Welcome!

Assigning ICD-10-CM codes to diagnoses and CPT/HCPCS Level II codes for physician office records can be somewhat intimidating to students at first. No fear! I am going to walk you through this entire process, page-by-page, so you learn how to assign codes to diagnosis and procedures.

You will also see where the codes are entered on a CMS-1500 claim, which is submitted to third-party payers for processing, resulting in reimbursement being provided to the physician (for physician office encounters).

**NOTE:** Chapter 19 of your textbook contains content about the purpose of the CMS-1500, which you can review. You will also take the MEDR 4214 (Insurance and Reimbursement Processing) course in future where you will learn how to complete the CMS-1500 for each type of third-party payer.
Before Assigning ICD-10-CM, CPT, and HCPCS Level II Codes

Before coding the POCases, review the following definitions.

**First-listed Diagnosis** – the condition treated or investigated during the relevant episode of care; coded according to ICD-10-CM.

**NOTE:** When there is no definitive diagnosis, the first-listed diagnosis is the main symptom, abnormal findings or problem.

**Secondary Diagnosis** – the condition(s) that co-exist during the relevant episode of care and affect the treatment provided to the patient; coded according to ICD-10-CM.

**NOTE:** Assign ICD-10-CM codes to secondary diagnoses only if one or more of the following are documented in the patient’s record: clinical evaluation of the condition, therapeutic treatment of the condition, diagnostic procedures performed to evaluate the condition.

**First-listed Procedure or Service** – the procedure or service that has the highest payment associated with it; coded according to CPT and HCPCS Level II.

**Secondary Procedure(s) or Service(s)** – the procedure(s) or service(s) that are less complex than the first-listed procedure; coded according to CPT and HCPCS Level II. Third party payers usually discount payment of secondary procedures and services by 50%.
First-listed Diagnosis

The first-listed diagnosis is the condition treated or investigated during the relevant episode of care, and it is coded according to ICD-10-CM. It is documented by the physician as the "diagnosis" or "assessment" in the progress note (of the physician documentation section of the patient record).

REMEMBER! Coders never assign an ICD-10-CM code to a qualified diagnosis (suspected condition) on an outpatient case. Instead, assign a code for the documented sign or symptom. Physician office records often include a qualified diagnosis because the intent is to identify an established diagnosis as the result of ordered ancillary tests (e.g., laboratory, radiology, and so on).
Secondary Diagnosis(es)

Secondary diagnosis(es) are condition(s) that co-exist during the relevant episode of care and affect the treatment provided to the patient, and they assigned ICD-10-CM code(s). They include comorbidities, complications, and other diagnoses that are documented by the physician in the progress note of physician documentation.

A comorbidity is any condition that co-exists during the relevant episode of care and affects the treatment provided to the patient. Examples include hypertension, asthma, and so on, which are considered when administering anesthesia during surgery.

A complication is any condition that arises during the relevant episode of care and affects treatment provided to the patient. Examples include postoperative wound infections, respiratory problems due to anesthesia administration, and so on, which are coded as complications of surgery.

Coders should also review the entire progress note patient to locate secondary diagnoses that are not documented in the "diagnosis" or "assessment" portion of the progress note.

- Physicians often document chronic conditions, which are coded only if they impact the patient's treatment.
  - For example, a patient is seen in the physician's office for acute bronchitis, and the physician also documents chronic asthma. It is acceptable to code the acute bronchitis as the first-listed diagnosis and the chronic asthma as the secondary diagnosis if the latter was medically managed or treated during the encounter.
  - For example, a patient is seen in the office for a sprained ankle, and the physician also documents hypertension. If the hypertension was not treated or medically managed during the encounter, assign a code to the sprained ankle only.
- Physicians often document personal history (of) and family history (of) conditions, all of which can be assigned codes. However, such codes do not impact the reimbursement rate, and coding them depends on office policy.
- Ancillary reports (e.g., lab data, radiology reports, and so on) document type of bacteria that cause infection (lab data), type of fracture (x-ray report), and so on. Such reports should be reviewed for coding specificity. However, do not assign a code based only on the results of an ancillary report; instead, initiate a physician query to obtain clarification about diagnoses to be coded.

Assign ICD-10-CM codes to secondary diagnoses only if one or more of the following are documented in the patient's record:
  - clinical evaluation of the condition (e.g., ancillary tests such as an X-ray to determine if the ankle is broken or sprained, and so on)
  - therapeutic treatment of the condition (e.g., prescribed medication, office surgery, and so on)
  - diagnostic procedures performed to evaluate the condition (e.g., ancillary tests ordered, such as a urinalysis, to determine if the patient has a urinary tract infection)

REMEMBER! Secondary diagnoses are documented by the physician in the:
  - Diagnosis or Assessment section of the progress notes
  - Narrative of the progress note

NOTE: If you have a question about whether a secondary diagnosis code should be assigned, generate a physician query to obtain clarification (and have the physician amend the list of diagnoses if appropriate). (In this course, post the query in the Discussion Board so your instructor can respond.)

