Medical Coding and Billing Specialist

Instruction Pack 3 Lessons **21-30**

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Medical Coding and Billing Specialist

Instruction Pack 3

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Answer Key

Lesson 21

Solving Problems with Insurance Carriers, Providers and Patients

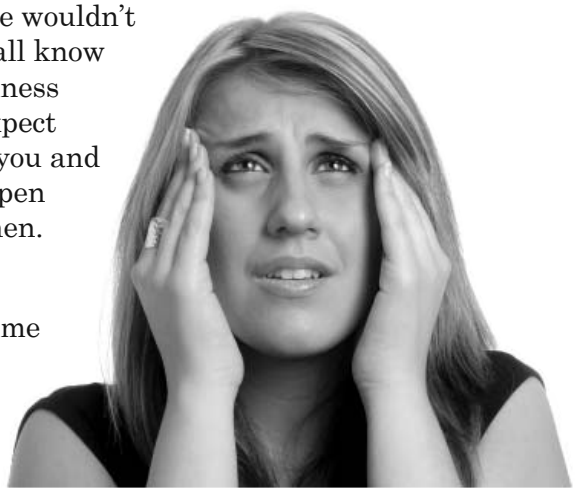
Step 1 Learning Objectives for Lesson 21

- When you have completed the instruction in this lesson, you will be trained to do the following:
  - Describe the steps needed to solve problems with insurance companies.
  - Explain how to handle misunderstandings and problems with providers and patients.
  - Discuss the possible approaches to pursue with each type of problem.
  - Describe what credit is and what an agreement to furnish credit contains.
  - Explain how to keep your own credit record clean.
  - Describe the options available to you if a client owes you money.

Step 2 Lesson Preview

- In a perfect world, perfect people would always come through. You would have no problems or misunderstandings. People wouldn't lose things or forget to complete tasks. Of course, we all know we don't live in a perfect world. As a professional business person, you should always strive for perfection and expect others to do the same. However, no matter how hard you and others try to do a good job, something is bound to happen from time to time; everyone has a bad day now and then.

  When a problem occurs, you need to know how to deal effectively with it. If you made the error, accept the blame and work to fix the situation. If you are trying to solve a problem created by someone else, you need to work through the difficulty constructively. This lesson will show you effective ways to solve problems with insurance companies, doctors and patients. After reading this lesson, you will be better prepared to tackle any problem. So move on to the next step—and you'll learn how to make your world a little better!



Everyone has a bad day now and then.

Step 3 Dealing With Insurance Problems

- Generally speaking, insurance companies are large businesses operating across the nation. Consequently, claims that you file might occasionally be delayed. If you have waited more than 30 days for reimbursement of a claim, you need to inquire about it. To do this, you will need to find a contact who handles claim questions for the insurance company that delayed the reimbursement.

  Sometimes this contact is a person assigned to your geographical area such as a regional representative. Or the contact might be located in the insurance company's home office. Some insurance companies have entire departments dedicated to answering questions, so you might have a contact telephone number instead of a single person. In any case, when you contact an insurance company regarding a claim, you should have access to the claim when you call. This enables you to answer any questions the insurance representative may have about the claim.

  Why should you get in touch with the insurance company that has delayed reimbursement? There are some very specific situations that call for an inquiry. Here are some examples.

Insurance Problems

You need to call the insurance company to make an inquiry when any of these situations occur:

- A claim is more than 30 days old and has had no explanation and no reimbursement issued.
- A claim has been delayed 30 days or more and the insurance company has notified you of an ongoing "investigation into the claim."
- You believe the reimbursement received is incorrect, or a claim has been denied and you don't understand why.
- The explanation of benefits is missing.
- Reimbursement is received for a claim you haven't filed.

The last situation listed in the box—reimbursement is received for a claim you haven't filed for—happens more often than you might think, but there are legitimate reasons. For example, the insurance policy might be in a parent's name and covers the child. If the parent's and child's last names are the same, this isn't likely to cause any confusion. However, that isn't always the case. Mary Jones's policy, for example, might cover her daughter, Julianna Cervantes. If the claim is in Julianna's name at the office, but the insurance company issues reimbursement for Mary Jones (the name on the policy), you might have to inquire to find out exactly who this reimbursement covers.

Once you have called the insurance company regarding the claim, you may be asked to do some follow-up work. You might simply have to resubmit the claim, or you might send a tracer, which we will discuss shortly. If the insurance company has questions about the claim, it might ask for a narrative. The following section describes these activities.

🕮 Step 4 Following Through on Insurance Problems

- ❑ When problems arise from insurance claims, you will be expected to deal with them. Let's look at some of the techniques you can use to address these issues.

Resubmitting a Paper Claim

When you **resubmit** an insurance claim, you submit the claim a second time. Write "SECOND BILLING" in bold, red letters at the top of the copy you will send. Resubmit the claim to the insurance company.

Usually, resubmitting a claim will at least get you more information about the status of the original claim. The insurance company may have reimbursed the patient directly and not notified you. If you resubmit the claim, the company will send you an explanation of what action was taken on the original claim. Sometimes the insurance company sends the patient notice of action on a claim, and the patient ignores it. This leaves you and the provider in the dark. However, your second submission will usually get you involved again and let you know if the patient was paid directly or if the claim was denied. If the original claim was lost, then the insurance company now has the copy of the claim and can process it.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SECOND BILLING

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid#) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH SEX M F

b. OTHER INSURED'S DATE OF BIRTH SEX M F

b. AUTO ACCIDENT? YES | NO Place (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1.														NPI	
2.														NPI	
3.														NPI	
4.														NPI	
5.														NPI	
6.														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

a. b.

Another reason to resubmit a claim is if you made a mistake with the original claim; if, for example, you entered the wrong procedure code or perhaps had the policy number wrong. To correct this, you should send the claim again, this time with the words "SECOND BILLING—CORRECTION" at the top in red ink. This tells the insurance company that it should ignore the first claim and use this new claim to process.

Electronic resubmittals are handled similarly.

Resubmitting an Electronic Claim

When submitting claims electronically, for example through a clearinghouse, there are usually fewer instances when you must resubmit a claim due to errors. Clearinghouse software edits claims, which identifies errors, such as incorrect codes and missing information. This way you have the opportunity to correct these errors and supply missing information *before* the claim is sent to the insurance company.

However, there will still be situations when an insurance company will require additional information, such as accident information or a copy of a medical record, in order to process the claim. You can simply resubmit the claim, along with the attached information, electronically. Or in some cases, the health insurance company will request a paper resubmittal so that you can indicate that the claim is a second billing.

Also, electronic billing almost always results in an acknowledgement report of some type. For instance, clearinghouses provide a list of received claims, each with a tracking number that can be used should someone need to trace a claim.

Sending a Tracer

Just as its name implies, a **tracer** is a form that enables insurance companies to locate a missing claim. The tracer contains billing information such as the patient's name, insured's name, identification number and plan number. When you submit a tracer, it lets the insurance company know there has been a problem with a particular claim. The company takes the information from the tracer and uses it to search for the claim. After the claim is found, the provider is notified and informed of any action taken.

CLAIM TRACER FORM

Date _____

Insurance carrier name _____

Address _____

Patient name _____

Insured's name _____

Policy number _____

Group name/number _____

Date of original claim submission _____ Amount _____

An excessive amount of time has passed since submission of our original claim as described above. We have not received a request for additional information or payment on this claim. Please review the attached copy of the claim and process for payment within seven days.

If there is any difficulty with this claim, please complete one of the items below and return this letter to our office.

Claim pending because _____

Payment of claim in process _____ Date _____

Payment made on claim _____

To whom _____ Date _____

Claim denied _____ Reason _____

Additional remarks _____

_____

Thank you for your assistance in this important matter. Please contact our office if you have any questions regarding this claim.

The office of (physician's name), MD

Address _____

Phone _____

Filing a Narrative Explanation

Occasionally the insurance company might ask for a **narrative explanation**, which is further explanation of procedures, diagnoses or other information on a claim. This additional information is usually required for evaluation purposes as the insurance company tries to decide if a claim is covered. In order to fulfill this request, you should simply write out a detailed description of the items the insurance company is questioning. On this narrative, you should include the patient's name, insured's name, policy number and claim number at the top and then complete the description below that information.

To create a narrative explanation, simply write out a detailed description of the items the insurance company is questioning.

Remember, if an insurance company denies a claim, you should bill the patient directly.

Appeals

Sometimes you might have to appeal an insurance company's decision regarding benefits. If you feel the insurance company's ruling is wrong, you must complete an *appeals letter*. An **appeals letter** is a document that spells out the claim filed, the action taken and why you consider the reimbursement to be incorrect. When completing an appeals letter, take into account all the information involved with the claim and use it to dispute the insurance company's action. The provider will provide you with the reason or reasons the reimbursement is incorrect. Be sure to use that information on the appeals letter. When submitting an appeal, address the letter to your contact person in the insurance company.

When you appeal an action by Medicaid, you have between 30 and 60 days from receipt of the denial to file the appeal, depending on the state. Appeals should include a cover letter and copies of the original claim form, any preauthorization forms and the explanation of benefits received. First, the regional fiscal intermediary reviews appeals, and then the Department of Welfare. At each level, an examiner reviews the case and makes a decision.

When you appeal an action by Medicare, you must do so within 60 days of the date you received the notice of denial. Unless you can prove otherwise, Medicare deems that you received the denial notice five days after the date on it. If you should need more than 60 days to file the appeal, you can request more time from the intermediary at the Medicare office. You will be notified in writing of the time granted you.

For TRICARE or CHAMPVA, if a claim is denied or returned by the claims processor requesting additional information, or if you wish to appeal a decision, resubmit the claim within 90 days of the notice. If you should need more time to correctly resubmit or provide the additional requested information, you must contact the claims processor for your area that is noted on the document you received and request an extension of time.

Here is an example of an appeals letter.

Doctor/Practice Name
Address
City, State ZIP code

Date (Very Important)

Insurance Company
Address
City, State ZIP code

Dear (Contact):

Our office recently received reimbursement for $ (insert amount) for (insert patient's name) for services on (insert date).

As you can see from the enclosed copy of the Explanation of Benefits, reimbursement was reduced for this claim because the services were found to be (insert reason noted on EOB).

Please review the services provided for (patient's name). (The physician will provide you with a short sentence that you should include here explaining the necessity of treatment.)

Thank you for your attention to this request.

Sincerely,

Your name
Enclosed: EOB
Original claim

Usually, resubmitting a claim, sending a tracer or filing a narrative explanation is enough to solve most problems with insurance companies. However, sometimes you need to do more. You might have to utilize the state insurance commissioner or the court system.

The Insurance Commissioner

Insurance companies are governed by state regulations in all 50 states. Each state has different requirements for insurance carriers, and each carrier must meet these requirements to operate in that state. Even though a company might be based in New York, in order to insure clients in Colorado, it must meet the requirements not only for New York, but also for Colorado. This applies to every state where the company operates. An insurance company is considered to be operating in a state if it issues any policies covering people in that state. The regulations for insurance operations are overseen by the state **insurance commissioner**—an official who reviews insurance companies and the companies' business habits and policy language to determine if they may operate in that particular state. The commissioner also helps solve disputes involving insurance companies.

If you have a problem with an insurance company that cannot be solved through normal channels (resubmission, tracer, narrative or appeals), you should contact the insurance commissioner in your state to discuss it. Sometimes the commissioner will step in and mediate the dispute, enabling both sides to come to an agreement.

Another reason to contact the insurance commissioner is if you suspect an insurance company is operating illegally. Fraudulent claims, arbitrary denial of benefits, policy cancellations and other actions have all been cause for insurance commissioner investigations. To contact the commissioner in your state, look in the government section of your phone book, usually under "Insurance Commission" or a similar listing.

Once in a while, you might have to go even beyond the insurance commissioner and use the court system to settle a dispute with an insurance company. Court cases can be costly and time consuming, so such disputes are usually large, involving a life-or-death situation or, perhaps, a great sum of money. Court cases occur most frequently when a dispute arises over the terms set forth in a policy rather than a simple billing inquiry or error.

Rejected Versus Denied Claims

As we discuss the medical bill process, it's important to understand the difference between a denial and a rejection of a claim.

Rejected claims (also called unprocessable claims) are either returned to the provider with an explanation of the rejection or unprocessability or an explanation of this is sent without the returned claim before any type of coverage determination is made. As you learned, incorrect policy numbers, patient birth dates or sending the claim to the wrong insurance company cause rejections. Once you resubmit the information, rejections are usually resolved.

Denials occur when the health insurance company receives and processes a claim, but determines that the treatment in question isn't a covered benefit in the plan. When claims are denied, the provider is informed with the explanation of benefits and/or denial letter. The letter includes denial codes that include a message like "service not a benefit in enrollee's plan," "denied for lack of medical necessity" or "denied coverage of experimental treatment." Denials can be appealed if a mistake has been made, and some denied claims are overturned.

You've explored various insurance problems in this section, and now it's time to apply what you learned. Let's complete a quick Practice Exercise before we move on.

✍ Step 5 Practice Exercise 21-1

❑ Match the term to the correct definition or description.

1. _____ **Inquiry**
2. _____ **Resubmission**
3. _____ **Narrative explanation**
4. _____ **State insurance commissioner**

a. Sending in a claim a second time with "SECOND BILLING" written at the top
b. Oversees the state insurance regulations
c. Asking an insurance company about a delayed claim
d. A further description of a procedure or other information on a claim

🗝 Step 6 Review Practice Exercise 21-1

❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

🕮 Step 7 Billing Patients

❑ Another responsibility of the coding and billing specialist is to bill patients. There are different reasons why a patient may be billed. One reason is that the patient does not have insurance and did not pay in full at the time of service. This would generate a monthly bill to the patient. Another reason may be that a patient does have insurance, but there is a deductible or portion still owed by the patient after the carrier has reimbursed its portion of the claim.

Providers often divide their bills into cycles. There are several common billing methods. Depending on the size of the practice, the patients may be divided using the alphabet. For instance, Cycle 1 includes patients with the last names beginning with the letters A through F. Cycle 1 patients are billed the first week of every month. Cycle 2 includes patients with last names beginning with G through L and bills are generated for these patients the second week of the month. And so on with two more cycles to cover patients whose last names begin with M through Z.

Another billing method is *event billing*. **Event billing** generates a bill every time something on the account is activated. For instance, when a patient has an office visit, a bill is triggered. Or if the insurance company paid a portion of a patient's claim, a bill is generated to the patient for the remaining account balance.

It is important to have some kind of system to follow up on patients who have outstanding balances. When an account slips through the cracks, it can be very costly to the provider.

Along with billing comes collection. With this in mind, you need to be familiar with credit and collection concepts. Let's discuss those concepts now.

Step 8 Credit

- If you choose to run your own medical coding and billing service, you will be an independent business person. You will deal with money every day. To understand the financial world, you should know about two very important and common concepts: *credit* and *collection*. Let's go over the ins and outs of credit, including both the lender side of the credit picture and the debtor side.

  Let's say you walk into a local department store and pick out a nice outfit. The clerk at the register inquires about how you intend to pay for your purchase. "Will this be cash or charge?" the clerk asks. You pull out your credit card and hand it to the clerk. You have just charged your purchase and used credit.

  When you receive goods or services in exchange for a promise to pay later, you have used credit. **Credit** is the merchant's acceptance of your promise to pay later for goods or services you receive immediately. Some people may think credit is only extended by large companies—companies or banks that issue credit cards, for example. The real case, however, is much different. Many small, local stores issue credit to people. The local hardware store might have credit accounts for contractors. The office supply store might extend credit to local businesses.

  Billions of dollars are charged every year. In one form or another, credit is issued not only by the largest department store in New York City but also by the little mom-and-pop shop in the smallest town. You might have a credit card issued by a bank. Or perhaps you use department store or gasoline credit cards. In any case, if you are operating an independent medical coding and billing service, you will need to decide if you will extend credit and, if you do, to whom.

  The person or business who issues the credit is called the **creditor**. The person or business that receives the credit is called the **debtor**. Creditors and debtors often set out the terms that the credit will follow. These terms, called a **credit agreement**, include method and amount of payment, payment due dates and consequences for missed payments or other problems, as well as procedures for canceling the agreement. The credit agreement is very important for both the creditor and debtor because it sets the terms for the repayment of the debt.

  Right now, you probably are on the debtor side of most credit agreements. However, that might not always be the case. You might allow providers to pay monthly for the medical claims you file. Each week, you submit the claims, but because you extend the provider credit, you do not require him to pay immediately. Instead, you send him an invoice at the end of the month listing the total amount he needs to pay. This makes you a creditor.

Your Credit Report

Credit is a large part of everyone's life—at least, nearly everyone. You use credit. Your neighbors use credit. Your parents and friends use credit. You use credit for the car and appliances you buy as well as the house you live in. If you have charged goods or services, used a credit card or bought a car through a loan from a finance company, you have a credit history.

Your credit history, called your **credit report**, lists all your credit accounts and your payment history with those accounts. There are three agencies that compile and keep credit reports—TransUnion, Experian and Equifax. Every time you apply for credit, whether it is a new bank card, a department store credit card or an automobile loan, the creditor will pull your credit report. This means the company considering whether or not to loan you the money you requested will review a copy of your credit report.

The credit report will tell the company how much money you owe and your history regarding debt repayment. It is important to keep your credit report clean. This means paying your bills on time. You might not think it matters if a bill is 10 days late. However, the company you paid late might report that information to the agencies that keep your credit report, and that information is attached to your report for a minimum of three years. Information such as late payments, bankruptcies or defaults is called **negative credit information**.

How can a potential creditor tell from your credit report how you made your payments? That is a simple procedure. The creditor pulls your report and looks at it. Usually, the report will list each credit account you have, and then under each account, your payment history will appear. The report uses codes to indicate payments. An *A* can mean you made that payment on time. A *B* means the payment was 10-29 days late. A *C* means the payment was 30-59 days late. An *X* means you missed the payment completely. (These abbreviations are meant for illustration only. The actual code used on your credit report might be different.)

Let's look at an example.

CREDIT REPORT
Harry Anyone
123 Anystreet
Anytown, US 00001

Credit Accounts:

AnyBank Credit Card
Amount owed:---------- $3,000

Payment history
(the last 36 months) --- Last month

AAAAABAAAAAAAAAAAAAAA
AAAAAAAAAAAAA

CREDIT REPORT
Lynn Nobody
123 Nostreet
Nowhere, US 00002

Credit Accounts:

NoBank Credit Card
Amount owed:---------- $3,000

Payment history
(the last 36 months) --- Last month

AABBBBBAAAAAAABAAXAABAA
ABBAABBBBAABA

Both Harry Anyone and Lynn Nobody want to buy a new car. They have been at their jobs for the same amount of time. They make about the same amount of money a month. However, when the staff at the automobile finance company look at Harry's and Lynn's credit reports, they see the following.

If you interpret the *A* codes to mean *on time* and the *B* codes to mean *late*, which person do you think is more likely to have a loan approved—Harry or Lynn? Harry would have a much easier time, don't you think? This is why it is so important to have a clean credit record. If you strive to keep it clean by making payments on time, you will find it is easier to get credit.

If your credit is not clean, do not give up hope. Finance companies do not usually reject people with less than perfect credit records. These people, referred to as *credit risks*, end up paying higher interest rates and, in some cases, making larger down payments.

You are entitled to see your credit report. In fact, you can request one free copy every year from the three credit reporting agencies—Experian, Equifax and TransUnion. Search the Internet for the address of each agency. As a rule, you should pull and review your credit report every year to make sure there are no errors. It has been estimated that 75 percent of credit reports contain at least one error. If there is an error, you need to write to the credit agency and request proof of the debt shown. If the agency cannot prove you are responsible for the debt listed, it must remove it from the credit report.

When you have your own business, a clean credit history can help you secure the financing you need for new equipment (office furniture, computers, etc.).

🕮 Step 9 Delinquent Accounts

- Dr. John Randolph uses your medical coding and billing service and pays you with a company check. However, when you deposit the check in your account, your bank sends it back to you marked "Insufficient Funds."

  Louise Baker also uses your medical coding and billing service. However, for the past two months, you haven't received any payment for your services.

  Look at the two examples. Which account, John's or Louise's, would you consider delinquent? The answer is that both accounts are delinquent. A **delinquent account** is any account in which the debtor has failed to live up to the credit agreement. John paid with a check that did not clear his bank, so he failed to make his payment. Right now, his account is just as delinquent as it would be if he hadn't made any payment at all.

  Louise's account is a little different. She has made no attempt to make a payment on her credit account with your business. How should you handle these two situations? Well, let's look at John's bad check first, then move on to Louise's nonpayment.

Handling Returned Checks

The next time you shop, look around at the cash registers. You probably will see signs that state some variation of: "There will be a charge for all returned checks." This sign warns people who write checks that, in addition to the amount on the check, the store will collect an extra $20 for each check that is returned by the bank.

When a check is returned, it means that, for some reason, the bank the check was drawn on has refused to honor it. Any time a check is returned, the merchant loses the amount of money the check was written for. Say, for example, that Yancy's Bait Shop goes to deposit the day's money. Included in the deposit is $400 cash and a check for $45. The check gets returned by the bank. Instead of a deposit totaling $445, Yancy's Bait Shop is credited with only $400. You can imagine how returned checks can cause havoc with a business. Why would a bank return a check? There are several reasons.

To solve a problem with a client who has paid with a check that does not clear, you should probably begin by contacting the client directly to arrange to receive payment. You can also try to redeposit the returned check and hope there is enough money in the bank to cover it. If all else fails, you can send the check to a collection agency or file a court action.

Reasons Banks Return Checks

1. If a bank returns a check for insufficient or nonsufficient funds, it means there is not enough money in the checking account to cover the amount of money on the check. Usually the letters NSF are stamped across the check. When the bank returns a check for nonsufficient funds, that check has "bounced."
2. Another reason a bank returns a check to a business is if the account is closed. Obviously, if an account has been closed, a person should not be writing checks on that account. The bank will not honor any such check.
3. A bank may return a check if the account holder stops payment on the check, which means the account holder tells the bank specifically not to honor a certain check. This process costs the account holder money and is usually reserved for disputes between the check writer and the business. An account holder who suspects a check has been stolen can use the stop payment option to make sure that check does not clear. When a check does not clear an account, no money is taken out of that account to cover that check.
4. Finally, a bank will not honor a check if the check is filled out incorrectly or illegibly. For example, if the numerical amount does not match the written out amount, if the signature appears altered or forged, or if the account number has been changed, the bank can refuse to honor the check.

Handling Nonpayment

Remember how Louise had ignored her bill and just did not paid at all? This can be a problem, obviously, for you and your business. Without compensation, you might quickly run out of money. How, then, can you go about collecting from Louise? The first course of action is to send a friendly reminder. Think of your own experience. If you've misplaced a bill, a simple "Have you forgotten?" letter reminds you to send payment. Such a letter from you should read something like this:

Dear Louise Baker:

Have our letters crossed in the mail? I am waiting for your payment for my services in June and July. I value your business and am looking forward to working with you more in the upcoming months. If you have not sent out your payment of _____, would you please do so now?

Thank you very much.

This first letter is to the point, but friendly. It simply reminds Louise that she hasn't paid you yet. It makes no threats. And it gives her an "out" by raising the possibility that she has already sent the payment. Money is a sensitive subject. People can become very embarrassed if they have to admit they haven't paid their bills. Don't press your delinquent clients too far in the first letter.

However, if another two weeks go by and you still haven't been paid, send a second letter. This one should be a little more serious and should list a consequence for nonpayment.

Dear Louise Baker:

In reviewing my bills, I noticed your account is more than two months past due. I hope you received my first reminder. This is your second notice in the past two weeks. If there is a problem with my invoice or services, please contact me immediately, and I'm sure we can work things out.

I must stress to you that I need to receive your payment of _____ by (fill in date two weeks from today), or I will be forced to take the next step in my effort to collect. This step can include a collection agency and, as per our contract, significant additional cost to you.

If you have already sent your payment, thank you very much.

You see, this second notice sounds more threatening than the first, but still doesn't go overboard and beat Louise over the head. She now knows exactly what she owes, what to do if she has a problem and what will happen if she doesn't pay her bill.

After two more weeks, if you still haven't received payment, then you should take the next step in the collection process. That next step could be either a collection agency or a court action.

Step 10 Collection Agencies

- Look back at the example of Louise's account. Let's say you have tried to contact her, but have not received any payment. Her account is now three months overdue, and she has made no effort to explain why. In cases such as this, you might be forced to take more drastic steps beyond cutting off your service to her and sending her letters. You might need to pass her account on to a collection agency.

Using Collection Agencies

Collection agencies are businesses that specialize in collecting unpaid debts for other businesses. Usually these agencies are under contract to handle the delinquent accounts of a variety of businesses. Collection agencies, and the collection agents they employ, handle all the contact, follow-up and other financial arrangements for a business's delinquent accounts.

Although the use of a collection agency might seem to be an ideal arrangement for a business that has delinquent accounts, it isn't always so terrific. You see, in order to perform their services, collection agents collect a commission for every delinquent account they settle. Ordinarily, this commission comes out of the total debt owed to the business. In the contract with a collection agency, the business agrees to give up a certain percentage of the amount owed if the collection agency is successful. This percentage can be as high as 50 percent. That means if you turn Louise's delinquent account over to a collection agency, you can expect to receive only half of what she owes you. The other half goes to the collection agency, to pay for its services. If Louise owes you $500, you would ultimately receive only $250—if the agency is successful in collecting at all.

Even collection agencies can have some problems collecting. Often the collection agent contacts the debtor and arranges for that person or business to make monthly payments. Sometimes this arrangement works and sometimes it doesn't.

When nothing seems to work, the collection agency might choose to file a court action against the debtor. You can also file a court action if you do not wish to use a collection agency. Small claims court can be a very effective method of recouping debts.

Collection agencies specialize in collecting unpaid debts.

🕮 Step 11 Small Claims Court

- In the United States, each state has a small claims court designed for parties to settle disputes without attorneys. Each state has its own rules for small claims court. These rules include the maximum dollar amount you can sue for, the method you must use to notify the other party (the defendant) and the procedures you must follow to file a valid claim.

Filing a Claim

Filing a claim usually requires a filing fee (most likely, less than $100). Then you must serve the person you are filing against—the **defendant**. The person filing the action, or suing the defendant, is called the **plaintiff**. Both the plaintiff and the defendant are said to be **parties** in the lawsuit.

Most states require you to have a responsible person hand-deliver the notice of the court action to the defendant, called **serving** the defendant. Mailing the notice is not acceptable in most states. After the defendant has been served, you both appear in court on the set date and present your sides of the case. If either party fails to appear, the person who does appear is awarded a default judgment. Basically, a **default judgment** means the person who appears wins. If the defendant wins, then the lawsuit is dismissed. If the plaintiff wins, the judge orders the defendant to pay compensation to the plaintiff.

Let's say you decide to take Louise to court. You file the court action with the county clerk and then have Louise properly served. The court date is September 21. On September 21, you arrive in court and Louise is there. You both present your sides of the case. The judge rules that Louise owes you the money and must pay. You have won the case. The judge then enters a **judgment** in your favor on the court records. This judgment shows how much you are owed and when the court case took place. But how do you collect? We will cover that question in the next section.

If you lose a small claims court action, you usually cannot take any further action. Also, any person who is served with a small claims court summons can choose to "bump" the case up to county court, where attorneys are permitted. This can increase your costs, so be sure of your case.

Collection agencies usually file in county court and use an attorney to collect delinquent debts. Even if the agency wins, you still will only see about 50 percent of the original debt.

Collecting a Judgment

Once you win a court case, you do not necessarily collect your money right then and there. The court case gives you a judgment. This judgment is your ammunition in your fight to collect. Depending on your state, you can use the judgment to collect part of the defendant's paycheck. Or you might be able to force the defendant to sell personal property to pay the judgment. In any case, you must take the judgment a step beyond the courtroom to collect money.

If your state permits, you can use the judgment to get an *order of garnishment*. An **order of garnishment** is a legal document requiring the defendant's employer to withhold a percentage of the defendant's pay each month and send that money to you. This goes on as long as the defendant owes money on the judgment and works for that employer. Each time the defendant changes employers, you must get a new order of garnishment.

Step 12 Solving Patient Problems

- ❑ If you work in a medical office, typically you deal with patients. This means that you see them on good days when they're happy and on bad days when something is wrong. Sometimes the patient feels fine physically, but has some serious concerns regarding the bill. Imagine this common scenario:

  Rosita Perez had surgery a month ago and saw the doctor two weeks ago for a follow-up examination. Today she comes into the office waving a bill around. When you try to talk to her, she breaks in.

  "Why are you sending me this? My insurance company should have paid it!" she exclaims.

  Now, you know that your billing software automatically prints bills for accounts that have outstanding balances. This bill is sent to the responsible party listed for the account. In Rosita's case, her insurance company has been billed, but hasn't paid yet, so the bill was generated and sent to Rosita. You need to explain this to her. How should you approach the subject? Remember, Rosita is currently very upset because she has just opened a bill that she hadn't counted on receiving, and we all know how stressful that can be.

When handling an upset patient, remain calm.

The first thing you need to do is *remain calm*! If you allow yourself to become agitated, all you have accomplished is to create a completely unworkable situation. If you stay calm, you can work first on calming down Rosita, and then you can move on into the explanation of the bill. You need to keep in mind that most people don't understand how the whole billing process works. You, as a medical coding and billing specialist, understand the process and you need to explain it, briefly, to troubled patients.

With this in mind, you should be prepared to weather a small storm as agitated patients vent their frustration. (This should never, however, become an assault on you—after all, the patient is not mad at you; she is mad at the bill.) If the venting becomes personal, you should gently guide the conversation elsewhere.

1. Take control of the situation by asking to see the bill. Once you have the bill, look it over and confirm the situation. Usually, a patient will give you the chance to look at the bill. If the patient won't, explain that you cannot help unless you see the item of concern. Always approach the situation from a "how can I help you" point of view. Be on the patient's side.
2. Once you have the patient's attention, explain the specific situation. In Rosita's case, you explain that the insurance company has been billed, but has not paid yet. This leads the computer to produce and send out a bill to the patient. Rosita shouldn't worry about the bill until she is contacted by the doctor's office and told exactly what the insurance company did and did not cover. Any portion of the bill remaining after the insurance company reimbursement is received is the patient's responsibility, unless, of course, the provider is a preferred provider, in which case the provider will write off any unpaid amount.
3. If patients have questions about their specific insurance policies, refer them to their insurance representatives or agents. You cannot possibly know everything about every patient's coverage, although some patients might think you are responsible for their insurance companies denying their claims.
4. When an insurance company has paid, but the patient believes the reimbursement is too low, step in and see if you can help. Again, be on the patient's side. Ask if you can call the insurance company for the patient to check the explanation of benefits. Then get in touch with your insurance contact and ask.

Overall, the most important thing to remember when dealing with anxious patients is to be on their side. Be an advocate, not an adversary. If you set yourself up as the "knight in shining armor," the patient will look on you as an ally, not someone to be yelled at. Because you have been trained to deal with insurance companies, you are better suited to ask questions about specific claims. Use this knowledge to help out patients who have questions and are worried about bills they thought were covered.

Insurance companies and patients are not the only potential trouble sources. You might, from time to time, encounter a problem with a provider.

Step 13 Solving Problems With Providers

- Doctors are human beings, as are medical coding and billing specialists. Human beings occasionally have misunderstandings or conflicting attitudes. When you run into such a problem with a provider, you must take a page from your solving-patient-problems book and *stay calm*. No matter what the problem, a screaming match won't solve anything. It is amazing how quickly an intelligent discussion can deteriorate into a match of volume if the two parties allow it. However, if you stay calm, you can more effectively deal with any problem because you present a professional image.

  If the doctor has a problem with something you're doing, stop. If you have a question about why what you're doing is wrong, ask it. You need to know. If you are performing a necessary task, explain why it is important. In any case, listen to what the doctor is saying. Sometimes you might have to accept the doctor's instruction, regardless of how you feel about it. After all, whether you are an outside coding and billing specialist or an in-house employee, it is likely that you work for the provider. Both sides may have to compromise. This constant give-and-take enables both the provider and the coding and billing specialist to be comfortable with the working environment.

  What would you do if a provider asked you to do something fraudulent? Let's look at Jason, a medical coding and billing specialist who works with Dr. King. One day when she hands him a bill, Dr. King says, "Don't use the surgical package code. I never do because we'll get more money if we code everything separately." If Jason does as Dr. King suggests, he will commit fraud. Jason knows this, and explains to Dr. King that he's not comfortable coding things separately—after all, his job is to code accurately. Jason goes on to say that he's liable if he knowingly submits fraudulent claims. Dr. King says she respects his integrity, and thanks him for saying something because she didn't realize that coding to receive more money was fraudulent.

  Another key to a professional attitude is to acknowledge your mistakes. If you forgot to file a claim, don't shrug off responsibility by claiming it was misplaced by the insurance company. It is important for the provider to know you are trustworthy. If you do not take responsibility for your actions, including those that are wrong, you lessen your own credibility.

  In addition to taking responsibility, be prepared to solve problems. If something needs to be done and you can do it (and you have time), volunteer to do it. Make yourself valuable to the office and to the doctor.

Step 14 Professional Liability Insurance

- When you begin your career as a professional medical coding and billing specialist, you might be a self-employed contractor with a doctor's office or healthcare facility. Or you might work as an employee for a doctor or an outpatient facility. Whatever the case, you will be responsible for many decisions related to medical codes. Because of this, you are partially responsible for financial reimbursement for medical services provided to patients. Although it's not an everyday event, in today's medical environment of high costs and frequent lawsuits, an unintentional but significant error in your work could put you at risk for malpractice.

This is not meant to scare you. Unfortunately however, lawsuits are a growing trend in many professions today. Healthcare professionals and medical coding and billing specialists are no exception. The best defense against a lawsuit is being properly trained and having *professional liability insurance*. You've taken the right step on the education front, so let's focus on liability.

Professional liability insurance is just what it sounds like. It's insurance to protect you if anyone decides to sue you for malpractice. In terms of coding and billing, this might be because of some coding or billing error. If you are sued, professional liability insurance typically pays for legal fees, court costs, court judgments and even out-of-court settlements. As those who have been sued for medical malpractice will tell you, the investment in liability insurance is worth the cost for the security and peace of mind it provides. Understand that if you are an employee, your employer should already have insurance. You won't need to worry about being protected. However, if you decided to form your own coding and billing business, you would need to arrange for your own liability insurance.

Professional liability insurance is a wise investment for self-employed coders.

Step 15 How Does Compliance Affect Medical Coders and Billers?

- We've briefly discussed compliance throughout your course, but you're probably wondering what it actually means. Well, **compliance** means making sure that your company or facility provides and bills for services according to the regulations, laws and guidelines that govern it. The correct handling of medical records is vitally important to compliance.

Elements of Compliance

In addition to following the guidelines given in this lesson, a company or facility must protect itself from the risk of prosecution and keep itself on course. The provider or office manager typically creates a compliance plan, and the medical coding and billing specialist follows the plan. Creating a compliance plan involves developing standards of conduct, education, auditing, monitoring and developing and updating a plan of conduct all are essential elements of compliance. Specifically, the plan should include statements that address current reimbursement, claims submission and proper documentation of services.

Essential Elements of Compliance

A plan for compliance should ensure the following:

1. The services billed are accurate and properly documented.
2. Marginal notes or late entries in the medical record must be noted and explained.
3. All bills follow current coding procedures and regulations.
4. Correct and appropriate documentation exists for DRG coding, Medicare Part B and patient discharges.

Compliance means not only abiding by the rules and regulations that govern your company or facility but also documenting proof that you are abiding by these rules and regulations. Some other areas that are expected to be included in compliance plans are:

5. Patient confidentiality/release of information
6. Human resources
7. Infection control
8. Plant safety and waste management
9. Marketing
10. Patient dumping
11. Admission and discharge policies
12. Medical necessity of services provided
13. Patient recruiting techniques

Yearly compliance training programs are necessary for all employees. These educational programs should include corporate ethics, coding and billing procedure, ethical marketing techniques, fraud and abuse laws, and ethical management styles. Coders, billers and coding managers are in a position to put the company or facility at risk and should be educated regularly on the following topics:

- ➤ Medicare reimbursement principles
- ➤ Billing Medicaid and Medicare for services not rendered
- ➤ Misrepresentations of the nature of services rendered
- ➤ Alterations of medical records
- ➤ Billing in violation of the Medicaid/Medicare bundling regulations
- ➤ Violating patient transfer policies

It's also a good idea to become familiar with the major investigative targets of government regulating agencies. Good sources of information about fraud investigations include the annual work plan of the Department of Health and Human Services or HHS, fraud alerts issued by the **Office of Inspector General** or **OIG**, and medical reviews in fiscal intermediaries' provider newsletters.

In all settlement agreements to date, the OIG requires an outside agency to audit coding and billing practices annually. Coding audits can be conducted as frequently as monthly, but they should definitely be validated annually.

Though extensive written policies on compliance sometimes gather dust in the employee lounge, it is important to take the time to carefully document policies and procedures. The documents act as references for staff members who never were trained on certain issues or who may not remember the training they had. The actual writing process helps improve current practices, as each step must be examined as it's documented. Also, written procedures help distribute important information in situations where a supervisor or manager is not available. It is always easier to follow the rules if you know what they are and if you understand the consequences for not following them.

Now, let's review what you've learned with a Practice Exercise.

✍ Step 16 Practice Exercise 21-2

❑ Complete each sentence below by determining the correct word(s) or phrase.

1. **_____ is the merchant's acceptance of your promise to pay later for goods or services you receive immediately.**

2. **The document listing your credit history is called your credit _____.**

3. **The document listing your credit history is important to potential _____ who are considering giving you credit.**

4. **Late payments, bankruptcies and defaults are called _____ _____.**

5. **People referred to as *credit risks* end up paying _____ interest rates.**

6. **If a debtor fails to live up to his credit agreement, his account is _____.**

7. **If a check bounces, the bank returns the check with the letters _____ stamped across the check.**

8. **The person filing the action in small claims court is the _____.**

9. **The person being sued in small claims court is the _____.**

10. **The defendant's employer withholds a percentage of the defendant's pay each month and sends the money to the creditor. In order to do this, a legal document called a(n) _____ is required.**

Step 17 Review Practice Exercise 21-2

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 18 Lesson Summary

- ❑ If you run into problems with an insurance company, go through your regional representative first, using inquiries, narrative explanations and the resubmission of bills to solve problems. If necessary, you can go through your state's insurance commissioner to help solve problems. The court system is also available, but that is usually a last resort.

  This lesson also illustrates just how important credit is today in the United States. Virtually everyone has used credit in some manner. Department stores, banks and even small mom-and-pop businesses issue credit and charge goods. Your credit rating is essential to any application for credit. The three credit reporting agencies keep your entire credit history in a file that is released to potential creditors when you apply for credit. You should look at your credit report at least once a year. These reports, while mostly accurate, can contain errors and omissions.

  If you ever run into a situation where a person or business owes you money, you should first try to work out the problem yourself. Use friendly reminders and follow-up letters. However, if those efforts fail, you might have to turn to the services of a collection agency or even to the legal system.

  When you deal with problems, how much you accomplish depends on how you approach the situation. If you allow yourself to become agitated and angry, you won't accomplish much. However, if you remember to stay calm and take control of the situation, you can solve problems quickly and effectively. When you deal with patients, remember that they don't know much about the billing process. Be prepared to explain yourself more than once, and use language the patient understands.

  Doctors are people, too. You might not care for the manner in which a doctor tells you to do something, but you should stay calm and work through the problem. Sometimes a compromise can be worked out; other times, you just have to complete the task as the doctor instructs. In any case, approach all problems with a professional attitude. This will enable you to be effective in dealing with whatever problems the medical field throws at you.

  Before completing the quiz for this lesson, take some time to review the sample business forms that you may encounter as a medical coding and billing specialist.

Business Forms for a Medical Coding and Billing Specialist

The medical coding and billing specialist is responsible for maintaining confidentiality of privileged information. This is an example of a Business Associate Agreement that may be used by an employer when she hires a medical coding and billing specialist.

SAMPLE BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT ("Agreement") is entered into on this _____ day of _____, 20__ (the "Effective Date"), between [your provider office] ("Covered Entity") and _____ ("Business Associate") (each a "Party" and collectively the "Parties").

WHEREAS, Covered Entity will disclose and/or make available to Business Associate Protected Health Information ("PHI") in connection with services provided to Covered Entity by Business Associate, which information is confidential and must be given special protection; and

WHEREAS, Business Associate will have access to and/or create on behalf of and/or receive from Covered Entity Protected Health Information that can be used or disclosed only in accordance with this Agreement and the HHS Privacy Standards Rule;

NOW, THEREFORE, the Parties hereby agree as follows:

1. **DEFINITIONS**.

1.1 Disclosure. Disclosure shall mean the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

1.2 Health Care Operations. Health Care Operations shall have the meaning as set out in its definition in 45 CFR § 164.501, as such provision is currently drafted and as it is subsequently updated, amended, or revised.

1.3 HHS. HHS shall mean the Department of Health and Human Services.

1.4 HHS Privacy Standards Rule. HHS Privacy Standards Rule shall mean the Code of Federal Regulations ("CFR"), Title 45, §§ 160 and 164, as such regulations are currently drafted and as they are subsequently updated, amended, or revised.

1.5 Individual. Individual shall mean the person who is the subject of the Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

1.6 Protected Health Information. Protected Health Information shall have the meaning as set out in its definition in 45 CFR §164.501, as such provision is currently drafted and as it is subsequently updated, amended, or revised.

1.7 Secretary. Secretary shall mean the Secretary of Health and Human Services or his/her designated representatives.

1.8 Use. Use shall mean, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

2. **PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION.**

[2.1 Permitted Uses and Disclosures. The Parties hereby agree that, except as otherwise specified herein, Business Associate may make any and all uses and disclosures of PHI received from, created on behalf of, and/or made available by Covered Entity for the following stated purposes:

Here list the purposes for which PHI will be used, such as: to file health care claims on behalf of Covered Entity; to properly track the status of such claims; and to generate any necessary documentation for the above.]

or, if a separate services contract is in place,

[2.1 Permitted Uses and Disclosures. The Parties hereby agree that, except as otherwise specified herein, Business Associate may make any and all uses and disclosures of PHI necessary to perform its obligations under the [name of services agreement].]

3. **USE AND DISCLOSURE OF PHI FOR MANAGEMENT, ADMINISTRATION, AND LEGAL RESPONSIBILITIES.**

3.1 Use. Notwithstanding the provisions of Section 2 above, Business Associate is permitted to use the PHI in its possession if necessary for its proper management and administration or to fulfill any present or future legal responsibilities of the Business Associate, *provided that* such uses are permitted under applicable Federal and State confidentiality laws.

3.2 Disclosure. Notwithstanding the provisions of Section 2 above, Business Associate is permitted to disclose the PHI in its possession to third parties if necessary for its proper management and administration or to fulfill any present or future legal responsibilities of the Business Associate, *provided that* the Business Associate represents to the Covered Entity in writing that (a) the disclosures are required by law, as provided for in 45 CFR § 164.501 or (b) the Business Associate has received from the third party written assurances regarding its confidential handling of such PHI as required under 45 CFR § 164.504(e)(4).

4. **OTHER PERMITTED USES AND DISCLOSURES.**

4.1 Data Aggregation Services. Notwithstanding the provisions of Section 2 above, Business Associate is permitted to use and/or disclose PHI to provide data aggregation services, as that term is defined in 45 CFR § 164.501, relating to the Health Care Operations of Covered Entity.

5. **RESPONSIBILITIES OF BUSINESS ASSOCIATE WITH RESPECT TO PHI.**

5.1 Limits on Use and Disclosure. Business Associate hereby agrees that PHI created on behalf of or provided or made available by Covered Entity shall not be further used or disclosed by Business Associate other than as permitted or required by this Agreement or as otherwise required by law. Except as permitted in Sections 3 and 4 above, Business Associate shall not use or further disclose PHI in a manner that would violate the requirement of the HHS Privacy Standards Rule if done by Covered Entity.

5.2 Reports of Improper Use or Disclosure. Business Associate hereby agrees to report to Covered Entity any use and/or disclosure of PHI that is not permitted or required by this Agreement of which Business Associate becomes aware within __ days of Business Associate's discovery of such unauthorized use and/or disclosure.

5.3 Appropriate Safeguards. Business Associate will establish and maintain appropriate safeguards to maintain the security of PHI and to prevent any use or disclosure of such PHI other than as provided for by this Agreement.

5.4 Subcontractors and Agents. Business Associate hereby agrees that whenever PHI is provided or made available to any of its subcontractors or agents as permitted by this Agreement, Business Associate will require such subcontractors or agents to agree, in writing, to adhere to the same terms, conditions, and restrictions on the use and/or disclosure of PHI that apply to Business Associate pursuant to this Agreement.

5.5 Right of Access of an Individual. At the request of and in the time and manner designated by Covered Entity, Business Associate hereby agrees to make available and provide a right of access to PHI by Covered Entity or the Individual, in accordance with the provisions of 45 CFR § 164.524.

5.6 Amendments to PHI. At the request of and in the time and manner designated by Covered Entity, Business Associate hereby agrees to make PHI available for amendment and to incorporate any amendment(s) to PHI pursuant to 45 CFR § 164.526.

5.7 Accounting of Disclosures. (a) Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.508. (b) Within 45 days of receiving a written request from Covered Entity, Business Associate hereby agrees to make such information available to Covered Entity as is requested by Covered Entity to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures in accordance with 45 CFR § 164.528.

5.8 Access to Books and Records. Business Associate shall make available to the Secretary its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity for the purposes of determining Covered Entity's compliance with the Privacy Rule, in accordance with 45 CFR § 164.504(e)(2)(ii)(H).

6. **RESPONSIBILITIES OF COVERED ENTITY WITH RESPECT TO PHI.**

6.1 Change in Notice of Privacy Practices. Covered Entity agrees to inform Business Associate of any changes in the form of the Notice of Privacy Practices that Covered Entity provides to Individuals pursuant to 45 CFR § 164.520, and agrees to provide Business Associate with a copy of the notice currently in use.

6.2 Change or Withdrawal of Permission. Covered Entity agrees to inform Business Associate of any changes in the form of, or revocation of, permission by an Individual to use or disclose PHI, to the extent such changes may affect Business Associate's use or disclosure of PHI.

6.3 Changes in Requirements. Covered Entity agrees to notify Business Associate of any arrangements permitted or required of Covered Entity under the HHS Privacy Standards Rule that may impact in any manner the use and/or disclosure of PHI by the Business Associate under this Agreement, including, but not limited to, restrictions on use and/or disclosure of PHI as provided for in 45 CFR § 164.522 agreed to by Covered Entity.

6.4 Permissible Requests. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HHS Privacy Standards Rule if done by Covered Entity, except as provided in Sections 3 and 4 above.

7. **TERM AND TERMINATION.**

7.1 Term. This Agreement shall become effective on the Effective Date and shall continue in effect until all obligations of the Parties have been met, unless terminated as provided in this section.

7.2 Termination of Agreement. Pursuant to 45 CFR § 164.504(e)(2)(iii), Business Associate agrees Covered Entity may immediately terminate this Agreement if Covered Entity determines that Business Associate has violated a material term of this Agreement. Alternatively, Covered Entity may choose to (a) provide Business Associate with __ days' written notice of the existence of an alleged material violation, and (b) afford the Business Associate an opportunity to cure said alleged material violation upon mutually agreeable terms. If mutually agreeable terms cannot be reached within __ days, then Business Associate must cure said violation within __ days to the satisfaction of Covered Entity. If Business Associate fails to cure such violation as set forth in this paragraph, Covered Entity may immediately terminate this Agreement. If neither termination nor cure are feasible, Covered Entity shall report the violation to the Secretary.

7.3 Effect of Termination. Upon the termination of this Agreement, Business Associate agrees to return or destroy or return all PHI received from, or created or received by Business Associate on behalf of, Covered Entity that Business Associate or its subcontractors or agents still maintain in any form, pursuant to 45 CFR § 164.504(e)(2)(ii)(I). Business Associate agrees that it shall not retain any copies of such PHI. Alternatively, if such return or destruction of such PHI is not feasible, then Business Associate agrees to extend the protections of this Agreement to such PHI for as long as necessary and to limit further uses and disclosures to those purposes that make the return or destruction of such PHI infeasible.

8. **MISCELLANEOUS.**

8.1 Governing Law. This Agreement shall be governed by the laws of the State of _____.

8.2 Notice. Whenever under this Agreement one Party is required to give notice to the other, such notice shall be deemed given if mailed by First Class United States mail or by express courier, postage prepaid, to such Party's address as given below, and/or via facsimile to the facsimile telephone numbers listed below.

Business Associate:	Covered Entity:
_____	_____
_____	_____
Attention: _____	Attention: _____
Fax: _____	Fax: _____

Each Party may at any time change its address and that of its representative for notice by giving notice thereof in the manner provided above.

8.3 Headings. The headings of this Agreement are included for ease of reference only and shall not enter into the interpretation of this Agreement.

8.4 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original. Facsimile copies of this Agreement shall be deemed to be originals.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf effective as of _____, 20__.

BUSINESS ASSOCIATE	COVERED ENTITY
By: _____	By: _____
Print name: _____	Print name: _____
Print title: _____	Print title: _____
Date: _____	Date: _____

This is an example of a provider's signature authorization form that can be completed, notarized and sent to the insurance carrier. This form allows insurance claims to be processed with the use of a signature stamp. A copy is retained for the medical coding and billing specialist and the physician's records.

PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

State of _____)

) ss

County of _____)

_____ being first duly sworn, deposes and says: I hereby authorize the _____ (name of fiscal administrator) to accept my facsimile or stamp signature shown below

_____

Facsimile or Stamp Signature

as my true signature for all purposes under the _____ (name of insurance program) in the same manner as if it were my actual signature, including my agreeing to abide by the full payment concept and the remainder of the certification normally signed by the source of care as it appears on all claim forms.

_____

Signature

Subscribed and sworn to before me this _____ day of _____ 20____.

_____

Notary Public

in and for _____ County, State of _____

(SEAL)

My Commission expires _____

This is an example of a fax cover sheet that would be used when transmitting patient information. It is used when transmitting claims data, when resubmitting an unpaid insurance claim, to send further documentation on a claim to insurance carriers or to obtain preauthorization for a patient. It is important to protect the patient's confidentiality. Documents containing sensitive information, such as information on sexually transmitted diseases, drug or alcohol treatment or human immunodeficiency virus, should not be faxed.

FAX COVER SHEET

Date: _____ Time: _____ Number of pages (including cover sheet): _____

To: _____ Fax number: _____

From: _____ Phone: _____

Fax number: _____

This fax transmittal may contain information that is privileged, confidential and exempt from disclosure under applicable law, and is intended only for the use of the identified individual to whom it is addressed. If you have received this transmittal in error, please notify this office immediately by telephone.

If you cannot read this fax, or if pages are missing, please contact this office by telephone.

Instructions to the authorized receiver: Please complete this statement of receipt and return to sender via the above fax number.

I, _____, verify that I have received _____ number of pages, including the cover sheet.

Many insurance carriers will reimburse the patient directly unless otherwise noted on the claim form. This is an example of an authorization form for payment of insurance benefits to be paid directly to the physician. The authorization may be a paragraph included on the encounter form or it may be a separate form that is maintained in the patient's medical chart. Below are examples of both.

CONSENT FOR PHYSICIAN REIMBURSEMENT

I request payment of insurance benefits either to myself or to the physician listed on this claim.

_____

Patient or Responsible Party signature

CONSENT FOR PHYSICIAN REIMBURSEMENT

I hereby authorize (insurance carrier's name) to mail insurance benefit payments directly to (physician's name and address) for medical services received for the time period of (specific dates).

_____

Patient or Responsible Party signature

_____

Relationship to patient

_____

Date of signature

This is an example of a claim tracer form. This form should be submitted to the insurance carrier with a copy of the original claim submitted for payment. The time limit for receiving insurance reimbursement can vary depending on the insurance carrier.

CLAIM TRACER FORM

Date _____

Insurance carrier name _____

Address _____

Patient name _____

Insured's name _____

Policy number _____

Group name/number _____

Date of original claim submission _____ Amount _____

An excessive amount of time has passed since submission of our original claim as described above. We have not received a request for additional information or payment on this claim. Please review the attached copy of the claim and process for payment within seven days.

If there is any difficulty with this claim, please complete one of the items below and return this letter to our office.

Claim pending because _____

Payment of claim in process _____ Date _____

Payment made on claim _____

To whom _____ Date _____

Claim denied _____ Reason _____

_____

Additional remarks _____

_____

Thank you for your assistance in this important matter. Please contact our office if you have any questions regarding this claim.

The office of (physician's name), MD

Address _____

Phone _____

An appeals letter must accompany all requests for a review of the reimbursement received for an insurance claim. This is an example of an appeals letter. Always attach a copy of the original claim form and a copy of the EOB received from the insurance carrier.

Doctor/Practice Name
Address
City, State ZIP code

Date (Very Important)

Insurance Company
Address
City, State ZIP code

Dear (Contact):

Our office recently received reimbursement for $ (insert amount) for (insert patient's name) for services on (insert date).

As you can see from the enclosed copy of the Explanation of Benefits, reimbursement was reduced for this claim because the services were found to be (insert reason noted on EOB).

Please review the services provided for (patient's name). (The physician will provide you with a short sentence that you should include here explaining the necessity of treatment.)

Thank you for your attention to this request.

Sincerely,

Your name

Enclosed: EOB
Original claim

This is an example of a letter asking for the claim to be reviewed. This letter is appropriate when the insurance carrier has denied the payment and after adequate research, you believe there may be an error and that payment should have been approved. Attach a copy of the original claim form and a copy of the EOB received from the insurance carrier.

Doctor/Practice Name
Address
City, State ZIP code

Date (Very Important)

Insurance Company
Address
City, State ZIP code

Dear (Contact):

Our office recently received a denied claim for (insert patient's name) for $ (insert amount) for services on (insert date) from your insurance office.

As you can see from the enclosed copy of the Explanation of Benefits, this claim was denied because (insert reason noted on EOB).

Please review the services provided for (patient's name). (The physician will provide you with a short sentence that you should include here explaining the necessity of treatment.)

If you need additional information, please contact our office. Thank you for your attention to this request.

Sincerely,

Your name

Enclosed: EOB
Original claim

When a workers' compensation claim becomes 45 days delinquent, a letter should be sent to the insurance carrier. Below is a sample of such a letter.

Doctor/Practice Name
Address
City, State ZIP code

Date

Insurance Company
Address
City, State ZIP code

Dear (Contact):

Re:

Case Number: _____

Patient: _____

Date of Injury: _____

Employer: _____

Claim Amount: _____

Our records indicate that payment for the above case number remains unpaid.

Please review the services provided for (patient's name). Your cooperation in furnishing us the present status of this claim will be appreciated.

Sincerely,

Your name

Managed care plans that utilize the capitation reimbursement system require a simple accounting sheet. (Remember that capitation plans reimburse physicians based on the number of patients seen.) Record all patients in one particular plan on one accounting sheet so you can track how many patients the provider sees. This is an example of a capitation accounting sheet.

CAPITATION ACCOUNTING SHEET

NAME OF PLAN _____

DATE	PATIENT NAME	CHARGES SERVICES/PLAN	PAYMENTS COPAY/CAPITATION

✉ Step 19 Mail-in Quiz 21

❑ Follow the steps to complete the Quiz.

a. Be sure you've mastered the instruction and the Practice Exercises that this Quiz covers.

b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.

d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your Quiz online.

e. Submit your answers to the school via mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 21

For each item, select the best answer from the choices provided. Each item is worth 5 points.

1. A _____ allows parties to settle disputes without attorneys.

a. small claims court
b. county court
c. default judgment
d. lawsuit

2. When you resubmit an insurance claim, you _____.

a. submit the claim a second time
b. are appealing the insurance reimbursement
c. must contact the insurance commissioner
d. send a narrative explanation as well

3. An example of a delinquent account is _____.

a. Tammy paying with a check that bounces
b. Rhonda making minimum payments
c. Fred submitting his payments late
d. Chris pays her account in full

4. Medicare appeals must be filed _____ days from the receipt of the denial.

a. 30
b. 60
c. 90
d. 120

5. You should contact the insurance commissioner _____.

a. any time a claim is denied
b. if you suspect fraudulent claims
c. before resubmitting a claim
d. rather that filing an appeal

6 _____ generates a bill when the insurance company pays its portion of the claim.

a. Cycle billing
b. The provider
c. Event billing
d. The EOB

7. _____ is a promise to pay later for goods or services immediately received.

a. Credit
b. Debit
c. NSF
d. Charging

8. A tracer _____.

a. allows you to submit medical records to substantiate medical necessity
b. explains procedures listed on the claim
c. enables insurance companies to locate missing claims
d. locates the EOB

9. Negative credit information may be _____.

a. late payments or charges
b. bankruptcies or paying the minimum balance
c. paying the minimum balance or late payments
d. late payments or bankruptcies

10. Which of the following statements is not true regarding a collection agency? _____

a. Collection agents collect a commission for every delinquent account they settle.

b. It specializes in collecting unpaid debts for other businesses.

c. They handle contact, follow-up and financial arrangements for delinquent accounts.

d. Collection agencies allow business to collect all debt that is owed to them.

11. In which situation should you inquire on the status of a claim? _____

a. A claim is 30 days old and EOB indicates the service was applied to the deductible.

b. Reimbursement was received for a claim you didn't file.

c. A claim is 10 days old and no reimbursement has been issued.

d. You should never inquire about the status of a claim.

12. An angry patient receives a bill for services she feels should be covered by insurance. What should you do? _____

a. Debate with the patient. Ask to see the bill and explain it in order to prove that you're correct.

b. Remain calm. Take control of the situation by asking to see the bill. Answer any questions about the patient's insurance policy.

c. Remain calm. Take control of the situation by asking to see the bill. Refer any questions about the patient's insurance policy to the insurance representative.

d. Ensure the patient that she is mistaken. Take control of the situation by asking to see the bill. Answer any questions about the patient's insurance policy.

13. When dealing with providers, it's important to _____.

a. acknowledge your mistakes

b. listen to what he is saying

c. be trustworthy

d. all of the above

14. SECOND BILLING indicates the claim has been _____.

a. resubmitted

b. submitted to the secondary carrier

c. denied by the clearinghouse

d. denied by the primary carrier

15. A benefit to clearinghouses includes _____.

a. edited claims and no denials
b. identifying incorrect codes and missing services
c. identifying errors before the claim is sent to the insurance company
d. identifying missing information and ensuring no denials

16. An appeals letter should _____.

a. be filed any time the insurance company denies a claim
b. include why you feel the reimbursement was incorrect
c. be filed with the insurance commissioner
d. include the provider's fee schedule

17. The _____ should be contacted when an insurance company arbitrarily denies claims.

a. insurance contact
b. patient
c. provider
d. insurance commissioner

18. When dealing with anxious patients, it's important to be _____.

a. an adversary
b. right
c. an advocate
d. loud

19. A(n) ____ is a legal document requiring withholding of a percentage of pay.

a. default judgment
b. order of garnishment
c. credit risk
d. judgment

20. To effectively deal with a problem, you must ____.

a. be louder than the provider
b. accept the providers instructions only when you agree with them
c. keep a professional attitude
d. explain to the patient that the provider does not understand the billing process

Congratulations!

You have completed Lesson 21.

Do not wait to receive the results of your Quiz before you move on.

Lesson 22

Coding and Billing Resources

Step 1 Learning Objectives for Lesson 22

- ❑ When you have completed the instruction in this lesson, you will be trained to do the following:
  - ➤ Discuss professional organizations pertaining to medical coding and billing, and explain services they offer.
  - ➤ Explain credentialing and how it relates to a coding and billing specialist.
  - ➤ Identify helpful print and Internet publications that relate to the coding and billing profession.

Step 2 Lesson Preview

- ❑ So far, you've studied insurance, medical terminology, documentation, ethical and legal issues, anatomy and the basics of medical billing, from completing a claim to solving problems with insurance, providers and patients! We're about to turn our attention to the medical coding aspect of your new career. Soon you'll learn how to determine the correct diagnostic code to apply to the medical records so you can submit the claim for reimbursement.

  In this lesson, we're going to step back from the "how-to" aspect of your training and take a look at your future career. There are many organizations and resources available to help you succeed. This lesson is chock full of information to help you find the guidance you need. We'll provide information on the professional organizations for medical coders and billers. In addition, we'll discuss credentialing and certification options, and peruse resources that can help you stay abreast of changes in the healthcare field. In fact, you might be surprised at all the help that's out there for you!

In this lesson, you'll explore Internet resources and publications that will be helpful in your future career.

Step 3 Associations for Professional Coders and Billers

- Over the years, several professional organizations have emerged to help healthcare professionals succeed. These organizations provide educational resources, community ties, job support and more. The two main associations are the American Academy of Professional Coders and the American Health Information Management Association. In the following sections, we'll take a look at these two associations, as well as others related to the healthcare profession.

American Academy of Professional Coders (AAPC)

The American Academy of Professional Coders (AAPC) was founded in 1988 as the American Academy of Procedural Coders. The goal of the original organization was to provide education, recognition and certification for physician-practice procedural coders. The AAPC also sought to raise the procedural coding standards.

The AAPC specializes in outpatient coding. Today, the AAPC represents coders who work for physicians, clinics, hospitals, outpatient facilities, payers and consulting firms. In all, the AAPC has more than 118,000 members worldwide. Membership is open to not just coders, but billers and other healthcare information professionals as well.

The AAPC offers the following coding-related services and programs:

- Coding certification exams and study guides
- Examination review classes
- Coding education
- An annual conference
- Local chapters
- AAPC publications

American Academy of Professional Coders (AAPC)
2480 South 3850 West, Suite B
Salt Lake City, UT 84120
(800) 626-CODE (2633)
www.aapc.com

American Health Information Management Association (AHIMA)

The American Health Information Management Association (AHIMA) is a membership organization representing more than 64,000 healthcare professionals. It provides reliable and valid information for all areas of health management. AHIMA began in 1928 as the Association of Record Librarians of North America (ARLNA). The purpose of this organization was to "elevate the standards of clinical records in hospitals and other medical institutions." This organization has undergone several name changes over the years. It became AHIMA in 1991. It is recognized as the leading source of "HIM knowledge," a respected authority for rigorous professional certification, and one of the industry's most active and influential advocates in Congress.[1]

AHIMA offers a number of services to their members. Among them are:

- Coding certification exams
- *Communities of Practice*
- Careers Assist: Job Board
- *Journal of AHIMA*
- *Perspectives in HIM*

American Health Information Management Association (AHIMA)
233 N. Michigan Avenue, 21st Floor
Chicago, IL 60601-5809
(312) 233-1100 or (800) 335-5535
www.ahima.org

American Medical Association

Since 1847, the American Medical Association (AMA) has had one mission: to promote the art and science of medicine and the betterment of public health.[2] The AMA is an important professional organization in the world of health care. The AMA speaks out on important issues like patient rights and the health of the nation, and also created and maintains the *CPT*. The AMA Web site features a variety of valuable resources. Some of the AMA resources that you might find helpful include:

- CPT code information, including revisions
- CPT licensing
- Annual CPT educational symposium
- *CPT Assistant* coding journal
- *Journal of the American Medical Association* (*JAMA*)
- AMA Code of Medical Ethics

American Medical Association (AMA)
515 N. State Street
Chicago, IL 60654
(800) 621-8335
www.ama-assn.org

American Hospital Association

The American Hospital Association (AHA) serves hospitals, healthcare networks, patients and communities. The AHA represents the people and organizations in the development of national healthcare policy.

Some of the AMA resources you might find helpful include:

- Publications covering healthcare legislation
- Research on healthcare services and information management

American Hospital Association (AHA)
155 N. Waker Drive
Chicago, IL 60606
(312) 422-3000 or (800) 424-4301
www.aha.org

Now, let's look at the credentialing available for medical coding and billing specialists.

Step 4 Credentialing

- You've probably heard people use the term *credentials*. Most likely, the word came up in a conversation about someone's qualifications for a job. In a market where there are so many people offering similar services, **credentials** help people let customers know they are qualified to do a certain job. There are credentials for teachers, accountants, attorneys and more! There are also credentials for medical coding and billing specialists like you.

  Credentialing is a growing trend; it validates your skills and knowledge and sometimes allows for job advancement opportunities. And pay increases! Whether or not you want to be credentialed is up to you. If you don't want to do it now, you can take that leap sometime in the future.

National Healthcareer Association

The National Healthcareer Association (NHA), established in 1989, provides preparation and certification in various healthcare professions. The Certified Billing and Coding Specialist (CBCS) exam focuses on converting a medical procedure and diagnosis into specific codes for submitting a claim for reimbursement. Certification is not necessary for the medical billing profession; however, according to the NHA, benefits to obtaining the CBCS "may include more job opportunities, higher wages and increased job security."[3]

For more information about the CBCS exam through the NHA, visit its Web site at http://www.nhanow.com.

American Academy of Professional Coders

According to the American Academy of Professional Coders, more than 84,000 healthcare professionals around the country hold AAPC certifications. The AAPC offers certifications in medical coding, auditing, compliance and practice management. We'll discuss the requirements of the medical coding certifications.

Certified Professional Coder (CPC)

The Certified Professional Coder (CPC) is the American Academy of Professional Coder's main coding certification, with the focus on diagnostic and procedural codes for outpatient services. In addition to the codes, the CPC's abilities include knowledge of coding rules and regulations including compliance and reimbursement.

Full CPC credentialing requires two years of coding experience. However, you can waive one year of experience with successful completion of this course! You're almost halfway there.

Certified Professional Coder-Hospital (CPC-H)

Another credential offered by the AAPC is the Certified Professional Coder-Hospital (CPC-H). This credential focuses on outpatient facilities such as ambulatory surgical centers or hospital outpatient coding and billing departments. In addition to coding the diagnosis and procedures for outpatient settings, this exam also focuses on reimbursement procedures, such as fee updates and how to complete the UB-04.

Just like the regular CPC credential, a CPC-H should have at least two years of coding experience. You can also waive a year of that experience when you successfully complete your Medical Coding and Billing Specialist course.

Certified Professional Coder-Payer (CPC-P)

The Certified Professional Coder-Payer (CPC-P) demonstrates a coder's aptitude, proficiency and knowledge of coding guidelines and reimbursement methodologies for all types of services from the payer's perspective, which is the insurance company. Claims reviewers, utilization management, auditors, benefits administrators, billing service, provider relations, contracting and customer service staff can each benefit their practices with the CPC-P credential.

The CPC-P certification exam certifies that the successful candidate has the knowledge and skills to adjudicate provider claims effectively. The exam tests the examinee's basic knowledge of coding-related payer functions with emphasis on how those functions differ from provider coding. The relationship between coding and payment functions will be explored in depth.

The CPC-P exam consists of two parts, testing coding accuracy and reimbursement methodologies. The Medical Coding Concepts section tests the examinee's understanding of medical terminology, anatomy and diagnostic and procedural coding concepts. The Reimbursement Methodologies section covers physician reimbursement, inpatient payment systems, outpatient payment systems, health insurance concepts and HIPAA.[4]

AAPC Apprentice Certifications

Many new coders have the education and basic knowledge to pass the medical coding certification exams, but not the required amount of experience. This is common with entry-level coders. To help these people out, the AAPC has an apprentice status.

If you successfully pass the medical coding certification exam but don't have the required two years of medical coding experience, you will be awarded the apprentice status, which is identified by an "A" on the certificate. Like other certifications, you will have to complete Continuing Education Units (CEUs). When you have completed the required work experience and submit documentation for that work, your credentials are upgraded to the full CPC, CPC-H or CPC-P!

American Health Information Management Association

AHIMA offers three coding certification exams: Certified Coding Associate (CCA), Certified Coding Specialist (CCS) and Certified Coding Specialist—Physician-based (CCS-P).

Certified Coding Associate (CCA)

The Certified Coding Associate (CCA) is an entry-level coding credential. If you are a new coder without much experience, you can immediately demonstrate your mastery of entry-level coding skills by earning the CCA. Earning a CCA also demonstrates a commitment to coding. It is a good starting point for coding credentials.

To take the CCA certification exam you must have a U.S. high school diploma or equivalent educational background. It is recommended that you have completed a formal coding training program, such as the one you're completing! It is also recommended, although not required, that you have experience in hospital-inpatient and ambulatory-care medical coding. AHIMA notes that previous examination results indicate that persons who have three or more years of coding experience are more likely to pass the exam.

To download a free, comprehensive *Certified Coding Associate Handbook*, go to AHIMA's Web site. This handbook also explains the CCA exam process in detail.

Certified Coding Specialist (CCS)

Certified Coding Specialists (CCS) are skilled professional coders with solid experience classifying medical data from patient records, generally from a hospital setting. A CCS must be an expert in the diagnostic and procedural coding systems. She must also be fluent in medical terminology, disease processes and pharmacology.

Examples of CCS level work include preparing coded data for Medicare and Medicaid recipients on the behalf of hospitals and medical providers. This data is also used by researchers and public health officials to monitor patterns and explore new interventions.

The CCS certification exam evaluates the individual's proficiency in coding. On top of entry-level coding skills, the CCS exam covers some information management skills. You would consider getting a CCS certification after you have experience in coding inpatient records. Experience coding the hospital portion of ambulatory surgery and emergency department care is also helpful. AHIMA recommends at least three years of experience before taking the CCS exam.

Certified Coding Specialist—Physician-based (CCS-P)

Another type of credentialing offered by AHIMA is the Certified Coding Specialist—Physician-based (CCS-P). Those with a CCS-P credentialing have expertise in physician-based settings. This can include doctors' offices, group practices, specialty centers and multi-specialty clinics. CCS-P coders have in-depth experience with diagnostic and procedural codes. They also are experts in health information documentation.

With the growth of managed care, the future looks good for this specialty. So if you develop solid experience and proficiency coding in a doctor's office, clinic or similar setting, you might want to consider obtaining the CCS-P certification to attest to your ability.

Here is a final note regarding the AHIMA certifications. According to AHIMA, "the CCA exhibits coding competency in any setting, including both hospitals and physician practices. The CCS and CCS-P exams demonstrate mastery level skills in an area of specialty: hospital-based for CCSs and physician practice-based for CCS-Ps."[5]

You can contact the NHA, AAPC or AHIMA for more information on all of these certifications. Before moving on to coding and billing resources, let's review what you've learned.

✍ Step 5 Practice Exercise 22-1

❑ Determine the term(s) to complete each sentence.

1. **_____ are skilled professional coders with solid experience classifying medical data from patient records.**

2. **_____ is recognized as one of the industry's most active and influential advocates in Congress.**

3. **The _____ exam focuses on converting a medical procedure and diagnosis into specific codes for submitting a claim for reimbursement.**

4. **The AMA speaks out on important issues like _____ _____ and the health of the nation.**

5. **The _____ exam tests the student on diagnostic and procedural codes, compliance and reimbursement policies.**

6. **In addition to coding the diagnosis and procedures for outpatient settings, the _____ exam also focuses on reimbursement procedures, such as fee updates and how to complete the UB-04.**

7. **The goal of the _____ is to provide education, recognition and certification for physician-practice procedural coders.**

8. **_____ coders have in-depth experience with diagnostic and procedural codes. They also are experts in health information documentation.**

Step 6 Review Practice Exercise 22-1

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 7 Coding and Billing Resources

- ❑ Whether you're just embarking on your coding and billing career or are an experienced coder and biller, you will need to be up-to-date on coding developments. You will always rely on resources to help you find codes and information on healthcare issues. Why are resources so important to coders? It is not humanly possible to remember every diagnostic or procedural code. Also, new and revised codes are published annually. Resources serve a number of functions:
  - ➤ Reference books allow you to store the information you don't use every day.
  - ➤ Resources can provide you with the information right now, when you need it.
  - ➤ Resources serve as a valuable support system if you are working independently or don't otherwise have much contact with other people where you work.

The professional organizations you just learned about will be very helpful to you in your new career. Now, we'll provide some resources from these professional organizations and others! Consider them as a starting point from which to develop your own pool of coding resources. They will give you a good idea of what's available.

AAPC Publications

Member of the AAPC, receive various publications to keep up-to-date on coding trends. These publications include *Coding Edge, EdgeBlast* and *BillingInsider*.

- ➤ *Coding Edge* is a monthly print publication that is written by and for members of the AAPC. Articles include issues facing the coding industry and updates on emerging trends and concerns. Members of the AAPC can subscribe to the coding news magazine.
- ➤ *EdgeBlast* is a newsletter distributed by e-mail twice a month to AAPC members. It includes summaries and links to important articles.
- ➤ *BillingInsider* is an e-newsletter available to members and nonmembers. Topics relate to the billing side of the medical practice.

AHIMA Publications

AHIMA provides both online and in print publications relating to the healthcare field. These publications include the *Journal of AHIMA* and *Perspectives in HIM*. In addition, members have access to an online tool for healthcare professionals.

AHIMA's *Communities of Practice* (*CoP*) is an online tool that AHIMA members use to network, share, problem-solve and stay informed of the latest trends in HIM-related topics. This growing professional network provides answers, support and career advice using the latest technology.[6]

The *Journal of AHIMA* is a monthly journal that includes both coding-specific and general health information management related articles. It also includes tips for on-the-job solutions and practical guidance on regulations, policies and procedures. This journal is available to nonmembers by subscription.

Perspectives in Health Information Management is a scholarly, peer-reviewed research journal that aims to advance health information management practice and encourage interdisciplinary collaboration between healthcare professionals and others in disciplines supporting the advancement of the management of health information.[7] It's an online journal that is free to members and nonmembers.

AHIMA e-Newsletters

AHIMA e-newsletters are primarily for members of AHIMA. You can find a complete listing of the e-newsletters on the AHIMA Web site.

- *Academic Advisor* is a quarterly e-newsletter for HIM educators.
- *CodeWrite* is a monthly e-newsletter containing coding, reimbursement and compliance information.
- Members receive *AHIMA Advantage* electronically six times each year. This publication includes healthcare and AHIMA news. In addition, members receive *AHIMA Advantage E-Alerts* weekly, which deliver news summaries on industry, AHIMA and government news related to healthcare. Members can view the most recent issue on the *CoP*.

American Medical Association

The AMA produces the *CPT Assistant*, the *Journal of the American Medical Association* and a slew of coding reference material, including express reference cards, specialty coding references and electronic data files of technical coding manuals.

The *CPT Assistant* is a monthly newsletter only available to AMA members. It provides detailed articles, commentaries and updates to keep your claims system running.

The *Journal of the American Medical Association* (*JAMA*) has been published continuously since 1883. It is an international peer-reviewed general medical journal published 48 times per year.[8] Its objective includes publishing original, important, valid, peer-reviewed articles on a diverse range of medical topics.

American Hospital Association

The *Coding Clinic* is quarterly publication that provides official coding guidelines and advice. A subscription allows you to access past issues for updates about coding-specific conditions or procedures.

OptumInsight

OptumInsight, previously Ingenix, publishes many of the coding manuals. In addition, OptumInsight offers a comprehensive mix of coding, billing, reimbursement and compliance products in a wide array of formats and services. These include Web-based tools, books, desktop software and print and electronic updates.

Among the many publications that might be of particular interest to you as a medical coding and billing specialist are:

- *Coder's Dictionary*. This dictionary is written by coders for coders. It includes definitions for medical nomenclature, eponyms, new technology and acronyms.
- *DRG Expert.* The nation's DRG information experts bring you this annual book organized by Major Diagnostic Category (MDC) for accurate assignment of DRGs and maintenance of the highest level of data quality. This book is for those who need to either accurately assign DRGs or verify DRG information.
- *Uniform Billing Expert*. This reference tool assists in managing the constant changes to Medicare billing and reimbursement. It provides information about UB-04 billing rules and requirements.
- *Outpatient Billing Expert*. This reference applies to hospital outpatient departments and free-standing ambulatory surgical centers. It provides guidance to improve reimbursement and reduce denied claims.
- *Coder's Desk Reference for Diagnoses.* This reference allows you to better understand the clinical meanings behind codes. It provides coding tips and includes coding scenarios to demonstrate the application of the codes.
- *Coder's Desk Reference for Procedures.* This manual helps you identify the differences between CPT codes that seem very similar.

You can access an online catalog of Optum/Ingenix products and services at www.optumcoding.com. You can also call 1-800-464-3649, option 1, to request a print catalog.

OptumInsight
2525 Lake Park Blvd.
Salt Lake City, UT 84120
(801) 464-3649
www.optumcoding.com

Just Coding

The *Just Coding* Web site provides answers to coding questions, access to coding articles and discussion groups, a free e-newsletter, job opportunities and a number of links to other helpful Web sites. Among the useful tools and links are the following:

- Continuing Education credits via articles, quizzes or Webcasts.
- Coding and reimbursement updates.
- Boot Camps, conferences and Webcasts.
- Coding guidance, practice questions and expert analysis.
- CPC practice exam and Job Board.

JustCoding.com
75 Sylvan Street
Suite A-101
Danvers, MA 01923
(800) 650 6787
www.justcoding.com

National Institute of Health

The National Institute of Health is the steward of medical and behavioral research for the United States. NIH funds scientific studies at universities and research institutions across the country. NIH is made up of 27 Institutes and Centers, each with a specific research agenda, often focusing on particular diseases or body systems.

If you visit the NIH Web site search for "medical coding," you will find a wide range of resources. There are publications, reports and research documents available—all related to coding. In the field of medical coding, the impact of ongoing medical research is great. The coding manuals are constantly being updated and revised to reflect new information that becomes available in medicine. The NIH is one of the primary resources for the details of such research.

National Institute of Health (NIH)
9000 Rockville Pike
Bethesda, MD 20892
(301) 496-4000
www.nih.gov

Other Coding and Billing Resources

A number of other companies and organizations provide a variety of coding- and billing-related resources. Here are a few that you might want to check out as you develop your network of resources.

For The Record

For The Record is published biweekly and provides reliable information on a range of health information issues. The subscription is free to members of the AACP and some members of AHIMA. The magazine is available in print, digital or both. For more information, visit the Web site at www.fortherecordmag.com or call (800) 278-4400.

Advance for Health Information Professionals

Advance for Health Information Professionals offers a free e-newsletter that provides an editorial advisory board, hands-on help and CCS prep information. You'll also receive notices on free Advance Job Fairs and job postings. The Web site for this publication is http://health-information.advanceweb.com. To subscribe by phone, call (800) 355-1088.

MedicalCoding.net

MedicalCoding.net was founded in 2001. It is a subsidiary of Provistas, Inc. *MedicalCoding.net* presents a variety of medical coding, billing and compliance books, eBooks, data files, claims forms and software to complement Provistas' educational and consulting programs. Provistas is focused on providing Medicare compliance solutions to hospital and physician-practice clients. You can also subscribe to e-mail news at the Web site www.medical-coding.net or call (888) 288-2043.

The Coding Institute

The Coding Institute is a national newsletter publishing company. This group offers a wide range of medical specialty newsletters, coding bulletins, audio conferences, video coding series, CDs, print transcripts and online discussion groups. Contact *The Coding Institute* for information about free, sample newsletters at (800) 508-2582 or www.codinginstitute.com.

RAmEX Ars Medica, Inc.

RAmEX Ars Medica, Inc. distributes medical multimedia materials for professionals, including billing and coding specialists. Resources include medical CD-ROMs, medical videos, medical books, medical journals, medical slides, medical audio tapes and other medical software covering a broad range of medical fields and topics. You can find out more about RAmEX Ars Medica products by visiting the Web site at www.ramex.com or calling (800) 633-9281.

Online Medical Dictionaries

If you have Internet access, perhaps you've discovered the handiness of online dictionaries. Many of them are even free! In particular, the medical dictionaries listed below can be an excellent source of information and support. Some of these Web sites include a variety of medical information and resources in addition to the dictionary. Take a few minutes to visit each Web site and bookmark them for future reference.

- www.online-medical-dictionary.org
- www.medical-dictionary.com
- www.medic8.com/MedicalDictionary.htm
- www.medterms.com
- www.medicinenet.com
- www.sciencekomm.at/advice/dict.html

✍ Step 8 Practice Exercise 22-2

❑ Identify the coding resource with the company or organization where you can find it.

1. _____ ***BillingInsider***
2. _____ ***CPT Assistant***
3. _____ ***Coding Clinic***
4. _____ ***Coder's Desk Reference for Diagnoses***
5. _____ ***Communities of Practice***
6. _____ ***Coder's Desk Reference for Procedures***
7. _____ ***Coding Edge***

🗝 Step 9 Review Practice Exercise 22-2

❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

🕮 Step 10 Lesson Summary

❑ You've probably heard the expression "the more you know, the more you'll grow." When it comes to medical coding and billing, that saying is exactly right. In this profession, you must keep up-to-date with coding regulations, medical advances and professional trends. The resources in this lesson are your Yellow Pages, grape vine and encyclopedia—all rolled into one. Whether you're searching for information on the latest coding changes or claims updates, these resources are a great place to start. As you explore these resources and network with other coding and billing specialists, you'll no doubt find other sources of information that you like.

Don't feel overwhelmed. There's more information in these resources than anyone could read through. What's important is that you know where to begin your search if you have any questions. You've learned a lot so far, so keep up the good work!

One final note: Web site addresses and phone numbers change frequently. The addresses and numbers listed in this lesson were current at the time of printing, but they may change in the future. You may want to keep a list of your favorite resources, and update the contact information regularly.

✉ Step 11 Mail-in Quiz 22

❑ Follow the steps to complete the Quiz.

a. Be sure you've mastered the instruction and the Practice Exercises that this Quiz covers.

b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.

d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your Quiz online.

e. Submit your answers to the school via mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 22

Select the best answer from the choices provided. Each item is worth 5 points.

1. Two main associations for coders are _____.

a. AHIMA and AHA
b. AMA and AHA
c. AAPC and AHIMA
d. AHA and AAPC

2. AHIMA's Communities of Practice is a(n) _____.

a. networking tool to meet other coders and find information
b. online store to purchase coding manuals
c. collection of practice exams for the CCS exam
d. group of healthcare providers who advise AHIMA members

3. The AAPC offers _____ to keep coders up-to-date on emerging trends.

a. *Prospectives in HIM*
b. *Coding Edge*
c. *CPT licensing*
d. *CPT Assistant*

4. Credentials can help you _____.

a. validate your skills and knowledge
b. get promoted
c. get raises
d. all of the above

5. Entry-level coders can earn a(n) _____.

a. CCA
b. CPC-H
c. AMA
d. CCS

6. CCSs must be _____.

a. entry-level coders
b. experienced in medical billing
c. able to demonstrate entry-level coding skills
d. experts in the diagnostic coding system

7. Which certification focuses on submitting claims for reimbursement? ____

a. CCA
b. CBCS
c. CPC
d. AMA

8. Which organization has the mission of promoting the art and science of medicine? _____

a. AAPC
b. AMA
c. AHA
d. AHIMA

9. Which of the following is not a reason for using coding resources? _____

a. Reference books allow you to store the information you don't use every day.
b. Resources can provide you with the information right now, when you need it.
c. Resources answer coding questions that come up, so you don't have to know the steps for diagnostic and procedural coding.
d. Resources serve as a valuable support system if you are working independently.

10. _____ is a monthly e-newsletter containing coding, reimbursement and compliance information.

a. *EdgeBlast*
b. *CodeWrite*
c. *Journal of AHIMA*
d. *Academic Advisor*

11. To find out about current medical research being conducted by the government, you could go to _____.

a. www.ramex.com
b. www.medterms.com
c. www.medical-coding.net
d. www.nih.gov

12. _____ is a national company that publishes medical newsletters.

a. Provistas
b. The Coding Institute
c. RAmEx Ars Medica, Inc.
d. Coding Edge

13. The following are all _____: www.medterms.com, www.medicinenet.com and www.sciencekomm.at/advice/dict.html.

a. discussion boards
b. online publications
c. search engines
d. print publications

14. If you passed the CPC exam but do not have two years of coding experience, _____.

a. you will not receive the CPC credential
b. you will not receive full CPC credentialing
c. you will receive the apprentice status
d. both b and c

15. The certification from the payer's prospective is the _____.

a. CPC
b. CCS
c. CPC-P
d. CCS-P

16. A new coder without much experience can take the exam for the _____.

a. CCA
b. CCS
c. CPC
d. CPC-H

17. _____ is a quarterly e-newsletter for HIM educators.

a. *Coding Edge*
b. *Academic Advisor*
c. *Communities of Practice*
d. *JAMA*

18. _____ is a reference tool that provides information about UB-04 billing rules and requirements.

a. *Outpatient Billing Expert*
b. *Uniform Billing Expert*
c. *DRG Expert*
d. *BillingInsider*

19. The _____ assists coders with the clinical meanings behind diagnostic codes.

a. *Coder's Dictionary*
b. *Coders Edge*
c. *Coder's Desk Reference for Procedures*
d. *Coder's Desk Reference for Diagnoses*

20. _____ is an e-newsletter related to the billing side of medical practice.

a. *Outpatient Billing Expert*
b. *Uniform Billing Expert*
c. *DRG Expert*
d. *BillingInsider*

Endnotes

[1] *AHIMA Facts*. American Health Information Management Association. Web. 28 June 2012.

[2] *About the American Medical Association (AMA)*. American Medical Association. Web. 28 June 2012.

[3] *Billing and Coding Specialist Certification (CBCS)*. National Healthcareer Association. Web. 28 June 2012.

[4] *Certified Professional Coder-Payer (CPC-P®)*. AAPC. Web. 28 June 2012.

[5] *Certified Coding Associate (CCA)*. American Health Information Management Association. Web. 28 June 2012.

[6] *Getting Started in AHIMA's Communities of Practice (CoP)*. American Health Information Management Association. Web. 28 June 2012.

[7] *About the Journal*. American Health Information Management Association. Web. 28 June 2012.

[8] *About JAMA*. American Medical Association. Web. 28 June 2012.

Congratulations!

You have completed Lesson 22.

Drive

Terrific

Quality

Accomplishment!

Learning

Skillful

Do not wait to receive the results of your Quiz before you move on.

Lesson 23

ICD-9-CM Coding Introduction

Step 1 Learning Objectives for Lesson 23

- When you have completed the instruction in this lesson, you will be trained to do the following:
  - Describe the history and development of the diagnostic coding system.
  - Explain the role of medical coding and its uses.
  - Compare and contrast the ICD-9-CM and ICD-10-CM coding systems.
  - Explain how Volumes 1 and 2 of the *ICD-9-CM* are organized.
  - Explain basic coding guidelines.
  - Distinguish among the *ICD-9-CM* conventions.
  - Describe *ICD-9-CM* terminology.
  - Locate the appendices in the *ICD-9-CM*.
  - Identify the steps to diagnostic coding.

Step 2 Lesson Preview

- Are you wondering when you'll get to code? Well, here we go! This lesson will introduce you to diagnostic coding.

  Whenever a patient sees a doctor for a health-related problem, the patient is asking for a diagnosis. We've talked quite a bit about diagnoses in previous lessons, and you already know a bit about diagnosis codes. You also know that when a doctor makes a diagnosis, it is you, the medical coding and billing specialist, who codes it.

Whenever a patient sees a doctor for a health-related problem, the patient is asking for a diagnosis.

The diagnosis codes that you assign are then used to determine the medical necessity. This helps the payer, such as the insurance companies, to determine reimbursement for the physician's services.

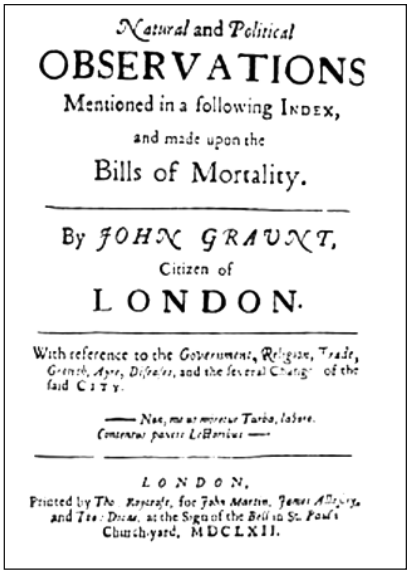
If you haven't borrowed or purchased the current *ICD-9-CM* manual, now is the time! You'll begin using it in this lesson as we discuss the manual's two volumes and the various aspects of each.

This lesson also will give you information on the appendices, chapters and sections of each volume of the *ICD-9-CM*. Perhaps one of the most important aspects of this lesson is that you will learn about the various *ICD-9-CM* conventions. These conventions are the accepted ways of doing things when it comes to medical coding. When you understand these conventions and how they are used, you will have no problem accurately assigning diagnostic codes in your work.

🕮 Step 3 History of the International Classification of Diseases

- We spoke briefly of the *International Classification of Diseases* in a previous lesson. The history of the *ICD* dates back to the 1600s in England! The system came to the United States in the mid-1700s. This classification of diseases originally was used to track mortality statistics to determine how many people died of different diseases.

In the seventeenth century, the statistical study of diseases began with the work of John Graunt on the *London Bills of Mortality*. The *Bills* was initially a list of only the number of burials. Graunt added to the *Bills*, to include the cause of deaths. He tabulated and studied the data from the annual bills from 1629 through 1660 and published *Natural and Political Observations Made upon the Bills of Mortality* in 1662. This publication is considered one of the forerunners of today's international mortality classifications.



Natural and *Political*

OBSERVATIONS

Mentioned in a following INDEX,

and made upon the

Bills of Mortality.

By JOHN GRAUNT,

Citizen of

LONDON.

With reference to the *Government*, *Religion*, *Trade*, *Growth*, *Ayre*, *Diseases*, and the several *Changes* of the said CITY.

—— *Nec, me ut miretur Turba, laboro,*
Contentus paucis Lectoribus ——

LONDON,

Printed by *Tho. Roycroft*, for *John Martin*, *James Allestry*, and *Tho. Dicas*, at the Sign of the *Bell* in St. *Paul's* Church-yard, MDCLXII.

The ICD originally was used to track mortality statistics.

In 1837, the General Register Office of England and Wales found its first medical statistician, William Farr. Farr labored to secure an improved classification, as well as international uniformity. In 1853, the first International Statistical Congress (ISC) asked Farr to prepare an internationally applicable, uniform classification of causes of death.[1] Although this classification was never universally accepted, the general arrangement survived as the basis of the *International List of Causes of Death*.

The International Statistical Institute created a committee, chaired by Dr. Jacques Bertillon, to prepare a classification of causes of death. The report was presented in 1893, and the *Bertillon Classification of Causes of Death*, as it was first called, received general approval. Several countries adopted it at that point. Jesus E. Monjaras first used the classification in the Americas for the statistics of San Luis de Potosi, Mexico.[2]

In 1900, the first international conference for the revision of the Bertillon or *International List of Causes of Death* convened. Representatives from 26 countries attended and adopted the first of the *ICD*s or *International Classification of Diseases*. It was determined that the classifications should be revised every 10 years; therefore, the succeeding conferences were held in 1909, 1920, 1929 and 1938, and a new version of the *ICD* was adopted at each.[3]

The WHO

The **World Health Organization** (**WHO**) is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.[4] In 1946, the United Nations gave the responsibility of the *ICD* to the WHO, which issued the sixth and subsequent revisions in 1948, 1958 and 1967.

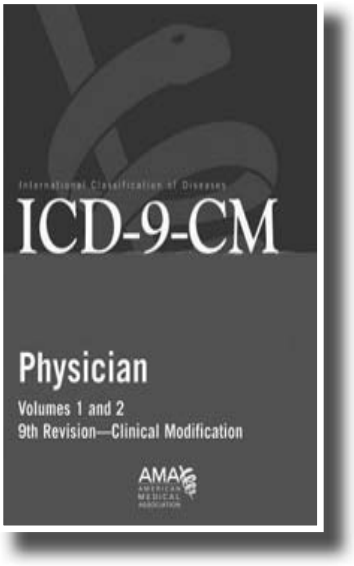
The *ICD* is the international standard diagnostic classification. It classifies diseases and other health problems recorded on many types of health and vital records, including death certificates and health records.[5]

ICD-9-CM

The World Health Organization published the *9th Revision, International Classification of Diseases* (*ICD-9*) in 1977. In 1979, the United States adopted the *International Classification of Diseases, 9th Revision, Clinical Modification* (*ICD-9-CM*) based on the *ICD-9*. The **Clinical Modification** expanded the number of diagnosis codes and developed a procedural coding system.

The *ICD-9-CM* consists of:

- Tabular List
- Alphabetical Index
- Procedure Alphabetic Index and Tabular List



The *Clinical Modification* expanded the number of diagnosis codes and developed a procedural coding system.

Reminder!

Do you have access to a diagnostic coding manual yet? You'll need it to complete the remaining instruction packs.

You can either borrow one from your local library, if your library has a current version, or purchase your own manual at a special student rate. Look for the coupon in your instructional materials, or call Student Services at 800-347-7899 for more information.

Step 4 Why Code?

- Through the years, the number of people who go to the doctor has increased. This increase has occurred for several reasons:
  - People live longer and require more health care.
  - Technological advances offer more options for better health care.
  - People have better access to health care than ever before.

Your role as the medical coding and billing specialist is to translate the physician's written diagnoses for all of these patients into numeric (number codes) and alphanumeric (combined letter and number) codes, and then submit claims for reimbursement. The physician's office uses this coded information for a number of purposes. A primary use of medical codes is to communicate to the insured the reason for a patient's medical visit. Thus, the diagnosis code communicates to the insurance payer the reason the physician provided medical services for the patient.

Medical coding can be used as a statistics-gathering tool for research, grants and financial analysis.

Another use for medical coding is as a statistics-gathering tool for research, grants and financial analysis. Hospitals use coding to index hospital records according to diseases and operations. By indexing—or organizing—records this way, they consistently can store and retrieve data. Coding is useful for reporting medical diagnostic trends to agencies that track this information. For instance, the American Cancer Society can access accurate cancer statistics thanks to coding.

As you can see, the coding system is a common language that the medical community uses as a standard communications device. Using this coding system correctly is important. You know by now that if a code is used that does not match the services performed, the claim will be rejected. In addition, for government claims, such as to Medicaid or Medicare, the correct code is required by law.

Originally, medical coding was used to allow access to medical records for easy retrieval of information for medical research, education and administration. Today, coding is used to:

- ➤ Facilitate payment of medical services.
- ➤ Study patients' use of healthcare facilities.
- ➤ Study the cost of health care.
- ➤ Research the quality of health care.
- ➤ Determine healthcare trends.
- ➤ Plan for future healthcare needs.

🕮 Step 5 *ICD-10*

❑ After 30 years, the *ICD-9* needs to be replaced. The terminology and classification of some conditions are outdated and/or obsolete. These outdated codes produce inaccurate and limited data. And, the limits of the categories result in an increasing lack of specificity. Finally, the *ICD-9-CM* hinders comparisons with international data. It's clear that the *ICD* must be flexible enough to adjust for emerging diagnoses and procedures and exact enough to identify precise diagnoses and procedures.

In 1989, the WHO prepared the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (*ICD-10*), which was released in 1994. The United Kingdom adopted it in 1995, followed by the Nordic countries of Denmark, Finland, Iceland, Norway and Sweden from 1994 through 1997. Each year, another country adopted the *ICD-10*: France (1997), Australia (1998), Belgium (1999), Germany (2000) and Canada (2001). On January 15, 2009, the Department of Health and Human Services (HHS) released the final rule for the implementation of the *International Classification of Diseases, 10th Revision, Clinical Modification* (*ICD-10-CM*) and the *International Classification of Diseases, 10th Revision, Procedural Classification System* (*ICD-10-PCS*). The final rule established the upcoming *ICD-10* (both CM and PCS) transition.

> To read about the *ICD-10* Final Rule, visit:
> http:edocket.access.gpo.gov/2009/pdf/E9-743.pdf

On April 17, 2012, the HHS released a notice to postpone the date of compliance to October 1, 2014.

Impact for Coders

How does this affect you? Is it a waste of time to learn coding from the *ICD-9-CM*? Absolutely not! Per U.S. government mandate, the *ICD-9-CM* will be used by all medical service providers up until midnight on September 30, 2014. The *ICD-10-CM* will be implemented on October 1, 2014. To make sure you have the information about the current industry standard, we will focus on discussing the *ICD-9-CM* in your course for the immediate future. Once you are familiar with the coding process with the *ICD-9-CM*, it'll be a smooth transition to the *ICD-10-CM*. You can get reference material in the format of an *ICD-10-CM* supplement available for purchase online through our bookstore. This supplement is optional and is not a required part of your course.

Step 6 *ICD-9-CM* vs. *ICD-10-CM*

- Let's briefly review the two different code sets and compare them.

ICD-9-CM	*ICD-10-CM*
Codes are 3 to 5 characters in length	Codes are 3 to 7 characters in length
Approximately 15,000 codes	Approximately 68,000 codes
First digit may be alpha (E or V) or numeric; digits 2 to 5 are numeric	Digit 1 is alpha; digits 2 through 7 are alpha or numeric
Limited space for new codes	Flexible for adding new codes
Lacks details	Very specific
Lacks **laterality**, which means left, right, or both sides is not defined (For example, with the *ICD-9-CM*, you might know that a patient's arm is broken, but you don't know if it was the right or left or even both arms.)	Has laterality (For example, the *ICD-10-CM* identifies which arm, such as right, left or both, the patient broke.)
Difficult to analyze data due to non-specific codes	Specificity improves coding accuracy and depth of data for analysis
Codes are non-specific and do not adequately define diagnoses needed for medical research	Detail improves the accuracy of data used in medical research
Does not support the ability to share data because it is not used in other countries	Supports interoperability and the exchange of healthcare data among other countries and the United States

Now that you understand the need for the *ICD-9-CM* update, let's pause for a quick review.

Step 7 Practice Exercise 23-1

❑ Choose the best answer from the choices provided.

1. The ICD originally was used to track _____.

a. new diseases
b. mortality statistics
c. clinical diagnoses
d. population statistics

2. The *Bertillon Classification of Causes of Death* was first used in the Americas in which country? _____

a. United States
b. Canada
c. Mexico
d. England

3. In 1946, the United Nations gave the responsibility for the *ICD* to the ____.

a. World Health Organization
b. General Register Office of England and Wales
c. International Statistical Institute
d. International Statistical Congress

4. The United States adopted the *International Classification of Diseases, 9th Revision, Clinical Modification* (*ICD-9-CM*), is based on the *ICD*-9, in _____.

a. 1946
b. 1977
c. 1967
d. 1979

5. The *ICD-9-CM* consists of a(n) _____.

a. tabular list
b. alphabetical index and procedural index
c. procedure index and tabular list
d. tabular list, alphabetical index and procedure alphabetic index and tabular list

Determine the correct answer to complete each sentence.

6. **A primary use of medical codes is to _____ to the insured the reason for a patient's medical visit.**

7. **Medical coding is a _____ for research, grants and financial analysis.**

8. **The *ICD-9-CM* outdated codes produce _____ _____.**

Step 8 Review Practice Exercise 23-1

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 9 Organization of Volume 2, *Alphabetic Index to Diseases ICD-9-CM*

- ❑ Before you really can begin coding, you need to understand the format and organization of the *ICD-9-CM* manual, Volumes 1 and 2. The manual itself is available from a number of different sources and publishers. Each publication presents the information in the *ICD-9-CM* manual in a slightly different format. For our purposes, all references to the *ICD-9-CM* manual, general arrangement and specific examples used are based on Optum, Inc.'s *2013 Professional ICD-9-CM for Physicians, Volumes 1 & 2* ©.

  You may see an *ICD-9-CM* manual that contains three volumes, but, in this course, we will use only Volumes 1 and 2. You will *not* use Volume 3 because it is used by hospitals for coding of inpatient procedures. **Inpatients** are those people admitted to a hospital or clinic who require at least a 24-hour stay for treatment. **Outpatients** receive treatment but do not necessarily need to stay for a 24-hour period at a medical facility.

You need to understand the format and organization of the *ICD-9-CM* manual.

When you begin your search for diagnostic codes in the *ICD-9-CM*, you first look in the *Alphabetic Index to Diseases*, or Volume 2 of the *ICD-9-CM*. It is located first in the manual but is called Volume 2. Confusing, isn't it? The *ICD-9-CM* originally was organized with Volume 1 before Volume 2, but medical coders found they always started their search in Volume 2 to locate codes. So, Volume 2 is presented first to make the manual user friendly.

Volume 2 is divided into three sections. Each section lists topics with a title and a description of the information that will be covered. The following are the names of these three sections and a brief description of each section's contents:

- Section 1—*Index to Diseases*—An alphabetical list of diseases with the corresponding diagnostic codes.
- Section 2—*Table of Drugs and Chemicals*—An alphabetical table listing substances to identify poisoning and external causes of adverse effects of drugs and other chemical substances.
- Section 3—*Index to External Causes*—An alphabetical list of external causes of injury and poisoning.

Think of this lesson as your guide to understanding the *ICD-9-CM*. Right now, take time to locate these sections in Volume 2 of your *ICD-9-CM* coding manual. As you become familiar with your manual, coding will get easier and become more fun!

Main Terms

The first important skill to develop in medical coding is the ability to identify *main terms* for the diagnosis in a *medical statement*. A **medical statement** is information a doctor documents in a patient's medical record, such as, "The patient is diagnosed with arm pain." You assign codes for the patient's chief complaint or symptoms when there is no other definitive diagnosis or cause listed for the condition. When you code a record that contains two or more equal diagnoses, the *principal* or *primary diagnosis* is the one for which the *main treatment* was given.

Main terms appear in boldface type in Volume 2 of the *ICD-9-CM* and are flush with the left margin of each column for easy reference. **Main terms** represent items such as the following:

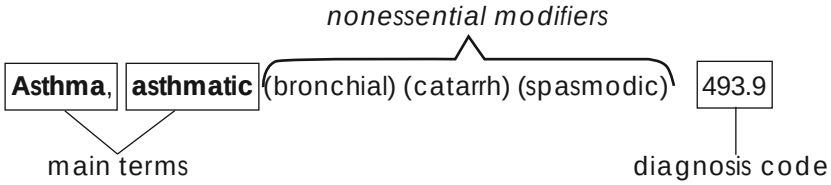
Diseases – for example: influenza, bronchitis

Conditions – for example: fatigue, fracture, injury, complication

Nouns – for example: disease, disturbance, syndrome

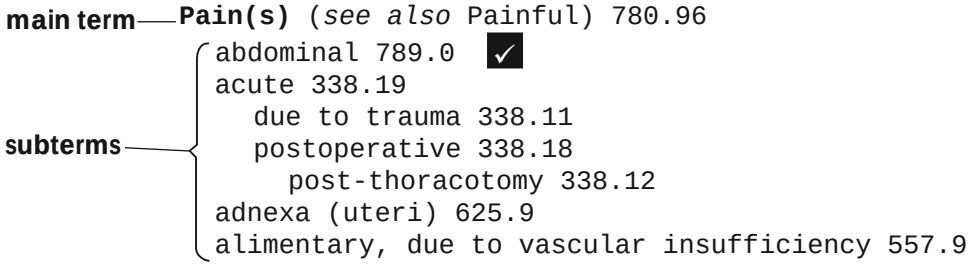
Adjectives – for example: double, large, kink

Anatomical sites, which are locations on the body, are not used for main terms. For example, you will find *bronchial asthma* under the disease term *asthma*, not under the anatomical term *bronchial*. When you look up the term *asthma* in the *Alphabetic Index of Diseases*—or Volume 2—the first entry you'll find for the main term is as follows:



The terms you see in parentheses after the word *asthmatic* are called *nonessential modifiers*. We will discuss nonessential modifiers later when we talk about the punctuation used in the *ICD-9-CM*.

