II. Coding Review

Patricia Schnering, RHIA, CCS
Leslie Moore, RHIT, CCS
Lisa Delhomme, MHA, RHIA
ICD-10-CM PREFACE
2014

This 2014 update of the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM) is being published by the United States Government in recognition of its responsibility to promulgate this classification throughout the United States for morbidity coding. The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), published by the World Health Organization (WHO), is the foundation of ICD-10-CM. ICD-10 continues to be the classification used in cause-of-death coding in the United States. The ICD-10-CM is comparable with the ICD-10. The WHO Collaborating Center for the Family of International Classifications in North America, housed at the Centers for Disease Control and Prevention’s National Center for Health Statistics (NCHS), has responsibility for the implementation of ICD and other WHO-FIC classifications and serves as a liaison with the WHO, fulfilling international obligations for comparable classifications and the national health data needs of the United States. The historical background of ICD and ICD-10 can be found in the Introduction to the International Classification of Diseases and Related Health Problems (ICD-10), 2008, World Health Organization, Geneva, Switzerland.

ICD-10-CM is the United States’ clinical modification of the World Health Organization’s ICD-10. The term “clinical” is used to emphasize the modification’s intent: to serve as a useful tool in the area of classification of morbidity data for indexing of health records, medical care review, and ambulatory and other health care programs, as well as for basic health statistics. To describe the clinical picture of the patient, the codes must be more precise than those needed only for statistical groupings and trend analysis.

Characteristics of ICD-10-CM
ICD-10-CM far exceeds its predecessors in the number of concepts and codes provided. The disease classification has been expanded to include health-related conditions and to provide greater specificity at the sixth and seventh character level. The sixth and seventh characters are not optional and are intended for use in recording the information documented in the clinical record.

ICD-10-CM extensions, interpretations, modifications, addenda, or errata other than those approved by the Centers for Disease Control and Prevention are not to be considered official and should not be utilized. Continuous maintenance of the ICD-10-CM is the responsibility of the aforementioned agencies. However, because the ICD-10-CM represents the best in contemporary thinking of clinicians, nosologists, epidemiologists, and statisticians from both public and private sectors, when future modifications are considered, advice will be sought from all stakeholders.

All official authorized addenda through October 1, 2013, have been included in this revision. The complete official authorized addenda to ICD-10-CM, including the “ICD-10-CM Official Guidelines for Coding and Reporting,” can be accessed at the following website: http://www.cdc.gov/nchs/icd/icd10cm.htm#10update
A description of the ICD-10-CM updating and maintenance process can be found at the following website: http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm

ICD-10-CM and ICD-10-PCS

The compliance date for implementation of ICD-10-CM/PCS is October 1, 2014, for all Health Insurance Portability and Accountability Act (HIPAA)-covered entities.

ICD-10-CM, including the “ICD-10-CM Official Guidelines for Coding and Reporting,” will replace ICD-9-CM Diagnosis Codes in all health care settings for diagnosis reporting with dates of service, or dates of discharge for inpatients, that occur on or after October 1, 2014.

ICD-10-PCS, including the “ICD-10-PCS Official Guidelines for Coding and Reporting,” will replace ICD-9-CM Procedure Codes.

BENEFITS OF ICD-10-CM

ICD-10-CM incorporates much greater clinical detail and specificity than ICD-9-CM. Terminology and disease classification are updated to be consistent with current clinical practice. The modern classification system will provide much better data needed for:

• Measuring the quality, safety, and efficacy of care;
• Reducing the need for attachments to explain the patient’s condition;
• Designing payment systems and processing claims for reimbursement;
• Conducting research, epidemiological studies, and clinical trials;
• Setting health policy;
• Operational and strategic planning;
• Designing health care delivery systems;
• Monitoring resource use;
• Improving clinical, financial, and administrative performance;
• Preventing and detecting health care fraud and abuse; and
• Tracking public health and risks.

Non-specific codes are still available for use when medical record documentation does not support a more specific code.

ICD-10-CM Diagnosis Codes:
There are 3–7 digits;
Digit 1 is alpha;
Digit 2 is numeric;
Digits 3–7 are alpha or numeric (alpha characters are not case sensitive); and a decimal is used after the third character.
Examples:
A78–Q    fever;
A69.21    Meningitis due to Lyme disease; and
S52.131A Displaced fracture of neck of right radius, initial encounter for closed fracture.
NEW FEATURES IN ICD-10-CM

The following new features can be found in ICD-10-CM:

1) Laterality (Left, Right, Bilateral)
   Examples:
   - C50.511 – Malignant neoplasm of lower-outer quadrant of right female breast;
   - H16.013 – Central corneal ulcer, bilateral; and
   - L89.012 – Pressure ulcer of right elbow, stage II.

2) Combination Codes for Certain Conditions and Common Associated Symptoms and Manifestations
   Examples:
   - K57.21 – Diverticulitis of large intestine with perforation and abscess with bleeding;
   - E11.341 – Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema; and
   - I25.110 – Atherosclerotic heart disease of native coronary artery with unstable angina pectoris.

3) Combination Codes for Poisonings and Their Associated External Cause
   Example:
   - T42.3x2S – Poisoning by barbiturates, intentional self-harm, sequela.

4) Obstetric Codes Identify Trimester Instead of Episode of Care
   Example:
   - O26.02 – Excessive weight gain in pregnancy, second trimester.

5) Character “x” Is Used as a 5th Character Placeholder in Certain 6 Character Codes to Allow for Future Expansion and to Fill in Other Empty Characters (For Example, Character 5 and/or 6) When a Code that Is Less than 6 Characters in Length Requires a 7th Character
   Examples:
   - T46.1x5A – Adverse effect of calcium-channel blockers, initial encounter; and
   - T15.02xD – Foreign body in cornea, left eye, subsequent encounter.

6) Two Types of Excludes Notes
   Excludes 1 Indicates that the code excluded should never be used with the code where the note is located (do not report both codes).
   Example:
   - Q03 – Congenital hydrocephalus.
     Excludes 1: Acquired hydrocephalus (G91-).

   Excludes 2 Indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time, in which case both codes may be assigned together (both codes can be reported to capture both conditions).
   Example:
   - L27.2 – Dermatitis due to ingested food.
     Excludes 2: Dermatitis due to food in contact with skin (L23.6, L24.6, L25.4).
7) Inclusion of Clinical Concepts that Do Not Exist in ICD-9-CM (For Example, Underdosing, Blood Type, Blood Alcohol Level)
Examples:
- T45.526D – Underdosing of antithrombotic drugs, subsequent encounter;
- Z67.40 – Type O blood, Rh positive; and
- Y90.6 – Blood alcohol level of 120 – 199 mg/100 ml.

8) A Number of Codes Are Significantly Expanded (For Example, Injuries, Diabetes, Substance Abuse, Postoperative Complications)
Examples:
- E10.610 – Type 1 diabetes mellitus with diabetic neuropathic arthropathy;
- F10.182 – Alcohol abuse with alcohol-induced sleep disorder; and
- T82.02xA – Displacement of heart valve prosthesis, initial encounter.

9) Codes for Postoperative Complications Are Expanded and a Distinction Is Made Between Intraoperative Complications and Postprocedural Disorders
Examples:
- D78.01 – Intraoperative hemorrhage and hematoma of spleen complicating a procedure on the spleen; and
- D78.21 – Postprocedural hemorrhage and hematoma of spleen following a procedure on the spleen.

ADDITIONAL CHANGES IN ICD-10-CM

The additional changes that can be found in ICD-10-CM are as follows:
- Injuries are grouped by anatomical site rather than by type of injury;
- Category restructuring and code reorganization occur in a number of ICD-10-CM chapters, resulting in the classification of certain diseases and disorders that are different from ICD-9-CM;
- Certain diseases are reclassified to different chapters or sections to reflect current medical knowledge;
- New code definitions (for example, definition of acute myocardial infarction is now 4 weeks rather than 8 weeks); and
- The codes corresponding to ICD-9-CM V codes (Factors Influencing Health Status and Contact with Health Services) and E codes (External Causes of Injury and Poisoning) are incorporated into the main classification (in ICD-9-CM, they were separated into supplementary classifications).

USE OF EXTERNAL CAUSE AND UNSPECIFIED CODES IN ICD-10-CM

Similar to ICD-9-CM, there is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless you are subject to a State-based external cause code reporting mandate or these codes are required by a particular payer, you are not required to report ICD-10-CM codes found in Chapter 20, External Causes of Morbidity.

If you have not been reporting ICD-9-CM external cause codes, you will not be required to report ICD-10-CM codes found in Chapter 20 unless a new State or payer-based requirement about the reporting of these codes is instituted. If such a requirement is instituted, it would be independent of ICD-10-CM implementation.
In the absence of a mandatory reporting requirement, you are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

In both ICD-9-CM and ICD-10-CM, sign/symptom and unspecified codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter.

Each health care encounter should be coded to the level of certainty known for that encounter. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined, but the specific type has not been determined). In fact, unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient’s condition at the time of that particular encounter. It is inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing to determine a more specific code. Reference: MLM Matters CMS Website

2014 release of ICD-10-CM

These files have been created by the National Center for Health Statistics (NCHS), under authorization by the World Health Organization.

These files linked below are the 2014 update of the ICD-10-CM. Content changes to the full ICD-10-CM files are described in the respective addenda files. This year, in addition to PDF (Adobe) files, the XML format is also being made available. Most files are provided in a compressed zip format for ease in downloading. These files have been created by the National Center for Health Statistics (NCHS), under authorization by the World Health Organization.

Although this release of ICD-10-CM is now available for public viewing, the codes in ICD-10-CM are not currently valid for any purpose or use. As noted earlier, the effective implementation date for ICD-10-CM (and ICD-10-PCS) is October 1, 2014. Updates to this version of ICD-10-CM are anticipated prior to its implementation.

