ICD-9-CM Back To Basics
Webinar

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ICD-9-CM: Back to the Basics

Angie Comfort, RHIT, CDIP, CCS

Agenda

• Present the characteristics and structure of ICD-9-CM Volumes 1, 2 and 3
• Discuss ICD-9-CM Official Guidelines for Coding and Reporting
• Hands on coding examples
• Provide practice cases for continued learning
ICD-9-CM Characteristics

- Volume 1 Diseases: Tabular List
- Volume 2 Diseases: Alphabetic Index
- Volume 3 Procedures: Tabular List and Alphabetic Index to Procedures

Volume 1: Tabular List of Diseases and Injuries

Contains the following major subdivisions:
- Classification of Diseases and Injuries
- Supplementary Classifications (V Codes and E Codes)
Classification of Diseases and Injuries

- Sections
- Categories
- Subcategories
- Fifth-digit Subclassification

ICD-9-CM Diagnosis Code – Format

#### 4 1 4 0 0

- **Category**: 4
- **Etiology, anatomic site, manifestation**: 1

**3 – 5 Characters**
Classification example

Chronic systolic heart failure

- Three-digit category
  - 428 Heart failure

- Fourth-digit subcategory
  - 428.2 Systolic Heart Failure

- Fifth-digit subclassification
  - 428.20 Unspecified systolic heart failure
  - 428.21 Acute systolic heart failure
  - 428.22 Chronic systolic heart failure
  - 428.23 Acute and chronic systolic heart failure

ICD-9-CM Code Format Examples

<table>
<thead>
<tr>
<th>3 digits</th>
<th>4 digits</th>
<th>5 digits</th>
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<tbody>
<tr>
<td>486</td>
<td>466.0</td>
<td>427.31</td>
</tr>
<tr>
<td>496</td>
<td>873.0</td>
<td>726.10</td>
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Supplementary Classifications

**V codes**
- Supplementary classification of factors influencing health status and contact with health services (V01-V91)

**E codes**
- Supplementary classification of external causes of injury and poisoning (E000-E999)

Volume 2:
Alphabetic Index to Diseases
- Index to Diseases and Injuries
- Table of Drugs and Chemicals
- Alphabetic Index to External Causes of Injury and Poisoning (E Codes)
Index to Diseases Terminology

Main terms
• Disease, condition, noun, or adjective documented. Boldface type, set flush with the left margins

Subterms
• Subterm or modifier that affects the code selection. Regular type, alphabetical order, one standard indentation from main terms.

Non-essential modifiers
• Series of terms in parentheses that sometimes directly follow main terms, as well as subterms. The presence or absence of these parenthetical terms in the diagnosis has no effect on the selection of the code listed for that main term or subterm.

Pneumonycosis 117.9
ICD-9-CM Diagnosis Coding Steps

To completely and accurately code each disease or condition, the coding professional should:

1. Identify all main terms included in the diagnostic statement.
2. Locate each main term in the Alphabetic Index (Vol. 2).
3. Refer to any subterms indented under the main term. These subterms form individual line entries and describe essential differences by site, etiology, or clinical type.
4. Follow cross-reference instructions if the needed code is not located under the first main entry consulted.
5. Read and be guided by any instructional terms in the Alphabetic Index (Vol. 2).
7. Read and be guided by any instructional terms in the Tabular List (Vol. 1).
8. Assign codes to their highest level of specificity:
   a. Assign three-digit codes only when no four-digit codes appear within the category.
   b. Assign a fifth digit for any subcategory where a fifth-digit subclassification is provided.
9. Continue coding the diagnostic statement until all the component elements are fully identified.

Volume 3: Tabular List and Alphabetic Index to Procedures

**Tabular list**

13.7 Insertion of prosthetic lens (pseudophakia)
Excludes: implantation of intraocular telescope prosthesis (13.91)

13.76 Insertion of pseudophakia, not otherwise specified

13.71 Insertion of intraocular lens prosthesis at time of cataract extraction, one-stage
Code also synonymous extraction of cataract (13.71-13.92)

13.72 Secondary insertion of intraocular lens prosthesis

**Alphabetic Index to Procedures**

Abbe operation
- construction of vagina 70.61
- with graft or prosthesis 70.63
- intestinal anastomosis — see Anastomosis, Intestine

Abdominoplasty 99.29
- Abdominocentesis 54.91
- Abdominohysterectomy 68.49
- Laparoscoppy 68.41
- Abdominoplasty 86.83
- Abdominocentesis 54.91
- Abdominocentesis 68.0
- Obstetric 74.99
- Abdominal 31.69
- Abdominal tract (fissure) by ERCP 51.64
- endominal (hysteroscopic) 68.23
- Inner ear (otoaural) (ultrasound) 70.79
Alphabetic Index to Procedures

• **Main terms:** boldface type which identifies the type of procedure performed.
  – Operations: cholecystectomy, Billroth II operation
  – Procedures or tests: bronchogram, physical therapy, scan
  – Nouns: examination, operation, pacemaker
  – Verbs: clipping, cooling, repair

• **Subterms:** listed under main terms and form individual line entries and describe essential differences in site, diagnosis, or surgical technique.

