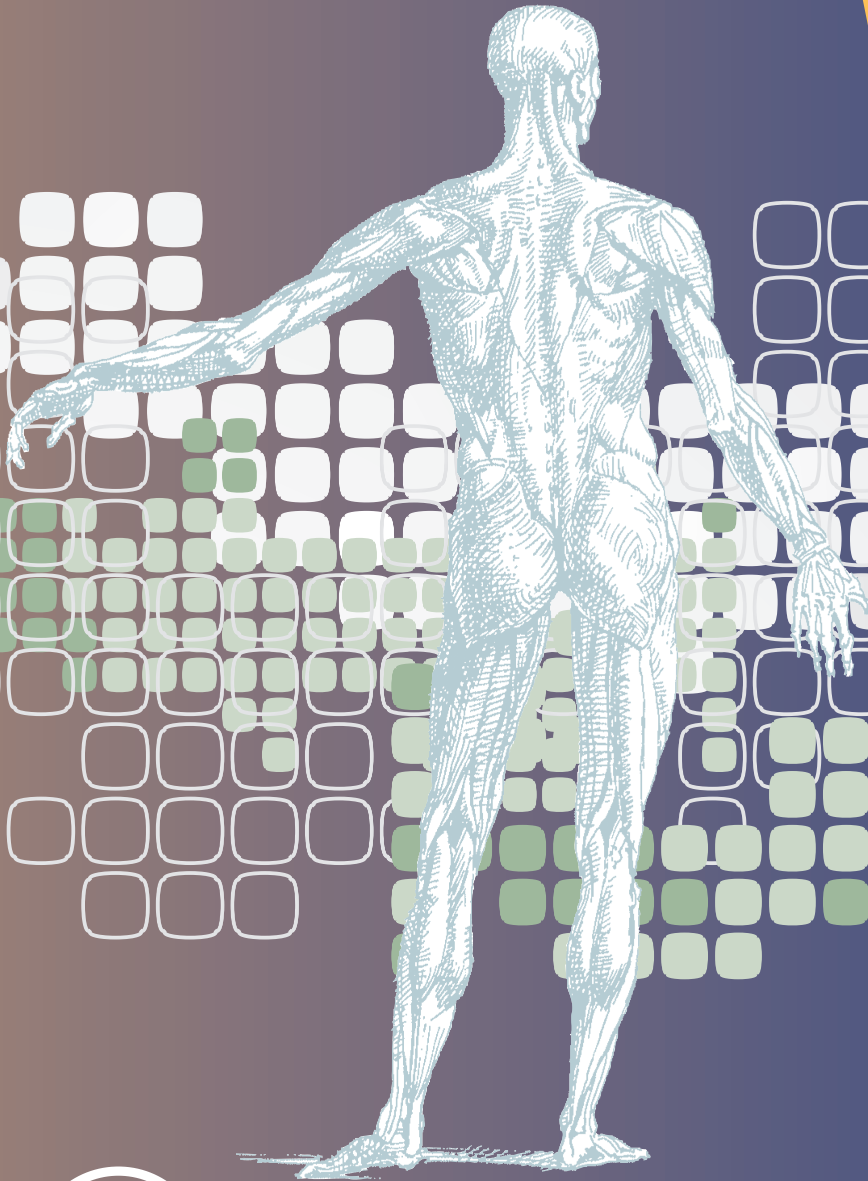
2011 Medical Coding Training: CPC®
Practical Application Workbook



AAPC

Credentialing the Business Side of Medicine

Chapter 3

Introduction to ICD-9-CM

Exercise 1

Directions: Using the ICD-9-CM coding manual, locate the diagnosis codes for the following conditions.

1. **Fever**

2. **Migraine headache**

3. **Otitis Media**

4. **Epigastric pain**

5. **Acute asthma exacerbation**

6. **Acute myocardial infarction**

7. **Hypertensive heart disease**

8. **Syncope**

9. **Nausea and vomiting**

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Chapter 3

Introduction to ICD-9-CM

Exercise 1

Directions: Using the ICD-9-CM coding manual, locate the diagnosis codes for the following conditions.

1. **Fever**

Answer: 780.60

Rationale: From the Index to Diseases, look up Fever. There is no additional information provided. The default code is 780.60. Review the code in the Tabular Index to verify code accuracy.

2. **Migraine headache**

Answer: 346.90

Rationale: From the Index to Diseases, look up Headache/migraine. You are referred to 346.9x. Refer to the code in the Tabular Index. There is no mention of intractable migraine or status migrainosus; therefore, the fifth digit is "0". The correct code is 346.90.

3. **Otitis Media**

Answer: 382.9

Rationale: From the Index to Diseases, look up Otitis and the subterm media. There is no additional information provided. You are referred to 382.9. Review the code in the Tabular Index to verify code accuracy. This is an infection of the middle ear (media).

