CHAPTER 6A

ICD-9-CM Coding

CHAPTER OUTLINE

Overview of ICD-9-CM  
Medical Necessity  
Outpatient ICD-9-CM Coding Guidelines  
ICD-9-CM Coding System  
ICD-9-CM Index to Diseases  
ICD-9-CM Tabular List of Diseases  
ICD-9-CM Index to Procedures and Tabular List of Procedures  
ICD-9-CM Index to Diseases Tables  
ICD-9-CM Supplementary Classifications  
Coding Special Disorders According to ICD-9-CM  
Reminders to Ensure Accurate ICD-9-CM Coding

OBJECTIVES

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

1. Define key terms.
2. Explain the concept of medical necessity as it relates to reporting diagnosis codes on claims.
3. List and apply CMS outpatient guidelines when coding diagnoses.
4. Identify and properly use ICD-9-CM’s coding conventions.
5. Accurately code diagnoses according to ICD-9-CM.
6. Explain key differences between ICD-9-CM and ICD-10-CM/PCS.

KEY TERMS

adverse effect  
adverse reaction  
benign  
carcinoma (Ca) in situ  

ICD-9-CM Classification of Drugs by AHFS List  
ICD-9-CM Classification of Industrial Accidents According to Agency  
coding conventions  
comorbidity  
complication  
computer-assisted coding (CAC)
INTRODUCTION

There are two related classifications of diseases with similar titles. The *International Classification of Diseases (ICD)* is published by the World Health Organization (WHO) and is used to code and classify mortality (death) data from death certificates. The *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)* was developed in the United States and is used to code and classify morbidity (disease) data from inpatient and outpatient records, including physician office records. The health insurance specialist employed in a physician’s office assigns ICD-9-CM codes to diagnoses, signs, and symptoms documented by the healthcare provider. Entering ICD-9-CM codes on insurance claims results in uniform reporting of medical reasons for healthcare services provided.
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OVERVIEW OF ICD-9-CM

ICD-9-CM was sponsored in 1979 as the official system for assigning codes to diagnoses (inpatient and outpatient care, including physician offices) and procedures (inpatient care). The ICD-9-CM is organized into three volumes:

- **Volume 1 (Tabular List of Diseases).**
- **Volume 2 (Index to Diseases).**
- **Volume 3 (Index to Procedures and Tabular List of Procedures).**

The National Center for Health Statistics (NCHS) and CMS are U.S. Department of Health and Human Services agencies that comprise the **ICD-9-CM Coordination and Maintenance Committee**, which is responsible for overseeing all changes and modifications to ICD-9-CM diagnosis (NCHS) and procedure (CMS) codes. The NCHS works with the World Health Organization (WHO) to coordinate official disease classification activities for ICD-9-CM (Index to Diseases and Tabular List of Diseases), which includes the use, interpretation, and periodic revision of the classification system. CMS is responsible for creating annual procedure classification updates for ICD-9-CM (Index to Procedures and Tabular List of Procedures). Updates are available from the official ICD-9-CM Web sites of the CMS and NCHS. A CD-ROM version that contains official coding guidelines as well as the complete, official version of the ICD-9-CM is available for purchase from the U.S. Government Bookstore (bookstore.gpo.gov).

ICD-9-CM coding books are also available from commercial publishing companies and are helpful in manual coding because they contain color-coded entries that identify required additional digits, nonspecific and unacceptable principal diagnoses, and more.

Mandatory Reporting of ICD-9-CM Codes

The Medicare Catastrophic Coverage Act of 1988 mandated the reporting of ICD-9-CM diagnosis codes on Medicare claims. Private payers adopted similar diagnosis coding requirements for claims submission in subsequent years (reporting procedure and service codes is discussed in Chapters 7 and 8). Requiring diagnosis codes to be reported on submitted claims establishes the medical necessity of procedures and services rendered to patients (e.g., inpatient care, office visit, outpatient visit, or emergency department visit). Medical necessity is defined by Medicare as “the determination that a service or procedure rendered is reasonable and necessary for the diagnosis or treatment of an illness or injury.” If it is possible that scheduled tests, services, or procedures may be found “medically unnecessary” by Medicare, the patient must sign an **advance beneficiary notice (ABN)**, which acknowledges patient responsibility for payment if Medicare denies the claim. (Chapter 14 contains a complete explanation about the ABN, including a sample form.)

**EXAMPLE:** A patient with insulin-dependent diabetes is treated at the physician's office for a leg injury sustained in a fall. When the physician questions the patient about his general health status since the last visit, the patient admits to knowing that a person on insulin should perform a daily blood sugar level check. The patient also admits to usually skipping this check one or two times a week, and he has not performed this check today. The physician orders an x-ray of the leg, which proves to be positive for a fracture, and a test of the patient’s blood glucose level.
If the only stated diagnosis on the claim is a fractured tibia, the blood glucose test would be rejected for payment by the insurance company as an unnecessary medical procedure. The diagnostic statements reported on the claim should include both the fractured tibia and insulin-dependent diabetes to permit reimbursement consideration for both the x-ray and the blood glucose test.

ICD-9-CM Annual Updates

CMS enforces regulations pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), which require that all code sets (e.g., ICD-9-CM) reported on claims be valid at the time services are provided. To be compliant, this means that traditional mid-year (April 1) and end-of-year (October 1) coding updates must be immediately implemented so that accurate codes are reported on submitted claims.

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

- Coders should consider using updateable coding manuals, which publishers offer as a subscription service. These coding manuals are usually stored in a three-ring binder so that coders can remove outdated pages and add new pages provided by the publisher.
- Another option is to purchase encoder software, also offered as a subscription service. Coders routinely download the most up-to-date encoder software, which contains edits for new, revised, and discontinued codes. An encoder automates the coding process using computerized or Web-based software; instead of manually looking up conditions (or procedures) in the coding manual index, the coder uses the software’s search feature to locate and verify diagnosis and procedure codes.
- Automating the medical coding process is the goal of computer-assisted coding (CAC) (Figures 6A-1 and 6A-2), which uses a natural language processing engine to “read” patient records and generate ICD-9-CM and HCPCS/CPT codes. Because of this process, coders become coding auditors, responsible for ensuring the accuracy of codes reported to payers. (CAC can be compared to speech recognition technology that has transitioned the role of medical transcriptionists in certain fields, such as radiology, to that of medical editors.)

MEDICAL NECESSITY

Today’s concept of medical necessity determines the extent to which individuals with health conditions receive healthcare services. (The concept was introduced in the 1970s when health insurance contracts intended to exclude care, such as voluntary hospitalizations, prescribed primarily for the convenience of the provider or patient.) Medical necessity is the measure of whether a healthcare procedure or service is appropriate for the diagnosis and/or treatment of a condition. This decision-making process is based on the payer’s contractual language and the treating provider’s
Computer-assisted coding (CAC) software obtains and displays a patient’s electronic health record (EHR)

Key terms associated with diagnoses and procedures are highlighted, and CAC software displays ICD, CPT, and HCPCS level II codes

Coder clicks on highlighted EHR key terms to manually review and validate accuracy of displayed codes, using references (e.g., official coding guidelines) to edit codes

Codes are delivered to financial management system and included on UB-04 bill or CMS-1500 claim

Codes are delivered to clinical management system, and data is used to improve quality of care provided

FIGURE 6A-1 Computer-assisted coding (CAC).

documentation. Generally, the following criteria are used to determine medical necessity:

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

**NOTE:** Cost-effective does not necessarily mean least expensive.
NOTE:
• Because variations may contradict the official guidelines, be sure to obtain each insurance company’s official coding guidelines.
• When reviewing the guidelines, remember that the terms encounter and visit are used interchangeably in describing outpatient and physician office services.

ICD-10 ALERT!
Chapter 6B contains a section about outpatient ICD-10-CM coding guidelines, including explanations about the ICD-10-CM Diagnostic Coding and Reporting Guidelines for Outpatient Services: Hospital-Based Outpatient Services and Provider-Based Office Visits.

OUTPATIENT ICD-9-CM CODING GUIDELINES
The ICD-9-CM Diagnostic Coding and Reporting Guidelines for Outpatient Services: Hospital-Based Outpatient Services and Provider-Based Office Visits were developed by the federal government for use in reporting diagnoses for claims submission. Four cooperating parties are involved in the continued development and approval of the guidelines:

1. American Hospital Association (AHA).
2. American Health Information Management Association (AHIMA).

Although the guidelines were originally developed for use in submitting government claims, insurance companies have also adopted them (sometimes with variation).

CODING TIP:
Begin the search for the correct code by referring to the Index to Diseases. Never begin searching for a code in the Tabular List of Diseases because this will lead to coding errors.

FIGURE 6A-2 Sample screen from PLATOCODE computer-assisted coding software.
A. Selection of First-Listed Condition

In the outpatient setting, the term **first-listed diagnosis** is used (instead of the inpatient setting’s **principal diagnosis**), and it is determined in accordance with ICD-9-CM’s **coding conventions** (or rules) as well as general and disease-specific coding guidelines (which follow). Because diagnoses are often not established at the time of the patient’s initial encounter or visit, two or more visits may be required before the diagnosis is confirmed. An **outpatient** is a person treated in one of four settings:

- **Ambulatory surgery center (ASC)** where the patient is released prior to a 24-hour stay (length of stay must be 23 hours, 59 minutes, and 59 seconds or less).
- **Healthcare provider’s office** (e.g., physician).
- **Hospital clinic, emergency department, outpatient department, same-day surgery unit** (length of stay must be 23 hours, 59 minutes, and 59 seconds or less).
- **Hospital observation** where the patient’s length of stay is • 23 hours, 59 minutes, and 59 seconds or less (commercial insurance) (unless documentation for additional observation is medically justified) or • 24 to 48 hours (Medicare).

**Coding Tip:**

- **Outpatient Surgery.** When a patient presents for outpatient surgery, code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.
- **Observation Stay.** When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the first-listed diagnosis.
- **Outpatient Surgery that Requires Observation Stay.** When a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses.

**NOTE:** The outpatient first-listed diagnosis was previously called the **primary diagnosis** because it was the most significant condition for which services and/or procedures were provided.

An **inpatient** is a person admitted to a hospital or long-term care facility (LTCF) for treatment (or residential care, if LTCF) with the expectation that the patient will remain in the hospital for a period of 24 hours or more. The inpatient status is stipulated by the admitting physician.

You may see **principal diagnosis** referred to as **first-listed diagnosis** in medical literature. Remember! The outpatient setting’s first-listed diagnosis is **not** the principal diagnosis. The outpatient first-listed diagnosis code is reported in Block 21 of the CMS-1500 claim. The inpatient principal diagnosis is defined as “the condition determined after study which resulted in the patient’s admission to the hospital.” The principal diagnosis code is reported in Form Locator 67 of the UB-04 (CMS-1450) claim.

**Secondary diagnoses** include comorbidities and complications. A **comorbidity** is a concurrent condition that coexists with the first-listed diagnosis (outpatient care) or principal diagnosis (inpatient care), has the potential to affect treatment of the first-listed diagnosis (outpatient care) or principal diagnosis (inpatient care), and is an active condition for which the patient is treated and/or monitored. (Insulin-dependent diabetes mellitus is an example of a...
comorbidity.) A **complication** is a condition that develops after outpatient care has been provided (e.g., ruptured sutures after office surgery) or during an inpatient admission (e.g., inpatient develops postoperative wound infection). Secondary diagnoses are reported in Block 21 of the CMS-1500 claim and Form Locators 67A–67Q of the UB-04.

**EXAMPLE 1:** A patient seeks care at the healthcare provider’s office for an injury to the right leg that, upon x-ray in the office, is diagnosed as a fractured tibia. While in the office, the physician also reviews the current status and treatment of the patient’s type II diabetes.

- What is the first-listed diagnosis?
- What is the secondary diagnosis?
- Which diagnosis justifies medical necessity of the leg x-ray?
- Which diagnosis justifies medical necessity of the office visit?

**Answer:** The first-listed diagnosis is “fracture, shaft, right tibia”; the secondary diagnosis is “type II diabetes mellitus.” On the CMS-1500 claim, report the diagnoses codes in Block 21 and enter the diagnosis link in Block 24E for the corresponding service or procedure.

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>LINK TO SERVICE OR PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture, shaft, right tibia</td>
<td>x-ray of leg</td>
</tr>
<tr>
<td>Insulin-dependent diabetes mellitus</td>
<td>Office visit</td>
</tr>
</tbody>
</table>

**EXAMPLE 2:** The patient has a history of arteriosclerotic heart disease and was admitted to the hospital because of severe shortness of breath. After study, a diagnosis of congestive heart failure is added. What is the principal diagnosis?

**Answer:** The principal diagnosis is congestive heart failure. (This diagnosis was determined after study to be the cause of the patient’s admission to the hospital. Arteriosclerosis alone would not have caused the hospitalization. Shortness of breath is not coded because it is a symptom of congestive heart failure.)

**EXAMPLE 3:** A patient was admitted with hemoptysis. The following procedures were performed: upper GI series, barium enema, chest x-ray, bronchoscopy with biopsy of the left bronchus, and resection of the upper lobe of the left lung. The discharge diagnosis was bronchogenic carcinoma. What is the principal diagnosis?

**Answer:** The principal diagnosis is bronchogenic carcinoma, left lung. (The hemoptysis precipitated the need for hospitalization, but is a symptom of the underlying problem, bronchogenic carcinoma. After admission to the hospital and after study, the diagnostic tests revealed the carcinoma.)
B. ICD-9-CM Tabular List of Diseases (Codes 001.0 through V91.99)

The appropriate code or codes from 001.0 through V91.99 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or any other reason for the encounter/visit.

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

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

D. Selection of Codes 001.0 through 999.9

Codes 001.0 through 999.9 will frequently be used to describe the reason for the encounter. These codes are from the section of ICD-9-CM for the classification of diseases and injuries (e.g., infectious and parasitic diseases; neoplasms; symptoms, signs, and ill-defined conditions).

E. Codes that Describe Signs and Symptoms

Codes that describe signs and symptoms, as opposed to definitive diagnoses, are acceptable for reporting purposes when the physician has not documented an established or confirmed diagnosis. ICD-9-CM Chapter 16, “Symptoms, Signs, and Ill-defined Conditions” (780.0–799.9), contains many, but not all, codes for symptoms. Some symptom codes are located in other ICD-9-CM chapters that can be found by using the ICD-9-CM Index to Diseases.

F. Encounters for Circumstances Other than a Disease or Injury

ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01.0–V91.99) is provided to deal with occasions when circumstances other than disease or injury are recorded as diagnoses or problems.

Coding Tip:

Coding guidelines require the assignment of a secondary code that identifies the underlying condition (e.g., abnormality of gait, 781.2) when rehabilitation codes, V57.0–V57.9, are reported as the first-listed code on an insurance claim.

Certain V codes can be reported as a first-listed or additional diagnosis for outpatient care. If a claim is denied due to a V code, contact your regional CMS office or the HIPAA enforcement office for resolution.

In some cases, the first-listed diagnosis may be a sign or symptom when a diagnosis has not been established (confirmed) by the physician.

G. Level of Detail in Coding

ICD-9-CM disease codes contain three, four, or five digits. Codes with three digits are included in ICD-9-CM as the heading of a category of disease codes that may be further subdivided by the assignment of fourth or fourth and fifth digits, which provide greater specificity.

