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Solution and Answer Guide

Green, 3-2-1 Code It!, 2021, ISBN 9780357516010; Chapter 1: Overview of Coding

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Exercises

Exercise 1.1: Career as a Coder

1. c
2. a
3. b
4. c
5. b

Exercise 1.2: Professional Associations

1. c
2. a
3. b
4. a
5. c

Exercise 1.3: Coding Overview

1. b
2. a
3. a

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4. a
5. a

Exercise 1.4: Other Classification Systems and Databases

1. c
2. g
3. a
4. h
5. f
6. j
7. b
8. e
9. d
10. i

Exercise 1.5: Documentation as Basis for Coding

1. a
2. b
3. b
4. b
5. b

Exercise 1.6: Health Data Collection

1. management
2. abstracting
3. CMS-1500
4. UB-04 (or CMS-1450)
5. medical

Review

Multiple Choice

1. a
2. d
3. c

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4. b
5. b
6. c
7. c
8. d
9. a
10. a
11. c
12. a
13. c
14. b
15. b
16. d
17. b
18. a
19. b
20. c
21. a
22. c
23. a
24. a
25. b

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Green, 3-2-1 Code It!, 2021, ISBN 9780357516010; Chapter 2: Introduction to ICD-10-CM and ICD-10-PCS Coding

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Exercise 2.1: Overview of ICD-10-CM and ICD-10-PCS

1. 2015
2. Maintenance
3. National Center for Health Statistics (or NCHS)
4. Modernization
5. subscription
6. encoder
7. diagnosis
8. necessity
9. chest pain
10. multiple lacerations

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Exercise 2.2: ICD-10-CM Index to Diseases and Injuries

1. Index
2. Drugs
3. alphabetical
4. alphabetical
5. boldfaced
6. nonessential
7. essential
8. Asplenia
9. History
10. disease

Exercise 2.3: ICD-10-CM Tabular List of Diseases and Injuries

1. Tabular List
2. Z
3. category (or valid)
4. invalid
5. placeholders

Exercise 2.4: ICD-10-CM Official Guidelines for Coding and Reporting

1. cooperating parties
2. encounter
3. provider
4. HIPAA
5. structure
6. principal
7. additional
8. complications
9. outpatient
10. admission

Exercise 2.5: ICD-10-PCS Index and Tables

1. ICD-10-PCS
2. inpatient

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3. 7
4. O
5. 001U076

Exercise 2.6: ICD-9-CM Legacy Coding System

1. R11.11
2. A88.1
3. A74.89
4. 078.88
5. 078.89

Review

Multiple Choice (ICD-10-CM)

1. a
2. b
3. b
4. b
5. a
6. d
7. a
8. a
9. a
10. d
11. c
12. a
13. d
14. c
15. d

Multiple Choice (ICD-10-PCS)

1. b
2. d
3. a

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4. d
5. b
6. d
7. b
8. b
9. d
10. b

Matching

1. b
2. c
3. a
4. d
5. e

Coding Practice

(Note: Beginning with this coding practice answer key (and continuing through remaining chapters in this instructor's manual), the main term for each diagnosis or procedure/service is underlined to help instructors locate codes in the index of each coding manual.)

Coding Practice: ICD-10-CM

K46.9	1. Abdominal hernia
R73.09	2. Abnormal nonfasting glucose tolerance test
H66.90	3. Acute otitis media
N85.00	4. Hyperplasia of endometrium
S42.301A	5. Traumatic fracture (closed), right humerus (initial encounter)
P27.8	6. Congenital fibrosis of the lung (Fibrosis, lung, congenital)
M19.90	7. Degenerative arthritis (Osteoarthritis)
N60.31, N60.32	8. Fibrosclerosis of right and left breasts
I78.0	9. Hereditary epistaxis
Z85.9	10. Personal history of cancer

Coding Practice: ICD-10-PCS

07B60ZX	1. Open biopsy, left axillary lymph node (Excision, Diagnostic)
0FT40ZZ	2. Open cholecystectomy, total (Resection, Gallbladder)
0TJB8ZZ	3. Cystoscopy
0WJG0ZZ	4. Exploratory laparotomy, open (Inspection, Cavity, Peritoneal)
BT1DZZZ	5. Intravenous right pyelogram (using fluoroscopy) (Fluoroscopy, Kidney)
0DTJ0ZZ	6. Incidental appendectomy (open) (Resection, Appendix)
09BT0ZX	7. Open biopsy of left frontal nasal sinus (Excision, Sinus, Frontal, Left)
0VB03ZX	8. Percutaneous biopsy of prostate (Excision, Prostate)
0N810ZZ	9. Right frontal craniotomy (open approach) (Division, Head and Facial Bones)
0TBB7ZX	10. Transurethral biopsy of bladder (Excision, Bladder)

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Solution and Answer Guide

Green, Workbook to Accompany 3-2-1 Code It!, 2021, ISBN 9780357516027; Chapter 1: Overview of Coding

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Assignments

Assignment 1.1: Career as a Coder: Interview of a Coding Professional

The student will submit in paragraph format (not Q&A) a two- to three-page word-processed interview of a coding professional. Each paragraph should contain a minimum of three sentences, and the student should write in complete sentences. The paper should contain no typographical or grammatical errors. The last paragraph of the paper should summarize what the student's reaction to the interview was and whether the student would be interested in having this professional's position (along with an explanation of why or why not). Also, the student should "predict the future" by writing about **their future** in terms of employment, family, and so on.

