

Chapter 1 Introduction to the Language of Coding

2025 Compliant

Learning Outcomes

LO 1.1 Explain the four purposes of medical coding.

LO 1.2 Identify the structure of the ICD-10-CM diagnosis coding manual.

LO 1.3 Differentiate between the types of procedures and the various procedure coding manuals. LO 1.4 Examine the HCPCS Level II coding manual used to report the provision of equipment and supplies.

Chapter Outline

Learning Outcomes

Key Terms

The Purpose of Coding

- Medical Necessity

- Statistical Analyses

- Reimbursement

- Resource Allocations

Diagnosis Coding

- Index to Diseases and Injuries [aka Alphabetic Index]

- Tabular List of Diseases and Injuries

- Ancillary Sections of ICD-10-CM

 - Neoplasm Table

 - Table of Drugs and Chemicals

 - Index to External Causes

- The Format of ICD-10-CM Codes

Procedure Coding

- Current Procedural Terminology (CPT)

 - The Organization of the CPT Code Book

 - The Formats of CPT Codes

International Classification of Diseases -10th Revision – Procedure Coding System
(ICD-10-PCS)

The Format of ICD-10-PCS Codes

HCPCS Level II Procedure Codes

Equipment and Supplies

The Format of HCPCS Level II Codes

Chapter Summary

Chapter 1 Review

Let's Check It! Terminology

Let's Check It! Concepts

Let's Check It! Rules and Regulations

Chapter Overview

Coding is not like anything you have ever studied before. No courses that you experienced in elementary, middle, or high school have prepared you for learning this skill. Biology and your science classes began your education that your anatomy and physiology class continued. Other courses you are taking as part of this program also typically connect to something, in some way, you have previously learned. As you begin this educational journey, you will use your critical thinking skills as well as some experiences you may have had as a patient yourself (or as the loved one of a patient). For the most part, though, this will be different, so prepare yourself for a new learning experience. In Part I, the chapters Introduction to the Languages of Coding, Abstracting Clinical Documentation, and The Coding Process share an overview of the concepts and skills you will apply in the chapters that follow. You will be introduced to the tools you have and will need to use as a professional coding specialist. Together, these three chapters create the foundation, the first layer, of a multilayered approach to learning coding. Then, the remaining Parts will share with you, one by one, the best practices for how to use each of these tools correctly. You will then be given many opportunities for hands-on practice so that you can build your skills and reinforce the knowledge you have obtained.

Discussion Activities

1. Discuss the different uses for medical (healthcare) coding.

Learning Outcome: 1.1

The purpose of coding is to provide clear and precise communications between all parties that need to know, including:

· Medical necessity · Statistical analyses · Reimbursement · Resource allocation

2. What are the sections of the ICD-10-CM coding manual and what role does each play in the coding process/

Learning Outcome: 1.2

The Alphabetic Index is the starting point, where one looks up the main terms used in the documentation to find a suggested code.

The Tabular List provides additional specificity, along with guidance such as symbols and notations.

The Official Guidelines for Coding and Reporting support accurate reporting,

The Neoplasm Table, the Table of Drugs and Chemicals, and the External Cause Code Index all support accurate coding in an efficient and effective manner.

3. What code would you use?

Learning Outcome: 1.3 and 1.4

Read this scenario then determine which type of procedure code or codes you would use. Explain why you chose this code(s).

PATIENT: Johnson, Jeffrey

ACCOUNT/EHR #: JOHNJEF001

ATTENDING PHYSICIAN: Calvin Arnold, MD

A 69-year-old man was fit and well until earlier today when he was stung on the back of his right hand by a wasp. He had previously been stung on several occasions, the last time 2 weeks earlier. Within 5 min, he felt faint, followed shortly by a pounding sensation in his head and tightness of his chest. He collapsed and lost consciousness and, according to his wife, became grey and made gasping sounds. After 2-3 min, he regained awareness but lost consciousness immediately when his wife and a friend tried to help him to his feet.

Fortunately, the emergency medical technicians (EMT) arrived in time to prevent him being propped up in a chair: they laid him flat, administered intramuscular injection of

epinephrine (adrenaline) and intravenous antihistamines. He was then taken to the emergency department by ambulance. He had recovered fully by the next day.

