Addendum

Subsequent to the original printing of this study guide, NHA determined that enough time had elapsed since the transition from ICD-9 to ICD-10 that the CBCS certification exam and study guide should only cover information on ICD-10. For clients who received a printed copy of the study guide prior to this change, this addendum provides details on the changes. These are:

- All references to ICD-9 have been removed and updated to ICD-10 as appropriate.
- The pages covering ICD-9 and ICD-10 in chapter 5 have been replaced with the pages attached to this document, which provide additional content on ICD-10.
- Quiz questions in chapter 5 that refer to ICD-9 have been removed or replaced.
CHAPTER 5
Apply Knowledge of Coding

OVERVIEW
Chapters 1 through 4 of this study guide emphasized the importance of coding. Different kinds of codes are used for different purposes. Clinical coding systems, such as the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), track a patient’s diagnosis and clinical history. Procedural coding systems, such as Current Procedural Terminology (CPT) codes and the Healthcare Common Procedure Coding System (HCPCS), are used to report physician services for the purpose of reimbursement. The codes reported on claims are based on solid documentation, which has been discussed throughout this study guide.

This chapter presents an overview of the coding systems that billing professionals use. These include ICD-10-CM codes, CPT codes and modifiers, and HCPCS Level II codes. The chapter will explain the structure of ICD-10-CM, CPT, and HCPCS Level II codes. The chapter also discusses abstracting and coding from abstracted information.

Finally, this chapter provides a targeted overview of need-to-know medical terminology, functions of body systems, and types of health care facilities and providers.

CODING GUIDELINES AND CONVENTIONS FOR DIAGNOSES AND PROCEDURES
There are several kinds of coding systems. This section will focus on ICD-10-CM. Beginning on October 1, 2015, the U.S. switched to ICD-10-CM. This system is the standard for reporting diagnoses in all U.S. health care settings. The coding system serves as a way for health care professionals to let third-party payers, such as insurance companies or Medicare, know what diagnoses were treated. The system helps ensure that health care professionals and facilities are reimbursed in a timely manner.

The ICD coding and classification system is used worldwide. It is maintained by the World Health Organization (WHO), which updates it about every 10 years. The version being used internationally is ICD-10. The United States decided that ICD-10 needed to be modified before acceptance. The result is the system called ICD-10-CM/PCS. ICD-10-CM was developed by the Centers for Disease Control and Prevention (CDC) and is used in all U.S. health care settings. The International Classification of Diseases, 10th edition, Procedure Coding System (ICD-10-PCS) was developed by the Centers for Medicare and Medicaid Services (CMS) and is used only in U.S. hospital settings.

By the end of this chapter, you should be able to answer the following questions.
1. List three purposes of ICD-10-CM.
2. True or False: The following represents a disease coded under ICD-10-CM: E10.2.
3. What are the goals of ICD-10-PCS?
4. What character of ICD-10 PCS for medical or surgical procedure would identify the body part?
   a. Character 1
   b. Character 2
   c. Character 3
   d. Character 4
5. CPT codes are used to describe which of the following?
   a. Supplies used during surgery
   b. Type of insurance a patient has
   c. Services rendered by the provider
   d. Payments received from third-party payers
6. What is the purpose for using modifiers?
7. What are HCPCS Level II codes used for?
8. Abstracting involves which of the following?
   a. Writing notes about codes
   b. Selecting relevant information from the health record
   c. Coding physicians’ notes
   d. Answering questions from insurance companies
9. Abstracted information is which of the following?
   a. Sent to the physician
   b. Sent to the patient
   c. Coded
   d. Sent to the insurance company
CHAPTER 5: APPLY KNOWLEDGE OF CODING
Coding Guidelines and Conventions for Diagnoses and Procedures

Using the ICD-10-CM Coding System
The ICD-10-CM/PCS coding system has separate manuals for diagnoses and procedures. Procedures are coded from the ICD-10-PCS manual, and diagnoses are coded from the ICD-10-CM manual. The ICD-10-PCS manual is discussed later. The designated uses of the ICD-10-CM system include the following.

- Classifying morbidity (number of cases of disease in a specific population) and mortality (incidence of death in a specific population)
- Indexing hospital records by disease and operations
- Reporting diagnoses by physicians
- Storing and retrieving data
- Reporting national morbidity and mortality data
- Serving as the basis of diagnosis-related group (DRG) assignment for inpatient hospital reimbursement
- Reporting and compiling health care data to assist in the evaluation of medical care planning for health care delivery systems
- Determining patterns of care among providers
- Analyzing payments for health services
- Conducting epidemiological and clinical research

Features of the ICD-10-CM
ICD-10-CM provides a high level of detail for diagnostic coding, which increases the accuracy of reporting codes for reimbursement, administrative, and statistical purposes. Features of the ICD-10-CM coding manual include the following.

