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ICD-9-CM Diagnostic Coding Guidelines for Outpatient Services

Audio Seminar/Webinar

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Practical Tools for Seminar Learning

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Faculty

Stacie L. Buck, RHIA, CCS-P, LHRM, RCC

Stacie has served in several different roles during her 14-year career in health information management including as a medical records coordinator, medical coder, a revenue analyst, an internal auditor, corporate compliance officer, and consultant.

Stacie is on the editorial advisory board for the HCPro newsletters *Mammography Regulation Report, Radiology Administrator's Compliance Insider*, *Health Care Auditing Strategies* and she is a frequent contributor to *Strategies for Health Care Compliance* and to *Compliance Monitor Q & A's Ask the Expert.* In addition, she is the author of the recently released *Radiology Technologist's Coding Compliance Handbook* and is a Contributing Editor for *The Radiology Manager's Handbook: Tools & Best Practices for Business Success.* Stacie also is an audioconference presenter for HCPro, the Coding Institute and the American Health Information Management Association (AHIMA).

Stacie is an adjunct instructor and advisory board member for the health information management program at Indian River Community College in Florida and she serves in the AHIMA Mentoring program. Recently Stacie was the recipient of several awards including the 2005 AHIMA Rising Star Award, FHIMA Outstanding Professional Award & FHIMA Literary Award.

Stacie is a current member of the American Health Information Management Association (AHIMA), the Florida Health Information Management Association (FHIMA) and the Suncoast Health Information Management Association (SHIMA). She serves on the AHIMA Physician Practice Council and is President-Elect of the Florida Health Information Management Association.

Stacie graduated Magna Cum Laude from Florida International University earning a Bachelor of Science degree in Health Information Management after earning an Associate of Arts degree in Business Administration.

Susan Von Kirchoff, MEd, RHIA, CCS, CCS-P

Ms. Von Kirchoff's ICD-9-CM knowledge base stems from a variety of experience in all types of facility settings including: hospital inpatient and outpatient (ER, Ambulatory Surgery, Clinic/E&M, PT, OT, & ST), home health using OASIS and long-term rehab/SNF. She has over eight years experience in providing education to healthcare professionals and has instructed students in Basic, Intermediate and Advanced inpatient and outpatient medical coding for the last 5 years.

Susan has authored and published study guides to assist healthcare professionals in successfully passing the National Certified Coding Specialist Exam and Physician Based Exam. She also authored 45 ICD-9-CM, CPT-4 and HCPCS instructor training material for Universities nationally, including hands-on training material and mock examinations. Susan has taught ICD-9-CM, CPT4, and HCPCS courses via compressed video with computerized instruction.

Ms. Von Kirchoff earned a Master's in Education, Instruction Technology from Arkansas Tech University. She is a Registered Health Information Administrator specializing in coding and auditing in various healthcare settings. Susan holds a Bachelor of Science degree in Health Information Management and is credentialed as a Certified Coding Specialist (CCS) and a Certified Coding Specialist-Physician (CCS-P). Susan also is credentialed in Compliance (CCP) from the Fraud and Abuse Institute.

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Objectives

- **Review the ICD-9-CM Diagnostic Coding and Reporting Guidelines for Outpatient Services**
- **Discuss Chapter Specific Coding Guidelines for V Codes.**
- **Discuss challenging coding areas: 1st listed diagnosis, signs and symptoms, and diagnostic/therapeutic encounters.**

1

Polling Question #1

Although conventions and general guidelines apply to all settings, coding guidelines for outpatient and physician reporting differ in which of the following:

- ***1 Coding guidelines for inconclusive diagnoses were developed for inpatient reporting.**
- ***2 UHDDS definition of Principal Diagnosis applies to inpatients only.**
- ***3 The first listed diagnosis take precedence over outpatient guidelines.**
- ***4 Both 1 and 2**

2

Coding Guidelines for Outpatient Services – Things to Remember

- **The terms encounter and visit are synonymous when describing outpatient service contacts.**
- **Inconclusive diagnoses are not acceptable for outpatient reporting.**
  -Probable, Suspected, Rule out
- **The term "first-listed" diagnosis is used in lieu of principal diagnosis.**

3

OP Coding Guidelines – Selection of First-listed Condition

- **The coding conventions of ICD-9-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines.**
- **Diagnosis may not be established at the time of an initial visit.**
  - **May take two or more visits before a diagnosis is confirmed.**

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OP Coding Guidelines – Selection of First-listed Condition *(cont.)*

- Outpatient Surgery
  - Code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.
- Observation Stay
  - Assign a code for the medical condition as the first-listed diagnosis.
  - OP surgery complications requiring admit to OBS code reason for surgery followed by complication codes

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Polling Question #2

A patient presents for outpatient surgery for removal of a polyp and has a history of CHF, Chronic Atrial Fibrillation and Hypertension. Following the polyp removal the patient begins having complications of the Atrial Fibrillation and is admitted to OBS.

