Inpatient and Outpatient Coding

Unit: Career Exploration and Planning

Problem Area: Medical Coding

Lesson: Inpatient and Outpatient Coding

Student Learning Objectives.

Instruction in this lesson should result in students achieving the following objectives:

1. **Summarize inpatient coding protocols.**
2. **Summarize outpatient coding protocols.**

Resources.

The following resources may be useful in teaching this lesson:

E-unit(s) corresponding to this lesson plan. CAERT, Inc. http://www.mycaert.com.

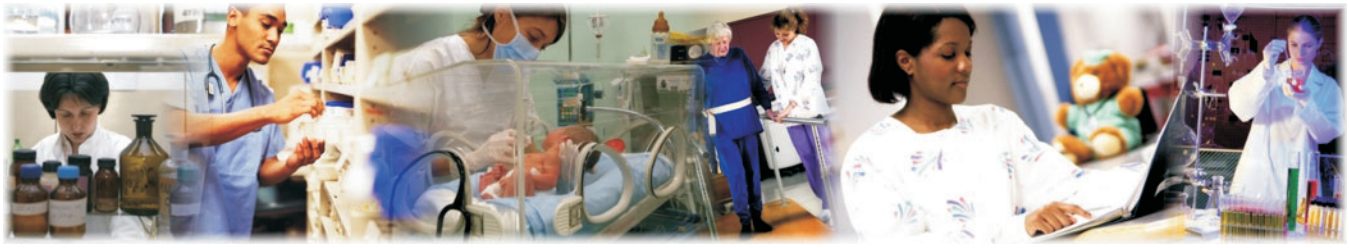
Centers for Medicare & Medicaid Services (CMS). Accessed Mar. 18, 2019. https://www.cms.gov/.

Hicks, Joy. "Accurate Coding for Outpatient Procedures," *VeryWell Health*. Accessed Mar. 18, 2019. https://www.verywellhealth.com/accurate-coding-for-outpatient-procedures-2317094.

"ICD-10-CM Official Guidelines for Coding and Reporting: FY 2018," *Centers for Medicare and Medicaid Services (CMS)*. Accessed Mar. 18, 2019. https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-ICD-10-CM-Coding-Guidelines.pdf.

"ICD-10 Coding Scenarios for Family Practice," *Practice Fusion*. Accessed Mar. 18, 2019. https://www.practicefusion.com/icd-10/clinical-concepts-for-family-practice/icd-10-clinical-scenarios/.

"Medical Billing and Coding and Coding Made Easy," *Find-A-Code*. Accessed Mar. 18, 2019. https://www.findacode.com/.



Equipment, Tools, Supplies, and Facilities

- ✓ Overhead or PowerPoint projector
- ✓ Visual(s) from accompanying master(s)
- ✓ Copies of sample test, lab sheet(s), and/or other items designed for duplication
- ✓ Materials listed on duplicated items
- ✓ Computers with printers and Internet access
- ✓ Classroom resource and reference materials

Key Terms.

The following terms are presented in this lesson (shown in bold italics):

- admission diagnosis
- chief complaint
- comorbidity
- complication
- diagnosis
- first-listed diagnosis
- ICD-10
- inpatient coder
- inpatient coding
- inpatient medical facility
- outpatient coder
- outpatient coding
- present on admission (POA) indicators
- Principal diagnosis
- secondary diagnosis
- subsequent hospital care

Interest Approach.

Use an interest approach that will prepare the students for the lesson. Teachers often develop approaches for their unique class and student situations. A possible approach is included here.

> *According to the Centers for Medicare and Medicaid Services, more than five billion medical claims are submitted for payment each year. Standardized coding is important to ensure that these claims are processed in a consistent manner. Insurance companies, third-party payers, and federal and state regulations have expressed an increasing concern regarding the importance of timely and accurate coding.*

> *The decision, as to whether the patient is an "inpatient" or an "outpatient," is one of the most important considerations during the medical billing and coding process. Inpatient and outpatient coding, although similar in theory, are very different. Services received in each setting are reported using different code sets and guidelines and those services are paid differently. For example, "original"*

Medicare inpatient claims are paid under Part A and outpatient claims are paid under Part B.

Another illustration of the difference between inpatient and outpatient coding is the coding of signs and symptoms. Signs and symptoms should NOT be coded in inpatient settings. However, additional signs and symptoms may be coded if a definitive diagnosis is not included. For example, inpatient coding requires the coding of suspected conditions and abnormal signs and symptoms, if the provider has not made a diagnosis. When outpatient procedures lack a definitive diagnosis, signs and symptoms are acceptable for coding purposes. Coders would check for any new results and information from the provider about a definitive diagnosis prior to entering the codes for such signs and symptoms.

In short, outpatient coding is less complex than inpatient coding, but not necessarily easier. An experienced, certified coder, specifically focused on outpatient or inpatient coding, can be the difference between a denied claim and deserved reimbursement.

