ICD-10-CM
For Long-Term Care

June 2015

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Objectives

• Review code structure;
• Review format of ICD-10-CM Volumes 1 and 2
• Review coding conventions
• Review basic coding guidelines related to long term care
• Review documentation concerns relating to code assignment
• Review actions to take now to prepare for October 1st
Code Structure

• Alphanumeric structure with all codes starting with an alphabetic character.
• Basic code structure consists of three characters.
• A decimal point is used to separate the basic three-character category code from its subcategory and sub-classifications.
• Most ICD-10-CM codes contain a maximum of six characters, with a few categories having a seventh-character code value.

Code Structure, continued

• Each chapter has the following subdivisions:
  • Sections (groups of three-character categories)
  • Categories (three-character code numbers)
  • Subcategories (four-character code numbers)
  • Fifth-, sixth-, or seventh-character sub-classifications (five-, six-, or seven-character code numbers).
• The basic code used to classify a particular disease or injury consists of three characters and is called a category
  • Example: K29, Gastritis and duodenitis
Code Structure, continued

• All categories have three characters. A three-character category that has no further subdivision is equivalent to a code.

• Valid codes may be three, four, five, six, or seven characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code.

• A code that has an applicable seventh character is considered invalid without the seventh character

• Truncated codes are codes that are “cut off” or incomplete. These codes are invalid and will be rejected when submitted on a bill

Placeholder Character

• The letter “x” is used as a placeholder character at certain codes to allow for future expansion.

• Certain categories have an additional seventh-character value. The applicable seventh-character value is required for all codes within the category, or as the notes in the Tabular List instruct. The seventh character must always be the seventh character in the code.

• If a code is not a full six characters, a placeholder character “x” must be used to fill in the empty characters when a seventh character value is required

• CANNOT SKIP THE X AND MOVE CHARACTERS OVER
Format of ICD-10-CM book

- The ICD-10-CM is divided into the Tabular List and the Alphabetic Index.
  - The Tabular List is a chronological list of codes divided into chapters based on body system or condition.
    - There are three-, four-, five-, six-, and seven-character codes.
    - Codes appear in alphanumerical order
  - The Index is an alphabetical list of terms and their corresponding code. There is a pattern to identations found in this volume
    - Main terms are flush to the left-hand margin.
    - Subterms are indented. The more specific the subterm, the farther the indent.
    - Carryover lines are two indents from the indent level of the preceding line.
    - There are also strict alphabetization rules

Tabular List of Disease and Injuries

- The main classification of diseases and injuries in the Tabular List of Diseases and Injuries consists of 21 chapters.
  - Approximately half of the chapters are devoted to conditions that affect a specific body system; the rest classify conditions according to etiology.
  - Codes in the Tabular List appear in numerical order.
  - References from the Alphabetic Index to the Tabular List are by code number, not by page number.
  - Code numbers and titles appear in bold type in the Tabular List.
Alphabetic Index

• The Alphabetic Index consists of:
  • Index of Diseases and Injuries
  • Index to External Causes
  • Neoplasm Table, and
  • Table of Drugs and Chemicals.
• The Alphabetic Index includes entries for main terms, subterms, and more specific subterms.
• An indented format is used for ease of reference.
• Main terms identify disease conditions or injuries.
• Subterms indicate site, type, or etiology for conditions or injuries.

Connecting Words

• Words such as “with,” “in,” “due to,” and “associated with” are used to express the relationship between the main term or a subterm indicating an associated condition or etiology.
• Subterms preceded by “with” or “without” are not listed in alphabetical order but appear immediately below the main term or appropriate subterm entries.
  • Subterms beginning with other connecting words appear in alphabetical order.
• Coders who fail to remember this feature of the alphabetization rules often make coding errors by overlooking the appropriate subterm.

