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DEPARTMENT OF HEALTH

Coding Manual

For Coding within the Emirate of Abu Dhabi

Effective: January 01, 2025

Department of Health Abu Dhabi

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Introduction

This Coding Manual has been revised with the aim of documenting all the coding guidelines and standards agreed on by the Department of Health Abu Dhabi, to support the coding practices of the public and private health sector within the Emirate of Abu Dhabi. In the event of any conflict between the content of this document and the Law and Rules, the aforementioned Coding Standards; the Law and Rules and the governance shall take precedence.

Version History

Version	Effective Date	Changes Made	Comments
1.0	1st June 2012	First version	Final
2.0	1st January 2025	2021 Code Set update	Final

Medical Coding

Medical Coding is the "translation of medical terminology as written by the clinician or healthcare provider to describe a patient's complaint, problem, diagnosis, treatment, or reason for seeking medical attention, into a coded format," which is then both nationally and internationally recognized.[1]

- Quality healthcare depends on the accurate and timely capture of medical data. Medical coding professionals abstract clinical data from health records and assign the relevant codes that are used for vital healthcare industry functions. Coders play a key role in protecting every patient's health story.
- Coding is the translation of medical terminology into coded data aligned with a classification, that can then be easily tabulated, aggregated, and sorted for statistical analysis in an efficient and meaningful manner and utilized for current and future healthcare planning.

The importance of reporting accurate medical coding will reflect into multiple areas as the coded data is used in the following:

- Revenue Cycle for Reimbursement of claims between payers and providers.
- Support of Analysis and Health Policy Decisions.
- Research Conducted on Diseases and New therapeutic Interventions.

Mandatory Certifications for Medical Coders

One of the below is required:

[1] What is Medical Coding? - AAPC

- Membership in one of the professional organizations that offer certifications in the data sets utilized within the Emirate of Abu Dhabi, with the most relevant being from the American Health Information Management Association (AHIMA)[2] or American Academy of Professional Coders (AAPC).[3] Or
- Bachelor of Science Degree in Health Information Management or Medical Records. Or
- Higher Diploma in Health Information Management or Medical Records

Credential Maintenance

Validation of a current Coder Certification and/or experience that includes proof of coding experience with a minimum of 2 years in coding (not billing), including evidence of CEUs within 2 years from the current year of active membership:

- Active member status for AAPC or annual AHIMA Membership.
- CEU reporting as required by additional certifications or organizations.
- Participation in continuing education activities to maintain and improve coding skills as well as to staying current with annual coding updates and changes, including coding seminars, articles, and conferences as evidenced by a CEU register.

Coding Ethics

The Standards of Ethical Coding recommended by the Department of Health, are based on the American Health Information Management Association's (AHIMA's) Code of Ethics.

The AHIMA Code of Ethics is relevant to all AHIMA members, non-members, credentialed HIM professionals, non-credentialed HIM professionals, coding staff, coding auditors, coding educators, clinical documentation improvement (CDI) professionals, managers responsible for the decision making processes and operations as well as Health Information Management (HIM) professions, regardless of their professional functions, the settings in which they work, or the populations they serve.

These Ethical principles of the Health Information Management (HIM) professional include the safeguarding of privacy and security of health information; appropriate disclosure of health information; development, use, and maintenance of health information systems and health information; and ensuring the accessibility and integrity of health information. [4]This includes expectations of Ethical professional conduct for coding professionals involved in diagnostic and/or procedural coding or other health record data abstraction in all settings of practice.

The standards of ethical coding have been revised to reflect the current healthcare environment and modern coding practices and are now located in Appendix B: AHIMA Code of Ethical Coding. The current version was approved in December 2016 with 11 principles.

[2] AHIMA Home
[3] Our Story - AAPC
[4] AHIMA Code of Ethics

User Guide

The structure of this manual has distinct sections relevant to the process of Coding.

Relevant rules, conventions or standards must be applied throughout the classification, as found within the applicable sections for the General Coding Guidelines, Diagnostic Guidelines specific for ICD-10-CM, Procedure Coding guidelines relevant to CPT conventions. Dental Guidelines reflect the Canadian Dental Association (CDA) requirements, with Quality & Data Standards and Coding Audit, Advisory, Policies, Processes and References addressing the awareness Coders should have.

Coding Principals will be introduced to assist Coders in identifying specific Coding requirements which are applicable to coding within the Emirate of Abu Dhabi for the Coding Manual. To ensure and support the collection of local data, compliance by the Coder for the relevant Coding Principals are essential. Each Principal is contained within a box, according to the applicable codeset. There are unique identifiers for the General Coding Principal (GP), Diagnostic (DP) or Procedure Principal (PP), the first having two elements, beginning with 'GS' followed by a unique number allocated to identify each principal (e.g. GS01) while the Diagnostic and Procedure principals have three elements, to include a number indicating the relevant ICD-CM or CPT Chapter (e.g. DP0101 or PP0101)

These supplementary Coding Principals are to be used concurrently with ICD-10-CM and CPT guidelines and will assist in keeping record of the localized coding changes required in a consolidated area.

The Coding guidelines are a statement or indication giving general guidance on the course of action[5] required while the Coding Principal requires a level of quality as approved by the regulator.[6]

Example of a Principle

Reference to ICD-10-CM or Local requirements
DP0*0*: Principal Title
Brief Description
Coding Principal Requirements
Example 1: Example of a Principal
Reference: Relevant References

[5] GUIDELINE Definition & Meaning | Dictionary.com
[6] STANDARD Definition & Meaning | Dictionary.com

General Principal

General Principal	
GP0101	
GP	General Principal for both Diseases and Procedures including any quality related matters.
01	A unique number allocated to the principal (Principal Number)

Diagnostic Principal

Diagnosis Principal	
DP0101	
DP	Diagnosis Principal for the Diseases, Health Related Problems and contact with Health Services within the Diagnosis chapters.
01	The number one will indicate the ICD-10 CM Chapter
01	A unique number allocated to the principal (Principal Number)

Procedural Principal

Procedural Principal	
PP0101	
PP	Procedural Principal for Procedures and Services within the Current Procedural Terminology (CPT) chapters
01	The number one will indicate the CPT Chapter
01	A unique number allocated to the principal (Principal Number)

General Coding Conventions

Coding Terms Definitions

Term	Definition
Acute Condition	An acute condition is a type of illness or injury that ordinarily lasts less than 3 months, was first noticed less than 3 months before the reference data of the interview and was serious enough to have had an impact on behaviour or having a short and relatively severe course. (Pregnancy is also considered to be an acute condition despite lasting longer than three months.)[7]
Adult	Age of 18 years and above.
Autopsy	The post-mortem examination of a body, including the internal organs and structures after dissection, to determine the cause of death or the nature of pathological changes.
Chronic Condition	Condition/s that are not cured once acquired (such as heart disease, diabetes, and hypertension) and are considered chronic.
Coding Books, Alphabetical	An alphabetical index to diseases with corresponding ICD codes.
Coding Books, Tabular	A numerical list of the ICD disease code numbers.
Complication (diagnosis)	In coding, a complication generally refers to a misadventure of a medical or surgical procedure, an adverse outcome from therapy. In medicine, an additional problem that arises following a procedure, treatment, or illness and is secondary to it. A complication complicates the situation.
Co-morbidity (diagnosis)	Co-morbidities are conditions that exist at the same time as the principal condition in the same patient (for example, hypertension is a co-morbidity of ischemic heart disease or diabetes), e.g., two or more co-existing medical conditions or disease processes that are additional to an initial diagnosis.
CPT Guidelines	There are specific guidelines that are presented at the beginning of each of the six sections in the CPT 2021 Book. These guidelines define items that are necessary to appropriately interpret and report the procedures and services contained in that section.
Discharge Summary	A concise summary of the patient's course in the hospital, which includes: The reason for admission, principal diagnoses, additional diagnoses, significant findings, operations, and procedures performed, consultations, medications and other treatments, condition at discharge, discharge instructions, and medications with follow up required.
Diagnosis	The identification of the nature of an illness or problem by examination of the symptoms. See Admitting, Principal or Secondary for further details.

[7] Chronic vs. Acute Medical Conditions: What's the Difference? (ncoa.org)

Term	Definition
DRG	Refers to the International Refined Diagnosis Related Groups (IR-DRG), as developed by Solventum. The Definitions Manual may be obtained directly from Solventum.
Etiology (diagnosis)	The cause or origin of a disease.
Guidelines	Set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM and Current Procedural Terminology. The instructions and conventions of the classification take precedence over guidelines. These include the coding and sequencing instructions. Adherence to these guidelines when assigning diagnosis and procedure codes is required.
HCPCS	Healthcare Common Procedure Coding System. The CPT Codes are divided into two subsystems, which are referred to as level I and level II. Level I HCPCS coding includes the Current Procedural Terminology (CPT®) codes, which are a numerical coding system maintained by the American Medical Association. CPT codes numerically identify medical services and procedures. Level II HCPCS coding consists of a single letter followed by four numbers. Level II HCPCS procedure codes are assigned in the Emirate of Abu Dhabi for additional reporting codes.
History Of (diagnosis)	A diagnosis of a condition that is no longer active, however does impact the current visit of the patient in terms of length of stay, follow-up considerations and/or residual effects. Examples of important history conditions for coding are cancers, organ replacements, traumas with residual effects such as amputations.
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification. This is a clinical modification of the World Health Organization's ICD-10 coding system. The term "clinical" is used to emphasize the modification intent; namely to serve as a useful tool in the area of classification of morbidity data for indexing medical records.
Manifestation (diagnosis)	The visible expression of a disease with signs and symptoms; for example, shortness of breath for a patient with congestive heart failure.
Maternal Death	Is defined by the WHO as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management.
Miscarriage	Loss of the products of conception from the uterus before the foetus is viable, before 24 weeks gestation; spontaneous abortion. (After 24 weeks this is stillborn.)
Morbidity	A diseased condition or state; the incidence or prevalence of a disease or of all diseases in a population.
Mortality	In coding this means "death" as in the mortality rate or death rate.

Term	Definition
Neonate	For coding purposes this refers to the timeframe or period from birth through to the 28th day.
Neoplasm	Any new and abnormal growth; specifically, a new growth of tissue in which the growth is uncontrolled and progressive. An abnormal growth of tissue. The word neoplasm is not synonymous with cancer. A neoplasm may be benign or malignant or of uncertain behaviour. The word neoplasm literally means a new growth, from the Greek neo-, new + plasma, that which is formed, or a growth = a new growth.
Newborn	For coding purposes, a newborn is only coded with the live born infant codes (Z38) with 4th digit to signify whether born in or outside of the hospital. Generally, codes from General Perinatal Rules[8] should be sequenced as the principal/first-listed diagnosis on the newborn record, with the exception of the appropriate Z38 code for the birth encounter, followed by codes from any other chapter that provide additional detail.
Operative Report	A summarised report available after a procedure has been performed on the patient, that describes the events occurring during the operation/s of the patient.
Outpatient / Ambulatory	A patient who receives medical services in an outpatient clinic, ambulatory care, or emergency department without occupying an inpatient bed overnight.
Paediatric	Infants, children, and adolescents. The age range of such patients ranges from zero to less than 18 years, including an adolescent subgroup of 12 to less than 18 years.[9] A medical practitioner who specializes in this area is known as a paediatrician.
Perinatal Period	For coding and reporting purposes the perinatal period is defined as before birth through to the 28th day following birth.
Post-mortem Examination:	An examination of a body of a patient after death; not an autopsy.
Procedure, Principal:	Is defined as the procedure performed for definitive treatment, rather than one performed for diagnostic or exploratory purposes or was necessary to take care of a complication. If there are two or more therapeutic procedures, then it is the one most related to the principal diagnosis. If all procedures are diagnostic, then it is the one most related to the principal diagnosis. If there is more than one, then it is the most resource intensive. The hierarchy is as follows: 1. Therapeutic 2. Related to Principal Diagnosis 3. Most resource intensive

[8] 2021 ICD-10-CM Guidelines (cms.gov) / Section I.B.16.a
[9] Triage Protocol for Pediatrics Emergencies and their Referrals in Prehospital and Emergency Department (ED) Settings: EMS-Driven and Self Presenting Emergency Departments' Arrivals. (Protocol/Peads/1.0)

