2019



# CERTIFIED PROFESSIONAL BILLER

STUDY GUIDE



# **CPB™ Certification Study Guide**



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# Introduction to ICD-10-CM

ICD-10 was endorsed by the 43rd World Health Assembly in May 1990 and came into use in World Health Organization (WHO) member states in 1994. The classification is the latest in a series, which has its origins in the 1850s. The first edition, known as the International List of Causes of Death, was adopted by the International Statistical Institute in 1893. WHO took over the responsibility for the ICD at its creation in 1948 when the Sixth Revision, which included causes of morbidity for the first time, was published. The World Health Assembly adopted the WHO Nomenclature Regulations that stipulate use of ICD in its most current revision for mortality and morbidity statistics by all member states in 1967.

The ICD is the international standard diagnostic classification for all general epidemiological, many health management purposes, and clinical use. These include the analysis of the general health situation of population groups and monitoring of the incidence and prevalence of diseases and other health problems in relation to other variables such as the characteristics and circumstances of the individuals affected, reimbursement, resource allocation, quality, and guidelines.

It is used to classify diseases and other health problems recorded on many types of health and vital records, including death certificates. In addition to enabling the storage and retrieval of diagnostic information for clinical, epidemiological, and quality purposes, these records also provide the basis for the compilation of national mortality and morbidity statistics by WHO member states.

The National Center for Health Statistics (NCHS) developed ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) in consultation with a technical advisory panel, physician groups, and clinical coders to assure clinical accuracy and utility. There are no codes for procedures in the ICD-10-CM and procedures are coded using the procedure classification appropriate for the encounter setting (e.g., Current Procedural Terminology, or CPT\*, and ICD-10-PCS).

ICD-10 includes 22 chapters for use; however, in the United States the clinical modification (CM) does not include codes that begin with the letter U. The letter U is not used for international data comparison and the codes are not being used in the United States.

### **BILLING TIP**

When submitting the primary diagnosis code, it is important to review other ICD-10-CM codes listed on the claim form and, if necessary, pertinent medical records. Other ICD-10-CM codes assigned to the encounter may provide additional information supporting treatment. For example, the primary reason for a visit may be headaches, but the patient also has urinary urgency which supports the medical necessity of a urinalysis. Headache is the primary diagnosis for the office visit and urinary urgency is the diagnosis attached to the urinalysis. Some insurance carriers will only review the first diagnosis attached to each procedure code.

During this chapter, we will discuss:

- Overview of the ICD-10-CM layout
- ICD-10-CM conventions
- How to look up an ICD-10-CM code
- Official ICD-10-CM coding guidelines

## Overview of ICD-10-CM Layout

ICD-10-CM is published in two sections:

- 1. Alphabetic Index or Index to Diseases and Injuries: Diagnostic terms organized in alphabetic order for the disease descriptions in the Tabular List.
- Tabular List: Diagnosis codes organized in numerical order and divided into chapters based on body system or condition.

These facts must be substantiated by the patient's medical record, which must be available to payers on request.

ICD-10-PCS includes procedure codes used by facilities for inpatient services.

We will focus on the proper use of ICD-10-CM in this chapter.

### **Tabular List of Diseases**

The Tabular List is a numerical listing of disease and injury. There are 21 chapters for the classification of diseases and injury, grouped by etiology (cause) or anatomical (body) site. The Tabular List is organized in three-character codes and their titles, called category codes. Some three-character codes are very specific and are not subdivided. These three-character



Introduction to ICD-10-CM Chapter 4

codes can stand alone to describe the condition being coded. Most three-character categories (rubrics) have been subdivided with the addition of a decimal point, followed by up to four additional characters.

Each character for all categories, subcategories, and codes may be either a letter or a number. Codes can be three, four, five, six, or seven characters. The first character of a category is a letter. The second is numeric. The third through seventh characters may be either numbers or alpha characters. Subcategories are either four or five characters and may be either letters or numbers. Codes are three, four, five, or six characters and the final character in a code may be either a letter or number. Certain categories have a seventh character extension (discussed later in this chapter). The fourth character in an ICD-10-CM code further defines the site, etiology, and manifestation or state of the disease or condition. The four-character subcategory includes the three-character category plus a decimal with an additional character to further identify the condition to the highest level of specificity. The fifth or sixth character subclassifications represent the most accurate level of specificity regarding the patient's condition or diagnosis. Certain ICD-10-CM categories have applicable seven characters. The applicable seventh character is required for all codes within the category, or as the notes in the Tabular List instruct. The seventh character must always be in the seventh position. If a code is three, four, or five characters, but requires a seventh character extension, a placeholder X must be used to fill the empty characters. There are symbols throughout the Tabular List to identify when a code requires an additional character.

EXAMPLE					
H27 Other disorders of lens					
H35.5 Hereditary retinal dystrophy					
H40.00 Preglaucoma, unspecified					
H40.10 Unspecified open-angle glaucoma					
H40.121 Low-tension glaucoma, right eye					

### Index to Diseases and Injuries (Alphabetic Index)

Main terms in the Index to Diseases and Injuries usually reference the disease, condition, or symptom. Subterms modify the main term to describe differences in site, etiology, or clinical type. Subterms add further modification to the main term.

### **EXAMPLE**

Look in the ICD-10-CM Alphabetic Index for swelling.

Swelling (of) R60.9

abdomen, abdominal (not referable to any particular organ) - see Mass, abdominal

ankle - see Effusion, joint, ankle

arm M79.89

forearm M79.89

breast (see also Lump, breast) N63.0

Calabar B74.3

cervical gland R59.0

chest, localized R22.2

In this example, the subterms further define the location of the swelling.

