

Understanding **ICD-10-CM & ICD-10-PCS** A Worktext

2022



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



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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 lives. 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.

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—*Mary Jo Bowie*

TABLE OF CONTENTS

Preface	xiii
Acknowledgments	xvi
About the Author	xvii

Chapter 1: Introduction to Coding and Coding Professions 1

Introduction	2
Professional Coding	2
History of Coding	3
Health Insurance Portability and Accountability Act of 1996	4
Professional Coding Associations	4
American Health Information Management Association (AHIMA)	4
American Academy of Professional Coders (AAPC)	5
American Association of Medical Assistants (AAMA)	5
American Medical Technologists (AMT)	6
American Medical Billing Association (AMBA)	6
Medical Association of Billers (MAB)	6
Employment Opportunities for Coders	6
Summary	6
Internet Links	7
Chapter Review	7

Chapter 2: An Overview of ICD-10-CM 10

Introduction	10
ICD-10-CM Coding Book Format	11
ICD-10-CM Tabular List of Diseases and Injuries	11
Chapters of the Tabular List of Diseases and Injuries	12
Chapter 1—Certain Infectious and Parasitic Diseases (Code Range A00–B99)	12
Chapter 2—Neoplasms (Code Range C00–D49)	13
Chapter 3—Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism (Code Range D50–D89)	13
Chapter 4—Endocrine, Nutritional, and Metabolic Diseases (Code Range E00–E89)	13
Chapter 5—Mental, Behavioral, and Neurodevelopmental Disorders (Code Range F01–F99)	14
Chapter 6—Diseases of the Nervous System (Code Range G00–G99)	14

Chapter 7—Diseases of the Eye and Adnexa (Code Range H00–H59)	15
Chapter 8—Diseases of the Ear and Mastoid Process (Code Range H60–H95)	15
Chapter 9—Diseases of the Circulatory System (Code Range I00–I99)	15
Chapter 10—Diseases of the Respiratory System (Code Range J00–J99)	16
Chapter 11—Diseases of the Digestive System (Code Range K00–K95)	16
Chapter 12—Diseases of the Skin and Subcutaneous Tissue (Code Range L00–L99)	17
Chapter 13—Diseases of the Musculoskeletal System and Connective Tissue (Code Range M00–M99)	17
Chapter 14—Diseases of the Genitourinary System (Code Range N00–N99)	18
Chapter 15—Pregnancy, Childbirth, and the Puerperium (Code Range O00–O9A)	18
Chapter 16—Certain Conditions Originating in the Perinatal Period (Code Range P00–P96)	18
Chapter 17—Congenital Malformations, Deformations, and Chromosomal Abnormalities (Code Range Q00–Q99)	19
Chapter 18—Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (Code Range R00–R99)	19
Chapter 19—Injury and Poisoning and Certain Other Consequences of External Causes (Code Range S00–T88)	19
Chapter 20—External Causes of Morbidity (Code Range V00–Y99)	20
Chapter 21—Factors Influencing Health Status and Contact with Health Services (Z00–Z99)	20
Chapter 22—Codes for Special Purposes (U00–U85)	21
Summary	21
Internet Links	21
Chapter Review	21

Chapter 3: ICD-10-CM Coding Conventions 23

Introduction	24
Convention Types	24
Instructional Notes	24
Excludes Instructional Notes	26
See Instructional Note	27

See Also Instructional Note	27
Use Additional Code and Code First Instructional Notes	28
Default Codes	30
Punctuation Marks	30
Abbreviations	32
Symbols	32
Coding Guidelines	33
Summary	37
Internet Link	37
Chapter Review	37

Chapter 4: Steps in Diagnostic Code Selection 39

Introduction	39
ICD-10-CM Documentation Essentials	40
Granularity and Laterality	40
Steps in Coding	45
1. Locate the Main Term in the Alphabetic Index	45
2. Scan the Main Term Entry for Any Instructional Notations	45
3. In the Diagnostic Phrase Being Coded, Identify Any Terms That Modify the Main Term	45
4. Follow Any Cross-Reference Notes	45
5. Always Verify the Code in the Tabular List	45
6. Follow Any Instructional Terms	46
7. Select the Code	
Coding Guideline References for Code Location	46
Summary	47
Chapter Review	47

Chapter 5: Diagnostic Coding Guidelines 50

Introduction	51
Section 1—ICD-10-CM Conventions, General Coding Guidelines, and Chapter-Specific Guidelines	51
General Coding Guidelines	52
Laterality	56
Documentation for BMI Depth of Non-Pressure Ulcers, Pressure Ulcer Stages, Coma Scale, and NIH Stroke Scale	56
Syndromes	57
Documentation of Complications of Care	57
Borderline Diagnosis	58

