

# SPECIFIC GUIDELINES FOR USING ICD-10-CM

## OBJECTIVES

When you complete this lesson, you'll be able to:

- Summarize the ICD-10-CM chapter-specific coding and reporting guidelines for ICD-10-CM Chapters 1–10
- Summarize the ICD-10-CM chapter-specific coding and reporting guidelines for ICD-10-CM Chapters 11–14
- Summarize the ICD-10-CM chapter-specific coding and reporting guidelines for ICD-10-CM Chapters 15–21

## ASSIGNMENT 6: CHAPTER-SPECIFIC GUIDELINES

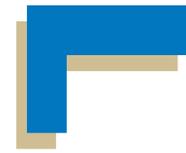
**Read through the following material in your study guide. Then read Chapters 5, 6, and 7 of your textbook, *Step-by-Step Medical Coding*. At the end of each chapter, complete the Chapter Review. You can check your answers using the Answers section at the end of this study guide.**

### Chapter-Specific Coding Guidelines, Chapters 1–10

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You previously learned about the general ICD-10-CM guidelines. Now, turn your attention to the chapter-specific guidelines, beginning with chapters 1–10. Chapter 5 of your textbook covers specific guidelines pertaining to assigning diagnosis codes for:

- Certain Infectious and Parasitic Diseases
- Neoplasms
- Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism
- Endocrine, Nutritional, and Metabolic Diseases



- Mental, Behavioral, and Neurodevelopmental Disorders
- Diseases of the Nervous System
- Diseases of the Eye and Adnexa
- Diseases of the Ear and Mastoid Process
- Diseases of the Circulatory System
- Diseases of the Respiratory System

In your career as a medical coder, you'll review charts that include diagnoses pertaining to infectious disease. These types of disease affect different parts of the body, and for this reason, it's important to understand the different types of codes that pertain to infectious diseases. In some instances, you'll assign a code that completely describes the condition and any manifestations of the condition. This is called a *combination code*. However, in other situations, you'll need to assign more than one code to fully describe the condition. This is called *multiple coding*. A patient diagnosed with candidiasis of the mouth would be assigned to B37.0, a combination code. A patient diagnosed with a urinary tract infection due to an infection such as E. coli would be assigned to N39.0, along with another code for the E. coli. You'll also assign diagnosis codes for patients diagnosed with *systemic inflammatory response syndrome (SIRS)*, wherein microorganisms exist in the blood, skin, lungs, or urinary system, and the patient may experience fever, hypothermia, tachycardia, increased respiratory rate, and increased or decreased blood count. When a patient who has been diagnosed with SIRS also has organ failure, SIRS becomes known as *severe sepsis*. If severe sepsis is documented in the patient's medical record (and only if this is the case), you would assign a code from subcategory R65.2. Patients with severe sepsis require three codes:

1. A code for the underlying systemic infection
2. A code from the R65.2 subcategory
3. A code to report the specific type of organ dysfunction that the patient is experiencing

A patient may also experience *septic shock*, a type of organ dysfunction involving circulatory failure. In these instances, you would report the underlying infection, then assign code R65.21 for severe sepsis with septic shock, and then assign codes for the organ dysfunction.

Another infectious disease condition that you'll code is viral hepatitis. Patients may be diagnosed with hepatitis A, B, C, D, or E. You'll report these conditions with codes in the B15–B19 range. These codes are classified according to the type of hepatitis as well as whether hepatic coma is a factor in the patient's diagnosis.

A patient diagnosed with HIV will be reported with code B20 for human immunodeficiency virus diseases, including AIDS, which is caused by HIV. You'll also report additional codes for any manifestation of AIDS. Remember to read the chart carefully to determine whether the physician has confirmed the AIDS diagnosis. A patient may be HIV-positive but without the manifestation of symptoms, in which case you would report Z21, asymptomatic HIV status. When assigning this code, the medical record documentation must state that the patient is HIV-positive, has known HIV, is HIV test-positive, or include similar terms. If the chart includes AIDS, or the patient is being treated for an illness related to HIV, or the patient has a condition resulting from HIV, you would assign code B20.

