CENGAGE

Understanding ICD-10-CM & ICD-10-PCS

A Worktext

2022

Mary Jo Bowie
MS, BS, AAS, RHIA, RHIT

Understanding ICD-10-CM & ICD-10-PCS

A Worktext

2022

Mary Jo Bowie

MS, BS, AAS, RHIA

AHIMA-approved ICD-10-CM and ICD-10-PCS Train the Trainer

CENGAGE

Australia • Brazil • Canada • Mexico • Singapore • United Kingdom • United States

***Understanding ICD-10-CM & ICD-10-PCS: A Worktext,* 2022 edition**
Mary Jo Bowie

SVP, Higher Education Product Management: Erin Joyner

VP, Product Management, Learning Experiences: Thais Alencar

Product Director: Jason Fremder

Senior Product Manager: Stephen G. Smith

Learning Designer: Kaitlin Schlicht

Product Assistant: Dallas Dudley

Product Marketing Manager: Courtney Cozzy

Content Manager: Mark Peplowski

Digital Delivery Quality Partner: Lisa Christopher

IP Analyst: Ashley Maynard

Manager, IP Product Analysis: Alexandra Ricciardi

Designer: Felicia Bennett

Cover image: antishock/Shutterstock.com

Library of Congress Control Number: 2021913668

ISBN: 978-0-357-62172-1

Cengage
200 Pier 4 Boulevard
Boston, MA 02210
USA

Printed in the United States of America
Print Number: 01 Print Year: 2021

To my husband, Bill, who is my encouragement and who finally is driving his sports car!

To my daughters and son-in-law and my granddaughters and grandsons, may you all find God's will for your lifes. Thanks for all you do to allow me the time to write. To my parents for making sure that you gave me all the opportunities to become who I am today.

To all of my Cengage family, who work to make my books happen. A special thanks to Mark Peplowski for all he does that goes above and beyond his job. A special thanks to Lou Ann Decker for her expertise reviewing this book.

—Mary Jo Bowie

TABLE OF CONTENTS

Chapter 6: Infectious and Parasitic Diseases 74

Chapter 7: Neoplasms 102

Chapter 8: Diseases of the Blood and Blood-Forming Organs 131

PREFACE

Understanding ICD-10-CM and ICD-10-PCS: A Worktext, 2022 Edition, provides a comprehensive textbook to learn and master ICD-10-CM and ICD-10-PCS coding. This book can be used to instruct learners in both academic and clinical settings.

The *ICD-10-CM Official Guidelines for Coding and Reporting* are highlighted in various book chapters, and the MindTap and Companion Site provide a link to the complete guidelines. Numerous clinical examples and case studies are used throughout the book to provide opportunities for learners to practice with real-life scenarios. Frequently encountered diseases are highlighted to enable the learner to become familiar with common disease signs and symptoms, clinical testing, and treatments.

Organization of the Worktext

Understanding ICD-10-CM and ICD-10-PCS: A Worktext provides a thorough introduction to both ICD-10-CM and ICD-10-PCS coding. Chapter 1 defines the field of medical coding and introduces coding professions. Chapters 2-5 then provide the foundation needed to understand ICD-10-CM coding, including an overview of the ICD-10-CM coding manual, ICD-10-CM coding conventions, the general process of selecting diagnostic codes, and an introduction to ICD-10-CM Official Guidelines for Coding and Reporting. Chapters 6-26 follow the organization of the ICD-10-CM coding manual, with each chapter devoted to covering a chapter of the coding manual, and numerous coding activities so that students become proficient in coding from all sections of the coding manual.

Students are introduced to ICD-10-PCS in Chapter 27. They then learn about each section of the ICD-10-PCS coding manual in Chapters 28-38.

Several features are incorporated into the chapters to facilitate learning:

- A **chapter outline** gives a brief overview of chapter content.
- **Learning objectives** familiarize the learner with chapter objectives.
- **Key terms** are listed at the start of each chapter and then highlighted and defined within the chapter.
- Many clinical **examples** are used throughout the text.
- **Illustrations** of human anatomy appear, based on the concept that learning is enhanced through visual tools.
- **Coding assignments** and **case studies** are used to determine comprehension of the material and to provide real-world practice.
- **Chapter summaries** review the main ideas for review purposes.
- **Internet links** provide additional reference materials for the learner and take learning beyond the textbook.
- **Chapter reviews** contain questions to reinforce content presented.

New to the 2022 Edition

- The most current code sets available at the time of publication
- Updated information from the 2022 ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting

- Expanded explanations, procedural case examples, and illustrations in Chapter 28: Medical and Surgical section
- Coverage of new codes for malignant bilateral ovaries, thrombocytosis, depression, toxic encephalopathy, abnormal findings on neonatal screening, and additions to social determinants of health
- Coverage of new COVID-19 guidelines
- New feedback for Coding Assignment answers in MindTap

Instructor and Student Resources

Additional instructor and student resources for this product are available online. Instructor assets include an Instructor's Manual, Solution and Answer Guide, MindTap Educator's Guide, Teaching Online Guide, Transition Guide, PowerPoint® slides, and a test bank powered by Cognero. Student assets include additional Peer Coding Audit Activities. Sign up or sign in at www.cengage.com to search for and access this product and its online resources.

Instructor's Manual

The Instructor's Manual includes an outline, list of activities, and key terms with definitions.

Solution and Answer Guide

This guide provides answers to all questions presented in the textbook, including Exercises, Chapter Reviews, Coding Assignments, and Case Studies.

MindTap Educator's Guide

This guide walks you through what the unique activities are in the MindTap, their purpose, and where you'll find them.

Guide to Teaching Online

This guide presents technological and pedagogical considerations and suggestions for teaching medical coding courses when you cannot be in the same room as students.

Transition Guide

This guide highlights all the changes in the text and in the digital offerings from the previous edition to this edition.

PowerPoint Lecture Presentation

PowerPoint Lecture Presentations offer ready-to-use outlines of each chapter, which may be easily customized for your lectures. To provide maximum pedagogical value, the 2022 edition PowerPoints have been updated to include additional interactive activities.

Cengage Learning Testing Powered by Cognero

Cognero is a flexible online system that allows you to author, edit, and manage test bank content from multiple Cengage solutions; create multiple test versions in an instant; and deliver tests from your LMS, your classroom, or wherever you want.

MindTap

MindTap is a fully online, interactive learning experience built upon authoritative Cengage content. By combining readings, multimedia activities, and assessments into a singular learning path, MindTap elevates learning by providing real-world application to better engage students. Instructors customize the learning path by selecting

Cengage resources and adding their own content via apps that integrate into the MindTap framework seamlessly with many learning management systems.

The MindTap includes:

- Auto-graded Exercises, Chapter Review, Coding Assignments, and Case Studies from the textbook
- Video Quizzes that walk students step-by-step through coding patient cases
- Video Case Studies that review pathophysiology and test students on their coding skills
- Chapter Quizzes
- Medical Coding Trainer which presents learners with realistic, multi-page patient records to code

The 2022 edition has been updated to include automated feedback explaining the correct answers for Coding Assignments, in addition to feedback already provided for Exercises, Chapter Reviews, Case Studies, Video Quizzes, and Video Case Studies.

To learn more, visit www.cengage.com/training/mindtap.

Optum360® EncoderPro.com

Enhance your course with Cengage learning materials and online coding tools from Optum360®. *EncoderPro.com Expert* is an online coding and reference tool designed to enhance your coding capabilities.

- Using online coding tools can help by: saving you time and money;
- increasing accuracy, reducing denials, and ensuring you receive complete reimbursement; and
- reducing required storage space and paper.

Features of EncoderPro.com Expert include:

- ICD-10-CM code content search
- ICD-10 mapping tools
- Coders' Desk Reference
- Complete code history
- Local Coverage Determinations (LCDs) and Medicare Pub. 100 access
- Medicare CCI edits
- Modifier crosswalk
- Enhanced compliance editor
- Enhanced LCD/NCD policy searching
- Cross-coder relationships from seven coding and billing specialty reference books

To make the switch and start saving on coding materials with Cengage and Optum360®, contact your Cengage Learning Consultant today at cengage.com/repfinder.

ACKNOWLEDGMENTS

A special thank-you is extended to the reviewers who have provided recommendations to enhance the content of this work.

Dr. Tammie Bolling
Associate Professor
Pellissippi State Community College
Knoxville, Tennessee

Melanie Galinger, CCA, CPC-A
Annual Adjunct
University of Cincinnati Clermont
Batavia, OH

Natasha Johnson, RHIT
Health Information Management Clinical Coordinator
Midlands Technical College
Columbia, South Carolina

NaTunya Davis Johnson, Ed.S.
Professor and District Department Chair
Holmes Community College
Ridgeland, MS

Lindsey Klimek, CPC, CIMC
Instructor
Alexandria Technical and Community College
Alexandria, Minnesota

Keita Kornegay, CEHRS, CMAA, CMRS
Professor
Wilson Community College
Wilson, North Carolina

Michelle Ruggiero, MsEd, CPC, CCS-P
Instructor
Bryant and Stratton College
Buffalo, New York

Karen S. Saba, CPC, CPC-I, AHIMA ICD-10-CM, ICD-10-PCS Trainer
Instructor/Tenured Professor
Spokane Community College
Spokane, WA

Tracy Smith, MBA
Department Chair
Hinds Community College
Pearl, MS

Technical Reviewer

Both Mary Jo and the Cengage team offer their profound thanks to Lou Ann Decker for her significant technical review efforts. Your efforts were invaluable on this revision. Many thanks for all that you do!