Assignment 1.2: Professional Discussion Forums

The student will go to http://list.nih.gov and click on About NIH Listserv to learn all about online discussion forums (listservs). The student will also select a professional discussion forum from Table 1-1 in the Workbook and follow its instructions to become a member. If this assignment is completed by the student outside of class, the instructor can require the student to submit a summary of the experience (or if teaching online, post a discussion).

Assignment 1.3: Coding Overview: Validating Accuracy of ICD-10-CM and ICD-10-PCS Codes

(Adapted from the American Health Information Management Association.)

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Validating ICD-10-CM and ICD-10-PCS Coding Accuracy

1. Code Z85.028 and 0DQ67ZZ are correct. However, code Z43.1 (Encounter for attention to gastrostomy) is missing, and it should be reported first.
2. Code 3E03305 is correct. However, code C40.80 is incorrect because *secondary carcinoma of the bone* is coded as metastatic spread from an unknown primary; therefore, assign C79.51 (Table of Neoplasms, bone, malignant secondary) and C80.1 (Table of Neoplasms, unknown or unspecific site, malignant primary) (instead of C40.80). Code Z08 is incorrect because it classifies an encounter for follow-up examination after a completed treatment (e.g., chemotherapy) for a malignant neoplasm; this patient has not completed such treatment.
3. Code I50.9 is correct. However, code I25.1 is missing its fifth digit "0" that classifies the native coronary artery site; assign code I25.10 (instead of I25.1).
4. Code N39.0 is correct; however, code B96.20 should be reported as another (additional) diagnosis to describe the *Escherichia coli* infection.
5. Codes O80 and 10E0XZZ are correct. However, code Z37.0 (Single live birth) should also be reported to classify the outcome delivery as a single live birth.

Assignment 1.4: Computer-Assisted Coding (CAC)

1. a. **Date of procedure:** August 5, YYYY

   b. **Preoperative diagnosis:** Right anterior cruciate ligament rupture with possible lateral meniscus tea

   c. **Postoperative diagnosis:** Right knee anterior cruciate ligament rupture with lateral meniscus tear

   d. **Procedures** Right knee arthroscopy
   Partial lateral meniscectomy and anterior cruciate ligament reconstruction
   Bone-patellar-bone autograft
   Arthroscopy

   (Note: The surgeon probably dictated or entered the Arthroscopy *procedure (as the last line of* Procedures *on the bottom half of the CAC demo application's computer screen) in error because* arthroscopy *is previously stated on line one of* Procedures.*)*

2. a. S83.509A, S83.289A

   b. S83.289A

   (Note:
   - *Code S83.289A (tear of lateral cartilage or meniscus of knee current) was selected by the coder as the* admitting diagnosis *(abbreviated as A below the* Admitting Diagnosis *heading in Figure 1-1. The Admitting Diagnosis box of the screen indicates that the coder originally deleted S83.289A and then set that code as the* admission diagnosis.*).*
   - *CAC software also assigned S83.509A (sprain of cruciate ligament of knee) as an admitting diagnosis, but the coder did not "set" that code as the admitting diagnosis. Most likely, review of the patient record face sheet and/or responsible physician's admission note resulted in*

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"tear of lateral cartilage or meniscus of knee current" as the reason for surgical admission/encounter.

- *CAC software assigned an* admitting diagnosis *and a reason* for admission *because the software option to capture both of these data elements was selected. In future, the health information director might omit the data capture of one of these elements (e.g., electronic health record entry field* reason for admission *is renamed* admitting diagnosis*).)*

3. a. S83.509A, S83.289A

   b. 29881-RT, 29888-RT

   c. 29875-RT

   (Note:
   - *CAC software most likely displayed code 29875-RT as Possible, and upon review of patient record documentation (e.g., operative report) the coder deleted the code.*
   - *Although an arthroscopy was performed, it is already included in the first documented procedure (located in the bottom half of the CAC demo application's computer screen).*
   - *The list of procedures (located in the bottom half of the CAC demo application's computer screen) does not include synovectomy, limited (e.g., plica or shelf resection) (separate procedure), which means that procedure was not performed. (In CPT, separate procedure is included in parentheses in code descriptions for procedures that are performed as distinct procedures, not in combination with another procedure.))*

Assignment 1.5: Health Data Collection: Face Validity of Data Management Reports

(Source: The American Health Information Management Association)

Section A

Under the Deaths column of the table (Column 3, Row 16), the number of ICU deaths should be 2.

