Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-01-144 **Date: SEPTEMBER 26, 2001**

CHANGE REQUEST 1724

SUBJECT: ICD-9-CM Coding for Diagnostic Tests

Introduction

This Program Memorandum (PM) clarifies our current coding guidelines for reporting diagnostic tests. Specifically, this PM clarifies the reporting of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes for diagnostic tests.

As required by the Health Insurance Portability and Accountability Act (HIPAA), the Secretary published a rule designating the ICD-9-CM and its *Official ICD-9-CM Guidelines for Coding and Reporting* as one of the approved code sets for use in reporting diagnoses and inpatient procedures. This final rule requires the use of ICD-9-CM and its official coding and reporting guidelines by most health plans (including Medicare) by October 16, 2002.

The *Official ICD-9-CM Guidelines for Coding and Reporting* provides guidance on coding. The ICD-9-CM Coding Guidelines for Outpatient Services, which is part of the *Official ICD-9-CM Guidelines for Coding and Reporting*, provides guidance on diagnoses coding specifically for outpatient facilities and physician offices.

The ICD-9-CM Coding Guidelines for Outpatient Services (hospital-based and physician office) have instructed physicians to report diagnoses based on test results. The Coding Clinic for ICD-9-CM confirms this longstanding coding guideline. CMS agrees with these long standing official coding and reporting guidelines.

Following are instructions for contractors, physicians, hospitals, and other health care providers to use in determining the use of ICD-9-CM codes for coding diagnostic test results. The instructions below provide guidance on the appropriate assignment of ICD-9-CM diagnoses codes to simplify coding for diagnostic tests consistent with the ICD-9-CM Guidelines for Outpatient Services (hospital-based and physician office). Note that physicians are responsible for the accuracy of the information submitted on a bill.

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

1. 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.

2. 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.

3. If the results of the diagnostic test are normal or non-diagnostic, and the referring physician records a diagnosis preceded by words that indicate uncertainty (e.g., probable, 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).

B. Instruction to Determine the Reason for the Test

As specified in §4317(b) of the Balanced Budget Act (BBA), referring physicians are required 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." As defined in §15021 of the Medicare Carrier Manual (MCM), 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. A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility;
b. A telephone call by the treating physician/practitioner or his/her office to the testing facility; and
c. 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.

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 and 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.

C. 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 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.

D. Unrelated/Co-Existing Conditions/Diagnoses

Unrelated and co-existing 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.

E. Diagnostic Tests Ordered in the Absence of Signs and/or Symptoms (e. g. screening tests)

When a diagnostic test is ordered in the absence of signs/symptoms or other evidence of illness or injury, the physician interpreting the diagnostic test should report the reason for the test (e. g. screening) as the primary ICD-9-CM diagnosis code. The results of the test, if reported, may be recorded as additional diagnoses.

F. Use of ICD-9-CM To The Greatest Degree of Accuracy and Completeness

NOTE: This section explains certain coding guidelines that address diagnoses coding. These guidelines are longstanding coding guidelines that have been part of the *Official ICD-9-CM Guidelines for Coding and Reporting.*

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.

In the past, there has been some confusion about the meaning of "highest degree of specificity," and in "reporting the correct number of digits." In the context of ICD-9-CM coding, the "highest degree of specificity refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis.

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 3, 4, or 5 digits. Codes with 3 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/or fifth digits to provide greater specificity. Assign three-digit codes only if there are no four-digit codes within that code category. Assign four-digit codes only if there is no fifth-digit subclassification for that category. Assign the fifth-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 5 digits. Reporting only three digits of a code that has 5 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 code book.

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

Refer to the attachment for further guidance on determining the appropriate ICD-9-CM diagnoses codes. The attachment is a listing of questions and answers that appeared in the American Hospital Association's (AHA) Coding Clinic for ICD-9-CM (1st Qtr 2000).

NOTE: Contractors are advised to make this PM available to physicians and other health care professionals. If available, immediately place this PM on your website. This PM should be distributed with your next regularly scheduled bulletin**.**

Attachment

The *effective date* for this PM is January 1, 2002.

The *implementation date* for this PM is January 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 1, 2003.

If you have any questions, contact your regional office.

Attachment

Question 1:
A skin lesion of the cheek is surgically removed and submitted to the pathologist for analysis. The surgeon writes on the pathology order, "skin lesion." The pathology report comes back with the diagnosis of "basal cell carcinoma." A laboratory-billing consultant is recommending that the ordering physician's diagnosis be reported instead of the final diagnosis obtained by the pathologist. Also, an insurance carrier is also suggesting this case be coded to "skin lesion" since the surgeon did not know the nature of the lesion at the time the tissue was sent to pathology. Which code should the pathologist use to report his claim?

