Section IV – Diagnostic Coding and Reporting for Outpatient Services

Section IV, here we come! Keep that book cracked open and let’s go through Diagnostic Coding and Reporting Guidelines for Outpatient Services. These guidelines deal specifically with hospital-based outpatient services and provider-based office visits. Also, keep in mind that the UHDDS definition of principal diagnosis does not apply to outpatient coding, and that you can’t code inconclusive diagnoses for outpatient coding either. You will be learning more about these as you go through the ICD-9-CM modules.

A. Selection of first-listed condition

Instead of the term “principal diagnosis,” outpatient settings use the words “first-listed diagnosis.” Use the coding conventions of ICD-9-CM to determine this, including general and disease specific guidelines. You’ll be learning these throughout this module.

1. Outpatient surgery: Always code the reason for surgery as the first-listed diagnosis

**EXAMPLE**

A 10-year-old patient presents to the outpatient surgery center for a tonsillectomy due to chronic tonsillitis. The patient was prepped and waiting to be taken to the operating room. While waiting the patient begins to have convulsions. The surgery is cancelled due to the convulsions and the patient is discharged home to follow-up with their primary care physician. The discharge statement reads, tonsillectomy cancelled due to probable epileptic seizure.

**Primary diagnosis:** would be the reason the patient was being seen today, chronic tonsillitis, code 474.00.

**Secondary diagnoses:** would be 780.39 for convulsions. We cannot code this as epilepsy because this is only a probable or suspected diagnosis. The other secondary code would be V64.1, Surgical or other procedure not carried out due to contraindication.

2. Observation stay: If a patient is being observed for a medical condition, that condition is the first-listed diagnosis. If the patient is being observed following complications from outpatient surgery, the same goes, and the complications codes are listed as secondary diagnoses.

**EXAMPLE**

A 36-year-old male patient was admitted to the observation unit from the emergency room with severe generalized abdominal pain and a markedly elevated white count. The admitting diagnosis was possible acute cholecystitis. A gallbladder ultrasound, cholecystogram, and intravenous pyelogram were all normal. The next day the abdominal pain was almost gone and the white count had dropped to normal. The patient was discharged home and was to follow up with his family physician. **Discharge diagnoses:**

1. Generalized abdominal pain, 2. Leukocytosis

**First listed diagnosis:** Generalized abdominal pain (789.07), only the symptoms can be coded since a confirmed diagnosis was not made

**Additional diagnosis:** Leukocytosis (288.60) was found on a blood test and is listed as an additional diagnosis
B. Codes from 001.0 through V89.09

These are the diagnosis codes in your ICD-9-CM book. Obviously, you will use them to identify diagnoses, symptoms, conditions, problems, complaints, or other reasons for the encounter.

EXAMPLE

A 36-year-old male HIV infected patient came into see the physician today because he has acute lymphadenitis due to his HIV infection. The glands in his neck were also affected. The physician prescribed antibiotics; however, the patient refused antiretroviral treatment at this time. He is of the opinion that his religion would eventually make antiretroviral medication unnecessary. Another problem was his narcotic dependency. He was encouraged to continue participation in both the narcotic addiction and HIV support groups. Diagnoses: 1. Acute lymphadenitis secondary to HIV infection, 2. Narcotic dependency, 3. Refusal of medication due to religious reasons

First listed diagnosis: HIV (042) this is the cause of the acute lymphadenitis and must be listed as the primary diagnosis

Secondary diagnoses: Acute lymphadenitis (683), unspecified narcotic dependency in remission (304.93), Refusal of treatment (antiretroviral medication) due to religious reasons (V62.6). The third-party payer must be informed when a patient is non-compliant to medical treatment and the reason why.

Section IV – Lesson 2

C. Accurate reporting of ICD-9-CM diagnosis codes

This simply states that you will be pulling your codes from medical documentation.

EXAMPLE

A 60-year-old male patient comes into the outpatient clinic today with a chief complaint of dyspnea on exertion. He also states he has moderate night sweats and has been running intermittent fevers. Today, in the office a routine chest x-ray was performed and a mass was visualized in the mediastinum. We will schedule a CT scan at the hospital for him to be done tomorrow. Diagnosis: Probable neoplastic disease.

Primary diagnosis: Mass in mediastinum (786.6) is the only confirmed diagnosis the physician has made. In an outpatient setting, probable or suspected diagnoses cannot be coded.