Disease, diseased (Continued)
breast (see also Disorder, breast) N64.9
cystic (chronic) – see Mastopathy, cystic
fibrocystic – see Mastopathy, cystic
Paget’s (M8540/3)
  female, unspecified side C50.91-
  male, unspecified side C50.92-
specified NEC N64.8
Breda’s – see Yaws
Bretonneau’s (diphtheritic malignant angina) A36.0

Cholecystitis K81.9
  - with
  - - calculus, stones in
    - - - bile duct (common) (hepatic) K80.4
    - - - biliary (chronic) K80.1
    - - - cystic duct K80.1
    - - - gallbladder K80.1
    - - cholecystolithiasis (chronic) K80.1
    - - choledocholithiasis K80.4
    - - choledolithiasis K80.1
    - acalculus K81.9
    - acute K81.0
  - with
    - - calculus, stones in
    - - - biliary K80.0
    - - - cystic duct K80.0
    - - - gallbladder K80.0
    - - - cholecystolithiasis K80.0
    - - - choledocholithiasis K80.4
Coding Conventions

• **General notes** appear in the Tabular List of Diseases and Injuries, providing information on usage in a specific section.

• **Inclusion and Exclusion** notes indicate when certain conditions are or are not included in a given subdivision. Their location at the beginning of a chapter or a section—applies to all codes within the chapter or section and is not repeated with individual categories or specific codes.

• **Cross Reference** Notes indicate the user should refer to another area within the alphabetical index; “see also....”

Inclusion Notes

• Used to further define, or give examples of, the content of the chapter, section, or category.

• Conditions may be synonyms or conditions similar enough to be classified to the same code.

• In the case of “other specified codes,” the terms may be a list of the various conditions that are assigned to that code.

• Inclusion notes are not exhaustive; rather, they list certain conditions to reassure the coder.
Exclusion Notes

**Excludes 1**
- Should never be used at the same time as the code above.
- Two conditions cannot occur together.
- Do not use two codes together.

**Excludes 2**
- Condition excluded is not part of the condition represented by the code.
- Acceptable to use both codes together if both conditions are present at the same time.
- Look elsewhere

"Code First"

**Tabular List**
- Identifies a code for a condition that is a manifestation of an underlying disease.
- Underlying condition must be sequenced before the code for the manifestation.
- The code for the underlying disease will also have an instructional note in the Tabular List to “use additional code” for the manifestation.
- The manifestation codes usually have the phrase “in diseases classified elsewhere” as part of the code title. Codes with this phrase are never used as a first-listed or principal diagnosis code. They must be used with the underlying condition code sequenced first.
“Use Additional Code”

- Indicates that another code may be needed to include a complete statement of the condition.
- If the condition mentioned in the note is documented as present, the additional code should always be assigned.
- It is not necessary to report the code identified in a "use additional code" note in the diagnosis field immediately following the primary code.

```
E08 Diabetes mellitus due to underlying condition
  Code first the underlying condition, such as:
    Congenital rubella (P15.0)
    Cushing's syndrome (E24.-)
    Cystic fibrosis (E84.-)
    Malignant neoplasm (C00-C97)
    Malnutrition (E40-E46)
    Pancreatitis and other diseases of the pancreas (K85-K86.-)
  Use additional code to identify any insulin use (E779.4)
  Excludes 1: drug or chemical induced diabetes mellitus (E09.-)
    gestational diabetes (O24.4-)
    neonatal diabetes mellitus (P70.2)
    type 1 diabetes mellitus (E10.-)
    type 2 diabetes mellitus (E11.-)
E08.0 Diabetes mellitus due to underlying condition with hyperosmolarity
  E08.00 Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
  E08.01 Diabetes mellitus due to underlying condition with hyperosmolarity with coma
E08.1 Diabetes mellitus due to underlying condition with ketoacidosis
  E08.10 Diabetes mellitus due to underlying condition with ketoacidosis without coma
```

“Code Also”

- Indicates two codes may be required to fully describe a condition.
- Sequencing order will depend on the reason for the encounter and the severity of the conditions
Abbreviations - NEC

• “Not Elsewhere Classified”
• Used in Alphabetic Index and Tabular List.
• This abbreviation means there is no unique code for the condition, even though the diagnostic statement may be very specific.
• Codes are ordinarily classified to a code with a fourth or sixth character “8” (or a fifth character “9”), and with a title that includes the words “other specified” or “not elsewhere classified.”

