Chapter 5

CERTAIN INFECTIOUS AND PARASITIC DISEASES, NEOPLASMS, ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES (A00-E89.89)

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Learning Objectives

- Review specific guidelines for systems and organs in Chapters 1 through 4 of ICD-10-CM.
- Understand the complexities of coding multiple procedures.
- Review coding examples and scenarios.
- Test your skills by completing checkpoint exercises.
- Test your knowledge by answering additional questions.

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Introduction

- Chapter 1 of the Tabular List of ICD-10-CM includes certain infectious and parasitic diseases.
- There are specific guidelines for conditions such as Human immunodeficiency virus (HIV), Sepsis, Infectious agent, as the cause of the diseases classified to other chapters, and Nosocomial infections.

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Introduction

- Chapter 1 in the Tabular List includes the following sections:
  - Infectious and Parasitic Diseases (A00-A09).
  - Tuberculosis (A15-A17).
  - Certain Zoonotic Bacterial Diseases (A20-A28).
  - Other Bacterial Diseases (A30-A49).
  - Infections with a predominately sexual mode of transmission (A50-A64).

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Introduction

- Other spirochetal diseases (A65-A69).
- Other diseases caused by Chlamydia (A70-A74).
- Rickettsioses (A75-A79).
- Viral and prion infections of the central nervous system (A80-A89).
- Arthropod-borne viral fevers and viral hemorrhagic fevers (A90-A99).
- Viral infections characterized by skin and mucous membrane lesions (B00-B99).
- Other human herpes viruses (B10).

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Introduction

- Human immunodeficiency virus (HIV) disease (B20).
- Other viral diseases (B25-B34).
- Mycoses (B35-B49).
- Protozoal diseases (B50-B64).
- Helminthiases (B65-B83).
- Pediculosis, acriasis, and other infestations (B85-B89).
- Squeal of infectious and parasitic diseases (B90-B94).
- Bacterial and viral infectious agents (B95-B97).
- Other infectious diseases (B99).

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Introduction

- Volume 1, Chapter 1, of ICD-10-CM covers transmissible infections and parasitic diseases, classified according to cause or etiology.
- Many of the diseases in this chapter are coded by using combination or multiple codes.
- The second type of coding that is common in Chapter 1 of ICD-10-CM is multiple coding.
  - Multiple coding involves assigning more than one code to provide information about a manifestation and the associated underlying condition.

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Coding Tip

- When referencing the index, remember to find the main term in the diagnosis first, then look up the reference “infection.”
- Make sure to read all notes in the code category and follow instructions.

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Tuberculosis (A15-A19)

- Tuberculosis is an infectious disease usually caused by the bacterium Mycobacterium tuberculosis.
  - Symptoms of tuberculosis occur when the body's immunity does not develop fast enough to prevent the infection from spreading to various parts of the body or when immunity is interrupted by age, certain drugs, or diseases.

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Coding Issue

- Tuberculosis is classified A15 through A19 in the Tabular List. Be careful when selecting a code that confirms an active condition of tuberculosis from a confirmed positive tuberculin skin test and no diagnosis of active tuberculosis (R76.1 Abnormal reaction to tuberculin test).

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Tuberculosis (A15-A19)

- Code R76.1 classifies a nonspecific reaction to a tuberculin skin test without active tuberculosis and includes:
  - Abnormal result of Mantoux test.
  - PPD positive.
  - Tuberculin (skin test).
  - Positive.
  - Reactor.

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Tuberculosis (A15-A19)

- Within this family of codes, a fourth or fifth character is available to indicate the method with which the diagnosis was determined.
- Publishers of ICD-10-CM use different symbols to indicate additional digits are required in the subclassification.

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Late Effects of Tuberculosis

- Late effects of tuberculosis are located in the Alphabetic Index under Squeal and are classified in category B90.-
- This category is used to indicate conditions classifiable as late effects, which are themselves classified elsewhere.
- Code the active condition being treated as the primary diagnosis and the “late effect” as the secondary diagnosis.

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Human Immunodeficiency Virus (HIV)

- The code for HIV (042) is found in Chapter 1 of the Tabular List of ICD-10-CM and is not assigned when the diagnostic statement indicates “suspected,” “probable,” or “rule out.”
  - Outpatient and/or physician diagnoses are selected based on confirmation of a diagnosis, not on suspicion or probability. However, the physician’s documentation of a positive serology for HIV or a statement indicating the patient is HIV-positive or has an HIV-related illness is sufficient.

