CHAPTER

15 Diagnosis Coding

Learning Objectives

After completing this chapter, you should be able to:

15.1 Define and spell the terms for this chapter.
15.2 Explain the medical assistant's role in diagnostic coding.
15.3 Describe the history of diagnostic coding.
15.4 List the expected benefits of the conversion to ICD-10.
15.5 Explain the organization of the ICD-10-CM manual.
15.6 Describe the purpose of each section of the ICD-10-CM manual.
15.7 Describe how to use the ICD-10-CM coding system to assign a diagnostic code.
15.8 Identify situations that require special diagnostic coding considerations.

Case Study

Sophia DiStefano, a 5-year-old female, is seen by Dr. Salpega. He diagnoses Sophia with bilateral chronic serous otitis media because this visit is the third bout of otitis media she has had within the past seven months. Dr. Salpega asks that David Dolan, a Registered Medical Assistant, conduct an audiometry screening on Sophia. He also suggests that Edvige, Sophia's mother, consider having Sophia undergo a bilateral tympanostomy and tube placement for a more permanent treatment of the chronic otitis media.

Terms to Learn

abuse
category
chapter
code
combination code
compliance
conventions
diagnosis coding
etiology
first-listed diagnosis
fraud
ICD-10-CM
Index to Diseases and Injuries
Index to External Causes
Main Term
medical coding
multiple coding
Office of the Inspector General (OIG)
Official Guidelines for Coding and Reporting (OGCR)
Patient Protection and Affordable Care Act (PPACA)
procedure coding
qualified diagnosis
section
subcategory
subterm
Table of Drugs and Chemicals
Table of Neoplasms
Tabular List
uncertain diagnosis
verify

Medical coding is the process of assigning alphanumeric characters that represent the diagnoses doctors give their patients (**diagnosis coding**) and the services they provide (**procedure coding**). Diagnosis codes are listed in **ICD-10-CM** (International Classification of Diseases, Clinical Modification) manual. These codes are used by all health care providers, including physicians. Procedure codes used by physicians and outpatient hospitals are listed in the CPT (Current Procedural Terminology) manual. Procedure codes used by inpatient hospitals are listed in the ICD-10-PCS (International Classification of Diseases, Procedure Coding System) manual.

MEDICAL CODING

In medical coding, the combination of diagnosis codes and related procedure codes provides the basis for health care reimbursement. The Health Insurance Portability and Accountability Act (HIPAA) mandates the approved code for all covered entities, such as medical offices, that handle claims related to health care services. On a broader scale, medical codes are used to compile and report statistics—within the United States and worldwide—regarding health status and health trends.

Physicians are responsible to code and bill for all the services they personally provide in medical offices, outpatient settings such as ambulatory surgery centers, and inpatient settings such as hospitals. This chapter, "Diagnosis Coding," focuses on how to assign ICD-10-CM diagnosis codes for patients seen in medical offices. The chapter titled "Procedure Coding" focuses on how to assign the CPT procedure codes.

The Role of Medical Assistants in Coding

Medical assistants usually do not perform medical coding as a regular part of their job because most offices hire or contract with professional certified coders who are trained in the details of assigning medical codes. However, the need may arise occasionally for medical assistants to research a code. In addition, medical assistants are among the few employees of medical offices who are trained in both the administrative and the clinical aspects of health care.

Therefore, medical assistants can fill an important role in the communication and understanding of medical codes in the following ways:

- Assist in communication between coders and physicians when a question arises.
- Provide appropriate diagnosis codes when an insurance preauthorization is required for a procedure or when a patient is referred to another provider for a procedure or consultation.
- Facilitate communication with attorneys who may need information about medical codes related to injured patients they represent. (Specific written authorization by patients is required for the release of protected health information [PHI] to attorneys.)
- Answer patient questions about the meanings of codes on their insurance claims or other paperwork.
- Review or facilitate medical documentation to help ensure it provides adequate specificity (detail) for coding.

Medical coding requires knowledge of anatomy and physiology; clinical procedures; local, state, and federal regulations; and attention to detail. Medical assistants should understand the scope and limitations of their training in medical coding, should provide assistance whenever possible, and should consult with a certified coder whenever they are not completely confident regarding the coding information requested.

History of Diagnosis Coding

Diagnosis coding began in 1893 with French physician Jacques Bertillon. Dr. Bertillon created the Bertillon Classification of Causes of Death, which the American Public Health Association (APHA) adopted in 1898. Historically, diagnosis coding was used to track the study of disease and causes of death. As the medical field became more sophisticated, so did the coding system. The system that began as a short list of diseases has now become a highly detailed classification of over 70,000 codes, each consisting of three to seven characters. Table 15-1 provides highlights of the history of diagnosis coding.

Overview of ICD-10-CM

ICD-10-CM is an update and major revision to the ICD-9-CM, which was used in the United States from 1979 to 2015 for diagnosis reporting.

TABLE 15-1 | **The History of Diagnosis Coding**

Date	Event
1893	French physician Jacques Bertillon creates the Bertillon Classification of Causes of Death.
1898	American Public Health Association (APHA) adopts the Bertillon Classification.
1901	APHA publishes the first coding manual, called the International Classification of Diseases (ICD), Volume I.
1910	APHA begins publishing updates to ICD approximately every 10 years.
1948	The World Health Organization (WHO), an arm of the United Nations (UN), takes responsibility for maintaining and publishing updates to what has become ICD-6.
1965	United States passes legislation authorizing government-funded health care programs for older adults (Medicare) and low-income families (Medicaid). United States publishes an adaptation of ICD-8 tailored to the needs of clinicians in this country, called International Classification of Diseases, Adapted (ICDA-8).
1979	WHO publishes ICD-9, and the United States publishes an adapted version, called International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM). The United States begins publishing annual updates to ICD-9-CM to refine the code set and keep pace with changes in medicine. The United States requires clinicians to report ICD-9-CM codes to receive reimbursement from Medicare and Medicaid.
1994	WHO publishes ICD-10 for worldwide reporting of morbidity and mortality data. The United States develops a clinical modification but does not implement it.
1999	The United States begins using ICD-10-CM for coding and classification of mortality data from death certificates.
2009	The United States passes legislation requiring the use of ICD-10-CM on October 1, 2013.
2012	The United States postpones the implementation of ICD-10-CM by clinicians one year, to October 1, 2014.
2014	The United States postpones implementation of ICD-10-CM until after October 1, 2015.
2015	The United States implements ICD-10-CM/PCS on October 1, 2015.

TABLE 15-2 | **Comparison of Codes in ICD-9-CM and ICD-10-CM**

Feature	ICD-9-CM	ICD-10-CM
Number of codes	16,000	70,000+
Code length	3 to 5 digits	3 to 7 characters
Code structure	3 digit category 4th and 5th digits for etiology, anatomic site, manifestation	3 character category 4th, 5th, 6th characters for etiology, anatomic site, severity 7th character used for additional information
First character	always numeric, except E-codes and V-codes	1st character is always alphabetic
Subsequent characters	all numeric	2nd character is always numeric; all other characters may be alphabetic or numeric
Decimal point	mandatory after 3rd character, except E codes where decimal point is after 4th character	mandatory after 3rd character on all codes
Placeholders	none	character "X" is used as a placeholder in certain 6- and 7-character codes

Because of numerous differences between ICD-9-CM and ICD-10-CM, the transition to the new coding system was one of health care's top priorities. Planning for ICD-10-CM began many years in advance, to analyze systems, update administrative processes, coordinate activities with vendors, train staff, and establish budgets for these activities. The overall process to plan for, implement, and monitor the ICD-10-CM transition required approximately five years.

