PEARSON'S

Comprehensive Medical Coding

A Path to Success

Second Edition

Lorraine M. Papazian-Boyce

Includes
ICD-10-CM/PCS
CPT
HCPCS

PEARSON'S COMPREHENSIVE MEDICAL CODING

A PATH TO SUCCESS

Second Edition

Lorraine M. Papazian-Boyce, MS, CPC

AHIMA-Approved ICD-10-CM/PCS Trainer

Educator of the Year—Instruction, 2011,
Career Education Corporation

Most Promising New Textbook Excellence Award, 2013, 2016,
Textbook and Academic Authors Association

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Pearson

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Your path to success in life starts with a decision to begin the journey.

Thank you to my family, friends, and colleagues who have supported and guided my path and life adventures.

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SECTION FOUR

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Preface

Pearson's Comprehensive Medical Coding: A Path to Success, 2e is a comprehensive text on the healthcare industry's coding systems: ICD-10-CM/PCS, CPT, and HCPCS. I am honored that the first edition was awarded *Most Promising New Textbook* by the Textbook and Academic Authors Association.

This text is intended for students studying coding at career colleges, community colleges, and universities. Students might be planning to become dedicated coders or be preparing for a related role, such as health information specialist, clinician, or administrator. The book is also useful for professional coders and providers, as well as billers, claims examiners, and medical assistants.

The material is written to be friendly to those with basic exposure to medical terminology and limited or no experience in the medical field. The flexibility of the organization allows the text to be used for a single comprehensive coding course or divided among separate courses on diagnosis coding, physician procedure coding, and inpatient hospital procedure coding. The "Instructor's Resource Manual" provides suggested outlines for various course configurations.

Over 6,200 exercise questions—more than any other coding text—give students ample opportunity to develop and fine-tune their skills. Progressively challenging exercises embedded within the text of each chapter build on one another and guide students through coding principles. End-of-chapter review questions further challenge students and reinforce key concepts.

NEW TO THE SECOND EDITION

My goal in the second edition is to provide updated information, clarify details where needed, and enhance what already works well to make it more useful to students and instructors. Highlights of improvements include:

- Completely updated to 2019 ICD-10 CM/PCS, CPT, HCPCS code sets
- Added a new appendix with all 115 "Key Criteria to Abstracting" tables for easy pull-out reference
- Updated learning objectives to align with the revised Bloom's Taxonomy articulated by AHIMA
- Added two chapters—"Advanced Coding" and "Professionalism and Patient Relations"—to the print text
- Moved most information on hospital reimbursement to Chapter 2, "Coding and Reimbursement"
- Added information on electronic coding tools to Chapter 2, "Coding and Reimbursement"
- Updated and reorganized ICD-10-PCS chapters for easier reference
- Added "Key Criteria to Abstracting" tables for characters 3 through 7 of ICD-10-PCS codes in Chapter 47
- Added multiple-choice coding questions in all coding chapters to mirror certification exam format
- Expanded emphasis on coding guidelines for all code sets
- Created new Professional Profiles to open each section
- Created new anatomic illustrations to enhance challenging concepts, including a new figure depicting the seven PCS surgical approaches and their variations
- Removed first edition chapter, "Transition ICD-10 CM/PCS"
- Removed first edition chapters on ICD-9-CM
- Updated and added tables, charts, and figures
- Updated and added new coding examples
- Updated and reorganized chapter review questions
- Added pertinent new coding information
- Added laterality to pertinent codes
- Expanded modifier coverage
- Updated and added Guided Examples where appropriate
- Updated all SpeedeCoder screenshot figures
- Updated Coder's Index
- Updated Glossary
- Added new "References" section at the end of the book, listing all sources mentioned in the text
- Updated *Success Step* and *Coding Caution* features for new coding guidelines
- Streamlined page layout by integrating selected content from first edition *Success Step* and *Coding Caution* features into the running narrative

CONCEPTUAL APPROACH

The goal of this text is not only to create a comprehensive coding text but to approach coding in a way that gives instructors unique tools to communicate successfully and gives students a unique approach to learn effective coding skills. This approach is applied to all code sets and has proven successful in the classroom over the past eight years of this text and its predecessor, *ICD-10-CM/PCS Coding: A Map for Success*. Four concepts are the focus of each chapter.

Abstracting, Assigning, and Arranging Codes

Students need a simple and methodical approach to the complex coding process. This text organizes coding around the learning mnemonic for an "Ace" coder: *abstract, assign, and arrange (sequence)* codes. Each coding chapter includes a section of the chapter for each concept, complete with a Guided Example and exercises.

The *Abstracting* section of each chapter focuses on how to read and interpret documentation and identify key pieces of information without assigning any codes. A unique and original table, Key Criteria for Abstracting, appears for each body system to guide students through details specific to each body system.

The *Assigning* section of each chapter focuses on the mechanics of navigating the coding manuals and determining the correct code. Annotated and color-coded illustrations of pages from the indices and tabular lists of each coding manual visually guide students through what can sometimes be a dizzying array of Main Terms, subterms, and code options.

The *Arranging* section of each chapter focuses on identifying when multiple codes are required and how to sequence them, as well as how to apply modifiers based on coding guidelines and conventions.

The *Official Guidelines for Coding and Reporting* (OGCR) and CPT guidelines are integrated into each chapter's discussion and highlighted with examples. We do not reprint guidelines in their entirety as is done in many texts. Students should be directed to the current year's guidelines in their coding manuals or online.

Guided Examples walk students through the three steps of coding and reveal the critical thinking process of applying guidelines and negotiating the intricacies of the coding manuals. By consistently and repeatedly focusing on these basic skills, the outcome is students who can tackle a variety of coding scenarios with confidence.

Application of Medical Terminology

Medical terminology skills present one of the greatest challenges to coding students. Unique features in this book help students apply what they learned in medical terminology and anatomy courses to coding. Each chapter begins with a review of medical terminology applicable to the body system being discussed. To support the emphasis on anatomy in ICD-10-CM/PCS, body system diagrams are dually labeled with the English word and the medical combining form, such as *stomach* and *gastr/o*. This helps students make both visual and verbal connections with medical terms. Commonly used prefixes and suffixes, as well as easily confused medical terms, are presented within each body system. Terminology exercises and examples in each chapter show students how to continue building terminology skills and apply them to coding. This section of the chapter reviews medical terminology skills students may have learned in a previous course and introduces basic concepts for students new to medical terminology. Curricula that does not have a medical terminology prerequisite should direct students to online tutorials to familiarize them with basic skills. The outcome is students who understand the terminology they encounter in coding exercises and, as a result, code more accurately.

Relationship of Diagnoses and Procedures

Students need to understand how diagnoses and procedures relate to each other. Every chapter highlights diagnoses and the related treatments together so students learn the relationship between the two. Exercises describe both diagnoses and services, even though the coding focus is on one or the other. End-of-chapter exercises in the procedure coding chapters require both diagnosis and procedure codes. The outcome is students who comprehend the full coding picture and, as a result, make a smooth transition into coding full cases.

Context of the Patient Encounter

Students need to abstract information from a patient encounter rather than code solely from isolated statements that are five to ten words in length. Exercises in this text use an original "mini-medical-record," which presents excerpts of patient, diagnostic, and procedural information. "Tips" accompany difficult exercises to help students interpret the information. The outcome is students who learn abstracting skills in every exercise and are better prepared for advanced coding courses and the workplace.

ORGANIZATION OF THE TEXT

Students are motivated and confident when they understand why they are studying a subject and where they are going before they begin. The organization of this text gives students a context and framework for coding, covers the technical coding topics for each code set in detail, then wraps up the content with a look ahead.

Section One, "Foundations of Coding", establishes the basis of the coding career and the reimbursement process. Students enter coding class with many questions about their future careers, so those questions are addressed up front. Then, by walking students through the claims and reimbursement process, they gain a contextual understanding of how codes are used and how they affect an organization's success.

Section Two, "ICD-10-CM Diagnosis Coding", arranges chapters based on ease of student learning, rather than following the strict order of the coding manual. Four chapters that are used across all body systems appear before the individual body system chapters: symptoms, neoplasms, Z-codes, and external cause codes. The Instructor's Resource Manual provides a cross-walk for those who wish to teach chapters in the traditional order of the coding manual.

Each ICD-10-CM coding manual chapter is covered in one textbook chapter. No coding manual chapters are combined or split, which allows great flexibility to adapt the book to any curriculum format. The chapters can be taught in any order that best suits the curriculum.

