ICD~10~CM

Complete Code Set

Clinical Modification

Sample

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Preface

ICD-10-CM Official Preface

This 2014 update of the International Classification of Diseases and, 10th revision, Clinical Modification (ICD-10-CM) is being published by the United States Government in recognition of its responsibility to promulgate this classification throughout the United States for morbidity coding. The International Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), published by the World Health Organization (WHO), is the foundation of ICD-10-CM. ICD-10 continues to be the classification used in cause-of-death coding in the United States. The ICD-10-CM is comparable with the ICD-10. The WHO Collaborating Center for the Family of International Classifications in North America, housed at the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS), has responsibility for the implementation of ICD and other WHO-FIC classifications and serves as a liaison with the WHO, fulfilling international obligations for comparable classifications and the national health data needs of the United States. The historical background of ICD and ICD-10 can be found in the Introduction to the International Classification of Diseases and Related Health Problems (ICD-10), 2008, World Health Organization, Geneva, Switzerland.

ICD-10-CM is the United States' clinical modification of the World Health Organization's ICD-10. The term "clinical" is used to emphasize the modification's intent: to serve as a useful tool in the area of classification of morbidity data for indexing of health records, medical care review, and ambulatory and other health care programs, as well as for basic health statistics. To describe the clinical picture of the patient the codes must be more precise than those needed only for statistical groupings and trend analysis.

Characteristics of ICD-10-CM

ICD-10-CM far exceeds its predecessors in the number of concepts and codes provided. The disease classification has been expanded to include health-related conditions and to provide greater specificity at the sixth and seventh character level. The sixth and seventh characters are not optional and are intended for use in recording the information documented in the clinical record.

ICD-10-CM: The Complete Draft Code Set

This *ICD-10-CM: The Complete Draft Code Set* edition includes the following features, designed in consultation with coding consultants and ICD-10 trainers, to provide a comprehensive and easy-to-use reference manual:

- A table of contents page
- The complete 2014 ICD-10-CM code set
- Full code descriptions
- Special color coding throughout to highlight instructional notes, bilateral indicators, and other features.
- Color coding for Medicare code edits to highlight age, sex, manifestation, other specified and unspecified codes
- Illustrations
- ICD-10-CM conventions
- ICD-10-CM official coding guidelines
- Official index to the tabular section
- Official index to external causes
- Table of drugs and chemicals
- Neoplasm table
- Extention "X" alert symbol to alert readers to the new ICD-10-CM placeholder "x" convention
- Anatomy and physiology drawings interspersed throughout and used to explain particular categories
- Trimester icon for O30 and O31 categories
- Appendix including new, changed, and deleted codes.

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ICD-10-CM Draft Official Conventions

The conventions for the ICD-10-CM are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the Alphabetic Index and Tabular List of the ICD-10-CM as instructional notes.

Format and Structure

The ICD-10-CM Tabular List contains categories, subcategories and codes. Characters for categories, subcategories and codes may be either a letter or a number. All categories are 3 characters. A three-character category that has no further subdivision is equivalent to a code. Subcategories are either 4 or 5 characters. Codes may be 3, 4, 5, 6 or 7 characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. Codes that have applicable 7th characters are still referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character.

The ICD-10-CM uses an indented format for ease in reference.

Codes for reporting purposes

For reporting purposes only codes, are permissible, not categories or subcategories, and any applicable 7th character is required.

Placeholder Character

The ICD-10-CM utilizes a placeholder character "X". The "X" is used as a placeholder at certain codes to allow for future expansion. An example of this is at the poisoning, adverse effect and underdosing codes, categories T36-T50.

Where a placeholder exists, the X must be used in order for the code to be considered a valid code.

7th Characters

Certain ICD-10-CM categories have applicable 7th characters. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct. The 7th character must always be the 7th character in the data field. If a code that requires a 7th character is not 6 characters, a placeholder X must be used to fill in the empty characters.

Abbreviations

a. Alphabetic Index abbreviations

NEC "Not elsewhere classifiable"

This abbreviation in the Alphabetic Index represents "other specified". When a specific code is not available for a condition, the Alphabetic Index directs the coder to the "other specified" code in the Tabular List.

NOS "Not otherwise specified"

This abbreviation is the equivalent of unspecified.

b. Tabular List abbreviations

NEC "Not elsewhere classifiable"

This abbreviation in the Tabular List represents "other specified". When a specific code is not available for a condition the Tabular List includes an NEC entry under a code to identify the code as the "other specified" code.

NOS "Not otherwise specified"

This abbreviation is the equivalent of unspecified.

Punctuation

[ ] Brackets are used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the Alphabetic Index to identify manifestation codes.

( ) Parentheses are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers.

: Colons are used in the Tabular List after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.

Notes

Other and Unspecified codes

a. "Other" codes

Codes titled "other" or "other specified" are for use when the information in the medical record provides detail for which a specific code does not exist. Alphabetic Index entries with NEC in the line designate "other" codes in the Tabular List. These Alphabetic Index entries represent specific disease entities for which no specific code exists so the term is included within an "other" code.

b. "Unspecified" codes

Codes titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the "other specified" code may represent both other and unspecified.

Includes Notes

This note appears immediately under a three character code title to further define, or give examples of, the content of the category.

Inclusion Terms

A list of terms is included under some codes. These terms are the conditions for which that code is to be used. The terms may

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be synonyms of the code title, or, in the case of "other specified" codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the Alphabetic Index may also be assigned to a code.

Excludes Notes

The ICD-10-CM has two types of excludes notes. Each type of note has a different definition for use but they are all similar in that they indicate that codes excluded from each other are independent of each other.

a. Excludes 1

   A type 1 Excludes note is a pure excludes note. It means "NOT CODED HERE!" An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

b. Excludes 2

   A type 2 Excludes note represents "Not included here". An Excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

Etiology/Manifestation Codes

Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes)

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

In most cases the manifestation codes will have in the code title, "in diseases classified elsewhere." Codes with this title are a component of the etiology/ manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first-listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition.

There are manifestation codes that do not have "in diseases classified elsewhere" in the title. For such codes, there is a "use additional code" note at the etiology code and a "code first" note at the manifestation code and the rules for sequencing apply.

In addition to the notes in the Tabular List, these conditions also have a specific Alphabetic Index entry structure. In the Alphabetic Index both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second.

An example of the etiology/manifestation convention is dementia in Parkinson's disease. In the Alphabetic Index, code G20 is listed first, followed by code F02.80 or F02.81 in brackets. Code G20 represents the underlying etiology, Parkinson's disease, and must be sequenced first, whereas codes F02.80 and F02.81 represent the manifestation of dementia in diseases classified elsewhere, with or without behavioral disturbance.

"Code first" and "Use additional code" notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/ manifestation combination.

And/With/See Also

a. "And"

   The word "and" should be interpreted to mean either "and" or "or" when it appears in a title.

   For example, cases of "tuberculosis of bones", "tuberculosis of joints" and "tuberculosis of bones and joints" are classified to subcategory A18.0, Tuberculosis of bones and joints.

b. "With"

   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.

c. "See" and "See Also"

   The "see" instruction following a main term in the Alphabetic Index indicates that another term should be referenced. It is necessary to go to the main term referenced with the "see" note to locate the correct code.

   A "see also" instruction following a main term in the Alphabetic Index instructs that there is another main term that may also be referenced that may provide additional Alphabetic Index entries that may be useful. It is not necessary to follow the "see also" note when the original main term provides the necessary code.

Code Also

A "code also" note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction.

Default Codes

A code listed next to a main term in the ICD-10-CM Alphabetic Index is referred to as a default code. The default code represents that condition that is most commonly associated with the main term, or is the unspecified code for the condition. If a condition is documented in a medical record (for example, appendicitis) without any additional information, such as acute or chronic, the default code should be assigned.

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Symbols and Conventions

Additional Characters Required

- 4th This red symbol cautions that the code requires an additional fourth character.
- 5th This red symbol cautions that the code requires an additional fifth character.
- 6th This red symbol cautions that the code requires an additional sixth character.
- 7th This red symbol cautions that the code requires an additional seventh character.

Extension "X" Alert

- 7th This blue symbol cautions that the code requires an additional seventh character following the placeholder X.

Medicare Code Edits Symbols and Colors

The Medicare Code Editor (MCE) Version-V30 detects and reports errors in the coding claims data. The coding edit information in this manual is effective from 10/01/2013 to 09/30/2014. However, it is not intended to be used to process claims as the ICD-10 code set will not be mandated for use until the implementation of ICD-10.

Age Conflict

The Medicare Code Editor detects inconsistencies between a patient's age and any diagnosis on the patient's record. For example, a five-year-old patient with benign prostatic hypertrophy or a 78-year-old patient coded with a delivery.

- N Age of 0 years; a subset of diagnoses intended only for newborns and neonates (e.g., fetal distress, perinatal jaundice).
- P Age range is 0–17 years inclusive (e.g., Reye's syndrome, routine child health exam).
- M Age range is 12–55 years inclusive (e.g., diabetes in pregnancy, antepartum pulmonary complication).
- A Age range is 15–124 years inclusive (e.g., senile delirium, mature cataract).

Sex Conflict

Medicare Code Editor detects inconsistencies between a patient's sex and any diagnosis or procedure on the patient's record. For example, a male patient with cervical cancer (diagnosis) or a female patient with a prostatectomy (procedure).

In both instances, the indicated diagnosis or the procedure conflicts with the stated sex of the patient. Therefore, either the patient's diagnosis, procedure or sex is presumed to be incorrect.

- ♂ This symbol indicates diagnoses for male only
- ♀ This symbol indicates diagnoses for females only

Manifestation Codes

Code description is highlighted with light blue color. Manifestation codes describe the manifestation of an underlying disease, not the disease itself, and therefore should not be used as a principal diagnosis.

Other Symbols and Color Coding

Key Terms

Bold green font is used in code descriptions throughout the Tabular List of Diseases to quicky identify key terms in a given category.

Other Specified Codes

Code description is highlighted with gray color. These codes are assigned when the documentation indicates a specified diagnosis, but the ICD-10-CM system does not have a specific code that describes the condition

Unspecified Codes

Code description is highlighted with yellow color. These codes are assigned when neither the diagnostic statement nor the documentation provides enough information to assign a more specific code.

PDx Principal Diagnosis Only

Certain Z codes may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined. A list of these codes can be found in ICD-10-CM official guidelines.

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ICD-10-CM Official Guidelines for Coding and Reporting 2014

Narrative changes appear in **bold** text.

Items underlined have been moved within the guidelines since the 2013 version.

