Internal Medicine Coding Alert

Code For Signs and Symptoms to Receive Optimum Pay Up

Internal medicine practices that are coding probable, suspected or rule-out diagnoses not only are violating Medicare coding guidelines, but also could be doing irreversible damage to their patients medical records. Instead of coding for rule outs, internists should be using ICD-9 codes that reflect the signs and symptoms that caused the patient to seek care.

Section 4020.3 of the Medicare Carriers Manual states, Do not code diagnoses documented as probable, suspected, questionable or rule out as if they were established. 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.

In other words, you dont want to say what the diagnosis is until the procedure is completed, or you are sure what the problem is, says **Cynthia DeVries, RN, CPC**, coding and reimbursement specialist with Lee Physicians, a 140-physician practice with 27 internists in Ft. Myers, Fla. Although signs and symptoms arent true diagnoses, they do illustrate why a patient sought care and can prove medical necessity for the services the internist rendered.

Internists who code for probable diagnoses not only face serious consequences in the case of Medicare audit, but also risk damaging a patients chance to get health or life insurance in the future. If an internist writes breast lump rule out cancer and that gets reported as a diagnosis of breast cancer, then that patient will be labeled as having breast cancer even if the tests come back negative, DeVries claims. Its almost impossible to get removed from a patients record and will be a reason for denying her health and life insurance in the future.

Facilities Can Code Rule Outs; Physicians Cannot

Although physicians are required by Medicare to code for signs and symptoms, hospitals and other medical facilities can code for probable diagnosis, a fact Medicare acknowledges. Physicians should be aware that this is contrary to the coding practices used by hospitals and medical record departments for coding the diagnoses of hospital inpatients, reads the Medicare Carriers Manual.

Hospitals and other medical facilities can code
or rule outs because they are billing for a facility fee, not a physicians fee, DeVries points out. If a test comes back as negative, the hospital will still bill for the original, suspected diagnosis.

Does this mean that an internist has to write up two sets of diagnosis codes, one for his or her bill and one for the hospitals bill? No, says **Jim Stephenson**, billing manager for Premium Medical Management, a multi-specialty physician group practice in Elyria, Ohio. Two sets of diagnosis codes are not necessary. Consistency is the key.

DeVries agrees that the internist only has to do one set of codes. The internist will write breast lump rule out cancer on the patients medical record, she explains. The internists coder will enter a diagnosis code for breast lump on the Part B claim for the physicians fee, and the hospital will put breast cancer on its claim.

If the test results come back before the claim is filed, The sign or symptom should remain in place, says DeVries. You can code with the definitive diagnosis in subsequent visits.

Four Tips for Better ICD-9 Coding

For those who may be confused about the difference between a sign, symptom and diagnosis, DeVries offers the following coding tips:

1. Know your definitions. A sign is any abnormality indicative of disease, discoverable on examination of the patient. A symptom, on the other hand, is a subjective indication of disease and is classified as any morbid phenomenon or departure from the normal in structure, function of sensation, experienced by the patient and indicative of disease. A lump is a sign, while loss of appetite is a symptom.

2. Know where the codes are listed. Most sign and symptom codes are in Chapter 16 (780-799) of Volume 1 of the ICD-9 manual. Some frequently used exceptions to that are hematuria (599.7, blood in urine), hematemesis (578.0, vomiting of blood), dehydration (276.5) and pain in limb (729.5).

3. Documentation should indicate when to code and not to code for a diagnosis. If the internist writes urinary incontinence due to benign prostatic hypertrophy (BPH), then the diagnosis code for BPH, which is 600 (hyperplasia of prostate), should be reported. If the internist writes urinary incontinence probably due to BPH, then urinary incontinence (788.30-788.39) should be used.

4. Signs and symptoms also may be coded as secondary codes because they are important problems in medical care. In the previously cited example in which urinary incontinence is caused by BPH, the BPH would be listed as the primary diagnosis code. But, according to the ICD-9 manual, an additional code to identify urinary incontinence also should be used.