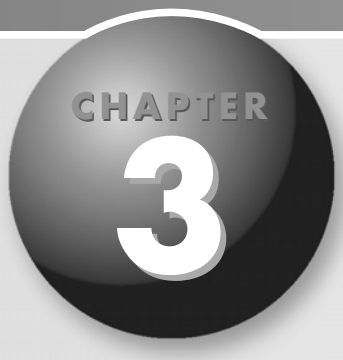


Diagnostic Coding

Learning Outcomes

After completing this chapter, you will be able to define the key terms and:

- 3-1 Explain how diagnostic coding affects the payment process.
- 3-2 Label the primary diagnosis and coexisting conditions.
- 3-3 Explain the ICD-9-CM format, and identify sections used by medical insurance specialists in physician practices.
- 3-4 Identify the purpose and correct use of V codes and E codes.
- 3-5 Use a five-step process to analyze diagnoses and locate the correct ICD-9-CM code.

Key Terms

Alphabetic Index
category
chief complaint (CC)
coexisting condition
conventions
cross-reference
diagnosis code
Dx
E code
etiology
International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)
main term
primary diagnosis
subcategory
subclassification
subterm
supplementary term
Tabular List
V code

Why This Chapter Is Important to You

The information in this chapter will enable you to:

- Use an important reference book, the ICD-9-CM.
- Expand your understanding of why errors in diagnostic coding interfere with the billing and payment cycle.
- Learn one of the most important steps in completing health care claims.

What Do You Think?

To diagnose a patient's condition, the physician follows a complex process of decision making based on the patient's statements, an examination, and evaluation of this information. When the diagnosis is made, the medical insurance specialist communicates it to the insurance carrier through codes on the health care claim. What impact does incorrect coding have on the medical office?

"You have a condition whose name is very hard to remember."

INTRODUCTION TO DIAGNOSTIC CODING

During the course of office encounters (visits) with patients, physicians document their evaluations of patients' conditions in their medical records. For example, in a section called Review of Systems (ROS), the patient's responses to the physician's questions about each body system are recorded. When an examination is conducted, physicians summarize the findings under various headings, such as "neck" or "neurologic" (for the nervous system). Patients' medical records also include treatments, progress notes, follow-up care, laboratory and X-ray reports, and special forms.

When a diagnosis is made by the physician, it is documented in the patient's medical record. The diagnosis, often abbreviated **Dx** in the medical record, describes illnesses or injuries using medical terminology. Medical insurance specialists become familiar with the most common diagnoses of patients seen in their medical offices. For example, in a cardiologist's office, terms such as *hypertension, cardiac infarction, vascular disease, coronary stenosis*, and *angina pectoris* are typical of the medical terminology used to describe a variety of heart conditions. Regardless of the type of medical practice, all diagnoses can be indicated by a coded "language" that is recognized worldwide.

Diagnosis Codes

One of the most important pieces of information on a health care claim is the diagnosis. The code number entered there is based on the physician's opinion of the patient's specific illness(es), sign(s), symptom(s), and complaint(s). This number is the **diagnosis code.**

Coding affects the medical billing and payment process. Diagnosis codes give insurance carriers clearly defined diagnoses to help process claims efficiently. An error in coding conveys to an insurance carrier the wrong reason a patient received medical services. This causes confusion, a delay in processing, and possibly a reduced payment or denial of the claim. An incorrect code may also raise the question of fraudulent billing if the payer decides that, based on the diagnosis, the services provided were not medically necessary.

In some practices, the physician selects the diagnosis codes. In others, a medical coder who has received specialized training in choosing codes handles this task. In still others, medical insurance specialists are expected to assign codes and to stay up to date on new codes.

The ICD-9-CM

The diagnosis codes are found in the **International Classification of Diseases, Ninth Revision, Clinical Modification,** referred to as the **ICD-9-CM.** The ICD-9-CM is a single book or a set of multiple volumes that lists codes according to a system assigned by the World Health Organization of the United Nations. The volumes are distributed by the United States Government Printing Office in Washington, D.C., and by commercial publishers.

HIPAA Tip

New ICD-9-CM codes go into effect twice a year, on April 1 and October 1. HIPAA requires the use of the codes that are in effect on the date of service. Medical offices should keep coding information up to date. The current codes are available on the Web site for the National Center for Health Statistics, which—with other health care industry groups—maintains the codes.

Compliance Tip

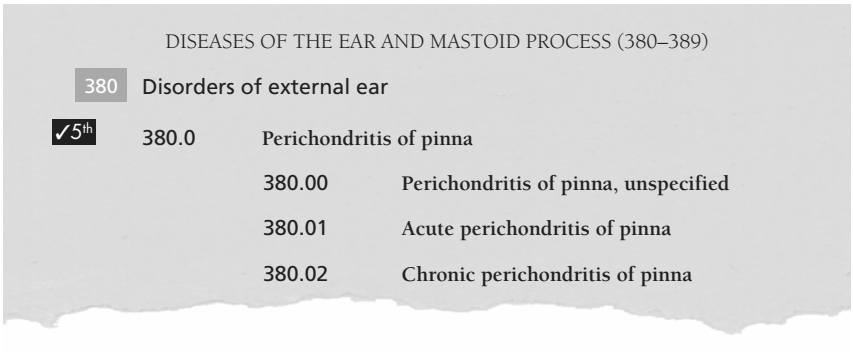
Using fourth- and fifth-digit ICD-9-CM codes is not optional. When coding, always use the most specific (highest level) code available. Use a three-digit code only if there are no four-digit codes within the category. Likewise, use a four-digit code only if there is no five-digit code for that subcategory. Use the five-digit subclassification code wherever possible. Most commercial publishers of the ICD-9-CM use a symbol such as 5 next to a subcategory to indicate that a five-digit code is required.

