Medicare Hospital Manual

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

Transmittal 790 **Date: SEPTEMBER 12, 2002**

REFER TO CHANGE REQUEST 2167

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents	17 - 17.1 (2 pp.)	17 - 17.1 (2 pp.)
230.7 (Cont.) – 232	32b.4.3 - 32b.4.10 (8 pp.)	32b.4.3 - 32b.5 (3 pp.)

CLARIFICATION--EFFECTIVE DATE: Not Applicable

Section 230.8, ICD-9-CM Coding For Diagnostic Tests, provides clarification on current ICD-9-CM Coding guidelines for reporting diagnostic tests. This transmittal manualizes CR 1724, Transmittal Number AB 01-144, dated September 26, 2001.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

COVERAGE OF HOSPITAL SERVICES

Section

Hospital Services Covered Under Part B

Section

Physical Therapy, Occupational Therapy, and Speech Pathology Services Furnished to Outpatients Covered Under Part B

Supplementary Medical Insurance Incurred Expenses Deductible and Coinsurance

Hospital-Based Physicians

o Treatment of chronic conditions without acute exacerbation of symptoms which place the individual at risk of relapse or hospitalization.

5. Documentation Requirements and Physician Supervision.--The following components will be used to help determine whether the services provided were accurate and appropriate.

a. Initial Psychiatric Evaluation/Certification.--Upon admission, a certification by the physician must be made that the patient admitted to the PHP would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided. The certification should identify the diagnosis and psychiatric need for the partial hospitalization. Partial hospitalization services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services identified in §1861 that are reasonable and necessary to treat the presentation of serious psychiatric symptoms and to prevent relapse or hospitalization.

b. Physician Recertification Requirements.--

o Signature – The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment.

o Timing – The first recertification is required as of the 18th calendar day following admission to the PHP. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.

o Content – The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the PHP and describe the following:

-- The patient's response to the therapeutic interventions provided by the PHP;

-- The patient's psychiatric symptoms that continue to place the patient at risk of hospitalization; and

-- Treatment goals for coordination of services to facilitate discharge from the PHP.

c. Treatment Plan.--Partial hospitalization is active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the patient, and includes a multidisciplinary team approach to patient care. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to treatment. Treatment goals should be designed to measure the patient's response to active treatment. The plan should document ongoing efforts to restore the individual patient to a higher level of functioning that would permit discharge from the program, or reflect the continued need for the intensity of the active therapy to maintain the individual's condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as partial hospitalization services.

d. Progress Notes.--Section 1833(e) of the Social Security Act prevents Medicare from paying for services unless necessary and sufficient information is submitted that shows that services were provided and to determine the amounts due. A provider may submit progress notes

to document the services that have been provided. The progress note should include a description of the nature of the treatment service, the patient's response to the therapeutic intervention and its relation to the goals indicated in the treatment plan.

230.8 ICD-9-CM Coding 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 Administrative Simplification Act of 2001, however, permits plans and providers to apply for an extension until October 2003. HHS anticipates that most plans and providers will obtain this extension.

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 diagnosis coding specific to 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 conforms with these longstanding official coding and reporting guidelines.

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

Additional examples of using ICD-9-CM codes consistently with the ICD-9-CM Coding Guidelines for Outpatient Services are provided at the end of this section.

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 testing facility or 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 related or integral 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 a 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 because the EKG was normal and 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, provisional, or working), then the testing facility or the interpreting physician should not code the questionable diagnosis from the referring provider. Rather, the testing facility or the interpreting physician should report the sign(s) or symptom(s) that prompted the study. Do not report diagnoses labeled as uncertain because they are considered by the ICD-9-CM Coding Guidelines as unconfirmed. 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. 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.

1. 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. The source of the information pertaining to the reason for the test should be documented in the patient's medical record. However, an attempt should be made to confirm any information obtained from the patient by contacting the referring physician.

Example 1: 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.

2. In the event the physician's interpretation of the test result is unclear or ambiguously stated in the patient's medical record, either the attending physician or the physician that performed the test should be contacted for clarification. This may result in the reporting of symptoms or a confirmed diagnosis.

3. If the test (i.e., 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, then code the symptom or the diagnosis provided by the referring physician.

4. In the event 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.

C. Incidental Findings.--Incidental findings should never be listed as primary diagnoses. If reported, incidental findings may be reported as secondary diagnoses by the testing facility or 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 testing facility or 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 testing facility or 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 testing facility or 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 testing facility or interpreting physician reports a primary diagnosis of pneumonia. The testing facility or the interpreting physician may report the hypertension and diabetes mellitus as secondary diagnoses.

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 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.

NOTE: This instruction does NOT supersede statutory payment guidelines (i.e., Medicare's screening colonoscopy or sigmoidoscopy reporting guidelines. If during the course of a screening colonoscopy or sigmoidoscopy a lesion or growth is detected, the lesion or growth should be reported as the primary diagnosis, not the reason for the test. This is consistent with the instruction in Section A.).

F. Use of ICD-9-CM To The Greatest Degree of Accuracy and Completeness.--This section explains certain coding guidelines that address diagnosis coding. These guidelines are longstanding coding guidelines that have been part of the *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 the 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 in the medical chart 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 of 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 ICD-9-CM code book.

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.

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

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.

232. LABORATORY SERVICES FURNISHED TO NONHOSPITAL PATIENTS BY HOSPITAL LABORATORY

A nonhospital patient is an individual who is neither an inpatient nor outpatient of the hospital furnishing the service. (See §210 for the definition of a hospital inpatient and §230.1 for the definition of a hospital outpatient. See §400ff regarding bill preparation.)

235. RENTAL AND PURCHASE OF DURABLE MEDICAL EQUIPMENT

A participating provider of services may be reimbursed under Part B on a reasonable cost basis for durable medical equipment, which it rents or sells to a beneficiary for use in his home if the following three requirements are met:

- The equipment meets the definition of durable medical equipment (§235.1); and
- The equipment is necessary and reasonable for the treatment of the patient's illness or injury or to improve the functioning of his malformed body member (§235.2); and
- The equipment is used in the patient's home (§235.6).

Payment may also be made under this provision for repairs, maintenance, and delivery of equipment as well as for expendable and nonreusable items essential to the effective use of the equipment subject to the conditions in §235.3. (See §210.9 for additional coverage rules for occupational therapy.)

235.1 Definition of Durable Medical Equipment.--For purposes of coverage under Part B, durable medical equipment is equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of illness or injury; and
- Is appropriate for use in the home.

All requirements of the definition must be met before an item is considered to be durable medical equipment.

A. Durability.--An item is considered durable if it can withstand repeated use, i.e., the type of item, which could normally be rented. Medical supplies of an expendable nature such as incontinent pads, lambs wool pads, catheters, ace bandages, elastic stockings, surgical face masks, irrigating kits, sheets and bags are not considered "durable" within the meaning of the definition. There are other items, which, although durable in nature, may fall into other coverage categories such as braces, prosthetic devices, artificial arms, legs, and eyes.

B. Medical Equipment.--Medical equipment is equipment, which is primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury. In most instances, no