- Preface [PDF - 35 KB]
- ICD-10-CM Guidelines [PDF - 512 KB]
- Detailed List of Codes Exempt from Diagnosis Present on Admission Requirement PDF Format
- Detailed List of Codes Exempt from Diagnosis Present on Admission Requirement XLSM Format
- ICD-10-CM PDF Format
- ICD-10-CM XML Format
- ICD-10-CM List of Codes and Descriptions (updated 7/3/2013)
- General Equivalence Mapping Files

To download these files, go to: http://www.cdc.gov/nchs/icd/icd10cm.htm#10update

Content source: CDC/National Center for Health Statistics
Page maintained by: Office of Information Services
http://www.cdc.gov/nchs/icd/icd10cm.htm

Development of the ICD-10 Procedure Coding System
(ICS-10-PCS)

Richard F. Averill, M.S., Robert L. Mullin, M.D., Barbara A. Steinbeck, RHIT, Norbert I. Goldfield, M.D, Thelma M. Grant, RHIA, Rhonda R. Butler, CCS, CCS-P

The International Classification of Diseases 10th Revision Procedure Coding System (ICD-10-PCS) has been developed as a replacement for Volume 3 of the International Classification of Diseases 9th Revision (ICD-9-CM). The development of ICD-10-PCS was funded by the U.S. Centers for Medicare and Medicaid Services (CMS). ICD-10-PCS has a multiaxial, seven-character, alphanumeric code structure that provides a unique code for all substantially different procedures, and allows new procedures to be easily incorporated as new codes. ICD-10-PCS was under development for over five years. The initial draft was formally tested and evaluated by an independent contractor; the final version was released in the Spring of 1998, with annual updates since the final release. The design, development, and testing of ICD-10-PCS are discussed.

Introduction
Volume 3 of the International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM) has been used in the U.S. for the reporting of inpatient procedures since 1979. The structure of Volume 3 of ICD-9-CM has not allowed new procedures associated with rapidly changing technology to be effectively incorporated as new codes. As a result, in 1992 the U.S. Centers for Medicare and Medicaid Services (CMS) funded a project to design a replacement for Volume 3 of ICD-9-CM. After a review of the preliminary design, CMS in 1995 awarded 3M Health Information Systems a three-year contract to complete development of the replacement system. The new system is the ICD-10 Procedure Coding System (ICD-10-PCS).

Attributes Used in Development
The development of ICD-10-PCS had as its goal the incorporation of four major attributes:

• Completeness
There should be a unique code for all substantially different procedures. In Volume 3 of ICD-9-CM, procedures on different body parts, with different approaches, or of different types are sometimes assigned to the same code.

• Expandability
As new procedures are developed, the structure of ICD-10-PCS should allow them to be easily incorporated as unique codes.

• Multiaxial
ICD-10-PCS codes should consist of independent characters, with each individual axis retaining its meaning across broad ranges of codes to the extent possible.

• Standardized Terminology
ICD-10-PCS should include definitions of the terminology used. While the meaning of specific words varies in common usage, ICD-10-PCS should not include multiple meanings for the same term, and each term must be assigned a specific meaning.

If these four objectives are met, then ICD-10-PCS should enhance the ability of health information coders to construct accurate codes with minimal effort.
General Development Principles
In the development of ICD-10-PCS, several general principles were followed:

- **Diagnostic Information Is Not Included in Procedure Description**
  When procedures are performed for specific diseases or disorders, the disease or disorder is not contained in the procedure code. There are no codes for procedures exclusive to aneurysms, cleft lip, strictures, neoplasms, hernias, etc. The diagnosis codes, not the procedure codes, specify the disease or disorder.

- **Not Otherwise Specified (NOS) Options Are Restricted**
  ICD-9-CM often provides a “not otherwise specified” code option. Certain NOS options made available in ICD-10-PCS are restricted to the uses laid out in the ICD-10-PCS official guidelines. A minimal level of specificity is required for each component of the procedure.

- **Limited Use of Not Elsewhere Classified (NEC) Option**
  ICD-9-CM often provides a “not elsewhere classified” code option. Because all significant components of a procedure are specified in ICD-10-PCS, there is generally no need for an NEC code option. However, limited NEC options are incorporated into ICD-10-PCS where necessary. For example, new devices are frequently developed, and therefore it is necessary to provide an “Other Device” option for use until the new device can be explicitly added to the coding system. Additional NEC options are discussed later, in the sections of the system where they occur.

- **Level of Specificity**
  All procedures currently performed can be specified in ICD-10-PCS. The frequency with which a procedure is performed was not a consideration in the development of the system. Rather, a unique code is available for variations of a procedure that can be performed.

ICD-10-PCS has a seven-character, alphanumeric code structure. Each character contains up to 34 possible values. Each value represents a specific option for the general character definition (e.g., stomach is one of the values for the body part character). The ten digits 0–9 and the 24 letters A–H, J–N, and P–Z may be used in each character. The letters O and I are not used in order to avoid confusion with the digits 0 and 1.

Procedures are divided into sections that identify the general type of procedure (e.g., medical and surgical, obstetrics, imaging). The first character of the procedure code always specifies the section. The sections are shown in Table 1.

Table 1: ICD-10-PCS Sections

<table>
<thead>
<tr>
<th>Character</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Medical and Surgical</td>
</tr>
<tr>
<td>1</td>
<td>Obstetrics</td>
</tr>
<tr>
<td>2</td>
<td>Placement</td>
</tr>
<tr>
<td>3</td>
<td>Administration</td>
</tr>
<tr>
<td>4</td>
<td>Measurement and Monitoring</td>
</tr>
<tr>
<td>5</td>
<td>Extracorporeal Assistance and Performance</td>
</tr>
<tr>
<td>6</td>
<td>Extracorporeal Therapies</td>
</tr>
<tr>
<td>7</td>
<td>Osteopathic</td>
</tr>
<tr>
<td>8</td>
<td>Other Procedures</td>
</tr>
<tr>
<td>9</td>
<td>Chiropractic</td>
</tr>
<tr>
<td>B</td>
<td>Imaging</td>
</tr>
<tr>
<td>C</td>
<td>Nuclear Medicine</td>
</tr>
<tr>
<td>D</td>
<td>Radiation Oncology</td>
</tr>
<tr>
<td>F</td>
<td>Physical Rehabilitation and Diagnostic Audiology</td>
</tr>
<tr>
<td>G</td>
<td>Mental Health</td>
</tr>
<tr>
<td>H</td>
<td>Substance Abuse Treatment</td>
</tr>
</tbody>
</table>
The second through seventh characters mean the same thing within each section, but may mean different things in other sections. In all sections, the third character specifies the general type of procedure performed (e.g., resection, transfusion, fluoroscopy), while the other characters give additional information such as the body part and approach. In ICD-10-PCS, the term “procedure” refers to the complete specification of the seven characters.

### ICD-10-PCS 2014 Version

**Update Summary / Change Summary Table**

<table>
<thead>
<tr>
<th>2013 Total</th>
<th>New Codes</th>
<th>Revised Titles</th>
<th>Deleted Codes</th>
<th>2014 Total</th>
</tr>
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<tr>
<td>71,920</td>
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### ICD-10-PCS Code 2013 Totals, by Section

<table>
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<th>2013 Total</th>
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<tbody>
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<td>Medical and Surgical</td>
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<td>Obstetrics</td>
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<td>Placement</td>
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<td>Administration</td>
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<td>Measurement and Monitoring</td>
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<td>Extracorporeal Assistance and Performance</td>
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<td>Osteopathic</td>
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<td>Other Procedures</td>
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<td>Rehabilitation and Diagnostic Audiology</td>
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<td>Mental Health</td>
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<td>Substance Abuse Treatment</td>
<td>59</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>71,924</strong></td>
</tr>
</tbody>
</table>
ICD-10-PCS Code Changes

Four codes added under new technology application, valid October 1, 2013

- **08H005Z** Insertion of Epiretinal Visual Prosthesis into Right Eye, Open Approach
- **08H105Z** Insertion of Epiretinal Visual Prosthesis into Left Eye, Open Approach
- **30280B1** Transfusion of Nonautologous 4-Factor Prothrombin Complex Concentrate into Vein, Open Approach
- **30283B1** Transfusion of Nonautologous 4-Factor Prothrombin Complex Concentrate into Vein, Percutaneous Approach

Three new codes added and three codes deleted, to correct body part value for temporary occlusion of abdominal aorta

- New: **04V00DJ** Restriction of Abdominal Aorta with Intraluminal Device, Temporary, Open Approach
- New: **04V03DJ** Restriction of Abdominal Aorta with Intraluminal Device, Temporary, Percutaneous Approach
- New: **04V04DJ** Restriction of Abdominal Aorta with Intraluminal Device, Temporary, Percutaneous Endoscopic Approach
- Deleted: **02VW0DJ** Restriction of Thoracic Aorta with Intraluminal Device, Temporary, Open Approach
- Deleted: **02VW3DJ** Restriction of Thoracic Aorta with Intraluminal Device, Temporary, Percutaneous Approach
- Deleted: **02VW4DJ** Restriction of Thoracic Aorta with Intraluminal Device, Temporary, Percutaneous Endoscopic Approach

Revised Section Title

Title for Radiation Oncology section revised to Radiation Therapy in response to public comment. Because the phrase “Radiation Oncology” is not used in code titles, no code titles were revised as a result of the section title change.