Term	Definition
	If there is more than one procedure to be reported in a hospital or ambulatory visit, then the procedures need to be sequenced as principal or secondary for reporting purposes.
Procedure, Secondary	All additional procedures following the principal procedure are to be reported as secondary procedures. A significant procedure is one that is surgical in nature or carries a procedural risk or carries an anaesthetic risk or requires specialized training.
Provider	The term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis.
Residual Condition	In coding this refers to the on-going effect of a previous illness or injury. For example, a patient who had a CVA (cerebrovascular accident) in the past and has a residual condition of aphasia.
Rule-Out Diagnosis	When a physician is performing tests on a patient to determine the final diagnosis, he may be working on a suspected diagnosis that he is attempting to "rule-out" or prove right or wrong. Sometimes the "rule-out" diagnosis is still the final diagnosis because the tests are not yet conclusive, and the true diagnosis has not been determined. In the Outpatient setting the physician may state R/O for the disease, however only the presenting signs and symptoms documented may be coded.
Sequela (late effect code)	A sequela is defined as residual effects (results produced) after termination of the acute phase of the illness or injury. Late effects are classified by the residues (nature of late effect) and by the cause of the late effect.
Stillbirth	The delivery of a dead infant, at least 24 weeks gestation. [10]
Symptom (diagnosis)	Any subjective evidence of a patient's disease or condition, such as a fever, is a symptom of a urinary tract infection.
Unbundling	To inappropriately bill more CPT/HCPCS codes than necessary; applied when certain codes represent procedures that are basic steps to accomplish a primary procedure already on the bill and, by definition, are included in the reimbursement of the primary procedure.
Unlisted Procedure/ Service	These are services or procedures performed by physicians or other qualified health care professionals that are not listed in the CPT codebook.
Unspecified (diagnosis)	In coding, this occurs when a physician fails to be as specific in his diagnosis as the coding system is, for example listing hypertension as a diagnosis and not specifying whether it is benign or malignant
Underlying Cause of Death	When the immediate cause of death is a symptom or a manifestation of a diagnosis, the underlying cause of death is the diagnosis responsible for the symptom or manifestation that led to the death. For example,

[10] Muashir - JAWDA Indicators Submission Guidelines | Department of Health Abu Dhabi (doh.gov.ae)

Term	Definition
	cardiopulmonary arrest due to myocardial infarction or respiratory failure due to acute pneumonia. The World Health Organization (WHO) defines the underlying cause of death as the disease or injury that initiated the train of events (circumstances) leading directly to the death.
Versus Diagnosis	In coding this refers to a situation where the physician has not yet determined which diagnosis is responsible for the condition of the patient and has two or more choices that are equally valid.
Visit Reason (diagnosis)	Generally, visit reasons are used for ambulatory visits. They can be symptoms or diagnoses or other reasons for contact with healthcare professionals, for example a follow up for healed fracture of the foot.
X, W or Y-Code	Specific ICD-10-CM codes used to identify the external cause of injury, poisoning and other adverse effects, never coded as a principal or stand-alone
Z Code	Specific ICD-10-CM codes used in classifying supplementary factors that influence the patient's health status and/or contact with health services. An example is the outcome of delivery codes in the Z38 category or personal history of cancer in the Z85 category.

General Conventions[11]

Other and Unspecified codes

a. "Other" codes

Codes titled "other" or "other specified" are for use when the information in the medical record provides detail for which a specific code does not exist. Alphabetic Index entries with NEC in the line designate "other" codes in the Tabular List. These Alphabetic Index entries represent specific disease entities for which no specific code exists, so the term is included within another code.

b. "Unspecified" codes

Codes titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the "other specified" code may represent both other and unspecified.[12]

Includes Notes

This note appears immediately under a three-character code title to further define, or give examples of, the content of the category.

[11] 2021 ICD-10-CM Guidelines (cms.gov) / See Section I.A.
[12] [12] 2021 ICD-10-CM Guidelines (cms.gov) /Section I.B.18 Use of Signs/Symptom/Unspecified Codes

Inclusion terms

List of terms is included under some codes. These terms are the conditions for which that code is to be used. The terms may be synonyms of the code title, or, in the case of “other specified” codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the Alphabetic Index may also be assigned to a code.

Excludes Notes

ICD-10-CM has two types of excludes notes. Each type of note has a different definition for use, but they are all similar in that they indicate that codes excluded from each other are independent of each other.

Excludes 1

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.

An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other. If it is not clear whether the two conditions involving an Excludes1 note are related or not, query the provider.

For example, code F45.8, Other somatoform disorders, has an Excludes1 note for "sleep related teeth grinding (G47.63)," because "teeth grinding" is an inclusion term under F45.8. Only one of these two codes should be assigned for teeth grinding. However psychogenic dysmenorrhea is also an inclusion term under F45.8, and a patient could have both this condition and sleep related teeth grinding. In this case, the two conditions are clearly unrelated to each other, and so it would be appropriate to report F45.8 and G47.63 together.

Excludes 2

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.

Etiology/manifestation convention (“code first,” “use additional code” and “in diseases classified elsewhere” notes)

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, if applicable, 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.

- In most cases the manifestation codes will have in the code title, “in diseases classified elsewhere.” Codes with this title are a component of the etiology/ manifestation convention. The code title indicates that it is a manifestation code. “In diseases classified elsewhere” codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code, and they must be listed following the underlying condition. See category F02, Dementia in other diseases classified elsewhere, for an example of this convention.
- There are manifestation codes that do not have “in diseases classified elsewhere” in the title. For such codes, there is a “use additional code” note at the etiology code and a “code first” note at the manifestation code, and the rules for sequencing apply.
- In addition to the notes in the Tabular List, these conditions also have a specific Alphabetic Index entry structure. In the Alphabetic Index both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second.
- An example of the etiology/manifestation convention is dementia in Parkinson’s disease. In the Alphabetic Index, code G20 is listed first, followed by code F02.80 or F02.81 in brackets. Code G20 represents the underlying etiology, Parkinson’s disease, and must be sequenced first, whereas code F02.80 and F02.81 represent the manifestation of dementia in diseases classified elsewhere, with or without behavioral disturbance. “Code first” and “Use additional code” notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/ manifestation combination.[13]

General Guidelines

Level of Detail in Coding

Diagnosis codes are to be used and reported at their highest number of characters available.

ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6, or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth characters, which provide greater detail.

A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.

Signs and 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.

[13] 2021 ICD-10-CM Guidelines (cms.gov) /Section I.B.7 Multiple coding for a single condition.

Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (Codes R00.0 - R99) contains many, but not all, codes for symptoms.[14]

Conditions that are an integral part of a disease process

Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

Multiple coding for a single condition

In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code. “Use additional code” notes are found in the Tabular List at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. The sequencing rule is the same as the etiology/manifestation pair, “use additional code” indicates that a secondary code should be added**,** if known.

For example, for bacterial infections that are not included in chapter 1, a secondary code from category B95, Streptococcus, Staphylococcus, and Enterococcus, as the cause of diseases classified elsewhere, or B96, Other bacterial agents as the cause of diseases classified elsewhere, may be required to identify the bacterial organism causing the infection. A “use additional code” note will normally be found at the infectious disease code, indicating a need for the organism code to be added as a secondary code.

“Code first” notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a “code first” note and an underlying condition is present, the underlying condition should be sequenced first, if known.

“Code, if applicable, any causal condition first” notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.

Multiple codes may be needed for sequela, complication codes and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

Acute and Chronic Conditions

If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

[14] 2021 ICD-10-CM Guidelines (cms.gov) /Section I.B.18 Use of Signs/Symptom/Unspecified Codes

Combination Code

A combination code is a single code used to classify:

- Two diagnoses, or
- A diagnosis with an associated secondary process (manifestation)
- A diagnosis with an associated complication

Combination codes are identified by referring to sub term entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.

Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs. Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.

Sequela (Late Effects)

A sequela 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 sequela 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.

Examples of sequela include scar formation resulting from a burn, deviated septum due to a nasal fracture, and infertility due to tubal occlusion from old tuberculosis. Coding of sequela generally requires two codes sequenced in the following order: the condition or nature of the sequela is sequenced first. The sequela code is sequenced second.

An exception to the above guidelines is those instances where the code for the sequela is followed by a manifestation code identified in the Tabular List and title, or the sequela code has been expanded (at the fourth, fifth- or sixth-character levels) to include the manifestation(s). The code for the acute phase of an illness or injury that led to the sequela is never used with a code for the late effect.

Impending or Threatened Condition

Code any condition described at the time of discharge as “impending” or “threatened” as follows:

- If it did occur, code as confirmed diagnosis.
- If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for “impending” or “threatened” and also reference main term entries for “Impending” and for “Threatened.”
- If the sub terms are listed, assign the given code.
- If the sub terms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

Documentation *by Clinicians Other than the Patient's Provider*

Code assignment is based on the documentation by patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis). There are a few exceptions, such as codes for the Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.

For social determinants of health, such as information found in categories Z55- Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses. Patient self-reported documentation may also be used to assign codes for social determinants of health, as long as the patient self-reported information is signed-off by and incorporated into the health record by either a clinician or provider.

The BMI, coma scale, NIHSS codes and categories Z55-Z65 should only be reported as secondary diagnoses.

Documentation of Complications of Care

Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure, unless otherwise instructed by the classification. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications.

There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication. Query the provider for clarification, if the complication is not clearly documented.

Diagnosis Guidelines

Codes for symptoms, signs, and ill-defined conditions

Codes for symptoms, signs, and ill-defined conditions from Chapter 18 are not to be used as principal diagnosis when a related definitive diagnosis has been established.

Two or more interrelated Conditions, each potentially meeting the definition for principal Diagnosis

When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

Two or more diagnoses that equally meet the definition for principal diagnosis

In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic work up and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guideline does not provide sequencing direction, any one of the diagnoses may be sequenced first.

Two or more comparative or contrasting conditions

In those rare instances when two or more contrasting or comparative diagnoses are documented as "either/or" (or similar terminology), they are coded as if the diagnoses were confirmed, and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, then either diagnosis may be sequenced first[15].

Original Treatment plan not carried out

If the original treatment plan is not carried out, sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.

Complication of surgery and other medical care

When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the T80-T88 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned.

Uncertain Diagnosis

If the diagnosis documented at time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," "compatible with," "consistent with," or other similar terms indicating uncertainty, code the condition as if it existed or was established. The basis for these guidelines is the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals

[15] ICD-10-CM Official Guidelines for Coding and Reporting FY 2021Page 114 of 126

Admission From Outpatient Surgery

When a patient receives surgery in the hospital's outpatient surgery department and is subsequently admitted for continuing inpatient care at the same hospital, the following guidelines should be followed in selecting the principal diagnosis for the inpatient admission:

- If the reason for the inpatient admission is a complication, assign the complication as the principal diagnosis.
- If no complication, or other condition, is documented as the reason for the inpatient admission, assign the reason for the outpatient surgery as the principal diagnosis.
- If the reason for the inpatient admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis.

Admitting Diagnosis

The admitting diagnosis that the physician identifies at the time of admission into an inpatient facility. This diagnosis may differ from the principal diagnosis. This will generally be documented by the physician in the history and physical exam, either on the form or in the progress notes or the orders. It may also be listed as an impression in the patient assessment.

If there are multiple admitting diagnoses, then pick the most resource intensive diagnosis for reporting purposes.

If the patient is admitted through the Emergency Room, then use the diagnosis that brought the patient to the Emergency Room as the admitting diagnosis.

Principal Diagnosis

The circumstances of inpatient admission always govern the selection of the principal diagnosis. The principal diagnosis is defined earlier as the “condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

Principal Diagnosis: Inpatient

Condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the healthcare facility including a suspected diagnosis or a rule-out diagnosis and is based on the patient’s presenting history and physical and the physician’s review of symptoms.

Principal Diagnosis: Outpatient

The condition or problem that is the reason the patient presented to healthcare and the clinician’s assessment of these presenting symptoms/problems and corresponds to the tests or services provided.

- Or a symptom where the underlying causes have yet to be determined.
- Or The reason why the patient presented to healthcare.

Principal Diagnosis in Long Term Care

Condition established, after study, to be chiefly responsible for occasioning the admission to and/or continuation of the long-term care encounter.

Secondary Diagnosis

Secondary Diagnosis: Inpatient

All conditions that co-exist at the time of admission, including chronic conditions, or develop subsequently, which affect the treatment received and/or the length of stay - that affect patient care in terms of requiring:

- Clinical evaluation; or
- Therapeutic treatment; or
- Diagnostic procedures; or
- Extended length of hospital stay; increased nursing care and/or monitoring
- Excluding diagnoses that refer to an earlier episode that have no bearing on the current hospital stay.

External causes of injury, poisoning or adverse effects are coded as supplementary codes to the diagnosis codes of the actual condition.

Secondary Diagnosis: Outpatient

- All co-existing conditions, including chronic conditions that exist at the time of the Encounter or visit and require or affect patient management; excluding diagnoses that have no bearing on the current encounter.
- External causes of injury, poisoning or adverse effects are coded as supplementary codes to the diagnosis codes of the actual condition.

