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Fourth Edition

You Code It!

Abstracting Case Studies Practicum

Shelley C. Safian
PhD, RHIA, CCS-P, COC, CPC-I

Mary A. Johnson
MBA-HM-HI, CPC

Mc Graw Hill

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FOURTH EDITION

Shelley C. Safian, PhD, RHIA

MAOM/HSM, CCS-P, COC, CPC-I

AHIMA-Approved ICD-10-CM/PCS Trainer

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YOU CODE IT!

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Acknowledgments

This book is dedicated to those students that we have had the privilege to work with and to those students who are beginning their journey into the world of medical coding. Enjoy this adventure!

Shelley Safian and Mary Johnson

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PREFACE

Welcome to *You Code It!* This book is part of a series that instructs 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 that the demand for health information management professions (which includes medical coders) will continue to consistently incredibly through 2030 and beyond.

These books were written to speak directly to the medical coding student using step-by-step instructions and conversational language to maximize understanding. Built into the structure of these texts are many opportunities for students to practice coding and apply what they have learned. Students will also have the chance to practice abstracting with real-world health professionals' documentation and accurately translating these facts into the best, most accurate codes.

To the Student

Your medical coding classes introduce you to the skills you will need to work in the health information management field. A fundamental role of an insurance coding and medical billing specialist's job is to work with the insurance companies that will reimburse the health care facility for the services and treatments provided to patients, and contribute to research and public health policies. You may be employed by a hospital, clinic, doctor's office, health maintenance organization, mental health care facility, insurance company, government agency, or long-term care facility. Your career will be challenging, interesting, and one of the top 10 fastest-growing Allied Health professions.

Before you begin your adventure, here are some tips to help you succeed:

- First, take a deep breath. Coding is complex and is not like anything else you have tackled to learn before. Remember that you are learning a new skill! Give yourself some time to become proficient.
- Second, *never* code directly from the Alphabetic Index. *Always* look the code up in the Tabular List or main listing before determining a code. If you remember this rule, you will always head in the right direction.
- Third, when you encounter a word or an abbreviation that you don't understand, stop and look it up in your medical dictionary.
- Fourth, after you finish coding the case studies, scenarios, or whatever you are coding, put it aside. Then, later or the next day, go back and do "back coding." In the Tabular List, or main section, look up each code you came up with and match the code description carefully with the case study or scenario words. Remember the importance of documentation by the health care provider—"If it's not documented, it didn't happen. If it didn't happen, you cannot code it!" This process is a very effective way to double-check your answers. Your fresh eyes will enable you to see words and notations you may have missed before.
- Finally, re-evaluate your work by checking every question to make certain you understand how you found your answer. When you find you have gotten an exercise, test question, or other activity wrong, try to figure out what happened. Make sure you ask your instructor for help when you need it!

Good luck on your medical coding journey!

To the Instructor

The Safian/Johnson Medical Coding series includes:

Let's Code It! 3e
You Code It! Abstracting Case Studies Practicum, 4e

These books are designed to give your students the medical coding experience they need in order to pass their first medical coding certification exams, such as the CCA, CCS/CCS-P, or CPC/COC. The products offer students a variety of practice opportunities by reinforcing the learning outcomes set forth in every chapter. This text enables students to actively code patient encounter documentation, written by health care providers in various specialties and locations.

In addition to providing innovative approaches to learning medical coding, McGraw-Hill Education knows how much effort it takes to prepare for a new course. Through focus groups, symposia, reviews, and conversations with instructors like you, we have gathered information about the materials you need in order to facilitate successful courses. We are committed to providing you with high-quality, accurate instructor support.

The following resources are available in the Instructor Resources located under the Library tab in Connect (available only to instructors who are logged into Connect):

- **Instructor's Manual** answers for case studies. Answer keys are updated annually.
- **PowerPoint Presentation** for Chapter 1 to reinforce key concepts and provide an additional visual review for students.

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Digital Resources

All of these case studies, Chapters 1–26, can be assigned through Connect.