Abbreviations - NOS

• “Not Otherwise Specified,” equivalent of “unspecified”
• Used in the Alphabetic Index and Tabular List
• Used only when neither the diagnostic statement nor the medical record provides information that permits classification to a more specific code.
• The codes are ordinarily classified to codes with a fourth or sixth character “9” and fifth character “0.”
• Conditions listed as both “not elsewhere classified” and “unspecified” are sometimes combined in one code.
Essential Modifiers

Nonessential modifiers
- Supplementary words or explanatory information that may either be present or absent in the statement of diagnosis or procedure without affecting the code to which it is assigned.
- Denoted in parentheses ( )

Essential modifiers
- Listed as subterms in the Alphabetic Index, not in parentheses; they do affect code assignment

Relational Terms

“and” or “with”
- The word “and” should be interpreted to mean either “and” or “or” when it appears in a title.
- The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.
- The word “with” in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.

“Due to”
- The words “due to” in either the Alphabetic Index or the Tabular List indicate that a causal relationship between two conditions is present.
- ICD-10-CM occasionally makes such an assumption when both conditions are present.
- In other combinations, however, the diagnostic statement must indicate this relationship.
Basic Coding Steps

• Locate the main term in the Alphabetic Index.
  • Review subterms and nonessential modifiers related to the main term.
  • Follow any cross-reference instructions.
  • Refer to any notes in the Alphabetic Index.
  • A dash (−) at the end of an Index entry indicates additional characters are required.

• Verify the code number in the Tabular List.
  • Read the code title.
  • Read and follow any instructional notes. Refer to other codes as instructed.
  • Determine whether an additional character must be added.

• Assign the verified code(s).

Basic Coding Steps – Important Tips for Alphabetical Index

• Search for subterms, notes, or cross-references.
• Subterms provide more specific information of many types and must be checked carefully, following all alphabetization rules.
• Do not assign main term code entry until all subterm possibilities have been exhausted.
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• Subterms provide more specific information of many types and must be checked carefully, following all alphabetization rules.
• Do not assign main term code entry until all subterm possibilities have been exhausted.

• Some conditions are indexed under more than one main term.
• Consider synonym, eponym, or other alternative term.
Basic Coding Steps – Verification of code

• Do not assign codes without verifying the Tabular List.
• Review title for the code entry, chapter, section, and category to ensure accuracy.
  • Note: Title in the Tabular List does not always match the Alphabetic Index entry exactly.
• Significant discrepancies between the Index entry and the Tabular List alert the coder to review Alphabetic Index for more appropriate term.
• Read and follow all instructional terms and notes.
• Pay particular attention to exclusion notes.
• Ordinarily the code listed with the main term entry in the index is for unspecified condition.
• Review other codes in the related area to determine whether more specific code can be assigned.

Coding example:

• Abscess abdominal wall due to Staphylococcus
  • Main term Abscess
  • Subterm abdomen, abdominal L02.211
  • “Use additional code” note: assign a code to identify the responsible organism (B95-B96).
  • Look up main term Infection and subterm staphylococcal as cause of disease classified elsewhere B95.8
  • Code title is “Unspecified staphylococcus as the cause of diseases classified elsewhere.”
  • Review medical record for mention of the specific type of Staphylococcus. If mentioned, consider B95.6- or B95.7; if not, assign code B95.8 as an additional code
Important things to remember:

Level of detail in coding

- Diagnosis codes are to be used and reported at their highest number of digits available.
- Composed of codes with three to seven digits
- A three-digit code is to be used only if it is not further subdivided.
General Coding Guidelines

Multiple coding for a single condition

• “dual classification” describes the required assignment of two codes to provide information about both a manifestation and the associated underlying disease or etiology.

• Mandatory multiple coding is identified in the Alphabetic Index by the use of a second code in brackets. The first code identifies the underlying condition, and the second identifies the manifestation. Both codes must be assigned and sequenced in the order listed.

• Also identified with “Use additional code”, “Code first”, “Code, if applicable, any causal condition first”

• Example: Dementia in Parkinson’s Disease is coded to G20 + F02.80

General Coding Guidelines

Combination codes

• Identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List

• Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs

• Example: Acute pharyngitis due to streptococcal infection is coded to J02.0
General Coding Guidelines

Sequelae (Late Effects)
• The condition or nature of the sequelae is sequenced first.
• The Sequelae code is sequenced second.
• There is NO time limit to when the sequela can be used; may be apparent early as in a cerebral infarction, or may appear months or years late, as in an injury
• The fact that a condition is a late effect may be inferred when the diagnostic statement includes terms such as the following:
  • Late
  • Old
  • Due to previous injury or illness
  • Following previous injury or illness
  • Traumatic, unless there is evidence of current injury

Example: Post-traumatic osteoarthritis of right shoulder due to old fracture of right humerus is coded as M19.11 + S42.301S

General Coding Guidelines

Sequelae (Late Effects) - Exception to the “two code rule”
• When the late effect code has been expanded at the fourth-, fifth-, or sixth-character level(s) to include the manifestation condition, only the cause of the late effect code is assigned.