Answer:

Injection of epinephrine = CPT for the injection; HCPCS Level II for the epinephrine

Intravenous antihistamines = CPT for the intravenous; HCPCS Level II for the antihistamines

Ambulance service = HCPCS Level II

Additional Resources

Grey's Anatomy Online: <http://www.bartleby.com/107/>

Stedman's Medical Dictionary: <http://www.stedmans.com/>

MedlinePlus Medical Encyclopedia: <http://www.nlm.nih.gov/medlineplus/mplusdictionary.html>

American Medical Association: <http://www.ama-assn.org>

American Hospital Association: <http://www.aha.org>

American Health Information Management Association: <http://www.ahima.org>

AAPC: <http://www.aapc.com>

ICD-10-PCS: <http://www.cdc.gov/nchs/icd/icd10cm.htm>

Chapter 1 Review Answer Key

Check It! Terminology:

Answer:

1. L Treatment
2. B Condition
3. G Medical Necessity
4. J Reimbursement
5. E External Causes
6. C Diagnosis
7. I Procedure
8. A Classification System
9. F Inpatient
10. K Services
11. H Outpatient
12. D Eponym

Let's Check It! Concepts:

1. Answer: D all of these

Feedback: Why is it so critical to code diagnoses and procedures accurately? The coding languages communicate information that is key to various aspects of the health care system, including Medical Necessity, Statistical analyses, Reimbursement, and Resource allocation.

2. Answer: D numbers or number-letter combinations
Feedback: The professional coding specialist has the responsibility to accurately interpret health care terms and definitions (medical terminology) into numbers or number-letter combinations (alphanumeric codes) that specifically convey diagnoses and procedures.
3. Answer: C why the patient requires attention of the provider
Feedback: A diagnosis explains WHY the patient requires the attention of a health care provider.
4. Answer: B what the provider did for the patient
Feedback: A procedure explains WHAT the physician or health care provider did for the patient.
5. Answer: A ICD-10-CM code book
Feedback: The International Classification of Diseases – 10th Revision- Clinical Modification (ICD-10-CM) code book contains all of the codes from which you will choose to report the reason why the health care professional cared for the patient during a specific encounter.
6. Answer: C the Tabular List
Feedback: The Alphabetic Index can only suggest a possible code to report the patient's diagnosis, and you will use this suggestion to guide you to the correct page or subsection in the Tabular List. You must always turn to this suggested code in the Tabular List, to confirm it is accurate, or to find another code that might be better.
7. Answer: D all of these
Feedback: Diagnostic descriptions are listed by:
 - Condition (e.g., infections, fractures, and wounds)
 - Eponyms (e.g., Epstein-Barr syndrome and Cushing's disease)
 - Other descriptors (e.g., history, family history).
8. Answer: C Arnold-Chiari disease
Feedback: Diagnostic descriptions are listed by:
 - Condition (e.g., infections, fractures, and wounds)
 - Eponyms (e.g., Epstein-Barr syndrome and Cushing's disease)
 - Other descriptors (e.g., history, family history).
9. Answer: A injuries and poisoning
Feedback: The Index to External Causes lists the causes of injury and poisoning. These codes are used to explain how a patient got injured, and where (place of occurrence) he or she was when the injury happened. As always, the code or codes must be confirmed in the Tabular List before you are permitted to report them.

10. Answer: C H61.022

Feedback: An example of an ICD-10-CM code is H61.022: Chronic perichondritis of left external ear.

H2031 is an example of a HCPCS Level II code

85460 is an example of a CPT code

08NTXZZ is an example of an ICD-10-PCS code

11. Answer: A there was a valid medical reason to provide care

Feedback: The diagnosis codes that you assign explain the justification for the procedure, service, or treatment provided to the patient during the encounter. Every time a health care professional provides care to a patient, there must be a valid medical reason. Certainly, everyone would agree that health care professionals must have a good reason to perform procedures on a patient. This is referred to as medical necessity.

