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You do not need to subscribe to Coding Clinic in order to access the official ICD-9-CM guidelines. The
guidelines are available on the NCHS website at:
http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

Remember that the guidelines are updated on an annual basis, effective October 1.

What if we don't have any signs and symptoms and the reason for the exam states pulmonary
embolism but the results of the exam determine that a pulmonary embolism does not exist. What
should the diagnosis code be?
If the referring physician documents the PE as confirmed (for example, if it is not documented as
“possible,” “question of,” etc.), and if there are no signs or symptoms documented, then you should code
the PE (415.19). The referring physician may have made the diagnosis on clinical grounds, or the patient
may have been receiving treatment for the PE and the referring physician is checking to make sure that it
has cleared.

If the report indicates signs and symptoms such as shortness of breath, then it would be appropriate to
code the signs/symptoms rather than the pulmonary embolism if the study is negative for PE.

A fall is listed as the indication. Hemorrhage is listed in the findings section of the report but not
specified as traumatic or nontraumatic. What is the appropriate code?
If it’s not clear from the documentation whether the hemorrhage is traumatic or non-traumatic, you should
use the “default” code that is listed in the ICD-9-CM Index.

For example, if you look up subarachnoid hemorrhage or subdural hemorrhage in the Index, the code that
appears next to the main term is for non-traumatic hemorrhage (430 for subarachnoid and 432.1 for
subdural). Additionally, the word “non-traumatic” appears in parentheses next to the main term. Words
in parentheses are non-essential modifiers, which are terms that do not affect the code assignment. In
other words, you would code a diagnosis of SAH as 430 regardless of whether it is documented as non-
traumatic or unspecified. You would use the traumatic SAH code only if the condition is documented as
traumatic.
If an order for a chest x-ray or chest CT identifies the reason for the exam as a chest mass, but the exam doesn’t show a mass, how should this be coded? There is no other information provided. You should code the mass (786.6), since this is the information provided by the treating physician.

Medicare does not pay for V codes. Do you have any suggestions to ensure reimbursement? Medicare reimburses for many V codes, depending on the type of exam you are billing for. For example, Medicare pays for screening mammograms under codes V76.11-V76.12. For some exams, the Medicare contractor’s Local Coverage Determination (LCD) may not include any payable V codes. You must assign the ICD-9-CM diagnosis code based on correct coding principles rather than coverage criteria, and that includes assigning a non-covered V code if that is the only code that can be appropriately assigned. If there are no covered V codes on the LCD list, but you believe that the exam meets the criteria in the narrative portion of the LCD, then you should submit the claim with the V code and appeal if denied.

What if a person has a fall and there is an abnormal finding on an exam and an MRI is recommended and there is a finding of fracture. Medicare doesn’t pay for most fractures on an MRI. Do we code the abnormal finding, then the fracture? The code assignment will depend on the specific circumstances and documentation. But in all cases the primary diagnosis must be consistent with the ICD-9-CM Official Guidelines for Coding and Reporting—specifically:

“List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided.”

Re 440.8, Iliac artery atherosclerosis, isn’t 440.20 more specific? According to Coding Clinic for ICD-9-CM (3rd Quarter 2009), you should “Assign code 440.8, Arteriosclerosis, of other specified arteries, for arteriosclerosis of the iliac artery.”

(Note: The ICD-9 Alphabetic Index has a note under “Atherosclerosis” to “see Arteriosclerosis.”)

What is the difference between an "inconclusive" mammogram and an "abnormal" mammogram? For clinical purposes, mammogram results are described in terms of the BI-RADS® category rather than as inconclusive or abnormal. For example, a Category 3 exam is a “Probably benign finding—initial short interval follow-up suggested.” These patients are referred for additional imaging studies. From a coding perspective, you should assign code 793.89, Other (abnormal) findings on radiological examination of breast, for a statement of “abnormal mammogram,” “breast calcification,” etc. You should use code 793.82, Inconclusive mammogram, when the report indicates the study was inconclusive or that the patient has dense breast tissue. Do not assign 793.82 if there is a definitive finding such as a mass (611.72), microcalcifications (793.81), etc.
What about fracture codes and the use of aftercare codes?
According to the ICD-9-CM Official Guidelines for Coding and Reporting:

Traumatic fractures are coded using the acute fracture codes (800-829) while the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

Fractures are coded using the aftercare codes (subcategories V54.0, V54.1, V54.8, or V54.9) for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase. Examples of fracture aftercare are: cast change or removal, removal of external or internal fixation device, medication adjustment, and follow up visits following fracture treatment.