Secondary Diagnosis: Long Term Care

For reporting purposes, the definition for secondary diagnosis is interpreted as additional conditions that affect patient care in terms of requiring:

- Clinical evaluation; or
- Therapeutic treatment; or
- Diagnostic procedures; or
- Extended length of hospital stay; or increased nursing care and/or monitoring

Previous Conditions

If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admissions that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.[16].

Abnormal Findings

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

[17]**Note:** This differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider.

Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” or “still to be ruled out,” “compatible with,” “consistent with,” or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

[18] Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

If the diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” or “still to be ruled out,” “compatible with,” “consistent with,” or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

[19] Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

[16] 2021 ICD-10-CM Guidelines (cms.gov) / See Section C.III. B. page 116
[17] 2021 ICD-10-CM Guidelines (cms.gov) / See Section C.III. B. page 116
[18] 2021 ICD-10-CM Guidelines (cms.gov) / See Section C.III. B. page 117
[19] 2021 ICD-10-CM Guidelines (cms.gov) / See Section C.III. B. page 117

Outpatient and Ambulatory Patient Coding

The terms encounter and visit are often used interchangeably in describing outpatient or ambulatory patient service contacts. These can range from Emergency Room visits to Specialty Clinic visits to Ancillary Services encounters.

Diagnoses are not often established at the time of the initial encounter/visit. It might take two or more visits before the diagnosis is confirmed.

Outpatient Surgery

When a patient presents for outpatient surgery, code the reason for the surgery as the principal diagnosis (reason for encounter) even if the procedure is not performed for any reason. You can use an additional code to describe why the procedure was not performed, if appropriate.

Observation

When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the principal diagnosis.

Complication

When a patient presents for outpatient surgery and develops a complication requiring **admission for observation**, code the reason for the surgery as the principal diagnosis, followed by codes for the complication as secondary diagnoses.

Symptoms and Signs

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established or confirmed by the caregiver.

Other Encounter

There are also codes to deal with encounters for circumstances other than injury or illness.

Sequencing

A similar definition of principal diagnosis is used for ambulatory visits; that is the condition, problem or other reason for the encounter/visit shown in the medical record documentation to be chiefly responsible for the services provided. List additional codes that describe any co-existing conditions.

Uncertain Diagnoses

Do **not** code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty in Outpatient Setting. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Note: **This differs from the coding rule for Inpatient admissions.**

Chronic Diseases

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

Coexisting Conditions

Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Diagnostic Services Only

For patients receiving **diagnostic services only** during an encounter/visit, sequence first the diagnosis, condition, problem or other reason for the encounter/visit, as shown in the medical record to be chiefly responsible for the outpatient diagnostic services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

- For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms or associated diagnoses, assign Z01.89and/or a code from a subcategory. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom or diagnosis, it is appropriate to assign both the Z code and the code describing the reason for the non-routine test.
- For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

  Note: This differs from the coding practice in the hospital inpatient setting regarding abnormal findings on test results.

Therapeutic Services Only

For patients receiving **therapeutic services only** during an encounter/visit, sequence first the diagnosis, condition, problem or other reason for the encounter/visit, as shown in the medical record to be chiefly responsible for the outpatient therapeutic services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy, radiation therapy or rehabilitation, then the appropriate Z-code for the service is listed first and the diagnosis or problem for which the service is being performed is listed second.

Preoperative Evaluations Only

For patients receiving preoperative evaluations only, sequence **first** a code from category Z01.81, Other Specified Examinations, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.

Ambulatory Surgery

Code the diagnosis for which the surgery was performed as the principal diagnosis. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

Routine Prenatal Visits

For routine outpatient prenatal visits when no complications are present, codes Z34, Encounter for supervision of normal pregnancy, should be used as the principal diagnosis. These codes should not be used in conjunction with Category III Codes (0019T - 0232T) codes.

Admission/Encounters for Rehabilitation

When the purpose for the admission/encounter is rehabilitation, sequence first the code for the condition for which the service is being performed.

For example, for an admission/encounter for rehabilitation for right-sided dominant hemiplegia following a cerebrovascular infarction, report code I69.351,Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, as the first-listed or principal diagnosis.

If the condition for which the rehabilitation service is being provided is no longer present, report the appropriate aftercare code as the first-listed or principal diagnosis, unless the rehabilitation service is being provided following an injury.

For rehabilitation services following active treatment of an injury, assign the injury code with the appropriate seventh character for subsequent encounter as the first-listed or principal diagnosis. For example, if a patient with severe degenerative osteoarthritis of the hip, underwent hip replacement and the current encounter/admission is for rehabilitation, report. code Z47.1, Aftercare following joint replacement surgery, as the first-listed or principal diagnosis.

If the patient requires rehabilitation post hip replacement for right intertrochanteric femur fracture, report code S72.141D, Displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, as the first-listed or principal diagnosis.

- See Section I.C.21.c.7, Factors influencing health states and contact with health services, Aftercare.
- See Section I.C.19.a, for additional information about the use of 7th characters for injury codes.

COVID Coding Conventions

Due to the pandemic nature of the Coronavirus Disease (COVID-19) the current coding guidelines are listed below to assist healthcare providers with allocating ICD-10-CM and CPT® codes.

ICD-10-CM COVID Conventions

Code only confirmed cases (U07.1)

Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider or documentation of a positive COVID- 19 test result. For a confirmed diagnosis, assign code U07.1, COVID-19. This is an exception to the hospital inpatient guideline Section II, H. In this context, “confirmation” does not require documentation of a positive test result for COVID-19; the provider’s documentation that the individual has COVID-19 is sufficient.

If the provider documents "suspected," "possible," "probable," or “inconclusive” COVID-19, do not assign code U07.1. Instead, code the signs and symptoms reported. See guideline I.C.1.g.1.g.[20]

Sequencing of codes

When COVID-19 meets the definition of principal diagnosis, code U07.1, COVID-19, should be sequenced first, followed by the appropriate codes for associated manifestations, except when another guideline requires that certain codes be sequenced first, such as obstetrics, sepsis, or transplant complications.

COVID-19 infection in pregnancy, childbirth, and the puerperium

During pregnancy, childbirth, or the puerperium, when COVID-19 is the reason for admission/encounter, code O98.5-, Other viral diseases complicating pregnancy, childbirth, and the puerperium, should be sequenced as the principal/first-listed diagnosis, and code U07.1, COVID-19, and the appropriate codes for associated manifestation(s) should be assigned as additional diagnoses. Codes from General Rules for Obstetric Cases[21] always take sequencing priority.

If the reason for admission/encounter is unrelated to COVID-19 but the patient tests positive for COVID-19 during the admission/encounter, the appropriate code for the reason for admission/encounter should be sequenced as the principal/first listed diagnosis, and codes O98.5- and U07.1, as well as the appropriate codes for associated COVID-19 manifestations, should be assigned as additional diagnoses.

COVID-19 Infection in Newborn

For a newborn that tests positive for COVID-19, assign code U07.1, COVID-19, and the appropriate codes for associated manifestation(s) in neonates/newborns in the absence of documentation indicating a specific type of transmission. For a newborn that tests positive for COVID-19 and the provider documents the condition was contracted in utero or during the birth process, assign codes P35.8, Other congenital viral diseases, and U07.1, COVID-19.

[20] 2021 ICD-10-CM Guidelines (cms.gov) /Guideline I.C.1.g.1.g.
[21] 2021 ICD-10-CM Guidelines (cms.gov) / Section I.B.15.a

When coding the birth episode in a newborn record, the appropriate code from category Z38, Liveborn infants according to place of birth and type of delivery, should be assigned as the principal diagnosis.

Refer to the guidelines for Sepsis, severe sepsis and septic shock and transplants other than kidney for sequencing guidelines for cases involving COVID-19.

Acute respiratory manifestations of COVID-19

When the reason for the encounter/admission is a respiratory manifestation of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the respiratory manifestation(s) as additional diagnoses, such as the following:

Pneumonia

For a patient with pneumonia confirmed as due to COVID-19, assign codes U07.1, COVID-19, and J12.82, Pneumonia due to coronavirus disease 2019.

Acute bronchitis

For a patient with acute bronchitis confirmed as due to COVID-19, assign codes U07.1, and J20.8, Acute bronchitis due to other specified organisms. Bronchitis not otherwise specified (NOS) due to COVID-19 should be coded using U07.1 and J40, Bronchitis, not specified as acute or chronic.

Lower respiratory infection

If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, codes U07.1 and J22, Unspecified acute lower respiratory infection, should be assigned. If the COVID-19 is documented as being associated with a respiratory infection, NOS, codes U07.1 and J98.8, Other specified respiratory disorders, should be assigned.

Acute respiratory distress syndrome

For acute respiratory distress syndrome (ARDS) due to COVID-19, assign codes U07.1, and J80, Acute respiratory distress syndrome.

Acute respiratory failure

For acute respiratory failure due to COVID-19, assign code U07.1, and code J96.0-, Acute respiratory failure.

Non-respiratory manifestations of COVID-19

When the reason for the encounter/admission is a non-respiratory manifestation (e.g., viral enteritis) of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the manifestation(s) as additional diagnoses.

Screening for COVID-19

During the COVID-19 pandemic, a screening code is generally not appropriate. Do not assign code Z11.52, Encounter for screening for COVID-19. For encounters for COVID-19 testing, including preoperative testing, code as exposure to COVID-19 (guideline I.C.1.g.1.e).

Exposure to COVID-19

For asymptomatic individuals with actual or suspected exposure to COVID-19, assign code Z20.822, Contact with and (suspected) exposure to COVID-19. For symptomatic individuals with actual or suspected exposure to COVID 19 and the infection has been ruled out, or test results are inconclusive or unknown, assign code Z20.822, Contact with and (suspected) exposure to COVID-19. See guideline I.C.21.c.1, Contact/Exposure, for additional guidance regarding the use of category Z20 codes.

Signs and symptoms without definitive diagnosis of COVID-19

For patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as R05 Cough, R06.02 Shortness of breath, R50.9 Fever, unspecified.

If a patient with signs/symptoms associated with COVID-19 also has an actual or suspected contact with or exposure to COVID-19, assign Z20.822, Contact with and (suspected) exposure to COVID19, as an additional code.

Asymptomatic individuals who test positive for COVID-19

For asymptomatic individuals who test positive for COVID-19, guideline I.C.1.g.1.a. Although the individual is asymptomatic, the individual has tested positive and is considered to have COVID-19 infection.

Personal history of COVID-19

For patients with a history of COVID-19, assign code Z86.16, Personal history of COVID-19.

Follow-up visits after COVID-19 infection has resolved

For individuals who previously had COVID-19 and are being seen for follow-up evaluation, and COVID-19 test results are negative, assign codes Z09, Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm, and Z86.16, Personal history of COVID-19.

Encounter for antibody testing.

For follow-up testing after a COVID-19 infection, see guideline I.C.1.g.1.j.[22]

Multisystem Inflammatory Syndrome

For individuals with multisystem inflammatory syndrome (MIS) and COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code M35.81, Multisystem inflammatory syndrome, as an additional diagnosis. If MIS develops as a result of a previous COVID-19 infection, assign codes M35.81, Multisystem inflammatory syndrome, and B94.8, Sequelae of other specified infectious and parasitic diseases.

[22] 2021 ICD-10-CM Guidelines (cms.gov) /Guideline I.C.1.g.1.j.

If an individual with a history of COVID-19 develops MIS and the provider does not indicate the MIS is due to the previous COVID-19 infection, assign codes M35.81, Multisystem inflammatory syndrome, and Z86.16, Personal history of COVID-19. If an individual with a known or suspected exposure to COVID-19, and no current COVID-19 infection or history of COVID-19, develops MIS, assign codes M35.81, Multisystem inflammatory syndrome, and Z20.822, Contact with and (suspected) exposure to COVID-19.

Additional codes should be assigned for any associated complications of MIS.

CPT® COVID-19 Conventions

Due to the pandemic nature of the Coronavirus Disease (COVID-19) the current coding guidelines are listed below to assist healthcare providers with the understanding of the newly added CPT® codes currently available for use in Abu Dhabi

COVID-19 CPT® Codes

**All CPT codes are included in the DRG grouping allocation

- 87804: Infectious agent antigen detection by immunoassay with direct optical observation; Influenza. **
- 87798: Infectious agent detection by nucleic acid, not otherwise specified; amplified probe technique, each organism**
- 87635[23]: Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique[24] **

[23] https://www.ama-assn.org/system/files/2020-05/cpt-reporting-covid-19-testing.pdf
[24] https://www.ama-assn.org/system/files/2020-03/cpt-assistant-guide-coronavirus.pdf

Coding Diagnostic Guidelines

Diagnosis Official Coding Guidelines for FY 2021

The ICD-10-CM Official Guidelines for Coding and Reporting for FY 2021 guidelines may be downloaded from the following site:

https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf

The direct links to the guideline files may be found as follows:

https://www.cdc.gov/nchs/icd/icd-10-cm/files.html#cdc_generic_section_5-fy21-icd-10-cm-releases

https://www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf

https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf

Diagnosis Principals

See Introduction User Guide for additional information.

