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# LET'S CODE IT!

2022–2023 CODE EDITION

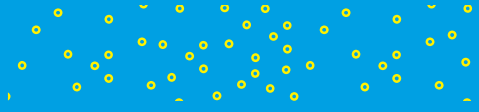
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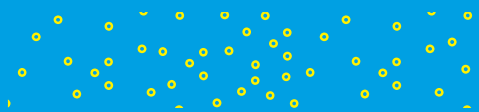
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# Let's Code It!

2022–2023 CODE EDITION







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Courtesy of Shelley C. Safian

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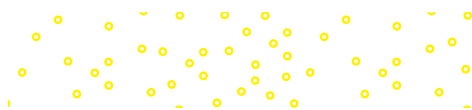


Courtesy of Jimmy Wood and Mary A. Johnson

## Dedications

—This book is dedicated to all of those who have come into my life sharing encouragement and opportunity to pursue work that I love; for the benefit of all of my students: past, present, and future.  
—*Shelley*

—This book is dedicated in loving memory of my parents, *Dr. and Mrs. Clarence J. Johnson Sr.*, for their love and support. Also, to those students with whom I have had the privilege to work and to those students who are beginning their journey into the world of medical coding.  
—*Mary*





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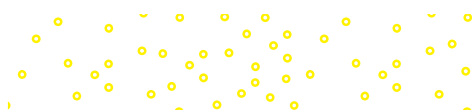
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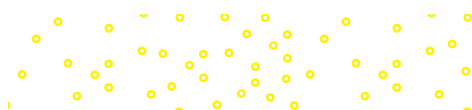
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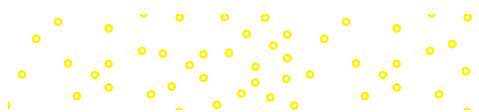
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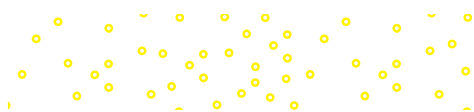
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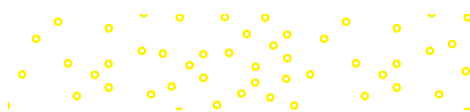
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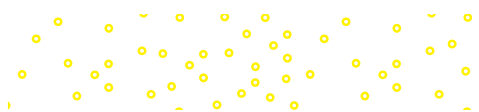
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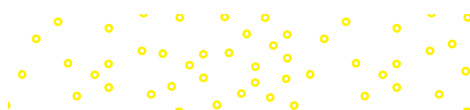
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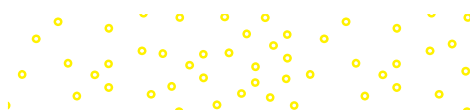
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# GUIDED TOUR

*Let's Code It!* was developed with student success in mind: success in college, success taking the certification exam, and success in their future health care career.

## Chapter Openers

Each chapter begins by clearly identifying the **Learning Outcomes** students need to master along with the **Key Terms** that they need to learn.

**1** Introduction to the Languages of Coding

**Key Terms**  
Classification Systems  
Condition  
Diagnosis  
Eponym  
External Cause  
Inpatient  
Medical Necessity  
Nonessential Modifiers  
Outpatient  
Procedure  
Reimbursement  
Services  
Treatments

**Learning Outcomes**  
*After completing this chapter, the student should be able to:*  
**LO 1.1** Explain the four purposes of medical coding.  
**LO 1.2** Identify the structure of the ICD-10-CM diagnosis coding manual.  
**LO 1.3** Differentiate between the types of procedures and the various procedure coding manuals.  
**LO 1.4** Examine the HCPCS Level II coding manual used to report the provision of equipment and supplies.

**1.1 The Purpose of Coding**  
Around the world, languages exist to enable clear and accurate communication between individuals in similar groups or working together in similar functions. The purpose of using health care coding languages is to enable the sharing of information, in a specific and efficient way, between all those involved in health care. Coding languages are constructed of individual codes that are more precise than words. (You will discover this as you venture through this textbook.) By communicating using codes rather than words, you can successfully convey to others involved (1) exactly what happened during a provider-patient encounter and (2) why it occurred. You, as the professional coding specialist, have the responsibility to accurately interpret

**CODING BITES**  
We use the concept of “languages” to help you relate medical coding—and its code sets—to an idea you already understand. In

## Coding Bites

These appear throughout the text to highlight key concepts and tips to further support understanding and learning.

### CODING BITES

This is just an overview to help you orient yourself to the structure of the code book. You will learn, in depth, how to use the ICD-10-CM code set to report any and all of the reasons *why* a patient needs the care of a health care professional in *Part II: Reporting Diagnoses*.

## Examples, Let's Code It! Scenarios, and You Code It! Case Studies

**Examples** are included throughout each chapter to help students make the connection between theoretical and practical coding. **Let's Code It! Scenarios** walk students through abstracting and the coding process, step-by-step, to determine the correct code. And **You Code It! Case Studies** provide students with hands-on practice coding scenarios and case studies throughout each chapter. In addition, **You Interpret It!** questions present opportunities for students to use critical-thinking skills to identify details needed for accurate coding.

### EXAMPLES

- C82.07 Follicular lymphoma grade I, spleen
- C82.16 Follicular lymphoma grade II, intrapelvic lymph nodes

These two codes are examples of those with code descriptions that require you to check the physician's documentation and pathology reports to identify the grade



### LET'S CODE IT! SCENARIO

Abby Shantner, a 41-year-old female, comes to see Dr. Branson to get the results of her biopsy that Abby has an alpha cell adenoma of the pancreas. Dr. Branson spends 30 minutes discussing the results.

