ICD 10 Coding Alert

Radiology: Case Study: Can You Determine How to Code Negative Findings?

Look to the report for symptoms when necessary.

Sometimes the ICD-10 coding options seem so vast that you might feel like you're better off just picking a code out of thin air than narrowing down the many options available to you—while in other cases, you might be struggling to find even one code that fits your documentation. Check out the following case study submitted to Radiology Coding Alert to determine why there will always be a black and white choice in your coding toolkit—if you know where to look.

Case Study: We got an order from a physician which read, "suspected closed ulna fracture in a patient complaining of lower right arm pain." The x-ray (73090, Radiologic examination; forearm, 2 views) does not show a fracture or reveal any other problem. The office manager said I should choose my diagnosis code off of the physician's order, and if that doesn't offer a valid ICD-10 code, then I can code off of the radiologist's report. But how should I code if I don't see a valid reason for the exam documented and the report is negative?

Solution: "Always look at both the radiologist's report and the physician's order before deciding which diagnosis to code," says **Allison Anderson,** owner of AAA Billing in Newark, N.J. "If the referring physician's order lists symptoms, and the radiologist's interpretation identifies a definitive diagnosis, then code the radiologist's diagnosis. If the exam results do not reveal a diagnosis, then code the signs and symptoms that prompted the test," she adds.

In your case, reporting a fracture code such as S52.601A (Unspecified fracture of lower end of right ulna; initial encounter for closed fracture) based on the order for a suspected closed ulna fracture would be incorrect. Instead, you should report the symptom that prompted the test, M79.631 (Pain in right forearm).

The ICD-10-CM Official Guidelines for Coding and Reporting for 2017 state, "Do not code diagnoses documented as 'probable,' 'suspected,' 'questionable,' 'rule out,' or 'working diagnosis' or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit."

Pitfall: Never report an incidental finding — an abnormality the radiologist identifies during the exam unrelated to the exam's reason — as the first-listed diagnosis code.

Example: You get a chest x-ray order that says, "Cough, rule out pneumonia." The radiologist states there is no active disease in the lungs but there is evidence of arthritis in the thoracic spine. The arthritis is an incidental finding. Code the cough as the primary diagnosis. You can report the arthritis as a secondary diagnosis if desired.