Lesson 23

ICD-9-CM Coding
Introduction

Step 1  Learning Objectives for Lesson 23

When you have completed the instruction in this lesson, you will be trained to do the following:

► Describe the history and development of the diagnostic coding system.
► Explain the role of medical coding and its uses.
► Compare and contrast the ICD-9-CM and ICD-10-CM coding systems.
► Explain how Volumes 1 and 2 of the ICD-9-CM are organized.
► Explain basic coding guidelines.
► Distinguish among the ICD-9-CM conventions.
► Describe ICD-9-CM terminology.
► Locate the appendices in the ICD-9-CM.
► Identify the steps to diagnostic coding.

Step 2  Lesson Preview

Are you wondering when you'll get to code? Well, here you go! This lesson will introduce you to diagnostic coding.

Whenever a patient sees a doctor for a health-related problem, the patient is asking for a diagnosis. We've talked quite a bit about diagnoses in previous lessons, and you already know a bit about diagnosis codes. You also know that when a doctor makes a diagnosis, it is you, the healthcare document specialist, who codes it.
The diagnosis codes that you assign are then used to determine the medical necessity. This helps the payer, such as the insurance companies, to determine reimbursement for the provider's services.

This lesson also will give you information on the appendices, chapters and sections of each volume of the ICD-9-CM. Perhaps one of the most important aspects of this lesson is that you will learn about the various ICD-9-CM conventions. These conventions are the accepted ways of doing things when it comes to medical coding. When you understand these conventions and how they are used, you will have no problem accurately assigning diagnostic codes in your work.

## Step 3 History of the International Classification of Diseases

We spoke briefly of the *International Classification of Diseases* in a previous lesson. The history of the ICD dates back to the 1600s in England! The system came to the United States in the mid-1700s. This classification of diseases originally was used to track mortality statistics to determine how many people died of different diseases.

In the seventeenth century, the statistical study of diseases began with the work of John Graunt on the *London Bills of Mortality*. The *Bills* was initially a list of only the number of burials. Graunt added to the *Bills*, to include the cause of deaths. He tabulated and studied the data from the annual bills from 1629 through 1660 and published *Natural and Political Observations Made upon the Bills of Mortality* in 1662. This publication is considered one of the forerunners of today's international mortality classifications.

In 1837, the General Register Office of England and Wales found its first medical statistician, William Farr. Farr labored to secure an improved classification, as well as international uniformity. In 1853, the first International Statistical Congress (ISC) asked Farr to prepare an internationally applicable, uniform classification of causes of death. Although this classification was never universally accepted, the general arrangement survived as the basis of the *International List of Causes of Death*. The ICD originally was used to track mortality statistics.
The International Statistical Institute created a committee, chaired by Dr. Jacques Bertillon, to prepare a classification of causes of death. The report was presented in 1893, and the Bertillon Classification of Causes of Death, as it was first called, received general approval. Several countries adopted it at that point. Jesus E. Monjaras first used the classification in the Americas for the statistics of San Luis de Potosí, Mexico.2

In 1900, the first international conference for the revision of the Bertillon or International List of Causes of Death convened. Representatives from 26 countries attended and adopted the first of the ICDs or International Classification of Diseases. It was determined that the classifications should be revised every 10 years; therefore, the succeeding conferences were held in 1909, 1920, 1929 and 1938, and a new version of the ICD was adopted at each.3

**The WHO**

The World Health Organization (WHO) is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.4 In 1946, the United Nations gave the responsibility of the ICD to the WHO, which issued the sixth and subsequent revisions in 1948, 1958 and 1967.

The ICD is the international standard diagnostic classification. It classifies diseases and other health problems recorded on many types of health and vital records, including death certificates and health records.5

**ICD-9-CM**


The ICD-9-CM consists of:

- Tabular List
- Alphabetical Index
- Procedure Alphabetic Index and Tabular List
Step 4  Why Code?

Through the years, the number of people who go to the doctor has increased. This increase has occurred for several reasons:

- People live longer and require more health care.
- Technological advances offer more options for better health care.
- People have better access to health care than ever before.

Your role as the healthcare document specialist is to transcribe/edit the physician’s dictated medical record for all of these patients and translate the information into numeric (number codes) and alphanumeric (combined letter and number) codes, and then submit claims for reimbursement. The physician’s office uses this coded information for a number of purposes. A primary use of medical codes is to communicate to the insured the reason for a patient’s medical visit. Thus, the diagnosis code communicates to the insurance payer the reason the physician provided medical services for the patient.

Another use for medical coding is as a statistics-gathering tool for research, grants and financial analysis. Hospitals use coding to index hospital records according to diseases and operations. By indexing—or organizing—records this way, they consistently can store and retrieve data. Coding is useful for reporting medical diagnostic trends to agencies that track this information. For instance, the American Cancer Society can access accurate cancer statistics thanks to coding.

As you can see, the coding system is a common language that the medical community uses as a standard communications device. Using this coding system correctly is important. You know by now that if a code is used that does not match the services performed, the claim will be rejected. In addition, for government claims, such as to Medicaid or Medicare, the correct code is required by law.
Originally, medical coding was used to allow access to medical records for easy retrieval of information for medical research, education and administration. Today, coding is used to:

- Facilitate payment of medical services.
- Study patients’ use of healthcare facilities.
- Study the cost of health care.
- Research the quality of health care.
- Determine healthcare trends.
- Plan for future healthcare needs.

### Step 5  ICD-10

- After 30 years, the ICD-9 needs to be replaced. The terminology and classification of some conditions are outdated and/or obsolete. These outdated codes produce inaccurate and limited data. And, the limits of the categories result in an increasing lack of specificity. Finally, the ICD-9-CM hinders comparisons with international data. It’s clear that the ICD must be flexible enough to adjust for emerging diagnoses and procedures and exact enough to identify precise diagnoses and procedures.

In 1989, the WHO prepared the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10)*, which was released in 1994. The United Kingdom adopted it in 1995, followed by the Nordic countries of Denmark, Finland, Iceland, Norway and Sweden from 1994 through 1997. Each year, another country adopted the ICD-10: France (1997), Australia (1998), Belgium (1999), Germany (2000) and Canada (2001). On January 15, 2009, the Department of Health and Human Services (HHS) released the final rule for the implementation of the *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM) and the *International Classification of Diseases, 10th Revision, Procedural Classification System* (ICD-10-PCS). The final rule established the upcoming ICD-10 (both CM and PCS) transition.


On April 17, 2012, the HHS released a notice to postpone the date of compliance until October 1, 2014.
Impact for Coders

How does this affect you? Is it a waste of time to learn coding from the ICD-9-CM? Absolutely not! Per U.S. government mandate, the ICD-9-CM will be used by all medical service providers up until midnight on September 30, 2014. The ICD-10-CM will be implemented on October 1, 2014. To make sure you have the information about the current industry standard, we will focus on discussing the ICD-9-CM in your program for the immediate future. Once you are familiar with the coding process with the ICD-9-CM, it’ll be a smooth transition to the ICD-10-CM. You can get reference material in the format of an ICD-10-CM supplement available for purchase online through our bookstore. This supplement is optional and is not a required part of your program.

Step 6  ICD-9-CM vs. ICD-10-CM

Let’s briefly review the two different code sets and compare them.