New Index Addenda

- New file showing new, revised, and deleted index entries in response to public comment
- First discussed at September 2012 Coordination and Maintenance Committee, proposed format shown at March 2013 Coordination and Maintenance Committee
- See list of updated files for details

New Definitions Addenda

- New file showing new, revised, and deleted PCS definitions entries (e.g., Body Part Key) in response to public comment
- First discussed at September 2012 Coordination and Maintenance Committee, proposed format shown at March 2013 Coordination and Maintenance Committee
- See list of updated files for details
List of Updated Files

2014 Official ICD-10-PCS Coding Guidelines
- Downloadable PDF file
- Revised in response to public comment and review by the cooperating parties

2014 ICD-10-PCS Code Tables and Index (Zip file)
- Downloadable PDF file, file name is PCS_2014.pdf
- Downloadable xml files for developers, file names are:
  - icd10pcs_tabular_2014.xml
  - icd10pcs_index_2014.xml
  - icd10pcs_definitions_2014.xml
- Accompanying schema for developers, file names are:
  - icd10pcs_tabular_2014.xsd
  - icd10pcs_index_2014.xsd
  - icd10pcs_definitions_2014.xsd

2014 ICD-10-PCS Code Titles, Long and Abbreviated (Zip file)
- Tabular order file defines an unambiguous order for all ICD-10-CM/PCS codes
- Text file format, file name is:
  - icd10pcs_order_2014.txt
  - Provides a unique five-digit “order number” for each ICD-10-PCS table and code
- Accompanying documentation, file name is:
  - ICD10OrderFiles.pdf

2014 ICD-10-PCS Final Addenda (Zip file)
- New code titles for FY2014 shown as ICD-10-PCS table entries. File name is:
  - PcsAddendaAdditionsNewLabels.pdf
- Deleted code titles for FY2014 shown as ICD-10-PCS table entries. File name is:
  - PcsAddendaDeletionsOldLabels.pdf
- Downloadable xml format for developers. File names are:
  - PcsAddendaAdditionsNewLabels.xml, PcsAddendaDeletionsOldLabels.xml
- Accompanying documentation. File name is:
  - pcs_addenda_readme2014.pdf
- Index addenda in downloadable PDF. File name is:
  - index_addenda_2014.pdf
- PCS Definitions addenda in downloadable PDF. File name is:
  - definitions_addenda_2014.pdf
- Index and Definitions addenda in machine-readable text format for developers. File names are:
  - index_addenda_2014.txt, definitions_addenda_2014.txt

2014 ICD-10-PCS Reference Manual (Zip file)
- Downloadable PDF file. File name is:
  - Revised in response to public comment and internal review
- Addenda to 2014 version of reference manual specifies the changes. File name is:
  - pcs_ref_addenda_2014.pdf
2014 ICD-10-PCS and ICD-9-CM General Equivalence Mappings (Zip file)
- Downloadable text format. File names are:
  gem_i9pcs.txt, gem_pcsi9.txt
  Contain entries for the new FY2014 ICD-9-CM and ICD-10-PCS codes and entries revised in response to public comment and internal review
- Documentation for general users and technical users. File name is:
  pcs_gemguide_2014.pdf
- Documentation for technical users. File name is:
  GemsTechDoc.pdf

2014 ICD-10 Reimbursement Mappings (Zip file)
- Downloadable text format. File names are:
  reimb_map_dx_2014.txt
  reimb_map_pr_2014.txt
  FY2014 version uses the FY2014 GEM files.
- Accompanying documentation includes rules used in the mapping. File name is:
  reimb_map_guide_2014.pdf
HEALTH RECORD CODING REVIEW
CODING PROCESS

Fine-tune your coding skills by seeking complete documentation and selecting the most detailed codes.

1. Assess the case by performing a quick review of the record’s demographic information and the first few lines of the History and Physical.

2. Get an overview of key reports because they contain valuable detailed information.
   A. The discharge summary sums up the patient’s hospital course and confirms conditions or complications. In ambulatory records, look at the final progress note and/or discharge instructions.
   B. Review the physician orders for treatment protocols. The orders may indicate chronic or acute conditions for which the patient is receiving treatment.
   C. Review the history and physical to complete the clinical picture. Social and family history, as well as past and present illnesses, may have clinical implications.
   D. Read the progress notes to track the course of hospitalization or outpatient treatment. These provide information concerning daily status, reactions, or postoperative complications.
   E. Study the operative reports. Additional procedures may be identified in the body of the operative report.

3. Check all data from clinical reports.
   A. Laboratory reports may show evidence of conditions such as anemia, renal failure, infections, and metabolic imbalances.
   B. Radiology reports may confirm diagnosis of pneumonia, COPD, CHF, degenerative joint diseases, and traumatic injuries.
   C. Medication Administration Reports (MARs) indicate all drugs that were administered to the patient. Look for documentation of diagnoses elsewhere in the medical record to correlate with each drug. If uncertain why a medication was administered, query the physician.
   D. Respiratory therapy notes document the use of mechanical ventilation and describe severity of respiratory disorders.
   E. Physical therapy reports detail useful information for coding musculoskeletal dysfunctions.
   F. Dietary reports describe nutritional deficiencies (e.g., malnutrition).
   G. Speech pathology reports give information on dysphasia, aphasia, and other speech-related conditions.
   H. Pathology reports are essential for accurate coding of conditions where excised tissue has been submitted for interpretation.

4. Perform a coding evaluation.
   A. Establish the principal diagnosis and formulate secondary diagnoses codes.
   B. Exclude all conditions not relevant to the case. Abnormal lab and X-ray findings and previous conditions having no effect on current management of the patient are not coded.

5. Take time to review and refine your coding.
   A. Review all diagnoses and procedures to confirm the selections of appropriate principal and secondary diagnoses and all procedure codes.
   B. For inpatient records, determine if each diagnosis was present on admission (POA) to adequately identify the POA indicator.
   C. Refine code assignments, where necessary, to make changes to more accurately classify the diagnoses and procedure codes selected.
**Sample 10-Step Inpatient ICD-10-CM Coding Process**

1. **Locate Patient’s Gender, Age, and Discharge Date.**

2. **Locate Discharge Status (Disposition).** Some examples include:
   - 01: Home
   - 02: Short-term hospital
   - 03: Skilled nursing facility
   - 04: Facility providing custodial or supportive care
   - 05: Cancer or child hospital
   - 06: Home health services
   - 07: Against medical advice
   - 20: Expired
   - 30: Still a patient
   - 61: Swing bed
   - 62: Inpatient rehab facility or distinct rehab unit
   - 63: Long-term care hospital
   - 65: Psychiatric hospital or distinct psych unit
   - 66: Critical access hospital

3. **List consultants** as you go through the consults.
   
   **Write down pertinent diagnoses** (histories and present illnesses).

4. **Locate and list all procedures.**
   
   Review description of each procedure performed.

5. **Go through the physician orders and medication administration orders.**
   
   This is where you will find drugs ordered and administered. Make sure that you look for the diagnosis that corresponds with each medication. If not, query the physician.

6. **Read the H&P, ER record, and progress notes.**
   
   **Write down all diagnoses that meet criteria for principal and secondary diagnosis:**
   
   If a diagnosis is ruled out, just cross it off the list.

7. **Select the Principal Diagnosis.**
   
   UHDDS Definition: The condition established *after study* to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
8. Select Other Diagnoses and indicate whether each was present on admission (POA) or not.

UHDDS Definition: All conditions that coexist at the time of admission, develop subsequently, or affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are to be excluded.

**Complication** UHDDS Definition: A condition arising during hospitalization, which increases the patient’s length of stay by 1 day in 75% of cases.

**Comorbidity** UHDDS Definition: Condition present at admission, in addition to the principal diagnosis, which increases the patient’s length of stay by 1 day in 75% of cases.

For reporting purposes, the definition of “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:
- clinical evaluation
- therapeutic treatment
- diagnostic procedures
- extended length of hospital stay
- increased nursing care and/or monitoring

9. **Principal Procedure.**

UHDDS Definition: One performed for definitive treatment (rather than performed for diagnostic or exploratory purposes) or one that was necessary to care for a complication. If two or more procedures appear to meet the definition, then the one most closely related to the principal diagnosis should be selected as the principal procedure.

10. **Other Procedures**

UHDDS Definition for significant procedures: One that meets any of the following conditions: is surgical in nature, carries an anesthetic risk, carries a procedural risk, or requires specialized training.
Some Additional Tips for Coding

1. When a patient is admitted with or develops a condition during his or her stay, look to see if there is documentation to differentiate if the complication is acute, chronic, or both acute and chronic.

2. When a patient presents with or develops infectious conditions, seek documentation of any positive cultures (urine, wound, sputum, blood) pertaining to that condition. If the positive cultures are available for that condition (e.g., sepsis due to Pseudomonas), it will help in being more specific in coding the diagnoses and may increase reimbursement in some cases. For example, in a case of pneumonia due to Pseudomonas, the MS-DRG may increase considerably. According to coding guidelines, if the culture is not documented, even though present in laboratory reports, the condition is to be coded as unspecified, which can affect reimbursement. Examples: sepsis, cellulitis, UTI, pneumonia, etc.

3. If a condition is due to surgery, ask the physician to verify and document that it is due to the procedure. If the patient has been discharged, and you are not sure but believe it was due to the procedure, seek verification that it is possibly due to the procedure by querying the physician.

4. If the patient had outpatient surgery for removal of a lesion, look for documentation of the size of the lesion that may have been removed. It should be documented in the operative report. The American Medical Association’s publication, CPT Assistant (issues from Fall 1995 and August 2000) states, “Since the physician can make an accurate measurement of the lesion(s) at the time of the excision, the size of the lesion should be documented in the OP (operative) report. A pathology report is likely to contain a less accurate measurement due to the shrinking of the specimen or the fact that the specimen may be fragmented.”

Reimbursement is based on the diameter of the lesion(s). Even 1 millimeter (mm) off in the diameter calculation can mean fewer dollars for the hospital and the physician. The documentation in the record ensures appropriate reimbursement.

5. Look for documentation in the final diagnoses in the discharge summary for clarification or to differentiate whether specific conditions are currently present, or if the patient only has a history of the condition.

Examples:
1. Acute CVA versus history of CVA
2. Current drug or alcohol abuse versus history of drug or alcohol abuse
3. Current neoplasm being treated versus history of malignancy

6. Verify if a condition is a manifestation of an existing condition.

Example: CRF secondary to DM or CRF due to HTN

7. Look for documentation of conditions that are secondary to previous conditions.

Examples:
1. Quadriplegia due to fall
2. Dysphagia due to previous CVA
ICD-10-CM Outpatient/Ambulatory Coding Guidelines

Note: This is a brief overview. ICD-10-CM codes are used for diagnoses. CPT codes are used for procedures for billing purposes.

1. Documentation should include specific diagnoses as well as symptoms, problems, and reasons for visits.
2. First-listed diagnosis is listed first with other codes following.
3. Chronic diseases may be coded as long as the patient receives treatment.
4. Code all documented conditions that coexist at the time of the visit and are treated or affect treatment. History codes may be used if they impact treatment.
5. Diagnosis coding for Diagnostic Services: Code the diagnosis chiefly responsible for the service. Secondary codes may follow.