Italics are used to indicate revisions to heading changes.

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS), provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for outpatient coding and reporting. It is necessary to review all sections of the guidelines to fully understand all of the rules and instructions needed to code properly.

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ICD-10-CM Index to Diseases and Injuries

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- **Abandonment** — *see* Maltreatment
- **Abasia** (-astasia) (hysterical) F44.4
- **Abderhalden-Kaufmann-Lignac** syndrome (cystinosis) E72.04
- **Abdomen,** abdominal (*see also* condition)
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  - angina K55.1
  - muscle deficiency syndrome Q79.4
- **Abdominalgia** — *see* Pain, abdominal
- **Abduction** contracture, hip or other joint — *see* Contraction, joint
- **Aberrant** (congenital) (*see also* Malposition, congenital)
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flank S30.811
foot (except toe(s) alone) S90.81-
toe — *see* Abrasion, toe
forearm S50.81-
elbow only — *see* Abrasion, elbow
forehead S00.81
genital organs, external
female S30.816
male S30.815
groin S30.811
gum S00.512
hand S60.51-
head S00.91
ear — *see* Abrasion, ear
eyelid — *see* Abrasion, eyelid
lip S00.511
nose S00.31
oral cavity S00.512
scalp S00.01
specified site NEC S00.81
heel — *see* Abrasion, foot
hip S70.21-
inguinal region S30.811
interscapular region S20.419
jaw S00.81
knee S80.21-
labium (majus) (minus) S30.814
larynx S10.11
leg (lower) S80.81-
knee — *see* Abrasion, knee
upper — *see* Abrasion, thigh
lip S00.511
lower back S30.810
lumbar region S30.810
malar region S00.81

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mammary — *see* Abrasion, breast
mastoid region S00.81
mouth S00.512
nail
finger — *see* Abrasion, finger
toe — *see* Abrasion, toe
nape S10.81
nasal S00.31
neck S10.91
specified site NEC S10.81
throat S10.11
nose S00.31
occipital region S00.01
oral cavity S00.512
orbital region — *see* Abrasion, eyelid
palate S00.512
palm — *see* Abrasion, hand
parietal region S00.01
pelvis S30.810
penis S30.812
perineum
female S30.814
male S30.810
periocular area — *see* Abrasion, eyelid
phalanges
finger — *see* Abrasion, finger
toe — *see* Abrasion, toe
pharynx S10.11
pinna — *see* Abrasion, ear
popliteal space — *see* Abrasion, knee
prepuce S30.812
pubic region S30.810
pudendum
female S30.816
male S30.815
sacral region S30.810
scalp S00.01
scapular region — *see* Abrasion, shoulder
scrotum S30.813
shin — *see* Abrasion, leg
shoulder S40.21-
skin NEC T14.8
sternal region S20.319
submaxillary region S00.81
submental region S00.81
subungual
finger (s) — *see* Abrasion, finger
toe (s) — *see* Abrasion, toe
supraclavicular fossa S10.81
supraorbital S00.81
temple S00.81
temporal region S00.81
testis S30.813
thigh S70.31-
thorax, thoracic (wall) S20.91
back S20.41-
front S20.31-
throat S10.11
thumb S60.31-
toe (s) (lesser) S90.416
great S90.41-
tongue S00.512
tooth, teeth (dentifrice) (habitual) (hard tissues) (occupational) (ritual) (traditional) K03.1
trachea S10.11
tunica vaginalis S30.813
tympanum, tympanic membrane — *see* Abrasion, ear
uvula S00.512
vagina S30.814
vocal cords S10.11
vulva S30.814
wrist S60.81-
Abrism — *see* Poisoning, food, noxious, plant
Abruptio placentae O45.9-
with
afibrinogenemia O45.01-
coagulation defect O45.00-
specified NEC O45.09-
disseminated intravascular coagulation O45.02-
hypofibrinogenemia O45.01-
specified NEC O45.8-
Abruption, placenta — *see* Abruptio placentae
Abscess (connective tissue) (embolic) (fistulous) (infective) (metastatic) (multiple) (pernicious) (pyogenic) (septic) L02.91
with
diverticular disease (intestine) K57.80
with bleeding K57.81
large intestine K57.20
with
bleeding K57.21
small intestine K57.40
with bleeding K57.41
small intestine K57.00
with
bleeding K57.01
large intestine K57.40
with bleeding K57.41
lymphangitis - code by site under Abscess
abdomen, abdominal
cavity K65.1
wall L02.211
abdominopelvic K65.1
accessory sinus — *see* Sinusitis
adrenal (capsule) (gland) E27.8
alveolar K04.7
with sinus K04.6
amebic A06.4
brain (and liver or lung abscess) A06.6
genitourinary tract A06.82
liver (without mention of brain or lung abscess) A06.4
lung (and liver) (without mention of brain abscess) A06.5
specified site NEC A06.89
spleen A06.89
anerobic A48.0
ankle — *see* Abscess, lower limb
anorectal K61.2
antecubital space — *see* Abscess, upper limb
antrum (chronic) (Highmore) — *see* Sinusitis, maxillary
anus K61.0
apical (tooth) K04.7
with sinus (alveolar) K04.6
appendix K35.3
areola (acute) (chronic) (nonpuerperal) N61
puerperal, postpartum or gestational — *see* Infection, nipple
arm (any part) — *see* Abscess, upper limb
artery (wall) I77.89
atheromatous I77.2
auricle, ear — *see* Abscess, ear, external
axilla (region) L02.41-
lymph gland or node L04.2
back (any part, except buttock) L02.212
Bartholin's gland N75.1
with
abortion — *see* Abortion, by type complicated by, sepsis
ectopic or molar pregnancy O08.0
following ectopic or molar pregnancy O08.0
Bezold's — *see* Mastoiditis, acute
bilharziasis B65.1
bladder (wall) — *see* Cystitis, specified type NEC
bone (subperiosteal) (*see also* Osteomyelitis, specified type NEC)
accessory sinus (chronic) — *see* Sinusitis
chronic or old — *see* Osteomyelitis, chronic
jaw (lower) (upper) M27.2
mastoid — *see* Mastoiditis, acute, subperiosteal
petrous — *see* Petrositis
spinal (tuberculous) A18.01
nontuberculous — *see* Osteomyelitis, vertebra
bowel K63.0
brain (any part) (cystic) (otogenic) G06.0
amebic (with abscess of any other site) A06.6
gonococcal A54.82
pheomycotic (chromomycotic) B43.1
tuberculous A17.81
breast (acute) (chronic) (nonpuerperal) N61
newborn P39.0
puerperal, postpartum, gestational — *see* Mastitis, obstetric, purulent
broad ligament N73.2
acute N73.0
chronic N73.1
Brodie's (localized) (chronic) M86.8X-
bronchi J98.09
buccal cavity K12.2
bulbourethral gland N34.0
bursa M71.00
ankle M71.07-
elbow M71.02-
foot M71.07-
hand M71.04-
hip M71.05-
knee M71.06-
multiple sites M71.09
pharyngeal J39.1
shoulder M71.01-
specified site NEC M71.08
wrist M71.03-
buttock L02.31
canthus — *see* Blepharoconjunctivitis
cartilage — *see* Disorder, cartilage, specified type NEC
cecum K35.3
cerebellum, cerebellar G06.0
sequelae G09
cerebral (embolic) G06.0
sequelae G09
cervical (meaning neck) L02.11
lymph gland or node L04.0
cervix (stump) (uteri) — *see* Cervicitis
cheek (external) L02.01
inner K12.2
chest J86.9
with fistula J86.0
wall L02.213
chin L02.01
choroid — *see* Inflammation, chorioretinal
circumtonsillar J36
cold (lung) (tuberculous) (*see also* Tuberculosis, abscess, lung)
articular — *see* Tuberculosis, joint
colon (wall) K63.0
colostomy K94.02
conjunctiva — *see* Conjunctivitis, acute
cornea H16.31-
corpus
cavernosum N48.21
luteum — *see* Oophoritis
Cowper's gland N34.0
cranium G06.0
cul-de-sac (Douglas') (posterior) — *see* Peritonitis, pelvic, female
cutaneous — *see* Abscess, by site
dental K04.7
with sinus (alveolar) K04.6
dentoalveolar K04.7
with sinus K04.6
diaphragm, diaphragmatic K65.1
Douglas' cul-de-sac or pouch — *see* Peritonitis, pelvic, female
Dubois A50.59
ear (middle) (*see also* Otitis, media, suppurative)
acute — *see* Otitis, media, suppurative, acute
external H60.0-
entamebic — *see* Abscess, amebic
enterostomy K94.12
epididymis N45.4
epidural G06.2
brain G06.0
spinal cord G06.1
epiglottis J38.7
epiploon, epiploic K65.1
erysipelatous — *see* Erysipelas
esophagus K20.8
ethmoid (bone) (chronic) (sinus) J32.2
external auditory canal — *see* Abscess, ear, external
extradural G06.2
brain G06.0
sequelae G09
spinal cord G06.1
extraperitoneal K68.19
eye — *see* Endophthalmitis, purulent
eyelid H00.03-
face (any part, except ear, eye and nose) L02.01
fallopian tube — *see* Salpingitis
fascia M72.8
fauces J39.1
fecal K63.0
femoral (region) — *see* Abscess, lower limb
filaria, filarial — *see* Infestation, filarial
finger (any) (*see also* Abscess, hand)
nail — *see* Cellulitis, finger
foot L02.61-
forehead L02.01
frontal sinus (chronic) J32.1
gallbladder K81.0
genital organ or tract
female (external) N76.4
male N49.9
multiple sites N49.8
specified NEC N49.8
gestational mammary O91.11-
gestational subareolar O91.11-
gingival K05.21
gland, glandular (lymph) (acute) — *see* Lymphadenitis, acute
gluteal (region) L02.31
gonorrheal — *see* Gonococcus

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ICD-10-CM Table of Neoplasms

The list below gives the code numbers for neoplasms by anatomical 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 to Diseases and Injuries 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 to Diseases and Injuries can be overridden if one of the descriptors mentioned above is present; e.g., malignant adenoma of colon is coded to C18.9 and not to D12.6 as the adjective "malignant" overrides the Index entry "Adenoma—*see also* Neoplasm, benign."

Codes listed with a dash -, following the code have a required additional character for laterality. The tabular must be reviewed for the complete code.