Secondary diagnoses: Dyspnea (786.09), fever (780.60) and sweating (780.8). The symptoms the patient came in with are also coded for this visit because they are not an integral part of the mass located in the mediastinum.

D. Selection of codes 001.0 through 999.9

These are the codes that are most used for classifying diseases and injuries.

EXAMPLE

A 36-year-old HIV infected female patient who had a long history of cocaine addiction, started using cocaine again. Several months ago, she was admitted for treatment of pneumocystis carinii pneumonia.
Today, severe depression about having HIV has brought her to the psychiatric clinic for an evaluation and treatment. We had an extensive discussion about returning to Narcotics Anonymous and also beginning the AIDS support group. A prescription for Lexapro was given for her depression. Diagnoses:
1. Depression, 2. Cocaine addiction, 3. HIV infection

**Primary diagnosis:** Depression (311), the depression is the primary reason for the encounter and a prescription was written for this problem. Even though the depression was related to the patient’s feelings of having HIV, it was symptoms of depression that brought the patient to the clinic.

**Secondary diagnoses:** 1. HIV (042), cocaine addiction (304.20)

**E. Codes that describe symptoms and signs**

For outpatient coding, these codes are acceptable for reporting purposes if you have an unconfirmed diagnosis. Many of these are found in Chapter 16 of ICD-9-CM.

**EXAMPLE**

A 68-year-old male patient who has been diagnosed with prostate cancer returns to the office today after completing a 14 day course of antibiotics. He still has a fever. Recent blood and urine cultures have come back negative. A digital rectal exam today shows no signs of infection or any abscesses. We are going to send him over to the hospital for a 24-hour admit for IV antibiotics, a radioisotope bone scan to rule out skeletal metastases and a transrectal ultrasound to rule out a prostate abscess. Diagnoses: 1. Fever of unknown origin, 2. Cancer of prostate

**Primary diagnosis:** Fever of unknown origin (780.60)

**Secondary diagnosis:** Prostate cancer (185)

**F. Encounters for circumstances other than a disease or injury**

This is where V codes come in! Codes V01.0–V89 will be used for these situations.

**EXAMPLE**

A patient with end stage renal disease (ESRD) due to hypertension reports to the outpatient dialysis center for one of their bi-weekly appointments for extracorporeal dialysis.

**Primary diagnosis:** Extracorporeal dialysis V56.0

**Secondary diagnosis:** Hypertensive Chronic Kidney Disease 403.91, 585.6

**Section IV – Lesson 3**

**G. Level of detail in coding**

*ICD-9-CM codes with 3, 4, or 5 digits:* All codes will have either 3, 4, or 5 digits. You'll learn more about assigning additional digits to 3-digit codes later.
1. Code 486, pneumonia, organism unspecified, is a 3 digit code that does not require further subdivision with a 4th or 5th digit.

2. Code 577.1, Chronic pancreatitis, is a 4 digit code. The first 3 digits, 577, show that it belongs to the code series for diseases of the pancreas. The 4th digit of (1) designates the specific disease of chronic pancreatitis.

3. Code 250.01, Diabetes Mellitus without mention of complication, type I is a 5 digit code. The first 3 digits, 250, show that it belongs to the code series for diabetes. The 4th digit of (0) designates that the diabetes is not complicated by another condition. The 5th digit of (1) designates that this is a patient with type I diabetes which has not been documented as uncontrolled. If the patient’s diabetes were documented as uncontrolled there would have been a 5th digit assignment of (3).

**Use of full number of digits required for a code:** Most 3-digit codes are further subdivided, getting more specific with 4 or 5 digits. Always code to the full number of digits—the most specific code.

**EXAMPLE**

A 46-year-old female patient presents to the emergency department with a chief complaint of severe right leg pain. She has not been able to bear weight on this leg since yesterday. Past history reveals she is status post 1 year from an oophorectomy for primary ovarian cancer. She was sent for a bone scan with contrast. This revealed a newly diagnosed metastatic bone cancer and a pathologic bone fracture in the tibia and fibula. The patient was put into a removable leg cast. An appointment was made with the oncology clinic for her tomorrow. The patient was sent home with pain medication. **Discharge diagnoses:** 1. Severe leg pain, 2. Status post oophorectomy ovarian cancer, 3. Pathological fracture tibia and fibula due to metastatic bone cancer

**Primary diagnosis:** 733.16 (pathological fracture of tibia and fibula) 733.1 is a 4 digit sub-category code which requires a 5th digit for further clarification. The 5th digit 6 signifies the fracture of the tibia and fibula. The severe leg pain is not coded because it is an integral part of the pathological leg fracture.