Everyone who is part of the health care system or uses its data is impacted by the change to ICD-10-CM, including providers, payers, regulators, vendors, claims clearinghouses, medical billing services, researchers, educational institutions, and support staff in each of these settings. All computer systems that collect, transmit, receive, or store diagnostic data needed updating to accommodate the expanded length, format, and structure of codes. These changes further impacted the budgets of organizations and the productivity of workers.

Industry leaders expect that ICD-10-CM will bring many benefits to the health care field over the next several years, including more accurate, detailed data about health trends, fewer coding and billing errors, and an overall savings of time and money.

Table 15-2 compares ICD-9-CM with ICD-10-CM. Table 15-3 lists expected benefits of ICD-10-CM.

Compliance

Compliance simply means following the rules. Health care providers must follow rules established by multiple federal, state, and county government agencies. Some rules are specific to health care, and others pertain to any type of business. Companies and organizations establish compliance programs to actively keep informed about regulations, educate employees, and make sure that everyone in the company is cooperating.

Violating coding and billing rules can be classified as fraud or abuse. Knowingly billing for services that were never given or billing for a service that has a higher reimbursement than the service actually provided is **fraud**. Mistakenly accepting payment for items or services that should

TABLE 15-3 | **Expected Benefits of ICD-10-CM**

- Detailed diagnosis codes reduce the need for attachments to claims.
- Provides more detailed and higher quality data for tracking quality, safety, and effectiveness of health services.
- Expected to save time and money in the long run.
- Consistency across codes and more specific code descriptions help reduce coding errors.
- Combined with the increased use of electronic health records, the new code set provides more consistent and more detailed data for physician use.
- Advancements in technology and medical practice are reflected in the organization and description of codes.
- The coding system in the United States becomes more consistent with that used in other countries.
- Public officials can better track and respond to domestic and international public health threats.
- The structure of the new code set provides the flexibility to add codes, as needed, in the future.

not be paid as a result of improper coding and billing practices is **abuse**. Examples of fraud or abuse (depending on whether they are done knowingly or by mistake) are billing for a noncovered service, assigning a more costly code to a lesser service, or coding in a way that does not follow national or local coding guidelines. Investigation of Medicare fraud and abuse is primarily the responsibility of the Department of Health and Human Services (HHS) **Office of the Inspector General (OIG)**. The purpose of the OIG is to fight waste, fraud, and abuse in Medicare, Medicaid, and more than 300 other HHS programs.

The OIG provided guidance to assist health care entities to develop effective internal controls to help them be aware of and follow the requirements of federal, state, and private health plans. The OIG believes that health care institutions that adopt and implement compliance programs significantly reduce fraud, abuse, and waste. Compliance programs identify internal controls to help providers be aware of and follow the requirements of federal, state, and private health plans. The OIG has issued sample compliance programs that include seven major characteristics (Table 15-4).

The **Patient Protection and Affordable Care Act (PPACA)**, passed in 2010, mandates compliance programs for providers who contract with Medicare and Medicaid. The timeline for defining and implementing compliance programs has not yet been established.

Professionalism The Workplace

Most people like to stay in their comfort zone and feel stressed when faced with many changes. In health care, change is constant, whether it be new clinical procedures, updated equipment, changes in regulations, or revised administrative policies. When faced with change, show your professionalism by adopting a positive outlook. Rather than complaining about needing to learn new procedures, be proactive and encourage others to learn them too. Offer to do anything you can to help make the transition smoother for everyone.

Professionalism The Law

All providers and their staff members have a responsibility to be aware of the billing and coding rules established by the federal government and to follow them. Just as telling a police officer, "I didn't see the speed limit sign" does not mean you won't get a speeding ticket, you cannot plead "ignorance" about health care laws.

TABLE 15-4 | Characteristics of a Compliance Program

1. Develop and distribute written standards of conduct, policies, and procedures that address specific areas of potential fraud.
2. Designate a high level manager to be the chief compliance officer who oversees compliance activities.
3. Develop and implement education and training for employees.
4. Establish a process for reporting exceptions.
5. Develop an internal system to respond to accusations or reports of improper activities, and implement disciplinary measures when appropriate.
6. Develop an auditing and monitoring system.
7. Investigate and correct system-wide problems and develop policies regarding employment or retention of sanctioned individuals.

ORGANIZATION OF THE ICD-10-CM MANUAL

ICD-10-CM provides the codes that identify the diagnoses physicians give patients. ICD-10-CM lists over 70,000 diagnostic codes in one volume. ICD-10-CM codes are updated annually and take effect October 1 of each year. Code changes are published by the National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS), in conjunction with the World Health Organization (WHO). Medical assistants should use the edition of the ICD-10-CM that was in effect on the date of service.

Several companies publish the ICD-10-CM manual, so the exact order of information may vary, based on which publisher's book is used. A table of contents page near the front of the manual outlines the contents, organization, and page numbers of the ICD-10-CM (Table 15-5). CMS provides electronic files for ICD-10-CM, which can be downloaded (www.cms.gov).

Introductory Material

The introductory material in the beginning of the ICD-10-CM provides important information for medical assistants. Not only does it provide instructions on how to use ICD-10-CM, it also includes the Official Guidelines for Coding and Reporting (OGCR), universal conventions, and publisher-specific conventions.

Conventions

Conventions are specialized rules, abbreviations, formatting, and symbols that alert users to important information. These

TABLE 15-5 | **Organization of the ICD-10-CM Manual**

Type of Information	Name of Section	Purpose
Introductory material	Preface Introduction How to Use the ICD-10-CM ICD-10-CM Conventions ICD-10-CM Official Guidelines for Coding and Reporting	Information and rules on how to use the manual.
Index	ICD-10-CM Index to Diseases and Injuries (Index) ICD-10-CM Table of Neoplasms ICD-10-CM Table of Drugs and Chemicals ICD-10-CM Index to External Causes	Alphabetical list of diseases and injuries, reasons for encounters, and external causes. Two tables provide quick lookups, one for neoplasms and one for drugs and chemicals causing injury. Coders must always reference one of these indices or tables when searching for a code.
Tabular list	ICD-10-CM Tabular List of Diseases and Injuries	Numerical list of diseases and injuries, reasons for encounters, and external causes. Provides additional instruction on how to use, assign, and sequence codes. Coders must always reference the Tabular List to verify a code, after consulting the Index, and before assigning the final code.

are described at the beginning of the manual. A key to selected symbols usually appears at the bottom of each page. Certain conventions are universal to all ICD-10-CM manuals, and others are specific to each publisher. Conventions that are an official part of the ICD-10-CM code set are explained in the OGCR and appear in Table 15-6. The most important of these for medical assistants are *Excludes1* and *Excludes2*. These notations explain which codes cannot be used together, as explained next.

