Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

ICD-9 Coding: Think 'Likely' Diagnosis Trumps Symptoms? Think Again

Look for these phrases in your physician's documentation.

Typically, your first-listed ICD-9 code is your physician's primary diagnosis. However, if your doctor performs a diagnostic test but offers no confirmed diagnosis, you may need to report the patient's signs and symptoms instead.

Balance these factors by confronting four frequent coding issues. Payoff: You'll avoid applying a definitive diagnosis prematurely, which can have long-standing consequences for a patient and the patient's insurance.

What Do Signs and Symptoms Entail?

Careful: When it comes to patient testing, a diagnosis code to support the necessity of a test must represent the documented reason why the patient has been sent for the test, says **Marianne Wink, RHIT, CPC, ACS-EM,** from the **University of Rochester Medical Center Department of Neurology Coding Office** in Rochester, N.Y. "If there is not a diagnosis that is documented by the physician, codes for documented signs and symptoms of a condition must be assigned."

ICD-9 defines sign and symptoms as the following:

• cases for which the physician can make no more specific diagnosis even after he has investigated all the facts bearing on the case

• signs or symptoms existing at the time of the initial encounter that proved to be transient and whose causes could not be determined

• provisional diagnoses in a patient who failed to return for further investigation or care

• cases referred elsewhere for investigation or treatment before the physician could make a diagnosis

• cases in which a more precise diagnosis was not available for any other reason

• certain symptoms that represent important problems in medical care and that the physician might wish to classify in addition to a known cause.

A Dx After a Procedure Is Not Always Possible

You won't necessarily always report a definitive diagnosis after a procedure or test. You should report a diagnosis when your physician has performed a procedure and the results confirm it. In other words, "you should never assign a diagnosis until its definitive," says **Doris Ward, CPC,** coder/biller at **KY Surgery Center** in Lexington, Ky.

Example: Your physician conducts an EEG and confirms a diagnosis of myoclonic epilepsy. In this case, you should report 345.10 (Generalized convulsive epilepsy; without mention of intractable epilepsy) as the primary diagnosis.

However, if your physician performs a procedure and the evidence is inconclusive or negative, you should fall back on reporting the patient's documented signs and symptoms.

Example: Your physician conducts a test, but he documents that the results are inconclusive for Parkinson's disease. In this case, you should rely only on the signs and symptoms to establish medical necessity for the diagnostic study your physician performs.

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"Diagnosis code reporting must match what the provider has documented as the reason for the encounter" says Wink. "The narrative should support the codes and visa versa."

'Rule Out' A Thing of the Past

You should never report "rule out" diagnoses in the outpatient setting. The Official ICD-9 Guidelines have allowances for facilities potentially to report rule outs, but an outpatient neurological practice should not. Rule out codes were themselves "ruled out" years ago.

Resource: The "ICD-9-CM Official Guidelines for Coding and Reporting" further clarify "rule out" diagnoses (http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf).

Watch out: The following phrases in your physician's documentation can could indicate that the physician has not formally diagnosed the patient with the condition or disease:

• probable

• R/O

• suspected

• likely

• questionable

• possible

• still to be determined.

"Outpatient coding rules state only a confirmed diagnosis should be used," Wink says. "In lieu of no confirmed problem in the outpatient place of service, the signs and symptoms under investigation must be coded to support the medical necessity for a diagnostic test."

Official rule: ICD-9 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 been established [confirmed] by the provider."

By taking this approach, you avoid labeling a patient with an unconfirmed diagnosis while still allowing for your doctor's reimbursement for services rendered -- even if he cannot establish a definitive diagnosis through testing.

Your physician's documentation should be strong enough to support the claim with the signs-and-symptoms diagnoses alone, regardless of the outcomes of any diagnostic testing.

Use Symptoms as Additional Dx on Occasion

Occasionally, you'll report sign and symptoms as secondary diagnoses, even if your physician has assigned a definitive diagnosis for a patient encounter.

You can report "signs and/or symptoms as additional diagnoses if they are not fully explained or related to the confirmed diagnosis," according to CMS transmittal AB-01-144.

Similarly, you may report signs and symptoms that are not related to the primary diagnosis but affect your doctor's medical decision making or otherwise determine how he formulates a patient's treatment.

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