- Provides more detailed clinical information, resulting in the following
  - Ability to measure health care services, such as the addition of information relevant to ambulatory and managed care encounters
  - Detailed injury and external cause codes
  - Sensitivity when refining grouping and reimbursement methodologies
  - Ability to conduct public health surveillance
  - Combination codes that reduce the number of codes needed to fully describe a condition
  - Decreased need to include supporting documentation with claims
- Current medical terminology and classification of diseases
- Codes that allow comparison of mortality and morbidity
- Data for the following
  - Measuring care given to patients
  - Designing payment systems
  - Processing claims
  - Making clinical decisions
  - Tracking public health
  - Identifying fraud and abuse
  - Conducting research
Structure of ICD-10-CM Codes and Manual

Code Structure

The code structure of ICD-10-CM consists of categories, subcategories, and codes. Each character for all categories, subcategories, and codes can be either a letter or number. Codes can be from three to seven characters in length. Only certain categories require the seventh character and sometimes placeholders (the letter x), as they are not required for all categories.

Three-Character Categories

Categories are three characters. Categories describe a single disease or condition, which is typically expanded by adding more characters (and more detail). The first category character is a letter; the second and third characters can be a number or letter. Each chapter begins with a list of three-character categories, such as A00-A09 Intestinal Infectious Diseases. ICD-10-CM refers to each of these grouped categories as blocks of codes.

Four-Character Sub-Categories

Codes that contain four characters provide definition for the site, the etiology and the manifestation or state of the disease or condition. For example, category C18 is malignant neoplasm of the colon. Reviewing the tabular list for this category demonstrates that the fourth character specifies greater detail for the site of the neoplasm.

Example:

C18 Malignant neoplasm of colon
  C18.0 Malignant neoplasm of cecum
  C18.1 Malignant neoplasm of appendix
  C18.2 Malignant neoplasm of ascending colon
  C18.3 Malignant neoplasm of hepatic flexure
  C18.4 Malignant neoplasm of transverse colon
  C18.5 Malignant neoplasm of splenic flexure
  C18.6 Malignant neoplasm of descending colon
  C18.7 Malignant neoplasm of sigmoid colon
  C18.8 Malignant neoplasm of overlapping sites of colon
  C18.9 Malignant neoplasm of colon, unspecified

Five-Six Character Classification

Codes that contain a fifth or sixth character provide the greatest level of specificity in the code set. For example, code M13.11 describes Monoarthritis, not elsewhere classified, of the shoulder. The sixth character indicates laterality of the Monoarthritis.

Example:

M13.11 Monoarthritis, not elsewhere classified, shoulder
  M13.111 Monoarthritis, not elsewhere classified, right shoulder
  M13.112 Monoarthritis, not elsewhere classified, left shoulder
  M13.119 Monoarthritis, not elsewhere classified, unspecified shoulder
**Placeholders**

Codes that require a seventh character extension don’t always contain six characters. The missing character(s) are filled in with a placeholder (the letter X) until the seventh character extension can be placed. For example, the code for a foreign body in the right ear is represented by code T16.1. This code requires a seventh character extension. Since the code is only four characters in length, placeholders are needed for the fifth and sixth characters. Then the required seventh character can be applied.

Example:

T16.1XXA Foreign body in right ear, initial encounter

**Seventh Character Extension**

Certain categories require a seventh character extension, typically in the injury and fracture categories. If a category indicates the need for a seventh character, it must be applied and must remain in the seventh character position. The tabular list will provide guidance for applicable seventh character extensions.

The seventh character typically identifies the episode of care (initial, subsequent, or sequela). In applicable fracture categories, it also identifies the type of fracture (open, closed, or type) and the healing phase of the patient (routine, delayed, nonunion, or malunion).