**Secondary diagnoses:** 1. 198.5 (metastatic bone cancer), 2. V10.43 (personal history of cancer of ovaries) The patient’s previous ovarian cancer is coded with a history code because the cancer has been removed and the patient is no longer receiving therapy directed at treating the malignancy.

**H. ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit**

Always list the diagnosis, condition, problem, or reason for encounter codes that are documented first. A symptom may only be coded first if there is an unconfirmed diagnosis.

**EXAMPLE**

A 42-year-old male patient who is HIV positive came in today to see the ophthalmologist for an eye exam because he was having difficulty focusing while reading books and the newspaper. His examination revealed no evidence of retinopathy. He did have presbyopia. The physician prescribed eyeglasses for him. Diagnoses: 1. HIV infection, 2. Presbyopia

**Primary diagnosis:** 367.4 (presbyopia) is listed first because it was the reason for the examination.
Secondary diagnosis: V08 (Asymptomatic human immunodeficiency virus (HIV) infection) status would be used as the patient does have HIV, but it is asymptomatic and is not the reason he came to the ophthalmologist.

I. Uncertain diagnosis

If any of those uncertain words pop up in an outpatient case, code any symptoms, signs, abnormal test results, or reasons for the visit that are confirmed.

EXAMPLE

An 18-year-old male patient came into the office today after he fell off a moving motorcycle. His chief complaint was right lower left leg pain. The physician noted swelling in the right lower extremity. He told the patient to go immediately over to the outpatient radiology clinic for x-rays and then to come back for further treatment. The physician called the radiology clinic and ordered a 3-view x-ray of the right lower leg to rule out a fracture of the tibia. The patient never showed up for the x-ray and never returned to the office for further treatment. Diagnosis: Suspected fracture, right tibia

Primary diagnosis: 729.5 (pain in limb) only the symptoms can be coded since a confirmed diagnosis was not made.

Section IV – Lesson 4

J. Chronic diseases

If a patient is being treated for an ongoing disease or condition, the code can be reported as often as the patient receives treatment and care for them.

EXAMPLES

A patient presents to their primary care physician with a chief complaint of an earache with an associated sore throat. During the patient’s work-up it is noted that their blood pressure is very elevated. The physician notes that the patient has a history of hypertension and has been prescribed medication for high blood pressure. On questioning the patient it is determined that they are taking their medication as prescribed. When the patient leaves they are given a prescription for antibiotics and a new blood pressure medication. The discharge diagnoses are otitis media, acute pharyngitis and hypertension, uncontrolled on current meds.

Primary diagnosis: for this visit is 382.9, Unspecified otitis media. This is the reason for visit.

Secondary diagnoses: are 462, Acute pharyngitis and 401.9, Essential hypertension, unspecified. Even though the hypertension wasn’t one of the reasons for the visit, it is a chronic condition that was treated and cared for on this visit so it would be coded for.

K. Code all documented conditions that coexist

While you don’t want to treat previously treated conditions (you’ll use History codes for those if they have an impact on the current situation), you do want to code all conditions that exist at the time of the encounter.
An 88-year-old female patient was seen for a stage II pressure ulcer with cellulitis on her right hip. She has previously been seen in the nursing home by her physician because she is an uncontrolled type 2 diabetic, also has benign hypertension. The patient has no other complaints at this time other than her blood pressure has been high for the past 3 days and her sugar levels have also been elevated as well. The physician examined the pressure ulcer and debrided it. The patient was put on an antibiotic for the pressure ulcer and the nurses were given pressure ulcer care instructions. The physician also changed the patient’s blood pressure medication and adjusted the patient’s insulin to be given. The nurses were told to call him if her blood pressure, blood sugars or pressure ulcer made any changes. Diagnoses: 1. Stage II pressure ulcer of hip, 2. Type 2 diabetes uncontrolled, 3. Benign hypertension 4. Cellulitis

**Primary diagnosis:** 707.04 (Ulcer of hip), since this is a pressure ulcer and not an ulcer due to the diabetes it is the first listed diagnosis. The main reason for the visit was the stage II pressure ulcer.

