Foundations of ICD-9-CM

2

CHAPTER TWO

Key Terms

Acute
And
Chronic
Code first
Excludes
Includes
Late effect
Main term
Manifestation
NEC
NOS
Parentheses
Sign
Slanted brackets
Square brackets
Symptom
Use additional code

Learning Outcomes

After completing this chapter, you will be able to:

- **2.1** Understand the format of the ICD-9-CM manual.
- **2.2** Apply the abbreviations, coding conventions, and punctuation marks used in ICD-9-CM.
- **2.3** Identify main terms and use the ICD-9-CM index.
- **2.4** Review ICD-9-CM chapter-specific guidelines.
- **2.5** Examine ICD-9-CM diagnostic outpatient guidelines.
- **2.6** Recognize the importance of translating provider terminology into accurate diagnostic codes.

Introduction The focus of this chapter is a general overview of the ICD-9-CM conventions and guidelines needed to be successful in completing the CPC exam. Later chapters provide more specific detail on the ICD-9-CM codes that are commonly used with specific body systems.

2.1 Format of ICD-9-CM Manual

The abbreviation *ICD-9-CM* stands for "International Classification of Diseases, Ninth Revision, Clinical Modification." The ICD-9-CM manual is the translation dictionary that coders use to translate medical terminology from provider documentation into the codes used to tell a patient's diagnostic story. ICD-9-CM is the "why" for the patient's service or procedure. Understanding the format of the ICD-9-CM manual and being able to implement the guidelines and coding conventions enable coders to not only succeed with the CPC exam but also achieve accuracy and consistency in coding of the medical record.

The ICD-9-CM is published in a two- or three-volume set. The two-volume set is used by providers to identify why the service or procedure was provided. The three-volume set is used exclusively by facilities to identify both why the service or procedure was provided and what service or procedure was provided.

Volume 1, also known as the *tabular portion* of the ICD-9-CM, contains the numerical code section and the full description (nomenclature) of each code. To ease the process of coding for the coder, this volume appears after Volume 2.

Volume 2, also known as the *index* of the ICD-9-CM, contains an alphabetic listing of main terms identifying a patient's condition, injury, sign, or symptom. Subterms follow the main term in a graduated indented format and provide for further clarification of the patient's condition, thus allowing the coder to drill down to a more accurate code before looking up the code in Volume 1.

Volume 3 codes are used by inpatient and outpatient facilities to report procedures and services.

MENTOR Coding Tip

When searching through the index, pay close attention to indentations as you move from one column to the next.

MENTOR Coding Tip

Only Volumes 1 and 2 of the ICD-9-CM are used for the CPC exam. Volume 3 is used for facility coding, and coders are not tested on facility coding on the CPC exam.

MENTOR Coding Tip

Students have found it very helpful to tab their ICD-9-CM manual. They use self-adhesive tabs or labels to mark the individual tables in the Alphabetic Index (hypertension, neoplasm, table of drugs and chemicals) and the individual chapters in the Tabular List to identify a range of codes. They have found that this saves them considerable time when they are taking the CPC exam since the tabs enable them to quickly locate the code indicated in the index.

EXERCISE 2.1

1. Explain the differences between the three volumes of the ICD-9-CM manual.
2. What is the main function of the ICD-9-CM manual for the coder?

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2.2 Abbreviations, Coding Conventions, Guidelines, Instructional Notes, and Punctuation

ICD-9-CM uses several abbreviations, symbols, and punctuation marks within the Tabular List (Volume 1). Many of them are used to save space within the ICD-9-CM manual. The significance of punctuation is reviewed later in this

chapter. This section begins with an explanation of two abbreviations that confuse even experienced coders.

Abbreviations

NEC and *NOS* are two coding-convention abbreviations that are important for a coder to differentiate and know how to use. The definitions of each can be found in the Conventions section of the ICD-9-CM manual guidelines.

NEC—not elsewhere classified—means that a more specific code is not provided in the ICD-9-CM manual. In this case, the provider documentation is more specific in its description of the patient's condition than the ICD-9-CM allows for in the code description.

NEC Notation meaning "not elsewhere classified"; indicates that a more specific code is not provided in the ICD manual.