Example: I69.01, Cognitive deficits following nontraumatic subarachnoid hemorrhage, includes the cause of the late effect (nontraumatic subarachnoid hemorrhage), as well as the manifestation (cognitive deficits).
Signs and Symptoms

• Signs and symptoms are classified in two ways in ICD-10-CM:
  • Those that point to a specific diagnosis have been assigned to a category in
    other chapters of ICD-10-CM.
  • Those that point to more than one disease or system, or that are of
    unexplained etiology, are classified to chapter 18 of ICD-10-CM.

  *Codes R00 – R99*

Note at beginning of chapter 18 also states this chapter includes the less well-defined conditions and symptoms... that may point equally to two or more diagnoses

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**CG C.18.a: Use of symptom codes**

Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

**CG B.5: Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.**
Diagnoses of Possible, Probable . . .

• Diagnoses described as possible, probable, and so on at the time of discharge are treated differently depending on whether the patient:
  
  • Is an inpatient; the diagnosis is considered to be an established diagnosis.
  
  • Is a long-term resident; the diagnosis is not considered to be an established diagnosis.
   • If there is not an established diagnosis, only whatever symptoms or signs that are available at the highest level of certainty are assigned.

Abnormal Findings

• Categories R90 through R97 in chapter 18 are provided for coding nonspecific abnormal findings.
• If the documentation indicates clinical findings outside the normal range but no related diagnosis is stated:
  • Review record to determine whether additional tests and/or consultations were carried out related to these findings or whether specific related care was given.
  • Ask the physician whether a code should be assigned.
Falls

• ICD-10 allows us to capture frequent falls and history of falls.
• Facilities should develop coding policies to ensure consistent use of these codes

C.18.d: Repeated falls
Code R29.6, Repeated falls, is for use for “encounters” when a patient has recently fallen and the reason for the fall is being investigated.
Code Z91.81, History of falling, is for use when a patient has fallen in the past and is at risk for future falls.
When appropriate, both codes R29.6 and Z91.81 may be assigned together.

Glasgow Coma Scale

• Scale for assessing the degree of consciousness, especially after a head injury.
• Scoring determined by three factors:
  • Amount of eye opening,
  • Verbal responsiveness, and
  • Motor responsiveness.
• The test score can function as an indicator for certain diagnostic tests or treatments and for predicting the duration and ultimate outcome of coma.

CG: 18.e: Codes in subcategory R40.2, Coma, can be used in combination with traumatic brain injury or acute cerebrovascular disease codes, or sequelae of cerebrovascular disease codes.
Subcategory R40.2, Coma

• Primarily for use by trauma registries but may be used in any setting where this information is collected.
• Facilities should develop coding policies to ensure consistent use of coma codes
• The coma scale codes should be sequenced after the diagnosis code(s).
  • One code from each subcategory (amount of eye opening, verbal responsiveness, and motor responsiveness) is needed to complete the scale.
  • The seventh character indicates when the scale was recorded (e.g., in the field, at arrival to emergency department, at hospital admission).
  • The seventh character should match for all three codes.
• R40.24, Glasgow coma score, total score, should be assigned only when the total score is documented and not the individual scores

Functional Quadriplegia

• Documentation should indicate functional versus neurologic

CG C.18.f: Functional quadriplegia (code R53.2) is the lack of ability to use one’s limbs or to ambulate due to extreme debility. It is not associated with neurologic deficit or injury, and code R53.2 should not be used for cases of neurologic quadriplegia. It should only be assigned if functional quadriplegia is specifically documented in the medical record.
Symptoms followed by comparative diagnoses

• In previous coding guidelines, there was a guideline for coding symptom followed by comparative diagnoses
• Example: Female with abdominal pain, possible UTI versus cholelithiasis