If the patient has been exposed to HIV but hasn't tested positive, you would report Z20.6. Inconclusive HIV serology would be reported with R75. A pregnant patient who is HIV positive would be assigned to code O98.7, HIV-related illness complicating pregnancy, childbirth, and the puerperium with B20 assigned as the secondary code, along with additional codes for any illness related to HIV. Screening for HIV is assigned to code Z11.4. Additional codes include Z72.51 (high-risk heterosexual behavior), Z72.52 (high-risk homosexual behavior), Z72.53 (high-risk bisexual behavior), or Z71.7 (HIV counseling).

Code range C00–D49 is used to report *neoplasms*. Neoplasms may be either benign or malignant. *Benign neoplasms* don't spread or become cancerous. *Malignant neoplasms* are cancerous and may spread to other sites in the body. You'll reference the neoplasm table in the Alphabetic Index first.

However, if the histological term is documented in the medical record, you would locate the term in the Alphabetic Index first, and then find it in the Neoplasm table. This helps you select the correct column in the Neoplasm table to locate your code. There are numerous guidelines for coding various aspects of neoplasms including: treatments directed at a malignant neoplasm, treatment directed at a secondary neoplasm, anemia pertaining to malignancy, complications pertaining to malignancy, management of dehydration related to malignancy, and pathologic fracture related to neoplasms. Pay special attention to the chapter guidelines for coding anemia due to malignancy. Code the malignancy first and then the anemia. You'll use Z codes to indicate a history of malignant neoplasm. Review the documentation thoroughly to determine whether the cancer is still being treated or whether it occurred in the past and is no longer currently being treated before you select your code(s).

You'll also review charts that include diagnoses pertaining to blood and blood-forming organs and immune disorders. You'll assign codes for these disorders using code range D50–D89. One of the most common blood disorders is *anemia*. You'll assign codes for common anemia disorders such as anemia of chronic disease and chronic simple anemia. The difference between these two conditions is that anemia of chronic disease is used when anemia is caused by another disease, whereas chronic simple anemia is a nutritional anemia. You'll assign D63.8 for anemia of chronic disease, and code D53.9 for chronic simple anemia.

You'll also assign codes for coagulation defects, such as von Willebrand's disease, using code range D65–D69. A patient diagnosed with blood disorders such as neutropenia or an elevated white blood cell count would be reported with D70–D77. Codes ranging from D80–D89 are used to report immune disorders such as Wiskott-Aldrich syndrome, an immunodeficiency disorder that impedes blood-clot formation.

Part of your responsibility as a medical coder includes assigning codes for chronic endocrine, nutritional, and metabolic diseases, such as diabetes. You'll find codes for these conditions in code range E00–E89. You'll regularly assign codes for type 1 and type 2 diabetic patients, most notably type 2, using code range E08–E13. One of the key differences between

the two is that type 1 diabetic patients develop diabetes prior to reaching puberty. If the physician doesn't document the type of diabetes, either type 1 or type 2, you would assign code E11-, for type 2 diabetes. If the patient is on long-term insulin, you would assign code Z79.4 as a secondary code. In some instances, the patient may receive insulin via an insulin pump. If the insulin pump fails and the patient receives an underdose of insulin, you would assign code T85.6- to indicate the mechanical malfunction, and then an additional code to indicate the underdose of insulin (T38.3X6-) as well as any complications resulting from the underdose. If the insulin pump fails and the patient receives an overdose of insulin, you would assign code T85.6- followed by T38.3X1- for an overdose of insulin.

You'll also assign codes for mental, behavioral, and neuro-developmental disorders using ICD-10. Mental conditions, in particular, may be harder to code because the physician may not be specific when indicating the diagnoses in the medical record. You'll assign codes for different types of dementia, such as vascular dementia (F01), dementia in other diseases classified elsewhere (F02), and dementia, unspecified (F03). Two of the most common mood disorders that you'll code are depression (F32-F33) and anxiety (F41-). You'll also frequently code substance abuse disorders, such as alcohol-related disorders or dependence (F10), and assign codes for patients with psychological disorders, such as schizophrenia (F20-F29).