---

Procedure Coding

**Eponyms**

– The name of a disease, structure, operation or procedure, usually derived from the name of the person who discovered or described it first

– Some surgical procedures are eponyms, and their main terms are indexed in one of the following three ways:
  • Under the eponym
  • Under the main term, "Operation" or "Procedure"
  • Under a main term or subterm describing the operation
ICD-9-CM: Back To Basics

ICD-9-CM Procedure Code - Format

1 2 4 3

Tabular List of Procedures

38.2 Other short or vascular bypasses
Code also precluded treatment of various bypasses grafted with pharmaceutical substances. It was performed (01-06).
38.21 Carotid-pulmonary artery anastomosis
38.22 Aneurysm repair or aneurysmectomy
38.23 Other aortic, thoracic, or abdominal aortic anastomosis/repair
38.24 Aorta-renal bypass
38.25 Arteriovenous bypass, femoral vein
38.26 Other intra-abdominal vascular anastomosis or bypass
38.27 Other renal artery bypass
38.28 Extrapleural, pectoral, or other thoracic procedures (excludes open lung bypass)
38.29 Other (excludes open lung bypass; other thoracic procedures, Aortic, thoracic, or abdominal aortic anastomosis/repair; aorta-renal bypass; other short or vascular bypasses, Aorta-renal bypass; other short or vascular bypasses)

Excludes: pectus excavatum surgery (26.04, 26.06)

38.27 Other renal artery bypass
38.28 Extrapleural, pectoral, or other thoracic procedures (excludes open lung bypass)
38.29 Other (excludes open lung bypass; other thoracic procedures, Aortic, thoracic, or abdominal aortic anastomosis/repair; aorta-renal bypass; other short or vascular bypasses, Aorta-renal bypass; other short or vascular bypasses)
ICD-9-CM Procedure Coding Steps

In order to completely and accurately code procedures performed for a patient, the coder must:

1. Identify all main terms included in the procedural statement.
2. Locate each main term in the Alphabetic Index.
3. Refer to any subterms indented under the main term.
4. Follow cross-reference instructions if the needed code is not located under the first main entry consulted.
5. Verify code selected from the Index in the Tabular List.
6. Read and be guided by any instructional terms in the Tabular List.
7. Continue coding the procedural statement until all of the component elements are fully identified.

Coding Incomplete or Failed Procedures

Incomplete procedures

- ICD-9-CM generally does not include codes for procedures that are not completed. The one exception is code 73.3, Failed forceps, in Chapter 13, "Obstetrical Procedures."

- When a planned procedure is started but not completed, it is coded according to the following principles:
  • If a cavity or space is entered, code to exploration of the site.
  • If an endoscopic approach is used but the definitive procedure could not be carried out, code the endoscopy only.
  • If only an incision is made, code the incision of the site.
  • If the procedure does not involve an incision, no procedure code is assigned. Instead, a code from the V64 category is used to indicate why the planned procedure was not carried out.

- There are also procedures that are considered to have failed. This means that not every objective of the procedure was secured, or that the procedure did not achieve the desired result. In such a situation, the procedure is coded as performed.
ICD-9-CM: Back To Basics

ICD-9-CM Official Coding Guidelines

- Section I. Conventions, general coding guidelines, and chapter specific guidelines
- Section II. Selection of principal diagnosis
- Section III. Reporting additional diagnoses
- Section IV. Diagnostic coding and reporting guidelines for outpatient services

Section I. Conventions, general coding guidelines, and chapter specific guidelines
Conventions

- Independent of the guidelines
- The general rules for use of the classification
- Incorporated within the index and tabular list of the ICD-9-CM as instructional notes
- Indented format for easy referencing

Conventions

- Abbreviations
- Punctuation
- Includes, Excludes Notes and Inclusion Terms
- Other and unspecified codes
- Etiology/manifestation convention
- “And”
- “With”
- “See” and “See Also”
Abbreviations

NEC – Not elsewhere classified
   – Found in the alphabetic index and tabular
   – Used when the information at hand specifies a condition but no separate code for that condition is provided.

Disease, diseased - see also Syndrome
vertebra, vertebral NEC 733.90
disc - see Disease, Intervertebral disc

Abbreviations

NOS – Not otherwise specified
   – Found in the tabular only
   – Equivalent of unspecified

402 Acute pharyngitis
   Acute sore throat NOS
   Pharyngitis (acute): NOS
   gonococcal
   infectious
   pharyngitis
   pneumococcal
   staphylococcal
   suppurative
   ulcerative
   Sore throat (viral) NOS
   Viral pharyngitis
Punctuation

[ ] Brackets
- To identify manifestation codes
- To enclose synonyms, alternative wording or explanatory phrases

Alzheimer’s
dementia (senile)
with behavioral disturbance 331.0 [294.11]
without behavioral disturbance 331.0 [294.10]
disease or sclerosis 331.0
with dementia - see Alzheimer’s, dementia

( ) Parentheses
To enclose supplementary words (referred to as nonessential modifiers) which may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned.

Angina (attack) (cardiac) (chest) (effort)
(heart) (pectoris) (syndrome) (vasomotor) 413.9
Punctuation

: Colon
after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.

