

ICD-10 and CPT Coding Complete Guide

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MASTER MEDICAL CODING FOR ACCURACY AND COMPLIANCE

Accurate medical coding is the foundation of proper healthcare reimbursement and compliance. This guide provides comprehensive coverage of both ICD-10 and CPT coding systems.

ICD-10-CM CODING MASTERY

Code Structure and Organization

ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) uses an alphanumeric format:

Position 1: Letter (category) Position 2-3: Etiology/anatomy/severity Position 4-6: Additional specificity (after decimal)

Chapters of ICD-10-CM: - A00-B99: Infectious and parasitic diseases - C00-D49: Neoplasms (cancer) - E00-E89: Endocrine/nutritional/metabolic - F01-F99: Mental and behavioral disorders - G00-G99: Nervous system diseases - H00-H59: Eye and adnexa - H60-H95: Ear and mastoid - I00-I99: Circulatory system - J00-J99: Respiratory system - K00-K95: Digestive system - M00-M99: Musculoskeletal system - N00-N99: Genitourinary system - O00-O9A: Pregnancy/childbirth - Z00-Z99: Factors influencing health status

Coding Guidelines

Guideline 1: Code to Highest Specificity Bad: M54.5 (Low back pain — too general when more specific code available) Better: M54.51 (Vertebrogenic low back pain)

Guideline 2: Signs and Symptoms When a definitive diagnosis has not been established, code the sign or symptom. Established diagnosis exists: Code the diagnosis, not the symptom.

Guideline 3: Chronic vs Acute Conditions Both chronic and acute conditions should be coded if both are addressed during the encounter.

Guideline 4: Laterality Always specify left, right, or bilateral when codes exist for each.

Common Coding Errors to Avoid

- Using an unspecified code when specific code is available
- Failing to code all documented conditions addressed
- Using signs/symptoms when definitive diagnosis available
- Incorrect sequencing (principal diagnosis must be listed first)
- Using codes from a previous code book (must use current year)

CPT CODING MASTERY

Evaluation and Management (E&M) Coding

E&M codes are based on either: 1. Medical Decision Making (MDM) — preferred 2. Total time on date of encounter

Medical Decision Making Levels:

Level	MDM Complexity	Typical Code
Straightforward	Minimal problems, minimal data, minimal risk	99202/99212
Low	Limited problems, limited data, low risk	99203/99213
Moderate	Multiple chronic or new problems, moderate data, moderate risk	99204/99214
High	High-complexity problems, extensive data, high risk	99205/99215

Time-Based Coding:

New Patient: - 99202: 15-29 minutes - 99203: 30-44 minutes - 99204: 45-59 minutes - 99205: 60-74 minutes

Established Patient: - 99212: 10-19 minutes - 99213: 20-29 minutes - 99214: 30-39 minutes - 99215: 40-54 minutes

Procedure Coding Tips

Modifiers: Modifiers provide additional information about procedures: - 25: Significant, separately identifiable E&M on same day as procedure - 57: Decision for surgery at E&M visit - 59: Distinct procedural service - 76: Repeat procedure by same physician - RT/LT: Right side/Left side

Bundling Rules (NCCI): The National Correct Coding Initiative (NCCI) defines which codes can and cannot be billed together. Always verify NCCI edits before billing procedure combinations.

HCPCS Level II Codes

HCPCS (Healthcare Common Procedure Coding System) Level II codes begin with letters A-V and cover: - Medical equipment and supplies - Ambulance services - Drugs administered in clinical settings - Services not in CPT

Common HCPCS codes: - G codes: Professional services not in CPT - J codes: Drugs administered by injection - L codes: Orthotic and prosthetic devices

Coding Compliance

Accurate coding protects providers from: - Insurance audits and recoupments - Medicare/Medicaid fraud investigations - OIG (Office of Inspector General) scrutiny - False Claims Act liability

The Compliance Mindset: Code only what is documented. Never code to maximize reimbursement. The code should tell the story of what actually happened — nothing more, nothing less.

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