



COMMUNITY HEALTH PLAN
of Washington

Committed to your health.®



Provider Education Webinars

Course 2:
Navigating the ICD-9-CM Manual

Housekeeping Items

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- exit the application and try re-establishing your internet and phone connections
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Webinar Questions

For questions concerning the content of this webinar, CHP has a dedicated email address:

providereducation@chpw.org.

Questions about Specific Coding Scenarios

If you have questions about particular documentation and coding questions (specific coding scenarios) please email it to us at providereducation@chpw.org.

Questions about Claims

If you have questions about specific coding/claims processing issues, please use your usual route for claims queries (the webinar project isn’t set up to be the best forum to access claims information).

Continuing Education Credit

At the end of each webinar, there are instructions detailing how to request Continuing Medical Education and/or Continuing Education Units, by using the dedicated email address that CHP has established for this activity: providereducation@chpw.org.

Welcome

Welcome to this presentation of Community Health Plan's Provider Education Webinar, Course 2: Navigating the ICD-9-CM Manual.

This webinar series is designed specifically for Community Health Plan's Physicians, Healthcare Professionals, and Administrative Staff who want to broaden their understanding and use of documentation and coding skills.

This webinar series consists of 10 one-hour courses.

Attendees may earn

- Continuing Medical Education (CME) through the AAFP*, and/or
- Continuing Education Units (CEU) through AAPC** and AHIMA***

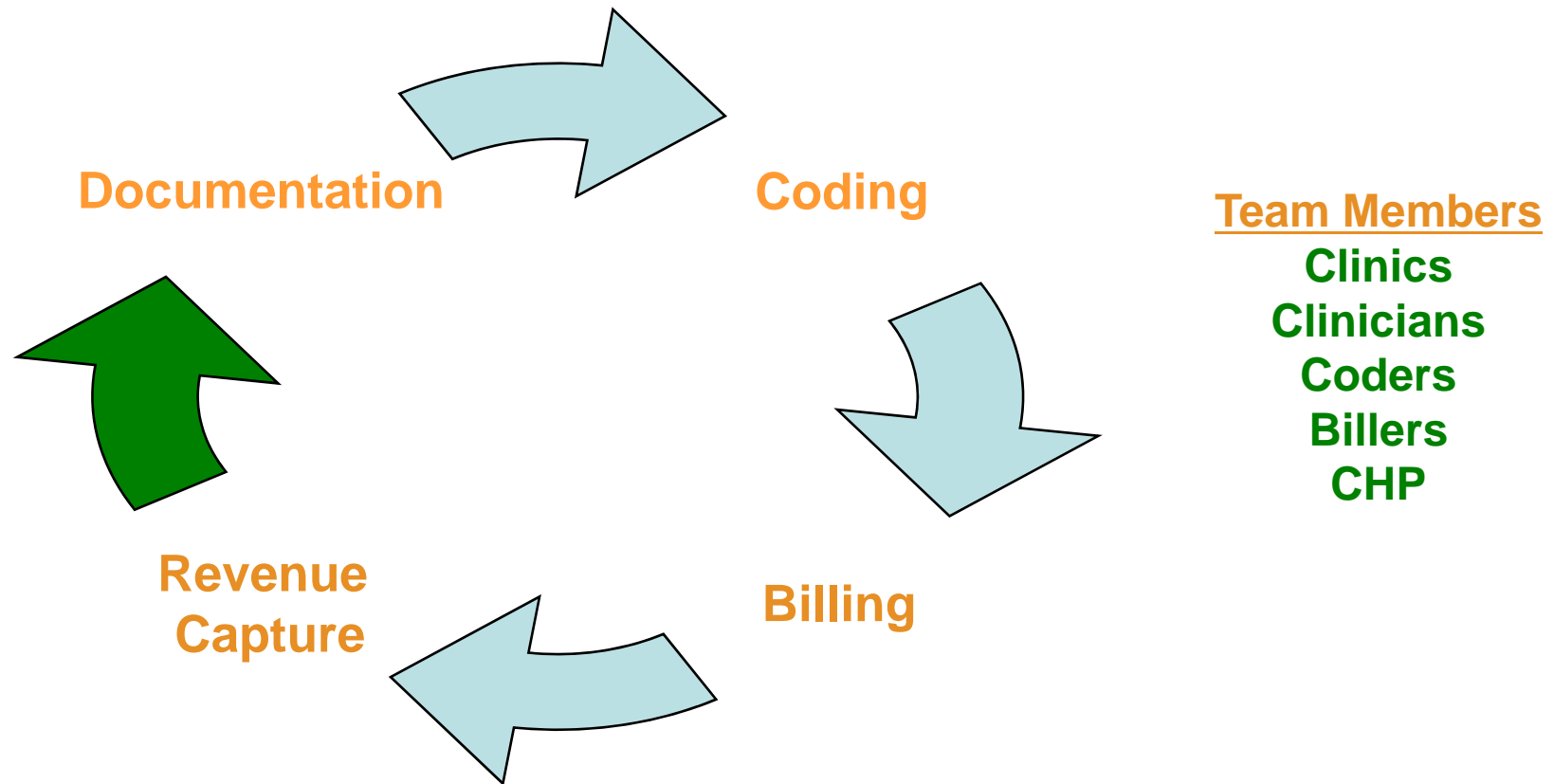
Courses and Self-Assessments must be completed to earn the CME/CEU credit.

