Chapter 2: Hospital Coding Overview

Learning Objectives

- Demonstrate an understanding of the basic principles of ICD-9/10-CM diagnostic coding
- Apply additional coding guidelines for assigning ICD-9/10-CM codes
- Discuss the concepts of ICD-9/10-CM procedural coding
- Demonstrate the basic concepts of CPT/HCPCS procedural coding
- Communicate the importance of documentation to the coding/billing process
- Apply all appropriate coding principles to coding documentation

Key Terms

CMS 1450/Uniform Billing, 2004 (UB-04) claim form

***Current Procedural Terminology* (CPT)**

E codes (valid for ICD-9-CM only)

Evaluation and Management (E & M)

Healthcare Common Procedure Coding System (HCPCS)

***International Classification of Diseases,* 9th edition, Clinical Modification (ICD-9-CM)**

***International Classification of Diseases,* 10th edition, Clinical Modification (ICD-10-CM)**

***International Classification of Diseases,* 10th edition, Procedure Classification System**

Modifier codes

Neoplasms

Not Elsewhere Classified (NEC)

Not Otherwise Specified (NOS)

Table of drugs and chemicals.

V codes (Valid for ICD-9-CM only)

Volume III ICD-9-CM procedural codes (Valid for ICD-9-CM only)

PRACTICE EXERCISE 2-1

Utilizing the ICD-9/10-CM, assign diagnosis codes to the following.

	ICD-9-CM	Codes
1.	Upper respiratory infection	465.9
2.	COPD (chronic obstructive pulmonary disease)	496
3.	Acute blood loss anemia	285.1
4.	Irritable bowel syndrome	564.1
5.	Acute bronchitis	466.0
6.	Mitral valve insufficiency	424.0
7.	Head injury	959.01
8.	Ankle arthritis	716.97
9.	Benign hypertension	401.1
10.	Migraine headache	346.90
11.	MI	410.90
12.	Postoperative hypertension	997.91
13.	Viral syndrome	079.99
14.	Acute appendicitis	540.9
15.	Cholecystitis with cholelithiasis	574.10

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16. CHF	428.0
17. Nausea and vomiting	787.01
18. Chest pain	786.50
19. CAD	414.01
20. Unstable angina	411.1

ICD-10-CM	Codes
1. Upper respiratory infection	J06.9
2. COPD	J44.9
3. Acute blood loss anemia	D62
4. Irritable bowel syndrome	K58.9
5. Acute bronchitis	J20.9
6. Aortic valve insufficiency	134.0
7. Head injury	S09.90XA
8. Ankle arthritis	M19.079
9. Benign hypertension	110
10. Migraine headache	G43.909
11. MI	121.3
12. Postoperative hypertension	197.3
13. Viral syndrome	B34.9
14. Acute appendicitis	K35.80
15. Cholecystitis with cholelithiasis	K80.10
16. CHF	150.9
17. Nausea and vomiting	R11.2
18. Chest pain	R07.9
19. CAD	125.10
20. Unstable angina	120.0

PRACTICE EXERCISE 2-2

Assign ICD-9/10-CM diagnostic codes to the following conditions, placing them in the correct diagnostic code order.

Diagnosis	**ICD-10-CM Code(s)**
1. Bronchitis	J40
2. Acute bronchitis	J20.9
3. Gastroenteritis, suspect food poisoning	K52.9
4. Infectious mononucleosis	B27.90
5. Acute asthmatic bronchitis	J45.901
6. Acute exacerbation of COPD	J44.1
7. Acute serous otitis media	H65.00
8. Streptococcal pneumonia	J15.4
9. Salmonella due to food poisoning	A02.9
10. Nausea and vomiting due to viral gastroenteritis	A08.4
11. Syncope, probably vasovagal response	R55
12. Chest pain due to myocardial infarction	121.3
13. Dysuria with possible UTI	R30.0
14. Urinary tract infection with dysuria and polyuria	N39.0
15. Abnormal glucose tolerance test	R73.09
16. Dehydration due to either polyuria or influenza	E86.0
17. Painful hematuria as the result of UTI	N39.0
18. Acute and chronic appendicitis	K35.80/K36
19. Acute and chronic bronchitis	J44.0
20. Chest pain, R/O MI	R07.9

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INSTRUCTOR NOTE:
Remind students to utilize only the rules and guidelines learned thus far. Reemphasize that rules will differ for inpatient and outpatient, and we will differentiate those later.

	Diagnosis	Code
1.	Bronchitis LOOK UP: Bronchitis, NOS	490
2.	Acute bronchitis LOOK UP: Bronchitis, Acute	466.0
3.	Gastroenteritis, suspect food poisoning LOOK UP: Gastroenteritis Suspect food poisoning not coded Suspect, Rule Out, Probable, Possible Not Coded	558.9
4.	Infectious mononucleosis LOOK UP: Mononucleosis, Infectious	075
5.	Acute asthmatic bronchitis LOOK UP: Bronchitis, Asthmatic, Acute	493.90
6.	Acute exacerbation of COPD LOOK UP: COPD, Acute Exacerbation found under Disease, Pulmonary, Obstructive, Chronic with Acute Exacerbation	491.21
7.	Acute serous otitis media LOOK UP: Otitis Media, Serous, Acute	381.01
8.	Streptococcal pneumonia LOOK UP: Pneumonia, Streptococcal	482.30
9.	Salmonella due to food poisoning LOOK UP: Salmonella, Food Poisoning	003.9
10.	Nausea and vomiting due to viral gastroenteritis LOOK UP: Gastroenteritis, Viral Nausea and Vomiting Not Coded Signs/Symptoms as integral part of coded disease are not assigned codes.	008.8
11.	Syncope, probably vasovagal response LOOK UP: Syncope Probably, possible, rule out not assigned codes	780.2
12.	Chest pain due to myocardial infarction LOOK UP: Infarction, Myocardial Chest Pain is not coded as integral sign/symptom of coded disease.	410.90
13.	Dysuria with possible urinary tract infection (UTI) LOOK UP: Dysuria Possible, probably, suspect not assigned codes	788.1
14.	Urinary Tract Infection with dysuria and polyuria LOOK UP: Infection, Urinary Tract Dysuria, Polyuria are integral part of a diagnostic statement and are not assigned codes.	599.0
15.	Abnormal glucose tolerance test LOOK UP: Abnormal/Abnormality, Glucose Tolerance Test	790.29
16.	Dehydration due to either polyuria or influenza LOOK UP: Dehydration When the sign/symptom has not definitively been determined as to its origin, only the sign/symptom may be coded. NOTE: This rule will change when we visit inpatient hospital coding.	276.51

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17. Painful hematuria as the result of UTI — 599.0
    LOOK UP: Hematuria
        Signs/symptoms that are an integral part of the diagnostic codes do not need assigned codes.
18. Acute and chronic appendicitis — 540.9/542
    LOOK UP: Appendicitis, Acute/Chronic
        Code both acute and chronic.
        Acute conditions are coded first, assumed to be the chief reason for the encounter.
19. Acute and chronic bronchitis — 491.22
    LOOK UP: Bronchitis, Acute/Chronic
        Utilize combination code for acute with chronic.
20. Chest Pain, R/O MI — 786.50
    LOOK UP: Pain, Chest
        Rule Out, possible, probably not assigned codes
        NOTE: This guideline varies for inpatient coding as we will discuss in inpatient hospital coding.