Instructions to Determine the Reason for the Test: The referring physicians are required to provide diagnostic information to the testing entity at the time the test is ordered. All diagnostic tests “must be ordered by the physician who is treating the beneficiary.” An order by the physician may include the following forms of communication:
1. A written document signed by the treating physician/practitioner, which is hand delivered, mailed, or faxed to the testing facility.
2. A telephone call by the treating physician/practitioner or his or her office to the testing facility.
3. An electronic mail by the treating physician or practitioner or his or her office to the testing facility.

Note: Telephone orders must be documented by both the treating physician or practitioner office and the testing facility.

If the interpreting physician does not have diagnostic information as to the reason for the test, and the referring physician is unavailable, it is appropriate to obtain the information directly from the patient or patient’s medical record. Attempt to confirm any information obtained from the patient by contacting the referring physician.

6. Diagnosis coding for Therapeutic Services: Code the diagnosis chiefly responsible for the service. Secondary codes may follow.

7. Diagnosis coding for Ambulatory Surgery: Code the diagnosis for which surgery was done. Use the postoperative diagnosis if it is available and more specific.
Commonly Missed Complications and Comorbidities (CCs)

Depending on the patient’s principal diagnosis, this list of commonly missed complications and comorbidities (CCs) and major complications and comorbidities (MCCs) may or may not help the MS-DRG when documented and coded. If any of these conditions are being managed while the patient is being hospitalized, it may change the MS-DRG to a higher paying one. Some MS-DRGs will not change even if these are present. The MS-DRG may or may not change if the patient has a major procedure performed. Some of these conditions may be considered CCs, while others may be considered Major CCs.

- Acidosis
- Alcoholism acute/chronic
- Alkalosis
- Anemia due to blood loss, acute/chronic (e.g., from GI bleed, or surgery)
- Angina pectoris (stable or unstable angina)
- Atrial fibrillation/flutter
- Atelectasis
- Cachexia
- Cardiogenic shock
- Cardiomyopathy
- Cellulitis
- CHF
- Combination of both acidosis/alkalosis
- COPD
- Decubitus ulcer
- Dehydration (volume depletion)
- Diabetes: If DM is uncontrolled (type 1 or 2)
- Electrolyte imbalance
- Hematuria
- Hematemeses
- Hypertension (HTN) accelerated or malignant HTN only qualifies (not uncontrolled, hypertensive urgency or hypertensive crisis)
- Hypertensive heart disease with CHF
- Hyponatremia (↓ Na)
- Hypernatremia (↑ Na)
- Hypochloremia (↓ Cl)
- Hyperchloremia (↑ Cl)
- Hyperpotassemia (↑ K)
- Malnutrition
- Melena
- Pleural effusion (especially if it has to be treated by a procedure, e.g., thoracentesis)
- Pneumonia
- Pneumothorax
- Postoperative complications
- Renal failure, acute or chronic (not renal insufficiency)
- Respiratory failure
- Septicemia
- Urinary retention
- UTI (e.g., urosepsis): If urosepsis is documented, it will be coded as a UTI unless otherwise specified.

Note: This is not an all-inclusive listing of possible complications and comorbidities.
SOME AREAS OF SPECIAL INTEREST

Adhesions

- When minor adhesions are present, but do not cause symptoms or increase the difficulty of an operative procedure, coding a diagnosis of adhesions and a lysis procedure is inappropriate.
- When adhesions are dense or strong or create problems during a surgical procedure, it is appropriate to code both the diagnosis of adhesions and the operative procedure to lyse the adhesions.

Anemia

- The coder must distinguish between chronic blood loss anemia and acute blood loss anemia because the two conditions are assigned to different category codes.
- Acute blood loss anemia occurring after surgery may or may not be a complication of surgery. The physician must clearly identify postoperative anemia as a complication of the surgery in order to use the complication code.
- Depending on the primary reason for admission, anemia of chronic disease can be used as the principal diagnosis (if the reason for admit is to treat the anemia) or as the secondary diagnosis.
- When assigning code D63.1 (anemia in chronic kidney disease), also assign a code from category N18.3 (chronic kidney disease) to identify the stage of chronic kidney disease.

Asthma

- Acute exacerbation of asthma is increased severity of asthma symptoms, such as wheezing and shortness of breath.
- Terms suggesting status asthmaticus include intractable asthma, refractory asthma, severe intractable wheezing, and airway obstruction not relieved by medication. It is a life-threatening complication that requires emergency care.
- The coder must not assume status asthmaticus is present. The physician must document the condition in order to code it.

Body Mass Index (BMI)

- The code(s) for body mass index should only be reported as secondary diagnoses and must meet the definition of a reportable additional diagnosis.
- Documentation from clinicians (such as dieticians) may be used for code assignment as long as the physician has documented the diagnosis of obesity.
- If there is conflicting documentation, query the attending physician.

Burns

- When coding multiple burns, assign separate codes for each site and sequence the burn with the highest degree first.
- When coding burns of the same site with varying degrees, code only the highest degree.
- Necrosis of burned skin is coded as a nonhealing burn. Nonhealing burns are coded as acute burns.
Cellulitis
- Coders must not assume that documentation of redness at the edges of a wound represents cellulitis. Rely on physician documentation of cellulitis.
- Coding of cellulitis with an injury or burn requires one code for the injury and one for the cellulitis. Sequencing will depend on the circumstances of admission.
- When the patient is seen primarily for treating the original injury, sequence that code first. When the patient is seen primarily for treatment of the cellulitis, the code for cellulitis is the principal diagnosis.

Complications
- When coding complications of surgical and medical care, if the code fully describes the condition, no additional code is necessary. If it does not fully describe the condition, an additional code should be assigned. Codes for medical and surgical care are found within the body system chapters.

Congenital Anomalies
- Congenital anomaly codes have been assigned to categories Q00–Q99 and may be used for a principal or secondary diagnosis.
- When there is a code that identifies the congenital anomaly, do not assign additional codes for the inherent manifestations. Do assign additional codes for manifestations that are not an inherent component.
- For the birth admission, category Z38 is still the principal diagnosis followed by any congenital anomaly code (Q00–Q99).
- Codes from Chapter 17, Congenital Anomalies, can be reported for patients of any age. Many congenital anomalies do not manifest any symptoms until much later in life.

Diabetes Mellitus
- When the type of diabetes mellitus is not documented, code it as type 2.
- Diabetes with a manifestation or complication requires documentation of a causal relationship to be coded. Assign as many codes from the diabetes category as needed to identify all associated conditions.
- Even if the patient is using insulin, it does not necessarily mean that the patient is type 1.
- Most patients with type 1 diabetes develop the condition before reaching puberty. That is why type 1 diabetes mellitus is also referred to as juvenile diabetes.
- For type 2 patients who routinely use insulin, code (long-term, current use of insulin) should also be assigned. Do not use this code if the patient receives insulin to temporarily bring a type 2 patient’s blood sugar under control.
- An underdose of insulin due to an insulin pump failure should be assigned T85.6- (mechanical complications due to insulin pump) as the principal diagnosis code, followed by a code from categories E08-E13.
- When the patient has an insulin pump malfunction resulting in an overdose of insulin, assign a code from the T85.6- category as the principal diagnosis code with an additional code of T38.3- (poisoning by insulin and antidiabetic agents). Also code the appropriate diabetes mellitus code from E08–E13.
- Use codes from category E08.9- (secondary diabetes mellitus) to identify diabetes caused by another condition or event. Category code E08.9- is listed first followed by the code for the associated condition.

The patient may be admitted for treatment of the secondary diabetes or one of its associated conditions OR for treatment of the condition causing the secondary diabetes. Code the primary reason for the encounter as the principal diagnosis, which will be a code from category E08.9 followed by the code for the associated condition or a code for the cause of the secondary diabetes.
• Assign code E89.1 for post-pancreatectomy diabetes mellitus. Assign a category code from E08.9 for secondary diabetes mellitus. Also assign Z90.410 for acquired absence of the pancreas. Also code any diabetes manifestations.

**Dysplasia of the Vulva and Cervix**

• A diagnosis of cervical intraepithelial neoplasia (CIN) III or vulvar intraepithelial neoplasia (VIN) III is classified as carcinoma in situ of the site.

• A diagnosis of CIN III or VIN III is made only on the basis of pathological evaluation of tissue.

**Elevated Blood Pressure vs. Hypertension**

• A diagnosis of high or elevated blood pressure without a firm diagnosis of hypertension is reported using code R03.0.

• This code is never assigned on the basis of a review of blood pressure readings; the physician must document elevated blood pressure/hypertension.

**Fracture**

• Traumatic fractures are coded as long as the patient is receiving active treatment.

• Subsequent care of traumatic fractures are coded to the acute fracture code with the appropriate 7th character. Aftercare Z codes should not be reported for aftercare of traumatic fractures.

• An open fracture is one in which there is communication with the bone. The following terms indicate open fracture: compound, infected, missile, puncture, and with foreign body.

• A closed fracture does not produce an open wound. Some types of closed fractures are impacted, comminuted, depressed, elevated, greenstick, spiral, and simple.

• When a fracture is not identified as open or closed, the code for a closed fracture is used.

• Internal fixation devices include screws, pins, rods, staples, and plates.

• External fixation devices include casts, splints, and traction device (Kirschner wire) (Steinman pin).

**Gastrointestinal Hemorrhage**

• Patients may be admitted for an endoscopy after a history of GI bleeding. It is acceptable to use a code for GI hemorrhage even if there is no hemorrhage noted on the current encounter.

**Hematuria**

• Blood in the urine discovered on a urinalysis is not coded as hematuria but as R82.3, Hemoglobinuria.

• Hematuria following a urinary procedure is not considered a postoperative complication.

**Human Immunodeficiency Virus (HIV)**

• Documentation of HIV infection as “suspected,” “possible,” “likely,” or “questionable”: physician must be queried for clarification. Code only confirmed cases of HIV infection. Confirmation does not require documentation of positive test results for HIV. A physician’s documentation is sufficient.

• B20: Patients with symptomatic HIV disease or AIDS. If HIV test results are positive and the patient has symptoms. Patients with known diagnosis of HIV-related illness should be coded to B20 on every subsequent admission.