The ICD had its beginnings in England in the 1600s. By the late 1800s it was used in the United States for reporting statistics on morbidity (the prevalence of an illness) and mortality (causes of death). Today, computers collect and analyze ICD-9-CM codes used by government health care programs, professional standards review organizations, medical researchers, hospitals, physicians, and other health care providers. Private and public medical insurance carriers also use the codes.

The ICD-9-CM has been revised a number of times. ICD-9, for example, refers to the ninth revision of the ICD. In the title *ICD-9-CM,* the initials *CM* indicate that the edition is a clinical modification. For example, the ICD-9-CM is the clinical modification of the ninth revision of the ICD. Codes in this modification describe various conditions and illnesses with more precision than did earlier codes. Under HIPAA, ICD-9-CM codes must be used to report diagnoses on all claims.

The coding system in the ICD-9-CM contains three-digit **categories** for diseases, injuries, and symptoms. Almost all of these three-digit categories are divided into four-digit code groups called **subcategories.** Many are further divided into five-digit codes called **subclassifications.** In the ICD-9-CM, the fourth and fifth digits are separated from the first three by a period. The purpose of the fourth- and fifth-level diagnosis codes is to permit reporting the most specific diagnosis possible. Figure 3-1 shows an example of several levels of ICD-9-CM codes.

In addition to the categories for diseases, one section of the ICD-9-CM codes begins with the letter *V,* and another section begins with *E.* These letters are followed by up to four digits. The codes that begin with *V* are used for encounters for reasons other than illness or injury. In these situations, patients often do not have a complaint or active diagnosis. For example, a routine annual physical examination is a reason for an office visit without a complaint. Visits for treatments of a diagnosed condition, such as chemotherapy for cancer, also receive codes beginning with *V.* Codes beginning with *E* indicate the external cause of an injury or poisoning. For example, a patient's harmful reaction to the proper dosage of a drug is assigned an E code. Both types of codes are described in more detail later in this chapter.


DISEASES OF THE EAR AND MASTOID PROCESS (380–389)

380 Disorders of external ear

✓5th 380.0 Perichondritis of pinna

380.00 Perichondritis of pinna, unspecified

380.01 Acute perichondritis of pinna

380.02 Chronic perichondritis of pinna

Figure 3-1 Examples of the Three Levels of ICD-9-CM Codes

Compliance Tip

- If a patient's medical record lists conditions that do not affect treatment during a particular encounter, these conditions are not reported on the claim.
- When a patient has undetermined conditions, indicated by words such as *rule out* or *suspected,* these possible conditions are not reported. Instead, the symptoms are coded and reported.
- If it is hard to determine the primary diagnosis, as in the case of multiple injuries from a motor vehicle accident, usually the diagnosis that supports the medical necessity of the highest-paying procedure is primary.

A health care claim for a patient must show the diagnosis that represents the patient's major health problem *for that particular encounter.* This condition is the **primary diagnosis.** The primary diagnosis must provide the reason for medical services listed on that claim. If a patient has cancer, for example, the disease is probably the patient's major health problem. However, if that patient sees the physician for an ear infection that is not related to the cancer, the primary diagnosis for that particular claim is the ear infection.

At times, there is more than one diagnosis because many patients are treated by a health care provider for more than one illness. Someone with hypertension (high blood pressure), for example, may also have heart disease. A patient with diabetes may seek care for a respiratory infection. The primary diagnosis—the condition that the doctor treated and documented as primary—is listed first on the insurance claim. After that, additional **coexisting conditions** may be listed. Coexisting conditions occur at the same time as the primary diagnosis. If these conditions affect the treatment or recovery from the condition shown as the primary diagnosis, they are reported. For example, a patient with diabetes mellitus often suffers from poor circulation. The diagnosis for this person's office visit to complain of numbness in the fingers and toes would be likely to include the diabetes as a coexisting condition. Sometimes, a diagnosis code contains both the primary and a coexisting condition. For example, code 365.63 means glaucoma associated with vascular disorders.

Examples

The information for identifying a patient's diagnosis and any coexisting conditions is found in the patient's medical record. When the patient goes into the examining room, a medical assistant or nurse may conduct a short interview to find out the patient's **chief complaint** (abbreviated **CC** in the documentation). The chief complaint is the reason the patient seeks medical care on this encounter. Notes about the chief complaint may be entered in the patient's medical record by the medical assistant, nurse, or physician. However, *only* the physician determines the diagnosis.

Suppose Rosa Hernandez, a patient, comes to the office. Notes about the encounter might appear as follows:

CC: Diarrhea X 5 days with strong odor and mucus, abdominal pain and tenderness, no meds.

Dx: Ulcerative colitis.

The notes mean that Ms. Hernandez has had symptoms for five days and has taken no medication. Her chief complaint is noted after the abbreviation *CC.* Her diagnosis, listed after the abbreviation *Dx,* is ulcerative colitis.

Now suppose another patient, Joel Perlman, sees the physician. His record indicates a history of heavy smoking and includes an X-ray report and notes such as these:

CC: Hoarseness, pain during swallowing, dyspnea during exertion.

Dx: Emphysema and laryngitis.

The physician listed emphysema, the major health problem, first. It is Mr. Perlman's primary diagnosis. Laryngitis is a coexisting condition that is being treated.

Finally, a third patient, Janet Chang, has a prior history of breast cancer. For today's visit, her progress notes read:

CC: Laceration of right great toe three days previously, experiencing pain, toe reddened and swollen.

Dx: Complicated open wound of toe.

