



Board of
Medical
Specialty
Coding

ICD-9 Basics Study Guide

for the Home Health ICD-9 Basic
Competencies Examination



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ICD-9 Basics Study Guide

Introduction

To master the basics of ICD-9-CM coding, you must understand the foundation of coding in the home health environment. There are main competencies that coders and clinicians will be tested on. These competencies are listed below, with some main points that each encompasses or that you must understand to code correctly with diagnoses, V and E codes.

In general, the core competencies of ICD-9-CM coding involve understanding:

- Guidelines and Conventions
- Sequencing issues regarding signs and symptoms, acute diseases and V codes, late effects and complications and OASIS item rules
- V code use
- Manifestation coding
- Late effects and complications

This short guide *highlights the main areas that you must understand* – and be able to apply in your ICD-9 Manual – in order to find the correct code.

Official Guidelines and Conventions

The ICD-9-CM Official Guidelines for Coding and Reporting and conventions are specific guidelines and general rules that are applicable to all health care settings, unless otherwise indicated. They provide additional instruction and are based on the coding and sequencing instructions in Volumes 1, 2 and 3 of the ICD-9-CM. Adherence to these guidelines when assigning diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

There are 16 main guidelines to know and reference when coding. These guidelines cover dozens of pages and are available at:

www.cdc.gov/nchs/dataawh/ftpserv/ftpicd9/ftpicd9.htm

Some highlights of what a competent basics coder needs to understand:

- Proper use, and sequence of use of the Alphabetical Index and Tabular List
- Locating terms within the Alphabetical Index
- Specificity in coding: coding to 3, 4 or 5 digits and knowing how to tell the specificity within the Tabular List
- Selecting diagnosis codes and V codes
- Proper signs and symptoms use
- Coding symptoms integral to a disease
- Multiple coding for a single condition
- Acute vs. chronic conditions
- Combination coding
- Late effects
- Ability to code the same diagnosis more than once
- Admissions or encounters for rehabilitation
- Pressure ulcer staging

In addition to general coding guidelines, there are guidelines for specific diagnoses and/or conditions in the classification. Unless otherwise indicated, these guidelines apply to all health care settings. These guidelines are specific to individual chapters in the ICD-9-CM manual. Many of them will be covered in the modules on common home care diagnosis coding.

Coding guidelines revolve around the ICD-9-CM code set, which is contained in 3 separate volumes:

Volume 1: Tabular List (located after Volume 2 in most manuals)

Volume 2: Alphabetical Index to Diseases (located 1st in the first manual).

Volume 3: Procedures Index and Tabular List

The Tabular List (Volume 1) contains:

- 17 Chapters (numerical codes 001 – 999.9) categorized by anatomical site
- Supplementary Classification: Factor Influencing Health Status and Contact with Health Services – V Codes (V01 – V86)
- Supplementary Classification: External Causes of Injury and Poisoning – E Codes (E800 – E999)

The Alphabetic Index (Volume 2) contains:

- An alphabetical listing of diseases and reasons for encounters in the health care system
- Hypertension table
- Neoplasm table
- Table of Drugs and Chemicals
- Index to External Causes of Injury and Poisoning Codes (E codes)

The Procedures Index and Tabular List (Volume 3) contains:

- Index to procedures
- Tabular list of procedures

Coding conventions

The conventions are general rules for ICD-9-CM code use, independent of the official coding guidelines. They include abbreviations, punctuation, symbols, typefaces, formatting methods, and rules.

The two sources of ICD-9-CM coding conventions are the ICD-9-CM Official Guidelines for Coding and Reporting and the ICD-9-CM publisher-specific formatting conventions. The coding conventions are incorporated within the Alphabetical Index and the Tabular list of an ICD-9-CM coding manual as instructional notes.

The Coding Conventions coders need to understand are:

- Format, such as indenting:
- Abbreviations such as NEC and NOS
- Punctuation such as [], [/], (), :
- Includes and Excludes Notes and Inclusion Terms
- Other and Unspecified Codes
- The meaning of “and,” “with,” “see,” “see also”
- Phrases such as Use Additional Code, and Code First

OASIS Items

While there are about 20 OASIS questions that directly affect payment, only five include diagnoses codes. These five are the most important for coders to know how to use. M1020, M1022 and M1024, especially, are crucial to understanding how to code and how OASIS interacts with ICD-9-CM.

