ICD-10-CM CHARACTER CARDS

01 / I.C.1.a.1

Confirmation Captain

THE RULE

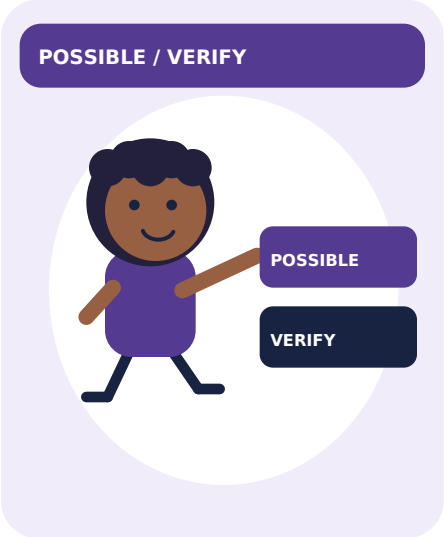
Code only confirmed HIV, even for inpatient discharge. A provider's confirmed diagnosis can suffice.

FICTIONAL PRACTICE

The inpatient discharge says possible HIV only.

ANSWER & WHY

Do not code HIV infection as confirmed. Apply any supported findings or status instead.



02 / I.C.1.a.2(a)

Disease Dee

THE RULE

Documented HIV disease, AIDS, or HIV-related illness calls for B20.

FICTIONAL PRACTICE

The provider diagnoses AIDS.

ANSWER & WHY

B20, plus codes for reportable related conditions as applicable.



03 / I.C.1.a.2(b)

Admission Ace

THE RULE

For admission chiefly for an HIV-related condition, generally sequence B20 before the related conditions.

FICTIONAL PRACTICE

The patient is admitted for pneumonia documented as HIV related.

ANSWER & WHY

B20 first, then the verified pneumonia code. The illness is HIV related.



04 / I.C.1.a.2(b)

HUS Hero

THE RULE

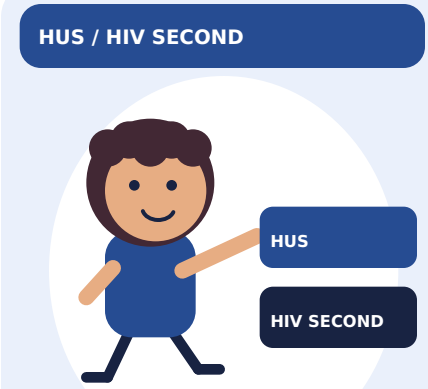
If HIV-associated hemolytic-uremic syndrome occasions admission, sequence it before HIV disease.

FICTIONAL PRACTICE

The admission is for HIV-associated HUS.

ANSWER & WHY

D59.31 then B20. This is an explicit exception.



05 / I.C.1.a.2(c)

Trauma Tasha

THE RULE

An unrelated condition chiefly responsible for inpatient admission leads; HIV disease is secondary.

FICTIONAL PRACTICE

A patient with HIV disease is admitted for an unrelated traumatic fracture.

ANSWER & WHY

The fracture code is principal; B20 is additional.



06 / I.C.1.a.2(d)

Timeline Tess

THE RULE

Newly diagnosed versus established HIV does not determine sequencing.

FICTIONAL PRACTICE

HIV disease is newly diagnosed during an admission for unrelated injury.

ANSWER & WHY

The injury still leads; B20 is secondary. The reason for admission controls.



07 / I.C.1.a.2(e)

Status Scout

THE RULE

Use Z21 for documented asymptomatic HIV status without HIV-related illness.

FICTIONAL PRACTICE

A provider confirms HIV-positive status without current or prior HIV-related illness.

ANSWER & WHY

Z21. Do not infer HIV disease.



08 / I.C.1.a.2(f)

Serology Sage

THE RULE

Inconclusive HIV serology may be coded R75.

FICTIONAL PRACTICE

The provider documents inconclusive HIV serology without diagnosis.

ANSWER & WHY

R75. Inconclusive evidence is not established infection.



09 / I.C.1.a.2(g)

History Hero

THE RULE

A prior HIV-related illness means continued B20 reporting at later encounters.

FICTIONAL PRACTICE

A patient with a documented past HIV-related illness has no symptoms today.

ANSWER & WHY

B20. Do not revert to Z21 or R75.



10 / I.C.1.a.2(h)

Maternity Maya

THE RULE

For symptomatic HIV or related illness in pregnancy, childbirth, or puerperium, sequence the applicable O98.7 code first.

FICTIONAL PRACTICE

The provider documents symptomatic HIV disease complicating a pregnancy.

ANSWER & WHY

Applicable O98.7- code, then B20 and reportable related illnesses. Obstetric priority applies.



11 / I.C.1.a.2(h)

Maternity Mila

THE RULE

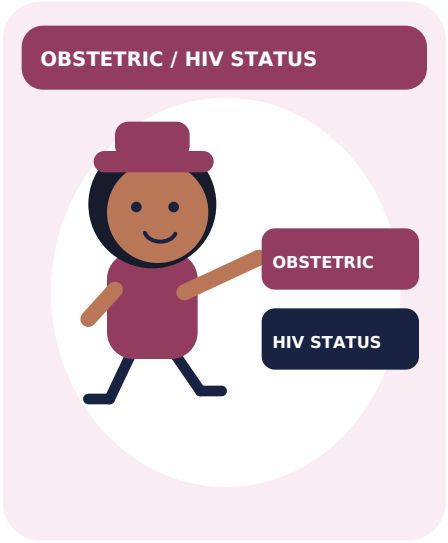
For asymptomatic HIV status in pregnancy, childbirth, or puerperium, add Z21 after the applicable obstetric code.

FICTIONAL PRACTICE

The chart documents asymptomatic HIV infection status complicating pregnancy.