ICD-10-CM codes are alphanumeric, meaning they consist of both letters and numbers. The letters are usually written as uppercase but are not case sensitive. Either uppercase or lowercase letters may be used with no change in meaning.

Excludes1. Excludes1 notes appear immediately under a code in the **Tabular List**. The note is followed by a list of other conditions and codes. Excludes1 means that the condition represented by the code and the condition listed as excluded are mutually exclusive and should not be coded together. When an Excludes1 note appears under a code, none of the codes that appear after it should be used with the code where the note appears. This occurs frequently with conditions that may be either congenital or acquired.

EXAMPLE: *Excludes1*

K55 Vascular disorder of intestine

Excludes1: necrotizing enterocolitis of newborn (P77.-)

The second condition, necrotizing enterocolitis of newborn, is not included in codes that begin with K55 Vascular disorder of intestine, and the codes are mutually exclusive. A patient cannot have both conditions. When coding for necrotizing enterocolitis of newborn, the correct code begins with P77, not K55.

Excludes2. Excludes2 notes also appear immediately under a code in the Tabular List. The note is followed by a list of other conditions and codes. Excludes2 means that the condition excluded is not part of the condition represented by the code, but the patient may have both conditions at the same time. These conditions are not mutually exclusive. When an Excludes2 note appears under a code, it is acceptable to use the main code and the excluded code if the patient is documented to have both conditions.

EXAMPLE: *Excludes2*

K86.0 Alcohol induced chronic pancreatitis

Excludes2: alcohol induced acute pancreatitis (K85.2)

The second condition, alcohol induced acute pancreatitis, is not included in code K86.0, but may be reported together with it, if the documentation states that the patient has both the acute and chronic forms of the condition.

Seventh Character. The seventh character of an ICD-10-CM code is reserved for special use, most commonly the episode of care for injuries. The seventh character must be assigned

TABLE 15-6 | **ICD-10-CM Conventions**

Convention	Meaning/Use
– Short dash	**Index and Tabular:** Additional characters should be assigned in place of the –. The additional characters may be numbers or letters.
( ) Parentheses	**Index and Tabular:** Nonessential modifiers that describe the default variations of a term. These words are not required to appear in the documentation to use the code.
: Colon	**Tabular:** Appears after an incomplete term that requires one or more modifiers following the colon to be classified to that code or category.
[ ] Square brackets	**Tabular:** Synonyms, alternative wording, explanatory phrases **Index:** Indicates sequencing on etiology/manifestation codes or other paired codes. The code in square brackets [ ] should be sequenced second.
And	**Tabular:** Means "and/or"
Boldface (Heavy type)	**Index:** Main terms **Tabular:** Code titles
Code Also	**Tabular:** More than one code may be required to fully describe the condition.
Code First/Use Additional Code	**Tabular:** Provides sequencing instructions for conditions that have both an underlying etiology and multiple body system manifestations and certain other codes that have sequencing requirements.
Excludes1	**Tabular:** Mutually exclusive codes. None of the codes that appear after this term should be used with the original code itself.
Excludes2	**Tabular:** The code(s) listed after this term are not part of the condition represented by the code but may be reported together if documented.
Includes notes	**Tabular:** Begin with the word "Includes" and further define, clarify, or give examples.
Inclusion terms	**Tabular:** A list of synonyms or conditions included within a classification.
Italics (Slanted type)	**Tabular:** Exclusion notes, manifestation codes.
NEC	**Index and Tabular:** Not Elsewhere Classifiable. The medical record contains additional details about the condition, but there is not a more specific code available to use.
NOS	**Tabular:** Not Otherwise Specified. Information to assign a more specific code is not available in the medical record.
See	**Index:** It is necessary to reference another Main Term or condition to locate the correct code.
See Also	**Index:** Coder may refer to an alternative or additional Main Term if the desired entry is not found under the original Main Term.
With	**Tabular:** In a code title, means "both" or "together."
With/Without	**Tabular:** Within a set of alternative codes, describe options for final character.
X	**Tabular:** A placeholder in codes with less than six characters that require a 7th character extension. The X itself has no meaning and is not replaced with an actual number or letter. In some codes, the X is used to reserve room for future expansion.

from the Tabular List. When a seventh character is required on a code of five or fewer characters, add the placeholder X to fill out the empty characters in the code.

Placeholders. The character X appears in certain codes that are four, five, or six characters long. It is used in two ways:

- Some codes that are five or six characters long use the X to reserve a position for future use. In the examples that follow, X is used to hold the fourth position of the code open for future use and has no meaning. The fifth and sixth characters are part of the core code.
  - J09.X1 Influenza due to identified novel influenza A virus with pneumonia
  - M01.X21 Direct infection of right elbow in infectious and parasitic diseases classified elsewhere
- When codes that are four or five characters long require a seventh character for special purposes, the

placeholder X is used to fill in any empty positions. In the example that follows, the core code is S69.80. The seventh characters A and D identify the initial and subsequent encounter for the injury and must appear in the seventh position, so X is used to expand the length of the code.

- S69.80XA Other specified injuries to the wrist, initial encounter
- S69.80XD Other specified injuries to the wrist, subsequent encounter

Official Guidelines for Coding and Reporting

The ICD-10-CM **Official Guidelines for Coding and Reporting (OGCR)** are rules that provide directions for how to code selected conditions and establish the rules for how to identify which diagnoses should be reported on a claim for any given patient (Figure 15-1). HIPAA requires that coders adhere to OGCR when assigning ICD-10-CM diagnosis codes. The OGCR also explain the conventions that are universal within the ICD-10-CM code set.

4. Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00-E89)

a. Diabetes mellitus

The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system. As many codes within a particular category as are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for a particular encounter. Assign as many codes from categories E08 – E13 as needed to identify all of the associated conditions that the patient has.

1. **Type of diabetes**
   The age of a patient is not the sole determining factor, though most type 1 diabetics develop the condition before reaching puberty. For this reason type 1 diabetes mellitus is also referred to as juvenile diabetes.
2. **Type of diabetes mellitus not documented**
   If the type of diabetes mellitus is not documented in the medical record the default is E11.-, Type 2 diabetes mellitus.
3. **Diabetes mellitus and the use of insulin**
   If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11, Type 2 diabetes mellitus, should be assigned. Code Z79.4, Long-term (current) use of insulin, should also be assigned to indicate that the patient uses insulin. Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient's blood sugar under control during an encounter.

FIGURE 15-1 Example of the Official Guidelines for Coding and Reporting.

Index to Diseases and Injuries

The **Index to Diseases and Injuries** (Index) lists conditions, diseases, and reasons for seeking medical care. Index entries are organized alphabetically by **Main Term** and **subterms** that aid in locating the most appropriate code. After identifying preliminary codes in the Index, verify them in the Tabular List. Final code selection should never be based only on the Index.

Although most conditions and reasons for the encounter are located in the Index to Diseases and Injuries, ICD-10-CM has three additional references for specialized purposes.

- **Table of Neoplasms**—Neoplasms are indexed on the Table of Neoplasms, located under "N" in the alphabetic Index. Some publishers may place this table at the end of the Index (Figure 15-2).
- **Table of Drugs and Chemicals**—Poisonings, adverse effects, and underdosing are indexed on the ICD-10-CM Table of Drugs and Chemicals, which is located at the end of the Index in most manuals (Figure 15-3).
- **Index to External Causes**—External causes of illness and injury are located in a separate index, the ICD-10-CM Index to External Causes, which follows the Table of Drugs and Chemicals in most manuals (Figure 15-4).

