NOTE: The chapter in which each term appears as a key term is indicated in parentheses.

A

ablation (11) removal.
abuse (19) actions that are inconsistent with accepted, sound medical, business, or fiscal practices; includes actions that result in unnecessary costs to payers and government programs, that result in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health care services.
accession (17) assignment of a number to record the order of tissue acquisition.
acellular dermal replacement (11) bioengineered artificial skin.
actinic keratosis (AK) (11) common sun-induced skin lesion of the epidermis that has the potential to become skin cancer.
acute care facility (ACF) (5) hospital that provides health care services to patients who have serious, sudden, or acute illnesses or injuries and/or who need certain surgeries.
acute care hospital (5) see short-term hospital.
add-on code (8) reported when another procedure is performed in addition to the primary procedure during the same operative session; modifier -51 (multiple procedures) is not used with add-on codes.
adenoids (13) located at the rear of the nose; contain lymphoid tissue that helps fight infections.
adhesiolysis (15) percutaneous lysis of epidural adhesions using solution injection or mechanical means.
adjacent tissue transfer/rearrangement (11) closure of defects by relocating a flap of adjacent normal, healthy tissue to a defect.
adjuvant (17) substance administered with an antigen that enhances the response to the antigen.
adjuvant chemotherapy (18) chemotherapy administered in addition to other cancer treatments, such as surgery and/or radiation therapy.
adjuvant technique (13) additional procedure or technique that may be required during a lower extremity bypass graft procedure.
admitting diagnosis (5) provisional or tentative diagnosis entered in a field on the inpatient face sheet by admissions office staff; it is often a sign or symptom.
advance beneficiary notice (ABN) (7) waiver signed by the patient acknowledging that because medical necessity for a procedure, service, or supply cannot be established, the patient accepts responsibility for reimbursing the provider or DMEPOS dealer for costs associated with the procedure, service, or supply.
advancement flap (11) movement of tissue in a straight line from donor to defect site; once movement is achieved, the flap is sutured in place.
aircraft (4) any device used for transporting passengers or goods in the air and includes airplanes, balloons, bombers, dirigibles, gliders (hang), military aircraft, and parachutes.
airway management (10) ensuring an open airway to the patient’s lungs.
A-line (10) see intra-arterial line.
aliquot (17) portion of a specimen used for testing.
alergen (18) allergy-causing substances to which a patient reacts.
alergen immunotherapy (18) small amounts of allergens administered to increase a patient’s tolerance to allergens.
alergy sensitivity test (18) performed on skin (cutaneous) and mucous membranes to identify the source of a patient’s allergies.
allogenous (12) graft that involves tissue organ transplanted from one person to another.
allograft (11) transplantation of tissue from someone of the same species.
ambulance fee schedule (19) reimburses ambulance service providers a preestablished fee for each service provided.
ambulatory care (6) see outpatient care.
ambulatory patient (6) patient who is treated and released the same day and who does not stay overnight in the hospital.
ambulatory surgery patient (6) patient who undergoes procedures that can be performed on an outpatient basis, with the patient treated and released the same day.
ambulatory surgical center (ASC) payment rate (19) reimbursement rate calculated on a prospective basis; rate is based on sample survey data and use of similar surgical techniques to establish reasonable estimated overhead allowances for each listed procedure.
A-mode (16) one-dimensional display that reflects the length of time a sound reaches a structure and is reflected back.
amplitude modulation (16) see A-mode.
analgesia (10) loss of pain sensation without loss of consciousness.
analgesic (10) drug that reduces pain, resulting in analgesia.
analysie (17) substance that a laboratory test is supposed to detect.
analye (17) substance that a laboratory test is supposed to detect.
anxiety (10) process of inducing a loss of sensitivity to pain in all or part of the body, resulting from the administration of an anesthetic.
anesthesia (10) process of inducing a loss of sensitivity to pain in all or part of the body, resulting from the administration of an anesthetic.
anesthesia conversion factor (10) dollar amount assigned to inpatients and outpatients.
anesthesia time unit (10) based on total anesthesia time and reported as one unit for each 15 minutes (or fraction thereof) of anesthesia time.
anesthesiologist (10) physician who, after medical school, completes a one-year internship and three-year residency in anesthesia.
anesthetic (10) drug or agent that causes a loss of feeling, awareness, and/or consciousness.
aneryx (13) bulge in an artery that can weaken the arterial wall and eventually burst, resulting in hemorrhage.
anngiogenesis (13) growth of new capillaries.
anngiography (16) x-ray of a blood vessel after injection of contrast material.
anngiography (13) microscopic visualization of substances as they pass through capillaries.
ananoscopy (14) diagnostic procedure during which anal mucosa and the lower rectum are visualized using an anoscope.
anans ASC X12 837(19) variable-length file format that is used to bill institutional, professional, dental, and drug claims.
anteptum care (15) begins with conception and ends with delivery, including initial and subsequent history; physical examinations; documentation of weight, blood pressures, and fetal heart tones; routine chemical urinalysis (glucose); monthly visits up to 28 weeks’ gestation; biweekly visits to 36 weeks’ gestation; and weekly visits until delivery.
anteorlateral approach (15) making an incision along (and removing) the rib that corresponds to the vertebra that is located above the compressed intervertebral disk.
anterior approach (15) making an incision overlying the intervertebral disc by cutting through epidermis, dermis, subcutaneous, fascia, and muscle tissue.
anterior approach (15) making an incision along (and removing) the rib that corresponds to the vertebra that is located above the compressed intervertebral disk.
anterolateral approach (15) making an incision along (and removing) the rib that corresponds to the vertebra that is located above the compressed intervertebral disk.
anteroposterior projection (16) patient is positioned with his or her back parallel to the film; the x-ray beam travels from front to back, or anterior to posterior.
antibody (Ab) (17) proteins in the body made by the immune system that fight infection and disease.
agnet (Ag) (17) foreign substances that elicit the formation of antibodies.
anortography (16) x-ray of the aorta after injection of contrast material.
Appendix B of CPT (8) contains annual CPT coding changes that include added, deleted, and revised CPT codes; it serves as the basis for updating interoffice documents and billing tools.
Appendix C of CPT (8) contains clinical examples for codes found in the Evaluation and Management section.
Appendix D of CPT (8) contains a list of add-on codes that are identified throughout CPT with a plus (+) symbol.
Appendix E of CPT (8) contains a list of codes that are exempt from modifier -51 reporting rules and that are identified throughout CPT with a forbidden (\(\square\)) symbol.
Appendix F of CPT (8) contains a list of codes that are exempt from modifier -63.
Appendix G of CPT (8) contains a summary of CPT codes that include conscious sedation and that are identified throughout CPT with a bull’s-eye (\(\circ\)) symbol.
Appendix H of CPT (8) contains an alphabetic index of performance measures by clinical condition or topic.
Appendix I of CPT (8) contains genetic testing modifiers.
Appendix J of CPT (8) contains an electrodiagnostic medicine listing of sensory, motor, and mixed nerves that are reported for motor and nerve studies codes 95900, 95903, and 95904, respectively.
Appendix K of CPT (8) contains a list of codes that are pending FDA approval but that have been assigned CPT codes; in the CPT manual, these codes are preceded by the flash (\(\ast\)) symbol.
Appendix L of CPT (8) contains a list of vascular families that is intended to assist in the selection of first-, second-, third-, and beyond third-order branch arteries.
Appendix M of CPT (8) contains a list of deleted CPT codes and descriptions with a crosswalk to new CPT codes.
application service provider (ASP) (1) third-party entity that manages and distributes software-based services and solutions to customers across a wide area network (WAN) from a central data center.
arterial puncture (17) puncture of an artery with a needle for the purpose of drawing blood.
arteriography (10) visualization of an artery via x-ray after injection of a radiopaque.
artery and a vein, which allows blood to flow directly into a vein.
arthrocentesis (12) procedure done to puncture a joint for fluid removal or medication injection.
arthrodesis (12) surgical fixation of a joint.
arthrography (16) x-ray of a joint after injection of contrast material.
arthroscopy (12) visual examination of the inside of a joint.
artificial ankylosis (12) see arthrodesis.
arytenoidectomy (12) excision of an arytenoid cartilage, which is located in the bilateral vocal fold.
arytenoidopexy (12) surgical fixation of arytenoidal cartilage and/or surrounding muscles.
assay (17) measurement of the amount of a constituent in a specimen, such as via laboratory test.
Assessment (A) (1) judgment, opinion, or evaluation made by the health care provider; considered part of the problem-oriented record (POR) SOAP note.
assumption coding (1) inappropriate assignment of codes based on assuming, from a review of clinical evidence in the patient’s record, that the patient has certain diagnoses or procedures/services even though the provider did not specifically document those diagnoses or procedures/services.
auditory system (15) organized anatomically according to the external ear; middle ear; inner ear; and temporal bone, middle fossa approach.
augmentation (12) process of enlarging or increasing.
autogenous (12) originating in the patient's body.
autograft (11) transplantation of tissue from the same individual.
automated case abstracting software (1) software program that is used to collect and report inpatient and outpatient data for statistical analysis and reimbursement purposes.
automated record (1) type of record that is created using computer technology.
autonomic function test (18) evaluates autonomic nervous system functioning.
aval plane (16) see transverse plane.
axis of classification (ICD-10-PCS) (5) the sections, body parts, root operations, and so on that comprise the 7-character ICD-10-PCS code; each axis specifies information about the procedure performed, and within a defined code range, a character specifies the same type of information for that axis of classification.

backbench work for lung transplantation (12) preparing the cadaver donor heart and/or lung allograft prior to lung transplantation and dissecting allograft from surrounding soft tissues to prepare the aorta, superior vena cava, inferior vena cava, pulmonary artery, left atrium, trachea, pulmonary venous/atrial cuff, and/or bronchus for implantation.

Balanced Budget Act of 1997 (19) legislated implementation of the skilled nursing facility prospective payment system, which uses resource utilization groups, version III (RUG-III), to reimburse Medicare SNF services according to a per diem prospective rate adjusted for case mix; also legislated implementation of an ambulance fee schedule, which reimburses ambulance service providers a preestablished fee for each service provided.

Balanced Budget Refinement Act of 1999 (BBRA) (19) mandated implementation of the long-term (acute) care hospital prospective payment system, which uses information from long-term acute care hospital patient records to classify patients into distinct long-term (acute) care hospital diagnosis-related groups based on clinical characteristics and expected resource needs.

base unit value (10) represents the degree of difficulty associated with providing anesthesia for a surgical procedure.

bed count (5) see bed size.

bed size (5) total number of inpatient beds for which a facility is licensed by the state; facility must be equipped and staffed to care for these patient admissions.

bedsores (11) see pressure ulcer.

behavior modifying psychotherapy (18) treatment that focuses on changing unhealthy or unwanted behaviors; typically includes a system of desensitization, reinforcements of positive behavior, and rewards; can also include biofeedback and relaxation training.

behavioral health care hospital (5) health care facility that specializes in treating individuals with mental health diagnoses.

Bell’s palsy (15) unilateral paralysis of facial muscles resulting from dysfunction of the 7th cranial nerve, probably due to a viral infection.

benign (2) not cancerous.

benign hypertension (4) hypertension of prolonged or chronic duration; this type of hypertension is usually controlled by medication.

Bethesda system (17) format for reporting cervical/vaginal cytology that includes a state of specimen adequacy, the general category, and a descriptive diagnosis.

Bier block (10) see intravenous regional anesthesia.

biliary system (14) organs and duct system that create, transport, store, and release bile into the duodenum (as part of the digestive process); includes the gallbladder, bile ducts inside the liver, bile ducts outside the liver, hepatic ducts, common bile duct, and cystic duct.

biofeedback (18) technique that trains the patient to gain some control over autonomic body functions.

biometric A-scan (16) diagnostic ultrasound that produces a one-dimensional view of normal and abnormal eye tissue and precise measurements of the eye’s length.

biomicroscopy (16) optical instrument that looks like a microscope with two eyepieces.

biopsy (11) removal and examination of tissue to establish a diagnosis, confirm a diagnosis, or determine the extent of a disease.

bipolar cautery (14) technique that uses an electric current that flows from one tip of the forceps to the other and does not require a grounding pad.

blepharoplasty (11) any surgical repair of an eyelid.

block (16) device used when a radiology procedure is performed; made of lead or another heavy metal, it is placed between the radiation beam and that portion of the patient’s body that requires protection from radiation.

block (17) portion of tissue obtained from a specimen that is placed in support medium, such as paraffin.

blocking (16) device, such as lead, that shields or protects critical or sensitive organs during radiology treatment.

blood (13) tissue that consists of plasma, red blood cells, white blood cells, and platelets (or thrombocytes).

Blue Cross and Blue Shield (BCBS) (19) cover the costs of hospital care and physician services; Blue Cross initially covered just hospital care and Blue Shield covered just physicians’ services; today each offers a full range of health care coverage.

bone density study (16) evaluates diseases of the bone; used to assess the response of bone disease to treatment.

bone marrow (13) spongy material that fills large bones’ cavities; consists of red marrow (produces red blood cells, white blood cells, and platelets) and yellow marrow (replaces red marrow with fatty tissue that does not produce blood cells).

bone marrow aspiration (13) use of a needle to remove a sample of the liquid bone marrow for examination under a microscope.

bone marrow biopsy (13) boring a small hole into a long bone and using a large, hollow needle to remove bone marrow for examination under a microscope.

breach of confidentiality (19) occurs when patient information is disclosed to other(s) who do not have a right to access the information.

brightness mode (16) see B-scan.

bronchography (12) visual examination of the interior of the bronchus.

brushing (12) combing the mucous lining of the trachea or bronchus with a bronchial brush to collect cells.

B-scan (16) diagnostic ultrasound that produces a two-dimensional cross-sectional view of tissues that cannot be seen directly; it reflects sound waves bouncing off tissues or organs; e.g., used to locate a lesion and determine its shape; also called brightness mode (B-mod).

bullet symbol (8) symbol (●) located to the left of CPT codes that identifies new procedures and services added to CPT.

bull’s-eye symbol (8) symbol (○) located to the left of CPT codes that identifies procedures that include conscious sedation.

bunion (12) caused by bone inflammation and swelling and results in medial deviation and axial rotation of the first metatarsophalangeal (MTP) joint.

burr hole (15) small opening in the skull made with a surgical drill.
case mix adjustment (19) decrease of average difference between preestablished payment and each patient's actual cost to a facility.

case mix diagnosis (6) first-listed diagnosis that determines the Medicare PPS case mix group; assigned to patients with selected conditions (e.g., burns/trauma, diabetic, neurological, or orthopedic) to generate a case mix group for Medicare PPS case mix adjustment.

category code (2) three-digit ICD-9-CM disease code or two-digit ICD-9-CM procedure code within a section.

Category I code (8) procedures/services identified by a five-digit CPT code and descriptor nomenclature; this type of code is traditionally associated with CPT and organized within six sections.

Category II code (8) optional CPT “performance measurements” tracking code that is assigned an alphanumeric identifier with a letter in the last field; this type of code is located after the CPT Medicine section.

Category III code (8) “emerging technology” temporary CPT code assigned for data collection purposes that are assigned an alphanumeric identifier with a letter in the last field; this type of code is located after the Medicine section, and it will be archived after five years if it is not accepted for placement within Category I sections of CPT.

caudal anesthesia (10) local anesthetic injected into the caudal canal, which is the sacral portion of the spinal canal.

cell washing (12) flushing fluid into an area and removing the fluid, using aspiration technique to collect cells.

Centers for Medicare & Medicaid Services (CMS) (1) administrative agency in the federal Department of Health & Human Services.

central motor evoked potential study (18) testing a patient’s nervous system's pathway by placing low-voltage electrodes on the scalp and target sites.

central nervous system (CNS) (10) brain and spinal cord.

central venous access device (CVAD) (10) thin plastic tube that is inserted into a vein and connected to a monitor.

central venous pressure (CVP) catheter (10) see central venous pressure (CVP) line.

central venous pressure (CVP) line (10) catheter that is inserted through a vein in the neck or a vein in the upper chest under the collarbone and then into a large central vein in the chest.

certification of medical necessity (CMN) (7) prescription for durable medical equipment, services, and supplies.

certified registered nurse anesthetist (CRNA) (10) licensed registered nurse who has earned a bachelor’s degree in science or nursing, has at least one year of acute care nursing experience, has completed a 24- to 36-month nurse anesthesia program leading to a master’s degree, and has passed the national certification exam.

charge description master (CDM) (19) see chargemaster.

chargemaster (19) document that contains a computer-generated list of procedures, services, and supplies and corresponding revenue codes along with charges for each.

chargemaster review process (19) routinely conducted by designated hospital personnel to ensure accurate reimbursement by updating CPT and HCPCS codes and linking each to appropriate UB-04 revenue codes.
check digit (19) one-digit character, alphabetic or numeric, that is used to verify the validity of a unique identifier.

cheiloplasty (14) plastic surgery of the lips.

chemical peel (11) use of chemical agents to remove wrinkles and abnormal pigmentation.

chemosurgery (11) use of chemicals to destroy diseased tissue, such as for skin cancer.

chemotherapy (18) treatment of cancer with drugs that serve to destroy cancer cells or slow the growth of cancer cells and keep cancer from spreading to other parts of the body, preventing recurrence of the cancer.