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Human Immunodeficiency Virus (HIV)

- When coding HIV infection or an HIV-related illness, it is important to understand the codes available and their proper uses.

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HIV ICD-10-CM Guidelines for Human Immunodeficiency Virus (HIV) Diseases

- In ICD-10-CM, the following codes are used when reporting the HIV virus, exposure, or screenings:
  - B20-Human immunodeficiency virus (HIV) disease.
  - Z21-Asymptomatic human immunodeficiency virus (HIV) infection status.
  - R75-Inconclusive laboratory evidence of human immunodeficiency virus (HIV).
  - Z20.6-Exposure to HIV Virus.

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HIV ICD-10-CM Guidelines for Human Immunodeficiency Virus (HIV) Diseases

- Z11.4-for the human immunodeficiency virus.
- Z71.7-Human immunodeficiency virus (HIV) counseling.
- O98.7- Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium.

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HIV ICD-10-CM Guidelines for Human Immunodeficiency Virus (HIV) Diseases

- One complication subcategory exists for HIV complicating pregnancy, childbirth, and the puerperium is reported with subcategory O98.7-.
- Special screening for the HIV virus is reported with code Z11.4 (screening for the human immunodeficiency virus (HIV).

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B20 Human Immunodeficiency Virus (HIV) Disease

- Category B20 is for use for symptomatic HIV patients.
  - The patient has had any of the opportunistic infections associated with HIV virus.
  - The code for HIV is synonymous with the term Acquired immune deficiency syndrome (AIDS), and the AIDS replaced complex (ARC).
  - This includes: acquired immune deficiency syndrome [AIDS] AIDS-related complex [ARC] HIV infection, symptomatic.

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B20 Human Immunodeficiency Virus (HIV) Disease

- Instructional notes in Category B20 indicate that all manifestations of the disease should be reported in addition to B20.
- Use additional code(s) to identify all manifestations of HIV infection.

- The appropriate code for a symptomatic HIV patient is B20 (HIV) adding an additional diagnosis code to identify the manifestations of the disease.

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Coding Tip

- When the patient is treated for an illness that is related to AIDS (HIV), B20 is reported as the first listed diagnosis followed by the condition treated.
- When a patient is treated for an illness unrelated to HIV; list the unrelated illness as the first listed diagnosis and any HIV-related condition secondary.

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Sequencing

- Patients with HIV-related illness should be assigned a minimum of two codes:
  - 1 Assign B20 to identify the HIV disease.
  - 2 Sequence additional codes to identify the other diagnosis/diagnoses.
- People with HIV can get many infections (called opportunistic infections, or Ois).

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Sequencing

- Code Z21 is used for reporting a patient diagnosed with HIV positive status but has never had any opportunistic infections. Once a patient has had a first opportunistic infection that patient is assigned code B20 thereafter.
- The draft guidelines state: "A patient should never be assigned a Z21 code, even if at a particular encounter no infection or HIV related condition is present. Codes B20 and Z21 should never appear on the same record."

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Coding Tip

- A (-) in the Index indicates additional digits are required and can only be located in the category or subclassification for the particular code in the Tabular List.

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Z20.6 Contact with and Exposure to Human Immunodeficiency Virus (HIV)

- Code Z20.6 is reported only when a patient believes he/she has been exposed or has come into contact with the HIV virus.
- In the instructional note there is an Excludes1not to exclude coding in this category for a patient who has been potentially exposed to the HIV virus but is not determined as positive.

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R75 Inconclusive Laboratory Evidence of Human Immunodeficiency Virus (HIV)

- Code R75 is used when a patient has an inconclusive lab finding for HIV. This code is reported for newborns of HIV positive mothers whose HIV status has not been confirmed.

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Z11.4 Special Screening for the Human Immunodeficiency Virus (HIV)

- If the patient is being tested to determine his/her HIV status the diagnosis code reported is Z71.4.
- If the patient has signs and/or symptoms is also tested for HIV status report the signs/symptoms codes along with Z71.4.
- If the patient returns for his/her HIV results or if the practitioner feels it is appropriate, the practitioner may counsel the patient regarding safe practices, etc.
- If counseling occurs also report Z71.7 for HIV counseling.

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HIV Infection in Pregnancy, Childbirth, and the Puerperium (098.7-)

- The last code related to HIV is 098.7- HIV disease complicating pregnancy, childbirth and the puerperium.
  - The ICD-10-CM guidelines state that during pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health related encounter) because of an HIV-related illness should receive a principal diagnosis code of O98.7- followed by B20 for the HIV-related illness.
  - Codes from Chapter 15 always take sequencing priority.