A three-digit disease code is to be assigned only if it is not further subdivided. Where fourth-digit subcategories or fifth-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code.
H. ICD-9-CM Code for the Diagnosis, Condition, Problem, or Other Reason for Encounter/Visit

Report first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. Then report additional codes that describe coexisting conditions that were treated or medically managed or that influenced the treatment of the patient during the encounter.

I. Uncertain Diagnoses

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

Another difference in coding inpatient hospitalizations versus outpatient and/or provider office encounters involves the assignment of codes for qualified diagnoses. A qualified diagnosis is a working diagnosis that is not yet proven or established. Terms and phrases associated with qualified diagnoses include suspected, rule out, possible, probable, questionable, suspicious for, and ruled out. For office visits, do not assign an ICD-9-CM code to qualified diagnoses; instead, code the sign(s) and/or symptom(s) documented in the patient’s chart.

EXAMPLE:

<table>
<thead>
<tr>
<th>For Qualified Diagnosis</th>
<th>Code the Sign or Symptom:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected pneumonia</td>
<td>Shortness of breath, wheezing, rales, and/or rhonchi</td>
</tr>
<tr>
<td>Questionable Raynaud’s</td>
<td>Numbness of hands</td>
</tr>
<tr>
<td>Ruled out wrist fracture</td>
<td>Wrist pain and/or swelling</td>
</tr>
<tr>
<td>Ruled out pneumonia</td>
<td>Influenza (flu)</td>
</tr>
</tbody>
</table>

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

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

J. Chronic Diseases

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
K. Code All Documented Conditions that Coexist

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

L. Patients Receiving Diagnostic Services Only

For patients receiving diagnostic services only during an encounter/visit, report first the diagnosis, condition, problem, or other reason for the encounter/visit that is documented in the patient record as being chiefly responsible for the outpatient services provided during the encounter/visit. (This is the first-listed diagnosis.)

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

In addition, report code(s) for other diagnoses (e.g., chronic conditions) that are treated or medically managed or would affect the diagnostic services provided to the patient during this encounter/visit.

M. Patients Receiving Therapeutic Services Only

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

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

The only exception is when the reason for admission/encounter is for chemotherapy, radiation therapy, or rehabilitation. For these services, the appropriate V code for the service is reported first, and the diagnosis or problem for which the service is being performed is reported second.

N. Patients Receiving Preoperative Evaluations Only

For patients receiving preoperative evaluation only, assign the appropriate subclassification code located under subcategory V72.8. Other specified examinations, to describe the preoperative consultation.

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

O. Ambulatory Surgery (or Outpatient Surgery)

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

P. Routine Outpatient Prenatal Visits

For routine outpatient prenatal visits when no complications are present, report code V22.0 (Supervision of normal first pregnancy) or V22.1 (Supervision of other normal pregnancy) as the first-listed diagnosis. Do not report these codes in combination with ICD-9-CM Chapter 11 codes.
ICD-9-CM CODING SYSTEM

The official version of ICD-9-CM was originally published in three volumes:

- **Volume 1 (Tabular List of Diseases).**
- **Volume 2 (Index to Diseases).**
- **Volume 3 (Index to Procedures and Tabular List of Procedures).**

Provider offices and healthcare facilities use the Tabular List of Diseases and Index to Diseases (Volumes 1 and 2 of ICD-9-CM) to code diagnoses. The Index to Procedures and Tabular List of Procedures (Volume 3) is used by hospitals to code inpatient procedures. Many publishers offer their own versions of ICD-9-CM; as a result, hospital (Volumes 1, 2, and 3) and outpatient (Volumes 1 and 2) editions of the coding manual are available. In addition, to make the coding procedure easier, publishers often place the Index to Diseases (Volume 2) in front of the Tabular List of Diseases (Volume 1).

ICD-9-CM Tabular List of Diseases (Volume 1)

The ICD-9-CM Tabular List of Diseases (Volume 1) contains 17 chapters that classify diseases and injuries, two supplemental classifications, and four appendices. The 17 chapters are organized as follows:

Chapter 1  Infectious and Parasitic Diseases (001–139)  
Chapter 2  Neoplasms (140–239)  
Chapter 3  Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders (240–279)  
Chapter 4  Diseases of the Blood and Blood Forming Organs (280–289)  
Chapter 5  Mental Disorders (290–319)  
Chapter 6  Diseases of the Nervous System and Sense Organs (320–389)  
Chapter 7  Diseases of the Circulatory System (390–459)  
Chapter 8  Diseases of the Respiratory System (460–519)  
Chapter 9  Diseases of the Digestive System (520–579)  
Chapter 10  Diseases of the Genitourinary System (580–629)  
Chapter 11  Complications of Pregnancy, Childbirth, and the Puerperium (630–679)  
Chapter 12  Diseases of the Skin and Subcutaneous Tissue (680–709)  
Chapter 13  Diseases of the Musculoskeletal System and Connective Tissue (710–739)  
Chapter 14  Congenital Anomalies (740–759)  
Chapter 15  Certain Conditions Originating in the Perinatal Period (760–779)  
Chapter 16  Symptoms, Signs, and Ill-defined Conditions (780–799)  
Chapter 17  Injury and Poisoning (800–999)

The two supplemental classifications are:

- **V codes**  
  Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01–V91)

- **E codes**  
  Supplementary Classification of External Causes of Injury and Poisoning (E000–E999)
The four appendices are:

- Appendix A  Morphology of Neoplasms (M Codes)
- Appendix C  Classification of Drugs by American Hospital Formulary Service List Number and Their ICD-9-CM Equivalents
- Appendix D  Classification of Industrial Accidents According to Agency
- Appendix E  List of Three-Digit Categories

**Supplementary Classifications: V Codes and E Codes**

ICD-9-CM V codes are located in a supplementary classification of the ICD-9-CM Tabular List of Diseases, and they are assigned for patient encounters when a circumstance other than a disease or injury is present. (ICD-9-CM V codes are indexed in the ICD-9-CM Index to Diseases.) Examples of ICD-9-CM V code assignment include:

- Removal of a cast applied by another physician (V54.89).
- Exposure to tuberculosis (V01.1).
- Personal history of breast cancer (V10.3).
- Well-baby checkup (V20.2).
- Annual physical examination (V70.0).

ICD-9-CM E codes, also located in a supplementary classification of the ICD-9-CM Tabular List of Diseases, describe external causes of injury, poisoning, or other adverse reactions affecting a patient's health. They are reported for environmental events, industrial accidents, injuries inflicted by criminal activity, and so on. Although assignment of these codes does not directly affect reimbursement to the provider, reporting E codes can expedite insurance claims processing because the circumstances related to an injury are indicated. (ICD-9-CM E codes are indexed in the ICD-9-CM Index to External Causes.)

**EXAMPLE 1:** A patient who falls at home in the kitchen and breaks his leg would have place of occurrence code E849.0 reported on the insurance claim (in addition to the fracture code). This code indicates that the patient's health insurance policy, and not a liability policy, should cover treatment.

**EXAMPLE 2:** A patient who falls at the grocery store and breaks his leg would have place of occurrence code E849.6 reported on the insurance claim (in addition to the fracture code). This code indicates that the store's liability insurance should be billed, not the patient's health insurance.

**Appendices**

ICD-9-CM appendices serve as a resource in coding neoplasms, adverse effects of drugs and chemicals, and external causes of disease and injury. In addition, the three-digit disease category codes are listed as an appendix. Some publishers (e.g., Ingenix's ICD-9-CM Experts for Hospitals Volumes 1, 2, & 3) include adjunct appendices such as major diagnostic categories (MDCs) (associated with diagnosis-related groups), diagnosis-related groups (DRG) categories, valid three-digit ICD-9-CM codes (those that do not require a fourth or fifth digit), and differences and similarities between inpatient and outpatient coding guidelines.
Morphology of Neoplasms (found in Appendix A of ICD-9-CM) contains a reference to the World Health Organization publication entitled International Classification of Diseases for Oncology (ICD-O). The appendix also interprets the meaning of each digit of the morphology code number. Morphology indicates the tissue type of a neoplasm. Morphology codes are reported to state cancer registries. A basic knowledge of morphology coding can be helpful to a coder because the name of the neoplasm documented in the patient’s chart does not always indicate whether the neoplasm is benign (not cancerous) or malignant (cancerous).

Referring to the morphology entry in the ICD-9-CM Index to Diseases helps determine which column in the Table of Neoplasms should be referenced to select the correct code. In addition, coding should be delayed until the pathology report is available in the patient’s chart for review.

EXAMPLE: The patient’s chart documents carcinoma of the breast. The Index to Diseases entry for carcinoma says “see also Neoplasm by site, malignant.” This index entry directs the coder to the Table of Neoplasms, and the code is selected from one of the first three columns (depending on whether the cancer is primary, secondary, or in situ—check the pathology report for documentation). (In situ is Latin for “in position” and refers to a malignant tumor that has not spread to deeper or adjacent tissues or organs.)

The Glossary of Mental Disorders (previously found in Appendix B of ICD-9-CM) corresponded to the psychiatric terms that appear in Chapter 5, “Mental Disorders,” and consisted of an alphabetic listing of terms and definitions based on those contained in ICD-9-CM and input from the American Psychiatric Association’s Task Force on Nomenclature and Statistics. Some definitions were based on those in A Psychiatric Glossary, Dorland’s Illustrated Medical Dictionary, and Stedman’s Medical Dictionary, Illustrated. This glossary has been permanently removed from ICD-9-CM and will not appear in future revisions. The mental health definitions it contained can be found in the DSM-IV manual published by the American Psychiatric Association.

EXAMPLE: Diagnosis chronic alcoholism (303.9x) requires the addition of a fifth digit to completely code the condition. Often providers do not document the term necessary to assign the fifth digit (e.g., chronic alcoholism that is continuous, episodic, or in remission); therefore, the coder must assign a fifth digit for “unspecified” (0). The DSM-IV defines alcoholism according to continuous, episodic, and in remission—depending on internal office or facility coding policies, the coder may be allowed to review these definitions and select the appropriate fifth digit based on documentation in the patient record (even if the provider did not document the specific term).

The ICD-9-CM Classification of Drugs by AHFS List (found in Appendix C of ICD-9-CM) contains the American Hospital Formulary Services List number and its ICD-9-CM equivalent code number, organized in numerical order according to AHFS List number. The List is published under the direction of the American Society of Hospital Pharmacists.

EXAMPLE: The patient’s chart documents a reaction to substance 76:00. By referring to the Classification of Drugs by AHFS List in Appendix C of ICD-9-CM, the coder can determine that 76:00 refers to oxytocics. The coder can then turn to the Table of Drugs and Chemicals in the Index to Diseases of ICD-9-CM and look up oxytocics (found in alphabetical order) to locate the reportable codes.
The ICD-9-CM Classification of Industrial Accidents According to Agency (found in Appendix D of ICD-9-CM) is based on employment injury statistics adopted by the Tenth International Conference of Labor Statisticians. Because it may be difficult to locate the E code entry in the ICD-9-CM Index to External Causes, coders may find the Industrial Accidents According to Agency appendix more helpful in identifying the category of equipment, and so on, for an external cause of injury.

**EXAMPLE:** The patient sustained an injury as the result of a malfunctioning combine reaper. While the E code for “accident, caused by, combine” can be easily located in the Index to External Causes, if the coder does not know what a combine reaper is, the location of the accident cannot be properly coded. The Industrial Accidents According to Agency appendix can be referenced to determine that a combine reaper is categorized under agricultural machines. Thus, the coder can assign the location E code as “Accident, occurring (at), farm.”

The ICD-9-CM List of Three-Digit Categories (found in Appendix E of ICD-9-CM) contains a breakdown of three-digit category codes organized beneath section headings.

**EXAMPLE:**

Acute rheumatic fever (390–392)

- 390 Rheumatic fever without mention of heart involvement
- 391 Rheumatic fever with heart involvement
- 392 Rheumatic chorea

**ICD-9-CM Index to Diseases (Volume 2)**

The ICD-9-CM Index to Diseases (Volume 2) contains three sections:

- **Index to Diseases.** This index includes two official tables that make it easier to code hypertension and neoplasms. Some publishers print special editions of ICD-9-CM manuals that contain additional tables to simplify the search for the correct code of other complex conditions.
- **Table of Drugs and Chemicals.** Adverse effects and poisonings associated with medicinal, chemical, and biological substances are coded by referring to this table.
- **Index to External Causes (E codes).** This separate index is often forgotten; it is helpful to mark it with a tab as a reminder of its usefulness.

**ICD-9-CM Index to Procedures and Tabular List of Procedures (Volume 3)**

The ICD-9-CM Index to Procedures and Tabular List of Procedures (Volume 3) is included in the hospital version of commercial ICD-9-CM books. It is a combined alphabetical index and numerical listing of inpatient procedures. Hospital outpatient departments and healthcare providers’ offices use the Current Procedural Terminology (CPT) published by the American Medical Association (AMA), and/or additional codes created by CMS to augment CPT codes on Medicare claims. These special CMS codes are known as HCPCS level II codes. HCPCS stands for Healthcare Common Procedure Coding System. (CPT and HCPCS level II codes are further discussed in Chapters 7 and 8 of this textbook.)
ICD-9-CM INDEX TO DISEASES

The Index to Diseases is an alphabetical listing of main terms or conditions. The items are printed in boldface type and may be expressed as nouns, adjectives, or eponyms (Figure 6A-3).

ICD-10-CM ALERT!
The ICD-10-CM index contains an arrangement of entities, diseases, and other conditions, similar to ICD-9-CM, according to the axis of classification (organizing entities, diseases, and other conditions according to etiology, anatomy, or severity).

Main Terms

Main terms (conditions) are printed in boldface type and are followed by the code number. Main terms may or may not be followed by a listing of parenthetical terms that serve as nonessential modifiers of the main term (see the main term in Figure 6A-3). Nonessential modifiers are supplementary words located in parentheses after a main term. They do not have to be included in the diagnostic statement for the code number to be assigned. Qualifiers are supplementary terms that further modify subterms and other qualifiers.

<table>
<thead>
<tr>
<th>START OF MAIN TERM IN INDEX TO DISEASES</th>
<th>CONTINUATION OF MAIN TERM AT TOP OF NEXT COLUMN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Term: Deformity 738.9</td>
<td>Main Term: Deformity—continued</td>
</tr>
<tr>
<td>Subterm: aortic</td>
<td>Subterm: appendix 751.5</td>
</tr>
<tr>
<td>Second Qualifier: arch 747.21</td>
<td>Subterm: arm (acquired) 736.89</td>
</tr>
<tr>
<td>Third Qualifier: acquired 447.8</td>
<td>Second Qualifier: congenital 755.50</td>
</tr>
</tbody>
</table>

Subterms

Subterms (or essential modifiers) qualify the main term by listing alternate sites, etiology, or clinical status. A list of subterms is indented two spaces under the main term. Secondary qualifying conditions are indented two spaces under a subterm.

FIGURE 6A-3 Display of main terms, subterms (essential modifiers), and qualifiers in the ICD-9-CM Index to Diseases.
Great care must be taken when moving from the bottom of one column to the top of the next column or when turning the page. The main term will be repeated and followed by “—continued.” Watch carefully to determine if the subterm has changed or new second or third qualifiers appear when moving from one column to another.

