CHAPTER OUTLINE

ICD-9-CM Legacy Coding System
Overview of ICD-10-CM and ICD-10-PCS
ICD-10-CM Coding Conventions
ICD-10-CM Index to Diseases and Injuries

ICD-10-CM Tabular List of Diseases and Injuries
Official Guidelines for Coding and Reporting

CHAPTER OBJECTIVES

Upon successful completion of this chapter, you should be able to:

1. Define key terms.
2. Use ICD-9-CM as a legacy coding system and interpret general equivalency mappings.
3. Describe the purpose and use of the ICD-10-CM and ICD-10-PCS coding systems.
4. Interpret ICD-10-CM coding conventions to accurately assign codes.
5. Interpret diagnostic coding and reporting guidelines for outpatient services.
6. Assign ICD-10-CM codes to outpatient and provider-based office diagnoses.

KEY TERMS

benign
in
carcinoma (Ca) in situ in diseases classified elsewhere
cat
computer-assisted coding (CAC) includes note
contiguous sites manifestation
colon not elsewhere classifiable (NEC)
Cooperating Parties for ICD-10-CM/PCS not otherwise specified (NOS)
encoder other and other specified code
essential modifier parentheses
excludes1 note
encoder
etiology and manifestation rules see
first-listed diagnosis see also
first-listed diagnosis see category
first-listed diagnosis general equivalency mapping (GEM)
general equivalency mapping (GEM) in diseases classified elsewhere
iatrogenic illness includes note
ICD-10-CM coding conventions manifestation
code first underlying disease not elsewhere classifiable (NEC)
code, if applicable, any causal other and other specified code
condition first parentheses
colon not otherwise specified (NOS)
due to other specified code
eponym parentheses
Excludes1 note
Excludes2 note parentheses
seesee category

Not For Sale
INTRODUCTION

There are four related classifications of diseases with similar titles.

- The International Classification of Diseases (ICD) is published by the World Health Organization (WHO) and is used to classify mortality (death) data from death certificates. In 1994, WHO published the 10th revision of ICD with a new name, International Statistical Classification of Diseases and Related Health Problems, and reorganized its three-digit categories. (Although the name of the publication was changed, the familiar abbreviation ICD remains in use.)

- The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) was developed in the United States and implemented in 1979 to code and classify morbidity (disease) data from inpatient and outpatient records, including provider-based office records.

- The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) was developed in the United States and is used to classify morbidity (disease) data from inpatient and outpatient records, including provider-based office records.

- The International Classification of Diseases, 10th Revision, Procedure Classification System (ICD-10-PCS) was developed in the United States and is used to code and classify procedures from inpatient records only.

CODING TIP:

- ICD-10-CM and ICD-10-PCS, also abbreviated as ICD-10-CM/PCS, will replace ICD-9-CM on October 1, 2013.

- All provider offices, outpatient health care settings (e.g., home health care, hospice), and healthcare facilities (e.g., hospitals, long-term care facilities) will report ICD-10-CM diagnosis codes.
The health insurance specialist employed in a provider’s office assigns ICD-10-CM codes to diagnoses, conditions, signs, and symptoms documented by the healthcare provider. Reporting ICD-10-CM codes on insurance claims results in uniform reporting of medical reasons for healthcare services provided. (CPT and HCPCS level II codes are reported to the provider’s office and outpatient health care setting procedures and services; Chapters 7 and 8 of this textbook cover those coding systems.)

ICD-9-CM LEGACY CODING SYSTEM

Effective October 1, 2013, when the ICD-10-CM (and ICD-10-PCS) coding systems are implemented, the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) will become a legacy coding system (or legacy classification system), which means it will be used to archive data but will no longer be supported or updated by the ICD-9-CM Coordination and Maintenance Committee. However, because ICD-9-CM has been used since 1979 in the United States to classify inpatient and outpatient/provider-based office diagnoses (Volumes 1 and 2) and inpatient procedures (Volume 3), general equivalency mappings (GEMs) (discussed in the following text) will be annually published by the National Center for Health Statistics (NCHS) and Centers for Medicare and Medicaid Services (CMS).

ICD-9-CM is over 30 years old, has outdated and obsolete terminology, uses outdated codes that produce inaccurate and limited data, and is inconsistent with current medical practice. It cannot accurately describe diagnoses or inpatient procedures of care delivered in the twenty-first century. ICD-9-CM does not provide the necessary detail about patients’ medical conditions or procedures performed on hospitalized inpatients; thus, effective October 1, 2013, provider-based offices and healthcare facilities (e.g., hospitals) will use ICD-10-CM to code diagnoses. (Hospitals will use ICD-10-PCS to code...
inpatient procedures. Provider-based offices and outpatient health care settings will continue to use CPT and HCPCS level II to code procedures and services.

**General Equivalency Mappings (GEMs)**

The National Center for Health Statistics (NCHS) and Centers for Medicare and Medicaid Services (CMS) annually publish *general equivalency mappings (GEMs)*, which are translation dictionaries or crosswalks of codes that can be used to roughly identify ICD-10-CM codes for their ICD-9-CM equivalent codes (and vice versa). (GEMs published by the NCHS and CMS do not contain code descriptions; however, other publishers include code descriptions to facilitate code translation.) GEMs facilitate the location of corresponding diagnosis codes between two code sets. In some areas of the classification, the correlation between codes is close; since the two code sets share the conventions of organization and formatting common to both revisions of ICD, translating between them is straightforward.

1. Some states will also require reporting of ICD-10-PCS codes.
**EXAMPLE:** There is straightforward correspondence between the two code sets for infectious diseases, neoplasms, eye diseases, and ear diseases.

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Code and Description</th>
<th>ICD-10-CM Diagnosis Code and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>003.21 Salmonella meningitis</td>
<td>A02.21 Salmonella Meningitis</td>
</tr>
<tr>
<td>205.01 Acute myeloid leukemia in remission</td>
<td>C92.01 Acute myeloid leukemia, in remission</td>
</tr>
</tbody>
</table>

**EXAMPLE:** In other areas of the two code sets, such as obstetrics, entire chapters are organized according to a different axis of classification. Translating between them offers a series of possible codes that must be verified in the appropriate tabular list (ICD-9-CM or ICD-10-CM) or table of codes (ICD-10-PCS) to identify the correct code. (Think about translating the English language into Chinese or any other foreign language, and you will see the problems inherent in such translation.)

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Code and Description</th>
<th>ICD-10-CM Diagnosis Code and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>649.51 Spotting complicating pregnancy, delivered, with or without mention of antepartum condition</td>
<td>026.851 Spotting complicating pregnancy, first trimester</td>
</tr>
<tr>
<td></td>
<td>026.852 Spotting complicating pregnancy, second trimester</td>
</tr>
<tr>
<td></td>
<td>026.853 Spotting complicating pregnancy, third trimester</td>
</tr>
</tbody>
</table>

**Partial Code Freeze**

CMS implemented a *partial code freeze* because continuous updates and changes to existing (ICD-9-CM) and new (ICD-10-CM and ICD-10-PCS) code sets have the potential to make the transition to ICD-10-CM/PCS difficult.

- Regular code updates to ICD-9-CM, ICD-10-CM, and ICD-10-PCS were discontinued October 1, 2011.
- *Limited* code updates will be made to all code sets to capture new technology and new diseases only beginning October 1, 2012.
- All code updates to ICD-9-CM will discontinue effective October 1, 2013, because that classification system will no longer be a HIPAA standard.
- Regular code updates to ICD-10-CM and ICD-10-PCS will resume effective October 1, 2013, because those classifications become the HIPAA standard.
EXERCISE 6B-1

ICD-9-CM LEGACY CODING SYSTEM

Instructions: Complete each statement.

1. Effective October 1, 2013, when ICD-10-CM and ICD-10-PCS are implemented, the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) will become a ________.

2. The NCHS and CMS will publish _______ to facilitate the location of corresponding diagnosis codes between ICD-9-CM and ICD-10-CM.

3. ICD-9-CM was the classification (or coding) system used since _______ in the United States to classify inpatient and outpatient/provider-based office diagnoses (Volumes 1 and 2) and inpatient procedures (Volume 3).

4. Because ICD-9-CM is over 30 years old, it contains _______, uses outdated codes that produce inaccurate and limited data, and is inconsistent with current medical practice.

5. CMS implemented a _______ because continuous updates and changes to existing (ICD-9-CM) and new (ICD-10-CM and ICD-10-PCS) code sets have the potential to make the transition to ICD-10-CM/PCS difficult.

6. When an ICD-9-CM code maps to a single ICD-10-CM code, reviewing the tabular list to validate the code is optional. (TRUE or FALSE)

Instructions: Use the diagnosis GEM depicted in the following table to complete each statement.

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Code and Description</th>
<th>ICD-10-CM Diagnosis Code and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>078.81 Epidemic vertigo</td>
<td>A88.1 Epidemic vertigo</td>
</tr>
<tr>
<td>078.82 Epidemic vomiting syndrome</td>
<td>R11.11 Vomiting without nausea</td>
</tr>
<tr>
<td>078.88 Other specified diseases due to <em>Chlamydiae</em></td>
<td>A74.89 Other <em>chlamydial</em> diseases</td>
</tr>
<tr>
<td>078.89 Other specified diseases due to viruses</td>
<td>A96.2 Lassa fever</td>
</tr>
<tr>
<td></td>
<td>A98.3 Marburg virus disease</td>
</tr>
<tr>
<td></td>
<td>A98.4 Ebola virus disease</td>
</tr>
<tr>
<td></td>
<td>B33.8 Other specified viral diseases</td>
</tr>
</tbody>
</table>

7. ICD-9-CM code 078.81 maps to ICD-10-CM code(s) ________.

8. ICD-9-CM code 078.89 maps to ICD-10-CM code(s) ________.

9. ICD-10-CM code A74.89 maps to ICD-9-CM code(s) ________.

10. ICD-10-CM code B33.8 maps to ICD-9-CM code(s) ________.
OVERVIEW OF ICD-10-CM AND ICD-10-PCS

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) is a clinical modification of WHO’s International Classification of Diseases, 10th Revision (ICD-10) that will be used to code and classify disease data from inpatient and outpatient records. The International Classification of Diseases, 10th Revision, Procedure Classification System (ICD-10-PCS) will be used to code and classify procedure data from inpatient records only. The Centers for Medicare and Medicaid Services (CMS) abbreviates ICD-10-CM and ICD-10-PCS as ICD-10-CM/PCS.

ICD-10-CM includes many more codes and applies to more users than ICD-9-CM because it is designed to collect data on every type of healthcare encounter (e.g., inpatient, outpatient, hospice, home health care, and long-term care). ICD-10-CM also enhances accurate payment for services rendered and facilitates evaluation of medical processes and outcomes. The term clinical emphasizes the modification’s intent, which is to:

- Describe the clinical picture of the patient, which means codes are more precise (when compared with classification systems designed for statistical data groupings and healthcare trend analysis, such as ICD-9-CM).
- Serve as a useful tool in the area of classification of morbidity data for indexing patient records, reviewing quality of care, and compiling basic health statistics.

ICD-10-CM was developed by the Centers for Disease Control and Prevention (CDC) for use in all U.S. healthcare treatment settings. ICD-10-CM codes require up to seven characters, are entirely alphanumeric, and have unique coding conventions (e.g., Excludes1 and Excludes2 notes).

CODING TIP:

The format of ICD-10-CM is similar to ICD-9-CM Volumes 1 and 2 in that both coding systems use a disease index to initially locate codes for conditions and a tabular list to verify codes.

ICD-10-CM and ICD-10-PCS (Figure 6B-1) incorporate much greater specificity and clinical information, which results in:

- Decreased need to include supporting documentation with claims.
- Enhanced ability to conduct public health surveillance.
- Improved ability to measure healthcare services.
- Increased sensitivity when refining grouping and reimbursement methodologies.

ICD-10-CM and ICD-10-PCS also include updated medical terminology and classification of diseases, provide codes to allow for the comparison of mortality and morbidity data, and provide better data for:

- Conducting research.
- Designing payment systems.
- Identifying fraud and abuse.
- Making clinical decisions.
- Measuring care furnished to patients.
- Processing claims.
- Tracking public health.
To prepare for implementation of ICD-10-CM/PCS, healthcare professionals should assess their coding staff to determine their needs and offer appropriate education and training to:

- Apply advanced knowledge of anatomy and physiology, medical terminology, and pathophysiology.
- Effectively communicate with members of the medical staff (e.g., physician queries).
- Interpret patient record documentation (e.g., operative reports).
- Interpret and apply coding guidelines that apply to the assignment of ICD-10-CM/PCS codes.

**CODING TIP:**

When coders have questions about documented diagnoses or procedures/services, they should use a **physician query process** to contact the responsible physician to request clarification about documentation and the code(s) to be assigned. The process is activated when the coder notices a problem with documentation quality (e.g., an incomplete diagnostic statement when clinical documentation indicates that a more specific ICD-10-CM code should be assigned). (Chapter 1 of Delmar's 3-2-1 Code It! by Michelle A. Green contains detailed content about the physician query process.)

**Comparing ICD-10-CM to ICD-9-CM**

ICD-10-CM far exceeds ICD-9-CM in the number of codes provided, having been expanded to (1) include health-related conditions, (2) provide much greater specificity at the sixth digit level, and (3) add a seventh digit extension (for some codes). Assigning the sixth and seventh characters when available for ICD-10-CM codes is mandatory because they report information documented in the patient record.
### ICD-9-CM Tabular List of Diseases

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>707.0</td>
<td>Pressure ulcer</td>
</tr>
<tr>
<td>707.03</td>
<td>Lower back</td>
</tr>
<tr>
<td>707.23</td>
<td>Pressure ulcer stages</td>
</tr>
<tr>
<td>707.23</td>
<td>Pressure ulcer stage III</td>
</tr>
</tbody>
</table>

### ICD-10-CM Tabular List of Diseases and Injuries

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L89.13</td>
<td>Pressure ulcer of right lower back</td>
</tr>
<tr>
<td>L89.130</td>
<td>Pressure ulcer of right lower back, unstageable</td>
</tr>
<tr>
<td>L89.131</td>
<td>Pressure ulcer of right lower back, stage I</td>
</tr>
<tr>
<td>L89.132</td>
<td>Pressure ulcer of right lower back, stage II</td>
</tr>
<tr>
<td>L89.133</td>
<td>Pressure ulcer of right lower back, stage III</td>
</tr>
<tr>
<td>L89.134</td>
<td>Pressure ulcer of right lower back, stage IV</td>
</tr>
<tr>
<td>L89.139</td>
<td>Pressure ulcer of right lower back, unspecified stage</td>
</tr>
</tbody>
</table>

**Example:** The diagnosis is “mechanical breakdown of femoral arterial graft, initial encounter.” In ICD-9-CM, just one code is available for any mechanical complication of a vascular graft. In ICD-10-CM, a combination code is reported, and the right side is classified.

- ICD-9-CM: 996.1
- ICD-10-CM: T82.312A

In ICD-9-CM, just one code classifies mechanical complications of vascular grafts. ICD-10-CM contains a greatly expanded number of codes because over 150 codes are available to classify mechanical complications of vascular grafts according to type of complication and/or type of graft (which also indicates the location of the graft).
ICD-10-PCS

ICD-10-PCS is an entirely new procedure classification system that was developed by CMS for use in inpatient hospital settings only, and it replaces Volume 3 of ICD-9-CM on October 1, 2013. ICD-10-PCS uses a multiaxial seven-character alphanumeric code structure (e.g., 047K04Z) that provides a unique code for all substantially different procedures. It also allows new procedures to be easily incorporated as new codes. ICD-10-PCS has more than 87,000 seven-character alphanumeric procedure codes. (ICD-9-CM has about 4,000 three- or four-digit numeric procedure codes.)

