

# Aapc chapter 4 practical application

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Which ICD-10-CM Must Be Listed First on a Claim?\*\*

The ICD-10-CM code that must be listed first on a claim is the code that best represents the patient's primary reason for the encounter.

### **Classifications of Anesthesia**

The three classifications of anesthesia, as defined by AAPC, are:

- **General anesthesia:** The patient is unconscious during the procedure.
- **Regional anesthesia:** A specific area of the body is anesthetized.
- **Local anesthesia:** Only the area of the body being operated on is anesthetized.

### **Diagnosis Code Order**

The diagnosis code obtained from D73-3 should be listed first on the claim, as it is the code for a confirmed diagnosis. The diagnosis code from B20 should be listed second, as it is a suspected diagnosis.

### **Number of Diagnosis Codes per Claim**

Up to 12 diagnosis codes can be submitted per claim.

### **First Listed Z Code**

The first listed Z code on a claim is Z00.0, indicating a routine check-up.

### **Types of Anesthesia**

The three types of anesthesia are:

- **General anesthesia**
- **Regional anesthesia**
- **Local anesthesia**

### **Correct Anesthesia Code**

The correct anesthesia code for a specific procedure will depend on the type of anesthesia used and the patient's condition.

### **MAC Modifier for Anesthesia**

The MAC modifier is used to indicate that the anesthesia was medically necessary.

### **First Listed Diagnosis Code on a Claim**

The first listed diagnosis code on a claim is the code that most accurately describes the patient's primary reason for the encounter.

### **Order of Diagnosis Codes**

Diagnosis codes should be listed in the following order:

1. Primary reason for the encounter
2. Other diagnoses related to the primary reason
3. Comorbidities

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