

Coding Fundamentals, ICD-9 and ICD-10 Basics

Your first lesson begins with an overview of coding concepts, terms, and procedures. You'll explore the system that will replace the ICD-9 in late 2013, the ICD-10, and why it's important to understand the ICD-9 before learning the new system. You'll begin to work directly with the ICD-9-CM manual, looking up codes and using them to create medical reports.

OBJECTIVES

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

- Discuss the components of government and private health care payer systems
- Apply HIPAA regulations
- Use the Index and Tabular List of the ICD-9 to locate diagnosis codes
- Understand the use and application of V-codes
- Explain the outpatient guidelines for using the ICD-9 manual
- Explain the reasons for the transition to the ICD-10-CM coding system
- Describe the major components of the ICD-10 system



ASSIGNMENT 1

Read through the following material in your study guide. After you've read the study guide commentary, read pages 1–27 of your textbook *Step-By-Step Medical Coding*.

Introduction to Coding

Medical coding is a process of converting medical terms into standardized numeric and alphanumeric equivalents that are defined by national and international health agencies. Reliance on standardized coding systems greatly expedites the processing of health insurance claims, so patients and health care practitioners can be reimbursed more quickly. Proper coding also helps prevent the submission of erroneous or fraudulent insurance claims, while providing a wide range of health care organizations with accurate statistics on disease, mortality, and treatments.

Health care employees responsible for coding are expected to be familiar with two different coding systems:

- The *Health Care Financing Administration Common Procedural Coding System* (commonly referred to as *HCPCS*), made up of two manuals: the *Current Procedural Terminology (CPT)* and *National Coding Manual*
- The *International Classification of Diseases, 9th Revision, Clinical Modification* (commonly referred to as *ICD-9-CM*)

A career in medical coding can involve many jobs, from coding for doctors' offices and hospitals to educating new coders. It's therefore likely that you'll hold more than one kind of coding position during your career. Opportunities in this field will increase in the coming years.

Most coders have a combination of formal education and on-the-job experience. Although not all coders are required to be certified, certification is recommended and leads to more opportunities and higher pay. Three institutions offer certification for coders. The organization you choose will depend on what you want from your career. However, choosing one organization doesn't prevent you from choosing another in the future.

Computer skills are necessary for today's coding environment. Knowledge of medical terminology, anatomy, and physiology is also helpful in this field.

Insurance fraud and abuse are partly responsible for increased premiums and rising health care costs. The Health Insurance Portability and Accountability Act (HIPAA) and the Omnibus Budget Reconciliation Act (OBRA) both have detection and penalty measures in place to help prevent fraud and abuse.

The only way to avoid even the appearance of wrongdoing is to follow meticulous record-keeping practices and to continuously update your knowledge of current coding regulations. Purchasing updated coding materials every year, participating in continuing-education seminars, reading coding newsletters and Internet sites regularly, and scrupulously documenting patient charts are crucial to this job.

ASSIGNMENT 2

Read through the following material in your study guide. After you've read the study guide commentary, read pages 199–364 in *Step-By-Step Medical Coding*.

ICD-9-CM

The ICD-9-CM system is contained in three separate volumes. Volume 1 consists of a tabular numerical listing of diagnostic codes, while Volume 2 provides an alphabetical listing of diagnostic codes. Volume 3 consists of both a tabular and alphabetical lists of medical procedures, most of which are performed in a hospital setting. All three volumes are contained in one book.

Hospital patients may present a variety of symptoms and conditions upon admission. The first—and most important—step in ICD-9-CM coding therefore involves determining the primary condition that led a patient to seek hospital care. This primary condition is commonly referred to as the *principal diagnosis*, while the process of distinguishing the principal diagnosis from additional diagnoses is known as *sequencing*.

Once you've determined the principal diagnosis, you can find the appropriate ICD-9-CM code by looking up the *main term* of the diagnosis in Volume 2 of the ICD-9-CM manual. The *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 almost never used as a main term.