Section Three, "CPT/HCPCS Procedure Coding", presents procedure coding for body systems *in the same order as Section Two*, with one body system per chapter. This is convenient for programs that wish to pair diagnosis and procedure coding.

Chapter 27 provides a basic overview of CPT and HCPCS modifiers. Additional details and examples are presented in the section in individual CPT body system chapters. This helps students develop their understanding as they progress through the course rather than isolating all modifier information in a single chapter.

Chapter 28 provides a basic overview of Evaluation and Management (E/M) coding. Subsequent chapters build on this foundation by presenting an E/M case, documentation guidelines, and Guided Example at the end of each CPT body system chapter. This enables students to develop their understanding of E/M throughout the course and to appreciate the total context of a given medical specialty. This approach also allows instructors to be selective about the depth of information covered in class. They can choose to include or exclude the more advanced E/M sections, as applicable to their specific program curriculum.

Section Four, "ICD-10-PCS Coding", provides an introduction to inpatient hospital coding. The emphasis is on helping students understand the purpose of each character of an ICD-10-PCS code and on identifying the characteristics of and differences between ICD-10-PCS root operations. Medical and surgical root operations, which account for 85% of all PCS codes, are covered in greatest detail, in Chapters 46-53, to help students learn the structure and use of ICD-10-PCS. These skills are then applied to the other sections of PCS in Chapters 54-55.

Section Five, "Putting It All Together", consists of two chapters, previously available online. Chapter 56 introduces students to coding from chart notes and operative reports, with hands-on practice. Chapter 57 discusses professionalism in depth to bring students full circle from where they started in Chapter 1 with an introduction to careers.

FEATURES

Consistent pedagogical elements appear in each chapter to facilitate instruction and learning.

Learning Objectives—Each chapter begins with a list of the primary skills students should have after completing the chapter, aligned with Bloom's Taxonomy levels of learning.

Key Terms and Abbreviations—A list of the important terms students need to know but may not have learned in previous classes is provided at the beginning of each chapter. These terms are set in blue boldface type and are defined upon first appearance in the chapter. They are also included in the Glossary at the end of the book.

Chapter Outline—A list of the major topics covered in the chapter appears at the beginning.

Introduction—The text uses analogies at the beginning of chapters to create a "hook" with a common frame of reference and provides a familiar perspective for relating to new information. ICD-10-CM/PCS chapters use travel analogies while CPT chapters use shopping analogies. Instructors can use these analogies as a springboard for student engagement in classroom discussion.

Success Step—Short tips help students abstract, assign, and arrange (sequence) codes.

Coding Caution—Short warnings alert students to coding situations that can be tricky or confusing.

Coding Practice—Coding exercises throughout the chapter consist of three to six patient scenarios related to a specific chapter topic, using the mini-medical-record format. The first exercise in the coding chapters reviews medical terms related to the body system or type of procedure and introduces students to simple coding for the body system. Subsequent exercises walk students through the skills of abstracting, assigning, and sequencing codes. Exercises increase in difficulty as the chapter progresses, while remaining appropriate for an introductory course.

Guided Examples—Step-by-step demonstrations allow students to experience the thinking process of a seasoned coder as they observe a coder abstract, assign, and sequence codes from a mini-medical-record.

Figures—Anatomic illustrations show English names and medical terms for major body parts and organs. Original drawings of disease processes and selected anatomic details clarify difficult coding concepts. Annotated diagrams of sample pages from the coding manuals guide students' understanding of layout and appropriate use. Photographs and graphics portray key points and clarify new information.

Tables—Tables provide definitions of terms, conditions, and treatments, key criteria for abstracting diagnoses, procedures and root operations, and comparative information that highlights key concepts.

Summary—Each chapter ends with a brief restatement of key points in the chapter.

Typefaces and Punctuation

Distinct fonts and color-coding enable students to visually identify various types of information. Typefaces are intermixed in the narrative to highlight information taken directly from a medical record or the coding manual. Three special fonts are used as follows:

- **Key terms and abbreviations**
- Simulated content in a patient's medical record
- **Codes, code titles, and instructional notes from the coding manuals**

The names of chapters, sections, and selected features in the coding manuals are treated as proper nouns and are therefore capitalized. This use is to be distinguished from the common use of a term. For example, the Digestive System subsection of the CPT manual is treated as a proper noun and capitalized. The organ system known as digestive system is a common noun and not capitalized. In Section Four, ICD-10-PCS, the term *Character* is capitalized when referring to the positions in a PCS code. The term *Table* is capitalized when referring to the reference tables in the PCS coding manual. The names of PCS-identified body systems, body parts, approaches, and devices are treated as proper nouns and thus capitalized when referring to a specific value in the PCS code set. Such terms usually appear in the text's designated font for codes. When a body system, body part, or approach is referenced as a common noun, it is not capitalized. This variation in capitalization is intentional for the sake of clarity and is not a copyediting or proofreading error. Information that appears in **this font** is a direct quote from the coding manuals. Spelling, punctuation, and abbreviations reflect the styles of the respective coding manuals

and have not been copyedited to Pearson's style for the text. This practice is intentional for the sake of consistency with the coding manuals and is not a copyediting or proofreading error.

End-of-Chapter Material

The review at the end of each chapter reinforces key concepts, provides opportunity for additional skills practice, and offers resources for additional learning.

Concept Quiz—Definitions and key concepts are reviewed using ten completion and ten multiple-choice questions. Multiple-choice questions include three coding questions formatted similarly to the certification examinations' format.

Keep on Coding—Twenty-five coding exercises in a one-line statement format provide beginning student practice.

Coding Challenge—Ten coding scenarios drawn review beginning and intermediate coding skills with an emphasis on applying the official coding guidelines. The Coding Challenge exercises in procedure coding chapters require both diagnosis and procedure codes for integrative practice. The length of courses and structure of curriculum varies widely among colleges. Based on an individual school's format, instructors may choose to incorporate Coding Challenge exercises into an introductory class or revisit them in a more advanced course.

End-of-Book Material

The following material at the end of the text provides reference information for students.

Glossary—The Glossary defines key terms, supplemental terms, and abbreviations.

Index—An alphabetic cross-walk identifies page references for major topics discussed in this text.

Coders' Index—The Coder's Index lists all codes found in the text and where they are discussed.

Key Criteria to Abstracting Tables—A quick reference pull-out guide provides easy access to all of the Key Criteria to Abstracting tables that appear in the coding chapters.

Resources

- Textbook

The instructor package:

- Instructor's Resource Manual contains detailed lesson plans, homework, discussion topics and teaching tips to help faculty plan and manage the medical coding course
- Answer Key for all exercises in the text
- PowerPoint® slides that align with learning objectives and summarize key learning points
- Testgen® computerized test bank

Interactive Media

Visit our new MyHealthProfessions Lab to accompany *Pearson's Comprehensive Medical Coding: A Path to Success*, 2e. Here you'll find extensive resources, including:

- A pre-/post-test homework engine, which enables students to learn and master concepts as homework, preparing them for classroom work.
- Access your free trial of SpeedeCoder® online medical coding software at **http://sec.pearsonhighered.com**.

ABOUT THE AUTHOR

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Lorraine M. Papazian-Boyce is an award-winning author and instructor. She received the Most Promising New Textbook Award—2016 from the Textbook and Academic Authors Association for this text. She also authored the Pearson text *ICD-10-CM/PCS Coding: A Map for Success*, which received the Most Promising New Textbook Award—2013. She was named Educator of the Year—Instruction in 2011 by Career Education Corporation (CEC).

Lorraine holds an MS in Health Systems Management from Rush University (Chicago) and the Certified Professional Coder (CPC) credential. She is an AHIMA-Approved ICD-10-CM/PCS Trainer. She has taught coding at several ground and online colleges.

Lorraine has over 35 years of experience in healthcare administration as a college instructor, in both traditional and online settings; owner of a medical billing service; office manager; consultant to hospitals, nursing homes, and physicians; and board of directors officer. She is a frequent speaker on billing, coding, and healthcare management. She has taught most aspects of healthcare operations and reimbursement both to practicing professionals and in a formal academic career college setting. She is known as someone who is thorough in covering material and effective in communicating it to learners, in both oral and written formats. She knows exactly where in the curriculum college students struggle, what their questions are, and what techniques best clarify information for them. As a former employer and as an externship coordinator, she also knows what today's students need to succeed in the medical workplace. Her driving passion is taking complex technical subjects and breaking them down into practical, understandable pieces that others can implement.