Chemstrip automated urine analyzer (17) see reagent strip automated urine analyzer.

chief complaint (CC) (9) patient’s description of medical condition stated in the patient’s own words.

chiropractic manipulative treatment (CMT) (18) manual treatment performed to influence joint and neurophysiological function.

cholecystectomy (14) surgical removal of the gallbladder.

choroid (15) opaque layer behind the retina that contains blood vessels.

chromatography (17) separation of chemical substances by differential absorption into a moving two-phase system; in gas-liquid chromatography, gaseous substances are separated by moving through a liquid.

chromosomal breakage syndrome (17) genetic disorder that is usually transmitted in a genetic autosomal recessive mode.

cyte (13) digestive fluid that contains proteins and fats.

ciliary body (15) adjusts the shape of the lens and focuses light rays onto the retina.

ciliary muscle (15) see ciliary body.

Civil Monetary Penalties Act (19) imposes a maximum penalty of up to $10,000 plus a maximum assessment of up to three times the amount claimed by providers who knew that a procedure/service was not rendered as submitted on the claim.

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) (19) program that provides health care benefits to dependents of veterans rated as 100 percent permanently and totally disabled as a result of service-connected conditions, veterans who died as a result of service-connected conditions, and veterans who died on duty with less than 30 days of active service.

claims examiner (1) see health insurance specialist.

Classification of Drugs by AHFS List (2) located in ICD-9-CM Appendix C; contains the American Hospital Formulary Services (AHFS) List number and its ICD-9-CM equivalent code number.

Classification of Industrial Accidents According to Agency (2) located in ICD-9-CM Appendix D; based on employment injury statistics adopted by the Tenth International Conference of Labor Statisticians.

classification system (1) see coding system.

clearinghouse (1) public or private entity that processes or facilitates the processing of health information and claims from a nonstandard to a standard format.

cleft lip (10) congenital deformity of the upper lip that failed to close during development; types include unilateral, bilateral, and median (harelip) and may be accompanied by defects of the maxilla and hard palate.

clinic outpatient (6) patient who receives scheduled diagnostic and therapeutic care.

clinical examples (9) contained in Appendix C of the CPT coding manual; assist providers in selecting the appropriate code for documented E/M services.

clinical laboratory fee schedule (19) methodology for determining fees for laboratory tests as a result of enacted legislation called the Deficit Reduction Act of 1984; the Consolidated Omnibus Budget Reconciliation Act of 1985 later established a national limitation amount (NLA) on the clinical laboratory fee schedule.

Clinical Laboratory Improvement Act of 1988 (CLIA) (17) certification that is required to perform certain pathology and laboratory tests (and to submit claims to Medicare and Medicaid).

closed fracture (4) type of fracture that is contained beneath the skin and has intact ligaments and skin.

closed fracture treatment (12) fracture site that is not surgically opened or exposed.

closed laparoscopy (14) insufflation of the abdominal cavity using a percutaneously placed needle; performed to examine peritoneal contents using a laparoscope.

closed procedure (4) procedure that requires the use of an endoscope to visualize an area and to pass instruments through the scope to complete the procedure.

closed-panel HMO (19) HMO-owned center or satellite clinic that provides health care services.

CMS-1450 (1) see UB-04.

CMS-1500 (1) standard claim submitted by physicians’ offices to third-party payers.

cochlear implant (15) implanted electronic device for treatment of sensory deafness.

code (1) acquires a working knowledge of coding systems (e.g., CPT, HCPCS level II, and ICD-9-CM), coding principles and rules, government regulations, and third-party payer requirements to ensure that all diagnoses (conditions), services (e.g., office visit), and procedures (e.g., surgery and x-ray) documented in patient records are coded accurately for reimbursement, research, and statistical purposes.

code (1) numeric and alphanumeric characters that are reported to health plans for health care reimbursement and to external agencies (e.g., state departments of health) for data collection, in addition to being reported internally (e.g., acute care hospital) for education and research.

coding (1) assignment of codes to diagnoses, services, and procedures based on patient record documentation.

coding conventions (ICD-9-CM) (3) general rules used in the ICD-9-CM classification systems that are independent of coding guidelines.

abbreviation (3) use of NEC (not elsewhere classifiable) and NOS (not otherwise specified). (NEC and NOS abbreviations do not appear in ICD-10-PCS.)

and (3) interpreted as meaning “and/or.”

boxed note (3) defines terms, provides coding instruction, and lists fifth-digit subclassifications for categories that use the same fifth digits; Index to Procedures boxed notes also provide coding instruction and list fourth-digit subclassifications for categories that use the same fourth digits. (Boxed notes do not appear in ICD-10-CM or ICD-10-PCS.)

code first underlying disease (3) tabular list instructional note that assists with proper sequencing of codes.
code, if applicable, any causal condition first (3) tabular list instructional note that requires causal conditions to be sequenced first, if present.

colon (3) used after an incomplete term in the tabular list when one or more additional terms (called modifiers) after the colon must be documented in the diagnostic or procedural statement to classify a condition or procedure.

cross-reference (3) instruction to refer to another entry in the index (e.g., see, see also, see condition) or tabular list (e.g., see category) to assign the correct code.

due to (3) index subterm (in alphabetical order) that indicates the presence of a cause-and-effect (or causal) relationship between two conditions.

eponym (3) disease, syndrome, or procedure named for a person.

etiology and manifestation rules (3) include the following in the tabular list: code first underlying disease; code, if applicable, any causal condition first; use additional code; and in diseases classified elsewhere.

excludes note (3) appears below codes in the tabular list to direct the coder to another location in the tabular list to classify conditions (or procedures) that are excluded from the code.

format (3) index subterms are indented two spaces below a main term; second, third, and fourth qualifiers are indented two, four, and six spaces, respectively, below the subterm.

in (3) Index to Diseases subterm (in alphabetical order) that indicates the presence of a cause-and-effect (or causal) relationship between two conditions.

in diseases classified elsewhere (3) phrase that indicates that manifestation codes are a component of the etiology/manifestation coding convention.

includes note (3) appears immediately below tabular list codes to further define terms or provide examples.

inclusion term (3) listed below certain codes in the tabular list; includes conditions or procedures for which that code number is to be assigned; can be synonyms of the code title or, for “other” codes, a list of conditions or procedures assigned to that code.

NEC (not elsewhere classifiable) (3) equivalent of “other specified”; identifies codes that are to be assigned when information needed to assign a more specific code cannot be obtained from the coding manual.

NOS (not otherwise specified) (3) the equivalent of “unspecified”; identifies codes that are to be assigned when information needed to assign a more specific code cannot be obtained from the provider.

other and other specified codes (3) assigned when patient record documentation provides detail for which a specific code does not exist in the coding manual.

parentheses (3) used in the indexes and tabular lists to enclose nonessential modifiers, which are supplementary words that may be present in or absent from the physician’s statement of a disease or procedure without affecting the code number to which it is assigned.

punctuation (3) slanted brackets, square brackets, parentheses, and colons.

see (3) instructional term in the index that directs the coder to refer to another term.

see also (3) instructional term in the index that is located after a main term or subterm and directs the coder to another main term (or subterm) that may provide additional useful index entries.

see category (3) instructional term in the index that directs the coder to the tabular list, where a code can be selected from the options provided.

see condition (3) instructional term in the index that directs the coder to the main term for a condition.

slanted brackets (3) used in the index to identify manifestation codes. (Square brackets are used in ICD-10-CM for this purpose.)

square brackets (3) used in the tabular lists to enclose synonyms, alternative wording, or explanatory phrases. (Used in ICD-10-CM index to enclose manifestation codes, which are always sequenced second.)

table (3) index feature that organizes subterms, second qualifiers, and third qualifiers and their codes in columns and rows to make it easier to select the proper code. (Tables also appear in ICD-10-PCS, instead of a tabular list, to facilitate assignment of values to create the seven-character code.)

unspecified code (3) assigned when patient record documentation is insufficient to assign a more specific code.

use additional code (3) instructional note that assists in proper sequencing of the codes.

with (3) located immediately below the main term in the indexes, not in alphabetical order.

coding conventions (ICD-10-CM) (3) general rules used in the ICD-10-CM classification system that are independent of coding guidelines.

abbreviations (3) use of NEC (not elsewhere classifiable) and NOS (not otherwise specified). (NEC and NOS abbreviations do not appear in ICD-10-PCS.)

and (3) interpreted as meaning “and/or.”

code first underlying disease (3) tabular list instructional note that assists with proper sequencing of codes.

code, if applicable, any causal condition first (3) tabular list instructional note requires causal conditions to be sequenced first, if present.

colon (3) used after an incomplete term in the tabular list when one or more additional terms (called modifiers) after the colon must be documented in the diagnostic statement to classify a condition.

cross-reference (3) instruction to refer to another entry in the index (e.g., see, see also, see condition) or tabular list (e.g., see category) to assign the correct code.

due to (3) index subterm (in alphabetical order) that indicates the presence of a cause-and-effect (or causal) relationship between two conditions.

eponym (3) disease, syndrome, or procedure named for a person.

etiology and manifestation rules (3) include the following in the tabular list: code first underlying disease; code, if applicable, any causal condition first; use additional code; and in diseases classified elsewhere.

excludes note (3) appears below codes in the ICD-10-CM tabular list to direct the coder to another location in the tabular list to classify conditions that are excluded from the code—code either the original code or the code to which the excludes1 note directs you.
excludes2 note (3) appears below codes in the ICD-10-CM tabular list to direct the coder to another location in the tabular list to classify conditions that are excluded from the code – both the original code and the code to which the excludes2 note directs you can be reported if documentation supports both conditions.

format (3) index subterms are indented two spaces below a main term; second, third, and fourth qualifiers are indented two, four, and six spaces, respectively, below the subterm.
in (due to) (3) index subterm (in alphabetical order) that indicates the presence of a cause-and-effect (or causal) relationship between two conditions.
in diseases classified elsewhere (3) indicates that manifestation codes are a component of the etiology/manifestation coding convention.
includes note (3) appears immediately below tabular list codes to further define terms or provide examples.
inclusion term (3) listed below certain codes in the tabular lists; includes conditions or procedures for which that code number is to be assigned; can be synonyms of the code title or, for “other” codes, a list of conditions or procedures assigned to that code.
NEC (not elsewhere classifiable) (3) equivalent of “other specified”; identifies codes that are to be assigned when information needed to assign a more specific code cannot be located in the coding manual.
NOS (not otherwise specified) (3) equivalent of “unspecified”; identifies codes that are to be assigned when information needed to assign a more specific code cannot be obtained from the provider.
other and other specified codes (3) codes that are assigned when patient record documentation provides detail for which a specific code does not exist in the coding manual.
parentheses (3) used in the index and tabular list to enclose nonessential modifiers, which are supplementary words that may be present in or absent from the physician’s statement of a disease or procedure without affecting the code number to which it is assigned.
punctuation (3) slanted brackets, square brackets, parentheses, and colons.
see (3) instructional term that directs the coder to refer to another term in the indexes the code.
see also (3) instructional term that is located after a main term or subterm in the index and directs the coder to another main term (or subterm) that may provide additional useful index entries.
see category (3) instructional term that directs the coder to the tabular list, where a code can be selected from the options provided there.
see condition (3) instructional term that directs the coder to the main term in the index for a condition.
square brackets (3) used in the tabular lists to enclose synonyms, alternative wording, explanatory phrases, and manifestation codes.
table (3) index feature that organizes subterms, second qualifiers, and third qualifiers and their codes in columns and rows to make it easier to select the proper code. (Tables also appear in ICD-10-PCS, which facilitate assignment of values to create the seven-character code.)
unspecified code (3) assigned when patient record documentation is insufficient to assign a more specific code.

Coding Guidelines for Outpatient Diagnostic Tests (6) instructions and examples that are to be used when assigning ICD-9-CM (or ICD-10-CM) codes for diagnostic test results.
coding system (1) organizes a medical nomenclature according to similar conditions, diseases, procedures, and services; it contains codes for each.
cold biopsy forceps (14) technique that does not use electroagulation; the polyp is simply pulled from the colon wall.
colectomy (14) removal of part or all of the large intestine.
colonoscopy (14) visual examination of the entire colon, from the rectum to the cecum, and may include the terminal ileum.
colostomy (14) removal of a portion of the colon or rectum; the remaining colon is brought to the abdominal wall.
column 1/column 2 edits (8) code pairs that should not be billed together because one service inherently includes the other; previously called comprehensive/component edits.
combination code (4) single code used to classify two diagnoses (or procedures), a diagnosis with an associated secondary process (manifestation), or a diagnosis with an associated complication.
commercial payer (19) private health insurance company or employer-based group health insurance company.
commercial transport aircraft (4) any device used for collective passenger or freight transportation by air, whether run on commercial lines for profit or by government authorities, with the exception of military craft.
commissurotomy (13) narrowed valve leaflets are widened by carefully opening the fused leaflets with a scalpel.
comorbidity (5) coexisting condition (e.g., diabetes mellitus) that is treated during the same encounter as or impacts the medical management of another condition (e.g., myocardial infarction).
compensator (16) irregularly shaped beam-modifying device used to reconfigure beam intensity so it matches irregular tissue contour.
complex fistulectomy (14) excision of multiple fistulas.
compliance guidance (19) document that identifies risk areas and offers concrete suggestions to improve and enhance an organization's internal controls so that billing practices and other business arrangements are in compliance with Medicare's rules and regulations.
complication (5) condition that occurs during the course of an inpatient hospital episode.
component coding (16) reporting a radiology procedure code and a surgical procedure code to completely describe the service provided.
composite graft (13) vein and synthetic graft material or segments of veins from two or more locations.
compound fracture (4) see open fracture.
comprehensive examination (9) general multisystem examination or complete examination of a single organ system.
comprehensive history (9) chief complaint, extended history of present illness, review of systems directly related to the area of the thoracic spine where the rib meets the vertebra.
comprehensive/component edits (8) code pairs that should not be billed together because one service inherently includes the other.
computed axial tomography (CT) (CAT) (16) x-ray of horizontal and vertical cross-sectional views or “slices” of the body that are computer-processed to create three-dimensional, or 3D, images.
computed tomography angiography (CTA) (16) x-rays of different angles to create cross-sectional images of organs, bones, and tissues that visualize blood flow in arterial and venous vessels throughout the body.
computer-assisted coding (CAC) (1) uses computer software to automatically generate medical codes by “reading” transcribed clinical documentation; uses “natural language processing” theories to generate codes that are reviewed and validated by coders for reporting on third-party payer claims.
concha (12) see turbinate.
concurrent care (9) provision of similar services, such as hospital inpatient visits, to the same patient by more than one provider on the same day.
concurrent medically directed anesthesia procedures (10) maximum number of procedures an anesthesiologist or a CRNA medically directs within the context of a single procedure when the procedures overlap.
confidentiality (19) process of keeping privileged communication secret; means that information cannot be disclosed without the patient's authorization.
conization (15) removal of a cone-shaped piece of tissue.
conjunctiva (15) mucous membrane that lines the underside of each eyelid and forms a protective covering over the exposed surface of the eyeball.
Consolidated Omnibus Budget Reconciliation Act of 1985 (19) federal legislation that established a national limitation amount, which serves as a payment ceiling, or cap, on the amount Medicare could pay for each test.
consultation (9) examination of a patient by a health care provider, usually a specialist, for the purpose of advising the referring or attending physician in the evaluation and/or management of a specific problem with a known diagnosis.
consumer-directed health plan (CDHP) (19) a sort of “401(k) plan for health care” includes many choices that provide individuals with an incentive to control the costs of health benefits and health care.
contiguous sites (4) adjacent locations as in cancer of multiple sites that overlap or border each other (e.g., nasopharynx and oropharynx cancer).
continent ileostomy (14) surgical variation of an ileostomy in which a reservoir pouch is created inside the abdomen using a portion of the terminal ileum, a valve is constructed in the pouch, and a stoma is brought through the abdominal wall.
continuity of care (1) documenting patient care services so that others who treat the patient have a source of information on which to base additional care and treatment.
contrast agent (16) radiopaque substances (solid or liquid) that obstruct the passage of x-rays, making the structure containing the agent appear white on radiographic film; administered to provide better radiographic visualization of organs studied.
contrast material (16) see contrast agent.
contrast medium (10) see contrast agent; plural is contrast media.
contrast medium injection device (16) instrument used to deliver a predetermined amount of contrast, typically for vascular imaging procedures.
contributory components (9) include counseling, coordination of care, nature of presenting problem, and time; they are used to select the appropriate E/M service code when patient record documentation indicates that they were the focus of the visit.
conversion factor (19) dollar multiplier that converts relative value units into payments using a formula.
cooperating parties for the ICD-9-CM (2) AHIMA, AMA, CMS, and NCHS.
cooperating parties for the ICD-10-CM/PCS (2) AHIMA, AMA, CMS, and NCHS.
coordination of care (9) component in which physician makes arrangements with other providers or agencies for services to be provided to a patient.
cornea (15) transparent layer on the eye’s surface; covers the iris and pupil; provides focusing power.
corneal pachymetry (16) noninvasive ultrasound procedure that determines thickness of the cornea.
coronal plane (16) divides the body into anterior or ventral and posterior or dorsal portions at a right angle to the sagittal plane, separating the body into front and back; also called ventral or dorsal plane.
coronary artery bypass graft (CABG) (13) procedure performed to improve flow of blood to the heart.
coronary endarterectomy (13) removal of the inner layer of coronary arteries that contain cholesterol plaques.
corpectomy (15) removal of a portion of the vertebra and adjacent intervertebral disks.
costovertebral (15) area of the thoracic spine where the rib meets the vertebra.
costovertebral approach (15) procedure performed where the ribs articulate with thoracic vertebrae.
counseling (9) see also psychotherapy. Discussion with a patient and/or family concerning one or more of the following areas: diagnostic results, impressions, and/or recommended diagnostic studies; prognosis; risks and benefits of management options; instructions for management and/or follow-up; importance of compliance with chosen management options; risk factor reduction; and patient and family education.
covered benefit (19) reimbursable medical benefit. covered entity (19) private or public sector organization that must follow HIPAA provisions.
critical access hospital (CAH) (5) located more than 35 miles from any hospital or another CAH; state certified as being a necessary provider of health care to area residents.
critical care (9) delivery of medical care services to critically ill or injured patients who require the full, exclusive attention of the physician.
critical illness or injury (9) one that acutely impairs one or more vital organ systems, jeopardizing the patient’s survival.
critical pathway (19) interdisciplinary guideline developed by health care facilities to facilitate management and delivery of quality clinical care in a time of constrained resources; allows for the planning of provision of clinical services that have expected time frames and resources targeted to specific diagnoses and/or procedures.
cross-over vein graft (13) making an incision to expose the vein’s incompetent valve, dividing that section of the vein, and connecting it to a nearby vein that has functioning valves.
cryosurgery (11) application of extreme cold, such as liquid nitrogen, to destroy abnormal tissue cells, such as warts or small skin tumors.

