

CODES *and* TIDBITS

The Medical Coding Academy Monthly Newsletter

Men are assailed by the diseases that can affect anyone—heart disease, stroke, diabetes, cancer, depression... But they also have unique issues such as prostate cancer and benign prostate enlargement.

Many of the major health risks that men face can be prevented with a healthy lifestyle: regular exercise, a healthy diet, not smoking, stress reduction, and alcohol consumption in the moderate range (no more than two drinks a day) if at all. Regular checkups and screening tests can spot disease early, when it is easiest to treat.

The all-woman Medical Coding Academy Team gives as much importance to men's health. We are encouraging all men, and women, to get on board with protecting your health today. In this month's **Codes and Tidbits** newsletter, we are exploring on men's health



Melanie, VP of Coding Education



Donna, Training Manager of Medical Coding Academy



Joanna, Training Supervisor of Medical Coding Academy



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Shanda, Home Health Coding and Outpatient Coding Training Expert



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WHAT'S WHAT

by Melanie Kiss, VP of Coding Education

June is Men's Health Month that is observed to raise awareness of preventable health problems by early detection and treatment to improve the health and well-being of men and boys. Did you know that men typically live 6 years less than women? There are many diseases that affect men much more than women, such as heart disease and cancer. Another factor contributing to this early-death statistic is that men are not always willing/able to do preventative health checks that could potentially catch these diseases earlier.

The men in my life only go to the doctor for life-threatening events and are not good about scheduling their annual wellness visits. They also see it as a sign of weakness to visit the doctor for what they feel are minor conditions. My goal this month is to remind my dad, brothers, and other men I love to schedule their annual exam. It truly could save their lives!

Here are the top 10 causes of premature death in men:

1. Ischemic heart disease
2. Trachea and lung cancer
3. Strokes
4. Chronic lower respiratory diseases
5. Prostate cancer
6. Dementia and Alzheimer's disease
7. Colon and rectum cancer
8. Blood and lymph cancer, including leukemia
9. Diabetes
10. Suicide

Many of these above listed diseases are preventable, or at least treatable if found early. To all the men reading this newsletter, please take care of your health! Schedule your annual exam, listen to your body and get help when needed, and maintain a healthy lifestyle.



SOURCE:

<https://minorityhealth.hhs.gov/mens-health/index.html>

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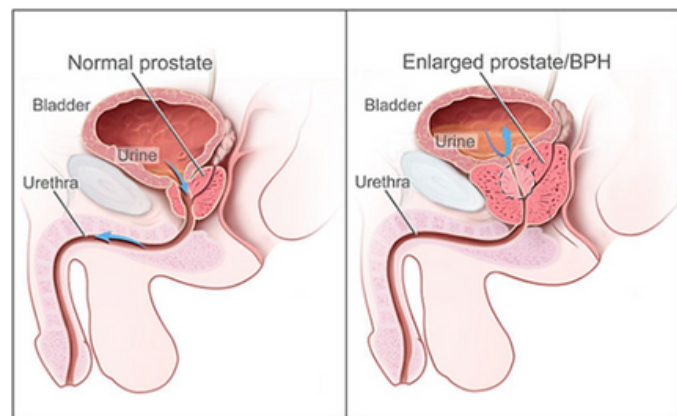
DID YOU KNOW?

by Nancy Serilo, *Training Supervisor of Medical Coding Academy*

June is National Men's Health Month! This month is all about encouraging the men in your life (including you, men out there!) to take care of their bodies by eating right, exercising, and working to prevent disease.

Benign Prostatic Hyperplasia (BPH)

BPH is nonmalignant adenomatous overgrowth of the periurethral prostate gland. Symptoms are those of bladder outlet obstruction—weak stream, hesitancy, urinary frequency, urgency, nocturia, incomplete emptying, terminal dribbling, overflow or urge incontinence, and complete urinary retention. Diagnosis is based primarily on digital rectal examination and symptoms; cystoscopy, transrectal ultrasonography, urodynamics, or other imaging studies may also be needed. Treatment options include 5 alpha-reductase inhibitors, alpha-blockers, tadalafil, and surgery.



Pathophysiology

Multiple fibroadenomatous nodules develop in the periurethral region of the prostate, probably originating within the periurethral glands rather than in the true fibromuscular prostate (surgical capsule), which is displaced peripherally by progressive growth of the nodules.