ANSWER & WHY

Applicable O98.7- code then Z21. The record supports status rather than disease.



12 / I.C.1.a.2(i)

Screening Skye

THE RULE

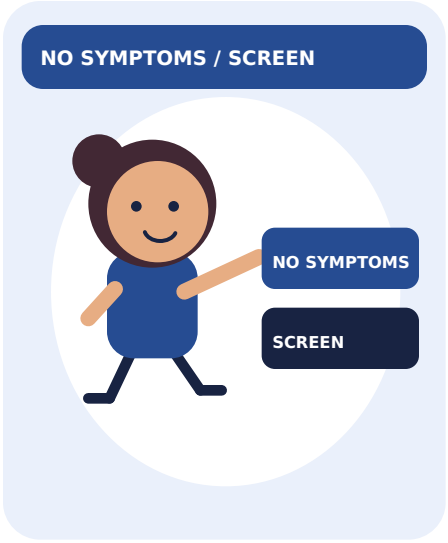
Use the screening code when testing an asymptomatic patient for HIV; add supported high-risk behavior when applicable.

FICTIONAL PRACTICE

An asymptomatic patient receives routine HIV screening.

ANSWER & WHY

Z11.4. This is a screening encounter.



13 / I.C.1.a.2(i)

Symptom Sydney

THE RULE

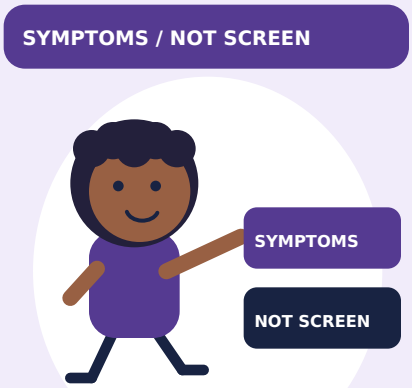
When signs or symptoms prompt HIV testing, report those findings, plus counseling if provided and applicable.

FICTIONAL PRACTICE

Fever prompts HIV testing, and counseling is provided.

ANSWER & WHY

Report the supported fever code and Z71.7 as applicable; omit Z11.4.



14 / I.C.1.a.2(i)

Results Riley

THE RULE

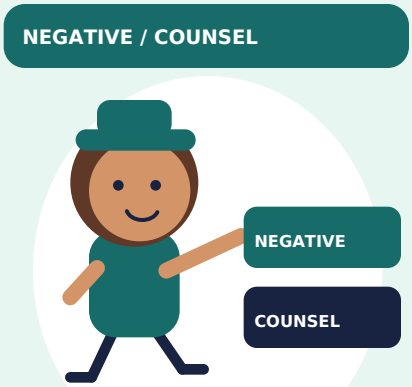
For follow-up of negative HIV test results, report Z71.7; positive results follow the disease/status guidance.

FICTIONAL PRACTICE

The patient returns to discuss a negative HIV test.

ANSWER & WHY

Z71.7. The purpose is follow-up regarding the result.



15 / I.C.1.a.2(j)

Medication Morgan

THE RULE

Antiretroviral medication does not distinguish HIV disease from asymptomatic status; use the documented diagnosis.

FICTIONAL PRACTICE

One patient has HIV disease and another has asymptomatic status; both take long-term antiretrovirals.

ANSWER & WHY

B20 for the first, Z21 for the second. Z79.899 may be added for long-term use.



16 / I.C.1.a.2(k)

Prevention Piper

THE RULE

Use Z29.81 for an encounter for HIV pre-exposure prophylaxis; add documented risk factors as applicable.

FICTIONAL PRACTICE

A patient without HIV presents for administration of PrEP.

ANSWER & WHY

Z29.81. The medication is for prevention.



17 / I.C.1.b

Organism Ollie

THE RULE

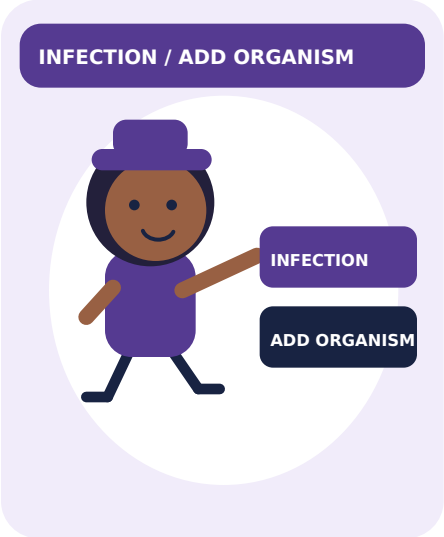
If an infection code does not identify its documented causative agent, add the applicable organism code as directed.

FICTIONAL PRACTICE

Acute cystitis without hematuria is due to unspecified E. coli.

ANSWER & WHY

N30.00 followed by B96.20. The organism needs a second code.



18 / I.C.1.c

Resistance Rae

THE RULE

If the infection code does not show antibiotic resistance, add the applicable Z16 code.

FICTIONAL PRACTICE

The provider identifies an infection resistant to an antibiotic; the verified infection code does not capture resistance.

ANSWER & WHY

Report the infection and add the applicable Z16 code. Do not add redundant resistance detail when already captured.



19 / I.C.1.d.1(a)

Sepsis Scout

THE RULE

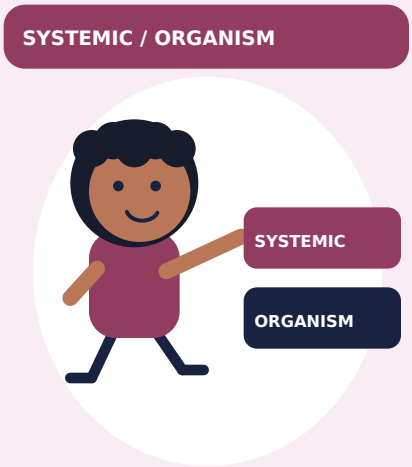
For confirmed sepsis, use the systemic infection code, using A41.9 if the organism is unspecified.

