ICD-9-CM Coding Seminar

****Information based upon current ICD-9-CM code sets and guidelines****

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Today's Objectives

- Learn why accurate diagnosis coding is important to your practice's reimbursement
- Learn methods to improve ICD-9 Coding in your practice
- Discuss how inaccurate coding may affect your practice

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Key Points

- Accurate ICD-9-CM coding supports medical necessity.
- Documenting all chronic conditions and specific diseases is necessary for completing the full diagnostic picture.
- The importance of specificity and coding out to the 4th and 5th digits.

ICD-9 Coding

What is ICD-9-CM?

- ICD-9-CM: International Classification of Diseases – 9th Edition – Clinical Modification.
- Used to code signs, symptoms, injuries, diseases and conditions. This indicates “why” the patient was seen.
- ICD-9 codes support the medical necessity for the CPT services performed. This is “what” was supported by the ICD-9 code.
- This why/what relationship structure is one of the most common reimbursement edits.

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ICD-9 Manual

Manuals are produced by many different publishers but share these common features:

> Volume 1– Tabular Index
- Main classification of diseases and injuries
- Organized by the numeric value representing a specific body system

> Volume 2 – Alphabetical Index
- Organized 1st by main terms, and then by specific sub-terms

> V Codes

> Tables

ICD-9 Manual

- ICD-9 codes are updated every October, so it is important to purchase a new ICD-9 Manual every year and check for updates online.
- New, deleted and revised codes available on CMS Web site. Codes for October 2009 available at:
  www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp
- Revised index and tabular listings for October 2009 can be found on the CDC Web site at:
  http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm
- Other Web sites of interest:
  www.cms.hhs.gov/MLNProducts/
  www.ama-assn.org

How to Use ICD-9

- Use Volume 2 to locate the main term that is described in the medical record as the reason for the encounter. Main terms are:
  - Diseases- such as asthma or diabetes
  - Conditions- such as fatigue
  - Nouns- such as syndromes and eponyms- Barrett's Syndrome
  - Adjectives- such as swelling or enlarged
- Follow any cross references in the index such as "See" and "See also". For example, "Disease-Renal" in the index says to "see also Disease-Kidney".

How to Use ICD-9

- When you have found the code in Volume 2, reference the code in Volume 1 Tabular Index. **Do not skip this step!**
- Verify that the codes agree and are appropriate for the documentation.
- Code to the highest level of specificity-apply all 4th and 5th digits as directed.

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ICD-9 Abbreviations & Symbols

- **NEC** - Not elsewhere classifiable - Used when ICD-9 does not provide a code specific for the patient's condition.

  Example: **008.67 Enterovirus NEC**
  Coxsackie virus
  Echovirus

- **NOS** - Not otherwise specified - This abbreviation is the same as "unspecified" and is used only when the coder lacks the information necessary to code to a higher specificity.

  Example: **382.9 Unspecified otitis media**
  Otitis Media:
  NOS
  acute NOS
  chronic NOS

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ICD-9 Abbreviations & Symbols

- Brackets [ ] - enclose synonyms, alternative terminology or explanatory phrases.
- Parentheses ( ) - enclose supplementary words or “non-essential” modifiers that may be present in the diagnostic statement without affecting the code assignment.

Example:

360.21 Progressive high (degenerative) myopia

ICD-9 Abbreviations & Symbols

- Colons : - are used in the Tabular List after an incomplete term that needs the one or two modifying statements that follow it to complete the code assignment.

  Example: **251.1 Other specified hypoglycemia**

  Hyperinsulinism:

  NOS

  ectopic

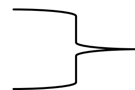
  functional

- Braces { } - enclose a series of terms which are modified by the statement to the right.

  Example: **368.63 Abnormal dark adaptation curve**

  Abnormal threshold

  Delayed adaptation

  of cones or rods

ICD-9 Instructional Statements

- These statements appear only in the Tabular list (Volume 1) to assist the coder in defining what is and is not included in a particular subdivision.
  - INCLUDES : A note that further defines or clarifies the content.
  - EXCLUDES : Terms following the word “Excludes” are not classified to that section and should be coded elsewhere.

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ICD-9 Instructional Statements: Example

AHA: 1Q, '88, 12

DEF: Acute inflammation of mucous membranes; extends from nares to pharynx.

