ICD-10-CM Specialized Coding Training

http://publichealth.nc.gov/lhd/icd10/training.htm

Child Health and Health Check Course

For Local Health Departments and Rural Health

Unit 1

North Carolina Public Health

Child Health, Health Check Training Objectives

- Develop a general understanding of the coding guidelines for those chapters in ICD-10-CM that will be utilized by health department staff for coding encounters in Child Health and Health Check
- Demonstrate how to accurately assign ICD-10-CM codes using Child Health and Health Check scenarios

NOTE: Basic ICD-10-CM Coding training is a prerequisite for this course

Chapter 21

Factors influencing health status and contact with health services

Instructional Notes

- **Code Range: Z00-Z99**
- Z codes represent reasons for encounters
- CPT code must accompany Z codes if a procedure is performed
- Provided for occasions when circumstances other than a disease, injury or external cause classifiable to categories A00-Y89 are recorded as 'diagnoses' or 'problems'
  - This can arise in two main ways:
    - When a person who may or may not be sick encounters health services for some specific purpose
      - Examples: Encounter for routine child health examination
    - When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury
      - Example: Body Mass Index

Chapter 21

Factors influencing health status and contact with health services

Content

Chapter 21 contains the following block – 1st character is Z

Z00-Z13	Persons encountering health services for examinations	Z40-Z53	Encounters for other specific health car
Z14-Z15	Genetic carrier and genetic susceptibility to disease	Z55-Z65	Persons with potential health hazards related to socioeconomic and psychosocial circumstances
Z16	Resistance to antimicrobial drugs	Z66	Do not resuscitate status
Z17	Estrogen receptor status	Z67	Blood type
Z18	Retained foreign body fragments	Z68	Body mass index (BMI)
Z20-Z28	Persons with potential health hazards related to communicable diseases	Z69-Z76	Persons encountering health services in other circumstances
Z30-Z39	Persons encountering health services in circumstances related to reproduction	Z77-Z99	Persons with potential health hazards related to family and personal history and certain conditions influencing health status

Chapter 21

Factors influencing health status **and contact with health services**

Coding Guidelines

- **Routine and administrative examinations**
  - Includes encounters for routine examinations and examinations for administrative purposes (e.g., a pre-school physical)
    - Do not use these codes if the examination is for diagnosis of a suspected condition or for treatment purposes; in such cases the diagnosis code is used
  - During a routine exam, any diagnosis or condition discovered during the exam should be coded as an additional code
  - Pre-existing and chronic conditions and history codes may be included as additional codes as long as the examination is for administrative purposes and not focused on any particular condition
  - Some codes for routine health examinations distinguish between "with" and "without" abnormal findings
    - Code assignment depends on the information that is known at the time the encounter is being coded
    - When assigning a code for "with abnormal findings," additional code(s) should be assigned to identify the specific abnormal finding(s)

Chapter 21

Factors influencing health status **and contact with health services**

Coding Guidelines

- **Routine and administrative examinations**
  - Pre-operative examination and pre-procedural laboratory examination Z codes are for use only in those situations when a client is being cleared for a procedure or surgery and no treatment is given
- **Z codes/categories for routine and administrative examinations**
  - Z00 Encounter for general examination without complaint, suspected or reported diagnosis
  - Z01 Encounter for other special examination without complaint, suspected or reported diagnosis
  - Z02 Encounter for administrative examination
    - Except: Z02.9, Encounter for administrative examinations, unspecified

Chapter 21

Factors influencing health status **and contact with health services**

Coding Guidelines

- **Contact/Exposure (Categories Z20 and Z77)**
  - Category Z20 indicates contact with, and suspected exposure to, communicable diseases
    - Do not show any sign or symptom of a disease
    - Suspected to have been exposed to a disease by close personal contact with an infected individual or are in an area where a disease is epidemic
    - **Z20.4 Contact with and (suspected) exposure to rubella**
  - Category Z77 indicates contact with and suspected exposures hazardous to health
    - **Z77.011 Contact with and (suspected) exposure to lead**
  - Contact/exposure codes may be used as a first-listed code to explain an encounter for testing, or, more commonly, as a secondary code to identify a potential risk

Chapter 21

Factors influencing health status **and contact with health services**

Coding Guidelines

- **Status Z code Z68 Body mass index (BMI)**
  - Secondary/additional diagnosis only
  - BMI can be assigned and documented by clinicians other than the physician or other qualified healthcare provider
    - e.g., nurse, dietician
  - Diagnoses such as overweight, obesity, underweight must be documented by the client's provider

Chapter 21

Factors influencing health status **and contact with health services**

Coding Guidelines

- **Screening**
  - Testing for disease or disease precursors in seemingly well individuals so early detection and treatment can be provided for those who test positive for the disease **(Z13.4: Encounter for screening for certain developmental disorders in childhood)**
  - Screening code may be a first-listed code if the reason for the visit is specifically the screening exam
    - Should a condition be discovered during the screening then the code for the condition may be assigned as an additional diagnosis
  - Screening code may also be used as an additional code if the screening is done during an office visit for other health problems
  - Screening code is not necessary if the screening is inherent to a routine examination
  - In addition to the Z code, a procedure code is required to confirm that the screening was performed

Chapter 21

Factors influencing health status **and contact with health services**

Coding Guidelines

- **Observation**
  - **Two observation Z code categories:**
    - Z03 Encounter for medical observation for suspected diseases and conditions ruled out
    - Z04 Encounter for examination and observation for other reasons
      - Except: Z04.72, Encounter for examination and observation following alleged child physical abuse
  - Used in very limited circumstances
    - Person is observed for suspected condition that is ruled out
    - Administrative and legal observation status
  - Observation codes are not for use if an injury or illness or any signs or symptoms related to the suspected condition are present
    - In such cases, the diagnosis/symptom code is used

Chapter 21

Factors influencing health status **and contact with health services**

Coding Guidelines

- **Follow-up**
  - Codes used to explain continuing surveillance following completed treatment of a disease, condition, or injury
    - They imply that the condition has been fully treated and no longer exists
    - Not aftercare codes, or injury codes with a 7th character for subsequent encounter, that explain ongoing care of a healing condition or its sequelae
    - Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment
      - Follow-up code is sequenced first, followed by the history code
        - » Follow up exam for bad ear infection, treatment complete (Z09)
        - » History of diseases of the sense organs (Z86.69)
  - A follow-up code may be used to explain multiple visits
  - Should a condition be found to have recurred on the follow-up visit, then the diagnosis code for the condition should be assigned in place of the follow-up code

Child Health and Health Check
Unit 1 ~ Review Questions
True/False

1. Any time a vaccine is administered, Z23 will be used as the diagnosis code
2. If a child is delinquent on his/her immunizations, use Status code Z28.3, Underimmunization status
3. Whenever a Z code is used, a CPT code is not needed
4. Testing of a person to rule out or confirm a suspected diagnosis because the person has some sign or symptom is a screening
5. Follow up codes are used when treatment for a disease, condition or injury is still ongoing

Child Health and Health Check
Unit 1 ~ Coding Exercises

- **Scenario 1:** *A 7 year old male is seen in clinic for his well child care visit. Mother states his older brother is being treated for ADHD and she thinks this child may have ADHD. Examination findings are normal. The child is delinquent on DTaP, IPV , MMR and VAR immunizations so those were administered.*

- **Scenario 2:** *Medical examination of 4 year old child for admission to preschool*

Specialized ICD-10-CM Coding Training

Child Health and Health Check Course

For Local Health Departments and Rural Health

Unit 2

NCPH

North Carolina Public Health

Child Health and Health Check
Unit 1 ~ Review Questions
True/False

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2. If a child is delinquent on his/her immunizations, use Status code Z28.3, Underimmunization status
3. Whenever a Z code is used, a CPT code is not needed
4. Testing of a person to rule out or confirm a suspected diagnosis because the person has some sign or symptom is a screening
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Child Health and Health Check
Unit 1 ~ Coding Exercises