CONTENT SUMMARY AND TEACHING STRATEGIES

Objective 1: Summarize inpatient coding protocols.

Anticipated Problem: What is inpatient coding? What are inpatient coding duties and protocols? What is a diagnosis?

I. Inpatient coding protocols

A. ICD-10: ***ICD-10*** (International Classification of Diseases, Tenth Revision) is the system used by physicians and other healthcare providers to define, classify, and code the universe of diseases, disorders, injuries, and other related health conditions. ICD-10 went into effect on October 1, 2015. The current ICD-10-CM revision includes more than 68,000 diagnostic codes. By comparison, ICD-9-CM contained 13,000 codes. ICD-10-CM diagnosis codes consist of three to seven digits. ICD-9-CM was a three to five-digit system. The increase in the amount and length of ICD-10-CM codes allows for greater coding specificity.

B. INPATIENT CODING: ***Inpatient coding*** is a review of the entire medical record for the length of stay and the selection of the principal diagnosis. Inpatient coding refers to the procedures (and the associated codes) for an individual who has been officially admitted to the hospital under a physician's order. The patient is classified as an inpatient until one day before discharge. Inpatient coding is

usually more complex than outpatient coding because the inpatient records are typically long and very detailed.

1. The ***principal diagnosis*** is the chief reason for an inpatient stay. It is the condition that prompted admission to the hospital. For example, a patient might present symptoms of dehydration and is admitted for gastroenteritis. In this example, gastroenteritis is the principal diagnosis. Coders also select the secondary diagnoses for a patient's coexisting conditions.
2. An ***inpatient medical facility*** is a healthcare setting that admits patients for 24 hour care (overnight). Hospitals are the most common types of inpatient facilities. During the hospital stay, the patient may have a variety of tests, and there might be changes in diagnosis and treatments. Other inpatient facilities include:
   a. Nursing homes
   b. Rehabilitation centers
   c. Acute and long-term care hospitals
   d. Skilled nursing facilities
   e. Hospices
   f. Home health services

C. INPATIENT CODER: An ***inpatient coder*** is a medical coding professional who is responsible for assigning the procedure codes that identify a patient's diagnosis and treatment while within a hospital or a long-term care facility. Inpatient coders primarily use International Classification of Diseases (ICD) codes that are designed to describe a patient's diagnoses or medical conditions. Accuracy is extremely important in medical coding. To ensure accuracy, inpatient coders may need to speak with physicians and nurses to clarify some patient information. Responsibilities for an inpatient coder include:

1. Reviewing patient charts and physician notes (either paper or electronic).
2. Determining and assigning the proper and most accurate medical codes for diagnoses and procedures.
3. Performing coding services for each day of a patient's stay in the facility.
4. Performing varied and complex diagnostic and procedural coding for accurate DRG (diagnosis-related group) severity of illness, and risk of mortality assignment.
5. Determining the patient's principal diagnosis that prompted admission to the hospital or long-term care facility. [NOTE: The physician must link the presenting symptoms, which necessitated the admission, to the final diagnosis. Coders cannot infer a cause-and-effect relationship.]

D. DIAGNOSIS: A ***diagnosis*** is the identification of the nature of a disease or condition, by examining a patient's signs and symptoms. A diagnosis describes the cause, nature, or indicators of a condition, situation, or problem. In some clinical situations, it may be impossible for the provider to make a definitive diagnosis at the time of admission. Sometimes, a patient may not recognize or report a condition immediately.

1. ***Present on admission (POA) indicators*** are the medical conditions that are present at the time the order for inpatient admission occurs. The POA indicator differentiates conditions present at the time of admission from those conditions that develop during the inpatient stay. When the same diagnosis code applies to two or more conditions during the same encounter (e.g., acute and chronic conditions classified with the same diagnosis code), the POA assignment depends on whether all conditions, represented by the single diagnosis code, were POA.
2. According to the Centers for Medicare and Medicaid Services, the ***admission diagnosis*** (admitting diagnosis) is the medical condition, identified by the physician, at the time of a patient's hospitalization. It is an initial analysis/judgment. Coders can only assign one admission diagnosis code, even if more than one is documented. The first admission diagnosis, documented on the inpatient face sheet, is documented by:
    a. The patient's primary care physician. This is the doctor who determined that inpatient care was necessary for treatment of a condition diagnosed in the doctor's office (e.g., acute exacerbation of chronic asthma).
    b. Elective surgery, which was previously scheduled (e.g., elective vasectomy).
    c. The facility's emergency department physician. This is the doctor who provided treatment and determined that inpatient care was necessary (e.g., trauma, heart attack, stroke, etc.).
    d. The ambulatory surgery unit surgeon who performed outpatient surgery and determined that inpatient care was necessary (e.g., laparoscopic cholecystectomy was converted to open cholecystectomy, requiring postoperative overnight monitoring.)

