

Coding Guidelines for All NCDs

1. 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 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).
2. 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. 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. 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).
3. A three-digit code is to be used only if it is not further subdivided. Where fourth-digit and/or fifth-digit sub-classifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code. (From Coding Clinic for ICD-9-CM, Fourth Quarter, 1995, page 44).
4. 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, page 45).
5. When a non-specific ICD-9 code is submitted, the underlying sign, symptom, or condition must be related to the indications for the test.

***October 14 Changes – Red**