**ICD-9-CM CODING**

**EXAMPLE:** The ICD-9-CM Index to Diseases entries are organized according to main terms, subterms, second qualifiers, and third qualifiers. Refer to the index entry for “Deformity, aortic arch, acquired (447.8)” and review the indented subterm and qualifiers. Notice that when the main term continues at the top of a column (or on the next page of the Index to Diseases), the term “—continued” appears after the main term, and subterms and qualifiers are indented below the main term.

**ICD-10 ALERT!**
The ICD-10-CM Index to Diseases entries are also organized according to main terms, subterms, second qualifiers, and third qualifiers.

**CODING TIP:**

1. A subterm or essential modifier provides greater specificity when included in the diagnosis. Select the code number stated after the essential modifier, not the one stated after the main condition. For example, the code to investigate in the Tabular List of Diseases for “acquired AC globulin deficiency” is 286.7.

2. Always consult the code description in the Tabular List of Diseases before assigning a code, because one or more instructional notes not included in the Index to Diseases may change the code selection.

**ICD-10 ALERT!**
In ICD-10-CM, the code located after the main term is called the “default code.”

**Using the Index to Diseases**

**STEP 1 Locate the main term in the Index to Diseases (Volume 2).**

This is accomplished by first locating the condition’s boldfaced main term and then reviewing the subterms listed below the main term to locate the proper disorder.

Underlined terms in the following examples are the conditions to locate in the Index to find possible codes.

**EXAMPLE:** Irritability of the bladder

- Impacted feces
- Comminuted fracture, left radius
- Upper respiratory infection

Table 6A-1 is a list of special main terms that should be considered when the main condition is not obvious from the healthcare provider’s diagnostic statement.

**STEP 2 If the phrase “—see condition” is found after the main term, a descriptive term (an adjective) or the anatomic site has been referenced instead of the disorder or the disease (the condition) documented in the diagnostic statement.**

**EXAMPLE:** The provider’s diagnostic statement is myocardial infarction.

In the Index to Diseases, look up the word myocardial. Notice that the phrase “—see condition” appears next to the word myocardial.

The phrase is instructing you to refer to the condition instead. In this case, the condition is infarction.
TABLE 6A-1 Main terms to use when the condition is difficult to find in the Index to Diseases

<table>
<thead>
<tr>
<th>Abnormal</th>
<th>Disease</th>
<th>Infection</th>
<th>Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>Disorder</td>
<td>Injury</td>
<td>Problem (with)</td>
</tr>
<tr>
<td>Aftercare</td>
<td>Examination</td>
<td>Late</td>
<td>Puerperal</td>
</tr>
<tr>
<td>Anomaly</td>
<td>Exposure to</td>
<td>Lesion(s)</td>
<td>Status (post)</td>
</tr>
<tr>
<td>Attention to</td>
<td>Foreign Body</td>
<td>Newborn</td>
<td>Syndrome</td>
</tr>
<tr>
<td>Complications</td>
<td>History (family) of Observation</td>
<td></td>
<td>Vaccination</td>
</tr>
</tbody>
</table>

**STEP 3** When the condition listed is not found, locate main terms such as syndrome, disease, disorder, derangement of, or abnormal. See Table 6A-1, which lists special main terms for additional help.

**EXAMPLE:** For the condition gum attrition, the main term attrition and subterm gum are found in the ICD-9-CM Index to Diseases. When code 523.20 is verified in the tabular list, the term attrition is not found; however, code 523.20 is still the correct code. (This is an example of “trust the index.”)

If unsuccessful in finding a code using the main terms suggested in Table 6A-1, turn to Appendix E—Three-Digit Categories—in the back of the ICD-9-CM code book. Review the categories listed under the chapter heading to determine which best fits the site of the patient’s problem.

When you need a code that describes an external cause of injury, look for these conditions in the separate E code index located after the Table of Drugs and Chemicals at the back of the Index to Diseases.

**EXERCISE 6A-1**

Finding the Condition in the Index to Diseases

**NOTE:** Items 6 through 8 are rather uncommon disorders, but they are listed in the Index.

Underline the condition in each of the following items, then, using only the Index to Diseases, locate the main term and the code number. Write the code number on the blank line provided.

1. Bronchiole spasm
2. Congenital candidiasis (age 3)
3. Irritable bladder
4. Fracture, alveolus (closed)
5. Exposure to AIDS
6. Ground itch
7. Nun’s knees
8. Mice in right knee joint
9. Contact dermatitis
10. Ascending neuritis


## Coding Conventions

**Coding conventions** are rules that apply to the assignment of ICD-9-CM (and ICD-10-CM/PCS) codes. They can be found in the Index to Diseases (Table 6A-2), Tabular List of Diseases (Table 6A-3), and Index to Procedures and Tabular List of Procedures (Table 6A-4).

### TABLE 6A-2  Coding conventions for the ICD-9-CM Index to Diseases

<table>
<thead>
<tr>
<th>CODING CONVENTION &amp; EXAMPLE</th>
<th>INDEX TO DISEASES ENTRY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CODES IN SLANTED BRACKETS</strong></td>
<td><strong>Diabetes, diabetic</strong> (brittle) (congenital) (familial) (mellitus) (severe) (slight) (without complication) 250.0 cataract 250.5 [366.41]</td>
</tr>
<tr>
<td><strong>EXAMPLE:</strong> Diabetic cataract.</td>
<td><strong>ICD-10 ALERT!</strong> The ICD-10-CM index contains “codes in brackets” (instead of “codes in slanted brackets”), which means italics have been removed in the formatting of this coding convention. “Codes in brackets” are always listed as secondary codes because they are manifestations (or results) of other conditions.</td>
</tr>
<tr>
<td><strong>EPONYMS</strong></td>
<td><strong>Syndrome</strong> see also Disease Barlow’s Syndrome.</td>
</tr>
<tr>
<td><strong>EXAMPLE:</strong> Barlow’s Syndrome.</td>
<td><strong>ESSENTIAL MODIFIERS</strong> are subterms that are indented below the main term in alphabetical order (except for “with” and “without”). The essential modifier clarifies the main term and must be contained in the diagnostic statement for the code to be assigned.</td>
</tr>
<tr>
<td><strong>EXAMPLE:</strong> Acute necrotizing encephalitis.</td>
<td><strong>Encephalitis</strong> (bacterial) (chronic) (hemorrhagic) (idiopathic) (nonepidemic) (spurious) (subacute) 323.9 acute—see also Encephalitis, viral disseminated (postinfectious) NEC 136.9 [323.61] postimmunization or postvaccination 323.51 inclusional 049.8 inclusional body 049.8 necrotizing 049.8</td>
</tr>
<tr>
<td><strong>NEC (not elsewhere classifiable)</strong> identifies codes to be assigned when information needed to assign a more specific code cannot be located in the ICD-9-CM coding book.</td>
<td><strong>Encephalitis</strong> (bacterial) (chronic) (hemorrhagic) (idiopathic) (nonepidemic) (spurious) (subacute) 323.9 acute—see also Encephalitis, viral disseminated (postinfectious) NEC 136.9 [323.61]</td>
</tr>
<tr>
<td><strong>EXAMPLE:</strong> Disseminated encephalitis.</td>
<td><strong>NONESSENTIAL MODIFIERS</strong> are subterms that are enclosed in parentheses following the main term. They clarify the code selection, but they do not have to be present in the provider’s diagnostic statement.</td>
</tr>
<tr>
<td><strong>EXAMPLE:</strong> Cerebral pseudomeningocele. In this example, cerebral pseudomeningocele and pseudomeningocele are both assigned code 349.2.</td>
<td><strong>Pseudomeningocele</strong> (cerebral) (infective) 349.2 postprocedural 997.01 spinal 349.2</td>
</tr>
</tbody>
</table>

(continues)
### TABLE 6A-2 (continued)

<table>
<thead>
<tr>
<th>CODING CONVENTION &amp; EXAMPLE</th>
<th>INDEX TO DISEASES ENTRY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NOTES</strong> are contained in boxes to define terms, clarify index entries, and list choices for additional digits (e.g., fourth and fifth digits). <strong>EXAMPLE:</strong> Spontaneous breech delivery. In this example, assign code 652.21.</td>
<td>Delivery</td>
</tr>
<tr>
<td><strong>SEE</strong> directs the coder to a more specific term under which the code can be found. <strong>EXAMPLE:</strong> Traumatic delirium, with spinal cord lesion. The coder is directed to the index entry “injury, spinal, by site” and code 952.9 would be assigned.</td>
<td>Delirium, delirious 780.09 traumatic—see also Injury, intracranial with lesion, spinal cord—see Injury, spinal, by site</td>
</tr>
<tr>
<td><strong>SEE ALSO</strong> refers the coder to an index entry that may provide additional information to assign the code. <strong>EXAMPLE:</strong> Mucus inhalation. The coder is directed to the index entry “Asphyxia, mucus”; in this case, there is no added information that would change the code.</td>
<td>Inhalation</td>
</tr>
<tr>
<td><strong>SEE ALSO CONDITION</strong> refers the coder to the patient's condition for code assignment. <strong>EXAMPLE:</strong> Late pregnancy. Main term “Late” directs the coder to “see also condition” because subterm “pregnancy” is not listed. (In this case, the coder would refer to main term “Pregnancy” as the condition.) <strong>SEE CATEGORY</strong> refers the coder directory to the Tabular List of Diseases three-digit code for code assignment. <strong>EXAMPLE:</strong> Late effect of intracranial abscess. The coder is directed to “see category” when main term “Late” and subterms “effect, abscess, intracranial” are located in the Index to Diseases.</td>
<td>Late—see also condition effect(s) (of)—see also condition abscess intracranial or intraspinal (conditions classifiable to 324) see category 326</td>
</tr>
</tbody>
</table>

### EXERCISE 6A-2

**Working with Coding Conventions (Index to Diseases)**

Underline the main term (condition) found in the Index to Diseases, and enter the ICD-9-CM code number and index convention on the blank lines.

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>ICD-9-CM CODE</th>
<th>INDEX CONVENTION USED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute purulent sinusitis</td>
<td>461.9</td>
<td>(purulent) is a nonessential modifier</td>
</tr>
<tr>
<td>2. Fracture, mandible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Actinomycotic meningitis
4. Psychomotor akinetic epilepsy
5. 3-cm laceration, right forearm
6. Contusion, abdominal organ
7. Pneumonia due to *H. influenzae*
8. Delayed healing, open wound, abdomen
9. Bile duct cicatrix
10. Uncontrolled type II diabetes mellitus with osteomyelitis

### ICD-9-CM TABULAR LIST OF DISEASES

ICD-9-CM codes for Chapters 1 through 17 (codes 001–999.9) are organized according to three-digit category codes. Specificity is achieved by assigning a decimal point and one or two digits, known as fourth (subcategory codes) and fifth (subclassification codes) digits, to the main three-digit code number (Figure 6A-4). Two supplemental classifications also classify health status (V codes) and external causes of injuries and poisonings (E codes).

V codes (supplementary classification) are expressed as a three-character alphanumeric code (the letter V plus two digits) that can be subdivided with fourth and fifth digits to provide a more definitive description (Figure 6A-5).

E codes (supplementary classification) are expressed as a four-character alphanumeric code (the letter E plus three digits). One additional decimal digit may be required to provide a more specific description of the external cause of the injury or poisoning (see Figure 6A-5). E codes are always secondary diagnostic codes. They are never reported as the first-listed diagnosis code on claims.

### Chapters

The chapter heading is printed in uppercase letters and is preceded by the chapter number. The instructional “Notes” that follow the chapter heading detail general guidelines for code selections within the entire chapter. If the note(s) include an **EXCLUDES** statement, the reference applies to the entire chapter (see Figure 6A-4).

**EXAMPLE:** Refer to Figure 6A-4 and the Chapter 3 heading, “Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders” (240–279). Notice that an **EXCLUDES** statement is located just below the chapter heading along with a regular note. Both references apply to all codes contained within the chapter.

### Major Topic Headings

ICD-9-CM chapters are subdivided into **major topic headings** printed in bold uppercase letters and followed by a range of codes enclosed in parentheses. Any note or
## DISORDERS OF THE THYROID GLAND (240–246)

**240** Simple and unspecified goiter

**DEF:** An enlarged thyroid gland often caused by an inadequate dietary intake of iodine.

- **240.0** Goiter, specified as simple
  - Any condition classifiable to 240.9, specified as simple
- **240.9** Goiter, unspecified
  - Enlargement of thyroid tissue
  - Goiter or struma:
    - NOS
    - Diffuse colloid
    - Nontoxic (diffuse)
    - Hyperplastic
    - Endemic
    - Sporadic

**EXCLUDES:** congenital (dyshormonogenic) goiter

**240.0** Diabetes mellitus without mention of complication or manifestation classifiable to 250.1–250.9

**DEF:** Diabetes mellitus: Inability to metabolize carbohydrates, proteins, and fats with insufficient secretion of insulin. Symptoms may be unremarkable, with long-term complications, involving kidneys, nerves, blood vessels, and eyes.

**DEF:** Uncontrolled diabetes: A nonspecific term indicating that the current treatment regimen does not keep the blood sugar level of a patient within acceptable levels.

### DISEASES OF OTHER ENDOCRINE GLANDS (249-259)

**250** Diabetes mellitus

**EXCLUDES:**
- Gestational diabetes (648.8)
- Hyperglycemia NOS (780.9)
- Neonatal diabetes mellitus (757.1)
- Nonclinical diabetes (790.2)
- Secondary diabetes (249.0–249.9)

The following fifth-digit subclassification is for use with category 250:

- **0** type II or unspecified type, not stated as uncontrolled
  - Fifth-digit 0 is for use for type II patients, even if the patient requires insulin
  - Use additional code, if applicable, for associated long-term (current) insulin use V58.67
- **1** type I (juvenile type), not stated as uncontrolled
- **2** type II or unspecified type, uncontrolled
  - Fifth-digit 2 is for use for type II patients, even if the patient requires insulin
  - Use additional code, if applicable, for associated long-term (current) insulin use V58.67
- **3** type I (juvenile type), uncontrolled
  - Def: Diabetes mellitus: inability to metabolize carbohydrates, proteins, and fats with insufficient secretion of insulin. Symptoms may be unremarkable, with long-term complications, involving kidneys, nerves, blood vessels, and eyes.

**DEF:** Uncontrolled diabetes: A nonspecific term indicating that the current treatment regimen does not keep the blood sugar level of a patient within acceptable levels.

**250.0** Diabetes mellitus without mention of complication or manifestation classifiable to 250.1–250.9

**DEF:** Diabetes mellitus: Inability to metabolize carbohydrates, proteins, and fats with insufficient secretion of insulin. Symptoms may be unremarkable, with long-term complications, involving kidneys, nerves, blood vessels, and eyes.

**DEF:** Uncontrolled diabetes: A nonspecific term indicating that the current treatment regimen does not keep the blood sugar level of a patient within acceptable levels.