Diagnosis Principal	
DP0101	
DP	Diagnosis Principal for the Diseases, Health Related Problems and contact with Health Services within the Diagnosis chapters.
01	The number one will indicate the ICD-10 CM Chapter
01	A unique number allocated to the principal (Principal Number)

Screening Examination Principal

Persons encountering health services for examination and investigation (Z00–Z13)
DP2101: Screening Examination
The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test.
• A screening code may be a first-listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done during an office visit for other health problems. • A screening code is not necessary if the screening is inherent to a routine examination, such as a pap smear done during a routine pelvic examination.

Example 1: Patient admitted for a colonoscopy as per colon cancer screening with family history of gastro-intestinal cancer. • PDX: Z12.10 Encounter for screening for malignant neoplasm of intestinal tract, unspecified • SDX: Z80.0 Family history of malignant neoplasm of digestive organs
Example 2: Patient admitted for a comprehensive screening package screening. • PDX: Z12.10 Encounter for screening for malignant neoplasm of intestinal tract, unspecified • PDX: Z13.9 Encounter for screening, unspecified
Reference: • 2021 ICD-10-CM Guidelines (cms.gov) /Guideline I.C.21.5.

Administration Examination Principal

Persons encountering health services for examination and investigation (Z00–Z13)
DPN2102: Administration Examination
The Z codes allow for the description of encounters for routine examinations, such as, a general check-up, or examinations for administrative purposes, such as, a pre-employment physical. The codes are not to be used if the examination is for diagnosis of a suspected condition or for treatment purposes. In such cases the diagnosis code is used.
During a routine exam, should a diagnosis or condition be discovered, it should be coded as an additional code. Pre-existing and chronic conditions and history codes may also be included as additional codes as long as the examination is for administrative purposes and not focused on any particular condition. ICD-10-CM Official Guidelines for Coding and Reporting FY 2021 Page 109 of 126. Some of the codes for routine health examinations distinguish between “with” and “without” abnormal findings. Code assignment depends on the information that is known at the time the encounter is being coded.
Example 1: Patient admitted for an examination for military service with personal history of Leukemia. • PDX: Z02.3 Encounter for examination for recruitment to armed forces. • SDX: Z88.6 Personal history of leukemia
Example 2: Patient admitted for an examination for premarital examination. • PDX: Z02.89 Encounter for other administrative examinations
Reference: • 2021 ICD-10-CM Guidelines (cms.gov) /Guideline I.C.21.13.

Present on Admission Guidelines

These guidelines are to be used as a supplement to the ICD-10-CM Official Guidelines for Coding and Reporting to facilitate the assignment of the Present on Admission (POA) indicator for each diagnosis and external cause of injury code reported on claims.

These guidelines are not intended to replace any guidelines in the main body of the ICD-10-CM Official Guidelines for Coding and Reporting. The POA guidelines are not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes that have been assigned in accordance with Sections I, II, and III of the official ICD-10-CM coding guidelines. After the assignment of the ICD-10-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

As stated in the Introduction to the ICD-10-CM Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. In the context of the official coding guidelines, the term “provider” means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient’s diagnosis.

These guidelines are not a substitute for the provider’s clinical judgment as to the determination of whether a condition was/was not present on admission. The provider should be queried regarding issues related to the linking of signs/symptoms, timing of test results, and the timing of findings.

For general reporting requirement related to the present on admission guidelines refer to Appendix I[25] within the 2021 ICD 10-CM Guidelines.

[25] 2021 ICD-10-CM Guidelines (cms.gov) /Appendix I

Procedure Coding Guidelines

Introduction

Current Procedural Terminology, (CPT®) Fourth Edition, is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals, or entities. Each procedure or service is identified with a five-digit code. This is the code set required for all procedure coding within the Emirate of Abu Dhabi. Only CPT five- digit or T Codes will be used for any procedure coding and all CPT Guidelines will take precedence too all other procedural Guidelines or Rules.

Inclusion of a descriptor and its associated five-digit code number in the CPT Category I code set is based on whether the procedure or service is consistent with contemporary medical practice and is performed by many practitioners in clinical practice in multiple locations. Inclusion in the CPT code set of a procedure, service, or proprietary name, does not represent endorsement by the American Medical Association (AMA) of any particular diagnostic or therapeutic procedure, or service or proprietary test or manufacturer. Inclusion or exclusion of a procedure or service, or proprietary name, does not imply any health insurance coverage or reimbursement policy.

The CPT code set is published annually in the late summer or early fall as both electronic data files and books in the United States of America. The release of CPT data files on the internet typically precedes the book by several weeks. In any case, January 1 is the effective date for use of the update of the CPT code set in the United States of America.

The main body of the Category I section is listed in six sections. Each section is divided into subsections with anatomic, procedural, condition, or descriptor subheadings. The procedures and services with their identifying codes are presented in numeric order with one exception-the entire Evaluation and Management section (99202-99499) appears at the beginning of the listed procedures. These items are used by most physicians in reporting a significant portion of their services.

It is important to recognize that the listing of a service or procedure and its code number in a specific section of this book does not restrict its use to a specific specialty group. Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician or other qualified health care professional as long as it meets the following criteria:

- The code does not specify the specialty e.g. a geneticist.
- The code is within the Scope of Work of the healthcare professional, as outlined in the scope of work for Health Care Professionals[26] within the Emirate of Abu Dhabi.
- The documentation fully supports the selection of the most appropriate code.
- Check with individual payers for reimbursement policies regarding these codes.

[26] Scope of Practice | Department of Health Abu Dhabi (doh.gov.ae)

Select the name of the procedure or service that accurately identifies the service performed. **Do not** select a CPT code that **merely approximates** the service provided. If no such procedure or service exists, then report the service using the appropriate unlisted procedure or service code. (See Unlisted Procedure or Service Codes.)

When reporting codes for services provided, it is important to ensure the accuracy and quality of coding through verification of the intent of the code by use of the related guidelines, parenthetical instructions, and coding resources, including *CPT Assistant* and other publications resulting from collaborative efforts of the American Medical Association with the medical specialty societies (e.g., *Clinical Examples in Radiology*).

It is equally important to recognize that as techniques in medicine and surgery have evolved, new types of services, including minimally invasive surgery, as well as endovascular, percutaneous, and endoscopic interventions have challenged the traditional distinction of Surgery vs Medicine. Thus, the listing of a service or procedure in a specific section of this book should not be interpreted as strictly classifying the service or procedure as “surgery” or “not surgery” for insurance or other purposes. The placement of a given service in a specific section of the book may reflect historical or other considerations (e.g., placement of the percutaneous peripheral vascular endovascular interventions in the Surgery/Cardiovascular System section, while the percutaneous coronary interventions appear in the Medicine/Cardiovascular section).

Instructions, typically included as parenthetical notes with selected codes, indicate that a code should not be reported with another code or codes. These instructions are intended to prevent errors of significant probability and are not all inclusive. For example, the code with such instructions may be a component of another code and therefore it would be incorrect to report both codes even when the component service is performed. These instructions are not intended as a listing of all possible code combinations that should not be reported, nor do they indicate all possible code combinations that are appropriately reported. When reporting codes for services provided, it is important to assure the accuracy and quality of coding through verification of the intent of the code by use of the related guidelines, parenthetical instructions, and coding resources, including *CPT Assistant* and other publications resulting from collaborative efforts of the American Medical Association with the medical specialty societies.

Procedure Coding Terms and Guidelines

Add-on Codes

Some of the listed procedures are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as add-on codes with the" ✚ symbol and they are listed in Appendix D of the 2021 CPT codebook. The add-on code concept in CPT 2018 applies only to the Add-on procedures or services performed by the same physician. Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. All Add-on codes in the CPT code set are exempt from the multiple procedure concept (see the modifier 51 definition in Appendix A of the 2021 CPT codebook).

Chief Complaint

A concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient's words.

Closed Treatment

Specifically means that the fracture site is not surgically opened (exposed to the external environment and directly visualized). This terminology is used to describe procedures that treat fractures by three methods: (1) without manipulation; (2) with manipulation; or (3) with or without traction.

Concurrent Care

Concurrent care is the provision of similar services, e.g., hospital visits, to the same patient by more than one physician on the same day.

Consultation

A consultation is a type of evaluation and management service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem. A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

A "consultation" initiated by a patient and/or family, and not requested by a physician or other appropriate source (e.g., physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech-language pathologist, psychologist, social worker, lawyer, or insurance company), is not reported using the consultation codes but may be reported using the office visit, home service, or domiciliary/rest home care codes as appropriate.

The written or verbal request for consultation may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.

If subsequent to the completion of a consultation the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the appropriate **Evaluation and Management** services code for the site of service should be reported. In the hospital or nursing facility setting, the consulting physician should use the appropriate inpatient consultation code for the initial encounter and then subsequent hospital, or nursing facility care codes. In the office setting, the physician should use the appropriate office or other services codes.

Counseling

Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies

- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education

Destruction

The ablation of benign, premalignant or malignant tissues by any method, with or without curettement, including local anesthesia, and not usually requiring closure. Any method includes electrosurgery, cryosurgery, laser, and chemical treatment. Lesions include condylomata, papillomata, molluscum contagiosum, herpetic lesions, warts (i.e., common, plantar, flat), milia, or other benign, pre-malignant (e.g., actinic keratoses), or malignant lesions. Surgical destruction is a part of a surgical procedure, and different methods of destruction are not ordinarily listed separately unless the technique substantially alters the standard management of a problem or condition. Exceptions under special circumstances are provided for by separate code numbers.

Excision

Excision is defined as full-thickness (through the dermis) removal of a lesion, including margins, and includes simple (non-layered) closure when performed.

External Fixation

External fixation is the usage of skeletal pins plus an attaching mechanism/device used for temporary or definitive treatment of acute or chronic bony deformity.

Family History

A review of medical events in the patient's family that includes significant information about:

- The health status or cause of death of parents, siblings, and children.
- Specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review.
- Diseases of family members that may be hereditary or place the patient at risk.

HCPCS - Healthcare Common Procedure Coding System

This system is broken down into two primary subsystems, which are referred to as level I and level II. Level I HCPCS system maintained by the American Medical Association. CPT codes numerically identify medical services and procedures. Level II HCPCS coding consists of a single letter followed by four numbers. Level II HCPCS procedure codes are assigned in the Emirate of Abu Dhabi for additional reporting.

Health Care Facility Group

Is a group of DoH Licensed Healthcare Facilities that are under the same ownership(s) of under the same direct management and oversight of a headquarters.

Imaging Guidance

When imaging guidance or imaging supervision and interpretation is included in a surgical procedure, guidelines for image documentation and report, included in the guidelines for Radiology Guidelines (Including Nuclear Medicine and Diagnostic Ultrasound) (70010 - 79999), will apply. Imaging guidance should not be reported for use of a non-imaging-guided tracking or localizing system (e.g., radar signals, electromagnetic signals). Imaging guidance should only be reported when an imaging modality (e.g., radiography, fluoroscopy, ultrasonography, magnetic resonance imaging, computed tomography, or nuclear medicine) is used and is appropriately documented.

History of Present Illness

A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s).

Manipulation

Used throughout the musculoskeletal fracture and dislocation subsections to specifically mean the attempted reduction or restoration of a fracture or joint dislocation to its normal anatomic alignment by the application of manually applied forces.

Modifiers – Category I and Category II

A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Select Modifier codes are utilized within the Emirate of Abu Dhabi in conjunction for reporting guidelines found in the DOH Claims and Adjudication Rules[27]

New and Established Patients (Evaluation & Management Coding)

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to faces services rendered by physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s).

[27] DOH Claims and Adjudication Rules 2024

- A new patient is one who has not received any professional services from the physician or another physician/ qualified health care professional of the same specialty and subspecialty who belongs to the same Health care facility group practice, within the past three years.
- An established patient is one who has received professional services from the physician/ qualified health care professional or another physician of the same specialty who belongs to the same Health care facility group practice, within the past three years.
- In the instance where a physician/qualified health care professional is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician / health care professional who is not available. No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

Open Treatment

Used when the fractured bone is either: (1) surgically opened (exposed to the external environment) and the fracture (bone ends) visualized and internal fixation may be used; or (2) the fractured bone is opened remote from the fracture site in order to insert an intramedullary nail across the fracture site (the fracture site is not opened and visualized).