Tabular List

The Tabular List is an alphanumerically sequenced list of all diagnosis codes, divided into 21 chapters based on cause, or **etiology**, and body system. After locating the diagnosis in the Index, medical assistants need to **verify** the code by referencing the Tabular List. To verify a code means to consult the Tabular List to read detailed code descriptions, conventions, and instructional notes, and to assign additional specificity. Medical assistants need to know where to find the beginning of each chapter, because the beginning of the chapter provides global instructions that apply to all codes within the chapter. Table 15-7 shows the organization of the Tabular List and the code ranges for each chapter. Most chapters begin with a unique letter of the alphabet.

HOW TO CODE DIAGNOSES

Coding begins and ends with the patient's medical record. Medical assistants abstract, or summarize, information from the medical record to code for services and the reasons they were provided.

	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified Behavior
-shoulder NEC	C76.4-	C79.89	D04.6-	D36.7	D48.7	D49.8
-sigmoid flexure (lower) (upper)	C18.7	C78.5	D01.0	D12.5	D37.4	D49.0
-sinus (accessory)	C31.9	C78.39	D02.3	D14.0	D38.5	D49.1
--bone (any)	C41.0	C79.51	–	D16.4-	D48.0	D49.2
--ethmoidal	C31.1	C78.39	D02.3	D14.0	D38.5	D49.1
--frontal	C31.2	C78.39	D02.3	D14.0	D38.5	D49.1
--maxillary	C31.0	C78.39	D02.3	D14.0	D38.5	D49.1
--nasal, paranasal NEC	C31.9	C78.39	D02.3	D14.0	D38.5	D49.1
--overlapping lesion	C31.8	–	–	–	–	–
--pyriform	C12	C79.89	D00.08	D10.7	D37.05	D49.0
--sphenoid	C31.3	C78.39	D02.3	D14.0	D38.5	D49.1
-skeleton, skeletal NEC	C41.9	C79.51	–	D16.9-	D48.0	D49.2
-Skene's gland	C68.1	C79.19	D09.19	D30.8	D41.8	D49.5
-skin NOS	C44.90	C79.2	D04.9	D23.9	D48.5	D49.2
--abdominal wall	C44.509	C79.2	D04.5	D23.5	D48.5	D49.2
---basal cell carcinoma	C44.519	–	–	–	–	–

FIGURE 15-2 Example of the Table of Neoplasms.

Substance	Poisoning, Accidental (unintentional)	Poisoning, Intentional Self-harm	Poisoning, Assault	Poisoning, Undetermined	Adverse Effect	Underdosing
Aconitum ferox	T46.991	T46.992	T46.993	T46.994	T46.995	T46.996
Acridine	T65.6X1	T65.6X2	T65.6X3	T65.6X4	–	–
-vapor	T59.891	T59.892	T59.893	T59.894	–	–
Acriflavine	T37.91	T37.92	T37.93	T37.94	T37.95	T37.96
Acriflavinium chloride	T49.0X1	T49.0X2	T49.0X3	T49.0X4	T49.0X5	T49.0X6
Acrinol	T49.0X1	T49.0X2	T49.0X3	T49.0X4	T49.0X5	T49.0X6
Acrisorcin	T49.0X1	T49.0X2	T49.0X3	T49.0X4	T49.0X5	T49.0X6
Acrivastine	T45.0X1	T45.0X2	T45.0X3	T45.0X4	T45.0X5	T45.0X6
Acrolein(gas)	T59.891	T59.892	T59.893	T59.894	–	–
-liquid	T54.1X1	T54.1X2	T54.1X3	T54.1X4	–	–
Acrylamide	T65.891	T65.892	T65.893	T65.894	–	–
Acrylic resin	T49.3X1	T49.3X2	T49.3X3	T49.3X4	T49.3X5	T49.3X6
Acrylonitrile	T65.891	T65.892	T65.893	T65.894	–	–
Actaea spicata	T62.2X1	T62.2X2	T62.2X3	T62.2X4	–	–
-berry	T62.1X1	T62.1X2	T62.1X3	T62.1X4	–	–

FIGURE 15-3 Example of the Table of Drugs and Chemicals.

Coding is to be performed to the highest level of certainty. Only conditions, diseases, and symptoms documented in the medical record can be coded and billed. If the medical record is incomplete or inaccurate, it should be corrected or amended before attempting to code.

Diagnosis coding involves three basic steps:

1. Identify the first-listed diagnosis.
2. Research the diagnosis in the Index.
3. Verify the code(s) in the Tabular List.

Abandonment (causing exposure to weather conditions) (with intent to injure or kill) NEC X58
[illegible]se (adult) (child) (mental) (physical) (sexual) X58
[illegible]cident (to) X58
-aircraft (in transit) (powered)—*see also* Accident, transport, aircraft
--due to, caused by cataclysm—*see* Forces of nature, by type
-animal-rider—*see* Accident, transport, animal-rider
-animal-drawn vehicle—*see* Accident, transport, animal-drawn vehicle occupant
-automobile—*see* Accident, transport, car occupant
-bare foot water skiier V94.4
-boat, boating—*see also* Accident, watercraft
--striking swimmer
---powered V94.11
---unpowered V94.12
-bus—*see* Accident, transport, bus occupant
-cable car, not on rails V98.0
--on rails—*see* Accident, transport, streetcar occupant
-car—*see* Accident, transport, car occupant
-caused by, due to
--animal NEC W64
--chain hoist W24.0
--cold (excessive)—*see* Exposure, cold
--corrosive liquid, substance—*see* Table of Drugs and Chemicals
--cutting or piercing instrument—*see* Contact, with, by type of instrument
--drive belt W24.0
--electric
[illegible]urrent—*see* Exposure, electric current
[illegible]motor (*see also* Contact, with, by type of machine) W31.3
----current (of) W86.8
--environmental factor NEC X58

FIGURE 15-4 Example of the Index to External Causes.

It is important to keep in mind that the diagnosis must describe (1) the reasons that the specific service was provided, and (2) related medical conditions that may affect the specific service. Diagnosis codes should not repeat a patient's entire problem list. The problem list is a comprehensive list of all active conditions that often appears in the front of the medical record, but it does not document the reason(s) for a specific encounter.

A patient's condition can require one or several codes, depending on the complexity of the patient's condition, the number of complications and comorbidities, and the organization of the coding manual. For many diagnoses, such as diabetes, a **combination code** identifies the condition and various manifestations or two conditions that commonly occur together. Other situations require **multiple coding**—reporting several codes to fully describe the condition.