424.1 Aortic valve disorders
Aortic (valve):
  - incompetence NOS of specified cause, except rheumatic
  - insufficiency NOS of specified cause, except rheumatic
  - regurgitation NOS of specified cause, except rheumatic
  - stenosis NOS of specified cause, except rheumatic

Includes, Excludes & Inclusion Terms

Includes
- Further define, or give examples of, the content of the category.

033 Whooping cough
Includes: pertussis
Use additional code to identify any associated pneumonia (484.3)
  033.0 Bordetella pertussis [B. pertussis]
  033.1 Bordetella parapertussis [B. parapertussis]
  033.8 Whooping cough due to other specified organism
     Bordetella bronchiseptica [B. bronchiseptica]
  033.9 Whooping cough, unspecified organism
Includes, Excludes & Inclusion Terms

Excludes
- Indicates that the terms excluded from the code are to be coded elsewhere or in some instances not coded at all.

Excludes, Acquired (736.70-736.79)
754.7 Other deformities of feet
- Talipes, unspecified
- Congenital deformity of foot NOS
754.71 Talipes cavus
- Cavus foot (congenital)
754.79 Other
- Asymmetric talipes
- Talipes:
  - calcaneus
  - equinus

Inclusion terms
- List of terms is included under certain four and five digit codes.
- Terms are the conditions for which that code number is to be used.
- Terms may be synonyms of the code title, or, in the case of "other specified" codes, the terms are a list of the various conditions assigned to that code.
- Not necessarily exhaustive.

066.1 Tick-borne fever
- Nairobi sheep disease
- Tick fever:
  - American mountain
  - Colorado
  - Kemerovo
  - Quaranfil
Other and unspecified codes

• “Other” codes
  – Use when the information in the medical record provides
detail for which a specific code does not exist.
  – Usually a 4th digit of 8 or 5th digit of 9
  – Represent specific disease entities for which no specific code
exists so the term is included within an other code.

• Unspecified codes
  – Should be used when the information in the medical record is
insufficient to assign a more specific code.
  – Usually a 4th digit of 9 or a 5th digit of 0 in some diagnosis
codes

519.8 Other diseases of respiratory system, not elsewhere classified
519.9 Unspecified disease of respiratory system

Etiology/Manifestations

• Code first
  199.2 Malignant neoplasm associated with transplanted organ
  Code first complication of transplanted organ (996.80-996.89)
  Use additional code for specific malignancy

• Use additional code
  245.0 Acute thyroiditis
  Abscess of thyroid
  Thyroiditis:
  - Nonsuppurative, acute
  - Pyogenic
  - Suppurative
  Use additional code to identify organism

• In diseases classified elsewhere
  – Alpha
    Pyelitis (congenital) (uremic) 290.80
    Tuberculosis (see also Tuberculosis) 916.0 [590.81]
  – Tabular
    590.81 Pyelitis or pyelonephritis in diseases classified elsewhere
    Code first underlying disease, as:
    Tuberculosis (916.0)
And, With, See and See Also

- **And** – Interpreted to mean either “and” or “or” in a code title
- **With** – Interpreted to mean “associated with” or “due to” in a code title or instructional note
- **See** – Means to go review the main term the note is referencing
- **See Also** – Another term may be referenced for additional useful index entries.

Volume 3 Conventions

- **Omit code** – Indicates that no code is to be assigned and usually applies to the following procedures:
  - An exploratory procedure incidental to the procedure carried out
  - The usual surgical approaches of a given procedure
  - The closure portion of a procedure

- **Coding Operative Approach** - When a definitive procedure (therapeutic or diagnostic) is performed, the operative approach is considered part of the procedure and is not coded.
Knowledge Check 01

True or false?
Brackets are used to identify manifestation codes.

a. True
b. False

Brackets are used to identify manifestation codes. Review the Official Coding Guidelines Section I.A.3 - Punctuation.
Knowledge Check 02

Injury 959.9

Note  For abrasion, insect bite (nonvenomous), blister, or scratch, see Injury, superficial.
For laceration, traumatic rupture, tear, or penetrating wound of internal organs, such as heart, lung, liver, kidney, pelvic organs, whether or not accompanied by open wound in the same region, see Injury, internal.
For nerve injury, see Injury, nerve.
For late effect of injuries classifiable to 850-854, 860-869, 990-919, 950-959, see Late effect, injury, by type.

abdomen, abdominal (viscera) - see also Injury, internal, abdomen
muscle or wall 959.12

Use the Alphabetic Index and the note following the main term "Injury" to answer this question: What main term and subterm should be indexed to code the diagnosis of nonvenomous insect bite?

a. Abrasion, insect bite
b. Injury, superficial
c. Bite, insect
d. Insect bite

Knowledge Check 02

B – Injury, superficial

See note under the main term "Injury" to view "Note – For abrasion, insect bite (nonvenomous), blister, or scratch, see Injury, superficial"
General Coding Guidelines

1. Use of both Alphabetic Index and Tabular List
2. Locate each term in the Alphabetic Index
3. Level of Detail in Coding
4. Code or codes from 001.0 through V91.99
5. Selection of codes 001.0 through 999.9
6. Signs and symptoms
7. Conditions that are an integral part of a disease process
8. Conditions that are not an integral part of a disease process
9. Multiple coding for a single condition
10. Acute and Chronic Conditions
11. Combination Code
12. Late Effects
13. Impending or Threatened Condition
14. Reporting Same Diagnosis Code More than Once
15. Admissions/Encounters for Rehab
16. Documentation for BMI and Pressure Ulcer Stages
17. Syndromes
18. Documentation of complications of care

General Coding Guidelines

- Signs and symptoms - Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the physician.

