

ICD 10 CM INTRO

Medical coding is a translation or conversion of diseases or conditions, procedures or surgeries, materials or supplies in to universally accepted codes.

Ex for diseases are: Appendicitis, Fever, Rhinitis, Nephritis, HIV, Sepsis etc.

EX for procedures are: Appendectomy, Rhinotomy, x- ray, MRI, Anesthesia etc.

Ex for materials: Ambulance services, wheelchair equipments, Bandages, injections, Durable medical equipment.

CODES: 3 types

Alphabetical, Numeric, Alphanumeric.

Numeric: only numbers

Alphanumeric: alphabets+ numbers

Alphabetical: only alphabets.

REVENUE CYCLE MANAGEMENT (RCM – cycle) :

Patients comes to hospital with disease, physician provides treatment to patient, insurance company pays fees for physician, patient pays premium to the insurance company.

Medical Tran scripter: Translates the Audio file in to Text file.

Medical coder: Converts the Text file in to Coding file.

Medical Biller: Converts coding file in to billing form.

BOOKS USED IN MEDICAL CODING ARE:

ICD – 10 – CM: International classification of diseases 10th Revision clinical modification.

- This book published by WHO.
- This book is used for to code Diseases.
- They are 3 – 7 digits, Alpha+ numeric codes.

CPT: Current procedural terminology

- Published by American medical association.
- This book is used for to code procedure or surgeries or services.
- They are 5 digit numeric codes

HCPCS – Health care common procedural coding system.

- Published by CMS (centre for Medicare and Medicaid services)
- This book is used to code the supplies or material codes.
- This book contain 5 digit alpha + numeric codes.

CPC – CERTIFICATION:

Certified professional coder exam conducted by AAPC.

100 – Marks exam 70% is qualifying percentage.

4 – Hours exam Duration.

Open book Exam.

CPC EXAM MARKS WEIGHTAGE

CPC -CERTIFIED PROFESSIONAL CODER EXAM CONDUCTED BY AAPC
[AMERICAN ACADEMY OF PROFESSIONAL CODER]

100 QUESTIONS.

4 - HOURS EXAM.

OPEN BOOK EXAM - 70% QUALIFYING MARKS. NO OF
QUESTIONS:-

ICD 10- CM : 5 MARKS

HCPCS [HEALTH CARE COMMON PROCEDURE CODING SYSTEM]- 3M

CODING GUIDLINES - 7 M

COMPLIANCE AND REGULATORY -3M

CODING CASES -10M

ANATOMY - 4M

MEDICAL TERMINOLOGY -4M

CPT: 64 MARKS

- EVALUATION AND MANAGEMENT-6M- 99000 SERIES
- ANESTHESIA - 4M- 00100 SERIES SURGERY
- INTEGUMENTARY SYSTEM -6M -10000 SERIES

- MUSCULOSKELETAL SYSTEM - 6M - 20000 SERIES

-RESPIRATORY SYSTEM - 6M - 30000 SERIES

-CARDIOVASCULAR SYSTEM

-LYMPHATIC SYSTEM

-DIGESTIVE SYSTEM - 6M - 40000 SERIES

- URINARY SYSTEM - 6M - 50000 SERIES

- MALE GENITAL SYSTEM

-FEMALE GENITAL SYSTEM

-MATERNITY CARE AND DELIVERY

- ENDOCRINE SYSTEM - 6M- 60000 SERIES

-NERVOUS SYSTEM

- EYE AND EAR

RADIOLOGY - 6M - 70000 SERIES

LAB AND PATHOLOGY - 6M -80000 SERIES

MEDICINE -6M – 90000.

ICD – 10 REVISION

International classification of diseases 10 revision.

Book is used to code diseases or diagnosis.

Book was published by WHO.

It changed from ICD -9th REVISION to ICD – 10TH REVISION IN OCT 2015.

DIFFERENCE BETWEEN 9TH AND 10TH REVISION ARE

IN 9TH REVISION

- Only numeric codes are present
- 3-5 minimum and maximum numbers
- Approximately 13 thousand codes are present
- Laterality is not present.
- It contain 17 chapters

IN 10TH REVISION

- Alphanumeric codes are present
- 3 -7 minimum and maximum numbers
- Approximately 54 thousand codes are present
- Laterality is present
- It contains 17 chapters.

ICD -10 – CM: INTERNATIONAL CLASSIFICATION OF DISEASES 10TH REVISION CLINICAL MODIFICATION.