Keep in mind that some payors may want the fracture code rather than the aftercare code on claims for follow-up exams.

If a patient comes in for a stroke protocol (MRI brain, MRA head, and MRA neck) and there is no finding on the MRA of the head and neck, is it ok to use the MRI findings as a code on the MRAs?
If an exam is negative, it is usually more appropriate to code the presenting signs and symptoms than a finding from a different exam. However, there may be exceptions depending on the specific circumstances and documentation.

If it is only a chest x-ray and we only receive an order from the referring physician (no other info) and there is no mass, what code should we use?
You should query the ordering physician or (if you have access to the medical record) check the encounter record to see why the exam was ordered. There is no diagnosis code that you can assign compliantly to a radiology report that has no clinical indications or abnormal findings.

Can you review coding DEXA scans for drug-induced osteoporosis?
Drug-induced osteoporosis should be reported with code 733.09 (Osteoporosis, other). If you know what drug is responsible for the condition, you can assign an adverse effect E code—for example, code E932.0 for corticosteroids.

Do you suggest utilizing E codes to describe the cause or effect?
We do recommend use of E codes to describe the external cause of injury, when that information is available. For example, code E819.9 (Motor vehicle traffic accident of unspecified nature, unspecified person) can be used together with an injury code when you know that the patient was in an MVA but do not know the specific circumstances. Use of E codes can sometimes cut down on requests for records from payors. Remember that E codes can never be used as the primary diagnosis.

What is the code for brain volume loss?
This is a nonspecific finding that could be age-related and/or unrelated to the reason for the exam. If the only finding is volume loss, you should code the presenting signs and symptoms.
What code should I assign when the study is ordered to check for retained instruments after surgery and none are found?
Ideally these exams should be paid for by the hospital rather than the patient’s insurance, since they are performed due to possible errors in the operating room. If they are billed to a third party payor, use code V71.89 (Observation and evaluation for other specified suspected conditions) unless the payor instructs otherwise.

What is the code for low lung volume?
This is a nonspecific finding. In the absence of a definitive diagnosis that explains the patient’s presenting signs/symptoms, you should code the signs/symptoms.

What code should be assigned when checking for pacemaker leads, left ventricular assistive device, etc.—just checking if everything is OK and in correct position?
Assign a code from category V53 (Fitting and adjustment of other device). For example, a chest x-ray performed following insertion of an ICD to check the position of the device should be reported with code V53.32 (Fitting and adjustment of automatic implantable cardiac defibrillator).

What code should we assign for pulmonary vascular congestion?
This is a nonspecific finding. In the absence of a definitive diagnosis that explains the patient’s presenting symptoms, you should code the signs/symptoms.

What code should we assign for pulmonary congestion? When do you use 786.9 and when do you use 514?
Always start your code search in the Alphabetic Index. The Index has been designed not just to help you locate a code in the Tabular List, but also to steer you to the code for the most common form of the condition when your documentation is nonspecific.

The Alpha Index indicates that pulmonary congestion not further specified should be assigned to code 786.9 (Other symptoms involving respiratory system and chest). If the pulmonary congestion is specified as chronic, it should be assigned to code 514 (Pulmonary congestion and hypostasis).

Keep in mind that 786.9 is a generic symptom code. If there is documentation of more specific clinical indications (for example, dyspnea, cough, hemoptysis, etc.), or definitive findings like pneumonia, you should generally code the more specific conditions.

When the reason for study is “elevated creatinine” for a kidney biopsy and there are no other signs or symptoms and no definitive findings, what diagnosis code should we use?
Coding Clinic indicates that elevated BUN and/or creatinine should be reported with code 790.6 (Other abnormal blood chemistry).
We have to provide the lab with a diagnosis code when we order blood tests prior to imaging studies. For example, we do BUN and creatinine on patients above a certain age who are scheduled for CT or MRI with contrast, and we do PTT/INR/platelet count on patients scheduled for myelograms, LP, paracentesis, or thoracentesis. We have been using V71.9. Are there better codes we could use?

