Coding Diagnoses: ICD-9-CM

5

OBJECTIVES

- Explain the foundation of diagnosis codes using ICD-9-CM.
- Identify the best way to determine the key words located in physician's notes as they relate to the diagnoses for a specific encounter.
- Describe the rules regarding the determination of choosing the best, most appropriate code.
- Use the determined diagnosis codes for establishing medical necessity.
- Use the diagnosis codes for creating a valid claim form.

KEY TERMS

Alphabetic Index to Diseases
adverse reaction
anatomical site
causal condition
condition
eponyms
E (External cause) code
greatest specificity
highest degree of certainty
manifestation
neoplasm
Tabular List of Diseases
underlying condition
V code

As mentioned in Chapter 4, the National Center for Health Statistics (NCHS) put together a committee to create the *International Classification of Diseases—9th revision—Clinical Modification* (ICD-9-CM)* in February 1977. The members of the committee represented a wide variety of organizations, including the American Hospital Association, the American College of Physicians, and the American Psychiatric Association. This revision was designed to serve as an indexing system to classify data relating to diseases. It was determined that a more precise listing of codes was needed to establish a more complete picture of patient care.

*Enhance the learning process by pairing this chapter with a current copy of the International Classification of Diseases—9th revision—Clinical Modification Volumes 1 and 2.

The contents of ICD-9-CM translate almost everything that could affect the human body into three-, four-, and five-digit numbers. The ICD-9-CM code(s) placed onto a health care claim form specifically describe the reasons the individual has come to see the health care provider on a given day. The health claim form does not describe the individual's entire medical history, or any other condition, injury, or illness. As a coder, the only thing you are interested in is the specific explanation (diagnosis as determined by the health care provider) as to why an individual has consulted with a health care professional on a given day, along with any other conditions that might be related to this visit. The patient's chief complaint is usually a key element in properly coding this explanation.

The health care provider does not get paid according to which diagnosis codes are shown on the claim form, and the insurance company does not pay for anything with regard to the diagnosis directly. The payment is for service—the procedures performed. However, the insurance carriers must know what the concern or problem is with the individual in order to justify providing the indicated health care service at the time. For example, a health care provider gives a patient an injection. Don't you agree that there should be a good medical reason for giving that injection? This is called medical necessity.

Requiring medical necessity to be established helps make certain the health care provider is not just performing tests and giving injections for no good medical reason. The ICD-9-CM diagnosis codes explain *why* the individual came to see the physician and support the physician's rationale for providing the appropriate services (the *what* as explained by the CPT codes).

Medical necessity is one of the main reasons it is so important to code the diagnosis correctly. One small number off, and you could accidentally cause the claim to be rejected, because the diagnosis indicated by the wrong code would not rationalize or justify the procedure that was actually done.

Memory Tip

ICD-9-CM codes = *why* the patient saw the provider

Example

Sarita is 33 weeks pregnant and having trouble with her legs. Dr. Timmons diagnoses her with varicose veins and prescribes physical therapy. The coder was in a hurry and reported 571.0 for the diagnosis code. The claim was denied. Here's why:

571.0 Alcoholic fatty liver

The correct code is 671.0 Varicose veins of legs

One number—big difference!

GETTING READY TO CODE

First, let's discuss the parts of the ICD-9-CM book, so you can understand where to look to find the best, most appropriate code. There are three sections in the book, referred to as volumes.

Volume 1, the **Tabular List of Diseases**, is the section of the book that lists all of the ICD-9-CM codes, in numerical order from 001 to 999.9, then the V codes V01–V84.8, and then E codes E800–E999.1. (More details about V and E codes, in the pages to come.)

Volume 2 is the **Alphabetic Index to Diseases**, the alphabetical portion of the book that lists all of the diagnoses in alphabetical order. Diagnoses are listed by

- **Condition**
- **Anatomical site**
- **Eponyms**
- Other descriptors (such as history)

In the back of Volume 2 is Section 2, which contains the

- Table of Drugs & Chemicals
- Index to External Causes, the alphabetical listing for the causes of injury and poisoning

IMPORTANT NOTE

Volume 1—Tabular List of Diseases is located after Volume 2—Alphabetic Index to Diseases in your ICD-9-CM book.

Volume 3, **the Procedure Classification**, is typically used only by hospitals to code inpatient services. These are the ICD-9-CM procedure codes that some hospitals use instead of CPT procedure codes. The first part is the alphabetic listing, followed by the numerical listing. We will discuss this section further in Chapter 8.

IMPORTANT NOTE

ICD-9-CM Volume 3 lists procedure codes, in alphabetical order, then numerical order, which hospitals use instead of CPT procedure codes.

Many physicians' offices are specialized, so you will most likely be working with a limited number of sections within the ICD-9-CM book. This will make the entire process of coding from the huge ICD-9-CM book less intimidating. However, because you do not know what type of health care facility you will be working in, and you may go to work in a hospital or clinic that typically sees a wide range of illnesses and injuries, this text will cover the entire spectrum.

Key Terms

Tabular List of Diseases: The portion of the ICD-9-CM book listed in numerical order.

Alphabetic Index to Diseases: The portion of the ICD-9-CM book listed in alphabetical order from *A* to *Z*.

Condition: The situation, such as infection, fracture, or wound.

Anatomical site: The place in the body, such as the knee or heart.

Eponyms: A condition named after a person, such as Epstein-Barr syndrome or Cushing's disease.

Example

If you are working for a gastroenterologist you would rarely use codes for Mental disorders 290–319.

Particularly for inexperienced coders, it is easiest to look in Volume 2, the alphabetic listing, first to find the diagnosis, as indicated by the key words in the physician's notes. Once you find the diagnosis in the alphabetic listing, use the code number shown to look in Volume 1, the tabular (numeric) listing. This is very important because the tabular listing may have additional information that makes another code more accurate.

You use the alphabetical listings to get to the correct page or area in the tabular (numerical) volume. From there, you need to look around in the tabular (numerical) listings, so you can make certain that you find the best code, to the highest level of specificity, according to the physician's notes for an individual encounter.

When you begin, you will find that looking for a diagnosis in the alphabetic listing is not as easy as it sounds. Remember that accuracy is the most important issue. It is not a race. You need to be careful and meticulous. Sometimes you find the code right away; other times, it is like looking for a contact lens on a carpet—you have to look very carefully. The first thing to do is break apart the diagnosis, as noted by the physician. If you recall from Chapter 4, this is called abstracting the physician's notes.

Let's look at a sample diagnosis: *family history of colon cancer.* There are four key words: *family, history, colon,* and *cancer.* Let's take them one at a time.

Key Term

Neoplasm: Abnormal tissue; malignant neoplasm is another term for cancer; carcinoma is any of a variety of types of malignant neoplasms.

CANCER: If we look up *cancer* in the alphabetical listing, we find that the ICD-9-CM book refers us to ***neoplasm, by site, malignant***. You know from medical terminology class that *malignant neoplasm* is the proper term for what is commonly called cancer. However, you must note that this individual does not *have* a malignant neoplasm, just a family history. If you follow this lead and go to the neoplasm listings, you will see that none of the headings match family history. The column headings malignant, benign, uncertain behavior, and unspecified are the only ones shown. Nothing indicates a family history. You now know that this part of the diagnosis will not lead to the correct ICD-9-CM code for this patient.

Let's go to the next word in the diagnosis.

COLON: When you look up the word *colon* in the alphabetic listing, the book directs you to *see condition*. This does not mean to go to the listing for the word condition; it means that you should go back to the physician's notes and look for the condition of this patient's colon. What is wrong with his colon? Well, there isn't anything in the notes indicating there is something wrong with his colon. So this is not going to get you any closer to the correct code. Don't get frustrated. Look at this as a treasure hunt. The correct answer is in the book; you just have to find it. Let's go to the next word in the diagnosis—*family.*

FAMILY: Next to the word *family* you see the book directs you to *see also condition*. Underneath, you see codes indicated for . . .

Family, familial—*see also* condition
disruption V61.0
Li-Fraumeni (syndrome) V84.01
planning advice V25.09
problem V61.9
specified circumstance NEC V61.8
retinoblastoma (syndrome) 190.5

None of these descriptions match what we are looking for.

Because the diagnoses specifically mentioned under the word *family* don't match the physician's notes, you need to move on to the last key word in the diagnosis.

HISTORY: Looks like we struck gold! There are over a page and a half of diagnosis codes listed under the word *history (personal) of*. So, what kind of history does this individual have? A *family* history. Look down the column under the word *history* until you get to *family*.

You will notice that beneath the word *family*, there is an indented column, in alphabetical order, of codes for conditions that individuals might have a family history of. Look down the listing to see if the word *colon* appears. It does not. That's because you can't have a family history of having a colon. Just about everyone has one. What does this individual actually have? He has a *family history* of a *malignant neoplasm* (cancer) of the colon. Let's continue down the list.

History
Family
Malignant neoplasm (of) NEC V16.9.

This translates to a Family History of a Malignant Neoplasm Not Elsewhere Classified (NEC). But, that's not your situation. Keep going down the new indented list under *malignant neoplasm:*

Colon V16.0. We found it!

IMPORTANT NOTE

When looking through these long lists with lots of indentations, you must be conscientious and go down the columns carefully. Use a ruler or your finger to keep things in line.

Each word or phrase indented below another word or phrase includes the one above. Look above to Family indented once under the heading History. You read this as Family History. Then, Malignant neoplasm is indented once under Family, which is indented once under History. So, we read this as Family History of Malignant Neoplasm. This can get a little confusing, so use a ruler or your finger to keep track of what is indented at which level. If you let your eyes jump ahead, you might accidentally look at the next column under History, which says malignant neoplasm (of) V10.9. If you look at the indentations of the columns, you will see that this means History of Malignant Neoplasm (indicating that the patient him- or herself had been previously diagnosed) and not *Family* History of a Malignant Neoplasm (indicating that someone in the family, not this individual, was diagnosed)—a big difference. Of course, you would be able to catch this mistake as soon as you went to the tabular (numeric) listing to check the V10 code, as it specifically states V10 *Personal history of malignant neoplasm* in comparison with V16 *Family history of malignant neoplasm.*

Now, we can turn to the numeric listings (Volume 1—Tabular) to make certain V16.0 is the best, most specific code available. It matches the physician's notes perfectly, so we know we have the correct code.

IMPORTANT NOTE

Never code from the alphabetical listings (Volume 2—Alphabetic Index to Diseases). *Always check* the tabular listing before deciding on the best code.

THREE CATEGORIES OF ICD-9-CM DIAGNOSTIC CODES

ICD-9-CM Codes

The majority of the ICD-9-CM book contains ICD-9-CM codes, which are three-, four-, and five-digit numbers that directly connect to specific, confirmed diagnoses of illness (disease) or injury. These codes specifically define why the individual met with the health care professional.

V Codes

Key Term

V code: Code used to describe an encounter between a provider and an individual without a specific current health care illness or injury.

