Diagnosis Code Guide 2012

Internal Medicine

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2012 Diagnosis Code Guide for Internal Medicine

A diagnosis code is an encrypted number that references the medical condition that a provider determines what is wrong with a patient during a medical encounter based on patient input, physical examination and diagnostic testing. For example, Mr. Jones has chest pain and then presents himself to his personal physician or emergency room. The chest pain diagnosis is encrypted or converted to numbers, which are used by an insurance company computer to decode what the provider documented in the patient's chart and health insurance claim. Diagnosis codes are created by the World Health Organization. Diagnosis codes are added, deleted or changed in October every year.

We currently use the diagnosis codes established in a coding manual called the International Classification of Diseases, 9th Revision, Clinical Module also called ICD-9-CM. Chest Pain in New York City is the same in Portland Maine, Beverly Hills, San Antonio, Albany, Miami, London, Paris, Monte Carlo, Australia, Costa Rica, Bagdad or Tehran. The doctor or medical coder would encrypt or code the chest pain to the number 786.50. Coders, doctors, specialists, and insurance companies who look at 786.50 knows that this is chest pain. You can say that medical coding might be similar to Morse Code where we know that dot dot dot, dash dash dash, dot dot dot means SOS or help. It doesn't matter what language you speak, SOS means help. The same is with coding. 786.50 is chest pain. We learned about SOS in the Scouts, movies, Gilligan's Island, and anything about the Titanic Sinking. So, 786.50 would be chest pain until ICD-9 is replaced by ICD-10 but then a new code will be assigned to Chest Pain.

Each physician specialty has their own codes that are specific to the types of medical conditions that they treat. Some codes cross over to other specialties because that specialty also treats patient with those medical conditions. For example, an internal medicine specialist, family practice provider, pediatrician, geriatric provider and emergency care provider may have patients with chest pain. There are many rules with coding. These rules are designed to help prevent fraud or abuse. We don't code to get a visit paid. An example is: My doctor did a cranialrectalectomy, what diagnosis code can I bill with this to get it paid? This is not how we code. A diagnosis must be documented by the provider, it must support the service provided and it must show medical necessity to support the visit. There is a coding rule: If it isn't documented, it doesn't exist. Lets say Mr Smith goes to see Dr Jones, Dr Jones does a cranialrectalectomy but doesn't document a diagnosis. Dr. Jones can say that Mr. Jones had his head up his rectum, which could be coded 9x9.99, but Dr. Jones didn't document this, so he has no proof to support doing the cranialrectalectomy. He has no proof Mr. Smith's head was where the sun doesn't shine. Mr. Smith may take Dr Jones to court to sue for malpractice. The lack of documentation may cause Dr Jones to lose the lawsuit or to settle out of court. There is a saying, "Document your medical record as if you were going to court. " Diagnosis coding is usually done by the doctor or a specialist known as a medical coder or coder who underwent special training to learn how to properly code a medical visit.

Medical coding can be complex and it requires special training. Being the spouse of a doctor, a receptionist, an office manager, or a medical biller doesn't qualify that person to be a coder. A medical biller has training in medical billing. That training contains just the basics of medical coding. This is

because a medical biller is also a specialist. A medical biller must know the basics of coding because the codes selected by the doctor or medical coder is placed on a medical claim that is sent to a patient's health benefit plan. If the claim is not paid correctly or is denied based on a coding issue, the biller can identify the problem and have the doctor or coder make the appropriate corrections. A good example is that Mr. Jones presents with an open wound on his hand. Dr Jones performs a surgical repair of the wound. A diagnosis of dandruff would be the wrong diagnosis to use with a surgical repair of the wound. Obviously the correct diagnosis would be an open wound of the hand. If the biller saw that a diagnosis of dandruff was selected, the coder or doctor would be informed of this so that incorrect diagnosis is replaced with the correct diagnosis. The biller sends the claim with the correct diagnosis. Again, the diagnosis is documented in the medical record. The doctor can argue until the cows come home that the patient had an open wound but if it isn't documented, there is no proof of this. Some specialties may come into contact with hundreds of diagnosis codes and there may be that one code that may be different because each patient is different, their medical condition is different. Mrs. Jones may not have the same diagnosis as Mrs. Smith or Mrs. Magillicuddy. So, you cant say Mrs. Jones came in and her diagnosis is 999.XX or when Mrs. Smucker brings in her child Tobi, his diagnosis will be 250.XX.

