

Procedures for Coding Medical Record Cases for the CCS Examination

Instructions and official guidelines for coding medical records are included in the following resources: ICD-9-CM, CPT, UHDDS, Coding Clinic for ICD-9-CM and CPT Assistant. However, hospitals and other organizations may develop their own procedures in the absence of approved guidelines. To ensure consistent coding, the following procedures have been developed for use in the CCS examination. The procedures do not supersede or replace official coding advice and guidelines included in the resources identified above.

These procedures are to be used only in completing the CCS examination. They will be provided to test takers as part of the examination packet. Not adhering to these procedures may result in the miscoding of an exercise, which may result in the deduction of points when the item is scored.

Inpatient Coding

1. Apply UHDDS definitions, ICD-9-CM instructional notations and conventions, and current approved national ICD-9-CM coding guidelines to assign correct ICD-9-CM diagnostic and procedural codes to hospital inpatient medical records.
2. Sequence the ICD-9-CM codes, listing the principal diagnosis first.
3. Code other diagnoses that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. These represent additional conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring.
 - A. Code diagnoses that require active intervention during hospitalization. For example: Admission for small-bowel ileus and subsequent aspiration pneumonia that is treated with antibiotics and respiratory therapy. Code the ileus and aspiration pneumonia.
 - B. Code diagnoses that require active management of chronic disease during hospitalization, which is defined as a patient who is continued on chronic management at time of hospitalization. For example: Admission for acute exacerbation of COPD. The patient has depression that extends the stay and for which psychiatric consultation is obtained. Code the COPD and depression. For example: Admission for acute exacerbation of COPD. Physician lists "history of depression" on face sheet, and the patient is given Desyrel. Code the COPD and depression.
 - C. Code diagnoses of chronic systemic or generalized conditions that are not under active management when a physician documents them in the record and that may have a bearing on the management of the patient. For example: Admission for breast mass; diagnosis is carcinoma. Patient is blind and requires increased care. Code the breast carcinoma and blindness.
 - D. Code status post previous surgeries or conditions likely to recur that may have a bearing on the management of the patient. For example: Admission for pneumonia; status post cardiac bypass surgery. Code the pneumonia and status post cardiac bypass surgery (V code).

E. Do not code status post previous surgeries or histories of conditions that have no bearing on the management of the patient. For example: Admission for pneumonia; status post hernia repair six months prior to admission. Code only the pneumonia. Previous surgeries involving transplants, internal devices, and prosthetics should be coded.

F. Do not code localized conditions that have no bearing on the management of the patient. For example: Admission for hernia repair; the patient has a nevus on his leg that is not treated or evaluated. Code only the hernia and its repair.

G. Do not code abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) unless there is documentary evidence from the physician of their clinical significance. For example: Admission for elective joint replacement for degenerative joint disease. The laboratory report shows a serum sodium of 133; no further documentation addresses this laboratory result. Code only the degenerative joint disease and the replacement surgery. For example: Admission for elective joint replacement for degenerative joint disease. The laboratory report shows a low potassium level, and the physician documents hypokalemia. Intravenous potassium was administered by the physician for hypokalemia. Code the degenerative joint disease, the replacement surgery, and hypokalemia.

H. Do not code symptoms and signs that are characteristic of a diagnosis. For example: A patient has dyspnea due to COPD. Code only the COPD.

I. Do not code condition(s) in the Social History section that has no bearing on the management of the patient.

4. Do not assign E codes, except those that identify the causative substance for an adverse effect of a drug that is correctly prescribed and properly administered and/or poisoning (E850-E949).

5. Do not assign Morphology codes (M codes).

6. Code all procedures that fall within the code range 00.01 through 86.99, but do not code 57.94 (Foley catheter).

7. Do not code procedures that fall within the code range 87.01 through 99.99. But code procedures in the following ranges:

87.51-87.54 Cholangiograms

87.74 and 87.76 Retrogrades, urinary systems

88.40-88.58 Arteriography and angiography

92.21-92.29 Radiation therapy

94.24-94.27 Psychiatric therapy

94.61-94.69 Alcohol/drug detoxification and rehabilitation.

96.04 Insertion of endotracheal tube

96.56 Other lavage of bronchus and trachea

96.70-96.72 Mechanical ventilation

98.51-98.59 ESWL

99.25 Chemotherapy

Ambulatory Care Coding

1. Apply ICD-9-CM instructional notations and conventions and current approved Diagnostic Coding and Reporting Guidelines for Outpatient Services (Section IV of the official ICD-9-CM Guidelines for Coding and Reporting), to select diagnoses, conditions, problems, or other reasons for care that require ICD-9-CM coding in an ambulatory care encounter/visit either in a hospital clinic, outpatient surgical area, emergency room, physician's office, or other ambulatory care setting.

2. Sequence the ICD-9-CM code so that the first diagnosis shown in the medical record is the one chiefly responsible for the outpatient services provided during the encounter/visit.

3. Code the secondary diagnoses as follows:

A. Chronic diseases that are treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

B. Code all documented conditions that coexist at the time of the encounter/visit that require or affect patient care, treatment, or management.

C. Conditions previously treated and no longer existing should not be coded.

4. Do not assign E codes, except those that identify the causative substance for an adverse effect of a drug that is correctly prescribed and properly administered and/or poisoning (E850-E949).

5. Do not assign Morphology codes (M codes).

6. Do not assign ICD-9-CM procedure codes.

7. Assign CPT codes for all surgical procedures that fall in the surgery section.

8. Assign CPT codes from the following ONLY IF indicated on the case cover sheet:

a) Anesthesia section

b) Medicine section

c) Evaluation and management services section

d) Radiology section

e) Laboratory and pathology section

9. Assign CPT/HCPCS modifiers for hospital-based facilities, if applicable (regardless of payer).

10. Do not assign HCPCS Level II (alphanumeric) codes.