She is a contributor and/or subject matter expert to several Pearson texts, including *Pearson's Comprehensive Medical Assisting*, 4th ed., by Nina M. Beaman, et al.; *Medical Coding: A Journey*, by Beth A. Rich; *Administrative Medical Assisting: Foundations and Practices*, 2nd ed., by Christine Malone; *Guide to Medical Billing and Coding*, 3rd edition, by Sarah Brown and Lori Tyler; *Comprehensive Health Insurance:*

Billing, Coding, and Reimbursement, by Deborah Vines, Ann Braceland, Elizabeth Rollins, and Susan H. Miller; *A Guided Approach to Intermediate and Advanced Coding*, by Jennifer Lame and Glenna Young; *Mastering Medisoft*, by Bonnie J. Flom; *Medical Assisting: Foundations and Practices*, by Margaret Frazier, et al.; and *Medical Insurance Billing* Course Connect.

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Marlene Pratt, Director, Portfolio Management, recognized my unique approach to coding and supported my vision to create a comprehensive coding solution. She assembled a development and production team who worked tirelessly throughout the project: Faye Gemmellaro, Content Producer; Joan Gill, Developmental Editor, who has been my publishing mentor and friend for more than 12 years; the production team at SPi; and many others unknown to me who finessed the details of this book.

A special thanks is due to Pearson's marketing team whom I've had the pleasure to work with over the years. Your enthusiasm and support for this text has brought a new coding experience to thousands of students and instructors: Brittany Hammond, Senior Field Marketing Manager; Regina Forbes, Sales Director; and Jeff McIlroy, Sales Director; and the many fun and dedicated inside and field reps.

Subject Matter Experts

A team of subject matter experts wrote exercises, reviewed content for accuracy, and added their expertise to the first edition of the text. Their work continues to help make the second edition the best medical coding text available.

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Reviewers from the front lines in the field provided valuable insight and confirmation of this text's approach.

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Guide to Key Features

This Guide to Key Features acquaints users with the text and shows them how to use the pedagogical features to their greatest advantage.

Chapter Opener Features

Learning Objectives—Each chapter begins with a list of the primary skills students should have after completing the chapter, aligned with Bloom's Taxonomy levels of learning.

Learning Objectives

After completing this chapter, you should have the skills to:

16.1 Spell and define the key words, medical terms, and abbreviations related to the nervous system and sense organs. (Remember)

16.2 Summarize the structure, function, and common conditions of the nervous system and sense organs. (Understand)

16.3 Adhere to the Official Guidelines for Coding and Reporting related to the nervous system and sense organs. (Apply)

Key Terms and Abbreviations—A list of the important terms students need to know but may not have learned in previous classes is provided at the beginning of each chapter. These terms are set in blue boldface type and are defined upon first appearance in the chapter. They are also included in the Glossary at the end of the book.

Key Terms and Abbreviations

absence
Alzheimer's disease (AD)
atonic
aura
brain
central nervous system (CNS)
clonic
complex partial
dementia
distributed
focal
generalized
grand mal
gustatory
hemiplegia
homeostasis
idiopathic
intractable
late onset
localized

Chapter Outline—A list of the major topics covered in the chapter appears at the beginning.

Chapter Outline

- **Nervous System Refresher**
- **Coding Guidelines for the Nervous System**
- **Abstracting for Conditions of the Nervous System**
- **Assigning Codes for Conditions of the Nervous System**
- **Arranging Codes for Conditions of the Nervous System**
- **Coding Neoplasms of the Nervous System**

In-Chapter Features

Introduction—The text uses analogies at the beginning of chapters to create a "hook" with a common frame of reference and provides a familiar perspective for relating to new information. ICD-10-CM/PCS chapters use travel analogies while CPT chapters use shopping analogies.

INTRODUCTION

Electrical problems can be one of the most troublesome to solve. A defect in the electrical system located in one part of a car can create a problem in a completely different area. The human nervous system is the electrical system in our bodies, sending and receiving messages that enable us to perform all functions.

A neurologist specializes in diagnosing and treating conditions of the nervous system. Neurosurgeons specialize in performing surgical procedures on the nervous system. Primary care physicians treat uncomplicated conditions of the nervous system and refer more complex cases to a specialist.

Success Step—Short tips help students abstract, assign, and arrange (sequence) codes.

Coding Caution—Short warnings alert students to coding situations that can be tricky or confusing.

SUCCESS STEP

Physicians do not need to use the exact word *intractable* to allow coders to abstract a migraine or epilepsy as intractable. Acceptable terms that mean intractable are *pharmacoresistant*, *pharmacologically resistant*, *treatment resistant*, *refractory*, and *poorly controlled*.

CODING CAUTION

Do not assume that all seizure activity is epilepsy. Seizures may also be caused by high fever, psychological disorders, or other medical conditions such as narcolepsy, Tourette syndrome, or cardiac arrhythmia.

Coding Practice—Coding exercises throughout the chapter consist of three to six patient scenarios related to a specific chapter topic, using the mini-medical-record format. The first exercise in the coding chapters reviews medical terms related to the body system or type of procedure and introduces students to simple coding for the body system.

CODING PRACTICE

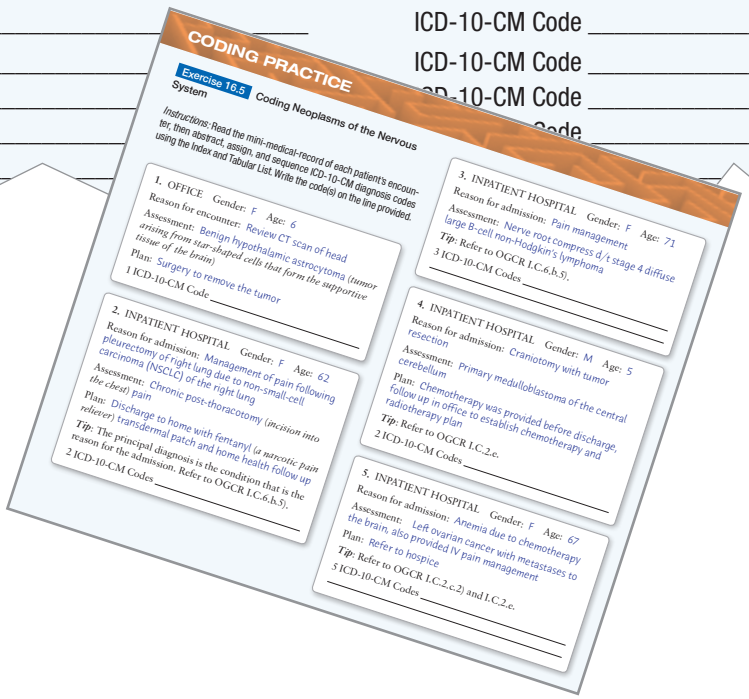
Exercise 16.1 Nervous System Refresher

Instructions: Use your medical terminology skills and resources to define the following conditions related to the nervous system, then assign the default diagnosis code.

Follow these steps:

- Use slash marks "/" to break down each term into its root(s) and suffix.
- Define the meaning of the word based on the meaning of each word part.
- Assign the default ICD-10-CM diagnosis code for the condition using the Index and Tabular List.

Example: neuropathy neuro/pathy	Meaning *abnormal condition of a nerve*	ICD-10-CM Code *G62.9*
1. neuroma (benign)	Meaning _____	ICD-10-CM Code _____
2. neuromyelitis	Meaning _____	ICD-10-CM Code _____
3. encephalomyeloradiculitis	Meaning _____	ICD-10-CM Code _____
4. causalgia	Meaning _____	ICD-10-CM Code _____
5. neuromyotonia	Meaning _____	ICD-10-CM Code _____
6. myelinolysis	Meaning _____	ICD-10-CM Code _____
7. hemichorea	Meaning _____	ICD-10-CM Code _____
8. meningoencephalopathy	Meaning _____	ICD-10-CM Code _____
9. myasthenia	Meaning _____	ICD-10-CM Code _____



Subsequent exercises walk students through the skills of abstracting, assigning, and sequencing codes. Exercises increase in difficulty as the chapter progresses, while remaining appropriate for an introductory course.

