Medicare
Intermediary Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 2723

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3632 (Cont.) - 3632 (Cont.)	6-178.9 - 6-178.10 (2 pp.)	6-178.9 - 6-178.10 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: October 1, 2003*
IMPLEMENTATION DATE: October 1, 2003

Section 3632, ICD-9-CM Coding for Diagnostic Tests, deletes the note in Part E due to concerns that the note is confusing and contradicts the Official ICD-9-CM Guidelines for Coding and Reporting.

These instructions should be implemented within your current operating budget.

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.

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: 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 not clear or 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.

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 for 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 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.

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

NOTE: 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 "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).