Percutaneous Skeletal Fixation

Describes fracture treatment which is neither open nor closed. In this procedure, the fracture fragments are not visualized, but fixation (e.g., pins) is placed across the fracture site, usually under X-ray imaging. provider and reported by a specific CPT code(s).

Principal Procedure

Is defined as the procedure performed for definitive treatment, rather than one performed for diagnostic or exploratory purposes or was necessary to take care of a complication. If there are two or more therapeutic procedures, then it is the one most related to the principal diagnosis. If all procedures are diagnostic, then it is the one most related to the principal diagnosis. If there is more than one, then it is the most resource intensive. The hierarchy is as follows:

- Therapeutic
- Related to Principal Diagnosis
- Most resource intensive

If there is more than one procedure to be reported in a hospital or ambulatory visit, then the procedures need to be sequenced as principal or secondary for reporting purposes.

Repair Closure

The repair of wounds may be classified as Simple, Intermediate, or Complex.

Simple repair

Used when the wound is superficial, e.g., involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires simple one layer closure. This includes local anesthesia and chemical or electrocauterization of wounds not closed.

Intermediate repair

Includes the repair of wounds that, in addition to the above, require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.

Complex repair

Includes the repair of wounds requiring more than layered closure, viz., scar revision, debridement, (e.g., traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. Necessary preparation includes creation of a defect for repairs (e.g., excision of a scar requiring a complex repair) or the debridement of complicated lacerations or avulsions. Complex repair does not include excision of benign (11400-11446) or malignant (11600-11646) lesions, excisional preparation of a wound bed (15002-15005), or debridement of an open fracture or open dislocation.

Results/Testing/Reports

Results are the technical component of a service. Testing leads to results; results lead to interpretation. Reports are the work product of the interpretation of numerous test results.

Secondary Procedures

All other significant procedures are to be reported as secondary procedures. A significant procedure is one that:

- Is surgical in nature
- Carries a procedural risk
- Carries an anesthetic risk
- Requires specialized training

Separate Procedure

Some of the procedures or services listed in the CPT codebook that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term “separate procedure.” The codes designated as “separate procedure” should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

However, when a procedure or service that is designated as a "separate procedure" is carried out independently or considered to be unrelated or distinct from other procedures/services provided at that time, it may be reported by itself, or in addition to other procedures/services by appending modifier 59 to the specific "separate procedure" code to indicate that the procedure is not considered to be a component of another procedure, but is a distinct, independent procedure. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, separate injury, or area of injury in extensive injuries.

Shaving of Epidermal or Dermal Lesions (11300-11313)

Shaving is the sharp removal by transverse incision or horizontal slicing to remove epidermal and dermal lesions without a full- thickness dermal excision. This includes local anesthesia, chemical, or electrocauterization of the wound. The wound does not require suture closure.

Specialty

Refers to the "Category" column in the DOH published listing of Clinician licenses on Shafafiya found at Dictionary - Shafafiya | Department of Health Abu Dhabi (doh.gov.ae).

Supervision and Interpretation

Supervision and interpretation (S&I) codes are used to describe the personal supervision of the performance of the radiologic portion of a procedure by one or more physicians and the interpretation of the findings. These codes would not be assigned when the S & I is included in the procedure code descriptor.

Subsection Information

Added to new chapter on Guidelines

Technical Component

Certain procedures or services described in CPT involve a technical component which is the 'test' component.

Traction

- Skeletal traction is the application of a force (distracting or traction force) to a limb segment through a wire, pin, screw, or clamp that is attached (e.g., penetrates) to bone.
- Skin traction is the application of a force (longitudinal) to a limb using felt or strapping applied directly to skin only.

Transfer of Care

The process whereby a physician who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services.

The physician transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate.

Consultation codes should not be reported by the physician who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.

Unbundling

To inappropriately bill more CPT/HCPCS codes than necessary, applied when certain codes represent procedures that are basic steps to accomplish a primary procedure already on the bill and, by definition, are included in the reimbursement of the primary procedure.

Unlisted Procedure/Service

These are services or procedures performed by physicians or other qualified health care professionals that are not found in the CPT codebook. The reference list of unlisted codes may be found throughout the CPT Book at either the beginning of the chapter or within the relevant section.[28]

Guidelines

Specific guidelines are presented at the beginning of each of the sections. These guidelines define items that are necessary to appropriately interpret and report the procedures and services contained in that section. For example, in the Medicine section, specific instructions are provided for handling unlisted services or procedures, special reports, and supplies and materials provided. Guidelines also provide explanations regarding terms that apply only to a particular section. For instance, Radiology Guidelines provide a definition of the unique term, “radiological supervision and interpretation.” While in Anesthesia, a discussion of reporting time is included.

A written report (e.g., handwritten or electronic) signed by the interpreting individual should be considered an integral part of a radiologic procedure or interpretation. Please see the guidelines regarding Imaging Guidance in each individual section

Many of the subheadings and subsections in the CPT book have special needs or instructions unique to that section. The coder is to always refer to the current mandated CPT guidelines in use when assigning codes and the relevant specific guidelines, as stated in the CPT book. Any additional rules for coding and reporting code(s) in the Emirate of Abu Dhabi will be indicated within the individual section of the Coding Manual.

As stated in the Introduction to the ICD-10-CM Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized.

[28] CPT© 2021 American Medical Association.

Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. In the context of the official coding guidelines, the term "provider" means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis. These guidelines are not a substitute for the provider's clinical judgment as to the determination of whether a condition was/was not present on admission. The provider should be queried regarding issues related to the linking of signs/symptoms, timing of test results, and the timing of findings.[29]

Add-on Codes

Some of the listed procedures are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as add-on codes with the ✚ symbol and they are listed in Appendix D of the CPT codebook.

Add-on codes in CPT 2021 can be readily identified by specific descriptor nomenclature that includes phrases such as "each additional" or "(List separately in addition to primary procedure)."

The add-on code concept in 2021 CPT applies only to the add-on procedures or services performed by the **same physician**. Add-on codes describe additional intra-service work associated with the primary procedure, e.g., additional digit(s), lesion(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s).

Add-on codes are always performed in addition to the primary service or procedure and must **never be reported as a stand-alone code**.

When the add-on procedure can be reported bilaterally and is performed bilaterally, the appropriate add-on code is reported twice, unless the code descriptor, guidelines, or parenthetical instructions for that particular add-on code instructs otherwise. Do not report modifier 50, Bilateral procedures, in conjunction with add-on codes. All add-on codes in the CPT code set are exempt from the multiple procedure concept. See the modifier 50 and 51 definition in Appendix A and E of the 2021 CPT codebook.

Modifiers

- Selected modifiers have been approved for assignment in the Emirate of Abu Dhabi.
- Selected modifiers have been approved for coding and reporting in the Emirate of Abu Dhabi.
- These modifies provide additional information about the medical procedure, service or supply involved, by some specific circumstance, without changing the meaning or definition of the code.
- Modifiers may be used for pricing where the modifier impacts the price of the code reported or informational modifiers as additional information is available by reporting them on the claims.

[29] 2021 ICD-10-CM Guidelines (cms.gov) /Appendix 1/POA

Types of Modifiers

There are two types of modifiers used in medical billing: CPT Level I and HCPCS Level II modifiers.

CPT Level I modifiers

- The American Medical Association (AMA) modifiers are two-digit numeric code listed after a procedure or supply code and separated from the code by a hyphen. A maximum of three modifiers may be coded on a CPT code.
- Example: "50" added to the CPT code for Bilateral procedure.

HCPCS Level II Modifiers

- HCPCS Codes and modifiers are either alphanumeric or consisting of 2 letters. The coding and reporting of these Modifiers are optional.
- Examples HCPCS Level II modifiers: E1-E4: Eyelids

Note: Refer to the routine reporting standards for the current modifier listing available on Reporting - Shafafiya | Department of Health Abu Dhabi (doh.gov.ae)

Currently Used Modifiers in Abu Dhabi

Select Modifier codes are utilized within the Emirate of Abu Dhabi in conjunction for reporting guidelines found in the DOH Claims and Adjudication Rules[30]

[30] DOH Claims and Adjudication Rules 2024

Unlisted Procedure or Service Codes

As a requirement, there may be services procedures performed by physicians without the exact code. A number of specified codes have been designated for reporting unlisted procedures. Each of these unlisted procedural code numbers relates to a specific section of the currently mandated CPT codebook and is presented in the guidelines of that section especially for services or procedures performed by physicians that are not found within the CPT codebook.

According to the Instructions for use within the Current Procedural Terminology, select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code. Any service or procedure must be adequately documented in the medical record.[31]

In the Emirate of Abu Dhabi, billing for an unlisted procedure or service should be followed as per the DOH Claims and Adjudication.

- An Observation may be reported in the eClaim as defined by the Routine reporting requirements of the electronic equivalent for the unlisted code which may be submitted holding up to **150 characters text**, which should include a **concise statement and description of the unlisted procedure code.** See the DOH Routine reporting for reporting requirements**:** **https://www.doh.gov.ae/-/media/Feature/shafifya/RoutineReporting.ashx.**
- If the description does not fit into the 150 characters text area provided, providers who submit claims should describe the services in an attachment. When filing claims for two or more procedures using the same unlisted CPT code, report the unlisted code only once.

Time

Time in Procedure Codes

The CPT code set contains many codes with a time basis for code selection. The following standards shall apply to time measurement, unless there are code or code-range-specific instructions in guidelines, parenthetical instructions, or code descriptors to the contrary.

Time is the face-to-face time with the patient. Phrases such as “interpretation and report” in the code descriptor are not intended to indicate in all cases that report writing is part of the reported time.

A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes). A second hour is attained when a total of 91 minutes has elapsed. When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used. (See also Evaluation and Management).

[31] Policy Guideline for provider performed unlisted CPT code | Medicare Payment, Reimbursement, CPT code, ICD, Denial Guidelines (medicarepaymentandreimbursement.com) https://www.fortherecordmag.com/archives/1018p28.shtml

When another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service.

Some services measured in units other than days extend across calendar dates. When this occurs, a continuous service does not reset and create a first hour. However, any disruption in the service does create a new initial service. For example, if intravenous hydration (96360, 96361) is given from 11 PM to 2 AM 96360 would be reported once and 96361 twice. However, if instead of a continuous infusion, a medication was given by intravenous push at 10 PM and 2 AM, as the service was not continuous; both administrations would be reported as initial (96374). For continuous services that last beyond midnight, use the date in which the service began and report the total units of time provided continuously.

General Guidelines in Evaluation & Management Coding for Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services.

Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently.

The Time-based factor is not utilized in determining the level of E/M outpatient services within the Emirate of Abu Dhabi, only Medical Decision Making.

It is important to review the instructions for each category.

Time as a Factor in the Emergency Department Setting

Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for physicians to provide accurate estimates of the time spent face-to-face with the patient.

Evaluation and Management

Evaluation and Management (E/M) Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, e.g., “Inpatient Hospital Care,” special instructions are presented before the listing of the specific E/M codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified healthcare professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support the care of the patient by current and future health care team(s).

There are two sets of guidelines: one for office or other outpatient services and another for the remaining E/M services. There are sections that are common to both (i.e., Guidelines in Common). These guidelines are presented as Guidelines Common to all E/M Services, Guidelines for E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care, Home) and Guidelines for Office or Other Outpatient Services.

The main differences between the two sets of guidelines are that the office or other outpatient services use medical decision making (MDM) or time as the basis for selecting a code level, whereas the other E/M codes use history, examination, and MDM and only use time when counselling and/or coordination of care dominates the service. The definitions of time are different for different categories of service. The use of the time-based factor in determining the level of E/M outpatient services within the Emirate of Abu Dhabi is not applicable. MDM (Medical Decision Making) is the only criteria for determining the level of E/M within Abu Dhabi.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) (The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, e.g., office consultation. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

In the Emirate of Abu Dhabi, E & M codes are used for coding and reporting in the Inpatient and the Outpatient Setting. The 2021 E&M coding guidelines shall be used for coding and reporting.

[32]The table below represents the E&M codes currently used within the Emirate of Abu Dhabi.

