Part B Insider (Multispecialty) Coding Alert

Reader Questions: Base Dx Code on Reason for Test

Question: A patient comes into the emergency room for a fall from a ladder, and the ER docs order a CT of the head and cervical spine. The radiologist notes no acute findings except for some degeneration in the spine. Is it OK to code the degeneration even though it wasn't really the reason the person had the scan and wasn't related to the reason the test was ordered?

Answer: You should report the reason for the exam rather than an incidental finding as your first-listed diagnosis. For example, if the ordering doctor notes swelling on the head and neck, you could report 784.2 (Swelling, mass, or lump in head and neck) and E881.0 (Fall from ladder).

ICD-9 official guidelines (section IV.H) state, "List first ICD-9 for encounter/visit shown in the medical record to be chiefly responsible for the services provided." You may list additional codes describing coexisting conditions, the guidelines say.

"In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician," the guidelines state.

The guidelines are available online at www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm.