Medical Coding ICD-10-CM

Diagnosis Coding

General Coding Conventions & Official Guidelines — SECTION I

1. The ICD-10-CM alphabetic index includes: Index to Diseases and Injuries; Neoplasm Table; Table of Drugs & Chemicals; and Index to External Causes.
2. The ICD-10-CM Tabular List includes all codes A–Z.
3. Never code directly from the alphabetic index. Always check the Tabular List to confirm the code is accurate and complete.
4. Codes must be reported to their highest level of specificity. When a coder cannot determine the appropriate specificity from the documentation, the physician should be queried for the detail required.
5. ICD-10-CM codes are three to seven alphanumeric characters. Codes must be reported with the required number of digits, including the seventh character, when applicable.
   - EX: S57.01XA Crushing injury of right elbow, initial encounter
6. INCLUDES, EXCLUDES1, and EXCLUDES2 notations:
   - A. INCLUDES provides additional diagnostic statements that are included in this code description.
     - EX: C93 Monocytic leukemia INCLUDES monocytoid leukemia
   - B. EXCLUDES1 is the same as EXCLUDES in ICD-9-CM, directing you to a more appropriate code category for this condition. This means that this code and the referenced alternative code are mutually exclusive (i.e., they cannot exist in the same patient at the same time).
     - EX: S02.5 Fracture of tooth (traumatic) EXCLUDES1 cracked tooth (nontraumatic) (K03.81)
   - C. EXCLUDES2 identifies conditions that are not included in the code category. The referenced alternative codes may or may not be appropriate to report in addition to this code.
     - EX: O22 Venous complications and hemorrhoids in pregnancy EXCLUDES2 obstetric pulmonary embolism (O88.–)
7. NEC (not elsewhere classifiable) means no other codes are appropriate (same as "other specified").
   - EX: Dependence, drug NEC F19.20
8. NOS (not otherwise specified) means that the documentation does not provide more detail (same as "unspecified").
   - EX: R63.2 Hyperalimentation NOS
9. Brackets [ ] indicate alternative terms (i.e., synonyms, abbreviations, acronyms) in the Tabular List.
   - EX: E05 Thyrotoxicosis [hyperthyroidism]
10. Brackets [ ] can also indicate secondary manifestation codes in the alphabetic index.
    - EX: Disorder, liver, malarial B54 [K77]
11. Italicized brackets [ ] appear in the alphabetic index to signal a second, mandatory code.
    - EX: Retinopathy, arteriosclerotic (I70.8) [H35.0–]
12. Colons (:) are used in the Tabular List to shorten a list by providing a repeated term only once, prior to the colon, to be paired with each of the terms following the colon.
13. Parentheses ( ) are shown surrounding nonessential modifiers—that is, optional terms that may or may not be included in the documentation.
    - EX: R68.11 Excessive crying of infant (baby)
14. Signs and symptoms should only be reported with separate codes when there is no documentation of a confirmed diagnosis that includes those signs and symptoms.
15. Combination codes (i.e., codes that report two diagnoses, a diagnosis with a complication, or a diagnosis with a manifestation) must be used in preference to multiple coding, when appropriate.
    - EX: H66.011 Acute suppurative otitis media with spontaneous rupture of ear drum, right ear
16. Combination codes do not preclude the use of additional codes to report additional details about that condition if they are not provided by the combination code.
17. Each diagnosis code may only be reported once per encounter. This applies to bilateral conditions and when two conditions are reported with the same code.
18. The word "and" should be translated as "and/or."
19. The word "with" also means "due to," as well as "associated with."
20. When the alphabetic index directs you to "see" or "see also," it is providing alternate main terms that might lead to the correct code.
    - Examples:
      - Inflammation, sinus – see Sinusitis
      - Fibrocystic disease – see also Fibrosis, cystic
21. When the direction "see condition" appears in the alphabetic index (typically after a main term that is an anatomical site), it means that you should turn to the main term describing the condition or problem with that anatomical site.
    - EX: Lung – see condition
22. A "Code first..." notation appearing in the Tabular List directs you to do two things:
    - A. Find a second code to completely report this circumstance
    - B. Sequence this second code after the first code
      - EX: H54 Blindness and low vision. Code first any associated underlying cause of the blindness
23. A "Use additional code..." notation appearing in the Tabular List directs you to do two things:
    - A. Find a second code to completely report this circumstance
    - B. Sequence this second code first (list first), before the other code
      - EX: K94.32 Esophagostomy infection. Use additional code to identify the infection
24. A "Code also..." notation appearing in the Tabular List directs you to determine from the documentation if a second code may be necessary to completely report this circumstance. This note relates nothing about how to sequence these codes.
    - EX: Q93.7 Deletions with other complex rearrangements. Code also any associated duplications due to unbalanced translocations, inversions, and insertions (Q92.5)
25. The "Code, if applicable, any causal condition..." notation appearing in the Tabular List directs you to report an additional code only when the documentation states that the additional manifestation is present.
    - EX: N13.8 Other obstructive and reflux uropathy. Code, if applicable, any causal condition first, such as: enlarged prostate (N40.1)
26. A code description that includes the phrase "in diseases classified elsewhere" indicates that this code is reporting the existence of a manifestation and should be indexed after the code reporting the underlying condition or disease.
    - EX: N22 Calculus of urinary tract in diseases classified elsewhere
27. A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a sequela code can be used. Coding of sequela often requires two codes: first the condition or nature of the sequela, followed by the sequela code.
28. A "borderline" diagnosis at the time of discharge is coded as confirmed unless the classification provides a specific entry (e.g., borderline diabetes). If it is a specific borderline code, that specific code should be reported.
29. For Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes, the code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified health care practitioner legally accountable for establishing the patient's diagnosis).
30. For a patient diagnosed with a bilateral condition, when each side is treated during separate encounters, assign the "bilateral" code (as the condition still exists on both sides) for the encounter to treat the first side. For the second encounter to treat the second side (after one side has previously been treated and no longer exists on that side), assign the appropriate unilateral code for the side where the condition still exists (e.g., cataract surgery performed on each eye in separate encounters).
31. Present-on-admission (POA) guidelines: Present on admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