- The ICD 10TH REVISION Book is clinically modified for United States health care services.
- They introduced some conventions and guidelines to this book.

GUIDLINE PROVIDERS ARE:

- Centre for Medicaid and Medicare services (CMS).
- National centre for health care statistics (NCHS) .
- Department of health and human services (DHHS)

GUIDLINES APPROVERS:

- American hospital administration (AHA)
- American health information management association (AHIMA)
- Centre for Medicaid and Medicare services (CMS)
- National centre for healthcare statistics (NCHS)

HIPPA : Health insurance portability and accountability act.

Act of 1996

- It provides rules and regulations for insurance companies and physicians and it protects the patients health information.

ICD 10TH CM - International classification of diseases 10th revision clinical modification.

- The book has 2 volumes and 22 chapters.
- Volume 1 is called TABULAR LIST.
- Volume 2 is called Alphabetical index.

ALPHABETICAL INDEX:

Name of the disease followed by – CODE.

It divided in to MAINTERM, SUBTERM, CARRY OVER LINE1, CARRY OVER LINE2.

- MAINTERM
 - SUBTERM
 - o CARRYOVERLINE1
 - CARRY OVERLINE 2.

It is an indented format which means Main term below Sub term below Carry over line1 and carry over line2.

A to Z – index to diseases and injuries pg 39 – 369.

- Main term starts with capital letter and it is in Bold form.
- Sub term present below the main term.
- C o l 1 present below the sub term
- C o l 2 present below the col1

DIABETIS – E11.9

PNEUMONITIS ALLERGIC – J67.9.

HOW TO FIND MAINTERM ?

- The main term may be diseases

Example : Gastritis, Rhinitis, Blepharitis, Hepatitis.

- The main term may be condition ?

Example : Fever, Fracture , Pain.

- The main term may be word ?

Example : Disease, disorder, syndrome etc.

- The main term may be Eponym.

Example : Alzheimer's disease , Parkinson's disease.

UNDER LINE THE MAIN TERM

- 1) ACUTE GASTRITIS
- 2) CHRONIC HEPATITIS
- 3) ALLERGIC RHINITIS

- 4) ABDOMINAL PAIN
- 5) YELLOW FEVER
- 6) HUMERUS FRACTURE
- 7) IRRITABLE BOWEL SYNDROME
- 8) MATHEMATICS DISORDER
- 9) CHRONIC OBSTRUCTIVE PULMONARY DISEASE.

- Salmonella enteritis = A02.0
- HIV = B20
- Acute hepatitis = B17.9
- Viral enteritis = A08.4
- Albumin abnormal = R77.0
- Abnormal Blood Level In Iron =
- Abnormal form of Tooth =
- Lower left Blepharitis =
- Adrenalcortical Carcinoma =
- Recurrent Toxic Colitis =
- Acquired forehead deformity =
- Congenital Forehead Deformity =
- Hematopoieticorgans Disease =
- Piercing Ear =
- Australian Encephalitis =
- Bacterial Endocarditis =
- Acute Kidney Failure =
- Hay fever =
- Neck Fracture =
- Spinalcord Hemorrhage =
- Infantile hypoglycaemia =
- Infectious Ileocolitis =
- Chest infection =
- Congenital Kyphosis =
- Protein Malabsorption =
- Artery Narrowing =
- Brain Necrosis =
- Larynx ossification =
- Pain respiration =
- Candidal sepsis =
- Weak mind =

Alphabetical index also contain

- TABLE OF NEOPLASMS
- TABLE OF DRUGS AND CHEMICALS
- INDEX FOR EXTERNAL CAUSES OF INJURIES.

TABULAR LIST (VOLUME1) :

- First code number followed then disease description.
- Example : A00 – cholera.
- The alphabetical index codes guides us to Tabular list .
- Example = Salmonella Enteritis = A02.0 the A02.0 alphabetical index guides us to Tabular list A02.0 = salmonella enteritis.
- We should confirm the alphabetical index codes with Tabular list.
- The tabular list codes give more information about diseases.
- Example :
- For salmonella Enteritis if we go to the Tabular list code A02.0 we will get more information in the heading like it is an interstinal infectious disease.

TABULAR LIST DIVIDED INTO :

- CATEGORY
- SUB CATEGORY
 - o SUB CLASSIFICATION
 - SUB CLASSIFICATION2
 - CODE

ICD 10 CM Codes are alphanumeric codes with 3 -7 characters.

Category is 3 digit , Sub category is 4 digit , Sub classification is 5 digit , subclassification2 is 6 digit , Code is 7 digit.