Lou Ann Decker, AAS, RHIT

ABOUT THE AUTHOR

Mary Jo Bowie, MS, BS, AAS, RHIA, RHIT

Mary Jo has worked in the health information field for more than 40 years as a consultant, HIM department director, and college HIM and medical coding program director and associate professor, and instructor and medical transcriptionist. As consultant and owner of Health Information Professional Services in Binghamton, New York, she has consulted nationally in various levels of care, including inpatient hospital settings, ambulatory care settings, skilled nursing facilities, physician offices, and clinics. She is an active member of the American Health Information Management Association (AHIMA). She has held the following positions in the New York Health Information Management Association: education director and a member of the board of directors, and Ambulatory Care Coding Guidelines Committee chairperson. At the collegiate level, teaching both in the classroom and in an Internet-based format, she has taught numerous health information technology and coding and reimbursement courses. Mary Jo also conducts professional coding workshops for coders as well as for physicians and clinical staff. She is also an AHIMA-approved ICD-10-CM and ICD-10-PCS Train the Trainer. She has led more than 60 workshops for Cengage on ICD-10-CM and ICD-10-PCS.

CHAPTER 1

Introduction to Coding and Coding Professions

Chapter Outline

Chapter Objectives

At the conclusion of this chapter, you should be able to:

1. Describe the purpose of coding.
2. Explain the development of the ICD classification system.
3. Discuss the standards mandated by the Health Insurance Portability and Accountability Act of 1996.
4. Describe professional associations with reference to their certifications, requirements, and purpose.
5. Identify the employment opportunities for coders.

Key Terms

Accrediting Bureau of Health Education Schools (ABHES)
Administrative Simplification
American Academy of Professional Coders (AAPC)
American Association of Medical Assistants (AAMA)
American Health Information Management Association (AHIMA)
American Medical Billing Association (AMBA)
American Medical Technologists (AMT)
Centers for Medicare and Medicaid Services (CMS)
Certified Coding Associate (CCA)
Certified Coding Specialist (CCS)
Certified Coding Specialist, Physician-Based (CCS-P)
Certified Documentation Improvement Practitioner (CDIP)
Certified Health Data Analyst (CHDA)
Certified in Healthcare Privacy and Security (CHPS)
Certified Inpatient Coder (CIC)

(*continues*)

Key Terms (*continued*)

Certified Medical Assistant (CMA)

Certified Medical Billing Specialist (CMBS)

Certified Medical Record Technician (CMRT)

Certified Medical Reimbursement Specialist (CMRS)

Certified Outpatient Coder (COC)

Certified Professional Coder (CPC)

Certified Risk Adjustment Coder (CRC)

Coding

Commission on Accreditation of Allied Health Education Programs (CAAHEP)

Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191

ICD-10-CM

ICD-10-PCS

ICD-10 Procedure Coding System

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)

International Classification of Diseases, Tenth Revision (ICD-10)

Medical Association of Billers (MAB)

Morbidity

Mortality

National Center for Health Statistics (NCHS)

Registered Health Information Administrator (RHIA)

Registered Health Information Technician (RHIT)

Registered Medical Assistant (RMA)

World Health Organization (WHO)

Introduction

Medical **coding** is the assignment of numeric or alphanumeric digits and characters to specific diagnostic and procedural phrases. This coding, like any other language, needs to be translated to be understood, and each combination of numbers or of numbers and letters represents a diagnostic or procedural phrase.

EXAMPLE: The diagnostic phrase "appendicitis" is translated into diagnostic code K37 in the ICD-10-CM coding system. The procedural phrase "open total appendectomy" is translated into procedure code 0DTJ0ZZ in ICD-10-PCS.

By using ICD-10-CM and ICD-10-PCS codes, health care professionals can effectively collect, process, and analyze diagnostic and procedural information.

Professional Coding

Coding is the language used by insurance companies and health care providers to describe what brought a person to a facility for treatment and what services were performed. The ability of health care professionals to communicate and translate these codes is vital to the care and treatment rendered to the patient. These codes are also communicated to the insurance company, which is required to make payment for the patient's care. All involved parties must be able to understand and fluently "speak" the coding language to convey the essence of the patient's visit and treatment.

In the chapters that follow, the student will gain a greater knowledge of the language of coding, specifically ICD-10-CM and ICD-10-PCS. By the completion of this book, the learner will have the knowledge base needed to become fluent in the language of ICD-10-CM and ICD-10-PCS coding, which is an ever-increasingly used tool in the health care industry.

ICD-10-CM and ICD-10-PCS codes are also used to collect information that is used for various purposes by hospitals, health departments and governmental organizations. For example, hospitals code diagnostic information and report that information to state health departments that in turn report the information to federal organizations such as the Centers for Disease Control and Prevention (CDC). The CDC then reports information to the World Health Organization. During 2020 the world has faced the COVID-19 pandemic and has collected and used information on the frequency of the disease and complications. This information was originally coded and generated by coders in hospitals and healthcare facilities.

History of Coding

ICD-10-CM, an abbreviation for the ***International Classification of Diseases,* Tenth Revision, Clinical Modification**, is an arrangement of classes or groups of diagnoses by systematic division that is used in the United States. ICD-10-CM is based on the official version of the ***International Classification of Diseases,* Tenth Revision (ICD-10)**, which was developed by the **World Health Organization (WHO)** in Geneva, Switzerland. ICD-10 is used throughout the world as a standard diagnostic tool for epidemiology, health management, and clinical purposes. In 1948, the WHO assumed responsibility for preparing and publishing the revisions to the ICD every 10 years. Thus, with every 10-year revision, the name of the current ICD changes.

EXAMPLE: ICD-8 was revised to become ICD-9; ICD-9 was revised to become ICD-10. An ICD-11 version for preparing implementation in Member States, including translations, was released on June 18, 2018. During 2019 ICD-11 was presented at the Seventy-second Work Health Assembly. At this current time it is anticipated that the Member States of the World Health Organization will begin reporting health data using ICD-11 in January of 2022. For the most up-to-date information on ICD-11, visit ***http://www.who.int/classifications/icd/revision/en/***. This website contains a wealth of information about ICD-11.

The ICD classification system was designed to compile and present statistical data on **morbidity** (the rate or frequency of disease) and **mortality** (the rate or frequency of deaths). Hospitals first used this form of classification to track, store, and retrieve statistical information. However, a more efficient basis for the storage and retrieval of diagnostic data was needed. In 1950, the Veterans Administration and the U.S. Public Health Service began independent studies of the use of the ICD for hospital indexing purposes. By 1956, the American Hospital Association and the American Association of Medical Record Librarians (now the American Health Information Management Association) felt that the ICD form of classification provided an efficient and useful vehicle for indexing hospital records.

With hospital indexing in mind, the WHO international conference published its eighth revision of the ICD in 1966. Health care professionals in some countries found that ICD-8 lacked the detail needed for diagnostic indexing. In the United States, consultants were asked to study ICD-8 for its applicability to various users. In 1968, the Advisory Committee to the Central Office on ICD published the *International Classification of Diseases,* Eighth Revision, adapted for use in the United States. It became known as ICDA-8 and was used for coding diagnostic data for both morbidity and mortality statistics in the United States.

In 1979, ICD-9-CM replaced earlier, less-specific versions of the classification system. ICD-9-CM streamlined the other versions of ICD classification into a single system that was intended for use primarily in U.S. hospitals. Please note that there is a difference between ICD-9 and ICD-9-CM. ICD-9 was developed by the WHO, and in the United States we take the ICD-9 version and modify codes to create the clinical modification of ICD-9 that will be used within the United States. The ICD-9-CM provided a more complete classification system for morbidity data to be used for indexing and reviewing patient records and medical care.

In 1992, the WHO published ICD-10, which is currently being used in many countries. In 1997, the National Center for Health Statistics (NCHS) began testing the ICD-10 system for implementation of the diagnostic codes in the United States. In the United States, the ICD codes are further developed into ICD-10-CM codes, which is the clinical modification of ICD codes. This modification allows for the ICD-10-CM codes to be more effectively used in clinical settings to capture diseases and signs and symptoms that patients display. In the United States, the **National Center for Health Statistics (NCHS)** is responsible for maintaining the ICD-10-CM diagnostic codes.

As the NCHS was testing ICD-10-CM, the draft and the preliminary crossfunctionality between ICD-9-CM and ICD-10-CM were made available on the NCHS website for public review and comment. In the summer of 2003, the American Hospital Association and the American Health Information Management Association conducted a field test for ICD-10-CM and reported the findings. Modifications were then made to the tenth revision.

