ICD-10-CM
Day 1
2015

American Health Information Management Association®

ICD-10-CM

RESOURCES AND REFERENCES

PREPARATION IS THE KEY TO SUCCESS

2015 ICD-10-CM is available at
http://www.cdc.gov/nchs/icd/icd10cm.htm or
http://www.cms.hhs.gov/ICD10

- **2015 ICD-10-CM Index to Diseases and Injuries**
- **2015 ICD-10-CM Tabular List of Diseases and Injuries**
  - Instructional Notations
- 2015 Official Guidelines for Coding and Reporting
- 2015 Table of Drugs and Chemicals
- 2015 Neoplasm Table
- 2015 Index to External Causes
- 2015 Mapping ICD-9-CM to ICD-10-CM and ICD-10-CM to ICD-9-CM

ICD-10-CM

CODING CONVENTIONS AND GUIDELINES

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1. The ICD-10-CM code for electrocution is T75.4 and requires the use of a seventh character to identify the encounter. Which of the following is the correct code for an initial encounter to treat the electrocution?

   a. T75.4A

   b. T75.4XA

   c. T75.4XXA

   d. T75.4

1.

Answer: c. T75.4XXA

Rationale: ICD-10-CM Coding Guideline I.A.5 states that the seventh character must always be the seventh character in the data field. If a code that requires a seventh character is not six characters long, a placeholder X must be used to fill in the empty characters. Additionally, Guideline A.4 indicates that ICD-10-CM utilizes a placeholder character X and where a placeholder exists, the X must be used in order for the code to be considered a valid code. All alpha characters in ICD-10-CM are *not* case sensitive, which means that if the placeholder X is entered in either the upper- or lowercase format, the meaning would not change.

2. Nonessential modifiers are enclosed in:

Answer: c. Parentheses

Rationale: Parentheses are used in ICD-10-CM in both the Alphabetic Index and Tabular to enclose supplementary words that may be present or absent in the statement of a disease without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers. Boxes are not a defined convention of ICD-10-CM. Square brackets in ICD-10-CM in the Tabular List are used to enclose synonyms, alternative wordings, abbreviations, and explanatory phrases. Brackets are used in the Index to identify manifestation codes. Colons are used in the Tabular List after an incomplete term that needs one or more of the modifiers following the colon to make it assignable to a given category.

3. True or false? When an *Excludes2* note appears under a code, it is acceptable to use both the code and the excluded code together.

Answer: True

Rationale: An *Excludes2* note indicates that the condition excluded is not part of the condition represented, but a patient may have both conditions at the same time. When an *Excludes2* note appears under a code, it is acceptable to use both the code and the excluded code together if the documentation indicates that the patient has both conditions (ICD-10-CM Coding Guideline I.A.12.b).

4. The first character of an ICD-10-CM code is:

Answer: b. Always a letter

Rationale: This is an ICD-10-CM convention with all codes beginning with a letter of the alphabet except the letter *U*.

5. A(n) _____ note means "not coded here."

Answer: c. *Excludes1*

Rationale: ICD-10-CM has two types of "excludes" notes. An *Excludes1* note indicates that the code excluded should never be used at the same time as the code above the *Excludes1* note (ICD-10-CM Coding Guideline I.A.12.a). An *Excludes2* note represents "not included here" and it is acceptable to use both the code and the excluded code together when both are documented (ICD-10-CM Coding Guideline I.A.12.b).

6. Codes titled "other" or "other specified" are to be used:

Answer: b. When the information in the medical record provides detail for which a specific code does not exist

Rationale: Codes titled "other" or "other specified" are for use when the information in the medical record provides detail for which a specific code does not exist (ICD-10-CM Coding Guideline I.A.9.a). This can be contrasted with "unspecified" codes when the information in the medical record is insufficient to assign a more specific code (ICD-10-CM Coding Guideline I.A.9.b).

7. True or false? Similar to ICD-9-CM, in ICD-10-CM all categories are three characters.

Answer: True

Rationale: All categories in ICD-10-CM are three characters. A three-character category that has no further subdivision is equivalent to a code. Subcategories are either four or five characters. Codes may be three, four, five, six, or seven characters.