• Z21: Patients with physician-documented asymptomatic HIV infection who have never had an HIV-related illness. If HIV results are positive and the patient is without symptoms. Do not use this code if the term “AIDS” is used or if the patient is being treated for HIV-related conditions. In these cases, use code B20.
• Patients previously diagnosed with HIV-related illness (B20) should never be assigned Z21 Z11.4: Patient seen to determine his or her HIV status (screening).
• Patients admitted with an HIV-related condition are assigned code B20 as the principal diagnosis followed by additional diagnosis codes for all reported HIV-related conditions.
• Patients admitted for a condition unrelated to the HIV (such as traumatic injury) are assigned the code for the unrelated condition as the principal diagnosis, then code B20.
• When an obstetric patient has the HIV infection, a code from subcategory O98.7 is sequenced first with either code B20 (symptomatic) or V08 (asymptomatic) used as an additional code.

Hypertension
• Hypertensive heart disease I11. Physician must document causal relationship between hypertension and heart disease that is stated as “due to hypertension” or implied by documenting “hypertensive.” Use an additional code from category I50 to identify the type of heart failure, if present. If the heart disease is stated as occurring “with hypertension,” do not assume a cause-and-effect relationship and code it separately.
• Hypertensive chronic kidney disease I12-. ICD-10-CM assumes a causal relationship between hypertension and chronic kidney disease. There is no causal relationship with acute renal failure. Use an additional code from category N18 to identify the stage of CKD.
• Hypertensive heart and chronic kidney disease I13.0-. Physician must document causal relationship with the heart disease, but you may assume a causal relationship with chronic kidney disease. Assign an additional code for category I50 to identify the type of heart failure, if present. More than one code for category I50 may be assigned if the patient has systolic or diastolic failure and congestive heart failure. Use an additional code from category N18 to identify the stage of CKD.

Injuries
• Superficial injuries (e.g., abrasions, contusions) are not coded when there are more severe injuries of the same site.

Mechanical Ventilation
• Codes for intubation or tracheostomy should also be assigned.
• It is possible for a patient to be placed back on mechanical ventilation, thus necessitating two codes for mechanical ventilation on the same admission.

Methicillin-Resistant Staphylococcus Aureus (MRSA)
• To code a current infection due to MRSA when that infection does not have a combination code that includes MRSA, code the infection first, and then add code A49.02; B95.62 (MRSA).
• Use code Z22.321 for MSSA (Methicillin-Susceptible Staphylococcus aureus) colonization.
• Use code Z22.322 for MRSA (Methicillin-Resistant Staphylococcus aureus) colonization.
• Use code Z22.31; Z22.39 for other types of Staphylococcus colonization.

Myocardial Infarction (MI)
• An MI that is documented as acute or with a duration of 4 weeks or less is coded to category I21, Acute MI.
• When a patient has a subsequent infarction at the time of the encounter for the original infarction, both the initial and the subsequent AMI should be reported with codes from categories I21.- and I22.-
• Subcategory codes I21.0–I21.2 are used for “ST elevation MI” (STEMI).
• Subcategory I21.4 is used for “non-ST elevation MI” (NSTEMI) and nontransmural MI.
• If only STEMI or transmural MI without the documentation of the site, query the physician.
• If an AMI is documented as transmural or subendocardial, but the site is provided, it is still coded as subendocardial AMI.
• If STEMI converts to an NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

Neoplasms
• Neoplasms are listed in the Alphabetic Index in two ways:
  - The Table of Neoplasms provides code numbers for neoplasms by anatomic site. For each site, there are six possible code numbers according to whether the behavior of the neoplasm is malignant primary, malignant secondary, malignant in situ, benign, of uncertain behavior, or of unspecified nature.
  - Histological terms for neoplasms (e.g., adenoma, adenocarcinoma, and sarcoma) are listed as main terms in the appropriate alphabetic sequence and are usually followed by a cross reference to the neoplasm table.
• In sequencing neoplasms, when the treatment is directed toward the malignancy, then the malignancy of that site is designated as the principal diagnosis, unless the patient is admitted for one of the reasons listed next.
• When the patient has a primary neoplasm with metastasis and the treatment is directed toward the secondary site only, the secondary site is sequenced as the principal diagnosis.
• When a patient is admitted solely for chemotherapy, immunotherapy, or radiation therapy, a code from category V58 (V58.11, V58.12, or V58.0) is assigned as the principal diagnosis with the malignant neoplasm coded as an additional diagnosis.
• Codes from category Z85.00–Z85.89 are used when the primary neoplasm is totally eradicated and the patient is no longer having treatment and there is no evidence of any existing primary malignancy. Codes from category Z85 can only be listed as an additional code, not as a principal diagnosis. If extension, invasion, or metastasis is mentioned, code secondary malignant neoplasm to that site as the principal diagnosis.
• When a patient is admitted for pain management associated with the malignancy, code G89.3 as the principal diagnosis followed by the appropriate code for the malignancy. When a patient is admitted for management of the malignancy, code the malignancy as the principal diagnosis with code G89.3 as an additional code.
• When a patient is admitted for management of an anemia associated with the malignancy, and the treatment is only for anemia, code the anemia code D63.0 as the principal diagnosis followed by the appropriate code for the malignancy. Code D63.0 can be used as a secondary code if the patient has anemia and is being treated for the malignancy.
• When a patient is admitted for management of dehydration associated with the malignancy or the therapy, or both, and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.
• If the patient is admitted for surgical removal of a neoplasm followed by chemotherapy or radiation therapy, code the neoplasm (primary or secondary) as the principal diagnosis.
• If the patient has anemia associated with chemotherapy, immunotherapy, or radiotherapy and the only treatment is for the anemia, code anemia due to antineoplastic chemotherapy, and then code the neoplasm as an additional code.
• If the patient is admitted for chemotherapy, immunotherapy, or radiation therapy and then complications occur (such as uncontrolled nausea and vomiting or dehydration); assign the appropriate code for chemotherapy, immunotherapy, or radiation therapy as the principal diagnosis followed by any codes for the complications.
• If the primary reason for admission is to determine the context of the malignancy or for a procedure, even though chemotherapy or radiotherapy is administered, code the malignancy (primary and secondary site) as the principal diagnosis.
• When a malignant neoplasm is associated with a transplanted organ, assign a code from category T86 (complications of transplanted organ), followed by code C80.2 (malignant neoplasm associated with transplanted organ) followed by a code for the specific malignancy.

Newborn
• Newborn (perinatal) codes P00–P96 are never used on the maternal record.
• The perinatal period is defined as before birth through the 28th day following birth.
• A code from category Z38.0 is assigned as the principal diagnosis for any live birth.
• Other diagnoses may be coded for significant conditions noted after birth as secondary diagnoses.
• Insignificant or transient conditions that resolve without treatment are not coded.
• Assign codes from subcategories P00–P04 for evaluation of newborns and infants for suspected condition not found, is used when a healthy baby is evaluated for a suspected condition that proves to not exist. These codes are used when the baby exhibits no signs or symptoms.

Obstetrics
• Chapter 15 codes take sequencing precedence over other chapter codes, which may be assigned to provide further specificity as needed.
• The postpartum period begins immediately after delivery and continues for 6 weeks after delivery.
• The peripartum period is defined as the last month of pregnancy to 5 months.
• Codes from Chapter 15 can continue to be used after the 6-week period if the doctor documents that it is pregnancy related.
• When the mother delivers outside the hospital prior to admission and no complications are documented, code Z39.0 (postpartum care and examination immediately after delivery) as the principal diagnosis. If there are complications, the complications would be coded instead. Do not code a delivery diagnosis code because she delivered prior to admission.
• Principal diagnosis is determined by the circumstances of the encounter or admission.
• Complications: Any condition that occurs during pregnancy, childbirth, or the puerperium is considered to be a complication unless the physician specifically documents otherwise.
• A code from category Z37 is assigned as an additional code to indicate the outcome of delivery on the maternal chart. Z38 codes are not to be used on subsequent records or on the newborn record.
• Code O80, normal delivery, is used only when a delivery is perfectly normal and results in a single live birth. No abnormalities of labor or delivery or postpartum conditions can be present; therefore, there can be no additional code from Chapter 16. Z38.0-, single liveborn, is the only outcome of delivery code appropriate for use with O80.
• Z-codes from category Z34 are used when no obstetric complications are present and should not be used with any codes from Chapter 16.
• When the fetal condition is responsible for modifying the management of the mother (requires diagnostic studies or additional observation, special care, or termination of pregnancy), use codes from categories O35 and O36. The mere fact that the condition exists does not justify assigning a code from categories O35 and O36.
• When in utero surgery is performed on the fetus, assign codes from category O35. No code from Chapter 16 (the perinatal codes) should be used on the mother’s record to identify fetal conditions.

• Patients with an HIV-related illness during pregnancy, childbirth, or the puerperium should have codes O98.7- and B20.

• Patients with asymptomatic HIV infection status during pregnancy, childbirth, or the puerperium should have codes O98.7- and V08.

• Patients with diabetes during pregnancy, childbirth, or puerperium should have codes O24 and categories E08-E13. Also code Z79.4 (long-term, current use of insulin), if the diabetes is being treated with insulin.

Pain

• Use a code from category G89 in addition to other codes to provide more detail about whether the pain is acute, chronic, or neoplasm-related.

• If pain is not specified as acute or chronic, do not assign a code from category G89 except for postthoracotomy pain, postoperative pain, neoplasm-related pain, or central pain syndrome.

• A code from subcategories G89.1 and G89.2 should not be used if the underlying diagnosis is known unless the primary reason for admission is pain control.

• A code from category G89 can be the principal or first-listed diagnosis code when pain control or management is the reason for the admission or encounter. Code the underlying cause of the pain as an additional diagnosis.

• When a patient is admitted for a procedure for purposes of treating the underlying condition (e.g., spinal fusion), code the underlying condition (e.g., spinal stenosis) as the principal diagnosis. Do not code the pain from category G89.

• When a patient is admitted for the insertion of a neurostimulator for pain control, assign the code for pain as the principal diagnosis.

• If the patient is admitted primarily for a procedure to treat the underlying condition and a neurostimulator is inserted for pain, code the underlying condition as the principal diagnosis, followed by a code for the pain.

• If a code describes the site of the pain, but does not indicate whether the type of pain is acute or chronic (category G89), use two codes (one for the site and one for the type). If the admission is for pain control, assign category code G89 (acute or chronic) as the principal diagnosis. If the admission is not for pain control and a related definitive diagnosis is not documented, assign the code for the specific site of the pain as the principal diagnosis.