What's New in Our 4th Edition

You Code It!, fourth edition, includes a greater number of updated and new real-world scenarios and case studies for students to gain hands-on learning with actual physicians' notes from more than 25 specialty health care facilities (physicians' offices, hospitals, ancillary facilities, etc.). The names, dates, and places have been changed to protect confidentiality; however, the physician documentation remains intact—as students would find once they got on the job. These exercises make it easier for students to connect learning concepts and specific official guidelines to critical thinking and realistic experiences.

The entire text has been updated to include clinical documentation improvement for accurate coding using ICD-10-CM, CPT, ICD-10-PCS, and HCPCS Level II code sets. The instructor's manual features a 2023-compliant answer key to all case studies in the book, using all appropriate code sets. Answer keys are updated annually to ensure inclusion of the newest codes as well as any adaptations and deletions, and they are made available in the password-protected Instructor Resources within *Connect.*

Instructors
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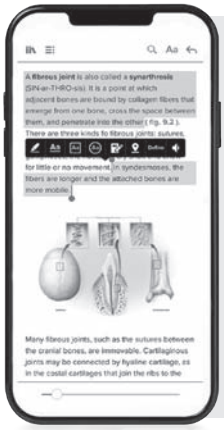

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"I really liked this app—it made it easy to study when you don't have your textbook in front of you."

- Jordan Cunningham, Eastern Washington University

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How to Abstract Notes

1

Introduction

The most efficient and effective way to code an encounter between a health care professional and a patient is to review the physician's notes, lab reports, and all documentation for that encounter (also referred to as a visit). When the coder can read exactly what the physician thought, heard, and observed in his or her own words, there is less confusion and miscommunication. The more accurate the communication between the providing professional and the professional coding specialist, the more accurate the codes will be—ensuring accurate and optimal reimbursement.

Many physicians' offices are specialized. So you will most likely end up working with a limited number of sections within the Current Procedural Terminology (CPT), ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification), ICD-10-PCS (International Classification of Diseases, Tenth Revision, Procedural Coding System), and HCPCS Level II (Healthcare Common Procedure Coding System Level II). The following chapters of this book are set up to align with types of health care specialties, so you can practice coding as if you were working for a specific health care facility.

EXAMPLE

If you are working for a men's health care center you would rarely, if ever, use codes for Pregnancy, Childbirth, and the Puerperium O00-O9A diagnoses.

The Seven Steps of Coding

There is a seven-step process for coding a health care encounter in the approved manner. As you gain experience, it will take less time. However, remember that time is not the number one consideration—accuracy is the most important factor.

The steps are as follows:

1. Read through the physician's notes for the encounter completely, from beginning to end. Use some scratch paper alongside so that you can jot down the details you want to remember.
2. Read through the physician's notes again, this time identifying key words and phrases regarding diagnoses and procedures directly relating to this encounter. Pulling out the *key words* is known as **abstracting** physician's notes. You will need to evaluate the key words and distinguish between diagnostic statements and procedural statements. A medical dictionary can be very helpful.
3. Make a list of any questions you have regarding unclear or missing information necessary to code the encounter. **Query** the health care provider who wrote or dictated the notes. *Never assume.* Code only what you know from actual documentation. It is the law that you must have documentation to back up every code you submit on a claim form.

   Note: In class, your instructor is the person to query about anything you need to code an encounter properly.

Key Terms

Abstracting
Betadine
Bursa
Durable medical equipment (DME)
Kenalog
Lidocaine
Medical necessity
Query

CODING TIP

Patient = *Who* came to see the provider for health care

Diagnosis = *Why* the provider is caring for this individual during this visit

In cases of injury or poisoning, external cause codes from ICD-10-CM will report *how* and *where* the patient got hurt.

Procedure = *What* the provider did for the individual

CODING TIP

Documentation is your watchword. You must have the information *in writing.* If it is not written down (or in a computer document), then as far as you are concerned, it never happened, and therefore, you cannot code it.

abstracting
The process of identifying the relevant words or phrases in health care documentation in order to determine the best, most appropriate code(s).

query
To ask.