Sometimes individuals go to see a health care provider without any particular illness or injury. It may be for services to ensure they continue to be healthy, such as a flu shot or an annual physical. Perhaps an individual has a personal history of a particular disease and wishes to get tests to assure that the disease has not returned, or he or she has a family history that might cause the person to be watchful. Because the individual does not have any illness or disease, you cannot use a standard ICD-9-CM code. However, you must have a diagnosis code to justify performing a test on, or giving an injection to, the individual. A standard ICD-9-CM code would indicate a confirmed diagnosis. You must, instead, use a **V code.**

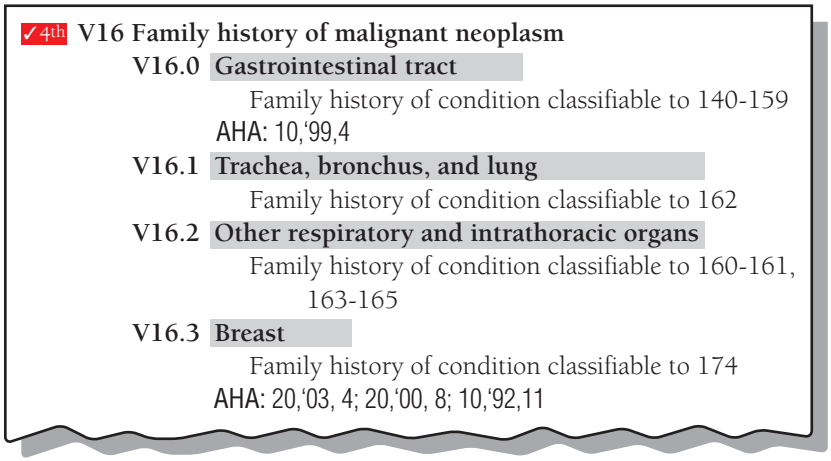


FIGURE 5-1
V Code for family history of malignant neoplasm.

Example

Harriet, a 22-year-old female, goes to her physician's office for a mammogram because she has a family history of malignant neoplasm of the female breast (breast cancer). The appropriate code would *not* be:

174 Malignant neoplasm of female breast

Using this code would indicate that Harriet has been confirmed to have a diagnosis of breast cancer, but she does not. The physician's notes do state that she has a family history of malignant neoplasm of the breast. Therefore, the correct code (Figure 5-1) is

V16.3 Family history of malignant neoplasm, breast

Take a few minutes to look through the V code section in the tabular listing of the ICD-9-CM book. Get a feeling for the category headlines and sections. The descriptions for all V codes are included in Volume 2, the Alphabetic Index to Diseases, so the ICD-9-CM book will guide you as to when to use them.

Example

V codes cover screenings, such as a mammogram or a colonoscopy; preventive medicines, such as vaccinations; fertility testing and treatments; prenatal checkups; and well-baby exams.

Memory Tip

V in **V** code stands for pre**V**entive.

CASE STUDY

Drew just found out that his son's best friend has come down with a case of rubella. His son was over at his house, playing, just two days ago. So, Drew takes his son to his pediatrician to get checked. Dr. Morgan writes in his notes that the reason for the visit was Exposure to Rubella. What is the best ICD-9-CM code to use on the claim form?

The correct code is: V01.4 Exposure to Rubella.

E Codes

Key Term

E (External cause) code: A code that explains *how* an injury or poisoning happened, and/or *where* it happened.

When an individual goes to see a health care provider with an injury or a case of poisoning, something had to cause it—an External cause. An **E code** is used, in addition to the ICD-9-CM and V codes, to explain what caused the individual to have the problem.

These codes are very important, because the event or element that caused the injury may require a different insurance company to pay for these medical expenses. Remember that, in Chapter 1, we discussed the types of insurance policies and plans. The situation that caused a person to have a fractured arm, for instance, helps determine which policy is responsible for the claim. If the individual hit her head

- *At work,* then Workers' Compensation insurance would pay the medical bills, not the health care plan
- While *shopping at a store,* the store's liability insurance might pay for the medical bills
- *In an automobile accident,* then her automobile insurance would probably be billed
- After slipping in her bathtub *in her own home,* then her health care policy would be billed

Therefore, you, as an insurance coder, must explain what happened, so the billing personnel and the insurance company will know who is responsible for these medical bills. The way you tell them is by adding an E code after the diagnosis code.

To make it easier to find the correct E code, Section 2 of Volume 2 has a separate Index to External Causes. This is the alphabetic listing of all the possible situations that might cause an injury or a poisoning to a human. Then, you can confirm that code in the E code section of the tabular listing.

IMPORTANT NOTE

In some circumstances, you need to include two E codes to tell the whole story—the how and the where.

In some cases, one E code will include both the cause and the location, such as (Figure 5-2)

> E816 Motor vehicle traffic accident due to loss of control, without collision on the highway

This E code includes both the how (motor vehicle accident) and the where (on the highway).

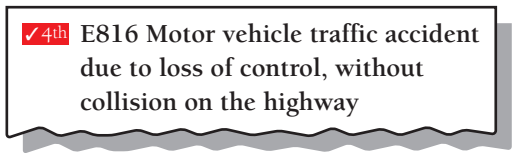


FIGURE 5-2
Example of one E code including both How and Where.

Remember, the main purpose of the E code is to help guide you in your determination as to which insurance policy should be responsible for paying the claim. Therefore, be certain you know the whole story, so your codes can tell the whole story. Although E codes are not required in all states, including them on your health care claim form will speed the process and get your claim paid faster, and that's what this is all about!

IMPORTANT NOTE

An E code can never be a principal, or first-listed, code. In other words, it cannot be first on a claim form.

Occasionally, the ICD-9-CM book reminds you to include an E code. However, you should learn when an E code is needed, because they are not included in the main alphabetic listing. Remember, they have their own alphabetic list in Volume 2, Section 2. This means that you have to look them up separately from the other diagnosis codes.

Examples

If a person comes to the physician's office with a brain concussion, something external had to hit her in the head, or bang against her head, to cause that concussion. One doesn't just wake up one day with a concussion. One can't catch a concussion from someone else, and one can't inherit a concussion from one's parents. An E code explains what caused the injury.

Keith sprains his ankle, falling from a ladder while changing a lightbulb in the foyer of his home. You need the codes:

845.00 Sprained ankle unspecified site.
E881.0 Fall from ladder
E849.0 Place of occurrence, home

Now, you and the insurance carrier will know that Keith's medical bills will be the responsibility of his own health insurance plan.

Memory Tip

The **E** code explains the **E**xternal cause of an individual's injury or poisoning.

CASE STUDY

Eric was walking barefoot through his living room when he jammed his toe against the leg of the coffee table. He was in so much pain, he went to his doctor. The X-ray confirmed a fracture of the great toe (closed). What are the best, most appropriate ICD-9-CM code(s)?

The correct codes are:

826.0 Fracture of one or more phalanges of foot (closed)
E917.3 striking against furniture without subsequent fall
E849.0 Place of occurrence, home

THREE, FOUR, OR FIVE NUMBERS—HOW DO YOU KNOW?

Key Term

Greatest specificity: The most detail available.

The primary purpose of coding is to be able to describe, with the **greatest specificity**, what is going on with regard to an individual. You need to explain, in as much detail as possible, exactly why the provider saw the patient. Five-digit codes have more detail, or specificity, than four-digit codes, which have more detail, or specificity, than three-digit codes.

IMPORTANT NOTE

The letter in V codes counts as a digit, but the E in E codes does not.

Three Digits

Each condition, illness, or injury is divided into a separate category identified by a three-digit number. Sometimes the three-digit number is all that is needed, as in the case of ICD-9-CM code (Figure 5-3)

325 Phlebitis and thrombophlebitis of intracranial venous sinuses

This three-digit code is complete and requires no further information or detail.

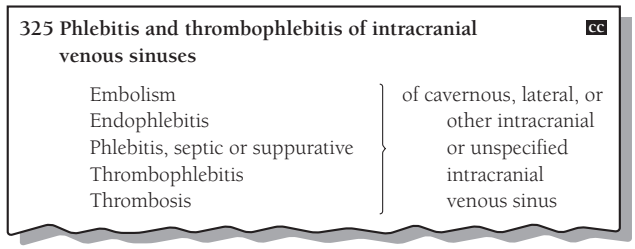


FIGURE 5-3
Example of a complete three-digit code.

Example

Alexander, a 56-year-old male, is seen at the physician's office and diagnosed with unspecified bronchitis. When you look for bronchitis in the alphabetic listing, you see the code 490. Because there are no other specifications to the bronchitis, you will go with the Bronchitis (simple) 490. When you turn to the numerical listing for 490, you see *Bronchitis, not specified as acute or chronic*. As you look down the column, you find this definition is best and most specifically matches the physician's notes. Therefore, the three-digit code 490 is correct.

IMPORTANT NOTE

ICD-9-CM books are printed by several different publishers. Each publisher uses their own colors and symbols for notations throughout the book. For example, in the following pages, we will review red boxes that direct you to add a digit to the code. Some publishers use black boxes, others a circle through a line ∅. Don't let this throw you—they will all direct you to the best code.

Four Digits

In some cases, a fourth digit is required to indicate a more specific description. In these cases, you will see a small red box with a check mark and "4th" next to the three-digit code ✓4th or a red dot ● that directs you to the legend across the bottom of the page that a fourth digit is needed. Let's use our example from before, the individual with the diagnosis of a family history of a malignant neoplasm of the colon. You found code V16.0 in the alphabetic listing and now must go to Volume 1, the numeric listing, to make certain this is the best, most specific code available.

✓4th V16 Family history of malignant neoplasm

You will notice the small red box with the check mark and the "4th" next to the V16. This reminds you that you must keep reading to find the correct four-digit code. If you continue reading down the column, you will see codes

V16.0 Gastrointestinal tract

V16.1 Trachea, bronchus and lung

V16.2 Other respiratory and intrathoracic organs

V16.3 Breast

The details you will need in order to determine which code is correct should be found in the physician's notes. In this example, the notes state that the family history was of a malignant neoplasm of the colon. You should remember from your anatomy course that the colon is part of the gastrointestinal tract. Therefore, V16.0 is the correct four-digit code for this diagnosis.

To make certain that this is the correct code, take a look at the notation under the V16.0 gastrointestinal tract listing: Family history of condition classifiable to 140–159. Let's use this note to double-check your work and go to code 140 Neoplasm. As you look through all the following codes, you get to code 153 Malignant neoplasm of colon. Code 153 is within the range shown, 140–159. Now you can be certain that the code V16.0 is the correct diagnosis code for an individual with a family history of colon cancer.

CASE STUDY

Abby, a 19-year-old female, was having a really bad time emotionally. Her counselor referred her to a psychiatrist, Dr. Crandle. After a thorough series of tests, Dr. Crandle diagnosed Abby with chronic paranoid psychosis, a delusional disorder.