**Coding Tip:**

In ICD-10-PCS, multiaxial means the codes contain independent characters, with each axis retaining its meaning across broad ranges of codes to the extent possible. (There is no decimal used in ICD-10-PCS codes. ICD-9-CM procedure codes contain three to four digits, including a decimal, such as 39.50.)

**Coding Manuals**

Many publishers produce their own versions of ICD-10-CM and ICD-10-PCS:

- ICD-10-CM is published as a single-volume coding manual, with the Index to Diseases and Injuries located in front of the Tabular List of Diseases and Injuries.
- ICD-10-PCS is published as a separate single-volume coding manual, with the Index to Procedures located in front of the tables.
Some companies also publish **encoders**, which automate the coding process. This means that computerized or Web-based software (Figure 6B-2) is used instead of coding manuals. (Coders use the software’s Search feature to locate and verify codes.)

### Updating ICD-10-CM and ICD-10-PCS

The National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS) are the U.S. Department of Health and Human Services (DHHS) agencies that comprise the **ICD-10-CM/PCS Coordination and Maintenance Committee**. That committee is responsible for overseeing all changes and modifications to ICD-10-CM (diagnosis) and ICD-10-PCS (procedure) codes. It also discusses issues such as the creation and update of general equivalency mappings (GEMs).

- NCHS works with the World Health Organization (WHO) to coordinate official disease classification activities for ICD-10-CM, including the use, interpretation, and periodic revision of the classification system.
- CMS is responsible for annually revising and updating the ICD-10-PCS procedure classification.
- Updates to ICD-10-CM and ICD-10-PCS are available at the official CMS (www.cms.hhs) and NCHS (www.cdc.gov/nchs) Web sites.
- A CD-ROM version of the code sets that contain official coding guidelines are available for purchase from the U.S. Government Bookstore (bookstore.gpo.gov).

The **Medicare Prescription Drug, Improvement, and Modernization Act (MMA)** requires all code sets (e.g., ICD-9-CM, ICD-10-CM/PCS) to be valid at the time services are provided. This means that midyear (April 1) and end-of-year (October 1) coding updates must be implemented immediately so accurate codes are reported on claims.

It is crucial that updated coding manuals be purchased and/or billing systems be updated with coding changes so that billing delays (e.g., due to waiting for new coding manuals to arrive) and claims rejections are avoided. If outdated codes are submitted on claims, providers and healthcare facilities will incur...
administrative costs associated with resubmitting corrected claims and delayed reimbursement for services provided.

- Updateable coding manuals are available from publishers as a subscription service, and they are usually stored in a three-ring binder so outdated pages can be removed and new pages can be added.
- Encoder software is also available as a subscription service. Coders routinely download the most up-to-date encoder software, which contains edits for new, revised, and discontinued codes. An encoder automates the coding process using computerized or Web-based software; instead of manually looking up conditions (or procedures) in the coding manual index, the coder uses the software’s search feature to locate and verify diagnosis and procedure codes.
- Automating the medical coding process is the goal of computer-assisted coding (CAC), which uses a natural language processing engine to “read” patient records and generate ICD-9-CM and HCPCS/CPT codes. Because of this process, coders become coding auditors, responsible for ensuring the accuracy of codes reported to payers. (CAC can be compared to speech recognition technology that has transitioned the role of medical transcriptionists in certain fields, such as radiology, to that of medical editors.)

ICD-10 Alert!
A partial freeze of all code sets prior to implementation of ICD-10-CM/PCS on October 1, 2013, will be implemented, as follows:
- Last regular annual update to all code sets (October 1, 2011).
- Limited annual updates to all code sets to capture new technology and new diseases (October 1, 2012).
- No new updates to ICD-9-CM because it will no longer be a HIPAA standard (October 1, 2013).
- Start of regular annual updates to ICD-10-CM and ICD-10-PCS (October 1, 2014).

Mandatory Reporting of ICD-10-CM and ICD-10-PCS Codes

Medical Necessity
Today’s concept of medical necessity determines the extent to which individuals with health conditions receive healthcare services. (The concept was introduced in the 1970s when health insurance contracts intended to exclude care, such as voluntary hospitalizations prescribed primarily for the convenience of the provider or patient.) Reporting diagnosis codes (ICD-10-CM) ensures the medical necessity of procedures and services (CPT/HCPCS level II) provided to patients during an encounter. Medicare defines medical necessity as “the determination that a service or procedure rendered is reasonable and necessary for the diagnosis or treatment of an illness or injury.” If it is possible that scheduled tests, services, or procedures may be found “medically unnecessary” by Medicare, the patient must sign an advance beneficiary notice (ABN), which acknowledges patient responsibility for payment if Medicare denies the claim. (Chapter 14 contains a complete explanation about the ABN, including a sample form.)

Coding Tip:
Be sure to clarify the definition of medical necessity by insurance companies (other than Medicare), because the definition can vary.
An encounter is a face-to-face contact between a patient and a healthcare provider (e.g., physician, nurse practitioner) who assesses and treats the patient's condition. Thus, medical necessity is the measure of whether a healthcare procedure or service is appropriate for the diagnosis and/or treatment of a condition. This decision-making process is based on the third-party payer contractual language and treating provider documentation. Generally, the following criteria are used to determine medical necessity:

- **Purpose.** The procedure or service is performed to treat a medical condition.
- **Scope.** The most appropriate level of service is provided, taking into consideration potential benefit and harm to the patient.
- **Evidence.** The treatment is known to be effective in improving health outcomes.
- **Value.** The treatment is cost-effective for this condition when compared to alternative treatments, including no treatment.

**EXAMPLE:** A 70-year-old male patient with type I diabetes mellitus is treated at the physician’s office for severe wrist pain resulting from a fall. When the physician asks the patient whether he has been regularly taking his insulin and checking his blood glucose levels, the patient says that most of the time he takes his insulin and sometimes he forgets to check his blood glucose levels. The physician orders a blood glucose test to be done in the office, which reveals elevated blood glucose levels. The physician provides counseling and education to the patient about the importance of taking his daily insulin and checking his blood glucose levels. The physician also orders an x-ray of the wrist, which proves to be negative for a fracture. The physician provides the patient with a wrist brace and instructs the patient to follow up in the office within four weeks.

The insurance specialist reports ICD-10-CM codes for type I diabetes mellitus and sprained wrist along with HCPCS/CPT codes for an office visit, blood glucose lab test, and the wrist brace. If the only diagnosis reported on the claim was a sprained wrist, the blood glucose lab test would be rejected for payment by the insurance company as an unnecessary medical procedure.

**EXERCISE 6B-2**

**Overview of ICD-10-CM and ICD-10-PCS**

Instructions: Complete each statement.

1. The *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM) will be used to code and classify ________.

2. The *International Classification of Diseases, 10th Revision, Procedure Classification System* (ICD-10-PCS) will be used to code and classify ________.

3. The Centers for Medicare and Medicaid Services (CMS) abbreviates ICD-10-CM and ICD-10-PCS as ________.

4. ICD-10-CM includes many more codes and applies to more users than ICD-9-CM because it is designed to collect data on every type of healthcare encounter, which includes ________.
ICD-10-CM CODING CONVENTIONS

ICD-10-CM coding conventions are general rules used in the classification, and they are independent of coding guidelines (covered later in this chapter and located at the Student Resources online companion). The conventions are incorporated into ICD-10-CM as instructional notes, and they include the following:

- Format and typeface
- Eponyms
- Abbreviations
- Punctuation
- Tables
- Includes notes, excludes notes, and inclusion terms
- Other, other specified, and unspecified codes
- Etiology and manifestation rules
- And
- Due to
- With
- Cross-references, including, see, see also, see category, and see condition
Format and Typeface

The ICD-10-CM index uses an indented format for ease in reference (Figure 6B-3). Index subterms associated with an index entry’s main term are indented two spaces, with second and third qualifiers associated with the main term further indented by two and four spaces, respectively. If an index entry requires more than one line, the additional text is printed on the next line and indented five spaces.

EXAMPLE: Locate the main term “Ulcer” in the ICD-10-CM index, and notice that the subterm “aphthous (oral) (recurrent) K12.0” is indented two spaces below the “U” of the main term “Ulcer.” Then, notice that the second qualifier “genital organ(s)” is further indented two spaces.

In the tabular list, additional terms are indented below the term to which they are linked. If a definition or disease requires more than one line, the additional text is printed on the next line and indented five spaces.

EXAMPLE: Locate code “P07.3 Other preterm newborn” in Figure 6B-8 on page 000, and notice that the code and description are boldfaced and its definition and synonym (e.g., Prematurity NOS) are indented.

Boldface type is used for main term entries in the alphabetic index and all codes and descriptions of codes in the tabular list. Italicized type is used for all tabular list exclusion notes and to identify manifestation codes, which are never reported as the first-listed diagnoses.

Eponyms

Eponyms are diseases or syndromes that are named for people. They are listed in appropriate alphabetical sequence as main terms in the index. They are also listed as subterms below main terms such as “Disease” or “Syndrome.” A description of the disease, syndrome, or procedure is usually included in parentheses following the eponym. (The tabular list usually includes the eponym in the code description.)

EXAMPLE: The index entry for “Barlow’s disease” can be located in alphabetic order. However, it can also be located under the main term “Disease.” (Although the tabular list entry for code E54 does not include the eponym, Barlow’s syndrome, other eponyms are routinely included in the tabular list.)

Abbreviations

The index and tabular list contains abbreviations to save space. The abbreviation NEC (not elsewhere classifiable) means “other” or “other specified” and identifies codes that are assigned when information needed to assign a more specific code cannot be located. When a specific code is not available in the index for a condition, the coder is directed to the “other specified” code in the tabular list.
The index and tabular list also contain the abbreviation **NOS (not otherwise specified)**, which is the equivalent of “unspecified.” It identifies codes that are to be assigned when information needed to assign a more specific code cannot be obtained from the provider. Because selecting a code from the index based on limited documentation results in the coder being directed to an “unspecified” code in the tabular list, the coder should contact the physician to request that additional documentation be provided so that a more specific diagnosis and/or procedure code can be assigned. A review of the patient record to assign a more specific code is also an important part of the coding process (e.g., laboratory data, radiology reports, operative report, pathology report).

**EXAMPLE 1:** The index entry for “aberrant, artery, basilar” contains the NEC abbreviation in front of code Q28.1, which means a more specific code cannot be assigned. When verifying code Q28.1 in the tabular list, notice that the code description is “Other malformations of pre-crbral vessels” and that the NEC abbreviation does not appear in the code description. Code Q28.1 is assigned to “aberrant basilar artery” because the index’s NEC abbreviation provides direction to that code.

**EXAMPLE 2:** Locate code Q28.8 in the tabular list, and notice that the NEC abbreviation is included next to “Congenital aneurysm, specified site NEC” below the code description.

**EXAMPLE 1:** The index entry for “Bronchomycosis NOS B49 [J99]” provides direction to category B49, which is an unspecified code.

**EXAMPLE 2:** Locate code A03.9 in the tabular list, and notice that the NOS abbreviation appears after “dysentery.”

### Punctuation

The index includes the following punctuation:

- **Colons**
- **Parentheses**
- **Square brackets**

A colon is used after an incomplete term or phrase in the index and tabular list when one or more modifiers (additional terms) is needed to assign a code.

**EXAMPLE 1:** The second qualifier “with gestation of:” (located after the index main term “Immaturity” and subterm “extreme”) requires the number of weeks gestation to be documented in the patient record so that a specific code can be selected.

**EXAMPLE 2:** The Excludes2 note below code C32.1 in the tabular list contains the phrase “malignant neoplasm of aryepiglottic fold or interarytenoid fold:” that ends with a colon. The three terms below the phrase are to be referenced to complete the phrase and assign an additional code (if the condition is documented in the patient record).
Parentheses are used in the index and tabular list to enclose nonessential modifiers, which are supplementary words that may be present in or absent from the physician’s statement of a disease or procedure without affecting the code number to which it is assigned.

**EXAMPLE 1:** The index entry “Abasia (-astasia) (hysterical) F44.4” contains two nonessential modifiers in parentheses, which means that the terms may be present or absent from the provider’s diagnostic statement.

**EXAMPLE 2:** Code I47.9 contains the nonessential modifier, (-Hoffman), in parentheses, which means that the term may be present or absent from the provider’s diagnostic statement.

Square brackets are used in the index to identify manifestation codes and in the index and tabular list to enclose abbreviations, synonyms, alternative wording, or explanatory phrases. A manifestation is a condition that occurs as the result of another condition, and manifestation codes are always reported as secondary codes. The code and description may or may not appear in italics in the tabular list. When code descriptions are not italicized in the tabular list, make sure you sequence the codes according to the sequence in the index entry.

**EXAMPLE 1:** The index entry for “Amyloid heart (disease) E85.4 [I43]” indicates that two codes should be reported: E85.4 and I43. Because code I43 appears in square brackets, it is reported as a secondary code. When verifying code I43 in the tabular list, notice that its description is italicized and a Code first underlying disease, such as: instruction is provided, prompting you to report code I43 as the second code.

**EXAMPLE 2:** The index entry for “Abnormal, electrocardiogram [ECG] [EKG] R94.31” encloses abbreviations in square brackets.

**EXAMPLE 3:** Code I45.89 in the tabular list uses square brackets to enclose the abbreviation for atrioventricular as [AV].

Tables

The index includes tables which organize subterms, second qualifiers, and third qualifiers and their codes in columns and rows to make it easier to select the proper code. ICD-10-CM organizes the following main terms in tables, which are located at the end of the Index to Diseases and Injuries (before the Index to External Causes):

- Table of Neoplasms
- Table of Drugs and Chemicals

The Table of Neoplasms is an alphabetic index of anatomic sites for which there are six possible code numbers according to whether the neoplasm in question is malignant primary, malignant secondary, malignant in situ, benign, of uncertain behavior, or of unspecified nature. The description of the neoplasm will often
indicate which of the six columns is appropriate (e.g., malignant melanoma of skin, benign fibroadenoma of breast, carcinoma in situ of cervix uteri).

The Table of Drugs and Chemicals is an alphabetic index of medicinal, chemical, and biological substances that result in poisonings and adverse effects. The first column of the table lists generic names of drugs and chemicals (although some publishers have added brand names) with six columns for

- Poisoning: Accidental (Unintentional)
- Poisoning: Intentional Self-harm
- Poisoning: Assault
- Poisoning: Undetermined
- Adverse Effect
- Underdosing

Includes Notes, Excludes Notes, and Inclusion Terms

An includes note appears in the ICD-10-CM tabular lists below certain categories to further define, clarify, or give examples of the content of a code category.

**EXAMPLE:** The includes note located below category code “H80 Otosclerosis” in the tabular list indicates that “otospongiosis” is classified to that same category. This means that the provider could document “otosclerosis” or “otospongiosis,” and a code from category H80 would be assigned.

