Introduction to Coding

Medical coders review the documents in the patient’s medical record and abstract (collect clinical data) or retrieve information from specific documents. They then assign numeric or alphanumeric codes to each piece of data they retrieve. Medical coders must use their skills in research, reasoning, and interpretation of medical coding guidelines to ensure that physicians and hospitals are reimbursed accurately and completely for the services that they provide.

This part of your program will introduce you to this exciting field. You’ll learn all about ICD-9 and ICD-10 medical coding and the steps involved in assigning diagnosis and procedure codes using each of these code sets. The material that follows will lead you step-by-step through a wide range of ICD-9 and ICD-10 coding examples, offering invaluable tips and suggestions that you can use along the way. The same tips and suggestions that you use in Basic Medical Coding Using ICD-9 and ICD-10 will also serve as a foundation for your next two courses, Intermediate Medical Coding and Advanced Medical Coding Scenarios. You’ll also find practical skill-building exercises in your textbook. Be sure to complete all of the practice exercises in your textbook because these exercises help you fine tune your coding skills, and help you master the fine points of ICD-9 and ICD-10 coding. At the same time, you’ll learn about a wide range of medical terms. Doing so will further sharpen your skills, strengthen your ability to accurately interpret these terms, and, in turn, translate these terms into accurate code.

By choosing to learn medical coding, you’re embarking on a journey that essentially means learning a new language. Although this new language may seem a bit complicated and overwhelming at first, it becomes easier once you learn the basics of ICD-9 and ICD-10 coding (and with lots and lots of practice!) Your confidence will increase as you learn the basics and then apply what you learn to basic coding scenarios. The important thing to remember is that you don’t ever have to feel lost. The coding steps, along with the coding guidelines, will tell you exactly what you need to do. If you do feel yourself getting off track though, connect with other
students in the program on the Medical Billing and Coding Academic Space on the Penn Foster Community. You can see if other students are encountering the same difficulties and learn how they’ve overcome these difficulties. You can also create study groups and find study buddies to help make your learning experience even better.

Your instructor is also a valuable resource. You can connect with your instructor on the Medical Billing and Coding Academic Space. It’s always much better to ask for help, rather than become frustrated and try to figure things out on your own. As you move forward, you’ll find yourself becoming more comfortable with the medical terms, processes, and procedures that coders use every day. Just remember not to put too much pressure on yourself to master coding overnight. When you begin to code, don’t expect to get every single code right—you won’t. The key to learning medical coding is being willing to make mistakes. Experienced coders had to make many coding errors along the way to gain the experience that they now have. When you make an error in your code selection, retrace your steps and find out where you went wrong, so the next time you’ll be less likely to make the same mistake again. Remember that a mistake is never a mistake if you learn from it! Keep this in mind as you move forward through this course, as well as your next two coding courses. By the time you finish Basic Medical Coding Using ICD-9 and ICD-10, you’ll have gained many of the skills you need to have in order to accurately assign ICD-9 and ICD-10 codes.

As a medical coder, you’ll use the ICD-9-CM, or “I-9,” to assign different codes depending on the circumstances surrounding the patient encounter. The patient encounter is the episode of care that takes place on one or more specific dates, when the physician evaluates the patient and provides treatment. During the encounter, the patient relates the symptoms or chief complaint that brought the patient to the office, clinic, or hospital. Based on the patient’s reported symptoms, as well as the results of any examinations, x-rays, laboratory reports, or consult with a specialist, the physician will determine the most likely cause of the patient’s symptoms, or diagnosis. If the patient comes in complaining of coughing, sneezing, and congestion, the physician may ultimately determine that the patient has the flu. As a coder,
you’d assign the diagnosis code for flu, along with codes that pertain to the service or treatment provided in relation to the patient’s flu. Likewise, if the patient is seen because of difficulty walking due to a swollen ankle, an x-ray may reveal a fracture, in which case the physician’s diagnosis would be ankle fracture. The physician may also determine that the patient has more than one diagnosis, in addition to the one that brought them to the office. The physician may determine that in addition to the fractured ankle, the patient has several chronic conditions that require treatment. Examples of chronic conditions include hypertension, diabetes mellitus, and any conditions that require ongoing treatment, regularly prescribed medication, and ongoing monitoring. You’d assign diagnosis codes for the fractured ankle and the chronic conditions that require ongoing treatment.

As a medical coder, you’ll use the ICD-9-CM to look up the patient’s diagnosis (or diagnoses if there is more than one). After you find the diagnosis, you’ll review the code descriptions, follow any additional instructions that are provided in the ICD-9-CM regarding code assignment, and then assign your code. You’ll then follow the same process to assign subsequent diagnosis codes. If you’re working as an inpatient coder, you’ll also use the ICD-9-CM to assign procedure codes for inpatient surgical procedures.