**Secondary diagnosis:** 707.22 (Stage II pressure ulcer), the stage of the ulcer must be listed after where the pressure ulcer is located. {{682.6 (Cellulitis, leg, except foot [hip])}} is recorded after the ulcer, 250.02 (type 2 diabetes, uncontrolled) 401.1 (hypertension, benign) the two chronic conditions diabetes and hypertension are coded because the physician treated them at this visit.

**L. Patients receiving diagnostic services only**

If the patient is only getting diagnostic services during an encounter, sequence the diagnosis, condition, or reason for the visit first. All other diagnoses will be sequenced as additional diagnoses. If the test is routine, and has no signs, symptoms, or diagnosis, assign V72.5 and V72.6 (you'll learn more about this later). Always code any confirmed diagnoses from diagnostic tests if they have been interpreted for the visit.

**EXAMPLE**

A 17-year-old female was recently hired to work in the cafeteria at a local hospital. Part of the pre-employment exam is a routine chest x-ray. She went to the outpatient radiology department for the chest x-ray which was normal. Diagnosis: Routine chest x-ray

**Primary diagnosis:** V70.5 (Health examination of defined subpopulations). This code for general health examination includes pre-employment screenings.

**Section IV – Lesson 5**

**M. Patients receiving therapeutic services only**

The same goes here as for patients receiving diagnostic services—code the diagnosis, condition, or reason for visit first, all others as additional diagnoses. There is an exception, however, for chemotherapy, radiation therapy, or rehabilitation. In those cases, the first-listed code is the appropriate V code, and the diagnosis or problem is listed second.

**EXAMPLE**

A 78-year-old male patient is here today for occupational therapy. He recently had a CVA which left him with hemiplegia on the left side (non-dominant side). We will be working with him to regain use and strength in his left hand and leg. Diagnosis: CVA with hemiplegia non-dominant side
First listed diagnosis: V57.21 (Occupational therapy), this is the reason for the visit.

Secondary diagnosis: 438.22 (Late effect of CVA hemiplegia non-dominant side)

N. Patients receiving preoperative evaluations only

In this case, always code V72.8 first. Conditions and findings from the evaluation will be listed as additional diagnoses.

EXAMPLE

A 78-year-old female patient was referred by her ophthalmologist to an internist for a consultation, pre-surgical clearance examination. The patient is scheduled for removal of senile cataracts and implantation of lenses; however, she also has benign hypertension and needs surgical clearance. The internist performs a comprehensive exam, notates the cataracts and determines the patient’s hypertension is well controlled and no risk for anesthesia/surgery. He writes a letter to the ophthalmologist stating the patient is cleared for surgery. Diagnoses: 1. Senile cataracts, 2. Hypertension

First listed diagnosis: V72.83 (Other specified pre-operative examination), the primary reason for the consultation was a surgical clearance exam.

Secondary diagnoses: 366.10 (senile cataracts, unspecified) is listed next because it is the reason for the surgery. 401.1 (benign hypertension) was the reason the patient needed the surgical clearance.

O. Ambulatory surgery

For this situation, code the diagnosis for which the surgery was performed first. If the pre- and post-operative diagnoses differ, use the postoperative diagnosis for coding.

EXAMPLE

Pre-operative Diagnosis: Rectal bleeding

Post-operative Diagnosis: Polyps, benign

Procedure: A 52-year-old female patient was brought to the Surgi-Center for a colonoscopy. She had been complaining of rectal bleeding off and on for the past few weeks. After the patient was prepped the physician inserts a flexible scope into the rectum, which appears to be clear of any lesions or polyps. The scope is then advanced into the sigmoid colon where three polyps are found and removed by snare technique. The remainder of the colonoscopy is free of polyps and lesions. The scope is withdrawn and the patient is taken to the recovery room.

First listed diagnosis: 211.3 (Benign polyps) only the post-operative diagnosis is listed because it is confirmed after the colonoscopy was performed.

P. Routine outpatient prenatal visits

You’ll learn more about this later, but use code V22.0 or V22.1 for the first-listed diagnosis in this case. Make sure not to use any chapter 11 codes with these, though!
EXAMPLE

A 32-year-old female patient came in today for her routine prenatal checkup. She is a primigravida in her first trimester. There are no complications. Diagnosis: Routine prenatal checkup

First listed diagnosis: V22.0 (Supervision of normal first pregnancy), this is the only ICD-9 code listed because there are no complications.