Instructional Notations — SECTION I (continued)

INCLUDES
The word "includes" appears immediately under certain categories to further define, or give examples of, the content of the category.

Excludes Notes
The ICD-10-CM has two types of excludes notes. Each note has a different definition for use, but they are both similar in that they indicate that codes excluded from each other are independent of each other.

EXCLUDES1
A type 1 excludes note is a pure excludes. It means "Not coded here." This note indicates that the code excluded should never be used at the same time as the code above the EXCLUDES1 note. It is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

EXCLUDES2
A type 2 excludes note represents "Not included here." It indicates that the condition excluded is not part of the condition it is excluded from, but a patient may have both conditions at the same time. When an EXCLUDES2 note appears under a code, it is acceptable to use both the code and the excluded code together.

Code First/Use Additional Code Notes
Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, followed by the manifestation. Wherever such a combination exists, there is a "Use additional code" note at the etiology code, and a "Code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation. In most cases, the manifestation codes will have in the code title, "in diseases classified elsewhere." Codes with this title are a component of the etiology/manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code, and they must be listed following the underlying condition.

Code Also
A Code also note instructs that two codes may be required to fully describe a condition, but the sequencing of the two codes is discretionary, depending on the severity of the conditions and the reason for the encounter.

7th Characters & Placeholder 'X'
For codes less than 6 characters that require a 7th character, a placeholder X should be assigned for all characters less than 6. The 7th character must always be the 7th character of a code.

