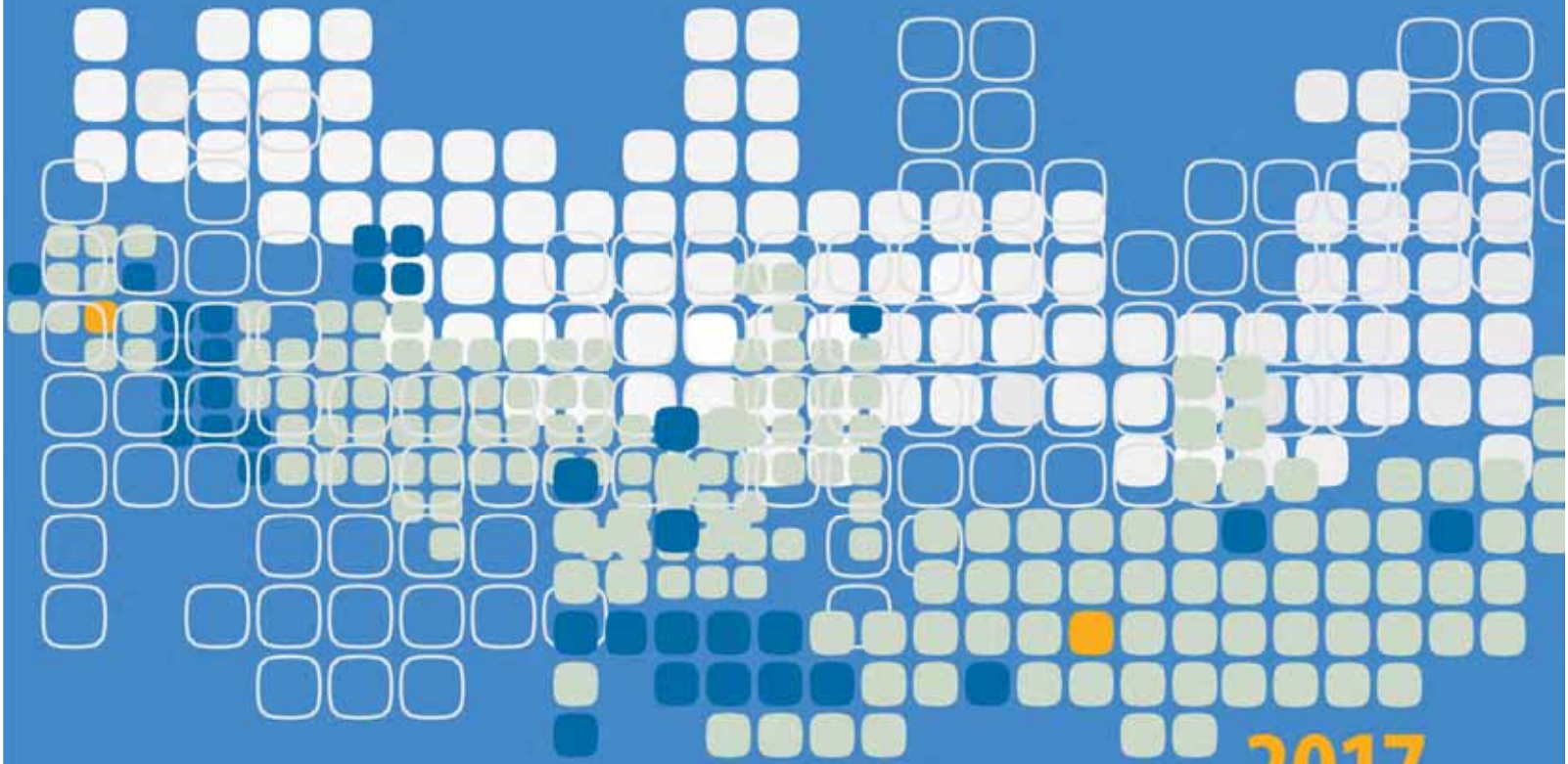
Medical Coding Training: CPC®

Practical Application Workbook



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AAPC
Advancing the Business of Healthcare

Exercise 1

Directions: Using the ICD-10-CM codebook locate the diagnosis codes for the following conditions.