Ms. Chang's primary diagnosis for this encounter is a complicated open wound of the toe. The cancer is not reported on the health care claim because the physician has not stated that it affects Ms. Chang's recovery time and or the way the wound is treated.

Case Study 3-1

Patient: Hector Garcia

CC: Red swollen lump on thigh noticed four days ago; became painful today.

Dx: Abscess.

What is Hector Garcia's primary diagnosis?

Answer: _____

Case Study 3-2

Patient: James Jacobson

CC: Left-knee pain, swelling, and weakness. Has had right-knee pain and arthritis in past.

Dx: Left-knee pain and swelling secondary to gouty arthritis.

What is James Jacobson's primary diagnosis?

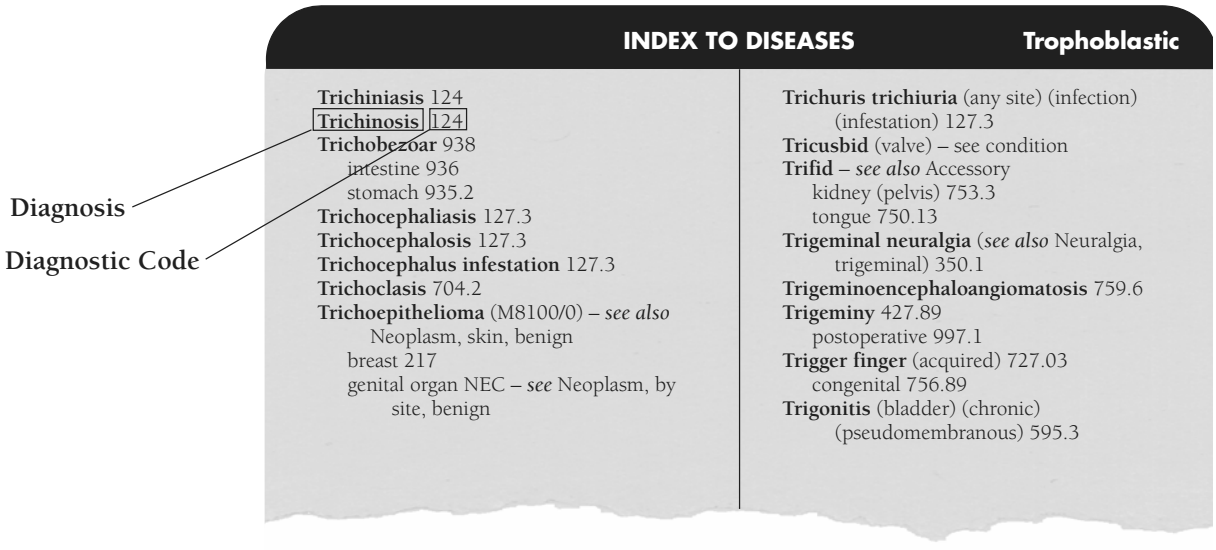
Answer: _____

As mentioned earlier, the ICD-9-CM comes in the form of a single book or a set of two or three books. Three sections are available:

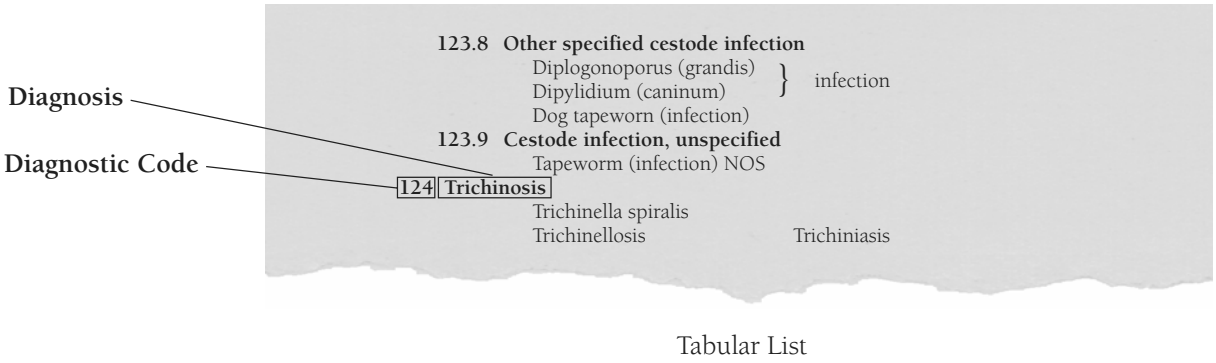
Volume 1—Diseases: Tabular List
Volume 2—Diseases: Alphabetic Index
Volume 3—Procedures: Tabular List and Alphabetic Index

Notice that the ICD-9-CM covers two major areas, diseases and procedures. Medical insurance specialists in a medical office use only the diagnosis codes (Volumes 1 and 2) in the ICD-9-CM. The procedures (Volume 3) are used only for hospital tests and treatments. Use of Volume 3 is covered in Chapter 15 of this text.

In the ICD-9-CM, diagnoses are listed two ways, as illustrated in Figure 3-2. One is the **Alphabetic Index,** which lists diagnoses in alphabetic order



Alphabetic Index



Tabular List

Figure 3-2 ICD-9-CM Alphabetic Index and Tabular List

with their corresponding diagnosis codes. The other is the **Tabular List**, which provides diagnosis codes in numerical order with additional instructions.

Both the Alphabetic Index and the Tabular List are used to find the right code. The Alphabetic Index does not contain all the necessary information, so it is never used alone. After a code is located in the Alphabetic Index, it is looked up in the Tabular List. Notes in this list may suggest or require the use of additional codes. Alternatively, notes may indicate that a condition should be coded differently because of exclusion from a category.

