

Study Guide

Basic Medical Coding Using ICD-10

By

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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-10 medical coding and the steps involved in assigning diagnosis and procedure codes using this code set. The material that follows will lead you step-by-step through a wide range of 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-10* will also serve as a foundation for your next two courses, *Intermediate Medical Coding* and *Advanced Medical Coding Scenarios*. You'll also find Quick Checks and Exercises in your textbook. Be sure to complete all of these additional practice tools to help you fine-tune coding skills, master the fine points of ICD-10 coding, and 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-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, 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 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. Remember that a mistake is never a mistake if you learn from it! Keep this in mind as you move forward through your coding courses.

By the time you finish Basic Medical Coding Using ICD-10, you'll have gained many of the skills you need to accurately assign ICD-10 codes.

As a medical coder, you'll use the ICD-10-CM (often called *ICD-10* or *I-10*), 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 specialist consultations, 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 him or her 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 or monitoring and regularly prescribed medication. 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-10-CM to look up the patient's diagnosis (or diagnoses if there's more than one). After you find the diagnosis, you'll review the code descriptions, follow any additional instructions that are provided in the ICD-10-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-10-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
- Summarize the history of medical coding
- Explain the process of general equivalence mapping
- Summarize how to use ICD-10-CM

ASSIGNMENT 1

Read through the following material in your study guide. Then, read the Introduction in your textbook, *Step-by-Step Medical Coding*.

Introduction to Medical Coding

Recent changes in healthcare have created a great demand for medical coders. An older population; advances in technology; an increased demand for healthcare services; and an increase in the number of medical tests, treatments, and procedures means that the number of people seeking healthcare services has increased. Additionally, the increased use of outpatient facilities means that the government is exerting greater control and becoming more involved with services provided to Medicare and Medicaid patients. These changes in healthcare have resulted in an increased demand for certified medical coders.

Prominent healthcare organizations in the field of medical coding include the *American Health Information Management Association (AHIMA)* and the *American Academy of Professional Coders (AAPC)*. Both of these organizations offer credentials in medical coding. Certifications offered by both organizations are nationally recognized and accepted by healthcare 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. *CPC (Certified Professional Coder)* indicates that you've completed the necessary educational requirements and now have experience in the field. In CPC-A, the *A* stands for *apprentice*. 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. After you earn the required two years of full-time coding experience, the *A* is dropped from the credential and you become a CPC.

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. At least one credential is needed to gain entry into the field of medical coding.

Basic Medical Coding Using 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!

Success in medical coding means being able to convert medical terms into standardized numeric and alphanumeric codes for physician and hospital reimbursement. The rule of thumb for medical coding is: If it wasn't documented, it wasn't done.

While coders are primarily concerned with correct interpretation of coding guidelines, accurate code assignment, and optimized reimbursement for physicians and hospitals, medical coding also involves ethical concerns. Medical coders must ensure that the codes they select accurately reflect what's in the patient's medical record. All diagnosis and procedure codes should be assigned based strictly on the content of the medical record.

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 aren't supported by the medical record to increase reimbursement constitutes fraud and can result in civil and criminal penalties for healthcare facilities.

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.

Note: As you proceed through your assigned reading, be sure to complete the Quick Checks and Exercises, which will reinforce the reading material.

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*, 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. 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.** Much of coding involves reading 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 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're good at analyzing pieces of information from different documents in the same record and finding contradictory information, then medical coding is a great career choice for you. Maybe you're 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 same 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.

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.

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

In addition to being able to accurately review and abstract clinical data from the medical record, 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're 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 may need to access and navigate specific websites and download certain programs in order to sign in to the system and begin to code your charts. The setup process should be relatively simple, but you'll need to be able to follow the directions provided by the IT person to set up the website 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 in order to locate your codes.
3. You'll also need to go online to research medical or surgical terms that pertain to a specific diagnosis or procedure. This is why it's important to complete courses in medical terminology, anatomy, and physiology in addition to your coursework in medical coding.