Signs, Symptoms, and Unspecified Codes	58	Other Diseases Caused by Chlamydiae (Category Codes A70–A74)	86	Surgical Procedure Performed for Treatment of a Malignancy	121
Coding for Healthcare Encounters in Hurricane Aftermath	59	Rickettsioses (Category Codes A75–A79)	87	Pain	121
Chapter-Specific Coding Guidelines	60	Viral and Prion Infections of the Central Nervous System (Category Codes A80–A89) and Arthropod-borne Viral Fevers and Viral Hemorrhagic Fevers (A90–A99)	87	Admissions and Encounters Involving Surgery, Chemotherapy, Immunotherapy, and Radiation Therapy	121
Section II—Selection of Principal Diagnosis	60	B Codes	88	Surgery Followed by Chemotherapy or Radiation	121
Codes for Symptoms, Signs, and Ill-Defined Conditions	61	Viral Infections Characterized by Skin and Mucous Membrane Lesions (Category Codes B00–B09)	88	Encounter or Admission Solely for Administration of Chemotherapy, Immunotherapy, or Radiation	122
Two or More Interrelated Conditions, Each Potentially Meeting the Definition for Principal Diagnosis	61	Other Human Herpesviruses (Category Code B10)	89	Radiation Therapy, Chemotherapy, or Immunotherapy Followed by Complications	122
Two or More Diagnoses That Equally Meet the Definition for Principal Diagnosis	62	Viral Hepatitis (Category Codes B15–B19)	89	Admission or Encounter to Determine Extent of Malignancy or to Perform a Procedure	123
Two or More Comparative or Contrasting Conditions	62	Human Immunodeficiency Virus (HIV) Disease (Category Code B20)	89	Breast Implant Associated Anaplastic Large Cell Lymphoma	123
Original Treatment Plan Not Carried Out	62	Other Viral Diseases (Category Codes B25–B34)	91	Symptoms, Signs, and Abnormal Findings Listed in Chapter 18 (of ICD-10-CM) Associated with Neoplasms, and Admission/Encounter for Pain Control/Management	124
Complications of Surgery and Other Medical Care	63	Mycoses (Category Codes B35–B49)	92	Summary	125
Uncertain Diagnosis	63	Additional B Codes	93	Internet Links	125
Admission from Observation Unit, Following Post-Operative Observation, or Outpatient Surgery	64	Coding COVID-19	96	Chapter Review	125
Admissions/Encounters for Rehabilitation	64	Summary	96	Coding Assignments	126
Section III—Reporting Additional Diagnoses	65	Internet Links	96	Case Studies	127
Section IV—Diagnostic Coding and Reporting Guidelines for Outpatient Services	67	Chapter Review	96		
Summary	71	Coding Assignments	97		
Internet Link	71	Case Studies	98		
Chapter Review	71				
Chapter 6: Infectious and Parasitic Diseases 74		Chapter 7: Neoplasms 102		Chapter 8: Diseases of the Blood and Blood-Forming Organs 131	
Introduction	75	Introduction	103	Introduction	132
Abbreviations	76	Abbreviations	103	Abbreviations	132
Organisms Found in Chapter	76	Introduction to the Body System 104		Introduction to the Body System 132	
Bacteria	76	Malignant Versus Benign Neoplasms	104	Blood Composition	132
Fungi	78	Coding of Neoplasms	107	Coding of Diseases of the Blood and Blood-Forming Organs	136
Parasites	78	General Neoplasm Guidelines	108	Anemia	136
Viruses	79	Locating a Neoplasm Code	108	Nutritional Anemias (D50–D53)	136
Coding of Infectious and Parasitic Diseases	80	Sequencing of Codes	112	Hemolytic Anemias (Category Codes D55–D59)	137
Single-Code Assignment	80	Malignancy as Principal Diagnosis	113	Aplastic and Other Anemias and Other Bone Marrow Failure Syndromes (Category Codes D60–D64)	139
Combination-Code Assignment	80	Eradication of Malignancy and Follow-Up Examinations	113	Coagulation Defects, Purpura, and Other Hemorrhagic Conditions (Category Codes D65–D69)	140
Dual-Code Assignment	81	Treatment Followed by Recurrence	113	Other Disorders of the Blood and Blood-Forming Organs (Category Codes D70–D77)	143
A Codes	81	Excised Malignancy Followed by Recurrence	113	Intraoperative and Postprocedural Complications of the Spleen (Category Code D78)	146
Intestinal Infectious Diseases (Category Codes A00–A09)	81	Follow-Up Visit with No Recurrence	113	Certain Disorders Involving the Immune Mechanism (Category Codes D80–D89)	146
Tuberculosis (Category Codes A15–A19)	82	Two Primary Sites	114	Summary	149
Certain Zoonotic Bacterial Diseases (Category Codes A20–A28)	83	Primary and Secondary Malignancies	114	Internet Links	149
Other Bacterial Diseases (Category Codes A30–A49)	83	Malignancy in Two or More Noncontiguous Sites	118	Chapter Review	149
Infections with a Predominantly Sexual Mode of Transmission (Category Codes A50–A64)	86	Unspecified Disseminated Malignant Neoplasm	118	Coding Assignments	150
Other Spirochetal Diseases (Category Codes A65–A69)	86	Malignant Neoplasm Without Specification of Site	119	Case Studies	151
		Additional Coding Guidelines for Sequencing of Neoplasm Codes	119		
		Complications Associated with Neoplasms	120		
		Anemia	120		
		Dehydration	120		