- **Scenario 1:** *A 7 year old male is seen in clinic for his well child care visit. Mother states his older brother is being treated for ADHD and she thinks this child may have ADHD. Examination findings are normal. The child is delinquent on DTaP, IPV , MMR and VAR immunizations so those were administered.*

- **Scenario 2:** *Medical examination of 4 year old child for admission to preschool*

Chapter 4
Endocrine, Nutritional and Metabolic Diseases
Content

Chapter 4 contains the following blocks – 1st character is E

E00-E07	Disorders of thyroid gland	E40-E46	Malnutrition
E08-E13	Diabetes mellitus	E50-E64	Other nutritional deficiencies
E15-E16	Other disorders of glucose regulation and pancreatic internal secretion	E65-E68	Overweight, obesity and other hyperalimentation
E20-E35	Disorders of other endocrine glands	E70-E88	Metabolic disorders
E36	Intraoperative complications of endocrine system	E89	Postprocedural endocrine and metabolic complications and disorders, not elsewhere classified

Chapter 4
Endocrine, Nutritional and Metabolic Diseases
Diabetes Mellitus

- **Code Range: E00-E89**
- Instead of a single category as in ICD-9-CM, there are 5 categories
  - E08 – Diabetes Mellitus due to underlying condition
  - E09 – Drug or chemical induced Diabetes Mellitus
  - E10 – Type 1 Diabetes Mellitus
  - E11 – Type 2 Diabetes Mellitus
  - E13 – Other specified Diabetes Mellitus
- The diabetes mellitus codes are combination codes that include:
  - type of diabetes mellitus
  - body system affected
  - complications affecting that body system

Chapter 4
Endocrine, Nutritional and Metabolic Diseases
Coding Guidance – Diabetes Mellitus

- For Diabetes Mellitus codes:
  - 4th Character = underlying conditions with specified complications
  - 5th Character = specific manifestations
  - 6th Character = even further manifestations
- As many codes within a particular category as are necessary to describe all of the complications of the disease may be used
- Most Type 1 diabetics develop the condition before reaching puberty but age is not the sole determining factor
- All of the categories, except E10, have an instructional note to use an additional code for any long term insulin use (Z79.4)
- If the Type is not documented, the default is E11.-, Type 2 Diabetes Mellitus

Chapter 4
Endocrine, Nutritional and Metabolic Diseases
Coding Guidance – Diabetes Mellitus

- Complications due to insulin pump malfunction
  - Underdose of insulin due to insulin pump failure
    - Assign first-listed code from subcategory T85.6, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts
    - Secondary code is T38.3x6-, Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs
    - Also assign additional codes for the type of Diabetes and any associated complications due to the underdosing
  - Overdose of insulin due to insulin pump failure
    - Assign first-listed code from subcategory T85.6, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts
    - Secondary code is T38.3x1-, Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional)
    - Also assign additional codes for the type of Diabetes and any associated complications due to the overdosing

Chapter 4
Endocrine, Nutritional and Metabolic Diseases
Coding Guidance – Diabetes Mellitus

- Secondary Diabetes Mellitus
  - Secondary codes are in categories
    - E08, Diabetes mellitus due to underlying condition
    - E09, Drug or chemical induced diabetes mellitus
    - E13, Other specified diabetes mellitus
  - Always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, adverse effect of drug, or poisoning)
  - Follow Tabular List instructions to determine sequencing of codes
  - If diabetes mellitus is due to the surgical removal of all or part of the pancreas (postpancreatectomy)
    - Assign code E89.1, Postprocedural hypoinsulinemia as first-listed
    - Assign secondary code from category E13, Other specified Diabetes Mellitus
    - Assign secondary code from subcategory Z90.41-, Acquired absence of pancreas
    - Assign secondary code for long term insulin use, Z79.4

Chapter 4
Endocrine, Nutritional and Metabolic Diseases
Documentation Differences

- Diabetes Mellitus
  - Controlled and Uncontrolled are no longer a factor in code selection
    - Uncontrolled is coded to Diabetes, by type, with hyperglycemia
      - **E10.65 Type 1 diabetes mellitus with hyperglycemia**
- More specific information is needed to assign codes in Chapter 4
  - Metabolic disorders require greater detail related to specific amino acid, carbohydrate, or lipid enzyme deficiency responsible for the metabolic disorder
  - Cushing's syndrome is now differentiated by type and cause
  - More specific information is required to code disorders of the parathyroid gland
  - Vitamins, mineral, and other nutritional deficiencies require more information on the specific vitamin(s) and mineral(s)

Chapter 4
Endocrine, Nutritional and Metabolic Diseases
Obesity

- Obesity codes are expanded

E66 Overweight and obesity

Code first obesity complicating pregnancy, childbirth and the puerperium, if applicable (O99.21-)

Use additional code to identify body mass index (BMI), if known (Z68.-)

Excludes1: adiposogenital dystrophy (E23.6)
lipomatosis NOS (E88.2)
lipomatosis dolorosa [Dercum] (E88.2)
Prader-Willi syndrome (Q87.1)

E66.0 Obesity due to excess calories

E66.01 Morbid (severe) obesity due to excess calories

Excludes1: morbid (severe) obesity with alveolar hypoventilation (E66.2)

E66.09 Other obesity due to excess calories

Body mass index [BMI] (Z68)

Z68 Body mass index [BMI]
Kilograms per meters squared

Note: BMI adult codes are for use for persons 21 years of age or older

BMI pediatric codes are for use for persons 2-20 years of age. These percentiles are based on the growth charts published by the Centers for Disease Control and Prevention (CDC)

Z68.1 Body mass index (BMI) 19 or less, adult

Z68.2 Body mass index (BMI) 20-29, adult

Z68.20 Body mass index (BMI) 20.0-20.9, adult

Z68.21 Body mass index (BMI) 21.0-21.9, adult

Chapter 6
Diseases of the Nervous System

- **Code Range: G00-G99**

Chapter 6 contains the following blocks – 1st character is G

G00-G09 Inflammatory diseases of the central nervous system	G50-G59 nerve, nerve root and plexus disorders
G10-G14 Systemic atrophies primarily affecting the central nervous system	G60-G65 Polyneuropathies and other disorders of the peripheral nervous system
G20-G26 Extrapyramidal and movement disorders	G70-G73 Diseases of myoneural junction and muscle
G30-G32 Other degenerative diseases of the nervous system	G80-G83 Cerebral palsy and other paralytic syndromes
G35-G37 Demyelinating diseases of the central nervous system	G89-G99 Other disorders of the nervous system
G40-G47 Episodic and paroxysmal disorders	

Chapter 6
Diseases of the Nervous System
Coding Guidelines

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

G81.0 Flaccid hemiplegia

- **G81.00 Flaccid hemiplegia affecting unspecified side**
- **G81.01 Flaccid hemiplegia affecting right dominant side**
- **G81.02 Flaccid hemiplegia affecting left dominant side**
- **G81.03 Flaccid hemiplegia affecting right nondominant side**
- **G81.04 Flaccid hemiplegia affecting left nondominant side**

Chapter 6
Diseases of the Nervous System
Coding Guidelines

- **Pain ~ Category G89**
  - May be used in conjunction with codes from other categories and chapters to provide more detail about acute or chronic pain and neoplasm-related pain, unless otherwise indicated
  - If the pain is not specified as acute or chronic, post-thoracotomy, postprocedural, or neoplasm-related, do not assign codes from category G89
  - A code from category G89 should <u>not</u> be assigned if the underlying (definitive) diagnosis is known (except for neoplasms), unless the reason for the encounter is pain control/ management and not management of the underlying condition
    - If pain control/management is reason for the encounter, G89 codes would be first-listed and underlying cause would be additional diagnosis
  - If there is not a definitive diagnosis and the encounter is not for pain control/management, site-specific pain will be first-listed

Chapter 6
Diseases of the Nervous System
Coding Guidelines

- **Pain ~ Category G89 (cont'd)**
  - Chronic pain is classified to subcategory G89.2
    - No time frame defining when pain becomes chronic pain
  - Central pain syndrome (G89.0) and chronic pain syndrome (G89.4)
    - Different than the term "chronic pain"
    - Pain syndrome codes should only be used when the clinician has specifically documented this condition

