Psychiatry Coding & Reimbursement Alert

Reader Question: Use Symptoms To Support Tests When Final Diagnosis is Unavailable

Question: I've been told that if the treating physician orders a test based on a sign or symptom, we should code the final diagnosis or findings if available instead of the symptom. Is that correct?

Ohio Subscriber

Answer: You're exactly right: Code the final diagnosis or results of the test if available rather than the symptom that led to the performance of the test.

You'll find this rule supported by the ICD-9-CM Official Guidelines for Coding and Reporting, Section I.B.6: "Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider."

Watch for: Review guidelines for how to code when the diagnosis isn't definite: "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." (Section IV.I)

Example: Your psychiatrist sees a patient suffering from headache following a traumatic head injury four months prior. Because of the headache, your clinician asks for a CT scan to rule out any possible complications from the previous head trauma. Since the final diagnosis of your clinician is not completed while performing the CT scan of the patient and you do not have an established diagnosis at the end of the visit, you'll report the symptom of headache (e.g., 339.20, Post-traumatic headache, unspecified) to support the scan that was performed.