the physician does not note any abnormal findings in the lung but does note that the patient's spine demonstrates scoliosis. The primary diagnosis in this case would be the symptom, wheezing (786.7, Abnormal chest sounds), that prompted the chest x-ray. The scoliosis (737.30, Scoliosis, idiopathic) would be coded as a secondary diagnosis because it is unrelated to the reason the chest x-ray was ordered and is an incidental finding.

4. Code coexisting or unrelated diagnoses on referral.

Often, illnesses may be unrelated to the diagnostic test being ordered, but the referring physician may list them on the referral request. These coexisting illnesses may be coded, but they should always be listed as secondary diagnoses.

For example, a chest x-ray is ordered for a hypertensive, diabetic patient with a cough. The x-ray reveals that the patient has pneumonia. The primary diagnosis code for the chest x-ray would be 486 (Pneumonia, organism unspecified). The presenting symptom, the patient's cough, would not be coded because it is a symptom of pneumonia. The patient's diagnosis explains the cough, so the cough would not be coded. The two unrelated, coexisting medical diagnoses, hypertension (401.9) and diabetes (250.00), would be coded as secondary diagnoses.

5. Code the diagnostic test in the absence of signs and symptoms (screening tests).

For compliance, this is the most important of Medicare's guidelines. Medicare considers any diagnostic test ordered in the absence of signs and symptoms a screening test. Because Medicare only pays for a limited number of screening tests, it requires that the physician's office indicate a screening diagnosis code as the primary diagnosis, even if the test result reveals that the patient is suffering from an illness. The result of the test may be reported as a secondary diagnosis. Failure to follow this specific guideline is considered a compliance violation and can result in fines and penalties.

For example, a patient undergoes a routine physical. She has no overt complaints. Her doctor orders a blood panel that includes thyroid function tests, which reveal that the patient has hypothyroidism. The primary diagnosis would be V77.0 (Screening for thyroid disorders). The secondary diagnosis would be the result of the test, hypothyroidism (244.9). Never code an abnormal result if the test was originally ordered as a screening test. It is very important in this scenario that the V code for screening be sequenced first.

The CMS transmittal (www.hcfa.gov/pubforms/ transmit/AB01144.pdf) provides an excellent review of many of the basic principles of ICD-9 coding.