Chapter 6
Diseases of the Nervous System
Coding Guidelines

- **Migraine (G43)**
  - 32 available codes
  - Documentation must include the following when appropriate
    - Intractable (pharmacologically resistant, treatment resistant, refractory and poorly controlled)
    - Not intractable
    - With status migrainosus (lasts more than 24 hrs) or without status migrainosus
    - With vomiting
    - Ophthalmoplegic
    - Menstrual
    - With or without aura
    - Hemiplegic
    - With or without cerebral infarction
    - Periodic
    - Abdominal

Chapter 6
Diseases of the Nervous System
Epilepsy

- **Epilepsy and Recurrent Seizures (G40)**
  - Code descriptions include:
    - Intractable (pharmacologically resistant, treatment resistant, refractory and poorly controlled) or not intractable
    - With status epilepticus (serious medical condition where prolonged or clustered seizures develop into non-stop seizures) or without status epilepticus
    - Documentation must address both of these
  - Examples:
    - G40.B01 Juvenile myoclonic epilepsy, not intractable, with status epilepticus
    - G40.B09 Juvenile myoclonic epilepsy, not intractable, without status epilepticus
    - G40.B11 Juvenile myoclonic epilepsy, intractable, with status epilepticus
    - G40.B19 Juvenile myoclonic epilepsy, intractable, without status epilepticus

Chapter 7
Diseases of the eye and adnexa
Content

- **Code Range: H00~H59**

Chapter 7 contains the following block – 1st character is H

H00-H05 Disorders of eyelid, lacrimal system and orbit	**H43-H44** Disorders of vitreous body and globe
H10-H11 Disorders of conjunctiva	**H46-H47** Disorders of optic nerve and visual pathways
H15-H22 Disorders of sclera, cornea, iris and ciliary body	**H49-H52** Disorders of ocular muscles, binocular movement, accommodation and refraction
H25-H28 Disorders of lens	**H53-H54** Visual disturbances and blindness
H30-H36 Disorders of choroid and retina	**H55-H57** Other disorders of eye and adnexa
H40-H42 Glaucoma	**H59** Intraoperative and postprocedural complications and disorders of eye and adnexa, not elsewhere classified

Chapter 8
Diseases of the ear and mastoid process
Content

- **Code Range: H60-H95**

Chapter 8 contains the following block – 1st character is H

H60-H62 Diseases of external ear	**H90-H94** Other disorders of ear
H65-H75 Diseases of middle ear and mastoid	**H95** Intraoperative and postprocedural complications and disorders of ear and mastoid process, not elsewhere classified
H80-H83 Diseases of inner ear	

H72 Perforation of tympanic membrane

Includes: persistent post-traumatic perforation of ear drum
postinflammatory perforation of ear drum

Code first any associated otitis media (H65.-, H66.1-, H66.2-, H66.3-, H66.4-, H66.9-, H67.-)

Excludes1: acute suppurative otitis media with rupture of the tympanic membrane (H66.01-)
traumatic rupture of ear drum (S09.2-)

Chapter 8
Diseases of the ear and mastoid process
Content

H62 Disorders of external ear in diseases classified elsewhere

H62.4 Otitis externa in other diseases classified elsewhere

Code first underlying disease, such as:
erysipelas (A46)
impetigo (L01.0)

Excludes1: otitis externa (in):
candidiasis (B37.84)
herpes viral [herpes simplex] (B00.1)
herpes zoster (B02.8)

H62.40 Otitis externa in other diseases classified elsewhere, unspecified ear

H62.41 Otitis externa in other diseases classified elsewhere, right ear

H62.42 Otitis externa in other diseases classified elsewhere, left ear

H62.43 Otitis externa in other diseases classified elsewhere, bilateral

H65 Nonsuppurative otitis media

Includes: nonsuppurative otitis media with myringitis

Use additional code for any associated perforated tympanic membrane (H72.-)

Use additional code to identify:
exposure to environmental tobacco smoke (Z77.22)
exposure to tobacco smoke in the perinatal period (P96.81)
history of tobacco use (Z87.891)
occupational exposure to environmental tobacco smoke (Z57.31)
tobacco dependence (F17.-)
tobacco use (Z72.0)

H65.0 Acute serous otitis media
Acute and subacute secretory otitis

H65.00 Acute serous otitis media, unspecified ear

H65.01 Acute serous otitis media, right ear

H65.02 Acute serous otitis media, left ear

Child Health and Health Check
Unit 2 ~ Review Questions
True/False

1. Type 2 Diabetes Mellitus is the default if Type is not documented
2. Code Z79.4, Long-term (current) use of insulin, is always used for all 5 categories of Diabetes Mellitus
3. If Obesity is coded, the BMI must always be coded as well
4. Most codes in Chapter 7, Diseases of the Eye and Adnexa, include anatomic site and/or laterality
5. A diagnosis of "Otitis Media" will surely be paid by Medicaid, no questions asked

Child Health and Health Check
Unit 2 ~ Coding Exercises

- **Scenario** : *13 year old obese female with secondary diabetes mellitus due to acute idiopathic pancreatitis. She has been on insulin for 3 years and today her blood sugar is 300. Height – 5'0"; Weight – 190 lbs*
- **Code the following**:
  - *Juvenile absence epilepsy, not intractable, with status epilepticus*
  - *Ear Infection*
  - *Acute conjunctivitis, right eye; and chronic conjunctivitis, both eyes*

Specialized ICD-10-CM Coding Training

Child Health and Health Check Course

For Local Health Departments and Rural Health

Unit 3

NCPH

North Carolina Public Health

Child Health and Health Check
Unit 2 ~ Review Questions
True/False

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3. If Obesity is coded, the BMI must always be coded as well
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Child Health and Health Check
Unit 2 ~ Coding Exercises

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Chapter 9
Diseases of the circulatory system
Content

- **Code Range: I00-I99**

Chapter 9 contains the following block – 1st character is I

I00-I02 Acute rheumatic fever	**I30-I52** Other forms of heart disease
I05-I09 Chronic rheumatic heart diseases	**I60-I69** Cerebrovascular diseases
I10-I15 Hypertensive diseases	**I70-I79** Diseases of arteries, arterioles and capillaries
I20-I25 Ischemic heart diseases	**I80-I89** Diseases of veins, lymphatic vessels and lymph nodes, not elsewhere classified
I26-I28 Pulmonary heart disease and diseases of pulmonary circulation	**I95-I99** Other and unspecified disorders of the circulatory system

Chapter 9
Diseases of the circulatory system
Coding Guidelines

- Hypertension no longer classified by type
- Additional code for any tobacco use of exposure

Hypertensive diseases (I10-I15)

Use additional code to identify:
exposure to environmental tobacco smoke (Z77.22)
history of tobacco use (Z87.891)
occupational exposure to environmental tobacco smoke (Z57.31)
tobacco dependence (F17.-)
tobacco use (Z72.0)

Excludes1: hypertensive disease complicating pregnancy, childbirth and the puerperium (O10-O11, O13-O16)
neonatal hypertension (P29.2)
primary pulmonary hypertension (I27.0)

I10 Essential (primary) hypertension

Includes: high blood pressure
hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)

Excludes1: hypertensive disease complicating pregnancy, childbirth and the puerperium (O10-O11, O13-O16)

Excludes2: essential (primary) hypertension involving vessels of brain (I60-I69)
essential (primary) hypertension involving vessels of eye (H35.0-)

Chapter 9
Diseases of the circulatory system
Coding Guidelines

- **Hypertension, Secondary**
  - Secondary hypertension is due to an underlying condition
  - Two codes are required
    - Underlying etiology
    - Code from category I15 to identify the hypertension
    - Sequencing of codes is determined by reason for admission/encounter
- **Hypertension, Transient**
  - Assign code R03.0, Elevated blood pressure reading without diagnosis of hypertension, unless patient has an established diagnosis of hypertension
  - Assign code O13.-, Gestational hypertension without significant proteinuria, or O14.-, Pre-eclampsia, for transient hypertension of pregnancy
- **Hypertension – controlled or uncontrolled**
  - Assign appropriate code from categories I10-I15