User Guide Of Medical Coding

AAPC

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Coders' Dictionary & Reference Guide - First Edition AAPC,2020-06-30 Finding the coding and billing information you need just got easier The Coders Dictionary Reference Guide is the perfect companion for coding and billing students and busy professionals This unique resource designed for your everyday use provides a complete reference library in one convenient and affordable volume Now you can clear the pile of books from your desk and find all the supporting information you need for medical billing and coding Boost your productivity with fingertip access to medical terms and industry acronyms Double check your modifier usage Find quick answers to your E M anesthesia and surgery coding questions Refer to educational illustrations and solidify your reporting know how with essential lay terms Speed up your workflow with these beneficial features Exhaustive list of thousands of medical terms with definitions in an easy to understand language Billing coding and reimbursement terms defined to familiarize you with current regulations requirements processes and agencies How to guidance for coding procedures from the Surgery section with explanations of common terms Evaluation and Management E M Survival Guideto help you identify the right choice for E M service levels Anesthesia primer to distinguish between various types of anesthesia Modifiers and lay descriptions for CPT and HCPCS modifiers in plain English to eliminate your confusion as to when and how to apply modifiers Lists of prefixes suffixes abbreviations and eponyms frequently used in coding Anatomical illustrations to enhance your understanding of services and procedures Place of service POS and type of service TOS lists And much more **Practice Management Reference Guide - First Edition** AAPC,2020-03-16 Effectively manage the business side of medicine Profit margin collections cash flow compliance human resources health information efficient business processes the broad responsibilities and complex requirements of practice management are endless Drop one ball in the daily juggle and the fallout can be costly There s never enough time which makes it tough to stay on top of regulations and best practices That s where AAPC s Practice Management Reference Guide becomes vital to your organization providing you with one stop access to the latest and best in practice management From office operations to financial oversight the Practice Management Reference Guide lays out essential guidance to help you optimize efficiency security and profitability Benefit from actionable steps to streamline accounts receivable Discover how to bring in new patients and keep the ones you have happy Leverage real world strategies to command payer relations recruitment training employee evaluations HIPAA MACRA Medicare CDI EHR everything you need to ensure bountiful operations in 2020 and beyond With the Practice Management Reference Guide you ll gain working knowledge covering the spectrum of practice management issues including Negotiating favorable payer contracts Preventing an appeals backlog Remaining audit ready Correctly applying incident to billing rules to maximize reimbursement Using assessment tools to evaluate your risk Preparing a risk plan and know what questions to ask Knowing how and why you should implement policies and protocols Complying with state and federal patient privacy rules **Clinical Documentation Reference**

Guide - First Edition AAPC,2020-03-12 It s not the quantity of clinical documentation that matters it s the quality Is your clinical documentation improvement CDI program identifying your outliers Does your documentation capture the level of ICD 10 coding specificity required to achieve optimal reimbursement Are you clear on how to fix your coding and documentation shortfalls Providing the most complete and accurate coding of diagnoses and site specific procedures will vastly improve your practice s bottom line Get the help you need with the Clinical Documentation Reference Guide This start to finish CDI primer covers medical necessity joint shared visits incident to billing preventative care visits the global surgical package complications and comorbidities and CDI for EMRs Learn the all important steps to ensure your records capture what your physicians perform during each encounter Benefit from methods to effectively communicate CDI concerns and protocols to your providers Leverage the practical and effective guidance in AAPC s Clinical Documentation Reference Guide to triumph over your toughest documentation challenges Prevent documentation deficiencies and keep your claims on track for optimal reimbursement Understand the legal aspects of documentation Anticipate and avoid documentation trouble spots Keep compliance issues at bay Learn proactive measures to eliminate documentation problems Work the coding mantra specificity specificity specificity Avoid common documentation errors identified by CERT and RACs Know the facts about EMR templates and the pitfalls of auto populate features Master documentation in the EMR with guidelines and tips Conquer CDI time based coding for E M The Clinical Documentation Reference Guide is approved for use during the CDEO certification exam   **Denials Management & Appeals Reference Guide - First Edition** AAPC,2020-03-17 Recoup lost time and revenue with denials management and appeals know how Claim denials can sink a profit margin And given the cost of appeals roughly 118 per claim not all denials can be reworked A practice submitting 50 claims a day at an average reimbursement rate of 200 per claim should bring in 10 000 in daily revenue But if 10% of those claims are denied and the practice can only appeal one they lose 800 per day upwards of 200K annually Your medical claims are the lifeblood of operations Don t compromise your financial health Learn how to preempt denials with the Denials Management Appeals Reference Guide This vital resource will equip you to get ahead of payers by simplifying the leading causes of denials and showing you how to address insufficient documentation failing to establish medical necessity coding and billing errors coverage stipulations and untimely filing Rely on AAPC to walk you through the appeal process We ll help you establish protocols to avoid an appeals backlog and teach you how to identify and prioritize denials likely to win an appeal What s more you ll learn when a claim can be reopened to fix a problem Collect the revenue your practice deserves with effective denials and appeals solutions Know how to analyze your denials Defeat documentation and compliance issues for successful claims success Utilize payer policy for coverage clues Lock in revenue with face to face reimbursement guidance Refine efforts to avoid E M claim denials Ace ICD 10 coding for optimum reimbursement Put an end to modifier confusion Stave off denials with CCI edits advice Navigate the appeals process like a pro And much more   *Nonphysician Practitioner Reference Guide*