Alphabetic Index

The Alphabetic Index has three sections:

- Section 1 is the index to diseases and injuries, which are the diagnosis codes used most often. This section also contains special tables for indexing the codes for hypertension and neoplasms (tumors).
- Section 2 is a table of drugs and chemicals in alphabetical order, with corresponding codes related to poisoning and external causes.
- Section 3 is an alphabetical index of all external causes of injuries and poisonings, not just those resulting from drugs or chemicals.

The Alphabetic Index is organized by **main terms** in boldfaced type according to condition, as shown in Figure 3-3. A main term may be followed by a series of terms in parentheses called **supplementary terms**. The supplementary terms help define the main term but have no effect on the selection of the code. Because of this fact, they are referred to as "nonessential" supplementary terms. A **subterm** is indented underneath the main term in regular type. Subterms do affect the selection of appropriate diagnosis codes. They describe essential differences in body sites, **etiology** (the cause of disease), or clinical type. Often, a main term or subterm in the Alphabetic Index includes a **cross-reference** that indicates where else to look for additional supplementary terms, anatomical sites, or main terms.

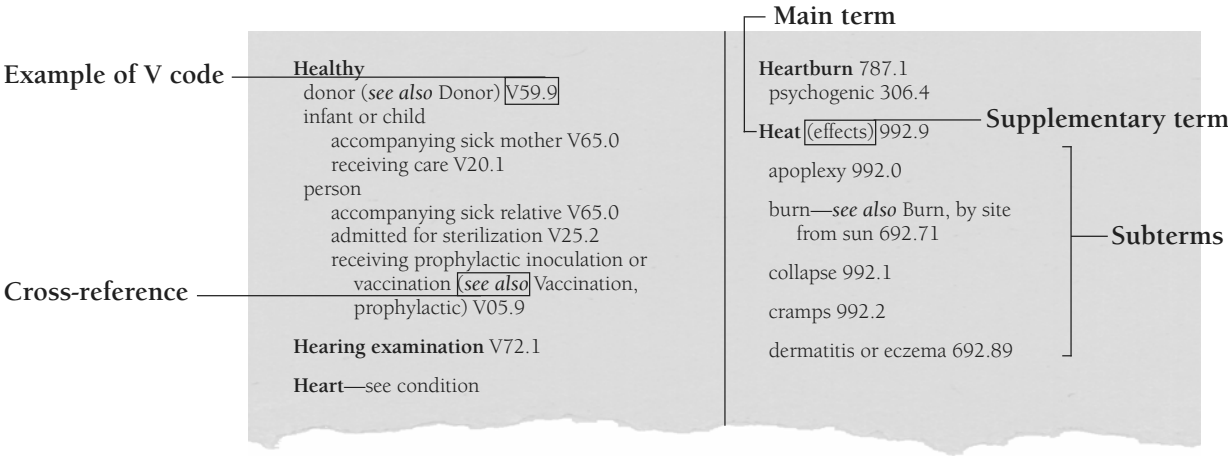


Figure 3-3 Sample of ICD-9-CM Alphabetic Index with Labels

Tabular List

The Tabular List in the ICD-9-CM presents diagnosis codes in numerical order. Many illnesses are classified according to body system, so a particular group of diseases can be found by checking the table of contents, as shown in Table 3-1.

Table 3-1 ICD-9-CM Tabular List Table of Contents

Chapter		Categories
1	Infectious and Parasitic Diseases	001–139
2	Neoplasms	140–239
3	Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders	240–279
4	Diseases of the Blood and Blood-Forming Organs	280–289
5	Mental Disorders	290–319
6	Diseases of the Central Nervous System and Sense Organs	320–389
7	Diseases of the Circulatory System	390–459
8	Diseases of the Respiratory System	460–519
9	Diseases of the Digestive System	520–579
10	Diseases of the Genitourinary System	580–629
11	Complications of Pregnancy, Childbirth, and the Puerperium	630–677
12	Diseases of the Skin and Subcutaneous Tissue	680–709
13	Diseases of the Musculoskeletal System and Connective Tissue	710–739
14	Congenital Anomalies	740–759
15	Certain Conditions Originating in the Perinatal Period	760–779
16	Symptoms, Signs, and Ill-Defined Conditions	780–799
17	Injury and Poisoning	800–999

Supplementary Classifications

V Codes	Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01–V83
E Codes	Supplementary Classification of External Causes of Injury and Poisoning	E800–E999

Appendices

A	Morphology of Neoplasms
B	Glossary of Mental Disorders (deleted in 2004)
C	Classifications of Drugs by American Hospital Formulary Service List Number and Their ICD-9-CM Equivalents
D	Classification of Industrial Accidents According to Agency
E	List of Three-Digit Categories

V Codes and E Codes

V codes and E codes are found in numerical order following the Tabular List. **V codes** classify factors that influence health status or the reasons patients seek medical services when they are not ill. Examples of V codes include routine physical examinations, routine care during pregnancy, and immunizations or vaccinations.

Compliance Tip

V codes such as family history or a patient's previous condition help show payers why a service was medically necessary.

It is appropriate to use V codes:

- When a patient is not sick but receives a service for a purpose, such as an ultrasound during pregnancy.
- When a patient with a current or recurring condition receives treatments, such as physical therapy.
- When a patient has a past condition that affects current health status or has a family history of disease.

Compliance Tip

- E codes are never primary.
- Special care should be given to the use of some E codes because of their sensitive nature. For example, suicide attempts and assaults are likely to be highly confidential matters.

A V code can be used as either a primary code for an encounter or as an additional code. The terms that indicate the need for V codes usually have to do with a reason for an encounter other than a disease or its complications. Examples of these terms are "contact with," "history of," "follow-up," "screening," and "status."