* American Academy of Family Physicians

** American Academy of Professional Coders

*** American Health Information Management Association

A Comprehensive Approach to Optimizing Documentation & Coding



Our Role – Clinical Components

- Deliver timely comprehensive care....
- Document the care you deliver....
- Code the care you document....
- Capture the codes you document...

Community Health Plan - Medicare Advantage
Member HCC Report



HEALTH CENTER - Clinic Name

Run Date: 10/27/2008

Patient Name: Doe, John
 Address: 1234 Main Street, Anytown, US 98765
 Phone: (555) 555-5555

Member ID: HP1000000000

How To Use This Report

Step 1: Please review the diagnoses (ICD9 codes) and conditions (Hierarchical Condition Categories (HCC Codes)) listed in Sections 1 and 2. If you believe that a diagnosis/condition listed here is not relevant to this patient, please circle the diagnosis/condition.

Step 2: After reviewing, please sign below and fax this form to our confidential fax: 206-652-7024, Attn: Member HCC Report.

Step 3: At your next visit with this patient, please check for the presence of these diagnoses/conditions and document each currently present diagnosis/condition accordingly in your visit note.

Section 1 - Conditions (HCCs) Reported in Current Year

(Reported diagnoses may come from multiple care settings, including primary care, specialty care and hospital providers. Only one HCC per patient is shown, with highest documented ICD9 code.)

ICD9 Code	ICD9 Description	HCC Code	HCC Description	Risk Score
250.00	Dmii Wo Cmp Nt St Uncntr	19	Diabetes without Complication	0.2

Section 2 - Additional Conditions (HCCs) Reported in Prior Years

ICD9 Code	ICD9 Description	HCC Code	HCC Description	Risk Score
291.81	Alcohol Withdrawal	51	Drug/Alcohol Psychosis	0.353
303.90	Alcoh Dep Nec/Nos-Unspec	52	Drug/Alcohol Dependence	0.265
780.39	Convulsions Nec	74	Seizure Disorders and Convulsions	0.269
428.0	Chf Nos	80	Congestive Heart Failure	0.417
		16	Diabetes with Neurologic or Other Specified Manifestation	0.552
		71	Polyneuropathy	0.268

I have reviewed the diagnoses/conditions listed on this page, along with the medical history of this patient. With the exception of those codes that are circled, I attest that these diagnoses/conditions are present in this patient's medical history as available to me beginning _____ (mm/yyyy).

 Printed Name & Credentials

 Signature

 Date

Community Health Plan of Washington Provider Education Webinar

Course 2: Navigating the ICD-9-CM Manual

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Cost Reimbursement and Research Analyst

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Cost Recovery Analyst

Learning Objectives

Webinar Learning Objective:

Community Health Plan's goal is that our Providers will apply this career training and best practices information across their care spectrum, regardless of Patients' ability to pay or insurance type.