As the lumen of the prostatic urethra narrows and lengthens, urine outflow is progressively obstructed. Increased pressure associated with micturition and bladder distention can progress to hypertrophy of the bladder detrusor, trabeculation, cellule formation, and diverticula. Incomplete bladder emptying causes stasis and predisposes to calculus formation and infection. Prolonged urinary tract obstruction, even if incomplete, can cause hydronephrosis and compromise renal function.

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DID YOU KNOW? (CONTINUED)

Lower Urinary Tract Symptoms

Symptoms of benign prostatic hyperplasia (BPH) include a constellation of symptoms that are often progressive, known collectively as lower urinary tract symptoms (LUTS):

- Urinary frequency
- Urgency
- Nocturia
- Hesitancy
- Intermittency
- .Frequency, urgency, and nocturia are due to incomplete emptying and rapid refilling of the bladder.
- Decreased size and force of the urinary stream cause hesitancy and intermittency.

Pain and dysuria are usually not present. Sensations of incomplete emptying, terminal dribbling, overflow incontinence, or complete urinary retention may ensue. Straining to void can cause congestion of superficial veins of the prostatic urethra and trigone, which may rupture and cause hematuria.

Treatment

- Drug therapy - for partial obstruction with troublesome symptoms, all anticholinergics and sympathomimetics (many available in over the counter [OTC] preparations), and opioids should be stopped, and any infection should be treated with antibiotics. For patients with mild to moderate obstructive symptoms, alpha-adrenergic blockers (eg, terazosin, doxazosin, tamsulosin, alfuzosin) may decrease voiding problems. The 5 alpha-reductase inhibitors (finasteride, dutasteride) may reduce prostate size, decreasing voiding problems over months, especially in patients with larger (> 30 mL) glands. A combination of both classes of drugs is superior to monotherapy. For men with concomitant erectile dysfunction, daily tadalafil may help relieve both conditions. Many OTC complementary and alternative agents are promoted for treatment of BPH, but none, including the thoroughly studied saw palmetto, has been shown to be more efficacious than placebo.



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DID YOU KNOW? (CONTINUED)

- Surgery - is done when patients do not respond to drug therapy or develop complications such as recurrent urinary tract infection, urinary calculi, severe bladder dysfunction, or upper tract dilation. Transurethral resection of the prostate (TURP) is the standard. Erectile function and continence are usually retained, although about 5 to 10% of patients experience some acute postsurgical problems, most commonly retrograde ejaculation. The incidence of erectile dysfunction after TURP is between 1 and 35%, and the incidence of incontinence is about 1 to 3%. However, technical advances such as the use of a bipolar resectoscope, which allows use of saline irrigation, have greatly improved the safety of TURP by averting hemolysis and hyponatremia. About 10% of men undergoing TURP need the procedure repeated within 10 years because the prostate continues to grow. Various laser ablation techniques are being used as alternatives to TURP. Larger prostates (usually > 75 grams) traditionally require open surgery via a suprapubic or retropubic approach (currently, most surgeons prefer laparoscopy or robotic laparoscopic assistance to open surgery), although some newer techniques such as the holmium laser enucleation of the prostate (HoLEP) can be done transurethrally. All surgical methods require postoperative catheter drainage for 1 to 7 days.
- Other procedures - alternatives to TURP include microwave thermotherapy, electrovaporization, various laser techniques, high-intensity focused ultrasonography, transurethral needle ablation, radiofrequency vaporization, pressurized heated water injection therapy, urethral lift, steam injection therapy, and intraurethral stents. Prostatic artery embolization (PAE) is being evaluated for men with an enlarged prostate gland, particularly those with hematuria who are poor candidates for surgery.

Erectile Dysfunction (ED)

is the inability to attain or sustain an erection satisfactory for sexual intercourse. Most erectile dysfunction is related to vascular, neurologic, psychologic, and hormonal disorders; drug use can also be a cause. Evaluation typically includes screening for underlying disorders and measuring testosterone levels. Treatment options include oral phosphodiesterase inhibitors, intraurethral or extracavernous prostaglandins, vacuum erection devices, and surgical implants.