RATIONALE: Because the Autopsies # data column is accurate and the subtotal of deaths is 62, there is an incorrect data entry in a cell above the Total row. Upon review of the data in each row for Autopsies, # and %, the calculated ICU autopsies percentage is 50%, which means that there were 2 ICU deaths.

Under the Autopsies column of the table (Column 4, Row 4), the Autopsies % for the Medicine service should be 20%. RATIONALE: The Autopsies % in the Medicine service data cell is incorrect because (8 ÷ 40) × 100 = 20% (not 25%). (The number 40 in the formula represents the number of Medicine deaths, located in Column 3.)

Under the Autopsies column of the table (Column 4, Row 18), the Autopsies % for the Obstetrics data cell should be 100%. RATIONALE: The Autopsies % in the Obstetrics service data cell is incorrect because (2 ÷ 2) × 100 = 100%.

Section B

Under the Discharge Disposition section of the table (Column 2, Row 3, bottom left), the total expired should be 66. The total expired is correctly reported as 66 in the top portion of the table. (All data located in subtotal and total rows in the upper portion of the spreadsheet are correct.)

Section C

The Results, # of Patients, Total (Column 5, Row 10, bottom middle) should be 3,030 because 2,964 + 54 + 12 = 3,030, which also matches the total in the top portion of the table (Column 1) and the bottom portion of the table (Column 1).

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Section A

Service	Discharges	Deaths	Autopsies[1]		Discharge Days	Average LOS[1]	Consults	Medicare Patients		Pediatric Patients	
			#	%				#	Days	#	Days
Medicine	725	40	8	25%	6,394	9	717	301	3,104	0	0
General Surgery	280	10	3	30%	2,374	8	184	80	916	0	0
Cardiac Surgery	64	1	1	100%	1,039	16	35	26	431	0	0
Hand Surgery	26	0	0	0%	81	3	2	3	10	0	0
Neurosurgery	94	0	0	0%	1,429	15	39	12	266	4	39
Plastic Surgery	46	0	0	0%	319	7	19	7	97	0	0
Dental Surgery	25	0	0	0%	81	3	46	2	11	1	3
Dermatology	20	0	0	0%	289	14	56	6	83	0	0
Neurology	83	0	0	0%	776	9	183	24	284	0	0
Ophthalmology	87	0	0	0%	352	4	98	51	183	0	0
Orthopedics	216	2	0	0%	1,920	9	64	39	563	1	2
Otolaryngology	139	2	0	0%	705	5	87	16	168	4	7
ICU[2]	8	1	1	50%	128	16	1	0	0	8	127
Psychiatry	126	0	0	0%	3,624	29	97	7	317	1	8
Urology	108	1	1	100%	810	8	74	36	318	0	0
Gynecology	184	2	1	50%	853	5	55	11	93	0	0
Obstetrics	451	2	2	0%	2,099	5	14	0	0	1	2
SUBTOTAL	2,682	62	17	27%	23,273	9	1,771	621	6,844	20	189
Newborn	310	0	0	0%	1,191	4	0	0	0	0	0
SCN[3]	38	4	1	25%	742	20	0	0	0	O	0
TOTAL	3,030	66	18	27%	25,206	8	1,771	621	6,844	20	189

Section B

Discharge Disposition	# of Patients
Against medical advice	15
Home	2,850
Home health care	10
Skilled nursing facility	37
Rehabilitation facility	39
Other hospital	13
Expired	65
TOTAL	3,030

Section C

Results	# of Patients
Discharged alive	2,964
Not treated	0
Diagnosis only	0
Expired over 48 hours	54
Expired under 48 hours	12
TOTAL	3,029

Section D

Type of Death	Number of Deaths	Autopsies	
		#	%
Anesthesia	0	0	0%
Postoperative	8	2	25%
Medical examiner	4	3	75%
Stillbirths	4	3	75%
TOTAL	16	8	50%

[1]Round up mathematical calculations to the whole number (e.g., 8.82 is reported as 9).
[2]ICU is the abbreviation for intensive care unit, where patients who need constant monitoring receive care.
[3]SCN is the abbreviation for special care nursery, where premature infants, twins, triplets, and so on, receive care.

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Assignment 1.6: Physician Query Process

Physician Query	
To:	Dr. Trevors
From:	Lisa Dubois (Coder04)
Date:	May 8, YYYY
Subject:	Query about patient record number 987654
Patient Name	**Patient Record Number**
Marian Reynolds	987654
Date of Encounter	**Location**
May 4, YYYY	Medical Center
Reason for Query	
Inadequate documentation	
Query or Comment	
Documentation indicates patient received intravenous fluids for the nursing diagnosis of dehydration. Would it be appropriate to document a diagnosis for coding? If so, add an addendum to the patient record. Thank you. LD	
Provider Reply	

Assignment 1.7: Documentation as a Basis for Coding: Determining Medical Necessity

1. e
2. b
3. a
4. c
5. g
6. i
7. j
8. f
9. h
10. d

Assignment 1.8: Other Classifications, Databases, and Nomenclatures: SNOMED CT

1. a
2. c
3. d
4. c
5. a

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Review

Multiple Choice

1. b
2. c
3. b
4. d
5. b
6. a
7. d
8. d
9. d
10. b
11. a
12. a
13. c
14. b
15. b
16. b
17. d
18. a
19. d
20. b

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Instructor Manual

Green, 3-2-1 Code It!, 2021, ISBN 9780357516010; Chapter 1: Overview of Coding

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Purpose and Perspective of the Chapter

This chapter focuses on coding career opportunities in health care, the importance of joining professional associations and obtaining coding credentials, the impact of networking with other coding professionals, and the development of opportunities for career advancement. A coding overview provides students with an introduction to coding concepts, including the role patient record documentation plays in accurate coding.