- For category or sub category or sub classification or subclassifiaction2 if there is an any additional characters it won't considered as code.
- Additional characters are
- (✓) tick mark in the alphabetical index after the code.
-
- (4th)
- (5th)
- (6th)
- (7th) these characters are found in tabular list before the code.

If any code has these characters we should not code or consider it as codes.

We have 3 digit codes ,4 digit codes , 5 digit codes , 6 digit codes and 7 digit codes.

Example for 3 digit codes are:

- B20 – HIV
- N10 – ACUTE PYELONEPHRITIS.

EXAMPLE FOR 4 DIGIT CODES:

- A02.9 – Salmonella infection
- A02.0 - salmonella enteritis

EXAMPLE FOR 5 DIGIT CODES ARE:

- A04.71 – Recurrent enterocolitis due to clostridium difficile.

EXAMPLE FOR 6 DIGIT CODES ARE:

- H01.005 - Unspecified Blepharitis of left lower eye lid.

EXAMPLE FOR 7 DIGIT CODES ARE :

- (7TH) S55.011 – laceration of ulnar artery at forearm level right arm
- It is not a code because it has additional character.
- Now we go to the category three digit code.
- S55 – Below these category we got mentioned about
- The appropriate 7th character is to be added to each code from category S55

- A – initial encounter
- B – subsequent encounter
- S – sequel / late effect
- We have to add these characters in the 7th character place only.

Example : laceration of ulnar artery at forearm level right arm initial encounter

Code is – S55.011A.

CONVENTIONS : Conventions are rules and guidelines which used in the icd 10 cm book.

1) Additional characters : (✓) in alphabetical index tick mark is present after the code.

ii) In tabular list

(4th) - xxx

(5th) - xxxx

(6th) - XXXXX

(7th) - XXXXXX

Characters present before the code.

If there is any additional characters those codes should not be considered as codes we should not code those codes.

These additional characters tell that there is a need of another character to get full code.

2) DUMMY PLACE HOLDER(X) : A 7th character can be present without 4th, 5th, 6th characters these characters are filled with dummy place holder (X).

Example: (5TH) T36.0 – Poisoning by, adverse effect of and under dosing of penicillin's.

(6th) – T36.OX - Poisoning by, adverse effect of and under dosing of penicillin's.

(7th) – T36.OX1 – poisoning by penicillin's, accidental (unintentional).

T36.OX1A - poisoning by penicillin, accidental (unintentional) initial encounter.

3) PARANTHESIS () : Parenthesis are present in mostly alphabetical index.

- Parenthesis give the extra information about the disease to the coder.
- Example :
- DIABETIS (Sugar) (mellitus) – E11.9
- CHOLESTEROL ELEVATED (High) E78.00

The parenthesis are used to enclose non –essential modifiers.

- A non essential modifier is a word that cannot change the medical code number.

4) BRACKETS [] : Brackets are used in mostly Tabular list , Brackets are used to enclose either synonym or alternative terms.

Synonym – J00 – Acute nasopharyngitis [common cold] synonym

Alternative terms : B96.20 – Escherichia coli [E.coli]

5) Slanted Brackets : The brackets present between the codes are called slanted brackets.

- The slanted brackets are used to enclose a manifestation code in etiology (cause) .

Example : Dementia in Parkinson's disease G20[F02. 80]

- Parkinson's disease is the loss of nerve cells and dementia is loss of memory.
- In these case Parkinson's disease is the cause and dementia is the manifestation.
- We should code cause as primary code and manifestation as secondary code.

NEC : Not elsewhere classifiable (or) Other specified.

When a specific code does not available for a given condition , the alphabetical index directs the coder to the other specified code in the tabular list. (or)

- The specific conditions present in patient records does not present In the ICD-10-CM book then we should take other specified code.

Example : Enteritis Bacterial specified – NEC – A04.8 (in alphabetical index)

A04.8 – other specified bacterial intestinal infection (Tabular list)

2) Backache specified – NEC – M54.89

M54.89 - other Dorsalgia

3) Fever arbovirus, arboviral

Specified type – NEC – A93.8

A93.8 - Other specified arthropod-borne viral fevers.

NOS : Not otherwise specified (or) Unspecified.

If the particular specificity of the condition is not provided in the patient medical record by the physician the alphabetical index (NOS) Guides us to Tabular list as unspecified.

