Coding Tips and Tricks: ICD-9 Tips and Review
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ICD-9-CM was designed for classification of patient morbidity and mortality. It is used in both the inpatient and outpatient settings. Physician coding for ICD-9-CM assigns a code or codes to substantiate medical necessity.

Here are some tips for using ICD-9-CM diagnosis codes:

- NEVER code directly from the alphabetic index. Always verify codes in the tabular list.
- If a 4th and 5th digit are available, they must be used. One common claim rejection is for using codes not coded to the highest specificity.
- Remember to be as specific as possible. With that being said, use NEC and NOS sparingly.
- Use NEC (not elsewhere classifiable) when ICD-9-CM has no further code that provides greater specificity
- Use NOS (not otherwise specified) when the condition, sign or symptom is unspecified in the documentation
- E codes are never reported as primary diagnoses

E codes can be used to report external causes of injuries, for reporting poisonings and adverse effects from use of a particular drug. An example of an adverse effect would be a rash caused by the use of Penicillin (the use of Penicillin was properly prescribed and properly taken by the patient).

V codes can be used to report encounters for health services for a specific purpose, and the person encountering the service is not sick. Examples include encounters for vaccinations or encounters for dialysis. V codes can also be used to indicate personal or family history of a disease, in which the history of the disease may affect treatment being rendered. Patient status, such as an organ transplant status, can also be coded using V codes.

It is important to remember that physician coding requires only CONFIRMED diagnoses to be reported. Do not use “rule-out” or “probable” in determining code selection. Always use the chief complaint (CC) or sign or symptom presented by the patient to determine code selection.

Example: Patient presents with cough and fever, physician notes “probable pneumonia”

Probable pneumonia would NOT be coded. Code selection would be for cough and fever, as these are the confirmed conditions presented.
Here are some hints for coding diagnoses:

1. Identify the main terms in the physician record / medical notes. These terms will be located within the chief complaint (CC) or reason for the patient’s encounter for services
2. Locate the main terms in the alphabetic index
3. NEVER CODE directly from the alphabetic index
4. Follow any cross-references, such as “see also” in the alphabetic index
5. Verify code in the tabular list
6. Review any instructional notations in the tabular list
7. Assign the highest level of specificity for the code—use a 4th or 5th digit if available