Once you start working as a coder, you'll find that the opportunities in coding are plentiful, from coding for doctors' offices and hospitals to educating new coders. You'll likely have more than one kind of coding position during your career. You might initially start working as a medical coder and later become a medical coding auditor, for example. A *medical coding auditor* reviews the charts coded by the medical coders, pinpoints errors, and provides feedback on making corrections. The auditor also provides references to supplemental coding documents to help coders improve their accuracy. You might become a medical coding supervisor, overseeing a team of medical coders and assigning accounts. Or, you may choose to specialize in one particular area of medical coding, such as cancer registry, where you review medical records and capture diagnoses for cancer patients, and obtain a medical coding certification 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 credentialed medical coders, categorized by region, job responsibility, workplace, work setting, and job level.

ASSIGNMENT 2

Read through the following material in your study guide. Then, read Chapter 2, pages 26–40, of your textbook, *Step-by-Step Medical Coding*.

History of ICD-10 Medical Coding

In order to understand the history of ICD-10-CM in relation to medical coding, it's necessary to understand how ICD-10-CM evolved and why it's necessary for accurate coding.

The United States started using ICD-10 to report mortality in 1999, but didn't fully adopt ICD-10 until October 1, 2015. However, the United Kingdom actually began using the ICD-10 in 1995, along with 200 other countries, that used all or part of ICD-10. The World Health Organization (WHO) still maintains the ICD, although they stopped supporting the ICD-9 in 2012. The Centers for Medicare and Medicaid Services (CMS) along with the American Hospital Association (AHA) and the National Center for Health Statistics (NCHS) are responsible for maintaining the ICD-10-CM and ICD-10-PCS. ICD-10-PCS replaced ICD-9-CM Volume 3 as the component used to assign procedure codes for patients having surgery in the hospital. We'll cover ICD-10-PCS later in this course.

ICD-10-CM was created for several reasons. First, ICD-9-CM had run out of room to expand. New diseases and new disorders are constantly being discovered, and the ICD-9-CM code set didn't have room for any new codes. Since the ICD-9-CM code structure didn't include sufficient detail about the patient's condition, these codes needed to be revised for greater specificity and more comprehensive coverage of each element of the patient's diagnosis.

ICD-10 is a new and improved version of the old ICD-9 code set. The ICD-10 is like a huge rubber band that can stretch to put more detail into each code, thereby eliminating the need for multiple codes while simultaneously improving specificity. The reason that more information can be packed into each ICD-10 code is because of its revised structure. ICD-10 incorporates common fourth- and fifth-character sub-classifications in one code. For example, F10.14 (alcohol

abuse and alcohol-induced mood disorder) uses one code for both conditions. Each ICD-10 code can accommodate six characters, and even expand to seven characters, whereas ICD-9 codes only contained four digits and could only expand to a maximum of five characters. In a case involving a patient with complications resulting from diabetes mellitus, for example, the coder would have had to assign two codes: one for the diabetes mellitus and one for the complication resulting from it. However, ICD-10 can expand to combine everything in one code.

Symptoms can be combined with the diagnosis in the same code. Injury codes can be expanded to include more details, such as whether the patient is being seen the first time for the injury, whether it's a subsequent visit, or whether the visit is due to a *sequel*, an aftereffect of a disease or injury. A patient who is diagnosed with abusing alcohol and also having mood disorders because of the alcohol abuse can now be assigned to one code in ICD-10, rather than two codes in ICD-9.

The structure of ICD-10-CM is similar to the structure of the old ICD-9-CM, but the new ICD-10 code set includes two additional chapters: one pertaining to diseases of the eye, and one pertaining to diseases of the ear. ICD-10 also adds information pertaining to ambulatory and managed care visits.