Neoplasm Index	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified Behavior
Neoplasm, neoplastic	**C80.1**	**C79.9**	**D09.9**	**D36.9**	**D48.9**	**D49.9**
abdomen, abdominal	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.89
cavity	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.89
organ	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.89
viscera	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.89
wall (*see also* Neoplasm, abdomen, wall, skin)	C44.509	C79.2-	D04.5	D23.5	D48.5	D49.2
connective tissue	C49.4	C79.8-	-	D21.4	D48.1	D49.2
skin	C44.509					
basal cell carcinoma	C44.519	-	-	-	-	-
specified type NEC	C44.599	-	-	-	-	-
squamous cell carcinoma	C44.529	-	-	-	-	-
abdominopelvic	C76.8	C79.8-	-	D36.7	D48.7	D49.89
accessory sinus—*see* Neoplasm, sinus						
acoustic nerve	C72.4-	C79.49	-	D33.3	D43.3	D49.7
adenoid(pharynx) (tissue)	C11.1	C79.89	D00.08	D10.6	D37.05	D49.0
adipose tissue (*see also* Neoplasm, connective tissue)	C49.4	C79.89	-	D21.9	D48.1	D49.2
adnexa(uterine)	C57.4	C79.89	D07.39	D28.7	D39.8	D49.5
adrenal	C74.9-	C79.7-	D09.3	D35.0-	D44.1-	D49.7
capsule	C74.9-	C79.7-	D09.3	D35.0-	D44.1-	D49.7
cortex	C74.0-	C79.7-	D09.3	D35.0-	D44.1-	D49.7
gland	C74.9-	C79.7-	D09.3	D35.0-	D44.1-	D49.7
medulla	C74.1-	C79.7-	D09.3	D35.0-	D44.1-	D49.7
ala nasi(external) (*see also* Neoplasm, skin, nose)	C44.301	C79.2	D04.39	D23.39	D48.5	D49.2
alimentary canal or tract NEC	C26.9	C78.80	D01.9	D13.9	D37.9	D49.0
alveolar	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
mucosa	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
ridge or process	C41.1	C79.51	-	D16.5-	D48.0	D49.2
carcinoma	C03.9	C79.8-	-	-	-	-
lower	C03.1	C79.8-	-	-	-	-
upper	C03.0	C79.8-	-	-	-	-
lower	C41.1	C79.51	-	D16.5-	D48.0	D49.2
mucosa	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C41.0	C79.51	-	D16.4-	D48.0	D49.2
sulcus	C06.1	C79.89	D00.02	D10.39	D37.09	D49.0
alveolus	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
ampulla of Vater	C24.1	C78.89	D01.5	D13.5	D37.6	D49.0
ankle NEC	C76.5-	C79.89	D04.7-	D36.7	D48.7	D49.89
anorectum, anorectal(junction)	C21.8	C78.5	D01.3	D12.9	D37.8	D49.0
antecubital fossa or space	C76.4-	C79.89	D04.6-	D36.7	D48.7	D49.89
antrum(Highmore) (maxillary)	C31.0	C78.39	D02.3	D14.0	D38.5	D49.1
pyloric	C16.3	C78.89	D00.2	D13.1	D37.1	D49.0
tympanicum	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
anus, anal	C21.0	C78.5	D01.3	D12.9	D37.8	D49.0
canal	C21.1	C78.5	D01.3	D12.9	D37.8	D49.0
cloacogenic zone	C21.2	C78.5	D01.3	D12.9	D37.8	D49.0
margin (*see also* Neoplasm, anus, skin)	C44.500	C79.2	D04.5	D23.5	D48.5	D49.2
overlapping lesion with rectosigmoid junction or rectum	C21.8	-	-	-	-	-
skin	C44.500	C79.2	D04.5	D23.5	D48.5	D49.2
basal cell carcinoma	C44.510	-	-	-	-	-
specified type NEC	C44.590	-	-	-	-	-
squamous cell carcinoma	C44.520	-	-	-	-	-
sphincter	C21.1	C78.5	D01.3	D12.9	D37.8	D49.0
aorta(thoracic)	C49.3	C79.89	-	D21.3	D48.1	D49.2
abdominal	C49.4	C79.89	-	D21.4	D48.1	D49.2
aortic body	C75.5	C79.89	-	D35.6	D44.7	D49.7
aponeurosis	C49.9	C79.89	-	D21.9	D48.1	D49.2
palmar	C49.1-	C79.89	-	D21.1-	D48.1	D49.2
plantar	C49.2-	C79.89	-	D21.2-	D48.1	D49.2
appendix	C18.1	C78.5	D01.0	D12.1	D37.3	D49.0
arachnoid	C70.9	C79.49	-	D32.9	D42.9	D49.7
cerebral	C70.0	C79.32	-	D32.0	D42.0	D49.7
spinal	C70.1	C79.49	-	D32.1	D42.1	D49.7
areola	C50.0-	C79.81	D05.-	D24.-	D48.6-	D49.3
arm NEC	C76.4-	C79.89	D04.6-	D36.7	D48.7	D49.89
artery—*see* Neoplasm, connective tissue						
aryepiglottic fold	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
hypopharyngeal aspect	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
laryngeal aspect	C32.1	C78.39	D02.0	D14.1	D38.0	D49.1
marginal zone	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
arytenoid(cartilage)	C32.3	C78.39	D02.0	D14.1	D38.0	D49.1
fold—*see* Neoplasm, aryepiglottic						
associated with transplanted organ	C80.2	-	-	-	-	-
atlas	C41.2	C79.51	-	D16.6	D48.0	D49.2
atrium, cardiac	C38.0	C79.89	-	D15.1	D48.7	D49.89
auditory						
canal(external) (skin) A81	C44.20-	C79.2	D04.2-	D23.2-	D48.5	D49.2
internal	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
nerve	C72.4-	C79.49	-	D33.3	D43.3	D49.7
tube	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
opening	C11.2	C79.89	D00.08	D10.6	D37.05	D49.0
auricle, ear (*see also* Neoplasm, skin, ear)	C44.20-	C79.2	D04.2-	D23.2-	D48.5	D49.2
auricular canal(external) (*see also* Neoplasm, skin, ear)	C44.20-	C79.2	D04.2-	D23.2-	D48.5	D49.2
internal	C30.1	C78.39	D02.3	D14.0	D38.5	D49.2
autonomic nerve or nervous system NEC (*see also* Neoplasm, nerve, peripheral)						
axilla, axillary	C76.1	C79.89	D09.8	D36.7	D48.7	D49.89
fold (*see also* Neoplasm, skin, trunk)	C44.509	C79.2	D04.5	D23.5	D48.5	D49.2
back NEC	C76.8	C79.89	D04.5	D36.7	D48.7	D49.89
Bartholin's gland	C51.0	C79.82	D07.1	D28.0	D39.8	D49.5
basal ganglia	C71.0	C79.31	-	D33.0	D43.0	D49.6
basis pedunculi	C71.7	C79.31	-	D33.1	D43.1	D49.6
bile or biliary(tract)	C24.9	C78.89	D01.5	D13.5	D37.6	D49.0
canaliculi(biliferi) (intrahepatic)	C22.1	C78.7	D01.5	D13.4	D37.6	D49.0

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Neoplasm Index	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified Behavior
canals, interlobular	C22.1	C78.89	D01.5	D13.4	D37.6	D49.0
duct or passage(common) (cystic) (extrahepatic)	C24.0	C78.89	D01.5	D13.5	D37.6	D49.0
interlobular	C22.1	C78.89	D01.5	D13.4	D37.6	D49.0
intrahepatic	C22.1	C78.7	D01.5	D13.4	D37.6	D49.0
and extrahepatic	C24.8	C78.89	D01.5	D13.5	D37.6	D49.0
bladder(urinary)	C67.9	C79.11	D09.0	D30.3	D41.4	D49.4
dome	C67.1	C79.11	D09.0	D30.3	D41.4	D49.4
neck	C67.5	C79.11	D09.0	D30.3	D41.4	D49.4
orifice	C67.9	C79.11	D09.0	D30.3	D41.4	D49.4
ureteric	C67.6	C79.11	D09.0	D30.3	D41.4	D49.4
urethral	C67.5	C79.11	D09.0	D30.3	D41.4	D49.4
overlapping lesion	C67.8	-	-	-	-	-
sphincter	C67.8	C79.11	D09.0	D30.3	D41.4	D49.4
trigone	C67.0	C79.11	D09.0	D30.3	D41.4	D49.4
urachus	C67.7	C79.11	D09.0	D30.3	D41.4	D49.4
wall	C67.9	C79.11	D09.0	D30.3	D41.4	D49.4
anterior	C67.3	C79.11	D09.0	D30.3	D41.4	D49.4
lateral	C67.2	C79.11	D09.0	D30.3	D41.4	D49.4
posterior	C67.4	C79.11	D09.0	D30.3	D41.4	D49.4
blood vessel—*see* Neoplasm, connective tissue						
bone(periosteum)	C41.9	C79.51	-	D16.9-	D48.0	D49.2
acetabulum	C41.4	C79.51	-	D16.8-	D48.0	D49.2
ankle	C40.3-	C79.51	-	D16.3-	-	-
arm NEC	C40.0-	C79.51	-	D16.0-	-	-
astragalus	C40.3-	C79.51	-	D16.3-	-	-
atlas	C41.2	C79.51	-	D16.6-	D48.0	D49.2
axis	C41.2	C79.51	-	D16.6-	D48.0	D49.2
back NEC	C41.2	C79.51	-	D16.6-	D48.0	D49.2
calcaneus	C40.3-	C79.51	-	D16.3-	-	-
calvarium	C41.0	C79.51	-	D16.4-	D48.0	D49.2
carpus(any)	C40.1-	C79.51	-	D16.1-	-	-
cartilage NEC	C41.9	C79.51	-	D16.9-	D48.0	D49.2
clavicle	C41.3	C79.51	-	D16.7-	D48.0	D49.2
clivus	C41.0	C79.51	-	D16.4-	D48.0	D49.2
coccygeal vertebra	C41.4	C79.51	-	D16.8-	D48.0	D49.2
coccyx	C41.4	C79.51	-	D16.8-	D48.0	D49.2
costal cartilage	C41.3	C79.51	-	D16.7-	D48.0	D49.2
costovertebral joint	C41.3	C79.51	-	D16.7-	D48.0	D49.2
cranial	C41.0	C79.51	-	D16.4-	D48.0	D49.2
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Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99)

Chapter Specific Coding Guidelines

a. Human Immunodeficiency Virus (HIV) Infections

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.

2) Selection and sequencing of HIV codes

(a) **Patient admitted for HIV-related condition**

If a patient is admitted for an HIV-related condition, the principal diagnosis should be B20, Human immunodeficiency virus [HIV] disease followed by additional diagnosis codes for all reported HIV-related conditions.