Example :

1) Infection spinal cord – NOS – G04.91 (Alphabetical index)

Myelitis unspecified – G04 .91 (Tabular list)

2) Birth injury – NOS – P15.9 (Alphabetical index)

P15. 9 - Birth injury unspecified - (Tabular list)

INCLUDES : It is an instruction given in Tabular list, the disease present in

INCLUDE notes are the synonym or may be condition carry same code.

Example : 1) B20 – HIV human infectious disorder

Includes : AIDS – acquired immunodeficiency syndrome

AIDS – Relaated complex

HIV infection, symptomatic.

2)- B07 – Viral Warts

Includes : Verruca simplex

Verruca vulgaris

Viral warts due to papilloma virus

EXCLUDE : It is an instruction present in the Tabular list the diseases present in

Exclude notes are coded separately.

Excludes divided in to 2 types :

Exclude 1

Exclude 2

Exclude1 : If we have Exclude 1 note below the code we should not code both conditions for a single patient.

Example : B20 - HIV

Exclude1 : Asymptomatic HIV (Z21)

Example2 : Congenital and acquired disorders.

-B25 - Cytomegalovirus disease

Exclude 1 : Congenital cytomegalovirus infection (P35.1)

EXCLUDE 2 : If we have Exclude2 note below the code we can code both conditions for a single patient separately.

Example : A18.2 – Tuberculous peripheral lymphadenopathy tuberculous adenitis.

Exclude2 : Tuberculous tracheobronchial adenopathy (A15.4)

Example2 : A54.42 – Gonococcal arthritis

Exclude 2 : Gonococcal infection of spine.

CROSS – REFERENCES :

SEE - It is a mandatory instruction present in alphabetical index that a coder must follow to get an accurate code .

Example1 : Inflammation of appendix (SEE APPENDICITIS)

Appendicitis – K37

Example2 : parkinsons disease – (SEE parkinsonism)

Parkinsonism – G20

Example 3 : Late effect – (SEE sequelae)

SEE ALSO : It is an optional instruction that a coder may follow to get some additional information.

Inflammation of liver (see also Hepatitis)

Hepatitis – K75.9

SEE CONDITION : It is an instruction given to the coder in alphabetical index if the coder not searching under condition.

Condition like : pain , fever , fracture etc.....

Example1 : Abdomen (See Condition)

Abdomen pain – R10.9

Example2 : Pericardium (see condition)

Pericarditis – I31.9

Example 3 : Sequelae (See also condition)

DEFAULT CODE : A code listed next to a main term in the ICD- 10 – CM book is called default code .

Example1 : DIABETIS – E11.9

Example 2 : Hypertension – I10

GENERAL CODING GUIDELINES

STEP1 : Analyse the medical record given by the health care physician and identify the diseases to be coded.

STEP2 : Take a diagnostic statement and divide it into Mainterm and Subterm and C.O.L.

STEP3 : Go to Alphabetical index and search for the Mainterm and search the subterm indented below the mainterm.

STEP4 : Before searching for the subterm search for non essential modifiers in paranthesis () if any

STEP5 : Follow the cross- references SEE,SEEALSO, SEE CONDITION etc if any.

STEP6 : Take a code opposite to Alphabetical index and should confirm it in Tabular list.

STEP7 : Follow the instructions like 'USE ADDITIONAL CODE' 'CODE FIRST' 'INCLUDES' 'EXCLUDES' etc .if any in tabular list.

STEP8 : Code all the highest level of specificity.

- a) If a 4 digit code is available don't assign a 3digit code.
- b) If a 5 digit code is available don't assign a 4 digit code.
- c) If a 6 digit code is available don't assign a 5 digit code.
- d) If a 7 digit code is available don't assign a 6 digit code.

STEP 9 : Follow the colour coding

STEP10 : Repeat all the above steps and assign codes to all diagnostic statements present in the medical record .

USE ADDITIONAL CODE : It is an instruction present in Tabular list Below the code sometimes a single code may not describe the Diagnostic statement completely hence another code must be used as secondary code.

Example :

C07 – Malignant neoplasm of parotid gland

USE ADDITIONAL CODE :

Tobacco use – Z72.0

In the patient record physician says tobacco using patient came with malignant neoplasm of parotid gland.

PDX should be : C07

SDX use additional code : Z72.0

CODE FIRST : It is an instruction present in tabular list above the code sometimes a single code may not describe a diagnostic statement completely hence another code must be used as primary code . or

Code first code is used as primary code.

Example :

Code first any human immunodeficiency virus (HIV) disease (B20).

C46.0 – Kaposi's sarcoma of skin.

In the patient record physician says HIV patient came with kaposi sarcoma of skin.

