Preparing for the *ICD-10-CM*
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Learning Objectives

When you complete the instruction in this supplement, you will be trained to:

- Explain the organization of the ICD-10-CM.
- Distinguish among the ICD-10-CM Conventions.
- Explain basic coding guidelines.
- Describe ICD-10-CM terminology.
- Determine the steps to locate a valid code in the ICD-10-CM.
- Define the diseases and conditions found in the Tabular List of the ICD-10-CM.
- Apply the General Notes provided in each chapter of the ICD-10-CM.
- Identify the correct ICD-10-CM code in diagnostic statements and coding challenges.

Preview

This supplement focuses on the *ICD-10-CM*, which will be the resource for all diagnostic codes for services beginning October 1, 2014. To better understand how to use the *ICD-10-CM*, we will walk through each chapter of the *ICD-10-CM Tabular List* and highlight notes, inclusions and exclusions. Then, you will determine the correct ICD-10-CM code(s) for diagnostic statements and coding challenges in the Practice Exercises provided. Remember, while it is important to understand the basics of the *ICD-10-CM*, the *ICD-9-CM* will be used to code every service up until midnight on September 30, 2014. ICD-10 codes will be applied to all services provided on or after October 1, 2014. According to the American Academy of Professional Coders, in many ways, *ICD-10-CM* is quite similar to *ICD-9-CM*. The guidelines, conventions and rules are comparable. The organization of the codes is very similar.

To complete this supplement, you may purchase the *ICD-10-CM* in draft form, or you can view the 2013 version of the *ICD-10-CM* at the CMS Web site.

For our purposes, all references to the *ICD-10-CM* manual, general arrangement and specific examples used are based on Ingenix, Inc.’s, 2013 *ICD-10-CM: The Complete Official Draft Code Set*.

Please note that this supplement covers the basics of the *ICD-10-CM*. While we outline the organization, conventions and steps to assign ICD-10-CM codes and provide plenty of practice here, you will need to refer to the ICD-10-CM guidelines in the coding manual. The guidelines in the *ICD-10-CM* will ensure that you assign the correct ICD-10-CM codes. Keep in mind that if you are familiar with the ICD-9-CM process, it’ll be a smooth transition to the ICD-10-CM.
ICD-10-CM Organization

The beginning is a very good place to start when you encounter something new. You’ll find the *ICD-10-CM Official Guidelines for Coding and Reporting* in the front of the *ICD-10-CM*. The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS) provide these guidelines to accompany and complement the conventions and instructions you’ll find within the *ICD-10-CM*. The Cooperating Parties for the ICD-10-CM (the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS and NCHS) have approved these guidelines. The Health Insurance Portability and Accountability Act (HIPAA) adopted these diagnosis codes for all healthcare settings and requires you to adhere to these guidelines.

The *ICD-10-CM* is made up of an *Alphabetic Index to Diseases*, sometimes referred to as the *Index*, and a *Tabular List of Diseases and Injuries*, sometimes referred to as the *Tabular List*. Let’s take a look at the contents of the *Index* and *Tabular List*.

Alphabetic Index to Diseases

The *Index* is divided into four parts; the *Index to Diseases and Injuries*, the *Neoplasm Table*, the *Table of Drugs and Chemicals* and the *Index to External Causes*. Let’s first examine the *Index to Diseases and Injuries*.

Index to Diseases and Injuries

The *Index to Diseases and Injuries* is an alphabetical list of terms and their corresponding code. The *Index to Diseases and Injuries* is arranged in alphabetic order by main term and subterms and includes nonessential modifiers.

Main Terms

The first important skill to develop in medical coding is the ability to identify main terms for the diagnosis in a medical statement. A medical statement is information a doctor documents in a patient’s medical record, such as, “The patient is diagnosed with abdominal pain.” You assign codes for the patient’s chief complaint or symptoms when there is no other definitive diagnosis or cause listed for the condition. When you code a record that contains two or more equal diagnoses, the principal diagnosis is the one for which the main treatment was given.

Main terms appear in boldface type in the *Index* of the *ICD-10-CM* and are flush with the left margin of each column for easy reference. Main terms represent items such as the following:

- Diseases—for example: influenza, bronchitis
- Conditions—for example: fatigue, fracture, injury, complication
- Nouns—for example: disease, disturbance, syndrome
- Adjectives—for example: double, large, kink
Anatomical sites, which are locations on the body, are not used for main terms. For example, you will find bronchial asthma under the disease term asthma, not under the anatomical term bronchial.

When you look up the term asthma in the *Index to Diseases and Injuries*, the first entry you’ll find for the main term is as follows:

```
Asthma, asthmatic (bronchial) (catarrh) (spasmodic) J45.909
```

The terms you see in parentheses after the word asthmatic are called nonessential modifiers and have no effect on selecting the correct code. We will discuss nonessential modifiers later when we talk about the punctuation used in the *ICD-10-CM*.

Let’s practice identifying main terms. Think back to the statement, “The patient is diagnosed with abdominal pain.” Begin by asking yourself, “What did the doctor document as being wrong with the patient?” Well, you know that the patient has abdominal pain. Now, where do you begin your search—abdomen or pain? You know that main terms in the *ICD-10-CM* are not listed under anatomical sites, so you can rule out looking under the term abdomen. Pain is a condition, so you would look there first. Following is an example of an entry from the *Index* in the *ICD-10-CM*. You can see how the main term pain is listed.

```
main term — Pain(s) (see also Painful) R52
abdominal R10.9
  colic R10.83
  generalized R10.84
    with acute abdomen R10.0
  lower R10.30
    left quadrant R10.32
    pelvic or perineal R10.2
    periumbilical R10.33
  right quadrant R10.31
```

### Subterms

In the example, the term abdominal describes where the pain is located in the body. Locating abdominal is the second step in determining what code to use. The first step was to identify pain as the main term. In this example, abdominal is a subterm. All terms listed below the main terms are called subterms. Subterms are modifiers of main terms and are always indented two spaces to the right below main terms. Each subterm has its own line, and all subterms are arranged in alphabetical order. Subterms describe the following three categories:

- Site—location on the body
- Cause—reason
- Clinical type—form
Look at the following examples:
The diagnosis is viral infection
The main term is: infection
The subterm is: viral
The main term, infection, is a condition. The subterm, viral, is the clinical type or form of infection.

Let’s try one more:
The diagnosis is Addison’s Disease
The main term is: Disease
The subterm is: Addison’s
The main term, disease, is a noun—a person, place or thing. The subterm, Addison’s, tells us the type of disease.

**Index to External Causes**

We’ve discussed the first part of the Index, which was the Index to Diseases and Injuries. Within the Index, you’ll also find the Neoplasms Table and the Table of Drugs and Chemicals, which will be discussed later in this supplement. The final part of the Index is the Index to External Causes. This section is arranged in alphabetical order by main term indicating the event. Chapter 20 of the ICD-10-CM is dedicated to external causes of morbidity (V00-Y99). According to the ICD-10-CM, this chapter permits the classification of environmental events and circumstances as the cause of injury and other adverse effects. These codes are intended to be secondary to another code, most often from Chapter 19, which codes injury, poisoning and certain other external causes. For example, in the Index to External Causes, you’ll find the following entry:

**Kicked by**
animal NEC W55.82

Now that you have studied the organization of the Index, let’s turn our attention to the Tabular List of Diseases and Injuries.
Tabular List of Diseases and Injuries

This section of the ICD-10-CM is arranged numerically within 21 separate chapters according to body system or nature of injury and disease. Each of the 21 chapters contains the following subject matter and the designated range of related ICD-10-CM codes.

The ICD-10-CM is an alphanumeric classification system divided into categories and subcategories. A valid code can be from three to seven characters with a decimal after the third character.

<table>
<thead>
<tr>
<th>X</th>
<th>X</th>
<th>X</th>
<th>X</th>
<th>X</th>
<th>X</th>
<th>X</th>
</tr>
</thead>
</table>

**Category**

The first three characters of the ICD-10-CM are considered the category. The first character of the three-digit category is a letter. The second and third may be numbers or alpha characters. This is considered “the block” of the code. According to the ICD-10-CM Conventions, a three-digit category without further subclassification is equivalent to a valid three-digit code. The following is an example of a valid three-digit code:

A09 Infectious gastroenteritis and colitis, unspecified

**Subcategory**

The subcategories are characters four, five or six, which may be either a letter or a number. The fourth, fifth and sixth characters of the ICD-10-CM code represent the etiology, anatomical site or the severity of the condition.

A valid four-digit code:

G60.0 Hereditary motor and sensory neuropathy

A valid five-digit code:

E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified

A valid six-digit code:

H10.401 Unspecified chronic conjunctivitis, right eye
Extension

Certain categories in Chapter 19 have a seventh-character extension, which is required to be added to each code when used. The extension identifies the services as an initial or subsequent encounter, or a sequela. You will find the following in the notes section of the category:

The appropriate 7th character is to be added to each code from category T16
  A  initial encounter
  D  subsequent encounter
  S  sequela

An initial encounter is the first visit for the current condition. A subsequent encounter is any visit after the first visit for the current condition. Sequela is used for complications or conditions that arise as a direct result of a condition.

Dummy Place-holder

The letter “X” is used as a dummy place-holder in the ICD-10-CM. According to the ICD-10-CM Conventions, a dummy “X” is used as a fifth- or sixth-character place-holder in certain six- and seven-character codes to allow for future expansion without disturbing the sixth- or seventh-digit structure. This can be confusing, so let’s look at an example to understand the concept better. Sometimes, the ICD-10-CM provides the dummy place-holder in the Tabular List, such as with this example:

H93.3 Disorders of acoustic nerve
  H93.3X Disorders of acoustic nerve
    H93.3X1 Disorders of right acoustic nerve
    H93.3X2 Disorders of left acoustic nerve
    H93.3X3 Disorders of bilateral acoustic nerves
    H93.3X9 Disorders of unspecified acoustic nerve

Now, let’s look at an example of having to build the code using your knowledge of a dummy place-holder.

Johnny was eating pretzels and decided to see how far he could push one in his ear. Unfortunately, the pretzel broke and a portion is now stuck in his ear. Johnny’s mom takes him to Urgent Care to have the foreign body removed.
Carol, the medical coder, receives the dictation for this visit and begins in the Index to code the diagnostic portion. Carol turns to the main term Foreign body and uses the subterms entering through orifice, ear to locate T16.– as the tentative code. Carol then turns to the Tabular List to find the valid code. The page looks like this:

T16  Foreign body in ear
    Foreign body in auditory canal

The appropriate 7th character is to be added to each code from Category T16
    A initial encounter
    D subsequent encounter
    S sequela

T16.1  Foreign body in right ear
T16.2  Foreign body in left ear
T16.9  Foreign body in ear, unspecified ear

The code provided, T16.9, is only four characters, but Carol is directed to add the appropriate seventh character to the code. She will add dummy place-holders to expand the code to seven characters: T16.9XXA.

So far in this supplement, you’ve learned about the Index and Tabular List of the ICD-10-CM. Let’s take a break and reinforce your knowledge with a Practice Exercise.

Practice Exercise 1

Answer the question or complete the sentence using the space provided.

1. Dr. Martin diagnosed Mrs. Abraham with diabetes type 2 on September 14, 2014. Which ICD coding manual will you use to code the diagnosis?

2. Dr. Martin saw Mrs. Abraham at a follow-up appointment on October 14, 2014. The diagnosis from this exam will be coded using the ____ edition of the ICD coding manual.

3. What are the four Cooperating Parties for the ICD-10-CM?
4. What are the four parts of the Index?
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Select the best answer from the choices provided.

5. The ICD-10-CM manual lists _____ codes.
   a. fundamental  
   b. procedural  
   c. treatment  
   d. diagnostic

   a. italicized  
   b. boldface  
   c. underlined  
   d. Times Roman

7. Information in parentheses following a main term is called a(n) _____ and it has no effect on selecting the correct code.
   a. nonessential modifier  
   b. essential modifier  
   c. subterm  
   d. subcategory

8. The ICD-10-CM manual is divided into the _____.
   a. Index and the Index to External Causes  
   b. Index to Diseases and Injuries and the Index to External Causes  
   c. Index and the Tabular List  
   d. Neoplasm Table and the Table of Drugs and Chemicals

9. The first ____ characters of the ICD-10-CM are considered the category.
   a. two  
   b. three  
   c. four  
   d. five
10. The _____ can be found within the *Index*.
   
   a. *Neoplasm Table*
   b. *Table of Drugs and Chemicals*
   c. *Index to External Causes*
   d. all of the above

**Review Practice Exercise 1**

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.

**ICD-10-CM Conventions**

Now that you understand the organization of the *ICD-10-CM*, as well as its format and structure, let’s look at the **conventions**, or standards, found at the front of the manual.

**Punctuation**

The *ICD-10-CM* manual uses the following punctuation symbols.

**Brackets []**

Brackets are used in the *Tabular List* to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the *Index* to identify manifestation codes. Look at the following example of what you would see in the *Tabular List*:

D65  Disseminated intravascular coagulation  
     [defibrination syndrome]

**Parentheses ()**

You’ll find parentheses in both the *Index* and the *Tabular List* to enclose supplementary words (nonessential modifiers) that may be present or absent in the statement of a disease without affecting the code number to which it is assigned. For instance, if you were to locate dumping syndrome in the *Index*, you will find the following:

Syndrome  
   dumping (postgastrectomy) K91.1  
   nonsurgical K31.89

**Colons:**

The *Tabular List* may use a **colon** after an incomplete term that requires an adjective or descriptor; however, the *ICD-10-CM* provides descriptions so specific that the colon is rarely used.
**Abbreviations**

You will encounter NEC and NOS and need to be familiar with the meaning of each.

NEC means **not elsewhere classifiable** and represents “other specified” in the *ICD-10-CM* manual. You should only assign codes with NEC when the information in the medical record provides detail for which a specific code does not exist.