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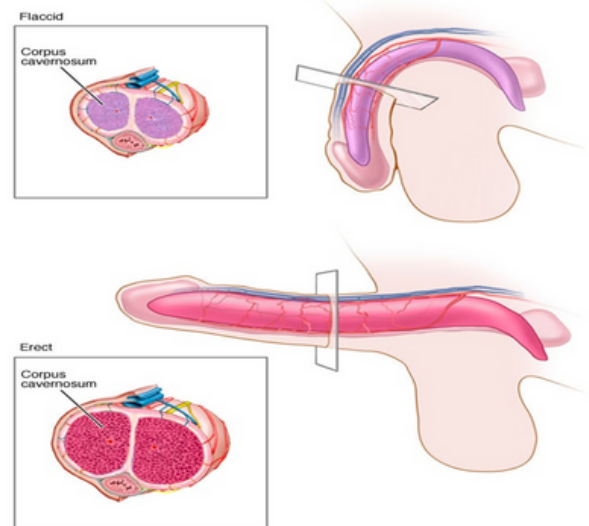
There are two types of ED:

- Primary ED - the man has never been able to attain or sustain an erection. This is rare and is almost always due to psychologic factors or clinically obvious anatomic abnormalities.
- Secondary ED - is more common, and > 90% of cases have an organic etiology. Many men with secondary ED develop reactive psychologic difficulties that compound the problem.

The major organic cause of ED are physiologic:

- Vascular disorders
- Neurologic disorders
- These disorders often stem from atherosclerosis or diabetes

The most common vascular cause is atherosclerosis of cavernous arteries of the penis, often caused by smoking, endothelial dysfunction, and diabetes. Atherosclerosis and aging decrease the capacity for dilation of arterial blood vessels and smooth muscle relaxation, limiting the amount of blood that can enter the penis. Endothelial dysfunction is a disease of the endothelial lining of the small arterioles that reduces the ability to vasodilate when needed to increase blood flow.



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DID YOU KNOW? (CONTINUED)

Endothelial dysfunction is a disease of the endothelial lining of the small arterioles that reduces the ability to vasodilate when needed to increase blood flow. Endothelial dysfunction appears to be mediated by reduced levels of nitric oxide and can result from smoking, diabetes, and/or low testosterone levels. Veno-occlusive dysfunction permits venous leakage, which results in inability to maintain erection.

Priapism, usually associated with trazodone use, cocaine abuse, and sickle cell disease, may cause penile fibrosis and lead to ED by causing fibrosis of the corpora cavernosa and thus impairment of the penile blood flow necessary for erection.

Neurologic causes include stroke, partial complex seizures, multiple sclerosis, peripheral and autonomic neuropathies, and spinal cord injuries. Diabetic neuropathy and surgical injury are particularly common causes.

Complications of pelvic surgery (eg, radical prostatectomy [even with nerve-sparing techniques], radical cystectomy, rectal cancer surgery) are other common causes. Occasionally, transurethral resection of the prostate is a cause. Other causes include hormonal disorders, drugs, pelvic radiation, and structural disorders of the penis (eg, Peyronie disease). Prolonged perineal pressure (as occurs during bicycle riding) or pelvic or perineal trauma can cause ED.

Any endocrinopathy or aging with testosterone deficiency (hypogonadism) may decrease libido and cause ED. However, erectile function only rarely improves with normalization of serum testosterone levels because most affected men also have neurovascular causes of ED.

Numerous drug causes are possible (see table Commonly Used Drugs That Can Cause Erectile Dysfunction). Alcohol can cause temporary ED.

Treatment of ED

- Drugs - usually oral phosphodiesterase inhibitors
- Vacuum erection device or self-administered intracavernosal or intraurethral prostaglandin E1 (2nd-line treatment)
- If other treatments fail, surgical implantation of penile prosthesis



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DID YOU KNOW? (CONTINUED)

Prostate Cancer

Prostate cancer is usually adenocarcinoma. Symptoms are typically absent until tumor growth causes hematuria and/or obstruction with pain. Diagnosis is suggested by digital rectal examination or prostate-specific antigen (PSA) measurement and confirmed by transrectal ultrasound biopsy.