You can really grasp the specificity of ICD-9-CM when you examine the number and variety of subterms and modifiers associated with most main terms. *Subterms* provide more precise details about main term conditions. For example, the list of subterms associated with main term "fracture" covers several pages, and includes a wide assortment of locations, causes, and related conditions. In most cases, you'll find the appropriate ICD-9-CM code listed alongside a subterm of the main term.

After you locate the correct ICD-9-CM code in the alphabetical index, verify the code in the tabular list in Volume 1 of the ICD-9-CM manual. The tabular list is divided into 17 sections, while the codes themselves are broken down into categories, subcategories, and subclassifications.

- *Category* codes consist of three digits, and may represent either the main term of a single disease or condition or a group of several similar diseases.
- *Subcategory* codes, which consist of four digits, provide greater detail, such as the cause or location of an illness or condition.
- *Subclassification* codes consist of five digits, representing the most specific level of detail regarding a particular disease or condition.

Assignment 2 will guide you step-by-step through the specific conventions and formats used in the ICD-9-CM manual. Be sure to complete each of the practice exercises that accompany each section of your reading assignment.

You're covering three chapters of the book for this section, and there's a lot of material to absorb, so take it slow. You'll be moving from an overview in Chapter 8 to actually using your

manual in Chapter 10. Chapter 9 is an important chapter, as many coders never learn to use the guidelines properly in their everyday coding. The ICD-9 guidelines are a wealth of information. Learning to use them will increase your coding accuracy and allow you to perform well if you decide to take any certification examinations.

Particular attention is given to diagnosing tumors or growths, which medical professionals commonly refer to as *neoplasms*. Accuracy is crucial when coding neoplasms, because incorrectly listing a tumor as malignant or cancerous on a patient's medical record can negatively affect that patient's insurance coverage. You'll also be working with injuries, fractures, burns, and poisonings.

Several special areas of concern are covered in Assignment 2, including E codes, which are special secondary codes used to describe external causes of injury. Two ranges of codes were introduced in 2010 and are still causing coders some consternation: E000 codes for external cause status and E001–E030 for activity codes. Both sets of codes add specificity to external causes of injury. For example, in 2009 the E-code for a soldier injured by falling from a cliff during a mountain-climbing training session would have been E884.1. Beginning in 2010, you would use three E-codes for this scenario: E000.1 to indicate that the injury happened during a military activity, E004.0 to indicate the mountain climbing, and E884.1 to indicate the fall. Not all E-coding will require these extra codes, but it's a good idea to review these new categories (E000–E030) so you'll know when to add them.

In addition, many complications resulting from surgical procedures or implanted medical devices, such as pacemakers, require special codes located in the 996–999 series of ICD-9-CM codes. You'll also learn about coding *late effects*, a term used to describe side effects or conditions that appear after the acute phase of an illness or injury has passed. Late effects can sometimes present months or years after the termination of a primary disease or injury. Note that this is one of the changes in the ICD-10 system, where late effects (called *sequelae* in the new system) are included as an option in codes for the original condition.

ASSIGNMENT 3

Read through the following material in your study guide. After you've read the study guide commentary, read pages 28–198 of your textbook *Step-By-Step Medical Coding*.

ICD-10-CM

Note: For Chapters 3–7, you don't have to attempt the Part II, Practical review exercises since you don't have the ICD-10 code book.

The *International Classification of Diseases (ICD)* system has a long and interesting history. It started in the late nineteenth century, when French physician and statistician Jacques Bertillon decided to track the reasons for *mortality* (death) in the *Bertillon Classification of Causes of Death*. 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. From this grew 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, the same year the American Medical Association released the first Current Procedural Terminology (CPT) manual.

To complement the CPT, the U.S. National Center for Health Statistics (NCHS) modified the ICD-9 to be useful for codifying 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 provide justification 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.”

As early as 1995, the United Kingdom began using the ICD-10, and the United States started using it for reporting mortality in 1999. More than 200 countries use all or part of the ICD-10 already. As part of regular health care reporting, however, the United States will only start using the modified version of the ICD-10—the ICD-10-CM—on October 1, 2013. This date is only a little more than one year before WHO approves the ICD-11!