Current Procedural Terminology (CPT) (1) coding system used by physicians and outpatient health care settings to assign CPT codes for reporting procedures and services on health insurance claims; considered level I of the Healthcare Common Procedure Coding System (HCPCS); published and updated by the American Medical Association (AMA) to classify procedures and services; listing of descriptive terms and identifying codes for reporting medical services and procedures; provides a uniform language that describes medical, surgical, and diagnostic services to facilitate communication among providers, patients, and third-party payers.
customized sub-capitation plan (CSCP) (19) funds health care expenses with insurance coverage; individual selects one of each type of provider to create a customized network and pays the resulting customized insurance premium.
cutdown (13) a procedure whereby a catheter is inserted directly into a vein through an incision.
cystography (16) x-ray of the urinary bladder after injection of contrast material.
cystometrogram (14) records urinary bladder pressure at various volumes; useful in diagnosing bladder outlet obstruction and other voiding dysfunctions.
cystoscopy (14) allows for direct visual examination of urinary bladder and urethra.
cystourethroscopy (14) see cystoscopy.
cytogenetic (17) study of the cell and its heredity-related components, including chromosomes.
cytopathology (17) study of diseased cells.

database (1) contains a minimum data set of patient information collected on each patient, including chief complaint; present conditions and diagnoses; social data; past, personal, medical, and social history; review of systems; physical examination; and baseline laboratory data; considered part of the problem-oriented record (POR).
decrypt (19) decode.
decubitus ulcer (11) see pressure ulcer.
Deficit Reduction Act of 1984 (19) established the clinical laboratory fee schedule as a methodology for determining fees for existing tests.
definitive identification (17) specialized testing performed for identification at the genus or species level.
delivery services (15) services from patient admission to the hospital through delivery of the placenta.
demographic data (1) patient identification information that is collected according to facility policy (e.g., patient’s name, date of birth, mother’s maiden name, and Social Security number).
dermabrasion (11) use of a rotary device to sand down raised lesions or thickened tissue, regenerating smoother skin; performed for conditions such as acne scarring, wrinkles, rhytids, and general keratosis.
descriptive qualifiers (8) clarify assignment of a CPT code; occur in the middle of a main clause or after the semicolon; may or may not be enclosed in parentheses.
desensitization (18) confronting something that causes anxiety.
Designated Standard Maintenance Organization (DSMO) (19) maintain, electronic transactions standards adopted by the Secretary of DHHS and develops or modifies adopted standards.
destruction (11) ablation of benign, premalignant, or malignant tissues by any method.
detailed examination (9) extended examination of the affected body area(s) and other symptomatic or related organ system(s).
detailed history (9) includes chief complaint, extended history of present illness, problem pertinent system review extended to include a limited number of additional systems, and pertinent past/family/social history directly related to patient’s problem.
determination of refractive state (18) establishes whether a prescription is required for vision correction.

Diagnosis Coding for Medicare Home Health under PPS (6) guidelines that assist home health agencies in assigning ICD-9-CM codes for reimbursement of Medicare home health care services.
diagnosis-related group (DRG) (19) classifies inpatient hospital cases into groups that are expected to consume similar hospital resources; each DRG has a payment weight assigned to it that is based on the average resources used to treat Medicare patients in that DRG.
Diagnostic and Statistical Manual (DSM) (19) manual published by the American Psychiatric Association that contains diagnostic assessment criteria used as tools to identify psychiatric disorders; DSM includes psychiatric disorders and codes, provides a mechanism for communicating and recording diagnostic information, and is used in the areas of research and statistics.

Diagnostic Coding and Reporting Guidelines for Outpatient Services: Hospital-Based and Physician Office (6) developed by the federal government and approved for use by hospitals and providers for coding and reporting hospital-based outpatient services and provider-based office visits.
diagnostic endoscopy (14) use of instrumentation for surgical visualization to determine extent of disease.
diagnostic mammography (16) assessment of suspected disease of breasts?
diagnostic/management plan (1) information about the patient’s condition and the planned management of conditions; considered part of the problem-oriented record (POR).
diagnostic procedure (11) laboratory, radiographic, and other tests performed to evaluate the patient’s complaints or symptoms and to establish the diagnosis.
diaphragm (14) thin muscle below the heart and lungs; separates the chest from the abdomen.
digestive system (14) bodily system that begins at the mouth and extends to the anus.
digital (19) applies a mathematical function to an electronic document, resulting in a unique bit string (computer code) called a message digest that is encrypted and appended to the electronic document.
dipstick (17) small strip of plastic that is infused with a chemical; reacts to products in urine by changing color.
direct contract model HMO (19) contracted health care services delivered to subscribers by individual physicians in the community.
direct laryngoscopy (12) insertion of a flexible (fiberoptic) or rigid laryngoscope to visualize throat structures.
discharge note (1) documented in the progress note section of the problem-oriented record (POR) to summarize the patient’s care, treatment, response to care, and condition on discharge.
disclosed (19) released.
disectomy (15) removal of an intervertebral disc.
dislocation (12) total displacement of bone from its joint.
diverticula (14) small pouches (herniations) in the colon that bulge outward through weak spots.
diverticulosis (14) presence of diverticula in the mucosa and submucosal, through or between fibers of the colon’s major muscle layer.
DME MAC medical review policies (7) local coverage determinations and national coverage determinations.
document imaging (1) see optical disk imaging.
documentation (1) includes dictated and transcribed, typed or handwritten, and computer-generated notes and reports recorded in the patient’s records by a health care professional.
Documentation Guidelines for Evaluation and Management Services (9) explain how E/M codes are assigned according to elements associated with comprehensive multisystem and single-system examinations.
Doppler ultrasonography (16) evaluates movement by measuring changes in the frequency of echoes reflected from moving structures.
dose (18) amount of antigen administered in a single injection from a multiple-dose vial.
dosimetry (16) measurement and calculation of radiation treatment doses.
double pedicle flap (11) maintains blood supply is from both ends of a flap incision that was made to create a curvilinear flap contiguous with the defect; flap is pivoted and sutured in place over the defect.
downcoding (1) routinely assigning lower-level CPT codes as a convenience instead of reviewing patient record documentation and the coding manual to determine the proper code to be reported.
DRG creep (19) federal Department of Justice (DOJ) initiative that focuses on medical necessity and billing patterns of DRG coding to determine whether claims hospitals submit accurately reflect care required or provided to the patient; DOJ investigates claims for which facilities receive higher reimbursement as a result of reporting higher paying ICD codes.
driver (4) occupant of a motor vehicle, whether operating it or intending to operate it.
dual chamber (13) contains two electrodes; one placed in the right atrium and the other is in the right ventricle.
dual energy x-ray absorptiometry (DEXA) (16) bone density study that uses two x-ray beams with different levels of energy pulsing alternately to create the image.
duplex scan (18) noninvasive test that is performed to evaluate a vessel’s blood flow.
dura mater (10) membrane that forms the outer covering of the central nervous system.
durable medical equipment (DME) (6) includes routine and nonroutine medical supplies (e.g., canes, crutches, IV supplies, hospital beds, ostomy supplies, oxygen, prostheses, walkers, and wheelchairs).
durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) (7) includes items such as artificial limbs, braces, medications, surgical dressings, and wheelchairs.
durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) dealers (7) supply patients with durable medical equipment.
durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule (19) payment methodology mandated by the Omnibus Budget Reconciliation Act of 1987 (OBRA); the fee schedule is released annually and updated on a quarterly basis to implement fee schedule amounts for new codes and to revise any amounts for existing codes that were calculated in error.
E
echo (16) effect of a sound that reflects off a distant surface and returns to its source.
echocardiography (18) diagnostic procedure that uses ultrasound to obtain two-dimensional images of the heart and/or great arteries (aorta and vena cavae).
E code (ICD-9-CM) (2) describes external causes of injury, poisoning, or other adverse reactions affecting a patient’s health; E codes are located in a supplementary classification in the ICD-9-CM Tabular List of Diseases.
electrocardiography (18) see cardiology.
electrocautery snare (14) technique that uses a wire loop to encircle, not grasp, a polyp.
electroconvulsive therapy (ECT) (10) briefly applying an electric current to the brain to produce a seizure; its purpose is to relieve depression, schizophrenia, and severe affective disorders.
electromyogram (EMG) (10) nerve conduction study that plots the electrical activity produced by muscle contractions; results in a graphic tracing of a muscle’s electrical activity at rest or during contraction; used to diagnose nerve and muscle disorders.
electromyography (18) test used to detect nerve function by measuring the electrical activity generated by muscles.
electronic data interchange (EDI) (19) computer-to-computer transfer of data between provider and third-party payer (or provider and health care clearing house) in a data format agreed upon by the sending and receiving parties.
electronic health record (EHR) (1) collection of patient information documented by a number of providers at one or more facilities regarding one patient; multidisciplinary and multievent enterprise approach to record keeping because it has the ability to link patient information created at different locations according to a unique patient identifier; provides access to complete and accurate health problems, status, and treatment data; contains alerts and reminders for health care providers.
electronic medical record (EMR) (1) created on a computer, using a keyboard, a mouse, an optical pen device, a voice recognition system, a scanner, or a touch screen; records are created using vendor software, which also assists in provider decision making regarding patient care and treatment.

electronic transaction standard (19) uniform language for electronic data interchange.

electrophysiology (13) study of heart arrhythmias.

electrosurgery (11) use of an electrical device to destroy abnormal tissue.

embolectomy (13) surgical removal of an embolus.

embolectomy (13) surgical removal of an embolus.

emergency care patient (6) patient treated for urgent problems and either released the same day or admitted to the hospital as an inpatient.

emergency condition (10) results when a delay in treatment of the patient would lead to a significant increase in threat to life or body part.

emergency department services (9) provided in a hospital, and open 24 hours a day for the purpose of providing unscheduled episodic services to patients who require immediate medical attention.

employer self-insurance plan (19) employer accepts direct responsibility for (or the risk of) paying employees' health care without purchasing health insurance.

en bloc (13) as a whole.

encoder (2) software that automates the coding process.

encoding (1) process of standardizing data by assigning numeric values (codes or numbers) to text or other information.

encounter (2) face-to-face contact between a patient and a health care provider who assesses and treats the patient's condition; Medicare uses the term encounter in the guidelines for coding and reporting using ICD-9-CM to indicate all health care settings, including inpatient hospital admissions.

equal (19) employer accepts direct responsibility for (or the risk of) paying employees' health care without purchasing health insurance.

endoscopist (19) document used to record encounter data about office procedures and services provided to patients.

encrypt (19) to encode a computer file, making it safe for electronic transmission so that unauthorized parties cannot read it.

end-stage renal disease (ESRD) composite payment rate system (19) single-payment fixed rate that does not vary according to the characteristics of the beneficiary treated (and includes the cost of some drugs, laboratory tests, and other items and services provided to Medicare beneficiaries receiving dialysis).

endocardium (13) inner lining of the heart.

endocrine system (15) composed of glands including the adrenal, gonads, pancreas, parathyroid, pituitary, thymus, and thyroid.

endorectal pull-through (14) see ileoanal anastomosis.

endoscopic retrograde cholangiopancreatography (ERCP) (14) passing an endoscope through the esophagus, stomach, and duodenum to the ducts of the biliary tree and pancreas.

endoscopy (11) procedure performed to visualize a body cavity, using a medical instrument that consists of a long tube that can be inserted into the body, either through a small incision or a natural opening.

endotracheal tube (ET) (10) artificial airway used for short-term airway management or mechanical ventilation due to potential or actual respiratory system insufficiency.

enterectomy (14) resection of small bowel segments.

enterolysis (14) freeing of intestinal adhesions.

enucleation of the eye (15) severing of the eyeball from extraorbital muscles and optic nerve and its removal.

epidural anesthesia (10) local anesthetic injected into the epidural space, where it acts primarily on spinal nerve roots; anesthetized area includes the abdomen or chest to large regions of the body.

epidurography (16) performed to assess the structure of the spine’s epidural space prior to percutaneous epidural adhesiolysis (to identify nerve construction or inflammation and the degree of fluid flow in the epidural space).

equivalent dose (16) radiation quantity measured by rem.

esophageal varices (14) uneven, enlarged, tortuous veins of the esophagus.

esophagogastroduodenoscopy (EGD) (14) use of a fiberoptic endoscope to visualize the esophagus, stomach, and proximal duodenum.

esophagogastroscopy (14) see upper GI endoscopy.

esophagoscopy (14) visualization of the esophagus, using an endoscope.

essential modifier (2) see subterm.

established patient (9) one who has received professional services within the past three years from the physician or from another physician of the same specialty who belongs to the same group practice.

etiology (2) cause of disease.

evisceration of ocular contents (15) removal of the contents of the eyeball; the sclera remains intact.

evocative (17) causing a specific response; this term is used to describe various tests intended to cause production of hormones or other secretions.

excision (11) removal of a portion or all of an organ or another tissue, using a scalpel or another surgical instrument.

excisional biopsy (11) removal of a lump or suspicious area in its entirety.

exclusion (19) “Medicare PPS Excluded Cancer Hospital” that applies for and is granted a waiver from mandatory participation in the hospital inpatient PPS.

exclusive provider organization (EPO) (19) managed care plan that provides benefits to subscribers if they receive services from network providers.

exenteration of the orbit (15) removal of orbital contents; may also include removal of bone, muscle, and/or the myocutaneous flap.

expanded problem focused examination (9) limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

expanded problem focused history (9) chief complaint, brief history of present illness, and problem pertinent system review.

explanation of benefits (EOB) (19) statement sent by the payer to the patient that contains the same information as a remittance advice but in an easy-to-read format.

extensive cellulitis (11) acute inflammation of skin’s connective tissue, caused by infection with bacteria.

extensor tendons (12) tendons that serve to straighten the fingers.
extent of examination (9) categorized according to problem focused examination, expanded problem focused examination, detailed examination, and comprehensive examination.

extent of history (9) categorized according to problem focused history, expanded problem focused history, detailed history, or comprehensive history.

external catheter (10) catheter that is not implanted under the patient’s skin and does not require a needle to be inserted into the skin to deliver medications.

external ear (15) auricle and external auditory meatus.

external fixation device (12) hardware inserted through bone and skin that is held rigid with cross-braces outside of the body; external fixation is always removed after the fracture has healed.

external radiation (16) radiation administered by a machine outside the body.

extracapsular cataract extraction (ECCE) (15) removal of lens and anterior portion of capsule.

extracorporeal shock wave lithotripsy (ESWL) (10) use of ultrasound shock waves to crush calculi (stones) located in the bladder, renal pelvis, or ureter.

extradural procedure (10) performed on the outer side of the dura mater.

eye and ocular adnexa (15) describes procedures performed on the eyeball, anterior and posterior segment, ocular adnexa, and conjunctiva.

eye socket (15) see orbit.

eyeball (15) see orbit.

F

face-to-face time (9) amount of time the office or outpatient care provider spends with the patient and/or family.

False Claims Act (FCA) (19) law enacted in 1863 in response to widespread abuses by government contractors during the Civil War; amended in 1986 to strengthen the law and increase monetary awards.

family history (9) review of medical events in the patient’s family, including diseases that may be hereditary or that may present a risk to the patient.

federal anti-kickback statute (19) prohibits the offer, payment, receipt, or solicitation of compensation for referring Medicaid/Medicare patients and imposes a $25,000 fine per violation, plus imprisonment for up to ten years.

Federal Claims Collection Act of 1966 (19) law that established uniform procedures for government agencies to follow in the collection, compromise, suspension, termination, or referral for litigation of debts owed to the government.

