Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Diagnostic Test Came Back Normal? Look to Signs, Symptoms

Heed 3 quick rules to code these testing results.

You think you may have mastered most ICD-9 challenges, but do you know how to deal with a diagnostic test that comes back sans a definitive diagnosis? When you make sure to convey to payers exactly what you found, you'll overcome these challenges. Here are sure-fire ways how to do that.

Follow 3 Rules for Normal Diagnostics Results

Scenario 1: The gastroenterologist refers a patient to a radiologist for an abdominal CT scan (74150-74170) with a symptom of abdominal pain (789.0). The CT scan, when interpreted by the GI, reveals the presence of an abscess. Both the radiologist -- when reporting for the technical component of the CT scan, and the gastroenterologist -- when reporting for the professional component of the same test, should report a diagnosis of "intra-abdominal abscess" (567.22, Peritoneal abscess).

Challenge: What should you do if the diagnostics came out normal?

Beware of three alternative rules:

Rule 1: If the diagnostic test did not provide a definitive diagnosis or came out normal results, you should code the sign and symptom that prompted the treating physician to order the study. Say, in the previous scenario, the CT scan results came back without any abnormal findings, then you would report the symptom 789.0 (Abdominal pain) instead of 567.22.

Rule 2: If the diagnostic test was normal, but the referring physician records a suspected (a.k.a. probable, suspected, questionable, rule out, or working) diagnosis, you should not code the referring diagnosis. Instead, you should report the presenting signs and symptoms. The ICD-9-CM guidelines warn, "The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for ordering the test." For instance, suppose the physician's notes indicated "suspected blockage of a bile duct by gallstones," but the CT scan came out normal. Again, you would report the symptom (789.0) rather than the suspected condition (i.e., 560.31, Gallstone ileus) as the reason for the test.

Rule 3: If the patient is receiving only diagnostic services during the outpatient visit, you would list first the condition that is the main reason for the visit on the claim. This code should be your primary diagnosis. Then, code for other diagnoses (such as chronic conditions) on the following lines. For example, say a patient with chronic gastritis went for the CT scan, and test results revealed the presence of peritoneal abscess. On your claim you should list 567.22 as your primary diagnosis; 535.10 (Atrophic gastritis [without hemorrhage]) as your secondary diagnosis.

Remember: "Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification," states the 2010 ICD-9-CM Official Guidelines for Coding and Reporting (www.cdc.gov/nchs/data/icd9/icdguide10.pdf). "Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present," the paper adds.

Tackle This Chronic Condition Scenario

Scenario 2: A patient already diagnosed with liver cancer visited the gastroenterologist for esophageal varices. On the

first line of your claim, you would list 456.1 (Esophageal varices without bleeding) for the presenting problem (varices), and then report 155.0 (Malignant neoplasm of liver primary) for the chronic disease (hepatocellular carcinoma).

Challenge: Should you report the chronic condition?

Do not code the chronic condition if it is unrelated to the primary reason for the visit. For instance, the liver cancer patient in Example 2 presents with dyspepsia, code only 536.8 (Dyspepsia and other specified disorders of function of stomach), and not 155.0.

Don't Overlook V Codes For Preop Exams

Scenario 3: If a patient who is scheduled for a gall bladder surgery presents for a pre-op evaluation. The GI lists the condition prompting the surgery as acute cholecystitis (575.0) and the underlying medical condition as diabetes (250.xx).

Challenge: Should you report the screening code?

Sometimes, a physician would order a diagnostic test in the absence of signs and symptoms, or perform a preop evaluation for the patient. If the chief reason for the encounter is a preop evaluation, list first a code from category V72.8 (Other specified examinations) to describe the preop evaluation. Then, assign a code for the condition prompting the surgery as an additional diagnosis (in this case, 575.0). Any condition discovered during the screening should be reported as additional diagnosis (i.e., 250.xx in the scenario given).

V codes take the spotlight, too, when a patient has no signs or symptoms and the gastroenterologist performs a test solely for screening purposes. In this case, you should disregard typical diagnosis codes and locate an applicable "V" code to describe the test to the payer.

Be careful with the V codes, however. Many payers will not pay for claims with only a V code as a diagnosis, with the exception of physicals or covered preventative health services, and, even then, they will only pay for one adult physical a year.

Other technicalities: List the screening code first if the reason for the visit is specifically the screening exam. Report the screening code as an additional code, however, if the physician performs the screening during an office visit for other health problems. Additionally, if the screening returns an abnormal result, then code those results as an additional diagnosis.