8. True or false? When the term "and" is used in a narrative statement it is interpreted to mean only "and."

Answer: False

Rationale: The word "and" should be interpreted to mean either "and" or "or" when it is used in a narrative statement (ICD-10-CM Coding Guideline I.A.8).

9. True or false? In ICD-10-CM all inclusion notes contain all conditions for which a particular code number is to be used and are considered to be "exhaustive."

Answer: False

Rationale: Inclusion notes contain terms that are the condition for which that code number is to be used. The terms may be synonyms of the code title, or in the case of "other specified" codes, the terms are a list of various conditions assigned to that code. The inclusion terms are not necessarily exhaustive (ICD-10-CM Coding Guideline I.A.11).

10. True or false? In ICD-10-CM a "code also" note provides sequencing guidance to the coding professional.

Answer: False

Rationale: ICD-10-CM Coding Guideline I.A.17 states a "code also" note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction. In contrast, the "code first" and "use additional code" notes provide sequencing order of the codes.

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11. If an encounter is solely for chemotherapy, immunotherapy, or radiation therapy for a neoplastic condition, the first reported diagnosis is:

Answer: b. The appropriate Z51 code

Rationale: If a patient admission or encounter is solely for the administration of chemotherapy, immunotherapy, or radiation therapy assign code Z51.0, Encounter for antineoplastic radiation therapy; or Z51.11, Encounter for antineoplastic chemotherapy; or Z51.12, Encounter for antineoplastic immunotherapy as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission more than one of these codes may be assigned, in any sequence (ICD-10-CM Coding Guideline I.C.2.e.2). An encounter for chemotherapy and immunotherapy for a nonneoplastic condition should be coded to the condition.

ICD-10

12. True or false? When assigning the principal diagnosis for a patient with AIDS, the AIDS code would always be sequenced before any other conditions.

Answer: False

Rationale: When a patient is admitted with an HIV-related condition, the principal diagnosis should be B20, Human immunodeficiency virus [HIV] disease, followed by additional diagnosis codes for all reported HIV-related conditions (ICD-10-CM Coding Guideline I.C.1.a.2.a). When a patient with HIV disease is admitted for an unrelated condition, for example, trauma, the code for the unrelated condition should be the principal diagnosis with B20 listed as an additional code (ICD-10-CM Coding Guideline I.C.1.a.2.b).

13. A patient has liver metastasis due to adenocarcinoma of the rectum which was resected two years ago. The patient has been receiving radiotherapy to the liver with some relief of pain. The patient is being admitted at this time for management of severe anemia due to the malignancy. The principal diagnosis listed on this admission is:

ICD-10

13.

Answer: a. Liver metastasis

Rationale: When an admission or encounter is for the management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first listed diagnosis followed by the appropriate code for the anemia (such as D63.0, Anemia in neoplastic disease) (ICD-10-CM Coding Guideline I.C.2.c.1). In addition, in the Tabular, the note under D63.0 states to code first neoplasm (C00-D49).

14. True or false? Code P95, Stillbirth, is only for use for institutions that maintain separate records for stillborns and should never be used on the mother's record.

Answer: True

Rationale: Code P95, Stillbirth, is only for use in institutions that maintain separate records for stillbirths. No other code should be used with P95. Code P95 should not be used on the mother's record (ICD-10-CM Coding Guideline I.C.16.g).

15. True or false? A fracture not described as "displaced" or "not displaced" by default should be coded as "not displaced."

Answer: False

Rationale: A fracture not indicated whether displaced or not displaced should be coded to displaced (ICD-10-CM Coding Guideline I.C.19.c). This information is also available in notes in the Tabular (see category S52). A fracture not described as open or closed is coded to the default of closed.

16. A patient is admitted six weeks post-acute anterolateral myocardial infarction with a subsequent posterior acute MI. Which is the appropriate coding and sequencing for the encounter for the posterior acute MI in ICD-10-CM?

ICD-10

16.

Answer: b. I21.29 STEMI of other sites

I25.2 Old Myocardial Infarction

Rationale: ICD-10-CM has two categories for acute myocardial infarction: I21, Acute myocardial infarction and I22, Subsequent acute myocardial infarction. I21 is for all cases of initial myocardial infarction and is to be used from onset of the AMI until 4 weeks following onset. A code from I22 is to be used if a patient who has suffered an AMI has a new AMI within the 4-week time frame of the initial AMI. A code from category I22 must be used in conjunction with a code from category I21 (ICD-10-CM Coding Guideline I.C.9.e.4).

