ICD-9, CPT Manuals, and SOAP Notes

Overview of the ICD-9-CM Coding Manual

The *International Classification of Diseases, Ninth Revision, Clinical Modification* (*ICD-9-CM*) manual is a diagnostic coding system that provides hospitals, outpatient services, physicians, and ancillary personnel in the health care industry with the right tool to effectively and efficiently code the appropriate classification of diseases, disorders, symptoms, or syndrome accurately.

The World Health Organization (WHO) is responsible for approving any changes, revisions, or updates to the ICD-9-CM manual, which is updated annually. The diagnostic coding manual has a numerical system in which the codes range between three and five digits. Volume 1 provides a tabular list. There are 17 diagnostic sections in Volume 1 ranging in numbers from 001 to 999.

Additionally, the 18th and 19th sections of Volume 1 are E-Codes and V-Codes. E-Codes cover *Supplementary Classification of the External Causes of Injury and Poisoning* (codes E800–E999), and V-Codes cover *Supplementary Classification of Factors Influencing Health Status and Contact with Health Services* (codes V01–V86). Volume 2 provides an alphabetic index. It is divided into three sections, and it includes two helpful tables. Volume 3 is made up of procedure codes and is mostly used when assigning codes to inpatient ailments, diagnostic conditions, or surgical procedures.

Overview of the CPT Coding Manual

The *Current Procedural Terminology* (CPT) manual is a technical procedure coding system that allows providers such as hospitals, outpatient services, physicians, and ancillary personnel greater ease in selecting the appropriate classifications. The CPT manual has six distinctive sections:

- Evaluation and Management (E/M)
- Anesthesia
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine

The American Medical Association (AMA) is responsible for approving any changes, revisions, or updates to the CPT manual, which is updated annually. The CPT codes consist of five digits, unlike the ICD-9-CM manual, which can range from three to five digits. For example, the code for a physician office visit for a new E/M Level 3 patient would be interpreted as 99203, or an established patient would be coded as
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99213. As you can see, there are always five-digit numbers with no alternative variations. This consistency makes working with a CPT diagnostic code much simpler for medical documentation than ICD-9-CM diagnostic code.

The SOAP (Subjective, Objective, Assessment, Plan) and the POMR (problem-orientated medical record) are medical record documentation forms that are filled out by the attending medical provider. These forms tell the written, initial impression used by the physician to assess any patient conditions; the clinical finds based on laboratory tests, such as EKGs (electrocardiograms), X-rays, or ultrasounds; the assessment, which is the final diagnosis or list of the patient's conditions; and the complete work-up information or instructions given to the patient to help in aiding follow-up care or treatment.

When written documentation submitted by the attending physician is completely filled out, the medical coding and billing professional should look for the three key components used to establish the proper level of service:

- history
- physical exam
- medical decision making

When the right information is located and obtained, then the medical coding and billing professional can enter the pertinent data into the specialized encoding CPT and ICD-9-CM software, designed for medical records or billing departments.

The medical billing professional should always read everything thoroughly before assigning or entering any information into the computer. The CPT and ICD-9-CM should always be accurately coded to the correct level of specificity that is justifiable. Ensuring accuracy of the codes will help eliminate problems with medical SOAP or POMR documentation forms being upcoded or downcoded incorrectly at a higher or lower CPT fee amount; procedures such as office visits, lab work, or surgeries would receive the correct reimbursement rates. Furthermore, there should never be any unbundling of CPT codes as separate procedures in an effort to receive a higher reimbursement unless it is specifically stated in the Correct Coding Initiative (CCI) manual established by the Center for Medicare and Medicaid Services (CMS).