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HIV Infection in Pregnancy, Childbirth, and the Puerperium (098.7-)

- Patients with asymptomatic infection status either admitted or receiving care during pregnancy, childbirth, or the puerperium should be coded as O98.7- and Z21 for the HIV positive status.

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Other Bacterial Diseases (A30-A49)

Septicemia

- Septicemia is a serious, rapidly progressing, life-threatening infection that can arise from infections throughout the body, including infections in the lungs, abdomen, and urinary tract.
- It may precede or coincide with infections of the bone (osteomyelitis), central nervous system (meningitis), or other tissues.
- Septicemia can rapidly lead to septic shock and death.

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Other Bacterial Diseases (A30-A49)

Sepsis

- Sepsis refers to an infection due to any organism that triggers a systemic inflammatory response, the systemic inflammatory response syndrome (SIRS).
- All codes with sepsis in the title include the concept of SIRS.
- For cases of sepsis that do not result in any associated organ dysfunction, a single code for the type of sepsis should be used.
- Review table 6.1, the Official ICD-10-CM Guidelines for Sepsis.

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Coding Tip

- The term urosepsis is a nonspecific term. If a physician uses the term in a medical record he/she should be asked for which specific condition is the term being used.

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Infectious Agents As the Cause of Diseases Classified to Other Chapters

- Certain infections are classified in chapters other than Chapter 1 and no organism is identified as part of the infection code.
- In these instances, it is necessary to use an additional code from Chapter 1 of ICD-10-CM to identify the organism.

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Infectious Agents As the Cause of Diseases Classified to Other Chapters

- A code from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified to other chapters, B96, Other bacterial agents as the cause of diseases classified to other chapters, or B97, Viral agents as the cause of diseases classified to other chapters, is to be used as an additional code to identify the organism.
- An instructional note will be found at the infection code advising that an additional organism code is required.

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Nosocomial Infections

- If a patient contracts an infection while in the hospital, assign code Y95 (Nosocomial condition) in addition to the diagnosis code for the infection code to identify the infection as nosocomially acquired. ICD-10-CM code Y95 is a three-digit classification.

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Chapter 2
Neoplasms

- Chapter 2 in the Tabular List includes the following sections:
  - Malignant neoplasms (C00-C96).
  - Carcinoma in situ (D00-D09).
  - Benign neuroendocrine tumors (D3A)
  - Benign neoplasms (D10-D36).
  - Uncertain behavior (D37-D48).
  - Unspecified behavior (D49).

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Malignant Neoplasms

- Malignant neoplasms are composed of tumor cells that can invade surrounding structures or distant organs.
- Their growth is more rapid than that of benign neoplasms.
- ICD-10-CM classifies malignant neoplasms as:
  - Primary.
  - Secondary.
  - Carcinoma in situ.

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Malignant Neoplasms

- Primary identifies the site of origin of the neoplasm.
- The point of origin is determined through the study of the morphology (form and structure) of the tumor cell.
- Determination of the point of origin and type of cells is important in establishing the severity of illness and in planning treatment.
  - Example: Primary lung cancer—site where cancer originates.

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Malignant Neoplasms

- Secondary identifies the site(s) to which the primary tumor has spread by direct extension to surrounding tissues or metastasized by:
  - Lymphatic spread.
  - Invasion of blood vessels.
  - Implantation as tumor cells are shed into body cavities.
- The morphology of a metastatic neoplasm is the same as that of the primary neoplasm.
  - Example: Secondary liver cancer—site where cancer has metastasized or spread to.

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Carcinoma in situ

- Carcinoma in situ is composed of tumor cells that are undergoing malignant changes; however, these changes do not extend beyond the point of origin or invade surrounding normal tissue.
- Carcinoma in situ is also described as:
  - Noninfiltrating carcinoma.
  - Noninvasive carcinoma.
  - Preinvasive carcinoma.
  - Example: Carcinoma in situ of the skin.

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Benign Neoplasms

- Benign neoplasms are tumors that do not invade adjacent structures or spread to distant sites.
- Their growth may displace or exert pressure on adjacent structures. Some benign neoplasms have no potential for malignancy.
- However, others, such as adenomatous gastric polyps, have a premalignant potential and removal is indicated.
- Fortunately, most benign tumors can be completely excised.
  - Example: Benign neoplasm of liver.