- Conditions that are an integral part of a disease process
  - Signs and symptoms that are integral to the disease process shouldn’t be coded separately.
  - Examples: Chest pain and acute myocardial infarction, Fever and urinary frequency with UTI

- Conditions that are not an integral part of a disease process
  - Signs and symptoms that may not be associated routinely with a disease process should be coded when present.
  - Examples: Seizures may be assigned with brain cancer, Coma may be assigned with metastases to the brain
General Coding Guidelines

Combination codes
- Two diagnoses, or
- A diagnosis with an associated secondary process (manifestation)
- A diagnosis with an associated complication

Gastritis 535.5

<table>
<thead>
<tr>
<th>Note</th>
<th>Use the following fifth-digit subclassification for category 535:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>without mention of hemorrhage</td>
</tr>
<tr>
<td>1</td>
<td>with hemorrhage</td>
</tr>
</tbody>
</table>

- acute 535.0
- alcoholic 535.3
- allergic 535.4
- antral 535.4

Documentation for BMI and Pressure Ulcer Stages
- Secondary diagnoses only
- Code assignment may be based on clinician’s documentation who are not the patient’s provider (e.g., dietitian, nurses)
- Associated diagnosis **must** be documented by the patient’s provider (e.g., overweight, obesity, pressure ulcer)
Chapter Specific Coding Guidelines

Chapter-specific coding guidelines* are guidelines for specific diagnoses and/or conditions in the classification. Unless otherwise indicated, these guidelines apply to all healthcare settings.

*This presentation does not contain every guideline in ICD-9-CM. For a complete listing, refer to Official Coding Guidelines in your code book or the link provided at the end of this presentation.

Specific Coding Guidelines: Chapter 1
Infectious and Parasitic Diseases

Human Immunodeficiency Virus (HIV) Infections

– Code only confirmed cases
– Selection and sequencing
  • Patient admitted with HIV-related condition, 042 is principal diagnosis
  • Patient with HIV disease admitted for unrelated condition, code for the unrelated condition is principal diagnosis followed by 042
  • Asymptomatic HIV, V08 – used when the patient documentation is HIV positive, known HIV or similar terminology. Not used for AIDS or HIV-related illnesses
  • Inconclusive serology, 795.71 may be assigned
Specific Coding Guidelines: Chapter 1
Infectious and Parasitic Diseases

Septicemia, Systemic Inflammatory Response Syndrome (SIRS), Sepsis, Severe Sepsis, and Septic Shock

— SIRS, Septicemia, and Sepsis – Used interchangeably by providers but are not synonymous terms.

— Coding of SIRS, sepsis and severe sepsis
  • requires a minimum of 2 codes: code for underlying cause and a code from subcategory 995.9, SIRS
  • Severe sepsis requires additional codes for any associated acute organ dysfunction

Specific Coding Guidelines: Chapter 2 Neoplasms

• Proper coding – determine from the documentation if the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior

• Treatment directed at malignancy – principal diagnosis is malignancy. Only exception is a patient admitted for chemo/radiation in which the principal would be a code from category V58, for the therapy provided.

• Treatment of secondary site – principal diagnosis is the secondary site if that is what the treatment was directed towards even though the primary malignancy is still present.
Specific Coding Guidelines: Chapter 2 Neoplasms

- Coding and sequencing of neoplasm related complications and encounters for chemotherapy, immunotherapy, or radiation

- When the admission/encounter is for:
  - Anemia associated with malignancy - if only the anemia associated with the malignancy is being treated, it will be coded with the appropriate anemia code as principal followed by the malignancy as secondary
  - Anemia associated with chemotherapy, immunotherapy, or radiation therapy - if only the anemia is being treated, it will be principal followed by the malignancy as secondary
  - Management of dehydration due to malignancy – if only the dehydration is being treated, it will be principal followed by the malignancy as secondary
  - Treatment of a complication resulting from a surgical procedure – the complication is principal if the treatment is directed at resolving the complication
  - Administration of chemotherapy, immunotherapy, or radiation – the appropriate code from category V58 is principal

Specific Coding Guidelines: Chapter 3 Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders

**Diabetes mellitus**

- 5th digit to identify the type of diabetes
- Type is coded to type II if not documented
- Type II patients who routinely use insulin, V58.67 should be assigned for the long term use
- Diabetes codes (category 250) are sequenced before the codes for the associated diabetic conditions
Specific Coding Guidelines: Chapter 4 Disease of Blood and Blood Forming Organs

Anemia of chronic disease – first code the appropriate anemia code followed by the code for the chronic disease