PRACTICE EXERCISE 2-3

Review the following case scenarios. Determine which diagnostic statements, signs, and/or symptoms would be appropriate to be reported and assign the appropriate ICD-9/10-CM code(s) to each. It is not important, at this point in our studies, to determine the specific order of diagnosis; simply decide whether each diagnostic statement is necessary and list the appropriate ICD-9/10-CM code(s) for each. Note that the number of lines does not necessarily represent the number of diagnoses and diagnostic codes that should be chosen for each condition.

INSTRUCTOR NOTES:

1. Remind students that the number of lines is not necessarily indicative of the correct number of code assignments.
2. Remind students that the same guidelines apply mentioned previously, including the chief reason for the encounter is the primary diagnosis.

1. Patient presents to the emergency room complaining of right upper quadrant abdominal pain. Tests were performed, and the pain was determined to be the result of acute pancreatitis.
   Condition Coded: Acute Pancreatitis — Code: 577.0
   Condition Coded: — Code:
   LOOK UP: Pancreatitis, Acute
   Condition Coded: Acute Pancreatitis — ICD-10-CM Code: K85.9

2. Patient presents with history of breast carcinoma. Patient complains of lump in breast. Biopsy of breast lesion is taken to rule out recurrent breast carcinoma.
   Condition Coded: Breast Lump — Code: 611.72
   Condition Coded: History of Breast Ca — Code: V10.3
   LOOK UP: Lump, Breast
       History, personal, malignant neoplasm, breast
   Condition Coded: Breast Lump — ICD-10-CM Code: N63
   Condition Coded: History of Breast Ca — ICD-10-CM Code: Z85.3

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3. Patient is admitted to the hospital with complaints of fever, hematuria, and lower back pain for the past several days. Upon examination, the patient presents with a fever of 103.1, frank hematuria. A urinalysis was performed that revealed UTI. A subsequent kidney ultrasound indicated that the patient was suffering from pyelonephritis.
   Condition Coded: Pyelonephritis Code: 590.80
   Condition Coded: Urinary Tract Infection (need not be coded)
   LOOK UP: Pyelonephritis
   Infection, Urinary Tract (inc in pyelonephritis)
   Fever and hematuria are signs/symptoms of coded diagnostic statements and need not be coded.
   Condition Coded: Pyelonephritis ICD-10-CM Code: N12

4. Patient presents to the emergency room with a pain in the left calf. Examination revealed an area of swelling in the left calf with a slight fever. Venous Doppler was performed that revealed the presence of a thrombus in the left calf. The patient was admitted and placed on Coumadin therapy and discharged on the third day of hospitalization with the diagnosis of deep venous thrombosis.
   Condition Coded: Deep Vein Thrombosis, Leg Code: 453.40
   Condition Coded: Code:
   LOOK UP: Thrombosis, Deep Vein
   Pain in calf and swelling are signs/symptoms and need not be coded.
   Condition Coded: Thrombosis, Vein, Deep ICD-10-CM Code: I82.4Z2
5. Patient was seen in the emergency room with complaints of abdominal pain. Patient has a history of alcohol dependency and appears to be intoxicated. The abdominal pain resolved over a two- to four-hour period of time with the assistance of a GI cocktail and IV fluids.
   Condition Coded: Abdominal Pain Code: 789.00
   Condition Coded: History Alcohol Dependency Code: V11.3
   LOOK UP: Pain, Abdominal, History, Personal, Alcohol Dependency
   "Appears to be intoxicated" not coded as statements, such as probably, possible, suspect should not be coded.
   Condition Coded: Abdominal Pain ICD-10-CM Code: Rl0.9
   Condition Coded: Hx Alcohol Dep ICD-10-CM Code: F10.21

6. Patient was seen in the emergency room due to a fall from stairs at her home. She reports pain in the right wrist and is unable to use her wrist. On examination, the wrist appears to be swollen, tender, and obviously displaced. Wrist X-ray indicates a closed fracture of the radius and ulna which will be treated with the application of cast. Surgery does not appear to be necessary.
   Condition Coded: Closed Fx, Radius/Ulna Code: 813.83
   Condition Coded: Fall From Stairs Code: E880.9
   Condition Coded: At Home Code: E849.0
   LOOK UP: Fracture, Radius/Ulnar, Closed,
   External Cause, Fall from Stairs,
   External Cause, Place of Occurrence, Home
   Pain in right wrist is integral to diagnosis already coded, and, therefore, does not need to be coded.
   Condition Coded: Closed Fx, Radius/Ulnar ICD-10-CM Code: S52.91XA
   Condition Coded: Fall from Stairs ICD-10-CM Code: W10.8XXA
   Condition Coded: At Home ICD-10-CM Code: Y92.009

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7. Patient presented to the emergency room with lower abdominal pain accompanied by nausea and vomiting. WBC was elevated; the patient had a recorded fever of 103.1. Diagnosis of acute cholecystitis was made and the patient was scheduled for a cholecystectomy on an urgent basis.
   Condition Coded: Acute Cholecystitis — Code: 575.0
   Condition Coded: — Code:
   LOOK UP: Cholecystitis, Acute
   Nausea, Vomiting, Abdominal Pain, Fever are all integral Signs/symptoms of Acute cholecystitis and need not be assigned codes
   Condition Coded: Acute Cholecystitis — ICD-10-CM Code: K81.0
   Condition Coded: — ICD-10-CM Code:

8. Patient who has been diagnosed with prostatic cancer presents for chemotherapy regimen on an outpatient basis. Patient developed shortness of breath and became diaphoretic. The patient is being admitted to the hospital at this time.
   Condition Coded: Diaphoresis — Code: 780.8
   Condition Coded: Shortness of Breath — Code: 786.05
   Condition Coded: Encounter for Chemo — Code: V58.11
   Condition Coded: Prostate Ca — Code: 185
   LOOK UP: Diaphoresis (Chief reason for admission)
   Breath, Shortness of,
   Encounter for, Chemotherapy,
   Neoplasm, Prostate, Malignant, Primary
   Condition Coded: Diaphoresis — ICD-10-CM Code: R61
   Condition Coded: Shortness of Breath — ICD-10-CM Code: R06.02
   Condition Coded: Encounter for Chemo — ICD-10-CM Code: Z5I.ll
   Condition Coded: Prostate Ca — ICD-10-CM Code: C61

9. Patient presents for chemotherapy treatment for uterine cancer that has metastasized from the breast.
   Condition Coded: Chemotherapy — Code: V58.11
   Condition Coded: Metastasized Uterine Cancer — Code: 198.82
   Condition Coded: Breast Cancer — Code: 174.9
   LOOK UP: Encounter for, Chemotherapy
   Neoplasm, Uterus, Malignant, Secondary,
   Neoplasm, Breast, Malignant, Primary
   Condition Coded: Chemotherapy — ICD-10-CM Code: Z51.ll
   Condition Coded: Met Uterine Ca — ICD-10-CM Code: C79.82
   Condition Coded: Breast Ca — ICD-10-CM Code: C50.919

10. Patient presented to the emergency room as the result of a laceration to the occipital area as the result of an auto traffic accident. The laceration is cleaned, sutured, and the patient is released following treatment.
   Condition Coded: Laceration Occipital Area — Code: 873.0
   Condition Coded: Auto Accident — Code: E819.9
   LOOK UP: Wound, Open, Occipital,
   External Cause, Accident, Motor Vehicle
   NOTE: No more specific information is available. In a real-world scenario, the coder would need to get additional clarification from the physician and have the appropriate addendum made to the record accordingly.
   Condition Coded: Laceration, Occipital — ICD-10-CM Code: S01.00XA
   Condition Coded: Auto Accident — ICD-10-CM Code: V89.2XXA

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PRACTICE EXERCISE 2-4

Assign ICD-9/10-CM diagnostic codes to the following based on the specific coding guidelines outlines thus far.

1. Coronary Artery Disease
   Hypertensive Heart Disease
   Diagnosis: Coronary Artery Disease Code: 414.01
   Diagnosis: Hypertensive Heart Disease Code: 402.90
   LOOKUP: Disease, Artery, Coronary
   Disease, Hypertensive Heart
   NOTE: Two codes must be assigned for these conditions.
   Fifth digit of CAD is native vessel unless condition of CABG has been specified.
   Coronary artery disease ICD-10 Code: 125.10
   Hypertensive heart disease ICD-10 Code: 111.9
2. Hypertension due to Cushing's disease
   Diagnosis: Hypertension due to Cushing's dz Code: 405.99
   Diagnosis: Code:
   LOOK UP: Hypertension, due to Cushing's disease
   NOTE: One code only is needed as the hypertension has specifically been attributed to Cushing's disease.
   Hypertension due to Cushing's disease ICD-10 Code: 115.8
3. Essential Hypertension Headache
   Diagnosis: Hypertension (essential) Code: 401.9
   Diagnosis: Headache Code: 784.0
   LOOKUP: Hypertension, Essential
   Listed in Hypertension Code
   Headache would be coded if not considered an integral sign/symptom to hypertension, i.e., was not a sign/symptom typically associated with the disease.
   Essential hypertension ICD-10 Code: 110
   Headache ICD-10 Code: R51
4. Patient presents for tetanus immunization due to dog bite wound of arm.
   Diagnosis: Tetanus Vaccination Code: V03.7
   Diagnosis: Dog Bite Code: E906.0
   LOOKUP: Vaccination, Prophylactic, Tetanus Only
   Chief reason for encounter coded as primary diagnosis .
   External Cause, Bite, Dog
   E codes never primary reason for encounter.
   Patient did not present for dog bite but for tetanus immunization.
   Tetanus Immunization ICD-10 Code: Z23
   Dog Bite: ICD-10 Code: W54.0XXA
5. Patient presents for routine immunization of MMR (Mumps, Measles, and Rubella)
   Diagnosis: MMR Immunization/Vaccination Code: V06.4
   Diagnosis: Code:
   LOOKUP: Vaccination, Prophylactic, Measles with Mumps and Rubella
   MMR Immuniz/Vaccination ICD-10 Code: Z23
6. Congestive Heart Failure
   Essential Hypertension
   Diagnosis: Congestive Heart Failure Code: 428.0
   Diagnosis: Hypertension (essential) Code: 401.9
   LOOKUP: Failure, Heart, Congestive Hypertension, Essential
   Congestive Heart Failure ICD-10 Code: 150.9
   Hypertension ICD-10 Code: 110

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7. Breast Carcinoma, History of GI Cancer
   Diagnosis: Breast Carcinoma — Code: 174.9
   Diagnosis: History GI Cancer — Code: V10.00
   LOOKUP: Neoplasm, Breast, Primary,
   History, Personal, Malignant Neoplasm, Gastrointestinal Tract
   Chief reason for encounter is breast carcinoma.
   Contributing to complexity is history of previous Ca.
   Breast Carcinoma — ICD-10 Code: C50.919
   History GI Cancer — ICD-10 Code: Z85.00
8. Metastatic malignant neoplasm from chest wall to axillary lymph node
   Diagnosis: Metastatic Axillary Lymph Node Ca — Code: 196.3
   Diagnosis: Malignant Neoplasm, Chest Wall — Code: 195.1
   LOOKUP: Neoplasm, Lymph Node, Axillary, Malignant, Secondary Neoplasm, Chest, Wall, Malignant, Primary
   Chief reason for encounter is the metastasized secondary Ca; therefore, coded first, regardless of fact it is a secondary neoplasm code.
   Met Axillary Lymph Node Ca — ICD-10 Code: C77.3
   Malig Neo, Chest Wall — ICD-10 Code: C76.1
9. Open Wound, Hand
   Contusion, Knee
   Abrasion, Foot
   Diagnosis: Open Wound, Hand — Code: 882.0
   Diagnosis: Knee Contusion — Code: 924.11
   Diagnosis: Foot Abrasion — Code: 917.0
   LOOKUP: Wound, Open, Hand
   Code most significant injury first.
   Contusion, Knee
   Injury, Superficial, Foot
   (Abrasion is coded as superficial injury)
   Open Wound Hand — ICD-10 Code: S61.409A
   Knee Contusion — ICD-10 Code: S80.00XA
   Foot Abrasion — ICD-10 Code: S90.819A
10. Fitting and Adjustment of Leg Prosthesis
   Diagnosis: Fitting/Adjustment Prosthesis, Leg — Code: V52.1
   Diagnosis: — Code:
   LOOKUP: Fitting, Prosthesis, Leg
   Chief reason for encounter is not an illness, sign, symptom, or injury but fitting or adjustment of leg prosthesis.
   Fitting/Adj Leg Prosthesis — ICD-10 Code: Z44.109

PRACTICE EXERCISE 2-5

Reference the ICD-10-CM Draft Tabular and Alphabetic Index online and assign ICD-10-CM codes to the following diagnoses.

