CHAPTER – 01 CERTAIN INFECTIOUS AND PARASITIC DISEASES (A00-B99)

HIV Guidelines

- As per the guidelines we have two conditions Asymptomatic and Symptomatic (Related illness).

Asymptomatic HIV/Z21	Symptomatic B20
1. HIV 2. HIV +ve 3. +ve HIV 4. Known HIV 5. HIV NOS	1. AIDS 2. Pneumonia 3. Tuberculosis 4. Kaposi's Sarcoma 5. Hemolytic Uremic Syndrome

Guidelines

1. We should code symptomatic HIV or Asymptomatic HIV only when its confirmed by physician(doctor).
2. Symptomatic HIV B20 and Asymptomatic HIV Z21 never be coded together as it falls under Exclude 1 rule.

Examples for HIV unrelated illness

1. Fractures**.**
2. Dislocations.
3. Lacerations.
4. Sprains.
5. Contusions.
6. Abrasions**.**
7. Burns etc……

Examples for HIV Related illness

1. Pneumonia**.**
2. Shingles.
3. Tuberculosis.
4. Kaposi's Sarcoma etc……..

Asymptomatic HIV Unrelated illness	**Symptomatic B20 Related illness**
PDx ⇨ Unrelated illness. SDx ⇨ Secondary illness. SDx ⇨ B20/Z21	Pdx ⇨ B20 SDx ⇨ Related illness **Exception:** Hemolytic uronic syndrome.

PDx = Primary diagnosis

SDx = Secondary Diagnosis

For example,

Case 1. If the patient is coming to the hospital with HIV unrelated illness we should code unrelated illness as (PDx) Primary Diagnosis and **B20/Z21** as (SDx) Secondary Diagnosis according to documentary.

Case 2. If the HIV patient is coming to the hospital with HIV related illness such as pneumonia, Tubercolosis, karposis sarcoma, we should code B20 as Pdx and related illness should be coded as Sdx. Only the exception we should code Hemolytic uronic syndrome as Pdx and B20 as Sdx

If the patient HIV test is inconclusive we should code **R75**.

HIV IN PREGNANCY

- Weeks of Gestations or Trimesters are calculated as
  1. **1 to < 14 Weeks**
  2. **14 to < 28 Weeks**
  3. **28 to < Till the birth**
- If the pregnancy patient is suffering from HIV we should code **O98.7 series** as pdx **Z21/B20** and followed by weeks of gestations as sdx.

We can code **1.O98.7 Series**
2.B20/Z21
3.Weeks of gestations.

- Once we code B20 for a HIV patient we should always code B20 for the further visits.

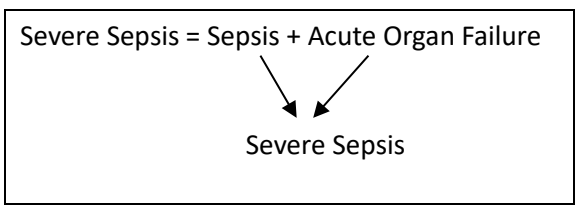
Sepsis Guidelines

Sepsis

- Septicaemia or Sepsis is a infection of blood. • The code for the unspecified sepsis is **A41.9**.

Severe Sepsis

- If a patient is suffering from sepsis with Acute organ failure we will consider as severe sepsis. It requires minimum of **two codes.**
- In case of Severe Sepsis the primary code should Sepsis **A41.9** is pdx, Severe Sepsis **R65.20** and acute organ failure if documented.



Septic Shock

- If the patient is suffering from Sepsis with circulatory failure we will consider it Septic Shock. To code Septic Shock we require minimum of two codes.
- In case of Septic Shock Sepsis is pdx and Septic Shock **R65.21,** acute organ failure are sdx if documented.

Conditions

Sepsis	**Severe Sepsis**	**Septic Shock**
1. A41.9	1. Sepsis (A41.9) 2. Severe Sepsis (R65.20) 3. Acute organ failure if documented	1.Sepsis (A41.9) 2.Septic Shock (R55.21) 3.Acute organ failure if documented.

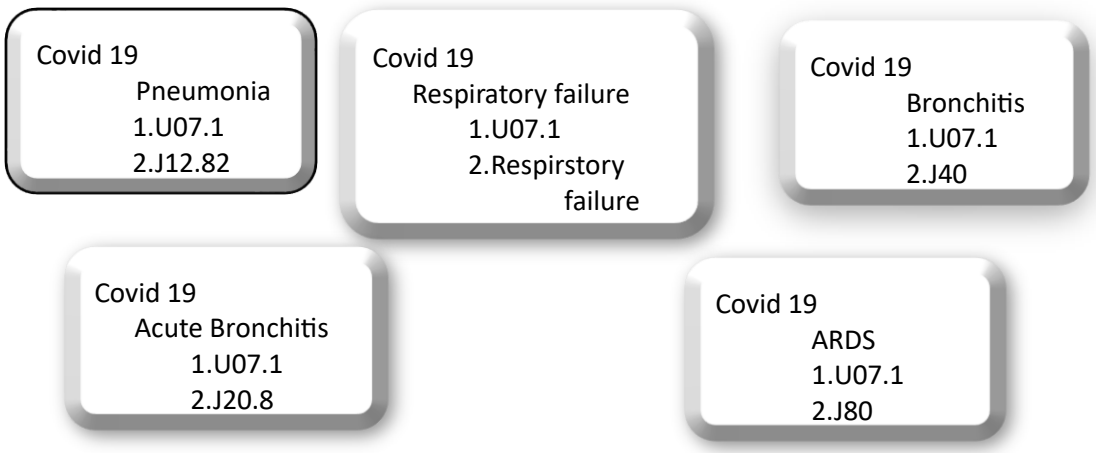
We should not code circulatory disfunction code for **septic shock**

Sepsis due to non-infectious process

If the patient is suffering from Sepsis or Severe Sepsis or Septic Shock due to non-infectious process such as Laceration, burns, open wounds then non-infectious process as pdx. We will follow rest of the sequence as normal.