1. Fever

2. Chronic non-intractable common migraine headache with status migrainosus

3. Otitis media left ear

4. Epigastric pain

5. Acute asthma exacerbation

6. Acute myocardial infarction

Exercise 1

Directions: Using the ICD-10-CM codebook locate the diagnosis codes for the following conditions.

1. Fever

   Answer: R50.9

   Rationale: In the ICD-10-CM Alphabetic Index, look for Fever. There is no additional information provided. The default code is R50.9. Review the code in the Tabular List to verify the code accuracy.

2. Chronic non-intractable common migraine headache with status migrainosus

   Answer: G43.701

   Rationale: Determine the main term which is headache. In the ICD-10-CM Alphabetic Index, look for Headache/migraine (type) (*see also* Migraine). In the same index, Migraine (idiopathic)/common directs you to *see* Migraine, without aura. Migraine/without aura/chronic/not intractable/with status migrainosus directs you to code G43.701. Review the code in the Tabular List to verify the code accuracy.

3. Otitis media left ear

   Answer: H66.92

   Rationale: The main term is otitis. In the ICD-10-CM Alphabetic Index, look for Otitis/media. There is no additional information provided. You are referred to H66.9-. The dash indicates an additional character is required for a complete code. Review the code in the Tabular List for the 5th character. Under subcategory H66.9 you will see Otitis Media NOS listed. The 5th character is 2 indicating the infection is in the left ear. This is an infection of the middle ear (media).

4. Epigastric pain

   Answer: R10.13

   Rationale: The main term is pain. In the ICD-10-CM Alphabetic Index, look for Pain/epigastric, epigastrium. You are referred to R10.13. Review the code in the Tabular List to verify the code accuracy.

5. Acute asthma exacerbation

   Answer: J45.901

   Rationale: The main term is asthma. In the ICD-10-CM Alphabetic Index, look for Asthma, asthmatic/with/exacerbation (acute) J45.901. Review the code in the Tabular List to verify the code accuracy. Note: There is a category note for J45 to use additional code to identify exposure to, use of, or dependence of tobacco. This is coded if known.

Case 10

Preoperative Diagnosis: Right ankle triplane fracture.

Postoperative Diagnosis: Right ankle triplane fracture.

Procedure: Open reduction and internal fixation (ORIF), right ankle triplane fracture.

Anesthesia: General endotracheal.

Complications: None.

Specimen: None.

Implant Used: Synthes 4.0 mm cannulated screws.

Indications for Procedure: The patient is a pleasant 15 year-old male who fell and sustained a right ankle triplane fracture. This was confirmed on both X-ray and CT scan. The indications for ORIF were explained to the patient, as well as the possible risks and complications, which include infection, bleeding, stiffness, hardware pain, the need for hardware removal, and there is no guarantee of a functional ambulatory result. The patient and family understood and wished to proceed.

Procedure in Detail: The patient was brought back to the operating room and placed on an operating table, given a general anesthetic without any complications, and given preoperative antibiotics per usual routine. He had the right lower extremity prepped and draped in the usual sterile fashion, with alcohol prep followed by routine Betadine prep.

Under X-ray guidance, a pointed reduction clamp was placed from the anterolateral corner of the distal tibia to the medial side, and I reduced the triplane fracture. It was confirmed on both AP and lateral X-ray images the gap was reduced. The patient then had guidewires taken from the Synthes 4.0 mm cannulated screw set. One was placed medially along the epiphysis on the anterior half of the epiphysis and parallel to the joint to catch the lateral aspect of the epiphysis. One screw was placed above the physis from anterior to posterior to capture that spike. Once the wires were in the appropriate position, the length was measured and partially threaded 4.0 mm cancellous screws were selected so all threads were across the fracture site. The appropriate length screws were placed, confirmed by an X-ray to be in good position. The fracture was anatomically reduced, and the ankle joint was anatomic. The patient had wounds copiously irrigated. Closure was done with interrupted horizontal mattress 3-0 nylon suture. The patient had a sterile compressive dressing applied, was placed into a three-sided posterior mold splint, was extubated, and brought to the recovery room in stable condition. There were no complications. There were no specimens. Sponge and needle counts were equal at the end of the case.

