Billing and Coding Glossary

Acute Conditions – The medical conditions characterized by sudden onset, severe change, and/or short duration.

Additional Diagnosis – The secondary diagnosis code used, if available, to provide a more complete picture of the primary diagnosis.

Bilateral – For bilateral sites, the final character of the codes in the ICD-10-CM indicates laterality. An unspecified side code is also provided should the side not be identified in the medical record. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side.

Category – The three-digit diagnosis code classifications that broadly define each condition (e.g., 250 for diabetes mellitus).

Centers for Disease Control and Prevention (CDC) – A federal health data organization that helps maintain several code sets included in the HIPAA standards, including the ICD-9-CM codes. A division of the Department of Health and Human Services responsible for monitoring, researching and developing public health policies for the prevention of disease, injury and disability and the promotion of healthy behaviors. The National Center for Health Statistics is the part of the CDC that maintains health related statistics including the coordination with World Health Organization (WHO) on use of International Classification of Diseases (ICD) in North America.

Chronic Conditions – Medical conditions characterized by long duration, frequent recurrence over a long period of time, and/or slow progression over time.

Combination Codes – A single code used to classify any of the following: two diagnoses; a diagnosis with an associated secondary process (manifestation); or a diagnosis with an associated complication.

Conventions of ICD-10 – The general rules for use of the classification independent of guidelines. These conventions are incorporated within the Index and Tabular of the ICD-10-CM as instructional notes. Possible conventions to include with code are:

> **Notes** – Extra information to define or clarify code choice.
>
> **Includes Notes** – This note appears immediately under a three character code title to further define, or give examples of, the content of the category.
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> **Not otherwise specified (NOS)** – This abbreviation is the equivalent of unspecified.
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> **Excludes Notes** – A type 1 Excludes note is a pure excludes note. 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 cannot occur together, such as a congenital form versus an acquired form of the same

condition. A type 2 excludes note represents “Not included here.” An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

Not elsewhere classifiable (NEC) – This abbreviation in the Tabular List represents “other specified.” When a specific code is not available for a condition the Tabular List includes an NEC entry under a code to identify the code as the “other specified” code.

Crosswalk/mapping – A new test is determined to be similar to an existing test, multiple existing test codes, or a portion of an existing test code. The new test code is then assigned to the related existing local fee schedule amounts and resulting national limitation amount. In some instances, a test may only equate to a portion of a test, and, in those instances, payment at an appropriate percentage of the payment for the existing test is assigned.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality healthcare.

Current Procedural Terminology (CPT)Codes – This is the procedural coding system that is currently used in America primarily to report physician professional services. Frequently called “CPT”, the Current Procedural Terminology, is a code set, developed in 1966 and maintained by the American Medical Association (AMA), used to describe what healthcare professional services were provided or utilized by healthcare professionals. CPT codes are also known as “Level I” codes. Additional codes to describe use of healthcare facilities and services provided by healthcare professionals are known as “Level II” or “Healthcare Common Procedure Coding System” (HCPCS). Level II codes were developed are maintained by CMS.

Federal Register – The “Federal Register” is the official daily publication for rules, proposed rules and notices of federal agencies and organizations, as well as Executive Orders and other Presidential documents.

GEMs - This reference mapping attempts to include all valid relationships between the codes in the ICD-9-CM diagnosis classification and the ICD-10-CM diagnosis classification.

Healthcare Common Procedure Coding System (HCPCS) – A medical code set that identifies healthcare procedures, equipment, and supplies for claim submission purposes. It has been selected for use in the HIPAA transactions. HCPCS Level I contains numeric CPT codes which are maintained by the AMA. HCPCS Level II contains alphanumeric codes used to identify various items and services that are not included in the CPT medical code set. These are maintained by Health Care Financing Administration (HCFA), Blue Cross and Blue Shield Association (BCBSA), and the Health Insurance Association of America (HIAA). HCPCS Level III contains alphanumeric codes that are assigned by Medicaid state agencies to identify additional items and services not included in levels I or II. These are usually called "local codes", and must have "W", "X", "Y", or "Z" in the first position.

HCPCS Procedure Modifier Codes can be used with all three levels, with the WA - ZY range used for locally assigned procedure modifiers.