Cengage Supplements

The following product-level supplements provide additional information that may help you in preparing your course. They are available in the Instructor Resource Center.

- AHIMA Associate Degree Competency Mapping
- AHIMA Baccalaureate Degree Competency Mapping
- Educator's Guide
- Guide to Teaching Online
- Medical Coding Trainer (MCT) Instructor Guide
- Instructor Guide to Creating and Managing CNOW Assignments in MindTap
- Comprehensive Cognero Instructor Guide
- HCPCS Level II Expert Sample Copy (Optum)
- ICD-10-CM Expert for Physicians 2021 Sample Copy (Optum)
- ICD-10-PCS 2021 Sample Copy (Optum)

List of Student Downloads

Students should download the following items from the Student Resource Center to complete the activities and assignments related to this chapter:

- Guidelines for Teaching Physicians, Interns, and Residents (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf)
- History of Medical Classifications and Coding Systems
- HIV-related Conditions and Opportunistic Infections

Chapter Objectives

At the conclusion of this chapter, the student should be able to:

01.01 Define key terms related to the overview of coding.

01.02 Summarize the training, job responsibilities, and career path for a coder.

01.03 Differentiate among types of professional associations for coders, health insurance specialists, and medical assistants.

01.04 Summarize coding systems and processes.

01.05 Identify other classification systems and databases.

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01.06 Identify how documentation serves as the basis for assigning codes.

01.07 Describe health data collection for the purpose of reporting hospital and physician office data.

Complete List of Chapter Activities and Assessments

For additional guidance refer to the Teaching Online Guide.

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Key Terms

application service provider (ASP): third-party entity that manages and distributes software-based services and solutions to customers across a wide area network (WAN) from a central data center.

Assessment (A): judgment, opinion, or evaluation made by the health care provider; considered part of the problem-oriented record (POR) SOAP note.

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assumption coding: inappropriate assignment of codes based on assuming, from a review of clinical evidence in the patient's record, that the patient has certain diagnoses or received certain procedures/services, even though the provider did not specifically document those diagnoses or procedures/services.

automated case abstracting software: software program that is used to collect and report inpatient and outpatient data for statistical analysis and reimbursement purposes.

automated record: type of record that is created using computer technology.

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

claims examiner: *see* health insurance specialist.

classification system: *see* coding system.

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

CMS-1450: *see* UB-04.

CMS-1500: standard claim submitted by physicians' offices to third-party payers.

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

coder: acquires a working knowledge of coding systems (e.g., CPT, HCPCS level II, ICD-10-CM, and ICD-10-PCS), coding principles and rules, government regulations, and third-party payer requirements to ensure that all diagnoses (conditions), services (e.g., office visit), and procedures (e.g., surgery and x-ray) documented in patient records are coded accurately for reimbursement, research, and statistical purposes.

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

coding system: organizes a medical nomenclature according to similar conditions, diseases, procedures, and services; it contains codes for each.

computer-assisted coding (CAC): uses computer software to automatically generate medical codes by "reading" transcribed clinical documentation; uses "natural language processing" theories to generate codes that are reviewed and validated by coders for reporting on third-party payer claims.

concurrent coding: review of records and/or use of encounter forms and chargemasters to assign codes during an inpatient stay or an outpatient encounter; typically performed

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for outpatient encounters because encounter forms and chargemasters are completed in "real time" by health care providers as part of the charge-capture process.

continuity of care: documenting patient care services so that others who treat the patient have a source of information on which to base additional care and treatment.

Current Procedural Terminology **(CPT)**: coding system used by physicians and outpatient health care settings to assign CPT codes for reporting procedures and services on health insurance claims; considered level I of the Healthcare Common Procedure Coding System (HCPCS); published and updated by the American Medical Association (AMA) to classify procedures and services; listing of descriptive terms and identifying codes for reporting medical services and procedures; provides a uniform language that describes medical, surgical, and diagnostic services to facilitate communication among providers, patients, and third-party payers.

database: contains a minimum data set of patient information collected on each patient, including chief complaint; present conditions and diagnoses; social data; past, personal, medical, and social history; review of systems; physical examination; and baseline laboratory data; considered part of the problem-oriented record (POR).

demographic data: patient identification information that is collected according to facility policy (e.g., patient's name, date of birth, mother's maiden name, and Social Security number).