What are the CPT® and ICD-10-CM codes reported?

to identify the left side and the 7th character A to indicate this is the initial encounter. The resulting code is S86.012A. External cause codes are reported to describe the circumstances of the injury. The patient was playing basketball and was hit by another player. Go to the Index to External Causes and look for Hit, hitting (accidental) by, you are directed to *see* Struck by. Look for Struck (accidently) by/other person(s), referring to W50.0-. Turn to the Tabular List to complete the code: W50.0XXA. Next, look for Activity/basketball, which directs you to code Y93.67. Because documentation indicates the patient was playing a sport, report an external cause status code. Look for Status of external cause/recreation or sport not for income or while a student, referring you to code Y99.8. Turn to the Tabular List to verify the code accuracy. The location of the activity is not documented and not reported.

Case 10

Preoperative Diagnosis: Right ankle triplane fracture.

Postoperative Diagnosis: Right ankle triplane fracture. [1]

Procedure: Open reduction and internal fixation (ORIF), right ankle triplane fracture. [2]

Anesthesia: General endotracheal. [3]

Complications: None.

Specimen: None.

Implant Used: Synthes 4.0 mm cannulated screws.

Indications for Procedure: The patient is a pleasant 15 year-old male who fell and sustained a right ankle triplane fracture. This was confirmed on both X-ray and CT scan. The indications for ORIF were explained to the patient, as well as the possible risks and complications, which include infection, bleeding, stiffness, hardware pain, the need for hardware removal, and there is no guarantee of a functional ambulatory result. The patient and family understood and wished to proceed.

Procedure in Detail: The patient was brought back to the operating room and placed on an operating table, given a general anesthetic without any complications, and given preoperative antibiotics per usual routine. He had the right lower extremity prepped and draped in the usual sterile fashion, with alcohol prep followed by routine Betadine prep.

Under X-ray guidance, [4] a pointed reduction clamp was placed from the anterolateral corner of the distal tibia [5] to the medial side, and I reduced the triplane fracture. [6] It was confirmed on both AP and lateral X-ray images the gap was reduced. The patient then had guidewires taken from the Synthes 4.0 mm cannulated screw set. One was placed medially along the epiphysis on the anterior half of the epiphysis and parallel to the joint to catch the lateral aspect of the epiphysis. One screw was placed above the physis from anterior to posterior to capture that spike. Once the wires were in the appropriate position, the length was measured and partially threaded 4.0 mm cancellous screws were selected so all threads were across the fracture site. [7] The appropriate length screws were placed, confirmed by an X-ray to be in good position. The fracture was anatomically reduced, and the ankle joint was anatomic. The patient had wounds copiously irrigated. Closure was done with interrupted horizontal mattress 3-0 nylon suture. The patient had a sterile compressive dressing applied, was placed into a three-sided posterior mold splint, was extubated, and brought to the recovery room in stable condition. There were no complications. There were no specimens. Sponge and needle counts were equal at the end of the case.

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[1] The postoperative diagnosis is used for coding.

[2] This is the working procedure until the report is read.

[3] The type of anesthesia utilized is provided. General anesthesia was used.

[4] Radiologic guidance was used.

[5] Documentation within the body of the report further specifies the fracture and treatment were of the distal tibia.

|6| The fracture was reduced.

|7| Internal fixation was accomplished with screws.

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What are the CPT® and ICD-10-CM codes reported?

CPT® Codes: 27827-RT

ICD-10-CM Code: S82.391A, W19.XXXA

Rationale:
CPT® Codes: In the CPT® Index, look for Fracture/Tibia/Distal, and you are directed to code range 27824–27828. The procedure performed was open treatment with internal fixation (ORIF). The treatment was of the distal tibia, making 27827 the correct code selection. Appending modifier RT reflects laterality as right.

ICD-10-CM Code: A triplane ankle fracture refers to a fracture in the distal tibia in three planes. In the ICD-10-CM Alphabetic Index, look for Fracture, traumatic/tibia (shaft)/distal end, which refers to *see* Fracture, tibia, lower end. Look for Fracture, traumatic/tibia (shaft)/lower end/specified NEC, and you are directed to S82.39-. In the Tabular List, the complete code is S82.391A, using the 6th character 1 for the right tibia and the 7th character A for the initial encounter. The injury is the result of a fall. Look in the Index to External Causes for Fall, falling (accidental) W19.-. In the Tabular List, a 7th character is required for a complete code. Placeholder X is needed for the 4th, 5th, and 6th characters, followed by 7th character A for the initial encounter, resulting in a final code of W19.XXXA.