Chapter 9: Endocrine, Nutritional, and Metabolic Diseases 154

Introduction155

Introduction to the Body System 155

Coding of Endocrine, Nutritional, and Metabolic Diseases157

Disorders of the Thyroid Gland (Category Codes E00–E07) 157

Diabetes Mellitus E08–E13 160

Types of Diabetes Mellitus 161

Other Disorders of Glucose Regulation and Pancreatic Internal Secretion (Category Codes E15–E16) 164

Disorders of Other Endocrine Glands (Category Codes E20–E35) 164

Malnutrition (Category Codes E40–E46) 165

Other Nutritional Deficiencies (Category Codes E50–E64) and Overweight, Obesity, and Other Hyperalimentation (Category Codes E65–E68) 165

Metabolic Disorders and Postprocedural Complications (Category Codes E70–E89) 166

Summary166

Internet Links166

Chapter Review166

Coding Assignments168

Case Studies169

Chapter 10: Mental, Behavioral, and Neurodevelopmental Disorders 173

Introduction174

Introduction to the Body System 174

Coding of Mental, Behavioral, and Neurodevelopmental Disorders .175

Mental Disorders Due to Known Physiological Conditions (Category Codes F01–F09) 175

Mental and Behavioral Disorders Due to Psychoactive Substance Use (Category Codes F10–F19) 176

Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders (Category Codes F20–F29) 179

Mood [Affective] Disorders (Category Codes F30–F39) 180

Anxiety, Dissociative, Stress-Related, Somatoform, and Other Nonpsychotic Mental Disorders (Category Codes F40–F48) 180

Behavioral Syndromes Associated with Physiological Disturbances and Physical Factors (Category Codes F50–F59) 181

Disorders of Adult Personality and Behavior (Category Codes F60–F69) 182

Intellectual Disabilities (Category Codes F70–F79) 183

Pervasive and Specific Developmental Disorders (Category Codes F80–F89) 184

Behavioral and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence (Category Codes F90–F98) 185

Unspecified Mental Disorder (Category Code F99) 186

Summary186

Internet Links186

Chapter Review187

Coding Assignments188

Case Studies189

Chapter 11: Diseases of the Nervous System 194

Introduction195

Introduction to the Body System 195

Coding of Diseases of the Nervous System195

Inflammatory Diseases of the Central Nervous System (Category Codes G00–G09) 195

Systemic Atrophies Primarily Affecting the Central Nervous System (Category Codes G10–G14) 196

Extrapyramidal and Movement Disorders (Category Codes G20–G26) 197

Other Degenerative Diseases of the Nervous System (Category Codes G30–G32) 197

Demyelinating Diseases of the Central Nervous System (Category Codes G35–G37) 198

Episodic and Paroxysmal Disorders (Category Codes G40–G47) 198

Nerve, Nerve Root, and Plexus Disorders (Category Codes G50–G59) 199

Polyneuropathies and Other Disorders of the Peripheral Nervous System (Category Codes G60–G65) 199

Diseases of Myoneural Junction and Muscle (Category Code G70–G73) 199

Cerebral Palsy and Other Paralytic Syndromes (Category Codes G80–G83) 200

Other Disorders of the Nervous System (Category Codes G89–G99) 201

Summary 202

Internet Links 202

Chapter Review 203

Coding Assignments 203

Case Studies 205

Chapter 12: Disorders of the Eye and Adnexa 208

Introduction 209

Abbreviations 209

Introduction to the Body System 209

Coding Disorders of the Eye and Adnexa211

Disorders of Eyelid, Lacrimal System, and Orbit (Category Codes H00–H05) 211

Disorders of Conjunctiva (Category Codes H10–H11) 212

Disorders of Sclera, Cornea, Iris, and Ciliary Body (Category Code H15–H22) 212

Disorders of Lens (Category Codes H25–H28) 213

Disorders of Choroid and Retina (Category Codes H30–H36) 214

Glaucoma (Category Codes H40–H42) 214

Disorders of Vitreous Body and Globe (Category Codes H43–H44) 215

Disorders of Optic Nerve and Visual Pathways (Category Codes H46–H47) 216

Disorders of Ocular Muscles, Binocular Movement, Accommodation, and Refraction (Category Codes H49–H52) 216

Visual Disturbances and Blindness (Category Codes H53–H54) 216

Other Disorders of Eye and Adnexa (Category Codes H55–H57, and Intraoperative and Postprocedural Complications and Disorders of Eye and Adnexa, Not Elsewhere Classified (H59) 216

Summary217

Internet Links217

Chapter Review217

Coding Assignments218

Case Studies219

Chapter 13: Diseases of the Ear and Mastoid Process 223

Introduction 224

Introduction to the Body System .224

Coding Diseases of the Ear and Mastoid Process 226

Diseases of the External Ear (Category Codes H60–H62) 226

Diseases of the Middle Ear and Mastoid (Category Codes H65–H75) 227

Diseases of Inner Ear (Category Codes H80–H83) 228

Other Disorders of Ear (Category Codes H90–H94) and Intraoperative and Postprocedural Complications and Disorders of Ear and Mastoid Process, Not Elsewhere Classified (H95) 229

