Welcome...

- Don’t forget to turn your phone off
- Please feel free to ask questions
  - Relevant to the topic
- The last portion of this presentation is reserved for open forum questions
  - As time allows...
Overview of ICD-9-CM: History

- Diagnostic coding dates back to the 17th century, when statistical information was gathered by a system known as the London Bills of Mortality.
- In 1948, the World Health Organization (WHO) published a list of statistics that included both morbidity and mortality.
  - Called the “International Classification of Diseases” (ICD), it has evolved into the current book we use today.
Overview of ICD-9-CM: History

- Worldwide recognition was attained by 1979, when WHO published its 9th revision to the ICD.
- The US modified this text with clinical information, resulting in the ICD-9-CM.
  - In order to describe the clinical picture of a patient, codes must be more precise than those needed for statistical purposes only.

Overview of ICD-9-CM: Medicare

- Medicare Catastrophic Coverage Act of 1988
  - Required use of ICD-9-CM codes for diagnosis
  - Act later repealed, but codes still used
  - Penalties for non-compliance can include claim denials and/or fines or sanctions.
Overview of ICD-9-CM: Conventions

- Conventions are: abbreviations, punctuation, symbols, typefaces, and formatting methods used in the ICD-9.
- There are two sources of coding conventions:
  - ICD-9-CM Official Guidelines for Coding and Reporting
  - ICD-9-CM publisher-specific formatting conventions

It is important that you familiarize yourself with your book’s publisher specific conventions and those that are found in the “Official Guidelines for Coding and Reporting”.
- Publishers may use different symbols
- Knowing the coding conventions will help you become a more efficient and accurate coder.
Overview of ICD-9-CM: Abbreviations

- Two key abbreviations used in the ICD-9-CM:
  - NEC (Not Elsewhere Classified) Used in Volumes 1 and 2
    - No more specific code exists
    - 692.4 Contact dermatitis, due to ...

Overview of ICD-9-CM: Abbreviations

- NOS (Not Otherwise Specified) Used in Volume 1
  - The information available does not permit a more specific code assignment (unspecified in documentation).
  - 198.89 Secondary Malignant neoplasm of other specified sites, other...
Overview of ICD-9-CM: Punctuation

- Three punctuation symbols listed in the guidelines:
  - **Brackets:**
    - Enclose synonyms, alternative wording, or explanatory phrases
    - Used to identify manifestation codes
  - **Parentheses:**
    - Nonessential modifiers
    - Have no effect on code selection
    - Does not have to be in diagnostic statement
  - **Colon:**
    - Completes a statement with one or more modifiers

Overview of ICD-9-CM: And/With

- **And:** means either “and” or “or”
  - Example: 237.0, Neoplasm of uncertain behavior of pituitary gland **and** Craniopharyngeal duct
- **With:** means that two conditions are included in the code
  - Example: 070.41, acute hepatitis C **with** hepatic coma
Overview of ICD-9-CM: See/See Also

- **See**: directs you to specific term
  - Example: Panotitis—see Otitis media
- **See also**: directs you to another term for more information
  - Example: Perivaginitis (see also Vaginitis)
- **See Category**: Direct you to a category note
  - Example: Late effect, encephalitis or encephalomyelitis (conditions classifiable to 323) - see category 326

Overview of ICD-9-CM: Format

- **Volume 1, Diseases, Tabular List (diagnosis)**
  - 17 chapters
- **Volume 2, Diseases, Alphabetic Index (diagnosis)**
  - 3 sections
- **Volume 3, Procedures, Tabular List and Alphabetic Index**
  - Inpatient use
Overview of ICD-9-CM: Volume II

- Section 1, Index to Diseases
  - Hypertension Table
  - Neoplasm Table
- Section 2, Table of Drugs and Chemicals
- Section 3, Index to External Causes of Injuries and Poisonings (E Codes)
  - Never a primary diagnosis
  - Medicare does not accept for professional billing

Overview of ICD-9-CM: Journey

- Looking up a diagnostic code starts with the medical record. Determine the diagnostic statement, and then select the main term to begin the “journey” of the ICD-9 code.
- A good “journey” will ensure rapid, accurate coding.
  - Remember to follow the rules and conventions as you go.
### Overview of ICD-9-CM: Main Terms

- Volume 2 is sequenced alphabetically by "main terms" which are key words from the medical record.
- The method of searching for a code in Volume 2 should always be by terms which are based on the:
  - Diagnosis, Symptom, Condition
- Should not be based on anatomy.