Two types of excludes notes are used in the tabular list, and each note has a different definition for use. However, they are similar in that they both indicate that codes excluded from each other are independent of each other. An Excludes1 note is a “pure” excludes. It means “not coded here” and indicates mutually exclusive codes; in other words, two conditions that cannot be reported together.

**EXAMPLE 1:** Locate ICD-10-CM code “Q03 Congenital hydrocephalus,” and find the Excludes1 note for acquired hydrocephalus (G91.-). Hydrocephalus diagnosed in a newborn is assigned a code from Q03.0–Q03.9. For hydrocephalus that develops later in life, a code from G91.0–G91.9 is assigned. A congenital form of a disease is not reported with an acquired form of the same condition. Thus, the excluded code is never reported with the code located above the Excludes1 note.

**EXAMPLE 2:** Locate ICD-10-CM code “E10 Type I diabetes mellitus,” and find the Excludes1 note for type II diabetes mellitus (E11.-). Type I diabetes mellitus is classified to a code from E10.1x–E10.9. Thus, a code for type II diabetes mellitus (E11.0x–E11.9) is never reported with a code for type I diabetes mellitus.

An Excludes2 note means “not included here” and indicates that, although the excluded condition is not classified as part of the condition it is excluded from, a patient may be diagnosed with all conditions at the same time. Therefore, when an Excludes2 note appears under a code, it may be acceptable to assign both the code and the excluded code(s) together if supported by the medical documentation.
Lists of inclusion terms are included below certain codes in the ICD-10-CM tabular lists. The inclusion terms indicate some of the conditions for which that code number may be assigned. They may be synonyms with the code title, or, in the case of “other specified” codes, the terms may also provide a list of various conditions included within a classification code. The list of inclusion terms in the tabular lists is not exhaustive. Each index may provide additional terms that may also be assigned to a given code.

**EXAMPLE:** Locate ICD-10-CM code “M19.14 Post-traumatic osteoarthritis, hand” and find the Excludes2 note for *post-traumatic osteoarthritis of first carpometacarpal joint (M18.2, M18.3-).* The Excludes2 note means that because a patient can be diagnosed with both “post-traumatic osteoarthritis of the hand” and “post-traumatic osteoarthritis of the first carpometacarpal joint,” it is acceptable to assign codes to both conditions if supported by medical documentation.

**EXAMPLE 1:** The following inclusion terms are located in the Tabular List of Diseases and Injuries for diagnosis code “M54.5, Low back pain:”
- Loin pain
- Lumbago NOS

**EXAMPLE 2:** If the provider documents “polyalgia” as the patient’s condition, assign code M79.89 even though the code description indicates it is an “other specified” code.

**EXAMPLE 3:** Locate the index entry for “Infection, fish tapeworm, larval B70.1.” Then, go to the tabular list to verify code B70.1 where you will notice that “infection due to fish tapeworm, larval” is not listed as an inclusion term. The coder has to *trust the index* and assign code B70.1 for the documented condition.

**Other, Other Specified, and Unspecified Codes**

*Other and other specified codes* are assigned when patient record documentation provides detail for which a specific code does not exist in ICD-10-CM. Index entries that contain the abbreviation NEC are classified to “other” codes in the tabular list. These index entries represent specific disease entities for which no specific code exists in the tabular list, so the term is included within an “other” code.

*Unspecified codes* are assigned because patient record documentation is insufficient to assign a more specific code. (Before assigning an unspecified code, ask the provider to document additional information so that a more specific code can be reported.) When an ICD-10-CM tabular list category does not contain an unspecified code, the “other specified” code may represent both “other and unspecified.” In ICD-10-CM, “other and unspecified” category and subcategory codes require assignment of extra character(s) to classify the condition.
When the index directs the coder to an “other, other specified, or unspecified code” in the tabular list, it is important to review the record carefully (or ask the physician for clarification of documentation) to determine if a more specific code can be assigned. This is referred to as “moving up the ladder” of codes in the tabular list.

**EXAMPLE:**
- D64.89 is an “other specified” code.
- D64.9 is an “unspecified” code.
- I70.9 is an “other and unspecified” code.

### Etiology and Manifestation Rules

Etiology and manifestation rules include the following notes in the ICD-10-CM Tabular List of Diseases and Injuries:

- Code first underlying disease
- Code, if applicable, any causal condition first
- Use additional code
- In diseases classified elsewhere

To classify certain conditions completely, codes must be assigned to the underlying etiology (cause or origin of disease) and multiple body system manifestations (resulting symptoms or conditions) due to the underlying etiology. For such conditions, the underlying condition is sequenced first, followed by the manifestation. Wherever an etiology and manifestation combination of codes exists, the tabular list etiology code contains a use additional code note and the manifestation code contains a code first underlying disease note. These instructional notes assist coders in the proper sequencing of the codes: etiology code followed by manifestation code. In most cases, the manifestation code will have in its title the in diseases classified elsewhere note, which indicates that the manifestation codes are a component of the etiology/manifestation coding convention. A manifestation code that does not contain “in diseases classified elsewhere” in its title will contain a “use additional code” note. (Sequence the manifestation code after the etiology code.)

The instruction to code, if applicable, any causal condition first requires the causal condition to be sequenced first if present. A causal condition is a disease (e.g., diabetes mellitus) that manifests (or results in) another condition (e.g., diabetic cataracts). If no causal condition is documented, the code that contains the instruction (code, if applicable, any causal condition first) may be reported without the causal condition code. (This differs from the instruction to code first underlying condition, which does not allow for the code that contains the instruction to be reported without first sequencing the underlying condition.)

**EXAMPLE 1:** Diagnostic statement “idiopathic pulmonary hemosiderosis” includes two codes in the ICD-10-CM index: E83.19 [J99]. Code J99 is listed in brackets in the index, which indicates it is the manifestation code and is reported second. The ICD-10-CM tabular list entry for J99 is in italics, and it contains a “code first underlying disease” note.
EXAMPLE 2: The patient is diagnosed with “benign hypertrophy of the prostate with urge and stress incontinence.” Locate subcategory code N40.1 in the ICD-10-CM tabular list, and notice that the “use additional code...” note instructs you to report an additional code. Therefore, assign codes N40.1 and N39.46. Next, notice that category code N39.4 in the tabular list includes a “code also any associated overactive bladder (N32.81)” note. Because the diagnostic statement (above) does not include “overactive bladder,” do not assign code N32.81.

EXAMPLE 3: A patient with an alcohol addiction (F10.20) was seen in the office, complaining of urinary incontinence. The physician determined that the condition was nonorganic in origin and most likely the result of the patient being too inebriated to realize he had urinated while unconscious. Code F98.0 is assigned to urinary incontinence that is of nonorganic origin. (Code R32 is assigned to urinary incontinence that is organic in nature [e.g., due to urethritis, N34.2]).

And

When the word and appears in category titles and code descriptions in the ICD-10-CM Tabular List of Diseases and Injuries, it is interpreted as meaning and/or.

EXAMPLE: Code “H61.0 Chondritis and perichondritis of external ear” is interpreted as “Chondritis of external ear” or “Perichondritis of external ear.”

Due to

The subterm due to is located in the index in alphabetical order to indicate the presence of a cause-and-effect (or causal) relationship between two conditions. When the index includes due to as a subterm, the code is assigned only if the physician documented the causal relationship between two conditions, such as meningitis due to adenovirus. It is possible that a patient could have meningitis along with an unrelated adenovirus at the same time. (The due to phrase is included in tabular list code descriptions, but it is not a coding instruction.)

ICD-10-CM occasionally presumes a causal relationship between two conditions. This means that the physician is not required to document “due to” in the diagnostic statement, such as when the patient has hypertension and renal failure. This condition is coded as hypertensive renal failure, which is interpreted as hypertension due to renal failure.

EXAMPLE: When the physician documents “pneumonitis due to inhalation of regurgitated food,” a causal relationship exists, and code J69.0 is assigned.

In

When the word in appears in the ICD-10-CM index, it is located in alphabetical order below the main term. To assign a code from the list of qualifiers below the word in, the physician must document both conditions in the patient’s record. ICD-10-CM classifies certain conditions as if there were a cause-and-effect
relationship present because they occur together much of the time (e.g., pneumonia in Q fever).

**EXAMPLE:** Locate the main term “pneumonia” in the index, and notice that the word *in* appears in alphabetical order above a list of second qualifiers. To assign a code from the list, the physician must document a relationship between both conditions, such as “pneumonia in measles” (or “postpneumonia measles”) for which combination code B05.2 is assigned. (Other conditions that occur together may require the assignment of multiple codes, one for the etiology and another for the manifestation.)

### With

When the word *with* appears in the ICD-10-CM index, it is located immediately below the main term, not in alphabetical order. To assign a code from the list of qualifiers below the word *with*, the physician must document the presence of both conditions (or procedures) in the patient’s record.

**EXAMPLE:** Locate the main term “measles” in the index, and notice that the word *with* appears above a list of second qualifiers. To assign a code from the list, the physician must document both conditions, such as measles with keratitis (B05.81). The physician could also document:

- Measles keratitis
- Measles associated with keratitis
- Measles and keratitis

### Cross-References, Including See, See Also, See Category, and See Condition

The ICD-10-CM index includes cross-references, which instruct the coder to refer to another entry in the index (e.g., see, see also, see condition) or to the tabular list (e.g., see category) to assign the correct code.

- The **see** instruction after a main term directs the coder to refer to another term in the ICD-10-CM index to locate the code. The coder must go to the referenced main term to locate the correct code.
- The **see also** instruction is located after a main term or subterm in the ICD-10-CM index and directs the coder to another main term (or subterm) that may provide additional useful index entries. The **see also** instruction does not have to be followed if the original main term (or subterm) provides the correct code.
- The **see category** instruction directs the coder to the ICD-10-CM tabular list, where a code can be selected from the options provided there.
- The **see condition** instruction directs the coder to the main term for a condition, found in the ICD-10-CM disease index.

**EXAMPLE 1:** Locate the main term “Laceration” and subterm “blood vessel” in the ICD-10-CM index. Notice that a cross-reference directs you to “See Injury, blood vessel,” which is at a different location in the index where the code can be found.
EXAMPLE 2: The *see also* instruction is optional if the correct code can be located below the main term (e.g., laceration of lower back, S31.010). If the correct code cannot be located, the *see also* cross-reference directs the coder to a different location in the index where the code can be found.

EXAMPLE 3: Locate the main term “Pyelitis,” subterm “with,” and second qualifier “calculus” in the ICD-10-CM index. Notice that a cross-reference directs you to *see category* N20. To assign the correct code, review category N20 in the tabular list to select the appropriate fourth digit.

EXAMPLE 4: Locate the main term “Accidental” in the ICD-10-CM index, and notice that a cross-reference directs you to *see condition*, which means the patient record needs to be reviewed to determine the condition (e.g., fracture).

**EXERCISE 6B-3**

ICD-10-CM Coding Conventions

Instructions: Assign ICD-10-CM codes to each diagnostic statement, interpreting coding conventions.

1. Acariasis infestation
2. Costen’s complex
3. ST elevation myocardial infarction, anterior wall, involving left main coronary artery
4. Malaria with hepatitis
5. Acute lymphangitis
6. Absence of menstruation
7. Arterial atheroembolism
8. Tetanic cataract in hypoparathyroidism
9. Acromegaly
10. Cirrhosis due to Wilson’s disease
11. Keratoconjunctivitis in exanthema
12. Appendicitis with perforation
13. Abnormal acid–base balance
14. Parietoalveolar pneumopathy
15. GM2 gangliosidosis, juvenile
ICD-10-CM INDEX TO DISEASES AND INJURIES

The ICD-10-CM Index to Diseases and Injuries (Figure 6B-3) is an alphabetical listing of terms and their corresponding codes, which include:

- Specific illnesses (e.g., hypertension)
- Injuries (e.g., fracture)
- Eponyms (e.g., Barlow’s disease)
- Abbreviations (e.g., BMI)
- Other descriptive diagnostic terms (e.g., acute)

![ICD-10-CM Index to Diseases and Injuries](image)

**FIGURE 6B-3** ICD-10-CM Index to Diseases and Injuries (partial) (Permission to reuse granted by Ingenix, Inc.)
The index is subdivided as follows:

- Index to Diseases and Injuries
- Table of Neoplasms
- Table of Drugs and Chemicals
- Index to External Causes

Main Terms, Subterms, and Qualifiers

Main terms in the index are boldfaced and listed in alphabetical order, which means hyphens within main terms are ignored, but a single space within a main term is not ignored. A code listed next to a main term in the ICD-10-CM index is referred to as a default code. The default code represents the code for the condition most commonly associated with the main term, or it may represent an unspecified code for the condition. (The ICD-10-CM Tabular List of Diseases and Injuries must always be referenced so that the most accurate and complete code is assigned.) When a condition is documented without any additional information (e.g., appendicitis), such as acute or chronic, the default code is assigned (after verifying the code in the ICD-10-CM Tabular List of Diseases and Injuries).

**EXAMPLE:** The hyphen in “Cat-scratch” is ignored, resulting in sequencing that main term after “Catatonic.”

Catatonic

Cat-scratch

**EXAMPLE:** The space between “bee” and “sting” is considered, resulting in that main term being sequenced above “Beer-drinkers’ heart (disease)"

Bee sting (with allergic or anaphylactic shock)—see Toxicity, venom, arthropod, bee

Beer-drinkers’ heart (disease) I42.6

Begbie’s disease (exophthalmic goiter)—see Hyperthyroidism, with, goiter

Main terms may or may not be followed by a listing of parenthetical terms that serve as nonessential modifiers of the main term. Nonessential modifiers are supplementary words located in parentheses after a main term that does not have to be included in the diagnostic statement for the code number to be assigned. Qualifiers are supplementary terms that further modify subterms and other qualifiers. Subterms (or essential modifiers) qualify the main term by listing alternative sites, etiology, or clinical status. A subterm is indented two spaces under the main term. Second qualifiers are indented two spaces under a subterm, and third qualifiers are indented two spaces under a second qualifier (Figure 6B-4). Care must be taken when moving from the bottom of one column to the top of the next column or when turning to the next page of the index. The main term will be repeated and followed by —continued. When moving from one column to another, watch carefully to determine whether the subterm has changed or new second or third qualifiers appear.
Neoplasms are new growths, or tumors, in which cell reproduction is out of control. For coding purposes, the provider should specify whether the tumor is benign (noncancerous, nonmalignant, noninvasive) or malignant (cancerous, invasive, capable of spreading to other parts of the body). It is highly advisable that neoplasms be coded directly from the pathology report (generated by a hospital’s or stand-alone laboratory’s pathology department and mailed to the provider’s office); however, until the diagnostic statement specifies...
whether the neoplasm is benign or malignant, coders should code the patient’s sign (e.g., breast lump) or report a subcategory code from the “unspecified nature” column of the documented site using the Index to Diseases Table of Neoplasms.

Another term associated with neoplasms is lesion, defined as any discontinuity of tissue (e.g., skin or organ) that may or may not be malignant. Disease index entries for “lesion” contain subterms according to anatomic site (e.g., organs or tissue), and that term should be referenced if the diagnostic statement does not confirm a malignancy. In addition, the following conditions are examples of benign lesions and are listed as separate Index to Diseases entries:

- Adenosis
- Cyst
- Dysplasia
- Mass (unless the word neoplasm is included in the diagnostic statement)
- Polyp

The Table of Neoplasms (Figure 6B-5) is indexed by anatomic site and contains four cellular classifications: malignant, benign, uncertain behavior, and unspecified nature. The malignant classification is subdivided into three divisions: primary, secondary, and carcinoma in situ. The six neoplasm classifications are defined as follows:

- Primary malignancy—The original tumor site. All malignant tumors are considered primary unless otherwise documented as metastatic or secondary.
• **Secondary malignancy**—The tumor has metastasized (spread) to a secondary site, either adjacent to the primary site or to a remote region of the body.