(b) **Patient with HIV disease admitted for unrelated condition**

If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (e.g., the nature of injury code) should be the principal diagnosis. Other diagnoses would be B20 followed by additional diagnosis codes for all reported HIV-related conditions.

(c) **Whether the patient is newly diagnosed**

Whether the patient is newly diagnosed or has had previous admissions/encounters for HIV conditions is irrelevant to the sequencing decision.

(d) **Asymptomatic human immunodeficiency virus**

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 the term "AIDS" is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use B20 in these cases.

(e) **Patients with inconclusive HIV serology**

Patients with inconclusive HIV serology, but no definitive diagnosis or manifestations of the illness, may be assigned code R75, Inconclusive laboratory evidence of human immunodeficiency virus [HIV].

(f) **Previously diagnosed HIV-related illness**

Patients with any known prior diagnosis of an HIV-related illness should be coded to B20. Once a patient has developed an HIV-related illness, the patient should always be assigned code B20 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (B20) should never be assigned to R75 or Z21, Asymptomatic human immunodeficiency virus [HIV] infection status.

(g) **HIV Infection in pregnancy, childbirth and the puerperium**

During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of an HIV-related illness should receive a principal diagnosis code of O98.7-, Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium, followed by B20 and the code(s) for the HIV-related illness(es). Codes from Chapter 15 always take sequencing priority.

Patients with asymptomatic HIV infection status admitted (or presenting for a health care encounter) during pregnancy, childbirth, or the puerperium should receive codes of O98.7- and Z21.

(h) **Encounters for testing for HIV**

If a patient is being seen to determine his/her HIV status, use code Z11.4, Encounter for screening for human immunodeficiency virus [HIV]. Use additional codes for any associated high risk behavior.

If a patient with signs or symptoms is being seen for HIV testing, code the signs and symptoms. An additional counseling code Z71.7, Human immunodeficiency virus [HIV] counseling, may be used if counseling is provided during the encounter for the test.

When a patient returns to be informed of his/her HIV test results and the test result is negative, use code Z71.7, Human immunodeficiency virus [HIV] counseling.

If the results are positive, see previous guidelines and assign codes as appropriate.

b. Infectious Agents as the Cause of Diseases Classified to Other Chapters

Certain infections are classified in chapters other than Chapter 1 and no organism is identified as part of the infection code. In these instances, it is necessary to use an additional code from Chapter 1 to identify the organism. A code from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified to other chapters, B96, Other bacterial agents as the cause of diseases classified to other chapters, or B97, Viral agents as the cause of diseases classified to other chapters, is to be used as an additional code to identify the organism. An instructional note will be found at the infection code advising that an additional organism code is required.

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.

d. Sepsis, Severe Sepsis, and Septic Shock

1) Coding of Sepsis and Severe Sepsis

(a) **Sepsis**

For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection. If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified organism.

A code from subcategory R65.2, Severe sepsis, should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.

(i) Negative or inconclusive blood cultures and sepsis

Negative or inconclusive blood cultures do not preclude a diagnosis of sepsis in patients with clinical evidence of the condition, however, the provider should be queried.

(ii) Urosepsis

The term urosepsis is a nonspecific term. It is not to be considered synonymous with sepsis. It has no default code in the Alphabetic Index. Should a provider use this term, he/she must be queried for clarification.

(iii) Sepsis with organ dysfunction

If a patient has sepsis and associated acute organ dysfunction or multiple organ dysfunction (MOD), follow the instructions for coding severe sepsis.

(iv) Acute organ dysfunction that is not clearly associated with the sepsis

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Certain infectious and parasitic diseases (A00-B99)

INCLUDES *diseases generally recognized as communicable or transmissible*

Use additional code to identify resistance to antimicrobial drugs (Z16.-)

EXCLUDES1 *certain localized infections - see body system-related chapters*

EXCLUDES2 *carrier or suspected carrier of infectious disease (Z22.-)*
infectious and parasitic diseases complicating pregnancy, childbirth and the puerperium (O98.-)
infectious and parasitic diseases specific to the perinatal period (P35-P39)
influenza and other acute respiratory infections (J00-J22)

Intestinal infectious diseases (A00-A09)

4th **A00 Cholera**
- **A00.0 Cholera due to Vibrio cholerae 01, biovar cholerae**
  Classical cholera
- **A00.1 Cholera due to Vibrio cholerae 01, biovar eltor**
  Cholera eltor
- **A00.9 Cholera, unspecified**

4th **A01 Typhoid and paratyphoid fevers**
- 5th **A01.0 Typhoid fever**
  Infection due to Salmonella typhi
  - **A01.00 Typhoid fever, unspecified**
  - **A01.01 Typhoid meningitis**
  - **A01.02 Typhoid fever with heart involvement**
    Typhoid endocarditis
    Typhoid myocarditis
  - **A01.03 Typhoid pneumonia**
  - **A01.04 Typhoid arthritis**
  - **A01.05 Typhoid osteomyelitis**
  - **A01.09 Typhoid fever with other complications**
- **A01.1 Paratyphoid fever A**
- **A01.2 Paratyphoid fever B**
- **A01.3 Paratyphoid fever C**
- **A01.4 Paratyphoid fever, unspecified**
  Infection due to Salmonella paratyphi NOS

4th **A02 Other salmonella infections**

INCLUDES *infection or foodborne intoxication due to any Salmonella species other than S. typhi and S. paratyphi*

- **A02.0 Salmonella enteritis**
  Salmonellosis
- **A02.1 Salmonella sepsis**
- 5th **A02.2 Localized salmonella infections**
  - **A02.20 Localized salmonella infection, unspecified**
  - **A02.21 Salmonella meningitis**
  - **A02.22 Salmonella pneumonia**
  - **A02.23 Salmonella arthritis**
  - **A02.24 Salmonella osteomyelitis**
  - **A02.25 Salmonella pyelonephritis**
    Salmonella tubulo-interstitial nephropathy
  - **A02.29 Salmonella with other localized infection**
- **A02.8 Other specified salmonella infections**
- **A02.9 Salmonella infection, unspecified**

4th **A03 Shigellosis**
- **A03.0 Shigellosis due to Shigella dysenteriae**
  Group A shigellosis [Shiga-Kruse dysentery]
- **A03.1 Shigellosis due to Shigella flexneri**
  Group B shigellosis
- **A03.2 Shigellosis due to Shigella boydii**
  Group C shigellosis
- **A03.3 Shigellosis due to Shigella sonnei**
  Group D shigellosis
- **A03.8 Other shigellosis**
- **A03.9 Shigellosis, unspecified**
  Bacillary dysentery NOS

4th **A04 Other bacterial intestinal infections**

EXCLUDES1 *bacterial foodborne intoxications, NEC (A05.-)*
tuberculous enteritis (A18.32)

- **A04.0 Enteropathogenic Escherichia coli infection**
- **A04.1 Enterotoxigenic Escherichia coli infection**
- **A04.2 Enteroinvasive Escherichia coli infection**
- **A04.3 Enterohemorrhagic Escherichia coli infection**
- **A04.4 Other intestinal Escherichia coli infections**
  Escherichia coli enteritis NOS
- **A04.5 Campylobacter enteritis**
- **A04.6 Enteritis due to Yersinia enterocolitica**
  EXCLUDES1 *extraintestinal yersiniosis (A28.2)*
- **A04.7 Enterocolitis due to Clostridium difficile**
  Foodborne intoxication by Clostridium difficile
  Pseudomembraneous colitis
- **A04.8 Other specified bacterial intestinal infections**
- **A04.9 Bacterial intestinal infection, unspecified**
  Bacterial enteritis NOS

4th **A05 Other bacterial foodborne intoxications, not elsewhere classified**

EXCLUDES1 *Clostridium difficile foodborne intoxication and infection (A04.7)*
Escherichia coli infection (A04.0-A04.4)
listeriosis (A32.-)
salmonella foodborne intoxication and infection (A02.-)
toxic effect of noxious foodstuffs (T61-T62)

- **A05.0 Foodborne staphylococcal intoxication**
- **A05.1 Botulism food poisoning**
  Botulism NOS
  Classical foodborne intoxication due to Clostridium botulinum
  EXCLUDES1 *infant botulism (A48.51)*
  wound botulism (A48.52)
- **A05.2 Foodborne Clostridium perfringens [Clostridium welchii] intoxication**
  Enteritis necroticans
  Pig-bel
- **A05.3 Foodborne Vibrio parahaemolyticus intoxication**
- **A05.4 Foodborne Bacillus cereus intoxication**
- **A05.5 Foodborne Vibrio vulnificus intoxication**
- **A05.8 Other specified bacterial foodborne intoxications**
- **A05.9 Bacterial foodborne intoxication, unspecified**

4th **A06 Amebiasis**

INCLUDES *infection due to Entamoeba histolytica*

EXCLUDES1 *other protozoal intestinal diseases (A07.-)*

EXCLUDES2 *acanthamebiasis (B60.1-)*
Naegleriasis (B60.2)

- **A06.0 Acute amebic dysentery**
  Acute amebiasis
  Intestinal amebiasis NOS
- **A06.1 Chronic intestinal amebiasis**
- **A06.2 Amebic nondysenteric colitis**
- **A06.3 Ameboma of intestine**
  Ameboma NOS
- **A06.4 Amebic liver abscess**
  Hepatic amebiasis
- **A06.5 Amebic lung abscess**
  Amebic abscess of lung (and liver)
- **A06.6 Amebic brain abscess**
  Amebic abscess of brain (and liver) (and lung)
- **A06.7 Cutaneous amebiasis**

Additional Character Required | Extension 'X' Alert | Unspecified Code | Other Specified Code | Manifestation Code | New Code | Revised Code Title

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A06.8 Amebic infection of other sites
- **A06.81 Amebic cystitis**
- **A06.82 Other amebic genitourinary infections**
  - Amebic balanitis
  - Amebic vesiculitis
  - Amebic vulvovaginitis
- **A06.89 Other amebic infections**
  - Amebic appendicitis
  - Amebic splenic abscess

A06.9 Amebiasis, unspecified

A07 Other protozoal intestinal diseases
- **A07.0 Balantidiasis**
  - Balantidial dysentery
- **A07.1 Giardiasis [lambliasis]**
- **A07.2 Cryptosporidiosis**
- **A07.3 Isosporiasis**
  - Infection due to Isospora belli and Isospora hominis
  - Intestinal coccidiosis
  - Isosporosis
- **A07.4 Cyclosporiasis**
- **A07.8 Other specified protozoal intestinal diseases**
  - Intestinal microsporidiosis
  - Intestinal trichomoniasis
  - Sarcocystosis
  - Sarcosporidiosis
- **A07.9 Protozoal intestinal disease, unspecified**
  - Flagellate diarrhea
  - Protozoal colitis
  - Protozoal diarrhea
  - Protozoal dysentery