Covid 19

- The code for the covid 19 is **U07.1**.
- Covid can cause some manifestations such as pneumonia, Respiratory failure, Lower Respiratory infection, Bronchitis, Acute Bronchitis, ARDS(Acute respiratory distress syndrome).
- If the patient is suffering from Covid 19 manifestation we should code U07.1 as pdx and Covid manifestation as sdx.



- If the patient is coming to hospital with covid symptoms and physician confirmed it as Covid19, we will code only for covid19.
- If the patient is suffering from covid19 symptoms and he is suspect of covid19 and tested negative we should code symptoms as pdx and exposure to covid 19 (Z20.822).

Covid History

- If the patient is suffering from covid symptoms and his tested negative and the patient have the history of covid we will code symptoms as primary suspect of covid **(Z20.822)** and history of covid19**(Z86.16)** are secondary**.**

Covid Vaccination status

Z28.310 - Unvaccinated covid19.
Z28.31 - Partially vaccinated covid 19.
Z28.39 - Other under immunization status.

CHAPTER-02 NEOPLASMS (C00-D49)

NEOPLASM

- An abnormal growth of cells is called Neoplasm.
- There are 5 types of Neoplasm.

1.Benign.
2. Malignant.
   a) Primary mallignency.
   b) Secondary malignancy.
3.Carcinoma insitu.
4.Uncertain behaviour.
5.Unspecified behaviour.

1.Benign

- Benign Neoplasm doesn't spread to other body parts.
- Benign Neoplasm are not harmful.

2.Malignant

- Malignant Neoplasm can spread one body to another body part.
- Malignant Neoplasm are very harmful in nature.

Example: -

i)

Lung cancer **Liver**
(Primary (Secondary malignancy) malignancy)

II)

- From Primary malignancy of left kidney to secondary malignancy of brain.

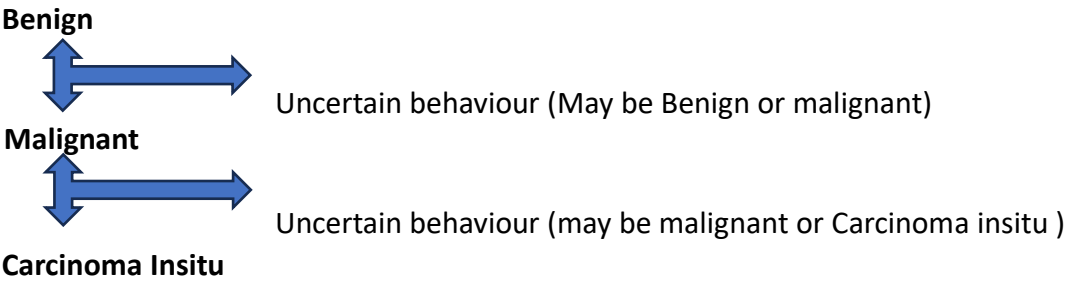
3) Carcinoma insitu

- Carcinoma insitu neoplasm can be spread only to the particular body part or the closest organs.
- Carcinoma insitu also harmful in nature.

4) Uncertain Behaviour

- If the patient is suffering from a Neoplasm and Physician is unable to identify the nature of Neoplasm will be consider as uncertain behaviour.

Ex)



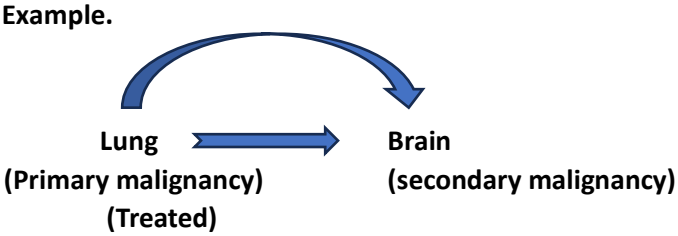
5) Unspecified Behaviour

- If the physician didn't specified anything about the type of Neoplasm then we consider it as a **unspecified behaviour**

Guidelines Of Neoplasm

1) If the patient is suffering from primary malignancy and secondary malignancy and there is no treatment mentioned we can code **primary malignancy as pdx** and **secondary malignancy as sdx.**

Example.



then as per guideline. **Pdx** primary malignancy of lung.

SDX secondary malignancy of Brain.

2) If the patient is suffering from primary malignancy and secondary malignancy but the treatment is provided for secondary malignancy we should code **secondary malignancy as pdx** and **Primary malignancy as sdx**. **Example:**

Lung **Brain**

(Primary malignancy) **(secondary malignancy)**

(Treated)

Here brain get treated then as per guideline.
Pdx is secondary malignancy of brain.
Sdx is primary malignancy of lung.

3) If the patient is suffering from primary malignancy and secondary malignancy but the treatment is provided for Primary malignancy we should code **Primary malignancy as pdx** and **secondary malignancy as sdx**.

Example:

Lung **Brain**

(Primary malignancy) **(secondary malignancy)**

(Treated)

Here brain get treated then as per guideline.
Pdx is secondary malignancy of Lung.
Sdx is primary malignancy of Brain.

Dehydration of Neoplasm

- If the patient is suffering from dehydration due to Neoplasm and the patient is treated for Dehydration as pdx and Neoplasm as sdx

Pdx ⟹ Dehydration.
Sdx ⟹ Neoplasm.

Anaemia in Neoplasm

- If the patient is suffering from anaemia due to Neoplasm and patient is treated for anaemia, we should code Neoplasm as PDx and Anaemia in Neoplasm Sdx.

Pdx ⟹ Neoplasm.
Sdx ⟹ Anaemia in Neoplasm.

Anaemia due to Chemotherapy or Radiotherapy or Immunotherapy

- If the patient is suffering from Anaemia due to Chemotherapy or Radiotherapy or immunotherapy we should code Anaemia as pdx and adverse effect of chemotherapy or radiotherapy or immunotherapy.

Pdx ⟹ Anaemia.
Sdx ⟹ T45.1×5 Series.
Neoplasm.

Patient encounter for Chemotherapy or Radiotherapy or Immunotherapy

- The patient is coming to the hospital only for the Chemotherapy or Radiotherapy or Immunotherapy then we should code pdx from **Z51.0 or Z51.11 Series** and Neoplasm as sdx

Pdx ⟹ Z51.0 or Z51.11 Series.
Sdx ⟹ Neoplasm.

