Internal Medicine Coding Alert

ICD-9 Coding A Screening Is a Screening Is a Screening

Many coders are unsure what to do when a screening test turns up a problem in a patient who had no signs or symptoms of the disease. Should the test still be coded as a screening, which Medicare and private payers often don't reimburse, or should it be coded with a diagnosis reflecting the problem found? The answer, spelled out in a recent CMS transmittal, is simple: For ICD-9 coding, a test that begins as a screening is forever a screening.

Some coders think it's OK to code the positive results instead of the original screening code because many payers will not cover screenings, says **Sharon O'Leary, CPC,** coding coordinator at Physician Associates of Florida and president of the Greater Orlando AAPC chapter. But "it goes against our code of ethics to change the diagnosis after the fact," she stresses.

Two scenarios illustrate correct coding for screenings:

Scenario 1: A 65-year-old patient with no previous heart problems is sent by the internist to a cardiologist in the practice for an EKG as part of a preoperative screening for upcoming major surgery. The EKG turns up evidence of atrial fibrillation.

Many coders mistakenly believe they can code the finding instead of the reason for the test in that scenario, says **Carol Sissom, CPC,** a senior healthcare consultant at the Indianapolis-based Health Care Economics Inc.

However, CMS Transmittal AB-01-144, which took effect January 2002, says in Section E that when a test is performed in the absence of signs and symptoms, "the physician interpreting the diagnostic test should report the reason for the test (e.g., screening) as the primary diagnosis. The results of the test, if reported, may be recorded as additional diagnoses."

Note: See the transmittal on the World Wide Web at CMS Regulations and Guidance Transmittals ab01144.pdf.

In the case above, code the EKG as 93000 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report). The primary diagnosis code is V72.81 (Preoperative cardiovascular examination). Use the problem that was found 427.31 (Atrial fibrillation) as a secondary diagnosis.

But if the patient had mentioned an occasional fast heartbeat, with no other symptoms, to the physician, the test would be diagnostic rather than screening, and the diagnosis code would be 785.0 (Tachycardia, unspecified), Sissom says.

Scenario 2: A patient takes home a colorectal cancer screening kit to test for blood in the stool. She has no signs or symptoms of colon cancer. When the fecal-occult blood test is returned, blood is found. Even though the results are positive, the test is still coded as a screening, says **Mary Beth Black, CPC,** a senior associate at Medical Management Associates Inc. in Atlanta. Use HCPCS code G0107 (Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations) for Medicare patients or 82270 (Blood, occult, by peroxidase activity [e.g., guaiac] qualitative; feces, 1-3 simultaneous determinations) for private payers. The diagnosis code is V76.50 (Special screening for malignant neoplasms; intestine, unspecified) for both public and private payers.

It remains a screening because "that's the reason you did the test," Black says. As in the above case, the positive result can be coded as a second diagnosis: 792.1 (Nonspecific abnormal findings in other body substances; stool contents).