E. SECONDARY DIAGNOSIS: A ***secondary diagnosis*** is a condition, which coexists with the principal diagnosis, at the time of admission, or a coexisting condition that develops after admission. Secondary diagnoses include comorbidities, complications, and other diagnoses, documented by the attending physician on the inpatient face sheet or discharge summary.
    1. ***Comorbidity*** is the presence of one or more medical conditions that exist simultaneously and, usually, independently, of each other. Comorbid diseases or disorders affect the treatment, which is provided to the patient during the current relevant episode of care.
    2. A ***complication*** is a condition that arises during the relevant episode of care, and affects treatment provided to the patient.
    3. Coders must review inpatient record reports to locate secondary diagnoses that are not documented on the face sheet or discharge summary. To assign secondary codes, inpatient coders research:
        a. History and physical documents
        b. Chronic conditions
        c. Personal history and family history of conditions
        d. Ancillary reports that document bacteria that cause infection (lab data), type of fracture (X-ray report), location of myocardial infarction

(electrocardiogram report), and other documented and reviewed secondary diagnoses.

4. When a question arises about a code assigned to a secondary diagnosis in the patient's health record, a physician query (a written question to a physician) may be generated to obtain clarification and an amendment of the list of secondary diagnoses.
5. ***Subsequent hospital care*** is the treatment of a patient that follows the initial hospital care. This is frequently referred to as "follow-up." The frequency of these follow-up visits is determined by the provider, based on the patient's condition and need. The provider, as a result of the physician query process, resolves issues related to inconsistent, missing, conflicting, or unclear documentation.

Teaching Strategy: *Many techniques can be used to help students master this objective. Prior to the lesson ask students what they already know about inpatient and outpatient coding. Use VM–A to display differences between outpatient and inpatient coding. Use VM–B to illustrate additional POA information. Use VM–C to review medical coding parameters for POA requirements. Use VM–D to provide additional information about secondary diagnoses and physician queries. Use VM–E to review a scenario linked to professional and facility claims and billing. Present and discuss additional coding scenarios in which one or both types of coding takes place (e.g., inpatient/facilities and outpatient/professional). For example, the AmeriHealth website contains several ICD-10 medical coding scenario exercises to practice coding at https://www.amerihealth.com/pdfs/providers/claims_and_billing/icd_10/icd_10_practice_ah.pdf.*

Objective 2: Summarize outpatient coding protocols.

Anticipated Problem: What is outpatient coding? What are outpatient coding duties and protocols?

II. Outpatient coding and protocols

A. OUTPATIENT CODING: ***Outpatient coding*** is a review of medical records from a particular date of service and the selection of the first-listed diagnosis code. Outpatient coding also included selecting codes for any secondary diagnoses. The selected codes support the services provided on the same day as the appointment, or trip to the outpatient facility. Outpatient coding comprises most of the coding performed in the healthcare industry. All coding for doctors' offices, clinics, outpatient and ambulatory care facilities, hospital emergency rooms, etc. is classified as outpatient coding. In the outpatient setting, ICD-10-CM coding guidelines are used and they take priority over other coding rules. A ***first-listed diagnosis*** is the term used by medical coders in an outpatient setting, in lieu of the term "principal diagnosis," because a diagnosis may not be established at the time of the initial visit. It often takes two or more visits before a diagnosis is confirmed. The ***chief complaint*** is the patient's reason for the medical visit. It is

one of the keys in determining the first-listed diagnosis. From the patient's perspective, the chief complaint is the reason for the visit.

1. Should no specific diagnosis be established, and the patient presents with only signs or symptoms, the first-listed diagnosis may be the signs and symptoms. Outpatient coders cannot code "probable," "suspected," "likely," or "rule out" conditions. Physicians tend to use this verbiage, even though the conditions cannot be coded unless definitively diagnosed.
2. For a patient who presents for outpatient surgery (same day surgery), the reason for the surgery is coded as the first-listed diagnosis, even if the surgery is not performed due to a contraindication.
3. For a patient who is admitted for observation for a medical condition, the medical condition is coded as the first-listed diagnosis.
4. For a patient who presents for outpatient surgery and develops complications requiring admission for observation, the reason for the surgery is coded as the first-reported diagnosis, and the complications are coded as secondary diagnoses.

B. OUTPATIENT CODER: An ***outpatient coder*** is a medical coding professional who is responsible for assigning the procedure codes that identify a patient's diagnosis and treatment, when hospital admission is not required and the treatment is performed outside the hospital setting. Outpatient coding, reimbursed under Medicare Part B, is used to report diagnostic services in which the patient does not stay at the medical facility long-term. Such services can include everything from conducting a blood test to treating trauma injuries in the emergency room. ICD-10-CM codes are used to report diagnoses. The CPT and HCPCS code sets are used to report services and the accompanying supplies.