What is the best, most accurate ICD-9-CM code?

Abby's diagnosis would be indicated with the code

297.1 Delusional disorder.

Five Digits

When an additional level of detail is available, a fifth digit is needed for the ICD-9-CM code. Similar to the fourth-digit red box, the need for the fifth digit is indicated by a similar red box, with a check mark and a "5th" next to the four-digit code ✓5th. A good example of this is the ICD-9-CM code

✓4th 368 Visual disturbances

Next to the 368 code is a red box with a check mark and "4th" next to it. This tells you that a fourth digit is required, so you keep reading down the column. The next code shown is

✓5th 368.0 Amblyopia ex anopsia

You can see that next to the 368.0 is a red box with a check mark and "5th." This tells you that you need to give even more detail with a fifth digit. When you keep reading down the column, you see codes

368.00 Amblyopia, unspecified

368.01 Strabismic amblyopia

368.02 Deprivation amblyopia

368.03 Refractive amblyopia

The red boxes that indicate a fourth or fifth digit are not suggestions: these boxes are telling you that the extra digit *is required.* They are helping guide you to the best, most appropriate code. If the extra digit is required and you do not include it, your claim will be denied.

IMPORTANT NOTE

A ✓4th box or a ✓5th box is *not* a suggestion for an additional digit. It means you *must* keep looking for a more specific code—a code with that additional digit.

Consider Barbara, a 15-year-old female, seen by her physician and diagnosed with non-organic bulimia. In the alphabetic listings, you see *Bulimia non-organic origin 307.51.* You go to the numerical listing for

✓4th 307 Special symptoms or syndromes, not elsewhere classified

and see that a fourth digit is required. As you move down the column, you find

✓5th 307.5 Other and unspecified disorders of eating

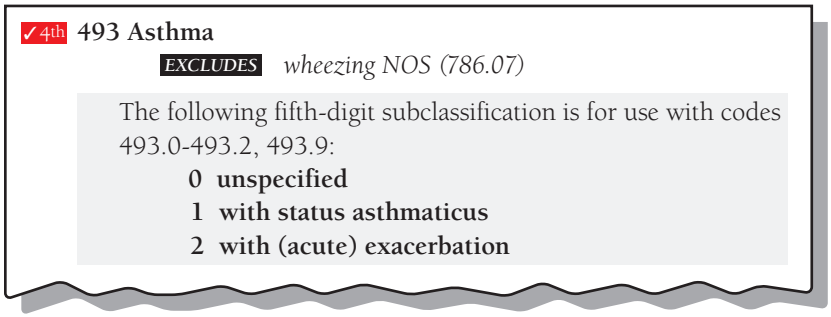


FIGURE 5-4
Boxes contain information that can apply to several diagnosis codes.

This requires a fifth digit, as indicated by the red box. You move farther down the column and see

307.51 Bulimia nervosa, overeating of non-organic origin

This matches the physician's notes, so you now know this is the correct five-digit code:

307.51 Bulimia, non-organic origin

On some pages in the ICD-9-CM book, you will find the fourth or fifth digit not by reading farther down in the column but, rather, by reading up—toward the top of the column, page, or sometimes to the page beforehand—to a pink box. This saves space when the addition of this digit means the same additional information for many different codes. A good example is ICD-9-CM code

✓4th 493 Asthma

showing the red box requiring a fourth digit. As you read down the column, you see a pink box (Figure 5-4).

Reading farther down the column, you see the definitions for the four-digit codes in this category.

✓5th 493.0 Extrinsic asthma

✓5th 493.1 Intrinsic asthma

✓5th 493.2 Chronic obstructive asthma

✓5th 493.8 Other forms of asthma

✓5th 493.9 Asthma, unspecified

All of these four-digit descriptions show red boxes with check marks and "5th" next to them. Here, you must first read down from the three-digit code to find your fourth digit. Then go back up, reading toward the top of the page, to find your fifth-digit code in the box.

Now, let's look at a case that will help us practice what we have learned so far.

CASE STUDY

Bobby Appleton is a 6-year-old male who is being seen in the office by his regular primary care physician for an open wound on his upper arm. Bobby's mother, Janet, tells the doctor that a strange dog from the neighborhood bit the boy, causing the wound. They do not know where the dog lives. It seems wild, or certainly has not been cared for in quite a while, and the people in the area believe the dog to be a stray. The doctor concludes from this scenario that the child should be treated as if he has been exposed to rabies.

Which key words will you use to find the ICD-9-CM codes? What are the best, most appropriate codes?

Begin by pulling out the elements of the diagnosis: open wound on upper arm. The key words are *open, wound, upper arm.* In the alphabetic listing, you see no description for *upper arm,* and *arm* directs us to *see condition.* That would be the wound. Wound, open is actually one listing. You read down the column to Arm, and indented under the word *arm* you find Upper 880.03. That sounds pretty good, so let's go to the numerical listing to confirm (Figure 5-5).

The code

✓4th 880 Open wound of shoulder and upper arm

indicates the need for a fourth digit. You have to look down past the pink box to find the four-digit choices. Because the physician's notes make no mention of complications, you will add the fourth digit of zero.

✓5th 880.0 Open wound of shoulder and upper arm without mention of complication

FIGURE 5-5
Numeric listing for wound, open, upper arm.

✓4th **880 Open wound of shoulder and upper arm**

The following fifth-digit subclassification is for use with category 880:

0 shoulder region
1 scapular region
2 axillary region
3 upper arm
9 multiple sites

✓5th **880.0 Without mention of complication**
✓5th **880.1 Complicated**
✓5th **880.2 With tendon involvement**

So far, this code description is in agreement with the notes. However, you will see that this code requires a fifth digit. You have to look back up the column, to the box, to find your choices. You know from the physician's notes that the boy's wound is on his upper arm. This leads you to the fifth digit of 3. This gives you the final, correct code of

880.03 Open wound of upper arm without mention of complication

You know that a wound is an injury, not an illness. Therefore, you must explain what external factor caused the wound. This means that you need to add an E code.

1. Go back to the physician's notes and see that the child's wound was the result of being bitten by a dog.
2. Go to the alphabetic listing and look up dog bite. Wow, it's actually right there, under D for Dog bite—see Wound, open, by site. This notation is the book directing us back to the wound itself, not an E code. Hmmm. If you look under B for Bite(s), then animal, the book gives you the same instruction. The reason this does not lead to an E code is because you mistakenly used the Alphabetic Index to Diseases (the regular alphabetic listing), not the E code alphabetic listings (Index to External Causes).
3. Remember, when an E code is needed, you must use the second alphabetic listing—the Index to External Causes in Volume 2, Section 2, right after the Table of Drugs & Chemicals. When you turn to the Index to External Causes and look under D for dog, it's right there.

Dog bite E906.0—of course, you should turn to the E code section in Volume 1 to double-check that this is the best available code, and it is!

IMPORTANT NOTE

When an E code is needed, you must use the separate alphabetic listing—the Index to External Causes in Volume 2, Section 2—immediately after the Table of Drugs & Chemicals.

Are you done? Not yet. You will remember that the physician's notes also mention that the dog is a stray and that the child has been exposed to rabies. When you go to the word *exposure* in the alphabetic listing and go down the column, you see

Exposure
To
Rabies V01.5

When you go to the V code section of the numerical listings, you can see that this is the correct code. The claim form for this encounter will show the three diagnoses codes: 880.03, E906.0, and V01.5. Now you are done. Good job!

Example

Dr. Hesse's notes state that Mrs. Alexander is diagnosed with unspecified asthma with acute exacerbation. What is the best ICD-9-CM code?

You first find the code for asthma, 493, and continue reading down the column to get the fourth digit, which is 493.9 for asthma, unspecified. Because a fifth digit is also required (as you can tell by the red box with the check mark and "5th" next to the 493.9 code), you move back up the page to the box and add the fifth digit for acute exacerbation. This gives you the final and correct code of

493.92 Asthma, unspecified, with acute exacerbation

WHAT TO CODE OR NOT CODE

The diagnosis codes that must be used on the health insurance claim form are the codes that explain or describe the answer to the question "Why did this individual come to see this health care provider today?" That is it. The health claim form does not relate the individual's medical history. Only the symptoms, conditions, problems, or complaints that directly correlate with why the individual is in this office on this day are to be coded and included on this health insurance claim form.

CASE STUDY

John Longenstein, a 48-year-old male, goes to see his physician because of a sore on his foot. He states that the sore has been present for three weeks and is not healing. John has a history of bronchial asthma. After examination, the physician notes that the patient has an ulcer on his right midfoot due to his type II diabetes.

First, *why did this individual come to see this health care provider today?* The reason is the ulcer on his foot. This is your first diagnosis code listed on the health insurance claim form. This is the principal—the number one—reason that the patient came to the physician's office today.

Second, you must include a code for the diabetes, because the diabetes is the **underlying condition** that has influenced this man's health and resulted in the ulcer.

Third, the patient has a history of bronchial asthma. The asthma would not be coded here because it has nothing to do with why the patient came to see the physician today. If the physician had addressed the asthma in any way (such as renewing a prescription), then you would code it. In this case, it is not coded.

Key Term

Underlying condition: One disease that affects or encourages another condition. Also referred to as a causal condition.

IMPORTANT NOTE

In some cases there are issues that are typically related to another diagnosis. In the ICD-9-CM book, this may be indicated by a small gray box, next to the code description with two letter *C*s. CC stands for **c**omplication/**c**omorbidity. A small blue box with an MC in it MC means that this diagnosis code is a **m**ajor **c**omplication of another diagnosis. When the diagnosis code is for a condition that is either a complication or comorbidity element of an HIV-positive status, a small black box with "HIV" may also be present HIV. In all of these cases, these boxes indicate that an additional diagnosis code *may* be required.

Let's code this case by first going to look up Ulcer, foot in the alphabetic listing, Volume 2. The code 707.15 is indicated. Now, let's go to the tabular listing to double-check.

707.15 Ulcer of other part of foot CC

But wait, look right above that at

707.14 Ulcer of heel and midfoot CC

That matches the physician's notes exactly. This is another reminder why you should never code from the alphabetic listings. Also, did you notice the CC box? That's there to remind you to code the diabetes.

Look up the column, toward the descriptions for the four-digit version of this code:

707.1 Ulcer of lower limbs, except decubitus

and take a look at the notation below:

Code, if applicable, any causal condition first:
Diabetes mellitus (250.80–250.83)

This patient does have diabetes and, as noted by the physician, it is a causal, or underlying, condition. Let's go back to the alphabetic listings to (Figure 5-6)

Diabetes
Ulcer (skin) 250.8 ✓5th *[707.9]*

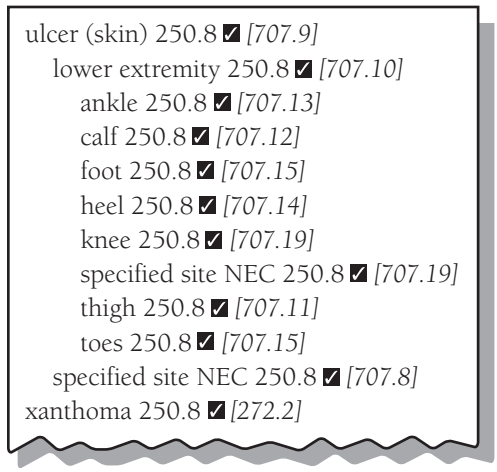
Keep looking. We always want to check our options.