Summary 229

Internet Links 229

Chapter Review 230

Coding Assignments 230

Case Studies231

Chapter 14: Diseases of the Circulatory System 235

Introduction	236
Introduction to the Body System	236
Coding of Diseases of the Circulatory System	239
Acute and Chronic Rheumatic Fever (Category Codes I00–I09)	239
Hypertensive Diseases (Category Codes I10–I16)	241
Ischemic Heart Diseases (Category Codes I20–I25)	243
Pulmonary Heart Disease and Diseases of Pulmonary Circulation (Category Codes I26–I28)	248
Other Forms of Heart Disease (Category Codes I30–I5A)	248
Cerebrovascular Diseases (Category Codes I60–I69)	250
Disease of Arteries, Arterioles, and Capillaries (Category Codes I70–I79)	251
Diseases of Veins, Lymphatic Vessels, and Lymph Nodes, Not Elsewhere Classified (Category Codes I80–I89)	252
Other and Unspecified Disorders of the Circulatory System (Category Codes I95–I99)	252
Summary	253
Internet Links	253
Chapter Review	253
Coding Assignments	254
Case Studies	255

Chapter 15: Diseases of the Respiratory System 260

Introduction	261
Introduction to the Body System	261
Coding Diseases of the Respiratory System	262
Acute Upper Respiratory Infections (Category Codes J00–J06)	263
Influenza and Pneumonia (Category Codes J09–J18)	263
Other Acute Lower Respiratory Infections (Category Codes J20–J22)	265
Other Diseases of Upper Respiratory Tract (Category Codes J30–J39)	265
Chronic Lower Respiratory Diseases (Category Codes J40–J47)	266
Lung Diseases Due to External Agents (Category Codes J60–J70)	267
Other Respiratory Diseases Principally Affecting the Interstitium (Category Codes J80–J84)	267
Suppurative and Necrotic Conditions of the Lower Respiratory Tract (Category Codes J85–J86)	267
Other Diseases of the Pleura (Category Codes J90–J94) and	

Intraoperative and Postprocedural Complications and Disorders of Respiratory System, Not Elsewhere Classified (Category Code J95)	268
Other Diseases of the Respiratory System (Category Codes J96–J99)	269
Vaping-related Disorders	270
Summary	270
Internet Links	270
Chapter Review	271
Coding Assignments	272
Case Studies	273

Chapter 16: Diseases of the Digestive System 276

Introduction	277
Introduction to the Body System	277
Coding Diseases of the Digestive System	278
Diseases of the Oral Cavity and Salivary Glands (Category Codes K00–K14)	278
Disease of Esophagus, Stomach, and Duodenum (Category Codes K20–K31)	279
Diseases of Appendix (Category Codes K35–K38)	282
Hernia (Category Codes K40–K46)	283
Noninfective Enteritis and Colitis (Category Code K50–K52)	283
Other Diseases of the Intestines (Category Codes K55–K64)	284
Diseases of Peritoneum and Retroperitoneum (Category Codes K65–K68)	284
Disease of Liver (Category Codes K70–K77)	284
Disorders of Gall Bladder, Biliary Tract, and Pancreas (Category Codes K80–K87)	285
Other Diseases of the Digestive System (Category Codes K90–K95)	286
Summary	287
Internet Links	287
Chapter Review	287
Coding Assignments	288
Case Studies	289

Chapter 17: Diseases of the Skin and Subcutaneous Tissue 293

Introduction	294
Introduction to the Body System	294
Coding of Diseases of the Skin and Subcutaneous Tissue	295
Infections of Skin and Subcutaneous Tissue (Category Codes L00–L08)	295
Bullous Disorders (Category Codes L10–L14)	298
Dermatitis and Eczema (Category Codes L20–L30)	298

Papulosquamous Disorders (Category Codes L40–L45) and Urticaria and Erythema (Category Codes L49–L54)	300
Radiation-Related Disorders of the Skin and Subcutaneous Tissue (Category Codes L55–L59)	301
Disorders of Skin Appendages (Category Codes L60–L75)	301
Intraoperative and Postprocedural Complications of Skin and Subcutaneous Tissue (Category Code L76)	301
Other Diseases of the Skin and Subcutaneous Tissue (Category Codes L80–L99)	301
Summary	305
Internet Links	305
Chapter Review	305
Coding Assignments	306
Case Studies	307

Chapter 18: Diseases of the Musculoskeletal System and Connective Tissue 311

Introduction	312
Introduction to the Body System	312
Coding of Diseases of the Musculoskeletal System and Connective Tissue	314
Infectious Arthropathies (Category Codes M00–M02)	315
Autoinflammatory Syndromes (M04) and Inflammatory Polyarthropathies (Category Codes M05–M14)	315
Osteoarthritis (Category Codes M15–M19)	316
Other Joint Disorders (Category Codes M20–M25)	316
Dentofacial Anomalies [Including Malocclusion] and Other Disorders of Jaw (Category Codes M26–M27)	317
Systemic Connective Tissue Disorders (Category Codes M30–M36)	317
Dorsopathies (Category Codes M40–M54)	318
Soft Tissue Disorders (Category Codes M60–M79)	318
Osteopathies and Chondropathies (Category Codes M80–M94)	319
Other Disorders of the Musculoskeletal System and Connective Tissue (Category Code M95)	322
Intraoperative and Postprocedural Complications and Disorders of Musculoskeletal System, Not Elsewhere Classified (Category Code M96) Periprosthetic Fracture Around Internal Prosthetic Joint (Category Code M97) and Biomechanical Lesions, Not Elsewhere Classified (Category Code M99)	322
Summary	322
Internet Links	323