FICTIONAL PRACTICE

The provider documents sepsis without identifying an organism or related acute dysfunction.

ANSWER & WHY

A41.9. Do not add severe sepsis without support.



20 / I.C.1.d.1(a)(i)

Culture Casey

THE RULE

Negative or inconclusive cultures do not by themselves exclude documented sepsis; query as needed.

FICTIONAL PRACTICE

The discharge diagnoses sepsis, but cultures were negative.

ANSWER & WHY

Do not discard the diagnosis solely because of culture results. Clarify unclear or conflicting documentation.



21 / I.C.1.d.1(a)(ii)

Urosepsis Uma

THE RULE

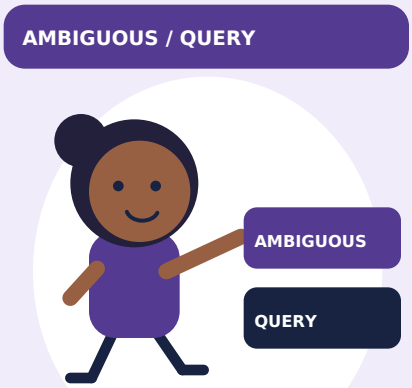
Urosepsis is not synonymous with sepsis and has no default code.

FICTIONAL PRACTICE

The discharge diagnosis says urosepsis with no clarification.

ANSWER & WHY

Query the provider. Do not substitute sepsis or a UTI on assumption.



22 / I.C.1.d.1(a)(iii)

Link Lia

THE RULE

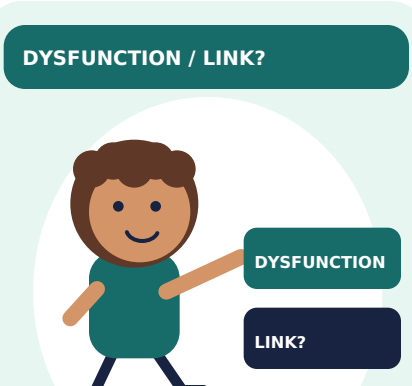
Acute organ dysfunction must be associated with sepsis for severe sepsis coding. Query if the link is unclear.

FICTIONAL PRACTICE

The provider documents sepsis and acute kidney failure but gives no relationship.

ANSWER & WHY

Query about the relationship. Do not infer severe sepsis from co-occurrence.



23 / I.C.1.d.1(b)

Severity Sam

THE RULE

For severe sepsis, report systemic infection, the applicable R65.2 code, and associated acute organ dysfunction.

FICTIONAL PRACTICE

Sepsis of unspecified organism causes documented severe sepsis with acute kidney failure and no shock.

ANSWER & WHY

A41.9, R65.20 and N17.9 for unspecified acute kidney failure.



24 / I.C.1.d.2

Shock Sequencer

THE RULE

For nonprocedural septic shock, sequence the systemic infection first, then R65.21; add other acute dysfunction as appropriate.

FICTIONAL PRACTICE

Documented sepsis of unspecified organism causes septic shock.

ANSWER & WHY

A41.9 then R65.21. The shock code cannot be principal.



25 / I.C.1.d.3

Admission Clock

THE RULE

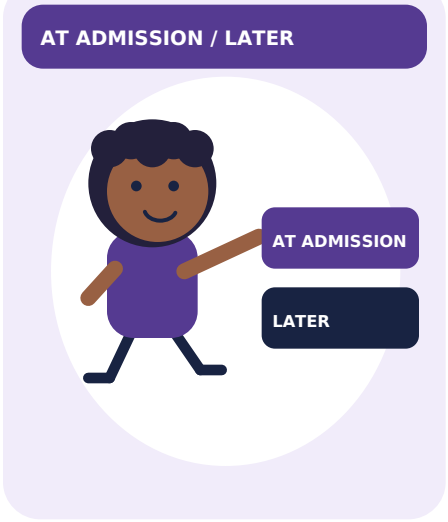
When severe sepsis is present on admission and meets the principal definition, sequence the infection first. If it develops later, report it as secondary.

FICTIONAL PRACTICE

A fracture occasions admission; severe sepsis develops days later.

ANSWER & WHY

Keep the fracture principal; report the verified severe sepsis codes as additional diagnoses.



26 / I.C.1.d.4

Local-Source Leo

THE RULE

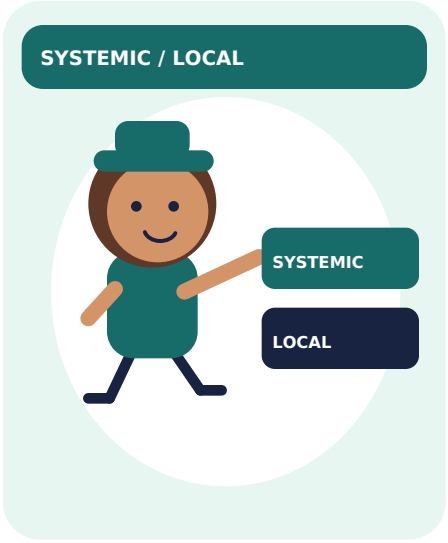
When sepsis with localized infection occasions admission, sequence the systemic infection first and add the local infection.

FICTIONAL PRACTICE

Sepsis and the pneumonia causing it are both present on admission; sepsis occasions admission.

ANSWER & WHY

Systemic infection first, pneumonia additional; add severe sepsis codes if supported.



27 / I.C.1.d.4

Later-Onset Lana

THE RULE

If the localized infection occasions admission and sepsis develops later, keep the localized infection first.

FICTIONAL PRACTICE

A patient is admitted for pneumonia and develops sepsis afterward.