Course 2 Learning Objective:

Focus on proper use of Volumes I and II of the ICD-9-CM Diagnosis Coding Manual, excluding the Volume III procedures.

Participants' learning objectives for Course 2 are:

- To learn where to find and how to use the current Official Guidelines for Coding and Reporting that dictate ICD-9-CM code usage
- Understand the overall structure and uses of Volumes I and II of the ICD-9-CM coding classification
- To obtain guidance needed to develop good coding habits

The Provider of services is the only person who has authority to formulate and determine a diagnosis. Non-Clinical Staff may not choose a diagnosis for a Patient, but may accurately convert a narrative description to a diagnosis code, ideally after they've been trained on the proper use of the ICD-9-CM Manual. These situations are addressed later in this course.

Much of the information in this curriculum is available free at the CMS website:

<http://www.cms.hhs.gov/home/outreacheducation.asp> and some of the training offers CEU credits for Coders. The category at this website for this kind of training is "Physician Center".

Ethical Responsibilities

The Standards of Ethical Coding from the American Health Information Management Association are at:

<http://www.ahima.org/infocenter/guidelines/standards.asp>

The Code of Ethics from the American Association of Professional Coders is at: <http://www.aapc.com/aboutUs/code-of-ethics.aspx>

Delivery and Documentation of Quality Care

- Documentation that supports the diagnosis has always been important from a quality of care perspective
- Accurate diagnosis in the chart accomplishes quality & continuity of care goals
- Specificity in diagnosis documentation results in accurate ICD-9-CM coding
- Accurate ICD-9-CM coding achieves accuracy in the diagnosis portion of the claim
- Accurate diagnosis claims data attains optimal reimbursement
- Positive vs. Negative monetary motivators
- Return on Investment of accurate diagnosis coding

Diagnosis Coding Facts

- Proper outpatient diagnosis coding requires using the ICD-9-CM Volumes I and II to choose appropriate codes
- Diagnosis codes submitted on claim forms establish necessity for the services performed
- The codes submitted on the claims are also used by outside agencies or organizations to forecast health care trends and needs

Additions, Deletions, and Revisions

- Updated ICD-9-CM codes are published in the Federal Register in April/May of each year
- Code changes include codes that
 - Are new codes entirely
 - Are revised descriptions of existing codes
 - Deleted codes that should no longer be used (except for rebilling dates of service that are in the date span before the code was deleted)
- The ICD-9-CM diagnosis coding classification is flexible and is a constantly changing product of the continuing research of medicine
- Annual Update:
<http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes>
- Annual Addenda and Errata:
<http://www.cdc.gov/nchs/datawh/ftpserv/ftpICD9/ftpICD9.htm>

Official Guidelines for ICD-9-CM

ICD-9-CM Official Guidelines for Coding and Reporting

Getting the Guidelines

- Updated roughly annually, but not always in the same month
- Tip: Place a recurring appointment reminder to yourself to look for them every week starting in September through November
- <http://www.cdc.gov/nchs/datawh/ftp/ftpICD9/icdguide08.pdf>

Using the Guidelines

- Use the current guideline set for the date of service in question
- Most of the guidelines are for inpatient coding. Per CMS, make sure you're using Guidelines that apply to your setting.

Guidelines Printed in the ICD-9-CM Book

Check Your Diagnosis Coding Book

See if the most current ICD-9-CM Official Guidelines for Coding and Reporting are included in the front of the book by checking the effective date of the Guidelines printed there.

Many times the publisher is not able to include the most current version of the Guidelines.

If you discover that the Guidelines published in your new book are indeed an old version, utilize the downloadable ones from the website (same as on last slide):
<http://www.cdc.gov/nchs/datawh/ftp/ftpICD9/icdguide08.pdf>.

