

Coding Guidelines

*Field notes can be found in the Inpatient/Outpatient Submittal Data Dictionary or quick reference

- ❖ A code from **category V57**, Care involving use of rehabilitation procedures, is assigned as the principal diagnosis when the patient is admitted for the purpose of rehabilitation following previous illness or injury, with the fourth digit indicating the focus of treatment. An additional code is assigned for the residual condition requiring rehabilitation. No code for the original injury or illness that led to the disability is assigned.¹
- ❖ The **'principal diagnosis code'** should be entered in the primary record (field 12). This is the ICD-9-CM diagnosis code describing the condition established **after study** to be chiefly responsible for occasioning the admission of the patient for care or for the outpatient services provided during the visit. This definition does not apply to the coding of all outpatient encounters. If the physician does not identify a definite condition or problem at the conclusion of an outpatient visit or encounter the coder should report the documented chief complaint as the reason for the encounter/visit.
- ❖ **'Other reportable diagnoses'** should be entered in the diagnoses record (field 14). They are defined as those conditions that coexist at the time of admission/outpatient visit or develop subsequently and affect patient care for the current episode of care. Usually reportable other diagnoses affect length of stay, total charges or accurate DRG classification. Diagnoses that have no impact on patient care during the hospital stay or outpatient visit are not reported even when they are present. **Code assignment is based on the medical record documentation. Please follow the Official Coding Guidelines for proper sequencing of other diagnoses codes that that may be reported.**
- ❖ **The 'principal procedure code'** should be entered in the primary record (field 45). The principal procedure is the one procedure most related to the principal diagnosis. If there is more than one procedure and both are equally related to the principal diagnosis, the most resource-intensive or complex procedure, or one that is necessary to care for a complication is usually designated as the principal procedure. If the only clinically significant procedure performed is diagnostic or exploratory in nature (i.e. MRI/CT scan or cardiac cath) it should be reported in the principal procedure field. When more than one procedure is reported, the principal procedure should be identified by the one that relates to the principal diagnosis. WHAIC does not recognize routine venipuncture (36415) codes or evaluation and management codes as acceptable principal procedure codes.
- ❖ **'Additional (Other) procedures'** performed during the principal episode of care (or during the length of stay for inpatients) or that may include diagnostic or exploratory procedures (i.e. MRI/CT scan or cardiac cath) should be entered in the additional procedure record (field 4). Procedures that affect **DRG** categorization must be included. **Code assignment is based on the medical record documentation.**
- ❖ **A code from category V27**, Outcome of delivery, should be included on every maternal record when a delivery has occurred with a corresponding principal diagnosis of 650. Codes 640-676 requires a 5th digit 0-4. This complies with Wisconsin Statute 69.14(1)(d)1 stating the place of birth is the location where the placenta is delivered. Therefore, if a delivery occurs at home or en route to the hospital, and the placenta is delivered at the hospital, the "place of birth" is the hospital.

¹ Faye Brown, *2010 ICD-9-CM Coding Handbook With Answers* (Chicago: Health Forum Incorporated, 2009) 84.
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- ❖ Codes **V64.1, V64.2 or V64.3** should be used as an additional diagnosis when a scheduled procedure is cancelled.² The principal diagnosis is the condition that occasioned the patient's admission for surgery.
- ❖ WHA Information Center generally follows the **V Code Table** parameters outlined in the *Coding Clinic*. Please note there are some codes that can only be used as principal **or** additional diagnosis codes. In the table below are a few of the V codes that cannot be used as principal diagnoses. To the right of each code are other V codes that may possibly be used as a principal diagnosis, **depending on the documentation in the record**. Some payers scan all diagnosis fields, and will pay the claim when the diagnosis code specified in their guidelines is in any diagnosis field.

V Code as Additional Only	Code Allowed as Principal	Comments
V15.85 - Personal history of contact with and (suspected) exposure to potentially hazardous body fluids	Toxic Effects of Substances Chiefly Nonmedicinal as to Source (980-989). > Use additional code to identify: Personal hx of retained foreign body fully removed (V15.53) retained foreign body status, if applicable	V71.8 – Observation and evaluation for other specified suspected conditions. Excludes: contact with and (suspected) exposure to (potentially) hazardous substances (V15.84-V15.86, V87.0-V87.31) 980-989.
V26.52 - Vasectomy status	V58.76 - Aftercare following surgery of the genitourinary system, not elsewhere classified	Or code may use V25.2 – Sterilization as the principal and V26.52 as reason for visit
V43.3 - Organ or tissue replaced by other means, heart valve (reason for visit is cardiac rehab)	V57.89 – Other specified rehabilitation procedure Acceptable as Princ. V67.09 – Following Other surg.	V57.89 - policy change does not meet medical necessity, Coder will need a specific code or review documentation for a new code.
V45.4 - Spinal fusion (arthrodesis) is a surgical procedure that joins, or fuses, two or more vertebrae	V54.09 – Other aftercare involving internal fixation device V54.89 – Other orthopedic aftercare. If the reason for the visit is a complication of the fusion graft site that requires refusing or revision, assign instead a code from subcategory 996.4	Arthrodesis is Spinal fusion a surgical procedure that joins, or fuses, two or more vertebrae.
V45.51 - Intrauterine contraceptive device	996.32 if the reason for the visit is a complication of the device	V45.5 – Presence of contraceptive device. Excludes checking of device (V25.42) complication from device (996.32) insertion and removal of device (V25.11 – V25.13) *These V codes are unacceptable princ. Dx codes
V45.81 (reason for visit is cardiac rehab)	V57.89 - Other specified rehabilitation procedure	V57.89 - policy change does not meet medical necessity, Coder will need a more specific code or review documentation for a new code.
V60.3, V60.4 and V60.5	V63.1 - Medical services in home not available – Unacceptable Princ. Dx	Would need to find an underlying reason for the visit that best describes encounter.