Z51.0 = Encounter for antineoplastic Radiotherapy.
Z51.11 = Encounter for antineoplastic Chemotherapy.
Z51.12 = Encounter for antineoplastic Immunotherapy.

- If the physician didn't specified the site of cancer or the site of malignant Neoplasm we should code **C80.1**

Present or current or Active Neoplasm	**History of Neoplasm (Z85) series**
Ex) 1)Mastectomy + Active treatment Or Active Medication 2) Malignant >>> **C Series** 3) Benign and Uncertain and Unspecified >>> **D Series**	1)**No Active Treatment** 2)**NAD** – No Active disease 3)**NED** – NO Evidence Disease

- If the patient is suffering from any type of Neoplasm and the physician perform excision and if the patient is on active medication, we will consider still that Neoplasm is present or active Neoplasm or current Neoplasm.
- If the malignant Neoplasm is already excised and the patient is not on active medication and physician says No Active Treatment or NAD (No Active Disease) or NED (No Evidence Disease) we will consider as history Neoplasm.

CHAPTER 3

DISEASES OF BLOOD/BLOOD-FORMING ORGANS& DISORDERS(D50-D89)

NO GUIDLINES

CHAPTER – 04 ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASE (E00-E89)

PRE-DIABETES:-

A temporary increase of blood sugar levels before the diabetes called PREDIABETES.

HYPERGLYCEMIA:-

Elevated sugar levels in blood is called Hyperglycemia.

DIABETES:-

A constant increase in blood sugar levels which requires of treatment is called diabetes.

TYPES OF DIABETES MILLTEUS

1)TYPE-01 (E10) Series :-

Diabetes occurs in children before the Puberty Juvenile insulin also called Insulin Dependent Diabetes Mellitus (IDDM).

2) **TYPE - 02 (E11) Series: -** Diabetes occurs in adults Non-Insulin Dependent Diabetes Mellitus(NIDM).

3) **GESTATIONAL DIABETES: - (O Series)** Diabetes which occurs during pregnancy period.

4) SECONDARY DIABETES:-

a) **DIABETES DUE TO CONDITIONS/PROBLEMS/DISEASE (E08 series).**
Ex) Pancreatitis, Pancreatic Cancer, Cystic Fibrosis etc…

b) **DIABETES DUE TO DRUGS AND CHEMICALS (E09 series). Ex)** Induced drug with ketoacidosis, Induced drug with CKD.

c) **DIABETES WITH PROCEDURES (E13 series).**

GUIDELINES:

1) If the physician didn't specify type 1 or type 2 DM we should code Type 2 as default.
2) If the patient is suffering from DM and the patient is on long-term use of insulin, we should code DM as primary and long-term use of insulin **(Z79.4)** as secondary.

DM + Long-term use of insulin
PDX → DM
SDX → Z79.4

3) We shouldn't code long-term use of insulin of insulin is given for temporary treatment or solution **Z79.4** shouldn't coded along with Type 1 DM.
4) If the patient is suffering from diabetes millets and the patient is on long term use of insulin injectables and oral hypoglycemic drugs we should code Diabetes Mellitus () as PDX and Complications as SDX.

PDX → Diabetes Millitus (DM)
SDX → Z79.4
Z79.85
Z79.84

Insulin Pump Malfunction/Complication

Under Dosing	Over Dosing
1) T85.6 Series. **2)** Underdosing of insulin **T38.3X6_.** **3)** Type of DM. **4)** Complications.	**1) T85.6 Series.** **2)** Overdosing. **T38.3X1_**

5) Diabetes Millitus due to conditions,

Secondary DM Due to Conditions

If the patient is suffering from DM due to conditions such as pancreatitis, pancreatic cancer, Cystic fibrosis, we should code condition should be PDX and secondary DM as SDX from **E08 series.**

Secondary conditions due to DM

PDX ⇨ Condition.

SDX ⇨ **E08 Series** DM

6) Secondary DM due to Pancreatectomy.

If the patient is suffering from DM due to pancreatectomy the primary code should be **E89.1** the code from the **E13 series** and **Z90.41** should be secondary diagnosis.

Secondary DM due to Pancreatectomy.

PDX ⇨ **E89.1 (**Low insulin due to procedures**)**

SDX ⇨ **E13 series**

Z90.410 (Acquired total absence of pancreas**)**

CHAPTER - 05

MENTAL, BEHAVIOURAL AND NEURODEVELOPMENTAL DISORDER(FO1-F99)

In this chapter we are going to discuses about the mainly on **1)Use 2)Abuse 3)Dependence 04) In Remission 05) Relapse and 6) Dementia with severity**

1)Use: If the patient is using required amount of drug or tobacco or alcohol is called **Use**. Ex)

F10.90 Alcohol use, unspecified, uncomplicated.

F14.90 cocaine use, unspecified, uncomplicated

2)Abuse: If the patient is using the more amount of drug, then required is called **Abuse** EX)

F10.10 Alcohol abuse, uncomplicated.

F14.10 Cocaine abuse, uncomplicated

3)Dependence: if the patient is unable to survive without taking the drug or tobacco or alcohol is called **Dependence.**

EX) **F10.20** Alcohol dependence, uncomplicated.

F14.20 Cocaine dependence, uncomplicated.

Guidelines:

i)If the Physician documented both **Use** and **Abuse**, we should code only code for **Abuse. ii)** If the Physician documented both **Abuse** and **Dependence** we should code only code for **Dependence.** iii) If the Physician documented **Dependence** and **Use**, we should code only code for **Dependence.**

iv) If the physician is documented **Use, Abuse,** and **Dependence** we should only code **Dependence.**

4) In Remission

If the patient is suffering from a particular disease and the patient is not suffering from any symptoms and sings related to disease is called **In Remission.**

Ex) F10.12 Alcohol abuse, in remission.

F15.11 other stimulant abuse, in remission.

5)Relapse

If the patient is suffering from any inactive disease and disease is suddenly active and becomes the severe situation is called Relapse.

