

How to Use this Text

Chapter Outline

- Career as a Coder
- Professional Associations and Discussion Boards

- Coding Overview
- Documentation as Basis for Coding
- Health Data Collection

Key Terms

application service provider (ASP)
Assessment (A)
assumption coding
automated case abstracting software
automated record
Centers for Medicare & Medicaid Services (CMS)
claims examiner
classification system
clearinghouse
CMS-1450
CMS-1500
coder
codes
coding
coding system
continuity of care
Current Procedural Terminology (CPT) database
demographic data

diagnostic/management plans
discharge note
document imaging
documentation
downcoding
electronic health record (EHR)
electronic medical record (EMR)
encoding
HCPCS level II
HCPCS national codes
health care clearinghouse
Healthcare Common Procedure Coding System (HCPCS)
health care provider
health data collection
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

health insurance specialist
health plan
hospitalist
hybrid record
indexed
initial plan
integrated record
International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)
International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)
International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS)
internship

internship supervisor
jamming
jukebox
Listserv
manual record
medical assistant
medical management software
medical necessity
medical nomenclature
medical record
Objective (O)
online discussion board
optical disk imaging
overcoding
patient education plans
patient record
physician query process
Plan (P)
problem list
problem-oriented record (POR)

Chapter Outline and Key Terms

The **Chapter Outline** organizes the chapter material at a glance. The **Key Terms** list represents new vocabulary in each chapter. Each term is highlighted in color in the chapter, where it is also defined and used in context. A complete definition of each term appears in the Glossary at the end of the textbook.

Introduction

The **Introduction** provides a brief overview about major topics covered in the chapter. The introduction (and the objectives) provide a framework for your study of the content.

Chapter Objectives

Chapter 3 ICD-9-CM Coding Conventions 65

- At the conclusion of this chapter, the student should be able to:
- Define key terms.
 - List ICD-9-CM coding conventions.
 - Explain ICD-9-CM coding conventions.
 - Identify ICD-9-CM coding conventions as they apply to patient cases.
 - Interpret ICD-9-CM coding conventions to assign codes accurately.

Introduction

The ICD-9-CM coding conventions (rules) can usually be found at the beginning of any ICD-9-CM coding manual. Coders are required to reference this material when reviewing case scenarios (and patient records) to assign ICD-9-CM codes. It is also helpful to coders when health care providers become familiar with coding conventions (and guidelines). When a coder initiates a physician query, an understanding of coding conventions and guidelines helps ensure the assignment of accurate codes for certain conditions and diagnoses.

Notes

Notes appear throughout the text and serve to bring important points to your attention. The notes clarify content, refer you to reference material, provide more background for selected topics, or emphasize exceptions to rules.

Note:

When reviewing examples and completing exercises and review questions in this chapter, use your ICD-9-CM coding manual to locate disease and procedure index entries and to verify them in the tabular lists.

Guidelines for Coding and Reporting

Medical Services (CMS) and the National Center for Health Statistics, U.S. Department of Health & Human Services (DHHS) that provide reporting using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). The ICD-9-CM Official Coding and Reporting, as approved by the four operating parties for the ICD-9-CM Coding and Reporting (AHIMA, CMS, and NCHS), is the official version of the ICD-9-CM coding and reporting. The ICD-9-CM Official Coding and Reporting provides conventions and instructions provided in the coding and sequencing manual and provide additional information on coding and reporting. The coder is responsible for complete and accurate code assignment and documentation. The guidelines were developed for use by health care providers and coders in identifying codes that are to be reported. Coders

HIPAA Alert!

Adherence to the ICD-9-CM Official Guidelines for Coding and Reporting when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA). ICD-9-CM diagnosis codes (Volumes I and II) have been adopted under HIPAA for all health care settings, and ICD-9-CM procedure codes (Volume III) have been adopted for inpatient procedures reported by hospitals.

HIPAA Alerts

The **HIPAA Alert** feature highlights issues related to the privacy and security of personal health information.

