ASSIGNMENT 5-1 REVIEW QUESTIONS

Part I Fill in the Blank on ICD-9-CM
1. primary, principal
2. Systematized Nomenclature of Human and Veterinary Medicine (SNOMED) International.
5. tabular/numerical
6. alphabetic
7. 3, 5
8. not elsewhere classifiable.
9. condition
10. external causes of injury, adverse reactions to medications.

Part II Multiple Choice on ICD-10
11. d. Centers for Medicare and Medicaid Services
12. e. seven digits
13. d. all of the above
14. b. etiology
15. c. combination code

Part III True/False
16. F
17. T
18. T
19. F
20. T

ASSIGNMENT 5–4 OBTAIN GENERAL DIAGNOSTIC CODES FOR CONDITIONS
1. ICD-9-CM: 611.72. Look in Volume 2 under the condition, which is mass. Select the site, which is breast.
   ICD-10-CM: N63. Look in the Alphabetic Index under the condition, which is mass. Select the site, which is breast.
2. ICD-9-CM: 482.0. Look in Volume 2 under the condition, which is pneumonia. Search through the list of modifiers under pneumonia until you find the type, Klebsiella, pneumoniae. Verify the code in Volume 1.
   ICD-10-CM: J15.0. Look in the Alphabetic Index under the condition, which is pneumonia. Search through the list of modifiers under pneumonia until you find the type, Klebsiella (pneumoniae). Verify the code in the Tabular List.
3. ICD-9-CM: 410.51. To determine the condition ask “What is wrong?” The patient has had an infarct so the condition and main term is infarction. Look under the location where this occurred, myocardium. Then look under myocardium until you find the area of the myocardium that is affected, lateral wall. Confirm the code in Volume 1 and assign the correct fifth digit. ICD-10-CM: I21.29. Look in the Alphabetic Index under infarction and locate myocardium. Then look under myocardium until you find ST elevation, lateral. Verify the code in the Tabular List. Note: ST elevation refers to a segment in an electrocardiogram (ECG) report. When this segment is elevated, there is usually heart muscle damage due to occlusion.


5. ICD-9-CM: 429.2. Locate the main term, disease. Find the type of disease, cardiovascular. Note the term arteriosclerotic in parentheses. You have now found all the descriptors. Verify the code in Volume 1. ICD-10-CM: I25.10. Locate the main term disease and find cardiovascular. Note the term arteriosclerotic in parentheses. Verify the code in the Tabular list.

6. ICD-9-CM: 786.09. Rule-out conditions should not be coded, so you will code dyspnea. Find this condition in the main index of Volume 2. Find the code in Volume 1 and confirm. However, if shortness of breath (dyspnea) is used as the diagnosis, then 786.05 would be the chosen code. ICD-10-CM: R06.00. Locate dyspnea in the Alphabetic index. Verify the code in the Tabular list. If shortness of breath is used as the diagnosis, then R06.02 would be the appropriate code.

7. ICD-9-CM: 558.9. Look under the term ileitis in the main index of Volume 2 and find code 558.9. See that the term chronic is in parentheses. This is a nonessential modifier to help clarify the code description. Verify the code in Volume 1. ICD-10-CM: K52.9. Locate the term ileitis in the Alphabetic index. Verify the code in the Tabular list.

8. ICD-9-CM: 716.92. Look under the main term, arthritis. See that acute, chronic, and subacute are assigned the same code: 716.9. Verify this code in Volume 2 and select the fifth digit that best describes the part of the body affected, elbow. Elbow is not listed, so determine whether forearm or upper arm includes elbow. Turn to the beginning of the chapter to find a description of the fifth digit codes listed. Elbow is listed under the fifth digit 2, upper arm. ICD-10-CM: M19.029. Locate the main term osteoarthritis in the Alphabetic index. Find the term elbow. Note that a 6th character is required to describe the affected body part.

9. ICD-9-CM: 388.30. Find ringing in the ear and in parentheses see also tinnitus. All the terms under ringing in the ear have been accounted for at this location, so you do not need to follow the “see also” instructions. Verify the code in Volume 1. **Note: The documentation does not state if the tinnitus is subjective or objective. Subjective tinnitus is the most common form of tinnitus. ICD-10-CM: H93.13. Locate the term tinnitus. Verify the code in the Tabular list. The 5th character indicates bilateral tinnitus.

10. ICD-9-CM: 493.22. Look under the main condition, bronchitis, in Volume 2. Find chronic, asthmatic as the subterms. Verify the code in Volume 1, and you will see that you must add a fifth digit specifying acute exacerbation. ICD-10-CM: J44.1. Locate the main term bronchitis in the Alphabetic index. Find the subterms asthmatic, chronic, with, exacerbation (acute). Verify the code in the Tabular list.