Chapter 10
Diseases of the respiratory system
Instructions/Content

- **Code Range: J00-J99**
  - When a respiratory condition is described as occurring in more than one site and is not specifically indexed, it should be classified to the lower anatomic site (e.g. tracheobronchitis to bronchitis in J40)
  - Use additional code, where applicable, to identify tobacco use or exposure

Chapter 10 contains the following block – 1st character is J

J00-J06 Acute upper respiratory infections	**J80-J84** Other respiratory diseases principally affecting the interstitium
J09-J18 Influenza and pneumonia	**J85-J86** Suppurative and necrotic conditions of the lower respiratory tract
J20-J22 Other acute lower respiratory infections	**J90-J94** Other diseases of the pleura
J30-K39 Other diseases of upper respiratory tract	**J95** Intraoperative and postprocedural complications and disorders of respiratory system, not elsewhere classified
J40-J47 Chronic lower respiratory diseases	**J96-J99** Other diseases of the respiratory system
J60-J70 Lung diseases due to external agents	

Chapter 10
Diseases of the respiratory system
Coding Guidelines

- **Chronic Obstructive Pulmonary Disease [COPD] and Asthma**
  - Codes in categories J44 and J45 distinguish between uncomplicated cases and those in acute exacerbation
    - Acute exacerbation is a worsening or a decompensation of a chronic condition
    - Acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection
  - Asthma terminology is updated to reflect current clinical classification of asthma
    - Mild intermittent
    - Mild persistent
    - Moderate persistent
    - Severe persistent
  - Intrinsic (nonallergic) and extrinsic (allergic) asthma are both classified to J45.909 – Unspecified asthma, uncomplicated

Chapter 10
Diseases of the respiratory system
Severity of Asthma Classification

Presentation of Asthma before (without) Treatment			
Type of Asthma	**Symptoms**	**Nighttime Symptoms**	**Lung Function**
Severe persistent	•Continual symptoms •Limited physical activity •Frequent exacerbations	Frequent	• FEV_1 or PEF ≤ 60% predicted •PEF variability > 30%
Moderate persistent	•Daily symptoms •Daily use of inhaled short-acting $beta_2$-agnonist •Exacerbation of affect activity •Exacerbation ≥ 2 times/week ≥ 1 day(s)	> 1time/week	• FEV_1 or PEF 60-80% predicted •PEF variability > 30%
Mild persistent	•Symptoms > 2 times/week but < 1 time/day •Exacerbation may affect activity	> 2 times/month	• FEV_1 or PEF ≥ 80% predicted •PEF variability 20-30%
Mild intermittent	•Symptoms ≤ 2 times/week •Asymptomatic and normal PEF between exacerbations •Exacerbations of varying intensity are brief (a few hours to a few days)	≤ 2 times/month	• FEV_1 or PEF ≥ 80% predicted •PEF variability < 20%

FEV_1 = The maximal amount of air a person can forcefully exhale over one second accounting for the variables of height, weight, and race used to denote the degree of obstruction with asthma

PEF= Peak Expiratory Flow is the maximum flow of expelled air during expiration following full inspiration (big breath in and then big breath out)

Source: National Heart, Lung, and Blood Institute - http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm

Chapter 10
Diseases of the respiratory system
Coding Guidelines

- **Influenza due to certain identified influenza viruses**
  - Code only confirmed cases of influenza due to certain identified influenza viruses (category J09), and due to other identified influenza virus (category J10)
    - "Confirmation" does not require documentation of positive laboratory testing specific for avian or other novel influenza A or other identified influenza virus
    - Coding may be based on the provider's diagnostic statement that the client has avian influenza, or other novel influenza A, for category J09, or has another particular identified strain of influenza, such as H1N1 or H3N2, but not identified as novel or variant, for category J10
  - If the provider records "suspected" or "possible" or "probable" avian influenza, or novel influenza, or other identified influenza
    - Use the appropriate influenza code from category J11, Influenza due to unidentified influenza virus
    - Do Not assign codes from category J09 or J10

Chapter 13
Diseases of the musculoskeletal system and connective tissue
Content

- **Code Range: M00~M99**

Chapter 13 contains the following block – 1st character is M

M00-M02 Infectious arthropathies	**M60-M63** Disorders of muscles
M05-M14 Inflammatory polyarthropathies	**M65-M67** Disorders of synovium and tendon
M15-M19 Osteoarthritis	**M70-M79** Other soft tissue disorders
M20-M25 Other joint disorders	**M80-M85** Disorders of bone density and structure
M26-M27 Dentofacial anomalies [including malocclusion] and other disorders of jaw	**M86-M90** Other osteopathies
M30-M36 Systemic connective tissue disorders	**M91-M94** Chondropathies
M40-M43 Deforming dorsopathies	**M95** Other disorders of the musculoskeletal system and connective tissue
M45-M49 Spondylopathies	**M96** Intraoperative and postprocedural complications and disorders of musculoskeletal system, not elsewhereclassified
M50-M54 Other dorsopathies	**M99** Biomechanical lesions, not elsewhere classified

Chapter 13
Diseases of the musculoskeletal system and connective tissue
Coding Guidelines

- **External Cause of Injury**

Chapter 13

Diseases of the musculoskeletal system and connective tissue (M00-M99)

Note: Use an external cause code following the code for the musculoskeletal condition, if applicable, to identify the cause of the musculoskeletal condition

- **Site and laterality**
  - Most codes within Chapter 13 have site and laterality designations
    - Site represents the bone, joint or the muscle involved.
    - For some conditions where more than one bone, joint or muscle is usually involved, such as osteoarthritis, there is a "multiple sites" code available
      - For categories where no multiple site code is provided and more than one bone, joint or muscle is involved, multiple codes should be used to indicate the different sites involved
  - Bone versus joint
    - For certain conditions, the bone may be affected at the upper or lower end, (e.g., avascular necrosis of bone, M87, Osteoporosis, M80, M81)
    - Though the portion of the bone affected may be at the joint, the site designation will be the bone, not the joint

Chapter 13
Diseases of the musculoskeletal system and connective tissue
Coding Guidelines

- **Acute traumatic versus chronic or recurrent musculoskeletal conditions**
  - Many musculoskeletal conditions are a result of previous injury or trauma to a site, or are recurrent conditions
    - Chronic or recurrent conditions should generally be coded with a code from chapter 13
  - Any current, acute injury should be coded to the appropriate injury code from chapter 19
- **Pathologic Fractures**

The appropriate 7th character is to be added to each code from subcategory M84.3:
A - initial encounter for fracture
D - subsequent encounter for fracture with routine healing
G - subsequent encounter for fracture with delayed healing
K - subsequent encounter for fracture with nonunion
P - subsequent encounter for fracture with malunion
S - sequela

Child Health and Health Check
Unit 3 – Review Questions
True/False

1. If the clinician suspects influenza but cannot confirm the type, use codes in category J11
2. Benign and malignant hypertension are the same code – I10
3. There is not a specific code for acute recurrent sinusitis
4. Intrinsic asthma and Extrinsic asthma have different codes
5. Laboratory results are required before a clinician can confirm the type of flu

Child Health and Health Check
Unit 3 ~ Coding Exercises

- **Scenario 1:** *Mother of 8 year old male states he has had a bad cough and diarrhea for two days. Dx: Intestinal flu; Acute URI*
- **Scenario 2:** *5 year old male diagnosed with severe persistent asthma with acute exacerbation*
- **Scenario 3:** *10 year old female is seen for cough, fever, body aches, sinus pressure. Diagnosis: Upper respiratory infection due to novel influenza A virus and acute frontal sinusitis*

Specialized ICD-10-CM Coding Training

Child Health and Health Check Course

For Local Health Departments and Rural Health

Unit 4

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North Carolina Public Health