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Uncertain Behavior

- The classification of uncertain behavior includes tumors that show features of both benign and malignant behavior.
- These tumors may require further study before a definitive diagnosis can be established.
- The codes in this category should be assigned only when documentation by the pathologist clearly indicates that the behavior of the neoplasm cannot be identified.

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Uncertain Behavior

- If neither the behavior nor the histologic type of tumor is specified in the diagnostic statement, a neoplasm is classified to be of unspecified nature.
- This situation may be encountered when the patient has been treated elsewhere and now is treated at a different facility without accompanying information to identify the nature or type of neoplasm or when the patient is referred elsewhere for definitive workup, or workup is not performed because of the patient's advanced age or poor condition.
  - Example: Neoplasm of skin, uncertain behavior.

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Unspecified Behavior

- The category for unspecified behavior, is to be used only when a diagnosis (behavior or morphology) cannot be clearly identified in the medical record.
- Many reasons for coding unspecified behavior exist.
- One reason could be that the patient has moved to a new location and the physician does not have access to the patient's previous medical record or the patient is sent to another facility for further study to determine the exact nature of the neoplasm.

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Unspecified Behavior

- ICD-10-CM classifies neoplasms by:
  - System (eg, respiratory).
  - Organ (eg, intrathoracic organs).
  - Site (eg, tract, upper).
- Exceptions to this are:
  - Lymphatic neoplasms.
  - Hematopoietic neoplasms.
  - Malignant melanoma of the skin.
  - Some common tumors of bone, uterus, and ovary.

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Unspecified Behavior

- Codes for neoplasms are indicated by anatomical site.
- For each site, there are six possible codes indicating whether the neoplasm is malignant, primary, secondary or carcinoma in situ, benign, of uncertain behavior, or unspecified.
  - Be careful to code to the highest degree of specificity.
- When coding neoplasms, ask the following questions:
  - Where did it originate?
  - Where is the neoplasm currently?
  - What has been its cause?

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Unspecified Behavior

- Neoplasms are located in Chapter 2 of the Tabular List.
  - Neoplasm is the medical term for any abnormal growth, commonly referred to as a tumor.
  - Benign and/or malignant lesions are called neoplasms.
  - Physicians must distinguish between malignant (cancerous) and benign (noncancerous) neoplasms.
  - Coding neoplasms requires a good understanding of anatomy and medical terminology.

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ICD-10-CM Official Guidelines for Coding Neoplasms

- It is important before coding neoplasms that you have a good understanding of the types of neoplasm:
  - When coding neoplasms the Alphabetic Index should be referenced first if the histological term is documented rather than going directly to the neoplasm.
  - If the term in the documentation indicates “adenoma” reference the adenoma first instead of immediately referencing the Neoplasm Table for any additional instructional notes.
  - Before selecting the code, always verify the code in the Tabular List as with other sections of ICD-10-CM.

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Neoplasm Table

- ICD-10-CM chapter 2 contains codes for most benign and malignant neoplasms:
- In order to properly code neoplasms, documentation in the medical record must indicate the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior.
  - If there is a malignancy, the secondary (metastatic) site should also be reported.

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Neoplasm Table

- There is a separate Table of Neoplasms.
- The codes should be selected from the table.
- The guidelines in ICD-10-CM state: “If the histology (cell type) of the neoplasm is documented, that term should be referenced first, in the main section of the Index, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate.”
- See Table 5.2 for an example of the neoplasm table.

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Guideline C2.a Treatment directed at the malignancy

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

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Guideline C2.a Treatment directed at the malignancy

- The malignancy may be the primary site or the secondary site. The primary site is where the cancer originated.
- The secondary site is the site where the cancer metastasized or spread to.

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Guideline C2.a Treatment directed at the malignancy

- The guidelines for ICD-10-CM indicate that a confirmed malignancy diagnosis is not reported without a pathology report on the record to confirm the histologic type of neoplasm.
  - If the pathology report is not in the medical record, the attending physician must confirm the diagnosis in the medical record documentation.
  - The pathology report is not required for encounters such as chemotherapy or radiation therapy.

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Guideline C2.a Treatment directed at the malignancy

- The only time you would not report where treatment is directed is if a patient's admission/encounter is solely for the administration of chemotherapy, immunotherapy, or radiation therapy.
  - In this instance assign the appropriate Z51.-- code as the first listed or principal diagnosis, and the diagnosis or problem for which the service is being performed as a secondary diagnosis.
    - For example if the patient is being treated for lung cancer and is undergoing chemotherapy, the chemotherapy code Z51.11 is reported first and the malignancy of the lung will be reported as the secondary diagnosis.