Diagnostic and Statistical Manual of Mental Disorders **(DSM)**: manual published by the American Psychiatric Association (APA) that contains diagnostic assessment criteria used as tools to identify psychiatric disorders; DSM includes psychiatric disorders and codes, provides a mechanism for communicating and recording diagnostic information, and is used in the areas of research and statistics.

diagnostic/management plan: information about the patient's condition and the planned management of conditions; considered part of the problem-oriented record (POR).

discharge note: documented in the progress note section of the problem-oriented record (POR) to summarize the patient's care, treatment, response to care, and condition on discharge.

documentation: includes dictated and transcribed, typed or handwritten, and computer-generated notes and reports recorded in the patient's records by a health care professional.

document imaging: converting paper records to an electronic image and saved on storage media.

downcoding: routinely assigning lower-level CPT codes as a convenience instead of reviewing patient record documentation and the coding manual to determine the proper code to be reported.

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electronic health record (EHR): collection of patient information documented by a number of providers at one or more facilities regarding one patient; multidisciplinary and multienterprise approach to record keeping because it has the ability to link patient information created at different locations according to a unique patient identifier; provides access to complete and accurate health problems, status, and treatment data; contains alerts and reminders for health care providers.

electronic medical record (EMR): created on a computer, using a keyboard, a mouse, an optical pen device, a voice recognition system, a scanner, or a touch screen; records are created using vendor software, which also assists in provider decision making regarding patient care and treatment.

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

evidence-based coding: clicking on codes that CAC software generates to review electronic health record documentation (evidence) used to generate the code; when it is determined that documentation supports the CAC-generated code, the coding auditor clicks to accept the code; when documentation does not support the CAC-generated code, the coding auditor replaces it with an accurate code.

evidence-verification coding: *see* evidence-based coding.

HCPCS level II: coding system managed by the Centers for Medicare & Medicaid Services (CMS) that classifies medical equipment, injectable drugs, transportation services, and other services not classified in the CPT.

HCPCS national codes: *see* HCPCS level II.

health care clearinghouse: *see* clearinghouse.

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

health care provider: *see* provider.

health data collection: performed by health care facilities to do administrative planning, to submit statistics to state and federal government agencies (and other organizations), and to report health claim data to third-party payers for reimbursement purposes.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): federal legislation that amended the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, combat waste/fraud/abuse in health insurance and health care delivery, promote the use of medical savings accounts, improve access to long-term care services and coverage, simplify the administration of health insurance by creating unique identifiers for providers/health plans/employers, create standards for electronic health information transactions, and create privacy/security standards for health information.

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health insurance specialist: employed by third-party payers to review health-related claims to determine whether the costs are reasonable and medically necessary based on the patient's diagnosis.

health plan: contract established by an insurance company to reimburse health care facilities and patients for procedures and services provided.

hospitalist: physician who provides care for hospital inpatients.

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

indexed: identified according to a unique identification number.

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

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

International Classification of Diseases for Oncology, Third Edition **(ICD-O-3)**: implemented in 2001 to classify a tumor according to primary site (topography) and morphology (histology, behavior, and aggression of tumor).

International Classification of Diseases, Ninth Revision, Clinical Modification **(ICD-9-CM)**: adopted in 1979 to classify diagnoses (Volumes 1 and 2) and procedures (Volume 3); all health care facilities assigned ICD-9-CM codes to report diagnoses, and hospitals reported ICD-9-CM procedure codes for inpatient procedures and services; replaced by ICD-10-CM and ICD-10-PCS in 2015.

International Classification of Diseases, Tenth Revision, Clinical Modification **(ICD-10-CM)**: developed by the Centers for Medicare & Medicaid Services (CMS) to classify all diseases and injuries.

International Classification of Diseases, Tenth Revision, Clinical Modification/Procedure Coding System **(ICD-10-CM/PCS)**: shortened name the Centers for Medicare & Medicaid Services uses to identify the classification systems.

International Classification of Diseases, Tenth Revision, Procedure Coding System **(ICD-10-PCS)**: developed by the National Center for Health Statistics (NCHS) to classify inpatient procedures and services.

International Classification of Functioning, Disability and Health **(ICF)**: classifies health and health-related domains that describe body functions and structures, activities, and participation; complements ICD-10, looking beyond mortality and disease.

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internship: student placement in a health care facility to provide on-the-job experience prior to graduation.

internship supervisor: person to whom a student reports at an intern-ship site.

jamming: routinely assigning an unspecified ICD-10-CM disease code instead of reviewing the coding manual to select the appropriate code number.

listserv: *see* online discussion board.

Logical Observation Identifiers Names and Codes (LOINC): electronic database and universal standard used to identify medical laboratory observations and for the purpose of clinical care and management.

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

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

medical coding process: requires the review of patient record documentation to identify diagnoses, procedures, and services for the purpose of assigning ICD-10-CM/PCS, HCPCS level II, and/or CPT codes.