More on Coding and Reporting Guidelines

- Use the ICD-9-CM codes that describe the patient's diagnosis, symptom, complaint, condition, or problem.
- Use the ICD-9-CM code that is chiefly responsible for the item or service provided.
- Assign codes to the highest level of specificity. Use the fourth and fifth digits when indicated as necessary in your ICD-9-CM volumes.
- Do not code suspected diagnoses in the outpatient setting. Code only the diagnosis symptom, complaint, condition, or problem reported. Medical records, not claim forms, should reflect that the services were provided for "rule out" purposes.
- Code a chronic condition as often as applicable to the patient's treatment.
- Code all documented conditions which coexist at the time of the visit that require or affect patient care or treatment. (Do not code conditions which no longer exist).

Additional Coding Tips

- Emergency encounters: the Provider should document the acute condition(s) or symptoms for outpatient services.
- For multiple injuries, sequence the most severe injury first (the Worst-First rule).
- Causes of infections are coded secondary.
- Other and unspecified diagnosis codes: limit to situations where no definitive information's available, or no other specific code is available. Distinguish between acute and chronic whenever the ICD-9-CM makes the distinction.
- Inpatient coding, code each condition identified in the record that coexisted at the time of admission and required or affected patient care or treatment. This differs from outpatient coding, and isn't acceptable for use on claims that indicate an outpatient place of service.
- Revise billing charge tickets and forms annually to include up-to-date ICD-9-CM codes.
- Note: These are only a few of the significant items you should keep in mind when coding. For additional information review the ICD-9-CM Official Guidelines for Coding and Reporting.

ICD-9-CM Volumes I, II, and III

- Volume I: Tabular List of Diseases & Injuries
- Volume II: Alphabetic Index of Diseases & Injuries
- Volume III: Tabular List and Alphabetic Index of Procedures
- Volumes I and II contain symptoms and diagnosis codes that are used for physician or hospital/facility billing.
- Volume III contains codes for both surgical and non-surgical procedures that are used for hospital billing.
- This course focuses on proper use of Volumes I and II only.

ICD-9-CM Volume I: Tabular List

Volume I is:

- Arranged in numerical sequence (001-999.9)
- Divided into seventeen chapters
- Contains two supplementary classifications (V codes and E codes)
- Appendices

Navigating Volumes I and II

Steps for Using Volumes I and II:

The steps to achieve correct diagnosis coding are:

First Step: Volume II

- Identify the Main Term in the diagnostic statement (diagnosis, symptom, or condition)
- Find the Main Term in Volume II Alphabetic Index
- Review Sub-terms (indented, and further defines the Main Term)
- Look for cross-reference instructions (such as “see” or “see also”)
- Look for any modifiers of the Main Term (essential or non-essential modifiers further define the Main Term)

Next Step: Volume I

- Verify the code in the Volume I Tabular List
- Read the Tabular List Notes for the code
- Code to the highest specificity
- **NEVER CODE DIRECTLY FROM THE VOLUME II ALPHABETICAL INDEX WITHOUT VERIFYING IT IN THE VOLUME I TABULAR LIST**

Volume II: Alphabetic Index

Volume II is an Alphabetic Index to Volume I and includes:

- Alphabetic Index of Diseases and Injuries
- Table of Drugs and Chemicals
- Index of External Causes of Injuries and Poisonings (E codes)
- Always begin the initial search for a code with Volume II, but do not code directly from Volume II. Coding from Volume II can lead to inaccurate codes because:
 - Not all fifth digits are indicated
 - Include, Exclude, and Notes are not included

Volume III: Tabular List & Alphabetic Index of Procedures

- Volume III contains codes for procedures, not diagnoses.
- Hospitals use Volume III for reporting procedures on claim forms.
- Training in the proper use of Volume III is not included in this webinar series. We can bring this training to you in the future, depending on your need.

ICD-9-CM Code Structure

ICD-9-CM Code Specificity

ICD-9-CM codes are:

- Made up of three, four, or five digits
- Either numeric or alphanumeric
- A decimal point always follows the third digit when a fourth or fifth digit is necessary.

Examples:

<i>Code</i>	<i>Diagnosis</i>
003	Other Salmonella infections
003.23	Salmonella arthritis
003.9	Salmonella infection, unspecified

Diagnosis codes are to be coded to their highest level of specificity. This means that when fourth or fifth digits are available, they must be used.

