Using ICD-10-CM

Corrina R. Lynch | CPC Preparation

Chapter contents

1. How the guidelines are organized

2. Accurate lookup, specificity and laterality

3. Integral symptoms and distinct findings

4. Multiple codes, acute and chronic, and combination codes

5. Sequela and repeated codes

6. Chapter review

Prior-edition readings and exercises follow the revised lesson and may use the earlier chapter arrangement.

Learning objectives

- Locate and apply the correct guideline section.
- Use Tabular instructions and supported specificity to build the code sequence.

1. How the guidelines are organized

Section I covers conventions and general and chapter-specific rules. Sections II and III concern non-outpatient principal and additional diagnoses; Section IV governs outpatient diagnosis reporting. Tabular instructions take precedence when they apply.

Worked example

For a clinic visit, start with Section IV for first-listed diagnosis selection, then apply relevant Section I rules and Tabular instructions.

2. Accurate lookup, specificity and laterality

I.B.1–2 and I.B.13: Locate the diagnosis in the Alphabetic Index, verify it in the Tabular List and report the full code supported by the record. If there is no bilateral code, report right and left separately when both are documented.

Worked example

For a documented right-sided condition, verify that the selected Tabular entry explicitly describes the right side. Do not add a left-sided code unless the left side is documented.

3. Integral symptoms and distinct findings

I.B.5–6: Do not separately code signs and symptoms routinely associated with a confirmed disease unless instructed otherwise. Findings not routinely associated may be reportable when supported.

Worked example

For confirmed acute cystitis with typical painful urination, do not add the symptom merely because it appears in the chief complaint.

4. Multiple codes, acute and chronic, and combination codes

I.B.7–9: Follow notes that require additional codes. When the same condition is described as acute and chronic and separate subentries exist at the same Index indentation, code both and sequence acute first. Use a combination code when it fully describes what is documented.

Worked example

Type 2 diabetes with CKD uses the diabetes-and-CKD combination code plus the documented CKD stage code, as required by the Tabular List.

5. Sequela and repeated codes

I.B.10 and I.B.12: A sequela is a residual after the acute phase. Generally sequence the residual before the sequela code, subject to exceptions and Tabular instructions. Report a unique diagnosis code only once per encounter.

Worked example

When treating a scar from an old burn, identify today's residual and then verify the applicable burn sequela code rather than coding a new burn.

Chapter review

1. When can you code a symptom alongside a confirmed diagnosis?
2. When are acute and chronic forms both reported, and which comes first?
3. Explain how laterality and a required seventh character change a code.

References

CMS/NCHS: FY 2026 Official Coding Guidelines

MEDICAL CODING MASTERY | STUDENT EDITION

CHAPTER 4

ICD-10-CM: Infectious Diseases, Neoplasms, Blood and Endocrine Conditions

Corrina Lynch | ACL Consulting Firm | CPC Preparation

▶ Chapter Objectives

Upon completion of this chapter, the student will be able to:

1. Define and differentiate infection, bacteremia, SIRS, sepsis, severe sepsis, and septic shock using ICD-10-CM coding guidelines.
2. Apply Official Guideline sequencing rules for sepsis, including multi-organism and postprocedural sepsis scenarios.
3. Identify the correct ICD-10-CM codes for HIV-positive asymptomatic status, AIDS, inconclusive HIV testing, and HIV exposure.
4. Demonstrate proper use of the Neoplasm Table in the ICD-10-CM Alphabetic Index to locate codes by site and behavior.
5. Sequence primary and secondary malignancy codes, chemotherapy encounter codes, and complication codes correctly.
6. Assign correct codes for the most common types of anemia, including anemia associated with malignancy, CKD, and chemotherapy.
7. Differentiate ICD-10-CM diabetes mellitus categories (E08–E13) and assign combination codes for diabetic complications.
8. Apply the insulin-use Z code (Z79.4) and oral hypoglycemic Z code

(Z79.84) appropriately based on diabetes type and treatment.