12. Answer: C what

Feedback: The WHY justifies the WHAT = Requiring medical necessity ensures that the health care provider is not performing tests and giving injections without a good medical reason. Diagnosis codes explain why the individual came to see the physician and support the physician's decision about what procedures to provide.

13. Answer: B procedure

Feedback: Once the physician has determined the patient's condition or problem, he or she can then determine how to treat it. Generally, there are three terms used to describe actions that the physician takes to support the patient's good health or to improve a current condition:

Procedures are actions, or series of actions taken to accomplish an objective (result). For example, surgically removing a mole or re-sectioning the small intestine.

Services are actions that will, more often, involve counseling, educating, and advising the patient, such as discussing test results or sharing recommendations for risk reduction. Treatments are, typically, an application of a health care product, such as radiation treatments for tumor reduction or acupuncture.

14. Answer: A Diagnostic

Feedback: Actions provided by the physician or other health care professional, are done for one of three reasons:

Diagnostic tests or procedures are performed to provide the physician with additional information to support the determination of a confirmed diagnosis.

Preventive procedures and services are provided to keep a healthy patient healthy. In other words, to avoid illness or injury. These will also include early detection testing, known as screenings.

Therapeutic procedures, treatments, and services are performed with the intention of removing, correcting, or repairing an abnormality or condition.

15. Answer: D all of these

Feedback: There are three (3) different code sets available for you to use in the process of translating health care procedures, services, and treatments into codes. These three code sets are:

Current Procedural Terminology (CPT)

Healthcare Common Procedure Coding System (HCPCS) Level II

International Classification of Diseases – 10th Revision – Procedure Coding System (ICD-10-PCS)

16. Answer: B 6

Feedback: The main body of the CPT book has six sections, presented in numerical order (generally speaking) by code number:

- Evaluation and Management: 99201–99499
- Anesthesia: 00100–01999 and 99100–99140
- Surgery: 10021–69990
- Radiology: 70010–79999
- Pathology and Laboratory: 80047–89398, 0001U-0017U
- Medicine: 90281–99199, 99500–99607

17. Answer: B 1134F

Feedback: *Category II codes*: used for supplemental tracking of performance measurements. Category II codes are five-character codes: four numbers followed by the letter F: for example, 1134F Episode of back pain lasting 6 weeks or less.

89398 is an example of a CPT code

V95.9 is an example of an ICD-10-CM external cause code

0241T is an example of an of a CPT category III code

18. Answer: C ICD-10-PCS code book

Feedback: The International Classification of Diseases – 10th Revision – Procedure Coding System (ICD-10-PCS) is the code set used for hospital facility reporting of the procedures, services, and treatments provided to a patient who has been admitted as an inpatient.

19. Answer: B one letter followed by four numbers

Feedback: The codes listed in the HCPCS Level II code book are all structured the same way: one letter followed by four numbers. No dots, no dashes.

20. Answer: A J3285

Feedback: An example of a HCPCS Level II code is J3285: Injection, treprostinil, 1mg

D7056ZZ is an example of an ICD-10-PCS code

58940 is an example of a CPT code

T84.010D is an example of an ICD-10-CM code

Let's Check It! Rules and Regulations

1. Answer: In most cases, there are three parties involved in virtually every encounter: the health care provider; the patient; and the person or organization paying for the care provided (frequently, a health care insurance company). However, the insurance company is not always an actual insurance company, so the broader term “third-party payer” is used. Third-party payers use our coding data to determine how much they should pay health care professionals for the attention and services they provide patients. This is the role that coding plays in the **reimbursement** process. The codes make it easier for the organizations involved to evaluate and manage all their data. In most cases, there are three parties involved in reimbursement:
 - The health care provider = First Party
 - The patient = Second Party
 - The insurance company or other organization financially responsible = Third-party payer

Feedback: In most cases, there are three parties involved in virtually every encounter: the health care provider; the patient; and the person or organization paying for the care provided (frequently, a health care insurance company). However, the insurance company is not always an actual insurance company, so the broader term “third-party payer” is used. Third-party payers use our coding data to determine how much they should pay health care professionals for the attention and services they provide patients. This is the role that coding plays in the **reimbursement** process. The codes make it easier for the organizations involved to evaluate and manage all their data. In most cases, there are three parties involved in reimbursement:

- The health care provider = First Party
 - The patient = Second Party
 - The insurance company or other organization financially responsible = Third-party payer
2. Answer: The Tabular List provides you with each and every available code in ICD-10-CM, in order of the code characters – alphanumeric order: A00 through Z99.89. You need to carefully read the descriptions, beginning at the top of the subheading, so you can make certain that you find the best code, to the highest level of specificity, according to the physician’s notes for a particular encounter and following the directions of the book.

