Codify BY AAPC

# Part B Insider (Multispecialty) Coding Alert

## Diagnosis Codes: Providing ICD-9s for Lab Claims Just Became Your Job, CMS Says 'No' to Suspected Diagnoses

When you order labs, you don't always know what diagnosis the patient will end up having. But that doesn't mean you shouldn't make sure labs use the correct diagnosis when they file claims for their services.

In a duo of mid-June program memos (B-03-045 and B-03-046) the **Centers for Medicare & Medicaid Services** makes it clear it expects physicians to take a more active role in making sure labs and suppliers bill with correct - and complete - diagnosis codes on claims after Oct. 1.

CMS notes that the Balanced Budget Act requires physicians to provide diagnostic information to laboratories or other Part B suppliers and practitioners at the time the physicians order a service. A lab or other provider has to report whichever diagnostic codes it gets from a physician on the claims it files.

If a physician doesn't give a code to a lab or other provider, the other provider should come up with an ICD-9 code that reflects the narrative diagnosis the physician supplied, CMS explains. And CMS insists that all providers must use the four- or five-digit ICD-9-CM codes instead of less specific codes wherever possible.

But if the lab or other provider doesn't have enough diagnostic info to support a detailed ICD-9-CM code, it can't bill.

In other words, you can expect to receive tons of phone calls from panicky lab billers seeking more diagnostic info starting in October.

***CPT® 2023 American Medical Association. All rights reserved.***