Federal Employee Health Benefits Program (FEHBP or FEP) (19) voluntary health care program that covers federal employees, retirees, and their dependents and survivors.

fee schedule (19) cost-based fee-for-service reimbursement methodology that includes a list of maximum fees and corresponding procedures/services; payers use fee schedules to compensate providers for health care services delivered to patients.

fee-for-service (19) method of reimbursing providers for individual health care services rendered.

female genital system (15) includes the vulva, perineum, and introitus; vagina; cervix uteri; and uterus, oviduct (fallopian tube), and ovary.

femur (12) long bone of the thigh; articulates with the hip bone, tibia, and patella.

field block (10) subcutaneous injection of local anesthetic in area bordering the field to be anesthetized.

fine-needle aspiration (FNA) (11) procedure in which a thin needle is inserted through a mass several times to remove fluid from a cyst or cells from a solid mass; suction is applied as the needle is withdrawn to obtain strands of single cells for cytologic diagnosis.

first-listed diagnosis (6) diagnosis, condition, problem, or other reason for encounter/visit documented in the patient record to be chiefly responsible for the services provided.

first-order vessels (13) blood vessels that extend as primary arterial branches from the aorta.

flexible spending account (FSA) (19) tax-exempt account offered by employers with any number of employees that individuals use to pay health care bills; participants enroll in a relatively inexpensive high-deductible insurance plan, and a tax-deductible savings account is opened to cover current and future medical expenses.

flexor tendons (12) tendons that serve to bend the fingers.

fluid management (10) administering IV fluids to avoid dehydration, maintain an effective circulating volume, and prevent inadequate tissue perfusion.

fluorescence in situ hybridization (FISH) (17) test performed to detect submicroscopic changes in chromosomes (e.g., genetic disorders such as Williams syndrome) or to identify unknown chromosomal material.

fluoroscopy (16) procedure in which a continuous x-ray beam generates a movielike image that is viewed on a monitor; used for invasive procedures such as intravenous/intra-arterial catheterization and extracorporeal shockwave lithotripsy.

forbidden symbol (8) symbol (§) located to the left of CPT codes that identifies products pending FDA approval but that have not been assigned a CPT code.

flat file (19) fixed-length file format that was developed for use in claims processing (because the ANSI ASC X12 837 variable-length file format is not suitable for use in an application program and must be translated into a flat file format prior to claims processing).

functional modifier (8) pricing modifier that a third-party payer considers when determining reimbursement.
gamma globulin (18) see immune globulin.
gastrectomy (14) removal of all or a portion of the stomach.
general anesthesia (10) administration of anesthetic agents that are inhaled or administered intravenously.
general equivalency mapping (GEM) (2) published crosswalks of codes that facilitate the location of corresponding diagnosis and procedure codes between two code sets, such as ICD-9-CM and ICD-10-CM.
general hospital (5) acute care facility that provides emergency care, general surgery, and inpatient admission services based on licensing by the state.
glabellar frown lines (11) vertical furrows located in the forehead area between the eyebrows.
global period (11) time established (0, 10, or 90 days) for each surgical procedure.
global service (16) combined technical and professional components.
global surgical package (11) ensures that payments are made consistently for the same services across all Medicare administrative contractor jurisdictions and prevents Medicare payments for services that are more or less comprehensive than intended.
globe (15) see eyeball.
government-sponsored programs (19) include CHAMPVA, Federal Employee Health Benefits Program, Indian Health Service, Medicaid, Medicare, Military Health System, Programs of All-Inclusive Care for the Elderly, and TRICARE.
graft (11) procedures that involve moving healthy tissue from one site to another to replace diseased or defective tissue.
Gram stain (17) method of classifying all bacteria as gram-positive or gram-negative.
gray (gy) (16) newer radiation terminology for the amount of radiant energy absorbed in a tissue; one gray equals 100 rads.
gray-scale ultrasound (16) see B-scan.
green reference symbol (8) symbol (2) located below a code description to indicate that the coder should refer to the CPT Assistant monthly newsletter and/or the CPT Changes: An Insider's View annual publication that contains all coding changes for the current year.
gross examination (17) evaluating a specimen visually, with the naked eye.
group model HMO (19) contracted health care services delivered to subscribers by participating physicians who are members of an independent multispecialty group practice.
group practice without walls (GPWW) (19) contract that allows physicians to maintain their own offices and share services such as appointment scheduling and billing.
guidelines (8) define terms and explain the assignment of codes for procedures and services located in a particular section of CPT.

harvesting (12) removing tissue for transplantation.

HCPcs level II (1) coding system managed by the Centers for Medicare & Medicaid Services (CMS) that classifies medical equipment, injectable drugs, transportation services, and other services not classified in the CPT.
HCPcs level II dental codes (7) classify dental procedures and supplies.
HCPcs level II miscellaneous codes (7) include miscellaneous/not otherwise classified codes that are reported when a DME-POS dealer submits a claim for a product or service for which there is no existing HCPcs level II code.
HCPcs level II modifiers (7) two-digit alpha or alphanumeric codes added to any HCPcs level I (CPT) or II (national) code to provide additional information regarding the product or service reported.
HCPcs level II permanent national codes (7) maintained by the HCPcs National Panel, which unanimously makes decisions about additions, revisions, and deletions.
HCPcs level II temporary codes (7) maintained by the CMS and other members of the HCPcs National Panel, independent of permanent level II codes, and allow payers the flexibility to establish codes that are needed before the next January 1 annual update.
HCPcs national codes (1) see HCPcs level II.
health care clearinghouse (1) see clearinghouse.
health care provider (1) see provider.
health care reimbursement account (HCRA) (19) tax-exempt account that is used to pay for health care expenses.
health data collection (1) performed by health care facilities to do administrative planning, to submit statistics to state and federal government agencies (and other organizations), and to report health claims data to third-party payers for reimbursement purposes.
health insurance claim (19) electronic transmission or paper-based document submitted by the provider to an insurance plan to request reimbursement for procedures performed or services provided.
health insurance policy (19) agreement between an individual and a third-party payer (or insurance company) that contains a list of reimbursable medical benefits.
Health Insurance Portability and Accountability Act of 1996 (HIPAA) (1) federal legislation that amended the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, combat waste/fraud/abuse in health insurance and health care delivery, promote the use of medical savings accounts, improve access to long-term care services and coverage, simplify the administration of health insurance by creating unique identifiers for providers/health plans/employers, create standards for electronic health information transactions, and create privacy/security standards for health information.
health insurance specialist (1) employed by third-party payers to review health-related claims to determine whether the costs are reasonable and medically necessary based on the patient’s diagnosis.
health maintenance organization (HMO) (19) alternative to traditional group health insurance coverage that provides comprehensive health care services to voluntarily enrolled members on a prepaid basis.
health plan (1) contract established by an insurance company to reimburse health care facilities and patients for procedures and services provided.
health reimbursement arrangement (HRA) (19) tax-exempt account offered by employers with more than 50 employees, which individuals use to pay health care bills.

health savings account (HSA) (19) see flexible spending account.

health savings security account (HSSA) (19) see flexible spending account.

Healthcare Common Procedure Coding System (HCPCS) (1) includes level I codes (CPT) and level II codes (HCPCS level II national codes).

heart murmur (13) extra heart sound.

hematology (17) study of the function and disorders of blood.

hemodialysis (18) process of removing waste products, toxins, and excess fluids from the blood; patient’s blood is diverted into a dialyzer, where it is treated and returned to the patient’s circulation by another tube inserted into a different blood vessel.

heparin (10) anticoagulant that prevents blood clots from developing in a catheter.

hepatotomy (14) open drainage of abscess or cyst.

hernia (14) protrusion of internal organs through a weakening in the musculature.

HIPAA administrative simplification (AS) (19) developed standards for the maintenance and transmission of health information required to identify individual patients; designed to improve efficiency and effectiveness of the health care system by standardizing the interchange of electronic data for specified administrative and financial transactions.

HIPAA standards for privacy of individually identifiable health information (19) provisions that protect the security and confidentiality of health information.

history (9) interview of the patient that includes the following elements: history of the present illness (including the patient’s chief complaint), a review of systems, and a past/family/social history.

history of present illness (HPI) (9) chronological description of patient’s present condition from time of onset to present.

hold harmless clause (19) statement that the patient is not responsible for paying what the insurance plan denies.

hollow circle symbol (8) symbol (○) located to the left of a Category III code to indicate a reinstated or recycled code.

Home Assessment Validation and Entry (HAVEN) (19) software that allows for entry of data elements from the outcome and assessment information set (OASIS), which is used to determine reimbursement rate for home health agency care based on a case mix methodology.

home health care (6) allows people who are seriously ill or dying to remain at home and receive treatment from nurses, social workers, therapists, and other licensed health care professionals who provide skilled care in the home.

home health prospective payment system (HH PPS) (19) uses home health resource groups (HHRGs) to reimburse Medicare home health care services according to prospectively determined rates.

home infusion care (6) provided by home health care agencies when intravenous administration of medication is medically appropriate for the patient’s condition and treatment is administered in the home instead of on an inpatient hospital basis.

home services (9) provided to individuals and families in their place of residence to promote, maintain, or restore health and/or to minimize the effects of disability and illness, including terminal illness.

horizontal plane (16) see transverse plane.

horizontal triangle symbols (8) symbols (▲ ▼) that surround revised guidelines and notes; these symbols are not used for revised code descriptions.

hospital discharge services (9) include the final examination of the patient; discussion of the hospital stay with the patient and/or caregiver; instructions for continuing care provided to the patient and/or caregiver; and preparation of discharge records, prescriptions, and referral forms.

hospital inpatient services (9) provided to hospital inpatients, including partial hospitalization services, and indicated when the patient’s condition requires services and/or procedures that cannot be performed in any other place of service without putting the patient at risk.

hospitalist (1) physician whose practice emphasizes providing care for hospital inpatients.

hot biopsy forceps (14) technique that uses tweezerlike forceps connected to a monopolar electrocautery unit and a grounding pad to remove lesions or polyps.

hybrid record (1) combined paper-based and computer-generated documents.

hyperthermia (16) use of an external heat-generating source to produce localized heating.

hyperventilation (18) deep or rapid breathing.

hypopharynx (14) organ that extends from the upper edge of the epiglottis to the larynx/esophagus juncture.

hypovolemia (10) abnormally decreased blood volume.

hysteroscopy (15) visualization of the cervical canal and uterine cavity using a hysteroscope.

ICD-9-CM Coordination and Maintenance Committee (2) NCHS and CMS Department of HHS federal agencies that are responsible for overseeing all changes and modifications to ICD-9-CM diagnosis (NCHS) and procedure (CMS) codes.

ICD-10 Coordination and Maintenance Committee (2) NCHS and CMS Department of HHS federal agencies that are responsible for overseeing all changes and modifications to ICD-10-CM (NCHS) and ICD-10-PCS (CMS).

ileal anastomosis (14) common alternative to conventional ileostomy, and it is not considered an ostomy because there is no stoma.

ileostomy (14) removal of the colon and rectum with the small intestine brought to the abdominal wall.

immobilize (12) see stabilize.

immune globulin (lg) (18) sterilized solution obtained from pooled human blood plasma, which contains immunoglobulins (or antibodies) that protect against infectious agents that cause various diseases.

immune serum globulin (18) see immune globulin.

immunoglobulin (17) protein produced by plasma cells that help fight infection; antibody that protects against infectious agents that cause various diseases.

immunology (17) study of the immune system.
implanted port (10) small reservoir that has a rubber plug attached to the catheter and is inserted into the patient’s vein below the collarbone and threaded into the superior vena cava.

incision (11) a cut made with a knife, electrosurgical unit, or laser especially for surgical purposes (e.g., on body tissue).

incision and drainage (I&D) (11) cutting open a lesion and draining its contents.

incisional biopsy (11) removal of a portion of a lesion by slicing into it or incising it.

incomplete abortion (15) miscarriage in which part, but not all, of the uterine contents are expelled.

indemnification (19) insurance against loss.

Index (ICD-10-PCS) (5) organizes ICD-10-PCS main terms in alphabetic order, providing the first 3-4 characters (and sometimes all 7 characters) of a code as well as direction to a specific location in the Tables.

Index to Diseases (ICD-9-CM) (2) alphabetical listing of ICD-9-CM main terms and their codes; sections include Index to Diseases, Table of Drugs and Chemicals, and Index to External Causes of Injury and Poisoning; main terms are boldfaced, and subterms and qualifiers are indented below main terms.

Index to Diseases and Injuries (ICD-10-CM) (2) alphabetical listing of ICD-10-CM main terms and their codes; subdivided into Index to Diseases and Injuries (includes a Neoplasm Table and a Table of Drugs and Chemicals) and Index to External Causes of Injury; main terms are boldfaced, and subterms and qualifiers are indented below main terms.

Index to Procedures and Tabular List of Procedures (2) included in the hospital version of commercial ICD-9-CM coding manuals as a combined alphabetical index and tabular list of inpatient procedures and services.

indexed (1) identified according to a unique identification number.

Indian Health Service (IHS) (19) DHHS agency that provides federal health care services to American Indians and Alaska Natives.

indirect laryngoscopy (12) insertion of a small hand mirror in the patient’s mouth at the back of the throat while the physician wears headgear that contains a mirror and light source; the mirror worn by the physician reflects light into the patient’s mouth, allowing the physician to visualize the patient’s throat.

individual practice association (IPA) HMO (19) contracted services enables to be delivered to subscribers by physicians who remain in their independent office settings.

induced abortion (15) deliberate termination of pregnancy.

infant (9) very young child, up to one year old.

inferred words (8) used to save space in the CPT index when referencing subterms.

infiltration anesthesia (10) topical injection of local anesthetic into tissue.

informational modifiers (8) clarify aspects of the procedure or service provided for the payer.

initial plan (1) documentation of the strategy for managing patient care and actions taken to investigate the patient’s condition and to treat/educate the patient; the initial plan consists of three categories: diagnostic/management plans, therapeutic plans, and patient education plans; considered part of the problem-oriented record (POR).

inner ear (15) includes the cochlea, saccule, acoustic nerve, semicircular canals, utricle, and superior and inferior vestibular nerves.

inpatient (5) patient who remains overnight in a facility for 24 or more hours and who is provided with room and board and nursing services.

inpatient neonatal and pediatric critical care and intensive services (9) provided to critically ill neonates and infants by a physician.

inpatient psychiatric facility prospective payment system (IPF PPS) (19) per diem patient classification system that reflects differences in patient resource use and costs; IPF PPS replaced a reasonable cost-based payment system; promotes long-term cost control and utilization management.

inpatient prospective payment system (IPPS) (19) implemented as part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA); uses diagnosis-related groups (DRGs) to classify inpatient hospital cases into groups that are expected to consume similar hospital resources.

Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) (19) use of information from a patient assessment instrument (PAI) to classify patients into distinct groups based on clinical characteristics and expected resource needs.

insight-oriented psychotherapy (18) treatment of mental illnesses and behavioral disturbances through resolution of unconscious psychological conflicts.

integrated delivery system (IDS) (19) organization of affiliated provider sites that offer joint health care services to subscribers.

integrated provider organization (IPO) (19) manages the delivery of health care services offered by hospitals, physicians who are employees of the IPO, and other health care organizations such as ambulatory surgery clinics and nursing facilities.

integrated record (1) arranged in strict chronological date order (or in reverse date order), which allows for observation of how the patient is progressing according to test results and how the patient responds to treatment based on test results.

intensivist (9) physician who has received extensive training and experience in critical care and who specializes in the care of critically ill patients, usually in an intensive care unit (ICU).

interactive psychotherapy (18) use of physical aids to enable interaction between the clinician and a patient who does not have the communication skills necessary to explain his or her symptoms or to understand the clinician.

interfacility transport (9) transfer of a patient from one health care facility to another; usually involves use of an ambulance or a helicopter.

internal catheter (10) catheter implanted completely under the skin.

internal fixation device (12) pins, screws, and/or plates inserted through or within a fracture area to stabilize and immobilize the injury; often called open reduction with internal fixation, or ORIF.

internal radiation (16) radiation placed inside the body. International Classification of Disease (ICD) (2) published by the World Health Organization and used to classify mortality data from death certificates.
International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) (1) adopted in 1979 to classify diagnoses (Volumes 1 and 2) and procedures (Volume 3); all health care facilities assign ICD-9-CM codes to report diagnoses, and hospitals report ICD-9-CM procedure codes for inpatient procedures and services.

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) (1) will replace ICD-9-CM as diagnosis classification system; implementation date has not yet been established.

International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) (1) developed by the National Center for Health Statistics (NCHS) to replace Volume 3 of ICD-9-CM; when implemented, it will be used to classify inpatient procedures and services.

International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System, (ICD-10-CM/PCS) (1) shortened name the Centers for Medicare and Medicaid Services uses to identify the classification systems.

Internship (1) student placement in a health care facility to provide on-the-job experience prior to graduation.

Internship supervisor (1) person to whom a student reports at an internship site.

Intersex surgery (15) performed as a series of staged procedures to transform the normal adult genitalia of one sex to that of the other sex; also called genital reconstructive surgery or sex reassignment surgery.

Interventional diagnostic imaging (16) see invasive diagnostic imaging.

Interventional therapeutic radiological procedures (10) therapeutic application of radiation, including analysis and interpretation of radiation equipment performance measurements, calibration of equipment associated with production and use of radiation, analysis and interpretation of measurements associated with patient dosages, and radiation safety aspects associated with production and use of radiation.

Intra-arterial cannula (10) see intra-arterial line.

Intra-arterial catheter (10) see intra-arterial line.

Intra-arterial line (10) thin plastic tube, cannula, or catheter that is inserted into an artery and connected to a monitor to measure immediate changes in intra-arterial blood pressure and concentrations of oxygen and carbon dioxide; also used to collect frequent blood samples for lab tests.

Intracapsular cataract extraction (ICCE) (15) removal of lens and surrounding capsule.

Intracranial (10) introduced into or within the skull.

Intradural test (intracutaneous) (18) injection of purified allergen extracts into skin to test for allergy to suspected insect venom or penicillin.