Signs and Symptoms of Prostate Cancer

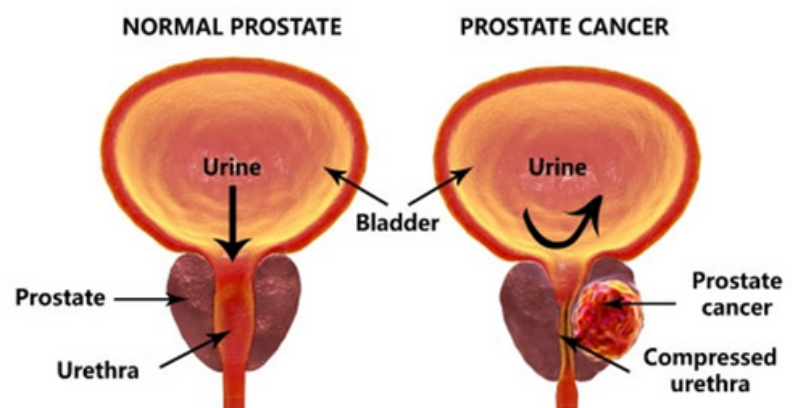
Prostate cancer usually progresses slowly and rarely causes symptoms until advanced. In advanced disease, hematuria, and symptoms of bladder outlet obstruction (eg, straining, hesitancy, weak or intermittent urine stream, a sense of incomplete emptying, terminal dribbling) or ureteral obstruction (eg, renal colic, flank pain, renal dysfunction) may appear. Bone pain, pathologic fractures, or spinal cord compression may result from osteoblastic metastases to bone (commonly pelvis, ribs, vertebral bodies).

Diagnosis of Prostate Cancer

- Screening by digital rectal examination (DRE) and prostate-specific antigen (PSA)
- Diagnosis by needle biopsy of the prostate (most common) or biopsy of metastatic lesion
- Grading by histology
- Staging by CT/MRI and bone scanning, possibly prostate-specific membrane antigen (PSMA)-based PET CT

Treatment of Prostate Cancer

- Radical prostatectomy (removal of prostate with seminal vesicles and regional lymph nodes) is probably best for patients < 75 years old with a tumor confined to the prostate. Prostatectomy is appropriate for some older men, based on life expectancy, coexisting disorders, and ability to tolerate surgery and anesthesia. Prostatectomy is done through an incision in the lower abdomen. Nerve-sparing radical prostatectomy reduces the likelihood of erectile dysfunction but cannot always be done, depending on tumor stage and location.



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DID YOU KNOW? (CONTINUED)

- Cryotherapy (destruction of prostate cancer cells by freezing with cryoprobes, followed by thawing) is less well established; long-term outcomes are unknown. Adverse effects include bladder outlet obstruction, urinary incontinence, erectile dysfunction, and rectal pain or injury.
- Brachytherapy involves the implantation of radioactive seeds into the prostate through the perineum. These seeds emit a burst of radiation over a finite period (usually 3 to 6 months) and are then inert. Brachytherapy also decreases erectile function, although onset may be delayed, and patients may be more responsive to phosphodiesterase type 5 inhibitors than patients whose neurovascular bundles are resected or injured during surgery. Urinary frequency, urgency, and, less often, retention is common but usually subside over time. Other adverse effects include increased bowel movements; rectal urgency, bleeding, or ulceration; and prostatic fistulas.
- HIFU (high-intensity focused ultrasound) uses intense ultrasound energy administered transrectally to ablate prostate tissue. The role of this technology in the management of prostate cancer is evolving; presently, it appears to be best suited for radiation-recurrent prostate cancer.
- Systemic therapies. If cancer has spread beyond the prostate gland, cure is unlikely; systemic treatment aimed at decreasing or limiting tumor extent is usually given.

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CAN YOU CODE ACCURATELY?

by Shanda Salting, Home Health and Outpatient Coding Training Expert

Here's last issue's correct code assignment. Did you get it right?

	Codes	Code description
Principal Diagnosis	F11.23	Opioid dependence with withdrawal
Secondary Diagnosis	F32.A	Depression, unspecified
Secondary Diagnosis	F41.9	Anxiety disorder, unspecified
Secondary Diagnosis	F17.210	Nicotine dependence, cigarettes, uncomplicated
Secondary Diagnosis	Z88.0	Allergy status to penicillin

HPI: Patient is a 57-year-old male who showed up at the ED complaining of Urinary Incontinence and frequent urination at night. He also states that he normally feels the urge to urinate and when he does go to visit the loo, he would either just have small amounts of urine or none, He expresses his frustration as he is not comfortable with it.

PAST MEDICAL HISTORY: BPH, HTN and chronic HFrEF

SOCIAL HISTORY: No alcohol. He used to Smoke 3 pack of cigarettes daily.

