

FROM : INT. AUDIT

PHONE NO. : 5612235987

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MEDICARE EDUCATION AND OUTREACH

December 15, 1999

Dari Bonner, Corporate Compliance Coordinator

Dear Ms. Bonner,

This correspondence is in response to your inquiry dated November 5, 1999 regarding clarification on proper billing and documentation requirements for ICD-9-CM (International Classification of Diseases, 9th Revision, Clinically Modified) coding.

The Medicare Carriers Manual (MCM), Section 4020.3 states:

"For patients receiving ancillary diagnostic services only during an encounter/visit, the appropriate V code for the examination is sequenced first, and the diagnosis for which the services are being performed is sequenced second."

For example, this category will be used frequently by radiologist who are performing radiological examinations, not elsewhere classified will describe the reason for the encounter and will be sequenced first on the bill. When the reason for the referral is for other than a routine screening exam, a second diagnosis code should be reported, (e.g., wheezing, coughing).

Failure to list a second code in addition to (V72.5) may lead to problems with carriers screens on bills submitted. The code for radiological examination, not else where classified (V72.5) includes referrals for routine chest x-rays which are not covered by Medicare. Carriers may establish screens to verify that the referrals were not covered by Medicare. Carriers may also establish screens to verify that the referrals were not for routine chest x-rays. By supplying a second code to describe the reason for the referral, these bills can clearly be identified as referrals to evaluate symptoms, signs, or diagnoses. The omission of a second code may lead to requests from carriers for more information prior to payment of the claim.

P. O. Box 2078 ♦ JACKSONVILLE, FLORIDA 32231-0048

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If a physician refers a patient for a diagnostic service, but does not indicate the reason for the test, the V code should be used for the service performed and the referring physician's office should be contacted for more specific information substantiating the referral for service. The reason for the referral should then be coded and reported on the bill.

The Medicare Carrier Manual also continues by stating:

"Should a physician refer a patient for a diagnostic service with the reason for the referral being signs and symptoms, but the diagnostic service confirms a diagnosis then both the V code for the service and the final definitive diagnosis should also be put on the bill."

The Health Care Financing Administration (HCFA) has informed the Florida Medicare contractor, First Coast Service Options, Inc., that this section of the Medicare Carrier's Manual has not been updated; however, an update to this section will be made in the very near future. HCFA has stated that signs and symptoms should be coded for diagnostic services.

This is further clarified by the Health Care Financing Administration coding and reporting requirements that were finalized and published in the final rule in the March 4, 1994 Federal Register, section 42 CFR Part 424. These guidelines state:

- As mandated, physicians must utilize ICD-9-CM codes as reported in categories 001.0 through V82.9.
- List the ICD-9-CM code for the diagnosis, condition, problem, or symptom that is documented in the medical record as the primary reason for the encounter. List any additional codes that describe any coexisting conditions. Never add to or subtract statements made by the provider. Request additional records to clarify conditions, if necessary.
- Assign codes to the highest level of specificity. Use the fourth and fifth digits when available within the coding structure (effective July 1, 1996).
- Do not code diagnoses documented as "probable", "suspect", "questionable" or "rule out". It is important to note physician records must include this documentation to support medical necessity for "rule out" services ordered or performed. However, these suspected diagnoses are not to be used on the Medicare claim form.
- Chronic conditions treated on an ongoing basis may be reported as many times as the patient receives treatment and care for the condition(s).
- For patients receiving **ancillary diagnostic** services only during an encounter, use the CPT code for the procedure
- For patients receiving **ancillary therapeutic** services only during an encounter, use the CPT code for the service being rendered.

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First Coast Service Options, Inc. educates and reviews providers using these guidelines. I hope this information is helpful.

Sincerely,



Sandra Grimsley

Senior Provider Relations Representative
Medicare Education and Outreach Department