461 Acute sinusitis

INCLUDES abscess, empyema, infection, inflammation, suppuration } acute, of sinus (accessory) (nasal)

EXCLUDES *chronic or unspecified sinusitis (473.0-473.9)*

461.0 Maxillary

Acute antritis

ICD-9 Instructional Statements

Use additional code

> Signals the coder that an additional code should be used (if the information is documented) to provide a more complete picture of that diagnosis.

Example:

250.50 Diabetes with ophthalmic manifestations

Use additional code to identify manifestation, as:

- Blindness (369.00-369.9)
- Glaucoma (365.44)

ICD-9 Instructional Statements

> Code first underlying disease: Instructional note found under certain codes as a sequencing rule.

Example:

456.21 Esophageal varices in diseases classified elsewhere, without mention of bleeding

Code first underlying cause, as:
Cirrhosis of liver (571.0-571.9)
Portal hypertension (572.3)

> Code, if applicable, any causal condition first: A code with this note indicates that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable.

ICD-9 Instructional Statements

Cross-Reference Terms

> *See* condition: Instructs the coder to refer to a main term for the condition.
> Example: Hip – see condition

> *See also*: Instructs the coder to review another main term that may provide additional useful entries.
> Example: Osteoarthritis – *see also* Osteoarthrosis 715.9
> hyperplastic 731.2
> spine, spinal NEC (see also Spondylosis) 721.90

> *See*: Directs coder to an alternative term in the Alphabetic Index (Volume 2)
> Example: Hemorrhage…
> ulcer – *see* Ulcer, by site, with hemorrhage

Note: the **see** instruction is also used when a condition is indexed under more than one main term.

ICD-9 Instructional Statements

Related Terms

- **AND** – The word “and” should be interpreted to mean either “and” or “or” when it appears in a title.

  Example: **474.0 Chronic tonsillitis <u>and</u> adenoiditis**

- **WITH** – The word “with” in the Alphabetic Index is sequenced immediately following the main term, not in alphabetic order.

  Example: **Tonsillitis (acute, etc) 463**
  with influenza, flu or grippe 487.1
  chronic 474.00
  diphtheritic (membranous) 032.0

ICD-9 V Codes

Used to explain why the service is being provided

> V Codes may be used as a primary diagnosis in the following situations:
- Preventive exams or services
- Aftercare of a condition (chemotherapy or dialysis)
- No current illness, but history of condition
- Birth status of newborns

> V Codes may be secondary diagnosis in the following situations:
- Patient has history, health status, etc. that may influence care.
  - For example, a personal history of breast cancer
  - Indicates outcome of delivery on mother's claim

As of 10/1/09, some V-Codes may only be used as primary diagnoses-see 2010 ICD-9-CM Guidelines for details

ICD-9-CM Tables

There are three tables contained in Volume 2 (Alphabetic Index) of the ICD-9-CM Manual:

- Hypertension Table
- Neoplasm Table
- Table of Drugs and Chemicals

ICD-9-CM Tables

Hypertension Table

- This table is located in Volume 2 under the main term hypertension.
- There are three categories of hypertension referenced in this table.
  1. **Malignant** - chronically high hypertension that is difficult to treat
  2. **Benign** - mild, chronic hypertension condition that can be controlled with medication
  3. **Unspecified** - details of the condition are unknown or not documented

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ICD-9-CM Tables

Neoplasm Table

> This table is located in Volume 2 under the main term neoplasm and identifies the neoplasm first by site.

> There are six categories referenced in this table:

1. **Malignant, Primary** - identifies the original site of the neoplasm
2. **Malignant, Secondary** - identifies a secondary malignant site, should be used for all secondary malignancies
3. **Malignant, CA in Situ** - identifies malignancies that are confined or non-invasive
4. **Benign** - identifies a neoplasm that is not cancerous
5. **Uncertain behavior** - identifies a tumor with similar traits of a neoplasm but where there is not enough evidence to determine malignancy
6. **Unspecified** - identifies a neoplasm when the origins have yet to be determined or are not specified in the documentation

ICD-9-CM Tables

Neoplasm, blood vessel						
	Malignant					
	Primary	Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified
Neoplasm, neoplastic --- *continued*						
aorta – *continued*						
abdominal	171.5	198.89	---	215.5	238.1	239.2
aortic body	194.6	198.89	---	227.6	237.3	239.7
aponeurosis	171.9	198.89	---	215.9	238.1	239.2
palmar	171.2	198.89	---	215.2	238.1	239.2
plantar	171.3	198.89	---	215.3	238.1	239.2
appendix	153.5	197.5	230.3	211.3	235.2	239.0

ICD-9-CM Tables

Table of Drugs and Chemicals

> This table lists specific types of agents, chemical substances and drugs that may cause an adverse effect or poisoning.