In summary, improvements offered with ICD-10-CM include

- Adding information that pertains to ambulatory and managed care visits
- Expanded codes pertaining to injury
- Extensive injury code expansion to increase the specificity of each code
- Combining diagnoses and symptoms in one code, thereby reducing the number of codes required to report a condition
- Adding a sixth character to the diagnosis code
- Incorporating subclassifications of fourth- and fifth characters

- Updating codes for diabetes mellitus and making them more specific
- Making code assignment more specific

Unlike ICD-9-CM, the category codes in the ICD-10-CM begin with a letter. The following sample illustrates the structure of the ICD-10-CM system:

Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99)

Chapter 2: Neoplasms (C00-D49)

Chapter 3: Diseases of the Blood and Blood-Forming Organs (D50-D89)

Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E00-E89)

Chapter 5: Mental, Behavioral and Neurodevelopmental Disorders (F01-F99)

General Equivalence Mapping (GEM)

You may wonder how to confirm whether you have the correct ICD-10-CM equivalent code that matches the code that you would have chosen in the earlier ICD-9-CM code set. The *general equivalence mapping (GEM)* files were developed to help you map ICD-10 codes back to the old ICD-9 code set and vice-versa. General equivalence mapping is *bidirectional*, meaning that you can map the new ICD-10 codes back to the original ICD-9 codes, and map the original ICD-9 codes to the new ICD-10 codes.

Mapping ICD-9 codes to ICD-10 codes is called *forward mapping*. When you map ICD-10 codes back to their original ICD-9 codes, the process is called *backward mapping*. One thing to keep in mind: when you review the GEM files to determine the equivalent mapping codes, you'll notice that the GEM files don't include decimals. Remember this when you map your codes. You'll have to mentally insert the decimal point so that you understand the code that you're seeing in the GEM file. For example, in ICD-9-CM, the diagnosis code for salmonella meningitis was 003.21. When you locate

this ICD-9-CM code in your GEM file, you'll see 00321, without the decimal. The new equivalent ICD-10-CM code is A02.21. So the old ICD-9-CM code 003.21 maps directly to the new ICD-10-CM code, which is A02.21. This is an example of forward mapping. If you found the ICD-10-CM code first, and then found the old ICD-9-CM code second, you would have done backward mapping.

There's one GEM file for forward mapping and one GEM file for backward mapping. The GEM file for forward mapping has three columns in this order: ICD-9, ICD-10, and Flag. The GEM file for backward mapping also has three columns: ICD-10, ICD-9, and Flag. It all depends on the direction that you're going in terms of mapping your codes. *Source code* is the code that you're mapping from and *target code* is the code that you're mapping to. If you're doing forward mapping from the old ICD-9 to the new ICD-10, your ICD-9 code is the source code and your ICD-10 code is the target code. If you're doing backward mapping from the new ICD-10 to the old ICD-9, your source code becomes your ICD-10 code, and your target code now becomes your ICD-9 code. The Flag column tells you whether you have a direct match between the two codes. The flags are five-digit numbers that appear in the third column of your GEM file. Each digit occupies a certain position in the overall flag number. The numbers are a combination of 0s, 1s, and 2s.

There are three types of flags:

- **Approximate.** You have an exact match.
- **No Map.** Sorry, you don't have an exact match; no similar codes available.
- **Combination.** You have a match, but your source code maps to more than one code in the target system.

Your goal is to match your ICD-10 code to the previous ICD-9 code and vice-versa, to make sure you select the correct ICD-10 code that corresponds to the old ICD-9 code. The process is similar to translating a word in English to another language; you want to ensure that your translation is accurate. Sometimes your code match won't be perfect, and you'll have to add more codes to get a perfect combination for the

coding scenario that you've indicated in the medical record. You may not always be able to make an exact match between a diagnosis in ICD-10 and a diagnosis in ICD-9.

Here are some examples of the types of flags that you'll see in the third column of the GEM file:

Flag# 00000. This means you have an exact diagnosis match between ICD-9 and ICD-10.