NOS means **not otherwise specified** and may be interpreted as “unspecifed” according to the *ICD-10-CM Conventions*. This is assigned when the information in the medical record is insufficient to assign a more specific code.

**General Notes**

General notes are found in the *Tabular List* and help coders assign codes at the highest level. It is important to read these notes when you assign the diagnostic code.

**Includes Notes**—Immediately under certain categories, you’ll find a note that further defines, clarifies or provides examples of the contents of a code category.

**A21 Tularemia**

- **INCLUDES**
  - deer-fly fever
  - infection due to Francisella tularensis
  - rabbit fever

**Inclusion Terms**—Under certain codes in the *Index* is a list of **inclusion terms**, which indicate some of the conditions for which that code may be used. These may be synonyms or a list of various conditions included within a code classification.

**R23.4 Changes in skin texture**

- Desquamation of skin
- Induration of skin
- Scaling of skin

**Excludes Notes**—There are two types of excludes notes in the *ICD-10-CM*, but they mean very different things. You need to be sure to note if Excludes1 or Excludes2 is identified.

According to the ICD-10-CM Conventions, **Excludes1** means “not coded here.” The two conditions cannot be coded together. For example, a congenital disease cannot be coded with an acquired form of the same condition.

**K51.4 Inflammatory polyps of colon**

- **EXCLUDES1**: adenomatous polyp of colon (D12.6)
- polyposis of colon (D12.6)
- polyyps of colon NOS (K63.5)
Excludes2, on the other hand, means “not included here.” In this case, the Excludes2 notes indicate that the excluded condition is not part of the condition but may be present at the same time and both conditions can be coded if documented.

T79 Certain early complications of trauma, not elsewhere classified

EXCLUDES2: acute respiratory distress syndrome (J80)
complications occurring during or following medical procedures (T80-T88)
complications of surgical and medical care NEC (T80-T88)
newborn respiratory distress syndrome (P22.0)

Instructional Notes

The Alphabetic Index uses cross-reference terms to instruct you to look in another place before you assign a code. These cross references provide possible modifiers for a term or its synonyms. Follow the cross references to the correct code when you don’t find the diagnosis under the first term you locate. The types of cross reference terms used are see; see also; and, with or without; and code first, use additional codes and code also.

See

The see cross reference points you to another term. You will follow the see cross reference to ensure that you assign the correct code to a diagnosis. The following example shows you how to use the see cross reference:

Roetheln—see Rubella

The see cross reference instructs you to go to Rubella to locate the correct code for this condition.

See Also

See also indicates that additional information about the term and code is available under the referenced term in another place in the Alphabetic Index. The see also cross reference gives you an additional diagnosis and code when the main term or subterm is insufficient. The additional information in the see also cross reference helps you select the correct code, so follow this instruction to ensure coding accuracy. Look at the following examples for the various formats found in the Alphabetic Index:

Leishmanoid, dermal (see also Leishmaniasis, cutaneous)
Narrowing (see also Stenosis)

It’s also important to use multiple codes to identify all components of a diagnosis when a single code does not fully describe a given condition. The see also cross reference helps you do this. However, medical record documentation must mention the presence of all the elements of any code you use. Always ask the physician involved if you are unsure about assigning multiple codes.
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And, With or Without

The ICD-10-CM Conventions note that when the term “and” is used in a title, it may be interpreted as “and/or.”

The ICD-10-CM Conventions also provide instruction on dealing with coding “with.” When “with” appears, it should be interpreted to mean “associated with” or “due to.” You’ll also note that in the Index, the word “with” is sequenced immediately following the main term; it’s not in alphabetical order.

Code First, Use Additional Codes and Code Also

Multiple coding is using more than one code to identify a diagnosis as accurately as possible. Several instructional phrases indicate that you are required to use multiple codes.

**Code first**—This instruction identifies diagnoses that are not principal and are incomplete when they are used alone. You’ll find these instructions in the Tabular List. First, you’ll code the underlying disease, followed by the manifestation. For example, turn to code N29 in the Tabular List of your ICD-10-CM. You’ll see the instructional note directs you to “Code first underlying disease” and then provides possible conditions that may lead to this manifestation.

**Use additional codes**—Similar to the “Code first” instruction, this identifies a diagnosis that may need additional codes to fully describe the situation; however, the codes are secondary, rather than principal codes. Locate N30 Cystitis in the Tabular List. The instructional notes tell you to “use additional code to identify the infectious agent.” Therefore, if the infectious agent is documented, you’ll code the cystitis as the principal diagnosis and the infectious agent as the secondary code.

**Code also**—This note alerts the coder that more than one code may be required to fully describe the condition, but does not provide sequencing direction. A good example of this situation is found in the Tabular Index for code S91 Open wound of ankle, foot and toes. You’ll see a red instructional note directing you to “Code also any associated wound infection.” So if the documentation indicates an infection in addition to the wound, you’ll code that as well.

ICD-10-CM Terminology

Many—if not most—of the terms used in the ICD-10-CM manual have other definitions and meanings when they are used elsewhere. You need to be familiar with terms that are used throughout the ICD-10-CM manual as they relate to medical coding. This will help you code a medical diagnosis correctly. The following definitions are specific to their use in the ICD-10-CM coding manual:

**Acute**—short and severe; for example, a new injury or disease

**Adverse**—any unfavorable, unintended response to a drug that occurs with proper dosage
Aftercare—a visit to the medical facility for something planned in advance; for example, the removal of sutures (stitches)

Chronic—to continue over a long period of time or recurring frequently

Concurrent—when a patient is treated simultaneously by more than one physician for different care conditions

Foreign body—an object not naturally occurring in the human body

Late effect—a residual effect after the acute phase of an illness or injury has ended

Manifestation—the characteristic signs or symptoms of an illness

Residual—the long-term conditions resulting from a previous acute illness or injury

When both an acute disease and a chronic disease coexist and no single code exists to code both diseases together, code the acute disease as the principal diagnosis and the chronic disease as the secondary, or coexisting, condition. Here’s an example. The physician documents acute and chronic thyroiditis. Now, look in your ICD-10-CM manual’s Index for Thyroiditis. Then look for the subterms acute and chronic. You will find codes E06.0 Acute thyroiditis and E06.5 Chronic thyroiditis. Go to the Tabular List to verify these codes. You will code the acute condition first, listing code E06.0 and then code E06.5.

A late effect (sequela) is a residual condition that occurs after the acute phase. When you code a late effect you generally assign two codes: the residual effect and the cause of the late effect. Sometimes a late-effect code has been expanded to include the manifestation or residual effect and only one code is needed. Remember when you code late effects that there is no time limit between the acute phase and the late effect. In other words, some period of time can pass between the acute phase of a condition and the point at which the late effect or residual condition is diagnosed.

Let’s look at two terms that weren’t covered in the basic terminology—chief complaint and diagnosis. The chief complaint is the main reason a patient sees a doctor. For example, if a patient tells a doctor that he has a sore throat, that is the chief complaint. The diagnosis occurs when the doctor identifies what is wrong with a patient. In our example, the doctor might examine the patient and determine the patient has strep throat. This is the diagnosis. One last important term with which you should be familiar is unconfirmed diagnoses. You do not code conditions when it is uncertain if they really exist. In other words, don’t code a condition until it has been determined to be the diagnosis.

Unconfirmed diagnoses are suspected conditions, such as those that contain words like suspicion of, probable or likely. It’s important that medical coders do not play doctor and narrow down the choices of categories for the diagnosis. The concept of unconfirmed diagnoses affects how insurance companies reimburse, so it is important that you understand it.

Now that you understand the terminology used in the ICD-10-CM, let’s examine the steps to ICD-10-CM coding.
Steps to Assign ICD-10-CM Codes

It is essential that you use both the Index and Tabular List to locate and assign a code. The Index does not always provide the complete code, and it is necessary to refer to the Tabular List to read the instructional notes and verify the code before you assign it.

1. Locate the main term in the Index.
2. Refer to any subterms under the main term.
3. Look at the punctuation, abbreviation and notes that may apply.
4. Note the tentative code.
5. Locate the tentative code in the Tabular List.
6. Read the notes from the category that may apply.
7. Review the general notes.
8. Assign the valid code to its highest levels of specificity.

Now that you have a foundation in the steps to apply ICD-10-CM codes, let’s pause to complete a Practice Exercise.

Practice Exercise 2

Select the best answer from the choices provided.

1. In the Tabular List, _____ enclose synonyms, alternative wording or explanatory phrases.
   a. parentheses
   b. colons
   c. brackets
   d. semicolons

2. In the Tabular List, _____ are used to enclose supplementary words.
   a. parentheses
   b. colons
   c. brackets
   d. semicolons

3. NEC may be interpreted as “unspecified.” _____
   a. True
   b. False
4. Excludes1 and Excludes2 mean essentially the same thing. _____
   a. True
   b. False

5. Inclusion terms may be synonyms or may provide a list of various conditions included within a code classification. _____
   a. True
   b. False

6. An object not naturally occurring in the human body is _____.
   a. a foreign body
   b. acute
   c. chronic
   d. a manifestation

7. A late effect is defined as a(n) ____ effect after the acute phase of an illness or injury has ended.
   a. aftercare
   b. concurrent
   c. chronic
   d. residual

Review Practice Exercise 2

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.

Hands-on Practice with the ICD-10-CM

Now that you understand the format and conventions of the ICD-10-CM, it’s time to explore the functions of the manual. We’re going to walk through each of the 21 chapters of the ICD-10-CM Tabular List and show you how to code some of the subject matter included in each chapter.

The material might seem like a lot of information, but don’t worry. We’ll work through everything one step at a time and give you plenty of practice along the way. We will define each section for you and show you the important references in the Tabular List. Then you will try your hand at coding diagnostic statements and coding challenges.

By the time you finish this ICD-10-CM supplement, you’ll be using your ICD-10-CM manual with ease and confidence! You’ll know where to look when you need assistance as you code, and you’ll have these materials to use as a reference tool in your career. So, get ready . . . Get set . . . Let’s code!
Certain Infectious and Parasitic Diseases (A00-B99)

Infectious and parasitic diseases generally are caused by a bacterium, virus, fungus or animal parasite. Occasionally, their cause may be unknown. These infections can be transmitted from a host organism, or they are simply created within the human body.

Let's start by looking at the notes at the beginning of this chapter. At the top of the page, just under the chapter title, you will see that this chapter includes diseases generally recognized as communicable or transmissible. It also has a note that directs you to use an additional code for any associated drug resistance (Z16.-) when it's documented. You also have Excludes1 and Excludes2 notes to review.

Excludes1 means not coded here. The conditions are mutually exclusive codes and cannot be reported together. The following conditions should not be coded with a code from this chapter:
- certain localized infections—see body system-related chapters
- infectious and parasitic diseases complicating pregnancy, childbirth and the puerperium (O98.-)
- influenza and other acute respiratory infections (J00-J22)

Excludes2 indicates that it may be acceptable to use both the code and the excluded code together if supported by the documentation. You may code carrier or suspected carrier of infectious diseases (Z22.-) or infectious and parasitic diseases specific to the perinatal period (P35-P39) in addition to a code in Chapter 1 as long as it’s documented.

One final note on locating codes for this chapter: If, from the dictation you receive, you have trouble finding the main term of a diagnosis in the Index, turn to the main term Infection. The diseases in this chapter are infections, so that is a great place to start when you find yourself stuck! Now you're ready to complete the following Practice Exercise to code from the first chapter of the Tabular List of Diseases and Injuries.

Practice Exercise 3

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Gastroenteritis due to salmonella caused by food poisoning

2. Pertussis

3. Infection due to Bacteroides

4. Pneumocystis carinii pneumonia with AIDS
5. Measles with otitis media _________

6. Hand, foot and mouth disease _________

7. Early cardiovascular syphilis _________

8. Fungal infection of the foot _________

9. Hookworm disease _________

10. Coding Challenge

SUBJECTIVE
The patient is a 52-year-old homosexual Latin male previously known to be HIV positive and seen in the emergency department with fever, night sweats, cough, dyspnea and diarrhea.

OBJECTIVE
Chest x-ray shows bilateral interstitial infiltrates. Physical exam is significant for oral thrush, lymphadenopathy and fever. Arterial blood gases demonstrate hypoxemia. He was initially treated with Bactrim. This was discontinued due to leukopenia and thrombocytopenia. The Bactrim was changed to pentamidine and his blood gases slowly improved. The patient refused bronchoscopy. His fever was reduced and his ABGs improved. Unfortunately, blood cultures are positive for Histoplasma capsulatum. Amphotericin B was begun 320 mg daily.

ASSESSMENT
1. Probable Pneumocystis carinii pneumonia.
2. American histoplasmosis.
3. Oral thrush.
4. Acquired immunodeficiency syndrome.

PLAN
Discharged to home care and will follow up with PCP in one week unless there is a negative change in his condition.

___________

___________

Review Practice Exercise 3

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.
Neoplasm (C00-D49)

The *ICD-10-CM* has the *Neoplasm Table* in the *Alphabetical Index* at the end of the *Index to Diseases and Injuries*. It’s important to read the notes in the *Alphabetical Index* before coding from this chapter. The *Neoplasm Table* provides codes for neoplasms based on anatomical site. You will read your documentation to determine the behavior of the neoplasm.

**Malignant Primary**—This refers to the site at which a neoplasm originated.

**Malignant Secondary**—This refers to the site or sites to which the neoplasm has spread from the primary site.

**Ca in situ**—This describes the situation when the tumor cells are undergoing malignant changes but still are confined to the point of origin without invasion of the surrounding normal tissue.

**Benign**—This term refers to noncancerous growths. In *benign neoplasms*, growth does not invade adjacent structures or spread to distant sites, but it might displace or exert pressure on adjacent structures.

**Uncertain**—This term refers to tumors that the pathologist cannot classify as benign or malignant because some features of each type are present.

**Unspecified Behavior**—This refers to tumors in which neither the behavior nor the histological type are specified in the diagnosis.