M1010: Inpatient Diagnosis

List the diagnoses (six slots) for which the patient received treatment in an inpatient facility within 14 days of the start of care assessment. List only those diagnoses that required treatment during the inpatient stay.

M1016: Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days

List new diagnoses or diagnoses that have exacerbated over the past 14 days. Lists six diagnoses.

M1020a: The principal diagnosis

This item identifies the chief reason for providing skilled services. It represents the most acute condition that requires the most intensive skilled services – the primary or principal reason for home care – the focus of care. The primary diagnosis may or may not be related to the most recent hospital stay. It is the condition most related to the current home health plan of care.

The primary diagnosis best reflects the care being provided for the *entire episode* and may best be described by a V code when the underlying reason for care no longer exists.

Consider services, medications, treatments and procedures ordered. If more than one diagnosis is treated concurrently, the primary diagnosis is that which represents the most acute condition and requires the most intensive skilled service. If two or more diagnoses are being equally

monitored, treated, and/or evaluated, the clinician may select which diagnosis is sequenced first based on coding guidelines.

M1022b-f: The Secondary Diagnoses

M1022 identifies all conditions (co-morbidities) that coexisted at the time the plan of care was established, which developed subsequently, or which affect the treatment or care. Include all pertinent diagnoses relevant to the care being rendered. The codes/diagnoses assigned in M1022 should be listed in the order that best reflects the seriousness of the patient's condition. There are five diagnoses to place in M1022, listed in M1022b-f on the OASIS form.

In general, M1022 should include not only conditions actively addressed in the patient's plan of care, but also any additional co-morbidity (illness/condition/health factor) affecting the patient's responsiveness to treatment and rehabilitative prognosis.

There is no sequencing rule that secondary diagnoses must be coded in the order or severity. There are several things to keep in mind when sequencing the secondary diagnoses, including manifestation coding rules, co-morbidity issues and acute conditions vs. V codes.

M1024: The Payment Question

M1024 is a complicated and technically optional OASIS item intended to facilitate payment under the Medicare Prospective Payment System (PPS). M1024 is used when a V code is reported as the primary diagnosis (M1020a) or as a secondary diagnosis (M1022b-f) in place of a case-mix diagnosis. Using case-mix codes in M1024 helps determine the PPS case mix. Case-mix codes are those diagnosis codes (and three V codes: V55.0, V55.5 and V55.6) that CMS has designated as adding potential points toward additional reimbursement.

A case-mix code If an HHA reports a V code in M1020 or M1022 in place of a case-mix diagnosis, the provider has the option of reporting the case-mix diagnosis in M1024 for payment purposes. Though

optional, if the case-mix diagnosis is not entered in M1024, the agency will lose case-mix points that may affect reimbursement.

M1024 is broken into two columns, Column 3 and Column 4. Column three is where a case-mix diagnosis is placed. Column 4 is where a manifestation of that diagnosis in Column 3, if a manifestation exists and must be coded with the etiology according to coding guidelines, is placed.

If a V code is reported in M1020 or M1022 in place of a case-mix diagnosis, list the diagnosis(es) and ICD-9-CM code(s) in M1024. In accordance with OASIS requirements – no V codes, E codes, or surgical procedure codes are allowed in M1024. ICD-9-CM sequencing requirements must be followed (e.g., mandatory multiple coding).

While there are far more intricate rules for appropriate coding in M1024, that rule knowledge is not needed for this exam. This exam will test your basic understanding of the use of M1024.

V codes

You should use V codes when:

- The V code is more specific to the care being rendered than a medical diagnosis
- The patient has a resolving disease or injury that is not a complication of care and is admitted for:
 - Therapy services only
 - Surgical, orthopedic or other routine aftercare
- Circumstances or problems influence a person's health status but are not in themselves a current illness or injury

How do you find V codes?

Look in the Alphabetical Index for these key terms that are most often related to home care:

- Absence
- Admission for
- Aftercare
- Attention to
- Encounter for
- Fitting of
- History of
- Long-term
- Resistance
- Status (post)

V codes and M1024

Remember that case-mix codes are placed in M1024 when a V code replaces a diagnosis case-mix code in M1020 or M1022b-f. If the case-mix code is the underlying diagnosis for why the case-mix code is being used, it can go in M1024 Column 3. If it has a manifestation, the manifestation can go in M1024 Column 4.

