How to Code Symptoms and Definitive Diagnoses

by Sue Prophet, RHIA, CCS

Determining when a symptom, definitive diagnosis, or both should be coded can be challenging for coding professionals. This challenge is complicated by the varying rules regarding the coding of symptoms versus definitive diagnoses, according to the type of encounter and the particular service rendered. In an era of increased focus on fraud/abuse and regulatory compliance, it is especially important for coding professionals to understand and properly apply official coding rules and guidelines. This article will explore the various guidelines affecting symptom and definitive diagnosis coding and what guidelines to apply.

Conditions Integral to Disease Process

Conditions that are integral to a disease process should not be assigned as additional codes. This guideline applies to all healthcare settings. For example, nausea and vomiting should not be coded in addition to gastroenteritis, because these symptoms would be considered integral to a diagnosis of gastroenteritis. Similarly, wheezing should not be coded in addition to a diagnosis of asthma. Conditions that are considered integral to a disease process are not always included in Chapter 16 of ICD-9-CM. For example, pain or stiffness in a joint, which are found in the Musculoskeletal chapter of ICD-9-CM, would be considered integral to a diagnosis of arthritis. Conversely, conditions that may not be associated routinely with a disease process should be assigned additional codes. A solid understanding of the disease process is necessary, and it may sometimes be necessary to confer with the physician.

"Probable," "Suspected," and "Rule Out" Diagnoses

In the inpatient setting, if a diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "rule out," the condition should be coded as if it existed or was established. The basis for this guideline are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

In the outpatient setting (including physician offices), diagnoses documented as "probable," "suspected," "questionable," or "rule out" should not be coded as if they are established. Rather, the conditions should be coded to the highest degree of certainty for that encounter, such as symptoms, signs, abnormal test results, or other reason for the visit. For example, if the physician documents "fever and cough, possible pneumonia" at the conclusion of an emergency room visit, only the fever and cough should be coded, because those symptoms represent the highest degree of certainty for that encounter. However, if the physician documents "fever and cough, possible pneumonia" on a requisition for an outpatient chest x-ray, and the radiologist's diagnosis on the radiology report is "pneumonia," it is appropriate to code the pneumonia, as this diagnosis represents the highest degree of certainty for the encounter for the x-ray. Based on *Coding Clinic for ICD-9-CM* 17, no. 1, it is appropriate to code based on the physician documentation available at the time of code assignment.

Symptoms Followed by Contrasting/Comparative Diagnoses

When selecting the principal diagnosis in the inpatient setting, if a symptom is followed by contrasting/comparative diagnoses, the symptom code should be sequenced first and all of the contrasting/comparative diagnoses should be coded as suspected conditions per the guideline mentioned above concerning the coding of "suspected" inpatient diagnoses. For contrasting/comparative diagnoses involving secondary diagnoses in the inpatient setting, only the symptom should be coded. The contrasting/comparative diagnoses should not be coded. However, when a symptom is followed by contrasting/comparative diagnoses in an outpatient setting, only the symptom should be coded.

Symptom Versus Malignancy as Principal Diagnosis

Symptoms, signs, and ill-defined conditions listed in Chapter 16 of ICD-9-CM that are characteristic of, or associated with, an existing primary or secondary-site malignancy can not be used to replace the malignancy as principal diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.

Specific Outpatient Coding Guidelines

These guidelines should be applied for facility-based outpatient services and physician offices. As stated in the *Diagnostic Coding and Reporting Guidelines for Outpatient Services*, codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when an established diagnosis has not been confirmed by the physician. However, this means that when a definitive diagnosis has been established for that encounter, the established diagnosis should be coded. In this case, those signs or symptoms that are integral to the established diagnosis should not be coded. Any conditions, including signs and symptoms, that are not routinely associated with the definitive diagnosis should be assigned as additional codes.

Encounters for Diagnostic Services

For patients receiving diagnostic services only during an outpatient encounter, sequence first the diagnosis, condition, problem, or other reason for the encounter shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. This guideline must be used in conjunction with all other applicable coding rules and guidelines. For example, it could be argued that the symptoms of "pain and swelling in wrist" documented on the requisition for an outpatient x-ray of the wrists are the conditions "chiefly responsible" for the outpatient service rendered. However, the guidelines regarding the assignment of codes for the "highest degree of certainty" and "conditions integral to the disease process" also need to be taken into consideration. If the radiologist's interpretation on the radiology report establishes a diagnosis of fractured wrist, then the fracture is the condition representing the highest degree of certainty for this encounter. The pain and swelling would not be coded, even as secondary diagnoses, because they are an integral part of the fracture diagnosis.