You’ll also find notes in the *Tabular List* that describe functional activity, morphology, overlapping boundaries and ectopic tissues.

**Functional Activity**

According to the *Tabular List* in the *ICD-10-CM*, all neoplasms are classified in this chapter, whether they are functionally active or not. An additional code from Chapter 4 may be used, if desired, to identify functional activity associated with any neoplasm.

For example, catecholamine-producing malignant pheochromocytoma of adrenal gland should be coded to code block *C74* with additional code *E27.5*; basophil adenoma of pituitary gland with Cushing’s syndrome should be coded to *D35.2* with additional code *E24.0*.

---

1. ...
Morphology [Histology]

As indicated previously, you will code neoplasms primarily by the behavior. However, there are cases, such as for malignant melanoma and certain neuroendocrine tumors, that the morphology (histology) may be included. The morphology type of a neoplasm is determined based on looking at abnormal cells from different parts of the body in a microscope and naming and classifying those cells according to their original tissue type. Such classification is possible because most benign tumors and many malignant ones retain some microscopic features of their original tissue. Tumors are named according to the cell type they resemble most.

Primary Malignant Neoplasm Overlapping Site Boundaries

At times a neoplasm can overlap two or more contiguous (next to each other) sites and should be classified to the subcategory/code.8 for “overlapping lesion.” You should not use separate codes.

For example if you have an unspecified malignant neoplasm of the anus, you’ll code C21.0. You’ll code C20 for a malignant neoplasm of the rectum. However, if you have a malignant neoplasm of the anorectum (which is the anus and rectum) you will code to the contiguous sites of rectum and anus, which is C21.8.

Malignant Neoplasm of Ectopic Tissue

This note is fairly straightforward. The Tabular List indicates that malignant neoplasms of ectopic tissue are to be coded to the site mentioned.

Now that you have read the notes found within Chapter 2, please proceed to the next Practice Exercise.

Practice Exercise 4

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Recurrent glioma of cerebrum ________
2. Metastatic carcinoma of the brain from the lung ________
3. Hodgkin sarcoma ________
4. Benign neoplasm scalp ________
5. Fibromyoma of the uterus ________
6. Coding Challenge

Pathology Report
SPECIMEN: Biopsy, lesser curvature.

DATE COMPLETED: June 7, 20XX

GROSS DESCRIPTION
Multiple fragments pale tan tissue, measuring 1 × 0.6 × 0.3 cm in aggregate.

MICROSCOPIC/DIAGNOSIS
Gastric biopsy: Adenocarcinoma.

Review Practice Exercise 4

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.

Diseases of the Blood and Blood-forming Organs and Certain Disorders Involving the Immune Mechanism (D50-D89)

Chapter 3 includes diseases such as nutritional and hemolytic anemia, anemia and other bone marrow failure syndromes, coagulation defects and certain disorders involving the immune mechanism, such as Di George's syndrome and sarcoidosis.

The Excludes2 at the beginning of this chapter indicates that it may be acceptable to use both the code and the excluded code together if supported by the documentation. These conditions are:

- autoimmune disease (systemic) NOS (M35.9)
- certain conditions originating in the perinatal period (P00-P96)
- complications of pregnancy, childbirth and the puerperium (O00-O9A)
- congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
- endocrine, nutritional and metabolic diseases (E00-E88)
- human immunodeficiency virus [HIV] disease (B20)
- injury, poisoning and certain other consequences of external causes (S00-T88)
- neoplasms (C00-D49)
- symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94)

Keep in mind this long list of exclusions as you try your hand at coding from Chapter 3 of the ICD-10-CM Tabular List.
Practice Exercise 5

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Addison anemia _________
2. Triple gene defect alpha thalassemia _________
3. Sickle-cell disease with crisis _________
4. Minkowski-Chauffard syndrome _________
5. Big spleen syndrome _________

6. Coding Challenge
   A 53-year-old recurrent breast cancer patient presents with a 2-week history of fatigue, for which rest does not relieve. She reports being “deeply tired; both physically and mentally” and describes having significantly limited energy to accomplish daily tasks. She reports difficulty maintaining concentration, adversely affecting her ability to return to work on a limited basis. She occasionally experiences chest pain and shortness of breath on exertion. Complete blood count (CBC) levels demonstrate decreased red blood cells (RBC) and a hemoglobin (Hb) value of 9 g/dL. Bone marrow biopsy ruled out bone metastasis. Diagnosis is microcytic normocytic anemia due to chronic neoplastic disease. The patient was placed on treatment with erythropoietin and iron supplementation. Hemoglobin levels will be monitored with follow-up outpatient laboratory testing.2

   _________
   _________
   _________

Review Practice Exercise 5

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.
Endocrine, Nutritional and Metabolic Diseases (E00-E89)

Chapter 4 of the ICD-10-CM Tabular List focuses on diseases and disorders of the endocrine system, nutritional deficiencies and metabolic diseases. This chapter contains codes for items such as hypothyroidism, diabetes, obesity and metabolic disorders.

As you are aware, all neoplasms are classified in Chapter 2. According to the ICD-10-CM Tabular List, appropriate codes in this chapter may be used as additional codes to indicate either functional activity by neoplasms and ectopic endocrine tissue or hyperfuction and hypofunction of endocrine glands associated with neoplasms or other conditions classified elsewhere.

Excludes1 indicates that transitory endocrine and metabolic disorders specific to newborn (P70-P74) should not be reported with a code in this chapter.

The diabetes section of the ICD-10-CM is quite different from the ICD-9-CM. Review it carefully to make sure you understand how to use it properly. Once you have a good grasp on this chapter, go ahead and complete the following Practice Exercise.

Practice Exercise 6

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Postsurgical hypothyroidism _________
2. Type 1 diabetes hypoglycemic coma _________
3. Primary hyperparathyroidism ________
4. Polycystic ovaries _________
5. Asymptomatic premature menopause _________
6. Coding Challenge

SUBJECTIVE
At a regular office visit, patient complains of constipation, nausea and vomiting, with abdominal pain, excessive thirst and muscle weakness. Patient is currently receiving treatment for thyroid cancer.

OBJECTIVE
A comprehensive examination is performed. The physician orders labs and an EKG, which are taken at the office. Results from the blood draw indicate an elevated calcium level and on the EKG, a shortened QT interval.

ASSESSMENT
The patient has acute hypercalcemia resulting from the thyroid cancer.

PLAN
Orders for immediate hydration (3 L/day) and diuretic administration.

Review Practice Exercise 6
Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.

Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99)
A mental disorder is any clinically significant behavioral or psychological syndrome that is characterized by the presence of distressing symptoms or significant impairment of function. Chapter 5 of the Tabular List includes the diagnosis codes for a broad range of mental disorders.

You’ll see at the beginning of this chapter that it includes disorders of psychological development, but excludes those symptoms, signs and abnormal clinical laboratory findings, not elsewhere classified (R00-R99). This means that you can code both the codes from this chapter as well as codes from R00-R99 as long as it’s supported by the dictation.

Before moving on to the nervous system, complete the following exercise to assist in your understanding of the ICD-10-CM codes related to mental and behavioral disorders.
Practice Exercise 7

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Alcoholic delirium ______
2. Acute hysterical psychosis ______
3. Obsessive-compulsive disorder ______
4. Anorexia nervosa ______
5. Kleptomania ______
6. Coding Challenge

SUBJECTIVE
This 16-year-old female is brought in by her mother because of a change in the daughter’s behavior. The mother notes hyperactivity, outbursts and over-involvement in activities. Patient notes she has been sleeping little and has been involved in sexual promiscuity. She denies medication, recreational or OTC drugs. Family history includes maternal bipolar disorder.

OBJECTIVE
A comprehensive physical exam does not indicate physical causes for these symptoms. Lab results indicate the thyroid is normal.

ASSESSMENT
Bipolar disorder.

PLAN
Recommend getting more sleep. Patient is prescribed lithium and encouraged to join a support group.

Review Practice Exercise 7

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.
Diseases of the Nervous System (G00-G99)

Chapter 6 of the ICD-10-CM manual’s Tabular List contains codes that pertain to the nervous system. The nervous system regulates almost every activity in the body. The central and peripheral nervous systems comprise the nervous system. The central nervous system is composed of the brain and spinal cord; the peripheral nervous system consists of the nerves and ganglia outside the brain and spinal cord.

The beginning of this chapter provides a list of conditions that may be coded in addition to codes found within the chapter. If supported by the documentation, it is acceptable to use both the code and the exclusion code together. These conditions include:

- certain conditions originating in the perinatal period (P04-P96)
- certain infectious and parasitic diseases (A00-B99)
- complications of pregnancy, childbirth and the puerperium (O00-O9A)
- congenital malformations, deformations, and chromosomal abnormalities (Q00-Q99)
- endocrine, nutritional and metabolic diseases (E00-E88)
- injury, poisoning and certain other consequences of external causes (S00-T88)
- neoplasms (C00-D49)
- symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94)

When coding from this chapter, you’ll want to read the notes within the Tabular List. There are many conditions that require you to use an additional code to further identify the organism. Some conditions in this section are manifestation codes that require you to code the underlying condition first. Be aware of these notes as you work through the following Practice Exercise.

Practice Exercise 8

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Staphylococcal meningitis ________ ________

2. Spasmodic torticollis ________

3. Spastic hemiplegia affecting the right dominant side ________

4. Intractable grand mal epilepsy ________

5. Bell’s palsy ________
6. Coding Challenge

SUBJECTIVE
A 30-year-old female is seen for an office consultation to confirm her physician’s diagnosis of multiple sclerosis. Patient notes that tingling sensations and weakness in her legs have increased.

OBJECTIVE
The patient history and recent MRI provided by her physician are reviewed by the neurologist. A comprehensive examination is performed.

ASSESSMENT
The neurologist confirms the diagnosis of multiple sclerosis.

PLAN
The patient is prescribed a 2-week course of prednisone to reduce her current symptoms. She was also given information on current injectable medications that could reduce the frequency of her exacerbations. A follow-up appointment is to be scheduled to discuss long-term treatment of her MS. A copy of the consultation notes will be sent to her primary care provider.

Review Practice Exercise 8
Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.

Diseases of the Eye and Adnexa (H00-H59)

While the ICD-9-CM combined the sense organs with the nervous system, the ICD-10-CM Tabular List has an entire chapter devoted just to the eye and adnexa. Chapter 7 consists of codes for disorders of all parts of the eye—from the eyelid to the optic nerve. You are directed to use an external cause code to identify the cause of the eye condition if applicable. In most cases, when coding conditions from this chapter you’ll select the final digit to identify the location of the disease or disorder.

Once again, at the beginning of this chapter you’ll find a list of conditions that may be coded in addition to codes in this chapter if documented. The conditions are:

certain conditions originating in the perinatal period (P04-P96)
certain infectious and parasitic diseases (A00-B99)
complications of pregnancy, childbirth and the puerperium (O00-O9A)
congenital malformations, deformations, and chromosomal abnormalities (Q00-Q99)
Preparing for the ICD-10-CM

diabetes mellitus related eye conditions (E09.3-, E10.3-, E11.3-, E13.3-)
endocrine, nutritional and metabolic diseases (E00-E88)
injury (trauma) of eye and orbit (S05.-)
injury, poisoning and certain other consequences of external causes (S00-T88)
neoplasms (C00-D49)
symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94)
syphilis related eye disorders (A50.01, A50.3-, A51.43, A52.71)

Complete the following Practice Exercise to enhance your understanding of disorders of the eye.

Practice Exercise 9

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Malignant myopia of the right eye _______

2. Macular degeneration, senile disciform _______

3. Pink eye _______

4. Orbital hemorrhage _______

5. Coding Challenge

PRESENTING PROBLEM
The patient notes flashes of light, followed by a sensation of curtain moving across the eye. Diagnosed with partial retinal detachment.

PROCEDURE
REPAIR OF RETINAL DETACHMENT, LEFT EYE.

The sclera is explored and stay sutures are placed under the rectus muscles to allow access to the surgical site. Cryotherapy (freezing retinal tissues to seal them) was used. Incisions are repaired by layered closures. A topical antibiotic is applied.

POSTOPERATIVE DIAGNOSIS
Partial retinal detachment, single defect.
Prepare for the ICD-10-CM

Review Practice Exercise 9

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.

Diseases of the Ear and Mastoid Process (H60-H95)

Again, you’ll find a separate chapter for the Diseases of the Ear and Mastoid Process in the ICD-10-CM, rather than combining it with the nervous system. Chapter 8 contains codes for diseases and disorders of the external, middle and inner ear; the mastoid process; vertiginous syndromes and other disorders of the vestibular system; otosclerosis; and hearing loss. If applicable, you are to use an additional external cause code to identify the cause of the ear condition.

The conditions that can be coded in addition to codes found in this chapter include:

- Certain conditions originating in the perinatal period (P04-P96)
- Certain infectious and parasitic diseases (A00-B99)
- Complications of pregnancy, childbirth and the puerperium (O00-O9A)
- Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
- Endocrine, nutritional and metabolic diseases (E00-E88)
- Injury, poisoning and certain other consequences of external causes (S00-T88)
- Neoplasms (C00-D49)
- Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94)

Similar to Chapter 7, you’ll need to determine if the condition affects the right or left side, or is documented as bilateral or unspecified, to determine the correct code. Keep this in mind as you code the conditions in the next Practice Exercise.
**Practice Exercise 10**

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Bullous myringitis _________
2. Meniere’s disease _________
3. Ear wax in both ears _________
4. Chondritis of the left external ear _________
5. Coding Challenge

**PRESENTING PROBLEM**
Protrusion of auricle. A 3-year-old patient has a history of otitis media that has not responded to multiple treatments of antibiotics. Review of recent CT reveals a fusion of mastoid air cells in the right ear.