Lower extremity 250.8 ✓5th *[707.10]*
Foot 250.8 ✓5th *[707.15]*

Ta da! Now not only do you have the code for the diabetes but you also have been able to verify the correct code for the ulcer. But you are not done yet. Remember that red box. You must go to the tabular listing and check for the fifth digit, and you find

250.80 Diabetes with other specified manifestations, type II, not stated as uncontrolled

FIGURE 5-6
Alphabetic listing showing required secondary code.



Are you done now? Yes, because the asthma does not get coded. It has nothing to do with this visit to the provider, so the claim form will show two diagnosis codes:

707.14

250.80

However, did you notice something? There is a notation underneath the 250.8 code listing. It says

Use additional code to identify ***manifestation,*** *as:*

Any associated ulceration (707.10–707.9)

Key Term

Manifestation: A condition caused by or developed from the existence of another condition, similar to a side effect.

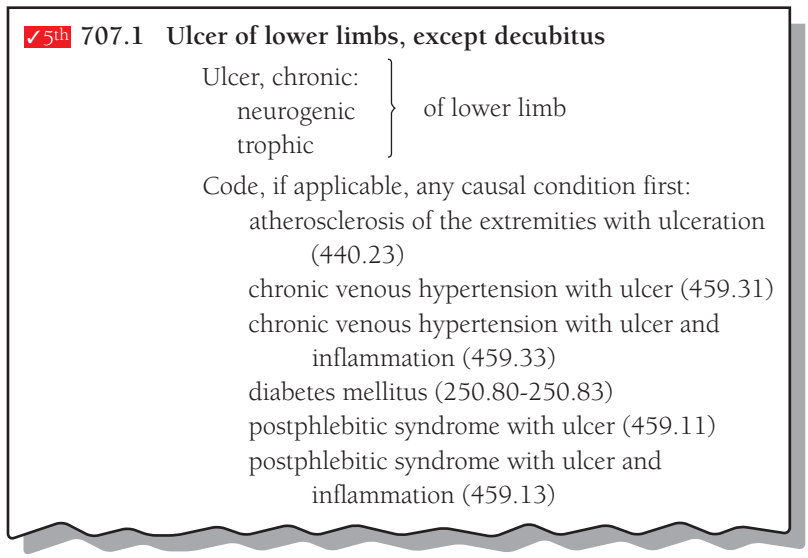
Remember the notation underneath the 707.1 code listing. See what it says (Figure 5-7).

Code, if applicable, any causal condition first:

atherosclerosis of the extremities with ulceration (440.23)

diabetes mellitus (250.80–250.83)

FIGURE 5-7
Example of a Code First notation.



And even the alphabetic listing told us not only do we need two codes but it tells us in which order they need to be shown.

Foot 250.8 ✓5th *[707.15]*

That seems to directly apply to this case, doesn't it? Therefore, you must change the order of your codes and put the diabetes not the ulcer, first. Isn't it great the way the book tells you exactly how to do this properly? So, the claim form will show two diagnosis codes:

250.80

707.14

CASE STUDY

Ashley Matthews, a 33-year-old female, goes to see her regular physician, Dr. Montoya, in his office with complaints of coughing and feeling very weak. After the appropriate tests, Dr. Montoya diagnoses her with pneumonia due to streptococcus, unspecified. Ashley was found to be HIV positive two years ago.

How many diagnosis codes should be used? What are the best, most accurate codes?

There would be two ICD-9-CM codes shown on the health insurance claim form:

042 Human immunodeficiency virus [HIV] disease

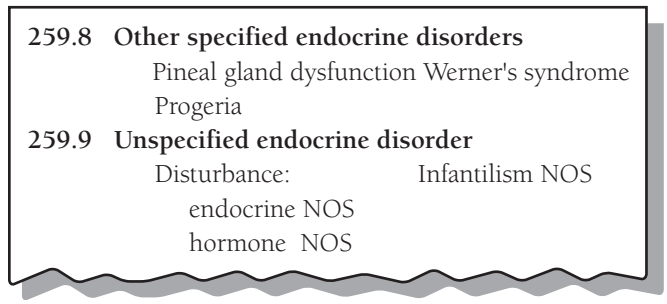
482.30 Pneumonia due to streptococcus, unspecified

You must show both codes, because the 482.30 Pneumonia is a complication of the patient's 042 HIV condition. Also be aware of the notation that the ICD-9-CM book shows under the 042 code. This guides you to the fact that the 042 code must be assigned first, then the manifestation, the pneumonia.

IMPORTANT NOTE

Be certain to double-check the physician's notes before choosing any "other" or "unspecified" description of a code. Make sure that either the physician wrote the word *unspecified* or there really is no indication of any more detail. When possible, ask the physician for more information to increase your opportunity to avoid an unspecified code.

FIGURE 5-8
Example of Other Specified and Unspecified code descriptions.



You will see *unspecified* and other types of vague code descriptions in a few different ways, such as (Figure 5-8):

259.8 *Other specified* endocrine disorders

This means that the physician did specify the dysfunction but the ICD-9-CM book did not include the same detail in any of the other codes in the category. (In other words, none of the codes available 259.0–259.4 matched what the physician wrote.) This is a similar notation to NEC, Not Elsewhere Classified.

259.4 Dwarfism, *Not elsewhere classified*

Not Elsewhere Classified (NEC) means that the physician *did* specify the specific aspect of the condition but the ICD-9-CM book did not include the same detail in any of the other codes in the category.

259.9 *Unspecified* endocrine disorder

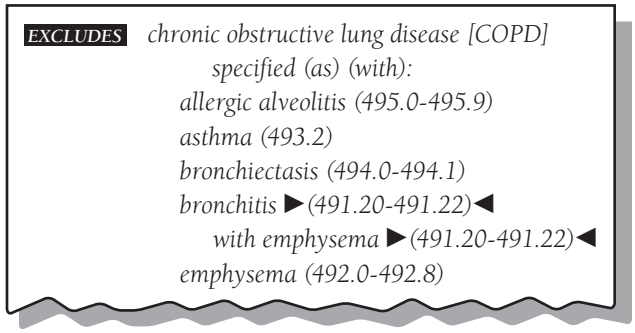
Unspecified means that the physician was not specific in his or her notes. *Never* assume or make up any detail of the description; if you have no more specific information available to you, you have to choose this code.

261 Nutritional marasmus, severe malnutrition NOS

Not Otherwise Specified (NOS) can mean the same thing as Unspecified indicating that the documentation did not mention additional detail.

There may be times when the ICD-9-CM book directs you with an *includes* or *excludes* notation (Figure 5-9). In these cases, below the description of the code, the notation will either: further describe other variations of the condition that is included in this code; or describe variations that are not included in this code, which means they are excluded.

FIGURE 5-9
Example of an Excludes notation.



CASE STUDY

Anita Carnahan is a 23-year-old female who is 18 weeks pregnant. She goes to see her OB-GYN physician, Dr. Harrison, because she has been vomiting quite a lot over the past few days. After a complete examination, Dr. Harrison diagnoses her with hyperemesis.

What are the best, most appropriate ICD-9-CM codes?

The alphabetical listing directs you to code

643 Excessive vomiting in pregnancy

When you continue to read, you will see the notation below that description

INCLUDES hyperemesis arising during pregnancy

The white box outlined in black shows the word *Includes* INCLUDES. This indicates that there are more descriptive words that are encompassed by this code. This tells you that you are in the correct category. Good work! (Figure 5-10.) These notations, along with all the others, are additional examples of how the ICD-9-CM book will guide you to the correct code, if you pay attention.

ICD-9-CM codes are to be used to indicate the **highest degree of certainty.** This means that those diagnoses that are not definite, those that are described as *probable, suspected, to be ruled out,* or *working,* are *not coded.* In these cases, you code only the symptoms, as directed by the *Official Guidelines Section IV: Diagnostic Coding and Reporting Guidelines for Outpatient Services* (e.g., physician's office, ambulatory surgery center, clinic).

Key Term

Highest degree of certainty: What we know for a fact.

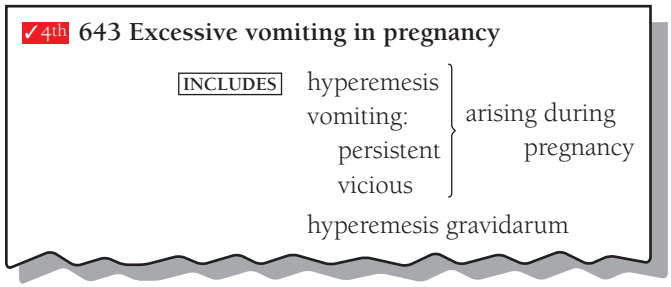


FIGURE 5-10
Example of an Includes notation.

IMPORTANT NOTE

The coding guideline that states the coder should *not* code those conditions described as probable, suspected, rule out, or working is *only* for outpatient coding. This rule changes for those coding for inpatient treatments.

When variations of a diagnosis, or similar diagnoses, are not a part of a code or group of codes, the ICD-9-CM book may list those other conditions with an EXCLUDES notation. This black box with white letters will direct you to other, possibly better, codes depending upon what the physician has written.

Examples

A 9-year-old male is seen by the physician and diagnosed with enuresis. The physician does not know at this point in time what is causing the problem. The coder finds

307.6 Enuresis

You can't get much better than that, can you? Well, actually, if you continue reading, you will see the description Enuresis (primary) (secondary) of non-organic origin. The physician did not write in her notes that the origin (or cause) of the enuresis is non-organic, so this code may not be correct after all. If you keep reading, you will see the black box with the word *Excludes* EXCLUDES below the description. You then see

EXCLUDES enuresis of unspecified cause (788.3). Aha!!

When you turn to 788.3, you see

✓5th 788.3 Urinary incontinence

788.30 Urinary incontinence, unspecified

Enuresis NOS

This matches the information in the physician's notes.

A patient was seen in the physician's office with a complaint of nausea and vomiting every morning; the physician will run a test to rule out pregnancy. Because the pregnancy is to be ruled out, and has not been confirmed, you would code only the vomiting and nausea. When a specific diagnosis has not yet been confirmed, you need to code the signs and/or symptoms, because the patient's symptoms are the only things you know for a fact.

787.01 Nausea with vomiting

Memory Tip

If you don't *know,* don't *code!*

NOTATIONS AND EXPLANATIONS

Punctuation is also used in ICD-9-CM to add information and to help you further in your quest for the best, most appropriate code.