The most common way to refer to the ICD-10-CM in the United States is simply “I-10.” While WHO still maintains the ICD (they’ll stop supporting the ICD-9 in 2012), the Centers for Medicare and Medicaid Services (CMS) along with the American Hospital Association (AHA) and the NCHS are responsible for maintaining all three volumes of the ICD-9-CM and will be responsible for maintaining the ICD-10-CM and ICD-10-PCS.

The biggest obstruction to implementing the ICD-10-CM is the multipayer health care system that exists in this country. Countries with socialized medicine have fewer entities to coordinate to change the system on which their statistics, research, and payments are based. Since its release in 1994, the rumor that the United States was going to start using the ICD-10 the very next year has been circulating. Because it’s been rumored for so long, there are still people at the time of this writing who don’t believe the ICD-10-CM/PCS implementation will ever occur. It’s true that the wheels of health care turn slowly in the face of change, but they’re starting to spin now, and it would be foolish for any health care provider to put off preparing for the change at this point. Part of the impetus for movement to the new system is the many other mandated changes occurring during the same year, including details of the Health Information Technology for Economic and Clinical Health (HITECH) Act. While this makes 2013–2014 a year of enormous stress for doctors’ offices and hospitals around the country, sometimes it’s not a bad idea to make a lot of adjustments at one time and get them all over with!

The ICD-10-CM isn’t just an update to the code numbers or code definitions. It’s the first change to the system of this magnitude since the code numbers were introduced in 1968. The most compelling reason for the change is that the ICD-9 is running out of room to expand. There aren’t enough available codes to encompass new diseases being discovered and the greater clinical detail being demanded for documentation of known conditions. According to the AMA, the ICD-9-CM has a maximum of 14,000 codes using the current configuration of 3–5 digits, with an additional 4,000 procedure codes in the third volume of the ICD-9 manual, which uses only 3–4 digits. That’s a total of 17,000 possible codes. There are that many codes in the ICD-10 just to cover fractures! The

ICD-10-CM has the capacity to contain more than 155,000 codes, and the 2011 draft contained just over 68,000 codes. Starting in 2012, there will be minimal changes to the ICD-10 until after its first full year of use—the 2015 version that will be released in October 2014.

The changes in specificity tend to scare people, but offsetting the clinical detail are alterations that make the coding process more intuitive and easier to understand once coders “get” the system. There are also several concepts that don’t change at all, which means anybody who already knows ICD-9 has an advantage in learning ICD-10.

One of the structural changes to the ICD-10 is the number of volumes. Within the ICD-9-CM, there are three volumes: Volume 1 is the tabular section, Volume 2 is the index, and Volume 3 contains the procedure codes for inpatient coding. With the new system, the ICD-10-CM is for diagnosis codes *only*, and the inpatient procedure codes are in the ICD-10-PCS. The only two “parts” of the ICD-10-CM are the index and the tabular sections—and since coders always use the index first, it remains in the front.

The manual used to code the hospital’s portion of the inpatient procedures is *The International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS)*. Just as Volume 3 of the ICD-9 doesn’t affect the procedure coding done by physicians, neither does the ICD-10-PCS. The ICD-10 system doesn’t have anything to do with the CPT or HCPCS manuals, which cover outpatient procedures, durable medical equipment, injectable medications, medical transportation, and other procedures and services performed by health care providers. Interestingly, the ICD-10-PCS also has nothing to do with the ICD-10 system maintained by the WHO! Remember that the ICD-9 and ICD-10 systems maintained by WHO are for coding mortality—reasons people die—*only*.

The third volume of the ICD-9-CM doesn’t codify disease processes. Rather, it lists surgical procedures performed in-house, which hospitals use to bill their portion of the charges (operating room time, nursing services, instruments, etc). The third volume of the ICD-9-CM, therefore, is only part of the clinical modification used by the United States and not

included in the ICD-9 maintained by WHO. There is no list of surgical procedures in the WHO version of the ICD-10 either. CMS was aware that Volume 3 of the ICD-9 was not meeting all the documentation needs of hospitals and asked 3M Health Information Systems to develop a new system. The result was the ICD-10-PCS, named for WHO's system just to keep it consistent, as the ICD-9-CM was. Most coders refer to it simply as "PCS."