Some practices develop Superbills. A superbill is a document that lists the most common CPT or procedure codes used by that provider. It may also list the most common diagnosis codes used in that practice. For example, an emergency care provider may use CPT codes 99281, 99282, 99283, 99284 and 99285 for medical care they provided in the emergency room. They may also use diagnosis codes 786.50, 250.00 which are for chest pain and diabetes. The superbill may also include the provider's usual and customary provider charges for each CPT code, for example, for CPT 99281, the charge might be $125 (not real charge), so if Mr. Jones presents with chest pain, the doctor might checkmark CPT 99283 and 786.50. This means that the biller sends a claim for an emergency department visit supported by the diagnosis of chest pain. We have encoded and decoded the visit, treatment and diagnosis. We encrypt and decrypt. The codes marked on a superbill must be supported by the medical record documentation. Due to the fact that every year codes are added, deleted or changed, a superbill must also be changed every year to reflect what CPT and ICD-9 codes are current for that given year. A superbill does not replace proper coding and medical record documentation. Many practices use superbills to give to patients so show the results of the visit. The Don Self website, www.donself.com has many superbills for different specialties. These are free to download. First and foremost, I did not invent this document. Someone created a neat internal medicine superbill. I didn't reinvent the wheel. I simply reviewed and verified the codes for the alphabetical diagnosis with current coding manuals to ensure accuracy of the diagnosis code itself. The following codes were obtained from a generic internal medicine superbill, from the Don Self website, so Don deserves most of the credit for having the information available for free for us all. This document is a guide only and is not the final authority for diagnosis coding and it does not replace proper and correct diagnosis coding using current ICD-9-CM with the medical record documentation. The doctor or coder should always double check the coding manual for additional information specific to the code. It is current for 2012 only. This guide does NOT replace the services that should be provided by a well trained and certified medical coder. The following diagnoses, in alphabetical order, and their corresponding ICD-9-CM codes, are used by Internal Medicine

Physicians (***This list is NOT all inclusive of every code used by Internal Medicine. This is just a guide only. Every practice should always code from medical record documentation and use current coding manuals***: **Please do not contact me to ask me what code do I use for a cranialrectalectomy. I never code from a message. I only code directly from the medical record documentation. If you are a student, bring any questions you have to your instructor. I do not support fraud in any form.**

Diagnosis	Code
Abdominal pain	789.00
Abnormal EKG	794.31
Abnormal Mammogram	793.80
Abnormal Weight Loss	783.21
Acute URI	465.9
Allergy, Unspecified	995.3
Alopecia	704.00
Anxiety	300.00
Arrhythmia, Cardiac	427.9
Arthrosclerosis – Aorta	440.0
Angina Pectoris.	413.9
Ankle Pain	719.47
Asthma	493.9
ASOM (Acute Supurative Otitis Media)	382.0
Aortic Valve Insufficiency	396.3
Atrial Fibrillation	427.31
Atrial Flutter	427.32
Atrial Tachycardia (PAT)	427.0
B-12 Deficiency	266.2
Back Pain	724.5