- **250.0** Diabetes mellitus without mention of complication or manifestation classifiable to 250.1–250.9
  - Diabetes mellitus NOS
- **250.1** Diabetes with ketoacidosis
  - Diabetic acidosis
  - Ketoacidosis
  - without mention of coma
  - without mention of coma

**DEF:** Diabetic hyperglycemic crisis causing ketone presence in body fluids.
### V Codes

**PERSONS WITHOUT REPORTED DIAGNOSIS ENCOUNTERED DURING EXAMINATION AND INVESTIGATION OF INDIVIDUALS AND POPULATIONS (V70–V96)**

Note: Nonspecific abnormal findings disclosed at the time of these examinations are classifiable to categories 790–796.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V70</td>
<td>General medical examination</td>
</tr>
<tr>
<td>V70.0</td>
<td>Routine general medical examination at a healthcare facility</td>
</tr>
<tr>
<td>V70.1</td>
<td>General psychiatric examination, requested by the authority</td>
</tr>
<tr>
<td>V70.2</td>
<td>General psychiatric examination, other and unspecified</td>
</tr>
<tr>
<td>V70.3</td>
<td>Other medical examination for administrative purposes</td>
</tr>
<tr>
<td>V70.4</td>
<td>Examination for medicolegal reasons</td>
</tr>
</tbody>
</table>

**EXCLUDES**

- Health checkup of infant or child (V20.2)
- Pre-procedural general physical examination (V72.83)

### E Codes

**DRUGS, MEDICINAL AND BIOLOGICAL SUBSTANCES CAUSING ADVERSE EFFECTS IN THERAPEUTIC USE (E930–E949)**

**INCLUDES:**

- Correct drug properly administered in therapeutic or prophylactic dosage, as the cause of any adverse effect including allergic or hypersensitivity reactions

**EXCLUDES:**

- Accidental overdose of drug and wrong drug given or taken in error (E850.0–E858.9)
- Accidents in the technique of administration of drug or biological substance, such as accidental puncture during injection, or contamination of drug (E870.0–E876.9)
- Administration with suicidal or homicidal intent or intent to harm, or in circumstances classifiable to E980–E989 (E950.0–E950.5, E962.0, E980.0–E980.5)
- Accidental overdose of drug and wrong drug given or taken in error (E850.0–E858.9)
- Accidents in the technique of administration of drug or biological substance, such as accidental puncture during injection, or contamination of drug (E870.0–E876.9)
- Administration with suicidal or homicidal intent or intent to harm, or in circumstances classifiable to E980–E989 (E950.0–E950.5, E962.0, E980.0–E980.5)

**INCLUDES:**

- That used as eye, ear, nose, and throat (ENT), and local anti-infectives (E946.0–E946.9)

**EXCLUDES:**

- Accidental overdose of drug and wrong drug given or taken in error (E850.0–E858.9)
- Accidents in the technique of administration of drug or biological substance, such as accidental puncture during injection, or contamination of drug (E870.0–E876.9)
- Administration with suicidal or homicidal intent or intent to harm, or in circumstances classifiable to E980–E989 (E950.0–E950.5, E962.0, E980.0–E980.5)

**EXCLUDES:**

- That used as eye, ear, nose, and throat (ENT), and local anti-infectives (E946.0–E946.9)

**EXCLUDES:**

- That caused by accidental overdosage and wrong drug given or taken in error (E850.0–E858.9)
- Accidents in the technique of administration of drug or biological substance, such as accidental puncture during injection, or contamination of drug (E870.0–E876.9)
- Administration with suicidal or homicidal intent or intent to harm, or in circumstances classifiable to E980–E989 (E950.0–E950.5, E962.0, E980.0–E980.5)

### FIGURE 6A-5

Sample pages from ICD-9-CM Supplementary Classifications, Tabular List of Diseases—V and E codes.

**EXCLUDES** statement printed below a major topic heading applies only to the code numbers listed in parentheses after the major topic heading, not to the entire chapter.

**EXAMPLE:**

**PSYCHOSES** (290–299)

**EXCLUDES** mental retardation (317–319)

### Categories

Major topics are divided into three-digit categories. The **categories** are printed in bold upper- and lowercase type and are preceded by a three-digit code. Any **EXCLUDES** note that appears at this point applies to all three-, four-, or five-digit disease codes in the category.

**EXAMPLE:** Refer to Figure 6A-4 and locate category code 250 Diabetes mellitus. Notice the **EXCLUDES** statement below category 250. This reference applies to all codes classified within category 250 codes.
Subcategories

Fourth-digit subcategories are indented and printed in the same fashion as the major category headings (see Figure 6A-4). An excludes note found at this level applies only to the specific fourth-digit code.

**EXAMPLE:** Refer to Figure 6A-4 and locate subcategory codes 240.0 Goiter, specified as simple and 240.9 Goiter, unspecified. As this condition contains codes at the subcategory (fourth-digit) level, it is incorrect to report the three-digit code (240) on an insurance claim.

Subclassifications

Some fourth-digit subcategories are further subdivided into subclassifications, which require the assignment of a fifth digit. This requirement is indicated by the presence of a section mark ($§$), a red dot, or some other symbol, depending on the publisher of the code book. The placement and appearance of fifth digits are not standardized throughout ICD-9-CM. As you assign codes, you will notice varying fifth-digit placement.

**REMEMBER!**

Fifth digits are required when indicated in the code book.

Fifth-digit entries are associated with:

- chapters
- major topic headings
- categories
- subcategories

**EXAMPLE 1:** Fifth-Digit Entries Associated with Chapters

Refer to Chapter 13, Diseases of the Musculoskeletal System and Connective Tissue (710–739). The fifth-digit subclassification listed below the chapter heading is limited to certain categories (711–712, 715–716, 718–719, 730) in Chapter 13. The remaining categories in Chapter 13 either do not require the use of a fifth-digit subclassification (e.g., category 713) or the fifth-digit subclassification to be used is listed within specific subcategories (e.g., 714.3).

**EXAMPLE 2:** Fifth-Digit Entries Associated with Major Topic Headings

Refer to major topic heading, Tuberculosis (010–018). The fifth-digit subclassification listed below the major topic heading is to be used with codes 010 through 018.

**EXAMPLE 3:** Fifth-Digit Entries Associated with Categories

Refer to category code 250 Diabetes mellitus. The fifth-digit subclassification listed below the category code is to be used with all subcategory codes.
EXAMPLE 4: Fifth-Digit Entries Associated with Subcategories
Refer to subcategory code 438.1. The fifth-digit subclassifications listed are to be used with subcategory 438.1 only. There are different fifth-digit subclassifications for subcategories 438.2, 438.3, and so on. Notice that subcategory codes 438.0, 438.6, 438.7, and 438.9 do not contain a fifth-digit subclassification list. They are considered complete as four-digit subcategory codes.

Using the Tabular List of Diseases

STEP 1 Locate the first possible code number after reviewing main terms and subterms in the Index to Diseases.

STEP 2 Locate the code number in the Tabular List of Diseases, and review the code descriptions. Review any EXCLUDES notes to determine whether the condition being coded is excluded.

If the condition is excluded, locate the code number listed as an alternative in the EXCLUDES note to determine whether it is the condition to be coded.

STEP 3 Assign any required fourth and fifth digits.

STEP 4 Check to be sure the code number is appropriate for the age and gender of the patient.

STEP 5 Return to the Index to Diseases for other possible code selections if the code description in the Tabular List of Diseases does not appear to fit the condition or reason for the visit.

STEP 6 Enter the final code selection.

EXERCISE 6A-3

Confirming Codes in the Tabular List of Diseases

Using only the Tabular List of Diseases, verify the following code numbers to determine whether the code matches the stated diagnosis or an EXCLUDES statement applies.

- Place a “C” on the blank line if the code number is confirmed.
- Place an “E” on the blank line if the condition is excluded.
- Enter required fifth digits if applicable.

1. 515 Postinflammatory pulmonary fibrosis
2. 250 Gestational diabetes
3. 727.67 Nontraumatic rupture of Achilles tendon
4. 422.0 Acute myocarditis due to Coxsackie virus

(continues)
ICD-9-CM Tabular List of Diseases Coding Conventions

Tabular List of Diseases coding conventions (Table 6A-3) apply to disease and condition codes and to supplementary classification codes (e.g., factors influencing health status and contact with health services [ICD-9-CM V codes], as well as external causes of injury and poisoning [ICD-9-CM E codes]).

<table>
<thead>
<tr>
<th>CODING CONVENTION</th>
<th>TABULAR LIST OF DISEASES ENTRY</th>
</tr>
</thead>
</table>
| **AND** is interpreted as “and/or” and indicates that either of the two disorders is associated with the category code. | 466 Acute bronchitis and bronchiolitis  
466.0 Acute bronchitis  
466.1 Acute bronchiolitis |
| **BOLD TYPE** is used for all category and subcategory codes and descriptions are printed in bold type. | 421 Acute and subacute endocarditis  
421.0 Acute and subacute bacterial endocarditis  
421.1 Acute and subacute infective endocarditis in diseases classified elsewhere |
| **BRACES** enclose a series of terms, each of which modifies the statement located to the right of the brace. | 478.5 Other diseases of vocal cords  
Abscess  
Cellulitis  
Granuloma  
Leukoplakia  
Other diseases of vocal cords  
Singers’ nodes |
| **BRACKETS** enclose synonyms, alternate wording, or explanatory phrases. | 482.2 Pneumonia due to Hemophilus influenzae [H. influenzae] |
| **CODE FIRST UNDERLYING DISEASE** appears when the code referenced is to be sequenced as a secondary code. The code, title, and instructions are italicized. | 366.42 Tetanic cataract  
Code first underlying disease, as:  
calcinosis (275.4)  
hypoparathyroidism (252.1) |
| **COLON** is used after an incomplete term and is followed by one or more modifiers (additional terms) | 472.0 Chronic rhinitis  
Ozena  
Rhinitis:  
NOS  
atrophic  
granulomatous  
hypertrophic  
obstructive  
purulent  
ulcerative |

(continues)
### CODING CONVENTION

**EXCLUDES** note directs the coder to another location in the codebook for proper assignment of the code.

### ICD-10 ALERT!

There are two types of excludes notes in ICD-10-CM:
- Excludes1 is a pure excludes note and means “not coded here!” The code excluded is never reported with the code above an Excludes1 note.
- Excludes2 means “not included here”; if the patient receives treatment for the excluded condition, an ICD-10-CM code is assigned to it.

### FORMAT

Is the way all additional terms are indented below the term to which they are linked, and if a definition or disease requires more than one line, that text is printed on the next line and further indented. (The additional terms are called description statements, which are located below the code description and include definitions, synonyms, types of complications, and so on.)

### FOURTH & FIFTH DIGITS

Are indicated by an instructional note located below the category or subcategory description.

---

### TABLE 6A-3  (continued)

<table>
<thead>
<tr>
<th>CODING CONVENTION</th>
<th>TABULAR LIST OF DISEASES ENTRY</th>
</tr>
</thead>
</table>
| **EXCLUDES** note directs the coder to another location in the codebook for proper assignment of the code. | 250 Diabetes mellitus  

**EXCLUDES**

- gestational diabetes (648.8)  
- hyperglycemia NOS (790.29)  
- neonatal diabetes mellitus (775.1)  
- nonclinical diabetes (790.29)  
- secondary diabetes (249.0–249.9)

| **FORMAT** is the way all additional terms are indented below the term to which they are linked, and if a definition or disease requires more than one line, that text is printed on the next line and further indented. (The additional terms are called description statements, which are located below the code description and include definitions, synonyms, types of complications, and so on.) | 455.2 Internal hemorrhoids with other complication  

**Internal hemorrhoids:**

- bleeding  
- prolapsed  
- strangulated  
- ulcerated

| **FOURTH & FIFTH DIGITS** are indicated by an instructional note located below the category or subcategory description. | 250 Diabetes mellitus  

**EXCLUDES**

- gestational diabetes (648.8)  
- hyperglycemia NOS (790.29)  
- neonatal diabetes mellitus (775.1)  
- nonclinical diabetes (790.29)  
- secondary diabetes (249.0–249.9)

The following fifth-digit subclassification is for use with category 250:

- **0** type II or unspecified type, not stated as uncontrolled  
  
  Fifth-digit 0 is for use for type II patients, even if the patient requires insulin  
  
  Use additional code, if applicable, for associated long-term (current) insulin use V58.67

- **1** type I [juvenile type], not stated as uncontrolled

- **2** type II or unspecified type, uncontrolled  
  
  Fifth-digit 2 is for use for type II patients, even if the patient requires insulin  
  
  Use additional code, if applicable, for associated long-term (current) insulin use V58.67

- **3** type I [juvenile type], uncontrolled

(continues)
<table>
<thead>
<tr>
<th>CODING CONVENTION</th>
<th>TABULAR LIST OF DISEASES ENTRY</th>
</tr>
</thead>
</table>
| **INCLUDES** notes appear below a three-digit category code description to further define, clarify, or provide an example. | **244** Acquired hypothyroidism  
  **INCLUDES**  
  athyroidism (acquired)  
  hypothyroidism (acquired)  
  myxedema (adult) (juvenile)  
  thyroid (gland) insufficiency (acquired) |
| **NOS** is the abbreviation for “not otherwise specified” and indicates that the code is unspecified. Coders should ask the provider for a more specific diagnosis before assigning the code. (Whereas NEC is the abbreviation for “not elsewhere classifiable” and indicates a specific code is not available for a condition, NOS identifies the code as an “other” or “other specified” code.) | **008.8** Intestinal infection due to other organism, NEC  
  **Viral** enteritis NOS  
  gastroenteritis  
  **EXCLUDES** influenza with involvement of gastrointestinal tract (487.8) |
| **NOTES** define terms, clarify information, and list choices for fourth and fifth digits. | **1. INFECTIOUS AND PARASITIC DISEASES (001–139)**  
  **NOTE:** Categories for “late effects” of infectious and parasitic diseases are found at 137–139. |
| **PARENTHESES** enclose supplementary words that may be present or absent in the diagnostic statement, without affecting assignment of the code number. | **241.1** Nontoxic multinodular goiter  
  Multinodular goiter (nontoxic) |
| **USE ADDITIONAL CODE** indicates that a second code is to be reported to provide more information about the diagnosis. | **510** Empyema  
  **Use additional code** to identify infectious organism (041.0–041.9) |
| **WITH** is used when codes combine one disorder with another (e.g., code that combines primary condition with a complication). The provider’s diagnostic statement must clearly indicate that both conditions are present and that a relationship exists between the conditions. | **454** Varicose veins of lower extremities  
  **454.0** With ulcer |

**NOTE:** An exception to this rule is “chronic renal failure and hypertension,” which assumes a relationship between the conditions.
EXERCISE 6A-4

Working with Tabular List of Diseases Coding Conventions

Underline the main term (condition) to be referenced in the Index to Diseases, and apply index coding conventions in locating the code. Verify the code selected in the tabular list. Enter the ICD-9-CM code number(s) and tabular list coding convention used on the blank lines provided. If more than one code number is assigned, be sure to list the first-listed condition code first.

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>ICD-9-CM CODE(S)</th>
<th>TABULAR LIST OF DISEASES CONVENTION(S) USED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnancy complicated by chronic gonorrhea; chronic gonococcal endometritis</td>
<td>647.10 098.36</td>
<td>fifth digit required use additional code</td>
</tr>
<tr>
<td>2. Benign neoplasm, ear cartilage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Cervicitis, tuberculous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Uncontrolled type II diabetes with polyneuropathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Congenital hemangioma on face</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Hiss-Russell shigellosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Closed fracture, right leg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Diabetic cataract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Muscular atrophy, left leg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Chronic smoker’s cough with acute bronchitis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ICD-10 ALERT!