MEDICATIONS: Tamsulosin 0.4 mg orally once a day

REVIEW OF SYSTEMS

Constitutional: No fever, chills, or sweats. | Neuro: No headache, seizures, or syncope. | HEENT: No vision changes, no diplopia or hearing loss. No sore throat. | CV: No chest pain or palpitations. | Resp: No SOB, wheezing, cough, sputum production or hemoptysis. | GI: No abdominal pain. | Skin: No rashes. | Musculoskeletal: No myalgias or joint pain.

PHYSICAL EXAMINATION

Vitals: Stable. | General: Alert and oriented. No distress. | Extremities: WNL. | Neuro: Intact.

ASSESSMENT AND PLAN

BPH, Urinary overflow incontinence, nocturia - increase the dosage of Tamsulosin to 0.8 mg orally once a day, He will also receive skilled nursing and occupational therapy for bladder training and is advised to consider TURP.

Feel free to send in your answers to
MedicalCodingAcademyTrainingTeam@swhealth.com

the correct code assignment will be released in the next Codes and Tidbits issue!



CODES *and* TIDBITS

The Medical Coding Academy Monthly Newsletter

TALK CODING TO ME

by Celine Villadares, Risk Adjustment and Outpatient Coding Training Expert

Talk Coding To Me is an article that provides you coding tips, tricks, and best practices from your Medical Coding Academy Team.

Atypical Small Acinar Proliferation

Atypical small acinar proliferation (ASAP) is a pathological finding of a group of small prostatic glands that are suspicious for, but not diagnostic of, malignancy. Although ASAP implies an underlying carcinoma, the condition is not diagnosable because of qualitative or quantitative criteria falling below a threshold for malignancy. ASAP is not thought of as a pre-malignancy or a carcinoma in situ; but rather a diagnosis of uncertainty that may actually increase a man's risk of ultimately developing prostate cancer.

Code N42.3 has been expanded to uniquely identify the following:

- **N42.30** Unspecified dysplasia of prostate
- **N42.31** Prostatic intraepithelial neoplasia
- **N42.32** Atypical small acinar proliferation of prostate
- **N42.39** Other dysplasia of prostate

Resources:
 ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2016 Page: 44 Effective with discharges:
 October 1, 2016

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TALK CODING TO ME

by Joanna Adriano, *Training Supervisor of Medical Coding Academy*

Talk Coding To Me is an article that provides you coding tips, tricks, and best practices from your Medical Coding Academy Team.

Prostate Disease

Diseases of the male genital organs are classified in categories N40 through N53, with conditions of the prostate using categories N40 through N42. Neoplasms of the prostate are classified elsewhere, as follows:

- C61 Malignant neoplasm of the prostate
- D29.1 Benign neoplasm of the prostate
- D07.5 In situ neoplasm of the prostate

Hyperplasia of the prostate is classified to category N40, Benign prostatic hyperplasia, with fourth characters providing additional specificity regarding the presence or absence of lower urinary tract symptoms. As indicated by the "use additional code" note under code N40.1, an additional code should be assigned to identify associated symptoms when specified, such as:

- incomplete bladder emptying (R39.14),
- nocturia (R35.1), straining on urination (R39.16),
- urinary frequency (R35.0), urinary hesitancy (R39.11),
- urinary incontinence (N39.4-), urinary obstruction (N13.8),
- urinary retention (R33.8), urinary urgency (R39.15), or
- weak urinary stream (R39.12).

Category N41 classifies inflammatory disease of the prostate as follows:

- N41.0 Acute prostatitis
- N41.1 Chronic prostatitis
- N41.2 Abscess of prostate
- N41.3 Prostatocystitis
- N41.4 Granulomatous prostatitis



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TALK CODING TO ME (CONTINUED)

- N41.8 Other inflammatory diseases of prostate
- N41.9 Inflammatory disease of prostate, unspecified

