Internal Medicine Coding Alert

How to Choose the Correct ICD-9 Codes For Diagnostic Tests and Lab Work

The previous issue of Internal Medicine Coding Alert covered how to correctly apply diagnosis codes for screening diagnostic tests and lab work (tests ordered as a preventive measure when the patient is not expected to be ill). Applying the correct ICD-9 codes for laboratory work is complicated, however, even when the test is prompted by a symptomatic patient and is not a screening.

Should you choose the ICD-9 code that indicates the signs or symptoms that prompted the test? Or should you wait for the test results and use the code that specifically states the patients condition?

And regardless of whether signs and symptoms or the final diagnosis is recorded, should the requesting physician or the laboratory coders assign the ICD-9 code?

It is difficult for coders to know what to do because there is conflicting information in writing, advises **Barbara J. Cobuzzi, CPC, MBA, CHBME,** president of Cash Flow Solutions Inc., a physician practice billing company in Lakewood, NJ. I know how I think it should be done, but I cannot find it definitively in writing anywhere.

Diagnosis Coding When Test Is Negative

Actually, assigning a diagnosis code when the test is ordered and comes back negative is not as controversial as when the test comes back positive for the suspected problem.

If it is a screening (and screening means there are no signs or symptoms or a chief complaint) and the test comes back negative, use a V code for a screening such as V76.44 (screening for prostate cancer). If the patient has signs and symptoms and the test is negative, I recommend coding the signs and symptoms, Cobuzzi says.

For example, a patient comes to the internist complaining of frequent severe thirst and episodes of weakness. The physician orders a complete metabolic panel to detect or rule out diabetes or kidney dysfunction. In the section for diagnostic information on the form sent to the lab, the physician lists the ICD-9 codes 783.5 (excessive thirst) and 780.79 (generalized weakness).

The Medicare Carriers Manual (MCM) section 4020.3, Item 23A, Diagnosis or Nature of Illness or Injury, states that Physicians must use the appropriate code or codes from 001.0 through V82.9 to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

The phrase reason for the encounter/visit seems to indicate that the physician should assign a diagnosis code that indicates the signs or symptoms that prompted the test or lab work.

The MCM continues: List first the ICD-9-CM code for the diagnosis, condition, problem or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions.

Physicians will be reporting up to four diagnosis codes, not narrative descriptors, on the billing form. In addition, they will indicate which diagnosis code relates to the service(s) reported. The physician must select among the four diagnosis codes to be reported that best describe the reason for the encounter, as discussed above. At times there may be several conditions that equally led to the encounter. In these cases the physician is free to select one to be listed first.

Even if the test is negative for diabetes or kidney dysfunction, the ICD-9 codes for the symptoms indicate the reason for the tests.

Tip: This information from the Medicare Carriers Manual Part 3 can be found on the Health Care Financing Administration Web site by pointing your browser to http://www.hcfa.gov/pubforms/14_car/3b4010.htm#_1_10.

However, coders should note that code 780.79 (generalized weakness) is listed in ICD-9 as a nonspecific code. Some payers may deny payment for lab tests submitted with nonspecific codes.

And many payers, most notably Medicare carriers, have specific lists of covered diagnoses for each laboratory or diagnostic test and procedure. The procedure or test is covered only if one of the diagnosis codes on the list is used.

If the codes for the signs or symptoms do not get the claim paid in this instance, there is generally nothing else for the coder to do. The symptoms were the reason for the tests, but no disease was found. If payment is denied, the physician can appeal and resubmit with documentation of the visit.

But, what if the tests had come back positive for diabetes, i.e., 250.00 (diabetes mellitus type II adult onset)? Should the ICD-9 used on the claim be the final diagnosis (more specific) or the presenting signs and symptoms (reason the test was performed)?

Coding When Final Diagnosis Is More Specific

Using the code that indicates the final diagnosis when it is a more specific illness is the choice most coders make. If the test gives a more specific result, I would recommend using that, Cobuzzi advises. However, many people disagree with that.

In contrast to the above citations from the carriers manual, other sections of the manual seem to support using the final diagnosis when applicable.

The section also lists this example for coders to follow: A pediatric patient presents with blood in the urine (hematuria) and high blood pressure. The physician makes a diagnosis of acute glomerulonephritis. There is a three-digit code for the category acute glomerulonephritis (580), but it is further subdivided into fourth and fifth digits. A claim with the diagnosis code 580 will not be accepted because more specificity is available and must be provided. For example, 580.0 is the code for acute poststreptococcal glomerulonephritis. If, as often is the case with initial visits, it is not certain whether the condition is poststreptococcal or associated with specified pathological lesion, then code 580.9 (acute glomerulonephritis with unspecified pathological lesion in kidney) would be appropriate.

This seems to indicate that more information than
the presenting signs and symptoms should be used if it is available.

In addition, Cobuzzi notes, the manual then states, Do not code diagnoses documented as probable, suspected, questionable or rule out as if they are 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 reasons for the test.

**Who Assigns Diagnosis Codes
for Laboratory Tests?**

For the most specific ICD-9 codes to be applied, many physicians just write a phrase indicating the reason for the lab test and allow the laboratory to apply the ICD-9 codes before the claim is sent to the payer. Many experts believe this may be incorrect, however, and the physician should assign the ICD-9 code.

In 1997, the Balanced Budget Amendment amended the Social Security Act by adding the following paragraph: The physician or practitioner will be required to provide the diagnostic information to the entity at the time the service is ordered by the physician or practitioner, says **Jeri Leong, RN, CPC,** an independent coding consultant in Honolulu, HI.

Although some physicians still interpret the phrase diagnostic information as permitting just a phrase instead of the code, Leong believes that is not the intent.

From the Medicare Part B manual, from the Blue Cross Blue Shield of North Dakota, it says that claims for clinical laboratory and pathology services performed by a physician must include a valid ICD-9 code for the service. And ICD-9 codes must be listed at the highest level of specificity, she adds.

Those guidelines would indicate that the physician should assign the codes but that the most specific code available can and should be used.