UC Riverside Health Professional Services Coding Guidelines

Diagnoses (ICD-9 CM) Coding

The CPT code or service is the driving force behind reimbursement. However, the ICD-9 diagnosis code must support the CPT code in order to reflect medical necessity.

The system of diagnosis codes used is the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9 CM).

The primary diagnosis must support or justify the physician's service. For instance, the inpatient consultant's primary diagnosis would be the reason for the consult and not necessarily the admitting diagnosis.

The highest level of specificity should be given when establishing a diagnosis. For instance, GI bleed has sub classifications, upper GI bleed and lower GI bleed. Sites of injuries, infections, and burns should also be provided. The claim should be as clean as possible. Therefore, try to avoid unspecified diagnoses and codes.

The highest level of certainty should be given when establishing the billing diagnosis. "Suspected" or "Rule Out" diagnoses cannot be coded. If the physician is working only with phenomena and has not yet formed a diagnosis, then the sign, symptom, or laboratory abnormality should be selected.

Document all conditions that coexist at the time of the visit that require or affect patient care, treatment or management. Conditions that were previously treated and no longer exist should not be coded.