AHIMA

17. When multiple burns are present, the first sequenced diagnosis is the:

Answer: c. Highest-degree burn

Rationale: ICD-10-CM Coding Guideline I.C.19.d.1 states to sequence first the code that reflects the highest degree of burn when more than one burn is present.

ICD-10

18. True or false? Generally a place of occurrence code should be used only at the initial encounter for treatment. However, in the rare instance that a new injury occurs during hospitalization, an additional place of occurrence code may be assigned.

Answer: True

Rationale: Codes from category Y92, Place of occurrence of the external cause, are secondary codes for use after other external cause codes to identify the location of the patient at the time of injury. A place of occurrence code should be used in conjunction with an activity code, Y93. (ICD-10-CM Coding Guidelines I.C.20.b and c).

19. In ICD-10-CM, diabetes mellitus codes include:

Answer: d. All of the above

Rationale: The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected and the complications affecting that body system (ICD-10-CM Coding Guideline I.C.4.a).

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20. True or false? A causal relationship can be assumed in a patient with both coronary atherosclerosis and angina pectoris and thus, the appropriate combination code should be assigned.

Answer: True

Rationale: ICD-10-CM has combination codes for atherosclerotic heart disease with angina pectoris. The subcategories for these codes are I25.11, Atherosclerotic heart disease of native coronary artery with angina pectoris and I25.7, Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris. When using one of these combination codes it is not necessary to use an additional code for the angina pectoris. A causal relationship can be assumed in a patient with both atherosclerosis and angina pectoris unless the documentation indicates the angina is due to something other than the atherosclerosis (ICD-10-CM Coding Guideline I.C.9.b).

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21. True or False? Patients with a prior diagnosis of an HIV-related illness should be assigned the code for AIDS (B20) on every subsequent admission.

Answer: True

Rationale: Patients with any known prior diagnosis of an HIV-related illness should be coded to B20. Once a patient has developed an HIV-related illness, the patient should always be assigned code B20 on every subsequent admission or encounter. Patients previously diagnosed with any HIV illness (B20) should never be assigned to R75 or Z21, Asymptomatic human immunodeficiency virus [HIV] infection status (ICD-10-CM Coding Guideline I.C.1.a.2.f).

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22. Which of the following would be assigned to code I11.0, Hypertensive heart disease with heart failure?

Answer: c. Congestive heart failure due to hypertension

Rationale: Heart conditions classified to I50.- or I51.4 through I51.9 are assigned to a code from category I11, Hypertensive heart disease, when a causal relationship is documented (due to hypertension) or implied (hypertensive). The same heart conditions with hypertension but without a stated causal relationship are coded separately (ICD-10-CM Coding Guideline I.C.9.a.1).

AHIMA

23. When an OB patient enters the hospital for complications of pregnancy during one trimester and remains in the hospital into a subsequent trimester, the final character selected for the antepartum conditions should be:

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23.

Answer: a. For the trimester in which the complication first occurred

Rationale: ICD-10-CM Coding Guideline I.C.15.a.4. states in the instances when a patient is admitted to a hospital for complications of pregnancy during one trimester and remains in the hospital into a subsequent trimester, the trimester character for the antepartum complication code should be assigned on the basis of the trimester when the complication developed, not the trimester of the discharge. If the condition developed prior to the current admission or encounter or represents a pre-existing condition, the trimester character for the trimester at the time of the admission or encounter should be assigned.

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24. True or false? In the case where a 20-day-old baby has a condition that may be either due to the birth process or community-acquired and there is no documentation to support either one, the default should be community-acquired rather than the birth process.

Answer: False

Rationale: If a newborn has a condition that may be either due to the birth process or community-acquired and the documentation does not indicate which it is, the default is due to the birth process and the code from Chapter 16 should be assigned (ICD-10-CM Coding Guideline I.C.16.a.5). By definition the perinatal period is defined as before birth through the 28th day following birth.

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25. True or false? Regardless of the number of external cause codes assigned on a particular record, there generally should only be one place of occurrence code and one activity code assigned to a record.

Answer: True

Rationale: ICD-10-CM Coding Guideline I.C.20.b states that generally, a place of occurrence code is assigned only once, at the initial encounter for treatment. However, in the rare instance that a new injury occurs during hospitalization, an additional place of occurrence code may be assigned.

