Eli's Rehab Report

Signs/Symptoms Codes Can Boost Reimbursement

Use ICD-9 signs and symptoms codes to provide medical necessity for a procedure or service when there isnt a more specific diagnosis available to the physician. Although physical medicine and rehabilitation (PM&R) providers are trained to look for a specific diagnosis, sometimes a patient might have a complaint that cannot be diagnosed right away.

A definitive diagnosis frequently cannot be ascertained before lab tests are returned, or a complaint may be gone by the time a PM&R provider evaluates the patient. In other cases, test results turn out normal and a diagnosis cannot be determined. For example, a patient comes to the physiatrist complaining of generalized weakness. The physiatrist performs an evaluation and conducts motor nerve conduction studies (95900) on the patients wrist, elbow and ankle, but the test results are normal. The physiatrist asks the patient to return if the symptoms worsen or if other symptoms appear.

In the absence of a specific diagnosis, practices can use diagnosis codes listed in the Symptoms, Signs, and Ill-Defined Conditions section of the ICD-9 manual to prove medical necessity for the visit. In this case, 780.79 (other malaise and fatigue) could be assigned to the claim.

What to Do in the Absence of a Clear Diagnosis

According to **Catherine A. Brink, CMM, CPC,** president of Healthcare Resources Management, Inc., a practice management and reimbursement consulting firm in Spring Lake, N.J., a not otherwise specified code is valid if it most closely describes the diagnosis, but such a code should be used only after checking all other options. The Medicare carrier could deny the service rendered for lack of medical necessity based on the ICD-9 code attached to the procedure. High-level evaluation and management (E/M) codes often are denied on this basis, says Brink. In addition, individual Medicare carriers may have their own ICD-9 requirements for the service, so practices should check which codes their carriers will accept.

Many Medicare insurers require more specific diagnoses for procedures such as motor nerve conduction studies. According to **Andrea Lamb, CPC,** a billing specialist for St. Josephs Medical Plaza, a multispecialty practice in Jane Lew, W.Va., consider more specific ICD-9 codes if the patient exhibits weakness in a particular area, such as the arm or leg. Depending on the patients symptoms, applicable codes could include **ICD-9 344.30** (monoplegia of lower limb, affecting unspecified side) or **ICD-9 344.40** (monoplegia of upper limb, affecting unspecified side).

Signs/Symptoms Codes vs. Rule-out Diagnoses

Some physicians may be wary of using the signs and symptoms codes because of their years of residence at hospitals, where rule-out diagnoses are allowed and signs and symptoms codes are not used as regularly. Such usage is the norm for hospitals that are paid based on the most severe diagnosis the patient receives during his or her stay, but it does not apply to physician office coding.

Physicians are not allowed to use suspected or rule-out diagnoses, says **Cynthia Thompson, CPC,** a senior coding specialist at Gates, Moore and Co., an Atlanta-based physician practice management consulting firm. Without a specific diagnosis, they have to use the signs or symptoms that the patient brought to the office and prompted the physician to perform the rule-out test.

A patient also may come to the office with a complaint, but after the examination, the physiatrist may find nothing wrong. For example, a primary care physician may refer a patient because he or she may not be able to walk without staggering or falling. During the examination, however, the patient seems to walk without any problems, and the

physiatrist discovers no other symptoms.

In such a scenario, the sign or symptom (781.2, abnormality of gait) should be coded to provide medical necessity for the exam. Of course, if the physiatrist discovers something more specific during the exam, such as difficulty in walking (719.7), that code should be reported instead.

Coding Chief Complaint

There usually is a reason in the history of present illness or in the chief complaint for the patients visit, Thompson says, and those symptoms justify the medical necessity of the visit. She notes, however, that the medical record of the visit must match the signs and symptoms code used when billing for the E/M visit. Thompson adds that this should be documented as the patients chief complaint in his or her history of the present illness.

You cannot make up signs and symptoms after the fact, Thompson says. You have to use the signs and symptoms documented in the patients medical record.

Coders should avoid using signs and symptoms codes to represent any condition that is specifically excluded in the ICD-9 manual. For example, code 784.0 for headache/ facial pain, excludes the more specific diagnoses for atypical face pain (350.2), neck pain (723.1), sore throat (462) and chronic sore throat (472.1). If any of those diagnoses are discovered during the exam, then they should be used instead of the signs and symptoms code.

Boost Evaluation and Management Levels

The signs or symptoms codes may justify higher levels of E/M services, Thompson says, because the medical decision-making portion of the E/M service often is boosted when the physician has only a sign or symptom to work with due to the undefined nature of the complaint. Often, you can cite medical decision-making of a moderate or high complexity when using signs and symptoms codes because the situation increases the number of diagnoses/management options in the decision-making category, Thompson maintains.

The other two components of medical decision-making (risk and tests ordered and reviewed) also are likely to be higher when there is no specific diagnosis, says **Kathleen Mueller, RN, CPC, CCS-P,** an independent coding and reimbursement specialist in Lenzburg, Ill. When a problem is undiagnosed, it often means the doctor will have to order tests to try to determine the patients problem. After all, a specific diagnosis is less likely to call for a wide variety of tests than a sign or symptom because the cause of the symptom is unknown and needs to be discovered.