C. GUIDELINES: Standards for outpatient coders promote accuracy and efficiency.

1. DOCUMENTED CONDITIONS: All documented conditions, which coexist at the time of the encounter/visit and require, or affect, patient care treatment or management, should be coded. Conditions that were previously treated and no longer exist, are not coded. However, patient history may be used as secondary codes if the historical condition or family history has an impact on current care, or influences treatment.
2. DIAGNOSTIC SERVICES: Outpatients, who receive only diagnostic services during their visit, should be coded first with the diagnosis, or condition, that is chiefly responsible for the outpatient services provided. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.
3. LABORATORY OR RADIOLOGY: Encounters for routine laboratory or radiology testing, in the absence of any signs, symptoms, or associated diagnosis, are assigned the code Z01.89 (encounter for other specified special examinations). If routine testing is also performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both Z01.89 and the code describing the reason for the non-routine test.
4. DIAGNOSTIC TESTS: When the results of outpatient, diagnostic tests have been interpreted by a physician, and the final diagnostic report is available at

the time of coding, any confirmed or definitive diagnosis(es) described in the interpretation should be coded. Coders should not code related signs and symptoms as additional diagnoses.

5. THERAPEUTIC SERVICES: For patients receiving therapeutic services only during a visit, coders should sequence first the diagnosis, or condition, that is chiefly responsible for the outpatient services provided. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses. [NOTE: The exception to this rule is a situation in which the primary reason for the admission/encounter is chemotherapy or radiation therapy. In this case the appropriate Z code for the service is listed first, and the diagnosis or problem for which the service is being performed is listed second.]
6. PREOPERATIVE EVALUATIONS: For patients receiving preoperative evaluations only, coders should first sequence a code from subcategory Z01.81 (encounter for pre-procedural examinations) to describe the pre-op consultations. As an additional diagnosis, coders should assign a code for the condition that led to the surgery. Any findings, which are related to the pre-op evaluation, should also be coded.
7. AMBULATORY SURGERY: For ambulatory surgery, the diagnosis, for which the surgery was performed, should be coded. If the confirmed, postoperative diagnosis is different from the preoperative diagnosis, the postoperative diagnosis should be selected for coding, since it is the most definitive.

Teaching Strategy: *Many techniques can be used to help students master this objective. Use VM–F to review examples of first-listed diagnosis and the patients' chief complaint. You can review the presented information with students or remove the first listed diagnosis and ask students to try to identify it. Use VM–G to review common outpatient coding errors and the consequences of coding errors. Assign LS–A for students to locate the appropriate ICD-10-CM code. Assign LS–B to give students the opportunity to read through scenarios and decipher information needed for coding.*

- **Review/Summary.** Use the student learning objectives to summarize the lesson. Have students explain the content associated with each objective. Student responses can be used in determining which objectives need to be reviewed or taught from a different angle. If a textbook is being used, questions at the ends of chapters may also be included in the Review/Summary.

- **Application.** Use the included visual master(s) and lab sheet(s) to apply the information presented in the lesson.

- **Evaluation.** Evaluation should focus on student achievement of the objectives for the lesson. Various techniques can be used, such as student performance on the application activities. A sample written test is provided.

Answers to Sample Test:

Part One: Matching

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

Part Two: Completion

1. follow-up
2. inpatient medical facility
3. admission diagnosis (admitting diagnosis)
4. ICD-10
5. chief complaint
6. first-listed diagnosis

Part Two: Short Answer

1. Answers may vary slightly and would be similar to the following differences between inpatient and outpatient coding.

   Inpatient coding reviews the entire medical record for the length of stay and selects the principal diagnosis, and it is typically more complex because it involves longer patient records. Outpatient coding focuses on the date of service and selects the first-listed diagnosis code and secondary diagnoses to support the services provided. Outpatient coding characterizes most of the coding performed in the healthcare industry.

Sample Test

Name _____

Inpatient and Outpatient Coding

Part One: Matching

Instructions: **Match the term with the correct definition.**

a. comorbidity
b. complication
c. diagnosis
d. inpatient coding
e. outpatient coding
f. present on admission (POA) indicators
g. principal diagnosis
h. secondary diagnosis

_____1. The identification of the nature of a disease or condition, by examining a patient's signs and symptoms

_____2. The medical conditions that are present, at the time the order for inpatient admission occurs

_____3. The presence of one or more medical conditions that exist simultaneously and, usually, independently, of each other

_____4. The chief reason for an inpatient stay

_____5. A review of the entire medical record for the length of stay and the selection of the principal diagnosis

_____6. A condition, which coexists with the principal diagnosis, at the time of admission, or a coexisting condition that develops after admission

_____7. A condition that arises during the relevant episode of care, and affects treatment provided to the patient

_____8. A review of medical records from a particular date of service and the selection of the first-listed diagnosis code

Part Two: Completion

Instructions: **Provide the word or words to complete the following statements.**

1. Subsequent hospital care, i.e., the treatment of a patient that follows the initial hospital care, is frequently referred to as _____.
2. A healthcare setting that admits patients for 24 hour care (overnight) is a/an _____.
3. The medical condition, identified by the physician, at the time of a patient's hospitalization is the _____.
4. The system used by physicians and other healthcare providers to define, classify, and code the universe of diseases, disorders, injuries, and other related health conditions is _____.
5. The patient's reason for the medical visit is called the _____.
6. Because a diagnosis may not be established at the time of the initial visit, medical coders in an outpatient setting, use the term _____, in lieu of the term, "principal diagnosis."