[ ] These brackets show you alternate terms or phrases to provide additional detail or explanation to the description.

[ ] Italicized, or slanted, brackets surround additional code(s) (secondary codes) that *must* be included with the initial code. This notation will only show up in the alphabetic listing of ICD-9-CM.

( ) Parentheses show you additional descriptions, terms, or phrases that are also included in the description of a particular code.

: A colon (two dots, one on top of the other) emphasizes that the following descriptors are also included in the notation. This notation shows up only in the tabular (numerical) listing of ICD-9-CM.

} A brace indicates that a list of words or terms is affected by the word or phrase to the right of the brace.

MULTIPLE AND ADDITIONAL CODES

Sometimes a patient has several conditions or concerns at the same time. When the physician indicates more than one diagnosis, it is easier for you to know what additional codes are to be included on that health insurance claim form.

In this case, the physician's notes indicate the patient suffers from a fractured hand (closed) and a dislocated shoulder ligament (closed):

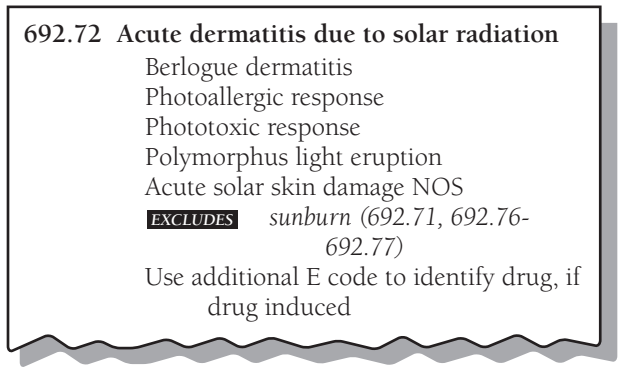
815.00 Fracture, of metacarpal bone(s), closed, site unspecified

831.00 Dislocation, shoulder, closed, unspecified

Therefore, you will have one code for the dislocation and an additional code for the fracture. Whenever, there are two diagnoses concurrently (at the same time) but one is not the result of, or caused by, the other, you put the codes onto the health insurance claim form in order of severity, with the more severe condition first. In our example, a fracture is more severe than a dislocation, so this claim form will place the fracture code as first-listed. (If you noticed that the above case would also require an E code to identify what caused the patient's dislocation and fracture, give yourself a cheer—good job!)

When a provider indicates a differential diagnosis using the word *versus* or *or* between two diagnostic statements, you need to code both as if they were confirmed.

FIGURE 5-11
Sometimes the ICD-9-CM book points you in a specific direction.


692.72 **Acute dermatitis due to solar radiation**
Berlogue dermatitis
Photoallergic response
Phototoxic response
Polymorphus light eruption
Acute solar skin damage NOS
EXCLUDES *sunburn (692.71, 692.76-692.77)*
Use additional E code to identify drug, if drug induced

There are times, however, when you will need to look for and code an underlying disease or condition that caused the reason the patient came to see the health care provider today. We reviewed this earlier in this chapter when we learned about major complications, coexisting conditions, and comorbidities. In addition to the small boxes indicating the possibility that another diagnosis is involved, the ICD-9-CM book will sometimes come right out and tell you when an additional code is necessary. Let's look at some codes that do exactly this.

> 330 Cerebral degenerations usually manifest in childhood. Use additional code to identify associated mental retardation.

This note is shown below the description of the code and not only directs you to add a code but also sends you in a specific direction (Figure 5-11).

> 333.3 Tics of organic origin. Use additional E code to identify drug, if drug induced.

Again, the ICD-9-CM book gives you fair warning that you might need an additional code.

> 590.81 Pyelitis or pyelonephritis in diseases classified elsewhere. Code first underlying disease as: tuberculosis (016.0).

This note is telling you that you need to code the disease or condition that existed first or perhaps caused the other diagnosis. When this is indicated, you put the diagnosis code 016.0 on the claim form first, followed by 590.81. Just as you saw with the patient suffering from a diabetic ulcer on his foot, the ICD-9-CM book is not only guiding you but also actually giving you the other code.

These notes are only included in the tabular section (Volume 1) of the ICD-9-CM book and not in the alphabetic listing (Volume 2). This is another good reason that you should *never code from Volume 2—the alphabetic listing.* However, these notations are not shown in all cases where a second code is required, so you will still have to read the physician's notes carefully.

The alphabetic listing (Volume 2) has a different way of letting you know that a second code is required (Figure 5-12). In these cases, next to the listing and code for a particular diagnosis, you may see a second code enclosed in brackets and italicized:

> Epstein-Barr infection (viral) 075
>
> chronic 780.79 *[139.8]*

Epstein-Barr infection (viral) 075
chronic 780.79 *[139.8]*

FIGURE 5-12
Secondary diagnosis code shown in brackets.

The code shown first, 780.79, is actually described as Other malaise and fatigue. You may notice that there is no "Use additional code" or "Code first underlying disease" notation. The second code, shown in the italicized brackets, is

> 139.8 Late effects of other and unspecified infectious and parasitic diseases

This is an example of how the alphabetic listing (Volume 2) can help you code correctly as well. Again, you must then check both codes in the numeric listing to be certain both codes match the patient's condition, according to the physician's notes for this visit.

Example

Marjorie Katz was seen by her regular physician in his office with a complaint of chest pain and shortness of breath. Dr. Healer admitted her into the hospital with a differential diagnosis of congestive heart failure versus pleural effusion with respiratory distress. Here, you would code the

1. Congestive heart failure (428.0)
2. Pleural effusion (511.9)
3. Respiratory distress (786.09)

TABLES IN THE ALPHABETIC LISTINGS

There are three conditions in Volume 2, which include extended information using a multicolumn table within the listing. These tables are

- Hypertension (commonly referred to as high blood pressure)
- Neoplasms (commonly referred to as tumors, whether cancer or not)
- Drugs & Chemicals

Hypertension Table

When you turn to hypertension in the alphabetic listing (Figure 5-13), you see a three-column table to the right of the indented column of descriptions. The three columns are titled

- Malignant
- Benign
- Unspecified

You will first look down the column of descriptions to find the definition that matches the physician's notes. Then, once you have found the correct description, you will look across the line to the right to find the correct code.

	Hypertension, hypertensive		
	Malignant	Benign	Unspecified
Hypertension, hypertensive (arterial) (arteriolar) (crisis) (degeneration) (disease) (essential) (fluctuating) (idiopathic) (intermittent) (labile) (low renin) (orthostatic) (paroxysmal) (primary) (systemic) (uncontrolled) (vascular)	401.0	401.1	401.9
with			
heart involvement ▶(conditions classifiable to 429.0-429.3, 429.8, 429.9 due to hypertension)◀(*see also* Hypertension, heart)	402.00	402.10	402.90
with kidney involvement—*see* Hypertension, cardiorenal			
renal involvement (only conditions classifiable to 585, 586, 587) (excludes conditions classifiable to 584) (*see also* hypertension, kidney)	403.00	403.10	403.90
renal sclerosis or failure	403.00	403.10	403.90
with heart involvement—*see* Hypertension, cardiorenal failure (and sclerosis) (*see also* Hypertension, kidney)	403.01	403.11	403.91
sclerosis without failure (*see also* Hypertension, kidney)	403.00	403.10	403.90
accelerated—(*see also* Hypertension by type, malignant)	401.0	—	—
antepartum—*see* Hypertension, complicating pregnancy, childbirth, or the puerperium			
cardiorenal (disease)	404.00	404.10	404.90
with			
heart failure	404.01	404.11	404.91
and renal failure	404.03	404.13	404.93
renal failure	404.02	404.12	404.92
and heart failure	404.03	404.13	404.93
cardiovascular disease (arteriosclerotic) (sclerotic)	402.00	402.10	402.90
with			
heart failure	402.01	402.11	402.91
renal involvement (conditions classifiable to 403) (*see also* Hypertension, cardiorenal)	404.00	404.10	404.90
cardiovascular renal (disease) (sclerosis) (*see also* Hypertension, cardiorenal)	404.00	404.10	404.90
cerebrovascular disease NEC	437.2	437.2	437.2
complicating pregnancy, childbirth, or the puerperium	642.2 ☑	642.0 ☑	642.9 ☑
with			
albuminuria (and edema) (mild)	—	—	642.4 ☑
severe	—	—	642.5 ☑
edema (mild)	—	—	642.4 ☑
severe	—	—	642.5 ☑
heart disease	642.2 ☑	642.2 ☑	642.2 ☑
and renal disease	642.2 ☑	642.2 ☑	642.2 ☑
renal disease	642.2 ☑	642.2 ☑	642.2 ☑
and heart disease	642.2 ☑	642.2 ☑	642.2 ☑
chronic	642.2 ☑	642.0 ☑	642.0 ☑
with pre-eclampsia of eclampsia	642.7 ☑	642.7 ☑	642.7 ☑
fetus or newborn	760.0	760.0	760.0
essential	—	642.0 ☑	642.0 ☑
with pre-eclampsia of eclampsia	—	642.7 ☑	642.7 ☑
fetus or newborn	760.0	760.0	760.0
fetus or newborn	760.0	760.0	760.0
gestational	—	—	642.3 ☑
pre-existing	642.2 ☑	642.0 ☑	642.0 ☑
with pre-eclampsia or eclampsia	642.7 ☑	642.7 ☑	642.7 ☑
fetus or newborn	760.0	760.0	760.0
secondary to renal disease	642.1 ☑	642.1 ☑	642.1 ☑
with pre-eclampsia or eclampsia	642.7 ☑	642.7 ☑	642.7 ☑
fetus or newborn	760.0	760.0	760.0
transient	—	—	642.3 ☑
due to			
aldosteronism, primary	405.09	405.19	405.99
brain tumor	405.09	405.19	405.99
bulbar poliomyelitis	405.09	405.19	405.99
calculus			
kidney	405.09	405.19	405.99
ureter	405.09	405.19	405.99
coarctation, aorta	405.09	405.19	405.99
Cushing's disease	405.09	405.19	405.99
glomerulosclerosis (*see also* Hypertension, kidney)	403.00	403.10	403.90
periarteritis nodosa	405.09	405.19	405.99
pheochromocytoma	405.09	405.19	405.99
polycystic kidney(s)	405.09	405.19	405.99
polycythemia	405.09	405.19	405.99
porphyria	405.09	405.19	405.99
pyelonephritis	405.09	405.19	405.99
renal (artery)			
aneurysm	405.01	405.11	405.91
anomaly	405.01	405.11	405.91
embolism	405.01	405.11	405.91
fibromuscular hyperplasia	405.01	405.11	405.91
occlusion	405.01	405.11	405.91
stenosis	405.01	405.11	405.91
thrombosis	405.01	405.11	405.91

FIGURE 5-13
The Hypertension Table, in part.

IMPORTANT NOTE

You still need to go to the numeric listing to double-check the code to be certain it is correct and has the correct number of digits (see Figure 5-13).