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Guideline C2.a Treatment directed at the malignancy

- The guidelines for ICD-10-CM indicate that a confirmed malignancy diagnosis is not reported without a pathology report on the record to confirm the histologic type of neoplasm.
- If the pathology report is not in the medical record, the attending physician must confirm the diagnosis in the medical record documentation.
- The pathology report is not required for encounters such as chemotherapy or radiation therapy.

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Guideline C2.b Treatment of Secondary Site

- When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.
- When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.
  - However in this instance, the primary site or origin of the cancer is reported as the secondary diagnosis.

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Guideline C2.c Coding and Sequencing of Complications

- Coding and sequencing of complications associated with the malignancies or with the therapy thereof are subject to the following guidelines:
  1. Anemia associated with malignancy:
     - When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first listed diagnosis followed by code D63.0, Anemia in neoplastic disease.

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Guideline C2.c Coding and Sequencing of Complications

2. Anemia associated with chemotherapy, immunotherapy, and radiation therapy:
   - When the admission/encounter is for management of an anemia associated with an adverse effect of chemotherapy or immunotherapy, and the only treatment is for the anemia, the appropriate adverse effect code should be sequenced first, followed by the appropriate codes for the anemia and neoplasm.

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Guideline C2.c Coding and Sequencing of Complications

- When the admission/encounter is for management of an anemia associated with an adverse effect of radiotherapy, the anemia code should be sequenced first, followed by the appropriate neoplasm code, and code T45.1x5 for the adverse effect of antineoplastic and immunosuppressive drugs as an additional diagnosis.

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Guideline C2.c Coding and Sequencing of Complications

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

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Guideline C2.c Coding and Sequencing of Complications

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

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C2.d Primary Malignancy Previously Excised

- When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.
- Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site.

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C2.e Admission/encounters involving chemotherapy, immunotherapy and radiation therapy

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

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C2.e Admission/encounters involving chemotherapy, immunotherapy and radiation therapy

2. Patient admission/encounter solely for administration of chemotherapy, immunotherapy, and radiation therapy:
   - If a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy, or radiation therapy, assign code Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy as the first listed or principal diagnosis.

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C2.e Admission/encounters involving chemotherapy, immunotherapy and radiation therapy

- If a patient receives more than one of these therapies during the same admission, more than one of these codes may be assigned, in any sequence.
- The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis.

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C2.e Admission/encounters involving chemotherapy, immunotherapy and radiation therapy

3. Patient admitted for radiation therapy, chemotherapy, or immunotherapy and develops complications:
   - When a patient is admitted for the purpose of radiotherapy, immunotherapy, or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first listed diagnosis is Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy followed by any codes for the complications.

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C2.f Admission/encounter to determine extent of malignancy

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

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C2.g Symptoms, signs, and abnormal findings listed in Chapter 18 associated with neoplasms

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

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C2.h Admission/encounter for pain control management

- When an encounter is for pain management due to the malignancy, one of the pain codes should be sequenced first, followed by appropriate neoplasm code(s).
- There is an instructional note to code also the neoplasm.

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C2.i Malignancy in two or more noncontiguous sites

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

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C2.j Disseminated malignant neoplasm, unspecified

- Code C80.0, Disseminated malignant neoplasm, unspecified, is for use only in those cases where the patient has advanced metastatic disease and no known primary or secondary sites are specified. It should not be used in place of assigning codes for the primary site and all known secondary sites.

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C2.k Malignant neoplasm without specification of site

- Code C80.1, Malignant (primary) neoplasm, unspecified, equates to Cancer, unspecified.
- This code should only be used when no determination can be made as to the primary site of a malignancy.
- This code should rarely be used in the inpatient setting.

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C2.I. Sequencing of neoplasm codes

1. Encounter for treatment of primary malignancy:
   - If the reason for the encounter is for treatment of a primary malignancy, assign the malignancy as the principal/first listed diagnosis. The primary site is to be sequenced first, followed by any metastatic sites.
2. Encounter for treatment of secondary malignancy:
   - When an encounter is for a primary malignancy with metastasis and treatment is directed toward the metastatic (secondary) site(s) only, the metastatic site(s) is designated as the principal/first listed diagnosis. The primary malignancy is coded as an additional code.

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C2.I. Sequencing of neoplasm codes

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

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C2.I. Sequencing of neoplasm codes

4. Encounter for complication associated with a neoplasm:
   - When an encounter is for management of a complication associated with a neoplasm, such as dehydration, and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm.
   - The exception to this guideline is anemia. When the admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first listed diagnosis followed by code D63.0, Anemia in neoplastic disease.