You'll also assign codes for nervous system disease using code range G00-G99. Codes for chronic pain and neoplasm-related pain, for example, are assigned with code G89. You would assign this code if the reason for the encounter is pain management. However, you would *not* assign this code if the underlying condition that's causing the pain is known and that underlying condition is the reason for the treatment. If the patient is experiencing postoperative pain that's expected after the surgery that was performed, you wouldn't assign code G89 since the pain is expected. However, if the postoperative pain is associated with a surgical complication, then you would assign G89. Be sure to review the guidelines for assigning code G89, as the rules for code assignment will vary depending on the circumstances.

You'll also regularly assign pain codes that are specific to certain anatomical locations in the body. For example, a patient diagnosed with chest pain would be assigned to code range R07.1–R07.9, depending on the nature of the chest pain. Normally, you'll assign code R07.9 for chest pain, unspecified. A patient diagnosed with a headache would be assigned to code R51. Codes for paralysis are also assigned using codes from this chapter, depending on whether the paralysis occurs on the patient's dominant side or nondominant side. You'll find this information in the medical record.

You'll report diseases of the eye and adnexa using code range H00–H59. Diseases related to the eye can be difficult to code, due to the complex structure of the eye and the surrounding structures (such as conjunctiva, sclera, cornea, iris, and so on). Be sure to consult a medical dictionary or search online if you're unsure about a particular part of the eye. A patient diagnosed with *conjunctivitis*, inflammation of the conjunctiva, would be assigned to a code from category H10. A diagnosis of acute follicular conjunctivitis of the left eye, but not the right eye, would be assigned to code H10.012, for example.

Definitions pertaining to certain eye conditions are equally important to understand for accurate code assignment. A patient with an *entropion* has an eyelid that turns inward. A patient with an *ectropion* has an eyelid that turns inside out. An entropion, if it's not further specified as to type, is assigned to code H02.00-, while an ectropion, if unspecified, is assigned to code H02.1-.

You'll report diseases of the ear and mastoid process using code range H60–H95. Conditions of the ear pertain to the inner ear, middle ear, or external ear. Conditions of the inner ear are classified to code range H80–H83. Conditions of the middle ear are found in code range H65–H75. Conditions of the external ear appear in code range H60–H62. Two of the most common conditions that you'll regularly code are otitis media, unspecified (H66.90 if the left or right ear is not indicated; H66.91 for otitis media of the right ear; H66.92 for otitis media of the left ear; H66.93 for bilateral otitis media) and otitis externa (H60.90 for unspecified ear; H60.91 for the right ear; H60.92 for the left ear; H60.93 for bilateral otitis extern). Pediatric patients will often be coded for cerumen (ear wax) impaction. Code H61.20 is assigned for cerumen

impaction if the ear is unspecified. Code H61.21 is assigned for cerumen impaction of the right ear. Code H61.22 is assigned for cerumen impaction of the left ear. Code H61.23 is assigned for cerumen impaction of both ears (bilaterally). Review the medical record closely to determine the correct anatomical location to assign the correct code.

The most common conditions that you'll code in the circulatory system (I00–I99) are hypertension and conditions related to hypertension. Hypertension may be benign (mild blood pressure elevation controlled on medication), malignant (accelerated hypertension with a poor prognosis and potentially resulting in organ failure), or unspecified (the physician doesn't indicate whether the hypertension is benign or malignant). Hypertension may be controlled or uncontrolled, so review the medical record closely to see if this is indicated by the physician.

ICD-10 guidelines make a distinction between assigning diagnosis codes for hypertension and chronic kidney disease versus hypertension with heart disease. The key difference between these two sets of conditions is that a causal relationship is assumed between hypertension and chronic kidney disease, but not assumed for hypertension with heart disease. The physician must state that the heart disease is due to the hypertension or must imply a causal relationship between the two conditions (as with hypertensive heart disease). Code category I11 is used to code these two conditions, plus an additional code from category I50, if the patient has heart failure. If the physician doesn't establish a causal relationship between hypertension and heart disease, they must be coded separately and sequenced based on the circumstances of the encounter. Since chronic kidney disease is assumed to result from hypertension, a causal relationship is already established. You would assign a code from category I12, hypertensive chronic kidney disease, and an additional code from N18, chronic kidney disease, to indicate the stage of chronic kidney disease (Stage 1: N18.1, Stage 2: N18.2 [mild], Stage 3: N18.3 [moderate], Stage 4: N18.4 [severe], Stage 5: N18.5, Stage 6: N18.6 [end stage renal disease], and Stage 9: N18.9 [unspecified]).