NOTE: When assigning ICD-10-CM codes to secondary diagnoses, review the patient record to locate supporting documentation that allows you to assign the most specific code possible. For example, the face sheet documents “urinary tract infection” as a secondary diagnosis. Upon review of laboratory test results, the coder determines that E. coli bacteria is the cause of the urinary tract infection. Thus, the coder assigns a code for the urinary tract infection and another code for the E. coli bacteria.

NOTE: Secondary diagnoses might not be associated with a particular physician office encounter. Thus, if only a first-listed diagnosis is documented, it is acceptable to report a code for just that condition. This is common for acute conditions (e.g., flu) or trauma encounters (e.g., sprained ankle).

(See image on next page.)
Global Care Medical Center
100 Main St, Alfred NY 14802
(607) 555-1234

PHYSICIAN OFFICE RECORD

PATIENT NAME: TIBBS, Carminie
PATIENT NUMBER: POCase001
DATE OF SERVICE: 08-26-YYYY
DATE OF BIRTH: 07-07-1948

NURSING DOCUMENTATION:

MEDICATIONS, ALLERGIES, REACTIONS: None
CURRENT MEDICATIONS: Lithium 1,500 mg
BP: 130/80 P: 84 R: T: WT: 265
CC: Patient states he feels well today. Was seen in outpatient psych today.
PMH: Bipolar disorder, manic type.
NOTES: Veteran here for scheduled appointment. Voices no concerns.
SIGNATURE OF NURSE: Reviewed and Approved: Jeanette Allen RN ATP-B-S:02:1001261385: Jeanette Allen RN (Signed: 8/26/YYYY 2:20:44 PM EST)

PHYSICIAN DOCUMENTATION:

HISTORY: Patient seen today for regular appointment. He appears relaxed, cooperative, and coherent. No evidence of recurrent manic behavior. He is a 46-year-old, divorced twice, Navy veteran, who served from 1971 to 1975 as a machinist mate in non-combat situation. He has been suffering from bipolar disorder, manic type, and takes medication, lithium 1,500 mg a day, which seems effective. He has been employed at Alstom plant as a machinist for nine years, full-time.
Mental Status Exam: He has been doing very well with the current medication. No evidence of memory loss or any psychotic behavior. His affect is appropriate, and mood is stable. Insight and judgment are good. He is not considered a danger to himself or others.
DIAGNOSIS: Bipolar disorder, manic type.
PLAN: Continue lithium 1,500 mg a day.

SIGNATURE OF PROVIDER: Reviewed and Approved: Raymond Massey MD ATP-B-S:02:1001261385: Raymond Massey MD (Signed: 8/26/YYYY 2:20:44 PM EST)
Raymond E. Massey, M.D.
Psychiatrist

Upon review of the entire physician progress note, it is determined that there are no secondary diagnoses. Thus, there are no secondary ICD-10-CM codes to be assigned.
First-listed Procedure or Service

In the physician office setting, the **first-listed procedure (or service)** is usually assigned a code from the CPT Evaluation and Management (E/M) section. The only exception to this rule is when the patient undergoes office surgery (e.g., excision of benign lesion), in which case a code is assigned from the CPT Surgery section (instead of the CPT E/M Section).

**NOTE:** If the patient receives E/M services during the same encounter as office surgery, and the E/M services resulted in performing the office surgery, add modifier -25 to the E/M code. Report the CPT Surgery code as the first-listed code and the CPT E/M code as the secondary code (adding modifier -25).
Secondary Procedure(s) or Service(s)

Secondary procedures (or services) are usually less complex than the first-listed procedure.

Secondary procedures are assigned CPT and HCPCS Level II codes, and they may require the addition of a modifier. Refer to the appendix of modifiers, located at the back of your CPT and HCPCS level II coding manuals. Third-party payers typically discount payment of secondary procedures by 50%.

Upon review of the entire physician progress note, it is determined that there are no secondary procedures or services. Thus, there is no secondary CPT or HCPCS level II codes to be assigned.
Sample CMS-1500 for Physician Office (PO) Case

This sample CMS-1500 contains patient data, ICD-10-CM diagnosis codes and CPT procedure and service codes.

In "real life," the physician office insurance specialist completes the CMS-1500 claim:
- Manually, by handwriting or typewriting patient data and codes onto the claim.
- Electronically, by using the electronic medical record to populate fields in the claim and by keyboarding, or selecting from a list, the codes.

The physician office's insurance specialist is responsible for reviewing the completed CMS-1500 claim to verify its accuracy and submitting it to third-party payers. When third-party payers deny a claim, the insurance specialist re-reviews the submitted claim to fix data entry and coding errors.