• THIS GUIDELINE HAS BEEN DELETED WITH THE FY 2015 guideline

• If your book contains older guidelines, you may want to make a note next to CG II.E

Infectious and Parasitic Diseases

INCLUDES:
• Diseases that are generally recognized as communicable or transmittable
• Use additional code to identify resistance to antimicrobial drugs (Z16.-)

EXCLUDES 1:
• Certain localized infections—see body system–related chapters, infectious and parasitic diseases complicating pregnancy, childbirth, and the puerperium (O98.-)
• Influenza and other acute respiratory infectious disease (Z22.-)

EXCLUDES 2:
• Carrier or suspected carrier of infectious disease (Z22.-)
• Infectious and parasitic diseases specific to the perinatal period (P35–39)
Infections by Type

- When coding infections, you start by locating the type of infection in the alphabetical listing.
- Coding a specific organism will require a culture or detailed description from the referral source.

**Example:**

Staphylococcal (staph) unspecified site:
- A49.01 methicillin susceptible
- A49.01 methicillin resistant
Streptococcal (strep) unspecified site: A49.1

MRSA

**CG C.1.e (1)(a):** When a patient is diagnosed with an infection that is due to methicillin resistant *Staphylococcus aureus* (MRSA), and that infection has a combination code that includes the causal organism (e.g., sepsis, pneumonia) assign the appropriate combination code for the condition (e.g., code A41.02, Sepsis due to Methicillin resistant Staphylococcus aureus or code J15.212, Pneumonia due to Methicillin resistant Staphylococcus aureus). Do not assign a code from subcategory Z16.11, Resistance to penicillins, as an additional diagnosis.

**CG C.1.e (1)(b):** When there is documentation of a current infection (e.g., wound infection, stitch abscess, urinary tract infection) due to MRSA, and that infection does not have a combination code that includes the causal organism, assign the appropriate code to identify the condition along with code B95.62, Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere for the MRSA infection. Do not assign a code from subcategory Z16.11, Resistance to penicillins.
MRSA colonization versus carrier

- Use a code from subcategory Z22.3- to show possible or suspected carrier or colonization.
- Colonization means that MSSA or MSRA is present on or in the body without necessarily causing illness. Do not automatically use an active MRSA infection code.
- Assign code Z22.322, Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus, for patients documented as having MRSA colonization. Assign code Z22.321, Carrier or suspected carrier of Methicillin susceptible Staphylococcus aureus, for patient documented as having MSSA colonization.
- It is acceptable to combine codes from subcategory Z22.3 and the MRSA codes when a resident is suspected of being a carrier AND has an active MRSA infection.
- Reference: Coding Guideline C.1.e (1)(c)

Drug Resistant Infections

- It is important to identify all infections documented as antibiotic resistant.
- If the attending physician states an infection has become resistant, the appropriate code from Z16, resistance to antimicrobial drugs, should follow the infection code.
- Note: the Excludes 1 note for Z16 disallows the use of specific MRSA codes.

**CG C.1.c: Infections resistant to antibiotics**

Many bacterial infections are resistant to current antibiotics. It is necessary to identify all infections documented as antibiotic resistant. Assign a code from category Z16, Resistance to antimicrobial drugs, following the infection code only if the infection code does not identify drug resistance.
HIV and AIDS

• Code only confirmed cases of AIDS and HIV
• B20 should not be used for suspected or possible HIV-related illness
• Sequencing is dependent on reason for admission/encounter

**CG C.1.a(1)** Code only confirmed cases Code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline Section II, H.
In this context, “confirmation” does not require documentation of positive serology or culture for HIV; the provider’s diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

HIV and AIDS

• If reason for admission or encounter is HIV-related illness, B20 is sequenced first followed by diagnoses for related conditions
• If reason for admission or encounter is not HIV-related illness, B20 is sequenced as a secondary diagnosis
  • Reference: CG C.1.a.(2) and (3)


• Z21 - Asymptomatic human immunodeficiency virus [HIV] infection status, is to be applied when the patient **without** any documentation of symptoms is listed as being “HIV positive,” “known HIV,” “HIV test positive,” or similar terminology.
  • Do not use this code if term AIDS is used as this indicates symptomatic HIV-related illness
Tuberculosis