Case 9

Hospital Progress Note

Subjective: Patient is without complaint. She states she feels much better. No vomiting or diarrhea. She did have bowel movement yesterday. No shortness of breath, no chest pain.

The patient and daughter were questioned again about her cardiac history. She denies any cardiac history. She has no orthopnea, no dyspnea on exertion, no angina in the past and she has never had any heart problems in the past.

Case discussed yesterday with Dr. Williams and I am waiting to find out on her surgery date.

Objective:
Vital signs: Shows a T-max of 99.6, T-current 98, pulse 72, respirations 18. Blood pressure 154/65, 02 sat 96% on room air. Accu-checks, 113, 132, 96, 98.

General: No apparent distress, oriented x 3, pleasant Spanish-speaking female.

Head, Ears, Eyes, Nose, Throat: Normocephalic, atraumatic. Oropharynx pink and moist. Left eye has sclera erythema. Pupils equal, round, and reactive to light accommodation (PERRLA).

Laboratory Data: Shows C Diff toxin negative. Sodium 129, potassium 3.4, chloride 96, CO_2 27, glucose 72, BUN 12, creatinine 0.6. Urine culture positive for E. coli, sensitive to Levaquin.

Assessment:

1. Cholelithiasis
2. Cystitis
3. Conjunctivitis
4. Hyponatremia
5. Hypokalemia
6. Diabetes mellitus type 2
7. Hypertension

If the patient is not to go to surgery today, will feed the patient and likely discharge her if she tolerates regular diet. Will add Norvasc 5 mg p.o. daily. Also pleural effusion, small. Will repeat a chest X-ray PA and lateral this morning to evaluate that.

What are the CPT® and ICD-10-CM code(s) reported?

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CPT® code: 99222

ICD-10-CM codes: R11.2, R19.7, N30.90, E87.6, E87.1, K80.20, E11.9, Z79.84, I10

Rationale:
CPT® code: Subcategory—Initial Hospital Care (3 of 3 key components)

History—Comprehensive (HPI—Extended, ROS—Complete, PFSH—Complete)

Exam—Comprehensive (8 organ systems)

MDM—Moderate Complexity (Extensive diagnoses, Limited data [reviewed radiology & labs, ordered labs], Risk—Moderate [IV hydration with additives]).

ICD-10-CM codes:

1. Nausea, vomiting, diarrhea, likely gastroenteritis (gastroenteritis is only a possible diagnosis, nausea, vomiting and diarrhea are symptoms, but the cause is undetermined, so they are coded). Look in the ICD-10-CM Alphabetic Index for Nausea/with vomiting R11.2 and Diarrhea, diarrheal R19.7.
2. Cystitis—Look in the Alphabetic Index for Cystitis. There are no other descriptors N30.90.
3. Hypokalemia—Look in the Alphabetic Index for Hypokalemia E87.6.
4. Hyponatremia—Look in the Alphabetic Index for Hyponatremia E87.1.
5. Cholelithiasis—Look in the Alphabetic Index for Cholelithiasis – *see* Calculus, gallbladder. Look for Calculus, calculi, calculous/gallbladder K80.20.
6. Diabetes mellitus type 2—Look in the Alphabetic Index for Diabetes, diabetic/type 2 E11.9.
7. The patient is on long-term metformin to control her blood sugar. Look in the Alphabetic Index for Long-term (current) (prophylactic) drug therapy (use of)/oral/hypoglycemia Z79.84.
8. Hypertension— Look in the Alphabetic Index for Hypertension I10.

Verify code selections in the Tabular List.

Case 9

Hospital Progress Note

Subjective: Patient is without complaint. She states she feels much better. [1] No vomiting or diarrhea. She did have bowel movement yesterday. [2] No shortness of breath, no chest pain. [3]

The patient and daughter were questioned again about her cardiac history. She denies any cardiac history. She has no orthopnea, no dyspnea on exertion, no angina in the past and she has never had any heart problems in the past. [4]

Case discussed yesterday with Dr. Williams and I am waiting to find out on her surgery date.