**ASSIGNMENT 5–5 CODE DIAGNOSES FROM MEDICAL RECORDS**

1. ICD-9-CM: 532.40. Look under the condition and main term ulcer. Find the location of the ulcer, duodenum. Look under the sub-subterms and see with hemorrhage. Verify the code in Volume 1 and assign the correct fifth digit. There is no mention of obstruction, so the fifth digit should be zero. However, if this case is considered as acute, the code would be 532.00. ICD-10-CM: K26.4. Locate the main term ulcer in the Alphabetic index. Find the subterms duodenum, with, hemorrhage. Verify the code in the Tabular list.
2. a. ICD-9-CM: 812.20. Look under the condition, fracture. Then look under the specific bone, humerus. If there is no indication that a fracture is open, then it is coded as a closed fracture. If there is no specific site on the humerus mentioned, then it is coded as an unspecified site. When coding in a physician’s office you may look at a radiograph report or ask the physician for this information.
   ICD-10-CM: S42.309A. Locate the main term fracture, traumatic in the Alphabetic index. Find the subterm humerus. Because the report does not indicate the specific site of the humerus, then it is coded as an unspecified site. Verify the code in the Tabular list.
b. ICD-9-CM: 496. Look under the main term, disease, in Volume 2. Find the site, pulmonary. See obstructive diffuse (chronic) and its code. Verify the code in Volume 1. Even though the COPD is not being treated in the second scenario it would be coded because it poses a risk factor.
   ICD-10-CM: J44.9. Locate the main term disease in the Alphabetic index. Find the subterms pulmonary, chronic obstructive. Verify the code in the Tabular list.

3. ICD-9-CM: V58.32. Look under suture in Volume 2. Then look under the subterm removal. Select the code and verify it in Volume 1. Remember that V codes are used on occasions when circumstances other than a disease or injury classifiable in categories 001 through 999 are recorded as a diagnosis or problem.
   ICD-10-CM: Z48.02. Locate the main term suture in the Alphabetic index. Find the subterm removal. Verify the code in the Tabular list. Note that code Z48.02 can be listed as the first or secondary diagnosis.

4. a. ICD-9-CM: 600.01. The diagnosis, benign prostatic hypertrophy, contributes to the condition of urinary retention. It is indexed under “hypertrophy, prostate” and then “benign,” “with,” “urinary,” “retention.”
   ICD-10-CM: N40.1. Locate the main term enlargement in the Alphabetic index. Find the subterms prostate, with lower urinary tract symptoms. Verify the code in the Tabular list.
b. ICD-9-CM: 788.20. Code 788.20, retention of urine, unspecified from Chapter 16, Symptoms, Signs, and Ill-Defined Conditions, is usually not sequenced as the primary diagnosis. Accordig to ICD-9-CM guidelines under the main term “Retention of Urine, 788.2, Code any causal condition first, such as hyperplasia of prostate.” Therefore, urinary retention should be coded in the second position.
   ICD-10-CM: R33.8. Code R33.8 is the additional code required to report the urinary retention.

5. a. ICD-9-CM: 462. Until a definitive diagnosis can be made, code the symptom, sore throat. In Volume 2, locate the main term sore and subterm throat. Verify the code in Volume 1.
   ICD-10-CM: J02.9. Locate the term pharyngitis in the Alphabetic index. Verify the code in the Tabular list.
b. ICD-9-CM: 034.0. Look under infection and find the type of infection, streptococcal. The location, throat, is listed as a sub-subterm. Select the code and verify it in Volume 1. No other code is necessary because it describes the type of infection and the body area that is infected.
   ICD-10-CM: J02.0. Locate the term pharyngitis in the Alphabetic index. Find the subterm streptococcal. Verify the code in the Tabular list.

**ASSIGNMENT 5–8 CODE DIAGNOSES FOR PATIENTS WITH DIABETES**

1. ICD-9-CM: 250.00. Look in Volume 2 under the term diabetes. Verify the code in Volume 1. Assign the fifth digit. There is no mention of insulin-dependent diabetes, so assign the code for non–insulin-dependent diabetes mellitus (NIDDM). Type is not specified and there is no mention of its being uncontrolled.

2. ICD-9-CM: 250.12. Look in Volume 2 under diabetes. Under the main term it says “with” and there is a long column of subterms listing types of diabetes and complications. Find the subterm ketosis, ketoacidosis. Verify the code in Volume 1. Assign the fifth digit for uncontrolled NIDDM.
   ICD-10-CM: E10.10. Locate the main term diabetes in the Alphabetic index. Find the subterms type 1, with, ketoacidosis. Verify the code in the Tabular list.

   ICD-10-CM: E10.52. Locate the main term diabetes in the Alphabetic index. Find the subterms type 1, with, gangrene. Verify the code in the Tabular list.