#### Let's Code It!

Dr. Branson has diagnosed Abby with an alpha cell adenoma of the pancreas. You have been assigned as his coder for a while, so you know that an adenoma is a neoplasm, but you need to determine if it is benign or malignant? To help you determine this, instead of going to neoplasm, let's go to the Alphabetic Index under adenoma. When you find adenoma, the book refers you to

**Adenoma** (see also Neoplasm, benign, by site)

This tells you an adenoma is a benign tumor. Or you can continue down this list to the

**Adenoma**  
alpha-cell  
pancreas D13.7

Turn to the Tabular List and read the complete description of code category D13:

D13.7 Benign neoplasm of other and ill-defined parts of digestive system

### YOU INTERPRET IT!

What is the mode of transmission for each condition?

- |                |       |                 |       |
|----------------|-------|-----------------|-------|
| 1. Hepatitis B | _____ | 4. Insect bites | _____ |
| 2. Measles     | _____ | 5. Influenza    | _____ |
| 3. Cholera     | _____ |                 |       |

## Guidance Connections

Each of these boxes connects the concepts students are learning in the chapter to the related, specific Official Guidelines in order to further students' knowledge and understanding of coding resources.



### GUIDANCE CONNECTION

Read the ICD-10-CM Official Guidelines for Coding and Reporting, section I. Conventions, General Coding Guidelines and Chapter-

## End-of-Chapter Reviews

Most chapters end with the following assessment types to reinforce the chapter learning outcomes: Let's Check It! Terminology; Let's Check It! Concepts; Let's Check It! Guidelines; Let's Check It! Rules and Regulations; and You Code It! Basics.

### CHAPTER 39 REVIEW Reimbursement



CHAPTER 39 REVIEW

#### Let's Check It! Terminology

Match each term to the appropriate definition.

##### Part I

- LO 39.2 A physician, typically a family practitioner or an internist, who serves as the primary care physician for an individual. This physician is responsible for evaluating and determining the course of treatment or services, as well as for deciding whether or not a specialist should be involved in care.
  - LO 39.1 A type of health insurance coverage that controls the care of each subscriber (or insured person) by using a primary care provider as a central health care supervisor.
  - LO 39.2 A type of health insurance that uses a primary care physician, also known as a gatekeeper, to manage all health care services for an individual.
  - LO 39.2 A policy that covers loss or injury to a third party caused by the insured or something belonging to the insured.
  - LO 39.1 The total management of an individual's well-being by a health care professional.
  - LO 39.3 An insurance company pays a provider one flat fee to cover the entire course of treatment for an individual's condition.
  - LO 39.2 The agency under the Department of Health and Human Services (DHHS) in charge of regulation and control over services for those covered by Medicare and Medicaid.
  - LO 39.3 Payment agreements that outline, in a written fee schedule, exactly how much money the insurance carrier will pay the physician for each treatment and/or service provided.
  - LO 39.3 An extra reduction in the rate charged to an insurer for services provided by the physician to the plan's members.
  - LO 39.1 The amount of money, often paid monthly, by a policyholder or insured, to an insurance company to obtain coverage.
  - LO 39.2 Auto accident liability coverage will pay for medical bills, lost wages, and compensation for pain and suffering for any person injured by the insured in an auto accident.
  - LO 39.3 Agreements between a physician and a managed care organization that pay the physician a predetermined amount of money each month for each member of the plan who identifies that provider as his or her primary care physician.
  - LO 39.2 A plan that reimburses a covered individual a portion of his or her income that is lost as a result of being unable to work due to illness or injury.
  - LO 39.2 Individuals who are supported, either financially or with regard to insurance coverage, by others.
- Automobile Insurance
  - Capitation Plans
  - Centers for Medicare & Medicaid Services (CMS)
  - Dependents
  - Disability Compensation
  - Discounted FFS
  - Episodic Care
  - Fee-for-Service (FFS) Plans
  - Gatekeeper
  - Health Care
  - Health Maintenance Organization (HMO)
  - Insurance Premium
  - Liability Insurance
  - Managed Care

CHAPTER 39 | REIMBURSEMENT 1183

## Real Abstracting Practice with You Code It! Practice, You Code It! Application, and Capstone Case Studies Chapters

Gain real-world experience by using actual patient records (with names and other identifying information changed) to practice ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Level II coding for both inpatients and outpatients. *You Code It! Practice* exercises give students the chance to practice coding with short coding scenarios. *You Code It! Application* exercises give students the chance to review and abstract physicians' notes documenting real patient encounters in order to code those scenarios. Both of these types of exercises can be found at the end of most chapters. *Capstone Chapters* come at the end of Parts II–V and include 15 additional real-life outpatient and inpatient case studies to help students synthesize and apply what they have learned through hands-on coding practice with each code set.



### YOU CODE IT! Practice

Using the techniques described in this chapter, carefully read through the case studies and determine the most accurate ICD-10-CM code(s) and external cause code(s), if appropriate, for each case study.