- Example: Anemia in chronic kidney disease –
  - 285.21, Anemia in chronic disease
  - 585, Chronic kidney disease

Specific Coding Guidelines: Chapter 6 Diseases of the Nervous System & Sense Organs

Pain – category 338

- Used in conjunction with codes from other categories and chapters to provide more detail
- If not documented as acute or chronic pain, do not use codes from category 338 except post-thoracotomy pain, postoperative pain, neoplasm related pain, or central pain syndrome
- Codes from 338.1 or 338.2 subcategories should not be used if the underlying diagnosis is known, unless the reason for admission is for pain control
- Principal or first listed diagnosis when
  - Admission is for pain control or pain management
  - Admission is for insertion of a neurostimulator for pain control
Specific Coding Guidelines: Chapter 7 Diseases of the Circulatory System

Hypertension

- Located in the Alphabetic Index under the main term hypertension
- Complete listing of all conditions due to or associated with hypertension
- Malignant, benign or unspecified classification

Hypertension table

- Full listing of all conditions due to or associated with hypertension
- Malignant, benign or unspecified classification

Hypertension

- Hypertension with heart disease – Causal relationship must be stated between the heart disease and hypertension in order to code the condition to category 402, hypertensive heart disease
- Hypertensive heart and chronic kidney disease – Codes to category 404, hypertensive heart and chronic kidney disease
- Hypertensive cerebrovascular disease – Appropriate cerebrovascular code from range 430-438 is assigned, followed by the code for the hypertension
- Hypertensive retinopathy – First listed code is from subcategory 362.11, Hypertensive retinopathy followed by the appropriate code for the hypertension
Specific Coding Guidelines: Chapter 7 Diseases of the Circulatory System

Cerebral infarction/stroke/cerebrovascular accident (CVA)

- Terms used interchangeably
- Indexes to 434.91, Cerebral artery occlusion, unspecified, with infarction
- Postoperative cerebrovascular accident – cause-and-effect relationship between the medical intervention and the cerebrovascular accident must be documented
- Late effects of cerebrovascular disease, category 438

Acute myocardial infarction (AMI)

- ST elevation (STEMI) and non ST elevation (NSTEMI)
- Use AMI when documented as such or when the stated duration is of 8 weeks or less as instructed by the includes note at category 410
Specific Coding Guidelines: Chapter 8 Diseases of the Respiratory System

Acute respiratory failure

– Principal diagnosis – when it is the condition established after study to be chiefly responsible for occasioning the admission to the hospital and the selection is supported by the Alphabetic Index and Tabular List. Chapter specific guidelines that provide sequencing direction take precedence.

– Sequencing of acute respiratory failure and another acute condition – selection of the principal diagnosis is dependent on the circumstances of admission.

Specific Coding Guidelines: Chapter 10 Diseases of the Genitourinary System

Chronic kidney disease (CKD)

– Stages I-V and end stage renal disease (ESRD)

– CKD and kidney transplant status – Assign the appropriate code from category 585 for the stage and V42.0 for the transplant status. Presence of CKD alone does not constitute a transplant complication as the patient’s kidney function may not be fully restored by the transplant. Complications must be clearly documented by the provider.
Specific Coding Guidelines: Chapter 11
Complications of Pregnancy, Childbirth & Puerperium

• Chapter 11 codes are always sequenced first over codes from other chapters
• In order to code V22.2, incidental pregnancy, the physician must document that the condition being treated is not affecting the pregnancy.
• Maternal record use only
• 5th digits indicate the encounter as antepartum, postpartum, and whether a delivery occurred

Specific Coding Guidelines: Chapter 11
Complications of Pregnancy, Childbirth & Puerperium

Selection of OB Principal or First-listed Diagnosis

– Supervision of pregnancy is used for routine outpatient prenatal visits (V22.0-V22.1). Not used with other chapter 11 codes
– V23 is for high risk pregnancy supervision. Additional codes from chapter 11 should be assigned if applicable
– If no delivery occurs during an encounter, the complication that necessitated the encounter should be principal/first-listed diagnosis.
– When a patient delivers, the principal diagnosis should correspond with the main circumstances or complication of the delivery.
– Outcome of delivery codes should be used on every maternal record when a delivery has occurred (V27.0-V27.9).
Specific Coding Guidelines: Chapter 12
Diseases of the Skin and Subcutaneous Tissue

Pressure ulcers

- Two codes required to describe a pressure ulcer
  - Subcategory 707.0, Pressure ulcer, to identify the site
  - Subcategory 707.2, Pressure ulcer stages

- Unstageable – 707.25, Pressure ulcer unstageable is used if clinical determination is not made in the documentation

- Pressure ulcer evolving into a different stage during admission – if a pressure ulcer progresses during an admission, the highest stage should be reported for the pressure ulcer.