Diagnosis	ICD-10-CM Codes
1. Bronchitis	J40
2. Acute bronchitis	J20.9
3. Gastroenteritis, suspect food poisoning	K52.9
4. Infectious mononucleosis	B27.90
5. Acute asthmatic bronchitis	J45.901
6. Acute exacerbation of COPD	J44.1
7. Acute serous otitis media	H65.00

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8. Streptococcal pneumonia J15.4
9. Salmonella due to food poisoning A02.9
10. Nausea and vomiting due to viral gastroenteritis A08.4
11. Syncope, probably vasovagal response R55
12. Chest pain due to myocardial infarction I21.3
13. Dysuria with possible UTI R30.0
14. Urinary tract infection with dysuria and polyuria N39.0
15. Abnormal glucose tolerance test R73.09
16. Dehydration due to either polyuria or influenza E86.0
17. Painful hematuria as the result of UTI N39.0
18. Acute and chronic appendicitis K35.80/K36
19. Acute and chronic bronchitis J44.0
20. Chest Pain, R/O MI R07.9

PRACTICE EXERCISE 2-6

Assign ICD-9-CM procedural codes to the following:

1. Open reduction, fracture, ankle ICD-9-CM Procedure Code: 79.26
2. Hemorrhoidectomy ICD-9-CM Procedure Code: 49.46
3. Cholecystectomy ICD-9-CM Procedure Code: 51.22
4. Open reduction and internal fixation (ORIF), left humerus ICD-9-CM Procedure Code: 79.31
5. Infusion therapy ICD-9-CM Procedure Code: 99.29
6. Exploratory laparotomy with appendectomy ICD-9-CM Procedure Code: 47.09
7. Open biopsy of breast followed by lumpectomy ICD-9-CM Procedure Code: 85.12/85.23
8. Needle breast biopsy ICD-9-CM Procedure Code: 85.11
9. Bronchoscopy with biopsy ICD-9-CM Procedure Code: 33.24
10. D & C ICD-9-CM Procedure Code: 69.09
11. Esophagogastroduodenoscopy ICD-9-CM Procedure Code: 45.13
12. Laparoscopic cholecystectomy ICD-9-CM Procedure Code: 51.23
13. Knee arthroscopy ICD-9-CM Procedure Code: 80.26
14. Arthroscopic meniscectomy ICD-9-CM Procedure Code: 80.6
15. Laceration repair, arm ICD-9-CM Procedure Code: 86.59
16. Vaginal hysterectomy ICD-9-CM Procedure Code: 68.59
17. Prostatectomy ICD-9-CM Procedure Code: 60.69
18. Cataract extraction ICD-9-CM Procedure Code: 13.41/13.71
19. Blood administration ICD-9-CM Procedure Code: 99.03
20. Chemotherapy infusion ICD-9-CM Procedure Code: 99.25

PRACTICE EXERCISE 2-6

INSTRUCTOR NOTE:

* indicates character that cannot be determined

Assign ICD-10-CM procedural code(s) to the following:

1. Open reduction, fracture, ankle ICD-10-CM Procedure Code: 0QS*0ZZ
2. Hemorrhoidectomy ICD-10-CM Procedure Code: 06BY*ZC
3. Cholecystectomy TCD-10-CM Procedure Code: 0FT40ZZ
4. ORIF, left humerus ICD-10-CM Procedure Code: 0PS*04Z
5. Infusion therapy ICD-10-CM Procedure Code: 3E0***
6. Exploratory laparotomy w appendectomy ICD-10-CM Procedure Code: 0DTJ0ZZ
7. Open bx breast followed by lumpectomy ICD-10-CM Procedure Code: 0HB*0ZX, 0HB*0ZZ
8. Needle breast biopsy ICD-10-CM Procedure Code: OH9**3ZX
9. Bronchoscopy with biopsy ICD-10-CM Procedure Code: OBB*8ZX
10. D & C ICD-10--CM Procedure Code: 0UDB*Z*

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11.	Esophagogastroduodenoscopy	ICD-10-CM Procedure Code: 0DJ08ZZ
12.	Laparoscopic cholecystectomy	ICD-10-CM Procedure Code: 0FT44ZZ
13.	Knee arthroscopy	ICD-10-CM Procedure Code: 0SJ*4ZZ
14.	Arthroscopic meniscectomy	ICD-10-CM Procedure Code: 0SB*4ZZ
15.	Laceration repair, arm	ICD-10-CM Procedure Code: 0HQ*XZZ
16.	Vaginal hysterectomy	ICD-10-CM Procedure Code: 0UT97ZZ
17.	Prostatectomy	ICD-10-CM Procedure Code: 0VT0*ZZ
18.	Cataract extraction	ICD-10-CM Procedure Code: 08B*3ZZ 08R*3JZ
19.	Blood administration	ICD-10-CM Procedure Code: 302*3H1
20.	Chemotherapy infusion	ICD-10-CM Procedure Code: 3E0*30*

PRACTICE EXERCISE 2-7

Use what you have learned about the CPT to determine which section the following services would be located in.

1.	Office Visit, Outpatient Encounter with Patient or Physician	Section: Evaluation and Management
2.	Bronchoscopy with Biopsy Restorative, Invasive, Definitive Procedure	Section: Surgery
3.	Vasectomy Restorative, Invasive, Definitive Procedure	Section: Surgery
4.	Laceration Repair Restorative, Invasive, Definitive Procedure	Section: Surgery
5.	CT Scan Imaging	Section: Radiology
6.	Chest X-Ray Imaging	Section: Radiology
7.	Hemoglobin Study of Body Tissues/Fluids	Section: Pathology
8.	CBC Study of Body Tissues/Fluids	Section: Pathology
9.	Pap Smear Study of Body Tissues/Fluids	Section: Pathology
10.	Nursing Home Visit Encounter with patient/physician	Section: Encounter with patient/physician

PRACTICE EXERCISE 2-8

For the following, note the system, anatomical part, and specific procedure.