6) Dementia

It is a neurological disorder which is characterized by the loss of memory and judgement.

To code Dementia we must check type of dementia and severity of dementia.

Types of dementia

F01 Vascular dementia (Vascular dementia is caused by infraction of the brain due to vascular disease)
Ex) Cerebro Vascular Disease

F02 Dementia in other disease (Dementia caused by due to other diseases)
For this we should code disease as **pdx** Dementia in other disease as **sdx** Ex)
Dementia caused by Alzheimer's Disease.
Pdx - G30- Alzheimer's Disease
Sdx - F02.80 Dementia in other disease.

F03 Unspecified Dementia
Physician won't specified type of dementia Ex)
F03.90

Severity

1)Mild
Ex) F01.A0 Vascular dementia Mild

2)Moderate
Ex) F01.B11 Vascular dementia moderate.

3)Severe
Ex) F01.C0 Vascular dementia severe.

CHAPTER 06 DISEASES OF THE NERVOUS SYSTEM (G00-G99)

Paralysis

Disfunction of body parts neurologically is called Paralysis or Plegia.
Paralysis caused by brain stroke, Cerebro Vascular Accident CVA.
Cerebral Infarction means death of the Cerebral tissue.

Paralysis are four types

1) **Monoplegia:** only single limb gets effected.
   Ex) G83.10 Monoplegia of lower limb affecting unspecified side.
2) **Paraplegia**: two limbs get effected upper limbs or lower limbs.
   Ex) G82.20 Paraplegia unspecified.
3) **Hemiplegia**: only half side gets paralysed either left side or right side.
   Ex) G81.90 Hemiplegia unspecified affecting unspecified side.
4) **Quadriplegia**: total 4 limbs paralyses.

Ex) G82.50 Quadriplegia unspecified.

Dominant and non-dominant sides

Dominate: If the patient is affected with right-handed side and patient is also a right hand got effected is called dominate.

Non – Dominant sides: If the patient is affected to left hand and patient is right-handed then it is called Non – Dominant

Active side	**Effected side**	**Type of dominant**
1) Right-handed side	Left hand	**Left non-dominate**
2) Right hand side	Right hand	**Right Dominate**
3) left-handed side	Right hand	**Right Non – Dominant**
4) left hand	Left hand	**Left dominate**

Ambidextrous

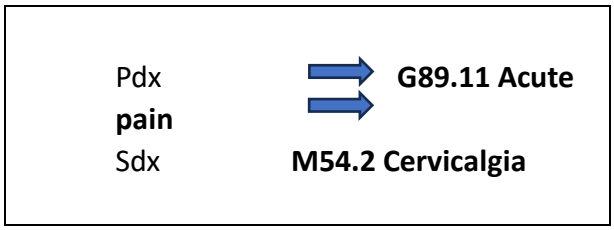
Patient is having the ability to do the works with the both the limbs is called ambidextrous if he affected with any one falls under dominates.

Guidelines:

If the physician didn't specify whether the patient is right-handed or left-handed, we can take right-handed as default.

Pain Catagories

I)if the patient is coming to the hospital especially for the pain control or pain management we should code from pain categories.
II) If the patient is coming to the hospital for the management of acute pain control due to trauma.



Chronic Pain management

If the patient is suffering from chronic pain, patient admitted in the hospital for management of chronic pain we should code chronic pain as pdx (**G89.29**) and site of pain as Sdx.

Ex)
PDX - **G89.29** other chronic pain
SDX - **M54.9** Dorsalgia, unspecified

Pain Related to Neoplasm

If the patient is suffering from pain due to neoplasm, we should code PDX
- G89.3 Neoplasm related pain.
SDX – Type of neoplasm may be Benign, Malignant etc… **G89.4**
Chronic pain syndrome.

CHAPTER 7 DISEASES OF THE EYE AND ADNEXA (H00-H59)

1.GLAUCOMA: -Damage of Optic nerve

PDX- Type of glaucoma
SDX- Severity {i.e mild, moderate, severe}
When the Patient has glaucoma same type and same severity for both eyes.
Example:
i) Same type + same severity + Both Eyes **ONLY ONE CODE.**
ii) Different type +Same severity + both Eyes **TWO CODES**.
PDX - Right Eye
SDX - left Eye iii) Same type + Different Severity+ Both eyes TWO CODES
PDX - Highest severity SDX - Lowest severity iv.) When the patient is admitted with one stage of glaucoma and during the stayA if it develops to another stage we will code the highest severity of glaucoma because it is an irreversible process.

CHAPTER 8

DISEASES OF EAR AND MASTOID PROCESS (H60-H59)

CHAPTER 09
HYPERTENSION

Elevated B.P or white code syndrome.

A temperature increase in blood pressure is called **Elevated B.P**.

Hypertension

A constant increase of blood pressure which requires treatment is called **Hypertension (I10)**.

Hypertension

Heart disease
Heart Failure

chronic kidney disease(CKD)
Stages of CKD
CKD unspecified N18.9
CKD Stage **1 N18.1**
CKD stage **2 N18.2**
CKD stage **3 N18.30**
3a N18.31
3b N18.32
CKD stage **4 N18.4** CKD stage **5 (without hydrolysis) N18.5 ESRD stage 6 (End Stage of Renal Disease) N18.6**

Hypertension	**Hypertension with Heart disease**	**Hypertension with Heart failure**	**Hypertension with CKD**	**Hypertension with Heart failure and CKD**
1.**I10**	**Primary** 1. **I11.9 series** 2. No need to code heart disease separately	**Primary** 1. **I11.0** **Secondary** 2. Type of heart failure.	**Primary** 1. **I12.9 or I12.0 Series** **Secondary** 2. Stages of CKD	**Primary** 1. **I13 series** **Secondary** 2. Heart failure 3. CKD

GUIDELINES

1. We shouldn't code elevated BP Hypertension together because elevated bp is a symptom of Hypertension**(I10)**.
2. If the patient is suffering from hypertension and heart disease, we should code **I11.9** no need to code heart disease additionally because heart disease is included in hypertension.
3. If the patient is suffering from hypertension with heart failure we should code **I11.0** as primary or PDX and type of heart failure as secondary SDX.
4. If the patient is suffering from hypertension with CKD we should code **I12 series** as primary and stage of CKD as secondary.
5. If the patient is suffering from heart failure and CKD we should code **I13 series** as primary and stage of CKD and type of heart failure as secondary.
6. If the patient is suffering from hypertension and **Hypertensive urgency,** we should code **(I16.0) Hypertensive urgency** as primary and **(I10)** Hypertension as secondary.