E codes are diagnosis codes for external causes of poisonings and injuries. An E code is used *in addition to* the main code that describes the injury or poisoning itself. For example, if a person had a concussion from the impact sustained in a car accident, an E code would be used to indicate the external cause of the diagnosis. E codes are often reported on workers' compensation claims and for liability insurance, since they are used to define what happened and where it happened.

Case Study 3-3

Patient Betty Standover received an endometrial biopsy and pelvic ultrasound to monitor any changes of the endometrium that may be caused by a medication she is taking.

What type of code is used to describe the medical need for the biopsy and the ultrasound?
Answer:

Case Study 3-4

Patient Frank Sherchasy fell off a ladder while on the job at Right's Painting Service. He sprained his left ankle and has a simple fracture of the right femur.

What type of code is used in addition to the main codes to describe his diagnosis?
Answer:

ICD-9-CM Conventions

A list of abbreviations, punctuation, symbols, typefaces, and instructional notes appears at the beginning of the ICD-9-CM. These items, called **conventions**, provide guidelines for using the ICD-9-CM system. Some key conventions are:

NOS—This abbreviation means not otherwise specified, or unspecified. This convention is used when a condition cannot be described more specifically. In general, codes with NOS should be avoided. The physician should be asked to help select a more specific code, if possible.

NEC—This abbreviation means not elsewhere classified. This convention is generally used when the ICD-9-CM does not provide a code specific enough for the patient's condition. NEC should not be used as a shortcut to avoid looking up more specific codes.

[ ] Brackets—Used around synonyms, alternative wordings, or explanations.

( ) Parentheses—Used around descriptions that do not affect the code, that is, nonessential supplementary terms.

: Colon—Used in the Tabular List after an incomplete term that needs one of the terms that follow to make it assignable to a given category.

} Brace—Encloses a series of terms, each of which is modified by the statement that appears to the right of the brace.

Includes—This note indicates that the entries following it refine the content of a preceding entry. For example, after the three-digit diagnosis code for acute sinusitis, the word *includes* is followed by the types of conditions that the code covers.

Excludes—These notes, which are italicized, indicate that an entry is not classified as part of the preceding code. The note may also give the correct location of the excluded condition.

Use additional code—This note indicates that an additional code should be used, if available.

Code first underlying disease—This instruction appears when the category is not to be used as the primary diagnosis. These codes may not be used as the first code; they must always be preceded by another code for the primary diagnosis.

FIVE STEPS TO DIAGNOSTIC CODING

Diagnostic coding follows a five-step process:

Step 1—Locate the statement of the diagnosis in the patient's medical record.

Step 2—Find the diagnosis in the ICD-9-CM's Alphabetic Index.

Step 3—Locate the code from the Alphabetic Index in the ICD-9-CM's Tabular List.

Step 4—Read all information and subclassifications to get the code that corresponds to the patient's specific disease or condition. Note fourth- or fifth-code requirements and exclusions.

Step 5—Record the diagnosis code on the insurance claim, and proofread the numbers.

Each step is explained in the following pages. Coding becomes easier with practice, but do not be tempted to take shortcuts. Every case is different, and additional terms or digits may be necessary to make a diagnosis code as specific as possible. If a step is skipped, important information may be missed. If more than one diagnosis is listed in a patient's medical record, work on only one diagnosis at a time to avoid coding errors.

Step 1. Locate the statement of the diagnosis in the patient's medical record.

First, find the place where the physician has indicated the diagnosis. This information may be located on the encounter form or elsewhere in the patient's medical record, such as in a progress note.

For example, a patient, Susan Tyne, age forty-five, comes to the office. Her medical record reads:

CC: Chest and epigastric pain; feels like a burning inside. Occasional reflux. Abdomen soft, flat without tenderness. No bowel masses or organomegaly.

Dx: Peptic ulcer.

Susan's diagnosis is peptic ulcer.

Then, if needed, decide which is the main term or condition of the diagnosis. For example, in Susan's diagnosis, the main term or condition is *ulcer.* The word *peptic* describes what type of ulcer it is.

Case Study 3-5

Patient: Hillary Baez

Dx: Complete paralysis.

What is the condition in this diagnosis? What is the supplementary term in this diagnosis?

Answer: _____

Case Study 3-6

Patient: Renate Martello

Dx: Heart palpitation.

What is the condition in this diagnosis? What is the supplementary term in this diagnosis?

Answer: _____

Case Study 3-7

Patient: Rob Blaze
Dx: Panner's disease.

What is the condition in this diagnosis?
Answer: _____

Step 2. Find the diagnosis in the ICD-9-CM's Alphabetic Index.

Look for the condition first. Then find descriptive words that make the condition more specific. Read all cross-references to check all the possibilities for a term and its synonyms.

Suppose the diagnosis is sebaceous cyst. Look under *cyst,* the condition, rather than *sebaceous,* the descriptive word. Many entries in the Alphabetic Index are cross-referenced. For example, *sebaceous* is followed by instructions in parentheses that say "(*see also* Cyst, sebaceous)." Observe all cross-reference instructions.

Examine all subterms under the main term in the Alphabetic Index to be sure the correct term is found. Do not stop at the first one that "sounds right." When you find the correct term, make a note of the code that follows it.

For example, Figure 3-4 illustrates how to look up Susan Tyne's diagnosis of peptic ulcer. First, find the term *ulcer.* Notice that the term *peptic* is found in the list of subterms that follows the main term. After *peptic,* the term *(site unspecified)* appears. Since parentheses around a term indicates that it does not affect the code number, this is tentatively the correct code. (It must be verified by using the Tabular List.)

Make a note of the code, which is 533.9.

FYI

An eponym is a disease or syndrome named for an individual. An example is Graves' disease. In the ICD-9-CM, eponyms are listed both as main terms in alphabetic order and under the main terms *Disease* or *Syndrome.* A description is often included in parentheses following the eponym.