Child Health and Health Check
Unit 3 – Review Questions
True/False

1. If the clinician suspects influenza but cannot confirm the type, use codes in category J11
2. Benign and malignant hypertension are the same code – I10
3. There is not a specific code for acute recurrent sinusitis
4. Intrinsic asthma and Extrinsic asthma have different codes
5. Laboratory results are required before a clinician can confirm the type of flu

Child Health and Health Check
Unit 3 ~ Coding Exercises

- **Scenario 1:** *Mother of 8 year old male states he has had a bad cough and diarrhea for two days. Dx: Intestinal flu; Acute URI*
- **Scenario 2:** *5 year old male diagnosed with severe persistent asthma with acute exacerbation*

Chapter 16
Certain conditions originating in the perinatal period
Instructional Notes

- **Code Range: P00-P96**

Note: Codes from this chapter are for use on newborn records only
  - Never on maternal records

Includes: conditions that have their origin in the fetal or perinatal period (before birth through the first 28 days after birth)even if morbidity occurs later
  - If a condition originates in the perinatal period and continues throughout the life of the client, the perinatal code should continue to be used regardless of client's age

Excludes2: congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
endocrine, nutritional and metabolic diseases (E00-E88)
injury, poisoning and certain other consequences of external causes (S00-T88)
neoplasms (C00-D49)
tetanus neonatorum (A33)

Chapter 16
Certain conditions originating in the perinatal period
Content

Chapter 16 contains the following block – 1st character is P

P00-P04	Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery	P50-P61	Hemorrhagic and hematological disorders of newborn
P05-P08	Disorders of newborn related to length of gestation and fetal growth	P70-P74	Transitory endocrine and metabolic disorders specific to newborn
P09	Abnormal findings on neonatal screening	P76-P78	Digestive system disorders of newborn
P10-P15	Birth trauma	P80-P83	Conditions involving the integument and temperature regulation of newborn
P19-P29	Respiratory and cardiovascular disorders specific to the perinatal period	P84	Other problems with newborn
P35-P39	Infections specific to the perinatal period	P90-P96	Other disorders originating in the perinatal period

Chapter 16
Certain conditions originating in the perinatal period
Coding Guidelines

- Codes from other Chapters with Codes from Chapter 16
  - Codes from other chapters may be used with codes from chapter 16 if the codes from the other chapters provide more specific detail
  - Codes for signs and symptoms may be assigned when a definitive diagnosis has not been established
  - If the reason for the encounter is a perinatal condition, the code from chapter 16 should be first-listed
- Coding Additional Perinatal Diagnoses
  - Assign codes for conditions that require treatment or further investigation or require resource utilization
  - Assign codes for conditions that have been specified by the provider as having implications for future health care needs

Chapter 16
Certain conditions originating in the perinatal period
Coding Guidelines

- Newborn has a condition that may be either due to the birth process or community acquired
  - If the documentation does not indicate which it is, the default is due to the birth process and the code from Chapter 16 should be used
  - If the condition is community-acquired, a code from Chapter 16 should not be assigned
- Bacterial Sepsis of Newborn
  - Category **P36, Bacterial sepsis of newborn**, includes congenital sepsis
  - Refer to chapter-specific coding guidelines for additional guidance

Chapter 16
Certain conditions originating in the perinatal period
Coding Guidelines

- Code all clinically significant conditions noted on routine newborn examination
  - A condition is clinically significant if it requires:
    - clinical evaluation; or
    - therapeutic treatment; or
    - diagnostic procedures; or
    - extended length of hospital stay; or
    - increased nursing care and/or monitoring; or
    - has implications for future health care needs

Chapter 16
Certain conditions originating in the perinatal period
Coding Guidelines

- Prematurity and Fetal Growth Retardation
  - Providers utilize different criteria in determining prematurity
    - A code for prematurity should not be assigned unless it is documented
  - Assignment of codes in categories **P05, Disorders of newborn related to slow fetal growth and fetal malnutrition**, and **P07, Disorders of newborn related to short gestation and low birth weight, not elsewhere classified**, should be based on the recorded birth weight and estimated gestational age
    - Codes from category P05 should not be assigned with codes from category P07
    - Exception: A code from P05 and codes from **P07.2** and **P07.3** may be used to specify weeks of gestation as documented by the provider in the record
  - When both birth weight and gestational age are available:
    - Two codes from category P07 should be assigned
    - Sequence the code for birth weight before the code for gestational age

Chapter 16
Certain conditions originating in the perinatal period
Coding Guidelines

- Low birth weight and immaturity status
  - Codes from category **P07, Disorders of newborn related to short gestation and low birth weight, not elsewhere classified**
    - Can be used for a child or adult who:
      - was premature or had a low birth weight as a newborn, and
      - this is affecting the client's current health status
- Observation and Evaluation of Newborns for Suspected Conditions not Found
  - Assign a code from categories **P00-P04, Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery** to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present
  - Do not use a code from categories P00-P04 when the patient has identified signs or symptoms of a suspected problem

Chapter 17

Congenital malformations, deformations and chromosomal abnormalities

Instructional Notes and Content

- **Code Range: Q00-Q99**

Note: Codes from this chapter are not for use on maternal or fetal records

Excludes2: inborn errors of metabolism (E70-E88)

Chapter 17 contains the following block – 1st character is Q

Q00-Q07	Congenital malformations of the nervous system	Q50-Q56	Congenital malformations of genital organs
Q10-Q18	Congenital malformations of eye, ear, face and neck	Q60-Q64	Congenital malformations of the urinary system
Q20-Q28	Congenital malformations of the circulatory system	Q65-Q79	Congenital malformations and deformations of the musculoskeletal system
Q30-Q34	Congenital malformations of the respiratory system	Q80-Q89	Other congenital malformations
Q35-Q37	Cleft lip and cleft palate	Q90-Q99	Chromosomal abnormalities, not elsewhere classified
Q38-Q45	Other congenital malformations of the digestive system		

Chapter 17

Congenital malformations, deformations and chromosomal abnormalities

Coding Guidelines

- Assign codes from Chapter 17 when a malformation/ deformation or chromosomal abnormality is documented
  - Chapter 17 codes may be first-listed or a secondary diagnosis
  - Chapter 17 codes can be used throughout life of client
  - If a congenital malformation or deformity has been corrected, use a personal history code instead of Chapter 17 code
- When a malformation/deformation/or chromosomal abnormality does not have a unique code assignment, assign additional code(s) for any manifestations that may be present
- When the code assignment specifically identifies the malformation/deformation/or chromosomal abnormality, manifestations that are an inherent component of the anomaly should not be coded separately
  - Additional codes should be assigned for manifestations that are not an inherent component

Chapter 18
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
Instructional Notes

- Chapter 18 includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditions regarding which no diagnosis classifiable elsewhere is recorded
- **Code Range: R00-R94** The conditions and signs or symptoms included in this code range consist of:
  - cases for which no more specific diagnosis can be made even after all the facts bearing on the case have been investigated
  - signs or symptoms existing at the time of initial encounter that proved to be transient and whose causes could not be determined
  - provisional diagnosis in a patient who failed to return for further investigation or care
  - cases referred elsewhere for investigation or treatment before the diagnosis was made
  - cases in which a more precise diagnosis was not available for any other reason
  - certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right

Chapter 18

Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified

Content

Chapter 18 contains the following block – 1st character is R

R00-R09	Symptoms and signs involving the circulatory and respiratory systems	R50-R69	General symptoms and signs
R10-R19	Symptoms and signs involving the digestive system and abdomen	R70-R79	Abnormal findings on examination of blood, without diagnosis
R20-R23	Symptoms and signs involving the skin and subcutaneous tissue	R80-R82	Abnormal findings on examination of urine, without diagnosis
R25-R29	Symptoms and signs involving the nervous and musculoskeletal systems	R83-R89	Abnormal findings on examination of other body fluids, substances and tissues, without diagnosis
R30-R39	Symptoms and signs involving the genitourinary system	R90-R94	Abnormal findings on diagnostic imaging and in function studies, without diagnosis
R40-R46	Symptoms and signs involving cognition, perception, emotional state and behavior	R97	Abnormal tumor markers
R47-R49	Symptoms and signs involving speech and voice	R99	Ill-defined and unknown cause of mortality