• Tuberculosis is classified based on affected body system or type. Active TB is captured on the MDS in Section I, I2200.
  • A15 Respiratory tuberculosis
  • A17 Tuberculosis of nervous system
  • A18 Tuberculosis of other organs
  • A19 Miliary tuberculosis

• Care should be used to distinguish between a diagnosis of active tuberculosis and a positive tuberculin skin test (R76.11). R76.11 includes:
  • Positive PPD (skin test)
  • Abnormal result of Mantoux test
  • Tuberculin (skin test) positive
  • Tuberculin (skin test) reactor

Sepsis and Severe Sepsis

• Cannot assume diagnosis of sepsis based on laboratory data. In ICD-10, sepsis replaced term septicemia
• Severe sepsis is sepsis complicated by organ dysfunction
• Systemic inflammatory response syndrome (SIRS) is the body’s systemic response to an infection, trauma/burn, or other serious condition. In SIRS, the patient has a widespread reaction to an infection or trauma and may have a high white blood cell count or changes in vital signs.
Sepsis and Severe Sepsis

• Two codes are required for coding SIRS, sepsis, and severe sepsis.
• The code for the underlying cause (such as trauma or infection) is sequenced first, followed by R65.10–R65.11 for the *systemic inflammatory response syndrome*).
• In order to assign a code, the physician must document either the term sepsis or SIRS. This code cannot be a primary diagnosis.
• If the physician did not document any underlying cause, the first code assigned should be A41.9.
• A third code may be needed to specify any acute organ dysfunction.
Examples: Sepsis is SIRS caused by an infection: A41.9
  Severe sepsis is sepsis with organ failure: A41.9, R65.20
  Septic shock is sepsis with failure of the cardiovascular system: A41.9, R65.21
• Hint: In coding sepsis, “A” comes before “R”
• Reference: Coding Guidelines C.1.d

Neoplasms

• To appropriately code a neoplasm, you must know the morphology (histology): malignant, benign, in situ, uncertain behavior
  • Malignant codes include primary and secondary sites
• The table of neoplasm should be used to correctly identify the topography code; It is located after Z in the alphabetical index
  • The table lists neoplasms by anatomical site, and the columns are utilized to select one of the six types and the associated code.
• Sequencing of codes is dependent on reason for admission or encounter. Reference: CG C.2.a and CG C.2.b
Steps for assigning Neoplasm Codes:

- Look under the histological term for the site in the alphabetical index first
- If present in the index, assign the code
- If the site is not present, follow the instructions and refer to the neoplasm table
- The neoplasm table is now found after the letter “Z” in the alphabetical index
- Determine whether the tumor is malignant or benign (Note: the instructions under the morphology type may tell you)
- Determine whether neoplasm is a primary or secondary site in the body
- Look up the code in the correct column in the neoplasm table
- If metastatic disease is documented, indicating a primary and a secondary site, be sure to use two codes
  - C80.1 is the code for unknown site, primary, and C79.9 is the unknown site, secondary.
- Confirm the code in the tabular list
- Follow any instructions provided to code additional codes

Carcinoma (M8010/3) - see also Neoplasm, malignant

Note - Except where otherwise indicated, the morphological varieties of carcinoma in the list below should be coded by site as for Neoplasm, malignant.

<table>
<thead>
<tr>
<th>Neoplasm, neoplastic—continued</th>
<th>In Situ</th>
<th>Design</th>
<th>Neoplasm</th>
<th>Malignant</th>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>- intramyeloid solid—continued</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C31.1</td>
<td>C78.3 D02.0 D14.1 D38.0</td>
</tr>
<tr>
<td>- marginal zone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C31.1</td>
<td>C79.8 D00.0 D10.7 D37.0</td>
</tr>
<tr>
<td>- internal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C71.0</td>
<td>C79.3 D33.0 D43.0</td>
</tr>
<tr>
<td>- mesenchymal borderless</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C55.0</td>
<td>C79.8 D06.0 D26.0 D39.0</td>
</tr>
<tr>
<td>- intervertebral cartilage or disk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C41.2</td>
<td>C79.5 D16.6 D48.0</td>
</tr>
<tr>
<td>- intima, intestinal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C26.0</td>
<td>C78.5 D01.4 D13.9 D35.7</td>
</tr>
<tr>
<td>- large</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C18.9</td>
<td>C78.5 D01.0 D12.6 D37.4</td>
</tr>
<tr>
<td>- appendix</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C18.9</td>
<td>C78.5 D01.0 D12.1 D37.3</td>
</tr>
<tr>
<td>- cecum</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C18.0</td>
<td>C78.5 D01.0 D12.0 D37.4</td>
</tr>
<tr>
<td>- colon</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C18.9</td>
<td>C78.5 D01.0 D12.6 D37.4</td>
</tr>
<tr>
<td>- with rectum</td>
<td></td>
<td></td>
<td></td>
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<td>C19</td>
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Sequencing of complications of neoplasms