Objective:
Vital signs: Shows a T-max of 99.6, T-current 98, pulse 72, respirations 18. Blood pressure 154/65, 02 sat 96% on room air. Accu-checks, 113, 132, 96, 98. [5]

General: No apparent distress, oriented x 3, pleasant Spanish-speaking female. [5]

Head, Ears, Eyes, Nose, Throat: Normocephalic, atraumatic. [6] Oropharynx pink and moist. [7] Left eye has sclera erythema. Pupils equal, round, and reactive to light accommodation (PERRLA). [8]

Laboratory Data: Shows C Diff toxin negative. Sodium 129, potassium 3.4, chloride 96, CO_2 27, glucose 72, BUN 12, creatinine 0.6. Urine culture positive for E. coli, sensitive to Levaquin. [9]

Assessment:

1. Cholelithiasis
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If the patient is not to go to surgery today, will feed the patient and likely discharge her if she tolerates regular diet. Will add Norvasc 5 mg p.o. daily. Also pleural effusion, small. Will repeat a chest X-ray PA and lateral this morning to evaluate that.

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[1] HPI: Quality

[2] ROS: GI

[3] ROS: Respiratory

[4] ROS: Cardiovascular

[5] Exam: Constitutional

[6] Exam: Head, including face

[7] Exam: ENMT

[8] Exam: Eyes

[9] Lab tests reviewed

What are the CPT® and ICD-10-CM code(s) reported?

CPT® code: 99232

ICD-10-CM codes: K80.20, N30.90, H10.9, E87.1, E87.6, E11.9, I10

Rationale:
CPT® code: Subcategory: Subsequent Hospital Care (2 of 3 components)

History—Expanded problem focused (HPI—Brief, ROS—Extended, PFSH—none)

Exam—Expanded problem focused (3 organ systems—limited exams of all three)

MDM—Moderate Complexity (Extensive diagnosis, Review labs, Moderate Risk [Two or more stable chronic illnesses]).

ICD-10-CM codes:

1. Cholelithiasis—In the ICD-10-CM Alphabetic Index, look for Cholelithiasis – *see* Calculus, gallbladder; Calculus, calculi, calculous/gallbladder K80.20.
2. Cystitis—Look in the Alphabetic Index for Cystitis. There are no other descriptors, use N30.90. Physician needs to document the infectious agent to report it.

3. Conjunctivitis—Look in the Alphabetic Index for Conjunctivitis NOS H10.9.
4. Hyponatremia—Look in the Alphabetic Index for Hyponatremia E87.1.
5. Hypokalemia—Look in the Alphabetic Index for Hypokalemia E87.6.
6. Diabetes mellitus type 2—Look in the Alphabetic Index for Diabetes, diabetic/type 2 E11.9.
7. Hypertension— Look in the Alphabetic Index for Hypertension I10.

Verify code selections in the Tabular List.

Case 10

Discharge Summary [1]

Hospital Course: The patient was hospitalized two days ago with nausea and vomiting. She had an uneventful hospital course. She was diagnosed with cholelithiasis. General surgery was consulted. Dr. Williams thought this was perhaps causing her upper GI symptoms. She was scheduled for surgery on Monday. She was tolerating a regular diet. Her nausea and vomiting resolved and she desired to be dismissed home. She was found to have a bladder infection. She was started on Levaquin and she also had left eye conjunctivitis and she was given Ciloxan eye ointment for that.

Discharge Diagnoses: [2]

1. Cholelithiasis
2. Cystitis
3. Conjunctivitis
4. Hyponatremia
5. Diabetes mellitus type 2
6. Hypertension

Discharge Medications:

1. Levaquin 500 mg p.o. daily x2 days
2. Ciloxan ointment, apply b.i.d.to left eye x 4 days/
3. Zofran 4 mg p.o. q. 4 hours p.r.n. nausea, vomiting #20
4. Benadryl 25 mg p.o. daily p.r.n. rash
5. Diovan 320 p.o. daily
6. Calcium 600 mg p.o. daily
7. Vitamin C 500 mg p.o. daily.
8. Metformin 1000 mg p.o. daily
9. Lipitor 20 mg p.o. at bedtime
10. Coreg CR 20 mg p.o. daily.

Discharge Diet: Cardiac

Activities: ad lib

Discharge instructions: Patient to be NPO after midnight Sunday.

Dismiss: Home [3]

Condition: Good

Follow-up: Follow up with me in 1 week. Follow up on Monday morning for cholecystectomy. NPO after midnight on Sunday. [4]

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[1] This indicates the provider is discharging the patient. Review the note to make sure discharge services where performed. Look for documented time in the note.