4. **Epigastric pain**

Answer: 789.06

Rationale: From the Index to Diseases, look up Pain and the subterm epigastric. You are referred to 789.06. Review the code in the Tabular Index to verify code accuracy.

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5. Acute asthma exacerbation

Answer: 493.92

Rationale: From the Index to Diseases, look up Asthma. There is not a subterm for acute or exacerbation. The default code is 493.9x. The fifth digit is “2” to report the acute exacerbation. The correct code is 493.92. Review the code in the Tabular Index to verify code accuracy.

6. Acute myocardial infarction

Answer: 410.90

Rationale: From the Index to Diseases, look up the main term Infarct, infarction and the subterm myocardium, myocardial. You are referred to 410.9x. Refer to the Tabular Index. The fifth digit is determined based on the episode of care which is “0” in this example because the episode of care is not provided.

7. Hypertensive heart disease

Answer: 402.90

Rationale: This code can be located three ways. The first way is check the Index and look up Disease/heart/hypertensive. The second way is to look in the Hypertension Table under Hypertension/with/heart involvement /Unspecified. Also listed in the Hypertensive Table is Hypertension/heart/Unspecified. This example is coded as unspecified because no additional information is provided. Review the code in the Tabular Index to verify code accuracy.

8. Syncope

Answer: 780.2

Rationale: Look up Syncope in the Index to Diseases. You are referred to 780.2. Review the code in the Tabular Index to verify code accuracy.

9. Nausea and vomiting

Answer: 787.01

Rationale: From the Index to Diseases, look up Nausea/with vomiting. You are referred to 787.01. Review the code in the Tabular Index to verify code accuracy.

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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. Explained to the patient are indications for ORIF as well as possible risks and complications which include but are not limited to infection, bleeding, stiffness, hardware pain, need for hardware removal, no guarantee of functional ambulatory result. The patient and the family understood and wished to proceed.

Procedure in detail:
The patient was brought back to operating room and placed on an operating table, given a general anesthetic without any complications, given preoperative antibiotics per usual routine. He had 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 reduced the triplane fracture. It was confirmed on both AP and lateral X-ray images that the gap was reduced. The patient then had guidewires taken from the Synthes 4.0 mm cannulated screw set, placed one from medial along the epiphysis on the anterior half of the epiphysis and parallel to the joint to catch the lateral aspect of the epiphysis. Then one screw was placed above the physis from anterior to posterior to capture that spike. Once wires were in appropriate position, length was measured, partially threaded 4.0 mm cancellous screws were selected so that all threads were across the fracture site. Appropriate length screws were placed, confirmed by X-ray to be in good position. Fracture was anatomically reduced, and ankle joint was anatomic. The patient had wounds copiously irrigated out. Closure was done with interrupted horizontal mattress 3-0 nylon suture. The patient had sterile compressive dressing, was placed into a 3-sided posterior mold splint, was extubated and brought to 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-9-CM codes reported?

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1. Postoperative diagnosis is used for coding.
2. Stated procedure.
3. General endotracheal anesthesia used.
4. Radiologic guidance used.
5. Confirms fracture and treatment were of the distal tibia.
6. Fracture reduced.
7. Internal fixation accomplished with screws.

Case 10

Preoperative diagnosis: Right ankle triplane fracture

1. **Postoperative diagnosis:** Right ankle triplane fracture

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

3. **Anesthesia:** General endotracheal

Complications: None

Specimen: None

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Indications for procedure:
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4. 5. Under X-ray guidance, a pointed reduction clamp was placed from the anterolateral corner of the distal tibia to the medial side and reduced the triplane fracture. It was 6. confirmed on both AP and lateral X-ray images that the gap was reduced. The patient then had guidewires taken from the Synthes 4.0 mm cannulated screw set, placed one from medial along the epiphysis on the anterior half of the epiphysis and parallel to the joint to catch the lateral aspect of the epiphysis. Then one screw was placed above the physis from anterior to posterior to capture that spike. Once wires were in appropriate position, length was measured, partially threaded 4.0 mm cancellous screws were selected 7. so that all threads were across the fracture site. Appropriate length screws were placed, confirmed by X-ray to be in good position. Fracture was anatomically reduced, and ankle joint was anatomic. The patient had wounds copiously irrigated out. Closure was done with interrupted horizontal mattress 3-0 nylon suture. The patient had sterile compressive dressing, was placed into a 3-sided posterior mold splint, was extubated and brought to 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-9-CM codes reported?