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

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

medical nomenclature: includes clinical terminologies and clinical vocabularies that are used by health care providers to document patient care; clinical terminologies include designations, expressions, symbols, and terms used in the field of medicine, and clinical vocabularies include clinical phrases or words along with their meanings.

medical record: *see* patient record.

National Drug Codes (NDC): contains prescription drugs and a few selected over-the-counter (OTC) products, which pharmacies use to report transactions and some health care professionals use for reporting on claims.

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

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

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

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

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

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

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

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

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

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

provider: physician or other health care professional who performs procedures or provides services to patients.

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

RxNorm: provides normalized names for clinical drugs and links its names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software, including those of First Databank, Micromedex, MediSpan, Gold Standard Drug Database, and Multum; by providing links among these vocabularies, RxNorm can mediate messages among systems that do not use the same software and vocabulary.

Scanner: equipment that captures paper record images onto the storage media.

sectionalized record: *see* source-oriented record (SOR).

source-oriented record (SOR): reports organized according to documentation source, each of which is located in a labeled section of the record.

specialty coders: individuals who have obtained advanced training in medical specialties (e.g., anesthesia, obstetrics) and who are skilled in that medical specialty's compliance and

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reimbursement areas. In addition to maintaining core credential(s), completes rigorous, in-depth exam, and earns additional continuing education units biannually. Specialty coders typically analyze provider documentation for accuracy, completeness, and timeliness; maintain and update chargemasters and/or encounter forms; meet with coding staff to educate them about revised rules and regulations; review patient charges to accuracy in reported codes and modifiers and enter billing edits; and write letters of appeals to address third-party payer reimbursement denials.

Subjective (S): patient's statement that describes how the patient feels, including symptomatic information; considered part of the problem-oriented record (POR) SOAP note.

***Systematized Nomenclature of Medicine Clinical Terms* (SNOMED CT)**: comprehensive and multilingual clinical terminology of body structures, clinical findings, diagnoses, medications, outcomes, procedures, specimens, therapies, and treatments.

teaching hospital: hospital engaged in an approved graduate medical education (GME) residency program in medicine, osteopathy, dentistry, or podiatry.

teaching physician: physician (other than another resident physician) who supervises residents during patient care.

therapeutic plan: specific medications, goals, procedures, therapies, and treatments used to treat the patient; considered part of the problem oriented record (POR).

third-party administrator (TPA): entity that processes health care claims and performs related business functions for a health plan; the TPA might contract with a health care clearinghouse to standardize data for claims processing.

third-party payer: *see* health plan.

transfer note: documentation when a patient is transferred to another facility; summarizes the reason for admission, current diagnoses and medical information, and reason for transfer.

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

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

Unified Medical Language System (UMLS): set of files and software that allows many health and biomedical vocabularies and standards to enable interoperability among computer systems; used to enhance or develop applications, including electronic health records, classification tools, dictionaries and language translators; used to link health information, medical terms, drug names, and billing codes across different computer systems.

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

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What's New in This Chapter

The following elements are improvements in this chapter from the previous edition:

- Revised content about professional associations and professional credentials.

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Chapter Outline

I. Career as a Coder
II. Professional Associations
III. Coding Systems and Coding Processes
IV. Other Classification Systems, Databases, and Nomenclatures
V. Documentation as Basis for Coding
VI. Health Data Collection

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Additional Resources

Internet Resources

- **Alternate Billing Codes (ABC codes)**: www.abccodes.com
- **AHA Coding Clinic Advisor Go to**: codingclinicadvisor.com to review resources available about the proper use of ICD-10-CM, ICD-10-PCS, and HCPCS level II codes for health care providers.
- **AAPC**: www.aapc.com
- **American Association of Medical Assistants (AAMA):** www.aama-ntl.org
- **American Health Information Management Association (AHIMA):** www.ahima.org
- **American Medical Technologists (AMT):** www.americanmedtech.org
- **Clinical Care Classification System:** www.sabacare.com
- **Current Dental Terminology (CDT):** Go to www.ada.org, click on the Publications link, and then click on the CDT: Code on Dental Procedures and Nomenclature link.
- **Diagnostic and Statistical Manual of Mental Disorders (DSM):** Go to psychiatric.org, click on the Psychiatrists link, and click on the Research and DSM link.

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- **Health Insurance Prospective Payment System (HIPPS) Rate Codes:** Go to **www.cms.gov**, click on the Medicare link, locate the Medicare Fee-for-Service Payment heading, click on the Prospective Payment Systems - General Information link, and click on the HIPPS Codes link.
- **International Classification of Diseases for Oncology (ICD-O-3):** Go to **https://training.seer.cancer.gov**, click on Resources, click on Links to Reference Materials, and scroll down and click on the ICD-O-3 Training module link.
- **Medical Association of Billers (MAB): https://mabillers.com**
- **National Drug Codes (NDC):** Go to **www.fda.gov**, and use the Search feature to enter National Drug Codes to navigate to the National Drug Code Directory.
- **National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Training Modules:** Go to **https://training.seer.cancer.gov**, click on the Cancer Registration & Surveillance Modules link, and click on the Coding Primary Site & Tumor Morphology link.
- **RxNorm:** Go to **www.nlm.nih.gov**, and enter RxNorm in the Search box.
- **Unified Medical Language Systems (UMLS):** Go to **www.nlm.nih.gov**, and enter UMLS in the Search box.