- George Donmoyer, a 58-year-old male, presents today with a sore throat, persistent cough, and earache. Dr. Selph completes an examination and appropriate tests. The blood-clotting parameters, the thyroid function studies, as well as the tissue biopsy confirm a diagnosis of malignant neoplasm of the extrinsic larynx.
- Monica Pressley, a 37-year-old female, comes to see Dr. Wheaton today because she has been having diarrhea and abdominal cramping and states her heart feels like it's quivering. The MRI scan confirms a diagnosis of benign pancreatic islet cell adenoma.
- Suber Wilson, a 57-year-old male, was diagnosed with a malignant neoplasm of the liver metastasized from the prostate; both sites are being addressed in today's encounter.
- William Amerson, a 41-year-old male, comes in for his annual eye examination. Dr. Leviner notes a benign right conjunctiva nevus.
- Edward Bakersfield, a 43-year-old male, presents with shortness of breath, chest pain, and coughing up blood. After a thorough examination, Dr. Benson notes stridor and orders an MRI scan. The results of the MRI confirm the diagnosis of bronchial adenoma.
- Elizabeth Conyers, a 56-year-old female, presents with unexplained weakness, weight loss, and dizziness. Dr. Amos completes a thorough examination and does a workup. The protein electrophoresis (SPEP) and quantitative immunoglobulin results confirm the diagnosis of Waldenström's macroglobulinemia.
- James Buckholtz, a 3-year-old male, is brought in by his parents. Jimmy has lost his appetite and is losing weight. Mrs. Buckholtz tells Dr. Ferguson that Jimmy's gums bleed and he seems short of breath. Dr. Ferguson notes splenomegaly and admits Jimmy to Weston Hospital. After reviewing the blood tests, MRI scan, and

In addition, all of the exercises in the Chapter Review can be assigned through Connect. Of particular note are the *You Code It! Practice* exercises, which offer our unique **CodePath** option. In Connect, students are presented with a series of questions to guide them through the critical thinking process to determine the correct code.



### YOU CODE IT! Application

The following exercises provide practice in abstracting physician documentation from our health care facility, Prader, Bracker, & Associates. These case studies are modeled on real patient encounters. Using the techniques described in this chapter, carefully read through the case studies and determine the most accurate ICD-10-CM code(s) for each case study. Remember to include external cause codes, if appropriate.

#### PRADER, BRACKER, & ASSOCIATES

A Complete Health Care Facility

159 Healthcare Way • SOMEWHERE, FL 32811 • 407-555-6789

PATIENT: Cassandra, Kelly

ACCOUNT/EHR #: KASSKE001

DATE: 09/16/22

Attending Physician: Oscar R. Prader, MD

S: Pt is a 19-year-old female who has had a sore throat and cough for the past week. She states that she had a temperature of 101.5 F last night. She also admits that it is painful to swallow. No OTC medication has provided any significant relief.

O: Ht 5'5" Wt. 148 lb. R 20. T 101 F. BP 125/82. Pharynx is inspected, tonsils enlarged. There is pus noted in the posterior pharynx. Neck: supple, no nodes. Chest: clear. Heart: regular rate and rhythm without murmur.

A: Acute pharyngitis

P: 1. Send pt for Strep test

2. Recommend patient gargle with warm salt water and use OTC lozenges to keep throat moist

3. Rx if needed once results of Strep test come back

4. Return in 2 weeks for follow-up

Determine the most accurate ICD-10-CM code(s).

#### WESTON HOSPITAL

629 Healthcare Way • SOMEWHERE, FL 32811 • 407-555-6541

PATIENT: DAVIS, HELEN

ACCOUNT/EHR #: DAVIHE001

DATE: 10/21/22

Attending Physician: Renee O. Bracker, MD

Patient, an 82-year-old that presents today to see Dr. Newson. Dr. Newson saw this patient 10 days ago in office, where she was diagnosed with a UTI and prescribed nitrofurantoin PO. Today she presents with the complaints of dysuria, low back pain, abdominal pain, nausea, and diarrhea. After a positive UA she was admitted to Weston Hospital.



Welcome to *Let's Code It!* This product has been created to instruct students on how to become proficient in medical coding—a health care field that continues to be in high demand. The Bureau of Labor Statistics notes the demand for health information management professionals (which includes coders) will continue to increase incredibly through 2029 and beyond.

*Let's Code It!* offers a 360-degree learning experience for anyone interested in the field of medical coding, with strong guidance down the path to coding certification. Theory is presented in easy-to-understand language and accompanied by lots of examples. Hands-on practice is included with real-life physician documentation, from both outpatient and inpatient facilities, to promote critical thinking analysis and evaluation. This is in addition to determination of accurate codes to report diagnoses, procedures, and ancillary services. All of this is assembled to support the reader's development of a solid foundation upon which to build a successful career after graduation.

*Let's Code It!* is designed to give your students the medical coding experience they need in order to pass their first medical coding certification exams, such as the CCS/CCS-P or CPC/COC. This product offers students a variety of practice opportunities by reinforcing the learning outcomes set forth in every chapter. The chapter materials are organized in short bursts of text followed by practice—keeping students active and coding!

**What's new for the 2022–2023 Code Edition:** Our content has been updated to include key advancements in our industry through the last year. For example, coding for cases of COVID-19 (testing through confirmed diagnosis) and Social Determinants of Health, have been added to this edition. All codes within the text, as well as the Instructor Manual answer keys, have been updated to be compliant with the 2022 code sets: ICD-10-CM, CPT, HCPCS Level II, and ICD-10-PCS. Updates will continue to be made to the answer keys and Connect exercises as necessary for currency.

## Here's What You Can Expect from *Let's Code It!*

- Each of the six parts of this product includes an Introduction to provide students with an overview of the information within that part and how they can use this knowledge.
  - Part I: Medical Coding Fundamentals
  - Part II: Reporting Diagnoses
  - Part III: Reporting Physicians Services and Outpatient Procedures
  - Part IV: DMEPOS & Transportation
  - Part V: Inpatient (Hospital) Reporting
  - Part VI: Legal, Ethical, and Reimbursement Issues
- **Part I: Medical Coding Fundamentals** helps students build a strong theoretical foundation regarding the various code sets. The chapters teach students how and when each code set is used and how to abstract documentation. These chapters also teach them how to use a solid coding process, including the importance of queries, how to write a legal query, exposure to the Official Guidelines, and confirmation of medical necessity.