**PROCEDURE PERFORMED**
COMPLETE MASTOIDECTOMY.

The mastoid cortex is removed. The fusion of mastoid air cells is exposed. The infected mastoid air cells are removed by a curette and drill. A temporary drain is placed, and the incision is sutured. The patient receives IV antibiotics. No complications are noted.

**POSTOPERATIVE DIAGNOSIS**
Acute mastoiditis.

_______

**Review Practice Exercise 10**

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.
Preparation for the ICD-10-CM

Diseases of the Circulatory System (I00-I99)

Chapter 9 of the Tabular List focuses on the circulatory system. This major body system includes the heart and blood vessels. As you probably know, many diseases of the heart are closely related. For example, one disease may be the cause of another, or the diseases may occur in conjunction with each other.

In the beginning of this chapter you will find a list of conditions that may be acceptable to code in addition to the codes within the chapter when documented. These conditions are:

- certain conditions originating in the perinatal period (P04-P96)
- certain infectious and parasitic diseases (A00-B99)
- complications of pregnancy, childbirth and the puerperium (O00-O9A)
- congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
- endocrine, nutritional and metabolic diseases (E00-E88)
- injury, poisoning and certain other consequences of external causes (S00-T88)
- neoplasms (C00-D49)
- symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94)
- systemic connective tissue disorders (M30-M36)
- transient cerebral ischemic attacks and related syndromes (G45.-)

When coding from this chapter, you’ll want to read the notes within the Tabular List. There are many conditions that require you to use an additional code to identify the type of heart failure, the stage of chronic kidney disease or the sequela. Some conditions in this section are manifestation codes that require you to code the underlying condition first. It’s important to read the notes as you work through the following Practice Exercise.


**Practice Exercise 11**

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Rheumatic chorea _________
2. Rheumatic endocarditis _________
3. Benign essential hypertension _________
4. Secondary hypertension due to Cushing’s disease _________
5. Acute anterolateral myocardial infarction with ST elevation, initial episode _________
6. Idiopathic pulmonary hypertension _________
7. Wenckebach’s phenomenon _________
8. Arteriolosclerosis of the extremities _________
9. Varicose veins of the left leg _________
10. Coding Challenge

PREOPERATIVE DIAGNOSIS
Sick sinus syndrome.

POSTOPERATIVE DIAGNOSIS
Sick sinus syndrome.

PROCEDURE PERFORMED
DUAL-CHAMBER PACEMAKER AND ATRIAL AND VENTRICULAR LEADS.

INDICATIONS
This patient has been experiencing increasing episodes of sick sinus syndrome which are not able to be controlled with medication. A dual-chamber pacemaker was recommended after discussion with the patient and his family. This gentleman and his family were informed of all potential complications, including infection, hematoma, pneumothorax, hemothorax, myocardial infarction and possibly death. The patient has agreed to the procedure and signed the consent.

PROCEDURE
The patient was admitted to the cardiac catheterization lab and placed on the table. He was prepped and draped in the usual manner. Adequate anesthesia was achieved and the procedure was started. The pacemaker pocket was created with hemostasis. The pocket was placed in the left infraclavicular area. A 9 French peel-away sheath was used to introduce an atrial and a ventricular lead into their correct position. The leads were sutured and secured. The pulse generator was then connected to the leads. The pocket was prepared for insertion of the generator. The pacemaker and leads were placed in the pocket, and the pocket was closed in 2 layers. The patient tolerated the procedure well and was discharged to the postanesthesia care unit.

Review Practice Exercise 11

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.
Diseases of the Respiratory System (J00-J99)

Chapter 10 of the Tabular List consists of codes for diseases of the respiratory system. Among the diseases in this chapter are respiratory infections, other diseases of the upper respiratory tract, pneumonia and influenza, COPD (chronic obstructive pulmonary disease) and allied conditions, pneumoconioses and lung diseases.

At the beginning of this chapter, you’ll find a general note to assist you with accurate coding. The ICD-10-CM indicates: When a respiratory condition is described as occurring in more than one site and is not specifically indexed, it should be classified to the lower anatomic site (e.g. tracheobronchitis to bronchitis in J40).

According to the Office of the Surgeon General, every year, more than 400,000 Americans die from smoking-related illnesses, which means it is still the leading preventable cause of death in the United States. Exposure or use of tobacco products often increases the chances of contracting a respiratory disease; therefore, the ICD-10-CM instructs you to use additional codes, if applicable, to identify exposure to environmental tobacco smoke, exposure to tobacco smoke in the perinatal period, history of tobacco use, occupational exposure to environmental tobacco smoke, tobacco dependence or tobacco use.

You may find conditions that occur at the same time but are not part of the codes within this chapter. It is acceptable to list both codes as long as documentation supports both conditions. These conditions include:

- certain conditions originating in the perinatal period (P04-P96)
- certain infectious and parasitic diseases (A00-B99)
- complications of pregnancy, childbirth and the puerperium (O00-O9A)
- congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
- endocrine, nutritional and metabolic diseases (E00-E88)
- injury, poisoning and certain other consequences of external causes (S00-T88)
- neoplasms (C00-D49)
- smoke inhalation (T59.81-)
- symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94)

Now that you have a good understanding of the notes found at the beginning of this chapter, try your hand at coding conditions found within the respiratory system.
Practice Exercise 12

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Acute pneumococcal bronchitis _______
2. Chronic maxillary sinusitis _______
3. Chronic asthmatic bronchitis _______
4. Acute respiratory distress syndrome _______
5. Coding Challenge

PREOPERATIVE DIAGNOSIS
Acute and chronic respiratory failure.

POSTOPERATIVE DIAGNOSIS
Same.

PROCEDURE PERFORMED
TRACHEOSTOMY.

PROCEDURE
Following informed consent of the patient’s family, the patient was brought to the operating room and placed supine on the table. After adequate induction of general anesthesia and application of appropriate monitoring devices, the patient was prepped and draped for the procedure. The neck was marked and injected with 5 mL of 1% Xylocaine and epinephrine. A scalpel was used to create a horizontal incision through the skin. Cautery was used to control bleeding and the muscles were split down to the level of the thyroid isthmus. Blunt dissection was used to dissect between the thyroid isthmus and it was divided. The cricoid cartilage was identified and the cricoid hook was placed. The inner space between the 2nd and 3rd thyroid cartilage was then incised and scissors were then used to enlarge the incision. A #8 Shiley tracheostomy tube was placed into the trachea. The cuff was then inflated, and the incision was sutured. The patient tolerated the procedure well and was transferred back to the ICU.

Review Practice Exercise 12

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.
Preparing for the ICD-10-CM

Diseases of the Digestive System (K00-K95)

The digestive system consists of the organs associated with the ingestion, digestion and absorption of food. You will progress through Chapter 11 of the Tabular List just as food moves through your body. You will begin at the oral cavity and then move down the esophagus and into the stomach and duodenum, which is the first portion of the small intestine. Then you study diseases of the appendix and hernias before you move on to the large intestine. You'll finish up the chapter with codes related to the peritoneum and retroperitoneum; liver; gallbladder; biliary tract; and pancreas.

Diseases of the digestive system are pretty straightforward to code. In addition to the standard codes to list separately, you'll need to read the notes within the chapter. You may need to identify circumstances that caused the disease or list an additional code to identify manifestations. As always, the notes found in the Tabular List are important to read to ensure you have an accurate and complete picture of the documentation.

Before getting to the Practice Exercise, review the conditions that may be coded in addition to codes in this chapter:

- certain conditions originating in the perinatal period (P04-P96)
- certain infectious and parasitic diseases (A00-B99)
- complications of pregnancy, childbirth and the puerperium (O00-O9A)
- congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
- endocrine, nutritional and metabolic diseases (E00-E88)
- injury, poisoning and certain other consequences of external causes (S00-T88)
- neoplasms (C00-D49)
- symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94)

**Practice Exercise 13**

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Ulcerative stomatitis ________
2. Acute prepyloric ulcer with hemorrhage ________
3. Chronic peptic duodenal ulcer, with hemorrhage ________
4. Appendicitis with peritonitis ________
5. Hiatal hernia with obstruction _______

6. Fecal impaction _______

7. Postgastrectomy dumping syndrome _______

8. Alcoholic cirrhosis of the liver _______

9. Coding Challenge

PREOPERATIVE DIAGNOSIS
Epigastric abdominal pain.

POSTOPERATIVE DIAGNOSIS
Gastritis, gastric ulceration and duodenal ulceration.

PROCEDURE PERFORMED
ESOPHAGOGASTRODUODENOSCOPY WITH BIOPSY.

DESCRIPTION OF PROCEDURE
Following consent, the patient was brought to the endoscopy suite and placed in the sitting position, where he received Hurricaine spray to his oropharynx. The patient was placed in the left lateral decubitus position, where a bite-block was placed between his incisors. The Olympus video gastroscope was placed and advanced under visualization down through the oropharynx, the proximal then distal esophagus, through the gastrooesophageal junction, and into the gastric body and duodenum via the pylorus. The endoscope was withdrawn back into the gastric antrum, and the antral mucosa was biopsied. The endoscope was withdrawn back into the gastric body, retroflexed with visualization of the gastric fundus. The endoscope was then straightened and withdrawn completely under suction. The patient tolerated this procedure very well.

________
________
________

Review Practice Exercise 13

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.
Diseases of the Skin and Subcutaneous Tissue (L00-L99)

Chapter 12 of the ICD-10-CM manual’s Tabular List contains codes for the skin, which is the largest organ in the body. The skin is the covering that protects all other organs by acting as a barrier against infection and disease. The cells of the skin constantly change and adapt to outside influences. Because the skin is constantly exposed, it is a prime target for infection, inflammation and other diseases.

As with previous chapters, you will find a list of conditions to code in addition to diseases of the skin and subcutaneous tissue. These conditions are:

- certain conditions originating in the perinatal period (P04-P96)
- certain infectious and parasitic diseases (A00-B99)
- complications of pregnancy, childbirth and the puerperium (O00-O9A)
- congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
- endocrine, nutritional and metabolic diseases (E00-E88)
- lipomelanotic reticulosis (I89.8)
- neoplasms (C00-D49)
- symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94)
- systemic connective tissue disorders (M30-M36)
- viral warts (B07.-)

Some skin conditions may be the result of another disease or a drug reaction. You are directed to code first to identify the drug or underlying disease. Now that you are aware of the notes found within this chapter, you’re ready to code.

Practice Exercise 14

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Severe sunburn of face and neck _________
2. Eczema due to cat hair _________
3. Lupus erythematosus _________
4. Perianal itch _________
5. Male-pattern baldness _________
6. Patient is hemiplegic due to cerebrovascular disease presenting with stage 2 pressure ulcer located on right buttocks, resulting from contact with wheelchair.

7. Coding Challenge

SUBJECTIVE
Patient developed “infection in my cuticle.” The patient gets regular acrylic manicures. Washes hands 1 or 2 times a day. Otherwise, no excessive exposure to water or detergents.

OBJECTIVE
Vital signs are normal. There is redness and swelling of the perionychium at the base of the right index finger. The nail is raised and there is suppuration present.

ASSESSMENT
Paronychia.

PLAN
Incision and drainage. Culture and sensitivity. Cephradine 500 mg p.o. t.i.d. for 10 days. Return in 3 days for observation and results of culture.

Review Practice Exercise 14

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.

Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)

Chapter 13 of the Tabular List contains codes for diseases, disorders and pains of the joints, bones and cartilage located in the musculoskeletal system, as well as acquired musculoskeletal deformities. The musculoskeletal system is composed of the skeletal system and the muscular system because they work closely together. The skeletal system is the “backbone” of the body, while the muscular system consists of tissues that produce movement anywhere in the body by contracting and relaxing. Connective tissues bind together and support various structures of the body.

When you look at the beginning of this chapter, you will find a note to assist you in accurate and complete coding. The ICD-10-CM notes: Use an external cause code following the code for the musculoskeletal condition, if applicable, to identify the cause of the musculoskeletal condition.
Next, you are provided a list of conditions to code in addition to diseases of the musculoskeletal system and connective tissues. These conditions are:

- arthropathic psoriasis (L40.5-)
- certain conditions originating in the perinatal period (P04-P96)
- certain infectious and parasitic diseases (A00-B99)
- compartment syndrome (traumatic) (T79.A-)
- complications of pregnancy, childbirth and the puerperium (O00-O9A)
- congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
- endocrine, nutritional and metabolic diseases (E00-E88)
- injury, poisoning and certain other consequences of external causes (S00-T88)
- neoplasms (C00-D49)
- symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94)

Codes found in Chapter 13 identify laterality. This means you will code to the right or left side if known. If the documentation does not indicate the side, simply code to unspecified. Let’s pause here to practice with the diagnostic statements and coding challenge in the Practice Exercise that follows.

**Practice Exercise 15**

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Arthralgia of the left shoulder ________
2. Herniation of C4 through C5 ________
3. Calcification of the lumbar disc ________
4. Lower back pain ________
5. Bursitis of the right hip ________
6. Acquired trigger finger ________
7. Infective myositis of the left foot ________
8. Idiopathic osteoporosis of the left radius ________
9. Coding Challenge

SUBJECTIVE
Patient states, “My hands hurt.” She rated the pain as 7 on a scale of 1 to 10, with 10 being the most severe pain.

OBJECTIVE
Observed swelling and inflammation in fingers and joints of both hands and wrists. Range of motion and strength decreased substantially. Paraffin bath given bilaterally for hands and wrists, with some improvement noted. Therapeutic activities performed for 15 minutes to improve ADLs. A 4 × 4 inch piece of dicem was given to patient to assist with opening jar lids and a rocker knife was given to assist patient with cutting when preparing meals. She was instructed in the use of both items.

ASSESSMENT
Rheumatoid arthritis in hands and wrists bilaterally.

PLAN
Patient to return in 1 week for occupational therapy to reevaluate treatment plan and progress.