MYOCARDIAL INFRACTION (MI)

- MI means Myocardial infraction which is death of the heart muscle due to lack of supply of oxygen and nutrients to the heart muscle.
- There are 2 types of walls. .
    1. **Anterior wall.**
    2. **Inferior wall.**

- Two types of MI ⇨ the time frame of MI is 4weeks or 28 days.
    1. Initial MI.
    2. Subsequent MI.

4weeks or 28days
Ex) 17/12/22 Anterior valve (Initial MI) 22/12/22 Lateral valve (Subsequent MI)

Examples

Patient had ST elevated myocardial infraction involving anterior left main coronary artery in 1st day after 15 days he came with ST elevated myocardial infraction in inferior.

CHAPTER-10 DISEASES OF THE RESPIRATORY SYSTEM (J00-J99)

ACUTE EXACERBATION:-

A suddenly patient showing Acute symptoms for chronic condition.
ACUTE EXACERBATION OF COPD AND ASTHAMA.
J44. 1 – COPD with acute exacerbation.
J45. 901 – unspecified asthama with acute exacerbation.

ACUTE AND CHRONIC CONDITIONS:

1.We should code first for acute conditions the secondary we should code chronic conditions.

2) If both acute and chronic conditions mentioned in the document we should code Acute as pdx and chronic as sdx.

e.g:- **PDX-N17.9** Acute Kidney failure
SDX-N18.9 Chronic Kidney failure

3) If combination code is present for both acute and chronic we should code combination code only.
Ex: J96. 22 – acute and chronic respiratory failure with hypercapnia.

ACUTE RESPIRATORY FAILURE :

1) Acute respiratory failure as primary diagnosis:
   - acute respiratory failure code should be primary when the patient admitted to the hospital with respiratory failure confirms by physician.
   Excpetions are : pregnency codes, hiv, new born.

2)Respiratory failure coded as secondary diagnosis.

If the patient has develop respiratory failure after the admission establishment of different admitting diagnosis e.g:- **PDX** - Heart failure

SDX - after 5days respiratory failure

4)VAP-ventilator Associated pneumonia.

J95.851 – ventilator-VAP associated pneumonia

IF physician documented patient with VAP we should code VAP code as pdx and type of organism as sdx.

Pdx : J95. 851

Sdx : B95 -. B96-.B97- series

If the patient is admitted in the hospital with pneumonia physician has provided ventilator management in this case we should not code VAP CODE .
Code for pneumonia only.

- we should not code pneumonia code J12-J18 with **J95.851(VAP)** .

6) When to code pneumonia and VAP

Pneumonia - ventilator-VAP

When the patient admitted in the hospital for pneumonia and physician has supported with ventilator after few days of ventilator fixation patient developed VAP in these case

PDX – pneumonia

SDX – VAP

7.Vaping related disorder:

PDX - U07.0

Manifestations

Sdx – acute Respiratory failure. (J96. 0)

Or pneumonitis J68. 0

CHAPTER 11 DISEASES OF DIGESTIVE SYSTEM (K00-K95)

NO GUIDELINES IN THIS CHAPTER

CHAPTER – 12 DISEASES OF SKIN AND SUBCUTANEOUS TISSUE (L00 – L99)

ULCERS :

Injury/ damage of the the skin.

Ulcers are 2 types

-Pressure ulcers(decubitus ulcers)

-Non pressure ulcers

1)Pressure ulcers:

a. injury of the skin or underlying tissues due to prolonged pressure due to lack of blood supply.

-**TO CODE PRESSURE ULCERS** we need to see.

PDX - Anatomical SITE OF PRESSURE ulcers

SDX - Severity of Pressure ulcers**.**

- **Unspecified stage**
- **Stage1**
- **Stage 2**
- **Stage3**
- **Stage 4**
- **Unstageable.**
- **Example: L89. 154** Sacral pressure ulcer stage 4

2) L89.142 - pressure ulcer of left lower back STAGE 2

L89.602 - Heel pressure ulcers stage -2

3)If the patient is admitted in the hospital with **HEALED pressure ulcers** no need to code

4) We should code **HEELING** pressure ulcers**.**

Patient admitted with one specific stage of ulcers and discharge with different stage of pressure ulcers we can code both stage of pressure ulcers **i.e.** at the admission and at discharge time.

Ex) Patient came to hospital with stage 4 pressure ulcer of left ankle then he discharged with stage 1 pressure ulcer. **PDX : L89. 524 Sdx : L89. 521.**

5)How to code non-pressure ulcers

Same guidelines are applied for Non-pressure ulcers.

CHAPTER-13

DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE (M00-M99)

GUIDELINES

Sides and laterality: -

Whenever we are coding conditions from Musculoskeletal system we should check for laterality.

Bi-lateral side = Both Sides
Laterality = sides
RT = Right Side
LT = Left Side Bones

= Osteo.
Joints = Arthro.
Tendon = The connective tissue which connects bone to muscle.
Ligaments = The Connective tissue which connects bone to bone.

TYPES OF FRACTURES

1)Traumatic Fracture: Fracture due to external causes of injuries.
Ex) Due to accidents.
S72.92 Unspecified fracture of left femur.

2) Pathological Fracture: Fractures due to Diseases.
Ex) Osteoporosis (Bone density and mass decrease), Bone Cancer, and other cancers.
M84.052 Age-related osteoporosis with current pathological fracture left femur.
If the physician is doesn't mention Pathological or Traumatic fracture then we should Code default as Traumatic fracture.

A) A 60yrs old female patient came with left femur fracture we should code **S72.92**.