KEYS TO CODING

Is it a diagnosis or a procedure?

Do the key words tell you WHY or WHAT?

- A **diagnostic statement** will explain WHY the physician cared for the patient, saw the patient, and/or provided a service or treatment or performed a procedure.
- A **procedural statement** will explain WHAT the physician did for the patient or to the patient.

Look at the parts of the medical term. There are parts of medical terms, particularly the suffixes that are specific to a diagnosis or a procedure.

Examples:

A diagnostic term might have a suffix like

-itis means inflammation (a condition or something wrong)

-edema means swelling (a condition or something wrong)

whereas a procedural term might have a suffix like

-ectomy means to surgically remove (an action)

-scopy means to view or look (an action)

EXAMPLE

The documentation indicates that the physician performed a posterior vestibuloplasty on Marion Jones. You pull out the key words: *vestibuloplasty* and *posterior.* However, when you look up the procedure in the CPT book, you see that there are two codes to choose from:

40842 Vestibuloplasty; posterior, unilateral

40843 Vestibuloplasty; posterior, bilateral

You must query the physician to find out whether the procedure was done unilaterally (one side) or bilaterally (both sides). Make certain the physician enters the additional details in the chart. Now, you know which code is the best, most appropriate code.

4. Code all diagnoses confirmed by the physician to be relevant during this encounter. Remember that coding, for both reimbursement and statistical purposes, will report only those conditions addressed by the provider during this encounter, not the patient's entire health history. In an outpatient facility, when there is no confirmed diagnosis to provide medical necessity for a procedure, service, or treatment performed, code the patient's signs and/or symptoms that led to the physician's decision to perform that procedure or test. Use the best, most appropriate code or codes available based on the documentation.

   Begin by dissecting the diagnostic statement. Take the statement apart and determine which word identifies the disease, illness, condition, or primary reason for the visit (also known as the "main term"). Separate this from any words that may simply describe the type of condition or the location of the condition (anatomical site/body site). Ask yourself WHY is the physician caring for the patient? Specifically. When you look at these examples, you can see the reason the physician is seeing the patient for this visit.

   EXAMPLES:

   i. Herpes zoster . . . the disease is "herpes" and "zoster" is the type of herpes.
   ii. Acute bronchospasm . . . the condition is "bronchospasm" and the term "acute" (which means severe) describes what type of bronchospasm the patient has.
   iii. Family history of lung cancer . . . the issue of concern is "history"—why the patient is being seen. The type of history is "family," and the secondary descriptor is "malignant neoplasm of the lung (lung cancer)" to explain "a history of what?"
   iv. Myocardial infarction . . . the condition is "infarction" (area of dead tissue) and "myocardial" (heart muscle) is the anatomical site of the infarction.
   v. Congenital pneumothorax . . . the condition is "pneumothorax" (air in the chest cavity) and the term "congenital" (occurring in utero) describes the cause of the condition.
   vi. Nicotine dependence . . . the issue of concern is "dependence"—why the patient is being seen. "Nicotine" is what the patient is dependent upon.

Once you have determined the condition or issue ("main term"), find that term(s) in the ICD-10-CM alphabetic index. If all the words in the diagnostic statement seem to have the same impact to you, just look up all the words, one at a time, in the Alphabetic Index. You will get to the correct "main term" and find the code. Write the suggested code down on a piece of scratch paper.

Next, turn to the Tabular List of ICD-10-CM to find the code suggested by the Alphabetic Index. This is a mandatory step. The Tabular List of ICD-10-CM provides more detail for the code description, as well as additional notations such as *includes* and *excludes* notes and directives for the requirement of additional characters and codes. **NEVER, NEVER, NEVER code from the Alphabetic Index.**

5. Code the procedure(s) as stated in the notes describing what the provider did for the patient. Use the best, most appropriate code(s) available based on the documentation.

   Begin by dissecting the procedural statement. Identify the term that describes WHAT action was taken and the anatomical site that was treated.