Review Practice Exercise 15

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.
Diseases of the Genitourinary System (N00-N99)

Diseases of the genitourinary system are found in Chapter 14 of the Tabular List. The term genitourinary pertains to the genital and urinary organs. The genital and urinary systems are usually considered together because anomalies of the genital and urinary tracts are often interrelated. The urinary system includes the kidneys, ureters, bladder and urethra; the genital system includes the male and female genital organs and the breasts.

The Excludes2 at the beginning of this chapter indicates that it may be acceptable to use both the code and the excluded code together if supported by the documentation. These conditions are:

- certain conditions originating in the perinatal period (P04-P96)
- certain infectious and parasitic diseases (A00-B99)
- complications of pregnancy, childbirth and the puerperium (O00-O9A)
- congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
- endocrine, nutritional and metabolic diseases (E00-E88)
- injury, poisoning and certain other consequences of external causes (S00-T88)
- neoplasms (C00-D49)
- symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94)

Diseases of the genitourinary system may be caused by an infectious agent. If documented, you should use an additional code to identify the infectious agent. For accurate coding, be sure to code underlying diseases and associated conditions when appropriate as well. With this in mind, you're ready to complete the Practice Exercise for this chapter.

Practice Exercise 16

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Carbuncle of the kidney _______
2. Acute cystitis _______
3. Enlarged prostate _______

41
4. Testicular abscess _______

5. Periodic fibroadenosis of the breast _______

6. Paravaginal prolapse _______

7. Primary amenorrhea _______

8. Coding Challenge

SUBJECTIVE
A 47-year-old male complains of dysuria and prostate nodule. Suspect UTI, rule out pyelonephritis and prostatic carcinoma.

OBJECTIVE
Urinalysis: specific gravity 1.030, pH 7.4, negative for protein, glucose and ketones. Microscopic: No RBCs, WBCs or casts seen. Urine culture results from outside lab positive for Enterobacter, resistant to ampicillin and cephalothin.

ASSESSMENT
Urinary tract infection secondary to Enterobacter sakazakii. No evidence of pyelonephritis or prostatic carcinoma from serologic or urine testing.

PLAN
Oral antibiotics. Patient to return in 1 week.

________

Review Practice Exercise 16

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.
Pregnancy, Childbirth and the Puerperium (O00-O9A)

The first note in the Tabular List for this chapter is important: CODES FROM THIS CHAPTER ARE FOR USE ONLY ON MATERNAL RECORDS, NEVER ON NEWBORN RECORDS. The ICD-10-CM capitalizes this note because it is often forgotten and leads to inaccurate coding. Conditions within this chapter range from pregnancy with abortive outcomes to complications of labor and delivery. As noted in the ICD-10-CM, codes from this chapter are for use for conditions related to or aggravated (to make worse or more troublesome) by the pregnancy, childbirth or by the puerperium (maternal causes or obstetric causes).

A pregnancy may be charted by either the number of weeks or by the trimester. The 40 weeks of pregnancy are divided into trimesters, each three months long. You’ll find a note in the beginning of this chapter to assist you in converting weeks to trimesters and trimesters into weeks. You are also directed to use an additional code to identify the specific week of the pregnancy.

Excludes1 means not coded here. The conditions are mutually exclusive codes and cannot be reported together. Supervision of normal pregnancy (Z34.-) should not be coded with any code from this chapter.

Excludes2 indicates that it may be acceptable to use both the code and the excluded code together if supported by the documentation. You may code the following conditions in addition to a code in Chapter 15 as long as it’s documented:

- mental and behavioral disorders associated with the puerperium (F53)
- obstetrical tetanus (A34)
- postpartum necrosis of pituitary gland (E23.0)
- puerperal osteomalacia (M83.0)

In this chapter of the ICD-10-CM, you will find that certain codes require a 7th character for an accurate code. The 7th character is 0 for a single gestation or if the multiple gestation is unspecified. The 7th characters 1 through 9 are for cases of multiple gestations to identify the fetus for which the code applies.

Finally, a code from category Z37, Outcome of delivery, should be included on every maternal record when a delivery has occurred. These codes are not to be used on subsequent records or on the newborn record.

Whew! There are quite a few notes, inclusions and exclusions in this chapter to assist you with accurate coding. Be sure to read carefully when coding the diagnostic statements and coding challenge in the following Practice Exercise.
Practice Exercise 17

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Ovarian pregnancy ________
2. Complete miscarriage at 12 weeks ________
   ________
3. Partial placenta previa with hemorrhage, at 18 weeks’ gestation ________
   ________
4. Hyperemesis gravidarum at 20 weeks’ gestation ________
   ________
   ________
   ________
   ________
   ________
   ________
   ________
8. Postpartum pulmonary embolism ________
9. Maternal cracked nipple two weeks after delivery ________
10. Coding Challenge

ADMITTING DIAGNOSIS
Intrauterine gestation, at term, in active labor.

HISTORY OF PRESENT ILLNESS
The patient is a 21-year-old gravida 1, para 0, who presented in active labor without prior prenatal care.

LABORATORY FINDINGS
Urine culture positive for Escherichia coli. Lochia culture negative for aerobic and anaerobic cultures.

HOSPITAL COURSE
A midline episiotomy was performed for the delivery after using local anesthesia. Spontaneous vaginal delivery produced a viable male infant weighing 3,450 gm with Apgar scores of 7 at five minutes and 9 at ten minutes. Twenty units of Pitocin were administered postpartum to control postpartum bleeding or hemorrhaging. Four plus meconium was present. The pediatrician attended to the neonate postpartum. Following normal vaginal delivery of a viable infant, the placenta was delivered intact. Three cord vessels were identified. Cord blood samples were sent to pathology.

ASSESSMENT
Normal spontaneous vaginal delivery with midline episiotomy.

_______
_______

Review Practice Exercise 17

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.
Now that you have a good understanding on coding the mother’s record, let’s turn to the newborn. Similar to Chapter 15, you’ll find an important note first thing in this chapter: *Codes from this chapter are for use on newborn records only, never on maternal records*. This reminder is critical for accurate coding.

The *ICD-10-CM* notes that Chapter 16 includes *conditions that have their origin in the fetal or perinatal period*, which consists of any time before birth through the first 28 days after birth, even if morbidity occurs later. For instance, a toddler recently diagnosed with fetal alcohol syndrome would be coded from this chapter as the condition originated during the fetal period, regardless of when the condition was discovered.

The Excludes2 at the beginning of this chapter indicates that it may be acceptable to use both the code and the excluded code together if supported by the documentation. These conditions are:

- *congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)*
- *endocrine, nutritional and metabolic diseases (E00-E88)*
- *injury, poisoning and certain other consequences of external causes (S00-T88)*
- *neoplasms (C00-D49)*
- *tetanus neonatorum (A33)*

When coding the birth in a newborn record, you will assign the principal diagnosis from category *Z38* according to the place of birth and type of delivery.

This concludes the basic information you need to know to code from this chapter of the *ICD-10-CM*. Take a few minutes to complete the Practice Exercise to reinforce what you have learned.
Practice Exercise 18

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Premature infant was delivered by cesarean at 35 weeks’ gestation due to fetal distress during the labor. Code the baby’s records.
   _______
   _______

2. Vaginal delivery of a term newborn in a hospital noted to be large for gestational age at 4000 gm. Code the baby’s records.
   _______
   _______

3. Post-term vaginal delivery of liveborn infant in a hospital. Code the baby’s records.
   _______
   _______

4. Term vaginal delivery of newborn in a hospital, small for gestational date. Code the baby’s records.
   _______
   _______

5. Newborn twins delivered in a hospital, premature at 32 weeks’ gestation, via c-section. Code the babies’ records.
   _______
   _______

Review Practice Exercise 18

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.
Chapter 17 of the *Tabular List* includes a variety of congenital malformations, deformations and chromosomal abnormalities. As you read through the documentation, you should be able to determine whether the condition is *congenital* or acquired. **Congenital** anomalies are those conditions that exist at birth, such as abnormal mental or physical traits and other anomalies, malformations or diseases. Such anomalies may be either hereditary or the result of an influence that occurs during gestation, up to the moment of birth.

The first note in this chapter is an important one: *Codes from this chapter are not for use on maternal or fetal records.*

The Excludes1 note indicates that *inborn errors of metabolism (E70-E88)* should not be coded with conditions in this chapter. Also note, a congenital form of a disease may not be reported with the acquired form of the same condition.

Amazingly, this chapter does not have an Excludes2 list for you, so you’re ready for the following Practice Exercise.

**Practice Exercise 19**

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Spina bifida of L3 through L4 _______
2. Simple hypoplasia of the right eye _______
3. Infant born with absence of external auditory canal _______
4. Roger’s disease _______
5. Fallot’s triad _______
6. Single umbilical artery of a newborn _______
7. Congenital honeycomb lung _______
8. Unilateral cleft lip, incomplete _______
9. Didelphic uterus _______
10. Coding Challenge

CONSULTATION REFERRAL
Noted to have left low-set ear, left string-like thumb attached to metacarpal and left clubfoot following breech cesarean section.

HISTORY OF PRESENT ILLNESS
The patient is a 1-day-old male infant born to a gravida 1 mother by a crash cesarean section for double footling breech with multiple congenital anomalies.

PHYSICAL EXAMINATION
GENERAL: Weight: 2500 gm. Length: 45 cm. Head circumference: 34.5 cm.
NECK: Very short and posterior, hairline appears low.
ABDOMEN: No organomegaly. Liver on the right. Umbilical cord stump dry.
GENITALIA: Normal male with descended testes.
RECTAL: Patent.
EXTREMITIES: Left hand with hypoplastic thumb which is attached by a piece of skin. Left forearm has mesomelia but not camptomelia. Right hand with proximally placed thumb.
NEUROLOGIC: Good cry and muscle tone.

DATABASE
X-rays reveal multiple cervical spine anomalies characterized by hypoplasia including hemiatrophy of T1, butterfly pattern of T3 and left rib anomalies. Chest film also shows evidence of congenital heart disease, patent ductus arteriosus and possible ventricular septal defect. Chest x-ray and abdominal films show no evidence of situs inversus. Stomach bubble on the left and heart on the left, liver on the right.

ASSESSMENT
Multiple congenital anomalies. Congenital anomalies found in this infant so far are:
1. Dysplasia of the left auricle.
2. Multiple vertebral anomalies in the cervical and upper thoracic spine.
3. Left thumb hypoplasia.

Ear anomalies and cervical spine anomalies are seen in Goldenhar’s syndrome (oculoauriculovertebral dysplasia). Vertebral anomalies and congenital heart disease are seen in VATER association. Both conditions are thought to occur as sporadic events during embryonic and fetal development. There is increased risk for other abnormalities such as renal and gastrointestinal malformations. Mental retardation is not a constant feature but is increased in Goldenhar’s, especially in those with a cerebral hemisphere involvement.
RECOMMENDATIONS
WCC. Intracranial sonography to rule out CNS malformation. Renal sonography, UGI and barium enema for evaluation of the urogenital and gastrointestinal tracts.

Review Practice Exercise 19
Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.
Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99)

When no other diagnosis code quite fits the condition identified in the documentation, you’ll code from this chapter of the Tabular List. This includes less well-defined conditions and symptoms that require further tests to establish a final diagnosis. The notes at the beginning of the chapter are quite extensive and require careful reading to understand the concepts presented.

The ICD-10-CM indicates that the conditions and signs or symptoms included in categories R00-R94 consist of:

(a) cases for which no more specific diagnosis can be made even after all the facts bearing on the case have been investigated;
(b) signs or symptoms existing at the time of initial encounter that proved to be transient and whose causes could not be determined;
(c) provisional diagnosis in a patient who failed to return for further investigation or care;
(d) cases referred elsewhere for investigation or treatment before the diagnosis was made;
(e) cases in which a more precise diagnosis was not available for any other reason;
(f) certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right.

Before you try coding diagnostic statements and the coding challenge in the Practice Exercise, review the conditions that may be coded in addition to codes within this chapter, if documented as such.

abnormal findings on antenatal screening of mother (O28.-)
certain conditions originating in the perinatal period (P04-P96)
signs and symptoms classified in the body system chapters
signs and symptoms of breast (N63, N64.5)
Practice Exercise 20

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Persistent vegetative state _______
2. Lethargy _______
3. Tendency to fall _______
4. Numbness in hands _______
5. Chest discomfort _______
6. Elevated blood pressure reading _______
7. Abnormal liver function study _______
8. Coding Challenge

SUBJECTIVE
Patient complains of pleuritic left chest pain and a low-grade fever.

OBJECTIVE
Temperature: 101°F. There are rales and decreased breath sounds in both bases with auscultation predominately in the left base. Percussion of the left lateral aspect of the thorax demonstrates an area of consolidation at the midaxillary line which extends from the precordium. There is a pleural rub in the same area.

ASSESSMENT
Suspected postoperative basilar atelectasis; associated aspiration pneumonia cannot be excluded at the present time. Due to this being the 2nd postoperative day, pulmonary emboli cannot be ruled out.

PLAN
Chest film to look for consolidative collapse of the lingula and lower lobes. Encourage deep breathing and frequent use of incentive spirometer. Arterial blood gasses. Consultation with pulmonary medicine.

_______
_______
Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.

**Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88), Part 1**

Chapter 19 of the *ICD-10-CM* manual is one of the largest chapters of codes, and it contains a wide variety of conditions. The S-section codes for different types of injuries related to single body regions, while the T-section covers injuries to unspecified body regions as well as poisoning and certain other consequences of external causes. So that you aren’t overwhelmed with the information, we will cover the S-section and T-section separately.

The note at the beginning of this chapter directs you to use secondary code(s) from Chapter 20, *External causes of morbidity*, to indicate cause of injury. Codes within the T-section that include the external cause do not require an additional external cause code. At this point, you have not been exposed to Chapter 20 and are not expected to include these codes on the S-section. We will revisit injury codes in conjunction with external causes when discussing Chapter 20.