In 2001, the Centers for Medicare and Medicaid Services funded a project to design a replacement system for the procedural codes of ICD-9-CM. The contract to redesign the procedural codes was awarded to 3M Health Information Systems. The new system is known as **ICD-10 Procedure Coding System** or **ICD-10-PCS**. The **Centers for Medicare and Medicaid Services (CMS)** is responsible for maintaining the procedure codes of ICD-10-PCS.

ICD-10-CM and ICD-10-PCS, when compared to ICD-9-CM, has additional information relevant to:

- Ambulatory and managed-care encounters.
- Expanded injury codes.
- More combination diagnosis-symptom codes to reduce the number of codes needed to fully describe a condition.
- Expanded use of sixth and seventh characters.
- Laterality and greater specificity in code assignment.

On August 22, 2008, the U.S. Department of Health and Human Services (HHS) published a proposed rule to adopt ICD-10-CM and ICD-10-PCS to replace ICD-9-CM. On January 16, 2009, the final rule on adoption of ICD-10-CM and ICD-10-PCS was published with an implementation date of October 1, 2013. During 2012 the implementation date of October 1, 2013 was reviewed and extended to October 1, 2014. And again in 2014, the implementation date was changed to October 1, 2015.

This system has become the key storyteller to the insurance companies, explaining what brought the patient into the office or facility (by means of a diagnostic code), as well as what services the facility provided (by means of a procedural code). Because coding plays such a critical role in the reimbursement for services rendered, *correct coding practices are essential*.

Health Insurance Portability and Accountability Act of 1996

The **Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191**, was passed by Congress to improve the portability and continuity of health care coverage. The **Administrative Simplification** aspect of this legislation developed standards for the electronic exchange of health care data for administrative and financial transactions. The final rule on transactions and code sets mandated the use of standardized code sets for the electronic submission of health care data.

HIPAA mandated that ICD-9-CM diagnostic codes must be reported for diagnoses for all levels of care, including all hospital services, clinic services, long-term care, and physician offices. ICD-9-CM procedural codes were to be reported for inpatient hospital services. Health care providers used ICD-9-CM codes to accurately report diagnoses and services provided on submitted insurance claims. The codes are used to determine not only payment, but also the medical necessity of care, which is defined by Medicare as "the determination that a service or procedure rendered is reasonable and necessary for the diagnosis or treatment of an illness or injury." Thus, coders perform a vital role in the health care system.

ICD-10-CM and ICD-10-PCS codes replaced ICD-9-CM for use by inpatient facilities starting on October 1, 2015. Also on that date, ambulatory services and physician services started using ICD-10-CM codes for diagnosis and continued to use CPT codes for procedures.

Professional Coding Associations

To assist and promote correct coding and reimbursement, several organizations educate, train, and credential coders. Credentialing ensures the proper training and education of coders. As the transition was made from ICD-9-CM to ICD-10-CM and ICD-10-PCS, many professional organizations offered educational materials to assist in the transition. These organizations also continue to support ongoing training and continuing education that apply to coding and other aspects of the health information management field.

American Health Information Management Association (AHIMA)

The **American Health Information Management Association (AHIMA)** represents health information professionals who manage, organize, process, and manipulate patient data. Health information professionals have knowledge of electronic and paper medical record systems, as well as of coding, reimbursement, and

research methodologies. The information that these professionals manage directly impacts patient care and financial decisions made in the health care industry. Members of AHIMA feel that the quality of patient care is directly related to the effectiveness of the information available.

Health care providers, insurance companies, and institutional administrators depend on the accuracy and quality of that information. For this reason, AHIMA members are trained to provide a level of service that maintains the quality and accuracy of the medical information they come into contact with.

AHIMA offers a number of certifications and credentials to ensure that its members meet the level of proficiency needed by educated professionals to manage health care information. Members receive the following certifications or credentials through a combination of education, experience, and performance on national certification examinations:

- CCA—**Certified Coding Associate**
- CCS—**Certified Coding Specialist**
- CCS-P—**Certified Coding Specialist, Physician-Based**
- CDIP—**Certified Documentation Improvement Practitioner**
- CHDA—**Certified Health Data Analyst**
- CHPS—**Certified in Healthcare Privacy and Security**
- RHIA—**Registered Health Information Administrator**
- RHIT—**Registered Health Information Technician**

Once the certifications have been obtained, continuing education credits are required to maintain them. These credits can be obtained through conferences, seminars, classes, or other avenues of career development that AHIMA publishes and makes available to its members.

American Academy of Professional Coders (AAPC)

The **American Academy of Professional Coders (AAPC)** was founded to elevate the standards of medical coding. The AAPC provides networking opportunities through local chapter memberships and conferences. It also provides ongoing educational opportunities for members. AHIMA deals with all aspects of health information, whereas AAPC focuses on coding and reimbursement.

Like AHIMA, AAPC offers certifications for professional proficiency. The **Certified Professional Coder (CPC)** certification validates a coder's proficiency in the physician office setting, the **Certified Inpatient Coder, (CIC)** certification validates proficiency in the inpatient hospital setting, and the **Certified Outpatient Coder (COC)** certification validates coding proficiency in outpatient hospital and outpatient facility coding. The AAPC also offers specialty credentials for experienced coders. To understand the various specialty coding examinations and credentials review the following website: https://www.aapc.com/certification/specialty-credentials.aspx.

AAPC also offers the **Certified Risk Adjustment Coder (CRC)** certification that validates that a coder can read a medical chart and assign the correct diagnosis (ICD-10-CM) codes for a wide variety of clinical cases and services for risk adjustment models. AAPC also offers specialty coding certifications. Information about these and other certifications from AAPC can be found at ***https://www.aapc.com/certification/.***

Continuing education credits are also required to maintain AAPC certification.

American Association of Medical Assistants (AAMA)

The **American Association of Medical Assistants (AAMA)** represents individuals trained in performing routine administrative and clinical jobs, including coding, that keep medical offices and clinics running efficiently and smoothly. Credentialing is voluntary in most states; a medical assistant is not required to be certified or registered. However, the AAMA offers the national credential of **Certified Medical Assistant (CMA)** certification for medical assistants. The **Commission on Accreditation of Allied Health Education Programs (CAAHEP)** collaborates with the Curriculum Review Board of the AAMA Endowment to accredit medical assisting programs in both public and private postsecondary institutions throughout the United States.

This accreditation prepares candidates for entry in the medical assisting field. Students who have graduated from a medical assisting program accredited by the CAAHEP or the **Accrediting Bureau of Health Education Schools (ABHES)** are eligible to take the CMA examination, which tests candidates on tasks performed in the workplace. Recertification is required every five years, either by continuing education or by examination.

American Medical Technologists (AMT)

American Medical Technologists (AMT) offers professional credentials, such as **Registered Medical Assistant (RMA)**. These professionals perform the same tasks as those of a CMA but are credentialed by AMT. Students who have completed a college-level program approved by the U.S. Department of Education may voluntarily take the examination that credentials them as RMAs.

American Medical Billing Association (AMBA)

The **American Medical Billing Association's (AMBA)** mission is to provide education and networking opportunities for medical billers. The AMBA offers the **Certified Medical Reimbursement Specialist (CMRS)** credential and also provides continuing education and ongoing research related to medical billing.

Medical Association of Billers (MAB)

The **Medical Association of Billers (MAB)** was founded in 1995 and is approved and licensed by the Commission for Post Secondary Education. The MAB offers the following credentials:

- CMBS—**Certified Medical Billing Specialist**
- CMRT—**Certified Medical Record Technician**

Employment Opportunities for Coders

Regardless of the credentialing path that an individual takes, career opportunities are numerous. Coders work in all aspects of health care, including hospitals, physicians' offices, clinics, long-term care facilities, insurance companies, and billing agencies. With the evolution of the electronic health record, more coders will be needed to review the generated information for its accuracy and compliance. The Bureau of Labor Statistics calculates that the number of coding jobs in the United States will grow faster through 2029 than the average of all occupations. As the population of the United States ages, more individuals will use health care services and at a greater rate, thus increasing the need for additional services and for coded health care data, therefore also increasing the demand for additional medical coders.

Summary

- Coding is the assignment of numeric or alphanumeric digits and characters to diagnostic and procedural phrases.
- ICD-10-CM and ICD-10-PCS was implemented in the United States to code diagnoses and procedures on October 1, 2015.
- The National Center for Health Statistics coordinates the modifications to disease classifications.
- The Centers for Medicare and Medicaid Services (CMS) coordinates the procedural classification updates.
- The American Health Information Management Association offers the following credentials: Certified Coding Associate; Certified Coding Specialist; Certified Coding Specialist, Physician-Based; Certified Documentation Improvement Practitioner; Certified Health Data Analyst; Certified in Healthcare Privacy and Security; Registered Health Information Administrator; and Registered Health Information Technician.
- The American Academy of Professional Coders offers the following credentials: Certified Professional Coder; Certified Inpatient Coder; Certified Outpatient Coder; Certified Risk Adjustment Coder; and various specialty coding certifications.

- The American Association of Medical Assistants offers the Certified Medical Assistant credential.
- American Medical Technologists offers professional credentials, such as a Registered Medical Assistant.
- The American Medical Billing Association offers the Certified Medical Reimbursement Specialist credential.
- The Medical Association of Billers offer the Certified Medical Billing Specialist, and Certified Medical Record Technician certifications.