FOR EXAMPLE Hypothyroidism due to autoimmune disorder would be coded as:

secondary hypothyroidism NEC or other specified acquired hypothyroidism (244.8)

This is because the level of detail needed to identify this condition fully is not provided in the description of any of the acquired forms of hypothyroidism listed in the ICD-9-CM manual. ■

NOS—not otherwise specified—is the equivalent of "unspecified." This abbreviation is to be used only when the documentation does not provide enough information to assign a more specific code.

NOS Notation meaning "not otherwise specified"; the equivalent of unspecified.

FOR EXAMPLE The diagnostic statement "goiter, nodular nontoxic" would be coded as:

unspecified nontoxic nodular goiter (241.9)

This is because the diagnostic statement does not clarify whether the condition is uninodular or multinodular. ■

MENTOR Coding Tip

Typically, NEC-specified codes are also known as *other-specified* codes and have an 8 as the fourth digit or a 9 as the fifth digit. NOS-specified codes are also known as *unspecified* codes and typically have a 9 as the fourth digit.

Coding Conventions, Guidelines, and Instructional Notes

The official ICD-9-CM coding conventions, as well as the Additional Conventions section, provides detail on the use of the symbols, official footnotes, instructional notes, conventions, and notations found in Volumes 1 and 2 of the ICD-9-CM manual.

Correct use and a comprehensive understanding of these conventions allow for consistency in coding and assist the coder in selecting the most accurate diagnosis code for the disease, condition, or injury as documented by the provider.

Acute and *Chronic*

acute Condition with a sudden onset, usually without warning, and of brief duration.

chronic Condition with a slow onset and of long duration.

One ICD-9-CM guideline addresses the use and sequencing of codes for **acute** and **chronic** conditions. The guideline instructs that when both the acute and chronic forms of a condition are documented, both conditions should be coded. Based on the guidelines, there are two ways these conditions may be coded: together, with a combination code that identifies both the chronic and acute forms of the condition in one code, or separately, with one code for the acute condition and another for the chronic condition.

Both combination codes and distinct codes are recognizable in the Alphabetic Index. After locating the main term of the condition (acute and chronic forms of the same condition are located under the same main term), review both subterms, *acute* and *chronic*. If the subterms *acute* and *chronic* are connected by a *with* statement, ICD-9-CM provides a combination code, or one code to indicate both conditions.

FOR EXAMPLE From the Alphabetic Index:

Bronchitis
  Chronic 491.9
    Obstructive 491.20
      with
        Acute bronchitis 491.22 ■

SPOTLIGHT on Terminology

Acute Conditions with sudden onset, usually without warning, and of brief duration. For example: fractures, intestinal flu, and rhinitis.
Chronic Conditions with slow onset and of long duration, even the lifetime of the patient. For example: diabetes, hypertension, and asthma.

MENTOR Coding Tip

Be sure to review both the *acute* and *chronic* subterms to identify available combination codes, since they are not always found under both terms, as is the case in the previous example.

When a combination code is not available and two distinct codes are needed to fully describe the patient's condition or disease, the ICD-9-CM guidelines instruct the coder to list both the acute and chronic codes with the acute condition listed first, followed by the chronic condition.

And

and Notation meaning "and/or."

The ICD-9-CM use of the word **and** is specified in the coding convention and is to be interpreted as meaning "and/or."

FOR EXAMPLE

373.32 Contact and allergic dermatitis of the eyelid

This code is to be used for contact and/or allergic dermatitis of the eyelid. ■

Late Effect

Late effect ICD-9-CM codes are used to describe a residual condition that occurs after the initial illness or injury.

late effect In ICD-9-CM, codes used to describe a residual condition that occurs after the initial illness or injury has healed.

MENTOR Coding Tip

Many coders have trouble with the late-effect residual condition concept. An easy way to distinguish between the two is to remember that the term *late* can be used to describe things or persons of the past (for example, my late husband). Residual refers to the present condition that exists as a result of the past condition or injury.

FOR EXAMPLE

In the following example the past condition is the wound:

906.0 Late effect of open wound of head, neck, and trunk

The residual may be scarring from the now-healed wound. ■

Excludes

The ICD-9-CM manual provides a list of conditions, diseases, and injuries that are not included in the code being considered in the tabular (Volume 1). The condition, disease, or injury being coded is located elsewhere in the ICD-9-CM manual.