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes are 3 to 5 characters in length</td>
<td>Codes are 3 to 7 characters in length</td>
</tr>
<tr>
<td>Approximately 15,000 codes</td>
<td>Approximately 68,000 codes</td>
</tr>
<tr>
<td>First digit may be alpha (E or V) or numeric; digits 2 to 5 are numeric</td>
<td>Digit 1 is alpha; digits 2 through 7 are alpha or numeric</td>
</tr>
<tr>
<td>Limited space for new codes</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Lacks details</td>
<td>Very specific</td>
</tr>
<tr>
<td>Lacks laterality, which means left, right, or both sides is not defined (For example, with the ICD-9-CM, you might know that a patient’s arm is broken, but you don’t know if it was the right or left or even both arms.)</td>
<td>Has laterality (For example, the ICD-10-CM identifies which arm, such as right, left or both, the patient broke.)</td>
</tr>
<tr>
<td>Difficult to analyze data due to non-specific codes</td>
<td>Specificity improves coding accuracy and depth of data for analysis</td>
</tr>
<tr>
<td>Codes are non-specific and do not adequately define diagnoses needed for medical research</td>
<td>Detail improves the accuracy of data used in medical research</td>
</tr>
<tr>
<td>Does not support the ability to share data because it is not used in other countries</td>
<td>Supports interoperability and the exchange of healthcare data among other countries and the United States</td>
</tr>
</tbody>
</table>

Now that you understand the need for the ICD-9-CM update, let’s pause for a quick review.
Step 7 Practice Exercise 23-1

Choose the best answer from the choices provided.

1. The ICD originally was used to track _____.
   a. new diseases
   b. mortality statistics
   c. clinical diagnoses
   d. population statistics

2. The Bertillon Classification of Causes of Death was first used in the Americas in which country? _____.
   a. United States
   b. Canada
   c. Mexico
   d. England

3. In 1946, the United Nations gave the responsibility for the ICD to the ___.
   a. World Heath Organization
   b. General Register Office of England and Wales
   c. International Statistical Institute
   d. International Statistical Congress

4. The United States adopted the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), is based on the ICD-9, in _____.
   a. 1946
   b. 1977
   c. 1967
   d. 1979

5. The ICD-9-CM consists of a(n) _____.
   a. tabular list
   b. alphabetical index and procedural index
   c. procedure index and tabular list
   d. tabular list, alphabetical index and procedure alphabetic index and tabular list
Determine the correct answer to complete each sentence.

6. A primary use of medical codes is to ______________________________ to the insured the reason for a patient’s medical visit.

7. Medical coding is a __________________________________________ for research, grants and financial analysis.

8. The *ICD-9-CM* outdated codes produce ______________________________ ______________________________.

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**Step 8  Review Practice Exercise 23-1**

- Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

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**Step 9  Organization of Volume 2, Alphabetic Index to Diseases *ICD-9-CM***

- Before you really can begin coding, you need to understand the format and organization of the *ICD-9-CM* manual, Volumes 1 and 2. The manual itself is available from a number of different sources and publishers. Each publication presents the information in the *ICD-9-CM* manual in a slightly different format. For our purposes, all references to the *ICD-9-CM* manual, general arrangement and specific examples used are based on Ingenix, Inc.’s 2013 Professional *ICD-9-CM* for Physicians, Volumes 1 & 2 © 2012.

You may see an *ICD-9-CM* manual that contains three volumes, but, in this program, we will use only Volumes 1 and 2. You will *not* use Volume 3 because it is used by hospitals for coding of inpatient procedures. **Inpatients** are those people admitted to a hospital or clinic who require at least a 24-hour stay for treatment. **Outpatients** receive treatment but do not necessarily need to stay for a 24-hour period at a medical facility.
When you begin your search for diagnostic codes in the *ICD-9-CM*, you first look in the *Alphabetic Index to Diseases*, or Volume 2 of the *ICD-9-CM*. It is located first in the manual but is called Volume 2. Confusing, isn’t it? The *ICD-9-CM* originally was organized with Volume 1 before Volume 2, but medical coders found they always started their search in Volume 2 to locate codes. So, Volume 2 is presented first to make the manual user friendly.

Volume 2 is divided into three sections. Each section lists topics with a title and a description of the information that will be covered. The following are the names of these three sections and a brief description of each section’s contents:

- **Section 1—*Index to Diseases***—An alphabetical list of diseases with the corresponding diagnostic codes.
- **Section 2—*Table of Drugs and Chemicals***—An alphabetical table listing substances to identify poisoning and external causes of adverse effects of drugs and other chemical substances.
- **Section 3—*Index to External Causes***—An alphabetical list of external causes of injury and poisoning.

Think of this lesson as your guide to understanding the *ICD-9-CM*. Right now, take time to locate these sections in Volume 2 of your *ICD-9-CM* coding manual. As you become familiar with your manual, coding will get easier and become more fun!

**Main Terms**

The first important skill to develop in medical coding is the ability to identify *main terms* for the diagnosis in a *medical statement*. A *medical statement* is information a provider documents in a patient’s medical record, such as, “The patient is diagnosed with arm pain.” You assign codes for the patient’s chief complaint or symptoms when there is no other definitive diagnosis or cause listed for the condition. When you code a record that contains two or more equal diagnoses, the *principal* or *primary diagnosis* is the one for which the *main treatment* was given.

Main terms appear in boldface type in Volume 2 of the *ICD-9-CM* and are flush with the left margin of each column for easy reference. **Main terms** represent items such as the following:

- Diseases - for example: influenza, bronchitis
- Conditions - for example: fatigue, fracture, injury, complication
- Nouns - for example: disease, disturbance, syndrome
- Adjectives - for example: double, large, kink
Anatomical sites, which are locations on the body, are not used for main terms. For example, you will find bronchial asthma under the disease term asthma, not under the anatomical term bronchial. When you look up the term asthma in the Alphabetic Index of Diseases—or Volume 2—the first entry you’ll find for the main term is as follows:

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Asthma, asthmatic (bronchial) (catarrh) (spasmodic) 493.9
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The terms you see in parentheses after the word asthmatic are called nonessential modifiers. We will discuss nonessential modifiers later when we talk about the punctuation used in the ICD-9-CM.

Let’s practice identifying main terms. Try coding the statement, “The patient is diagnosed with abdominal pain.” Begin by asking yourself, “What did the doctor document as being wrong with the patient?” Well, you know that the patient has abdominal pain. Now, where do you begin your search—abdominal or pain? You know that main terms in the ICD-9-CM are not listed under anatomical sites, so you can rule out looking under the term abdomen. Pain is a condition, so you would look there first. Following is an example of an entry from the Alphabetic Index to Diseases in the ICD-9-CM. You can see how the main term pain is listed.

```
main term—Pain(s) (see also Painful) 780.96

abdominal 789.0 ✓
acute 338.19
  due to trauma 338.11
  postoperative 338.18
  post-thoracotomy 338.12
adnexa (uteri) 625.9
  alimentary, due to vascular insufficiency 557.9
```

**Subterms**

In the example, the term abdominal describes where the pain is located in the body. Locating abdominal is the second step in determining what code to use. The first step was to identify pain as the main term. In this example, abdominal is a subterm. All terms listed below the main terms are called subterms. Subterms are modifiers of main terms and always are indented two spaces to the right below main terms. Each subterm has its own line, and all subterms are arranged in alphabetical order. Subterms describe the following three categories:

- Site—location on the body
- Cause—reason
- Clinical type—form
Look at the following examples:

The diagnosis is: viral infection
The main term is: infection
The subterm is: viral

The main term, infection, is a condition. The subterm, viral, is the clinical type or form of infection. Let’s try one more:

The diagnosis is: Addison’s Disease
The main term is: Disease
The subterm is: Addison’s

The main term, disease, is a noun—a person, place or thing. The subterm, Addison’s, tells you the type of disease.