Which of the following should be the first-listed diagnosis for the Observation stay?

*1 Polyp

*2 CHF

*3 Atrial Fibrillation

*4 HTN

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OP Coding Guidelines – Codes from 001.0 – V86.1

- **The appropriate code or codes from 001.0 through V86.1 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reasons for the encounter/visit.**

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OP Coding Guidelines – Accurate Reporting ICD-9-CM Dx

- **For accurate reporting of ICD-9-CM diagnosis codes, the documentation should describe the patient's condition, using terminology that includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-9-CM codes to describe all of these.**

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OP Coding Guidelines – Selection of 001.0 – 999.9

- The selection of codes 001.0 through 999.9 will frequently be used to describe the reason for the encounter. These codes are from the section of ICD-9-CM for the classification of diseases and injuries (e.g. infectious and parasitic diseases, neoplasms, and symptoms, signs, and ill-defined conditions).

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OP Coding Guidelines – Signs/Symptoms

- Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when an established diagnosis has not been diagnosed (or confirmed) by the physician. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined Conditions (codes 780.0–799.9), contains many, but not all, codes for symptoms.
  - Note: This rule is not to be ignored regarding payer specific medical necessity issues.

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OP Coding Guidelines –

Encounters for circumstances other than disease or injury

- **ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01.0–V82.9) is provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.**

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OP Coding Guidelines – Level of Detail

1. **Code to the highest level of specificity. ICD-9-CM is composed of codes with either 3, 4, or 5 digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater specificity.**
2. **A three-digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit sub classifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code.**

   Note: See Section I.b.3., General Coding Guidelines , Level of Detail in Coding.

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OP Coding Guidelines – ICD-9-CM code "chiefly responsible"

- **List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions.**

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OP Coding Guidelines – "Highest degree of certainty"

- **Do not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working diagnosis." Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.** ***This is contrary to the coding practices used by hospitals and medical record departments for coding the diagnosis of hospital inpatients.***

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OP Coding Guidelines – Chronic Diseases

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

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OP Coding Guidelines – Co-existing conditions

- Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care, treatment, or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10–V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

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OP Coding Guidelines – Diagnostic Services Only

- **For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.**

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OP Coding Guidelines – Diagnostic Services Only (cont.)

- **For outpatient encounters for diagnostic tests that have been interpreted by a physician and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs/symptoms as additional diagnoses.**

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Polling Question #3

When coding outpatient diagnostic radiology services at your facility, what piece of documentation do you use to assign the primary diagnosis code?

- *1 Test order only (signs/symptoms)
- *2 Radiology report – impression only
- *3 Radiology report – impression and body of report only
- *4 Radiology report and test order are reviewed prior to assigning the primary diagnosis

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OP Coding Guidelines - Therapeutic Services

- For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses. The only exception to this rule is that patients receiving chemotherapy, radiation therapy, or rehabilitation, the appropriate V code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

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OP Coding Guidelines – Pre-op Evaluations

- For patient's receiving preoperative evaluations only, sequence a code from category V72.8, Other specified examinations, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.

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OP Coding Guidelines – Ambulatory Surgery

- For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

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OP Coding Guidelines – Routine Prenatal Visits

- **For routine prenatal visits when no complications are present, code V22.0 Supervision of normal first pregnancy, or V22.1 Supervision of other normal pregnancy, should be used as the principal diagnosis. These codes should not be used in conjunction with chapter 11 codes.**

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General Coding Guidelines - Highlights *Coding Clinic,* 4 qtr 2002

- **Use both the Alphabetical Index and Tabular List when assigning codes.**
- **Follow instructional notes.**
- **Use all available digits.**
- **Codes for signs and symptoms are acceptable for reporting when a related definitive diagnosis has not been established.**

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General Coding Guidelines - Highlights *Coding Clinic,* 4 qtr 2002

- Signs and symptoms that are integral to the disease process should not be reported as additional codes.
- Signs and symptoms not routinely associated with a disease process should be reported separately.
- If a condition is listed as both acute and chronic, code both and sequence the acute condition first.

