Chapter 4

THE CODING PROCESS

AMA
AMERICAN MEDICAL ASSOCIATION

Learning Objectives

- Describe the ICD-10-CM coding process.
- Apply the steps to correctly select a diagnosis code.
- Demonstrate the ability to code to the highest level of specificity.

© 2013 American Medical Association. All rights reserved.

The Coding Process

- Diagnoses reported in the medical record remain the responsibility of the rendering provider.
- A joint effort between the provider and the coder is essential in reporting accurate documentation and code selection.
- Guidelines in ICD-10-CM were developed to assist the provider and coder in assigning the appropriate diagnosis.

AMA
AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

The Coding Process

- Use both Alphabetic Index (Volume 2) and Tabular List (Volume 1).
- Make sure the user reads all instructional notes in both the Index and Tabular List and verifies that the documentation in the medical record supports the code assigned.
- Even if a dash is not included in the Alphabetic Index, the user should never code from this volume and always reference the Tabular List for the final code selection.

AMA
AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

The Coding Process

- The ICD-10-CM codes are comprised of up to six characters in specificity with a seventh character in some diagnoses codes identifying the extension.
- Not all codes have seventh characters. A three-digit code can only be used if no more specificity is realized.

© 2013 American Medical Association. All rights reserved.

Six Steps in the Coding Process

- Step 1: Identify the main term in the diagnostic statement.
- Step 2: Locate the main term in the Alphabetic Index, Volume 2.
- Step 3: Refer to any cross-references and notes under the main term.
- Step 4: Refer to any modifiers of the main term.
- Step 5: Verify the code number in the Tabular List, Volume 1.

AMA AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

Six Steps in the Coding Process

- Step 6: Code to the highest level of specificity:
  - Assign three-character codes only if there are no fourth-character code(s) within that code category.
  - Assign fourth-character code only if there is no fifth-character subclassification for that category.
  - Assign the fifth- or sixth-character subclassification code for those categories where it exists.
  - Assign the seventh-character extension which further identifies the condition if available. Use placeholders “x” when a fifth or sixth character is not defined in the code.

© 2013 American Medical Association. All rights reserved.

Combination Coding

- Combination codes are a single code to classify two diagnoses, which includes a diagnosis with an associated sign/symptom or a complication.
- Combination codes are identified by subentries in the Index and by reading the Includes and Excludes notes in the Tabular List.

© 2013 American Medical Association. All rights reserved.

Combination Coding

- Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Index so directs.
- Multiple codes should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis.
- When the combination code lacks the necessary specificity to fully describe all elements of a diagnosis, an additional code(s) may be used.

AMA
AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

Use of Multiple Coding for Multiple Diagnoses (Etiology/Manifestations)

- The etiology/manifestation convention in the Official ICD-10 Guidelines requires two codes to fully describe a single condition that affects multiple body systems.
- “Use additional code” notes are found in the tabular at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition.
- The sequencing rule is the same as the etiology/ manifestation pair, “use additional code” indicates that a secondary code should be added.

AMA AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

Use of Multiple Coding for Multiple Diagnoses (Etiology/Manifestations)

- “Code first” notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause.
- When a “code first” note is present and an underlying condition is present, the underlying condition should be sequenced first.
- “Code, if applicable, any causal condition first” note indicates that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable.

AMA AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

Coding Uncertain Diagnoses

- Do not code diagnoses as “probable,” “possible,” “suspected,” “questionable,” or “rule out.”
  - The provider should document these in his/her assessment, but we only code signs/symptoms of the condition.
- Instead, code the signs, symptoms, and abnormal test result(s) or other reason for the visit.
- Manifestations are characteristic signs or symptoms of an illness.
- Signs and symptoms that point rather definitely to a given diagnosis are assigned to the appropriate ICD-10-CM code.

AMA AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

Guideline Tip

- A sign or symptom is only to be used if no definitive diagnosis is established at the time the patient encounter is coded.
- When the diagnosis is confirmed prior to coding the encounter, the confirmed diagnosis is reported.

© 2013 American Medical Association. All rights reserved.

Acute, Subacute, and Chronic Conditions

- The ICD-10-CM Guidelines state: “When a condition is documented as both acute, subacute, and chronic and separate codes exist in the Index, both are coded with the acute (subacute) sequenced first followed by the code for the chronic condition.”

© 2013 American Medical Association. All rights reserved.

Laterality

- For bilateral sites, the final character of the codes in the ICD-10-CM indicates laterality.
- The right side is always character 1, the left side character 2. In those cases where a bilateral code is provided, the bilateral character is always 3.
- An unspecified side code is also provided when the side is not identified in the medical record.
- The unspecified side is either a character 0 or 9 depending on whether it is a fifth or sixth character.
  - If there is not a code in the category that identifies laterality, then a code for each (right and left) is assigned.

© 2013 American Medical Association. All rights reserved.

Selection of Principal or First Listed Diagnosis

- The code sequenced first on a medical record at the end of an encounter is most important because it defines the main reason for the encounter as determined at the end of the encounter.
  - The Uniform Hospital Discharge Data Set (UHDDS) definition states: “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

AMA AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

Selection of Principal or First Listed Diagnosis

- Selection of principal diagnosis/first listed code is based first on the conventions in the classification that provide sequencing instructions.
- If no sequencing instructions apply, then sequencing is based on the condition(s) that brought the patient into the hospital or physician office and the condition that was the primary focus of treatment.

© 2013 American Medical Association. All rights reserved.