ANSWER & WHY

Pneumonia remains principal; sepsis is secondary.



28 / I.C.1.d.5(a)

Procedure Petra

THE RULE

A postprocedural infection or sepsis linkage must be documented; query when unclear.

FICTIONAL PRACTICE

Sepsis follows surgery but the record does not say it is related.

ANSWER & WHY

Query as appropriate. Timing alone does not establish a procedural complication.



29 / I.C.1.d.5(b)

Site Sequencer

THE RULE

For sepsis due to a surgical site infection, follow the site, postprocedural sepsis, and organism instructions as applicable.

FICTIONAL PRACTICE

Sepsis is linked to a documented deep incisional surgical site infection.

ANSWER & WHY

Verify the applicable surgical site infection code first, then T81.44- and the infectious agent as directed. Add severe sepsis detail when supported.



30 / I.C.1.d.5(b)

Device Dani

THE RULE

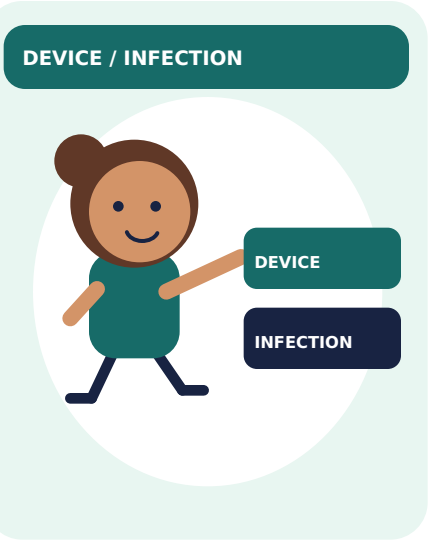
For sepsis due to a device, infusion or similar complication, follow the relevant complication-code and systemic infection instructions.

FICTIONAL PRACTICE

The provider links sepsis to a central venous catheter infection.

ANSWER & WHY

Verify the applicable device complication first, followed by the systemic infection as instructed.



31 / I.C.1.d.5(c)

Shock After Surgery

THE RULE

Use postprocedural septic shock coding for shock linked to a postprocedural infection; do not also assign R65.21.

FICTIONAL PRACTICE

A patient develops documented septic shock due to a surgical site infection.

ANSWER & WHY

Sequence the precipitating infection codes before the applicable T81.12- code; add other acute dysfunction codes as applicable.



32 / I.C.1.d.6

Trauma Timing

THE RULE

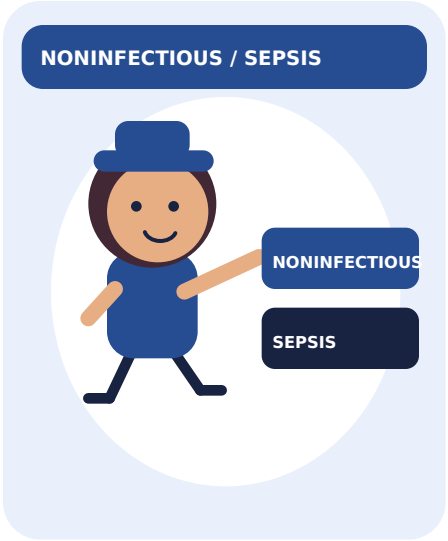
If a noninfectious condition leads to infection and meets principal criteria, it may lead; follow sequencing instructions and add infection and severity as applicable.

FICTIONAL PRACTICE

A serious burn occasions admission and later becomes infected, causing severe sepsis.

ANSWER & WHY

The burn remains principal. Add the verified infection, severe sepsis and associated dysfunction codes.



33 / I.C.1.d.7

Obstetric Oak

THE RULE

For obstetric sepsis or septic shock, follow the applicable Chapter 15 guidance.

FICTIONAL PRACTICE

Sepsis is documented as complicating childbirth.

ANSWER & WHY

Apply the obstetric sepsis pathway and its priority instructions, rather than using the ordinary adult sequence alone.



34 / I.C.1.d.8

Newborn Nell

THE RULE

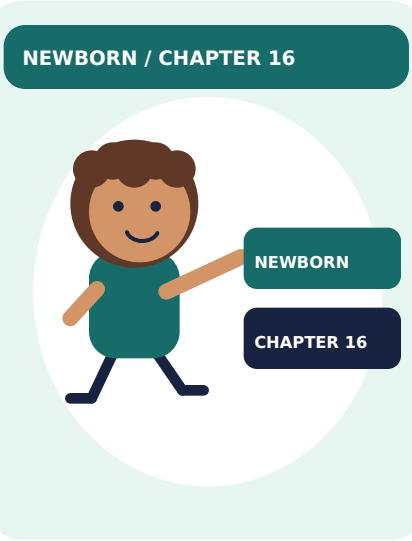
Apply the newborn-specific sepsis rules when appropriate.

FICTIONAL PRACTICE

The provider diagnoses bacterial sepsis of a newborn.

ANSWER & WHY

Look to P36 and Chapter 16 guidance. Verify organism and any additional codes.



35 / I.C.1.d.9

HUS Hannah

THE RULE

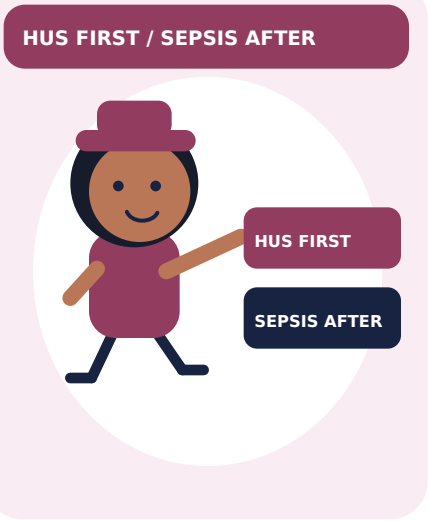
If sepsis-associated HUS is the reason for admission, sequence D59.31 first.