EXAMPLE: *Code actively managed conditions*

[illegible]ne physician sees a patient for a sinus infection, who also has chronic gastric reflux. The physician prescribes an

TABLE 15-7 | **ICD-10-CM Tabular List**

Chapter	Title	Code Range
Chapter 1	Certain infectious and parasitic diseases	A00-B99
Chapter 2	Neoplasms	C00-D49
Chapter 3	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	D50-D89
Chapter 4	Endocrine, nutritional, and metabolic diseases	E00-E89
Chapter 5	Mental, behavioral, and neurodevelopmental disorders	F01-F99
Chapter 6	Diseases of the nervous system	G00-G99
Chapter 7	Diseases of the eye and adnexa	H00-H59
Chapter 8	Diseases of the ear and mastoid process	H60-H95
Chapter 9	Diseases of the circulatory system	I00-I99
Chapter 10	Diseases of the respiratory system	J00-J99
Chapter 11	Diseases of the digestive system	K00-K95
Chapter 12	Diseases of the skin and subcutaneous tissue	L00-L99
Chapter 13	Diseases of the musculoskeletal system and connective tissue	M00-M99
Chapter 14	Diseases of the genitourinary system	N00-N99
Chapter 15	Pregnancy, childbirth, and the puerperium	O00-O9A
Chapter 16	Certain conditions originating in the perinatal period	P00-P96
Chapter 17	Congenital malformations, deformations, and chromosomal abnormalities	Q00-Q99
Chapter 18	Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified	R00-R99
Chapter 19	Injury, poisoning, and certain other consequences of external causes	S00-T88
Chapter 20	External causes of morbidity	V01-Y99
Chapter 21	Factors influencing health status and contact with health services	Z00-Z99

antibiotic for the acute sinus infection and inquires how the gastric reflux is doing, but does not further evaluate, treat, or manage it. The medical assistant codes only the sinus infection.

ICD-10-CM code: J01.90 Acute sinusitis, unspecified

EXAMPLE: *Code all relevant medical conditions*

A diabetic patient comes into the office for a second-degree burn on the right hand. The physician treats the burn and indicates that the diabetes may slow the healing process and requires more frequent follow-up visits as a result. The medical assistant codes both the burn and the diabetes. The first-listed diagnosis is the burn. The secondary diagnosis is diabetes.

ICD-10-CM codes: T23.201A Burn of second degree of right hand, unspecified site, initial encounter

E11.9 Type 2 diabetes mellitus without complications

EXAMPLE: *Use a combination code when one is available*

A patient with type 1 diabetes sees an ophthalmologist because of changes in vision. The physician examines the patient and diagnoses moderate nonproliferative retinopathy due to diabetes. The medical assistant assigns a combination code that describes both conditions.

ICD-10-CM code: E10.339 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema

EXAMPLE: *Use multiple codes when required*

A patient presents with a skin abscess on the abdomen. The physician prescribes antibiotics. A culture and sensitivity test is positive for the organism *Staphylococcus aureus* that is responsive to methicillin. The medical assistant codes for skin abscess and notes that the coding manual instructs to also code for the causal organism.

ICD-10-CM codes: L02.211 Cutaneous abscess of abdominal wall

B95.61 Methicillin susceptible Staphylococcus aureus infection as the cause of diseases classified elsewhere

The following coding steps provide the practical details needed to patiently and accurately execute the process. This discussion is oriented toward office-based coding.

Abstract Diagnostic Information

Medical assistants abstract information from the medical record to identify the information necessary to code for services and the reasons they were provided. When coding for office-based or other outpatient services, medical assistants refer to the patient registration form, the encounter form, visit notes, lab and radiology reports, and operative reports for outpatient procedures. Often the physician indicates a diagnosis code on the encounter form, but medical assistants may need to verify it against the medical record. Look for a definitive diagnostic statement by the physician regarding the reason for the visit. The diagnosis might be indicated with the word *Impression* or, in SOAP notes (Subjective, Objective, Assessment, Plan), under A (*Assessment*). This is the **first-listed diagnosis**, formerly known as the primary diagnosis, the reason chiefly responsible for the services provided.

Uncertain diagnosis or **qualified diagnosis** is a diagnosis accompanied by a term such as *possible, probable, suspected, rule out (R/O),*or *working diagnosis*, indicating the physician has not determined the root cause. For outpatient coding, do not use uncertain diagnoses. Instead, look for the patient's signs or symptoms that are part of the patient's chief complaint. The chief complaint is a statement in the patient's own words of the reason for the visit. Signs are indications of a condition that the physician can observe or measure, such as a rash. Symptoms are indications reported by the patient that the physician cannot observe or measure, such as a headache.

CRITICAL THINKING

Refer to the Case Study at the beginning of the chapter.

1. With what type of otitis media was Sophia diagnosed?
2. Does the condition occur in the right ear, left ear, or bilaterally?

Research Codes in the Index

After determining the diagnosis in the patient's medical record, use the ICD-10-CM coding manual to assign the actual code number. The first step in using the coding manual is to identify the diagnosis in the Index. Using the Index involves three steps:

1. Locate the Main Term.
2. Read the subterms and modifiers.
3. Identify the preliminary code(s).

Identify the word(s) from the first-listed diagnosis to be looked up as the Main Term in the Index (Figure 15-5). The Main Term is always boldfaced with an initial capital letter in the Index. The Main Term may be any of the following:

- A condition, such as *Fracture*
- A disease, such as *Pneumonia*
- Reason for a visit, such as *Screening*
- Eponym (a disease or condition named after an individual), such as *Colles' fracture*

- Abbreviation or acronym, such as *AIDS*
- Nontechnical synonym (a word similar in meaning), such as *Broken* instead of fracture
- An adjective, such as *Twisted*

Some Main Terms, such as *Disease*, are rather generic with pages of subterms, but others, such as *Duroziez disease*, are quite specific and list only one code.

Main Terms usually do not include anatomic sites. To locate a condition that affects a specific site, look up the condition itself as the Main Term. Then read the subterms to locate the anatomic site (Figure 15-6).

EXAMPLE: *Anatomic sites are not Main Terms*

A medical assistant needs to code for an ankle sprain. She looks in the Index under A for the Main Term *Ankle*, and finds an entry with the cross-reference *Ankle—see condition*. The condition is a *sprain*. She looks under *S* for the Main Term *Sprain* in the Index. Under *Sprain*, she locates the subterm *ankle*. The subterm entry *ankle* provides additional subterms for the exact site and type of sprain.

Gastrinoma
-malignant
--pancreas C25.4
--specified site NEC—*see* Neoplasm, malignant, by site
--unspecified site C25.4
-specified site—*see* Neoplasm, uncertain behavior
-unspecified site D37.9
Gastritis (simple) K29.70
-with bleeding K29.71
-acute (erosive) K29.00
-with bleeding K29.01
-alcoholic K29.20
--with bleeding K29.21
-allergic K29.60
--with bleeding K29.61
-atrophic (chronic) K29.40
--with bleeding K29.41
-chronic (antral) (fundal) K29.50
--with bleeding K29.51
--atrophic K29.40
---with bleeding K29.41
--superficial K29.30
---with bleeding K29.31
-dietary counseling and surveillance Z71.3
-due to diet deficiency E63.9
-eosinophilic K52.81
-giant hypertrophic K29.60
--with bleeding K29.61
-granulomatous K29.60
--with bleeding K29.61
-hypertrophic (mucosa) K29.60
--with bleeding K29.61
-nervous F54
-spastic K29.60
--with bleeding K29.61
-specified NEC K29.60
--with bleeding K29.61
-superficial chronic K29.30

FIGURE 15-5 Example of the Index to Diseases and Injuries.