• Routine or expected postoperative pain immediately after surgery should not be coded.

• Postoperative pain not associated with a specific postoperative complication is coded using the appropriate code in category G89.

• Postoperative pain can be listed as the principal diagnosis when the reason for admission is pain control.

Pleural Effusion

• Pleural effusion is almost always integral to the underlying condition and therefore is usually not coded.

• When the effusion is addressed and treated separately, it can be coded.

• Pleural effusion noted only on an X-ray is not coded.
Pneumonia

- There are many combination codes that describe the pneumonia and the infecting organism.
- In some situations, the pneumonia is a manifestation of an underlying condition. In this situation, two codes are needed—one for the underlying condition and the other for the pneumonia.
- Lobar pneumonia does not refer to the lobe of the lung that is affected. It is a particular type of pneumonia.
- Gram-negative pneumonias are much more difficult to treat than gram-positive pneumonias. If the findings suggest a gram-negative pneumonia, and it is not documented as such, query the physician.
- Signs of gram-negative pneumonia include: worsening of cough, dyspnea, fever, purulent sputum, elevated leukocyte count, and patchy infiltrate on chest X-ray.
- When the physician has documented Ventilator Associated Pneumonia (VAP), use code J95.851.
  Add an additional code to identify the organism. Do not assign an additional code from categories J12–J18 to identify the type of pneumonia. Do not use code J95.851 just because the patient is on a ventilator and has pneumonia. The physician must document that the pneumonia is attributed to the ventilator.

Postoperative Complications

- Physician must document that a condition is a complication of the procedure before assigning a complication code.
- “Expected” conditions occur in the immediate post-op period. These are not reported unless they exceed the usual post-op period and meet the criteria for reporting as an additional diagnosis.

Pressure Ulcers

- When the patient has multiple pressure ulcers at different sites and each is at different stages, code each of the sites and each of the different stages.
- When the patient has pressure ulcers documented as “healed,” no code is assigned.
- When the patient has pressure ulcers documented as “healing,” code the site(s) and the stage(s).
- When the patient has a pressure ulcer at one stage at the time of admission, but then it progresses to a higher stage, assign the code for the highest stage.

Pulmonary Edema

- Pulmonary edema can be cardiogenic or noncardiogenic.
- Pulmonary edema is a manifestation of heart failure and, as such, is included in heart failure, hypertension, or rheumatic heart disease. Therefore, it is not coded separately.
- Noncardiogenic acute pulmonary edema occurs in the absence of heart failure or other heart disease.

Respiratory Failure (Acute)

- Careful review of the medical record is required for the coding and sequencing of acute respiratory failure. If it meets the definition of principal diagnosis, it is coded as such. If it does not, it is coded as a secondary diagnosis.
- When a patient is admitted with acute respiratory failure and another acute condition, the principal diagnosis will depend on the individual patient’s condition and the chief (main) reason that caused the admission of the patient to the hospital.
Septicemia

- A diagnosis of bacteremia R78.81 refers to the presence of bacteria in the bloodstream following a relatively minor injury or infection.
- Septicemia and sepsis are often used to mean the same thing, but they have two distinct and separate meanings.
- Septicemia is a systemic condition associated with pathogenic microorganisms or toxins in the blood (such as bacteria, viruses, fungi, or other organisms). Most septicemias are classified to category A41.-. Additional codes are assigned for any manifestations, if present.
- Negative blood cultures do not preclude a diagnosis of septicemia or sepsis. Query the physician.
- Septicemia is used only when the physician documents a diagnosis of septicemia.
- Urosepsis is not a condition that is classified in ICD-10-CM. A physician query should be initiated for clarification of the condition under treatment.
- Systemic Inflammatory Response Syndrome (SIRS) refers to the systemic response to infection, trauma, burns, or other insult (such as cancer) with symptoms (such as fever, tachycardia, tachypnea, and leukocytosis).
- When a patient has SIRS with no subsequent infection, and is a result of a noninfectious disease (such as trauma, cancer, or pancreatitis), code the noninfectious disease first, and then code R65.10 or R65.11. If an acute organ dysfunction is documented, code that also.
- Sepsis generally refers to SIRS due to infection.
- Severe sepsis generally refers to sepsis with associated acute organ dysfunction.
- If sepsis or severe sepsis is present on admission and meets the definition of principal diagnosis, the systemic infection code should be coded first, followed by the appropriate code from subcategory R65.2- . Codes from subcategory R65.2- can never be assigned as a principal diagnosis. An additional code should be added for any localized infection, if present.
- If sepsis or severe sepsis develops during admission, assign the code for the systemic infection and a code from subcategory R65.2- as a secondary code.
- Septic shock is defined as sepsis with hypotension, which is a failure of the cardiovascular system. Septic shock is used as an additional code when the underlying infection is present.
- For all cases of septic shock, code the systemic infection first (such as A40.-; A41.-; B37.7) followed by code R65.21. Any additional codes for other acute organ dysfunction should also be assigned.

Substance Abuse

- Substance abuse and dependence are classified as mental disorders in ICD-10-CM.
- Alcohol dependence is classified to category F10.2, and nondependent alcohol use is coded to category F10.1.

The physician documentation must indicate the pattern of use.
- There are codes for alcohol withdrawal and drug withdrawal symptoms. These codes are used in conjunction with the dependence codes.
- When a patient is admitted in withdrawal or when withdrawal develops after admission, the withdrawal code is principal.
- There are procedure codes for rehabilitation, detoxification, and combination rehabilitation and detoxification for both alcohol and drug dependence.
Z-Codes

Z-Codes (Z00–Z99) characterize the purpose for an encounter when a disease or injury is not the reason a patient is seeking healthcare services. Z codes can be used in any healthcare setting. Certain Z-codes can be assigned as the principal or first listed diagnosis.

- Special main terms for Z-Codes in the Alphabetic Index of Diseases include:

<table>
<thead>
<tr>
<th>Abnormal</th>
<th>Foreign Body</th>
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<tbody>
<tr>
<td>Admission</td>
<td>Healthy</td>
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<tr>
<td>Aftercare Anomaly</td>
<td>History (family)</td>
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<tr>
<td>Attention to</td>
<td>History</td>
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<tr>
<td>(personal) Boarder</td>
<td>Maintenance</td>
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<tr>
<td>Care of</td>
<td>Maladjustment</td>
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<tr>
<td>Carrier</td>
<td>Observation</td>
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<tr>
<td>Checking</td>
<td>Problem with</td>
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<tr>
<td>Complication</td>
<td>Procedure (surgical)</td>
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<tr>
<td>Contraception</td>
<td>Prophylactic</td>
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<tr>
<td>Counseling</td>
<td>Replacement</td>
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<tr>
<td>Delivery</td>
<td>Screening</td>
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<tr>
<td>Dialysis</td>
<td>Status</td>
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<tr>
<td>Donor</td>
<td>Supervision (of)</td>
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<tr>
<td>Examination</td>
<td>Test</td>
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<tr>
<td>Exposure to</td>
<td>Transplant</td>
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<tr>
<td>Fitting of</td>
<td>Unavailability of medical facilities</td>
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<tr>
<td>Follow-up</td>
<td>Vaccination</td>
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</table>
OUTPATIENT PROCEDURE CODING REVIEW

CMS (Centers for Medicare and Medicaid Services, formerly HCFA, Health Care Financing Administration) administers Medicare and Medicaid.

HCPCS (Healthcare Common Procedure Coding System)
- A coding system describing the physician and nonphysician patient services covered by the government’s Medicare and Medicaid programs.
- Designed by CMS and used primarily to report reimbursable services rendered to the patient.
- Consists of two levels of HCPCS codes for ambulatory (outpatient) patients.

LEVEL I—CPT (Current Procedural Terminology) is a coding system developed by the American Medical Association (AMA) to convert descriptions of medical, surgical, and diagnostic services rendered by health care providers into five-digit numerical codes. The codes are updated annually by AMA.

The CPT coding system:
- provides uniform language to accurately designate medical, surgical, and diagnostic services.
- provides effective means of reliable, nationwide communication between physicians, patients, and third-party payers.
- allows for the ability to compare reimbursements for procedures.

Justification for listing of a procedure:
- The procedure is commonly performed by physicians nationally.
- The procedure must be consistent with modern medical practice.

LEVEL II—National Codes
- Updated by CMS
- Five-digit alphanumeric codes
- Codes exist for products, supplies, and services not included in CPT.
Rules for Coding CPT

1. Determine the service provided by analyzing the statement provided by the physician.
2. Identify the main term(s) in the Alphabetic Index.
   To locate a code in the index, the coder should first look up the procedure or service provided. If the procedure is not listed, look under the anatomic site involved, the condition, the synonym, or the eponym. Follow the guidance of the index in locating the code most accurately describing the service.
3. Write down or note the code number(s) found for the term.
   - If a single code number is given, locate the code in the body of the CPT book. Verify the code and its description against the statement, ensuring they match.
   - If two or more codes separated by a comma are given, locate each code in the body of the CPT book. Read the description of each and select the appropriate code matching the statement.
   - If a range of codes is given, locate the range of codes in the body of the CPT book. Review the description of each entry prior to selecting a code.
4. NEVER code from the Alphabetic Index; look up the codes to verify accuracy.
5. Read all notes that apply to the code selected.
   Notes may appear at the beginning of a section, subsection, before or after a code, or within the code description. Notes are utilized throughout the CPT, requiring special attention and review by the coder. Some of these notes define terms, such as simple, intermediate, and complex wound repair. Other notes provide specific coding instruction applicable to specific codes.
6. Select the appropriate modifier, if applicable, to complete the code description.
7. Code multiple procedures from highest resource intensive to lowest (most complicated to least complicated).

Common Errors That Prevent Payment to Physicians

1. No documentation or incomplete documentation for services billed
2. Missing signatures
3. Consistently assigning the same level of services
4. Billing of a consult instead of an office visit
5. Using invalid codes in the bill due to use of old coding resources or forms
6. Unbundling procedure codes
7. Not listing the chief complaint
8. Abbreviations that are misinterpreted
9. Billing of services included in global fee as a separate professional fee
10. Not using a modifier or use of an inappropriate modifier for accurate payment of a claim
CPT Code Book Format Information

Guidelines provide specific instructions about coding for each section. The guidelines contain definitions of terms, explanations of notes, subsection information, unlisted services, and special reports information.

