Internal Medicine Coding Alert

Correct Diagnosis Codes Are Key to Adequate Reimbursement for Tests and Lab Orders

Has this happened in your practice?

A patient who has been experiencing mild chest pain makes an appointment to see your internist. After obtaining a history and performing a brief examination, the physician orders an ECG to determine whether the pain is a cardiac problem. The test comes back; the physician reads the results and determines that there is no evidence of heart disease or disturbance. On his documentation he writes: normal exam. For the patient, this is good news. But for the internal medicine practice, it may spell bad news when they seek payment for this service.

Many coders who see the words normal exam will attach the ICD-9 code V70.0 (routine general medical examination at a health care facility, health checkup) when coding for the physical examination and ECG interpretation, says **Susan Stradley, CPC, CCS-P**, a practice management consultant with the accounting firm Elliott, Davis, and Company in Augusta, GA.

To the payer, this bill will appear to be for a routine health exam, not a problem-focused visit to determine the cause of chest pain, Stradley continues.

The miscoded claim goes to the patients health insurer, which doesnt cover preventive screenings, their computer system reads the V code, and it is denied. However, this test should have been covered because it was not a screening, the consultant notes. The physician performed the test because the patient had chest pain.

The diagnosis code that should be used for this procedure in this scenario is 786.50 (chest pain, unspecified), Stradley adds. This code gives the medical justification for performing the ECG.

If you are doing the test because the patient presents with vague signs and symptoms, such as chest pain or abdominal pain, use those diagnosis codes, Stradley emphasizes. You shouldnt use preventive care or pre-op screening codes.

Preventive vs. Diagnostic Tests

Applying the correct diagnosis code for tests and laboratory work is particularly important because Medicare doesnt cover preventive screening or services in most cases, notes **Kathryn L. Cianciolo, MA, RRA, CCS, CCS-P**, chair of the Society for Clinical Coding and an independent practice management consultant in Waukesha, WI. And in many instances, the claims for the diagnostic tests and laboratory work are submitted by medical billing departments other than the one at the internists practice, usually the hospital where the test is performed or the laboratory where a sample is examined. (See box below for list of common diagnosis coding mistakes.)

Items and services not deemed reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, are excluded under Medicare Part A and Part B, Cianciolo notes.

Medicare carriers determine what is reasonable and necessary by preset lists of tests that must be accompanied by specific diagnostic information to establish medical necessity. In many cases, these individual carriers and intermediaries have a list of specific ICD-9 codes that will justify the medical necessity of a particular test, Cianciolo explains. For example, 786.50 (chest pain, unspecified) as a justifying reason for ordering an ECG. (See box below 36 that lists Medicares limited coverage tests.)

Submit claims for a test or lab work with an unlisted ICD-9 code and the claim is automatically denied.

Many other insurance plans also limit coverage to just those procedures and services that are directed at identifying and treating suspected illness, adds Stradley. Its not just Medicare.

Some insurance companies offer coverage for preventive care, some dont. Quite honestly, its about fifty-fifty, she says.

If, in the above scenario, the ECG had come back indicating possible heart disease such as unstable angina (411.1, intermediate coronary syndrome, impending infarction, preinfarction angina, preinfarction syndrome, unstable angina), the medical justification would be clear.

However, when no underlying illness is found, many physicians and coders mistakenly record this exam as a screening procedure. The reason for the office visit is often the key to differentiating between whether a test was diagnostic or screening, Stradley says.

Screenings are usually performed during annual exams, she explains. The patient comes into the office, there are no problems, the physician runs some tests to make sure there are no underlying illnesses that are being missed.

These exams are preventive care and the tests performed would be screening exams, she says. The physicians and the patient didnt think anything was wrong [when the test was ordered] and nothing was wrong. Paradoxically, if the test did uncover a medical problem, the diagnosis code for the problem found would justify the medical necessity of the test.

However, in the instance of a patient who presents with an unknown problem, and tests are ordered to help determine the cause of the complaint, the fact that nothing is found does not mean that the test performed is a screening service.

The fact that no illness is found does not mean that a test isnt diagnostic, stresses Stradley. The patients subjective complaint is sometimes the only thing you have: its the reason the patient came to you.