Excludes notes may be found at the beginning of a chapter, section, or category or directly below the code. The placement of an *excludes* note identifies the range of codes to which the note applies.

excludes In ICD-9-CM, a note that lists conditions that are not included in the code being considered in the Tabular List.

FOR EXAMPLE

An *excludes* note found at the chapter level, Chapter 3 in this example, is:

endocrine and metabolic disturbances specific to the fetus and newborn (775.0–775.9)

The note placement indicates that these conditions are coded in another chapter of the ICD-9-CM manual. ■

By contrast, an *excludes* note found at the category level governs only codes within that category (codes beginning with the same three numbers).

FOR EXAMPLE The *excludes* note found below category 250 provides a list of conditions that are not included in this category but may still be found within the same chapter of ICD-9-CM. ■

Includes

Includes notes further clarify the code or category being considered by providing definitions or examples of conditions included in the code. Although *includes* notes are not found at the four- and five-digit code levels, inclusion terms may be found at these levels that aid the coder by providing synonyms of the diagnostic statement being coded.

includes Notes that clarify the code or category being considered by providing definitions or examples of conditions included in the code.

MENTOR Coding Tip

Remember that the inclusion terms are not all-inclusive and other terms may be listed in the index and not included in the tabular list. When this occurs, be sure to double-check the term and code in the index to avoid transposition of code digits before selecting the code.

MENTOR Coding Tip

If the sign or symptom is inherent to (commonly a part of) the definitive diagnosis, the sign or symptom is not coded in addition to the diagnosis.

Symptoms and Signs

In addition to listing codes for conditions, diseases, and injuries, the ICD-9-CM manual includes codes to be used by providers when no definitive diagnosis has been established. The Symptoms, Signs, and Ill-Defined Conditions chapter contains a comprehensive list of these codes.

According to the ICD-9-CM Section IV guidelines, providers must use codes for **signs** and **symptoms** instead of codes for diagnosis when a definitive diagnosis has not been made. Review the ICD-9-CM guidelines at Section IV, E and I.

By contrast, signs and symptoms are not coded when they are commonly found with the definitive diagnosis. See the ICD-9-CM coding guideline at Section I, B, 7.

sign An objective condition that can be measured and recorded.

symptom A subjective condition that is relayed to the provider by the patient.

FOR EXAMPLE Pain would be inherent to or normal with appendicitis. ■

SPOTLIGHT on Terminology

Sign A condition that can be measured and recorded. *Sign* is an objective term.

Symptom A condition that is relayed to the provider by the patient. *Symptom* is a subjective term.

Code First and *Use Additional Code*

At times more than one code is needed to clearly define a condition, injury, or disease as documented by the provider. This may occur when the condition is a **manifestation** produced by another condition (etiology) or is a complication of a treatment, disease, or condition.

manifestation How the condition due to the underlying disease presents itself.

ICD-9 CM provides the instructional notes **code first** and **use additional code** in the tabular section when additional information is needed to further define the patient's diagnosis. The *use additional code* note differs from the *code also* instruction as *use additional code* implies sequencing of the codes when reported.

code first and **use additional code** Directional terms that identify required sequencing. The directional "code first" informs the coder that the code being referenced is sequenced second to the primary code. The directional "use additional code" informs the coder that the code being referenced is sequenced as the first listed code in a pairing of codes.

FOR EXAMPLE

acute chest syndrome (517.3) in a patient with Hb-SS sickle-cell disease with crisis (282.62)

For this example, the ICD-9-CM provides guidance within the Tabular List that instructs the coder to code first sickle-cell disease in crisis. The *use additional code* instruction is found below the first-listed code in the tabular section of the ICD-9-CM manual. ■

Regardless of the type of instructional note, the official ICD-9-CM conventions instruct the coder to list the additional code only if the documentation provides the additional information needed to accurately select the code.

MENTOR Coding Tip

When searching for additional codes, be aware that unspecified codes may be used for the second-listed code when the provider's documentation is less detailed than needed to select a more accurate code. For example: 041.9 Bacterial infection, unspecified.

Punctuation

Discussed below are some of the more common punctuation marks that a coder needs to be aware of and know how to use effectively. Knowing what information each of these punctuation marks relays and how each impacts the selection of the code will help speed the process of coding as well as increase the accuracy of the codes used. As stated earlier, many of the conventions, abbreviations, and punctuation marks used in the ICD-9-CM manual are means of saving space within the text.