AHIMA

26. True or false? A noncompliance code or complication of care code is to be used with an underdosing code to indicate intent.

Answer: True

Rationale: Underdosing refers to taking less of a medication than is prescribed by a provider or a manufacturer's instruction. Noncompliance (Z91.12-, Z91.13-) or complication of care (Y63.8-Y63.9) codes are to be used with an underdosing code to indicate intent, if known (ICD-10-CM Coding Guideline I.C.19.e.5.c). Codes for underdosing should never be assigned as principal or first-listed codes.

27. When reporting an encounter for a patient who is HIV positive but has never had any symptoms, the following code is assigned:

Answer: b. Z21, Asymptomatic HIV infection status

Rationale: Z21, Asymptomatic HIV infection status is to be used when the patient without any documentation of symptoms is listed as being "HIV positive," "known HIV," "HIV test positive," or similar terminology. Do not use this code if the term "AIDS" is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from HIV positive status; use B20 in these cases (ICD-10-CM Coding Guideline I.C.1.a.2.d).

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28. In reviewing the medical record of a patient admitted for a left herniorrhaphy, the coder notes an extremely low potassium level on the laboratory report. In examining the physician's order, the coder notices that intravenous potassium was ordered. The physician has not listed any indication of an abnormal potassium level or any related condition within the medical record. The best course of action for the coder to take is to:

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28.

Answer: a. Confer with the physician and request the condition be listed as a final diagnosis

Rationale: Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal findings should be added (ICD-10-CM Coding Guidelines III.B).

ICD-10

29. True or false? When coding severe sepsis, a minimum of three codes is required.

Answer: False

Rationale: The coding of severe sepsis requires a minimum of two codes: first a code for the underlying systemic infection, followed by a code from subcategory R65.2, Severe sepsis. If the causal organism is not documented, assign code A41.9, Sepsis, unspecified organism, for the infection (ICD-10-CM Coding Guideline I.C.1.d.1.b). Additional codes for the other acute organ dysfunctions should also be assigned. This condition usually will result in a total of three codes, except in the case of combination codes, such as severe sepsis with septic shock.

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30. When a patient seeks medical attention for an injury that occurred several days prior to the medical encounter, which is the appropriate seventh character to use?

Answer: a. A, initial encounter

Rationale: Seventh character A, initial encounter, is used while the patient is receiving active treatment for the condition. Seventh character D, subsequent encounter, is used for encounters after the patient has received active treatment for the condition and is receiving routine care for the condition during the healing or recovery phase. Seventh character S, sequela, is used for complications or conditions that arise as a direct result of a condition (ICD-10-CM Coding Guideline I.C.19.a).