A08 Viral and other specified intestinal infections

EXCLUDES1 *influenza with involvement of gastrointestinal tract (J09.X3, J10.2, J11.2)*

- **A08.0 Rotaviral enteritis**
- **A08.1 Acute gastroenteropathy due to Norwalk agent and other small round viruses**
  - **A08.11 Acute gastroenteropathy due to Norwalk agent**
    - Acute gastroenteropathy due to Norovirus
    - Acute gastroenteropathy due to Norwalk-like agent
  - **A08.19 Acute gastroenteropathy due to other small round viruses**
    - Acute gastroenteropathy due to small round virus [SRV] NOS
- **A08.2 Adenoviral enteritis**
- **A08.3 Other viral enteritis**
  - **A08.31 Calicivirus enteritis**
  - **A08.32 Astrovirus enteritis**
  - **A08.39 Other viral enteritis**
    - Coxsackie virus enteritis
    - Echovirus enteritis
    - Enterovirus enteritis NEC
    - Torovirus enteritis
- **A08.4 Viral intestinal infection, unspecified**
  - Viral enteritis NOS
  - Viral gastroenteritis NOS
  - Viral gastroenteropathy NOS
- **A08.8 Other specified intestinal infections**

A09 Infectious gastroenteritis and colitis, unspecified
- Infectious colitis NOS
- Infectious enteritis NOS
- Infectious gastroenteritis NOS

EXCLUDES1 *colitis NOS (K52.9)*
diarrhea NOS (R19.7)
enteritis NOS (K52.9)
gastroenteritis NOS (K52.9)
noninfective gastroenteritis and colitis, unspecified (K52.9)

Tuberculosis (A15-A19)

INCLUDES *infections due to Mycobacterium tuberculosis and Mycobacterium bovis*

EXCLUDES1 *congenital tuberculosis (P37.0)*
nonspecific reaction to test for tuberculosis without active tuberculosis (R76.1-)
pneumoconiosis associated with tuberculosis, any type in A15 (J65)
positive PPD (R76.11)
positive tuberculin skin test without active tuberculosis (R76.11)
sequelae of tuberculosis (B90.-)
silicotuberculosis (J65)

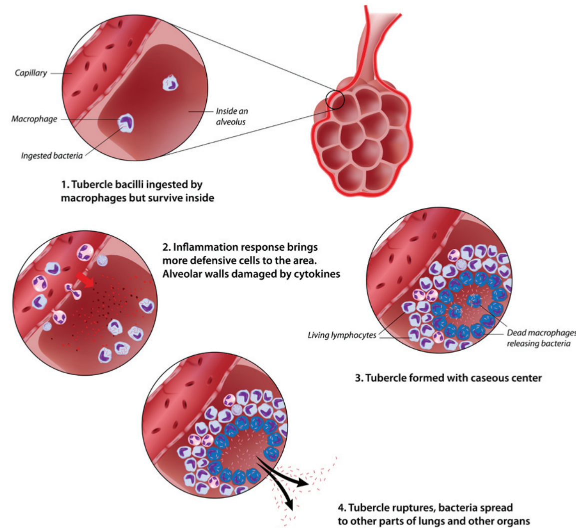

Figure 1.1 Progression of Tuberculosis

A15 Respiratory tuberculosis
- **A15.0 Tuberculosis of lung**
  - Tuberculous bronchiectasis
  - Tuberculous fibrosis of lung
  - Tuberculous pneumonia
  - Tuberculous pneumothorax
- **A15.4 Tuberculosis of intrathoracic lymph nodes**
  - Tuberculosis of hilar lymph nodes
  - Tuberculosis of mediastinal lymph nodes
  - Tuberculosis of tracheobronchial lymph nodes
  - EXCLUDES1 *tuberculosis specified as primary (A15.7)*
- **A15.5 Tuberculosis of larynx, trachea and bronchus**
  - Tuberculosis of bronchus
  - Tuberculosis of glottis
  - Tuberculosis of larynx
  - Tuberculosis of trachea
- **A15.6 Tuberculous pleurisy**
  - Tuberculosis of pleura Tuberculous empyema
  - EXCLUDES1 *primary respiratory tuberculosis (A15.7)*
- **A15.7 Primary respiratory tuberculosis**
- **A15.8 Other respiratory tuberculosis**
  - Mediastinal tuberculosis
  - Nasopharyngeal tuberculosis
  - Tuberculosis of nose
  - Tuberculosis of sinus [any nasal]
- **A15.9 Respiratory tuberculosis unspecified**

A17 Tuberculosis of nervous system
- **A17.0 Tuberculous meningitis**
  - Tuberculosis of meninges (cerebral)(spinal)
  - Tuberculous leptomeningitis

EXCLUDES 1 Not coded here | EXCLUDES 2 Not included here | N Newborn Age: 0 | P Pediatric Age: 0-17
M Maternity Age: 12-55 | A Adult Age: 15-124 | PDx Primary Diagnosis Only | ♂ Male | ♀ Female

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Chapter 2: Neoplasms (C00-D49)

Chapter Specific Coding Guidelines

General Guidelines

Chapter 2 of the ICD-10-CM contains the codes for most benign and all malignant neoplasms. Certain benign neoplasms, such as prostatic adenomas, may be found in the specific body system chapters. To properly code a neoplasm it is necessary to determine from the record if the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior. If malignant, any secondary (metastatic) sites should also be determined.

Primary malignant neoplasms overlapping site boundaries

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

Malignant neoplasm of ectopic tissue

Malignant neoplasms of ectopic tissue are to be coded to the site of origin mentioned, e.g., ectopic pancreatic malignant neoplasms involving the stomach are coded to pancreas, unspecified (C25.9).

The neoplasm table in the Alphabetic Index should be referenced first. However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate. For example, if the documentation indicates "adenoma," refer to the term in the Alphabetic Index to review the entries under this term and the instructional note to "see also neoplasm, by site, benign." The table provides the proper code based on the type of neoplasm and the site. It is important to select the proper column in the table that corresponds to the type of neoplasm. The Tabular List should then be referenced to verify that the correct code has been selected from the table and that a more specific site code does not exist.

See Section I.C.21. Factors influencing health status and contact with health services, Status, for information regarding Z15.0, codes for genetic susceptibility to cancer.

a. Treatment directed at the malignancy

If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis.

The only exception to this guideline is if a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy, assign the appropriate Z51.-- code as the first-listed or principal diagnosis, and the diagnosis or problem for which the service is being performed as a secondary diagnosis.

b. Treatment of secondary site

When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

c. Coding and sequencing of complications

Coding and sequencing of complications associated with the malignancies or with the therapy thereof are subject to the following guidelines:

1) Anemia associated with malignancy

When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by the appropriate code for the anemia (such as code D63.0, Anemia in neoplastic disease).

2) Anemia associated with chemotherapy, immunotherapy and radiation therapy

When the admission/encounter is for management of an anemia associated with an adverse effect of the administration of chemotherapy or immunotherapy and the only treatment is for the anemia, the anemia code is sequenced first followed by the appropriate codes for the neoplasm and the adverse effect (T45.1X5, Adverse effect of antineoplastic and immunosuppressive drugs).

When the admission/encounter is for management of an anemia associated with an adverse effect of radiotherapy, the anemia code should be sequenced first, followed by the appropriate neoplasm code and code Y84.2, Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure.

3) Management of dehydration due to the malignancy

When the admission/encounter is for management of dehydration due to the malignancy and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.

4) Treatment of a complication resulting from a surgical procedure

When the admission/encounter is for treatment of a complication resulting from a surgical procedure, designate the complication as the principal or first-listed diagnosis if treatment is directed at resolving the complication.

d. Primary malignancy previously excised

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.

e. Admissions/Encounters involving chemotherapy, immunotherapy and radiation therapy

1) Episode of care involves surgical removal of neoplasm

When an episode of care involves the surgical removal of a neoplasm, primary or secondary site, followed by adjunct chemotherapy or radiation treatment during the same episode of care, the code for the neoplasm should be assigned as principal or first-listed diagnosis.

2) Patient admission/encounter solely for administration of chemotherapy, immunotherapy and radiation therapy

If a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy assign code Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission more than one of these codes may be assigned, in any sequence.

The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis.

3) Patient admitted for radiation therapy, chemotherapy or immunotherapy and develops complications

When a patient is admitted for the purpose of radiotherapy, immunotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11,

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Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy followed by any codes for the complications.

f. Admission/encounter to determine extent of malignancy
When the reason for admission/encounter is to determine the extent of the malignancy, or for a procedure such as paracentesis or thoracentesis, the primary malignancy or appropriate metastatic site is designated as the principal or first-listed diagnosis, even though chemotherapy or radiotherapy is administered.

g. Symptoms, signs, and abnormal findings listed in Chapter 18 associated with neoplasms
Symptoms, signs, and ill-defined conditions listed in Chapter 18 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal or first-listed diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.

See section I.C.21. Factors Influencing Health Status and Contact with Health Services, Encounter for Prophylactic Organ Removal.

h. Admission/encounter for pain control/management
See Section I.C.6. for information on coding admission/encounter for pain control/management.

i. Malignancy in two or more noncontiguous sites
A patient may have more than one malignant tumor in the same organ. These tumors may represent different primaries or metastatic disease, depending on the site. Should the documentation be unclear, the provider should be queried as to the status of each tumor so that the correct codes can be assigned.

j. Disseminated malignant neoplasm, unspecified
Code 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. It should not be used in place of assigning codes for the primary site and all known secondary sites.

k. Malignant neoplasm without specification of site
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. This code should rarely be used in the inpatient setting.

l. Sequencing of neoplasm codes

1) Encounter for treatment of primary malignancy
If the reason for the encounter is for treatment of a primary malignancy, assign the malignancy as the principal/first-listed diagnosis. The primary site is to be sequenced first, followed by any metastatic sites.

2) Encounter for treatment of secondary malignancy
When an encounter is for a primary malignancy with metastasis and treatment is directed toward the metastatic (secondary) site(s) only, the metastatic site(s) is designated as the principal/first-listed diagnosis. The primary malignancy is coded as an additional code.

3) Malignant neoplasm in a pregnant patient
When a pregnant woman has a malignant neoplasm, a code from subcategory O9A.1-, Malignant neoplasm complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by the appropriate code from Chapter 2 to indicate the type of neoplasm.