   ICD-10-CM: E11.36. Locate the main term diabetes in the Alphabetic index. Find the subterms type 2, with, cataract. Verify the code in the Tabular list.

b. ICD-9-CM: 366.41. Verify the cataract code in Volume 1. The note indicates this code is not allowed as a principal diagnosis.

c. ICD-9-CM: 250.61. Look in Volume 2 under diabetes and find the subterm polyneuropathy. Obtain that code and the code in brackets that describes the manifestation of the diabetes (357.2). Verify the diabetes code in Volume 1 and assign the fifth digit; the diabetes is not stated to be uncontrolled.

   ICD-10-CM: E10.42. Locate the term diabetes in the Alphabetic index. Find the subterms type 1, with, polyneuropathy. Unlike the diabetic code found in the ICD-9-CM, code E10.42 encompasses both the diabetes and polyneuropathy.


c. ICD-9-CM: 250.51. Go back to Volume 2 and find the subterm retinopathy under diabetes. List the code shown in brackets for retinopathy manifestation in diabetes (362.01). Verify the diabetes code in Volume 1 and assign a fifth digit.

   ICD-10-CM: E10.319. Go back to the Alphabetic index and locate the main term diabetes. Under the main term, find the subterms type 1, with, retinopathy. No additional code is needed for the retinopathy.


ASSIGNMENT 5–9 CODE DIAGNOSES FOR PATIENTS WITH HYPERTENSION

1. ICD-9-CM: 401.9. Hypertension. Look in Volume 2 under high blood pressure or hypertension. Under high blood pressure, find the main term high and the subterm blood pressure (see also hypertension) and obtain the code. Under hypertension, find the Hypertension Table, which begins with 401.0 (malignant), 401.1 (benign), and 401.9 (unspecified) listed in the first row. Verify the code chosen in Volume 1. If the patient is listed as having high blood pressure, unless the physician specifies otherwise, code it as essential hypertension, unspecified.


2. ICD-9-CM: 401.0. Using the Hypertension Table in Volume 2, find malignant hypertension in the first row listed.

   ICD-10-CM: I10. Locate the term hypertension in the Alphabetic index. Note that malignant is in parenthesis. Verify the code in the Tabular list.

3. ICD-9-CM: 642.93. Using the Hypertension Table find complicating pregnancy, childbirth, or the puerperium listed as a subterm. Verify the code chosen in Volume 1. Next to code 642.9 is a symbol or note indicating that the section requires a fifth digit. Go to the beginning of the section, read all choices, and select the fifth digit.

   ICD-10-CM: O16.9. Locate the term hypertension in the Alphabetic index. Under the main term, find the subterms complicating, pregnancy. The fourth digit “9” indicates unspecified maternal hypertension and trimester.

4. ICD-9-CM: 403.90. Using the Hypertension Table, find with…renal involvement…see also hypertension, kidney. Verify the code selected in Volume 2. Assign the fifth digit considering that the
hypertension is unspecified and there is no mention of renal failure.

5. ICD-9-CM: 402.91. Using the Hypertension Table, find the subterm cardiovascular disease. Find a sub-subterms with, heart failure(congestive). Verify the code selected in Volume 2. Note that the physician stated the hypertension was due to the ASCVD and CHF. Unless the term due to or Hypertensive is used, the codes in this section cannot be used.
ICD-10-CM: I11.0 and I50.20. Locate the main term hypertension in the Alphabetic index. Find the subterms heart, with, heart failure (congestive). Verify the code in the Tabular list. Note that an additional code is required to identify the type of heart failure (I50.-).

6. a. ICD-9-CM: 402.01. Using the Hypertension Table, find the subterm with cardiovascular disease. Look further and find the sub-subterms with, heart failure (congestive). Look across the table and choose the hypertensive code for malignant.
ICD-10-CM: I10 and I50.9. Locate the main term hypertension in the Alphabetic index. Note that malignant is in parenthesis. Verify the code in the Tabular list. Next, locate the main term failure and subterm heart. Do not forget to verify the code in the Tabular list.
b. ICD-9-CM: 429.0. Verify the code in Volume 2. A question may arise concerning whether myocarditis needs to be coded separately. Look up myocarditis in Volume 2 and see a general code listed (429.0). This code includes the statement "Excludes: that due to hypertension (402.0-402.9)." This is considered a sequencing exclusion, which means it may not be coded in the first position. To understand this, consider diagnostic codes being used for research information. If research is done on hypertensive patients with myocarditis, and myocarditis is not coded separately, it would be impossible to find these patients for statistical data. In this case, ignore the exclusion and code myocarditis in the second position.
ICD-10-CM: I51.4. Locate the main term myocarditis in the Alphabetic index. Verify the code in the Tabular list.

