Eli's Rehab Report

CMS Clarifies Reporting of Diagnostic Test Results

CMS Program Memorandum AB-01-144 (effective Jan. 1, 2002) offers physicians much-needed direction on when to use signs or symptoms as the reason for ordering a test, as well as when to use the test results as the diagnosis. Carrier restrictions and ambiguity left many PM&R coders confused over whether to use the patients symptoms as the reporting diagnosis for tests such as electromyography (EMG) (95860-95872) or nerve conduction studies (95900-95904).

Sylvia Albert, CPC, customer support manager at AcSel Billing Corp., a medical billing and reimbursement firm in Virginia Beach, Va., says the new guidelines are intended specifically for outpatient facilities and physician offices and make it user-friendly for the physician and coders to know when to code the signs and symptoms versus the test results.

Billing Tips

The following tips will help PM&R coders with claims for diagnostic testing based on the new program memorandum.

Do not code the signs and symptoms if a confirmed diagnosis is known. If the physician has confirmed a diagnosis based on test results, the physician interpreting the test should code that diagnosis, Albert says. The confirmed diagnosis should be listed as primary, and the signs and/or symptoms that prompted ordering the test reported as additional diagnoses if they are not fully explained or related to the confirmed one.

For instance, a primary care physician refers to the physiatrist a patient who he or she suspects has arthritis, based on complaints of stiffness in joints (719.50-719.59) or limb pain (729.5). The physiatrist requests an EMG and finds that the patient has carpal tunnel syndrome (354.0). The practice would code carpal tunnel syndrome, rather than the joint stiffness or limb pain, as the reason for ordering the EMG.

We often see primary care physicians who refer for certain symptoms and have their own suspected diagnosis written on the referral, but the test ends up producing a completely different diagnosis, says **Kimberly Ritter,** billing coordinator for Ambrose Physical Medicine, a one-physiatrist practice in Little Rock, Ark. Our physiatrist sometimes cannot even find the symptoms that the primary care physician found. The other doctor might report range-of-motion limitations, and then when we see the patient, they move normally. In those cases, we do not list the referring physicians suspected diagnosis or symptoms, since we havent been able to reproduce them in our office.

Code signs and symptoms if test results are unknown or return normal. If the diagnostic test did not provide a diagnosis or was normal, the interpreting physician should code the signs or symptoms that prompted the treating physician to order the test, Albert says.

For instance, if the patient presented with limb pain and the physiatrist suspected carpal tunnel syndrome but ended up finding no new diagnosis following the EMG, the coder could revert back to the pre-EMG diagnosis (in this case, 729.5). Most Medicare carriers will cover limb pain for an EMG.

Sometimes well send a claim for EMG with the patients symptoms, such as low back pain (724.2), and the EMG will get denied even though low back pain is listed as covered on the Medicare policy, Ritter says. Then we have to send a copy of their policy back to them with our appeal letter, and eventually they will pay it. Its frustrating, but after we had to do it a few times, they stopped denying the claims. Its correct coding to revert to the patients symptoms if a test result comes back normal, but you should never code for the suspected problem if the test does not support that diagnosis.

Code signs and symptoms if a diagnosis is questionable or suspected, or the physician is ordering the tests to rule out. ICD-9 coding guidelines state that diagnoses that are classified as uncertain should not be reported, Albert

says. For instance, if the physiatrist performs a nerve conduction study to rule out the possibility of a radial nerve lesion (354.3), code the test using the patients symptoms. In this case, symptoms would most likely include elbow pain (719.42) or numbness (782.0) and tingling of the limb.

Use screening diagnoses when there are no signs or symptoms. In the absence of signs and symptoms, a diagnostic test is considered screening, Albert says. CMS allows the physician or practice to list the results of the test as a secondary diagnosis. For instance, if a physiatrist is seeing a rehab patient who recently started hormone replacement therapy, the physician might perform an osteoporosis screening (V82.81) with the secondary code V07.4 (Postmenopausal hormone replacement therapy) even if the patient does not have other symptoms of osteoporosis. If osteoporosis (733.00-733.09) is found, that can be reported as a third ICD-9 code to denote the test results.

Outside Testing Facilities

Remember that all of these examples are based on the assumption that the physiatrist is interpreting the test and making the diagnosis. In some cases, however, the physiatrist does not have the testing equipment or refers a test to an outside facility for other reasons. These physicians are required to supply diagnostic information to the parties performing the test; therefore, the physiatrist should code for his or her office visit and the signs and symptoms that prompted him or her to order the test. The outside facility that interprets the test will code for the results if and when a diagnosis is determined.

Note: CMS Program Memorandum AB-01-144 can be found at www.hcfa.gov/pubforms/transmit/AB01144.pdf.