### Overview of ICD-9-CM: Steps

- Locate the main term (bold) in the Index
- Review any non-essential modifiers (in parentheses)
- Evaluate any cross reference terms (see, see also)
  - Read all essential modifiers (indented terms, aka sub-terms)
  - Check for further modifiers (sub-term to a sub-term)
- Write your code reference down
- Verify code in the Tabular volume
  - Read up, read down, read your notes
    - Includes, Excludes, Code also, Code first...
Overview of ICD-9-CM: Volume I, Tabular List

Two major divisions
- Classification of Diseases and Injuries (codes 001.0-999.9)
- Supplementary Classification (V codes and E codes)

Main portion of ICD-9-CM, Classification of Diseases
- 17 Chapters: codes from 001.0-999.9
- Most chapters are systems (Digestive, Respiratory)
- Some are based on the cause/type of disease or neoplasm (Infectious and Parasitic Diseases)

Overview of ICD-9-CM: Structure

Volume I (Tabular list) structure:
- Chapter
  - Section
    - Category
    - Subcategory
- Subclassification

Notes can be located at the beginning of any/all of these... see code 405.01
Overview of ICD-9-CM: Specificity

- Each digit adds more detail (specificity).
- Always code to the highest level of specificity.
  - If you follow the conventions, the book will tell you what to do.

Three-digit code: 730
Fourth digit: 0
Fifth digit: 01

= 730.01 = acute osteomyelitis of the shoulder
Out-patient Coding and Reporting Guidelines

- Most publishers of the ICD-9 manual include the official guidelines in the Introduction section of the book.
  - PMIC does not, but they do give instruction and examples
- The guidelines are usually set up in a two step fashion (like coding).
  - The first part is an outline of topics.
    - Section I. A. 2. = Abbreviations, eg.
  - After that, the actual guidelines (instructions) begin.
- The answers to your coding questions are in the book – locating them is sometimes the challenge

Selection of First-Listed Diagnosis

- In an outpatient setting, coders should indicate the main reason for the visit as the primary diagnosis, as well as subsequent diagnoses to substantiate other services provided, such as laboratory or radiology.
- Sequence the primary diagnosis first.
  - Why patient presented, not necessarily most serious condition noted
- Documented
- Chiefly responsible for services provided
- Also list co-existing conditions
Diagnosis and Services

- Diagnosis and procedure codes MUST correlate on an out-patient claim.
- Medical necessity must be established through documentation.
- No correlation = No reimbursement

Symptoms, Signs, and Ill-Defined Conditions

- Can be the first-listed diagnosis if no more specific diagnosis is available.
- Diagnoses often are not established at the time of the initial encounter/visit.
Routine Tests

- Assign V72.5 and/or V72.6x
  - for routine lab/radiology test ordered without signs, symptoms, or associated diagnosis

Uncertain Diagnoses

- Do NOT code diagnoses documented as probable, suspected, questionable, rule out, or working diagnoses.
- Rather, code condition(s) to highest degree of certainty for that encounter/visit.
  - Symptoms, signs, abnormal test results, or other reason for visit.
Chronic Conditions

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as patient receives treatment and care for said condition(s).
  - Hypertension, Diabetes, Arteriosclerotic heart disease, Asthma, COPD

“History” Codes

- “History of” codes (V10-V19) may be used as secondary codes if:
  - Impacts current care or treatment
    - Personal history of malignant neoplasm
    - Personal history of allergy
    - Family history of malignant neoplasm
    - Family history of certain chronic disabling diseases
Caution about History

• If the patient record states that there is a “history of” a disease, such as diabetes, it does not mean that the patient no longer has the disease; but that the patient’s medical history includes the disease.

• A V code is not assigned to indicate a previous history of diabetes; rather, the code for the current disease (250.0X) is used.

Diagnostic or Therapeutic Services

• For patients receiving diagnostic or therapeutic services ONLY
• Sequence first
  o Diagnosis
  o Condition
  o Problem
  o Other reason shown in medical record to be chiefly responsible for encounter
• Do not code related signs and symptoms as additional diagnoses
Pre-op Evaluations

- For patients receiving preoperative evaluations ONLY
  - Code from category V72.8 (Other specified examinations)
  - Assign secondary code for reason for surgery
  - Code also any findings related to preoperative evaluation
    - Fever, anemia, etc...