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C2.l. Sequencing of neoplasm codes

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

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C2.l. Sequencing of neoplasm codes

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

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C2.m Current malignancy versus personal history of malignancy

- When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy, or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.
- When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.

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Chapter 3
Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism (D50-D89)

- Chapter 3 of ICD-10-CM contains the following classifications:
  - Nutritional anemias (D50-D53).
  - Hemolytic anemias (D55-D59).
  - Aplastic and other anemias and other bone marrow failure syndromes (D60-D64).
  - Coagulation defects, purpura and other hemorrhagic conditions (D65-D69).
  - Other disorders of the blood and blood- forming organs (D70-D77).

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Chapter 3

  - Intraoperative and post procedural complications of the spleen (D78).
  - Certain disorders involving the immune mechanism
  - (D80-D89).
- The conditions in Chapter 3 include:
  - Anemia.
  - Bone marrow.
  - Lymphatic tissue.
  - Platelets.
  - Coagulation factors.

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Anemia

- Anemia is a reduction in hemoglobin or in the volume of packed red blood cells. Anemia is attributed to a number of causes. They include:
  - Bleeding.
  - Aging.
  - Cell destruction.

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Anemia

- Accuracy is important when coding anemia.
  - You may need to refer to a laboratory or pathology report for a more precise diagnosis.
  - However, make sure the documentation in the medical record supports your code selection.
  - When the diagnosis is unclear or unspecified, check with the physician for the most accurate diagnosis.

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Anemia

- Anemia is the main term, under which you will find many subterms that relate to anemia.
- Many of the subterms for anemia have lengthy additional subterms listed under them.
- Anemia complicating pregnancy or the puerperium is excluded from this category and is coded as O99.0.
- Iron Deficiency Anemias (D50).
- Conditions include blood loss, menorrhagia and iron deficiency
- When specific type is not know report D50.9.

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Secondary Anemia

- Secondary anemia often results from chronic conditions such as infection or blood loss. Anemia should be coded to the specific type of anemia, when the information is available.
- Use “anemia unspecified” only when the type of anemia cannot be identified.

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Secondary Anemia

- There are two types of anemia that are often confusing, “anemia of chronic disease” and “chronic anemia.”
- These two diagnostic statements are not the same. In “anemia of chronic disease,” chronic describes the name of the disease that is the cause of the anemia.

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Sickle-cell Anemia

- Sickle-cell anemia (D57):
  - Category D57 contains hereditary conditions characterized by escalated erythrocyte (red blood cell) destruction.
  - Sickle-cell anemia is a common disorder within this category of diagnosis codes.
  - When coding sickle-cell disorders, it is important to understand the difference between the sickle-cell trait and sickle-cell anemia.

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Sickle-cell Anemia

- Sickle-cell anemia is a hereditary disease of the red blood cells passed to a child when both parents carry the genetic trait.
- It is present in up to 1% of the black population.
- The cells contain an abnormal type of hemoglobin that, when deoxygenated, precipitates into long crystals, deforming the cells and damaging the membrane. Organ damage and death may result from this very serious condition.

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Sickle-cell Anemia

- Some complications of sickle-cell disease are
  - Skin ulcers.
  - Anemia.
  - Nocturia.
  - Cardiomegaly.
  - Chest syndrome.
  - Renal failure.

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

- Chapter 4 in the Tabular List includes the following sections:
  - Disorders of the thyroid gland (E00-E07).
  - Diabetes mellitus (E08-E13).
  - Other disorders of glucose regulation and pancreatic internal secretion (E15-E16).
  - Disorders of other endocrine glands (E20-E35).
  - Intraoperative complications of endocrine system (E36).

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Chapter 4

- Malnutrition (E40-E46).
- Other nutritional deficiencies (E50-E64).
- Overweight, obesity, and other hyperalimentation (E65-E68).
- Metabolic disorder (E70-E88).
- Postprocedural endocrine and metabolic complications and disorders, not elsewhere classified (E89).

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Chapter 4

- Chapter 4 in the Tabular List describes diseases or conditions that affect the endocrine system.
- The endocrine system involves the glands that are located throughout the body.
- The function of these glands is to secrete hormones into the bloodstream.
- The thyroid, an important endocrine gland, varies greatly in size.
- This gland secretes hormones governing the body's metabolic rate.