FICTIONAL PRACTICE

Infection-associated HUS due to sepsis chiefly occasions admission.

ANSWER & WHY

D59.31 first; report the applicable sepsis and severe sepsis details as additional diagnoses.



36 / I.C.1.e.1(a)

MRSA Guardian

THE RULE

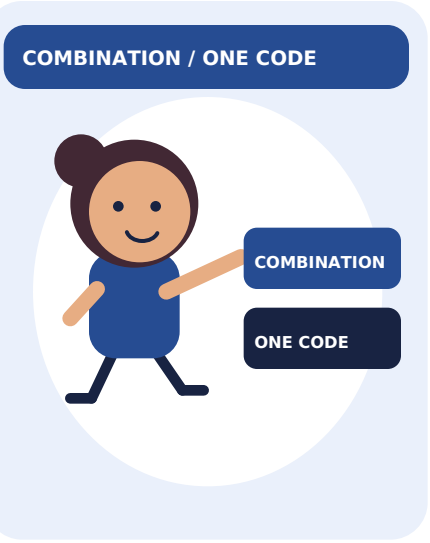
Use the MRSA combination code when it already identifies the infection and organism.

FICTIONAL PRACTICE

The provider diagnoses MRSA pneumonia.

ANSWER & WHY

J15.212. Do not add B95.62 or a resistance code for the same infection.



37 / I.C.1.e.1(b)

MRSA Matchmaker

THE RULE

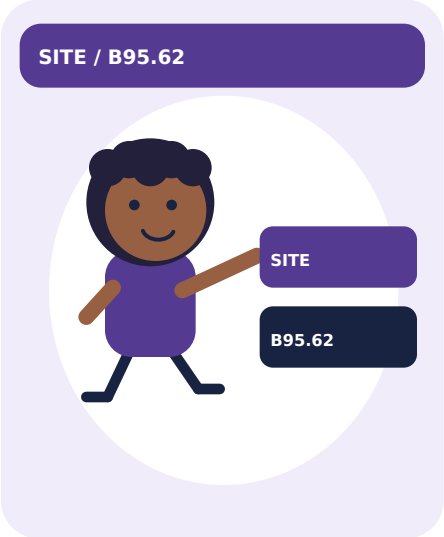
When the infection lacks an MRSA combination code, code the site and add B95.62; do not add a redundant resistance code.

FICTIONAL PRACTICE

The provider documents a reportable MRSA wound infection with no combination code for the site.

ANSWER & WHY

Verify the site code and add B95.62. Do not also add a methicillin resistance code.



38 / I.C.1.e.1(c)

Colonization Cleo

THE RULE

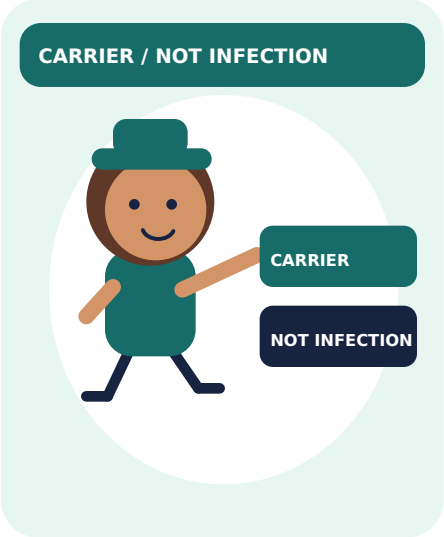
Carrier status is different from infection. Use the documented MRSA or MSSA colonization status code.

FICTIONAL PRACTICE

Preoperative screening is documented as MRSA colonization without infection.

ANSWER & WHY

Z22.322. MSSA colonization uses Z22.321 when documented instead.



39 / I.C.1.e.1(d)

Dual-Status Drew

THE RULE

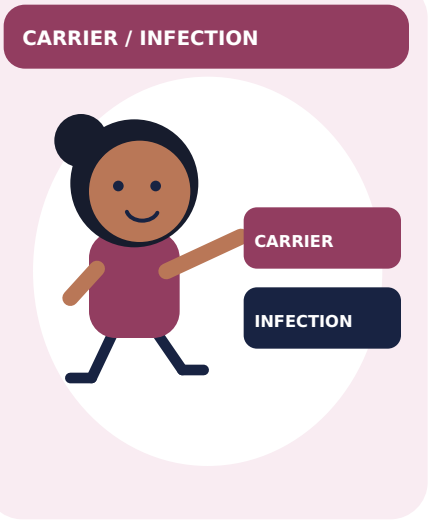
Documented MRSA colonization and MRSA infection can both be reported when applicable.

FICTIONAL PRACTICE

A patient has documented MRSA nasal colonization and separately treated MRSA pneumonia.

ANSWER & WHY

J15.212 plus Z22.322 when both are reportable. The two codes describe distinct states.



40 / I.C.1.f.1

Zika Zoe

THE RULE

Code only confirmed Zika. For suspected Zika, report supported symptoms or exposure as applicable.

FICTIONAL PRACTICE

A discharge note says possible Zika with a rash, without confirmation.

ANSWER & WHY

Do not assign A92.5. Code the supported finding or exposure as appropriate.



41 / I.C.1.g.1(a)

COVID Confirm

THE RULE

Apply the COVID-19 confirmation rule; suspected or possible COVID-19 is not coded as confirmed.

FICTIONAL PRACTICE

The ED provider documents probable COVID-19 only; test results are unknown.

ANSWER & WHY

Do not use U07.1. Report supported symptoms and exposure as applicable.



42 / I.C.1.g.1(b)

COVID Sequencer

THE RULE

When COVID-19 meets the principal or first-listed definition, it generally leads, subject to applicable sequencing exceptions.