Ambulatory Surgery

- Code the diagnosis which necessitated the ambulatory surgery.
- Pre- and post-op diagnosis are sometimes different.
  - Code the post-op diagnosis, as it is the most definitive
### Prenatal Encounters

- Code routine prenatal visits with no complications:
  - V22.0 (Supervision of normal first pregnancy)
  - V22.1 (Supervision of other normal pregnancy)
  - DO NOT use these codes with pregnancy complication codes (Chapter 11, ICD-9-CM)

### Incidental Pregnancy

- V22.2 Pregnant state incidental
  - Secondary code only
  - Requires physician documentation that the treated condition is not complicating the pregnancy management.
  - Lacking this documentation, chapter 11 codes will be used.
Other and Unspecified Codes

- **Other**: Codes titled "other" or "other specified" (usually with a fourth digit of 8 or fifth digit of 9) are for use when the information in the medical record provides detail for which a specific code does not exist.

- **Unspecified**: Codes (usually with a fourth digit of 9 or fifth digit of 0) titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code.

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Other and Unspecified Codes

- Decimal digits .8 or .9 are usually used to indicate other specified or unspecified conditions. You should only use them when information that is more specific is not available or does not exist. You should not use these digits when it is not convenient to get more detailed information.

- Look at code **979.9** (both "other" and "unspecified")
  Look at code **980.8** ("other specified")
  Look at code **980.9** ("unspecified")
Additional Coding Tips

- For multiple injuries and burns, always sequence the most severe injury first.
- For causes of infections, code them as secondary.
- Distinguish between acute and chronic whenever the ICD-9-CM makes the distinction.
- Revise billing charge tickets and forms annually to include current ICD-9-CM codes.

Abstracting

- Abstracting is selecting relevant information from the patients medical record and converting it into standard, billable codes for reimbursement purposes.
- Your knowledge of medical terminology, anatomy and physiology, and standard medical abbreviations factor into correct abstracting.
  - A coder’s best friend is a medical dictionary.
  - Good coders are always learning.
For diagnostic codes, the coder's test is to ask; what was the reason for the visit (service)?
- That reason will be the diagnostic statement.
  - Select your main term (not anatomy)
  - Follow coding rules to assign additional codes for any: manifestations, causative organisms, circumstances, comorbidities, etc...

An example of a coding situation where the health care provider's notes may not match the terms in the ICD-9-CM is *strep throat*.
- Where to start?
Abstracting

• The Alphabetic Index (Volume 2) lists *Streptococcus* and *Throat*, but no codes are provided for either.
  ○ research more about the condition.
• Strep throat is an infection. Start with the main term *infection* in the Index (what the patient is suffering from), you will see subterms *throat* and *streptococcal* and be able to locate the correct code.

Practice Abstracting

• The patient was prepped and draped in the usual sterile fashion. The left arm was adducted to expose the axilla. Two carbuncles were identified and infiltrated separately with 1% lidocaine after the incisions were made over both affected areas, and dissection was carried down to encompass subdermal and deeper tissue. An inflamed lymph node was also identified, and this was taken with the more superficial tissue. After this, the wounds were irrigated and closed with 4-0 subcuticular stitch. Steri-Strips and sterile dressings were applied. The patient tolerated the procedure well and was returned to the recovery room in good condition.
• Pathology report indicated: Lymph node was negative for neoplastic behavior.
The patient was prepped and draped in the usual sterile fashion. The left arm was adducted to expose the axilla. Two carbuncles were identified and infiltrated separately with 1% lidocaine after the incisions were made over both affected areas, and dissection was carried down to encompass subdermal and deeper tissue. An inflamed lymph node was also identified, and this was taken with the more superficial tissue. After this, the wounds were irrigated and closed with 4-0 subcuticular stitch. Steri-Strips and sterile dressings were applied. The patient tolerated the procedure well and was returned to the recovery room in good condition.

Pathology report indicated: Lymph node was negative for neoplastic behavior.