Chapter Review	323
Coding Assignments	324
Case Studies	325

Chapter 19: Diseases of the Genitourinary System 329

Introduction	330
Introduction to the Body System	330
Coding Diseases of the Genitourinary System	332
Glomerular Diseases (Category Codes N00–N08)	332
Renal Tubulo-Interstitial Diseases (Category Codes N10–N16)	333
Acute Kidney Failure and Chronic Kidney Disease (Category Codes N17–N19)	334
Urolithiasis (Category Codes N20–N23)	335
Other Disorders of Kidney and Ureter (Category Codes N25–N29)	336
Other Diseases of the Urinary System (Category Codes N30–N39)	336
Diseases of Male Genital Organs (Category Codes N40–N53)	338
Disorders of Breast (Category Codes N60–N65)	338
Inflammatory Diseases of Female Pelvic Organs (Category Codes N70–N77)	339
Noninflammatory Disorders of the Female Genital Tract (Category Codes N80–N98)	339
Intraoperative and Postprocedural Complications and Disorders of Genitourinary System, Not Elsewhere Classified (Category Code N99)	340
Summary	340
Internet Links	341
Chapter Review	341
Coding Assignments	342
Case Studies	343

Chapter 20: Pregnancy, Childbirth, and the Puerperium 347

Introduction	348
Introduction to the Body System	348
Coding for Pregnancy, Childbirth, and the Puerperium	349
Pregnancy with Abortive Outcome (Category Codes O00–O08) and Supervision of High-Risk Pregnancy (Category Code O09)	351
Routine Outpatient Prenatal Visits	354
Edema, Proteinuria, and Hypertensive Disorders in Pregnancy, Childbirth, and the Puerperium (Category Codes O10–O16)	354
Other Maternal Disorders Predominantly Related to Pregnancy (Category Codes O20–O29)	355

Maternal Care Related to the Fetus and Amniotic Cavity and Possible Delivery Problems (Category Codes O30–O48)	356
Complications of Labor and Delivery (Category Codes O60–O77)	358
Encounter for Delivery (Category Codes O80 and O82)	359
Complications Predominately Related to the Puerperium (Category Codes O85–O92)	361
Other Obstetric Conditions, Not Elsewhere Classified (Category Codes O94–O9A)	361
Additional Coding Guidelines	363
Summary	363
Internet Links	363
Chapter Review	363
Coding Assignments	364
Case Studies	365

Chapter 21: Certain Conditions Originating in the Perinatal Period 369

Introduction	369
Coding Guidelines for Certain Conditions Originating in the Perinatal Period	370
Newborn Affected by Maternal Factors and by Complications of Pregnancy, Labor, and Delivery (Category Codes P00–P04)	371
Disorders of Newborn Related to Length of Gestation and Fetal Growth (Category Codes P05–P08)	372
Abnormal Findings on Neonatal Screening (Category Code P09)	372
Birth Trauma (Category Codes P10–P15)	373
Respiratory and Cardiovascular Disorders Specific to the Perinatal Period (Category Codes P19–P29)	374
Infections Specific to the Perinatal Period (Category Codes P35–P39)	374
Hemorrhagic and Hematologic Disorders of Newborn (Category Codes P50–P61)	375
Transitory Endocrine and Metabolic Disorders Specific to Newborn (Category Codes P70–P74)	375
Digestive System Disorders of Newborn (Category Codes P76–P78)	375
Conditions Involving the Integument and Temperature Regulation of Newborn (Category Codes P80–P83) and Other Problems with Newborns (Category Code P84)	376
Other Disorders Originating in the Perinatal Period (Category Codes P90–P96)	376
Summary	377
Internet Links	377
Chapter Review	377

Coding Assignments	378
Case Studies	379

Chapter 22: Congenital Malformations, Deformations, and Chromosomal Abnormalities 383

Introduction	384
Introduction to the Body System	384
Coding Congenital Malformations, Deformations, and Chromosomal Abnormalities	384
Congenital Malformations of the Nervous System (Category Codes Q00–Q07)	385
Congenital Malformations of Eye, Ear, Face, and Neck (Category Codes Q10–Q18)	386
Congenital Malformations of the Circulatory System (Category Codes Q20–Q28)	387
Congenital Malformations of the Respiratory System (Category Codes Q30–Q34)	387
Cleft Lip and Cleft Palate (Category Codes Q35–Q37)	387
Other Congenital Malformations of the Digestive System (Category Codes Q38–Q45)	388
Congenital Malformations of Genital Organs (Category Codes Q50–Q56)	388
Congenital Malformations of the Urinary System (Category Codes Q60–Q64)	389
Congenital Malformations and Deformations of the Musculoskeletal System (Category Codes Q65–Q79)	390
Other Congenital Malformations (Category Codes Q80–Q89) and Chromosomal Abnormalities, Not Elsewhere Classified (Category Codes Q90–Q99)	391
Summary	391
Internet Links	391
Chapter Review	392
Coding Assignments	392
Case Studies	393