Other Important Terms

Carryover lines appear in the manual because there is a limit to the number of words that can fit on a single line of print in the Index. In entries that don’t fit on a single line, the extra words carry over to the next line and usually are indented an additional four spaces. The following demonstrates a carryover line:

Rubella (German measles) 056.9 [main term]
complicating pregnancy, childbirth
or puerperium 647.5 [carryover line]

Let’s take a moment to talk about nonessential modifiers. Nonessential modifiers follow a main term or subterm in parentheses. However, when you are dealing with nonessential modifiers, the presence or absence of the information in parentheses has no bearing on your selecting the correct code. In other words, the information does not necessarily need to be documented in order for you to determine which code is correct for the diagnosis. An example of a main term with nonessential modifiers follows:

Pneumonia (acute) (Alpenstich) (benign) (bilateral) (brain) (cerebral)

Do you remember talking about eponyms in the medical terminology lessons? Eponyms are diseases or operations named for persons. The main terms for eponyms are found in the Index to Diseases under the eponym itself or under the main term, such as Disease, Syndrome and Disorder. For example, if you look in the index under the eponym Alzheimer’s disorder, you find the following:

Alzheimer’s
disease or sclerosis 331.0

If you look under the main term Disease, you’ll find:

Disease, diseased
Alzheimer’s—see Alzheimer’s

In this case, you would go back to Alzheimer’s in the Index to Diseases to locate code 331.0. We will talk about see and see also later in this lesson.
Terms not listed in the Tabular List, or Volume 1 of the ICD-9-CM, occasionally are provided only in Volume 2, the Alphabetic Index to Diseases. In these cases, only similar terms are included in the Tabular List, and you should follow the Alphabetic Index to Diseases for the correct code. An example of a term listed in Volume 1, the Tabular List but listed differently in Volume 2, Section 1, Index to Diseases, follows:

780.79 Other malaise and fatigue
   Asthenia NOS
   Lethargy
   Postviral (asthenic) syndrome
   Tiredness

However, in Volume 2, Index to Diseases, you find this term:

Listlessness 780.79

Although listlessness is assigned a code, 780.79, in Volume 2, Section 1, the Index to Diseases, that term is not listed in Volume 1, the Tabular List description under the same code. In this case, you should note that similar terms were shown in the Tabular List; however, trust the guidance of the Index to Diseases and use the code indicated there. You will find that the Tabular List may not have the exact description as the medical record. It is up to you, the healthcare document specialist, to decide which code is most specific for a diagnosis. Don’t worry, your upcoming lessons will prepare you to do that, but remember to trust the guidance that the Index to Diseases provides.

 bütün 10 Organization of Volume 1, Tabular List

Volume 1 of the ICD-9-CM is referred to as the Tabular List and is presented second in the manual. The Tabular List is a numerical index of specific diagnosis codes. This list is cross-referenced with diseases and injuries according to the anatomical system affected and/or the etiology, which is the cause of the disorder. Volume 1 is divided into seven parts: three sections and four appendices. The three sections consist of codes 001-999.9, the V codes and the E codes. Following those are the four appendices which we will discuss later in this lesson. Always be familiar with the organization of the coding manual you are using because the format will vary according to publishers.
The first section of Volume 1 contains 17 chapters. Each chapter contains the following subject matter and the designated range of related ICD-9-CM codes in parentheses:

Chapter 1  Infectious and Parasitic Diseases (001–139)
Chapter 2  Neoplasms (140–239)
Chapter 3  Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders (240–279)
Chapter 4  Diseases of the Blood and Blood-Forming Organs (280–289)
Chapter 5  Mental, Behavioral and Neurodevelopmental Disorders (290–319)
Chapter 6  Diseases of the Nervous System and Sense Organs (320–389)
Chapter 7  Diseases of the Circulatory System (390–459)
Chapter 8  Diseases of the Respiratory System (460–519)
Chapter 9  Diseases of the Digestive System (520–579)
Chapter 10 Diseases of the Genitourinary System (580–629)
Chapter 11 Complications of Pregnancy, Childbirth, and the Puerperium (630–679)
Chapter 12 Diseases of the Skin and Subcutaneous Tissue (680–709)
Chapter 13 Diseases of the Musculoskeletal System and Connective Tissue (710–739)
Chapter 14 Congenital Anomalies (740–759)
Chapter 15 Certain Conditions Originating in the Perinatal Period (760–779)
Chapter 16 Symptoms, Signs, and Ill-Defined Conditions (780–799)
Chapter 17 Injury and Poisoning (800–999)
Each of the 17 chapters in Volume 1, *Tabular List*, contains the following subdivisions:

- **Sections**—Sections, are groups of three-digit categories that represent a single disease entity or a group of similar or closely related conditions. For example, in Volume 1 you’ll find that codes 001-009 represent the category of Intestinal Infectious Diseases.

- **Categories**—Within sections, each three-digit category represents a single disease entity or a group of similar or closely related conditions. As you look at Intestinal Infectious Diseases (001-009) in Volume 1, you’ll see categories such as 003 for Other salmonella infections and 004 for Shigellosis.

- **Subcategories**—Within categories, each fourth-digit subcategory provides specific information regarding the cause of death or etiology, site, or **manifestation**—the signs or symptoms of an illness. You cannot assign a three-digit code if a category has fourth digits available. You must assign the most specific code possible—the subcategory if it is available. For example, you would use the four-digit code 003.1 for Salmonella septicemia in Volume 1, the *Tabular List*.

- **Fifth-Digit Subclassifications**—A fourth-digit subcategory sometimes is expanded to the fifth-digit level to provide more specific information. These **fifth-digit subclassifications**, appear in four locations: at the beginning of a chapter, at the beginning of a section, at the beginning of a three-digit category, or in a four-digit subcategory. The fifth-digit subclassification provides very specific information, such as the site of lymph nodes involved in a diagnosis, and you must assign it if it is available. In Volume 1 you see a fifth-digit code 003.21 for Salmonella meningitis.

- **Residual Subcategories**—These subcategories are codes with titles of **Other** and **Unspecified**. **Residual subcategories** classify conditions that are not assigned a separate subcategory. This ensures that a code can be assigned for every disease. Residual subcategories titled **Other** often have an 8 as the fourth digit; for example, 003.8 **Other specified salmonella infections**. Residual subcategories titled Unspecified usually are assigned the fourth digit of 9, for example, 003.9 **Salmonella infection, unspecified**.

Two supplementary classifications are provided in addition to the main classification for diseases and injuries. These classifications contain alphanumerical codes, or letters and numbers, whereas the other classifications only are numeric. These **supplementary classifications** can be V codes or E codes.

Now let’s pause to reinforce your understanding of the organization of the *ICD-9-CM*.
Choose the best answer from the choices provided.

1. The *ICD-9-CM for Physicians* manual is divided into ____ volumes.
   a. 12
   b. two
   c. three
   d. 10

2. The *ICD-9-CM for Physicians* manual lists ____ codes.
   a. fundamental
   b. procedural
   c. treatment
   d. diagnostic

3. Main terms appear in ____ type.
   a. italicized
   b. boldface
   c. underlined
   d. Times Roman

4. Information in parentheses following a main term is called a(n) ____ , and it has no effect on selecting the correct code.
   a. nonessential modifier
   b. essential modifier
   c. tabular reference
   d. alphabetic code

5. The ____ uses a numerical index cross-referenced with diseases and injuries according to the anatomical system affected and/or etiology.
   a. Appendix
   b. Glossary
   c. *Alphabetic Index*
   d. *Tabular List*
6. A healthcare document specialist must assign the most ____ code possible—a subcategory, if it is available.
   a. obvious
   b. basic
   c. specific
   d. likely

7. Supplementary classifications might be ____ codes.
   a. V or E
   b. J or K
   c. V or J
   d. E or K

8. ____ classifications ensure that there is always a code for every disease.
   a. Late effect
   b. Residual
   c. Supplementary
   d. Rudimentary

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**Step 12  Review Practice Exercise 23-2**

- Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

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**Step 13  Introduction to Coding Guidelines**

- Near the beginning of your *ICD-9-CM* manual is a section titled *Coding Guidelines: ICD-9-CM Official Guidelines for Coding and Reporting*. This section contains coding guidelines, conventions and chapter-specific guidelines. Take a few moments to find this section in your manual. Remember that there’s no need to memorize the guidelines—they will always be available to you in your manual. However, it’s important to know where to find this information and how to use this resource. When you begin coding in upcoming lessons, you will need to refer to these guidelines for additional information regarding certain diseases and how to code them.