Flag# 10000. This means you have multiple diagnoses that might be a potential match between the old ICD-9 and the new ICD-10. For example, code 733.95 in ICD-9-CM (stress fracture of other bone) maps to 16 possible new codes in ICD-10-CM. This is what flag# 10000 is telling you: there are multiple possibilities. There isn't a one-size-fits-all code available in this particular example. You have to review the medical record and choose the code that describes the specific encounter from one of the 16 possible choices in ICD-10-CM.

Flag# 11000. A 1 in the second slot of the flag number tells you that you have a *no map* (or *no match*) because there's no similar code that maps between the old ICD-9 and the new ICD-10. You'll also see *NoDx* listed in one of the columns to indicate this.

Flag# 10112. A 1 in the third slot of the flag number tells you that you do have a diagnosis match between the old ICD-9 and the new ICD-10, but there's more than one code in the target system that might be the perfect match. This is called the *combination field*.

Flag# 10112. The fourth slot of the flag number is the scenario field. This is a mapping situation that involves multiple codes, and a 1 in this slot indicates that there's only one possible variation of diagnosis code combinations in the source code.

Flag# 10111. A 1 in the fifth slot of the flag number tells you that this is the choice field. The fifth slot tells you the possible number of target codes that make one complete coding scenario when you combine them. One example is ICD-9-CM codes 995.92 and 785.52. Code 995.92 was the ICD-9 code for severe sepsis, and 785.52 was the ICD-9 code for septic shock. The rules for septic shock indicated

that 995.52 needed to be sequenced first, followed by 785.52. This is the only combination that could be assigned when the patient was diagnosed with septic shock. These two codes went together. The scenario field indicated that there was only one possible source code combination available in ICD-9-CM for severe sepsis and septic shock (995.92 + 785.52). The choice field pointed you to both of these ICD-9-CM codes. It essentially said that you must assign both of these codes together to paint the complete picture of the patient's condition. Unlike the old ICD-9-CM codes, the new ICD-10 code for both severe sepsis and septic shock is R65.21.

Using ICD-10-CM

You'll use the Alphabetic Index and Tabular List to locate codes in the ICD-10-CM. The main terms in the Alphabetic Index appear in bold, with subterms indented directly beneath the main term. In ICD-10-CM, each code begins with a letter rather than a number, and the code descriptions become much more specific than those found in ICD-9-CM. As you begin to code using ICD-10-CM, you'll see different sets of instructions to guide you along the way.

ASSIGNMENT 3

Read through the following material in your study guide. Then, read Chapter 2, pages 41–50, of your textbook, *Step-by-Step Medical Coding*. When you’ve finished reading Chapter 2, complete the Chapter Review on pages 51–54. You can check your answers using the Answers section at the end of this study guide.

ICD-10-CM codes are divided into sections, categories, subcategories, and subclassifications. *Sections* are three-digit categories for conditions or related conditions. *Categories* are three-character codes that represent one condition or disease. *Subcategories* are four-character subcategory codes that are more specific than three-character codes. Subcategory codes provide more information on the site, cause, or manifestation of the condition. *Subclassifications* provide even greater specificity than subcategory codes, using five to seven characters. Codes that can be expanded by adding more characters should be coded to the fullest extent possible.

ICD-10-CM codes are listed in the Alphabetic Index and the Tabular List. You would locate the codes in the Alphabetic Index first, and then verify the codes in the Tabular List. Codes and titles in the Tabular List are in bold font. Codes not assigned as the first-listed diagnosis, as well as all exclusion notes, are listed in italicized font. Any codes listed in italicized type are *always* assigned as secondary codes (that is, after the primary diagnosis). For example, the phrase “code first,” which appears in italicized font, instructs the coder to assign another code first before assigning the code in italics.