- Sequencing is influenced by condition AND the treatment rendered
- Anemia due to malignancy
  - Malignancy sequenced first, followed by anemia
- Anemia due to chemotherapy, or immunotherapy
  - Anemia sequenced first, followed by malignancy and code for adverse reaction of chemotherapy/immunotherapy
- Dehydration due to malignancy
  - Dehydration sequenced first, followed by malignancy

Reference: Coding Guideline C.3
Neoplasms, continued

- Malignancy in two or more contiguous sites
  - Most anatomical sites allow use of subcategory .8 for overlapping lesions
- Malignancy in two or more non-contiguous sites
  - Recommend querying physician
- Disseminated malignancy
  - C80.0, Disseminated malignant neoplasm, unspecified, is for use only in those cases where the patient has advanced metastatic disease and no known primary or secondary sites are specified.
- Malignant neoplasm, site unspecified
  - Code C80.1, Malignant (primary) neoplasm, unspecified, equates to Cancer, unspecified. This code should only be used when no determination can be made as to the primary site of a malignancy.

History of primary malignancy

CG C.2.d: When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.

Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site.

The secondary site may be the principal or first-listed with the Z85 code used as a secondary code.
Anemia

• Due to blood loss
  • It is important to distinguish between anemia due to acute blood loss from anemia due to chronic blood loss.
  • Clinical documentation, such as a lowered hematocrit or hemoglobin, does not indicate a coder in a long-term care facility can assume that a newly diagnosed blood loss anemia is considered an acute blood loss.

• Due to chronic disease
  • If the anemia is due to or caused by a chronic disease process, code both the chronic condition and the anemia

Note: there are no specific coding guidelines for diseases of the blood and blood forming organs at this time.

Prolonged Prothrombin Time

• Prolonged Prothrombin Time for residents receiving Coumadin is an expected effect of the medication.

• It is not appropriate to code R79.1, Abnormal coagulation profile, in these situations.

• To capture these residents, the facility may decide to code Z79.01, Long-term (current) use of anticoagulant
Diabetes

• Distinction between Type I, Type II, and Secondary Diabetes.
  • No longer based on insulin dependent versus non-insulin dependent
  • Type I often referred to as juvenile diabetes
• If the type is not specified, must assume Type II
• If type is not specified and resident uses insulin, must assume Type II
• Code Z79.4, Long-term (current) use of insulin, should also be
  assigned to indicate that the patient uses insulin. Code Z79.4 should
  not be assigned if insulin is given temporarily to bring a type 2
  patient’s blood sugar under control during an encounter.
  
Reference:  Coding Guideline C.4.a.1 – C.4.a.3

Diabetes, continued

Coding guidelines C.4.a states "as many codes within a particular category to describe ALL complications may be used." When coding multiple manifestations, a diabetic code is assigned with each manifestation from a different category

Example: Diabetic neuropathy and diabetic angiopathy have two codes.

  E11.42 Diabetes with polyneuropathy
  E11.51 Diabetes with peripheral angiopathy without gangrene
  (or E11.52 with gangrene)
Diabetes

• Uncontrolled diabetes is coded to diabetes, by type, with hyperglycemia
  • E10.65, Type I diabetes with hyperglycemia
  • E11.65, Type II diabetes with hyperglycemia
• Facility should develop policy regarding use of code Z79.4, Long-term (current) use of insulin to ensure consistency
  • Note under E11 to use additional code to identify insulin use

E11  Type 2 diabetes mellitus
  Includes:  diabetes (mellitus) due to insulin secretory defect
            diabetes NOS
            insulin resistant diabetes (mellitus)
  Use additional code to identify any insulin use (Z79.4)
  Excludes1: diabetes mellitus due to underlying condition (E08.-)