There is no need to memorize the guidelines, as they will always be available in your manual.
The Coding Guidelines section begins with a Table of Contents that divides the material into four parts. For now, focus on Section IV of the Coding Guidelines, Diagnostic Coding and Reporting Guidelines for Outpatient Services. This section includes specific guidelines for coding outpatient services. (Keep in mind that outpatients are patients who do not stay overnight in a healthcare facility.)

The ICD-9-CM manual is printed each year before the guidelines are updated. Therefore, the manual you have covers the previous year’s guidelines. For instance, if you have the ICD-9-CM 2013 edition, you’ll find the 2012 guidelines.

This time gap means you must always be on the lookout for updated information as it becomes available. The coding resources you just learned about will help you out!

Who Develops Diagnostic Coding Guidelines?
A team of four organizations is actively involved with in-depth coding principles and practices. The groups include the Centers for Medicare and Medicaid Services, or CMS; the National Center for Health Statistics; the American Health Information Management Association, or AHIMA; and the American Hospital Association, or AHA. These organizations cooperatively developed and approved the “Diagnostic Coding and Reporting Guidelines for Outpatient Services,” which is Section IV in your ICD-9-CM manual. The Editorial Advisory Board of the AHA Coding Clinic publications this document.

You will find references to the AHA in the Tabular List, or Volume 1, under many code descriptions.

As you continue to become more familiar with your ICD-9-CM manual, you will find references to the AHA in the Tabular List, or Volume 1, under many code descriptions. Take a look at this example:

275.4 Disorders of calcium metabolism
AHA: 4Q, ’97, 33
AHA: 4Q, '97, 33 refers you to the AHA Coding Clinic for ICD-9-CM a publication that discusses official advice concerning coding topics. It is a quarterly newsletter published by the American Hospital Association. As a student, you do not need to have access to this publication to complete this program, but we do want you to be aware of these references.

Now let’s get familiar with the cross-reference terms you may encounter.

**Cross-reference Terms**

Volume 2, the *Alphabetic Index to Diseases* uses cross-reference terms to instruct you to look in another place before you assign a code. These cross references provide possible modifiers for a term or its synonyms. Follow the cross references to the correct code when you don’t find the diagnosis under the first term you locate. The following three types of cross reference terms are used: see, see also and the see category. Before you look more closely at each term and its use, be advised that you will be provided with examples to assist in understanding the ICD-9-CM's meaning. You might not have enough information to determine exact coding.

**See**

The *see* cross reference points you to another term. You will follow the *see* cross reference to ensure that you assign the correct code to a diagnosis. The following example from Volume 2 shows you how to use the *see* cross reference:

**Roentgen ray, adverse effect**—*see* Effect, adverse, x-ray

The *see* cross reference instructs you to go to *Effect, adverse* and go down the list of subterms until you come to *x-ray*. This is what you will find:

- **Effect, adverse** NEC
  - •
  - •
  - •

  x-rays NEC 990
dermatitis or eczema 692.82

Cross references provide possible modifiers for a term or its synonyms.
See Also

*See also* indicates that additional information about the term and code is available under the referenced term in another place in the *Alphabetic Index to Diseases*. The *see also* cross reference gives you an additional diagnosis and code when the main term or subterm is insufficient. The additional information in the *see also* cross reference helps you select the correct code, so follow this instruction to ensure coding accuracy. Here's an example from Volume 2 that includes the *see also* cross reference:

**Tuberculoma — see also Tuberculosis**

- brain (any part) 013.2
- meninges (cerebral) (spinal) 013.1
- spinal cord 013.4

When you go to the *Tuberculosis* main term, you will find a very long list of subterms to review. You must determine whether any of them is appropriate to include based on the diagnosis with which you are working.

It’s also important to use multiple codes to identify all components of a diagnosis when a single code does not fully describe a given condition. The *see also* cross reference helps you do this. However, medical record documentation must mention the presence of all the elements of any code you use. Always ask the physician involved if you are unsure about assigning multiple codes. We will discuss multiple codes further in a moment.

See Category

The *see category* cross reference directs you to an additional three-digit category in Volume 1, *Tabular List*. If the *see category* is included with a term, you cannot assign the correct code unless you follow this instruction and read the applicable notes in Volume 1. For example, in Volume 2 under the main term *Hemiplegia* with a code of 342.9, the subterm thrombotic (current), late effect, includes a *see category* directing you to *Late effect(s) (of) cerebrovascular disease*:

**Hemiplegia** 342.9

- 
- 
- 

thrombotic (current) (see also Thrombosis, brain) 434.0

**General adjectives**, or *descriptive words*, such as acute and hereditary, appear as main terms, usually with a cross reference to *see conditions or see also*. In addition, if anatomic sites such as *arm or neck* appear as main terms, there will be a cross reference to *see conditions or see also*. 
Includes and Excludes

The *ICD-9-CM* manual uses [INCLUDES] and [EXCLUDES] instructional notes to help you assign diagnostic codes at the highest level.

The [INCLUDES] box appears immediately after a three-digit code’s title to provide additional information regarding the category’s contents. The *Tabular List* uses inclusion notes to define a category in greater detail. Look at the following example from Volume 1:

633      Ectopic pregnancy

     [INCLUDES] ruptured ectopic pregnancy

The [EXCLUDES] box appears in a listing when terms are not to be coded under the referenced term; such terms are listed somewhere else. A code reference is provided in parentheses directing you to the correct term or area. The *Tabular List* uses exclusion notes, and you can see them easily because [EXCLUDES] is printed in reverse type with a box around it to define the category in greater detail. Look at the following example from Volume 1:

711      Arthropathy associated with infections

     •

     [EXCLUDES] rheumatic fever (390)

Notes

Notes, which give coding instructions, appear in Volume 1, the *Tabular List* and in Volume 2, the *Alphabetic Index to Diseases* of the *ICD-9-CM* manual. The length of the notes varies. Depending on where the notes are located, their appearance also varies. When notes are in Volume 2, they are boxed and italicized. Notes in Volume 1 are located at various levels of the classification system. The following examples show some notes from different parts of the *ICD-9-CM* manual and how these notes instruct you.

This note from Volume 2 gives you additional coding instructions and defines terms:

Injury 959.9

Note—For abrasion, insect bite (nonvenomous), blister, or scratch, see Injury, superficial. For laceration, traumatic rupture, tear, or penetrating wound of internal organs, such as heart, lung, liver, kidney, pelvic organs, whether or not accompanied by open wound in the same region, see Injury, internal.

For nerve injury, see Injury, nerve.

For late effect of injuries classifiable to 850-854, 860-869, 900-919, 950-959, see Late, effect, injury, by type.
This note from Volume 1 instructs you to assign a fifth digit because subclassification categories are available:

831 Dislocation of shoulder

| EXCLUDES | sternoclavicular joint (839.61, 839.71)  
|          | sternum (839.61, 839.71) |

The following fifth-digit subclassification is for use with category 831:

- 0 shoulder, unspecified
  - Humerus NOS
- 1 anterior dislocation of humerus
- 2 posterior dislocation of humerus
- 3 inferior dislocation of humerus
- 4 acromioclavicular (joint)
  - Clavicle
- 9 other
  - Scapula

**Multiple Coding**

Multiple coding simply means using more than one code to identify a diagnosis as accurately as possible. Several instructional phrases indicate that you are required to use multiple codes. The following examples instruct you in multiple coding:

Use additional code if desired—Volume 1, the *Tabular List* includes this notation, which instructs you to use an additional code to provide a more complete picture of the diagnosis or procedure. You should ignore the words *if desired*—use additional codes when this multiple coding note is provided as long as the documentation supports the code.