Diagnosis	Code
Barrett's Esophagus	530.85
Blood in Stool	578.1
Bilateral Bundle Block (BBB)	426.53
Bradycardia	427.89
Bronchitis	491.2
Bursitis	727.3
Benign Hypertrophy Prostate (BPH)	600.00
Cancer, Breast	233.0
Cancer, Lung	162.9
Cancer, Prostate	233.4
Candidiasis – Oral (Thrush)	112.0
Cardiomyopathy, Hypertropic	425.11
Cardiomegaly	429.3
Carpal Tunnel Syndrome	354.0
Chest Pain	786.50
Celaic Disease	579.0
Cellulitis, Abscess	682.9
Cellulitis of digit	681.9
Cellulitis of Pharynx`	478.21
Cellulitis of face	682.0
Cellulitis of neck	682.1
Cellulitis of trunk	682.2
Cellulitis of arm	682.3

Diagnosis	Code
Cellulitis of hand	682.4
Cervicalgia	723.1
Cervical Neuropathy	353.0
Chronic Lymphoid Leukemia (CLL)	204.1
Cirrhosis of Liver	571.5
Coccyx pain	724.79
Common Cold	460
COPD	496
Colitis, Ulcerative	556.9
Confusion	298.2
Congestive Heart Failure	428.0
Conjunctivitis	372.30
Coronary Artery Disease	414.00
Constipation	564.00
Contusion, Face/neck/scalp	920
Contusion, abdominal wall	922.2
Contusion, back	922.31
Contusion, Chest	922.1
Contusion, Elbow	923.10
Contusion, eye (Black Eye)	921.0
Contusion, eye	921.9
Contusion Lower leg	924.10
Contusion, shoulder	923.00

Diagnosis	Code
Contusion, trunk	922.9
Cough	786.2
Crohn's Disease	555.9
Cyanosis	782.5
Congestive Heart Failure (CHF)	428.0
CVA (Stroke)	436
Disk Degeneration Disease, Cervical	722.4
Deficiency of Vitamin D	268.9
Dehydration	276.51
Dementia, Senile	290.0
Depression	311
Diabetes, type II	250.00
Diarrhea	787.91
Diverticulitis	562.11
Dizziness	780.4
Downs Syndrome	758.0
Dysphagia	787.2
Dysuria	788.1
Dyspepsia	536.8
Deep Vein Thrombosis (DVT)	453.3
Ear Ache/Pain (Otalgia)	388.7
Edema	782.3
Emphysema	492.8

Diagnosis	Code
Endocarditis	424.90
Erectile Dysfunction	607.84
Epigastric Pain	789.06
Esophagitis	530.10
Fatigue	780.79
Fever	780.60
Fibromyalgia	729.1
Gait Abnormality	781.2
Gastritis	535.00
GERD	530.11
Glaucoma	365.9
Gout	274.9
Goiter	240.9
Head Ache	784.0
Head injury	959.01
Health Checkup	V70.0
Hematuria	599.7
Hemmorhoids	455.6
Herpes Simplex	054.9
Herpes Zoster	053.9
Hiatial Hernia	553.3
Hip pain	719.46
HIV	042.00
Hepatitis B	V02.61

Diagnosis	Code
Hormone Replacement Therapy	V07.4
Hypercalcemia	275.42
Hypercoagulate State	289.81
Hyperglyceridemia	272.1
Hyperlipidemia	272.4
Hyperparathyroidism	252.00
Hypertension	401.9
Hypocalcemia	275.41
Hypogylcemia	251.2
Hypothyroidism	244.9
Impacted Cerumen	380.4
Impotence	302.72
Influenza w/pneumonia	487.0
Insomnia, NOS	780.52
Irritable Bowel Syndrome	564.1
Knee Pain	719.46
Knee contusion	924.11
Kyphosis	737.10
Leukocytosis	288.60
Lumbago	724.2
Lung Nodule	518.89
Lupus	695.4
Left Bundle Branch Block	426.3