Part Three: Short Answer

Instructions: **Answer the following.**

1. Summarize the differences between inpatient and outpatient coding.

OUTPATIENT VERSUS INPATIENT CODING

Hospital status (inpatient or outpatient) determines how hospital services are billed.

Outpatient / Physician Coding	Inpatient / Facility Coding
ICD-10 for diagnoses	ICD-10 for diagnoses
Coding for probable, suspected, or ruled-out conditions *is not* allowed	Coding for probable, suspected, or ruled-out conditions *is* allowed
Medical/surgical procedures: CPT and HCPCS Level II	Medical/surgical procedures: ICD-10-PCS
Reimbursement: Primarily based on physician fee, insurance contracted rates, ambulatory surgical center rates, etc.	Reimbursement: Primarily based on diagnosis-related group (DRG)

POA: PROSPECTIVE PAYMENT SYSTEMS (PPS)

Inpatient rehabilitation facilities provide comprehensive rehabilitation services to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social/psychological services, and orthotics/prosthetics services.

A PPS is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount is based on the classification of a service. PPS is used in:

- Acute inpatient hospitals
- Home health agencies
- Hospice
- Hospital outpatient
- Inpatient psychiatric facilities
- Inpatient rehabilitation facilities
- Long-term care hospitals
- Skilled nursing facilities

A comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis and are used for:

- Physicians
- Ambulance services
- Clinical laboratory services
- Durable medical equipment, prosthetics, orthotics, and supplies

MEDICAL CODING PARAMETERS: POA REQUIREMENTS

Present on admission (POA) indicators are the medical conditions that are present at the time the order for inpatient admission occurs. The POA indicator differentiates conditions present at the time of admission from those conditions that develop during the inpatient stay. Centers for Medicare and Medicaid Services reporting options and definitions include the following codes:

Y	Yes	Present at the time of inpatient admission
N	No	Not present at the time of inpatient admission
U	Unknown	Documentation is insufficient to determine if the condition was present at the time of inpatient admission
W	Clinically undetermined	Provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not

SECONDARY DIAGNOSES

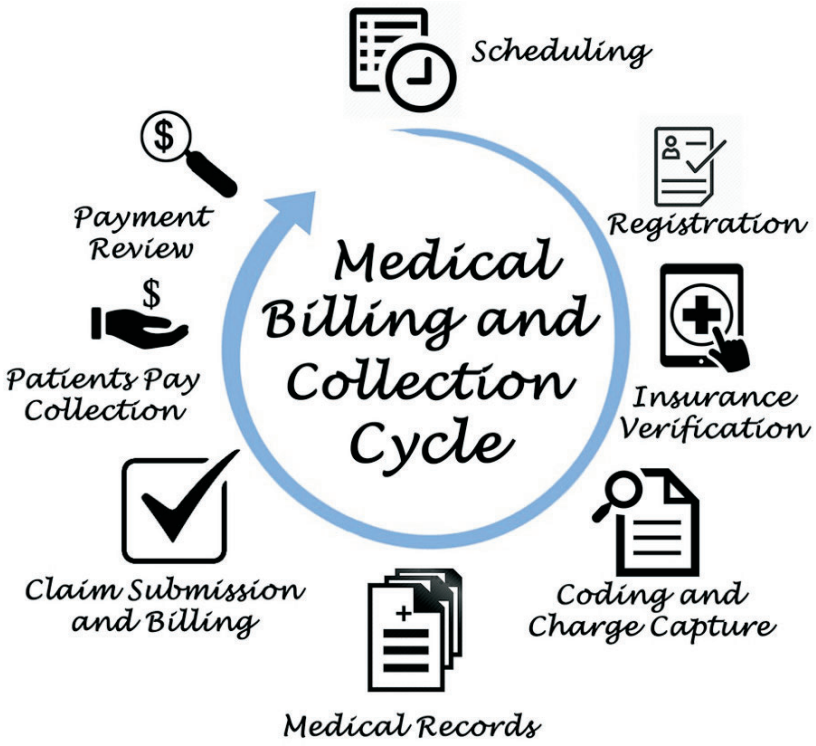
Diagnostic procedures could include examination of the inside of the body by using a lighted, flexible instrument called an endoscope.

Note that secondary diagnoses codes may be managed by one or more of the following in the table.

Clinical evaluation of the condition	Ancillary tests such as radiology, laboratory, etc.
Therapeutic treatment of the condition	Medication, surgery, therapy such as physical or respiratory, etc.
Diagnostic procedures performed to evaluate the condition	Exploratory surgery, oscopy (observation or visual examination), biopsy (tissue examination), etc.
Extended length of hospital stay	Patient's length of stay was increased by days, weeks, or months due to medical management of chronic conditions or treatment of complications that developed after admission.
Increased nursing care or monitoring	Chronic conditions: Hypertension (requires nursing staff to monitor blood pressure), Diabetes (requires nursing staff to provide patient education), etc.

