

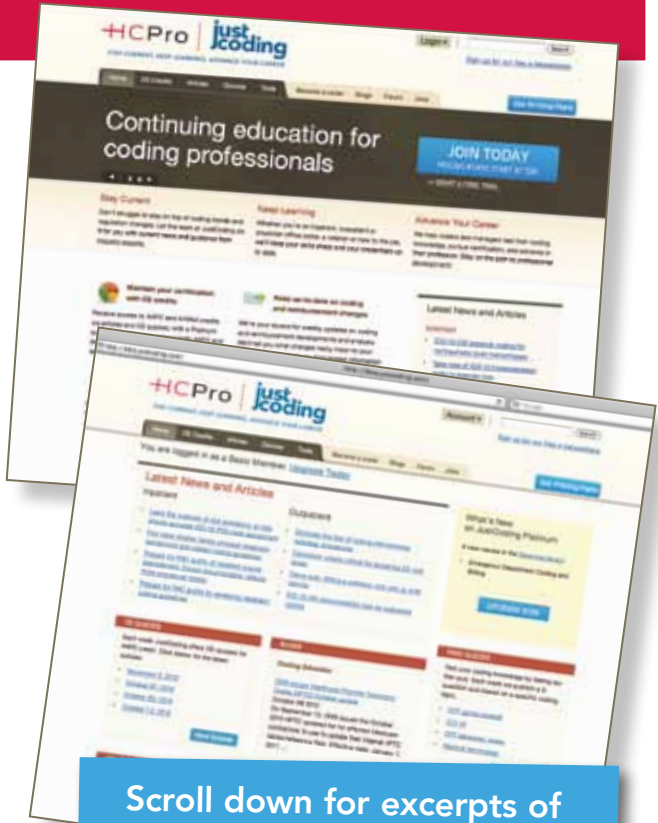
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—Debi Hatfield, RHIT; Coding Manager
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Start preparing for ICD-10-CM: Note differences between ICD-9-CM and ICD-10-CM

Coders will still be using ICD-9-CM for awhile, and trying to learn the new codes too early could end up being confusing.

However, it's not too early to start learning the structure of ICD-10-CM and preparing for some of the major changes that the new coding system will bring. Here is a closer look at a few of the big changes.

ICD-9-CM contains one type of excludes note, but it can mean two different things. "The issue with that is there is nothing in the ICD-9-CM Manual that tells you which one it is," says **Shannon E. McCall RHIA, CCS, CCS-P, CPC, CPC-I, CCDS, CEMC**, director of HIM and coding at HCPro, Inc., in Marblehead, MA. "So that kind of leaves it up to the coder to determine by applying logic what the excludes note means."

An excludes note in ICD-9-CM could mean that the coder should not use a particular code for a particular condition. Instead the coder needs to look in a different category because coders can't code the two conditions together.

For example, coders should never report a congenital condition with an acquired form of the same condition. Malaria is one condition that can be congenital or acquired. Both the acquired form of the disease (ICD-9-CM category 084) and the congenital form (code 771.2) have excludes notes identifying that the codes should not be assigned together because they are considered mutually exclusive.

In ICD-9-CM, an excludes note can also mean that a condition is not

included in a particular code. In those cases, the coder should assign both codes (if applicable) when the patient has both conditions at the same time.

For example, a patient may have a closed fracture of the shaft of the tibia (code 823.20) and a Pott's fracture of the ankle (code 824.4). Coders will find an excludes note under fractures of the tibia and fibula, specifying that Pott's fractures, among others, are excluded. However a patient could indeed have both fractures, so coders would need to assign both codes.

When coders are looking at the excludes notes, they can become confused, says McCall. ICD-10-CM will resolve that confusion by using two different excludes notes—Excludes1 and Excludes2—to differentiate the meanings.

An Excludes1 note is a pure excludes note. An Excludes1 note indicates that a coder should never use the code excluded at the same time as the code above the Excludes1 note. The two conditions cannot occur together.

An Excludes2 note means the condition is not included in the code. An Excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, coders may report both the code and the excluded code together when appropriate.

Both ICD-10-CM excludes notes represent the same things as the single ICD-9-CM excludes notes.