4) Encounter for complication associated with a neoplasm
When an encounter is for management of a complication associated with a neoplasm, such as dehydration, and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm.

The exception to this guideline is anemia. When the admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by code D63.0, Anemia in neoplastic disease.

5) Complication from surgical procedure for treatment of a neoplasm
When an encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of the neoplasm, designate the complication as the principal/first-listed diagnosis. See guideline regarding the coding of a current malignancy versus personal history to determine if the code for the neoplasm should also be assigned.

6) Pathologic fracture due to a neoplasm
When an encounter is for a pathological fracture due to a neoplasm, and the focus of treatment is the fracture, a code from subcategory M84.5, Pathological fracture in neoplastic disease, should be sequenced first, followed by the code for the neoplasm.

If the focus of treatment is the neoplasm with an associated pathological fracture, the neoplasm code should be sequenced first, followed by a code from M84.5 for the pathological fracture.

m. Current malignancy versus personal history of malignancy
When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) 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.

See Section I.C.21. Factors influencing health status and contact with health services, History (of)

n. Leukemia, Multiple Myeloma, and Malignant Plasma Cell Neoplasms in remission versus personal history
The categories for leukemia, and category C90, Multiple myeloma and malignant plasma cell neoplasms, have codes indicating whether or not the leukemia has achieved remission. There are also codes Z85.6, Personal history of leukemia, and Z85.79, Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues. If the documentation is unclear, as to whether the leukemia has achieved remission, the provider should be queried.

See Section I.C.21. Factors influencing health status and contact with health services, History (of)

o. Aftercare following surgery for neoplasm
See Section I.C.21. Factors influencing health status and contact with health services, Aftercare

p. Follow-up care for completed treatment of a malignancy
See Section I.C.21. Factors influencing health status and contact with health services, Follow-up

q. Prophylactic organ removal for prevention of malignancy
See Section I.C. 21, Factors influencing health status and contact with health services, Prophylactic organ removal

r. Malignant neoplasm associated with transplanted organ
A malignant neoplasm of a transplanted organ should be coded as a transplant complication. Assign first the appropriate code from category T86.-, Complications of transplanted organs and tissue, followed by code C80.2, Malignant neoplasm associated with transplanted organ. Use an additional code for the specific malignancy.

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Chapter 3: Disease of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)

EXCLUDES2 *autoimmune disease (systemic) NOS (M35.9)*
certain conditions originating in the perinatal period (P00-P96)
complications of pregnancy, childbirth and the puerperium (O00-O9A)
congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
endocrine, nutritional and metabolic diseases (E00-E88)
human immunodeficiency virus [HIV] disease (B20)
injury, poisoning and certain other consequences of external causes (S00-T88)
neoplasms (C00-D49)
symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94)

Nutritional anemias (D50-D53)

D50 Iron deficiency anemia

INCLUDES *asiderotic anemia*
hypochromic anemia

D50.0 Iron deficiency anemia secondary to blood loss (chronic)

Posthemorrhagic anemia (chronic)

EXCLUDES1 *acute posthemorrhagic anemia (D62)*
congenital anemia from fetal blood loss (P61.3)

D50.1 Sideropenic dysphagia

Kelly-Paterson syndrome
Plummer-Vinson syndrome

D50.8 Other iron deficiency anemias

Iron deficiency anemia due to inadequate dietary iron intake

D50.9 Iron deficiency anemia, unspecified

D51 Vitamin B12 deficiency anemia

EXCLUDES1 *vitamin B12 deficiency (E53.8)*

D51.0 Vitamin B12 deficiency anemia due to intrinsic factor deficiency

Addison anemia
Biermer anemia
Pernicious (congenital) anemia
Congenital intrinsic factor deficiency

D51.1 Vitamin B12 deficiency anemia due to selective vitamin B12 malabsorption with proteinuria

Imerslund (Gräsbeck) syndrome
Megaloblastic hereditary anemia

D51.2 Transcobalamin II deficiency

D51.3 Other dietary vitamin B12 deficiency anemia

Vegan anemia

D51.8 Other vitamin B12 deficiency anemias

D51.9 Vitamin B12 deficiency anemia, unspecified

D52 Folate deficiency anemia

EXCLUDES1 *folate deficiency without anemia (E53.8)*

D52.0 Dietary folate deficiency anemia

Nutritional megaloblastic anemia

D52.1 Drug-induced folate deficiency anemia

Use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)

D52.8 Other folate deficiency anemias

D52.9 Folate deficiency anemia, unspecified

Folic acid deficiency anemia NOS

D53 Other nutritional anemias

INCLUDES *megaloblastic anemia unresponsive to vitamin B12 or folate therapy*

D53.0 Protein deficiency anemia

Amino-acid deficiency anemia
Orotaciduric anemia

EXCLUDES1 *Lesch-Nyhan syndrome (E79.1)*

D53.1 Other megaloblastic anemias, not elsewhere classified

Megaloblastic anemia NOS

EXCLUDES1 *Di Guglielmo's disease (C94.0)*

D53.2 Scorbutic anemia

EXCLUDES1 *scurvy (E54)*

D53.8 Other specified nutritional anemias

Anemia associated with deficiency of copper
Anemia associated with deficiency of molybdenum
Anemia associated with deficiency of zinc

EXCLUDES1 *nutritional deficiencies without anemia, such as:*
copper deficiency NOS (E61.0)
molybdenum deficiency NOS (E61.5)
zinc deficiency NOS (E60)

D53.9 Nutritional anemia, unspecified

Simple chronic anemia

EXCLUDES1 *anemia NOS (D64.9)*

Hemolytic anemias (D55-D59)

D55 Anemia due to enzyme disorders

EXCLUDES1 *drug-induced enzyme deficiency anemia (D59.2)*

D55.0 Anemia due to glucose-6-phosphate dehydrogenase [G6PD] deficiency

Favism
G6PD deficiency anemia

D55.1 Anemia due to other disorders of glutathione metabolism

Anemia (due to) enzyme deficiencies, except G6PD, related to the hexose monophosphate [HMP] shunt pathway
Anemia (due to) hemolytic nonspherocytic (hereditary), type I

D55.2 Anemia due to disorders of glycolytic enzymes

Hemolytic nonspherocytic (hereditary) anemia, type II
Hexokinase deficiency anemia
Pyruvate kinase [PK] deficiency anemia
Triose-phosphate isomerase deficiency anemia

EXCLUDES1 *disorders of glycolysis not associated with anemia (E74.8)*

D55.3 Anemia due to disorders of nucleotide metabolism

D55.8 Other anemias due to enzyme disorders

D55.9 Anemia due to enzyme disorder, unspecified

D56 Thalassemia

EXCLUDES1 *sickle-cell thalassemia (D57.4-)*

D56.0 Alpha thalassemia

Alpha thalassemia major
Hemoglobin H Constant Spring
Hemoglobin H disease
Hydrops fetalis due to alpha thalassemia
Severe alpha thalassemia
Triple gene defect alpha thalassemia

Use additional code, if applicable, for hydrops fetalis due to alpha thalassemia (P56.99)

EXCLUDES1 *alpha thalassemia trait or minor (D56.3)*
asymptomatic alpha thalassemia (D56.3)
hydrops fetalis due to isoimmunization (P56.0)
hydrops fetalis not due to immune hemolysis (P83.2)

Additional Character Required | Extension 'X' Alert | Unspecified Code | Other Specified Code | Manifestation Code | New Code | Revised Code Title

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D56.1 Beta thalassemia
Beta thalassemia major
Cooley's anemia
Homozygous beta thalassemia
Severe beta thalassemia
Thalassemia intermedia
Thalassemia major
EXCLUDES1 *beta thalassemia minor (D56.3)*
beta thalassemia trait (D56.3)
delta-beta thalassemia (D56.2)
hemoglobin E-beta thalassemia (D56.5)
sickle-cell beta thalassemia (D57.4-)

D56.2 Delta-beta thalassemia
Homozygous delta-beta thalassemia
EXCLUDES1 *delta-beta thalassemia minor (D56.3)*
delta-beta thalassemia trait (D56.3)

D56.3 Thalassemia minor
Alpha thalassemia minor
Alpha thalassemia silent carrier
Alpha thalassemia trait
Beta thalassemia minor
Beta thalassemia trait
Delta-beta thalassemia minor
Delta-beta thalassemia trait
Thalassemia trait NOS
EXCLUDES1 *alpha thalassemia (D56.0)*
beta thalassemia (D56.1)
delta-beta thalassemia (D56.2)
hemoglobin E-beta thalassemia (D56.5)
sickle-cell trait (D57.3)

D56.4 Hereditary persistence of fetal hemoglobin [HPFH]

D56.5 Hemoglobin E-beta thalassemia
EXCLUDES1 *beta thalassemia (D56.1)*
beta thalassemia minor (D56.3)
beta thalassemia trait (D56.3)
delta-beta thalassemia (D56.2)
delta-beta thalassemia trait (D56.3)
hemoglobin E disease (D58.2)
other hemoglobinopathies (D58.2)
sickle-cell beta thalassemia (D57.4-)

D56.8 Other thalassemias
Dominant thalassemia
Hemoglobin C thalassemia
Mixed thalassemia
Thalassemia with other hemoglobinopathy
EXCLUDES1 *hemoglobin C disease (D58.2)*
hemoglobin E disease (D58.2)
other hemoglobinopathies (D58.2)
sickle-cell anemia (D57.-)
sickle-cell thalassemia (D57.4)

D56.9 Thalassemia, unspecified
Mediterranean anemia (with other hemoglobinopathy)

4th **D57 Sickle-cell disorders**
Use additional code for any associated fever (R50.81)
EXCLUDES1 *other hemoglobinopathies (D58.-)*

5th **D57.0 Hb-SS disease with crisis**
Sickle-cell disease NOS with crisis
Hb-SS disease with vasoocclusive pain
D57.00 Hb-SS disease with crisis, unspecified
D57.01 Hb-SS disease with acute chest syndrome
D57.02 Hb-SS disease with splenic sequestration

D57.1 Sickle-cell disease without crisis
Hb-SS disease without crisis
Sickle-cell anemia NOS
Sickle-cell disease NOS
Sickle-cell disorder NOS

5th **D57.2 Sickle-cell/Hb-C disease**
Hb-SC disease
Hb-S/Hb-C disease
D57.20 Sickle-cell/Hb-C disease without crisis

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6th **D57.21 Sickle-cell/Hb-C disease with crisis**
D57.211 Sickle-cell/Hb-C disease with acute chest syndrome
D57.212 Sickle-cell/Hb-C disease with splenic sequestration
D57.219 Sickle-cell/Hb-C disease with crisis, unspecified
Sickle-cell/Hb-C disease with crisis NOS