Encounters for Ancillary Tests

Coding Clinic for ICD-9-CM 17, no. 1, clarifies that it is appropriate for coding professionals to use physician interpretations of tests as a basis for accurate code assignments in the outpatient setting. For example, if the surgeon removes a lesion and the pathologist's diagnosis on the pathology report is carcinoma, the carcinoma should be coded, as it is the more definitive diagnosis.

This advice is consistent with the official outpatient coding guidelines, including the guideline regarding the assignment of codes to the highest degree of certainty for that encounter. The diagnosis documented by the pathologist or radiologist is the condition representing the highest degree of certainty for that visit. When the physician interpretation of a test performed in the outpatient setting establishes a definitive diagnosis, this definitive diagnosis should be coded and any presenting symptoms that are integral to this diagnosis should not be coded. Any documented symptoms or conditions that are not routinely associated with the definitive diagnosis should be assigned additional codes. It is not necessary to code incidental findings documented in physician interpretations of tests.

Abnormal findings in test results that are not interpreted by a physician, such as clinical laboratory tests like CBC or urinalysis, should not be coded unless confirmation of a definitive diagnosis is obtained from the patient's physician. In these cases, the presenting symptoms, conditions, or other reasons for the test should be coded.

Reason for Visit

Some payers have encouraged, or insisted, that hospitals report the presenting symptoms for emergency room visit, even when a definitive diagnosis is established and reporting the symptoms would violate the official coding guideline concerning the reporting of symptoms integral to the definitive diagnosis. The payers are requesting this information in order to establish the emergent nature of the patient's complaint. The presenting symptoms (such as chest pain) may justify an emergency room visit, but the definitive diagnosis (such as hiatal hernia) is a non-urgent condition and would not, by itself, justify a trip to the emergency room.

To solve this dilemma while maintaining data integrity and adhering to official coding guidelines, the National Uniform Billing Committee agreed to expand the title and definition of the admitting diagnosis field on the UB-92 claim form to accommodate the need for information regarding the presenting sign or symptom. The title of this data element has been expanded to include "patient's reason for visit." The definition has been modified to read: "the ICD-9-CM diagnosis code describing the patient's diagnosis or reason for visit at the time of admission or outpatient registration." For outpatient claims, this should be the ICD-9-CM code describing the patient's stated reason for seeking care (or as stated by the patient's representative, such as parent, legal guardian, or paramedic). The modification of the description and definition of the Admitting Diagnosis field met several objectives, including:

- facilitating claims processing by allowing providers to report the reason the patient presented for treatment
- the new outpatient definition is consistent with the intent of the prudent layperson legislation that seeks to establish the reason the patient is seeking care (which may differ from the diagnosis established by the physician at the conclusion of the visit)
- the outpatient definition is consistent with various national definitions for the patient's reason for visit
- providing explanation as to why certain tests may have been ordered and performed
- reducing administrative burden on providers and payers by eliminating requests for additional documentation in some cases
- promoting adherence to established national coding guidelines

An ICD-9-CM diagnosis code should be reported in the admitting diagnosis field on the UB-92 whenever there is an unscheduled outpatient visit to a healthcare facility's emergency room or urgent care center. Currently, the UB-92 claim form can only accommodate one diagnosis code to describe the patient's primary reason for seeking care or treatment. The diagnosis code describing the patient's reason for the unscheduled visit should only be reported on outpatient claims. If the unscheduled visit results in an inpatient admission, the admitting diagnosis code should be reported instead of the reason for the outpatient visit. The use of the admitting diagnosis field for outpatient emergent and urgent encounters became effective April 1, 2000, and applies to all payers.

Note: Information in *Coding Clinic for ICD-9-CM* 17, no. 1, regarding the use of physician interpretations of tests in correct code assignment applies only to outpatient encounters. Please refer to the first quarter 2000 issue of *Coding Clinic for ICD-9-CM* for complete information on coding outpatient laboratory, pathology, and radiology encounters, including specific examples.

References

American Hospital Association. *Coding Clinic for ICD-9-CM* 15, no. 1. Chicago, IL: American Hospital Association, 1998.

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Official ICD-9-CM Guidelines for Coding and Reporting. Available at the National Center for Health Statistics Web site, www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm.

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Sue Prophet *is AHIMA's Director of Coding Policy and Compliance. She can be reached at sprophet@ahima.org.*

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