We recommend code V72.63 (Pre-procedural laboratory examination) for this purpose. Although this code can be used for preop lab tests, it can also be used for lab tests performed prior to other types of procedures or treatments.

**How do we code for patients undergoing PET scans, especially when the patient doesn’t have a confirmed diagnosis of cancer, or when the cancer is metastatic?**

Medicare coverage criteria for PET and PET-CT scans depend on whether the scan was performed for initial treatment strategy (for example, staging) or subsequent treatment strategy (for example, restaging).

**Initial Treatment Strategy**

Under the Medicare National Coverage Determination (NCD), Medicare covers scans for initial treatment strategy in patients “who have solid tumors that are biopsy proven or strongly suspected based on other diagnostic testing.” Initial treatment strategy studies include studies performed for diagnosis or for staging.

If the patient has a known (biopsy-proven) malignancy, assign the ICD-9-CM code for the primary site. Also code any known secondary sites.

Coding for studies performed for “strongly suspected” malignancies can be problematic. Do not assign a malignant neoplasm code if malignancy is not documented as confirmed. Check your local contractor’s coverage policy to see which of the non-cancer ICD-9 codes they will cover. Remember that in order for Medicare to cover a study performed for a “strongly suspected” neoplasm, the suspicion must be based on abnormal conventional imaging studies.

Here are some examples of local Medicare policies that recognize non-cancer codes for initial treatment strategy scans:

- Highmark Medicare covers 518.89, 793.1 (for “suspicion of solitary pulmonary nodule”), and V71.1 (observation for suspected malignant neoplasm).

- Trailblazer covers codes 793.0-793.7 (abnormal findings on imaging exams) as well as V71.1 (observation for suspected malignant neoplasm).

- WPS Medicare covers 518.89 and 793.1.

If your facility performs a scan for a non-cancer code that is not on your contractor’s covered list, Medicare will deny the claim, but you may be able to get the denial overturned on appeal.

Keep in mind that Medicare does not cover initial treatment strategy scans for prostate cancer, regardless of whether the scan is performed for diagnosis or staging. Any initial treatment scan with a diagnosis code of 185 must be billed to Medicare under the HCPCS code for non-covered studies (G0235).

Additionally, the Medicare NCD no longer covers PET for diagnosing cervical cancer. Medicare will cover the study only if the patient has a confirmed tissue diagnosis of cervical cancer (ICD-9 category 180) and conventional imaging has shown no evidence of extra-pelvic metastasis.
Subsequent Treatment Strategy

Subsequent treatment strategy includes scans performed for restaging after treatment has been completed, or for monitoring the patient’s response to treatment. The primary diagnosis on a subsequent treatment scan will normally be a code for active cancer or for personal history of cancer. Check your contractor’s policy to make sure they cover the V10 codes for history of cancer. For example, Trailblazer does not cover personal history of malignant neoplasm (V10.x) for subsequent treatment scans, but it does cover codes V67.1-V67.2 (follow-up following radiation/chemo), V67.00 (follow-up following surgery), and V58.42 (aftercare following surgery for neoplasm).

If a patient has a confirmed metastatic site, the code for the secondary neoplasm should normally be listed second, following the code for the primary site, since the claim will be adjudicated based on whether it meets the criteria for the primary site.

Here are two examples of code assignment for subsequent treatment scans:

1. A scan is performed for restaging on a patient with non-small cell lung cancer metastatic to the liver. You should report 162.X and 197.7.

2. A scan is performed for restaging on a patient with breast cancer. The patient had a mastectomy two years ago and there is no sign of recurrence at the primary site, nor is she receiving treatment directed to the primary site. However, a CT scan shows liver lesions, and the PET scan shows probable liver metastases. Assign V10.3 for the history of breast cancer. If the contractor does not cover the V10 codes, it may be necessary to assign a follow-up code (V67.X) based on the patient’s last mode of treatment.