Intraservice time (9) a variable that is predictive of the "work" of E/M services, which includes face-to-face time for office and other outpatient visits or unit/floor time for hospital and other inpatient visits.

Intrathecal (16) fluid-filled space between layers of tissue that cover the brain and spinal cord.

Intravenous push (18) injection administered by a health care professional who is in constant attendance to administer the injection and observe the patient.

Intravenous regional anesthesia (10) insertion of IV cannula into the extremity on which the procedure is to be performed and a tourniquet applied to interrupt blood circulation; then a large volume of local anesthetic injected into a peripheral vein, anesthetizing the extremity.

Introduction (11) procedures that inject, insert, puncture, or scope.

Invasive diagnostic imaging (16) administration of contrast material orally, rectally, or parenterally.

IPPS 3-day payment window (19) requires outpatient preadmission services provided by a hospital up to three days prior to a patient's inpatient admission to be covered by the IPPS DRG payment for diagnostic services or therapeutic services for which the inpatient principal diagnosis code (ICD-9-CM) exactly matches that for preadmission services.

IPPS 72-hour rule (19) see IPPS 3-day payment window.

IPPS transfer rule (19) states that any patient with a diagnosis from one of ten CMS-determined diagnosis-related groups who is discharged to a post acute provider is treated as a transfer case.

IRF PPS 1-day payment window (19) requires that outpatient preadmission services provided by an IRF up to one day prior to a patient's inpatient admission be covered by the IRF PPS payment.

IRF PPS 24-hour rule (19) see IRF PPS 1-day payment window.

IRF PPS transfer rule (19) states that any patient who is discharged to an inpatient rehabilitation facility is treated as a transfer case.

Iris (15) colored tissue that surrounds the pupil of the eye.

J

Jamming (1) routinely assigning an unspecified ICD-9-CM or ICD-10-CM disease code instead of reviewing the coding manual to select the appropriate code number.

J-Pouch (14) see ileoanal anastomosis.

Jukebox (1) equipment that stores large numbers of optical disks, resulting in huge storage capabilities.

K

Key components (9) history, examination, and medical decision making; required when selecting an E/M level of service code.

Kidney (14) filters and cleans blood, producing urine that carries waste.

Knee (12) "hinge" joint composed of bones, cartilage, ligaments, and tendons.

Kock pouch (14) see continent ileostomy.

L

Lacrimal apparatus (15) contains structures that produce, store, and remove tears.

Lacrimal puncta (15) small openings in the inner canthus of the eyelids that channel tears.

Laminectomy (15) excision of the entire posterior arch or lamina of a vertebra.

Laminotomy (15) removal of part of the lamina from one side of the vertebra.

Laparoscopy (14) examination of the peritonealcontents using a laparoscope that is inserted through the abdominal wall.

Laryngoscopy (12) visualization of the back of the throat, including the larynx and vocal cords.

Larynx (12) voice box.

Laser (light amplification by stimulated emission of radiation) (11) device filled with a gas, liquid, or solid substance that is
stimulated to emit light to a specific wavelength for the purpose of burning, cutting, or dissolving tissue.

**laser technique** (14) technique that is most suitable for treatment of rectal lesions and uses a waveguide to deliver the laser beam through the endoscope to the lesion.

**laser-assisted uvulopalatoplasty** (14) procedure that uses a laser technique to remove tissue from the uvula, soft palate, and pharynx.

**late effect** (4) residual (long-term condition produced, called the sequelae) that develops after the acute phase of an illness or injury has ended.

**lateral extracavitary approach** (LECA) (15) making a midline incision in the area of the affected vertebral segment, is inferiorly curved out to the lateral plane.

**lateral projection** (16) positioning patient at a right angle to the film, so the x-ray beam travels through the side of the body.

**LEEP electrodissection conization** (15) superficial dissection of the cervix.

**LeFort I** (12) procedure that brings the midface forward (from the level of the upper teeth) to just above the nostrils.

**LeFort II** (12) surgical fracture of the midfacial skeleton at an apex near the superior aspect of the nasal bones.

**LeFort III** (12) procedure that brings the entire midface forward, from the upper teeth to just above the cheekbones.

**lens** (15) clear, flexible, curved structure that focuses images on the retina of the eye.

**lesion** (10) abnormal tissue resulting from autoimmune or metabolic disorders, infection, neoplasm, or trauma.

**lexicon** (4) glossary of terms.

**ligament** (12) tissue that connects bone to bone.

**List of Codes (ICD-10-PCS)** (5) comprehensive listing of all valid ICD-10-PCS codes, with a complete text description accompanying each code.

**List of Three-Digit Categories** (2) located in ICD-9-CM Appendix E; contains a list of three-digit category diseases codes organized beneath section headings.

**listserv** (1) see online discussion board.

**lithotripter** (10) device that administers a high-voltage electrical discharge through a spark gap under water, which produces a compressive force and breaks apart the stones so they can pass in urine.

**lobectomy** (12) removal of a single lobe of the lung.

**local anesthesia** (10) applying a topical agent on the body’s surface or injecting a local anesthetic agent for the purpose of numbing a small part of the body; appropriate for minor surgeries.

**local coverage determinations (LCDs)** (7) define coverage criteria, payment rules, and documentation required as applied to DMEPOS claims processed by DME MACs for frequently ordered DMEPOS equipment, services, and supplies; formerly called local medical review policies (LMRPs).

**long-term acute care (LTAC) hospital** (5) health care facility designed specifically for patients who need functional restoration and/or rehabilitation and medical management for an average of three to six weeks; LTAC hospitals have an average inpatient length of stay of more than 25 days and provide extended medical and rehabilitative care for patients who are clinically complex and may suffer from multiple acute or chronic conditions.

**long-term (acute) care hospital prospective payment system (LTC PPS)** (19) uses information from long-term care hospital patient records to classify patients into distinct long-term (acute) care diagnosis-related groups based on clinical characteristics and expected resource needs.

**long-term hospital** (5) see long-term acute care (LTAC) hospital.

**LOOP electrodissection conization** (15) deep dissection of the cervix.

**low birth weight** (9) less than 1500 grams.

**LTC PPS 1-day payment window** (19) requires that outpatient preadmission services provided by a long-term acute care hospital up to one day prior to a patient’s inpatient admission be covered by the LTC PPS diagnosis-related group payment.

**LTC PPS 24-hour rule** (19) see LTC PPS 1-day payment window.

**lumbar puncture (LP)** (10) inserting a cannula at the L3-4 or L4-5 (lumbar vertebrae) to remove cerebrospinal fluid for diagnostic or therapeutic purposes.

**lumen** (10) opening.

**lumpectomy** (11) partial mastectomy.

**luxation** (12) see dislocation.

**lymph** (13) clear fluid that contains chyle, some red blood cells, and lymphocytes, which help fight infection and disease.

**lymph nodes** (13) clusters of bean-shaped nodules that act as the body’s filtration system, removing cell waste and excess fluid and helping to fight infection.

**lymphatic system** (13) consists of the spleen, thymus, tonsils, adenoids, vessels that carry lymph, and lymph nodes.

**M**

**magnetic resonance angiography (MRA)** (16) noninvasive diagnostic study that is used to evaluate disorders of arterial and venous structures.

**magnetic resonance imaging (MRI)** (16) noninvasive x-ray procedure that uses an external magnetic field to produce a two-dimensional view of an internal organ or structure such as the brain or spinal cord.

**main term** (2) printed in boldfaced type and followed by the ICD-9-CM code number.

**major diagnostic category (MDC)** (19) refers to mutually exclusive categories that are loosely based on body systems (e.g., nervous system); diagnosis-related groups (DRGs) are organized into MDCs.

**male genital system** (15) includes the prostate, seminal vesicles, penis, testicles (testes), epididymis, tunica vaginalis, vas deferens, scrotum, spermatic cord, seminal vesicles, and prostate.

**malignant** (2) cancerous.

**malignant hypertension** (4) accelerated, severe hypertensive disorder with progressive cardiovascular damage and a poor prognosis; characterized by rapidly rising blood pressure greater than 140 diastolic.

**malunion** (4) failure of the ends of a fractured bone to heal (unite).

**mammography** (16) radiological examination of the soft tissue and internal structures of the breast.

**managed care** (19) combines financing and delivery of health care services; replaces conventional fee-for-service health insurance plans with more affordable care for consumers and providers who agree to certain restrictions.
management service organization (MSO) (19) physician- or hospital-owned organization that provides practice management, administrative, and support services to individual physicians.

manifestation (3) condition that occurs as the result of another condition; a manifestation code is always reported as a secondary code.

manipulation (12) realignment of bones.

diagnostic test that measures muscle function using a pressure-sensitive tube.

manual record (1) paper-based record that includes handwritten progress notes and physician orders, graphic charts, and so on.

mass spectrometry (10) monitors proper levels of the anesthetic.

maximizing reimbursement (5) reimbursement that is not permitted because it involves selecting and reporting as principal diagnosis the ICD-9-CM code that results in the highest level of reimbursement for the facility whether that diagnosis meets the criteria for selection or not; it also includes assigning a higher-paying ICD-9-CM code to a diagnosis (or ICD-9-CM or CPT/HCPCS code to a procedure) even if patient record documentation does not support that code selection.

Maze procedure (13) stops atrial fibrillation or atrial flutter by using incisions in heart tissue to stop abnormal heart rhythm.

M code (2) see Morphology of Neoplasms.

Meckel's diverticulum (14) common congenital abnormality of the gastrointestinal tract that results in a pouch in the wall of the small bowel that contains remnants of fetal gastrointestinal tissue.

mediastinum (14) space in the thoracic cavity between the lungs that contains the aorta, the esophagus, the heart, and other structures.

Medicaid (19) joint federal and state program that provides health care coverage to elderly and disabled individuals.

medical assistant (1) health care professional employed by a provider to perform administrative and clinical tasks.

medical decision making (MDM) (9) refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by the number of diagnoses or management options, the amount and/or complexity of data to be reviewed, and the risk of complications and/or morbidity or mortality.

medical foundation (19) nonprofit organization that contracts with and acquires the clinical and business assets of physician practices; the foundation is assigned a provider number and manages the practice's business.

medical management software (1) combination practice management and medical billing software that automates the daily workflow and procedures of a physician's office or clinic.

medical necessity (1) determination that a service or procedure rendered is reasonable and necessary for the diagnosis or treatment of an illness or injury.

medical nomenclature (1) vocabulary of clinical and medical terms (e.g., arthritis, gastritis, and pneumonia) used by health care providers to document patient care.

medical record (1) see patient record.

Medicare (19) provides health care coverage to elderly and disabled persons; federal spending is funded by the Medicare Trust Fund (payroll tax).

Medicare administrative contractor (MAC) (19) processes claims for physicians, health care facilities, and suppliers of durable medical equipment, prosthetics, orthotics, and supplies.

Medicare Carriers Manual (MCM) (7) provides direction about services and procedures to be reimbursed by the Medicare administrative contractor.

Medicare National Coverage Determinations Manual (7) indicates whether a service is covered or excluded under the Medicare program.

Medicare physician fee schedule (MPFS) (19) common name for resource-based relative value scale system, which is used to reimburse physician services covered by Medicare Part B.

Medicare Prescription Drug, Improvement, and Modernization Act (MMA) (2) federal legislation that requires all code sets to be valid at the time services are provided.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (19) eliminated carriers, fiscal intermediaries, and durable medical equipment regional carriers and created Medicare administrative contractors.

Medicare Pricing, Data Analysis, and Coding (PDAC) contractor (7) Assists suppliers and manufacturers in determining HCPCS codes to be used; previously called the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC).

Medicare severity diagnosis-related groups (MS-DRGs) (19) classifies inpatient hospital cases into groups according to similar resource utilization, which results in hospitals receiving a predetermined payment according to MS-DRG for treating Medicare patients; like the original DRGs, MS-DRGs are based on diagnoses, procedures, other demographic information, and the presence of complications or comorbidities (CCs); however, hospital inpatients are distinguished according to those with no CCs, CCs, or major CCs (MCCs), which allows Medicare to distinguish “sick patients” from “very sick patients” and reimburse hospitals accordingly; the number of MS-DRGs expands to 745 (as compared to 538 original DRGs).

Medicare severity long-term (acute) care diagnosis-related groups (MS-LTC-DRGs) (19) based on clinical characteristics and expected resource needs; replaced the reasonable cost-based LCT PPS authorized by TEFRA that had mandated the implementation of DRGs (and originally exempted long-term acute care hospitals from participation).

medicare severity long-term (acute) care diagnosis-related group (MSLTC DRG) (5) prospective payment system that classifies patients based on clinical characteristics and expected resource needs.

megaelectron volt (16) see MeV.

megavolt (16) see MeV.

metastatic cancer (4) see secondary malignancy.

MeV (16) 1 million electron volts.

microbiology (17) study of microbes.

microdermabrasion (11) skin-freshening technique used to repair facial skin that is damaged by the sun and the effects of aging.

microtechnique (17) one of three types of micromanipulation techniques that may be used for the preparation of an embryo for transfer.

middle ear (15) includes the tympanic membrane, auditory ossicles, muscles, and conduction pathways.

mid sagittal plane (16) vertically divides the body through the midline into two equal left and right halves.
Military Health System (MHS) (19) provides and maintains readiness to provide health care services and support to members of the Uniformed Services during military operations; also provides health care services and support to members of the Uniformed Services, their family members, and others entitled to Department of Defense health care.

**minimally invasive procedure (18)** includes percutaneous access.

**missed abortion (15)** miscarriage in which a dead fetus and other products of conception remain in the uterus for four or more weeks.

**M-mode (16)** one-dimensional display that reflects the movement of structures.

**moderate (conscious) sedation (11)** moderate sedation or analgesia that results in a drug-induced depression of consciousness.

**modified Maze procedure (13)** see cardiac ablation.

**modified radical mastectomy (11)** total mastectomy that includes removal of the breast and nipple, axillary lymph nodes, and pectoralis minor muscle.

**modifier (3)** additional term included after the colon in the ICD-9-CM tabular lists that is to be included in the statement to classify a condition or procedure.

**modifying unit (10)** part of anesthesia formula that recognizes added complexities associated with the administration of anesthesia, including physical factors and difficult circumstances.

**Molts microsurgery (11)** technique of excising skin tumors by removing tumor tissue layer by layer, examining the removed portion microscopically for malignant cells, and repeating the procedure until the entire tumor is removed.

**monitored anesthesia care (MAC) (10)** administration of varying amounts of local, regional, and certain mind-altering drugs by an anesthesiologist or a CRNA during a patient’s diagnostic or therapeutic procedure.

**morbidity (2)** disease

**morphology (2)** indicates the tissue type of a neoplasm.

**Morphology of Neoplasms (2)** located in ICD-9-CM Appendix A; contains a reference to the World Health Organization publication *International Classification of Diseases for Oncology* (ICD-O); also called M codes.

**mortality (2)** death.

**motion mode (16)** see M-mode.

**motor vehicle (4)** any mechanically or electrically powered device not operated on rails upon which any person or property may be transported or drawn upon a highway.

**motor vehicle accident (4)** transport accident involving a motor vehicle.

**motor vehicle traffic accident (4)** any motor vehicle accident occurring on a public highway (i.e., originating, terminating, or involving a vehicle partially on the highway).

**motor vehicle nontraffic accident (4)** any motor vehicle accident that occurs entirely in any place other than a public highway.

**motorcycle (4)** two-wheeled motor vehicle having one or two riding saddles and sometimes having a third wheel for the support of a sidecar.

**motorcyclist (4)** driver of a motorcycle.

**muco-cutaneous margin (14)** consists of mucous membrane and skin.

**multiaxial approach (ICD-10-PCS (5)** a value from each of seven hierarchies (positions) is assigned to construct an ICD-10-PCS code.

**multihospital system (5)** two or more hospitals owned, managed, or leased by a single organization; these may include acute, long-term, pediatric, rehabilitation, or psychiatric care facilities.

**multiple codes (4)** more than one ICD-9-CM code that is assigned to completely classify the elements of a complex diagnosis (or procedure) statement.

**multiple sleep latency (18)** observation of a patient during at least a six-hour period of sleep and includes assessment of sleep latency (dormancy) and/or wakefulness after the sleep period.

**mutually exclusive edits (8)** code pairs that, for clinical reasons, are unlikely to be performed on the same patient on the same day.

**myocardium (13)** muscle layer of the heart.

**myringotomy (15)** surgical incision of the tympanic membrane; usually performed to release pressure or fluid.

**narcosynthesis (18)** form of psychotherapy that is provided when the patient is under the influence of a drug, such as a sedative or narcotic.

**nasal vestibule (12)** entrance to the nose.

**nasopharynx (14)** located above the soft palate.

**National Correct Coding Initiative (NCCI) (8)** implemented by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies and to control the improper assignment of codes that results in inappropriate reimbursement of Medicare Part B claims.

**national coverage determinations (NCDs) (7)** define coverage criteria, payment rules, and documentation required as applied to DMEPOS claims processed by DME MACs for frequently ordered DMEPOS equipment, services, and supplies.

**national health plan identifier (PlanID) (19)** assigned to third-party payers, contains 10 numeric positions including a check digit in the tenth position (e.g., 1234567890); formerly called the PAYERID.

**national individual identifier (patient identifier) (19)** HIPAA provision for a national individual identifier (or patient identifier) has been withdrawn.

**national limitation amount (NLA) (19)** serves as a payment ceiling, or cap, on the amount Medicare could pay for each test.