Service Category	Codes Range	
	From	To
Office and Other Outpatient Services	99202	99215
Hospital Observation Services	99217	99226
Hospital Inpatient Services	99221	99239
Consultations	99241	99255
Emergency Department Services	99281	99288
Critical Care Services	99291	99292
Nursing Facility Services	99304	99318
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services	99324	99337
Domiciliary, Rest Home (e.g., ALF), or Home Care Plan Oversight Services	99339	99340
Home Services	99341	99350
Prolonged Services	99354	99417
Case Management Services	99366	99368
Care Plan Oversight Services	99374	99380
Preventive Medicine Services	99381	99429
Non-Face to Face Physicians Services	99421	99443
Non-Face to Face Services	99446	99474
Special Evaluation and Management Services	99450	99458
Newborn Care Services	99460	99463
Delivery/Birthing Room Attendance & Resuscitation Services	99464	99465
Inpatient Neonatal Intensive Care services and Pediatric & Neonatal Critical Care Services	99466	99486
Cognitive Assessment and Care Plan Services	99483	99486
General Behavioral Health Integration Care Management	99484	
Care Management Services	99487	99491*
Psychiatric Collaborative Care Management Services	99492	99494
Transitional Care Management Services	99495	99496
Advanced Care Planning	99497	99498
Other Evaluation and Management Services	99499	

**Re-sequenced Codes 99490, 99439, and 99491 represent Chronic Care management services*

However, it is important to liaise with the Payor(s) as to whether these codes will be reimbursed.

[32] CPT© 2021 American Medical Association

Auditing for E/M Codes

All Healthcare Facilities will be required to pass JAWDA Data Certifications (JDC) and to be listed as a Coding Certified Facility.

Telemedicine Services

The CPT® codebook distinguishes between on-line medical evaluation and telephone services provided by a physician or another healthcare professional to a patient, however only Tele-Medicine services are provided within Abu Dhabi. For coding purposes see the Claims and Adjudication Rules, Appendix C for the detailed description of the codes and section 4.2.1.12 for billing and reporting of these services.

Anesthesia (0100-0258U,99100-99140)

The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure. Unless specified in the procedure code, they are assigned in addition to the procedure code. Services involving administration of anesthesia are reported by the use of the anesthesia five-digit procedure code (00100-01999).

These services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). Unusual forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz) are not included.

Separate or Multiple Procedures

When multiple surgical procedures are performed during a single anesthetic administration, the anesthesia code representing the most complex procedure is reported. The time reported is the combined total for all procedures

Time for Reporting

Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision.

Aborted Procedure

Unlisted Procedure code 01999 will be coded for aborted or discontinued anesthesia procedures in addition to the relevant anesthesia code

Qualifying Circumstances

More than one qualifying circumstance may be selected.

Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative conditions, and/or unusual risk factors. This section includes a list of important qualifying circumstances that significantly affect the character of the anesthesia service provided. These procedures would not be reported alone but would be reported as additional procedure numbers qualifying an anesthesia procedure or service.

✚ **99100** Anesthesia for patient of extreme age, younger than 1 year and older than 70 (list separately in addition to code for primary anesthesia procedure)

✚ **99116** Anesthesia complicated by utilization of total body hypothermia (list separately in addition to code for primary anesthesia procedure)

✚ **99135** Anesthesia complicated by utilization of controlled hypotension (list separately in addition to code for primary anesthesia procedure)

✚ **99140** Anesthesia complicated by emergency conditions (specify) (list separately in addition to code for primary anesthesia procedure)

An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.

For further information see the CPT Surgical Package Definition as well as the DOH Claims and Adjudication Rules.

Surgery (10004 – 69990)

Physicians' services rendered in the office, home, or hospital, consultations, and other medical services are listed in the section entitled Classification of Evaluation and Management (E/M) Services.

CPT Surgical Package Definition

The services provided by the physician to any patient by their very nature are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services "included" in a given CPT surgical code, the following services related to the surgery when furnished by the physician or other qualified health care professional who performs the surgery are included in addition to the operation per se:

- Evaluation and Management (E/M) service(s) subsequent to the decision for surgery on the day before and/or day of surgery (including history and physical)
- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia

- Immediate postoperative care, including dictating operative notes, talking with the family, and other physicians or other qualified health care professionals
- Writing orders
- Evaluating the patient in the post anesthesia recovery area
- Typical postoperative follow-up care

Follow-up Care for Diagnostic Procedures

Follow-up care for diagnostic procedures (e.g., endoscopy, arthroscopy, injection procedures for radiography) includes only that care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be listed separately.

Follow-up Care for Therapeutic Surgical Procedures

Follow-up care for therapeutic surgical procedures includes only that care which is usually a part of the surgical service. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services should be separately reported.

Materials Supplied by Physician

Supplies and materials provided by the physician (e.g., sterile trays/drugs), over and above those usually included with the procedure(s) rendered are reported separately. List drugs, trays, supplies, and materials provided. Identify specific supply code.

Reporting More than One Procedure /Service

When more than one procedure/service is performed on the same date, same session or during a post-operative period (subject to the "surgical package" concept), several CPT modifiers may apply (see 2021 CPT Appendix A for further definitions).

Surgical Destruction

Surgical destruction is a part of a surgical procedure, and different methods of destruction are not ordinarily listed separately unless the technique substantially alters the standard management of a problem or condition. Exceptions under special circumstances are provided for by separate code numbers.

Chemotherapy

For provision of chemotherapeutic agents, report both the specific service in addition to code(s) for the specific substance(s) or drug(s) provided. Use DOH Drug codes found on Shafafiya in the following location: https://shafafiyaportal.doh.gov.ae/dictionary/DrugCoding/Drugs.xlsx (NOT CPT product codes).

Maternity Care and Delivery

- The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care; Pregnancy confirmation during a problem oriented or preventive visit is not considered a part of antepartum care and should be reported using the appropriate E/M service codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99384, 99385, 99386, 99394, 99395, 99396 for that visit.
- Antepartum care includes the initial prenatal history and physical examination; subsequent prenatal history and physical examinations; recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation; biweekly visits to 36 weeks gestation; and weekly visits until delivery. Any other visits or services within this time period should be coded separately.
- Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery. When reporting delivery only services (59409, 59514, 59612, 59620), report inpatient post-delivery management and discharge services using Evaluation and Management Services codes. (99217-99239). Delivery and postpartum services (59410, 59515, 59614, and 59622) include delivery services and all inpatient and outpatient postpartum services. Medical complications of pregnancy (e.g., cardiac problems, neurological problems, diabetes, hypertension, toxemia, hyperemesis, preterm labor, premature rupture of membranes, trauma) and medical problems complicating labor and delivery management may require additional resources and may be reported separate.
- The code(s) for Postpartum care only services (59430) include office or other outpatient visits following vaginal or cesarean section delivery. Postpartum care includes hospital and office visits following vaginal or cesarean section delivery.
- For surgical complications of pregnancy (e.g., appendectomy, hernia, ovarian cyst, Bartholin cyst), see services in the Surgery section.
- If all or part of the antepartum and/or postpartum patient care is provided except delivery due to termination of pregnancy by abortion or referral to another physician or other qualified health care professional for delivery, see the antepartum and postpartum care codes 59425, 59426, and 59430.
- For circumcision of newborn, see 54150, 54160.

Radiology Guidelines (Including Nuclear Medicine and Diagnostic Ultrasound) (70010 - 79999)

All codes in this section apply when radiological services are performed by or under the responsible supervision of a DOH Licensed physician / Healthcare professional.

Supervision and Interpretation

Imaging may be required during the performance of certain procedures or certain imaging procedures may require surgical procedures to access the imaged area.

Many services include image guidance, and imaging guidance is not separately reportable when it is included in the base service. The CPT code set typically defines in descriptors and/or guidelines when imaging guidance is included. When imaging is not included in a surgical procedure or procedure from the Medicine section, image guidance codes or codes labeled "radiological supervision and interpretation" (RS&I) may be reported for the portion of the service that requires imaging. All imaging guidance codes require: (1) image documentation in the patient record and (2) description of imaging guidance in the procedure report. All RS&I codes require: (1) image documentation in the patient's permanent record and (2) a procedure report or separate imaging report that includes written documentation of interpretive findings of information contained in the images and radiologic supervision of the service.

The RS&I codes are not applicable to the Radiation Oncology subsection.

Administration of Contrast Materials

- The phrase “with contrast” used in the codes for procedures performed using contrast for imaging enhancement represents contrast material administered intravascularly, intra-articularly or intrathecally.
- For intra-articular injections, use the appropriate joint injection code. If radiographic arthrography is performed, also use the arthrography supervision and interpretation code for the appropriate joint (which includes fluoroscopy). If computed tomography (CT) or magnetic resonance (MR) arthrography are performed without radiographic arthrography, use the appropriate joint injection code, the appropriate CT or MR code (“with contrast” or “without followed by contrast”), and the appropriate imaging guidance code for needle placement for contrast injection.
- For spine examinations using computed tomography, magnetic resonance imaging, magnetic resonance angiography, “with contrast” includes intrathecal or intravascular injection. For intrathecal injection, use also 61055 or 62284.
- Injection of intravascular contrast material is part of the “with contrast” CT, computed tomographic angiography (CTA), magnetic resonance imaging (MRI), and magnetic resonance angiography (MRA) procedures.
- Oral and/or rectal contrast administration alone does not qualify as a study “with contrast.”

Written Reports

A written report signed by the interpreting physician should be considered an integral part of a radiologic procedure or interpretation

With regard to CPT descriptors for imaging services, “images” must contain anatomic information unique to the patient for which the imaging service is provided. “Images” refer to those acquired in either an analog (i.e., film) or digital (i.e., electronic) manner.

Pathology and Laboratory (80143 - 0284U)

Services in Pathology and Laboratory

Services in Pathology and Laboratory are provided by a physician or by technologists under responsible supervision of a physician.

Separate or Multiple Procedures

It is appropriate to designate multiple procedures that are rendered on the same date by separate entries.

Proprietary Laboratory Analyses (0001U - 0284U)

Proprietary Laboratory analyses (PLA) codes describe proprietary clinical laboratory analyses provided by a laboratory, with either a single or multiple licenses, approved by the FDA (Food and Drug Administration).

Organ or Disease-Oriented Panels (80047- 80076)

- These panels were developed for coding purposes only and should not be interpreted as clinical parameters. The tests listed with each panel identify the defined components of that panel.
- These panel components are not intended to limit the performance of other tests. If one performs tests in addition to those specifically indicated for a particular panel, those tests should be reported separately in addition to the panel code.
- Do not report two or more panel codes that include any of the same constituent tests performed from the same patient collection. If a group of tests overlaps two or more panels, report the panel that incorporates the greater number of tests to fulfill the code definition and report the remaining tests using individual test codes (e.g., do not report 80047 in conjunction with 80053).

Surgical Pathology (88300 - 88399)

- Services 88300 through 88309 include accession, examination, and reporting. They do not include the services designated in codes 88311 through 88365 and 88399, which are coded in addition when provided.
- The unit of service for codes 88300 through 88309 is the specimen. A specimen is defined as tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. Two or more such specimens from the same patient (e.g., separately identified endoscopic biopsies, skin lesions) are each appropriately assigned an individual code reflective of its proper level of service.
- Service code 88300 is used for any specimen that in the opinion of the examining pathologist can be accurately diagnosed without microscopic examination.
- Service code 88302 is used when gross and microscopic examination is performed on a specimen to confirm identification and the absence of disease.

- Service codes 88304 through 88309 describe all other specimens requiring gross and microscopic examination and represent additional ascending levels of physician work. Levels 88302 through 88309 are specifically defined by the assigned specimens.
- Any unlisted specimen should be assigned to the code which most closely reflects the physician work involved when compared to other specimens assigned to that code.

Medicine (except anesthesia) (90281 - 99607)

Codes 90281 - 90399

Identify the serum globulins, extracted from human blood; or recombinant immune globulin products created in a laboratory through genetic modification of human and/or animal proteins. These product codes are **not** assigned in the Emirate of Abu Dhabi. For correct coding and reporting one must assign the required Mandatory Tariff version of the Pharmacy Drug Codes (DOH Drug code List) as defined by DOH Pharma and regulated by MOHAP and found on Shafafiya in the following location https://shafafiyaportal.doh.gov.ae/dictionary/DrugCoding/Drugs.xlsx.

Both Pharmacy Drug Code(s) (Pharmacy Drug Codes (DOH Drug codes) as defined by DOH Pharma and regulated by MOHAP in addition to the administration codes 96365-96368, 96372, 96374, 96375 are reported as appropriate.

Immunization Administration for Vaccines/Toxoids (90460 -0042A)

These vaccine and toxoid codes are **not** assigned in the Emirate of Abu Dhabi. For correct coding and reporting one must assign the required Mandatory Tariff version of the Pharmacy Drug Codes (DOH Drug codes) as defined by DOH Pharma and regulated by MOHAP. The Pharmacy Drug Code(s) must be reported in addition to the administration code(s) 90460 and 90461 with the following criteria:

Report codes 90460 and 90461 only when the qualified health care professional provides face-to-face counseling of the patient and family during the administration of a vaccine. For immunization administration of any vaccine that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family or for administration of vaccines to patients over 18 years of age, report codes 90471-90474.

