Rules of the Road Differ for Inpatient and Outpatient Coding

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As facilities approach the final laps in the race towards implementation of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), they should heed the yellow caution flag warning of basic challenges with the vast differences between inpatient and outpatient coding. It is important to use caution during our current race and to stay in the correct lane with code assignment of inpatient stays and outpatient encounters. This article will provide some rules of the road as facilities stay focused on the implementation of ICD-10-CM.

First Warning Lap: Resources

Coders should be well equipped with the proper resources they need for assigning inpatient diagnoses and procedures codes. For inpatient coding, an understanding of the Uniform Hospital Discharge Data Set (UHDDS) definitions, anatomy and physiology, the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) instructional notations and conventions, and ICD-9-CM Official Guidelines for Coding and Reporting is needed. This will help in the assignment of correct ICD-9-CM diagnoses and procedures to hospital inpatient medical records. ICD-9-CM contains three volumes to aid in choosing the correct diagnoses and procedures—Volume 1 Tabular List: Diagnosis Classification; Volume 2 Alphabetic Index: Diagnosis Classification; and Volume 3 Tabular List and Alphabetic Index: Procedure Classification. A supplemental resource to use when coding is the American Hospital Association's (AHA's) *Coding Clinic for ICD-9-CM*, which provides coding advice.

Changing Lanes: Outpatient Coding

Coders need to know how to switch gears when it comes to acquiring resources for outpatient coding. The terms "encounter" and "visit" are often used interchangeably in describing outpatient services, but the term "encounter" will be used for this article. For diagnosis coding of outpatient encounters, one needs a full understanding of the UHDDS definitions, anatomy and physiology, Volumes 1 and 2 of ICD-9-CM, along with ICD-9-CM instructional notations and conventions, and the current version of ICD-9-CM Official Guidelines for Coding and Reporting. Diagnoses are assigned using the first two volumes of the ICD-9-CM coding book, supplemented with AHA's *Coding Clinic for ICD-9-CM*. Outpatient procedures are assigned from the American Medical Association's (AMA's) *Current Procedural Terminology (CPT) Manual* which includes Level I modifiers approved for hospital outpatient use and the Centers for Medicare and Medicaid Services (CMS) Level II Healthcare Common Procedure Coding System (HCPCS), including Level II National Modifiers. Procedure coding is supplemented with the AMA's *CPT Assistant* and AHA's *Coding Clinic for HCPCS*. Although outpatient encounters are not required by CMS or third-party payers to report ICD-9-CM Volume III procedure codes, and do not base reimbursement on the use of these codes, some facilities continue to utilize them for internal data capture.

Ground Rules for the Road

Now that everyone is in the correct lane, what are the rules of the road? The principal diagnosis for inpatient coding is defined in the UHDDS as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." Once the principal diagnosis is established, the coder should continue to read through the entire medical record and assign any and all applicable secondary diagnoses. In the inpatient hospital stay, if a diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "rule out," and has not been ruled out at the time of discharge, the condition should be coded as an existing or established diagnosis. In addition to assigning ICD-9-CM diagnoses, hospitals are required to report present on admission information for all diagnoses when submitting inpatient claims.

Although both inpatient and outpatient coding utilizes Volumes 1 and 2 of the ICD-9-CM manuals in the assignment of diagnoses, there are vast differences. The UHDDS definition of principal diagnosis applies to non-outpatient settings: acute care short-term hospitals, long-term care hospitals, psychiatric hospitals, home health agencies, rehabilitation facilities, nursing homes, and other settings.

Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatient coding. Do not code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out,” “working diagnosis,” or other similar terms indicating uncertainty for outpatient encounters. Instead, code the condition(s) to the highest degree of certainty for that encounter, such as symptoms, signs, abnormal test results, or other reason for the encounter.

Instead of using the term “principal diagnosis” as with inpatient stays, the term “first-listed diagnosis” is appropriate in the outpatient setting. The conventions of ICD-9-CM, along with the general and disease-specific guidelines, take precedence over the outpatient guidelines of first-listed diagnosis. List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for the encounter shown in the medical record to be chiefly responsible for the services provided. In some cases, the first-listed diagnosis may be a symptom when a diagnosis has not been established or confirmed by the physician. Outpatient encounters for circumstances other than a disease or injury are assigned ICD-9-CM codes under The Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01.0-V91.99).

Furthermore, clarification on assignment of the first-listed diagnosis is based on the outpatient encounter service type. The first-listed code for an outpatient surgical encounter should be the reason for the surgery. Even if the patient is scheduled for outpatient surgery and develops a complication requiring admission to observation, the first-listed code remains the reason for surgery, followed by secondary diagnosis codes for all applicable documented complications.

However, if the postoperative diagnosis is known to be different from the preoperative diagnosis, select the postoperative diagnosis because it is the most definitive diagnosis. An example of this is when a patient presents for outpatient surgery for evaluation of rectal bleeding and after colonoscopy it is determined that the patient has bleeding from internal hemorrhoids. The preoperative diagnosis is 569.3-rectal bleeding and the more definitive postoperative diagnosis is 455.2-internal hemorrhoids with other complication. The first-listed diagnosis for outpatient diagnostic and therapeutic services is the diagnosis, condition, problem, or other reason shown in the medical record to be chiefly responsible for the outpatient services.

Codes for diagnoses (i.e., chronic conditions) may be sequenced as additional diagnoses. For outpatient encounters with diagnostic tests that have been interpreted by a physician and the final report is available at the time of coding, code any confirmed or definitive diagnosis documented in the interpretation.

Do not code related signs and symptoms as additional diagnoses. An example of this is when a patient presents for an MRI for evaluation of shoulder pain and the interpretation portion on the radiology report lists a tear of the biceps tendon. In this case the first-listed diagnosis would be 840.8, Sprains and strains of other specified sites of shoulder and upper arm. A code for shoulder pain would not be assigned since a definitive diagnosis has been established.

The first-listed diagnosis for outpatient therapeutic services for chemotherapy, radiation therapy, or rehabilitation is the appropriate V code for the therapy followed by secondary codes for the diagnosis or problem for which the service is being performed. The first-listed diagnosis for preoperative evaluation services should be from category V72.8, Other specified examinations, to describe the preoperative consultations. Code also any findings related to the preoperative evaluation. For routine outpatient prenatal encounters without complications, the first-listed code should be either V22.0, Supervision of normal first pregnancy, or V22.1, Supervision of other normal pregnancy.

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