**national provider identifier (NPI) (19)** assigned to hospitals, doctors, nursing homes, and other health care providers contains 10 numeric digits (e.g., 1234567890).

**national standard employer identifier number (EIN) (19)** IRS’s federal tax identification number (EIN) adopted as the national employer identifier, retaining the hyphen after the first two numbers (e.g., 12-3456789); the EIN is assigned to employers who, as sponsors of health insurance for their employers, must be identified in health care transactions.

**nature of the presenting problem (9)** disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for the encounter, with or without a diagnosis being established at the time of the encounter.

**necropsy (17)** autopsy.
Physician or health care facility under patient who receives services for a noninvasive x-ray procedure that creates an image by measuring radiation emission, or radiation “uptake,” of body areas after the administration of a radionuclide.

- **nontunneled catheter** (10) see external catheter.
- **nonunion** (4) see malunion.
- **Notes** (8) appear throughout CPT sections to clarify the assignment of codes.

**Notice of Exclusions from Medicare Benefits (NEMB)** (8) form completed and signed by a Medicare beneficiary before items, procedures, and services excluded from Medicare benefits are provided.

- **nuclear imaging** (16) noninvasive x-ray procedure that creates an image by measuring radiation emission, or radiation “uptake,” of body areas after the administration of a radionuclide.
- **nuclear medicine** (16) use of radioactive elements for diagnostic imaging and radiopharmaceutical therapy.
- **Number symbol** (8) symbol (#) located to the left of CPT codes to indicate out-of-numerical sequence codes.

**Objective** (0) (1) observations about the patient, such as physical findings or lab or x-ray results; considered part of the problem-oriented record (POR) SOAP note.

- **Oblique projection** (16) positioning the patient with the body slanted sideways toward the film, halfway between a parallel and right-angle position; the x-ray beam travels through this angle of the body.
- **Observation patient** (6) patient who receives services furnished on a hospital’s premises that are ordered by a physician (or another authorized individual), including use of a bed and periodic monitoring by nursing or other staff, and that are reasonable and necessary to evaluate the outpatient’s condition or determine the need for possible admission as an inpatient.
- **Observation services** (9) provided in a hospital outpatient setting; the patient is considered an outpatient.
- **Obturator** (12) object used to close a gap.
- **Ocular adnexa** (15) includes the orbit, eye muscles, eyelids, eyelashes, conjunctiva, and lacrimal apparatus.
- **Ocular implant** (15) inserted inside the muscular cone.
- **Office** or **other outpatient services** (9) provided in a physician’s office, a hospital outpatient department, or another ambulatory care facility.

**Official ICD-9-CM Guidelines for Coding and Reporting** (2) rules developed to accompany and complement official conventions and instructions provided in ICD-9-CM.

**Official ICD-10-CM Guidelines for Coding and Reporting** (2) rules developed to accompany and complement official conventions and instructions provided in ICD-10-CM.

**Official ICD-10-PCS Guidelines for Coding and Reporting** (2) rules developed to accompany and complement official conventions and instructions provided in ICD-10-PCS.

- **Off-road motor vehicle** (4) motor vehicle of special design that enables it to negotiate rough terrain, soft terrain, or snow.
- **Omentectomy** (15) surgical removal of the omentum.

**Omnibus Budget Reconciliation Act of 1980** (19) federal legislation mandating that an ambulatory surgery center could participate in Medicare if certain conditions were met and stated that the ambulatory surgical centers payments are “expected to be calculated on a prospective basis . . . utilizing sample survey and similar techniques to establish reasonable estimated overhead allowances for each of the listed procedures which take account of volume (within reasonable limits).”

- **Neuromuscular junction.**
- **Neuroplasty** (15) freeing or decompression of an intact nerve from scar tissue.
- **Neuropathy** (15) repair of nerves.
- **Neurostimulator** (15) electrode and pulse generator that are implanted along the spine to alleviate pain or control spasms.
- **New patient** (9) one who has not received any professional services within the past three years from the physician or from another physician of the same specialty who belongs to the same group practice.
- **Newborn care** (9) includes services provided to newborns in a variety of health care settings.
- **Newborn patient** (5) patient who receives infant care upon birth and, if necessary, receives neonatal intensive care (either within a hospital or as the result of transfer to another hospital).
- **Nissen fundoplasty** (14) mobilizing the lower end of the esophagus by suturing the fundus of the stomach around the circumference of the lower esophagus at the esophagogastric junction.
- **Noncovered benefits** (19) procedures and services that are not covered by the third-party payer.
- **Nonessential modifier** (2) qualifying word contained in parentheses after the main term in the ICD-9-CM Index to Diseases that do not have to be included in the diagnostic or procedural statement for the code number listed after the parenthesses to be assigned.
- **Noninterventional diagnostic imaging** (16) see noninvasive diagnostic imaging.
- **Noninvasive diagnostic imaging** (16) includes standard radiographs (x-rays) (single or multiple views), contrast studies, computed tomography, and magnetic resonance imaging.
- **Noninvasive procedure** (18) requires no surgical incision or excision; not an open procedure.
- **Nonparticipating provider** (nonPAR) (19) health care provider (e.g., physician) who is not a member of a health care plan; nonPAR providers do not receive reimbursement directly from a payer; the reimbursement is sent to the patient, and the nonPAR provider must collect payment for services rendered from the patient.
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Omnibus Budget Reconciliation Act of 1987 (OBRA) (19) federal legislation that mandated the payment methodology for durable medical equipment, prosthetics, orthotics, and supplies fee schedule.

Omnibus Budget Reconciliation Act of 1989 (19) federal legislation that implemented the resource-based relative value scale (RBRVS) system, which is used to reimburse physician services covered by Medicare Part B.

Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCESAA) of 1999 (19) federal legislation that implemented the home health prospective payment system for Medicare home health services.

one lung ventilation (OLV) (10) isolation of the right or left lung so that one lung is ventilated and the other is allowed to collapse.

online discussion board (1) Internet-based or e-mail discussion forum that covers a variety of topics and issues.

ooocyte (15) immature female reproductive cell, or egg.

oophorectomy (15) surgical removal of an ovary or ovaries.

open biopsy (11) incisional or excisional removal of a lesion.

open fracture (4) type of fracture that has an associated open wound.

open fracture treatment (12) surgically opening fracture site or exposing it so treatment can be provided.

open laparoscopy (14) insufflation of the abdomen using a trocar, which is placed under direct vision (using a laparoscope) after making a small celiotomy incision.

open procedure (4) making an incision through the skin, underlying tissues, and possibly muscle to access the affected body area that requires surgery.

open transulminal angioplasty (13) making an incision in the skin overlying the artery and carrying it down to free the artery from surrounding structures.

open transulminal atherectomy (13) making an incision in the skin overlying the artery, and puncturing the artery with a large needle.

open-panel HMO (19) health care provided by individuals who are not employees of the HMO or who do not belong to a specially formed medical group that serves the HMO.

operating microscope (15) used during a surgical procedure to perform microsurgery techniques.

opportunistic infection (4) one that takes advantage of the body's weakened defenses, such as in an HIV-positive patient.

optical disk imaging (1) alternative to traditional microfilm or remote storage systems because patient records are converted to an electronic image and saved on storage media.

optimizing reimbursement (5) determining which of several diagnoses to report as the principal diagnosis when multiple diagnoses equally meet the criteria for selection as the principal diagnosis.

orbicularis oculi (18) blink test that is monitored with sensors.

orbit (15) bony cavity in the skull that contains and protects the eyeball and its associated blood vessels, muscles, and nerves.

orbital implant (15) inserting an implant outside the muscular cone into the eye socket, and placing an intraocular lens (IOL).

organ harvest (10) surgical removal of an organ for transplantation.

oropharynx (14) area between the soft palate and the upper portion of the epiglottis, including the tonsils.

orthotics (7) branch of medicine that deals with the design and fitting of orthopedic (relating to bone disorders) devices.

oscilloscope (18) device that displays electrical waveforms on a monitor.

osteogenesis (12) bone growth.

osteopathic manipulative treatment (OMT) (18) manual treatment performed by a physician during which emphasis is placed on normal body mechanics and manipulative methods to detect and correct structure.

osteophytectomy (15) removal of bone spurs to relieve compression of the spinal cord or nerve roots.

ostomy (12) surgical incision into bone.

ostomy (14) surgically creating an opening in the body for the discharge of body wastes.

other (additional) diagnosis (5) any condition that coexists at the time of admission, that develops subsequently, or that affects the treatment received and/or the length of stay.

other road vehicle (4) any device (except a motor vehicle and pedestrian conveyance) in, on, or by which any person or property may be transported on a highway.

other significant procedure (5) carries an operative or anesthetic risk, requires highly trained personnel, or requires special facilities or equipment; also called secondary procedures.

Outcome and Assessment Information Set (OASIS) (6) core set of comprehensive assessment for adult home care patients.

outlier (19) inpatient case that is unusually costly.

outpatient (6) see ambulatory patient.

outpatient care (6) any health care service provided to a patient who is not admitted to a facility.

outpatient encounter (19) all outpatient procedures and services (e.g., same-day surgery, x-rays, laboratory tests, and so on) provided during one day to the same patient; also called outpatient visit.

outpatient prospective payment system (OPPS) (19) uses ambulatory payment classifications (APCs) to reimburse hospital outpatient services.

outpatient visit (19) see outpatient encounter.

overcoding (1) reporting codes for signs and symptoms associated, in addition to an established diagnosis code.

overlapping sites (4) see contiguous sites.

overpayment recovery (19) collecting excess payments made by Medicare, Medicaid, and other payers.

overpayment (19) reimbursement a provider or beneficiary receives in excess of amount due.

Pacemaker (13) device that regulates the patient's heartbeat to prevent arrhythmias; includes a pulse generator and electrodes.

pacing cardioverter-defibrillator (PCD) (13) similar to a pacemaker in that it includes a pulse generator and electrodes, but it uses a combination of antitachycardia pacing and low-energy cardioversion or defibrillating shocks to regulate the patient's heartbeat and prevent arrhythmias.

palatopharyngoplasty (14) surgical resection of excess tissue from the uvula, soft palate, and pharynx to open the airway.

panniculectomy (10) surgical removal of excess abdominal panniculus.
panniculus adiposus (10) layer of subcutaneous adipose tissue, or fat, below the dermis that contains fat deposits, blood vessels, and nerves.

pannus (10) see panniculus adiposus.

parenterally (16) other than by mouth or rectum, such as implantation, infusion, or injection.

paring and curettement (11) removal of growths or other material from the wall of a cavity or another surface.

partial hospitalization (9) short-term, intensive treatment program in which individuals who are experiencing an acute episode of an illness can receive medically supervised treatment during a significant number of daytime or nighttime hours.

partial mastectomy (11) involves making an incision through skin and fascia over the breast tumor and clamping lymphatic and blood vessels; the physician then excises the tumor mass along with a section of breast tissue.

participating provider (PAR) (19) health care provider (e.g., physician) who is a member of a health care plan; PAR providers receive reimbursement directly from the payer.

passenger (4) authorized occupant of a motor vehicle.

past medical history (9) summary of past illnesses, operations, injuries, treatments, and known allergies.

patch test (epicutaneous) (18) applying an allergen to a patch, which is placed on skin; the test is performed to identify substances that cause contact dermatitis, such as latex, medications, fragrances, preservatives, hair dyes, metals, and resins.

patency (13) open and unblocked status of a blood vessel or another tube in the body.

patient education plan (1) program to educate the patient about conditions for which the patient is being treated; considered part of the problem-oriented record (POR).

patient record (1) business record for an inpatient or outpatient encounter that documents health care services provided to a patient; stores patient demographic data and documentation that supports diagnoses and justifies treatment; and contains results of treatment provided.

Payment Error and Prevention Program (PEPP) (19) identifies and reduces improper Medicare payments, resulting in a reduction in the Medicare payment error rate.

pedal cycle (4) any road transport vehicle operated solely by pedals that includes bicycles, pedal cycles, and tricycles.

pedal cyclist (4) any person riding on a pedal cycle or in a sidecar attached to such a vehicle.

pedestrian (4) any person involved in an accident who was not at the time of the accident riding in or on a motor vehicle, railroad train, streetcar, animal-drawn or other vehicle, or on a bicycle or animal.

pedestrian conveyance (4) any human-powered device by which a pedestrian may move other than by walking or by which a walking person may move another pedestrian.

pediatric critical care patient transport (9) includes the physical attendance and direct face-to-face care provided by a physician during the interface facility transport of a critically ill or critically injured patient aged 24 months or younger.

pedicle skin graft (11) transferring a portion of skin graft to the recipient area, and attaching a remaining portion (the base) to the donor site so there is a vasculature and nerve supply for the recipient area.

percutaneous lithotomy (14) two-stage procedure that requires a percutaneous nephrostomy and dilation of the nephrostomy tract.

percutaneous myocardial revascularization (PMR) (13) insertion of a catheter with a laser inside through an artery into the left ventricle of the heart.

percutaneous needle biopsy (12) insertion of a long needle through the skin and into other tissue (e.g., chest wall, lung, or mediastinum) to obtain tissue for diagnostic evaluation.

percutaneous skeletal fixation (12) use of an external or internal fixation device to stabilize and immobilize a fracture; types include external fixation and internal fixation.

percutaneous transluminal angioplasty (PTA) (13) puncturing an artery and inserting a sheath, guidewire, and guiding catheter (after removing the guidewire).

percutaneous transluminal atherectomy (13) puncturing an artery with a large needle, inserting a guidewire and introducer sheath into the artery, and inserting an atherectomy device for the purpose of removing plaque from inside a blood vessel.

percutaneous transmyocardial laser revascularization (PTMR) (13) see percutaneous myocardial revascularization (PMR).

percutaneous vertebroplasty (12) injection of bone cement (that hardens in about 10 minutes) under pressure directly into a fractured vertebra; cement causes fragments of fractured vertebra to congeal, providing stability.

pericardial sac (13) see pericardium.

pericardiectomy (13) removal of part of the pericardium (to treat chronic pericarditis).

pericardiocentesis (13) removal of a needle to withdraw fluid from the pericardial sac.

pericardiotomy (13) requires thoracotomy as incision for pericardial drainage, fluid collection, or foreign body removal.

pericardium (13) membrane that surrounds the heart; also called pericardial sac.

perinatal period (4) interval of time occurring before, during, and up to 28 days following birth.

peripheral nerve blocks (10) injection of local anesthetic in the vicinity of a peripheral nerve to anesthetize that nerve’s area of innervation.

peripherally (13) access via a peripheral vein.

peristalsis (14) wavelike motions that propel urine.

peritoneal dialysis (18) insertion of soft catheter into abdominal cavity and infusion of dialysate fluid at intermittent times.

peritoneoscopy (14) see laparoscopy.

personal care and support services (6) assistance in performing daily living activities such as bathing, dressing, grooming, going to the toilet, and fixing meals; instruction in how to travel and how to access recreational services is also provided.

pharmacologic management (18) evaluation of a patient’s medications for effect, proper dosage, and renewal of prescribed medications.

phlebotomy (17) see venipuncture.

photoc simulation (18) reaction to light.

photon (16) invisible electromagnetic energy wave.

physiatrist (18) physician who specializes in physical medicine and rehabilitation and treats acute/chronic pain and musculoskeletal disorders.

physical examination (9) assessment of the patient’s organ and body systems.
physical medicine and rehabilitation (18) branch of medicine that focuses on the prevention, diagnosis, and treatment of disorders of the musculoskeletal, cardiovascular, and pulmonary systems that may produce temporary or permanent impairment.

physical status modifier (10) added to each reported anesthesia code to indicate the patient’s condition at the time anesthesia was administered.

physician case management (9) process in which a physician is responsible for direct care of a patient and for the coordination and control of access to or initiation and/or supervision of other health care services needed by the patient.

physician query process (1) contacting the responsible physician to request clarification about documentation and codes to be assigned; the process is activated when the coder notices a problem with documentation quality.

physician self-referral law (19) prohibits a physician from referring Medicare patients to clinical laboratory services where they or a member of their family have a financial interest; enacted as part of the Omnibus Budget Reconciliation Act of 1989.

physician standby services (9) physician spending a prolonged period of time without patient contact waiting for an event to occur that will require the physician’s services.

physician-hospital organization (PHO) (19) owned by hospital(s) and physician groups that obtain managed care plan contracts; physicians maintain their own practices and provide health care services to plan members.

Physicians at Teaching Hospitals (PATH) initiative (19) federal program that resulted from the discovery that some health care organizations were billing Medicare Part B for services that were already paid under Part A.

plantarial cyst (11) entrapped epithelial tissue and hair located in the sacral area at the top of the crease between the buttocks, which can become infected.

place of service (POS) (9) the physical location where health care is provided to patients.

