Part B Insider (Multispecialty) Coding Alert

ICD-10: CMS Updates ICD-10 Instructions

New advice more accurately mirrors the current ICD-9 regulations.

Although ICD-10 won't be taking effect this October as originally planned, that doesn't mean CMS has stopped preparing for the new diagnosis coding system. In fact, the agency released a transmittal last week that should help you clarify some of the rules surrounding how you'll report these codes when insurers start requiring them next year.

CMS issued Transmittal 3020 on Aug. 8, and it announces revisions to the official ICD-10 Coding Guidelines which put them more in line with the current ICD-9 rules. For example, CMS revised the ICD-10 regs to now say, "Do not code diagnoses documented as 'probable,' 'suspected,' 'questionable,' 'rule out,' or 'working diagnosis' or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit."

Here's why: You should always code the final diagnosis or results of the test if available rather than the symptom that led to the performance of the test. However, signs and symptoms are acceptable coding to support the tests when there is not a definitive diagnosis at the time of the encounter.

This new ICD-10 guideline mirrors the ICD-9-CM Official Guidelines for Coding and Reporting, Section I.B.6: "Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider."

Do this: Review guidelines for how to code when the diagnosis isn't definite. In 2005, Coding Clinic for ICD-9-CM (vol. 22, no. 3) stated that "consistent with," "compatible with," "indicative of," "suggestive of," and "comparable with" also indicate probable or suspected conditions (which you should not code as confirmed).

ICD-10 update: Because you must report the full diagnosis code (up to seven digits/characters under ICD-10) that represents the chief reason for the patient's visit, you should report the symptoms if no confirmed diagnosis is found. If, however, the patient arrives at your office with no referring diagnosis or complaint, you can report a more general code such as the following, the CMS Transmittal advises:

- Z00.00: Encounter for general adult medical examination without abnormal findings
- Z01.10: Encounter for examination of ears and hearing without abnormal findings

You'll also report the diagnoses that coexisted at the time of the visit, such as diabetes or hypertension.

Resource: To read CMS Transmittal 3020 in its entirety, visit www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3020CP.pdf.