• **Carcinoma (Ca in situ)**—A malignant tumor that is localized, circumscribed, encapsulated, and noninvasive (has not spread to deeper or adjacent tissues or organs).

• **Benign**—A noninvasive, nonspread, nonmalignant tumor.

• **Uncertain behavior**—It is not possible to predict subsequent morphology or behavior from the submitted specimen. In order to assign a code from this column, the pathology report must specifically indicate the “uncertain behavior” of the neoplasm.

• **Unspecified nature**—A neoplasm is identified, but no further indication of the histology or nature of the tumor is reflected in the documented diagnosis. Assign a code from this column when the neoplasm was destroyed or removed and a tissue biopsy was performed and results are pending.

To go directly to the Table of Neoplasms, you must know the classification and the site of the neoplasm. Some diagnostic statements specifically document the “neoplasm” classification; others will not provide a clue. If the diagnostic statement classifies the neoplasm, the coder can refer directly to the Table of Neoplasms to assign the proper code (after verifying the code in the tabular list, of course).

**EXAMPLE:**

<table>
<thead>
<tr>
<th>Diagnostic Statement</th>
<th>Table of Neoplasms Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracheal carcinoma <em>in situ</em></td>
<td>trachea, Malignant, Ca <em>in situ</em> (D02.1)</td>
</tr>
<tr>
<td>Benign breast tumor, male</td>
<td>breast, male, Benign (D24.-)</td>
</tr>
<tr>
<td>Cowper’s gland tumor, uncertain behavior</td>
<td>Cowper’s gland, Uncertain Behavior (D41.3)</td>
</tr>
<tr>
<td>Metastatic carcinoma</td>
<td>unknown site or unspecified, Malignant—Secondary (C79.9)</td>
</tr>
<tr>
<td>Cancer of the breast, primary</td>
<td>breast, Malignant—Primary (C50.9-)</td>
</tr>
</tbody>
</table>

If the diagnostic statement does not classify the neoplasm, the coder must refer to the disease index entry for the condition documented (instead of the Table of Neoplasms). That entry will either contain a code number that can be verified in the tabular list or will refer the coder to the proper Table of Neoplasms entry under which to locate the code.

**EXAMPLE:**

<table>
<thead>
<tr>
<th>Diagnostic Statement</th>
<th>Index to Diseases Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>non-Hodgkin’s lymphoma</td>
<td>Lymphoma <em>(of)</em> <em>(malignant)</em> C85.90</td>
</tr>
<tr>
<td></td>
<td>non-Hodgkin <em>(see also)</em> Lymphoma, by type C85.9</td>
</tr>
<tr>
<td></td>
<td>specified NEC C85.8-</td>
</tr>
<tr>
<td>Adrenal adenolymphoma</td>
<td>Adenolymphoma</td>
</tr>
<tr>
<td></td>
<td>specified site—see Neoplasm, benign, by site unspecified site D11.9</td>
</tr>
</tbody>
</table>
CODING TIP:

1. Assigning codes from the Table of Neoplasms is a two-step process. First, classify the neoplasm by its behavior (e.g., malignant, secondary) and then by its anatomic site (e.g., acoustic nerve).

2. To classify the neoplasm’s behavior, review the provider’s diagnostic statement (e.g., carcinoma of the throat), and look up “carcinoma” in the index. The entry will classify the behavior for you, directing you to the proper column in the Table of Neoplasms. (If malignant, you will still need to determine whether it is primary, secondary, or in situ based on documentation in the patient’s record.)

Primary Malignancy

A malignancy is coded as the primary site if the diagnostic statement documents:

- Metastatic from a site.
- Spread from a site.
- Primary neoplasm of a site.
- A malignancy for which no specific classification is documented.
- A recurrent tumor.

EXAMPLE: For carcinoma of cervical lymph nodes, metastatic from the breast, assign two codes:

- Primary malignancy of left breast (male) (C50.922)
- Secondary malignancy of cervical lymph nodes (C77.0)

Secondary Malignancy

Secondary malignancies are metastatic and indicate that a primary cancer has spread (metastasized) to another part of the body. Sequencing of neoplasm codes depends on whether the primary or secondary cancer is being managed and/or treated. To properly code secondary malignancies, consider the following:

Cancer described as metastatic from a site is primary of that site. Assign one code to the primary neoplasm and a second code to the secondary neoplasm of the specified site (if the secondary site is known) or unspecified site (if the secondary site is unknown).

EXAMPLE: For metastatic carcinoma from the right breast (female) to lung, assign two codes:

- Primary malignancy of right breast (C50.911)
- Secondary malignancy of right lung (C78.01)

Cancer described as metastatic to a site is considered secondary of that site. Assign one code to the secondary site and a second code to the specified
primary site (if the primary site is known) or unspecified site (if the primary site is unknown).

**EXAMPLE:** For metastatic carcinoma from the liver to left lung, assign two codes:
- Primary malignancy of liver (C22.9)
- Secondary malignancy of left lung (C78.02)

When anatomic sites are documented as metastatic, assign secondary neoplasm code(s) to those sites, and assign an unspecified site code to the primary malignant neoplasm.

**EXAMPLE:** For metastatic renal cell carcinoma of the left lung, assign two codes:
- Primary malignancy of right kidney (C64.1)
- Secondary malignancy of left lung (C78.02)

If the diagnostic statement does not specify whether the neoplasm site is primary or secondary, code the site as primary unless the documented site is bone, brain, diaphragm, heart, liver, lymph nodes, mediastinum, meninges, peritoneum, pleura, retroperitoneum, or spinal cord. These sites are considered secondary sites unless the physician specifies that they are primary.

**EXAMPLE 1:** For left lung cancer, assign one code (because lung does not appear in the above list of secondary sites):
- Primary malignancy of left lung (C34.92)

**EXAMPLE 2:** For spinal cord cancer, assign two codes:
- Primary malignancy of unspecified site (C80.1)
- Secondary malignancy of spinal cord (C79.49)

**Anatomic Site Is Not Documented**

If the cancer diagnosis does not contain documentation of the anatomic site, but the term metastatic is documented, assign codes for unspecified site for both the primary and secondary sites.

**EXAMPLE:** For metastatic chromophobe adenocarcinoma, assign two codes as follows:
- Primary chromophobe adenocarcinoma of unknown site (C75.1)
- Secondary malignancy of unknown site (C79.9)
Primary Malignant Site Is No Longer Present

If the primary site of malignancy is no longer present, do not assign the code for “primary of unspecified site.” Instead, classify the previous primary site by assigning the appropriate code from category Z85, “Personal history of malignant neoplasm.”

**EXAMPLE:** For metastatic carcinoma to right lung from left breast (left radical mastectomy performed last year), assign two codes as follows:

- Secondary neoplasm of right lung (C78.01)
- Personal history of malignant neoplasm of breast (Z85.3)

Contiguous or Overlapping Sites

Contiguous sites (or overlapping sites) occur when the origin of the tumor (primary site) involves two adjacent sites. Neoplasms with overlapping site boundaries are classified to the fourth-digit subcategory .8, “Other.”

**EXAMPLE:** For cancer of the jejunum and ileum, go to the index entry for “intestine, small, overlapping lesion” in the Table of Neoplasms. Locate code C17.8 in the Malignant Primary column, and verify the code in the tabular list.

Re-excision of Tumors

A re-excision of a tumor occurs when the pathology report recommends that the surgeon perform a second excision to widen the margins of the original tumor site. The re-excision is performed to ensure that all tumor cells have been removed and that a clear border (margin) of normal tissue surrounds the excised specimen. Use the diagnostic statement found in the report of the original excision to code the reason for the re-excision. The pathology report for the re-excision may not specify a malignancy at this time, but the patient is still under treatment for the original neoplasm.

**CODING TIP:**

1. Read all notes in the Table of Neoplasms that apply to the malignancy that you are coding.
2. Never assign a code directly from the Table of Neoplasms or Index to Diseases and Injuries.
3. Be certain you are submitting codes that represent the current status of the neoplasm.
4. Assign a neoplasm code if the tumor has been excised and the patient is still undergoing radiation or chemotherapy treatment.
5. Assign a Z code if the tumor is no longer present or if the patient is not receiving treatment, but is returning for follow-up care.
6. Classification stated on a pathology report overrides the morphology classification stated in the Index to Diseases and Injuries.
EXERCISE 6B-4

Table of Neoplasms

Instructions: Complete each statement.

1. For oat cell carcinoma of the right lung with spread to the brain, the primary site is ________, and the secondary site is ________.

2. For metastatic carcinoma from right breast, the primary site is ________, and the secondary site is ________.

3. For metastatic carcinoma from right kidney to bone, the primary site is ________, and the secondary site is ________.

4. For metastatic malignant melanoma of bone, the primary site is ________, and the secondary site is ________.

5. For frontal lobe brain cancer, the primary site is ________, and the secondary site is ________.

Instructions: Assign code to each diagnostic statement, sequencing the primary site code first.

6. Oat cell carcinoma of the right lung with spread to the brain ________

7. Metastatic carcinoma from right breast ________

8. Metastatic carcinoma from right kidney to bone ________

9. Metastatic malignant melanoma of bone ________

10. Brain cancer ________

Table of Drugs and Chemicals

The Table of Drugs and Chemicals (Figure 6B-6) is an alphabetic index of medicinal, chemical, and biological substances that result in poisonings and adverse effects. The first column of the table lists generic names of drugs and chemicals (although some publishers have added brand names) with six columns for:

- Poisoning: Accidental (Unintentional) (poisoning that results from an inadvertent overdose, wrong substance administered/taken, or intoxication that includes combining prescription drugs with nonprescription drugs or alcohol)

- Poisoning: Intentional Self-harm (poisoning that results from a deliberate overdose, such as a suicide attempt, of substance(s) administered/taken or intoxication that includes purposely combining prescription drugs with nonprescription drugs or alcohol)

- Poisoning: Assault (poisoning inflicted by another person who intended to kill or injure the patient)

- Poisoning: Undetermined (subcategory used if the patient record does not document whether the poisoning was intentional or accidental)

- Adverse Effect (development of a pathologic condition that results from a drug or chemical substance that was properly administered or taken)

- Underdosing (taking less of a medication than is prescribed by a provider or a manufacturer's instruction)

NOTE: An iatrogenic illness can result from a medical intervention, such as an adverse reaction to contrast material injected prior to a scan, and is classified within individual ICD-10-CM chapters. For example, code E81.43 (iatrogenic carnitine deficiency) is classified in ICD-10-CM Chapter 4, Endocrine, nutritional and metabolic diseases (E00–E90).
EXAMPLE 1: For hives due to penicillin taken as prescribed, report codes T36.0x5 (adverse effect, penicillin) and L50.0 (hives).

EXAMPLE 2: For coma due to overdose of barbiturates, which was the result of an attempted suicide, report codes T42.3x2 (poisoning intentional self-harm, barbiturates) and R40.20 (coma).

Codes in categories T36–T65 are combination codes that include the substances related to adverse effects, poisonings, toxic effects, and underdosing, as well as the external cause. (No additional external cause code is required for poisonings, toxic effects, adverse effects, and underdosing codes.) A code from categories T36–T65 is sequenced first, followed by the code(s) that specify the nature of the adverse effect, poisoning, or toxic effect. The exception to this rule is the sequencing of underdosing codes (e.g., T36.0x6-) when the condition treated is sequenced first followed by the underdosing code.

### Table of Drugs and Chemicals

<table>
<thead>
<tr>
<th>Substance</th>
<th>Poisoning, Accidental (Unintentional)</th>
<th>Poisoning, Intentional Self-harm</th>
<th>Poisoning, Assault</th>
<th>Poisoning, Undetermined</th>
<th>Adverse Effect</th>
<th>Under-dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-propanol</td>
<td>T51.3x1</td>
<td>T51.3x2</td>
<td>T51.3x3</td>
<td>T51.3x4</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>2-propanol</td>
<td>T51.2x1</td>
<td>T51.2x2</td>
<td>T51.2x3</td>
<td>T51.2x4</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>2,4-D (dichloro-phenoxyacetic acid)</td>
<td>T60.3x1</td>
<td>T60.3x2</td>
<td>T60.3x3</td>
<td>T60.3x4</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>2,4-toluene diisocyanate</td>
<td>T65.0x1</td>
<td>T65.0x2</td>
<td>T65.0x3</td>
<td>T65.0x4</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>2, 4, 5-T (trichloro-phenoxyacetic acid)</td>
<td>T60.1x1</td>
<td>T60.1x2</td>
<td>T60.1x3</td>
<td>T60.1x4</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>14-hydroxydihydromorphone</td>
<td>T40.2x1</td>
<td>T40.2x2</td>
<td>T40.2x3</td>
<td>T40.2x4</td>
<td>T40.2x5</td>
<td>T40.2x6</td>
</tr>
<tr>
<td>ABOB</td>
<td>T37.5x1</td>
<td>T37.5x2</td>
<td>T37.5x3</td>
<td>T37.5x4</td>
<td>T37.5x5</td>
<td>T37.5x6</td>
</tr>
<tr>
<td>Abrine</td>
<td>T62.2x1</td>
<td>T62.2x2</td>
<td>T62.2x3</td>
<td>T62.2x4</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Abrus (seed)</td>
<td>T62.2x1</td>
<td>T62.2x2</td>
<td>T62.2x3</td>
<td>T62.2x4</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Absinth</td>
<td>T51.0x1</td>
<td>T51.0x2</td>
<td>T51.0x3</td>
<td>T51.0x4</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Acaricide</td>
<td>T60.8x1</td>
<td>T60.8x2</td>
<td>T60.8x3</td>
<td>T60.8x4</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Acebutolol</td>
<td>T44.7x1</td>
<td>T44.7x2</td>
<td>T44.7x3</td>
<td>T44.7x4</td>
<td>T44.7x5</td>
<td>T44.7x6</td>
</tr>
<tr>
<td>Acecarbromal</td>
<td>T42.6x1</td>
<td>T42.6x2</td>
<td>T42.6x3</td>
<td>T42.6x4</td>
<td>T42.6x5</td>
<td>T42.6x6</td>
</tr>
<tr>
<td>Aceclidine</td>
<td>T44.1x1</td>
<td>T44.1x2</td>
<td>T44.1x3</td>
<td>T44.1x4</td>
<td>T44.1x5</td>
<td>T44.1x6</td>
</tr>
<tr>
<td>Acedapsone</td>
<td>T37.0x1</td>
<td>T37.0x2</td>
<td>T37.0x3</td>
<td>T37.0x4</td>
<td>T37.0x5</td>
<td>T37.0x6</td>
</tr>
<tr>
<td>Aceflylline piperazine</td>
<td>T48.6x1</td>
<td>T48.6x2</td>
<td>T48.6x3</td>
<td>T48.6x4</td>
<td>T48.6x5</td>
<td>T48.6x6</td>
</tr>
</tbody>
</table>

**CREDIT:** The Table of Drugs and Chemicals lists drugs and chemicals along with codes that identify the drug/chemical intent. No additional external cause of injury and poisoning codes are assigned in ICD-10-CM.
Official Guidelines for Coding and Reporting Adverse Effects, Poisoning, Underdosing, and Toxic Effects

According to official coding guidelines, the occurrence of drug toxicity is classified in ICD-10-CM as follows:

1. **Adverse Effect**
   - Assign the appropriate code for adverse effect (for example, T36.0x5-) when the drug was correctly prescribed and properly administered. Use additional code(s) for all manifestations of adverse effects. Examples of manifestations are tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure.