D57.3 Sickle-cell trait
Hb-S trait
Heterozygous hemoglobin S

5th **D57.4 Sickle-cell thalassemia**
Sickle-cell beta thalassemia
Thalassemia Hb-S disease
D57.40 Sickle-cell thalassemia without crisis
Microdrepanocytosis
Sickle-cell thalassemia NOS

6th **D57.41 Sickle-cell thalassemia with crisis**
Sickle-cell thalassemia with vasoocclusive pain
D57.411 Sickle-cell thalassemia with acute chest syndrome
D57.412 Sickle-cell thalassemia with splenic sequestration
D57.419 Sickle-cell thalassemia with crisis, unspecified
Sickle-cell thalassemia with crisis NOS

5th **D57.8 Other sickle-cell disorders**
Hb-SD disease
Hb-SE disease
D57.80 Other sickle-cell disorders without crisis

6th **D57.81 Other sickle-cell disorders with crisis**
D57.811 Other sickle-cell disorders with acute chest syndrome
D57.812 Other sickle-cell disorders with splenic sequestration
D57.819 Other sickle-cell disorders with crisis, unspecified
Other sickle-cell disorders with crisis NOS

4th **D58 Other hereditary hemolytic anemias**
EXCLUDES1 *hemolytic anemia of the newborn (P55.-)*

D58.0 Hereditary spherocytosis
Acholuric (familial) jaundice
Congenital (spherocytic) hemolytic icterus
Minkowski-Chauffard syndrome

D58.1 Hereditary elliptocytosis
Elliptocytosis (congenital)
Ovalocytosis (congenital) (hereditary)

D58.2 Other hemoglobinopathies
Abnormal hemoglobin NOS
Congenital Heinz body anemia
Hb-C disease
Hb-D disease
Hb-E disease
Hemoglobinopathy NOS
Unstable hemoglobin hemolytic disease
EXCLUDES1 *familial polycythemia (D75.0)*
Hb-M disease (D74.0)
hemoglobin E-beta thalassemia (D56.5)
hereditary persistence of fetal hemoglobin [HPFH] (D56.4)
high-altitude polycythemia (D75.1)
methemoglobinemia (D74.-)
other hemoglobinopathies with thalassemia (D56.8)

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Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00-E89)

Chapter Specific Coding Guidelines

a. Diabetes mellitus
The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system. As many codes within a particular category as are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for a particular encounter. Assign as many codes from categories E08 – E13 as needed to identify all of the associated conditions that the patient has.

1) Type of diabetes
The age of a patient is not the sole determining factor, though most type 1 diabetics develop the condition before reaching puberty. For this reason, type 1 diabetes mellitus is also referred to as juvenile diabetes.

2) Type of diabetes mellitus not documented
If the type of diabetes mellitus is not documented in the medical record the default is E11.-, Type 2 diabetes mellitus.

3) Diabetes mellitus and the use of insulin
If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11, Type 2 diabetes mellitus, should be assigned**.** 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.

4) Diabetes mellitus in pregnancy and gestational diabetes
See Section I.C.15. Diabetes mellitus in pregnancy.

See Section I.C.15. Gestational (pregnancy induced) diabetes

5) Complications due to insulin pump malfunction

(a) **Underdose of insulin due to insulin pump failure**

An underdose of insulin due to an insulin pump failure should be assigned to a code from subcategory T85.6, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, that specifies the type of pump malfunction, as the principal or first-listed code, followed by code T38.3x6-, Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs. Additional codes for the type of diabetes mellitus and any associated complications due to the underdosing should also be assigned.

(b) **Overdose of insulin due to insulin pump failure**

The principal or first-listed code for an encounter due to an insulin pump malfunction resulting in an overdose of insulin, should also be T85.6-, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, followed by code T38.3x1-, Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional).

6) Secondary diabetes mellitus
Codes under categories E08, Diabetes mellitus due to underlying condition, E09, Drug or chemical induced diabetes mellitus, and E13, Other specified diabetes mellitus, identify complications/manifestations associated with secondary diabetes mellitus. Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning).

(a) **Secondary diabetes mellitus and the use of insulin**

For patients who routinely use insulin, code Z79.4, Long-term (current) use of insulin, should also be assigned. Code Z79.4 should not be assigned if insulin is given temporarily to bring a patient's blood sugar under control during an encounter.

(b) **Assigning and sequencing secondary diabetes codes and its causes**

The sequencing of the secondary diabetes codes in relationship to codes for the cause of the diabetes is based on the Tabular List instructions for categories E08, E09 and E13.

(i) Secondary diabetes mellitus due to pancreatectomy

For postpancreatectomy diabetes mellitus (lack of insulin due to the surgical removal of all or part of the pancreas), assign code E89.1, Postprocedural hypoinsulinemia. Assign a code from category E13 and a code from subcategory Z90.41-, Acquired absence of pancreas, as additional codes.

(ii) Secondary diabetes due to drugs

Secondary diabetes may be caused by an adverse effect of correctly administered medications, poisoning or sequela of poisoning.

See section I.C.19.e for coding of adverse effects and poisoning,andsectionI.C.20forexternalcausecodereporting.

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Chapter 6: Diseases of the Nervous System (G00-G99)

Chapter Specific Coding Guidelines

a. Dominant/nondominant side
Codes from category G81, Hemiplegia and hemiparesis, and subcategories, G83.1, Monoplegia of lower limb, G83.2, Monoplegia of upper limb, and G83.3, Monoplegia, unspecified, identify whether the dominant or nondominant side is affected. Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:

- For ambidextrous patients, the default should be dominant.
- If the left side is affected, the default is non-dominant.
- If the right side is affected, the default is dominant.

b. Pain - Category G89

1) General coding information
Codes in category G89, Pain, not elsewhere classified, may be used in conjunction with codes from other categories and chapters to provide more detail about acute or chronic pain and neoplasm-related pain, unless otherwise indicated below.

If the pain is not specified as acute or chronic, post-thoracotomy, postprocedural, or neoplasm-related, do not assign codes from category G89.

A code from category G89 should not be assigned if the underlying (definitive) diagnosis is known, unless the reason for the encounter is pain control/ management and not management of the underlying condition.

When an admission or encounter is for a procedure aimed at treating the underlying condition (e.g., spinal fusion, kyphoplasty), a code for the underlying condition (e.g., vertebral fracture, spinal stenosis) should be assigned as the principal diagnosis. No code from category G89 should be assigned.

(a) **Category G89 codes as principal or first-listed diagnosis**

Category G89 codes are acceptable as principal diagnosis or the first-listed code:

- When pain control or pain management is the reason for the admission/encounter (e.g., a patient with displaced intervertebral disc, nerve impingement and severe back pain presents for injection of steroid into the spinal canal). The underlying cause of the pain should be reported as an additional diagnosis, if known.
- When a patient is admitted for the insertion of a neurostimulator for pain control, assign the appropriate pain code as the principal or first-listed diagnosis. When an admission or encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is inserted for pain control during the same admission/encounter, a code for the underlying condition should be assigned as the principal diagnosis and the appropriate pain code should be assigned as a secondary diagnosis.

(b) **Use of category G89 codes in conjunction with site specific pain codes**

(i) Assigning category G89 and site-specific pain codes

Codes from category G89 may be used in conjunction with codes that identify the site of pain (including codes from chapter 18) if the category G89 code provides additional information. For example, if the code describes the site of the pain, but does not fully describe whether the pain is acute or chronic, then both codes should be assigned.

(ii) Sequencing of category G89 codes with site-specific pain codes

The sequencing of category G89 codes with site-specific pain codes (including chapter 18 codes), is dependent on the circumstances of the encounter/admission as follows:

- If the encounter is for pain control or pain management, assign the code from category G89 followed by the code identifying the specific site of pain (e.g., encounter for pain management for acute neck pain from trauma is assigned code G89.11, Acute pain due to trauma, followed by code M54.2, Cervicalgia, to identify the site of pain).
- If the encounter is for any other reason except pain control or pain management, and a related definitive diagnosis has not been established (confirmed) by the provider, assign the code for the specific site of pain first, followed by the appropriate code from category G89.

2) Pain due to devices, implants and grafts
See Section I.C.19. Pain due to medical devices

3) Postoperative Pain
The provider's documentation should be used to guide the coding of postoperative pain, as well as *Section III. Reporting Additional Diagnoses* and *Section IV. Diagnostic Coding and Reporting in the Outpatient Setting*.

The default for post-thoracotomy and other postoperative pain not specified as acute or chronic is the code for the acute form.

Routine or expected postoperative pain immediately after surgery should not be coded.

(a) **Postoperative pain not associated with specific postoperative complication**

Postoperative pain not associated with a specific postoperative complication is assigned to the appropriate postoperative pain code in category G89.

(b) **Postoperative pain associated with specific postoperative complication**

Postoperative pain associated with a specific postoperative complication (such as painful wire sutures) is assigned to the appropriate code(s) found in Chapter 19, Injury, poisoning, and certain other consequences of external causes. If appropriate, use additional code(s) from category G89 to identify acute or chronic pain (G89.18 or G89.28).

4) Chronic pain
Chronic pain is classified to subcategory G89.2. There is no time frame defining when pain becomes chronic pain. The provider's documentation should be used to guide use of these codes.

5) Neoplasm Related Pain
Code G89.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic.

This code may be assigned as the principal or first-listed code when the stated reason for the admission/encounter is documented as pain control/pain management. The underlying neoplasm should be reported as an additional diagnosis.

When the reason for the admission/encounter is management of the neoplasm and the pain associated with the neoplasm is also documented, code G89.3 may be

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assigned as an additional diagnosis. It is not necessary to assign an additional code for the site of the pain.

See Section I.C.2 for instructions on the sequencing of neoplasms for all other stated reasons for the admission/ encounter (except for pain control/pain management).

6) Chronic pain syndrome
Central pain syndrome (G89.0) and chronic pain syndrome (G89.4) are different than the term "chronic pain," and therefore codes should only be used when the provider has specifically documented this condition.

See Section I.C.5. Pain disorders related to psychological factors

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Chapter 9: Diseases of the Circulatory System (I00-I99)

Chapter Specific Coding Guidelines

a. Hypertension

1) Hypertension with Heart Disease
Heart conditions classified to I50.- or I51.4-I51.9, are assigned to, a code from category I11, Hypertensive heart disease, when a causal relationship is stated (due to hypertension) or implied (hypertensive). Use an additional code from category I50, Heart failure, to identify the type of heart failure in those patients with heart failure.