Acute Manifestation versus Underlying Condition

- If the acute manifestation is immediately life threatening and primary treatment is directed at the acute manifestation, the acute manifestation should be sequenced before the underlying condition.
- If the acute manifestation is not the primary focus of treatment, the underlying condition should be sequenced first.

© 2013 American Medical Association. All rights reserved.

Two or More Diagnoses That Equally Meet the Definition of Principal Diagnosis/First Listed Diagnosis

- There may be instances when two or more confirmed diagnoses equally meet the criteria for principal/first listed diagnosis as determined by the circumstances of admission, diagnostic workup, and/or therapy provided, and the Index, Tabular List, and coding guidelines do not provide sequencing direction.

AMA
AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

Two or More Diagnoses That Equally Meet the Definition of Principal Diagnosis/First Listed Diagnosis

- In this situation, any one of the diagnoses may be sequenced first. This rule also applies to the inpatient and outpatient setting.
- If anticipated treatment is not carried out due to unforeseen circumstances, the principal diagnosis/ first listed code remains the condition or diagnosis that was planned to be treated.

AMA
AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

Complications of Surgery and Other Medical Care

- When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the first listed code.

© 2013 American Medical Association. All rights reserved.

Selection of Secondary Diagnoses

- In most cases, more than one code is necessary to fully explain a health care encounter.
- Though a patient has an encounter for a primary reason (the principal/first listed diagnosis), the additional conditions or reasons for the encounter also need to be coded.
- These codes are referred to as secondary, additional, or “other” diagnoses.

AMA
AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

Selection of Secondary Diagnoses

- For reporting purposes, the definition of “other” diagnoses is interpreted as conditions affecting patient care requiring:
  - Clinical evaluation.
  - Therapeutic treatment.
  - Diagnostic procedures.
  - Extended length of hospital stay.
  - Increased nursing care and/or monitoring.

AMA
AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

Previous Conditions

- Some physicians include in the diagnostic statement resolved conditions or diagnoses and previous procedures that have no bearing on the current treatment.
- Such conditions are not to be reported and are coded only if required by the hospital or provider office policy.

© 2013 American Medical Association. All rights reserved.

Abnormal Test Findings

- Abnormal test findings (laboratory, X-ray, pathologic, and other diagnostic results) are **not** coded and reported unless the physician indicates their clinical significance.
- If the findings are outside the normal range and the physician has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the physician whether the abnormal finding should be added.

AMA
AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

Abnormal Test Findings

- If the abnormal test finding corresponds to a confirmed diagnosis, it should not be coded in addition to the confirmed diagnosis.
- A sign or symptom code is to be used as principal/ first listed if no definitive diagnosis is established at the time of coding.
- If the diagnosis is confirmed (eg, an X ray confirms a fracture or a pathology; or a laboratory report confirms a diagnosis) prior to coding the encounter, the confirmed diagnosis code should be reported.

AMA AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

Coding Chronic Conditions

- Chronic conditions treated on an ongoing basis may be coded as many times as required for treatment and care of the patient or when applicable to the patient's plan of care.
- Do not code conditions previously treated or those that no longer exist, although a history of previous conditions should be coded if it affects patient care or provides the need for a patient to seek medical care (eg, history of lung cancer).
- Some diseases have both acute and chronic manifestations. These manifestations may exist alone or together.

AMA AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

Coding Chronic Conditions

- Use only one code when the code description includes both the acute (subacute) and chronic conditions.
- When the medical record states that the patient has both acute and chronic disease and no single code exists for the combined acute and chronic disease, observe the following rules:
  - The acute condition is the first listed diagnosis.
  - The chronic condition is listed as the secondary diagnosis.

AMA AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

Coding Diagnoses for Surgical Procedures

- For surgical procedures, code the diagnosis that is applicable to the procedure.
- If at the time the claim is filed the postoperative diagnosis is different from the preoperative diagnosis, report the postoperative diagnosis, since it is the most definitive.
- These guidelines are applicable to physicians and to nonphysician practitioners' professional services.

© 2013 American Medical Association. All rights reserved.

ICD-10-CM and Medical Necessity

- ICD-10-CM codes form a crucial partnership with CPT procedural codes by supporting the medical necessity of the CPT procedure or service performed.
- Diagnosis codes identify the medical necessity of services provided by describing the circumstances of the patient's condition.
- An important point to realize when filing claims is that neither CPT codes nor ICD-10-CM codes can stand alone!

AMA AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

ICD-10-CM and Medical Necessity

- Apply the following principles to diagnosis coding to properly demonstrate medical necessity for physician or outpatient services:
  - List the principal/first listed diagnosis, condition, problem, or other reason for the medical service or procedure.
  - Assign the code to the highest level of specificity.
  - Never use a “rule-out,” “probable,” “possible,” or “suspect” statement; this could label the patient with a condition that does not exist. Code signs, symptoms, abnormal test results, or other reason for the visit if no definitive diagnosis is determined.

AMA AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

ICD-10-CM and Medical Necessity

- Be specific in describing the patient's condition, illness, or disease.
- Distinguish between acute and chronic conditions, when appropriate.
- Identify the acute condition of an emergency situation (eg, coma, loss of consciousness, hemorrhage).
- Identify chronic complaints, or secondary diagnoses, only when treatment is provided or when they impact the overall management of the patient's care.
- Identify how injuries occur.

AMA AMERICAN MEDICAL ASSOCIATION

© 2013 American Medical Association. All rights reserved.

AMA
AMERICAN MEDICAL
ASSOCIATION