- **Part II: Reporting Diagnoses** provides students with an incremental walkthrough of the ICD-10-CM code set.
- **Part III: Reporting Physicians Services and Outpatient Procedures** provides students with a progressive learning experience for using CPT® procedure codes.
- **Part IV: DMEPOS & Transportation** gives students insight into, and hands-on practice using, the HCPCS Level II code set to report the provision of durable medical equipment, prosthetics, orthotics, and other medical supplies.
- **Part V: Inpatient (Hospital) Reporting** shows students how to build an accurate ICD-10-PCS code to report inpatient procedures, services, and treatments.
- The coding chapters in Parts II–V all include real-life scenarios, as well as physician documentation mainly in the form of procedure notes and operative reports (both inpatient and outpatient) for students to practice abstracting and coding.
  - *Let's Code It! Scenarios* provide step-by-step instruction so students can learn to use their critical-thinking skills throughout the coding process to determine the correct code.
  - *You Code It! Case Studies* provide students with hands-on practice coding scenarios and case studies throughout each chapter.
  - *You Interpret It!* questions present additional opportunities for students to use critical-thinking skills to identify details required for accurate coding.
  - *Chapter Reviews* include assessments of chapter concepts:
    - Let's Check It! Terminology
    - Let's Check It! Concepts
    - Let's Check It! Guidelines
    - Let's Check It! Rules and Regulations
    - You Code It! Basics
    - You Code It! Practice Case Studies
    - You Code It! Application Case Studies
  - *Examples* are included throughout each chapter to help students make the connection between theoretical and practical coding.
  - *Coding Bites* highlight key concepts and tips to further support understanding and learning.
  - *Guidance Connection* features point to the specific Official Guideline applicable for the concept being discussed.
  - *Capstone Chapters* come at the end of Parts II–V with 15 additional real-life outpatient and inpatient case studies to help students synthesize and apply what they have learned through hands-on coding practice with each code set.
- **Part VI: Legal, Ethical, and Reimbursement Issues** provides a concise overview connecting these broad topics to a professional coding specialist's job requirements.
- *Examples* again take students through real-life scenarios to help them understand how they will use this information.
- *Coding Bites* provide tips and highlight key concepts.
- This part also includes material to teach students how to access credible resources on the Internet.
- *Codes of Ethics* from both AHIMA and AAPC are discussed as well as information on compliance plans.
- *You Interpret It!* questions present students with opportunities to use critical-thinking skills to identify details required for accurate job performance.

- *Chapter Reviews* include assessments of chapter concepts:
  - Let's Check It! Terminology
  - Let's Check It! Concepts
  - Let's Check It! Which Type of Insurance?
  - Let's Check It! Rules and Regulations
  - You Code It! Application Case Studies





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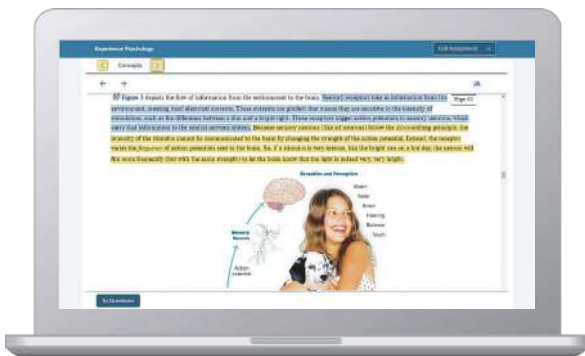
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## CONNECT FOR LET'S CODE IT!

McGraw-Hill Connect for *Let's Code It!* includes:

- All end-of-chapter questions.
- CodePath versions of You Code It! practice questions, in which students are presented with a series of questions to guide them through the critical thinking process to determine the correct code.
- Interactive Exercises, such as Matching, Sequencing, and Labeling activities.
- Testbank questions.
- Lecture-style videos, which provide additional guidance on challenging coding questions. With the 2022–2023 Code Edition, the videos are now assignable through the Question Bank with new assessment questions for students to complete after each video. The videos are also available in the Connect Media Bank.

## INSTRUCTORS' RESOURCES

You can rely on the following materials to help you and your students work through the material in the book; Instructor's manual, PowerPoint presentations, testbank, and additional tools to plan your course. These materials are available in the Instructor Resources under the Library tab in *Connect* (available only to instructors who are logged in to *Connect*).

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# PART I

## MEDICAL CODING FUNDAMENTALS

### INTRODUCTION

*Coding is not like anything you have ever studied before. No courses that you experienced in elementary, middle, or high school have prepared you for learning this skill. Biology and your science classes began your education that your anatomy and physiology class continued. Other courses you are taking as part of this program also typically connect to something, in some way, you have previously learned.*

*As you begin this educational journey, you will use your critical thinking skills as well as some experiences you may have had as a patient yourself (or as the loved one of a patient). For the most part, though, this will be different, so prepare yourself for a new learning experience.*

*In Part I, the chapters *Introduction to the Languages of Coding*, *Abstracting Clinical Documentation*, and *The Coding Process* share an overview of the concepts and skills you will apply in the chapters that follow. You will be introduced to the tools you have and will need to use as a professional coding specialist. Together, these three chapters create the foundation, the first layer, of a multilayered approach to learning coding. Then, the remaining parts will share with you, one by one, the best practices for how to use each of these tools correctly. You will then be given many opportunities for hands-on practice so that you can build your skills and reinforce the knowledge you have obtained.*

# 1

# Introduction to the Languages of Coding

## Key Terms

Classification Systems  
Condition  
Diagnosis  
Eponym  
External Cause  
Inpatient  
Medical Necessity  
Nonessential Modifiers  
Outpatient  
Procedure  
Reimbursement  
Services  
Treatments

## Learning Outcomes

After completing this chapter, the student should be able to:

- LO 1.1** Explain the four purposes of medical coding.
- LO 1.2** Identify the structure of the ICD-10-CM diagnosis coding manual.
- LO 1.3** Differentiate between the types of procedures and the various procedure coding manuals.
- LO 1.4** Examine the HCPCS Level II coding manual used to report the provision of equipment and supplies.