9. Code thyroid disorders, obesity, BMI, and fluid/electrolyte imbalances from Chapter 4 of ICD-10-CM (E00–E89).

10. Synthesize coding from multiple ICD-10-CM chapters to produce complete, correctly sequenced code sets from real clinical documentation.

▶️ Key Terms

Adverse effect — harm caused by a properly administered drug

Bacteremia — bacteria in the bloodstream without systemic response

Benign neoplasm — non-cancerous, non-invasive tumor

Carcinoma in situ — cancer confined to original cells; not yet invasive

Diabetes mellitus — chronic metabolic disorder of glucose regulation

Endocrine system — gland-based system that regulates hormones

Etiology — the underlying cause of a disease or condition

HIV — Human Immunodeficiency Virus

Hyperglycemia — elevated blood glucose level

Hyperlipidemia — elevated lipid (fat) levels in the blood

Hypo/hyperkalemia — low/high potassium levels in the blood

Malignant neoplasm — cancerous tumor capable of invasion and spread

Manifestation — a sign or complication of an underlying disease

Metastatic — cancer that has spread from primary to secondary sites

Neoplasm — any abnormal new growth of tissue

Obesity — excess body fat; BMI ≥ 30 in adults

Opportunistic infection — infection that exploits a weakened immune system

Primary site — original location where a cancer first developed

Sepsis — life-threatening organ dysfunction due to infection

Secondary site — location to which cancer has spread (metastatic)

Chapter Overview

Chapter 4 of Medical Coding Mastery covers four of the most heavily tested ICD-10-CM coding chapters on the CPC exam: Infectious and Parasitic Diseases (A00–B99), Neoplasms (C00–D49), Diseases of the Blood and Blood-Forming Organs (D50–D89), and Endocrine, Nutritional, and Metabolic Diseases (E00–E89). These chapters are not just high-yield for exam purposes — they represent some of the most complex, multi-code scenarios you will face every single day as a working coder. Sepsis, AIDS, cancer, anemia, and diabetes are bread-and-butter diagnoses in every care setting, from inpatient hospitals to oncology clinics to primary care offices. Master these four chapters, and you will walk into the CPC exam — and your first coding job — with real confidence.

SECTION 4.1 — ICD-10-CM Chapter 1: Infectious and Parasitic Diseases (A00–B99)

Overview of Chapter 1: A00–B99

ICD-10-CM Chapter 1 covers diseases caused by **bacteria, viruses, fungi, and parasites**. The chapter is organized primarily by the type of organism and, secondarily, by the body system affected. One of the most important concepts in this chapter is that many infections require **two codes** — one for the infectious condition and one for the causative organism or the body site involved.

- **Excludes1 Note:** Certain localized infections are coded in the body system chapter where they occur (e.g., pneumonia codes in Chapter 10, UTIs in Chapter 14) rather than in Chapter 1.
- **Excludes2 Note:** Infections complicating pregnancy, childbirth, and the puerperium are reported in Chapter 15 (O00–O9A).

4.1A — Sepsis and Severe Sepsis (HIGH YIELD CPC TOPIC)

Sepsis coding is **one of the most complex and most frequently tested topics** on the CPC exam. Before you can code it correctly, you must know exactly what each term means — and why they are NOT interchangeable.

Definitions You MUST Know

Term	Definition	Key Distinction
Infection	Localized invasion by bacteria, virus, or fungus — confined to a specific body site	No systemic response; one code typically
Bacteremia	Bacteria present in the bloodstream WITHOUT a systemic inflammatory response — generally transient	Not the same as sepsis; code A49.9 or organism-specific
SIRS	Systemic Inflammatory Response Syndrome — systemic response to a NON-infectious insult (burns, trauma, pancreatitis)	NOT sepsis; code R65.10/R65.11 + underlying condition
Sepsis	Life-threatening organ dysfunction caused by a dysregulated host response to infection — previously called "systemic infection"	Requires physician documentation; code the infection FIRST
Severe Sepsis	Sepsis WITH associated acute organ dysfunction	Requires R65.20 or R65.21 + organ dysfunction code(s)