Specific Coding Guidelines: Chapter 13
Diseases of Musculoskeletal & Connective Tissue

Pathologic fractures - Acute fracture versus aftercare

- Pathologic fractures are coded to subcategory 733.1 when the fracture is newly diagnosed or receiving active treatment for the fracture.
  - Active treatment = surgical treatment, emergency department encounter, evaluation and treatment by a new physician

- Aftercare codes (V54.0, V54.2, V54.8 or V54.9) are used when the patient is no longer receiving active treatment and is receiving routine care during the healing or recovery phase.
  - Aftercare treatment = cast change or removal, removal of external or internal fixation device, medication adjustment and follow up visits following fracture treatment.
Specific Coding Guidelines: Chapter 14 Congenital Anomalies

Congenital anomalies

- May be principal/first listed or secondary depending on the circumstances of admission
- When there is no unique code for a congenital anomaly, assign codes for any manifestations
- When the code specifically identifies the anomaly, manifestations that are inherent should not be coded separately
- Used throughout the lifetime of a patient as long as the condition is present
- History of the anomaly may be used if the anomaly has been corrected.

Specific Coding Guidelines: Chapter 15 Newborn

- V30-V39 – only used on newborn encounters at the time of birth
- Can be used throughout the life of patient if condition is still present
- Should not be assigned unless the provider has established a definitive diagnosis
- Code all clinically significant conditions
  - Clinical evaluation; or
  - Therapeutic treatment; or
  - Diagnostic procedures; or
  - Extended length of hospital stay; or
  - Increased nursing care and/or monitoring; or
  - Has implications for future health care needs
Specific Coding Guidelines: Chapter 17 Injury and Poisoning

- Traumatic fractures
- Acute fracture versus aftercare
  - Traumatic fractures are coded using code range 800-829 when the patient is receiving active treatment for the fracture.
    - Active treatment = surgical treatment, emergency department encounter, evaluation and treatment by a new physician
  - Aftercare codes (V54.0, V54.1, V54.8 or V54.9) are used when the patient is no longer receiving active treatment and is receiving routine care during the healing or recovery phase.
    - Aftercare treatment = cast change or removal, removal of external or internal fixation device, medication adjustment and follow up visits following fracture treatment.

Specific Coding Guidelines: Chapter 17 Injury and Poisoning

Burns
- Depth: First, second or third degree
- Highest degree sequenced first
- Same site burns, use the highest degree documented
- Separate codes for each site
- Body surface involvement of over 20% with third degree burns
Specific Coding Guidelines: Chapter 17 Injury and Poisoning

**Adverse effects**
- Hypersensitivity, reaction, or correct substance properly administered
- Assign code for the nature of the adverse effect followed by the code for the drug (E930-E949)

**Poisoning**
- Overdose of substances, wrong substance given or taken in error, interaction of drug(s) and alcohol, non-prescribed drug taken with correctly prescribed and administered drug
- Assign code for poisoning followed by the code for the manifestation of the poisoning

**Toxic effects**
- Harmful substance ingested by or in contact with a person, categories 980-989
- Sequence toxic effect first followed by the code for the manifestation of the toxic effect

Specific Coding Guidelines: Chapter 18 Classification of Factors Influencing Health Status and Contact with Health Services

- **Used in any healthcare setting**

- **Primary circumstances for use of V codes**
  - Encounters for health services for a specific purpose (patient may or may not be sick)
    - Examples: organ donation, vaccination, lab draw
  - Person with resolving disease or injury, or a chronic condition requiring care
    - Examples: Dialysis for renal disease, chemotherapy, cast change
  - Condition that influences a person's health status, but is not a current illness or injury
    - Examples: history of cancer, status post CABG
  - Newborns, to indicate birth status
    - Examples: V30-V39, birth type
Specific Coding Guidelines: Chapter 18 Classification of Factors Influencing Health Status and Contact with Health Services

**Categories of V codes**
- Contact/exposure
- Inoculations and vaccinations
- Status
- History (of)
- Screening
- Observation
- Aftercare
- Follow-up
- Donor
- Counseling
- Obstetrics and related conditions
- Newborn, infant and child
- Routine and administrative examinations
- Miscellaneous V codes
- Nonspecific V codes

Specific Coding Guidelines: Chapter 19 Supplemental Classification of External Causes of Injury and Poisoning

**Major categories of E codes**
- Transport accidents
- Poisoning and adverse effects of drugs and medicinal substances and biologicals
- Accidental falls
- Accidents caused by fire and flames
- Accidents due to natural and environmental factors
- Late effects of accidents, assaults, or self injury
- Assaults or purposely inflicted injury
- Suicide or self inflicted injury
### Specific Coding Guidelines: Chapter 19 Supplemental Classification of External Causes of Injury and Poisoning

- What happened? – External cause code
- Where did it happen? Place of occurrence code
- What were you doing? Activity code
- Y99-External Status code

### Specific Coding Guidelines: Chapter 19 Supplemental Classification of External Causes of Injury and Poisoning

- External cause codes are never sequenced first
- External cause codes provide data for injury research and evaluation of injury prevention strategies
- No national requirement for mandatory external cause reporting
- Some states require reporting of external cause codes
Section II
Selection of principal diagnosis

Principal Diagnosis

• Condition after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care — as defined by Uniform Hospital Discharge Data Set (UHDDS)