Chapter 23: Symptoms, Signs, and Abnormal Clinical Laboratory Findings 397

Introduction	398
Coding of Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified	398
Coding Guidelines for Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified	400

Guideline for Principal Diagnosis .400	Injuries to the Head (Category Codes S00–S09) .422	Accident (Category Codes V30–V39) .445
Symptoms and Signs as Secondary Codes .401	Injuries to the Neck (Category Codes S10–S19) .422	Car Occupant Injured in Transport Accident (Category Codes V40–V49) .446
Difference Between Inpatient and Outpatient Coding Guidelines. .401	Injuries to the Thorax (Category Codes S20–29) .423	Occupant of Pickup Truck or Van Injured in Transport Accident (Category Codes V50–V59) .446
Chapter 18 Specific Coding Guidelines .402	Injuries to the Abdomen, Lower Back, Lumbar Spine, Pelvis, and External Genitals (Category Codes S30–S39) .423	Occupant of Heavy Transport Vehicle Injured in Transport Accident (Category Codes V60–V69) .447
Symptoms and Signs Involving the Circulatory and Respiratory Systems (Category Codes R00–R09) .402	Injuries to the Shoulder and Arm, Elbow, Wrist, and Hand (Category Codes S40–S69) .423	Bus Occupant Injured in Transport Accident (Category Codes V70–V79) .447
Symptoms and Signs Involving the Digestive System and Abdomen (Category Codes R10–R19) .403	Injuries to the Hip and Thigh, Knee and Lower Leg, Ankle and Foot, and Toes (Category Codes S70–S99) .424	Other Land Transport Accidents (Category Codes V80–V89) .447
Symptoms and Signs Involving the Skin and Subcutaneous Tissue (Category Codes R20–R23) .403	T Codes .425	Water Transport Accidents (Category Codes V90–V94) .447
Symptoms and Signs Involving the Nervous and Musculoskeletal Systems (Category Codes R25–R29) .403	Injuries Involving Unspecified Multiple Body Regions (Category Code T07) .425	Air and Space Transport Accidents (Category Codes V95–V97) .448
Symptoms and Signs Involving the Genitourinary System (Category Codes R30–R39) .404	Injury of Unspecified Body Region (Category Code T14) .425	Other and Unspecified Transport Accidents (Category Codes V98–V99) .448
Symptoms and Signs Involving Cognition, Perception, Emotional State, and Behavior (Category Codes R40–R46) .404	Effects of Foreign Body Entering Through Natural Orifice (Category Codes T15–T19) .425	Other External Causes of Accidental Injury (Category Codes W00–X58) .448
Symptoms and Signs Involving Speech and Voice (Category Codes R47–R49) .405	Burns and Corrosions (Category Codes T20–T32) .425	Slipping, Tripping, Stumbling, and Falls (Category Codes W00–W19) .448
General Symptoms and Signs (Category Codes R50–R69) .406	Frostbite (Category Codes T33–T34) .428	Exposure to Inanimate Mechanical Forces (Category Codes W20–W49) .449
Abnormal Findings on Examination of Blood Without Diagnosis (Category Codes R70–R79) and Abnormal Findings on Examination of Urine Without Diagnosis (Category Codes R80–R82) .407	Poisoning by Adverse Effects of and Underdosing of Drugs, Medicaments, and Biological Substances (Category Codes T36–T50) .429	Exposure to Animate Mechanical Forces (Category Codes W50–W64) .450
Abnormal Findings on Examination of Other Body Fluids, Substances, and Tissues, Without Diagnosis (Category Codes R83–R89) .407	Toxic Effects of Substances Chiefly Nonmedicinal as to Source (Category Codes T51–T65) .430	Accidental Non-Transport Drowning and Submersion (Category Codes W65–W74) .450
Abnormal Findings on Diagnostic Imaging and in Function Studies, Without Diagnosis (Category Codes R90–R94), Abnormal Tumor Markers (Category Code R97), and Ill-defined and Unknown Cause of Mortality (Category Code R99) .408	Other and Unspecified Effects of External Causes (Category Codes T66–T78) .431	Exposure to Electric Current, Radiation, and Extreme Ambient Air Temperature and Pressure (Category Codes W85–W99) .450
Summary .409	Complications of Surgical and Medical Care, Not Elsewhere Classified (Category Codes T80–T88) .432	Exposure to Smoke, Fire, and Flames (Category Codes X00–X08) .450
Chapter Review .409	Summary .433	Contact with Heat and Hot Substances (Category Codes X10–X19) .451
Coding Assignments .410	Internet Links .434	Exposure to Forces of Nature (Category Codes X30–X39) .451
Case Studies .411	Chapter Review .434	Overexertion and Strenuous or Repetitive Movement (Category Code X50) and Accidental Exposure to Other Specified Factors (Category Codes X52, X58) .451
	Coding Assignments .435	Intentional Self-Harm (Category Codes X71–X83) .451
	Case Studies .436	Assault (Category Codes X92–Y09) .451
		Event of Undetermined Intent (Category Codes Y21–Y33) .452
		Legal Intervention, Operations of War, Military Operations, and Terrorism (Category Codes Y35–Y38) .452
Chapter 24: Injury, Poisoning, and Certain Other Consequences of External Causes 415	Chapter 25: External Causes of Morbidity 440	Complications of Medical and Surgical Care (Category Codes Y62–Y84) .452
Introduction .416	Introduction .441	Supplementary Factors Related to Causes of Morbidity Classified Elsewhere (Category Codes Y90–Y99) .453
Coding Guidelines .417	Coding External Causes of Morbidity .442	
Terminology .418	Transport Accidents (Category Codes V00–V99) .444	
Fractures .418	Pedestrian Injured in Transport Accident (Category Codes V00–V09) .445	
Gustilo Classification of Fractures 420	Pedal Cycle Rider Injured in Transport Accident (Category Codes V10–V19) .445	
S Codes .421	Motorcycle Rider Injured in Transport Accident (Category Codes V20–V29) .445	
	Occupant of Three-Wheeled Motor Vehicle Injured in Transport	