FICTIONAL PRACTICE

A nonpregnant patient is admitted for confirmed COVID-19 pneumonia, without an exception.

ANSWER & WHY

U07.1 then J12.82. Apply other priority rules when required.



43 / I.C.1.g.1(c)(i)

Pneumonia Pal

THE RULE

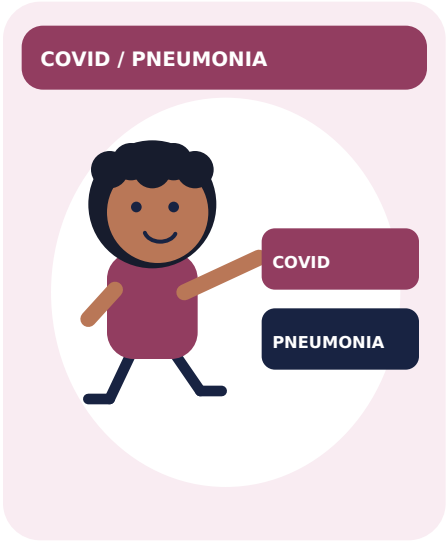
Use the specific pneumonia code for pneumonia confirmed as due to COVID-19.

FICTIONAL PRACTICE

The provider confirms COVID-19 pneumonia.

ANSWER & WHY

U07.1 and J12.82.



44 / I.C.1.g.1(c)(ii)

Bronchitis Bea

THE RULE

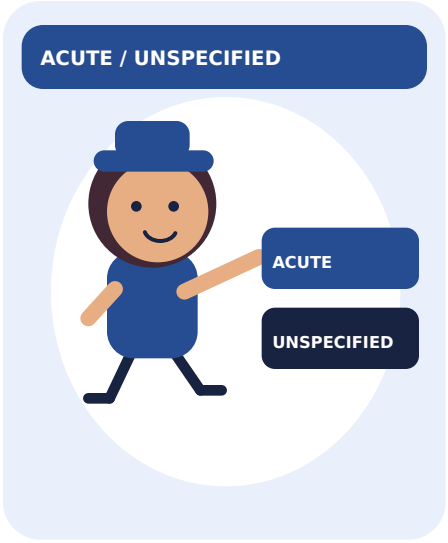
Distinguish acute bronchitis due to COVID-19 from bronchitis without an acute or chronic designation.

FICTIONAL PRACTICE

One patient has COVID-19 acute bronchitis; another has COVID-19 bronchitis NOS.

ANSWER & WHY

Add J20.8 in the first case and J40 in the second, with U07.1.



45 / I.C.1.g.1(c)(iii)

Airway Ari

THE RULE

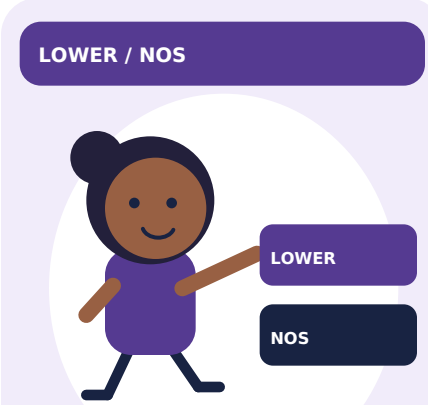
The documented respiratory infection wording changes the additional code.

FICTIONAL PRACTICE

COVID-19 is linked to a lower respiratory infection NOS in one chart and respiratory infection NOS in another.

ANSWER & WHY

Use U07.1 with J22 for the first and J98.8 for the second.



46 / I.C.1.g.1(c)(iv)

ARDS Arrow

THE RULE

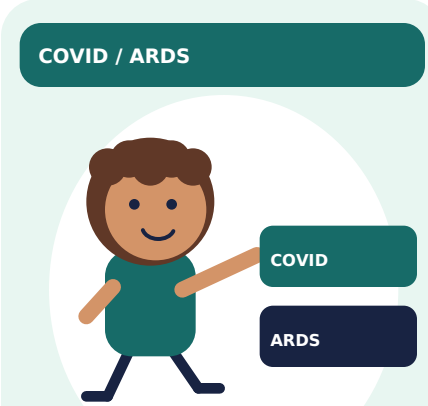
Report ARDS as an additional code for ARDS due to COVID-19.

FICTIONAL PRACTICE

The provider documents COVID-19 causing ARDS.

ANSWER & WHY

U07.1 and J80.



47 / I.C.1.g.1(c)(v)

Failure Finder

THE RULE

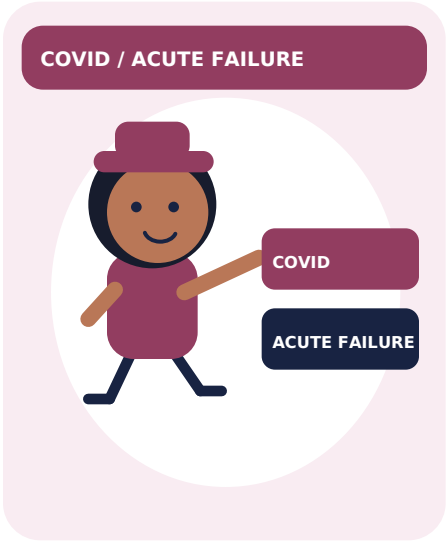
Add the applicable acute respiratory failure code for failure due to COVID-19.

FICTIONAL PRACTICE

The provider documents acute respiratory failure with hypoxia due to COVID-19.

ANSWER & WHY

U07.1 and J96.01. The failure code reflects hypoxia.