Guided Examples—Step-by-step demonstrations allow students to experience the thinking process of a seasoned coder as they observe a coder abstract, assign, and sequence codes from a mini-medical-record.

Guided Example of Assigning Codes for Symptoms and Signs

Refer to the following example to learn how to assign codes for symptoms. This case is similar to the earlier example of Chad Wang, who was seen for nausea, vomiting, and diarrhea and was diagnosed with gastroenteritis. However, notice how this example should be coded differently based on the wording of the Assessment.

Date: 6/1/yy Location: Branton Family Practice
Provider: Kristen Conover, MD
Patient: Charlene Winger Gender: F Age: 15
Chief Complaint: Nausea, vomiting, and diarrhea
Assessment: Suspected gastroenteritis
Plan: Stool culture, bedrest, and plenty of fluids

- Sherry checks for instructional notes in the Tabular List.
  - She cross-references the beginning of category **R11** and reads the **Excludes1** instructional note. None of the conditions listed describe the patient, so she may proceed.
  - She cross-references the beginning of the block **R10-R19** and reads the **Excludes1** instructional note. None of the conditions listed describe the patient, so she may proceed.
  - She cross-references the beginning of **Chapter 18 (R00-R99)** and reads the detailed instructional notes. She determines that note **(e) cases in which a more precise diagnosis was not available** describes this case and that she is coding correctly.
- Next, Sherry searches the Index for the Main Term **Diarrhea**.

Figures—Anatomic illustrations show English names and medical terms for major body parts and organs. Original drawings of disease processes and selected anatomic details clarify difficult coding concepts. Annotated diagrams of sample pages from the coding manuals guide students' understanding of layout and appropriate use. Photographs and graphics portray key points and clarify new information. Screen shots from online coding software introduce students to computerized coding.

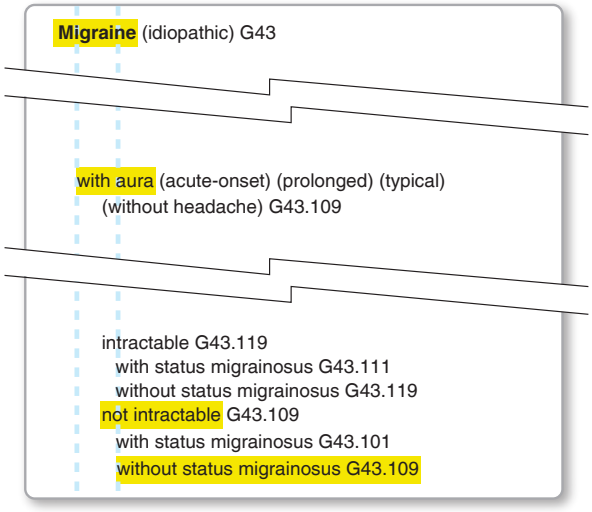
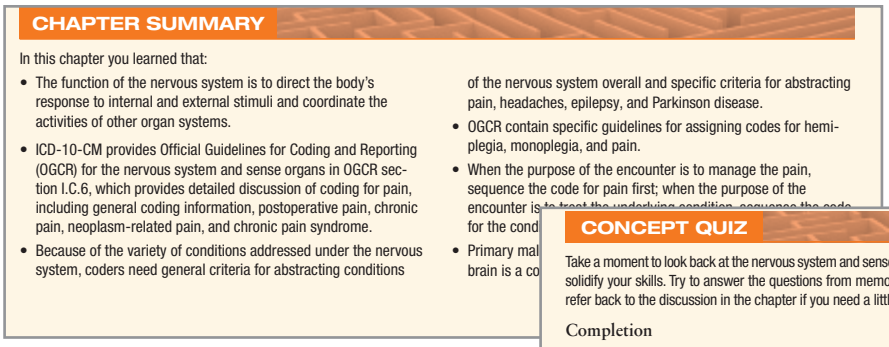


Figure 16-8 ■ Index entry for "Migraine".

Tables—Tables provide definitions of terms, conditions, and treatments, key criteria for abstracting diagnoses, procedures and root operations, and comparative information that highlights key concepts.

Table 16-2 ■ **COMMON DISEASES OF THE NERVOUS SYSTEM**

Condition	Definition
Alzheimer's disease	A progressive degenerative brain disease
Amyotrophic lateral sclerosis (ALS) or Lou Gehrig disease	A chronic, terminal neurological disease characterized by a progressive loss of motor neurons and muscle atrophy
Bell's Palsy	Inflammation of the seventh (VII) cranial nerve, the facial nerve
Cerebral palsy	A functional disorder of the brain manifested by motor impairment
Chronic pain syndrome (CPS)	A collection of pain conditions lasting more than six months and unresponsive to treatment
Cluster headache	Unilateral pain in the eye or temple
Complex regional pain syndrome	A chronic pain syndrome in which an extremity experiences intense burning pain and changes in skin texture and temperature; also called reflex sympathetic dystrophy (RSD)



CHAPTER SUMMARY

In this chapter you learned that:

- The function of the nervous system is to direct the body's response to internal and external stimuli and coordinate the activities of other organ systems.
- ICD-10-CM provides Official Guidelines for Coding and Reporting (OGCR) for the nervous system and sense organs in OGCR section I.C.6, which provides detailed discussion of coding for pain, including general coding information, postoperative pain, chronic pain, neoplasm-related pain, and chronic pain syndrome.
- Because of the variety of conditions addressed under the nervous system, coders need general criteria for abstracting conditions of the nervous system overall and specific criteria for abstracting pain, headaches, epilepsy, and Parkinson disease.
- OGCR contain specific guidelines for assigning codes for hemiplegia, monoplegia, and pain.
- When the purpose of the encounter is to manage the pain, sequence the code for pain first; when the purpose of the encounter is to treat the underlying condition, sequence the code for the cond
- Primary mal brain is a co

Summary—Each chapter ends with a brief restatement of key points in the chapter.

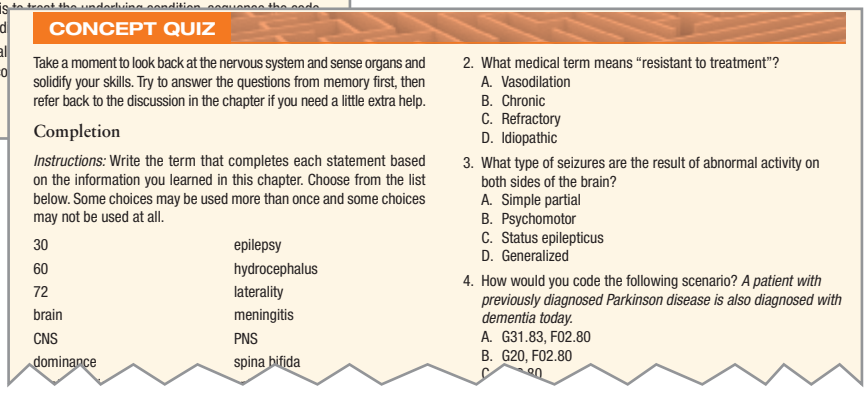
End-of-Chapter Features

The review at the end of each chapter reinforces key concepts and provides opportunity for additional skills practice.

Concept Quiz—Definitions and key concepts are reviewed using ten completion and ten multiple-choice questions. Multiple-choice questions include three coding questions formatted similarly to the certification examinations' format.

Keep on Coding—Twenty-five coding exercises in a one-line statement format provide beginning student practice.

Coding Challenge—Ten coding scenarios drawn from all sections of the chapter review beginning and intermediate coding skills with an emphasis on applying the official coding guidelines. The Coding Challenge exercises in procedure coding chapters require both diagnosis and procedure codes for integrative practice.



CONCEPT QUIZ

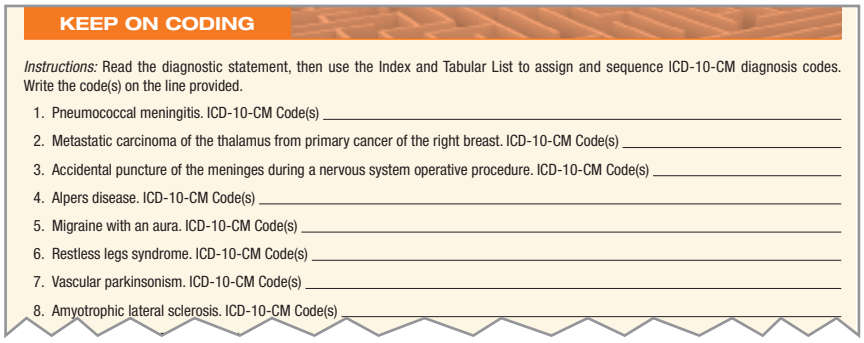
Take a moment to look back at the nervous system and sense organs and solidify your skills. Try to answer the questions from memory first, then refer back to the discussion in the chapter if you need a little extra help.