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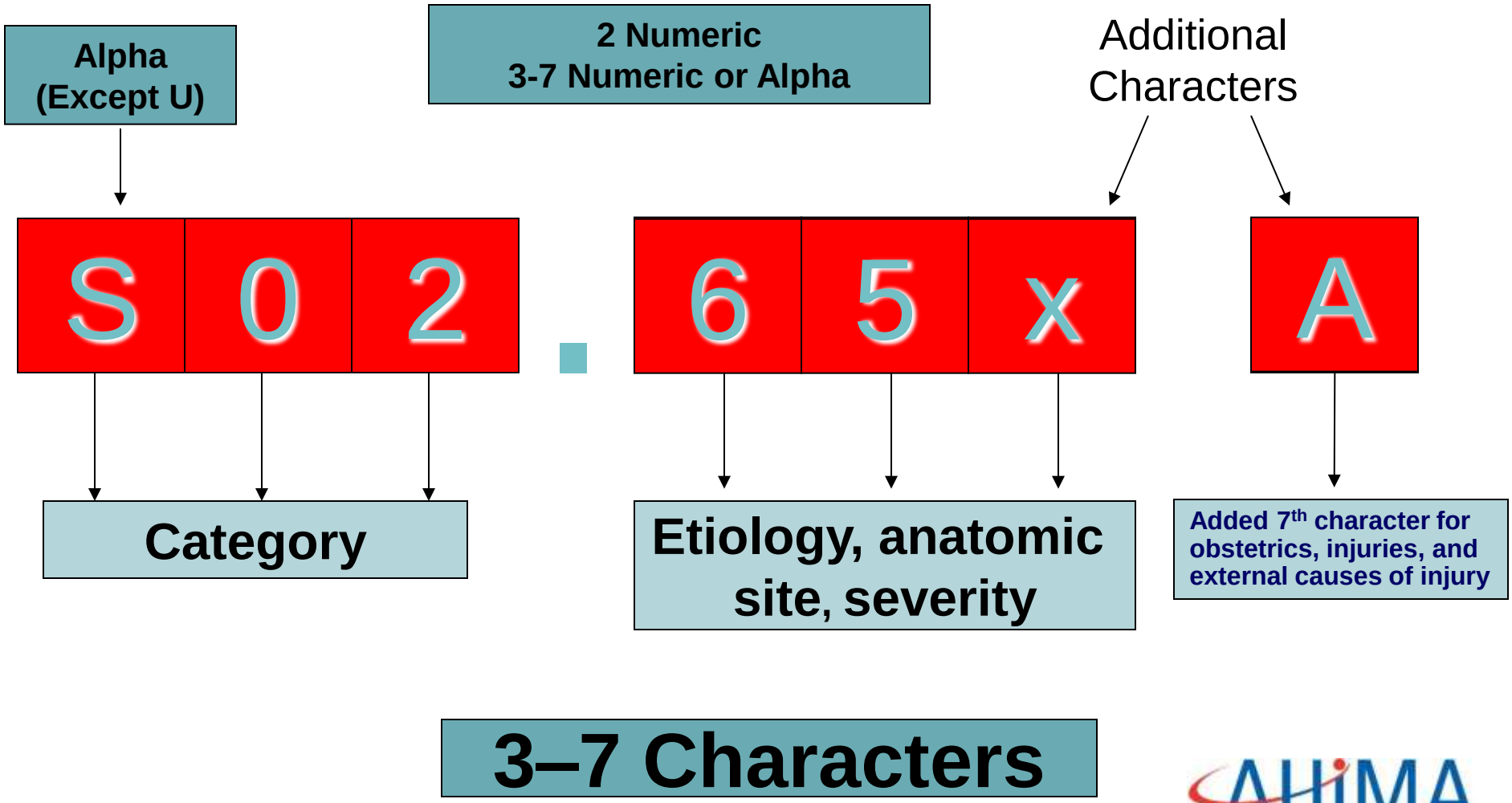
Coding and Seventh Character S



3–7 Characters

Coding in ICD-10-CM

ICD-9-CM	ICD-10-CM
Three to five characters	Three to seven characters
First digit is numeric but can be alpha (E or V)	First character always alpha; all letters used except U
2–5 are numeric	Character 2 always numeric: 3–7 can be alpha or numeric
Always at least three digits	Always at least three digits
Decimal placed after the first three characters (or with E codes, placed after the first four characters)	Decimal placed after the first three characters
Alpha characters are not case-sensitive	Alpha characters are not case-sensitive

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Coding and Use of Seventh Character

- Obstetrics
- Injury
- External cause

- Either alpha or numeric

- Placeholder X

- Meanings vary

Injury and External Cause - Identifies Injury

Initial – Receiving active treatment	Subsequent – Receiving routine care during healing or recovery (after active treatment)	Sequela – Complications or conditions arising as result of a condition

AHIMA

Coding and Use of Seventh Character

Aftercare Z codes are not used for aftercare for injuries

Combination codes for poisonings and external cause (accidental, intentional self-harm, assault, undetermined)

Chapter 15 – represents fetus in multiple gestation affected by condition being coded

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CERTAIN INFECTIOUS AND PARASITIC DISEASES

PREPARATION IS THE KEY TO SUCCESS

- Includes diseases generally recognized as communicable or transmissible
- Use additional code to identify resistance to antimicrobial drugs (Z16)
- New section called infections with a predominantly sexual mode of transmission (A50–A64)

PREPARATION IS THE KEY TO SUCCESS

- When coding sepsis or AIDS, it is important to review the Coding Guidelines and the notes at the category level of ICD-10-CM
- Categories B90-B94 are to be used to indicate conditions in categories A00-B89 as the cause of sequelae, which are themselves classified elsewhere

