Coding Rules OF THE ROAD FOR ICD-10-CM

Medical coding is a critical component of the healthcare industry, providing a standardized system for classifying diseases, diagnoses, and medical procedures. The adoption of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) has brought significant changes to medical coders. Whether you are new to coding or an experienced professional, mastering the rules of the road for ICD-10-CM is essential for accurate and efficient coding. Sometimes, new coding professionals receive on-the-job training and aren't given the time to study the guidelines. And more experienced coding professionals sometimes fall into the trap of "I know how to code for XYZ" and don't study the updates when they come out. In this article, some key principles and guidelines to help new and experienced coders navigate the complexities of ICD-10-CM will be addressed.

Understand the Structure of ICD-10-CM

Understanding the structure of ICD-10-CM codes is important for accurate coding.

Here's a breakdown of each character:

- **Character 1:** Represents the category of the disease or condition.
- **Characters 2 and 3:** Further specify the etiology, anatomical site, severity, or other clinical details.
- **Characters 4 to 6:** Provide additional information regarding the cause, manifestation, or site.
- **Character 7:** Indicates the episode of care (initial, subsequent, or sequela).

Follow Official Coding Guidelines

The ICD-10-CM coding guidelines provide instructions and conventions that coding professionals must follow to ensure consistency and accuracy in coding. Understanding and adhering to these guidelines is fundamental for both new and experienced coders. The chapter-specific guidelines will be covered in future issues of BC Advantage. For this first article in the series, the guidelines from Section IV, Diagnostic Coding and Reporting Guidelines for Outpatient Services, will be reviewed, by section.

A. Selection of First-Listed Condition

In outpatient settings, the term "first-listed diagnosis" is used instead of "principal diagnosis." The determination of the first-listed diagnosis is guided by the coding conventions of ICD-10-CM, as well as general and disease-specific guidelines, which take precedence over outpatient guidelines. Often, diagnoses are not immediately established during the initial encounter; it may require multiple visits for confirmation. The key rule is to initiate the code search using the Alphabetic Index, avoiding starting directly from the Tabular List to prevent coding errors.

1. **Outpatient Surgery:** For patients undergoing outpatient surgery (commonly known as same-day surgery), the reason for the surgery is coded as the first-listed diagnosis, irrespective of whether the surgery is performed due to a contraindication.
2. **Observation Stay:** When a patient is admitted for observation due to a medical condition, the code for that medical condition is assigned as the first-listed diagnosis. In scenarios where a patient initially presents for outpatient surgery but develops complications necessitating admission for observation, the reason for the surgery is coded as the first-listed diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses.

B. Codes From A00.0 Through T88.9, Z00-Z99, U00-U85

When documenting diagnoses, symptoms, conditions, problems, complaints, or reasons for an encounter or visit in outpatient settings, utilize the appropriate codes from A00.0 through T88.9, Z00-Z99, and U00-U85. These codes provide a comprehensive framework for accurately identifying and recording various healthcare-related issues, ensuring thorough and standardized documentation.

C. Accurate Reporting of ICD-10-CM Diagnosis Codes

Precision in reporting ICD-10-CM diagnosis codes hinges on documentation that thoroughly describes the patient's condition. This entails employing terminology that encompasses specific diagnoses, symptoms, problems, or reasons for the encounter. Fortunately, the ICD-10-CM coding system offers a comprehensive array of codes tailored to capture each facet of the patient's healthcare status, ensuring thorough and accurate representation.

D. Codes That Describe Symptoms and Signs

When a definitive diagnosis has not yet been confirmed by the healthcare provider, it's permissible to use codes that

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describe symptoms and signs for reporting purposes. For example, if a physician believes a patient has pneumonia due to fever, cough, and shortness of breath, he gives the patient an order for a chest X-ray to rule out pneumonia, which the patient goes over to the diagnostic center to have performed. For the E/M visit, pneumonia should not be coded. Rather, the fever, cough, and shortness of breath would be coded.

Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings Not Elsewhere Classified (codes R00-R99), encompasses a wide range of codes specifically designed for this purpose. It's important to note that while many symptoms are covered within this chapter, it may not encompass all potential symptoms. For example, back pain is coded to M54.9.

E. Encounters for Circumstances Other Than a Disease or Injury

ICD-10-CM offers a comprehensive set of codes to address encounters involving circumstances beyond diseases or injuries. The Factors Influencing Health Status and Contact with Health Services codes (Z00-Z99) are specifically designed to handle instances where diagnoses or issues recorded involve factors other than diseases or injuries like personal and family history of diseases. These codes play a crucial role in accurately documenting various healthcare encounters, ensuring comprehensive and detailed medical records.

F. Level of Detail in Coding

1. **Variability in ICD-10-CM Code Length:** ICD-10-CM codes are structured with three, four, five, six, or seven characters. Initially, codes with three characters serve as the category headings, which can be refined through the addition of fourth, fifth, sixth, or seventh characters to offer increased specificity.
2. **Complete Utilization of Characters:** A three-character code should only be used when further subdivisions are unnecessary. Failure to utilize the full number of characters required for a code renders it invalid, including the application of the seventh character where applicable.
3. **Pursuit of Specificity:** It's important to code to the highest level of specificity supported by the medical documentation present in the record.