Term	Definition	Key Distinction
Septic Shock	Severe sepsis with circulatory failure despite adequate fluid resuscitation	NEVER coded as principal diagnosis; always a manifestation of severe sepsis

◆ **Official Guidelines for Coding and Reporting**

ICD-10-CM Official Guidelines, Section I.C.1.d — Sepsis, Severe Sepsis, and Septic Shock

"For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection. If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified organism... If a patient has sepsis and an acute organ dysfunction, assign the appropriate code for the acute organ dysfunction... Severe sepsis requires a minimum of 2 codes: first a code for the underlying systemic infection, followed by a code from subcategory R65.2."

Plain English: Sepsis = code the infection first, then the systemic response. Severe sepsis = infection code + R65.20/R65.21 + organ dysfunction code(s). Septic shock (R65.21) is NEVER principal — it always follows the infection and severe sepsis codes. Always code to the highest level of specificity for the organism.

Sepsis Coding Rules — Memorize These

- **Basic Sepsis:** Code the underlying systemic infection FIRST (A40.– or A41.–), then any associated organ dysfunction or additional codes.
- **Specific Organism Codes:**
  - A40.0 — Sepsis due to Streptococcus, Group A
  - A41.01 — Sepsis due to Methicillin-susceptible Staphylococcus aureus (MSSA)

- A41.02 — Sepsis due to Methicillin-resistant Staphylococcus aureus (MRSA)
- A41.51 — Sepsis due to Escherichia coli (E. coli)
- A41.9 — Sepsis, unspecified organism (use when organism not documented)

- **Severe Sepsis:** Code systemic infection first + R65.20 (without septic shock) or R65.21 (with septic shock) + code(s) for acute organ dysfunction.
- **Septic Shock:** NEVER the principal diagnosis. It is always a manifestation — sequence the underlying sepsis first.

⚠️ **STOP!**

"Urosepsis" is NOT a valid ICD-10-CM code. It does not exist in the classification system. If the physician documents "urosepsis," do NOT assume sepsis. Query the physician to clarify whether the patient has (1) a urinary tract infection only, (2) sepsis with a urinary source, or (3) another condition entirely. Without clear documentation of systemic involvement meeting sepsis criteria, code only the UTI (N30.– or N39.0). Assigning a sepsis code based solely on the term "urosepsis" in the documentation is an overcoding error.

⚠️ **CAUTION!**

Compliance Alert — Sepsis Overcoding: Assigning a sepsis code without explicit physician documentation of systemic involvement constitutes **overcoding** and is considered a compliance violation. Sepsis codes carry significantly higher DRG weights than UTI or localized infection codes. Upcoding to a higher-reimbursing DRG without clinical support is **fraud under the False Claims Act** and can result in claim recoupment, exclusion from Medicare/Medicaid, and civil monetary penalties. When in doubt, query — never assume.

★ **From the Trenches**

"I've been coding in the emergency department for eleven years, and I will tell you straight up — sepsis is the single most complex, most audited, and most important thing to get right in this entire classification system. One sequencing error on a sepsis case can change the DRG, the reimbursement, and your facility's compliance exposure all at once. I spend more time querying physicians on sepsis documentation than any other condition. Learn these rules cold. Not kind-of cold. Frozen solid."

— Marcus T., CPC, CEDC | ED Revenue Integrity Coder | Regional Medical Center, Atlanta, GA

● **Check This Out!**

Sepsis is the **#1 most expensive hospital condition billed to Medicare**, costing the U.S. healthcare system over **$24 billion annually**. Approximately 1.7 million Americans develop sepsis each year, and nearly 270,000 die as a result. Accurate coding of sepsis directly affects billions of dollars in Medicare reimbursement and is a top target of Recovery Audit Contractor (RAC) reviews. Getting this right is not just an exam skill — it protects your facility and your patients.