## CODING BITES

We use the concept of “languages” to help you relate medical coding—and its code sets—to an idea you already understand. In the health care industry, however, the various code sets, such as ICD-10-CM or HCPCS Level II, are referred to as **Classification Systems**.

### Classification Systems

The term used in health care to identify ICD-10-CM, CPT, ICD-10-PCS, and HCPCS Level II code sets.

## CODING BITES

A **diagnosis** explains WHY the patient requires the attention of a health care provider and a **procedure** explains WHAT the physician or health care provider did for the patient.

## 1.1 The Purpose of Coding

Around the world, languages exist to enable clear and accurate communication between individuals in similar groups or working together in similar functions. The purpose of using health care coding languages is to enable the sharing of information, in a specific and efficient way, between all those involved in health care.

Coding languages are constructed of individual codes that are more precise than words. (You will discover this as you venture through this textbook.) By communicating using codes rather than words, you can successfully convey to others involved (1) exactly what happened during a provider-patient encounter and (2) why it occurred. You, as the professional coding specialist, have the responsibility to accurately interpret health care terms and definitions (medical terminology) into numbers or number-letter combinations (alphanumeric codes) that specifically convey **diagnoses** and **procedures**.

Why is it so critical to code diagnoses and procedures accurately? The coding languages, known as **classification systems**, communicate information that is key to various aspects of the health care system, including

- Medical necessity
- Statistical analyses
- Reimbursement
- Resource allocation

### Medical Necessity

The diagnosis codes that you report explain the justification for the procedure, service, or treatment provided to a patient during his or her encounter. Every time a health care professional provides care to a patient, there must be a valid medical reason. Patients certainly want to know that health care professionals performed procedures or provided care for a specific, justified purpose, and so do third-party payers! This is referred to as **medical necessity**. Requiring medical necessity ensures that health care providers are not performing tests or giving injections without a good medical reason. Diagnosis codes explain *why* the individual came to see the physician and support the physician’s decision about *what* procedures to provide.

Medical necessity is one of the reasons why it is so very important to code the diagnosis accurately and with all the detail possible. If you are one number off in your code



selection, you could accidentally cause a claim to be denied because the diagnosis, identified by your incorrect code, does not justify the procedure.

Let's analyze an example:

### EXAMPLE

Dr. Justini performs a colonoscopy on Shoshanna because a lab test identified that she had blood in her feces (melena).

A colonoscopy involves the insertion of a camera, with surgical tools, into the patient's anus, rectum, and up through the large intestine. If you are Shoshanna, or if you are the one paying for this procedure, you want to make certain that this colonoscopy was done to support Shoshanna's good health and not any other reason. This is clearly communicated when you report the code **K92.1 Melena** (the presence of blood in feces). Now, whether for resource allocation or reimbursement, it is understood that Dr. Justini was caring properly for Shoshanna and her good health.

## Statistical Analyses

Research organizations and government agencies statistically analyze the data provided by codes to develop programs, identify research areas, allocate funds, and write public health policies that will best address areas of concern for the health of our nation. For example, we can only know that a disease such as Alzheimer's needs diagnostic tests, treatments, and possibly a vaccine or a cure by studying statistics to see what individual signs and symptoms are being identified and treated around the country and around the world.

## Reimbursement

In most cases, there are three parties involved in virtually every encounter: the health care provider, the patient, and the person or organization paying for the care provided (frequently, a health care insurance company). However, the insurance company is not always an actual insurance company, so the broader term "third-party payer" is used. Third-party payers use our coding data to determine how much they should pay health care professionals for the attention and services they provide patients. This is the role that coding plays in the **reimbursement** process. The codes make it easier for the organizations involved to evaluate and manage all their data.

## Resource Allocations

Whether a health care facility is a one-physician office or a large hospital, there are not unlimited resources available. Administrators and managers must ensure that all resources are employed in the most efficient and effective manner. Computer programs can easily and quickly organize data (the codes) to identify the largest patient population's diagnoses and the most frequently provided treatments and services. With these details, staff members, equipment, and money can be directed to those patients and locations that need them the most.

## 1.2 Diagnosis Coding

When a person goes to see a health care provider, he or she must have a reason—a health-related reason. After all, as much as you might like your physician, you probably wouldn't make an appointment, sit in the waiting room, and go through all the paperwork just to say, "hello." Whether the reason is a checkup, a flu shot, or something more serious, there is always a reason *why*. The physician will create notes, either written or dictated, recounting the events of the visit. The diagnosis,

### Diagnosis

A physician's determination of a patient's condition, illness, or injury.

### Procedure

Action taken, in accordance with the standards of care, by the physician to accomplish a predetermined objective (result); a surgical operation.

### Medical Necessity

The assessment that the provider was acting according to standard practices in providing a procedure or service for an individual with a specific diagnosis.

### CODING BITES

The **WHY** justifies the **WHAT**.

### Reimbursement

The process of paying for health care services after they have been provided.

### CODING BITES

In most cases, there are three parties involved in reimbursement:

- The health care provider = First party
- The patient = Second party
- The insurance company or other organization financially responsible = Third-party payer



or diagnostic statement, in these notes will explain the reason *why* the patient was seen and treated.

