The Complete Diagnosis Coding Solution, 3e by Shelley C. Safian

Chapter 2: Introduction to ICD-10-CM

Learning Outcomes

2.1 Correctly abstract the key words located in physicians' notes as they relate to the diagnoses.

2.2 Identify the terms used to describe diagnoses in the Alphabetic Index of ICD-10-CM.

2.3 Confirm the most appropriate code in the Tabular List.

2.4 Apply the guidelines to determine when to report a Z code.

2.5 Recognize the conditions under which external cause codes are required.

2.6 Distinguish between co-morbidities, manifestations, and sequelae.

Chapter Outline

Using Terminology
Checking Your Understanding
Applying Your Knowledge
You Code It! Practice
You Code It! Application

Chapter Overview

The ICD-10-CM book contains all of the codes your students will need to report the reason or reasons *why* the patient came to see this health care professional for a specific encounter. The codes included in this directory are available to your students in printed form on the Internet.

In this chapter, as well as in the rest of this textbook, all references are made to the printed version of these codes. Let's begin by reviewing the sections of this book so your students can begin to learn where to find the best, most accurate code or codes.

Discussion Activities

1. ICD-10-CM Guidelines

Learning Objective: 2.2

A separate section of the guidelines is specifically for outpatient coding [Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services].

• One difference in the guidelines between coding for outpatient and inpatient services is the guideline regarding RULE OUT, PROBABLE, POSSIBLE, and OTHER UNCONFIRMED DIAGNOSES.

• How does the guideline change for outpatient facilities versus inpatient facilities with regard to this issue? Why do you think this is different?

This is a good opportunity to get students used to referencing the official guidelines contained inside their ICD-10-CM book. Reinforce the importance of following the guidelines. Help them to interpret the guidelines and convert them into understanding the proper way to determine a code. Discuss the differences between coding for outpatient services and inpatient services, including the above guideline that is one of the few different depending upon the facility. Discuss why it is important to outpatient coders to code only what they know for a fact.

2. Levels of Diagnosis Code Specificity

Learning Objective: 2.2

Explain the differences between the various number of characters used in these diagnosis code. What do the additional numbers add?

Why would it be necessary to add this information?

This topic is an excellent way to help students understand why a diagnosis code may have only three digits, or why it may need a fourth and/or fifth digit. Discuss the guidelines [Section 1. subsection B. General Coding Guidelines, 2. Level of Detail in Coding as well as Section IV. Subsection F Level of detail in coding, parts 1 and 2]. Explain the importance of specificity and how the more specific the code the more information about why the patient was cared for and which standard of care would apply. For example: A patient is admitted to the hospital due to a current asthma attack. If code J45.20 is reported as the reason for admission, the claim will most likely be denied because mild intermittent asthma, uncomplicated is not a valid reason to be admitted into a hospital. However, J45.52 Severe persistent asthma with status asthmaticus (severe episode of asthma unresponsive to typical treatment) is a very valid reason to admit a patient into the hospital for acute care.

Discussion can also include emphasis of the mandatory nature of including an additional character when indicated in the tabular list.

3. Sequencing

Learning Objective: 2.2

Section II, Selection of Principal Diagnosis, and Section III, Reporting Additional Diagnoses, of the official guidelines tell us in what order to place diagnosis codes when a patient has more than one health care issue.

Read through these sections and pick out a guideline that you find important. Share that guideline with your classmates and explain why you find that to be something that you should know. Be specific!

The sooner students begin to pay attention to sequencing when multiple codes are required, the better quality of their coding as they progress. When folded in with understanding

how to use the guidelines and how to read the notations, punctuation, and symbols included in the tabular list, sequencing codes correctly is a great deal easier to master.

Additional Resources

Grey's Anatomy Online: http://www.bartleby.com/107/

Stedman's Medical Dictionary: http://www.stedmans.com/

MedlinePlus Medical Encyclopedia: http://www.nlm.nih.gov/medlineplus/mplusdictionary.html

American Medical Association: http://www.ama-assn.org

American Hospital Association: http://www.aha.org

American Health Information Management Association: http://www.ahima.org

AAPC: http://www.aapc.com

ICD-10-PCS: http://www.cdc.gov/nchs/icd/icd10cm.htm

2018 Updates

2018 ICD-10-CM Coding Guidelines
https://www.cms.gov/Medicare/Coding/ICD10/2018-ICD-10-CM-and-GEMs.html

Chapter 2 Review Answer Key

Using Terminology

Learning Outcomes: 2.1, 2.2, 2.3, 2.5, and 2.6

1. C
2. J
3. K
4. I
5. F
6. A
7. G
8. B
9. E
10. D
11. H

Checking Your Understanding

Learning Outcomes: 2.1, 2.2, 2.3, 2.4, 2.5, and 2.6

1. C
2. D
3. B
4. C
5. A
6. D
7. B
8. C
9. B
10. D

Applying Your Knowledge

Learning Outcomes: 2.1, 2.2, 2.3, 2.4, 2.5, and 2.6

1) Explain what the principal or first-listed diagnosis is for a hospital admission.

