Choosing the Correct Codes for Screening and Diagnostic Labs

Although Allscripts includes the Health Maintenance V70.0 code on all patients in the EHR as a default, rarely is this code covered for lab orders by most payors. Below is some information that can be helpful for choosing codes that are accepted by most insurance plans.

- SCREENING is the testing for disease or disease precursors so that early detection and treatment can be provided for those who test positive for the disease. Screening tests are performed when no specific sign, symptom, or diagnosis is present and the patient has not been exposed to a disease.

- Tests for screening purposes (i.e. labs) that are performed in the absence of signs, symptoms, complaints, or personal history of disease or injury are typically NOT covered by Medicare except as explicitly authorized by statute. These include exams required by insurance companies, business establishments, government agencies, or other third parties.

TIP:
Do Your Research: Find out what screenings *are* covered by statute.
*For example, cardiovascular disease screenings for cholesterol, lipid, and triglyceride levels is covered by Medicare Part B (Medical Insurance) every **5 years.** Search for "Screen Cardiovascular." The code is **V81.2.***

- The testing of a person to rule out or to confirm a suspected diagnosis because the patient has a sign and/or symptom is a DIAGNOSTIC test, NOT a screening. In these cases, the sign or symptom should be used to explain the reason for the test.

- Any claim for a clinical diagnostic laboratory service must be submitted with an ICD-9-CM diagnosis code. Codes that describe symptoms and signs, as opposed to a diagnosis, should be provided for reporting purposes when a diagnosis has not been established by the physician. *(Based on Coding Clinic for ICD-9-CM, Fourth Quarter 1995, page 43).*

TIP:
Always document (link) signs, symptoms, and histories so that the diagnostic gets paid.

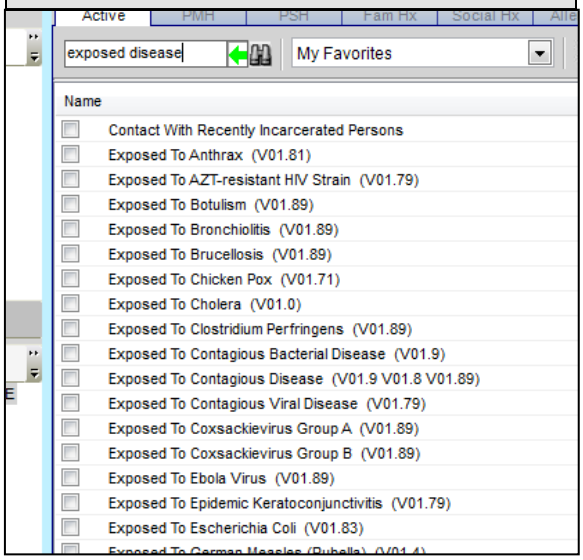
- Diagnoses documented as "probable," "suspected," "questionable," "rule-out," or "working diagnosis" should NOT be coded as though they exist. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as

signs, symptoms, abnormal test results, exposure to communicable disease or other reasons for the visit. *(From Coding Clinic for ICD-9-CM, Fourth Quarter 1995, page45).*

TIP: Use Your Medical Training.
Document why you suspect the diagnosis by linking signs and symptoms.

- When the reason for performing a test is because the patient has had contact with, or exposure to, a communicable disease, the appropriate code from category- "V01, Contact with or exposure to communicable diseases"- should be assigned, not a screening code, but the test may still be considered screening and not covered by Medicare. For screening tests, the appropriate ICD-9-CM screening code from categories V28 or V73-V82 (or comparable narrative) should be used. *(From Coding Clinic for ICD-9-CM, Fourth Quarter 1996, pages 50 and 52).*

TIP:
Try searching for "exposed disease."



- When a non-specific ICD-9 code is submitted, the underlying sign, symptom, or condition must be related to the indications for the test.

TIP
Search for the following codes when documenting signs and symptoms related to a suspected **urinary infection.**

780.96	Generalized pain
780.97	Altered mental status
780.99	Other general symptoms
785.0	Tachycardia, unspecified
785.50-785.59	Shock without mention of trauma
788.0-788.63, 788.64, 788.65, 788.69, 788.7-788.8	Symptoms involving urinary system (renal colic, dysuria, retention of urine, incontinence of urine, frequency, polyuria, nocturia, oliguria, anuria, other abnormality of urination, urethral discharge, extravasation of urine.)
788.99	Other symptoms involving urinary system

Mammogram Screenings

Medicare covers **screening** mammography depending on the age of the woman:

Age	Frequency
Younger than age 35	No Medicare payment allowed
Aged 35 – 39 years	Baseline (Medicare pays for only one screening for women in this age group)
Aged 40 and older	Annual (at least 11 months after the last covered screening mammograph

You must report one of the following ICD-9-CM screening ("V") diagnosis codes, listed in below for **screening** mammography:

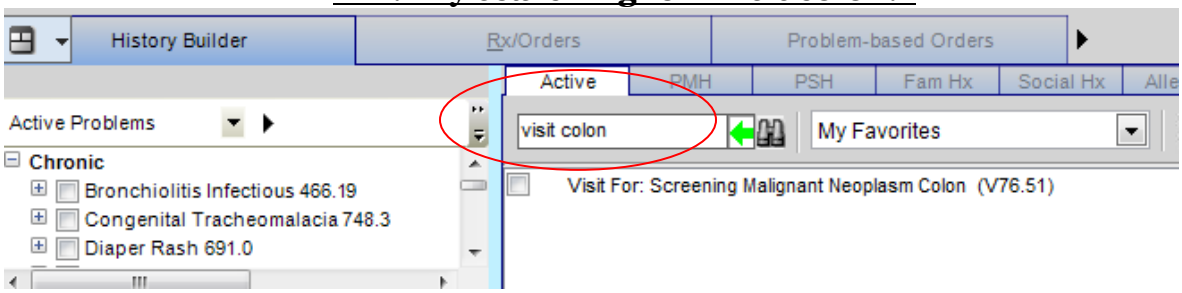
Code	Description
V76.11	Special screening for malignant neoplasms, screening mammogram for high-risk patient
V76.12	Special screening for malignant neoplasms, other screening mammogram

Colonoscopy Screening

Screening Colonoscopies are performed on patients that have NO presenting signs or symptoms related to the digestive system, but have reached the age for routine screenings (**age 50** for both men and women). Medicare covers one screening colonoscopy every 10 years for individuals not considered high risk.

Code	Description
V76.51	Special screening for malignant neoplasm, colon

TIP: Try searching for "visit colon."



High Risk Codes (Medicare provides coverage of a screening colonoscopy once every 2 years for high risk.)

Code	Description
V10.05	Personal history of malignant neoplasm, large intestine
V12.72	Personal history of colonic polyps
V16.0	Family history of malignant neoplasm, gastrointestinal tract
V10.06	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus

You need to **assess the actual medical necessity** behind performing the colonoscopy in the first place. It would not be medically necessary for an asymptomatic average risk patient (V76.51) to be screened at a two, three, or five-year interval. However, it might be medically necessary for an asymptomatic high-risk patient (V12.72, V16.0, etc.) to be screened every two, three or five years, therefore the diagnosis code used should reflect that.

Diagnostic Colonoscopy
When signs and symptoms are related to the GI tract (i.e., abdominal pain, blood in stool, chronic diarrhea, change in bowel habits, weight loss or blood loss anemia), **V-code (V76.51) should never be assigned**. A symptom code should be assigned when there is no definitive diagnosis. If the patient's history notes a family history or personal history of colonic malignancy or polyps, the above appropriate V- should be assigned as a secondary code.

Digestive Disease Condition ICD-9-CM Codes ICD-9-CM Code	ICD-9-CM Code Descriptor
555.0	Regional enteritis of small intestine
555.1	Regional enteritis of large intestine
555.2	Regional enteritis of small intestine with large intestine
555.9	Regional enteritis of unspecified site
556.0	Ulcerative (chronic) enterocolitis
556.1	Ulcerative (chronic) ileocolitis
556.2	Ulcerative (chronic) proctitis
556.3	Ulcerative (chronic) proctosigmoiditis
556.8	Other ulcerative colitis
556.9	Ulcerative colitis, unspecified
558.2	Toxic gastroenteritis and colitis
558.9	Other and unspecified non infectious gastroenteritis and colitis

Pap Test

Medicare provides coverage of a screening Pap test for all female beneficiaries once every 12 months if a) there has been evidence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years or b) is considered high risk. Coverage is provided every 24 months for low risk female beneficiaries.

Diagnosis Requirements

Use one of the screening ("V") diagnosis codes listed below. Code selection depends on whether the beneficiary is classified as low risk or high risk. This diagnosis code, along with other applicable diagnosis codes, must also be reported. **Failure to report the V76.2, V76.47, V76.49, or V15.89 diagnosis code will result in denial of the claim.**

Diagnosis Codes	ICD-9-CM Code Descriptor
V76.2	Special screening for malignant neoplasms; Cervix; Routine cervical Papanicolaou smear. *Excludes: that as part of a general gynecological examination (V72.3)*
V76.47	Special screening for malignant neoplasms; Other sites; Vagina; Vaginal pap smear status-post hysterectomy for non-malignant condition. Use additional code to identify acquired absence of uterus (V45.77). *Excludes: vaginal pap-smear status-post hysterectomy for malignant condition (V67.01)*
V76.49	Special screening for malignant neoplasms; Other sites.
V15.89	Other personal history presenting hazards to health; Other specified personal history presenting hazards to health; Other.

The above information, as well as more information about other screening/preventative procedures is available by downloading **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals.**