CPT® codes: 27827-RT

ICD-9-CM code: 824.8

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Rationale:
CPT® codes: In the CPT® Index, look under Fracture, tibia, distal and you are directed to code range 27824-27828. This code range is for open treatment with internal fixation (ORIF). The treatment was of the distal tibia making 27827 the correct code selection.

ICD-9-CM code: The diagnosis is stated as a right ankle triplane fracture. A triplane ankle fracture refers to a fracture in the distal tibia in three planes. In the alphabetic index, look for fracture, ankle, you are directed to 824.8. Verification of 824.8 confirms it codes to fracture of the ankle, unspecified. There is not a "not otherwise specified" code for a fracture of the ankle, so this would be correct.

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Chest/breast: Breasts normal to inspection with no deformity, no breast tenderness or masses.

GI: Soft, non-tender, without masses, hernias or bruits. Bowel sounds are active in all four quadrants.

GU: external/vaginal: Normal in appearance with good hair distribution. No vulvar irritation or discharge. Normal clitoris and labia. Mucosa clear without lesions. Pelvic support normal.

Cervix: The cervix is clear, firm and closed. No visible lesions. No abnormal discharge. Specimens taken from the cervix for thin prep.

Uterus: Uterus non-tender and of normal size, shape and consistency. Position and mobility are normal.

Adnexa/Parametria: No masses or tenderness noted.

Lymphatics: No lymphadenopathy in the neck, axillae, or groin.

Musculoskeletal exam: Gait intact. No kyphosis, lordosis, or tenderness. Full range of motion. Normal rotation. No instability.

Extremities: bilateral lower: No misalignment or tenderness. Full range of motion. Normal stability, strength and tone.

Skin: Warm, dry, no diaphoresis, no significant lesions, irritation, rashes or ulcers.

Neurologic: CNS II-XII grossly intact.

Psychiatric: Mood and affect appropriate.

Labs/Radiology/Tests: The following labs/radiology/tests results were discussed with the patient: Alb, Bili, Ca, Cl, Cr, Glu, Alk Phos, K, Na, SGOT, BUN, Lipid profile, CBC, TSH, Pap smear.

Assessment/plan:
244.9 Unspecified acquired hypothyroidism

What are the CPT® and ICD-9-CM codes reported?

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4. Breast exam.

5. Thin prep Pap smear collection.

6. Pelvic exam.

Chest/Breast: Breasts normal to inspection with no deformity, no breast tenderness or masses. 4.

GI: Soft, non-tender, without masses, hernias or bruits. Bowel sounds are active in all four quadrants.

GU: external/vaginal: Normal in appearance with good hair distribution. No vulvar irritation or discharge. Normal clitoris and labia. Mucosa clear without lesions. Pelvic support normal. 5.

Cervix: The cervix is clear, firm and closed. No visible lesions. No abnormal discharge. Specimens taken from the cervix for thin prep.

Uterus: Uterus non-tender and of normal size, shape and consistency. Position and mobility are normal. 6.

Adnexa/Parametria: No masses or tenderness noted.

Lymphatics: No lymphadenopathy in the neck, axillae, or groin.

Musculoskeletal exam: Gait intact. No kyphosis, lordosis, or tenderness. Full range of motion. Normal rotation. No instability.

Extremities: Bilateral Lower: No misalignment or tenderness. Full range of motion. Normal stability, strength and tone.

Skin: Warm, dry, no diaphoresis, no significant lesions, irritation, rashes or ulcers.

Neurologic: CNS II-XII grossly intact.

Psychiatric: Mood and affect appropriate.

Labs/Radiology/Tests: The following labs/radiology/tests results were discussed with the patient: Alb, Bili, Ca, Cl, Cr, Glu, Alk Phos, K, Na, SGOT, BUN, Lipid profile, CBC, TSH, Pap smear.

Assessment/Plan:

244.9 Unspecified acquired hypothyroidism

What are the CPT® and ICD-9-CM codes reported?

CPT® Code: 99395—for some insurance carriers, also code G0101 for the pelvic and breast exam.

ICD-9-CM Code: V70.0, V72.31, 244.9

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Rationale: CPT® Codes: Subcategory—Preventive Medicine Services, established patient

Age 33—code 99395

Some insurance carriers will also allow reporting of HCPCS Level II code G0101 for the pelvic and breast exam. The Pap smear results were discussed with the patient during the visit indicating the Pap analysis was performed in the office. If we had a Pap report, we could also bill for the Pap smear.

ICD-9-CM Codes: In the ICD-9-CM index, look for examination, annual and you are directed to V70.0. There is also a code for examination, pelvic, which is V72.31. The provider also has documented unspecified acquired hypothyroidism. Since the provider confirmed her medication compliance, this can be listed as an additional code. Note: Some payers will require specific ICD-9-CM codes be reported with screening pelvic and breast exams. Check your payer policies.

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