Diagnosis	Code
Macular Degeneration	362.50
Malaise	780.79
Menopause	627.2
Mental Status Change	780.97
Medial Meniscus Tear	717.3
Migraine	346.00
Morbid Obesity	278.01
Multiple Sclerosis	340
Murmur, heart	785.3
Muscle Pain	729.1
Myocardial Infarction, NOS	410.92
Neck Pain	723.1
Nausea, alone	787.02
Nausea with vomiting	787.01
Nicotine Dependence	305.1
Neutropenia	288.0
Nocturia	788.43
Obesity	278.00
Obesity, morbid	278.01
OCD	300.3
Oral Thrush	112.0
Osteoarthrotis	715.90
Osteoarthritis	721.2

Diagnosis	Code
Osteomalicia	268.2
Otitis Media	382.9
Ovarian Cyst	620.2
Panic Disorder	300.01
Pain, Acute	338.19
Palpitations	785.1
Parkinsons Disease	332.0
Paresthesia	355.1
Polycystic Ovaries	256.4
Peripheral neuropathy	356.8
Peripheral Vascular Disease	443.9
Pharyangitis	462
Plantar Nerve Lesion	355.6
Pleurisy	511.0
Pneumonia	486
Post Nasal Drip	784.91
Prostatitis	601.9
Post Menopausal Disorder	627.8
Proteinuria	791.0
Prostate Specific Antigen, elevated	790.93
Radiculitis	729.2
Rectal Pain	569.42

Diagnosis	Code
Renal Calculus	592.0
Renal Failure	586
Renal Hernia	593.89
Rheumatoid Arthritis	714.0
Rhinitis, chronic	472.0
Rotator Cuff Tear	727.61
Sarcoidosis	135
Sciatica	724.3
Scoliosis	737.30
Seasonal Allergies	477.9
Seizures, Post Traumatic	780.33
Sinusitus	461.0
Sleep Apnea	780.57
Shortness of Breath	786.05
Spasm of Muscle	728.85
Sprain/Strain Uspc.	848.9
Supraventricular Tachycardia	427.0
Swelling of limb	729.81
Syncope	780.2
Tachycardia	785.0
Tendonitis	726.5
Transient ischemic attack [TIA]	435.9
Thyroiditis	245.9
Thrombocytopenia	287.39

Diagnosis	Code
Ulcer, Duodenal	532.90
Ulcer, gastric	531.90
Ulcer, peptic	533.90
Unstable Angina	411.1
Upper Respiratory Infection (URI)	465.9
Urinary Tract Infection (UTI)	599.0
Urethral Instability	599.83
Urinary Incontinence stress, Female	625.6
Urinary Frequency	788.41
Urinary Hesitancy	788.64
Vertigo	438.85
Venous insufficiency	459.81
Viral Infection	079.99
Vision Impairment, one eye	369.70
Vision Impairment, both eyes	369.20
Vomiting	787.03
Weight loss, abnormal	783.21
Weight gain, abnormal	783.1
Wheezing	786.07
Vitamin K Deficiency	269.0
Vitamin D Deficiency	268.9
Vitamin B12 Deficiency	281.1

About The Author

Steve Verno is a Certified Medical Billing Specialist Instructor, a Certified Multispecialty Coding Specialist, an Emergency Medicine Coding Specialist, a Certified Practice Manager-Medical Coding Specialist. Steve's specialties include emergency medicine, family practice, internal medicine, pediatrics, ERISA, ICD-10-CM, appeals, AR Recovery, provider health insurance contracts, the Patient Centered Medical Home, and Training. Steve is a member of the Medical Economics Committee of the Florida College of Emergency Physicians, the Professional Association of Healthcare Coding Specialists, the Physician Office Managers Association of America, the Medical Association of Billers as well as editorial board member of Billing-Coding Advantage, the Coding Institute, and Codetrends magazine. He is a subject matter expert and coding consultant to the National Center for Competency Testing. He provides coding and billing consulting/instruction to the Lake-Sumter Medical Society, Lake Sumter State College, and Heal Your Practice. Steve is a coding and billing professor with Everest University currently on medical leave. He has co-authored a book on the Employee Retirement Income Security Act with Don Self, through Greenleaf Publishing. Steve served as a medic in the United States Army from 1972 to 1992.