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confidence improve accuracy and increase their chances of success Additionally the MCG tm Manual serves as an invaluable reference for working professionals looking to stay updated on the latest coding standards and best practices Key Features of the MCG tm Manual The MCG tm Manual is packed with powerful tools and resources designed to support learners at every stage of their medical coding journey Some of its standout features include Comprehensive CPT ICD 10 CM and PCS Guidelines Clearly explains medical coding systems with real world applications Step by Step Code Sequencing Instructions Provides detailed guidance on selecting and sequencing codes correctly 2025 Code Guideline Updates Ensures users stay current with the latest coding changes and industry standards Medical Coding Scenarios Enhances practical coding skills by offering real life coding examples and applications AMCI Principal First Listed Principal Procedure Code Selection Charts Helps users determine the correct code assignments efficiently AMCI Test Taking Techniques Proven strategies designed to improve accuracy and confidence during exams AMCI Medical Coding Exam Strategies Offers guidance on navigating certification exams with ease AMCI s Simple E M MDM Scoring Chart Simplifies Evaluation and Management E M coding with an easy to use scoring system AMCI s Location Determination Chart A quick reference guide for accurate location based coding decisions Integrated AMCI ADVANCED Medical Coding Lectures Ten in depth lectures covering critical coding concepts not course lectures Nine Integrated AMCI TAP Lectures Detailed instruction on how to annotate ICD 10 CM guidelines into ICD CM for better retention and understanding Exclusive Introduction to Evaluation and Management Lectures Four brand new lectures covering E M coding essentials NEW for 2025 1 000 Digital Medical Coding Exam Practice Questions with Rationales Enhances exam readiness by providing practice questions with detailed explanations Who Can Benefit from the MCG tm Manual This manual is an invaluable resource for Medical Coding Students Provides structured learning to help students grasp coding fundamentals Certification Exam Candidates Equips test takers with strategies and practice materials for passing exams Medical Coding Professionals Supports ongoing learning and professional development Healthcare Administrators a **Evaluation and Management Coding Reference Guide - First Edition** AAPC,2020-06-30 Defeat the challenges that threaten your E M claims and compliance success Evaluation and management E M services are the lifeblood of your revenue stream and yet they re the most problematic to report Claim denials remain high E M coding errors in fact rose from 11 9% in 2018 to account for 12 8% of CMS s overall 2019 improper payment rate How much E M revenue are you losing Safeguard your organization from claim denials and audit scrutiny with the Evaluation Management Coding Reference Guide Our experts break down E M coding rules and requirements into simple manageable steps written in everyday language to boost your E M reporting skills Learn how to capture the key components of medical history physical exam and medical decision making and capitalize on real world clinical scenarios to prevent over or under coding The Evaluation Management Coding Reference Guide will help you prep for 2021 E M guideline changes overhauling new and established office and outpatient services and walk you through online digital E M services remote physiologic

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EHR Immunize your workstations Implement HIPAA compliant use of mobile devices Ensure your BAAs are HIPAA compliant Prepare for community wide disasters Plot out your practice s security incident response plan **Guide to U.S. Government Publications** ,2008-08 This comprehensive yet concise annual annotated reference source catalogs the important series periodicals and reference tools published by U S government agencies Over the years the index section of the Guide to U S Government Publications has expanded to more than 40 000 entries Agencies and titles are indexed followed by a keyword title index for quick and easy referencing No other single resource provides historical and current information on U S government publications in one place **Medical Coding Online (Classroom) for Step-by-Step Medical Coding 2006 (User Guide and Access Code)** Carol J. Buck,2005-12 Medical Coding Online represents a complete course on advanced coding combining content self study and assessment into one product that can be immediately implemented as part of a distance learning program or used to enhance a traditional classroom The course book provides all the content in detail while the online component reinforces the important concepts in concise lessons incorporating figures photographs audio narrated slide shows and links to relevant web sites Self study includes a variety of interactive activities including unique case based exercises designed specifically for medical coding Includes a variety of student and instructor communication options such as real time chat class calendar e mail connections bulletin board digital drop box discussion board Instructor syllabus and gradebooks to allow for flexibility and enhanced learning Uses a unique case approach to advanced coding so students will get a more accurate feel for what a coder does on the job as well as matching fill in the blank multiple choice and true false Each on line chapter includes engaging synopses of all the lessons in the textbook Includes approximately 18 slide shows with audio narration to explain physical processes being demonstrated Hot concept key terms within text provides definitions of key concepts terms at a single click to enables student to access correct definitions instantly Lesson Lectures contain hypertext links opening pop up boxes with further explanations to enable students to dig deeper into the content Automatically scores end of chapter assessments to allow instructors to evaluate their students comprehension and know their grades at any time during the progression through the course Extensive glossary provides definitions of approximately 650 key terms All content has been updated to current industry standards and for use with Step by Step Medical Coding 2006 edition The entire design has been updated to make the course more easy to use **Medical Coding ICD-10-CM** Shelley C. Safian,2017-11 Updated for 2018 ICD 10 CM International Classification of Diseases Clinical Modification guidelines this 6 page laminated guide covers core essentials of coding clearly and succinctly Author Shelley C Safian PhD RHIA CCS P COC CPC I AHIMA approved ICD 10 CM PCS trainer used her knowledge and experience to provide the largest number of valuable facts you can find in 6 pages designed for you to find answers fast with color coded sections and bulleted lists A must for students seeking coding certification and a great desktop refresher for professionals for classifying and coding diagnoses symptoms and procedures recorded in conjunction with hospital care 6 page laminated guide includes