Completion

Instructions: Write the term that completes each statement based on the information you learned in this chapter. Choose from the list below. Some choices may be used more than once and some choices may not be used at all.

30	epilepsy
60	hydrocephalus
72	laterality
brain	meningitis
CNS	PNS
dominance	spina bifida

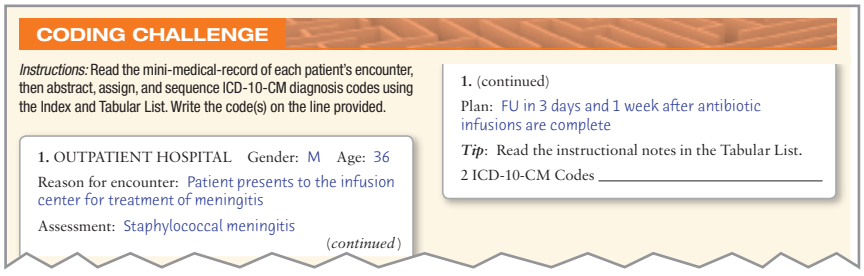
2. What medical term means "resistant to treatment"?
   A. Vasodilation
   B. Chronic
   C. Refractory
   D. Idiopathic
3. What type of seizures are the result of abnormal activity on both sides of the brain?
   A. Simple partial
   B. Psychomotor
   C. Status epilepticus
   D. Generalized
4. How would you code the following scenario? *A patient with previously diagnosed Parkinson disease is also diagnosed with dementia today.*
   A. G31.83, F02.80
   B. G20, F02.80
   C. [illegible]



KEEP ON CODING

Instructions: Read the diagnostic statement, then use the Index and Tabular List to assign and sequence ICD-10-CM diagnosis codes. Write the code(s) on the line provided.

1. Pneumococcal meningitis. ICD-10-CM Code(s) _____
2. Metastatic carcinoma of the thalamus from primary cancer of the right breast. ICD-10-CM Code(s) _____
3. Accidental puncture of the meninges during a nervous system operative procedure. ICD-10-CM Code(s) _____
4. Alpers disease. ICD-10-CM Code(s) _____
5. Migraine with an aura. ICD-10-CM Code(s) _____
6. Restless legs syndrome. ICD-10-CM Code(s) _____
7. Vascular parkinsonism. ICD-10-CM Code(s) _____
8. Amyotrophic lateral sclerosis. ICD-10-CM Code(s) _____



CODING CHALLENGE

Instructions: Read the mini-medical-record of each patient's encounter, then abstract, assign, and sequence ICD-10-CM diagnosis codes using the Index and Tabular List. Write the code(s) on the line provided.

1. OUTPATIENT HOSPITAL Gender: M Age: 36

Reason for encounter: Patient presents to the infusion center for treatment of meningitis

Assessment: Staphylococcal meningitis

(*continued*)

1. (continued)

Plan: FU in 3 days and 1 week after antibiotic infusions are complete

Tip: Read the instructional notes in the Tabular List.

2 ICD-10-CM Codes _____

SECTION ONE

Foundations of Coding

Welcome to your new career in coding! You are in for the trip of a lifetime, one that is sure to take you to new and unknown places, a few familiar ones, and perhaps some that seem a little scary. This text lays out the path to follow, complete with success steps and caution signs.

Section One: Foundations of Coding acquaints you with the medical coding field, potential career opportunities, and how coding relates to reimbursement and payment. It also introduces the three skills of the "Ace" coder—abstracting, assigning, and arranging (sequencing) codes—skills that are the foundation of working with all medical codes.

PROFESSIONAL PROFILE

Jennifer Holland, RHIT, CPC, CIRCC
Coding Audit Response Specialist
Novant Health, Inc.

I have worked in the health information management (HIM) field for 16 years and in coding for 13 years. My first exposure to coding was as an insurance claims specialist where I would process the insurance claims based on the member's benefits. My first coding job was in the HIM department assisting the preregistration team with CPT codes for preauthorizations and precertifications.

Currently I work as a coding audit response specialist working with the charge description master (CDM), billing, and coding denials. I also perform audits as requested by leadership, research trends and offer solutions, and assist teammates with any questions they may have. I enjoy that coding is always changing and that makes it interesting. No two charts are ever the same.

The most challenging part of the job is getting answers to difficult questions that involve other stakeholders in the organization, such as other departmental supervisors, managers, team leads, and clinical documentation staff. I am able to meet the challenge by researching and providing my information to my own supervisor, who will then communicate with the other stakeholders. Usually if there needs to be further dialogue, my supervisor will set up a meeting for the discussion to take place where we are able to come to an agreement.

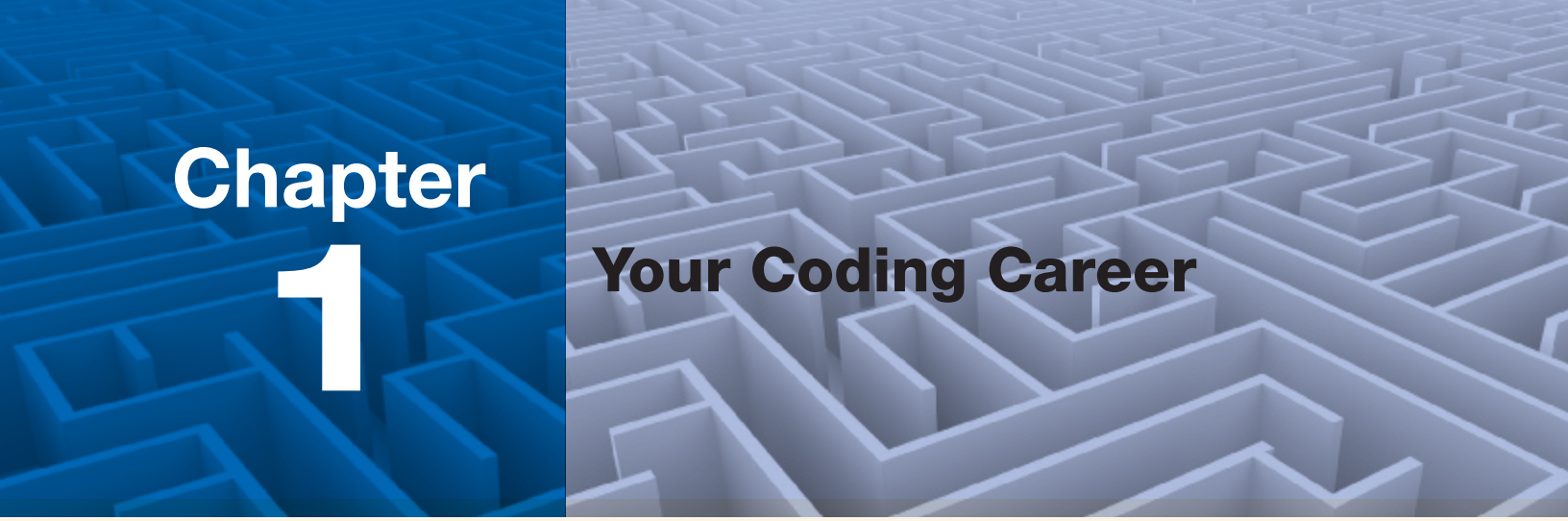
I use an encoder in my job for assigning ICD-10-CM and CPT codes. The software also allows me to look up Correct Coding Initiative (CCI) edits and access coding resources like the *CPT Assistant*.

I have two associate degrees, one in health information technology (HIT) and one in medical office administration. Both degrees have aided in my career preparation because they gave me an understanding of billing and coding. My degree in medical office administration taught me the ins and outs of working in a medical office.

I have my registered health information technician (RHIT), certified professional coder (CPC), and certified interventional radiology cardiovascular coder (CIRCC) certifications. I believe these credentials are vital to my career as it shows potential employers that I am not a novice to this field. They show employers my dedication and commitment to the field and how I will pursue opportunities to maintain and continue my education.