Brackets: Square [ ], Slanted *[ ]*

ICD-9-CM uses two types of brackets to convey information. **Square brackets,** [ ], are found in the tabular section and are used in two specific ways: to enclose explanatory phrases or to enclose other terms or names of the condition in the nomenclature of the code or inclusion list.

square brackets In ICD-9-CM, punctuation marks used to enclose explanatory phrases or synonyms of the condition and valid fifth digits for the code being reviewed.

FOR EXAMPLE

code 038.2 Pneumococcal septicemia [Streptococcus pneumonia septicemia] ■

Square brackets, [ ], may also be found directly below a code and are used to enclose valid fifth digits for the code being reviewed.

FOR EXAMPLE

678.0-
[0,1,3] ■

By contrast, **slanted brackets,** *[ ]*, are found only in the index and identify mandatory sequencing of etiology/manifestation coding.

slanted brackets In ICD-9-CM, punctuation marks used to identify the mandatory sequencing of etiology/manifestation coding.

FOR EXAMPLE When using the index to find diabetic retinitis, the coder would find:

250.5-, *[362.01]* ■

SPOTLIGHT on Terminology

Etiology The underlying cause or origin of a condition or disease.

Manifestation How the condition due to the underlying disease presents itself.

MENTOR Coding Tip

When the etiology/manifestation coding is identified in the index with the slanted-bracket convention, the codes must be reported in the sequencing identified by the convention regardless of which condition, etiology or manifestation, is being treated by the provider.

Parentheses ( )

parentheses Punctuation marks used to enclose supplemental terms, or nonessential modifiers.

Parentheses, ( ), are found in both the Tabular List and the Alphabetic Index and are used in both to enclose supplemental terms, also known as *nonessential modifiers.* These terms may or may not be included in the provider's documentation, but their noninclusion does not affect the code choice.

FOR EXAMPLE Look up *pneumonia* in the Alphabetic Index (Volume 2). There are multiple words listed in parentheses next to the word *pneumonia.* When any of these words are listed with pneumonia in a diagnostic statement, the appropriate code to use is 486 and not one of the more specific pneumonia codes listed below the main term in the index. ■

EXERCISE 2.2

1. Explain the difference between the abbreviations *NEC* and *NOS.*
2. How do slanted brackets affect the sequencing of codes?
3. What must be present for the coder to report an additional code?

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2.3 Main Terms and the ICD-9-CM Index

One of the main components of correct coding with ICD-9-CM is coding to the highest degree of specificity. This means telling the patient's story to the highest degree of detail allowed by ICD-9-CM. ICD-9-CM has approximately 14,000 codes that can be used to translate the diagnostic story.

The provider's documentation must be reviewed before the coder can translate it into the appropriate ICD-9-CM code(s). The coder must determine whether there is a definitive diagnosis. If none is available, the coder may use the appropriate sign or symptom (as reviewed in Section 2.1).

The coder refers to the index using diagnoses, conditions, signs, symptoms, syndromes, and eponyms. Codes cannot be found in the index under anatomical sites. If a coder looks up a term in the index under an anatomical site, the index will refer the coder to "see condition."

FOR EXAMPLE At the entry "lung" the index states "see condition," meaning that the coder must look under the specific disease, sign, or symptom occurring at this anatomical site. ■

Main Term

The **main term,** as found in the provider's diagnostic statement, identifies, without further descriptive clarifications, the patient's condition, injury, or disease. Determining the main term is the first step in locating a code in the Alphabetic Index (Volume 2) of the ICD-9-CM manual. Main terms are boldfaced, and each is further defined by indented subterms.

main term In the provider's diagnostic statement, the term that identifies the patient's condition, injury, or disease; used in locating a code in the Alphabetic Index of ICD.

FOR EXAMPLE Congestive heart failure:

Failure
  Heart
    Congestive ■

MENTOR Coding Tip

When unsure of the main term in a diagnostic statement, ask the question, "What did the patient suffer from?" Nonmain terms should sound out of place as answers to this question.