Anisocytosis R71.8

Anisometropia (congenital) H52.31

Ankle—*see* condition

Ankyloblepharon (eyelid) (acquired)—*see also* Blepharophimosis
filiforme (adnatum) (congential) Q10.3
total Q10.3

FIGURE 15-6 Example of Index entry for an anatomic site with a cross-reference.

Subterms are words indented two spaces under the boldfaced Main Term that further describe variations of the condition. Examples of types of subterms are:

- Etiology: Pneumonia, *allergic*
- Coexisting condition: Pneumonia, *with influenza*
- Anatomic site: Pneumonia, *interstitial*
- Episode: Pneumonia, *chronic*, or similar descriptors

Subterms often have second-, third-, and additional-level subterms, each level being indented another two spaces under the preceding level. The meaning of each indented level includes the subterm at the previous level. It is important to carefully follow the sequence of subterms and subsequent levels of subterms to locate the most specific code. Figure 15-7 shows an example of an Index entry with multiple levels of subterms.

When the Main Term or subterm is too long to fit on one line, a carryover line is used. Carryover lines are indented more than two spaces from the level of the preceding line. It is important to read carefully to distinguish between carryover lines and subterms.

Main Terms or subterms may contain instructional notes, such as *see* or *see also*, which direct the user to other entries. For example, *Pleurobronchopneumonia—see Pneumonia, broncho-*. This directs the user to the appropriate entry for the code needed. In this example, the user should look under the Main Term *Pneumonia* and the subterm *broncho-* to locate the code for *Pleurobronchopneumonia*.

Entries under the Main Term may contain special formatting, such as slanted brackets, indicating that multiple coding may be required. The second code in slanted brackets is

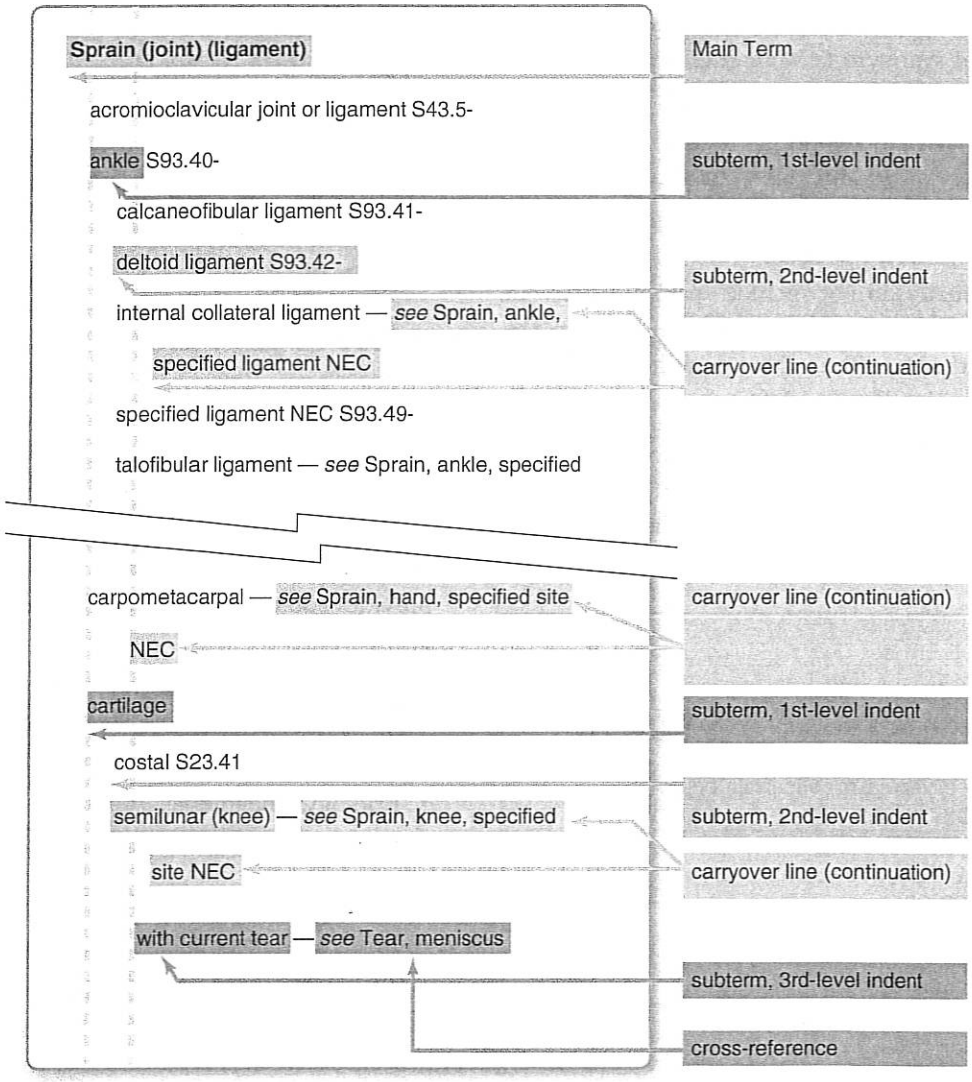

FIGURE 15-7 Example of Index entry with Main Term and indented subterms.

required in addition to the first code to completely describe the condition.

When the appropriate subterms are located, the preliminary code(s) appears immediately to the right. It is helpful to jot down the appropriate preliminary codes before verifying in the Tabular List. Never use the Index to make the final code selection.

CRITICAL THINKING

Refer to the Case Study at the beginning of the chapter.

1. What is the Main Term to be looked up in the Index?
2. What subterms should be located?
3. What cross-referencing instruction appears next to the fourth-level subterm *serous*?
4. What code is suggested in the Index?

Verify Codes in the Tabular List

Preliminary codes found in the Index must be verified in the Tabular List to confirm the code description and assign additional characters that specify details of the condition, such as laterality (the side of the body) and episode of care. Look for the preliminary code number in the Tabular List, which lists codes in alphanumeric order. The Tabular List contains 21 **chapters** based on etiology or the body system. The chapter numbers do not correlate directly with the code numbers. Review Table 15-7. Chapters are divided into **sections** with boldfaced or highlighted headings. Within the sections, the actual code numbers are tabulated in three levels: **category** (three-character entries), **subcategory** (four- and five-character entries), and **code** (the most specific entry that requires no additional characters) (Figure 15-8). It is helpful to learn the specific meanings of

Level	Example
Chapter	Chapter 10 Diseases of the respiratory system (J00-J99)
Block	Influenza and pneumonia (J09-J18)
Category	J15 Bacterial pneumonia, not elsewhere classified
Subcategory	J15.2 Pneumonia due to staphylococcus
	J15.21 Pneumonia due to staphylococcus
Code	J15.211 Pneumonia due to staphylococcus

FIGURE 15-8 Organizational structure of ICD-10-CM chapters.

these designations, because the terms are used frequently in coding instructions.

Before verifying and finalizing the code, medical assistants must interpret the conventions that appear with the code and its category. Tabular List conventions include punctuation, instructional notes, and symbols. Conventions may appear on the same line with the code, above it, below it, or at the beginning of a subcategory, category, section, or chapter. Look carefully for any information that may be relevant to the code selection. Additional information may direct you when to use a different code or an additional code, depending on your original diagnostic statement. Figure 15-9 shows an example of conventions in the Tabular List.