ASSIGNMENT 5–10 CODE DIAGNOSES FOR INJURIES, FRACTURES, BURNS, LATE EFFECTS, AND COMPLICATIONS

ICD-10-CM: S72.461A. Locate the main term fracture, traumatic in the Alphabetic index. Find the subterms femur, lower end, supracondylar, with intracondylar extension (displaced). Verify the code in the Tabular list. Per the Guidelines, if a fracture is not indicated as displaced or not displaced, it should be coded as displaced. The 6th character “1” indicates a displaced fracture of the right femur. The 7th character “A” indicates initial encounter for a closed fracture.

2. a. ICD-9-CM: 812.20. Look under fracture and locate the subterm humerus. Verify the code for shaft for unspecified part of humerus, closed.
ICD-10-CM: S42.302A. Locate the main term fracture, traumatic in the Alphabetic index. Find the subterm humerus. Verify the code in the Tabular list and assign the appropriate 6th character. The 7th character “A” indicates initial encounter for closed fracture.
b. ICD-9-CM: 825.20. Look under fracture and locate the subterm foot, except toe(s) alone (closed). Verify the code in Volume 1.
ICD-10-CM: S92.902A. Locate the main term fracture, traumatic in the Alphabetic index. Find the subterm foot. Verify the code in the Tabular list and assign the appropriate 6th character. The 7th character “A” indicates initial encounter for closed fracture.

ICD-10-CM: S52.355A and S52.255A. Locate the main term fracture, traumatic in the Alphabetic index. Find the subterms radius, shaft, comminuted, nondisplaced. Verify the code in the Tabular list and assign the appropriate 6th character. The 7th character “A” indicates initial encounter for closed fracture. Under the same main term, fracture, traumatic, locate the subterms ulna, shaft,
comminuted, nondisplaced. Verify the code in the Tabular list and assign the appropriate 6th character. The 7th character “A” indicates initial encounter for closed fracture.

b. ICD-9-CM: 733.09. Locate osteoporosis in Volume 2 and find the subterm drug induced. Verify the code in Volume 1. An E code should be used if the drug name is known.

5. ICD-9-CM: 884.1. Look under laceration in Volume 2 and find the notation, see also wound, open, by site. Locate wound, open in Volume 2. Read the note that says that wounds with foreign bodies constitute complicated wound. Find the subterm arm and locate the sub-subterm complicated. Verify the code in Volume 1. ICD-10-CM: S41.129A. Locate the main term laceration in the Alphabetic index. Find the subterms arm, with foreign body. The 7th character “A” indicates initial encounter.

6. ICD-9-CM: 941.09. Look under burn in Volume 2. Locate the subterm face and it states, “See Burn, head.” Find the subterm head (and face). Locate the sub-subterm multiple. Verify the code in Volume 1. Note that the fourth digit, zero, is used because the degree is unspecified. The fifth digit “9” is used for the multiple sites (face and neck). Only one code is needed.

ICD-10-CM: T20.00XA. Locate the main term burn and subterm head (and face) (and neck) in the Alphabetic index. Verify the code in the Tabular list. The 6th character “X” is referred to as a placeholder and is required in order for this code to be seven characters long. The 7th character “A” indicates initial encounter.

7. a. ICD-9-CM: 942.32. Look under burn in Volume 2 and locate the subterm chest wall. Note: “Classify burns of the same local site but of different degrees to the highest degree.” Find the most severe degree, third degree. Verify the code in Volume 1. ICD-10-CM: T21.31XA. Locate the main term burn and subterms chest wall, third degree in the Alphabetic index. Verify the code in the Tabular list. The 6th character “X” is referred to as a placeholder and is required in order for this code to be seven characters long. The 7th character “A” indicates initial encounter.
b. ICD-9-CM: 948.21. To code the extent of body involved look under burn. Locate the subterm extent. Find the percentage of body involved, 20%. Verify the code in Volume 1 and note that a fifth digit is needed. The fifth digit indicates percentage of the body that has third-degree burns.


8. a. ICD-9-CM: 726.60. Look under bursitis in Volume 2 and locate the subterm knee. Verify the code in Volume 1. ICD-10-CM: M70.50. Locate the main term bursitis and subterm knee in the Alphabetic index. Verify the code in the Tabular list and assign the appropriate 5th character.
b. ICD-9-CM: 906.4. To code this as a late effect look under late, effects of in Volume 2. Locate the subterm crushing injury. Verify the code in Volume 1. ICD-10-CM: S87.00XS. Locate the main term crush and subterm knee in the Alphabetic index. Verify the code in the Tabular list and assign the appropriate 6th character, X, which is referred to as a placeholder and is required in order for this code to be seven characters long. The 7th character ‘S’ indicates sequela, which refers to the late effect of the injury. Note: In the ICD-10-CM 2010 Draft, the code is listed as S87.00S.