JustCoding devotes an entire issue to ICD-10 each month.

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The changing role of coders requires clinical mindset and attention to medical necessity

The process of coding continues to evolve, especially considering the recent focus on complete, accurate, and clinically relevant documentation that supports accurate ICD-9 and MS-DRG assignment.

In the not-too-distant past, coding was a task that required basic coding knowledge and an understanding of official coding guidelines, regulations, and policies as they relate to principal and secondary diagnoses selection and proper sequencing. Coders reviewed records and translated clinical medical record documentation into proper ICD-9 codes.

Today, however, clinical coders must possess specific skill sets and

competencies to meet additional elements now part of the coding process, including but not limited to the following:

- Present on admission indicators
- Core measures
- Discharge dispositions
- Optimal reimbursement
- Clinical documentation improvement initiatives
- Medical necessity concepts in principal diagnosis

Each of these elements consumes additional coding time while the standard coding productivity benchmarks remain the same.

Medical records coding requires a clinical mindset. These coders need to have a practical understanding of clinical medicine, particularly the following aspects:

- Interrelationships of different disease processes
- Atypical presentations of clinical disease entities
- Similar symptomatology of diseases that may manifest with distinctly different clinical disease processes

These aspects combine to add diverse complexity to the coding process and turn coding into more of a significant profession than a mere task. ■

Access full articles in our archives devoted to inpatient, outpatient, and physician services coding; clinical documentation improvement, and management topics.

Healthcare insiders such as Glenn Krauss, Lolita Jones, Lori-Lynn Webb, and Dr. Joel Moorehead regularly contribute articles to JustCoding.

Shannon McCall, Shelly Safian, and Sandra Silliman, are among the coding experts who answer reader questions in weekly Q&As.

Q&A: Coding chief complaints for ED observation

*This is one of dozens of peer questions and industry expert answers you'll find on the **JustCoding** site. This answer has been edited for space, so be sure to read the entire response when you start your membership!*

Q With regards to ED observation coding, how many chief complaints should I code? I always thought you chose the chief complaint that best matched the final diagnosis and if there were other chief complaints you coded them as secondary codes to support any tests performed. Is this incorrect?

A ED services are most often classified as outpatient. Observation services can be categorized as either outpatient or inpatient. Several applicable 2011 ICD-9-CM Official Coding Guidelines in Section IV (Diagnostic coding and reporting guidelines for outpatient services) guide the answers to your questions.

Once you have a final diagnosis, you may not code any additional inclusive signs or symptoms (chief complaints).

Section IV part E (Codes that describe symptoms and signs) explains that the "chief complaints" are only to be reported when the provider hasn't established a final diagnosis. It is part of a professional coding specialist's job to know (or learn) which signs and symptoms are included in the final diagnosis. Coders should not report those issues separately.

In those cases in which additional signs and symptoms supported medical necessity for tests and other services and the provider does not determine a confirmed diagnosis, report the additional signs and ...

*Read the entire answer by accessing the **JustCoding** archives.*

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Continuing Education Quiz

This is a sample of a weekly **JustCoding** quiz. Each quiz includes 10 questions with four answer options.

1. What letter serves as a placeholder in ICD-10-CM?
a. A b. C c. U d. X
2. In ICD-10-CM, when a condition is listed in an Excludes2 note, that condition:
 - a. Can be coded at the same time as the code above the Excludes1 note
 - b. Should never be coded at the same time as the code above the Excludes1 note
 - c. Is not part of the condition represented by the code, but a patient may have both conditions at the same time
 - d. Is part of the condition represented by the code, but a patient may have both conditions at the same time
3. What is the correct MS-DRG for GI obstruction without CC/MCC?
a. 379 b. 388 c. 389 d. 390
4. In ICD-10-CM, which character identifies whether a fracture is the initial encounter, subsequent encounter, or sequelae?
 - a. Fourth
 - b. Fifth
 - c. Sixth
 - d. Seventh

Once you submit your quiz, it's graded immediately and you'll know which questions—if any—you missed. Retake until you achieve a passing grade—then submit for AAPC and or AHIMA CEs

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