> Usually located after the Alphabetic Index.

> Six column format:

- First column lists the involved substances followed by the poisoning code for that substance.
- The next five columns are grouped under a heading of External Cause (E-Code) and identify the circumstances of the poisoning.

ICD-9 Coding Fundamentals

- Do not code diagnoses documented as "probable", "suspected", "questionable", "rule out", or "working".
- Code condition(s) to highest degree of certainty for that visit, i.e. symptoms, signs, abnormal test results, etc.
- **Primary diagnosis is the reason the physician saw the patient that day. Why did the patient make the appointment?**
- **The underlying disease if known is always the primary diagnosis.**
- **Only code what you can verify in the medical record**

ICD-9 Coding Fundamentals

- Chronic conditions may be coded if they play a part in the E & M service and are documented in the medical record.
  - Code all conditions that the physician actively manages during the encounter.
- Combination codes may be necessary to accurately reflect the patient's medical condition.

  Example:
  574.00 Calculus of gallbladder <u>with</u> acute cholecystitis
- Multiple codes may also be necessary in order to note a late effect (residual effect after the acute phase of an illness or injury has ended).

ICD-9 Coding Fundamentals

ICD-9 Coding Tips

> Account for new problems when coding, don't rely on the continual use of previously reported codes when the patient is experiencing new problems.

Example: 250.00 Diabetes, not stated as uncontrolled

250.02 when blood sugars are uncontrolled

> Avoid using a nonspecific code when a more specific code better describes the condition.

Example: 784.0 Headache

346.10 Common migraine

ICD-9 Coding Fundamentals

ICD-9 Unspecified Codes

> Avoid unspecified codes if information to code more specifically is in the medical record.

Examples:

If stated in record —

Use:	**Instead of:**
401.1 Hypertension, benign	401.9 Hypertension
786.52 Chest pain, Painful respiration	786.50 Chest pain, unspecified
617.5 Endometriosis of intestine	617.9 Endometriosis, unspecified

Supporting of CPT Codes

- Diagnosis codes must support the services/procedures performed.
- Lack of Medical Necessity is one of the primary reasons that claims are denied.

Examples:

	Inappropriate Dx	**Appropriate Dx**
EKG:	Sore Throat	Chest Pain
Pulmonary Function Test:	Skin Lesion	Asthma
Rapid Strep:	Broken Finger	Sore Throat

Implementation of Proper Coding

Review your Super Bills / Encounter forms:

- Review for unspecified codes.
- Review the newest ICD-9-CM Manual or the Web site for changes and new codes.
- Ensure all codes on the super bill have the proper 4th and 5th digits applied.
- Ensure a method to write in more specific coding information (i.e., site of the problem).
- Avoid automatic assignment of diagnosis codes based upon encounters previously billed.
- Verify that a more specific code isn't available and/or applicable – avoid submitting non-specific codes.

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Supporting CPT Codes

- Preventive care must be coded with a V code for well child care and adult general physical exams.
- Evaluation and Management (E&M) codes require diagnostic codes be billed – this can help support the necessity for the higher level E&M's.
- If the diagnosis is uncertain, code the symptoms the patient presented with.

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Key Points

> Accurate ICD-9-CM coding supports medical necessity which in turn can expedite claim processing and ensure fewer denials.

> Documentation of chronic conditions and specific diseases is necessary to complete the full diagnostic picture.

> Coding to the highest level of specificity will ensure fewer denials for invalid coding.

ICD-9 Coding Example 1

Established female patient, age 22, presents for annual examination. Patient wishes to continue with oral contraception.

> **V72.31 - Routine gynecological exam**

General gynecological examination with or without Papanicolaou cervical smear

Pelvic exam (annual) (periodic)

Use additional code to identify:

human papillomavirus (HPV) screening (V73.81)

routine vaginal Papanicolaou smear (V76.47)

> **V25.41 - Surveillance of previous prescribed contraceptives methods - Contraceptive pill**

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ICD-9 Example 2

A patient is seen for chest pain. The EKG is normal, and the final diagnosis is chest pain due to suspected Gastroesophageal reflux disease (GERD).

- **786.50 Chest Pain**
- GERD would not be coded in this example since the medical record states it is only suspected.