Internet Links

To obtain information about ICD-10-CM, visit ***www.cdc.gov/nchs/icd/icd10cm.htm***. On this site you will find information about ICD-10-CM. Review the section entitled "ICD-10-CM."

To obtain information on the AAMA, visit ***www.aama-ntl.org***.

To obtain information on the AAPC, visit ***www.aapc.com***.

To obtain information on the AHIMA, visit ***www.ahima.org***.

To obtain information on AMT, visit ***www.americanmedtech.org***.

To obtain information on the AMBA, visit ***www.ambanet.net***.

To obtain information on the MAB, visit *https://mabillers.com/*.

To obtain information on career statistics and opportunities, visit the Bureau of Labor Statistics at ***www.bls.gov***.

Chapter Review

True/False

Indicate whether each statement is true (T) or false (F).

1. _____ The CPC credential is offered by the American Health Information Management Association.
2. _____ AHIMA requires credentialed professionals to obtain continuing education credits to maintain their credentials.
3. _____ CMAs must be licensed to practice in the United States.
4. _____ The final rule on transactions and code sets mandated the use of ICD-9-CM for the electronic submission of health care data.
5. _____ The Centers for Medicare and Medicaid Services coordinates the procedural classification updates of ICD-10-PCS.

Fill-in-the-Blank

Enter the appropriate term(s) to complete each statement.

6. The rate or frequency of a disease is known as _____.
7. ICD-9 was developed by the _____.
8. ICD-10-CM is an abbreviation for the *International Classification of Diseases,* Tenth Revision, _____.
9. Modifications of the ICD-10-CM disease classification is coordinated by _____.
10. Public Law 104-191, known as _____, was passed by Congress to improve the portability and continuity of health care coverage.

Short Answer

Define each abbreviation and acronym.

11. AHIMA

12. RHIA

13. CIC

14. RHIT

15. CPC

16. AAMA

17. RMA

18. CMA

19. CCS

20. CCS-P

21. COC

22. CRC

23. AAPC

24. Molly RHIT has been asked by the medical staff director to prepare a presentation for the medical staff describing the purpose of coding. Briefly describe what should be included in the presentation.

25. Identify the employment opportunities for coders.

CHAPTER 2

An Overview of ICD-10-CM

Chapter Outline

Chapter Objectives

At the conclusion of this chapter, you should be able to:

1. Explain the basic structure and components of the ICD-10-CM coding book.
2. Distinguish between the two ways chapters are organized in the Tabular List of Diseases and Injuries.
3. Identify the chapters of the Tabular List of Diseases and Injuries to which a code corresponds.

Key Terms

Index to Diseases and Injuries
Index to External Causes of Injury
Tabular List of Diseases and Injuries (Tabular)

REMINDER: As you work through this chapter and the remaining chapters, you will need to have a copy of the ICD-10-CM coding book to reference.

Introduction

The ICD-10-CM coding system allows health care providers and facilities to answer the question, "What brought the patient to my office/facility?" This information is needed for statistical purposes, reimbursement, and continuity of patient care. To accurately convey this information, the coder must become familiar with all aspects of the ICD-10-CM coding book. This chapter presents an overview of ICD-10-CM.

ICD-10-CM Coding Book Format

ICD-10-CM is used by the U.S. government for morbidity coding. ICD-10-CM is compatible with ICD-10, which is used for cause of death coding in the United States. Compared to the past editions, ICD-10-CM has a greater number of codes and has been expanded to include health-related conditions and to provide greater specificity in code assignment.

ICD-10-CM has two parts:

- The Index
- The Tabular List of Diseases and Injuries

The Index to Diseases and Injuries is an alphabetic listing of terms and corresponding codes. The two sections of the index are:

- **Index to Diseases and Injuries**
- **Index to External Causes of Injury**

A Neoplasm Table and a Table of Drugs and Chemicals are also included in the Index.

The **Tabular List of Diseases and Injuries** is an alphanumerical list of codes, commonly referred to as the *Tabular*. The Tabular is divided into chapters based on body system (anatomical site) or condition (etiology). The specific organization of the chapters is discussed throughout this book and overviewed in the next section.

ICD-10-CM Tabular List of Diseases and Injuries

The Tabular List of Diseases and Injuries is an alphanumerical list of the diseases and injuries found in ICD-10-CM. The Tabular consists of the following chapters:

1. Certain Infectious and Parasitic Diseases
2. Neoplasms
3. Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism
4. Endocrine, Nutritional, and Metabolic Diseases
5. Mental, Behavioral, and Neurodevelopmental Disorders
6. Diseases of the Nervous System
7. Diseases of the Eye and Adnexa
8. Diseases of the Ear and Mastoid Process
9. Diseases of the Circulatory System
10. Diseases of the Respiratory System
11. Diseases of the Digestive System
12. Diseases of the Skin and Subcutaneous Tissue
13. Diseases of the Musculoskeletal System and Connective Tissue
14. Diseases of the Genitourinary System
15. Pregnancy, Childbirth, and the Puerperium
16. Certain Conditions Originating in the Perinatal Period
17. Congenital Malformations, Deformations, and Chromosomal Abnormalities
18. Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, not elsewhere classified

19. Injury, Poisoning, and Certain Other Consequences of External Causes
20. External Causes of Morbidity
21. Factors Influencing Health Status and Contact with Health Services
22. Codes for Special Purposes

Exercise 2.1—Identifying Chapters

For each chapter title, indicate whether the chapter is organized by etiology or by anatomical site. Example: Diseases of the Musculoskeletal System and Connective Tissue. Answer: anatomical site

1. Congenital Malformations, Deformations, and Chromosomal Abnormalities _____
2. Diseases of the Circulatory System _____
3. Diseases of the Digestive System _____
4. Endocrine, Nutritional, and Metabolic Diseases _____
5. Certain Infectious and Parasitic Diseases _____
6. Diseases of Skin and Subcutaneous Tissue _____
7. Mental, Behavioral, and Neurodevelopmental Disorders _____
8. Diseases of the Nervous System _____
9. Diseases of the Genitourinary System _____
10. Diseases of the Respiratory System _____

Chapters of the Tabular List of Diseases and Injuries

The Tabular contains the following chapters.

Chapter 1—Certain Infectious and Parasitic Diseases (Code Range A00–B99)

This chapter includes diseases generally recognized as communicable or transmissible.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 1. Here you will find the code listing for infectious and parasitic diseases. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
A01.00	Typhoid fever, unspecified
A06.0	Acute amebic dysentery
A59.09	Other urogenital trichomoniasis
B36.2	White piedra
B86	Scabies

Chapter 2—Neoplasms (Code Range C00–D49)

This chapter contains code assignments for malignant, benign, carcinoma in situ, and neoplasms of uncertain and unspecified behavior.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 2. Here you will find the code listing for neoplasms. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
C02.4	Malignant neoplasm of lingual tonsil
C46.9	Kaposi's sarcoma, unspecified
C94.02	Acute erythoid leukemia, in relapse
D37.1	Neoplasm of uncertain behavior of stomach
D38.4	Neoplasm of uncertain behavior of thymus

Chapter 3—Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism (Code Range D50–D89)

Contained within this chapter are:

- Types of anemias.
- Coagulation defects.
- Hemorrhagic conditions.
- Diseases of the white blood cells and other components of the blood.
- Some diseases of the spleen and lymphatic system.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 3. Here you will find the code listing for diseases of the blood and blood-forming organs. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
D56.0	Alpha thalassemia
D67	Hereditary factor IX deficiency
D73.0	Hyposplenism
D73.4	Cyst of spleen
D86.0	Sarcoidosis of lung

Chapter 4—Endocrine, Nutritional, and Metabolic Diseases (Code Range E00–E89)

In this chapter are:

- Disorders and diseases of the thyroid and other endocrine glands.
- Nutritional deficiencies.
- Metabolic disorders.
- Disorders of the immune mechanism and immunity deficiencies.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 4. Here you will find the code listing for diseases of the endocrine system, as well as nutritional and metabolic diseases. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
E04.0	Nontoxic diffuse goiter
E30.0	Delayed puberty
E55.0	Rickets, active
E61.2	Magnesium deficiency
E67.3	Hypervitaminosis D

Chapter 5—Mental, Behavioral, and Neurodevelopmental Disorders (Code Range F01–F99)

This chapter contains:

- Mental disorders, including psychotic, personality, neurotic, and nonpsychotic disorders.
- Chemical dependencies, such as alcoholism and drug dependence.
- Mental retardation and developmental disorders.
- Psychopathic symptoms that are not part of an organic illness.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 5. Here you will find the code listing for mental and behavioral disorders. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
F01.50	Vascular dementia without behavioral disturbance
F20.0	Paranoid schizophrenia
F41.9	Anxiety disorder, unspecified
F60.6	Avoidant personality disorder
F84.0	Autistic disorder

Chapter 6—Diseases of the Nervous System (Code Range G00–G99)