You are instructed to use an additional code to identify any retained foreign body, if applicable (Z18.-)

The Excludes1 in the beginning of this chapter reminds you that you cannot code birth trauma (P10-P15) and obstetric trauma (O70-O71) in addition to conditions from this chapter.

**The S-section**

The S-section of the chapter is used for coding different types of injuries related to single body regions. For example, the block (the first three characters of the code) may be further divided into the following types of injury:

- Superficial injury
- Open wound
- Fracture
- Dislocation
- Injury of nerves
- Injury of blood vessels
- Injury of muscle, fascia and tendon
- Crushing injury
- Traumatic amputation
- Other and unspecified injuries

Certain categories in Chapter 19 have a seventh-character extension, which you are required to add to each code when using it. The extension identifies the services as an initial or subsequent encounter, or a sequela. You will find notes similar to the following in the category:
Preparing for the ICD-10-CM

The appropriate 7th character is to be added to each code from category S00

A initial encounter
D subsequent encounter
S sequela

You’ll recall, an initial encounter is the first visit for the current condition; a subsequent encounter is any visit after the first visit for the current condition; and sequela is used for complications or conditions that arise as a direct result of a condition.

Finally, before you complete the next Practice Exercise, review the use of the dummy place-holder. Remember that the letter “X” is used as a dummy place-holder in the ICD-10-CM. According to the ICD-10-CM Conventions, a dummy “X” is used as a fifth- or sixth-character place-holder at certain six- and seven-character codes to allow for future expansion without disturbing the sixth- or seventh-digit structure.

**Practice Exercise 21**

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. **Blow-out fracture of the orbital floor, initial encounter** _______

2. **Initial encounter for closed neck fracture of the C1-C4**
   _______
   _______
   _______
   _______
   _______

3. **Displaced fracture of left humerus at the lateral condyle, initial encounter** _______

4. **Subsequent encounter for subluxation of lumbar vertebra at L1 through L2** _______

5. **Traumatic rupture of the interphalangeal joint of the toe, initial encounter** _______
6. Coding Challenge

HISTORY

CHIEF COMPLAINT
The patient is admitted to the emergency department after a motorcycle accident (MCA), complaining of right wrist and extreme bilateral leg pain, especially in the right leg.

HISTORY OF PRESENT ILLNESS
The patient was involved in an MCA, wearing a helmet. There is no nausea, vomiting or change in vision. There was a ten-minute loss of consciousness. There is no complaint of neck, chest, LUE or back pain.

PAST HISTORY
No smoking, drinking or IV drug use. Right inguinal bullet removed in 1987.
ALLERGIES: NONE.

REVIEW OF SYSTEMS
No skull or facial tenderness. ROS otherwise noncontributory.

PHYSICAL EXAMINATION
Temperature: Afebrile.
HEENT: PERRLA. EOMs intact.
CHEST: No clavicular, sternal or rib tenderness. Heart: Regular rhythm and rate.
Lungs: Clear to P&A.
EXTREMITIES: RUE: 2+ swelling at wrist. Skin intact. Radial pulse is 2+. Positive tenderness at the base of the small metacarpal and snuffbox. Apposition is 2/5.
RLE: Dorsalis pedis and posterior tibial pulses are 2+ and equal bilaterally. Left leg reveals decreased strength with passive resistance. There is 2-3+ laxity of the LCL with varus stress and 2+ laxity of the ACL at 30 degrees of flexion and extension. There is no medial laxity. Right leg exam restricted due to severe pain.

DATABASE
X-ray confirms Barton’s fracture and anterior dislocation of tibia, proximal end.

IMPRESSION
1. Barton’s fracture, right wrist.
2. Anterior dislocation of right tibia, proximal end.

PLAN
Admit for open reduction and internal fixation, right knee, right wrist. Knee immobilizer.

_________
Review Practice Exercise 21

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.

Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88), Part 2

Now that you’ve completed coding from the S-section of this chapter, let’s move to the T-section.

The T-section

The T-section contains codes related to foreign body, burns, frostbite and poisonings. You’ll recall that a foreign body is anything in the body that has been introduced through its openings, such as when a person swallows an object not ordinarily eaten or swallowed. When coding a foreign body, you’ll want to be careful in selecting the accurate code to identify the site, as well as the episode of care, correctly.

Coding for burns in the *ICD-10-CM* is very similar to the *ICD-9-CM* in many ways. When burns are documented at more than one site, you first sequence the code for the site of the highest-degree, sequencing the additional codes for the other sites in descending order of degree. You’ll use an additional code from *T31* or *T32* to identify the extent of the body surface area involved. Unlike the *ICD-9-CM*, the *ICD-10-CM* does not refer to the “rules of nines” in estimating the body surface involved; therefore, the percent of the body surface and percent of this involving third degree burns must be documented for accurate coding. Estimating should not be an option.

According to the *ICD-10-CM*, poisoning is defined as an overdose of a substance, the wrong substance is given or the wrong substance is taken in error. An adverse effect, on the other hand, is when a drug is correctly prescribed and properly administered, but the patient suffers a bad reaction as a result. When coding poisoning and adverse effects, you use an additional code to identify all manifestations documented. When a patient either inadvertently or deliberately takes less of a medication than is prescribed or instructed by the manufacturer, it is termed underdosing. You will use an additional code to identify the intent of underdosing. Unlike the *ICD-9-CM*, the *ICD-10-CM* has an all inclusive code to relay the drug and intent, rather than coding an external cause in addition to the poisoning code. You just need to remember to add the final digit to identify the type of encounter as initial, subsequent or sequela.

Let’s pause here to practice coding from the T-section.
Practice Exercise 22

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. Initial encounter of a child for poisoning due to accidental ingestion of an antihistamine drug resulting in respiratory distress.
   __________
   __________

2. 1st- and 2nd-degree burns of the right thigh, 2nd-degree burns of the lower back, 13% of the body surface involved, initial encounter.
   __________
   __________
   __________

3. Patient seen in the ED for an accidental barbiturate overdose.
   __________

4. Patient brought to the ED by ambulance after swallowing nail polish remover as a suicide attempt.
   __________
5. Coding Challenge

CONSULTATION REPORT

REASON FOR REFERRAL
Evaluation of cellulitis secondary to burn injury.

HISTORY OF PRESENT ILLNESS
This 30-year-old male was in the shower and he burned the posteromedial upper arm with hot water. In spite of local treatment initiated after an ED visit, he developed increasing cellulitis.

PAST HISTORY
No medications. Denies history of diabetes. NO KNOWN ALLERGIES.

REVIEW OF SYSTEMS
Noncontributory.

PHYSICAL EXAMINATION
General: The patient is afebrile. The right upper arm above the elbow is swollen, erythematous and warm. There is a 2nd- and 3rd-degree burn measuring 20 cm × 7 cm on the posteromedial upper arm. One-third of the area had ruptured bullae, and the remainder is covered by a black eschar.

DATABASE
White blood cell count 20,200.

ASSESSMENT
There is a 2nd- and 3rd-degree burn, right upper arm, with cellulitis.

Review Practice Exercise 22

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.
External Causes of Morbidity (V00-Y99)

External causes of morbidity identify environmental events, circumstances and conditions that relate to the cause of injury, poisoning and other adverse effects. These codes are supplemental to the diagnostic code and are never to be used as principal diagnosis codes. They are intended to provide data for research and analysis for injury prevention. The rules that follow apply to external causes in all circumstances.

You may code the external cause with any diagnosis code found in the ICD-10-CM. Use the external cause to indicate how and where the accident occurred, if known. You are to assign as many external cause codes as necessary to fully describe each cause of injury.

Practice Exercise 23

Determine the correct ICD-10-CM code(s), including the external causes of morbidity, for the following diagnostic statements and coding challenge.

1. Patient is seen by his family doctor after he fell from a skateboard while at the park, resulting in a sprained left wrist.

   ______
   ______
   ______

2. Passenger suffers 3rd-degree burns to front and back of both legs, involving 33% TBSA, due to sailboat explosion on a lake and is seen in the ED for treatment.

   ______
   ______
   ______
   ______
   ______
   ______

3. Patient is seen for a follow up visit to assess contusions of abdomen as a result of being a passenger of the second car in a two-car collision.

   ______
   ______
4. Fractured lower end of the radius on the right side due to falling down the stairs at the museum, seen in the ED.

5. Coding Challenge

SUBJECTIVE
A 10-year-old boy is seen in the physician’s office with a right-ankle injury. He was injured 24 hours ago when he fell down steps at the mall.

OBJECTIVE
Ankle appears erythematous and swollen. It is tender to the touch. Patient walks with a hint of a limp. X-ray rules out fracture.

ASSESSMENT
Patient has an ankle sprain.

PLAN
Recommend ibuprofen as needed for pain.

Review Practice Exercise 23

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.
Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

Whew! You made it to the last chapter of the ICD-10-CM Tabular List. Z codes represent reasons for encounters. When circumstances other than a disease, injury or external cause are documented, you will use a code from category Z00-Z99. According to the ICD-10-CM, this occasion may arise in two main ways. First, when a person who may or may not be sick encounters the health service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination or to discuss a problem which is in itself not a disease or injury. Second, when some circumstance or problem is present that influences the person’s health status but is not in itself a current illness or injury.

Let’s wrap up this final chapter of the ICD-10-CM Tabular List with the following Practice Exercise.

Practice Exercise 24

Determine the correct ICD-10-CM code(s) for the following diagnostic statements and coding challenge.

1. 68-year-old female is seen at the clinic for a flu (influenza) vaccination. ________

2. Metastatic carcinoma to the brain, with a personal history of breast cancer. ________
   ________

3. Patient complains of chest pain and her status is “post coronary artery angioplasty.” ________
   ________

4. An eight-month-old female is seen by her pediatrician for a well-child exam and receives a DTaP vaccination. ________
   ________
5. Coding Challenge

SUBJECTIVE
This pleasant 54-year-old female, with a history of left mastectomy due to estrogen-sensitive breast cancer, was sent by her oncologist to have a fractional curettage. The patient states she has been on 20 mg Tamoxifen once daily for the past 2 years. Her oncologist informed her that one of the side effects of Tamoxifen is endometrial carcinoma and encouraged her to have this test done by her gynecologist.

OBJECTIVE

ASSESSMENT
Histological confirmation was negative for carcinoma.

PLAN
Continue Tamoxifen as ordered. Return if any abnormal cramping or bleeding occurs.

Review Practice Exercise 24
Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.

Sequencing ICD-10-CM
The principal diagnosis reflects the current and most significant reason the patient is seeking treatment when you code a physician’s diagnosis of a patient. The ability to sequence the ICD-10-CM codes in the correct order is a learning process. A principal diagnosis is the condition that is responsible for the current episode of care.

Multiple Coding
You’ll recall that multiple coding means that two or more codes are necessary to fully describe the patient’s condition. The Tabular List provides instructions for multiple coding. “Use additional code” and “code first” are found in the Tabular List to indicate another code is necessary and the sequence in which the codes are to be written. Multiple codes may be needed to more fully describe a condition and may be found in late effect, complication codes and obstetric codes.
**Acute and Chronic Conditions**

If a condition is described as both acute and chronic and separate codes are found in the *Index*, you will code both, sequencing the acute code first.

**Combination Codes**

When a single code describes conditions that frequently occur together, it is a combination code. Coexisting diagnosis codes should be related to the current episode of care. If the coexisting conditions have no bearing on the care of the principal diagnosis, they should not be coded. For example, a blind woman is diagnosed with a URI. Being blind has no impact on how the URI will be treated and is not coded as a coexisting condition.

The guidelines at the front of the *ICD-10-CM* provide a wealth of information and should be used as a reference when coding the diagnosis. Now that you’ve covered the entire *ICD-10-CM*, as well as the sequencing guidelines, you’re ready to wrap up with this final practice exercise.

**Practice Exercise 25**

Determine the correct ICD-10-CM code(s) for the following coding scenarios.

**Scenario 1**

**SUBJECTIVE**
Patient underwent exploratory laparotomy 3 days previously for bowel obstruction. There were 2 days of fever postoperatively. Today is the 3rd postoperative day but is the initial encounter for the complaint.

**OBJECTIVE**
There is redness and swelling of the wound with pus emanating from around the suture material.

**ASSESSMENT**
Postoperative wound infection. Wound culture confirms E.coli.

**PLAN**
Obtain culture of wound for E.coli. Open wound, debride with acetic acid and pack with W-70 dressings. Prescription for cephadine 500 mg 1 p.o. q.6 h.

**ICD-10-CM:** _______

**ICD-10-CM:** _______
Scenario 2

SUBJECTIVE
This is a 56-year-old female with a history of type 2 diabetes for the past 4 years and has been using insulin long-term. She has noticed decreased vision in both eyes for the past 1 year. She was seen in the eye clinic 2 weeks ago where fluorescein angiography revealed vitreous hemorrhages. The patient was scheduled for vitrectomy to extract the contents of the vitreous chamber.

OBJECTIVE
Ophthalmoscopy reveals proliferative retinopathy resulting in blood staining the vitreous humor. Tonometer reveals tension in both eyes is 14.

ASSESSMENT
Diabetic retinopathy.

PLAN
Vitrectomy. Maintain control of diabetes and blood pressure.

ICD-10-CM: _________
ICD-10-CM: _________

Scenario 3

TWO-VIEW CHEST X-RAY
No old films are available for comparison. Consolidation is present in the lower lobes bilaterally. A right-sided chest tube is present. There is a small amount of subcutaneous emphysema against the right chest wall. The most proximal portion of the chest tube lies within the margins of the rib cage.

IMPRESSION
1. Bilateral lower lobe pneumonia
2. Right-sided chest tube. No significant pneumothorax is evident.

ICD-10-CM: _________
Scenario 4

LUMBAR SPINE MRI WITHOUT CONTRAST

HISTORY
Low back pain.

TECHNIQUE
Sagittal and axial proton density and T2-weighted sequences were obtained through the lumbar spine.