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Appendix

Generic Rubrics

Providing students with rubrics helps them understand expectations and components of assignments. Rubrics help students become more aware of their learning process and progress, and they improve students' work through timely and detailed feedback.

Customize these rubric templates as you wish. The writing rubric indicates 40 points and the discussion rubric indicates 30 points.

Standard Writing Rubric

Criteria	Meets Requirements	Needs Improvement	Incomplete
Content	The assignment clearly and comprehensively addresses all questions in the assignment. 15 points	The assignment partially addresses some or all questions in the assignment. 8 points	The assignment does not address the questions in the assignment. 0 points
Organization and Clarity	The assignment presents ideas in a clear manner and with strong organizational structure. The assignment includes an appropriate introduction, content, and conclusion. Coverage of facts, arguments, and conclusions are logically related and consistent. 10 points	The assignment presents ideas in a mostly clear manner and with a mostly strong organizational structure. The assignment includes an appropriate introduction, content, and conclusion. Coverage of facts, arguments, and conclusions are mostly logically related and consistent. 7 points	The assignment does not present ideas in a clear manner and with strong organizational structure. The assignment includes an introduction, content, and conclusion, but coverage of facts, arguments, and conclusions are not logically related and consistent. 0 points
Research	The assignment is based upon appropriate and adequate academic literature, including peer reviewed journals and other scholarly work. 5 points	The assignment is based upon adequate academic literature but does not include peer reviewed journals and other scholarly work. 3 points	The assignment is not based upon appropriate and adequate academic literature and does not include peer reviewed journals and other scholarly work. 0 points
Research	The assignment follows the required citation guidelines. 5 points	The assignment follows some of the required citation guidelines. 3 points	The assignment does not follow the required citation guidelines. 0 points
Grammar and Spelling	The assignment has two or fewer grammatical and spelling errors. 5 points	The assignment has three to five grammatical and spelling errors. 3 points	The assignment is incomplete or unintelligible. 0 points

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Standard Discussion Rubric

Criteria	Meets Requirements	Needs Improvement	Incomplete
Participation	Submits or participates in discussion by the posted deadlines. Follows all assignment instructions for initial post and responses. 5 points	Does not participate or submit discussion by the posted deadlines. Does not follow instructions for initial post and responses. 3 points	Does not participate in discussion. 0 points
Contribution Quality	Comments stay on task. Comments add value to discussion topic. Comments motivate other students to respond. 20 points	Comments may not stay on task. Comments may not add value to discussion topic. Comments may not motivate other students to respond. 10 points	Does not participate in discussion. 0 points
Etiquette	Maintains appropriate language. Offers criticism in a constructive manner. Provides both positive and negative feedback. 5 points	Does not always maintain appropriate language. Offers criticism in an offensive manner. Provides only negative feedback. 3 points	Does not participate in discussion. 0 points

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Instructor Manual

Green, 3-2-1 Code It!, 2021, ISBN 9780357516010; Chapter 2: Introduction to ICD-10-CM and ICD-10-PCS Coding

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Purpose and Perspective of the Chapter

This chapter focuses on the organization of the ICD-10-CM and ICD-10-PCS coding systems and the official guidelines for coding and reporting.

Cengage Supplements

The following product-level supplements provide additional information that may help you in preparing your course. They are available in the Instructor Resource Center.

- AHIMA Associate Degree Competency Mapping
- AHIMA Baccalaureate Degree Competency Mapping
- Educator's Guide
- Guide to Teaching Online
- Medical Coding Trainer (MCT) Instructor Guide
- Instructor Guide to Creating and Managing CNOW Assignments in MindTap
- Comprehensive Cognero Instructor Guide
- HCPCS Level II Expert Sample Copy (Optum)
- ICD-10-CM Expert for Physicians 2021 Sample Copy (Optum)
- ICD-10-PCS 2021 Sample Copy (Optum)

Chapter Objectives

At the conclusion of this chapter, the student should be able to:

2.01 Define key terms related to the introduction of ICD-10-CM and ICD-10-PCS coding.

2.02 Explain the purpose of assigning ICD-10-CM and ICD-10-PCS codes.

2.03 Locate main terms for diagnostic statements using the ICD-10-CM Index to Diseases and Injuries.

2.04 Assign diagnosis codes using the ICD-10-CM Index to Diseases and Injuries and the ICD-10-CM Tabular List of Diseases and Injuries.

2.05 Explain general ICD-10-CM official guidelines for coding and reporting.

2.06 Assign procedure codes using the ICD-10-PCS Index and Tables.

2.07 Use general equivalence mappings (GEMs) as part of the ICD-9-CM legacy coding system.

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Complete List of Chapter Activities and Assessments

For additional guidance refer to the Teaching Online Guide.