Additional circulatory system diseases include myocardial infarction, categorized as either STEMI (ST elevation myocardial infarction) or NSTEMI (non-ST elevation myocardial infarction). The *ST* is an indicator on an *electrocardiogram* (a recording of heart activity). ST elevation indicates potential occlusion of the coronary artery or potential heart muscle damage. The diagnosis of STEMI is assigned to subcategory codes I21.0–I21.2 and I21.3. Code I21.4 is assigned for patients diagnosed with NSTEMI.

You'll report diseases of the respiratory system using code range J00–J99. You'll assign codes for common respiratory diseases and disorders including pneumonia (J18.9, if the organism isn't specified), acute sinusitis, unspecified (J01.90), and unspecified asthma with acute exacerbation (J45.901). You may regularly assign the code for unspecified conditions because the physician may not provide more specific information in the diagnosis. If the physician provides more specific information, then you would assign the code that includes the additional term(s). For example, if the physician indicates acute maxillary sinusitis rather than acute sinusitis (that is, the sinusitis is contained within the maxillary sinus only), then you would assign code J01.00 for acute maxillary sinusitis rather than acute sinusitis. You would also assign an additional code for the etiology (origin) of the condition, if known. Acute maxillary sinusitis due to *Haemophilus influenzae* would be assigned to J01.00 and B96.3, respectively.

## Chapter-Specific Coding Guidelines, Chapters 11–14

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This section discusses the guidelines in chapters 11–14. Chapter 6 of your text covers specific guidelines pertaining to diagnosis codes for

- Diseases of the Digestive System
- Diseases of the Skin and Subcutaneous Tissue
- Diseases of the Musculoskeletal System and Connective Tissue
- Diseases of the Genitourinary System

You'll report diseases of the digestive system using code range K00–K95. A patient with gastrointestinal hemorrhage, unspecified, would be assigned to code K92.2. A patient diagnosed with diverticulitis of the large intestine in the setting of perforation and abscess with bleeding would be assigned to code K57.21. Likewise, acute gastric ulcer with hemorrhage would be assigned to K25.0.

Diseases of the skin and subcutaneous tissue are assigned to code range L00–L99. A patient diagnosed with acne vulgaris would be coded to L70.0, which is found in code range L60–L75, disorders of skin and appendages. Skin, hair, and nail conditions that originate from birth (that is, *congenital* conditions) are assigned to codes Q80–Q89. Cellulitis of the right finger would be coded as L03.011, whereas cellulitis of the left finger would be coded as L03.012. A patient who is bedridden for an extended period of time after being admitted to the hospital may develop pressure ulcers, which vary according to the stage of the ulcer and the anatomical location. Pressure ulcer of the left hip, stage 1, is coded as L89.221. On the other hand, a pressure ulcer of the sacrum, stage 4, is assigned to code L89.154. Read the medical chart carefully when determining the correct code assignment.

Diseases of the musculoskeletal system and connective tissue are assigned to code range M00–M99. Common conditions coded using this code range include osteoarthritis (inflammation of the bone and joint), arthritis (inflammation of the joints only), and fractures (breaks in the bone), to name some examples. When you assign codes for these types of conditions, you must pay special attention to the anatomic site as well as the laterality. The *anatomic site* indicates the part of the body where the condition occurred; laterality indicates the side of the body where the condition occurred. For example, a patient may be diagnosed with primary osteoarthritis occurring in the hip. The osteoarthritis may occur in the right hip, in the left hip, or in both hips, or the physician may not indicate in which hip the condition occurred (unspecified). To assign musculoskeletal codes accurately, you must thoroughly review the medical record to verify the anatomic site as well as the laterality that pertains to the diagnosis. Additionally, for fractures, you must check the record to verify whether the patient sustained a pathologic fracture or a traumatic

fracture. A *pathologic fracture*, or *spontaneous fracture*, occurs due to weakened bone resulting from the surrounding bone tissue or bone disease. A *traumatic fracture* occurs due to an accident, or *trauma*, sustained to the body that causes a break in the bone. Never assign a code for a traumatic fracture and a pathologic fracture to the same bone. It must be one or the other based on the documentation in the medical record.