48 / I.C.1.g.1(d)

Beyond Lungs Ben

THE RULE

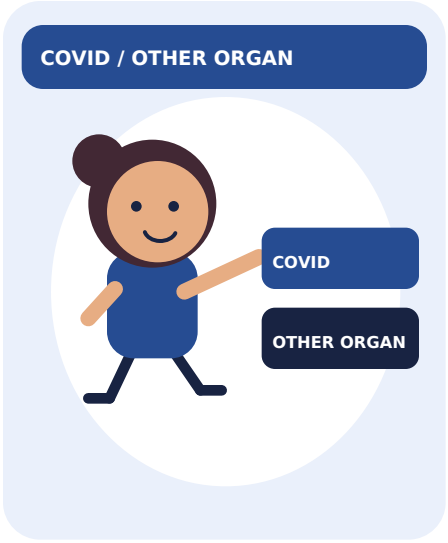
When a nonrespiratory manifestation of COVID-19 drives the encounter, list COVID-19 first under this rule and add the manifestation.

FICTIONAL PRACTICE

COVID-19 viral enteritis occasions the visit.

ANSWER & WHY

U07.1 first, then the applicable enteritis code.



49 / I.C.1.g.1(e)

Exposure Eva

THE RULE

Use Z20.822 for actual or suspected exposure when infection is not established under the exposure rule.

FICTIONAL PRACTICE

An asymptomatic patient is evaluated after household exposure; no infection is diagnosed.

ANSWER & WHY

Z20.822. Known exposure is not routine screening.



50 / I.C.1.g.1(f)

Screening Sid

THE RULE

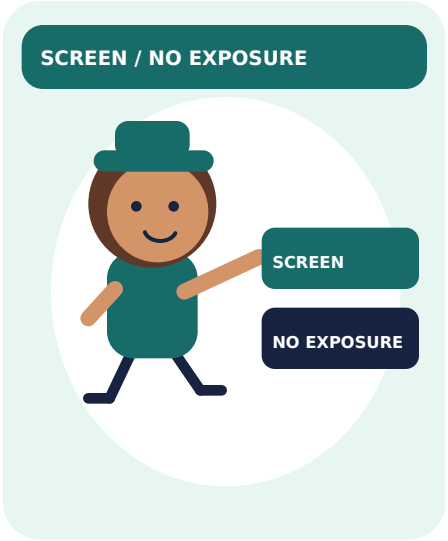
Use Z11.52 for COVID-19 screening, including preoperative screening.

FICTIONAL PRACTICE

An asymptomatic patient without known exposure receives preoperative COVID-19 screening.

ANSWER & WHY

Z11.52. The purpose is screening.



51 / I.C.1.g.1(g)

Symptom Sol

THE RULE

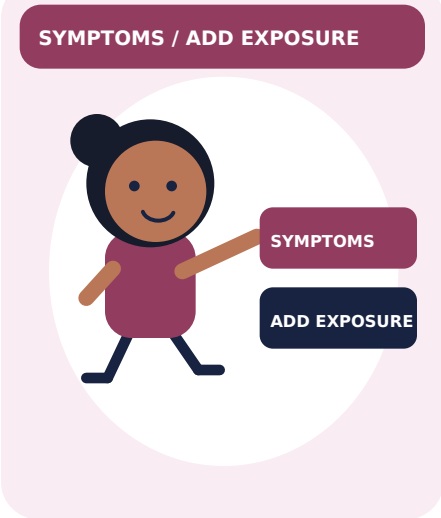
Report symptoms when COVID-19 is not established; add exposure when documented.

FICTIONAL PRACTICE

An exposed patient has acute cough; no COVID-19 diagnosis is confirmed.

ANSWER & WHY

R05.1 plus Z20.822. Do not assign U07.1.



52 / I.C.1.g.1(h)

Lab Liaison

THE RULE

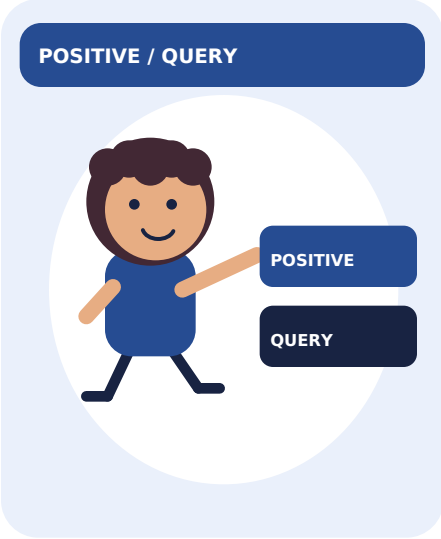
For an asymptomatic positive test without provider diagnosis, query the provider.

FICTIONAL PRACTICE

An asymptomatic patient has a positive result but no diagnostic statement.

ANSWER & WHY

Query to confirm whether the patient has COVID-19.



53 / I.C.1.g.1(i)

History Harper

THE RULE

Use the personal history code for resolved COVID-19 when relevant.

FICTIONAL PRACTICE

A visit notes a past resolved COVID-19 infection without residual illness.

ANSWER & WHY

Z86.16 when reportable; there is no active COVID-19.



54 / I.C.1.g.1(j)

Follow-Up Frankie

THE RULE

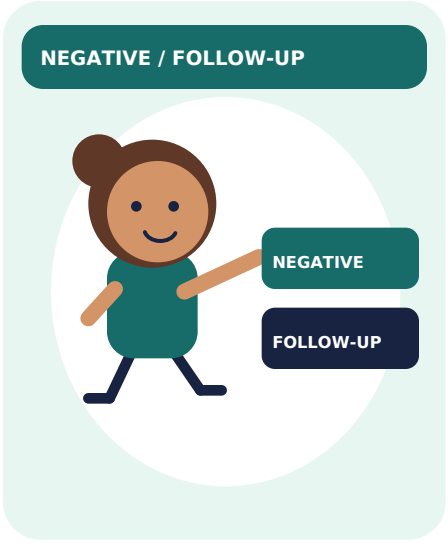
Use follow-up and history codes when the infection has resolved, testing is negative, and there are no residuals.