FOR EXAMPLE The diagnostic statement includes "left ventricular myocardial infarction." Answer the question using each term: The patient suffers from *left*—obvious wrong answer. The patient suffers from *ventricular*—again this answer makes no sense. The same is true of the term *myocardial.* However, the final term resonates as a viable statement: The patient suffers from *infarction.* Therefore, the main term in this statement is *infarction.* ■

Major Steps in Locating the Appropriate ICD-9-CM Code

After reading the provider documentation thoroughly, the coder should follow these steps:

1. Determine the main term(s) from the documentation.
2. Locate the main term in the Alphabetic Index (Volume 2).
3. Identify and review any subterms listed below the main term in the Alphabetic Index. Then identify in the provider's documentation the subterm that further defines and supports the level of specificity of the condition as documented.
4. Review all notes listed in the Alphabetic Index and Tabular List.
5. Verify the code identified in the Alphabetic Index by checking it in the Tabular List (Volume 1).
6. Determine the code to the highest degree of specificity (use a fourth or fifth digit if required).

Be sure to read all of the instructional notes that exist for the chapter, section, and category of ICD-9-CM code(s) that you are choosing, as these guidelines supersede the chapter-specific guidelines found in the official coding guidelines of the ICD-9-CM manual.

MENTOR Coding Tip

One of the tricks used by successful students when checking the tabular section or chapter of the ICD-9-CM is to look at the five codes above and five codes below the code identified in the index just to make sure they are not missing something.

EXERCISE 2.3

Underline the main term in each diagnostic statement below, follow the steps listed above, and determine the appropriate ICD-9-CM code.

1. Capsular congenital cataract.
2. Family history of malignant neoplasm of the bladder.
3. Laceration of the forearm.

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2.4 ICD-9-CM Chapter-Specific Guidelines

In this section we identify various chapter-specific guidelines. Remember: When we refer to chapter guidelines in this section, we are referring to the chapters in the ICD-9-CM manual.

FOR EXAMPLE "Chapter 1" refers to the Infectious and Parasitic Diseases chapter in the ICD-9-CM manual. ■

MENTOR Coding Tip

When preparing for the CPC exam, study the chapter-specific guidelines a few days before taking the exam. This is a good review, and it will remind you during the test that you just "read something about this." This reminder during the exam often takes away the feeling of being overwhelmed.

ICD-9-CM contains 17 chapters plus sections on V and E codes. Table 2.1 presents an overview of some of the guidelines. In this text, we examine these guidelines in detail in the chapters pertaining to particular body systems.

EXERCISE 2.4

1. ICD-9-CM chapter-specific guidelines for Chapter 2 include which type of guidelines?
2. ICD-9-CM chapter-specific guidelines for Chapter 7 include which type of guidelines?
3. ICD-9-CM chapter-specific guidelines for Chapter 17 include which type of guidelines?

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Table 2.1 Chapter-Specific Guidelines for ICD-9-CM *(Data from ICD-9-CM, Centers for Medicare and Medicaid Services and the National Center for Health Statistics.)*

CHAPTER	GUIDELINES
1. Infectious and Parasitic Diseases	These guidelines are very specific and concern the coding of HIV, septicemia, SIRS, sepsis, and MRSA. The guidelines include selection and sequencing instructions specific to these conditions.
2. Neoplasms	These guidelines pertain to general guidelines for reporting neoplasms and sequencing instructions pertaining to history of malignant neoplasm, administration of chemotherapy, radiotherapy, and complications due to the condition or therapy.
3. Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders	Included in this chapter are the guidelines for diabetes. The codes in this chapter require fifth digits. There are also multiple-sequencing guidelines, including those on the use of slanted brackets (etiology/manifestation sequencing).
4. Diseases of Blood and Blood-Forming Organs	General and sequencing instructions for anemia are included in these guidelines. Also included are instructions for coding anemia associated with other diseases.
5. Mental Disorders	Currently there are no guidelines for this chapter.
6. Diseases of the Nervous System and Sense Organs	Very specific guidelines for coding pain are included in these guidelines.
7. Diseases of the Circulatory System	Hypertension and hypertensive heart and kidney disease guidelines are located in this chapter, along with guidelines on cerebral infarction, stroke, cerebral vascular accident, late effects, and myocardial infarction.
8. Diseases of the Respiratory System	Instructions and code sequencing for chronic obstructive pulmonary disease (COPD), asthma, bronchitis, and respiratory failure are included in these guidelines.
9. Diseases of the Digestive System	Currently there are no guidelines for this chapter.
10. Diseases of the Genitourinary System	These guidelines include instructions for the coding and sequencing of chronic kidney disease (CKD).
11. Complications of Pregnancy, Childbirth, and the Puerperium	These guidelines include general rules for obstetric care and coding and sequencing instructions for fetal conditions affecting management of pregnancy, HIV infection in pregnancy, normal delivery and postpartum conditions, and abortions.
12. Diseases of the Skin and Subcutaneous Tissue	Guidelines for coding pressure ulcer stages are located in this chapter.
13. Diseases of the Musculoskeletal System and Connective Tissue	Guidelines for the coding of pathologic fractures are included in this chapter.
14. Congenital Anomalies	Currently there are no guidelines for this chapter.
15. Newborn (Perinatal) Guidelines	General perinatal rules and sequencing are included in these guidelines. The use of some V codes is also reviewed here.
16. Symptoms, Signs, and Ill-Defined Conditions	Currently there are no guidelines for this chapter.
17. Injury and Poisoning	Instructions on injuries, fractures, burns, adverse effects, poisoning, and toxic effects are included in these guidelines.
V and E codes:	Guidelines for V and E codes and their sequencing are also included in the chapter-specific guideline section.