	System	Anatomical Part	Specific Procedure
1. Appendectomy	Digestive	Appendix	Excision
2. Laparoscopic Cholecystectomy	Digestive	Biliary	Laparoscopy
3. Laceration Repair, Arm, 3.0 cm	Integumentary	Skin	Closure/Repair
4. Extracapsular Cataract Extraction with Intraocular Lens Implant	Eye	Lens	Intraocular Cataract Lenses (IOL) Procedure
5. Excision Benign Lesion, 4.0 cm, Arm	Integumentary	Skin	Excision Lesion
6. Colonoscopy with Removal of Polyp By Snare Technique	Digestive	Rectum	Endoscopy
7. Cystourethroscopy with Fulguration of 2.0 cm Bladder Lesion	Urinary	Bladder	Transurethral

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8. Cystourethroscopic Placement of Ureteral Stent	Urinary	Bladder	Transurethral
9. Dilation and Curettage (Non-Ob)	Female	Corpus Uteri	Excision
10. Removal of Foreign Body, External Ear	Ear	External Ear	Removal

PRACTICE EXERCISE 2-9

Let's take another look at our previous exercise in which we simply identified where we would locate the CPT code for services, and let's now assign the appropriate CPT code.

	System	Anatomical Part	Specific Procedure	Code
1. Appendectomy	Digestive	Appendix	Excision	44950
2. Laparoscopic Cholecystectomy	Digestive	Biliary	Laparoscopy	47562
3. Laceration Repair, Arm, 3.0 cm	Integumentary	Skin	Closure/Repair	12002
4. Extracapsular Cataract Extraction with Intraocular Lens Implant	Eye	Lens	IOL Procedure	66984
5. Excision Benign Lesion, 4.0 cm, Arm	Integumentary	Skin	Excision Lesion	11404
6. Colonoscopy with Removal of Polyp by Snare Technique	Digestive	Rectum	Endoscopy	45385
7. Cystourethroscopy with Fulguration of 2.0 cm Bladder Lesion	Urinary	Bladder	Transurethral	52235
8. Cystourethroscopic Placement of Ureteral Stent	Urinary	Bladder	Transurethral	52332
9. Dilation and Curettage (Non-Ob)	Female	Corpus Uteri	Excision	58120
10. Removal of Foreign Body, External Ear	Ear	External Ear	Removal	69200

PRACTICE EXERCISE 2-10

Use the "breakdown" technique to locate the appropriate codes:

1. Arthroscopic Repair of Meniscus Tear, Knee
   Section: Surgery (Definitive, Restorative)
   Next Breakdown: Musculoskeletal (Specific System)
   Next Breakdown: Arthroscopy (Specific Procedure)
   Next Breakdown: Meniscus Tear Repair
   Code Assignment: 29882
2. 2.5 cm Laceration Repair of the Knee, Simple
   Section: Surgery (Definitive/Restorative)
   Next Breakdown: Integumentary (Specific System)
   Next Breakdown: Skin and Subcutaneous Tissue (Specific Part)
   Next Breakdown: Closure (Repair), Simple, Knee, 2.5 cm
   Code Assignment: 12001
3. Radical Modified Mastectomy with Axillary Lymphadenectomy
   Section: Surgery (Definitive/Restorative/Invasive)
   Next Breakdown: Integumentary (Specific System)
   Next Breakdown: Breast (Specific Part)
   Next Breakdown: Excision, Mastectomy, Modified Radical
   Code Assignment: 19307
4. Fracture Repair, Closed, Distal Radius
   Section: Surgery (Definitive / Restorative / Invasive)
   Next Breakdown: Musculoskeletal (Specific System)
   Next Breakdown: Radius (Specific Part)

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Next Breakdown: Fracture, Closed Distal
Code Assignment: 25600

5. Esophagogastroduodenoscopy (Upper GI) with Biopsy
Section: Surgery (Definitive / Restorative / Invasive)
Next Breakdown: Digestive Disease (Specific System)
Next Breakdown: Esophagus (Specific Part)
Next Breakdown: Endoscopy, Upper GI, with Biopsy
Code Assignment: 43239

6. Bronchoscopy with Removal of Foreign Body
Section: Surgery (Definitive / Restorative / Invasive)
Next Breakdown: Respiratory (Specific System)
Next Breakdown: Bronchus (Specific Part)
Next Breakdown: Endoscopy, Bronchus, Foreign Body Removal
Code Assignment: 31635

7. Colonoscopy with Polypectomy by Hot Biopsy Forceps
Section: Surgery (Definitive / Restorative / Invasive)
Next Breakdown: Digestive Disease (Specific System)
Next Breakdown: Rectum (Specific Part)
Next Breakdown: Endoscopy, Colonoscopy, Polyp Removal, Hot Biopsy Forceps
Code Assignment: 45384

8. Upper GI Endoscopy with Esophageal Dilation
Section: Surgery (Definitive / Restorative / Invasive)
Next Breakdown: Digestive Disease (Specific System)
Next Breakdown: Esophagus (Specific Part)
Next Breakdown: Endoscopy, Upper GI, Esophageal Dilation
Code Assignment: 43248/Guidewire
OR 43249/Balloon

9. Abdominal Hysterectomy with Colpocystourethropexy
Section: Surgery (Definitive/Restorative/Invasive)
Next Breakdown: Female Genital System (Specific System)
Next Breakdown: Corpus Uteri (Specific Part)
Next Breakdown: Abdominal Hysterectomy, Colpocystourethropexy
Code Assignment: 58152

10. Laparoscopic Tubal Ligation
Section: Surgery (Definitive/Restorative/Invasive)
Next Breakdown: Female Genital System (Specific System)
Next Breakdown: Oviducts and Ovaries (Specific Part)
Next Breakdown: Laparoscopy, Ligation of Tubes
Code Assignment: 58670
Could Be Assigned 58671 if occlusion of oviducts.

PRACTICE EXERCISE 2-11

Let us take a look at the following scenarios and determine:

1. Whether the use of a modifier is appropriate (Yes/No) and, if so,
2. What modifier would be assigned in this instance?

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Base your answers on outpatient facility guidelines discussed.