V codes account for:

- Occasions when a patient with a resolving disease or injury or a chronic condition encounters the health care system for specific aftercare or treatment
- When circumstances or problems influence a person's health status but are not in themselves a current illness or injury
- Reporting reasons for encounters with health care providers.

Some V codes can be designated as primary codes, only to be coded in M1020a; others can be assigned only as secondary (M1022b-f), some as both. Coders must pay attention to the designations in the coding manual indicating whether a V code can be primary only, secondary only, either, or unspecified.

Sequencing

The first step in successful sequencing is a great assessment and determining the relevant diagnoses and procedures is the first step to accurate coding. To begin your coding with the primary diagnosis, you must choose the diagnosis that is the chief reason for providing skilled services in home care.

When determining the primary diagnosis, ask yourself What is the focus of care? Which of the other diagnoses will impact the healing or recovery of the primary diagnosis the most? and several other questions. The primary focus of care is placed in M1020a. Secondary diagnoses go in M1022b-f. The sequencing rules surrounding M1022 are fuzzier than with M1022a.

The secret to sequencing is prioritizing the care. All pertinent diagnoses must be listed on the Plan of Care in the order of their seriousness to justify the services being rendered.

Manifestation coding

Manifestations are characteristics, signs or symptoms of an illness. When one disease or condition causes another disease or condition, the one that caused it is the etiology and the resulting second condition is the manifestation.

According to the coding guidelines, manifestation codes must be preceded by the code for the underlying condition or etiology. For example, the code for diabetic gangrene, gangrene caused by diabetes where gangrene is the manifestation and diabetes the etiology, would be listed

1. Diabetes (the etiology) 250.7x
2. Gangrene (the manifestation) 785.4

With manifestation coding, the usual rule of the focus of care being sequenced first is broken. If a manifestation is the focus of care, it is still sequenced second, behind its etiology. This guideline supersedes usual guidelines on first-listed diagnoses.

Complications

A complication is a problem that arises complicating the healing process of the initial illness, injury or medical/surgical procedure. There is *no time limit* as to when a complication may occur.

Complications are generally found in categories 996-999. Look in the Alphabetical Index under “Complications.” Make sure you verify the code in the Tabular List and follow the directions to use additional codes.

Do not use a V code with a complication unless instructed by the code book to do so!

Late effects

A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early such as an infection of the central nervous system, or it may occur months or years later, such as that due to a previous injury.

When coding a late effect, reference the word “late” in the Alphabetical Index. Coding of late effects generally requires two codes sequenced as follows:

- First – the condition or nature of the late effect (residual)
- Second – the cause of the late effect
- For example, gait abnormality as a late effect of hip fracture
 - 781.2 *Abnormality of gait*
 - 905.3 *Late effect of hip fracture*

Exception to the rule: If the late effect code includes the manifestation, or late effects of CVA. Many codes in Category 438 are **combination codes**. In that case, use one code to describe the late effect: If a patient develops aphasia from a CVA, code 438.11, Late effect of CVA, Aphasia.

Symptom coding

Symptom codes, found in Chapter 16 of Volume 1 – Signs, Symptoms and Ill-Defined Conditions (780-799), describe patient problems, not diseases. While Chapter 16 codes can be assigned as the principal diagnosis in M1020, it is required under the coding guidelines to code a definitive diagnosis, if determined. Home health cannot code on suspected diagnoses or assumed diagnoses. Symptoms should be coded in that situation.

The acute or chronic condition underlying a symptom, if determined, should always be coded for coding accuracy and risk adjustment. Code only “confirmed” diagnoses. Do not code “rule out,” “suspected” or “probable” diagnoses. If there is no definitive diagnosis, coding the symptom may be the only option.

E codes

Coding guidelines state to assign an E code for *the initial encounter* of an injury, poisoning, or adverse effect due to an external cause. However, home health agencies are not prohibited from using them for subsequent treatment. The use of E codes in home care may be helpful in medical review, especially in reporting how and where an injury or trauma wound occurred.

E codes are required to identify the causative substance for an adverse effect of a drug correctly prescribed and properly administered. In this case, the adverse effect is coded first, and is followed by the appropriate E code from E930-E949.