2.5 Diagnostic Outpatient Guidelines

The official ICD-9-CM coding guidelines are located in Section IV, I, of the ICD-9-CM manual. These guidelines are used for reporting hospital-based outpatient services and provider-based office visits.

MENTOR Coding Tip

According to ICD-9-CM, "The coding conventions of ICD-9-CM as well as the general and disease specific guidelines take precedence over the outpatient guidelines." When coding, remember that there is a hierarchy to the coding guidelines and conventions. Guidelines or conventions listed at the code level in the Tabular List take precedence over those at the section level. Those listed at the section level take precedence over those at the chapter level. Basically, this means that the closer a guideline or convention is to the code in the Tabular List (Volume 1), the higher it is in the hierarchy of guidelines and thus it supersedes the other guidelines or conventions.

Highlights of Diagnostic Outpatient Guidelines

- **First-listed diagnosis versus principal diagnosis:** The first-listed diagnosis (reason for the visit) is used for provider/outpatient coding. The principal diagnosis (reason for admission after study) is used for facility coding.
- **Signs and symptoms:** Signs and symptoms are acceptable for reporting when a diagnosis has not been confirmed and reported by the provider.
- **Coding to the highest level of specificity:** This guideline refers to the use of fourth and fifth digits when required.
- **Unconfirmed diagnosis term:** Unconfirmed diagnosis terms such as *rule out, probable, access,* and *questionable* may *not* be used in outpatient diagnostic coding. A sign or symptom must be used in place of an unconfirmed diagnosis.
- **Chronic disease:** Chronic conditions may be coded if the chronic condition affects the treatment or management of the presenting condition.

These guidelines are examined in detail in the system-specific chapters of this textbook, as appropriate.

EXERCISE 2.5

1. Explain the difference between a first-listed diagnosis and a principal diagnosis.
2. When is it acceptable to report a sign or symptom?
3. When may a chronic condition be coded?

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2.6 Translating Provider Documentation to Ensure Medical Necessity

As you work through this text, you will notice that we continue to stress the importance of being able to translate the provider's documentation correctly to ensure that the proper ICD-9-CM code is chosen. One very important aspect of being able to accomplish this translation is the ability to link the medical necessity of the documented encounter to the service provided.

The ability to do this accurately and efficiently and within compliance guidelines is achieved by having a good knowledge of anatomy, medical terminology, physiology, pathophysiology, and basic coding rules and guidelines. The example below demonstrates the importance of this knowledge.

FOR EXAMPLE The provider documents that the patient presents to the provider's office for evaluation of cervical pain and determination of treatment via facet injections. The provider also documents that this patient has diabetes type 2 and benign hypertension. In this example, a coder's knowledge is tested in several ways. First is the term *cervical.* As there are two areas in the female anatomy that may be identified by this main term, the coder needs the additional information provided in the documentation to identify which area is the site of the patient's pain. The proposed treatment of facet injections keys the coder to an anatomical area and provides the additional information necessary to identify the term *cervical* as related to the neck and not the genital/urinary body system.

