Basics of Diagnostic Coding
Consider the following while reading this chapter:

• How do the format, layout, and conventions of the ICD-9-CM manual help the medical assistant search for the most accurate and specific diagnostic code?

• Why is medical record documentation so critical in relationship to diagnostic coding?

• Why does the medical assistant need to know the steps for performing diagnostic coding?

• What are the benefits of using diagnostic codes found in the ICD-9-CM?
What Is Diagnostic Coding?

- **Diagnostic coding** is described as the translation or transformation of written descriptions of diseases, illnesses, and injuries into numeric codes.
- The medical assistant facilitates accurate medical record keeping and the efficient processing of claims for disease or injury for which a patient was treated.
- Codes are used in the claims submission process to request reimbursement from payors, to track the diagnoses treated by the physician, and to provide statistical data for research and other purposes.
What is Coding System?

• *ICD-9-CM* is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States.

• The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9).
Why Use ICD Codes?

• Standardizing a system of diagnostic coding accepted and understood by all parties in the reimbursement cycle
• Creating a more convenient method of data storage and retrieval
• **Assisting in the maximization of reimbursement**
• Shortening the claims-processing time
• Facilitating and measuring regulatory compliance by use of guidelines and other instructions
• **Assisting in measuring the appropriateness and timeliness of medical care**
The ICD-9-CM Code

- **The ICD-9-CM code is located in Volume 1, the Tabular Index, of the ICD-9-CM coding manual.**
- **The code consists of a three-digit category code that represents a specific disease, illness, condition, or injury, within a general disease category.**
- Up to two additional digits can be used, which add further definition and specificity.
- These two additional digits are the fourth digit, or subcategory, and the fifth digit, or subclassification, respectively.
Structure of the ICD-9-CM

• **Volumes 1 and 2** are used for diagnostic coding by hospitals, physicians, and all other providers of service.

• **Volume 1, also known as the Tabular Index**, contains all of the diagnostic codes grouped into 17 chapters of disease and injury.

• **Volume 2 is called the Alphabetic Index** and is used in the same way an alphabetic index in any textbook is used except that it refers the user back to the category codes in the Tabular Index, rather than page numbers.

• **Volume 3 is used by hospitals** to code procedures and services performed within the hospital environment. Volume 3 is not used by most physician-providers.
Volume 1—Tabular Index

What does this entail?

• Volume 1 of the ICD-9-CM consists of 17 chapters that classify diseases and injuries:

• Each chapter can contain the following four subdivisions, each of which provides more detail about the illness, condition, disease, or injury:
  1. Section, also called a Chapter
  2. Category, also called a Classification
  3. Subcategory
  4. Subclassification
     (We will discuss these in the next slide)

• Two sections contain supplementary classification codes V and E

• Five appendices
Volume 1—Tabular Index

The Subdivisions from each of the 17 chapters provide more detail about the illness, condition, disease, or injury:

1. **Section or Chapter**: A group of three-digit code numbers describing a general category.

2. **Category**: A three-digit code representing a specific disease, illness, condition, or injury within a Section or Chapter.

3. **Subcategory**: Adds additional information or description to the Category code. The subcategory is generally used to assign a fourth digit. Fourth digits are used to describe whether any disease process or manifestation exists.

4. **Subclassification**: Adds the highest level of detail to the illness or injury. The subclassification is used to assign a fifth digit, when appropriate. Fifth digits are used to describe the type of disease.
Volume 1—Tabular Index, Supplemental Classifications

The two supplementary chapters included in the Tabular Index are V and E codes.

• V Codes-describe factors influencing health status and which describe contact with health services that cannot be classified elsewhere.

• The V code is used on occasions when the patient is not currently ill or to explain problems that influence a patient’s current illness, condition, or injury.

• E codes-describe external causes of injury and poisoning.

• The E code is used to classify environmental or external causes of injury, poisoning, or other adverse effects on the body.
Volume 1—Tabular Index, 5 Appendixes

- Appendix B—Glossary of Mental Disorders. This glossary is an alphabetic listing of the psychiatric terminology that appears in Chapter 5 of Volume 1.
- Appendix C—Classification of Drugs. The adverse effects of drugs are coded according to the American Hospital Formulary Service (AHFS) list.
- Appendix D—Classification of Industrial Accidents. This appendix concerns the Statistics of Employment Injuries categorized by the type of industry in which the accident occurred.
- Appendix E—List of Three-Digit Categories. All of the three-digit category codes from the Tabular Index are listed in order, by chapter.
Conventions Used
in Volume 1—The Tabular Index

• *Conventions* refer to abbreviations, punctuation, symbols, instructional notations, and related entities that provide guidance to the medical assistant or coder in the selection of an accurate and specific code.
  – *Abbreviations*. There are two primary abbreviations used in the Tabular Index of the ICD-9-CM, NEC and NOS.
  – *Punctuation*. Four basic forms of punctuation are used in the Tabular Index: brackets, parentheses, colon, and braces.
  – *Symbols*. Symbols are used to designate the requirement of a fourth and/or fifth digit, new entries, and revised text or codes.
  – *Other Conventions*. Two other conventions used in both the Alphabetic Index and the Tabular Index are the use of bold and italic fonts.
  – *Instructional Notations*. Instructional notations are notes included in the Tabular Index to provide additional guidance when selecting a specific diagnosis code.
Volume 2—Alphabetic Index

• Volume 2, consists of 3 things:

  1. *The Alphabetic Index* - An alphabetic list of diagnostic terms and related codes

  2. *Three supplementary sections*
     a. Hypertension Table
     b. Neoplasm Table
     c. Table of Drugs and Chemicals

  3. *A separate Alphabetic Index for E Codes*
Supplementary Sections of the Alphabetic Index

- Hypertension Table—The Hypertension Table lists the types of hypertension and the manifestations and causes of hypertension and is further subdivided into three categories.
  - Main terms
  - Modifying terms
  - Subterms

- Neoplasm Table—The Neoplasm Table lists neoplasms by anatomic location and is further subdivided into four categories.
  - Malignant Neoplasm
  - Benign Neoplasm
  - Unspecified Behavior
  - Uncertain Behavior

- Table of Drugs and Chemicals—This table contains a classification of drugs and other chemical substances to identify poisoning states and external causes of adverse effects.