2. **Poisoning**
   - When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration), assign the appropriate code from categories T36–T50. Poisoning codes have an associated intent: accidental, intentional self-harm, assault, and undetermined. Use additional code(s) for all manifestations of poisonings. If there is also a diagnosis of abuse or dependence on the substance, the abuse or dependence is coded as an additional code. Examples of poisoning include:
     - (i) **Error was made in drug prescription**
       - These are errors made in drug prescription or in the administration of the drug by provider, nurse, patient, or other person.
     - (ii) **Overdose of a drug intentionally taken**
       - If an overdose of a drug was intentionally taken or administered and resulted in drug toxicity, it would be coded as a poisoning.
     - (iii) **Nonprescribed drug taken with correctly prescribed and properly administered drug**
       - If a nonprescribed drug or medicinal agent was taken in combination with a correctly prescribed and properly administered drug, any drug toxicity or other reaction resulting from the interaction of the two drugs would be classified as a poisoning.
     - (iv) **Interaction of drug(s) and alcohol**
       - When a reaction results from the interaction of a drug(s) and alcohol, this would be classified as poisoning.

3. **Underdosing**
   - Underdosing refers to taking less of a medication than is prescribed by a provider or a manufacturer’s instruction. For underdosing, assign the code from categories T36–T50 (fifth or sixth character “6”). **Codes for underdosing are never assigned as principal or first-listed codes.** If a patient has a relapse or exacerbation of the medical condition for which the drug is prescribed because of the reduction in dose, code the medical condition. Noncompliance (Z91.12-, Z91.13-) or complication of care (Y63.61, Y63.8–Y63.9) codes are to be used with an underdosing code to indicate intent, if known.

4. **Toxic Effects**
   - When a harmful substance is ingested or comes in contact with a person, this is classified as a toxic effect. The toxic effect codes are in categories T51–T65. Toxic effect codes have an associated intent: accidental, intentional self-harm, assault, and undetermined.
CODING TIP:

Complications due to insulin pump malfunction include:

(a) Underdose of insulin due to insulin pump failure
   An underdose of insulin due to an insulin pump failure should be assigned to a code from subcategory T85.6, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, that specifies the type of pump malfunction as the principal or first-listed code, followed by code T38.3x6-, Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs. Additional codes for the type of diabetes mellitus and any associated complications due to the underdosing should also be assigned.

(b) Overdose of insulin due to insulin pump failure
   The principal or first-listed code for an encounter due to insulin pump malfunction resulting in an overdose of insulin should also be T85.6-, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, followed by code T38.3x1-, Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional).

EXERCISE 6B-5

Table of Drugs and Chemicals

Instructions: Assign ICD-10-CM code(s) to each diagnostic statement.

1. Adverse reaction to pertussis vaccine, initial encounter ______
2. Cardiac arrhythmia caused by interaction between prescribed ephedrine and wine (accident), initial encounter ______
3. Stupor, due to overdose of Nytol (suicide attempt), initial encounter ______
4. High blood pressure due to prescribed Albuterol, initial encounter ______
5. Rash due to combining prescribed Amoxicillin with prescribed Benadryl, initial encounter ______

Index to External Causes

The ICD-10–CM Index to External Causes of Injuries (Figure 6B-7) is arranged in alphabetical order by main term indicating the event. These codes are secondary codes for use in any health care setting. External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred, the activity of the patient at the time of the event, and the person’s status (e.g., civilian, military).
CODING TIP:
Refer to ICD-10-CM Index to External Causes main terms to begin the process of assigning an external cause code. Common main terms include:

- Accident
- Injury, injured
- Misadventure(s) to patient(s) during surgical or medical care

Before assigning an ICD-10-CM external cause code, review the notes located at the beginning of Chapter 21 in the ICD-10-CM tabular list.

EXAMPLE: A patient fell off the toilet in the downstairs bathroom of her single-family house during an attempt to coax her cat to come down from the top of a cabinet. It apparently worked because the cat jumped off the cabinet and landed on the patient. However, the patient was so surprised that she screamed and fell off the toilet onto the floor. The patient landed on her left arm due to the fall and experienced extremely sharp pain. She was evaluated in the emergency department where she was diagnosed with a closed nondisplaced comminuted fracture of the humerus, left. She received treatment and was discharged home to follow-up with her primary care physician in the office.

For ICD-10-CM, report the injury (fracture) (S42.355A), cause of injury (fall) (W18.11xA), and place of injury (bathroom of patient’s home) (Y92.012). ICD-10-CM’s level of specificity results in different codes for other locations in the patient’s home (e.g., bathroom). For ICD-10-CM code W18.11xA (fall from toilet), the seventh character (A) indicates she received initial treatment. ICD-10-CM place of injury codes for this case indicate that the patient’s health insurance policy should be billed (not a liability or workers’ compensation policy). If the place of injury had been at a grocery store or another place of business, that business’s liability insurance would be billed instead of the patient’s health insurance.

The ICD-10-CM place of injury codes for this case indicate that the patient’s health insurance policy should be billed, not a liability or workers’ compensation policy. If the place of injury had been at a grocery store or other place of business, the business’s liability insurance would be billed instead of the patient’s health insurance.

Basic Steps for Using the Index to Diseases and Injuries

It is important to remember that you should never code directly from the Index to Diseases and Injuries. After locating a code in the index, go to that code in the Tabular List of Diseases and Injuries to find important instructions (e.g., includes notes and excludes notes) and to verify the code selected. Instructions may require the assignment of additional codes or indicate conditions that are classified elsewhere.

STEP 1 Locate the main term in the Index to Diseases and Injuries.

Begin the coding process in the ICD-10-CM Index to Diseases and Injuries by locating the condition’s boldfaced main term and then reviewing the subterms listed below the main term to locate the proper disorder.
ICD-10-CM EXTERNAL CAUSE INDEX

Abuse (adult) (child) (mental) (physical) (sexual) X58
Accident (to) X58
  aircraft (in transit) (powered)—see also Accident, transport, aircraft
  due to, caused by cataclysm—see Forces of nature, by type
  animal-rider—see Accident, transport, animal-rider
  animal-drawn vehicle—see Accident, transport, animal-drawn vehicle occupant
  automobile—see Accident, transport, car occupant
  bare foot water skier V94.4
  boat, boating—see also Accident, watercraft
  striking swimmer
  powered V94.11
  unpowered V94.12

ICD-10-CM TABULAR LIST OF DISEASES AND INJURIES

CHAPTER 20: External causes of morbidity (V01-Y99)

V94 Other and unspecified water transport accidents

EXCLUDES1: military watercraft accidents in military or war operations (Y36, Y37)
The appropriate 7th character is to be added to each code from category V94
  A Initial encounter
  D Subsequent encounter
  S Sequela
V94.0 Hitting object or bottom of body of water due to fall from watercraft
EXCLUDES2: drowning and submersion due to fall from watercraft (V92.0-)
V94.1 Bather struck by watercraft
  Swimmer hit by watercraft
  V94.11 Bather struck by powered watercraft
  V94.12 Bather struck by nonpowered watercraft

FIGURE 6B-7 ICD-10-CM External Causes of Injury (partial) (Permission to reuse in accordance with www.cms.gov Content Reuse and Linking policy.)

EXAMPLE: The underlined terms in the following conditions are main terms:

Allergens investigation
Auditory agnosia secondary to organic lesion
Intussusception, ileocolic
Status (post) angioplasty

STEP 2 If the instructional phrase —see condition is found after the main term, a descriptive term (an adjective) or the anatomic site has been mistakenly referenced instead of the disorder or the disease (the condition) documented in the diagnostic statement.
EXAMPLE: The provider's diagnostic statement is upper respiratory infection. In the ICD-10-CM Index to Diseases and Injuries, look up the phrase upper respiratory. Notice that the instructional phrase—see condition appears next to the phrase upper respiratory. This instruction directs you to the condition, which is infection.

STEP 3 When the condition in the diagnostic statement is not easily found in the index, use the main terms below to locate the code.

<table>
<thead>
<tr>
<th>Abnormal</th>
<th>Findings</th>
<th>Neoplasm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anomaly</td>
<td>Foreign body</td>
<td>Obstruction</td>
</tr>
<tr>
<td>Complication</td>
<td>Infection</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Delivery</td>
<td>Injury</td>
<td>Puerperal</td>
</tr>
<tr>
<td>Disease</td>
<td>Late effects</td>
<td>Syndrome</td>
</tr>
<tr>
<td>Disorder</td>
<td>Lesion</td>
<td>Wound</td>
</tr>
</tbody>
</table>

NOTE: To locate a code that classifies an external cause of injury, refer to the separate Index to External Causes, which is located after the Table of Drugs and Chemicals (after the Index to Diseases and Injuries).

STEP 4 Sometimes terms found in the Index to Diseases and Injuries are not found in the Tabular List of Diseases and Injuries when the code number is reviewed for verification. When this occurs, the coder should trust the index because, to save space in the tabular list, more terms are listed in the index than in the tabular list.

EXAMPLE: For the condition “gum attrition,” the main term “attrition” and subterm “gum” are found in the ICD-10-CM Index to Diseases and Injuries. When code K06.0 is verified in the tabular list, the term “attrition” is not found; however, code K06.0 is still the correct code. (This is an example of trust the index.)

ICD-10-CM Index to Diseases and Injuries

Instructions: Complete each statement.

1. The ICD-10-CM alphabetical listing of main terms or conditions printed in boldfaced type that may be expressed as nouns, adjectives, or eponyms is called the _______.

2. The ________ contains adverse effects and poisonings associated with medicinal, chemical, and biological substances.

3. Main terms in the ICD-10-CM index are listed in alphabetical order, which means a single hyphen between words in a main term (are / are not) ________ ignored when locating main terms in the ICD-10-CM indexes, and a single space within a main term (is / is not) ________ ignored.

4. For the following list of main terms found in the ICD-10-CM Index to Diseases and Injuries, the main term ________ is not in alphabetical order.

   Lathyrism
   Launois-Cleret syndrome
   Launois’ syndrome

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ICD-10-CM TABULAR LIST OF DISEASES AND INJURIES

The ICD-10-CM Tabular List of Diseases and Injuries (Table 6B-1) is a chronological list of codes contained within 21 chapters, which are based on body system or condition. ICD-10-CM codes are organized within:

- **Major topic headings**, also called a code block, are printed in bold uppercase letters and followed by groups of three-character disease categories within a chapter (e.g., Intestinal Infectious Diseases, A00–A09).
- **Categories, subcategories, and codes**, which contain a combination of letters and numbers.
  - All categories contain three characters (e.g., A09).
  - A three-character category that has no further subdivision is a valid code.
  - Subcategories contain either four or five characters.
  - Codes may contain three, four, five, six, or seven characters.
    - The final level of subdivision is a code.
    - All codes in the ICD-10-CM tabular list are boldfaced.
  - Codes that have an applicable seventh character are referred to as codes (not subcategories).
  - Codes that have an applicable seventh character are considered invalid without the seventh character.

**Structure**

The ICD-10-CM tabular list contains three-character categories, four-, five-, or six-character subcategories, and four-, five-, six-, or seven-character codes (Figure 6B-8), which contain letters and numbers. Each level of subdivision within a category is called a subcategory, and the final level of subdivision is a code. Codes that have applicable seventh characters are referred to as codes (not subcategories or subclassifications), and a code that has an applicable seventh character is considered invalid without the seventh character.

- **Use of codes for reporting purposes.** For reporting purposes, only codes are permissible (not categories or subcategories), and any applicable seventh character is required.
TABLE 6B-1  ICD-10-CM Tabular List of Diseases and Injuries

<table>
<thead>
<tr>
<th>CHAPTER NUMBER</th>
<th>RANGE OF CODES</th>
<th>CHAPTER TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 1</td>
<td>A00–B99</td>
<td>Certain Infectious and Parasitic Diseases</td>
</tr>
<tr>
<td>Chapter 2</td>
<td>C00–D49</td>
<td>Neoplasms</td>
</tr>
<tr>
<td>Chapter 3</td>
<td>D50–D89</td>
<td>Diseases of the Blood and Blood-forming Organs and Certain Disorders Involving the Immune Mechanism</td>
</tr>
<tr>
<td>Chapter 4</td>
<td>E00–E90</td>
<td>Endocrine, Nutritional, and Metabolic Disorders</td>
</tr>
<tr>
<td>Chapter 5</td>
<td>F01–F99</td>
<td>Mental and Behavioral Disorders</td>
</tr>
<tr>
<td>Chapter 6</td>
<td>G00–G99</td>
<td>Diseases of the Nervous System</td>
</tr>
<tr>
<td>Chapter 7</td>
<td>H00–H59</td>
<td>Diseases of the Eye and Adnexa</td>
</tr>
<tr>
<td>Chapter 8</td>
<td>H60–H95</td>
<td>Diseases of the Ear and Mastoid Process</td>
</tr>
<tr>
<td>Chapter 9</td>
<td>I00–I99</td>
<td>Diseases of the Circulatory System</td>
</tr>
<tr>
<td>Chapter 10</td>
<td>J00–J99</td>
<td>Diseases of the Respiratory System</td>
</tr>
<tr>
<td>Chapter 11</td>
<td>K00–K94</td>
<td>Diseases of the Digestive System</td>
</tr>
<tr>
<td>Chapter 12</td>
<td>L00–L99</td>
<td>Diseases of the Skin and Subcutaneous Tissue</td>
</tr>
<tr>
<td>Chapter 13</td>
<td>M00–M99</td>
<td>Diseases of the Musculoskeletal System and Connective Tissue</td>
</tr>
<tr>
<td>Chapter 14</td>
<td>N00–N99</td>
<td>Diseases of the Genitourinary System</td>
</tr>
<tr>
<td>Chapter 15</td>
<td>O00–O99</td>
<td>Pregnancy, Childbirth, and the Puerperium</td>
</tr>
<tr>
<td>Chapter 16</td>
<td>P00–P96</td>
<td>Certain Conditions Originating in the Perinatal Period</td>
</tr>
<tr>
<td>Chapter 17</td>
<td>Q00–Q99</td>
<td>Congenital Malformations, Deformations, and Chromosomal Abnormalities</td>
</tr>
<tr>
<td>Chapter 18</td>
<td>R00–R99</td>
<td>Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified</td>
</tr>
<tr>
<td>Chapter 19</td>
<td>S00–T88</td>
<td>Injury, Poisoning, and Certain Other Consequences of External Causes</td>
</tr>
<tr>
<td>Chapter 20</td>
<td>V01–Y99</td>
<td>External Causes of Morbidity</td>
</tr>
<tr>
<td>Chapter 21</td>
<td>Z00–Z99</td>
<td>Factors Influencing Health Status and Contact with Health Services</td>
</tr>
</tbody>
</table>

- **Placeholder character.** ICD-10-CM utilizes the character “x” as a fifth character placeholder for certain six-character codes to allow for future expansion without disturbing the six-character structure (e.g., H62.8x1, other disorders of right external ear in diseases classified elsewhere). When a placeholder exists, the x must be entered in order for the code to be considered a valid code.