ICD-10-CM codes can be between three and seven characters in length (Table 15-8). There is no general rule regarding how many characters any given code must have. The number of characters is determined after reading the instructional notes and conventions available in the category. Use the most specific code available for each condition. Most coding manuals display a symbol or color-coding with entries that provide a more specific code.

Within a preliminary code or category, the Tabular List often provides options for anatomic site, laterality, with or without manifestations, and other details. When provided, these details must be coded with additional characters to assign a code with the highest level of specificity.

The seventh character of an ICD-10-CM code is reserved for special use, most commonly the episode of care. Episode of care characters do not appear sequentially within the Tabular List. They appear at the beginning of a subcategory or category and apply to all codes within that division. Be certain to review the subcategory and category headings thoroughly to locate the correct seventh characters when required. It sometimes requires a little detective work and reviewing several pages of codes to locate the appropriate listing (Figure 15-10).

As a final check, with coding manual instructions fresh in your mind, refer back to the original documentation and verify that all conditions of the code agree with the medical record. If a discrepancy arises, work through the process again from the beginning. Procedure 15-1 summarizes how to assign ICD-10-CM diagnosis codes.

K29 Gastritis and duodenitis

Excludes1: eosinophilic gastritis or gastroenteritis (K52.81)
Zollinger-Ellison syndrome (E16.4)

K29.0 Acute gastritis
Use additional code to identify:
alcohol abuse and dependence (F10.-)
Excludes1: erosion (acute) of stomach (K25.-)
K29.00 Acute gastritis without bleeding
K29.01 Acute gastritis with bleeding

K29.2 Alcoholic gastritis
Use additional code to identify:
alcohol abuse and dependence (F10.-)
K29.20 Alcoholic gastritis without bleeding
K29.21 Alcoholic gastritis with bleeding

K29.3 Chronic superficial gastritis
K29.30 Chronic superficial gastritis without bleeding
K29.31 Chronic superficial gastritis with bleeding

K29.4 Chronic atrophic gastritis
Gastric atrophy
K29.40 Chronic atrophic gastritis without bleeding
K29.41 Chronic atrophic gastritis with bleeding

FIGURE 15-9 Example of the Tabular List and instructional notes (conventions).

TABLE 15-8 | Examples of ICD-10-CM Codes with Varying Number of Characters

Code Length	Code	Description
3-characters	I10	Essential (primary) hypertension
4-characters	F52.8	Other sexual dysfunction not due to a substance or known physiological condition
5-characters	K70.30	Alcoholic cirrhosis of liver without ascites
6-characters	L89.511	Pressure ulcer of right ankle, stage 1
7-characters	T22.761A	Corrosion of third degree of right scapular region, initial encounter
7-characters with placeholder X	O33.4XX0	Maternal care for disproportion of mixed maternal and fetal origin, fetus 1

S94 Injury of nerves at ankle and foot level

The appropriate 7th character is to be added to each code from category S94
A - initial encounter
D - subsequent encounter
S - sequela

S94.0 Injury of lateral plantar nerve
S94.02 Injury of lateral plantar nerve, right leg

Final codes with placeholder X and episode of care characters:

S94.02XA Injury of lateral plantar nerve, right leg, initial encounter
S94.02XD Injury of lateral plantar nerve, right leg, subsequent encounter
S94.02XS Injury of lateral plantar nerve, right leg, sequela

FIGURE 15-10 Example use of a placeholder (X) and episode of care characters.

Professionalism

Patients may not understand the diagnosis stated on the encounter form or insurance statement. This may be especially true of patients with multiple chronic conditions. The medical assistant can help patients with any questions they may have concerning the encounter form by patiently explaining the information in terms that are easily understood.

CRITICAL THINKING

Refer to the Case Study at the beginning of the chapter.

1. When verifying the code in the Tabular List, what information is needed to assign the correct code?
2. What is the final diagnostic code and description for Sophia's encounter?

PROCEDURE 15-1

Performing ICD-10-CM Diagnostic Coding

Objective ◆ *Assign ICD-10-CM codes based on documentation.*

EQUIPMENT AND SUPPLIES

Patient's medical chart; current ICD-10-CM coding manual; superbill with doctor's written diagnosis

METHOD

1. Locate the patient's diagnostic code(s) or description on the encounter form or in the chart notes.
2. Verify that the diagnostic code(s) or description on the encounter form also appears in the patient's chart in the form of a patient complaint (subjective finding) or a test finding (objective finding).
3. Look in the Index of the ICD-10-CM coding manual to find the Main Term. Search the subterms for the most specific description, and identify the preliminary diagnosis code.
4. Look up the preliminary code(s) in the Tabular List. Confirm that the written description matches the chart notes. If in doubt, check with the physician.
5. Read and apply the conventions in the Tabular List. Assign any additional characters required.
6. Assign the code for each diagnosis, beginning with the appropriate first-listed diagnosis.

Coding for Special Situations

Many diagnoses require advanced coding skills to accurately capture the details of a specific patient's situation. Table 15-9 summarizes how to code for diagnoses that may present special challenges. Because some of these may exceed some medical assistants' experience, they should show their professionalism by recognizing when additional expertise is required. Medical assistants may work in offices that hire certified coders to assign and audit diagnosis codes.

Reporting incorrect diagnosis codes on an insurance claim can create problems such as improper reimbursement, inaccurate patient medical history, and fraud. Whenever medical assistants are unsure of how to select a code, they should reach out to their supervisor or a certified coder.

TABLE 15-9 | **Coding for Special Situations**

Condition	Coding Steps
Burns	**Index (Main Term):** Use *Burn* for burns caused by heat. Use *Corrosion* for chemical burns. **Subterms:** Anatomic site and degree (first, second, third). **Tabular List:** Assign code for the highest degree of burn at each site. Assign additional code for percentage of body surface affected by third-degree burns. Assign external cause codes where applicable.
Diabetes	**Index (Main Term):** *Diabetes* **Subterms:** Select *type 1, type 2, due to drug or chemical, due to underlying condition.* **Additional subterms:** Type of complication(s), if any. **Tabular List:** Verify the combination code for the type of diabetes and complication.
External causes	**Index (Main Term):** Use the Index of External Causes. Locate the event that caused the injury, such as accident, fall, burn, bite. For the first encounter, assign additional codes indexed under *Activity, Place of occurrence*, and *Status.* **Subterms:** Accidents are classified as *transport* and *nontransport.* Transport accidents are listed by type of vehicle, such as boat, car, or motorcycle. Also identify whether the victim was a *driver* or a *passenger.* **Tabular List:** Verify the description and assign a seventh character for episode of care.
Fractures	**Index (Main Term):** *Fracture, pathological* or *Fracture, traumatic.* **Subterms:** Anatomic site and type **Tabular List:** Verify all details of the fracture, and assign characters for laterality and episode of care.
HIV	**Index:** *Human* + subterm *immunodeficiency virus.* **Subterms:** Subterms include the following: *asymptomatic, contact, counseling, dementia, exposure to, laboratory evidence.* Use default code B20 for symptomatic HIV/AIDS. **Tabular List:** Verify the code. Assign additional codes for any AIDS-related conditions.
Hypertension	**Index (Main Term):** *Hypertension* **Subterms:** Comorbidities **Tabular List:** Verify the code and comorbidities.
Influenza	**Index (Main Term):** *Influenza* **Subterms:** Locate the specific type of virus and manifestations. **Tabular List:** Verify the type and manifestation(s).
Neoplasms	**Index (Main Term):** Look up the clinical name of the tumor, such as melanoma or carcinoma. Carcinoma and many other tumors are coded using the Table of Neoplasms (review Figure 15-2). **Table of Neoplasms:** Locate the row for the anatomic site and the column for the behavior (malignant, benign, cancer in situ). **Tabular List:** Verify the code, noting any additional characters required and other instructional notes.