The ICD-10-CM/PCS transition is going to cost both time and money. The Department of Health and Human Services estimates the monetary costs at nearly \$2 billion, but it projects the benefits at about \$4.5 billion over 15 years. The savings will be seen in increased efficiency (after the learning curve has crested), faster payments, fewer claims that require documentation because of imprecise coding, and fewer denied claims. The time investment will affect the entire industry as well—from software vendors to physicians, and coders most of all. Coders—even experienced coders—will need greater clinical knowledge, including medical terminology, anatomy/physiology, disease processes, and operative techniques. Certified coders will also be required to train in the new system and take an online test to ensure their certifications stay current. There's an anticipated lag in claim processing involved as coders learn the new way to code even the simple procedures and diagnoses they've coded every day for years. The key to making this change without overwhelming office staff is making incremental moves toward the final goal. It's true—baby steps are the best approach!

Navigating the ICD-10-CM

The 2012 version of the ICD-10-CM will be used for demonstration purposes here. Pertinent parts will be reproduced within this section. To download the various parts of the ICD-10-CM manual for additional study or your own use, go to <http://tinyurl.com/yl3kf8x> and scroll down to the "2012 Release of the ICD-10-CM." From there, you can separately download the preface, guidelines, code set (in PDF or XML format), addenda, a list of codes and descriptions, and the CMS General Equivalent Mapping files (GEMs) so you can compare ICD-9 to ICD-10 codes.

First, start with the guidelines. Anybody familiar with the ICD-9 guidelines will see a lot that looks the same. It's important to note that the coding process doesn't change. The only thing that's changing is the way the codes are grouped and how they're identified.

Secondly, the ICD-10-CM Tabular List contains categories, subcategories, and codes. Characters for categories, subcategories, and codes may be either a letter or a number. All categories are three characters. A three-character category that has no further subdivision is equivalent to a code. Subcategories are either four or five characters. Codes may be three, four, five, six, and seven characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. Codes that have applicable seventh characters are still referred to as codes, not subcategories. A code that has an applicable seventh character is considered invalid without the seventh character (Centers for Disease Control [CDC], 2012).

In the ICD-9-CM, the format consisted of a three-digit rubric that indicated the category of code with a possible fourth or fifth digit. The fourth and fifth digits meant different things for different categories. For instance, in the burn code section of 940-949.5, there are 9 three-digit category rubrics, and all of them have four-digit subcategories, and 6 of those extend to the five-digit subcategories.

The ICD-10 structure retains the three-digit category (although in the ICD-10, it's called a *block*), the first character of which is always be a capital letter. All letters except *U* are used in the ICD-10-CM. The second and third characters can be either letters or numbers, and if a letter is used, it will be a lowercase letter. The fourth, fifth, and sixth characters indicate etiology of disease, anatomic site, and severity. The seventh character (known as an *extension*) is used only in certain sections (obstetrics, musculoskeletal, injuries, and external causes of injury) to indicate whether the encounter is initial or follow-up, has external causes, and whether the condition is a "late effect," now referred to as "sequela," of an earlier condition (in the ICD-9, late effects had their own classifications). In the pregnancy chapter, the seventh digit extension can also indicate information about complications

involving the fetus. The greatest difference here between the I-9 and the I-10 is that there may be codes where a seventh digit extension is used, but there's no fifth or sixth digit information. In these cases, we can't just slide the seventh digit over to make it a fifth or sixth digit. That extension always has to be in the seventh character place. In these cases, the I-10 uses a placeholder character, a lowercase *x*, to indicate that there's no character needed for those missing places because there's no detail corresponding to the axis definition, but that there's still an extension for the code.