**OBJECTIVES**

When you complete this lesson, you’ll be able to

- Define the process of medical coding
- Explain the tools used by medical coders
- Outline the skills necessary for a successful career in medical coding
- Summarize examples of medical coding certifications
- Describe other careers in medical coding
ASSIGNMENT 1

Read through the following material in your study guide. After you’ve read the study guide commentary, read the Introduction, pages xx–xxiv, and the Introduction on page 2 of your textbook, Step-By-Step Medical Coding.

Overview of Medical Coding

Medical coding is the process of converting medical terms into standardized numeric and alphanumeric codes for physician and hospital reimbursement. While coders are primarily concerned with correct interpretation of coding guidelines, accurate code assignment, and optimized reimbursement for physicians and hospitals, there are also ethical issues involved with medical coding. Medical coders must ensure that the codes they select accurately reflect what is in the patient’s medical record. All diagnosis and procedure codes should be assigned based strictly on the content of the medical record. The rule of thumb for medical coding is: “If it wasn’t documented, it wasn’t done.”

Coders use standardized code sets to assign codes for diagnoses, procedures, drugs, medical devices, supplies, and equipment. (You’ll learn more about the code set used for drugs, medical devices, supplies, and equipment in Intermediate Medical Coding). Accurate and complete coding helps minimize turnaround in terms of medical claims processing, and as a result, it helps expedite reimbursement for physicians and hospitals. In addition to increasing the likelihood of faster claims turnaround, accurate and complete coding also minimizes the likelihood of fraud. Medical coders are required by law to assign codes based only on the documentation in the medical record. Assigning codes that are not supported by the medical record to increase reimbursement constitutes fraud. This can result in civil and criminal penalties for health care facilities that bill fraudulent charges. Proficiency in medical coding means learning both how to determine the specific piece of data that requires a code assignment and the rules for assigning your codes.
Coders use two types of tools to assign codes: textbooks and/or encoders. Encoders are coding software programs that you can use to locate and assign diagnoses and procedure codes. However, when you test for a medical coding certification such as the CPC-A, you’ll be required to use your coding textbooks to assign codes. The textbooks that you’ll use in this course are:

- The *International Classification of Diseases, 9th Revision, Clinical Modification* (commonly referred to as *ICD-9-CM*)
- The *International Classification of Diseases, 10th Revision, Clinical Modification* (commonly referred to as *ICD-10-CM*)
- The *International Classification of Diseases, 10th Revision, Procedure Coding System* (commonly referred to as *ICD-10-PCS*)

To be successful in medical coding, you must be

- **Detail oriented.** In medical coding, the old adage “Little things mean a lot” is especially true. If you like paying attention to *every single word* in *every single part* of a code description in order to assign the correct code, then you’ll enjoy medical coding. The descriptions for two codes may be identical except for one word. That one word may be the difference in choosing code A vs. code B. If you’re good at picking up on the little things, then you’ll enjoy coding.

- **A detective.** If you like being a sleuth and researching coding guidelines to understand how, when, and where you should assign a specific code, then you’ll like medical coding.

- **A good storyteller.** If you like putting together pieces of a puzzle to form the “story” of what took place in the doctor’s office, clinic, emergency room, or hospital, so that you can translate the “story” into one or more codes, then you’ll love medical coding. Much of coding involves reading the words in the medical record and then painting a mental picture in your mind of what took place, as if you were right there in the doctor’s office, or
right there in the emergency room. If you can visualize what occurred based on what you read in the medical record, you’ll love medical coding.

■ **Analytical.** If you like analyzing pieces of information from different documents in the same medical record and finding contradictory information, then medical coding is a great career choice for you. Maybe you are working on a medical chart for a patient who was admitted to the hospital. Dr. Brown’s report indicates that the patient has diabetes, which is well controlled on insulin, but Dr. Smith’s report indicates that the patient has diabetes, but it isn’t well controlled on insulin. These are two different doctors saying two different things about the patient’s diabetes, and hence, these two statements would translate into two different diabetes codes for the same admission. You would need to determine which statement is correct so that you can assign the right code. So if you are analytical, you’ll enjoy medical coding.

■ **Inquisitive.** If you like asking questions to clarify information that’s unclear, and that’s keeping you from assigning a specific code, then you’ll enjoy medical coding. In the previous example, you’d need to send a query to the hospital to determine whether the patient’s diabetes is controlled or out of control. You’d then assign your diabetes code based on the answer that you receive from the hospital, and the answer would be placed in the patient’s medical record so that the record is kept up to date. If you like asking questions when something isn’t clear, then you’ll like medical coding.