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ICD-9 Example 3

A patient presents to their Primary Care Physician with a cough and congestion. The PCP determines the patient is suffering from bronchitis and prescribes an anti-biotic. During the course of the visit, the PCP also inquires about the status of the patient's Diabetes Mellitus. They spend 20 minutes discussing diet and lab results.

> **490 Bronchitis, not specified as acute or chronic**

> **250.00 Diabetes** should be listed as secondary diagnoses

Highlights of 2010 Code Updates:

- There are approximately 313 new codes, 45 revised codes and 23 deleted codes.
- Please note, this is not all inclusive of every code update or guideline change. Please refer to the 2010 ICD-9-CM manual for the complete and most comprehensive information.

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Highlights of 2010 Code Updates:

- Category 209 – Neuroendocrine Tumors
  - Quite a few new codes added:
    - Subcategory 209.3 – Malignant poorly differentiated neuroendocrine carcinoma has included more specific Merkel cell carcinoma codes that require a 5th digit
    - New Subcategory 209.7 – Secondary neuroendocrine tumors
      - 5th digits are required

Highlights of 2010 Code Updates:

- Code 239.8 – Neoplasm of unspecified nature of other specified sites – has been deleted and two new codes with 5th digit requirements have been added:
  - 239.81 – Neoplasms of unspecified nature, retina and choroid
  - 239.89 – Neoplasms of unspecified nature, other specified sites

Highlights of 2010 Code Updates:

- Category 453 – Other venous embolism and thrombosis
  - New subcategory 453.5 – Chronic venous embolism and thrombosis of deep vessels of lower extremity
    - Require a 5th digit
  - New Code 453.6 – Venous embolism and thrombosis of superficial vessels of lower extremity
  - New subcategory 453.7 – Chronic venous embolism and thrombosis of other specified vessels
    - Require a 5th digit
  - New series of 5-digit codes for subcategory 453.8 – Acute venous embolism and thrombosis of other specified veins

Highlights of 2010 Code Updates:

- New codes for the H1N1 Virus:
  - Code 488 – Influenza due to identified avian influenza virus has been deleted and new more specific codes have been added to address the H1N1 Virus
    - 488.0 - Influenza due to identified avian influenza virus (Avian influenza, bird flu, influenza A/H5N1)
    - 488.1 - Influenza due to identified novel H1N1 influenza virus (2009 H1N1 (swine) influenza virus, Novel 2009 influenza H1N1, Novel H1N1 influenza, Novel influenza A/H1N1, Swine flu)
  - Code only confirmed cases – coding should be based upon the provider's diagnostic statement. If the provider records "suspected or possible or probable avian or novel H1N1 influenza," the appropriate influenza code from category 487 should be assigned.

Highlights of 2010 Code Updates:

- V-Codes:
  - New Personal History codes
    - V10.90 – Personal history of unspecified malignant neoplasm
    - V10.91 – Personal history of malignant neuroendocrine tumor
    - V87.44 – Personal history of inhaled steroid therapy
    - V87.45 – Personal history of systemic steroid therapy
    - V87.46 – Personal history of immunosuppressive therapy
  - New health supervision codes
    - V20.31 – Health supervision for newborn under 8 days old
    - V20.32 – Health supervision for newborn 8 to 28 days old

Highlights of 2010 Code Updates:

- E-Codes:
  - Many new E-Codes have been added
  - New section of Activity E-Codes:
    - Range E001 – E030
    - Codes are to be used to indicate the activity of a person seeking care for an injury or health condition brought on by an activity
      - Example: Heart attack while shoveling snow
    - These codes should be used in conjunction with other external cause codes for external cause status and place of occurrence.
    - These codes are also appropriate for use with external cause codes for cause and intent if identifying the activity provides additional information on the event.
  - New series of E-Codes for injury resulting from operations of war

Highlights of 2010 Guideline Updates:

- 251.3 – Postsurgical hypoinsulinemia
  - The manual now states "Assign a code from category 249 (Secondary diabetes) and code V45.79 (Other acquired absence of organ) as additional codes. Code any diabetic manifestations."
- V-Codes that may only be principal/first-listed diagnosis:
  - V-Codes contained in this listing may only be reported as the principal or first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined, or when there is more than one V-Code that fits the definition of principal diagnosis.
  - These codes should not be reported if they do not meet the definition of principal diagnosis.
  - There are approximately 43 codes in this listing

Wrap-up

Always remember:

- If it isn't documented, it didn't happen.
- If it didn't happen, you can't code it.
- Always code to the highest level of specificity.

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Questions

If you have any additional questions or would like clarification please contact us.

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