Four-Code Scenario: Walked Through Step by Step

► **Worked Example 4.1.1 — Severe Sepsis with Septic Shock**

Clinical Scenario:

Patient is admitted with sepsis due to MRSA with septic shock and acute kidney injury.

Step 1 — Identify the sepsis type and organism: Sepsis due to MRSA → **A41.02** (Sepsis due to Methicillin-resistant Staphylococcus aureus). This is the **principal diagnosis**.

Step 2 — Identify the severity level: Septic shock is present → **R65.21** (Severe sepsis with septic shock). This always follows the infection code. Septic shock is a manifestation — it cannot lead the code set.

Step 3 — Identify organ dysfunction: Acute kidney injury is documented → **N17.9** (Acute kidney failure, unspecified). This is an additional code representing the organ dysfunction that defines severe sepsis.

Final Code Set (in correct sequence):

Sequence

Code

Description

Why This Position

1st (Principal)

A41.02

Sepsis due to MRSA

The underlying systemic infection — always leads in sepsis coding

2nd

R65.21

Severe sepsis with septic shock

Manifestation code — follows the infection; documents severity

3rd

N17.9

Acute kidney failure, unspecified

Organ dysfunction associated with severe sepsis

★ **Coding Shot**

When you see "septic shock" in the documentation, your first question should be: **what infection is driving it?** Locate the organism or infection source, code that FIRST, then add R65.21, then the organ dysfunction. Think of it as a tower: infection on the bottom, severity in the middle, complications on top. The tower always has its foundation at the bottom.

4.1B — HIV and AIDS Coding (HIGH YIELD)

HIV and AIDS coding has a very specific set of rules that are tested on virtually every CPC exam. The key distinction that controls your code selection is whether the patient is **asymptomatic** (HIV-positive but no HIV-related illness) or **symptomatic** (has HIV disease with related conditions or AIDS).

Core HIV Coding Rules

- **HIV Positive, Asymptomatic (Z21):** Patient tests positive for HIV but has NO HIV-related conditions or illnesses. Code **Z21** — Asymptomatic human immunodeficiency virus (HIV) infection status. Do NOT use B20 for this patient.

- **AIDS / Symptomatic HIV Disease (B20):** Patient has confirmed HIV disease WITH HIV-related conditions (opportunistic infections, AIDS-defining illnesses). Code **B20** as the **principal diagnosis**, then the manifestation(s) or opportunistic infections as additional codes.
- **B20 is a Lifetime Code:** Once a patient has been assigned B20, code B20 on **every future encounter** — HIV disease does not go away. Even if the patient is on antiretroviral therapy and doing well, B20 is always reported.
- **AIDS Patient Admitted for Unrelated Condition:** Code B20 first (or as an additional code if the unrelated condition is the reason for admission — guidelines vary by setting). Always include B20 on every encounter once established.
- **Inconclusive HIV Test (R75):** Test results are not definitive — code **R75** (Inconclusive laboratory evidence of HIV).
- **HIV Exposure (Z20.6):** Patient was exposed to HIV but no confirmed positive test — code **Z20.6** (Contact with and (suspected) exposure to HIV).
- **HIV Screening (Z11.4):** Patient presents for HIV testing with no known HIV status — code **Z11.4** (Encounter for screening for HIV).

> ★ **Coding Shot**
>
> **B20 is a lifetime code.** Once you assign it, it never goes away. Think of it as a permanent flag in the medical record. Every single encounter for a patient with established AIDS — regardless of why they're being seen — includes B20. A patient with AIDS coming in for a broken wrist? B20 + fracture code. A patient with AIDS coming in for a routine medication check? B20 + Z code for the encounter type. This rule does NOT apply to Z21 patients — Z21 can change if the patient later develops AIDS.