I am a member of AAPC and AHIMA, as well as the North Carolina HIMA local chapter. In my local chapter I have served as the education chair and mentorship program coordinator.

My advice to students is to stay focused, work hard, be patient, continually learn, and do not despise small beginnings. Learn as much as you possibly can and explore new opportunities when afforded to you. You never know what may come of the opportunity that is presented to you.



Chapter 1 Your Coding Career

Chapter Outline

Learning Objectives

After completing this chapter, you should have the skills to:

1.1 Spell and define the key words, medical terms, and abbreviations related to your coding career. (Remember)

1.2 Describe coding, HIPAA-mandated code sets, and coding skills. (Understand)

1.3 Explain how patient encounters relate to coding. (Understand)

1.4 Describe the types of coding certification. (Understand)

1.5 Summarize the career path and performance expectations for a coding career. (Understand)

Key Terms and Abbreviations

AAPC
abstract
admitting privileges
advanced-level job
amend
American Health Information Management Association (AHIMA)
ancillary
arrange
assign
attending physician
career path
case production
certification
clinical documentation improvement (CDI)
code
code set
coding
covered entities
diagnosis
document
encounter
entry-level job
Health Insurance Portability and Accountability Act (HIPAA)
inpatient encounter
midlevel job
outpatient encounter
payers
procedure
query
sequence

In addition to the key terms listed here, students should know the terms defined within tables in this chapter.

INTRODUCTION

When starting on a trip, you are more likely to get where you want to go when you have a destination in mind. In this chapter you learn about your ultimate destination: the coding profession. By understanding what coding is, the nature of patient encounters, professional certification, and potential career opportunities, you will formulate ideas on your career goals and the steps needed to reach them.

Many jobs in the healthcare field work with codes even though they may not have a job title of coder. For example, medical assistants, billers, schedulers, and medical secretaries may use codes as part of their jobs. This text uses the term *coder* to refer to those who assigns, reads, or uses codes as part of job responsibilities.

A wide variety of healthcare professionals, in addition to medical doctors (MDs), provides patient services and uses codes to bill for their services. For example, dentists (DDSs or DMDs), osteopaths (DOs), chiropractors (DCs), and nurse practitioners (NPs) also bill their services with the same codes as physicians. This text uses the terms *physician* and *provider* interchangeably to refer to any healthcare professional who provides services that are billed with codes.

WHAT IS CODING?

Coding is the process of accurately assigning codes to verbal descriptions of patients' conditions and the healthcare services provided to treat those conditions. Medical **codes** are a combination of letters and numbers, three to seven characters in length. **Diagnosis** codes describe patient illnesses, diseases, conditions, injuries, or other reasons for seeking healthcare services. **Procedure** codes describe the services healthcare professionals provide to patients, such as evaluation, consultation, testing, treatments, and surgery.

Code Sets

The healthcare system in the United States uses several distinct systems of medical codes, called **code sets**, for different purposes. The various systems were developed by different organizations and follow different guidelines for their use. The **Health Insurance Portability and Accountability Act (HIPAA)**, a federal law passed in 1996, has numerous provisions relating to consumer health insurance and electronic health transactions. HIPAA defines the code sets that **covered entities** must use for electronic health transactions and the purpose of each (■ TABLE 1-1). Covered entities are health plans, healthcare clearinghouses, and healthcare providers who electronically transmit any health information in connection with transactions for which the Department of Health and Human Services (HHS) has adopted standards.

> **SUCCESS STEP**
>
> When speaking of ICD-10-CM/PCS, coding professionals often use the shorthand *CM* to refer to ICD-10-CM and the shorthand *PCS* to refer to ICD-10-PCS.

Three Skills of an "Ace" Coder

Coding is more than looking up numbers in a manual or software program. Accurate coding requires three major skills, which are described next: abstracting, assigning, and arranging

Table 1-1 ■ **HIPAA-MANDATED CODE SETS**

Code Set Name	Purpose	Developed By	Code Format and Examples
CDT Codes on Dental Procedures and Nomenclature	Dental services (occupies section D of HCPCS codes)	American Dental Association (ADA)	Letter *D* + 4 numbers • D7230
CPT Current Procedural Terminology	Hospital outpatient and physician procedures and services	American Medical Association (AMA)	5 numbers • 99213 • 36415
HCPCS Healthcare Common Procedure Coding System	Supplies, items, and services not covered by CPT, physician and nonphysician services, Medicare services, supplies	Centers for Medicare and Medicaid Services (CMS)	1 letter + 4 numbers • A6461 • G9874
ICD-10-CM International Classification of Diseases, 10th Revision, Clinical Modification	Diagnoses	National Center for Health Statistics (NCHS) based on ICD-10 from the World Health Organization (WHO)	3 to 7 alphanumeric characters • I10 • A52.15 • T50.A11D
ICD-10-PCS International Classification of Diseases, 10th Revision, Procedure Coding System	Hospital inpatient procedures	CMS	7 alphanumeric characters • 0B7B8DZ • 4A04XB1 • F029GCZ
NDC National Drug Codes	Identification of the manufacturer, product, and package size of all drugs and biologics recognized by the Food and Drug Administration (FDA)	Department of Health and Human Services (HHS)	10 numbers divided into 3 segments • 1234-5678-90 • 12345-678-90 • 12345-6789-0

(sequencing). Memorize these definitions and remind yourself of them each time you sit down to code.

Abstracting

Before coders can assign codes, they **abstract** information from the medical record. To abstract, coders read the medical record and determine which elements of the encounter require codes. They identify the reason for the encounter, diagnostic statements from the physician, complications and coexisting conditions, and the services provided. If the medical record is not properly abstracted, it is impossible to assign the correct codes. Each code set has rules for abstracting, and some rules are specific to a particular condition or procedure.

SUCCESS STEP

The term *abstract* also describes a task in health information management in which inpatient coders review the medical record and cull data required for reporting, such as patient demographics and length of stay.

Assigning

Coders must select or **assign** codes to accurately describe both the information documented in the medical record and the patient's condition and services. Each character of the code must be correct. Diagnosis and procedure codes must reflect the highest level of specificity possible and contain the correct number of characters for that code. The official guidelines on how to assign codes vary among code sets because each has slightly different requirements.

Arranging (Sequencing)

When more than one diagnosis or procedure code is required for an encounter, coders must **arrange**, or **sequence**, the codes in a specific order. This coding step requires that you learn the rules for multiple coding (*situations in which more than one code is required*). Sequencing rules are different for each code set. Code sequencing affects how reimbursement is calculated. Official coding guidelines of the various code sets dictate the proper sequencing, based on the codes assigned and the circumstances of the patient encounter. Codes that are not sequenced properly are considered to be incorrect.

CODING PRACTICE

Exercise 1.1 What Is Coding?

Instructions: Write the answers to the following questions in the space provided.

1. Define *coding*. _____

2. What is the difference between diagnosis coding and procedure coding? _____

3. List and briefly define the three skills of an "Ace" coder. _____

UNDERSTANDING PATIENT ENCOUNTERS

Coders assign diagnosis and procedure codes to a patient **encounter** (*a specific interaction between a patient and healthcare provider*) after an encounter has been completed. The provider documents the reason(s) for the encounter and the services provided in the patient's medical record. Coders read the medical record and other information the physician provides to identify the main reason for the encounter, any additional reasons for the service, the main service provided, and any additional services provided. The following sections describe an overview of patient encounters with the healthcare system, including the types of encounters and the process of an encounter. This helps coders better understand their role.

Types of Encounters

Patient encounters are generally classified by the location of the encounter because different coding and billing rules apply to each. The two basic types of locations are outpatient and inpatient, which are described next.

Outpatient Encounters

An **outpatient encounter** is a physician interaction with a patient who receives services and has not been formally admitted to a healthcare institution, such as an acute-care hospital, long-term care facility, or rehabilitation facility. Patients request outpatient encounters when they have particular health problems, need preventive services, or for follow-up or ongoing treatment for known problems. ■ TABLE 1-2 lists examples of outpatient encounters.