		Appropriate Y/N	Modifier Code Assignment
1.	Two emergency rooms encounters on the same date	Y	27
2.	Two surgical procedures performed on the same anatomical part	N	
3.	Excision of lesion of 01/01/YY, with need for return to the OR 10 days later for additional excision of margins	N	
4.	Patient was in ER on 01/01/YY for laceration repair returns for dressing change on 01/05/YY	N	
5.	Colonoscopy completed to the cecum with one biopsy completed and one unable to be completed	N	
6.	ER visits performed with nasal tamponade inserted during encounter for control of nasal hemorrhage	Y	25
7.	ER visits with chest X-Ray performed during same encounter	N	
8.	CT Abdomen and CT Pelvis performed in the outpatient setting	N	
9.	Two laceration repairs performed during the same encounter in the ED	N	
10.	Two EKGS performed during the same ED encounter	Y	76 OR 77

PRACTICE EXERCISE 2-12

Identify which sections in the HCPCS Level II the following codes should be selected from.

1. Hospital Bed, NOS — Section: E0100-E9999
2. Wheelchair, Electric — Section: E0100-E9999
3. Methotrexate, 50 mg, IM — Section: J9000-J9999
4. Spectacles, single vision — Section: S0000-S9999
5. Hearing Aid Battery — Section: V5000-V5999
6. Pap Smear — Section: P0000-P9999
7. Full Foot Orthotic — Section: L0000-L4999
8. Nebulizer — Section: E0100-E9999
9. Lasix, 20 mg, IV — Section: J0000-J8999
10. Rocephin, 1 gm, IV — Section: J0000-J8999

PRACTICE EXERCISE 2-13

Identify the place of service (inpatient/outpatient), the types of codes needed (ICD-9/10-CM diagnostic and/or procedural, CPT, and/or HCPCS codes), and assign codes accordingly.

! ***INSTRUCTOR NOTE:***
* indicates character that cannot be determined

ICD-9-CM Diagnosis Codes **CPT-4/ICD-9-CM Procedural Codes**

1. Outpatient *Diagnostic Knee Arthroscopy* performed for **Knee Pain.**

Location of Service:	Outpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 719.46
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 80.26
CPT-4 Procedural Code(s) Needed:	X Y ___N	Code(s): 29870
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10/ICD-lO-PCS:		
ICD-10-CM Diagnostic Code(s) Needed:	X Y ___ N	Code(s): M25.569
ICD-10-CM Procedural Code(s) Needed:	X___ Y N	Code(s): 0SJ*4ZZ

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2. Patient S/P Breast Cancer who has become **dehydrated** and is admitted to the hospital for *IV* rehydration. *Chemotherapy* also completed during hospitalization.

Location of Service:	Inpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 276.51/V58.11/V10.3
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 99.25 Code(s): 99.18
CPT-4 Procedural Code(s) Needed:	___ Y XN	Code(s):
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10/ICD-lO-PCS :		
ICD-10-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): E86.0, Z51.11, Z85.3
ICD-10-CM Procedural Code(s) Needed:	X ___ Y N	Code(s): 3E0*305, 3E0*37Z

3. Patient admitted for abdominal pain and swelling of the abdominal region. Admitted for exploratory laparotomy and an **ovarian cancer** was diagnosed. *Oophorectomy* was performed and *chemotherapy* treatment began while the patient was still hospitalized.

Location of Service:	Inpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 183.0/V58.11
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 65.39/99.25
CPT-4 Procedural Code(s) Needed:	___ Y XN	Code(s):
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10/ICD-lO-PCS:		
ICD-10-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): C56.9, 11
ICD-10-CM Procedural Code(s) Needed:	X ___ Y N	Code(s): 0UT*0ZZ, 3E0*305

4. Patient presents outpatient for Upper GI endoscopy due to **blood in stools, weight loss,** and **diarrhea.** Procedure is performed with *biopsy* of two polyps and *polypectomy by snare* of one polyp.

Location of Service:	Outpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 578.1/787.91/783.21
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 42.33/esophagus 43.41/stomach OR 45.30/duodenum OR 45.16/biopsy
CPT-4 Procedural Code(s) Needed:	X Y ___N	Code(s): 43251/43239
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10/ICD-lO-PCS :		
ICD-10-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): K92.1, R19.7, R63.4
ICD-10-CM Procedural Code(s) Needed:	X ___ Y N	Code(s): 0DB58Z* esophagus 0DB68Z* stomach 0DB98Z* duodenum 0DB*8Z* biopsy

5. Patient with previous history of **leukemia** is admitted due to abnormal white blood count. Patient has *packed red blood cell transfusion* and diagnosis is **exacerbation of leukemia.**

Location of Service:	Inpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 208.9/790.6
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 99.04
CPT-4 Procedural Code(s) Needed:	___ Y XN	Code(s):
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s)
ICD-10/ICD-10-PCS:		
ICD-10-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): C95.90,D72.9
ICD-10-CM Procedural Code(s) Needed:	X ___ Y N	Code(s): 302*3N1

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6. A 6-year-old patient presents on an outpatient basis for *tonsillectomy and adenoidectomy.*

Location of Service:	Outpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): No dx given
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 28.3
CPT-4 Procedural Code(s) Needed:	X Y ___N	Code(s): 42820
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10/ICD-lO-PCS :		
ICD-10-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): None given
ICD-10-CM Procedural Code(s) Needed:	X ___ Y N	Code(s): 0CTPXZZ, 0CTQXZZ

7. Patient seen in emergency room for **migraine headache.** Treated with *IM* Demerol and Vistaril and released.

Location of Service:	Outpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 346.90
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 99.29
CPT-4 Procedural Code(s) Needed:	X Y ___N	Code(s): 96372/ER Visit 99281-99285-25
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10/ICD-lO-PCS :		
ICD-10-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): G43.909
ICD-10-CM Procedural Code(s) Needed:	X ___ Y N	Code(s): 3E023NZ

8. Patient was admitted as the result of an **open fracture of the shaft of the right tibia** as a result of an **auto accident** where **driver** who is the patient **collided on the highway with another vehicle.**

Location of Service:	Inpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 823.30/E813.0/E849.5
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): None/no procedure indicated
CPT-4 Procedural Code(s) Needed:	___ Y XN	Code(s):
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10/ICD-lO-PCS:	X Y ___N	Code(s): S82.201B, V46.5XXA, Y92.410
ICD-10-CM Diagnostic Code(s) Needed:	X ___ Y N	
ICD-10-CM Procedural Code(s) Needed:		Code(s):

9. Patient was admitted to the hospital for uncontrolled **hypertension.** Patient was admitted approximately **5 weeks ago for myocardial infarction.** Patient received hypertensive medication and an *EKG* and *CXR* will be ordered to assess their cardiovascular status.