HIV Coding Decision Table

Clinical Scenario	Code to Use	Rationale
Asymptomatic HIV positive — no HIV-related illness	Z21	No HIV disease present; patient is a carrier only
HIV disease with AIDS-related pneumonia	B20 first, then J18.9	Symptomatic HIV disease; pneumonia is a manifestation
Admitted for femur fracture — known AIDS patient	B20 + fracture code	B20 always coded once AIDS is established
Inconclusive HIV test result	R75	Test result is not definitive — neither positive nor negative
Patient comes in for HIV screening — no known status	Z11.4	Screening encounter, no known infection
Contact with HIV-positive individual — no confirmed exposure outcome	Z20.6	Exposure, not confirmed infection or positive test

4.1C — Common Infectious Disease Codes

Code	Description	Key Notes for Coders
A09	Infectious gastroenteritis and colitis, unspecified	Not the same as food poisoning (A05.–); confirm etiology
A41.9	Sepsis, unspecified organism	Use ONLY when organism is not documented or cannot be determined
A41.01	Sepsis due to MSSA	Methicillin-susceptible Staph aureus; distinguish from MRSA (A41.02)
B00.9	Herpesviral infection, unspecified	Query for type before defaulting to unspecified; B00.1 = herpes labialis
B97.–	Viral agents as the cause of diseases classified elsewhere	Use as additional code; not principal; added to identify viral agent

Code	Description	Key Notes for Coders
J02.9	Acute pharyngitis, unspecified	Very common outpatient code; strep throat = J02.0
J06.9	Acute upper respiratory infection, unspecified	Common cold; use when no further specification is documented
J20.9	Acute bronchitis, unspecified	Code to organism if identified (J20.0–J20.8)
U07.1	COVID-19	Code first; if patient has associated pneumonia, add J12.82; follow current COVID coding guidelines

✓ Quick Check 4.1

1. A patient is admitted with sepsis due to E. coli with acute respiratory failure. What is the **correct sequencing** of the first two codes?

2. A patient tests positive for HIV but has no HIV-related illness. Which code is assigned: **B20 or Z21**?

3. True or False: "Urosepsis" is a valid ICD-10-CM code that should be assigned when a physician documents that term.

T **F**

4. What does code R75 represent in HIV coding?

5. A patient with established AIDS is admitted for an unrelated knee injury. Which HIV-related code, if any, should still be reported?

EXERCISE 4-A

—

Infectious Diseases: Sepsis, HIV, and Common Infections

Instructions: Answer each question using your ICD-10-CM code book. Write all codes in correct sequence. For multiple-code scenarios, fill in each code blank. Do not guess — look it up.

1. A patient is admitted with **sepsis due to Streptococcus, Group A**. Assign the correct principal diagnosis code.

Code: ___ ___ ___ . ___ ___

2. A patient has **severe sepsis due to E. coli with septic shock** and acute liver failure. Assign all codes in the correct sequence.

Code 1 (Principal): ___ ___ ___ . ___ ___

Code 2: ___ ___ ___ . ___ ___

Code 3: ___ ___ ___ . ___ ___

3. A patient with known AIDS presents for treatment of **Pneumocystis jirovecii pneumonia** (PCP). Assign codes in correct sequence.

Code 1: ___ ___ ___

Code 2: ___ ___ ___ . ___ ___

4. A patient tests **positive for HIV** but has no HIV-related symptoms or illness.

Code: ___ ___ ___

5. The physician documents that the patient had a recent **HIV test with inconclusive results**.

Code: ___ ___ ___

6. True or False: Bacteremia and sepsis are coded using the same ICD-10-CM

code.

T F

7. A patient is admitted with **sepsis due to MRSA**. There is no documentation of organ dysfunction or septic shock. Assign the correct code.

Code: ___ ___ ___ . ___ ___

8. True or False: Once a patient has been coded as having AIDS (B20), that code must be assigned at every future encounter.

T F

9. A patient presents with an **acute upper respiratory infection** (common cold) and no further specification is documented.

Code: ___ ___ ___ . ___ ___

10.