Inpatient Encounters

An **inpatient encounter** is a physician interaction with a patient who has been formally admitted to a healthcare facility, such as an acute-care hospital, long-term care facility, or rehabilitation facility. Patients cannot admit themselves to a facility; a

Table 1-2 ■ **EXAMPLES OF OUTPATIENT ENCOUNTERS**

Setting	Purpose	Examples
Ambulatory surgery	Surgical procedure that does not require an overnight stay in the hospital	Tonsillectomy, cataract removal
Cardiology lab	Testing to evaluate a heart problem	EKG, echocardiogram, cardiac catheterization
Diagnostic radiology	Imaging study to evaluate or diagnose a health problem	X-ray, MRI, CT, PET
Emergency department	Treatment of an injury or health problem that cannot be delayed without harm to the patient	Broken leg, chest pain
Laboratory	Specimen collection	Blood draw
Observation	Extended monitoring that may require an overnight stay but does not meet the requirements for a formal inpatient admission	Chest pain
Physical therapy	Treatment of a musculoskeletal problem	Therapeutic exercises, electrical muscle stimulation
Physician office	Evaluation and management of a new or existing health problem; preventive care services	Back pain, diabetes checkup, immunization
Therapeutic radiology	Receive a treatment using radiation	Anticancer radiation therapy

physician must admit a patient for a specific medical reason, which is to either diagnose or treat a health problem. Physicians contract with hospitals for **admitting privileges**, meaning they have authority to admit patients and care for them in a specific hospital. They write admitting orders, conduct an admitting history and physical, and complete paperwork required by the institution. One physician, usually the one who admits the patient, is the **attending physician** who oversees and coordinates all aspects of the patient's care while an inpatient. Other physicians also may be involved in the diagnosis or treatment of the patient. A patient may also receive **ancillary** services—such as laboratory, radiology, or physical therapy—as an inpatient.

The facility codes and bills for the room, board, nursing care, use of the operating room, and most ancillary services. Physicians code and bill for services they personally provide, such as hospital visits, surgical procedures, and interpretation of laboratory or radiology tests. A third-party company may contract with the facility to provide services such as radiology or physical therapy, in which case that company codes and bills its own services to the patient.

Therefore, coders do not code for everything pertaining to a specific patient. They code for the services provided by their employer, such as the hospital, the surgeon, or the physical therapist. They also code for the diagnoses that describe why the patient received these particular services, but they do not code for unrelated diagnoses.

Steps in the Encounter

While each encounter is unique to the patient's situation, it generally involves three steps: diagnosis, treatment, and documentation ■ FIGURE 1-1).

Diagnosis

When a patient presents to a physician with a health problem, the physician needs to establish a diagnosis. If a diagnosis was established in a previous encounter, the physician reviews the patient's progress and updates the diagnosis. Establishing or updating a diagnosis involves a history, a physical examination, and testing.

History. A physician takes a patient's medical history, which includes questions about current symptoms and past medical problems. Because most symptoms can be caused by several different conditions, the physician asks a series of questions to narrow the possibilities. If a diagnosis was established in a previous encounter, the physician updates the history based on what has happened since the last encounter.

Physical Examination. The physician conducts a physical examination to further identify and evaluate abnormalities. The examination may focus on a specific body system or it may cover the entire body. Examinations include visual inspection, palpation (*physical touching*), and auscultation (*listening to various parts of the body*).

Testing. A physician performs or orders diagnostic tests, including blood tests, imaging, biopsies, and physical function tests, such as EKGs, based on the patient's situation. In some cases, the patient's condition does not require any tests.

Antoniodiaz/Shutterstock

Figure 1-1 ■ Patient encounters include a diagnosis, treatment plan, and documentation.

Based on the findings from these sources, the physician identifies the most likely diagnosis and the rationale for it. Depending on the complexity of the problem, the physician may determine the diagnosis in a single encounter or it may take multiple patient encounters and multiple rounds of testing to arrive at a conclusion.

Treatment Plan

After establishing the diagnosis, the physician formulates a treatment plan. The treatment plan may include medication, surgery, lifestyle changes, or therapy. For complicated problems that take time to diagnose, the physician may treat symptoms to provide relief to the patient until the underlying cause is determined. Payers do not reimburse for every treatment recommended by physicians. Some treatments require preauthorization by the payer. As codes become more specific and detailed, payers update requirements and often place more restrictions on approvals. If a payer does not offer reimbursement for a recommended service, patients have the option to pay for it themselves. Providers may negotiate a payment plan to make this more manageable for patients. Preauthorization is discussed in greater detail throughout this text.

Coders do not code for services listed in the treatment plan that will be provided at a later date or by a different provider. Code only for services completed on a specific date of service.

Documentation

After each patient encounter, the physician must **document** the encounter, recording the reason for the encounter, the diagnostic techniques used, tests or treatments planned, and the overall assessment of the patient.

Although physicians generally do not assign the final codes, they must ensure that their documentation provides the information required for accurate coding. Physicians need to be knowledgeable of documentation requirements for ICD-10-CM diagnoses and CPT procedures. Those who perform inpatient hospital procedures also must be familiar with ICD-10-PCS requirements. Recall that hospitals use PCS codes to report the facility portion of inpatient procedures that physicians perform. Even though physician offices do not report ICD-10-PCS codes, physicians' hospital documentation must provide the required information for hospital coders.

Clinical documentation improvement (CDI) is an internal process to identify areas in which documentation does not provide all the information needed to code and educate providers regarding the details needed. Hospitals as well as physician practices conduct studies that evaluate random samples of various types of medical records. They determine whether the documentation contains the required level of detail for coding to the greatest level of specificity. Then they develop a priority list of specific diagnoses and procedures that require more detail or other changes and implement a provider education process.

Physician documentation is the basis from which coders assign diagnostic and procedure codes for each encounter. Coders *do not* do the following:

- Determine what is wrong with the patient
- Determine what condition(s) the patient has based on the symptoms
- Code for services provided prior to the current encounter
- Code for services planned but not provided during the current encounter
- Code for services delivered by other providers
- Code for past conditions that are resolved
- Code for current conditions that the physician does not document as relevant to the current encounter

When the documentation is unclear, coders do not make assumptions about missing information. They send a **query** (*a written communication asking for clarification and/or additional details*) to the physician for more information. The physician must **amend** (*add information to*) the medical record, if necessary.

Guided Example of a Patient Encounter

Refer to the following example to learn more about how physicians diagnose a problem, develop a treatment plan, and document patient encounters. Sherry Whittle, CPC, is a fictitious certified coder who guides you through documentation and coding.

▶ Patient Norman Markowitz, age 41, schedules an office appointment to see Dr. Kristen Conover, a family practice physician, on January 5, due to back pain.

- ❑ Dr. Conover takes a history by asking Mr. Markowitz when the pain started, how severe it is, what makes it better or worse, and if it has occurred before.
- ❑ She performs a physical examination to see if she can detect abnormalities such as tightness, lumps, knots, or protrusions.
- ❑ She asks Mr. Markowitz to perform specific maneuvers, such as standing, sitting, and leaning forward or backward, to determine his physical abilities.
- ❑ She uses a reflex hammer to test his reflexes.
- ❑ She takes an x-ray in the office, which is negative for a fracture.

▶ Next, Dr. Conover provides a treatment plan.

- ❑ She prescribes methocarbamol and tramadol to relieve Mr. Markowitz's back pain while waiting for results of blood tests and an MRI. She orders blood tests, which come back negative for arthritis on January 12.
- ❑ She schedules Mr. Markowitz for an MRI examination on January 17, which reveals a displaced intervertebral disc.

- ❑ After she receives the MRI results of a displaced disc, she asks Mr. Markowitz to schedule another appointment for follow-up.

▶ Dr. Conover documents the January 5 encounter.

Date: 01/5/yy

Patient: Norman Markowitz Gender: M Age: 41

Chief complaint: Low back pain that started about a month ago.

Assessment: Patient was last seen 6 months ago for annual checkup.

History: Detailed history of low back pain problem that started about a month ago. Patient does not recall a specific incident or injury that may have led to the pain.

Examination: Lumbar region is tight to palpation. Patient shows limited range of motion on flexion, extension and rotation. Reflexes are normal. X-ray taken in office is negative for fracture.

Plan: Rx methocarbamol and tramadol. Lab work ordered. MRI scheduled for January 17.

▶ On January 24, Mr. Markowitz returns for a follow-up visit to review next steps.

- ❑ They discuss treatment options and decide to continue medication and refer Mr. Markowitz for physical therapy.
- ❑ They also discuss the possibility of surgery if physical therapy does not provide adequate relief.

▶ Dr. Conover documents the January 24 encounter.