Plan (P) (1) diagnostic, therapeutic, and education plans to resolve the problems; considered part of the problem-oriented record (POR) SOAP note.

plane of view (16) terminology used when performing a radiology procedure.

pleura (12) membrane that envelopes the lungs and lines the walls of the pleural cavity.

pleural effusion (12) fluid in the pleural cavity preventing the lung from fully expanding, making it difficult for the patient to breathe.

plexus anesthesia (10) injection of local anesthetic in the vicinity of a nerve plexus.

plus symbol (8) symbol (+) located to the left of CPT codes that identifies add-on codes (also located in Appendix D of CPT) for procedures that are commonly, but not always, performed at the same time and by the same surgeon as the primary procedure.

pneumocentesis (12) puncture of the pleural space with a transthoracic needle to drain fluid or to obtain material for diagnostic study.

point-of-service plan (POS) (19) offers patients the freedom to use an HMO panel of providers or to self-refer to non-HMO providers.

polysomnography (18) sleep study that includes sleep staging with additional parameters of sleep.

port (16) skin site where radiation beams enter the body.

positron emission tomography (PET) (16) producing x-ray images of the body after administering radioisotopes, which tracks metabolism or blood flow, not anatomy.

postanesthesia evaluation (10) evaluation of the patient during recovery from anesthesia, as well as evaluation, treatment, and follow-up of possible anesthesia-related complications.

posteroanterior (PA) projection (16) positioning the patient facing the film and parallel to it; the x-ray beam travels from back to front, or posterior to anterior.

postoperative pain management (10) administration of epidural or subarachnoid medications on the date(s) of service after the date of surgery.

postpartum care (15) begins after vaginal or cesarean section delivery and includes the recovery room visit; any uncomplicated inpatient hospital and outpatient postpartum visits; episiotomy; and repair of cervical, vaginal, or perineal lacerations.

preadmission testing (PAT) (6) occurs after a surgical patient registers with a facility’s admitting department, when the patient undergoes preoperative nursing assessment and receives preanesthesia evaluation by an anesthesiologist.

preanesthesia evaluation (10) assessing information from the patient’s record, interviewing the patient, conducting a physical examination, evaluating preoperative test results, and ensuring that informed anesthetic consent has been obtained.

preauthorization (19) prior approval.

preexisting medical condition (19) illness or injury that required treatment during a prescribed period of time prior to the insured’s effective date of coverage under a new insurance policy.

preferred provider organization (PPO) (19) network of physicians and hospitals that join together to contract with insurance companies, employers, or other organizations.

preoperative clearance (9) occurs when a surgeon requests that a specialist or another physician examine a patient and indicate whether the patient can withstand the expected risks of a specific surgery.

present on admission (POA) indicator (19) assigned to each diagnosis and external cause of injury code that is coded and reported on inpatient UB-04 or 837 Institutional (electronic) claims.

pressure ulcer (11) ulceration of the skin and underlying tissue that occurs over a bony prominence.

presumptive identification (17) identification by colony morphology, growth on selective media, or Gram stains.

preventive medicine services (9) include routine examinations or risk management counseling for children and adults who exhibit no overt signs or symptoms of a disorder while presenting to the medical office for a preventive medical physical.

pricing modifier (8) see functional modifier.

primary care (6) acute care and preventive services provided as outpatient care and referred to as the point of first contact.

primary care provider (6) manages and coordinates the patient’s care, including referring the patient to a medical specialist for consultation and a second opinion; physician responsible for supervising and coordinating health care services and preauthorizing referrals to specialists and for overseeing inpatient hospital admissions, except in emergencies.
primary malignancy (4) original tumor site.

principal diagnosis (5) condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

principal procedure (5) performed for definitive treatment rather than for diagnostic or exploratory purposes; necessary to treat a complication, or is most closely related to the principal diagnosis.

privacy (19) patient’s right to prohibit disclosure of information without his or her authorization.

privacy rule (19) see HIPAA standards for privacy of individually identifiable health information.

privileged communication (19) any information communicated by a patient to a health care provider.

problem focused examination (9) limited examination of the affected body area or organ system.

problem focused history (9) consists of chief complaint and brief history of present illness or problem.

problem list (1) serves as a table of contents for the patient record because it is filed at the beginning of the record and contains a numbered list of the patient’s problems, which helps to index documentation throughout the record; considered part of the problem-oriented record (POR).

problem-oriented record (POR) (1) systematic method of documentation that consists of four components: database, problem list, initial plan, and progress notes.

proctectomy (14) surgical removal of the rectum.

proctosigmoidoscopy (14) visual examination of the rectum and sigmoid colon.

professional component (16) services provided by the physician, which include supervising the performance of a diagnostic imaging procedure, interpreting imaging films, and documenting the imaging report.

professional services (9) face-to-face services provided by a physician or nonphysician practitioner (e.g., nurse practitioner, physician assistant) and reported by assigning an E/M code.

Programs of All-inclusive Care for the Elderly (PACE) (19) community-based Medicare and Medicaid programs that provide integrated health care and long-term care services to elderly persons who require a nursing-facility level of care.

progress note (1) narrative note documented by the provider to demonstrate continuity of care and the patient’s response to treatment; when using the SOAP format, a narrative is documented for each problem assigned to the patient according to subjective (S), objective (O), assessment (A), and plan (P).

prohibitory symbol (8) see forbidden symbol.

prolonged services (9) physicians’ services involving patient contact that are considered beyond the usual service in either an inpatient or an outpatient setting.

prospective cost-based rate (19) based on reported health care costs from which a prospective per diem rate is determined; annual rate is usually adjusted using actual costs from the prior year; may be based on the facility’s case mix (patient acuity of types and categories of patients).

prospective payment system (19) reimbursement methodology that establishes predetermined rates based on patient category or type of facility, with annual increases based on an inflation index and a geographic wage index.

prospective price-based rate (19) associated with a particular category of patient; rate is established by the payer prior to the provision of health care services.

prosthetics (7) branch of medicine that deals with the design, production, and use of artificial body parts.

protected health information (PHI) (19) information that is identifiable to an individual, such as name, address, telephone numbers, date of birth, and Medicaid ID number.

provider (1) physician or other health care professional who performs procedures or provides services to patients.

psychodynamic psychotherapy (18) see insight-oriented psychotherapy.

psychosocial therapy (18) see psychotherapy.

psychotherapy (18) treatment of mental and emotional disorders by having patients talk about their condition(s) and related issues with a mental health physician or therapist.

public highway (4) entire width between property lines (or other boundary lines) of every way or place of which any part is open to the use of the public for purposes of vehicular traffic as a matter of right or custom.

pull-through (14) see ileoanal anastomosis.

pulmonary wedge pressure (10) indirect measurement of left atrial pressure that is useful in the diagnosis of left ventricular failure and mitral valve disease.

pulse oximetry (10) arterial oxyhemoglobin saturation.

pump oxygenator (10) device that substitutes for the heart (pump) and lungs (oxygenator) during open heart surgery.

puncture, prick, or scratch test (percutaneous) (18) procedure in which tiny drops of purified allergen extracts are pricked or scratched into the skin’s surface; performed to identify allergies to pollen, mold, pet dander, dust mites, foods, insect venom, and penicillin.

pupil (15) black opening in the center of the iris that permits light to enter the eye.

pyramidal fracture (12) see LeFort II.

Q

qualified diagnoses (6) diagnoses documented as probable, suspected, questionable, rule out, or working diagnosis.

qualifying circumstances (10) coded when anesthesia services are provided during situations or circumstances that make anesthesia administration more difficult.

qualitative assay (17) detects whether a particular substance is present.

quantitative A-scan (16) diagnostic ultrasound that produces quantitative data about the posterior eye segment and evaluates tissue consistency, mobility, and vascularity.

quantitative assay (17) detects the amount of a substance in a specimen.

R

radiation absorbed dose (rad) (16) amount of radiant energy absorbed in a tissue.

radiation oncology (16) specialty of medicine that utilizes high-energy ionizing radiation in the treatment of malignant neoplasms and certain nonmalignant conditions.
radical mastectomy (11) total mastectomy, which includes removal of the breast and nipple, pectoralis muscles (major and/or minor), axillary lymph nodes, and internal mammary lymph nodes.

radiographic projection (16) describes the path that the x-ray beam travels through the body, from entrance to exit.

radiologic guidance (16) performed during a procedure to visualize access to an anatomic site fluoroscopic guidance to guide the placement, replacement, or removal of a catheter, central venous access device (CVAD), or needle.

radiologist (16) physician who has undergone specialized training to interpret diagnostic x-rays, perform specialized x-ray procedures, and administer radiation for the treatment of disease.

radiology (16) branch of medicine that uses imaging techniques to diagnose and treat disease.

radionuclide (16) radioactive material, such as an isotope of iodine.

radiopaque (10) cannot be penetrated by electromagnetic radiation.

radiopharmaceutical therapy (16) destroys diseased tissue, such as a malignant neoplasm.

railroad (4) see railway.

railway (4) right-of-way designed for traffic on rails that is used by carriages or wagons transporting passengers or freight and by other rolling stock and that is not open to other public vehicular traffic.

railway accident (4) transport accident involving a railway train or another railway vehicle operated on rails, whether in motion or not.

railway train (4) any device with or without cars coupled to it that is designed for traffic on a railway.

railway vehicle (4) see railway train.

range of codes (8) code numbers separated by a dash or a series of codes separated by commas in the CPT index.

reagent strip automated urine analyzer (17) instrumentation used to determine various components in the urine.

real-time scan (16) two-dimensional display of structures and movement that indicates the movement, shape, and size of the tissue or organ.

recipient heart with or without lung allotransplantation (13) removal (harvesting) of heart with or without lung tissue; includes transplantation of the allograft and care of the recipient.

recipient lung allotransplantation (12) transplantation of a single or double lung allograft and care of the recipient.

reconstruction (11) surgical rebuilding of a body part, such as the breast or the knee joint.

reconstruction of the vena cava (13) surgical procedure performed to correct a congenital defect or to repair the vena cava when the patient sustains trauma or the vena cava is damaged due to long-term drug therapy.

red reference symbol (8) symbol (⊙) located below a code description to indicate that the coder should refer to the Clinical Examples in Radiology quarterly newsletter.

reduction (12) see manipulation.

referral (12) recommendation to transfer a patient’s care from one provider to another.

referred outpatient (6) patient who receives diagnostic or therapeutic care because such care is unavailable in the primary care provider’s office.

regional anesthesia (10) anesthesia agents injected into or near the spinal fluid and around a nerve or network of nerves to block the nerve supply to a specific part of the body.

rehabilitation hospital (5) health care facility that admits patients who are diagnosed with trauma or disease and who need to learn how to function.

relative value unit (RVU) (19) payment component that consists of physician work, practice expense, and malpractice expense.

remittance advice (remit) (19) statement sent by the payer to the provider that details how submitted claims were processed and contains reimbursement amounts.

removal (11) procedures performed to eliminate tissue (e.g., amputations) or take something out (e.g., removal of implants, such as buried wire, pins, or screws).

renal dialysis (18) artificial removal of toxic waste products from the body when the patient’s kidneys are unable to perform this function due to disease or deterioration.

repair (11) procedure performed to surgically improve improperly functioning parts of the body.

replantation (12) surgical reattachment of a finger, a hand, a toe, a foot, a leg, or an arm that has been completely severed from a person’s body.

resequenced code (8) - CPT codes that appear out of numerical order and are preceded by the # symbol (so as to provide direction to the out-of-sequence code).

Resident Assessment Validation and Entry (RAVEN) (19) data entry system that allows a skilled nursing facility (SNF) to capture and transmit the minimum data set (MDS).

resident physician (1) individual who participates in an approved graduate medical education (GME) program.

residual condition (4) long-term condition produced after the acute phase of an illness or injury has terminated, which is called the sequela.

resource utilization group (RUG) (19) prospective payment system implemented by the federal government to control costs in nursing facilities.

retina (15) part of eye that contains nerve tissue.

roadway (4) that part of the public highway designed, improved, and ordinarily used for vehicular travel.

roentgen (16) international unit of exposure dose for x-rays or gamma rays.

roentgen-equivalent-man (rem) (16) unit of measurement that includes different biological responses to different kinds of radiation.

roster billing (19) simplified claims submission process available to public health clinics and other noninstitutional entities that offer mass immunization programs.
rotation flap (11) incision made to create a curvilinear flap contiguous with the defect; flap is dissected, freed, and pivoted and sutured in place over the defect.

rule of nines (11) divides total body surface area (BSA) into nine segments by percentage.

S

saddle block anesthesia (10) see caudal anesthesia.
safe harbor regulation (19) specifies various payment and business practices that, although potentially capable of inducing referrals of business reimbursable under the federal health care programs, would not be treated as criminal offenses under the anti-kickback statute.
sagittal plane (16) vertically divides the body into unequal left and right portions.
salpingo-oophorectomy (15) surgical removal of both fallopian tubes and ovaries.
saphenopopliteal vein anastomosis (13) surgical incision to expose the saphenous vein and connect it to the popliteal vein using end-to-end anastomosis.
scanner (1) equipment that captures paper record images onto the storage media.
sclera (15) white of the eye that comprises the eye’s outer layer; contains fibrous tissue that maintains the eye’s shape and protects the eye’s inner layers.
screening mammography (16) radiographic (x-ray) of the breast that is performed when a patient presents without signs and symptoms of breast disease.
second-order vessel (13) branches from first-order vessel.
second stage (14) in treatment of anal fistulas, use of a seton to cut through the fistula; the seton is left in place until later removal.
secondary malignancy (4) tumor that has metastasized, or spread, to a secondary site either adjacent to the primary site or to a remote region of the body.
secondary procedure (5) see other significant procedure.
section (17) thin slice of tissue prepared from a block that is examined.
section (2) group of ICD-9-CM three-digit disease categories within a chapter.
sectionalized record (1) see source-oriented record.
security (19) ensures that facilities, equipment, and patient information are safe from damage, loss, tampering, theft, or unauthorized access.
security rule (19) HIPAA regulation that requires covered entities to adopt standards and safeguards to protect health information that is collected, maintained, used, or transmitted electronically.
sedation (10) administration of medication into a vein to relieve pain and anxiety, making the patient feel calm.
segmentectomy (12) removal of one segment of a lobe.
selective vascular catheterization (13) insertion and manipulation or guidance of a catheter into the branches of the arterial system (other than the aorta or the vessel punctured) for the purpose of performing diagnostic or therapeutic procedures.
self-referral (19) an enrollee seeing a non-HMO panel specialist without a referral from the primary care physician.
semicolon (8) symbol (:) used to save space in CPT code descriptions.