Let's practice identifying main terms. Try coding the statement, "The patient is diagnosed with abdominal pain." Begin by asking yourself, "What did the doctor document as being wrong with the patient?" Well, you know that the patient has abdominal pain. Now, where do you begin your search—*abdominal* or *pain*? You know that main terms in the *ICD-9-CM* are not listed under anatomical sites, so you can rule out looking under the term abdomen. *Pain* is a condition, so you would look there first. Following is an example of an entry from the *Alphabetical Index to Diseases* in the *ICD-9-CM*. You can see how the main term *pain* is listed.



Subterms

In the example, the term *abdominal* describes *where* the pain is located in the body. Locating *abdominal* is the second step in determining what code to use. The first step was to identify *pain* as the main term. In this example, *abdominal* is a subterm. All terms listed below the main terms are called *subterms*. **Subterms** are modifiers of main terms and always are indented two spaces to the right below main terms. Each subterm has its own line, and all subterms are arranged in alphabetical order. Subterms describe the following three categories:

- Site—location on the body
- Cause—reason
- Clinical type—form

Look at the following examples:

The diagnosis is: viral infection

The main term is: *infection*

The subterm is: *viral*

The main term, *infection*, is a condition. The subterm, *viral*, is the clinical type or form of infection. Let's try one more:

The diagnosis is: Addison's Disease

The main term is: *Disease*

The subterm is: *Addison's*

The main term, *disease*, is a noun—a person, place or thing. The subterm, *Addison's*, tells you the type of disease.

The main term, *disease*, is a noun—a person, place or thing.

Other Important Terms

Carryover lines appear in the manual because there is a limit to the number of words that can fit on a single line of print in the Index. In entries that don't fit on a single line, the extra words carry over to the next line and usually are indented an additional four spaces. The following demonstrates a carryover line:

```
Rubella (German measles) 056.9              [main term]
 complicating pregnancy, childbirth
   or puerperium 647.5 ✓                    [carryover line]
```

Let's take a moment to talk about nonessential modifiers. Nonessential modifiers follow a main term or subterm in parentheses. However, when you are dealing with **nonessential modifiers**, the presence or absence of the information in parentheses has no bearing on your selecting the correct code. In other words, the information does not necessarily need to be documented in order for you to determine which code is correct for the diagnosis. An example of a main term with nonessential modifiers follows:

Pneumonia (acute) (Alpenstich) (benign) (bilateral) (brain) (cerebral)

Do you remember talking about eponyms in the medical terminology lessons? **Eponyms** are diseases or operations named for persons. The main terms for eponyms are found in the *Index to Diseases* under the eponym itself or under the main term, such as **Disease**, **Syndrome** and **Disorder**. For example, if you look in the index under the eponym **Alzheimer's disease**, you find the following:

```
Alzheimer's
   disease or sclerosis 331.0
```

If you look under the main term **Disease**, you'll find:

```
Disease, diseased
   Alzheimer's—see Alzheimer's
```

In this case, you would go back to **Alzheimer's** in the *Index to Diseases* to locate code 331.0. We will talk about *see* and *see also* later in this lesson.

Terms not listed in the *Tabular List*, or Volume 1 of the *ICD-9-CM*, occasionally are provided only in Volume 2, the *Alphabetic Index to Diseases*. In these cases, only similar terms are included in the *Tabular List*, and you should follow the *Alphabetic Index to Diseases* for the correct code. An example of a term listed in Volume 1, the *Tabular List* but listed differently in Volume 2, Section 1, *Index to Diseases*, follows:

```
780.79  Other malaise and fatigue
           Asthenia NOS
           Lethargy
           Postviral (asthenic) syndrome
           Tiredness
```

However, in Volume 2, *Index to Diseases*, you find this term:

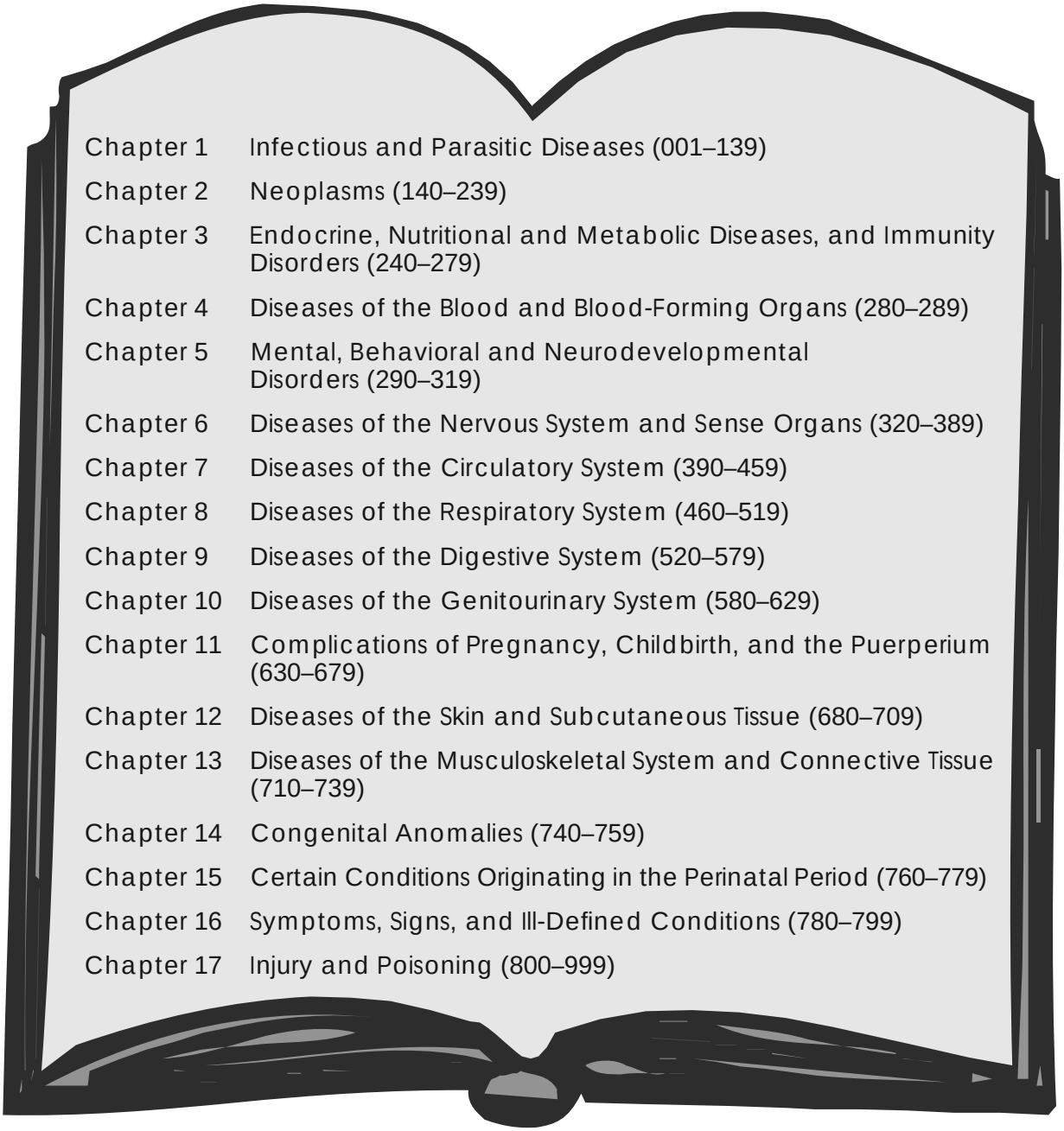
```
Listlessness 780.79
```

Although listlessness is assigned a code, 780.79, in Volume 2, Section 1, the *Index to Diseases*, that term is not listed in Volume 1, the *Tabular List* description under the same code. In this case, you should note that similar terms were shown in the *Tabular List*; however, trust the guidance of the *Index to Diseases* and use the code indicated there. You will find that the *Tabular List* may not have the exact description as the medical record. It is up to you, the medical coding and billing specialist, to decide which code is most specific for a diagnosis. Don't worry, your upcoming lessons will prepare you to do that, but remember to trust the guidance that the *Index to Diseases* provides.

Step 10 Organization of Volume 1, *Tabular List*

- Volume 1 of the *ICD-9-CM* is referred to as the *Tabular List* and is presented second in the manual. The *Tabular List* is a numerical index of specific diagnosis codes. This list is cross-referenced with diseases and injuries according to the anatomical system affected and/or the **etiology**, which is the cause of the disorder. Volume 1 is divided into seven parts: three sections and four appendices. The three sections consist of codes 001-999.9, the V codes and the E codes. Following those are the four appendices which we will discuss later in this lesson. Always be familiar with the organization of the coding manual you are using because the format will vary according to publishers.

The first section of Volume 1 contains 17 chapters. Each chapter contains the following subject matter and the designated range of related ICD-9-CM codes in parentheses:



Chapter 1	Infectious and Parasitic Diseases (001–139)
Chapter 2	Neoplasms (140–239)
Chapter 3	Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders (240–279)
Chapter 4	Diseases of the Blood and Blood-Forming Organs (280–289)
Chapter 5	Mental, Behavioral and Neurodevelopmental Disorders (290–319)
Chapter 6	Diseases of the Nervous System and Sense Organs (320–389)
Chapter 7	Diseases of the Circulatory System (390–459)
Chapter 8	Diseases of the Respiratory System (460–519)
Chapter 9	Diseases of the Digestive System (520–579)
Chapter 10	Diseases of the Genitourinary System (580–629)
Chapter 11	Complications of Pregnancy, Childbirth, and the Puerperium (630–679)
Chapter 12	Diseases of the Skin and Subcutaneous Tissue (680–709)
Chapter 13	Diseases of the Musculoskeletal System and Connective Tissue (710–739)
Chapter 14	Congenital Anomalies (740–759)
Chapter 15	Certain Conditions Originating in the Perinatal Period (760–779)
Chapter 16	Symptoms, Signs, and Ill-Defined Conditions (780–799)
Chapter 17	Injury and Poisoning (800–999)

Each of the 17 chapters in Volume 1, *Tabular List*, contains the following subdivisions:

- **Sections**—Sections, are groups of three-digit categories that represent a single disease entity or a group of similar or closely related conditions. For example, in Volume 1 you'll find that codes 001-009 represent the category of Intestinal Infectious Diseases.

- **Categories**—Within sections, each three-digit category represents a single disease entity or a group of similar or closely related conditions. As you look at **Intestinal Infectious Diseases (001-009)** in Volume 1, you'll see categories such as 003 for Other salmonella infections and 004 for Shigellosis.

- **Subcategories**—Within categories, each fourth-digit subcategory provides specific information regarding the cause of death or etiology, site, or **manifestation**—the signs or symptoms of an illness. You cannot assign a three-digit code if a category has fourth digits available. You must assign the most specific code possible—the subcategory if it is available. For example, you would use the four-digit code 003.1 for Salmonella septicemia in Volume 1, the *Tabular List*.

- **Fifth-Digit Subclassifications**—A fourth-digit subcategory sometimes is expanded to the fifth-digit level to provide more specific information. These **fifth-digit subclassifications**, appear in four locations: at the beginning of a chapter, at the beginning of a section, at the beginning of a three-digit category, or in a four-digit subcategory. The fifth-digit subclassification provides very specific information, such as the site of lymph nodes involved in a diagnosis, and you must assign it if it is available. In Volume 1 you see a fifth-digit code 003.21 for Salmonella meningitis.

- **Residual Subcategories**—These subcategories are codes with titles of *Other* and *Unspecified*. **Residual subcategories** classify conditions that are not assigned a separate subcategory. This ensures that a code can be assigned for every disease. Residual subcategories titled **Other** often have an 8 as the fourth digit; for example, **003.8 Other specified salmonella infections**. Residual subcategories titled Unspecified usually are assigned the fourth digit of 9, for example, **003.9 Salmonella infection, unspecified**.

Two supplementary classifications are provided in addition to the main classification for diseases and injuries. These classifications contain alphanumeric codes, or letters and numbers, whereas the other classifications only are numeric. These **supplementary classifications** can be V codes or E codes.

Now let's pause to reinforce your understanding of the organization of the *ICD-9-CM*.

✍ Step 11 Practice Exercise 23-2

❑ Choose the best answer from the choices provided.

1. The *ICD-9-CM for Physicians* manual is divided into _____ volumes.

a. 12
b. two
c. three
d. 10

2. The *ICD-9-CM for Physicians* manual lists _____ codes.

a. fundamental
b. procedural
c. treatment
d. diagnostic

3. Main terms appear in _____ type.

a. italicized
b. boldface
c. underlined
d. Times Roman

4. Information in parentheses following a main term is called a(n) _____, and it has no effect on selecting the correct code.

a. nonessential modifier
b. essential modifier
c. tabular reference
d. alphabetic code

5. The _____ uses a numerical index cross-referenced with diseases and injuries according to the anatomical system affected and/or etiology.

a. Appendix
b. Glossary
c. *Alphabetic Index*
d. *Tabular List*

6. **A medical coder must assign the most _____ code possible—a subcategory, if it is available.**
   a. obvious
   b. basic
   c. specific
   d. likely

7. **Supplementary classifications might be _____ codes.**
   a. V or E
   b. J or K
   c. V or J
   d. E or K

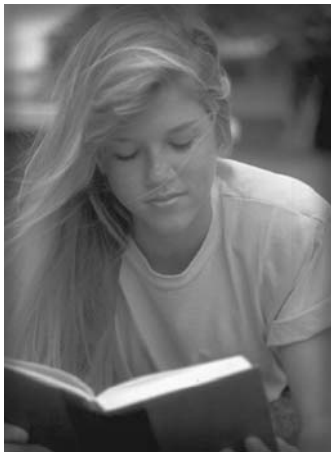
8. **_____ classifications ensure that there is always a code for every disease.**
   a. Late effect
   b. Residual
   c. Supplementary
   d. Rudimentary

Step 12 Review Practice Exercise 23-2

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 13 Introduction to Coding Guidelines

- ❑ Near the beginning of your *ICD-9-CM* manual is a section titled *Coding Guidelines: ICD-9-CM Official Guidelines for Coding and Reporting*. This section contains coding guidelines, conventions and chapter-specific guidelines. Take a few moments to find this section in your manual. Remember that there's no need to memorize the guidelines—they will always be available to you in your manual. However, it's important to know where to find this information and how to use this resource. When you begin coding in upcoming lessons, you will need to refer to these guidelines for additional information regarding certain diseases and how to code them.



There is no need to memorize the guidelines, as they will always be available in your manual.

The *Coding Guidelines* section begins with a Table of Contents that divides the material into four parts. For now, focus on Section IV of the *Coding Guidelines, Diagnostic Coding and Reporting Guidelines for Outpatient Services*. This section includes specific guidelines for coding outpatient services. (Keep in mind that outpatients are patients who do not stay overnight in a healthcare facility.)

The *ICD-9-CM* manual is printed each year *before* the guidelines are updated. Therefore, the manual you have covers the *previous* year's guidelines. For instance, if you have the *ICD-9-CM* 2013 edition, you'll find the 2012 guidelines.

This time gap means you must always be on the lookout for updated information as it becomes available. The coding resources you just learned about will help you out!

Who Develops Diagnostic Coding Guidelines?

A team of four organizations is actively involved with in-depth coding principles and practices. The groups include the Centers for Medicare and Medicaid Services, or CMS; the National Center for Health Statistics; the American Health Information Management Association, or AHIMA; and the American Hospital Association, or AHA. These organizations cooperatively developed and approved the "Diagnostic Coding and Reporting Guidelines for Outpatient Services," which is Section IV in your *ICD-9-CM* manual. The Editorial Advisory Board of the AHA Coding Clinic publishes this document.

You will find references to the AHA in the *Tabular List*, or Volume 1, under many code descriptions.

As you continue to become more familiar with your *ICD-9-CM* manual, you will find references to the AHA in the *Tabular List*, or Volume 1, under many code descriptions. Take a look at this example:

```
275.4   Disorders of calcium metabolism
        AHA: 4Q, '97, 33
```

AHA: 4Q, '97, 33 refers you to the *AHA Coding Clinic for ICD-9-CM* a publication that discusses official advice concerning coding topics. It is a quarterly newsletter published by the American Hospital Association. As a student, you do not need to have access to this publication to complete this course, but we do want you to be aware of these references.

Now let's get familiar with the cross-reference terms you may encounter.

Cross-reference Terms

Volume 2, the *Alphabetic Index to Diseases* uses cross-reference terms to instruct you to look in another place before you assign a code. These cross references provide possible modifiers for a term or its synonyms. Follow the cross references to the correct code when you don't find the diagnosis under the first term you locate. The following three types of cross reference terms are used: s*ee*, s*ee also* and the s*ee category*. Before you look more closely at each term and its use, be advised that you will be provided with examples to assist in understanding the ICD-9-CM's meaning. You might not have enough information to determine exact coding.

See

The ***see*** cross reference points you to another term. You will follow the *see* cross reference to ensure that you assign the correct code to a diagnosis. The following example from Volume 2 shows you how to use the *see* cross reference:

Roentgen ray, adverse effect—*see* Effect, adverse, x-ray

The *see* cross reference instructs you to go to *Effect, adverse* and go down the list of subterms until you come to *x-ray*. This is what you will find:

Effect, adverse NEC
•
•
•
x-rays NEC 990
dermatitis or eczema 692.82

Cross references provide possible modifiers for a term or its synonyms.

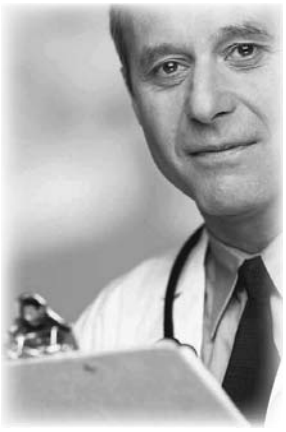
See Also

See also indicates that additional information about the term and code is available under the referenced term in another place in the *Alphabetic Index to Diseases*. The *see also* cross reference gives you an additional diagnosis and code when the main term or subterm is insufficient. The additional information in the *see also* cross reference helps you select the correct code, so follow this instruction to ensure coding accuracy. Here's an example from Volume 2 that includes the *see also* cross reference:

Tuberculoma — *see also* Tuberculosis
brain (any part) 013.2 ✓
meninges (cerebral) (spinal) 013.1 ✓
spinal cord 013.4 ✓

When you go to the **Tuberculosis** main term, you will find a very long list of subterms to review. You must determine whether any of them is appropriate to include based on the diagnosis with which you are working.

It's also important to use multiple codes to identify all components of a diagnosis when a single code does not fully describe a given condition. The *see also* cross reference helps you do this. However, medical record documentation must mention the presence of all the elements of any code you use. Always ask the physician involved if you are unsure about assigning multiple codes. We will discuss multiple codes further in a moment.



Always ask the physician involved if you are unsure about assigning multiple codes.

See Category

The ***see category*** cross reference directs you to an additional three-digit category in Volume 1, *Tabular List*. If the *see category* is included with a term, you cannot assign the correct code unless you follow this instruction and read the applicable notes in Volume 1. For example, in Volume 2 under the main term **Hemiplegia** with a code of 342.9 ✓ , the subterm thrombotic (current), late effect, includes a *see category* directing you to **Late effect(s) (of) cerebrovascular disease**:

Hemiplegia 342.9 ✓
•
•
•
thrombotic (current) (*see also* Thrombosis, brain) 434.0 ✓
late effect — *see* Late effect(s) (of) cerebrovascular disease

General adjectives, or **descriptive words**, such as acute and hereditary, appear as main terms, usually with a cross reference to *see* conditions or *see also*. In addition, if anatomic sites such as *arm* or *neck* appear as main terms, there will be a cross reference to *see* conditions or *see also*.

Includes and Excludes

The *ICD-9-CM* manual uses INCLUDES and EXCLUDES instructional notes to help you assign diagnostic codes at the highest level.

The INCLUDES box appears immediately after a three-digit code's title to provide additional information regarding the category's contents. The *Tabular List* uses inclusion notes to define a category in greater detail. Look at the following example from Volume 1:

633 Ectopic pregnancy

INCLUDES ruptured ectopic pregnancy

The EXCLUDES box appears in a listing when terms are not to be coded under the referenced term; such terms are listed somewhere else. A code reference is provided in parentheses directing you to the correct term or area. The *Tabular List* uses exclusion notes, and you can see them easily because EXCLUDES is printed in reverse type with a box around it to define the category in greater detail. Look at the following example from Volume 1:

711 Arthropathy associated with infections

•
•
•

EXCLUDES rheumatic fever (390)

Notes

Notes, which give coding instructions, appear in Volume 1, the *Tabular List* and in Volume 2, the *Alphabetic Index to Diseases* of the *ICD-9-CM* manual. The length of the notes varies. Depending on where the notes are located, their appearance also varies. When notes are in Volume 2, they are boxed and italicized. Notes in Volume 1 are located at various levels of the classification system. The following examples show some notes from different parts of the *ICD-9-CM* manual and how these notes instruct you.

This note from Volume 2 gives you additional coding instructions and defines terms:

Injury 959.9

Note—For abrasion, insect bite (nonvenomous), blister, or scratch, see Injury, superficial.

For laceration, traumatic rupture, tear, or penetrating wound of internal organs, such as heart, lung, liver, kidney, pelvic organs, whether or not accompanied by open wound in the same region, see Injury, internal.

For nerve injury, see Injury, nerve.

For late effect of injuries classifiable to 850-854, 860-869, 900-919, 950-959, see Late, effect, injury, by type.

This note from Volume 1 instructs you to assign a fifth digit because subclassification categories are available:

831 Dislocation of shoulder

EXCLUDES sternoclavicular joint (839.61, 839.71)
sternum (839.61, 839.71)

The following fifth-digit subclassification is for use with category 831:

0 shoulder, unspecified
Humerus NOS
1 anterior dislocation of humerus
2 posterior dislocation of humerus
3 inferior dislocation of humerus
4 acromioclavicular (joint)
Clavicle
9 other
Scapula

Multiple Coding

Multiple coding simply means using more than one code to identify a diagnosis as accurately as possible. Several instructional phrases indicate that you are required to use multiple codes. The following examples instruct you in multiple coding:

Multiple coding means using more than one code to identify a diagnosis as accurately as possible.

Use additional code if desired—Volume 1, the *Tabular List* includes this notation, which instructs you to use an additional code to provide a more complete picture of the diagnosis or procedure. You should ignore the words *if desired*—use additional codes when this multiple coding note is provided as long as the documentation supports the code.

When you see an instruction at the beginning of a chapter, that instruction applies to all the codes in the chapter. Instructions also may appear at the beginning of a section or a category. In the following example from Volume 1, the notation instructs you to identify other aspects of the disease, such as manifestation, cause, associated condition and nature of the condition.

358.2 Toxic myoneural disorders
Use additional E code to identify toxic agent

Code first underlying disease—This instruction identifies diagnoses that are not primary (or principal) and are incomplete when they are used alone. Only Volume 1, the *Tabular List*, uses this instruction. First, record the underlying disease, which often is the second line in the code. Then record the primary disease or first line in the code.

Look at the following example from Volume 1:

595.4 Cystitis in diseases classified elsewhere
Code first underlying disease, as:
actinomycosis (039.8)
amebiasis (006.8)
bilharziasis (120.0–120.9)
Echinococcus infestation (122.3, 122.6)

In this example, if amebiasis is documented as the underlying disease, you first would code amebiasis (006.8), and then **Cystitis in diseases classified elsewhere 595.4**. You will code: **006.8 595.4**

Connecting Words

Connecting words are words that connect main terms with subterms. These words connect the terms and subterms to show that there is a relationship between the main term and an associated condition or etiology. The following words are examples of some connecting words used in Volume 2, the *Alphabetic Index to Diseases*:

associated with	during	secondary to
complicated (by)	following	with
due to	in	with mention of
of	without	

In the example that follows, the connecting terms are italicized to demonstrate their use:

883 Open wound *of* finger(s)
INCLUDES fingernail
thumb (nail)
883.0 *Without* mention *of* complication
883.1 *Complicated*
883.2 *With* tendon involvement

Abbreviations

The *ICD-9-CM* manual frequently uses the following two abbreviations with which you need to be familiar:

- **NEC**—NEC means **not elsewhere classifiable** in the *ICD-9-CM* manual. This abbreviation is to be used only when there is not enough information available to code the term more specifically, even when a diagnostic statement was very specific; and only with ill-defined terms included in Volume 1, the *Tabular List,* to warn you that specified forms of the condition are classified differently. In such cases, use NEC codes only if more precise information is not available.

- **NOS**—NOS means **not otherwise specified**. Use NOS codes only when the diagnosis statement does not provide enough information.

These abbreviations are for your reference only. You will not record them with the assigned code.

Symbols

Symbols often are used in the *ICD-9-CM* manual to identify a code number that is new since the previous edition of the manual. Symbols also might be used to indicate a change in a code's description. Diagnostic codes that require a fourth or fifth digit are marked with a symbol. Some codes are marked to indicate a footnote that is applicable to all subdivisions in the code.

We will be discussing, in detail, some of the symbols. In the front of your *ICD-9-CM* manual, you will find more information about these symbols under the heading *Additional Conventions, Symbols and Notations*. These symbols, just like the abbreviations, are for your reference only and will not be recorded with the assigned code.

Punctuation

The *ICD-9-CM* manual uses the following punctuation symbols:

- **Parentheses ( )**

  Parentheses enclose supplementary information; this information consists of words whose presence or absence in the statement of a disease does not affect the code number. For example, in Volume 2, *Alphabetic Index to Diseases, erythroblastic anemia* is included as supplemental information, but the terms have no bearing on the code used:

  Dameshek's syndrome (erythroblastic anemia) 282.49

➤ Square Brackets [ ]

Brackets enclose synonyms, alternative wordings or explanatory phrases. For example from Volume 1, the *Tabular List,* the bracketed information—**[and kyphoscoliosis]**—is included for clarification:

737.3 **Kyphoscoliosis and scoliosis**
DEF: Kyphoscoliosis: backward and lateral curvature of the spinal column; it is found in vertebral osteochondrosis.

DEF: Scoliosis: an abnormal deviation of the spine to the left or right of midline.

737.30 Scoliosis [and kyphoscoliosis], idiopathic

➤ Slanted Brackets *[ ]*

Slanted brackets, or brackets that are italicized, appear in Volume 2, *Alphabetic Index to Diseases*, to indicate that another code is required in addition to the first code listed. You must record both codes in the order they are given in the volume, but you will not include the slanted brackets when recording the code. For example, in Volume 2, if the diagnosis is **diphtheritic epididymitis**, you must code both the **032.89** and the **604.91**—in that order:

Epididymitis (nonvenereal) 604.90
with abscess 604.0
•
•
•
diphtheritic 032.89 *[604.91]*

You will code: 032.89 604.91

➤ Colon :

Volume 1, the *Tabular List*, uses a colon after an incomplete term that requires an adjective, or descriptor. For example, in Volume 1, if **hypostatic** is included in the diagnosis without either of the terms below it, **hypostatic** would *not* be listed under **514.** See the example below:

514 **Pulmonary congestion and hypostasis**
Hypostatic:
bronchopneumonia
pneumonia

Hypostatic is a descriptor meaning congestion of blood in a part of the body due to impaired circulation. Since hypostatic is an adjective (descriptor), it must be followed by a noun identifying the etiology, or cause of the conditon. Note: If the pneumonia were *not* hypostatic, it would be coded differently.

➤ **Braces }**

Braces enclose a series of terms, each of which is changed by the statement to the right of the brace. For example, in Volume 1:

755.2 Reduction deformities of upper limb
755.20 Unspecified reduction deformity of upper limb
Ectromelia NOS
Hemimelia NOS
} of upper limb

● A bullet indicates a new code.

▲ A triangle in the *Tabular List* indicates that the code title has been revised. In the *Alphabetic Index* the triangle indicates that the code has been changed.

► ◄ These symbols appear at the beginning and at the end of a section of new or revised text.

Coding Enhancements Included in the Ingenix ICD-9-CM System:

☑ This symbol indicates that additional digits are required and are found in Volume 2, *Alphabetic Index to Diseases.*

DEF: This symbol indicates a definition of a disease. The definition will appear in blue type in the *Tabular List*.

****

In the *Tabular List*, the symbols listed below indicate when additional digits are required:

☑**4th** This symbol indicates that the code requires a fourth digit.

☑**5th** This symbol indicates that the code requires a fifth digit.

More About Fourth- and Fifth-Digit Coding

The following example is found in Volume 2, Section 1, *Index to Diseases*:

Milk-leg (deep vessels) 671.4 ☑

In the *Index to Diseases*, you will find a check box like this ☑ at the end of some codes to indicate that additional digits are required. As a medical coder, you will look in Volume 1, the *Tabular List*, to choose the appropriate digits to complete the assigned code.

When coding for diagnoses, always check codes in the *Tabular List*. A ✓4th or ✓5th box in front of a three-digit code indicates that a fourth or fifth digit is needed to complete the code. Fourth-digit codes are found within the three-digit code category. Designated three-digit code categories include four digits, so it is important to keep looking after you locate the three-digit code. Look at this example taken from the *Tabular List*:

```
✓4th 331 Other cerebral degenerations
        331.0 Alzheimer's disease
✓5th 331.1 Frontotemporal dementia
```

Because code 331 has a ✓4th box located to the left, it cannot be used by itself. A code from the codes listed in that category must be chosen for effective coding. Notice that only the subclassification, 331.1-Frontotemporal dementia, requires a fifth digit. Once again, you will code only the digits and not the symbols found in front of the codes.

An example of a fourth-digit subclassification box is found in the *Tabular List* at the beginning of the section titled ***Other Pregnancy With Abortive Outcome (634-639)***. This information guides you to use digits .0-.9 as fourth digits for code categories 634-638. Within the *ICD-9-CM* manual, the boxed text is shaded in the *Tabular List*.

Remember that fifth-digit subclassifications can be found in several areas of the *ICD-9-CM* Volume 1, the *Tabular List*.

➤ **At the Beginning of a Chapter**

Take a look at ***Chapter 13 Diseases of the Musculoskeletal System and Connective Tissue (710-739)***. Notice the shaded box just below the chapter title that contains fifth-digit subclassifications 0-9. This area states that we can use these digits for categories 711-712, 715-716, 718-719, and 730. Be sure to look back to the chapter beginning to see whether there are fifth digits applicable to the codes that you are assigning.

➤ **At the Beginning of a Section**

Look in the *Tabular List* at ***Complications Mainly Related to Pregnancy (640-649)*** in Chapter 11. This is a good example of fifth-digit subclassifications being located at the beginning of a section. This information tells us to use digits 0-4 with code categories 640-649.

➤ **At the Beginning of a Three-digit Category**

Locate category **715 Osteoarthrosis and allied disorders** in the *Tabular List*. Do you see the shaded box after code 715 that includes the fifth-digit subclassifications? These classifications are for use with category 715 only. In coding a diagnosis of osteoarthrosis of the shoulder, you would select **715.9 Osteoarthrosis, unspecified whether generalized or localized** and add the fifth-digit "1" for shoulder region, making a complete code **715.91**.

A shaded box after code 715 includes fifth-digit subclassifications.

➤ **In a Four-digit Subcategory**

Look at this example taken from the *Tabular List*:

```
✓4th 331  Other cerebral degenerations
          331.0 Alzheimer's disease
     ✓5th 331.1 Frontotemporal dementia
               331.11 Pick's disease
               331.19 Other frontotemporal dementia
          331.2 Senile degeneration of brain
```

Because there is a ✓4th box listed in front of code 331, medical coders know they must choose a four-digit code from the *Tabular List*. As we mentioned earlier, code **331.1** has a ✓5th box in front of it. If you look at the indented codes under code **331.1**, you will find two choices: **331.11 Pick's disease** and **331.19 Other frontotemporal dementia**. If we were coding for Pick's disease, we could not use **331.1** but instead must use **331.11** for complete and accurate coding. Note, as well, that if the condition was specified as frontotemporal dementia, without mention of Pick's disease, you would use the code 331.19.

By paying close attention to the enhancements in the *Tabular List*, you can accurately locate the fifth-digit subclassification information to assign a fifth digit.

Not all codes have fourth or fifth digits, but when they are available, it is the medical coding and billing specialist's responsibility to include them for accurate and specific coding.

Also noteworthy is the legend at the bottom of each page in the *Tabular List*. Being familiar with the terms and symbols at the bottom of each page will help you understand what you are reading in the *Tabular List*. Manuals may differ according to publisher, but if you develop detective-type skills and look for all the clues that are provided, you will do your best in the medical coding and billing field!

Once again, let's review what you've learned about the conventions the *ICD-9-CM* coding manual uses before you move on.

✍ Step 14 Practice Exercise 23-3

❑ Choose the best answer from the choices provided.

1. When a diagnosis is not principal and is used alone, you should code the _____ first.

a. primary disease
b. underlying disease
c. always secondary disease
d. usually secondary diagnosis

2. ICD-9-CM coding uses the INCLUDES and EXCLUDES instructional notes to assist coders in assigning diagnostic codes at the _____ level.

a. lowest
b. median
c. highest
d. most obvious

3. Notes, when found in the *Index to Diseases*, are _____.

a. boxed and italicized
b. boldface and circled
c. boxed and boldface
d. underlined and highlighted

4. In the multiple coding instruction, "Use additional code, if desired," you should ignore the words _____.

a. use additional
b. additional code
c. use code
d. if desired

5. NEC means _____.

a. never ever code
b. not elsewhere classifiable
c. not enough classification
d. never endeavor coding

6. **NOS means _____.**
   a. never occupied specialty
   b. nine other subclassifications
   c. not otherwise specified
   d. not often subdivided

7. **A note might instruct you to assign a(n) _____ digit because subclassification categories are available.**
   a. third
   b. fourth
   c. additional
   d. fifth

Step 15 Review Practice Exercise 23-3

❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 16 ICD-9-CM Terminology

❑ Many—if not most of—the terms used in the *ICD-9-CM* manual have other definitions and meanings when they are used elsewhere. You need to be familiar with terms that are used throughout the *ICD-9-CM* manual as they relate to medical coding. This will help you code a medical diagnosis correctly.

The following definitions are specific to their use in the *ICD-9-CM* coding manual:

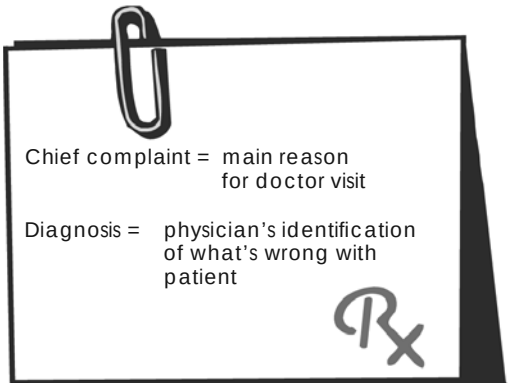
- **Acute**—Short and severe; for example, a new injury or disease.
- **Adverse**—Any unfavorable, unintended response to a drug that occurs with proper dosage.
- **Aftercare**—A visit to the medical facility for something planned in advance; for example, the removal of sutures (stitches).
- **Chronic**—To continue over a long period of time or recurring frequently.
- **Concurrent**—When a patient is treated simultaneously by more than one physician for different care conditions.
- **Foreign body**—An object not naturally occurring in the human body.
- **Late effect**—A residual effect after the acute phase of an illness or injury has ended.
- **Manifestation**—The characteristic signs or symptoms of an illness.
- **Residual**—The long-term conditions resulting from a previous acute illness or injury.

When both an acute disease and a chronic disease coexist and no single code exists to code both diseases together, code the acute disease as the principal diagnosis and the chronic disease as the secondary, or coexisting, condition. Here's an example. The physician documents acute and chronic thyroiditis. With the help of your medical terminology knowledge, you can figure out that this condition is inflammation of the thyroid gland. Now, look in your *ICD-9-CM* manual's *Index to Diseases* for *thyroiditis*. Then look for the subterms *acute* and *chronic*. You will find codes **245.0 Acute thyroiditis** and **245.8 Chronic thyroiditis**. Go to the *Tabular List* to verify these codes. You will code the acute condition first, listing code 245.0, and then code 245.8.

A *late effect* is a residual condition that occurs after the acute phase. Late-effect categories are three-digit categories, and they can require additional digits. When you code a late effect you *generally* assign two codes: the residual effect and the cause of the late effect. Sometimes a late-effect code has been expanded to a fourth or even fifth digit to include the manifestation or residual effect, and only one code is needed. Remember when you code late effects that there is no time limit between the acute phase and the late effect. In other words, some period of time can pass between the acute phase of a condition and the point at which the late effect or residual condition is diagnosed.

The chief complaint is the main reason a patient sees a doctor.

Let's also review two terms we talked about in previous lessons—*chief complaint* and *diagnosis*. You recall that the chief complaint is the *main reason* a patient sees a doctor. For example, if a patient tells a doctor that he has a sore throat, that is the chief complaint. The diagnosis occurs when the doctor *identifies what is wrong* with a patient. In our example, the doctor might examine the patient and determine the patient has strep throat. This is the diagnosis.



One last important term with which you should be familiar is *unconfirmed diagnoses*. You do not code conditions when it is uncertain if they really exist. In other words, don't code a condition until it has been determined to be the diagnosis. **Unconfirmed diagnoses** are suspected conditions, such as those that contain words like *suspicion of*, *probable* or *likely*.

It's important that medical coders do not play doctor and narrow down the choices of categories for the diagnosis. The concept of unconfirmed diagnoses affects how insurance companies reimburse, so it is important that you understand it. We'll discuss how to deal with unconfirmed diagnoses later in your studies.

Step 17 The Appendices

- Volume 1, the *Tabular List* of the *ICD-9-CM* manual contains four appendices. (Prior to October 1, 2004, there were five. Appendix B no longer exists.) As a group, these appendices provide additional information about the coding for a patient's diagnosis, further define a diagnostic statement, provide clarification about new drugs and reference three-digit categories. Appendices are a good place to look when you need detailed information about a specific topic. Specifically, each appendix of the *ICD-9-CM* includes the following information.

Appendix A—Morphology of Neoplasms

Morphology is the study of neoplasms, or tumors. This appendix provides additional detailed information about coding diagnoses in this category, such as types of tumors, behavior of tumors and one-digit codes that are used to code neoplasms. The following is an example entry from Appendix A:

M975 **Burkitt's tumor**
M9750/3 *Burkitt's tumor*

These codes are optional and are usually used for statistical information only. The morphology codes will not be used in this course.

Appendix B—Glossary of Mental Disorders

This appendix was deleted October 1, 2004.

Appendix C—Classification of Drugs by AHFS List

This appendix is an alphabetized listing of drugs. A division of the American Hospital Formulary Service, or AHFS, publishes a coded listing of drugs. Appendix C is an alphabetized listing of those drugs and their ICD-9-CM codes. The AHFS codes in this appendix contain up to five digits and always begin with a number, followed by a colon and up to four more digits to provide adequate detail. The following is an example entry from Appendix C:

AHFS List	ICD-9-CM Diagnosis Code
28:04 General Anesthetics	968.4
gaseous anesthetics	968.2
halothane	968.1
intravenous anesthetics	968.3

Appendix C is an alphabetized listing of drugs.

Appendix D—Industrial Accidents According to Agency

Appendix D codes are often used to track job-related causes of injury and death.

This appendix contains three-digit codes to classify occupational, or job-related, hazards. Seven categories contain all the occupational categories. You often will use these codes to track job-related causes of injury and death. The following is an example entry from Appendix D:

```
 1 MACHINES
11    Prime-Movers, except Electrical Motors
111   Steam engines
112   Internal combustion engines
119   Others
```

Appendix E—List of Three-Digit Categories

Appendix E contains a list of all the three-digit codes in the *ICD-9-CM* manual. These codes are grouped by chapter to correspond with Chapters 1 through 17 of Volume 1, the *Tabular List*, diagnostic codes. The following is an example entry from Appendix E:

```
                LIST OF THREE-DIGIT CATEGORIES
                1. INFECTIOUS AND PARASITIC DISEASES
Intestinal Infectious Diseases (001 – 009)
001     Cholera
002     Typhoid and paratyphoid fevers
003     Other salmonella infections
004     Shigellosis
005     Other food poisoning (bacterial)
006     Amebiasis
007     Other protozoal intestinal diseases
008     Intestinal infections due to other organisms
009     Ill-defined intestinal infections
```

Wow! We're almost done with this lesson. Stop for a moment to review what you learned about terminology and the *ICD-9-CM* manual's appendices by completing the following Practice Exercise.

✍ Step 18 Practice Exercise 23-4

❑ Choose the best answer from the choices provided.

1. An object not naturally occurring in the human body is _____.

a. a foreign body
b. acute
c. chronic
d. a manifestation

2. A late effect is defined as a(n) _____ effect after the acute phase of an illness or injury has ended.

a. aftercare
b. concurrent
c. chronic
d. residual

Match each appendix with the description of its contents.

3. _____ Appendix A

4. _____ Appendix B

5. _____ Appendix C

6. _____ Appendix D

7. _____ Appendix E

a. Drug classification
b. Three-digit categories
c. Study of tumors
d. Was deleted in 2004
e. Job-related accidents

🗝 Step 19 Review Practice Exercise 23-4

❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

🕮 Step 20 The Steps to Correct Coding

❑ So how do you actually begin to assign codes? Well, one of the first sections you will come across in the very beginning of the *ICD-9-CM* book is a section that outlines the *10 Steps to Correct Coding*. Take a few moments to read these steps now.

Now that you're familiar with the steps provided in the *ICD-9-CM* book, let's break them down into the basics here. In later lessons, as you start to code, you will work through the following steps:

Steps for Assigning Diagnostic Codes

1. Identify the main terms in the diagnostic statement.
2. Locate each main term in the *Index to Diseases* and read any notes that appear with the main term.
3. Refer to any subterms indented under the main term in the *Index to Diseases*.
4. Look at abbreviations, cross-references, symbols and brackets.
5. Choose the tentative code you find in the *Index to Diseases,* Volume 2, then locate and determine the highest level of specificity in the *Tabular List*, Volume 1.
6. Read and use any instructional terms in the *Tabular List* as a guide. Look for INCLUDES and EXCLUDES, notes and other instructional comments at the beginning of each chapter. Also, look at the three-digit code at the beginning of each category or group of codes that you are using within the chapter and check for additional instructions for the group.
7. Assign codes to their highest level of specificity, using the following guidelines:
   - ➤ Assign three-digit codes only when there are no four-digit codes within that category.
   - ➤ Assign a four-digit code only when there is no fifth-digit subdivision for that subcategory.
   - ➤ Assign a fifth-digit to the code for any subcategory for which a fifth-digit subclassification is provided.
   - ➤ Remember to continue coding the dictation until all conditions have been fully identified before assigning the code.

Outpatient Coding Tips

- If it is not documented, it did not happen.
- Do not assume anything.
- Terms such as *possible*, *suspect*, *probable*, *rule out* or *consistent with* are not assigned codes.
- Code symptoms only when a definitive diagnosis is not documented.
- Check with the physician if the information is unclear.

Practice Makes Perfect

The key to diagnosis coding is to ask yourself a series of questions. Let's practice this process and the basic steps to coding. Take out your *ICD-9-CM* manual and follow along with the coding examples listed below. As you know from the basic steps to coding that you just learned, each example begins in the *Index to Diseases*, or Volume 2, and is verified in the *Tabular List*, or Volume 1. Don't worry if you have a hard time following this series of steps at first. In the next lesson, you'll walk through scenarios like this step-by-step as you begin to code on your own.

Asking a series of questions is the key to diagnosis coding.

Diagnosis: noncardiac chest pain
What's the main term? *pain*
Where's the pain? *chest*
What's the type of pain? *noncardiac*
The Volume 2 coding pathway is *pain, chest, noncardiac 786.59*
Now turn to the *Tabular List* and verify the code description for 786.59.

Note: Because *noncardiac* chest pain was specified, code **786.59 Chest pain, Other** is used instead of an unspecified code. Trust the coding pathway you found in Volume 2, *Index* to *Diseases*, to lead you to the correct code.

Diagnosis: sprained ankle
What's the main term? *sprain*
Where's the sprain? *ankle*
Does it include the foot? *no*
The Volume 2 coding pathway is *sprain, ankle 845.00*
Turn to the *Tabular List* and verify the code description for 845.00.
Notice that the specific part of the ankle is not documented, and so we code for *unspecified site* using the fifth-digit 0.

The main term for sprained ankle is *sprain*.

Diagnosis: diabetic cataracts
What's the main term? *cataracts*
What's the cause? *diabetes*
The Volume 2 coding pathway is *cataract, diabetic 250.5* ✓ *[366.41]*

What does this boxed symbol mean? Turn to code *250.5* in the *Tabular List*. You'll note the fifth-digit subclassification box for the code category *250*. In this example, the type of diabetes is not specified, so the fifth digit would be 0. Now let's talk about the code in slanted brackets *[366.41]*. Remember that slanted brackets mean you must use the code in those brackets, too. So in this example, *250.50* is the primary diagnosis, and *366.41* is the secondary diagnosis. When you look up both these codes in the *Tabular List,* you'll see that the code descriptions are verified.

Step 21 Pathways

- Remember that the key to diagnosis coding is to ask yourself a series of questions once you have the documentation we discussed in previous lessons. The main question is "What is the problem?" After you identify the problem or diagnosis, use the main terms and subterms to locate the code in Volume 2 of the *ICD-9-CM*, as we just discussed.

The **coding pathway** refers to the series of main terms and subterms used to find the diagnostic code in that manual. The main term is listed first, and then the subterm. Think of a coding pathway as a road map you would follow to arrive at your destination. To what city are you going? What highway do you follow, and what exit do you use to arrive at your destination? So you see, a coding pathway is like a road map to the correct code!

Think of a coding pathway as a road map you would follow to arrive at your destination.

Let's take a look at an example of a coding pathway.

Aaron, age 7, presents with a fever and a pain in his right ear. The doctor examines him, and this is her diagnosis: otitis media, right ear.

You know the diagnosis is otitis media because the doctor has documented it in the patient's medical record. What do you look for first? *Otitis* is the main term. Remember your medical terminology? **Otitis** means inflammation of the ear. It is a medical condition. **Media** means middle, so now you know that *media* is the *subterm* because it describes the location of the condition within the ear.

So the coding pathway for Aaron's diagnosis is **otitis**, **media**. Following is a sample entry from the *ICD-9-CM* that shows how this condition looks in Volume 2.

Volume 2 INDEX TO DISEASES

Othematoma 380.31

Otitic hydrocephalus 348.2

main term → **Otitis** 382.9
with effusion 381.4
acute 382.9
adhesive (*see also* Adhesions, middle ear) 385.10
chronic 382.9
diffuse parasitic 136.8
externa (acute) (diffuse) (hemorrhagica) 380.10
insidiosa (*see also* Otosclerosis) 387.9
interna (*see also* Labyrinthitis) 386.30
subterm → media (hemorrhagic) (staphylococcal) (streptococcal) 382.9

Well done! Let's take a look at some clinical applications of the coding rules.

Step 22 Clinical Applications of Coding Rules

- As a medical coding and billing specialist, you are something of a translator. You will take diagnoses and translate them into medical codes. To do that, you must understand small but significant differences that you might find as you code. In addition, you must know the rules of coding to accurately assign specific codes. Knowing how to properly sequence and report diagnostic codes is your goal.

  Let's consider some clinical applications of coding rules. As you deal with the bulleted situations that follow, be aware of the rules that accompany them.

  - **Physician Coding**—When you code a physician's diagnosis of a patient's condition, the *principal* or *primary,* diagnosis is the most important because it reflects the current and most significant reason a patient seeks treatment. You assign *secondary* codes to coexisting diseases and conditions *after* you code the primary diagnosis. Remember that when you assign a code for a pre-existing condition, you must ensure that the diagnostic code identifies the current reason for medical care. Do not assign codes for rule-out statements such as *probable, possible, questionable, rule out* and *suspected* in outpatient settings.

When you code a physician's diagnosis, the principal or primary diagnosis is the most important.

➤ **Common Coding for Outpatients and Inpatients**—You will assign codes for the principal outpatient or principal inpatient diagnosis and sequence the codes in the correct order. Use the appropriate coding rules and guidelines that you are learning. The following tips will be helpful to remember:

You will assign codes for the principal outpatient or principal inpatient diagnosis and sequence the codes in the correct order.

1. *Assign codes in the order of importance.* The order in which the doctor writes the diagnosis might not determine the main diagnosis. Determine the correct diagnosis order before you list the codes. As the coder, you sometimes will not be able to determine the principal diagnosis and might have to ask the doctor.
2. *Assign unspecified or other specified codes when the reason a patient seeks healthcare is not clarified.* For example, use unspecified codes when the diagnosis has not been finalized. Use other specified codes when a diagnosis has been made and there is no code to identify the diagnosis more specifically.
3. *Assign coexisting condition codes as supplementary diagnoses codes in order of importance* after *you assign the principal diagnosis code.* The order of importance might be based in part on the time it takes to complete the patient's health care and on the resources that are used for each relevant code.

Inpatients and Outpatients

An inpatient is someone admitted to the hospital to stay overnight.

Even though you are already familiar with the terms *inpatient* and *outpatient*, let's talk about them in greater detail here. An inpatient is someone admitted to the hospital to stay overnight. People who come to the hospital for an x-ray or laboratory test are referred to as outpatients. These are patients who are receiving **ancillary services**—they come to the hospital to receive the medical service or treatment, and then they go home the same day. Outpatients include patients who go to the hospital for outpatient surgeries or procedures, IV therapies or ED visits. Outpatients also are patients at doctors' offices and other outpatient facilities such as MRI centers, outpatient surgery centers and chemotherapy or dialysis specialty clinics.

This is an example of what makes your job as a medical coding and billing specialist so important! When a patient is admitted for surgery at a hospital, he receives two bills. One is from the hospital, and one is from the surgeon. The *surgeon's* medical coding and billing specialist assigns codes for the diagnosis the surgeon gave and the procedure she performed for the inpatient. Then the claim form is sent to the patient's insurance company for reimbursement. The services that a patient uses while he is in the hospital, such as the room charge, the operating room and any medications received, are charged and coded by the *hospital* inpatient medical coding and billing specialist.

Now, let's pause to complete a Practice Exercise.

✍ Step 23 Practice Exercise 23-5

❑ Choose the best answer from the choices provided.

1. The first step in ICD-9-CM coding is to identify all _____.

a. *Tabular Lists*
b. *Alphabetic Indexes*
c. main terms
d. three-digit codes

2. Assign codes to their _____ level of specificity.

a. individual
b. highest
c. diagnostic
d. subclassified

3. When you assign codes for an outpatient or inpatient diagnosis, the _____ is the first code sequenced.

a. coexisting condition
b. unspecified code
c. principal diagnosis
d. questionable diagnosis

4. Do not assign codes for _____ statements in outpatient settings.

a. rule-out
b. line-in
c. opt-out
d. add-in

For the following items, fill in the blanks as directed.

5. Urinary tract infection

Main term _____

Subterm _____

Coding pathway _____

6. Recurrent appendicitis

Main term _____

Subterm _____

Coding pathway _____

7. Unknown pain in leg

Main term _____

Subterm _____

Coding pathway _____

8. Diaper rash

Main term _____

Subterm _____

Coding pathway _____

9. Loss of appetite

Main term _____

Subterm _____

Coding pathway _____

10. Inflammation of the sinus

Main term _____

Subterm _____

Coding pathway _____

11. High-altitude sickness

Main term _____

Subterm _____

Coding pathway _____

12. Vision examination

Main term _____

Subterm _____

Coding pathway _____

13. Ear examination

Main term _____

Subterm _____

Coding pathway _____

Step 24 Review Practice Exercise 23-5

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. If you have questions, review your lesson material, then contact your instructor.

Step 25 Lesson Summary

- ❑ Think of how much you've already learned about diagnostic coding! You understand how each volume is organized, and you have a firm grasp of the content of each section, appendix and chapter. This lesson also taught you about the numerous conventions of the *ICD-9-CM*. We covered a lot of information here, so if you found any of it confusing, go back and reread the lesson step(s) that you found difficult to understand. And remember, your instructor is available to answer your questions!

  In addition to what you've learned in this lesson, you have seen a lot of examples of actual medical codes. Although looking at all of these codes might have been a bit intimidating at first, remember, just as is true of the *ICD-9-CM*, the more you see these codes and study their uses, the more familiar they will become to you. Before you know it, you'll be using these codes without thinking twice as you embark on your new career as a medical coding and billing specialist!

✉ Step 26 Mail-in Quiz 23

❑ Follow the steps to complete the Quiz.

a. Be sure you've mastered the instruction and the Practice Exercises that this Quiz covers.

b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.

d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your Quiz online.

e. Submit your answers to the school via mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 23

Each item is worth 2.5 points.

Choose the best answer from the choices provided.

1. ICD stands for _____.

a. *Instructional Classification of Diseases*
b. *International Class of Diagnoses*
c. *Instructional Classification of Diagnoses*
d. *International Classification of Diseases*

2. In *ICD-9-CM*, CM stands for _____.

a. *Coding Modification*
b. *Clinical Medicine*
c. *Clinical Modification*
d. *Coding Main Terms*

3. _____ today is used to facilitate payment of medical services and study the cost of health care.

a. Insurance
b. Coding
c. Medicine
d. Billing

4. The ICD coding system appeared in the United States in the _____.

a. 1700s
b. 1600s
c. 1900s
d. 1800s

5. Which of the following is NOT one of the reasons that the number of people who go to the doctor has increased? _____

a. People are living longer and require more health care.
b. The cost of health care has decreased.
c. Technological advances offer more options for better health care.
d. People have better access to health care than ever before.

6. _____ published *Natural and Political Observations Made upon the Bills of Mortality* in 1662.

a. William Farr
b. Bill London
c. John Graunt
d. Bill Graunt

7. The _____ is the directing and coordinating authority for health within the United Nations system.

a. World Heath Organization (WHO)
b. General Register Office of England and Wales
c. International Statistical Institute
d. International Statistical Congress

8. The *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (*ICD-10*) was released in _____.

a. 1989
b. 1994
c. 1979
d. 2000

9. _____ was the first medical statistician.

a. Jesus E. Monjaras
b. Dr. Jacques Bertillon
c. John Graunt
d. William Farr

Determine which code set applies to each description.

10. Lacks laterality _____

a. *ICD-9-CM*
b. *ICD-10-CM*

11. Codes are 3 to 7 characters in length _____

a. *ICD-9-CM*
b. *ICD-10-CM*

12. Flexible for adding new codes _____

a. *ICD-9-CM*
b. *ICD-10-CM*

13. Difficult to analyze data due to nonspecific codes _____

a. *ICD-9-CM*
b. *ICD-10-CM*

14. Detail improves the accuracy of data used in medical research _____

a. *ICD-9-CM*
b. *ICD-10-CM*

15. Limited space for new codes _____

a. *ICD-9-CM*
b. *ICD-10-CM*

16. First digit may be alpha or numeric _____

a. *ICD-9-CM*
b. *ICD-10-CM*

17. Has laterality _____

a. *ICD-9-CM*
b. *ICD-10-CM*

18. Specificity improves coding accuracy and depth of data for analysis_____

a. *ICD-9-CM*
b. *ICD-10-CM*

19. Supports interoperability and the exchange of healthcare data among other countries and the United States _____

a. *ICD-9-CM*

b. *ICD-10-CM*

20. Approximately 15,000 codes _____

a. *ICD-9-CM*

b. *ICD-10-CM*

Choose the best answer from the choices provided. Refer to your *ICD-9-CM* manual when needed.

21. The *Index to Diseases* of the *ICD-9-CM* is in Volume _____.

a. 1

b. 2

c. 3

d. 4

22. Volume 1 of the *ICD-9-CM* is called the _____.

a. *Alphabetic Index*

b. *Tabular List*

c. E Codes List

d. Subsection

23. The codes in *ICD-9-CM* Volume 1 for *Infectious and Parasitic Diseases* are contained in Chapter _____ and range from 001–139.

a. 2

b. 4

c. 11

d. 1

24. The codes in Volume 1 for *Diseases of the Digestive System* are contained in Chapter 9 and range from _____.

a. 629–670

b. 520–579

c. 400–429

d. 570–599

25. Codes ranging from 680–709 cover _____.

a. diseases of the blood and blood-forming organs
b. diseases of the respiratory system
c. complications of pregnancy
d. diseases of the skin and subcutaneous tissue

26. The three types of cross-reference terms are _____.

a. *see also*, *refer to*, *see category*
b. *see*, *see also*, *see category*
c. *refer to*, *glance at*, *always note*
d. *glance at*, *always note*, *see*

27. Suspected conditions are also known as _____.

a. acute conditions
b. recurrent diagnoses
c. unconfirmed diagnoses
d. recurrent conditions

Match each symbol with the correct description.

28. _____ ✓4th ✓5th

29. _____ **Colon :**

30. _____ **Braces }**

a. Used in the *Tabular List* after an incomplete term that requires an adjective or descriptor, which follows it, to be assignable to the category
b. Needs additional digit
c. Enclose a series of terms, each of which is changed by the statement appearing to the right

Match each symbol with the correct description.

31. _____ **Parentheses ( )**

32. _____ **Slanted Brackets *[ ]***

33. _____ **Brackets [ ]**

a. Used in the *Index* and indicate the need for another code in addition to the first code listed
b. Enclose synonyms, alternative wordings or explanatory phrases
c. Enclose supplementary information

Match each word with the correct definition.

34. _____ **Aftercare**

35. _____ **Concurrent**

36. _____ **Residual**

a. Treatment for a patient being treated simultaneously by more than one physician
b. A visit for something planned in advance
c. The long-term conditions resulting from a previous acute illness or injury

Match the disease, system or condition with its correct chapter in the *Tabular List*.

37. _____ **Neoplasms**

38. _____ **Circulatory system**

39. _____ **Digestive system**

40. _____ **Connective tissue**

a. Chapter 9
b. Chapter 2
c. Chapter 7
d. Chapter 13

Congratulations!

You have completed Lesson 23.

Do not wait to receive the results of your Quiz before you move on.

Lesson 24

ICD-9-CM Coding—From Infections to Blood Diseases

Step 1 Learning Objectives for Lesson 24

- When you have completed the instruction in this lesson, you will be trained to do the following:
  - Define and provide examples of the following:
    - infectious and parasitic diseases
    - neoplasms
    - endocrine diseases
    - nutritional diseases
    - metabolic diseases
    - immunity disorders
    - diseases of the blood and blood-forming organs.
  - Apply the rules related to Chapters 1 through 4 of the *Tabular List* in the *ICD-9-CM* manual.
  - Identify the diagnoses, outline the coding pathway and assign the final code for the documented disorders and diseases.

Step 2 Lesson Preview

- Now that you understand the format and conventions of the *ICD-9-CM* you're ready to learn the functions of the manual. In the next few lessons, we're going to group the information from each of the chapters in Volume 1 of the *ICD-9-CM* manual, the *Tabular List,* and show you how to code some of the subject matter included in each chapter. This lesson covers the contents of Chapters 1 through 4: Infectious and Parasitic Diseases; Neoplasms; Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders; and Diseases of the Blood and Blood-forming Organs.

The material in this lesson might seem like a lot of information, but don't worry. You may ask yourself, "Why are we starting with the information in the *Tabular List*, Volume 1, when we've been taught to begin our search for codes in the *Alphabetic Index to Diseases*, Volume 2"? Because the *Tabular List* is organized numerically, it will be easier to discuss each disease category as they are listed in the 17 chapters. We'll work through everything methodically and give you plenty of practice along the way. For example, each chapter of the *ICD-9-CM* manual is divided into sections. Each section contains a group of closely related conditions, or categories. We will define each section for you and show you the important references in the *Tabular List*. Then you will begin the step-by-step process of diagnostic coding for sample dictations and scenarios!

Keep one thing in mind as you code the practice exercises and scenarios throughout the following ICD-9-CM coding lessons: for now, we are focusing *only* on ICD-9-CM codes—*not* CPT (or procedure) codes. You will see physician notes and documentation about specific procedures in some of the scenarios we use just because we want you to practice with authentic examples. But remember that you will code only the diagnoses during these lessons. You will have plenty of time and lots of practice combining procedural and diagnostic codes in later lessons, after you've become more familiar and comfortable with the ICD-9-CM codes.

By the time you finish these diagnostic coding lessons, you'll be using your *ICD-9-CM* book with ease and confidence! You'll know where to look when you need assistance as you code, and you'll have these materials to use as a reference tool during the remainder of the course and in your career as a medical coding and billing specialist. So, get ready... Get set... Let's code!

Get ready . . . Get set . . . Let's code!

🕮 Step 3 Infectious and Parasitic Diseases (001-139), Part 1

- Infectious and parasitic diseases generally are caused by a bacterium, virus, fungus or animal parasite. Occasionally, their cause also may be unknown. These infections can be transmitted from a host organism, or they simply can be created within the human body. Some examples of infectious and parasitic diseases discussed in this chapter are *food poisoning, bubonic plague, HIV, warts* and *thrush*.

  Let's start by opening your *ICD-9-CM* manual to the *Tabular List* at the beginning of the "Infectious and Parasitic Diseases" chapter. At the top of the page, just under the chapter title, you will see a note. Remember what you learned about notes in Lesson 23? The note here in Chapter 1 indicates that you will find the categories for late effects of infectious and parasitic diseases in codes 137 through 139. Below the note, you see INCLUDES. This informs you that you will find diseases generally recognized as communicable or transmissible, and a few diseases of unknown but possibly infectious origin, in this chapter. Below the INCLUDES you'll find EXCLUDES . The EXCLUDES directs you to other codes for diseases that are not included within this chapter.

  One final note on locating codes for this chapter: If, from the dictation you receive, you have trouble finding the main term of a diagnosis in the *Index to Diseases*, turn to the main term *Infection*. The diseases in this chapter are infections, so that is a great place to start when you find yourself stuck! An example of this is Staphylococcus aureus. You will not locate the correct code by using *Staphylococcus* as the main term. Use *Infection* as the main term in the *Index to Diseases*. The subterms *staphylococcal* and *aureus* will lead you to the correct code for this condition.

  Now that you have a bit of information about the "Infectious and Parasitic Diseases" chapter, let's move on to the first section. In each section, we'll provide you with examples so you can see how the codes fall into place.

Intestinal Infectious Diseases (001-009)

Intestinal infectious diseases are located in the intestine. Infectious organisms or parasites cause diseases, which include *cholera, shigellosis, food poisoning, Escherichia coli* (*E. coli)* and *infectious diarrhea.*

Take a look at the section "Intestinal Infectious Diseases (001-009)" in your *ICD-9-CM* book, and see what information is provided. Remember to look for inclusions, exclusions and additional notes to assist you in assigning accurate codes. In this case, you see by the EXCLUDES under the subheading mentioned above, that codes in the 001-009 section are not to be used if you are coding *helminthiases*.

Let's look at a few diseases and the information available in Chapter 1 to assist you as you code. Turn to code **005 Other food poisoning (bacterial)**. The EXCLUDES informs you that if you code food poisonings caused by salmonella infections, you use codes 003.0 through 003.9. Now turn to code **008 Intestinal infections due to other organisms**. You see that this category INCLUDES any condition classifiable to 009.0 through 009.3 with mention of the responsible organisms. Code 008 EXCLUDES food poisoning by diseases with the codes 005.0 through 005.9. If you turn to codes 005.0 through 005.9, you see that those diseases include *staphylococcal, botulism, C. welchii, Clostridia, Vibrio parahaemolyticus, other bacterial food poisonings* and *unspecified food poisoning*. Are you starting to see the importance of the information the *ICD-9-CM* manual provides as you code?

To find the main term, remember to ask yourself, "What is the problem?"

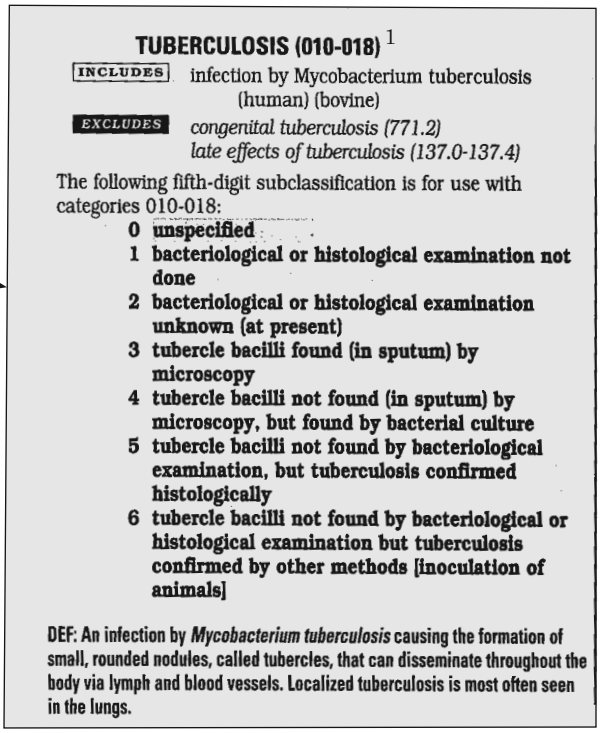
Now, put your *ICD-9-CM* manual to work. Let's say a patient is diagnosed with Salmonella septicemia. To begin your search for the accurate code, start with the *Index to Diseases* in Volume 2 and work through those basic coding steps presented in the previous lesson. To find the main term, remember to ask yourself, "What is the problem?" The problem is septicemia, so locate *Septicemia* in the alphabetical index. Next, ask yourself, "What type of septicemia does the physician say it is?" If you answered *Salmonella*, you're on the right track! Under *Septicemia* in the index, find *Salmonella*. The *Index to Diseases* indicates the tentative code is **003.1**.

But you're not done yet! Remember, this code is only a tentative code. Once you find the code in the *Index to Diseases*, you must always look up that code in the *Tabular List* to determine the highest level of specificity. The *Tabular List* is organized numerically, so you just need to locate 003.1. The description provided in the *Tabular List* for 003.1 is Salmonella septicemia. There are no inclusions, exclusions, additional digits or notes provided. Therefore, you will assign code **003.1 Salmonella septicemia** for the diagnosis.

Tuberculosis (010-018)

The second section in Chapter 1 of the *Tabular List* is "Tuberculosis (010-018)." **Tuberculosis** is an infectious disease caused by the genus Mycobacterium. At one time, tuberculosis was one of our society's most deadly diseases, but the invention of new drugs has steadily decreased the spread of this disease since the 1950s. Nevertheless, the illness still afflicts nearly 25,000 Americans every year, most of whom have lung disease. **Tubercles**, or small, rounded lesions and tissues that begin to resemble cheese are a couple of the characteristics of the disease. Tuberculosis can affect any organ, although the disease usually is found in the lung.

What does the *Tabular List* tell us about tuberculosis? Let's take a look. The section "Tuberculosis (010-018)" INCLUDES infection by Mycobacterium tuberculosis (human) (bovine). It EXCLUDES congenital tuberculosis (771.2) and late effects of tuberculosis (137.0-137.4). Do you see a shaded box similar to this one?



TUBERCULOSIS (010-018) [1]

INCLUDES infection by Mycobacterium tuberculosis (human) (bovine)

EXCLUDES *congenital tuberculosis (771.2)*
late effects of tuberculosis (137.0-137.4)

The following fifth-digit subclassification is for use with categories 010-018:

- **0 unspecified**
- **1 bacteriological or histological examination not done**
- **2 bacteriological or histological examination unknown (at present)**
- **3 tubercle bacilli found (in sputum) by microscopy**
- **4 tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture**
- **5 tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically**
- **6 tubercle bacilli not found by bacteriological or histological examination but tuberculosis confirmed by other methods [inoculation of animals]**

DEF: An infection by *Mycobacterium tuberculosis* causing the formation of small, rounded nodules, called tubercles, that can disseminate throughout the body via lymph and blood vessels. Localized tuberculosis is most often seen in the lungs.

This boxed information indicates that all codes in the 010 through 018 range require a fifth-digit subclassification. This means that if you submit **011.0** as a code for **infiltrative pulmonary tuberculosis**, the code is invalid because a fifth digit is required. You will need to use the boxed chart to determine the final digit.

Now let's use the following dictation to practice what you've just learned:

Pathology Report

CHIEF COMPLAINT: Productive cough, rule out tuberculosis

LABORATORY FINDINGS: Sputum was positive for AFB by microscopy. PPD was positive. Hct 25, MCV 72, total protein 5.8; iron studies pending

IMPRESSION: Miliary tuberculosis

Your first step is to determine the main term, and then locate that term in the *Index to Diseases*. The condition is *tuberculosis*, so locate that term in the index. What type of tuberculosis is it? It is miliary tuberculosis. The answers to these questions tell you the coding pathway in the index is *Tuberculosis, miliary*.

The tentative diagnostic code indicated is **018.9** ✓. However, you know that if you stop here, your code is invalid. Turn to the *Tabular List* to determine the highest level of specificity. Locate code 018.9 in the *Tabular List,* then look to the beginning of the category, which provides you with the information for the fifth-digit subclassification. The dictation indicates that the tuberculosis was found in the sputum by microscopy, which means **3** is the correct fifth digit. Therefore, the code you assign for the diagnosis of miliary tuberculosis found in the sputum by microscopy would be **018.93 Miliary tuberculosis, unspecified, tubercle bacilli found (in sputum) by microscopy**.

Zoonotic Bacterial Diseases (020-027)

The next section in the "Infectious and Parasitic Diseases" chapter is "Zoonotic Bacterial Diseases (020-027)." **Zoonotic bacterial diseases** are transmitted from animal to person under natural conditions. Diseases in this section include the *plague, deerfly fever* and *anthrax*. The **bubonic plague** is the most common, acute and severe form of the plague characterized by lymphadenopathy, chills, fever and headache.

Other Bacterial Diseases (030-041)

The section "Other Bacterial Diseases (030-041)" covers *leprosy, diphtheria, whooping cough, scarlet fever, tetanus* and *septicemia*. In this section, you will find an EXCLUDES that directs you to use codes 098.0 through 099.9 if you are coding bacterial venereal diseases. The EXCLUDES also indicates that you are to use code 088.0 if you are coding bartonellosis.

Locate **033 Whooping Cough** in the *Tabular List*. Do you see the note to use an additional code to identify any associated pneumonia? This means that if whooping cough is documented with pneumonia in the dictation you receive, you must code the pneumonia, as well. You will find similar directions under code **041 Bacterial infection in conditions classified elsewhere and of unspecified site**. The note informs you that this category is provided for use as an additional code to identify the bacterial agent in diseases classified elsewhere. You will also use this category to classify bacterial infections of unspecified nature or site. As you continue reading, you will see that *septicemia* is excluded.

Let's try an example. As a medical coding and billing specialist, you must code laryngeal diphtheria. As usual, you begin in the *Index to Diseases* with the main term *Diphtheria*. The subterm is *laryngeal*, the type of diphtheria. The coding pathway of *diphtheria, laryngeal* indicates **032.3** as the tentative code. Turn to the *Tabular List* and locate 032.3 to determine the highest level of specificity. Based on the information here, you will assign the ICD-9-CM code **032.3 Laryngeal diphtheria**.

Septicemia is treated with antibiotics and fluid hydration.

Septicemia is a systemic infection associated with organisms in the bloodstream. Symptoms of septicemia include fever, malaise and, possibly, impaired organ function. Septicemia is treated with antibiotics and fluid hydration. It is a serious condition that could lead to death.

What information does the *ICD-9-CM* manual provide about septicemia? In the *Tabular List*, code category 038 states to use an "additional code for systemic inflammatory response syndrome (SIRS) (995.91-995.92)." This general statement requires some more detail for accurate coding, and you will find that information in the guidelines in the front of your *ICD-9-CM* manual.

As you see in the *Tabular List,* category 038 codes for septicemia. In most cases, you will use code 038 in conjunction with code 995.9 ✓. However, sepsis or SIRS must be documented for you to use the 995.9 ✓ code. Let's look at some examples for a better understanding of when you need to apply the additional code, and when it is not necessary.

Streptococcal septicemia. The coding pathway is *Septicemia, streptococcal,* which you use to locate the tentative code of **038.0**. You then turn to the *Tabular List* to verify the highest level of specificity for this code. The note indicates to use an additional code for SIRS. But SIRS or sepsis is not documented; therefore, you will assign **038.0 Streptococcal septicemia** as the only code for this diagnosis.

Streptococcal sepsis. This is a challenging diagnosis to code because the pathway is not straightforward and requires some knowledge about the disease. **Sepsis** occurs when there is a breakdown of local defense barriers, which permits the spread of an infection, or absorption of toxic materials. Sepsis may be seen as *cellulitis*, *lymphangitis*, *lymphadentitis* or *septicemia*. So septicemia is a form of sepsis. If the physician documents streptococcal sepsis, you will code **038.0 Streptococcal septicemia** in conjunction with the **SIRS** (Systemic inflammatory response syndrome) code **995.91**.

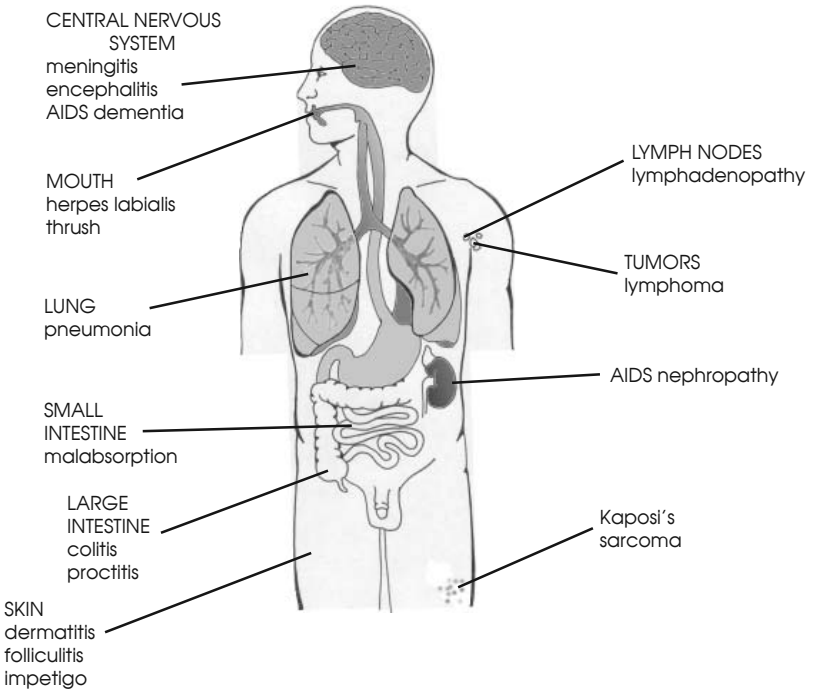
Although we won't focus on the codes in Chapter 17 for awhile, you will find it helpful to familiarize yourself with code 995.9 in the *Tabular List* now. Take a look at the five-digit code 995.91 from above, together with its detailed description: **995.91 Systemic inflammatory response syndrome (SIRS), Sepsis**.

Human Immunodeficiency Virus (HIV) Infection (042)

HIV is a virus that can be separated into two stereotypes: *HIV-1* and *HIV-2*. **HIV** is the cause of *acquired immunodeficiency syndrome*, or *AIDS*. HIV-1 is found worldwide, while HIV-2 is largely confined to West Africa. As its name implies, **AIDS** is a syndrome (a mixture of symptoms) that results from severe immunodepression caused by the human immunodeficiency virus (HIV). AIDS is the profound depression of cell-mediated immunity that affects patients with a wide variety of backgrounds.

HIV cannot survive outside of human cells, and humans are the only source of HIV infection. HIV is transmitted from one person to another by close contact that allows for the transfer of body fluids.

AIDS affects almost all organs of the body. Because the body can no longer fight infection or organ disease, AIDS victims eventually become ill with cancer, pneumonia and many other diseases. AIDS is a prime example of the body's immune system malfunctioning to the point that all organs eventually become affected, as the following figure shows.



Body sites commonly affected by AIDS

ICD-9-CM Guidelines for HIV

Following are some rules to keep in mind when coding HIV and AIDS. They are taken from the *Coding Guidelines, C. Chapter-Specific Coding Guidelines* in the front on the *ICD-9-CM* manual. Be sure to review these guidelines in detail when you use code 042 for any patient. The guidelines also discuss code V08 for asymptomatic HIV. We will discuss V codes in a later lesson, but be aware that this is an important code when coding for patients who have tested positive for HIV but are currently showing no symptoms of the disease.

- Code only confirmed cases of HIV infection or illness stated by a physician. In other words, if the physician does not document HIV as a definite diagnosis, then you cannot code for it.

- When a patient is treated for an HIV-related condition or infection, code 042 as the principal diagnosis, followed by additional codes for related diagnoses. Many conditions can be related to HIV such as pneumonia or thrush. If the patient has an HIV-related condition, you must use code 042 as the principal diagnosis code and then code for the condition.

- When an HIV patient is being treated for an unrelated condition (e.g., fracture of ankle), code *that* condition as the principal diagnosis. Then code 042 as an additional diagnosis to identify the patient's HIV status. In the example given, the fractured ankle is unrelated to the HIV infection. The fracture is the reason the patient is being treated, so the code for the fractured ankle is listed as the principal diagnosis, and the HIV status is coded as a secondary diagnosis.

- Use **V08 Asymptomatic human immunodeficiency virus [HIV] infection status** for patients with no documented symptoms but with a positive HIV test result. You will *not* use code V08 if AIDS is already documented or if the patient has any HIV-related illnesses. Once a patient has had documented symptoms of HIV, V08 cannot be used again.
- Code **795.71 Nonspecific serologic evidence of human immunodeficiency virus [HIV]** for patients with inconclusive HIV serology but no definitive diagnosis or manifestations of the illness. Use this code *only* if test results are inconclusive and HIV has not been given as a definitive diagnosis.
- Once a patient has been coded 042, you must use this code on every following visit. You cannot assign 795.71 or V08 to that patient again.

Now take a look at the following dictation and consider how you would code the diagnosis if you were the medical coding specialist in this clinic.

SUBJECTIVE
A 24-year-old established patient is seen at the clinic for 2-week history of flu-like symptoms, including fever, headache, and tiredness. Patient history indicates weight loss and an enlarged lymph node x 3 months. Social history of intravenous drug abuse.

OBJECTIVE
After a comprehensive examination, HIV antibody and Western blot tests were ordered.

ASSESSMENT
Symptoms are consistent with HIV. Results of the HIV antibody and Western blot tests confirm the patient is HIV positive.

PLAN
The patient is provided a prescription for Retrovir.

Once again, use your *ICD-9-CM* manual to practice. You know the problem is that the person has an infection. The type of infection is HIV, and the virus is showing symptoms. Locate the main term *Infection* in the *Index to Diseases*, followed by the subterm *HIV*.

If you stop there, you will have the tentative code, V08. **Asymptomatic** means there are no symptoms. In the example, the physician dictated that there were symptoms, so you must continue your search for the correct code. Just below the term *HIV*, you see: *with symptoms, symptomatic* 042. Turn to code **042** in the *Tabular List* to determine the highest level of specificity so that you know you have accurately coded the symptomatic HIV infection. You will then assign **042 Human immunodeficiency virus [HIV] disease** as the correct code.

Before we move on to the other sections, let's review what you've learned so far. You'll get a little hands-on practice here, too!

✍ Step 4 Practice Exercise 24-1

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Food poisoning**
   ICD-9-CM code: _____

2. **Infiltrative pulmonary tuberculosis, found by culture**
   ICD-9-CM code: _____

3. **Rabbit fever**
   ICD-9-CM code: _____

4. **Pertussis**
   ICD-9-CM code: _____

5. **Septicemia due to Bacteroides**
   ICD-9-CM code: _____

6. **Pneumocystis carinii pneumonia with AIDS**
   ICD-9-CM code: _____
   ICD-9-CM code: _____

Use the following information to complete the CMS-1500 that follows:

7. ICD-9-CM Coding/Billing Challenge

James Hahns, MD
800 Medical Court
Yourtown, CO 80000
(970) 555-2222

Patient Information

Name Rebecca Bloomquist
Address 409 Yorkshire
City Yourtown **State** CO
ZIP 80001
Home Phone 970-555-5875
Date of Birth June 25, 1997
Sex F **Marital Status** single

Employment Information

Name of Employer
Occupation
Student X **Full-time** **Part-time**

Insurance Information

Primary Insurance
Name Med Link HMO
ID# 521 00 900602
Group# WBHMO
Address PO Box 560
City Yourtown
State CO **ZIP** 80001
Primary Insured Name Dick Bloomquist
Relation to Patient father
DOB 03-10-1967
Employer Wilton Bookstore

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Dick Bloomquist
Signature of patient (or parent of minor child)

Secondary Insurance
Name none
ID#
Group#
Address
City
State **ZIP**
Secondary Insured Name
Relation to Patient
DOB
Employer

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

_____
Signature of patient (or parent of minor child)

Physician signature: *James Hahns MD*
SSN: 900-00-9000
NPI: 0405674390
Participating Provider for: Medicaid and all private insurance

Date of Service	*5-8-20XX*	
Diagnosis	**Procedure**	**Charge**
	99283 Emergency Dept. Level 3	*$187.00*

Today's Charge	$187.00
Cash/Check	$0.00
Balance	$187.00

Rebecca Bloomquist
DOB: 6-25-1997
Date of service 5-8-20XX

SUBJECTIVE
The patient presents to the emergency department with fever, chills, lethargy and loss of appetite for the past 2 days.

OBJECTIVE
Physical examination was significant for fever and decrease in body temperature and blood pressure. Hands and feet are cold to the touch. Urine culture, CBC and blood gasses are ordered. Patient is given IV fluid and oxygen.

ASSESSMENT
Lab results indicate gram-negative septicemia with systemic inflammatory response syndrome.

PLAN
Patient is admitted by her PCP for further treatment.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid#) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH SEX M F

b. OTHER INSURED'S DATE OF BIRTH SEX M F

b. AUTO ACCIDENT? YES NO Place (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1.														NPI	
2.														NPI	
3.														NPI	
4.														NPI	
5.														NPI	
6.														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

a. b.

Step 5 Review Practice Exercise 24-1

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 6 Infectious and Parasitic Diseases (001-139), Part 2

- ❑ Now that you've "gotten your feet wet" with some real coding practice on a number of different diseases, let's continue learning about the diseases contained in Chapter 1 of your *ICD-9-CM* manual's *Tabular List*.

Poliomyelitis and Other Non-Arthropod-Borne Viral Diseases and Prion Diseases of Central Nervous System (045-049)

This section focuses on viral diseases of the central nervous system that are *not* caused by parasites or infective organisms. Symptoms of these diseases are fever, sore throat, headache and vomiting, often with stiffness of the neck and back.

Code category 045 is another example of codes that require the fifth-digit subclassification. Turn to code category 045 in your *ICD-9-CM*. Under code **045 Acute poliomyelitis**, you see a note that indicates you must submit a five-digit code for your code to be accurate for this code category. The fifth-digit indicates the poliovirus type.

Now let's code nonparalytic poliomyelitis. To begin coding, you must determine the coding pathway. The main term is *Poliomyelitis*, and the subterm is *nonparalytic*. When you follow that coding pathway, you will find the tentative code **045.2** ✓ in Volume 2, the *Index to Diseases*. Now turn to **045.2** in the *Tabular List* to determine the highest level of specificity. The description is **acute nonparalytic poliomyelitis**, yet *acute* is not in the dictation. So is 045.2 the correct code?

To begin coding, you must determine the coding pathway.

First, think back to your coding pathway. Did you locate the main term and subterm correctly? Yes. Next, look at the terms under **045.2 Acute nonparalytic poliomyelitis** and you will see **Poliomyelitis (acute)** listed. Do you remember those nonessential modifiers you learned about previously? The words in parentheses here are nonessential modifiers. They may or may not be in the dictation you receive, and they do not affect the code you assign. This means that code **045.2** is correct, but it is lacking the fifth-digit. Refer to the shaded box at the beginning of the 045 code group, and you'll find the fifth-digit subclassification is 0 for **poliovirus, unspecified type**. You will assign **045.20 Acute nonparalytic poliomyelitis, poliovirus, unspecified type** as the final code for this condition.

Viral Diseases Generally Accompanied by Exanthem (050-059)

Viral diseases accompanied by **exanthem** are diseases that cause skin rashes, such as *smallpox*, *cowpox*, *chickenpox*, *herpes zoster*, *herpes simplex*, *measles* and *rubella*. Here are a few quick facts about some of these diseases:

- **Variola major** is a form of smallpox known for its high mortality. This disease exists only in laboratories.
- **Cowpox** is a disease one contracts by milking infected cows.
- **Chickenpox** is also known as *varicella*.
- **Herpes zoster** is an infection that tends to cease after a definite period of time. It causes unilateral skin eruptions along affected nerves.
- **Rubella** is an acute but usually benign infection that causes fever, sore throat and rash.

You'll find that most coding in this section is straightforward. Fourth and fifth digits are provided in the *Tabular List*. Be sure to review each tentative code to verify inclusions, exclusions and additional notes that will assist you.

Arthropod-Borne Viral Diseases (060-066)

The "Arthropod-borne Viral Diseases (060-066)" section focuses on diseases that parasites and infective agents cause. These are diseases such as *yellow fever, mosquito-borne viral encephalitis, tick-borne viral encephalitis* and *West Nile fever*. **West Nile fever** is mosquito-borne and may cause fatal inflammation of the brain, the lining of the brain or the lining of the brain and spinal cord.

West Nile fever is mosquito-borne.

Now see how quickly you can determine the correct code or codes for this sample dictation.

SUBJECTIVE
A 54-year-old male has just returned from a trip to Asia and complains of fever, headache, lethargy, conjunctivitis and lower back pain.

OBJECTIVE
Lab tests indicate serological detection of IgM and IgG antibodies.

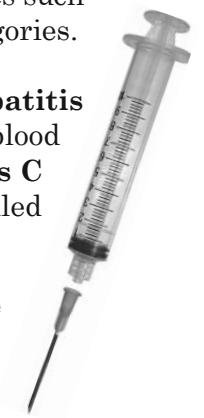
ASSESSMENT
Sandfly fever.

PLAN
CDC (Center for Disease Control and Prevention) will be contacted for treatment.

To accurately code this condition, begin with the main term *Fever* in the *Index to Diseases*. Once you have located *Fever*, find *sandfly*, the subterm, for the tentative code **066.0**. Then turn to the *Tabular List* and find this code to determine the highest level of specificity. You will assign as the correct code **066.0 Phlebotomus fever** for the diagnosis of sandfly fever.

Other Diseases Due to Viruses and Chlamydiae (070-079)

The "Other Diseases Due to Viruses and Chlamydiae" section includes diseases such as *viral hepatitis, rabies, warts* and *mumps*. Viral hepatitis has several categories. **Hepatitis A** often is found in areas of poor hygiene and low socioeconomic standards. This form of hepatitis is transmitted via the fecal-oral route. **Hepatitis B** is transmitted through contaminated needles, syringes, instruments and blood products. This form of hepatitis also is spread by intimate contact. **Hepatitis C** is the most common form of post-transfusion hepatitis. **Hepatitis E**, also called **non-A and non-B**, usually is transmitted through contaminated water.



Hepatitis B may be transmitted through contaminated needles, syringes, instruments and blood products.

You will find the fifth-digit subclassification for codes 070.2 and 070.3 under the **070 Viral hepatitis** heading. Turn to 070 in the *Tabular List* now, and look at the shaded fifth-digit subclassification box.

Let's practice by looking up the diagnosis code for viral hepatitis B with a hepatic coma. You will find the main term *Hepatitis* in the *Index to Diseases*. Once you have located the main term, find the subterms *viral* and *type B*. But your search is not complete yet! Once you have located the subterms *with* and *hepatic coma*, you are provided the tentative code of **070.20**. You then turn to the *Tabular List* to determine the highest level of specificity. You will assign code **070.20 Viral hepatitis B with hepatic coma, acute or unspecified, without mention of hepatitis delta.**

Rickettsioses and Other Arthropod-Borne Diseases (080-088)

Rickettsia is a type of parasitic organism. These organisms multiply by invading the cells of another life form, usually arthropods (lice, fleas, ticks and mites). These arthropods can then transmit rickettsiae to rodents, dogs and even humans through saliva from a bite or feces being deposited on a small break in the skin. The codes in this section are fairly simple; but do note that when you look in this section of the *Tabular List*, you will find instructions to use codes 060.0 through 066.9 for arthropod-borne viral diseases instead of the codes you find in this section. If you have a hard time understanding anything in this section, call your instructor. Remember, we want you to succeed, and your instructor will be available to answer your questions!

The use of the *ICD-9-CM* manual gets easier with practice.

Use of the *ICD-9-CM* manual gets easier with practice. The more you use the volumes and learn to recognize additional information, the easier diagnostic coding becomes! Now let's take a few minutes to review the sections you just studied.

✍ Step 7 Practice Exercise 24-2

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Viral encephalitis**
   ICD-9-CM code: _____

2. **Varioloid**
   ICD-9-CM code: _____

3. **Measles with otitis media**
   ICD-9-CM code: _____

4. **German measles**
   ICD-9-CM code: _____

5. **West Nile fever**
   ICD-9-CM code: _____

6. **Rabies**
   ICD-9-CM code: _____

7. **Hand, foot and mouth disease**
   ICD-9-CM code: _____

8. **Lyme disease**
   ICD-9-CM code: _____

9. **ICD-9-CM Coding Challenge**

   SUBJECTIVE
   Two weeks ago this 7-year-old female presented with a low-grade fever, headache, and stuffy nose lasting three days. A couple of days after symptoms subsided, patient noticed a bright red rash on her face. Patient now presents with similar rash on trunk, arms, and legs, times one week.

   OBJECTIVE
   Physical examination reveals net-like rash on face, trunk, arms and legs.

   ASSESSMENT
   Patient has fifth disease.

   PLAN
   Plenty of bed rest. Drink lots of clear fluids and take acetaminophen as needed to reduce fever. Call office if rash does not begin to clear within 10 days.

   ICD-9-CM code: _____

🕮 Step 8 Review Practice Exercise 24-2

❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

🕮 Step 9 Infectious and Parasitic Diseases (001-139), Part 3

❑ This is the final section in Chapter 1 of the *ICD-9-CM* manual's Volume 1, the *Tabular List*. So read on, and let's finish the diseases in this chapter!

Syphilis and Other Venereal Diseases (090-099)

Syphilis is a chronic infectious disease usually transmitted through sexual contact. Untreated syphilis progresses through three clinical stages: primary, secondary and tertiary. In the **primary stage** of syphilis, a painless lesion appears. The **secondary stage** produces widespread lesions. The **tertiary stage** produces destructive lesions that involve many organs and tissues.

If you turn to "Syphilis and Other Venereal Diseases (090-099)" in the *Tabular List*, you'll find that this section EXCLUDES nonvenereal endemic syphilis, stating that you should use code 104.0 instead; it also EXCLUDES urogenital trichomoniasis, stating you should use code 131.0 instead.

Turn again to your *ICD-9-CM* manual for some coding practice in this section, using the following dictation sample:

SUBJECTIVE
A 19-year-old female is seen in the emergency department complaining of a sore on her buttocks. Sore was noted about 13 days ago.

OBJECTIVE
Anus was examined. Blood tested positive for syphilis.

ASSESSMENT
Primary anal syphilis.

PLAN
Patient discharged with prescription for antibiotics.

As the medical coding and billing specialist, you begin with the main term *Syphilis* in the *Index to Diseases*. The subterms *anus* and *primary* will direct you to **091.1** as the tentative code. To determine the highest level of specificity, locate that code in the *Tabular List*. Based on what you find there, you can then assign code **091.1 Primary anal syphilis** as the accurate code.

Other Spirochetal Diseases (100-104)

A **spirochete** is a spiral-shaped bacterium that causes diseases such as *leptospirosis*, *yaws* and *pinta*. **Leptospirosis** is a rare disease where the spirochete is harbored by rodents and excreted in their urine. After about one to three weeks, there is an acute illness with fever, chills, an intense throbbing headache, severe muscle aches, eye inflammation and a skin rash. The kidneys are severely affected, and there is jaundice due to liver damage. **Yaws** is an infection that mainly affects the skin and bones. It is found throughout the poorer subtropical and tropical areas of the world. It is almost always acquired by children. After about three or four weeks following infection, an itchy, raspberry-like growth appears. Scratching spreads the infection. **Pinta** occurs in some remote villages in tropical America. It is unknown how the disease is spread. Small spots surrounding a large spot appear on the face, neck, buttocks, hands or feet. About one to twelve months later, red skin patches appear. They eventually turn blue, then brown and finally white.

Although the codes in this section are not used much because these diseases are rarely seen, be sure to call your instructor if you have any questions as you read through the details about them in your coding manual.

Mycoses (110-118)

Mycoses are diseases such as *dermatophytosis*, *candidiasis*, *coccidioidomycosis* and others that are caused by a fungus. **Dermatophytosis** is a common fungal infection of the skin, hair and nails. **Candidiasis** is a fungal infection usually found in the mucous membranes or on moist skin. **Coccidioidomycosis** is caused by inhalation of dust particles that contain arthrospores. This disease is a self-limiting respiratory infection, and the primary form is known as **San Joaquin fever**, **desert fever** or **valley fever**.

Many do not discover they suffer from mycoses until diseases such as those just mentioned are activated because of the fungus.

The *Tabular List* instructs you to use additional codes to identify the manifestations of the diseases in this section. You'll recall that manifestations are signs of a disease, or the outward expressions of an underlying condition.

Let's work through an example. As the medical coding and billing specialist for a pediatrician, you have the following situation to code:

> *An office visit takes place for an established patient with oral thrush. A detailed history and problem focused examination are documented. The pediatrician prescribes antifungal agent for oral thrush and instructs the patient to return if the problem persists.*

Open your *ICD-9-CM* manual to the main term *Thrush* in the *Index to Diseases*. The subterm *oral* has no effect on the tentative code **112.0**. Determine the highest level of specificity for this code in the *Tabular List*. Note that the description for code **112.0 Candidiasis, Of mouth** is appropriate because **thrush (oral)** is included in that description. Therefore, you assign code **112.0** as the correct code.

How are you doing by this point? Are you beginning to automatically move through the steps of identifying the main term and subterm? Are you then using these terms to locate the condition in the *Index to Diseases,* and then going to the *Tabular List* to determine the degree of specificity and confirm the accuracy of the tentative code you've selected? If the process doesn't feel quite automatic yet, be patient—it's only a matter of time until you'll be coding more easily, without having to think about each step you take.

Helminthiases (120-129)

Helminthiases are infections associated with worms. Diseases of this section include *tapeworms, hookworms* and other intestinal parasites. For example, **echinococcosis** is an infection caused by larval forms of tapeworms. Direct contact with infected feces transmits this disease. Most people with echinococcosis are asymptomatic until cysts are formed, which then cause pain, occlusion or organ dysfunction.

Other Infectious and Parasitic Diseases (130-136)

Diseases of this section are *toxoplasmosis, scabies* and *sarcoidosis*. As the title suggests, these diseases are either contagious or the result of parasites. Some examples of parasites that can cause diseases in these code groups are lice, mites and fleas.

For our coding example in this section, let's code trichomonal urethritis. To begin your search for the accurate code, once again start with the *Index to Diseases*. To find the main term, remember to ask yourself, "What is the problem?" The problem is urethritis, so locate *Urethritis* in the alphabetical index. Next, ask yourself, "What type of urethritis does the physician say it is?" If you answered *trichomonal*, you're on the right track! Under *Urethritis* in the index, find *trichomonal*. The *Index to Diseases* indicates the tentative code is **131.02**. Determine the highest level of specificity of this code in the *Tabular List*. Based on the information there, you can confidently assign **131.02 Trichomonal urethritis** as the correct code for this condition.

Late Effects of Infectious and Parasitic Diseases (137-139)

Remember that using the term *late effects* indicates that an infection no longer is present. Do you remember learning about late effects in a previous lesson? If a residual condition was documented with the late effect, you would code that condition first, and then the late effect. Turn to code groups 137, 138 and 139 in your manual, and be sure to read the notes associated with each group before you complete the Practice Exercise for this section.

✍ Step 10 Practice Exercise 24-3

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Early cardiovascular syphilis**
   ICD-9-CM code: _____

2. **Acute gonococcal cystitis**
   ICD-9-CM code: _____

3. **Fungal infection of the foot**
   ICD-9-CM code: _____

4. **Desert fever**
   ICD-9-CM code: _____

5. **Hookworm disease**
   ICD-9-CM code: _____

6. **Norwegian scabies**
   ICD-9-CM code: _____

Use the following information to complete the CMS-1500 that follows:

7. ICD-9 Coding/Billing Challenge

James Hahns, MD
800 Medical Court
Yourtown, CO 80000
(970) 555-2222

Patient Information

Name Benjamin Fox
Address 1227 Comet Drive Apt 6B
City Springtown **State** CO
ZIP 80002
Home Phone 970-555-1001
Date of Birth 12/2/70
Sex male **Marital Status** single

Employment Information

Name of Employer Philco Gas
Occupation Driver
If Minor, Name of School

Insurance Information

Primary Insurance
Name Mountain States
ID# 520 00 7777
Group# 120
Address 1801 SW Vine St
City Denver
State CO **ZIP** 80217
Primary Insured Name Benjamin Fox
Relation to Patient Self
Employer Philco Gas

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Benjamin Fox
Signature of patient (or parent of minor child)

Secondary Insurance
Name
ID#
Group#
Address
City
State **ZIP**
Secondary Insured Name
Relation to Patient
Employer

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Signature of patient (or parent of minor child)

Physician signature: James Hahns MD

SSN: 900-00-9000
NPI: 0405674390
Participating Provider for: Medicaid and all private insurance

Date of Service	6/14/XX	
Diagnosis	**Procedure**	**Charge**
	99213 Established patient Level 3	$63.00

Today's Charge	$63.00
Cash/Check	$0.00
Balance	$63.00

Name: Benjamin Fox
DOB: December 2, 1970
Date of Service: June 14, 20XX

CHIEF COMPLAINT
The patient comes for a routine follow-up appointment.

HISTORY OF PRESENT ILLNESS
This is a middle-aged African American male who comes today for routine follow-up. He has no acute complaints. No neurological deficits or other specific problems. The patient denies any symptoms associated with opportunistic infection.

PAST MEDICAL HISTORY
Immunizations: Up to date.
Current medications: (1) He is on Trizivir 1 tab p.o. b.i.d. (2) Ibuprofen over the counter p.r.n.
Medication compliance: The patient is 100% compliant with his meds. He reports he does not miss any doses. Drug intolerance: There is no known drug intolerance in the past.
Illnesses: (1) Significant for HIV. (2) Chronic hepatitis. (3) PPD status was negative in the past. PPD will be placed again today. Treatment adherence counseling was performed by both nursing staff and myself. Again, the patient is 100% compliant with his meds. Last dental exam was in 11/07, where he had 2 teeth extracted.
ALLERGIES: HE HAS NO KNOWN DRUG ALLERGIES.
Nutritional status: The patient eats regular diet and eats 3 meals a day.
Sexual history: He has had no recent STDs, and he is not currently sexually active.
Mental health and substance abuse: No history of substance abuse.

REVIEW OF SYSTEMS: Noncontributory except as mentioned in the HPI.

PHYSICAL EXAMINATION
GENERAL: This is a thinly built male, not in acute distress.
VITAL SIGNS: Blood pressure 132/89 and pulse of 82.
HEAD AND NECK: Reveals bilaterally reactive pupils. Supple neck. No thrush. No adenopathy.
HEART: Heart sounds S1 and S2 regular. No murmur.
LUNGS: Clear bilaterally to auscultation.
ABDOMEN: Soft and nontender with good bowel sounds.
NEUROLOGIC: He is alert and oriented x 3 with no focal neurological deficit.
EXTREMITIES: Peripheral pulses are felt bilaterally. He has no pitting pedal edema, clubbing or cyanosis.
GENITALIA: Examination of external genitalia is unremarkable. There are no lesions.

DATABASE
Most recent labs show hemoglobin and hematocrit of 16 and 46. Creatinine of 0.6. LFTs within normal limits. Viral load of less than 48 and CD4 count of 918.

CONTINUED

ASSESSMENT
1. Human immunodeficiency virus, stable on Trizivir.
2. Chronic hepatitis C, stable.

PLAN
Continue his current meds. I have discussed with him in the past about possibility of having to change off of his Trizivir in the future, if he develops resistance, since triple NRTI therapy is not the preferred, but he is not amenable to that at this time. He has excellent viremic control and good CD4 count. We will readdress this with him in the future if his status changes. The patient is to have PPD placed today. He has received his annual influenza vaccination for this season. He will be seen again by the dental clinic for routine evaluation and have labs today including CD4, viral load, RPR, and urinalysis. He will return to our clinic in 6 months. The patient does not want to be seen more often since he has a job that he reports to and cannot miss more days off work. Again this is acceptable since he has excellent viremic control. The patient has been educated regarding his meds and plan. His prognosis is excellent, and he will follow up with us in 6 months.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid#) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH SEX M F

b. OTHER INSURED'S DATE OF BIRTH SEX M F

b. AUTO ACCIDENT? YES NO Place (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1.														NPI	
2.														NPI	
3.														NPI	
4.														NPI	
5.														NPI	
6.														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

a. b.

Step 11 Review Practice Exercise 24-3

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 12 Neoplasms (140-239)

- ❑ All neoplasms are classified in Chapter 2 of the *ICD-9-CM* manual's *Tabular List*. The following sections are included there:

140-195	Malignant neoplasms, stated or presumed to be primary, of specified sites, except of lymphatic and hematopoietic tissue
196-198	Malignant neoplasms, stated or presumed to be secondary, of specified sites
199	Malignant neoplasms, without specification of site
200-208	Malignant neoplasms, stated or presumed to be primary, of lymphatic and hematopoietic tissue
209	Neuroendocrine tumors
210-229	Benign neoplasms
230-234	Carcinoma in situ
235-238	Neoplasms of uncertain behavior
239	Neoplasms of unspecified nature

In the *ICD-9-CM* manual, neoplasms are classified according to the following:

1. *Behavior of the neoplasm*, such as malignant or benign
2. *Anatomical site involved*, such as lung, brain or stomach
3. *Morphology type*, such as leukemia, melanoma or adenocarcinoma

Let's look at each in more detail.

Classification by Behavior

The term **neoplasm** refers to any new and abnormal growth. The following definitions describe the behavior of specific neoplasms:

Malignant—Malignant neoplasms are collectively referred to as *cancers*.

Primary—This term refers to the site at which a neoplasm originated.

Secondary—This term refers to the site or sites to which the neoplasm has spread from the primary site.

In Situ—This term describes the situation when the tumor cells are undergoing malignant changes but still are confined to the point of origin without invasion of the surrounding normal tissue.

