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Optometry Coding & Billing Alert

Compliant Coding: FAQs About Foreign-Body Sensation - Complain When Tests Yield Negative Results

When a patient comes in with a complaint but the suspected diagnosis comes out negative, what should you do?

Optometry coders are constantly facing the diagnosis coding dilemma of a patient presenting with symptoms of a condition that the test results confirm he doesn't have. And patients who present with foreign-body sensation are often at the source of the diagnosis coding quandary. Check out these answers to your most frequently asked questions about coding foreign-body sensation for appropriate reimbursement.

Question: What is proper diagnosis coding for a patient who presents with a foreign-body sensation and an exam shows no sign of a foreign body or irritating substance?

Answer: Diagnosis coding is one of the few activities in which a complaint will get you somewhere.
Although many physicians feel the need to provide a definitive diagnosis when submitting a claim, there are many circumstances when the symptom the patient presented with is the only thing they can find.

Proper diagnosis coding requires you to report the reason patients come in the door, not necessarily what you find when they get there, says **Susan Callaway, CPC, CCS-P**, an independent coding consultant in North Augusta, S.C. "The patient's perception of the problem is a perfectly valid reason for performing an exam, and the fact that you examine them and find nothing doesn't mean that the suspected diagnosis isn't what the ophthalmologist was looking for and trying to treat."

You need to give the patient's chart a thorough once-over, because you may discover that the patient has dry-eye syndrome, for example, a possible cause of foreign-body sensation, says **Nina Bagley, CPC**, coding specialist in Fayetteville, N.C. In this case, you would use a diagnosis code for dry-eye syndrome, she adds.

If it is a foreign-body complaint, chances are the patient is in some kind of pain, and if the pain cannot be attributed to something specific - an eyelash, for example, 374.05 (Trichiasis without entropion) - you can use an unspecified eye-pain code (379.91, Pain in or around eye), Bagley says. These unspecified diagnosis codes include 379.91 For example, if the foreign-body sensation resulted in inflammation, you could use 918.1 for corneal abrasion or 918.2 for conjunctival abrasion.

Question: Will we still get paid for an exam that does not confirm a condition?

Answer: Carriers won't give you much trouble if you code carefully when if comes to getting paid for an exam that doesn't yield a definitive diagnosis. Try to give the most specific diagnosis possible when billing private payers to avoid any claim delays or denials, Bagley says. But how do you know if the diagnosis code you chose is to the highest degree of specificity?

According to CMS, there has been some confusion defining ICD-9 codes that are to the "highest degree of specificity." In part, this confusion stems from the fact that diagnosis codes can be composed of three, four or five digits, depending on your physician's documentation. CMS advocates using the following guidelines to assign diagnosis codes that most fully explain the narrative description of the symptom when diagnosis coding: Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided to provide greater specificity.

Assign three-digit codes only if there are no four-digit codes within that code category. Assign four-digit codes only if there is no fifth-digit subclassification for that category. Assign the fifth-digit subclassification code for those categories

where it exists.

One thing you should not do, Callaway says, is indicate on the claim that it was a "normal exam" just because the physician didn't find anything - you won't get paid without battling with the insurance company and sending in medical records to prove the patient had a medical complaint. And never code what the physician thinks or suspects the problem is, because this is not proper diagnosis coding, she says.

Question: How does Medicare handle claims for services linked just to signs and symptoms?

Answer: You are more likely to be reimbursed by Medicare as well as many third-party payers when you list symptoms or complaints as primary diagnosis codes for an evaluation. A definitive diagnosis gives the carrier a reason to say, "No, we don't cover that service for that diagnosis," Callaway says.

According to CMS Program Memorandum AB-01-144, Medicare has taken the following stance on assigning diagnosis codes for diagnostic services:

If the physician has confirmed a diagnosis based on the results of the diagnostic test, the physician interpreting the test should code that diagnosis. You may report the signs and/or symptoms that prompted the physician to order the test if they are not fully explained by or related to the confirmed diagnosis.

If the diagnostic test did not provide a diagnosis or was normal, the interpreting physician should code the sign(s) or symptom(s) that prompted the treating physician to order the study.

If the results of the diagnostic test are normal or nondiagnostic, and the referring physician records a diagnosis preceded by words that indicate uncertainty (for example, "probable," "suspected," "questionable," "rule out" or "working"), the interpreting physician should not code the referring diagnosis. Rather, the interpreting physician should report the sign(s) or symptom(s) that prompted the study. Diagnoses that the ICD-9-CM labels as uncertain are considered unconfirmed and should not be reported. This is consistent with the requirement to code the diagnosis to the highest degree of certainty.

And unless you use V72.0 (Routine eye exam), Medicare will consider reimbursing for the service.