This chapter contains diseases of the central and peripheral nervous systems that include the brain, spinal cord, meninges, and nerves.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 6. Here you will find the code listing for diseases of the nervous system. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
G00.0	Hemophilus meningitis
G35	Multiple sclerosis
G43.011	Migraine without aura, intractable, with status migrainosus
G80.2	Spastic hemiplegic cerebral palsy
G91.9	Hydrocephalus, unspecified

Chapter 7—Diseases of the Eye and Adnexa (Code Range H00–H59)

This chapter includes diseases of the eye and adnexa.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 7. Here you will find the code listing for diseases of the eye and adnexa. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
H04.131	Lacrimal cyst, right lacrimal gland
H11.151	Pinguecula, right eye
H16.149	Punctate keratitis, unspecified eye
H17.9	Unspecified corneal scar and opacity
H27.00	Aphakia, unspecified eye

Chapter 8—Diseases of the Ear and Mastoid Process (Code Range H60–H95)

This chapter includes diseases of the ear and mastoid process.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 8. Here you will find the code listing for diseases of the ear and mastoid process. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
H61.21	Impacted cerumen, right ear
H65.22	Chronic serous otitis media, left ear
H81.311	Aural vertigo, right ear
H83.02	Labyrinthitis, left ear
H92.09	Otalgia, unspecified ear

Chapter 9—Diseases of the Circulatory System (Code Range I00–I99)

The circulatory system includes the heart, arteries, veins, and lymphatic system. Therefore, this chapter contains:

- Cardiac disorders.
- Arterial, venous, and some lymphatic diseases.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 9. Here you will find the code listing for diseases of the heart, arteries, arterioles, capillaries, veins, and lymphatic system. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
I05.0	Rheumatic mitral stenosis
I38	Endocarditis, valve unspecified
I51.0	Cardiac septal defect, acquired
I82.0	Budd-Chiari syndrome
I89.1	Lymphangitis

Chapter 10—Diseases of the Respiratory System (Code Range J00–J99)

In this chapter are diseases of the:

- Pharynx.
- Larynx.
- Trachea.
- Bronchus.
- Vocal cords.
- Sinuses.
- Nose.
- Tonsils and adenoids.
- Parts of the lung.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 10. Here you will find the code listing for diseases of the respiratory system. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
J12.89	Other viral pneumonia
J35.1	Hypertrophy of tonsils
J43.1	Panlobular emphysema
J86.0	Pyothorax with fistula
J94.0	Chylous effusion

Chapter 11—Diseases of the Digestive System (Code Range K00–K95)

This chapter deals with diseases of the:

- Oral cavity.
- Salivary glands.
- Jaws.
- Esophagus.
- Stomach.
- Duodenum.
- Appendix.
- Abdominal cavity.
- Small and large intestines.
- Peritoneum.
- Anus.
- Liver.
- Gallbladder.
- Biliary tract.
- Pancreas.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 11. Here you will find the code listing for diseases of the digestive system. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
K11.9	Disease of salivary gland, unspecified
K22.0	Achalasis of cardia
K59.00	Constipation, unspecified
K65.0	Generalized (acute) peritonitis
K81.0	Acute cholecystitis

Chapter 12—Diseases of the Skin and Subcutaneous Tissue (Code Range L00–L99)

This chapter includes:

- Inflammatory and infectious conditions of the skin and subcutaneous tissue.
- Diseases of the nail, hair and hair follicles, sweat, and sebaceous glands.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 12. Here you will find the code listing for diseases of the skin and subcutaneous tissue. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
L03.012	Cellulitis of left finger
L55.0	Sunburn of first degree
L85.0	Acquired ichthyosis
L89.514	Pressure ulcer of right ankle, stage 4
L94.1	Linear scleroderma

Chapter 13—Diseases of the Musculoskeletal System and Connective Tissue (Code Range M00–M99)

This chapter includes diseases of the:

- Bones.
- Joints.
- Bursa.
- Muscles.
- Ligaments.
- Tendons.
- Soft tissues.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 13. Here you will find the code listing for diseases of the musculoskeletal system and connective tissue. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
M06.9	Rheumatoid arthritis, unspecified
M21.531	Acquired clawfoot, right foot
M24.232	Disorder of ligament, left wrist
M24.569	Contracture, unspecified knee
M91.0	Juvenile osteochondrosis of pelvis

Chapter 14—Diseases of the Genitourinary System (Code Range N00–N99)

Coded from this chapter are diseases of the:

- Kidney.
- Ureter.
- Urinary bladder.
- Urethra.
- Male genital organs.
- Male and female breast, and female genital organs (not related to pregnancy, childbirth, and the postpartum period).

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 14. Here you will find the code listing for diseases of the genitourinary system. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
N17.0	Acute kidney failure with tubular necrosis
N34.1	Nonspecific urethritis
N48.1	Balanitis
N75.0	Cyst of Bartholin's gland
N89.0	Mild vaginal dysplasia

Chapter 15—Pregnancy, Childbirth, and the Puerperium (Code Range O00–O9A)

This chapter includes:

- Ectopic and molar pregnancies.
- Spontaneous abortions.
- Legally and illegally induced abortions.
- Complications of pregnancy, abortions, labor and delivery, and the postpartum period.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 15. Here you will find the code listing for complications of pregnancy, childbirth, and the puerperium. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
O02.9	Abnormal product of conception, unspecified
O23.02	Infections of kidney in pregnancy, second trimester
O92.4	Hypogalactia
O99.011	Anemia complicating pregnancy, first trimester
O9A.53	Psychological abuse complicating the puerperium

Chapter 16—Certain Conditions Originating in the Perinatal Period (Code Range P00–P96)

This chapter includes conditions that have their origin in the perinatal period, a period of time before birth through the first 28 days after birth.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 16. Here you will find the code listing for conditions originating in the perinatal period. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
P03.82	Meconium passage during delivery
P15.5	Birth injury to external genitalia
P28.3	Primary sleep apnea of newborn
P76.0	Meconium plug syndrome
P93.0	Grey baby syndrome

Chapter 17—Congenital Malformations, Deformations, and Chromosomal Abnormalities (Code Range Q00–Q99)

This chapter contains any congenital anomaly or malformation, regardless of the body system involved. A congenital anomaly is an anomaly present at or existing from the time of birth.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 17. Here you will find the code listing for congenital anomalies. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
Q01.0	Frontal encephalocele
Q06.0	Amyelia
Q21.3	Tetralogy of Fallot
Q36.0	Cleft lip, bilateral
Q52.0	Congenital absence of vagina

Chapter 18—Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (Code Range R00–R99)

This chapter includes symptoms, signs, abnormal results of laboratory tests and investigative procedures, as well as ill-defined conditions.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 18. Here you will find the code listing for symptoms, signs, and ill-defined conditions. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
R10.0	Acute abdomen
R25.0	Abnormal head movements
R43.0	Anosmia
R57.0	Cardiogenic shock
R94.2	Abnormal results of pulmonary function studies

Chapter 19—Injury and Poisoning and Certain Other Consequences of External Causes (Code Range S00–T88)

This chapter includes:

- Fractures, dislocations, sprains, and strains of joints and muscles.
- Intracranial injuries.

- Internal injuries to the chest, abdomen, and pelvis.
- Open wounds.
- Superficial injuries.
- Contusions.
- Burns.
- Poisonings by drugs and by medicinal and biological substances.
- Effects of external cause.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 19. Here you will find the code listing for injuries and poisonings. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
S00.211A	Abrasion of right eyelid and periocular area, initial encounter
S09.91xA	Unspecified injury of ear, initial encounter
S68.721A	Partial traumatic transmetacarpal amputation of right hand, initial encounter
S76.212D	Strain of adductor muscle, fascia and tendon of left thigh, subsequent encounter
S81.841A	Puncture wound with foreign body, right lower leg, initial encounter
T14.91	Suicide attempt

Chapter 20—External Causes of Morbidity (Code Range V00–Y99)

This chapter includes the classification of environmental events and circumstances as the cause of injury and other adverse effects. These codes are intended to be secondary codes to accompany those from other chapters.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 20. Here you will find the code listings for external causes of morbidity. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
V00.131A	Fall from skateboard, initial encounter
W00.0xxA	Fall on same level due to ice and snow, initial encounter
W17.0xxA	Fall into well, initial encounter
W20.1xxA	Struck by object due to collapse of building, initial encounter
Y35.211A	Legal intervention involving injury by tear gas, law enforcement official injured, initial encounter

Chapter 21—Factors Influencing Health Status and Contact with Health Services (Z00–Z99)

This chapter codes reasons for encounters when a person may or may not be sick and when some circumstance or problem influences the person's health status but is not in itself a current illness or injury.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 21. Here you will find the code listing for factors influencing health status and contact with health services. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
Z00.00	Encounter for general adult medical examination without abnormal findings
Z01.110	Encounter for hearing examination following failed hearing screening
Z04.42	Encounter for examination and observation following alleged child rape
Z17.0	Estrogen receptor positive status [ER+]
Z20.3	Contact with and (suspected) exposure to rabies

Chapter 22—Codes for Special Purposes (U00–U85)

This chapter was added in October of 2020 to report codes for special purposes. At this time the chapter only contained one block of codes.