Code Building

The American Academy of Professional Coders (AAPC) offers an online translation tool, using the GEM mapping files at <http://tinyurl.com/7n7jstr> or <http://www.aapc.com>, and click on **ICD-10** and then **ICD-10 Code Translator**. Using that tool, we can find some code equivalents and compare the differences in code structure.

We'll start with a straightforward ICD-10 code—six digits, no extension, no placeholders—and map it to an ICD-9 code:

ICD-10: L97.312 Non-pressure chronic ulcer of right ankle limited to breakdown of skin

The primary axis of classification (the chapter under which the code is listed) is L, Diseases of the Skin and Subcutaneous Tissue. The block rubric, L97, indicates *Non-pressure chronic ulcer of the lower limb, not elsewhere classified*. The fourth digit, 3, is the anatomy axis and indicates that the ankle is the affected body part. The fifth digit, 1, indicates laterality, and 1 always means the right side. The sixth digit, 2 indicates severity and, in this case shows that the fat layer was exposed.

Using the ICD-10 Code Translator, if you choose the option of “ICD-10 to ICD-9” and enter the above code, the translator returns the following code:

ICD-9: 707.13 Ulcer of ankle

Notice that the primary axis of classification, the first digit of 7, is the same as for the ICD-10—*Diseases of the Skin and Subcutaneous Tissue*. The category rubric, 707, indicates Chronic ulcer of skin. The fourth digit, 1, is also an anatomy axis and indicates lower limb. It also indicates that pressure ulcers are excluded from this code.

The fifth digit, 3, further delineates anatomy, indicating the ankle.

Notice that the ICD-9 code addresses fewer details than the ICD-10 code. In the ICD-9 code, the fourth digit does double duty, identifying the code as a non-pressure ulcer and a lower limb ulcer. Although the ankle is identified, there’s no indication about whether the affected ankle is left or right. Finally, there’s no indication of the severity of the ulcer.

An interesting exercise is to switch the ICD-10 Code Translator to the “ICD-9 to ICD-10” option and enter **707.13** into the translator. Doing so shows the mapped ICD-10 code as follows:

L97.309 Non-pressure chronic ulcer of unspecified ankle with unspecified severity.

There’s no mapping to L97.312 at all. This is because of the rules of the GEM mapping system. If the “source” code (here, the ICD-9 code) doesn’t have all the detail of the “target” code, the map will indicate the least specific code in the target choices. Notice that the mapped code indicates an unspecified ankle and an unspecified severity. It’s obvious that L97.309 couldn’t possibly be used in all situations that called for the ICD-9 code of 707.13 (unless there were a severe lack of documentation on the physician’s part). In reality, the ICD-9 code of 707.13 maps only to the subcategory of L97.3 (*Non-pressure chronic ulcer of ankle*) and has the possibility of mapping to *all* the following ICD-10 codes:

- L97.301 Non-pressure chronic ulcer of unspecified ankle limited to breakdown of skin
- L97.302 Non-pressure chronic ulcer of unspecified ankle with fat layer exposed

- L97.303 Non-pressure chronic ulcer of unspecified ankle with necrosis of muscle
- L97.304 Non-pressure chronic ulcer of unspecified ankle with necrosis of bone
- L97.309 Non-pressure chronic ulcer of unspecified ankle with unspecified severity
- L97.311 Non-pressure chronic ulcer of right ankle limited to breakdown of skin
- L97.312 Non-pressure chronic ulcer of right ankle with fat layer exposed
- L97.313 Non-pressure chronic ulcer of right ankle with necrosis of muscle
- L97.314 Non-pressure chronic ulcer of right ankle with necrosis of bone
- L97.319 Non-pressure chronic ulcer of right ankle with unspecified severity
- L97.321 Non-pressure chronic ulcer of left ankle limited to breakdown of skin
- L97.322 Non-pressure chronic ulcer of left ankle with fat layer exposed
- L97.323 Non-pressure chronic ulcer of left ankle with necrosis of muscle
- L97.324 Non-pressure chronic ulcer of left ankle with necrosis of bone
- L97.329 Non-pressure chronic ulcer of left ankle with unspecified severity

