Codify
BY AAPC

Outpatient Facility Coding Alert

Coding Update: Combat the Challenges of Coding Symptoms and Definitive Diagnoses for Outpatient Services

Hint: Understand the disease process and its associated symptoms.

Knowing how to code when reporting a symptom, definitive diagnosis, or both, can be challenging because the rules make it complicated. Read on to refresh your knowledge of the various guidelines and their implications.

Starting point: Conditions that are intrinsic to a disease should not be reported as additional codes. For example, wheezing should not be coded in addition to a diagnosis of asthma as it is an integral part of the disease. Similarly, in gastroenteritis, nausea and vomiting should not be coded separately. Contrarily, conditions that may not be associated routinely with a disease process should be assigned additional codes. A solid understanding of the disease process is necessary, and it may sometimes be necessary to confirm with the physician.

Code Diagnoses Which Are Certain or Near to Certain

Indications documented as "probable," "suspected," "questionable," or "rule out" should not be coded as if they are established. Code those diagnoses which have the highest degree of certainty for that encounter, such as symptoms, signs, abnormal test results, or other reason for the visit. For example, if the physician documents "fever and cough, possible pneumonia" at the conclusion of an emergency room visit, code only the fever and cough, because those symptoms represent the highest degree of certainty for that encounter.

However, if the physician documents "fever and cough, possible pneumonia" on a requisition for an outpatient chest X-ray, and the radiologist's diagnosis on the radiology report is "pneumonia," it is appropriate to code the pneumonia, as this diagnosis represents the highest degree of certainty for the need of the X-ray. It is best to code based on the physician documentation available.

Know What the Guidelines Say

As stated in the Diagnostic Coding and Reporting Guidelines for Outpatient Services, codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when an established diagnosis has not been confirmed by the physician. However, this means that when a definitive diagnosis has been established for that encounter, the established diagnosis should be coded. In this case, those signs or symptoms that are integral to the established diagnosis should not be coded. Any conditions, including signs and symptoms, that are not routinely associated with the definitive diagnosis should be assigned as additional codes.

Understand How to Bill the Diagnostic Services

The sequence for billing these situations should be as follows: first the diagnosis, then the condition, problem, or other reason which is chiefly responsible for the outpatient services provided during the encounter/visit.

Focus on Conditions Integral to the Disease Process

The Diagnostic Coding and Reporting Guidelines for Outpatient Services must be used in conjunction with all other applicable coding rules and guidelines.

For example, the symptoms of "pain and swelling in wrist" are documented on the requisition for an outpatient X-ray of the wrists. These are the conditions "chiefly responsible" for the outpatient service provided. However, the guidelines say that the "highest degree of certainty" and "conditions integral to the disease process" need to be taken into

consideration.

In the case of a fracture, the radiologist's interpretation on the radiology report will indicate a diagnosis of fractured wrist. So fracture is the condition which has the highest degree of responsibility for the service rendered. You will not code pain and swelling, even as secondary diagnoses, because they are an integral part of the fracture diagnosis.

Use Physician's Diagnosis for Additional Tests

Coding Clinic for ICD-9-CM 17, No. 1, clarifies that it is appropriate for coding professionals to use physician interpretations of tests for correct code assignments in the outpatient setting. For example, if the surgeon removes a lesion and the pathologist's diagnosis on the pathology report is carcinoma, the carcinoma should be coded, as it is the more definitive diagnosis.

This conforms to the official outpatient coding guidelines because the diagnosis documented by the pathologist or radiologist is the condition representing the highest degree of certainty for that visit. When the physician interpretation of a test performed in the outpatient setting establishes a definitive diagnosis, this definitive diagnosis should be coded and any presenting symptoms that are integral to this diagnosis should not be coded. Any documented symptoms or conditions that are not routinely associated with the definitive diagnosis should be assigned additional codes. It is not necessary to code incidental findings documented in physician interpretations of tests.

Focus on Symptoms and Condition for Abnormal Findings

Abnormal findings that are not interpreted by a physician, such as clinical laboratory tests like CBC or urinalysis, should not be coded unless there is a confirmation of a definitive diagnosis. In these cases, rely on symptoms, conditions, or other reasons for the test. Examples of the types of symptoms you might report in these cases would include dysuria (788.1) hypercholesterolemia (272.0), and hematuria (599.70), says **Sarah L. Goodman, MBA, CHCAF, CPC-H, CCP, FCS,** president SLG, Inc. Consulting.