680.3 Carbuncle, axilla
289.3 Inflammation, lymph node or gland
MEDICAL NECESSITY

- This concept is defined in different ways by different payers to contain costs and prevent abuse of health care resources.
- Insurers will not pay for treatment unless they consider it to be medically necessary.
- Medicare defines a service as medically necessary if it is needed for the diagnosis or treatment of a medical condition, meets the standards of good medical practice in the local area, and is not for the convenience of the patient or doctor.

MEDICAL NECESSITY

- Out-patient claims are paid on the basis of medical necessity.
  - Valid ICD-9-CM code that explains the reason for the treatment.
    - Can be a sign/symptom, when no definitive diagnosis has been assigned.
    - Can change from claim to claim, or encounter to encounter.
MEDICAL NECESSITY = DOCUMENTATION

- It's not enough to have a code listed on the claim form, it also must be documented.
  - The medical record and the billing record should match.
  - Insurance carriers routinely audit processed claims. They will verify that documentation supports each service billed for.
  - Illegible documentation is of no value.

MEDICARE DOCUMENTATION

- Providers may have their own policy regarding documentation, and may not even require daily record entries. However, Medicare regulations do require charting for each visit/service submitted by physicians.
- Lack of documentation can be considered fraud or abuse.
  - Subject to monetary penalties.
  - And/or exclusion from participation in federal programs.
A claim form is a bill. What payer in today’s healthcare environment would pay for a claim that doesn’t meet the definition of medical necessity?

Out-patient claims must explain item by item, exactly what was done to the patient, and why.

Why was the service needed? ICD-9-CM codes that are unspecified, “other” or vague may impact your reimbursement

- Ask yourself – does this code descriptor explain the reason for the treatment?
  - Verify the information charted, for a more specific diagnosis
  - Request additional information from MD
- Know your ICD-9-CM conventions, follow the guidelines
Examples

Billing 2 E/M for a patient on the same DOS
- 99396 Preventive medicine
- 99213-25 Problem oriented office visit
  - V70.0 General medical examination
    - Assign a code for the condition (heart murmur, enlarged prostate...)

Billing for a procedure with a vague code
- 17260 Destruction, malignant lesion
  - 709.9 Lesion, skin (Dermatosis NOS)
    - Assign a code that describes the need for this service
      - 173.5 Primary malignancy, skin of chest
Multiple and Combination Codes

- **Multiple (component) coding** means that two or more codes are used together to accurately identify a diagnosis. Multiple codes are necessary whenever you see the ICD-9-CM notes "Use additional code" or "Code first underlying disease."
- **A combination code** is one code that describes conditions that frequently occur together. Combination terms are often listed as subterms in the Alphabetic Index. Some key words that may indicate a combination term are:
  - associated with, complicated by, due to, secondary to, with or without

Sequencing

- Multiple codes are necessary whenever you see the ICD-9-CM notes Use additional code or Code first underlying disease.
  - These are also your sequencing instructions.
  - Note the use of slanted brackets in Volume II, as well.
    - Follow the conventions of ICD-9
    - Read, Read, Read
Etiology/Manifestation

- The etiology/manifestation convention requires two codes to fully describe a single condition that affects multiple body systems.
  - Other instances (single conditions) may require more than one code to fully describe the condition.
- Etiology (cause)
  - Diabetes Mellitus
- Manifestation (symptom)
  - Cataract

Examples

- Combination Code:
  - Encephalomyelitis (manifestation) due to rubella (etiology), 056.01
- Multiple/Component Coding:
  - Chronic cerebral ischemia due to malignant hypertension, 437.1, 401.0
Late effects

- Sometimes, an acute illness or injury leaves a patient with a problem that remains after the illness or injury has resolved.
- Late effect is a residual of (remaining from) a previous illness/injury
  - e.g., Scar produced by previous burn
- Residual coded first (scar)
- Late effect cause (burn) coded second 906.6

Late effects

- Late effect codes are not in a separate chapter
  - Rather, they are found throughout the Tabular volume
  - Reference the term “Late” in the Index
- There is no time limit on developing a residual.
- There may be more than one residual.
Late effects

- Example: Patient had a stroke and has residual paralysis on dominant side (hemiparesis, 438.21) and aphasia, (438.11)
- Late effect means the original injury has healed and you are dealing with a “residual” condition.
  - Do not give your patient a previous problem!