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General Coding Guidelines - Highlights *Coding Clinic,* 4 qtr 2002

- Use multiple codes, when necessary, to completely describe a condition.
  - Etiology/manifestation
  - Use additional code
  - Code first/causal condition

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General Coding Guidelines - Highlights *Coding Clinic,* 4 qtr 2002

- Assign a combination code when that code fully identifies the diagnostic conditions involved or when the index so directs.
- Late Effects
  - no time limit
  - sequence residual condition first
  - follow Tabular guidelines for combination codes

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General Coding Guidelines - Highlights *Coding Clinic,* 4 qtr 2002

- Impending or threatening condition
  - if occurs, code as confirmed
  - report "impending or threatening" condition if identified by Alphabetic Index
  - report signs or symptoms if condition does not occur AND the index does not list "impending or threatening" subterms

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CMS and Outpatient Coding Guidelines for Diagnostic Tests

CMS - Program Memoranda Carriers 2001
PM Rev. B-01-61, ICD-9-CM Coding for Diagnostic Tests

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CMS - Coding Guidelines for Diagnostic Tests

- **Use the ICD-9-CM code that describes the patient's diagnosis, symptom, complaint, condition, or problem. Do not code a suspected diagnosis.**
- **Use the ICD-9-CM code that is chiefly responsible for the item or service provided.**
- **Assign codes to the highest level of specificity.**
- **Code chronic conditions when they apply to the patients treatment and code all documented conditions that affect treatment at the visit.**
- **Do not code conditions that no longer exist.**

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ICD-9 Coding for Diagnostic Tests

- **Determining the appropriate primary ICD-9 code to assign**
- **Determining the reason for the test**
- **Incidental findings**
- **Unrelated/co-existing Conditions**
- **No signs/symptoms given (screening)**
- **Coding to the highest degree of specificity and certainty**

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CMS - Coding Guidelines for Diagnostic Tests (cont.)

- **Use the following guidelines to assign the primary diagnosis code**
  - **Code a diagnosis confirmed by test results**
  - **Code signs/symptoms when findings are normal or when the findings are uncertain (ie. Probable, suspected, questionable)**
  - **Do not code incidental findings or unrelated co-existing conditions**
  - **For screening tests (those performed in the absence of signs/symptoms) assign the appropriate V code (findings are coded as secondary)**

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Code Signs/Symptoms

- Test performed and the results are back but the physician has not yet reviewed them to make a diagnosis, or there is no interpretation
- No report of the physician interpretation at the time of billing, code what is known at the time of billing.

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TIPS for Handling Coding Guidelines and Payer Rule Conflicts

1. If a payer really does have a policy that clearly conflicts with official coding rules or guidelines, every effort should be made to resolve the issue with the payer. Provide applicable coding rule/guideline to payer. For Medicare claims, contact the fiscal intermediary (FI) or carrier contractor for clarification.
2. If the payer refuses to change their policy, obtain the payer requirements in writing. If the payer refuses to provide their policy in writing, document all discussions with the payer, including dates and the names of individuals involved in the discussion. Confirm the existence of the policy with the payer's supervisory personnel.
3. Keep a permanent file of the documentation obtained regarding payer coding policies. It may be come in handy in the event of an audit.

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Example

- **A patient is referred to a radiologist for an abdominal CT scan with a diagnosis of abdominal pain. The CT scan reveals the presence of an abscess.**
  - **What diagnosis should be reported?**

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Example

- **A patient is referred to a radiologist for a chest X-ray with a diagnosis of “cough.” The chest X-ray reveals a 3 cm peripheral pulmonary nodule.**
  - **What diagnosis code should be reported?**

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Example

- **A patient is referred to a radiologist for a spine X-ray due to complaints of "back pain." The radiologist performs the X-ray, and the results are normal.**
  - **What diagnosis code should be reported?**

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Example

- **A patient is referred to a radiologist for a gastrograffin enema to rule out appendicitis. However, the referring physician does not provide the reason for the referral and is unavailable at the time of the study. The patient is queried and indicates that he/she saw the physician for abdominal pain and was referred to rule out appendicitis. The radiologist performs the X-ray, and the results are normal.**
  - **What diagnosis code should be assigned?**

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Example

- **Patient has multiple EKGs for complaints of chest pain, however the final diagnosis is a gastritis problem causing the chest pain**
  - **Therefore based on coding and Medicare payer rules, the sign and symptom (chest pain) should *not* be coded, as it is integral to the disease process**

Note: Chest Pain may be coded as the admitting diagnosis

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Radiology Coding FAQs

- **Can I code from the header of the radiology report?**
  - **Must the body of the report support the exam stated in the header?**
- **If a radiologist uses the phrase “consistent with” in his report can I code the condition as a definitive diagnosis?**
  - ***Coding Clinic*, 3rd Quarter 2005**