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Chapter 4

- Some common disorders identified in Chapter 4 of the Tabular List are:
  - Disorders of the thyroid gland.
  - Disorders of the pituitary gland.
  - Disorders of the adrenal gland.
  - Diabetes mellitus.
  - Disorders of the parathyroid gland.
  - Disorders relating to metabolism.

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Disorders of the thyroid gland

- Disorders of the thyroid gland:
  - Hyperthyroidism is a condition in which excessive levels of hormones are secreted, resulting in abnormal enlargement of the gland (goiter) in numerous forms.
  - Thyroid storm or (thyrotoxic crisis) is uncontrolled hyperthyroidism, a life-threatening condition caused by underproduction of follicle-stimulating hormone (FSH).

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Disorders of the thyroid gland

- Symptoms and characteristics include:
  - Nervousness.
  - Weight loss.
  - Diarrhea.
  - Heat intolerance.
  - Palpitations.
  - Insomnia.

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Disorders of the thyroid gland

- Weakness.
- Bulging eyes.
- Lymph system swelling.
- Blurred or double vision.
- Skin problems.

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Diabetes mellitus

- Diabetes mellitus is one of the most frequently used categories in Chapter 4 of the ICD-10-CM codebook.
- Diabetes mellitus is a chronic metabolic disease of the pancreatic islet cells.
- Millions of people have this serious, lifelong condition, and more than 650,000 people are newly diagnosed with diabetes each year.
- Although it occurs most often in older adults, diabetes is also one of the most common chronic childhood diseases in the United States today.

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Diabetes mellitus

- In order to code diabetes mellitus correctly, it is critical that the coder understand the types of diabetes and underlying conditions related to diabetes mellitus.
- The three main types of diabetes are:
  - Type I, insulin dependent.
  - Type II, non–insulin dependent.
  - Gestational diabetes, which occurs during pregnancy.
- In ICD-10-CM there are combination codes to identify the type of diabetes along with any associated manifestations.

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Coding Tip

- Be careful when coding diabetes mellitus.
- Make sure the documentation in the medical record indicates controlled or uncontrolled.
- Also be sure the documentation indicates if the patient is IDDM (insulin dependent) or NIDDM (non-insulin dependent).

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Diabetes mellitus

- A patient with type I, insulin-dependent diabetes mellitus requires insulin to live.
- The patient must be monitored to identify complications of the disease, monitor insulin levels, and control diet.
- Type I diabetes mellitus indicates that:
  - Insulin is not produced by the body, or
  - Production of insulin is decreased.
- Non–insulin dependent diabetes mellitus (NIDDM), or type II diabetes, is the most common type of diabetes. It accounts for 90% to 95% of diagnosed diabetes.

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Diabetes mellitus

- Gestational diabetes is demonstrated by abnormal glucose tolerance test results during pregnancy.
  - It usually ends after delivery, but women with gestational diabetes may develop NIDDM later in life.
  - Gestational diabetes results from the body's resistance to the action of insulin.
  - Hormones produced by the placenta cause this resistance.

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Diabetes mellitus

- Women with gestational diabetes require treatment for blood glucose control during pregnancy to prevent adverse effects to the fetus, but they return to normal glucose tolerance after pregnancy.

- Diabetes mellitus codes in ICD-10-CM are combination codes that include:
  - Type of diabetes mellitus.
  - Body system affected.
  - The complications affecting that body system.

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Diabetes mellitus

- There are six (6) diabetes mellitus categories in the ICD-10-CM:
  - E08 Diabetes mellitus due to an underlying condition.
  - E09 Drug or chemical induced diabetes mellitus.
  - E10 Type I diabetes mellitus.
  - E11 Type 2 diabetes mellitus.
  - E13 Other specified diabetes mellitus.

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Diabetes mellitus

- Documentation requirements for coding diabetes mellitus include:
  - Type of diabetes.
  - Body system affected.
  - Complication or manifestation.
  - Use of insulin.
  - If type 2 DM, if long-term insulin use.

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Coding Tip

- Use an additional code to identify insulin usage (Z79.4) if applicable when coding diabetes mellitus.

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Review the guidelines for Diabetes mellitus: *C4. a. Diabetes mellitus*

- The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system.

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

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C4. a. Diabetes mellitus

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

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C4. a. Diabetes mellitus

3. Diabetes mellitus and the use of insulin:
   - If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11, Type 2 diabetes mellitus, should be assigned.
   - Code Z79.4, Long-term (current) use of insulin, is assigned to indicate that the patient uses insulin.
   - Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient's blood sugar under control during an encounter.