• Used by hospitals to report inpatient data

• Includes all non-outpatient settings including but not limited to:
  – Acute care
  – Short term care
  – Long term care
  – Psychiatric hospitals
  – Home health agencies
  – Rehab facilities
  – Nursing homes
Principal Diagnosis

- Codes for symptoms, signs, ill-defined – not used when a related definitive diagnosis has been established
- Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis – either condition may be sequenced first, unless the circumstances of admission, therapy provided, Alphabetic Index or Tabular List indicate otherwise
- Two or more diagnoses that meet the definition for principal diagnosis – either may be used as principal unless the circumstances of admission, therapy provided, Alphabetic Index, or Tabular List indicate otherwise or another coding guideline provides sequencing guidance
- Two or more comparative or contrasting conditions – documented as “either/or” or similar terminology, code as if the diagnoses were confirmed and are sequenced according to the circumstances of admission
- A symptom followed by contrasting/comparative diagnoses – the symptom code would be sequenced first with the contrasting/comparative diagnoses as secondary

Principal Diagnosis

- Original treatment plan not carried out – condition after study that occasioned the admission to the hospital even if treatment was not carried out due to unforeseen circumstances
- Complications of surgery and other medical care – admission is for treatment of a complication resulting from surgery or other medical care, complication is principal
- Uncertain diagnosis – code the condition as if it exists or was established if the following or similar terms are used to describe the condition (only applicable to inpatient admissions for short-term, acute, long-term care and psychiatric hospitals)
  - Probable, possible, suspected, likely, questionable, still to be ruled out
Principal Diagnosis

- Admission from an observation unit – the medical condition that led to the hospital admission from the observation unit

- Admission from outpatient surgery – follow the below
  - If a complication of the surgery, assign complication as the principal
  - If no complication or other condition, assign the reason for the outpatient surgery as the principal
  - If the reason for admission is another condition that is unrelated to the surgery, assign the unrelated condition as the principal

Section III
Reporting additional diagnoses
Additional Diagnoses

Other diagnoses are interpreted as additional conditions that affect patient care in terms of requiring
– Clinical evaluation; or
– Therapeutic treatment; or
– Diagnostic procedures; or
– Extended length of hospital; or
– Increased nursing care and/or monitoring

All conditions that exist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded. – UHDDS definition

Additional Diagnoses

• Used by hospitals to report inpatient data

• Includes all non-outpatient settings including but not limited to:
  – Acute care
  – Short term care
  – Long term care
  – Psychiatric hospitals
  – Home health agencies
  – Rehab facilities
  – Nursing homes
Additional Diagnoses

• Previous conditions – resolved conditions or diagnoses that have no bearing on the current stay are not reported

• Abnormal findings – not coded and reported unless the provider indicates the clinical significance (this differs in the outpatient setting for diagnostic tests that have been interpreted by a provider)

• Uncertain diagnosis – code the condition as if it exists or was established if the following or similar terms are used to describe the condition (only applicable to inpatient admissions for short-term, acute, long-term care and psychiatric hospitals)
  – Probable, possible, suspected, likely, questionable, still to be ruled out

Section IV
Diagnostic coding and reporting guidelines for outpatient services
Outpatient Guidelines

Selection of first-listed condition

- Outpatient setting
  - First-listed (reason for encounter) used in lieu of principal diagnosis
  - Outpatient surgery – code the reason for the surgery as first-listed
  - Observation stay
    - Admission for observation for a medical condition, assign the code(s) for the medical condition as first-listed
    - Admission for outpatient surgery and develops complications requiring admission to observation, code the surgery as the first-listed, followed by the codes for the complications as secondary diagnoses

- Uncertain diagnoses – Do not code diagnoses documented as probable, possible, suspected, questionable, rule out or working diagnoses or any similar terms indicating uncertainty. (This differs from the inpatient coding practices.)

- Code all documented conditions that coexist – conditions that require or affect patient treatment or management should be coded
Outpatient Guidelines

• Patients receiving diagnostic services only – code the condition that is chiefly responsible for the encounter followed by any additional diagnoses
  – Routine lab/radiology testing without signs, symptoms or an associated diagnoses should be coded with V72.5 and/or a code from subcategory V72.6
  – Outpatient encounters for diagnostic tests that have been interpreted by a physician, code any confirmed or definitive diagnosis(es) documented in the interpretation. (This differs from the inpatient coding practices)

• Patients receiving therapeutic services only - code the condition that is chiefly responsible for the encounter followed by any additional diagnoses
  – Exception: Primary reason for the admission/encounter is chemotherapy, radiation therapy, or rehabilitation. Appropriate V code for this service is listed first, followed by the diagnosis for the therapy.

• Patients receiving preoperative evaluations only – sequence first a code from category V72.8, Other specified examinations, to describe the pre-op consultations. Code the reason for surgery and any findings related to the pre-op evaluation that are provider documented.