   EXAMPLES:

   i. Cranial nerve neuroplasty . . . the procedure is a "neuroplasty" and the anatomical site is the "cranial nerve."
   ii. Pelvic ultrasound . . . the procedure is an "ultrasound" and the anatomical site is the "pelvis."
   iii. Coronary thrombolysis . . . the procedure is a "thrombolysis" and the anatomical site is the "heart" (*coronary* refers to the heart).

Next, look for the "action" term in the CPT Alphabetic Index. The "action" term is the specific procedure (such as hysterectomy), the service (such as counseling), or the treatment (such as injection). If you are reporting procedures and services performed in a hospital for an inpatient, you may use the ICD-10-PCS code set. To report services provided by a physician at any type of facility or procedures and services provided at an outpatient facility, you will use the CPT code set.

Now, find the code(s) suggested by the Alphabetic Index in the numeric listing of CPT or the Tables section of ICD-10-PCS. This is not a suggestion; it is a mandatory step. The section listing all the codes in numerical order provides additional detail for the code description, as well as additional notations and directives for the requirement of additional codes and/or modifiers.

Often, the CPT Alphabetic Index will suggest several codes (12345, 12349, 25443) or a range of codes (12345–12357). You must look at ALL suggested codes in the numeric list (not just the first one), read the complete code descriptions and all notations, and *then* choose the most accurate. And, the correct code is NEVER a range.

NEVER, NEVER, NEVER code from the Alphabetic Index.

6. Connect every procedure code to at least one diagnosis code for the same encounter to document **medical necessity**. This is known as linking; it is not only required on the claim form, but it is also an excellent way to confirm that all your procedure codes are supported by a diagnosis code.
7. Double-check your work by back coding. It means that you look up the code you have chosen in the Tabular List or main listing, reread the code description, and compare it to the original notes to make certain they match. This will help you catch innocent typos, accidentally missing characters or modifiers, or another relevant notation.

Following these steps will help you code precisely, resulting in a greater number of your claims being paid quickly, at the highest earned reimbursement rate.

CODING TIP

Use a medical dictionary to learn the true meaning of a medical term. If you don't know what the term means, you will have a problem interpreting it into an accurate code.

CODING TIP

Before using an unspecified diagnosis code, query the physician to gain the details needed to use a more specific code. Unspecified or NOS (not otherwise specified) codes should only be used as a last resort when the physician cannot be contacted.

CODING TIP

Be careful that you do not code component signs or symptoms in addition to its diagnosis. If you do, it is considered overcoding. An important part of your job as a coding professional is to know which signs and/or symptoms are included in the diagnoses you code. This is where your knowledge of pathology and physiology comes in.

Diagnosis and Medical Necessity

The International Classification of Diseases, tenth revision, Clinical Modification (ICD-10-CM) is a directory of every diagnosis, sign, symptom, and reason a health care provider would spend time with, and/or provide a service to, a patient. Diagnosis codes establish medical necessity. Every procedure code reported must be accompanied by a diagnosis code that justifies providing that specific procedure to the patient at the time he or she is seen by the provider. Some examples of diagnoses are a fractured ankle, diabetes, and the flu.

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, signs, or symptoms.

CODING TIP

Only code those procedures, services, and treatments provided by this physician at this encounter. Writing an order is part of the evaluation and management service.

CODING TIP

A physical examination, ordering and/or performing a test, and writing a prescription are all ways that a physician might address a condition. *Only code those conditions that are relevant to this visit.*

ICD-10-PCS TIP

In ICD-10-PCS, the "action" is known as the "*root operation.*" This is the term that clarifies the specific service or type of procedure. The anatomical site affected by the root operation, in ICD-10-PCS, may be categorized by the "body system" or specific "body part."

CPT & ICD-10-PCS: ICD-10-PCS is used to report inpatient services and treatments. CPT codes report physician services and outpatient facility services.