The physician's notes explain, in writing, the reasons *why* the encounter occurred. The notes may document a specific condition or illness, the signs or symptoms of a yet-unnamed problem, or another reason for the encounter, such as a preventive service. As a coding specialist, it is your job to translate this explanation into a diagnosis code (or codes) so that everyone involved will clearly understand the issues of a particular patient at a particular time.

The International Classification of Diseases - 10th Revision - Clinical Modification (ICD-10-CM) code book contains all of the codes from which you will choose to report the reason *why* the health care professional cared for the patient during a specific encounter.

## Overview of the International Classification of Diseases – 10th Revision – Clinical Modification (ICD-10-CM) Code Book Sections

The ICD-10-CM code book (whether paper or electronic) is made up of several sections. Here is an overview of its parts and how you will utilize the information in these sections to determine the most accurate code or codes to report the reasons *why* an encounter occurred.

### Index to Diseases and Injuries [aka Alphabetic Index]

The Alphabetic Index [Index to Diseases and Injuries] lists, in alphabetic order, the terms used by the physician to describe the reasons why the patient required attention from a health care professional.

The Alphabetic Index lists all diagnoses and other reasons to provide health care by their basic description alphabetically from A to Z (see Figure 1-1). Diagnostic descriptions are listed by

- **Condition** (e.g., infection, fracture, and wound)
- **Eponym** (e.g., Epstein-Barr syndrome and Cushing's disease)
- Other descriptors (e.g., personal history, family history)

Therefore, whichever type of words you read in the documentation, you should be able to find them in the Alphabetic Index in one form or another.

The Alphabetic Index can only suggest a possible code to report the patient's diagnosis, and you will use this suggestion to guide you to the correct page or subsection in the

### CODING BITES

This is just an overview to help you orient yourself to the structure of the code book. You will learn, in depth, how to use the ICD-10-CM code set to report any and all of the reasons *why* a patient needs the care of a health care professional in *Part II: Reporting Diagnoses*.

#### Condition

The state of abnormality or dysfunction.

#### Eponym

A disease or condition named for a person.

#### Abnormal, abnormality, abnormalities (see also Anomaly)

acid-base balance (mixed) E87.4  
albumin R77.0  
alphafetoprotein R77.2  
alveolar ridge K08.9  
anatomical relationship Q89.9  
apertures, congenital, diaphragm Q79.1  
auditory perception H93.29-  
    diplacusis—see Diplacusis  
    hyperacusis—see Hyperacusis  
    recruitment—see Recruitment, auditory  
    threshold shift—see Shift, auditory threshold  
autosomes Q99.9

**FIGURE 1-1** ICD-10-CM Alphabetic Index, partial listing under main term Abnormal

## B67 Echinococcosis

**INCLUDES** *hydatidosis*

**B67.0 Echinococcus granulosus infection of liver**

**B67.1 Echinococcus granulosus infection of lung**

**B67.2 Echinococcus granulosus infection of bone**

**B67.3 Echinococcus granulosus infection, other and multiple sites**

**B67.31 Echinococcus granulosus infection, thyroid gland**

**B67.32 Echinococcus granulosus infection, multiple sites**

**B67.39 Echinococcus granulosus infection, other sites**

**B67.4 Echinococcus granulosus infection, unspecified**

Dog tapeworm (infection)

**FIGURE 1-2** ICD-10-CM Tabular List, partial list of codes included in code category B67 Echinococcosis

Tabular List (see the next subsection of this text, *Tabular List of Diseases and Injuries*). The Official Guidelines require you to always find a suggested code in the Tabular List to confirm it is accurate, or to find another code that might be better.

### Tabular List of Diseases and Injuries

The Tabular List provides you with each and every available code in the ICD-10-CM code book, in order of the code characters—alphanumeric order. You need to carefully read the descriptions, beginning at the top of the three-character code category. When you begin reading at this point, you can make certain that you find the best code, to the highest level of specificity, according to the physician’s documentation.

You will find that the Tabular List section shows all ICD-10-CM codes, first in alphabetic order and then in numeric order: A00 through Z99.89 (see Figure 1-2), along with additional details (notations and symbols) that guide you to the accurate code.

### Ancillary Sections of ICD-10-CM

#### Neoplasm Table

The Neoplasm Table (Figure 1-3) itemizes all of the anatomical sites in the human body that may develop a tumor (neoplasm). Columns in this table further describe the type of neoplasm and suggest a code that may be accurate. As with other codes suggested by the Alphabetic Index, you will need to go to the Tabular List to look up any code found on the Neoplasm Table to confirm accuracy, additional characters required, and other details before you can determine the accurate code to report.

You will learn how to use the Neoplasm Table to report diagnoses of benign, malignant, and other types of neoplasms in the *Coding Neoplasms* chapter.

#### Table of Drugs and Chemicals

The Table of Drugs and Chemicals (Figure 1-4) lists pharmaceuticals and chemicals that may cause poisoning or adverse effects in the human body. The multiple columns in this table categorize the intent of how or why the patient became ill from the drug or chemical to suggest a possible code. As with all of these, this suggested code must be reviewed in the Tabular List to ensure completeness and accuracy before you can report it.

You will learn how to use the Table of Drugs and Chemicals in the chapter *Coding Injury, Poisoning, and External Causes*.

### CODING BITES

Notations in the Tabular List help make your coding process more accurate and a bit easier. For example, as you can see in Figure 1-2, the condition represented by code category B67 is Echinococcosis. Now, read the **INCLUDES** note directly below B67; it reads . . . **INCLUDES** *hydatidosis*. This notation lets you know that, if the physician wrote “echinococcosis” or “hydatidosis” in the documentation, this is the correct code category.