Summary	456
Chapter Review	456
Coding Assignments	458
Case Studies	459

Chapter 26: Factors Influencing Health Status and Contact with Health Services, and Codes for Special Purposes 462

Introduction	463
Introduction to Z Codes	463

Persons Encountering Health Services for Examinations (Category Codes Z00–Z13)	464
Genetic Carrier and Genetic Susceptibility to Disease (Category Codes Z14–Z15)	468
Resistance to Antimicrobial Drugs (Category Code Z16)	471
Estrogen Receptor Status (Category Code Z17)	471
Persons with Potential Health Hazards Related to Communicable Diseases (Category Codes Z20–Z29)	471
Persons Encountering Health Services in Circumstances Related to Reproduction (Category Codes Z30–Z39)	472
Encounters for Other Specific Health Care (Category Codes Z40–Z53)	474
Persons with Potential Health Hazards Related to Socioeconomic and Psychosocial Circumstances (Category Codes Z55–Z65)	477
Do Not Resuscitate Status (Category Code Z66)	477
Blood Type (Category Code Z67)	477
Body Mass Index (BMI) (Category Code Z68)	477
Persons Encountering Health Services in Other Circumstances (Category Codes Z69–Z76)	477
Persons with Potential Health Hazards Related to Family and Personal History and Certain Conditions Influencing Health Status (Category Codes Z77–Z99)	478

Additional Guidelines 481

Introduction to Chapter 22 of ICD-10-CM—Codes for Special Purposes 483

Vaping-related Disorder	484
COVID-19	485

Summary 492

Internet Links 492

Chapter Review 492

Coding Assignments 493

Case Studies 494

Chapter 27: Introduction to ICD-10-PCS 498

Introduction	499
Code Structure	499
Format	500
Introduction	500
Index	501
Tables	502
ICD-10-PCS Coding Guidelines	503
Selection of Principal Procedure	505
Summary	506
Chapter Review	506

Chapter 28: Medical and Surgical Section 509

Introduction	510
Medical and Surgical Section Character Meanings	510
Section	510
Body Systems	510
ICD-10-PCS Official Coding Guidelines Relating to Body System	511
Root Operations	512
ICD-10-PCS Official Coding Guidelines Relating to Root Operation	517
Body Part	524
ICD-10-PCS Official Coding Guidelines Relating to Body Part	524
Approach	528
ICD-10-PCS Official Coding Guidelines Relating to Approach	532
Device	533
ICD-10-PCS Official Coding Guidelines Relating to Device	534
Qualifier	535
Principles for the Medical and Surgical Section	536
Selecting Codes	537
Summary	541
Internet Links	541
Chapter Review	541
Coding Assignments	542
Case Studies	543

Chapter 29: Obstetrics Section 547

Introduction	548
ICD-10-PCS Official Coding Guidelines for Obstetric Section	548
Obstetrics Section of the ICD-10-PCS	548
Section	548
Body System	548
Root Operation	549

Body Part	549
Approach	549
Device	550
Qualifier	550
Procedure Highlights	552
Abortion	552
Amniocentesis	552
Delivery	552
Cesarean Deliveries	552
Forceps Extraction	552
Selecting Codes	554
Summary	555
Internet Links	556
Chapter Review	556
Coding Assignments	556
Case Studies	557

Chapter 30: Placement Section 560

Introduction	561
Placement Section of the ICD-10-PCS	561
Section	561
Body System: Anatomical Regions and Anatomical Orifices	561
Root Operation	561
Body Regions and Orifices	561
Approach	561
Device	563
Qualifier	563
Procedure Highlights	563
Cast Application	563
Dressing Application	564
Packing	564
Summary	564
Internet Link	564
Chapter Review	564
Coding Assignments	565
Case Studies	565

Chapter 31: Administration Section 567

Introduction	568
Administration Section of the ICD-10-PCS	568
Section	568
Body System: Physiological Systems and Anatomical Regions	568
Root Operation	568
Body/System Region	568
Approach	569
Substance	570
Qualifier	570
Summary	573
Chapter Review	574
Coding Assignments	574
Case Studies	575

