



ICD-9-CM Coding Requirements for Diagnostic Tests

CMS requires following the ICD-9-CM Coding Guidelines for Outpatient Services (hospital-based and physician office). These guidelines instruct physicians to report diagnoses based on test results, if available. Health care providers must comply with the following instructions in determining the appropriate ICD-9-CM diagnoses code for diagnostic test results. These instructions simplify coding for diagnostic tests consistent with the ICD-9-CM Guidelines for Outpatient Services (hospital-based and physician office).

General rules for reporting diagnosis codes on the claim are:

- Use the ICD-9-CM code that describes the patient’s diagnosis, symptom, complaint, condition or problem. Do not code suspected diagnosis.
- Use the ICD-9-CM code that is chiefly responsible for the item or service provided.
- Assign codes to the highest level of specificity. Use the fourth and fifth digits where applicable.
- Code a chronic condition as often as applicable to the patient’s treatment.
- Code all documented conditions that coexist at the time of the visit that require or affect patient care or treatment. (Do not code conditions that no longer exist.)

Determining the Appropriate Primary ICD-9-CM Diagnosis Code for Diagnostic Tests Ordered Due to Signs and/or Symptoms

Confirmed Diagnosis Based on Results of Test

If the physician has confirmed a diagnosis based on the results of the diagnostic test, the physician interpreting the test should code that diagnosis. The signs and/or symptoms that prompted ordering the test may be reported as additional diagnoses if they are not fully explained or related to the confirmed diagnosis.

Example: A patient is referred to a radiologist for an abdominal CT scan with a diagnosis of abdominal pain. The CT scan reveals the presence of an abscess. The radiologist should report a diagnosis of “intra-abdominal abscess.”

If the individual responsible for reporting the codes for the testing facility or the physician’s office does not have the report of the physician interpretation at the time of billing, the individual responsible for reporting the codes for the testing facility or the physician’s office should code what they know at the time of billing. Sometimes reports of the physician’s interpretation of diagnostic tests may not be available until several days later, which could result in delay of billing. Therefore, in such instances, the individual responsible for reporting the codes for the testing facility or the physician’s office should code based on the information/ reports available to them, or what they know, at the time of billing.

Signs or Symptoms

If the diagnostic test did not provide a diagnosis or was normal, the interpreting physician should code the sign(s) or symptom(s) that prompted the treating physician to order the study.

Example: A patient is referred to a radiologist for a spine x-ray due to complaints of “back pain.” The radiologist performs the x-ray, and the results are normal. The radiologist should report a diagnosis of “back pain” since this was the reason for performing the spine x-ray.

On the rare occasion when the interpreting physician does not have diagnostic information as to the reason for the test and the referring physician is unavailable to provide such information, it is appropriate to obtain the information directly from the patient or the patient's medical record if it is available. However, an attempt should be made to confirm any information obtained from the patient by contacting the referring physician.

Example: A patient is referred to a radiologist for a gastrograffin enema to rule out appendicitis. However, the referring physician does not provide the reason for the referral and is unavailable at the time of the study. The patient is queried, indicates that he/she saw the physician for abdominal pain, and was referred to rule out appendicitis. The radiologist performs the x-ray, and the results are normal. The radiologist should report the abdominal pain as the primary diagnosis.

If the physician's interpretation of the test result is not clear or is ambiguously stated in the patient's medical record, either the attending physician or the physician that performed that test should be contacted for clarification. This may result in the reporting of symptoms or a confirmed diagnosis.

Diagnosis Preceded by Words that Indicate Uncertainty

If the results of the diagnostic test are normal or nondiagnostic and the referring physician records a diagnosis preceded by words that indicate uncertainty (e.g., probably, suspected, questionable, rule out, or working), then the interpreting physician should not code the referring diagnosis. Rather the interpreting physician should report the sign(s) or symptom(s) that prompted the study. Diagnoses labeled as uncertain are considered by the ICD-9-CM Coding Guidelines as unconfirmed and should not be reported. This is consistent with the requirement to code the diagnosis to the highest degree of certainty.

Example: A patient is referred to a radiologist for a chest x-ray with a diagnosis of "rule out pneumonia." The radiologist performs a chest x-ray, and the results are normal. The radiologist should report the sign(s) or symptom(s) that prompted the test (e.g., cough).

Incidental Findings

Incidental findings should never be listed as primary diagnoses. If reported, incidental findings may be reported as secondary diagnoses by the physician interpreting the diagnostic test.

Example: A patient is referred to a radiologist for an abdominal ultrasound due to jaundice. After review of the ultrasound, the interpreting physician discovers that the patient has an aortic aneurysm. The interpreting physician reports jaundice as the primary diagnosis and may report the aortic aneurysm as a secondary diagnosis because it is an incidental finding.

Example: A patient is referred to a radiologist for a chest x-ray because of wheezing. The x-ray is normal except for scoliosis and degenerative joint disease of the thoracic spine. The interpreting physician reports wheezing as the primary diagnosis since it was the reason for the patient's visit and may report the other findings (scoliosis and degenerative joint disease of the thoracic spine) as additional diagnoses.

Unrelated Coexisting Conditions/Diagnoses

Unrelated and coexisting conditions/diagnoses may be reported as additional diagnoses by the physician interpreting the diagnostic test.

Example: A patient is referred to a radiologist for a chest x-ray because of a cough. The result of the chest x-ray indicates the patient has pneumonia. During the performance of the diagnostic test, it was determined that the patient has hypertension and diabetes mellitus. The interpreting physician reports a primary diagnosis of pneumonia. The interpreting physician may report the hypertension and diabetes mellitus as secondary diagnoses.

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Diagnostic Tests Ordered in the Absence of Signs and/or Symptoms

When a diagnostic test is ordered in the absence of signs/symptoms or other evidence of illness or injury, the testing facility or the physician interpreting the diagnostic test should report the screening code as the primary diagnosis code. Any condition discovered during the screening should be reported as a secondary diagnosis.

Example: A patient is referred to a radiologist for a chest x-ray as part of a routine physical. The result of the chest x-ray indicates a lung mass. The interpreting physician reports the appropriate screening code as the primary diagnosis and reports the lung mass as a secondary diagnosis.

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