Benign—This term refers to noncancerous growths. In *benign neoplasms*, growth does not invade adjacent structures or spread to distant sites, but it might displace or exert pressure on adjacent structures.

Uncertain Behavior—This term refers to tumors that the pathologist cannot classify as benign or malignant because some features of each type are present.

Unspecified Nature—This term refers to tumors in which neither the behavior nor the histological type are specified in the diagnosis.

The Neoplasm table is in Volume 2, *Index to Diseases*, under the main term *Neoplasm*. This table includes seven columns, with the first column listing the anatomical sites in alphabetic order. The remaining six columns identify the behavior of the neoplasm. The first three columns include codes of *Malignant* neoplasms and are further classified as *Primary, Secondary* and *Ca in Situ,* which stands for *Carcinoma in Situ*. The fourth column identifies codes for *benign* neoplasms. The last two columns include codes for neoplasms of *Uncertain Behavior* or of *Unspecified* type.

Classification by Primary Site

The primary site is defined as the tumor's point of origin. In some cases, the physician cannot identify the primary site; in these cases, the code 199.1 is provided for *unknown site or unspecified*. You can assign this code whether the site is primary or secondary in nature.

When adjunct chemotherapy or radiotherapy follows surgical removal of a primary-site malignancy, you assign the malignancy code as long as chemotherapy or radiotherapy is actively administered. If a primary malignant neoplasm that previously was removed by surgery or eradicated by radiotherapy or chemotherapy reoccurs, you assign the primary malignant code for that site unless the *Index to Diseases* directs you otherwise.

The terms *metastasis* and *direct extension* both are classified as secondary malignant neoplasms in the *ICD-9-CM* manual. Cancer described as metastatic to a specific site is interpreted as a secondary neoplasm of that site. We'll discuss this in more detail shortly.

Classification by Morphology Type

The morphology type of a neoplasm is determined based on looking at abnormal cells from different parts of the body in a microscope and naming and classifying those cells according to their original tissue type. Such classification is possible because most benign tumors and many malignant ones retain some microscopic features of their original tissue. Tumors are named according to the cell type they resemble most.

The codes in this chapter of the *ICD-9-CM* book do not include personal or family history of malignant neoplasms. **Personal history** of a malignant neoplasm means that the past medical condition no longer exists, and the patient is not receiving any treatment. **Family history** codes are used when a patient has a family member who had a particular disease, which causes the patient to be at higher risk for contracting the disease. These instances are coded from the V10 and V16 categories instead.

Malignant Neoplasms (140-208)

Malignant neoplasms often become progressively worse and can eventually result in death. These neoplasms are cancers. Malignant neoplasms are grouped into the behavioral categories of *primary, secondary* and *carcinoma in situ*. You'll remember that *primary* refers to the site at which the neoplasm originated. *Secondary* refers to the site to which the primary site has spread. *Carcinoma in situ* refers to tumor cells that are confined to the site of origin and have not invaded the surrounding normal tissue. You also may see the terms *metastasis* and *direct extension* when you are classifying a secondary malignant neoplasm.

Metastasis is the transfer of a disease from one organ or part to another organ or part not directly connected with it. Only malignant tumor cells have the capacity to metastasize. Malignant cells can spread through the body very quickly. The three main pathways they use are the lymph nodes, the blood and the surface of body cavities. If a person has lung cancer that has metastasized to the brain, the primary malignant neoplasm is the lung, and the secondary malignant neoplasm is the brain. It is possible to have a secondary neoplasm with the primary site unknown.

Let's code for a patient being treated for a secondary malignant neoplasm of the lymph gland located in the leg, with the primary site unknown. First, code the secondary neoplasm as the treatment is directed toward that site. Use the Neoplasm table, found in the *Index to Diseases*, under the main term *Neoplasm*. Locate *lymph, gland*, *leg* and then move to the *Malignant, Secondary* column for the tentative code of **196.5**. Now, code the primary neoplasm. Locate the subterms *unknown site or unspecified* in the Neoplasm table (you are no longer under the subterm lymph) then move to the *Malignant, Primary* column. The tentative code is **199.1**. Turn to the *Tabular List* to determine the highest level of specificity for both codes. You will then assign **196.5 Secondary and unspecified malignancy neoplasm of lymph nodes, Lymph nodes of inguinal region and lower limb**, as well as coexisting condition **199.1 Malignant neoplasm without specification of site, Other**.

The morphological names for malignant neoplasms come from the names of the cell type, with the suffix *-sarcoma* added. For example, **fibrosarcoma** is a malignant neoplasm derived from fibrous tissue. **Chondrosarcoma** is a malignant neoplasm of cartilage cells. **Liposarcoma** is a malignant neoplasm of adults that occurs in the tissues and the thigh.

Of course, you don't need to memorize these meanings because the *Index to Diseases* assists you when you're using these morphological classifications to code. For example, open your *ICD-9-CM* manual to the index and locate *Fibrosarcoma*. The manual directs you to *see* also *Neoplasm, connective tissue, malignant*. You will then use the Neoplasm Table to locate *connective tissue NEC*. Unless otherwise stated, the malignant neoplasm is primary. Move to the *Malignant, Primary* column for the tentative code **171.9**, and then check this code in the *Tabular List* to determine the highest level of specificity.

Let's make sure you have the general idea of everything you've just read. One form of malignant tumor is known as **Kaposi's sarcoma**, which is a dermal tumor made up of blood vessels and vascular tissue cells. These tumors are red due to the leakage of blood at the surface of the skin. They multiply rapidly and can cover the entire surface of the body. Kaposi's sarcoma is an eponym, named for a person. Remember learning about eponyms in previous lessons? To locate the code for Kaposi's sarcoma in the *Index to Diseases*, find the main term *Kaposi's*. The subterm *sarcoma* indicates that the code **176.9** would be the tentative code for this condition. As always, determine the highest level of specificity in the *Tabular List*.

Neuroendocrine Tumors (209)

Neuroendocrine tumors affect hormone-producing cells, present throughout the nervous and endocrine systems. Most neuroendocrine tumors are not able to be described as a specific type of cancer, therefore are termed *carcinoid tumors*. **Carcinoid tumors** are a slow-growing type of cancer that can arise in several places throughout your body, usually in the gastrointestinal tract (appendix, stomach, small intestine, colon, rectum) and in the lungs. The American Cancer Society defines carcinoid as the following:

"Like most cells of the body, gastrointestinal system neuroendocrine cells sometimes undergo certain changes that cause them to grow too much and form tumors. The tumors that develop from neuroendocrine cells are known as neuroendocrine tumors (or neuroendocrine cancers). There are many varieties of neuroendocrine tumors, but the most common are the carcinoid tumors or carcinoids."

Carcinoid tumors act like the cells they come from. They often release certain hormone-like substances into the bloodstream. In about 10 percent of people, the carcinoid tumors spread and grow very large and release high amounts of those hormones. These cause symptoms such as facial flushing (redness and warm feeling), wheezing, diarrhea and a fast heartbeat. These symptoms are grouped together and called the *carcinoid syndrome*. Most cancers cause symptoms only in the organs they start in or spread to. But carcinoid tumors can release substances into the blood that cause symptoms throughout the body.

Turn in your *Tabular List* to code **209.3**. This code specifies the neuroendocrine tumor is *poorly differentiated*. **Poorly differentiated** tumors are rare, fast growing and, therefore, highly malignant.

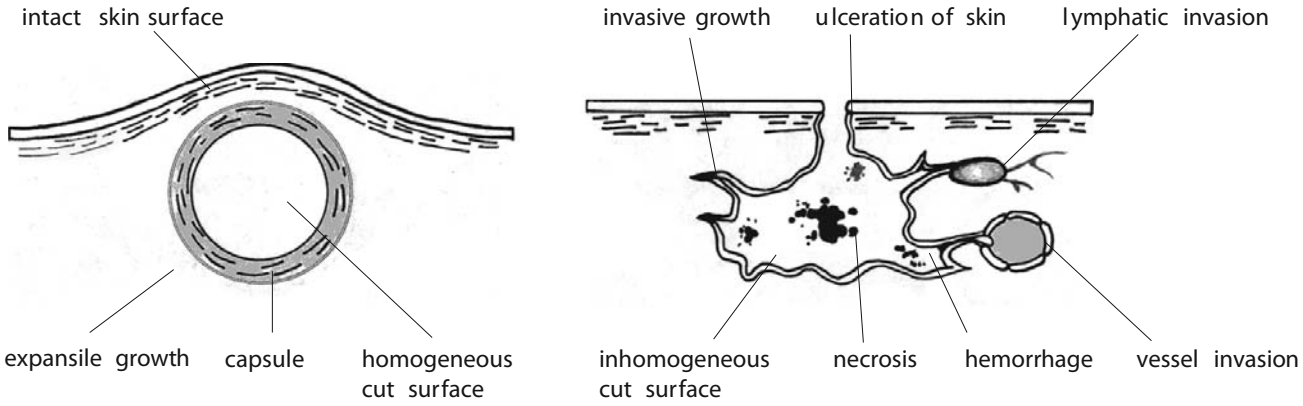
Benign Neoplasms (210-229)

Benign neoplasms are noncancerous growths. These growths do not invade adjacent structures or spread to distant sites, but they might displace or exert pressure on adjacent structures. Benign tumors always remain localized and never metastasize.

To understand the morphological classification of benign neoplasms, refer to your medical terminology lessons. The suffix *-oma* is a word part that means "tumor" or "neoplasm." For example, **adenoma** is a benign neoplasm of epithelial cells. Again, you do not need to memorize such terms because the *Index to Diseases* is available to assist you. When you look up the main term *Adenoma* in the index, you are directed to *see also Neoplasm, by site, benign.* This cross-reference instructs you to turn to the Neoplasm Table and locate the site and then find the correct code in the *Benign* column.

Let's say you are given the diagnosis of papilloma of the larynx. First, locate the main term *Papilloma* in the *Index to Diseases*. Note that you are directed to *see also Neoplasm, by site, benign.* Again, turn to the Neoplasm Table and locate *larynx NEC.* Once you find the term, move to the *Benign* column to determine that code **212.1** is the tentative code for **papilloma of the larynx**. Check the code 212.1 in the *Tabular List* to determine the highest level of specificity and assign that code.

Now that we have described benign and malignant tumors, compare the difference in the tumor types in the following illustrations.



A Benign tumor

B Malignant tumor

Carcinoma in Situ (230-234)

In situ describes tumor cells that are undergoing malignant changes but are still confined to the site of origin without invasion of surrounding normal tissue. The physician will specifically state the behavior of the neoplasm as being *in situ* if you are to code this type.

Neoplasms of Uncertain Behavior (235-238)

Now, let's turn to code 235 in the *Tabular List*. There, you'll see a note for code categories 235 through 238. The note under the title of this section tells you that the codes **classify by site certain histomorphologically well-defined neoplasms** whose subsequent behavior **cannot be predicted from the present appearance**. You should be aware that this note means you must assign the code of uncertain behavior for tumors that the pathologist cannot classify as benign or malignant because some features of each type are present. Review the code categories in this section, and notice the various INCLUDES and EXCLUDES, as well as those codes that require fourth- and fifth-digit classifications.

Take a look at the following operative report and see whether you can identify the correct code or codes for the indicated diagnosis.

PREOPERATIVE DIAGNOSIS
Mass on right breast.

A 40-year-old female presents with mass on the right breast. Review of recent mammogram indicates the mass is in the upper-outer quadrant.

PROCEDURE PERFORMED
BREAST BIOPSY.

A large-gauge needle is inserted through the skin of the breast into the mass. The needle is removed with the core of breast tissue. Pressure is applied for bleeding. The sample was sent to the pathologist, who was unable to classify the mass as benign or malignant.

POSTOPERATIVE DIAGNOSIS
Breast neoplasm of uncertain behavior.

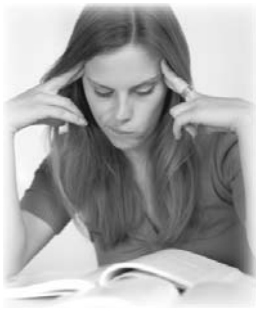
To code this operative report, begin at the Neoplasm Table in the *Index to Diseases*. Locate *breast* in this table, and then move to the *Uncertain Behavior* column, where you'll find the tentative code of **238.3**. Once you have determined the highest level of specificity in the *Tabular List*, you can comfortably assign **238.3 Neoplasm of uncertain behavior of other and unspecified sites and tissues, Breast** for this report.

Neoplasms of Unspecified Nature (239)

U*nspecified nature* refers to tumors in which neither the behavior nor the histological types are specified in the diagnosis. Turn to the *Tabular List* to read the note found for code 239. Notice that the note refers to **neoplasms of unspecified morphology and behavior**. To help you code conditions in this group, keep in mind that the words *histology* and *histological* mean the same thing as do *morphology* and *morphological*.

Exceptions and Clarifications

You should be aware of some important exceptions to the rules we've discussed for codes included in Chapter 2 of the *Tabular List*. For example, not all tumors that end in *-oma* are benign, and not all malignant tumors are labeled as carcinomas or sarcomas. An important example of this exception is **lymphoma**, a malignant tumor of lymphoid cells. However, there is no need to memorize this information because the *Index to Diseases* will guide you when you are searching for these main terms.



Be aware of some important exceptions to the rules we've discussed.

✍ Step 13 Practice Exercise 24-4

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Recurrent glioma of cerebrum**
   ICD-9-CM code: _____

2. **Metastatic carcinoma of the brain from the lung**
   ICD-9-CM code: _____
   ICD-9-CM code: _____

3. **Hodgkin's sarcoma**
   ICD-9-CM code: _____

4. **Benign neoplasm scalp**
   ICD-9-CM code: _____

5. **Fibromyoma of the uterus**
   ICD-9-CM code: _____

6. **ICD-9-CM Coding Challenge**
   PATHOLOGY REPORT
   SPECIMEN: Biopsy, lesser curvature.
   DATE COMPLETED: June 7, 20XX
   GROSS DESCRIPTION: Multiple fragments pale tan tissue, measuring 1 x 0.6 x 0.3 cm in aggregate.
   MICROSCOPIC/DIAGNOSIS: Gastric biopsy: Adenocarcinoma.
   ICD-9-CM code: _____

🕮 Step 14 Review Practice Exercise 24-4

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

🕮 Step 15 Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders (240-279)

- ❑ Chapter 3 of the *Tabular List* focuses on diseases and disorders of the endocrine system, nutritional deficiencies and disorders and disturbances of the metabolic and immunity systems. When these systems are off balance, the body is affected. We will discuss items such as *hyperplasia, diabetes, Cushing's syndrome* and *anemia*.

  First, let's look at this chapter in the *Tabular List* to become familiar with the inclusions, exclusions and additional notes provided. Next to EXCLUDES under the chapter title, you see that you should use codes 775.0 through 775.9 for endocrine and metabolic disturbances specified to the fetus and newborn. There also is a note stating that all neoplasms, whether functionally active or not, are classified in Chapter 2. Codes in Chapter 3, that is, codes 242.8, 246.0, 251 through 253, and 255 through 259 may be used to identify such functional activity associated with any neoplasm, or by ectopic endocrine tissue.

  Now, let's talk about each of this chapter's four sections.

Look at Chapter 3 in the *Tabular List* to become familiar with the inclusions, exclusions and additional notes provided.

Disorders of Thyroid Gland (240-246)

The **thyroid gland** is one of the endocrine glands, and it is normally situated in the lower part of the front of the neck. The thyroid gland has two lobes, one on either side of the trachea. This gland secretes and stores thyroid hormones. Inadequate iodine levels often cause an enlarged thyroid gland.

In this section of the *Tabular List*, you will find EXCLUDES to assist you in selecting the correct code. For example, in category **241 Nontoxic nodular goiter**, you are instructed to use category 226 instead for adenoma of thyroid and cystadenoma of thyroid. Category 242 EXCLUDES neonatal thyrotoxicosis. Category 242 also requires a fifth-digit subclassification. If you were to submit 242.0 for toxic diffuse goiter, your code would be invalid until you applied the proper fifth digit.

Diseases of Other Endocrine Glands (249-259)

This section includes secondary diabetes mellitus, *primary diabetes mellitus*, disorders of the parathyroid and pituitary glands and other endocrine disorders.

Diabetes mellitus is a chronic syndrome of insufficient insulin production that leads to the body's inability to metabolize carbohydrates, protein and fat. This disease is genetic, but its development also depends on the individual's environment, including diet, weight and exercise habits. Diabetes mellitus occurs in two major forms: **type 1** and **type 2**. It is important that coders do not take the patient's age or the fact that insulin is documented when determining the final digit for diabetes. Documentation must specifically note "type 1" or "type 2" for consideration. If the type of diabetes is not documented, you should check with the physician for clarification. If the type can still not be documented, you will code to unspecified. Long-term complications of the disease involve the kidneys, nerves, blood vessels and eyes. Diabetes also is identified as *controlled* or *uncontrolled*. For a diagnosis to be coded as uncontrolled, the physician must specifically document it as such. We will discuss how to use this information to determine codes when we look through the *Tabular List*.

Secondary diabetes mellitus is defined as a diabetic condition not as a result of genetics or environmental conditions. Sometimes, determining primary or secondary diabetes may be a challenge; however, the major differentiating factor of secondary diabetes is the presence of another underlying condition that is determined to be the cause of the diabetes. For instance, a patient may develop secondary diabetes when pancreatic tissue is destroyed by chronic pancreatitis.

You will find reporting and sequencing issues addressed in the *Coding Guidelines* in the front of your *ICD-9-CM*.

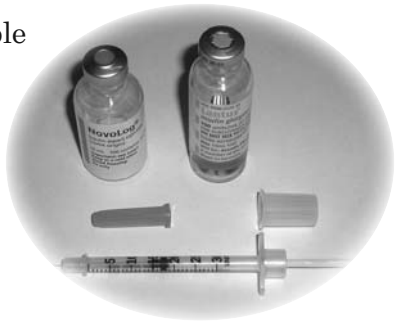
Now, open your *ICD-9-CM* manual to the *Tabular List* to review the fifth-digit subclassification of code **250 Diabetes mellitus**. The fifth-digit 0 indicates **type 2 or unspecified type, not stated as uncontrolled**. Use 0 as the final digit when the physician documents type 2 diabetes or does not state the type.

If it is documented that a type 2 diabetic patient uses insulin on a long-term basis, code **V58.67 Long-term (current) use of insulin** will also be assigned. You *will not* use code V58.67 if insulin is given *temporarily* to a type 2 diabetic patient to bring their diabetes under control. Remember, you will learn more about using V codes in a later lesson.

The fifth-digit 1 indicates **type 1 [juvenile type], not stated as uncontrolled**. Use 1 as the final digit when the physician documents type 1 diabetes.

Controlled and Uncontrolled Diabetes

A patient with a diagnosis of **controlled** diabetes has acceptable blood sugar levels in his blood. **Uncontrolled** diabetes may be documented when according to the patient's current treatment regimen, the blood sugar levels are not acceptable. You will use the fifth-digits 2 and 3 only when *uncontrolled* is clearly documented. Documenting the blood sugar level is not within an acceptable level or the insulin requires adjusting is not "uncontrolled." In other words, if you do not see "uncontrolled" in the dictation, you will not use 2 or 3 as the fifth digit. The fifth-digit would be 2 when uncontrolled is documented with type 2 or when the type is not specified. You will use the fifth-digit 3 when uncontrolled and type 1 diabetes is documented.



A patient with a diagnosis of *controlled* diabetes has acceptable blood sugar levels in his blood.

Let's use your *ICD-9-CM* book to code the disease you've just learned so much about. A type 2 diabetic patient with long-term insulin use is diagnosed with ketoacidosis. Begin your search for the accurate code in the *Index to Diseases*. To determine the main term, ask yourself "what is the problem?" The problem is the **ketoacidosis**. Once you find *Ketoacidosis* in the index, locate the subterm *diabetic*, and you will find the tentative code **250.1** ✓ . If you stop there, you will not have the correct code because you haven't attended to the fifth-digit subclassification box. Turn to code 250.1 in the *Tabular List* to determine the highest level of specificity. The description of **diabetes with ketoacidosis** is correct. Now, refer to the top of this category for the fifth digit. You will use the fifth-digit **0** to indicate **type 2, not stated as uncontrolled**. Be sure to read the notes in the 250 category. You are directed to use an additional code for associated long-term insulin use with V58.67. It is documented that the patient uses insulin on a long term basis, so this code would apply. The final codes for this situation are **250.10 Diabetes with ketoacidosis, type 2, not stated as uncontrolled** and **V58.67 Long-term (current) use of insulin**.

You know that conditions can cause diabetes, resulting in secondary diabetes; however, diabetes can cause the manifestation of other diseases as well. Turn to the *Tabular List* and locate codes 250.4 through 250.8. These subcategories are for diabetes with manifestations, and below each category you are instructed to use an additional code to identify the manifestation. You must assign both codes to fully describe the condition, and the codes must be sequenced in the order listed in the manual.

Diabetes is a challenging disease to code, so let's try another example. This time, let's code a patient with manifestations resulting from the diabetes. You are the medical coding and billing specialist for an ophthalmologist, and you must code the following dictation:

SUBJECTIVE
A 64-year-old male with a history of type 1 diabetes complains of cloudy, obstructed vision.

OBJECTIVE
Exam of the eye reveals snowflake shaped opacity.

ASSESSMENT
The physician determines the patient has diabetic cataracts and suggests outpatient surgery.

PLAN
The extracapsular cataract is removed with insertion of an intraocular lens. The patient is instructed to return for follow-up treatment.

The patient complains of cloudy, obstructed vision, but you don't code symptoms when a final diagnosis is provided. The physician's assessment revealed diabetic cataracts to be the problem. So, is the main term the **diabetes** or the **cataracts**? To find out, let's use *Cataract* as the main term and turn to the *Index of Diseases*. Once you have located the main term, you'll look for the subterm *diabetic*. So the tentative codes are **250.5** ✓ ***[366.41].*** (Remember that the slanted brackets indicate the manifestation of the underlying condition.) Now, what if diabetes is the main term? Locate *Diabetes* as the main term in the index, with *cataract* as the subterm. What do you see? The tentative codes listed are **250.5** ✓ ***[366.41]***. So you see that there is more than one way to the correct code.

Now let's go back to the manual and search for the final codes for this example. You know from the information you just read about coding manifestations that you must use both codes and sequence them in the order listed. Turn to code 250.5 in the *Tabular List* to determine the highest level of specificity. It is documented that the patient has type 1 diabetes, and the disease is not stated as uncontrolled. Therefore, you would assign codes **250.51 Diabetes with ophthalmic manifestations, type 1 [juvenile type], not stated as uncontrolled** and **366.41 Diabetic cataract** for this scenario. You will use code 366.41 without recording the brackets.

Now that you have a basic understanding of diabetes, let's move on by looking at the *Tabular List* for other notes in this section. The section lists many INCLUDES and EXCLUDES . We will discuss some of those here, but be sure to read this area closely on your own, as well.

Many codes in category 251 EXCLUDES conditions related to diabetes mellitus and suggest other codes. For example, subcategories 251.0 and 251.1 indicate the need for an E code to identify the cause if the condition is drug induced.

Cushing's syndrome, another disease included in this section, is a syndrome that causes fatty tissue of the face, neck and body. Note in the *Tabular List* that, for code **255.0 Cushing's syndrome**, you are instructed to use an additional E code to identify the cause if the condition is drug-induced. We will discuss E codes and how they are used later on in this course.

Nutritional Deficiencies (260-269)

There are diseases and conditions that are caused by a lack of protein and vitamins, and other nutritional deficiencies.

This section covers diseases or conditions that are caused by a lack of protein and vitamins and other nutritional deficiencies. Under the heading "Nutritional Deficiencies (260-269)" in the *Tabular List,* note that you are to use codes 280.0 through 281.9 for deficiency anemias. Code 263.9 Unspecified protein-calorie malnutrition EXCLUDES code 269.9, which would be more appropriate for an unspecified nutritional deficiency. And codes 266.1 Vitamin B_6 deficiency and 266.2 Other B-complex deficiencies direct you to other codes, as well. You also can see that code 269.0 Deficiency of vitamin K EXCLUDES deficiency of coagulation factor due to vitamin K deficiency (286.7) and vitamin K deficiency of a newborn (776.0).

Carefully read through the following report, thinking about how you would determine the correct codes for the diagnosis.

Operative Report

PREOPERATIVE DIAGNOSIS:
Suspect Osteomalacia.

A 52-year-old female presents with pain and tenderness in hip area as well as overall weakness. Review of x-ray suggests signs of osteomalacia.

PROCEDURE PERFORMED
BONE BIOPSY.

Local anesthesia applied to procedure site. A small incision is made in the skin, and a biopsy needle is pushed and twisted into the bone. Once the bone sample is obtained, the needle is removed. Pressure is applied to biopsy site for several minutes. No excess bleeding is noted. Site is covered with gauze patch and secured.

POSTOPERATIVE DIAGNOSIS
Biopsy sample confirms osteomalacia.

To locate the code for this condition, open your *ICD-9-CM* manual to the *Index to Diseases,* and then turn to the main term *Osteomalacia.* The tentative code you find is **268.2**. Now turn to the *Tabular List* to determine the highest level of specificity. Based on the information you find, you see that you have coded the condition correctly—**268.2 Vitamin D deficiency, Osteomalacia, unspecified**.

Other Metabolic and Immunity Disorders (270-279)

Anything that is considered abnormal when one is dealing with metabolism and immunity is found in this section. Some diseases included in this chapter are *albinism*, *gout* and *obesity*. This section also contains many eponyms, which are listed as inclusions under the *Tabular List* code description. You are directed to use additional code(s) to identify any associated intellectual disabilities with codes in this section.

Albinism is a rare inherited disorder in which melanocytes are present but they do not form melanin. People with albinism have pale skin and white hair. Their eyes are pink because the retina lacks pigment. Individuals with this condition are at high risk for sunburn and skin cancer, and they must avoid the sun as much as possible. There is no treatment for this disorder. To code for albinism, turn to the main term *Albinism, albino* in the *Index to Diseases*. You will see many nonessential modifiers. Remember, these words may not be present in the narrative description of a disease, and they do not affect the code assignment. The tentative code **270.2** is indicated for the disorder of albinism. Be sure to determine the highest level of specificity in the *Tabular List* before you assign the code. Based on the information you have, the correct code is **270.2 Other disturbances of aromatic amino-acid metabolism**.

Gout is a group of diseases, all of which are characterized by various combinations of deposits of uric acid crystals in the joints, certain tissues and the kidneys. Many people who have gout show a family disposition to it, and the disease affects men almost exclusively. The *Tabular List* notes that this category (274) EXCLUDES lead gout, and you are directed to use codes 984.0 through 984.9 instead. To code asymptomatic gout—gout with no symptoms—you begin in the *Index to Diseases* by locating the main term *Gout, gouty*. Once you've found *Gout, gouty* in the index, you will stop there because you do not have additional information to choose a subterm. The tentative code provided is **274.9**. Turn to the *Tabular List* to determine the highest level of specificity for 274.9. You will then assign that code, **274.9 Gout, unspecified**.

🕮 Step 16 Diseases of the Blood and Blood-Forming Organs (280-289)

- ❑ Chapter 4 in your *ICD-9-CM* manual is the last one we'll cover in this lesson. The chapter includes diseases such as *anemias*, coagulation defects, *purpura*, diseases of the white blood cells and other diseases of blood and blood-forming organs. Note from the *Tabular List* that this chapter EXCLUDES anemia complicating pregnancy or the puerperium, for which you would use code 648.2. Become familiar with the INCLUDES EXCLUDES and additional notes this chapter has to offer to assist you in accurate coding.

Anemia is any condition in which the number of red blood cells is less than normal. Common signs of anemia include shortness of breath, palpitations of the heart and lethargy. As you review the anemia section, be sure to note the inclusions, exclusions and additional notes.

Iron deficiency anemia is the most common form of anemia and probably the easiest to address. Iron deficiency is more common in women than in men.

Iron deficiency is more common in women than men.

Sickle-cell anemia is a genetic disease most prevalent in Africans and African-Americans. Just because an individual has sickle cell anemia does not mean he will experience symptoms. Symptoms depend on the amount of abnormal hemoglobin in the blood. Persons with high levels of abnormal hemoglobin (at least above 40 percent, but usually more) experience what are known as **sickling crises**. Such crises result in **infarcts** (inadequate supply of blood to the tissues), which damage the vital organs. The diagnosis of sickle cell anemia is made on the basis of clinical findings, but the disease can be confirmed only with laboratory tests.

Aplastic anemia is a rare type of anemia. There is a reduction in the number of red, white and platelet cells in the blood. The earliest form of all blood cells in the bone marrow is called stem cells. Aplastic anemia is a result of the failure to produce these stem cells. The two major forms of aplastic anemia are *idiopathic aplastic anemia* and *secondary aplastic anemia*. **Idiopathic aplastic anemia**, the more common type, is a form of bone marrow failure that has no apparent cause. The only known treatment for this type of anemia is a bone-marrow transplant. The other major form, **secondary aplastic anemia**, is caused by bone marrow suppression as a result of drugs, radiation therapy or viral infections. Secondary aplastic anemias usually can be reversed by removing whatever caused the bone marrow suppression in the first place.

Are you ready for another practice scenario? Consider that you're the medical coding and billing specialist for a physician who has prepared the following dictation:

PRESENTING PROBLEM
Suspect Anemia.

Patient presents with fatigue, SOB upon exertion, nosebleeds, and bleeding gums, times three months. CBC indicates low RBC, WBC and platelet count.

PROCEDURE
BONE-MARROW BIOPSY.

Hip area is cleansed and local anesthetic is injected into site. Biopsy needle is inserted into the bone. After the core of the needle is removed, the needle is pressed forward and rotated, forcing tiny samples of the bone into the needle. The needle is removed and pressure placed on the biopsy site.

POSTOPERATIVE DIAGNOSIS
Biopsy confirms idiopathic aplastic anemia.

How did you do? Let's review the main steps to correctly code this diagnosis. The main term is *Anemia,* and the subterms are *idiopathic* and *aplastic.* Looking in the *Index to Diseases*, you'll find *Anemia* with a tentative code of **285.9**. Looking further, you see the subterm *aplastic* with a code of **284.9**. But *aplastic* also has subterms, including *idiopathic,* which once again indicates a tentative code of **284.9**. Now you turn to the *Tabular List* to determine the level of specificity for code 284.9. There you'll see that you have selected the correct code, **284.9 Aplastic anemia, unspecified**, which includes a sublisting for aplastic (idiopathic) NOS.

Coagulation defect is a failure to form blood clots. When you look in the *Tabular List* under code 286, you will see a number of eponyms listed in this category (for example, Rosenthal's disease, Owren's disease, von Willebrand's disease and others).

Purpura is a condition visible through the skin and characterized by reddish-brown or purplish spots. It is caused by bleeding within underlying tissues. The *Tabular List* indicates that code **287 Purpura and other hemorrhagic conditions** EXCLUDES hemorrhagic thrombocythemia and purpura fulminans. **Allergic purpura** is any hemorrhagic condition caused by a presumed allergic reaction to food, drugs or insect bites.

When you look in the *Tabular List*, you'll notice that code **288 Diseases of white blood cells** does not include leukemia. You should use subcategories 204.0 through 208.9 to code that disease. Eponyms also are often used in this category and are listed under the *Tabular List* code description.

Leukopenia is a disease in which the white blood cell count is below normal. Anything from drugs and environmental chemicals to radiation therapy and certain chronic diseases can cause leukopenia. To code this condition, locate the main term *Leukopenia* in the *Index to Diseases*, where you will find tentative code **288.50**. Turn to the *Tabular List* to determine the highest level of specificity. You will see the code and description **288.50 Leukocytopenia, unspecified**.

Leukopenia is a disease in which the white blood cell count is below normal.

Finally, Chapter 4 addresses other diseases of blood and blood-forming organs. These other diseases include *chronic lymphadenitis* and *hypersplenism*. Turn to coding group 289 in the *Tabular List* to familiarize yourself with this group of codes, and be sure to call your instructor if you need any help understanding what you have read.

Now review Chapters 3 and 4 of the *ICD-9-CM* manual by taking the following Practice Exercise.

✍ Step 17 Practice Exercise 24-5

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Postsurgical hypothyroidism**
   ICD-9-CM code: _____

2. **Type 1 diabetes hypoglycemic coma, uncontrolled**
   ICD-9-CM code: _____

3. **Primary hyperparathyroidism**
   ICD-9-CM code: _____

4. **Polycystic ovaries**
   ICD-9-CM code: _____

5. **Gouty arthropathy**
   ICD-9-CM code: _____

6. **Sickle-cell disease with crisis**
   ICD-9-CM code: _____

7. **Big spleen syndrome**
   ICD-9-CM code: _____

Use the following information to complete the CMS-1500 that follows.

8. ICD-9-CM Coding/Billing Challenge

FRONT RANGE FAMILY CARE
1800 Circle Court
Yourtown, CO 80000
(970) 555-3344

_____ Greg Stephen, MD NPI: 0267679942
__X__ Donald Milford, MD NPI: 0810998051
_____ Douglas Smart, MD NPI: 0144878804
Group NPI: 0881099885

Patient Information

Name Bonnie Schmidt
Address 1810 Bluegrass Drive
City Springtown **State** CO
ZIP 80002
Home Phone 970-555-9041

Date of Birth June 25, 1952
Sex F **Marital Status** married

Employment Information

Name of Employer Kain Graphics
Occupation graphic designer
If Minor, Name of School

Insurance Information

Primary Insurance
Name Country Group
ID# 560001113
Group# 208
Address PO Box 324
City Springtown
State CO **ZIP** 80002
Primary Insured Name Bonnie
Relation to Patient self
DOB same as above
Employer Kain Graphics

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Bonnie Schmidt
Signature of patient (or parent of minor child)

Secondary Insurance
Name CHAMPVA
ID# 635 00 7213
Group#
Address 4500 Cherry Creek Drive South; Box 64
City Denver
State CO **ZIP** 80222
Secondary Insured Name Richard Schmidt
Relation to Patient Spouse
DOB Sept 15, 1952
Employer USAF

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

_____
Signature of patient (or parent of minor child)

Physician signature: *Donald Milford, MD*
SSN: 300-03-0303
EIN 66-6000600
Participating Provider for: TRICARE, CHAMPVA, Country Group and Blue Cross

Date of Service	10/17/XX	
Diagnosis	**Procedure**	**Charge**
	99213 Est. Patient Level 3	$63.00

Today's Charge	$63.00
Cash/Check	$0.00
Balance	$63.00

Bonnie Schmidt
DOB 06 25 1952
Date of Service 10/17/XX

SUBJECTIVE
At a regular office visit, patient complains of constipation, nausea and vomiting, with abdominal pain, excessive thirst and muscle weakness. Patient is currently receiving treatment for thyroid cancer.

OBJECTIVE
An expanded problem focused examination is performed. The physician orders labs and an EKG, which are taken at the office. Results from the blood draw indicate an elevated calcium level and, on the EKG, a shortened Q-T interval.

ASSESSMENT
The patient has acute hypercalcemia resulting from the thyroid cancer.

PLAN
Orders for immediate hydration (3 L/day) and diuretic administration.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid#) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH SEX M F

b. OTHER INSURED'S DATE OF BIRTH SEX M F

b. AUTO ACCIDENT? YES NO Place (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1.														NPI	
2.														NPI	
3.														NPI	
4.														NPI	
5.														NPI	
6.														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

a. b.

Step 18 Review Practice Exercise 24-5

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 19 Lesson Summary

- ❑ What do you think of diagnosis coding so far? Are you beginning to see how everything you learned in previous lessons, from medical terminology to the *ICD-9-CM Coding Guidelines*, helps you as you code?

Call your instructor if you need help.

In this lesson we covered the first four chapters of Volume 1 (the *Tabular List)* of your *ICD-9-CM* manual. You learned about the sections of each chapter and about some of the diseases in each section. We showed you important notes, inclusions and exclusions from each section, which are designed to assist you as you code. And throughout the lesson were plenty of examples and practice exercises to give you more chances to code as you moved through the material. If you found parts of this lesson challenging, that's understandable! We covered a lot of information here, and this is your first real attempt at diagnosis coding, so it's only natural to have questions. Reread through the parts you found confusing, and be sure to contact your instructor with any remaining questions. Remember: Our goal is the same as yours—for you to succeed!

The format of the next few lessons will be similar to this one. We'll continue to talk about the chapters in Volume 1 of your manual, the *Tabular List,* and you'll have more diagnosis coding practice. But before you move on, take the quiz for this lesson to reinforce what you've learned.

Step 20 Mail-in Quiz 24

- ❑ Follow the steps to complete the Quiz.

  a. Be sure you've mastered the instructions and the Practice Exercises that this Quiz covers.

  b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

  c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.

  d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your Quiz online.

  e. Submit your answers to the school via mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 24

❑ Choose the best answer from the choices provided.

Each item is worth 3.33 points.

1. **The first four chapters of the *Tabular List* cover *Infectious and Parasitic Diseases;* _____; and *Diseases of the Blood and Blood-Forming Organs.***
   a. Neoplasms; Endocrine and Diabetes
   b. Endocrine, Nutritional and Metabolic Diseases; Immunity Disorders
   c. Neoplasms; Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders
   d. Metabolic Diseases; Natural Disasters

2. **Spirochete are spiral bacterium found in diseases such as _____.**
   a. leptospirosis
   b. yaws
   c. pinta
   d. all of the above

3. **The most common form of anemia is _____.**
   a. idiopathic aplastic anemia
   b. sickle-cell anemia
   c. secondary aplastic anemia
   d. iron-deficiency anemia

4. **Which is *not* a fifth-digit subclassification for category 045? _____**
   a. Poliovirus, unspecified type
   b. Poliovirus type II
   c. Poliovirus type III
   d. Poliovirus type IV

5. **In the *Tabular List*, category 038 states to use an additional code _____.**
   a. if you feel so inclined
   b. for systemic inflammatory response syndrome (SIRS) (995.91-995.92)
   c. to identify the organism
   d. because 038 has been deleted

6. **Once a patient's condition has been coded 042, you _____ assign 795.71 or V08 to that patient again.**
   a. always
   b. sometimes
   c. probably
   d. cannot

7. Which statement is *not* true about the term *metastasis*? _____

a. It's used when classifying a primary malignant neoplasm.
b. It's the transfer of a disease from one organ or part to another organ or part.
c. It's used when classifying a secondary malignant neoplasm.
d. Only malignant tumor cells have the capacity to metastasize.

8. To code 250.02, the documentation must indicate _____.

a. Type 2
b. Type 2, uncontrolled
c. Type 1, uncontrolled
d. Type 1

9. Which statement is *not* true of people with albinism? _____

a. They have pale skin and white hair.
b. They can stay out in the sun as much as possible.
c. Their eyes are pink because the retina lacks pigment.
d. They are at high risk for sunburn and skin cancer.

10. After looking up *Dermatofibroma* in the *Index to Diseases*, you should _____.

a. assign M8832/0 as the final diagnosis
b. *see* Neoplasm, skin, uncertain behavior
c. *see also* Neoplasm, skin, benign
d. turn to Appendix A to locate the correct code

11. Varicella is commonly known as _____.

a. cowpox
b. chickenpox
c. smallpox
d. duckpox

12. Tubercles, or small, rounded lesions and tissues that begin to resemble cheese are some of the characteristics of what disease? _____

a. Tuberculosis
b. Leprosy
c. Whooping cough
d. Bubonic plague

13. Which is the most common form of post-transfusion hepatitis? _____

a. Hepatitis B
b. Hepatitis C
c. Hepatitis E
d. None of the above

14. Code 041.4 is for an infection called Escherichia coli, or _____.

a. Eaton's agent
b. E. coli
c. Escherichia colicianism
d. Esch-coli

15. For a diagnosis of diabetes to be coded as uncontrolled, the physician must _____.

a. indicate the patient is not taking insulin
b. specifically document it as such
c. document the medication is not effective
d. tell the medical coder directly

16. Untreated syphilis progresses through three clinical stages: _____.

a. primary, secondary and tertiary
b. principal, secondary and coexisting
c. first, second and third
d. I, II and III

17. Malignant neoplasms are grouped into the behavioral categories of _____.

a. first, second and third
b. primary, secondary and carcinoma in situ
c. primary, secondary and tertiary
d. malignant, benign and carcinoma in situ

18. Category 286 codes for coagulation defect. Which is not an eponym listed in this category? _____

a. Rosenthal's disease
b. Owren's disease
c. von Willebrand's disease
d. Alzheimer's disease

19. Which is an important exception to the rules we've discussed for codes included in Chapter 2 of the *Tabular List?* _____

a. Not all tumors that end in *-oma* are benign.
b. Not all malignant tumors are labeled as carcinomas or sarcomas.
c. Both a and b.
d. None of the above.

20. To accurately code category 042, you must _____.

a. be familiar with the *Coding Guidelines* in the front of your *ICD-9-CM* manual
b. know the patient's medical history
c. understand all complications of this disease
d. apply a fourth- and fifth-digit subclassification

Choose the best diagnostic code(s) from the choices provided.

21. Carcinoma in situ of the colon _____

a. 230.3
b. 230.4
c. 153.9
d. 239.0

22. Bacterial culture indicates tuberculoma of brain _____

a. 013.24
b. 012.3
c. 013.34
d. 012.30

23. Adenocarcinoma involving both intrahepatic and extrahepatic bile ducts _____

a. M8160/3
b. 156.9
c. 156.1
d. 197.8

24. Secondary malignant neoplasm of the larynx, with primary site not identified _____

a. 197.3 161.9
b. 197.3 199.1
c. 161.9 199.1
d. 199.0 161.9

25. Diabetic coma, without insulin use _____

a. 250.3
b. 250.30
c. 250.31
d. 250.13

26. Enterobacter aerogenes of unspecified site _____

a. 127.4
b. 041.85
c. 041.89
d. 008.2

27. Addison's disease _____

a. 255.41
b. 281.0
c. 017.6
d. 272.2

28. HIV infection, symptomatic _____

a. V08
b. 042
c. 42
d. 08

29. Office visit for an established patient _____

SUBJECTIVE
A 54-year-old female complains of fatigue and lack of motivation. Tires easily and SOB upon exertion. Patient states her eating habits have not changed, but she has been less active the past 6 months.

OBJECTIVE
Expanded problem focused exam performed.

ASSESSMENT
Obesity.

PLAN
Healthy diet and exercise recommended.

a. 278.00
b. 244.9
c. 278.01
d. 255.8

30. Pathology Report _____

SUBJECTIVE
Patient complains of leg pains, extreme thirst and frequent urination.

OBJECTIVE
Serum potassium 2.5 mEq/L.

ASSESSMENT
Hypokalemia.

PLAN
Give oral potassium supplement.

a. 729.5 783.5 788.41 276.8
b. 729.5 276.8
c. 276.8 729.5 783.5 788.41
d. 276.8

Endnote

[1] *2005 ICD-9-CM Professional for Physicians - Volumes 1 & 2*, Salt Lake City, Utah: Ingenix, Inc. August 2004, page 3, Volume 1

Congratulations!

You have completed Lesson 24.

Do not wait to receive the results of your Quiz before you move on.

Lesson 25

ICD-9-CM Coding— From Mental Disorders to Circulatory System

Step 1 Learning Objectives for Lesson 25

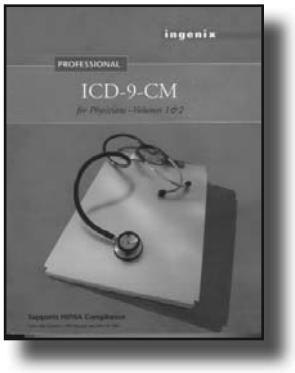
- When you have completed the instruction in this lesson, you will be trained to do the following:
  - Assess mental disorders, diseases of the nervous system and sense organs and diseases of the circulatory system.
  - Explain the exclusions, inclusions and rules related to Chapters 5 through 7 of the *Tabular List* in the *ICD-9-CM* manual.
  - Identify the diagnoses, outline the coding pathway and assign the final code for documented disorders and diseases.

Step 2 Lesson Preview

- Now that you've begun to practice coding medical conditions, you have taken a big step toward your goal of becoming a medical coding and billing specialist. You will move even further toward that goal in this lesson, which introduces you to the codes in Chapters 5 through 7 of the *ICD-9-CM* manual's *Tabular List*. These chapters encompass the major disease categories of mental, behavioral and neurodevelopmental disorders, diseases of the nervous system and sense organs and diseases of the circulatory system.

  Just as in the previous lesson, you'll find a lot of detailed information here. But just as before, you'll have as much time as you need to study the material and make sense of it. And as always, you can contact your instructor whenever you have questions you need answered.

  Again, we subdivide all the chapters in this lesson into discussions about each section and refer you often to the *Index to Diseases* and the *Tabular List* so you can see exactly what we're talking about. And we provide you with lots of practice exercises to allow you to apply your coding skills as you learn.



This chapter introduces you to the codes in Chapters 5 through 7 of the *ICD-9-CM* manual's *Tabular List.*

When you have completed this lesson, you will be more than half-way through all the chapters of the *Tabular List*. So let's get moving! Take a few deep breaths, relax, and you're ready to start learning how to code mental disorders.

To help make sure you don't get confused as you code the practice exercises and scenarios throughout the following ICD-9-CM coding lesson, it's important to keep in mind that we are focusing for now only on ICD-9-CM codes—*not* CPT codes. You will see physician notes and documentation about specific procedures in some of the scenarios we use just because we want you to practice with authentic examples. But remember that you will code only the diagnoses during these lessons—you'll have plenty of time and lots of practice combining procedural and diagnostic codes in later lessons, after you've become more familiar and comfortable with the ICD-9-CM codes.

Step 3 Mental, Behavioral and Neurodevelopmental Disorders (290-319)

- A **mental disorder** is any clinically significant behavioral or psychological syndrome that is characterized by the presence of distressing symptoms or significant impairment of function. Chapter 5 of the *Tabular Lis*t includes the diagnosis codes for a broad range of mental disorders. Specifically, the sections focus on *psychoses*; *neurotic*, *personality* and other nonpsychotic mental disorders; and intellectual disabilities. As before, we will discuss each section in detail to help you build your knowledge of this subject.

Another widely used set of codes comes from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, which American Psychiatric Publishing, Inc. publishes. When you assign codes for mental disorders, use both books as a reference aid, but *ultimately* use the *ICD-9-CM* manual to assign a code. As a student in this course, you do not need the *Diagnostic and Statistical Manual of Mental Disorders*. You will use the *ICD-9-CM* manual to assign this type of diagnosis.

Chapter 5 of the *Tabular List* includes the diagnosis codes for a broad range of mental disorders.

Psychoses (290-299)

Psychoses are mental disorders in which the person demonstrates a loss of ego, boundaries or a gross impairment in reality testing, with delusions or prominent hallucinations. Turn to the *Tabular List* in your *ICD-9-CM* manual and locate this section of Chapter 5.

Under the section heading, you will see EXCLUDES "intellectual disabilities." You are directed to use code categories 317 through 319 for that diagnosis. The "Psychoses" section is further broken down into "Organic Psychotic Conditions (290-294)" and "Other Psychoses (295-299)."

The code category for Organic Psychotic Conditions (290-294) INCLUDES "psychotic organic brain syndrome." It EXCLUDES "nonpsychotic syndromes of organic etiology," (310.0 through 310.9) and "psychoses classifiable to 295-298 and without impairment of orientation, comprehension, calculation, learning capacity and judgment, but associated with physical disease, injury, or condition affecting the brain [e.g., following childbirth] (295.0-298.8)."

Category 290 codes **dementias**, which are characterized by a general loss of intellectual abilities, involving impairment of memory, judgment and abstract thinking, as well as changes in personality. You are instructed to code first the associated neurological condition for category 290. This means that if a neurological condition is documented together with dementia, that neurological condition will be your principal diagnosis code, and the dementia will be your secondary diagnosis code.

Using your *ICD-9-CM* manual, let's code uncomplicated senile dementia. First, go to the *Index to Diseases* and locate the main term *Dementia*. The subterm is *senile*. You will quickly find the code **290.0**. Note this tentative code, and then turn to the *Tabular List* to determine the highest level of specificity. Based on the information you find you will assign **290.0 Senile dementia, uncomplicated** as the correct code. Great job!

The other organic psychotic conditions in this section are caused by a chemical imbalance in the patient. This imbalance may be the result of alcohol intoxication or withdrawal, or it may represent disorders caused by consumption of drugs. This category has many inclusions, exclusions and additional notes to assist you with accurate coding. Be sure you use additional codes, when indicated, to identify drugs and code underlying conditions.

Now that we've introduced you to organic psychotic conditions, let's look at "Other Psychoses (295-299)" to give you a better understanding of the category. If the condition is documented, you are to use an additional code to identify any associated physical disease, injury or condition affecting the brain with psychoses classifiable to codes 295-298. These other psychotic conditions include schizophrenia, episodic mood disorders, delusional disorders, other nonorganic psychoses and pervasive developmental disorders.

Schizophrenic disorders, found in category 295, represent a group of disorders with disturbances in thought, mood, sense of self and relationship to the world. Schizophrenic disorders also include bizarre, purposeless behavior, repetitious activity or inactivity. This category INCLUDES schizophrenia of the types described in codes 295.0 through 295.9 occurring in children. The category EXCLUDES childhood type schizophrenia (299.9) and infantile autism (299.0). Category 295 requires a fifth-digit subclassification to describe the current condition of the disorder.

Review the following box, which identifies the fifth digits you will select from when you code this category.

> The following fifth-digit subclassification is for use with category 295:
>
> **0 unspecified**
> **1 subchronic**
> **2 chronic**
> **3 subchronic with acute exacerbation**
> **4 chronic with acute exacerbation**
> **5 in remission**

Code category 296 covers **Episodic Mood Disorders** that range from *bipolar I disorder* to *major depressive disorder*. The fifth-digit subclassification for the subcategories 296.0 through 296.6 indicates whether the disorder is unspecified, mild, moderate, severe or in remission. Once again, take a closer look here at the box, which identifies these fifth digits:

> The following fifth digits are for use with categories 296.0-296.6:
>
> **0 unspecified**
> **1 mild**
> **2 moderate**
> **3 severe, without mention of psychotic behavior**
> **4 severe, specified as with psychotic behavior**
> **5 in partial or unspecified remission**
> **6 in full remission**

Code category **297 Delusional disorders** INCLUDES paranoid disorders and EXCLUDES acute paranoid reaction (298.3), alcoholic jealousy or paranoid state (291.5) and paranoid schizophrenia (295.3). A **shared psychotic disorder** (297.3) is a mental disorder two people share. Because of their close relationship and shared experiences, the first person with the delusional disorder convinces the second person to accept the delusions.

Now that you have an initial understanding of other psychotic conditions, let's get some practice coding them!

SUBJECTIVE
A patient presents with sadness and low self-esteem. Patient notes her normal sleep is now "interrupted sleep." The patient is very critical of herself and feels inadequate. The patient denies suicidal thoughts.

OBJECTIVE
Detailed physical exam is normal.

ASSESSMENT
The doctor's impression is the patient has psychotic depression.

PLAN
Antidepressants will be prescribed.

As the medical coding and billing specialist, would you choose *depression* or *psychosis* as the main term? A quick look at each term in the *Index to Diseases* indicates that either path will result in the same code. Let's use *Psychosis* as the main term and *depressive* as the subterm. Using that pathway, the *Index to Diseases* notes to "*see also* Psychosis, affective." Refer to Lesson 23 and note that *see also* indicates that additional information about the term and code is available to you under the referenced term in the *Index to Diseases*. After you review the information provided, your conclusion should be that you're on the right track with the original pathway; so return to *Psychosis*, *depressive* in the *Index to Diseases* and note the tentative code of **296.2** ✓ . Then turn to the *Tabular List* to determine the highest level of specificity. You'll note that code 296.2 describes major depressive disorder, single episode. *Psychotic depression* is included as a subterm under that description. To determine the fifth-digit subclassification for the code, you must determine whether the doctor documented mild, moderate, severe or in remission. This information is not documented, so you must select the fifth-digit 0 for "unspecified." You will assign code **296.20 Major depressive disorder, single episode, unspecified** for the final diagnosis.

Neurotic Disorders, Personality Disorders, and Other Nonpsychotic Mental Disorders (300-316)

As you may be able to tell from the title of this section, it contains a variety of disorders, dependencies and disturbances. Anxiety, personality disorders, sexual and gender-identity disorders, alcohol and drug dependency, nondependent abuse of drugs and other special symptoms or syndromes not elsewhere classified are covered in this one section. We will discuss the fifth-digit subclassification, but you will discover important information on your own as you review the EXCLUDES information and additional notes in this section.

In the categories **303 Alcohol dependence syndrome**, **304 Drug dependence** and **305 Nondependent abuse of drugs**, note the boxes for the fifth-digit subclassifications that relate to each category. Let's take a look at examples from each subclassification and do some coding practice so that you fully understand the meaning of the various fifth-digit terms. The fifth-digit options are the same for each of these codes. Use the following box to select the appropriate fifth digit as you code these examples.

0 unspecified
1 continuous
2 episodic
3 in remission

Fifth-Digit 0—Unspecified

Now try your hand at coding the following: A male of unknown age is brought unconscious to the ED. Once the patient has regained consciousness, the physician obtains a problem focused history and performs an expanded problem focused exam. The physician recommends detoxification. The patient refuses treatment and leaves AMA (against medical advice). He is diagnosed with chronic alcoholism.

To code this condition, locate the main term *Alcoholism* in the *Index to Diseases*. The subterm *chronic* suggests that **303.9** ✓ is tentatively the correct code. Now turn to the *Tabular List* to determine the highest level of specificity. You do not know whether this patient's dependency is continuous, episodic, or in remission, so you must code to "unspecified," or 0, for the fifth-digit subclassification. You will assign **303.90 Alcohol dependence syndrome, Other and unspecified alcohol dependence**, **unspecified** as the accurate code for this scenario.

Fifth-Digit 1—Continuous

Here's the next example to code: A 42-year-old female was involved in a car accident six months ago and suffers from whiplash. At the time of the accident, she was prescribed 1 to 2 tablets of Percodan to be taken every six hours as needed for pain. She is being seen by her physician for a prescription refill. The physician performs a detailed exam. He strongly advises the patient to find an alternative method for pain relief. The patient decides to schedule another visit in one month. The physician's assessment for this encounter is continuous dependency of Percodan.

To code this condition, use the coding pathway *Dependence*, *Percodan*. Note the tentative code of **304.0** ✓ in the *Index to Diseases*, and then turn to the *Tabular List* to determine the highest level of specificity. Based on the physician's notes, the fifth digit you will use is 1 for "continuous." So you assign code **304.01 Drug dependence, Opioid type dependence, continuous** as the correct code for this condition.

Fifth-Digit 2—Episodic

You're getting the hang of things now, aren't you? See how quickly you can determine the correct code for the following example: A 21-year-old college student is a new patient in the clinic. She admits the use of cocaine during her "finals week," believing its use increases her performance, confidence and energy. Now that her exams are over, she reports problems with insomnia related to the episodic use of the drug. After a problem focused exam the patient is encouraged to discontinue use of the drug. The patient is diagnosed with episodic cocaine abuse.

To code this condition, find the main term *Abuse* in the *Index to Diseases*. The subterms *drugs, nondependent, cocaine type* provide the tentative code of **305.6** ✓ . Now turn to the *Tabular List* to determine the highest level of specificity. Given all that you see here, including the fifth-digit options, you will assign code **305.62 Nondependent abuse of drugs, Cocaine abuse, episodic** based on the documentation of "episodic" in the notes.

Fifth-Digit 3—In Remission

Okay, here's the last example for you to code in this group: A 36-year-old patient has a history of sedative abuse but has been in remission for six months.

To code this condition, locate *Abuse* as the main term in the *Index to Diseases*. The subterms of *drugs*, *nondependent* and *sedative* provide you the tentative code of **305.4** ✓ .

Note the code and find it in the *Tabular List* to determine the highest level of specificity. Because remission is documented, you determine that the fifth-digit subclassification is 3, and you assign code **305.43 Nondependent abuse of drugs, Sedative, hypnotic or anxiolytic abuse, in remission** as the correct choice.

Intellectual Disabilities (317-319)

Intellectual disabilities are characterized by significantly subaverage general intellectual functioning that is associated with impairments in adaptive behavior, and that manifests during the child's developmental period. The *Tabular List* instructs you to use additional code(s) to identify any associated psychiatric or physical conditions if they are documented. The intellectual disabilities diagnosis can be classified as mild, moderate, severe, profound or unspecified. IQ levels are indicated in the *ICD-9-CM* with codes to correlate with each classification.

This completes your introduction to the codes in Chapter 5 of the *Tabular List*. Before we move ahead to the contents of Chapter 6, complete the following exercises to review what you've learned.

✍ Step 4 Practice Exercise 25-1

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Alcoholic delirium**
   ICD-9-CM code: _____

2. **Catatonic stupor**
   ICD-9-CM code: _____

3. **Acute hysterical psychosis**
   ICD-9-CM code: _____

4. **Obsessive-compulsive disorder**
   ICD-9-CM code: _____

5. **Anorexia nervosa**
   ICD-9-CM code: _____

6. **Kleptomania**
   ICD-9-CM code: _____

7. **Mild mental subnormality**
   ICD-9-CM code: _____

Use the following information to complete the CMS-1500 that follows.

8. ICD-9-CM Coding Challenge

Dwight Harrison, MD
NPI: 6574900497
Provider for Medicaid and
Western Workers Insurance

Leslie Jones, MD
NPI: 0405891109
Provider for Medicare,
Mutual Insurance and Blue Cross

Clifford Phillips, MD
NPI: 0275695402
Provider for Medicaid

Medical Care Center
100 South Main
Yourtown, CO 80000
(970) 555-1111

Patient Information

Name Kami Reynolds
Address 4575 Dixon Court Apt 7
City Youngstown **State** CO
ZIP 80004
Home Phone 970-555-6996
Date of Birth June 25, 1997
Sex F **Marital Status** single

Employment Information

Name of Employer
Occupation
Student Status **X Full time** **Part time**

Insurance Information

Primary Insurance
Name Medicaid
ID# 521-00-3333
Group#
Address PO Box 1461
City Denver
State CO **ZIP** 80203
Primary Insured Name Kami Reynolds
Relation to Patient Self
Employer

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Nicole Reynolds
Signature of patient (or parent of minor child)

Secondary Insurance
Name none
ID#
Group#
Address
City
State **ZIP**
Secondary Insured Name
Relation to Patient
Employer

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

_____
Signature of patient (or parent of minor child)

Physician signature: *Clifford Phillips MD*

Group NPI: 0665544004
EIN: 99-0000009
CLIA# CM8402

Date of Service	*5/1/20XX*	
Diagnosis	**Procedure**	**Charge**
	99213 Est. Patient Level 3	*$63.00*

Today's Charge	$63.00
Cash/Check	$0.00
Balance	$63.00

Kami Reynolds
DOB June 25, 1997
Date of Service 5/1/XX

SUBJECTIVE
This patient is brought in by her mother because of a change in the daughter's behavior. The mother notes hyperactivity, outbursts and over-involvement in activities. Patient notes she has been sleeping little and has been involved in sexual promiscuity. She denies medication, recreational or OTC drugs. Family history includes maternal bipolar disorder.

OBJECTIVE
An expanded problem focused physical exam does not indicate physical causes for these symptoms. Lab results indicate the thyroid is normal.

ASSESSMENT
Bipolar disorder.

PLAN
Recommend getting more sleep. Patient is prescribed lithium and encouraged to join a support group.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid#) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH SEX M F

b. OTHER INSURED'S DATE OF BIRTH SEX M F

b. AUTO ACCIDENT? YES NO Place (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1.														NPI	
2.														NPI	
3.														NPI	
4.														NPI	
5.														NPI	
6.														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

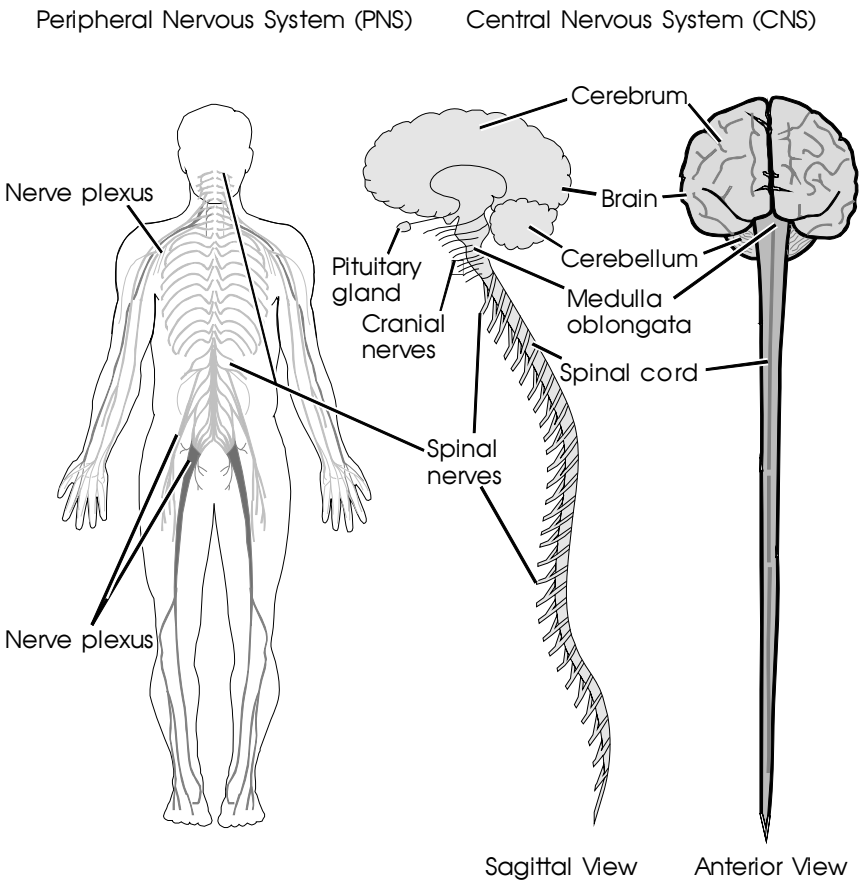
a. b.

Step 5 Review Practice Exercise 25-1

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 6 Diseases of the Nervous System and Sense Organs (320-389), Part 1

- ❑ Chapter 6 of the *ICD-9-CM* manual's *Tabular List* contains codes that pertain to the nervous system and sense organs. The **nervous system** regulates almost every activity in the body. The central and peripheral nervous systems comprise the nervous system. The **central nervous system** is composed of the brain and spinal cord. In this step, we will discuss this system and each of its sections, which include inflammatory diseases, hereditary and degenerative diseases and other disorders of the central nervous system. We will then discuss the disorders of the **peripheral nervous system**, which consist of the nerves and ganglia outside the brain and spinal cord. Finally, later in the lesson, we will identify the diagnostic process that deals with the sense organs, specifically of the eye and the ear.



Overview of neurologic system anatomic divisions

Inflammatory Diseases of the Central Nervous System (320-326)

In this section you will find diagnosis codes for *meningitis, encephalitis, abscesses, phlebitis* and *thrombophlebitis*, as well as codes for the late effects of intracranial abscess or pyogenic infection. This section lists many INCLUDES, EXCLUDES and additional notes that will assist you in accurate coding of these disease diagnoses.

Meningitis is an inflammation of the meninges, usually by either a bacterium or a virus. **Meninges** are the three membranes, the **dura mater**, the **pia mater** and the **arachnoid**, that cover the brain and spinal cord. Open your *ICD-9-CM* manual to the *Tabular List,* code category 320, and note that this category is specific to bacterial meningitis. This section lists many INCLUDES listed under the code description. All of the infections that cause inflammation are bacterial, as well. Subcategory 320.7 directs you to first code the underlying diseases, and then, to assist you in coding, it provides a list of some diseases. Move to category 321, and you will note that diseases in this category are caused by organisms other than bacteria. Another noteworthy item is that each subcategory of code 321 directs you to code first the underlying diseases. Finally, you should use code category 322 if no organism is specified as the cause of meningitis.

You will use code category 323 for the conditions of *encephalitis*, *myelitis* and *encephalomyelitis*. Note that each of these conditions ends with "itis." You know from your terminology lessons that this suffix means "inflammation of." **Encephalitis** is inflammation of the brain. **Myelitis** is inflammation of the spinal cord and of the bone marrow. **Encephalomyelitis** is inflammation of the brain and spinal cord. The *Tabular List* instructs you to code first the underlying disease in this category, as well.

Now that you are aware of the INCLUDES, EXCLUDES and additional notes in this section, it's time to give coding a try! Code for a diagnosis of meningitis due to whooping cough. Open your *ICD-9-CM* manual to the *Index to Diseases*, and locate the main term *Meningitis*. As you look down the list of subterms, you will find *due to*. This sounds like a good path to take, so let's continue. Under that subterm, you will find *whooping cough*, followed by codes **033.9 *[320.7]***. Remember from Lesson 23 that the slanted brackets indicate that another code is required in addition to the first code listed. You must record both codes, in the order they are given. Remember—do not include the slanted brackets when you record the second code. Note these tentative codes, and then turn to the *Tabular List* to determine the highest level of specificity. You will assign codes **033.9 Whooping cough, unspecified organism** and **320.7 Meningitis in other bacterial diseases classified elsewhere** as the correct codes for this condition. You're doing well!

The next section, **Organic sleep disorders** (**327**), is fairly straightforward to code, so let's move on to the next section.

Hereditary and Degenerative Diseases of the Central Nervous System (330-337)

The term **neurodegenerative disease** is a catch-all phrase that describes several poorly understood diseases that affect only the central nervous system (CNS). The etiology of these diseases is unknown, and they are all incurable, although some are treatable. Easily recognized symptoms often lead to the diagnosis of neurodegenerative disease. Sometimes, however, patients do not display all the common clinical features of a disease, so the diagnosis can be made only by the process of elimination relative to other CNS diseases. Before we discuss some of the diseases you will find within this section, review the *Tabular List* to note the inclusions, exclusions, notes and the many eponyms provided to assist you with accurate coding. Remember that eponyms are diseases named for persons. Four neurodegenerative diseases worth a closer look are *Alzheimer's disease, Parkinson's disease, Huntington's disease* and *amyotrophic lateral sclerosis* (known by many people as *ALS* or *Lou Gehrig's disease*, as discussed later).

As the overall population of the United States ages, awareness of and the predominance of Alzheimer's disease grows. **Alzheimer's disease** is a disease of diffuse atrophy throughout the cerebral cortex. The disease causes a progressive decline in intellectual and physical functions, including memory loss, personality changes and profound dementia. Technically speaking, Alzheimer's disease is a form of dementia, and its cause is unknown. We discussed dementia earlier in this lesson, so let's apply what you've learned to see how that information helps you in the coding process.

Consider that you are the medical coding specialist for a nursing home. You are to code the following dictation:

SUBJECTIVE
A 65-year-old rest home resident is seen for evaluation. Patient complains of memory disturbance, and the staff notes personality changes but no behavioral disturbances. The physician reviews the patient's history from the medical records.

OBJECTIVE
A detailed exam is performed.

ASSESSMENT
The patient is diagnosed with Alzheimer's dementia.

PLAN
The patient will be monitored by the staff for signs of increased agitation.

To code this condition, would you use *Alzheimer's* or *dementia* as the main term? Let's try *Dementia* as the main term and *Alzheimer's* as the subterm. Turn to the *Index to Diseases* and locate this coding pathway. You are instructed to "*see* Alzheimer's dementia." We chose the wrong coding pathway, but you have directions now! We will use *Alzheimer's* as the main term and *dementia* as the subterm. The coding pathway of *Alzheimer's*, *dementia* gives you a choice of "with or without behavioral disturbances." According to the notes, the staff sees changes in the patient's personality, but no behavioral disturbances. So you will note a tentative code *without behavioral disturbances*, which indicates **331.0** ***[294.10]***. Remember that the slanted brackets indicate that another code is required in addition to the first code listed. You must record both codes, in the order as they are given, but you do not include the slanted brackets when recording the second code. Now turn to the *Tabular List* with these tentative codes to determine the highest level of specificity. Based on the information you find there, you will assign codes **331.0 Alzheimer's disease** and **294.10 Dementia in conditions classified elsewhere without behavioral disturbance** as the final diagnosis codes for this encounter.

Parkinson's disease is a well-known and relatively common disease that creates movement disorders and pathologic changes in the midbrain that affect the involuntary muscle system. This disease results in decreased numbers of dopaminergic neurons in the brain. These neurons produce dopamine, and many symptoms of Parkinson's are related to the brain's underproduction of this chemical. For this reason, administration of the drug L-dopa has been known to temporarily reduce the effects of Parkinson's in a minority of patients. Category 332 is where you will find the specific codes for this disease.

Huntington's disease, coded in category 333, is a genetic disease characterized by chronic progressive mental deterioration, twisting movements of the face, limbs and body. Facial movements are affected, which can cause aspiration and malnutrition. Walking becomes impossible due to deterioration of gait. This disease does not usually appear or show symptoms until individuals are in the middle of their lives. Once the symptoms appear, the course of the disease is rapid. Death usually occurs 10 to 20 years after the onset of symptoms.

Amyotrophic lateral sclerosis (**ALS**) is a disease that became well-known when baseball player Lou Gehrig contracted it. Since then, the disease has commonly been referred to as **Lou Gehrig's disease**. Involuntary twitching of the hand muscles is a common early symptom, and the disease can lead to slurring of speech in advanced cases. In the end, patients are immobilized, and death usually results from paralysis of the respiratory muscles. The ICD-9-CM code for this disease is 335.20. To locate the code in the *Index to Diseases*, you can follow many different coding pathways:

Main term: *Disease;* subterm: *Lou Gehrig's*
Main term: *Lou Gehrig's disease*
Main term: *Sclerosis*; subterm: *amyotrophic (lateral)*
Main term: *Amyotrophia*; subterm: *sclerosis (lateral)*

Other Headache Syndromes (339)

In a later lesson, we will discuss how to code a headache when it's a symptom of an unconfirmed diagnosis or an uncertain condition. However, a headache may be the problem, not just the symptom of another condition. In this case, you will code from category **339**, **Other headache syndromes**. These conditions include cluster, tension, post-traumatic, drug-induced, complicated and other specified headache syndromes.

A cluster headache is one of the most painful types of headache, which occurs in cyclical patterns, or clusters. This type of headache is rare, although it is more common in men and it's most common among those between ages 20 and 40. Based on the length of the cluster periods and the remission periods, the International Headache Society has classified cluster headache into two types:

Episodic—In this form, cluster headache occurs at least daily for one week to one year, followed by a pain-free remission period lasting at least one month before another cluster period develops.

Chronic—In this form, cluster headache occurs daily for more than a year with no remission or with pain-free periods lasting less than one month.

The most common headache is the tension headache. A tension headache often feels like a tight band is around the head. It may be triggered by neck strain or eyestrain. The tension headache can be classified as episodic, chronic or unspecified. Turn in the *Tabular List* to **339.1**, **Tension type headache** and review that this code EXCLUDES "tension headache NOS" and "tension headaches related to psychological factors." Most tension headaches are easily treated with over-the-counter medications, including aspirin, ibuprofen and acetaminophen.

If you've been taking pain medication often, even common medications such as aspirin, acetaminophen and ibuprofen, the drugs may actually be contributing to your headaches rather than easing them. Drug induced headaches or rebound headaches may be dull, achy, throbbing or pounding and are caused by medication overuse. The only way to stop rebound headaches is to reduce or stop taking the pain medication that's causing them.

Other Disorders of the Central Nervous System (340-349)

The disorders you will find in this section are varied. Multiple sclerosis, hemiplegia, epilepsy, migraine and encephalopathy are among the many disorders included here. As before, we will cover some important items in this section, but when you are coding, be sure to read the inclusions, exclusions and additional notes in the *Tabular List* so you can code the diagnoses accurately.

Multiple sclerosis (**MS**) is an autoimmune disease of the central nervous system. This relatively common disease affects approximately one out of every 1,000 people in the United States. MS affects mostly people from 20 years to 45 years of age, and it is the number one neurological disease in young adults.

MS affects women about twice as often as it does men. The cause of MS is completely unknown, and it currently has no cure. This disease involves both sensory and motor abnormalities. The course of multiple sclerosis is chronic, and it is characterized by periods of intense symptoms followed by periods of remission. Symptoms involving the senses include blurred vision, a loss of the feeling of touch and unusual tingling sensations. The physical symptoms include weakness, difficulty or unsteadiness in walking and urinary- and sphincter-control problems. Currently MS can be treated with interferon drugs, which help reduce the frequency of symptoms.

Now turn to code category **342 Hemiplegia and hemiparesis** in the *Tabular List*, and locate the fifth-digit subclassification box. You will find information like the box on the page that follows.

> The following fifth digits are for use with codes 342.0-342.9:
>
> **0 affecting unspecified side**
> **1 affecting dominant side**
> **2 affecting nondominant side**

You will use these fifth digits to identify the side of the body affected by the hemiplegia, and they require some definition. Your **dominant** side is the side of the body you use primarily for **activities of daily living** (**ADLs**). For example, a right-handed person is **right-side dominant**. Usually the doctor will include in the dictation which side was affected, as well as whether that side is **dominant** or **nondominant**. If the doctor does not include this information, you will code to "unspecified." You will also see reference to the "dominant side," "nondominant side" and "unspecified side" in subcategories 344.3 and 344.4 for monoplegia of the lower and upper limbs.

Epilepsy is a brain disorder characterized by uncontrolled electrical discharges of neurons that interrupt normal function in the brain. Individuals with epilepsy may experience brief periods of unconsciousness, starring spells or even convulsions. Although epilepsy is a chronic condition, it does not usually get worse over time. People with epilepsy can expect to live a normal life span. There is no cure for epilepsy, but seizure-preventing medication can control those symptoms in a majority of persons with the disease. The condition for those individuals who do not respond to current medications is termed **intractable**. You can see this term in the box for fifth-digit subclassification in the **345 Epilepsy and recurrent seizures** code category. If the term intractable is not specified, you can determine by the documented medication which digit would be most appropriate.

Turn in the *Tabular list* to category **346 Migraine**. You will note this category excludes headaches not otherwise specified, which you'll use 784.0, as well as the headache syndromes, codes 339.00 through 339.89. You will note a box similar to the one that follows:

The following fifth digit subclassification is for use with category 346:

- **0 without mention of intractable migraine without mention of status migrainosus**
- **1 with intractable migraine, so stated without mention of status migrainosus**
- **2 without mention of intractable migraine with status migrainosus**
- **3 with intractable migraine, so stated, with status migrainousus**

For you to code the fifth-digits 1 or 3, the physician must specifically document that the patient does not respond to current medications related to the disease. If that is not documented you will use either 0 or 2 as the fifth digit. **Status migrainosus** is a debilitating migraine attack lasting for 72 hours or longer. Again, the physician must clearly document status migrainosus if the fifth digit is a 2 or 3.

Migraines can be classified as with or without an aura. A migraine with aura, or classic migraine, is characterized by visual disturbances such as flashes of light, zigzagging patterns or even blind spots. These warning symptoms may occur anywhere from a few minutes to 24 hours before the headache. Migraines without aura are also known as common migraines. Remember, if the documentation only provides "migraine" as the diagnosis, you'll code **346.90 Migraine, unspecified, without mention of intractable migraine without mention of status migrainosus** as the final code.

Time for some form coding practice: You are the medical coding and billing specialist for emergency physicians, and you are to code the following dictation:

SUBJECTIVE
A 55-year-old female is seen in the emergency department complaining of nausea, vomiting, and an intense headache. She experienced flashes of light prior to onset of symptoms.

OBJECTIVE
An expanded problem focused exam is performed.

ASSESSMENT
The impression is that the patient is suffering from a classic migraine.

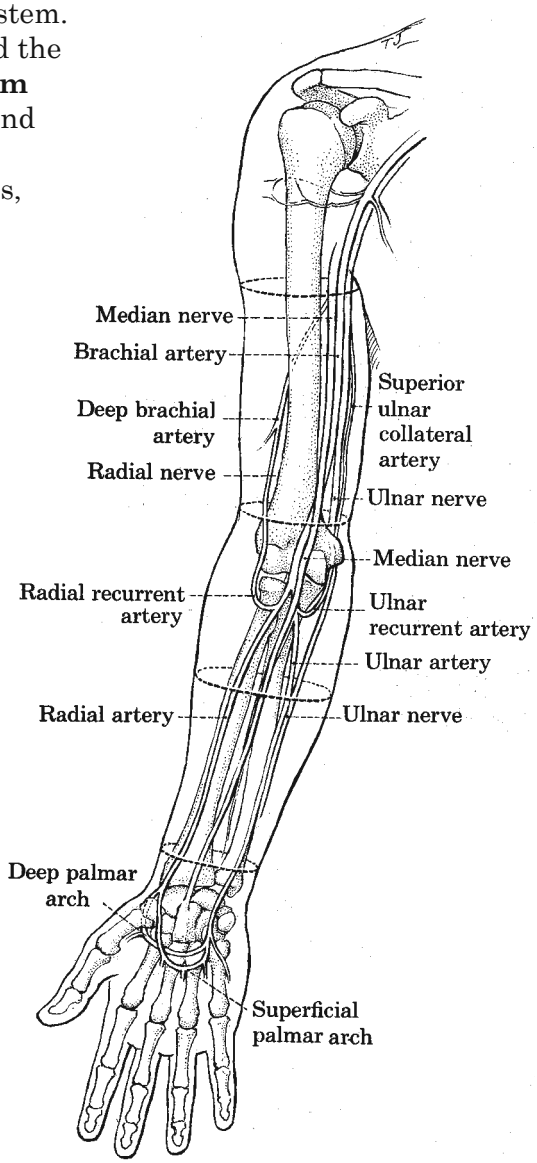
PLAN
The doctor suggests OTC (over-the-counter) medication and a follow-up with the patient's primary provider.

The patient presented with symptoms of nausea, vomiting and a headache. You do not code symptoms when a final diagnosis is provided. Therefore, you will begin in the *Index to Diseases* with the coding pathway of *Migraine*, *classic*. Note the tentative code of **346.0** ✓ and then turn to the *Tabular List* to determine the highest level of specificity. The doctor does not indicate whether the patient is currently taking medication for this condition and status migrainosus is not documented. You will assign the final diagnosis code of **346.00 Migraine with aura, without mention of intractable migraine without mention of status migrainosus**.

Disorders of the Peripheral Nervous System (350-359)

Now that you have a basic understanding of the central nervous system (CNS), let's turn to the peripheral nervous system. Remember that the CNS is composed of the brain and the spinal cord, and that the **peripheral nervous system** consists of the nerves and ganglia outside the brain and spinal cord. The peripheral nervous system section includes codes for disorders and diseases of the nerves, muscles and the combination of nerves and muscles, such as *carpal tunnel syndrome*, *myasthenia gravis* and *muscular dystrophy*, among others. You will find many eponyms in this section of the *Tabular List*. Once again, remember that eponyms are diseases named for persons. This section also has many INCLUDES and EXCLUDES for you to be aware of when you code from it. If an underlying disease is indicated with codes 357.1 through 357.4, 358.1, or 359.5 through 359.6, you must code that disease first.

Carpal tunnel syndrome is the result of the compression of the median nerve beneath the transverse carpal ligament within the narrow confines of the carpal tunnel, which is located at the wrist. A physician may diagnose a patient with carpal tunnel syndrome by having her hold her wrist back in an acute bent position for 60 seconds. If this results in pain, tingling, numbness and burning sensations in the palmar surface of the thumb, the index finger, the middle finger and part of the ring finger, it is called a positive Phalen's sign. One treatment for this condition consists of resting the hand and wrist for a period of time, avoiding activities that may aggravate the symptoms. The wrist may be splinted by the physician to avoid movement that might cause further damage to the nerves.



Source: *Dorland's Illustrated Medical Dictionary.* (1994). W.B. Saunders Company: Philadelphia, PA.

To code this condition, use the coding pathway of *Syndrome*, *carpal tunnel* in the *Index to Diseases*. Note **354.0** as the tentative code, and then turn to the *Tabular List* to determine the highest level of specificity. Based on the information you find, you can confidently assign code **354.0 Carpal tunnel syndrome** for the condition.

Myasthenia gravis (**MG**) is a disease of the neuromuscular function characterized by fluctuating weakness of certain skeletal muscle groups. It is an autoimmune process that affects the neuromuscular junction by impairing muscle contraction. The cause of MG is unknown. The symptoms of this disease involve fatigue of voluntary muscles. Because the facial muscles are often affected, many persons with this condition experience drooping eyelids, fatigue while reading or double vision. The disease tends to spread first to the upper muscles, especially the eye, face, lips, tongue, throat and neck. Eventually, MG spreads to the entire muscular system, causing immobility. Death often results from paralysis of the respiratory muscles and the diaphragm. You can locate code **358.00** for this condition in the *Index to Diseases* by selecting the main term *Myasthenia* and the subterm *gravis*. If you try to find the code using *Gravis* as the main term, you will be directed to "*see* condition," which is *myasthenia*.

Let's pause here so you can take a few deep breaths and then review the information from this section to see how well you understand all the details. We'll continue with the next section of the *Tabular List* and eye disorders after you have completed Practice Exercise 25-2.

✍ Step 7 Practice Exercise 25-2

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Staphylococcal meningitis**
   ICD-9-CM code: _____

2. **Tay-Sachs disease**
   ICD-9-CM code: _____

3. **Spasmodic torticollis**
   ICD-9-CM code: _____

4. **Spastic hemiplegia affecting the dominant side**
   ICD-9-CM code: _____

5. **Intractable grand mal epilepsy**
   ICD-9-CM code: _____

6. **Bell's palsy**
   ICD-9-CM code: _____

Use the following information to complete the CMS-1500 that follows.

7. ICD-9-CM Coding/Billing Challenge

FRONT RANGE FAMILY CARE
1800 Circle Court
Yourtown, CO 80000
(970) 555-3344

__X__ Greg Stephen, MD NPI: 0267679942
_____ Donald Milford, MD NPI: 0810998051
_____ Douglas Smart, MD NPI: 0144878804
Group NPI: 0881099885

Patient Information

Name Cathy Harrison
Address 2419 Zendt Drive
City Anytown **State** CO
ZIP 80000
Home Phone (970) 555-2112
Date of Birth August 9, 1967
Sex F **Marital Status** Married

Employment Information

Name of Employer Sandy's Nails
Address 452 Link Lane
City Anytown **State** CO
ZIP 80000
Phone (970) 555-1397
Occupation receptionist
Student **Full time** **part time** **If minor, name of school**

Insurance Information

Primary Insurance
Name Blue Cross of Wyoming
ID# 641-00-0000
Group# GE54002
Address PO Box 456
City Casper
State WY **ZIP** 82002
Primary Insured Name Tom Harrison
Relation to Patient Spouse
DOB 08-02-59
Employer Front Range Auto Sales

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Tom Harrison
Signature of patient (or parent of minor child)

Secondary Insurance
Name none
ID#
Group#
Address
City
State **ZIP**
Secondary Insured Name
Relation to Patient
DOB
Employer

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

_____
Signature of patient (or parent of minor child)

Physician signature: *Greg Stephen MD*
SSN: 700-07-0007
EIN: 66-6000600
Participating Provider for: Blue Cross, HMO and Mutual Life

Date of Service	*3/19/XX*	
Diagnosis	**Procedure**	**Charge**
	99242 Consultation, level 2	*$102.00*

Today's Charge	$102.00
Cash/Check	$20.00
Balance	$82.00

Cathy Harrison
DOB 8/9/1967
Date of Service 3/19/XX
Referred by Carolyn Hooper, MD
NPI: 0188123456

SUBJECTIVE
The patient is seen for an office consultation to confirm her physician's diagnosis of multiple sclerosis. Patient notes that tingling sensations and weakness in her legs have increased.

OBJECTIVE
The patient history and recent MRI provided by her physician are reviewed by the neurologist. An expanded problem focused examination is performed.

ASSESSMENT
The neurologist confirms the diagnosis of multiple sclerosis.

PLAN
The patient is prescribed a 2-week course of prednisone to reduce her current symptoms. She was also given information on current injectable medications that could reduce the frequency of her exacerbations. A follow-up appointment is to be scheduled to discuss long-term treatment of her MS. A copy of the consultation notes will be sent to her primary care provider.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid#) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH SEX M F

b. OTHER INSURED'S DATE OF BIRTH SEX M F

b. AUTO ACCIDENT? YES NO Place (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1.														NPI	
2.														NPI	
3.														NPI	
4.														NPI	
5.														NPI	
6.														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

a. b.

Step 8 Review Practice Exercise 25-2

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may may have made.

Step 9 Diseases of the Nervous System and Sense Organs (320-389), Part 2

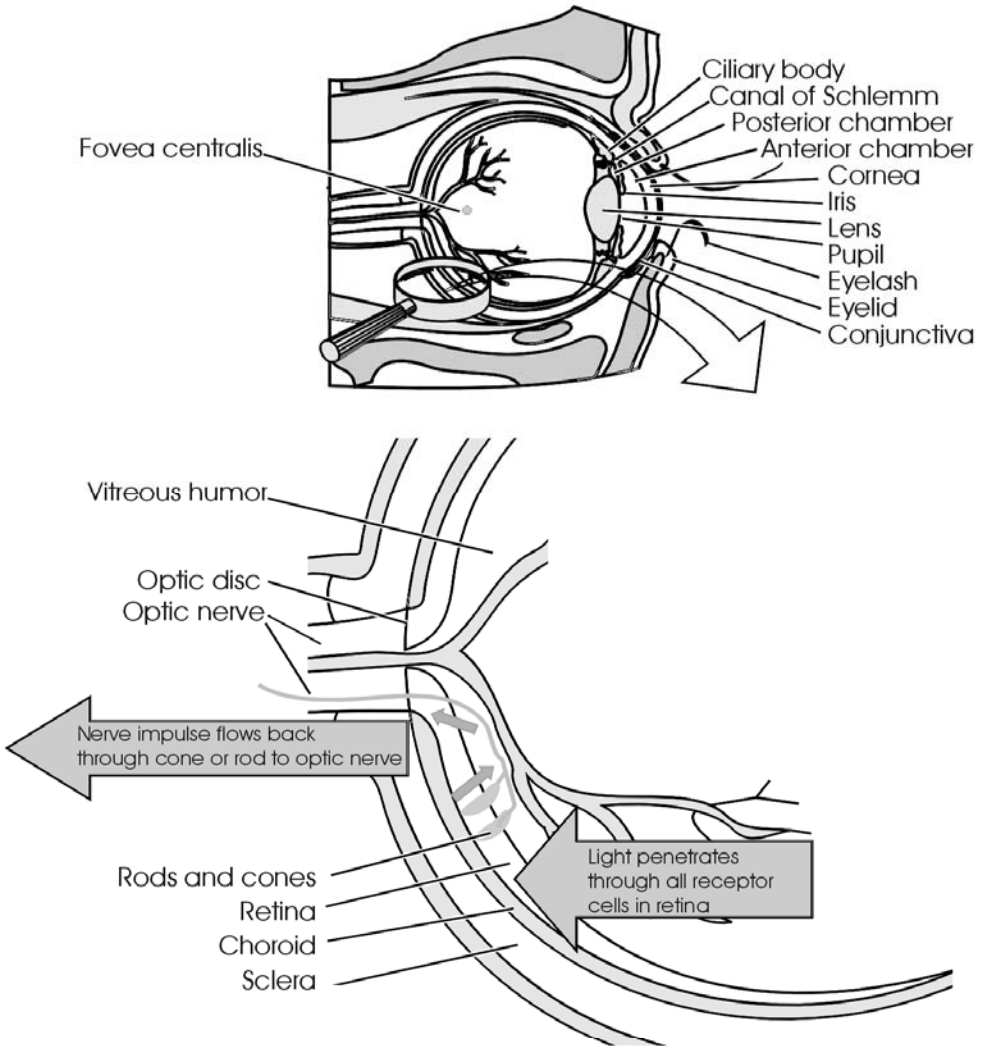
- ❑ We're now ready to discuss the diagnosis codes that pertain to diseases and conditions related to the sense organs. As noted earlier, our focus will be on disorders of the eye and the ear.

Disorders of the Eye and Adnexa (360-379)

This section contains codes for disorders of the eye, including the lids and other accessory organs of the eye. You are directed to use an additional external cause code, if applicable, to identify the cause of the eye condition. In this section, you will find codes for disorders of the globe, retina, choroid and iris. You will find diseases such as glaucoma and cataracts. Visual disturbances and blindness are also covered. And then you will discover many diseases that pertain to the appendages of the eye, such as the conjunctiva and optic nerves.

In this section, you will note that the code description is at the highest level of specificity—in other words, there are no fifth-digit subclassification boxes to consider. A few codes are manifestations of other diseases, and the text directs you to first code the underlying disease. We will include some of the information from the *Tabular List* in this step, but you will want to review the details carefully on your own when you are coding from this section.

Turn to the *Tabular List* and locate code category 360, which contains codes for disorders of the globe. The **globe** of the eye is also referred to as the **eyeball**. The first disorder you encounter in subcategories 360.0 and 360.1 is **endophthalmitis**, which is an inflammation of the tissues within the eyeball. Note subcategories 360.5 and 360.6 for codes pertaining to retained (old) foreign bodies, and you are to use an additional code to identify the foreign body. Code 360.5 EXCLUDES current penetrating injury with magnetic foreign body, while code 360.6 EXCLUDES nonmagnetic foreign bodies. Instead, you will use a code in the 800 range for current injuries. These subcategories are specifically for those foreign bodies that have been present for a while and are not likely to be removed.



Anatomy and basic physiology of the globe

Categories 361 and 362 supply diagnostic codes for the **retina**. This light-sensitive membrane forms the innermost layer of the eyeball. When you have a **retinal detachment**, the light-sensitive layer at the back of the eye separates from the blood supply, causing disruption to vision. **Retinopathy** is a noninflammatory degenerative disease of the retina. There are two types of **background retinopathy**; one is designated as a manifestation from diabetes, and one is not. Persons who have diabetes for a long period become susceptible to retinal changes that may lead to this degenerative disease of the retina. If this is the case, you are directed to code the diabetes first and use the diabetic retinopathy code 362.01 as the secondary code. If diabetes is not documented, code 362.10 for background retinopathy, is applied.

Try your hand at the following scenario, and see how well you do:

PRESENTING PROBLEM
The patient notes flashes of light, followed by a sensation of curtain moving across the eye. Diagnosed with partial retinal detachment.

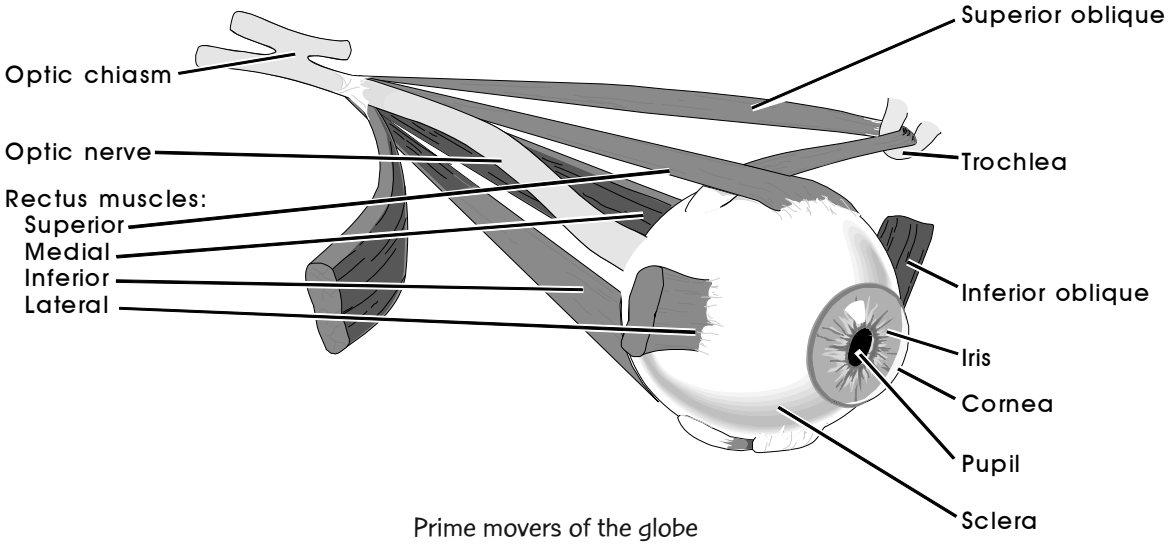
PROCEDURE
REPAIR OF RETINAL DETACHMENT.

The sclera is explored, and stay sutures are placed under the rectus muscles to allow access to the surgical site. Cryotherapy (freezing retinal tissues to seal them) was used. Incisions are repaired by layered closures. A topical antibiotic is applied.

POSTOPERATIVE DIAGNOSIS
Partial retinal detachment, single defect.

To code this condition, determine the *Index to Diseases* coding pathway. You will select the main term *Detachment* and the subterms *retina, with retinal defect, single,* which suggests a tentative code of **361.01**. Now, as always, go to the *Tabular List* to determine the accuracy of this code, and you will find **361.01 Recent detachment, partial, with single defect**. You have the correct code!

Code category 364 covers disorders of the iris and ciliary body. You are probably aware that the **iris** is the colored area of your eye, located behind the cornea. You might not know that the **ciliary body** refers to the muscles and tissues that are involved in focusing the eye. The disorders of the iris and ciliary body include inflammations, vascular disorders, degenerations, cysts and adhesions. **Iridocyclitis** is an inflammation of the iris and ciliary body. Symptoms of this condition include eye pain and redness, sensitivity to light, watering of the eye and decreased vision. **Iridoschisis** is a condition in which the iris is split into two layers.



Prime movers of the globe

Glaucoma, included in code category 365, is a rise in intraocular pressure, which restricts blood flow. In the *Tabular List* for this category, you will find descriptions such as "open angle" and "angle closure." **Open angle** means that the drainage angle is open, but the outflow of **aqueous humor**, the watery substance that fills the cavity between the lens and the cornea, is blocked. **Angle closure**, or **closed angle**, means the iris closes the drainage angle and obstructs outflow of aqueous humor. The most common condition is primary open-angle glaucoma. If the condition is something other than this, the physician will document it.

We discussed cataracts earlier, in Lesson 24, as a manifestation of diabetes. A variety of conditions that create a cloudy, or calcified, lens that obstructs vision are known as **cataracts**. This obstruction can be partial or complete, in one eye or both eyes, and in or on the lens. There are many kinds of cataracts, and they are classified by their **etiology** (cause and time of occurrence), and then by their **morphology** (size, shape, location). Open your *ICD-9-CM* manual to the *Tabular List* to code category **366 Cataract**. The first subcategory, **366.0 Infantile, juvenile and presenile cataract**, is classified as the etiology. The etiology indicates the individual is younger than age 50 by categorizing infantile, juvenile and presenile. The morphology further divides this subcategory. Subcategory **366.1 Senile cataract** is the most common kind of cataract, affecting those persons older than age 50. Cataracts in this group are of unknown cause, painless, and develop as one ages. Cataracts that result from injury to the eye are known as traumatic, again classified by etiology. In subcategory 366.4 you will find cataracts associated with other diseases. In most cases, these cataracts are manifestations of another disease, and you are instructed to code the underlying disease first. **After-cataract** is a recurrent capsular cataract or any membrane in the pupillary area that occurs after a procedure has been performed for extraction or absorption of the lens. You will code this condition under category 366.5.

Category 367 includes codes for disorders of refraction and accommodation. **Refraction** refers to the most common visual problem, **refractive error**. This defect happens when the refracting media of the eye prevents light rays from coming together into a single focus on the retina. This is due to an irregular cornea curvature, problems with the focusing power of the lens, and the length of the eye. This condition is known as *farsightedness*, *nearsightednes*s and *astigmatism*. **Farsightedness**, or **hyperopia**, initially causes difficulty in seeing objects that are near and eventually affects distance vision. **Nearsightedness**, or **myopia**, is when near objects can be seen clearly while those in the distance appear blurred. **Astigmatism** is a condition where a perfectly healthy eye has a cornea that is not spherical. A minor degree of this condition is normal and does not require glasses. More severe conditions require special corrective glasses or contact lenses that have no optical power, but rather, correct the curvature. **Accommodation** is the process by which the eye adjusts itself to focus on near objects.

Severe conditions of astigmatism require special corrective glasses or contact lenses.

Eye strain, double vision, color blindness and night blindness are just a few of the visual disturbances included in code category 368. **Deutan defect** is a disorder that affects only males. This condition is characterized by difficulty distinguishing green and red colors. To code this condition, locate the main term *Defect* in the *Index to Diseases*. Locating the subterm *deutan* provides the tentative code of **368.52**. Then turn to the *Tabular List* to determine the highest level of specificity, and assign your chosen code, **368.52 Color vision deficiencies, Deutan defect**, as the correct one.

We will discuss categories 370 and 371 together because they both relate to the cornea. **Keratitis**, code category 370, is an inflammation of the cornea. Corneal ulcers and superficial inflammation with and without inflammation of the conjunctiva are associated with keratitis. Corneal scars, deposits, edema and degenerations are some of the disorders you will find in code category 371.

The most common disorder of the conjunctiva is *conjunctivitis*. **Conjunctivitis** is an inflammation of the conjunctiva. The common symptoms of this acute contagious disease are redness, discharge, itching and burning of the lids. A form of conjunctivitis may be referred to as **pink eye**. A wedge-shaped conjunctival thickening that advances from the inner corner of the eye toward the cornea is termed **pterygium**. Other conditions in this code category consist of degeneration, scars, vascular disorders and cysts.

Category 376 covers disorders of the orbit, which should not be confused with the globe. Remember that the globe was also referred to as the eyeball. The orbit is the bone cavity that *contains* the eyeball. Inflammation, protrusion, recession and deformity are some of the disorders of the orbit. **Enophthalmos** is the term for recession of the eyeball deep into the eye socket. This condition may be due to atrophy of the orbital tissue, trauma, or surgery or the cause may be unspecified. To code enophthalmos resulting from atrophy of the orbital tissue, you would locate the main term *Enophthalmos* in the *Index to Diseases*. The subterms *due to* and *atrophy of the orbital tissue* provide **376.51** as the tentative code. After you determine the highest level of specificity for the code in the *Tabular List*, you should be confident that you've coded the condition correctly as **376.51 Enophthalmos due to atrophy of orbital tissue**.

Diseases of the Ear and Mastoid Process (380-389)

This section contains codes for diseases and disorders of the external, middle and inner ear; the mastoid process; vertiginous syndromes and other disorders of the vestibular system; otosclerosis; and hearing loss. If applicable, you are to use an additional external cause code to identify the cause of the ear condition. Note that there are some INCLUDES, a few EXCLUDES and three manifestation codes that direct you to code underlying diseases first.

Now let's look at some of the terms you may encounter when you are dealing with diseases of the ear and mastoid process.

- **Otitis** is an inflammation of the ear. The symptoms of otitis usually are pain, fever, abnormalities of hearing, hearing loss, **tinnitus** (ringing, buzzing, roaring or clicking noise in the ear) and **vertigo** (a form of dizziness).
- **Externa** refers to the external auditory canal. **Otitis externa** is an inflammation of the external auditory canal.
- **Media** refers to the middle ear. **Otitis media** is an inflammation of the middle ear.
- **Suppurative** means "to produce pus." **Acute nonsuppurative otitis media** is a brief, relatively severe inflammation of the middle ear without the discharge of pus.
- **Serous** refers to a clear, watery fluid. **Acute serous otitis media** is a brief, relatively severe inflammation with a collection of clear, watery fluid in the middle ear.

Now that you are a little more comfortable with the terminology, let's code a disorder from category 380.

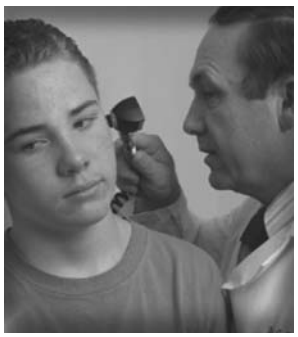
SUBJECTIVE
A 25-year-old female seeks assistance at an urgent care facility. She complains of an inability to hear out of her left ear, and that her balance has been off x 1 day. Patient denies cold or cough and is afebrile. She has no pain in the right ear.

OBJECTIVE
Using suction, the physician removes a large ball of wax under direct visualization. No infection is noted. The ear canal is then irrigated.

ASSESSMENT
Ear wax.

PLAN
The patient is discharged in stable condition.

What is the problem? The problem isn't that the patient has an ear; rather, the wax is the problem. Turn in the *Index to Diseases* to locate the main term *Wax*, and you will find *Wax in ear* with code **380.4**. Note this tentative code, and then turn to the *Tabular List* to determine the highest level of specificity. The code description of **Impacted cerumen** is the medical term for wax in the ear, which is included under that description. So you will assign code **380.4 Disorders of external ear, Impacted cerumen** for this scenario.



Impacted cerumen is the medical term for wax in the ear.

The **mastoid process** is the nipple-like projection of the petrous part of the temporal bone, that part which contains the structures of the internal ear. As you know from your terminology, "itis" is an inflammation; therefore, **mastoiditis** is an inflammation of any part of the mastoid process. This condition most often affects children. Acute mastoiditis usually begins as a middle-ear infection (otitis media). In severe cases of this disease, the mastoid air cells are fused together. **Mastoid air cells** are numerous small, intercommunication cavities in the mastoid process.

The **tympanic membrane** constitutes the boundary between the external and middle ear. This thin, tense membrane is also referred to as the **drumhead**, **drum**, **eardrum** and **tympanum**. Disorders you will find in code category 384 are *inflammation* and *perforation of the eardrum*.

Disorders of the ear often affect our balance. Code category 386 contains diseases and conditions that include dizziness as a symptom. Open your manual to the *Tabular List*, and note that this category EXCLUDES "vertigo NOS." Meniere's disease, for instance, causes hearing and balance dysfunction. Symptoms of **Meniere's disease** include fluctuating deafness, ringing in ears and dizziness.

You will use code category 387 for **otosclerosis**, which is a pathological condition of the bony part of the internal ear, called the **bony labyrinth**. Otosclerosis causes formation of spongy bone, which may cause **bony ankylosis**, or a union of the bones of a joint by proliferation (to grow and increase in number by means of reproduction) of bone cells. This process can result in complete immobility of the bones and cause progressive hearing impairment. Code 387 INCLUDES *otospongiosis*, as you will note when you look at the code in the *Tabular List*.

You can find other disorders of the ear in code category 388. These disorders range from degenerative disorders, to noise-induced hearing loss, to the basic earache. *Tinnitus* is also located in this category. **Tinnitus** is defined as abnormal noises in the ear, including ringing, clicking, roaring and buzzing.

Conditions included within code 389 for hearing loss range from conductive and sensorineural hearing loss to deaf mutism. **Conductive deafness** is caused by a defective sound-conducting apparatus of the external or middle ear. Turn to this section in the *Tabular List*, and note that it is subdivided into the specific sites of the ear. **Sensorineural hearing loss**, perceptive hearing loss or deafness, is caused by a defect in nerve conduction.