Location of Service:	Inpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 401.9/412
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s):
CPT-4 Procedural Code(s) Needed:	___ Y XN	Code(s):
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-l0ACD-10-PCS :		
ICD-10-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 110,125.2
ICD-I0-CM Procedural Code(s) Needed:	X ___ Y N	Code(s): 4A02X4Z, BW03ZZZ

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10. Patient admitted to the hospital with acute hip pain, no history of trauma, just began experiencing hip pain after walking in the garden. She also has a history of **diabetes, CHF, and COPD.** *X-ray* was performed that revealed **fracture femur shaft.** Cast applied and the patient will attend physical therapy on an outpatient basis.

Location of Service:	Inpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 821.01/250.00/428.0/496
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 93.53
CPT-4 Procedural Code(s) Needed:	___ Y XN	Code(s):
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10/ICD-10-PCS :		
ICD-10-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): S72.309A, E11.9, 150.9, J44.9
ICD-10-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 2W3*X2Z

PRACTICE EXERCISE 2-14

Practice Exercise 2-14 represents some basic outpatient coding scenarios. Look at the documentation and determine what information is integral to applying inpatient or outpatient coding principles in assigned code(s) as appropriate.

! ***INSTRUCTOR NOTE:***
* indicates character that cannot be determined

1. Chart 1 – Operative Report
Diagnostic Arthroscopy of the Right Shoulder with Mini-Open Rotator Cuff Repair Postoperative Diagnosis: **Right rotator cuff tear**
Patient was taken to the operating room and after general anesthesia was administered; her shoulder was examined. She was placed in the beach chair position and shoulder prepped and draped in sterile fashion. Scope was inserted and a diagnostic *arthroscopy* was performed. There were no significant findings other than a small rotator cuff tear at the anterior most aspect of the supraspinatus tendon. *Cuff edges were debrided* and the area of insertion was roughened at the humeral head. A suture anchor was used to fix the cuff back down to the bone; however, this ripped through the tendon. After this complication, it was decided to perform a mini-open approach to further evaluate. A small 4–5 cm *incision* was made with sharp dissection through the deltoid. The cuff tear was identified and it was indeed about a centimeter in size and was easily repaired. The suture anchor that had been used with the tendon was unable to be retrieved, so another *suture anchor was placed.*
The shoulder was able to be placed through a full range of motion with no obvious extension or impingement noted. Sterile dressing was applied. Patient was taken to the recovery room in stable condition.

Location of Service:	Outpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 840.4
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 83.63
CPT-4 Procedural Code(s) Needed:	X Y ___N	Code(s): 23410-RT
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10-CM Diagnostic Code(s) Needed:	Y X N	Code(s):M75.101
ICD-10-CM Procedural Code(s) Needed:	Y X N	Code(s):0LQ10ZZ

2. Chart 2 – Operative Report
Excision of Mass, Right Arm
Diagnosis: **Mass, Right Arm**
Patient's right arm was prepped and draped in standard fashion. A tourniquet was placed about the right arm and was elevated to 250 mm of mercury. The area of the skin incision was infiltrated with 1% Lidocaine with Epinephrine. An incision was made slightly lateral to the biceps tendon. Blunt

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dissection was then carried out and the firm *mass* encountered. It was *removed* without difficulty and sent for pathology.
The wound was irrigated and skin was closed using 5-0 Nylon in horizontal mattress fashion.
Dressing applied, tourniquet was released, and the patient tolerated the procedure well.

Location of Service:	Outpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 238.2
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 86.3
CPT-4 Procedural Code(s) Needed:	X Y ___N	Code(s): 11400
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10-CM Diagnostic Code(s) Needed:	Y X N	Code(s): D48.5
ICD-10-CM Procedural Code(s) Needed:	Y X N	Code(s): 0HB*XZZ

3. Chart 3 – Operative Report
Operative Arthroscopy of the Left Knee with Chondroplasty of the Patellofemoral Joint and Partial Medial Meniscectomy
Diagnosis: **Chondromalacia patellofemoral joint, Left Knee**
Degenerative tear Medial Meniscus Left Knee
Patient given satisfactory spinal anesthetic and placed in the supine position in the OR. Tourniquet placed and area was prepped and draped in usual sterile manner. *Scope was placed* inferolaterally and instrumentation portal was inferomedial. Examination showed Grade II *chondromalacia that was smoothed off* with a shaver. Lateral compartment showed minimal chondromalacia. Lateral meniscus was intact. Medial compartment showed large area of 3 cm of Grade IV chondromalacia and other areas of Grade III chondromalacia. There was a complex *tear* of the anterior horn of the *medial meniscus* that was *shaved off* with a shaver down to the stable rim. Posterior horn was intact.
Portals were closed with interrupted nylon sutures. Patient was taken to the recovery room in stable condition.

Location of Service:	Outpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 836.0/717.7
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 80.6/80.86
CPT-4 Procedural Code(s) Needed:	X Y ___N	Code(s): 29881-LT
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10-CM Diagnostic Code(s) Needed:	Y X N	Code(s):S83.242A,M22.42
ICD-10-CM Procedural Code(s) Needed:	Y X N	Code(s): 0SBD4ZZ, 0DBF4ZZ

4. Chart 4 – Operative Report
Closed reduction of distal tibia, casting with *fluoroscopic guidance*
Diagnosis: Refracture **left distal Tibia, Delayed Union**
Patient underwent open reduction internal fixation of a distal tibia fracture approximately six months ago. In a subsequent follow-up, it was determined that the fracture had not healed appropriately, and therefore, she is taken to the operating room for *closed reduction of distal tibia fracture.*
Posteromedial angulation was corrected with manipulation and the fracture was placed in a cast. The patient tolerated the procedure well with no complications.

Location of Service:	Outpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 733.82
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 78.47
CPT-4 Procedural Code(s) Needed:	X Y ___N	Code(s): 27720-LT
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10-CM Diagnostic Code(s) Needed:	Y X N	Code(s): S82.392K
ICD-10-CM Procedural Code(s) Needed:	Y X N	Code(s): 0QSHXZZ

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5. Chart 5 – Operative Report
   Trigger Point Injections
   Diagnosis: **Chronic low back pain,** mostly myofascial in origin
   A total of *three trigger points* were identified and marked on either side of the spine at the L1-L2 levels in the *erector spinae muscles.* The skin overlying these trigger points were prepped and draped in the usual sterile fashion and each of these *trigger points were infiltrated with 0.5 to 1 cc of solution containing 0.25% Marcaine with 4 mg per cc of Kenalog.* Patient tolerated the procedure well.