Physicians Must Document Medical Necessity

Physicians need to be educated about the proper way to document the medical necessity for the work they do, Stradley explains.

If the internist doesnt accurately record the signs and symptoms that the patient presented with, and fails to report them as the reason for ordering the test, the coder has almost no hope of applying the correct diagnosis code.

A vague sign or symptom is a perfectly acceptable diagnosis for a physician, if he or she doesnt know the answer right away. They need to know its OK to write down abdominal pain (789.0x) as a diagnosis, because they dont know if its gastroenteritis, colitis, or appendicitis before performing the diagnostic tests.

In addition, notes Cianciolo, diagnostic tests like chest x-rays, MRIs, and CAT scans are often performed at a local hospital. The internist will write the reason for the test on his order and refer the patient.

In these cases, the hospital coders will submit the bill for the test, applying a diagnosis code that most closely fits the physicians reason for ordering the test.
If the doctor does not indicate the correct diagnosis, the hospital will not get paid for performing the test. And, the physician who interprets the results (either a specialist at the hospital or the internist) will not get paid either.

Patients Must Often Pay for Screening

Of course, there are instances in internal medicine when lab work and diagnostic tests are performed as screening measures. For example, many male patients request screening for prostate cancer.

The PSA (prostate-specific antigen) test is only covered under Medicare for patients at some known risk for the disease (i.e., carcinoma of prostate, or personal history of neoplasm of prostate).

While many medical experts recommend that men age 50 and above undergo a PSA screening, it may not be covered by Medicare or by the patients private insurance.

In cases such as this, it is important for practice managers and coders to remember that they must represent the services that have been rendered and not adjust the codes just to get the claim paid, contends Stradley.

This is where I really get on my soapbox, she adds. One of the biggest problems we have in health care today is that people seem to have forgotten that some part of the bill is always the patients responsibility, she says.
Stradley recommends that internal medicine practices develop brochures that educate patients about their potential financial responsibility.

I usually recommend that they develop a simple brochure that states what services the practice provides when the patient has a medical problem, what services and tests they perform during an annual exam. It should be written in very simple terms what the patients financial responsibility might be, she adds. Sum it up with a statement that says, Some insurance companies pay for these services and some dont. However, we are committed to the letter of the law, which means we must represent our services exactly as they are rendered, which means that occasionally a service will not be covered by your insurance company and it will be your responsibility.

When instituting this policy, the brochures should be given to all patients for six months, and then given to every new patient after that, Stradley recommends.

Advance Notice to Medicare Beneficiaries

Of course with Medicare, practices dont have a choice. They must bill Medicare for all services rendered and are not allowed to bill the patient separately unless the patient has signed a waiver known as an advance beneficiary notice (ABN), adds Cianciolo.

If a Medicare patient is going to receive a service that the internist believes is not covered, he or she should get the patient to sign an ABN before undergoing the procedure. The waiver informs the patient that the service may not be covered and, by signing it, the patient agrees to pay the provider.

The ABN would be used when there is no indication that the test is medically necessary, she states.

There are four required components to a valid ABN, Cianciolo adds.

It must be in writing;

It must be obtained prior to the beneficiary receiving the test;

It must state that the provider believes Medicare will most likely deny payment;

It must include the patients signature and the date.

Justification for Tests Under Scrutiny

Both Cianciolo and Stradley predict that documentation of the medical necessity for laboratory and diagnostic tests will be the next big area of compliance scrutiny for medical practices.

My feeling is that its going to be the next hot topic for [Medicare] audits, says Stradley. They are going to be looking at preventive care services.

As Medicare increases its scrutiny of the medical justification for laboratory work and other diagnostic tests, other carriers will follow suit, experts predict.

Many large health plans may begin to take a hard look at contracts with physicians who are unable or unwilling to document the medical necessity, not only for the examinations they perform, but also for the tests and other ancillary services they order.

Internal medicine practices shouldnt panic. They should just make sure that they are accurately recording medical necessity. This will both ensure that the practice receives adequate reimbursement and that it stays out of trouble if the government looks at their billing records.