Other and Unspecified Diagnosis Codes

"Other" codes

Codes titled "other" or "other specified" (usually with a fourth digit of 8 or fifth digit of 9 for diagnosis codes) are for use when the information in the medical record provides detail for which a specific code does not exist.

"Unspecified" codes

Codes (usually with a fourth digit of 9 or fifth digit of 0 for diagnosis codes) titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code.

Decimal digits .8 or .9 are usually used to indicate "other specified" or "not otherwise specified" conditions. The unspecified fourth or fifth digits are residual subheadings. You should only use them when information that is more specific is not available or does not exist. You should not use these digits when it is not convenient to get more detailed information.

More ICD-9-CM Volumes I & II Elements

- Sequencing of multiple codes
- V and E codes and their roles in appropriate, accurate coding
- Conventions
- Abbreviations
- Notes and Inclusion Terms
- Etiology and Manifestations
- Hypertension and Neoplasm Tables
- Table of Drugs and Chemicals
- Appendices

Diagnosis Code Sequencing

Knowing how to properly sequence and report diagnoses is very important to “paint a picture” of the Patient’s condition or reason for visit.

Primary* Diagnosis Sequencing

- The most significant reason for the procedure or service provided.

Secondary and Tertiary Diagnosis Sequencing

- Diseases and Conditions that co-exist and affect the overall management of the Patient’s care should be sequenced secondary.
- Tip: Do not code conditions at all that don’t affect the overall management of the Patient and/or that no longer exist.*

*V-Codes that describe Personal or Family ‘History Of’ a condition are appropriate to code when a condition no longer exists.

*The ‘Primary’ Diagnosis=outpatient first listed diagnosis. The ‘Principal’ Diagnosis=inpatient first listed diagnosis.

Diagnosis Sequencing Scenario

ICD-9-CM Diagnosis Scenario:

Provider documentation:

Patient presents complaining of right foot pain for three days, no history of a similar complaint. Non-smoker, no numbness or tingling in extremities. Today's glucose measurement here in the office (Patient reports having a low-carb lunch) indicates that the Patient's IDDM is not well-controlled. Patient reports she feels it's possible that her insulin not working as well as usual. There is R foot redness, swelling, and tenderness. No changes in blood pressure at this visit, patient reports no problems from the antihypertensive medication. Referral to registered diabetic educator, and we will schedule blood testing to assess the potential cause of the foot pain.

Correct ICD-9-CM Diagnosis Sequencing:

1. R Foot Pain (Reason for visit-Chief complaint)
2. Insulin-Dependent Diabetes Mellitus II, uncontrolled (worst first: of the remaining conditions after the CC, one is uncontrolled-IDDM II-and one is controlled-HTN).
3. Hypertension, controlled (Evaluated and managed medications-no changes)

Reporting V Codes

When are V Codes Reported?

V codes are used when treatment or diagnosis is necessary for a condition or problem that is not caused by a disease or injury, but rather is due to certain circumstances.

These circumstances arise in various ways:

1. When a person who is not sick or injured acquires a condition or problem from a visit to a health care facility.
2. When a person with a known disease or injury visits a health care facility for treatment of the known disease or injury.
3. When a circumstance or problem influences a person's health status, such as personal or family history of ____, or exposure to ____, but the circumstance or problem itself is not an illness or injury.
4. Identify health status of newborns

Locating V Codes

Locating V Codes:

- Found in the Alphabetic Index Volume II; the V codes do not have their own Index (Unlike E codes, which have their own index).
- Common index terms are used to describe V codes
- Section 18 of the ICD-9-CM Official Guidelines for Coding and Reporting (Page 65, FY 2009, effective October 1, 2008) gives excellent advice for locating V codes

Reporting and Locating E Codes

Reporting ICD-9-CM E Codes

- E codes classify external causes of injury or poisoning
- E codes are coded as additional codes to provide more details about an accident or event
- E codes are **never** to be recorded as the principal diagnoses
- E codes are not "required" for reporting, but there are guidelines (Chapter 19 in the ICD-9-CM Official Guidelines) that apply to the coding and collection of E codes, except when other specific guidelines apply.