Date: 01/24/yy

Patient: Norman Markowitz Gender: M Age: 41

Reason for encounter: Follow-up on MRI and lab results

Assessment: Bloodwork is negative for arthritis. MRI shows displacement of L4-5 disc.

Plan: Continue medication. Referral made to physical therapy. Consider surgery if physical therapy does not provide relief. Follow up 6 weeks.

▶ Sherry Whittle, CPC, codes for two outpatient encounters for Mr. Markowitz, January 5 and January 24, because those were the two dates that Dr. Conover saw him in the office.

▶ For the January 5 encounter, Sherry assigns the ICD-10-CM diagnosis code **M54.5 Low back pain** because Dr. Conover had not yet determined the cause of the back pain.

- ❑ She assigns CPT procedure codes for the office visit and the x-ray that was performed in the office.
- ❑ She does not assign procedure codes for the blood test or the MRI because Dr. Conover did not provide those services. She does not assign codes for the medications prescribed because the prescription will be filled at the patient's pharmacy. These services will be billed by the organization that provides the service. The physician's service of writing the prescription is included in the office visit code.

▶ Sherry finalizes the codes for January 5:

(1) ICD-10-CM: **M54.5 Low back pain**

(2) CPT: **99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity.**

(3) CPT: **72100 Radiologic examination, spine, lumbosacral; 2 or 3 views**

▶ For the January 24 encounter, Sherry assigns the ICD-10-CM diagnosis code **M51.26 Other intervertebral disc displacement, lumbar region** because Dr. Conover established the diagnosis based on the MRI results.

- ❑ She also assigns a CPT code for the office visit.
- ❑ She does not assign procedure codes for physical therapy because Mr. Markowitz will go to a physical therapy clinic for the service. The physical therapy clinic will bill for the services it provides.
- ❑ She does not assign procedure codes for surgery because surgery was not performed.

▶ Sherry finalizes the codes for January 24:

(1) ICD-10-CM: **M51.26 Other intervertebral disc displacement, lumbar region**

(2) CPT: **99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity.**

▶ Finally, Sherry enters the codes and billing information into the computer and submits the claims to the patient's insurance company for payment.

CODING PRACTICE

Exercise 1.2 **Understanding Patient Encounters**

Instructions: Write the answers to the following questions in the space provided.

1. When do coders assign codes to patient encounters?

2. What are the three steps in a patient encounter?

3. What are the three elements involved in establishing a diagnosis?

CERTIFICATION

Certification is a voluntary achievement that documents that a coder has attained a certain level of proficiency by passing a rigorous examination. Certification is offered by professional organizations and is an additional step beyond a formal educational degree. It does not replace a degree and a degree generally is not required to become certified. Certification began as a form of recognition before there were many educational degrees in this area. Today, certification plus education enhances a coder's professional standing and often results in higher compensation.

Certification is not mandated by federal or state governments and is not a legal requirement. Individual employers determine whether certification is required and which certification is acceptable.

Most large clinics and hospitals require coders to be nationally certified. Two organizations offer coding certifications that are recognized by most employers: **AAPC** (formerly known as the American Academy of Professional Coders) and the **American Health Information Management Association (AHIMA)**. Both organizations offer several certification credentials, each with a unique focus.

AAPC

Founded in 1988, AAPC has historically focused on physician-based and outpatient coders. Current membership is approximately 155,000. AAPC has local chapters in many cities that hold monthly meetings and workshops and provide networking opportunities for members. Members must follow the AAPC Code of Ethics, which outlines ethical principles of professional conduct related to integrity, respect, commitment, competence, fairness, and responsibility. AAPC offers a wide variety of certifications related to the business side of coding, encompassing areas such as professional (physician) coding, billing, medical auditing, clinical documentation, medical compliance, and physician practice management. The primary certification is Certified Professional Coder (CPC), which focuses on coding of services, procedures, and diagnoses for physician offices. The Certified Outpatient Coder (COC) certification focuses on outpatient hospital services, and the Certified Professional Coder-Payer (CPC-P) focuses on coding and reimbursement skills needed by **payers** (*insurance companies or public programs that pay for healthcare services*). The Certified Professional Coder-Apprentice (CPC-A) is earned by coders with less than two years' professional experience. AAPC also offers specialty coding certifications that enable coders to demonstrate superior levels of expertise in a medical specialty, such as orthopedics, obstetrics, or cardiology. Coders take a separate examination to achieve each type of certification.

AHIMA

Founded in 1928 as the Association of Record Librarians of North America, AHIMA has historically focused on hospital coders and clinical records. Current membership is approximately 103,000. AHIMA's goal is to advance informatics, data analytics, and information governance for healthcare while continuing to lead and support world-class HIM practices and standards. AHIMA has 52 Component State Associations (CSAs) that provide professional education and networking opportunities for members. Members must follow the AHIMA Code of Ethics, which outlines 11 ethical principles related to the coding profession's values and ethical behavior.

The primary certification is Certified Coding Specialist (CCS), which focuses on hospital inpatient and outpatient coding. The Certified Coding Specialist-Physician (CCS-P) certification focuses on physician-based coding. The Certified Coding Associate (CCA) credential is geared toward entry-level coders with little or no job experience. Additional certifications are offered in more specialized functions such as the administration of privacy and security programs in healthcare organizations, data analysis, and medical records administration. Each type of certification requires coders to take a separate examination. When considering which certification to pursue, it is helpful to know if one particular credential is preferred over another in the local geographic area. Research this information by reviewing job postings, talking to the human resources department at area employers, and asking experienced coders in the community. As their careers progress,

some coders choose to obtain certification in more than one area of expertise, such as both physician and inpatient, and may become certified by both AAPC and AHIMA. Refer to the organizations' websites, **www.aapc.com** and **www.ahima.org**, to determine the current requirements for earning each certification.

SUCCESS STEP

Joining your local chapter of AAPC or AHIMA will give you the chance to get to know coders in other companies and can potentially lead to future job opportunities. Networking in this manner is an important part of your career path.

CODING PRACTICE

Exercise 1.3 Certification

Instructions: Write the answers to the following questions in the space provided.

1. What is certification?

_____

_____

_____

2. List and define three certifications offered by AAPC.

_____

_____

_____

3. List and define three certifications offered by AHIMA.

_____

_____

_____

CODING CAREERS

Most coding students are seeking a long-term coding career. In addition to learning the mechanics of coding, students are wise to begin learning about their career path and job performance expectations for accuracy and productivity.

Career Path

A **career path** is the progression of jobs and responsibilities throughout one's working life. In coding, like most careers, new graduates do not start at the top; they start at a basic level and work their way up with greater responsibility and more skills at each level. The career options, compensation, and benefits generally increase at each level of advancement. Advancement may come from within the same organization or it may come by moving to a new organization. In order to plan a possible career path, coding students want to learn about the job market, levels of advancement, and internal and external jobs.

Understanding the Job Market

Coders have many career options regarding where they work and what type of job they perform. While many students imagine themselves working in a hospital, the healthcare field offers many other types of organizations as well. Potential employers include all types of healthcare providers, payers, and third-party service organizations such as medical billing services. Sometimes it is best to start out in a small medical or dental office to get basic experience and then move to a larger organization later in your career. Working for a health insurance company or medical billing service can give coders a broad range of experience that will open up many career options later on. ■ TABLE 1-3 lists examples of various types of healthcare employers.

There are many job titles in the field of medical coding (■ TABLE 1-4). The same job might be called by different titles

Table 1-3 ■ **EXAMPLES OF TYPES OF ORGANIZATIONS THAT MAY REQUIRE CODING SKILLS**

- ❑ Acupuncturist (LAc)
- ❑ Ambulance service
- ❑ Ambulatory surgery center (ASC)
- ❑ Chiropractic office (DC)
- ❑ Clearinghouse
- ❑ Consulting firm
- ❑ Dental office
- ❑ Durable medical equipment (DME) supplier
- ❑ Health insurance company
- ❑ Home healthcare
- ❑ Hospital
- ❑ Laboratory
- ❑ Medical billing service
- ❑ Naturopathic office (ND)
- ❑ Nursing facility (NF)
- ❑ Optometrist (OD)
- ❑ Osteopath (DO)
- ❑ Pharmacy
- ❑ Physician office (medical, surgical, all specialties) (MD)
- ❑ Physical therapy clinic
- ❑ Self-insured employer
- ❑ Temporary staffing agency
- ❑ Third-party administrator (TPA)
- ❑ Workers' compensation (WC)