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"Pecking" Order for Radiology Dx Coding

- **Radiology Report**
  - **Impression vs. Findings?**
  - **Indications**
- **Test orders**

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Classification of Factors Influencing Health Status

- **Guidelines may be found in the AHA *Coding Clinic for ICD-9-CM*, 4th Qtr 2002**
- **A V code table defining whether the V code should be reported as first listed, first or additional or additional only is found in the same publication on page 86**

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Primary Circumstances for V Code Use

1. A person is not currently sick but has a health care encounter for a specific reason, i.e. inoculations, screening, etc.
2. Aftercare for resolving condition or long term condition requiring continuous care, i.e. dialysis
3. Health status influenced by other than current illness or injury
4. Birth status for newborns

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V Code Guidelines

- May be used in any setting, but generally more applicable to outpatient settings
- Have designations to list first, list only as an additional diagnosis, or list as either (see V code list, pg 86, CC 4Qtr 2002)

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V Code Categories

- Contact/Exposure (V01)
  - Exposure to communicable disease
  - No signs/symptoms
  - May be primary or secondary
- Vaccinations (V03-V06)
  - Encounter for prophylactic inoculation against a disease
  - Use as secondary if given as part of routine preventive care

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Influenza and PPV Vaccines

New! October 2006

Effective for dates of service on or after October 1, 2006:

- Report diagnosis code V06.6 on claims that contain Influenza Virus and/or PPV vaccines and their administration when the purpose of the visit was to receive both vaccines
- Continue reporting diagnosis code V03.82 on claims that contain only PPV vaccine and its administration
- Continue reporting diagnosis code V04.81 on claims that contain only Influenza Virus vaccine and its administration

http://www.cms.hhs.gov/mlnmattersarticles/downloads/MM5037.pdf

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V Code Categories (cont.)

- **Status**
  - **Patient is either a carrier or has the sequelae or residual of a past disease or condition**
  - **Status affects course of treatment and outcome**
  - **Status vs. history – history patient no longer has condition**

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V Code Categories (cont.)

- **History of (Personal)**
  - **No longer exists, no treatment but has potential for recurrence and may require monitoring**
    - **Exceptions V14 & V15.0**
  - **May be used w/ follow-up codes**

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Neoplasm Guidelines

- **V10XX, Personal History of Malignant Neoplasm is reported if the primary malignancy has been excised or eradicated and there is not further treatment directed to the site nor evidence of any existing primary malignancy.**

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V Code Categories *(cont.)*

- **History of (Family)**
  - **Patient family member has had a disease that causes patient to be at higher risk for the disease**
  - **May be used w/ screening codes**

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V Code Categories (cont.)

- Screening (V28, V73-V82)
  - testing for disease or indicators in seemingly well individuals for early detection and treatment for those who test positive
  - May use as additional code if done during visit for other reason
  - Findings of screening reported as secondary

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Screening Mammography – V76.11 vs. V76.12

- What constitutes "high risk"?
- CMS considers the following patients to be high risk:
  - Has a personal history of breast cancer (V10.3)
  - Has family history of breast cancer (V16.3)
    - Mother
    - Sister
    - Daughter
  - Had her first baby after age 30 (V15.89)
  - Has never had a baby (V15.89)
- Assign V76.11 as primary, above as secondary

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Screening Colonoscopy – V76.41 & V76.51

- **High Risk Factors Colorectal Ca**
  - Sibling, parent, or child w/ colon ca or adenomatous polyp (V16.0 & V15.81)
  - Family history
    - Familial adenomatous polyposis (V15.81)
    - Hereditary nonpolyposis colorectal cancer (V16.0)
  - Personal history
    - Adenomatous polyps (V12.72)
    - Colorectal cancer (V10.05)
    - Inflammatory bowel disease
    - Crohn's
    - Ulcerative colitis

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V Code Categories (cont.)

- **Observation (V29, V71)**
  - Used when a person is being observed for a suspected condition that is ruled out and the patient does not have sign/symptoms related to the suspected condition
  - Used as principal only
    - Exception V30 – V29 is sequenced after V30
    - Additional codes for conditions unrelated to obs may be sequenced as additional codes

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V Code Categories (cont.)