EXAMPLE: Using the Tabular section of your ICD-10-CM book, locate the start of Chapter 22. Here you will find the code listing for codes for special purposes. Reference the following codes to familiarize yourself with this chapter.

Diagnostic Code	Diagnostic Description
U07.0	Vaping-related disorder
U07.1	COVID-19
U09.9	Post COVID-19 condition, unspecified

Summary

- ICD-10-CM consists of an Index to Diseases and Injuries and a Tabular Listing of Diseases and Injuries.
- The Tabular List of Diseases and Injuries is divided into 22 chapters.
- The Index to Diseases and Injuries contains a Neoplasm Table and Table of Drugs and Chemicals.

Internet Link

The National Center for Health Statistics (NCHS) maintains information about ICD-10-CM. For a wealth of information, explore *www.cdc.gov/nchs/icd.htm*.

Chapter Review

For each of the following ICD-10-CM Tabular chapters, list the related category code range.

Chapter	*Code Range*
1. Neoplasms	_____
2. Endocrine, Nutritional, and Metabolic Diseases	_____
3. Diseases of the Circulatory System	_____
4. Diseases of the Digestive System	_____
5. Congenital Malformations, Deformations, and Chromosomal Abnormalities	_____
6. Diseases of the Nervous System	_____

7. External Causes of Morbidity _____
8. Diseases of the Skin and Subcutaneous Tissue _____
9. Pregnancy, Childbirth, and the Puerperium _____
10. Mental, Behavioral, and Neurodevelopmental Disorders _____
11. Certain Infectious and Parasitic Diseases _____
12. Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism _____
13. Diseases of the Eye and Adnexa _____
14. Diseases of the Ear and Mastoid Process _____
15. Diseases of the Respiratory System _____
16. Diseases of the Musculoskeletal System and Connective Tissue _____
17. Diseases of the Genitourinary System _____
18. Certain Conditions Originating in the Perinatal Period _____
19. Symptoms, Signs, and Abnormal Clinical and Laboratory Findings _____
20. Injury, Poisoning, and Certain Other Consequences of External Causes _____
21. Codes for special purposes _____

For each of the codes listed, state the chapter in which the code would be located.

22. Code D02.1 _____
23. Code F03.90 _____
24. Code E87.8 _____
25. Code A82.0 _____
26. Code M61.269 _____
27. Code P94.2 _____
28. Code K12.1 _____
29. Code H44.392 _____
30. Code G56.12 _____
31. Code I80.291 _____
32. Code U07.1 _____
33. Code Z96.9 _____

Short Answer

Briefly respond to each question.

34. List the two parts of ICD-10-CM.

_____

_____

35. Describe how the Tabular List of Diseases and Injuries is organized.

_____

_____

ICD-10-CM Coding Conventions

CHAPTER 3

Chapter Outline

Chapter Objectives

At the conclusion of this chapter, you should be able to:

1. Explain the general purpose of the conventions used in ICD-10-CM.
2. Identify the abbreviations, symbols, and instructional notes used in ICD-10-CM.
3. Locate instructional notes in the ICD-10-CM code book.
4. Identify the difference between type 1 and type 2 Excludes notes.
5. Define the abbreviations NOS and NEC.
6. Define the punctuation used in the ICD-10-CM code book.
7. Define the symbols used in the ICD-10-CM code book.

Key Terms

Brackets
Code Also
Code First
Colon
Conventions
Excludes
Excludes1
Excludes2
In Diseases Classified Elsewhere
Includes
Instructional
NEC (not elsewhere classified)
Nonessential modifiers
NOS (not otherwise specified)
Parentheses
Point dash
See
See Also
Use Additional Code

REMINDER: As you work through this chapter, you will need to have a copy of the ICD-10-CM coding manual to reference. For this chapter, you will also need to reference the ICD-10-CM Official Guidelines for Coding and Reporting. These guidelines can be found in Appendix A, available on the Companion Site and in MINDTAP.

Introduction

This chapter highlights concepts that must be followed for coding to be accurate. Appendix A, Section 1, A, lists the ICD-10-CM Official Guidelines for Coding and Reporting that are relevant to this chapter.

Stop! When you see a stop sign while driving, you must stop and then proceed with caution. Similarly, ICD-10-CM uses the equivalent of "traffic signs" to guide coders: instructional notes, punctuation marks, abbreviations, and symbols, all of which are called **conventions**. To code accurately, a coder must understand what these conventions mean. You must follow these "traffic signs" to ensure accurate coding.

Convention Types

Conventions are used in both the ICD-10-CM Tabular List of Diseases and Injuries and the ICD-10-CM Index to Diseases and Injuries. Four types of conventions are used in ICD-10-CM to provide guidance to the coder:

- Instructional notes
- Punctuation marks
- Abbreviations
- Symbols

Some of the conventions are used in one volume and not in the other; other conventions are used in both the Tabular and Alphabetic volumes.

Instructional Notes

Instructional notes appear in both the Tabular List and Alphabetic Index of ICD-10-CM.

Includes Note

The **Includes** note is used to define, give examples, or both, of the content of a category of ICD-10-CM or of a block of category codes.

The location of the Includes note determines the category or block of category codes that the note governs.

When an Includes note appears in the Tabular List immediately *under a three-digit code title*, the note applies to the three-digit category. The word *Includes* is followed by examples of diagnostic terms that are included in that category.

EXAMPLE: The category code A02, Other salmonella infections, appears as follows in ICD-10-CM:

```
A02 Other salmonella infections
Includes:  infection or foodborne intoxication due to any Salmonella species
                   other than S. typhi and S. paratyphi
```

The Includes note signifies that infections or foodborne intoxication due to any Salmonella species other than *S. typhi* and *S. paratyphi* are included in this category.

When the Includes note appears *after the start of a chapter or block title*, the note governs the entire chapter or block of category codes.

EXAMPLE: The block of category codes A15–A19, Tuberculosis, appears as follows in the Tabular List of ICD-10-CM:

```
TUBERCULOSIS (A15–A19)
Includes:  infections due to Mycobacterium tuberculosis and Mycobacterium bovis
Excludes1: congenital tuberculosis (P37.0)
           nonspecific reaction to test for tuberculosis without active
              tuberculosis (R76.1–)
           pneumoconiosis associated with tuberculosis, any type in A15
           (J65)
           positive PPD (R76.11)
           positive tuberculin skin test without active tuberculosis
           (R76.11)
           sequelae of tuberculosis (B90.–)
           silicotuberculosis (J65)
```

When the Includes note appears at this level, the block of category codes is governed by the note. Therefore, in this example, code block A15–A19 is governed by the notes that follow the block title.

At times, the word *Includes* is not listed before the list of terms in the code; only the diagnostic terms are listed.

ICD-10-CM Official Coding Guidelines

Inclusion terms

List of terms is included under some codes. These terms are the conditions for which that code is to be used. The terms may be synonyms of the code title, or, in the case of "other specified" codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the Alphabetic Index may also be assigned to a code. (See Appendix A, Section I.A.11.)

Courtesy of the Centers for Medicare & Medicaid Services, www.cms.gov

Exercise 3.1—Identifying Inclusion Notes

For each of the following items, list the diagnoses that are included as described by the inclusion note. The first one is completed for you.

1. category A06 — infection due to *Entamoeba histolytica*
2. code A04.9 _____
3. code N18.6 _____
4. category R51.9 _____
5. code R48.8 _____
6. category F30 _____
7. code D10.1 _____
8. category K13 _____
9. code J42 _____
10. code L20.81 _____

Excludes Instructional Notes

The **Excludes** notes are used to signify that the conditions listed are not assigned to the category or block of category codes. There are two types of Excludes notes in ICD-10-CM.

Excludes1 Note

The **Excludes1** note is easy to understand and apply. This note means that the diagnostic terms listed are *not* coded to the category or subcategory; therefore, the two conditions are mutually exclusive. The Official Coding Guidelines for Coding and Reporting define the Excludes1 note, as shown below.

ICD-10-CM Official Coding Guidelines

Excludes1

A type 1 Excludes note is a pure excludes note. It means "NOT CODED HERE!" An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition. (See Appendix A, Section I.A.12.a for further information on this guideline.)

Courtesy of the Centers for Medicare & Medicaid Services, www.cms.gov

Category I00 is an example of the use of the Excludes1 note. The following appears for code I00.

EXAMPLE:

```
I00 Rheumatic fever without heart involvement
      Includes:  arthritis, rheumatic, acute or subacute
      Excludes1: rheumatic fever with heart involvement (I01.0–I01.9)
```

Reading the category title and the diagnostic description following the Excludes1 note, you can see that the two are mutually exclusive because rheumatic fever would occur with or without heart involvement; therefore the two codes could not be used together.

Excludes2 Note

The **Excludes2** note is used to signify that the diagnostic terms listed after the note are *not* part of the condition(s) represented by the code or code block. This note also indicates that, at times, the assignment of more than one code should occur to fully represent the diagnostic statement being coded and to accurately record the patient's condition.

The Official Coding Guidelines define the Excludes2 note, as shown below.

ICD-10-CM Official Guidelines

Excludes2

A type 2 Excludes note represents "Not included here." An Excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate. (See Appendix A, Section I.A.12.b.)