Chapter 32: Measurement and Monitoring Section 577

Introduction	578
Measurement and Monitoring Section of the ICD-10-PCS	578
Section	578
Body System	578
Root Operation	578
Body System	578
Approach	578
Function/Device	579
Qualifier	580
Summary	581
Chapter Review	581
Coding Assignments	581
Case Studies	582

Chapter 33: Extracorporeal or Systemic Assistance and Performance Section and Extracorporeal or Systemic Therapies Section 584

Introduction	585
Extracorporeal or Systemic Assistance and Performance Section of ICD-10-PCS	585
Section	585
Body System/Physiological System	585
Root Operation	585
Body System	586
Duration	586
Function	587
Qualifier	587
Extracorporeal or Systemic Therapies Section of ICD-10-PCS	587
Section	587
Body System/Physiological System	587
Root Operation	587
Body System	588
Duration	588
Qualifier	588
Qualifier	588
Summary	589
Chapter Review	590
Coding Assignments	590
Case Studies	591

Chapter 34: Osteopathic, Other Procedures, and Chiropractic Sections 593

Introduction	594
Osteopathic Section	594
Anatomical Region and Root Operation	594

Body Region	594
Approach, Method, and Qualifier	594
Other Procedures	595
Root Operation	595
Body Region	595
Approach	596
Method	596
Qualifier	596
Chiropractic Section	597
Root Operation	597
Body Region	597
Approach, Method, Qualifier	598
Summary	598
Internet Links	598
Chapter Review	598
Coding Assignments	598
Case Studies	599

Chapter 35: Imaging, Nuclear Medicine, and Radiation Therapy Sections 601

Introduction	602
Imaging Section	602
Body System and Type	602
Body Part	602
Contrast	603
Qualifier	603
Nuclear Medicine Section	604
Body System	604
Type	604
Body Part or Region	604
Radionuclide	605
Qualifier	605
Radiation Therapy Section	606
Body System	607
Modality	607
Treatment Site	607
Modality Qualifier	608
Isotope	608
Qualifier	608
Summary	609
Internet Links	609
Chapter Review	609
Coding Assignments	610
Case Studies	611

Chapter 36: Physical Rehabilitation and Diagnostic Audiology Section 614

Introduction	615
Physical Rehabilitation and Diagnostic Audiology Section	615
Section Qualifier	615
Type	615
Body System and Region	615
Type Qualifier	616

Equipment and Qualifier	616
Summary	617
Internet Links	617
Chapter Review	617
Coding Assignments	617
Case Studies	618

Chapter 37: Mental Health and Substance Abuse Treatment 621

Introduction	622
Mental Health Section	622
Type	622
Qualifier	623
Qualifier	624
Substance Abuse Treatment Section	624
Type	624
Qualifier	625
Qualifiers	625
Summary	625
Internet Links	626
Chapter Review	626
Coding Assignments	627
Case Studies	628

Chapter 38 New Technology Section 630

Introduction	630
New Technology Section Character Meanings	631
Section Organization	631
Body System	631
Root Operation	631
Body Part	632
Approach	632
Device/Substance/Technology	633
Qualifier	633
Coding Guidelines for Section X of ICD-10-PCS	633
Summary	633
Internet Links	634
Chapter Review	634
Coding Assignments	634

Appendix A This appears in the MINDTAP & Student Companion Site

Appendix B This appears in the MINDTAP & Student Companion Site

Glossary	636
Index	650

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 Cengage. 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.

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- Chapter Quizzes
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Introduction to Coding and Coding Professions

Chapter Outline

Chapter Objectives

Key Terms

Introduction

Professional Coding

History of Coding

Health Insurance Portability
and Accountability Act of 1996

Professional Coding Associations

Employment Opportunities for Coders

Summary

Internet Links

Chapter Review

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)	Coding Commission on Accreditation of Allied Health Education Programs (CAAHEP)	<i>International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)</i>	National Center for Health Statistics (NCHS)
Certified Medical Billing Specialist (CMBS)	Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191	<i>International Classification of Diseases, Tenth Revision (ICD-10)</i>	Registered Health Information Administrator (RHIA)
Certified Medical Record Technician (CMRT)	ICD-10-CM	Medical Association of Billers (MAB)	Registered Health Information Technician (RHIT)
Certified Medical Reimbursement Specialist (CMRS)	ICD-10-PCS	Morbidity	Registered Medical Assistant (RMA)
Certified Outpatient Coder (COC)	ICD-10 Procedure Coding System	Mortality	World Health Organization (WHO)
Certified Professional Coder (CPC)			
Certified Risk Adjustment Coder (CRC)			

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 ODTJ0ZZ 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 World 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.

An Overview of ICD-10-CM

Chapter Outline

Chapter Objectives	Chapters of the Tabular List of Diseases and Injuries
Key Terms	Summary
Introduction	Internet Link
ICD-10-CM Coding Book Format	Chapter Review
ICD-10-CM Tabular List of Diseases and Injuries	

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)
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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 alphanumeric 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 alphanumeric 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 erythroid 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	Achalasia 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

Key Terms

Introduction

Convention Types

Coding Guidelines

Summary

Internet Link

Chapter Review

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

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 | <u>infection due to <i>Entamoeba histolytica</i></u> |
| 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 immunodeficiency 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.