Time for a breather! We're now more than one-third of the way through the chapters of the *ICD-9-CM* manual's *Tabular List*! Are you surprised at how many significant details there are relevant to such apparently small regions of the body as the eyes and the ears? Of course, when you consider how complex the systems of sight and sound are, all the parts, pieces and processes required for them to function properly shouldn't surprise you too much. Now, once again, complete the following Practice Exercise to review some of the details you've just learned.

✍ Step 10 Practice Exercise 25-3

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Malignant myopia**
   ICD-9-CM code: _____

2. **Macular degeneration, senile disciform**
   ICD-9-CM code: _____

3. **Pink eye**
   ICD-9-CM code: _____

4. **Orbital hemorrhage**
   ICD-9-CM code: _____

5. **Bullous myringitis**
   ICD-9-CM code: _____

6. **Meniere's disease**
   ICD-9-CM code: _____

7. **ICD-9-CM Coding Challenge**

   PRESENTING PROBLEM
   Protrusion of auricle.

   A 3-year-old patient has a history of otitis media that has not responded to multiple treatments of antibiotics. Review of recent CT reveals a fusion of mastoid air cells.

   PROCEDURE PERFORMED
   COMPLETE MASTOIDECTOMY.

   The mastoid cortex (a plate of bone on the lateral surface of the mastoid process of the temporal bone) is removed. The fusion of mastoid air cells is exposed. The infected mastoid air cells are removed by a curette and drill. A temporary drain is placed, and the incision is sutured. The patient receives IV antibiotics. No complications are noted.

   POSTOPERATIVE DIAGNOSIS
   Acute mastoiditis.

   ICD-9-CM code: _____

Step 11 Review Practice Exercise 25-3

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 12 Diseases of the Circulatory System (390-459), Part 1

- ❑ Chapter 7 of the *Tabular List* focuses on the circulatory system. This major body system includes the heart and blood vessels. As you will learn, many diseases of the heart are closely related. For example, one disease may be the cause of another, or the diseases may occur in conjunction with each other. Because the circulatory system includes so many diseases and related codes, we are once again dividing our discussion into two major sections. In the first section, we discuss acute rheumatic fever (codes 390 through 392), chronic rheumatic heart disease (codes 393 through 398), hypertensive disease (codes 401 through 405) and ischemic disease (codes 410 through 414). You will have several opportunities to practice coding some diagnoses within these disease categories. So let's get started!

Acute Rheumatic Fever (390-392)

Acute rheumatic fever is a febrile disease that occurs mainly in children or young adults. Rheumatic fever usually appears weeks after the person has experienced untreated or inadequately treated strep throat or scarlet fever. Symptoms of rheumatic fever include fever, joint pain, lesions of the heart, abdominal pain, rash or nodules on the skin and chorea. The heart lesions can eventually affect the heart valves and the normal blood flow, which would lead to disease diagnoses in the subsequent section of the *Tabular List*, which focuses on rheumatic heart disease. Because of this relationship, rheumatic fever can be categorized "without mention of heart involvement," "with heart involvement" or as "Rheumatic chorea." Turn to the *Tabular List* to find more information about coding this condition. Rheumatic fever with mention of heart involvement EXCLUDES any diagnosis that indicates chronic heart diseases of rheumatic origin unless rheumatic fever is also present or there is evidence of recrudescence or activity of the rheumatic process. **Chorea** is the occurrence of irregular, spasmodic, involuntary movements of the limbs or facial muscles. In this section, chorea is linked with rheumatic fever and streptococcal infections. The *Tabular List* for the rheumatic chorea code EXCLUDES Huntington's chorea.

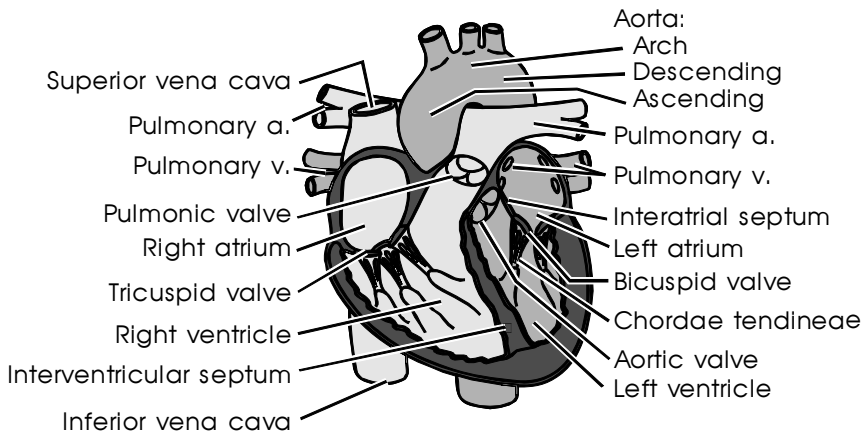
Acute rheumatic fever is a febrile disease that occurs mainly in children or young adults.

Let's get right into some coding practice related to rheumatic fever to see how well you understand this section of the *Tabular List*. See how accurately and quickly you can code this description: A patient is diagnosed with acute rheumatic fever with myocarditis.

To accurately code this scenario, would you begin with *fever* or *myocarditis* as your main term? One coding pathway is more direct, but let's take a look at both options. First, turn to the *Index to Diseases* and locate the main term *Myocarditis*. The subterm *rheumatic* provides us with code 398.0, but look further, to the phrase "active or acute." You know the condition is acute, so your tentative code would be **391.2**. This is not a particularly straightforward coding pathway, so let's try the other option. Use the coding pathway of *Fever, rheumatic, with heart involvement, myocarditis* to locate the tentative code **391.2**. Now you will need to determine the highest level of specificity using the *Tabular List*. Based on the information you find there, you can confidently assign **391.2 Rheumatic fever with heart involvement, Acute rheumatic myocarditis** for the given diagnosis of acute rheumatic fever with myocarditis.

Chronic Rheumatic Heart Disease (393-398)

As we mentioned previously, **rheumatic heart disease** is the condition that develops when the heart valves are damaged by rheumatic fever. This resulting condition may be a life-long disease. To avoid contracting rheumatic heart disease, one must prevent rheumatic fever from ever occurring. In this section, you will find abnormalities of the heart valves, such as *stenosis*, *insufficiency* and other valve diseases. **Stenosis** is a narrowing, or stricture, of the valve. **Insufficiency** indicates a malfunction and/or narrowing of the valve. The narrowing and malfunction of the various valves restrict the heart's normal blood flow. These valves are flaps, or cusps, within the heart. Codes for the *mitral valve*, the *aortic valve* and a *combination* of the mitral and aortic valves are subdivided into categories 394, 395 and 396. *Tricuspid, pulmonary* and *unspecified* valves are included within the 397 code category. As you look through this portion of the *Tabular List*, you will note that in several subcategories the designated code EXCLUDES diseases that are not specified as rheumatic.



Internal cardiac anatomy and circulation flow

The bicuspid, or more commonly called, **mitral valve** is located between the left atrium and the left ventrical of the heart. The **aortic valve** is positioned between the left ventricle and the ascending aorta. The **tricuspid valve** is located between the right atrium and right ventricle. The **pulmonary valve** lies at the entrance to the pulmonary trunk, coming from the right ventricle.

Okay—let's code the following scenario associated with what you've just read about chronic rheumatic heart disease.

SUBJECTIVE
A 47-year-old male is admitted to the emergency department. He has been feeling fatigued and has had a cough and swollen feet, for the past week. Two hours prior to admission, he was awakened by difficulty breathing and chest tightness.

OBJECTIVE
Blood pressure is normal. Patient is afebrile. HEENT normal. Cardiovascular exam notes rumbling apical diastolic murmur with presystolic accentuation. Crackles heard on respiratory exam. Feet are swollen. Chest x-ray, echocardiogram, and ECG are ordered. Chest x-ray shows signs of pulmonary edema.

ASSESSMENT
Patient suffers from mitral stenosis.

PLAN
He will be admitted by his PCP for additional work-up.

To code this scenario, you will need to determine the coding pathway to follow in the *Index to Diseases*. Is the problem that the patient has a mitral valve? No, the problem is the **stenosis**, or narrowing, of that valve. So begin with the main term *Stenosis* in the *Index to Diseases*. Once you've located this term, find the subterm *mitral*, and you have the tentative code **394.0**. But, as you know, you aren't done until you turn to the *Tabular List* to determine the highest level of specificity. In the *Tabular List*, code 394.0 has no inclusions, exclusions or additional notes, so you can confidently assign **394.0 Diseases of the mitral valve, Mitral stenosis**, for this condition.

Hypertensive Disease (401-405)

Hypertension refers to high blood pressure. The diagnosis of hypertension is confirmed in adults when the average of two or more blood pressure measurements on at least two visits reveal a diastolic (bottom number) pressure of 90 mmHg or higher or a systolic (top number) pressure of 140 mmHg or higher.

Hypertension refers to high blood pressure.

Benign hypertension refers to a relatively mild degree of hypertension of prolonged or chronic duration. *Malignant hypertension* is an accelerated, severe hypertensive disorder, with progressive vascular damage and a poor prognosis. A diagnosis of hypertension without further qualification is classified as *unspecified*.

The *Index to Diseases* includes a table under the main term *Hypertension* with subterms indexed in the usual way. The three columns included in this table provide codes for *Malignant, Benign* and *Unspecified*. If the conditions are specified by the dictation you receive, you might code many conditions in combination with hypertension.

Hypertensive Heart Disease—Certain heart conditions are assigned to code group **402 Hypertensive heart disease** when a causal relationship is stated due to hypertension. Note that the 402 group of codes includes *heart failure*. If heart failure is stated in the dictation, an additional code is required to identify the type of heart failure. When a heart condition and hypertension are documented but are not linked as causal relationships, code the two conditions separately.

Hypertension and Chronic Kidney Disease—The *ICD-9-CM* presumes a cause-and-effect relationship between hypertension and chronic kidney disease, so you should code these combined diagnoses to group **403 Hypertensive chronic kidney disease**, when classified as renal failure with hypertension.

Hypertensive Heart and Chronic Kidney Disease—When a heart condition and a kidney condition both exist, assign a combination code from code group **404 Hypertensive heart and chronic kidney disease**. Fifth digits are provided to indicate whether *congestive heart failure*, *renal failure* or *both* are present. For this category, use an additional code to specify the type of heart failure.

Essential hypertension, also known as **primary hypertension**, is the state of having elevated blood pressure with no apparent cause. Modern drugs and appropriate changes in diet and lifestyle are often successful as treatment for this condition. When elevated blood pressure is documented, be careful not to assume that hypertension is the correct diagnosis. Another specific code exists for elevated blood pressure, and it's not in this section.

Hypertensive heart disease is the description used for any condition due to hypertension classifiable to codes 429.0 through 429.3, 429.8 and 429.9. You are directed to use an additional code to specify the type of heart failure if it is documented. When the causal relationship between hypertension and heart disease is not documented, code each condition separately.

So let's code for hypertensive cardiovascular disease with CHF (congestive heart failure). Based on what we just said, this condition requires two codes for accurate coding. Locate the Hypertension table in the *Index to Diseases*. You will quickly find *Hypertension* because it is the main term in the Hypertension table, and applies to all subterms in that table. So the coding pathway is *hypertension*, *cardiovascular disease*, *with*, *heart failure*. Malignant or benign is not documented, so you move to the *Unspecified* column of the Hypertension table.

Then turn to the *Tabular List* to determine the highest level of specificity for the tentative code **402.91**. Although this does seem to be the correct code, you aren't done coding just yet! Remember that you need to use an additional code to specify the type of heart failure. So now locate *Failure* as the main term in the *Index to Diseases*. The subterm *congestive* provides the tentative code of **428.0** and directs you to "*see also* Failure, heart." The coding pathway *Failure*, *heart*, *congestive* provides the same tentative code. Once again, turn to the *Tabular List* to determine the highest level of specificity. You can now assign codes **402.91 Hypertensive heart disease Unspecified, With heart failure** and **428.0 Congestive heart failure, unspecified** for accurate coding of this condition.

> Terminology: Nephros is Greek for kidney while the Latin term for kidney is renal.

The *ICD-9-CM* presumes a cause-and-effect relationship between hypertension and kidney disease, so you should code these combined diagnoses to group **403 Hypertensive chronic kidney disease**. Turn to the *Tabular List* to review the fifth-digit subclassification box for hypertensive kidney disease.

When a heart condition and a kidney condition both exist, you will assign a combination code from code group **404 Hypertensive heart and chronic kidney disease**. You will presume a relationship between the hypertension and renal failure, whether the relationship is documented or not. The relationship between hypertension and heart and chronic kidney disease is discussed in *Diagnostic Coding and Reporting Guidelines for Outpatient Services* in the front of the *ICD-9-CM* manual. If in doubt ask the physician so that you will assign accurate diagnostic codes for this hypertension category.

Let's code malignant hypertensive cardiovascular renal disease for practice. Once again, turn to the Hypertension table in the *Index to Diseases*. Then locate the subterm *cardiovascular renal* in the table. The *Malignant* column provides the tentative code of **404.00**. You will determine the highest level of specificity in the *Tabular List*, and based on the information you find there, assign **404.00 Hypertensive heart and chronic kidney disease, Malignant, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified** as the accurate code. However, the notes found with the fifth-digit subclassification instruct you to use an additional code to identify the state of the chronic kidney disease. Return to the *Index* and locate the coding pathway *Disease, kidney, chronic*. Code 585.9 is provided as the tentative code. A quick check with the *Tabular List* verifies **585.9 Chronic kidney disease**, **unspecified** is correct because the stage is not documented.

Secondary hypertension affects about 10 percent of all cases of hypertension. Unlike essential hypertension, this condition has an identifiable cause. Secondary hypertension is due to or associated with a variety of primary diseases, such as renal disorders, disorders of the central nervous system, endocrine diseases and vascular diseases. When you code secondary hypertension, two codes are necessary to identify the underlying disease and the hypertension.

Ischemic Heart Disease (410-414)

Any of a group of acute or chronic cardiac disabilities resulting from insufficient supply of oxygenated blood to the heart is known as **ischemic heart disease**. This section includes conditions such as *myocardial infarction*, *angina pectoris* and *aneurysms*.

Myocardial infarction (**MI**) is a sudden insufficiency of blood supply to an area of the heart muscle, usually as the result of a coronary artery occlusion. In the *ICD-9-CM* manual, the area of the heart muscle is subdivided into anatomical sites at which the MI might occur. Diagnostic statements do not always mention the affected wall, but you can usually find this information in the EKG report. If that report is not available, you will code to "Unspecified site." Turn to the *Tabular List* to review the fifth-digit subclassifications provided for the myocardial infarction category 410. Select the fifth digit to indicate that the current infarction is unspecified, the initial episode of care, or a subsequent episode of care for the same infarction. Patients sometimes experience a second infarction that involves another wall. In that case, you would code for both infarctions according to the site involved, and you would assign a fifth-digit 1 to indicate an initial episode of care for each infarction.

Myocardial infarctions are also a challenge to code. To help you understand the coding hierarchy for MIs, here is a summary of the codes you would use:

1. **410 Acute myocardial infarction**—Use this classification if the documented duration of the MI is eight weeks or less.
2. **414.8 Other specified forms of chronic ischemic heart disease**—Use this classification after the acute period has expired.
3. **412 Old myocardial infarction**—Use this category for "old," healed MIs that show no symptoms.

The eight-week rule for coding MIs, combined with the fifth digits for code 410, can cause diagnosis difficulties for both you as the coder and the insurance payer. According to *ICD-9-CM* rules, you use the acute diagnosis throughout the entire eight-week phase of treatment. If the patient is dismissed from the hospital, and then readmitted with a new MI during the eight-week time period, you will assign the fifth-digit 1, which indicates an initial episode of care. However, if the second admission is related to the previous admission and not to a new MI, it is a subsequent episode of care, and you would assign the fifth-digit 2. Look again in the *Tabular List* at code 410. Do you see the box that says "The following fifth-digit subclassification is for use with category 410:"? This gives you the information you need to assign the fifth digit correctly!

Here's another scenario for you to review, and demonstrate your increasing coding skills pertaining to heart disease. When you've completed your assessment and identified the code or codes you would assign to the diagnosis, compare your steps to the summary that follows the scenario to see how well they match.

CHIEF COMPLAINT
Chest pain.

HISTORY OF PRESENT ILLNESS
The patient is a white male who presents with a chief complaint of "chest pain." The patient has a prior history of coronary artery disease. The patient presents today stating that his chest pain started yesterday evening and has been somewhat intermittent. The severity of the pain has progressively increased. He describes the pain as a sharp and heavy pain which radiates to his neck and left arm. He ranks the pain a 7 on a scale of 1-10. He admits some shortness of breath and diaphoresis. He states that he has had nausea and 3 episodes of vomiting tonight. He denies any fever or chills. He admits prior episodes of similar pain prior to his PTCA in 19XX. He states the pain is somewhat worse with walking and seems to be relieved with rest. There is no change in pain with positioning. He states that he took 3 nitroglycerin tablets sublingually over the past 1 hour, which he states has partially relieved his pain. The patient ranks his present pain a 4 on a scale of 1-10. The most recent episode of pain has lasted 1 hour. The patient denies any history of recent surgery, head trauma, recent stroke, abnormal bleeding such as blood in urine or stool or nosebleed.

PAST MEDICAL HISTORY
Hypertension, coronary artery disease, atrial fibrillation, status post PTCA in 19XX.
Medications: Aspirin 81 mg daily. Humulin N insulin 50 units in a.m. HCTZ 50 mg daily. Nitroglycerin 1/150 sublingually p.r.n. chest pain.
ALLERGIES: PENICILLIN.
Social history: Denies alcohol or drugs. Smokes 2 packs of cigarettes per day. Works as a banker.
Family history: Positive for coronary artery disease (father and brother).

REVIEW OF SYSTEMS
All other systems reviewed and are negative.

PHYSICAL EXAMINATION
GENERAL: The patient is a 40-year-old white male. The patient is moderately obese, but he is otherwise well developed and well nourished. He appears in moderate discomfort, but there is no evidence of distress. He is alert and oriented to person, place and circumstance. There is no evidence of respiratory distress. The patient ambulates without gait abnormality or difficulty.
HEENT: Normocephalic, atraumatic head. Pupils are 2.5 mm, equal, round and react to light bilaterally. Extraocular muscles are intact bilaterally. External auditory canals are clear bilaterally. Tympanic membranes are clear and intact bilaterally.
NECK: No JVD. Neck is supple. There is free range of motion and no tenderness, thyromegaly or lymphadenopathy noted. Pharynx: Clear, no erythema, exudates or tonsillar enlargement.
CHEST: No chest wall tenderness to palpation. Heart: Irregularly irregular rate and rhythm, no murmurs, gallops or rubs. Normal PMI. Lungs: Clear to auscultation bilaterally.
ABDOMEN: Soft, nondistended. No tenderness noted. No CVAT.
SKIN: Warm, diaphoretic, mucous membranes moist, normal turgor, no rash noted.
EXTREMITIES: No gross visible deformity, free range of motion. No edema or cyanosis. No calf or thigh tenderness or swelling.

COURSE IN EMERGENCY DEPARTMENT
The patient's chest pain improved after the sublingual nitroglycerin and completely resolved with the nitroglycerin drip at 30 ug/min. He tolerated the TPA well. He was transferred to the CCU in a stable condition.

IMPRESSION
Acute inferior myocardial infarction.

How did you do? Let's compare notes. Begin by locating the main term *Infarction* in the *Index to Diseases*, and then the subterms *myocardial, inferior*. This coding pathway provides the tentative code of **410.4** ✓ **.** Determine the highest level of specificity in the *Tabular List*. Note that code 410.4 is for an **Acute myocardial infarction, Of other wall inferior**. The shaded box under code 410 indicates that a fifth-digit subclassification is required for accurate coding of this disease. And so you use 1 as the fifth digit because the initial episode is documented, and you assign **410.41** for this scenario.

This is a lot of information to take in! Let's pause here and do a quick review. If there are sections you're struggling with, be sure to contact your instructor for assistance.

✍ Step 13 Practice Exercise 25-4

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Rheumatic chorea**
   ICD-9-CM code: _____
2. **Rheumatic endocarditis**
   ICD-9-CM code: _____
3. **Benign essential hypertension**
   ICD-9-CM code: _____
4. **Secondary hypertension due to Cushing's disease**
   ICD-9-CM code: _____
   ICD-9-CM code: _____
5. **Acute anterolateral myocardial infarction, initial episode**
   ICD-9-CM code: _____

6. ICD-9-CM Coding Challenge

PREOPERATIVE DIAGNOSIS
Chronic renal failure with hypertension, with need for dialysis access due to end-stage renal disease.

POSTOPERATIVE DIAGNOSIS
Same.

PROCEDURE PERFORMED
PLACEMENT OF ARTERIOVENOUS FISTULA.

After informed consent, this 25-year-old female was brought to the operating room and placed in a supine position on the table. After induction of anesthesia, the patient was prepped and draped appropriately. I identified the cephalic vein, marked it and the radial artery. An area was marked between these two, and the area was infiltrated with Marcaine and epinephrine prior to making the incision. I dissected out the cephalic vein first, followed by the radial artery. The distal end of the vein was clamped and transected. I then occluded the radial artery and both ends. Bleeding was controlled appropriately with clamps.

I then performed an end-to-end anastomosis with Gore-Tex sutures. Prior to completing the anastomosis, the fistula was flushed with heparinized saline. The procedure was completed with the final sutures, and the fistula was opened to evaluate the flow in the vessel. Good thrill (vibration) and bruit (harsh or musical sound) were present over the entire area. The subcutaneous tissue and skin were closed appropriately, and sterile dressings were applied. The fistula will be evaluated in the next 24 hours for dialysis use.

ICD-9-CM code: _____

ICD-9-CM code: _____

Step 14 Review Practice Exercise 25-4

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

🕮 Step 15 Diseases of the Circulatory System (390-459), Part 2

- In this second part of our discussion about Chapter 7 of the *Tabular List*, you will learn about how to code diseases of pulmonary circulation (codes 415 through 417); other forms of heart disease (codes 420-429); cerebrovascular disease (codes 430 through 438); diseases of the arteries, arterioles and capillaries (codes 440 through 449); diseases of the veins and lymphatics and other diseases of the circulatory system (codes 451 through 459).

  This lesson is loaded with coding information and details, so if you are feeling at all overwhelmed at this point, stop for a few minutes and reflect on how much you have already learned, and consider how familiar many of the details from this and the previous lessons about ICD-9-CM coding have already become. You're doing great! So take a few slow, deep breaths, and let's continue the journey over some new coding pathways.

Diseases of Pulmonary Circulation (415-417)

Diseases of pulmonary circulation include *acute pulmonary heart disease*, c*hronic pulmonary heart disease* and *other diseases of the pulmonary circulation*. A **pulmonary embolism** is the closure of the pulmonary artery or branch as the result of a blood clot. **Infarction** is necrosis of lung tissue as the result of an obstruction of the arterial blood supply. The infarction is usually the result of an embolism. **Primary pulmonary hypertension** is a rare disease characterized by an increase in pulmonary circulation with no apparent cause.

Take a look at the *Tabular List* for this range of codes, and search for inclusions, exclusions and notes to assist you with accurate coding. For example, notice that code 415.0 EXCLUDES "cor pulmonale NOS;" you are directed to use code 416.9 instead. Code 415.1 EXCLUDES pulmonary embolisms and infarctions that are complications of abortion (codes 634 through 638 with a fourth digit of .6 and code 639.6); ectopic or molar pregnancy (code 639.6); pregnancy, childbirth or the puerperium (codes 673.0 through 673.8); and personal history of pulmonary embolism (code V12.55). Also note that codes within category 417 EXCLUDES "congenital arteriovenous fistula, congenital aneurysm and congenital arteriovenous aneurysm" and alternative codes are included for use with these conditions.

Other Forms of Heart Disease (420-429)

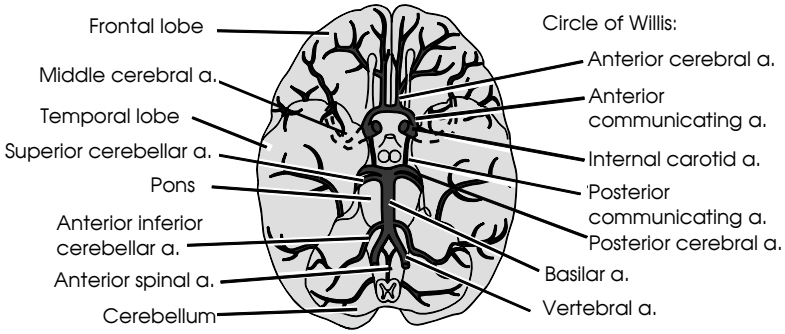
This section includes codes for inflammations, disorders and failures of the heart. Although this group of codes is quite large, you should find that coding these conditions is fairly straightforward. And, as always, if you have questions about anything in this or any other section, call your instructor. Remember, we want you to succeed, and someone will be available to answer your questions!

Cerebrovascular Disease (430-438)

Cerebrovascular diseases (**CVDs**) belong to a group of conditions that relate to any disease affecting an artery supplying blood to the brain. *Intracranial hemorrhage*, *occlusions*, *transient cerebral ischemia* and late effects of cerebrovascular disease are some conditions you will find in this section. This group of codes INCLUDES conditions that are a result of hypertension. You will need to use an additional code for those conditions to identify the presence of hypertension.

Ruptured blood vessels in the brain result in **intracranial hemorrhages**. There are four basic types of intracranial hemorrhage, classified according to where the hemorrhage occurs: **subarachnoid** (430), **intracerebral** (431), **extradural** (432.0) and **subdural** (432.1). To locate the ICD-9-CM code for each of these conditions, use the main term *Hemorrhage*, and then the type of hemorrhage as the subterm. This type of hemorrhage is nontraumatic, or not caused by trauma.

Subarachnoid hemorrhages, code category 430, are located on the surface of the brain. Another source of subarachnoid hemorrhages is ruptured congenital aneurysms located along the middle or anterior cerebral arteries or the communicating branches, known as the **Circle of Willis**. These small aneurysms are known as **berry aneurysms**, and they are frequently lethal if they are not recognized and treated with surgery.

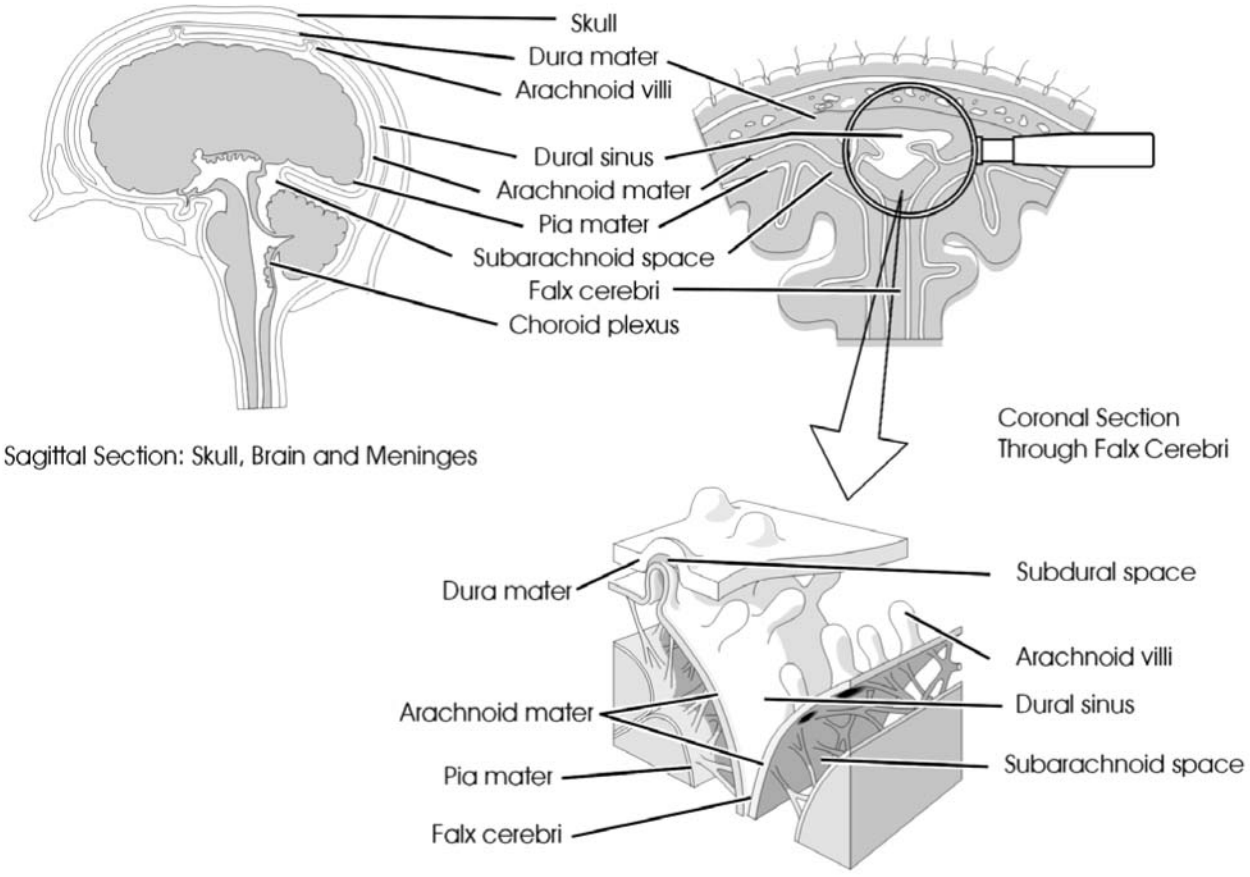


Intracranial arterial systemic circulation

Intracerebral hemorrhage is bleeding within the brain caused by ruptured blood vessels in the head. It is one of the three main mechanisms by which a stroke can occur. The blood can irritate the brain tissue, causing swelling, or it can collect in a mass, referred to as a **hematoma**. Either of these conditions can cause pressure on the brain tissues and can rapidly destroy them. Intracerebral hemorrhages are confirmed by a CT or MRI; treatment may range from medication to surgical removal of the hematoma.

Extradural hemorrhages (also known as epidural hemorrhages) are located in the space between the skull and the dura, or brain lining. These hemorrhages tend to form slowly over a period of several hours. Because they form so slowly, the hemorrhages can often be drained before they cause serious consequences. If they are left untreated, epidural hemorrhages are fatal.

Bleeding between the outer covering of the brain (dura) and the brain's surface is referred to as **subdural hemorrhage**.



Three-dimensional detail of meninges

Here's another sample to code. You'll probably have this one figured out as quickly as you can locate the codes in your manual.

PREOPERATIVE DIAGNOSIS
A 76-year-old male complains of headache, weakness, slurred speech and lethargy. Patient does not recall hitting his head. CT confirms subdural hemorrhage.

PROCEDURE PERFORMED
CRANIOTOMY.

An incision is made in the scalp, and the scalp is peeled away. A bur drill is used to drill into the skull to access the hematoma. The dura mater is then incised to reach the hemorrhage under the dura mater. The hematoma is decompressed, and the bleeding is controlled. The dura is sutured closed, followed by repositioning and suturing of the scalp.

POSTOPERATIVE DIAGNOSIS
Subdural hemorrhage.

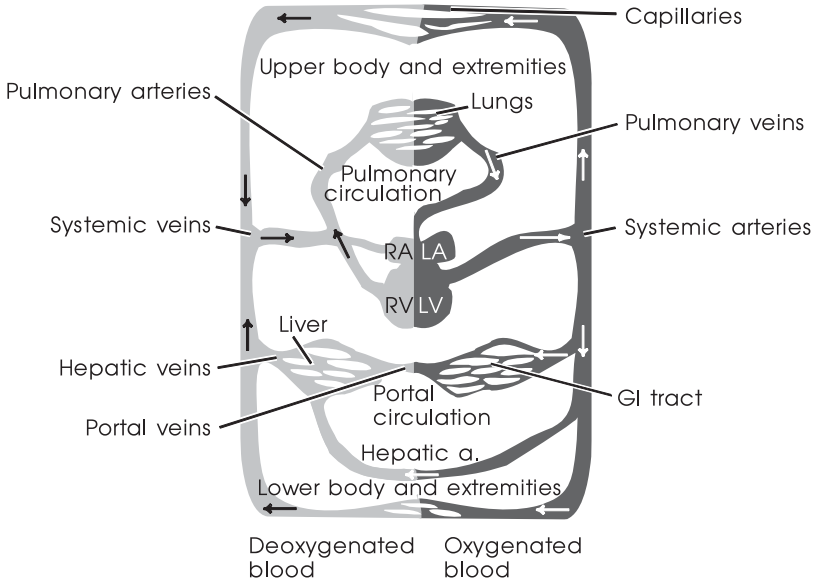
The correct code can be determined fairly easily on this one. Go to the *Index to Diseases* using the coding pathway of main term *Hemorrhage* and subterm *subdural*. You should note a tentative code of **432.1**. Then go to the *Tabular List* to determine highest level of specificity. As you probably already know, the accurate code to assign is **432.1 Subdural hemorrhage**. Great job!

The next two categories in the "Cerebrovascular Disease (430-438)" section deal with **occlusions**, a term that refers to the act of closing, or the state of being closed. An obstruction of the cerebral or precerebral arteries can result in a **cerebral infarction**. You will note the fifth-digit subclassification box in the *Tabular List* for categories 433 and 434. Use of the fifth digit here indicates whether or not a cerebral infarction was mentioned. Categories 433 and 434 also instruct you to use an additional code, if applicable, to identify status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility, noting V45.88 is the correct code to apply. The drugs tPA (tissue plasminogen activator) and rtPA (recombinant tissue plasminogen activator) are given within three hours of a stroke, after which its detriments may outweigh its benefits of breaking down blood clots.

The last code category we will discuss in this section is that for late effects of cerebrovascular disease, 438. Do you remember learning about late effects? A late effect is the residual condition produced after the acute phase of an illness or injury has terminated. If a residual condition is documented with the late effect, you will code that condition first, and then the late effect. Turn to code group 438 in your manual and be sure to read the notes associated with it, as well as all the various subcategories and the EXCLUDES associated with code 438.5.

Diseases of Arteries, Arterioles, and Capillaries (440-449)

This section contains diagnosis codes for *atherosclerosis*, *aortic aneurysms*, *embolisms*, *thrombosis* and a variety of other diseases that pertain to the blood vessels. An **aneurysm** is a sac formed by the dilation of the wall of an artery, vein or the heart. The sac is filled with fluid or clotted blood, often forming a pulsating tumor. When this sac is formed at the site of the aorta, it is termed **aortic aneurysm**. An **embolism** is when an artery is suddenly blocked by a clot or foreign material. **Thrombosis** is the formation, development or presence of a thrombus, or an aggregation of blood factors. These blood factors are primarily platelets and protein with entrapment of cellular elements. There are many INCLUDES and EXCLUDES listed in these code groups, so be sure to read the details closely when you code from this section.



Atherosclerosis is a common disorder of the arteries. This condition is set in motion when cells that line the arteries are damaged. **Plaque** develops at the site of the damage. These deposits impede or eventually shut off the blood flow. This condition can be specified to the aorta, the renal artery or the extremities. Atherosclerosis of the extremities is more common in the legs than in the arms. When a person with this condition runs or walks a long way, the blood supply is inadequate, which results in cramping of the legs. Atherosclerosis can be prevented with a low-fat, low-cholesterol and low-salt diet.

Now let's try your skills coding for an aneurysm of the subclavian artery. To begin, locate the main term *Aneurysm* in the *Index to Diseases*. Locating the subterm *subclavian* provides the tentative code of **442.82**. Turn to the *Tabular List* to determine the highest level of specificity. You can easily and confidently assign **442.82 Other aneurysm, Subclavian artery** as the correct code.

Diseases of Veins and Lymphatics, and Other Diseases of the Circulatory System (451-459)

In this section of Chapter 7, you will see conditions that pertain to the veins and lymph channels, *hypotension* and other disorders of the circulatory system. Code categories 451 through 456 cover inflammation, obstruction, dilation and distention of veins. **Hemorrhoids** are an example of a varicose condition of external hemorrhoidal veins and can be found in code category 455. The *Tabular List* provides inclusions and exclusions to assist you with your diagnostic coding of these conditions. Category 451 also notes to use an additional E code to identify the drug if the condition is drug induced.

Note in the *Tabular List* that the conditions of the lymph channels in code group 457 are specifically for noninfectious disorders. It's also important to know that **lymphedema** may or may not be due to a mastectomy but that it is caused by a reduction in the lymphatic circulation. **Lymphangitis** is an inflammation of the lymph vessel.

The condition of abnormally low blood pressure is known as **hypotension**. This condition is covered in the code group 458. **Orthostatic** or postural hypotension refers to a drop in the blood pressure when there is a sudden change in body position. Hypotension caused by medication is referred to as **iatrogenic hypotension**.

✍ Step 16 Practice Exercise 25-5

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Idiopathic pulmonary hypertension**
   ICD-9-CM code: _____

2. **Wenckebach's phenomenon**
   ICD-9-CM code: _____

3. **Arteriolosclerosis of the extremities**
   ICD-9-CM code: _____

4. **Varicose veins of the lower extremity**
   ICD-9-CM code: _____

5. ICD-9-CM Coding Challenge

PREOPERATIVE DIAGNOSIS
Sick sinus syndrome.

POSTOPERATIVE DIAGNOSIS
Sick sinus syndrome.

PROCEDURE PERFORMED
DUAL CHAMBER PACEMAKER AND ATRIAL AND VENTRICULAR LEADS.

INDICATIONS FOR PROCEDURE
This patient has been experiencing increasing episodes of sick sinus syndrome which are not able to be controlled with medication. A dual-chamber pacemaker was recommended after discussion with the patient and his family. This gentleman and his family were informed of all potential complications, including infection, hematoma, pneumothorax, hemothorax, myocardial infarction, and possibly death. The patient has agreed to the procedure and signed the consent.

PROCEDURE
The patient was admitted to the cardiac catheterization lab and placed on the table. He was prepped and draped in the usual manner. Adequate anesthesia was achieved, and the procedure was started. The pacemaker pocket was created with hemostasis. The pocket was placed in the left infraclavicular area. A 9 French peel-away sheath was used to introduce an atrial and a ventricular lead into their correct position. The leads were sutured and secured.

The pulse generator was then connected to the leads. The pocket was prepared for insertion of the generator. The pacemaker and leads were placed in the pocket, and the pocket was closed in 2 layers.

The patient tolerated the procedure well and was discharged to the postanesthesia care unit.

ICD-9-CM code: _____

Step 17 Review Practice Exercise 25-5

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

🕮 Step 18 Lesson Summary

- ❑ Hurray! You've completed all the new information in this lesson. You should be feeling really proud of your progress toward becoming a medical coding and billing specialist! You've made it through an introduction to Chapters 5 through 7 of the *ICD-9-CM* manual's *Tabular List*, and you've learned a lot of valuable coding information in the process.

  Do you know how it feels to be training for some challenging physical event? Maybe even for a marathon? If you do, you might recognize some things in common between doing that and working your way through these lessons. There are periods of intensity when you wonder whether you're going to reach the smaller goals you set for yourself along the way to the finish line. Each time you do, you are inspired and feel even more energy for the next step. You are in the final lap of this lesson and well on your way toward your goal of consistently using ICD-9-CM codes correctly!

  To finish this part of your training to become a medical coding and billing specialist, take whatever time you need to go back and review anything in this lesson that you still have questions about, or any coding exercises that you're not totally comfortable with. If anything still confuses you, remember that you can call your instructor and ask for help. When you're ready, go ahead and take the quiz. Then take a few more deep breaths, clear your head and you'll be ready to start fresh with the next lesson.

✉ Step 19 Mail-in Quiz 25

- ❑ Follow the steps to complete the Quiz.

  a. Be sure you've mastered the instruction and the Practice Exercises that this Quiz covers.

  b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

  c. When you've finished, transfer your answers to the Answer Sheet. Use only blue or black ink.

  d. **Important!** Please fill in all information requested on your Answer Sheet or when submitting your Quiz via e-mail.

  e. Submit your answers to the school via mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 25

Choose the best answer from the choices provided. Each item is worth 2 points.

1. **Which is true of the diagnosis hypertensive chronic kidney disease? _____**
   a. You should code hypertension as the primary diagnosis and chronic kidney disease as a coexisting diagnosis.
   b. You should code one combined diagnosis because there is a cause-and-effect relationship between hypertension and chronic kidney disease.
   c. You should only code the chronic kidney disease.
   d. You should code hypertensive heart disease with chronic kidney disease.

2. **The central nervous system is composed of the _____.**
   a. brain and nerves
   b. brain and spinal cord
   c. ganglia and nerves
   d. nerves and spinal cord

3. **_____ is the closure of the pulmonary artery or branch as the result of a blood clot.**
   a. An infarction
   b. Primary pulmonary hypertension
   c. A pulmonary embolism
   d. Secondary hypertension

4. **Which is a true statement of shared psychotic disorder? _____**
   a. It is a mental disorder two people share.
   b. It is sharing patient files with other physicians.
   c. The first person with the delusional disorder convinces the second person to accept the delusions.
   d. Both a and c

5. **Cataracts are classified by _____.**
   a. their size and location
   b. cause and time of occurence
   c. time of occurrence and their location
   d. etiology and their morphology

6. Which statement is true about the term intractable? _____

a. This term is found in the fifth-digit subclassification for category 345.

b. Intractable indicates the patient is responding to current medications for the disease.

c. Intractable can be coded for 346 Migraine even if it is not documented.

d. You can guess by the medications for migraines if you should use this code.

7. _____ is a disease made famous when baseball player Lou Gehrig contracted it.

a. Amyotrophic lateral sclerosis

b. ALS

c. Lou Gehrig's disease

d. All of the above

8. Which is *not* a true statement of secondary hypertension? _____

a. Two codes are necessary to identify the underlying disease and the hypertension.

b. It affects about 90 percent of all cases.

c. This condition has an identifiable cause.

d. This condition is due to or associated with a variety of primary diseases.

9. Which statement is *not* true of category 295? _____

a. It INCLUDES schizophrenia of the types described in codes 295.0 through 295.9 that occur in children.

b. The category EXCLUDES childhood type schizophrenia (299.9).

c. Category 295 requires a fifth-digit subclassification to describe the current condition of the disorder.

d. The category INCLUDES infantile autism.

10. Rheumatic heart disease is the condition that develops when the heart valves are damaged by rheumatic fever. Which heart valves are specified within the 397 code category? _____

a. A combination of the mitral and aortic valves

b. Mitral valve

c. Tricuspid, pulmonary and unspecified valves

d. Mitral, tricuspid and pulmonary valves

11. Which is *not* a true statement of iridocyclitis? _____

a. It is an inflammation of the iris and ciliary body.

b. It is a condition in which the iris is split into two layers.

c. Symptoms of this condition include eye pain and redness, sensitivity to light, watering of the eye and decreased vision.

d. None of the above

12. Which statement is *not* true of an extradural hemorrhage? _____

a. It forms very quickly.

b. It is also known as an epidural hemorrhage.

c. If left untreated, it is fatal.

d. It is located in the space between the skull and the dura.

13. Categories 303, 304 and 305 require a fifth-digit subclassification consisting of the following: _____ and in remission.

a. Specified type, continuous, epic

b. Unspecified, continuous, epic

c. Unspecified, continuous, episodic

d. Specified type, continuous, episodic

14. Which is *not* a true statement? _____

a. Otitis is an inflammation of the ear.

b. Media refers to the external auditory canal.

c. Otitis externa is an inflammation of the external auditory canal.

d. Otitis media is an inflammation of the middle ear.

15. Which statement is *not* true about multiple sclerosis? _____

a. This disease involves both sensory and motor abnormalities.

b. Symptoms involving the senses include blurred vision, a loss of the feeling of touch and unusual tingling sensations.

c. MS affects men about twice as often as it does women.

d. Currently MS can be treated with interferon drugs, which help reduce the frequency of symptoms.

16. What are the two types of background retinopathy? _____

a. One is a detachment and one is not.

b. One is noninflammatory and one is inflammatory.

c. One is designated as a manifestation from diabetes and one is not.

d. None of the above

17. The four basic types of intracranial hemorrhage are _____.

a. subarachnoid, intracranial, extradural, subdural
b. subarachnoid, intracerebral, extracerebral, subdural
c. subcerebral, intracerebral, extracerebral, subdural
d. subarachnoid, intracerebral, extradural, subdural

18. Which is a true statement of the mastoid process? _____

a. It is part of the external ear.
b. Mastoiditis is an inflammation of any part of the mastoid process.
c. Inflammation of the mastoid process usually affects adults.
d. None of the above

19. Which statement is *not* true of atherosclerosis? _____

a. It is caused when cells in the arteries are damaged.
b. This condition can be prevented with a low-fat, low-cholesterol and low-salt diet.
c. It is a rare disorder of the arteries.
d. This condition can be specified to the aorta, the renal artery or the extremities.

20. The most common condition of glaucoma is _____.

a. open-angle
b. closed-angle
c. angle closure
d. aqueous humor

Assign the accurate diagnostic code for the following conditions. Verify final digits with the *Tabular List* and double-check your answers. Each code is worth 3 points.

21. Conjunctivitis of both eyes

_____

22. Acute posttraumatic stress disorder

_____

23. Ruptured abdominal aorta

_____

24. Delirium tremens

_____

25. Left otitis media

_____

26. Paralysis of nondominant lower limb

_____

27. Unstable angina

_____

28. Histiocytic leukemia in remission

_____

29. Background retinopathy

_____

Review the documentation provided for each scenario that follows, and then apply the appropriate ICD-9-CM code(s) to each scenario. Verify final digits with the *Tabular List* and double-check your answers. Each code is worth 3 points.

30. Office Visit—Established Patient

SUBJECTIVE
This 63-year-old Hispanic female, who is a long-term insulin-dependent diabetic, experienced the onset of headache, blurred vision, vomiting and hypotension this morning after she did not take her morning insulin. The patient has a long-standing history of hypertension. She denies chest pain or diaphoresis. The patient does not smoke, drink or use recreational drugs. Medications include insulin and nadolol (Corgard). No prior history of hepatitis, anemia, pulmonary, renal or gastrointestinal disease. Allergies: NONE.

OBJECTIVE
This is an obese Hispanic female in no acute distress. She is alert, oriented and cooperative. Heart: 46, regular rhythm. S1 and S2 present without abnormal heart sounds, murmurs. PMI difficult to assess. Respiratory rate: 16, clear to auscultation bilaterally. Temperature 96.6. Blood pressure: 130/60. Neck: No JVD. Supple without masses. Abdomen: Bowel sounds normal. No organomegaly. Abdomen protuberant. Extremities: No edema, cyanosis or clubbing. Neurologic: Grossly intact.

ASSESSMENT
1. First-degree AV heart block. This may be secondary to nadolol (Corgard).
2. Diabetes mellitus, type 2, requiring insulin adjustment, with long-term insulin use.
3. Hypertension.

PLAN
Fasting and 2-hour postprandial blood sugars, regular insulin p.r.n. until blood sugar adjusted, discontinue nadolol (Corgard), begin clonidine 0.1 mg t.i.d., stress thallium test, Holter monitoring.

_____

_____

_____

_____

31. PREOPERATIVE DIAGNOSIS
Right tympanic membrane perforation.

POSTOPERATIVE DIAGNOSIS
Right tympanic membrane perforation with acute suppurative otitis media, and conductive hearing loss.

PRIMARY PROCEDURE
RIGHT EAR EXAMINATION UNDER ANESTHESIA.

INDICATIONS FOR PROCEDURE
The patient is a 15-year-old child with history of a right tympanic membrane perforation, as well as right conductive hearing loss. Exam in the office revealed a posterior superior right marginal tympanic perforation. Risks and benefits of surgery including risk of bleeding, general anesthesia, hearing loss as well as recurrent perforation were discussed with the mother. The mother wished to proceed with surgery.

FINDINGS AND PROCEDURE
The patient was brought to the room, placed in supine position, given general endotracheal anesthesia. The postauricular crease was then injected with 1% Xylocaine with 1:200,000 epinephrine along with the external meatus. An area of the scalp was shaved above the ear and then also 1% Xylocaine with 1:200,000 epinephrine injected. A total of 4 mL local anesthetic was used. The ear was then prepped and draped in the usual sterile fashion. The microscope was then brought into view, and examining the marginal perforation, the patient was noted to have large granuloma under the tympanic membrane at the anterior border of the drum. The granulation tissue was debrided as much as possible. Decision was made to cancel the tympanoplasty after debriding the middle ear space as much as possible. The middle ear space was filled with Floxin drops. The patient woke up from anesthesia,was extubated, and brought to recovery room in stable condition. There were no intraoperative complications. Needle and sponge count was correct. Estimated blood loss: Minimal.

_____

_____

32. ADMITTING DIAGNOSIS
Congestive heart failure (CHF) with left pleural effusion.

DISCHARGE DIAGNOSIS
1. Congestive heart failure (CHF) with pleural effusion.
2. Hypertension.
3. Prostate cancer, primary.
4. Leukocytosis.
5. Anemia due to neoplastic disease.

LABORATORY AT DISCHARGE
Sodium 134, potassium 4.2, chloride 99, CO2 26, glucose 182, BUN 17, and creatinine 1.0. Glucose was elevated because of several doses of Solu-Medrol given to him because of bronchospams. Magnesium was 1.8, calcium was 8.1. Liver enzymes were unremarkable. Cardiac enzymes were normal as mentioned. PT/INR is 1.02, PTT 31.3, white blood cell count 15, 000 with a left shift. This was presumed due to the corticosteroids. H&H was 32.3/11.3 and platelets 352,000, and MCV was 99. The patient's O2 saturations on room air were normal.

HOSPITAL COURSE
The patient was admitted to the emergency room. He has diuresed with IV Lasix. He was placed on Prinivil, aspirin, oxybutynin, docusate, and Klor-Con. Chest x-rays were followed. He did have free-flowing fluid in his left chest. Radiology consultation was obtained for thoracentesis. The patient was seen by Dr. Yang. An echocardiogram was done. This revealed an ejection fraction of 60% with diastolic dysfunction and periaortic stenosis with an opening of 1 cm^3. An adenosine sestamibi was done in March 20XX, with a small fixed apical defect but no ischemia. Cardiac enzymes were negative. Dr. Yang recommended a beta-blocker with an ACE inhibitor; therefore, the lisinopril was discontinued. The patient felt much better after the thoracentesis. I do not have the details of this, i.e., the volumes. No fluid was sent for routine studies. Vital signs were stable.

FOLLOW-UP
He will be followed in my office in 1 week. He is to notify if recurrent fever or chills.

PROGNOSIS
Guarded.

DISCHARGE MEDICATIONS
He is being discharged home on Lasix 40 mg daily, potassium chloride 10 mEq daily, atenolol 25 mg daily, aspirin 5 grains daily, Ditropan 5 mg b.i.d., and Colace 100 mg b.i.d.

_____

_____

_____

_____

_____

Medical Coding and Billing Specialist
Mail-in Quiz 25

1. Fill in your **student ID** and your **course code** below.

STUDENT ID NUMBER _____ COURSE CODE _____

2. Be sure your **name** and **address** are filled in below.
3. **Transfer your answers** to this cover sheet.

For School Use Only:
Grade: _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

U.S. Career Institute
2001 Lowe Street
Fort Collins, CO 80525

CD-2

This Space for Instructor Use

Fold on dotted line

1.	_____	**11.**	_____
2.	_____	**12.**	_____
3.	_____	**13.**	_____
4.	_____	**14.**	_____
5.	_____	**15.**	_____
6.	_____	**16.**	_____
7.	_____	**17.**	_____
8.	_____	**18.**	_____
9.	_____	**19.**	_____
10.	_____	**20.**	_____

21. _____

22. _____

23. _____

24. _____

25. _____

26. _____

27. _____

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31. _____

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32. _____

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Congratulations!

You have completed Lesson 25.

Do not wait to receive the results of your Quiz before you move on.

Lesson 26

ICD-9-CM Coding— From Respiratory System to Complications of Pregnancy

Step 1 Learning Objectives for Lesson 26

- ❑ When you have completed the instruction in this lesson, you will be trained to do the following:
  - ➤ Define diseases of the respiratory, digestive and genitourinary systems and complications of pregnancy, childbirth and the puerperium.
  - ➤ Explain the exclusions, inclusions and rules related to Chapters 8 through 11 of the *Tabular List* in the *ICD-9-CM* manual.
  - ➤ Identify the diagnoses, outline the coding pathway and assign the final code for documented disorders and diseases.

Step 2 Lesson Preview

- ❑ Are you well rested and ready to expand your understanding of ICD-9-CM coding? Great! This is another lesson in which you'll want to both stay focused and divide your study time into reasonable "chunks," because it covers a lot of material. You will be learning about and working with all the ICD-9-CM codes for Chapters 8, 9, 10 and 11 of the *Tabular List.* These include the codes for diseases of the respiratory, digestive and genitourinary systems and the codes for complications of pregnancy, childbirth and the puerperium.

  We'll be following the same routine that you've become accustomed to in recent lessons—lots of definitions and descriptions of diseases and conditions; explanations to help you find the correct codes in the *Index to Diseases* and the *Tabular List*; and, as always, plenty of examples and practice exercises for your hands-on practice. So let's get started!

To help make sure you don't get confused as you code the practice exercises and scenarios throughout the following ICD-9-CM coding lesson, it's important to keep in mind that we are focusing for now only on ICD-9-CM codes—*not* CPT codes. You will see physician notes and documentation about specific procedures in some of the scenarios we use just because we want you to practice with authentic examples. But remember that you will code only the diagnoses during these lessons—you'll have plenty of time and lots of practice combining procedural and diagnostic codes in later lessons, after you've become more familiar and comfortable with the ICD-9-CM codes.

🕮 Step 3 Diseases of the Respiratory System (460-519)

- We start this lesson with Chapter 8 of the *Tabular List*, which includes codes for diseases of the respiratory system. Among the diseases in this chapter are respiratory infections, other diseases of the upper respiratory tract, *pneumonia* and *influenza, COPD* (*chronic obstructive pulmonary disease)* and allied conditions, *pneumoconioses* and lung diseases and other diseases of the respiratory system. As with previous lessons and chapters, we move through our review of Chapter 8 by looking into the code categories within each section.

  At the beginning of Chapter 8 in the *Tabular List*, you are instructed to use an additional code to identify the infectious organism. This note applies to the entire chapter. So keep in mind that when you are coding diseases of the respiratory system, and the infectious organism causing the disease is documented, you must code for that organism as well as for the respiratory disease.

Acute Respiratory Infections (460-466)

Acute respiratory infections include the *common cold, acute sinusitis, acute pharyngitis, acute laryngitis* and *acute bronchitis*. This section EXCLUDES pneumonia and influenza, and directs you to use codes 480.0 through 488.19 instead for those conditions. An important note related to this section has to do with the term *acute*. The term might be required, or it may be a nonessential modifier in the categories included here. You will not find chronic infections in this code category, and the *Tabular List* often directs you to the accurate code.

An "acute inflammation of mucous membranes extending from the nostrils to the pharynx" is termed **acute nasopharyngitis**, but the condition is known as the common cold. This category (460) EXCLUDES chronic nasopharyngitis, pharyngitis, rhinitis and sore throat. Category 465 codes "Acute upper respiratory infections of multiple or unspecified sites." This category EXCLUDES upper respiratory infections due to: influenza and Streptococcus. An **upper respiratory infection** is often referred to as a **URI**—an important acronym to learn and remember.

Are you ready to try your hand at coding another scenario, this time relating to a respiratory system condition? Great—go for it, and see how quickly and accurately you can complete the coding.

CHIEF COMPLAINT
Respiratory distress and fever x 12 hours.

HISTORY OF PRESENT ILLNESS
This 20-month-old Caucasian male began coughing yesterday, late afternoon. Fever and coughing were aggravated in the evening. Patient was given Tylenol and slept well. Today at 8:00 a.m., the patient showed respiratory distress and increased mucous secretions.

PAST HISTORY
The patient experienced similar symptoms 4 months ago, but they were relieved spontaneously. The patient is the product of a normal spontaneous vaginal delivery. Birth weight: 6 pounds 1 ounce.
ALLERGIES: NONE.
Family history: No family history of maternal or paternal diabetes, hypertension or tuberculosis.

REVIEW OF SYSTEMS
Noncontributory.

PHYSICAL EXAMINATION
VITAL SIGNS: Pulse: 168/min. Respiratory rate: 38/min and labored. Temperature: 104.4 °F.
HEENT: Increased nasal discharge. Trachea midline. TMs clear. Pharynx not examined.
NECK: Supple. No jugular venous distention.
CHEST: Heart: Sinus rhythm with tachycardia. No murmurs. Lungs: There is inspiratory wheezing and respiratory retraction bilaterally. Tachypnea is present. There are bilateral rhonchi. No area of consolidation.
ABDOMEN: Soft and flat. No organomegaly.
EXTREMITIES: No venous distention.
NEUROLOGIC: No neurologic deficits. Moves all extremities well.

IMPRESSION
Croup. Rule out epiglottitis.

PLAN
NPO. Lateral neck film to rule out subglottic edema. Thirty percent oxygen mist tent. Racemic epinephrine 0.125 mL in 2.5 mL normal saline. Tylenol p.r.n. for fever. Intubation precautions until radiographicevidence of subglottic edema is excluded.

Let's briefly review your steps to see how you did. You should have located the main term *Croup* in the *Index to Diseases* for a tentative code of **464.4**. You then determined the highest level of specificity for this condition in the *Tabular List* and correctly assigned a final code of **464.4 Croup**. Easy, wasn't it? We'll just keep moving forward with the next group of codes, and you'll soon be breathing easily because you will have completed your basic review of the respiratory system codes in the *Tabular List*.

Other Diseases of the Upper Respiratory Tract (470-478)

Diseases of the upper respiratory tract include diseases of the nose, throat, sinuses, tonsils and adenoids. You may recall seeing *sinusitis, pharyngitis* and *laryngitis* in the previous section. Remember that the codes in that section cover *acute* conditions. You will use this section of the *Tabular List* for conditions that are not stated as acute, and some are *chronic* conditions. As always, using the *Index to Diseases* coding pathway will point you in the right direction for identifying the accurate codes. And you will encounter INCLUDES and EXCLUDES in this section of the *Tabular List*, as well, that will assist you in identifying the correct ICD-9-CM codes.

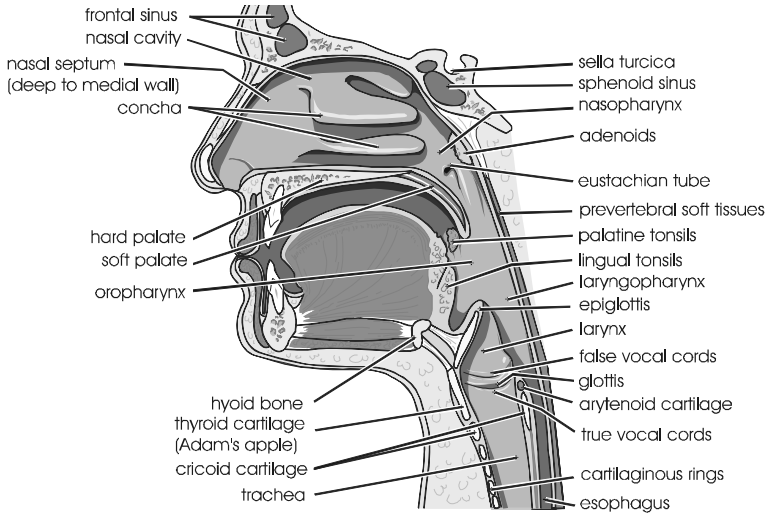


Figure 26-1: Gross Anatomy of the upper respiratory tract

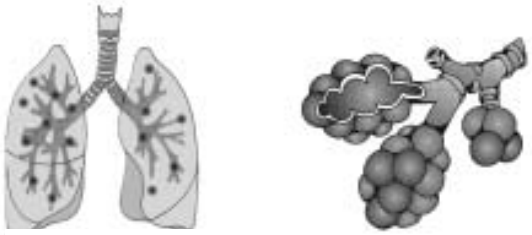
Pneumonia and Influenza (480-488)

Pneumonia is an inflammation of the lungs with **consolidation**, or the process of the lungs becoming firm as the air spaces are filled with exudate. Pneumonia can be classified as viral, bacterial, or due to other specified organisms. **Bacterial pneumonia** is treated with antibiotics. Antibiotics will not be effective for **viral pneumonia**, however. Determining a viral or bacterial cause for the pneumonia may be difficult, in which case antibiotics will be prescribed to treat the condition in case it *is* bacterial.

Pneumonia comes in many forms. We will be discussing three types of pneumonia that seem to cause confusion in coding. These types are *lobular, lobar* and *lobe pneumonia.* Each type, although it seems to be very similar to the others, has a different ICD-9-CM code.

Lobular pneumonia, code 485, is primarily known as **bronchopneumonia**. This condition is an inflammation of the lungs that usually begins in the terminal bronchioles. The lungs become clogged with mucopurulent exudate that forms consolidated patches in adjacent **lobules** (small lobes). You can see the dark patches in Figure 26-2.

ICD-9-CM code 481 or 486



ICD-9-CM code 485

Figure 26-2: Affected areas of the lung with bronchopneumonia, lobar pneumonia

Lobar pneumonia, code 481 and **lobe pneumonia**, code 486, look the same when they are reviewed on an x-ray. Each condition is an inflammation of one or more lobes of the lung, together with consolidation. The right lung has three lobes (superior, middle and inferior). The left lung has two lobes (upper and middle). Lobar pneumonia, code 481, is an acute febrile disease produced by *Streptococcus pneumoniae*. This condition is verified by a culture. If the physician notes that the x-ray reveals right, lower-lobe pneumonia, you will code to 486 because the presence or absence of streptococcal bacterium is not known. You would code 481 *only* if "*streptococcal pneumoniae*" is documented, or if the physician specifically notes "lobar pneumonia" in the dictation.

All right; now that you've been introduced to the differences among *lobular, lobar* and *lobe* pneumonias, it's time to demonstrate your coding skills on the following problem.

SUBJECTIVE
A 47-year-old male admitted to the ED with complaints of fever, chills, and a painful cough that is producing yellow mucus.

OBJECTIVE
Comprehensive examination performed. Respiratory examination reveals crackles. Anterior, posterior and lateral chest x-rays ordered.

ASSESSMENT
Results of x-rays confirm right lower lobe pneumonia.

PLAN
Patient admitted for further work-up.

The patient has pneumonia, which is located in the right lower lobe. "Lobular" is not documented. "Lobar" is not documented. And a culture was not done to check for the presence of streptococcal bacterium. So you simply have the main term *Pneumonia.* This main term in the *Index to Diseases* provides the tentative code of **486**. After you have determined the highest level of specificity in the *Tabular List*, you should assign **486 Pneumonia, organism unspecified** as the accurate code.

The other main code group to know more about in this section is **487 Influenza**. **Influenza** is an acute viral infection that involves the respiratory tract. Influenza is marked by inflammation of the nasal mucosa, the pharynx and the conjunctiva. The condition of influenza can be documented "With pneumonia," "With other respiratory manifestations" or "With other manifestations." You will code influenza with any form of pneumonia as 487.0. You will code influenza not otherwise specified (NOS) or with laryngitis, pharyngitis or a respiratory infection (upper) (acute) as 487.1. You will code influenza with involvement of the gastrointestinal tract or encephalopathy due to influenza as 487.8. Finally, code category 488 is used when influenza is due to certain identified influenza viruses.

Chronic Obstructive Pulmonary Disease and Allied Conditions (490-496)

Chronic obstructive pulmonary disease, or **COPD**, is actually a group of diseases characterized by ongoing obstruction of the airway. Three common forms of COPD are *acute bronchitis with COPD*, *chronic bronchitis* and *emphysema*. **Acute bronchitis** is a sudden inflammation of the trachea and is typically associated with a viral URI. When documentation indicates acute bronchitis with COPD, code **491.22 Obstructive chronic bronchitis, With acute bronchitis** is assigned.

It is not necessary to code 466.0 as the acute bronchitis is included in the code description for 491.22. **Chronic bronchitis** is essentially a cough that lasts for at least three months out of a consecutive two years. In the majority of cases, smoking is the cause of this condition. Other causes include toxic fumes, air pollution and respiratory infections. **Emphysema** is a condition of the lung characterized by an abnormal increase in the size of air spaces distal to the terminal bronchioles, or destruction of their alveolar walls. This disease affects cigarette smokers almost exclusively. Symptoms of chronic bronchitis often, but not always, coexist with emphysema.

Let's code COPD with acute exacerbation. Using the coding pathway of *Disease, pulmonary*, you are directed to *see also* Disease, lung. The new coding pathway, *Disease, lung, obstructive (chronic), with, acute, exacerbation* offers the tentative code of **491.21**. Now, go to the *Tabular List* to determine the highest level of specificity. You can comfortably select **491.21 Obstructive chronic bronchitis, With (acute) exacerbation** as the correct code.

Some of the allied conditions (490-496) included in this section are *asthma, bronchiectasis, extrinsic allergic alveolitis a*nd chronic airway obstruction, not elsewhere classified. Most of these conditions are relatively straightforward to code, but asthma requires a closer look.

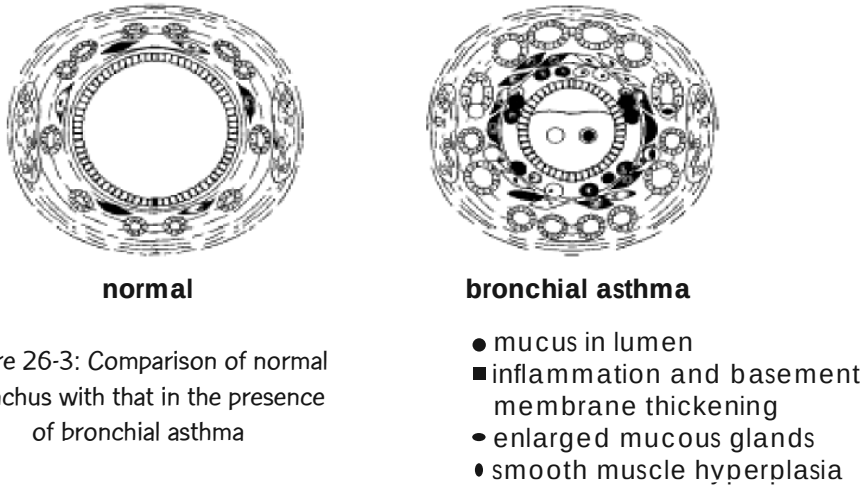


Figure 26-3: Comparison of normal bronchus with that in the presence of bronchial asthma

Asthma is a condition marked by recurrent attacks of dyspnea with wheezing due to spasmodic contractions of the bronchi. The *Tabular List* indicates that code 493 EXCLUDES wheezing, NOS (786.07). Wheezing is a symptom of asthma. So if wheezing is documented without the final diagnosis of asthma, you will review the code description for 786.07 and assign it. Category 493 also contains a fifth-digit subclassification box.

Review the contents of this box below before you continue.

> The following fifth-digit subclassification is for use with codes 493.0-493.2, 493.9:
>
> **0 unspecified**
> **1 with status asthmaticus**
> **2 with (acute) exacerbation**

A particularly severe episode of asthma that does not respond to therapeutic measures is termed **status asthmaticus**. The physician will document "status asthmaticus" if you are to use 1 as the fifth-digit subclassification. Likewise, "with exacerbation" or "with acute exacerbation" will be documented if you are to use 2 as the fifth-digit subclassification. If neither term is documented, you will use 0 as the fifth-digit subclassification for "unspecified." In sequencing the codes, if status asthmaticus were documented with COPD of any type or with acute bronchitis, you would sequence the status asthmaticus first.

Okay, now that we've reviewed the basic information, you're ready to see how quickly and accurately you can code the diagnoses based on the following transcribed notes:

SUBJECTIVE
A 12-year-old male presents with a cough for several days. He claims albuterol is not helping the cough. He denies any real wheezing with this current illness. His asthma symptoms have been under control this winter. He has not had a fever with this coughing episode.

OBJECTIVE
He is alert and pleasant. HEENT is unremarkable. He has a very slight inspiratory crackle and end-expiratory wheeze in his larger airways. Inspiratory breath sounds are clear. No signs of respiratory distress. Heart without murmur.

ASSESSMENT
Asthmatic bronchitis.

PLAN
Reviewed his asthma regimen and refilled his Advair Diskus. He continues on Singulair daily as well as Claritin-D. Recommend he use the albuterol 1-2 inhalations every 4-6 hours for the next couple of days until cough subsides. Also put him on Zithromax suspension with a double dose on the 1st day. He is to return if symptoms continue. This young man has a very good grasp on his asthma, and he is using a peak flow meter appropriately. Peak flows have been about 100 mL lower than normal.

This office visit requires one code for accurate coding. To code the primary diagnosis, locate the main term *Bronchitis* in the *Index to Diseases.* Now, locate the subterm *asthmatic* in the *Index to Diseases* and locate the tentative code **493.90**. Note that status asthmaticus or exacerbation is not documented in the notes, so the fifth digit of 0 is used for "unspecified." The notes in the *Tabular List* for code 493.9 include asthmatic bronchitis. You will record code **493.90 Asthma, unspecified** for this office visit diagnosis.

Pneumoconioses and Other Lung Diseases due to External Agents (500-508)

Pneumoconiosis is an inflammation that commonly leads to fibrosis of the lungs; this disease is caused by the inhalation of dust in various occupations. Pneumoconiosis is characterized by pain in the chest, a cough with little or no expectoration, dyspnea, reduced thoracic excursion, sometimes cyanosis and fatigue after slight exertion. The three types of pneumoconiosis you will most likely encounter as a medical coding and billing specialist are *coal workers' pneumoconiosis, asbestosis* and *silicosis*.

Coal workers' pneumoconiosis, formerly known as "**black lung**" **disease**, used to be a deadly killer among miners. With increased health standards in the workplace, coal workers' lung disease has been greatly reduced, although not eliminated. Sometimes called **anthracosis**, this condition essentially refers to lungs that have become filled with coal dust. Prolonged inhalation of dust that is rich in carbon particles and other earth minerals causes the disease. There is no effective treatment for this disease, and it usually runs a slow but steady course toward lung failure.

Asbestosis is the name given to the lung disease that results from exposure to asbestos. When asbestos fibers are inhaled, the shorter and smaller ones have a chance of passing the mucous membranes and reaching the lungs. Once the fibers enter the alveoli, they are seized by macrophages, and the process results in extensive pulmonary fibrosis.

Silicosis is the most widespread and oldest of all known occupational diseases. This environmentally induced lung disease is caused by the inhalation of tiny silica crystals found in the dust that is generated during sand blasting, mining and stone cutting. Silicosis is characterized by fibronodular lesions in the lung tissue.

If you have questions, be sure to call your instructor!

Respiratory conditions caused by fumes, vapors and aspiration of various other substances are examples of other lung diseases and conditions referred to in this section of the *Tabular List*. For the most part, these are straightforward diagnostic codes, but if you have questions, be sure to call your instructor!

Other Diseases of the Respiratory System (510-519)

This final section of codes in the "Respiratory System" chapter contains the diseases and conditions that pertain to the respiratory system that do not fit into any other section. These diseases and conditions are *empyema, pleurisy, pneumothorax,* abscesses and other diseases of the lung. Be sure to review the inclusions, exclusions and additional notes throughout this section to assist you as you apply these codes.

Code **510**, **Empyema** is pus found within the pleural space. The *Tabular List* instructs you to use an "additional code to identify infectious organism (041.0 - 041.9)," and that this category EXCLUDES abscess of the lung. Empyema may be described with or without mention of a fistula. A **fistula** in this section is the passage of the purulent infection from the respiratory cavity to another structure.

Pleurisy, code **511**, is an inflammation of the pleura serous membrane of the lungs and the lining of the thoracic cavity. Often, fluid accumulates at the site of this inflammation, which results in what is known as **pleural effusion**. Sometimes, the pleural effusion is an integral part of the underlying disease. When that is the case, you assign a code only for the underlying disease. Congestive heart failure (CHF), for example, would not exist without some degree of pleural effusion. In that case, you would code only the CHF.

Pneumothorax is the presence of air or gas in the pleural cavity, which results in a collapsed lung. Let's look at the subcategories for pneumothorax and air leak. **512.0 Spontaneous tension pneumothorax** is a collapsed lung caused by air leaking from the lung into the lining. **512.1 Iatrogenic pneumothorax** occurs when air is trapped in the lining of the lung following surgery, which in turn causes the lung to collapse. **512.2** codes to postoperative leaks. Finally, codes found in the **512.8** range cover acute, chronic or conditions EXCLUDES congenital and traumatic pneumothorax and current tuberculous pneumothorax.

Atelectasis is a condition that may also result in the collapse of a lung. This condition should not be confused with pneumothorax. The cause of the collapsed lung with pneumothorax is the *presence* of gas or air, while the cause of the collapsed lung with atelectasis is the *reduction* or *absence* of air in part or all of the lung. Atelectasis is coded using 518.0.

It's time for a Practice Exercise to see how well you understand the information in this current section. Then you'll be ready to wrap up the discussion of Chapter 8 and move forward to Chapter 9 of the *Tabular List*.

✍ Step 4 Practice Exercise 26-1

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Acute pneumococcal bronchitis**
   ICD-9-CM code: _____

2. **Chronic maxillary sinusitis**
   ICD-9-CM code: _____

3. **Legionnaires' disease**
   ICD-9-CM code: _____

4. **Chronic asthmatic bronchitis**
   ICD-9-CM code: _____

5. **Adult respiratory distress syndrome**
   ICD-9-CM code: _____

6. **ICD-9-CM Coding Challenge**

PREOPERATIVE DIAGNOSIS
Acute respiratory failure.

POSTOPERATIVE DIAGNOSIS
Same.

PRIMARY PROCEDURE
TRACHEOSTOMY.

PROCEDURE
Following informed consent of the patient's family, the patient was brought to the operating room and placed supine on the table. After adequate induction of general anesthesia and application of appropriate monitoring devices, the patient was prepped and draped for the procedure.

The neck was marked and injected with 5 mL of 1% Xylocaine and epinephrine. A scalpel was used to create a horizontal incision through the skin. Cautery was used to control bleeding, and the muscles were split down to the level of the thyroid isthmus. Blunt dissection was used to dissect between the thyroid isthmus, and it was divided.

The cricoid cartilage was identified, and the crocoid hook was placed. The inner space between the 2nd and 3rd thyroid cartilage was then incised, and scissors were then used to enlarge the incision. A #8 Shiley tracheostomy tube was placed into the trachea. The cuff was then inflated, and the incision was sutured. The patient tolerated the procedure well and was transferred back to the ICU.

ICD-9-CM code: _____

Step 5 Review Practice Exercise 26-1

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 6 Diseases of the Digestive System (520-579)

- ❑ The digestive system consists of the organs associated with the ingestion, digestion and absorption of food. You will progress through this chapter, Chapter 9, of the *Tabular List* just as food moves through your body. We begin our discussion at the oral cavity, and then we move down the esophagus and into the stomach. We discuss diseases of the stomach and duodenum, which is the first portion of the small intestine. We then review appendicitis and hernias before we move on to the large intestine. We end our discussion of coding in this chapter with other diseases of the digestive system.

  Chapter 9 includes a number of sections, and we will move at a steady pace from one section to the next. You can stop at any point and review what you have learned before you move on to the next section. In other words, pace yourself so that you feel comfortable with what you're learning—don't go so fast that you miss important details, but don't go so slowly that you lose momentum and have to go back and review material more often than necessary.

Diseases of Oral Cavity, Salivary Glands, and Jaws (520-529)

The **oral cavity** is the cavity of the mouth and its associated structures, including the **cheek**, **palate**, **oral mucosa**, **glands** whose ducts open into the cavity, **teeth** and **tongue**. In looking through the *Tabular List* for this section, you will find the diagnosis codes to be straightforward. You also will find some EXCLUDES in this section. As always, be sure to follow the directions, and you will find the accurate code.

Teeth are the hard, calcified structures set in the alveolar processes of the **mandible**, the lower jaw and the **maxilla**, the upper jaw. During the body's development, disorders associated with the teeth may arise, such as an absence of teeth, a mottling, or spotting with patches of color, of the enamel and premature eruption or appearance of teeth. Diseases of the teeth include *dental caries, abscesses* and *gingivitis*. Abnormal jaw size, dental arch, or position of fully erupted teeth and *temporomandibular joint disorder* are just a few of the anomalies you will find in these code categories.

Dental caries, or **cavities**, represent one of the most common diseases. They are bacterial in nature. Dental caries are a multifactorial disease that involves oral bacteria that have eroded the surface enamel of the tooth. The defect spreads down into the dentin, which becomes decalcified and disintegrates, so that the bacteria spreads deep into the tooth and invades the pulp chamber. **Pulpitis**, inflammation of the root canal, affects the nerves and blood vessels inside the tooth, causing pain. Superficial caries can be treated; but if the infection spreads to the root canal, abscesses and bone infection of the jaw can develop, requiring removal of the tooth. To code this condition, locate the main term *Caries* in the *Index to Diseases,* followed by the subterm *dental*. You will find the tentative code of **521.00**. Checking the *Tabular List* to determine the highest level of specificity, you will find that the correct code for this condition without further details specified is **521.00 Dental caries, unspecified**.

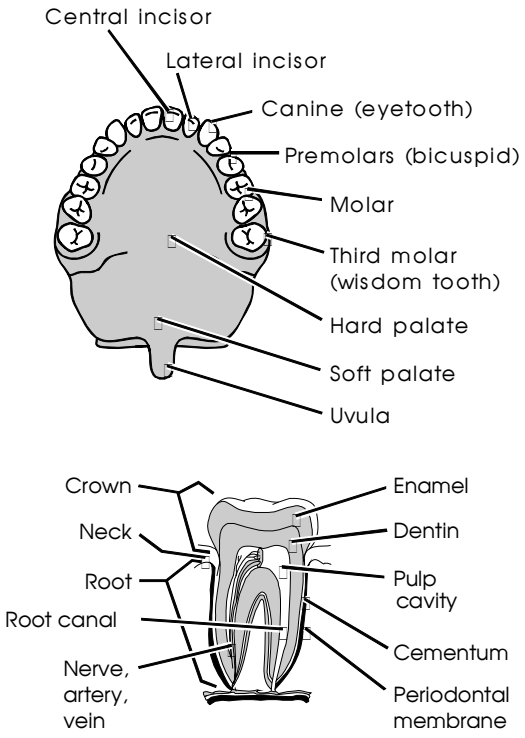


Figure 26-4: Dental anatomy overview

Did you know that *periodontal disease* accounts for more tooth loss than dental caries and all other dental diseases combined? **Periodontal disease** occurs when bacteria around the tooth cause plaque to form that then calcifies into tartar. This process can cause inflammation, swollen gums, and loosening and even loss of teeth. Poor oral hygiene seems to be the main cause of periodontal disease.

The **temporomandibular joint** (**TMJ**) connects the lower jaw to the skull; this joint is located just in front of the ears. The term *TMJ* literally refers to the joint itself, but it also is often used to describe disorders of the joint. **TMJ disorder** can be caused by clenching or grinding one's teeth, poor posture or the lack of relaxation or sleep. There are many symptoms related to this condition, including popping sounds, inability to fully open the jaw, jaw pain, headache, earache and toothache.

Diseases of Esophagus, Stomach, and Duodenum (530-539)

The **esophagus** is the portion of the digestive system that extends from the pharynx to the stomach. The function of the esophagus is to efficiently transport food from the mouth to the stomach. When diseases of the esophagus occur, this transportation may be painful, prolonged or nonexistent. **Esophageal reflux** occurs when there is a backflow of gastric acids from the stomach to the esophagus, and possibly to the pharynx.

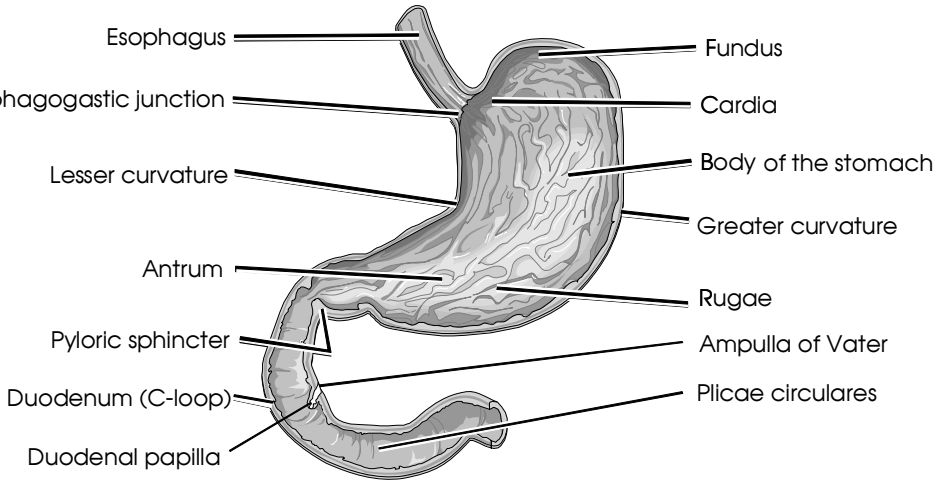


Figure 26-5: Esophagus, stomach and duodenum

Operative Report

PREOPERATIVE DIAGNOSIS
Gastroesophageal reflux. Rule out ulcers.

A 52-year-old male presenting with difficulty swallowing and a burning sensation in epigastric area.

PROCEDURE PERFORMED
ENDOSCOPY.

After patient was adequately sedated by anesthesiologist, a flexible esophagoscope is passed from the mouth into the esophagus. Esophageal mucosa appears to be normal. Inflammation consistent with gastroesophageal reflux. No signs of ulcerations.

POSTOPERATIVE DIAGNOSIS
Gastroesophageal reflux.

To code this operative report, you will need to ask yourself, "What's the problem?" The problem, *Reflux*, is the main term you will locate in the *Index to Diseases*. Using *gastroesophageal* as the subterm provides the tentative code of **530.81**. Now turn to the *Tabular List* to determine the highest level of specificity for this code. In the *Tabular List*, note that code **530.81 Esophageal reflux** EXCLUDES reflux esophagitis, and indicates that code 530.11 would be more appropriate. **Reflux esophagitis** is an inflammation of the lower esophagus due to regurgitated gastric acid from a malfunctioning lower esophageal sphincter. The operating report does not note any malfunction, so you can be comfortable assigning code **530.81** for the condition, which is confirmed by the documentation of the procedure.

An **ulcer** is a lesion on the mucous membrane that leads to the destruction of the normal tissue lining. These ulcers are caused by the action of gastric acid and pepsin on the gastric mucosa, which decreases its resistance to ulcer. This section contains four categories for ulcers: *gastric, duodenal, peptic* and *gastrojejunal*. **Gastric ulcers** are those of the stomach. **Duodenal** and **gastrojejunal ulcers** are in the small intestine. The **duodenum** is the first part of the small intestine. **Gastrojejunal** refers to the stomach and the **jejunum** to the portion of the small intestine located between the duodenum and ileum. While these categories are locations of ulcers, the fourth category, **peptic**, is a type of ulcer. **Peptic ulcers** can be found in the esophagus, stomach or duodenum. When the site of the peptic ulcer is not specified, you will use a code in the category 533. Also note in the *Tabular List* for these codes that you are to use an E code for gastric, duodenal and peptic ulcers if the ulcer is drug-induced, to identify the drug.

The fourth-digit subcategory further identifies an ulcer. Ulcers can be classified as acute or chronic. **Acute ulcers** are associated with shallow erosion and minimal inflammation. They are of short duration and resolve quickly when the cause is identified and removed. **Chronic ulcers** are associated with a long duration and erode through the muscular wall with the formation of fibrous tissue. It is continuously present for many months or intermittently present throughout the person's lifetime. Complications caused by an ulcer are *hemorrhages, perforations* and *obstructions*. To code **hemorrhages** (or bleeding ulcers) and **perforations** (holes in the tissue lining), these conditions must be noted in the documentation. These complications are confirmed by the physician's direct observation using an endoscope.

The size or location of the mucosal ulceration may cause an obstruction of the digestive system. Code categories 531 through 534 require similar fifth-digit subclassifications, depending on whether or not an obstruction is documented.

Keep in mind, the physician must document the obstruction; otherwise, you must apply the fifth digit 0, which indicates "without mention of obstruction."

Appendicitis (540-543)

The **appendix** is described as a worm-like appendage that branches off the large intestine at the **cecum**, which is the first part of the colon. You know from your terminology lessons that the "-itis" suffix means "inflammation of." So **appendicitis** is inflammation of the appendix. Appendicitis begins when the opening from the appendix to the cecum becomes blocked. Bacteria, usually found within the appendix, begin to invade the appendix wall, which causes an inflammation. The infection and inflammation can cause the appendix to rupture. The infection can spread throughout the **peritoneum**, or the lining of the abdominal cavity. Alternatively, this infection can be confined to the area surrounding the appendix, forming a **peritoneal abscess**.

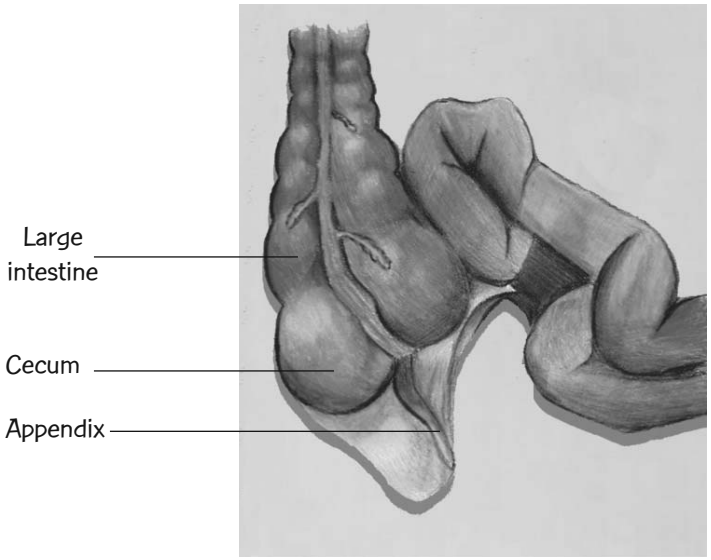


Figure 26-6: Large intestine and appendix

To code appendicitis, you will go to the *Index to Diseases* and look for the main term *Appendicitis*. Using this tentative code of **541**, go to the *Tabular List* to determine whether this code represents the highest level of specificity for the diagnosis. Based on the information there, you confirm that code **541 Appendicitis, unqualified** is correct.

Hernia of Abdominal Cavity (550-553)

A **hernia** is the protrusion of a part or structure through the tissues that normally contain it. This section concentrates on hernias located in the abdominal cavity. Under the heading for this section in the *Tabular List*, you will note that it INCLUDES hernias that are acquired or congenital, except for diaphragmatic or hiatal hernias. Note in particular that code category 550 includes a fifth-digit subclassification box to identify whether the hernia is "unilateral or unspecified (not specified as recurrent)," "unilateral or unspecified, recurrent," "bilateral (not specified as recurrent)" or "bilateral, recurrent." Each of the other hernia codes in this group, however, list the entire five-digit code, with descriptions, for you.

Hernias are classified by:

- the *location* of the hernia, such as the body area, unilateral or bilateral.
- *occurrence*, such as recurrent or not specified as recurrent.
- documenting *with or without obstruction*; "with obstruction" can be specified as *incarcerated, irreducible, strangulated* or *causing obstruction.*
- documenting *with or without* ***gangrene***, which is the death of tissue due to the obstruction, loss or diminution of blood supply.

Now read through the following note for an office visit by a patient with a hernia, and then determine how to code the condition.

SUBJECTIVE
A 42-year-old male complains of a lump in the groin, which is tender to the touch. He states the pain increases when he is lifting.

OBJECTIVE
Abdominal exam confirms inguinal hernia on the right side. Attempt to push the protrusion back into the abdominal cavity was unsuccessful.

ASSESSMENT
Unilateral inguinal hernia.

PLAN
Outpatient surgery is required for repositioning.

To code this visit, locate the main term *Hernia* in the *Index to Diseases*. The type of hernia is *inguinal*, so that will be the subterm. Neither gangrene nor an obstruction is noted in the dictation. Also note that the *Index to Diseases* states that a fifth digit is required with code 550.9 ✓ . Once again, turn to the *Tabular List* to determine the highest level of specificity. Based on the fifth-digit sub-classifications included here, you will select **550.90** as the tentative code for this diagnosis. The hernia was specified as unilateral but not specified as recurrent. So the final code for this condition is **550.90 Inguinal hernia, without mention of obstruction or gangrene, unilateral or unspecified (not specified as recurrent)**.

Noninfectious Enteritis and Colitis (555-558)

This small section includes codes for inflammation and insufficiency of the intestines and inflammation of the colon. Diseases of this type include *Crohn's disease, ileitis, ulcerative enterocolitis, bowel infarction* and *gastroenteritis.*

Other Diseases of Intestines and Peritoneum (560-569)

This section contains codes for all the remaining diseases and conditions of the intestine and peritoneum that are not classified within the previous code groups. Codes 560 through 569 cover conditions such as *diverticulosis, constipation, peritonitis* and *anal polyp*.

You will note that code category 560 lists many EXCLUDES . In other words, you should not use this category "intestinal obstructions without mention of a hernia" if a specific cause or reason has been documented.

A **diverticulum** is a saccular dilatation or outpouching through a weakened area in the intestinal wall. Diverticula may occur at any point within the gastrointestinal tract but are most commonly found in the sigmoid colon. **Diverticulosis** is a condition in which the person has multiple diverticula. **Diverticulitis** is an inflammation of the diverticula. In this section, you will find both of these conditions associated with both the small intestine and the colon.

Peritonitis is an inflammation of the peritoneal cavity. Turn to the *Tabular List* to review the EXCLUDES for code 567. You will see that you do not code from this category peritonitis with or following abortion, appendicitis or an ectopic or molar pregnancy. If you have a diagnosis for which you use code **567.0 Peritonitis in infectious diseases classified elsewhere**, you must first code the underlying disease. Also note that code 567.0 EXCLUDES gonococcal, syphilitic and tuberculous peritonitis.

Now it's your turn to practice coding again. Read through the following procedure report, review what you've learned so far in this step, and see how accurate you are at identifying the correct code or codes for the documented diagnosis.

PREOPERATIVE DIAGNOSIS
Rectal bleeding with history of polyps.

POSTOPERATIVE DIAGNOSIS
Rectal bleeding due to rectal polyp and diverticulosis.

PRIMARY PROCEDURE
TOTAL COLONOSCOPY WITH SNARE POLYPECTOMY IN RECTUM.

DESCRIPTION OF PROCEDURE
This 74-year-old female was taken to the outpatient area, placed in the left lateral decubitus position, and given 1 mg midazolam hydrochloride and 60 mcg fentanyl, intravenously titrated by anesthesiologist, with good sedation achieved. The Olympus video colonoscope was easily introduced over the cecum and then slowly withdrawn in a spiraling fashion, visualizing mucosa circumferentially. It was retroflexed in the rectum. The polyp was biopsied with cold biopsy forceps and then removed in its entirety with the snare, with cautery current. Good hemostasis was noted at the base. The polyp was sent for pathologic study. The scope was withdrawn.

To code the diagnosis for this procedure, refer to the postoperative diagnosis. The patient has rectal bleeding, which is due to the rectal polyp. Because the bleeding is caused by the polyp, you code only to the rectal polyp. The coexisting diagnosis is diverticulosis. The procedure indicates the scope was in the **cecum**, which is the first part of the colon, so you code diverticulosis of the colon. You would not have that information if you hadn't read through the report. So remember that as you review the physician's notes to determine correct codes, it is important not only to look at the postoperative diagnosis, but also to read through the procedure. You must thoroughly review all the information available to ensure that your coding is accurate.

Okay; let's walk through the details of this coding example. You identify the primary coding pathway as *Polyp, rectum* which provides a tentative code of **569.0**. Then, you refer to the *Tabular List* to determine the highest level of specificity; you will find code **569.0 Anal and rectal polyp** is the right one.

Next you will follow the pathway of *Diverticulosis, colon* for the coexisting diagnosis. Under *Diverticula, diverticulosis, diverticulum* you will find *colon* (*acquired*) with a tentative code of **562.10**. A check in the *Tabular List* confirms that this is the correct code: **562.10 Diverticulosis of colon (without mention of hemorrhage)**.

Remember: In this scenario, the bleeding is due to the rectal polyp, not the diverticulosis, so you do not associate the bleeding with the coexisting condition.

You've come to the final section of diseases of the digestive system. And your coding skills are starting to show!

Other Diseases of Digestive System (570-579)

Diseases in this subchapter are those of the liver, the gallbladder and biliary ducts and the pancreas. The conditions *gastrointestinal hemorrhage* and *intestinal malabsorption* are also included in this code group.

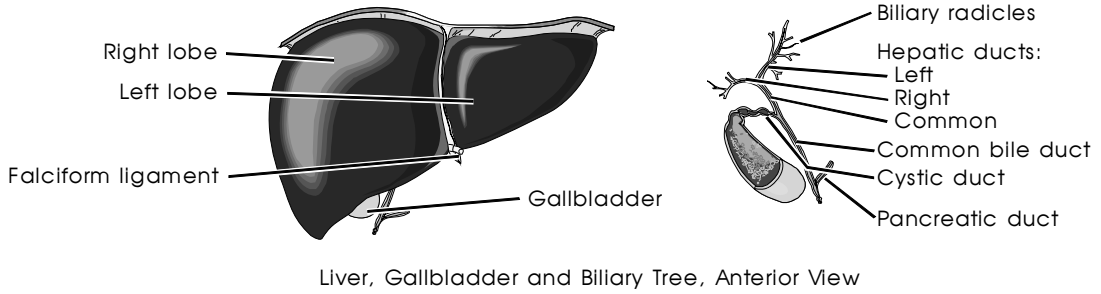


Figure 26-7: Liver, gallbladder and biliary ducts

Code category 571 includes chronic liver disease and **cirrhosis**, which is end-stage liver disease. Liver diseases might be the result of alcohol use, or they might not be alcohol related. Category 572 codes liver abscess and *sequelae* of, or "condition following," chronic liver disease. Other disorders of the liver include **hepatitis**, or inflammation of the liver, which is noninfectious. Note that you will code viral hepatitis from Chapter 1 and code group 070 of the *Tabular List*.

Cholelithiasis is the presence or formation of *gallstones*. **Gallstones** are composed almost entirely of excessive blood pigment, with calcium deposits in some. This blood pigment is released by the destruction of red blood cells. This code category, 574, requires use of a fifth-digit subclassification to indicate whether or not an obstruction is documented. The fifth digit will be 0 if no obstruction is documented, and 1 with a documented obstruction, as the following box shows:

The following fifth-digit subclassification is for use with category 574:
0 without mention of obstruction
1 with obstruction

Gallstones may be lodged in the neck of the gallbladder or the cystic duct, which may lead to an inflammation of the gallbladder. When this happens, the inflammation is documented, as with cholecystitis. Since these conditions usually occur together, having a cause-and-effect relationship, one code group, 574, covers both conditions. Be aware, though, that you will use a specific code category, 574.0, if the cholecystitis is documented as acute. Also, if only inflammation is documented, do not assume that the inflammation was caused by cholelithiasis. Finally, you will use a separate code group, 575, for a diagnosis of cholecystitis alone.

The **biliary tract**, which you will also code to this section, consists of the organs, ducts and other structures that participate in the secretion, storage and delivery of bile into the duodenum. Inflammation, obstruction, perforation and abnormal passages are disorders associated with the bile duct. **Cholangitis** is the term used to indicate inflammation of the biliary ducts.

Let's code a diagnosis from this section of the "Digestive System" chapter. A patient's diagnosis is acute cholecystitis with cholelithiasis. What code would you use to indicate this condition? Would you have two codes for the two conditions? What main term would you use for your coding pathway? The answers to these questions will direct you to the accurate code.

First, you will need to determine the meaning of the diagnosis. **Cholecystitis** is an inflammation of the gallbladder. **Cholelithiasis** is the presence or formation of gallstones. Remember, these diagnoses indicate a cause-and-effect relationship that requires one code. For the coding pathway, begin with the inflammation, using *Cholecystitis* as the main term. When you look up this term in the *Index to Diseases,* you will find "Cholecystitis 575.10," then "with," then "calculus, stones in," and then "gallbladder — *see* Cholelithiasis." So you need to use the cause, or *Cholelithiasis*, as the main term. That approach takes you to "Cholelithiasis (impacted) (multiple) 574.2 ✓," then "with," and "cholecystitis 574. ✓." The further documentation of "acute" provides the tentative code of **574.0** ✓. Now turn to the *Tabular List* to determine the highest level of specificity. Note that this code has a fifth-digit subclassification to indicate whether an obstruction is mentioned. It is not, so **574.00 Calculus of gallbladder with acute cholecystitis, without mention of obstruction** is the code you will assign.

You've done well with Diseases of the Digestive System. You're ready to tackle Diseases of the Genitourinary System after completing a Practice Exercise.

✍ Step 7 Practice Exercise 26-2

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Ulcerative stomatitis**
   ICD-9-CM code: _____

2. **Acute prepyloric ulcer with hemorrhage**
   ICD-9-CM code: _____

3. **Chronic peptic duodenal ulcer, with obstruction**
   ICD-9-CM code: _____

4. **Appendicitis with peritonitis**
   ICD-9-CM code: _____

5. **Strangulated hiatal hernia**
   ICD-9-CM code: _____

6. **Impacted colon**
   ICD-9-CM code: _____

7. **Dumping syndrome postgastric surgery**
   ICD-9-CM code: _____

8. **Cirrhosis of the liver**
   ICD-9-CM code: _____

9. **ICD-9-CM Coding Challenge**

PREOPERATIVE DIAGNOSIS
Epigastric abdominal pain.

POSTOPERATIVE DIAGNOSIS
Gastritis, gastric ulceration and duodenal ulceration.

PRIMARY PROCEDURE
ESOPHAGOGASTRODUODENOSCOPY WITH BIOPSY.

DESCRIPTION OF PROCEDURE
Following consent, the patient was brought to the endoscopy suite and placed in the sitting position, where he received Hurricaine spray to his oropharynx. The patient was placed in the left lateral decubitus position, where a bite-block was placed between his incisors. The Olympus video gastroscope was placed and advanced under visualization down through the oropharynx, the proximal then distal esophagus, through the gastroesophageal junction, and into the gastric body and duodenum via the pylorus. The endoscope was withdrawn back into the gastric antrum, and the antral mucosa was biopsied. The endoscope was withdrawn back into the gastric body, retroflexed with visualization of the gastric fundus. The endoscope was then straightened and withdrawn completely under suction. The patient tolerated this procedure very well.

ICD-9-CM codes:

_____

_____

_____

Step 8 Review Practice Exercise 26-2

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 9 Diseases of the Genitourinary System (580-629)

- ❑ Chapter 10 of the *Tabular List* includes diseases of the genitourinary system. The term *genitourinary* pertains to the genital and urinary organs. The genital and urinary systems are usually considered together because anomalies of the genital and urinary tracts are often interrelated. The **urinary system** includes the kidneys, ureters, bladder and urethra. We also will discuss the **genital system**, which includes the male and female genital organs and the breasts.

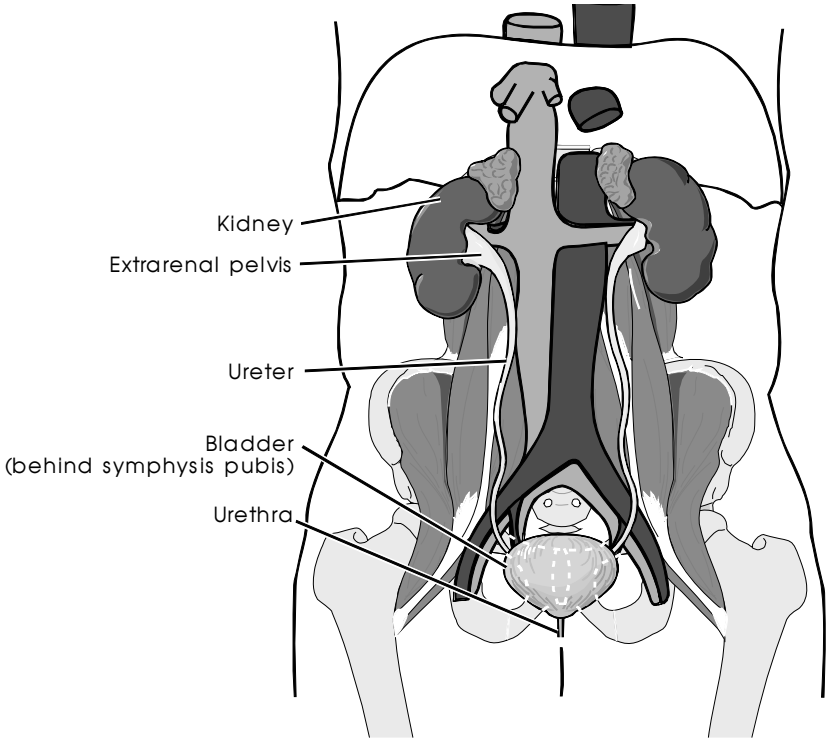


Figure 26-8: Urinary system

Nephritis, Nephrotic Syndrome, and Nephrosis (580-589)

This section deals with diseases of the kidneys. Your terminology lessons will be helpful in your understanding that the word *kidney* is *renal* in Latin and *nephros* in Greek. A number of other terms will help you code conditions related to the kidneys. Note that the section EXCLUDES hypertensive chronic kidney disease. As we discussed in reference to Chapter 7 of the *Tabular List*, the *ICD-9-CM* classification system presumes a cause-and-effect relationship between hypertension and renal failure, so you should code these combined diagnoses to code group 403, "Hypertensive chronic kidney disease" or code group 404 "Hypertensive heart and chronic kidney disease." **Nephritis** is an inflammation of the kidneys. **Nephrosis**, or **nephrotic syndrome**, is a general name for a group of diseases that damage the kidneys. Symptoms of these diseases include protein in the urine, low blood-protein levels, high cholesterol levels and swelling.

The **kidneys** are two bean-shaped organs located in the lumbar region. They filter the blood, remove ion wastes and toxins and eliminate liquid waste from the body in the form of urine.

Glomeruli are tufts, or clusters, of capillary loops at the beginning of each nephric tubule in the kidney. **Glomerulonephritis** is nephritis accompanied by inflammation of the capillary loops in the glomeruli of the kidneys. Glomerulonephritis occurs in acute, subacute and chronic forms, and it might be secondary to streptococcal infections. **Acute glomerulonephritis** is typically preceded by tonsillitis or febrile pharyngitis and is characterized by **proteinuria** (protein in the urine), edema, **hematuria** (blood in the urine), renal failure and hypertension. A slowly progressive, or chronic glomerulonephritis, generally leads to irreversible renal failure. Renal failure is the impairment of renal function, either acute or chronic, with retention of urea, creatinine and other waste products.