Next is the understanding of when to code for an additional diagnosis. The ICD-9-CM guidelines for listing additional diagnoses instruct the coder to code for all conditions that affect the patient's care, treatment, or management (Section IV, K). The guidelines further guide the coder in regard to the coding of chronic conditions, such as those in the example, diabetes and hypertension. A chronic condition may be listed if during the encounter the patient receives care or treatment for the condition (Section IV, J). In the example above, there is no documentation to support care or treatment directed at either of the additional chronic conditions listed, and therefore neither would be coded. Finally, the coder's knowledge of pathophysiology is tested to determine whether the conditions that coexist, diabetes and hypertension, with the reason for the encounter, cervical pain, affect either the condition or treatment of the cervical pain. In this example, these chronic conditions do not impact the treatment or management of the condition being treated and therefore would not be coded in addition to the cervical pain. ■

Throughout this text you will have ample opportunity to test your knowledge of anatomy, medical terminology, physiology, pathophysiology, and basic coding rules and guidelines and to practice translating data in each of these categories into diagnostic codes. The CPC exam will test you on your ability to translate this information.

EXERCISE 2.6

1. Briefly discuss the importance of translating the medical record into accurate coding data, and explain why it is important to have a thorough knowledge of anatomy, medical terminology, and pathophysiology.

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Chapter Two Summary

Learning Outcome	Key Concepts/Examples
2.1 Understand the format of the ICD-9-CM manual.	Volume 1: Tabular List Volume 2: Alphabetic Index Volume 3: Alphabetic Index and Tabular List for Procedures Volumes 1 and 2 are used for hospital-based outpatient services and provider-based office visits.
2.2 Apply the abbreviations, coding conventions, and punctuation marks used in ICD-9-CM.	**Abbreviations** *NEC—not elsewhere classified:* A more specific code is not provided. *NOS—not otherwise specified:* This is the equivalent of unspecified. **Coding conventions/instructional notes** *Acute:* sudden onset, short duration *Chronic:* slow onset, long duration *Excludes:* list of conditions, diagnoses, etc., *not* included in codes in Tabular List *Includes:* further clarifies the definition of terms included in codes in the Tabular List **Punctuation** *Slanted brackets [ ]:* used to identify sequencing of etiology/manifestation *Square brackets* [ ]: used to enclose explanatory phrases or other terms or names of conditions *Parentheses* ( ): used to enclose supplemental terms, which are also known as nonessential modifiers
2.3 Identify main terms and use the ICD-9-CM index.	*Main term:* describes the patient illness or injury (the reason for the present encounter) documented by the provider **Steps in locating the appropriate ICD-9-CM code** After reading the documentation thoroughly: 1. Identify the main term. 2. Locate the main term in the Alphabetic Index. 3. Identify appropriate subterms in the Alphabetic Index. 4. Read all instructional notes. 5. Verify the code in the Tabular List. 6. Code to the highest level of specificity.
2.4 Review ICD-9-CM chapter-specific guidelines.	ICD-9-CM contains 17 chapters and most have specific guidelines. There are also guidelines for V and E codes.
2.5 Examine ICD-9-CM diagnostic outpatient guidelines.	*First-listed diagnosis:* This is the reason for the visit and is used for provider/outpatient coding. *Signs and symptoms:* These may be reported when a diagnosis has not been confirmed. *Code to highest level of specificity:* Use fourth and fifth digits, as appropriate. *Unconfirmed diagnoses:* Do not use unconfirmed terms such as rule out. *Chronic conditions:* A chronic condition may be coded if it affects the treatment or management of the presenting condition.
2.6 Recognize the importance of translating provider terminology into accurate diagnostic codes.	An important aspect is the ability to link the medical necessity of the documented encounter to the service provided.

Chapter Two Review

Using Terminology

Match each key term to the appropriate definition.