EXAMPLE

Jerri Cavanaugh, a 13-year-old female, is brought to the emergency department by her mother after she fell off her skateboard and hurt her ankle. Dr. Roberts orders x-rays that confirm Jerri's ankle is fractured, and applies a short leg (knee-to-toe) cast. The diagnosis of a broken ankle makes taking the x-ray and applying the cast good medical decisions. Dr. Roberts documented medical necessity (fractured ankle) for both services (x-ray and cast application).

EXAMPLE

Morris Cruz, a 65-year-old male, went to see his physician, Dr. Bridges. Morris was complaining of pain upon urination. Dr. Bridges ordered a urinalysis. The results of the test showed that Morris had a urinary tract infection (UTI). Dr. Bridges was in a hurry and typed in URI. The problem is that URI stands for upper respiratory infection (chest congestion). You can see that the diagnosis of an upper respiratory infection does not justify the urinalysis that was ordered. This will be looked at as either an error or very poor medical judgment. In either case, the claim will be denied for lack of medical necessity.

Procedures (Services and Treatments)

During the process of translating health care services, treatments, and procedures into codes, you might use any of the following code sets:

- CPT—Current Procedural Terminology
- HCPCS—Healthcare Common Procedure Coding System, Level II
- ICD-10-PCS International Classifications of Diseases, tenth revision, Procedure Coding System

Current Procedural Terminology (CPT) is used for reporting procedures, treatments, and services provided to outpatients—such as an x-ray, a vaccination, or the removal of a cyst—as well as physician's services provided almost anywhere.

The Healthcare Common Procedure Coding System, Level II (HCPCS, which is pronounced "hick-picks") lists codes used to identify the provision of **durable medical equipment (DME)**, medications, and certain other services not listed in the CPT book. Items coded from the HCPCS book might include a wheelchair, crutches, or a unit of blood for a transfusion.

International Classification of Diseases, tenth revision, Procedure Coding System (ICD-10-PCS) is used to report procedures, treatments, and other services provided to an inpatient, one who has been admitted into a hospital and stays overnight in this acute care facility. Codes are used from this volume to reimburse the hospital for its expenses. The physician's, or surgeon's, services are typically reported from CPT, by the physician's office coder, even though the services were provided in a hospital.

durable medical equipment (DME)
Items that are used in the care and treatment of a patient that can either last a long time or be used again and again.

Accuracy

Each set of numbers and letters is a code that means something so specific that a code number just one character off could mean something totally unrelated. Everyone can make an error occasionally transposing two numbers when writing, or typing, a sequence. You will be thinking 1-7-1 and accidentally write down 711. Instead of calling the wrong phone number, that difference could cause the claim to be rejected, denied, or pulled for investigation, resulting in your office having to deal with delayed payment, or no payment at all, for the work it did. That is why it is critical to be careful and accurate when coding. *Always* double-check your codes.

EXAMPLE

R35.1 Nocturia (excessive urination at night)
R53.1 Weakness (asthenia)

EXAMPLE

30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft . . . *nose surgery*
50320 Donor nephrectomy (including cold preservation); open, from living donor . . . *the removal of a kidney from a live person to be transplanted into another*

The Coding Process

As you read in *The Seven Steps of Coding,* the best place to begin the coding process is with the physician's notes for the encounter. Abstract, or pull out, the key words relating to *why* the patient was treated by the physician during this encounter to determine accurate diagnosis codes and *what* the physician did for the patient to get accurate procedure codes.

Remember, the key words may be identified directly as the diagnosis, or you may need to find the patient's signs and symptoms (often called the patient's *chief complaint*). The procedure provided may be labeled as such, or you may need to read through the complete notes to identify everything that was done for the patient during the encounter.

Once you have identified the related key words abstracted from the notes, turn to the Alphabetic Index of the appropriate book: ICD-10-CM or CPT. You will use Alphabetic Index to guide you to the correct code category in the Tabular List. Then you need to carefully and completely read the code descriptions, beginning at the top of the category, so you can make certain that you find the best code, to the highest level of specificity, according to the physician's notes for a particular encounter, and within the guidelines of the code set.

When you begin, you will find that looking for a diagnostic or procedural key word in the Alphabetic Index may be a snap!