Answer 1:
The pathologist is a physician and if a diagnosis is made it can be coded. It is appropriate for the pathologist to code what is known at the time of code assignment. For example, if the pathologist has made a diagnosis of basal cell carcinoma, assign code 173.3, Other malignant neoplasm of skin, skin of other and unspecified parts of face. If the pathologist had not come up with a definitive diagnosis, it would be appropriate to code the reason why the specimen was submitted, in this instance, the skin lesion of the cheek.

Question 2:
A patient presents to the hospital for outpatient x-rays with a diagnosis on the physician's orders of questionable stone. The abdominal x-ray diagnosis per the Radiologist is "bilateral nephrolithiasis with staghorn calculi." No other documentation is available. Is it correct to code this as 592.0, Calculus of kidney, based on the radiologist's diagnosis?

Answer 2:
The radiologist is a physician and he/she diagnosed the nephrolithiasis. Therefore, it is appropriate to code this case as 592.0, Calculus of kidney.

Question 3:
A patient undergoes outpatient surgery for removal of a breast mass. The pre- and post-operative diagnosis is reported as "breast mass." The pathological diagnosis is fibroadenoma. How should the hospital outpatient coder code this? Previous *Coding Clinic* advice has precluded us from assigning codes on the basis of laboratory findings. Does the same advice apply to pathological reports?

Answer 3:
Previously published advice has warned against coding from laboratory results alone, without physician interpretation. However, the pathologist is a physician and the pathology report serves as the pathologist's interpretation and a microscopic confirmatory report regarding the morphology of the tissue excised. Therefore, a pathology report provides greater specificity. Assign code 217, Benign neoplasm of breast, for the fibroadenoma of the breast. It is appropriate for coders to code based on the physician documentation available at the time of code assignment.

Question 4:
A referring physician sent a urine specimen to the cytology lab for analysis with a diagnosis of "hematuria" (code 599.7). However, a cytology report authenticated by the pathologist revealed abnormal cells consistent with transitional cell carcinoma of the bladder. Although the referring physician assigned code 599.7, Hematuria, the laboratory reported code 188.9, Malignant neoplasm of bladder, Bladder, part unspecified. For reporting purposes, what would be the appropriate diagnosis code for the laboratory and the referring physician?

Answer 4:
The laboratory should report code 188.9, Malignant neoplasm of bladder, Bladder, part unspecified. It is appropriate to code the carcinoma, in this instance, because the cytology report was authenticated by the pathologist and serves as confirmation of the cell type, similar to a pathology report. The referring physician should report code 599.7, Hematuria, if the result of the cytological analysis is not known at the time of code assignment.

Question 5:
A patient presents to the physician's office with complaints of urinary frequency and burning. The physician ordered a urinalysis and the findings were positive for bacteria and increased WBCs in the urine. Based on these findings a urine culture was ordered and was positive for urinary tract infection. Should the lab report the "definitive diagnosis," urinary tract infection, or is it more appropriate for the lab to report the signs and symptoms when submitting the claim?

Answer 5:
Since this test does not have physician interpretation, the laboratory (independent or hospital-based) should code the symptoms (i.e., urinary frequency and burning).

Question 6:
The physician refers a patient for chest x-ray to outpatient radiology with a diagnosis of weakness and chronic myelogenous leukemia (CML). The radiology report demonstrated no acute disease and moderate hiatal hernia. For reporting purposes, which codes are appropriate for the facility to assign?

Answer 6:
Assign code 780.79, Other malaise and fatigue, and code 205.10, Myeloid leukemia, without mention of remission, for this encounter. It is not necessary to report code 553.3, Diaphragmatic hernia, for the hiatal hernia, because it is an incidental finding.

[For CMS purposes, the primary diagnosis would be reported as 780.79 (Other malaise and fatigue), and the secondary diagnosis as 205.10 (Myeloid leukemia, without mention of remission, for this encounter).]

Question 7:
A patient presents to the doctor's office with a complaint of fatigue. The physician orders a complete blood count (CBC). The CBC reveals a low hemoglobin and hematocrit. Should the lab report the presenting symptom fatigue (code 780.79) or the finding of anemia (code 285.9)?

Answer 7:
The laboratory (independent or hospital-based) should code the symptoms, because no physician has interpreted the results. Assign code 780.79, Other malaise and fatigue, unless the lab calls the physician to confirm the diagnosis of anemia.