As you code, pay attention to the instructional notes and conventions pertaining to diagnosis codes. These notes provide guidance in accurately assigning your codes. Review the front matter of the ICD-10-CM manual to become familiar with the instructional notes and conventions pertaining to ICD-10-CM codes. Two commonly known conventions include *NEC* (not elsewhere classifiable) and *NOS* (not otherwise specified). The *NEC* convention indicates that a more specific code for the condition is not available. The *NOS* convention indicates that the information that you have, based on what’s indicated in the medical record, means that you can’t assign

a more specific code (although a more specific code may be available). In this instance, you may need to query the physician for more information and see if you can obtain a more specific diagnosis.

Additional conventions include brackets, parentheses, colons, as well as essential and nonessential modifiers. You'll find brackets in the Tabular List enclosing synonyms, alternate words, or explanatory phrases. Parentheses enclose *nonessential modifiers*, also called *supplementary words*. Nonessential modifiers don't affect the code assignment, but only clarify the diagnosis. For example, K56.7, the diagnosis for inhibitory ileus, includes the term "inhibitory" in brackets. The term "inhibitory" is a nonessential modifier. It's not essential for code assignment, but only further explains the diagnosis. Colons appear after incomplete terms in the Tabular List. Incomplete terms require at least one modifier to assign the diagnosis code. Make special note of how the terms *and* and *with* are used in ICD-10-CM. In ICD-10-CM, the term *and* means *and/or*, while the term *with* means that the code includes two conditions, and both conditions *must* be present in order to assign the code. The note *Includes* provides additional examples that pertain to the content of the category.

You'll also see Excludes notes in ICD-10-CM. There are two types of Excludes notes: Excludes1 and Excludes2. The *Excludes1* notes means *not coded here* and indicates that you shouldn't assign the excluded code along with the code being referenced prior to the note. The note for code D61.82, myelophthisis, in the Tabular List, includes Excludes1 notes for several conditions that shouldn't be coded along with code D61.82. The *Excludes2* note indicates *not included here*. This means that the condition being excluded is a distinct condition that isn't a part of the condition that it's being excluded from, so the patient may have both conditions simultaneously. If you see an Excludes2 note beneath a code, this indicates that you can assign the code as well as the Excludes2 code together. For example, in Chapter 1, the first Excludes2 note indicates that the infectious and parasitic disease doesn't include the carrier of the suspected disease, so it's possible for both conditions to exist at the same time.

You may code some conditions that have an underlying etiology, along with multiple manifestations. This coding scenario represents the etiology/manifestation paired code rule. You will recognize this rule when you see a notation that indicates code first and *use additional code*. This tells you to sequence the underlying condition first, and the code for the manifestation second. The term *code first* appears at the manifestation code. The term *use additional code* appears in relation to the etiology code. You'll also see the code title in *diseases classified elsewhere*, which indicates that the code is a manifestation code. Code D77, Other disorders of blood and blood-forming organs in diseases classified elsewhere, is an example of this convention.

The term *code* also indicates that you may need to assign two codes in order to fully describe a condition. You would sequence the two codes according to the reason for the patient's visit and the level of severity inherent in the condition. In the example referenced earlier for code D61.82, in addition to the Excludes1 note, the Tabular List directs you to also code the underlying disorder. Examples of underlying disorders include malignant neoplasm of the breast (C50.-) and tuberculosis (A15.-).

A code adjacent to a main term in the Alphabetic Index of ICD-10-CM is a *default code*. The default code represents a common condition associated with the main term, or represents the unspecified code for the condition. If a condition in the medical record doesn't include additional information pertaining to the condition, assign the default code (that is, unspecified).

Any codes with fewer than six characters require a placeholder only if a seventh character is needed. You'll assign a placeholder of X for any characters fewer than six. An example is code S43.50, unspecified sprain of the acromioclavicular joint, initial encounter, explained on page 49 of your text.

You'll also encounter cross-references when assigning codes in ICD-10-CM. *Cross-references* are possible alternatives or synonyms for a term. Examples of cross-references include *see*, *see also*, and *see category*.