Part B Insider (Multispecialty) Coding Alert

TESTS: If The Test Comes Up Negative, You Must Bill Symptoms

Don't saddle your patients with a wrong diagnosis forever

When your physician orders a test for a suspected diagnosis, and it comes back negative, what diagnosis can you use to bill for the test and interpretation? This question has been a source of confusion for many coders for years, say experts. Here's some clarification.

Example: The physician believes a patient has a renal cyst, based on a physical examination and review of systems. The doctor even palpates what appears to be a cyst. But when the doctor sends the patient to your physician for a renal Doppler test, the test comes back normal. Can you bill for the test under the diagnosis code for a renal cyst?

Potential misstep: Some coding sources encourage you to go ahead and use the renal cyst diagnosis because the referring doctor believed there was a cyst when she ordered the test. Maybe the patient actually had a cyst, but it resolved itself, they argue.

Warning: You should **never** code a diagnosis that the patient didn't actually have, say experts. Even if the ordering doctor had listed a suspected diagnosis, you should never list a definitive diagnosis unless the test results confirm it. If the test comes up negative, you should bill based on the patient's symptoms.

Answer: In the case of the renal cyst, you would code pelvic pain, depending on the cyst's exact location, says **Maggie Mac**, a healthcare consultant in Clearwater, FL. Look in the 780.xx section of the ICD-9 book for an appropriate symptom code, she advises. If the referring doctor had already made a definitive diagnosis of a cyst, why would she be ordering the test? Mac asks.

Another way: If the physician actually palpated something that felt like a renal cyst, you could bill using the diagnosis of mass, or -abnormal findings on exam,- says **Linda Parks**, an independent coding consultant in Marietta, GA.

This problem sometimes comes up with fecal occult blood tests (FOBTs), where a physician will decide a patient has colorectal cancer, but the test will come up negative, notes Mac.

The pitfall: If you give a definitive diagnosis to the patient, it will go into his medical record until the end of time, Mac warns. Even if your patient never actually had a particular condition, the medical record will say that he did, and it may make it harder for the patient to get health coverage in the future. -I-ve seen that happen,- says Mac.

Physicians used to have a -rule-out- diagnosis, notes Parks. This would explain why they were ordering a particular test to eliminate a particular diagnosis. But too many physicians abused this loophole by billing for too many diagnoses that their patients didn't have, and so the payors closed this loophole, says Parks.

If the test does come up with a definitive diagnosis, you can go ahead and bill for the test using that diagnosis, Mac says. Other experts, however, argue that you should still bill using the symptoms that led to the test, since the symptoms explain the medical necessity for ordering the test in the first place (see PBI, Vol. 7, No. 12).