Principal and Significant Procedures

• Principal procedure - that which was performed for definitive treatment rather than for diagnostic or exploratory purposes or for treatment of a complication (UHDDS definition)

• Significant procedure – Additional procedures should also be coded, including those that are surgical in nature, as well as those that carry a procedural or anesthetic risk or that requires specialized training
Coding Example 01

In the diagnostic statement “newborn male with meconium aspiration syndrome, subarachnoid hemorrhage, and neonatal jaundice due to prematurity,” what is the ICD-9-CM principal diagnosis?

a. 772.2
b. V30.00
c. 770.1
d. 774.2

Coding Example 02

b. V30.00, Single liveborn, born in hospital, delivered without mention of cesarean delivery

The Alphabetic Index main term is Newborn, subterm single, born in hospital. Per ICD-9-CM coding guidelines, the code for liveborn infant (V30–V39) is assigned as the principal diagnosis. See Coding Clinic 2002, 4Q. Additional codes would be assigned for all the complications of the newborn period.
Coding Example 02

A 5 year old female is seen in the emergency room for a cough and fever. The physician orders an x-ray which reveals pneumonia. The physician discharges the patient with antibiotics and a diagnosis of pneumonia. What is the first listed diagnosis on this outpatient encounter?

486, Pneumonia

The cough and fever are symptoms of the pneumonia and according to the Official Coding Guidelines Section I.B.6, signs and symptoms are not coded when a related definitive diagnosis has been established.
Coding Example 03

This 80-year-old female patient was admitted as an inpatient with fever, malaise, and left flank pain. A urinalysis was performed and showed bacteria more than 100,000/mL. This was followed by a culture, showing Escherichia coli growth documented as E. coli urinary tract infection (UTI). On day 2 the patient had an exacerbation of chronic obstructive pulmonary disease (COPD) and was treated with an inhaler. This resolved the same day. Patient is also on current medication therapy for hypertension and arteriosclerotic heart disease (ASHD) of the native vessels. What codes are assigned for this encounter?

599.0, UTI
041.49, Other and unspecified E.Coli
491.21, COPD with acute exacerbation
414.01, ASHD
401.9, Hypertension

The symptoms of the UTI are not coded, as they are integral to the UTI. The additional conditions meet reporting guidelines as secondary diagnoses because they are current conditions evaluated and/or treated during the hospitalization.
ICD-9-CM: Back To Basics

Coding Example 04

This 70-year-old female has been treated for progressive increasing pain in her back. She is to the point that she is unable to move. She was brought to the ER and admitted after x-ray shows severe compression fractures of the lumbar vertebrae due to her senile osteoporosis. An injection of local anesthetic was done into the spinal canal. What diagnosis and procedure codes are assigned?

Diagnosis
733.13, Pathologic fracture of vertebrae
733.01, Senile osteoporosis

Procedure
03.91, Injection of anesthetic into spinal canal for analgesia

This is coded as a pathologic fracture because it is due to disease process rather than trauma. Both conditions were present on admission.
Coding Example 05

This 35-year-old female patient was a driver involved in an automobile accident when she was rear-ended by another driver in a car. She was seen in the emergency room complaining of pain in the arm and neck. She was brought into the hospital by the EMTs on a backboard and after proper splinting to the right arm. It was evident that compound fractures were present. After a CT scan of the head and neck, the patient was removed from the backboard. She was admitted to the hospital for an open reduction, internal fixation of the type II fractures of the radius and ulna. The surgery was completed without problems. Postoperative x-rays show the radial and ulnar shafts in good alignment. Patient was advised to wear a collar for her cervical strain.

Final Diagnoses, in Order of Significance:
Compound radius and ulna shaft fractures
Whiplash injury, cervical spine

Coding Example 05

Diagnosis
813.33, Fracture of radius with ulna
847.0, Sprain, neck
E812.0, Other motor vehicle traffic accident involving collision with motor vehicle

Procedure
79.32, Open reduction of fracture with internal fixation, radius and ulna
A compound fracture is an open fracture. The site of the fractures was specified. The procedure is ORIF.
Get ICD-9 Code Sets and Guidelines

- ICD-9-CM Official Coding Guidelines FY 2011* -
- ICD-9-CM FY 2011* Code Files -
- ICD-9-CM Procedure Addendum -
  [http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnost icCodes/codes.html](http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnost icCodes/codes.html)

*Note – There has not been an update to the Official Coding Guidelines nor have there been any new diagnoses codes for the ICD-9-CM code set since 10/01/11. New technology codes for procedures can be located at the CMS procedure addendum site above that were implemented each fiscal year.

Additional Learning Resources

- AHIMA is currently reprinting ICD-9 and ICD9/10 books, workbooks and exam prep resources for self-study
  -CCA
  -CCS
  -RHIA
  -RHIT
- A 15 week online course, “ICD-9 Coding Basics” will be available soon for students who would like more extensive instruction in ICD-9
- Visit our ICD-10 Delay site for details on when ICD-9 books and courses will be available. [http://www.ahima.org/icd10](http://www.ahima.org/icd10)
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http://www.ahima.org/ContinuingEd/Audio/2014seminars.aspx

and click on the link to

**Sign In and Complete Online Evaluation**

listed for this seminar.

You will be automatically linked to the

CE certificate for this seminar after

completing the evaluation.

*Each person seeking CE credit must complete the mandatory self-assessment which can be found in the appendix of the resource materials, as well as complete the sign-in form and evaluation to view and print their CE certificate.*