Codify
BY AAPC

Avoid Six Common Diagnosis Documentation Errors

When ordering lab or other ancillary tests, it is extremely important for the internist to document the reason for ordering the test so that a coder will assign the correct ICD-9-CM code, states **Kathryn L. Cianciolo, MA, RRA, CCS, CCS-P**, chair of the Society for Clinical Coding and an independent practice management consultant in Waukesha, WI.

This will often mean documenting a diagnosis of a sign, symptom or condition, rather than a concrete medical diagnosis.

Here are some common justifying reasons listed by internists when requisitioning ancillary tests that may present problems when coders attempt to assign the diagnosis code.

1. Use of the term rule out when listing the reason for the test. For example, some physicians may list rule out diabetes as the justifying reason for ordering blood glucose tests. If the coder uses the diabetes diagnosis code, that patient could end up labeled with a condition that he or she doesnt have, Cianciolo says.

2. Pre-op. Many internists will just use the term pre-op as the justification when requisitioning tests. The documentation for the test should indicate what surgery is being planned and whether the test is being done for a reason, Cianciolo continues.

3. Thyroid test. Does the patient have a current thyroid condition thats being monitored, or is there a symptom (i.e., fatigue) that is the real reason for performing the test? the consultant asks. If the test is being done as part of a routine exam for a person with a history of thyroid problems, it will be coded as a screening.

4. Rule-out urinary tract infection [R/O UTI]. Again, notes Cianciolo, this could result in the coder choosing the ICD-code for a UTI (599.0, urinary tract infection, site not specified). This code should not be used unless the test is positive. If the test is negative, a symptom such as dysuria (788.1), or urinary frequency (788.41) should be listed.

5. Testing for protime levels. Not all lab diagnosis coding errors occur as a result of documentation error on the part of the physician. Sometimes, it is just a lack of information available to the coder. Many internal medicine offices have a standard check-off list of ICD-9 codes that dont include the proper diagnosis codes for lab results, Cianciolo says.

For example, an abnormal protime level is often coded as 286.5 (hemorrhagic disorder due to circulating anticoagulants).

This is a specific medical condition that is often coded in error, notes Cianciolo. The correct code for an abnormal protime is 790.92.

Protime levels are normally checked in patients on the heart medication Coumadin.

If the protime level check uncovers an adverse reaction (i.e., hematuria) , then that should be coded followed by an E code for Coumadin, she adds. The correct codes would be 599.7 and E932.1

6. Miscellaneous. Finally, Cianciolo advises, physicians must remember that listing a surgical procedure or specific test ordered is not the same as listing the diagnosis or justifying medical reason for performing the test.

Also, the internist must document whether the patient is pregnant, as the ICD-9 codes for conditions are different when the patient is pregnant.

Codify
BY AAPC

Medicare Limited Coverage Tests

This is a list of diagnostic laboratory tests that are covered by Medicare only if a justifying medical reason is documented with a certain ICD-9 code.

Check with your local Medicare carrier for a list of diagnosis codes that will be accepted as justifying reasons for each test.

Alpha-fetoprotein
Aluminum
CA 125/CA 27.27 (Immunoassay for Tumor Antigen)
Carcinoembyronic Antigen (CEA)
Digoxin
Electron Microscopy
Ferritin
Flow Cytometry; Cell Cycle or DNA Analysis
Flow Cytometry; Each Cell Surface Marker
Folic Acid
Gammaglobulin; IgA, IgD, IgG, IgM, each
Glucose Testing, Blood
Glycated Protein/Glycated Hemoglobin
HIV-1, Quantification
Human Chorionic Gonadotropin (HCG)
Iron Studies (Iron, Iron Binding Capacity, Transferrin)
Lipid and Cholesterol Testing
Magnesium
Occult Blood, Feces
Pap Smear, Diagnostic
Pap Smear, Screening
Parathormone (Parathyroid Hormone)
Prostate Specific Antigen (PSA)
Prostatic Acid Phosphatase
Prothrombin Time (PT)
Rheumatoid Factor Testing
Sedimentation Rate
Syphilis Confirmatory Testing (FTA-abs and MHA-TP)
Syphilis Testing, Qualitative and Quantitative (RPR, VDRL, ART)
Thyroid Testing
Urine Cultures