This exercise exposes the greater granularity of the ICD-10 when compared to the ICD-9. Now let's see how the placeholder concept works. By far, the greatest concentration of codes containing placeholders is in chapter 19, *Injury, Poisoning and Certain Other Consequences of External Causes*, specifically the codes starting with *T*. Just as the ICD-9 manual has a box under some rubrics indicating what numbers can be used as fifth digits for certain four-digit

codes, the ICD-10 manual has a seventh digit box. For codes up to six digits, each separate code is listed in the manual with full descriptions of the code following. In the printed manual, four- and five-digit codes requiring a seventh digit, are marked with a blue box containing a checkmark, a small *x* and “seventh.” This indicates that you must add a seventh character and any necessary placeholder *x*’s to fill empty characters. Six-digit codes in the printed manual are marked with a red box containing only a checkmark and “seventh” because there will be no required placeholder characters. Please note that the online ICD-10-CM manual doesn’t include either of the indicator boxes. A seventh character box under a rubric in the online manual means that you must use a seventh character extension with every code under that rubric. Let’s build a few of these codes with placeholders and extensions.

Seven-Digit Code with No Placeholder

T24.132D Burn of first degree of left lower leg, subsequent encounter

The rubric T24, *Burn and corrosion of lower limb, except ankle and foot*, is part of the block of codes from T20-T25 that cover *Burns and corrosions of external body surface, specified by site*. The fourth digit indicates degree of burn, and 1 corresponds to first-degree burns. The fifth digit is the anatomy axis, and 3 indicates the lower leg. The sixth digit indicates laterality, and 2 always indicates left. The seventh digit, found in the box below the T24 rubric, indicates the nature of the patient’s encounter with the doctor. *D* is for a subsequent encounter, which means that the patient is following up in his care of this condition—he has already had initial treatment during another visit.

Seven-Digit Code with Placeholder in Sixth Place

T36.92xA Poisoning by unspecified systemic antibiotic, intentional self-harm, initial encounter

The rubric T36, *Poisoning by, adverse effect of and underdosing of systemic antibiotics*, is the first in this block of codes that covers T36-T50, *Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances*. The fourth digit indicates the type of antibiotic poisoning, and 9 indicates an unspecified systemic antibiotic. The fifth digit indicates intent of the poisoning, and 2 is for intentional self-harm. There's no detail that corresponds to the sixth character place in this code, but we do have a seventh digit extension requirement to indicate that this was the patient's first encounter for this condition. The letter A indicates initial encounter. It must be in the seventh digit place, so a "dummy character" x must hold the unused sixth digit place in this code.

Seven-Digit Code with Placeholders in Fifth and Sixth Places

T19.1xxA Foreign body in bladder, initial encounter

The rubric T19, *Foreign body in genitourinary tract*, is part of the block *Effects of foreign body entering through natural orifice* (T15-T19). The fourth digit is the anatomy axis, and the 1 in that place indicates that the foreign body is in the bladder. The seventh digit extension indicates an initial encounter. Since there are no further available details for this code, the fifth and sixth places are held by x's.

Rubric with Seventh-Digit Extension

T66.xxxS

The rubric T66 is the first in the T66-T78 block of *Other and unspecified effects of external causes* and indicates *Radiation sickness, unspecified*.

Even though there are no other details indicated for this code, there's still a seventh-digit extension required to code the encounter information. The S at the end of this code stands for "sequelae" and is used to indicate a patient encounter where complications or conditions that arise from the condition are treated. This term takes the place of "late effect" in the ICD-9. If you code S in the seventh digit place, the code must be sequenced after the specific type of sequelae being treated at that visit.

Tricks of the Trade

The previous example brings us to an important aspect of the ICD-10. Anybody familiar with the tabular section of the ICD-9 will know that notes within the code descriptions indicate what other types of codes are included or excluded from a code description. For example,

712 Crystal arthropathies

includes crystal-induced arthritis and synovitis

excludes gouty arthropathy (274.0)

From this entry, we can deduce that 712 covers all crystal-induced arthritis and synovitis, but to code gouty arthropathy, 274.0 should be used instead of 712.