_____ 1. [LO2.2] Acute
_____ 2. [LO2.2] And
_____ 3. [LO2.3] Main term
_____ 4. [LO2.2] Brackets
_____ 5. [LO2.2] Slanted brackets
_____ 6. [LO2.2] Late effect
_____ 7. [LO2.2] Includes
_____ 8. [LO2.2] Excludes
_____ 9. [LO2.2] NEC
_____ 10. [LO2.2] Sign
_____ 11. [LO2.2] Symptom
_____ 12. [LO2.2] Chronic
_____ 13. [LO2.2] Manifestation
_____ 14. [LO2.2] Parentheses
_____ 15. [LO2.2] NOS

A. Not elsewhere classified
B. Means "and/or" in ICD-9-CM
C. Describes the patient's illness or injury in the documentation
D. The equivalent of unspecified
E. The way the condition due to the underlying disease presents itself
F. Condition with a slow onset and of long duration
G. A residual condition that occurs after the initial injury or illness
H. Punctuation marks used to enclose supplemental terms, which are also known as nonessential modifiers
I. Condition with a sudden onset and of brief duration
J. Instructional note that provides a list of conditions, diseases, or injuries that are not included in the code listed in Volume 2 (Tabular List)
K. Condition that can be measured and recorded.
L. Condition that is relayed to the provider by the patient
M. Punctuation marks used to enclose explanatory phrases or other appropriate descriptive terms for the code
N. Instructional note that further clarifies the code or category by providing examples of conditions included in the code
O. Punctuation marks that identify mandatory sequencing of etiology/manifestation coding

Checking Your Understanding

Choose the most appropriate answer for each of the following questions.

1. [LO2.2] This abbreviation is next to an ICD-9-CM code when a more appropriate code is not provided elsewhere in the manual:
a. NOS
b. NEC
c. DEF
d. None of these

2. [LO2.4] Which chapter-specific guidelines include instructions for coding chronic kidney disease?
a. Chapter 7, Diseases of the Circulatory System
b. Chapter 10, Diseases of the Genitourinary System
c. Chapter 16, Symptoms, Signs, and Ill-Defined Conditions
d. None of these (There are no guidelines for the kidney system.)

3. [LO2.2] Which of the following, when noted in the Alphabetic Index or Tabular List, instructs the coder on the mandatory sequencing of the etiology/manifestation?
a. Slanted brackets
b. Brackets
c. Parentheses
d. Code first

4. [LO2. 3] Which is *not* an appropriate step in determining an ICD-9-CM code?
a. Determine the main term from the provider documentation.
b. Determine any appropriate subterms.
c. Determine the code directly from the Alphabetic Index.
d. Code to the highest level of specificity by using appropriate fourth- and fifth-digit codes.

5. [LO2.5] According to the diagnostic outpatient guidelines, which of the following best fits the guidelines for the use of signs and symptoms?
   a. They are always to be used.
   b. They are reported only when a diagnosis has not been confirmed and reported by the provider.
   c. There are no specific guidelines as to their use.
   d. They must be documented in the provider records to be used.

6. [LO2.5] Coding to the highest level of specificity means:
   a. Coding all the conditions listed in the patient's chart
   b. Coding just the condition for which the patient is being seen
   c. Using a fourth- or fifth-digit when required
   d. None of these

7. [LO2.6] Which of the following are important aspects of a coder's being able to translate provider documentation?
   a. Ensuring that the proper ICD-9-CM code is chosen
   b. Being able to stay within compliance guidelines
   c. Linking the medical necessity of the encounter to the service provided
   d. All of these

8. [LO2.1] Which volume or volumes of ICD-9-CM are used when taking the CPC exam?
   a. Volume 1
   b. Volume 2
   c. Volume 3
   d. Volumes 1 and 2

9. [LO2.2] What is the term for a condition due to an underlying disease or condition?
   a. Manifestation
   b. Etiology
   c. Sign
   d. Symptom

10. [LO2.2] Which term is used to describe a residual condition that occurs after the initial illness or injury?
    a. Sign
    b. Symptom
    c. Manifestation
    d. Late effect

Applying Your Knowledge

Use your critical-thinking skills to answer the questions below.

1. [LO2.3] Discuss the main steps that a coder needs to follow when translating a provider's documentation and determining the appropriate code using the ICD-9-CM manual.

   _____

2. [LO2.2] Explain the differences between *acute* and *chronic,* and list one of the guidelines pertaining to these terms.

   _____

3. [LO2.2] Explain the difference between *includes* and *excludes* and the importance each plays in determining the correct ICD-9-CM code.

   _____

4. [LO2.1–L02.6] List five mentor coding tips discussed in this chapter that you considered most helpful.

   _____