You may also occasionally assign codes for infectious arthropathies using categories M00–M02. There are two types of infections: direct and indirect. *Direct infections*, an infection in which the invading organism has been identified, occur in the joint as well as in the synovial tissue. *Indirect infections* include *reactive arthropathy* (a condition in which the infection is found in the body, but the invading organism isn't identified in the joint) and *postinfective arthropathy* (a condition in which a microbial immune response occurs but the organism recovery isn't regular, and multiplication of the microorganisms isn't apparent). Examples of infectious arthropathies include reactive arthritis (M02.3) and reactive arthropathy, unspecified (M02.9).

You'll report diseases of the genitourinary system using code range N00–N99. Common conditions reported within this code range include kidney stones (calculus, calculi, or calculous), different stages of chronic kidney disease (most notably in relation to hypertension, as discussed previously), and other diagnoses of the male genitalia, the female genitalia, and the urinary system.

## Chapter-Specific Coding Guidelines, Chapters 15–21

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This section discusses the guidelines in chapters 15–21. Chapter 7 of your text covers specific guidelines pertaining to assigning diagnosis codes for

- Pregnancy, Childbirth, and Puerperium
- Certain Conditions Originating in the Perinatal Period
- Congenital Malformations, Deformations, and Chromosomal Abnormalities

- Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified
- Injury, Poisoning, and Certain Other Consequences of External Causes
- External Causes of Morbidity
- Factors Influencing Health Status and Contact with Health Services

As a coder, you'll often assign codes that pertain to pregnancy, childbirth, and the puerperium, most notably during the patient's pregnancy. Conditions that originate during pregnancy, childbirth, and the puerperium are assigned to categories O00–O9A and found in Chapter 15. Obstetric coding is one of the most challenging forms of coding that you'll do, based on the wide variety of conditions and complications that may occur during the stages of pregnancy, as well as the guidelines for obstetric coding. One of the most important guidelines to remember when assigning codes related to pregnancy is that pregnancy codes (codes from O00–O9A) are always assigned *first*, before any other codes. These codes always take sequencing priority over codes from any other chapters. These codes are always reported on the mother's record, *never* on the newborn record. After you report these codes, you may assign additional codes pertaining to diagnoses from other chapters. It's also important to determine whether the patient's condition occurred before the pregnancy (a pre-existing condition) or whether it occurred sometime during or after the pregnancy. If the physician indicates that the patient's condition was incidental to the pregnancy but not related to the pregnancy, you would assign code Z33.1, pregnant state, incidental. If the patient is seen only for routine supervision of pregnancy, you would assign a code from category Z34, encounter for supervision of normal pregnancy. However, if there are any complications pertaining to the pregnancy, you can't assign code Z34. Instead, assign a code from O00–O9A as the principal diagnosis. You must always assign a code from category Z37, outcome of delivery, if the patient delivers during the medical encounter. Pay special attention to the trimester indicated in the medical record.

*Trimesters* are three-month periods counted from the first day of the patient’s last menstrual period. The patient may be having complications in the first, second, or third trimester of pregnancy. Accurate code assignment means selecting the diagnosis that includes the correct trimester. A first-trimester patient who is experiencing asthma during the pregnancy (or who has a past medical history of asthma, for which she’s using an inhaler), would be assigned O99.511, diseases of the respiratory system, complicating pregnancy, first trimester. If the patient was in her second trimester, you would use O99.512, and O99.513 in the third trimester. If the trimester is unspecified, the code to use is O99.519, diseases of the respiratory system, complicating pregnancy, unspecified.