² Faye Brown, *2010 ICD-9-CM Coding Handbook With Answers* (Chicago: Health Forum Incorporated, 2009) 72.
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- ❖ The **Present on Admission (POA) Indicator** is the eighth digit of FL 67 – Principal Diagnosis, each of the secondary diagnosis fields FLs 67a-q, and FL – 72 External Cause of Injury on the UB-04 paper claim and the 837I electronic claim. Required 1/1/08.
 - The POA Indicator applies to the diagnosis codes for records involving inpatient admission to general acute-care hospitals.
 - The POA indicator is based not only on the conditions known at the time of admission, but also include those conditions that were clearly present, but not diagnosed, until after the admission took place.
 - Present on admission is defined as present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, are considered as present on admission.
 - The POA Indicator is applied to the principal diagnosis as well as all secondary diagnoses that are reported.
 - The five reporting options for all diagnosis reporting are as follows:

Code	Definition
Y	Yes
N	No
U	No information in the record
W	Clinically undetermined
Blank	Exempt from POA reporting

The American Health Information Management Association, American Hospital Association, CMS and the National Center for Health Statistics (known as the “Cooperating Parties”) published a list of ICD-9-CM codes for which the POA indicator does not apply. The indicator can be left unreported only for the codes on this list. This list is included in the POA guidelines published annually in October in the ICD-9-CM Official Guidelines for Coding and Reporting and will be updated online as needed.

❖ **CPT/HCPCS Codes that may be selected as a principal procedure**

Please choose the procedure most related to the principal diagnosis.

**** Venipuncture or routine collection of blood specimen (eg. 36415) Does NOT meet WHAICs definition of acceptable principal procedure****

Code	Description	Rationale
10021-69990	Surgical CPT Section	Most, (not all) codes in these sections qualify per the definition of principal procedure.
70010-76499	Diagnostic Radiology (Diagnostic Imaging)	If the only clinically significant procedure performed is diagnostic or exploratory in nature (i.e. MRI/CT Scan) it should be reported in the principal procedure field.
77371-77373	Stereotactic Radiation Tx Delivery	Definitive treatment
77401-77421	Radiation Tx Delivery	Definitive treatment
77422-77423	Neutron Beam Tx Delivery	Definitive treatment
96360, 96365, 96372, 96374, 96379,	Injections and Infusions, excluding Chemotherapy	Frequently used as therapeutic (definitive treatment)
90870	Electroconvulsive Therapy	Definitive treatment
90901-90911	Biofeedback	Definitive treatment
< age 2 90951-90953, 90963, 90967 Age 2-11 90954- 90956, 90964, 90968 Age 12-19 90957- 90959, 90965,	ESRD Services, including Dialysis	Therapeutic procedure, invasive

Code	Description	Rationale
90969 Age 20 > 90960- 90962, 90966, 90970		
91000-91299	Gastroenterology (medical)	Diagnostic procedures, some invasive (91105 therapeutic)
92015-92287	Special Ophthalmological Services	Diagnostic in nature, some definitive treatment, some invasive
92502-92700	Special Otorhinolaryngologic Services	Most are diagnostic in nature, 92502 invasive, 92507-92508 therapeutic, 92601-92604 postsurgical adjustments to cochlear implant, 92606 and 92609 therapeutic
92950-92998	Cardiovascular, Therapeutic	Include all codes in range 92950-92998, since they are all therapeutic or invasive
93451-93581	Cardiac Catheterization	Therapeutic or invasive
93600-93662	Intracardiac Electrophysiological Procedures/Studies	Invasive Mostly diagnostic procedures, few definitive (ablation)
96401-96549	Chemotherapy	Definitive Treatment
	Select Temporary Codes	T codes are allowed at the facility's discretion.
G0104	Colorectal cancer screening; flexible sigmoidoscopy	Invasive, but diagnostic
G0105	Colorectal cancer screening; colonoscopy on individual at high risk	Invasive, but diagnostic
G0121 45378 (non Medicare pt's)	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	Invasive, but diagnostic
G0166	External counterpulsation	Noninvasive therapy for patients in whom bypass surgery or balloon angioplasty has not been successful and has proven safe and effective for treating chronic angina for as long as three years.
G0259	Injection procedure for sacroiliac joint, arthrography	Invasive, definitive treatment
G0260	Injection procedure for sacroiliac joint, provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography	Invasive, definitive treatment
G0290	Transcatheter placement of a drug eluting intracoronary stent(s), single vessel	Invasive, definitive treatment
G0339-G0340	Image guided robotic linear accelerator base stereotactic radiosurgery	Definitive treatment
G0341-G0343	Islet cell transplant, includes portal vein catheterization and infusion	Invasive, definitive treatment
G0364	Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service	Invasive
G0168	Wound closure utilizing tissue adhesive(s) only	Invasive, definitive treatment