Effective October 1, 2013, the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) will be implemented (replacing ICD-9-CM, Volume 3). ICD-10-PCS is covered in Chapter 6B of this textbook.

ICD-9-CM INDEX TO PROCEDURES AND TABULAR LIST OF PROCEDURES

As mentioned previously, the Index to Procedures and Tabular List of Procedures (Volume 3) is included only in the hospital version of commercial ICD-9-CM books. It is a combined alphabetical index and numerical listing of inpatient procedures. Hospital outpatient departments and healthcare providers’ offices report procedures and services using Current Procedural Terminology (CPT) and HCPCS level II national codes.

Principal versus Secondary Procedures

Depending on third-party payer guidelines, hospital inpatient coders may be required to differentiate between principal and secondary procedures rendered using the criteria discussed in the following text. (CMS no longer requires identification of the principal procedure.) These criteria do not affect coding for healthcare providers’ offices but are discussed here to introduce the full scope of ICD-9-CM diagnosis and procedure coding. Hospitals are required to rank all inpatient procedures according to specific criteria for selection of principal and secondary procedures and to code them using the ICD-9-CM procedure index and tabular list.
A principal procedure is a procedure performed for definitive treatment rather than diagnostic purposes; one performed to treat a complication; or one that is most closely related to the principal diagnosis. There may be cases in which procedures performed are not directly related to the principal diagnosis, but are related to secondary conditions. In such cases, the principal procedure is considered to be the major definitive treatment performed. Secondary procedures are additional procedures performed during the same encounter as the principal procedure.

**EXAMPLE 1:** A patient was admitted to the hospital because of a fractured left hip. During the hospital stay, the patient developed a pulmonary embolism. The following procedures were performed: x-rays of the right and left hips, a lung scan, and a surgical pinning of the hip. Which is the principal procedure?

**Answer:** Pinning of the hip, also known as open reduction with internal fixation (ORIF), is the principal procedure; it is the major definitive treatment for the principal diagnosis of fractured hip. The lung scan was a necessary diagnostic procedure for confirmation of a pulmonary embolism. This diagnosis is the most life-threatening problem for the patient, but it does not meet the principal diagnosis criterion, which is the major cause, determined after study, for the hospitalization.

**EXAMPLE 2:** A patient entered the hospital with symptoms of profuse sweating, tremors, and polyuria. The patient has an existing problem with control of type I diabetes mellitus, as well as carpal tunnel syndrome. The diabetes was controlled within 18 hours by adjusting the patient’s insulin dosage. A surgical carpal tunnel release was performed. The final diagnoses were carpal tunnel syndrome and uncontrolled type I diabetes mellitus. What is the principal procedure?

**Answer:** The principal procedure is the carpal tunnel release. The principal diagnosis is uncontrolled type I diabetes mellitus. (Carpal tunnel syndrome is not the principal diagnosis because it was not the problem that brought the patient to the hospital. Uncontrolled type I diabetes caused the admission in this case.)

### Index to Procedures and Tabular List of Procedures Coding Conventions

Although the purpose of this textbook is to cover provider-based office coding (for which ICD-9-CM Index to Diseases and Tabular List of Procedures is used), Table 6A-4 is included to provide comprehensive coverage of ICD-9-CM coding conventions.

#### TABLE 6A-4 Coding conventions for the ICD-9-CM Index to Procedures and Tabular List of Procedures

<table>
<thead>
<tr>
<th>Coding Convention</th>
<th>Index to Procedures Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OMIT CODE</strong></td>
<td>Laparotomy NEC 54.19 as operative approach—<em>omit code</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding Convention</th>
<th>Tabular List of Procedures Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CODE ALSO ANY SYNCHRONOUS PROCEDURES</strong></td>
<td>08.2 Excision or destruction of lesion or tissue of eyelid</td>
</tr>
<tr>
<td></td>
<td>Code also any synchronous reconstruction (08.61–08.74)</td>
</tr>
</tbody>
</table>
ICD-9-CM INDEX TO DISEASES TABLES

Three tables appear in the Index to Diseases: Hypertension, Neoplasm, and Table of Drugs and Chemicals. The discussion that follows provides a basic understanding of how to use each table. Because the official tables consist of three to six columns, it will be helpful to use a ruler or paper guide when working with a specific diagnosis within a table, to ensure that you stay on the same horizontal line.

Hypertension/Hypertensive Table

The hypertension/hypertensive table contains a complete listing of hypertension codes and other associated conditions. Column headings are shown in Figure 6A-6.

- **Malignant**—A severe form of hypertension with vascular damage and a diastolic pressure reading of 130 mm Hg or greater. (Hypertension is out of control or there was a rapid change from a benign state for a prolonged period.)
- **Benign**—Mild and/or controlled hypertension, with no damage to the patient’s vascular system or organs.
- **Unspecified**—No notation of benign or malignant status is found in the diagnosis or in the patient’s chart.

**CODING TIP:**

1. Always check the Tabular List of Diseases before assigning a code for hypertension/hypertensive conditions.
2. The table uses all three levels of indentations when the word “with” is included in the diagnostic statement. Be sure you review the subterms carefully. You may need to assign two codes when “with” separates two conditions in the diagnostic statement.
3. Secondary hypertension is a unique and separate condition listed on the table. In this case hypertension was caused by another primary condition (e.g., cancer).
4. Assign the fourth digit (9) sparingly.

Most insurance companies insist on conditions being coded to the highest degree of specificity known at the time of the encounter. They will not accept 401.9 Hypertension, unspecified, except during the first few weeks of treatment for hypertension. After that point, the physician usually knows whether the patient has benign (controlled by medication) or malignant (out-of-control) hypertension. If “benign” or “malignant” is not specified in the diagnosis, ask the physician to document the type of hypertension.

**EXERCISE 6A-5**

**Hypertension/Hypertensive Coding**

Code the following conditions.

1. Essential hypertension ___________
2. Transient hypertension due to pregnancy ___________
3. Malignant hypertensive crisis ___________
4. Heart disease with hypertension ___________
5. Orthostatic hypertension, benign ___________
Neoplasms are new growths, or tumors, in which cell reproduction is out of control. For coding purposes, the provider should specify whether the tumor is benign (noncancerous, nonmalignant, noninvasive) or malignant (cancerous, invasive, capable of spreading to other parts of the body). It is highly advisable that neoplasms be coded directly from the pathology report (generated by a hospital’s or stand-alone laboratory’s pathology department and mailed to the provider’s office); however, until the diagnostic statement specifies whether the neoplasm is benign or malignant, coders should code the patient’s sign (e.g., breast lump) or report a subcategory code from the “unspecified nature” column of the documented site using the Index to Diseases Table of Neoplasms.

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

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

The Table of Neoplasms (Figure 6A-7) is indexed by anatomic site and contains four cellular classifications: malignant, benign, uncertain behavior, and unspecified nature. The malignant classification is subdivided into three divisions: primary, secondary, and carcinoma in situ. The six neoplasm classifications are defined as follows:

- Primary malignancy—The original tumor site. All malignant tumors are considered primary unless otherwise documented as metastatic or secondary.
### Notes

1. The list below gives the code numbers for neoplasms by anatomic site. For each site there are six possible code numbers according to whether the neoplasm in question is malignant, benign, in situ, of uncertain behavior, or of unspecified nature. The description of the neoplasm will often indicate which of the six columns is appropriate; e.g., malignant melanoma of skin, benign fibroadenoma of breast, carcinoma in situ of cervix uteri.

   Where such descriptors are not present, the remainder of the Index should be consulted where guidance is given to the appropriate column for each morphological (histological) variety listed; e.g., Mesonephroma — see Neoplasm, malignant; Embryoma — see also Neoplasm, uncertain behavior; Disease, Bowen’s — see Neoplasm, skin, in situ.

   However, the guidance in the Index can be overridden if one of the descriptors mentioned above is present; e.g., malignant adenoma of colon is coded to 153.9 and not to 111.3 as the adjective "malignant" overrides the Index entry "Adenoma — see also Neoplasm, benign."

2. Sites marked with the sign * (e.g., face NEC*) should be classified to malignant neoplasm of skin of these sites if the variety of neoplasm is a squamous cell carcinoma or an epidermal carcinoma, and to benign neoplasm of skin of these sites if the variety of neoplasm is a papilloma (any type).

### FIGURE 6A-7 ICD-9-CM Table of Neoplasms (partial).

<table>
<thead>
<tr>
<th>Neoplasm, neoplastic</th>
<th>Primary</th>
<th>Secondary</th>
<th>Ca in situ</th>
<th>Benign</th>
<th>Uncertain Behavior</th>
<th>Unspecified</th>
</tr>
</thead>
<tbody>
<tr>
<td>abdomen, abdominal</td>
<td>195.2</td>
<td>198.89</td>
<td>234.8</td>
<td>229.8</td>
<td>238.8</td>
<td>239.8</td>
</tr>
<tr>
<td>cavity</td>
<td>195.2</td>
<td>198.89</td>
<td>234.8</td>
<td>229.8</td>
<td>238.8</td>
<td>239.8</td>
</tr>
<tr>
<td>organ</td>
<td>195.2</td>
<td>198.89</td>
<td>234.8</td>
<td>229.8</td>
<td>238.8</td>
<td>239.8</td>
</tr>
<tr>
<td>viscera</td>
<td>195.2</td>
<td>198.89</td>
<td>234.8</td>
<td>229.8</td>
<td>238.8</td>
<td>239.8</td>
</tr>
<tr>
<td>wall</td>
<td>173.5</td>
<td>198.2</td>
<td>232.5</td>
<td>216.5</td>
<td>238.2</td>
<td>239.2</td>
</tr>
<tr>
<td>connective tissue</td>
<td>171.5</td>
<td>198.89</td>
<td>—</td>
<td>215.5</td>
<td>238.1</td>
<td>239.2</td>
</tr>
<tr>
<td>abdominopelvic</td>
<td>195.8</td>
<td>198.89</td>
<td>234.8</td>
<td>229.8</td>
<td>238.8</td>
<td>239.8</td>
</tr>
<tr>
<td>accessory sinus — see Neoplasm, sinus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>acoustic nerve</td>
<td>192.0</td>
<td>198.4</td>
<td>—</td>
<td>225.1</td>
<td>237.9</td>
<td>239.7</td>
</tr>
<tr>
<td>acromion (process)</td>
<td>170.4</td>
<td>198.5</td>
<td>—</td>
<td>213.4</td>
<td>238.0</td>
<td>239.2</td>
</tr>
</tbody>
</table>

- **Secondary malignancy**—The tumor has metastasized (spread) to a secondary site, either adjacent to the primary site or to a remote region of the body.

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

- **Benign**—A noninvasive, nonspreading, nonmalignant tumor.

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

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

To go directly to the Table of Neoplasms, you must know the classification and the site of the neoplasm. Some diagnostic statements specifically document “neoplasm” classification; others will not provide a clue.

If the diagnostic statement classifies the neoplasm, the coder can refer directly to the Index to Diseases Table of Neoplasms to assign the proper code (verifying the code in the Tabular List of Diseases, of course). Because sufficient information is documented in the diagnostic statements in Example 1, coders can refer directly to the Index to Diseases Table of Neoplasms.
### EXAMPLE 1:

<table>
<thead>
<tr>
<th>Diagnostic Statement</th>
<th>Table of Neoplasms Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracheal carcinoma <em>in situ</em></td>
<td>trachea, Malignant, Ca <em>in situ</em> (231.1)</td>
</tr>
<tr>
<td>Benign breast tumor, male</td>
<td>breast, male, Benign (217)</td>
</tr>
<tr>
<td>Cowper’s gland tumor, uncertain behavior</td>
<td>Cowper’s gland, Uncertain Behavior (236.99)</td>
</tr>
<tr>
<td>Metastatic carcinoma</td>
<td>unknown site or unspecified, Malignant—Secondary (199.1)</td>
</tr>
<tr>
<td>Cancer of the breast, primary</td>
<td>breast, Malignant—Primary (174.9)</td>
</tr>
</tbody>
</table>

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

### EXAMPLE 2:

<table>
<thead>
<tr>
<th>Diagnostic Statement</th>
<th>Index to Diseases Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>non-Hodgkin’s lymphoma</td>
<td>Lymphoma (malignant) (M9590/3) 202.8</td>
</tr>
<tr>
<td>Adrenal adenolymphoma</td>
<td>Hodgkin’s type NEC (M9591/3) 202.8</td>
</tr>
<tr>
<td></td>
<td>Adenolymphoma (M8561/0)</td>
</tr>
<tr>
<td></td>
<td>specified site—see Neoplasm, by site, benign</td>
</tr>
<tr>
<td></td>
<td>Neoplasm (table)</td>
</tr>
<tr>
<td></td>
<td>adrenal (cortex) (gland) (medulla)</td>
</tr>
<tr>
<td></td>
<td>benign (227.0)</td>
</tr>
</tbody>
</table>

For non-Hodgkin’s lymphoma, refer to code 202.8 in the Tabular List of Diseases to select the fifth digit (after referring to “lymphoma” in the Index to Diseases). There is no need to go to the Table of Neoplasms. In fact, referencing the Table of Neoplasms in this case would have been improper, and the coder would most likely have assigned an incorrect code (e.g., perhaps the coder would have referenced “lymph, lymphatic” within the Table of Neoplasms and selected code 171.9 from the Malignant—Primary column, the wrong code).

For adrenal adenolymphoma, refer to “adenolymphoma” in the Index to Diseases. Because “adrenal” is the site specified in the diagnostic statement, the coder should follow the Index to Diseases instructions to “see Neoplasm, by site, benign.” This instructional note refers the coder to the Table of Neoplasms and the anatomic site for adrenal (cortex) (gland) (medulla). The coder would next refer to the “Benign” column and assign code 227.0 (after verifying the code in the Tabular List of Diseases).

### CODING TIP:

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

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

Underline the main term found in the Index to Diseases, and enter the code number (after verifying it in the Tabular List of Diseases) on the blank line.

1. Kaposi’s sarcoma  
2. Lipoma, skin, upper back  
3. Carcinoma in situ, skin, left cheek  
4. Scrotum mass  
5. Neurofibroma  
6. Cyst on left ovary  
7. Ganglion right wrist  
8. Yaws, frambeside  
9. Breast, chronic cystic disease  
10. Hürthle cell tumor

Primary Malignancies

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

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

EXAMPLE:

Carcinoma of cervical lymph nodes, metastatic from the breast

Primary: breast
Secondary: cervical lymph nodes

Oat cell carcinoma of the lung with spread to the brain

Primary: lung
Secondary: brain

Secondary Malignancies

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

To properly code secondary malignancies, consider the following:

● Cancer described as metastatic from a site is primary of that site. Assign one code to the primary neoplasm and a second code to the secondary neoplasm of the specified site (if secondary site is known) or unspecified site (if secondary site is unknown).
EXAMPLE 1: Metastatic carcinoma from breast to lung
Assign two codes:
- primary malignant neoplasm of breast (174.9)
- secondary neoplasm of lung (197.0)

EXAMPLE 2: Metastatic carcinoma from breast
Assign two codes:
- primary malignant neoplasm of breast (174.9)
- secondary neoplasm of unspecified site (199.1)

- Cancer described as metastatic to a site is considered secondary of that site. Assign one code to the secondary site and a second code to the specified primary site (if primary site is known) or unspecified site (if primary site is unknown). In the following example, the metastatic site is listed first; in practice, the sequencing of codes depends on the reason for the encounter (e.g., whether the primary or secondary cancer site is being treated or medically managed).

