Part B Insider (Multispecialty) Coding Alert

Diagnosis Coding Quiz: Are Your Dx Coding Skills Up to Snuff? Take This Quick Quiz to Find Out

Hint: Coders shouldn't be interpreting test results to get quick diagnosis codes.

As your practice continues to prepare for the ICD-10 transition, it's important to still remain up-to-date on the ICD-9 coding rules, which remain in effect until Oct. 1, 2013. Read the following diagnosis coding questions submitted by our readers and check out our expert answers below.

Leave Diagnosing Patients to the Doctor

Question 1: If the physician hasn't indicated ECG results in his final diagnosis, should I code the findings? The doctor wrote a complete interpretation on the strip. He says "yes," because usually he has another diagnosis to justify the ECG.

Answer 1: The bottom line is if the test is positive, you should report the findings from the electrocardiogram (ECG) as the final diagnosis. If the test is negative, you should report the indications. For you to report positive findings from the ECG, the physician must document the findings as a final diagnosis. Choosing a diagnosis based on the patient's test results -- even when that diagnosis seems obvious-- is inappropriate and possibly fraudulent coding. CMS describes its guidelines for this issue in Transmittal AB-01-144 (Sept. 26, 2001) in which the agency states that a physician must confirm a diagnosis based on the test results.

This CMS transmittal goes on to say that if the test results are normal or nondiagnostic, you should code the signs or symptoms that prompted the test -- in other words, the indications. Similarly, the ICD-9 coding guidelines for diagnostic testing instruct you not to "interpret" what a study says, but rather to rely on the physician's stated diagnosis. If the ECG findings seem like an important component of the case -- and may play a role in substantiating the medical necessity for the visit-- you should query the physician regarding the diagnosis.

Heads up: Choose the CPT ECG code based on how much of the ECG service the physician's office provided. If the physician's office provided the entire service (both technical and professional components), assign 93000 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report).

Code the technical component only as 93005 (... tracing only, withoutinterpretation and report). If the physician provided only the professional component, use 93010 (... interpretation and report only).

Don't Let Diabetes Dx Trip Up Your Claims

Question 2: Our physician treated a patient with diabetes, but he was actually seeing the patient to treat a complication of the diabetes, diabetic neuropathy. During his evaluation, the physician also noted that the patient had joint inflammation. Should we report the neuropathy complication only, or several of the ICD-9 codes?

Answer 2: Normally, the primary diagnosis code that you list on your claim should represent the main reason for the encounter, or the condition with the highest risk of morbidity/mortality that the physician addresses during the visit. The situation changes, however, when you deal with a condition like diabetes.

According to Section 1.A.6 of the ICD-9-CM Official Guidelines for Coding and Reporting, "Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-9-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation."

The Guidelines continue, explaining that you may report more than one code from category 250 to "fully describe the patient's complete diabetic condition" if the patient has "more than one manifestation of diabetes."

Therefore, you should first report 250.6x (Diabetes with neurological manifestations) on the claim. Remember to add a fifth digit to reflect the type of diabetes the patient has.

Your secondary code should represent the specific neurological manifestation. In most cases, you will report 357.2 (Polyneuropathy in diabetes).Because the neurologist documented that the patient also has joint inflammation, you should report the appropriate code describing that condition (716.9x, Arthropathy, unspecified).

Although the insurer's computer will scan only the first, main diagnosis code that you list, you should list all of the codes that apply. That way, if the payer challenges a claim, you can help your appeal by having already sent the insurer all the patient's applicable diagnoses on record.

Nail Down Signs/Symptoms Rules

Question 3: A new patient reported to our office complaining of wheezing and shortness of breath. The physician performed a level-four E/M, and then ordered a spirometry with graphic record (we own the equipment, and the test was performed and interpreted in-house). Encounter notes describe "likely" emphysema, though the spirometry would not be expected to confirm it. How should I handle the diagnosis coding here? Should I wait for a definitive diagnosis before coding this claim?

Answer 3: Just because the encounter resulted in an inconclusive diagnosis, that does not mean you cannot report -- and be paid for -- the physician's services. Just make sure the documentation supports the patient's presenting symptoms.

ICD-9-CM coding guidelines (Section I.B.6. and Section IV.E) state, "Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not beenestablished (confirmed) by the provider."

Translation: If the doctor does not confirm emphysema, do not consider reporting any emphysema diagnoses. If the patient comes back for further testing that does reveal emphysema, then you can report an emphysema diagnosis. Instead, you'll probably look to 786.05 (Shortness of breath) and 786.07 (Wheezing).