In ICD-10-CM, the **INCLUDES** note provides you with alternative words or phrases that the physician might use that mean the same condition. In English, they are known as synonyms. In ICD-10-CM, they are known as **nonessential modifiers**.

You will learn more about notations in the *Introduction to ICD-10-CM* chapter.

#### Nonessential Modifiers

Descriptors whose inclusion in the physician’s notes are not absolutely necessary and that are provided simply to further clarify a code description; optional terms.

	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified Behavior
<b>Neoplasm, neoplastic</b>	C80.1	C79.9	D09.9	D36.9	D48.9	D49.9
abdomen, abdominal	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.89
cavity	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.89
organ	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.89
viscera	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.89
wall (see <i>also</i> Neoplasm, abdomen, wall, skin)	C44.509	C79.2-	D04.5	D23.5	D48.5	D49.2
connective tissue	C49.4	C79.8-	—	D21.4	D48.1	D49.2
skin	C44.509	—	—	—	—	—
basal cell carcinoma	C44.519	—	—	—	—	—
specified type NEC	C44.599	—	—	—	—	—
squamous cell carcinoma	C44.529	—	—	—	—	—

**FIGURE 1-3** The Neoplasm Table from ICD-10-CM, listings for abdominal neoplasms

Substance	Poisoning, Accidental (Unintentional)	Poisoning, Intentional Self-harm	Poisoning, Assault	Poisoning, Undetermined	Adverse Effect	Underdosing
Acefylline piperazine	T48.6X1	T48.6X2	T48.6X3	T48.6X4	T48.6X5	T48.6X6
Acemorphan	T40.2X1	T40.2X2	T40.2X3	T40.2X4	T40.2X5	T40.2X6
Acenocoumarin	T45.511	T45.512	T45.513	T45.514	T45.515	T45.516
Acenocoumarol	T45.511	T45.512	T45.513	T45.514	T45.515	T45.516
Acepifylline	T48.6X1	T48.6X2	T48.6X3	T48.6X4	T48.6X5	T48.6X6
Acepromazine	T43.3X1	T43.3X2	T43.3X3	T43.3X4	T43.3X5	T43.3X6
Acesulfamethoxy pyridazine	T37.0X1	T37.0X2	T37.0X3	T37.0X4	T37.0X5	T37.0X6
Acetal	T52.8X1	T52.8X2	T52.8X3	T52.8X4	—	—
Acetaldehyde (vapor)	T52.8X1	T52.8X2	T52.8X3	T52.8X4	—	—
liquid	T65.891	T65.892	T65.893	T65.894	—	—
P-Acetamidophenol	T39.1X1	T39.1X2	T39.1X3	T39.1X4	T39.1X5	T39.1X6
Acetaminophen	T39.1X1	T39.1X2	T39.1X3	T39.1X4	T39.1X5	T39.1X6

**FIGURE 1-4** The Table of Drugs and Chemicals from ICD-10-CM, listings from Acefylline piperazine to Acetaminophen  
Source: *ICD-10-CM Official Guidelines for Coding and Reporting*, The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS)

## Index to External Causes

### External Cause

An event, outside the body, that causes injury, poisoning, or an adverse reaction.

The Index to **External Causes** (Figure 1-5) lists the causes of injury and poisoning. These codes are used to explain *how* a patient got injured and *where* (place of occurrence) he or she was when the injury happened.

As with the other content in the Alphabetic Index, the code or codes shown here are only suggestions and must be confirmed in the Tabular List before you are permitted to report them. You will learn about the importance of reporting these codes as you progress through your learning experience, particularly in the chapter *Coding Injury, Poisoning, and External Causes*.

**Abandonment** (causing exposure to weather conditions) (with intent to injure or kill) NEC X58

**Abuse** (adult) (child) (mental) (physical) (sexual) X58

**Accident** (to) X58

aircraft (in transit) (powered) (see *also* Accident, transport, aircraft)

due to, caused by cataclysm—see Forces of nature, by type

animal-rider—see Accident, transport, animal-rider

animal-drawn vehicle—see Accident, transport, animal-drawn vehicle occupant

automobile—see Accident, transport, car occupant

bare foot water skier V94.4

boat, boating (see *also* Accident, watercraft)

striking swimmer

powered V94.11

unpowered V94.12

bus—see Accident, transport, bus occupant

cable car, not on rails V98.0

**FIGURE 1-5** The Index to External Causes, first listings including main terms Abandonment, Abuse, and Accident

## The Format of ICD-10-CM Codes

A complete, valid ICD-10-CM code will always begin with a three (3)-character code category: a letter of the alphabet followed by a minimum of two (2) characters (either letters or numbers).

**E54**      **Ascorbic acid deficiency (scurvy)**

**L26**      **Exfoliative dermatitis**

A majority of the codes will require additional characters to communicate more specific information about the patient's condition. When an additional character is needed to complete the code, a symbol to the left of the code in the Tabular List will identify that additional characters are necessary. The symbol may be a bullet ● or it may be a box with a check mark , depending upon the publisher of your code book. You will find a legend to explain the meaning of each symbol at the bottom of the page in your code book. As you evaluate the options available for the additional character, make certain to place a dot (period) between the third and fourth characters.

Let's take a look at an example together:

**M17 Osteoarthritis of knee**

**M17.0 Bilateral primary osteoarthritis of knee**

The symbol to the left of code M17 alerts you that this code requires a fourth (4th) character. In looking at the second line of this example (M17.0), you can see that this fourth character shares additional, important information about the patient's condition. It is not enough to communicate that the patient has been diagnosed with osteoarthritis of the knee. You must explain the specific location (from our example, bilateral = both knees) and specific type of condition (from our example, primary osteoarthritis).