INPATIENT AND OUTPATIENT CLAIMS SCENARIO

CODING SCENARIO: A patient living in a rural area travels to a university medical center for her yearly eye exam. Because she will already be in the area, she also schedules her annual wellness checkup with a gynecologist at the same medical center. Following these visits, she is involved in an auto accident and is taken to the emergency room at that same medical center. X-rays determine no surgical treatment is needed. Her cardiologist is called in to evaluate her high blood pressure and elevated heart rate. Finally, she is able to return safely home. For this date of service, there are multiple professional and facility claims submitted. Read the following table of professional and facility claims. What, if anything, should be added or deleted from the claims?



Professional Claims	Facility Claims
• Ophthalmologist • Gynecologist • ER Physician • Radiologist • Cardiologist	A single facility claim is submitted for all services provided to the patient on that date.
Each physician claim contains: • HCPCS Level II/CPT • Diagnosis code linked to the HCPCS Level II/CPT	• Condition code G0 (distinct medical visit) is submitted. This lets the payer know that the evaluation and management codes are distinct, potentially reimbursable services. They are not duplicates.
	• The occurrence code and date indicate some services were related to an accident. This lets the payer know other medical coverage may apply for the services on the claim.
	• Revenue codes indicate the facility department or area (e.g., 450 for the ER).
	• HCPCS Level II/CPT codes for all services

FIRST-LISTED DIAGNOSIS: EXAMPLES

The chief complaint is the patient's reason for the medical visit. It is one of the keys in determining the first-listed diagnosis.

Example #1: A patient consumed a soup containing shellfish. The patient is allergic to shellfish and develops hives. The chief complaint and the first-listed diagnosis are "allergic hives, due to an allergy to shellfish." The coding is:

- **L50.0: Allergic urticaria**
- **Z91.013: Allergy to seafood**

Example #2: Sometimes, the patient's complaint is a symptom of a more complex diagnosis. For example, a patient presents a chief complaint of a backache. After examination, the physician determines the patient has an acute kidney infection due to Escherichia coli. The chief complaint is a backache, but the first-listed diagnosis is an acute kidney infection due to E. coli. A backache was a symptom of the acute kidney infection. The coding is:

- **N10: Acute tubulointerstitial nephritis**
- **B96.2: Escherichia coli [E. coli] as the cause of diseases classified elsewhere**

Example #3: Sometimes, a patient schedules a visit without a chief complaint. For example, the patient requests a physical to qualify for insurance or the patient is an expectant parent seeking to establish a pediatrician. The coding is:

- **Z02.6: Encounter for examination for insurance purposes**
- **Z76.81: Expectant parent(s) pre-birth pediatrician visit**

Example #4: An established 50-year-old patient was seen in the clinic for acute bronchitis. The patient also received a prescription for a refill of medication for hypertension. The first-listed diagnosis is acute bronchitis. The coding is:

- **J20: Acute bronchitis**

Example #5: A 36-year-old female patient, complaining of irregular menses, makes an initial office visit. A review of her systems identified unexplained weight loss. The first-listed diagnosis is irregular menses. The coding is:

- **N92.6: Irregular menstruation, unspecified**

Example #6: An established 75-year-old male patient complains of substernal chest pain, which is relieved by rest. The patient has a history of hypertension and his blood pressure was above the baseline on this visit. The first-listed diagnosis is substernal chest pain. The coding is:

- **R07.2: Precordial pain**

COMMON OUTPATIENT CODING ERRORS

Under the PPS and Fee Schedule, each provider is reimbursed a predetermined amount based on the reported procedure code. Inaccurate coding may result in a failure to comply with coding requirements. Coding errors can be attributed to several factors: time pressures and/or restraints; distractions; lack of coding experience; human error; lack of communication; and, outdated patient encounter forms.

10 Areas Associated with Incorrect Outpatient Procedure Coding*

1. Reporting incorrect units of service
2. Inappropriate billing for observation services
3. Reporting incorrect charges due to outdated chargemaster descriptions
4. Submitting duplicate charges or failure to follow NCCI (National Correct Coding Initiative) guidelines for Medicare and Medicaid
5. Inappropriate reporting of procedure code modifiers
6. Improper E/M (Evaluation and Management) code selection
7. Reporting an "inpatient only" procedure on an outpatient claim
8. Submitting claims for medically unnecessary services
9. Failure to follow the multiple procedure discounting rules
10. Services furnished by an intern, resident, or another professional with an unapproved status without the required physician supervisor

***NOTE:** These factors tend to be unintentional. However, when coding errors occur on a consistent basis, providers may be considered in violation of the False Claims Act for abusive billing practices.