You develop each of these skills as you proceed through *Basic Medical Coding Using ICD-9 and ICD-10*, as well as the courses that follow, *Intermediate Medical Coding* and *Advanced Medical Coding Scenarios*.

In order to demonstrate your skill in medical coding, most positions require that you earn at least one certification, or that you obtain a certification within several months of hire. Coders obtain certifications through one of two major organizations: The American Health Information Management Association (AHIMA) or the American Academy of Professional
Coders (AAPC). Certifications offered by both organizations are nationally recognized and accepted by health care employers worldwide. Most coders choose to sit for one of four certifications: the CPC-A, CPC, CCS, or CCS-P. The CPC-A and the CPC are both offered by the AAPC. The CPC-A demonstrates that you’ve completed the necessary educational requirements for a career in coding but haven’t yet obtained the required experience in reviewing, abstracting, interpreting, and correctly assigning codes. In CPC-A, the “A” stands for apprentice. After you earn the required two years of full-time coding experience, the A is dropped from the credential and you become a CPC. CPC, Certified Professional Coder, indicates that you’ve completed the necessary educational requirements and now have experience in the field. CCS and CCS-P are certifications offered by AHIMA. CCS, Certified Coding Specialist, demonstrates that you’ve gained proficiency in assigning codes to inpatient as well as outpatient medical records. CCS-P indicates that a coder is adept at coding medical records in the outpatient setting, such as in the physician’s office, emergency room, or clinic. Although many coders do, it isn’t necessary to earn more than one credential to demonstrate proficiency in a certain area of coding. (The most important factor is to earn at least one credential to gain entry into the field of medical coding.)

Basic Medical Coding Using ICD-9 and ICD-10, Intermediate Medical Coding, and Advanced Medical Coding Scenarios combine in one comprehensive package to prepare you to sit for the CPC-A exam, pass the exam, and become a working medical coder!

In addition to earning at least one certification in medical coding, you must have good computer skills and be able to navigate the Internet with relative ease. Good computer skills are essential to your success as a medical coder for several reasons:

1. If you work from home, you’ll need to set up a connection to your employer’s office or the hospital client that you are assigned to in order to access medical charts. Your company’s IT department or the hospital’s technical support department will help you do this. You’ll need to access specific websites, click on certain links, and download certain programs in order to sign in to the system and begin to code your charts. The setup process is
relatively simple, but you’ll need to be able to follow the
directions provided by the IT person to set up the web-
site links on your computer and begin coding.

2. On a daily basis, you’ll log in to the website provided by
your company, retrieve charts, open reports within each
chart, and review the documents to locate your codes.

3. You’ll also need to go online to research medical or surgi-
cal terms that pertain to a specific diagnosis or
procedure. This is why it’s also important to complete
courses in medical terminology, anatomy, and physiology
in addition to completing your coursework in medical
coding.

Once you start working as a coder, you’ll find that the oppor-
tunities in coding are limitless. A career in medical coding
can encompass many jobs, from coding for doctors’ offices
and hospitals to educating new coders. You’ll probably have
more than one kind of coding position during your career.
Even though you may initially start working as a medical
coder, you may later become a medical coding auditor, for
example. A medical coding auditor reviews the charts coded
by the medical coders, pinpoints errors, and provides feed-
back on making corrections. The auditor also provides
references to supplemental coding documents to help coders
improve their accuracy. You might also become a medical
coding supervisor, overseeing a team of medical coders and
assigning accounts. You may choose to specialize in one par-
ticular area of medical coding, such as cancer registry, where
you review medical records and capture diagnoses for cancer
patients. You might decide to obtain a medical coding certifi-
cation in cancer registry.

Now that you’ve completed Assignment 1, it’s time to review
the Introduction to Step-By-Step Coding. As you review the
Introduction, you’ll learn more about the anticipated job
growth in the medical coding field, as well as the salaries for
credentialied medical coders, categorized by region, job
responsibility, workplace, work setting, and job level.
ASSIGNMENT 2

Read through the following material in your study guide. After you’ve read the study guide commentary, read Chapter 8, pp. 200–232 in your textbook, *Step-By-Step Medical Coding*.