separate procedure (11) performed as an integral component of a total service or procedure.
septal defect (13) occurs when the tissue doesn’t completely close between the heart’s chambers.
septic abortion (15) abortion-related pelvic and uterine infection.
septum (13) tissue that separates the heart’s left and right sides.
seton (14) large silk suture or rubber bands.
severity of illness (19) physiologic complexity that comprises the extent and interactions of a patient’s disease(s) as presented to medical personnel.
shaving (11) horizontal slicing to remove epidermal and dermal lesions; removal includes scissoring or any sharp method.
shock therapy (10) see electroconvulsive therapy.
short-latency somatosensory evoked potential study (18) electrical stimulation of nerves to evaluate their responsiveness to the body’s superficial surface and internal structures.
short-term hospital (5) hospital that presents as inpatient care for a period of 4–5 days and a total LOS of fewer than 25 days.
side view (16) see lateral projection.
sigmoidoscopy (14) visual examination of the entire rectum and sigmoid colon and may include a portion of the descending colon.
simple closure (11) see simple repair.
simple fracture (4) see closed fracture.
simple repair (11) involves the use of staples, sutures, and/or tissue adhesives to repair superficial wounds involving epidermis, dermis, and/or subcutaneous tissues; also called one-layer closure, nonlayered closure, and single-layer closure.
single chamber (13) contains a single electrode that is positioned in the heart’s right atrium or right ventricle.
single code (8) single code number listed in the CPT index.
single hospital (5) hospital that is self-contained and not part of a larger organization.
single photon emission computerized tomography (SPECT) (16) three-dimensional x-ray images of internal organs produced after administration of a radioactive material, which visualizes anatomy and function.
skeletal traction (12) exerts a pulling force on the affected limb to realign bone or joint.
skilled care (6) services ordered by a physician and provided under the supervision of a registered nurse or a physical, occupational, or speech therapist.
skilled nursing facility prospective payment system (SNF PPS) (19) classifies residents into resource utilization groups.
sleep laboratory (18) area in a hospital facility that is managed by a sleep technologist who explains and performs the sleep studies.
sleep staging (18) during a sleep study (polysomnography), involves the use of a 1-4 lead electroencephalogram (EEG), electro-oculogram (EOG), and submental electromyogram (EMG).
sleep study (18) evaluation of adult and pediatric patients during sleep by monitoring brain waves, heart rate, and eye movements; performed to diagnose sleep disorders, which include breathing, movement, and neurologic disorders that occur at night.
slitlamp exam (16) high-intensity light source that can be focused to shine as a slit to visualize anterior structures, including the eyelid, sclera, conjunctiva, iris, natural crystalline lens, and cornea.
small boat (4) any watercraft propelled by paddle, oars, or small motor, with a passenger capacity of fewer than 10.
social history (9) age-appropriate review of past and current activities such as daily routine, dietary habits, exercise routine, marital status, occupation, sleeping patterns, smoking, use of alcohol and other drugs, and sexual activities.
somatic nerves (15) control voluntary movements and conscious sensation; include voluntary motor and sensory nerves.
source-oriented record (SOR) (1) report organized according to documentation source, each of which is located in a labeled section of the record.
special evaluation and management services (9) provided for establishment of baseline information prior to life or disability insurance certificates being issued and for examination of a patient with a work-related or medical disability problem.
special report (8) document that must accompany the claim to describe the nature, extent, and need for the procedure or service when an unlisted procedure or service code is reported.
specialty coder (1) individual who has obtained advanced training in medical specialties (e.g., anesthesia, obstetrics) and who is skilled in that medical specialty’s compliance and reimbursement areas. In addition to maintaining core credential(s), completes rigorous, in-depth exam, and earns additional continuing education units biannually. Specialty coders typically analyze provider documentation for accuracy, completeness, and timeliness; maintain and update chargemasters and/or encounter forms; meet with coding staff to educate them about revised rules and regulations; review patient charges to accuracy in reported codes and modifiers and enter billing edits; and write letters of appeals to address third-party payer reimbursement denials.
specialty hospital (5) health care facility that delivers care to a particular population of patients or type of disease.
specimen (17) tissue submitted for laboratory or pathologic evaluation; also the unit of service used to report surgical pathology codes.
spinal anesthesia (10) local anesthetic injected into cerebrospinal fluid at the lumbar spine, where it acts on spinal nerve roots and part of the spinal cord; anesthetized area extends from the legs to the abdomen or chest.
spinal tap (10) see lumbar puncture.
spleen (13) organ that produces mature lymphocytes, destroys worn-out red blood cells, and serves as a reservoir for blood.
splenopancreatic anatomy (13) radiographic visualization of the splenic and portal veins.
split-thickness skin graft (11) graft of entire epidermis and a portion of the dermis; typically used to repair edematous, infected, or large wounds (e.g., result of burns).
stab phlebectomy (13) multiple tiny incisions made over varicose vein sites; at each stab site the varicosity is extracted and then the varicose segment is removed.
stabilize (12) to secure bone in a fixed position.
staff model HMO (19) health care services provided to subscribers by physicians employed by an HMO.
Stark I (19) see physician self-referral law.
Stark II (19) expanded the Stark I physician self-referral law by including referrals of Medicare and Medicaid patients for designated health care services.
State Children’s Health Insurance Program (SCHIP) (19) federal health program established to provide health assistance to uninsured, low-income children either through separate programs or through expanded eligibility under state Medicaid programs.
status indicator (SI) (19) payment indicator that identifies how each code is paid (or not paid) under the Outpatient Prospective Payment System (OPPS).
stem cells (13) cells contained in bone marrow.
stented valve (13) includes framework on which the replacement heart valve is mounted to provide support for the valve’s leaflets.
stentless valve (13) an actual heart valve obtained from either a human donor (homograft) or a pig; it does not contain framework.
stereotactic localization (11) use of specialized three-dimensional imaging to target a nonpalpable lesion.
stereotaxis (15) use of a stereotactic guidance system to allow the physician to determine three-dimensional coordinates in order to create a lesion on the spinal cord (to alleviate chronic pain in a particular part of the body); to stimulate the spinal cord percutaneously (to create a lesion that will block pain); or to facilitate the biopsy, aspiration, or excision of a spinal cord lesion.
stoma (14) surgically created opening between ureter, small intestine, or large intestine, through to abdominal wall.
strabismus (15) improperly aligned eyes.
streetcar (4) device that is designed and used primarily for transporting people within a municipality, that runs on rails, that is usually subject to normal traffic control signals, and that operates principally on a right-of-way that forms part of the traffic way.
subacute care patient (5) receives specialized services such as chemotherapy, injury rehabilitation, ventilator support, wound care, and other types of health care services provided to seriously ill patients.
subcategory code (2) four-digit ICD-9-CM disease code or three-digit ICD-9-CM procedure code within a category; each subcategory code contains a decimal followed by one number.
subclassification code (2) five-digit ICD-9-CM disease code or four-digit ICD-9-CM code within a subcategory; each subclassification code contains a decimal followed by two numbers.
subcutaneous fistulectomy (14) removal of an anal fistula, without division of the sphincter muscle.
subglottic stenosis (12) narrowing of the airway below the vocal cords, adjacent to the cricoid cartilage.
Subjective (5) (1) patient’s statement about how he or she feels, including symptomatic information; considered part of the problem-oriented record (POR) SOAP note.
subluxation (12) partial displacement of a bone from its joint.
submuscular fistulectomy (14) removal of an anal fistula, including division of the sphincter muscle.
subterm (2) qualifying word listed below the main term in the ICD-9-CM Index to Diseases; list alternate sites, etiology, or clinical status.
superbill (19) see encounter form.
supervision and interpretation (16) term for the radiological portion of a procedure when two different physicians perform the surgical and radiological components of a procedure.
supportive psychotherapy (18) treatment that uses supportive interactions and various activities to facilitate maintenance, restoration, and improvement of a patient’s self-esteem.
surface anesthesia (10) topical application of local anesthetic cream, solution, or spray to skin or mucous membranes.
surgical curettement (11) scraping tissue to remove abnormal tissue.
surgical endoscopy (14) performed when anything in addition to visualization is done, such as the removal of a foreign body.
surgical package (11) services performed that are integral to the standard of medical/surgical services, such as the cleansing, shaving, and prepping of skin and the insertion of intravenous access for medication.
suture (11) surgical closure of a wound, using catgut, glue, silk thread, wire, or other materials.
Swan-Ganz catheter (10) thin, flexible, flow-directed multilumen plastic tube (or catheter) that is advanced from a peripheral vein into the right atrium and then positioned in a branch of the pulmonary artery.
swing bed (5) allows a rural hospital to admit a nonacute care patient.
sympathectomy (13) excision of a segment of the sympathetic nerve.
sympathetic nerve (15) part of the involuntary autonomic nervous system; originates in the thoracic and lumbar regions of the spinal cord; inhibits the physiological effects of the parasympathetic nervous system.
system review (9) inventory by systems to document subjective symptoms stated by the patient; also provides an opportunity to gather information that the patient may have forgotten to mention or that may have seemed unimportant.
systemic radiation therapy (16) unsealed radioactive materials that travel throughout the body.

T
Tables (ICD-10-PCS) (5) used to construct a complete and valid ICD-10-PCS code; contain terms (and definitions) and rows that contain values (characters) needed to construct a valid code.
Tabular List of Diseases (2) ICD-9-CM tabular list of diseases arranges codes and descriptions in numerical order and contains 17 chapters, 2 supplemental classifications, and 4 appendices; ICD-10-CM tabular list of diseases is chronological list of codes, divided into 21 chapters based on body system or condition.
talk therapy (18) see psychotherapy.
Tax Equity and Fiscal Responsibility Act of 1983 (TEFRA) (19) federal legislation that resulted in implementation of the inpatient prospective payment system, which uses diagnosis-related groups to reimburse short-term hospitals a predetermined rate for Medicare inpatient services.
teaching hospital (1) hospital engaged in an approved graduate medical education (GME) residency program in medicine, osteopathy, dentistry, or podiatry.
teaching physician (1) physician (other than another resident physician) who supervises residents during patient care.
tear apparatus (15) see lacrimal apparatus.
technical component (16) use of equipment and supplies as well as the employment of radiologic technologists to perform diagnostic imaging examinations and administer radiation therapy treatments.
tenosynovitis (15) swollen tendon sheaths.
Tensilon test (18) involves injecting the drug Tensilon (or its generic form edrophonium chloride) into a vein to block the action of the enzyme that breaks down the neurotransmitter acetylcholinesterase.
tetralogy of Fallot (13) congenital heart condition that includes ventral septal defect, stenosis of the infundibulum, hypertrophy of the right ventricle, and an abnormally positioned aorta.
thetapeutic apheresis (13) removal of blood components, cells, or plasma solute and retransfusion of the remaining components into the patient.
thetapeutic plan (1) specific medications, goals, procedures, therapies, and treatments used to treat the patient; considered part of the problem oriented record (POR).
thetapeutic port film (16) x-rays taken during delivery of radiation treatment that utilize the treatment beam of the machine.
thetapeutic surgical procedure (11) performed to treat specific conditions or injuries; includes the procedure itself and normal, uncomplicated follow-up care.
third-order (and beyond) vessels (13) blood vessels that branch from second-order vessels.
third-party administrator (TPA) (1) entity that processes health care claims and performs related business functions for a health plan; the TPA might contract with a health care clearinghouse to standardize data for claims processing.
third-party payer (1) see health plan.
thoracentesis (12) surgical puncture of the chest wall with a needle to obtain fluid from the pleural cavity.
thoracoscopy (12) visual examination of the pleural cavity; provides an alternative to open lung or thoracotomy procedures to treat pleural disorders surgically.
thrombectomy (13) surgical removal of a thrombus.
thromboendarterectomy (13) surgical excision of a thrombus and atherosclerotic inner lining from an obstructed artery.
thymus (13) produces T lymphocytes, which are important to the body’s immune function.
tibia (12) larger of the two lower leg bones.
tibial plateau (12) lower portion of the femur, which articulates with the tibia.
tissue (11) group of similar cells that work together to perform a specific function.
tissue rearrangement (11) defined by anatomic site and size of defect; includes excision of the defect or lesion.
tissue-cultured autograft (11) graft material supplied by laboratories; such grafting is often performed as part of a staged procedure.
tonsils (13) located at the back of the throat; contain lymphoid tissue that helps fight infections.
total mastectomy (11) surgical removal of the entire breast, including the pectoral fascia and a sampling of axillary lymph nodes.
total pneumonectomy (12) removal of the entire lung.
tracea (12) windpipe.
tracheobronchoscopy (12) visual examination of the interior of the trachea and bronchus.
trachoma (15) chronic inflammation of the conjunctiva in which granulations form.
trafficway (4) see public highway.
transient note (1) documentation when a patient is transferred to another facility; summarizes the reason for admission, current diagnoses and medical information, and reason for transfer.

transitional pass-through payments (7) temporary additional payments (over and above the OPPS payment) made for certain innovative medical devices, drugs, and biologicals provided to Medicare beneficiaries.

transluminal angioplasty (13) surgical repair of a blood vessel through its lumen (opening).

transluminal atherectomy (13) excision of plaque from inside a blood vessel.

transmyocardial revascularization (13) procedure that uses a high-powered laser to create small channels in the heart muscle to increase blood supply to the myocardium.

transpedicular approach (15) performed through and inside the pedicle (segment between transverse process and vertebral body) of a thoracic vertebra to access a thoracic disk.

transport accident (4) any accident involving a device designed primarily for, or being used at the time primarily for, conveying people or goods from one place to another.

transposition of great vessels (13) congenital reversal of the aorta and pulmonary artery.

transurethral resection of the prostate (TURP) (14) resection of the prostate gland via transurethral approach using an electrosurgical device.

transurethral resectoscopic lithotripsy (14) procedure in which a cystoscope is inserted through the urethra into the bladder and a resectoscope is passed into the ureters.

transverse plane (16) horizontally divides the body into superior and inferior portions.

treatment volume determination (16) region within the body to which radiation therapy is directed.

triage (6) organized method of identifying and treating patients according to urgency of care required.

triangle symbol (8) symbol (▲) located to the left of CPT codes that identifies revised code descriptions.

TRICARE (19) military health plan that covers active duty and retired members of the uniformed services and their dependents.

triple option plan (19) health plan that is offered as a single insurance plan or as a joint venture among two or more third-party payers.

truncus arteriosus (13) congenital malformation in which just one artery arises from the heart to form the aorta and pulmonary artery.

trust the index (3) concept that inclusion terms listed in the Tabular List of Diseases are not meant to be exhaustive and that additional terms found only in the Index to Diseases (but not in the Tabular List of Diseases) may also be assigned to a code.

tube pericardiostomy (13) insertion of a tube for drainage or specimen collection.

tunneled (13) implanted.

tunneled catheter (10) see internal catheter.

turbinates (12) bony plates covered by spongy mucosa with curved margins; there are three turbinates on each side of the nasal vestibule: inferior, middle, and superior.

tympanoplasty (15) repair or reconstruction of the eardrum.

tympanostomy (15) see myringotomy.

type 1 diabetes mellitus (4) a condition in which patient’s body is unable to produce insulin.

type 2 diabetes mellitus (4) a condition in which patient’s body is unable to properly use insulin produced.

type of service (TOS) (9) refers to the kind of health care services provided to patients, including critical care, consultation, initial hospital care, subsequent hospital care, and confirmatory consultation.

UB-04 (1) standard claim submitted by health care institutions to payers for inpatient and outpatient services.

ultrasonography (16) see ultrasound.

ultrasound (16) high-frequency sound waves that bounce off internal organs and create echoes; the echo pattern is displayed on the ultrasound machine monitor.

unbundling (1) reporting multiple codes to increase reimbursement when a single combination code should be reported.

uncertain behavior (4) subsequent morphology or behavior that cannot be predicted based on the submitted specimen; the tissue appears to be in transition, and the pathologist cannot establish a definitive diagnosis.

Uniform Ambulatory Care Data Set (UACDS) (6) established by the federal government as a standard data set for ambulatory care facility records.

Uniform Hospital Discharge Data Set (UHDDS) (5) established by the federal government to define data collected for inpatient hospitalizations.

unit/floor time (9) amount of time the provider spends at the patient’s bedside and at management of the patient’s care on the unit or floor.

unlisted procedure (8) code assigned when the provider performs a procedure or service for which there is no CPT code.

unlisted service (8) see unlisted procedure.

unspecified hypertension (4) ICD-9-CM subcategory assigned when the provider does not document benign or malignant type hypertension, likely because the provider has the mistaken impression that a “benign” condition is limited or minor in nature.

unspecified nature (4) neoplasm is identified, but the results of pathology examination are not available; thus, there is no indication as to histology or nature of the tumor.

upcoding (1) reporting codes that are not supported by documentation in the patient record for the purpose of increasing reimbursement.

upper GI endoscopy (14) direct visualization of the esophagus and the stomach.

uptake (16) absorption by a tissue of a substance, material, or mineral and its permanent or temporary retention.

ureterolithotomy (14) surgical removal of stones from the ureter.

ureter (14) tube that conveys urine from each kidney to the urinary bladder; there are two ureters.

urethra (14) muscular tube that discharges urine from the urinary bladder to the outside of the body.

urethrocytostomy (10) visualization of urethra and urinary bladder.

urethroplasty (14) surgical repair of the urethra.

urinary bladder (14) hollow organ that serves as a reservoir for urine until it passes from the body (via urination).

urinary system (14) consists of the kidneys, ureters, urinary bladder, and urethra.
uroflowmetry (14) measures the amount of urine that flows from the urinary bladder per second.

eye (15) eye’s vascular layer, which includes the choroid, ciliary body, and iris.

vaginal birth after cesarean (VBAC) (15) planned vaginal birth after previous cesarean section.

value (ICD-10-PCS) (5) characters (individual letters and numbers) assigned to each of seven unique hierarchies (positions), which construct a valid ICD-10-PCS code.

valvular atresia (13) valve failure to develop properly; completely closed at birth.

valvular heart disease (13) abnormality or dysfunction of one or more of the heart’s four valves (aortic, mitral, pulmonary, and tricuspid).

valvular prolapse (13) condition in which two valvular flaps do not close properly, resulting in backflow of blood.

valvular regurgitation (13) backflow of blood because one or more cardiac valves closes improperly.

valvular stenosis (13) narrowing of one or more cardiac valves.

valvuloplasty (heart) (13) open-heart surgery during which the surgeon removes the damaged valve and replaces it with a prosthetic, homograft or allograft, stented, or stentless valve.

valvulotomy (13) open heart surgery in which an incision is made into a valve to repair valvular damage.

varicocele (15) abnormal dilation of the veins of the spermatic cord in the scrotum.

vas deferens (15) tube that carries spermatozoa from the testis.

vascular family (13) group of vessels that is accessed by the same first-order vessel and is supplied by the same primary branch from the aorta.

V code (ICD-9-CM) (2) reported for patient encounters when a circumstance other than disease or injury is documented; V codes are located in a supplementary classification in the ICD-9-CM Tabular List of Diseases.

venipuncture (17) puncture of a vein with a needle for the purpose of drawing blood; most common method of collecting blood specimens.

venography (16) x-ray of a vein after injection of contrast material.

venous valve transposition (13) surgical procedure performed to treat chronic deep venous insufficiency.

ventricular assist device (VAD) (13) provides temporary support for the heart by substituting for left or right heart function.

very low birth weight (9) 1500–2500 grams.

view (16) patient’s position in relation to the camera during radiographic procedures.

visceral arteries (13) supply blood to the intestines, liver, and spleen.

visual evoked potential (VEP) test (18) stimulation of the eye using the checkerboard or flash technique to monitor the patient’s response.

volvulus (14) twisting or displacement of the intestines, causing obstruction.

V-Y-plasty (11) procedure whereby, after surgical creation of a V-shaped incision, the edges of the incision are drawn together and sutured, converting the incision to a Y shape.

wage index (19) adjusts payments to account for geographic variations in hospitals’ labor costs.

watercraft (4) any device for transporting passengers or goods on the water.

wedge resection (12) surgical removal of a portion of lung that is less than a segment.

wedge (16) treatment beam-modifying device that acts to change the beam intensity profile.

Whipple procedure (14) surgical removal of the pancreas, duodenum, bile duct, and stomach with reconstruction.

workers’ compensation (19) state-mandated insurance program that reimburses health care costs and lost wages if an employee suffers a work-related disease or injury.

W-plasty (11) surgical trimming of both edges of a wound or defect into the shape of a W or multiple Ws.

xenograft (11) surgical transplantation of tissue from a different species.

x-ray (16) radiographic visualization or imaging of internal body structures using low-dose high-energy radiation.

x-ray beam (16) consists of invisible electromagnetic energy waves that are emitted from a radiation machine and used to produce images and treat disease.

Z code (ICD-10-CM) (2) reported for patient encounters when a circumstance other than disease or injury is documented; Z codes are located in Chapter 21 of the ICD-10-CM Tabular List of Diseases.

Z-plasty (11) making a surgical incision along with two additional incisions, one above and another below, creating a Z formation.