<b>Pregnancy Trimester Quick Reference</b>	
First trimester	Less than 14 weeks since the patient’s last menstrual period
Second trimester	14 weeks to less than 28 weeks since the patient’s last menstrual period
Third trimester	28 weeks from the last menstrual period

You’ll be able to determine the patient’s current trimester based on the statement in the medical record (usually found at the very beginning under *History of Present Illness*). The statement will indicate the number of weeks in relation to the reason for the patient’s medical encounter. For example, a statement that begins with “The patient is 22 weeks...,” indicates that the patient is in the second trimester of pregnancy. Based on the trimester guidelines noted in the chart, you can see that 22 weeks corresponds to the second trimester. This tells you that the diagnosis for the patient’s condition should indicate the second trimester of pregnancy. You’ll also add another code for weeks of gestation (in this case 22) for greater specificity: Z3A.22. You would also add a code for the specific respiratory condition indicated (in the example, asthma).

Complications may also occur in the *peripartum period* (the last month of pregnancy to five months postpartum) or in the *postpartum period* (shortly after the delivery until six weeks after the delivery). The important factor to remember is that the physician must document that the condition occurred in the postpartum period.

If the patient delivers a normal, full-term infant, you would assign code O80. If there are any pregnancy complications, you would instead assign the pregnancy complication code(s) previously indicated. If the complication previously existed but resolved prior to the delivery, you can still assign code O80. You would add code Z37, single live birth, for the outcome of delivery.

**Note:** Z37 is the only code that you can assign as an outcome of delivery code in connection with code O80.

In addition to the example of asthma in pregnancy, you may also assign other chronic condition codes related to pregnancy. Pre-existing hypertension in pregnancy would be assigned to category O10. A patient with diabetes mellitus in pregnancy would be assigned to code O24, followed by an additional code for the specific type of diabetes (E08–E13). If a patient wasn't diabetic prior to pregnancy but has developed diabetes during the pregnancy, you would assign a code for gestational diabetes from subcategory O24.4. Abnormal glucose tolerance in pregnancy is assigned to subcategory code O99.81.

Using Chapter 16, you'll assign codes for congenital conditions originating in the perinatal period (P00–P96). The *perinatal period* begins before birth and extends through 28 days after birth. *Never* assign codes for the newborn to the mother's record or vice versa. You would assign a code from category Z38, liveborn infants according to place of birth and type of delivery, as the principal diagnosis on the newborn record. Examples of the types of conditions reported using Chapter 16 codes include birth trauma, newborn infections in the perinatal period, and newborns affected by conditions inherent to the mother's pregnancy.

Chapter 17 codes (Q00–Q99) pertain to congenital malformations, deformations, and chromosomal abnormalities that begin in the perinatal period. An example of a common chromosomal abnormality is Down Syndrome (Q90). A chromosomal abnormality must be documented in the medical record by the physician. If the chromosomal abnormality isn't documented, or if it's unclear, ask the physician to clarify the diagnosis. The query is made in writing using a standard form that becomes a permanent part of the patient's medical record after the physician's written response is received.

Codes for chapter 18 (R00–R99) are assigned for symptoms, signs, and abnormal clinical and laboratory findings. These codes are most often assigned when the physician can't make a more definitive diagnosis because the cause of the patient's symptoms can't be determined. As indicated in Lesson 2, signs and symptoms shouldn't be reported as the final diagnosis when the physician makes a definitive diagnosis. For example, if a patient is seen for abdominal pain and the physician renders a diagnosis of appendicitis, you would assign the final diagnosis code of appendicitis, not abdominal pain, since the abdominal pain is a common symptom of appendicitis. Some symptoms, however, may be unrelated to the final diagnosis.

**Tip:** If you're ever unsure about the symptoms for the final diagnosis, perform an Internet search using the final diagnosis, along with the word *symptoms*. Select one or more results to review the common symptoms found in the diagnosis. For example, an Internet search of *appendicitis + symptoms* would return a list of websites citing abdominal pain as a common symptom of appendicitis.