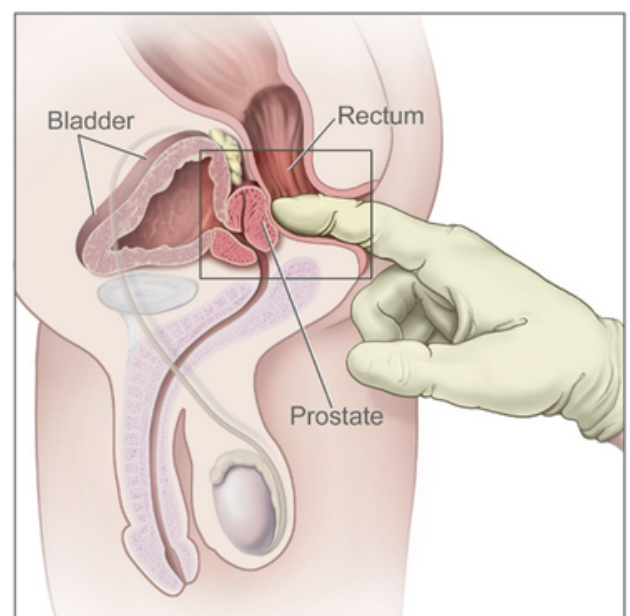
Category N42 classifies other disorders of the prostate with such conditions as follows:

- N42.0 Calculus of prostate
- N42.1 Congestion and hemorrhage of prostate
- N42.3 Dysplasia of prostate
- N42.81 Prostatodynia syndrome
- N42.82 Prostatosis syndrome
- N42.83 Cyst of prostate
- N42.89 Other specified disorders of prostate
- N42.9 Disorder of prostate, unspecified

Codes for Prostate Cancer Screening

As prostate screening is one of the most common procedures performed in urology practices, correct coding of the procedure and diagnosis is crucial for accurate claim submission and reimbursement.

There are two types of PSA tests: screening and diagnostic. Screening PSA tests are performed in the absence of signs or symptoms of prostate cancer. Diagnostic PSA tests are performed when the patient has signs or symptoms. Coding for screening and diagnostic PSA tests can be challenging as the requirements differ among payers, including Medicare.



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TALK CODING TO ME (CONTINUED)

If a diagnostic PSA test is performed, report the following codes based on the results:

- R97.20 – Elevated prostate specific antigen (PSA)
- N40.0 – Benign prostatic hyperplasia without lower urinary tract symptoms
- N40.1 – Benign prostatic hyperplasia with lower urinary tract symptoms

For PSA determinations, Medicare may also consider payment for urological sign or symptoms, such as:

- R31.0 – Gross hematuria
- R31.1 – Benign essential microscopic hematuria
- R35.0 – Frequency of micturition
- R35.1 – Nocturia

The overall goal of cancer screening is to reduce the number of people who die from the disease, lower the number of people who develop the disease, and eliminate deaths from cancer altogether. Following payer guidelines and knowing local coverage determinations (LCDs) for screening frequency limits and diagnostic codes is crucial for accurate screening and diagnostic PSA testing. Providers should ensure proper documentation in the patient's record to support the coding.



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INCREDIBLE CODING DUDE (ICD)

by Donna Abigail Della, *Training Manager of Medical Coding Academy*

Our Incredible Coding Dude for June 2023 is none other than **Alderic Lacambra** from QA!

Read below as Alderic shares his career story - starting as a Medical Coding Academy scholar and then working his way up to be a QA Specialist of Paterson.

Alderic, tell us something about yourself.

I'm Alderic S. Lacambra, a Quality Audit Specialist of Paterson SDS-Obs at Shearwater Health. Shearwater opened the doors and paved the way for where I am now in the medical coding industry.

How long have you been with Shearwater Health?

I have been with Shearwater Health for almost 2 years now.



I joined the Medical Coding Academy in January of 2022 and I got my AAPC CPC coding license two months after. But before Shearwater, I was a Fire Master Sergeant at the Bureau of Fire Protection (BFP) of Makati City.

What has your experience been with our company culture?

Shearwater Health is my first employment in the corporate world after my BFP career. I always believed that company culture makes a great team, and I found that in Shearwater Health. What I admire the most in Shearwater is the teamwork. Most of the teams that I have worked with are working closely together as one to to achieve the same goal. Although we are from different departments (QA and Ops), we all have the same goal. I think that's one of the many contributing factors to keep an employee.



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INCREDIBLE CODING DUDE (ICD) (CONTINUED)



What was the moment you knew that you had made the right decision to work here?

When I joined Shearwater, I was a bit terrified of my career path since it was new to me. Comparing my work experience from those of my batchmates, I had the least experience in medical coding, and that made me feel intimidated. Surprisingly, after the MCA program, I was informed that I was the top student in our class. All the worries have been replaced by excitement. This was the time that I felt I had made the right decision. I knew that I can be a greater contribution to the company.

What is your favorite thing about working in Shearwater?