EXAMPLE 1: Metastatic carcinoma from liver to lung
Assign two codes:
- secondary neoplasm of lung (197.0)
- primary malignant neoplasm of liver (155.0)

EXAMPLE 2: Metastatic carcinoma to lung
Assign two codes as follows:
- secondary neoplasm of lung (197.0)
- primary malignant neoplasm of unspecified site (199.1)

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

EXAMPLE 1: Metastatic renal cell carcinoma of lung
Assign two codes:
- secondary neoplasm of lung (197.0)
- primary renal cell carcinoma (189.0)
EXAMPLE 2: Metastatic osteosarcoma of brain
Assign two codes:
  secondary neoplasm of brain (198.3)
  primary malignant neoplasm of bone (170.9)

EXAMPLE 3: Metastatic melanoma of lung and liver
Assign three codes:
  secondary neoplasm of lung (197.0)
  secondary neoplasm of liver (197.7)
  primary malignant melanoma of unspecified site (172.9)

EXAMPLE 4: Metastatic adenocarcinoma of prostate and vertebra
Assign three codes:
  primary adenocarcinoma of unspecified site (199.1)
  secondary neoplasm of prostate (198.82)
  secondary neoplasm of bone (198.5)

Anatomic Site Is Not Documented
If the cancer diagnosis does not contain documentation of the anatomic site, but the term metastatic is documented, assign codes for “unspecified site” for both the primary and secondary sites.

EXAMPLE: Metastatic chromophobe adenocarcinoma
Assign two codes as follows:
  secondary neoplasm of unspecified site (199.1)
  primary chromophobe adenocarcinoma of unspecified site (194.3)

Primary Malignant Site Is No Longer Present
If the primary site of malignancy is no longer present, do not assign the code for primary of unspecified site. Instead, classify the previous primary site by assigning the appropriate code from category V10, “Personal history of malignant neoplasm.”

EXAMPLE: Metastatic carcinoma to lung from breast (left radical mastectomy performed last year)
Assign two codes as follows:
  secondary neoplasm of lung (197.0)
  personal history of malignant neoplasm of breast (V10.3)
Contiguous or Overlapping Sites

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

**EXAMPLE:** Cancer of the jejunum and ileum

Go to the Index to Diseases entry for “intestine, small, contiguous sites” in the Table of Neoplasms. Locate code 152.8 in the Malignant—Primary column, and verify the code in the Tabular List of Diseases, which appears as:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>152</td>
<td>Malignant neoplasm of small intestine, including duodenum</td>
</tr>
<tr>
<td>152.8</td>
<td>Other specified sites of small intestine</td>
</tr>
<tr>
<td></td>
<td>Duodenojejunal junction</td>
</tr>
<tr>
<td></td>
<td>Malignant neoplasm of contiguous or overlapping sites of small intestine</td>
</tr>
<tr>
<td></td>
<td>whose point of origin cannot be determined</td>
</tr>
</tbody>
</table>

Re-excision of Tumors

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

**CODING TIP:**

1. Read all notes in the table that apply to the condition you are coding.
2. Never assign a code directly from the table or Index to Diseases.
3. Be certain you are submitting codes that represent the current status of the neoplasm.
4. Assign a neoplasm code if the tumor has been excised and the patient is still undergoing radiation or chemotherapy treatment.
5. Assign a V code if the tumor is no longer present or if the patient is not receiving treatment, but is returning for follow-up care.

**EXAMPLE:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V10–V15</td>
<td>Personal history of a malignancy</td>
</tr>
<tr>
<td>V67.xx</td>
<td>Examination follow-up, no disease</td>
</tr>
</tbody>
</table>

6. Classification stated on a pathology report overrides the morphology classification stated in the Index to Diseases.
**EXERCISE 6A-7**

**Neoplasm Coding II**

**STEP 1** Review the notes located at the beginning of the Table of Neoplasms and at the beginning of Chapter 2 in the Tabular List of Diseases.

**STEP 2** Code the following diagnostic statements.

1. Ca (carcinoma) of the lung
2. Metastasis from the lung
3. Abdominal mass
4. Carcinoma of the breast (female) with metastasis to the axillary lymph nodes
5. Carcinoma of axillary lymph nodes and lungs, metastatic from the breast (female)

---

**Table of Drugs and Chemicals**

The Table of Drugs and Chemicals is used to identify drugs or chemicals that caused poisonings and adverse effects (Figure 6A-8).

The official ICD-9-CM table contains a listing of the generic names of the drugs or chemicals, one column for poisonings, and five separate columns to indicate the external causes of adverse effects or poisonings. (Some publishers are now adding brand names to the list of drugs and chemicals.)

An **adverse effect** or **adverse reaction** is the appearance of a pathologic condition caused by ingestion or exposure to a chemical substance properly administered or taken.

Code first the adverse effect(s) (or manifestations) (e.g., coma) by referring to the Index to Diseases.

The chemical substance is coded by referring to the Therapeutic Use column of the Table of Drugs and Chemicals.

---

**ICD-10 ALERT!**

Iatrogenic illnesses (adverse effects or adverse reactions) are classified within individual ICD-10-CM chapters (e.g., E81.43, iatrogenic carnitine deficiency, in Chapter 4, Endocrine, nutritional and metabolic diseases (E00-E90)).

---

**CODING TIP:**

Never assign a code from the Poisoning column with a code from the Therapeutic Use column. Consider highlighting the Therapeutic Use column (Figure 6A-8) in your coding manual as a reminder that these codes are not assigned with any of the others in the Table of Drugs and Chemicals.

---

**EXAMPLE:** Gastritis due to prescribed tetracycline

In this statement, gastritis (535.50) is the adverse effect (or manifestation) of the properly administered drug, tetracycline (E930.4).

---

**Poisonings** occur as the result of an overdose, wrong substance administered or taken, or intoxication (e.g., combining prescribed drugs with nonprescribed...
### FIGURE 6A-8 ICD-9-CM Table of Drugs and Chemicals.

Drugs or alcohol. The Table of Drugs and Chemicals categorizes poisonings according to accident, suicide attempt, assault, or undetermined. Poisonings are coded by referring first to the Poisoning column of the Table of Drugs and Chemicals and then the External Cause (E code) columns within the table (with the exception of the Therapeutic Use column).

**EXAMPLE:** Accidental overdose of tetracycline

In this statement, the poisoning code is listed first (960.4), followed by the accidental overdose E code (E856).

Review the patient’s record to determine the manifestations of the poisoning (e.g., headache, coma); refer to the Index to Diseases and sequence these codes after the codes for the poisoning and external cause.

The Table of Drugs and Chemicals contains six columns of codes:
- **Poisoning** (codes 960–989) is assigned according to classification of the drug or chemical.
- **Accident** (codes E850–E869) is used for accidental overdosing, wrong substance given or taken, drug inadvertently taken, or accidents in the use of drugs and chemical substances during medical or surgical procedures, and to show external causes of poisonings classifiable to 960–989.

<table>
<thead>
<tr>
<th>Substance</th>
<th>Poisoning</th>
<th>Accident</th>
<th>Therapeutic Use</th>
<th>Suicide Attempt</th>
<th>Assault</th>
<th>Undetermined</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-propanol</td>
<td>E800.4</td>
<td>—</td>
<td>—</td>
<td>E950.9</td>
<td>E962.1</td>
<td>E980.9</td>
</tr>
<tr>
<td>2-propanol</td>
<td>E800.3</td>
<td>—</td>
<td>—</td>
<td>E950.9</td>
<td>E962.1</td>
<td>E980.9</td>
</tr>
<tr>
<td>2, 4-D (dichlorophenoxyacetic acid)</td>
<td>E863.5</td>
<td>—</td>
<td>E950.6</td>
<td>E962.1</td>
<td>E980.7</td>
<td></td>
</tr>
<tr>
<td>2, 4-toluene disiocyanate</td>
<td>E864.0</td>
<td>—</td>
<td>E950.7</td>
<td>E962.1</td>
<td>E980.6</td>
<td></td>
</tr>
<tr>
<td>2, 4, 5-T (trichlorophenoxyacetic acid)</td>
<td>E863.5</td>
<td>—</td>
<td>E950.6</td>
<td>E962.1</td>
<td>E980.7</td>
<td></td>
</tr>
<tr>
<td>14-hydroxyhydromorphone</td>
<td>E850.2</td>
<td>E935.2</td>
<td>E950.0</td>
<td>E962.0</td>
<td>E980.0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance</th>
<th>Poisoning</th>
<th>Accident</th>
<th>Therapeutic Use</th>
<th>Suicide Attempt</th>
<th>Assault</th>
<th>Undetermined</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABOB</td>
<td>E857</td>
<td>E931.7</td>
<td>E950.4</td>
<td>E962.0</td>
<td>E980.4</td>
<td></td>
</tr>
<tr>
<td>Absinthe</td>
<td>E800.1</td>
<td>—</td>
<td>—</td>
<td>E950.9</td>
<td>E962.1</td>
<td>E980.9</td>
</tr>
<tr>
<td>Acetaminophen</td>
<td>E863.5</td>
<td>—</td>
<td>E950.9</td>
<td>E962.1</td>
<td>E980.9</td>
<td></td>
</tr>
<tr>
<td>Acetaminosalol</td>
<td>E850.4</td>
<td>—</td>
<td>—</td>
<td>E950.9</td>
<td>E962.1</td>
<td>E980.9</td>
</tr>
<tr>
<td>Acetarnilide(e)</td>
<td>E850.5</td>
<td>—</td>
<td>—</td>
<td>E950.9</td>
<td>E962.1</td>
<td>E980.9</td>
</tr>
<tr>
<td>Acetarsol, acetarsone</td>
<td>E857</td>
<td>—</td>
<td>—</td>
<td>E950.9</td>
<td>E962.1</td>
<td>E980.9</td>
</tr>
<tr>
<td>Acetaldehyde (vapor)</td>
<td>E862.4</td>
<td>—</td>
<td>—</td>
<td>E950.9</td>
<td>E962.1</td>
<td>E980.9</td>
</tr>
<tr>
<td>Acetate</td>
<td>E862.2</td>
<td>—</td>
<td>—</td>
<td>E950.9</td>
<td>E962.1</td>
<td>E980.9</td>
</tr>
<tr>
<td>Acetalsalol</td>
<td>E850.3</td>
<td>—</td>
<td>—</td>
<td>E950.9</td>
<td>E962.1</td>
<td>E980.9</td>
</tr>
<tr>
<td>Acetalsalol</td>
<td>E850.4</td>
<td>—</td>
<td>—</td>
<td>E950.9</td>
<td>E962.1</td>
<td>E980.9</td>
</tr>
<tr>
<td>Acetaminophen</td>
<td>E863.5</td>
<td>—</td>
<td>E950.4</td>
<td>E962.0</td>
<td>E980.4</td>
<td></td>
</tr>
<tr>
<td>Acetanilid(e)</td>
<td>E850.5</td>
<td>—</td>
<td>—</td>
<td>E950.9</td>
<td>E962.1</td>
<td>E980.9</td>
</tr>
<tr>
<td>Acetamid(e)</td>
<td>E862.4</td>
<td>—</td>
<td>—</td>
<td>E950.9</td>
<td>E962.1</td>
<td>E980.9</td>
</tr>
<tr>
<td>Acetic acid</td>
<td>E850.4</td>
<td>—</td>
<td>—</td>
<td>E950.9</td>
<td>E962.1</td>
<td>E980.9</td>
</tr>
</tbody>
</table>

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- **Therapeutic use** (codes E930–E949) is used for the external effect caused by correct substance properly administered in therapeutic or prophylactic dosages.
- **Suicide attempt** (codes E950–E952) is a self-inflicted poisoning.
- **Assault** (codes E961–E962) is a poisoning inflicted by another person who intended to kill or injure the patient.
- **Undetermined** (codes E980–E982) is used if the record does not state whether the poisoning was intentional or accidental.

**CODING TIP:**
The term *intoxication* often indicates that alcohol was involved (e.g., alcohol intoxication) or that an accumulation effect of a medication in the patient’s bloodstream occurred (e.g., Coumadin intoxication). When *alcohol intoxication* occurs, assign a code from the Poisoning column along with the appropriate E code. When an accumulation effect of a medication occurs, assign the manifestation code first (e.g., dizziness) and an E code from the Therapeutic Use column (e.g., daily Coumadin use).

E codes are used to explain the cause of the poisoning or the adverse effect. They are external causes or results of injury codes (not diagnosis codes). Therefore, *E codes are always reported as secondary codes, never first-listed or principal diagnosis codes.*

**EXAMPLE 1:** Hives, due to prescribed penicillin

**Answer:** 708.9 (hives NOS), E930.0 (therapeutic use of penicillin)

**EXAMPLE 2:** Coma due to overdose of barbiturates, attempted suicide

**Answer:** 967.0 (poisoning by barbiturates), E950.1 (suicide by barbiturates), 780.01 (coma)

**EXERCISE 6A-8**

Using the Table of Drugs and Chemicals

Code the following statements using ICD-9-CM.

1. Adverse reaction to pertussis vaccine
2. Cardiac arrhythmia caused by interaction between prescribed ephedrine and social alcohol
3. Stupor, due to overdose of Nytol (suicide attempt)
4. High blood pressure due to prescribed Albuterol
5. Rash due to combining prescribed Amoxicillin with nonprescribed Benadryl.
ICD-9-CM SUPPLEMENTARY CLASSIFICATIONS

ICD-9-CM contains two supplementary classifications:

- V codes: factors influencing health status and contact with health services (V01–V91).
- E codes: external causes of injury and poisoning (E000–E999).

V Codes

V codes are contained in a supplementary classification of factors influencing the person’s health status (Table 6A-5A). These codes are used when a person seeks health care but does not have active complaints or symptoms, or when it is necessary to describe circumstances that could influence the patient’s health care. These services fall into one of three categories:

1. Problems—issues that could affect the patient’s health status.
2. Services—Person is seen for treatment that is not caused by illness or injury.
3. Factual reporting—used for statistical purposes (e.g., outcome of delivery or referral of patient without examination).

Refer to Table 6A-5B for a list of main terms found in the ICD-9-CM Index to Diseases.

CODING TIP:
Consult Appendix E (List of Three-Digit Categories) if you have trouble locating a V code category in the Index to Diseases.

EXERCISE 6A-9

Exploring V Codes

Code the following statements using ICD-9-CM.