- *Malignant.* This is a rather unusual diagnosis, which signifies extremely high blood pressure accompanied by swelling of the optic nerve behind the eye (known as papilledema). Most typically, this condition is associated with other organ damage, such as heart failure, kidney failure, and hypertensive encephalopathy. This diagnosis occurs in only about 5% of all patients who have hypertension.
- *Benign.* This is a standard case of high blood pressure and is typically brought under control with medication and diet. This type of hypertension is fairly stable over many years.
- *Unspecified.* Choose codes in this column when the physician's notes do not include any specific information regarding the nature of the hypertension. However, this code should always be a last resort only after you have read all of the physician's notes thoroughly and/or spoken to the physician.

IMPORTANT NOTE

Even though 95% of all hypertension cases are benign, you cannot assume. Code benign or malignant only when the physician specifically uses these words in the notes. If the physician does not use either of those words, you must code the hypertension as unspecified.

CASE STUDY

A 65-year-old female is seen by the physician and diagnosed with hypertension. The physician's notes state that this is a result of her prior diagnosis of Cushing's disease.

How would you code this diagnosis?

First, go to the alphabetic listing and look under Hypertension. Look down the column and see *"due to"* (which is the same as "result of" stated in the physician's notes). Review the indented listing under *"due to"* until you get to *"Cushing's disease."* Now that you have found the basic description, according to the physician's notes, you need to look across the table to find the correct code. Look back at the physician's notes and you will see that this diagnosis was not specified as malignant or benign. Therefore, you are going to go all the way across and use

405.99 Hypertension, due to Cushing's disease, unspecified

Then, add 255.0 Cushing's syndrome

Remember, you are not to assume anything when you are coding. It can be very easy to look at these physician's notes and think, "Well, the physician didn't specify, and malignant hypertension is so unusual. I don't want to bother the doctor, so I will just code it as benign. I'm sure that's right." No. *Never assume*. Never put words in the mouth—or pen—of the physician. You can go only by what is documented in the patient's record. Ask the physician. If you cannot, then code only what you know.

Neoplasm Table

Turn to Neoplasm in the alphabetic listing and you will see a table as well (Figure 5-14). Neoplasms are listed by anatomical site in alphabetical order down the description column. This means that the first column is in order by the part of the body where the tumor is located. This table has six columns across: Primary, Secondary, Ca in Situ, Benign, Uncertain Behavior, and Unspecified. Let's review what each of these titles mean.

- *Primary.* This indicates the anatomical site (the place in the body) where the neoplasm originated—the first place a tumor was seen and identified as malignant. If the physician's notes do not specify primary or secondary, then the site mentioned is primary.
- *Secondary.* This identifies an anatomical site to which the malignant neoplasm has spread or metastasized. One very strange thing about cancerous cells is that they travel through the body and do not necessarily spread to adjoining body parts. Cancer can be identified primarily in the breast and metastasize to the liver, not actually interacting with anything in between. Notes will state that this site is "secondary to [primary site]," "metastasized from [primary site]," or "[primary site] metastasized to [secondary site]."
- *Ca in Situ.* This indicates that the tumor has undergone malignant changes but is still limited to the site where it originated and has not spread. Ca is short for carcinoma, and you can remember *situ* like the word *situated*. Think of this as cancerous cells that are staying in place.
- *Benign.* This means there is no indication of invasion of adjacent cells. Generally, *benign* means not cancerous.
- *Uncertain Behavior.* This classification indicates that the pathologist is not able to specifically determine whether this is benign or malignant, because indicators of both are present.
- *Unspecified.* Choose a code from this column when the physician's notes do not include any specific information regarding the nature of the tumor.

IMPORTANT NOTE

It can be easier, and more accurate, to look up the histiologic type of malignancy, such as melanoma, before going to the neoplasm table.

Neoplasm, bone — Index to Diseases

Neoplasm, neoplastic — *continued*	Malignant: Primary	Malignant: Secondary	Malignant: Ca in situ	Benign	Uncertain Behavior	Unspecified
bone — *continued*						
atlas	170.2	198.5	—	213.2	238.0	239.2
axis	170.2	198.5	—	213.2	238.0	239.2
back NEC	170.2	198.5	—	213.2	238.0	239.2
calcaneus	170.8	198.5	—	213.8	238.0	239.2
calvarium	170.0	198.5	—	213.0	238.0	239.2
carpus (any)	170.5	198.5	—	213.5	238.0	239.2
cartilage NEC	170.9	198.5	—	213.9	238.0	239.2
clavicle	170.3	198.5	—	213.3	238.0	239.2
clivus	170.0	198.5	—	213.0	238.0	239.2
coccygeal vertebra	170.6	198.5	—	213.6	238.0	239.2
coccyx	170.6	198.5	—	213.6	238.0	239.2
costal cartilage	170.3	198.5	—	213.3	238.0	239.2
costovertebral joint	170.3	198.5	—	213.3	238.0	239.2
cranial	170.0	198.5	—	213.0	238.0	239.2
cuboid	170.8	198.5	—	213.8	238.0	239.2
cuneiform	170.9	198.5	—	213.9	238.0	239.2
ankle	170.8	198.5	—	213.8	238.0	239.2
wrist	170.5	198.5	—	213.5	238.0	239.2
digital	170.9	198.5	—	213.9	238.0	239.2
finger	170.5	198.5	—	213.5	238.0	239.2
toe	170.8	198.5	—	213.8	238.0	239.2
elbow	170.4	198.5	—	213.4	238.0	239.2
ethmoid (labyrinth)	170.0	198.5	—	213.0	238.0	239.2
face	170.0	198.5	—	213.0	238.0	239.2
lower jaw	170.1	198.5	—	213.1	238.0	239.2
femur (any part)	170.7	198.5	—	213.7	238.0	239.2
fibula (any part)	170.7	198.5	—	213.7	233.0	239.2
finger (any)	170.5	198.5	—	213.5	238.0	239.2
foot	170.8	198.5	—	213.8	238.0	239.2
forearm	170.4	198.5	—	213.4	238.0	239.2
frontal	170.0	198.5	—	213.0	238.0	239.2
hand	170.5	198.5	—	213.5	238.0	239.2
heel	170.8	198.5	—	213.8	238.0	239.2
hip	170.6	198.5	—	213.6	238.0	239.2
humerus (any part)	170.4	198.5	—	213.4	238.0	239.2
hyoid	170.0	198.5	—	213.0	238.0	239.2
ilium	170.6	198.5	—	213.6	238.0	239.2
innominate	170.6	198.5	—	213.6	238.0	239.2
intervertebral cartilage or disc	170.2	198.5	—	213.2	238.0	239.2
ischium	170.6	198.5	—	213.6	238.0	239.2
jaw (lower)	170.1	198.5	—	213.1	238.0	239.2
upper	170.0	198.5	—	213.0	238.0	239.2
knee	170.7	198.5	—	213.7	238.0	239.2
leg NEC	170.7	198.5	—	213.7	238.0	239.2
limb NEC	170.9	198.5	—	213.9	238.0	239.2
lower (long bones)	170.7	198.5	—	213.7	238.0	239.2
short bones	170.8	198.5	—	213.8	238.0	239.2
upper (long bones)	170.4	198.5	—	213.4	238.0	239.2
short bones	170.5	198.5	—	213.5	238.0	239.2
long	170.9	198.5	—	213.9	238.0	239.2
lower limbs NEC	170.7	198.5	—	213.7	238.0	239.2
upper limbs NEC	170.4	198.5	—	213.4	238.0	239.2
malar	170.0	198.5	—	213.0	238.0	239.2
mandible	170.1	198.5	—	213.1	238.0	239.2
marrow NEC	202.9 ☑	198.5	—	—	—	238.7
mastoid	170.0	198.5	—	213.0	238.0	239.2
maxilla, maxillary (superior)	170.0	198.5	—	213.0	238.0	239.2
inferior	170.1	198.5	—	213.1	238.0	239.2
metacarpus (any)	170.5	198.5	—	213.5	238.0	239.2
metatarsus (any)	170.8	198.5	—	213.8	238.0	239 2
navicular (ankle)	170.8	198.5	—	213.8	238.0	239.2
hand	170.5	198.5	—	213.5	238.0	239.2
nose, nasal	170.0	198.5	—	213.0	238.0	239.2
occipital	170.0	198.5	—	213.0	238.0	239.2
orbit	170.0	198.5	—	213.0	238.0	239.2
parietal	170.0	198.5	—	213.0	238.0	239.2
patella	170.8	198.5	—	213.8	238.0	239.2
pelvic	170.6	198.5	—	213.6	238.0	239.2
phalanges	170.9	198.5	—	213.9	238.0	239.2
foot	170.8	198.5	—	213.8	238.0	239.2
hand	170.5	198.5	—	213.5	238.0	239.2
pubic	170.6	198.5	—	213.6	238.0	239.2
radius (any part)	170.4	198.5	—	213.4	238.0	239.2
rib	170.3	198.5	—	213.3	238.0	239.2
sacral vertebra	170.6	198.5	—	213.6	238.0	239.2
sacrum	170.6	198.5	—	213.6	238.0	239.2
scaphoid (of hand)	170.5	198.5	—	213.5	238.0	239.2
of ankle	170.8	198.5	—	213.8	238.0	239.2
scapula (any part)	170.4	198.5	—	213.4	238.0	239.2
sella turcica	170.0	198.5	—	213.0	238.0	239.2
short	170.9	198.5	—	213.9	238.0	239.2
lower limb	170.8	198.5	—	213.8	238.0	239.2
upper limb	170.5	198.5	—	213.5	238.0	239.2
shoulder	170.4	198.5	—	213.4	238.0	239.2
skeleton, skeletal NEC	170.9	198.5	—	213.9	238.0	239.2
skull	170.0	198.5	—	213.0	238.0	239.2
sphenoid	170.0	198.5	—	213.0	238.0	239.2
spine, spinal (column)	170.2	198.5	—	213.2	238.0	239.2
coccyx	170.6	198.5	—	213.6	238.0	239.2
sacrum	170.6	198.5	—	213.6	238.0	239.2
sternum	170.3	198.5	—	213.3	238.0	239.2
tarsus (any)	170.8	198.5	—	213.8	238.0	239.2
temporal	170.0	198.5	—	213.0	238.0	239.2
thumb	170.5	198.5	—	213.5	238.0	239.2
tibia (any part)	170.7	198.5	—	213.7	238.0	239.2
toe (any)	170.8	198.5	—	213.8	238.0	239.2
trapezium	170.5	198.5	—	213.5	238.0	239.2
trapezoid	170.5	198.5	—	213.5	238.0	239.2
turbinate	170.0	198.5	—	213.0	238.0	239.2
ulna (any part)	170.4	198.5	—	213.4	238.0	239.2
unciform	170.5	198.5	—	213.5	238.0	239.2
vertebra (column)	170.2	198.5	—	213.2	238.0	239.2
coccyx	170.6	198.5	—	213.6	238.0	239.2
sacrum	170.6	198.5	—	213.6	238.0	239.2
vomer	170.0	198.5	—	213.0	238.0	239.2
wrist	170.5	198.5	—	213.5	238.0	239.2
xiphoid process	170.3	198.5	—	213.3	238.0	239.2
zygomatic	170.0	198.5	—	213.0	238.0	239.2
book-leaf (mouth)	145.8	198.89	230.0	210.4	235.1	239.0
bowel—see Neoplasm, intestine						
brachial plexus	171.2	198.89	—	215.2	238.1	239.2
brain NEC	191.9	198.3	—	225.0	237.5	239.6
basal ganglia	191.0	198.3	—	225.0	237.5	239.6
cerebellopontine angle	191.6	198.3	—	225.0	237.5	239.6
cerebellum NOS	191.6	198.3	—	225.0	237.5	239.6
cerebrum	191.0	198.3	—	225.0	237.5	239.6
choroid plexus	191.5	198.3	—	225.0	237.5	239.6
contiguous sites	191.8	—	—	—	—	—
corpus callosum	191.8	198.3	—	225.0	237.5	239.6
corpus striatum	191.0	198.3	—	225.0	237.5	239.6
cortex (cerebral)	191.0	198.3	—	225.0	237.5	239.6
frontal lobe	191.1	198.3	—	225.0	237.5	239.6
globus pallidus	191.0	198.3	—	225.0	237.5	239.6
hippocampus	191.2	198.3	—	225.0	237.5	239.6
hypothalamus	191.0	198.3	—	225.0	237.5	239.6
internal capsule	191.0	198.3	—	225.0	237.5	239.6
medulla oblongata	191.7	198.3	—	225.0	237.5	239.6
meninges	192.1	198.4	—	225.2	237.6	239.7
midbrain	191.7	198.3	—	225.0	237.5	239.6
occipital lobe	191.4	198.3	—	225.0	237.5	239.6
parietal lobe	191.3	198.3	—	225.0	237.5	239.6
peduncle	191.7	198.3	—	225.0	237.5	239.6
pons	191.7	198.3	—	225.0	237.5	239.6
stem	191.7	198.3	—	225.0	237.5	239.6
tapetum	191.8	198.3	—	225.0	237.5	239.6
temporal lobe	191.2	198.3	—	225.0	237.5	239.6
thalamus	191.0	198.3	—	225.0	237.5	239.6
uncus	191.2	198.3	—	225.0	237.5	239.6
ventricle (floor)	191.5	198.3	—	225.0	237.5	239.6
branchial (cleft) (vestiges)	146.8	198.89	230.0	210.6	235.1	239.0
breast (connective tissue) (female) (glandular tissue) (soft parts)	174.9	198.81	233.0	217	238.3	239.3
areola	174.0	198.81	233.0	217	238.3	239.3
male	175.0	198.81	233.0	217	238.3	239.3
axillary tail	174.6	198.81	233.0	217	238.3	239.3
central portion	174.1	198.81	233.0	217	238.3	239.3
contiguous sites	174.8	—	—	—	—	—
ectopic sites	174.8	198.81	233.0	217	238.3	239.3
inner	174.8	198.81	233.0	217	238.3	239.3
lower	174.8	198.81	233.0	217	238.3	239.3