PDX : B20

SDX : C46.0

COMBINATION CODING : Assigning only one code for 2 (or) more Diseases is called Combing coding .

Example : Nausea – R11.0

Vomiting – R11.10

If the patient came to hospital nausea with vomiting we should code combination code –

Nausea with vomiting – R11.2

DUAL/ MULTIPLE CODING : Assigning two or more codes for single diagnostic statement is called dual/ multiple coding.

DEMENTIA IN PARKINSONS DISEASE – G20 [F02.80]

SIGNS AND SYMPTOMS :

CASE 1 : A patient is 30 year old female came with the complaints of abdominal pain in the Right lower quadrant , fever ,with vomiting physician confirmed it is due to appendicitis .

Code for APPENDICITIS : K37

CASE 2 : A patient is 30 year old female came with the complaints of abdominal pain in Right lower quadrant , fever , with vomiting physician suspected it is due to appendicitis.

Code for Abdominal pain in Right lower quadrant : R10.31

- Fever : R50.9

- Vomiting: R11.10

NOTE 1 : If the disease or diagnostic statement confirmed by the physician assign code for confirmed diagnosis only not for the signs and symptoms.

EXAMPLE : CASE1

NOTE 2 : If physician uses (suspected , probable , maybe ,query questionable , Rule out , Ruled out ...etc) terms we should code all the signs and symptoms codes.

EXAMPLE : CASE 2

CONDITIONS THAT ARE INTEGRAL PART OF DISEASE PROCESS :

Signs and symptoms that associated Routinely with a disease process should not be assigned as additional codes , unless otherwise instructed by guidelines.

CONDITIONS THAT ARE NOT INTEGRAL PART OF DISEASE PROCESS :

The conditions which are not related to the confirmed disease should be coded separately.

Example : A patient came with abdominal pain in right lower quadrant , fever and vomiting physician confirmed appendicitis and patient also had fracture of his right hand humerus bone.

Code for :

APPENDICITIS :

FRACTURE OF RIGHT HUMERUS :

LATE EFFECT / SEQUELAE : A late effect is a residual condition that remained after an acute phase of illness or injury that has terminated. (or)

Present effects due to past cured conditions.

- It is also called Sequela.
- We should code first code number should be present condition
- Second code should be for late effect.
- There is no time frame for sequelae.

CASE : A 28 year old female patient she is anxious to conceive she got married 4 years back her past medical records shows that she suffered from TB of UTERUS 6 years ago which was cured at that time.

- Physician confirmed INFERTILITY OF FEMALE DUE TO LATE EFFECT OF TB of UTERUS.
- We should code present condition infertility of female as primary code and late effect Tb of uterus as secondary code.

Code PDX : INFERTILITY OF FEMALE : N97.9

SDX : LATE EFFECT (SEE SEQUELAE)

SEQUELAE (SEE ALSO CONDITION)

TB – TUBERCULOSIS

GENITOURINARY – B90.1

BOARDER LINE CONDITION : If any condition described as in boarder line condition go to the main term and search for the sub term “ Boarder line” If not present assign code for confirmed condition.

- If patient has Boarder line hypertension go to alphabetical index search for hypertension as main term boarder line as sub term.
- CODE : Boarder line hypertension – R03.0

DIFFERENCE BETWEEN ACUTE AND CHRONIC CONDITIONS :

ACUTE CONDITIONS	CHRONIC CONDITIONS
1) Acute conditions appears all of sudden.	C.C persists longer period
2) They create lot of suffering	They not create lot of suffering
3) Usually they are dangerous	They are not dangerous
Example : Heart attack, Brain stroke Acute appendicitis, Acute Gastritis etc..	EX : Hypertension , Diabetes , Chronic gastritis , hypothyroidism.
- If same condition described as both Acute and Chronic search for the main term of the condition and search for the sub terms acute and chronic and code acute first then chronic. Example : Patient came with both Acute and Chronic Gastritis . Pdx – Acute Gastritis - K29.00 Sdx – Chronic Gastritis – K29.50	

LATERALITY : SIDES ICD-9-CM lacks laterality where as ICD- 10 – CM contain laterality .

- Separate codes present for Right side , Left side ,Bilateral side, unspecified eye .

H15.011 – Anterior scleritis , Right eye

H15.012 - Anterior scleritis , Left eye

H15.013 - Anterior scleritis , Bilateral eyes

H15.019 - Anterior scleritis , Unspecified eye.

DATE OF SERVICE (D.O.S) :

- We should only code for the present day services .