Other Diseases of Urinary System (590-599)

Some of the other categories of urinary system diseases, whose codes are contained in this section, include infection, distention, calculus, inflammation and malfunctions. Infections of the kidney, bladder and urinary tract are bacterial infections for which the *ICD-9-CM* manual directs you to use an additional code to identify the organism that has caused the infection, if that is known. **Pyelonephritis** is an infection of the kidney. **Cystitis** is an inflammation of the urinary bladder. A **urinary tract infection** is referred to as a **UTI**.

Calculus, or stones, can be found in the kidneys, ureter, bladder, urethra or lower urinary tract. Kidney stones are the most common. Although kidney stones are painful, they usually pass on their own without permanent damage. Medication can be used to decrease the chances of stone formation and to aid in the breakdown of already-formed stones. If the stones are too large to pass naturally, ultrasonic waves can be used to break up the stone. Surgery might also be elected for removal of the stone.

The **urethra** is the tube that carries the urine from the bladder to the exterior of the body. Inflammation of this urinary organ is known as **urethritis**. An **abscess**, or pocket of pus, may form in the tube. A narrowing of the tube is termed a **stricture**. As you review the details of this section, note that you are to use an additional code if this stricture is associated with urinary incontinence.

Carefully review the following operation transcription before you practice coding the indicated diagnosis. Then we will compare notes to see how you did.

PREOPERATIVE DIAGNOSIS
Left ureteral stone.

POSTOPERATIVE DIAGNOSIS
Same.

PRIMARY PROCEDURE
CYSTOURETHROSCOPY, URETERAL DILATION, AND URETHROSCOPY WITH STONE EXTRACTION.

PROCEDURE
After general anesthesia was done, the patient was placed in the dorsal lithotomy position. The genital area was prepped and draped. A cystourethroscopy was done, which was unremarkable. Under direct vision, a 0.035-inch guidewire was inserted into the right ureter, all the way to the renal pelvis. A 4 cm 12 French ureteral balloon dilator was inserted over the guidewire, and the lower ureter was dilated at 16 mL. After the dilation was accomplished, the dilator was removed from the guidewire, and the ureteroscope was inserted into the ureter. The stone could be seen above the ureterovesical junction. It was engaged into a Segre basket, and gradually it was removed. Ureteroscopy was done. There was some redness of the ureteral vault, but it was otherwise unremarkable. The bladder was drained, and the patient was sent to the recovery room.

For outpatient coding, you are to code the postoperative diagnosis, so you are coding for a ureteral stone. Go ahead and determine the coding pathway, the tentative code, and the final code you would assign for this diagnosis before we walk through the process together.

How do you think you did? Let's compare notes. You'll use the coding pathway of *Stone, ureter*. The *Index to Diseases* provides the tentative code of **592.1**. Determine the highest level of specificity in the *Tabular List*. You can then assign **592.1 Calculus of ureter**, which is the accurate code for the diagnosis of left ureteral stone.

Diseases of Male Genital Organs (600-608)

The primary reproductive organ in the male is the **testis** (**testicle**). The job of the two testes is to produce sperm for reproduction and to produce the male hormone testosterone. The external organs of the male reproductive system include the **penis** and the **scrotum**. The testes are enclosed by the scrotum. The only portions of the male reproductive system that are internal are the accessory glands and the reproductive ducts. The **accessory glands** include the **seminal vesicle**, the **prostate gland** and the **bulbourethral gland**. These glands make semen, which contains sperm. The reproductive duct system includes the **epididymis**, the **ductus deferens** and the **urethra**. These ducts carry the sperm and semen on their way out of the body.

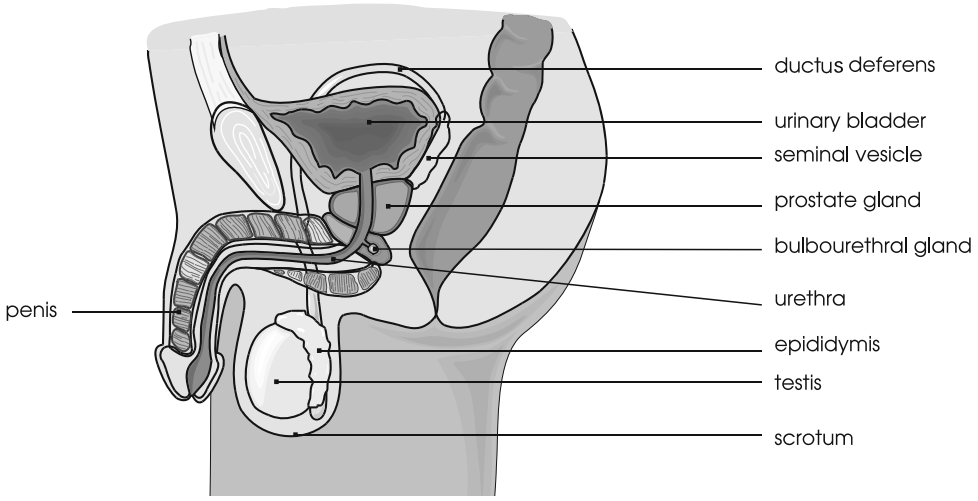


Figure 26-9: Male reproductive system

The **prostate gland**, one of the accessory glands that contributes to the making of semen, surrounds the neck of the bladder and the urethra. Diseases of the prostate include enlargement, inflammation, calculus and stricture.

Hyperplasia is an increase in the number of cells in a tissue or an organ, *excluding* tumor formation, whereby the bulk of the part or organ may be increased. The condition of hyperplasia may cause various urinary conditions, in which case you are directed to use an additional code to identify urinary condition. Keep in mind that this increase in cells does *not* correlate with a neoplasm. If the increase in cells is attributed to malignant or benign neoplasm, you will code from Chapter 2 of the *Tabular List,* "Neoplasms."

Prostatitis is an inflammation of the prostate. If the organism causing the infection is identified, you are to use an additional code for that organism. When the inflammation develops suddenly, it is referred to as **acute prostatitis**. **Chronic prostatitis** develops gradually and continues for a long period. **Prostatocystitis** is when the inflammation is of the prostate and of the bladder.

Code category **607**, disorders of the penis EXCLUDES **phimosis**, which is a narrowness of the opening of the prepuce, or foreskin, preventing its being drawn back over the glans penis. Disorders of the **glans penis**, or the head of the penis, include **leukoplakia** (white, thickened patches) and **balanitis** (inflammation of the glans penis). Other specific disorders of the penis are *thrombosis, edema* and impotence of organic origin.

Now that we've introduced you to many of the relevant terms and definitions, and a few coding pointers for this section, let's try coding an example.

SUBJECTIVE
A 25-year-old male is seen in the office complaining of fever, chills, and lower abdominal discomfort. He states it is tender between his genitals and anus. For the past 2 days, he has noted a burning sensation when urinating.

OBJECTIVE
Upon physical exam, prostate is warm and tender. The groin lymph nodes appear enlarged. The scrotum is swollen and tender. Urethral discharge is noted. A triple-void urine specimen was taken for urinalysis and culture. Results of urinalysis indicate elevated WBC. The urine culture shows a concentration of bacterial growth.

ASSESSMENT
Acute inflammation of the prostate.

PLAN
Patient is discharged with a prescription for Bactrim to be taken for 14 days.

Using the coding pathway of *Inflammation, prostate* in the *Index of Diseases*, You are directed to *see also* Prostatitis. The new coding pathway of *Prostatitis, acute* provides the tentative code of **601.0**. The *Tabular List* confirms code **601.0 Acute prostatitis** as the correct code. Do you see the relationship between the patient's sex and diagnosis? Note that 601.0 is a male diagnosis only.

Know the following terms and related definitions to aid in your understanding of the physician's dictation for conditions related to the male genital organs. And remember: If an infection for any of the following is indicated, you will use an additional code to identify the organism.

- ➢ Hydrocele—a collection of fluid found in the spermatic cord or in the space of the tunica vaginalis testis.
- ➢ Orchis—a Greek term that means "testis." Orchitis is an inflammation of the testis.
- ➢ Epididymis—an elongated structure connected to the posterior surface of the testis. The epididymis stores and matures spermatozoa and transports them from testis to ductus deferens (vas deferens). Inflammation of this structure is known as epididymitis.

Disorders of Breast (610-612)

This brief section contains codes for disorders of the breast, which include conditions classifiable to both males and females. Abnormal tissue growths that are nonneoplastic in nature (that is, are not neoplasms) are referred to as **benign mammary dysplasias**. These conditions are cysts and fibroids of the breast and dilation of the mammary ducts. These disorders consist of the breast being inflamed or enlarged or a mass in the breast. Other disorders of the breasts exclude those disorders associated with lactation or of the puerperium period. The puerperium period is that period of time that begins immediately following delivery and continues for six weeks.

PREOPERATIVE DIAGNOSIS
Bilateral gynecomastia.

POSTOPERATIVE DIAGNOSIS
Same.

PRIMRY PROCEDURE
BILATERAL SUBCUTANEOUS MASTECTOMY.

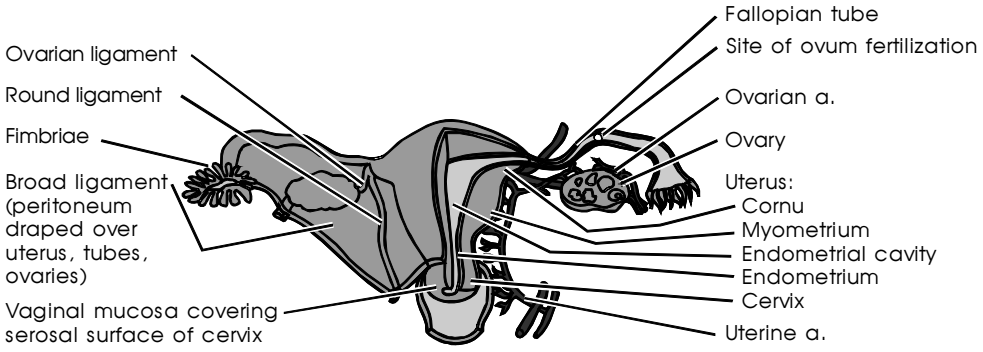
PROCEDURE
The patient was brought to the operating room and given 1 mg midazolam hydrochloride in intravenous incremental doses. The area of concern was then infiltrated with 1% Xylocaine mixed with 0.5% Marcaine. The area was infiltrated extensively. An incision was made beneath the nipple of the right breast, extending down into the skin and subcutaneous tissue. A wide excision was then taken, grasping all of the breast tissue and completely dissecting it free. Hemostasis was achieved with electrocautery and suture ligatures. Dissection was carried up, to include the tail of the breast and laterally and inferiorly. Hemostasis was determined to be intact. The breast tissue was removed and sent off as a separate specimen. The wound was then approximated and closed with interrupted 4-0 Vicryl sutures.

I then proceeded to perform the same procedure on the left breast. This wound was then approximated and closed with interrupted 4-0 Vicryl sutures. The patient was awakened and taken to the recovery room in excellent condition.

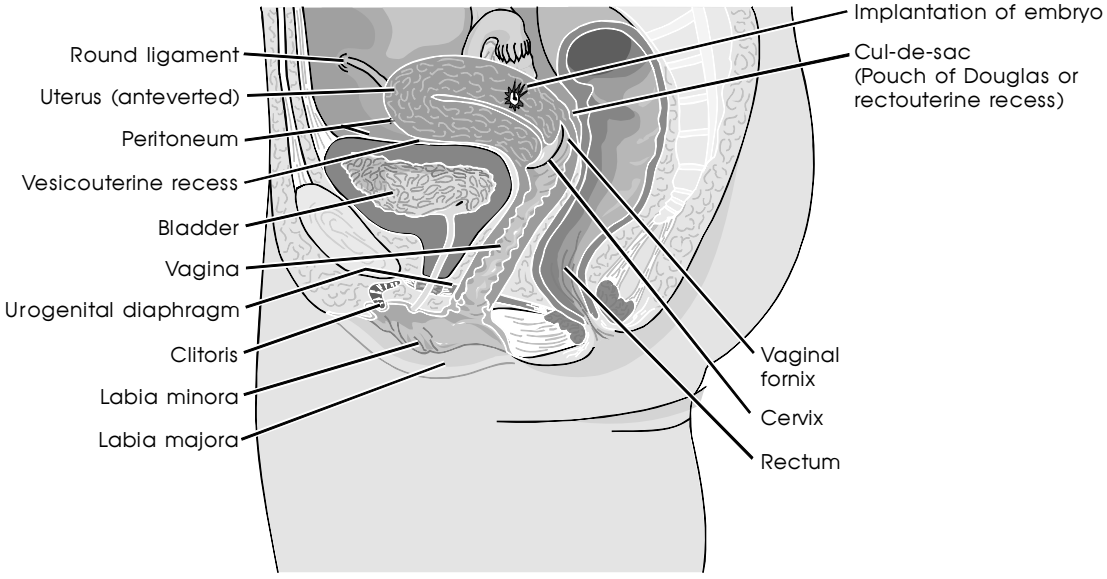
To code the postoperative diagnosis locate the main term *Gynecomastia* in the *Index to Diseases*. The tentative code **611.1** is provided. Turn to the *Tabular List* to determine the highest level of specificity. **611.1 Hypertrophy of breast** is the correct code for the procedure documented.

Inflammatory Disease of Female Pelvic Organs (614-616)

The codes for inflammatory conditions of the female pelvic organs that you will find in this section include inflammation of the ovaries, fallopian tubes, pelvic cellular tissue, peritoneum, uterus, cervix, vagina and vulva. You will note that inflammation of the ovary, fallopian tube, pelvic cellular tissue, peritoneum and uterus are further classified as acute, chronic or unspecified.



Female reproductive tract, anterior view



Female pelvis, sagittal plane

Figure 26-10: Female reproductive system

Also, note in the *Tabular List* that you are directed to use an additional code to identify the organism, if known, responsible for the inflammation. Be aware that these codes EXCLUDES conditions that are associated with pregnancy, abortion, childbirth or the puerperium. Finally, you will probably find that reviewing your terminology will be particularly helpful with this section. For example, *salpingo* is a combining form for "tube," meaning the uterine or fallopian tube; *oophoron* is Latin for "ovary."

Here's another scenario for you to code—see how quickly and accurately you can determine the correct code, and then compare your results with the summary that follows.

SUBJECTIVE
An 18-year-old sexually active female complains of vaginal discharge with odor x 1 month. She has had multiple sex partners in the past 6 months. There has been pain with intercourse and an increase in menstrual cramping.

OBJECTIVE
Physical exam indicates abdominal tenderness. Pelvic exam reveals cervical discharge and motion tenderness. Labs requested: WBC, serum HCG, endocervical culture.

ASSESSMENT
Examination and labs confirm pelvic inflammatory disease (PID).

PLAN
Recommend antibiotic treatment and follow-up appointment in 2 weeks.

Here's what you should have found in the *ICD-9-CM* manual for the diagnosis of PID, or pelvic inflammatory disease. You'll determine the coding pathway to be *Disease, pelvis, pelvic, inflammatory (female) (PID)*, with a tentative code of **614.9**. Then, go to the *Tabular List* to determine the highest level of specificity, and you confirm that **614.9 Unspecified inflammatory disease of female pelvic organs and tissues** is the accurate code.

Other Disorders of Female Genital Tract (617-629)

This final section of Chapter 10 of the *Tabular List* contains disorders of the female genital tract, such as *endometriosis, genital prolapse, fistula,* noninflammatory disorders of the female genital organs, pain, disorders of menstruation, menopausal disorders, infertility and other disorders of the genital organs. You might find this section challenging because of the number of disorders it includes. We discuss the categories in detail so that you can become comfortable with the information. So take as much time as you need and be sure you understand each area before you go ahead to the next section. And, as always, be sure to contact your instructor if you have any unresolved questions.

The **endometrium** is tissue that lines the uterus. The presence of endometrial tissue in abnormal locations, such as in the pelvic area, outside of the uterus, or on the ovaries, bowel, rectum or bladder, is referred to as **endometriosis**. This condition can cause pain, irregular bleeding and infertility.

Genital prolapse occurs when pelvic organs bulge into the vagina or cause pelvic pressure with movement. Prolapse is a hernia and requires surgical repair. When the bulge causes pressure, urinary incontinence can occur. The *ICD-9-CM* manual directs you to use an additional code within code category 618 to identify the urinary incontinence if it is documented. This group of codes EXCLUDES conditions that complicate pregnancy, labor or delivery. Also note that prolapse of the vaginal walls can be classified to the cystocele, urethrocele, rectocele or perineocele. Here's a brief review of what these terms mean:

- **Cystocele**—protrusion of the urinary bladder into the vaginal wall.
- **Urethrocele**—weakness of the tissues in the front wall of the vagina causing the overlying urethra to bulge backward and downward into the vagina.
- **Rectocele**—protrusion into the back of the vaginal wall caused by the rectum pushing against weakened tissues of the vaginal wall (usually associated with a cystocele).
- **Perineocele**—hernia in the perineal region, found between the rectum and the vagina or the rectum and the bladder, or alongside the rectum.

Pain and other symptoms associated with female genital organs may occur during sexual intercourse, menstruation or at unexpected times, such as with stress incontinence. **Dyspareunia** is pain experienced during sexual intercourse. This pain can occur in the pelvic area during or soon after sexual intercourse. Causes of this condition range from vaginal dryness due to inadequate lubrication to current medications.

Pain relating to menstruation can be classified as "pain between periods," "pain during periods" or "pain before periods." **Mittelschmerz**, or ovulation pain, is one-sided, lower-abdominal pain that occurs at or around the time of ovulation. This is not a harmful condition, but often requires treatment to relieve the cramping pain. Some pain during menstruation is normal. Pain that is severe enough to limit usual activities or that requires medication is termed **dysmenorrhea**. Premenstrual tension syndromes include *menstrual migraine, premenstrual dysphoric disorder, premenstrual syndrome (PMS)* and *premenstrual tension.*

Involuntary leakage of urine due to insufficient sphincter control is referred to as **stress incontinence** or **urinary incontinence**. The leakage may occur upon sneezing, laughing, coughing, sudden movement or lifting. This incontinence might be sudden and temporary or ongoing and long term. Strengthening the pelvic muscles using Kegel exercises can help manage this condition. Surgery might be required if symptoms continue or worsen.

By now, you're probably feeling like a pro in terms of your ability to move around the *ICD-9-CM* manual. Quickly assessing each scenario, determining the best starting place for determining the tentative code, verifying the code, and making any final adjustments for additional digits as needed in the *Tabular List*. Go ahead and complete the following Practice Exercise to review what you've learned in this step before you begin your study of the group of codes that include all the possible complicating conditions related to pregnancy, childbirth and the puerperium.

✍ Step 10 Practice Exercise 26-3

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Diabetic nephrosis with long-term insulin use**
   ICD-9-CM code: _____
   ICD-9-CM code: _____
   ICD-9-CM code: _____

2. **Carbuncle of the kidney**
   ICD-9-CM code: _____

3. **Acute cystitis due to E. coli**
   ICD-9-CM code: _____
   ICD-9-CM code: _____

4. **Hard firm prostate**
   ICD-9-CM code: _____

5. **Testicular abscess**
   ICD-9-CM code: _____

6. **Periodic fibroadenosis of the breast**
   ICD-9-CM code: _____

7. **Paravaginal prolapse**
   ICD-9-CM code: _____

8. **Amenorrhea**
   ICD-9-CM code: _____

Use the following information to complete the CMS-1500 that follows.

9. ICD-9-CM Coding/Billing Challenge

Matthew Grimm, MD
NPI: 0304851124
Provider of Blue Cross and Medicaid

Springtown Clinic
1824 Park Avenue
Springtown, CO 80000
970-555-1834

EIN: 86-8000600
NPI: 0304455166

David Rhodes, MD
NPI: 0189218600
Provider of all private insurance

Patient Information

Name Samuel Jones
Address 3 HWY South
City Anytown **State** CO
ZIP 80000
Home Phone (970) 555-1313

Date of Birth May 19, 1972
Sex M **Marital Status** Divorced

Employment Information

Name of Employer Green Finger Nursery
Occupation
If Minor, Name of School

Insurance Information

Primary Insurance
Name Blue Cross of Iowa
ID# 666 00 6663
Group# VE001
Address PO Box 1677
City Sioux City
State IA **ZIP** 51102
Primary Insured Name self
DOB
Relation to Patient self
Employer Green Finger Nursery

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Samuel Jones
Signature of patient (or parent of minor child)

Secondary Insurance
Name none
ID#
Group#
Address
City
State **ZIP**
Secondary Insured Name
DOB
Relation to Patient
Employer

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Signature of patient (or parent of minor child)

Physician signature: *Matthew Grimm, MD*

Date of Service	*2/28/XX*	
Diagnosis	**Procedure**	**Charge**
	99213 Office visit level 3	*$63.00*
	81000 Urinalysis	*$10.00*

Today's Charge	*$73.00*
Cash/Check	*$0.00*
Balance	*$73.00*

Samuel Jones
DOB 05 19 1972
Date of Service: 02/28/XX

SUBJECTIVE
This patient complains of dysuria and prostate nodule. Suspect UTI, rule out pyelonephritis and prostatic carcinoma.

OBJECTIVE
Expanded problem focused exam performed on established patient. Urinalysis: Specific gravity 1.030, pH 7.4. Negative for protein, glucose and ketones. Microscopic: No RBCs, WBCs or casts seen. Urine culture results from outside lab positive for Enterobacter, resistant to ampicillin and cephalothin.

ASSESSMENT
Urinary tract infection secondary to Enterobacter aerogenes. No evidence of pyelonephritis or prostatic carcinoma from serologic or urine testing.

PLAN
Oral antibiotics. Patient to return in 1 week.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid#)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE SEX M F					4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other					7. INSURED'S ADDRESS (No., Street)
CITY	STATE	8. PATIENT STATUS Single Married Other					CITY STATE
ZIP CODE	TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student					ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES NO					a. INSURED'S DATE OF BIRTH SEX M F
b. OTHER INSURED'S DATE OF BIRTH SEX M F		b. AUTO ACCIDENT? YES NO Place (State)					b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES NO					c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.) 1. ____ 2. ____ 3. ____ 4. ____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM DD YY	TO MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1.										NPI	
2.										NPI	
3.										NPI	
4.										NPI	
5.										NPI	
6.										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # a.	b.	

Step 11 Review Practice Exercise 26-3

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 12 Complications of Pregnancy, Childbirth, and the Puerperium (630-679)

- ❑ Conditions that affect the management of pregnancy, childbirth and the puerperium are classified in categories 630 through 679 in Chapter 11 of the *Tabular List*. Conditions from other chapters usually are reclassified in this chapter when those conditions either complicate the obstetrical experience or are aggravated by the pregnancy. Any condition that occurs during the pregnancy is considered to be a complication of the pregnancy unless the physician documents otherwise. This chapter contains many fifth-digit subclassification boxes, notes INCLUDES and a few EXCLUDES. The purpose of this abundance of information is to assist you in accurately coding all the possible conditions related to pregnancy, childbirth and the puerperium. Carefully reading the information provided in the *Tabular List* and understanding how to apply that information are essential in this chapter. Again, we methodically walk you through the information provided in each section. We provide definitions when they are necessary or particularly helpful. We step through examples and provide plenty of practice to assist you in understanding this chapter. So take a deep breath, and let's begin.

ICD-9-CM Guidelines: General Rules for Obstetric Cases

To accurately code Chapter 11 of the *Tabular List*, you must be familiar with "Section I ICD-9-CM Conventions, General Coding Guidelines and Chapter-Specific Guidelines" of the *Coding Guidelines* in the front of your *ICD-9-CM* manual. The following are some of the specific rules to keep in mind, but be sure to review all the guidelines in detail when you code from Chapter 11 for any patient. We will expand on these guidelines as we discuss the respective subchapters.

- ➤ Codes you find in Chapter 11 have sequencing priority over codes used in other chapters. You can use additional codes from other chapters in conjunction with Chapter 11 codes to further specify conditions.
- ➤ You are to use Chapter 11 codes only on the maternal record, never on the record of a newborn.
- ➤ Code categories 640 through 649 and 651 through 676 have required fifth digits, which indicate whether the encounter is antepartum, postpartum or whether a delivery has occurred.

- The fifth digits that are appropriate for each code number are listed in brackets under each code. In most cases, the fifth digits on each code should be consistent with each other. That is, for example, if a delivery occurs, all of the fifth digits should indicate the delivery.
- You should include an outcome of delivery code, V27.0 through V27.9, on every maternal record when a delivery has occurred. You are not to use these codes on subsequent records for the mother or on the newborn record.

Ectopic and Molar Pregnancy (630-633)

A **molar pregnancy** is the result of over-production of the tissue that is supposed to develop in the placenta. This condition is characterized by a mass of cysts that resemble a bunch of grapes. A pelvic exam may reveal signs of a normal pregnancy, although some bleeding may be present. However, because there is no fetus, the size of the uterus may be abnormally large and there will be no fetal heart tones. Once the diagnosis is confirmed, if the mass of tissue is not miscarried, it must be removed by **suction curettage**, or **D and C**, which means dilation and curettage.

When a fertilized egg develops outside the uterus, this is called an **ectopic pregnancy**. Although the most common site of an ectopic pregnancy is in the fallopian tubes, it can also occur in the abdominal or pelvic cavity, ovary, uterine tube or cervix. When a fetus begins to develop outside the uterus, the pregnancy is not viable, and the fetus must be surgically removed.

Other Pregnancy with Abortive Outcome (634-639)

The format of the *Tabular List* in this section is different from anything you have seen to this point. Under the heading for this section is a large shaded box that indicates the fourth-digit subdivisions for categories 634 through 638.

Let's look at the box carefully because it's a little different from what you're used to. You will note the fourth digit with the definition. Then, under the fourth digit and definition are several inclusions to each fourth-digit subdivision. The definition and inclusions are all listed in this one box at the beginning of the category, so that you can refer to them when you are coding. If you turn to code category 634, for example, you will see the definitions provided, but then it is up to you to go back to the box at the beginning of the section to identify all of the possible inclusions under each fourth digit.

This section also has a fifth-digit subclassification box for categories 634 through 637. Each category lists the box separately, but it's the same box with the same meanings in each instance.

The fifth digit for these codes is required to identify the stage of the abortion. "Complete" indicates that all of the products of conception have been expelled from the uterus before 20 weeks gestation. "Incomplete" indicates that not all of the products of conception have been expelled during this time period. "Unspecified" indicates that the stage of abortion is not specified in the documentation.

Abortion is the expulsion of an embryo or fetus from the uterus before the stage of viability. A **spontaneous abortion**, or **miscarriage**, is when the loss of the fetus is the result of natural causes. Therapeutic, elective or legally induced abortions are intentional or deliberate termination of the pregnancy. **Therapeutic abortions** are those recommended by physicians to protect the mother's health. **Elective abortions** are initiated by individual choice, not medical necessity. When the pregnancy continues despite an attempt to end it by legal means, it is termed a **failed attempted abortion**.

To indicate the complication leading to the abortion, you might use additional codes from categories 640 through 649 and 651 through 659. When used with an abortive code, you would apply the fifth-digit 3 to codes in these categories, which identifies "antepartum condition or complication." Antepartum means before the onset of labor. You will code complications following abortions using code category 639. This means you cannot use codes from categories 634 through 638 in conjunction with category 639.

Complications Mainly Related to Pregnancy (640-649)

This section INCLUDES conditions even if they arose or were present during labor, delivery or the puerperium. Codes from categories 640 through 649 apply throughout the entire obstetrical experience, which begins at conception and ends six weeks after delivery. A fifth digit provides information regarding the current episode of care. We will explain these fifth-digit classifications in more detail now.

You will use the fifth digits for codes 640 through 649 to denote the current episode of care. To use these fifth digits appropriately, you need to know some terminology. **Delivery** indicates childbirth, **antepartum** refers to before onset of labor and **postpartum** indicates after childbirth. The fifth digits you can use with each subcategory code are listed in brackets under the code. For example, code 640.0 has [0,1,3] under the code. This means you cannot use a 2 or a 4 as the fifth digit with code 640.0. Be sure to refer to the information in brackets before you make your decision when you apply the final digit for these codes. Also, because multiple coding is common for these code categories, be certain that the fifth-digit assignments are consistent with each other.

Pregnancy sometimes creates conditions that might not otherwise affect the woman. These conditions include *hypertension, diabetes* and *anemia*. These conditions did not exist before the pregnancy and will likely not exist after the pregnancy, and so they are known as **gestational** or **transient**.

Pregnancy sometimes creates conditions that might not otherwise affect the woman.

For example, let's code the diagnosis of pregnancy-induced hypertension, undelivered. If you begin the coding pathway using *Pregnancy* as the main term and *complicated (by), hypertension* as the subterms, you are redirected to "*see* Hypertension, complicating pregnancy." Turn to the Hypertension table, and locate "complicating pregnancy." The term "pregnancy-induced" tells you that the hypertension was not pre-existing, but was caused by the pregnancy and will probably leave once the baby is delivered. This condition is gestational or transient. So let's look for *gestational* in the Hypertension table. Once you find *gestational,* you go to the *Unspecified* column and are provided with the tentative code of **642.3**. Then turn to the *Tabular List* to determine the highest level of specificity. The fifth-digit subclassification box is located at the beginning of the section. "Undelivered" is specified in the diagnosis, so you will use the fifth-digit 3 to indicate "antepartum condition or complication." You assign **642.33 Transient hypertension of pregnancy, antepartum condition or complication** as the correct code for the diagnosis.

Category 648 includes conditions in the mother that are classifiable elsewhere but complicate the pregnancy, childbirth or puerperium. When coding **648.2 Anemia**, remember that an additional digit is required and that you should include the applicable condition classifiable to codes 280 through 285.

Normal Delivery, and Other Indications for Care in Pregnancy, Labor, and Delivery (650-659)

A **normal delivery** is the spontaneous, full-term birth of one live baby, delivered vaginally, head first, with no fetal manipulation or instrumental assistance *except* for an episiotomy. An **episiotomy** is a surgical incision into the perineum and vagina to prevent laceration at the time of delivery, or to facilitate vaginal surgery. Be aware that you cannot use code 650 with any other code from groups 630 through 676 because these codes are not within the boundaries of the definition of a normal delivery. For example, a woman who will be 35-years-old or older at the expected date of delivery will be coded 659.5 ✓ or 659.6 ✓ and code 650 will not apply. V27.0 is the only appropriate code to use with code 650.

Before you try your hand at coding a scenario, here are a few more terms for you to understand to help you code accurately:

- **Gravida**—means a pregnant woman. *Gravida* followed by an Arabic numeral or preceded by a Latin prefix (primi-, secundi-) designates the number of pregnancies.
- **Gravida 1** or **primigravida**—refers to a woman in her first pregnancy.
- **Gravida 2** or **secundigravida**—refers to a woman in her second pregnancy.
- **Para**—means a woman who has given birth to one or more viable infants. *Para* followed by an Arabic numeral or preceded by a Latin prefix (primi-, secundi-, terti-, quadri-) designates the number of times a pregnancy has culminated in a single or multiple birth.

- **Para 1** or **primipara**—refers to a woman who has given birth for the first time.
- **Para 2** or **secundipara**—refers to a woman who has given birth for the second time to one or more infants.

In our next example, the patient is gravida 2, para 1, which means this is her second pregnancy and she has given birth once. Carefully read through the delivery notes, and then see how far you can go in determining the correct code or codes for the information presented.

DELIVERY NOTE

The patient is a 32-year-old, gravida 2, para 1, at term who presented to labor and delivery in active labor. The patient's labor progressed rapidly, and she was completely dilated at approximately a +2 station. The patient went on to have a normal spontaneous vaginal delivery over an intact perineum. She was delivered of a viable female in cephalic presentation, Apgars were 8 at five minutes and 9 at ten minutes. The birth weight was 3628 gm.

The delivery time was 1628. The placenta delivery time was 1637 and was spontaneous. The perineum was examined and noted to have no lacerations of any type. The estimated blood loss at delivery was 300 mL. There were no complications during delivery.

The patient had a normal spontaneous vaginal delivery without manipulation or assistance, resulting in a single liveborn infant.

Based on the documentation, you can code this to a **normal delivery**, code **650**, with **a single liveborn** as the outcome of delivery, code **V27.0**. Did you come up with the same codes? Excellent!

Here are a few more explanations and clarifications to help you as you practice coding conditions from this section. Indications for care in pregnancy, labor and delivery include malposition and malpresentation of fetus, disproportion and abnormality of organs and soft tissues of pelvis. You'll note in the *Tabular List* that these conditions direct you to code first any associated obstructed labor, and to provide the obstruction code. We will revisit these codes when we discuss obstructions in the next section.

Known or suspected fetal abnormalities that affect the management of the mother, in code category 655, are conditions that range from central nervous system malformations, to chromosomal abnormalities, to decreased fetal movement. Other fetal and placental problems that affect the management of the mother, in code category 656, include fetal-maternal hemorrhage, Rh incompatibility and intrauterine death. Keep in mind that you can assign these codes only when the fetal condition is actually responsible for modifying the management of the mother. Just the fact that the fetal condition exists does not justify assigning a code from this series to the mother's record.

Polyhydramnios, or **hydramnios**, is the presence of excess amounts of amniotic fluid. This code category, 657, instructs you to use 0 as the fourth digit and 0, 1 or 3 as the fifth-digit subclassification. To code the mother's condition of antepartum hydramnios, for example, you would locate the main term *Hydramnios* in the *Index to Diseases*. Remember that when you refer to the mother's condition, so you will not choose the code for "affecting fetus or newborn." Instead, you will select the tentative code of **657.0** ✓ . Then turn to the *Tabular List* to determine the highest level of specificity. There, you are explicitly instructed to choose 0 as the fourth digit for this code category. And because this is an antepartum condition, you will select 3 as the fifth-digit subclassification. So the correct code to assign is **657.03 Polyhydramnios, antepartum condition or complication**.

Complications Occurring Mainly in the Course of Labor and Delivery (660-669)

This section contains codes for conditions such as obstructions, trauma to perineum and vulva during delivery, complications of the administration of anesthetic or other sedation in labor and delivery and other complications of labor and delivery, not elsewhere classified. You will note that the fifth-digit subclassification that applies to categories 660 through 669 is identical to the fifth-digit subclassifications used previously in this chapter.

Let's slow down here and focus carefully as you read through the guidelines for coding the following conditions. You might even want to highlight this portion so you can quickly come back to it throughout the rest of your coding practice. You might want to review this even as you begin coding professionally, until you're comfortable with how to apply these codes. The main thing to remember is that when another condition causes obstruction of labor, you will use an additional code to identify that condition.

- Code **660.0** ✓ **Obstruction caused by malposition of fetus at onset of labor** requires an additional code to identify the condition that is classifiable to code category **652 Malposition and malpresentation of fetus**.

- Code **660.1** ✓ **Obstruction by bony pelvis** requires an additional code to identify the condition that is classifiable to code category **653, Disproportion**.

- Code **660.2** ✓ **Obstruction by abnormal pelvic soft tissue** requires an additional code to identify the condition that is classifiable to code category **654, Abnormality of organs and soft tissues of pelvis**.

In sequencing these codes, you will code the obstruction (660) first, followed by the cause. When malposition or malpresentation of the fetus occurs, it can cause an obstruction.

A breech delivery, in code category 652, is when the fetal presentation is that of the buttocks or feet first. This presentation usually causes an obstruction, which requires assistance during delivery, and sometimes, with manipulation, it can be converted to cephalic presentation. Remember, with this situation, you will use code 660.0 in conjunction with a code from category 652.

When you're ready, go ahead and read carefully through the following childbirth-related operative report, and then, based on the information presented, try your skills at solving the puzzle to identify the accurate diagnosis code or codes.

PREOPERATIVE DIAGNOSIS
Intrauterine pregnancy at term. Premature rupture of membranes. Frank breech, causing obstruction.

POSTOPERATIVE DIAGNOSIS
Cesarean delivery due to breech presentation.

PRIMARY PROCEDURE
PRIMARY LOW TRANSVERSE CESAREAN SECTION.

DESCRIPTION AND FINDINGS
The patient underwent an epidural block administered by anesthesiology, and immediately after that, she was prepped and draped in the usual manner. A Pfannenstiel incision was used, and the abdominal wall was then dissected using sharp and blunt dissection. With careful extraction, a female fetus was then delivered in the frank breech position. Apgars of the fetus were 8 and 9. Cord was clamped and cut. Blood was drawn from the infant for type and cross match and Rh factor. The placenta was expressed manually and visually inspected. The pelvic cavity was then inspected, and intensive irrigation was carried out. The uterus was closed. Ovaries and tubes were inspected and noted to be normal. Closure of the abdomen was accomplished. The skin was then closed with staples. The patient then was transferred to a recovery room in stable condition.

Are you comfortable with your results? Don't worry if coding this one took you a while, or you had a little trouble figuring it all out—the scenario is quite involved, and you can easily go down the wrong coding pathway until you have had enough practice and experience working with these code groups. Let's go through the steps to solve this puzzle together, and you can see how well you did and, if necessary, get some pointers that will help you improve your skills for next time.

1. Assess the information and recognize that there are several conditions you need to be aware of and code for. Try the principal coding pathway of *Delivery, breech.* Following this path in the *Index to Diseases*, you find a tentative code of **652.2** ✓ . You should also note that you must use a fifth-digit subclassification with this group of codes.

2. In the *Tabular List,* you find code **652.2 Breech presentation without mention of version**; the fifth-digit options of 0, 1 and 3 are included in brackets under the code. From the fifth-digit options given, you should make a mental note of 1 for "delivered, with or without mention of antepartum condition" as the fifth digit to assign. You should also note that "Frank breech" is included as a subterm under code 652.2. Finally, code 652 instructs us to code first any associated obstructed labor, using code 660.0. Putting all the information together, you determine that the final code for this part of the diagnosis is **652.21**.

3. Next, you focus on the coexisting diagnosis code for obstructed labor, **660.0 Obstruction caused by malposition of fetus at onset of labor**. Again, the fifth-digit options of 0, 1 and 3 are indicated in brackets below this code, and you already know that the correct fifth digit based on the operative report is 1, "delivered, with or without mention of antepartum condition." So the final coexisting diagnosis code is **660.01**.

4. You must also include an outcome of delivery V code from codes V27.0 through V27.9 for the mother's record. To locate the proper V code, use *outcome of delivery, single, liveborn* as the pathway for the tentative code **V27.0** Based on the documentation, you determine that code **V27.0 Single liveborn** is the correct code for this portion of the diagnosis.

5. The only thing left to do is put the codes in the correct order. Again, based on the guidelines in the *ICD-9-CM* manual, you know that you are to code 660.01 first. The correct listing of the three codes for this report is **660.01 652.21 V27.0**.

You've accomplished a lot so far in this lesson! That coding exercise took some time and careful maneuvering through all the guidelines and instructions we've discussed. Just know that if you are working as a medical coding and billing specialist in the maternity and childbirth areas, you will have frequent and regular practice using these codes, and you will quickly become quite familiar with them!

More Pregnancy, Childbirth, and Puerperium Terminology and Examples

Trauma to the perineum and vulva during the delivery are categorized as *perineal laceration* or *vulva and perineal hematoma*. These conditions INCLUDES both damage from instruments and that from the extension of the episiotomy. Remember that an episiotomy is a surgical incision into the perineum and vagina to prevent laceration at the time of delivery, or to facilitate vaginal surgery. If an episiotomy is not sufficient in length, the perineum may tear, which can result in a second- to fourth-degree laceration. If the extent of the perineal laceration is not noted, you will code to "unspecified." Otherwise, you will assign one of the following types:

- **First-degree perineal**—indicates the perineal skin is torn.
- **Second-degree perineal**—laceration, rupture or tear involves the perineal muscles.

- **Third-degree perineal**—laceration, rupture or tear consists of the anal sphincter.
- **Fourth-degree perineal**—laceration, rupture or tear is classifiable to a third-degree laceration but includes the anal or rectal mucosa.

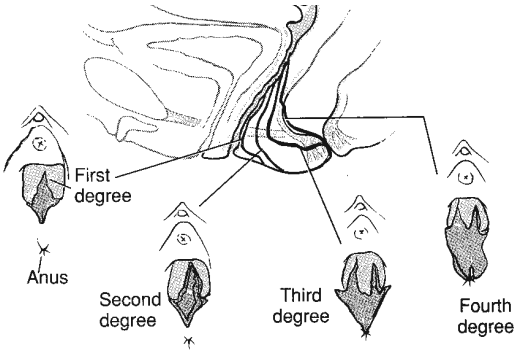


Figure 26-11: Perineal lacerations

2013 ICD-9-CM Professional for Physicians – Volumes 1 & 2, Salt Lake City, Utah: Ingenix, Inc. page 207, Volume 1

So let's say the physician notes excessive fetal growth and performs an episiotomy during labor to assist the vaginal delivery. Upon delivery, the episiotomy tears, extending to the vaginal muscles. What would you code for this condition? You would code the perineal laceration, the excessive fetal growth and the outcome of the delivery. Let's do that now.

For the perineal laceration, try a coding pathway of *laceration, perineum*. In the *Index to Diseases,* under *Laceration*, you find *perineum, perineal* and then, under that, *complicating delivery*. Going further, you find *involving* and then *vaginal muscles*, with a suggested code of **664.1** ✓. Remember that you must also include a fifth digit to indicate the status of delivery—in this case a 1 for "delivered." Now you go to the *Tabular List* to determine the highest level of specificity, and the information there confirms our selection of code **664.11 Second-degree perineal laceration, delivered, with or without mention of antepartum condition** as the correct choice.

Next, you will code for the excessive fetal growth. A reasonable coding pathway is *excessive, fetal*. You find *Excess, excessive, excessively,* but *fetal* isn't listed as a subterm. *Large*, however, is a subterm, and *fetus or infant* is listed under *large.* Of the subterms under *fetus or infant*, the most appropriate is *affecting management of pregnancy* **656.6** ✓. Also remember that you must add the fifth digit of 1 for "delivered." Going to the *Tabular List*, you find **656.6 Excessive fetal growth**, and add the fifth-digit 1, for a final code of **656.61**.

Finally, you review the V codes for the correct outcome of delivery code, and determine that once again **V27.0 Single liveborn** is the correct choice. Following the coding guidelines discussed earlier, you will list these codes in the following order: **664.11 656.61 V27.0**.

Here are some final notes to help you code diagnoses in code groups 668 and 669. Codes for complications resulting from the administration of anesthetic or other sedation in labor and delivery, code group 668 INCLUDES those complications that arise from the administration of general or local anesthetic, analgesic or other sedation in labor and delivery. It EXCLUDES any reaction to a spinal or lumbar puncture, as well as a spinal headache. These complications can be pulmonary, cardiac or central nervous system conditions.

Shock, hypotension and renal failure are conditions that might appear during or following labor and delivery that you will code to category **669 Other complications of labor and delivery, not elsewhere classified**. Complications included in category 669 are methods of delivery without mention of indication. This means the reason the physician selected this type of delivery is not specified. Forceps or vacuum extractor delivery, breech extraction and cesarean delivery are examples of these types of complications.

Complications of the Puerperium (670-677)

This section includes a collection of various complications that might occur during the puerperium. The **puerperium** is the period of time from the end of the third stage of labor until the uterus returns to its normal size, which usually requires three to six weeks. Code categories 670 and 673 through 676 include the listed conditions, even if they occur during the pregnancy or childbirth. You will find the fifth-digit subclassification box for code options to denote the current episode of care. Conditions in this section include major puerperal infection, *deep phlebothrombosis, obstetrical pulmonary embolism,* disorders of the breast associated with childbirth and late effects of complications of pregnancy and childbirth.

Infection and inflammation following childbirth are coded in group **670 Major puerperal infection**. Turn to the *Tabular List* for additional notes pertaining to this category. First, you will note that the fourth digit for this category is 0, "unspecified as to episode of care or not applicable." You will determine the episode of care from the fifth-digit subclassification choices of 0, 2 or 4. Infections and inflammations included in this category are listed. Finally, note the EXCLUDES to ensure that you code accurately from this section.

Deep phlebothrombosis, or **deep-vein thrombosis**, is the presence of blood clots deep in the veins, usually in the leg. Pregnant women have an increased chance of developing these clots, both antepartum (671.3 ✓) and postpartum (671.4 ✓). This condition becomes life-threatening if one of those clots moves to the lungs and results in a **pulmonary embolism**, code 673 ✓ .

Infections of the breast and nipple associated with childbirth pertain to the mother and INCLUDES the conditions present during pregnancy, childbirth or the puerperium. These conditions include abscess of the nipple and breast and **mastitis**, which is an inflammation of the breast tissue. Let's code the following situation to give you some practice working with codes in this section.

SUBJECTIVE
A 26-year-old female is seen by her OB/GYN 2 weeks after giving birth to her 1st child. She complains of pain and swelling of the right breast. She has had no problem breastfeeding.

OBJECTIVE
Physical exam of breast reveals a lump in the right breast. There is tenderness when palpating the nodes in the right armpit. She is afebrile.

ASSESSMENT
Mastitis.

PLAN
Recommend moist heat on affected breast for 20 minutes, 4 x a day until symptoms subside.

With this basic diagnosis, the coding pathway is simply *Mastitis*. Looking up this term in the *Index to Diseases* should give you a tentative code of **611.0**. Now turn to the *Tabular List* to determine the highest level of specificity, and you will note that category 611 EXCLUDES mastitis associated with lactation or the puerperium, which is what you're coding. So go back to the *Index to Diseases* and check the subterms more closely.

You will find *puerperal, postpartum (interstitial) (nonpurulent) (parenchymatous)* under *Mastitis*, and **675.2** ✓ as the tentative code. Turn back to the *Tabular List* and find this code. You are now in the category for infections of the breast and nipple associated with childbirth, so code 675.2 ✓ seems right so far. Remember to add a fifth-digit 4 to indicate that the episode of care is a postpartum condition or complication. Because the delivery occurred two weeks ago, you would not assign a code for the outcome of the delivery in this case. Based on all the information you have found through this process and in the *Tabular List,* you will assign **675.24 Nonpurulent mastitis, postpartum condition or complication** as the correct code.

Once again, you should feel very good about all the hard work you have done, and all the new information you have learned in this lesson. Now it's time to complete the last practice exercise of the lesson to review this last step before you wrap things up with the Mail-in Quiz.

✍ Step 13 Practice Exercise 26-4

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Ovarian pregnancy**
   ICD-9-CM code: _____

2. **Complete miscarriage at 12 weeks**
   ICD-9-CM code: _____

3. **Partial placenta previa with hemorrhage, undelivered**
   ICD-9-CM code: _____

4. **Hyperemesis gravidarum at 20 weeks' gestation**
   ICD-9-CM code: _____

5. **Normal vaginal delivery of healthy twins**
   ICD-9-CM code: _____
   ICD-9-CM code: _____
   ICD-9-CM code: _____

6. **Secundigravida, with previous cesarean delivery, delivered a single liveborn by vaginal delivery**
   ICD-9-CM code: _____
   ICD-9-CM code: _____

7. **Third-degree perineal laceration extending to anal sphincter during delivery of healthy baby girl**
   ICD-9-CM code: _____
   ICD-9-CM code: _____

8. **Postpartum pulmonary embolism**
   ICD-9-CM code: _____

9. **Maternal cracked nipple two weeks after delivery**
   ICD-9-CM code: _____

10. ICD-9-CM Coding Challenge

ADMITTING DIAGNOSIS
Intrauterine gestation, at term, in active labor.

HISTORY OF PRESENT ILLNESS
This is a 30-year-old, gravida 1, para 0, with unknown LMP and no prenatal care who came in complaining of contractions and active labor.

DELIVERY NOTE
The patient had ultrasound done on admission that showed gestational age of 38-2/7 weeks. The patient progressed to a normal spontaneous vaginal delivery over an intact perineum. Rupture of membranes occurred on December 25, 20XX, at 2008 hours via artificial rupture of membranes. No meconium was noted. Infant was delivered on December 25, 20XX, at 2154 hours. Prior to rupture of membranes, 2 doses of ampicillin were given. GBS status unknown. Intrapartum events, no prenatal care. The patient had epidural for anesthesia. No observed abnormalities were noted on initial newborn exam. Apgar scores were 9 and 9 at 1 and 5 minutes respectively. There was a nuchal cord x 1, nonreducible, which was cut with 2 clamps and scissors prior to delivery of body of child. Placenta was delivered spontaneously and was normal and intact. There was a 3-vessel cord. Baby was bulb suctioned and then sent to newborn nursery. Mother and baby were in stable condition. EBL was approximately 500 mL. NSVD with postpartum hemorrhage. No active bleeding was noted upon deliverance of the placenta. Upon delivery of the placenta, the uterus was massaged, and there was good tone. Pitocin was started following delivery of the placenta. Baby delivered vertex from OA position. Mother following delivery had a temperature of 100.7, denied any specific complaints and was stable following delivery.

ICD-9-CM code: _____

ICD-9-CM code: _____

Step 14 Review Practice Exercise 26-4

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

🕮 Step 15 Lesson Summary

❑ Do you remember our discussion comparing running a marathon to completing the previous lesson in this course? We can now expand that analogy and consider that you've completed another major marathon with the completion of this complex lesson about how to code conditions related to the respiratory and digestive systems, including all those conditions associated with pregnancy and childbirth. Soon you will be a star "athlete" when it comes to ICD-9-CM coding skills!

Always remember to balance your time between hard work on these lessons and enough rest and time away to keep your mind fresh. And continue to review the basics of everything you've studied before you begin a new lesson so you go into the new material with the previous information fresh in your mind.

Good work on this lesson! Now go ahead and complete the Mail-in Quiz and you'll soon be ready to begin a new "chapter" in your medical coding and billing specialist education!

✉ Step 16 Mail-in Quiz 26

❑ Follow the steps to complete the Quiz.

a. Be sure you've mastered the instruction and the Practice Exercises that this Quiz covers.

b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.

d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your Quiz online.

e. Mail the Answer Sheet to the school via mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 26

Choose the best answer from the choices provided. Each item is worth 3.33 points.

1. How are hernias classified? _____

a. By occurrence only

b. Unilateral or bilateral only

c. By location, occurrence, with or without obstruction and with or without gangrene

d. Incarcerated, irreducible, strangulation or causing obstruction

2. Which statement is *not* true of Chapter 11? _____

a. These codes have sequencing priority over codes in other chapters.
b. Chapter 11 codes are used only on the maternal record, never on the record of a newborn.
c. Fifth digits do not have to be consistent with each other.
d. You should include an outcome of delivery code on every maternal record when a delivery has occurred.

3. Gravida 3, secundipara means a woman _____.

a. in her third pregnancy, who has given birth to twins
b. in her third pregnancy, who has given birth twice
c. has given birth three times, one stillborn birth
d. has given birth twice and had a hysterectomy

4. _____ means inflammation of the kidneys.

a. Nephritis
b. Renalitis
c. Nephrosis
d. Nephrotic syndrome

5. Pneumonia can be classified as _____.

a. acute or chronic
b. viral, bacterial or due to other specified organisms
c. lobular, lobar or lobe
d. primary or secondary

6. Involuntary leakage of urine due to insufficient sphincter control is referred to as _____.

a. stress incontinence
b. dyspareunia
c. urinary incontinence
d. Both a and c

7. What is true about TMJ? _____

a. It is the joint that connects the lower jaw to the skull.
b. It is an abbreviation for temporomandibular joint.
c. It is often used to describe disorders of the joint.
d. All of the above

8. The fourth-digit subcategory for ulcers classifies them as _____.

a. primary or secondary
b. malignant or benign
c. with or without obstruction
d. acute or chronic

9. Where is the duodenum located? _____

a. It is a portion of the stomach.
b. It is the first portion of the small intestine.
c. It extends from the pharynx to the stomach.
d. It is the first part of the colon.

10. _____ is an acute viral infection that involves the respiratory tract.

a. Influenza
b. Pneumonia
c. COPD
d. Pneumoconiosis

11. Which does the acronym "PID" stand for? _____

a. Pelvic Intrauterine Device
b. Pelvic Inflammatory Disease
c. Penile Inflammation Disease
d. Pre-Isolated Dilation

12. Which is *not* a true statement? _____

a. Cholelithiasis is coded from category 574.
b. Cholelithiasis is an inflammation of the gallbladder.
c. Cholelithiasis requires a fifth-digit subclassification to indicate with or without obstruction.
d. Cholelithiasis is the presence or formation of gallstones.

13. Which is a true statement of Acute Respiratory Infections (460-466)? _____

a. This subchapter codes for pneumonia and influenza.
b. Acute may be a nonessential modifier.
c. Chronic infections are found in this subchapter.
d. It excludes the common cold.

14. Which is a true statement of lobar pneumonia? _____

a. The diagnosis code category is 481 or 486.
b. This condition must be verified by a culture.
c. The x-ray reveals dark patches.
d. All of the above

15. Disorders of the Breasts (610-612) applies to _____.

a. females
b. males
c. both males and females
d. disorders associated with lactation

Choose the best diagnostic code(s) from the choices provided.

16. COPD with acute bronchitis _____

a. 466.0
b. 491.22 466.0
c. 491.22
d. 490

17. Asthmatic croup with acute exacerbation _____

a. 493.92
b. 464.4
c. 464.4 493.90
d. 493.90

18. Empyema due to Aerobacter aerogenes _____

a. 492.8
b. 510.9
c. 510.9 041.85
d. 041.85

19. Pneumonia of the left lower lobe, culture confirms Streptococcus pneumoniae _____

a. 486
b. 482.3
c. 481
d. 481 038.0

20. Acute duodenal peptic ulcer with perforation _____

a. 532.20
b. 533.10
c. 532.10
d. 533.20

21. Incarcerated scrotal hernia, bilateral _____

a. 550.92
b. 550.12
c. 550.90
d. 550.02

22. Diverticulitis of the jejunum _____

a. 562.00
b. 562.02
c. 562.03
d. 562.01

23. Diabetic nephritis with long-term insulin use _____

a. 583.9
b. 250.40 583.81 V58.67
c. 250.4 581.81 V58.67
d. 250.4 583.81

24. Incomplete miscarriage at 12 weeks gestation complicated by excessive hemorrhaging requires D&C _____

a. 634.1
b. 634.91
c. 634.11
d. 634.90

25. Pre-eclampsia with pre-existing hypertension, undelivered _____

a. 642.33
b. 401.9 642.73
c. 642.73
d. 401.9

26. Normal spontaneous vaginal delivery of a healthy baby boy _____

a. 650
b. 650 V27.9
c. 650 V27.0
d. V27.9

27. Spontaneous vaginal delivery complicated by an excessively large fetus obstructing labor, requiring an episiotomy for delivery of single liveborn _____

a. 660.11 653.51 V27.0
b. 653.51 V27.0
c. 660.10 653.50
d. 660.10 653.50 V27.0

28. Postpartum hemorrhage of cesarean section wound _____

a. 641.94
b. 674.34
c. 641.84
d. 674.30

29. SUBJECTIVE
The patient is a 38-year-old white male with a 20-year history of alcoholism and acute pain following a coughing episode on the day prior to the admission. Following the episode of acute pain, there was brisk hematemesis of dark blood.

OBJECTIVE
The patient was premedicated with Valium 5 mg IV and Demerol 50 mg IV. The patient was examined with a 1T-10 endoscope. The GE junction was at 38 cm, and there appeared to be 1+ varices. The stomach was easily distensible with some blood seen in the fundus. There was a Mallory-Weiss tear with overlying clots and no active bleeding. There was a prepyloric ulcer seen. The duodenum and postbulbar region were normal. The patient tolerated the procedure well. There were no complications.

ASSESSMENT
1. Mallory-Weiss syndrome.
2. Prepyloric ulcer.

PLAN
Treat with H2 blockers and arrange surgical consultation.

a. 786.2 578.0
b. 578.0 530.7 531.90
c. 530.7 531.90
d. 530.7 531.40

30. SUBJECTIVE
Suspected intussusception. Patient with nausea, vomiting and diarrhea for 2 days. Supine abdomen film shows multiple air-filled loops of bowel. The pattern is indeterminate for obstruction versus adynamic ileus. ROS is noncontributory.

OBJECTIVE
Abdomen: Rebound tenderness. Abnormal bowel sounds. Genitalia: External genitalia normal. Database: Barium enema performed to rule out obstruction. An intussusception was encountered at the level of the transverse colon. The intussusception was reduced using hydrostatic pressure.

ASSESSMENT
Intussusception, reduced.

PLAN
Repeat abdominal film daily x 3 to look for recurrence.

a. 560.0
b. 787.01 787.91
c. 560.0 787.01 787.91
d. 560.1

Just for Fun

Before you begin the next lesson, let's think about the organ systems you've studied so far. You've looked at diagrams of different systems such as the respiratory, digestive and circulatory. You probably know that medical students don't just look at pictures of organ systems; they must dissect them as well. Are you too squeamish to do this? Don't worry. It's natural. After a few days, the feeling passes. But thank goodness all you have to do as a coder is code diagnoses and procedures. The only things you have to dissect are terms.

You may think that working with organs, dissecting them, handling them and talking about them would make a doctor callous to the wonder of life. If you forget to honor your patients, that might happen. The answer lies in attitude.

An important part of medical education is to remember to honor life and your patients. How do you do this? You develop the feeling of honor. How does that feel? Well, if you just learned that you'd won a prestigious award, you'd probably take in a deep breath and smile inside. Do that right now. Take in a deep breath, look at that award and think about how happy you are inside. It's such an honor to receive it!

Should you have the opportunity to look at organs, feel the honor given to you to learn from what was once a living being. Treat the organs with the respect they deserve. Make sure they are used for only the best of intentions. Apply this same feeling to the honor patients give to you by entrusting you with their medical information.

Now, let's get started with your next lesson and learn about even more organ systems.

Congratulations!

You have completed Lesson 26.

Do not wait to receive the results of your Quiz before you move on.

Lesson 27

ICD-9-CM Coding— From Diseases of the Skin to Conditions in the Perinatal Period

Step 1 Learning Objectives for Lesson 27

- When you have completed the instruction in this lesson, you will be trained to do the following:
  - Define complications of diseases of the skin, subcutaneous tissue, musculoskeletal system and connective tissue; congenital anomalies; and conditions in the perinatal period.
  - Explain the basic exclusions, inclusions and rules related to Chapters 12 through 15 of the *Tabular List* in the *ICD-9-CM* manual.
  - Identify the diagnosis, outline the coding pathway and assign the final code for the documented disorders and diseases.

Step 2 Lesson Preview

- In this ICD-9-CM coding lesson, you will encounter a broad mix of diagnosis codes with lots of tips and pointers to help you select the correct codes. You will learn about diseases and conditions of the skin, muscles, bones and connective tissue. You will also learn about congenital anomalies and conditions in the perinatal period. Moreover, you will learn how to find and confirm the correct codes for these many conditions and diseases. As always, you will have the opportunity to apply what you are learning as you practice coding the sample scenarios and exercises provided for you throughout the lesson. So let's continue on the journey through the *ICD-9-CM* manual and diagnosis coding!

> To help make sure you don't get confused as you code the practice exercises and scenarios throughout the following ICD-9-CM coding lesson, it's important to keep in mind that we are focusing for now only on ICD-9-CM codes—not CPT codes. You will see physician notes and documentation about specific procedures in some of the scenarios we use just because we want you to practice with authentic examples. But remember that you will code only the diagnoses during these lessons—you'll have plenty of time and lots of practice combining procedural and diagnostic codes in later lessons.

Step 3 Diseases of the Skin and Subcutaneous Tissue (680-709)

- Chapter 12 of the *ICD-9-CM* manual's *Tabular List* contains codes for the skin, which is the largest organ in the body. The skin is the covering that protects all other organs by acting as a barrier against infection and disease.

The cells of the skin constantly change and adapt to outside influences. Because the skin is constantly exposed, it is a prime target for infection, inflammation and other diseases. The skin has a limited reaction pattern to diseases. This means that it responds to most infections and diseases by producing the same symptoms, such as redness or blistering.

The skin consists of a thick outer layer, called the **epidermis**, and a thicker inner layer, called the **dermis**. The skin also includes appendages, which are structures that grow within the skin. Skin appendages are hair, nails and glands (sebaceous, apocrine and eccrine). The *epidermis* continually forms new cells in its deepest layer and sheds dead cells at its surface.

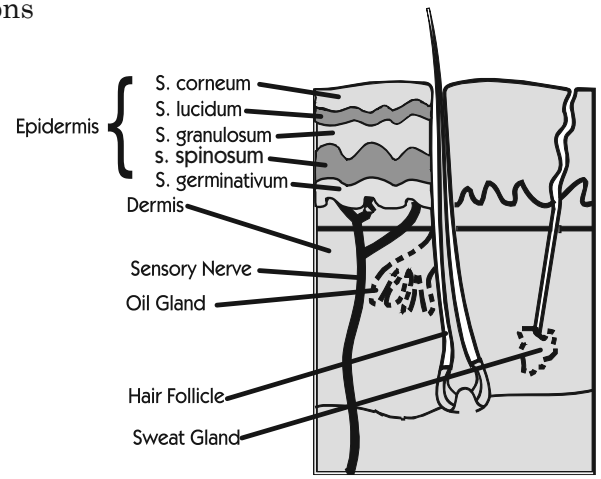


Figure 27-1: Layers of the epidermis

The epidermis contains **melanin**, the pigment that gives the skin color. The epidermis or cuticle consists of stratified squamous epithelial tissue. The epidermis of the palms of the hands and soles of the feet has the following layers: **stratum corneum** (horny layer), **stratum lucidum** (clear layer), **stratum granulosum** (granular layer), **stratum spinosum** (prickle cell layer) and **stratum germinativum** (basal layer). The stratum lucidum is present only in the thick skin of the palms and soles.

The *dermis* or corium consists of fibrous connective tissue. It is primarily composed of fibrils of collagen. Collagen is responsible for the mechanical strength of the skin. The dermis is the layer of skin that lies beneath the epidermis and consists of the **papillary** (or superficial) layer and the **reticular** (or deeper) layer. The dermis contains blood vessels, lymphatics, nerves, nerve endings, muscle, hair follicles and sebaceous glands and sweat glands.

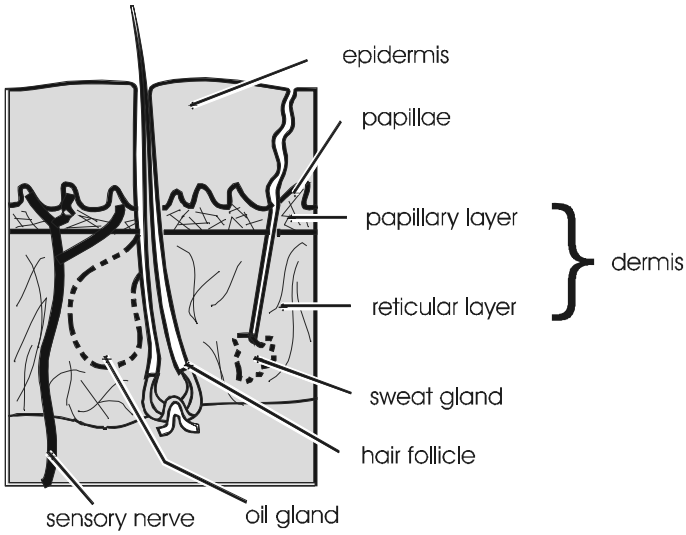


Figure 27-2: Layers of the dermis

Infections of Skin and Subcutaneous Tissue (680-686)

This section of Chapter 12 contains codes for infections of the skin and **subcutaneous tissue**, which is the layer of loose connective tissue located directly beneath the skin. These conditions EXCLUDES certain infections of skin classified in Chapter 1 of the *Tabular List,* "Infectious and Parasitic Diseases." Examples of these exclusions are listed at the beginning of the section. For categories 681 through 683, and for category 686, you are to use an additional code to identify the organism that is causing the infection if the organism is documented.

A **furuncle** is a painful nodule formed in the skin by enclosing an inflammation of the dermis and the subcutaneous tissue enclosing a central core. The furuncle is commonly known as a **boil**. A furuncle is caused by *staphylococci* that enter through the hair follicles. A **carbuncle** is an infection of the skin and subcutaneous tissue composed of a cluster of furuncles, or boils, usually due to *Staphylococcus aureus*, which results in cell death. When you code a carbuncle or furuncle, you will code to the site. Note that codes found in this category, **680 Carbuncle and furuncle** contain some EXCLUDES .

Cellulitis is an acute, widely distributed, spreading, fluid-filled, pus-producing, suppurative inflammation of the deep subcutaneous tissues and sometimes muscles. This condition may be associated with abscess or localized collection of pus formation. Again, codes are provided for you to specify the site of the infection. The following terminology will help you code conditions in this section correctly:

- **Felon** is a painful abscess caused by infection in the closed space of the fingertip.
- **Onychia** is an inflammation of the nail matrix that causes nail loss.
- **Paronychia** is an inflammation of the tissue folds around the nail.

Now that you have some basic definitions and coding information for this section, let's put your *ICD-9-CM* book to work by coding the following scenario:

CT (Computed Tomography) OF NECK
Axial slices were obtained from the base of the skull to the thoracic inlet, following intravenous contrast infusion. Soft-tissue and bone window images were obtained for interpretation. There is an irregular fluid collection seen with adjacent soft-tissue density at the level of the vocal cord, just medial to the sternocleidomastoid muscle. Further collection appears to extend superiorly to the level of the hyoid bone and inferior to the level of the thyroid. Adjacent soft-tissue swelling is seen. There are several small lymph nodes seen at the left side of the neck. The findings are consistent with the clinical diagnosis of left deep neck abscess. Remainder of the findings appear unremarkable.

IMPRESSION
Left deep neck abscess as described above.

To code this radiology scenario, use the coding pathway of *Abscess, neck*. Following this pathway in the *Index to Diseases*, you find **682.1** as the tentative code. Then, turning to the *Tabular List* to determine the highest level of specificity, you find code **682.1 Other cellulitis and abscess, Neck** is the correct code.

Other Inflammatory Conditions of Skin and Subcutaneous Tissue (690-698)

This section contains a variety of diseases with symptoms such as inflamed, erupting, red, scaly and itching skin. These conditions include *seborrheic dermatitis*, *contact dermatitis*, *erythematous* conditions, *psoriasis* and *pruritus*.

Seborrheic dermatitis is a common chronic disease that affects about 15 percent of the U. S. population. The symptoms of seborrheic dermatitis are typically reddening, scaling and itching of the skin, especially under the nose, in the eyebrows and on the scalp. The skin becomes dry and begins to flake. This condition can be categorized as "infantile," "cradle cap" or "unspecified." On the scalp, this condition is known as dandruff. To code dandruff, for example, locate that main term in the *Index to Diseases*, and you will find the code of **690.18**. In the *Tabular List,* you find **690.18 Other seborrheic dermatitis**. And although dandruff isn't specified as an inclusion, based on the *Index to Diseases* directions, you can be comfortable that this is the correct code.

Contact dermatitis, also referred to as **eczema**, is an acute or chronic inflammatory rash marked by itching and redness that is the result of cutaneous contact with a specific allergen or irritant. This code category, 692, has many inclusions to assist you with accurate coding. Review the codes carefully when you are coding from this section.

Psoriasis is a common skin inflammation characterized by the eruption of reddish, thick, dry, silvery-scaled skin, predominantly on the elbows, knees, scalp and trunk. This condition is incurable, and treatment is focused on controlling the symptoms. A specific type of psoriasis, **pityriasis rosea** is an eruption of macules or papules that involves the trunk and, less frequently, the extremities, scalp and face. The onset of pityriasis rosea is frequently preceded, about a week before, by a single, larger, scaling lesion known as the **herald patch**, which lasts about six to eight weeks. Then the lesions, which are usually oval, occur, following the crease lines of the skin. Spontaneous remission occurs in approximately eight weeks. Treatment for this condition consists of relieving the symptoms rather than curing the rash.

Other Diseases of Skin and Subcutaneous Tissue (700-709)

This section EXCLUDES conditions that are confined to the eyelids, and congenital conditions of the skin, hair and nails. The codes here cover *corns* and *calluses*, *seborrheic keratosis*, nail diseases, hair loss, heat rash, *acne*, bed sores, *hives* and *freckles*. We will discuss some of these conditions in this lesson.

Corns are localized thickening of the skin. They are caused by continuous pressure over bony areas of the foot, especially the metatarsal head. This frequently causes localized pain. Shoes that do not fit properly can cause corns. **Callosities** is commonly known as a **callus**. It is an area of thickened skin. It is caused by regular or prolonged pressure or friction. Gardeners can develop calluses on the palms of their hands, joggers on the soles of their feet, and guitarists on the tips of their fingers.

Diseases of the nails EXCLUDES congenital anomalies, as well as onychia and paronychia, which we discussed earlier in this lesson. An **ingrowing nail** (also often called an **ingrown nail**) is a condition that usually affects the toenail, but it can be of the fingernail, as well. In this condition, one edge of the nail is overgrown by the nailfold and a pus-forming lesion is produced. Ingrown nails are the result of faulty trimming of the nails or pressure from a tight shoe on the toenails. You are to use code 681.9 if a general infection of the nail is documented. To code an ingrowing toenail, simply locate *Ingrowing* as the main term in the *Index to Diseases*, and then *nail* as the subterm. When you check out the tentative code of **703.0** in the *Tabular List,* you will find that **703.0 Diseases of nail, Ingrowing nail** is the accurate code.

One condition included in diseases of the hair and hair follicles is **alopecia**, which is a lack of hair, or **baldness**. Baldness is not usually caused by a disease but instead is influenced by age, genetics and testosterone. The average scalp contains approximately 100,000 hairs, and it loses about 100 hairs per day. When a hair falls out, it is replaced within six months with a new one. When the body fails to replace the fallen hair, this is known as genetic hair loss. Hair loss is a gradual process of losing hair in patches or over the entire head.

Code group **707 Chronic ulcers of the skin** INCLUDES noninfected sinus of the skin and nonhealing ulcers. This condition EXCLUDES varicose ulcers.

A **pressure ulcer** (code 707.0), commonly known as a **bed sore** or a **decubitus ulcer**, is an area of skin that breaks down as the result of constant pressure that reduces the blood supply, which in turn causes the tissue in that area to die. Bed sores are a common condition for persons confined to beds or wheelchairs.

When coding a pressure ulcer, you are instructed to use an additional code to identify the pressure ulcer stage, using codes 707.20 through 707.25.

There are four stages of pressure ulcers:

Stage I—Pressure pre-ulcer skin changes are limited to persistent focal erythema. In this stage, the sores are not opened wounds, although the skin is closed, it can be very painful. The skin may be warm, firm or stretched.

Stage II—Pressure ulcer may have abrasions, blisters or partial thickness skin loss involving the epidermis and/or dermis. The skin is tender and painful. Bacteria can enter the site due to the opened wound.

Stage III—Pressure ulcer with full thickness skin loss involving damage or necrosis of the subcutaneous tissue. The skin breaks down and looks like a crater, in which there is damage to the tissue below the skin. The fat layer is exposed.

Stage IV—Pressure ulcer with necrosis of soft tissues through to the underlying muscle, tendon or bone. The pressure ulcer is very deep, causing extensive damage.

Let's practice coding one more diagnosis from this section before you review what you've studied so far. Read through the following report and determine the correct code or codes for the diagnosis.

PREOPERATIVE DIAGNOSIS
Chronic fourth-stage decubitus ulcer of the right heel.

POSTOPERATIVE DIAGNOSIS
Same.

PRIMARY PROCEDURE
EXCISIONAL DEBRIDEMENT OF SKIN AND SUBCUTANEOUS TISSUE OF HEEL.

PROCEDURE
The patient's foot was prepped with dilute betadine solution. Following this, the necrotic tissue surrounding the ulcer was sharply excised through the skin and the subcutaneous tissue. The tissue was debrided until it started to bleed around the edge of the ulcer. Adequate hemostasis was noted. This process was accomplished with minimal local anesthesia, and the patient tolerated it with little or no pain. The wound was packed with saline-dampened gauze and wrapped with sterile dressings.

For this operative report, you will choose a coding pathway of *Ulcer, decubitus, heel*, which provides the tentative code of 707.07 in the *Index to Diseases*. Check that code in the *Tabular List* and you'll find it's correct. Now, you need to identify the stage of the ulcer. This time your coding pathway is *Ulcer, pressure, stage, IV*. The code indicated is 707.24. After verifying this code you will assign **707.07 Chronic Ulcer of skin, Pressure ulcer, Heel** and **707.24 Pressure ulcer stage IV** to this operative report.

✍ Step 4 Practice Exercise 27-1

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Boil located on the back of the right ear**
   ICD-9-CM code: _____

2. **Severe sunburn of face and neck**
   ICD-9-CM code: _____

3. **Eczema due to cat hair**
   ICD-9-CM code: _____

4. **Lupus erythematosus**
   ICD-9-CM code: _____

5. **Perianal itch**
   ICD-9-CM code: _____

6. **Baldness**
   ICD-9-CM code: _____

7. **Patient is hemiplegic due to cerebrovascular disease presenting with stage II pressure ulcer located on buttocks, resulting from contact with wheelchair.**
   ICD-9-CM code: _____
   ICD-9-CM code: _____
   ICD-9-CM code: _____

Use the following information to complete the CMS-1500 that follows.

8. ICD-9-CM Coding/Billing Challenge

Sarah Duncan, MD
1414 Swallow Street
Yourtown, CO 80000
(970) 555 -1514

SSN: 333-33-0003
NPI: 0203048901
Participating Provider for
Blue Cross, Mutual Life and Medicare

Patient Information

Name Emma Smith
Address 1410 Iris Drive
City Mytown **State** CO
ZIP 80001
Home Phone 970-555-5843

Date of Birth 1-30-30
Sex F **Marital Status** widowed

Employment Information

Name of Employer retired
Occupation
Student **Full time** **Part time**

Insurance Information

Primary Insurance
Name Medicare
ID# 501 00 7319A
Group#
Address 600 Grant Street Ste 600
City Denver
State CO **ZIP** 80203
Primary Insured Name Emma
Relation to Patient
DOB
Employer

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Emma Smith
Signature of patient (or parent of minor child)

Secondary Insurance
Name none
ID#
Group#
Address
City
State **ZIP**
Secondary Insured Name
Relation to Patient
DOB
Employer

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Signature of patient (or parent of minor child)

Physician signature: *Sarah Duncan, MD*

Date of Service	*7/12/XX*	
Diagnosis	**Procedure**	**Charge**
	99212 Office visit level 2	*$50.00*

Today's Charge	$50.00
Cash/Check	$0.00
Balance	$50.00

Emma Smith
DOB 01 30 1930
Date of Service: 7/12/XX

SUBJECTIVE
Patient developed "infection in my cuticle." The patient gets regular acrylic manicures. Washes hands 1 or 2 x a day. Otherwise, no excessive exposure to water or detergents.

OBJECTIVE
Vital signs are normal. There is redness and swelling of the perionychium at the base of the right index finger. The nail is raised, and there is suppuration present.

ASSESSMENT
Paronychia.

PLAN
Incision and drainage. Culture and sensitivity. Cephradine 500 mg p.o. t.i.d. for 10 days. Return in 3 days for observation and results of culture.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid#) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH SEX M F

b. OTHER INSURED'S DATE OF BIRTH SEX M F

b. AUTO ACCIDENT? YES NO Place (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1.														NPI	
2.														NPI	
3.														NPI	
4.														NPI	
5.														NPI	
6.														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

a. b.

Step 5 Review Practice Exercise 27-1

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 6 Diseases of the Musculoskeletal System and Connective Tissue (710-739)

- ❑ Chapter 13 of the *Tabular List* contains codes for diseases, disorders and pains of the joints, bones and cartilage located in the musculoskeletal system, as well as acquired musculoskeletal deformities. The **musculoskeletal system** is composed of the *skeletal system* and the *muscular system* because they work closely together. The **skeletal system** is the "backbone" of the body, while the **muscular system** consists of tissues that produce movement anywhere in the body by contracting and relaxing. Connective tissues bind together and support various structures of the body.

  At the beginning of Chapter 13 of the *Tabular List*, you will find a fifth-digit subclassification box to be used with codes in categories 711 through 712, 715 through 716, 718 through 719 and 730. The fifth-digit subclassification indicates the affected site. You will refer to this box often when coding from the sections of Chapter 13. You are also instructed to use an additional external cause code to identify the cause of the musculoskeletal condition if applicable.

Arthropathies and Related Disorders (710-719)

You will find codes for diseases that affect the joints and disorders related to these conditions in this section. The section includes codes for diseases of the connective tissue, infections of the joints, *rheumatoid arthritis, osteoarthritis, derangement* and other disorders of the joints. The codes in this section EXCLUDES disorders of the spine, which are included in the next section. **Systemic lupus erythematosus**, also referred to as **SLE** or **lupus**, is a chronic inflammatory disease of the connective tissue that can affect many organ systems. Characteristics of this disease include fever, weakness, muscle and joint pain, anemia and a "butterfly" rash around the cheeks and forehead. There is no cure for SLE. Treatment focuses on the symptoms.

Because SLE can affect many organ systems, you are to use an additional code to identify the manifestation. To code systemic lupus erythematosus, locate the main term *Lupus* in the *Index to Diseases*, where you will find the tentative code of **710.0**. If you look down the list of subterms, you will find that *erythematosus, systemic* provides the same code. Turn to the *Tabular List* to determine the highest level of specificity. Based on the information here, you will see that **710.0 Diffuse disease of connective tissue, Systemic lupus erythematosus** is the correct code.

"Arthropathy associated with infections" refers to any infectious disease that affects a joint. This code category EXCLUDES rheumatic fever, which you will code from category 390. **Crystal arthropathies** are joint diseases caused by **urate**, or salt of uric acid, crystal deposits in joints or synovial membranes. This category EXCLUDES gouty arthropathy, codes 274.00-274.03.

You will note a modified fifth-digit subclassification box in each of these sections. The box is a condensed version of the box located at the beginning of **Arthropathies and Related Disorders**.

Although the box lists fifth-digits to specify the sites, refer to the beginning of the chapter for more detailed information so you are sure your coding is accurate. Most conditions you will find in each of these categories are manifestations of underlying diseases. For this reason, you are directed to code the underlying disease first.

Rheumatoid arthritis, or **RA**, is a chronic systemic disease characterized by recurrent inflammation of the synovial joints and related structures. Onset may be abrupt, with simultaneous inflammation in multiple joints, or gradual, with progressive joint involvement. The most sensitive physical sign is the tenderness in nearly all of the inflamed joints. Symmetric involvement of small hand joints, feet, wrist, elbows and ankles is typical, but RA may occur in any joint. This condition occurs more often in women than men. The course is variable but often is chronic and progressive, and leads to deformities and disability. The treatment for RA includes medication, physical therapy and even surgery to relieve some of the symptoms.

Now read through the following SOAP note and determine the correct code for the diagnosis:

SUBJECTIVE
Patient states, "My hands hurt." She rated the pain as 7 on a scale of 1-10, with 10 being the most severe pain.

OBJECTIVE
Observed swelling and inflammation in fingers and joints of both hands and wrists. Range of motion and strength decreased substantially. Paraffin bath given bilaterally for hands and wrists, with some improvement noted. Therapeutic activities performed for 15 minutes to improve ADLs. A 4 x 4 inch piece of dicem was given to patient to assist with opening jar lids, and a rocker knife was given to assist patient with cutting when preparing meals. She was instructed in the use of both items.

ASSESSMENT
Rheumatoid arthritis in hands and wrists bilaterally.

PLAN
Patient to return in 1 week for occupational therapy to reevaluate treatment plan and progress.

To code the diagnosis of rheumatoid arthritis, you begin, as always, in the *Index to Diseases*. Following the coding pathway of *Arthritis, rheumatoid*, you will identify a tentative code of **714.0**. Now turn to the *Tabular List* to determine the highest level of specificity, where you will confirm that **714.0 Rheumatoid arthritis** is the accurate code for the scenario.

Osteoarthritis, also known as degenerative joint disease, is a noninflammatory degenerative joint disease characterized by the repair of joint cartilage not keeping up with cartilage degeneration. This condition tends to occur in the weight-bearing joints, such as the knees and hips. The exact cause of osteoarthritis is unknown, but it is believed that metabolic, genetic, chemical and mechanical factors play a role, as well as the aging process.

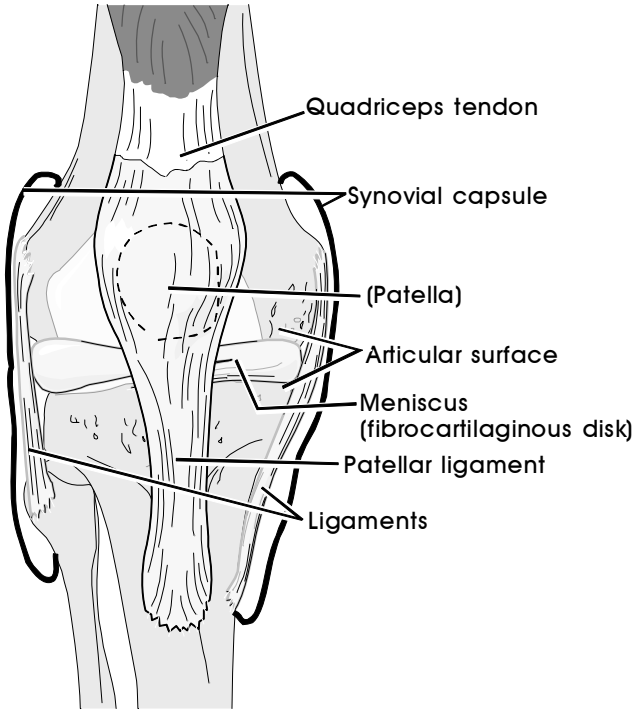


Figure 27-3: Knee joint, ligaments and tendon

Derangement is the disturbance of the regular order or arrangement. Category 717 includes codes for the internal derangement of the knee. This code group INCLUDES degeneration, rupture and old rupture or tear of the articular cartilage or meniscus of the knee, and EXCLUDES current injury, deformity and recurrent dislocations. **Joint mice** of the knee indicates the presence of small, calcified, loose bodies in the joint synovial area. To code this condition, use the coding pathway *Joint, mice* in the *Index to Diseases*. This pathway directs you to *see Loose, body, joint, by site*. This new coding pathway, *Loose, body, joint, knee,* provides the tentative code of **717.6**. When you turn to the *Tabular List* to determine the highest level of specificity, you will confirm that **717.6 Internal derangement of knee, Loose body in knee** is the accurate code for this condition.

Dorsopathies (720-724)

Dorsopathy is a general term for diseases and disorders of the spine. Inflammation, stiffening, displacement and degeneration are a few of the conditions you will find within this section. This is a fairly straightforward section to code from, but understanding the anatomy of the spine will assist you with accurate coding.

The spine is called the **vertebral column** because it is composed of a stack of 33 vertebrae, which are divided into 5 distinct regions. There are 7 **cervical vertebrae**, numbered C1 though C7; 12 **thoracic vertebrae**, numbered T1 through T12; 5 **lumbar vertebrae**, numbered L1 through L5; 5 fused **sacral vertebrae**, numbered S1 though S5; and 4 fused **coccygeal**, **vertebrae** forming the coccyx.

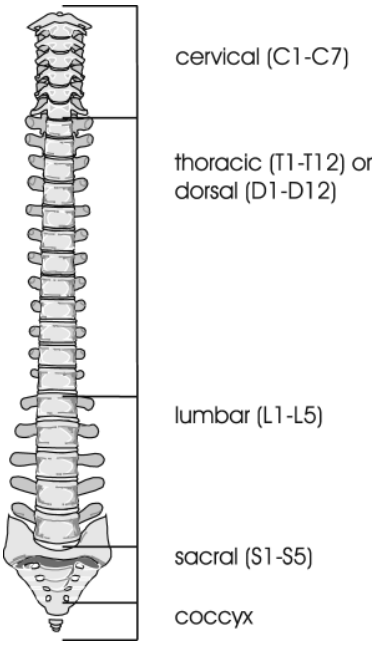


Figure 27-4: Vertebral column

Intervertebral discs form the major joint at each level of the spine. These discs cushion the vertebrae from the shock of weight-bearing movements by the rest of the body. The discs also allow the spine to bend. A disorder of the discs without a disorder of the spine is specified as "without myelopathy." As the spine flexes and extends, the discs protect the vertebral bodies from injury. Injuries to the discs include *displacement* and degeneration. **Displacement**, or the lack of normal positioning, may also be referred to as **herniation**. When you locate *Herniation* in the *Index to Diseases,* you are directed to *see also* Hernia. The coding pathway *Hernia, intervertebral cartilage or disc* redirects you to *see Displacement, intervertebral disc.*

Let's code hernia of the L4-L5 intervertebral disc. With your anatomy knowledge, you know that L4-L5 refers to the lumbar region. So let's look up *Hernia, lumbar* in the *Index to Diseases*. This coding pathway provides the tentative code of 553.8. That code is in the range for the "Digestive System" chapter—that's not right! Go back to the *Index to Diseases* and continue from the *Hernia, lumbar* pathway to the subterm *intervertebral disc*. This provides the tentative code of **722.10**. You then turn to the *Tabular List* to determine the highest level of specificity. You can comfortably conclude that **722.10 Intervertebral disc disorder, Displacement of thoracic or lumbar intervertebral disc without myelopathy, Lumbar intervertebral disc without myelopathy** is the accurate code.

Rheumatism, Excluding the Back (725-729)

Rheumatism is an indefinite term applied to various conditions marked by inflammation and degeneration or metabolic derangement of the connective tissue structures of the body. Its symptoms include pain, stiffness or limitation of movement. When rheumatism affects only the joints, it is called **arthritis**. This section does not include codes for conditions of the back because they are included in the previous section. It INCLUDES disorders of muscles, tendons and other attachments and of other soft tissues. You'll find that most coding in this section is straightforward. Fourth and fifth digits are provided in the *Tabular List*. Be sure to review each tentative code to verify inclusions, exclusions and additional notes that will assist you.

Let's go straight to the sample physician notes so you can practice coding the diagnosis. Work carefully but as quickly as you can, and then we'll review the process to see how you did.

SUBJECTIVE
This 16-year-old male has experienced mild pain in the back of his lower heel that increases when he is playing basketball. The season just started, and he admits to being out of shape.

OBJECTIVE
Physical exam reveals swelling of the back of the leg. Palpation notes a hard knot of tissue.

ASSESSMENT
The patient suffers from Achilles tendinitis.

PLAN
An MRI is scheduled to determine the extent of the injury. He is to follow up in this office in 2 weeks to review the MRI results.

The diagnosis seems straightforward enough—let's see if the code is also. Use the coding pathway of *Tendinitis, Achilles*. In the *Index to Diseases*, you find a tentative code of **726.71**. Turn to the *Tabular List* to determine the highest level of specificity. You find code **726.71 Peripheral enthesopathies and allied syndromes, Enthesopathy of ankle and tarsus, Achilles bursitis or tendinitis** is the correct code.

Osteopathies, Chondropathies, and Acquired Musculoskeletal Deformities (730-739)

The final section of the "Musculoskeletal System and Connective Tissue" chapter deals with *osteopathies, chondropathies* and acquired musculoskeletal deformities. **Osteopathy** is any disease of the bone, while **chondropathy** is any disease of the cartilage. **Acquired musculoskeletal deformities** are deformities not present at birth.

Code category **730 Osteomyelitis, petriostitis, and other infections involving bone** EXCLUDES the jaw (526.4-526.5) and the petrous bone (383.2). You are directed to use an additional code if the organism causing the infection is identified. Again, the condensed version of the fifth-digit code subclassifications is provided. The list at the beginning of the chapter contains the definitions for these fifth digits.

Osteomyelitis is an inflammation of the bone tissue and marrow caused by a pus forming organism. **Periostitis** is an inflammation of the **periosteum**, or the thick, fibrous membrane that covers the entire surface of a bone. Acute osteomyelitis can be documented as acute or subacute, and with or without periostitis. Chronic osteomyelitis EXCLUDES aseptic necrosis of the bone (733.40-733.49). If osteitis or osteomyelitis is not otherwise stated, you will code the condition as unspecified.

Category **733 Other disorders of the bone and cartilage** contains a broad spectrum of disorders. *Osteoporosis* and pathological fractures are two conditions that we will discuss. Be sure to read through the notes, inclusions and exclusions in the *Tabular List* when you are coding from this section.

Osteoporosis is a commonly occurring bone disease characterized by a reduction in bone mass. **Senile osteoporosis** accounts for most cases of this disease. It affects persons older than age 70, and is due to the natural aging process. When there is no apparent cause for the disease, it is termed **idiopathic osteoporosis**. **Disuse osteoporosis** is defined as localized or generalized bone loss that results from the reduction of mechanical stress on bones. In other words, this condition is caused by prolonged inactivity that results in loss of bone mass. This inactivity may be due to bed rest, paralysis or casting. Osteoporotic bones become thin and brittle, making them prone to fractures.

A **fracture** is a break or rupture in a bone. **Traumatic fractures** occur because of mechanical injury. We will discuss this type of fracture in a later lesson. **Pathological fractures**, or **spontaneous fractures**, occur without major external trauma. Pathological or spontaneous fractures are the result of the bone structure weakening by a pathological process, such as occurs with osteoporosis and neoplasms. Subcategory **733.1 Pathologic fractures** EXCLUDES stress fracture, which you will code from codes 733.93 through 733.95, and traumatic fracture, which you will code from codes 800 through 829. **Stress fractures** are caused by unusual or repeated stress on a bone. Athletes frequently experience stress fractures.

As mentioned, acquired musculoskeletal deformities are those that are *not* genetic. Conditions that exist at birth, such as mental or physical traits, anomalies, malformations or diseases, and that might be either hereditary or the result of an influence during gestation up to the moment of birth, are termed **congenital**. We will discuss congenital anomalies in the next chapter, but it is important to understand the difference between the two to accurately code this section. You will note that each code category from 735 through 738 EXCLUDES a type of congenital condition. The acquired deformities you will be coding in this section include *hammer toe* (acquired), *club hand* (acquired), *swan-neck deformity*, *bowleg* (acquired), *claw foot* (acquired), *scoliosis* and deformity of the nose (acquired). You should be able to determine whether the condition is congenital or acquired by the documentation in the medical record.

We've covered quite a bit of information since your last Practice Exercise. Let's stop and give you a chance to review the material. Then you can complete the following coding exercises to see how well you understand the material in this section.

✍ Step 7 Practice Exercise 27-2

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Arthralgia of the left shoulder**
   ICD-9-CM code: _____

2. **Herniation of C4-C5**
   ICD-9-CM code: _____

3. **Calcification of the cervical disc**
   ICD-9-CM code: _____

4. **Lower back pain**
   ICD-9-CM code: _____

5. **Bursitis of the right hip**
   ICD-9-CM code: _____

6. **Acquired trigger finger**
   ICD-9-CM code: _____

7. **Infective myositis**
   ICD-9-CM code: _____

8. **Idiopathic osteoporosis**
   ICD-9-CM code: _____

Use the following information to complete the CMS-1500 that follows.

9. ICD-9-CM Coding/Billing Challenge

FRONT RANGE FAMILY CARE
1800 Circle Court
Yourtown, CO 80000
(970) 555-3344

_____ Greg Stephen, MD NPI: 0267679942
__X__ Donald Milford, MD NPI: 0810998051
_____ Douglas Smart, MD NPI: 0144878804
Group NPI: 0881099885

Patient Information

Name Janet Scott
Address HQ USAF SP PSC 5
City Ellsworth AFB **State** SD
ZIP 57706
Home Phone 605-555-6330

Date of Birth November 11, 1985
Sex F **Marital Status** married

Employment Information

Name of Employer Harrison Elementary School
Occupation Administration
If Minor, Name of School

Insurance Information

Primary Insurance
Name TRICARE
ID# 352005515
Group#
Address PO Box 100502
City Florence
State SC **ZIP** 29501-0502
Primary Insured Name James Scott
Relation to Patient Spouse
DOB 9/13/1985
Employer USAF

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Janet Scott
Signature of patient (or parent of minor child)

Secondary Insurance N/A
Name
ID#
Group#
Address
City
State **ZIP**
Secondary Insured Name
Relation to Patient
DOB
Employer

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

_____
Signature of patient (or parent of minor child)

Physician signature: *Donald Milford MD*
SSN: 300-03-0303
EIN 66-6000600
Participating Provider for: TRICARE, CHAMPVA, Country Group and Blue Cross

Date of Service	*8/20/XX*	
Diagnosis	**Procedure**	**Charge**
	99214 Office Visit, Est. Patient	*$85.00*

Today's Charge	$85.00
Cash/Check	$20.00
Balance	$65.00

Name: Janet Scott
DOB: November 11, 1985
Date of Service: August 20, 20XX

HISTORY OF PRESENT ILLNESS
The patient is white female who presents for a checkup.

PAST HISTORY
Medications: Methotrexate 2.5 mg 5 weekly, Fosamax 70 mg weekly, folic acid daily, amitriptyline 15 mg daily, Synthroid 0.088 mg daily, calcium 2 in the morning and 2 at noon, multivitamin daily, baby aspirin daily and Colace 1-3 b.i.d.
Illnesses: Reactive airway disease; rheumatoid arthritis; gravida 4, para 5, with one set of twins, all vaginal deliveries; iron-deficiency anemia; osteoporosis; and hypothyroidism.
Operations: Recent surgery on her hands and feet.
ALLERGIES: NONE.
Social history: She is married. Denies tobacco, alcohol and drug use.
Family history: Unremarkable.

REVIEW OF SYSTEMS
HEENT, pulmonary, cardiovascular, GI, GU, musculoskeletal, neurologic, dermatologic, constitutional and psychiatric are all negative except for HPI.

PHYSICAL EXAMINATION
GENERAL: She is a well-developed, well-nourished white female in no acute distress.
VITAL SIGNS: Weight: 146. Pulse: 80. Blood pressure: 100/64. Respiratory rate: 16. Temperature: 97.7 °F.
HEENT: Grossly within normal limits.
NECK: Supple. No lymphadenopathy. No thyromegaly.
CHEST: Clear to auscultation bilaterally. Heart: Regular rate and rhythm. Breasts: No nipple discharge. No lumps or masses palpated. No dimpling of the skin. No axillary lymph nodes palpated. Self-breast exam discussed and encouraged.
ABDOMEN: Positive bowel sounds, soft and nontender. No hepatosplenomegaly.
PELVIC: Normal female genitalia. Atrophic vaginal mucosa. No cervical lesions. No cervical motion tenderness. No adnexal tenderness or masses palpated.
RECTAL: Normal sphincter tone. No stool present in the vault. No rectal masses palpated.
EXTREMITIES: No cyanosis, clubbing or edema. She does have obvious rheumatoid arthritis of her hands.
NEUROLOGIC: Grossly intact.

ASSESSMENT AND PLAN
1. Hypothyroidism. We will recheck TSH to make sure she is on the right amount of medication at this time, making adjustments as needed.
2. Rheumatoid arthritis. Continue her methotrexate, and she will follow up as needed.
3. Osteoporosis. It is time for her to have a repeat DEXA at this time, and that will be scheduled.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid#) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH SEX M F

b. OTHER INSURED'S DATE OF BIRTH SEX M F

b. AUTO ACCIDENT? YES NO Place (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1.														NPI	
2.														NPI	
3.														NPI	
4.														NPI	
5.														NPI	
6.														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

a. b.

Step 8 Review Practice Exercise 27-2

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 9 Congenital Anomalies (740-759)

- ❑ Chapter 14 of the *Tabular List* includes a variety of anomalies, and the conditions are not broken down into sections. We will discuss only some of the conditions included in this chapter. As you read through the material, remember that you should be able to determine by the documentation in the medical record whether the condition is congenital or acquired. **Congenital** anomalies are those conditions that exist at birth, such as abnormal mental or physical traits, and other anomalies, malformations or diseases. Such anomalies may be either hereditary or the result of an influence that occurs during gestation, up to the moment of birth.

  Spina bifida is a herniation, or abnormal bulging, of the membranes that surround the spinal cord. This condition may cause an excess accumulation of spinal fluid within the ventricles, known as **hydrocephalus**. When you use code category 741, indicate the region of the unfused vertebral bone with the fifth-digit subclassification.

  Glaucoma and **cataract** can be congenital anomalies of the eye. **Congenital**, **newborn**, or **infantile** glaucoma is an enlargement and hazing of the corneas. This condition EXCLUDES glaucoma of childhood (365.14) and traumatic glaucoma due to birth injury (767.8). The term **congenital cataract** is for common, usually bilateral opacities present at birth. This condition EXCLUDES infantile cataracts (366.00-366.09).

  Let's code a capsular cataract found in a newborn. First, locate the problem in the *Index to Diseases*. The problem, C*ataract*, is the main term. The condition is found in a newborn, meaning it is a congenital anomaly. The subterm *congenital* is next in the coding pathway, followed by *capsular*. Following this route, you find that the tentative code is **743.31**. Then, turn to the *Tabular List* to determine the highest level of specificity, and you'll confirm that code **743.31 Congenital anomalies of eye, Congenital cataract and lens anomalies, Capsular and subcapsular cataract** is correct.

  Code category **744 Congenital anomalies of ear, face and neck** contains a list of exclusions that you should be aware of when you code from it. Conditions included in the codes for anomalies of the ear that cause impairment of hearing vary from absence of the auditory canal to absence of the entire ear. Deafness without mention of cause and indicates that codes in the range of 389.0 through 389.9 are more appropriate. In subcategory 744.2, you will find codes for other specified anomalies of the ear that do not cause impairment of hearing. These conditions include the absence of an ear lobe, absence of the eustachian tube and *bat ear*.

Some ears stick out more than normal, which can be referred to as **bat ear**. Although correcting this condition is not medically necessary, some people choose to do so because of self-esteem issues. To code this condition, simply locate *Bat ear* in the *Index to Diseases* and you find code **744.29**. Determine the highest level of specificity in the *Tabular List*. This confirms code **744.29 Congenital anomalies of ear, face, and neck, Other specified anomalies of ear, Other** is the accurate code.

In code group **745 Bulbus cordis anomalies and anomalies of cardiac septal closure**, you will find conditions such as aortic and ventricular septal defects. A combination of cardiac defects *pulmonary stenosis, interventricular septal defect, dextroposition of the aorta* and *right ventricular hypertrophy* is termed **tetralogy of Fallot**. This condition EXCLUDES *Fallot's triad*, which you would code as **746.09 Anomalies of pulmonary valve, Other**. To code *tetralogy of Fallot*, use *Fallot's* as the main term to locate in the *Index to Diseases*. Locating the subterm *tetrad* or *tetralogy* provides you with the tentative code of **745.2**. An alternative pathway would be *Tetralogy of Fallot* that also provides the tentative code of **745.2**. Now turn to the *Tabular List* to determine the highest level of specificity. If you find **745.2 Bulbus cordis anomalies and anomalies of cardiac septal closure, Tetralogy of Fallot**, you have the correct code. Great job!

A **cleft palate** is a congenital fissure of the soft palate alone, or of both the soft palate and the hard palate. The cleft typically opens through the roof of the mouth into the nasal cavity, and extends anteriorly to the premaxilla, where it deviates to the right or left, following the line of fusion. A **cleft lip** is the separation of two sides of the lip. Conditions in category 749 are *cleft palate, cleft lip* and *cleft palate with cleft lip*. The conditions are further classified as *unilateral* or *bilateral*, and *complete* or *incomplete*. **Unilateral** refers to one side, while **bilateral** indicates that the cleft occurs on both sides. When the cleft involves a small portion of either the palate or the lip, it is termed **incomplete**. A complete separation of both the anterior bony hard palate and the posterior fleshy soft palate is termed **complete**.

The group of codes for congenital anomalies of the genital organs EXCLUDES syndromes associated with anomalies in the number and form of chromosomes (codes 758.0 through 758.9). Female organs affected by such anomalies include the ovaries, fallopian tubes, uterus, cervix, vagina and external female genitalia. Male organs of this category include the testicles and penis. **Pseudohermaphroditism** is the presence of gonads of one sex and external genitalia of the other sex.

Code category **754 Certain congenital musculoskeletal deformities** INCLUDES deformities that are **nonteratogenic** (not a product of congenital anomalies) but that are considered to be the result of intrauterine malposition and pressure. The sites affected by these conditions include the face, spine, hip, leg and feet. Code category **755 Other congenital anomalies of limbs** EXCLUDES those deformities that are classifiable to codes 754.0 through 754.8. Code group 755 is specific to the upper and lower limbs.

Now let's code a deformed finger of a newborn. Again, the term *newborn* indicates this is a congenital deformity. In the *Index to Diseases,* use the coding pathway of *Deformity, finger, congenital*. Determine the highest level of specificity of the tentative code of **755.50** in the *Tabular List*. You find **755.50 Other congenital anomalies of limbs, Other anomalies of upper limb, including shoulder girdle, Unspecified anomaly of upper limb**. "Anomalies of upper limb" applies, because the finger is part of the upper limb. "Unspecified anomaly" applies, because the type of deformity is not noted. You have the correct code.

Code group **757 Congenital anomalies of the integument** INCLUDES anomalies of the skin, subcutaneous tissue, hair, nails and breast. The category EXCLUDES *hemangioma* (228.00 through 228.09) and *pigmented nevus* (216.0 through 216.9). *Birthmarks* are included in this category. A benign tumor of blood vessels due to malformed *angioblastic* tissue is termed a *birthmark*, *strawberry nevus*, *port-wine stain* or *vascular hamartomas*. **Albinism** is not included as a congenital skin condition because it is a disorder of the amino-acid metabolism.

Category **758 Chromosomal anomalies** INCLUDES syndromes associated with anomalies related to the number and form of chromosomes. You are to use additional codes for conditions associated with the chromosomal anomaly. **Down syndrome**, or **Trisomy 21**, is usually caused by an extra copy of the twenty-first chromosome. Characteristics of Down syndrome include a smaller-than-normal and abnormally shaped head, a flattened nose, protruding tongue and upwardly slanted eyes. The hands of individuals with Down syndrome are short and broad, and their fingers are short, as well. Their mental and social skills also are delayed. Although the severity of intellectual disabilities vary, it usually is moderate to severe in persons with Down syndrome. The average life span is shortened for people with this condition because of increased episodes of congenital heart disease.

The final code category of this chapter is **759 Other and unspecified congenital anomalies**. This group of codes consists of absence of the spleen, adrenal gland or parathyroid gland; conjoined twins; and *Marfan syndrome*. **Marfan syndrome** is a connective-tissue multisystemic disorder. The disorder is characterized by skeletal changes and cardiovascular defects. Skeletal changes include having a tall, lanky body with long limbs and spider-like fingers. Curvature of the spine, or **scoliosis**, is common with Marfan syndrome, as well. Defects of the cardiovascular system might include enlargement of the base of the aorta, aortic regurgitation, mitral valve prolapse and dissecting aortic aneurysms. Since there is not just one treatment for this condition, the characteristics of Marfan syndrome should be addressed as needed.

The following is a cardiology consultation report for you to read through. Take your time and review the details so you have a good sense of the patient's condition and the diagnoses. Then, when you're ready, determine the correct diagnosis code or codes based on this report. Figure out the coding pathway(s), determine the tentative code(s) from the *Index to Diseases*, and then confirm the accuracy of your conclusions in the *Tabular List*. When you're done, compare the process you went through and the final code results with our summary that follows the report.