Chapter 18

Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified

CMS Guidance Related to Chapter 18 codes

- Specific diagnosis codes should be reported when they are supported by:
  - medical record documentation, and
  - clinical knowledge of the patient's health condition
- Codes for signs/symptoms have acceptable, even necessary, uses
  - There are instances when signs/symptom codes are the best choice for accurately reflecting a health care encounter
  - If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis
- Each health care encounter should be coded to the level of certainty known for that encounter

Chapter 19

Injury, poisoning, and certain other consequences of external causes

Content

Chapter 19 contains the following block – 1st characters are S and T

S00-S09 Injuries to the head	T15-T19 Effects of foreign body entering through natural orifice
S10-S19 Injuries to the neck	T20-T32 Burns and corrosions
S20-S29 Injuries to the thorax	T20-T25 Burns and corrosions of external body surface, specified by site
S30-S39 Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals	T26-T28 Burns and corrosions confined to eye and internal organs
S40-S49 Injuries to the shoulder and upper arm	T30-T32 Burns and corrosions of multiple and unspecified body regions
S50-S59 Injuries to the elbow and forearm	T33-T34 Frostbite
S60-S69 Injuries to the wrist, hand and fingers	T36-T50 Poisoning by, adverse effect of and underdosing of drugs, medicaments and biological substances
S70-S79 Injuries to the hip and thigh	T51-T6 Toxic effects of substances chiefly nonmedicinal as to source
S80-S89 Injuries to the knee and lower leg	T66-T78 Other and unspecified effects of external causes
S90-S99 Injuries to the ankle and foot	T79 Certain early complications of trauma
T07 Injuries involving multiple body regions	T80-T88 Complications of surgical and medical care, not elsewhere classified
T14 Injury of unspecified body region	

Chapter 19

Injury, poisoning, and certain other consequences of external causes

Coding Guidelines

- Adverse Effects, Poisoning, Underdosing and Toxic Effects
  - Codes in categories T36-T65 are combination codes that include the substance that was taken as well as the intent
  - **Do not** code directly from the Table of Drugs and Chemicals. The Alphabetic Index will direct you to the Table of Drugs and Chemicals and then always refer back to the Tabular List
    - From the Tabular, look at the instructional notes at the beginning of the code block as well as the beginning of each category
  - Use as many codes as necessary to describe completely all drugs, medicinal or biological substances
  - If the same code would describe the causative agent for more than one adverse reaction, poisoning, toxic effect or underdosing, assign the code only once

Chapter 19
Injury, poisoning, and certain other consequences of external causes
Coding Guidelines

- Adverse Effects, Poisoning, Underdosing and Toxic Effects (cont'd)
  - The occurrence of drug toxicity is classified in ICD-10-CM as follows:
    - **Adverse Effect** - When coding an adverse effect of a drug that has been <u>correctly prescribed and properly administered</u>
      - assign the appropriate code for the nature of the adverse effect
        - » Examples: Tachycardia, delirium, vomiting
      - followed by the appropriate code for the adverse effect of the drug (T36-T50)
    - **Poisoning**-When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration)
      - First assign the appropriate code from categories T36-T50
        - » The poisoning codes have an associated intent as their 5th or 6th character (accidental, intentional self-harm, assault and undetermined)
      - Use additional code(s) for all manifestations of poisonings
      - If there is also a diagnosis of abuse or dependence of the substance, the abuse or dependence is assigned as an additional code

Chapter 19

Injury, poisoning, and certain other consequences of external causes

Coding Guidelines

- Adverse Effects, Poisoning, Underdosing and Toxic Effects (cont'd)
  - The occurrence of drug toxicity is classified in ICD-10-CM as follows: (cont'd)
  - Examples of **Poisoning**:
    - Errors made in drug prescription or in the administration of the drug by provider, nurse, patient, or other person
    - Overdose of a drug intentionally taken or administered that results in drug toxicity
    - Nonprescribed drug or medicinal agent (e.g., NyQuil) taken in combination with correctly prescribed and properly administered drug - any drug toxicity or other reaction resulting from the interaction of the two drugs would be classified as a poisoning
    - Interaction of drug(s) and alcohol causing a reaction would be classified as a poisoning

Chapter 19
Injury, poisoning, and certain other consequences of external causes
Coding Guidelines

- Adverse Effects, Poisoning, Underdosing and Toxic Effects (cont'd)
  - The occurrence of drug toxicity is classified in ICD-10-CM as follows: (cont'd)
  - **Underdosing**
    - Taking less of a medication than is prescribed by a provider or a manufacturer's instruction
    - For underdosing, assign the code from categories T36-T50 (fifth or sixth character "6")
      - Example: **T38.2X6- Underdosing of antithyroid drugs**
    - Codes for underdosing should never be assigned as first-listed codes
      - If a patient has a relapse or exacerbation of the medical condition for which the drug is prescribed because of the reduction in dose, then the medical condition itself should be coded (e.g., Goiter develops)
    - Noncompliance (Z91.12-, Z91.13-) or complication of care (Y63.8-Y63.9) codes are to be used with an underdosing code to indicate intent, if known

Z91.130 Patient's unintentional underdosing of medication regimen due to age-related debility

Y63.8 Failure in dosage during other surgical and medical care

Child Health and Health Check
Unit 4 – Review Questions
True/False

1. When a combination code that identifies both the definitive diagnosis and common symptoms of that diagnosis, code the symptoms
2. When both birth weight and gestational age are available code one or the other but not both.
3. Codes for signs and symptoms are not reported in addition to a related definitive diagnosis
4. If a condition originates in the perinatal period and continues throughout the life of the client, the perinatal code should continue to be used regardless of client's age
5. Codes from Chapter 17 cannot be used after a client reaches age 18

Child Health and Health Check
Unit 4 ~ Coding Exercises

- **Scenario 1:** *A 9 year old with asthma was seen in the clinic two weeks ago at which time Advair was prescribed. The child has been experiencing nausea and dizziness since starting the Advair. It appears she is having a adverse reaction to the Advair so is told to discontinue taking the Advair.*
- **Scenario 2:** *An 8 year old comes in for WCC and it is suspected that he has been sexually abused. Social Services is notified.*

Child Health and Health Check Coding Exercises for Course

Use the Coding Steps to Code the following scenarios/diagnoses

#	Scenario/Diagnosis	Answer
1	5 year old male seen in Child Health clinic today for Chalazion, right upper and lower eyelids.	
2	During a routine Health Check physical exam, an 8 year old white female is discovered to be dehydrated. The mother reports the child has had diarrhea for several days.	
3	4 year old female is experiencing acute pain in both ears. This child has been seen on several occasions for serous otitis media, right ear. Both parents are heavy cigarette smokers. Diagnosis: Acute serous otitis media, left year; Total perforated tympanic membrane due to chronic serous otitis media, right ear.	
4	A 14 year old female is seen in child health clinic for irregular periods. A pregnancy test is given and it is determined patient is pregnant.	
5	6 year old female diagnosed with Erythema multiforme minor due to azithromycin prescribed for recurrent acute suppurative otitis media, both ears. Client has approximately 9 percent body surface exfoliation, primarily on her arms and legs.	