Step 3. Locate the code from the Alphabetic Index in the ICD-9-CM's Tabular List.

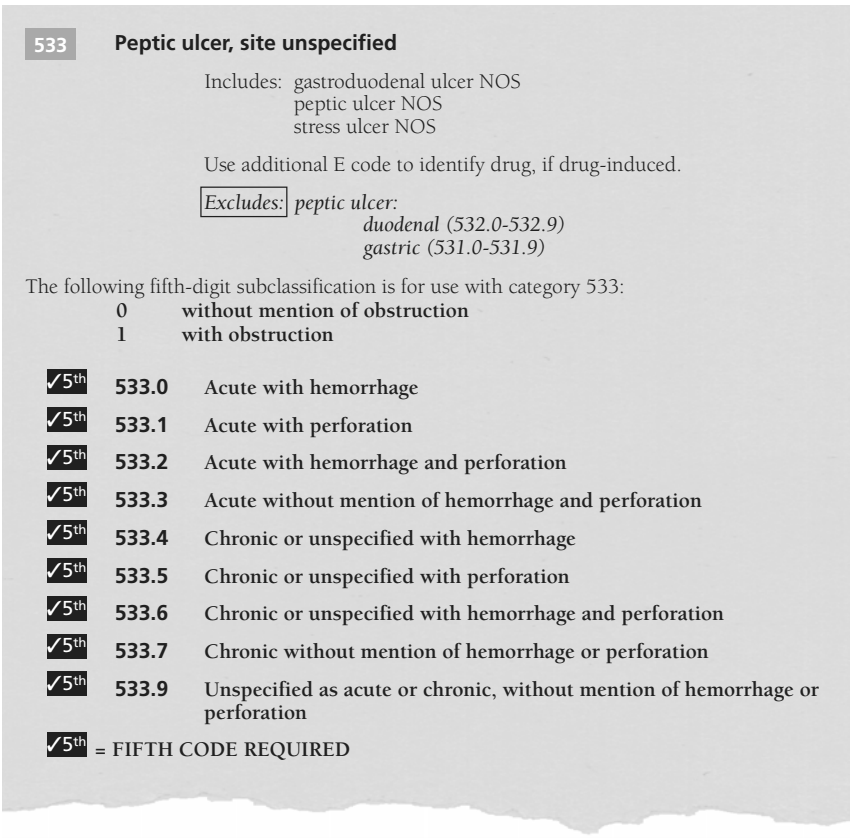
Remember, the number to check is a code number, not a page number. The Tabular List gives codes in numerical order. Look for the number in boldfaced type. For Susan Tyne's diagnosis, look for the number 533.9 in the ICD-9-CM's Tabular List.

Ulcer, ulcerated, ulcerating, ulceration, ulcerative—*continued*

. . .

peptic (site unspecified) 533.9

Figure 3-4 Locating an Item in the Alphabetic Index



533 **Peptic ulcer, site unspecified**

Includes: gastroduodenal ulcer NOS
peptic ulcer NOS
stress ulcer NOS

Use additional E code to identify drug, if drug-induced.

Excludes: *peptic ulcer:*
duodenal (532.0-532.9)
gastric (531.0-531.9)

The following fifth-digit subclassification is for use with category 533:
0 without mention of obstruction
1 with obstruction

✓5th	533.0	Acute with hemorrhage
✓5th	533.1	Acute with perforation
✓5th	533.2	Acute with hemorrhage and perforation
✓5th	533.3	Acute without mention of hemorrhage and perforation
✓5th	533.4	Chronic or unspecified with hemorrhage
✓5th	533.5	Chronic or unspecified with perforation
✓5th	533.6	Chronic or unspecified with hemorrhage and perforation
✓5th	533.7	Chronic without mention of hemorrhage or perforation
✓5th	533.9	Unspecified as acute or chronic, without mention of hemorrhage or perforation

✓5th = FIFTH CODE REQUIRED

Figure 3-5 Locating an Item in the Tabular List

Step 4. Read all information and subclassifications to get the code that corresponds to the patient's specific disease or condition. Note fourth- or fifth-code requirements and exclusions.

Refer to Figure 3-5, which shows all the Tabular List entries that are under the three-digit code 533. Observe all instructional notations in the list.

Next to Susan Tyne's code of 533.9, the ICD-9-CM indicates "fifth code required." This note means that the correct code for the diagnosis must have five digits. In Susan Tyne's case, the diagnosis does not mention an obstruction. Therefore, the correct code is 533.90.

Note that if the ICD-9-CM indicates that a fifth digit is required, it must be included. But if it is not required, a zero or zeroes should not be added to the four-digit or three-digit code. The use of a fifth digit when it is not required makes the code invalid.

Notice also that if this diagnosis had been peptic ulcer: duodenal or gastric, it would have been excluded from the 533 code number. The italicized word *Excludes,* boxed under the main term *Peptic ulcer, site unspecified,* is an instructional note that points to alternative code numbers.

Compliance Tip

Even after performing these steps, the medical insurance specialist may not be sure the correct code has been found. In these cases, the code should be verified with the physician. Never guess a code or enter one that might not be correct.

Step 5. **Record the diagnosis code on the health care claim, proofreading the numbers on the screen.**

Enter the correct diagnosis code in the medical billing program (explained in detail in Chapter 6), and then proofread it. The medical insurance specialist should ask these questions:

- Are the numbers entered correctly? If numbers are transposed, the insurance carrier will receive the wrong diagnosis. Proofread the numbers on the computer screen or on the printed claim form.
- Are the codes complete? If the phone rang in the middle of coding a diagnosis, the last number of the code may have been omitted.
- Is the most specific code always used?

