Codify
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Part B Insider (Multispecialty) Coding Alert

ICD-9 CODING QUIZ ANSWERS: Can You Sequence Your Diagnosis Codes Properly on Your Medicare Claims?

Check out the answers to our ICD-9 coding quiz to find out how you fared.

You know that you should list your patient's primary diagnosis code first, but many coders are unable to figure out which diagnosis is primary. Find out whether you've sequenced your ICD-9 codes properly with the answers to our quiz (see questions on page 42).

Answer 1: You should first code the definitive diagnosis (382.00, Acute suppurative otitis media without spontaneous rupture of ear drum), not the presenting diagnoses (780.60, Fever; and 388.70, Otalgia, unspecified). Because the ear pain and fever are "inherent" in the diagnosed condition, you should not separately code them.

Some circumstances, however, do warrant assigning additional ICD-9 codes for a patient's symptoms:

If the symptoms are not part of the disease process, you should separately code them. A classic example of this involves a patient who presents with pneumonia and vomiting. In this case, coding the symptom of vomiting in addition to the pneumonia shows that the patient is sicker than if he just had pneumonia. Listing both ICD-9 codes (such as 486, Pneumonia, organism unspecified and 787.03, Vomiting alone) would potentially support a higher level of E/M code. When a doctor does not establish or confirm a diagnosis, you may report the patient's symptoms.

Answer 2: If, after examining the patient, the physician definitively concludes that the patient has sciatica (724.3), the coder should sequence that first. However, in our example the sciatica was simply suspected, and you should not report ICD-9 codes based on suspicions only. Therefore, with only the symptoms to go on, the coder in our example should just report the symptoms (pain in her left leg, 729.5, and her hip joint, 719.45) as the diagnoses, says **Laureen Jandroep, OTR, CPC,** coding analyst with CodeRyte.

"Any other conditions can be coded if they relate to the visit or affect the physician's decision making," Jandroep says. "In this case, the V code (V17.7, Family history of arthritis) would be okay to code," she advises. "You just don't want to code every single condition a patient has" if the condition doesn't relate to the presenting problem.

Answer 3: The acute problem in this scenario was pain from the accident, so you should list the neck and back pain first, then you'll list the multiple sclerosis (MS) because it will play into the physician's medical decision-making, and finally the E code. E codes should always be listed last since they are informational. Between the cervical and lowback pain, choose the condition that required the most attention. In this case, the patient's cervical spine was more affected than her low back. Therefore, this claim would be coded as follows:

• 723.1

• 724.2

• 340

• E812.0.

Answer 4: If a symptom is a part of a previously diagnosed disorder, you should report the ICD-9 code for the disorder, says coding consultant **Maxine Lewis, CMM, CPC, CPCI, CCS-P,** in Cincinnati, Ohio. "If a diagnosis is known, that should be used in lieu of a symptom," Lewis advises. "A symptom should be used in the absence of a known diagnosis."

Therefore, in this situation, your physician's E/M probably centered on the patient's chronic bleeding ulcer (531.4x), which you should report as your primary diagnosis. You can also report the underlying GERD (530.81) as a secondary diagnosis.

You don't need to code the stomach pain, since it is inherent in the patient's bleeding ulcer.

Best practice: If you code a claim with several diagnoses and are unsure which should be listed first, always consult with the physician to determine the reason for the patient's visit and the conditions most seriously affecting the patient.