Child Health and Health Check Coding Exercises for Course

Use the Coding Steps to Code the following scenarios/diagnoses

#	Scenario/Diagnosis	Answer
6	Full term newborn delivered 4 days ago and discharged with no problems. After going home he was jaundiced so the mother brings him to the health department for evaluation. Infant is diagnosed with hyperbilirubinemia and will have phototherapy provided at home.	
7	2 month old male is seen for initial Child Health examination. He has a cleft palate involving both the soft and hard palate, with bilateral cleft lip.	
8	12 year old female complaining of painful urination and an urge to urinate frequently. Diagnosis: Acute suppurative cystitis, with hematuria due to E coli.	
9	A 9 year old is seen for sore throat and upper respiratory symptoms with an onset 2 days ago. A rapid strep test is negative and an Albuterol nebulizer treatment is given before sending child out via EMS for acute respiratory distress.	
10	3 year, 8 month old male presents to clinic for ADHD/Behavior issues according to mother; physical exam finds 3cm lymph node below chin—Rx given for Acute Lymphadenitis. Mother states during exam that child has killed multiple small animals and constantly tortures cat. Referral to mental health for Conduct Disorder and possible ADHD; follow up lymphadenitis in 2 weeks	

Child Health and Health Check Coding Exercises for Course

Use the Coding Steps to Code the following scenarios/diagnoses

#	Scenario/Diagnosis	Answer
11	A 3 yr old male with nutritional deficiency was referred from his primary care physician to receive Medical Nutrition Therapy (MNT) from a Registered Dietitian. The child weighed 1000 grams at birth after 32 weeks gestation. He has fetal alcohol syndrome as the mother suffered from alcohol abuse prior to and during the pregnancy. The mother has been in remission for 1 year. The primary care physician ordered 3 visits with a return visit to his office upon completion of the MNT services.	
12	A 2 year old comes in for WCC and it is discovered that child has pink eye and is treated. WCC rescheduled.	
13	A 1 year old Child Health client presents for their annual periodic Child Health visit and receives the following: Bright Futures history, exam, lead level, vision, hearing, developmental screening and is found to have an inner ear infection of the right ear.	

Specialized ICD-10-CM Coding Training

Child Health and Health Check Course

For Local Health Departments and Rural Health

Unit 5

NCPH

North Carolina Public Health

Child Health and Health Check
Unit 4 – Review Questions
True/False

1. When a combination code that identifies both the definitive diagnosis and common symptoms of that diagnosis, code the symptoms

   Answer: False (do not code symptoms that commonly occur with a definitive diagnosis and especially don't code them if they are included in a combination code)

2. When both birth weight and gestational age are available code one or the other but not both

   Answer: False (When both birth weight and gestational age are available: Two codes from category P07 should be assigned. Sequence the code for birth weight before the code for gestational age. NOTE: There are codes related to light for gestational age and small for gestational age. Light refers to the infant's weight while small refers to the infant's size (including head, body & weight))

3. Codes for signs and symptoms are not reported in addition to a related definitive diagnosis

   Answer: False (Codes for signs and symptoms may be reported in addition to a related definitive diagnosis – When the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes; The definitive diagnosis code should be sequenced before the symptom code)

Child Health and Health Check
Unit 4 – Review Questions
True/False

4. If a condition originates in the perinatal period and continues throughout the life of the client, the perinatal code should continue to be used regardless of client's age

   Answer: True (As long as the documentation specifies that the condition was present in the perinatal period)

5. Codes from Chapter 17 cannot be used after a client reaches age 18

   Answer: False (Codes from Chapter 17 may be used throughout the life of the client)

Child Health and Health Check
Unit 4 ~ Coding Exercises

- **Scenario 1:** *A 9 year old with asthma was seen in the clinic two weeks ago at which time Advair was prescribed. The child has been experiencing nausea and dizziness since starting the Advair. It appears she is having a adverse reaction to the Advair so is told to discontinue taking the Advair.*

  Answer: **R42** Dizziness and giddiness; **J45.909** Unspecified asthma, uncomplicated (with more specificity, could code to higher level); **R11.0** Nausea; **T49.1x5A** Adverse effect of antipruritics; **T48.6x5A** Adverse effect of antiasthmatics (NOTE: Advair = fluticasone and salmeterol) so both chemical names are used in Table of Drugs and Chemicals. If you can't find your drug in the Table, go to internet and look up the generic name or chemical name.) At beginning of Block T36-T50, there is a note: Code first, for adverse effects, the nature of the adverse effect

- **Scenario 2:** *An 8 year old comes in for WCC and it is suspected that he has been sexually abused. Social Services is notified.*

  Answer: **Z00.121** Encounter for routine child health examination with abnormal findings; **T76.22xA** Child sexual abuse, suspected, initial encounter

Child Health and Health Check Coding Exercises for Course

Use the Coding Steps to Code the following scenarios/diagnoses

#	Scenario/Diagnosis	Answer
1	5 year old male seen in Child Health clinic today for Chalazion, right upper and lower eyelids. **H00.11** (Chalazion, right upper eyelid) and **H00.12** (Chalazion, right lower eyelid)	
2	During a routine Health Check physical exam, an 8 year old white female is discovered to be dehydrated. The mother reports the child has had diarrhea for several days. **Z00.121** Encounter for routine child health examination with abnormal findings; **E86.0** Dehydration; **R19.7** Diarrhea, unspecified	
3	4 year old female is experiencing acute pain in both ears. This child has been seen on several occasions for serous otitis media, right ear. Both parents are heavy cigarette smokers. Diagnosis: Acute serous otitis media, left year; Total perforated tympanic membrane due to chronic serous otitis media, right ear. **H65.02** – Acute serous otitis media, left ear; **H65.21** – chronic serous otitis media, right ear; **H72.821** – Total perforation of tympanic membrane, right year; **Z77.22** – Contact with and exposure to environmental tobacco smoke	

Child Health and Health Check Coding Exercises for Course

Use the Coding Steps to Code the following scenarios/diagnoses

#	Scenario/Diagnosis	Answer
4	A 14 year old female is seen in child health clinic for irregular periods. A pregnancy test is given and it is determined patient is pregnant. **N92.6** Irregular menstruation, unspecified; **Z32.01** Encounter for pregnancy test, result positive	
5	6 year old female diagnosed with Erythema multiforme minor due to azithromycin prescribed for recurrent acute suppurative otitis media, both ears. Client has approximately 9 percent body surface exfoliation, primarily on her arms and legs. **L51.9** – Erythema multiforme, unspec (Use Additional Code Note: to identify percentage of skin exfoliation L49.-); **L49.0**-Exfoliation due to erythematous condition involving less than10% body surface; **T36.3x5A** – Adverse effect of macrolides, initial encounter (For adverse effects, code first note: code first the nature of the adverse effect); **H66.003**-Acute suppurative otitis media, without spontaneous rupture of eardrum, recurrent, bilateral	

Child Health and Health Check Coding Exercises for Course

Use the Coding Steps to Code the following scenarios/diagnoses

#	Scenario/Diagnosis	Answer
6	Full term newborn delivered 4 days ago and discharged with no problems. After going home he was jaundiced so the mother brings him to the health department for evaluation. Infant is diagnosed with hyperbilirubinemia and will have phototherapy provided at home. **Z00.110** (Key word, "Newborn", examination, under 8 days old); **P59.9** - Neonatal jaundice, unspecified	
7	2 month old male is seen for initial Child Health examination. He has a cleft palate involving both the soft and hard palate, with bilateral cleft lip. **Z00.121** (Child Health Exam with abnormal findings); **Q37.4** – Cleft hard and soft palate with bilateral cleft lip	
8	12 year old female complaining of painful urination and an urge to urinate frequently. Diagnosis: Acute suppurative cystitis, with hematuria due to E coli. **N30.01** – Cystitis, acute, with hematuria; **B96.20** – E coli as cause of disease	

Child Health and Health Check Coding Exercises for Course

Use the Coding Steps to Code the following scenarios/diagnoses

#	Scenario/Diagnosis	Answer
9	A 9 year old is seen for sore throat and upper respiratory symptoms with an onset 2 days ago. A rapid strep test is negative and an Albuterol nebulizer treatment is given before sending child out via EMS for acute respiratory distress. **J80** Acute respiratory distress syndrome; **J02.9** Acute pharyngitis, unspecified (Includes Sore throat (acute) NOS)	
10	3 year, 8 month old male presents to clinic for ADHD/Behavior issues according to mother; physical exam finds 3cm lymph node below chin—Rx given for Acute Lymphadenitis. Mother states during exam that child has killed multiple small animals and constantly tortures cat. Referral to mental health for Conduct Disorder and possible ADHD; follow up lymphadenitis in 2 weeks **F91.1** Conduct disorder, childhood-onset type (ADHD not coded since this is possible); **L04.0** Acute lymphadenitis of face, head and neck	