- **Seventh characters.** Certain ICD-10-CM categories contain applicable seventh characters, which are required for all codes within the category (or as notes in the tabular list instruct). The seventh character must always be located in the seventh-character data field. If a code that requires a seventh character is not six characters in length, the placeholder x is entered to fill in the empty character(s) (e.g., M48.46xS, reporting sequelae of fracture for previous fatigue fracture of lumbar vertebrae; an additional code is assigned to the sequelae, such as pain).

**EXAMPLE 1:** ICD-10-CM CATEGORY AND SUBCATEGORY CODES:
Go to Figure 6B-8, refer to the “Disorders of newborn related to length of gestation and fetal growth (P05–P08)” section, and locate the four-character subcategory code (P07.3) and the five-character subcategory codes (P07.30, P07.31, and P07.32).
Chapter 16. Certain Conditions Originating in the Perinatal Period (P00–P96)

NOTE
CODES FROM THIS CHAPTER ARE FOR USE ON NEWBORN RECORDS ONLY, NEVER ON MATERNAL RECORDS

Includes note
INCLUDES: conditions that have their origin in the fetal or perinatal period (before birth through the first 28 days after birth) even if morbidity occurs later

Excludes1 note
EXCLUDES: apparent life threatening event in newborn and infant (R08.1)

Excludes2 note
EXCLUDES: congenital malformations, deformations and chromosomal abnormalities (Q00–Q99)

congenital endocrine, nutritional and metabolic diseases (E00–E90)

injury, poisoning and certain other consequences of external causes (S00–T98)

neoplasms (C00–D49)

tetanus neonatorum (A33)

Blocks of codes within a chapter
This chapter contains the following blocks:

P00–P04  Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery

P05–P08  Disorders related to length of gestation and fetal growth

P09  Abnormal findings on neonatal screening

P10–P15  Birth trauma

P19–P29  Respiratory and cardiovascular disorders specific to the perinatal period

P35–P39  Infections specific to the perinatal period

P50–P61  Hemorrhagic and hematological disorders of newborn

P70–P74  Transitory endocrine and metabolic disorders specific to newborn

P76–P78  Digestive system disorders of newborn

P80–P83  Conditions involving the integument and temperature regulation of newborn

P84  Other problems with newborn

P90–P96  Other disorders originating in the perinatal period

Major topic heading of 3-character codes
Disorders of newborn related to length of gestation and fetal growth (P00–P08)

Subcategory code
P07.3  Other preterm newborn

Description statements
28 completed weeks or more but less than 37 completed weeks (196 completed days but less than 259 completed days) of gestation

Prematurity NOS

Subcategory codes
P07.30 Other preterm newborn, unspecified weeks

P07.31 Other preterm newborn, 28–31 completed weeks

P07.32 Other preterm newborn, 32–36 completed weeks

Seventh-character codes
The appropriate seventh character is to be added to each code from category T36. A initial encounter

D subsequent encounter

S sequel

T36.0  Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances (T36–T50)

Poisoning by, adverse effect of and underdosing of systemic antibiotics

EXCLUDES: antibiotic, antibiotic (T33–T34)

antibiotic, antibiotic (T33–T34)

locally applied antibiotic, antibacterial NEC (T49.0)

topically used antibiotic for ear, nose and throat (T49.6)

topically used antibiotic for eye (T49.5)

Seventh-character codes
The appropriate seventh character is to be added to each code from category T36. A initial encounter

D subsequent encounter

S sequel

T36.0x  Poisoning by, adverse effect of and underdosing of penicillins

T36.0x1 Poisoning by penicillins, accidental (unintentional)

T36.0x2 Poisoning by penicillins, intentional self-harm

T36.0x3 Poisoning by penicillins, assault

T36.0x4 Poisoning by penicillins, undetermined

T36.0x5 Adverse effect of penicillins

T36.0x6 Underdosing of penicillins

EXAMPLE 2: ICD-10-CM SIX-CHARACTER AND SEVEN-CHARACTER CODES: Go to Figure 6B-8, refer to the “Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances (T36–T50)” section, and locate the six-character subcategory codes (T36.0x1, T36.0x2, T36.0x3, T36.0x4, and T36.0x5), which also contain “x” as a placeholder to allow for future expansion. Then, locate the seventh characters (A, D, and S), one of which is to be added to each code from category T36 (depending on the status of encounter or whether the condition is a sequela).
ICD-10-CM External Cause Codes

Injury, Poisoning, and Certain Other Consequences of External Causes and External Causes of Morbidity are incorporated into ICD-10-CM’s Tabular List of Diseases and Injuries as Chapter 19 (S and T codes) and Chapter 20 (V-Y codes), respectively. External cause codes are also reported for environmental events, industrial accidents, injuries inflicted by criminal activity, and so on. While assigning the codes does not directly impact reimbursement to the provider, reporting them can expedite insurance claims processing because the circumstances related to an injury are indicated.

CODING TIP:

In ICD-10-CM, codes for external causes are incorporated into ICD-10-CM’s tabular list as Chapter 20 (S00–T98) and Chapter 21 (V01–Y99). (The codes are no longer located in a supplementary classification as they were in ICD-9-CM.)

ICD-10-CM Health Status and Contact with Health Services Codes

Factors Influencing Health Status and Contact with Health Services are incorporated into ICD-10-CM’s Tabular List of Diseases and Injuries as Chapter 21 (Z codes) (Figure 6B-9). (In ICD-9-CM, V codes were located in a supplementary classification.) The Z codes are located in the last chapter of the ICD-10-CM tabular list (similar to the location of V codes in the ICD-9-CM tabular list), and they are reported for patient encounters when a circumstance other than disease or injury is documented (e.g., well-child visit).

CODING TIP:

- ICD-10-CM Z codes are always reported as diagnosis codes. They are not reported as procedure codes even though some ICD-10-CM Z codes classify situations associated with procedures (e.g., canceled procedure Z59 category code).
- Although indexed in the ICD-10-CM Index to Diseases and Injuries, it can be challenging to locate main terms. Consider using terms from the following list to locate the codes:

<table>
<thead>
<tr>
<th>Admission</th>
<th>Examination</th>
<th>Outcome of delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aftercare</td>
<td>Exposure to</td>
<td>Problem</td>
</tr>
<tr>
<td>Attention to</td>
<td>Fitting</td>
<td>Screening</td>
</tr>
<tr>
<td>Contact</td>
<td>Follow-up</td>
<td>Status</td>
</tr>
<tr>
<td>Counseling</td>
<td>History</td>
<td>Test</td>
</tr>
<tr>
<td>Donor</td>
<td>Newborn</td>
<td>Therapy</td>
</tr>
<tr>
<td>Encounter</td>
<td>Observation</td>
<td>Vaccination</td>
</tr>
</tbody>
</table>
Z Codes

Chapter 21. Factors Influencing Health Status and Contact With Health Services (Z00–Z99)

NOTE
Z codes represent reasons for encounters. A corresponding procedure code must accompany a Z code if a procedure is performed. Categories Z00–Z99 are provided for occasions when circumstances other than a disease, injury or external cause classifiable to categories A00–Y89 are recorded as “diagnoses” or “problems.” This can arise in two main ways:
(a) When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition; to donate an organ or tissue; to receive prophylactic vaccination, or to discuss a problem which is in itself not a disease or injury.
(b) When some circumstance or problem is present which influences the person’s health status but is not in itself a current illness or injury.

This chapter contains the following blocks:
Z00–Z13 Persons encountering health services for examination and investigation
Z14–Z15 Genetic carrier and genetic susceptibility to disease
Z16 Infection with drug resistant microorganisms
Z17 Estrogen receptor status
Z20–Z28 Persons with potential health hazards related to communicable diseases
Z30–Z39 Persons encountering health services in circumstances related to reproduction
Z40–Z53 Persons encountering health services for specific procedures and health care
Z55–Z65 Persons with potential health hazards related to socioeconomic and psychosocial circumstances
Z66 Do not resuscitate [DNR] status
Z67 Blood type
Z68 Body mass index (BMI)
Z69–Z76 Persons encountering health services in other circumstances
Z77–Z99 Persons with potential health hazards related to family and personal history and certain conditions influencing health status

Persons encountering health services for examinations (Z00–Z13)

NOTE
Nonspecific abnormal findings disclosed at the time of these examinations are classified to categories R70–R94.

EXCLUDES
Examinations related to pregnancy and reproduction (Z30–Z36, Z39.–)

Z00 Encounter for general examination without complaint, suspected or reported diagnosis
EXCLUDES
encounter for examination for administrative purposes (Z02.–)
EXCLUDES
encounter for pre-procedural examinations (Z01.81–)
special screening examinations (Z11–Z13)

Z00.0 Encounter for general adult medical examination
Encounter for adult periodic examination (annual) (physical) and any associated laboratory and radiologic examinations
EXCLUDES
encounter for examination of sign or symptom—code to sign or symptom general health check-up of infant or child Z00.12.–

Z00.00 Encounter for general adult medical examination without abnormal findings
Encounter for adult health check-up NOS

Z00.01 Encounter for general adult medical examination with abnormal findings
Use additional code to identify abnormal findings

FIGURE 6B-9 Sample page of Z codes from ICD-10-CM Tabular List of Diseases and Injuries (Permission to reuse granted by Ingenix, Inc.)

Morphology of Neoplasm Codes

Effective October 1, 2013, provider offices will report morphology codes in addition to ICD-10-CM neoplasm codes. Morphology indicates the tissue type of a neoplasm (e.g., adenocarcinoma and sarcoma); and while they are not reported on insurance claims, they are reported to state cancer registries. Neoplasms are now growths, or tumors, in which cell reproduction is out of control. A basic knowledge of morphology coding can be helpful to a coder because the name of the neoplasm documented in the patient’s record does not always indicate whether the neoplasm is benign (not cancerous) or malignant (cancerous).
ICD-10-CM Chapter 2 classifies neoplasms primarily by site (topography), with broad groupings for behavior, malignant, *in situ*, benign, and so on. The ICD-10-CM Table of Neoplasms in its Index to Diseases and Injuries is used to identify the correct topography code. Morphology codes for most of ICD-10-CM’s Chapter 2 (Neoplasms) codes do not include histologic type. Thus, a comprehensive separate set of morphology codes is used from the *International Classification of Diseases for Oncology, 3rd Revision* (ICD-O-3). (In a few cases, such as for malignant melanoma and certain neuroendocrine tumors, the morphology or histologic type is included in the ICD-10-CM category and code.)

Morphology codes contain five digits preceded by the letter M and range from M8000/0 to M9989/3. The first four digits (e.g., M8000) indicate the specific histologic term. The fifth digit, after the slash, is a behavior code, which indicates whether a tumor is malignant, benign, *in situ*, or uncertain whether malignant or benign. In addition, a separate one-digit code is assigned for histologic grading to indicate differentiation.

**NOTE:** Do not confuse morphology codes with ICD-10-CM’s Chapter 13, Diseases of the Musculoskeletal System and Connective Tissue (M00-M99) codes.

**CODING TIP:**

In ICD-9-CM, the disease index contains morphology codes (e.g., adenocarcinoma, M8140/31) that can be verified in ICD-9-CM Appendix A, Morphology of Neoplasm Codes (M codes) before reporting the code to the state cancer registry. At this time, it is unknown whether ICD-10-CM will contain appendices. Therefore, use the *International Classification of Diseases for Oncology, 3rd Revision* (ICD-O-3) to locate morphology codes when assigning topography codes from ICD-10-CM.

**EXERCISE 6B-7**

**ICD-10-CM Tabular List of Diseases and Injuries**

Instructions: Complete each statement.

1. The ICD-10-CM Tabular List of Diseases and Injuries is a chronological list of codes contained within ________, which are based on body system or condition.

2. Intestinal Infectious Diseases (A00–A09) is an example of a(n) ________, which is printed in bold uppercase letters and followed by groups of three-character disease categories within a chapter.

3. ICD-10-CM categories, subcategories, and codes contain a combination of ________.

4. All of ICD-10-CM’s categories contain ________ characters.

5. A three-character ICD-10-CM category that has no further subdivision is a ________

6. ICD-10-CM subcategories contain either ________ or ________ characters.

7. ICD-10-CM codes may contain ________ characters.

8. The final level of an ICD-10-CM tabular list subdivision is a(n) ________.

9. All codes in the ICD-10-CM tabular list are ________.
10. Codes that have an applicable seventh character are referred to as ________.

11. Codes that have an applicable seventh character are considered ________ without the seventh character.

12. The seventh character must always be located in the seventh-character data field, and if a code that requires a seventh character is not six characters in length, the placeholder ________ is entered to fill in the empty character(s).

13. *Factors Influencing Health Status and Contact with Health Services* are incorporated into ICD-10-CM’s Tabular List of Diseases and Injuries as ________.

14. Effective October 1, 2013, provider-based offices will report morphology codes, abbreviated as ________.

15. ICD-10-CM Chapter 2 classifies neoplasms primarily by site (topography), and morphology codes are classified using the ________.

### OFFICIAL GUIDELINES FOR CODING AND REPORTING

The ICD-10-CM Official Guidelines for Coding and Reporting and the ICD-10-PCS Coding Guidelines are prepared by the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS). The guidelines are approved by the Cooperating Parties for ICD-10-CM/PCS, which include CMS, NCHS, American Hospital Association (AHA), and American Health Information Management Association (AHIMA). The official guidelines contain rules that accompany and complement ICD-10-CM and ICD-10-PCS coding conventions and instructions. HIPAA regulations require adherence to the guidelines when assigning diagnosis and procedure codes.

- **ICD-10-CM** diagnosis codes were adopted under HIPAA for all health care settings.
- **ICD-10-PCS** procedure codes were adopted for inpatient procedures reported by hospitals.

A joint effort between the healthcare provider and the coder is essential for complete and accurate (1) documentation, (2) code assignment, and (3) reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized because without such documentation, accurate coding cannot be achieved. Review all documentation in the patient record to determine the specific reason for the encounter as well as conditions treated. Official guidelines use the term:

- **Encounter** to indicate all health care settings, including inpatient hospital admissions.
- **Provider** to refer to physicians or any qualified healthcare practitioners who are legally accountable for establishing the patient’s diagnosis.

ICD-10-CM official guidelines are organized as:

- **Section I:** Conventions, general coding guidelines, and chapter-specific guidelines.
- **Section II:** Selection of principal diagnosis.
- **Section III:** Reporting additional diagnoses.
Section IV: Diagnostic coding and reporting guidelines for outpatient services

Appendix I: Present on admission reporting guidelines.

ICD-10-PCS official guidelines are organized according to:

- Conventions.
- Medical and surgical section guidelines.
- Obstetrics section guidelines.

Diagnostic Coding and Reporting Guidelines Outpatient Services—Hospital-Based Outpatient Services and Provider-Based Office Visits

The ICD-10-CM Diagnostic Coding and Reporting Guidelines for Outpatient Services—Hospital-Based Outpatient Services and Provider-Based Office Visits were developed by the federal government and approved for use by hospitals and providers for coding and reporting hospital-based outpatient services and provider-based office visits. Although the guidelines were originally developed for use in submitting government claims, insurance companies have also adopted them (sometimes with variation).