Sections: There are eight major areas into which all CPT codes and descriptions are categorized. The majority of CPT codes are arranged in numerical order in each section. The first six sections are comprised of five-digit numerical codes. The codes in the last two sections, Category II and Category III Codes, are comprised of five-digit codes—four numbers and a letter.

- Evaluation and Management
- Anesthesia
- Surgery
- Radiology
- Pathology/Laboratory
- Medicine
- Category II Codes
- Category III Codes

Category II Codes are optional tracking codes used to measure performance.

Category III Codes are temporary codes for emerging technology, services, and procedures. These codes can be used for data collection purposes or possibly in the FDA approval process. If a Category III code is available, this code must be reported instead of a Category I unlisted code.

Subsections, subcategories, and headings divide the sections into smaller units, based on anatomy, procedure, condition, description, or approach.

Symbols used in CPT coding: The following symbols are special guides that help the coder compare codes and descriptors with the previous year’s CPT edition, or that provide additional coding guidance.

- Bullet is used to indicate a new procedure or service code added since the previous edition of the CPT manual.
- ▲ Triangle indicates that the code has been changed or modified since the last CPT manual edition.
- + A plus sign is used to indicate an add-on code.
- Null symbol is used to identify a modifier -51 exempt code.
- A right and left triangle indicates the beginning and end of the text changes.
- A circled bullet indicates the code includes moderate sedation.
- Reference to CPT Assistant, Clinical Examples in Radiology, and CPT Changes
- The number sign is used to identify codes that have been resequenced and are not placed numerically.
- Indicates a reinstated/recycled code.

Modifiers: Two-character codes added to CPT codes to supply more specific information about the services provided.

Special reports: Detailed reports that include adequate definitions or descriptions of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service.
Unlisted procedures: Procedures that are considered unusual, experimental, or new and do not have a specific code number assigned. Unlisted procedure codes are located at the end of the subcategories, or headings, and may be used to identify any procedure that lacks a specific code and requires a “special report” submitted at the time of billing.

CPT Index: Located at the back of the CPT manual and arranged alphabetically. To locate terms in the alphabetic index, look under the

- Service/procedure
- Anatomic site/body organ
- Condition/disease/problem
- Synonym
- Eponym (procedure named after someone)
- Abbreviation or acronym (e.g., CBC)

Notations:

- “see”—sends you to a more appropriate section.
- “see also”—cross-reference to refer to another main term.

CPT Appendices in back section of the CPT manual:

- Appendix A: Lists all modifiers with complete explanations for use
- Appendix B: Contains a complete list of additions to, deletions from, and revisions of the previous year’s edition
- Appendix C: Provides clinical examples of Evaluation and Management (E&M) codes
- Appendix D: Contains a listing of the CPT add-on codes
- Appendix E: Contains a list of modifier-51 exempt codes
- Appendix F: Contains a list of modifier-63 exempt codes
- Appendix G: Summary of CPT codes that include moderate (conscious) sedation
- Appendix I: Genetic testing code modifiers
- Appendix J: Electrodiagnostic medicine listing of sensory, motor, and mixed nerves
- Appendix K: Product pending FDA approval
- Appendix L: Vascular families
- Appendix M: Crosswalk to deleted CPT codes
- Appendix N: Summary of resequenced CPT codes
- Appendix O: Multianalyte Assays with Algorithmic Analyses
1. Determine place of service: office, emergency room, or nursing home.
2. Determine type of service: consult, admission, newborn.
3. Determine patient status: new unless seen in last 3 years by the physician or another physician of the same specialty in the same group.
4. Determine the level of each of the three key components:
   A. **History:** problem focused, expanded problem focused, detailed, comprehensive
   B. **Physical examination:** problem focused, expanded problem focused, detailed, comprehensive
   C. **Medical decision making:** straightforward, low, moderate, high
      - New patients, consultations, emergency department services, and initial care: generally require all three key components.
      - Established patients and subsequent care: usually require two of the three key components.
      - Some codes are based on time: critical care, prolonged services.
5. Read Critical Care guidelines carefully. Watch for the procedures that are included in the codes.
6. Read Inpatient Neonatal and Pediatric Critical Care Services and intensive (noncritical) low birth weight services guidelines carefully. Watch for procedures that are inclusive in this area.
7. Be sure to read the coding guidelines for E&M coding carefully.
8. Review definition for “consultations” and determine when consult codes are more appropriate than office visit codes.
9. There are specific codes used for hospital observation services (initial care, subsequent care, and discharge services) and codes for same-day admissions and discharges.
10. When a patient is admitted as an inpatient on the same day that services are provided at another site (office, ER, observation, etc.), only the inpatient services are reported. The E&M services provided in these outpatient settings can be used to determine the level of inpatient services provided.
11. Preventive Care codes are based on the patient’s age.
Some Additional Areas of Interest When Coding with CPT

Abortion

“Incomplete Abortions” and “Miscarriages” are alternate terms for missed and spontaneous abortions.

Spontaneous abortion that occurs during any trimester and is completed surgically, assign 59812.
Missed abortion that occurs during the first trimester, assign 59820.
Induced abortion, which combines curettage and evacuation, assign 59851.
Induced abortion by dilation and evacuation, code 59841.
Induced abortion by dilation and curettage, code 59840. Code 58120 is used for a nonobstetrical D&C.

Angioplasty

Determination of the site and whether it is open or percutaneous.
Open transluminal angioplasty of renal or other visceral arteries, aortic, brachiocephalic, or venous sites code from 35450 to 35460.
Percutaneous transluminal angioplasty of renal or other visceral arteries, aortic, brachiocephalic, or venous sites code from 35471 to 35476.
Endovascular revascularization (open or percutaneous, transcatheater) of lower extremities code from 37220 to 37235.
PTCA: Percutaneous transluminal coronary angioplasty: assign code appropriately from 92920 and 92921.
Percutaneous transluminal angioplasty of the peripheral arteries and visceral arteries: 75962–75968 (Radiology Section) for the radiological supervision and interpretation Codes 92928 and 92929 for stent placement include the PTCA and thus the PTCA is not coded separately.

Appendectomy

There are several codes that are used to describe appendectomies: open surgical appendectomy (including incidental), laparoscopic appendectomy, appendectomy done for a ruptured appendix, and appendectomy done for a specified purpose at the time of other major surgery.

Auditory

Simple mastoidectomy is also called a transmastoid antrotomy (69501).
Apicetomy is the excision of the tip of the petrous bone. This is often performed with a radical mastoidectomy (69530). It would be inappropriate to code 69511 in addition.
Tympanostomy (requiring insertion of ventilating tube). Code 69436, Tympanostomy (requiring insertion of ventilating tube) general anesthesia, and 69433, Tympanostomy (requiring insertion of ventilating tube), local or topic anesthesia, are used for “insertion of tubes.”
Removal of impacted cerumen from one or both ears, use code 69210.
Some Additional Areas of Interest When Coding with CPT (continued)

**Bronchoscopy and Biopsy**

- **Surgical bronchoscopy** includes a diagnostic bronchoscopy.
- **Endobronchial biopsy**, code 31625.
- **Review for types of specimen collection:**
  - Biopsy forceps used to remove tissue
  - Bronchial brush used to obtain surface cells
  - Bronchial alveolar lavage (BAL) used to collect cells from peripheral lung tissue
  - Cell washings used to exfoliate cells from crevices

  Note: Cell washings or brushings are NOT biopsies.

- **Transbronchial biopsy** is performed by positioning the scope in the bronchus nearest to the lesion. A hole is punctured through the bronchus into the lung tissue where the lesion is located. The lesion is then biopsied. Transbronchial lung biopsy is reported with code 31628.
- **Transbronchial needle aspiration biopsy** (31629).
- **Catheter aspiration of tracheobronchial tree at bedside** (31725).

**CABG**

To report combined arterial-venous grafts, it is necessary to report two codes:

1. The appropriate combined arterial-venous graft code (33517–33523)
2. The appropriate arterial graft code (33533–33536)

Procurement of the saphenous vein graft is included in the description of the work for 33517–33523 and is not reported separately.

Procurement of an upper extremity artery is reported separately.

**Casting and Strapping**

Services in the musculoskeletal system include the application or removal of the first cast or traction device only. Subsequent replacement of casts, traction devices, or removals is reported using codes from the 29000–29750 series of codes.

The codes in the 29000–29750 series of codes have very specific guidelines directing the use of the codes.

**Endoscopy**

- **Codes** specify the purpose and site of application.
- **Dx endoscopy** is coded only if a surgical procedure was not done. Surgical endoscopy always includes a diagnostic endoscopy.
- **Code as far as the scope is passed.**
- **Stomach endoscopy** is included with UGI endoscopy, not separately.
- **Multiple codes may be necessary** to cover one endoscopic episode.
- **Colonoscopy**: first determine the route the procedure follows (via colostomy, colotomy, or rectum).
- **Colonoscopy with dilation** of rectum or anorectum, code 45999.
- **Biliary endoscopy** (47550) is only used with 47420 or 47610.
- **EGDs** are coded to 43235–43259.
Some Additional Areas of Interest When Coding with CPT (continued)

Eye and Ocular

**Preliminary iridectomy** is not coded separately if performed as part of a cataract extraction or prior to lens extraction. It is included in the code for the lens extraction.

Two types of cataract extraction:
- ICCE: Intracapsular cataract extraction
- ECCE: Extracapsular cataract extraction

**Do not code medication injections** used in conjunction with cataract surgery. Injections are considered part of the procedure.

**Cataract removal includes** the following in codes 66830–66984.

DO NOT CODE THE FOLLOWING PROCEDURES SEPARATELY: anterior capsulotomy, enzymatic zonulysis, iridectomy, iridotomy, lateral canthotomy, pharmacological agents, posterior capsulotomy, viscoelastic agents, subconjunctival, and subtenon injections.

Female Genital System

Codes 57452–57461 are used to report various cervical colposcopic procedures.