FIGURE 5-14
The Neoplasm Table, in part.

CASE STUDY

Stephen Mathis is a 44-year-old male who has been seen by his regular primary care physician. After the radiological and laboratory test results came back, Mr. Mathis was diagnosed with a benign neoplasm of the ascending colon.

Can you find the correct ICD-9-CM code?

First turn to the neoplasm table in the alphabetic listing (Volume 2). The listings are in alphabetical order by the anatomical site (part of the body where the neoplasm is located). Go down the descriptive list until you get to *Colon*. There is a notation that directs you to look under *Intestine, large*. Continue through the descriptions in this neoplasm table until you get to *Intestine, intestinal*. Under *Intestine,* you find an indentation labeled *Large,* and indented under *Large* is *Colon*. Indented under *Colon* is *Ascending*—finally the correct descriptive listing of the neoplasm! Now you must go across the table to the right to the fourth column (the column titled Benign). There you find code 211.3. Now go to the numerical listing (Volume 1) to make certain this is the best code. There you find

✓4th 211 Benign neoplasm of other parts of digestive system

211.3 Colon

Ta da! Good job.

Neoplasms and Morphology (M) Codes

In addition to the code for a neoplasm, the alphabetic index may also include an M code. The M stands for Morphology, and this additional code identifies the behavior and histological (cell structure) type of the neoplasm.

Craniopharyngioma (M9350/1) 237.0

The histology is described by the first four digits of the M code.

The behavior is described by the number shown after the slash of the M code.

Behavior classifications are

0 Benign

1 Uncertain behavior

2 Carcinoma in situ

3 Malignant, primary site

6 Malignant, secondary site

9 Malignant, uncertain whether primary or metastatic site

Refer to Appendix A of the ICD-9-CM book Volume 1, immediately after the E codes tabular (numerical) listings, for a complete listing of the M codes.

Table of Drugs & Chemicals

Directly located after the alphabetic listing in Volume 2 is Section 2. This portion of the first part of the ICD-9-CM book contains the Table of Drugs & Chemicals and the alphabetical listing for E codes.

The Table of Drugs & Chemicals has nothing to do with prescriptions that the physician may write for a patient during an encounter. The only time that a drug or chemical comes into the picture of ICD-9-CM coding is when that drug or chemical has caused an **adverse reaction**—in other words, when the patient has been harmed and/or put in jeopardy because of the ingestion of (entering the body) or exposure to a drug or chemical. When this happens, a *poisoning* code should be used, with one exception. If the drug or chemical was properly prescribed by a licensed health care professional and given to the correct person in the correct dosage and the patient has an adverse reaction, this is not a poisoning and does not get a poisoning code.

Key Term

Adverse reaction: When an individual is harmed or put in danger after interacting with a drug or chemical.

The first column of this table lists the names of drugs and chemicals, in alphabetical order. This list includes prescription medications, over-the-counter medications, household chemicals, and any other items with a chemical basis. Aspirin, indigestion relief medication, drugstore-brand allergy relievers, window cleaner, battery acid, and the like are all included, as are medications prescribed by the physician. Some of these drugs and chemicals are listed by their brand, or common, names such as Metamucil. Others are shown by their chemical, or generic, names such as barbiturates (sedatives). If you are not certain, consult a *Physicians' Desk Reference* (PDR), which lists all of these drugs by brand name as well as chemical name.

Depending on which drug or chemical caused the adverse reaction to the patient, the six titled columns will help you find the correct code(s) to identify the intent of a bad or unexpected reaction (Figure 5-15). The column titles are

- *Poisoning.* For coders, the word *poisoning* indicates that the patient's body reacted negatively to a drug or chemical. This is the first code you will use to identify the cause of the poisoning.

Note: The following columns in this table lead you to the E code that will identify the *intent* of the poisoning or the adverse reaction to the drug or chemical. The intent of a poisoning or an adverse reaction identifies the reasoning behind the incident.

- *Accident.* This E code will be added to the poisoning code to indicate that the adverse reaction was caused by an accidental overdose, an accidental taking of the wrong substance, or an accident that happened during the use of drugs and chemical substances. Basically, this means that the ingestion of or exposure to this drug or this quantity of a drug that caused the problem was unintentional.

	External Cause (E Code)				
	Poisoning	Accident	Therapeutic Use	Suicide Attempt	Assault	Undetermined
1-propanol	980.3	E860.4	—	E950.9	E962.1	E980.9
2-propanol	980.2	E860.3	—	E950.9	E962.1	E980.9
2,4-D (dichlorophenoxyacetic acid)	989.4	E863.5	—	E950.6	E962.1	E980.7
2,4-toluene diisocyanate	983.0	E864.0	—	E950.7	E962.1	E980.6
2,4,5-T (trichlorophenoxyacetic acid)	989.2	E863.5	—	E950.6	E962.1	E980.7
14-hydroxydihydromorphinone	965.09	E850.2	E935.2	E950.0	E962.0	E980.0
ABOB	961.7	E857	E931.7	E950.4	E962.0	E980.4
Abrus (seed)	988.2	E865.3	—	E950.9	E962.1	E980.9
Absinthe	980.0	E860.1	—	E950.9	E962.1	E980.9
beverage	980.0	E860.0	—	E950.9	E962.1	E980.9
Acenocoumarin, acenocoumarol	964.2	E858.2	E934.2	E950.4	E962.0	E980.4
Acepromazine	969.1	E853.0	E939.1	E950.3	E962.0	E980.3
Acetal	982.8	E862.4	—	E950.9	E962.1	E980.9
Acetaldehyde (vapor)	987.8	E869.8	—	E952.8	E962.2	E982.8
liquid	989.89	E866.8	—	E950.9	E962.1	E980.9
Acetaminophen	965.4	E850.4	E935.4	E950.0	E962.0	E980.0
Acetaminosalol	965.1	E850.3	E935.3	E950.0	E962.0	E980.0
Acetanilid(e)	965.4	E850.4	E935.4	E950.0	E962.0	E980.0
Acetarsol, acetarsone	961.1	E857	E931.1	E950.4	E962.0	E980.4
Acetazolamide	974.2	E858.5	E944.2	E950.4	E962.0	E980.4
Acetic						
acid	983.1	E864.1	—	E950.7	E962.1	E980.6
with sodium acetate (ointment)	976.3	E858.7	E946.3	E950.4	E962.0	E980.4
irrigating solution	974.5	E858.5	E944.5	E950.4	E962.0	E980.4
lotion	976.2	E858.7	E946.2	E950.4	E962.0	E980.4
anhydride	983.1	E864.1	—	E950.7	E962.1	E980.6
ether (vapor)	982.8	E862.4	—	E950.9	E962.1	E980.9
Acetohexamide	962.3	E858.0	E932.3	E950.4	E962.0	E980.4
Acetomenaphthone	964.3	E858.2	E934.3	E950.4	E962.0	E980.4
Acetomorphine	965.01	E850.0	E935.0	E950.0	E962.0	E980.0
Acetone (oils) (vapor)	982.8	E862.4	—	E950.9	E962.1	E980.9
Acetophenazine (maleate)	969.1	E853.0	E939.1	E950.3	E962.0	E980.3
Acetophenetidin	965.4	E850.4	E935.4	E950.0	E962.0	E980.0
Acetophenone	982.0	E862.4	—	E950.9	E962.1	E980.9
Acetorphine	965.09	E850.2	E935.2	E950.0	E962.0	E980.0
Acetosulfone (sodium)	961.8	E857	E931.8	E950.4	E962.0	E980.4
Acetrizoate (sodium)	977.8	E858.8	E947.8	E950.4	E962.0	E980.4
Acetylcarbromal	967.3	E852.2	E937.3	E950.2	E962.0	E980.2
Acetylcholine (chloride)	971.0	E855.3	E941.0	E950.4	E962.0	E980.4
Acetylcysteine	975.5	E858.6	E945.5	E950.4	E962.0	E980.4
Acetyldigitoxin	972.1	E858.3	E942.1	E950.4	E962.0	E980.4
Acetyldihydrocodeine	965.09	E850.2	E935.2	E950.0	E962.0	E980.0
Acetyldihydrocodeinone	965.09	E850.2	E935.2	E950.0	E962.0	E980.0
Acetylene (gas) (industrial)	987.1	E868.1	—	E951.8	E962.2	E981.8
incomplete combustion of — *see* Carbon monoxide, fuel, utility						
tetrachloride (vapor)	982.3	E862.4	—	E950.9	E962.1	E980.9
Acetyliodosalicylic acid	965.1	E850.3	E935.3	E950.0	E962.0	E980.0
Acetylphenylhydrazine	965.8	E850.8	E935.8	E950.0	E962.0	E980.0
Acetylsalicylic acid	965.1	E850.3	E935.3	E950.0	E962.0	E980.0
Achromycin	960.4	E856	E930.4	E950.4	E962.0	E980.4
ophthalmic preparation	976.5	E858.7	E946.5	E950.4	E962.0	E980.4
topical NEC	976.0	E858.7	E946.0	E950.4	E962.0	E980.4
Acidifying agents	963.2	E858.1	E933.2	E950.4	E962.0	E980.4
Acids (corrosive) NEC	983.1	E864.1	—	E950.7	E962.1	E980.6
Aconite (wild)	988.2	E865.4	—	E950.9	E962.1	E980.9
Aconitine (liniment)	976.8	E858.7	E946.8	E950.4	E962.0	E980.4
Aconitum ferox	988.2	E865.4	—	E950.9	E962.1	E980.9
Acridine	983.0	E864.0	—	E950.7	E962.1	E980.6
vapor	987.8	E869.8	—	E952.8	E962.2	E982.8
Acriflavine	961.9	E857	E931.9	E950.4	E962.0	E980.4
Acrisorcin	976.0	E858.7	E946.0	E950.4	E962.0	E980.4
Acrolein (gas)	987.8	E869.8	—	E952.8	E962.2	E982.8
liquid	989.89	E866.8	—	E950.9	E962.1	E980.9
Actaea spicata	988.2	E865.4	—	E950.9	E962.1	E980.9
Acterol	961.5	E857	E931.5	E950.4	E962.0	E980.4
ACTH	962.4	E858.0	E932.4	E950.4	E962.0	E980.4
Acthar	962.4	E858.O	E932.4	E950.4	E962.0	E980.4
Actinomycin (C) (D)	960.7	E856	E930.7	E950.4	E962.0	E980.4
Adalin (acetyl)	967.3	E852.2	E937.3	E950.2	E962.0	E980.2
Adenosine (phosphate)	977.8	E858.8	E947.8	E950.4	E962.0	E980.4
Adhesives	989.89	E866.6	—	E950.9	E962.1	E980.9