- Index to External Causes of Injuries and Poisoning (E Codes)—E codes classify environmental events, circumstances, and other conditions as the cause of injury and other adverse effects.
Volume 3—Procedures: Tabular Index and Alphabetic Index

- Volume 3 contains a Tabular Index and Alphabetic Index of procedures
- *Primarily used in hospitals and other facilities to code the procedures performed in those settings*
- Procedure codes are two digits, followed by a decimal and one or two additional digits
- The Tabular Index of Volume 3 includes 16 chapters containing codes and descriptions for surgical, diagnostic, and therapeutic procedures performed in a hospital setting
- *The Alphabetic Index of Volume 3 is an alphabetic listing of the surgical, diagnostic, and therapeutic procedure codes used as a guide to finding a specific code or codes in Volume 3 of the ICD-9-CM*
Beginning the Coding Process

9 listed documents and how each plays in the coding and reimbursement process.

1. Medical Documentation
2. Encounter Form
3. Treatment or Progress Notes
4. History and Physical Report (H&P)
5. Discharge Summary
6. Operative Report
7. Radiology, Laboratory, or Pathology Report
8. Extracting Diagnostic Statements
9. Main and Modifying Terms
Beginning the Coding Process:

1. Medical Documentation

- Information pertinent to code selection is culled from a variety of medical documents
- Sources of diagnostic statements include the encounter form, treatment notes, discharge summary, operative report, and radiology, pathology, and laboratory reports
Beginning the Coding Process:

2. Encounter Form

- Encounter form typically contains
  - the practice name, address, phone number, and tax and insurance identification numbers
  - the patient’s demographic and insurance information
  - a list of common procedures and services and their codes performed by the provider of care
  - a list of common diagnoses, or blank lines in which the physician can write in the patient diagnosis or diagnoses from the encounter
Beginning the Coding Process:

3. Treatment or Progress Notes

– Treatment notes are the second most common medical document from which diagnostic information can be obtained.

– Treatment notes or SOAP notes are a system of charting that includes the subjective findings, objective findings, assessment, and plan for treatment.

- **History and Physical Report** (H&P, HPE) is the starting point of the patient's "story" as to why he or she sought medical attention or are now receiving medical attention.
- The H&P begins with a statement in the patient’s own words that describes why he or she is seeking medical attention.
- The H&P (Figure 18-6) begins with a statement in the patient’s own words that describes why he/she is seeking medical attention.
- Following the chief complaint, the physician will also document any other pertinent history about the patient's medical, behavioral, and social aspects, such as smoking, drinking, drug use, family history, previous surgeries and hospitalizations, etc.
- Following the History, the physician then performs a Physical Examination (PE). The Physical Examination includes both objective and subjective assessments of the patient's physical being.
- The final sections of a History and Physical Examination include an Assessment and Plan. Assessment is the physician’s assessment of findings from the H&P. Plan is the plan for treatment of the Assessment, and can include x-rays, laboratory work, surgery, or administration of medications, etc.
Beginning the Coding Process:
5. Discharge Summary

• Discharge Summary is used primarily for extracting procedure and diagnostic information for patients who were hospitalized, rather than seen in the physician’s office.

• The main elements of a Discharge Summary are:
  – patient demographic information
  – admission date
  – date of discharge
  – history and examination findings
  – clinical course
  – condition on discharge
  – discharge diagnosis
  – aftercare plan
Beginning the Coding Process:
6. Operative Report

- *Operative Report* will also be used for extracting *procedure and diagnostic* information for patients who underwent surgery as an outpatients or inpatients.

- An Operative Report includes
  - preliminary diagnosis and procedure
  - the final diagnosis and procedure
  - detailed description of the operative procedure from start to finish
Beginning the Coding Process:
7. Radiology, Laboratory, and Pathology

- Radiology, laboratory, and pathology reports are not used to obtain diagnostic statements.
- Findings from these reports must be documented in the treatment notes in the medical record in order to be used for diagnostic coding, charge entry, or insurance billing purposes.
Beginning the Coding Process: 8. Extracting Diagnostic Statements

• The basic steps in diagnostic coding are to:
  – analyze and **abstract** the diagnosis or assessment documented in the medical record
  – and, using the conventions, guidelines, and Alphabetic and Tabular Index of the ICD-9-CM coding manual, select the most accurate and applicable diagnostic code.
  
• These abstracted diagnosis statements are then broken down into main term(s) and any modifying term(s) or subterm(s).
Beginning the Coding Process:
9. Main and Modifying Terms

• *The Alphabetic Index is organized by main term, modifying, and subterms.*
  – Main terms are the condition, disease, illness, or injury
  – Modifying terms, as described earlier, are terms that modify or act as adjectives to main terms. Modifying terms are indented two spaces below the main term.
  – Subterms are indented two spaces below the modifying term and add more detail or information to the modifying term.
  – *
Diagnostic Coding Decision Tree

• A series of questions called a decision tree can assist the medical assistant in navigating the Alphabetic and Tabular Index while the steps for diagnostic coding are performed.