3) Closed fracture: - The fracture that occurs inside the skin is called closed fracture.
Ex) S72.92XA Unspecified closed fracture of left femur

4) Open fracture: - The bone exposed to external environment is called Open Fracture.
EX) S72.92XB unspecified fracture of left femur.

If the physician is doen't mention open or closed fracture then we should code default as closed fracture.

a)A 30year old male patient came with accident he has fracture on right femur.
S72.91XA unspecified fracture of right femur.
5)Displaced fracture:- The bone moves from its original position or displaced from normal position.
Ex) S72.041A Displaced fracture of base of the neck of the right femur.

6) Non-displaced fracture: - In non-displaced fracture bone won't move from its original position
Ex) S72.044A non-displaced fracture of base of neck of the right femur.

If the physician is not mentioned fracture is displaced or non-displaced, we should code default as Displaced fracture.

a) A 42 years old female patient is came to the hospital with the fracture of base of the neck of the right femur.
S72.041A

CHAPTER-14
DISEASES OF GENETOURINARY SYSTEM (N00-N19)

CKD= Chronic Kidney Disease

Stages of CKD (N18)

N18.9 - CKD unspecified stage.
N18.1 - CKD Stage **1**
N18.2 – CKD Stage **2 (Mild)**
N18.3 – CKD Stage **3 (Moderate) N18.30**
CKD Stage 3 Unspecified
N18.31 CKD Stage **3a**
N18.32 CKD Stage **3b**
N18.4 – CKD Stage 4 **(Severe)**
N18.5 – CKD Stage 5
If the CKD stage 5 patient undergoes chronic dialysis he will be consider as ESRD patient.
N18.6 – (ESRD) End Stage Renal Disease
It is a chronic disease which requires Chronic Dialysis.

The removal of native kidney and transplantation of other kidney is called kidney transplantation.

EX)
If the patient is suffering from CKD the physician performs the kidney transplantation if the transplanted kidney can't work properly in this case we can code CKD we should not code complication of transplanted kidney.

If the complications occurred for kidney transplantation like rejection, failure, infection, we can code from **T86.1 Complications of kidney transplantation.**

CHAPTER 15 PREGNANCY, CHILDBIRTH AND THE PUPERPERIUM (O00 – O9A)

1) If the pregnant women come to hospital without any complication, then we should code **Z series** codes.
Ex) **Z34.90** encounter for supervision of normal pregnancy unspecified, unspecified trimester.

2) If the pregnant women come to the hospital with in complication of pregnancy or risks of the pregnancy we should code from **O series.**
Ex) O00.90 Unspecified ectopic pregnancy without intrauterine pregnancy.

Super vision of high-risk pregnancy (O09)

If the pregnant patient falls under high-risk pregnancy, we should code the codes from O09 series.
Ex) **O09.01** super vision of pregnancy with history of infertility 1st trimester

Delivery

If the pregnant patient delivery a baby without any complications we should code **O80** as primary code and **Z37 series** as Secondary code for outcome of delivery.

Pdx = O80
Sdx = Z37 series

Counting weeks of Gestation

We should calculate or count weeks of gestations only with completed weeks when we are coding weeks of gestations or trimester, we consider the weeks of gestations when the complicated stated.
Ex) Patient is suffering from pre-existing hypertension in 12 weeks pregnancy.
O10.911 Unspecified pre-existing hypertension complicating pregnancy 1st trimester.
Z3A.12 twelve weeks gestation of pregnancy**.**

There are 3 trimesters in pregnancy. They are

1st trimester.
2nd trimester.
3rd trimester.

Weeks of Gestations

1 < 14 weeks 1st trimester
14 < 28 weeks 2nd trimester
28 < till delivery 3rd trimester

Ex) Z3A weeks of gestations

New born = 0 - 28days
Infant = 29days to 2years
Child = 2years to 18 years

Adult = above 18years

Antepartum = before delivery.
Post partum = After delivery to 6 weeks.
Peripartum = Around delivery
Before 1 month delivery to after 6 months of delivery.

Guidelines

1) We should code **O codes** in maternal records only we shouldn't code maternal codes and **fetal codes** in single record.
2) We should always check for trimester if the trimester are not documented we should take unspecified trimester.
   Ex) O10.411 Pre-existing secondary hypertension complicating, pregnancy, First trimester.
3) If the patient is admitted in the hospital at 1st trimester and discharge at 2nd trimester in this case we should code weeks of gestation or trimester from the patient joined into the hospital.
   Ex) A 40year old female patient came to the hospital with the anaemia complicating pregnancy, 1st trimester and she discharged in 2nd trimester in this case we should code **O99.011** Anaemia complicating pregnancy 1st trimester.
4) Whenever we are coding pregnancy-related conditions, we should check for whether the condition is pre-existing condition or is It gestational condition.
   Ex) O10.912 Pre-existing hypertension.
   Use additional codes from I15 to identify type of secondary hypertension.
   O24.119 Pre-existing diabetes.
   Use additional code for type of diabetes
5) **Gestational conditions:** Conditions that occur during the pregnancy.
   Ex) 1**. HIV in pregnancy**
   PDX – Pregnancy
   SDX – HIV.

   2. Diabetes Mellitus in pregnancy
   We should not code additionally.
   Z79.4 – Long term use of insulin**.**
   279.85 – not insulin injectable
   279.84 – Oral Hypoglycaemia**.**

   3.Sepsis in pregnancy 098.81
   Severe sepsis
   PDX – 098.81(sepsis in Pregnancy **)**
   SDX – R65.20 (severe sepsis**)**
   Followed by acute organ failure
   Weeks of gestations.
   4.Septic shock in pregnancy
   PDX – 098.81
   SDX – R65.22(severe sepsis**)**

Followed by acute organ failure

Weeks of gestations.