Comment: (given as feedback)

The Uniform Hospital Discharge Data Set (UHDDS) defines the principal or first-listed diagnosis to be "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

2) What does *abstracting the physician's notes* mean?

Comment: (given as feedback)

Abstracting means to identify the key words relating to the reason *why* the physician is caring for this patient during this visit.

3) Explain the difference between co-morbidities and manifestations.

Comment: (given as feedback)

A co-morbidity is a condition that is present in the same body at the same time as another problem or disease but the two conditions are unrelated.

Manifestations: There are some diseases that actually cause the patient to develop another condition. This second condition, directly the result of the first condition, is known as a manifestation.

4) What is an external cause code, and what part of the patient encounter does it tell?

Comment: (given as feedback)

An external cause code is the event, outside the body, that causes injury, poisoning, or an adverse reaction. External cause codes report how and/or where an injury or poisoning happened.

5) What is the minimum number of codes required to code a sequela or late effect, and in what sequence or order are they listed?

Comment: (given as feedback)

Coding a sequela or late effect will require at least two codes, in the following order:
1. The sequela condition--the condition that resulted and that is being treated
2. The sequela (late effect) or original condition code with seventh character "S"

6) What is a Z code, and when would it be assigned?

Comment: (given as feedback)

A Z code is used for a patient who doesn't have a current disease or injury but comes to see the physician to validate his or her current healthy status—to prevent something from going wrong or to ensure continued health.

Some examples would be: preventive care, an annual physical, a well-baby check, monitoring care, screenings and counseling

7) Explain the difference in the guidelines between coding for outpatient services and coding for inpatient services.

Comment: (given as feedback)

When coding **outpatient services** you must be certain that the patient's file verifies that the patient actually has the condition, disease, illness, or injury. The guideline (Section IV. I. Uncertain diagnosis) states that you are to use the code or codes that identify the condition to its highest level of *certainty*. This means that you code only what you know for a fact. You are not permitted to assign an ICD-10-CM diagnosis code for a condition that is described by the provider as probably, suspected, possible, questionable, or to be ruled out.

When coding **inpatient facilities** you are directed by the guideline (Section II, H. Uncertain diagnosis), when at the time of discharge the diagnosis is described as probable, possible,

suspected, likely, or still to be ruled out, you must code that condition as if it did exist. This directive applies only when you are coding services provided in a short-term, acute, long-term care, or psychiatric hospital or facility.

8) When is it appropriate to code from the Alphabetic Index?

Comment: (given as feedback)

NEVER, NEVER, NEVER code from the Alphabetic Index.

You Code It! Practice

Learning Outcomes: 2.1, 2.2, 2.3, 2.4, 2.5, and 2.6

1. Z02.5: Examination > medical > sport competition

2. R10.84: Pain > abdominal > generalized
   T42.3X5A: Drug table > Amobarbital > Adverse Reaction > initial encounter

3. S33.8XXA: Sprain > Pelvis > initial encounter
   V80.010A: External Cause alphabetic index > accident > transport > animal-rider > non-collision > specified as horse rider > initial encounter
   Y92.830: External Cause alphabetic index > place of occurrence > park > public

4. H66.92: Otitis > media > acute >unspecified > left ear

5. Z71.89: Counseling > medical > specified reason NEC
   J45.909: Asthma > unspecified

6. Z01.419: Examination > gynecological

7. L05.91: Cyst > pilonidal

8. Q82.8: Tag > skin > congenital

9. Z80.3: History > family > malignant > breast

10. C43.39: Melanoma > skin > forehead

11. L55.1: Sunburn > second degree

12. T36.0X1A: Drug table > ampicillin > poisoning accidental (unintentional) > initial encounter
    R40.0: Drowsiness

13. A69.20: Lyme disease
    W57.XXXA: External Cause alphabetic index > Bitten by > arthropod (nonvenomous) NEC > initial encounter
    Y92.833: External Cause alphabetic index > place of occurrence > campsite

14. T17.1XXA: Foreign body > entering through orifice > nostril > initial encounter
    T17.890A: Foreign body > respiratory tract > specified site > causing > asphyxiation > specified type > initial encounter

15. Z00.129: Examination > child (over 28 days old)

You Code It! Application

Learning Outcomes: 2.1, 2.2, 2.3, 2.4, 2.5, and 2.6

Case study 1: Patient: VAN DYKE, OLIVIA

J02.9: Pharyngitis (acute)

Case study 2: Patient: WILLIAMS, CONRAD

K60.2: Fissure > anus, anal

Case study 3: Patient: BEVINS, NANCY

Z85.51: History > personal > malignant neoplasm > bladder

Case Study 4: Patient: ROMANO, JOSEPH

S61.210A: Laceration > finger > index > right > initial encounter
W26.0XXA: Contact > with > knife > initial encounter
Y92.511: External Cause alphabetic index > place of occurrence > restaurant
Y99.0: External Cause alphabetic index > status of external cause > civilian activity done for income or pay

Case study 5: Patient: HADLEY, HELEN

S06.0X1A: Concussion > initial encounter
V97.21XA: External Cause alphabetic index > accident > parachutist > entangled in object > initial encounter