In the outpatient setting, physicians should never assign a diagnosis unless that diagnosis has been confirmed by diagnostic testing, or is otherwise certain.

Source: Physicians Practice

Accurate diagnosis coding is crucial for patient care and compliant, optimal reimbursement. In the outpatient setting, you should never assign a diagnosis unless that diagnosis has been confirmed by diagnostic testing, or is otherwise certain. Uncertain diagnoses include those that are:

- Probable
- Suspected
- Questionable
- “Rule out”
- Differential
- Working

If you are unable to determine a definitive diagnosis, you should document and code for the signs, symptoms, abnormal test result(s), or other conditions that prompted the patient encounter. ICD-9-CM coding guidelines (Section I.B.6. of the ICD-9 manual) confirm, “Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.”

Many signs and symptoms codes are found in ICD-9-CM Chapter 16 (Symptoms, Signs and Ill-defined Conditions: 780.0-799.9); however, signs and symptoms codes may appear throughout the ICD-9-CM codebook. Chapter 16 defines signs and symptoms as:

(a) Cases for which no more specific diagnosis can be made even after all facts bearing on the case have been investigated;
(b) Signs or symptoms existing at the time of initial encounter that proved to be transient and whose causes could not be determined;
(c) Provisional diagnoses in a patient who failed to return for further investigation or care;
(d) Cases referred elsewhere for investigation or treatment before the diagnosis was made;
(e) Cases in which a more precise diagnosis was not available for any other reason;
(f) Certain symptoms which represent important problems in medical care and which it might be desired to classify in addition to a known cause.

For example, you document “Fatigue, suspect iron deficiency anemia,” you should code only for the fatigue (780.79 Other malaise and fatigue) because the encounter note does not confirm the diagnosis of iron deficiency anemia.

“Abnormal test result” is acceptable as a primary diagnosis when ordering follow-up testing based on positive findings. For instance, if an ultrasound suggests an anomaly in a patient’s gastrointestinal tract, but a subsequent MRI returns negative, you may report 793.4 Nonspecific (abnormal) findings on radiological and other examination of gastrointestinal tract to establish medical necessity for the MRI.

If diagnostic testing confirms a diagnosis, report the definitive diagnosis rather than the signs and symptoms that prompted the test. CMS program memorandum AB-01-144 (ICD-9-CM Coding for Diagnostic Tests) specifies:

*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.”

If the definitive diagnosis fails to present a complete picture of the patient’s condition, you may assign additional signs and symptoms codes. You also may report unrelated signs and symptoms that affect your medical decision-making, or otherwise influence the patient’s care.

Note that the above coding rules apply to professional services, and to those services performed in an outpatient setting. In the inpatient setting for facility diagnosis coding, you may report suspected or rule out diagnoses as if the condition exists. If a diagnosis is uncertain at the time of discharge, the condition should be coded as if it existed or was established.

HIV is an exception to this rule: HIV is the only condition that must be confirmed if it is to be reported in the in-patient setting. Confirmation does not require documentation of positive serology or culture for HIV. The physician’s diagnostic statement that the patient is HIV positive or has an HIV-related illness is sufficient.

For example, a patient with severe right lower quadrant abdominal pain, nausea, and vomiting is admitted with suspected acute appendicitis. The facility may report the suspected condition of acute appendicitis (540.9 Acute appendicitis without peritonitis). For the same patient, a physician reporting his professional services must follow the “no unconfirmed diagnoses” rule and report the signs and symptoms of 789.06 Abdominal pain epigastric and 787.01 Nausea with vomiting.

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