Poisoning

- Table of Drugs and Chemicals
  - Alphabetic listing with codes
  - Do NOT code directly from Table
  - Always reference Tabular
    - Verify your code
Table of Drugs and Chemicals

- First column: “Poisoning” code for substance involved, wrong substance given or taken
- First-listed before manifestation condition

<table>
<thead>
<tr>
<th>Poisoning code</th>
<th>How the poisoning occurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meperidine</td>
<td>960.69</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>960.7</td>
</tr>
<tr>
<td>Anisodamine</td>
<td>960.9</td>
</tr>
<tr>
<td>Amphetamine (yohimbine)</td>
<td>960.4</td>
</tr>
</tbody>
</table>

Table of Drugs and Chemicals: Headings

- Accident: Unintentional
- Therapeutic: Correct dosage, correctly administered, with adverse effects (example, allergic reaction)
- Suicide attempt: (must be documented)
- Assault: Intentionally inflicted by another person
- Undetermined: Unknown intent
### E Codes (E800-E999)

- Supplementary Classification of External Causes of Injury and Poisoning
- Alpha-numerical designations for injuries and poisonings
- Provides additional information about external causes
- Never a primary diagnosis
- Separate E code index

### Guidelines: Table Of Drugs And Chemicals

- If 2 or more substances are reported, code each one individually unless a combination code exists.
- When a reaction occurs because of the interaction of a drug and alcohol – assign poisoning codes for both substances.
- The first-listed E code should correspond to the cause of the most serious diagnosis.
- If the same E code would describe the causative agent for more than one adverse reaction, assign the code only once.
Poisoning

Poisoning occurs when drugs/chemical substances are not taken as directed
- Wrong dosage given in error
- Medication given to wrong person
- Medication taken by wrong person
- Medication overdose has occurred
- Medications (prescription or over-the-counter) taken in combination with alcohol and/or recreational drugs
- Over-the-counter taken in combination with prescription drugs without provider approval

Adverse Effect

- An adverse effect occurs when a medicine or drug is taken according to the instructions, but the patient develops a reaction to the substance.
- Remember - If the patient is being treated for an adverse reaction due to a combination of alcohol and another substance in the blood stream (prescribed appropriately or not), refer to the poisoning codes.
Poison Sequencing

Correct Sequencing of Poisoning:
- Poisoning code from Table of Drugs & Chemicals first
- Manifestation(s) of the poisoning second
- Corresponding E-code from the Table of Drugs and Chemicals last
  - If intent unknown or questionable, report intent as undetermined (E980-E989)

Sequence of Adverse Effect

Correct sequencing of Adverse Effects:
- The manifestations (conditions) that resulted from the drug reaction (it can be more than 1).
- An E code from categories E930 – E949 (Therapeutic Use Column) to identify the substance responsible for the adverse effect.
Poisoning or Adverse Effects?

- The patient received prochlorperazine capsules for nausea and vomiting. At home she placed the pill bottle on the bathroom counter. Her 2 year old daughter saw the bottle, dumped out some capsules and ate them. Within minutes the patient found her child unconscious on the bathroom floor. The child was rushed to the emergency room where she was treated and admitted to the hospital.

Poisoning or Adverse Effects?

- Poisoning, because the substance was not prescribed for the child.
  - The correct codes & sequencing for this scenario are:
    - 969.1 Poisoning with Phenothiazine-based tranquilizers (poisoning code)
    - 780.09 Unconscious (manifestation)
    - E853.0 Accidental poisoning by Phenothiazine-based tranquilizers (how poisoning occurred)
A 25 year old female was given trimethobenzamide hydrochloride capsules for severe nausea and vomiting. She took the medication as directed. After a short time, she developed dizziness and palpitations. The patient quickly returned to the doctor for a change in medication.

Poisoning or Adverse Effects?

Adverse reaction, because the patient took the appropriate amount of a correctly prescribed medication.

- The correct codes & sequence for this scenario are:
  - 780.4 Dizziness (manifestation)
  - 785.1 Palpitations (manifestation)
  - E933.0 Therapeutic use of antiemetic drugs (external cause)
Q & A

• Open forum

• Need a CEU certificate?
  o AAPC has a certificate available
    ▪ 1.5 CEU’s
  o NHA or other
    ▪ Submit copy of registration & flyer for evaluation