- Aftercare (V51-V58)
  - The initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase or long-term consequences of the disease
  - Generally listed first, but may be additional code
  - Certain aftercare codes require secondary dx code
  - Status and aftercare codes may be used together
  - Do not use if treatment is directed at current, acute disease or injury
    - Exceptions V58.0, V58.1, V56.x

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Fracture Aftercare – "The Great Debate"

- V54.1 Aftercare for healing traumatic fracture
- *Coding Clinic* 4thQ 2003 p.8
  - "Coding guidelines require that an aftercare code be used for all subsequent encounters after the initial encounter for care of a fracture. For statistical purposes, a fracture should only be coded once."

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V Code Categories (cont.)

- **Follow-up (V24, V67)**
  - **Explain continuing surveillance following completed treatment of a disease, condition or injury**
  - **Infer that the condition has been fully treated and no longer exists**
  - **If the condition recurs then the diagnosis code should be used in place of the follow-up code**
  - **Can be used w/history codes**
    - **Code follow-up as first**

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Case Study

- **A patient who had a coronary bypass two years ago is seeing the physician for a follow-up stress test and subsequent evaluation. The patient has no complaints. This is:**
  1. **aftercare**
  2. **a follow-up visit**
  3. **a routine exam**

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V Code Categories (cont.)

- **Donor**
  - **for use with individuals donating for others, not for self donations and not for cadaveric donations.**
- **Counseling**
  - **patient or family receives assistance in the aftermath of an illness or injury and support is required for coping.**
  - **Not necessary with a diagnosis code when counseling component is integral to treatment**

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V Code Categories (cont.)

- **Obstetrics and Related Conditions**
  - **Use when no problems or complications**
    - **V22.0 & V22.1 always primary, do not use with codes from OB chapter**
    - **V27 outcome of delivery – secondary code on all maternal records**

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V Code Categories *(cont.)*

- **Routine and Administrative Exams**
  - describe routine encounters, e.g. school or pre-employment exams
  - if exam is for a suspected condition or treatment, report the condition code
  - a diagnosis or condition discovered during a routine exam may be reported as an additional code
  - pre-op exam is used only for surgical clearance, when no treatment is given.

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V Code Categories *(cont.)*

- **Special Investigations and Examinations (V72)**
  - Diagnostic service only
  - No problem, diagnosis or condition is identified
  - Pre-op Exams
    - V72.81, V72.82, V72.83
    - Assign as primary, followed by reason for surgery

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New V codes for 2007
effective 10/1/2006

- V18.51, Family history of colon polyps
- V26.34, Testing of male for genetic disease carrier status
- V26.35, Testing of a male partner of a habitual aborter
- V26.39, Other genetic testing of male
- V45.86, Bariatric surgery status
- V58.30, Encounter for change or removal of nonsurgical wound dressing
- V58.31, Encounter for change or removal of surgical wound dressing
- V58.32, Encounter for removal of sutures
- V72.11, Encounter for hearing examination following failed screening

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New V codes for 2007
effective 10/1/2006 (cont.)

- V85.51, Body mass index, pediatric, less than 5th percentile for age
- V85.52, Body mass index, pediatric, 5th percentile to less than 85th percentile for age
- V85.53, Body mass index, pediatric, 85th percentile to less than 95th percentile for age
- V85.54, Body mass index, pediatric, greater than or equal to 95th percentile for age
- V86.0, Estrogen receptor positive status
- V86.1, Estrogen receptor negative status (a note instructs that the appropriate code for malignant neoplasm of breast would be sequenced first)

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Resource/Reference List

- International Classification of Diseases, 9th Revision, Clinical Modification : ICD-9-CM, 4th ed.; US Health Care Financing Administration, DHHS publication
- AHA *Coding Clinic for ICD-9-CM*, Vol 19, Number 4, Fourth Quarter 2002, pg 115
- AHA *Coding Clinic for ICD-9-CM,* Vol 12, Number 4, Fourth Quarter 1995
- http://aspe.os.dhhs.gov/admnsimp/
- http://www.cdc.gov/nchs/about/otheract/icd9/maint/maint.htm

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Resource/Reference List

- ICD-9-CM Official Guidelines for Coding and Reporting Effective December 1, 2005
- Program Memoranda Rev. B-01-61, ICD-9-CM Coding for Diagnostic Tests
- AHA *Coding Clinic* for ICD-9 CM Volume 20 Third Quarter - Number 3 2003
- AHA *Coding Clinic* for ICD-9 CM Volume 17 Third Quarter - Number 3 2000

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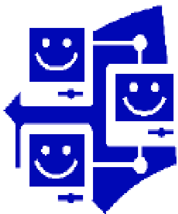
Audience Questions

Audio Seminar Discussion



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Key Points of the UB-04

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