The terms encounter and visit are often used interchangeably when describing outpatient service contacts and, therefore, appear together in the official guidelines without distinguishing one from the other. Though the coding conventions and general coding guidelines apply to all health care settings, coding guidelines for outpatient hospital-based and provider-based office reporting of diagnoses differ from reporting of inpatient diagnoses.

- The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis applies only to inpatients in acute, short-term, long-term care, and psychiatric hospitals.
- Coding guidelines for inconclusive diagnoses (or qualified diagnoses) (e.g., possible, probable, suspected, rule out) were developed for inpatient reporting only and do not apply to outpatients.

A. Selection of First-Listed Condition

In the outpatient setting, the first-listed diagnosis is reported (instead of the inpatient hospital principal diagnosis); it is the diagnosis, condition, problem, or other reason for encounter/visit documented in the patient record to be chiefly responsible for the services provided. It is determined in accordance with ICD-10-CM coding conventions (or rules) as well as general and disease-specific coding guidelines. Because diagnoses are often not established at the time of the patient’s initial encounter or visit, two or more visits may be required before a diagnosis is confirmed. An outpatient is a person treated in one of four settings:

- **Ambulatory Surgery Center**: Patient is released prior to a 24-hour stay and length of stay must be 23 hours, 59 minutes, and 59 seconds or less.
- **Healthcare Provider’s Office** (e.g., physician).
- **Hospital Clinic, ED, Outpatient Department, Same-day Surgery Unit**: Length of stay must be 23 hours, 59 minutes, and 59 seconds or less.
- **Hospital Observation Status or Hospital Observation Unit**: Patient’s length of stay is 23 hours, 59 minutes, and 59 seconds or less unless documentation for additional observation is medically justified.
B. ICD-10-CM Tabular List of Diseases (A00.0 through T88.9, Z00–Z99)

The appropriate code or codes from the ICD-9-CM Tabular List of Diseases (001.0 through V86) or ICD-10-CM Tabular List of Diseases (A00.0 through T88.9, Z00–Z99) must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

C. Accurate Reporting of ICD-9-CM or ICD-10-CM Diagnosis Codes

For accurate reporting of ICD-9-CM or ICD-10-CM diagnosis codes, the documentation should describe the patient’s condition, using terminology that includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-10-CM codes to describe all of these.

D. Codes that Describe Signs and Symptoms

Codes that describe symptoms and signs, as opposed to definitive diagnoses, are acceptable for reporting purposes when the physician has not documented an established diagnosis or confirmed diagnosis. ICD-10-CM Chapter 18 (Symptoms, Signs, and Abnormal Clinical and Laboratory Findings Not Elsewhere Classified) (R00–R99) contain many, but not all codes for symptoms. Some symptom codes are located in other ICD-10-CM chapters, which can be found by properly using the ICD-10-CM Index to Diseases and Injuries.

E. Encounters for Circumstances Other than a Disease or Injury (V Codes)

ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or an injury. In ICD-10-CM, Factors Influencing Health Status and Contact with Health Services (Z00–Z99) classifies occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

F. Level of Detail in Coding

ICD-10-CM diagnosis codes contain three, four, five, six, or seven characters.

- **ICD-10-CM codes with three, four, five, six, or seven characters**: Disease codes with 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, fifth, sixth, or seventh characters to provide greater specificity.

- **Use of full number of characters required for a code**: A three-character code is to be assigned only if it cannot be further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the seventh character extension, if applicable.

G. ICD-10-CM Code for the Diagnosis, Condition, Problem, or Other Reason for Encounter/Visit

Report first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. Then report additional codes that describe any coexisting conditions that were treated or medically managed or that...
influenced the treatment of the patient during the encounter. In some cases, the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

H. Uncertain Diagnoses

Do not code diagnoses documented as probable, suspected, questionable, rule out, or working diagnosis, or other similar terms indicating uncertainty, all of which are considered qualified diagnoses. Instead, code condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reasons for the visit.

<table>
<thead>
<tr>
<th>FOR QUALIFIED DIAGNOSIS:</th>
<th>CODE THE FOLLOWING SIGNS OR SYMPTOMS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected pneumonia</td>
<td>Shortness of breath</td>
</tr>
<tr>
<td>Questionable Raynaud's</td>
<td>Numbness of hands</td>
</tr>
<tr>
<td>Possible wrist fracture, right</td>
<td>Wrist pain, right</td>
</tr>
<tr>
<td>Rule out pneumonia</td>
<td>Influenza</td>
</tr>
</tbody>
</table>

Qualified or uncertain diagnoses are a necessary part of the hospital and office chart until a specific diagnosis can be determined. Although qualified diagnoses are routinely coded for hospital inpatient admissions and reported on the UB-04 claim, CMS specifically prohibits the reporting of qualified diagnoses on the CMS-1500 claim submitted for outpatient care. CMS regulations permit the reporting of patients' signs and/or symptoms instead of the qualified diagnoses.

An additional incentive for not coding qualified diagnoses resulted from the Missouri case of Stafford v. Neurological Medicine Inc., 811 F. 2d 470 (8th Cir., 1987). In this case, the diagnosis stated in the physician’s office chart was rule out brain tumor. The claim submitted by the office listed the diagnosis code for rule out brain tumor although test results were available that proved a brain tumor did not exist. The physician assured the patient that although she had lung cancer, there was no metastasis to the brain. Sometime after the insurance company received the provider’s claim, it was inadvertently sent to the patient. When the patient received the claim, she was so devastated by the diagnosis that she committed suicide. Her husband sued and was awarded $200,000 on the basis of negligent paperwork because the physician’s office had reported a qualified or uncertain diagnosis.

I. 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).

J. Code All Documented Conditions that Coexist

Code all documented conditions that coexist at the time of the encounter/visit and that require or affect patient care, treatment, or management. Do not code conditions that were previously treated and no longer exist. However, history codes (ICD-9-CM categories V10–V19 or ICD-10-CM categories Z80–Z87) may be reported as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

K. Patients Receiving Diagnostic Services Only

For patients receiving diagnostic services only during an encounter/visit, report first the diagnosis, condition, problem, or other reason for encounter/visit
that is documented in the medical record as being chiefly responsible for the outpatient services provided during the encounter/visit. (This is the first-listed diagnosis.) Codes for other diagnoses (e.g., chronic conditions) may be reported as additional diagnoses.

For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign Z01.89, Encounter for other specified special examinations. If routine testing is performed during the same diagnosis, it is appropriate to assign both the sign and/or symptom V code and the code describing the reason for the nonroutine test.” (Remember! In ICD-10-CM, the V codes classify signs and symptoms.)

For outpatient encounters for diagnostic tests that have been interpreted by a physician and for which the final report is available at the time of coding, code any confirmed or definitive diagnoses documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

L. Patients Receiving Therapeutic Services Only

For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit.

Assign codes to other diagnoses (e.g., chronic conditions) that are treated or medically managed or that would affect the patient’s receipt of therapeutic services during this encounter/visit.

The only exception to this rule is when the reason for admission/encounter is for chemotherapy, radiation therapy, or rehabilitation. For these services, the appropriate ICD-10-CM Z code for the service is listed first and the diagnosis or problem for which the service is being performed is reported second.

M. Patients Receiving Preoperative Evaluations Only

For patients receiving preoperative evaluations only, assign and report first the appropriate code from ICD-9-CM subcategory V72.8 (other specified examinations) or ICD-10-CM subcategory Z01.81 (encounter for pre-procedural examinations) to describe the pre-op consultations.

Assign an additional code for the condition that describes the reason for the surgery. Also assign additional code(s) to any findings discovered during the preoperative evaluation.

N. Ambulatory Surgery (or Outpatient Surgery)

For ambulatory surgery (or outpatient surgery), assign a code to the diagnosis for which the surgery was performed. If the postoperative diagnosis is different from the preoperative diagnosis when the diagnosis is confirmed, assign a code to the postoperative diagnosis instead (because it is more definitive).

O. Routine Outpatient Prenatal Visits

For routine outpatient prenatal visits when no complications are present:

- Report ICD-9-CM code V22.0 (Supervision of normal first pregnancy) or V22.1 (Supervision of other normal pregnancy) as the first-listed diagnosis. Do not report either of these codes in combination with ICD-9-CM Chapter 11 codes.
- Report a code from ICD-10-CM category Z34 (encounter for supervision of normal pregnancy) as the first-listed diagnosis.

Do not report this code in combination with ICD-10-CM Chapter 15 codes.

For routine prenatal outpatient visits for patients with high-risk pregnancies, report an ICD-10-CM code from category O09 (supervision of
high-risk pregnancy) as the first-listed diagnosis. A code from ICD-10-CM Chapter 15 may also be reported as a secondary diagnosis, if appropriate.

P. Encounters for General Medical Examinations with Abnormal Findings

ICD-10-CM subcategories Z00.0 (encounters for general medical examinations) provide codes for encounters with and without abnormal findings. When a general medical examination results in an abnormal finding, report the code for general medical examination with abnormal finding as the first-listed diagnosis. Then, report a secondary code for the abnormal finding.

Q. Encounters for Routine Health Screenings

Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease (e.g., screening mammogram).

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.

Should a condition be discovered during the screening, then the code for the condition may be assigned as an additional diagnosis.

The Z code indicates that a screening exam is planned. A procedure code is required to confirm that the screening was performed. The screening Z codes/categories are:

- Z11 Encounter for screening for infectious and parasitic diseases
- Z12 Encounter for screening for malignant neoplasms
- Z13 Encounter for screening for other diseases and disorders

**Except:** Z13.9, Encounter for screening, unspecified

- Z36 Encounter for antenatal screening for mother

ICD-10-CM Z codes describe encounters for routine examinations (e.g., general check-up) or examinations for administrative purposes (e.g., pre-employment physical). Z codes are not to be reported if the examination is for diagnosis of a suspected condition or for treatment purposes. In such cases, report an ICD-10-CM diagnosis code.

- During a routine exam, if a diagnosis or condition is discovered, report it as an additional ICD-10-CM code.
- Pre-existing conditions, chronic conditions, and history codes may also be reported as additional ICD-10-CM codes if the examination performed is for administrative purposes and does not focus on any particular condition.
- Some ICD-10-CM 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.
  - If no abnormal findings were found during examination, but the encounter is being coded before test results are back, it is acceptable to assign the code for “without abnormal findings.”
  - When assigning a code for “with abnormal findings,” additional code(s) should be assigned to identify the specific abnormal finding(s).
- Preoperative examination and preprocedural laboratory examination Z codes are reported only for those situations when a patient is being cleared for a procedure or surgery and no treatment is provided.
Diagnostic Coding and Reporting Guidelines Outpatient Services

Instructions: Complete each statement.

1. The guidelines for coding and reporting using ICD-10-CM/PCS have been approved by the four organizations that comprise the ________.

2. The abbreviations for the four organizations that develop and approve the coding guidelines are ________, ________, ________, and ________.

3. Adherence to the coding guidelines when assigning ICD-9-CM (or ICD-10-CM/PCS) diagnosis and procedure codes is required by ________ legislation.

4. The guidelines use the term ________ to indicate all health care settings, including inpatient hospital admissions.

5. The term ________ is used throughout the guidelines to refer to physicians or any qualified healthcare practitioners who are legally accountable for establishing the patient’s diagnosis.

Instructions: Underline the first-listed diagnosis in each statement.

6. The physician treated the patient’s chronic asthma during an office visit, and she also received a renewed prescription for hypertension.

7. The physician ordered an ultrasound to rule out cholecystitis; the patient presented to the office with severe abdominal pain.

8. The patient slipped on ice and fell as she was walking down the steps of her porch. She was treated in the emergency department for severe swelling of the left leg, and x-ray of the left leg was negative for fracture.

9. The patient was treated in the office for nausea and vomiting. The physician diagnosed gastroenteritis.

10. The patient was treated in the outpatient department for a sore throat, which was cultured. The physician documented possible strep throat in the record.

11. The patient was treated on an outpatient basis for both acute and chronic bronchitis, for which each was assigned an ICD-10-CM diagnosis code.

12. The patient was treated for acne in the physician’s office during this visit. The physician also documented that his previously diagnosed hives had totally resolved.

13. The patient was seen for complaints of fainting accompanied by nausea and vomiting. Her blood was drawn and sent to the lab to have a blood glucose level performed. Lab results were normal. The patient was scheduled for outpatient testing to rule out seizure disorder.

14. The patient underwent outpatient radiation therapy for treatment of prostate cancer during today’s encounter; the patient had previously complained of painful urination.

15. The patient’s preoperative diagnosis was possible appendicitis and right lower quadrant pain; he underwent laparoscopic appendectomy. The postoperative diagnosis was acute appendicitis.
SUMMARY

ICD-10-CM is used to classify *morbidity* (disease) data from inpatient and outpatient records, including provider-based office records. (ICD-10-PCS is used to code and classify *procedures* from inpatient records only.) ICD-10-CM and ICD-10-PCS, also abbreviated as ICD-10-CM/PCS, will replace ICD-9-CM on October 1, 2013. All provider offices, outpatient health care settings, and healthcare facilities will report ICD-10-CM diagnosis codes.

Effective October 1, 2013, when the ICD-10-CM (and ICD-10-PCS) coding systems are implemented, ICD-9-CM will become a *legacy coding system* (or *legacy classification system*), which means it will be used as archive data but it will no longer be supported or updated. *General equivalency mappings (GEMs)*, which are translation dictionaries or crosswalks of codes that can be used to roughly identify ICD-10-CM codes for their ICD-9-CM equivalent codes (and vice versa), will be annually published by NCHS and CMS.

The ICD-10-CM Index to Diseases and Injuries is organized according to alphabetical main terms (boldfaced conditions), nonessential modifiers (in parentheses), and subterms (essential modifiers that are indented below main terms). The index also contains a Table of Neoplasms, a Table of Drugs and Chemicals, and an index to external causes and injuries. To properly assign an ICD-10-CM code, locate the main term in the index, apply coding conventions (and guidelines), and verify the code in the ICD-10-CM Tabular List of Diseases and Injuries. Medical necessity is the measure of whether a healthcare procedure or service is appropriate for the diagnosis and/or treatment of a condition. Third-party payers use medical necessity measurements to make a decision about whether or not to pay a claim. ICD-10-CM coding conventions are incorporated into the coding system as instructional notes.

Outpatient care includes any healthcare service provided to a patient who is not admitted to a facility. Such care may be provided in a physician’s office, a stand-alone healthcare facility, a hospital outpatient or emergency department, or the patient’s home. The CMS *Diagnostic Coding and Reporting Guidelines for Outpatient Services: Hospital-Based and Provider-Based Office* were developed by the federal government and have been approved for use by hospitals and providers for coding and reporting hospital-based outpatient services and provider-based office visits. Although the guidelines were originally developed for use in submitting government claims, insurance companies have also adopted them (sometimes with variation).