When you see an instruction at the beginning of a chapter, that instruction applies to all the codes in the chapter. Instructions also may appear at the beginning of a section or a category. In the following example from Volume 1, the notation instructs you to identify other aspects of the disease, such as manifestation, cause, associated condition and nature of the condition.

358.2 Toxic myoneural disorders

Use additional E code to identify toxic agent

**Code first underlying disease**—This instruction identifies diagnoses that are not primary (or principal) and are incomplete when they are used alone. Only Volume 1, the *Tabular List*, uses this instruction. First, record the underlying disease, which often is the second line in the code. Then record the primary disease or first line in the code.
Look at the following example from Volume 1:

595.4  Cystitis in diseases classified elsewhere
Code first underlying disease, as:
actinomycosis (039.8)
amebiasis (006.8)
bilharziasis (120.0–120.9)
Echinococcus infestation (122.3, 122.6)

In this example, if amebiasis is documented as the underlying disease, you first would code amebiasis (006.8), and then Cystitis in diseases classified elsewhere 595.4. You will code: 006.8 595.4

Connecting Words

Connecting words are words that connect main terms with subterms. These words connect the terms and subterms to show that there is a relationship between the main term and an associated condition or etiology. The following words are examples of some connecting words used in Volume 2, the Alphabetic Index to Diseases:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>associated with</td>
<td>during</td>
<td>secondary to</td>
</tr>
<tr>
<td>complicated (by)</td>
<td>following</td>
<td>with</td>
</tr>
<tr>
<td>due to</td>
<td>in</td>
<td>with mention of</td>
</tr>
<tr>
<td>of</td>
<td>without</td>
<td></td>
</tr>
</tbody>
</table>

In the example that follows, the connecting terms are italicized to demonstrate their use:

883  Open wound of finger(s)
| INCLUDES | fingernail
|          | thumb (nail)
883.0  Without mention of complication
883.1  Complicated
883.2  With tendon involvement
Abbreviations

The *ICD-9-CM* manual frequently uses the following two abbreviations with which you need to be familiar:

- **NEC**—NEC means **not elsewhere classifiable** in the *ICD-9-CM* manual. This abbreviation is to be used only when there is not enough information available to code the term more specifically, even when a diagnostic statement was very specific; and only with ill-defined terms included in Volume 1, the *Tabular List*, to warn you that specified forms of the condition are classified differently. In such cases, use NEC codes only if more precise information is not available.

- **NOS**—NOS means **not otherwise specified**. Use NOS codes only when the diagnosis statement does not provide enough information.

These abbreviations are for your reference only. You will not record them with the assigned code.

Symbols

Symbols often are used in the *ICD-9-CM* manual to identify a code number that is new since the previous edition of the manual. Symbols also might be used to indicate a change in a code’s description. Diagnostic codes that require a fourth or fifth digit are marked with a symbol. Some codes are marked to indicate a footnote that is applicable to all subdivisions in the code.

We will be discussing, in detail, some of the symbols. In the front of your *ICD-9-CM* manual, you will find more information about these symbols under the heading *Additional Conventions, Symbols and Notations*. These symbols, just like the abbreviations, are for your reference only and will not be recorded with the assigned code.

Punctuation

The *ICD-9-CM* manual uses the following punctuation symbols:

- **Parentheses ( )**

  Parentheses enclose supplementary information; this information consists of words whose presence or absence in the statement of a disease does not affect the code number. For example, in Volume 2, *Alphabetic Index to Diseases*, *erythroblastic anemia* is included as supplemental information, but the terms have no bearing on the code used:

  **Dameshek’s syndrome** *(erythroblastic anemia)* 282.49
Square Brackets []

Brackets enclose synonyms, alternative wordings or explanatory phrases. For example from Volume 1, the Tabular List, the bracketed information—[and kyphoscoliosis]—is included for clarification:

737.3 Kyphoscoliosis and scoliosis
DEF: Kyphoscoliosis: backward and lateral curvature of the spinal column; it is found in vertebral osteochondrosis.
DEF: Scoliosis: an abnormal deviation of the spine to the left or right of midline.

737.30 Scoliosis [and kyphoscoliosis], idiopathic

Slanted Brackets / /

Slanted brackets, or brackets that are italicized, appear in Volume 2, Alphabetic Index to Diseases, to indicate that another code is required in addition to the first code listed. You must record both codes in the order they are given in the volume, but you will not include the slanted brackets when recording the code. For example, in Volume 2, if the diagnosis is diphtheritic epididymitis, you must code both the 032.89 and the 604.91—in that order:

Epididymitis (nonvenereal) 604.90
  with abscess 604.0
  *
  *
  diphtheritic 032.89 [604.91]

You will code: 032.89 604.91

Colon :

Volume 1, the Tabular List, uses a colon after an incomplete term that requires an adjective, or descriptor. For example, in Volume 1, if hypostatic is included in the diagnosis without either of the terms below it, hypostatic would not be listed under 514. See the example below:

514 Pulmonary congestion and hypostasis
  Hypostatic:
    bronchopneumonia
    pneumonia

Hypostatic is a descriptor meaning congestion of blood in a part of the body due to impaired circulation. Since hypostatic is an adjective (descriptor), it must be followed by a noun identifying the etiology, or cause of the condition. Note: If the pneumonia were not hypostatic, it would be coded differently.
Braces}

**Braces** enclose a series of terms, each of which is changed by the statement to the right of the brace. For example, in Volume 1:

755.2 Reduction deformities of upper limb
   755.20 Unspecified reduction deformity of upper limb
   [Ectromelia NOS]
   [Hemimelia NOS] of upper limb

- A bullet indicates a new code.

- A triangle in the *Tabular List* indicates that the code title has been revised. In the *Alphabetic Index* the triangle indicates that the code has been changed.

- These symbols appear at the beginning and at the end of a section of new or revised text.

## Coding Enhancements Included in the Ingenix ICD-9-CM System:

- This symbol indicates that additional digits are required and are found in Volume 2, *Alphabetic Index to Diseases*.

- This symbol indicates a definition of a disease. The definition will appear in blue type in the *Tabular List*.

---

In the *Tabular List*, the symbols listed below indicate when additional digits are required:

- This symbol indicates that the code requires a fourth digit.
- This symbol indicates that the code requires a fifth digit.

## More About Fourth- and Fifth-Digit Coding

The following example is found in Volume 2, Section 1, *Index to Diseases*:

**Milk-leg** (deep vessels) 671.4

In the *Index to Diseases*, you will find a check box like this at the end of some codes to indicate that additional digits are required. As a healthcare document specialist, you will look in Volume 1, the *Tabular List*, to choose the appropriate digits to complete the assigned code.
When coding for diagnoses, always check codes in the *Tabular List*. A ✔️ **4th** or ✔️ **5th** box in front of a three-digit code indicates that a fourth or fifth digit is needed to complete the code. Fourth-digit codes are found within the three-digit code category. Designated three-digit code categories include four digits, so it is important to keep looking after you locate the three-digit code. Look at this example taken from the *Tabular List*:

✔️ **4th** 331 Other cerebral degenerations  
   331.0 Alzheimer’s disease  
   ✔️ **5th** 331.1 Frontotemporal dementia

Because code 331 has a ✔️ **4th** box located to the left, it cannot be used by itself. A code from the codes listed in that category must be chosen for effective coding. Notice that only the subclassification, 331.1-Frontotemporal dementia, requires a fifth digit. Once again, you will code only the digits and not the symbols found in front of the codes.