5.Severe sepsis in Puerperal

PDX – 085 (Puerperal**)**

SDX – R65.20 (Severe sepsis**)**

Followed by Acute organ failure

6. Alcohol in pregnancy

PDX – 099.31(Alcohol in pregnancy**)**

SDX – F10 (Alcohol use, abuse, dependence**)**

7. Tobacco in Pregnancy

PDX – 099.33 (Tobacco in pregnancy**) SDX** -

F13 (Tabacco use, abuse, dependence**)**

8. poisoning, Adverse effect, toxic, injury

PDX – O9A.2

SDX - poisoning, adverse effect, toxic, injury

Pregnancy Associated with Cardiomyopathy O90.3

CHAPTER 16

CERTAIN CONDITION ORGINATING IN PARINATEL PERIOD (P00 – P96)

- Perinatal period means a time period of new born babies upto 28days.
  New born = 28days
  Infant = 29days – 2years.
- The **O series** codes are used in maternal records
- The **P series** codes are used in baby records.
- We should not **c**ode **P series** codes in maternal records.
- For delivery of new born we will code Z38 series codes according to the type of delivery in place of delivery.

  Ex) Z38.0 single live born infant born in hospital **Z38.1**
  single live born infant born out side the hospital.
  Z38.2 Single live born infant unspecified as to place of birth.

Examples:

1) **P36.9** Bacterial sepsis of new born unspecified.
2) **P36.9** Sever sepsis new born **R65.20**
3) **ARDS** in new born **P22.9**
4) Respiratory failure of new born **P28.5**

5) Covid 19 in new born **P35.8**
PDX – **P35.8 SDX – U07.1**

6) New born vomiting **P92.09**

7) New born brady cardia **P29.12 8)** New born Jaundice **P59.29**

9) Low birth weight and pre maturity.

Whenever the baby delivered without completion of gestational age we will code the codes from **P07 Category.**
Ex) P07.00 extremely low birth weight ,unspecified weight.

P07.01 Extremely low birth weight new born 500 – 749grams

P07.20 Extremely immaturity of new born unspecified weeks of gestations

P07.21 extreme immaturity new born gestational age less then 23 completed weeks.

10. After the birth of the baby, baby underwent observation we should code status of observation **Z05 codes**.

CHAPTER 17 CONGENITAL MALFORMATION, DEFORMATIONS, AND CHROMOSOMAL OBNORMALITIES (Q00-Q99)

NO GUIDELINES FROM THIS CHAPTER

- Codes from this chapter may be used through the life of the patient.
- If a congenital malformation or deformity has been corrected, a personal history code should be used to identify the history of Malformation.

CHAPTER 18

SIGNS AND SYMPTOMS AND ABNORMAL CLINICAL AND LABORATORY FINDINGS (R00-R19)

1. If the patient is coming to the hospital with symptoms and patient doesn't have any other problems or diseases we will code only symptoms. **Ex) R50.9** fever.

2. if the patient is admitted in the hospital with symptoms and physician diagnoses it is due to specific disease, we should code only for confirmed diagnosis we shouldn't code symptoms.

   Ex) A 30 year old male patient came with the right lower abdominal pain and vomiting and the physician diagnosed it is due to Appendicitis in this, we should code only for Appendicitis.

Repeated falls R29.6

If the patient is suffering from repeated falls and he as a history of falling we should code **pdx R29.6** as repeated falls **sdx as Z91.81** history of fall.

COMA R40.20

A period of prolonged unconsciousness brought on illness or injury. R40.20 unspecified coma.

To code coma we should see.

i)type of response

ii) coma scale

Ex) R40.211 Coma scale eyes open never Coma score is 1.

R40.212 Coma scale eyes open, to pain Coma score 2

R40.223 Coma scale best verbal response in appropriate words coma score 3

SIRS (SYSTAMIC INFLAMATION RESPONSE SYNDROME).

without the inflammation is called **SIRS.**

pdx ⇒	**problem sdx**
SIRS ⇒	

Suffering with fever due to **SIRS.**

PDX ⇒	**R50.9**
SDX ⇒	**R65.10**

Death

If the cause of death is unknown we should code **R99.**

Brain Stroke

Caused due to Cerebral infraction or cerebro vascular accident due to blood clot in brain blood vessels.

NIHSS (National Institutes of Health Strokes Scale**)** gives the scores for the strokes **(R29.7)**

PDX I63.9 Cerebral infraction unspecified

SDX R29.7 NIHSS Stroke Scale

CHAPTER – 19 INJURY, POISONING, AND CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES (S00-T88)

Types of injuries

1. Fractures
2. Dislocations
3. Lacerations
4. Sprains
5. Contusions
6. Abrasions
7. Burns **(T Series)**

Ex) i) Head injury **S09.90XA ii)** Laceration of left hand **S61.412A**

- Always we should code highest degree of severity in injuries.

- If the patient having the fraction on right hand and laceration on lest hand we must code fracture on right hand as PDX and left one is SDX.

To code Injury.

1. **Type of injury**
2. **External cause of injury (X W)**
3. **Place of Occurrence (Y)**
4. **Activity (Y)**

Ex) i) weight ligting **Y93.F2 ii)**
Cutting vegetables **Y93.G3 iii)**
Fall from chair **W07.XXXA iv)**
Fall from ladder **W11.XXXA**.

Adverse Effect

- If any unwanted effect is caused by correctly prescribed medicine or medication and correctly administer as per prescription is called adverse effect.
- In case of adverse effect the problem should be coded as PDX and adverse affect of drug is **(T series)** SDX.

PDX	⇨ Problem
SDX	⇨ Adverse effect drug (T Code)

POISONING T SERIES

- If any effect is caused by over dosage or taking wrong medication or wrong dosage from other than the prescribed instruction, we call it as poisoning**.**
- **In case of poisoning, poisoning as a primary code and problem code should secondary code.**

PDX	⇨ **POISONING**
SDX	⇨ **PROBLEM**

DEGRES OF BURNS OR SEVERITY OF BURNS

a. **Unspecified**
b. **1st Degree** ⇨ **S**uperfacial burn**.**
c. **2nd Degree** ⇨ **Blister (**parital thickness burn**.)**
d. **3rd Degree** ⇨ Full thickness burn**.**

GUIDELINES

1.if the patient suffering from different severities or degrees of burns at the same site we should code only for highest degree of burn.

Ex) A 3year old patient came with 1st degree burn of cheek and forehead,2nd degree burn in cheek and forehead and 3rd degree brun in cheek and forehead, here code only for 3rd degree burn.**T20.36XA** 3rd degree burn of fore head and cheek.