Locating E Codes

- E codes have their own Alphabetic Index, therefore they need to be verified in the E code Tabular List after first identifying them in their Alphabetic Index.

ICD-9-CM Coding Conventions

What are ICD-9-CM Coding Conventions?

The abbreviations, punctuation, symbols, typefaces, and formatting methods used in the ICD-9-CM.

There are two sources of ICD-9-CM coding conventions:

- ICD-9-CM Official Guidelines for Coding and Reporting
- ICD-9-CM publisher-specific formatting conventions
each publisher may use a different symbol to indicate when a fourth or fifth digit is required

Abbreviations

Abbreviations

The official guidelines identify two key abbreviations that are used in the ICD-9-CM:

NEC (Not elsewhere classified)

Used only in Volumes I (Tabular List)

Used only when the documentation specifies a that there is no specific separate code for the condition in the ICD-9-CM

Example: the cause of a diagnosis of Pneumonia is known, but the cause is not a choice in the ICD-9-CM

NOS (Not otherwise specified)

Used only in Volume I (Tabular List)

The Coder should query the Provider for more specific information

Example: the cause of a diagnosis of Pneumonia is known, and is a choice in the ICD-9-CM, but the cause is not a documented in the information sent to the Coder

These abbreviations are located in Section 1.A.2 of the Official Guidelines and is recommended reading to learn what each represents and their proper use.

Notes and Inclusion Terms

Notes and Inclusion Terms

- 'Include Notes' and 'Exclude Notes' are found in Volume I under the code entries, and will help you select the correct code to use. These describe conditions that are excluded from the code specified above the note.

Example of exclusion term:

490

**Bronchitis NOS, not specified as acute or chronic
catarrhal
with tracheitis NOS
Tracheobronchitis NOS**

excludes *allergic NOS (493.9)*
asthmatic NOS (493.9)
due to fumes and vapors (506.0)

- Conversely, a list of terms included under certain four and five digit codes are 'inclusion terms.' These describe conditions that are included in the specified code.
- It will make Coding easier for you if you read what each of these note types mean in the official guidelines.

Etiology and Manifestation

Etiology

- refers to a primary or underlying condition (such as below example: neurofibromatosis 237.7)

Manifestation

- refers to conditions that are due to the etiology (such as below example: glaucoma 365.44)

365.44

Glaucoma associated with systemic syndromes

Code first associated disease, as

neurofibromatosis (237.7)

Sturge-Weber (-Dimitri) syndrome (759.6)

- Certain conditions have both an underlying etiology and multiple body system manifestations that are due to the underlying etiology.
- Etiology is sequenced first, followed by the manifestation.
- Manifestation Codes usually state:
 - “Use additional code”
 - “Code First”
 - “In diseases classified elsewhere”

Where to find additional information about manifestation codes:

- Section 1.A.6 of the Official Guidelines

Hypertension Table

Hypertension Table

- The Hypertension table is located under the Hypertension main heading in Volume II. The table contains a comprehensive listing of conditions due to or related to hypertension. Each set of hypertension conditions is categorized based on one of three elements:

Hypertension Categorization

- Malignant: Chronically high hypertension that is difficult to treat.
- Benign: A mild, chronic hypertension condition that can usually be controlled with medication. This is the most common type of hypertension.
- Unspecified Hypertension for which the details of the condition are unavailable or unknown.

Neoplasm Table

The Neoplasm Table is located in Chapter 2 of Volume I (Tabular List)