Courtesy of the Centers for Medicare & Medicaid Services, www.cms.gov

An example of the use of the Excludes2 note appears for code C02.0. The code appears as follows in ICD-10-CM.

EXAMPLE:

```
C02.0 Malignant neoplasm of dorsal surface of tongue
        Malignant neoplasm of anterior two-thirds of tongue, dorsal
        surface
        Excludes2: malignant neoplasm of dorsal surface of base of tongue
        (C01)
```

The Excludes2 note means that code C02.0 does not code a malignant neoplasm of the dorsal surface of base of tongue. Code C01 is the appropriate code. Both code C02.0, malignant neoplasm of dorsal surface of tongue, and code C01, malignant neoplasm of base of tongue, would be selected if the patient had a neoplasm in both sites.

See Instructional Note

The **See** note is used in the Alphabetic Index of ICD-10-CM and instructs the coder to cross-reference the term or diagnosis that follows the notation.

EXAMPLE: In the Alphabetic Index, the following appears for the entry of Thromboarteritis:

```
Thromboarteritis—see Arteritis
```

This notation instructs the coder to cross-reference to the term *Arteritis* in the Alphabetic Index to obtain the correct code.

ICD-10-CM Official Coding Guidelines

The "see" instruction following a main term in the Alphabetic Index indicates that another term should be referenced. It is necessary to go to the main term referenced with the "see" note to locate the correct code. (See Appendix A, Section I.A.16.)

Courtesy of the Centers for Medicare & Medicaid Services, www.cms.gov

See Also Instructional Note

Another cross-reference note used in ICD-10-CM, the **See Also** note refers the coder to another location in the Alphabetic Index when the initial listing does not contain all the necessary information to accurately select a code.

EXAMPLE: When coding a diagnosis of altitude hypoxia, the coder first references the term *hypoxia* in the Alphabetic Index. Here the coder finds the following:

```
Hypoxia (see also Anoxia) R09.02
          cerebral, during a procedure NEC G97.81
            postprocedural NEC G97.82
          intrauterine P84
          myocardial—see Insufficiency, coronary
          newborn P84
          sleep related G47.34
```

Since the modifying term *altitude* does not appear in the entries under the main term of *hypoxia*, the coder references the term *anoxia* in the Alphabetic Index. The following appears at the start of the entry for Anoxia:

```
Anoxia (pathological) R09.02
        altitude T70.29
        cerebral G93.1
            complicating
              anesthesia (general)
                (local) or other
                sedation T88.59
              in labor and delivery
              074.3
```

Since the modifying term *altitude* appears, the coder selects T70.29, from the ICD-10-CM Index to Diseases and Injuries, for the diagnostic statement of altitude hypoxia. To verify the code for the diagnosis, the coder must reference the ICD-10-CM Tabular List of Diseases and Injuries.

ICD-10-CM Official Guidelines

A "see also" instruction following a main term in the Alphabetic Index instructs that there is another main term that may also be referenced that may provide additional Alphabetic Index entries that may be useful. It is not necessary to follow the "see also" note when the original main term provides the necessary code. (See Appendix A, Section I.A.16.)

Courtesy of the Centers for Medicare & Medicaid Services, www.cms.gov

Use Additional Code and *Code First* Instructional Notes

The Use Additional Code and the Code First notes appear in the Tabular section of ICD-10-CM and must always be followed. These notes are used to signal that, when there is an underlying etiology and multiple body system manifestation due to the underlying etiology, two codes are needed. The **Use Additional Code** note instructs the coder to use an additional code to identify the manifestation that is present. The **Code First** note instructs the coder to select a code to represent the etiology that caused the manifestation. The two codes must appear in the correct order. The code that represents the etiology is sequenced first, followed by the code that represents the manifestation.

EXAMPLE: In coding the diagnostic statement of encephalitis in poliovirus, the coder references first the Alphabetic Index and then the Tabular List. In the Tabular List, the coder finds the following entry for the start of G05—Encephalitis, myelitis and encephalomyelitis in diseases classified elsewhere.

```
G05 Encephalitis, myelitis and encephalomyelitis in diseases classified
elsewhere
            Code first underlying disease, such as:
              congenital toxoplasmosis encephalitis, myelitis and
              encephalomyelitis (P37.1)
              cytomegaloviral encephalitis, myelitis and encephalomyelitis
              (B25.8)
              encephalitis, myelitis and encephalomyelitis (in) systemic
              lupus erythematosus (M32.19)
              eosinophilic meningoencephalitis (B83.2)
              human immunodeficieny virus [HIV] disease (B20)
```

```
poliovirus (A80.–)
suppurative otitis media (H66.01–H66.4)
trichinellosis (B75)
```

The phrase "Code first underlying disease" signals to the coder that two codes are needed: code G05 and a code for the poliovirus from the A80.– subcategory, with the A80.– code listed first.

In addition to the notes found in the Tabular List, the coding for an etiology and manifestation has a unique Alphabetic Index entry structure. This is explained by the Official Coding Guidelines as follows:

ICD-10-CM Official Guidelines

In addition to the notes in the Tabular List, these conditions also have a specific Alphabetic Index entry structure. In the Alphabetic Index, both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second. (See Appendix A, Section I.A.13.)

Courtesy of the Centers for Medicare & Medicaid Services, www.cms.gov

In Diseases Classified Elsewhere Note

A third note applies to the etiology/manifestation conventions: **In Diseases Classified Elsewhere**. The Official Coding Guidelines for Coding and Reporting explain the use of this note as follows:

ICD-10-CM Official Guidelines

In most cases the manifestation codes will have in the code title, "in diseases classified elsewhere." Codes with this title are a component of the etiology/manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition. See category F02, Dementia in other diseases classified elsewhere, for an example of this convention. There are manifestation codes that do not have "in diseases classified elsewhere" in the title. For such codes, there is a "use additional code" note at the etiology code and a "code first" note at the manifestation code and the rules for sequencing apply. (See Appendix A, Section I.A.13.)

Courtesy of the Centers for Medicare & Medicaid Services, www.cms.gov

Code Also Instructional Note

The **Code Also** note is used in ICD-10-CM to instruct the coder that two codes may be needed to fully code a diagnostic phrase. The note, however, does not provide sequencing direction. Code F80.4 provides an example of the Code Also note:

```
F80.4 Speech and language development delay due to hearing loss
Code also type of hearing loss (H90.–, H91.–)
```

Therefore, when both codes are assigned, the coder must determine the proper sequencing of the codes based on the case. The ICD-10-CM Official Guidelines state the following:

ICD-10-CM Official Guidelines

A "code also" note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction. The sequencing depends on the circumstances of the encounter. (See Appendix A, Section I.A.17.)

Courtesy of the Centers for Medicare & Medicaid Services, www.cms.gov

Default Codes

When a code is listed next to a main term in the Alphabetic Index, it is known as a default code. If no additional information, found in the medical record, modifies the main term, then the default code should be assigned.

ICD-10-CM Official Guidelines

A code listed next to a main term in the ICD-10-CM Alphabetic Index is referred to as a default code. The default code represents that condition that is most commonly associated with the main term, or is the unspecified code for the condition. If a condition is documented in a medical record (for example, appendicitis) without any additional information, such as acute or chronic, the default code should be assigned. (See Appendix A, Section I.A.18.)

Courtesy of the Centers for Medicare & Medicaid Services, www.cms.gov

Exercise 3.2—Identifying Notes

For each item listed, indicate the type of instructional note found. The first one is done for you.

1. Start of Chapter 3, Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism — Excludes2
2. Category D55 _____
3. Category F07 _____
4. Category K70 _____
5. Category K90 _____
6. Code R22.2 _____
7. Subcategory M10.1 _____
8. Category J05 _____
9. Category O02 _____
10. Category P00 _____

Punctuation Marks

Coders must understand the meaning of the punctuation marks used in the code book as ICD-10-CM defines them. Their definitions are unique to the coding system.

Parentheses: ( )

Parentheses are used in both the Tabular List and Alphabetic Index. Parentheses are used around terms that provide additional information about the main diagnostic term. The terms found within the parentheses are referred to as **nonessential modifiers**. The terms do not affect the code assignment for the diagnostic statement being coded.

EXAMPLE: In the Alphabetic Index, the term *dermatitis* is found as follows at the start of the entry:

```
Dermatitis (eczematous) L30.9
  ab igne L59.0
  acarine B88.0
  actinic (due to sun) L57.8
```

The parentheses are used around the nonessential modifying term of *eczematous*. If a coder is coding dermatitis or eczematous dermatitis, then code L30.9 is assigned.

ICD-10-CM Official Guidelines

( ) Parentheses are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers. The nonessential modifiers in the Alphabetic Index to Diseases apply to subterms following a main term except when a nonessential modifier and a subentry are mutually exclusive, the subentry takes precedence. For example, in the ICD-10-CM Alphabetic Index under the main term Enteritis, "acute" is a nonessential modifier and "chronic" is a subentry. In this case, the nonessential modifier "acute" does not apply to the subentry "chronic". (See Appendix A, Section A.7.)