Objectives

The **Objectives** list the outcomes expected of the learner after a careful study of the chapter. Read the objectives before reading the chapter content. When you complete the chapter, read the objectives again to see if you can say for each one, "Yes, I know that." If you cannot say this about an objective, go back to the appropriate content and reread. These outcomes are critical to a successful career as an insurance specialist.

Examples

Examples appear throughout the text to promote understanding of presented concepts.

Coding Tips

The **Coding Tips** feature provides recommendations and hints for selecting codes and for the correct use of the coding manuals.

EXAMPLE
ICD-9-CM COMBINATION CODE: Assign combination code 28.3 to the Procedure "tonsillectomy and adenoidectomy" because the code description includes both procedures. Note that the code 28.6 is "tonsillectomy without adenoidectomy," while the description for 28.6 to a tonsillectomy and adenoidectomy procedure.

EXAMPLE
ICD-9-CM MULTIPLE CODES: Assign two codes (28.3 and 28.7) for a tonsillectomy and adenoidectomy case if the patient record includes documentation of "control of hemorrhage after tonsillectomy and adenoidectomy." The Index to Procedures entry for "Control, hemorrhage, tonsils (postoperative)" lists code 28.7, which should be verified in the Tabular List of Procedures.

The word *and* in the code description is interpreted as "and/or." If the patient had undergone tonsillectomy without adenoidectomy (28.2) or adenoidectomy without tonsillectomy (28.6) the patient record documented "control of hemorrhage after tonsillectomy and adenoidectomy," code 28.7 would be reported with either code 28.2 or 28.6, depending on the procedure performed.

11. When laparoscopic, thoroscopic, or arthroscopic procedures are converted to open procedures (for which a lengthier surgical incision is made), assign only the open procedure code. An open procedure involves making an incision through skin, underlying tissues, and possibly muscle to access the affected body area that requires surgery (e.g., an abdominal hysterectomy). A closed procedure uses an endoscope to visualize an area (e.g., a colonoscopy), and instruments are passed through the scope to complete the procedure (e.g., a closed biopsy).

Coding Tip:
 Assign the appropriate V code, listed below, as an additional diagnosis code when laparoscopic, thoroscopic, or arthroscopic procedures are converted to open procedures.

- V64.41 (laparoscopic surgical procedure converted to open procedure)
- V64.42 (thoroscopic surgical procedure converted to open procedure)
- V64.43 (arthroscopic surgical procedure converted to open procedure)

Exercises

Exercises reinforce chapter content.

119. Patient underwent placement of hearing aid.

120. Provision of binaural, behind-the-ear hearing aid, analog, in the canal (ITC)

121. Provision of digitally programmable monaural hearing aid, analog, in the canal (ITC)

122. Dispensing fee, binaural contralateral routing of signals (BICROS)

123. Patient purchased prescribed telephone amplifier assistive living device

Coding Practice II

Instructions: Assign appropriate HCPCS level II code(s) and modifier(s) to each case.

124. **SUBJECTIVE:** The patient is an 89-year-old white female resident of the county nursing facility. I was asked to see her today because the nursing staff had noticed the patient was having difficulty breathing and was coughing up purulent material. A chest x-ray was ordered, and the mobile x-ray service arrived and took the x-ray while I was seeing my other patients.

OBJECTIVE: The patient appears ill. Temperature is 100.7. CHEST: Scattered rhonchi throughout all lung fields, with severely diminished breath sounds in the left lower lung. Expiratory and inspiratory wheezes present. HEART: Within normal limits. ABDOMEN: No tenderness on palpation. EXTREMITIES: Mild dependent edema is noted; otherwise within normal limits.

TIES: Mild dependent edema is noted; otherwise within normal limits.

ASSESSMENT: The chest x-ray revealed a density consistent with left lower lobe pneumonia.