The same heart conditions (I50.-, I51.4-I51.9) with hypertension, but without a stated causal relationship, are coded separately. Sequence according to the circumstances of the admission/encounter.

2) Hypertensive Chronic Kidney Disease
Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present. Unlike hypertension with heart disease, ICD-10-CM presumes a cause-and-effect relationship and classifies chronic kidney disease with hypertension as hypertensive chronic kidney disease.

The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease.

See Section I.C.14. Chronic kidney disease.

If a patient has hypertensive chronic kidney disease and acute renal failure, an additional code for the acute renal failure is required.

3) Hypertensive Heart and Chronic Kidney Disease
Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the chronic kidney disease, whether or not the condition is so designated. If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.

The appropriate code from category N18, Chronic kidney disease, should be used as a secondary code with a code from category I13 to identify the stage of chronic kidney disease.

See Section I.C.14. Chronic kidney disease.

The codes in category I13, Hypertensive heart and chronic kidney disease, are combination codes that include hypertension, heart disease and chronic kidney disease. The Includes note at I13 specifies that the conditions included at I11 and I12 are included together in I13. If a patient has hypertension, heart disease and chronic kidney disease then a code from I13 should be used, not individual codes for hypertension, heart disease and chronic kidney disease, or codes from I11 or I12.

For patients with both acute renal failure and chronic kidney disease an additional code for acute renal failure is required.

4) Hypertensive Cerebrovascular Disease
For hypertensive cerebrovascular disease, first assign the appropriate code from categories I60-I69, followed by the appropriate hypertension code.

5) Hypertensive Retinopathy
Subcategory H35.0, Background retinopathy and retinal vascular changes, should be used with a code from category I10 – I15, Hypertensive disease to include the systemic hypertension. The sequencing is based on the reason for the encounter.

6) Hypertension, Secondary
Secondary hypertension is due to an underlying condition. Two codes are required: one to identify the underlying etiology and one from category I15 to identify the hypertension. Sequencing of codes is determined by the reason for admission/encounter.

7) Hypertension, Transient
Assign code R03.0, Elevated blood pressure reading without diagnosis of hypertension, unless patient has an established diagnosis of hypertension. Assign code O13.-, Gestational [pregnancy-induced] hypertension without significant proteinuria, or O14.-, Pre-eclampsia, for transient hypertension of pregnancy.

8) Hypertension, Controlled
This diagnostic statement usually refers to an existing state of hypertension under control by therapy. Assign the appropriate code from categories I10-I15, Hypertensive diseases.

9) Hypertension, Uncontrolled
Uncontrolled hypertension may refer to untreated hypertension or hypertension not responding to current therapeutic regimen. In either case, assign the appropriate code from categories I10-I15, Hypertensive diseases.

b. Atherosclerotic Coronary Artery Disease and Angina
ICD-10-CM has combination codes for atherosclerotic heart disease with angina pectoris. The subcategories for these codes are I25.11, Atherosclerotic heart disease of native coronary artery with angina pectoris and I25.7, Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris.

When using one of these combination codes it is not necessary to use an additional code for angina pectoris. A causal relationship can be assumed in a patient with both atherosclerosis and angina pectoris, unless the documentation indicates the angina is due to something other than the atherosclerosis.

If a patient with coronary artery disease is admitted due to an acute myocardial infarction (AMI), the AMI should be sequenced before the coronary artery disease.

See Section I.C.9. Acute myocardial infarction (AMI)

c. Intraoperative and Postprocedural Cerebrovascular Accident

Medical record documentation should clearly specify the cause-and-effect relationship between the medical intervention and the cerebrovascular accident in order to assign a code for intraoperative or postprocedural cerebrovascular accident.

Proper code assignment depends on whether it was an infarction or hemorrhage and whether it occurred intraoperatively or postoperatively. If it was a cerebral hemorrhage, code assignment depends on the type of procedure performed.

d. Sequelae of Cerebrovascular Disease

1) Category I69, Sequelae of Cerebrovascular disease
Category I69 is used to indicate conditions classifiable to categories I60-I67 as the causes of sequela (neurologic deficits), themselves classified elsewhere. These "late effects" include neurologic deficits that persist after initial onset of conditions classifiable to categories I60-I67. The neurologic deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to categories I60-I67.

Codes from category I69, Sequelae of cerebrovascular disease, that specify hemiplegia, hemiparesis and monoplegia identify whether the dominant or nondominant side is affected. Should the affected side be documented, but not specified as dominant or nondominant, and the

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classification system does not indicate a default, code selection is as follows:

- For ambidextrous patients, the default should be dominant.
- If the left side is affected, the default is non-dominant.
- If the right side is affected, the default is dominant.

2) Codes from category I69 with codes from I60-I67
Codes from category I69 may be assigned on a health care record with codes from I60-I67, if the patient has a current cerebrovascular disease and deficits from an old cerebrovascular disease.

3) Codes from category I69 and Personal history of transient ischemic attack (TIA) and cerebral infarction (Z86.73)
Codes from category I69 should not be assigned if the patient does not have neurologic deficits.

See Section I.C.21. 4. History (of) for use of personal history codes

e. Acute Myocardial Infarction (AMI)

1) ST elevation myocardial infarction (STEMI) and non ST elevation myocardial infarction (NSTEMI)
The ICD-10-CM codes for acute myocardial infarction (AMI) identify the site, such as anterolateral wall or true posterior wall. Subcategories I21.0-I21.2 and code I21.3 are used for ST elevation myocardial infarction (STEMI). Code I21.4, Non-ST elevation (NSTEMI) myocardial infarction, is used for non ST elevation myocardial infarction (NSTEMI) and nontransmural MIs.

If NSTEMI evolves to STEMI, assign the STEMI code. If STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

For encounters occurring while the myocardial infarction is equal to, or less than, four weeks old, including transfers to another acute setting or a postacute setting, and the patient requires continued care for the myocardial infarction, codes from category I21 may continue to be reported. For encounters after the 4 week time frame and the patient is still receiving care related to the myocardial infarction, the appropriate aftercare code should be assigned, rather than a code from category I21. For old or healed myocardial infarctions not requiring further care, code I25.2, Old myocardial infarction, may be assigned.

2) Acute myocardial infarction, unspecified
Code I21.3, ST elevation (STEMI) myocardial infarction of unspecified site, is the default for unspecified acute myocardial infarction. If only STEMI or transmural MI without the site is documented, assign code I21.3.

3) AMI documented as nontransmural or subendocardial but site provided
If an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as a subendocardial AMI.

See Section I.C.21.3 for information on coding status post administration of tPA in a different facility within the last 24 hours.

4) Subsequent acute myocardial infarction
A code from category I22, Subsequent ST elevation (STEMI) and non ST elevation (NSTEMI) myocardial infarction, is to be used when a patient who has suffered an AMI has a new AMI within the 4 week time frame of the initial AMI. A code from category I22 must be used in conjunction with a code from category I21. The sequencing of the I22 and I21 codes depends on the circumstances of the encounter.

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Appendix - New, revised, and deleted codes

New Codes

No new codes introduced in 2014.

Revised Codes

Revised text: Underlined

Deleted text: ~~Strikeout~~

Code	Description
L70.5	Acne excoriée des jeunes filles
M08.88	Other juvenile arthritis, ~~vertebrae~~other specified site
M12.08	Chronic postrheumatic arthropathy [Jaccoud], ~~vertebrae~~other specified site
M12.28	Villonodular synovitis (pigmented), ~~vertebrae~~other specified site
M12.38	Palindromic rheumatism, ~~vertebrae~~other specified site
M12.58	Traumatic arthropathy, ~~vertebrae~~other specified site
M12.88	Other specific arthropathies, not elsewhere classified, ~~vertebrae~~other specified site
M25.08	Hemarthrosis, ~~vertebrae~~other specified site
M25.18	Fistula, ~~vertebrae~~other specified site
M50.01	Cervical disc disorder with myelopathy, ~~occipito-atlanto-axial~~high cervical region
M50.11	Cervical disc disorder with radiculopathy, ~~occipito-atlanto-axial~~high cervical region
M50.21	Other cervical disc displacement, ~~occipito-atlanto-axial~~high cervical region
M50.31	Other cervical disc degeneration, ~~occipito-atlanto-axial~~high cervical region
M50.81	Other cervical disc disorders, ~~occipito-atlanto-axial~~high cervical region
M50.91	Cervical disc disorder, unspecified, ~~occipito-atlanto-axial~~high cervical region
M84.58XA	Pathological fracture in neoplastic disease, ~~vertebrae~~other specified site, initial encounter for fracture
M84.58XD	Pathological fracture in neoplastic disease, ~~vertebrae~~other specified site, subsequent encounter for fracture with routine healing
M84.58XG	Pathological fracture in neoplastic disease, ~~vertebrae~~other specified site, subsequent encounter for fracture with delayed healing
M84.58XK	Pathological fracture in neoplastic disease, ~~vertebrae~~other specified site, subsequent encounter for fracture with nonunion
M84.58XP	Pathological fracture in neoplastic disease, ~~vertebrae~~other specified site, subsequent encounter for fracture with malunion
M84.58XS	Pathological fracture in neoplastic disease, ~~vertebrae~~other specified site, sequela
T20.56XA	Corrosion of first degree of forehead and cheek, initial encounter
T20.56XD	Corrosion of first degree of forehead and cheek, subsequent encounter
T20.56XS	Corrosion of first degree of forehead and cheek, sequela
W94.31XA	Exposure to sudden change in air pressure in aircraft during ~~ascent or~~ descent, initial encounter
W94.31XD	Exposure to sudden change in air pressure in aircraft during ~~ascent or~~ descent, subsequent encounter
W94.31XS	Exposure to sudden change in air pressure in aircraft during ~~ascent or~~ descent, sequela
Y92.002	Bathroom of unspecified non-institutional (private) residence single-family (private) house as the place of occurrence of the external cause

Deleted Codes

Code	Description
M47.17	Other spondylosis with myelopathy, lumbosacral region
M47.18	Other spondylosis with myelopathy, sacral and sacrococcygeal region
M51.07	Intervertebral disc disorders with myelopathy, lumbosacral region
T40.1X5A	Adverse effect of heroin, initial encounter
T40.1X5D	Adverse effect of heroin, subsequent encounter
T40.1X5S	Adverse effect of heroin, sequela
T40.8X5A	Adverse effect of lysergide [LSD], initial encounter
T40.8X5D	Adverse effect of lysergide [LSD], subsequent encounter
T40.8X5S	Adverse effect of lysergide [LSD], sequel

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