Preparing for ICD-10 By Addressing "Incomplete Diagnosis Information Received" Errors

In less than 7 months, on October 1, 2015 the health industry is changing from ICD-9-CM to ICD-10-CM for diagnosis coding. This will increase the number of diagnosis code options to approximately 69,000. ICD-10-CM contains a more extensive vocabulary of clinical concepts, body part specificity, patient encounter information, and other components from which codes are built.

While most of the coding changes do not directly affect pathology diagnosis practices (e.g. right vs. left breast or initial vs. subsequent encounter for fracture), it is not yet known how well payers will accept "unspecified" code options. Pathology practices and laboratories can start now to secure a smoother transition from ICD-9 to ICD-10 – and decrease the likelihood of denials – by ensuring they are receiving complete diagnosis information from referring physicians on every case. This may require both enhancement of your lab intake protocols and education of referring physicians/staff to make certain the clinical reason for each request is properly and thoroughly documented.

Diagnosis coding rules for Lab tests differ from those for Pathology. Because lab tests are not interpreted by the pathologist, they are coded from the referring physician's reason for ordering the test (this includes Paps). Pathologist-interpreted tests are coded from the pathologist's diagnosis, but not all specimens have pathology. In these negative-for-pathology cases, the clinician's reason is once again used to obtain the diagnosis code.

Listed below are the most common scenarios of insufficient diagnosis information on pathology and laboratory cases, and tips on how to address these errors.

1. **No History Provided**
   Federal law requires that the referring physician must give the reason for ordering a diagnostic service, and if not provided, the pathologist/lab must request this information. Many lab tests have payment rules related to whether the test is screening vs. diagnostic, and limitations on qualifying ("payable") diagnoses. Review your requisitions on accessioning to ensure the clinician's reason for request is clear.

2. **Uncertain Diagnosis-**
   Coders cannot assign diagnoses that are uncertain. Wording such as "suspected", "suggestive of, " or "rule out" does not constitute a definitive diagnosis. If the patient doesn't yet have a diagnosis, the referring physician should provide the patient's presenting signs or symptoms that prompted the ordering of the pathology or lab service.

3. **Incomplete, Vague, or Irrelevant Clinical History Supplied**
   While knowing the procedure that was performed – such as breast biopsy or FNA thyroid – is helpful to know otherwise, this is not sufficient detail from which we can assign a diagnosis code. And remember, diagnosis codes are used by payers to support the medical necessity of the service being charged – diabetes may well be an accurate diagnosis, but it wouldn't support the need for a thyroid FNA charge.

4. **Inaccurate or Invalid ICD Codes Supplied**
   Does your requisition have ICD9 codes on it, or a blank for the clinician's ICD code? If you have actual codes, remember those are going to be obsolete after September 30th of this year. It's not too early to start updating your requisition for ICD10, and making sure your referring physician offices understand to only use the ICD10s after 10/1. If your requisition has blank line for ICD numbers, you shouldn't need to update your forms, but ICD9 or 10 numbers can easily be transposed or digits can be missing. Create a "cheat sheet" at least for your most common diagnosis codes, and use it to check your requisitions against to ensure they are using valid codes.

5. **Products of Conception, Delivery, and Placentas**
   Even in ICD9 these specimens' diagnosis code options are often more specific than the information supplied. For example, were the products of conception the result of a missed abortion, legal abortion, or was it a retained placenta post-delivery? For placenta specimens we need gestational age, whether vaginal or C-section delivery, and documentation of normal vs. complications during labor/delivery. Visit your L&D and outpatient departments to educate the nursing staff on the kind of specificity you need, or review the EMR on these cases and include the details in your clinical histories.

6. **Paps and Pap-specimen tests**
   Medicare requires that we distinguish diagnostic vs. high-risk screening vs. low- risk screening for payment of Pap tests. Many state Medicaid plans require distinguishing if for family planning, and many commercial payers require only diagnostic vs. screening. For any additional testing performed on the Pap specimen we need the reason for each test, though rules vary between payers and between tests – the Pap code doesn't necessarily explain the need for additional tests. Creating a user-friendly requisition to prompt the clinician to provide all of this information upon ordering the services is imperative.

Key Points;

- Check all requisitions for complete diagnosis information, and contact referring MDs or hospital personnel or records if sufficient information is not provided.

- Monitor the cases McKesson returns to you for incomplete diagnosis information and identify common threads, such as repeat offender referring MDs, surgical nursing staff, or types of specimens.

- Address the errors at the source, and track to ensure issues are being fixed. Focus on higher dollar and higher volume first.

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