PREPARATION IS THE KEY TO SUCCESS

- Code first condition resulting from (sequela) the infectious or parasitic disease
- Bacterial and viral infectious agents (B95-B97) are provided for use as supplementary or additional codes to identify the infectious agent(s) in diseases classified elsewhere
  - Index
    - Infection
    - Organism (Streptococcus)

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Case 1.1

N39.0 **Infection, infected, infective (opportunistic), urinary (tract)**

B96.20 **Infection, infected, infective (opportunistic), bacterial NOS, as cause of disease classified elsewhere, Escherichia coli [E. coli] (*see also* Escherichia coli)**

Rationale: The symptoms associated with the UTI should not be coded. The "use additional code" note under N39.0 instructs the coder to an additional code (B95-B97) to identify the infectious agent.

Case 1.2

A07.0	**Colitis (acute) (catarrhal) (chronic) (noninfective) (hemorrhagic), b. coli**
Z16.29	**Resistance, resistant (to), organism(s), to drug, antibiotic specified NEC**

Rationale: ICD-10-CM provides a code to identify resistance to antimicrobial drugs (Z16._). The "use additional code" note is found at the beginning of Chapter 1.

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Case 1.3

M62.561	**Atrophy, atrophic (of), muscle, muscular (diffuse) (general) (Idiopathic) (primary), lower leg**
B91	**Late effect(s) – *see* Sequelae, Sequelae (of), poliomyelitis (acute)**

Rationale: In ICD-10-CM, late effect conditions are classified to "sequelae." In Chapter 1, Sequelae of Infectious and Parasitic Diseases are classified to categories B90-B94. The condition resulting from the sequela is sequenced first.

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Case 1.4

A02.9 **Poisoning (acute), food (acute) (diseased) (infected) (noxious), bacterial – *see* Intoxication, foodborne, by agent, Intoxication, foodborne, due to Salmonella**

Rationale: Food poisoning is classified to Chapter 1, Certain infectious and parasitic diseases (A00-B99). If gastroenteritis was documented, the code would be A02.0.

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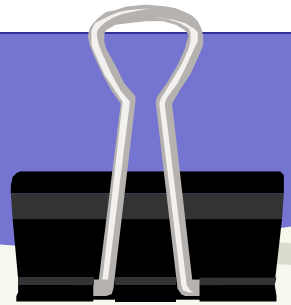

Coding Note: ICD-10-CM has created a range of codes to identify infections with a predominantly sexual mode of transmission (A50-A64). It is important to note that human immunodeficiency virus (HIV) disease is excluded from this range of codes.

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Case 1.5

A56.11 Disease, diseased, sexually transmitted, chlamydial infection – *see* Chlamydia, female, pelvic inflammatory disease

Rationale: With documentation of a sexually transmitted condition, the correct diagnosis code is found beginning with disease, sexually transmitted.

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Case 1.6

B20	**AIDS (related complex)**
B59	**Pneumonia, Pneumocystis (carinii) (jiroveci)**

Rationale: Per the Official Coding Guidelines, if a patient is admitted for an HIV-related condition, the principal diagnosis should be B20, Human immunodeficiency virus [HIV] diesase, followed by additional diagnosis codes for all reported HIV-related conditions.

Case 1.7

A41.51 **Sepsis (generalized), Escherichia coli (E. coli). Review Tabular for complete code assignment.**

Rationale: Without documentation of severe sepsis or an associated organ dysfunction, only one code from category A41 is necessary for correct code assignment.

Case 1.8

A41.50 **Sepsis (generalized), gram-negative (organism)**

R65.20 **Sepsis, with organ dysfunction (acute) (multiple)**

J96.00 **Failure, respiration, respiratory, acute**

Rationale: Under the R65.2 subcategory, there is a "code first underlying infection" note; therefore, A41.50 should be listed as the principal diagnosis followed by R65.20 as a secondary diagnosis. Coding Guideline C.1.d.1.b provides sequencing guidance for severe sepsis: "the coding of severe sepsis requires a minimum of two codes: first a code for the underlying systemic infection, followed by a code from subcategory R65.2, Severe sepsis. Code J96.00 is used to identify the acute respiratory failure."

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Case 1.9

A39.2 Sepsis (generalized), meningococcal, acute

R65.21 Shock, septic (due to severe sepsis)

Rationale: The combination code of severe sepsis with septic shock is assigned as a secondary diagnosis although severe sepsis is not documented. The underlying infection, meningococcal sepsis is sequenced first.