The *International Classification of Diseases (ICD)* system has a long and interesting history. Statistics on the causes of mortality (death) were being tracked by the French physician Jacques Bertillon. The *Bertillon Classification of Causes of Death* was adopted for use in several countries. Through revision, diseases that weren’t necessarily fatal were added. In 1948, the World Health Organization (WHO) took over the responsibility for updating what had by then become the International Classification of Diseases, in its fifth revision. WHO revised the manual twice more before the U.S. Public Health Service used a version of it to classify hospital records. This revision became the ICD-8 in 1968, which was the first to include numeric codes for each of the entries. In 1978, the manual was revised again to become the ICD-9; in the same year, the American Medical Association released the first Current Procedural Terminology (CPT) manual (you will learn more about the CPT in your next course, *Intermediate Medical Coding*). To complement the CPT, the U.S. National Center for Health Statistics (NCHS) modified the ICD-9 for use in coding patient diagnoses, or *morbidity* (as opposed to documenting only conditions that caused death). This *Clinical Modification* created the ICD-9-CM, which has been used by the health care profession ever since to obtain reimbursement for procedures and services provided to patients. Because of its long moniker, when people in the health care profession in the United States talk about the ICD-9-CM, they usually refer to it only as “ICD-9” or sometimes even “I-9.”

As a medical coder, you will use the ICD-9-CM to look up the patient’s diagnosis or diagnoses. After you find the diagnosis, you will review the code descriptions, follow any additional instructions that are provided in the ICD-9-CM regarding code assignment, and then assign your code. You will then follow the same process to assign subsequent diagnosis
Basic Medical Coding Using ICD-9 and ICD-10

Now that you’ve completed Assignment 2, it’s time to review Chapter 8 in *Step-By-Step Medical Coding*. In Chapter 8, you will learn more about ICD-9-CM, its format and appendices, as well as more about Volumes 1 and 2, the two volumes used for diagnosis coding.

**ASSIGNMENT 3**

Read through the following material in your study guide. After you’ve read the study guide commentary, read Chapter 10 of your textbook, *Step-By-Step Medical Coding*.

**Using ICD-9-CM Volumes 1 and 2**

The ICD-9-CM has three volumes. Volume 1 is called the *Tabular List*. This is a list of numeric and alphanumerical codes that correspond to the diagnoses for numerous medical conditions. Volume 2 is called the *Alphabetic Index*. This is a list of diagnoses, or medical terms, listed in alphabetical order. Volume 2 includes the *Table of Drugs and Chemicals* (for coding poisonings related to drugs and chemicals, described in more detail later in the study guide) and the *Index to External Causes of Injury* (the index used to locate “E” codes, which are discussed below). Tables for coding hypertension and neoplasms, or cancers, are also included.

Volume 3 is called the *Index to Procedures*. Volume 3 is used to assign surgical codes for patients who have been admitted to the hospital for a surgical procedure. (Volume 3, discussed in the next lesson, is only used to assign procedure codes, never diagnosis codes).

As a medical coder, you’ll assign several types of diagnoses, depending on whether you’re working as an inpatient coder or an outpatient coder. An inpatient coder assigns codes based on the medical records of patients who were admitted to the hospital. An outpatient coder assigns codes based on the medical records of patients who were seen in the outpatient setting, such as the doctor’s office, clinic, or emergency room.
As an inpatient coder, you’d determine the \textit{principal diagnosis}, or primary condition that led to the patient being admitted to the hospital. The process of adding secondary diagnoses is called \textit{sequencing}. Likewise, as an outpatient coder, you’d determine the primary condition that led the patient to come in to the doctor’s office, clinic, or treatment center. In the outpatient setting, the principal diagnosis is called the \textit{first-listed diagnosis}. You’d still add additional secondary diagnoses, if necessary, to fully describe all of the diagnoses pertinent to the patient’s medical encounter.

Regardless of whether you’re working as an inpatient coder or as an outpatient coder, there are certain steps that you must follow \textit{in exact order, every time}, to accurately choose your code(s). If you don’t follow the steps in the correct order, or you omit a specific step, you’ll end up choosing the wrong code.

Your first step is to thoroughly review the medical record to determine the patient’s diagnosis. Once you determine the patient’s diagnosis, you must determine the main term in the diagnosis, and then any subterms in the diagnosis. The \textit{main term} represents the most basic aspect of a disease or condition. For example, the main term of a diagnosis involving a broken arm would be “fracture.” The anatomical location of a diagnosed condition—in this case, arm—is never used as a main term. An easier way to think about the relationship between main terms and subterms is to think in terms of the relationship between a noun and an adjective. If a patient comes to the doctor’s office wearing a blue dress, the word “dress” would be the main term, and the word “blue” would be the subterm because it describes the color of the dress. Likewise, if a patient’s diagnosis is abdominal pain, then “pain” would be your main term, and “abdominal,” would be your subterm because it describes the \textit{kind} of pain that the patient is having. You’ll find a complete list of main terms listed in Volume 2 of the ICD-9-CM, with an indented list of subterms that appear directly beneath the main term that they apply to. It might help to use your finger or an index card to trace the subterms that appear beneath the main term. The main term is always in bold in Volume 2 (the Alphabetic Index), so this should help make it easier to determine which subterms pertain to the main term.