If a significant separately identifiable Evaluation and Management service (e.g., office or other outpatient services, preventive medicine services) is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration codes.

Category II (0001F - 9007F)

- Category II codes contain a set of supplemental tracking codes that can be used for performance measurement. It is anticipated that the use of Category II codes for performance measurement will decrease the need for record validation and chart review, and thereby minimize administrative burden on physicians, other health care professionals, hospitals, and entities seeking to measure the quality of patient care. These codes are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that

support nationally established performance measures and that have an evidence base as contributing to quality patient care.

- These codes describe clinical components that may be typically included in evaluation and management services or clinical services and, therefore, do not have a relative value associated with them. Category II codes may also describe results from clinical laboratory or radiology tests and other procedures, identified processes intended to address patient safety practices, or services reflecting compliance with legal requirements.
- Category II codes described in this section make use of alphabetical characters as the 5th character in the string (i.e., 4 digits followed by the letter F). These digits are not intended to reflect the placement of the code in the regular (Category I) part of the CPT code set. To promote understanding of these codes and their associated measures, users are referred to the Alphabetical Clinical Topics Listing, which contains information about performance measurement exclusion modifiers, measures, and the measure's source.
- Cross-references to the measures associated with each Category II code and their source are included for reference in the Alphabetical Clinical Topics Listing. In addition, acronyms for the related diseases or clinical condition(s) have been added at the end of each code descriptor to identify the topic or clinical category in which that code is included.
- A complete listing of the diseases/clinical conditions, and their acronyms are provided in alphabetical order in the Alphabetical Clinical Topics Listing. The Alphabetical Clinical Topics Listing can be accessed on the website at www.ama-assn.org, under the Category II link. Users should review the complete measure(s) associated with each code prior to implementation.
- The use of these codes is optional. The codes are not required for correct coding and may not be used as a substitute for Category I codes.
- In the Emirate of Abu Dhabi, the use of these Supplemental Codes (Category II) for performance management are **optional** for Coding and reporting a procedure or service but may not be used as a substituted as a Category I Code.

Category III Codes (0019T - 0232T)

Temporary Codes for New Technology

- This section contains a set of temporary codes for emerging technology, services, and procedures. Category III codes will allow data collection for these services/procedures. If a Category III code is available, this code **must** be reported instead of a Category I unlisted code.
- All CPT codes are relevant for assignation; however, it is advised that the Facility/ Provider communicate with the Payer prior to assigning these codes for correct coding and reporting purposes. Services/procedures described in this section make use of alphanumeric characters.
- These codes have an alpha character as the 5th character in the string, preceded by four digits. The digits are not intended to reflect the placement of the code in the Category I section of CPT nomenclature.
- Codes in this section may or may not eventually receive a Category I CPT code. In either case, in general, a given Category III code will be archived five years from its date of publication or revision in the CPT code book unless it is demonstrated that a temporary code is still needed.

Services/procedures described by Category III codes which have been archived after five years, without conversion, may be reported using the Category I unlisted code. New codes in this section are released semi-annually via the AMA/CPT internet site, to expedite dissemination for reporting. The full set of temporary codes for emerging technology, services, and procedures are published annually in the CPT codebook. Go to CPT Codes | American Medical Association (ama-assn.org) for the most current listing.

- In the Emirate of Abu Dhabi, temporary codes for new technology may be used for coding and reporting a procedure or service as per the contracting agreement with Payer (Daman).

Dental Guidelines

Coding Guidelines Based on the Canadian Dental Association (CDA)

All CDA coding rules, guidelines and descriptors will be followed explicitly, for the coding of Canadian Dental Codes (CDA) effective 15 October 2012. The 2011 version is currently mandated for use within the Emirate of Abu Dhabi and any questions and issues will be addressed to the Healthcare Payer Sector (HPS).

The following issues have been addressed:

- Rules as published by CDA with the full descriptor, for v2011 will be followed.

Quality and Data Standards

Health Data Elements for Standardization

Medical Coders are responsible for data validation within patient health records thus ensuring that the discharge disposition of the patient is correct, and that coding reflects the service area accurately.

In the Emirate of Abu Dhabi, the Data Elements for verifying the information on a record may be found as per the DOH Data Elements Common Type Schema and validation rules on the DOH website at https://doh.gov.ae/en/Shafafiya.

Code Sets for Reporting and Claiming with Effective Dates

Diagnostic Coding

- ICD-10-CM 2008 valid until Service Date 1st April 2012
- ICD-10-CM 2011 valid as of Service Dated 1st April 2012
- ICD-10-CM 2015 (2016) effective 01 January 2017
- ICD-10-CM 2018 effective 01 July 2021
- ICD-10-CM 2021 effective 01 January 2024

Procedure Coding

- CPT 4th Edition 2008 valid until Service Date 1st April 2012
- CPT 4th Edition 2011 valid as of Service Date 1st April 2012
- CPT 4th Edition 2018 effective 01 July 2021
- CPT 4th Edition 2021 effective 01 January 2024

Consumable Coding

- HCPCS 2008 valid until Service Date 1st April 2012
- HCPCS 2011 valid as of Service Dated 1st April 2012
- HCPCS 2018 effective 01 July 2021
- HCPCS 2021 effective 01 January 2024

Dental Coding

- Canadian Dental Codes (CDA) 2008 valid until Service Date 1st April 2012
- Canadian Dental Codes (CDA) 2011 valid as of Service Date 1st April 2012

3M™ International Refined Diagnosis Related Groups (IR-DRG) Version

- IR-DRG v2.2 effective 01 January 2021
- IR-DRG v.2.3 effective 15 October 2012
- IR-DRG v3.01 effective 01 January 2017
- IR-DRG v 3.3 effective 15 September 2023

IR-DRG Purpose and Scope

Purpose

The DOH DRG Standard establishes and mandates the diagnosis related groupings system, definitions and rules for the management and monitoring of health insurance claims by healthcare providers and payers under the health insurance scheme of Abu Dhabi. [33].

Scope

- The Standard applies to all inpatient healthcare services – except for long-term care services, as defined by the DOH Standard for the Provision of Long-Term Care, and dental inpatient cases – provided by all DOH licensed healthcare providers and payers operating in the emirate of Abu Dhabi. Refer to Standards - resources - Department of Health (doh.gov.ae) for any updates related to the DRG standard.
- DRGs must be used for payment from the service date 1st August 2010, and 31st December 2011 for all other products. (See DOH Standard establishing the Diagnosis Related Groupings System Reference: HSF/DRG/1.0 as well as DOH Claims and Adjudication Rules.)

Standard Definitions

The definitions applicable for interpretation and enforcement to the DRG may be found with the DRG Standard[34]

[33] DOH Standard establishing the Diagnosis Related Groupings System Reference: HSF/DRG/1.0 & (DOH Claims and Adjudication Rules)
[34] DOH Standard establishing the Diagnosis Related Groupings System Reference: HSF/DRG/1.0 & (DOH Claims and Adjudication Rules

Coding Audit, Advisory, Policies, Processes and References

Coding References

This coding manual focuses on the main aim of medical coding which is the translation of records into quality data with accuracy. There are many reference sources available to medical coders to assist in coding a diagnosis or procedure however to assist in the uniformity of the reference sources used, the references should be used according to the mandated code set currently in use and the normative listing which may be found in Appendix A utilized for all references of coding and auditing within the Emirate of Abu Dhabi.

Coding Policies

- **Coders must review the medical record for the entire visit they are coding before finalizing the coding process.** The purpose of this is to provide the most accurate and specific coding possible, by reviewing all the pertinent notes, exams and tests before completing the coding assignment. Special care should be given in reviewing the listed documents:
  - Consultation reports
  - Day care visit notes
  - Discharge Summary
  - Emergency visit notes
  - Histopathology reports
  - Special procedure reports such as endoscopy
  - Lab reports, i.e., microbiology
  - Operative Report
  - Progress notes
  - Radiology reports
- **If in doubt, consult with the attending physicians.** There will be times when the Coder is unable to assign the correct code because of unclear or conflicting documentation in the medical record. In those instances, it is best practice to consult with the attending physician for that visit to get clarification before assigning the final codes.
- **Code specificity as documented in laboratory and radiology reports.** It is recommended best practice for the Coder to refer to the laboratory and/or radiology reports to obtain the specificity necessary for accurate coding. If, for example, the physician documents a UTI (urinary tract infection) but does not identify the organism, you can code the organism from the microbiology report, such as E. Coli.

  The same applies to radiology reports; if the physician documents a fracture of the femur but does not identify the site, you can refer to the radiology report to find the specific site, such as the shaft of the femur. This does not mean, however, that the Coder should code everything directly from the reports, if the physician has not documented the condition in the medical record, then he/she must be consulted before coding it. *For example*, if the blood culture lists staph aureus as an organism found on the test, you cannot assume that the patient has sepsis, the physician must be consulted first. The same applies to the radiology report; if the chest X-ray shows a slight pleural effusion but the doctor has not documented this in his notes, you cannot code it without consulting him/her first.

- **If the patient has a neoplasm that was excised or biopsied and sent to Pathology, code the specific diagnosis from the pathology report.** The pathology report is the best reference for the Coder when coding any type of neoplasm such as cancer, tumor or other abnormal growth. The pathology report will give the final, definitive diagnosis of the specific type of neoplasm and the specific site of the neoplasm for accurate coding.
- **Review the pathology report for specificity of diagnosis.** Whenever a specimen is sent to the Pathology Department for analysis, it is best practice for the Coder to review the pathology report before coding. The pathology report will provide the specificity needed for more accurate coding of the diagnosis. For example, if the physician documents that the patient had appendicitis, the pathology report may more accurately document acute, gangrenous appendicitis, which is a different diagnosis code.
- **Code all significant procedures.** If in doubt, Coders should always code those procedures that were performed in the Operating Room; were performed under any type of anesthesia, including local anesthesia; where any tissue was removed and sent to Pathology; and any excisional or sharp debridement of a wound.

Proposed Coding Policies

Diagnostic Coding

All diagnostic coding will be coded and reported using the mandated version of ICD 10-CM following all the rules and conventions.

Procedure Coding

All procedure coding will be coded and reported using the mandated version of CPT 4 following all the standards and guidelines.

Documentation Requirements

Policies addressing the required documentation and level of detail required in medical records to support coding and reporting. Policies may address missing documentation and/or any other specific documentation elements with how these are managed within the organization.

Querying

Clear guidelines on the processes for querying physicians when documentation is incomplete or unclear ensure that coding is not delayed and can be completed accurately. This ensures the potential for decreased denials.

Key Performance Indicators

Accuracy and efficiency for full-time equivalent coders should be established in line with their functions. Capability should be supported to improve the standards in line with data quality.

Compliance and Audit

Regular internal audits should be conducted for all coding specialties monthly using the mandated code sets to identify potential coding errors and ensure compliance. Coding Managers and Data quality should be involved in discussions to ensure coding accuracy, especially in areas of Mortality review.

Audits ensure that coding adheres to relevant regulatory requirements and changes to guidelines set by the regulators and healthcare insurance companies or third-party administrators.

Coding Training

An induction and training program must be offered for all new coding staff with continual training and mentorship. Coding refresher workshops or specialist training should be scheduled.

Training for Healthcare Professionals

The clinical coding department should collaborate with medial staff who have significant turnover, to highlight the importance of medical coding. By offering workshops to train on the impact of incomplete documentation leading to incorrect coding, initiatives such as regular communication with coding staff are created.

Coding Processes

Locating Codes in ICD-10-CM

- The first step in coding is to locate the main term in the Alphabetic Index. Some conditions are indexed under more than one main term.
- If a main term cannot be located, the coder should consider a synonym, eponym, or other alternative term.
- Once the main term is located, a search should be made of sub terms, notes, or cross-references. Sub terms provide more specific information of many types and must be checked carefully, following all the rules of alphabetization.
- The main term code entry should not be assigned until all sub term possibilities have been exhausted.
- During this process, it may be necessary to refer again to the medical record to determine whether any additional information is available to permit assignment of a more specific code.
- If a sub term cannot be located, the nonessential modifiers following the main term should be reviewed to see whether the sub term may be included there. If not, alternative terms should be considered.
- The first coding principle is that both the Alphabetic Indexes and the Tabular Lists must be used to locate and assign appropriate codes. The condition or procedure to be coded must first be in the index, and the code provided there must then be verified in the Tabular List.