Location of Service:	Outpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 338.29,724.2
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 83.98
CPT-4 Procedural Code(s) Needed:	X Y ___N	Code(s): 20552
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10-CM Diagnostic Code(s) Needed:	Y X N	Code(s): G89.29, M54.5
ICD-10-CM Procedural Code(s) Needed:	Y X N	Code(s): 3E023BZ

6. Chart 6 – Operative Report
   Paracentesis Under *Ultrasound*
   History of Ascites
   An area of **ascites** was seen in the midline anterior abdomen. The area was cleansed and appropriately anesthetized. A 16 gauge *paracentesis catheter was placed* in this area removing 2400 cc of milky turbid fluid. The vital signs were stable throughout the procedure.

Location of Service:	Outpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 789.59
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 54.91
CPT-4 Procedural Code(s) Needed:	X Y ___N	Code(s): 49082
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10-CM Diagnostic Code(s) Needed:	Y X N	Code(s):R18.8
ICD-10-CM Procedural Code(s) Needed:	Y X N	Code(s): 0W9G30Z

7. Chart 7 – Operative Report
   Declotted ASH Catheter
   The examination was initially done through the **venous port** that was **occluded.** Wires were inserted through the catheter and a 4 French glide catheter was also inserted over the wire. This did not resolve the occlusion; 2 mg of *TPA* was *inserted into the venous side of the catheter* and left in position for 20 minutes. This improved the flow somewhat but not adequately. At this point, the right groin was cleansed and anesthetized appropriately. A goose neck snare was inserted and the end of the ash catheter was snared. The *catheter was* stripped with reestablishment of excellent flow through the catheter.

Location of Service:	Outpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 996.74/E878.9
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 39.49
CPT-4 Procedural Code(s) Needed:	X Y ___N	Code(s): 36596
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10-CM Diagnostic Code(s) Needed:	Y X N	Code(s): T82.898A, Y83.9
ICD-10-CM Procedural Code(s) Needed:	Y X N	Code(s): 03C*3ZZ

8. Chart 8 – Operative Report
   Left Heart Catheterization due to **Angina**
   Right groin was prepped and draped in the usual sterile fashion. Right *femoral vein was entered via percutaneous technique;* 8 French sheath inserted into vein. Right femoral artery was entered and the

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LCA selected and assessed via *angiography.* Catheter was exchanged and *RCA selected* and assessed via *angiography. LV* was next selected and *assessed* via *angiography.* Catheter removed over wire. Perclose device was deployed and hemostasis obtained.

Location of Service:	Outpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 413.9
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 37.22/88.55/88.53
CPT-4 Procedural Code(s) Needed:	X Y ___N	Code(s): 93458
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10-CM Diagnostic Code(s) Needed:	Y X N	Code(s): 120.9
ICD-10-CM Procedural Code(s) Needed:	Y X N	Code(s): 4A023N7 B201*ZZ B205*ZZ

9. Chart 9 – Operative Report
Colonoscopy with pedicle cauterization of AV malformations, Upper GI with CLOtest biopsy
Diagnosis: **Hematochezia** and **chronic pyrosis** with **history of gastric Resection**
First *colonoscopy* was performed and the scope was advanced all the way to the cecum. There were several *AV malformations* were identified, and I *electrocauterized* at least six lesions. The rest of the colon mucosa appears normal. The scope was straightened and pulled out.
The *upper endoscopy was performed.* Mouth sprayed with Cetacaine and EGD scope introduced into the esophagus. Esophagus appeared normal, and the scope was advanced into the stomach. Pylorus normal but duodenal bulb appeared severely erythematous. Scope was advanced further and a CLOtest *biopsy was performed.* Scope was dropped down into the fundus which also appeared normal. Scope was taken out and patient tolerated procedure well.

Location of Service:	Outpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 569.84/578.1/787.1/V45.89
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 45.43/45.16
CPT-4 Procedural Code(s) Needed:	X Y ___N	Code(s): 45382/43239
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10-CM Diagnostic Code(s) Needed:	Y X N	Code(s): K55.20, K92.1, R12, Z90.3
ICD-10-CM Procedural Code(s) Needed:	Y X N	Code(s): 0D5E8ZZ 0DB68ZX

10. Chart 10 – Operative Report
Esophagogastroduodenoscopy with biopsy and esophageal dilation **Gastritis**
Gastroscope was introduced into the patient's mouth and passed through the pharynx and into the esophagus. Mucosa was normal in appearance. The *endoscope* was then passed through the EG junction into the *stomach.* The endoscope was then passed through the pylorus *into the duodenum.* The endoscope was brought back into the stomach and a wire was deployed in the antrum. She was then *dilated with a 60 French savory dilator.* The wire and dilator were removed. *Biopsies were obtained from the distal esophagus* to assess esophagitis. Biopsies were also obtained from the gastric body from the area of the **gastritis.**

Impression:	Nonerosive Gastritis in the Stomach	
Location of Service:	Outpatient	
ICD-9-CM Diagnostic Code(s) Needed:	X Y ___N	Code(s): 535.50/530.3
ICD-9-CM Procedural Code(s) Needed:	X Y ___N	Code(s): 42.92/45.16
CPT-4 Procedural Code(s) Needed:	X Y ___N	Code(s): 43248/43239
HCPCS Procedural Code(s) Needed:	___ Y XN	Code(s):
ICD-10-CM Diagnostic Code(s) Needed:	Y X N	Code(s): K29.70, K22.2

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ICD-10-CM Procedural Code(s) Needed: Y X N Code(s): 0D758ZZ, 0DB58ZX, 0DB78ZX

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SUGGESTED CODING ACTIVITIES

1. Have the class compile a listing of surgical procedures they are familiar with—procedures they have had performed, or performed on family members, or just procedures they are aware of.

   Create a listing of these procedures to assign CPT-4 codes.
2. Take the listing created in Exercise 1 and discuss the possible reasons for performing the procedures indicated. Assign ICD-9/10-CM code(s) as appropriate.
3. Record a current program on DVD that involves "Life in the ER" or "trauma." Have the coding students watch the video, make note of all diagnostic statements, and code each encounter.

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