Which code category is used for septic shock? (circle one)

A. A41.– B. R65.21 C. A40.– D. R78.81

11. A patient is admitted for **COVID-19** with associated pneumonia. Assign codes in correct sequence.

Code 1: ___ ___ ___ . ___

Code 2: ___ ___ ___ . ___ ___

12. A patient presents for **HIV screening** with no known HIV status and no symptoms.

Code: ___ ___ ___ . ___

☠️ **Toolbox — Section 4.1 Key Takeaways**

- Sepsis requires the **infection coded first**; severe sepsis adds R65.20/R65.21; septic shock is never principal.
- "Urosepsis" is **not a valid ICD-10-CM code** — query the physician or code

the UTI only.

• HIV-positive asymptomatic = **Z21**; AIDS/symptomatic HIV disease = **B20** (lifetime code).

• Bacteremia is **NOT sepsis** — do not confuse them or use the same codes interchangeably.

• Always check Excludes notes in Chapter 1 — many localized infections are coded in body system chapters, not here.

SECTION 4.2 — ICD-10-CM Chapter 2: Neoplasms (C00–D49)

Overview of Chapter 2: C00–D49

Neoplasms are abnormal tissue growths. Chapter 2 of ICD-10-CM is organized first by **anatomic site** (where the growth is located) and then by **behavior** (whether it is malignant, benign, in situ, or uncertain). This chapter is unique in ICD-10-CM because it relies on a special reference tool — **the Table of Neoplasms** in the Alphabetic Index — as the required starting point for code selection.

4.2A — Neoplasm Terminology and Behavior

Before you can code neoplasms, you must understand the five behavior categories used in ICD-10-CM. These categories are not just clinical terms — they correspond directly to **five separate columns in the Neoplasm Table**.

Behavior	Clinical Meaning	ICD-10-CM	Key Point

		Range	
Malignant — Primary	Cancer at its original site of origin	C00–C75, C80–C96	Where the cancer started
Malignant — Secondary	Cancer spread (metastasized) to another location from the primary site	C77–C79	Where the cancer traveled to
Carcinoma in Situ	Cancer cells present but confined to original epithelium; not yet invasive	D00–D09	"In situ" = in place; has NOT spread
Benign	Non-cancerous; does not invade or spread	D10–D36	Still needs treatment in many cases
Uncertain Behavior	Pathologist cannot determine if benign or malignant	D37–D48	Based on pathology report; not guessed
Unspecified Behavior	Behavior not documented by physician	D49	Last resort — query provider first

4.2B — The Table of Neoplasms: How to Use It

The **Neoplasm Table** is located in Volume 2 (the Alphabetic Index) of ICD-10-CM. It contains thousands of anatomic sites arranged alphabetically, each with six columns corresponding to the six behavior categories. This is your **required starting point** for ALL neoplasm coding — no exceptions.

⚠️ **STOP!**

NEVER go directly to the Tabular List for neoplasms. The Neoplasm Table in the Alphabetic Index is the mandatory first step. If you skip the table and flip straight to the C-codes in the Tabular, you are bypassing the system designed

to guide you to the correct code column. You will make errors, and those errors can mean the difference between a correct primary and secondary code — which can change DRG assignment and reimbursement by thousands of dollars. Table first. Always.

Six Columns of the Neoplasm Table

Column	Behavior	Use When...
1	Malignant Primary	Cancer is at its original site of development
2	Malignant Secondary	Cancer has spread FROM another site TO this location
3	Ca in Situ	Pathology confirms pre-invasive cancer, confined to epithelium
4	Benign	Growth is non-cancerous and confirmed by pathology
5	Uncertain Behavior	Pathologist states behavior cannot be determined
6	Unspecified Behavior	Behavior is not documented — query first

Step-by-Step Process: Using the Neoplasm Table

1. Identify the **anatomic site** of the neoplasm from the documentation. Site comes first — not the behavior.
2. Locate that **site in the Neoplasm Table** (alphabetically in the Alphabetic Index).
3. Identify the **behavior** documented: primary malignant, secondary, in situ, benign, uncertain, or unspecified.
4. Select the code from the **correct column** that matches the behavior.