### ICD-10-CM Conventions

To apply the diagnosis coding system correctly, billers need to understand and apply the various conventions and terms. Section I of the official guidelines includes conventions, general coding guidelines, and chapter specific guidelines. Examinees taking the CPB® exam are expected to be familiar with these and other conventions noted in the code book to accurately identify correct use of the ICD-10-CM codes.

NEC Not elsewhere classifiable—This abbreviation is used in the Alphabetic Index and the Tabular List when the ICD-10-CM system does not provide a code specific for the patient's condition. Selecting a code with the NEC classification means the provider documented more specific information regarding the patient's condition, but there is no code in ICD-10-CM that reports the condition accurately.

**NOS Not otherwise specified**—This abbreviation is used in the Alphabetic Index and the Tabular List and is the equivalent of "unspecified" and is used only when the coder lacks the information necessary to report to a more specific code.

[ ] **Brackets** are used in the Tabular List to enclose synonyms, alternate wording, or explanatory phrases.

### **EXAMPLE**

√4th B01 Varicella [chickenpox]

Chapter 7 Medical Necessity

### **EXAMPLE**

A patient is brought to the surgical suite for a planned laparoscopic cholecystectomy. After the procedure is initiated, the procedure is converted to an open cholecystectomy. The appropriate code assignment is 47600, *Cholecystectomy*, only. Code 47562, *Laparoscopy, surgical, cholecystectomy*, according to the NCCI edits would not be reported in addition.

	Column1/Column 2 Edits					
Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
47600	47562		20010101	*	0	More extensive procedure

According to the NCCI edits, code 47562 is included in code 47600. The CCM 0 indicates it is not allowed under any circumstance.

### Modifier 59

Modifier 59 Distinct procedural service. The NCCI Policy Manual reiterates the CPT\* code book's definition: "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not

ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

If one of the specific anatomic modifiers (RT, LT, E1-E4, etc.) may be assigned, it should be used instead of modifier 59.

### **EXAMPLE**

A physician performs destruction by cryotherapy of 10 actinic keratosis on a patient's back (17000, 17003 x 9). During the same session, he also removes seven skin tags from the patient's neck (11200).

	Column1/Column 2 Edits					
Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
17000	11200		19980401	*	1	Mutually exclusive procedures

According to the NCCI edit, the removal of the skin tags (11200) is considered inclusive to the destruction; however, the CCM 1 indicates a modifier can be used to bypass the edits if supported by the documentation. Because the lesions were at different sites, modifier 59 is appropriate. The correct code assignment would be 11200-59 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions, 17000 Destruction, premalignant lesions; first lesion, and 17003 X 9 Destruction, premalignant lesions; second through 14 lesions, each.

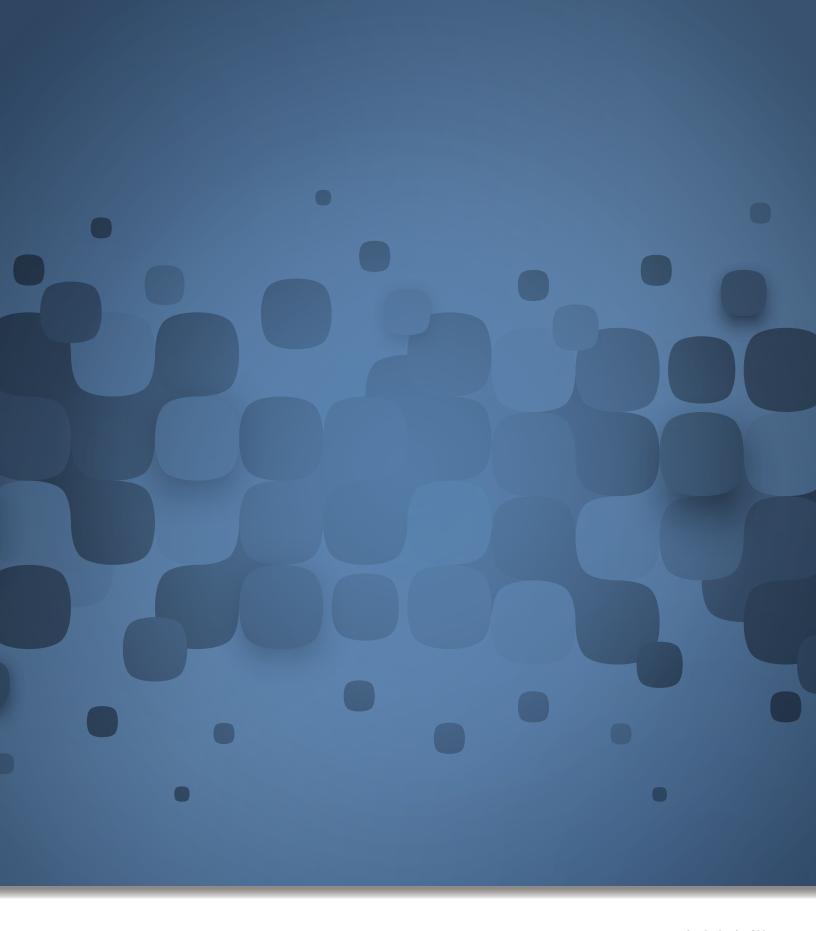




### **HEALTH INSURANCE CLAIM FORM**

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	(I certify that the statements on the reverse apply to this bill and are made a part thereof.)  597 PARKWAY														597 PARK								
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