(continued)

TABLE 15-9 | **Coding for Special Situations (*continued*)**

Condition	Coding Steps
Obstetrics	**Index (Main Term):** *Pregnancy* **Subterms:** Subterms include the following: *complicated by, management affected by, supervision of.* **Tabular List:** Verify the appropriate trimester. Assign as many codes as necessary to describe all complications. Assign a code for the preexisting medical condition when appropriate. Assign a code from Z3A.- to identify the weeks of gestation. **Index (Main Term):** *Delivery* **Subterms:** Select *cesarean* or *complicated by.* **Tabular List:** Assign as many codes as necessary to describe all complications. Assign a code from Z38.- to identify the outcome of delivery.
Poisonings and adverse effects	**Index (Main Term):** Use the Table of Drugs and Chemicals (review Figure 15-3). **Table of Drugs and Chemicals:** Locate the substance in the left-hand column. Locate column for the intent for the poisoning (injury due to substance that should not be consumed or an overdose of a medication) as: *accidental, self-harm, assault, undetermined; adverse effect* (injury resulting from a medication taken as prescribed), *underdosing* (injury resulting from taking too little of prescribed medication). **Tabular List:** Verify the substance and intent. Assign seventh character for episode of care.
Well Visits, Health Status (Z-codes)	**Index (Main Term):** *Encounter for, Examination, Status (post), History-personal, History-family* **Subterms:** Select the type of encounter or status, as applicable. **Tabular List:** Verify the code; note any sequencing instructions.

SUMMARY

Medical coding is the process of assigning alphanumeric characters that represent the diagnoses patients have and the services they receive. Medical assistants play an important role in communication and understanding of medical codes. The diagnosis coding system that began as a short list of diseases in 1893 has now become a highly detailed classification of over 70,000 codes, each consisting of three to seven characters. ICD-10-CM is the HIPAA-mandated code set for diagnostic coding used for billing and reimbursement. Health care providers must follow billing and coding rules established by multiple federal, state, and country government agencies.

The introductory material to the ICD-10-CM manual provides instructions on how to use ICD-10-CM, outlines the Official Guidelines for Coding and Reporting (OGCR), and lists universal conventions and publisher-specific conventions. Medical assistants abstract information from the medical record to identify the informa needed to code for services and the reasons they were provided. After determining the diagnosis in the patient's medical record, they research the code in the Index using a Main Term and subterms to locate preliminary codes that describe the condition(s). The codes found in the Index must be verified in the Tabular List to confirm the code description and assign additional characters that specify details of the condition, such as laterality and episode of care. Many diagnoses require advanced coding skills to accurately capture the details of a specific patient's situation. Whenever medical assistants are unsure of how to select a code, they should reach out to their supervisor or a certified coder.

15 CHAPTER REVIEW

COMPETENCY REVIEW

1. Define and spell the terms for this chapter.
2. Discuss the role of medical assistants in diagnostic coding.
3. Name, locate, and explain the purpose of each section the ICD-10-CM coding manual.

4. Explain how to abstract diagnostic information from the medical record.
5. Identify and locate in the Index the Main Terms and subterms for a diagnostic statement.
6. Explain how to verify codes in the Tabular List.
7. Discuss how to code for special situations.

PREPARING FOR THE CERTIFICATION EXAM

1. What convention identifies two codes that are mutually exclusive and cannot be used together?
   a. Code also
   b. Excludes1
   c. NEC
   d. See also
   e. Excludes2

2. Which of the following is *not* a benefit of ICD-10-CM?
   a. Detailed diagnosis codes reduce the need for attachments to claims.
   b. Provides more consistent and more detailed data for physician use.
   c. Allows anyone in the office to perform diagnosis coding.
   d. Reflects advancements in technology and medical practice.
   e. Provides the flexibility to add codes in the future.

3. What term describes knowingly billing for services that were never given or billing for a service that has a higher reimbursement than the service actually provided?
   a. fraud
   b. maximizing
   c. unbundling
   d. flexible billing
   e. abuse

4. When do annual updates to ICD-10-CM codes take effect each year?
   a. January 1
   b. April 15
   c. July 1
   d. October 1
   e. November 15

5. What character functions as a placeholder in ICD-10-CM?
   a. 0
   b. 9
   c. #
   d. A
   e. X

6. Which section of the ICD-10-CM manual is an alphanumerically sequenced list of all diagnosis codes, divided into 21 chapters based on cause and body system?
   a. Index to Diseases and Injuries
   b. Index to External Causes
   c. Tabular List
   d. Table of Neoplasms
   e. Table of Drugs and Chemicals

7. Which of the following is a combination code?
   a. E10.339 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
   b. L02.211 Cutaneous abscess of abdominal wall
   c. J01.90 Acute sinusitis, unspecified
   d. K55 Vascular disorder of intestine
   e. B95.61 Methicillin susceptible Staphylococcus aureus infection as the cause of diseases classified elsewhere

8. Main Terms in the Index may be any of the following *except*
   a. condition.
   b. eponym.
   c. abbreviation.
   d. adjective.
   e. anatomic site.

9. What is the maximum length of an ICD-10-CM code?
   a. 4
   b. 5
   c. 6
   d. 7
   e. 8

10. What should medical assistants do when they are unsure of how to select a code for a particular situation?
    a. ask the physician
    b. search the Internet
    c. ask a certified coder
    d. assign a generic code
    e. use the placeholder character

CRITICAL THINKING

Refer to the case study at the beginning of the chapter and use what you have learned to answer the following questions.

1. Why is it necessary for David to code for the specific condition *chronic serous otitis media* rather than a nonspecific condition such as *otitis media*?
2. Why must David be sure to code for the *bilateral* nat of the condition?
3. What are the benefits of having over 70,000 diagnosis codes?

ON THE JOB

Lisa Medina, a certified coder, performs medical coding for a large multi-specialty clinic. You have just been hired as Lisa's assistant. She has asked you to review the encounter forms for the day, on which physicians have checked off the diagnoses of each patient. You notice that Dr. Parker, an endocrinologist, has checked off the box for *Diabetes unspecified* for most of his patients without checking off any manifestations or complications. You think this is unusual because many diabetic patients do have complications.

1. What are the options for handling this situation?
2. Which option would you select?
3. Give three reasons for your choice.
4. Who should you consult before acting on your choice?

INTERNET ACTIVITY

Perform an Internet search for "medical coding ethics." What organizations offer a code of ethics for coders? Discuss why a code of ethics is necessary. What guidelines in a code of ethics for coders stand out to you?