An example of a fourth-digit subclassification box is found in the *Tabular List* at the beginning of the section titled *Other Pregnancy With Abortive Outcome (634-639)*. This information guides you to use digits .0-.9 as fourth digits for code categories 634-638. Within the *ICD-9-CM* manual, the boxed text is shaded in the *Tabular List*.

Remember that fifth-digit subclassifications can be found in several areas of the *ICD-9-CM* Volume 1, the *Tabular List*.

**At the Beginning of a Chapter**

Take a look at *Chapter 13 Diseases of the Musculoskeletal System and Connective Tissue (710-739)*. Notice the shaded box just below the chapter title that contains fifth-digit subclassifications 0-9. This area states that we can use these digits for categories 711-712, 715-716, 718-719, and 730. Be sure to look back to the chapter beginning to see whether there are fifth digits applicable to the codes that you are assigning.

**At the Beginning of a Section**

Look in the *Tabular List* at *Complications Mainly Related to Pregnancy (640-649)* in Chapter 11. This is a good example of fifth-digit subclassifications being located at the beginning of a section. This information tells us to use digits 0-4 with code categories 640-649.
At the Beginning of a Three-digit Category

Locate category **715 Osteoarthrosis and allied disorders** in the *Tabular List*. Do you see the shaded box after code 715 that includes the fifth-digit subclassifications? These classifications are for use with category 715 only. In coding a diagnosis of osteoarthrosis of the shoulder, you would select **715.9 Osteoarthrosis, unspecified whether generalized or localized** and add the fifth-digit “1” for shoulder region, making a complete code **715.91**.

In a Four-digit Subcategory

Look at this example taken from the *Tabular List*:

- **4th** 331 Other cerebral degenerations
  - 331.0 Alzheimer’s disease
  - **5th** 331.1 Frontotemporal dementia
    - 331.11 Pick’s disease
    - 331.19 Other frontotemporal dementia
  - 331.2 Senile degeneration of brain

Because there is a **4th** box listed in front of code 331, the healthcare document specialist knows to choose a four-digit code from the *Tabular List*. As mentioned earlier, code **331.1** has a **5th** box in front of it. If you look at the indented codes under code 331.1, you will find two choices: **331.11 Pick’s disease** and **331.19 Other frontotemporal dementia**. If you were coding for Pick’s disease, you could not use 331.1 but instead must use 331.11 for complete and accurate coding. Note, as well, that if the condition was specified as frontotemporal dementia, without mention of Pick’s disease, you would use the code 331.19.

By paying close attention to the enhancements in the *Tabular List*, you can accurately locate the fifth-digit subclassification information to assign a fifth digit.

Not all codes have fourth or fifth digits, but when they are available, it is the healthcare document specialist’s responsibility to include them for accurate and specific coding.

Also noteworthy is the legend at the bottom of each page in the *Tabular List*. Being familiar with the terms and symbols at the bottom of each page will help you understand what you are reading in the *Tabular List*. Manuals may differ according to publisher, but if you develop detective-type skills and look for all the clues that are provided, you will do your best in the healthcare field!

Once again, let’s review what you’ve learned about the conventions the *ICD-9-CM* coding manual uses before you move on.
**Step 14 Practice Exercise 23-3**

- Choose the best answer from the choices provided.

1. When a diagnosis is not principal and is used alone, you should code the _____ first.
   a. primary disease
   b. underlying disease
   c. always secondary disease
   d. usually secondary diagnosis

2. ICD-9-CM coding uses the **INCLUDES** and **EXCLUDES** instructional notes to assist healthcare document specialists in assigning diagnostic codes at the _____ level.
   a. lowest
   b. median
   c. highest
   d. most obvious

3. Notes, when found in the *Index to Diseases*, are _____.
   a. boxed and italicized
   b. boldface and circled
   c. boxed and boldface
   d. underlined and highlighted

4. In the multiple coding instruction, “Use additional code, if desired,” you should ignore the words _____.
   a. use additional
   b. additional code
   c. use code
   d. if desired

5. NEC means _____.
   a. never ever code
   b. not elsewhere classifiable
   c. not enough classification
   d. never endeavor coding
6. NOS means _____.
   a. never occupied specialty
   b. nine other subclassifications
   c. not otherwise specified
   d. not often subdivided

7. A note might instruct you to assign a(n) ____ digit because subclassification categories are available.
   a. third
   b. fourth
   c. additional
   d. fifth

**Step 15  Review Practice Exercise 23-3**

- Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

**Step 16  ICD-9-CM Terminology**

- Many—if not most of—the terms used in the *ICD-9-CM* manual have other definitions and meanings when they are used elsewhere. You need to be familiar with terms that are used throughout the *ICD-9-CM* manual as they relate to medical coding. This will help you code a medical diagnosis correctly.

The following definitions are specific to their use in the *ICD-9-CM* coding manual:

- **Acute**—Short and severe; for example, a new injury or disease.
- **Adverse**—Any unfavorable, unintended response to a drug that occurs with proper dosage.
- **Aftercare**—A visit to the medical facility for something planned in advance; for example, the removal of sutures (stitches).
- **Chronic**—To continue over a long period of time or recurring frequently.
- **Concurrent**—When a patient is treated simultaneously by more than one physician for different care conditions.
- **Foreign body**—An object not naturally occurring in the human body.
- **Late effect**—A residual effect after the acute phase of an illness or injury has ended.
- **Manifestation**—The characteristic signs or symptoms of an illness.
- **Residual**—The long-term conditions resulting from a previous acute illness or injury.
When both an acute disease and a chronic disease coexist and no single code exists to code both diseases together, code the acute disease as the principal diagnosis and the chronic disease as the secondary, or coexisting, condition. Here’s an example. The physician documents acute and chronic thyroiditis. With the help of your medical terminology knowledge, you can figure out that this condition is inflammation of the thyroid gland. Now, look in your ICD-9-CM manual’s Index to Diseases for thyroiditis. Then look for the subterms acute and chronic. You will find codes 245.0 Acute thyroiditis and 245.8 Chronic thyroiditis. Go to the Tabular List to verify these codes. You will code the acute condition first, listing code 245.0, and then code 245.8.

A late effect is a residual condition that occurs after the acute phase. Late-effect categories are three-digit categories, and they can require additional digits. When you code a late effect you generally assign two codes: the residual effect and the cause of the late effect. Sometimes a late-effect code has been expanded to a fourth or even fifth digit to include the manifestation or residual effect, and only one code is needed. Remember when you code late effects that there is no time limit between the acute phase and the late effect. In other words, some period of time can pass between the acute phase of a condition and the point at which the late effect or residual condition is diagnosed.

Let’s also review two terms we talked about in previous lessons—chief complaint and diagnosis. You recall that the chief complaint is the main reason a patient sees a doctor. For example, if a patient tells a doctor that he has a sore throat, that is the chief complaint. The diagnosis occurs when the doctor identifies what is wrong with a patient. In our example, the doctor might examine the patient and determine the patient has strep throat. This is the diagnosis.

One last important term with which you should be familiar is unconfirmed diagnoses. You do not code conditions when it is uncertain if they really exist. In other words, don’t code a condition until it has been determined to be the diagnosis. Unconfirmed diagnoses are suspected conditions, such as those that contain words like suspicion of, probable or likely.
It’s important that the healthcare document specialist does not play doctor and narrow down the choices of categories for the diagnosis. The concept of unconfirmed diagnoses affects how insurance companies reimburse, so it is important that you understand it. We’ll discuss how to deal with unconfirmed diagnoses later in your studies.

