# Medicare Claims Processing Manual

## 10.1 - ICD-9-CM Coding for Diagnostic Tests

(Rev. 1, 10-01-03)

PM AB-01-144, PM B-01-61, A3-3632, HO-230.8, B3-15021.1,

The CMS requires following the ICD-9-CM Coding Guidelines for Outpatient Services (hospital-based and physician office). These guides instruct physicians to report diagnoses based on test results, if available. The Coding Clinic for ICD-9-CM confirms this longstanding coding guideline.

Contractors, physicians, hospitals, and other 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).

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

(Rev. 1, 10-01-03)

A3-3632, HO-230.8, B3-15021.1

A - 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 1: A surgical specimen is sent to a pathologist with a diagnosis of “mole.” The pathologist personally reviews the slides made from the specimen and makes a diagnosis of “malignant melanoma.” The pathologist should report a diagnosis of “malignant melanoma” as the primary diagnosis.

EXAMPLE 2: 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.”

EXAMPLE 3: A patient is referred to a radiologist for a chest x-ray with a diagnosis of “cough.” The chest x-ray reveals 3 cm. peripheral pulmonary nodule. The radiologist should report a diagnosis of “pulmonary nodule” and may sequence “cough” as an additional diagnosis.

B - 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 1: 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.

EXAMPLE 2: A patient is seen in the ER for chest pain. An EKG is normal, and the final diagnosis is chest pain due to suspected gastroesophageal reflux disease (GERD). The patient was told to follow up with his primary care physician for further evaluation of the suspected GERD. The primary diagnosis code for the EKG should be chest pain. Although the EKG was normal, a definitive cause for the chest pain was not determined.

C - 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).

## 10.1.2 - Instructions to Determine the Reason for the Test

(Rev. 1, 10-01-03)

A3-3632, HO-230.8, B3-15021.1,

The Balanced Budget Act (BBA) §4317(b) requires referring physicians to provide diagnostic information to the testing entity at the time the test is ordered. As further indicated in 42 CFR 410.32 all diagnostic tests "must be ordered by the physician who is treating the beneficiary. An "order" is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. An order may include the following forms of communication:

- A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility;

• A telephone call by the treating physician/practitioner or his/her office to the testing facility; or

• An electronic mail by the treating physician/practitioner or his/her office to the testing facility.

NOTE: If the order is communicated via telephone, both the treating physician/practitioner or his/her office and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

A. 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.

B. 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.

C. If the test (e.g., lab test) has been performed and the results are back, but the patient's physician has not yet reviewed them to make a diagnosis, or there is no physician interpretation, code the symptom or the diagnosis provided by the referring physician.

D. 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.

## 10.1.3 - Incidental Findings

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A3-3632, HO-230.8, B3-15021.1

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 1: 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 2: 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.

EXAMPLE 3: A patient is referred to a radiologist for a magnetic resonance imaging (MRI) of the lumbar spine with a diagnosis of L-4 radiculopathy. The MRI reveals degenerative joint disease at L1 and L2. The radiologist reports radiculopathy as the primary diagnosis and may report degenerative joint disease of the spine as an additional diagnosis.

## 10.1.4 - Unrelated Coexisting Conditions/Diagnoses

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B3-3632, HO-230.8, B3-15021.1

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.

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

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A3-3632, HO-230.8, A3-3632, R1891.A.3, B.3-15021.1, R1807.B.3

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 diagnoses.

## 10.1.6 - Use of ICD-9-CM to the Greatest Degree of Accuracy and Completeness

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A3-3632, HO-230.8, B3-15021.1

The following longstanding coding guidelines are part of "Official ICD-9-CM Guidelines for Coding and Reporting."

The testing facility or the interpreting physician should code the ICD-9-CM code that provides the highest degree of accuracy and completeness for the diagnosis resulting from test, or for the sign(s)/ symptom(s) that prompted the ordering of the test.

The "highest degree of specificity means assigning the most precise ICD-9-CM code that most fully explains the narrative description in the medical chart of the symptom or diagnosis.

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| EXAMPLE 1: | A chest x-ray reveals a primary lung cancer in the left lower lobe. The interpreting physician should report the ICD-9-CM code as 162.5 for malignancy of the left "lower lobe, bronchus or lung," not the code for a malignancy of "other parts of bronchus or lung" (162.8) or the code for "bronchus and lung unspecified" (162.9). |
| EXAMPLE 2: | If a sputum specimen is sent to a pathologist and the pathologist confirms growth of "streptococcus, type B" which is indicated in the patient's medical record, the pathologist should report a primary diagnosis as 482.32 (Pneumonia due to streptococcus, Group B). However, if the pathologist is unable to specify the organism, then the pathologist should report the primary diagnosis as 486 (Pneumonia, organism unspecified). |

In order to report the correct number of digits when using ICD-9-CM, refer to the following instructions:

ICD-9-CM diagnosis codes are composed of codes with three, four, or five digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and fifth digits to provide greater specificity. Assign 3-digit codes only if there are no 4-digit codes within that code category. Assign 4-digit codes only if there is no 5-digit subclassification for that category. Assign the 5-digit subclassification code for those categories where it exists.

EXAMPLE 3: A patient is referred to a physician with a diagnosis of diabetes mellitus. However, there is no indication that the patient has diabetic complications or that the diabetes is out of control. It would be incorrect to assign code 250 since all codes in this series have five digits. Reporting only three digits of a code that has five digits would be incorrect. One must add two more digits to make it complete. Because the type (adult onset/juvenile) of diabetes is not specified, and there is no indication that the patient has a complication or that the diabetes is out of control, the correct ICD-9-CM code would be 250.00. The fourth and fifth digits of the code would vary depending on the specific condition of the patient. One should be guided by the codebook.

For the latest ICD-9-CM coding guidelines, please refer to the following Web site: http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm guide.