Health Insurance Portability & Accountability Act (HIPAA) – A law passed in 1996 which is also sometimes called the "Kassebaum-Kennedy" law. This law expands healthcare coverage for patients who have lost or changed jobs, or have pre-existing conditions. HIPAA does not replace the states' roles as primary regulators of insurance. The HIPAA legislation has the following broad goals, to provide: 1) a way to uniquely identify providers, employers and health plans, 2) a uniform level of protection of health information, known as the "Security Rule," 3) a uniform level of protection of the privacy of health data associated with patients, known as the "Privacy Rule" and 4) a simpler healthcare electronic transaction process by describing standards by which all healthcare administrative entities would use, which is known as the "Transactions and Code Sets Rule".

HIPAA 4010 – The original healthcare transactions version of HIPAA (officially known as Version 004010 of the ASC X12 transaction implementation guides) named as part of HIPAA's Electronic Transaction Standards regulation. Version 4010 was required to be used by HIPAA covered healthcare entities by Oct. 16, 2003.

HIPAA 5010 – Required by Jan. 1, 2012 to be the new version of the HIPAA healthcare transactions. Officially known as Version 005010 of the ASC X12 transaction Technical Report Type 3. This new version was required as a result of Department of Health and Human Services (HHS) final rules published on Jan. 6, 2009.

International Classification of Diseases (ICD) – A medical code set maintained by the World Health Organization (WHO). The primary purpose of this code set is to classify both causes of death or mortality and diseases or morbidity. A U.S. extension, known as ICD-CM, "Clinical Modification," is maintained by the NCHS within the CDC to more precisely define ICD use in the U.S.

ICD-9 – The mortality and morbidity classification coding system that is currently used throughout most of the world, including the United States. The ICD-9 classification of death and disease is based a series of classifications systems first adopted in 1893.

ICD-9-CM – The "clinical modification" to the ICD-9 code set that is currently used in America to report medical diagnoses. The "Clinical Modification" refers to the base WHO defined ICD-9 code set that has been defined for use in United State by the National Center for Health Statistics (NCHS) division of the Centers for Disease Control (CDC).

ICD-9-PCS – The procedural coding system currently used in America primarily for hospital inpatient services. It is contained in Volume 3 of ICD-9-CM.

ICD-10 – The mortality and morbidity classification coding system implemented by WHO in 1993 to replace ICD-9.

ICD-10-CM – The updated version of the clinical modification coding set defined by the National Center for Health Statistics that will replace ICD-9-CM no sooner than Oct. 1, 2015.

ICD-10-PCS – The updated procedural coding system defined by CMS that will replace Volume 3 of ICD-9-CM for hospital inpatient services.

Index (to diseases) – The ICD-10-CM is divided into the Alphabetic Index, an alphabetical list of terms and their corresponding code, and the Tabular List, a chronological list of codes divided into chapters based on body system or condition. The Alphabetic Index consists of the following parts: the Index of Diseases and Injury, the Index of External Causes of Injury, the Table of Neoplasms and the Table of Drugs and Chemicals.

Manifestation Codes – Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

Medical Necessity – Services or supplies that: are proper and needed for the diagnosis or treatment of a medical condition; are provided for the diagnosis, direct care, and treatment of a medical condition; meet the standards of good medical practice in the local area; and are not mainly for the convenience of the patient or doctor.

Morbidity – Term refers to the disease rate or number of cases of a particular disease in a given age range, gender, occupation, or other relevant population based grouping.

Mortality –Term refers to the death rate reflected by the population in a given region, age range, or other relevant statistical grouping

National Center for Health Statistics (NCHS) – A federal organization within the CDC that collects, analyzes, and distributes healthcare statistics. The NCHS helps maintain the ICD-CM codes.

Principle Diagnosis – First-listed/primary diagnosis code. The code sequenced first on a medical record defines the primary reason for the encounter as determined at the end of the encounter.

Signs/Symptoms – Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

Sequelae – A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebral infarction, or it may occur months or years later, such as that due to a previous injury.

Tabular List – It is essential to use both the Alphabetic Index and Tabular List when locating and assigning a code. The Alphabetic Index does not always provide the full code. Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular List. A dash (-) at the end of an Alphabetic Index entry indicates that additional characters are required.

Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required.

Uniform Hospital Discharge Data Set (UHDDS) – The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

Volume I – The detailed, tabular list of diagnosis codes in the ICD-9-CM manual.

Volume II – The alphabetical index to diseases in the ICD-9-CM diagnosis coding manual.

Volume III – The ICD-9/ICD-10 list of procedure codes, used in inpatient settings.

World Health Organization (WHO) – An organization that maintains the International Classification of Diseases (ICD) medical code set.