### Step 17  The Appendices

- Volume 1, the *Tabular List* of the *ICD-9-CM* manual contains four appendices. (Prior to October 1, 2004, there were five. Appendix B no longer exists.) As a group, these appendices provide additional information about the coding for a patient’s diagnosis, further define a diagnostic statement, provide clarification about new drugs and reference three-digit categories. Appendices are a good place to look when you need detailed information about a specific topic. Specifically, each appendix of the *ICD-9-CM* includes the following information.

#### Appendix A—Morphology of Neoplasms

**Morphology** is the study of neoplasms, or tumors. This appendix provides additional detailed information about coding diagnoses in this category, such as types of tumors, behavior of tumors and one-digit codes that are used to code neoplasms. The following is an example entry from Appendix A:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M975</td>
<td>Burkitt’s tumor</td>
</tr>
<tr>
<td>M9750/3</td>
<td>Burkitt’s tumor</td>
</tr>
</tbody>
</table>

These codes are optional and are usually used for statistical information only. The morphology codes will not be used in this program.

#### Appendix B—Glossary of Mental Disorders

This appendix was deleted October 1, 2004.

#### Appendix C—Classification of Drugs by AHFS List

This appendix is an alphabetized listing of drugs. A division of the American Hospital Formulary Service, or AHFS, publishes a coded listing of drugs. Appendix C is an alphabetized listing of those drugs and their ICD-9-CM codes. The AHFS codes in this appendix contain up to five digits and always begin with a number, followed by a colon and up to four more digits to provide adequate detail. The following is an example entry from Appendix C:

<table>
<thead>
<tr>
<th>AHFS List</th>
<th>ICD-9-CM Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>28:04 General Anesthetics</td>
<td>968.4</td>
</tr>
<tr>
<td>gaseous anesthetics</td>
<td>968.2</td>
</tr>
<tr>
<td>halothane</td>
<td>968.1</td>
</tr>
<tr>
<td>intravenous anesthetics</td>
<td>968.3</td>
</tr>
</tbody>
</table>

Appendix C is an alphabetized listing of drugs.
Appendix D—Industrial Accidents According to Agency

This appendix contains three-digit codes to classify occupational, or job-related, hazards. Seven categories contain all the occupational categories. You often will use these codes to track job-related causes of injury and death. The following is an example entry from Appendix D:

1 MACHINES
   11 Prime-Movers, except Electrical Motors
      111 Steam engines
      112 Internal combustion engines
      119 Others

Appendix E—List of Three-Digit Categories

Appendix E contains a list of all the three-digit codes in the *ICD-9-CM* manual. These codes are grouped by chapter to correspond with Chapters 1 through 17 of Volume 1, the *Tabular List*, diagnostic codes. The following is an example entry from Appendix E:

```
LIST OF THREE-DIGIT CATEGORIES
1. INFECTIOUS AND PARASITIC DISEASES
   Intestinal Infectious Diseases (001 - 009)
      001 Cholera
      002 Typhoid and paratyphoid fevers
      003 Other salmonella infections
      004 Shigellosis
      005 Other food poisoning (bacterial)
      006 Amebiasis
      007 Other protozoal intestinal diseases
      008 Intestinal infections due to other organisms
      009 Ill-defined intestinal infections
```

Wow! We’re almost done with this lesson. Stop for a moment to review what you learned about terminology and the *ICD-9-CM* manual’s appendices by completing the following Practice Exercise.
Step 18 Practice Exercise 23-4

Choose the best answer from the choices provided.

1. An object not naturally occurring in the human body is _____.
   a. a foreign body
   b. acute
   c. chronic
   d. a manifestation

2. A late effect is defined as a(n) ____ effect after the acute phase of an illness or injury has ended.
   a. aftercare
   b. concurrent
   c. chronic
   d. residual

For the following questions, match each appendix with the description of its contents.

3. _____ Appendix A
   a. Drug classification
4. _____ Appendix B
   b. Three-digit categories
5. _____ Appendix C
   c. Study of tumors
6. _____ Appendix D
   d. Was deleted in 2004
7. _____ Appendix E
   e. Job-related accidents

Step 19 Review Practice Exercise 23-4

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 20 The Steps to Correct Coding

So how do you actually begin to assign codes? Well, one of the first sections you will come across in the very beginning of the ICD-9-CM book is a section that outlines the 10 Steps to Correct Coding. Take a few moments to read these steps now.
Now that you’re familiar with the steps provided in the *ICD-9-CM* book, let’s break them down into the basics here. In later lessons, as you start to code, you will work through the following steps:

**Steps for Assigning Diagnostic Codes**

1. Identify the main terms in the diagnostic statement.
2. Locate each main term in the *Index to Diseases* and read any notes that appear with the main term.
3. Refer to any subterms indented under the main term in the *Index to Diseases*.
4. Look at abbreviations, cross-references, symbols and brackets.
5. Choose the tentative code you find in the *Index to Diseases*, Volume 2, then locate and determine the highest level of specificity in the *Tabular List*, Volume 1.
6. Read and use any instructional terms in the *Tabular List* as a guide. Look for [INCLUDES] and [EXCLUDES], notes and other instructional comments at the beginning of each chapter. Also, look at the three-digit code at the beginning of each category or group of codes that you are using within the chapter and check for additional instructions for the group.
7. Assign codes to their highest level of specificity, using the following guidelines:
   - Assign three-digit codes only when there are no four-digit codes within that category.
   - Assign a four-digit code only when there is no fifth-digit subdivision for that subcategory.
   - Assign a fifth-digit to the code for any subcategory for which a fifth-digit subclassification is provided.
   - Remember to continue coding the dictation until all conditions have been fully identified before assigning the code.
Outpatient Coding Tips

- If it is not documented, it did not happen.
- Do not assume anything.
- Terms such as possible, suspect, probable, rule out or consistent with are not assigned codes.
- Code symptoms only when a definitive diagnosis is not documented.
- Check with the physician if the information is unclear.

Practice Makes Perfect

The key to diagnosis coding is to ask yourself a series of questions. Let’s practice this process and the basic steps to coding. Take out your ICD-9-CM manual and follow along with the coding examples listed below. As you know from the basic steps to coding that you just learned, each example begins in the Index to Diseases, or Volume 2, and is verified in the Tabular List, or Volume 1. Don’t worry if you have a hard time following this series of steps at first. In the next lesson, you’ll walk through scenarios like this step-by-step as you begin to code on your own.

Diagnosis: noncardiac chest pain
What’s the main term? pain
Where’s the pain? chest
What’s the type of pain? noncardiac
The Volume 2 coding pathway is pain, chest, noncardiac 786.59
Now turn to the Tabular List and verify the code description for 786.59.

Note: Because noncardiac chest pain was specified, code 786.59 Chest pain, Other is used instead of an unspecified code. Trust the coding pathway you found in Volume 2, Index to Diseases, to lead you to the correct code.

Diagnosis: sprained ankle
What’s the main term? sprain
Where’s the sprain? ankle
Does it include the foot? no
The Volume 2 coding pathway is sprain, ankle 845.00
Turn to the Tabular List and verify the code description for 845.00.
Notice that the specific part of the ankle is not documented, and so you code for unspecified site using the fifth-digit 0.
Diagnosis: diabetic cataracts
What’s the main term? cataracts
What’s the cause? diabetes
The Volume 2 coding pathway is cataract, diabetic 250.5  

What does this boxed symbol mean? Turn to code 250.5 in the Tabular List.
You’ll note the fifth-digit subclassification box for the code category 250. In this example, the type of diabetes is not specified, so the fifth digit would be 0. Now let’s talk about the code in slanted brackets [366.41]. Remember that slanted brackets mean you must use the code in those brackets, too. So in this example, 250.50 is the primary diagnosis, and 366.41 is the secondary diagnosis. When you look up both these codes in the Tabular List, you’ll see that the code descriptions are verified.