CARDIOLOGY CONSULTATION REPORT

REASON FOR REFERRAL
Severe chest pain.

HISTORY OF PRESENT ILLNESS
This is a 24-year-old white male with Marfan's syndrome diagnosed 11 years ago and since then complains of intermittent severe chest pain. He was admitted yesterday after 10 hours of sharp, substernal chest pain, radiating to the neck, back, left arm, and left leg. No history of nausea, vomiting, shortness of breath, or diaphoresis. Over the past several years, the pain has been increasing in intensity. Exertion will almost always bring it on, although it also occurs at rest and with anxiety. He was started on Isordil, then diltiazem 1 year ago with initial improvement, now not effective. Inderal was started with uncertain efficacy. Over the past 5-6 years, he has 10-block dyspnea on exertion and chest pain. He was previously followed at another institution. His last hospitalization was 5 months ago. At that time, echocardiography showed no mitral regurgitation, positive mitral valve prolapse, and tricuspid valve prolapse with 4+ tricuspid regurgitation. The patient states he has had MVP and stated he had a global decrease in left ventricular function. The prior hospitalization had a negative aortogram to look for aortic dissection. A chest x-ray at that time was also negative. The patient has a history of staphylococcal endocarditis. Cardiac catheterization done at that time showed pulmonary artery stenosis.

PAST MEDICAL HISTORY
Medications: Diltiazem 30 mg t.i.d., Inderal 20 mg b.i.d., nitroglycerin, Motrin.
Illnesses: Marfan's syndrome, chronic diarrhea, possible malabsorption syndrome for 1 year.

Operations: Exploratory laparotomy 2 years prior to the admission for appendectomy and removal of Meckel's diverticulum.
ALLERGIES: THE PATIENT IS ALLERGIC TO PENICILLIN WITH HISTORY OF RASH.
Social history: No history of alcohol or tobacco use.
Family history: Incidences of sudden death in grandparents and mother. He has a brother with Marfan's and a maternal grandmother with Crohn's disease.

REVIEW OF SYSTEMS
Otherwise noncontributory.

PHYSICAL EXAMINATION
GENERAL: The patient is alert and comfortable and in no distress.
VITAL SIGNS: Pulse: 60/min. Respiratory rate: 18/min. Blood pressure: 88/60.
Temperature: 98.4 °F.
SKIN: Nondiaphoretic.
HEENT: PERRLA. Normocephalic, atraumatic. Funduscopic examination normal. EOMs intact. Tympanic membranes clear.
NECK: Supple without JVD or carotid bruits.
CHEST: Heart: Regular rate and rhythm with distant heart tones. Normal S1, S2 without gallops or murmurs. There is a 1+ midsystolic click when patient is turned to 30 degrees.
ABDOMEN: There is a well-healed scar in the midline of the lower abdomen. Normal bowel sounds, nontender, no hepatosplenomegaly.
EXTREMITIES: No cyanosis, clubbing, or edema. Slender body habitus.

DATABASE
Chest x-ray: Slender cardiac silhouette. EKG has a sinus rhythm of 71/min with an incomplete right bundle branch block. This study is unchanged from a prior electrocardiogram of 1 month ago. Chest CT: Aneurysm present without evidence of dissection.

ASSESSMENT AND RECOMMENDATIONS
1. Recurrent severe chest pain attributed to mitral valve prolapse, increasing in frequency and intensity. History of global poor left ventricular function. Cannot rule out cardiomyopathy. Suggest that Inderal and Isordil be discontinued. Increase diltiazem to 60 mg t.i.d. and continue to increase diltiazem as symptoms necessitate.
2. The EKG suggests the presence of septal defect. Will schedule 2D Doppler echocardiogram with flow study.
3. Marfan's syndrome with aortic aneurysm without evidence of dissection.

This coding example has several parts, so we'll review them one part at a time.

1. You note in the assessment and plan for this patient that mitral valve prolapse is causing the chest pains, which is the reason for this encounter. So the first coding pathway is *Prolapse, mitral valve*. Following this pathway in the *Index to Diseases,* you identify a tentative code of **424.0**. When you look up this code in the *Tabular List*, you find **424.0 Other diseases of endocardium, Mitral valve disorders** to be accurate.

2. The next primary problem to address is the aortic aneurysm, for which you identify a coding pathway of *Aneurysm, aorta.* Following that pathway in the *Index to Diseases*, you find a tentative code of **441.9**, which you then check to determine the highest level of specificity in the *Tabular List*. Based on the information you find there, you choose **441.9 Aortic aneurysm of unspecified site without mention of rupture** as the correct code for this portion of the diagnosis.

3. Now you must find the correct code for the diagnosis of Marfan syndrome. Follow a coding pathway of *Syndrome, Marfan's* in the *Index to Diseases*, and you will come up with a tentative code of **759.82**. You could also have found the same tentative code if you had chosen the alternative pathway of *Marfan's, syndrome*. Once again, check the *Tabular List* to determine the highest level of specificity. You can comfortably conclude that code **759.82 Other and unspecified congenital anomalies, Other specified anomalies, Marfan syndrome** is correct.

Finally, you are ready to assign diagnosis codes **424.0 441.9 759.82** to this consultation report.

We're now about two-thirds of the way through this lesson, and it's time to stop and review what you've read and practiced in this section to see how well you understand it. Complete the following Practice Exercise before you learn about the next chapter of the *Tabular List*.

✍ Step 10 Practice Exercise 27-3

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Spina bifida of L3-L4**
   ICD-9-CM code: _____

2. **Simple hypoplasia of the right eye**
   ICD-9-CM code: _____

3. **Infant born with absence of external auditory canal**
   ICD-9-CM code: _____

4. **Roger's disease**
   ICD-9-CM code: _____

5. **Fallot's triad**
   ICD-9-CM code: _____

6. **Single umbilical artery of a newborn**
   ICD-9-CM code: _____

7. **Congenital honeycomb lung**
   ICD-9-CM code: _____

8. **Unilateral cheilopalatoschisis, incomplete**
   ICD-9-CM code: _____

9. **Didelphic uterus**
   ICD-9-CM code: _____

10. **Coding Challenge**

    CONSULTATION REPORT

    REASON FOR REFERRAL
    Noted to have left low-set ear, left string-like thumb attached to metacarpal and left clubfoot following breech cesarean section.

    HISTORY OF PRESENT ILLNESS
    The patient is a 1-day-old male infant born to a gravida 1 mother by a crash cesarean section for double footling breech with multiple congenital anomalies.

PHYSICAL EXAMINATION
GENERAL: Weight: 2500 gm. Length: 45 cm. Head circumference: 34.5 cm.
HEENT: Head: Normocephalic. Anterior fontanelle small but open. Eyes: Mild mongoloid slant and hypertelorism (IC 2.5 cm). Ears: Left auricle small and crumpled appearance. External auditory canal appears patent. Mouth: Palate high and arched.
NECK: Very short and posterior, hairline appears low.
CHEST: No deformity. Nipples well formed. Heart: PMI on the left. Lungs: Clear.
ABDOMEN: No organomegaly. Liver on the right. Umbilical cord stump dry.
GENITALIA: Normal male with descended testes.
RECTAL: Patent.
EXTREMITIES: Left hand with hypoplastic thumb which is attached by a piece of skin. Left forearm has mesomelia but not camptomelia. Right hand with proximally placed thumb.
NEUROLOGIC: Good cry and muscle tone.

DATA BASE
X-rays reveal multiple cervical spine anomalies characterized by hypoplasia including hemiatrophy of T1, butterfly pattern of T3, and left rib anomalies. Chest film also shows evidence of congenital heart disease, patent ductus arteriosus, and possible ventricular septal defect. Chest x-ray and abdominal films show no evidence of situs inversus. Stomach bubble on the left and heart on the left, liver on the right.

ASSESSMENT
Multiple congenital anomalies. Congenital anomalies found in this infant so far are:
1. Dysplasia of the left auricle.
2. Multiple vertebral anomalies in the cervical and upper thoracic spine.
3. Left thumb hypoplasia.
4. Mesomelia (abnormally short) left forearm without camptomelia.
5. Congenital heart disease.
6. Ear anomalies and cervical spine anomalies are seen in Goldenhar's syndrome (oculoauriculovertebral dysplasia). Vertebral anomalies and congenital heart disease are seen in VACTERL association. Both conditions are thought to occur as sporadic events during embryonic and fetal development. There is increased risk for other abnormalities such as renal and gastrointestinal malformations. Intellectual disabilities is not a constant feature but is increased in Goldenhar's, especially in those with cerebral hemisphere involvement.

RECOMMENDATIONS
WCC. Intracranial sonography to rule out CNS malformation. Renal sonography, UGI and barium enema for evaluation of the urogenital and gastrointestinal tracts.

ICD-9-CM code: _____
ICD-9-CM code: _____
ICD-9-CM code: _____
ICD-9-CM code: _____
ICD-9-CM code: _____

Step 11 Review Practice Exercise 27-3

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 12 Certain Conditions Originating in the Perinatal Period (760-779)

- ❑ Chapter 15 of the *Tabular List* contains codes that pertain to the *mortality* and *morbidity* of the fetus or newborn. Conditions that occur during, or pertaining to, the periods before, during or through the 28th day after birth are included in this range of codes. This chapter INCLUDES conditions that have their origin in the perinatal period, even if death or morbidity occurs later. You are directed to use an additional code or codes to further specify the conditions in this chapter. The chapter is divided into two sections: "Maternal Causes of Perinatal Morbidity and Mortality" and "Other Conditions Originating in the Perinatal Period."

Maternal Causes of Perinatal Morbidity and Mortality (760-763)

This section consists of maternal conditions or complications that affect the fetus or newborn to cause **morbidity** (disease) or **mortality** (death) to the fetus or newborn. These conditions can be coded only if they are in fact affecting the fetus or newborn—not just because the conditions exist. You will use the codes in this group to code for the newborn record. These codes are used as a secondary diagnosis for the codes that indicate liveborn infants according to the type of birth. Remember when you coded the outcome of delivery in addition to the delivery code for the mother's records? When coding the baby's record, you will always assign a code from category V30 through V39, according to the type of birth. This code represents the principal diagnosis, and you can assign it only once, at the time of birth.

Category **760 Fetus or newborn affected by maternal conditions which may be unrelated to present pregnancy** INCLUDES the listed maternal conditions *only* when they are specified as a cause of morbidity or mortality of the fetus or newborn. The code group EXCLUDES maternal endocrine and metabolic disorders that affect the fetus or newborn. You are directed to code these conditions from codes 775.0 through 775.9. Category 760 conditions include hypertensive disorders, infections, injuries and noxious influences.

Remember coding 642.33 for the diagnosis of pregnancy-induced hypertension, undelivered-fetus example in a previous lesson? We assigned that code to the mother's records. If the baby's health or life is affected by this condition during the perinatal period, you will assign code 760.0 to the newborn's records. We will revisit this guideline in a later example.

When the fetus or newborn is affected by noxious substances transmitted via the placenta or breast milk, you will find the condition of the fetus or newborn in subcategory 760.7. This subcategory EXCLUDES anesthetic and analgesic drugs administered during labor and delivery (763.5), and drug withdrawal syndrome in a newborn (779.5). Drugs and alcohol ingested by a pregnant woman pass through the placenta to the fetus, and through the breast milk to the newborn, and so these substances affect the health and life of the fetus or newborn. Noxious substances include alcohol, narcotics, hallucinogenic agents, antibiotics and cocaine. Remember, these codes apply to the newborn's records.

Complications of the placenta, cord and membranes can affect the fetus or newborn. When the documentation specifies a maternal condition as a cause of morbidity or mortality in the fetus or newborn, you will code the diagnosis under category 762.

Placenta previa is the term used when the placenta develops in the lower part of the uterus, covering the opening. Hemorrhaging in the last trimester is a common symptom of this condition. When placenta previa affects the health and life of the fetus, you will use code 762.0 for that condition.

The **umbilical cord** provides oxygen and nutrients to the fetus, and removes waste. A **prolapsed cord** occurs when the cord slips into the vagina after the membranes have ruptured and before the baby enters the birth canal. As the baby passes through the cervix and vagina during labor and delivery, he can put pressure on the cord, which reduces or cuts off the baby's oxygen supply. Unless the baby is delivered quickly, the situation could result in a stillborn delivery. The risk of prolapsed cord is increased in breech presentations or premature deliveries.

Code category **763 Fetus or newborn affected by other complications of labor and delivery** probably seems familiar to you because we discussed many of these complications earlier, when you studied conditions relating to pregnancy. These conditions include breech, forceps, vacuum extraction or cesarean deliveries. When these conditions are specified as a cause of mortality or morbidity in the fetus or newborn, you will assign the codes to the newborn's records.

Let's practice applying some of this information now. You'll code for a term newborn, born in the hospital and delivered by cesarean section because of an abnormal fetal heart rate during labor; the abnormal heart rate was caused by a prolapsed cord.

Once again, for the situation presented, we will go through several steps to determine all the required codes and the correct order of those codes.

1. Based on what you have learned, you know that you must include a code indicating liveborn infants according to the type of birth, so let's do that first. You choose a coding pathway of Newborn, single, born in hospital, with cesarean delivery or *section* and the tentative code of **V30.01** is provided. Confirm that code with the *Tabular List* and you find **V30.01 Single liveborn, Born in hospital, delivered by cesarean delivery** is the accurate code.

2. Next, you will code for the abnormal fetal heart rate. The coding pathway of *Abnormal, heart, rate, newborn, during labor* for the *Index to Diseases* gives you a tentative code of **763.82**. Then you turn to the *Tabular List* to review all the information there and determine the highest level of specificity. Code **763.82 Fetus or newborn affected by other complications of labor and delivery, Other specified complications of labor and delivery affecting fetus or newborn, Abnormality in fetal heart rate or rhythm during labor** is the correct code for this portion of the description.

3. Then, you will code for the prolapsed cord documented in the notes. The problem is not the presence of the cord, but that it is prolapsed. In the *Index to Diseases,* locate the coding pathway of *Prolapse, cord.* You find a note that tells us to *see* Prolapse, umbilical cord. Following the new pathway, you will choose *affecting fetus or newborn* since you are coding for the newborn, not the delivery. Determine the highest level of specificity for code **762.4** in the Tabular List. You find that **762.4 Fetus or newborn affected by complications of placenta, cord and membranes, Prolapse cord** is correct.

4. Finally, assign the codes to the newborn's records as **V30.01 763.82 762.4**.

How'd you do? If you have questions on this scenario, be sure to contact your instructor for guidance. Now let's move ahead where you can apply your expanding skills to the next section of Chapter 15.

Other Conditions Originating in the Perinatal Period (764-779)

As the title indicates, this section includes codes for other conditions that originate in the perinatal period. In the *ICD-9-CM* manual and for most medical purposes, birth weight is denoted in grams, for accuracy. Consequently, you will find a fifth-digit subclassification box in this section, with weight ranges in grams for birth weight. These subclassifications apply to code category 764 and to codes 765.0 through 765.1. **Codes in category 764 Slow fetal growth and fetal malnutrition** are often paired with codes in category **765 Disorders relating to short gestation and low birth weight**. The 765 category INCLUDES the listed conditions without further specification as causes of mortality, morbidity, or additional care in the fetus or newborn. When you specify codes 765.0 or 765.1, you will apply an additional code to indicate the weeks of gestation. Long gestation is defined as more than 40 completed weeks to 42 completed weeks. High birth weight is usually defined as 4,500 grams or more.

Now let's code a scenario that includes maternal causes of perinatal morbidity and mortality as well as causes from this section. Earlier, you learned about pregnancy-induced hypertension, undelivered and determined the code for the mother's record to be 642.33. If the newborn was delivered at the hospital at 34 weeks gestation as the result of maternal hypertension, and the hypertension was documented in the maternal record, what ICD-9-CM codes would you assign to the newborn's record?

To help simplify the material, we'll break it down into specific steps once again.

1. First, because pregnancy-induced hypertension is a condition at the time of birth, you will need to indicate the liveborn infant according to the type of birth. Using the coding pathway of *Newborn, single, born in hospital* the tentative code **V30.00** is suggested. When you check the *Tabular List* for this code, you find **V30.00 Single liveborn, Born in hospital, delivered without mention of cesarean delivery** is the right code for this portion of the documentation.
2. Next, you know that the baby was premature because it was delivered at 34 weeks gestation. So, start with the coding pathway of *Newborn* as the main term, and find *gestation* as a subterm, with additional subterms under that for number of completed weeks. The tentative code for *33-34 completed weeks* is **765.27**. Now you go to the *Tabular List* to determine whether this is the accurate code, and you find **765.27 Disorders relating to short gestation and low birth weight, Weeks of gestation, 33-34 completed weeks of gestation**. So we can feel comfortable that this is the correct code.
3. Then, you need to know that a premature delivery is often associated with the newborn's mortality and morbidity; in this case, the premature delivery is the result of the mother's hypertension. Therefore, it's logical to consider a coding pathway that begins with *Hypertension* as the main term. You locate this main term in the Hypertension table of the *Index to Diseases*, and then look for a reasonable subterm within the table. Try "complicating pregnancy," since that's a common description for problems related to pregnancy and childbirth, and see where that takes you. Under *complicating pregnancy, childbirth, or the puerperium*, you find *fetus or newborn*. The *Malignant* column is the only one to provide a code, so you have a tentative code of **760.0**. Now, go to the *Tabular List* once more, and determine the highest level of specificity for this code to be sure you have the correct one. You find **760.0 Fetus or newborn affected by maternal conditions which may be unrelated to present pregnancy, Maternal hypertensive disorders** and verify you have the correct code.
4. The final step is to make sure you have all the necessary codes, and that you have assigned them in the correct order. Based on the guidelines, you will assign codes **V30.00 765.27 760.0**. Good work!

Birth trauma, hypoxia, asphyxia and *respiratory distress syndrome* are some other conditions you will encounter in this section. Injury to the newborn during the delivery is a **birth trauma**. Injuries might be due to vacuum extraction or breech presentation. You will use code category **768 Intrauterine hypoxia and birth asphyxia** only when the condition is associated with a newborn morbidity classified elsewhere. When the oxygen intake is insufficient, it causes fetal distress and possibly death.

Code category **771 Infections specific to the perinatal period** INCLUDES infections acquired before or during birth, or via the umbilical cord or during the first 28 days after birth. These are infections such as *congenital rubella, congenital herpes simplex,* infection of the umbilical stump and *thrush* in a newborn. **Other infection specific to the perinatal period** (**771.8**) requires you to use an additional code to identify the organism for septicemia, UTI or bacteremia of a newborn.

Two prominent diseases that are included in code category **773 Hemolytic disease of fetus or newborn, due to isoimmunization** are *ABO isoimmunization* and *Rh isoimmunization*. Blood types are composed of groups (A, B, AB, O) and types (Rh positive and Rh negative). In most cases, the blood of the mother and fetus are compatible. However, when there is incompatibility, the health and life of the fetus are at risk. For **ABO isoimmunization**, the mother's blood group is O, and the fetus' blood group is either A or B. The mother develops antibodies against this "foreign" blood, and these antibodies cross the placenta and destroy the infant's red blood cells. The same destruction process occurs when the mom is Rh negative and the fetus is Rh positive, which is known as **Rh isoimmunization**. The risks for the fetus include premature delivery (before 37 weeks gestation), severe anemia at birth and excessive bilirubin levels. Testing can be done to determine whether the Rh factor might be a problem in the pregnancy. If so, Rh-immune globulin will be given to the mother at 28 weeks into the pregnancy to help prevent the destruction of the red blood cells in the fetus.

Jaundice is a yellowing of the skin and the whites of the eyes caused by an accumulation of the yellow-brown bile pigment bilirubin in the blood. In certain subcategories for this disease, you will use an additional code to identify the cause. You will find that neonatal jaundice is a manifestation of an underlying disease, and so you should code the underlying disease first. In general, perinatal jaundice is a straightforward category to code. But if you have questions, remember that your instructors are just a phone call away!

Now it's your turn to practice coding from this section. Read through the following physician's notes and then determine what code or codes you think are correct. As usual, we'll review the process afterward to see how well you did.

SUBJECTIVE
A 3-day-old baby is brought in by mother, presenting with fever, jaundice, and is inconsolable. Poor weight gain is also noted. Mother has been typed as Rh negative, while baby is Rh positive.

OBJECTIVE
Physical exam: Febrile, yellowish eyes and skin noted.

ASSESSMENT
Baby is jaundiced due to Rh antibodies still in her system.

PLAN
Baby will be hospitalized for a transfusion to completely exchange the infant's blood.

Based on the notes, you start with a coding pathway of *Jaundice* as the main term, which you locate in the *Index to Diseases*. Under the main term, you find the subterms *fetus or newborn.* Looking at the subterms here, you first find *due to or associated with, Rh, antibodies* provides the tentative code **773.0**. You then turn to the *Tabular List* to determine the highest level of specificity. You find **773.0 Hemolytic disease of fetus or newborn, due to isoimmunization, Hemolytic disease due to Rh isoimmunization**, is the correct code.

The next code group is **775 Endocrine and metabolic disturbances specific to the fetus and newborn.** This category INCLUDES transitory conditions caused by the infant's response to maternal endocrine and metabolic factors, the infant's removal from those conditions, or its adjustment to extrauterine existence. The syndrome of "infant of a diabetic mother" is an example of conditions in this category. This condition occurs when the maternal diabetes mellitus affects the fetus or newborn, usually in the form of hypoglycemia. **Neonatal diabetes** occurs when the infant's sugar level is abnormally high and requires insulin to control it.

Code group **779 Other and ill-defined conditions originating in the perinatal period** includes convulsions, feeding problems, drug reactions and withdrawals and stillbirth not elsewhere classified. **Feeding problems** in a newborn consist of regurgitating, slow feeding and vomiting. An infant of a drug-dependent mother might suffer from drug withdrawal syndrome because the fetus was exposed to the drugs the mother has taken. A newborn experiencing drug withdrawal requires supportive care, such as swaddling, frequent small feedings and observation until he has stabilized from the drug withdrawal.

You're on the home stretch of this lesson! This concludes the basic information you need to know as you begin coding medical diagnoses and conditions in Chapters 12 through 15 of the *Tabular List*. Before you review the lesson and complete the Mail-in Quiz, take a few minutes to review Step 12 and then complete the Practice Exercise to reinforce what you have learned about codes in the 760 through 779 categories.

✍ Step 13 Practice Exercise 27-4

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Premature infant was delivered by cesarean at 35 weeks' gestation due to fetal distress during the labor. Code the baby's record.**

   ICD-9-CM code: _____

   ICD-9-CM code: _____

   ICD-9-CM code: _____

2. **Vaginal delivery of a term newborn in a hospital noted to be large for gestational age at 4000 grams. Code the baby's record.**

   ICD-9-CM code: _____

   ICD-9-CM code: _____

3. **Post-term vaginal delivery of liveborn infant in a hospital with Down syndrome. Code the baby's record.**

   ICD-9-CM code: _____

   ICD-9-CM code: _____

   ICD-9-CM code: _____

4. **Term vaginal delivery of newborn in a hospital, small for gestational date, diagnosed with fetal alcohol syndrome. Code the baby's record.**

   ICD-9-CM code: _____

   ICD-9-CM code: _____

   ICD-9-CM code: _____

5. **Newborn twins delivered in a hospital, premature at 32 weeks gestation, via c-section, one stillborn. Code the baby's record.**

   ICD-9-CM code: _____

   ICD-9-CM code: _____

🗝 Step 14 Review Practice Exercise 27-4

❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

✉ Step 15 Lesson Summary

❑ Once again, we've covered a lot of coding territory in this lesson. You've learned many new terms and even more instructions and details about how to code correctly for a wide range of diagnoses. You've studied conditions and diseases from the skin and subcutaneous tissue, to the musculoskeletal system and connective tissue, and to congenital anomalies and conditions in the perinatal period. Now that you've made it this far in your study of ICD-9-CM codes, your confidence should be increasing. You are very close to completing all of this new information about ICD-9-CM coding!

Take whatever time you need to review the content and Practice Exercises in this lesson, and then go ahead and complete the Mail-in Quiz.

✉ Step 16 Mail-in Quiz 27

❑ Follow the steps to complete the Quiz.

a. Be sure you've mastered the instruction and the Practice Exercises that this Quiz covers.

b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.

d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your Quiz online.

e. Mail the Answer Sheet to the school via mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 27

Choose the best answer from the choices provided. Each item is worth 2.5 points.

1. Which is a true statement of congenital anomalies? _____

a. They are conditions that exist at birth.

b. Congenital anomalies cannot be surgically repaired.

c. These are mechanical injuries.

d. Congenital and acquired anomalies are the same.

2. Which region of the vertebral column is composed of 12 vertebrae? _____

a. Thoracic
b. Sacral
c. Lumbar
d. Cervical

3. Which is a true statement of the section 760-763, *Maternal Causes of Perinatal Morbidity and Mortality*? _____

a. This group of codes is assigned to the newborn record.
b. These conditions are only coded if they are affecting the fetus, not just because they exist.
c. This section consists of maternal conditions or complications that affect the fetus or newborn to cause disease or death to the fetus or newborn.
d. All of the above

4. Which is *not* a true statement of cellulitis? _____

a. It is an acute, pus-producing inflammation.
b. Cellulitis is never found in the muscle.
c. Cellulitis may be associated with an abscess.
d. It can be a localized collection of pus.

5. In which stage of pressure ulcers does the skin blister, allowing bacteria to enter the site? _____

a. Stage IV
b. Stage V
c. Stage II
d. Stage III

6. Which type of fracture occurs as the result of the bone structure weakening by a pathological process? _____

a. Pathological fracture
b. Traumatic fracture
c. Spontaneous fracture
d. Both a and c

7. Which condition is *not* coded in subcategory 744.2? _____

a. Absence of an ear lobe
b. Absence of the auditory canal
c. Absence of the eustachian tube
d. Bat ear

8. What are the layers of skin called? _____

a. Epidermis and dermis
b. Hair, nails and glands
c. Sebaceous, apocrine and eccrine
d. Horny, clear, granular, prickle cell and basal layers

9. _____ is a chronic, systemic disease characterized by recurrent inflammation of the synovial joints and related structures.

a. Systemic lupus erythematosus
b. Rheumatoid arthritis
c. Joint mice
d. Degenerative joint disease

10. Which is *not* a true statement of jaundice? _____

a. It is a yellowing of the skin and the whites of the eyes.
b. There is no treatment for jaundice.
c. Neonatal jaundice is a manifestation of an underlying disease.
d. It is caused by an accumulation of the yellow-brown bile pigment bilirubin in the blood.

11. Injury to the newborn during the delivery is _____.

a. a birth trauma
b. never coded
c. an unlikely event
d. none of the above

12. Which is *not* a true statement of Down syndrome? _____

a. Those with this condition have increased episodes of congenital heart disease.
b. Characteristics include a flattened nose and protruding tongue.
c. It is also known as Trisomy 21.
d. The average lifespan is the same as one without Down syndrome.

13. _____ is any disease of the bone.

a. Osteomyelitis
b. Osteopathy
c. Osteoporosis
d. Osteoarthritis

14. Which is *not* a condition categorized as seborrheic dermatitis? _____

a. Cradle cap
b. Dandruff
c. Diaper rash
d. Seborrheic infantile dermatitis

15. Blood types are composed of _____.

a. groups and types
b. A, B, AB and O
c. Rh positive and Rh negative
d. All of the above

16. Which is *not* a true statement of intervertebral discs? _____

a. They cushion the vertebrae from shock from movement.
b. Disorders of the spine always exist with disorders of the discs.
c. The discs form the major joint at each level of the spine.
d. They allow the spine to bend.

17. _____ is an acute or chronic inflammatory rash marked by itching and redness that is a result of cutaneous contact with a specific allergen or irritant.

a. Contact dermatitis
b. Atopic dermatitis
c. Seborrheic dermatitis
d. None of the above

18. Which is *not* a true statement of systemic lupus erythematosus? _____

a. You are to use an additional code to identify manifestations.
b. Lupus is a chronic inflammatory disease of the connective tissue.
c. There is a cure for SLE.
d. Characteristics of this disease include fever and weakness.

19. Which condition is influenced by age, genetics and testosterone? _____

a. Alopecia
b. Lack of hair
c. Baldness
d. All of the above

20. Which is a noninflammatory degenerative joint disease characterized by the repair of joint cartilage not keeping up with cartilage degeneration? _____

a. Osteomyelitis
b. Osteoporosis
c. Osteoarthritis
d. Osteopathy

Choose the best diagnostic code(s) from the choices provided. Each item is worth 2.5 points.

21. Newborn triplets delivered via c-section at the hospital at 28 weeks gestation. The babies are small for dates but otherwise healthy. Code for the baby's record. _____

a. V37.01 765.24 764.0
b. V34.01 765.24 765.00
c. V37.01 765.24 764.00
d. V34.01 765.24 764.00

22. Carbuncle located on the back of the ear lobe _____

a. 680.0
b. 680.9
c. 680.8
d. 680.09

23. Old bucket handle tear of medial meniscus _____

a. 836.0
b. 891.0
c. 717.0
d. 717.41

24. Recurrent bilateral congenital hip subluxation _____

a. 718.25
b. 835.00
c. 754.33
d. 754.30

25. Staphylococcal arthritis of the forearm _____

a. 711.03 038.10
b. 711.03
c. 711.03 041.11
d. 711.03 041.10

26. Systemic sclerosis with lung involvement _____

a. 710.1
b. 710.1 517.2
c. 515
d. 710.10

27. Term newborn delivered vaginally at the hospital. Due to the baby being exceptionally large for the gestational age at 5000 grams, his clavicle was fractured during the delivery. Code the baby's records. _____

a. V30.00 767.2 766.1
b. V30.00 810.00 766.0
c. V30.00 810.00 766.1
d. V30.00 767.2 766.0

28. Herniated intervertebral disc, L4-L5 _____

a. 722.10
b. 553.9
c. 553.8
d. 722.73

29. Unilateral incomplete cleft palate and cleft lip _____

a. 749.20
b. 749.22
c. 749.02 749.12
d. 749.03 749.14

30. Heat rash _____

a. 782.1
b. 691.0
c. 705.1
d. 693.0

31. Spondylolisthesis due to weightlifting _____

a. 738.4
b. 756.12
c. 721.90
d. 720.9

32. Congenital hip dislocation _____

a. 835.00
b. 754.35
c. 754.30
d. 718.75

33. Stage I pressure ulcer located at the upper back _____

a. 707.0 707.21
b. 707.19 707.21
c. 707.9 707.21
d. 707.02 707.21

34. Late effect of fetal alcohol syndrome _____

a. 655.44
b. 760.71
c. 305.00
d. 779.89

35. A 20-year-old male with Marfan syndrome diagnosed with a dissecting aortic aneurysm _____

a. 441.00 759.82
b. 441.9 759.82
c. 441.02 759.82
d. 441.0 759.82

36. Eczema due to detergents _____

a. 692.9
b. 692.0
c. 690.18
d. 692.4

37. Newborn found on steps of hospital is now hospitalized and diagnosed with hypothermia _____

a. V30.1 778.3
b. V30.00 780.99
c. V30.10 778.3
d. V30.1 780.99

Quiz continues on next page ➔

38. DERMATOLOGY CONSULTATION REPORT

REASON FOR REFERRAL
Referred for blisters and rash of mucous membranes and skin.

HISTORY OF PRESENT ILLNESS
Rash developed inside mouth, then "bumps" appeared under skin at various places. Oral lesions painful after rupture.

PAST HISTORY
Habits: No smoking, drinking or drug use.
Medications: No medications.
ALLERGIES: ALLERGIC TO TETRACYCLINE.
Social history: Patient is an investigative reporter. Recent travels include Iran and China. Has recently returned from Brazil one week before onset of symptoms.
Family history: Noncontributory.

REVIEW OF SYSTEMS
Skin: Other than HPI, no complaints.
Hair: No alopecia.
Cardiorespiratory: No murmurs, palpitations.
Gastrointestinal: No diarrhea, nausea, vomiting.
Genitourinary: No dysuria or hematuria.
Neurologic: No seizures or headaches.

PHYSICAL EXAMINATION
GENERAL: The patient is a thin, quiet 28-year-old black male in no acute distress.
VITAL SIGNS: Pulse: 66, regular. Blood pressure: 122/78. Respiratory rate: 20, regular. Temperature: 99.4 °F.
HEENT: Head: Normocephalic. Eyes: EOMs intact. Funduscopic examination normal. Ears: Tympanic membranes clear. Nose: Mucous membranes clear. Mouth: Multiple tense and flaccid bullae scattered throughout the buccal mucosa and pharyngeal mucosa. There are interspersed areas of erosion.
NECK: Supple. No adenopathy.
CHEST: Clear to auscultation and percussion.
ABDOMEN: Soft and flat. No organomegaly or inguinal adenopathy.
GENITALIA: Normal male genitalia. Testicles descended.
RECTAL: No prostate enlargement. Stool guaiac negative. No blood on the examining glove.
EXTREMITIES: Multiple ruptured bullae in various stages are seen, from raw and denuded to crusted.
NEUROLOGIC: DTRs normoreflexive. Cranial nerves 2-12 are intact.

DATABASE
CBC normal. Chest film clear. Skin biopsy shows suprabasal epidermal cell separation.

ASSESSMENT
Pemphigus. Rule out toxic epidermal necrolysis, bullous contact dermatitis and erythema multiforme.

RECOMMENDATIONS
Review skin biopsy and immunofluorescence test. Begin prednisone 60 mg daily until diagnosis confirmed. If new lesions still appear after 5 days, consider hospitalization and use of immunosuppressive medications.

a. 782.1 709.8
b. 782.1 709.8 694.4
c. 694.4
d. 694.4 782.1

Quiz continues on next page ➔

39. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS
Cervical spondylosis myelopathy.

POSTOPERATIVE DIAGNOSIS
Cervical spondylosis myelopathy.

PRIMARY PROCEDURE
C3-C7 LAMINECTOMY.

SECONDARY PROCEDURE
SECTIONING OF BILATERAL C3-C6 DENTATE LIGAMENTS.

ANESTHESIA
General endotracheal, administered by anesthesiologist.

PROCEDURE
The patient was taken to the operating room and placed in a supine position. After endotracheal intubation and induction of general anesthesia, the patient had a precordial Doppler monitoring system placed, as well as a central venous catheter. He was then placed in a sitting position with Mayfield three-point pin headrest fixed to the table. The patient's head was kept in a neutral position due to the significant anterior compressive disease in his spine, and the posterior portion of the head was shaved. The head and neck were prepped and draped in the usual fashion. A midline incision was then marked out from the external occipital protuberance down to the T1 spinous process, and the subperiosteal area over the lamina from C3-C7 bilaterally was infiltrated with 0.5% Xylocaine containing 1:100,000 epinephrine. The incision was then carried down through the skin and subcutaneous tissues, and self-retaining retractors were placed, while sharp dissection was used to carry out the dissection down to the spinous processes from C2-C7. Unipolar cautery and periosteal elevators were used to elevate the paraspinous muscles off the spinous processes and off the lamina bilaterally from the inferior aspect of C2-C7, and self-retaining retractors were put into place. The spinous processes were then removed with a spine cutter, and a high-speed drill was used then to fashion a trough bilaterally from C3-C7 at the lateral aspect of the lamina. This was done bilaterally, and then a small Kerrison was used to slightly widen and complete the bony trough down to the ligamentum flavum. Then the lamina segments from C3-C7 were dissected off as a unit from the ligamentum flavum with sharp dissection.

The laminectomy was then widened somewhat to complete it with a small Kerrison rongeur, and the dura was then pulsating nicely. The dura was then opened in the midline with sharp dissection, and under the operating microscope, the C3-C6 dentate ligaments bilaterally were sectioned, using microinstrumentation. There did seem to be some posterior displacement of the cord after this, and it seemed to ride a bit more freely. The dura was then closed with a running 4-0 nylon suture, and Gelfoam was placed over the dural opening. The wound was irrigated copiously with Ringer's lactate containing bacitraci, and the muscle was closed in layers with 2-0 Vicryl as was the subcutaneous tissue. Staples were used for the skin edges. Local dressing was applied, and the patient was taken out of the Mayfield pin headrest and placed in the supine position, extubated, and then taken to the Neurosurgical Intensive Care Unit. Sponge and needle counts were correct.

a. 756.19

b. 756.11

c. 721.91

d. 721.1

Quiz continues on next page ➔

40. RHEUMATOLOGY CONSULTATION REPORT

HISTORY

REASON FOR REFERRAL
Evaluation for status of rheumatoid arthritis.

HISTORY OF PRESENT ILLNESS
The patient is a Caucasian female. The patient has had long-standing rheumatoid arthritis for over 20 years, treated with various medications whose names she cannot recall, and states that her joints are not particularly worse than one month ago. She says there is morning stiffness that has increased somewhat during the last five weeks. There is no acute flare-up of joint pain. The right and left knee joints and the right ankle and foot borders bother her the most. She also complains of subluxation of the metacarpophalangeal joints for many years. Denies temporomandibular tenderness or difficulty swallowing. Denies skin rashes.

PAST HISTORY
Medications: Motrin 800 mg p.o. t.i.d., prednisone 20 mg p.o. b.i.d., aspirin daily of unknown amounts, chlorpromazine 10 mg p.o. t.i.d.
Operations: Foot surgery years ago for deformity. Appendectomy and cholecystectomy. ALLERGIES: NONE.
Family history: The father died at age 65 of pulmonary carcinoma. Mother died at age 48 of uterine cancer. She also had diabetes.

PHYSICAL EXAMINATION
VITAL SIGNS: Blood pressure: 150/90, which is reported as elevated by the patient.
HEENT: PERRLA. Sclerae clear. Thyroid not enlarged. No adenopathy.
CHEST: Heart: Regular rate and rhythm without murmurs. Lungs: Clear.
ABDOMEN: Soft, protuberant, normal bowel sounds.
EXTREMITIES: No clubbing, cyanosis, or edema. Mostly MCP joint involvement of both hands and MTP involvement of right foot. There are proximal interphalangeal and MCP, MTP subluxations with overlapping toes of the right foot. There is decreased range of motion in the ankles, wrists and digits. Relatively good range of function of elbows, shoulders and sacroiliac joints. No joint swelling or erythema at the present time.

ASSESSMENT
Rheumatoid arthritis with multiple joint involvement, stable. With current conditions, hypertension may develop.

RECOMMENDATIONS
ANA, RF and thyroid panel to document rheumatoid arthritis. Bone survey. Taper steroids to 10 mg p.o. daily. Begin Feldene for symptomatic relief. Patient to track blood pressure readings 3x/week for three weeks and report readings to physician.

a. 716.99 401.9
b. 714.09
c. 714.0
d. 714.09 401.9

Congratulations!

You have completed Lesson 27.

Do not wait to receive the results of your Quiz before you move on.

Lesson 28

ICD-9-CM Coding—From Symptoms to Complications

Step 1 Learning Objectives for Lesson 28

- When you have completed the instruction in this lesson, you will be trained to do the following:
  - Define and describe condition symptoms, signs and ill-defined medical conditions.
  - Explain the basic exclusions, inclusions and rules related to Chapters 16 and 17 of the *ICD-9-CM* manual's *Tabular List*.
  - Identify the diagnoses, outline the coding pathway and assign the final code for documented disorders and diseases.

Step 2 Lesson Preview

- In this lesson, you will learn the details of coding conditions that are included in ICD-9-CM codes 780 through 999. In particular, the code groups in Chapters 16 and 17 of the *Tabular List* focus on symptoms, signs and ill-defined conditions; and on injury and poisoning.

  As you've experienced in recent lessons, this lesson consists of varied and important details that you need to understand to become a proficient and accurate medical coding and billing specialist. Focus carefully as you work through the material, take plenty of breaks to refresh your mind and always remember that your instructor is available to assist you if you are uncertain about any of the information or how to find the correct codes. So let's get started on these last chapters of the *ICD-9-CM* manual.

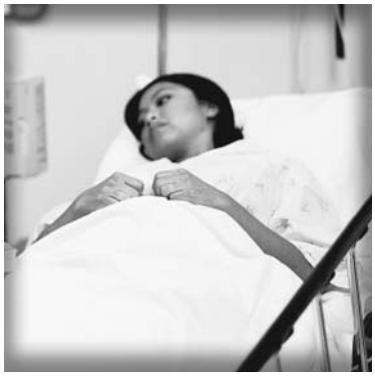
To help make sure you don't get confused as you code the practice exercises and scenarios throughout the following ICD-9-CM coding lesson, it's important to keep in mind that we are focusing for now only on ICD-9-CM codes—not CPT codes. You will see physician notes and documentation about specific procedures in some of the scenarios we use just because we want you to practice with authentic examples. But remember that you will code only the diagnoses during these lessons—you'll have plenty of time and lots of practice combining procedural and diagnostic codes in later lessons, after you've become more familiar and comfortable with the ICD-9-CM codes.

Step 3 Symptoms, Signs, and Ill-Defined Conditions (780-799)

- When no other diagnosis code quite fits the condition identified in the physician's documentation, you will turn to this chapter, Chapter 16 in the *ICD-9-CM* manual, which contains symptoms, signs and ill-defined conditions, to assist you. Review the notes provided at the beginning of the chapter to understand when it is appropriate to use these codes. As we introduce this portion of the manual to you, we will discuss both general symptoms and symptoms associated with specific body systems. We also will define and discuss nonspecific abnormal findings. Now let's take a look at the section that focuses on codes for symptoms of diseases and other conditions.

Symptoms (780-789)

A **symptom** is defined as any evidence of a disease or disorder (such as pain) that is discovered. When a positive diagnosis is not or cannot be provided, you will code the symptom or symptoms of the presenting problem. In Lesson 23, we discussed unconfirmed diagnoses, or uncertain conditions. When the physician's final diagnosis is an unconfirmed diagnosis, you will look to the symptoms for the correct code.



A symptom is defined as any evidence of a disease or disorder (such as pain) that is discovered.

General symptoms include alteration of consciousness, hallucinations, syncope and collapse, convulsions, dizziness and giddiness, sleep disturbances, fever, malaise and fatigue, generalized hyperhidrosis and other general symptoms. Let's look at each of these conditions so that you have a good understanding of this category.

Consciousness is a state of being aware of self and surroundings and knowing what you are doing and intend to do. Alteration of this state can range from drowsiness to a state of unconsciousness, known as a **coma**, from which a patient cannot be awakened.

For various reasons, a person might hear, taste, smell or feel a stimulus that is not there. When one has a perception of an object or event when no such stimulus or situation is present, the condition is known as a **hallucination**. The hallucinations referenced in code group 780.1 EXCLUDES those associated with mental disorders, organic brain syndromes and visual hallucinations.

Syncope is a sudden, temporary suspension of consciousness due to a reduced blood flow to the brain. This condition is often referred to as a **blackout** or **fainting**. Code 780.2 EXCLUDES syncope related to the carotid sinus and the heart and to neurocirculatory asthenia, orthostatic hypotension and shock.

Sudden, involuntary contractions of the muscles are termed **convulsions**. Code group 780.3 for convulsions EXCLUDES epileptic convulsions and convulsions in newborns. **Febrile convulsions**, or **seizures**, code 780.31, are those associated with high fever and that occur in infants and children. Other convulsions, under code 780.39, include seizures, fits and convulsive disorders not otherwise specified. To code a febrile seizure, two coding pathways will provide the same tentative code. *Febrile*, *seizure*, or *Seizure*, *febrile* each provides **780.31** as the tentative code. When you then turn to the *Tabular List* to determine the highest level of specificity, you will confirm that code **780.31 General symptoms**, **Convulsions**, **Febrile convulsions (simple), unspecified** is the accurate code.

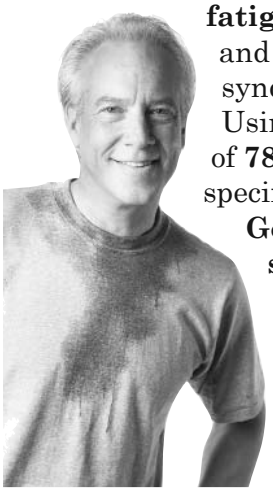
A sensation of unsteadiness with a feeling of movement might be called dizziness, giddiness, light-headedness or vertigo not otherwise specified. The experience might be a whirling sensation in the head, with a feeling of falling. This subcategory, 780.4, EXCLUDES Meniere's disease and other specified vertiginous syndromes.

Sleep disturbances consist of insomnia, sleep apnea, hypersomnia and other dysfunctions associated with sleep stages or arousal from sleep. **Insomnia** is the inability to sleep during the period when sleep should normally occur. **Sleep apnea** is the periodic absence of spontaneous breathing while sleeping. **Hypersomnia** occurs when a person has excessively long sleep cycles, but is still tired and requires naps. These sleep disturbances can also be found in conjunction with other disorders. For example, let's code insomnia with sleep apnea. Turn in the *Index to Diseases* to the main term *Insomnia*. You will locate a code for insomnia alone, but look to the subterm *with sleep apnea*, *unspecified* and you will see the tentative code of **780.51**. Now turn to the *Tabular List* to determine the highest level of specificity. The code **780.51 General symptoms, Sleep disturbances, Insomnia with sleep apnea, unspecified** is correct for the diagnosis.

When the body temperature is elevated above normal, the condition is called a fever or pyrexia.

When the body temperature is elevated above normal, the condition is called a **fever** or **pyrexia**. When the cause of the fever is unknown or not otherwise specified, you will use code 780.60.

Malaise is a vague feeling of physical discomfort or lack of good health. **Fatigue** results from overwork or lack of sleep, resulting in weariness, irritability and boredom. A persistent fatigue, with symptoms of weak muscles, sore throat, tender lymph nodes, headaches, depression and mild fever is known as **chronic fatigue syndrome**. There is no known cause for this condition, and treatment is focused on the symptoms. To code chronic fatigue syndrome, locate the main term *Syndrome* in the *Index to Diseases*. Using *fatigue*, *chronic* as the subterms, you will find the tentative code of **780.71**. Then turn to the *Tabular List* to determine the highest level of specificity. Based on the information there, you will confirm code **780.71 General symptoms, Malaise and fatigue, Chronic fatigues syndrome** as accurate.



Hyperhidrosis is excessive sweating.

Hyperhidrosis is excessive sweating. The sweat appears as droplets on the skin. Code **780.8** EXCLUDES focal hyperhidrosis and Frey's syndrome. Let's say that in the dictation, instead of the medical term *hyperhidrosis*, just "excessive sweating" is provided, and you are to code that condition. Again, two coding pathways will lead you to the same code. *Excessive*, *sweating* or *Sweat*, *excessive* each direct you to *see also* Hyperhidrosis and the tentative code of **780.8** is provided. Once you determine the highest level of specificity in the *Tabular List*, you will assign **780.8 General symptoms, Generalized hyperhidrosis** as the correct code.

Other general symptoms in code group 780.9 EXCLUDES hypothermia that is due to anesthesia, accidental or of newborns. Code group 780.9 also EXCLUDES memory disturbances as part of a pattern of a mental disorder. This subcategory includes fussy infants, excessive crying of infants, memory loss, the premature feeling of being full and generalized pain.

Now it's your turn to practice coding this scenario of a patient who was treated in the emergency department.

SUBJECTIVE
Altered transient confusion and general weakness without tremors or involuntary movement. Gait normal.

OBJECTIVE
Appearance and affect are appropriate. Level of consciousness normal. Speech grossly intact. Oriented to time, place, person and purpose. Remote and recent memory intact. Attention span normal. Calculating ability normal. Abstract thinking normal. Cranial nerves:

I: Sense of smell intact.
II: Visual acuity normal. Visual fields intact at confrontation. Optic nerve normal at funduscopic examination.
III, IV and VI: Pupil size normal. PERRLA. Extraocular movements/muscles intact.
V: Facial sensation intact. Masseter muscle strength normal.
VII: Facial symmetry and muscle strength normal.
VIII: Hearing acuity is normal bilaterally. Normal Weber test, does not determine lateralized sound. Air and bone conductivity intact.
IX, X: Palate elevates in the midline. Gag reflex is normal. Uvula is midline.
XI: Trapezius and stemocleidomastoid strength 5/5.
XII: No tongue fasciculations, deviation or weakness.

Sensory examination: Pinprick, position and vibratory sensation normal.

Meningeal examination: Neck supple, no Brudzinski or Kernig signs present.

Motor function: Motor strength and tone decreased in the involved extremities. No tremor or involuntary movements or fasciculations are seen. Gait is normal. No muscle atrophy.

Cerebellar testing: Finger-to-nose and heel-to-shin testing normal. RAM normal. No intention tremor, nystagmus. Biceps, triceps, patellar and Achilles tendon reflexes are 2+ and equal bilaterally. Babinski's reflex is negative.

ASSESSMENT
The findings are most likely consistent with transient ischemic attack [TIA]. Cannot exclude meningitis, multiple sclerosis, peripheral neuropathy, arteriovenous malformation, Takayasu's disease, subclavian steal syndrome, neurosyphilis or focal seizures.

PLAN
Emergency CT scan and spinal tap with cell count, VDRL and culture.

In coding this outpatient scenario, you cannot code the TIA because it is unconfirmed. The terms "most likely" and "consistent with" indicate that the physician is not certain of the TIA diagnosis. The physician lists many other possible causes but does not provide a definite diagnosis. In this situation, you should then look at the examination section to see whether the physician confirms a diagnosis area. However, the exam does not offer a definite diagnosis. Next, look to the presenting symptoms that brought the patient in for care. The patient complains of altered transient confusion and general weakness. Based on all this information, you will first code the transient confusion by turning to *Alteration, altered* in the *Index to Diseases*.

The subterms *awareness*, *transient*, or *consciousness*, *transient* each provide a tentative code of **780.02** for this condition. Next, turn to the *Tabular List* to determine the highest level of specificity. Now you will code the general weakness. The coding pathway *Weak*, *weakness* (*generalized*) provides **780.79** as the tentative code. Determine the highest level of specificity and the accuracy of this code in the *Tabular List*. Finally, for this scenario, you will assign code **780.02 General symptoms, Alteration of consciousness, Transient alteration of awareness** and code **780.79 General symptoms, Malaise and fatigue, Other malaise and fatigue** as the accurate codes based on these notes.

Now we're ready to discuss symptoms that involve specific body systems. The diagnoses that cover these symptoms and conditions include codes 781 through 789. As in previous lessons, we will highlight some of the codes, but you should read the category carefully whenever you are coding. There are many inclusions, exclusions and additional notes to be aware of with the symptoms and conditions included when coding in these codes. As always, if you have questions or concerns about the information provided, be sure to call your instructor for assistance.

Symptoms Involving Nervous and Musculoskeletal Systems (781)

This code category EXCLUDES depression, specific disorders relating to the back, hearing, joint, limb, neck and vision, as well as pain in a limb. You will find codes for symptoms such as disturbances of the sensations of smell and taste, clubbing of the fingers and facial weakness in this category. **Anosmia** is the loss of the sense of smell usually due to intranasal or neurologic diseases. A distortion of the sense of taste, or bad taste in the mouth, is termed **parageusia**. A distortion of the sense of smell, especially the smelling of odors that do not exist, is called **parosmia**. You will assign code 781.1 for these three sensory disturbances.

Thickening and broadening of the tips of the fingers with increased curving of the nails is termed **clubbing** of the fingers. You will often see clubbing of fingers listed as a symptom of another disease or disorder. If the disease is unconfirmed, you will code clubbing of fingers as the symptom, which is code 781.5.

Code 781.94 for facial weakness, or facial droop, EXCLUDES facial weakness that is due to the late effect of cerebrovascular accidents (438.83). Facial weakness might be a symptom of a number of conditions, including *Bell's palsy*, *Lyme disease*, *Myasthenia Gravis*, *Primary Lateral Sclerosis* and *TIA*.

Symptoms Involving the Skin and Other Integumentary Tissue (782)

Symptoms involving skin and other integumentary tissue, found in code category 782, EXCLUDES symptoms that relate to the breast. This category consists of a variety of skin conditions, from rash to excessive blushing. A **rash**, or **exanthem**, is a general term for a skin eruption. **Edema** is an excessive amount of watery fluid in cells, tissues or serous cavities. The edema included in this code group does not include ascites, fluid retention, hydrothorax or nutritional edema.

You learned about jaundice in a newborn in a previous lesson. When jaundice other than that of a newborn occurs, you will code 782.4 for the condition. Finally, pallor or excessive paleness (782.61) and flushing or excessive blushing (782.62) are also included in this code category.

Now let's try coding a symptom that involves the skin.

SUBJECTIVE
A 5-year-old female presenting with a rash on her arm and legs and complaining of itching skin.

OBJECTIVE
Examination of skin is inconsistent with chickenpox.

ASSESSMENT
Rash.

PLAN
Patient is to treat the rash with hydrocortisone as needed for the itching.

The physician does not provide a definite diagnosis for the condition, so you will code for the rash. To do so, first locate *Rash* in the *Index to Diseases*, where you will see code **782.1** indicated as the tentative code. Then turn to the *Tabular List* to determine the highest level of specificity. Based on what you find there, you will assign **782.1 Symptoms involving skin and other integumentary tissue, Rash and other nonspecific skin eruptions** as the accurate code for this scenario.

Symptoms Concerning Nutrition, Metabolism, and Development (783)

Symptoms that concern nutrition, metabolism and development include *anorexia*, abnormal gain or loss of weight and *failure to thrive* in children or adults. **Anorexia** is usually a temporary loss of appetite due to an emotional upset or illness with a fever. This condition EXCLUDES anorexia nervosa (307.1) and loss of appetite of nonorganic origin (307.59). Abnormal weight gain EXCLUDES excessive weight gain in pregnancy (646.1) and obesity (278.00) or morbid obesity (278.01). When an acute or chronic illness interferes with nutritional intake, absorption, metabolism, excretion and energy requirements, the condition is known as organic **failure to thrive**. This condition is not a symptom of neglect or abuse. Failure to thrive is categorized separately for childhood development (783.41) and for adults (783.7).

Organic failure to thrive is not a symptom of neglect or abuse.

Symptoms Involving Head and Neck (784)

Symptoms that involve the head and neck, included within code category 784, range from headache and throat pain to *nosebleeds*. Subcategory 784.0 includes headache, facial pain and pain in the head not otherwise specified. This group of codes EXCLUDES atypical face pain, migraines and tension headaches. Code **784.1 Throat pain** EXCLUDES dysphagia (difficulty swallowing), neck pain and a sore throat. The correct code for a hemorrhage from the nose, **epistaxis**, or simply a **nosebleed**, is 784.7.

Symptoms Involving the Cardiovascular System (785)

Code category 785 contains codes for symptoms that involve the cardiovascular system. Conditions included in this category include *tachycardia, palpitations* and *septic shock*. **Tachycardia** is a rapid beating of the heart, conventionally applied to heart rates greater than 100 beats per minute. This code group EXCLUDES neonatal tachycardia (779.82) and paroxysmal tachycardia (427.0-427.2). Awareness of one's own heartbeat, whether it appears unusually rapid or irregular is called **palpitations**.

Septic shock is a serious, abnormal condition that usually affects the very old or the very young. Septic shock occurs when an overwhelming infection of bacteria causes a release of toxins, which results in low blood pressure and low blood flow. Septic shock can occur only when severe sepsis is present. Therefore, if septic shock is documented, it is necessary to code first the initiating systemic infection or trauma, and then code 995.92 (severe sepsis), followed by code **785.52 Septic shock**. Now let's code this condition from the following scenario.

SUBJECTIVE
An 82-year-old male arrives in the emergency department by ambulance, complaining of chills and a fever for the last week. His wife notes he has had shortness of breath, dizziness and confusion during this time as well. He has had decreased urine output for the past 2 days.

OBJECTIVE
A comprehensive physical exam is performed. Extremities are cool to the touch. Palpitations noted. Blood gas reveals low oxygen saturation and respiratory alkalosis. Blood tests confirm kidney failure. Blood cultures, EKG and chest x-ray are pending.

ASSESSMENT
Patient has septic shock due to a massive infection, with evidence of acute kidney failure.

PLAN
Patient is admitted to ICU by his primary care provider.

Based on the dictation, you will code the acute renal failure and the septic shock. First, you will locate the code for the diagnosis of the acute kidney failure because it is causing the systemic infection. Using the coding pathway *Failure*, *kidney* you are directed to see *Failure, renal*. The new pathway *Failure*, *renal*, *acute* provides the tentative code **584.9**. Then, locate the coding pathway *Shock*, *septic* in the *Index to Diseases*. Turn to the *Tabular List* to determine the highest level of specificity for code **785.52**. The notes you will find under code 785.52 direct you to code first the systemic inflammatory response syndrome due to infectious process with organ dysfunction (995.92). The code you need is provided in the notes, and you will assign code **995.92**. Finally, assign the diagnostic codes in the correct order: the systemic infection, the systemic inflammatory response syndrome and the septic shock. You will assign **584.9 Acute renal failure, unspecified, 995.92 Systemic inflammatory response syndrome (SIRS), Severe sepsis** and **785.52 Shock without mention of trauma, Septic shock** to this emergency department visit.

Symptoms Involving Respiratory System and Other Chest Symptoms (786)

Symptoms that involve the respiratory system and other chest symptoms include *apnea*, shortness of breath, *wheezing*, cough and chest pain. We discussed apnea before as a general symptom of sleep disturbances. **Apnea** is a temporary stopping of breathing. When this condition is not associated with the sleep process, you will use code 786.03 for it. Shortness of breath, or SOB, has been a symptom of many of the scenarios we have presented in the *ICD-9-CM* lessons. When this inability to take in sufficient oxygen has no diagnosed cause, you will assign code 786.05 as the symptom that involves the respiratory system. Wheezing is a symptom that EXCLUDES asthma (493.00-493.92). To **wheeze** is to breathe with a high-pitched or whistle-like sound caused by the narrowing of airways. This condition may be due to asthma, croup, emphysema, hay fever, edema or pleural effusion. As with the other symptoms in this chapter, if the disease is undiagnosed, you will code wheezing instead. A cough (code group 786.2) is another common symptom of many diseases. This code subcategory EXCLUDES psychogenic and smokers' cough, as well as a cough with hemorrhage.

Chest pain consists of several subclassifications to further explain the type of chest pain. **786.50 Chest pain, unspecified** is a common code when further classification is not noted. **Precordial pain**, code 786.51, is chest pain over the heart and the lower thorax. The location, or "precordial," must be documented to use this specific code. You will code pleurodynia, pleuritic and anterior chest wall pain with code **786.52 Painful respiration**. This condition EXCLUDES epidemic pleurodynia (074.1). Code **786.59 Other** refers to discomfort, pressure and tightness in the chest. This code group EXCLUDES pain in the breast, for which you are directed to use code 611.71 instead. Always keep in mind that proper use of the *Index to Diseases* will assist you in determining the correct code for the documented circumstance.

Symptoms Involving Digestive System (787)

Code category 787 consists of symptoms that involve the digestive system, which include symptoms such as nausea and vomiting, *dysphagia*, gas and diarrhea. Codes in the nausea and vomiting (also referred to as emesis) code group, list several EXCLUDES that you should take note of when you code from this section. These symptoms have subclassifications to fully describe the condition. You might code nausea with vomiting, nausea alone or vomiting alone. *Dysphagia* is the medical term to describe difficulty in swallowing. You will use code 787.2 ✓ for this condition, with the fifth digit identifying the phase of the dysphagia.

Symptoms Involving Urinary System (788)

Symptoms that involve the urinary system, which you will find in code category 788, include codes for *dysuria, urinary incontinence* and *urgency of urination.* Codes in this category EXCLUDES hematuria (599.70-599.72), nonspecific findings on examination of the urine (791.0-791.9), small kidney of unknown cause (589.0-589.9), uremia NOS (586) and urinary obstruction (599.60, 599.69). **Dysuria** is difficult or painful urination, which often indicates a UTI (urinary tract infection). **Urinary incontinence** is the inability to control the passage of urine from the bladder. This incontinence can range from post-void discharge to continuous, involuntary urine seepage. For conditions in this code group, you are directed, if applicable, to code first any causal conditions, such as congenital ureterocele (753.23), genital prolapse (618.00-618.9) or hyperplasia of prostate (600.0-600.9). Code **788.32 Stress incontinence, male** EXCLUDES stress incontinence relating to females, for which you will use code 625.6. Note that **urge incontinence**, with a code of 788.31, is the inability to control urination upon the urge to urinate, while **urgency of urination**, with a code of 788.63, consists of the urge to urinate without the lack of control.

Other Symptoms Involving Abdomen and Pelvis (789)

Other symptoms involving the abdomen and pelvis, in code category 789, EXCLUDES symptoms that are referable to the genital organs. A fifth-digit subclassification applies to codes 789.0, 789.3, 789.4 and 789.6. The fifth digit specifies the abdominal site of the pain, swelling, mass, lump, rigidity or tenderness.

The following fifth-digit subclassification is to be used for codes 789.0, 789.3, 789.4, 789.6:

- 0 unspecified site
- 1 right upper quadrant
- 2 left upper quadrant
- 3 right lower quadrant
- 4 left lower quadrant
- 5 perimbilic
- 6 epigastric
- 7 generalized
- 9 other specified site
  Multiple sites

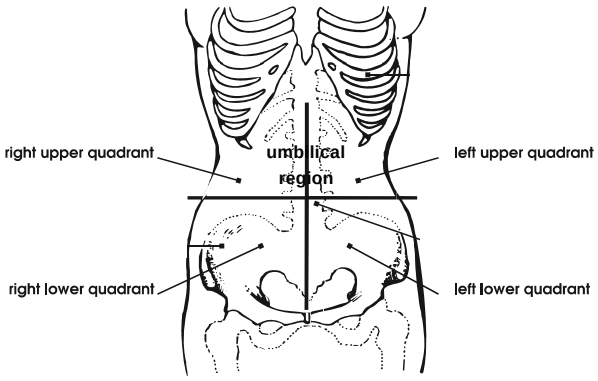


Figure 28-1: Four abdominal quadrants

When you are coding symptoms that fit within this code group, it is important to know the acronyms that might be used to identify one of the four main quadrants.

RUQ	Right Upper Quadrant
LUQ	Left Upper Quadrant
RLQ	Right Lower Quadrant
LLQ	Left Lower Quadrant

Are you ready for more coding practice? Great! Look carefully at the diagnostic radiology report and see how quickly and accurately you can code the diagnosis.

CT ABDOMINAL SCAN WITH CONTRAST

CLINICAL HISTORY
RLQ abdominal pain.

TECHNIQUE
Spiral abdominopelvic CT with oral and intravenous contrast material.

FINDINGS
There is mild thickening of the wall of the terminal ileum. There is an increased number of normal sized mesenteric lymph nodes in the right lower quadrant of the abdomen. The appendix is visualized and is unremarkable. There is a trace amount of free fluid in the pelvis. No renal, hepatic, splenic, or pancreatic abnormalities are seen. Renal uptake of contrast material is prompt and symmetric. There is no evidence of hydronephrosis. The bladder is unremarkable.

IMPRESSION
Constellation of findings consistent with ileitis, which may be due to an infectious process or inflammatory bowel disease. No CT evidence of appendicitis.

Let's go over the details of this example together now. The impression notes the findings are consistent with ileitis. However, *consistent with* indicates an unconfirmed diagnosis. You'll code the symptom documented, which is abdominal pain. As you review the documentation, you note that the abdominal pain is located in the right lower quadrant, and the findings verify that location, as well. First, turn in the *Index to Diseases* to *Pain*, *abdominal*, and you find the tentative code of **789.0** ✓ . Now, use the *Tabular List* to determine the highest level of specificity of this code. To specify the right lower quadrant, you'll apply 3 as the final (fifth) digit. You assigned **789.03 Abdominal pain, right lower quadrant** for this diagnostic radiology report.

Did you get the same result? Congratulations! This completes our review of the first section and code groups of Chapter 16. Let's move on to the next section!

Nonspecific Abnormal Findings (790-796)

This section of Chapter 16 of the *ICD-9-CM* manual includes codes for nonspecific abnormal findings based upon the examination of blood, urine and other body substances; upon the radiological and other examination of body structure; and upon function, immunological findings and nonspecific abnormal findings. You will use these codes when the notes indicate that lab, x-ray, pathology and other diagnostic studies reveal abnormal findings, and the physician documents the clinical significance of these findings. It is also used when no definite diagnosis can be made, and the documentation indicates that additional work up is needed.

For example, let's say a woman has a routine mammogram. The radiologist reviews the results, notes abnormal mammogram and requests that the patient be contacted to have a second mammogram. To code for the radiologist, you will use the coding pathway *Abnormal, mammogram* to locate the tentative code of **793.80**. Then, turning to the *Tabular List*, you will confirm that **793.80 Abnormal mammogram, unspecified** is the accurate code.

We're moving right along with the material in this lesson—only one more section to complete our introduction to the basic codes in Chapter 16 of the *Tabular List*!

Ill-Defined and Unknown Causes of Morbidity and Mortality (797-799)

The final section in this chapter contains codes for conditions that pertain to ill-defined and unknown causes of morbidity and mortality. These conditions include senility, sudden death with an unknown cause and other ill-defined and unknown causes of morbidity and mortality. In code category 797, "Senility without mention of psychosis" is also known as **old age**. This category EXCLUDES senile psychoses (290.0-290.9). Some examples of sudden death with cause unknown are sudden infant death syndrome (SIDS), instantaneous death, death without signs of disease and unattended death. Other ill-defined and unknown causes of disease conditions of a fatal outcome are asphyxia, respiratory arrest and wasting disease.

Now it's time to test your skills in coding symptoms, signs and ill-defined conditions with a Practice Exercise.

✍ Step 4 Practice Exercise 28-1

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Persistent vegetative state**
   ICD-9-CM code: _____
2. **Hypersomnia with sleep apnea**
   ICD-9-CM code: _____
3. **Pyrexia of unknown origin**
   ICD-9-CM code: _____
4. **Lethargy**
   ICD-9-CM code: _____
5. **Transient monoplegia**
   ICD-9-CM code: _____
6. **Numbness in hands**
   ICD-9-CM code: _____
7. **Chest discomfort**
   ICD-9-CM code: _____
8. **Elevated blood-pressure reading**
   ICD-9-CM code: _____
9. **Abnormal pap smear of the cervix**
   ICD-9-CM code: _____

Use the following information to complete the CMS-1500 that follows.

10. ICD-9-CM Coding/Billing Challenge

Clinton Fangman, MD
NPI: 010203321

Carolyn Hooper, MD
NPI: 0188123456

Scott Ludwig, MD
NPI: 0199654321

Stewart Center for Women
1200 Carol Lane
Yourtown, CO 80000
(970) 555-1010

Provider of Blue Cross
NPI: 0220332233
EIN: 99-9009009

Patient Information

Name Sally Tucker
Address 1801 Peterson Court
City Springtown **State** CO
ZIP 80002
Home Phone (970) 555-3255

Date of Birth 11-26-60
Sex female **Marital Status** married

Employment Information

Name of Employer Allied Professions
Occupation
If Minor, Name of School

Insurance Information

Primary Insurance
Name Blue Cross of Iowa
ID# 321 00 1010
Group# BA1503
Address PO Box 1677
City Sioux City
State IA **ZIP** 51102
Primary Insured Name Sally
DOB 11-26-60
Relation to Patient self
Employer Allied Professions

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Sally Tucker
Signature of patient (or parent of minor child)

Secondary Insurance
Name Mutual Life
ID# 402 00 4679
Group# LA4832
Address PO Box 911
City Denver
State CO **ZIP** 80111
Secondary Insured Name Gregory Tucker
DOB 9-2-61
Relation to Patient spouse
Employer Lakeside Auto

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Signature of patient (or parent of minor child)

Physician signature: *Scott Ludwig, MD*

Date of Service	*6/6/XX*	
Diagnosis	**Procedure**	**Charge**
	99214 Office Visit, Est. Patient	*$85.00*

Today's Charge	$85.00
Cash.Check	$10.00
Balance	$75.00

Sally Tucker
DOB 11 26 1960
Date of Service: 6/6/20XX

SUBJECTIVE
Patient complains of pleuritic left chest pain and a low-grade fever.

OBJECTIVE
Temperature: 101 °F. There are rales and decreased breath sounds in both bases with auscultation predominately in the left base. Percussion of the left lateral aspect of the thorax demonstrates an area of consolidation at the midaxillary line that extends from the precordium. There is a pleural rub in the same area.

ASSESSMENT
Suspected postoperative basilar atelectasis; associated aspiration pneumonia cannot be excluded at the present time. Due to this being the 2nd postoperative day, pulmonary emboli cannot be ruled out.

PLAN
Chest film to look for consolidative collapse of the lingula and lower lobes. Encourage deep breathing and frequent use of incentive spirometer. Arterial blood gasses. Consultation with pulmonary medicine.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid#) (Sponsor's SSN) (Member ID #) (SSN or ID) (SSN) (ID)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	
CITY STATE	8. PATIENT STATUS Single Married Other
CITY STATE	
ZIP CODE TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student
ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH SEX M F	
b. OTHER INSURED'S DATE OF BIRTH SEX M F	b. AUTO ACCIDENT? YES NO Place (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES NO $CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.) 1. 3. 2. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM DD YY	TO MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1.										NPI	
2.										NPI	
3.										NPI	
4.										NPI	
5.										NPI	
6.										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # a.	b.	

Step 5 Review Practice Exercise 28-1

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 6 Injury and Poisoning (800-999) Part 1

- ❑ Chapter 17 of the *ICD-9-CM* manual is one of the largest chapters of codes, and it contains a wide variety of conditions. We will divide this chapter into two sections for our discussion to assist you with what might otherwise seem like an overwhelming amount of information. Remember, you do not need to memorize the information because you will have your *ICD-9-CM* manual and course materials to refer to whenever you are coding. We will discuss the inclusions, exclusions and additional notes in the *Tabular List*, as usual, and we will refer you to the *ICD-9-CM* manual's *Coding Guidelines* section located in the front of the book. As you will remember from earlier lessons, the *Coding Guidelines* provide supplementary information to assist you in determining the accurate codes for a number of conditions. In addition, your instructors are a telephone call away to support you as you continue your studies.

Before we dive into the contents of this chapter, let's look to see what assistance the *Tabular List* includes for coding from this chapter. You will note under the heading for Chapter 17 that you are to use an additional code for retained foreign body, if applicable, and you are to use E codes to identify the cause and intent of the injury or poisoning (E800-E999). E codes classify environmental events, circumstances and conditions as the cause of injury, poisoning and other adverse effects. You will use E codes in conjunction with poisonings, and we will return to this topic of using E codes to identify the cause and intent of the injury later. So for right now, don't worry about including the E codes for injuries just yet, but rather focus your attention on coding the injury itself.

E codes classify environmental events, circumstances and conditions as the cause of injury, poisoning and other adverse effects.

The *Tabular List* contains notes about coding injuries—specifically, multiple and combination coding, as well as coding multiple sites of an injury. We will look closer at these notes, as they apply, when we discuss each category. The *Tabular List* also notes that you will find categories for "late effects" in codes 905 through 909.

Fractures (800-829)

The codes in this section EXCLUDES the conditions of malunion (733.81), nonunion (733.82), pathological or spontaneous fractures (733.10-733.19) and stress fractures (733.93-733.95). We have discussed pathological, spontaneous and stress fractures in a previous lesson. Here, we will discuss body parts very specifically. We also refer to this information throughout the lesson.

A **fracture** is a break or rupture in a bone. Fractures are classified as "closed" or "open," and identified as such by the different fourth digits. If the skin is not injured, the fracture is termed *closed*. If the broken bone protrudes through the skin, the fracture is referred to as *open*. A fracture not indicated as closed or open is coded as closed. To ensure proper coding, you also should be aware of other terms that might be used to describe an open or closed fracture. Review the boxed information that follows to keep these other terms in mind as you code.

A closed fracture might be identified by the following terms:

comminuted	depressed	elevated
fissured	fracture NOS	greenstick
impacted	linear	simple
slipped epiphysis	spiral	

An open fracture might be identified by the following terms:

compound	infected	missile
puncture	with foreign body	

Once again, when a fracture is not identified as open or closed, or by any of the above terms, you will code to a closed fracture. You will code fractures of multiple sites to each specific site at the level documented by the physician. If the documentation does not provide enough information to identify each specific site, you will code from the category that indicates multiple fractures. For more information about coding fractures, review the *Coding Guidelines* in the front of your *ICD-9-CM* manual.

Fracture of Skull (800-804)

This section provides fifth-digit subclassifications for use with the appropriate codes in categories 800, 801, 803 and 804. Fracturing the skull can be associated with loss of consciousness. You will use the fifth-digit subclassification for the indicated categories to identify whether there was a loss of consciousness and, if so, the length of the unconsciousness. The fourth-digit classifications for categories 800, 801, 803 and 804 identify whether there was a laceration and contusion; a subarachnoid, subdural or extradural hemorrhage; an intracranial hemorrhage; and whether the fracture was open or closed.

Let's code a depressed fracture of the parietal bone with a subdural hemorrhage and the patient has been unconscious for an undetermined amount of time. In coding this diagnosis, you will first determine the main term by asking, "What's the problem?" The problem is the fracture. So turn in the *Index to Diseases* and locate *Fracture*, *parietal bone*. This coding pathway directs you to *see Fracture, skull, vault*. So the new coding pathway will be *Fracture*, *skull*, *vault*. When you locate these terms, you will see that a subdural hematoma is noted, so you will continue down the pathway *Fracture*, *skull*, *vault*, *with*, s*ubdural hemorrhage* and you have the tentative code of **800.2** ✓ . Now turn to the *Tabular List* to determine the highest level of specificity. You will see that 800.2 is correct but that you need to apply the fifth digit. From the information you've been given, you know the patient was unconscious for an unspecified duration, so the correct fifth digit is 6. The final code you assign for the given description is **800.26 Fracture of vault of skull, Closed with subarachnoid, subdural and extradural hemorrhage, with loss of consciousness of unspecified duration**.

Fracture of Neck and Trunk (805-809)

The vertebral column is the flexible, bony case for the spinal cord. A fracture of the vertebral column could likely include a spinal cord injury. You will note that this section contains codes with and without mention of spinal cord injury. As with the codes for diseases and disorders of the spine, those for fractures of the vertebral column are organized by the specific vertebra involved. In addition, codes 805.0 through 805.1 require a fifth-digit subclassification to indicate the specific vertebra fractured. Be sure to select a fifth digit from that box when coding a fractured cervical vertebra without mention of spinal cord injury.

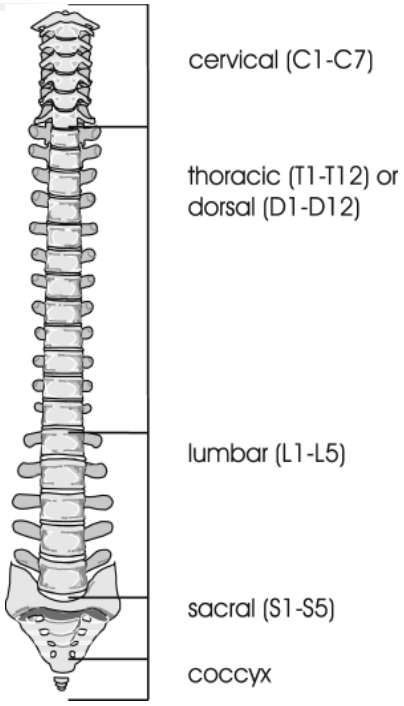


Figure 28-2: Vertebral column

Code category **807 Fracture of rib(s), sternum, larynx and trachea** includes a fifth-digit subclassification box for you to use to identify the number of ribs fractured when you are applying codes 807.0 through 807.1. For example, if you are to determine the *ICD-9-CM* code for a patient who fractured four ribs, you would locate *Fracture*, *rib*(s) in the *Index to Diseases* and find the tentative code of **807.0** ✓. When you determine the highest level of specificity in the *Tabular List*, you will remember that four ribs are noted, so the correct code will be **807.04 Rib(s), closed, four ribs**. Do you understand why it is to a closed fracture? Remember that if open or closed is not specified, you code to a closed fracture.

The **sternum**, commonly known as the breastbone, is a long, flat bone that forms the center part of the chest. The sternum consists of the manubrium, the body and the xiphoid process. The upper part of the manubrium joins with the inner ends of the two **clavicles** (collarbones). Attached to the sides of the manubrium and the body are the seven pairs of **costal** (rib) cartilages that join the sternum to the ribs.

Parts of the pelvis that might be fractured are the acetabulum, the pubis or other specified parts such as the ilium and the ischium. The **acetabulum** is the hip socket. The rounded, upper end of the femur, known as the head of the femur, fits into the acetabulum or hip socket.

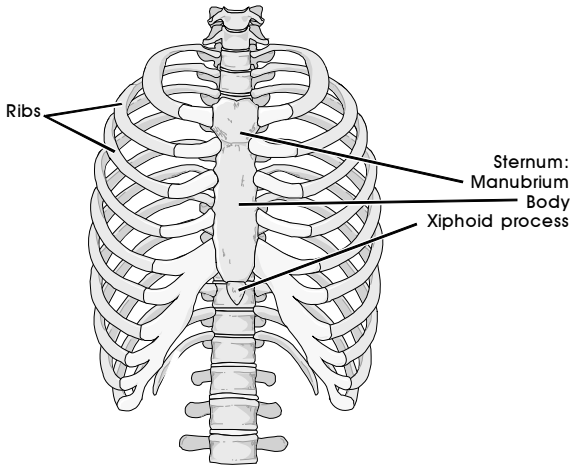


Figure 28-3: Anterior view of the rib cage

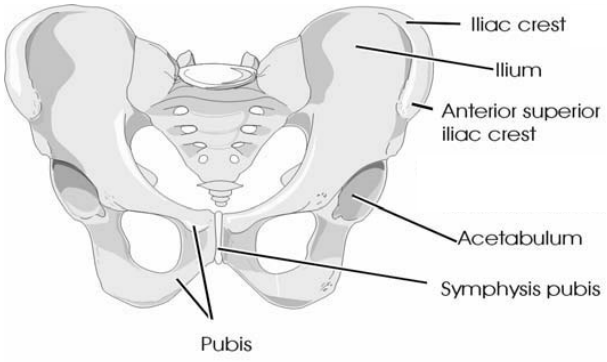


Figure 28-4: Anterior view of the pelvic bones

Fracture of Upper Limb (810-819)

The area of the upper limb includes the *clavicle*, *scapula*, *humerus*, *radius* and *ulna*. It also includes the *carpals, metacarpals* and *phalanges* of the hand. We will discuss each of these code groups briefly. As you review the details of each code group in the *Tabular List*, notice that the fifth-digit subclassifications throughout identify the specific anatomical site of each bone at which the fracture occurs. You will have lots of opportunity to review your anatomy terminology when you are coding for fractures of these bones of the upper limb! Let's begin by identifying the bones of the shoulder girdle and how you go about coding for fractures of this area.

Code category 810 contains codes for fractures of the **clavicle**, commonly referred to as the collar bone. The fifth-digit subclassifications identify the site of a fracture of the clavicle. The site might be unspecified; at the sternal end of the clavicle where the collar bone meets the breastbone; at the **shaft**, or long slender part of the clavicle; or at the **acromial end** of the clavicle, which is the highest point of the shoulder.

Fractures of the **scapula**, or shoulder blade, are listed in code category 811. This category also identifies the site of the fracture with a fifth-digit subclassification. The **acromion process** is the highest point and outer-most projection of the shoulder joint. It extends sideways from the **scapular spine**, which is the sharp ridge that runs across the back surface of the shoulder blade and forms the **acromioclavicular joint** with the clavicle. The **coracoid process** projects from the front surface of the upper border of the scapula. It can be felt between the **deltoid** and **pectoralis** major muscles, about an inch below the clavicle. The **glenoid cavity** or arm socket, forms a depression where the head of the humerus bone fits.

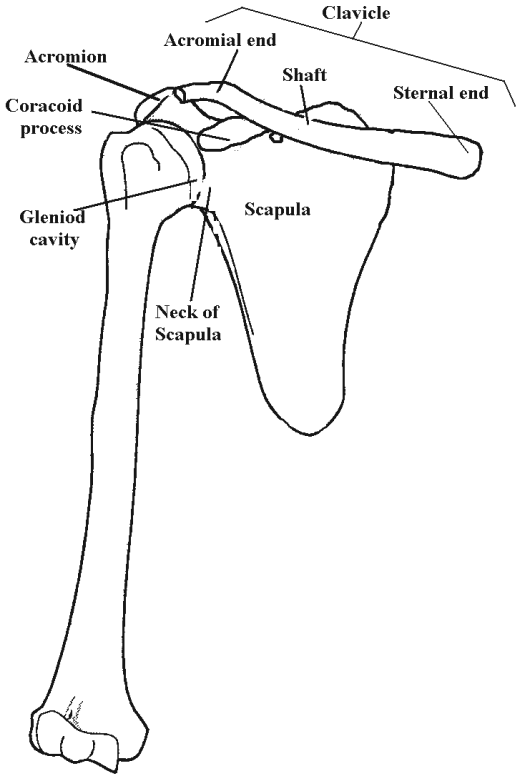
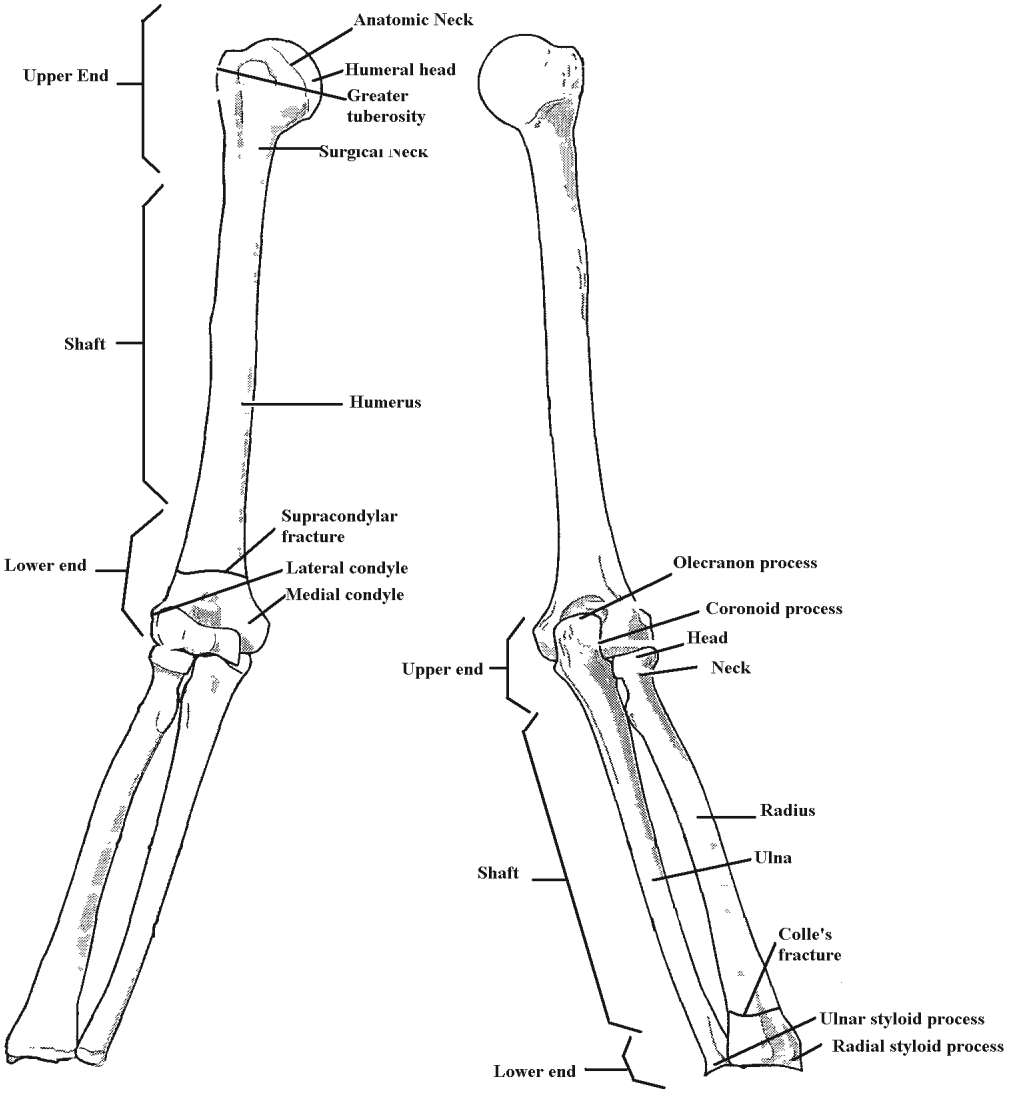


Figure 28-5: The shoulder girdle and upper limb

You will use code category 812 for fractures of the **humerus**, the bone that extends from the shoulder to the elbow. The fourth digit identifies the location of the fracture as the upper end, the shaft, which is the long slender part, or the lower end of the humerus. It also specifies whether the fracture is open or closed. The fifth-digit subclassification indicates the portion of the upper end, shaft or lower end of the humerus that was fractured.

Category 813 codes for fractures of the *forearm*. The **forearm** consists of the radius and the ulna. The **radius** is located on the outer or thumb side of the forearm, while the **ulna** is the inner and larger bone of the forearm. With the forearm, fractures can be of the radius alone, the ulna alone or the radius with the ulna. Again, the fourth digit identifies the fracture location as the upper end, shaft or lower end of the radius and ulna, and whether the fracture is open or closed. You must closely examine the fifth digit in this category because the fracture might be of the radius alone, the ulna alone or the radius with the ulna. **Monteggia's fracture** is sometimes called a parry fracture because it oftentimes occurs when the patient has tried to stop a punch or blow with their forearm. **Colles' fracture** is a break of the lower end of the radius, in which the lower fragment is displaced posteriorly or behind the radius. It is called a **reverse Colles' fracture** if the fragment is displaced anteriorly or in front of the radius. This type of fracture is most commonly found in people older than age 40 and usually results from a fall with the hand outstretched to break the fall.



Now that you have some of the basic terminology and coding details in mind for these groups of codes, it's time to try your hand again at coding a related diagnosis. Carefully read the following operative report and see what code or codes you come up with for the indicated diagnosis.

OPERATIVE INDICATIONS
This patient presents with an open Colles fracture of the left wrist following an automobile accident. The patient was a passenger in the vehicle that was struck by another vehicle. The patient attempted to brace herself against the dashboard with her left hand resulting in the fracture.

PREOPERATIVE DIAGNOSIS
Open Colles fracture, left wrist.

POSTOPERATIVE DIAGNOSIS
Same.

PROCEDURE PERFORMED
OPEN REDUCTION INTERNAL FIXATION LEFT COLLES FRACTURE WITH DEBRIDEMENT OF OPEN FRACTURE SITE.

PROCEDURE
After the attainment of adequate general anesthesia, the left upper extremity was prepped and draped. A skin marker was used to mark the appropriate location using the positioner on the forearm for the radius pins. The fracture and open wound were addressed. The wound required significant debridement of the skin and subcutaneous tissue prior to proceeding with the repair of the fracture.

After adequate debridement, the fracture was addressed. I was able to reduce the fracture to the appropriate anatomical position. Fixation was obtained using a modular hand 2-0 titanium plate with 6 cortices on either side of the fracture. Excellent stable fixation was obtained. Rotational alignment appeared to be satisfactory.

The wound was irrigated with normal saline and closed using 3-0 Vicryl and 4-0 nylon monofilament sutures. Sterile Xeroform 4 x 4 cast padding and ace bandage were used. The patient tolerated the procedure well and went to the recovery room in good condition.

After you've determined what you think is the correct code, compare the process you used and your results to the following summary. To code the postoperative diagnosis for this dictation, you must determine the problem. According to the notes, the patient has a Colles fracture. There are two routes for this code. First, open your *ICD-9-CM* manual to the *Index to Diseases* and follow the coding pathway *Fracture*, *Colles*, *open* for the tentative code of **813.51**. Now try using the coding pathway of *Colles fracture*, *open*. You find the same code! Now determine the highest level of specificity for the tentative code **813.51** in the *Tabular List*. Based on the information there, you can comfortably assign **813.51 Fracture of radius and ulna, Lower end, open, Colles fracture** for this scenario. Does that match your results? Great!

Next, we will discuss fractures of the **carpal** bone(s), or wrist, (code group 814); and of the **metacarpals** or the five bones of the hand that lie between the wrist and the *phalanges*; and the **phalanges** or fingers and thumb of the hand (code group 815). The fourth digit of each category identifies the fracture as open or closed. Each category also has a fifth-digit subclassification to identify the location of the fracture(s).

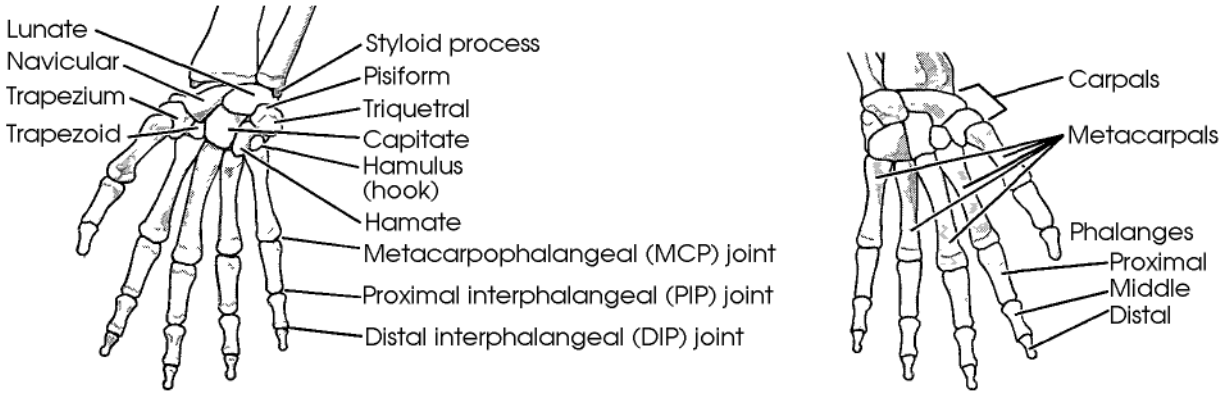


Figure 28-7: Bones of the hand and wrist

As noted at the beginning of this section on fractures, you will code fractures of multiple sites to each specific site at the level documented by the physician. If the documentation does not provide enough information to identify each specific site, you will code from the category that indicates multiple fractures. Code category 817 applies to multiple fractures of the hand bones, including the metacarpal bone(s) with the phalanges of the same hand. You will use code category 819 to code for multiple fractures that involve both of the upper limbs and an upper limb with the rib(s) and sternum. This group includes arm(s) with rib(s) or sternum, as well as any other bones of both arms.

Fracture of Lower Limb (820-829)

The lower limbs of the body include the *femur*, *tibia* and fibula, the ankle, the *tarsal* and *metatarsal* bones and the *phalanges* of the foot.

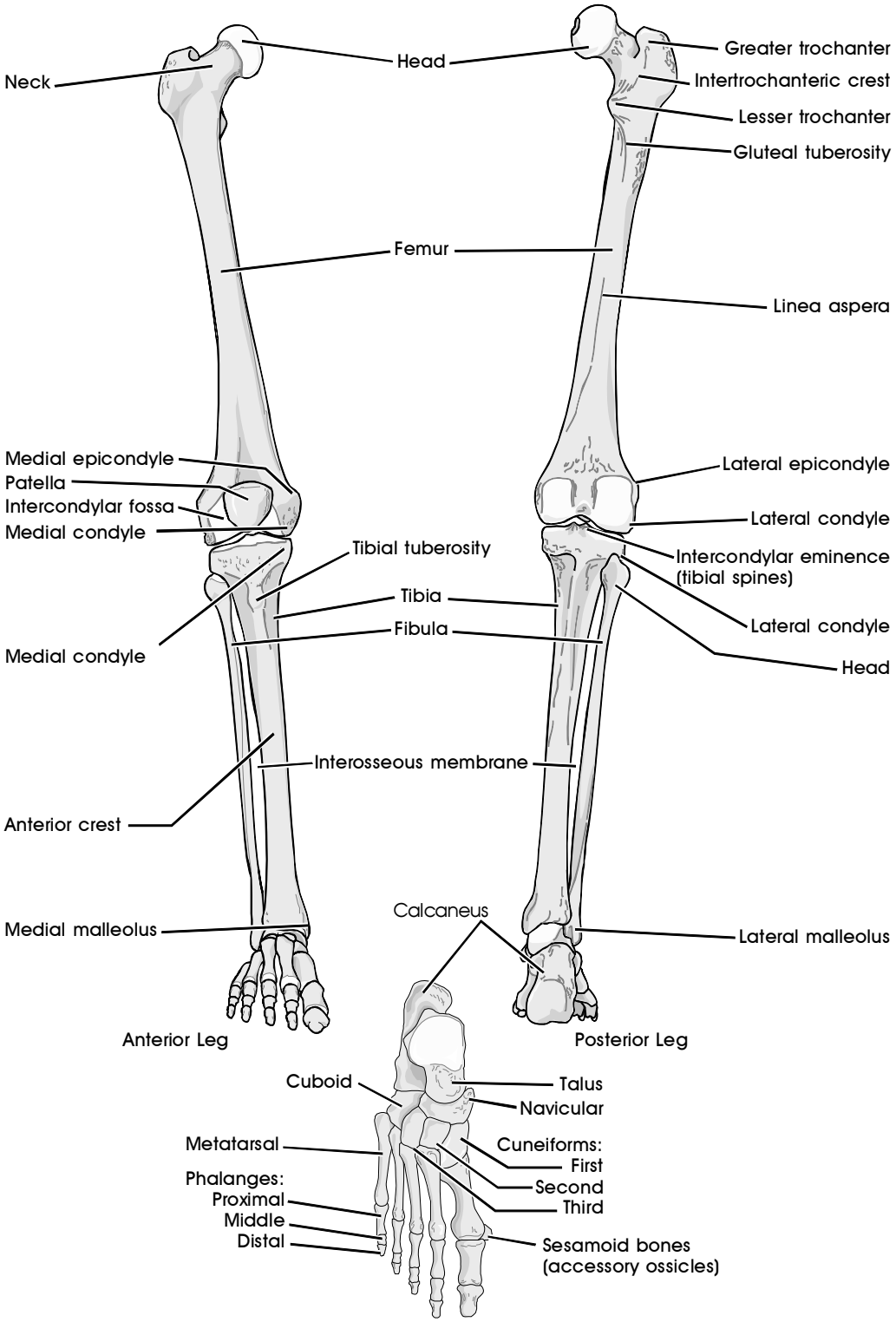


Figure 28-8: Dorsal ankle and foot

The **femur** is the long bone of the thigh that extends from the pelvis to the knee. The femur is the longest and largest bone in the body. Fractures of this bone are classified as fracture of the neck of the femur and fracture of other and unspecified parts of the femur. Conditions that relate to the neck of the femur are in code category 820 and are classified to the fourth digit, which identifies the fracture as *transcervical* or *pertrochanteric* and open or closed. A fracture through the neck of the femur is termed **transcervical**, where as **pertrochanteric** refers to a fracture of the femur that passes through the greater trochanter. Code category **821**, **Fractures of other and unspecified parts of the femur**, includes the shaft or unspecified part of the femur and the lower or distal end.

The **patella**, or knee cap, is the largest sesamoid bone in the body. This triangular bone is located at the front of the joint of the knee. Category 822 simply describes a fracture of the patella as opened or closed.

In medical terminology, the leg is the part of the lower extremity that extends from the knee to the ankle. The leg contains two bones, the tibia and the fibula. The **tibia** is the larger and weight-bearing bone in the leg. The fifth-digit subclassification of code category 823 identifies whether the fracture consists of the tibia alone, the fibula alone, or the fibula with the tibia. Again, the fourth digit identifies the upper end, shaft or unspecified part of the leg. It also describes the fracture as open or closed.

A fracture of the ankle, category 824, can be classified as medial or lateral malleolus, bimalleolar, trimalleolar or unspecified. If only "ankle fracture" is specified on the documentation you would code to **824.8 Fracture of ankle, Unspecified, closed**.

Code categories 825 and 826 consist of codes that pertain to tarsal and metatarsal bone fractures and fractures of one or more phalanges of the foot. There are seven **tarsal** bones, two of the largest are the **talus** and the **calcaneus**, or heel bone. The other tarsal bones are lined up in a row between the large tarsal bones and the metatarsals. These bones are the navicular, first, second and third cuneiforms and the cuboid. The **metatarsal** bones are five bones that form the arch of the foot. The **phalanges** of the toes are named like the phalanges of the fingers.

Now, look at code categories 828 and 829. Once again, you will find multiple fractures in these codes that involve both lower limbs, lower limb with upper limb and lower limb(s) with rib(s) and sternum. You are to use this category only when the specific bones are not documented. Otherwise, be sure to code each fracture separately.

Whew! That is quite a bit of information, and we have discussed much of the skeletal system in this section of the lesson, as well. As you continue with the lesson, you can refer to the graphics and descriptions of the skeletal system to help you understand dislocations, sprains and strains, superficial injuries, contusions, crushing injuries and burns. Next, we'll give you a basic overview of the subcategory of codes you will use for dislocations, from code 830 through 839.

Dislocation (830-839)

A separation of two bones in a joint so they no longer touch each other, usually caused by an injury, is called complete **displacement**. Displacement that leaves the bones in partial contact is called **subluxation**. Dislocation of a joint is usually accompanied by the tearing of the joint ligaments and damage to the membrane that encases the joint. This section EXCLUDES congenital dislocations (754.0-755.8), pathological dislocations (718.2) and recurrent dislocations (718.3). Dislocations can be described as "closed" or "open," and are identified as such by the fourth-digit subdivision. An opened dislocation is complicated by a wound opening from the surface down to the affected joint. When the joint is not penetrated by a wound, it is a closed dislocation.

An open dislocation might be identified by the following terms:

Compound	Infected	With foreign body

A closed dislocation might be identified by the following terms:

Complete	Dislocation NOS	Partial
Simple	Uncomplicated	

With your knowledge of the anatomy provided in the fracture section, understanding the various sites of dislocations should be fairly straightforward. Some terminology review, though, will help you to code accurately.

Anterior—in front of

Posterior—in back of

Inferior— below

Lateral—farther away from the middle

Medial—closer to the middle

Remember, the acromioclavicular joint is the joint between the acromial end of the clavicle and the medial margin of the acromion. Let's code a compound dislocation of the acromioclavicular joint. Begin in the *Index to Diseases* with the main term *Dislocation*. The subterm *acromioclavicular (joint)* suggests **831.04** as the tentative code. Reading closer, though, you will note that (closed) is indicated, and a compound dislocation is an open dislocation. So you need to continue in the *Index to Diseases* until you locate *Dislocation, acromioclavicular, open* and you note that **831.14** is the tentative code. The *Tabular List* will confirm that this code is at the highest level of specificity. So **831.14 Dislocation of shoulder, Open dislocation, acromioclavicular (joint)** is the correct code to assign for a compound dislocation of the acromioclavicular joint.

Moving on, we'll now take a look at the next subcategory of codes, ranging from 840 through 848. You will use these codes for diagnoses of sprains and strains of joints and the muscles adjacent to them.

Sprains and Strains of Joints and Adjacent Muscles (840-848)

In this section of codes, the joint capsule, ligament, muscle or tendon might be classified as an avulsion, hemarthrosis, laceration, rupture, sprain, strain or tear. The codes in this group EXCLUDES laceration of the tendon in open wounds, which you would code instead from categories 880 through 884 and 890 through 894. You will not find fifth-digit subclassifications in this category, and there are no open or closed distinctions. A good understanding of the body parts and of various ways strains and sprains might be described are key to coding accurately from this category.

Intracranial Injury, Excluding Those with Skull Fracture (850-854)

Previously, you studied intracranial hemorrhages and intracranial injuries associated with skull fractures. This section deals with intracranial injuries excluding those with skull fractures. Again, as you saw in the intracranial injuries associated with skull fractures, you will use the fifth-digit subclassification for categories 851 through 854 to identify whether there was an associated loss of consciousness and, if so, the length of the unconsciousness.

A **concussion**, in code category 850, is a significant blow to the head that might result in unconsciousness. This might be a mild concussion with a temporary loss of consciousness, or a severe concussion, with prolonged unconsciousness and inability to function properly. You will code a concussion with mental confusion or disorientation, without actual loss of consciousness, as **850.0 Concussion, With no loss of consciousness**. This section EXCLUDES a concussion with cerebral laceration or contusion (851.0-851.9), with a cerebral hemorrhage (852-853) and head injury NOS (959.01).

Remember learning about subarachnoid, subdural and extradural hemorrhages? The hemorrhages in this section are those that occur as a result of an injury rather than a cerebrovascular disease. Let's review the location of each hemorrhage type: The meninges are three layers of protective membranes that surround the brain and the spinal cord. The thick dura mater forms the outermost layer, followed by the arachnoid and the pia mater.

- The extradural is located outside the dura mater layer.
- The subdural is located between the dura mater and the arachnoid layer.
- The subarachnoid is located between the arachnoid and the pia mater layer.

Internal Injury of Thorax, Abdomen, and Pelvis (860-869)

This section lists many terms that INCLUDES notes to describe injuries of an internal organ. It consists of codes that relate to injuries of the heart, lungs, gastrointestinal tract, liver, spleen, kidneys, pelvic organs and intra-abdominal organs. Be sure to review and become familiar with these terms. As always, there is no need to memorize them. The fourth digit for these codes again identifies the injury with or without mention of an open wound. Those injuries that are mentioned with infection or a foreign body are also considered open wounds.

You will use code category 864 to code for an injury to the liver. This code group requires a fifth-digit subclassification to further describe the injury. Review the details of those fifth digits in the following box.

A **hematoma** is usually a clotted, localized collection of blood in the organ. It is caused by a break in the wall of a blood vessel. A **contusion** is a bruise or hemorrhage without a break in the skin. The involvement and disruption of the **parenchyma**, or the functional elements of the liver, if it is lacerated, can be classified as minor, moderate or major.

Codes for injury to the spleen and kidney also require a fifth-digit subclassification to further describe the extent of the injury. The term **capsule** refers to the fibrous tissue layer surrounding the organ, either the spleen or the kidney. The capsule can tear without disrupting the functional elements of the organ, or the tear can extend into the parenchyma.

The following fifth-digit subclassification is for use with category 864:

0 unspecified injury
1 hematoma and contusion
2 laceration, minor
Laceration involving capsule only, or without significant involvement of hepatic parenchyma [i.e., less than 1 cm deep]
3 laceration, moderate
Laceration involving parenchyma but without major disruption of parenchyma [i.e., less than 10 cm long and less than 3 cm deep]
4 laceration, major
Laceration with significant disruption of hepatic parenchyma [i.e., 10 cm long and 3 cm deep]
Multiple moderate lacerations, with or without hematoma
Stellate lacerations of liver
5 laceration, unspecified
9 other

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In case you haven't realized it, you're at the half-way point in this lesson, and it's time to stop for a review of the most recent material. When you feel comfortable that you understand this information, go ahead and complete the following Practice Exercise to see how much you remember. When you're done and have checked your work, you're ready to begin the second half of the lesson.