**Code 57455** describes colposcopy with single or multiple biopsies of the cervix.

**Code 58150** describes total abdominal hysterectomy with or without removal of tube(s) or ovary(s).

**Code 58611** is an add-on code that describes tubal ligation or transection when done at the time of Cesarean delivery or intra-abdominal surgery.

Fractures/Dislocations

- Treatment of fractures/dislocations can be open or closed.
- Closed treatment means that the fracture or dislocation site is not surgically opened. It is used to describe procedures that treat fractures by three methods: without manipulation, with manipulation, and with or without traction.
- Open treatment implies that the fracture is surgically opened and the fracture is visualized to allow treatment.
- Skeletal fixation is neither open nor closed treatment. Usually pins are placed across the fracture using X-ray guidance.
- Manipulation is used to indicate the attempted reduction or restoration of a fracture or dislocation.

Genitourinary

Many of the procedures in the urinary system are performed endoscopically—cystoscopy, urethroscopy, cystourethroscopy, ureteroscopy, pyeloscopy, and renal endoscopy.

Most cystourethroscopy codes are unilateral. When a cysto is performed bilaterally, modifier -50 should be appended.

Codes in the 52320–52355 series include the insertion and removal of a temporary stent during diagnostic or therapeutic cystourethroscopic intervention(s).

Cystourethroscopy with removal of a self-retaining/indwelling ureteral stent, planned or staged during the associated normal postoperative follow-up period of the original procedure, is reported by means of code 52310 or 52315 with the modifier -58 appended as appropriate.

Be careful to differentiate between codes for ureteral and urethral procedures.
Some Additional Areas of Interest When Coding with CPT (continued)

**GI Biopsy**

- **Code only the biopsy** if a single lesion is biopsied but not excised.
- **Code only the biopsy** and list only one time if multiple biopsies are done (from the same or different lesions) and none of the lesions are excised.
- **Code only the excision** if a biopsy of a lesion is taken and the balance of the same lesion is then excised.
- **Code both the biopsy and the excision** if both are performed and if the biopsy is taken from a lesion different from that which is excised, and the code for the excision does not include the phrase “with or without biopsy.” If such a phrase is in the code narration, then a separate biopsy code should not be used.

**Surgical endoscopy** always includes a diagnostic endoscopy.

**Modifer -59** may be used to explain unusual circumstances when coding both biopsy and removal of a different lesion.

**Hernia Repair**

- Hernia repair codes are categorized by type (inguinal, femoral, etc.).
- Hernias are further categorized as “initial” or “recurrent” based on whether or not the hernia has required previous repair.
- Age and clinical presentation (reducible versus strangulated).
- Code 49568 is used only with nonlaparoscopic incisional or ventral hernia repairs.

**Immunizations**

**Codes 90460–90474** are used to report the administration of vaccines/toxoids.

**Codes 90476–90749** identify the vaccine PRODUCT alone.

If a combination vaccine code is provided (MMR) it is not appropriate to report each component of the combination vaccine separately.

When the physician provides face-to-face counseling of the patient and family during the administration of a vaccine, report codes 90460–90461.

Do not append modifier -51 to the vaccine/toxoid product codes 90476–90749.

**Integumentary**

**Three types of repairs**: Add lengths of repairs together and use one code for repairs of the same location and same type.

- **Simple**: Superficial wound involving skin and/or subcutaneous tissues and requiring simple suturing.
- **Intermediate**: Involving skin, subcutaneous tissues, and fascia and requiring layer closure. May also be used when a single closure requires intensive cleaning.
- **Complex** repairs requiring reconstructive surgery or time-consuming or complicated closures.

**Debridement is coded separately**: When gross contamination requires cleaning, when appreciable amounts of devitalized or contaminated tissue are removed, and when debridement is carried out separately without primary closure.

**Lesion size** is best found on the operative report.

**Benign or malignant lesion(s)**: Code each lesion excised separately; simple closure after excision of lesion(s) is included in the code.

**Adjacent tissue transfers** include excision of tissues, including lesions.
Some Additional Areas of Interest When Coding with CPT (continued)

Integumentary (continued)

Free skin grafts: Identify by size and location of the defect (recipient area) and the type of graft; includes simple debridement of granulations or recent avulsion.

There are three code ranges:
- Use 15002–15005 for initial wound preparation.
- Use 15040–15261 for autografts and tissue-cultured autografts.
- Use 15271–15278 for skin substitute grafts (homografts, allografts, and xenografts).

Repair of donor site requiring skin graft or local flaps is to be added on as an additional procedure.

Report excision of lesion(s) separately.

Excisional biopsy is used when the entire lesion, whether benign or malignant, is removed.

Breast lesion excisions performed after being identified by pre-op radiological marker (localization wires), use codes 19125 and 19126.

Placement of needle localization wires prior to biopsies, excisions, and other breast procedures, use additional codes 19281–19288.

Laryngoscopy

Many of the codes used to report laryngoscopies include the use of an operating microscope. Therefore, code 69990, microsurgical techniques, requiring the use of an operating microscope (list separately in addition to code primary procedure), would not be used with any codes that include the use of the microscope.

Maternity Care and Delivery

Antepartum care or services provided above the normally expected care (as defined in the CPT book) should be coded separately.

Medical problems complicating labor and delivery management may require additional resources and should be identified by using E&M codes in addition to the codes for maternity care.

For surgical complications of pregnancy, see services in the surgery section.

If a physician provides all or part of the antepartum and/or postpartum patient care, but does not perform delivery due to termination of pregnancy by abortion or referral to another physician for delivery, see the antepartum and postpartum care codes 59425–59426 and 59430.

Patients who have had a previous Cesarean delivery and now present with the expectation of a vaginal delivery are coded using codes 59610–59622. If the patient has a successful vaginal delivery after a previous Cesarean delivery (VBAC), use codes 59610–59614. If the attempt is unsuccessful and another Cesarean delivery is carried out, use codes 59618–59622.

Nasal Hemorrhage

Was it anterior or posterior?
- If anterior, was the hemorrhage simple or complex?
- If posterior, was the control of the hemorrhage an initial or subsequent procedure?

Anterior nasal hemorrhage has likely occurred if the physician inserts gauze packing or anterior packing or performs cauterization.
Some Additional Areas of Interest When Coding with CPT (continued)

Posterior nasal hemorrhage has likely occurred if the physician inserts nasal stents, tampons, balloon catheters, or posterior packing, or if the patient is taken to the OR for ligation of arteries to control bleeding.

Nosebleed subsequent to initial one (30906).

Neurology/Spine Surgery

The spinal and spinal cord injection codes reflect the specific spinal anatomy, such as subarachnoid or epidural; the level of the injection (cervical, thoracic, lumbar, or sacral); and the types of substances injected, such as anesthetic steroids, antispasmodics, phenol, etc.

Injection of contrast material during fluoroscopic guidance is included in codes 62263–62264, 62267, 62270–62273, 62280–62282, and 62310–62319. The fluoroscopic guidance itself is reported by code 77003. Code 62263 describes treatment involving injections of various substances over a multiple-day period. Code 62263 is not reported for each individual injection but is reported once to describe the entire series of injections or infusions.

Code 62264 describes multiple treatments performed on the same day.

Other codes in this section refer to laminectomies, excisions, repairs, and shunts. A basic distinction among the codes is the condition, such as herniated disk, as well as the approach used, such as anterior or posterior or costovertebral.

Lumbar punctures (62270) are also called spinal taps and are used to obtain cerebrospinal fluid by inserting a needle into the subarachnoid space in the lumbar area.

When coding surgery on the spine, there are many sets of guidelines for the coder to review, including those at the beginning of the subsection, as well as throughout the subsection.

Co-surgery is common in spinal surgeries. When two surgeons work together, both as primary surgeons, each surgeon should report his or her distinct operative work by adding modifier -62 to the procedure code and any associated add-on codes for that procedure as long as both surgeons continue to work together as primary surgeons.

Spinal instrumentation is used to stabilize the spinal column during repair procedures. There are two types: segmental and nonsegmental.

- Segmental instrumentation involves attachment at each end of the spinal area and at least one intermittent fixation.
- Nonsegmental instrumentation involves attachment at each end and may span several vertebral segments without intermittent fixation.

Pacemakers

1. Is it permanent or temporary?
2. What was the approach (transvenous or epicardial)?
3. What type of device (electrodes and/or pulse generator)?
4. Where were the electrodes placed (atrial, ventricle, or both)?
6. Was revision of the skin pocket done?
Some Additional Areas of Interest When Coding with CPT (continued)

**Sentinel Nodes**

**Sentinel node** procedures utilize injection of a radiotracer or blue dye. After absorption of dye, the physician can visualize the node(s). Code 38792 is used for identification of sentinel nodes. For excision of sentinel nodes, see 38500–38542.

**Use appropriate lymph node excision codes** to report the excision.

**A second sentinel node** from a different lymphatic chain excised from a separate incision, report the excision and add modifier -59.

**Lymphoscintigraphy**, code 78195.

**Injection for gamma probe** node detection with imaging code 38790.

**Thyroid**

- **Recall** that the thyroid has two lobes, one on each side of the trachea. The procedure may only be unilateral (60220), but it is still considered to be a total lobectomy.

- **Thyroidectomy may be**
  - Total or complete (60240), removing both the lobes and the isthmus. It is not necessary to list the code twice.
  - Partial lobectomy (60210), unilateral, with or without isthmusectomy.

- **Thyroidectomy with neck dissection** (60252 and 60254). Do not assign these codes if an isolated lymph node is excised or biopsied.

**Tonsillectomy and Adenoidectomy**

- Separate codes describe tonsillectomy and adenoidectomy; tonsillectomy alone, whether primary or secondary; adenoidectomy alone, primary; adenoidectomy alone, secondary.

- Separate codes are reported for procedures performed on patients under age 12, and age 12 or older.

- A primary procedure is one in which no prior tonsillectomy or adenoidectomy has been performed. A secondary procedure is one that is performed to remove residual or regrowth of tonsil or adenoid tissue.

**Wound Exploration**

- Wound exploration codes (20100–20103) are used when repair of a penetrating wound requires enlargement of the existing defect for exploration, cleaning, and repair.

- If the wound does not need to be enlarged, then only repair codes from the integumentary section are used.