**Step 21 Pathways**

- Remember that the key to diagnosis coding is to ask yourself a series of questions once you have the documentation we discussed in previous lessons. The main question is “What is the problem?” After you identify the problem or diagnosis, use the main terms and subterms to locate the code in Volume 2 of the ICD-9-CM, as we just discussed.

The **coding pathway** refers to the series of main terms and subterms used to find the diagnostic code in that manual. The main term is listed first, and then the subterm. Think of a coding pathway as a road map you would follow to arrive at your destination. To what city are you going? What highway do you follow, and what exit do you use to arrive at your destination? So you see, a coding pathway is like a road map to the correct code!

Let’s take a look at an example of a coding pathway.

Aaron, age 7, presents with a fever and a pain in his right ear. The doctor examines him, and this is her diagnosis: otitis media, right ear.

You know the diagnosis is otitis media because the doctor has documented it in the patient’s medical record. What do you look for first? Otitis is the main term. Remember your medical terminology? Otitis means inflammation of the ear. It is a medical condition. Media means middle, so now you know that media is the subterm because it describes the location of the condition within the ear.

So the coding pathway for Aaron’s diagnosis is **otitis, media**. Following is a sample entry from the ICD-9-CM that shows how this condition looks in Volume 2.
Well done! Let’s take a look at some clinical applications of the coding rules.

### Step 22 Clinical Applications of Coding Rules

- **As a healthcare document specialist, you are something of a translator.** You will take diagnoses and translate them into medical codes. To do that, you must understand small but significant differences that you might find as you code. In addition, you must know the rules of coding to accurately assign specific codes. Knowing how to properly sequence and report diagnostic codes is your goal.

Let’s consider some clinical applications of coding rules. As you deal with the bulleted situations that follow, be aware of the rules that accompany them.

- **Physician Coding**—When you code a physician’s diagnosis of a patient’s condition, the principal, or primary, diagnosis is the most important because it reflects the current and most significant reason a patient seeks treatment. You assign secondary codes to coexisting diseases and conditions after you code the primary diagnosis. Remember that when you assign a code for a pre-existing condition, you must ensure that the diagnostic code identifies the current reason for medical care. Do not assign codes for rule-out statements such as probable, possible, questionable, rule out and suspected in outpatient settings.

### Volume 2 INDEX TO DISEASES

**Othematoma** 380.31

**Otitic hydrocephalus** 348.2

**Otitis** 382.9
  - with effusion 381.4
  - acute 382.9
  - adhesive (*see also* Adhesions, middle ear) 385.10
  - chronic 382.9
  - diffuse parasitic 136.8
  - externa (acute) (diffuse) (hemorrhagica) 380.10
  - insidiosa (*see also* Otosclerosis) 387.9
  - interna (*see also* Labyrinthitis) 386.30
  - media (hemorrhagic) (staphylococcal) (streptococcal) 382.9

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*When you code a physician's diagnosis, the principal diagnosis is the most important.*
Common Coding for Outpatients and Inpatients—You will assign codes for the principal outpatient or principal inpatient diagnosis and sequence the codes in the correct order. Use the appropriate coding rules and guidelines that you are learning. The following tips will be helpful to remember:

1. **Assign codes in the order of importance.** The order in which the doctor writes the diagnosis might not determine the main diagnosis. Determine the correct diagnosis order before you list the codes. As the healthcare document specialist, you sometimes will not be able to determine the principal diagnosis and might have to ask the doctor.

2. **Assign unspecified or other specified codes when the reason a patient seeks healthcare is not clarified.** For example, use unspecified codes when the diagnosis has not been finalized. Use other specified codes when a diagnosis has been made and there is no code to identify the diagnosis more specifically.

3. **Assign coexisting condition codes as supplementary diagnoses codes in order of importance after you assign the principal diagnosis code.** The order of importance might be based in part on the time it takes to complete the patient’s health care and on the resources that are used for each relevant code.

### Inpatients and Outpatients

Even though you are already familiar with the terms *inpatient* and *outpatient*, let’s talk about them in greater detail here. An inpatient is someone admitted to the hospital to stay overnight. People who come to the hospital for an x-ray or laboratory test are referred to as outpatients. These are patients who are receiving **ancillary services**—they come to the hospital to receive the medical service or treatment, and then they go home the same day. Outpatients include patients who go to the hospital for outpatient surgeries or procedures, IV therapies or ED visits. Outpatients also are patients at doctors’ offices and other outpatient facilities such as MRI centers, outpatient surgery centers and chemotherapy or dialysis specialty clinics.

An inpatient is someone admitted to the hospital to stay overnight.
This is an example of what makes your job as a healthcare document specialist so important! When a patient is admitted for surgery at a hospital, he receives two bills. One is from the hospital, and one is from the surgeon. The surgeon’s healthcare document specialist assigns codes for the diagnosis the surgeon gave and the procedure she performed for the inpatient. Then the claim form is sent to the patient’s insurance company for reimbursement. The services that a patient uses while he is in the hospital, such as the room charge, the operating room and any medications received, are charged and coded by the hospital inpatient healthcare document specialist.

Now, let’s pause to complete a Practice Exercise.

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**Practice Exercise 23-5**

Choose the best answer from the choices provided.

1. The first step in ICD-9-CM coding is to identify all _____.
   - a. *Tabular Lists*
   - b. *Alphabetic Indexes*
   - c. main terms
   - d. three-digit codes

2. Assign codes to their ____ level of specificity.
   - a. individual
   - b. highest
   - c. diagnostic
   - d. subclassified

3. When you assign codes for an outpatient or inpatient diagnosis, the ____ is the first code sequenced.
   - a. coexisting condition
   - b. unspecified code
   - c. principal diagnosis
   - d. questionable diagnosis

4. Do not assign codes for ____ statements in outpatient settings.
   - a. rule-out
   - b. line-in
   - c. opt-out
   - d. add-in
For the following items, fill in the blanks as directed.

5. **Urinary tract infection**
   - Main term
   - Subterm
   - Coding pathway

6. **Recurrent appendicitis**
   - Main term
   - Subterm
   - Coding pathway

7. **Unknown pain in leg**
   - Main term
   - Subterm
   - Coding pathway

8. **Diaper rash**
   - Main term
   - Subterm
   - Coding pathway

9. **Loss of appetite**
   - Main term
   - Subterm
   - Coding pathway

10. **Inflammation of the sinus**
    - Main term
    - Subterm
    - Coding pathway

11. **High-altitude sickness**
    - Main term
    - Subterm
    - Coding pathway
12. Vision examination
   Main term __________________________________
   Subterm __________________________________
   Coding pathway ______________________________

13. Ear examination
   Main term __________________________________
   Subterm __________________________________
   Coding pathway ______________________________

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**Step 24  Review Practice Exercise 23-5**

- Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. If you have questions, review your lesson material, then contact your instructor.

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**Step 25  Lesson Summary**

- Think of how much you’ve already learned about diagnostic coding! You understand how each volume is organized, and you have a firm grasp of the content of each section, appendix and chapter. This lesson also taught you about the numerous conventions of the *ICD-9-CM*. We covered a lot of information here, so if you found any of it confusing, go back and reread the lesson step(s) that you found difficult to understand. And remember, your instructor is available to answer your questions!

In addition to what you’ve learned in this lesson, you have seen a lot of examples of actual medical codes. Although looking at all of these codes might have been a bit intimidating at first, remember, just as is true of the *ICD-9-CM*, the more you see these codes and study their uses, the more familiar they will become to you. Before you know it, you’ll be using these codes without thinking twice as you embark on your new career as a healthcare document specialist!
Nice job!

You’ve learned the basics of the ICD-9-CM.

Let’s get some hands-on practice!

Turn the page to learn how to code conditions, such as measles, mumps and rubella.

Continue to Lesson 24.