Chapter 19 codes (S00–T88) are external causes codes, used to report injury, poisoning, and other related conditions. When assigning injury codes, pay special attention to the seventh character. The seventh character indicates whether the patient's visit is the initial encounter (A) or subsequent encounter (D). Or, the patient's visit may be a *sequela* (S), a condition that arises from a previously diagnosed condition, such as a scar that's formed after a burn. S00–S99 codes are used to report injuries to specific locations of the body (such as the head, hip, and thorax), while T07 and T14 are used to report injuries to unspecified body regions.

You'll also use Chapter 19 to report conditions pertaining to injuries involving damage to the nerves and blood vessels, as well as open and closed traumatic fractures. When coding fractures, review the medical record thoroughly to determine whether the patient is still being actively treated for the fracture or whether the patient has completed active treatment and is in the recovery phase. If the patient has completed active treatment and is receiving aftercare, such as a cast change or cast removal, you'll assign codes to indicate fracture aftercare. There may be other instances in which the patient has delayed seeking treatment for the fracture and is currently being seen for the nonunion of the fracture. The seventh character of the code that you choose will change depending on the circumstances of the fracture, so be sure to review the guidelines for Chapter 19 coding in conjunction with the medical record when assigning codes for fractures.

Codes from Chapter 19 are also used when a patient is diagnosed with

- Burns and corrosions
- Adverse effects, poisoning, underdosing, and toxic effects
- Abuse, neglect, and other maltreatment
- Open wounds, lacerations, and punctures
- Complications of care

When coding burns, you'll assign diagnosis codes according to depth of the burn, extent of the burn, and the agent. Burns may be first, second, or third degree. When the patient has more than one burn, sequence the burn that's the highest degree first. For example, a third-degree burn is more serious than a second- or first-degree burn; therefore, the third-degree burn would be sequenced first. Nonhealing burns are coded as acute burns. Necrosis of burned skin is coded as a nonhealing burn.

You'll use the Table of Drugs and Chemicals to assign codes for adverse effects, poisoning, underdosing, and toxic effects. *Never* code directly from the Table of Drugs and Chemicals. Always verify your codes in the Tabular List, and use as many codes as possible. If the medical record indicates a drug overdose, review the record closely to determine whether the

poisoning was accidental, intentional, assault, undetermined, an adverse effect (of a medication that was taken correctly), or due to underdosing.

For situations in which the patient is being abused, neglected, or mistreated, use a code from category T74- (confirmed child or adult abuse) or T76- (suspected child or adult abuse) followed by a mental health or injury code. The code Y07 (perpetrator of abuse) should also be added for confirmed cases of abuse. Additional guidelines apply for assigning physical injury codes pertaining to abuse, as well as observation codes and encounters in which abuse has been ruled out. Be sure to review the guidelines thoroughly when assigning codes for child- or adult-abuse situations.

When assigning codes for open wounds, locate the term *wounds* in the Alphabetic Index, followed by the subterm(s) pertaining to the wound. An example of a wound includes an open wound of the right knee (S81.001). *Laceration* is also a main term in the Alphabetic Index. Examples of lacerations include laceration of the right knee, without a foreign body in the knee (S81.011).

You may also assign codes for medical or surgical complications. For example, a patient who undergoes a kidney transplant may experience complications as a result of the surgery; these would be assigned to code T86.1-.

Codes from Chapter 20, External Causes of Morbidity, (V00-Y99) are assigned as secondary codes to indicate the circumstances surrounding a patient's injury (reported first with a code from Chapter 19). If the patient was painting a house and fell off a ladder, you would assign codes from Chapter 20 to indicate *painting, house, and fall on and from ladder*. These codes are always reported as secondary codes.

Chapter 21 codes (Z00-Z99) are assigned for factors that influence a patient's health status and contact with health services. These codes begin with the letter *Z* and can be used in any healthcare setting. If a patient comes to the doctor's office for a flu vaccine, you would report Z23, encounter for immunization. If a patient is seen for an annual mammogram, you would report Z12.31, encounter for screening mammogram for malignant neoplasm of breast. Likewise, an encounter for a routine gynecological examination would be assigned to code Z01.41.