2.If the patient is suffering from different degrees of burns at different sites we can code for the all the sites and pdx should be highest degree.
Ex) the patient came with 1st degree burn of lips and 2nd degree burn of chin and 3rd degree burn of nose to code.

PDX should be **T20.34XA** 3rd degree burn on nose
SDX should be **T20.23XA** 2nd degree burn of chin
T20.12XA 1st degree burn of lips

We can code healing burns as active burns but we can't code healed burns as active burns.

Concept of TBSA (Total Body Surface Area**)**

- **a.** Right hand = 9%
- **b.** Left hand = 9%
- **c.** Face = 9%
- **d.** Anterior trunk = 18%
- **e.** Posterior trunk = 18%
- **f.** Right legs = 18%
- **g.** Left leg = 18%
- **h.** Genital region = 1%

This TBSA codes used as the primary codes only when the site of burn is unspecified, it should be used as additional code with categories **T20-T25** when site is specified.

TBSA used if there is any 3rd degree burn for the patient
Ex) patient had 2nd degree burn on face 3rd degree burn on legs and 1st degree burn on hand.

Leg = 3rd degree TBSA 18%
Face = 2nd degree TBSA 9%
Hand = 1st degree TBSA 9%
Total TBSA = 36% in 18% 3rd degree for this we should code
PDX = 3rd degree burns legs
SDX = 2nd degree burn face
1st degree burn face
Total TBSA T31.31 burns involving **30-39%** body surface area with **1019%** 3rd degree burns.

Examples:

1. Patient came with the fracture of right mandible and dislocation of right jaw.
   PDX = **S02.601A** fracture of right mandible. **SDX = S03.01** dislocation of right jaw.

2. Patient had laceration with foreign body on ear and dislocation of jaw.
   PDX = S03.00XA dislocation of jaw
   SDX = S01.329A laceration with foreign body unspecified ear.

3. Patient had contusions on eye ball and orbital tissues and ocular laceration without prolapse or loss of intra ocular tissue.
   PDX = **S05.30XA**

SDX = S05.10XA.

4. Patient had abrasions of nose and contusion of ear. **PDX = S00.439A**
   SDX = S00.31XA

BURNS

1.Patient had second degree burn on wrist and 3rd degree burn on wrist.

PDX **T23.379A.**

2.Patinet had 1st degree burn on left lower limb except ankle and foot and 3rd degree burn on right knee.

PDX **T24.321A**

SDX **T24.102A**

3.Patient had 1st degree burn on right thigh 2nd degree burn on left thigh and 3rd degree burn on left knee.

PDX **T24.329A**

SDX **T24.222A**

T24.111A

CONCEPT OF TBSA

1.Patient had 1st degree burn on right hand and 2nd degree burn on left wrist.

PDX = T22.272A

SDX = T23.101A

Here we shouldn't use TBSA because of there is no 3rd degree burn.

2.Patient had 1st degree burn on chest wall 2nd degree burn on abdominal wall and 3rd degree burn on upper back.

PDX **T21.33XA**

SDX **T21.22XA**

T21.11XA

T31.20

TBSA = chest wall 9%

Abdominal wall 9%

Upperback 9%

Total TBSA 27% with 9% of 3rd degree.

Chapter - 20 EXTERNAL CAUSES OF MORBIDITY(V00-Y99)

Difference between morbidity and mortality

Mortality = death rate/ death ratio it tracks the number of deaths from illness or disease with in the populations.

Morbidity = It tracks the data on number of people or percentage effected by illness or disease.

Ex) Morbidity = **Covid 19** effected percentage in india

Mortality = Covid 19 deaths in india**.**

External causes = external force or reasons for the injuries or illness**.(W,X Series)**

Guidelines

External cause codes never be sequenced 1st this codes are used as additional codes.

Ex) 1. It contain place of occurrence codes and activity code.

Patient had fall from chair at home while playing the carroms physician confirmed contusions on head.

PDX = Contusion **S00.93XA.**

SDX = Fall from chair **W07.XXA**.

Home **Y92.009.**

Playing carroms **Y93.89.**

2.Patient participated in wrestling practice in hotel and he had a fall due to slip and trip during the game now the patient is suffering from left distal radius fracture.

PDX S52.502A

SDX W01.10XA

Y92.59

Y93.72

Sequala/late effect

Sequala are reported using the external cause with the 7th character S for sequala in this present condition should be primary code and sequala should be SDX.

Ex) Patient came to the hospital for the treatment of removing of scars due to burns.

PDX = removing of scars SDX = Burns.

Chapter 21
Factors influencing health status and contact with health services (Z00-Z99)

In this chapter we have contact codes like contact HIV.

Contact with covid 19.

Exposure to HIV.

Exposure to Tuberculosis.

Status codes are Z17 Histogen receptor status.

Z67 blood type.
Z79 long term use of drugs.
Z76.82 Awaiting from organ transplant status.
Z95 presence of cardiac and vascular implants and graphs.
Z94 transplanted organ and tissues.

History codes

Z80 family history of primary malignant neoplasm.
Z811 family history of mental and behavioural disorders.
Z85 personal history of malignant neoplasm.
Z91.5 personal history of self harm.
Z91.81 history of falling.

Screening codes

Z11 encounter for screening for infectious and parasitic disorders.
Z12 encounter for screening for malignant neoplasm.
Z36 encounter for antenatal screening for mother.

Observation codes

Z03 encounter for medical observation for suspected disease and conditions ruled out.
Z05 encounter for observation and evaluation of new born for suspected disease and condition rules out.

After care

Z47 orthopaedic after care
Z48 encounter for other postprocedural after care

Follow up

Z08 encounter for follow up examination after completed treatment for malignant neoplasm.
Z39 encounter for maternal post-partum care and examination.

And we have many codes for counselling etc….

CHAPTER 22
CODES FOR SPECIAL PURPOSES (U00-U85)

U07.0 waping related disorder.
U07.1 Covid 19
U09.9 Post covid 19 condition, unspecified.