LS–A

Name _____

Determine the Correct ICD-10-CM Code

Purpose

The purpose of this activity is to determine the correct ICD-10-CM code for each given diagnosis.

Objectives

1. Look up the appropriate main term for each diagnosis.
2. Determine the correct ICD-10-CM code for each diagnosis.

Materials

- lab sheet
- device with Internet access
- pen or pencil

Procedure

1. Work independently to complete this lab activity.
2. Determine the main term information for the diagnosis. Then, lookup the ICD-10-CM code using the "Find-a-Code" website at https://www.findacode.com/.

Diagnosis	ICD-10-CM Code & Description
a. Benign neoplasm of breast	
b. Benign neoplasm of parathyroid gland	

Diagnosis	ICD-10-CM Code & Description
c. Benign neoplasm thyroid	
d. Brain tumor	
e. Cancer, rectum	
f. Emphysema with chronic (obstructive) bronchitis	
g. Greenstick fracture of shaft of humerus	
h. Lung tumor	
i. Malignant melanoma of skin	
j. Malignant tumor duodenum	
k. Pelvic fibroma	
l. Secondary cancer, pancreas	

3. Turn your completed lab sheet in to your instructor.

Determine the Correct ICD-10-CM Code

Diagnosis	ICD-10-CM Code & Description
a. Benign neoplasm of breast	D24.9—Benign neoplasm of unspecified breast
b. Benign neoplasm of parathyroid gland	D35.1—Benign neoplasm of parathyroid gland
c. Benign neoplasm thyroid	D34—Benign neoplasm of thyroid gland
d. Brain tumor	D33.2—Benign neoplasm of brain, unspecified
e. Cancer, rectum	C20—Malignant neoplasm of rectum
f. Emphysema with chronic (obstructive) bronchitis	J44.9 COPD—Unspecified (includes asthma with COPD, chronic bronchitis with emphysema, chronic obstructive asthma)
g. Greenstick fracture of shaft of humerus	S42.319S Greenstick fracture of shaft of humerus, unspecified arm, sequela
h. Lung tumor	D14.30—Benign neoplasm of unspecified bronchus and lung
i. Malignant melanoma of skin	C43.9—Malignant melanoma of skin, unspecified
j. Malignant tumor duodenum	C7A.010—Malignant carcinoid tumor of the duodenum
k. Pelvic fibroma	D21.5—Benign neoplasm of connective and other soft tissue of pelvis
l. Secondary cancer, pancreas	C78.89—Secondary malignant neoplasm of other digestive organs

LS–B

Name _____

First-Listed Diagnoses

Purpose

The purpose of this activity is to illustrate specific ICD-10-CM documentation and coding nuances related to first-listed diagnosis.

Objectives

1. Determine the first-listed diagnosis for each provided scenario.
2. Determine the correct ICD-10 code.

Materials

- lab sheet
- device with Internet access
- pen or pencil

Procedure

1. Work independently to complete this lab activity.
2. Read each scenario and determine the first-listed diagnosis.
3. Underline the important information. Then, look up the ICD-10 code on the "Find-a-Code" website at https://www.findacode.com/.

Scenario One:

A. Chief Complaint: "My stomach hurts and I feel full of gas."

B. History: A 57-year-old male with mid-abdominal epigastric pain, associated with nausea and vomiting; unable to keep down any food or liquid. Pain has become "severe" and constant.

   1. Has had an estimated 10-pound weight loss over the past month.
   2. Patient reports eating four Italian sausages at a pool party five days ago. He believes this action initiated his symptoms.
   3. Patient admits to a history of alcohol dependence. Consuming five to six beers per day now, down from 10 to 12 per day six months ago. Patient states that, when he does not drink, he has nausea and sweating with "the shakes."

C. Exam Results:

1. VS: T 99.8°F, otherwise normal
2. Mild jaundice noted
3. Abdomen distended and tender across upper abdomen. Guarding is present. Bowel sounds diminished in all four quadrants.
4. Oral mucosa dry, chapped lips, decreased skin turgor.

D. List ICD-10-CM Codes:

Scenario #2:

A. Chief Complaint: "I'm here for my annual checkup."

B. History: A 66-year-old male with a history of coronary artery disease, stent placement, and hyperlipidemia.

1. Recent admission to hospital following a hypertensive crisis. Sent home with medication that he discontinued due to a headache.
2. Regular activity includes walking, golfing. Active social life. No complaints of chest pain, or dyspnea on exertion.

C. Exam Results:

1. Chest clear. Heart sounds normal. Mental status exam intact.
2. EKG shows no changes from prior EKG.
3. Vitals: BP is 159/95, otherwise normal. Per patient, he had good control of BP on meds, but it has risen without medication.

D. List ICD-10-CM Codes:

Scenario #3:

A. Chief Complaint: Right earache and ear pain.

B. History: An 18-year-old female is an established patient. She is a full-time college student, and presents with right-side ear pain, noted 8/10. The symptoms started yesterday and continued to worsen with no pain relief using acetaminophen. Denies discharge, hearing loss, or ringing/roaring. She denies trauma to ear. She denies fever, sore throat, and cough today. She reports recently having a URI that resolved with OTC medications.