COMPARISON
4/30/20XX plain film lumbar spine.

FINDINGS
Examination demonstrates normal alignment of the lumbar spine. The conus medullaris is located posterior to the L1 vertebral body. There is no evidence of abnormal signal within the lumbar vertebral bodies.
Disc spaces:
L1 through L2: Unremarkable.
L2 through L3: Unremarkable.
L3 through L4: At this level, there is mild disc desiccation. There is a small left lateral disc protrusion. There is mild left neural foraminal stenosis. There is no significant right neural foraminal stenosis. There is no significant spinal stenosis.
L4 through L5: At this level, there is minimal diffuse disc protrusion. This does not cause significant neural foraminal stenosis or spinal stenosis.
L5 through S1: At this level, there is a small central disc protrusion. This does not cause significant neural foraminal stenosis or spinal stenosis.

IMPRESSION
Very mild lumbar spondylopathy. At the level of L3 through L4, there is a left lateral disc protrusion.

ICD-10-CM: ________
Scenario 5

ORTHOPEDIC CONSULTATION REPORT

REASON FOR REFERRAL
Continuous pain, right ankle and foot.

HISTORY OF PRESENT ILLNESS
This patient has severe arthritic destructive disease in the right subtalar joint. She cannot walk because of continuous pain in the ankle and foot. Any inversion or eversion causes immediate severe discomfort. The patient has had long-standing, severe osteoporosis and rheumatoid arthritis. In addition, she has been on long-term steroid therapy. The patient has spontaneously fractured ribs with delayed healing.

PAST HISTORY
Long-term corticosteroid therapy for rheumatoid arthritis.
Medications: Currently, prednisone 40 mg daily p.o.
Illnesses: Rheumatoid arthritis, osteoporosis.
ALLERGIES: NO ALLERGIES TO FOOD OR MEDICATION.
Social History: The patient was employed as a plumber until the age of 50 when progressive arthritis limited her ability to continue working.
Family History: There is no family history of cancer, diabetes. A paternal uncle and a sister have RA.

REVIEW OF SYSTEMS
Cardiorespiratory: Pleuritic pain and dyspnea and focal pain over the left 4th, 5th and 6th ribs began 1 week ago spontaneously. No history of trauma.

PHYSICAL EXAMINATION
GENERAL: This is a 65-year-old, 180 pound white female in moderate distress. Pulse: 100 and regular. Blood pressure: 140/110. Respiratory rate: 20, guarded. Temperature: 99.6 °F.
CHEST: There is pinpoint tenderness over the left fourth, fifth and sixth ribs in the left midaxillary line. Heart: PMI left midclavicular line. Regular rate and rhythm without murmurs. Lungs: Clear.
NEUROLOGIC: There is a decrease in sensation in the right ankle and foot. Cranial nerves II-XII are intact.

DATABASE
A bone survey shows diffuse, widespread changes of rheumatoid arthritis with destruction of taloscaphoid axis and pronation of the right foot.

ASSESSMENT
1. Rheumatoid arthritis with severe destructive diseases of the subtalar joint, right ankle and foot.
2. Spontaneous pathologic fractures, left ribs 4-6.
3. Osteoporosis.
RECOMMENDATIONS
The severe pain and limitation of motion of right foot argues in favor of triple arthrodesis with bone graft from the right iliac crest to the right subtalar joint and transfer of the peroneal tendons of the right ankle. It is well known that the patient has severe osteoporosis and spontaneously fractured ribs. However, because of the severity of the destruction of the right ankle, arthrodesis is recommended at this time.

ICD-10-CM: ________

Scenario 6

OFFICE VISIT FOR AN ESTABLISHED PATIENT

HISTORY

CHIEF COMPLAINT
Daily severe chest discomfort.

HISTORY OF PRESENT ILLNESS
The patient has had cardiac surgery and a prior myocardial infarction. She rarely has chest pain with her heart disease. For the past week, she has had daily severe discomfort. Nitroglycerin offers no relief for this pain. There has been no shortness of breath, dyspnea, sweating or loss of consciousness.

PAST HISTORY
Habits: Less than half a pack of cigarettes a day. Alcohol and coffee, minimal to none. Medications: Cardizem 30 mg p.o. t.i.d., Nitro-Bid 6.5 mg p.o. b.i.d. ALLERGIES: PENICILLIN AND ERYTHROMYCIN.

REVIEW OF SYSTEMS
Cardiorespiratory: No history of hypertension. She has done very well since her cardiac surgery with the exception of recurrent discomfort and some fatigue.

PHYSICAL EXAMINATION

IMPRESSION
1. Chest pain which does not respond to cardiac medications. Rule out costochondritis or myofascial syndrome.
2. Status post cardiac surgery.
PLAN
Cardiology consultation for cardiac evaluation.

ICD-10-CM: ________

ICD-10-CM: ________

Scenario 7

EMERGENCY DEPARTMENT REPORT

HISTORY

CHIEF COMPLAINT
Pain and deformity of distal right forearm.

HISTORY OF PRESENT ILLNESS
The patient was in good health until today when he fell over a Doberman while walking down a sidewalk. He fell on his outstretched arm, resulting in severe pain and deformity of the distal right forearm.

PHYSICAL EXAMINATION
EXTREMITIES: There is palpable deformity over the distal radius with 1/5 apposition and strength in the right hand and 4+ swelling in the right wrist.

DATABASE
CBC and electrolytes are normal. X-ray confirms Colles’ fracture.

ASSESSMENT
Colles’ fracture.

RECOMMENDATIONS
Refer to orthopedic surgery clinic for reduction and immobilization. Right forearm sling and wrist immobilizer.

ICD-10-CM: ________

ICD-10-CM: ________

ICD-10-CM: ________
Scenario 8

PREOPERATIVE DIAGNOSIS
Persistent leukocytosis of unknown etiology

POSTOPERATIVE DIAGNOSIS
Same, pending pathology.

PROCEDURE PERFORMED
ASPIRATION OF BONE MARROW FROM RIGHT POSTERIOR ILIAC CREST.

PROCEDURE
The patient was placed in a prone position. The posterior iliac crest was palpated, and the biopsy site was marked. A 26-gauge needle was used to inject 1% lidocaine solution subcutaneously. A 22-gauge needle was then used to infiltrate the deeper tissues with lidocaine. A #11 scalpel blade was used to make a 2 mm skin incision of the biopsy site. The bone marrow biopsy needle was firmly seated on the periosteum, advanced through the outer table of bone and into the marrow cavity with rotating motion and gentle pressure. It was advanced 2 mm. The stylet was removed and a 10 mL syringe was attached to the needle hub. A brisk withdrawal of the plunger resulted in 2 mL of marrow aspiration. The site was observed for any excess bleeding, cleaned thoroughly with alcohol and a gauze patch secured the site. The patient was in satisfactory condition with no operative complications noted.

ICD-10-CM: _________
Scenario 9

PREOPERATIVE DIAGNOSIS
Hemorrhoids.

POSTOPERATIVE DIAGNOSIS
Thrombosed internal hemorrhoids.

PROCEDURE PERFORMED
HEMORRHOIDECTOMY.

PROCEDURE
The patient was taken to the operating room and placed in the prone position. A 1st-degree internal hemorrhoid, which was significantly thrombosed, was palpated. After allowing adequate time for the anesthesia to take effect, the hemorrhoid was grasped with a clamp while another clamp was placed at the base of the hemorrhoid. The hemorrhoid was excised above the clamp and a running stitch going in the opposite direction was looped over the clamp. The clamp was then removed and the stitch was tightened. The area was dressed and packed with gauze. The patient tolerated the procedure well and was discharged to the postanesthesia care unit.

ICD-10-CM: _________

Scenario 10

PREOPERATIVE DIAGNOSIS
Medial and lateral meniscus tears, left knee.

POSTOPERATIVE DIAGNOSIS
Same.

PROCEDURE PERFORMED
ARTHROSCOPY WITH MEDIAL AND LATERAL MENISCECTOMIES, LEFT KNEE.

PROCEDURE
The patient was placed on the operating table in the supine position under general anesthesia, administered by the anesthesiologist. Arthroscopy was carried out beginning in the inferolateral portal. After initial exploration, the medial compartment was explored. The arthroscopy exposed the meniscus which revealed a tear. The torn portion was removed with forceps. Attention was then turned to the lateral compartment which also revealed a tear in the lateral meniscus. The torn portion was removed with forceps. After completion of the meniscectomies, there were no other significant findings. Dressing was applied. The patient tolerated the procedure well and left the operating room in good condition.

ICD-10-CM: _________

ICD-10-CM: _________
Review Practice Exercise 25

Check your answers with the Answer Key at the back of this supplement. Correct any mistakes you may have made.

Summary

Your ICD-10-CM coding practice is complete. If you are still feeling a little unsure of yourself, that’s OK. As you review the Practice Exercise answers, compare your pathway with the pathway in the Answer Key. The best way to determine why you didn’t get to the correct code is to understand the pathway used. As you practice, you’ll become faster and more proficient at ICD-10-CM coding.

Endnotes

Preparing for the
ICD-10-CM
Answer Key

Practice Exercise 1

1. Dr. Martin diagnosed Mrs. Abraham with diabetes type 2 on September 14, 2014. Which ICD coding manual will you use to code the diagnosis? The **ICD-9-CM coding manual**

2. Dr. Martin saw Mrs. Abraham at a follow-up appointment on October 14, 2014. The diagnosis from this exam will be coded using the **10th edition of the ICD coding manual**.

3. What are the four Cooperating Parties for the ICD-10-CM? **The American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS)**

4. What are the four parts of the *Index*? **The Index to Diseases and Injuries, Neoplasm Table, Table of Drugs and Chemicals and the Index to External Causes.**

5. The **ICD-10-CM** manual lists **d. diagnostic codes**.

6. Main terms appear in **b. boldface type**.

7. Information in parentheses following a main term is called a(n) **a. nonessential modifier** and it has no effect on selecting the correct code.

8. The **ICD-10-CM** manual is divided into the **c. Index and the Tabular List**.

9. The first **b. three** characters of the **ICD-10-CM** are considered the category.

10. The **d. all of the above** can be found within the **Index**.
**Practice Exercise 2**

1. In the *Tabular List*, **c. brackets** enclose synonyms, alternative wording or explanatory phrases.

2. In the *Tabular List*, **a. parentheses** are used to enclose supplementary words.

3. NEC may be interpreted as “unspecified.” **b. False**

4. Excludes1 and Excludes2 mean essentially the same thing. **b. False**

5. Inclusion terms may be synonyms or may provide a list of various conditions included within a code classification. **a. True**

6. An object not naturally occurring in the human body is **a. a foreign body**.

7. A late effect is defined as a(n) **d. residual** effect after the acute phase of an illness or injury has ended.

**Practice Exercise 3**

1. **A02.0** Poisoning, food, due to, salmonella, with, gastroenteritis

2. **A37.90** Pertussis (*see also* Whooping cough)

3. **A49.8** Infection, Bacteroides NEC

4. **B20** AIDS (related complex)  
   **B59** Pneumocystis carinii pneumonia

5. **B05.3** Measles, with, otitis media

6. **B08.4** Disease, hand, foot and mouth

7. **A52.00** Syphilis, early, cardiovascular

8. **B35.3** Infection, fungus, foot

9. **B76.9** Disease, hookworm

10. **B20** Syndrome, acquired immunodeficiency — *see* Human, immunodeficiency virus (HIV) disease; Human, immunodeficiency virus (HIV) disease  
    **B39.4** Histoplasmosis, American — *see* Histoplasmosis, capsulati; Histoplasmosis, capsulati  
    **B37.0** Thrush, oral
Practice Exercise 4

1. **C71.0** Glioma, specific site NEC – see Neoplasm, malignant, by site; Neoplasm, cerebrum, Malignant Primary

2. **C79.31** Carcinoma (see also Neoplasm, malignant, by site); Neoplasm, brain NEC, Malignant Secondary

   - **C34.90** Neoplasm, lung, Malignant Primary; unspecified part of bronchus or lung

3. **C81.90** Sarcoma, Hodgkin – see Lymphoma, Hodgkin; Lymphoma, Hodgkin; unspecified site

4. **D23.4** Neoplasm, scalp, Benign

5. **D25.9** Fibromyoma, uterus (see also Leiomyoma, uterus); Leiomyoma, uterus

6. **C16.5** Adenocarcinoma (see also Neoplasm, malignant, by site); Neoplasm, stomach, lesser curvature NEC, Malignant Primary

Practice Exercise 5

1. **D51.0** Addison’s, anemia

2. **D56.0** Thalassemia, alpha (triple gene defect)

3. **D57.00** Disease, sickle-cell, with crisis

4. **D58.0** Syndrome, Minkowski-Chauffard

5. **D73.1** Syndrome, big spleen

6. **C50.919** Neoplasm, breast, Malignant Primary; female; unspecified breast

   - **D63.0** Anemia, in, neoplastic disease

   - **Y84.2** Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure

   *Note: See Chapter-Specific Guidelines for Y84.2.*
Preparation for ICD-10-CM

Practice Exercise 6

1. **E89.0** Hypothyroidism, postsurgical
2. **E10.641** Diabetes, type 1, with hypoglycemia, with coma
3. **E21.0** Hyperparathyroidism, primary
4. **E28.2** Polycystic, ovary
5. **E28.319** Menopause, premature, asymptomatic
6. **E83.52** Hypercalcemia, hypocalciuric, familial
   *C73 Neoplasm, thyroid (gland), Malignant Primary*

Practice Exercise 7

1. **F10.921** Delirium, alcoholic
2. **F44.9** Psychosis, acute, hysterical
3. **F42** Disorder, obsessive-compulsive
4. **F50.00** Anorexia, nervosa
5. **F63.2** Kleptomania
6. **F31.9** Disorder, bipolar