My responsibility as a QA specialist is very challenging. However, I like what I do now. I am never bored. Since I need to be fully adept to new client guidelines and processes, learning never stops, and it keeps things interesting as I learn new things everyday. Aside from that, I have a good working environment because of my colleagues and workplace.

What are you most proud of?

As a rookie to the corporate world, and considering my zero experience in medical coding, my greatest accomplishment has to be graduating top of our MCA class and promoted as a QA specialist, all in a span of one year. This experience has taught me the value of asking for help because as soon as I expressed my intent to learn and improve, my superiors supported me all the way. I am proud of myself for committing to improve despite any self-doubt.

"I am proud of myself for committing to improve despite any self-doubt."



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INCREDIBLE CODING DUDE (ICD) (CONTINUED)

Tell us about your career progression

After my career as a firefighter at BFP for a decade, I decided to transition into medical coding. I was a newbie in this field, so I had to study everything. After I graduated MCA, I was identified to join the Paterson SDS-Obs Team. At this point, we had new KPIs to follow. We were expected to carry out Shearwater's quality work. A few months of being consistent in my performances, I was asked by our team lead if I wanted to become the team's POC. I knew it was a huge responsibility, but I knew that if I kept stacking on different experiences and remained open to possibilities, I would be ready for the next opportunity. After a year, an opportunity opened, and I am now a QA specialist for Paterson SDS-OBS. Do you want to know how I did this? Force growth on yourself. Embrace the uncomfortable and lastly, ask and listen to feedback from leaders and colleagues.



How have you benefited from Medical Coding Academy?

The Medical Coding Academy is where I learned everything I know about medical coding. For somebody like me who had no medical coding experience, joining the Academy made it easier for me to understand the processes and guidelines. I find everything that was taught to me in the Academy is still relevant and will remain relevant throughout my career in medical coding.

What have you learned from Medical Coding Academy?

The MCA training program is a good opportunity for both tenured and newbies like me in the medical coding industry to expand our knowledge. The MCA Training Program has helped me prepare myself for the real world of medical coding. In this program, we were taught the general coding guidelines, procedural coding for different body systems, level II modifiers, etc. These are my key takeaways from MCA as these topics have been very helpful on my career when I was a medical coder and even became more essential when I became a QA.

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INCREDIBLE CODING DUDE (ICD) (CONTINUED)



What was your life like before joining MCA? How is your life like now?

Before I joined MCA, I was a public servant focused on ensuring people's safety. At my previous work, we were guided by the motto “safe system saves lives” and one must possess the skills to be ready to go into the field. During MCA, I can say that it’s no different. The Academy thoroughly prepares all its students into the real world of medical coding where the lives of people is also in our hands through our gained knowledge and accuracy in mapping diagnoses and procedures.

Can you describe how you felt when you started the MCA program?

I was excited for the endless possibilities of gaining new knowledge and skills. I knew that the MCA program would be relevant to my incoming role and responsibilities. I expected that the training program would provide me one of the best learning experiences as the whole idea of medical coding is new to me.



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INCREDIBLE CODING DUDE (ICD) (CONTINUED)

Was there a particular moment or memory that stands out for you while in the program?

I was able to get a good grasp of what medical coding is all about because of the MCA program. Aside from the knowledge and skills I gained, what stood out the most was the methodology of the training program during my time with the Academy. We were part of the hybrid group during the pandemic to which we were trained to be more independent. It was a combination of listening and doing. For me, the best way to help root information is through practical tasks, discussions, etc.

What advice would you give to someone starting out in the Medical Coding Academy?

The MCA is a good opportunity for everyone who is starting their medical coding career. My advice to the newcomers is to unload half of your cup before training to make room for new learnings. Allow yourselves to explore and do not fear making mistakes during training. This is the training ground where asking questions is free. Maximize your resources as they are readily available to you.

I am a nurse by profession, and I thought it would not be a rocket science for this new career. When I started MCA, it was a bit of a challenge to familiarize yourself with the guidelines and processes of medical coding as they are overwhelmingly new. I will share a few of the techniques I used to overcome the challenges. LISTEN and ASK QUESTIONS - If there's a key concept that you just don't quite get, don't be afraid to ask your trainer. Also, if you have spare time, study the topics. Studying will help you learn the topic faster and make use of the resources provided to you.



I enjoyed creating this article for you, Alderic! Thank you for sharing your story with us! You are inspiration to all! Keep up that fighting spirit and never stop learning! Your MCA family is proud of you!