Activity/Assessment
Exercise 2.1
Exercise 2.2
Exercise 2.3
Exercise 2.4
Exercise 2.5
Exercise 2.6
Chapter 2 Review
Chapter 2 Coding Practice
MindTap: Knowledge Check
MindTap: Quiz
Workbook: Assignment 2.1 – ICD-10-CM Index to Diseases and Injuries
Workbook: Assignment 2.2 – ICD-10-PCS Index
Workbook: Assignment 2.3 – ICD-10-PCS Index and Tables
Workbook: Assignment 2.4 – General Equivalence Mappings (GEMs)
Workbook: Assignment 2.5 – ICD-10-CM Official Guidelines for Coding and Reporting
Workbook: Review

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Key Terms

category: three-character ICD-10-CM disease code within a section.

combination code: single code used to classify two diagnoses (or procedures), a diagnosis with an associated secondary process (manifestation), or a diagnosis with an associated complication.

cooperating parties for the ICD-10-CM/PCS: AHA, AHIMA, CMS, and NCHS.

encoder: software that automates the coding process; software search features facilitate the location and verification of diagnosis and procedure codes.

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

essential modifier: *see* subterm.

etiology: cause of disease.

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general equivalence mapping (GEM): published crosswalks of codes that facilitate the location of corresponding diagnosis and procedure codes between two code sets, such as ICD-9-CM and ICD-10-CM.

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

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

International Classification of Diseases (ICD): published by the World Health Organization (WHO) and used to classify mortality data from death certificates.

laterality: in ICD-10-CM, whether the condition occurs on the left, the right, or is bilateral; in CPT, whether the procedure is performed bilaterally; in CPT, when laterality is not indicated in the procedure description for paired organs or body parts, add HCPCS level II modifier -LT or -RT to indicate the left or right side, respectively.

legacy classification system: *see* legacy coding system.

legacy coding system: classification system that is used as archive data; it is no longer supported or updated; for example, when ICD-10-CM and ICD-10-PCS were implemented, ICD-9-CM became a legacy coding system.

main term: printed in boldfaced type and followed by the ICD-10-CM code number.

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

morbidity: disease.

mortality: death.

multiple codes: more than one ICD-10-CM code that is assigned to completely classify the elements of a complex diagnosis (or procedure) statement.

nonessential modifier: qualifying word contained in parentheses after the main term in the ICD-10-CM Index to Diseases and Injuries that does not have to be included in the diagnostic or procedural statement for the code number listed after the parentheses to be assigned.

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

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

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placeholder: use of the letter "X" in certain ICD-10-CM codes to allow for future expansion; it is used when a code contains fewer than six characters and a seventh character applies.

residual effect: condition produced (sequela) after the acute phase of an illness or injury has terminated.

sequela: residual (long-term condition produced) that develops after the acute phase of an illness or injury has ended. (Historically, ICD-9-CM referred to a sequela as a *late effect* of an illness or injury.)

subcategory: ICD-10-CM codes that contain four, five, six, or seven characters; subcategory codes that require additional characters are invalid if the fifth, sixth, or seventh character(s) is absent.

subterm: qualifying word listed below the main term in the ICD-10-CM Index to Diseases and Injuries; list alternate sites, etiology, or clinical status.

Tabular List of Diseases and Injuries: chronological list of ICD-10-CM codes, divided into 21 chapters based on body system or condition.

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What's New in This Chapter

The following elements are improvements in this chapter from the previous edition:

- Chapter 2 was revised to update ICD-10-CM and ICD-10-PCS content.
- The new ICD-10-CM search tool (https://icd10cmtool.cdc.gov) website was added to the end-of-chapter list of Internet links, which can be used to assign ICD-10-CM codes for textbook Chapters 2 through 7 diagnosis statements and coding cases.

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Chapter Outline

I. Overview of ICD-10-CM and ICD-10-PCS
II. ICD-10-CM Index to Diseases and Injuries
III. ICD-10-CM Tabular List of Diseases and Injuries
IV. ICD-10-CM Official Guidelines for Coding and Reporting
V. ICD-10-PCS Index and Tables
VI. ICD-9-CM Legacy Coding System

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Additional Resources

Internet Resources

- **AHA Coding Clinic Advisor: www.codingclinicadvisor.com**

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- **ICD-10-CM and ICD-10-PCS encoder (subscription-based): www.encoderpro.com** (free trial available)
- **ICD-10-CM search tool: https://icd10cmtool.cdc.gov**
- **ICD-10-CM/PCS updates:** Go to **www.cdc.gov**, scroll to the Science at CDC heading, click on the Data & Statistics link, scroll to Tools and click on the Classification of Diseases, Functioning, and Disability link, and click on any of the ICD links.
- **ICD-10-CM/PCS:** Go to **www.cms.gov**, click on Medicare, click on ICD-10 under Coding, and click on links in the first column to locate coding manual PDF files, general equivalence mappings (GEMs), and more.

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