EXAMPLE

Dr. Kinner diagnoses Alvira Gomez with polyphagia. Turn to the Alphabetic Index in ICD-10-CM and find Polyphagia R63.2. Confirm this in the Tabular List and you've got the correct code.

Sometimes, it is like looking for a contact lens on a carpet—you have to really look carefully and think about what the facts are.

EXAMPLE

While washing the dishes, Darlene Samanski broke a drinking glass in her hand. She was pretty certain she got all the glass out and cleaned the wound well, but, 2 days later, it was still hurting. She went to Dr. Mahoney, who removed several tiny shards of glass from the wound.

You have to think about this and realize that the glass is actually a foreign body. In addition, you must figure out that the glass is not actually in Darlene's hand; it is in her soft tissue. Now, you will be able to find this in the Alphabetic Index:

Foreign Body, in, soft tissue (residual) M79.5

CODING TIP

Never, never, never code *only* from the Alphabetic Index in any of your coding books. *Always check* the code in the Tabular List and read the entire code description and all notations before deciding on the code. You may feel this is slowing you down or frustrating, but, honestly, your coding will be accurate when you read all the information available to you.

ICD-10-CM CODING TIP

When you see a hyphen (-) after a code in the Alphabetic Index, it means that more characters are required for a valid code. You must find these additional characters in the Tabular List.

betadine
Antibacterial topical substance to assure that an injection does not penetrate the skin and permit bacteria in with it. Similar to the alcohol swipe one uses prior to giving a regular injection.

lidocaine
A local anesthetic, to numb the area so the patient will not feel pain.

kenalog
A steroid medication.

bursa
A closed, fluid-filled sac that functions to provide a gliding surface to reduce friction between tissues of the body.

Other times, you may have to use alternate terms, or synonyms, from those used in the notes to find the correct listing. A medical dictionary will help you in these situations.

EXAMPLE

Adbul Ben Jamal fell off of his bicycle and scraped his knee very badly, so he came to see Dr. Bartlett.

Scrape is not in the ICD-10-CM Alphabetic Index. The medical term for scrape is *abrasion.* Turn to abrasion in the Alphabetic Index. It will direct you to *Injury, Superficial, by site,* and you find:

Injury, superficial, knee S80.91-

Now, you will need to turn into the Tabular List to determine the accurate additional characters required (as indicated by that hyphen).

Remember that accuracy is the *most* important issue here. It is not a race. You need to be careful and meticulous.

LET'S CODE IT! SCENARIO

Patient: *Brackman, Nathan*
Procedure: *Steroid injection*
Indications: *Left shoulder subacromial bursitis*

Procedure: Patient arrived at our office for the procedure as planned during his visit earlier in the week. After obtaining consent, the area of the left shoulder was prepped in the usual fashion with **betadine**. *6cc of 1%* **lidocaine** *with 10 mg of* **Kenalog** *were injected in the left subacromial bursa without difficulty. He tolerated the procedure well without immediate complications. There was moderate relief of pain afterward. He was advised to call me if he exhibits any signs of infection, such as fever, chills, erythema, or swelling. He agreed to call me in 3–4 days and tell me how he is doing.*

Let's Code It! The Diagnosis

Diagnosis codes report the medical rationale for providing the procedure, in this case, the injection.

WHY was it medically necessary to give Nathan this injection? Because he had *subacromial bursitis of his left shoulder.*

The condition = bursitis

Specific location of bursitis = subacromial (an area within the shoulder)

The anatomical site affected by this condition = shoulder, left

In the ICD-10-CM Alphabetic Index find the term "bursitis." In the list of terms indented beneath you must find the term that describes the specific location of the bursitis . . . "subacromial." The Alphabetic Index directs you to—See Bursitis, shoulder. Find this and see suggested code M75.5-

Turn to ICD-10-CM tabular list, and find the M75 code category.

Begin reading at the three-character code.

√4th M75 Shoulder lesions

There is an *excludes* notation. You will notice that it does not relate to our case, so keep reading down to review all the choices for that required 4th character.