Courtesy of the Centers for Medicare & Medicaid Services, www.cms.gov

Brackets: [ ]

Brackets are used in the Tabular Listing and in the Alphabetic Index.

In the Tabular List, the brackets enclose synonyms, alternative wording, abbreviations, or explanatory phrases. The presence or absence of the phrase in the bracket does not affect code assignment.

EXAMPLE: Category Code B01 appears in the Tabular List as follows:

```
B01 Varicella [chickenpox]
```

Chickenpox is enclosed in brackets to provide an alternative word for *varicella*. Therefore, this category would be used to code the diagnoses chickenpox and varicella. Brackets are used in the Alphabetic Index to identify manifestation codes.

Colon: :

A **colon** is used in the Tabular listing after a term that is modified by one or more of the terms following the colon. The term to the left of the colon must be modified by a term to the right to be included in the code or instructional note being considered.

F20 Schizophrenia

```
Excludes1: brief psychotic disorder (F23)
           cyclic schizophrenia (F25.0)
           mood [affective] disorders with psychotic symptoms (F30.2,
              F31.2, F31.5, F31.64, F32.3, F33.3)
           schizoaffective disorder (F25.-)
           schizophrenic reaction NOS (F23)
Excludes2: schizophrenic reaction in:
           alcoholism (F10.15-, F10.25-, F10.95-)
           brain disease (F06.2)
           epilepsy (F06.2)
           psychoactive drug use (F11-F19 with .15, .25, .95)
           schizotypal disorder (F21)
```

The use of the colon after the phrase "schizophrenic reaction in:" means that the phrase must be followed by any of the diagnoses that follow to be validated for this Excludes2 note. If the diagnosis does not specify the terms to the right of the colon, the diagnosis is not valid for this Excludes2 note.

Abbreviations

Two abbreviations are consistently used in ICD-10-CM, NEC and NOS.

NEC: Not Elsewhere Classifiable

NEC means **not elsewhere classifiable**. This abbreviation is used in both the Tabular List and Alphabetic Index.

- In the Alphabetic Index, NEC represents "other specified." When a specific code is not available for a condition, the Alphabetic Index directs the coder to the "other specified" code in the Tabular List.
- In the Tabular List, NEC still means "not elsewhere classifiable" and can be read as "other specified." When a specific code is not available in the Tabular List for the condition being coded, the NEC entry under a code identifies it as the "other specified" code.

NOS: Not Otherwise Specified

NOS is the abbreviation for **not otherwise specified**. The note is used in both the Alphabetic Index and Tabular List and is interpreted to mean "unspecified." NOS codes are not specific and should be used only after the coder has clarified with the physician that a more specific diagnosis is not available. The coder should also reference the medical record to see if it contains documentation that can further specify the diagnosis.

EXAMPLE: The physician makes a diagnosis of sinusitis, orders a series of sinus x-rays, and records sinusitis on the coding form for the order. The coder then references sinusitis in the Alphabetic Index and Tabular List and records code J32.9. However, after the reading of the x-ray, a diagnosis of chronic frontal sinusitis is established.

The coder should then select code J32.1, which identifies chronic frontal sinusitis. If there were no further documentation or findings—in this case, no x-rays taken—to expand on the original diagnosis of sinusitis, then code J32.9 is correct. The entry in the Tabular appears as follows:

```
J32.9 Chronic Sinusitis, unspecified
      Sinusitis (chronic) NOS
```

The abbreviation *NOS* should signal to the coder to try to clarify the diagnosis more specifically prior to assigning the code.

Symbols

Symbols are used in ICD-10-CM to give direction to the coder.

Point Dash: . –

The **point dash** symbol (.–) tells the coder that the code contains a list of options at a level of specificity past the three-character category.

EXAMPLE: In the Tabular List, at the start of the code block for mycoses, the following appears:

```
MYCOSES     (B35–B49)
Excludes2:  hypersensitivity pneumonitis due to organic dust (J67.–)
            Mycosis fungoides (C84.0–)
```

The point dash after J67 and the .0– after code C84 indicate that the codes are defined to a level of specificity higher than the three-character and four-character levels.

Coding Guidelines

The following ICD-10-CM Official Guidelines for Coding and Reporting apply to the conventions discussed in this chapter.

ICD-10-CM Official Coding Guidelines

Section I. Conventions, general coding guidelines and chapter specific guidelines

The conventions, general guidelines and chapter-specific guidelines are applicable to all health care settings unless otherwise indicated. The conventions and instructions of the classification take precedence over guidelines.

A. Conventions for the ICD-10-CM

The conventions for the ICD-10-CM are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the Alphabetic Index and Tabular List of ICD-10-CM as instructional notes.

1. The Alphabetic Index and Tabular List

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

See Section I.C2. General guidelines

See Section I.C.19. Adverse effects, poisoning, underdosing and toxic effects

2. Format and Structure:

The ICD-10-CM Tabular List contains categories, subcategories and codes.

Characters for categories, subcategories and codes may be either a letter or a number. All categories are 3 characters. A three-character category that has no further subdivision is equivalent to a code. Subcategories are either 4 or 5 characters. Codes may be 3, 4, 5, 6, or 7 characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. Codes that have applicable 7th characters are still referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character.

The ICD-10-CM uses an indented format for ease in reference

3. Use of codes for reporting purposes

For reporting purposes only codes are permissible, not categories or subcategories, and any applicable 7th character is required.

4. Placeholder character

The ICD-10-CM utilizes a placeholder character “x”. The “x” is used as a placeholder at certain codes to allow for future expansion. An example of this is at the poisoning, adverse effect and underdosing codes, categories T36–T50.

Where a placeholder exists, the x must be used in order for the code to be considered a valid code.

5. 7th Characters

Certain ICD-10-CM categories have applicable 7th characters. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct. The 7th character must always be the 7th character in the data field. If a code that requires a 7th character is not 6 characters, a placeholder x must be used to fill in the empty characters.

6. Abbreviations

a. Alphabetic Index abbreviations

NEC “Not elsewhere classifiable”

This abbreviation in the Alphabetic Index represents “other specified”. When a specific code is not available for a condition the Alphabetic Index directs the coder to the “other specified” code in the Tabular List.

NOS “Not otherwise specified”

This abbreviation is the equivalent of unspecified.

b. Tabular List abbreviations

NEC “Not elsewhere classifiable”

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

NOS “Not otherwise specified”

This abbreviation is the equivalent of unspecified.

7. Punctuation

[ ] Brackets are used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the Alphabetic Index to identify manifestation codes.

( ) Parentheses are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers. The nonessential modifiers in the Alphabetic Index to Diseases apply to subterms following a main term except when a nonessential modifier and a subentry are mutually exclusive, the subentry takes precedence. For example, in the ICD-10-CM Alphabetic Index under the main term Enteritis, “acute” is a nonessential modifier and “chronic” is a subentry. In this case, the nonessential modifier “acute” does not apply to the subentry “chronic”.

: Colons are used in the Tabular List after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.

8. Use of “and”

See Section I.A.14. Use of the term “And”

9. Other and Unspecified codes

a. “Other” codes

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

b. “Unspecified” codes

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

See Section I.B.18 Use of Signs/Symptom/Unspecified Codes

10. Includes Notes

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

11. Inclusion terms

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

12. Excludes Notes

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

a. Excludes1

A type 1 Excludes note is a pure excludes note. It means "NOT CODED HERE!" An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other. If it is not clear whether the two conditions involving an Excludes1 note are related or not, query the provider. For example, code F45.8, Other somatoform disorders, has an Excludes1 note for "sleep related teeth grinding (G47.63)," because "teeth grinding" is an inclusion term under F45.8. Only one of these two codes should be assigned for teeth grinding. However, psychogenic dysmenorrhea is also an inclusion term under F45.8, and a patient could have both this condition and sleep related teeth grinding. In this case, the two conditions are clearly unrelated to each other, and so it would be appropriate to report F45.8 and G47.63 together.

b. Excludes2

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

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

In most cases the manifestation codes will have in the code title, "in diseases classified elsewhere." Codes with this title are a component of the etiology/manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition. See category F02, Dementia in other diseases classified elsewhere, for an example of this convention.

There are manifestation codes that do not have "in diseases classified elsewhere" in the title. For such codes, there is a "use additional code" note at the etiology code and a "code first" note at the manifestation code and the rules for sequencing apply.

In addition to the notes in the Tabular List, these conditions also have a specific Alphabetic Index entry structure. In the Alphabetic Index both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second.

An example of the etiology/manifestation convention is dementia in Parkinson's disease. In the Alphabetic Index, code G20 is listed first, followed by code F02.80 or F02.81 in brackets. Code G20 presents the underlying etiology, Parkinson's disease, and must be sequenced first, whereas codes F02.80 and F02.81 represent the manifestation of dementia in diseases classified elsewhere, with or without behavioral disturbance.

"Code first" and "Use additional code" notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/manifestation combination.

See section I.B.7. Multiple coding for a single condition.

14. "And"

The word "and" should be interpreted to mean either "and" or "or" when it appears in a title. For example, cases of "tuberculosis of bones", "tuberculosis of joints" and "tuberculosis of bones and joints" are classified to subcategory A18.0, Tuberculosis of bones and joints.