G. ICD-10-CM Code for the Diagnosis, Condition, Problem, or Other Reason for Encounter/Visit

When documenting medical encounters, prioritize listing the ICD-10-CM code corresponding to the diagnosis, condition, problem, or primary reason for the visit as indicated in the medical record. This code should primarily reflect the service provided. Additionally, include supplementary codes for any coexisting conditions identified.

Occasionally, the first-listed diagnosis may pertain to a symptom, especially when a definitive diagnosis has not yet been confirmed by the provider.

H. Uncertain Diagnosis

When documenting diagnoses, avoid coding terms such as "probable," "suspected," "questionable," "rule out," "compatible with," "consistent with," or "working diagnosis," as these indicate uncertainty. Instead, code the condition(s) to the highest degree of certainty for that encounter or visit, focusing on symptoms, signs, abnormal test results, or other reasons for the visit.

It is important to note that this approach differs from the coding practices used in short-term acute care, long-term care, and psychiatric hospitals.

I. 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).

J. Code All Documented Conditions That Coexist

When coding documented conditions, include all those that coexist at the time of the encounter or visit and that require or influence patient care, treatment, or management. Do not code conditions that have been previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history impacts current care

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or influences treatment.

K. Patients Receiving Diagnostic Services Only

For patients receiving diagnostic services only during an encounter or visit, first sequence the diagnosis, condition, problem, or other reason for the encounter as documented in the medical record that is chiefly responsible for the outpatient services provided. Codes for other diagnoses, such as chronic conditions, may be sequenced as additional diagnoses.

For encounters for routine laboratory or radiology testing without any signs, symptoms, or associated diagnosis, assign Z01.89, Encounter for Other Specified Special Examinations. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, assign both the Z code and the code for the non-routine test.

For outpatient encounters where diagnostic tests have been interpreted by a physician and the final report is available at the time of coding, code any confirmed or definitive diagnoses documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Note: This practice differs from hospital inpatient coding regarding abnormal findings on test results.

L. Patients Receiving Therapeutic Services Only

For patients receiving therapeutic services only during an encounter or visit, first sequence the diagnosis, condition, problem, or other reason for the encounter as documented in the medical record that is chiefly responsible for the outpatient services provided. Codes for other diagnoses, such as chronic conditions, may be sequenced as additional diagnoses. The only exception to this rule is when the primary reason for the admission or encounter is chemotherapy or radiation therapy. In such cases, the appropriate Z code for the service is listed first, followed by the diagnosis or problem for which the service is being performed.

M. Patients Receiving Preoperative Evaluations Only

For patients undergoing preoperative evaluations only, first sequence a code from subcategory Z01.81, Encounter for Pre-Procedural Examinations, to describe the preoperative consultations. Additionally, assign a code for the condition that necessitates the surgery as a secondary diagnosis. Also, code any findings related to the preoperative evaluation.

N. Ambulatory Surgery

For ambulatory surgery, code the diagnosis that prompted the surgery. If the postoperative diagnosis differs from the preoperative diagnosis at the time of confirmation, use the postoperative diagnosis for coding, as it provides the most definitive information.

P. Encounters for General Medical Examinations With Abnormal Findings

The subcategories for encounters for general medical examinations (Z00.0-) and routine child health examinations (Z00.12-) include codes for both with and without abnormal findings. If a general medical examination reveals an abnormal finding, the code for a general medical examination with abnormal findings should be assigned as the primary diagnosis. An examination with abnormal findings refers to a newly identified condition or a change in the severity of a chronic condition (such as uncontrolled hypertension or an acute exacerbation of chronic obstructive pulmonary disease) discovered during a routine physical examination. Additionally, a secondary code for the abnormal finding should be assigned.

Conclusion

For both new and experienced coders, mastering the rules of the road for ICD-10-CM is essential for accurate and efficient coding. Adhering to the official coding guidelines, understanding the coding structure, staying updated on annual revisions, and leveraging coding software and resources are some essential strategies to ensure success in the world of medical coding. By continually improving your knowledge and skills, you'll become a proficient medical coder capable of providing accurate coding and contributing to the overall efficiency and effectiveness of the healthcare industry.

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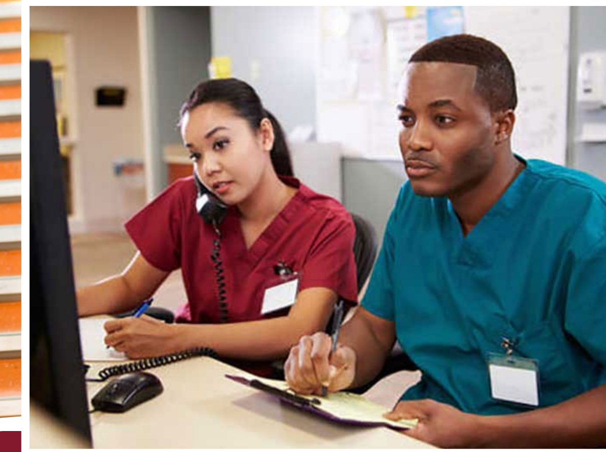

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