√5th M75.5 Bursitis of shoulder

There are three choices for the 5th digit and you will find that M75.52 fits the physician's diagnosis for this patient.

M75.52 Bursitis of left shoulder

Let's Code It! The Procedure

Ask yourself WHAT did the physician do for this patient? The physician INJECTED the patient. So, in the CPT Alphabetic Index, look up INJECTION.

You will see the indented list under the term INJECTION contains mostly anatomical sites. At what ANATOMICAL SITE did the physician INJECT the patient? You might begin with "shoulder." However, when you look at the term "shoulder" under Injection, you will see that it describes an arthrographic radiologic procedure. There is nothing in the notes about this type of procedure, so that can't be correct.

Go back to the notes . . . what other words do we have to describe the exact location where the injection was inserted? Do you see the term **bursa?**

Look for the term BURSA indented under the term INJECTION. This suggests codes 20600, 20604, 20605, 20610, 20611.

Let's now go to the main portion of CPT to check these codes out.

20600 Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., Fingers, toes); without ultrasound guidance

20604 Arthrocentesis, aspiration and/or injection, small joint or bursa; with ultrasound guidance, with permanent recording and reporting

20605 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., Temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa); without ultrasound guidance

20610 Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa); without ultrasound guidance

20611 Arthrocentesis, aspiration and/or injection, major joint or bursa; with ultrasound guidance, with permanent recording and reporting

All of these code descriptions seem to include our key words: injection and bursa. However, only one code description includes the correct anatomical site for this patient . . . shoulder. Therefore, code 20610 is the correct code.

Let's Code It! The Medication

There is one more item that this physician provided to this patient for which the physician deserves to get reimbursed. As you read, code 20610 reports the administration of the injection. However, to tell the WHOLE story, you also need to report WHICH medication was injected into Nathan's bursa.

Drugs administered to a patient by a health care professional are reported by using codes from the HCPCS Level II code set. In this separate book of codes, you can look up this particular drug one of two ways: using the Alphabetic Index or the Table of Drugs in Appendix 1.

In the HCPCS Level II Alphabetic Index, look up the name of the medication injected into Nathan—Kenalog. You will see

Continued

Kenalog -10, J3301

The Table of Drugs in Appendix 1 also lists drugs in alphabetic order. You will find the same reference to code J3301.

Find code J3301 in the alphanumeric listing of HCPCS Level II and confirm this is the correct code. You will see

J3301 Injection, triamcinolone acetonide, not otherwise specified, 10 mg

Other: Cenacort A-40, Kenaject-40, Kenalog, Triam A, Triesence, Tri-Kort, Trilog

When you put this all together, you have the accurate codes for Nathan's encounter.

Diagnosis code: M75.52

Procedure code: 20610

Medication code: J3301

KEYS TO CODING

WHAT did the physician do for Nathan? The physician gave him a steroid injection in the left shoulder. More specifically, there were two parts to this procedure:

The administration of the injection; the skill to insert the syringe. This will be reported with a CPT code.

What was injected . . . in this case, the Kenalog. This will be reported with an HCPCS Level II code (starting with a J).

CODING TIP

The CPT code for the injection administration will ensure the reimbursement of the provider for the knowledge and skill to give the injection, the cost of the sterilization of the injection site (e.g., alcohol swab, betadine), topical anesthetic, the syringe, and the bandage or sterile cover of the injection site.

Different Styles of Medical Notes

SOAP Notes

No, SOAP notes do not have anything to do with the importance of washing your hands before seeing a patient. These notes are written in an outline format using four sections: subjective, objective, assessment, and plan. The term SOAP is an acronym for the four section titles.

*S*ubjective is the first section and will include the reason for the patient's visit today (chief complaint), status regarding current medications and/or treatments, history (past, family, and/or social), and an itemization of any signs and/or symptoms as described by the patient.

*O*bjective, the second section, will contain the results of any physical examination performed, including vital signs, height/weight, physician's observations, and the results of any diagnostic testing related to the concern at hand.