INTERNET LINKS

- APC Payment Insider Listserv (free)
  [www.decisionhealth.com/apc-enroll](http://www.decisionhealth.com/apc-enroll)
- CDC Topics A–Z
  Go to [www.cdc.gov](http://www.cdc.gov) and click on the A–Z Index link.
- Coding Pro Listserv (free)
  [www.decisionhealth.com/codingpro-l-enroll](http://www.decisionhealth.com/codingpro-l-enroll)
- Encoder Pro
  [www.EncoderPro.com](http://www.EncoderPro.com)
- HCPro, Inc.
  Go to [www.hcmarketplace.com](http://www.hcmarketplace.com), and click on the *Sign up for our FREE e-Newsletters* link. Click on the box located in front of the *JustCoding News: Outpatient* (along with other e-Newsletters of interest) to subscribe.
- ICD-9-CM to ICD-10-CM GEMs
  Go to [www.findacode.com](http://www.findacode.com), click on the *Cross-a-Code™* link (located below the *Search* heading) to use the general equivalency mapping (GEM).
- ICD-10 Training (free)
  Go to [www.who.int](http://www.who.int), click on the *Health Topics* link, click on the *Classifications* link, click on the *International Classification of Diseases (ICD-10)* link, and click on the *ICD-10 Training* link. Content
at ICD-10 Training is based on the WHO’s ICD-10 classification system (not ICD-10-CM). According to the web site, “the course provides an overview of coding, focuses on the different chapters, gives a minimum of medical background, and provides short summaries.”

- ICD-10-CM MS-DRG v28 Definitions (Draft) (free)
  Go to www.cms.gov, click on the Medicare link, click on the ICD-10 link, click on the ICD-10 MS-DRG Conversion Project link, and click on the ICD-10-CM/PCS MS-DRGv28 Definitions Manual Table of Contents - Full Titles - HTML Version link.

- ICD-10-CM search engines (free)
  Go to http://findacode.com, and click on the ICD-10-CM - New for 2013 link (located below the Code Sets and Diagnosis (Dx) headings)

- Web-based training courses (free)
  Go to http://cms.meridianksi.com and click on the Web-Based Training Courses link.

**STUDY CHECKLIST**

- Read this textbook chapter and highlight key concepts.
- Create an index card for each key term.
- Access the chapter Internet links to learn more about concepts.
- Complete the chapter review, verifying answers with your instructor.
- Complete WebTutor assignments and take online quizzes.
- Complete the Workbook chapter assignments, verifying answers with your instructor.
- Complete the StudyWARE activities to receive immediate feedback.
- Form a study group with classmates to discuss chapter concepts in preparation for an exam.

**REVIEW**

Instructions: The ICD-10-CM coding review is organized according to the ICD-10-CM chapters. To properly code, refer first to the Index to Diseases and Injuries (to locate the main term and subterm entries) and then to the Tabular List of Diseases and Injuries (to review notes and verify the code selected). Underline the main term in each item; then, use coding conventions and guidelines to assign the code(s). Enter the code(s) on the line next to each diagnostic statement. Be sure to list the first-listed code first.

**CERTAIN INFECTIOUS AND PARASITIC DISEASES**

1. Aseptic meningitis due to AIDS
2. Asymptomatic HIV infection
3. Septicemia due to streptococcus
4. Dermatophytosis of the foot
5. Measles; no complications noted
6. Nodular pulmonary tuberculosis
7. Acute cystitis due to *E. coli*
8. Tuberculous osteomyelitis of left lower leg
9. Gas gangrene
10. Rotaviral enteritis
NEOPLASMS

11. Primary malignant melanoma of skin of scalp
12. Lipoma of face
13. Glioma of the parietal lobe of the brain
14. Primary adenocarcinoma of prostate
15. Carcinoma in situ of vocal cord
16. Hodgkin’s granuloma of intra-abdominal lymph nodes and spleen
17. Paget’s disease with primary infiltrating duct carcinoma of nipple, and areola of right breast (female)
18. Secondary liver cancer
19. Metastatic adenocarcinoma from breast to brain (right mastectomy performed 5 years ago; breast cancer is no longer present)
20. Cancer of the pleura (primary site)

DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM

21. Sickle cell disease with crisis
22. Iron deficiency anemia secondary to chronic blood loss
23. Von Willebrand’s disease
24. Chronic congestive splenomegaly
25. Congenital nonspherocytic hemolytic anemia
26. Essential thrombocytopenia
27. Malignant neutropenia
28. Fanconi’s anemia
29. Microangiopathic hemolytic anemia
30. Aplastic anemia secondary to antineoplastic medication for breast cancer

ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES

31. Cushing’s Syndrome
32. Hypokalemia
33. Type II diabetes mellitus with malnutrition
34. Hypogammaglobulinemia
35. Hypercholesterolemia
36. Nephrosis due to type II diabetes
37. Toxic diffuse goiter with thyrotoxic crisis
38. Cystic fibrosis
39. Panhypopituitarism
40. Rickets
MENTAL AND BEHAVIORAL DISORDERS
41. Acute exacerbation of chronic undifferentiated schizophrenia
42. Reactive depressive psychosis due to the death of a child
43. Hysterical neurosis
44. Anxiety reaction manifested by fainting
45. Alcoholic gastritis due to chronic alcoholism (episodic)
46. Juvenile delinquency; patient was caught shoplifting
47. Depression
48. Hypochondria; patient also has continuous laxative habit
49. Acute senile dementia with Alzheimer’s disease
50. Epileptic psychosis with generalized grand mal epilepsy

DISEASES OF THE NERVOUS SYSTEM
51. Neisseria meningitis
52. Intracranial abscess
53. Postvaricella encephalitis
54. Hemiplegia due to old CVA
55. Encephalitis
56. Congenital diplegic cerebral palsy
57. Tonic-clonic epilepsy
58. Bell’s palsy
59. Spastic quadriplegia
60. Intraspinal abscess

DISEASES OF THE EYE AND ADNEXA
61. Retinal detachment with single retinal break, right eye
62. Infantile glaucoma
63. Mature cataract
64. Blepharochalasis of right upper eyelid
65. Xanthelasma of right lower eyelid
66. Lacrimal gland dislocation, bilateral lacrimal glands
67. Stenosis of bilateral lacrimal sacs
68. Cyst of left orbit
69. Acute toxic conjunctivitis, left eye
70. Ocular pain, right eye

DISEASES OF THE EAR AND MASTOID PROCESS
71. Acute contact otitis externa, right ear
72. Chronic perichondritis, left external ear
73. Chronic serous otitis media, bilateral
74. Acute eustachian salpingitis, right ear
75. Postauricular fistula, left ear
76. Attic perforation of tympanic membrane, left ear
77. Cochlear otosclerosis, right ear
78. Labyrinthitis, right ear
79. Tinnitus, left ear
80. Postprocedural stenosis of right external ear canal

**DISEASES OF THE CIRCULATORY SYSTEM**

81. Congestive rheumatic heart failure
82. Mitral valve stenosis with aortic valve disease
83. Acute rheumatic heart disease
84. Hypertensive cardiovascular disease
85. Congestive heart failure; hypertension
86. Secondary hypertension; stenosis of renal artery
87. Hypertensive nephropathy with chronic uremia
88. Hypertensive chronic end-stage renal disease
89. Acute STEMI myocardial infarction of inferolateral wall, initial episode of care
90. Arteriosclerotic heart disease (native coronary artery) with angina pectoris

**DISEASES OF THE RESPIRATORY SYSTEM**

91. Aspiration pneumonia due to regurgitated food
92. Streptococcal Group B pneumonia
93. Respiratory failure due to myasthenia gravis
94. Mild intrinsic asthma with status asthmaticus
95. COPD with emphysema
96. Acute tracheitis with obstruction
97. Chlamydial pneumonia
98. Chronic tonsillitis and adenoiditis
99. Simple chronic bronchitis
100. Moderate persistent asthma with (acute) exacerbation

**DISEASES OF THE DIGESTIVE SYSTEM**

101. Supernumerary tooth
102. Unilateral femoral hernia with gangrene
103. Cholesterosis of gallbladder
104. Diarrhea
105. Acute perforated peptic ulcer
106. Acute hemorrhagic gastritis with acute blood loss anemia
107. Acute appendicitis peritoneal abscess
108. Acute cholecystitis with cholelithiasis
109. Aphthous stomatitis
110. Diverticulosis and diverticulitis of large intestine

DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE

111. Diaper rash
112. Acne vulgaris
113. Postinfective skin cicatrix
114. Cellulitis of left foot; culture reveals staphylococcus
115. Infected ingrowing nail, thumb, left hand
116. Carbuncle of face
117. Pemphigus foliaceus
118. Pressure ulcer of right elbow, stage 2
119. Factitial dermatitis
120. Seborrhea

DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE

121. Displacement of thoracic intervertebral disc
122. Primary localized osteoarthrosis of the left hip
123. Acute juvenile rheumatoid arthritis
124. Chondromalacia of the right patella
125. Pathologic fracture, cervical vertebra
126. Staphylococcal arthritis, left knee
127. Postimmunization arthropathy, right ankle and foot
128. Idiopathic chronic gout, right shoulder
129. Kaschin-Beck disease, left shoulder
130. Fibromyalgia

DISEASES OF THE GENITOURINARY SYSTEM

131. Vesicoureteral reflux with bilateral reflux nephropathy
132. Acute glomerulonephritis with necrotizing glomerulitis
133. Actinomycotic cystitis
134. Subserosal uterine leiomyoma, cervical polyp, and endometriosis of uterus
135. Dysplasia of the cervix
136. Recurrent and persistent hematuria with dense deposit disease
137. Chronic obstructive pyelonephritis
138. Acute kidney failure with medullary necrosis
139. Stage 3 chronic kidney disease
140. Urethral stricture due to childbirth
DISEASES OF PREGNANCY, CHILDBIRTH, AND THE Puerperium

141. Defibrination syndrome following termination of pregnancy procedure 2 weeks ago

142. Miscarriage at 19 weeks gestation

143. Incompetent cervix resulting in miscarriage and fetal death

144. Postpartum varicose veins of legs

145. Spontaneous breech delivery

146. Triplet pregnancy, delivered spontaneously

147. Retained placenta without hemorrhage, delivery this admission

148. Postpartum pyrexia of unknown origin (delivery during previous admission)

149. Late vomiting of pregnancy, undelivered

150. Pre-eclampsia complicating pregnancy, delivered this admission

CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD

151. Erythroblastosis fetalis

152. Hyperbilirubinemia of prematurity, prematurity (birthweight 2,000 grams)

153. Erb’s palsy

154. Hypoglycemia in infant with diabetic mother

155. Premature “crack” baby born in hospital to cocaine-dependent mother (birthweight 1,247 grams); neonatal withdrawal; cocaine dependence

156. Neonatal hematemesis

157. Sclerema neonatorum

158. Failure to thrive in newborn

159. Grey baby syndrome

160. Congenital renal failure

CONGENITAL MALFORMATIONS, DEFORMATIONS, AND CHROMOSOMAL ABNORMALITIES

161. Congenital diaphragmatic hernia

162. Single liveborn male (born in the hospital, vaginally) with polydactyly of fingers

163. Unilateral cleft lip and palate, incomplete

164. Patent ductus arteriosus

165. Congenital talipes equinovarus

166. Cervical spina bifida

167. Coloboma of left iris

168. Tetralogy of Fallot

169. Atresia of vas deferens

170. Klinefelter syndrome, karyotype 47, XXY
SYMPTOMS, SIGNS, AND ABNORMAL CLINICAL AND LABORATORY FINDINGS

171. Abnormal cervical Pap smear
172. Sudden infant death syndrome
173. Sleep apnea
174. Fluid retention and edema
175. Elevated blood pressure reading
176. Epistaxis
177. Acute abdomen
178. Dysphagia, pharyngeal phase
179. Retrograde amnesia
180. Irritable infant

INJURY, POISONING, AND CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES

181. Open frontal fracture with traumatic subarachnoid hemorrhage (initial encounter)
182. Traumatic anterior dislocation, left elbow (initial encounter)
183. Sprain of lateral collateral ligament, right knee (subsequent encounter)
184. Chronic headaches due to old traumatic avulsion, left eye
185. Traumatic below-the-knee amputation, right (initial encounter)

BURNS

Instructions: Burns require two codes:

- One code for each site and highest degree (which means more than one code can be assigned).
- One code for the percentage of body surface (not body part) affected.

Refer to the following chart to calculate the percentage of burns for an extent of body surface. The percentage of total body area or surface affected follows the “rule of nines,” as depicted in the following chart:

<table>
<thead>
<tr>
<th>BODY SURFACE</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head and neck</td>
<td>9%</td>
</tr>
<tr>
<td>Back (trunk)</td>
<td>18%</td>
</tr>
<tr>
<td>Chest (trunk)</td>
<td>18%</td>
</tr>
<tr>
<td>Leg (each)</td>
<td>18%</td>
</tr>
<tr>
<td>Arm (each)</td>
<td>9%</td>
</tr>
<tr>
<td>Genitalia</td>
<td>1%</td>
</tr>
<tr>
<td>TOTAL BODY SURFACE</td>
<td>100%</td>
</tr>
</tbody>
</table>

186. Third-degree burn of left lower leg and second-degree burn of left thigh (initial encounter)

187. Third-degree burn of right forearm (initial encounter)
188. Third-degree burn of upper back (subsequent encounter)  
189. Thirty percent body burns with 10 percent third-degree burns (initial encounter)  
190. Painful scarring due to old first- and second-degree burns of right palm  

FOREIGN BODIES

191. Coin in the bronchus causing asphyxiation (initial encounter)  
192. Foreign body in right eye (initial encounter)  
193. Marble in colon (initial encounter)  
194. Bean in nose (initial encounter)  
195. Q-tip stuck in left ear (initial encounter)  

COMPLICATIONS

196. Infected ventriculoperitoneal shunt (initial encounter)  
197. Displaced left breast prosthesis (initial encounter)  
198. Leakage of mitral valve prosthesis (initial encounter)  
199. Postoperative superficial thrombophlebitis of right leg (initial encounter)  
200. Dislocated left hip internal prosthesis (initial encounter)  

POISONINGS, ADVERSE EFFECTS, AND UNDERDOSING

201. Accidental lead poisoning (child discovered eating paint chips) (initial encounter)  
202. Anaphylactic shock due to allergic reaction to penicillin (initial encounter)  
203. Theophylline toxicity (initial encounter)  
204. Carbon monoxide poisoning from car exhaust (suicide attempt) (initial encounter)  
205. Hypertension due to underdosing of Aldomet (initial encounter)  

EXTERNAL CAUSES OF MORBIDITY

206. Bicyclist fell off bicycle in parking lot, lacerating chin (initial encounter)  
207. Boy wearing heelies collided with tree in yard of single family home, getting upset ________ (initial encounter)  
208. Pedestrian was walking through deep snow at local college and fell, spraining ________ right wrist (initial encounter)  
209. Patient walked into lamppost while walking on sidewalk, striking her head causing dizziness (initial encounter)  
210. Patient lacerated right hand while slicing tomatoes in college dormitory kitchen (initial encounter)
FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVICES

211. Exposure to tuberculosis

212. Family history of colon carcinoma

213. Postoperative follow-up examination, human kidney donor

214. Encounter for removal of cast from healed pathologic fracture of right ankle

215. Admitted as bone marrow donor

216. Encounter for chemotherapy for patient with Hodgkin lymphoma

217. Encounter for reprogramming (adjustment) of cardiac pacemakers

218. Encounter for replacement of tracheostomy tube

219. Encounter for renal dialysis in patient with end-stage renal failure

220. Encounter for speech therapy for patient with dysphasia secondary to an old CVA