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Case 1.10

N20.0	**Nephrolithiasis (congenital) (pelvis) (recurrent) – *see also* Calculus, kidney, Calculus, calculi, calculous, kidney (impacted) (multiple) (pelvis) (recurrent) (staghorn)**
J15.1	**Pneumonia, Pseudomonas, NEC**
Y95	**Index to External Causes, Nosocomial condition**

Rationale: The renal colic is a symptom of the patient's nephrolithiasis and would not be coded. The nosocomial infection external cause diagnosis should be added to identify the patient's hospital-acquired pneumonia.

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Case 1.11

B18.1 Hepatitis, viral, virus, chronic, type B

Rationale: In ICD-10-CM chronic (viral) hepatitis B without delta-agent is coded B18.1. Delta agent is a type of virus called hepatitis D that causes symptoms only in people who have hepatitis B infection. Because of this there are no other hepatitis D codes (in the Index or Tabular List). It is a combination code available for use with hepatitis B codes. The Delta-agent can be shown with or without hepatic coma by individual codes.

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NEOPLASMS

ICD-10

I.C.2 General Neoplasm Guidelines

- The Neoplasm Table in the Alphabetic Index should be referenced first. However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate.

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PREPARATION IS THE KEY TO SUCCESS

- A primary malignant neoplasm overlapping two or more contiguous (next to each other) sites should be classified to the subcategory/code .8 (overlapping lesion), unless the combination is specifically indexed elsewhere.
- For multiple neoplasms of the same site that are not contiguous, such as tumors in different quadrants of the same breast, codes for each site should be assigned.

Case 1.12

C34.31	**Carcinoma, *see also* Neoplasm, by site, malignant. Refer to Neoplasm Table, by site (lung), malignant, primary site, lower lobe**
C77.1	**Refer to Neoplasm Table, by site, lymph gland, malignant, intrathoracic, secondary site**
C79.31	**Refer to Neoplasm Table, by site, brain, malignant, secondary site**
C79.51	**Refer to Neoplasm Table, by site, bone, malignant, rib, secondary site**

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Case 1.12 (continued):

Rationale: The primary site is the small cell carcinoma of the right lower lobe of the lung. The intrathoracic lymph nodes, brain, and rib are secondary sites. Index the term Carcinoma because the histological term is documented. This refers you to the Neoplasm Table, by site, malignant. It is correct to list each metastatic site.

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Case 1.13

D3A.021 **Carcinoid, *see* Tumor, carcinoid, benign, cecum**

Rationale: When indexing carcinoid, the note directs to Tumor. It is not necessary to use the Neoplasm Table to code this tumor. Under carcinoid, there is a differentiation between benign or malignant, with specific sites listed. Benign carcinoid tumors fall into category D3A, Benign neuroendocrine tumors. The following notes are present: Code also any associated multiple endocrine neoplasia [MEN] syndromes; and Use additional code to identify any associate endocrine syndrome, such as carcinoid syndrome (E34.0).

Case 1.14

C93.91 Leukemia, leukemic, monocytic (subacute)

Rationale: Leukemia is not coded from the Neoplasm Table, but rather indexed under the term Leukemia. Subacute monocytic is classified to subcategory C93.9-.

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Case 1.15

C43.52 Melanoma (malignant), skin, breast (female) (male)

C43.62 Melanoma (malignant), skin, arm. Review the Tabular for complete code assignment.

Rationale: To code melanoma, the code is found directly in the Index rather than the Neoplasm Table. It is incorrect to assign primary site of skin (C44.52, C44.62) when melanoma is documented. Melanoma in situ is classified in category D03.1-.

AHIMA

Case 1.16

E86.0	**Dehydration**
G89.3	**Pain(s) *(see also* Painful), chronic, neoplasm related**
C50.111	**Carcinoma, *see also* Neoplasm, by site, malignant. Refer to Neoplasm Table, by site (breast), malignant, primary site, central portion**
C79.31	**Refer to Neoplasm Table, by site, brain, malignant, secondary site**
C78.7	**Refer to Neoplasm Table, by site, liver, malignant, secondary site**

Case 1.16 (continued):

Rationale: ICD-10-CM chapter-specific guideline for neoplasms states that when the encounter is for management of dehydration due to the malignancy or the therapy, or a combination of both, and only the dehydration is being treated, the dehydration is sequenced first, followed by the code(s) for the malignancy. An additional ICD-10-CM Coding Guideline states that when the reason for the encounter is for neoplasm-related pain control or pain management, the pain code may be assigned as the first-listed diagnosis. Because the focus of this encounter was both the dehydration and the intractable pain, either may be sequenced first.