✍ Step 7 Practice Exercise 28-2

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Blow-out fracture of the orbital floor**
   ICD-9-CM code: _____

2. **Fracture of the C1-C4 with complete lesion of cord, paraplegia**
   ICD-9-CM code: _____

3. **Fracture of humerus at the lateral condyle, infected**
   (HINT: Review the section for descriptions of "closed" and "open" fractures)
   ICD-9-CM code: _____

4. **Displacement of lumbar vertebra due to major trauma**
   ICD-9-CM code: _____

5. **Traumatic rupture of the interphalangeal joint of the toe**
   ICD-9-CM code: _____

6. **Subarachnoid hemorrhage with open intracranial wound following a fall from a two-story building. Patient does not regain consciousness before death.**
   ICD-9-CM code: _____

7. **Anterior dislocation of the humerus with a fracture of the acromial end of the clavicle**
   ICD-9-CM code: _____
   ICD-9-CM code: _____

8. ICD-9-CM Coding Challenge

HISTORY OF PRESENT ILLNESS
The patient is an 88-year-old white female, household ambulator with a walker, who presents to the emergency department this morning after incidental fall at home. The patient states that she was on the ladder on Saturday, and she stepped down after the ladder and felt some pain in her left hip. Subsequently fell injuring her left shoulder. It is unclear how long she was on the floor. She was taken by EMS to hospital where she was noted radiographically to have a left proximal humerus fracture and a nondisplaced left hip fracture. Orthopedics was consulted. Given the nature of the injury and the unclear events, an extensive workup was performed including a head CT and CT of the abdomen, which identified no evidence of intracranial injury and renal calculi only. She presently is complaining of pain to the left shoulder.
She states she also has pain to the hip with motion of the leg. She denies any numbness or paresthesias. She states prior to this, she was relatively active within her home. She does care for her daughter who has MS. The patient denies any other injuries. Denies back pain.

PAST HISTORY
Medications: Presently: (1) Lipitor 20 mg daily. (2). Metoprolol 25 mg b.i.d. (3) Plavix 75 mg once a day. (4) Aspirin 325 mg. (5). Combivent aerosol 2 puffs twice a day. (6) Protonix 40 mg daily. (7) Fosamax 70 mg weekly. (8). Multivitamins including calcium and vitamin D. (9) Hydrocortisone. (10) Nitroglycerin. (11). Citalopram 20 mg daily.
Illnesses: Extensive including coronary artery disease, peripheral vascular disease, status post MI, history of COPD, diverticular disease, irritable bowel syndrome, GERD, PMR, depressive disorder, and hypertension.
Operations: Includes a repair of a right intertrochanteric femur fracture.
ALLERGIES: (1) PENICILLIN. (2) SULFA. (3) ACE INHIBITOR.
Social history: She denies alcohol or tobacco use. She is the caretaker for her daughter who is widowed and lives at home.
Family history: Not obtainable.

REVIEW OF SYSTEMS
Patient is hard of hearing. She also has vision problems. Denies headache syndrome. Presently, denies chest pain or shortness of breath. She denies abdominal pain. Presently, she has left hip pain and left shoulder pain. No urinary frequency or dysuria. No skin lesions. She does have swelling to both lower extremities for the last several weeks. She denies endocrinopathies. Psychiatric issues include chronic depression.

PHYSICAL EXAMINATION
GENERAL: The patient is alert and responsive.
EXTREMITIES: In the left upper extremity, there is moderate swelling and ecchymosis to the brachial compartment. She is diffusely tender over the proximal humerus. She is unable to actively elevate her arm due to pain. The neurovascular exam to the left upper extremity is otherwise intact with a 1+ radial pulse. She does have chronic degenerative change to the MP and IP joints of both hands. In the left lower extremity, the thigh compartment is supple. She has pain with log rolling tenderness over the greater trochanter. The patient has pain with any attempt at hip flexion passively or actively. The knee range of motion is between 5° and 60° with no point specific tenderness, no joint effusion, and an intact extensive mechanism. She has 2-3+ bilateral pitting edema pretibially and pedally. The patient has a weak motor response to the left lower extremity. She has a 1+ dorsalis pedis pulse. Her sensory examination is intact plantarly and dorsally on the foot.

DATABASE
Patient's H&H is 13 and 38.7, white blood cell count is 6.9, and there are 198,000 platelets. Electrolytes: Sodium 137, potassium 4.1, chloride 102. CO_2 is 27, BUN is 20, and creatinine 0.62. Urinalysis: The urine is clear yellow, 0-2 white cells, and no bacteria. Radiographs: Left shoulder series was performed which identifies a 3-part valgus-impacted left proximal humerus fracture with displacement of the greater tuberosity fragment, approximately 1 cm. There is no evidence of dislocation. There was an AP pelvis as well as left hip series, which identify a nondisplaced valgus-impacted type 1 femoral neck fracture. There is also evidence of severe degenerative disc disease with degenerative scoliosis of the LS spine. There is evidence of previous surgical repair of the right proximal femur with an intact intramedullary nail.

ASSESSMENT
This is an 88-year-old household ambulator with a walker, status post fall with injuries to left shoulder and left hip. The left shoulder fracture is a proximal humerus fracture, and the left hip is a nondisplaced femoral neck fracture.

PLAN
I have discussed this case with the emergency room physician as well as the patient. Patient should be admitted to medical service for medical clearance for surgery of her left hip, which will include a percutaneous screw fixation. Since the patient is on Plavix, I recommend that the Plavix be discontinued, and she should be placed on Lovenox 30 mg subcutaneous daily, which may be stopped 24 hours before the procedure. She will need cardiology clearance, which would include an echocardiogram in advance of the procedure. I have explained the nature of the injuries to the patient, the recommended surgical procedures, and the postoperative course and rehabilitation required thereafter. She presently understands and agrees with the plan.

ICD-9-CM code: _____

ICD-9-CM code: _____

Step 8 Review Practice Exercise 28-2

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 9 Injury and Poisoning (800-999) Part 2

- As you complete this second half of the lesson, continue to focus carefully on all the details provided in the notes and guidelines of the *ICD-9-CM* manual. Don't get discouraged if you find some information challenging (remember that your instructors are there to clarify things and help you succeed). Keep in mind that when you complete this lesson, you will be ready to apply all the knowledge and skills you have gained to the *ICD-9-CM* coding practicum in the next lesson!

Open Wound (870-897)

An **open wound** is simply a trauma to the body in which the tissues have direct exposure to the atmosphere. Terms used in this section of the *Tabular List* to describe an open wound INCLUDES animal bite, avulsion (ripping or tearing away of a part), cut, laceration, puncture wound and traumatic amputation. The codes in this section EXCLUDES any burn, crushing injury, puncture of internal organs, superficial injury and those conditions incidental to dislocation, fracture, internal injury and intracranial injury. You will code open wounds with mention of delayed healing, delayed treatment, foreign body or infection as "complicated." Finally, you are to use an additional code to identify an infection if it is specified in the documentation. Understanding both the alternative words that describe an open wound and when you are to code for "complicated" open wounds will help you in coding diagnoses that pertain to this rather fairly straightforward section, which is divided into the following three groups:

1. Open wound of head, neck and trunk (870-879)
2. Open wound of upper limb (880-887)
3. Open wound of lower limb (890-897)

With these guidelines in mind, go ahead and work up the coding diagnosis for the following wound repair.

SUBJECTIVE
Patient sustained a 1.2 cm forehead laceration resulting from a fall down the stairs at home.

OBJECTIVE
Patient seen in the emergency department presenting with a wound to the forehead and requested an evaluation. After examination of the forehead, no foreign body was noted. The laceration was approximately 1.2 cm in length. It was felt sutures would provide the best healing for this injury. Laceration was lavaged, anesthetized, and repaired with 6-0 nylon monofilament sutures. An antiseptic dressing was then applied.

ASSESSMENT
Simple repair of 1.2 cm forehead laceration.

PLAN
The patient is to see his family physician within 3 days.

What coding pathway did you decide to use? The most obvious is probably *Laceration, forehead*. What code do you find if you use that coding pathway? Nothing? Go back and look again at the beginning of the *Laceration* section to see what direction the notes provide. You are directed to "*see also Wound, open, by site*." When you try that coding pathway, *Wound, open*, *forehead*, the *Index to Diseases* suggests **873.42** as the tentative code. Turn to the *Tabular List* to confirm this suggestion and you'll find that **873.42 Other open wound of head, Face without mention of complication, Forehead** is the right choice. Did you get the correct code the first time? If so, that's great! If not, be sure you understand where you got off track before you go to the next section.

Injury to Blood Vessels (900-904)

Injuries whose codes are included in this section INCLUDES arterial hematoma, avulsion, cut, laceration, rupture and traumatic aneurysm or fistula of blood vessels. An injury included under these codes might be secondary to another injury, such as a fracture or an open wound. Injuries included in this section EXCLUDES accidental puncture or laceration of blood vessels during a medical procedure (998.2) and any intracranial hemorrhage following an injury (851.0-854.1).

Late Effects of Injuries, Poisonings, Toxic Effects, and Other External Causes (905-909)

As we've discussed before, late effects indicate a condition that may occur at any time after the acute injury. You will use the codes in this section to indicate conditions that are classifiable to codes from groups 800 through 999. For example, let's say a patient is being seen for an ulcer on his knee. He had a traumatic amputation from the knee down and is currently fitted with a prosthesis. The prosthesis is not fitting well, rubbing the knee, which resulted in an ulcer. The principal diagnosis is the ulcer on the knee. So to code this diagnosis, you will turn in the *Index to Diseases* to *Ulcer*, *knee*, where you are redirected to *see Ulcer, lower extremity*. Following the new pathway of *Ulcer, lower extremity, knee* provides you with **707.19** as the tentative code. You then will confirm from the *Tabular List* that **707.19** is correct. Now, the reason the patient has this ulcer is the ill-fitting prosthesis, which in turn exists as a result of the amputation. So the ulcer is a late effect of the amputation. In the *Index to Diseases*, locate *Late, effect(s) (of), amputation, traumatic*, where you will find a tentative code of **905.9**, which you then need to confirm in the *Tabular List* through the usual process. In summary, for this diagnosis, you will assign code **707.19 Ulcer of lower limbs, except decubitus, Ulcer of other part of lower limb**, and code **905.9 Late effects of musculoskeletal and connective tissue injuries, Late effect of traumatic amputation**.

Superficial Injury (910-919)

Damage inflicted on the body that pertains to or is situated near the body's surface is considered a **superficial injury**. An example of a superficial injury is a scratch. In fact, if you look up *Scratch* in the *Index to Diseases*, you are directed to see *Injury, superficial, by site*. Other terms used in the *ICD-9-CM* manual to describe a superficial injury include abrasion, blister, insect bite and superficial foreign body. The fourth-digit subcategory for the codes in this section identifies these descriptive injuries. A superficial injury EXCLUDES a burn or blister due to a burn; contusions; a foreign body that pertains to granuloma and that was inadvertently left in the operative wound, or is residual in soft tissue; a venomous insect bite; and an open wound with incidental foreign body. Superficial injuries are also categorized as with or without mention of infection. This section is further broken down into 10 categories. Be sure to always review the INCLUDES and EXCLUDES of a category to assist you in accurate coding.

Contusion with Intact Skin Surface (920-924)

A **contusion** might be identified as a bruise or a hematoma. This section contains codes for contusions without fracture or open wounds. The code categories are organized by site. These codes EXCLUDES concussion, hemarthrosis, internal organs and contusions that are incidental to other injury categories. When you code contusions, be sure you are familiar with the exclusions of this section.

Crushing Injury (925-929)

For the codes in this section, you are to use an additional code to identify any associated injuries, such as fractures, internal injuries and intracranial injuries. Again, these codes are categorized by anatomical sites.

For a coding example from this section, let's say a four-year-old boy was playing on the driveway, and his sister ran over his hand as she rode her bike. The injury was extensive enough to break two distal phalanx and crush two metacarpal bones. To code this injury, you will code the crushed hand as well as the broken fingers. Begin your code search in the *Index to Diseases* at the main term *Broken*. You will not find the subterm fingers. The problem is that the term broken is not considered a medical term. A broken bone is a fracture. So now turn to *Fracture*, and under that you will find the subterms *finger(s), of one hand*. You are directed to *see also Fracture, phalanx, phalanges, hand*. Following the alternative pathway of *Fracture, phalanx, hand, distal* provides the tentative code of **816.02**. You'll then confirm that code based on the information in the *Tabular List*.

Now let's turn to the crushing injury of the hand. The coding pathway of *Crush, hand, except for finger(s) alone (and wrist)* suggests the tentative code of **927.20**. Is that the correct code? Turn to the *Tabular List* to read the description for code **927.20**. The text indicates a crushing injury to the wrist and hands, except for the fingers alone. Only the fingers were broken, but the entire hand is indicated as crushed, so you do have the correct code. So to complete your coding for the injury documented in this scenario, you will assign code **816.02 Fracture of one or more phalanges of hand**, **Closed, distal phalanx or phalanges** and code **927.20 Crushing injury of upper limb, Wrist and hand(s), except finger(s) alone, Hand(s)**.

Effects of Foreign Body Entering Through Orifice (930-939)

For the codes in this section, a **foreign body** is anything in the body that has been introduced through its openings, such as when a person swallows an object not ordinarily eaten or swallowed. These codes EXCLUDES foreign bodies in open wounds or superficial injuries, residual in soft tissues and those inadvertently left in an operative wound. Site categories included within this section are the external eye, ear and nose. A foreign body might be inhaled into the trachea, bronchus and lung. A swallowed foreign body might be found anywhere in the body that is involved in the digestive tract, from the mouth to the bladder!

Burns (940-949)

The definition of the burns section INCLUDES scalding, chemical burns and burns from electrical heating appliances, electricity, flame, hot objects, lightning and radiation. It EXCLUDES friction burns and sunburns. You will assign codes from categories 940 through 949 for current unhealed burns. The first criterion for classifying burns is the anatomical site.

You cannot code burns using a single code. You code burns by site, by severity or degree of burn, and by the percent of total body surface burned.

You will assign codes from categories 940 through 949 for current unhealed burns. The first criteria, or *axis*, for classifying burns is the anatomical site. You should code burns individually to the greatest extent possible. For example, if the physician's report indicates a person has multiple burns and of varying degrees on different areas of the body, you will assign codes for each of the burns to the extent you can. Although there are codes that classify multiple burns, you should assign these codes only when the location of the burns is not documented.

For categories 941 through 946, the fourth digit designates the degree of the burn. First-degree burns are superficial burns involving only the epidermal layer of the skin. They are inflamed and painful, but they do not blister. Second-degree burns involve the dermal layer of the skin. These burns do include blisters, and they are also quite painful since the nerve endings are still intact. Third-degree burns are frequently called full-thickness burns. They go completely through the skin, which may appear charred and black or dry and white, depending on the burning agent. Third-degree burns are not usually painful, since the nerve endings have been severely damaged or destroyed.

As you code burns, you will classify them according to the highest degree recorded in the diagnostic statement. In other words, when you code, a third-degree burn takes precedence over a second-degree burn, and a second-degree burn takes precedence over a first-degree burn. For example, let's practice coding for the diagnosis of first- and second-degree burns of the upper arm. Turn to the main term *Burn* in the *Index to Diseases*. Next, find the site of the burn, which is *arm, upper*. The burns are indicated to be first- and second-degree burns, but you will code to the higher degree, so locate *second degree*. The tentative code of **943.23** will be confirmed when you check it out in the *Tabular List*. You will code **943.23 Burn of upper limb, except wrist and hand, Blisters, epidermal loss [second degree], upper arm** for this example. You will not code the first-degree burn because it is at the same site as the second-degree burn.

When burns are documented at more than one site, you first sequence the code for the site of the highest-degree burn, sequencing the additional codes for the other sites in descending order of degree. Say you have a patient with a first-degree burn of the forearm, with first- and second-degree burns of the upper arm. For the second-degree burn of the upper arm in the example above, you determined that 943.23 is the accurate code. Now, return to *Burn* in the *Index to Diseases*, and locate the subterms *forearm*, *first degree*. Code **943.11** is the tentative code provided. Turn to the *Tabular List* to confirm this code. You will sequence the highest degree burn first, so you will assign **943.23 Burn of upper limb, except wrist and hand, Blisters, epidermal loss [second degree], upper arm,** followed by **943.11 Burn of upper limb, except wrist and hand, Erythema [first degree], forearm**.

Category 948 is used to classify burns according to the extent of the body surface area involved. This code can be used by itself when the site of the burn is unspecified, or it is used in conjunction with a code from 940 to 947 to further describe the patient's condition.

Code 948 requires both a fourth digit and a fifth digit. The fourth digit specifies the total percent of the body surface burned at any degree. The fifth digit specifies the percent of the body surface with third-degree burns only. Code 948 could also be used for a patient who suffered first-degree burns to the chest wall and second-degree burns to the abdominal wall with 11 percent of the total body surface area burned. Along with codes **942.23** and **942.12** showing the site and degree, you may use **948.10** to show that 11 percent of the total surface area was burned, but none of the burns were third-degree burns.

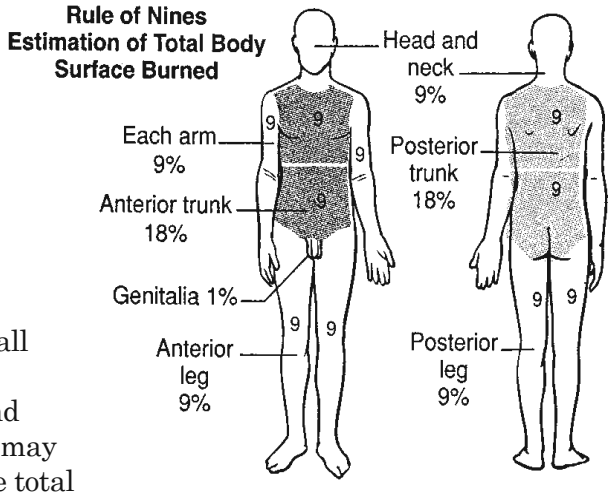

Figure 28-9: The rule of nines

The method used to estimate burned body surface in burn patients is called the **Rule of Nines**. The different areas of the body make up percentages: Head and neck 9%, each arm 9%, anterior leg 9%, posterior leg 9%, anterior trunk 18%, posterior trunk 18%, genitalia 1%. This rule applies to adults only and is not to be used for children. Consult the physician caring for the child before you assign burn percentages for children.

So let's build on our previous example with a diagnosis of first-degree burn of the forearm, with first- and second-degree burns of the upper arm and 4 percent of the total body surface area is documented as burned. You've already determined the first two codes to be **943.23** and **943.11**. For the third code, you'll return to the main term *Burn* in the *Index to Diseases*, and then locate the subterm *extent (percentage of body surface)*. The tentative code indicated for less than 10 percent of body surface is **948.0** ✓. You then turn to the *Tabular List* to determine the highest level of specificity. Remember that the fifth-digit subclassification pertains to third-degree burns, which these are not. So the correct percentage code is **948.00 Burns classified according to extent of body surface involved, Burn [any degree] involving less than 10 percent of body surface, less than 10 percent or unspecified (third-degree burn)**. You will record the final codes for this complete diagnosis as **943.23 943.11 948.00**.

Injury to Nerves and Spinal Cord (950-957)

This section INCLUDES codes for division of nerve, lesions in continuity, traumatic neuroma and traumatic transient paralysis that may occur with an open wound. These codes EXCLUDES accidental puncture or laceration during a medical procedure, which in that circumstance you are to code to 998.2 instead. Injuries to nerves include injuries to the optic nerve, cranial nerves, nerve roots and peripheral nerves. Spinal cord injuries are classified by site: cervical, dorsal or thoracic, lumbar, sacral, cauda equina, multiple or unspecified sites. Both the cervical and dorsal sites indicate the level of the spinal cord injury.

Certain Traumatic Complications and Unspecified Injuries (958-959)

Category 958 consists of codes for early complications of trauma. This code group EXCLUDES adult respiratory distress syndrome, flail chest, post-traumatic seroma, shock lung related to trauma and surgery and those that occur during or following medical procedures. These conditions include air and fat embolism, secondary and recurrent hemorrhage and traumatic shock.

You will use code category 959 only for unspecified injuries. If the documentation notes an injury of the ear but doesn't specify what type of injury, you will assign code 959.09.

Poisoning by Drugs, Medicinal, and Biological Substances (960-979)

Turn to the *Tabular List* to see what information is provided to help you accurately code the conditions included in this section. Poisonings listed in codes 960 through 979 INCLUDES an overdose of any drug, medicinal or biological substance and instances of the wrong substance given or taken in error. This section contains exclusions that you should review when you are coding any poisoning by drugs, medicinal and biological substances. Note, for example, that the section EXCLUDES adverse effects of any correct substance properly administered. In this case, only the code for the adverse effect and the E code are used—not the poisoning code.

The *Tabular List* also notes that you are to use an additional code to specify the effects of poisoning. Remember that at the beginning of this chapter, the *Tabular List* instructs you to use an E code to identify the cause and intent of the injury or poisoning. Although we put our discussion of the E codes that pertain to injuries on hold, we will be explaining the use of E codes in conjunction with the poisoning codes. Remember: E codes are a *Supplemental Classification of External Causes of Injury and Poisonings*. Finally, when you assign poisoning codes always sequence the poisoning code first, followed by the manifestation code, if noted, and then the E code.

The primary goal of this portion of the lesson is to learn to use the *Table of Drugs and Chemicals* accurately so you can find the correct code. Turn to the beginning of the *Table of Drugs and Chemicals, Section 2* of Volume 2. You are to use the codes contained in this section when the documentation includes a statement of poisoning, overdose, wrong substance given or taken or intoxication. The table headings that pertain to external causes are defined as follows:

- **Accidental poisoning**—accidental overdose of a drug, the wrong drug given or taken, or a drug unintentionally taken or administered. It is also used to show toxic external causes of substances that are mainly nonmedicinal.
- **Therapeutic use**—a correct substance properly administered but that results in an adverse effect.
- **Suicide attempt**—self-inflicted poisonings.
- **Assault**—poisoning inflicted by another person with intent to injure or kill.
- **Undetermined**—intent of the poisoning, whether intentional or accidental, cannot be determined.

Let's look at an example scenario and walk through the process of using the *Table of Drugs and Chemicals*.

SUBJECTIVE
A 15-year-old female is brought into the emergency department after accidentally taking an antihistamine drug. She is complaining of shortness of breath.

OBJECTIVE
The physician performs a detailed physical examination.

ASSESSMENT
Poisoning from the medicine, resulting in respiratory distress.

PLAN
Use pulse oximetry to maintain SaO2 at 96% via nasal cannula. Continuous blood pressure and pulse monitoring. Give patient 30 mL ipecac syrup followed by 200-300 mL of water. Repeat dose one time if vomiting does not occur in 20 minutes. Will reassess following treatment.

What is the problem? Respiratory distress. So you'll turn to the *Index to Diseases* and find the coding pathway *Distress*, *respiratory*. The tentative code of **786.09** is provided. Then, determine the highest level of specificity and confirm that this is the accurate code based on the information provided in the *Tabular List*.

Now you need to determine what drug is causing the respiratory distress. The documentation indicates it is an antihistamine. You'll find *Antihistamine* in the *Table of Drugs and Chemicals*. In the first column, you'll find the poisoning code **963.0**, and then you'll look across the columns until you find *Accident*. The corresponding code for antihistamine in the Accident column is **E858.1**. You can then confirm each of these codes in the *Tabular List*.

To accurately sequence the codes, you list the poisoning code first, followed by the manifestation and then the E code. You assign the codes as **963.0**, **786.09** and **E858.1** for this scenario. Did you follow the process and how to determine all three codes? If not, go back over the steps; then, if you still have questions, check with your instructor for clarification.

Toxic Effects of Substances Chiefly Nonmedicinal As to Source (980-989)

This section consists of codes for toxic effects that pertain to, are due to, or are of the nature of a poison or toxin from a substance that does not have a healing quality. Examples of such substances are mercury, mushrooms or asbestos poisonings.

Other and Unspecified Effects of External Causes (990-995)

Conditions you will find within this section of codes are frostbite, heat stroke, motion sickness, *adverse effects* not elsewhere classified and systemic inflammatory response syndrome.

An **adverse effect** of a drug is when it is correctly prescribed and properly administered but the patient suffers with a bad reaction. These adverse effects include tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure or respiratory failure. When you are coding an adverse effect to proper use of medication, you will sequence the adverse effect first, followed by the E code to identify the agent as a therapeutic use. You will not record the poisoning code.

Now it's your turn. Code and sequence the following scenario, and then compare your results to the summary that follows.

SUBJECTIVE
A 42-year-old male complaining of severe dizziness is seen by his family physician. He has been taking fluoxetine for the past 2 weeks as prescribed for his depression.

OBJECTIVE
A detailed physician examination is performed.

ASSESSMENT
The patient is having dizziness secondary to the fluoxetine hydrochloride.

PLAN
Patient is advised to discontinue use of the drug. Begin Xanax XR 0.5 mg once daily and call in 3 days for dosage increase if necessary.

To code this scenario, you will code the dizziness as the principal diagnosis and then the appropriate E code. Turn to the *Index to Diseases* and locate *Dizziness*, for which you are provided the tenative code of **780.4**. Using the *Tabular List*, determine the highest level of specificity for that code. Now turn in the *Table of Drugs and Chemicals*, and locate the drug *Fluoxetine hydrochloride*. Find the code provided in the *Therapeutic Use* column, which is **E939.0**. So you will assign codes **780.4 Dizziness and giddiness** and **E939.0 Antidepressants**, in that order, for this example.

The *ICD-9-CM* manual provides code **995.2 Unspecified adverse effect of drug, medicinal and biological substance** to identify an adverse reaction when the nature of the reaction is not specified. You will apply a final digit to identify the substance.

Also remember that when you assign poisoning codes, you always sequence the poisoning code first, followed by the manifestation code, such as *coma*, and then the appropriate E code.

Complications of Surgical and Medical Care, Not Elsewhere Classified (996-999)

As you will see when you look at this section of codes for surgical and medical complications, it EXCLUDES a number of conditions. Turn to the *Tabular List* to review the extensive list of exclusions to this section. If the complication can be classified elsewhere, you will not use the codes of this section. No time limit is defined for the development of a complication. The complication might occur during the hospital episode in which the care was provided, shortly thereafter or even years later. When the complication occurs during the episode in which the operation or other care was given, the complication code is assigned as a coexisting condition to the principal diagnosis. When the complication develops later and is the reason for the visit, the complication is designated as the principle diagnosis. Category 996 codes for any complication peculiar to certain specified procedures. These conditions pertain to a device, implant or graft of the cardiac, vascular, genitourinary, internal orthopedic nature; prosthetics; transplanted organs; or reattached extremity or body parts. You will use an additional code to identify the specified infections pertaining to internal prosthetics. For transplanted organs, identify the nature of the complication with an additional code.

Let's try coding a complication of a breast prosthesis due to a Staphylococcal aureus infection. In the *Index to Diseases* locate the coding pathway of *Complications, breast implant (prosthetic), infection or inflammation* and you will find the tentative code of **996.69**. Turn to the *Tabular List* to verify this code. The beginning of **996.6** directs you to use an additional code to identify the specified infection, which is the staphylococcus aureus. Now turn to *Infection, staphylococcal, aureus* in the *Index to Diseases*. The tentative code **041.11** would be confirmed in the *Tabular List* as well. Now you can assign **996.69 Infection and inflammation reaction due to internal prosthetic device, implant, graft, Due to other internal prosthetic device, implant or graft** and **041.11 Staphylococcal aureus** for this diagnosis.

Complications affecting specified body systems, not elsewhere classified, are coded from category 997. You are to use an additional code to identify the complications. The anatomical sites are provided, with inclusions, exclusions and additional notes to assist you in accurate coding.

Postoperative shock, accidental puncture during a procedure and postoperative infection are some conditions found in category 998. Category 999 includes codes for air embolisms, phlebitis and infections following an infusion, injection, transfusion or vaccination.

This concludes the first 17 chapters of the *Tabular List*. Let's pause to review what you've learned before wrapping up the ICD-9-CM lessons.

✍ Step 10 Practice Exercise 28-3

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Patient on bicycle crashed into the windshield of a parked car, resulting in traumatic enucleation of right eyeball and multiple lacerations of the forehead.**
   ICD-9-CM code: _____
   ICD-9-CM code: _____

2. **Laceration of the forearm, with tendon involvement**
   ICD-9-CM code: _____

3. **Compound femoral shaft fracture with femoral vein avulsion**
   ICD-9-CM code: _____
   ICD-9-CM code: _____

4. **Blister on heel of foot due to uncomfortable shoes**
   ICD-9-CM code: _____

5. **Black eye, fractured nose and multiple facial contusions**
   ICD-9-CM code: _____
   ICD-9-CM code: _____
   ICD-9-CM code: _____

6. **Compound fracture of the medial malleolus with crushing injury to the ankle**
   ICD-9-CM code: _____
   ICD-9-CM code: _____

7. **Patient presents with 1st and 2nd degree burns of the thigh, 2nd degree burns of the back, 13% of the body surface involved**
   ICD-9-CM code: _____
   ICD-9-CM code: _____
   ICD-9-CM code: _____

8. **Accidental barbiturate overdose**
   ICD-9-CM code: _____
   ICD-9-CM code: _____

9. **Swallowed nail polish remover as a suicide attempt**
   ICD-9-CM code: _____
   ICD-9-CM code: _____

Use the following information to complete the CMS-1500 that follows.

10. ICD-9-CM Coding/Billing Challenge

Eric Sulliman, MD
1000 Main Street
Yourtown, CO 80000
(970) 555-1717

Patient Information

Name Steven Gibbs **Date of Birth** 08-10-2000
Address 1343 Oval Street **Sex** M **Marital Status** single
City Windsor **State** CO
ZIP 80520
Home Phone 970-555-7643

Employment Information

Name of Employer
Address
City **State**
ZIP
Phone
Occupation
Student **Full time** X **Part-time** **If minor, name of school** Windsor Public Schools

Insurance Information

Primary Insurance
Name Mountain States
ID# 012-34-5678
Group# 420
Address 1801 SW Vine Street
City Denver
State CO **ZIP** 80217
Primary Insured Name Michael Gibbs
Relation to Patient father
DOB 2-11-1969
Employer Advanced Communications

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Michael Gibbs
Signature of patient (or parent of minor child)

Secondary Insurance
Name
ID#
Group#
Address
City
State **ZIP**
Secondary Insured Name
Relation to Patient
DOB
Employer

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Signature of patient (or parent of minor child)

Physician signature: *Eric Sulliman, MD*
SSN: 987-21-5432
NPI: 0377484809
Participating Provider for: All private insurance

Date of Service	9/10/20XX	
Diagnosis	**Procedure**	**Charge**
	99204 New Patient, Office Service	$88.00

Today's Charge	$88.00
Cash/Check	$0.00
Balance	$88.00

Name: Steven Gibbs
DOB: August 10, 2000
Date of Service: September 10, 20XX

CHIEF COMPLAINT
Burn, right arm.

HISTORY OF PRESENT ILLNESS
This patient had hot oil splashed onto his arm, burning from the elbow to the wrist on the medial aspect. He has had it cooled and presents with his father to the office as a new patient for care.

PAST HISTORY
Noncontributory.
Medications: None.
ALLERGIES: NONE.

PHYSICAL EXAMINATION
GENERAL: Well-developed, well-nourished male child who is appropriate and cooperative. His only injury is to the right upper extremity. There are 1st- and 2nd-degree burns on the right forearm, ranging from the elbow to the wrist. The 2nd-degree areas with blistering are scattered through the medial aspect of the forearm. There is no circumferential burn, and I see no areas of deeper burn. The patient moves his hands well. Pulses are good. Circulation to the hand is fine.

DISPOSITION
Home.

ASSESSMENT
There are 1st-degree and 2nd-degree burns, right arm, secondary to hot oil spill.

PLAN
The wound is cooled and cleansed with soaking in antiseptic solution. The patient was given Demerol 50 mg IM for pain. A burn dressing is applied with Neosporin ointment. The patient is given Tylenol No. 3, tabs #4, to take home with him and take 1 or 2 every 4 hours p.r.n. for pain. He is to return tomorrow for a dressing change. Tetanus immunization is up to date. Preprinted instructions are given.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid#) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH SEX M F

b. OTHER INSURED'S DATE OF BIRTH SEX M F

b. AUTO ACCIDENT? YES NO Place (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1.														NPI	
2.														NPI	
3.														NPI	
4.														NPI	
5.														NPI	
6.														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

a. b.

Step 11 Review Practice Exercise 28-3

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 12 Lesson Summary

- ❑ Congratulations—you've completed another lesson in your ICD-9-CM coding training, and the end of your introductory journey through the coding pathways of ICD-9-CM coding is in sight! As you are well aware, you've covered a tremendous amount of information. Whenever you use the *ICD-9-CM* manual, both during the remainder of this course and as you gain experience in your new profession as a medical coding and billing specialist, you will increase your understanding and coding skills along the way. Hopefully, though, you already have a solid sense of what's involved in coding medical conditions and diagnoses.

Step 13 Mail-in Quiz 28

- ❑ Follow the steps to complete the Quiz.

  a. Be sure you've mastered the instruction and the Practice Exercises that this Quiz covers.

  b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

  c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.

  d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your Quiz online.

  e. Mail the Answer Sheet to the school via mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 28

For questions 1 through 20, choose the best answer from the choices provided. Each item is worth 2.86 points.

1. **When you assign poisoning codes, how should you sequence the codes? _____**
   a. Manifestation code first, followed by the poisoning code, if noted, and then the E code.
   b. Poisoning code first, followed by the manifestation code, if noted, and then the E code.
   c. E code first, followed by the poisoning code, if noted, and then the manifestation code.
   d. Sequencing doesn't matter.

2. **Which is a true statement of septic shock? _____**
   a. If septic shock is documented, you will code first the initiating systemic infection or trauma, and then to code 995.92, followed by code, 785.52.
   b. Septic shock can occur only when severe sepsis is present.
   c. Septic shock is a serious, abnormal condition that usually affects the very old or the very young.
   d. All of the above

3. **You will code to a closed fracture when _____.**
   a. a fracture is not identified as open or closed
   b. a foreign body is identified
   c. infection is noted
   d. it is described as a puncture fracture

4. **Which is *not* part of the upper limb? _____**
   a. Carpals
   b. Radius and ulna
   c. Femur
   d. Collarbone

5. **A persistent fatigue, with symptoms of weak muscles, sore throat, tender lymph nodes, headaches, depression and mild fever is known as _____.**
   a. chronic fatigue syndrome
   b. febrile seizure
   c. malaise
   d. hypersomnia

6. When no other diagnosis code quite fits the condition identified in the physician's documentation, you will _____.

a. determine a code that is close to accurate

b. not code the medical record

c. code from Chapter 16, which contains symptoms, signs and ill-defined conditions

d. ask the physician to provide better documentation

7. A term used to describe an open wound INCLUDES _____.

a. laceration

b. superficial injury

c. burn

d. crushing injury

8. Which is *not* a true statement when coding burns? _____

a. Use the code for multiple burns any time more than one site is documented.

b. You should code burns individually to the greatest extent possible.

c. When burns are documented at more than one site, you first sequence the code for the site of the highest degree burn, sequencing the additional codes for the other sites. Code in descending order of degree.

d. You will classify burns according to the highest degree recorded in the diagnostic statement.

9. Which acronym does *not* accurately describe one of the four main quadrants for category 789? _____

a. LLQ Left Lower Quadrant

b. RUQ Right Upper Quadrant

c. LUQ Lower Upper Quadrant

d. RLQ Right Lower Quadrant

10. Code 786.51 codes for _____.

a. pleuritic chest pain

b. anterior chest wall pain

c. precordial pain

d. all of the above

11. Which of the following terms identifies an open fracture? _____

a. greenstick
b. with foreign body
c. impacted
d. depressed

12. A sensation of unsteadiness with a feeling of movement might be called _____.

a. dizziness
b. giddiness
c. light-headedness
d. all of the above

13. The _____ is the bone that extends from the shoulder to the elbow.

a. humerus
b. ulna
c. radius
d. forearm

14. The _____ consists of the manubrium, the body and the xiphoid process.

a. sternum
b. ribs
c. breast bone
d. both a and c

15. When coding clubbing of fingers as a symptom, you will assign code _____.

a. 736.29
b. 781.5
c. 754.89
d. none of the above

16. Displacement that leaves the bones in partial contact is called _____.

a. complete displacement
b. subluxation
c. dislocation
d. all of the above

17. A distortion of the sense of taste, or bad taste in the mouth, is termed _____.

a. parosmia
b. parageusia
c. anosmia
d. none of the above

18. Which is *not* a term used in the *ICD-9-CM* manual to describe a superficial injury? _____

a. Abrasion
b. Insect bite
c. Contusion
d. Superficial foreign body

19. A(n) _____ is defined as any evidence of a disease or disorder (such as pain) that is discovered.

a. symptom
b. unconfirmed diagnosis
c. uncertain conditions
d. none of the above

20. Which is *not* included in code category 788? _____

a. dysuria
b. urgency of urination
c. urinary incontinence
d. hematuria

For questions 21 through 35, choose the best diagnostic code(s) from the choices provided. Each item is worth 2.86 points.

21. Methadone poisoning, accidental _____

a. 965.02
b. 965.02 E850.1
c. 965.02 E980.0
d. E850.1

22. Bead in ear _____

a. 382.9
b. 931
c. 388.70
d. 930.8

23. Anterior dislocation of the elbow _____

a. 709.92
b. 832.00
c. 832.01
d. 832.11

24. Urinary incontinence _____

a. 788.32
b. 625.6
c. 788.31
d. 788.30

25. Adverse effect of allergic dermatitis due to insulin, therapeutic use _____

a. 693.0 E932.3
b. 692.9 962.3 E932.3
c. 693.0 962.3 E932.3
d. 692.9 E932.3

26. LUQ abdominal pain _____

a. 789.00
b. 789.02
c. 789.09
d. 789.04

27. Comminuted fracture of distal humerus _____

a. 812.40
b. 812.44
c. 812.20
d. 812.50

28. Coma due to acute barbiturate intoxication, attempted suicide _____

a. 967.0 E950.1
b. 967.0 780.01 E950.1
c. 780.01 E950.1
d. 967.0 780.01 E950

29. Laceration of external ear _____

a. 872.02
b. 872.69
c. 872.10
d. 872.00

30. Severe shock due to third-degree burns of the entire back. Eighteen percent of the total body surface is burned. _____

a. 942.34 958.4
b. 942.34 948.1 958.4
c. 942.34 948.11 958.4
d. 957.1 958.4

31. Febrile convulsions _____

a. 780.31
b. 780.39
c. 780.6 780.39
d. 780.6

32. Hypokalemia resulting from reaction to Diuril given by mistake in physician's office _____

a. 974.3 E858.5
b. 974.3 276.8 E858.5
c. 974.3 276.8
d. 276.8 E858.5

33. Patient presents with 1st and 2nd degree burns to thumb and two fingers. _____

a. 944.11 944.21 944.12 944.22
b. 944.21 944.22 948.00
c. 944.14 944.24 948.00
d. 944.24 948.00

34. Compound fracture of lower end of ulna _____

a. 813.53
b. 813.92
c. 813.43
d. 813.44

35. Emergency Department Report

PREOPERATIVE DIAGNOSIS
Multiple complex lacerations of the orbital region.

POSTOPERATIVE DIAGNOSIS
Multiple complex lacerations of the orbital region.

PRIMARY PROCEDURE
CLOSURE OF MULTIPLE COMPLEX LACERATIONS.

ANESTHESIA
Local 1% with epinephrine.

ESTIMATED BLOOD LOSS
Minimal.

SPECIMEN
None.

COMPLICATIONS
None.

BRIEF HISTORY
The patient is a 19-year-old Caucasian male who presented status post a bicycle versus MVA. The patient obtained multiple complex lacerations of the right orbital region.

PROCEDURE
Informed consent was properly obtained from the patient, and he was placed in a 45° angle. Topical viscous lidocaine was applied for pain management, and then 1% epinephrine was injected into the periorbital area for anesthetic effect. A #5-0 Vicryl suture was used to close the deep layers, and then #6-0 Prolene was used in interrupted fashion for superficial closure. The patient was instructed to take Keflex antibiotic for 10 days. He was also instructed and given prescription for erythromycin ophthalmic ointment to be applied to the periorbital areas t.i.d. The patient is to ice the area and to follow up in 1 week for suture removal. The patient tolerated the procedure well, and he was discharged from the emergency room in stable condition.

a. 918.9
b. 870.2
c. 921.9
d. 870.8

Congratulations!

You have completed Lesson 28.

Do not wait to receive the results of your Quiz before you move on.

Lesson 29

V Codes, E Codes and ICD-9-CM Coding Practicum

Step 1 Learning Objectives for Lesson 29

- When you have completed the instruction in this lesson, you will be trained to do the following:
  - Define and identify factors and conditions classified in the *ICD-9-CM's* V codes and E codes.
  - Identify the diagnoses, outline the coding pathway and assign the final code for conditions that require the use of V codes and E codes.
  - Review the steps for correct coding.
  - Review Outpatient Coding Tips for accurate coding.
  - Explain the sequencing guidelines.
  - Assign ICD-9-CM diagnostic codes for outpatient medical records.

Step 2 Lesson Preview

- Whew! You're probably relieved to have reached the last ICD-9-CM coding lesson! But just think about how much you've accomplished already. You're well on your way to becoming a medical coding and billing specialist. In this lesson you're going to get a quick review of all you've learned about diagnostic coding. Then you'll be ready to tackle your coding practicum.

  Before we get to that practicum, though, there's just a bit more we need to cover. We're going to discuss the V codes and E codes in your *ICD-9-CM* manual. As always, you'll learn when and how they're used. And you'll get some practice coding with them. You'll be a pro in no time!

  We want to remind you one more time that your instructor is available to help you. You'll want to make sure you have all your questions answered before you take your practicum. So don't hesitate to call your instructor. Now, let's get started with this lesson.

🕮 Step 3 Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01-V91)

- ❑ Turn in the *Coding Guidelines* in the front of your *ICD-9-CM* manual to *C18, Classification of Factors Influencing Health Status and Contact with Health Service* coding guidelines. As the guidelines indicate, there are four primary circumstances for the use of V codes. They are used for those not currently sick, those with a resolving disease, those with influencing factors to their health and for the birth status of newborns. You can use some V codes as primary or secondary diagnosis codes, while others can only be assigned as secondary diagnosis codes. Before we discuss the specifics of this chapter, following is a list of main terms that indicate the need for a V code:

Admission (encounter) for	Aftercare	Attention to
Boarder	Care (of)	Carrier
Checking (of)	Contact	Contraception, Contraceptive
Counseling	Dialysis	Donor
Examination	Fitting (of)	Follow-up
Health	Healthy	History
Maintenance	Maladjustment	Observation
Problem (with)	Prophylactic	Replacement by artificial or mechanical device or prosthesis of
Screening (for)	Status (post)	Supervision (of)
Test (s)	Transplant (ed)	Unavailability of medical facilities (at)
Vaccination		

Persons with Potential Health Hazards Related to Communicable Diseases (V01-V06)

You will use the codes in this section to code for persons who receive medical treatment as a result of their contact or exposure to various communicable diseases. This section is also used for vaccinations and inoculations individuals receive to protect against certain communicable diseases. Among the many communicable diseases that are included in these code groups are anthrax, cholera, the common cold, encephalitis, hepatitis, influenza, measles, plague, poliomyelitis, rabies, rubella, smallpox, tetanus, tuberculosis, typhoid, venereal diseases and other viral diseases. Vaccinations and inoculations also include those available for the diseases mentioned here and others.

Contact or Exposure

When a person has been exposed to a disease but does not show signs or symptoms of the disease, you will use code category V01. Assigning this code as a principal diagnosis indicates the need for testing. As a secondary diagnosis, code V01 identifies the potential risk for the person to contract the disease.

Take a look at the following SOAP note, and then practice coding the diagnosis. When you're done, compare your results to the summary that follows.

SUBJECTIVE
A 9-year-old male who presents with a fever is seen by the family doctor. The boy's sister was diagnosed with chickenpox last week.

OBJECTIVE
Physical exam reveals a low-grade fever. No rash.

ASSESSMENT
Fever. Rule out chickenpox.

PLAN
Patient will be sent for a blood test to verify whether the varicella-zoster virus is present.

Chickenpox is not confirmed at this time, so you cannot code it. You will code the fever and the fact that the patient has been exposed to the varicella virus. To do so, first locate *Fever* in the *Index to Diseases*, where you will find the tentative code of **780.60**. Be sure to verify that code in the *Tabular List*. Then turn to *Exposure,* in the *Index to Diseases*, and locate *to, varicella,* with a tentative code of **V01.71**. The *Tabular List* indicates that code **V01.71** is correct. You will assign **780.60 Fever** as the principal diagnosis because the fever is the reason for the visit, and **V01.71 Contact with or exposure to communicable diseases, Other viral diseases, Varicella** as the coexisting diagnosis and the reason for the blood test.

Inoculations and Vaccinations

You will assign codes from V03 through V06 when the patient is being seen for inoculations and vaccinations. When the vaccinations are given as part of the well baby visit, you can assign codes V03 through V06 as secondary codes to the well baby code.

Let's say a 68-year-old female is seen at the clinic for a flu (influenza) vaccination. To assign the ICD-9-CM code for this encounter, locate *Vaccination, prophylactic, influenza* with a tentative code of **V04.81**. Find this code in the *Tabular List*. The information there will confirm that **V04.81 Need for prophylactic vaccination and inoculation against certain viral diseases, Other viral diseases, Influenza** is the accurate code for this encounter.

Persons with Need for Isolation, Other Potential Health Hazards and Prophylactic Measures (V07-V09)

Prophylactic measures are tactics used to prevent a disease. In a previous lesson, in the "Certain Conditions Originating in the Perinatal Period" section, we discussed Rh isoimmunization. Remember that this is the situation in which the mother is Rh negative and the fetus is Rh positive, and the mother develops antibodies against the "foreign" blood of the fetus. When antibodies cross the placenta, they destroy the infant's red blood cells. Testing can be done to determine whether the Rh factor might be a problem in the pregnancy. Rh-immune globulin can be given to the mother at 28 weeks into the pregnancy to help prevent the destruction of the red blood cells in the fetus. This is an example of prophylactic immunotherapy, and will be coded V07.2.

Persons with Potential Health Hazards Related to Personal and Family History (V10-V19)

History codes are important because they might alter the type of treatment ordered. Applying a personal history code indicates that the condition no longer exists and the patient is no longer receiving treatment for that condition. The potential for recurrence or the development of other conditions still exists, and therefore the patient requires careful monitoring. Family history of certain conditions causes the patient to be at a higher risk for those conditions, as well. History codes can be assigned to any medical record regardless of the reason for the visit.

Persons Encountering Health Services in Circumstances Related to Reproduction and Development (V20-V29)

The following guidelines govern your selection of the principal diagnosis when the encounter is for obstetric care other than delivery:

- The principal diagnosis should correspond to the complication of the pregnancy that necessitated the admission or encounter. If more than one complication is present, all of which are treated or monitored, you can first sequence any of the complication codes.
- For routine prenatal visits when no complications are present, you will assign code V22.0 or V22.1 as the reason for the encounter.
- When the admission or encounter is for the care of a condition totally unrelated to the pregnancy, you will assign code V22.2 as an additional code.
- You can assign a code from category V23 either as the principal diagnosis or as an additional diagnosis when a pregnant patient is in a high-risk category.

- When a patient delivers *outside* of the hospital and is then admitted for routine postpartum care with no complications present, you will assign V24.0 as the principal diagnosis.

- If a patient encounter is for the purpose of prenatal screening for fetal abnormality, you will assign a code from category V28, with the fourth digit indicating the area of concern.

The codes for encounters for routine exams and general check-ups are found located within this section. Routine infant or child health check, coded to **V20.2 Routine infant or child health check**, includes developmental testing, immunizations and routine vision and hearing testing. When coding "well child care," you will use the coding pathway of *Examination*, *health (of), child*, *routine* to locate **V20.2**. When the vaccinations are given as part of the well-baby visit, you can assign codes V03 through V06 as secondary codes, but these codes are not required.

Routine infant or child health checks include developmental testing, immunizations and routine vision and hearing testing.

For example, an eight-month-old female is seen by her pediatrician for a well child exam and receives a DTaP vaccination. DTaP stands for diphtheria, tetanus toxoids and acellular pertussis. In this scenario, you will code **V20.2**, as determined above, for the well child examination. This is the only necessary code, but you can code for the vaccination as a secondary diagnosis. To do so, locate the coding pathway of *Vaccination*, *prophylactic, diphtheria*, *with tentanus*, *pertussis combined* in the *Index to Diseases*. DTaP is indicated in parentheses and the tentative code **V06.1** is provided.

Turn to the *Tabular List* to verify this code. You would assign **V20.2 Health supervision of infant or child, Routine infant or child health check** and **V06.1 Need for prophylactic vaccination and inoculation against combinations of diseases, Diphtheria-tetanus-pertussis, combined [DTP] [DTaP]** for this scenario.

Normal pregnancy can be classified as **V22.0 Supervision of normal first pregnancy**, **V22.1 Supervision of other normal pregnancy**, or **V22.2 Pregnant state, incidental**. You will use these codes for normal, routine, prenatal visits. These codes are usually the principal diagnosis.

Persons with a Condition Influencing Their Health Status (V40-V49)

A status code is important because the individual's health "status" might affect the course of treatment and its outcome. For instance, let's say a person complains of chest pain and her status is "postcoronary artery bypass graft" or post CABG. If you code only to the chest pain, that code does not provide the entire story. The fact that the person had the CABG indicates a previous problem with the heart. The current chest pain might be related to the CABG or the previous problems, but the conditions also might not be related. The physician may order additional tests or require a higher level of service because of the uncertainty. To code for this example, you will locate *Pain, chest* with a tentative code of **786.50** and *Status (post)*, *coronary artery bypass or shunt* with a tentative code of **V45.81**. To confirm these codes, be sure to determine the highest level of specificity in the *Tabular List* before you assign them.

Persons Encountering Health Services for Specific Procedures and Aftercare (V50-V59)

When the initial treatment of a disease or injury has been completed, but continued care is required during the healing or recovery time, aftercare V codes are assigned. These codes are generally the principal codes because the conditions they specify are the reason for the encounter. The code for a person seen to have a hearing aid fitted will be coded from this category. The coding pathway *Fitting*, *hearing aid* suggests the tentative code of **V53.2**. Turning to the *Tabular List* and reviewing the information there confirms that **V53.2 Fitting and adjustment of other device, Hearing aid** is the correct code.

You will use codes in category V59 for living individuals who are donating blood or other body tissue to others. This code group is not for self-donations. In other words, you do not use code V59 to identify cadaveric, or dead body, donations.

Persons Encountering Health Services in Other Circumstances (V60-V69)

You will find housing, household and economic circumstances are found in code category V60. These circumstances includes inadequate housing and lack of housing, to persons living alone. Counseling codes, which are a large portion of this section, have two classifications. First, you will use counseling codes to describe assistance in the aftermath of an illness or injury. Second, you will use them when support is required for individuals to cope with family or social problems. You can use these in conjunction with a diagnosis code but doing so is not necessary.

Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82)

Screening refers to testing for any number of disease indicators in seemingly well individuals, so that early detection and treatment can be provided for those who test positive. A routine mammogram, code **V76.12**, is an example of this type of screening. Code V76.12 is the principle diagnosis, and it indicates the reason for the screening is a routine mammogram. The diagnosis code V76.12 must be specific to that type of screening with the procedure documented. If a condition is discovered during the screening, you will then code that condition as an additional diagnosis. Testing to "rule out" or "confirm" a suspected diagnosis does not fall into the category of screening. When testing is documented for these purposes, you will code to the signs or symptoms of the unconfirmed diagnosis.

To help clarify these guidelines related to screening codes, review the following SOAP note and the explanation about how you would determine the correct codes.

SUBJECTIVE
This pleasant 54-year-old female, with a history of left mastectomy due to estrogen-sensitive breast cancer, was sent by her oncologist to have a fractional curettage. The patient states she has been on 20 mg tamoxifen once daily for the past 2 years. Her oncologist informed her that one of the side effects of tamoxifen is endometrial carcinoma and encouraged her to have this test done by her gynecologist.

OBJECTIVE
Blood pressure: 112/80. Pulse: 76, regular. Respiratory rate: 14. Temperature: 96.8 ºF. Lungs: Clear to P&A. Tissue sample was taken from the endometrial lining. Patient tolerated procedure well.

ASSESSMENT
Histological confirmation was negative for carcinoma.

PLAN
Continue tamoxifen as ordered. Return if any abnormal cramping or bleeding occurs.

When endometrial carcinoma is a possibility, either from a personal or family history, the physician can order fractional curettage. Because tamoxifen is taken to reduce the chances of the patient's breast cancer from reoccurring, and a side effect of this drug is endometrial carcinoma, a fractional curettage can be justified. You will use a V code to establish that the patient has a personal history of a malignant neoplasm.

For these SOAP notes, you will code the screening for the malignant neoplasm and the patient's personal history of breast cancer. The coding pathway for the screening is *Screening*, *malignant neoplasm*, *specified sites* with a tentative code of **V76.49**. The personal history coding pathway is *History of*, *malignant neoplasm*, *breast*, with a tentative code of **V10.3**. When you have verified the codes in the *Tabular List*, you will assign **V76.49 Special screening for malignant neoplasms, Other sites** and **V10.3 Personal history of malignant neoplasm, Breast** for this dictation.

The code categories not specifically highlighted in this section are fairly straightforward to code. Just use the *Index to Diseases* carefully and read the notes in the *Tabular List* before assigning a code.

It's time for a Practice Exercise to review and apply what you've learned in this portion of the lesson. It won't be long now until you have completed this introduction to ICD-9-CM coding and be ready to demonstrate your coding expertise in this area!

✍ Step 4 Practice Exercise 29-1

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Metastatic carcinoma to the brain, with a personal history of breast cancer**
   ICD-9-CM code: _____
   ICD-9-CM code: _____

2. **Chest pain, status postsurgical**
   ICD-9-CM code: _____
   ICD-9-CM code: _____

3. **Normal delivery of a single liveborn infant**
   ICD-9-CM code: _____
   ICD-9-CM code: _____

4. ICD-9-CM Coding Challenge

GYNECOLOGICAL CONSULTATION REPORT

REASON FOR REFERRAL
Patient referred for pelvic examination as part of routine physical before beginning diet and exercise program. The patient is 10 lb overweight, otherwise feeling fine.

PAST HISTORY
The patient does not smoke or drink. Usual childhood diseases. No serious illnesses. NO KNOWN DRUG ALLERGIES.
FAMILY HISTORY
Parents and four siblings alive and well. No family history of breast cancer or uterine cancer.

REVIEW OF SYSTEMS
GASTROINTESTINAL: Stools brown. No diarrhea or constipation. No nocturia or hematuria.
GYNECOLOGIC: Last regular menses two days ago. Sexually active. No birth control methods used. Breast tenderness, only premenstrual.

PHYSICAL EXAMINATION
GENERAL: This is a well-nourished, well-developed 26-year-old female in no acute distress. Alert and oriented. Pulse: 80/min. Blood Pressure: 100/80. Respiratory Rate: 20/min. Temperature: 98.6°F.
NECK: No thyromegaly.
CHEST: Clear to auscultation and percussion. Heart: Regular rate and rhythm. Normal heart tones. No murmurs. Breasts: Symmetrical. No masses or discharge.
ABDOMEN: Soft and slightly full in the suprapubic region. No masses or organomegaly palpated.
PELVIC: Normal perineum. Bimanual: Uterus nongravid, anteflexed, and anteverted. No enlargement, masses or fixation. No adnexal masses or fixation. Cervical smears obtained. No cervical erosions. No cul-de-sac fluid.
RECTAL: No blood on the examining glove. Stool guaiac negative.
DATABASE: CBC normal. Electrolytes: Na 138, K 4.3, Cl 97, pH 7.4. Pap smear results pending. Stool guaiac negative.

ASSESSMENT
Normal gynecologic examination.

PLAN
Call office in one week for results of Pap smear. Agree with diet plan.

ICD-9-CM code: _____

Step 5 Review Practice Exercise 29-1

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

🕮 Step 6 Supplementary Classification of External Causes of Injury and Poisonings (E000-E999)

- External causes, or E codes, identify environmental events, circumstances and conditions that relate to the cause of injury, poisoning and other adverse effects. We've explained the use of E codes in relation to poisoning. They are used to identify the cause as accidental, a suicide attempt, an assault or of undetermined intent. We've discussed adverse effects and how to code for the manifestation and identification of the therapeutic use of a drug. Now it's time to discuss the use of E codes in relation to injuries.

  E codes are supplemental to the diagnostic coding and are never to be used as principal diagnosis codes. You are not required to report these codes to the Centers for Medicare and Medicaid Services (CMS). E codes are intended to provide data for research and analysis for injury prevention. Some physicians do not report E codes unless the case is one of poisoning or of adverse effects or unless directed to by the principal diagnosis. You will want to verify with your provider whether you are to apply E codes in other instances. The rules that follow apply to those circumstances in which the provider requests coding of the external causes in all circumstances.

  - ➤ You might code the external cause with any diagnosis.
  - ➤ To indicate how and where the accident occurred, if that information is known, you will code the external cause with any diagnosis in the range of codes 800 through 999.
  - ➤ You are to assign as many E codes as necessary to fully describe each cause of injury.

  To locate the appropriate E code, you will use the *Index to External Causes of Injury and Poisonings (E code)*, which you will find in Section 3 of Volume 2 of the *ICD-9-CM* manual. This section comes just before the *Tabular List*. Using the index to E codes is similar to using the *Index of Diseases*; you will locate the main term, followed by the subterm. Once you have a tentative code, you will turn to the E codes in the *Tabular List* to verify its accuracy. Let's code an injury and include the external cause to give you some practice applying E codes.

SUBJECTIVE
A 10-year-old boy is seen in the physician's office with a right-ankle injury. He was injured 24 hours ago when he fell down steps at home.

OBJECTIVE
Ankle appears erythematous and swollen. It is tender to the touch. Patient walks with a hint of a limp. X-ray rules out fracture.

ASSESSMENT
Patient has an ankle sprain.

PLAN
Recommend ibuprofen as needed for pain.

For this scenario, you will code the diagnosis, as well as how and where the injury happened. First, the diagnosis is the sprained ankle. Using the coding pathway of *Sprain, strain, ankle*, you find the tentative code of **845.00** in the *Index to Diseases*. Confirm that code in the *Tabular List*. Now, turn to the *Index to External Causes of Injury and Poisonings (E Code*) located in Section 3 of Volume 2 to code the how and where of the injury. The sequencing of E codes does not matter as long as the injury is the primary ICD-9-CM. To code how the injury occurred, locate *Fall, falling, down, stairs, steps* and you are directed to see *Fall, from, stairs*. This pathway suggests code **E880.9**. Now, to code where the injury happened, you locate *Accident (to), occurring (at) (in), house (private) (residential)*. The tentative code provided for this pathway is **E849.0**. You'll then turn to the *Tabular List* to confirm these codes. You will assign the following sequence of codes for this scenario: **845.00 Sprains and strains of ankle and foot, Unspecified site**, **E880.9 Fall on or from stairs or steps, Other stairs or steps** and **E849.0 Place of occurrence, Home**.

Remember, you are to use E codes for injuries if the provider has requested that you do so. For your lessons in this course, you are not required to include E codes for injuries. If you would like to try your hand at using E codes to code external causes for codes 800 through 900 codes, that would be great practice for you. Just remember that in these circumstances you use E codes in addition to the required codes. Finally, you will include E codes for poisonings, adverse effects and when the *Tabular List* notes indicate that you are to identify the external cause.

Now it's time to review what you've just learned about E codes and complete the following Practice Exercise. Then you'll be ready to proceed to the review and Practicum.

✍ Step 7 Practice Exercise 29-2

❑ Determine the correct ICD-9-CM code(s) for the following conditions.

1. **Patient fell from a skateboard while at the park, resulting in a sprained wrist.**

   ICD-9-CM code: _____

   ICD-9-CM code: _____

   ICD-9-CM code: _____

2. **Passenger on railway suffers third-degree burns to front and back of both legs, involving 33% TBSA, due to railway explosion.**

   ICD-9-CM code: _____

   ICD-9-CM code: _____

   ICD-9-CM code: _____

3. **Two-car collision resulting in contusions of abdomen of passenger of second car**

   ICD-9-CM code: _____

   ICD-9-CM code: _____

4. **Fractured distal radius due to falling at home**

   ICD-9-CM code: _____

   ICD-9-CM code: _____

   ICD-9-CM code: _____

Step 8 Review Practice Exercise 29-2

- ❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 9 Practicum Preview

- ❑ Congratulations, you've made it through the entire *ICD-9-CM*! You now have the knowledge to be able to locate diagnostic codes. The past lessons contained an abundance of information pertaining to diseases. Not only did you learn about the diseases, but you are accustomed to the coding process as well! This material contains a variety of scenarios so that you will become familiar with coding situations. These scenarios give you real-life experiences coding the *ICD-9-CM* book from a physician's dictation. When you code for a physician, only the ICD-9-CM codes are recorded. You will not record "NEC," "NOS" or check marks. You will not write pathways or code descriptions. Only the ICD-9-CM code is necessary for diagnostic coding. This is the case for graded quizzes as well, unless indicated otherwise. Now, let's get started on this comprehensive material relative to the ICD-9-CM codes. Keep focused on the steps in coding. Remember the outpatient coding rules. Be sure you follow the sequencing guidelines provided. With these in mind, you'll be able to code accurately with confidence!

Step 10 Guidelines for Assigning Codes

- ❑ When you assign diagnostic codes to outpatient records, there are a few guidelines to consider as you code. The guidelines in this section will give you a checklist to review as you code. Familiarize yourself with these steps and keep them handy. Don't worry about memorizing them, you will soon know the guidelines well enough that you will only need to refer to them occasionally.

Steps for Assigning Diagnostic Codes

1. Identify the main terms in the diagnostic statement.
2. Locate each main term in the *Index to Diseases* and read any notes that appear with the main term.
3. Refer to any subterms indented under the main term in the *Index to Diseases*.
4. Look at abbreviations, cross-references, symbols and brackets.
5. Choose the tentative code you find in the *Index to Diseases,* Volume 2, then locate and determine the highest level of specificity in the *Tabular List*, Volume 1.
6. Read and use any instructional terms in the *Tabular List* as a guide. Look for INCLUDES and EXCLUDES, notes and other instructional comments at the beginning of each chapter. Also, look at the three-digit code at the beginning of each category or group of codes that you are using within the chapter and check for additional instructions for the group.
7. Assign codes to their highest level of specificity, using the following guidelines:
   - ➤ Assign three-digit codes only when there are no four-digit codes within that category.
   - ➤ Assign a four-digit code only when there is no fifth-digit subdivision for that subcategory.
   - ➤ Assign a fifth-digit to the code for any subcategory for which a fifth-digit subclassification is provided.
   - ➤ Remember to continue coding the dictation until all elements are fully identified before assigning the code.

Outpatient Coding Tips

- ➢ If it is not documented, it did not happen.
- ➢ Do not assume anything.
- ➢ Terms such as *possible*, *suspect*, *probable*, *rule out* or *consistent with* are not assigned codes.
- ➢ Code symptoms only when a definitive diagnosis is not documented.
- ➢ Check with the physician if the information is unclear.

Sequencing ICD-9-CM Codes

The principal diagnosis reflects the current and most significant reason the patient is seeking treatment when you code a physician's diagnosis of a patient. The ability to sequence the ICD-9-CM codes in the correct order is a learning process. A principal diagnosis is the condition that is responsible for the current episode of care.

Multiple Coding—Multiple coding means that two or more codes are necessary to fully describe the patient's condition. The *Tabular List* provides instructions for multiple coding. "Use additional code" and "code first underlying disease" indicate another code is necessary and the sequence in which the codes are to be written. Turn in the *Tabular List* to code 652. The notes direct you to "code first any associated obstruction." Which means code 660.0 is the principal diagnosis and the appropriate 652 code will be a coexisting condition.

Mandatory Codes—The slanted brackets in the ICD-9-CM indicate that you must use both codes and sequence them in the order listed. Let's use diabetic cataracts as an example. Locate *Diabetes, cataract* in the *Index to Diseases* and you are provided 250.5 ✓ *[*366.41*]*. You would list the codes **250.50** and **366.41** for this condition and sequence them in this order as well.

Combination Codes—When a single code describes conditions that frequently occur together, it is a combination code. An open wound of the finger with tendon involvement is coded with a single code of 883.2. Coding to the open wound of the finger and then coding tendon involvement as a separate code is not necessary.

Coexisting diagnosis codes should be related to the current episode of care. If the coexisting conditions have no bearing on the care of the principal diagnosis, they should not be coded. For example, a blind woman is diagnosed with a URI. Being blind has no impact on how the URI will be treated and is not coded as a coexisting condition.

Step 11 Practice Exercises 29-3, 29-4

- ❑ Read the following SOAP reports to assign the appropriate ICD-9-CM code(s) for each dictation. Record the diagnostic code in the space(s) provided.

Practice Exercise 29-3

SUBJECTIVE
Patient underwent exploratory laparotomy 3 days previously for bowel obstruction. There were 2 days of fever postoperatively. Today is the 3rd postoperative day.

OBJECTIVE
There is redness and swelling of the wound with pus emanating from around the suture material.

ASSESSMENT
Postoperative wound infection.

PLAN
Obtain culture of wound for E. coli. Open wound, debride with acetic acid and pack with W-70 dressings. Prescription for cephradine 500 mg 1 p.o. q.6 h.

_____

Practice Exercise 29-4

SUBJECTIVE
This is a 56-year-old female with a history of type 2 diabetes for the past 4 years and has been using insulin long-term. She has noticed decreased vision in both eyes for the past 1 year. She was seen in the eye clinic 2 weeks ago where fluorescein angiography revealed vitreous hemorrhages. The patient was scheduled for vitrectomy to extract the contents of the vitreous chamber.

OBJECTIVE
Ophthalmoscopy reveals proliferative retinopathy resulting in blood staining the vitreous humor. Tonometer reveals tension in both eyes is 14.

ASSESSMENT
Diabetic retinopathy.

PLAN
Vitrectomy. Maintain control of diabetes and blood pressure.

_____

_____

_____

Step 12 Review Practice Exercises 29-3, 29-4

- ❑ Check your answers with the Answer Key at the end of this book. Correct any mistakes you may have made.

Step 13 Practice Exercises 29-5, 29-6

- ❑ Read the following radiology reports to assign the appropriate ICD-9-CM code(s) for each dictation. Record the diagnostic code(s) in the space(s) provided.

Practice Exercise 29-5

TWO-VIEW CHEST X-RAY
No old films are available for comparison. Consolidation is present in the lower lobes bilaterally. A right-sided chest tube is present. There is a small amount of subcutaneous emphysema against the right chest wall. The most proximal portion of the chest tube lies within the margins of the rib cage.

IMPRESSION
1) Bilateral lower lobe pneumonia.
2) Right-sided chest tube. No significant pneumothorax is evident.

_____

Practice Exercise 29-6

LUMBAR SPINE MRI WITHOUT CONTRAST

HISTORY
Low back pain.

TECHNIQUE
Sagittal and axial proton density and T2-weighted sequences were obtained through the lumbar spine.

COMPARISON
April 30, 20XX plain film lumbar spine.

FINDINGS
Examination demonstrates normal alignment of the lumbar spine. The conus medullaris is located posterior to the L1 vertebral body. There is no evidence of abnormal signal within the lumbar vertebral bodies.

Disc spaces:
L1-L2: Unremarkable.

L2-L3: Unremarkable.

L3-L4: At this level, there is mild disc desiccation. There is a small left lateral disc protrusion. There is mild left neural foraminal stenosis. There is no significant right neural foraminal stenosis. There is no significant spinal stenosis.

L4-L5: At this level, there is minimal diffuse disc protrusion. This does not cause significant neural foraminal stenosis or spinal stenosis.

L5-S1: At this level, there is a small central disc protrusion. This does not cause significant neural foraminal stenosis or spinal stenosis.

IMPRESSION
Very mild lumbar spondylopathy. At the level of L3-L4, there is a left lateral disc protrusion.

_____

_____

Step 14 Review Practice Exercises 29-5, 29-6

- ❑ Check your answers with the Answer Key at the end of this book. Correct any mistakes you may have made.

✍ Step 15 Practice Exercises 29-7, 29-8, 29-9

- ❑ Read the following History and Physical Examination reports to assign the appropriate ICD-9-CM code(s) for each dictation. Record the diagnostic code in the space(s) provided.

Practice Exercise 29-7

ORTHOPEDIC CONSULTATION REPORT

REASON FOR REFERRAL
Continuous pain, right ankle and foot.

HISTORY OF PRESENT ILLNESS
This patient has severe arthritic destructive disease in the right subtalar joint. She cannot walk because of continuous pain in the ankle and foot. Any inversion or eversion causes immediate severe discomfort. The patient has had long-standing, severe osteoporosis and rheumatoid arthritis. In addition, she has been on long-term steroid therapy. The patient has spontaneously fractured ribs with delayed healing.

PAST HISTORY
Medications: Long-term corticosteroid therapy for rheumatoid arthritis. Currently, prednisone 40 mg daily p.o.
Illnesses: Rheumatoid arthritis, osteoporosis.
ALLERGIES: NO ALLERGIES TO FOOD OR MEDICATION.
Social history: The patient was employed as a plumber until the age of 50 when progressive arthritis limited her ability to continue working.
Family history: There is no family history of cancer, diabetes. A paternal uncle and a sister have RA.

REVIEW OF SYSTEMS
CARDIORESPIRATORY: Pleuritic pain and dyspnea and focal pain over the left 4th, 5th and 6th ribs began one week ago spontaneously. No history of trauma.

PHYSICAL EXAMINATION
GENERAL: This is a 65-year-old, 180-pound white female in moderate distress. Pulse: 100 and regular. Blood pressure: 140/110. Respiratory rate: 20, guarded. Temperature: 99.6 °F.
CHEST: There is pinpoint tenderness over the left 4th, 5th and 6th ribs in the left midaxillary line. Heart: PMI left midclavicular line. Regular rate and rhythm without murmurs. Lungs: Clear.
NEUROLOGIC: There is a decrease in sensation in the right ankle and foot. Cranial nerves 2-12 are intact.

DATABASE
A bone survey shows diffuse, widespread changes of rheumatoid arthritis with destruction of taloscaphoid axis and pronation of the right foot.

ASSESSMENT
1. Rheumatoid arthritis with severe destructive diseases of the subtalar joint, right ankle and foot.
2. Spontaneous pathologic fractures, left ribs 4-6.
3. Osteoporosis.

RECOMMENDATIONS
The severe pain and limitation of motion of right foot argues in favor of triple arthrodesis with bone graft from the right iliac crest to the right subtalar joint and transfer of the peroneal tendons of the right ankle. It is well known that the patient has severe osteoporosis and spontaneously fractured ribs. However, because of the severity of the destruction of the right ankle, arthrodesis is recommended at this time.

_____

_____

_____

_____

_____

Practice Exercise 29-8

CHIEF COMPLAINT
Follow-up on diabetes mellitus, status post cerebrovascular accident.

HISTORY OF PRESENT ILLNESS
This is a 70-year-old male who has no particular complaints other than he has discomfort on his right side. We have done EMG studies. He has noticed it since his stroke about 5 years ago. He has been to see a neurologist. We have tried different medications, and it just does not seem to help. He checks his blood sugars at home 2-3 x a day. He kind of adjusts his own insulin himself. Re-evaluation of symptoms is essentially negative.

PAST HISTORY
Habits: He has a past history of heavy tobacco and alcohol usage.
Medications: Refer to chart.
ALLERGIES: REFER TO CHART.

PHYSICAL EXAMINATION
GENERAL: A 70-year-old male who does not appear to be in acute distress but does look older than his stated age. He has some missing dentition.
VITAL SIGNS: Weight: 118 pounds. Pulse: 80 and regular. Blood pressure: 108/72. Temperature 96.5.
SKIN: Dry and flaky.
CHEST: Cardiovascular: Heart tones are okay, adequate carotid pulsations. He has 2+ pedal pulse on the left and 1+ on the right. Lungs: Diminished but clear.
ABDOMEN: Scaphoid.
RECTAL: His prostate check was normal.
NEUROLOGIC: Sensation with monofilament testing is better on the left than it is on the right.

IMPRESSION
1. Diabetes mellitus, type 2 with long-term insulin.
2. Neuropathy.
3. Late effects of cerebrovascular disease.

PLAN
Refill his medications x 3 months. We will check a BMP. I have talked to him several times about a colonoscopy, which he has refused, and so we have been doing stools for occult blood. We will check a PSA. Continue with yearly eye exams, foot exams, Accu-Cheks, and we will see him in 3 months and p.r.n.

_____

_____

_____

_____

Practice Exercise 29-9

EMERGENCY DEPARTMENT REPORT

HISTORY

CHIEF COMPLAINT
Pain and deformity of distal right forearm.

HISTORY OF PRESENT ILLNESS
The patient was in good health until today when he fell over a Doberman while walking down a sidewalk. He fell on his outstretched arm, resulting in severe pain and deformity of the distal right forearm.

PHYSICAL EXAMINATION
GENERAL: The patient appears in some distress with acute pain in the distal right forearm.

VITAL SIGNS: Pulse: 78/min. Blood pressure: 150/88. Temperature: Normal.
EXTREMITIES: There is palpable deformity over the distal radius with 1/5 opposition and strength in the right hand and 4+ swelling in the right wrist.

DATABASE
CBC and electrolytes are normal. X-ray confirms Colles fracture.

IMPRESSION
Colles fracture.

PLAN
Refer to orthopedic surgery clinic for reduction and immobilization. Right forearm sling and wrist immobilizer.

_____

Step 16 Review Practice Exercises 29-7, 29-8, 29-9

- ❑ Check your answers with the Answer Key at the end of this book. Correct any mistakes you may have made.

✍ Step 17 Practice Exercises 29-10, 29-11, 29-12

- ❑ Read the following Operative reports to assign the appropriate ICD-9-CM code(s) for each dictation. Record the diagnostic code(s) in the space(s) provided.

Practice Exercise 29-10

PREOPERATIVE DIAGNOSIS
Persistent leukocytosis of unknown etiology.

POSTOPERATIVE DIAGNOSIS
Same, pending pathology.

PRIMARY PROCEDURE
ASPIRATION OF BONE MARROW FROM RIGHT POSTERIOR ILIAC CREST.

PROCEDURE
The patient was placed in a prone position. The posterior iliac crest was palpated, and the biopsy site was marked. A 26-gauge needle was used to inject 1% lidocaine solution subcutaneously. A 22-gauge needle was then used to infiltrate the deeper tissues with lidocaine. A #11 scalpel blade was used to make a 2 mm skin incision of the biopsy site. The bone marrow biopsy needle was firmly seated on the periosteum, advanced through the outer table of bone and into the marrow cavity with rotating motion and gentle pressure. It was advanced 2 mm. The stylet was removed, and a 10 mL syringe was attached to the needle hub. A brisk withdrawal of the plunger resulted in 2 mL of marrow aspiration. The site was observed for any excess bleeding, cleaned thoroughly with alcohol, and a gauze patch secured the site. The patient was in satisfactory condition with no operative complications noted.

_____

Practice Exercise 29-11

PREOPERATIVE DIAGNOSIS
Hemorrhoids.

POSTOPERATIVE DIAGNOSIS
Thrombosed internal hemorrhoids.

PRIMARY PROCEDURE
HEMORRHOIDECTOMY.

PROCEDURE
The patient was taken to the operating room and placed in the prone position. A large internal hemorrhoid, which was significantly thrombosed, was palpated. After allowing adequate time for the anesthesia to take effect, the hemorrhoid was grasped with a clamp while another clamp was placed at the base of the hemorrhoid. The hemorrhoid was excised above the clamp, and a running stitch going in the opposite direction was looped over the clamp. The clamp was then removed, and the stitch was tightened. The area was dressed and packed with gauze. The patient tolerated the procedure well and was discharged to the postanesthesia care unit.

_____

Practice Exercise 29-12

PREOPERATIVE DIAGNOSIS
Medial and lateral meniscus tears, left knee.

POSTOPERATIVE DIAGNOSIS
Same.

PRIMARY PROCEDURE
ARTHROSCOPY WITH MEDIAL AND LATERAL MENISCECTOMIES, LEFT KNEE.

PROCEDURE
The patient was placed on the operating table in the supine position under general anesthesia, administered by the anesthesiologist. Arthroscopy was carried out beginning in the inferolateral portal.

After initial exploration, the medial compartment was explored. The arthroscopy exposed the meniscus which revealed a tear. The torn portion was removed with forceps.

Attention was then turned to the lateral compartment which also revealed a tear in the lateral meniscus. The torn portion was removed with forceps.

After completion of the meniscectomies, there were no other significant findings. Dressing was applied. The patient tolerated the procedure well and left the operating room in good condition.

_____

_____

Step 18 Review Practice Exercises 29-10, 29-11,29-12

- ❑ Check your answers with the Answer Key at the end of this book. Correct any mistakes you may have made.

Step 19 Lesson Summary

- ❑ Your diagnostic coding practice of health records is complete. If you are still feeling a little unsure of yourself, that's OK. As you review the Practice Exercise answers and compare them to your pathways, contact your instructor with any questions. The best way to determine why you didn't get to the correct code is to understand the pathway used. As you practice, you'll become faster and more proficient at coding. Now, let's move on to the comprehensive ICD-9-CM Quiz!

✉ Step 20 Mail-in Quiz 29

- ❑ Follows the steps to complete the Quiz.

  a. Be sure you've mastered the instructions and the Practice Exercises that this Quiz covers.

  b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

  c. When you've finished, transfer your answers to the Quiz Cover Sheet. Use only blue or black ink.

  d. **Important!** Please fill in all information requested on your Quiz Cover Sheet or when submitting your Quiz online.

  e. Submit your answers to the school via mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 29

Part 1 True or False

Circle to indicate if the statement is true or false. Each item is worth 0.5 points.

1. **A normal delivery is the spontaneous, full-term birth of one live baby, delivered vaginally, head first, with no fetal manipulation or instrumental assistance *except* for an episiotomy.**

   True

   False

2. **Category 717 includes codes for the internal derangement of the knee, which is the disturbance of the regular order or arrangement.**

   True

   False

3. **Peptic ulcers are not found in the esophagus, stomach or duodenum.**

   True

   False

4. **Spina bifida is always associated with an excess accumulation of spinal fluid within the ventricles, known as hydrocephalus.**

   True

   False

5. **Eczema is an acute or chronic inflammatory rash marked by itching and redness that is the result of cutaneous contact with a specific allergen or irritant.**

   True

   False

6. **A contusion is a bruise or hemorrhage with a break in the skin.**

   True

   False

7. **Once a patient has been coded 042, you must use 795.71 or V08 as a coexisting condition.**

   True

   False

8. **Septic shock can only occur when severe sepsis is present.**

   True

   False

9. **The peripheral nervous system consists of the nerves and ganglia outside the brain and spinal cord.**

   True

   False

10. **You are to use Chapter 11 codes only on the maternal record, never on the record of a newborn.**

    True

    False

Part 2 Multiple Choice

For the following questions, choose the best answer from the choices provided. Each item is worth 0.5 points.

11. **Infectious and parasitic diseases are generally caused by a(n) _____.**

    a. fungus

    b. virus

    c. animal parasite agent

    d. all of the above

12. Which is a correct statement regarding burns? _____

a. You should assign multiple burns codes even when the location of the burn is documented.

b. The site of the burn is indicated with the fourth digit.

c. Code burns individually to the greatest extent possible.

d. Sequence burns from the lowest to highest degree.

13. Which stage of pressure ulcers is identified by necrosis extending through the skin to the underlying muscle? _____

a. Stage II

b. Stage IV

c. Stage I

d. Stage III

14. Chapter 15 of the Tabular List contains codes that pertain to _____.

a. the mortality and morbidity of the mother

b. only the baby's records

c. only the mother's records

d. all of the above

15. Which is *not* a true statement of sepsis? _____

a. Septicemia is a form of sepsis.

b. Sepsis occurs when there is a breakdown of local defense barriers.

c. If the physician documents streptococcal sepsis, you will code 038.0 and 995.91.

d. Coding streptococcal sepsis requires only one code.

16. Which is a true statement of rheumatoid arthritis? _____

a. Onset may be abrupt with simultaneous inflammation in multiple joints or gradual, with progressive joint involvement.

b. RA is characterized by recurrent inflammation of the synovial joints and related structures.

c. It is a chronic systemic disease.

d. All of the above

17. Which is *not* a true statement of the vertebral column? _____

a. There are seven cervical vertebrae numbered C1 through C7.

b. There are 12 thoracic vertebrae numbered T1 through T12.

c. There are seven lumbar vertebrae numbered L1 through L7.

d. There are five fused sacral vertebrae numbered S1 through S5.

18. The term *in situ* _____.

a. describes tumor cells that are undergoing malignant changes but are still confined to the site of origin without invasion of surrounding normal tissue

b. can "classify by site certain histomorphologically well-defined neoplasms" whose subsequent behavior "cannot be predicted from the present appearance"

c. describes cells that do not invade adjacent structures or spread to distant sites, but they might displace or exert pressure on adjacent structures

d. describes the transfer of a disease from one organ or part to another organ or part not directly connected with it

19. *Mental, Behavioral and Neurodevelopmental Disorders* (290-319) focus on _____.

a. psychoses

b. neurotic, personality and other nonpsychotic mental disorders

c. intellectual disabilities

d. all of the above

20. Which is part of the upper limb? _____

a. Tibia

b. Clavicle

c. Femur

d. Fibula

21. Self-inflicted poisoning is classified as _____.

a. a suicide attempt

b. an accident

c. an assault

d. undetermined

22. _____ fractures are the result of the bone structure weakening by a pathological process, such as occurs with osteoporosis and neoplasms.

a. Stress

b. Traumatic

c. Pathological

d. All of the above

23. Intellectual disabilities can be classified as _____.

a. first degree, second degree or third degree

b. mild, moderate, severe, profound or unspecified

c. chronic or acute

d. first stage, second stage or third stage

24. Which is *not* a true statement of the nervous system? _____

a. The brain, spinal cord, nerves and ganglia comprise the nervous system.
b. It regulates almost every activity in the body.
c. The nervous system consists of the brain and spinal cord only.
d. The central and peripheral nervous systems comprise the nervous system.

25. Which condition is found in subcategory 744.2, *Other specified anomalies of the ear*? _____

a. Bat ear
b. Organ of Corti
c. Polyotia
d. Absence of external ear

26. An open fracture may be termed as _____.

a. comminuted
b. compound
c. greenstick
d. impacted

27. *Supplementary Classification of Factors Influencing Health Status and Contact with Health Services* (V codes) are used for _____.

a. sick people
b. those with a resolving disease
c. unconfirmed diagnoses
d. external causes

28. Which is *not* a true statement of acute rheumatic fever? _____

a. Rheumatic fever usually appears weeks after the person has experienced untreated or inadequately treated strep throat or scarlet fever.
b. Symptoms of rheumatic fever include fever, joint pain, lesions of the heart, abdominal pain, rash or nodules on the skin and chorea.
c. Rheumatic fever is a febrile disease mainly occuring in the elderly.
d. This condition could lead to rheumatic heart disease.

29. The *ICD-9-CM* presumes a cause-and-effect relationship between hypertension and chronic kidney disease, so you should begin with the three-digit code _____.

a. 403 Hypertensive chronic kidney disease
b. 404 Hypertensive heart and chronic kidney disease
c. 402 Hypertensive heart failure and 585 Chronic kidney disease
d. 401 Essential hypertension

30. Acute respiratory infections include _____.

a. the common cold
b. pneumonia
c. influenza
d. all of the above

31. Which is a true statement of pneumonia? _____

a. Bacterial pneumonia is treated with antibiotics.
b. Antibiotics will not be effective for viral pneumonia.
c. Determining a viral or bacterial cause for the pneumonia may be difficult, in which case antibiotics will be prescribed to treat the condition in case it *is* bacterial.
d. All of the above

32. _____ is an inflammation of the serous membrane of the lungs and the lining of the thoracic cavity.

a. Pleurisy
b. Empyema
c. Pneumothorax
d. Atelectasis

33. Gastric ulcers are those of the _____.

a. small intestine
b. esophagus
c. stomach
d. duodenum

34. Hernias "with obstruction" can be specified as _____.

a. incarcerated
b. strangulated
c. irreducible
d. all of the above

35. _____ is an inflammation of the tissue folds around the nail.

a. Felon
b. Paronychia
c. Onychia
d. None of the above

36. _____ is an inflammation of the urinary bladder.

a. A urinary tract infection
b. Cystitis
c. Pyelonephritis
d. Calculus

37. Which is *not* a true statement of the male reproductive system? _____

a. The reproductive duct system includes the epididymis, the ductus deferens and the urethra.
b. The accessory glands include the seminal vesicle, the prostate gland and the bulbourethral gland.
c. The external organs of the male reproductive system include the penis and the scrotum.
d. The only internal portions of the male reproductive system are the penis and the scrotum.

38. The leakage that might occur upon sneezing, laughing, coughing, sudden movement or lifting is termed _____.

a. stress incontinence
b. genital prolapse
c. endometriosis
d. none of the above

39. Codes V27.0 through V27.9 include _____.

a. an outcome of delivery code for the newborn's records
b. codes that are used on subsequent records for the mother when a delivery has occurred
c. an outcome of delivery code for every maternal record when a delivery has occurred
d. all of the above

40. Current medical conditions that did not exist before the pregnancy and more than likely will not exist after the pregnancy are termed _____.

a. gestational
b. temporary
c. transient
d. both a and c

Part 3 Diagnostic Coding

Read the following scenarios. Use your ICD-9-CM to assign the accurate diagnosis code(s). Verify final digits within the *Tabular List* and double-check your answers. Each code is worth 2 points.

41. Term birth, living male, cesarean delivery, with hemolytic disease due to ABO incompatibility. Code for the baby's record.

_____

_____

42. Type 2 diabetic polyneuropathy, without insulin use

_____

_____

43. Traumatic rupture of the abdominal aorta secondary to a cut in the anterior abdominal wall

_____

_____

44. Patient presents with 1st-degree burn of lower leg and 2nd-degree burns of left foot, estimated 7% of total body surface.

_____

_____

_____

45. Elderly primigravida, term delivery, spontaneous, of living female infant. Code for mother's records.

_____

_____

46. Severe sunburn of face, neck and shoulders

_____

47. Syncope due to adverse effect of the prescribed dosage of antidepressant medication

_____

_____

48. Normal, full-term female, spontaneous delivery at the hospital, with congenital left hip subluxation. Code for baby's records.

_____

_____

49. Anemia due to blood loss from chronic gastric ulcer

_____

_____

50. Accessory fifth digit, right foot

_____

51. Pneumonia due to fungus

_____

_____

52. Benign prostatic hypertrophy with urinary retention and incontinence

_____

_____

_____

53. Severe manic depressive disorder, recurrent manic episode

_____

54. Unintentional overdose of sleeping pills

_____

_____

55. Polyneuropathy in sarcoidosis

_____

_____

56. Premature delivery, frank breech presentation, single female liveborn. Code mother's record.

_____

_____

_____

57. Bone atrophy due to infection

_____

58. BURN CLINIC SCENARIO

SUBJECTIVE
A 25-year-old presents to the wound care clinic for care for burns to his left forearm. The burn was sustained 1 week ago after he spilled boiling water at home. This is a 2nd-degree burn of the left forearm with the TBSA being 1.5%.

OBJECTIVE
Patient is here today for a dressing change. The existing dressing is removed, and the wound is examined. The wound appears to be healing nicely with new granulation in the wound. The wound is gently cleaned, and new sterile dressings are applied.

ASSESSMENT
A 2nd-degree forearm burn with TBSA of 1.5%.

PLAN
No anesthesia was used during today's visit, and the patient tolerated the procedure with little pain. He is to return to the clinic in one week for additional treatment and evaluation.

_____

_____

_____

59. EMERGENCY ROOM SCENARIO

HISTORY OF PRESENT ILLNESS
The patient is a 20-year-old female with an 8-year history of IV heroin abuse. On the day of admission, she appeared in the emergency department complaining of shortness of breath, chills and fever.

PHYSICAL EXAMINATION
Blood pressure: 94/50. Pulse: 160. Respirations: 52 and labored with bilateral rhonchi. Temperature: 100.8ºF. Numerous petechiae on the lower extremity were noted. Jugular venous distention was noted. The GI exam showed a tender liver.

DATABASE
EKG showed a right axis deviation and sinus tachycardia. The chest x-ray showed multiple pulmonary opacities with a right upper lobe cavitation. Platelets 9000, hemoglobin 9.1, hematocrit was 27.9, WBCs 10,000.

IMPRESSION
Due to progressive respiratory failure, the patient was intubated prior to admission. The patient was diagnosed with acute renal failure and was placed in the ICU. The patient also has bacterial endocarditis due to a staphylococcal infection and was started on triple antibiotics.

_____

_____

_____

_____

Medical Coding and Billing Specialist
Mail-in Quiz 29

1. Fill in your **student ID** and your **course code** below.

STUDENT ID NUMBER _____ COURSE CODE _____

2. Be sure your **name** and **address** are filled in below.
3. **Transfer your answers** to this cover sheet.

For School Use Only:
Grade: _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

U.S. Career Institute
2001 Lowe Street
Fort Collins, CO 80525

CD-2

This Space for Instructor Use

Fold on dotted line

Part 1 True or False

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Part 2 Multiple Choice

11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
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Part 3 Diagnostic Coding

41. _____

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42. _____

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43. _____

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59. _____

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Congratulations!

You have completed Lesson 29.

Do not wait to receive the results of your Quiz before you move on.

Lesson 30

The Future of Health Care

Step 1 Learning Objectives for Lesson 30

- When you have completed the instruction in this lesson, you will be trained to do the following:
  - Discuss important trends in the electronic health record.
  - Differentiate between encoders and autocoding.
  - Summarize the pros and cons of electronic coding.
  - Explain key concerns with remote coding.

Step 2 Lesson Preview

- From experimental drugs and cutting-edge procedures to computers and the Internet, health care is changing. From the operating room to the front office, every level of medicine is undergoing a revolution. Why? What's driving this change? Technology! Technology is rewriting not only the rules of what is necessary, but what is possible.

  In this lesson, you'll look at how technology is shaping the future of health care. We'll focus on trends in electronic health records and examine what they mean for the medical coding and billing specialist. You'll learn about new and upcoming coding tools, such as encoders and computer-assisted coding. You'll also learn about the possibility of working from home with Web-based coding.

  Coding, billing and health care are changing. Understanding those changes will help prepare you for success in the years to come.

Step 3 Technology and Health Care: Today

- The goal of medicine is quality patient care. The backbone of patient care is health information management. Transcriptionists, coders, billers and administrators keep the gears of our health system spinning. Without them, providers wouldn't get paid; medical files couldn't be located; and the system would back up like a traffic jam.

Without health information management, the system would back up like a traffic jam.

Healthcare professionals, like yourself, are the unsung heroes of health care. They make sure the provider has the medical record when she's examining the patient. They make sure the patient doesn't overpay for services, supplies and advice. They keep an eye out to make sure the diagnosis, the procedure and the bill all match. All in all, they manage the massive amount of information needed by the healthcare industry.

In the past, a medical record was a thick paper file containing notes on all of the patient's visits.

In the past, a medical record was a thick paper file containing notes on all of your visits. Hospitals and physician offices maintained hundreds and thousands of these files which took up a lot of space and time. More importantly, files at one hospital could not easily be shared with another hospital. This was not only a matter of distance. Different providers often used different record formats and filing systems. When the healthcare industry was smaller, this was not a big deal. But now, with health care booming, patients, providers, insurance companies and the government all realize the drawbacks of the old paper system.

The healthcare industry is in the middle of a major shift. On one front they are slowly converting from paper medical files to electronic health records. Top to bottom they are learning to use computers in health information management.

Health information exchange (**HIE**) is the transmission of healthcare-related data among facilities, health information organizations and government agencies according to national standards.[1] The goal of HIE is to provide safe, timely, efficient and effective access to and retrieval of patient information for providers.

The Institute of Medicine (IOM) originally created the term *CPR* (*computer-based patient record*) to describe the computerized version of a medical record. The IOM defined the **CPR** as "an electronic patient record that resides in a system specifically designed to support users by providing accessibility to complete and accurate data," with other uses, as well (IOM, 1997).

In 2003, the IOM report established eight core functions that a computer-based patient record should be capable of performing.[2]

1. **Health Information and Data**. The IOM determined that the electronic health record should contain the same items that are found in the paper chart, including problem lists, medications and test results. In addition, the IOM further stated that it should be a well designed interface to enable the provider to review the information efficiently.

2. **Result Management**. This function refers to accessing information easily when and where it is needed. The focus should be on availability, convenience, reliability and ease of use. The provider should be able to access lab or x-ray results any time and from anywhere.

   For example, Bonnie had severe pain in the bottom side of her heel for the past two days. The pain is localized to a single location. After exam, the provider has an x-ray taken to rule out a fracture or tumor. Bonnie has the x-ray taken onsite and returns to the exam room. Her provider returns and pulls the image up on her computer. The provider determines there is no sign of a fracture or mass, but suspects a bone spur is causing the pain. Bonnie is provided symptomatic care and is advised that a radiologist will review the x-ray as well, so she'll be called the next day to confirm the diagnosis.

   In this case, the electronic health record allowed the provider to import the x-ray. However, the level of access should be considered as well. For instance, the dietitian and pharmacist do not require the same level of access to a patient record.

3. **Order Management**. Computerized entry and storage of data on all medications, tests and other services is an important function of a computer-based patient record. **Computerized provider order entry** (**CPOE**) refers to any system in which clinicians directly enter medication orders (and, increasingly, tests and procedures) into a computer system, which then transmits the order directly to the pharmacy.[3] The advantages of CPOE include standardized, legible and complete orders, which will reduce medical errors.

4. **Decision Support**. This function of the electronic health record will alert providers and patients to vaccines, screenings and or preventative measures. In addition, it provides warnings and reminders to assist providers in making the decision in patient care. Decision support can aid in: drug interactions/prescriptions/prevention, detection of disease outbreaks, evidence-based guidelines, etc.[4]

5. **Electronic Communications and Connectivity**. This function focuses on patient safety and quality of care. It allows multiple providers in multiple setting to communicate and coordinate care.

6. **Patient Support**. Studies have found that home monitoring and educational materials are directly related to improving the control of a chronic illness, such as diabetes.

7. **Administrative Processes**. Providing better, timelier services to patients also helps the efficiency of a healthcare organization. Electronic health records also assist with billing and claims management. The provider can immediately validate insurance eligibility, as well as obtain authorizations. This function results in more timely payments and less paperwork.
8. **Reporting and Population Health Management**. Computer-based patient records provide a standardized system for reporting requirements for safety and quality that are necessary for state, federal and local entities.

🕮 Step 4 Electronic Health Records

❑ When the IOM suggested the key functions in 2003, it also established the term electronic health record for this format. Let's look at the alternative terms and requirements of an electronic health record.

Electronic medical record, or **EMR**, is another description that is widely used for this type of record. In hospital or office settings, EMR often refers to entire systems that are based on document imaging, or electronic document management systems as a whole. However, a more accurate term for the actual electronic record is **electronic health record**, or **EHR**. The health information management field generally recognizes the distinction between EMR and EHR as the degree of interoperability that each offers. For our purposes, an EHR is defined as follows, according to the Health Information Technology for Economic and Clinical Health (HITECH) component of the American Recovery and Reinvestment Act (ARRA) of 2009:

A **qualified EHR** "includes patient demographics and clinical health information, and has the capacity to provide clinical decision support; support physician order entry; capture and query information relevant to health care quality; and exchange electronic health information with and integrate such information from other sources."[5]

Certified EHR technology "gives assurance to purchasers and other users that an EHR system or module offers the necessary technological capability, functionality and security to help them meet the *meaningful use* criteria. Certification also helps providers and patients be confident that the electronic health IT products and systems they use are secure, can maintain data confidentially and can work with other systems to share information."[6]

Meaningful use generally describes the ability to demonstrate quality improvement through the use of EHRs. However, HITECH identifies three base requirements for meaningful use:

- ➤ Use of certified or qualified EHR technology.
- ➤ Electronic exchange of health information.
- ➤ Use of EHR in reporting on clinical and other quality measures.[7]

The Certified Commission for Health Information Technology (CCHIT) is recognized by the U.S. Department of Health and Human Services as the entity to certify that EHRs support meaningful use.

To ensure meaningful use, data comparability standards are necessary. Data comparability standards make certain the meaning of a term is consistent across all users. Standard vocabulary helps achieve data comparability. Until recently, the specific vendor that developed the EHR software established most vocabularies. However, HITECH requirements demand the use of *controlled vocabulary* to allow for electronic exchange of health information. **Controlled vocabulary** means that a specific set of terms in the EHR's data dictionary must be used.

Providers may use different terms that mean the same thing. For instance, one provider may document a *heart attack*, while another indicates an *MI*, and still another notes a *myocardial infarction*. While these terms mean the same thing to a cardiologist, they are entirely different to a computer. Without standard terminology, it's difficult to gather and retrieve information for research. Controlled vocabulary allows users to index, store and retrieve information from an EHR.

The National Committee on Vital and Health Statistics (NCVHS) was asked to recommend a national standard for vocabulary use in an EHR. The NCVHS recommended that the federal government use the following "core set" of terminologies:[8]

- SNOMED CT—Systematized Nomenclature of Medicine - Clinical Terms
- LOINC—Logical Observation Identifiers Names and Codes
- RxNorm—federal drug terminologies

SNOMED CT presents data in a completely machine-readable format. While the ICD coding database was designed for billing and reimbursement, SNOMED CT is meant to organize the contents of a medical record to capture, encode and use data for clinical care of patients and research. Due to the controlled vocabulary, SNOMED CT can increase quality of care because it allows more accurate descriptions of a patient's medical issues in words physicians understand and doesn't cross into the administrative interpretations of diagnosis codes that are more familiar to coding staff.[9]

Health Level Seven (**HL7**) develops specifications for electronic healthcare information. HL7's mission is to increase the effectiveness and efficiency of healthcare information.

HL7 standards identify types of errors and corrections in an electronic medical record. HL7 has created computer messages to communicate corrections to different computer systems. Let's take a look at a couple of scenarios:

1. To create an addendum: Author dictates additional information as an addendum to a previously transcribed document. A new document is transcribed. This addendum has its own unique document ID that is linked to the original document via the parent ID. Addendum document notification is transmitted. This creates a composite document.

2. To correct errors that were discovered in the original health document that haven't been made available for patient care: Errors, which need to be corrected are discovered in a document. The original document is edited, and an edit notification is sent.[10]

One variation of the EHR is the **personal health record** (**PHR**), which is medical information that the patient maintains. The PHR puts control in the consumer's hands. Instead of being a tool for the provider, the health record will become a tool for the patient. In the future, people will have more responsibility for their own well-being. Insurance companies are not the only ones pushing for a shift from doctor as repairman to doctor as coach. Many people see the benefits of healthy living and preventative medicine. The fitness and nutrition industry is growing. So is interest in alternative medicines such as acupuncture and chiropractics. Knowledge is power. Taking personal responsibility for your own health is the first step in the fight against death, disease and aging. Personal health records will be valuable weapons in this fight.

Now, you'll learn about different types of Internet connections and networks.

🕮 Step 5 Access the Internet and the Web from a Computer

❑ OK, you have a computer and a Web browser; you're viewing Web sites left and right. But how exactly does it happen that these Web pages appear in your browser?

The Internet does not exist in one location. It exists in shared locations between hundreds of millions of computers, servers and networks. For example, Erik in Denmark may publish the photographs he took on his recent trip to Thailand. Xing Mao in China may publish statistics on the ratios of female and male children that families in the United States adopt. And Gabriela in Chile may publish a daily **blog** (short for **Web log**, which is like an online diary) that describes her life in South America, including sales information for the handmade products from her alpaca, sheep and goat farm.

So where is all of this information? Well, remember that each of these Web pages is published on the World Wide Web, which exists on the Internet. You, Erik, Xing Mao and Gabriela can view these Web pages—and all the others that people everywhere write—anytime you want, as long as you have access to the Internet.

Before you learn about the computer network, let's look at the language of the Internet. Many know that **HTML** (**Hypertext Markup Language**) was designed to display data and is the most widely used language for Web-based documents. A document using HTML contains embedded tags that provide guidance to HTML viewers (usually called Web browsers) as to how to display the document and connect it to other documents.[10] HTML has its advantages and disadvantages:

Advantages	Disadvantages
Linkability—data is hyperlinked, letting you move from one site to another	Intelligibility—limited in how well data knows itself
Simplicity—it's easy to learn and to display	Adaptability—limited in data changes in response to environmental changes
Portability—it's portable over networks, operating systems and languages	Maintainability—limited in ease of data maintenance

Basically, the HTML format is not interoperable, which means that data cannot be shared across organizations. EHRs don't just "contain" or transmit information, they also compute with it—for example, a qualified EHR will not merely contain a record of a patient's medications or allergies, it will also automatically check for problems whenever a new medication is prescribed and alert the clinician to potential conflicts. HTLM is unable to compute. **XML** (**Extensible Markup Language**) was designed to overcome this limitation, which improves the functionality of the Web by letting you identify your information in a more accurate, flexible and adaptable way. XML is the language of EHRs.

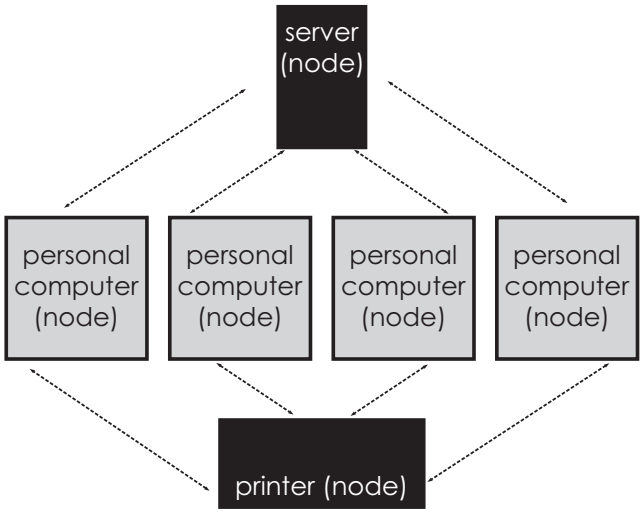
The Computer Network

To access the information on the Internet, your computer must be part of a network. A network is a system of computers and/or servers, printers and databases that communications lines connect. All computers, servers, printers or databases connected to one network are called nodes. All nodes have the means to share information and communicate with one another.

Types of Networks

Networks exist so that different computers can rely on one another to perform functions like storing, sending and retrieving information.

Network Diagram



To access the information on the Internet, your computer must be part of a network.

There are four basic types of computer networks.