FICTIONAL PRACTICE

The patient returns after recovery and has a negative test and no ongoing symptoms.

ANSWER & WHY

Z09 then Z86.16. Residual conditions use a different pathway.



55 / I.C.1.g.1(k)

Antibody Avery

THE RULE

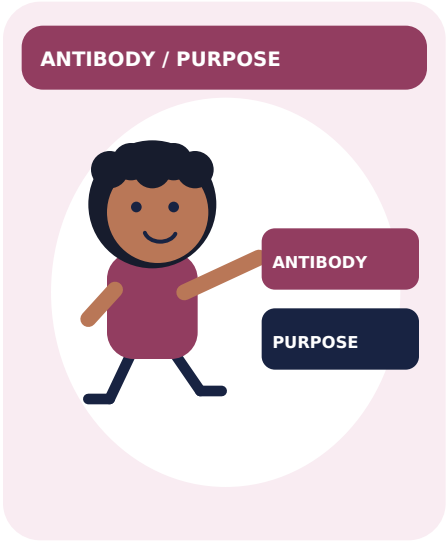
Use Z01.84 for antibody testing that is neither diagnosis of current infection nor follow-up after resolved infection.

FICTIONAL PRACTICE

The only reason for the visit is an antibody response check under those conditions.

ANSWER & WHY

Z01.84. Code the reason for the test.



56 / I.C.1.g.1(l)

MIS Morgan

THE RULE

With active COVID-19 and MIS, list COVID-19 first and add MIS and any associated complications.

FICTIONAL PRACTICE

The provider diagnoses active COVID-19 and MIS.

ANSWER & WHY

U07.1 then M35.81. Add supported MIS complications as applicable.



57 / I.C.1.g.1(l)

MIS Aftercare Mae

THE RULE

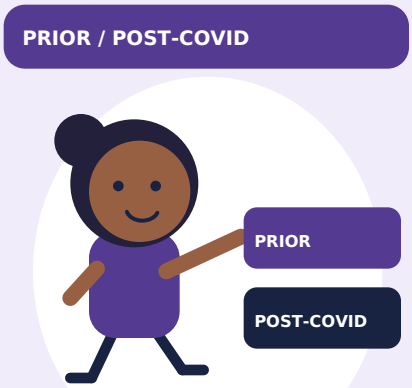
For MIS following prior COVID-19, use MIS and the post-COVID code.

FICTIONAL PRACTICE

A recovered patient develops documented MIS associated with the prior infection.

ANSWER & WHY

M35.81 and U09.9; add supported complications.



58 / I.C.1.g.1(l)

MIS Exposure Eli

THE RULE

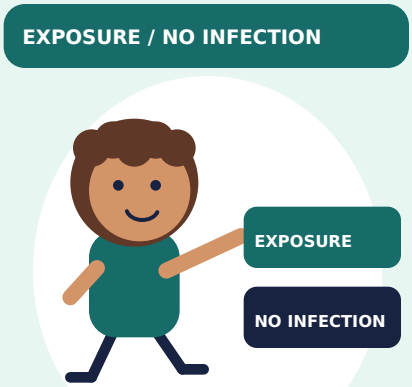
With MIS and documented exposure but no current or prior COVID-19, report MIS and exposure.

FICTIONAL PRACTICE

A patient with MIS had a known contact but has no active or past COVID-19.

ANSWER & WHY

M35.81 and Z20.822; add supported complications.



59 / I.C.1.g.1(m)

Residual Remy

THE RULE

Code the known residual associated with a prior infection and add U09.9. Do not use it for a current infection manifestation.

FICTIONAL PRACTICE

The provider links ongoing shortness of breath to resolved COVID-19.

ANSWER & WHY

R06.02 followed by U09.9. The symptom is a residual of the earlier infection.



60 / I.C.1.g.1(m)

Two-Timeline Taylor

THE RULE

Both U07.1 and U09.9 may be appropriate for a new active infection plus a separate residual of an old infection.

FICTIONAL PRACTICE

The provider distinguishes current COVID-19 pneumonia from persistent symptoms linked to a prior infection.

ANSWER & WHY

Report active COVID-19 and pneumonia plus the supported old residual and U09.9, following applicable sequence.



61 / I.C.1.g.1(n)

Vaccine Val

THE RULE

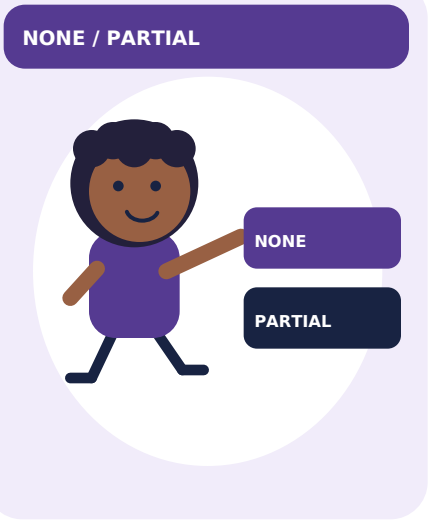
Distinguish unvaccinated status from partial vaccination under recommendations at the encounter date.

FICTIONAL PRACTICE

One patient has received no COVID-19 vaccines; another is documented as partially vaccinated.

ANSWER & WHY

Z28.310 for the first and Z28.311 for the second when reportable.



62 / I.C.2 opening

Tumor Type Tia

THE RULE

Verify a neoplasm's behavior and site using the documentation and appropriate Index or Neoplasm Table route.

FICTIONAL PRACTICE

The provider documents a benign neoplasm; a coder starts in the malignant column because of the site.

ANSWER & WHY

Use the benign classification route and confirm the site and instructions in the Tabular List.

