Part B Insider (Multispecialty) Coding Alert

PART B MYTH BUSTER: No Diagnosis? No Problem. Code Signs And Symptoms--And Get Paid

Don't make up your own extra digit for incomplete ICD-9 codes

Myth: You should expect denials if you report signs and symptoms as primary diagnoses.

Reality: In the absence of a confirmed diagnosis, you should report signs and symptoms--and you should expect to get paid.

When your physician confirms a diagnosis, you have to use that ICD-9 code, according to program memorandum AB-01-144 from 2002. But when your physician doesn't specify a diagnosis, you should report the patient's signs and symptoms, coding experts say.

ICD-9 coding rules state that you can't use a -rule-out- diagnosis on claims, says **Kim Garner Huey**, a consultant with **KGG Coding and Reimbursement Consulting** in Auburn, AL. You should code signs and symptoms--but only if there's no definitive diagnosis.

Example: An oncologist examines the patient for suspected stomach cancer (151.x, Malignant neoplasm of stomach). Your oncologist documents -Rule out stomach cancer- in the medical chart. You can assign other symptoms, such as -blood in stool- (578.1) and -abdominal pain- (789.0x), if documented, to describe the patient's symptoms in the absence of a stomach-cancer diagnosis.

You could also code signs and symptoms if your doctor orders a test and it comes up negative, notes **Rhonda Gudell** with **Lakefront Billing Service** in Milwaukee, WI. For example, a patient turns up with a productive cough and fatigue. The physician orders a chest X-ray to rule out pneumonia, but the X-ray comes up clear. So you use the cough as the diagnosis.

If your doctor provides you with an ICD-9 code that is missing a fourth or fifth digit, **don't** try to -invent- your own extra digit, experts caution. Instead, you should query your doctor for the extra digit, Garner Huey says. Failing that, you can try using an -unspecified- code.

-Don't waste your time submitting the incomplete code the doctor used,- Garner Huey adds. -It will probably not even pass your billing software edits and would just be denied by Medicare even if it did.-

-I would never submit a -guessed- missing digit,- says Gudell.

Some payors don't like unspecified codes (which end in .9). But if your physician can't confirm a definitive diagnosis, these may be your best option, notes **Christina Neighbors,** charge capture reconciliation specialist and coder with **St. Joseph Heart & Vascular** Center in Tacoma, WA.

If the physician provides different pre-operative and post-operative diagnosis codes during a procedure, always use the post-operative diagnosis codes, Neighbors advises.