Summary

A coder is expected to master the use of coding systems, coding principles and rules, government regulations, and third-party payer requirements to ensure that all diagnoses, services, and procedures documented in patient records are accurately coded for reimbursement, research, and statistical purposes. To prepare for entry into the profession, students are encouraged to join a professional association. They usually pay a reduced membership fee and receive most of the same benefits as active members. The benefits of joining a professional association include eligibility for scholarships and grants, opportunity to network with members, free publications, reduced certification exam fees, and Web site access for members only.

Coding systems and medical nomenclatures are used by health care facilities, health care providers, and third-party payers to collect, store, and process data for a variety of purposes. A coding system organizes a medical nomenclature according to similar conditions, diseases, procedures, and services; it contains codes for each. A medical nomenclature is a vocabulary of clinical and medical terms used by health care providers to document patient care. Codes include numeric and alphanumeric characters that are reported to health plans for health care reimbursement and to external agencies for data collection and internally for education and research. Coding is the assignment of codes to diagnoses, services, and procedures based on patient record documentation.

Health care providers are responsible for documenting and authenticating legible, complete, and timely patient records in accordance with federal regulations and accrediting agency standards. The provider is also responsible for correcting or altering errors in patient record documentation. Health data collection is performed by health care facilities to do administrative planning, to submit statistics to state and federal government agencies, and to report health claims data to third-party payers for reimbursement purposes.

Summary

The **Summary** at the end of each chapter recaps the key points of the chapter. The summary also serves as a review aid when preparing for tests.

Internet Links

Internet Links are provided to encourage you to expand your knowledge at various state and federal government agency, commercial, and organization sites.

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By type, Digestive System subsection codes are also reported for other, endoscopic, and laparoscopic procedures. The consecutive report must be carefully reviewed to correctly identify the surgical approach, urinary incision, urethrotomy, endoscopic, or laparoscopic. The subsection also substitutes endoscopy procedures as an additional code from the Radiology section is assigned to report the radiological service performed.

Internet Links

American College of Gastroenterology (ACG)	Go to http://www.acg.org and click on the Patients link to access information about clinical and research.
American Biological Association (ABA)	http://www.abas.org
Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)	http://www.sages.org
Webpage: "Gastric"	http://www.gastric.com
Webpage: World Virtual University	http://www.worldvirtual.com
	http://www.pw.org

Study Checklist

- Read this textbook chapter and highlight key concepts.
- Create an index card for each key term.
- Access the chapter Internet links to learn more about concepts.
- Complete the chapter review, verifying answers with your instructor.
- Complete WebTutor assignments and take online quizzes.
- Complete StudyAlerts, including coding cases, and receive immediate feedback.
- Access the Online Companion Web site for updates and additional information at www.StudentEdition.com/companion. Click on Allied Health, and then click on 3.2.1 Code 88.
- Form a study group with classmates to discuss chapter concepts in preparation for an exam.

Review

Multiple Choice

Instructions: Circle the most appropriate response.

- Which types of hernias are assigned codes from the Mediastinum and Diaphragm subsection of Surgery?
 - abdominal and epigastric
 - hiatus and diaphragmatic
 - incisional and inguinal
 - umbilicus and femoral
- Procedures performed on the gallbladder, bile ducts, hepatic ducts, and cystic ducts are assigned codes from which heading of the Digestive System subsection of Surgery?
 - Abdomen, Peritoneum, and Omentum
 - Biliary Tract
 - Liver
 - Urter
- Hernia repair codes (49.930–49.990) are classified in which heading of the Digestive System subsection of Surgery?
 - Abdomen, Peritoneum, and Omentum
 - Appendix
 - Rectum

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Study Checklist

The **Study Checklist** appears toward the end of each chapter and directs you to other learning and application aids. Completing each of the items in the checklist will help you to gain confidence in your understanding of the key concepts and in your ability to apply them correctly.

Review

Each chapter **Review** includes multiple-choice questions and coding practice cases that will test your understanding of chapter content and critical thinking ability.