ICD-10-CM codes can be as short as three (3) characters and can add additional characters containing more specificity about the patient's condition . . . up to a total of seven (7) characters. These additional characters ensure that as much detail as possible about the patient's condition is communicated accurately and completely.

## CODING BITES

When additional characters are required, those codes with fewer characters are invalid. The need for additional characters is mandatory, not a suggestion.

## CODING BITES

You will learn many more details about reporting diagnoses in *Part II: Reporting Diagnoses*, with more in-depth introduction to ICD-10-CM as well as details by body system.

## EXAMPLE

The Tabular List shows you which details to abstract from the documentation. All you have to do is keep reading. The portion of the ICD-10-CM Tabular List below shows options for additional characters and the information these characters convey.

### **S43.3 Subluxation and dislocation of other and unspecified parts of shoulder girdle**

#### **S43.30 Subluxation and dislocation of unspecified parts of shoulder girdle**

Dislocation of shoulder girdle NOS

Subluxation of shoulder girdle NOS

#### **S43.301 Subluxation of unspecified parts of right shoulder girdle**

#### **S43.302 Subluxation of unspecified parts of left shoulder girdle**

#### **S43.303 Subluxation of unspecified parts of unspecified shoulder girdle**

#### **S43.304 Dislocation of unspecified parts of right shoulder girdle**

#### **S43.305 Dislocation of unspecified parts of left shoulder girdle**

#### **S43.306 Dislocation of unspecified parts of unspecified shoulder girdle**



## LET'S CODE IT! SCENARIO

### MCGRAW GENERAL HOSPITAL

**DATE OF ADMISSION:** 05/27/22

**DATE OF DISCHARGE:** 05/28/22

**PATIENT:** YOUNG, MATTHEW JAMES

**HISTORY:** Neonate is male, delivered 05/27/2022 at 1915 hours by C-section due to previous C-section. Mother is:

- gravida 2, para 2, AB 1
- blood type B positive
- GBS negative
- hepatitis B surface antigen negative
- rubella immune
- VDRL nonreactive

#### **VITAL SIGNS:**

Weight: 6 pounds 9 ounces

Height: 19-1/2 inches

Head circumference: 14 inches

#### **GENERAL:**

APGAR = 10 @1 min., 10 @ 5 min

SKIN: Portwine nevus on right ankle

NEUROLOGIC: Alert, vigorous cry, good tone, nonfocal

#### **DISPOSITION:**

The neonate was discharged to his mother. I instructed the mother to phone me PRN. I told her that I want to see both in my office in 10 days for a follow-up.

### Let's Code It!

Dr. Michaels delivered Matthew James Young and examined him. Being born is the confirmed reason why the baby needed Dr. Michael's time and expertise. You need to translate the reason *why* into an ICD-10-CM

diagnosis code. Therefore, begin in the Alphabetic Index of your ICD-10-CM manual. What should you look up? Matthew needed to be examined right after being born, so let's look up:

Birth . . . nothing here that matches.

Next, try: Newborn. We have a match!

Newborn (infant) (liveborn) (singleton) Z38.2

Turn in the Tabular List to this code and begin by reading at the three-character code category:

✓4 Z38 Liveborn infants according to place of birth and type of delivery

*NOTE: This category is for use as the principal code on the initial record of a newborn baby. It is to be used for the initial birth record only. It is not to be used on the mother's record.*

You know that Matthew was just born, so this note confirms you are in the right place in the code book. Notes, notations, symbols, and other marks in the code book are there to help point you in the right direction and to support your determination of the correct code.

Our next step is to look at the mark to the left of the code . . . it may be a box with a check mark ✓4, it may be a dot ●, or the following lines may just be indented. However your copy of the code book alerts you, it is clear . . . this code needs an additional character. And this is not a suggestion; it is mandatory.

There are three options for a fourth character:

✓5 Z38.0	Single liveborn infant, born in hospital
Z38.1	Single liveborn infant, born outside hospital
Z38.2	Single liveborn infant, unspecified as to place of birth

You can see in the record above that Matthew was born in McGraw General Hospital and, therefore, Z38.0 is the most accurate.

But we aren't done yet. There is a symbol to the left of code Z38.0. It is telling you that an additional character is required. Let's look at the two options:

Z38.00	Single liveborn infant, delivered vaginally
Z38.01	Single liveborn infant, delivered by cesarean

Go back to the documentation and read the information provided by the doctor. He noted that Matthew was born via a C-section (the C stands for cesarean).

There are no more symbols or notations here in the Tabular List. Next, double-check the **Official Guidelines, Section 1C. Chapter 21, subsection 12) Newborns and Infants** as well as **Chapter 16, subsection 6) Code all clinically significant conditions**. It appears that there are no further details or codes needed . . . so this is the code.

Good job! You were able to determine that code Z38.01 most accurately reports Matthew's birth. You did it!

## 1.3 Procedure Coding

Once the physician has determined the patient's condition or problem, he or she can then establish a treatment plan. Generally, there are three terms used to describe actions that the physician can take to support a patient's good health or to improve a current condition:

*Procedures* are actions, or a series of actions, taken to accomplish an objective (result). For example, surgically removing a mole or resectioning the small intestine.

**Services** are actions that will most often involve counseling, educating, and advising the patient, such as discussing test results or sharing recommendations for risk reduction.

**Treatments** are typically an application of a health care service, such as radiation treatments for tumor reduction or acupuncture.

### Services

Spending time with a patient and/or family about health care situations.

### Treatment

The provision of medical care for a disorder or disease.