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C4. a. Diabetes mellitus

4. Diabetes mellitus in pregnant patient:
   - Codes for pregnancy, childbirth and the puerperium, which are located in chapter 15 of ICD-10-CM, are always sequenced first on the medical record.
   - A patient who has a pre-existing diabetes mellitus (DM) who becomes pregnant should be assigned a code from category O24 (Diabetes Mellitus in Pregnancy, Childbirth, and the Puerperium, followed by the diabetes code from chapter 4 of ICD-10-CM).
   - These codes have been expanded in ICD-10-CM.

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C4. a. Diabetes mellitus

- The fourth character subcategory codes identify the type of diabetes as pre-existing type I or type 2, unspecified, or gestational.
- The fifth character indicates whether the diabetes is treated during pregnancy, childbirth, or the puerperium. The sixth character indicates the trimester during which treatment is sought.
- With gestational diabetes the sixth character identifies whether the gestational diabetes is diet-controlled, insulin controlled, or unspecified control.

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C4. a. Diabetes mellitus

5. Complications due to insulin pump malfunction:

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

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

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C4. a. Diabetes mellitus

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

- The principal or first listed code for an encounter due to an insulin pump malfunction resulting in an overdose of insulin, should also be T85.6-, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, followed by code T38.3x1-, Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional).
- An insulin overdose can be extremely dangerous. It can be a difficult medication to properly dose and it is fairly easy to accidentally overdose on this medication.

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C4. a. Diabetes mellitus

6. Secondary diabetes mellitus:
   - Secondary diabetes is a form of the disease that develops as a result of, or secondary to, another disease or condition.
     - Secondary diabetes can be caused by a wide range of health problems that damage, injure, interfere with, or destroy the pancreas. For example, secondary diabetes may develop from inflammation of the pancreas (pancreatitis), cystic fibrosis, or conditions related to the overproduction of growth hormone or cortisol.

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C4. a. Diabetes mellitus

– Some medicines may also affect how the body uses insulin or prevent the pancreas from producing enough insulin.

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

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

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C4. a. Diabetes mellitus

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

- The sequencing of the secondary diabetes codes in relationship to codes for the cause of the diabetes is based on the Tabular List instructions for categories E08 and E09.
- For example, for category E08, Diabetes mellitus due to underlying condition, code first the underlying condition; for category E09, Drug or chemical induced diabetes mellitus, code first the drug or chemical (T36-T65).

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C4. a. Diabetes mellitus

(i) Secondary diabetes mellitus due to pancreatectomy:

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

(ii) Secondary diabetes due to drugs:

- May be caused by an adverse effect of correctly administered medications, or poisoning.

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C4. a. Diabetes mellitus

(iii) Manifestations and complications of diabetes mellitus:

- Patients with diabetes mellitus are susceptible to other chronic conditions as a result of this disease.

- Some body systems that can be affected are:
  - Renal system.
  - Nervous system.
  - Peripheral vascular system.
  - Eyes and feet (most commonly affected).

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C4. a. Diabetes mellitus

- Use your medical dictionary to identify clinical terms for infectious diseases.
  - When coding chronic complications, the code for diabetes mellitus in most cases a combination code is available to describe both the diabetes and the manifestation of the diabetes.
  - The manifestation is the complication or condition caused by diabetes mellitus.

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C4. a. Diabetes mellitus

- Diabetic patients who receive a new pancreas for treatment of DM may no longer require insulin or other care for their diabetes mellitus, but pre-existing complications from the diabetes may still exist after transplant.
  - Codes from the DM categories are still applicable to describe the complication is these cases.
  - A transplant status code should be used with the diabetes code in this circumstance.

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Hypoglycemia

- Very low blood sugar is called hypoglycemia and is sometimes referred to as an “insulin reaction.” This condition can be caused by too much insulin, too little or delayed food intake, exercise, alcohol, or any combination of these factors.
- The patient with IDDM must constantly adjust the insulin dose to match exercise and eating patterns. If there is too much insulin, blood sugar drops and hypoglycemia results.

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Hypoglycemia

- Because the nervous system requires glucose to function properly, neurologic symptoms occur if the blood sugar continues to fall.
- The patient becomes confused, may lose consciousness or experience convulsions, and, if left untreated, will lapse into a coma.

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Hypoglycemia

- You will find these conditions, in several classifications and the code category will depend on whether the condition is due to diabetes, non-diabetes (E15) drug, induced or pregnancy.
- Before selecting a code, make sure to read all notes carefully within the code selection.

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