Practice Exercise 8

1. **G00.3** Meningitis, staphylococcal
   *B95.8 Staphylococcus, as cause of disease classified elsewhere*
2. **G24.3** Torticollis, spasmodic
3. **G81.11** Hemiplegia, spastic; affecting right dominant side
4. **G40.419** Grand mal – *see* Epilepsy, generalized, specified NEC; epilepsy, generalized, specified NEC, intractable
5. **G51.0** Bell’s, palsy
6. **G35** Sclerosis, multiple
Practice Exercise 9

1. **H44.21** Myopia, malignant; right eye
2. **H35.30** Degeneration, macula (senile)
3. **H10.029** Pink, eye – see Conjunctivitis, acute, mucopurulent; unspecified eye
4. **H05.239** Hemorrhage, orbital; unspecified orbit
5. **H33.012** Detachment, retina, with retinal: break, single; left eye

Practice Exercise 10

1. **H73.019** Myringitis, bullous – see Myringitis, acute, bullous; unspecified ear
2. **H81.09** Meniere’s disease, syndrome or vertigo; unspecified ear
3. **H61.23** Wax in ear – see Impaction, cerumen; Impaction, cerumen; bilateral
4. **H61.032** Chondritis, external ear; left ear
5. **H70.001** Mastoiditis, acute; right ear

Practice Exercise 11

1. **I02.9** Chorea, rheumatic
2. **I09.1** Endocarditis, rheumatic
3. **I10** Hypertension (benign) (essential)
4. **I15.2** Hypertension, secondary, due to, endocrine disorders
   - **E24.9** Cushing’s, syndrome or disease
5. **I21.09** Infarct, ST elevation (STEMI), anterior (anterolateral)
6. **I27.0** Hypertension, pulmonary, primary (idiopathic)
7. **I44.1** Wenckebach’s block or phenomenon
8. **I70.209** Arteriolosclerosis, extremities
9. **I83.92** Varicose, vein – see Varix; Varix, leg, left
10. **I49.5** Syndrome, sick, sinus
**Practice Exercise 12**

1. **J20.2** Bronchitis, pneumococcal, acute or subacute
2. **J32.0** Sinusitis, maxillary
3. **J44.9** Bronchitis, chronic, asthmatic
4. **J80** Syndrome, respiratory, distress, acute
5. **J96.20** Failure, respiratory, acute and (on) chronic

**Practice Exercise 13**

1. **K12.1** Stomatitis (ulcerative)
2. **K25.4** Ulcer, prepyloric – *see* Ulcer, stomach; Ulcer, stomach, with, hemorrhage
3. **K26.4** Ulcer, duodenum, chronic, with, hemorrhage
4. **K35.2** Appendicitis, with, peritonitis
5. **K44.0** Hernia, hiatal, with, obstruction
6. **K56.41** Impaction, fecal
7. **K91.1** Syndrome, dumping (postgastrectomy)
8. **K70.30** Cirrhosis, liver, alcoholic
9. **K29.70** Gastritis
   **K25.9** Ulcer, gastric – *see* Ulcer, stomach; Ulcer, stomach
   **K26.9** Ulcer, duodenum

**Practice Exercise 14**

1. **L55.9** Sunburn
2. **L30.9** Eczema
3. **L93.0** Lupus, erythematosus
4. **L29.0** Itch, perianal
5. **L64.9** Baldness, male pattern – *see* Alopecia, androgenic
6. **L89.312** Ulcer, pressure, stage, 2, buttock; right buttock, stage 2  
**I69.959** Hemiplegia, following, cerebrovascular disease

7. **L03.011** Paronychia (see also Cellulitis, digit); Cellulitis, digit, finger – see Cellulitis, finger; Cellulitis, finger; right finger

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**Practice Exercise 15**

1. **M25.512** Arthralgia (see also Pain, joint); Pain, joint, shoulder; left shoulder

2. **M50.20** Hernia, intervertebral cartilage or disc – see Displacement, intervertebral disc; Displacement, intervertebral disc NEC, cervical

3. **M51.86** Calcification, intervertebral cartilage or disc – see Disorder, disc, specified NEC; Disorder, disc, specified NEC, lumbar region

4. **M54.5** Pain, lower back

5. **M70.71** Bursitis, hip NEC; right hip

6. **M65.30** Trigger finger (acquired)

7. **M60.074** Myositis, infective, lower limb, foot; left foot

8. **M81.8** Osteoporosis, idiopathic – see Osteoporosis, specified type NEC; Osteoporosis, specified type NEC

9. **M06.9** Arthritis, rheumatoid

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**Practice Exercise 16**

1. **N15.1** Carbuncle, kidney – see Abscess, kidney; Abscess, kidney

2. **N30.00** Cystitis, acute

3. **N40.0** Enlargement, prostate

4. **N45.4** Abscess, testis

5. **N60.29** Fibroadenosis, breast (periodic); unspecified breast

6. **N81.12** Prolapse, vagina – see Cystocele; Cystocele, female paravaginal

7. **N91.0** Amenorrhea, primary

8. **N39.0** Infection, urinary (tract)  
   **B96.89** Infection, Enterobacter sakazakii
Practice Exercise 17

1. **O00.2** Pregnancy, ovarian

2. **O03.9** Miscarrage, complete
   - **Z3A.12** Pregnancy, weeks of gestation, 12 weeks

3. **O44.12** Previa, placenta (partial) (with hemorrhage); second trimester
   - **Z3A.18** Pregnancy, weeks of gestation, 18 weeks

4. **O21.0** Hyperemesis, gravidarum
   - **Z3A.20** Pregnancy, weeks of gestation, 20 weeks

5. **O63.2** Delivery, complicated (by), delayed NOS, second twin, triplet, etc.
   - **Z37.2** Outcome of delivery, twins, both liveborn

6. **O34.21** Delivery, vaginal, following previous cesarean delivery
   - **Z37.0** Outcome of delivery, single, liveborn

7. **O70.2** Delivery, complicated, by, laceration, perineal, third degree
   - **Z37.0** Outcome of delivery, single, liveborn

8. **O88.83** Embolism, obstetric (pulmonary), puerperal

9. **O92.13** Cracked nipple, associated with, lactation

10. **O80** Delivery, normal
    - **Z37.0** Outcome of delivery, single, liveborn
**Practice Exercise 18**

1. **Z38.01** Infant, liveborn, born in hospital, by cesarean  
   **P84** Distress, fetal

2. **Z38.00** Newborn, born in hospital  
   **P08.1** Large-for-dates NEC (infant) (4000g to 4499g)

3. **Z38.00** Newborn, born in hospital  
   **P08.21** Post-term, infant

4. **Z38.00** Newborn, born in hospital  
   **P05.10** Small-for-dates (infant)

5. **Z38.31** Newborn, twin, born in hospital, by cesarean  
   **P07.35** Premature, newborn, less than 37 completed weeks – *see* Preterm, newborn; Preterm, newborn, gestation age, 32 completed weeks

**Practice Exercise 19**

1. **Q05.7** Spina bifida, lumbar

2. **Q11.2** Hypoplasia, eye

3. **Q16.1** Absence, auditory canal (congenital)

4. **Q21.0** Disease, Roger’s

5. **Q22.3** Fallot’s, triad

6. **Q27.0** Single, umbilical artery

7. **Q33.0** Honeycomb lung, congenital

8. **Q36.9** Cleft, lip (unilateral)

9. **Q51.2** Didelphia – *see* Double uterus; Double, uterus

10. **Q17.8** Dysplasia (*see also* Anomaly); Anomaly, auricle, ear  
    **Q76.49** Anomaly, vertebra  
    **Q71.892** Hypoplasia, finger (congenital) – *see* Defect, reduction, upper limb, specified type NEC; Defect, reduction, limb, upper, specified type NEC; left upper limb  
    **Q71.812** Short, arm, congenital; left upper limb  
    **Q24.9** Disease, heart, congenital
Practice Exercise 20

1. **R40.3** State, persistent vegetative
2. **R53.83** Lethargy
3. **R29.6** Tendency, to fall
4. **R20.0** Numbness
5. **R07.89** Discomfort, chest
6. **R03.0** Elevated, blood pressure, reading, no diagnosis of hypertension
7. **R94.5** Abnormal, function studies, liver
8. **R07.89** Pain, pleuritic
   **R50.82** Fever, postoperative

Practice Exercise 21

1. **S02.3XXA** Fracture, traumatic, blow-out; initial encounter for closed fracture
2. **S12.000A** Fracture, traumatic, neck, cervical vertebra, first; initial encounter for closed fracture
   **S12.100A** Fracture, traumatic, neck, cervical vertebra, second; initial encounter for closed fracture
   **S12.200A** Fracture, traumatic, neck, cervical vertebra, third; initial encounter for closed fracture
   **S12.300A** Fracture, traumatic, neck, cervical vertebra, fourth; initial encounter for closed fracture
3. **S42.452A** Fracture, traumatic, humerus, lower end, condyle, lateral (displaced); left humerus; initial encounter for closed fracture
4. **S33.110D** Subluxation, vertebral, traumatic, lumbar, joint between, L1 and L2; subsequent encounter
5. **S93.519A** Rupture, joint capsule, traumatic – *see* Sprain; Sprain, toe, interphalangeal joint; unspecified toe(s); initial encounter
6. **S52.561A** Fracture, traumatic, Barton’s – *see* Barton’s fracture; Barton’s fracture; right radius; initial encounter for closed fracture
   **S83.114A** Dislocation, tibia, proximal end – *see* Dislocation, knee; Dislocation, knee, proximal tibia, anteriorly; right knee; initial encounter
Practice Exercise 22

1. **T45.0X1A Table of Drugs and Chemicals:** Antihistamine, Poisoning, Accidental; initial encounter  
   **J80** Distress, respiratory, child

2. **T24.211A** Burn, thigh, right, second degree; initial encounter  
   **T21.24XA** Burn, back, second degree; initial encounter  
   **T31.10** Burn, extent, 10-19 percent

3. **T42.3x1A Table of Drugs and Chemicals:** Barbiturate NEC, Poisoning, Accidental; initial encounter

4. **T52.92XA Table of Drugs and Chemicals:** Nail polish remover, Poisoning, Intentional Self-harm; initial encounter

5. **T223.339S** Burn, arm (lower) (upper) – see Burn, upper, limb; Burn, upper limb, above elbow – see Burn, above elbow; Burn, above elbow, third degree; sequela  
   **T31.10** Burn, extent; 10-19 percent, with 0-9 percent third degree burns  
   **L03.113** Cellulitis, arm – see Cellulitis, upper limb; Cellulitis, upper limb; right upper limb

Practice Exercise 23

1. **S63.502A** Sprain, wrist; left wrist; initial encounter  
   **V00.131A Index to External Causes:** Fall, involving, skateboard(s) – see Accident, transport, pedestrian, conveyance; Accident, transport, pedestrian, conveyance, skate board, fall; initial encounter  
   **Y92.830 Index to External Causes:** Place of occurrence, park

2. **T24.302A** Burn, leg(s) – see Burn, lower, limb; Burn, lower, limb, left, third degree; initial encounter  
   **T24.301A** Burn, leg(s) – see Burn, lower, limb; Burn, lower, limb, right, third degree; initial encounter  
   **T31.33** Burn, extent, 30-39 percent, with 30-39 percent third degree burns  
   **V93.54XA Index to External Causes:** Explosion, in, on, watercraft, powered craft, sailboat; initial encounter  
   **Y92.828 Index to External Causes:** Place of occurrence, lake

3. **S30.1XXD** Contusion, abdomen; subsequent encounter  
   **V43.62XD Index to External Causes:** Collision (see also Accident, transport); Accident, transport, car occupant, passenger, collision (with), car; subsequent encounter
4. **S52.501A** Fracture, traumatic, radius, lower end; right radius; initial encounter  
**W10.9XXA** *Index to External Causes*: Fall, down, stairs; initial encounter  
**Y92.251** *Index to External Causes*: Place of occurrence, museum

5. **S93.401A** Sprain, ankle; right ankle; initial encounter  
**W10.9XXA** *Index to External Causes*: Fall, down, stairs; initial encounter  
**Y92.59** *Index to External Causes*: Place of occurrence, mall

**Practice Exercise 24**

1. **Z23** Vaccination, encounter for
2. **C79.31** Neoplasm, brain NEC, Malignant Secondary  
**Z85.3** History, personal, malignant neoplasm (of), breast
3. **R07.9** Pain, chest  
**Z98.61** Status, angioplasty, coronary artery
4. **Z00.129** Examination, child (over 28 days old)  
**Z23** Vaccination, encounter for
5. **Z12.79** Screening, neoplasm, genitourinary organs NEC  
**Z85.3** History, personal, malignant neoplasm, breast

**Practice Exercise 25**

Scenario 1  
**T81.4XXA** Infection, postoperative; initial encounter  
**A49.8** Infection Escherichia (E) coli NEC

Scenario 2  
**E11.359** Diabetic, type 2, with, retinopathy, proliferative  
**Z79.4** Long-term drug therapy, insulin

Scenario 3  
**J18.9** Pneumonia

Scenario 4  
**M47.817** Spondylosis, without myelopathy or radiculopathy, lumbosacral region

Scenario 5  
**M84.48XA** Fracture, pathological, rib; initial encounter for fracture
Scenario 6
- **R07.89** Pain, chest, non-cardiac
- **Z98.89** Status, postoperative

Scenario 7
- **S52.531A** Fracture, traumatic, Colles’ – see Colles’ fracture; Colles’ fracture; right radius; initial encounter for closed fracture
- **W01.0XXA** *Index to External Causes:* Fall, over, animal; initial encounter
- **Y93.01** *Index to External Causes:* Activity, walking

Scenario 8
- **D72.829** Leukocytosis

Scenario 9
- **K64.0** Hemorrhoids, 1st degree

Scenario 10
- **S83.252A** Tear, meniscus, lateral, bucket-handle; left knee; initial encounter
- **S83.212A** Tear, meniscus, medial, bucket-handle; left knee; initial encounter