The ICD-10 also makes use of the “includes” and “excludes” notes to guide coders in their final decisions about instances when a code can and can’t be used. However, in the ICD-10-CM, there are two types of “excludes” notes: Excludes1 and Excludes2. The ICD-10 guidelines say it best (CDC, 2012):

- **Excludes Notes.** The ICD-10-CM has two types of excludes notes. Each note has a different definition for use, but they’re both similar in that they indicate that codes excluded from each other are independent of each other.
- **Excludes1.** A type 1 Excludes note is a pure excludes. It means “NOT CODED HERE!” An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions can’t occur together, such as a congenital form versus an acquired form of the same condition.
- **Excludes2.** A type 2 excludes note represents “Not included here.” An Excludes2 note indicates that the condition excluded isn’t part of the condition it’s excluded from, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it’s acceptable to use both the code and the excluded code together.

An example that incorporates both types of Excludes notes is J00 Acute *nasopharyngitis [common cold]*. Note the terms just under the main code description are alternate terms for that code description and all carry that same code assignment. The codes listed under Excludes1 aren't included in the code set under the J00 rubric, and they can't be coded along with any of the J00 codes. The codes under the Excludes2 code set aren't included in any of the J00 code set, but they can be coded along with the codes in this code set:

J00 Acute nasopharyngitis [common cold]	pharyngitis NOS (J02.9)
Acute rhinitis	rhinitis NOS (J31.0)
Coryza (acute)	sore throat NOS (J02.9)
Infective nasopharyngitis NOS	Excludes2: allergic rhinitis (J30.1-J30.9)
Infective rhinitis	chronic pharyngitis (J31.2)
Nasal catarrh, acute	chronic rhinitis (J31.0)
Nasopharyngitis NOS	chronic sore throat (J31.2)
Excludes1: acute pharyngitis (J02.)	nasopharyngitis, chronic (J31.1)
acute sore throat NOS (J02.9)	vasomotor rhinitis (J30.0)

Other familiar conventions remain the same with ICD-10. For example, “Code first underlying disease . . .” and “Use additional code to identify . . .” notes are in their usual places within the code frameworks. Abbreviations of NEC (Not Elsewhere Classified) and NOS (Not Otherwise Specified) are still used in the ICD-10, although they occur less frequently because of the greater detail in the manual.

One nice addition to the ICD-10-CM index is a clearer indication of indentations. Anybody familiar with the ICD-9-CM knows how hard it is to follow some of the indentations to determine subdivisions of terms, especially when a list runs across several pages, like in “History (personal) of” codes or “Diabetes, diabetic.” Each main term in the ICD-10-CM index is printed in bold type. In the printed draft of the ICD-10-CM, there are two vertical grey lines running along the edges of the columns so you can follow the indentations (a lot like

that ruler coders sometimes use). In the online version of the codes, dashes are used to indicate how far indented the terms are. Each dash indicates an indentation:

Epidermolysis

- | | |
|-----------------------------|--|
| —bullosa (congenital) Q81.9 | —letalis Q81.1 |
| —acquired L12.30 | —simplex Q81.0 |
| —drug-induced L12.31 | —specified NEC Q81.8 |
| —specified cause NEC L12.35 | —necroticans combustiformis L51.2 |
| —dystrophica Q81.2 | —due to drug—see Table of drugs and chemicals, by drug |

Another use of the dash in the index is *after* a code listing, such as the following:

Episcleritis (suppurative) H15.10—

The dash after the code means that further digits are necessary to complete this code. Now, just as in the ICD-9, an indication that the code is complete doesn't mean you can skip looking up the code in the tabular section! The process remains the same: Look up the term in the index, confirm the code in the tabular, search for any additional instructions and code the condition. On to the next one!

After you've finished Lesson 1, take the time to review all the study assignments. Then, proceed to your examination before moving on to Lesson 2.