- The coder must follow all instructional notes to determine that more specific sub terms or important instructional notes are not overlooked.
- Experienced coders sometimes rely on their memory for commonly used codes, but consistent reference to the Alphabetic Index and the Tabular Lists is imperative, no matter how experienced the coder is.

Locating Codes in the CPT Codebook

- Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided.
- If no such specific code exists, then report the service using the appropriate unlisted procedure or service code. In surgery, it may be an operation; in medicine, a diagnostic or therapeutic procedure; in radiology, a radiograph.
- Other additional procedures performed, or pertinent special services are also listed. When necessary, any modifying or extenuating circumstances are added. Any service or procedure should be adequately documented in the medical record.
- Instructions, typically included as parenthetical notes, with selected codes indicate that a code should not be reported with another code or codes. These instructions are intended to prevent errors of significant probability and are not all inclusive. For example, the code with such instructions may be a component of another code and therefore it would be incorrect to report both codes even when the component service is performed.
- These instructions are not intended as a listing of all possible code combinations that should not be reported, nor to indicate all possible code combinations that are appropriately reported.
- When reporting codes for services provided, it is important to assure the accuracy and quality of coding through verification of the intent of the code by use of the related guidelines, parenthetical instructions, and coding resources, including CPT Assistant and other publications resulting from collaborative efforts of the American Medical Association with the medical specialty societies (i.e., Clinical Examples in Radiology).

General Coding Processes

The general clinical coding process may be used as a guideline or reference in all areas of medical coding to ensure the steps required for complete quality documentation to begin coding are appropriate for consistent code assignment and involves several key steps for validation on the path to successful code assignment.

Collect and Analyse Patient Records:

Initial step in the process begins with obtaining the patient's medical records, which may include different documents to review all relevant information.

- Physician notes
- Laboratory results
- Other relevant documentation
- Radiology reports
- Discharge summaries.

Reviewing and Abstracting Information

The medical coder carefully reviews the patient's medical records to identify:

- Diagnoses
- Procedures performed.
- Other relevant clinical information

Match Clinical Statements to Codes

- Using their knowledge of medical coding systems the coder assigns the appropriate codes to each diagnosis and procedure.
- ICD-10-CM: International Classification of Diseases, Tenth Revision, Clinical Modification - codes for diagnoses
- CPT®: Current Procedural Terminology - codes for procedures
- HCPCS Level II: Healthcare Common Procedure Coding System, Level II – additional codes for specific services and supplies

Querying and Clarification

Any documentation that is unclear or incomplete, may require that the coder send a query to the physician for clarification to ensure completed documentation for accurate coding.

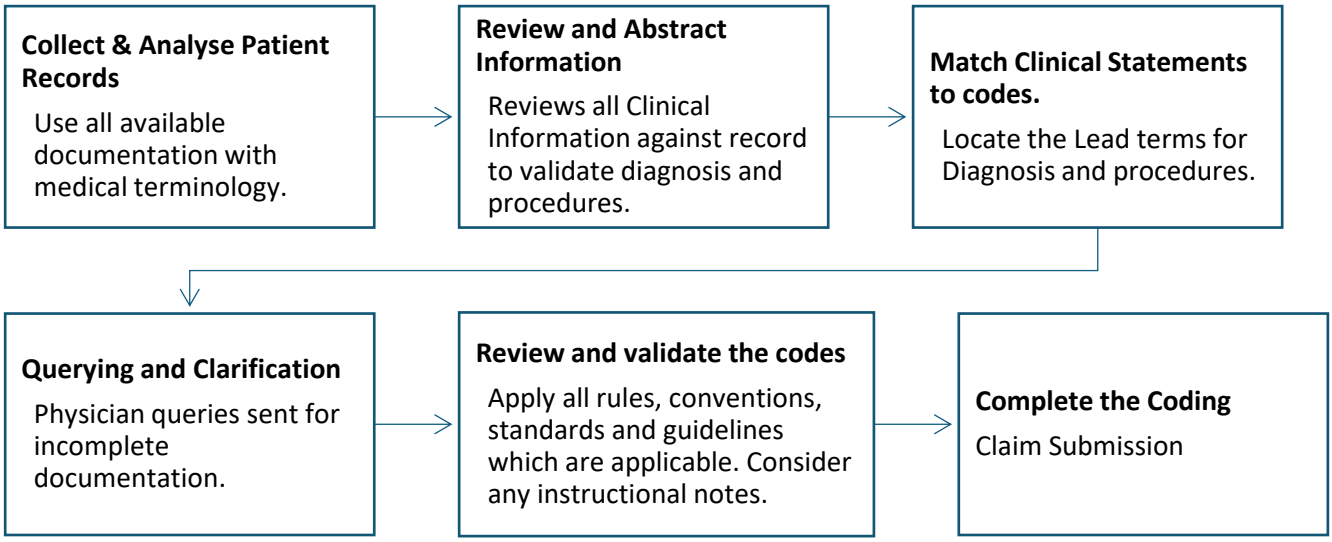
Review and Validate the Codes

- The assigned codes are reviewed by a coder applying all rules, conventions, standards and guidelines which are applicable.
- Any instructional notes are considered and finalized.

Claim Submission

Finalised Codes are used to create a claim that is submitted as per the claim submission rules of Shafafiya.

General Clinical Coding Process Workflow Figure



Clinical Coding Audit

Objective

This coding audit will endeavor to build trust between payers and providers by:

- Creating a shared understanding of the facility's coding quality.
- Giving the payers confidence that a facility is coding accurately.
- Giving the facility the right, if certified, to bill for Evaluation and Management (E/M) codes and potentially achieve higher levels of reimbursement and/or lower payer scrutiny.
- Providing the facility with an action plan of recommendations to improve the quality of coding.

The coding audit will give:

- A coding accuracy score for the facility, which will range from 0-100.
- A coding completeness score for the facility, which will range from 0- 100.
- JAWDA Data Certification (JDC) for Health care Providers

  See JAWDA Certification for Healthcare Providers on the following link: https://doh.gov.ae/en/Shafafiya/standards

Qualifications of Each Auditor

- Active and current AHIMA (American Health Information Management Association) or AAPC Certifications in Auditing.
- The Lead Auditor will have a minimum of 2 years' experience (after certification) in external clinical coding audits, incorporating ICD 10-CM and CPT 4, as evidenced by a CV and sample audits for Inpatient, Outpatient and Emergency Department coding auditing.
- Must be able to generate the Coding Audit in the required Excel format in coherent English, as evidenced by a sample summary of a previous audit.

Knowledge of UAE Rules and Regulations

Auditors must understand the Coding Audit methodology and current coding and documentation standards in the Emirate, as ascertained in an interview by a Payer and a Provider representative of the Coding Advisory Panel.

Conflict of Interest

Auditing Company must submit a declaration not to audit any facility in which either the Auditor or the Auditing Company has any involvement in supporting any aspect of the revenue cycle within the past 12 months.

Coding Certified Facilities

For the list, see the following link: https://doh.gov.ae/en/Shafafiya/dictionary.

DOH Coding Advisory Panel

The DOH Coding Advisory Panel is responsible for advising DOH on coding classifications, including reviews and updates of the coding guidelines and coding adjudication matters.

In case of unresolved coding disagreements, these may be referred to the DOH Coding Advisory Panel for consideration and advice.

Objective

The DOH Coding Advisory Panel is responsible for advising DOH on coding classifications, including reviews and updates of the coding guidelines and coding adjudication matters.

The scope of the panel:

- Advise DOH on code set updates.
- Consider and advise DOH on revisions and/or updates to coding guidelines and practice.
- Promote ethical coding practice and professionalism in coding, as defined in the coding guidelines.
- Serve as an expert for DOH on coding policies, standards, procedures, rulings, and practice.
- Assist in decision making so as to provide resolutions to coding queries/issues raised by providers and/or payers.
- Ensure the DOH coding manual is up-to-date based on the current coding practices.

Appendix A: List of Approved Normative References

** References should be used as applicable to the code set in use.

1. American Medical Association (AMA)
2. Coding Manual for Hospitals & Other Healthcare Institutions, published by Health Authority of Abu Dhabi
3. ICD-10-CM Official Guidelines for Coding and Reporting updated to the applicable code set. *
4. AHA Coding Clinic® American Hospital Association updated to the applicable code set. *
5. AHA Coding Clinic® for HCPCS, updated to the applicable code set. *
6. AMA CPT® Assistant, updated to the applicable code set. *
7. American Health Information Management System (AHIMA) Body of Knowledge
8. American Hospital Association (AHA) Coding Clinics
9. Anatomy and Physiology in Health and Illness, publisher of choice
10. ASTM E1869-04(2014) Standard Guide for Confidentiality, Privacy, Access, and Data Security Principles for Health Information Including Electronic Health Records
11. Atlas of Anatomy publisher of choice. For Example: Grants or Elsevier's Anatomy Plates
12. Canadian Dental Codes (USCLS) version 2011
13. Centers for Medicare & Medicaid Services (CMS) manual system
14. CPT Assistants updated to the applicable code set. *
15. Current Procedural Terminology, 4th Edition, Code set American Medical Association. *
16. DoH JAWDA Quality Performance Guidelines for Healthcare facilities (latest version as applicable)
17. Encoding Software - 3M™ Codefinder
18. DOH CLAIMS & ADJUDICATION RULES V2012 and all related Addendums
19. DOH Data Standard Fourth Revision 14 April 2014 according to DSP decision 265
20. DOH Health Insurance Claims Adjudication Standard
21. DOH Healthcare Professional Policy Manual
22. DOH JAWDA Waiting Time (as applicable)

* Applicable to the code set in use at the time of coding and submission of claim.
* Applicable to the code set in use at the time of coding and submission of claim.
* Applicable to the code set in use at the time of coding and submission of claim.
* Applicable to the code set in use at the time of coding and submission of claim.
* Applicable to the code set in use at the time of coding and submission of claim.
* Applicable to the code set in use at the time of coding and submission of claim.

23. DOH Policy for Quality and Patient Safety (Document Ref No: Policy/Quality and Patient Safety/V1.0)
24. DOH Provider's Policy Manual
25. DOH reference Quality Performance KPI Profile - Dec. 2015
26. DOH reference. Per Circular CEO 38/ 12
27. DOH Regulator Policy Manual
28. DOH Service Standards for Post-Acute Rehabilitation Services in the Emirate of Abu Dhabi
29. DOH Standard for Authorization of Homecare Health Services in the Emirate of Abu Dhabi Version 1.4 and Appendices
30. DOH Standard for Medical Billing Services in the Emirate of Abu Dhabi
31. DOH Standard for Provision of Long-Term Care in healthcare facilities in the Emirate of Abu Dhabi and Appendices
32. DOH Standards for Tele-consultation in the Emirate of Abu Dhabi
33. Health Information Management Concepts, Principles and Practice, current edition, AHIMA
34. ICD-10-CM Coding Handbook, With and Without Answers. *
35. Medical Dictionary
36. Medical Record, Health Information Retention and Disposal Policy
37. Shafafiya and related references such as in Data Dictionary on DoH website
38. The Merck Manual of Diagnosis and Therapy, edited by M. H. Beers, MD and R. Berkow, MD, Merck Research Laboratories

* Applicable to the code set in use at the time of coding and submission of claim.

Appendix B: AHIMA Code of Ethical Coding

Coding professionals should: [35]

1. Apply accurate, complete, and consistent coding practices that yield quality data.
2. Gather and report all data required for internal and external reporting, in accordance with applicable requirements and data set definitions.
3. Assign and report, in any format, only the codes and data that are clearly and consistently supported by health record documentation in accordance with applicable code set and abstraction conventions, and requirements.
4. Query and/or consult as needed with the provider for clarification and additional documentation prior to final code assignment in accordance with acceptable healthcare industry practices.
5. Refuse to participate in, support, or change reported data and/or narrative titles, billing data, clinical documentation practices, or any coding related activities intended to skew or misrepresent data and their meaning that do not comply with requirements.
6. Facilitate, advocate, and collaborate with healthcare professionals in the pursuit of accurate, complete and reliable coded data and in situations that support ethical coding practices.
7. Advance coding knowledge and practice through continuing education, including but not limited to meeting continuing education requirements.
8. Maintain the confidentiality of protected health information in accordance with the Code of Ethics.
9. Refuse to participate in the development of coding and coding related technology that is not designed in accordance with requirements.
10. Demonstrate behavior that reflects integrity, shows a commitment to ethical and legal coding practices, and fosters trust in professional activities.
11. Refuse to participate in and/or conceal unethical coding, data abstraction, query practices, or any inappropriate activities related to coding and address any perceived unethical coding related practices.

[35] AHIMA Code of Ethics