Unspecified Diagnosis Codes, Preoperative Examinations, and Tuberculosis Skin Tests

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Q. We are afraid of getting denials for using unspecified ICD-10-CM [*International Classification of Diseases, 10th Revision, Clinical Modification*] codes. In an urgent care center, we sometimes will see a particular patient only one time for minor illnesses and injuries, and follow-up with their primary-care physician is always advised. Do you have any advice on documenting to get claims paid?

A. Within ICD-10-CM, you may select codes defined as "Not Otherwise Specified" (NOS). Generally, this should be reserved for claims that lack sufficient documentation to select a more specific code. Prior to October 1, 2015, many consultants were warning providers to be prepared for an onslaught of denials for lack of specificity. Although we were skeptical of this advice, we can now confirm that nationally (at least for now), payors are denying almost no claims for NOS ICD-10 codes. In addition, Congress has passed a bill that specifically forbids Medicare carriers from denying a code for lack of specificity.

When sufficient clinical information is not known about a particular condition, it is acceptable to report an unspecified code. For example, in most patients with pneumonia in an urgent care center, the specific organism has not been identified. In these cases, the most accurate code would be J18.9, "Pneumonia, unspecified organism."

Unspecified codes are not the same as ICD-10 codes that are defined as "Not Elsewhere Classifiable" (NEC). These should be used when specific information is documented for the diagnosis but there is not an existing ICD-10-CM code to report. In this case, the documentation on the medical record is sufficiently specific, but the ICD-10-CM manual lacks the specificity to allow the coder to identify the diagnosis documented. Even with the massive number of additional codes in ICD-10, coders have been surprised to find that so many specific diagnoses do not have corresponding ICD-10 codes. ■

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Q. With ICD-10-CM, is it ever acceptable to use symptoms as a primary diagnosis for an urgent care visit?

A. Yes, many times a sign or symptom is the most specific code available. For example, if the physician sees a patient who has a cough but she is not sure whether the cough is due to bronchitis, asthma, pneumonia, or some other condition, then it would be appropriate to code for cough. It would be inappropriate to code for any of those specific diagnoses. According to the ICD-10-CM Official Guidelines for Coding and Reporting, Section I.B.18:

> Signs/symptom, and "unspecified" codes have acceptable, even necessary uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. . . .
>
> If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptoms. . . .[1] ■

Q. What diagnosis code should we use when a patient just needs a preoperative examination?

A. For patients receiving a preoperative evaluation, code first the reason for the encounter from ICD-10-CM code set Z01.810 to Z01.818:

1. https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf

- **Z01.810:** "Encounter for preprocedural cardiovascular examination"
- **Z01.811:** "Encounter for preprocedural respiratory examination"
- **Z01.812:** "Encounter for preprocedural laboratory examination"
- **Z01.818:** "Encounter for other preprocedural examination"

Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. For example, a patient presents for a preoperative examination for carpal tunnel surgery on the right wrist and has orders from his surgeon for laboratory tests. You would assign diagnosis code Z01.812, as already noted, for the primary diagnosis, and G56.01, "Carpal tunnel syndrome, right upper limb" as the additional diagnosis. Code also any findings related to the preoperative evaluation. ■

Q. When giving a tuberculosis skin test, can we charge for a subcutaneous injection?

A. Use *Current Procedural Terminology* (CPT) code 86580 ("Skin test; tuberculosis, intradermal") for purified protein derivative testing in the office. This test is not a vaccine; rather, it is a screening test for the presence of an immune response, indicating the presence of tuberculosis. In addition, code 86580 includes intradermal injection of the substance.

The Resource-Based Relative Value Scale (RBRVS) does not include the work for reading the test. Therefore, you can also use CPT code 99211 for the nurse reading. However, per incident-to regulations, the physician must be in the office at the time of the reading in order to code the 99211.

If the test results are positive, you can code for the additional services rendered during the visit. Typically, the physician will perform a face-to-face encounter with the patient for further evaluation and management (E/M), such as reviewing the diagnosis, conducting a physical examination, assessing risk, dealing with false-positive test results, and deciding among treatment options. You would choose the E/M code appropriately (99212–99214). You would also want to code for any additional testing, such as a chest x-ray.

The appropriate ICD-10-CM code for the initial screening and the reading is Z11.1, "Encounter for screening for respiratory tuberculosis." If the test findings are positive, then you would add another code, such as R76.11, "Nonspecific reaction to tuberculin skin test without active tuberculosis." ■