Case Study 3-8

Using the table shown here and the following progress notes, answer the question about this case study.

Harold Dayton's progress notes read as follows:

CC: Fatigue, chills, upset stomach, severe headache, moderate cough X 3 days, meds asa (aspirin only).

Dx: Influenza.

What is Harold Dayton's diagnosis? Use the five-step process to determine the correct ICD-9-CM diagnosis code.

Answer: _____

Index to Diseases	Tabular List
Influenza, influenzal 487.1 with bronchitis 487.1 bronchopneumonia 487.0 cold (any type) 487.1 digestive manifestations 487.8 hemoptysis 487.1 involvement of gastrointestinal tract 487.8 nervous system 487.8 laryngitis 487. 1 manifestations NEC 487.8 respiratory 487.1	**487** Influenza **487.0** With pneumonia **487.1** With other respiratory manifestations **487.8** With other manifestations

Explore the Internet

The American Academy of Professional Coders (AAPC) is a coding association that certifies medical coders and provides information on coding issues. Using a search engine such as Google or Yahoo, visit the website of the AAPC and investigate the ways that this association keeps its members up to date about changes in procedural coding. Also review the activities of this group in your local area.

Case Study 3-9

Using the table shown here and the following progress notes, answer the questions about this case study.

Hazel Knight came to the office because of a sore, red throat. She has pus pockets in the back of her throat and has experienced fever for the past two days. A test showed streptococcal infection. Part of her examination included a blood pressure check that read 150/98. The physician diagnosed essential hypertension and streptococcal pharyngitis.

Which diagnosis is Hazel Knight's primary diagnosis?
What is the coexisting condition?
Use the five-step process to determine the correct ICD-9-CM diagnosis codes.
Answer:

Primary code:

Secondary code:

Index to Diseases	Tabular List
essential—*see* condition … **hypertension, hypertensive** (arterial) (arteriolar)(crisis) (degeneration) (disease) (essential)… . **malignant 401.0** **benign 401.1** **unspecified 401.9** … **pharyngitis** … streptococcal **034.0**	**401 Essential hypertension** **401.0 Malignant** **401.1 Benign** **401.9 Unspecified** … **034 Streptococcal sore throat and scarlet fever** **034.0 Streptococcal sore throat** **034.1 Scarlet fever**

Case Study 3-10

Using the table shown here and the following progress notes, answer the questions about this case study.

Patient: Lee Yong

Patient is a fifty-eight-year-old Asian female who presents for an annual exam.

Dx: Routine health maintenance.

What is the diagnosis?
What is the correct code?
Answer:

Index to Diseases	Tabular List
Health advice V65.4 audit V70.0 checkup V70.0 education V65.4 hazard (*see also* History of) V15.9 specified cause NEC V15.89 instruction V65.4 services provided because … . .	**V70 General medical examination** **V70.0 Routine general medical examination at health care facility** **V70.1 General psychiatric examination, requested by the authority**

Case Study 3-11

Using the table shown here and the following progress notes, answer the question about this case study.
Patient: Ralph Kramer
Patient reported accidental injury due to the firing of a rifle by his brother during a hunting trip.

What E code should be listed following the main diagnosis code?
Answer:

_____

Index to External Causes	E Code
Accident … firearm missile—*see* Shooting … Shooting, shot E922.9 handgun (pistol) (revolver) E922.0 … inflicted by other persons … rifle (hunting) E922.2	**E922 Accident caused by firearm missile** **E922.0 Handgun** **E922.1 Shotgun** **E922.2 Hunting rifle** **E922.3 Military firearms**

Professional Focus

Preview of ICD-10-CD

The tenth edition of the ICD was published by the World Health Organization in the mid-1990s. In the United States, the new *Clinical Modification* (ICD-10-CM) is being reviewed by health care professionals and is expected to be put into use. An effective date of October 1, 2011, has been proposed. The major changes include:

- The ICD-10 contains 2,033 categories of diseases, 855 more than the ICD-9. The additional codes permit more-specific reporting of diseases and newly recognized conditions.
- Codes are alphanumeric, containing a letter followed by up to five numbers.
- A sixth digit is added to capture clinical details. For example, all codes that relate to pregnancy, labor, and childbirth include a digit that indicates the patient's trimester.
- Codes are added to show which side of the body is affected when a disease or condition can be involved with the right side, the left side, or bilaterally.

Although the code numbers look different, the basic systems are very much alike. People who are familiar with the current codes will find that their training quickly applies to the new system.

Chapter Summary

1. Coding affects the payment process by giving the insurance carrier a clearly defined diagnosis that helps the carrier process the claim efficiently.

2. When a patient's medical record lists more than one diagnosis, the primary diagnosis is recorded first on the insurance claim. Additional diagnoses that occur at the same time as the primary condition and affect the patient's treatment or recovery are listed with additional diagnosis codes.

3. V codes identify encounters for reasons other than illness or injury and are used for healthy patients who are receiving routine services, for therapeutic encounters, for a problem that is not currently affecting a patient's condition, and for preoperative evaluations. E codes, which are never used as primary codes, classify the injuries resulting from various environmental events.

4. The ICD-9-CM is divided into three volumes. ICD-9-CM codes appear in lists arranged alphabetically and numerically. Medical offices use only the diagnosis codes that appear in the Tabular List (Volume 1) and the Alphabetic Index (Volume 2). ICD-9-CM procedure codes (Volume 3) are used by hospitals.

5. The five steps for analyzing diagnoses and locating the correct ICD-9-CM code are:

(a) Locate the diagnosis in the patient's medical record.

(b) Find the diagnosis in the ICD-9-CM's Alphabetic Index.