Case 1.17

C79.31 Refer to Neoplasm Table, by site, brain, malignant, secondary site

Z85.3 History, personal (of), malignant neoplasm (of), breast

Z90.12 Absence (of) (organ or part) (complete or partial), breast(s) (and nipple(s)) (acquired)

Z92.21 History, personal (of) chemotherapy for neoplastic condition

Case 1.17 (continued)

Rationale: The reason for this encounter is the metastatic brain cancer. The breast cancer was previously excised with no further treatment directed at that site, therefore, it is coded as history of breast cancer. Because the patient had a previous mastectomy, a code for the acquired absence of the breast is also coded. Laterality can be specified in the Z90.1 subcategory. It was documented that the brain metastasis was causing the symptoms, so they are not assigned additionally. If it is not clear by the documentation, a query might be in order. There is also a code available for history of chemotherapy if the facility takes coding to that level of detail.

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Case 1.18

Z51.11	**Chemotherapy (session) (for), cancer**
C17.8	**Carcinoma, *see also* Neoplasm, by site, malignant. Refer to Neoplasm Table, by site, intestine, small, overlapping lesion, malignant, primary site**
Z90.49	**Absence (of) (organ or part) (complete or partial), intestine (acquired) (small)**

ICD-10

Case 1.18 (continued):

Rationale: The reason for the encounter (chemotherapy) is the first listed diagnosis. The neoplasm is coded as current (even though it was excised) because the patient is still receiving chemotherapy. The overlapping sites code is used because the cancer is part in the duodenum and part in the jejunum. The acquired absence of the small intestine may be coded because the category includes the organ or part, complete or partial.

ICD-10-CM

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

ICD-10

Case 1.19

C50.912 **Carcinoma, *see also* Neoplasm, by site, malignant. Neoplasm, breast (connective tissue) (glandular tissue) (soft parts)**

D63.0 **Anemia (essential) (general) (hemoglobin deficiency) (infantile) (primary) (profound), in (due to) (with), neoplastic disease (see also Neoplasm)**

Rationale: When the patient is treated for anemia due to a malignancy, Coding Guideline I.C.2.c.1 directs the coding professional to sequence the malignancy as principal or first listed diagnosis followed by a code for the anemia. There is a "code first neoplasm" note under code D63.0.

Case 1.20

D61.01 Anemia (essential) (general) (hemoglobin deficiency) (infantile) (primary) (profound), aplastic, red cell (pure), congenital

Rationale: ICD-10-CM has provided greater specificity in aplastic anemia. In the Index, it is important to find Red Cell, than congenital under the term aplastic. The first term, Congenital (D61.09), is not specific to red cell.

Case 1.21

D70.4 **Neutropenia, neutropenic (chronic) (genetic) (idiopathic) (immune) (infantile) (malignant) (pernicious) (splenic), periodic**

Rationale: ICD-10-CM has provided greater specificity in neutropenia. A note provided at category D70 states that an additional code should be assigned for any associated fever or mucositis

Case 1.22

D56.3 Thalassemia (anemia) (disease), minor

Rationale: ICD-10-CM has provided greater specificity in the coding of Thalassemia.

ICD-10

Case 1.23

D57.01 Anemia, sickle-cell – *See* Disease, sickle-cell, with crisis (vasoocclusive pain), with, acute chest syndrome

Rationale: In some cases, combination codes are used for sickle-cell crisis with manifestation.

AHIMA

Case 1.24

D81.1 Immunodeficiency, combined, severe (SCID), with, low T- and B-cell numbers

Rationale: ICD-10-CM has added additional specificity to the severe combined immunodeficiency subcategory. SCID is a genetic disorder in which B and T cells are crippled due to a defect in genes. It is also known as "bubble boy" disease, and patients are extremely vulnerable to infectious diseases.