General Coding Conventions Official Guidelines Instructional Notations Chapter Specific Official Guidelines Selection of Principal Diagnosis Reporting Additional Diagnoses Diagnostic Coding Reporting Guidelines for Outpatient Services Steps to Coding Diagnoses Using the ICD 10 CM Manual Documentation of Complications of Care Rules of Compliance External Cause Codes Sequencing Multiple Codes Correctly What to Code What Not to Code The Process of Abstracting Medical Coding ICD 10 PCS Selection of Principal Procedure ICD 10 PCS Coding Conventions ICD 10 PCS Sections Subsections Medical Surgical Section Guidelines Obstetrics Section Guidelines New Technology Section Guidelines ICD 10 PCS Terms

   The Software Encyclopedia ,1986   *A Directory of Computerized Data Files & Related Technical Reports* ,1980
   Medical Coding Shelley C. Safian,2017-11 Updated for 2018 ICD 10 guidelines this 6 page laminated guide covers core essentials of coding clearly and succinctly Author Shelley C Safian PhD RHIA CCS P COC CPC I AHIMA approved ICD 10 CM PCS trainer used her knowledge and experience to provide the largest number of valuable facts you can find in 6 pages designed so that answers can be found fast with color coded sections and bulleted lists A must for students seeking coding certification and a great desktop refresher for professionals 6 page laminated guide includes General Coding Legal Guidelines Coding Tips Conditions Diagnoses Diagnosis Coding Pathology Laboratory Reimbursement Billing Tips Coding Evaluation Management Services ICD 10 Terms Notations Symbols Wounds Injuries Important Resources Anesthesia Surgery Radiology Diagnostic Coding   *A Directory of Computerized Data Files, Software & Related Technical Reports* ,1978

   CPT/HCPCS Coding and Reimbursement for Physician Services, 2007 Edition Lynn Kuehn,2006-12   Directory of Computerized Data Files 1989 Kathleen Thacker,1989   Learning to Code with CPT/HCPCS 2011 Thomas Falen,Alice Noblin,Brandy Ziesemer,2010-12-06 3rd YEAR 2011 ANNUAL UPDATE Updated for 2011 this book will be the primary textbook for CPT HCPCS coding courses for Health Information Management HIM Medical Billing Insurance and Coding MBIC Health Information Technology HIT and Health Administration Services HSA programs Using a template similar to our Learning to Code with ICD 9 CM textbook this book teaches students how to code with CPT HCPCS using real world medical record examples   **Monthly Catalog of United States Government Publications** United States. Superintendent of Documents,1993 February issue includes Appendix entitled Directory of United States Government periodicals and subscription publications September issue includes List of depository libraries June and December issues include semiannual index

Adopting the Beat of Term: An Psychological Symphony within **User Guide Of Medical Coding**

In some sort of used by screens and the ceaseless chatter of instantaneous conversation, the melodic splendor and psychological symphony developed by the written term usually diminish in to the backdrop, eclipsed by the constant sound and distractions that permeate our lives. Nevertheless, located within the pages of **User Guide Of Medical Coding** a charming literary treasure filled with fresh emotions, lies an immersive symphony waiting to be embraced. Crafted by a wonderful composer of language, this interesting masterpiece conducts visitors on a psychological journey, skillfully unraveling the concealed songs and profound influence resonating within each carefully constructed phrase. Within the depths of this poignant analysis, we will discover the book is main harmonies, analyze their enthralling publishing type, and surrender ourselves to the profound resonance that echoes in the depths of readers souls.

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