1. **Client/Server Network**—One or more computers (called clients) are connected to one another and to a central computer or mainframe (called a server). We'll talk about servers in more detail in a moment, but first, let's look at an example of a client/server network.

   A manufacturing plant in Michigan makes engines for hybrid vehicles. All of the conveyer belts that move the engines throughout the plant are connected to a central computer. Based on signals from other, smaller computers at different workstations, the central computer knows how fast or how slow to run the conveyer belts. It even knows when to turn the conveyer belts off if there is an emergency or a breakdown in one area of the plant. These computers are on a client/server network.

2. **Peer-to-Peer Network**—Two or more computers are connected to one another and share information without the presence of a server.

   Let's say that Cody and Ben are college roommates, and both young men use Mac Book laptops with iTunes and iPods. Cody has a great collection of more than four thousand listening hours of Classic Rock, Pop and Indie Rock music, while Ben has a substantial amount of rare Jazz and Blues recordings. They've decided to set up a peer-to-peer network so they can easily share music files without violating copyright laws.

3. **LAN Network**—LAN stands for **local area network**. Such a network consists of one or more computers in a home or office that are connected to one another and a server. They are a self-contained network with a gateway or link to the Internet. Let's study an example.

   Martin is a freelance graphic designer and avid photographer who runs his own business from the comforts of his home office. Martin uses three printers, a copier, a laptop computer and a large desktop computer with a huge flat screen monitor for his work. Meanwhile, his wife owns a laptop, and his daughters share a desktop computer and printer in their bedroom. Martin and his family's computers all have Internet access, and they are connected to one server (and one back up server) that he keeps in the basement. This arrangement is an example of a LAN.

4. **WAN Network**—WAN stands for **wide area network**. Such a network consists of two or more LANs in several different buildings that are connected to one another.

   An example of a WAN might be an international broadcasting company that has offices in the United States, Canada, Panama, Brazil, Great Britain, Germany, France, Spain, Poland, Saudi Arabia, Sri Lanka, South Korea, the Philippines and New Zealand. Each of these offices contain multiple LANs, but the LANs are connected into a larger WAN to facilitate faster e-mail communication and to share full access to photographic images and video footage database files.

Servers

A **server** is a data resource that other computers access for information. Some people call a server a **host computer**, and that analogy works well when you think about the functions a server performs. For example, when you host a party, you make introductions among your guests. You refill the drinks, make important announcements and manage the music or overall atmosphere at the party. A server operates in much the same way. Since the server is a host to the computers attached to its network, the server relays information, transfers files, delivers programs and awaits and fulfills the requests of its client computers.

Step 6 Electronic Coding

- **Electronic coding** uses computers to speed up the coding process. As technology develops, more and more computers will be used in coding. While this may alter some of your responsibilities, it is important to know everything you're learning in this course. With more computers helping in the health information department, medical coding and billing specialists will act more as editors to the computer's coding.

  There are several different levels of electronic coding: *encoder programs*, *computer-assisted coding* and *NLP autocoding*. Let's take a look at each.

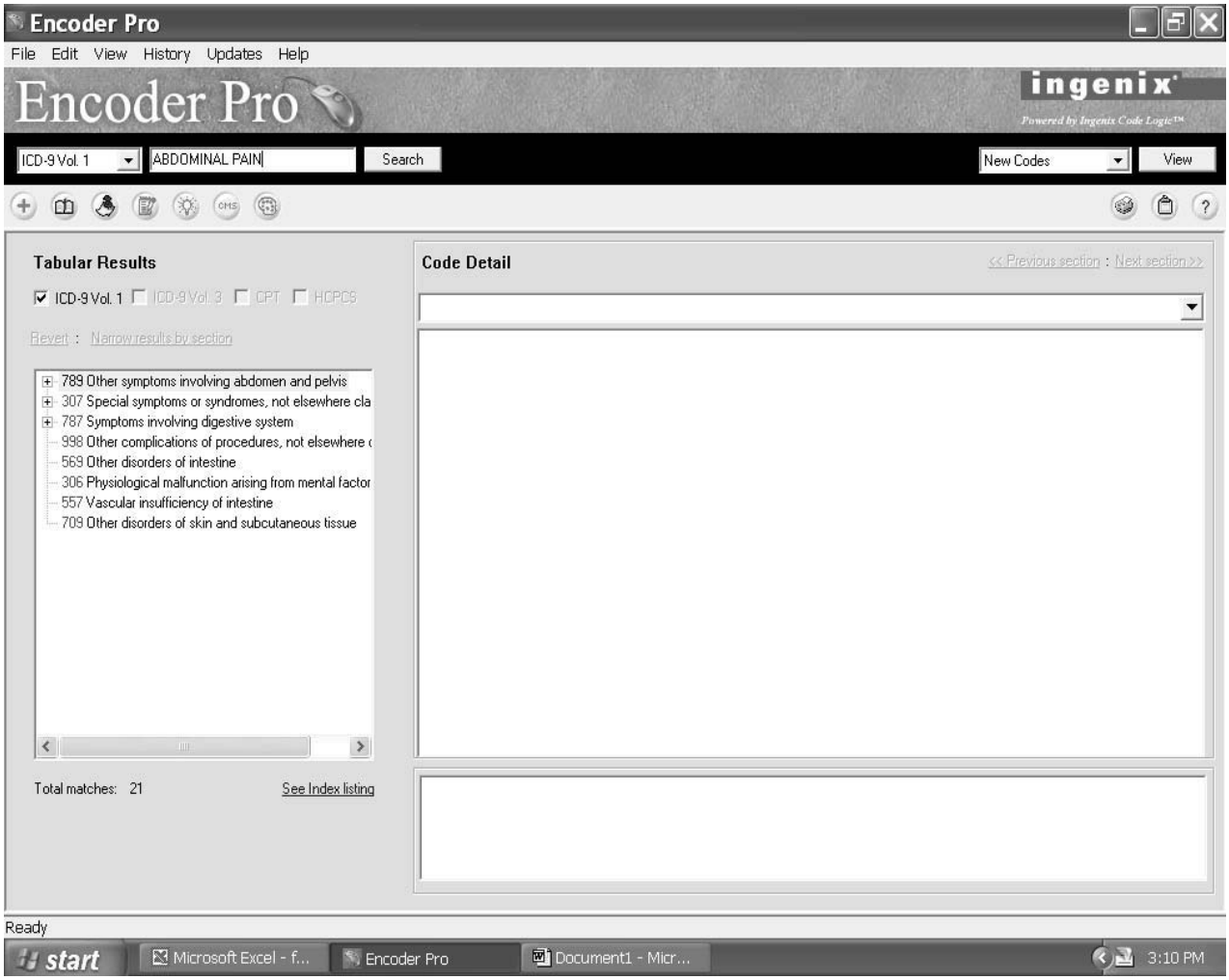
Encoder Programs

An **encoder** is an interactive computer program that helps you assign codes. With this program, the user inserts a keyword and then selects different sections, subsections, headings, subheadings and code listings related to that keyword. Think of this type of encoder as a computer-version of your *ICD-9-CM*, *ICD-10-CM, CPT* and the *HCPCS* manual, all rolled into one. This encoder assists you in navigating your code quickly and with the click of a button. In Pack 5, you will receive a demonstration CD-ROM of one of these encoders. You'll also receive a supplement showing you how to use it like a pro.

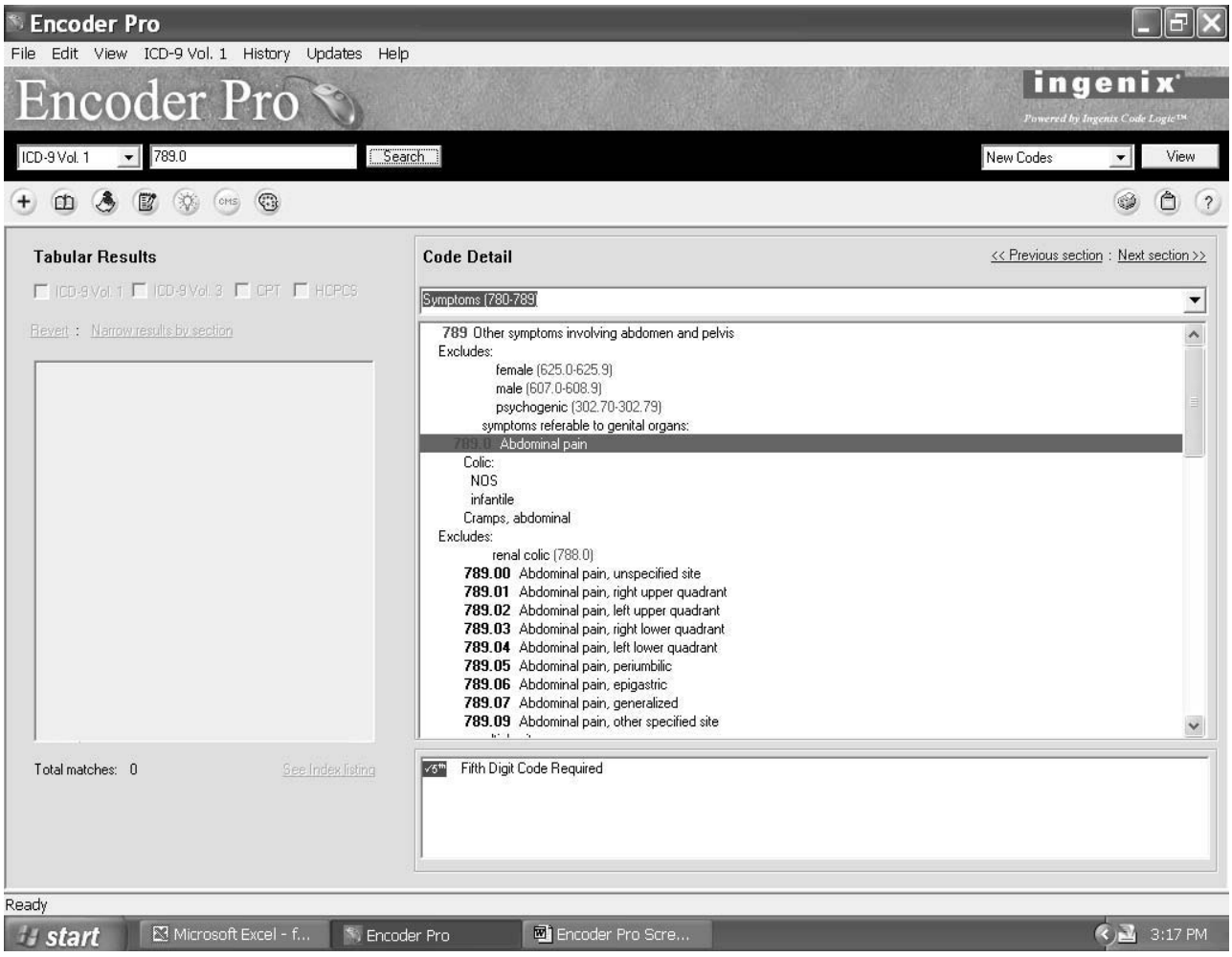
However, using an encoder program doesn't mean you don't need to be familiar with coding rules and the manuals. You need to have a clue to locate the accurate code! For many coders, the encoder program is more useful as a verification tool. For example, let's say you're looking up the code for abdominal pain. If you use this as the basis for your encoder search, you are likely to get so many potential codes that you'll have a hard time narrowing it down to the right one.

One of the benefits of using encoders is efficiency. And when it comes to coding, efficiency equals money.

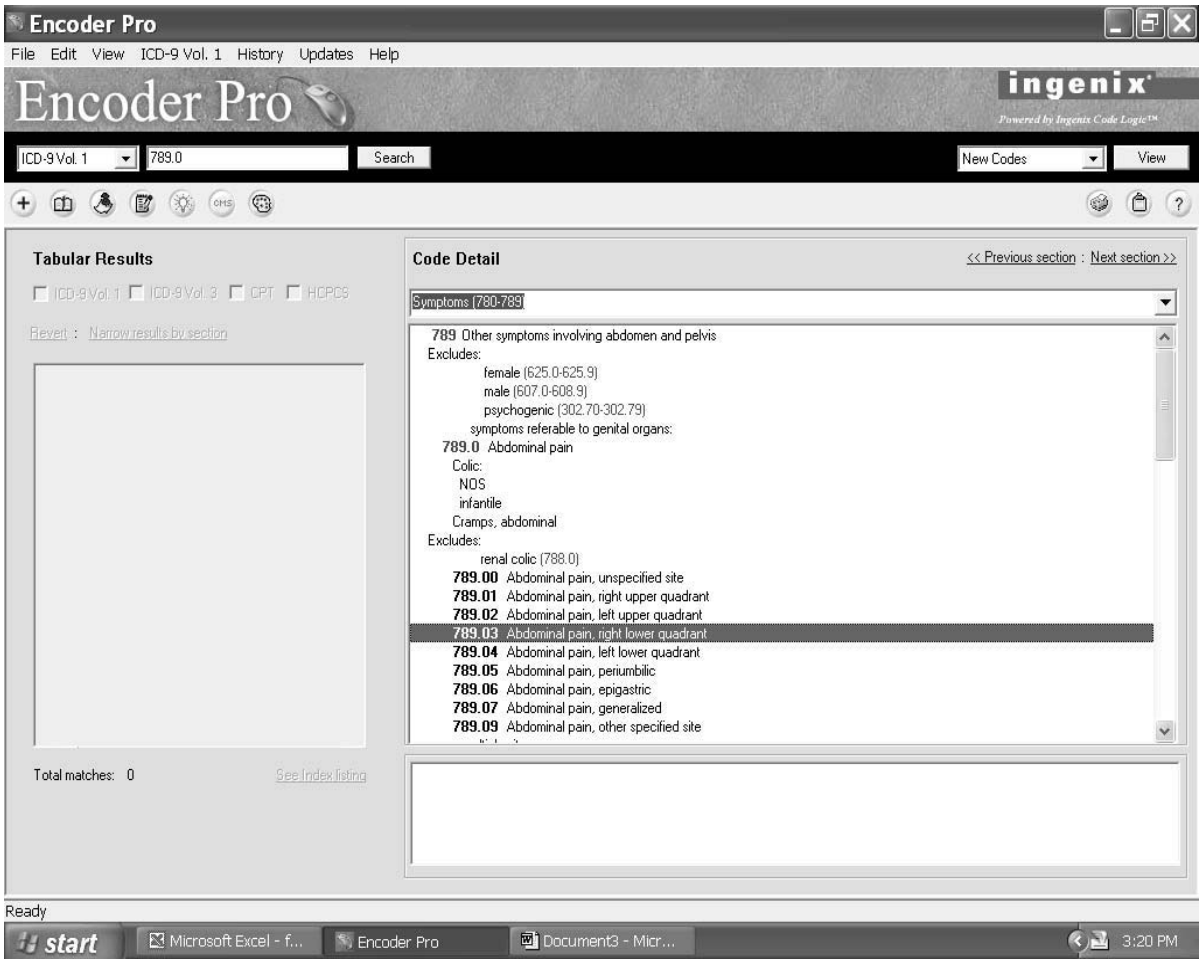
Look at the following example. Search for *Abdominal pain,* and the encoder program retrieves several code categories.



Let's narrow down our search. If you already know that the code for abdominal pain is 789.0, you can use the encoder to fine-tune your search. Here's an example using the encoder in that way.



If you are unsure of the correct fifth digit to use for RLQ (right lower quadrant), just scroll down the list like the example below. Do you see the code 789.03? Great!



Computer-assisted Coding

After encoders, the next level of technology is computer-assisted coding (CAC). **CAC** uses a computer to assign an actual code. Whereas an encoder determines the best code, a computer-assisted program is programmed to pick codes itself. The computer can do this in one of two ways: by using inputted information or by finding the diagnosis and procedure in the chart itself. Let's examine how each of these methods work.

In addition to improving accuracy, computer-assisted programs can shorten the time it takes to code a chart.

The most common automated coding systems require a user to input data. The user will read a medical chart and figure out the diagnoses and the procedures. Next she will type this information into the computer-assisted program. The computer uses logic and coding rules programmed into its memory to code the diagnoses and the procedures. Of course, this system isn't perfect. CAC programs are not advanced enough to handle rules which can be interpreted in several different ways. As you've learned with your ICD-9-CM coding, not all codes are black and white. However, CAC software can draw the user's attention to any codes it has trouble with. This is where you, the medical coding and billing specialist, come in!

The second type of CAC software is much more advanced than the first. Some medical providers use a software called **natural language processing** (**NLP**), which can read and translate English. Instead of having to input the diagnoses and procedures to be coded, the entire medical chart can be uploaded into the NLP autocoder. This program will read the chart, pick out the diagnoses and procedures, and then assign the appropriate code.

Natural language processing can translate doctor reports into medical codes.

But how accurate is it? Today, NLP technology is not advanced enough to rival the accuracy of an experienced, human coder. However, NLP software is getting better. Instead of using a rigid set of rules to program the computer-assisted coding, NLP uses complex statistical methods to predict how an experienced human would code the information. Using statistics gives NLP autocoders flexibility, as well as the ability to improve. Like a human, the more the NLP software translates and codes, the better it gets. Like standard computer-assisted programs, NLP software can alert the user when it is unsure about a code. In fact, because it uses statistics, it can say exactly how unsure it is.

But NLP technology isn't perfect. There is more to coding than just connecting the dots, as you now know. While the NLP autocoding software companies are touting their programs as the next wave in health information management, not everyone is so sure. Many providers are skeptical and question just how valid the programs are. It doesn't matter how fast the programs are if they aren't accurate enough.

What does computer-assisted coding mean for the medical coding and billing specialist? Will they be replaced by computers? The answer is no, although there will be some changes. Computers will eventually take over much of the manual work of assigning simple codes and transcribing basic medical reports. Computer-assisted coders will zip through the easy and routine codes. However, healthcare professionals will still be needed to tackle all of the challenging reports which stump the computer. And with medicine constantly evolving, there will always be plenty of exciting and new charts to code.

In addition, coders may be responsible for managing these programs and their coded data. Coders will be in charge of quality-control, security, and monitoring the regular additions, deletions, and changes to the code sets. It is an exciting time to be a coder. You're getting in on the first wave of a whole new system!

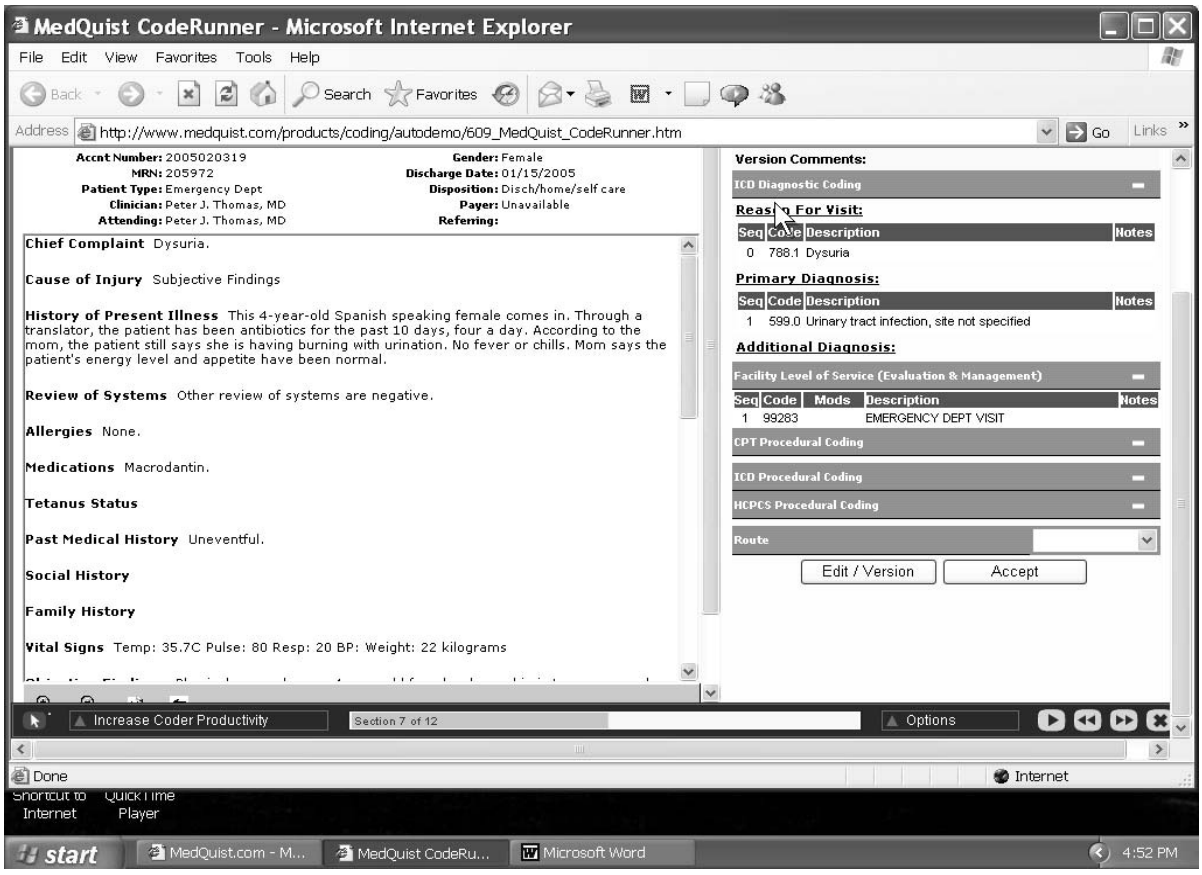
Step 7 Web-based Coding

- One of the advantages of medical coding and billing is that you may work from home. While three years of experience are generally required for coding, more and more coders telecommute. As providers become used to managing information electronically, you can expect less-experienced coders to work from home.

  With **Web-based coding**, also called **remote coding**, the provider scans or captures the medical record, encrypts the file so unauthorized people can't read it and e-mails it to a secure computer server. The chart is given a digital certificate. A digital certificate is like an electronic lock. Only the person with the right electronic key—such as a password—can open it. When a chart is stored on the server and assigned to a medical coder, it is given a digital certificate that only that medical coder can open.

  You can either work with the medical chart while it is saved on the server, or you may download the file and work with it after disconnecting from the Internet. The latter is more secure because there are less opportunities for hackers to break in and view the information. Once you're done, you e-mail the coded chart back to the server and delete the information from your computer.

  Here's an example of how remote or Web-based coding may look like through an Internet connection.



Source: http://www.medquist.com/products/coding/autodemo/609_MedQuist_CodeRunner.htm

Security is a very important issue for Web-based coders. This is especially true with all of the security guidelines mandated by HIPAA. In addition to encryption and digital certificates, physical security is important. The computer you use for home coding shouldn't be used for non-work activities (like Internet shopping). The system should be protected by a password, and others should not have access to it. Some remote coding companies and agreements stipulate that management can inspect the home office at any time to ensure that security is being maintained.

Security is a very important issue for Web-based coders.

On the following page is an example of an agreement between an employer and a remote coder. As you can see, computer set-up and security measures must be in place before the employee can initiate coding from home.

SAMPLE HOME CODER CONFIDENTIALITY POLICY

Confidentiality and Non-Disclosure Agreement

As an employee / contracted employee affiliated with the (name of organization), I understand that I must maintain the confidentiality of any and all data and information to which I have access. Organizational information that may include, but is not limited to, financial, patient identifiable, employee identifiable, intellectual property, financially non-public, contractual, of a competitive advantage nature, and is from any source or in any form (i e paper, magnetic or optical media, conversations, film, etc), may be considered confidential. The value and sensitivity of information is protected by law and by the strict policies of (name of organization). The intent of these laws and policies is to assure that confidential information will remain confidential through its use, only as a necessity to accomplish the organization's mission.

As a condition to receiving a computer sign-on code and allowed access to a system and/or being granted authorization to access any form of confidential information identified above, I agree to comply with the following terms and conditions:

1. My Sign-On Code is equivalent to my LEGAL SIGNATURE and I will not disclose this code to anyone or allow anyone to access the system using my Sign-On Code.
2. I am responsible and accountable for all entries made and all retrievals accessed under my Sign-On Code, even if such action was made by me or by another due to my intentional or negligent act or omission. Any data available to me will be treated as confidential information.
3. I will not attempt to learn or use another's Sign-On Code.
4. I will not access any on-line computer system using a Sign-On Code other than my own.
5. I will not access or request any information for which I have no responsibility.
6. If I have reason to believe that the confidentiality of my User Sign-On Code/password has been compromised, I will immediately notify (responsible party) by calling the helpdesk at (helpdesk phone number).
7. I will not disclose any confidential information unless required to do so in the official capacity of my employment or contract. I also understand that I have no right or ownership interest in any confidential information.
8. While signed on, I will not leave a secured computer application unattended.
9. I will comply with all policies and procedures and other rules of (name of organization) relating to confidentiality of information and sign-on codes.
10. I understand that my use of the system may be periodically monitored to ensure compliance with this agreement.
11. I agree not to use the information in any way detrimental to the organization and will keep all such information confidential.
12. I will not disclose protected health information or other information that is considered proprietary, sensitive, or confidential unless there is a need to know basis.
13. I will limit distribution of confidential information to only parties with a legitimate need in performance of the organization's mission.
14. I agree that disclosure of confidential information is prohibited indefinitely, even after termination of employment or business relationship, unless specifically waived in writing by an authorized party.
15. This agreement cannot be terminated or canceled, nor will it expire.
16. I will report to the Corporate Compliance Hotline any unauthorized access or use of confidential information. I understand that my reporting is confidential and that I will remain anonymous.

I further understand that if I violate any of the above terms, I may be subject to disciplinary action, including discharge, loss of privileges, termination of contract, legal action, or any other remedy available to (name of organization).

User's Name _____ Date _____
(Please Print)

User's Signature: _____ Department: _____

However, if you follow the rules, Web-based coding can give you a lot of flexibility and save you the daily commute. (And that's something to look forward to!) Of course, not everyone likes working at home. Many coders and billers prefer the socialization of working in an office. Some like the easy access to tech support and reference material. It is also easier to ask physicians questions and communicate with your manager. You have to decide which work setting works best for you!

✍ Step 8 Practice Exercise 30-1

❑ Determine five trends in the technology of health care.

1. _____

2. _____

3. _____

4. _____

5. _____

🔑 Step 9 Review Practice Exercise 30-1

❑ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

📖 Step 10 Lesson Summary

❑ Computers are revolutionizing health care. With electronic health records, they're helping ensure consistent, quality care. With personal health records, computers empower people to manage their own health. On the coding front, they improve accuracy with encoders and speed with computer-assisted coding (CAC) programs. Natural language programming (NLP) will free coders up to focus more on managing medical information. The Internet allows more and more people to work safely and efficiently from home. All in all, computers are the future. The change to a fully-electronic health information system will be slow. But it will come, and health care will never be the same. And you will be on the front line of this exciting technology!

✉ Step 11 Mail-in Quiz 30

❑ Follow the steps to complete the Quiz.

a. Be sure you've mastered the instruction and the Practice Exercises that this Quiz covers.

b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.

d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your Quiz online.

e. Submit your answers to the school via mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 30

Choose the best answer from the choices provided. Each item is worth 5 points.

1. **The Institute of Medicine (IOM) originally created the term CPR (computer-based patient record), and it also established _____ core functions that a computer-based patient record should perform.**
   a. eight
   b. seven
   c. six
   d. five

2. **Healthcare professionals may do which of the following? _____**
   a. Make sure diagnoses and procedures match
   b. Apply codes for patient encounters
   c. Process billing for patient encounters
   d. All of the above

3. **A medical record that the patient has access to and control over is called a(n) _____.**
   a. PPO
   b. HMO
   c. PVP
   d. PHR

4. According to the IOM, a computer-based patient record should include _____, which can aid in drug interactions/prescriptions/prevention, detection of disease outbreaks and evidence-based guidelines.

a. Order Management
b. Patient Support
c. Decision Support
d. Result Management

5. Electronic coding _____.

a. uses computers to speed up the coding process
b. is decreasing in popularity
c. is against HIPAA regulations
d. is illegal

6. A(n) _____ is an interactive coding program that works like a computerized version of the *ICD-9-CM*, *ICD-10-CM*, *CPT* and *HCPCS* manuals.

a. digital coder
b. encoder
c. CAC (computer-assisted coding)
d. NLP autocoder

7. A(n) _____ is a coding program that automatically assigns codes once the coder inputs the diagnoses and procedures.

a. digital coder
b. encoder
c. CAC (computer-assisted coding)
d. NLP autocoder

8. A(n) _____ is a coding program that reads medical charts, picks out the diagnoses and procedures and automatically assigns codes.

a. digital coder
b. encoder
c. CAC (computer-assisted coding)
d. NLP autocoder

9. Web-based coding requires _____.

a. a computer
b. an Internet connection
c. a password to access secure information
d. all of the above

10. Which of the following is the most secure solution for Web-based coding? _____

a. Opening and working with encrypted files while online from your family computer

b. Opening and working with encrypted files while online from your work-only computer

c. Downloading then working with encrypted files offline from your family computer

d. Downloading then working with encrypted files offline from your work-only computer

11. What is one of the base requirements for meaningful use? _____

a. Certified or qualified EHR technology

b. Paper based exchange of health information

c. Use of ICD vocabulary

d. A firm understanding of EHR software development

12. A _____ EHR gives assurance that the criteria for meaningful use have been met.

a. qualified

b. valued

c. certified

d. national

13. Which is a true statement of controlled vocabulary? ____

a. It is needed to assign the correct ICD code.

b. Controlled vocabulary is needed to index, store and retrieve EHR information.

c. Providers need controlled vocabulary to interact with nurses.

d. It is needed for proper reimbursement from third-party payers.

14. A computerized version of a medical record is termed _____.

a. encoded

b. encrypted

c. CPR

d. EDMS

15. The encoder program ____.

a. assigns codes based on the uploaded dictation
b. will put medical coding and billing specialists out of work
c. assists in locating the accurate code efficiently
d. should only be used by experienced medical coding and billing specialists

16. Which is a true statement about natural language processing? _____

a. It uses a rigid set of rules to determine the accurate code.
b. NLP software will alert the coder when it's unsure of a code.
c. NLP technology always works correctly.
d. NLP will eventually replace the medical coding and billing specialist.

17. ____ presents data in a completely machine-readable format.

a. NLP
b. CAC
c. Encoder
d. SNOMED CT

18. The core set of terminologies include _____.

a. NLP, LOINC and RxNorm
b. CAC and NLP
c. SNOMED CT and CAC
d. SNOMED CT, LOINC and RxNorm

19. What is a drawback of the paper medical record? _____

a. They take up a lot of space.
b. They are easily shared among hospitals.
c. The record formats are consistent.
d. It is expensive to transition to EHRs.

20. _____ is very important to Web-based coders.

a. Efficiency
b. Commuting
c. Security
d. Increased pay

Endnotes

1 "Health information exchange (HIE)." Search Health IT. May 10, 2012. Web. 18 June 2012.

2 "Core Functions of an EHR." EHR Scope. July 14, 2009. Web. 18 June 2012.

3 "Computerized Provider Order Entry." Agency for Healthcare Research and Quality. Web. 18 June 2012.

4 "Core Functions of an EHR." EHR Scope. July 14, 2009. Web. 18 June 2012.

5 "Frequently Asked Questions on HITECH Provider Incentives Under Medicare." Minnesota e-Health, 18 June, 2009. Web. 10 April 2012.

6. "Overview." Centers for Medicare & Medicaid Services, 9 April, 2012. Web. 10 April 2012.

7. "Frequently Asked Questions on HITECH Provider Incentives Under Medicare." Minnesota e-Health, 18 June, 2009. Web. 10 April 2012.

8. Lumpkin, John. "Letter to The Honorable Tommy G. Thompson." 5 Nov., 2003. Web. 10 April 2012.

9. Fluckinger, Don. "SNOMED CT will be coming to EHR systems and patient records near you." TechTarget, n.d. 10 April 2012.

10. "XML vs. HTML: A Publishing Comparison." United States Bureau of the Census's Statistical Compendia Branch. July 19, 2002. Web. 18 June 2012.

Dedication • Professional • Gain • EXTRAORDINARY
Happiness • Nice • Progress • Superb • Fantastic
TRIUMPH • Incredible • Victory • Accurate • Growth
Remarkable • Nicely done • Study • Brilliant
ADVANCEMENT • First-rate • Splendid • Strategy

Congratulations

Detailed • Fine • Winning • Tremendous • GREAT
Perseverance • Work • IMPRESSIVE • Astonishing
Drive • PERSISTENCE • Consistent • Skillful
Determination • QUALITY • Terrific • Resolution
ACCOMPLISHMENT • Super • Learning

You've completed Pack 3!

Do not wait to receive the results of your Quiz before you move on.

Pack 3

Medical Coding and Billing Specialist Answer Key

Lesson 21

Practice Exercise 21-1

1. Inquiry **c. Asking an insurance company about a delayed claim**
2. Resubmission **a. Sending in a claim a second time with "SECOND BILLING" written at the top**
3. Narrative explanation **d. A further description of a procedure or other information on a claim**
4. State insurance commissioner **b. Oversees the state insurance regulations**

Practice Exercise 21-2

1. **Credit** is the merchant's acceptance of your promise to pay later for goods or services you receive immediately.
2. The document listing your credit history is called your credit **report**.
3. The document listing your credit history is important to potential **creditors** who are considering giving you credit.
4. Late payments, bankruptcies and defaults are called **negative credit information**.
5. People referred to as *credit risks* end up paying **higher** interest rates.
6. If a debtor fails to live up to his credit agreement, his account is **delinquent**.
7. If a check bounces, the bank returns the check with the letters **NSF** stamped across the check.
8. The person filing the action in small claims court is the **plaintiff**.
9. The person being sued in small claims court is the **defendant**.
10. The defendant's employer withholds a percentage of the defendant's pay each month and sends the money to the creditor. In order to do this, a legal document called a(n) **order of garnishment** is required.

Lesson 22

Practice Exercise 22-1

1. **Certified Coding Specialists (CCS)** are skilled professional coders with solid experience classifying medical data from patient records.

2. **AHIMA** is recognized as one of the industry's most active and influential advocates in Congress.

3. The **Certified Billing and Coding Specialist (CBCS)** exam focuses on converting a medical procedure and diagnosis into specific codes for submitting a claim for reimbursement.

4. The AMA speaks out on important issues like **patient rights** and the health of the nation.

5. The **CPC** exam tests the student on diagnostic and procedural codes, compliance and reimbursement policies.

6. In addition to coding the diagnosis and procedures for outpatient settings, the **CPC-H** exam also focuses on reimbursement procedures, such as fee updates and how to complete the UB-04.

7. The goal of the **AAPC** is to provide education, recognition, and certification for physician-practice procedural coders.

8. **CCS-P** coders have in-depth experience with diagnostic and procedural codes. They also are experts in health information documentation.

Practice Exercise 22-2

1. *BillingInsider* **AAPC**

2. *CPT Assistant* **AMA**

3. *Coding Clinic* **AHA**

4. *Coder's Desk Reference for Diagnoses* **OptumInsight**

5. *Communities of Practice* **AHIMA**

6. *Coder's Desk Reference for Procedures* **OptumInsight**

7. *Coding Edge* **AAPC**

Lesson 23

Practice Exercise 23-1

1. The ICD originally was used to track **b. mortality statistics**.

2. The *Bertillon Classification of Causes of Death* was first used in the Americas in which country? **c. Mexico**

3. In 1946, the United Nations gave the responsibility for the ICD to the **a. World Health Organization**.

4. The United States adopted the *International Classification of Diseases, 9th Revision, Clinical Modification* (*ICD-9-CM*), based on the ICD-9, in **d. 1979**.

5. The *ICD-9-CM* consists of a(n) **d. tabular list, alphabetical index and procedure alphabetic index and tabular list**.

6. A primary use of medical codes is to **communicate** to the insured the reason for a patient's medical visit.

7. Medical coding is a **statistics-gathering tool** for research, grants and financial analysis.

8. The *ICD-9-CM* outdated codes produce **inaccurate and limited data**.

Practice Exercise 23-2

1. The *ICD-9-CM for Physicians* manual is divided into **b. two** volumes.

2. The *ICD-9-CM for Physicians* manual lists **d. diagnostic** codes.

3. Main terms appear in **b. boldface** type.

4. Information in parentheses following a main term is called a(n) **a. nonessential modifier**, and it has no effect on selecting the correct code.

5. The **d. *Tabular List*** uses a numerical index cross-referenced with diseases and injuries according to the anatomical system affected and/or etiology.

6. A medical coder must assign the most **c. specific** code possible—a subcategory, if it is available.

7. Supplementary classifications might be **a. V or E** codes.

8. **b. Residual** classifications ensure that there is always a code for every disease.

Practice Exercise 23-3

1. When a diagnosis is not principal and is used alone, you should code the **b. underlying disease** first.

2. ICD-9-CM coding uses the INCLUDES and EXCLUDES instructional notes to assist coders in assigning diagnostic codes at the **c. highest** level.

3. Notes, when found in the *Index to Diseases*, are **a. boxed and italicized**.

4. In the multiple coding instruction, "Use additional code, if desired," you should ignore the words **d. if desired**.

5. NEC means **b. not elsewhere classifiable**.

6. NOS means **c. not otherwise specified**.

7. A note might instruct you to assign a(n) **d. fifth** digit because subclassification categories are available.

Practice Exercise 23-4

1. An object not naturally occurring in the human body is **a. a foreign body**.

2. A late effect is defined as a(n) **d. residual** effect after the acute phase of an illness or injury has ended.

3. **c. Study of tumors** Appendix A

4. **d. Was deleted in 2004** Appendix B

5. **a. Drug classification** Appendix C

6. **e. Job-related accidents** Appendix D

7. **b. Three-digit categories** Appendix E

Practice Exercise 23-5

1. The first step in ICD-9-CM coding is to identify all **c. main terms**.

2. Assign codes to their **b. highest** level of specificity.

3. When you assign codes for an outpatient or inpatient diagnosis, the **c. principal diagnosis** is the first code sequenced.

4. Do not assign codes for **a. rule-out** statements in outpatient settings.

5. Urinary tract infection

Main term	**infection**
Subterm	**urinary (tract)**
Coding pathway	**infection, urinary (tract)**

6. Recurrent appendicitis

Main term	**appendicitis**
Subterm	**recurrent**
Coding pathway	**appendicitis, recurrent**

7. Unknown pain in leg

Main term	**pain**
Subterm	**leg**
Coding pathway	**pain, leg**

8. Diaper rash

Main term	**rash**
Subterm	**diaper**
Coding pathway	**rash, diaper**

9. Loss of appetite

		Alternative Answer:
Main term	**appetite**	**loss**
Subterm	**lack or loss**	**appetite**
Coding pathway	**appetite, lack or loss**	**loss, appetite**

10. Inflammation of the sinus

Main term	**inflammation**
Subterm	**sinus**
Coding pathway	**inflammation, sinus**

11. High-altitude sickness

Main term	**sickness**
Subterm	**altitude**
Coding pathway	**sickness, altitude**

12. Vision examination

Main term	**examination**
Subterm	**vision**
Coding pathway	**examination, vision**

13. Ear examination

Main term	**examination**
Subterm	**ear**
Coding pathway	**examination, ear**

Lesson 24

Practice Exercise 24-1

1. **005.9**

   Coding pathway: Poisoning, food 005.9

   Tabular List description: 005.9 Food poisoning, unspecified

2. **011.04**

   Coding pathway: Tuberculosis, pulmonary, infiltrative 011.0 ✓
   Fifth-digit subclassification: 4= tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture

   Tabular List description: 011.04 Tuberculosis of lung, infiltrative, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.

3. **021.9**

   Coding pathway: Fever, rabbit 021.9

   Alternative pathway: Rabbit fever 021.9

   Tabular List description: 021.9 Unspecified tularemia

4. **033.9**

   Coding pathway: Pertussis—see also Whooping cough 033.9

   Tabular List description: 033.9 Whooping cough, unspecified organism

5. **038.3**

   Coding pathway: Septicemia, Bacteroides 038.3

   Tabular List description: 038.3 Septicemia due to anaerobes

   Note: use additional code for SIRS but SIRS or sepsis not noted so no additional code needed.

6. **042 136.3**

   Principal coding pathway: AIDS 042

   Principal *Tabular List* description: 042 Human immunodeficiency virus [HIV] disease

   Coexisting coding pathway: Pneumonia, Pneumocystis (carinii) 136.3

   Coexisting *Tabular List* description: 136.3 Pneumocystosis

7. Coding pathway: Septicemia, gram-negative **038.40**
   Coding pathway: SIRS (systemic inflammatory response syndrome) due to, infectious process **995.91**

1500

MED LINK HMO

PO BOX 560
YOURTOWN, CO 80001

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid#)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
				X		

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 52100900602

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): BLOOMQUIST REBECCA

3. PATIENT'S BIRTH DATE: 06 25 1997 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): BLOOMQUIST DICK

5. PATIENT'S ADDRESS (No., Street): 409 YORKSHIRE

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street): SAME

CITY: YOURTOWN STATE: CO

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 80001 TELEPHONE (Include Area Code): (970) 5555875

Employed [ ] Full-Time Student [X] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NONE

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: WBHMO

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 03 10 1967 SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] Place (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: WILTON BOOKSTORE

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: MED LINK HMO

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 05 08 XX

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 05 08 XX

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.)

1. 038.40
2. 995.91
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1. 05	08	XX	05	08	XX	23		99283		1 2	187 00	1		NPI	
2.														NPI	
3.														NPI	
4.														NPI	
5.														NPI	
6.														NPI	

25. FEDERAL TAX I.D. NUMBER: 900 00 9000 SSN [X] EIN [ ]

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? YES [X] NO [ ]

28. TOTAL CHARGE: $ 187 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 187 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
JAMES HAHNS MD
800 MEDICAL COURT
YOURTOWN CO 80000
a. 0405674390 b.

33. BILLING PROVIDER INFO & PH # (970) 5552222
JAMES HAHNS MD
800 MEDICAL COURT
YOURTOWN CO 80000
a. 0405674390 b.

Practice Exercise 24-2

1. **049.9**
   Coding pathway: Encephalitis, viral 049.9
   Tabular List description: 049.9 Unspecified non-arthropod-borne viral diseases of central nervous system

2. **050.2**
   Coding pathway: Varioloid 050.2
   Tabular List description: 050.2 Modified smallpox

3. **055.2**
   Coding pathway: Measles, with, otitis media 055.2
   Tabular List description: 055.2 Postmeasles otitis media

4. **056.9**
   Coding pathway: Measles, German 056.9
   Tabular List description: 056.9 Rubella without mention of complication

5. **066.40**
   Coding pathway: Fever, West, Nile 066.40
   Tabular List description: 066.40 West Nile fever, unspecified

6. **071**
   Coding pathway: Rabies 071
   Tabular List description: 071 Rabies

7. **074.3**
   Coding pathway: Disease, hand, foot and mouth 074.3
   Tabular List description: 074.3 Hand, foot and mouth disease

8. **088.81**
   Coding pathway: Disease, Lyme 088.81
   Alternative pathway: Lyme disease 088.81
   Tabular List description: 088.81 Lyme disease

9. **057.0**
   Coding pathway: Disease, fifth 057.0
   Tabular List description: 057.0 Erythema infectiosum [fifth disease]

Practice Exercise 24-3

1. **093.9**
   Coding pathway: Syphilis, cardiovascular (early) 093.9
   Tabular List description: 093.9 Cardiovascular syphilis, unspecified

2. **098.11**
   Coding pathway: Cystitis, gonococcal (acute) 098.11
   Tabular List description: 098.11 Gonococcal cystitis (acute) upper

3. **110.4**
   Coding pathway: Infection, fungus, foot 110.4
   Tabular List description: 110.4 Dermatophytosis, Of foot

4. **114.0**
   Coding pathway: Fever, desert 114.0
   Tabular List description: 114.0 Primary coccidioidomycosis (pulmonary)

5. **126.9**
   Coding pathway: Disease, hookworm 126.9
   Tabular List description: 126.9 Ancylostomiasis and necatoriasis, unspecified

6. **133.0**
   Coding pathway: Scabies (any site) 133.0
   Tabular List description: 133.0 Scabies

7. Coding pathway: Human immunodeficiency virus, infection **V08**
   Coding pathway: Hepatitis, viral, type C, chronic **070.54**
   Note: "Probable" pneumocystis carinii pneumonia is an unconfirmed diagnosis.

1500

MOUNTAIN STATES
1801 SW VINE ST
DENVER, CO 80217

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
GROUP HEALTH PLAN [X] (SSN or ID)	520007777
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FOX BENJAMIN	3. PATIENT'S BIRTH DATE: 12 02 1970 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
5. PATIENT'S ADDRESS (No., Street): 1227 COMET DRIVE APT 6B	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)	
CITY: SPRINGTOWN STATE: CO	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [X] Full-Time Student [ ] Part-Time Student [ ]
CITY STATE	
ZIP CODE: 80002 TELEPHONE (Include Area Code): (970) 5551001	ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NONE	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: 120	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] Place (State)
b. EMPLOYER'S NAME OR SCHOOL NAME: PHILCO GAS	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: MOUNTAIN STATES	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 06 14 XX

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
06 14 XX		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.) 1. V08. 2. 070.54 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1. 06 14 XX 06 14 XX	23		99213		1 2	63 00	1		NPI	
2.									NPI	
3.									NPI	
4.									NPI	
5.									NPI	
6.									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? YES [X] NO [ ]	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
900 00 9000 [X]			$ 63 00	$ 0 00	$ 63 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (970) 5552222
SIGNED DATE	JAMES HAHNS MD 800 MEDICAL COURT YOURTOWN CO 80000	JAMES HAHNS MD 800 MEDICAL COURTT YOURTOWN CO 80000
	a. 0405674390 b.	a. 0405674390 b.

Practice Exercise 24-4

1. **191.0**

   Coding pathway: Glioma, specified site NEC – see Neoplasm, by site, malignant

   Neoplasm table: Neoplasm, cerebrum, Malignant, Primary 191.0

   Tabular List description: 191.0 Malignant neoplasm of brain, Cerebrum, except lobes and ventricles

2. **198.3 162.9**

   Coding pathway: Carcinoma - see also Neoplasm, by site, malignant

   Neoplasm table: Neoplasm, brain NEC, Malignant, Secondary 198.3

   Tabular List description: 198.3 Secondary malignant neoplasm, Brain and spinal cord

   Neoplasm table: Neoplasm, lung, Malignant, Primary 162.9

   Coexisting *Tabular List* description: 162.9 Malignant neoplasm of trachea, bronchus and lung, Bronchus and lung, unspecified

3. **201.20**

   Coding pathway: Hodgkin's, sarcoma 201.2 ✓

   Alternative pathway: Sarcoma, Hodgkin's 201.2 ✓

   Fifth-digit subclassification: 0 = unspecified site, extranodal and solid organ sites

   Tabular List description: 201.20 Hodgkin's sarcoma, unspecified site, extranodal and solid organ sites

4. **216.4**

   Neoplasm table: Neoplasm, scalp, Benign 216.4

   Tabular List description: 216.4 Benign neoplasm of skin, Scalp and skin of neck

5. **218.9**

   Coding pathway: Fibromyoma, uterus 218.9

   Tabular List description: 218.9 Leiomyoma of uterus, unspecified

6. **151.5**

   Coding pathway: Adenocarcinoma – *see also* Neoplasm, by site, malignant

   Neoplasm table: Neoplasm, gastric – *see* Neoplasm, stomach

   New pathway: Neoplasm, stomach, lesser curvature, Malignant, Primary 151.5

   Tabular List description: 151.5 Malignant neoplasm of stomach, Lesser curvature, unspecified

   Note: the type of biopsy helps determine the site of the neoplasm.

Practice Exercise 24-5

1. **244.0**

   Coding pathway: Hypothyroidism, postsurgical 244.0

   Tabular List description: 244.0 Acquired hypothyroidism, Postsurgical hypothyroidism

2. **250.33**

   Coding pathway: Diabetic, coma, hypoglycemia 250.3 ✓

   Alternative pathway: Hypoglycemia, coma, diabetic 250.3 ✓

   Fifth-digit subclassification 3 = type 1, uncontrolled

   Tabular List description: 250.33 Diabetes with other coma, type 1, uncontrolled

3. **252.01**

   Coding pathway: Hyperparathyriodism, primary 252.01

   Tabular List description: 252.01 Primary hyperparathyroidism

4. **256.4**

   Coding pathway: Polycystic, ovary, ovaries 256.4

   Tabular List description: 256.4 Polycystic ovaries

5. **274.00**

   Coding pathway: Gouty, arthropathy 274.00

   Alternative pathway: Arthropathy, gouty 274.00

   Tabular List description: 274.00 Gouty arthropathy

6. **282.62**

   Coding pathway: Disease, sickle cell, with, crisis 282.62

   Tabular List description: 282.62 Sickle-cell disease, Hb-SS disease with crisis

7. **289.4**

   Coding pathway: Syndrome, big spleen 289.4

   Alternative pathway: Big spleen syndrome 289.4

   Tabular List description: 289.4 Hypersplenism

8. Coding pathway: Hypercalcemia **275.42**
   Coding pathway: Cancer –see also Neoplasm, by site, malignant
   Neoplasm table: Neoplasm, thyroid, Malignant, Primary **193**

1500

Country Group

PO BOX 324
SPRINGTOWN, CO 80002

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid#) (Sponsor's SSN) (Member ID #) X (SSN or ID) (SSN) (ID)	560001113
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SCHMIDT BONNIE	3. PATIENT'S BIRTH DATE: 06 25 1952 SEX: M F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
5. PATIENT'S ADDRESS (No., Street): 1810 BLUEGRASS DRIVE	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
CITY: SPRINGTOWN STATE: CO	8. PATIENT STATUS: Single Married X Other
ZIP CODE: 80002 TELEPHONE (Include Area Code): (970) 5559041	Employed X Full-Time Student Part-Time Student
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): SCHMIDT RICHARD	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 635007213	a. EMPLOYMENT? (Current or Previous) YES X NO
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX: 09 15 1952 M X F	b. AUTO ACCIDENT? YES X NO Place (State)
c. EMPLOYER'S NAME OR SCHOOL NAME: USAF	c. OTHER ACCIDENT? YES X NO
d. INSURANCE PLAN NAME OR PROGRAM NAME: CHAMPVA	10d. RESERVED FOR LOCAL USE
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: SIGNATURE ON FILE DATE: 10 17 XX	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: SIGNATURE ON FILE
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (MM DD YY): 10 17 XX	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY)
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.) 1. 275.42 2. 193. 3. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1. 10 17 XX	10 17 XX	11		99213		1 2	63 00	1		NPI	0810998051
2.										NPI	
3.										NPI	
4.										NPI	
5.										NPI	
6.										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
66 6000600		X		X YES NO	$ 63 00	$ 0 00	$ 63 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (970) 5553344
SIGNED DATE	FRONT RANGE FAMILY CARE 1800 CIRCLE COURT YOURTOWN CO 80000	FRONT RANGE FAMILY CARE 1800 CIRCLE COURT YOURTOWN CO 80000
	a. 0881099885 b.	a. 0881099885 b.

Lesson 25

Practice Exercise 25-1

1. **291.0**

   Coding pathway: Delirium, alcoholic 291.0

   Tabular List description: 291.0 Alcohol withdrawal delirium

2. **295.20**

   Coding pathway: Stupor, catatonic 295.2 ✓

   Fifth-digit subclassification 0 = unspecified

   Tabular List description: 295.20 Schizophrenic disorders, Catatonic type, unspecified

3. **298.1**

   Coding pathway: Psychosis, hysterical, acute 298.1

   Tabular List description: 298.1 Other nonorganic psychoses, Excitative type psychosis

4. **300.3**

   Coding pathway: Disorder, obsessive-compulsive 300.3

   Alternative pathway: Obsessive-compulsive 300.3

   Tabular List description: 300.3 Obsessive-compulsive disorders

5. **307.1**

   Coding pathway: Anorexia, nervosa 307.1

   Tabular List description: 307.1 Anorexia nervosa

6. **312.32**

   Coding pathway: Kleptomania 312.32

   Tabular List description: 312.32 Disorders of impulse control, not elsewhere classified, Kleptomania

7. **317**

   Coding pathway: Subnormality, mental, mild 317

   Tabular List description: 317 Mild intellectual disabilities

8. Coding pathway: Disorder, bipolar **296.80**

1500

MEDICAID

PO BOX 1461
DENVER, CO 80203

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE	MEDICAID	TRICARE CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
(Medicare #)	X (Medicaid#)	(Sponsor's SSN)	(Member ID #)	(SSN or ID)	(SSN)	(ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 521003333

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
REYNOLDS KAMI	06 25 1997	M F X	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED		
4575 DIXON COURT APT 7	Self Spouse Child Other		
CITY: YOUNGSTOWN	STATE: CO	8. PATIENT STATUS: Single X Married Other	
ZIP CODE: 80004	TELEPHONE (Include Area Code): (970) 5556996	Employed Full-Time Student X Part-Time Student	

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? YES X NO Place (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 05 01 XX

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
05 01 XX		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.) 1. 296.80 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1. 05 01 XX 05 01 XX	11		99213		1	63 00	1		NPI	0275695402
2.									NPI	
3.									NPI	
4.									NPI	
5.									NPI	
6.									NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
99 0000009		X		X YES NO	$ 63 00	$ 0 00	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (970) 5551111
SIGNED DATE	MEDICAL CARE CENTER 100 SOUTH MAIN YOURTOWN CO 80000	MEDICAL CARE CENTER 100 SOUTH MAIN YOURTOWN CO 80000
	a. 0665544004 b.	a. 0665544004 b.

Practice Exercise 25-2

1. **320.3**
   Coding pathway: Meningitis, staphylococcal 320.3
   Tabular List description: 320.3 Staphylococcal meningitis

2. **330.1**
   Coding pathway: Disease, Tay-Sachs 330.1
   Alternative pathway: Tay-Sachs, disease 330.1
   Alternative pathway: Disease, Sachs (-Tay) 330.1
   Tabular List description: 330.1 Cerebral lipidoses

3. **333.83**
   Coding pathway: Torticollis, spasmodic 333.83
   Tabular List description: 333.83 Spasmodic torticollis

4. **342.11**
   Coding pathway: Hemiplegia, spastic 342.1 ✓
   Fifth-digit subclassification 1 = affecting dominant side
   Tabular List description: 342.11 Spastic hemiplegia, affecting dominant side

5. **345.11**
   Coding pathway: Epilepsy, grand mal 345.1 ✓
   Fifth-digit subclassification 1 = with intractable epilepsy
   Tabular List description: 345.11 Generalized convulsive epilepsy, with intractable epilepsy

6. **351.0**
   Coding pathway: Bell's, palsy 351.0
   Alternative pathway: Palsy, Bell's 351.0
   Tabular List description: 351.0 Bell's palsy

7. Coding pathway: Sclerosis, multiple **340**

1500

BLUE CROSS OF WYOMING

PO BOX 456
CASPER, WY 82002

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid#) (Sponsor's SSN) (Member ID #) [X] (SSN or ID) (SSN) (ID)	641000000
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARRISON CATHY	3. PATIENT'S BIRTH DATE SEX 08 09 1967 M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARRISON TOM	
5. PATIENT'S ADDRESS (No., Street) 2419 ZENDT DRIVE	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [X] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street) SAME	
CITY: ANYTOWN — STATE: CO	8.PATIENT STATUS Single [ ] Married [X] Other [ ] Employed [X] Full-Time Student [ ] Part-Time Student [ ]
CITY — STATE	
ZIP CODE: 80000 — TELEPHONE (Include Area Code): (970) 5552112	ZIP CODE — TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) NONE	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER GE54002	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH SEX MM DD YY 08 02 1959 M [X] F [ ]	
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M [ ] F [ ]	b. AUTO ACCIDENT? Place (State) YES [ ] NO [X]
b. EMPLOYER'S NAME OR SCHOOL NAME FRONT RANGE AUTO SALES	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME BLUE CROSS OF WYOMING	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 03 19 XX

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 03 19 XX	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE CAROLYN HOOPER MD	17a. 17b. NPI 0188123456	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — MM DD YY TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? $ CHARGES YES [ ] NO [X]
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.) 1. 340. 3. . 2. . 4. .		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1. 03 19 XX	03 19 XX	11		99242		1	102 00	1		NPI	0267679942
2.										NPI	
3.										NPI	
4.										NPI	
5.										NPI	
6.										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
66 6000600 [ ] [X]		YES [X] NO [ ]	$ 102 00	$ 20 00	$ 82 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SIGNED DATE	FRONT RANGE FAMILY CARE 1800 CIRCLE COURT YOURTOWN CO 80000	(970) 5553344 FRONT RANGE FAMILY CARE 1800 CIRCLE COURT YOURTOWN CO 80000
	a. 0881099885 b.	a. 0881099885 b.

Practice Exercise 25-3

1. **360.21**
   Coding pathway: Myopia, malignant 360.21
   Tabular List description: 360.21 Progressive high (degenerative) myopia

2. **362.52**
   Coding pathway: Degeneration, macula, disciform 362.52
   Tabular List description: 362.52 Exudative senile macular degeneration

3. **372.03**
   Coding pathway: Pink, eye 372.03
   Tabular List description: 372.03 Acute conjunctivitis, Other mucopurulent conjunctivitis

4. **376.32**
   Coding pathway: Hemorrhage, orbit 376.32
   Tabular List description: 376.32 Orbital hemorrhage

5. **384.01**
   Coding pathway: Myringitis, bullous 384.01
   Tabular List description: 384.01 Bullous myringitis

6. **386.00**
   Coding pathway: Disease, Meniere's 386.00
   Alternative pathway: Meniere's disease, syndrome, or vertigo 386.00
   Tabular List description: 386.00 Meniere's disease, unspecified

7. **383.00**
   Coding pathway: Mastoiditis, acute 383.00
   Tabular List description: 383.00 Acute mastoiditis without complications

Practice Exercise 25-4

1. **392.9**

   Coding pathway: Chorea, rheumatic 392.9

   Tabular List description: 392.9 Rheumatic chorea, Without mention of heart involvement

2. **397.9**

   Coding pathway: Endocarditis, rheumatic 397.9

   Tabular List description: 397.9 Rheumatic diseases of endocardium, valve unspecified

3. **401.1**

   Coding pathway: Hypertension, benign 401.1

   Tabular List description: 401.1 Essential hypertension, Benign

4. **405.99 255.0**

   Coding pathway: Hypertension, due to, Cushing's disease Unspecified 405.99

   Tabular List description: 405.99 Secondary hypertension, Unspecified, Other

   Coding pathway: Disease, Cushing 255.0

   Tabular List description: 255.0 Cushing's syndrome

5. **410.01**

   Coding pathway: Infarction, myocardial, anterolateral 410.0 ✓

   Fifth-digit subclassification 1 = initial episode of care

   Tabular List description: 410.01 Acute myocardial infarction, Of anterolateral wall, initial episode of care

6. **403.91 585.6**

   Coding pathway: Hypertension, kidney, with, chronic kidney disease, stage V or end stage renal disease, Unspecified 403.91

   Tabular List description: 403.91 Hypertensive chronic kidney disease, Unspecified, with chronic kidney disease stage V or end stage renal disease

   Tabular List 403 notes to identify the stage

   Coding pathway: Disease, renal, end-stage 585.6

   Tabular List description: 585.6 Chronic kidney disease

   [CKD], End stage renal disease

Practice Exercise 25-5

1. **416.0**

   Coding pathway: Hypertension, pulmonary, idiopathic, Unspecified 416.0

   Tabular List description: 416.0 Primary pulmonary hypertension

2. **426.13**

   Coding pathway: Phenomenon, Wenckebach's, heart block 426.13

   Alternative pathway: Wenckebach's phenomenon, heart block 426.13

   Tabular List description: 426.13 Other second degree atrioventricular block

3. **440.20**

   Coding pathway: Arteriolosclerosis, extremities 440.20

   Tabular List description: 440.20 Atherosclerosis of the extremities, unspecified

4. **454.9**

   Coding pathway: Varicose, vein (lower extremity) 454.9

   Tabular List description: 454.9 Asymptomatic varicose veins

5. **427.81**

   Coding pathway: Syndrome, sick, sinus 427.81

   Tabular List description: 427.81 Sinoatrial node dysfunction

Lesson 26

Practice Exercise 26-1

1. **466.0**
   Coding pathway: Bronchitis, pneumococcal, acute or subacute 466.0
   Tabular List description: 466.0 Acute bronchitis

2. **473.0**
   Coding pathway: Sinusitis, maxillary 473.0
   Tabular List description: 473.0 Chronic sinusitis, Maxillary

3. **482.84**
   Coding pathway: Disease, Legionnaires' 482.84
   Alternative Pathway: Legionnaires' disease 482.84
   Tabular List description: 482.84 Legionnaires' disease

4. **493.20**
   Coding pathway: Bronchitis, asthmatic, chronic 493.2 ✓
   Fifth-digit subclassification 0 = status or exacerbation are not stated
   Tabular List description: 493.20 Chronic obstructive asthma, unspecified

5. **518.82**
   Coding pathway: Syndrome, respiratory distress, adult, specified NEC 518.82
   Tabular List description: 518.82 Other pulmonary insufficiency, not elsewhere classified

6. **518.81**
   Coding pathway: Failure, respiration, acute 518.81
   Tabular List description: 518.81 Other diseases of lung, Acute respiratory failure

Practice Exercise 26-2

1. **528.00**

   Coding pathway: Stomatitis, ulcerative 528.00

   Tabular List description: 528.00 Stomatitis and mucositis, unspecified

2. **531.00**

   Coding pathway: Ulcer, prepyloric –see Ulcer, stomach

   New pathway: Ulcer, stomach, acute, with, hemorrhage 531.0 ✓

   Fifth-digit subclassification 0 = without mention of obstruction

   Tabular List description: 531.00 Gastric ulcer, Acute with hemorrhage, without mention of obstruction

3. **532.71**

   Coding pathway: Ulcer, duodenum, chronic 532.7 ✓

   Fifth-digit subclassification 1 = with obstruction

   Tabular List description: 532.71 Duodenal ulcer, Chronic without mention of hemorrhage or perforation, with obstruction

4. **540.0**

   Coding pathway: Appendicitis, with, perforation, peritonitis (generalized), or rupture 540.0

   Tabular List description: 540.0 Acute appendicitis, With generalized peritonitis

5. **552.3**

   Coding pathway: Hernia, hiatal, with, obstruction (strangulated means obstruction) 552.3

   Tabular List description: 552.3 Diaphragmatic hernia with obstruction

6. **560.30**

   Coding pathway: Impaction, impacted, bowel, colon, rectum 560.30

   Tabular List description: 560.30 Impaction of intestine, unspecified

7. **564.2**

   Coding pathway: Syndrome, dumping 564.2

   Alternative pathway: Dumping syndrome (postgastrectomy) 564.2

   Tabular List description: 564.2 Postgastric surgery syndromes

8. **571.5**

   Coding pathway: Cirrhosis, liver 571.5

   Tabular List description: 571.5 Cirrhosis of liver without mention of alcohol

9. **535.50 531.90 532.90**

   Coding pathway: Gastritis 535.5 ✓

   Fifth-digit subclassification 0 = without mention of hemorrhage

   Tabular List description: 535.50 Unspecified gastritis and gastroduodenitis, without mention of hemorrhage

   Coding pathway: Ulcer, gastric – see Ulcer, stomach

   New pathway: Ulcer, stomach, 531.9 ✓

   Fifth-digit subclassification 0 = without mention of obstruction

   Tabular List description: 531.90 Gastric ulcer, Unspecified as acute or chronic, without mention of hemorrhage or perforation, without mention of obstruction

   Coding pathway: Ulcer, duodenal 532.9 ✓

   Fifth-digit subclassification 0 = without mention of obstruction

   Tabular List description: 532.90 Duodenal ulcer, Unspecified as acute or chronic, without mention of hemorrhage or perforation, without mention of obstruction

Practice Exercise 26-3

1. **250.40 581.81 V58.67**

   Coding pathway: Nephrosis, diabetic 250.4 ✓ [581.81]

   250 Fifth-digit subclassification 0 = unspecified type, not stated as uncontrolled

   Tabular List description: 250.40 Diabetes with renal manifestation, type II or unspecified type, not stated as uncontrolled

   Tabular List note: Use additional code, if applicable, for associated long-term (current) insulin use V58.67

   Tabular List description: 581.81 Nephrotic syndrome in diseases classified elsewhere

   Tabular List description: V58.67 Long-term (current) use of insulin

2. **590.2**

   Coding pathway: Carbuncle, kidney 590.2

   Tabular List description: 590.2 Renal and perinephric abscess

3. **595.0 041.49**

   Coding pathway: Cystitis, acute 595.0

   Tabular List description: 595.0 Acute cystitis

   Note: Use additional code to identify organism

   Coding pathway: Infection, Escherichi coli 041.49

   Tabular List description: 041.49 Other and unspecified Escherichia coli [E. coli]

4. **600.10**

   Coding pathway: Hard firm prostate 600.10

   Tabular List description: 600.10 Nodular prostate without urinary obstruction

5. **604.0**

   Coding pathway: Abscess, testicle – see Orchitis

   New pathway: Orchitis, with abscess 604.0

   Tabular List description: 604.0 Orchitis, epididymitis and epididymo-orchitis with abscess

6. **610.2**

   Coding pathway: Fibroadenosis, breast (periodic) 610.2

   Tabular List description: 610.2 Fibroadenosis of breast

7. **618.02**

   Coding pathway: Prolapse, vagina, paravaginal 618.02

   Tabular List description: 618.02 Prolapse of vaginal walls without mention of uterine prolapse, Cystocele, lateral

8. **626.0**

   Coding pathway: Amenorrhea 626.0

   Tabular List description: 626.0 Absence of menstruation

9. Coding pathway: Infection, urinary (tract) **599.0**
   Note: Use additional code to identify organism.
   Coding pathway: Infection, Enterobacter aerogenes **041.85**

1500

BLUE CROSS OF IOWA
PO BOX 1677
SIOUX CITY, IA 51102

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid#) (Sponsor's SSN) (Member ID #) X (SSN or ID) (SSN) (ID)	666006663
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JONES SAMUEL	3. PATIENT'S BIRTH DATE SEX 05 19 1972 M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
5. PATIENT'S ADDRESS (No., Street) 3 HWY SOUTH	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	
CITY: ANYTOWN — STATE: CO	8.PATIENT STATUS Single Married Other X Employed X Full-Time Student Part-Time Student
CITY — STATE	
ZIP CODE: 80000 — TELEPHONE (Include Area Code): (970) 5551313	
ZIP CODE — TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) NONE	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER VE001	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO
a. INSURED'S DATE OF BIRTH SEX MM DD YY M F	
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M F	b. AUTO ACCIDENT? Place (State) YES X NO
b. EMPLOYER'S NAME OR SCHOOL NAME GREEN FINGER NURSERY	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME BLUE CROSS OF IOWA	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 02 28 XX

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 02 28 XX	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? $ CHARGES YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.) 1. 599.0 3. . 2. 041.85 4. .		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1. 02 28 XX	02 28 XX	11		99213		1 2	63 00	1		NPI	0304851124
2. 02 28 XX	02 28 XX	11		81000		1 2	10 00	1		NPI	0304851124
3.										NPI	
4.										NPI	
5.										NPI	
6.										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
86 8000600 X		X YES NO	$ 73 00	$ 0 00	$ 73 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SIGNED DATE	SPRINGTOWN CLINIC 1824 PARK AVENUE SPRINGTOWN CO 80000	(970) 5551834 SPRINGTOWN CLINIC 1824 PARK AVENUE SPRINGTOWN CO 80000
	a. 0304455166 b.	a. 0304455166 b.

Practice Exercise 26-4

1. **633.20**

   Coding pathway: Pregnancy, ovarian 633.20

   Tabular List description: 633.20 Ovarian pregnancy without intrauterine pregnancy

2. **634.92**

   Coding pathway: Miscarriage – see Abortion, spontaneous

   New pathway: Abortion, spontaneous, 634.9 ✓

   Fifth-digit subclassification 2 = complete

   Tabular List description: 634.92 Spontaneous abortion, Without mention of complication, complete

3. **641.13**

   Coding pathway: Pregnancy, complicated (by), placenta, previa, 641.1 ✓

   Fifth-digit subclassification 3 = antepartum condition or complication

   Tabular List description: 641.13 Hemorrhage from placenta previa, antepartum condition or complication

4. **643.03**

   Coding pathway: Hyperemesis, gravidarum 643.0 ✓

   Fifth-digit subclassification 3 = antepartum condition or complication

   Tabular List description: 643.03 Mild hyperemesis gravidarum, antepartum condition or complication

5. **651.01 V91.00 V27.2**

   Coding pathway: Delivery, twins 651.0 ✓

   Fifth-digit subclassification 1 = delivered, with or without mention of antepartum condition

   Tabular List description: 651.01 Twin pregnancy, delivered, with or without mention of antepartum condition

   Coding pathway: Gestation, multiple, placenta status, twin, unspecified number of placenta, unspecified number of amniotic sacs V91.00

   Tabular List description: V91.00 Twin gestation, unspecified number of placenta, unspecified number of amniotic sacs

   Coding pathway: Outcome of delivery, twins, both liveborn V27.2

   Tabular List description: V27.2 Twins, both liveborn

6. **654.21 V27.0**

   Coding pathway: Delivery, complicated (by), previous, cesarean delivery 654.2 ✓

   Fifth-digit subclassification 1 = delivered, with or without mention of antepartum condition

   Tabular List description: 654.21 Previous cesarean delivery, delivered, with or without mention of antepartum condition

   Coding pathway: Outcome of delivery, single, liveborn V27.0

   Tabular List description: V27.0 Single liveborn

7. **664.21 V27.0**

   Coding pathway: Delivery, complicated (by), laceration, perineum, third degree 664.2 ✓

   Fifth-digit subclassification 1 = delivered, with or without mention of antepartum condition

   Tabular List description: 664.21 Third-degree perineal laceration, delivered, with or without mention of antepartum condition

   Coding pathway: Outcome of delivery, single, liveborn V27.0

   Tabular List description: V27.0 Single liveborn

8. **673.24**

   Coding pathway: Pregnancy, complicated (by), embolism (pulmonary) 673.2 ✓

   Alternative pathway: Embolism, obstetrical (pulmonary) 673.2 ✓

   Fifth-digit subclassification 4 = postpartum condition or complication

   Tabular List description: 673.24 Obstetrical blood-clot embolism, postpartum condition or complication

9. **676.14**

   Coding pathway: Cracked nipple, puerperal, postpartum 676.1 ✓

   Fifth-digit subclassification 4 = postpartum condition or complication

   Tabular List description: 676.14 Cracked nipple, postpartum condition or complication

10. **650 V27.0**

    Coding pathway: Delivery, normal – see category 650

    Tabular List description: 650 Normal delivery

    Coding pathway: Outcome of delivery, single, liveborn V27.0

    Tabular List description: V27.0 Outcome of delivery, Single liveborn

Lesson 27

Practice Exercise 27-1

1. **680.0**

   Coding pathway: Boil, ear (any part) 680.0

   Tabular List description: 680.0 Carbuncle and furuncle, Face

2. **692.71**

   Coding pathway: Sunburn 692.71

   Tabular List description: 692.71 Contact dermatitis and other eczema, Due to solar radiation, Sunburn

3. **692.84**

   Coding pathway: Eczema, due to specified cause – see Dermatitis, due to

   New pathway: Dermatitis, due to, hair, animal (cat) (dog) 692.84

   Tabular List description: 692.84 Contact dermatitis and other eczema, Due to other specified agents, Due to animal (cat) (dog) dander

4. **695.4**

   Coding pathway: Lupus, erythematosus 695.4

   Alternative pathway: Erythema, erythematous, lupus 695.4

   Tabular List description: 695.4 Lupus erythematosus

5. **698.0**

   Coding pathway: Itch, perianal 698.0

   Tabular List description: 698.0 Pruritus and related conditions, Pruritus ani

6. **704.00**

   Coding pathway: Baldness 704.00

   Tabular List description: 704.00 Alopecia, unspecified

7. **707.05 707.22 438.20**

Coding pathway: Ulcer, pressure, buttock 707.05

Tabular List description: 707.05 Chronic ulcer of skin, Pressure ulcer, Buttock

Coding pathway: Ulcer, pressure, stage, II 707.22

Tabular List description: 707.22 Pressure ulcer stage II

Coding pathway: Late, effect, cerebrovascular disease, with, hemiplegia, affecting, unspecified side 438.20

Tabular List description: 438.20 Late effects of cerebrovascular disease, Hemiplegia/hemiparesis, Hemiplegia affecting unspecified side

Note: late effect is coded because the patient would not have the pressure sore if not in a wheelchair. The patient is in the wheelchair because of the hemiplegia which was caused by the cerebrovascular disease.

8. Coding pathway: Paronychia, finger **681.02**

   Tabular List description: 681.02 Cellulitis and abscess of finger and toe, Finger, Onychia and paronychia of finger

1500

MEDICARE

600 GRANT ST STE 600
DENVER, CO 80203

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE	MEDICAID	TRICARE CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
X (Medicare #)	(Medicaid#)	(Sponsor's SSN)	(Member ID #)	(SSN or ID)	(SSN)	(ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
501007319A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
EMMA SMITH	01 30 1930 M F X	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1410 IRIS DRIVE	Self Spouse Child Other	
CITY / STATE	8.PATIENT STATUS	CITY / STATE
MYTOWN / CO	Single Married Other X	
ZIP CODE / TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (Include Area Code)
80001 / (970) 5555843		

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
		NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
	YES X NO	MM DD YY M F
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? Place (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
MM DD YY M F	YES X NO	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	MEDICARE
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 07 12 XX

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 12 XX		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? $ CHARGES
		YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.)		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
1. 681.02 3. .		23. PRIOR AUTHORIZATION NUMBER
2. . 4. .		

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1. 07 12 XX 07 12 XX	11		99212		1	50 00	1		NPI	
2.									NPI	
3.									NPI	
4.									NPI	
5.									NPI	
6.									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
333 33 0003 X		X YES NO	$ 50 00	$ 0 00	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
	SARAH DUNCAN MD 1414 SWALLOW STREET YOURTOWN CO 80000	(970) 5551514 SARAH DUNCAN MD 1414 SWALLOW STREET YOURTOWN CO 80000

Practice Exercise 27-2

1. **719.41**

   Coding pathway: Arthralgia—*see also* Pain, joint

   New pathway: Pain, joint, shoulder 719.41

   Tabular List description: 719.41 Other and unspecified disorders of joint, Pain in joint, shoulder region

2. **722.0**

   Coding pathway: Hernia, intervertebral cartilage or disc – see Displacement, intervertebral disc

   New pathway: Displacement, intervertebral disc, cervical 722.0

   Tabular List description: 722.0 Intervertebral disc disorders, Displacement of cervical intervertebral disc without myelopathy

3. **722.91**

   Coding pathway: Calcification, disc, intervertebral, cervical 722.91

   Tabular List description: 722.91 Intervertebral disc disorders, Other and unspecified disc disorder, Cervical region

4. **724.2**

   Coding pathway: Pain, back, low 724.2

   Tabular List description: 724.2 Other and unspecified disorders of back, Lumbago

5. **726.5**

   Coding pathway: Bursitis, hip 726.5

   Tabular List description: 726.5 Peripheral enthesopathies and allied syndromes, Enthesopathy of hip region

6. **727.03**

   Coding pathway: Trigger finger (acquired) 727.03

   Tabular List description: 727.03 Other disorders of synovium, tendon, and bursa, Synovitis and tenosynovitis, Trigger finger (acquired)

7. **728.0**

   Coding pathway: Myositis, infective 728.0

   Tabular List description: 728.0 Disorders of muscle, ligament and fascia, Infective myositis

8. **733.02**

   Coding pathway: Osteoporosis, idiopathic 733.02

   Tabular List description: 733.02 Other disorders of bone and cartilage, Osteoporosis, Idiopathic osteoporosis

9. Coding pathway: Hypothyroidism **244.9**
   Coding pathway: Arthritis, rheumatoid **714.0**
   Coding pathway: Osteoporosis **733.00**

1500

TRICARE

PO BOX 100502
FLORENCE, SC 29501 0502

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid#) X (Sponsor's SSN) (Member ID #) (SSN or ID) (SSN) (ID)	352005515
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SCOTT JANET	3. PATIENT'S BIRTH DATE: 11 11 1985 SEX: M F X	4. INSURED'S NAME (Last Name, First Name, Middle Initial): SCOTT JAMES
5. PATIENT'S ADDRESS (No., Street): HQ USAF SP PSC 5	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse X Child Other	7. INSURED'S ADDRESS (No., Street): HQ USAF SP PSC 5
CITY: ELLSWORTH AFB STATE: SD	8.PATIENT STATUS: Single Married X Other	CITY: ELLSWORTH AFB STATE: SD
ZIP CODE: 57706 TELEPHONE (Include Area Code): (605) 5556330	Employed X Full-Time Student Part-Time Student	ZIP CODE: 57706 TELEPHONE (Include Area Code): (605) 5556330
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NONE	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH (MM DD YY) SEX: 09 13 1985 M X F
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX: M F	b. AUTO ACCIDENT? YES X NO Place (State)	b. EMPLOYER'S NAME OR SCHOOL NAME: USAF
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: TRICARE
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 08 20 XX

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT (MM DD YY) ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 08 20 XX	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY)	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO (MM DD YY)
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO (MM DD YY)
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.) 1. 244.9 2. 714.0 3. 733.00 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From (MM DD YY) To (MM DD YY)	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1. 08 20 XX 08 20 XX	11		99214		1 2 3	85 00	1		NPI	0810998051
2.									NPI	
3.									NPI	
4.									NPI	
5.									NPI	
6.									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
66 6000600 X		X YES NO	$ 85 00	$ 20 00	$ 65 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (970) 5553344
SIGNED DATE	FRONT RANGE FAMILY CARE 1800 CIRCLE COURT YOURTOWN CO 80000 a. 0881099885 b.	FRONT RANGE FAMILY CARE 1800 CIRCLE COURT YOURTOWN CO 80000 a. 0881099885 b.

Practice Exercise 27-3

1. **741.93**

   Coding pathway: Spina bifida 741.9 ✓

   Fifth-digit subclassification 3 = lumbar region

   Tabular List description: 741.93 Spina bifida, Without mention of hydrocephalus, lumbar region

2. **743.11**

   Coding pathway: Hypoplasia, eye (*see also* Microphthalmos)

   New pathway: Microphthalmos, simple 743.11

   Tabular List description: 743.11 Congenital anomalies of eye, Microphthalmos, Simple microphthalmos

3. **744.01**

   Coding pathway: Absence, auditory canal (congenital) 744.01

   Tabular List description: 744.01 Congenital anomalies of ear, face and neck, Anomalies of ear causing impairment of hearing, Absence of external ear

4. **745.4**

   Coding pathway: Disease, Roger's 745.4

   Tabular List description: 745.4 Bulbus cordis anomalies and anomalies of cardiac septal closure, Ventricular septal defect

5. **746.09**

   Coding pathway: Fallot's, triad or trilogy 746.09

   Tabular List description: 746.09 Other congenital anomalies of heart, Anomalies of pulmonary valve, Other

6. **747.5**

   Coding pathway: Single, umbilical artery 747.5

   Tabular List description: 747.5 Other congenital anomalies of circulatory system, Absence or hypoplasia of umbilical artery

7. **748.4**

   Coding pathway: Honeycomb lung, congenital 748.4

   Tabular List description: 748.4 Congenital anomalies of respiratory system, Congenital cystic lung

8. **749.22**

   Coding pathway: Cheilopalatoschisis—*see also* Cleft, palate, with cleft lip

   New pathway: Cleft, palate, with cleft lip, unilateral, incomplete 749.22

   Tabular List description: 749.22 Cleft palate and cleft lip, Cleft palate with cleft lip, Unilateral, incomplete

9. **752.2** Didelphic uterus

   Coding pathway: Didelphys, didelphic—*see also* Double uterus 752.2

   Tabular List description: 752.2 Congenital anomalies of genital organs, Doubling of uterus

10. **744.3 756.10 755.29 755.20 746.9**

    Coding pathway: Dysplasia – *see also* Anomaly

    New pathway: Anomaly, auricle, ear 744.3

    Tabular List description: 744.3 Congenital anomalies of ear, face and neck, Unspecified anomaly of ear

    Coding pathway: Anomaly, vertebra 756.10

    Tabular List description: 756.10 Other congenital musculoskeletal anomalies, Anomaly of spine, unspecified

    Coding pathway: Hypoplasia, finger (*see also* Absence, finger, congenital)

    New pathway: Absence, finger, congenital 755.29

    Tabular List description: 755.29 Other congenital anomalies of limbs, Longitudinal deficiency, phalanges, complete or partial

    Coding pathway: Short, arm, congenital 755.20

    Tabular List description: 755.20 Other congenital anomalies of limbs, Unspecified reduction deformity of upper limb

    Coding pathway: Disease, heart, congenital 746.9

    Tabular List description: 746.9 Other congenital anomalies of heart, Unspecified anomaly of heart

Practice Exercise 27-4

1. **V30.01 768.3 765.28**

   Coding pathway: Newborn, single, born in hospital, with cesarean delivery or section V30.01

   Tabular List description: V30.01 Single liveborn, Born in hospital, delivered by cesarean delivery

   Coding pathway: Distress, fetal, liveborn infant, first noted, during labor or delivery 768.3

   Tabular List description: 768.3 Intrauterine hypoxia and birth asphyxia, Fetal distress first noted during labor, in liveborn infant

   Coding pathway: Newborn, gestation, 35-36 completed weeks 765.28

   Tabular List description: 765.28 Disorders relating to short gestation and low birthweight, Weeks of gestation, 35-36 completed weeks of gestation

2. **V30.00 766.1**

   Coding pathway: Newborn, single, born in hospital (without mention of cesarean delivery or section) V30.00

   Tabular List description: V30.00 Single liveborn, Born in hospital, delivered without mention of cesarean delivery

   Coding pathway: Large, for dates, fetus or newborn 766.1

   Tabular List description: 766.1 Disorders relating to long gestation and high birthweight, Other "heavy-for-dates" infants

3. **V30.00 766.21 758.0**

   Coding pathway: Newborn, single, born in hospital (without mention of cesarean delivery or section) V30.00

   Tabular List description: V30.00 Single liveborn, Born in hospital, delivered without mention of cesarean delivery

   Coding pathway: Post-term, infant 766.21

   Tabular List description: 766.21 Disorders relating to long gestation and high birthweight, Late infant, not "heavy-for dates," Post-term infant

   Coding Pathway: Syndrome, Down's 758.0

   Tabular List description: 758.0 Chromosomal anomalies, Down's syndrome

4. **V30.00 764.00 760.71**

   Coding pathway: Newborn, single, born in hospital (without mention of cesarean delivery or section) V30.00

   Tabular List description: V30.00 Single liveborn, Born in hospital, delivered without mention of cesarean delivery

   Coding pathway: Small, for dates, fetus or newborn 764.0 ✓

   Fifth-digit subclassification 0 = unspecified [weight]

   Tabular List description: 764.00 Slow fetal growth and fetal malnutrition, "Light-for-dates" without mention of fetal malnutrition, unspecified [weight]

   Coding pathway: Syndrome, fetal alcohol 760.71

   Tabular List description: 760.71 Fetus or newborn affected by maternal conditions which may be unrelated to present pregnancy, Noxious influences affecting fetus or newborn via placenta or breast milk, Alcohol

5. **V32.01 765.26**

   Coding pathway: Newborn, twin, mate stillborn, born in hospital V32.0 ✓

   Fifth-digit subclassification 1 = delivered by cesarean delivery

   Tabular List description: V32.01 Twin, mate stillborn, Born in hospital, delivered by cesarean delivery

   Coding pathway: Newborn, gestation, 31-32 completed weeks 765.26

   Tabular List description: 765.26 Disorders relating to short gestation and low birthweight, Weeks of gestation, 31 – 32 completed weeks of gestation

Lesson 28

Practice Exercise 28-1

1. **780.03**
   Coding pathway: State, vegetative (persistent) 780.03
   Alternative pathway: Vegetation, Vegetative, state (persistent) 780.03
   Tabular List description: 780.03 Alteration of consciousness, Persistent vegetative state

2. **780.53**
   Coding pathway: Hypersomnia, unspecified, with sleep apnea, unspecified 780.53
   Tabular List description: 780.53 General symptoms, Sleep disturbance, Hypersomnia with sleep apnea, unspecified

3. **780.60**
   Coding pathway: Pyrexia (of unknown origin) 780.60
   Tabular List description: 780.60 Fever, unspecified

4. **780.79**
   Coding pathway: Lethargy 780.79
   Tabular List description: 780.79 Malaise and fatigue, Other malaise and fatigue

5. **781.4**
   Coding pathway: Monoplegia, transient 781.4
   Tabular List description: 781.4 Transient paralysis of limb

6. **782.0**
   Coding pathway: Numbness 782.0
   Tabular List description: 782.0 Disturbance of skin sensation

7. **786.59**
   Coding pathway: Discomfort, chest 786.59
   Tabular List description: 786.59 Chest pain, Other

8. **796.2**
   Coding pathway: Elevation, blood pressure, reading, no diagnosis of hypertension 796.2
   Tabular List description: 796.2 Elevated blood pressure reading without diagnosis of hypertension

9. **795.00**
   Coding pathway: Abnormal, Papanicolaou (smear) cervix 795.00
   Tabular List description: 795.00 Abnormal glandular Papanicolaou smear of cervix

10. Coding pathway: Pain, pleuritic **786.52**

    Coding pathway: Fever, postoperative **780.62**

1500

BLUE CROSS OF IOWA

PO BOX 1677
SIOUX CITY, IA 51102

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid#) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID #) GROUP HEALTH PLAN [X] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 321001010
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) TUCKER SALLY	3. PATIENT'S BIRTH DATE 11 26 1960 SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME
5. PATIENT'S ADDRESS (No., Street) 1801 PETERSON COURT	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: SPRINGTOWN STATE: CO	8. PATIENT STATUS Single [ ] Married [X] Other [ ] Employed [X] Full-Time Student [ ] Part-Time Student [ ]	CITY: STATE:
ZIP CODE: 80002 TELEPHONE (Include Area Code): (970) 5553255		ZIP CODE: TELEPHONE (Include Area Code):
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) TUCKER GREGORY	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER BA1503
a. OTHER INSURED'S POLICY OR GROUP NUMBER 402004679 LA4832	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY 09 02 1961 SEX M [X] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] Place (State)	b. EMPLOYER'S NAME OR SCHOOL NAME ALLIED PROFESSIONS
c. EMPLOYER'S NAME OR SCHOOL NAME LAKESIDE AUTO	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME BLUE CROSS OF IOWA
d. INSURANCE PLAN NAME OR PROGRAM NAME MUTUAL LIFE	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO *If yes,* return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 06 06 XX		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE
14. DATE OF CURRENT MM DD YY 06 06 XX ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.) 1. 786.52 3. . 2. 780.62 4. .		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1. 06 06 XX 06 06 XX	11		99214		1 2	85 00	1		NPI	0199654321
2.									NPI	
3.									NPI	
4.									NPI	
5.									NPI	
6.									NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
99 9009009	[ ]	[X]		[X] YES [ ] NO	$ 85 00	$ 10 00	$ 75 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION STEWART CENTER FOR WOMEN 1200 CAROL LANE YOURTOWN CO 80000 a. 0220332233 b.	33. BILLING PROVIDER INFO & PH # (970) 5551010 STEWART CENTER FOR WOMEN 1200 CAROL LANE YOURTOWN CO 80000 a. 0220332233 b.

Practice Exercise 28-2

1. **802.6**

   Coding pathway: Fracture, orbit, floor (blow-out) 802.6

   Tabular List description: 802.6 Fracture of face bones, Orbital floor (blow-out), closed

2. **806.01**

   Coding pathway: Fracture, vertebra, cervical, with spinal cord injury – see Fracture, vertebra, with spinal cord injury, cervical

   New pathway: Fracture, vertebra, with spinal cord injury, cervical 806.0 ✓

   Tabular List description: 806.01 Fracture of vertebral column with spinal cord injury, Cervical, closed, C1-C4 level with complete lesion of cord

3. **812.52**

   Coding pathway: Fracture, humerus, condyle(s), lateral, open 812.52

   Tabular List description: 812.52 Fracture of humerus, Lower end, open, Lateral condyle

4. **839.20**

   Coding pathway: Displacement, intervertebral disc, due to trauma – see Dislocation, vertebra, lumbar

   New pathway: Dislocation, vertebra, lumbar 839.20

   Tabular List description: 839.20 Other, multiple and ill-defined dislocations, Thoracic and lumbar vertebra, closed, Lumbar vertebra

5. **845.13**

   Coding pathway: Rupture, joint capsule- see Sprain, by site

   New pathway: Sprain, interphalangeal, toe 845.13

   Tabular List description: 845.13 Sprains and strains of ankle and foot, Foot, Interphalangeal (joint), toe

6. **852.15**

   Coding pathway: Hemorrhage, intracranial, traumatic – see Hemorrhage, brain, traumatic, subarachnoid

   New pathway: Hemorrhage, brain, traumatic, subarachnoid, with open intracranial wound 852.1 ✓

   Fifth-digit subclassification 5 = with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level

   Tabular List description: 852.15 Subarachnoid hemorrhage following injury with open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level

7. **810.03 831.01**

   Coding pathway: Fracture, clavicle, acromial end 810.03

   Tabular List description: 810.03 Fracture of clavicle, Closed, acromial end of clavicle

   Coding pathway: Dislocation, humerus, proximal end, anterior 831.01

   Tabular List: 831.01 Dislocation of shoulder, Closed dislocation, anterior dislocation of humerus

8. **812.00 820.8**

   Coding pathway: Fracture, humerus, proximal end – *see* Fracture, humerus, upper end; Fracture, humerus, upper end 812.00

   Tabular List description: 812.00 Fracture of humerus, Upper end, closed, Upper end, unspecified part

   Coding pathway: Fracture, femur, neck 820.8

   Tabular List description: 820.8 Fracture of neck of femur, Unspecified part of neck of femur, closed

Practice Exercise 28-3

1. **871.3 873.42**

   Coding pathway: Enucleation of eye 871.3

   Tabular List: 871.3 Open wound of eyeball, Avulsion of eye

   Coding pathway: Laceration – see also Wound, open, by site

   New pathway: Wound, open, forehead 873.42

   Tabular List: 873.42 Other open wound of head, Face, without mention of complication, Forehead

2. **881.20**

   Coding pathway: Laceration – see also Wound, open, by site

   New pathway: Wound, open, forearm, with tendon involvement 881.20

   Tabular List: 881.20 Open wound of elbow, forearm and wrist, With tendon involvement, forearm

3. **821.11 904.2**

   Coding pathway: Fracture, femur, shaft, open 821.11

   Tabular List: 821.11 Fracture of other and unspecified parts of femur, Shaft or unspecified part, open, Shaft

   Coding pathway: Avulsion, blood vessel – see Injury, blood vessel, by site

   New pathway: Injury, blood vessel, femoral, vein 904.2

   Tabular List: 904.2 Injury to blood vessel of lower extremity and unspecified sites, Femoral veins

4. **917.2**

   Coding pathway: Blister – see also Injury, superficial, by site

   New pathway: Injury, superficial, heel (and foot or toe) 917 ✓

   Fourth-digit 2 = Blister without mention of infection

   Tabular List: 917.2 Superficial injury of foot and toe(s), Blister without mention of infection

5. **802.0 921.0 920**

   Coding pathway: Fracture, nose 802.0

   Tabular List: 802.0 Fracture of face bones, Nasal bones, closed

   Coding pathway: Black, eye 921.0

   Tabular List: 921.0 Black eye, not otherwise specified

   Coding pathway: Contusion, face 920

   Tabular List: 920 Contusion of face, scalp and neck except eye(s)

6. **824.1 928.21**

   Coding pathway: Fracture, malleolus, medial, open 824.1

   Tabular List: 824.1 Fracture of ankle, Medial malleolus, open

   Coding pathway: Crush, ankle 928.21

   Tabular List: 928.21 Crushing injury of lower limb, Ankle and foot, excluding toe(s) alone, Ankle

7. **945.26 942.24 948.10**

   Coding pathway: Burn, thigh, second degree 945.26

   Tabular List: 945.26 Burns of lower limb(s), Blisters, epidermal loss [second degree], thigh [any part]

   Coding pathway: Burn, back, second degree 942.24

   Tabular List: 942.24 Burn of trunk, Blisters, epidermal loss [second degree], back [any part]

   Coding pathway: Burn, extent (percent of body surface), 10-19 percent 948.1 ✓

   Fifth-digit 0 = less than 10 percent or unspecified as third degree

   Tabular List: 948.10 Burns classified according to extent of body surface involved, 10-19 percent of body surface

8. **967.0 E851**

   Table of Drugs and Chemicals: Barbiturates, barbituric acid

   Poisoning: 967.0 Accident: E851

   Tabular List: 967.0 Poisoning by sedatives and hypnotics, Barbiturates

   Tabular List: E851 Accidental poisoning by barbiturates

9. **982.8 E950.9**

   Table of Drugs and Chemicals: Nail polish remover

   Poisoning: 982.8 Suicide Attempt: E950.9

   Tabular List: 982.8 Toxic effect of solvents other than petroleum-based, Other nonpetroleum-based solvents

   Tabular List: E950.9 Suicide and self-inflicted poisoning by solid or liquid substances, Other and unspecified solid and liquid substances

10. Coding pathway: Burn, forearm, second degree **943.21**
    Coding pathway: Burn, extent, less than 10 percent **948.00**
    Fifth-digit 0= less than 10 percent or unspecified (third degree burn)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

MOUNTAIN STATES
1801 SW VINE STREET
DENVER, CO 80217

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) / (Medicaid#) / (Sponsor's SSN) / (Member ID #) X (SSN or ID) / (SSN) / (ID)	012345678
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) GIBBS STEVEN	3. PATIENT'S BIRTH DATE SEX 08 10 2000 M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial) GIBBS MICHAEL
5. PATIENT'S ADDRESS (No., Street) 1343 OVAL STREET	6. PATIENT RELATIONSHIP TO INSURED Self / Spouse / Child X / Other
7. INSURED'S ADDRESS (No., Street) SAME
CITY: WINDSOR — STATE: CO	8.PATIENT STATUS Single X / Married / Other Employed / Full-Time Student X / Part-Time Student
CITY — STATE
ZIP CODE: 80520 — TELEPHONE (Include Area Code): (970) 5557643
ZIP CODE — TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) NONE	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER 420
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES / X NO	a. INSURED'S DATE OF BIRTH SEX 02 11 1969 M X F
b. OTHER INSURED'S DATE OF BIRTH SEX M / F	b. AUTO ACCIDENT? Place (State) YES / X NO	b. EMPLOYER'S NAME OR SCHOOL NAME ADVANCED COMMUNICATIONS
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME MOUNTAIN STATES
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / X NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 09 10 XX

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 09 10 XX	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? $CHARGES YES / X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line.) 1. 943 . 21 3. . 2. 948 . 00 4. .		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1. 09	10	XX	09	10	XX	11		99204		1 2	88 00	1		NPI	
2.														NPI	
3.														NPI	
4.														NPI	
5.														NPI	
6.														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
987 21 5432 X		X YES / NO	$ 88 00	$ 0 00	$ 88 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION ERIC SULLIMAN MD 1000 MAIN STREET YOURTOWN CO 80000 a. 0377484809 b.	33. BILLING PROVIDER INFO & PH # (970) 5551717 ERIC SULLIMAN MD 1000 MAIN STREET YOURTOWN CO 80000 a. 0377484809 b.

Lesson 29

Practice Exercise 29-1

1. **198.3 V10.3**

   Coding pathway: Carcinoma – see also Neoplasm, by site, malignant

   New pathway: Neoplasm, brain, malignant, secondary 198.3

   Tabular List: 198.3 Secondary malignant neoplasm of other unspecified sites, Brain and spinal cord

   Coding pathway: History (personal) (of), malignant neoplasm (of), breast V10.3

   Tabular List: V10.3 Personal history of malignant neoplasm, Breast

2. **786.50 V45.89**

   Coding pathway: Pain, chest 786.50

   Tabular List: 786.50 Chest pain, unspecified

   Coding pathway: Status, postsurgical V45.89

   Tabular List: V45.89 Other postprocedural status, Other

3. **650 V27.0**

   Coding pathway: Delivery, normal –see category 650

   Tabular List: 650 Normal delivery

   Coding pathway: Outcome of delivery, single, liveborn V27.0

   Tabular List: V27.0 Outcome of delivery, Single liveborn

4. **V72.31**

   Coding pathway: Examination, gynecological V72.31

   Tabular List: V72.31 Special investigations and examinations, Gynecological examination, Routine gynecological examination

Practice Exercise 29-2

1. **842.00 E849.4 E885.2**

   Coding pathway: Sprain, wrist 842.00

   Tabular List: 842.00 Sprains and strains of wrist and hand, Wrist, Unspecified site

   Index to External Causes: Accident, occurring (at), park (public) E849.4

   Tabular List: E849.4 Place of occurrence, Place for recreation and sport

   Index to External Causes: Fall, from, skateboard E885.2

   Tabular List: E885.2 Fall on same level from slipping, tripping, or stumbling, Fall from skateboard

2. **945.30 948.33 E803.1**

   Coding pathway: Burns, leg, third degree 945.30

   Tabular List: 945.30 Burn of lower limb(s), Full-thickness skin loss [third degree NOS], lower limb [leg], unspecified site

   Coding pathway: Burns, extent (percent of body surface), 30-39 percent 948.3 ✓ .
   Remember, each anterior or posterior leg equals 9%. For our diagnosis, two anterior legs equal 18% and two posterior legs equal 18%. This results in a total of 36% body surface burned.

   Fifth-digit subclassification 3 = 30-39 percent (third degree burn)

   Tabular List: 948.33 Burns classified according to extent of body surface involved, 30-39 percent of body surface

   Index to External Causes: Explosion, railway engine, locomotive, train E803 ✓

   Fourth-digit 1 = Passenger on railway

   Tabular List: E803.1 Railway accident involving explosion, fire, or burning, Passenger on railway

3. **922.2 E812.1**

   Coding pathway: Contusions, abdomen 922.2

   Tabular List: 922.2 Contusion of trunk, Abdominal wall

   Index to External Causes: Collision, motor vehicle and another motor vehicle E812 ✓

   Fourth-digit 1 = Passenger in motor vehicle other than motorcycle

   Tabular List: E812.1 Other motor vehicle accident involving collision with motor vehicle

   Note: only "how" is coded because "where" is not documented.

4. **813.42 E849.0 E888.9**

   Coding pathway: Fracture, radius, distal end – see Fracture, radius, lower end

   New pathway: Fracture, radius, lower end 813.42

   Tabular List: 813.42 Fracture of radius and ulna, Lower end, closed, Other fractures of distal end of radius (alone)

   Index to External Causes: Accident, occurring (at), home E849.0

   Tabular List: E849.0 Place of occurrence, Home

   Index to External Causes: Fall, falling (accidental) E888.9

   Tabular list: E888.9 Other and unspecified fall

Practice Exercise 29-3

998.59

Coding pathway: Infection, postoperative, wound 998.59

Tabular List: 998.59 Other complications of procedures, not elsewhere classified, postoperative infection, Other postoperative infection

Practice Exercise 29-4

250.50 362.02 V58.67

Coding pathway: Diabetes, diabetic, retinopathy, proliferative 250.5 [362.02]

Tabular List: 250.50 Diabetes with ophthalmic manifestations

Fifth-digit 0 = type 2 or unspecified type, not stated as uncontrolled

Tabular List: 362.02 Diabetic retinopathy, Proliferative diabetic retinopathy

Coding pathway: Long-term, insulin V58.67

Tabular List: Long-term (current) use of insulin

Practice Exercise 29-5

486

Coding pathway: Pneumonia 486

Tabular List: 486 Pneumonia, organism unspecified

Practice Exercise 29-6

720.9 722.10

Coding pathway: Spondylopathy, inflammatory 720.9

Tabular List: 720.9 Ankylosing spondylitis and other inflammatory spondylopathies, Unspecified inflammatory spondylopathy

Coding pathway: Protrusion, intervertebral disc—*see* Displacement, intervertebral disc

New pathway: Displacement, intervertebral disc, lumbar 722.10

Tabular List: 722.10 Intervertebral disc disorders, Displacement of thoracic or lumbar intervertebral disc without myelopathy, Lumbar intervertebral disc without myelopathy

Practice Exercise 29-7

714.0 718.97 733.19 733.00 V13.51

Coding pathway: Arthritis, rheumatoid 714.0

Tabular List: 714.0 Rheumatoid arthritis and other inflammatory polyarthropathies, Rheumatoid arthritis

Coding pathway: Destruction, joint—*see also* Derangement, joint

New pathway: Derangement, joint, foot 718.97

Tabular List: 718.97 Other derangement of joint, Unspecified derangement of joint, ankle and foot

Coding pathway: Fracture, pathologic, specified site 733.19

Tabular List: 733.19 Other disorders of bone and cartilage, Pathologic fracture, Pathologic fracture of other specified site

Coding pathway: Osteoporosis (generalized) 733.00

Tabular List: 733.00 Other disorders of bone and cartilage, Osteoporosis, Osteoporosis, unspecified

Coding pathway: History of, fracture, healed, pathological V13.51

Tabular List: Personal history of other diseases, Pathological fracture

Practice Exercise 29-8

250.60 357.2 438.9 V58.67

Coding pathway: Diabetes, neuropathy; type 2 250.6 *[357.2]*; type 2
Tabular List description: 250.60 Diabetes with neurological manifestations; type 2
Tabular List description: 357.2 Polyneuropathy in diabetes
Coding pathway: Late effects (of), cerebrovascular disease 438.9
Tabular List description: 438.9 Unspecified late effects of cerebrovascular disease
Coding pathway: Long-term, insulin V58.67
Tabular List description: V58.67 Long-term (current) use of insulin

Practice Exercise 29-9

813.41

Coding pathway: Fracture, Colles' 813.41
Tabular List: 813.41 Fracture of radius and ulna, lower end, closed, Colles' fracture

Practice Exercise 29-10

288.60

Coding pathway: Leukocytosis 288.60
Tabular List: 288.60 Diseases of white blood cells, Leukocytosis, unspecified

Practice Exercise 29-11

455.1

Coding pathway: Hemorrhoids, internal, thrombosed 455.1
Tabular List: 455.1 Hemorrhoids, Internal thrombosed hemorrhoids

Practice Exercise 29-12

836.0 836.1

Coding pathway: Tear, meniscus, medial 836.0

Tabular List: 836.0 Dislocation of knee, Tear of medical cartilage or meniscus of knee, current

Coding pathway: Tear, meniscus, lateral 836.1

Tabular List: 836.1 Dislocation of knee, Tear of lateral cartilage or meniscus of knee, current

Lesson 30

Practice Exercise 30-1

1. **Electronic health records will replace paper health records.**
2. **People will use personal health records and take more responsibility for their health and well-being**
3. **Providers will move toward an electronic document management system based on computers.**
4. **Electronic coding will complete many of the easy, simple coding tasks.**
5. **More and more coders will telecommute from home.**