Child Health and Health Check Coding Exercises for Course

Use the Coding Steps to Code the following scenarios/diagnoses

#	Scenario/Diagnosis	Answer
11	A 3 yr old male with nutritional deficiency was referred from his primary care physician to receive Medical Nutrition Therapy (MNT) from a Registered Dietitian. The child weighed 1000 grams at birth after 32 weeks gestation. He has fetal alcohol syndrome as the mother suffered from alcohol abuse prior to and during the pregnancy. The mother has been in remission for 1 year. The primary care physician ordered 3 visits with a return visit to his office upon completion of the MNT services. **E63.9** - Nutritional deficiency, unspecified; **Q86.0** Fetal alcohol syndrome (dysmorphic); **P07.14** Other low birth weight newborn, 1000-1249 grams; **P07.35** Preterm newborn, gestational age 32 completed weeks; **Z81.1** Family history of alcohol abuse and dependence.	
12	A 2 year old comes in for WCC and it is discovered that child has pink eye and is treated. WCC rescheduled. **Z00.121** Encounter for routine child health examination with abnormal findings; **H10.029** Other mucopurulent conjunctivitis, unspecified eye (could code more specifically if affected eye(s) had been documented)	

Child Health and Health Check Coding Exercises for Course

Use the Coding Steps to Code the following scenarios/diagnoses

#	Scenario/Diagnosis	Answer
13	A 1 year old Child Health client presents for their annual periodic Child Health visit and receives the following: Bright Futures history, exam, lead level, vision, hearing, developmental screening and is found to have an inner ear infection of the right ear. **Z00.121** – Encounter for routine child health exam with abnormal findings; **H83.91** – Unspecified disease of right inner ear (Infection, ear, inner. Index states see subcategory H83.0 but most appropriate code is under sub-category H83.9 – Unspecified disease of inner ear. Otitis Media is not specified so cannot code to that.) If screenings are part of routine exam, do not code. If not, Z13.5 Encounter for screening for eye and ear disorders; **Z13.4** Encounter for screening for certain developmental disorders in childhood; **Z13.88** Encounter for screening for disorder due to exposure to contaminants	

Child Health and Health Check
Unit 1 ~ Review Questions
True/False

1. Any time a vaccine is administered, Z23 will be used as the diagnosis code

   Answer: True (Covered in Basic training)

2. If a child is delinquent on his/her immunizations, use Status code Z28.3, Underimmunization status

   Answer: True (Z28.3, Underimmunization status includes delinquent or lapsed immunization schedule status. Covered in Basic training)

3. Whenever a Z code is used, a CPT code is not needed

   Answer: False (Z codes will be a diagnostic code but there must also be at least one CPT procedure code (or an LU code)

Child Health and Health Check
Unit 1 ~ Review Questions
True/False

4. Testing of a person to rule out or confirm a suspected diagnosis because the person has some sign or symptom is a screening

   Answer: False (Testing of a person to rule out or confirm a suspected diagnosis because the person has some sign or symptom is a **diagnostic examination**, not a screening. In these cases, the **sign or symptom** is used to explain the reason for the test.

5. Follow up codes are used when treatment for a disease, condition or injury is still ongoing

   Answer: False (Follow up codes are used when treatment for a disease, condition or injury is complete and it may be used to explain multiple visits.)

Child Health and Health Check
Unit 1 ~ Coding Exercises

- **Scenario 1:** *A 7 year old male is seen in clinic for his well child care visit. Mother states his older brother is being treated for ADHD and she thinks this child may have ADHD. Examination findings are normal. The child is delinquent on DTaP, IPV , MMR and VAR immunizations so those were administered.*

  Answer: **Z00.129** Encounter for routine child health examination without abnormal findings. **Z81.8** Family history of other mental and behavioral disorders; **Z28.3** Underimmunization status; **Z23** Encounter for immunization (Note: If there had been documentation that the child was screened for ADHD, could have coded Z13.89, Encounter for screening for other disorder)

- **Scenario 2:** *Medical examination of 4 year old child for admission to preschool*

  Answer: **Z02.0** Encounter for examination for admission to educational institution (ICD-10-CM provides much more specificity for administrative examinations)

Child Health and Health Check
Unit 2 ~ Review Questions
True/False

1. Type 2 Diabetes Mellitus is the default if Type is not documented

   Answer: True

2. Code Z79.4, Long-term (current) use of insulin, is always used for all 5 categories of Diabetes Mellitus

   Answer: False (Do not use for Type 1 Diabetes since use is implied by type; for other 4 categories, only use if client uses insulin long-term)

3. If Obesity is coded, the BMI must always be coded as well

   Answer: True or False (Use additional code, if known. BEST PRACTICE: BMI should be documented and coded)

4. Most codes in Chapter 7, Diseases of the Eye and Adnexa, include anatomic site and/or laterality

   Answer: True

5. A diagnosis of "Otitis Media" will surely be paid by Medicaid, no questions asked

   Answer: False (at a minimum must specify type of otitis media and laterality)

Child Health and Health Check
Unit 2 ~ Coding Exercises

- **Scenario :** *13 year old obese female with secondary diabetes mellitus due to acute idiopathic pancreatitis. She has been on insulin for 3 years and today her blood sugar is 300. Height – 5'0"; Weight – 190 lbs*

Answer: **K85.0** Pancreatitis (in tabular under E08-E13, it says to code first underlying condition); **E08.65** DM due to underlying condition with hyperglycemia; **Z79.4** long term insulin use; E66.9 Obesity, unspecified; BMI Code **Z68.54**

Child Health and Health Check
Unit 2 ~ Coding Exercises

- **Code the following:**
  - *Juvenile absence epilepsy, not intractable, with status epilepticus*

Answer: G40.A01 Juvenile absence epilepsy, not intractable, with status epilepticus

  - *Ear Infection*

Answer: Not enough information to code – need to know the type of ear infection. Even if you assume Otitis Media, the only code you can use is H66.90, Otitis media, unspecified, unspecified ear. However documentation will not support that dx

  - *Acute conjunctivitis, right eye; and chronic conjunctivitis, both eyes*

Answer: H10.31 Unspecified acute conjunctivitis, right eye; H10.403 Unspecified chronic conjunctivitis, bilateral (Documentation needs to be more specific to code to higher level of specificity – e.g., follicular, giant papillary, simple

Child Health and Health Check
Unit 3 – Review Questions
True/False

1. If the clinician suspects influenza but cannot confirm the type, use codes in category J11

   Answer: True

2. Benign and malignant hypertension are the same code – I10

   Answer: True

3. There is not a specific code for acute recurrent sinusitis

   Answer: False (In ICD-9-CM, there was no specific code for acute recurrent sinusitis – a condition I am sure many of you have. In ICD-10-CM, there are multiple codes for this in category J01)

4. Intrinsic asthma and Extrinsic asthma have different codes

   Answer: False (Asthma terminology has been updated to reflect the current clinical classification of asthma. Clinicians no longer have to categorize asthma as intrinsic and extrinsic – they are both coded to J45.909)

Child Health and Health Check
Unit 3 – Review Questions
True/False

5. Laboratory results are required before a clinician can confirm the type of flu

Answer: False (Only confirmed cases of influenza due to identified viruses should be coded from categories J09 and J10. Confirmation does not mean you have to have lab results – the clinician's documentation is sufficient. If the clinician confirms influenza but cannot confirm the type, use codes in category J11)

Child Health and Health Check
Unit 3 ~ Coding Exercises

- **Scenario 1:** *Mother of 8 year old male states he has had a bad cough and diarrhea for two days. Dx: Intestinal flu; Acute URI*

  Answer: A08.4 – Intestinal flu; J06.9 ~ Acute URI

- **Scenario 2:** *5 year old male diagnosed with severe persistent asthma with acute exacerbation*

  Answer: J45.51 Severe persistent asthma with acute exacerbation

Evaluation and Questions

Evaluation Forms are in the ICD-10- CM Specialized Coding Training Workbook and at:

http://publichealth.nc.gov/lhd/icd10/docs/training

Submit Evaluation Forms and Questions to:

Marty.Melvin@dhhs.nc.gov