1. Family history of epilepsy with no evidence of seizures
2. Six-week postpartum checkup
3. Premarital physical
4. Consult with dietitian for patient with diabetes mellitus
5. Rubella screening
<table>
<thead>
<tr>
<th>SECTION</th>
<th>DESCRIPTION</th>
<th>CODE CATEGORY AND USE</th>
</tr>
</thead>
</table>
| V01-V06 | Persons with potential health hazards related to communicable diseases | • V01—Patients who have been exposed to communicable diseases but have not been diagnosed  
• V02—Patients who have been identified as or are suspected of being infectious disease carriers  
• V03-V06—Patients who are seeking immunization against disease |
| V07-V09 | Persons with need for isolation, other potential health hazards, and prophylactic measures | • V07—Patients who are placed in an isolation area or who are receiving prophylactic measures (e.g., prophylactic fluoride administration by a dentist)  
• V08—Asymptomatic HIV infection status |
| V09 | Patient’s infection is drug-resistant; these are reported as a secondary code(s) |
| V10-V19 | Persons with potential health hazards related to personal and family history | • V10-V15—Patient has personal history of malignant neoplasm, mental disorder, disease, allergy, hazard to health, or having undergone certain surgeries  
• V16-V19—Patient has family history of malignant neoplasm or other diseases/conditions |
| V20-V29 | Persons encountering health services in circumstances related to reproduction and development | • V20-V21—Patient is seen for a well-baby or well-child office visit |
| V30-V39 | Liveborn infants according to type of birth | • V30-V39—Type of birth is coded on the baby’s insurance claim |

**CODING TIP:**
- Codes from categories V10-V15 are reported when the patient’s condition no longer exists.  
- Verify history of codes in the tabular list before reporting.  
- Do not confuse personal history of with family history of codes.

**CODING TIP:**
- If documentation supports treatment of a condition during the well-baby/child visit, report a code for the condition in addition to a code from category V20-V21.
- V22-V23—Patient is supervised during pregnancy, whether normal or high-risk  
- V24—Patient is treated after having given birth  
- V25-V26—Patient is seen for contraceptive or procreative management  
- V27—Outcome of delivery is coded on the mother’s insurance claim

**CODING TIP:**
- V27.x is never reported as the first code on the insurance claim. Report a code from 650-659 first.
- V28—Patient is screened during pregnancy  
- V29—Newborn is observed/evaluated, but no condition is diagnosed

**CODING TIP:**
- V3.xx is always reported as the first code on the insurance claim. If documented, also report congenital, perinatal, and other conditions.

**NOTE:**
- Do not report code V08 if the patient is diagnosed with:  
  • AIDS (042)  
  • Exposure to HIV (V01.79)  
  • Nonspecific serologic evidence of HIV (795.71)
<table>
<thead>
<tr>
<th>SECTION</th>
<th>DESCRIPTION</th>
<th>CODE CATEGORY AND USE</th>
</tr>
</thead>
</table>
| V40–V49 | Persons with a condition influencing their health status | ● V40–V49—Patients who have not been diagnosed, but who have conditions that influence their health status  
**EXAMPLE:** Patient undergoes colostomy as the result of colon cancer, which was successfully treated. Patient is seen for hay fever, and the provider documents that the patient is adjusting to having a colostomy. Code V44.3 is reported in addition to hay fever (477.9). |
| V50–V59 | Persons encountering health services for specific procedures and aftercare | ● V50—Patient undergoes elective surgery (most payers will not provide reimbursement)  
● V51—Patient undergoes plastic surgery as aftercare  
**EXAMPLE:** Patient receives breast implant following mastectomy. Assign code V51.0  
● V52–V54—Patient is fitted for prosthesis or implant or has device adjusted or removed  
● V55—Patient receives attention to artificial opening, such as colostomy cleansing  
● V56—Patient undergoes dialysis and dialysis catheter care  
**CODING TIP:** When reporting V56.xx, code also the associated condition (e.g., renal failure).  
● V57—Patient undergoes rehabilitation procedures  
**CODING TIP:** When reporting V57.xx, code also the associated condition (e.g., dysphasia).  
● V58—Patient receives other treatment or aftercare  
**EXAMPLE:** Patient is diagnosed with breast cancer, undergoes mastectomy, and is admitted for chemotherapy. Assign V58.1 as well as the appropriate breast cancer code.  
● V59—Individual is donating an organ or tissue  
**CODING TIP:** Do not report V59.x on the recipient’s insurance claim. |
| V60–V69 | Persons encountering health services in other circumstances | ● V60–V69—Individuals are seen for reasons other than resulting from illness or injury  
**NOTE:** Payers usually do not reimburse for these services.  
**EXAMPLE:** Patient pretends to be in pain so a narcotic will be prescribed, and the provider is alerted to the pretense by another provider (V65.2). |

(continues)
TABLE 6A-5A  (continued)

<table>
<thead>
<tr>
<th>SECTION</th>
<th>DESCRIPTION</th>
<th>CODE CATEGORY AND USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>V70-V91</td>
<td>Persons without reported diagnosis encountered during examination and investigation of individuals and populations</td>
<td>● V70—Patient seen for routine examination, such as annual physical&lt;br&gt;<strong>CODING TIP:</strong> V70.x may be reported with other ICD codes when documentation supports the exam as well as treatment of a condition.&lt;br&gt;● V71—Patient is observed and evaluated for a suspected condition, which is ruled out&lt;br&gt;<strong>CODING TIP:</strong> Before reporting a V71 code, review the record to determine whether a sign or symptom can be coded instead.&lt;br&gt;● V72-V82—Patient undergoes special investigations, examinations, or screenings&lt;br&gt;EXAMPLE: Patient has extensive family history of ovarian cancer (e.g., mother, aunts, sisters) and elects to undergo screening as a preventive measure (V76.46).&lt;br&gt;● V83—Patient has genetic carrier status determined&lt;br&gt;● V84—Patient has genetic susceptibility to disease&lt;br&gt;● V85—Patient has body mass index determined&lt;br&gt;● V86—Patient has Estrogen receptor status determined&lt;br&gt;● V87—Patient was exposed to or has history of other hazard to health&lt;br&gt;● V88—Patient underwent surgery to have organs or other tissue removed&lt;br&gt;● V89—Patient has other suspected condition that was not found&lt;br&gt;● V90—Patient has retained foreign body&lt;br&gt;● V91—Patient has multiple gestation placenta status</td>
</tr>
</tbody>
</table>

TABLE 6A-5B  Main terms to use when the ICD-9-CM V code is difficult to find

| Admission | History, family |
| Aftercare | History (personal) of |
| Attention to | Maladjustment |
| Carrier (suspected) of | Newborn |
| Checking | Observation |
| Checkup | Outcome of delivery |
| Closure | Pregnancy |
| Contact | Procedure (surgical) not done |
| Contraception, contraceptive | Prophylactic |
| Counseling | Removal |
| Dialysis | Resistance, resistant |
| Donor | Routine postpartum follow-up |
| Encounter for | Screening |
| Examination | Status |
| Exposure | Test(s) |
| Fitting | Vaccination |
| Follow-up | |
Assign code 079.53 in addition to 042 when HIV type 2 is identified by the provider.
Assign code 795.71 when screening for HIV was reported as nonspecific. For example, this code is used when a newborn tests positive upon HIV screening, but it cannot be determined whether the positive result reflects the true status of the baby or the seropositive status of the mother.
V01.71–V01.79 are assigned for patients who were exposed to the virus but not tested for infection.
V08 is assigned when the patient is HIV-positive, asymptomatic, and does not exhibit manifestations of AIDS. Once the patient presents with symptoms, V08 can never again be reported.
Assign V65.44 when the reason for the encounter is counseling of a patient who has been tested for HIV. It does not matter whether the patient’s HIV status is positive or negative.

Fracture Cases

**CODING TIP:**
Study the fifth-digit subclassification note at the beginning of the Musculoskeletal System chapter before coding fractures. This information is extremely helpful in selecting the correct code.

Distinction is required between closed and open fractures. If the diagnostic statement does not specify closed or open, select the appropriate closed fracture code. (It is important to realize that an open fracture does not always require an open reduction.) A list of common types of fractures appears in Table 6A-6.

When a patient has suffered multiple injuries, list the injuries in descending order of severity on the claim.

**TABLE 6A-6** Common types of fracture

<table>
<thead>
<tr>
<th>COMMON CLOSED FRACTURE TERMS</th>
<th>COMMON OPEN FRACTURE TERMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comminuted</td>
<td>Compound</td>
</tr>
<tr>
<td>Linear</td>
<td>Missile</td>
</tr>
<tr>
<td>Spiral</td>
<td>Puncture</td>
</tr>
<tr>
<td>Impacted</td>
<td>Fracture with a foreign body</td>
</tr>
<tr>
<td>Simple</td>
<td>Infected fracture</td>
</tr>
<tr>
<td>Greenstick</td>
<td></td>
</tr>
<tr>
<td>Compressed</td>
<td></td>
</tr>
</tbody>
</table>
**EXERCISE 6A-10**

**Coding HIV/AIDS and Fracture Cases**

Code the following statements.

1. Patient is HIV-positive with no symptoms _______
2. AIDS patient treated for candidiasis _______
3. Open fracture, maxilla _______
4. Greenstick fracture, third digit, right foot _______
5. Multiple fractures, right femur, distal end _______

**Late Effect**

A **late effect** is a residual effect or sequela of a previous acute illness, injury, or surgery. The patient is currently dealing with long-term chronic effects of the disorder or trauma. The underlying acute condition no longer exists (Table 6A-7).

In most cases, two codes will be required to classify diagnostic statements specifying residual conditions of an original illness or injury. The primary code is the residual (condition currently affecting the patient). The secondary code represents the original condition or etiology of the late effect. Locate the appropriate code by referencing the Index to Diseases under the main term “Late.” If the late effect is also due to an external cause, reference the Index to External Causes under the word “Late.” Occasionally, one combination code is used to classify the diagnostic statement.

**NOTE:** Sequelae (singular form is sequela) are late effects of injury or illness. In ICD-9-CM, these are classified within sections 990–995, which are located at the end of the injury and Poisoning chapter.

**ICD-10 ALERT!**

In ICD-10-CM, late effects of injury or illness (sequelae) codes appear at the end of each anatomic chapter, as appropriate.

**EXAMPLE:** For dysphasia due to CVA 6 months ago, the combination code is 438.12.

Occasionally, there will be a reversal of the primary and secondary positions. This occurs when the index references the late effect first followed by a slanted bracketed residual code.

**TABLE 6A-7 Common late effects**

<table>
<thead>
<tr>
<th>ORIGINAL CONDITION/ETIOLOGY</th>
<th>LATE EFFECT/SEQUELA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture</td>
<td>Malunion</td>
</tr>
<tr>
<td>CVA</td>
<td>Hemiplegia</td>
</tr>
<tr>
<td>Third-degree burn</td>
<td>Deep scarring</td>
</tr>
<tr>
<td>Polio</td>
<td>Contractures</td>
</tr>
<tr>
<td>Laceration</td>
<td>Keloid</td>
</tr>
<tr>
<td>Breast implant</td>
<td>Ruptured implant</td>
</tr>
</tbody>
</table>

**EXAMPLE:** Scoliosis due to childhood polio

Index entry is: Scoliosis (acquired) (postural) 737.30
due to or associated with poliomyelitis 138 [737.43]

The first-listed code is 138. The secondary code is 737.43 (as indicated by the slanted bracketed code in the index convention).
Burns

Burns require two codes: one for the site and degree and a second for the percentage of body surface (not body part) affected.

The percentage of total body area or surface affected follows the “rule of nines”:

- Head and neck = 9%
- Back (trunk) = 18%
- Chest (trunk) = 18%
- Log (each) = 18%
- Arm (each) = 9%
- Genitalia = 1%

\[
\text{Total body surface (TBS)} = 100\%
\]

**NOTE:** To find the total percentage affected, health professionals add the affected extremities or regions together and state the combined total.

**EXERCISE 6A-11**

**Coding Late Effects and Burns**

1. Malunion due to fracture, right ankle, 9 months ago
2. Brain damage due to traumatic subdural hematoma, 18 months previously
3. Second-degree burn, anterior chest wall
4. Scalding with erythema, right forearm and hand
5. Third-degree burn, back, 18 percent body surface

**Congenital versus Perinatal Conditions**

**Congenital anomalies** (codes 740–759) are disorders diagnosed in infants at birth. (Adults can also be diagnosed with congenital anomalies because such disorders may have been previously undetected.)

**EXAMPLE:** ICD-9-CM category 746 contains subcategory and sub-classification codes, which classify heart defects that develop prior to birth and result from a failure of the heart or the blood vessels near the heart to develop normally. The causes are mostly unknown, but in some cases the disorder is due to alcohol consumption during pregnancy, heredity (genetics), or an infection during pregnancy. The disorder may be diagnosed before birth, or it may not be detected until birth (and even weeks or years after birth).

**Perinatal conditions** (codes 760–779) occur before birth, during birth, or within the perinatal period, or the first 28 days of life. Think of these conditions as something that happens to the patient.

**EXAMPLE:** Drug withdrawal syndrome in a newborn (779.5) results when a mother is dependent on narcotics during the pregnancy. The narcotics taken by the mother pass from the mother’s bloodstream through the placenta to the fetus, resulting in fetal addiction. At birth the baby’s dependence continues, but the narcotics are no longer available, and the baby’s central nervous system becomes overstimulated, causing withdrawal symptoms. The infant may also develop related problems, such as extreme immaturity with a birthweight of less than 500 grams (765.01).
Use of E Codes

An E code consists of a four-character number (an E followed by three digits) and one digit after a decimal point. The Index to External Causes (E codes) is located separately in the Index to Diseases, after the Table of Drugs and Chemicals.

Although many states require the reporting of E codes, provider-based office insurance claims do not. However, reporting E codes on claims can expedite payment by health insurance carriers when no third-party liability for an accident exists. In such cases, it is necessary to report two E codes in addition to the appropriate injury codes. (E codes are never reported as first-listed codes.)

**EXAMPLE:** Patient is seen for treatment of a fractured pelvis, which was sustained when he fell from a ladder while repairing his house. The fractured pelvis is coded and sequenced first on the claim followed by two E codes, one for the external cause and another for the place of occurrence: 808.8, E881.0, and E849.0.

<table>
<thead>
<tr>
<th>Injury: Fracture pelvis</th>
<th>808.8</th>
</tr>
</thead>
<tbody>
<tr>
<td>External Cause: Fall (falling) from, off ladder</td>
<td>E881.0</td>
</tr>
<tr>
<td>Place of Occurrence: Accident (to) occurring (at) (in) home (private) (residential)</td>
<td>E849.0</td>
</tr>
</tbody>
</table>

(Homeowners insurance covers injuries sustained by visitors, but not family members living in the home.)

**CODING TIP:** Review the note at the beginning of the E-Code tabular list before coding external causes of injuries and poisonings.

At the end of the Index to External Causes is a section entitled: “Fourth-Digit Subdivisions for the External Cause (E) Codes.”

It may be necessary to consult the Appendix E List of Three-Digit Categories for assistance in locating possible main terms in the E code index.

**EXERCISE 6A-12**

Coding External Cause of Injury

Code the following statements.