FIGURE 5-15
The Table of Drugs and Chemicals.

- *Therapeutic Use.* This code is used when the right drug is taken in the right dose by the right person, but an unexpected reaction occurred. The guidelines direct coders not to use a poisoning code when the intent was proper therapeutic use, as prescribed.
- *Suicide attempt.* This code indicates that the overdose or incorrect substance was taken with the full intent of causing one's own death. The E code shown in this column accompanies the poisoning code on the same line.
- *Assault.* This code specifies that one person caused the poisoning on purpose to inflict illness, injury, or death upon another person. This code implies attempted murder. The E code shown in this column accompanies the poisoning code on the same line.
- *Undetermined.* The same as unspecified used elsewhere in the ICD-9-CM book, this code is to be used only when the record does not state what caused the poisoning. The E code shown in this column accompanies the poisoning code on the same line.

Examples

Joe looks into a barrel he has found in the back of the warehouse where he works. Fumes from the industrial solvent being stored in that barrel overcome Joe and he passes out. He is taken to the doctor immediately. He has been adversely affected by a chemical, but it is an accident.

982.8 Poisoning, solvent industrial

780.09 Unconsciousness

E 862.9 Accidental poisoning by industrial solvent.

Mrs. Smith fills the new prescription for naproxen given to her by her physician. By the second day of taking the drug, her whole body is covered with a rash. She has been taking the drug as prescribed, in the proper dosage. However, she is allergic to it, but no one could have foreseen that. She has had an adverse reaction to a drug given to her for therapeutic use.

693.0 Dermatitis due to drugs

E 935.6 Adverse effect, therapeutic use

Memory Tip

When coding an encounter involving a poisoning—think PEE for Poison:

P = Poisoning code
E = Effect or reaction code
E = E code showing intent

TOO MUCH TO REMEMBER?

Using the ICD-9-CM book to identify diagnoses is like going on a treasure hunt. Sometimes it is very easy to find the best, most appropriate code in accordance with the physician's notes. Other times, it seems as though the code just isn't there. However, you must remember that, if the health care provider can diagnose it, it's in the book somewhere!

Multiple resources, such as the following, can help you in your search for the best, most appropriate code.

- A medical dictionary and/or *The Merck Manual of Medical Information,* if you don't understand the provider's notes or if you need further clarification to find an alternate term that might be easier to find in the ICD-9-CM book
- A *Physicians' Desk Reference* (PDR), if you are not certain of alternate or generic names for drugs or other chemicals
- Publications including *Coding Clinic* and *Correct Coding Initiative,* as well as *CodeWrite*
- Official guidelines focusing on the sections that relate directly to your workplace's health care specialty
- Many websites, including www.ahima.org, www.aapc.org, and www.cms.gov

Of course, if you need to, ask the provider who saw the patient.

CHAPTER SUMMARY

E codes, V codes, three digits, four digits, five digits, major complications, underlying diseases, and so on—don't worry; as you look back over this chapter, you should notice one very important thing—the ICD-9-CM book will almost always guide you to the correct code. The book will tell you when you need a fourth or a fifth digit. The alphabetic listing will guide you to the correct page in the numerical (tabular) listings, so you can find the best, most appropriate code. And, if the code's description doesn't match the physician's notes, just go back and keep looking.

IMPORTANT NOTE

There are two primary things you need to remember to be a good coder:

1. Remember how to identify the key words in the physician's notes, so that you can look up the best, most appropriate code(s).
2. Remember that when a patient has a case of poisoning or an injury you will need to add an E code.

The ICD-9-CM book will guide you through the rest of the coding process with its notations and instructions. It can point you in the right direction toward the best, most appropriate code. Just look and read.

Chapter Review

Find the best diagnosis code(s) for the following patients.

1. A 35-year-old female comes into the physician's office for an elective sterilization (to have her tubes tied). _____

2. A 27-year-old female is seen in the physician's office for a checkup. Her pregnancy has been complicated by a case of gonorrhea. _____

3. A 5-year-old male is seen by the physician for a Rubella screening. _____

4. A 65-year-old male is seen in the physician's office. The diagnosis is type I uncontrolled diabetes with circulatory problems. _____

5. A 47-year-old male is seen in the physician's office for stomach pains. The diagnosis is confirmed for a sigmoid colon carcinoma. _____

6. A 3-year-old male is seen by the physician because he has gotten a jelly bean stuck up his nose. _____

7. A 29-year-old female is brought into the emergency room diagnosed with anaphylactic shock caused by eating peanuts. _____

8. A 43-year old female is seen by the physician and diagnosed with an endometrial ovarian cyst. _____

9. A 32-year-old male is seen by the physician, complaining that he cannot stay awake. The diagnosis of narcolepsy is confirmed. _____

10. An 18-year-old male is seen by the physician and diagnosed with a seizure disorder. _____

11. An infant is born in a hospital, single birth, with no mention of cesarean delivery or section. _____

12. A 25-year-old male sees the physician for a checkup due to a family history of epilepsy. The patient has no evidence of seizures. _____

13. A 55-year-old male is diagnosed with a malignant neoplasm of the mandible. _____

14. A 79-year-old female is diagnosed by the physician with cardiorenal hypertension, benign. _____

15. A 49-year-old female sees the physician for a routine annual physical. _____

16. A 41-year-old female is diagnosed as HIV positive. She has no symptoms and does not exhibit any manifestations of AIDS. _____

The following patients will need more than one ICD-9-CM code.

17. A 21-year-old female is seen by the physician for headaches. The confirmed diagnosis is temporal lobe epilepsy and migraine headaches. _____ _____

18. A 37-year-old female is seen by the physician, complaining of morning sickness. This is a regularly scheduled 16-week appointment for the physician to supervise her high-risk pregnancy. _____ _____

19. A 5-month-old male is seen by the physician after evidence of being shaken. The diagnosis was confirmed for shaken infant syndrome with an intracranial contusion of the brainstem, with no loss of consciousness. _____ _____ _____

20. A 9-year-old female is seen by the physician for malnutrition, caused by her negligent mother. _____ _____

21. A 15-year-old male is brought into the emergency room and diagnosed with third-degree burns on his back, 18% body surface. He was caught in a house fire. _____ _____ _____

22. A 23-year-old male is seen by the physician, suffering from edema in his legs and hypertension, both caused by his morbid obesity. _____ _____ _____

23. A 32-year-old male is seen by the physician for a brain concussion, having been unconscious for five minutes. The man is an employee of NASA and was hurt while training in a weightlessness simulator. _____ _____

24. A 60-year-old male was brought in to see the physician with a stress fracture of the tibia. The patient stated that he had fallen off a ladder at home. _____ _____

25. A 28-year-old male is seen by the physician with a dislocated temporomandible (closed). The patient states that he was involved in a fist fight and was punched. _____ _____

26. A 34-year-old female is seen by the physician with wrist pain. She is diagnosed with carpal tunnel syndrome due to overexertion and strenuous movements. _____ _____

27. A 41-year-old male is seen by the physician with organic pneumonia, a complication of the patient's HIV-positive status. _____ _____

28. A 12-year-old female is seen by the physician with a closed fractured femur, (unspecified part). She fell off her bicycle. _____ _____

29. A 23-year-old female is seen by the physician with a crushed wrist, caused by her involvement in an automobile accident. _____ _____

30. A 57-year-old male is seen by the physician and diagnosed with gastritis due to taking tetracycline, as prescribed by the physician the week before. _____ _____

31. A 35-year-old male is brought into the physician's office and diagnosed with poisoning by an industrial-strength solvent he used at work. The patient states that he accidentally inhaled the solvent. _____ _____

32. A 90-year-old male is seen by the physician due to signs of malnutrition. This is the result of his daughter's neglecting him on a continued basis. _____ _____

33. A 29-year-old male is seen by the physician. He is diagnosed with Kaposi's sarcoma, a manifestation of his HIV-positive status. _____ _____