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About Maxim Health Information Services

Maxim Health Information Services (MHIS) provides superior quality [coding, auditing, clinical documentation improvement, and health information technology services](#) to healthcare organizations across the country. MHIS offers on-site coding support, remote coding services, auditing and review services, education and training, HIM outsourcing solutions, and services to the Department of Veterans Affairs' Medical Centers. MHIS provides qualified healthcare professionals to customers to meet their needs in an efficient and cost-effective manner. MHIS has some of the best [career opportunities](#) in the industry, with positions including on-site coding, remote coding, travel coding, auditing, and more.

Welcome to the first September issue of Maxim Coding CornerSM! As a leader in the HIM industry, [Maxim Health Information Services](#) is committed to providing you with coding-related topics that matter to you. This month, we are focusing on coding for signs and symptoms. Read on below to learn more and be sure to look for information at the end of this article about our new [Ask a Coding Question](#) feature!

Coding for Signs and Symptoms

Diagnosis codes 780-799 are used to reflect signs, symptoms, and ill-defined conditions. However, coders often inappropriately overuse these codes. This article addresses appropriate use of codes from categories 780-799.

Codes for signs and symptoms should never be assigned on an inpatient encounter when they are integral to a definitive diagnosis unless the sign or symptom affects the severity of the patient's condition and/or treatment rendered. For example:

- Patient is admitted for dyspnea, which is determined to be due to an acute exacerbation of congestive heart failure. Dyspnea would not be coded in this circumstance because it is due to a more definitive diagnosis and does not alter the severity of the patient's condition or impact the patient's care.
- Patient is admitted for treatment of pneumonia with hypoxemia. The hypoxemia (799.02) would be assigned as a secondary diagnosis because it increases the severity of the patient's condition.
- Patient is admitted for treatment of cirrhosis and paracentesis is performed to remove the patient's ascites. Ascites (789.59) would be assigned as an additional code because it required additional treatment.

The UHDDS definition of principal diagnosis is "the condition established after study to be chiefly responsible for admission of the patient to the hospital." Thus, when a patient is admitted for a sign or symptoms, the final diagnosis is the underlying condition determined after study.

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However, the following are examples of scenarios where it is appropriate to assign a sign or symptom as the principal diagnosis:

1. There is no definitive diagnosis for the presenting symptom. Occasionally, the physician is unable to determine a cause for a patient's symptoms or will transfer the patient for further work-up prior to determining a definitive diagnosis. In these cases, the coder would identify the sign or symptom as the principal diagnosis since it was the reason for the patient's admission.

2. Symptom followed by comparative or contrasting conditions. When the physician documents that a patient's presenting sign or symptom is due to two or more comparative or contrasting conditions, the symptom is designated as principal diagnosis and all comparative/contrasting conditions are sequenced as secondary diagnoses. The exception to this rule is if the symptom code is integral to each of the comparative/contrasting conditions. In this case, only the comparative/contrasting conditions are coded and no code is reported for the symptom.

3. Symptom as the result of an adverse effect. Sequencing guidelines for adverse effects of medical treatment require the adverse effect to be sequenced as the principal diagnosis, followed by the E code for the responsible medication(s). Thus, if the patient's adverse effect is a sign/symptom with no other definitive diagnoses, then the sign/symptom must be sequenced first.

Outpatient procedures are not reimbursable by Medicare if the patient does not meet medical necessity for the procedure. Typically, outpatient procedures are performed to identify the cause of a patient's symptoms. In order for the facility to appropriately receive reimbursement for outpatient procedures, coders must remember to assign the symptom for each outpatient procedure or treatment performed. Medical necessity requirements can vary from state to state, depending on the fiscal intermediary (FI). To identify the medical necessity requirements for your FI, go to www.cms.hhs.gov and search for the Medicare Coverage Database under Medicare Coverage – General Information.

Ask a Coding Question

Have a coding-related question that you would like to get answered by an MHIS coding expert? Visit our new ["Ask a Coding Question"](#) page to submit your question for review. If your question is selected as the **Coding Question of the Month**, a full answer will be posted on our website for you and all MHIS website visitors to reference!

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