1. Automobile accident, highway, passenger
2. Employee injured by fall from ladder at work
3. Accidental drowning, fell from power boat located on lake
4. Soft tissue injury, right arm, due to snowmobile accident in patient’s yard
5. Fall from playground equipment
REMINDERS TO ENSURE ACCURATE ICD-9-CM CODING

1. Preprinted diagnosis codes on encounter forms, routing slips, and coding lists should be reviewed to verify accuracy.
2. The latest edition code books should be purchased because codes are updated (added/deleted/revised).
3. Providers and insurance specialists should be kept informed of coding changes (e.g., newsletter subscription).
4. Diagnosis codes should be reviewed for accuracy when updates are installed in office management software.
5. A policy should be established to address assignment of codes when the office is awaiting the results of laboratory and pathology reports.
6. Reports of diagnostic tests performed at other facilities should be reviewed to ensure accurate coding.
7. The postoperative diagnosis should be coded (not the preoperative diagnosis).
8. Some computer programs automatically generate insurance claims for each encounter. Office staff should intercept these claims to verify the diagnosis code(s) assigned (e.g., review for definitive diagnosis).
9. M codes (morphology codes) should not be reported on the CMS-1500 claim.
10. Diagnosis codes should be proofread to ensure proper entry in the permanent record (e.g., onscreen, paper, and electronic claims).

SUMMARY

The United States adopted the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) to facilitate the coding and classification of morbidity (disease) data from inpatient and outpatient records, physician office records, and statistical surveys. The Medicare Catastrophic Coverage Act of 1988 mandated the reporting of ICD-9-CM diagnosis codes on Medicare claims. (Private insurers adopted similar requirements in subsequent years.) (ICD-10-CM and ICD-10-PCS will replace ICD-9-CM on October 1, 2013.)

Medical necessity is the measure of whether a healthcare procedure or service is appropriate for the diagnosis and/or treatment of a condition. Third-party payers use medical necessity measurements to make a decision about whether to pay a claim.

Diagnostic Coding and Reporting Guidelines for Outpatient Services: Hospital-Based and Provider-Based Office were developed by the federal government for use in reporting diagnoses for claims submission. Outpatient claims (CMS-1500) require reporting of the patient’s first-listed diagnosis, secondary diagnoses, procedures, and services. Diagnoses are assigned ICD-9-CM codes, and procedures or services are assigned CPT and HCPCS national (level II) codes. Inpatient claims (UB-04) require reporting of the principal diagnosis, secondary diagnoses, principal procedure, and secondary procedures.

ICD-9-CM consists of Volume 1 (Tabular List of Diseases), Volume 2 (Index to Diseases), and Volume 3 (Index to Procedures and Tabular List of Procedures). The ICD-9-CM Index to Diseases is organized according to alphabetical main terms (boldfaced conditions), nonessential modifiers (in parentheses), and subterms (essential modifiers that are indented below main terms). It also contains a hypertension table, Table of Neoplasms, and Table of Drugs and Chemicals. To properly assign an ICD-9-CM code, locate the main term in the Index to Diseases, apply coding conventions, and verify the code in the Tabular List of Diseases (applying additional coding conventions).
INTERNET LINKS

- Computer-assisted coding (CAC)
  www.coderyte.com
  www.platocode.com
- ICD-9-CM encoders (free)
  www.ICD9coding.com
- ICD-9-CM encoders (subscription-based)
  www.EncoderPro.com (free trial available)
- ICD-9-CM searchable indexes and tabular lists (free)
  icd9cm.chrisendres.com
  www.eICD.com
- ICD-9-CM coding updates and ICD-10-CM/PCS information
  Go to www.cdc.gov and click on the letter “I” link, and then click on the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) link.
- Federal Register listerv
  At listserv.access.gpo.gov, click on the Online mailing list archives link, click on the FEDREGTOC-L link, and click on the Subscribe or Unsubscribe link to register to receive the daily Federal Register table of contents via e-mail. The document will contain the Centers for Medicare and Medicaid Services final rule about implementation of ICD-10-CM and ICD-10-PCS.
- ICD-9 Special Updates and ICD-10 Corner: Latest News
  Go to www.ingenixonline.com and mouse over the Coding Central menu item to select a link.
- Official version of ICD-9-CM from the U.S. Government Bookstore
  bookstore.gpo.gov
- ICD-10
  Go to www.who.int, enter “ICD-10” in the Search box, and click Search to locate information about the World Health Organization’s ICD-10.

STUDY CHECKLIST

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

REVIEW

The ICD-9-CM coding review is organized according to the ICD-9-CM chapters and supplemental classifications. To properly code, refer first to the Index to Diseases (to locate main term and subterm entries) and then to the Tabular List of Diseases (to review notes and verify the code selected).

Underline the main term in each item; then use Index to Diseases and Tabular List of Diseases coding rules and conventions to assign the code(s). Enter the code(s) on the line next to each diagnostic statement. Be sure to enter the first-listed code first.
INFECTIONOUS AND PARASITIC DISEASES (INCLUDING HIV)

1. Aseptic meningitis due to AIDS
2. Asymptomatic HIV infection
3. Septicemia due to streptococcus
4. Dermatophytosis of the foot
5. Measles; no complications noted
6. Nodular pulmonary tuberculosis; confirmed histologically
7. Acute cystitis due to *E. coli*
8. Tuberculosis osteomyelitis of lower leg; confirmed by histology
9. Gas gangrene

NEOPLASMS

10. Primary malignant melanoma of skin of scalp
11. Lipoma of face
12. Glioma of the parietal lobe of the brain
13. Primary adenocarcinoma of prostate
14. Carcinoma *in situ* of vocal cord
15. Hodgkin’s granuloma of intra-abdominal lymph nodes and spleen
16. Paget’s disease with primary infiltrating duct carcinoma of breast, nipple, and areola
17. Liver cancer
18. Metastatic adenocarcinoma from breast to brain (right mastectomy performed 5 years ago)
19. Cancer of the pleura (primary site)

ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES, AND IMMUNITY DISORDERS

20. Cushing’s Syndrome
21. Hypokalemia
22. Type II diabetes mellitus, uncontrolled, with malnutrition
23. Hypogammaglobulinemia
24. Hypercholesterolemia
25. Nephrosis due to type II diabetes
26. Toxic diffuse goiter with thyrotoxic crisis
27. Cystic fibrosis
28. Panhypopituitarism
29. Rickets

DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS

30. Sickle cell disease with crisis
31. Iron deficiency anemia secondary to chronic blood loss
32. Von Willebrand’s disease
33. Chronic congestive splenomegaly
34. Congenital nonspherocytic hemolytic anemia
35. Essential thrombocytopenia
36. Malignant neutropenia
37. Fanconi’s anemia
38. Microangiopathic hemolytic anemia
39. Aplastic anemia secondary to antineoplastic medication for breast cancer

MENTAL DISORDERS
40. Acute exacerbation of chronic undifferentiated schizophrenia
41. Reactive depressive psychosis due to the death of a child
42. Hysterical neurosis
43. Anxiety reaction manifested by fainting
44. Alcoholic gastritis due to chronic alcoholism (episodic)
45. Juvenile delinquency; patient was caught shoplifting
46. Depression
47. Hypochondria; patient also has continuous laxative habit
48. Acute senile dementia with Alzheimer’s disease
49. Epileptic psychosis with generalized grand mal epilepsy

DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS
50. Neisseria meningitis
51. Intracranial abscess
52. Postvaricella encephalitis
53. Hemiplegia due to old CVA
54. Encephalitis
55. Retinal detachment with retinal defect
56. Congenital diplegic cerebral palsy
57. Tonic-clonic epilepsy
58. Infantile glaucoma
59. Mature cataract

DISEASES OF THE CIRCULATORY SYSTEM
60. Congestive rheumatic heart failure
61. Mitral valve stenosis with aortic valve insufficiency
62. Acute rheumatic heart disease
63. Hypertensive cardiovascular disease, malignant
64. Congestive heart failure; benign hypertension
65. Secondary benign hypertension; stenosis of renal artery
66. Malignant hypertensive nephropathy with uremia
67. Acute renal failure; essential hypertension
68. Acute myocardial infarction of inferolateral wall, initial episode of care
69. Arteriosclerotic heart disease (native coronary artery) with angina pectoris

**DISEASES OF THE RESPIRATORY SYSTEM**
70. Aspiration pneumonia due to regurgitated food
71. Streptococcal Group B pneumonia
72. Respiratory failure due to myasthenia gravis
73. Intrinsic asthma in status asthmaticus
74. COPD with emphysema

**DISEASES OF THE DIGESTIVE SYSTEM**
75. Supernumerary tooth
76. Unilateral femoral hernia with gangrene
77. Cholesterosis of gallbladder
78. Diarrhea
79. Acute perforated peptic ulcer
80. Acute hemorrhagic gastritis with acute blood loss anemia
81. Acute appendicitis with perforation and peritoneal abscess
82. Acute cholecystitis with cholelithiasis
83. Aphthous stomatitis
84. Diverticulosis and diverticulitis of colon
85. Esophageal reflux with esophagitis

**DISEASES OF THE GENITOURINARY SYSTEM**
86. Vesicoureteral reflux with bilateral reflux nephropathy
87. Acute glomerulonephritis with necrotizing glomerulitis
88. Actinomycotic cystitis
89. Subserosal uterine leiomyoma, cervical polyp, and endometriosis of uterus
90. Dysplasia of the cervix

**DISEASES OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM**
91. Defibrination syndrome following termination of pregnancy procedure 2 weeks ago
92. Miscarriage at 19 weeks gestation
93. Incompetent cervix resulting in miscarriage and fetal death
94. Postpartum varicose veins of legs
95. Spontaneous breech delivery
96. Triplet pregnancy, delivered spontaneously
97. Retained placenta without hemorrhage, newborn delivered this admission
98. Pyrexia of unknown origin during the puerperium (postpartum), delivery during previous admission

99. Late vomiting of pregnancy, undelivered

100. Pre-eclampsia complicating pregnancy, delivered this admission

**DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE**

101. Diaper rash

102. Acne vulgaris

103. Post-infectional skin cicatrix

104. Cellulitis of the foot; culture reveals staphylococcus

105. Infected ingrowing nail

**DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE**

106. Displacement of thoracic intervertebral disc

107. Primary localized osteoarthrosis of the hip

108. Acute juvenile rheumatoid arthritis

109. Chondromalacia of the patella

110. Pathologic fracture of the vertebra due to metastatic carcinoma of the bone from the lung

**CONGENITAL ANOMALIES**

111. Congenital diaphragmatic hernia

112. Single liveborn male (born in the hospital) with polydactyly of fingers

113. Unilateral cleft lip and palate, incomplete

114. Patent ductus arteriosus

115. Congenital talipes equinovalgus

**CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD**

116. Erythroblastosis fetalis

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

118. Erb’s palsy

119. Hypoglycemia in infant with diabetic mother

120. Premature “crack” baby born in hospital to cocaine-dependent mother (birthweight 1,247 grams)

**SYMPTOMS, SIGNS, AND ILL-DEFINED CONDITIONS**

121. Abnormal cervical Pap smear

122. Sudden infant death syndrome

123. Sleep apnea with insomnia

124. Fluid retention and edema

125. Elevated blood pressure reading
## INJURY AND POISONING
### FRACTURES, DISLOCATIONS, AND SPRAINS

126. Open frontal fracture with subarachnoid hemorrhage with brief loss of consciousness

127. Supracondylar fracture of right humerus and fracture of olecranon process of the right ulna

128. Anterior dislocation of the elbow

129. Dislocation of the first and second cervical vertebrae

130. Sprain of lateral collateral ligament of knee

## OPEN WOUNDS AND OTHER TRAUMA

131. Avulsion of eye

132. Traumatic below-the-knee amputation with delayed healing

133. Open wound of buttock

134. Open wound of wrist involving tendons

135. Laceration of external ear

136. Traumatic subdural hemorrhage with open intracranial wound; loss of consciousness, 30 minutes

137. Concussion without loss of consciousness

138. Traumatic laceration of the liver, moderate

139. Traumatic hemothorax with open wound into thorax and concussion with loss of consciousness

140. Traumatic duodenal injury

## BURNS

141. Third-degree burn of lower leg and second-degree burn of thigh

142. Deep third-degree burn of forearm

143. Third-degree burns of back involving 20 percent of body surface

144. Thirty percent body burns with 10 percent third-degree

145. First- and second-degree burns of palm

## FOREIGN BODIES

146. Coin in the bronchus with bronchoscopy for removal of the coin

147. Foreign body in the eye

148. Marble in colon

149. Bean in nose

150. Q-tip stuck in ear

## COMPLICATIONS

151. Infected ventriculoperitoneal shunt

152. Displaced breast prosthesis

153. Leakage of mitral valve prosthesis
154. Postoperative superficial thrombophlebitis of the right leg
155. Dislocated hip prosthesis

**V CODES**

156. Exposure to tuberculosis
157. Family history of colon carcinoma
158. Status post unilateral kidney transplant, human donor
159. Encounter for removal of cast
160. Admitted to donate bone marrow
161. Encounter for chemotherapy for patient with Hodgkin’s lymphoma
162. Reprogramming of cardiac pacemaker
163. Replacement of tracheostomy tube
164. Encounter for renal dialysis for patient in chronic renal failure
165. Encounter for speech therapy for patient with dysphasia secondary to an old CVA
166. Encounter for fitting of artificial leg
167. Encounter for observation of suspected malignant neoplasm of the cervix
168. Visit to radiology department for barium swallow to rule out ulcer; barium swallow performed and the findings are negative
169. Follow-up examination of colon adenocarcinoma resected 1 year ago, no recurrence found
170. Routine general medical examination
171. Examination of eyes
172. Outpatient encounter for laboratory test to rule out tuberculosis
173. Encounter for physical therapy; status post below-the-knee amputation 6 months ago
174. Kidney donor
175. Encounter for chemotherapy; breast carcinoma

**CODING LATE EFFECTS**

*Place an X on the line in front of each diagnostic statement that identifies a late effect of an injury/illness.*

176. ______ Hemiplegia due to previous cerebrovascular accident
177. ______ Malunion of fracture, right femur
178. ______ Scoliosis due to infantile paralysis
179. ______ Keloid secondary to injury 9 months ago
180. ______ Gangrene, left foot, following third-degree burn of foot 2 weeks ago
181. ______ Cerebral thrombosis with hemiplegia
182. ______ Mental retardation due to previous viral encephalitis
183. ______ Laceration of tendon of finger 2 weeks ago. Admitted now for tendon repair
Code the following:

184. Residuals of poliomyelitis
185. Sequela of old crush injury to left foot
186. Cerebrovascular accident 2 years ago with late effects
187. Effects of old gunshot wound, left thigh
188. Disuse osteoporosis due to previous poliomyelitis
189. Brain damage following cerebral abscess 7 months ago
190. Hemiplegia due to old cerebrovascular accident

ADVERSE REACTIONS AND POISONINGS

191. Ataxia due to interaction between prescribed carbamazepine and erythromycin
192. Vertigo as a result of dye administered for a scheduled IVP
193. Accidental ingestion of mother’s oral contraceptives (no signs or symptoms resulted)
194. Hemiplegia; patient had an adverse reaction to prescribed Enovid 1 year ago
195. Stricture of esophagus due to accidental lye ingestion 3 years ago
196. Listlessness resulting from reaction between prescribed Valium and ingestion of a six-pack of beer
197. Lead poisoning (child had been discovered eating paint chips)
198. Allergic reaction to unspecified drug
199. Theophylline toxicity
200. Carbon monoxide poisoning from car exhaust (suicide attempt)