- Neoplasm: Abnormal growth of tissue
- Terms: Lesion, tumor, cyst, or mass
- Behavior: capacity to invade surrounding tissue
- Neoplasms are identified in the table by anatomical site, then by their behavior:
 - Malignant, PRIMARY: Identifies the site of the original neoplasm.
 - Malignant, SECONDARY: Identifies a secondary cancerous neoplasm site; Malignant, Secondary should be used for all secondary cancers, even if the primary malignancy has been arrested.
 - Malignant, CA in situ: Identifies cancerous neoplasms that are confined, or non-invasive.
 - BENIGN: Identifies a neoplasm that is non-cancerous.
 - UNCERTAIN BEHAVIOR: A tumor that has characteristics of a neoplasm, but there is not enough evidence to determine malignancy; the behavior is unpredictable and needs further investigation by a physician.
 - UNSPECIFIED: So many changes have occurred that it is indeterminate as to where the tumor began, or the nature is unknown pending lab results.
- Provider's Responsibility - document
- Coder's Responsibility-verify

Additional Tips on Coding Neoplasm

Additional Tips on Coding Neoplasm

- Neoplasm sites marked with an asterisk (*) (Example: face, NEC*) should be classified to Malignant Neoplasm of skin of these sites if the variety of neoplasm is a squamous cell carcinoma or an epidermoid carcinoma, and to Benign Neoplasm of skin of these sites if the neoplasm is a papilloma (any type).
- Carcinoma stated as metastatic **from** a specific site is interpreted as the **Primary** of that site.
- Carcinoma stated as metastatic **to** a site is interpreted as the **Secondary** neoplasm of the stated site.

Examples:

- Metastatic carcinoma **from** breast is coded 174.9 and code 199.1 is used to indicate metastatic site unspecified.
- Metastatic carcinoma **to** lung is coded 197.0 with code 199.1 to indicate primary site not specified.

Building a Bridge, and Using it

Ethical Responsibility

Guessing about where to find rules that apply to documentation and coding questions is not necessary, is unethical, and wastes your valuable time and energy.

CHP is here to help you build a foundation for understanding this valuable career skill, and to assist you with official references when questions about proper documentation and coding arise.

Feedback about the Webinar

Community Health Plan chose this enterprise-wide, long-term approach of online training to serve our Providers, achieve our training objectives, and optimize the delivery of this information (which ultimately benefits the Patients, the Providers, and the Plan).

To that end, CHP has created a dedicated email address for our Providers and their Staff to send questions and comments about this training: please email us at: providereducation@chpw.org. CHP encourages our Providers to give us feedback about this educational webinar, so that it may be continuously improved.

Continuing Education Credit Requirements

CHP has arranged to award CMEs (through AAFP) and CEUs (through AAPC and AHIMA) for Participants who:

- attend this webinar,
- are counted as present,
- complete a brief Self-Assessment and Quality Survey at the end of the webinar, and
- request the continuing, education credit in the manner described in the steps in the next slide.

Obtaining Continuing Education Credits

1. Send an email to providereducation@chpw.org with “Continuing Education Credit Request” in the subject line.
2. Be sure to let us know which organization/s you’re requesting continuing education credit from, and
3. Include your contact information in the body of the email.
4. A *brief* Self-Assessment will be emailed to requesters. The brief Self-Assessment is evidence of learning objectives met (and is a requirement of the continuing education granting organizations), and
5. Upon completion of your Self-Assessment, email it back to CHP at the above email address.
6. CHP will process and send the continuing education certificates to the Participants at the contact information provided in Step 3 (above).
7. As always, it’s the responsibility of the Participant to submit and/or make available proof of continuing education credit earned (CME/CEU certificates) to the AAFP, AAPC, and AHIMA on demand. CHP doesn’t submit certificates to these organizations on behalf of webinar Attendees.

Additional Resources: much of the information in the Webinar is available in a more comprehensive form at CMS’s website: <http://www.cms.hhs.gov/MLNGenInfo/> and click on the Web-Based Training Modules. There are additional CMS web-based training courses there as well.

Thank You for Participating

Community Health Plan would like to thank you for taking time out of your busy schedule to participate in today's Provider Education Course 2 Webinar: ICD-9-CM Coding.

Community Health Plan has arranged for documentation and coding resources to be made available to you by email for questions about the materials covered in this webinar series. We cannot address specific, individual claims processing queries. There are other resources available for reimbursement questions, and the usual route for claims questions should be used for them.

The Provider Education Team is looking forward to delivering the next course in this webinar series, and it will reinforce the concepts and complement the content of this course.