

Part B Insider (Multispecialty) Coding Alert

CARDIOLOGY: Turn Inconclusive Test Findings Into Conclusive Reimbursement With This Tip

Helpful: Cover your bases and have patients sign an ABN

If you receive documentation that reveals inconclusive test results, there are steps you can take to get to the proper diagnosis. Here's what you should - and should not - do when you don't have all of the information you need.

Coding problem: For an inconclusive diagnostic test, you shouldn't report a diagnosis that the laboratory gives you after a pathology test, says consultant **Maxine Lewis** with **Medical Coding Reimbursement Management** in Cincinnati. But many practices are tempted to report the lab's diagnosis because you may be more likely to get paid if you use it.

You also shouldn't report the presumed diagnosis that is the reason for the test, such as a -rule-out- diagnosis, says experienced coder **Carrie Caldewey, CPC**, coding supervisor for **Northern California Medical Associates** in Santa Rosa, CA.

Correct coding solution: Code the signs and/or symptoms that the patient has, says **Linda Parks**, an independent coding consultant in Marietta, GA. If you code them completely and carefully, you should get paid.

Example: A patient presents with complaints of chest pain and presumptive angina. The cardiologist performs a cardiac workup, which turns out negative. Further determination reveals that the patient has only gastroesophageal reflux - a diagnosis that alone doesn't medically justify the cardiac tests.

Do this: You should report 786.50 (Chest pain, unspecified) for the cardiac workup, not 530.81 (Gastroesophageal reflux). When a patient has multiple symptoms, some may be covered for certain tests, while others are not, Parks says.

Tip: For Medicare, you can check your carrier's local coverage determination (LCD) to find out which symptoms and diagnoses are covered for each diagnostic test, Lewis says.

Keep in mind: Medicare will allow you to report more than one ICD-9 code, so if the patient has more than one sign and/or symptom that led to the order for the imaging test, you may report all appropriate diagnosis codes.

Payment strategy: Consider asking the patient to sign an advance beneficiary notification (ABN) for the test, Parks says. But only use an ABN when you have a reasonable expectation that your carrier will deny payment. Explain to the patient that Medicare may not pay for the test and that the patient may be financially liable if Medicare denies the claim. If your payor does deny claims for interpreting results, you should appeal and try to figure out your insurer's guidelines for tests, Lewis says.