Codify
BY AAPC

Internal Medicine Coding Alert

ICD-9: Use This Step-By-Step Guide to Become an ICD-9 Coding Pro

Bypass presenting complaints in outpatient setting if diagnosis is clear.

Your CPT codes aren't justified if they aren't linked to an appropriate ICD-9 code, but selecting the appropriate ICD-9 code for presenting problems versus underlying conditions can be challenging. Boost your ICD-9 coding repertoire with this four-step guide.

Step 1: Rely on Current Problem for Diagnostics

Whether the patient is symptomatic is an important distinction to make when coding.

When the internist tests a patient to rule out or confirm a suspected diagnosis because the patient has some sign or symptom, he is performing a diagnostic examination, not a screening, explains **Bruce Rappoport, MD, CPC, CHCC,** a board-certified internist and medical director of Broward Health's Best Choice Plus and Total Claims Administration in Fort Lauderdale, Fla. In these cases, code the sign or symptom to explain the reason for the test.

Sequence: If the patient is receiving only diagnostic services during the outpatient visit, list the diagnosis, condition, problem, or other reason for the visit on the claim form first, instructs the ICD-9-CM Official Guidelines for Coding and Reporting, Oct. 2009, www.cdc.gov/nchs/data/icd9/icdguide09.pdf. This code should be the chief focus of the internist's services on that day. Then, code for other diagnoses (such as chronic conditions) on the following lines.

Example: If a patient already diagnosed with bladder cancer visited the doctor for finding blood in his urine, on the first line you would list 599.71 (Gross hematuria) for the presenting problem (blood in urine), and then report 188.9 (Malignant neoplasm of bladder, unspecified) for the chronic disease.

However: Do not code the chronic condition if it is unrelated to the primary reason for the visit, counsels **Becky Zellmer, CPC, MBS, CBCS,** operations supervisor for Madison, Wis.- based SVA Healthcare Services. For instance, if a diabetic patient presents with a persistent cough that the internist diagnoses as pneumonia (and the internist limits her evaluation and management to the patient's presenting symptoms), code only the pneumonia, such as 486 (Pneumonia, organism unspecified), and not diabetes (250.xx) on the claim form, Zellmer says.

The same coding sequence applies to patients receiving only therapeutic services during an encounter. Code first for the diagnosis or condition documented in the medical record as the chief reason for the visit, and then code for other diagnoses, including chronic conditions, as additional diagnoses.

Step 2: Match Coding to Final Diagnosis

The presenting symptoms may not be relevant if the internist has interpreted a diagnostic test before you code for the encounter.

"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 and symptoms as additional diagnoses," states the ICD-9-CM Official Guidelines for Coding and Reporting.

Example: A patient presents with headache and fatigue; during the office visit, the patient received a blood draw and the results confirmed the ultimate diagnosis as dehydration. On the claim form report only 276.51 for dehydration and dismiss the presenting symptoms.

If the final diagnostic report is not available at time of coding, you would proceed with coding signs and symptoms.

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Step 3: Think in Threes for Pre-Op Exams

If the internist performs a pre-op evaluation for a patient, don't code the reason for surgery as the primary diagnosis.

Sequence: If the chief reason for the encounter is a preop evaluation, list first a code from category V72.8 (Other Specified Examinations) to describe the pre-op evaluation.

Then, assign a code for the condition prompting the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.

Example: If a patient who is scheduled for a gall bladder surgery presents for a pre-op evaluation, report V72.83 (Other specified preoperative examination) first on the claim form. As an additional diagnosis, list the appropriate ICD-9 code for the condition prompting surgery (for instance, 575.0, Acute cholecystitis) and underlying medical conditions (for instance, diabetes, 250.xx).

Don't forget: As the third part of the diagnosis, code for any findings related to the pre-op evaluation.

Step 4: Select 'V' Codes for Screenings

When the patient has no signs or symptoms and the internist is performing a test solely for screening purposes, sail past typical diagnosis codes and locate an applicable "V" code to describe the test to the payer.

Sequence: List the screening code first if the reason for the visit is specifically the screening exam, states the ICD-9-CM Official Guidelines for Coding and Reporting. Report the screening code as an additional code, however, if the internist performs the screening during an office visit for other health problems.

If the screening returns an abnormal result, then code those results as an additional diagnosis.

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