1. Medical history includes major depressive disorder with recurrent episodes of mild severity, and bipolar II disorder. Her current medications include aripiprazole, and duloxetine.
2. No known allergies.

C. Exam Results:

1. Healthy appearing female
2. Vital signs: BP: 130/78 HR: 70 bpm T: 99.8°F Wt: 135 lbs Ht: 5' 6"
3. ENT: auricle and external canals normal bilaterally. Right ear: erythematous membrane, bulging, with loss of landmarks. Pharynx, teeth, and nose exam are normal. No cervical adenopathy bilaterally.
4. Integumentary: Skin is flushed, warm, and dry with no edema. Mucous membranes are moist.
5. Respiratory: Lungs clear CTA with normal respiratory effort.

D. List ICD-10-CM Codes:

Scenario #4:

A. Chief Complaint: “My neck hurts and I have a tingling pain sensation going down my right arm.”

B. History: Patient is a 54-year-old male with history of neck pain that has worsened over the last two years. He recently experienced some numbness and a painful tingling sensation in his right arm going down to his thumb. No other symptoms or pertinent medical history.

C. Exam Results: Review of Systems, Physical Exam, and Laboratory Tests

1. Review of systems is negative except for the neck pain and sensations in his right arm described above. No history of acute injury to neck or arm.
2. Physical exam is normal except for neurological exam of the right upper extremity, which reveals slight decrease to sensation in the thumb and forefinger region of the hand in the C6 nerve root distribution. No evidence of weakness in the muscles of the arm or hand.
3. MRI scan of the neck shows degenerative changes of the C5-6 disc with lateral protrusion of disc material. No other abnormalities noted.

D. List ICD-10-CM codes:

Scenario #5:

A. Chief Complaint: "I just got out of the hospital two days ago. I'm a little better, but I can still barely breathe."

B. History: A 73-year-old male with one pack/day history of cigarette use (still smoking) and severe, oxygen-dependent COPD, developed cough with increased production of green/gray sputum two weeks prior to office visit. Admitted to hospital through Emergency Department with diagnosis of presumed pneumonia superimposed on severe COPD. Hospital exam confirmed acute RLL pneumococcal pneumonia. Patient treated with an IV cephalosporin as he has known penicillin allergy and was discharged from hospital to home two days prior to office visit.

1. Severe O2 dependent COPD, with type II diabetes mellitus secondary to chronic prednisone therapy, which is treated with oral hypoglycemics.
2. Patient also has known hypertension; on ACE inhibitor therapy

C. Exam Results: Review of Systems, Physical Exam, and Laboratory Tests

1. T 99, BP 145/105, P 92 and irregular, RR 28
2. Chest exam shows decreased lung sounds throughout all lung fields except in RLL where there were mild rhonchi and wheezes noted.
3. ABG's on 2L O2 by nasal cannula show PO2 62, PCO2 47, pH 7.40

4. Chest X-Ray shows hyperinflation of lungs with small RLL alveolar infiltration. In comparison to CXR from hospitalization, shows approximately 75% resolution of pneumonia.
5. ECG reveals persistent atrial fibrillation that was not present on previous ECG of six months earlier, but had been found at time of recent hospitalization.
6. Labs show finger stick glucose of 195mg%.

D. List ICD-10-CM codes:

4. Turn your completed lab sheet in to your instructor.

First-Listed Diagnoses

Scenario #1 ICD-10-CM Codes:

- R10.13: Epigastric pain
- R10.819: Abdominal tenderness, unspecified site
- R17: Unspecified jaundice
- E86.0: Dehydration
- F10.20: Alcohol dependence, uncomplicated

Scenario #2 ICD-10-CM Codes:

- Z00.01: Encounter for general adult medical examination with abnormal findings
- I10: Essential (primary) hypertension
- T46.5X6A: Underdosing of other antihypertensive drugs, initial encounter
- Z91.128: Patient's intentional under-dosing of medication regimen for other reason

Scenario #3 ICD-10-CM Codes:

- H66.001: Acute suppurative otitis media without spontaneous rupture of ear drum, right ear

Scenario #4 ICD-10-CM Codes:

- M50.12: Cervical disc disorder with radiculopathy, mid-cervical region

Scenario #5 ICD-10-CM Codes:

- J13: Pneumonia due to Streptococcus pneumoniae
- J44.0: Chronic obstructive pulmonary disease with acute lower respiratory infection
- Z99.81: Dependence on supplemental oxygen
- I48.1: Persistent atrial fibrillation
- E09.9: Drug or chemical induced diabetes mellitus without complications
- I10: Essential (primary) hypertension
- Z88.0: Allergy status to penicillin
- F17.210: Nicotine dependence, cigarettes, uncomplicated