The Alphabetic Index can only suggest a possible code to report the patient’s diagnosis, and you will use this suggestion to guide you to the correct page or subsection in the Tabular List. You must always turn to this suggested code in the Tabular List, to confirm it is accurate, or to find another code that might be better.

Feedback: The Tabular List provides you with each and every available code in ICD-10-CM, in order of the code characters – alphanumeric order: A00 through Z99.89. You need to carefully read the descriptions, beginning at the top of the subheading, so you can make certain that you find the best code, to the highest level of specificity, according to the

physician's notes for a particular encounter and following the directions of the book.

The Alphabetic Index can only suggest a possible code to report the patient's diagnosis, and you will use this suggestion to guide you to the correct page or subsection in the Tabular List. You must always turn to this suggested code in the Tabular List, to confirm it is accurate, or to find another code that might be better.

3. Answer: *Diagnostic* tests or procedures are performed to provide the physician with additional information required to determine a confirmed diagnosis.
Preventive procedures and services are provided to keep a healthy patient healthy. In other words...to avoid illness or injury. These also include early detection testing, known as screenings.

Feedback:

Diagnostic tests or procedures are performed to provide the physician with additional information required to determine a confirmed diagnosis.

Preventive procedures and services are provided to keep a healthy patient healthy. In other words...to avoid illness or injury. These also include early detection testing, known as screenings.

Therapeutic procedures, treatments, and services are performed with the intention of removing, correcting, or repairing an abnormality or condition.

4. Answer: The diagnosis codes that you assign explain the justification for the procedure, service, or treatment provided to the patient during the encounter. Every time a health care professional provides care to a patient, there must be a valid medical reason. Certainly, everyone would agree that health care professionals must have a good reason to perform procedures on a patient. This is referred to as **medical necessity**. Requiring medical necessity ensures that the health care provider is not performing tests and giving injections without a good medical reason. Diagnosis codes explain *why* the individual came to see the physician and support the physician's decision about *what* procedures to provide. Medical necessity is one of the reasons it is so very important to code the diagnosis accurately and with all the specifics possible. If you are one number off, you could accidentally cause the claim to be denied because the diagnosis, identified by the incorrect code, does not justify the procedure the doctor performed.

Feedback: The diagnosis codes that you assign explain the justification for the procedure, service, or treatment provided to the patient during the encounter. Every time a health care professional provides care to a patient, there must be a valid medical reason. Certainly, everyone would agree that health care professionals must have a good reason to perform procedures on a patient. This is referred to as **medical necessity**. Requiring medical necessity ensures that the health care provider is not performing tests and giving injections without a good medical reason. Diagnosis codes explain *why* the individual came to see the physician and support the physician's decision about *what* procedures to provide. Medical necessity is one of the reasons it is so very important to code the diagnosis accurately and

with all the specifics possible. If you are one number off, you could accidentally cause the claim to be denied because the diagnosis, identified by the incorrect code, does not justify the procedure the doctor performed.

5. Answer: Not all insurance carriers accept HCPCS Level II codes, but Medicare and Medicaid want you to use them. It is your responsibility, as a coding specialist, to find out whether each third-party payer with which your facility works will permit the reporting of HCPCS Level II codes on a claim form. If not, you have to ask for the payer's policies on reporting the services and supplies covered by HCPCS Level II.

Feedback: Not all insurance carriers accept HCPCS Level II codes, but Medicare and Medicaid want you to use them. It is your responsibility, as a coding specialist, to find out whether each third-party payer with which your facility works will permit the reporting of HCPCS Level II codes on a claim form. If not, you have to ask for the payer's policies on reporting the services and supplies covered by HCPCS Level II.