

ICD-9 (Diagnosis) Coding

This education is Part 1 of a 2-part series on
Guidelines for ICD-9 (Diagnosis Code) selection.

All presentations are available on the Tulane University School of Medicine
website: http://www.som.tulane.edu/fpp/billing_new/

Part 1: Guidelines for ICD-9 Codes

Part 2: Guidelines for V-codes (Status codes)

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To access the Tulane University Tulane University Medical Group Health Care Compliance
Policy Manual: <http://www.som.tulane.edu/fpp/pdfdocs/healthcare.pdf>

Sources cited:

2005 Expert ICD-9-CM for Physicians, page 14

Section IV Diagnostic Coding and Reporting Guidelines for Outpatient Services

2005 Faye Brown's ICD-I CM Coding Handbook

ICD-9 CODING

PURPOSE OF PRESENTATION

To assist physicians in selecting the appropriate diagnosis code(s) as it pertains to the chief complaint, signs & symptoms, follow up and aftercare status, or results from diagnostic test and x-rays.

INTRODUCTION

Diagnostic codes serve to identify and justify the medical necessity of services provided by describing the circumstances of the patient's condition. ICD-9 codes are useful for statistical purposes. ICD-9 codes convey a patient's clinical picture to third-party payers.

Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The ICD-9 codes are updated annually in October. Encounter forms should be revised periodically to ensure they contain only accurate and complete codes. Note: Out-of-date ICD-9 codes can result in Workfile edit or denials

General Guidelines

Coding Guideline 1

Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

Coding Guideline 2

Physicians should select an ICD-9 code to describe the diagnosis, symptom, complaint, condition, or problem, indicating why the service was performed.

Guidelines Directed Toward ICD-9 Code Selection That Properly Demonstrates Medical Necessity

Coding Guideline 3

Code the primary diagnosis first, followed by the secondary, then tertiary, and so on.

Patient presents to the clinic with shortness of breath, a cough and fever. Lab test and X-rays were ordered. Physician prescribed cough medication. Patient asked to return in 1 week.

- **DX 1 - Shortness of breath (786.05)**
- **DX 2 - Cough (786.2)**
- **DX 3 - Fever (780.6)**

A definitive diagnosis was not confirmed; therefore, physician codes signs and symptoms.

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Coding Guideline 4

Use fourth and fifth digits when they are available.

Example 2: Patient has been diagnosed with osteoarthritis, generalized in the hand. The physician codes 715.0.

The correct diagnosis is 715.04.

04 is the fifth digit sub classification that describes the location of the osteoarthritis disorder.

Coding Guideline 5

**Code what you know. Use symptom codes when a definitive diagnosis is not determined.
Do not code rule-out statements as if they exist.**

Example 3: Patient presents to the clinic with shortness of breath. An x-ray was ordered to rule out pneumonia. Patient asked to return in 1 week. Physician codes pneumonia (486).

The correct diagnosis is shortness of breath (786.05).

Until the results of the x-ray have been returned, no definitive diagnosis has been determined.

Coding Guideline 6

Code a chronic diagnosis only as often as it is applicable to the patient's treatment.

Patient presents to the clinic after having a few days of dizziness. Patient has a history of diabetes and is not sure what his /her blood sugar levels are. Lab tests are ordered. Results are returned within the hour and are in normal limits for diabetes. BP taken indicates that patient's pressure is high.

Patient is diagnosed with hypertension (401.9) and diabetes (250.00).

Coding Guideline 7

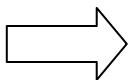
Assign each medical service and surgical procedure a corresponding diagnostic code.

Patient presents to the clinic for knee pain. Physician provides a problem focused level of service. The patient mentions to the physician that he has been having problems with his ears. Physician removes wax from patient's ear.

The diagnosis code for knee pain is (719.46). Modifier 25 is applicable.

The diagnosis code for impacted cerumen is 380.4 .

The encounter form should show the linkage of each set of codes otherwise the diagnosis codes may be keyed to both the medical service and the surgical procedure codes.



Conditions that have been successfully treated and no longer exist as a health threat to the patient should not be coded.

Coexisting Conditions

- All coexisting conditions affecting any aspect of patient care present or active at the time of the encounter should be coded.
- Some patients present with coexisting conditions that affect the management of care. These conditions should be reported as supplemental information.
- The following situations require multiple diagnostic codes to identify medical necessity.
 - ◆ multiple injuries
 - ◆ multiple diseases
 - ◆ surgical and postoperative complications

◆ injury and trauma, late effects

ICD-9 (Diagnosis Codes) Quiz

Name _____	Date _____
Department _____	Signature _____

1. Diagnostic codes serve to identify and justify the medical necessity of services provided by describing the circumstances of the patient’s condition.

 True False

2. ICD-9 codes are useful for _____ purposes and they convey a patient’s _____ picture to the third-party payers.

3. Diagnoses are always established at the time of the initial encounter/visit.

 True False

4. The ICD-9 codes are updated annually in _____.

5. Rule-out or probable diagnosis codes are appropriate to use for outpatient services.

 True False

6. ICD-9 codes describe the diagnosis, symptom, complaint, condition or problem indicating why the service was performed.

 True False

7. Code the _____ diagnosis code first, followed by the secondary, then tertiary and so on.

8. Use _____ codes when a definitive diagnosis is not determined. Do not code rule-out codes as if they exist.

9. Chronic diagnosis can be coded as often as it is applicable to the patient’s treatment.

 True False

10. Conditions that have been successfully treated and no longer exist as a health threat to the patient (should) (should not) be coded. **Circle the correct answer.**

To receive one compliance credit:
 Complete quiz, be sure to print name (must be legible), the date, and your department at the top of the form.
SIGN the form (no credit will be given without a signature)
 Fax to 504-988-7777 (fax information at top of form, no cover sheet required)