*A*ssessment is the diagnosis, or the physician's conclusions. If there is no definitive diagnosis, the coder must reread the objective portion of the notes to look for positive test results (such as a statement reading "X-ray showed lateral fracture of the tibia") for coding a diagnosis. If there is no confirmed diagnosis as a result of the testing, then the patient's signs and symptoms must be coded.

*P*lan, the last part of the notes, will document the physician's orders for the patient. These may include diagnostic tests to be done in the future, procedures to be performed ("Colonoscopy scheduled to be done in 1 week"), recommendations for lifestyle changes ("Patient is advised to quit drinking alcoholic beverages as soon as possible"), and follow-up care ("Recheck CBC in 2 weeks"). None of these recommendations or orders can be coded.

Many physicians like SOAP notes because they are more orderly and tend to be more thorough. With this format, they are reminded to address each portion, as they are dictating, or typing in, to document all aspects of the encounter with the patient.

Figure 1-1 is an example of SOAP notes taken from a family practitioner. See if you can determine what each of the four terms means by the content of each paragraph or section.

Narrative Notes

Some physicians prefer to dictate their notes using the narrative format, as shown in Figure 1-2. It means that they tell the story of the encounter with the patient, including all the details. This is documented in paragraph format.

PROGRESS NOTE

PT NAME: YORK, MARY LOU

DOB: 05/27/88

MRN: 05015979

S: This pt is an 18-year-old white female, G0, LMP 2/18, not sexually active, not on any birth control that presents today with two main complaints. The first complaint is she feels a lump in her right groin. The second complaint is a vaginal discharge, no odor or itching, just feels irritated.

O: Pelvic exam revealed the external genitalia to be within normal limits. The vagina was without lesions. Scant discharge seen. Wet mount neg for Trichomonas, clue cells or hyphae. Increased bacteria in the background noted. Inspection of the rt groin revealed no abnormality. The pt was asked to point out the area of abnormality and this felt to be dilated areas within one of the vessels in the groin. These were less than the size of a pea and did not feel like lymphadenopathy. Similar areas were felt on the lt side as well. The patient was reassured.

A: Possible nonspecific vaginitis

P:

1. Cleocin vaginal cream qhs times seven nights
2. Follow up in one month for reinspection of the rt groin
3. Otherwise follow up with us prn. She verbalized understanding.
4. All questions were answered. She will follow up with us prn or for her yearly Pap smear.

Harold Donnelson, MD

FIGURE 1-1 Example of SOAP Notes

PROGRESS NOTE

PT NAME: GROGANZI, ALFRED

DOB: 07/13/78

MRN: 06002795

DATE: 08/14/22

[Office Visit] This patient is coming along well since his colonoscopy. He is having minimal problems. Examination reveals mild colitis. He was told I would not put him on any type of treatment at this time. The patient doesn't want to take steroids; he is not having enough problems to warrant steroids. We will see him again in 3 months.

DATE: 12/18/22

[Office Visit] This patient is getting along exceptionally well. He was scoped up to 40 cm and has colitis up this far. However, the worst of it is in the last 10 centimeters. The patient will be given another course of Flagyl to see if we can get this to resolve. We will check him in 3 weeks.

DATE: 01/09/23

[Office Visit] This patient is in today and he still has his colitis. It is getting worse. We will start him on some Rowasa. We will give him one a night for 3 weeks. We will see him after that and see how he is getting along. He will probably have to take it for 6 weeks before we will see a difference.

Suzanne Esperanza, MD

FIGURE 1-2 Example of Narrative Notes

CODING TIP

The betadine and the lidocaine are already included in the injection procedure because it would be wrong to inject the patient without these two elements. However, because all sorts of drugs can be injected into a patient, we must code the contents of the injection separately, in this case, the Kenalog.

CODING TIP

It is important that the coder always read the entire document. Remember that you are permitted to code and report only procedures, services, and treatments that have been DONE by your staff. Just because the physician *ordered* a test or procedure is not a valid reason to report the code. It must have been provided, and provided by a professional for whom you are responsible to report codes.