(c) Locate the code from the Alphabetic Index in the ICD-9-CM's Tabular List.

(d) Read all information and subclassifications to get the code that corresponds to the patient's specific disease or condition. Note fourth- or fifth-code requirements and exclusions.

(e) Record the diagnosis code on the health care claim, and proofread the numbers.

Check Your Understanding

Part 1. Choose the best answer.

____ **1.** The person who determines a patient's diagnosis is the:
- **a.** physician
- **b.** medical insurance specialist
- **c.** nurse

____ **2.** The person who reports the diagnosis code on the health care claim is the:
- **a.** physician
- **b.** medical insurance specialist
- **c.** nurse

____ **3.** Medical insurance specialists should proofread code numbers:
- **a.** to ensure accuracy
- **b.** to perform step 3 in the five-step coding process
- **c.** both a and b

____ **4.** The person who uses the procedure codes in the ICD-9-CM (Volume 3) is the:
- **a.** medical insurance specialist in a medical office
- **b.** hospital coder
- **c.** both a and b

____ **5.** The first step in the five-step process of diagnostic coding is to:
- **a.** record the diagnosis code on the insurance claim
- **b.** locate the diagnosis in the patient's encounter form or elsewhere in the medical record
- **c.** find the diagnosis in the ICD-9-CM's Alphabetic Index

____ **6.** The medical insurance specialist uses the five-step diagnostic coding process:
- **a.** until shortcuts are discovered
- **b.** only during training
- **c.** for every diagnosis

____ **7.** Additional diagnoses that occur at the same time as the primary condition and affect its treatment or recovery are:
- **a.** chief complaints
- **b.** coexisting conditions
- **c.** none of the above

____ **8.** When assigning diagnosis codes, the medical insurance specialist uses:
- **a.** the Alphabetic Index
- **b.** the Tabular List
- **c.** both a and b

____ **9.** V codes are used primarily for:
- **a.** emergency situations
- **b.** medical services having no clear diagnosis or for preventive care
- **c.** statistical purposes in hospital reports

____**10.** Diagnosis codes should be proofread to be sure they are:
- **a.** keyed correctly
- **b.** complete
- **c.** both a and b

Check Your Understanding (cont.)

Part 2. Underline the main term in the following list. Then, using the Alphabetic Index and Tabular List in the most recent ICD-9-CM available to you, code the diagnostic statements.

____ **1.** Abdominal pain

____ **2.** Acute cerebrovascular disease

____ **3.** Postoperative fibrillation

____ **4.** Night sweats

____ **5.** Singer's nodule

____ **6.** Carpal tunnel syndrome

____ **7.** Popliteal fat pad hernia

____ **8.** Harvest itch

____ **9.** Urinary incontinence without sensory awareness

____**10.** Little's disease, congenital

Part 3. Using the Alphabetic Index and Tabular List in the most recent ICD-9-CM available to you, code the following diagnostic statements.

____ **1.** Breast mass

____ **2.** Muscle spasms

____ **3.** Verruca plantaris

____ **4.** Newborn vomiting

____ **5.** Herpes zoster (NOS)

____ **6.** Normal delivery

____ **7.** Menopausal syndrome

____ **8.** Diabetes, type II, uncontrolled, unspecified complication

____ **9.** Attention deficit disorder with hyperactivity

____**10.** Acute pulmonary heart disease, unspecified

Part 4. Using the most recent ICD-9-CM available to you, code each of the following diagnostic statements with the correct V code or E code.

____ **1.** Routine medical health checkup of infant at health care facility

____ **2.** Fall from ladder

____ **3.** Exposure to smallpox

____ **4.** Vaccination against chickenpox

____ **5.** Accidental poisoning from motor vehicle exhaust gas

Check Your Understanding (cont.)

____ **6.** HIV positive with no HIV infection symptoms or conditions

____ **7.** Mechanical failure of equipment during kidney dialysis

____ **8.** Accidental poisoning by gasoline

____ **9.** Father allergic to penicillin

____ **10.** Exposure to HIV virus but not tested for infection

Part 5. Audit the following cases to determine if the correct codes have been reported in the correct order. If a coding mistake has been made, state the correct code and your reason for assigning it.

Case 1

Chart note for Henry Blum, date of birth 11/4/57:

> Examined patient on 12/6/2010. He was complaining of a facial rash. Examination revealed sebopsoriasis and extensive seborrheic dermatitis over his upper eyebrows, nasolabial fold, and extending to the subnasal region.

The following codes were reported: 696.1, 690.1. _____
_____

Case 2

Physician's notes, 2/24/2010, patient George Kadar, DOB 10/11/1940:

> *Subjective:* This seventy-year-old patient complains of voiding difficulties, primarily urinary incontinence. No complaints of urinary retention.
> *Objective:* Rectal examination: enlarged prostate. Patient catheterized for residual urine of 200 cc. Urinalysis is essentially negative.
> *Assessment:* Prostatic hypertrophy, benign.
> *Plan:* Refer to urologist for cystoscopy.

The following code was reported: 600.0. _____
_____

Check Your Understanding (cont.)

Case 3

Patient: Gloria S. Diaz:

Subjective: This twenty-five-year-old female patient presents with pain in her left knee both when she moves it and when it is inactive. She denies previous trauma to this area but has had right-knee pain and arthritis in the past.
Objective: Examination revealed the left knee to be warm and slightly swollen compared to the right knee. Extension is 180 degrees; flexion is 90 degrees. Some tenderness in area.
Assessment: Left-knee pain probably due to chronic arthritis.
Plan: Daypro 600 mg 2-QD x 1 week; recheck in one week.

The following codes were reported: 719.48, 716.98. _____
_____
_____
_____
_____