Example:

S62.241 Displaced fracture of shaft of first metacarpal bone, right hand

S62.241A ...... initial encounter for closed fracture
S62.241B ...... initial encounter for open fracture
S62.241D ...... subsequent encounter for fracture with routine healing
S62.241G ...... subsequent encounter for fracture with delayed healing
S62.241K ...... subsequent encounter for fracture with nonunion
S62.241P ...... subsequent encounter for fracture with malunion
S62.241S ...... sequela

**Manual Structure**

The ICD-10-CM coding manual can be arranged according to the wishes of its various publishers. It is, however, typically similar in content. The main components of an ICD-10-CM manual are:

- Preface/Introduction
- Official ICD-10-CM Conventions and Guidelines
- Alphabetic Index to Diseases
- Neoplasm Table
- Table of Drugs and Chemicals
- Index to External Causes
- Tabular List of Diseases and Injuries
  - 21 chapters of codes, arranged according to body system or disease process
- Appendixes
Some manuals contain additional resources such as anatomy plates, and instructions to correct coding. Familiarizing yourself with the details and resources of your manual is important to improving speed and accuracy in coding.

**Coding Guidelines and Conventions for Diagnoses and Procedures**

Each ICD-10-CM and ICD-10-PCS coding manual requires the use of coding conventions and contain official coding guidelines for correct code assignment. While essential reading for use of both coding manuals, these guidelines are critical for correct code assignment and sequencing instructions for ICD-10-CM and ICD-10-PCS.

Conventions and General Coding Guidelines include:

- **Abbreviations**
  - NEC “Not elsewhere classifiable” An alphabetic index entry that states NEC directs the coder to an “other specified” code in the Tabular List.
  - NOS “Not otherwise specified” This abbreviation is the equivalent of “unspecified.”

- **Use of “And” and “With”**
  - The word “and” should be interpreted to mean either “and” or “or” when it appears in a title.
  - The word “with” or “in” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.

- **Excludes Notes**
  - Excludes1 indicates the code excluded should never be used at the same time as the code above the Excludes1 note. The exception is when the provider documents that both conditions exist, and more than one code is assigned.
  - Excludes2 indicates the condition excluded is not part of the condition represented by the code, but from a patient who may have both conditions at the same time. Thus, the assignment of multiple codes are permitted.

- **Code First/Use Additional Code Notes**
  - Etiology/manifestation paired codes have specific sequencing
    - The etiology code first
    - The manifestation code (in brackets) sequenced second; do not enter the brackets when reporting manifestation codes

- **Locating a code:** Read and be guided by instructional notations that appear in both the Index and the Tabular List.

- **Level of detail in coding:** A code is invalid if it has not been coded to the full number of characters required for that code.

- **Signs and Symptoms:** should not be reported with a confirmed diagnosis if the symptom is integral to the diagnosis.

- **Multiple coding for a single condition:** conditions that require more than one code. The notation “Code, if applicable, any causal condition first,” will be referenced.

- **Acute and Chronic Conditions:** If the same condition is described as acute and chronic, and separate subentries exist in the alphabetic index
  - Code both, and sequence the acute condition first.
• Combination Code: a single code used to classify
  ◦ Two diagnoses, or a diagnosis with an associated secondary process (e.g., manifestation)
  ◦ A diagnosis with an associated complication

• Late Effects (Sequela): the residual effect (condition produced) after the acute phase of an illness or injury has terminated.

• Impending or Threatened Condition: If the condition did occur, code as a confirmed diagnosis. If it did not occur, reference the alphabetic index to determine if the condition has a subentry term for impending or threatened. If the subterms are listed, assign the subterms. If they are not listed, code the existing underlying conditions or signs/symptoms.

• Documentation of Complications of Care: a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication.

**Basic Features and Format of ICD-10-PCS Coding System**

ICD-10-PCS codes are made up of seven digits using numbers and 24 letters (A-H, J-N, and P-Z). The letters are not case-sensitive, and letters O and I are not used to avoid confusion with numbers zero and one. No decimal points are used. Procedures are divided into 16 sections related to whether it is a medical, surgical, imaging, or other kind of procedure. All procedure codes have seven characters. The first digit always corresponds to the section where the procedure is classified. The second through seventh characters have specific meanings, which are identified below.

**EXAMPLE OF MEDICAL/SURGICAL SECTION CHARACTER MEANINGS**
1 = Section of the ICD-10-PCS system where the code is indexed
2 = The body system
3 = Root operation, such as excision or incision
4 = Specific body part
5 = Approach used
6 = Device used to perform the procedure
7 = Qualifier to provide additional information about the procedure (diagnostic vs. therapeutic)

**EXAMPLE OF AN ICD-10-PCS CODE AND HOW TO INTERPRET IT**
Code: 097F7DZ
Section: Medical and surgical 0
Body system: Ear, nose, sinus 9
Root operation: Dilation 7
Body part: Eustachian tube, right F
Approach: Via natural or artificial opening 7
Device: Intraluminal (done with tubes) D
Qualifier: No qualifier Z