5. **Verify in the Tabular List** — read ALL instructional notes, Excludes1, Excludes2, and "Use Additional Code" notes before finalizing.

► Worked Example 4.2.1 — Primary Malignant Neoplasm of the Breast

Documentation: "Patient has primary malignant neoplasm of the right breast, upper outer quadrant."

Step 1: Site = Breast, right, upper outer quadrant

Step 2: Look up "Neoplasm, breast" in the Neoplasm Table → find "upper-outer quadrant"

Step 3: Behavior = Primary malignant → Column 1

Step 4: Code selected from Column 1 → **C50.411**

Step 5: Verify in Tabular — confirm site, laterality, confirm no exclusion notes applicable.

Final Code: C50.411 — Malignant neoplasm of upper-outer quadrant of right female breast

► Worked Example 4.2.2 — Colon Cancer with Liver Metastases

Documentation: "Patient with known colon cancer now presents with liver metastases."

Step 1: Two sites: Colon (primary) + Liver (secondary/metastatic)

Step 2–4: Colon cancer → Column 1 → C18.– (verify specific colon segment). Liver → Column 2 (secondary malignant) → **C78.7**

Sequencing Question: What is the reason for the encounter? If the patient is being seen for the liver metastasis treatment → C78.7 first, then C18.– as additional.

Final Code Set (if admitted for metastatic liver disease):
Code 1: **C78.7** — Secondary malignant neoplasm of liver

Code 2: **C18.9** — Malignant neoplasm of colon, unspecified (or specific segment)

► Worked Example 4.2.3 — Carcinoma In Situ of the Cervix

Documentation: "Pathology report shows carcinoma in situ of the cervix uteri."

Site: Cervix uteri | **Behavior:** Ca in Situ → Column 3

Final Code: D06.9 — Carcinoma in situ of cervix uteri, unspecified (or D06.0/D06.1 for specific zone)

► Worked Example 4.2.4 — Benign Neoplasm of the Parotid Gland

Documentation: "Patient has benign neoplasm of the parotid gland."

Site: Parotid gland | **Behavior:** Benign → Column 4

Final Code: D11.0 — Benign neoplasm of parotid gland

★ From the Trenches

"When I first learned neoplasm coding, that table scared the daylights out of me. Six columns, hundreds of sites, and all those C and D codes — I didn't know where to begin. What finally clicked for me was this: site first, behavior second, table always. I stopped worrying about memorizing codes and started trusting the process. Now I can navigate that table in my sleep. Drill the step-by-step process until it's automatic, and the codes will follow."

— Vanessa R., CPC-H, COC | Oncology HIM Coding Specialist | University Cancer Center, Houston, TX

4.2C — Neoplasm Coding Rules (Official Guidelines — HIGH YIELD)

◆ **Official Guidelines for Coding and Reporting**

ICD-10-CM Official Guidelines, Section I.C.2 — Neoplasms

"When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy... When an encounter is for management of a complication associated with the malignancy... and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the malignancy."

Plain English: Cancer coding is driven by the answer to this question: why is this patient here today? That answer determines what gets coded first. Past cancer no longer under treatment = Z85 history code. Current cancer with a complication driving the visit = complication code first. Cancer currently being treated = the malignancy leads.

Rule 1 — Primary vs. Secondary Sequencing

- Admitted for treatment of the **primary** malignancy → code the **primary first**.
- Admitted for treatment of a **secondary (metastatic) site** → code the **secondary first**, primary as additional.
- Both primary and secondary receive treatment → sequence based on **what is the primary reason for this specific admission**.

Rule 2 — Treatment of Complications of Malignancy

- Admitted for a **complication** of the malignancy (anemia, dehydration, nausea, pain) → code the **complication as principal** + malignancy as additional.
- **Anemia due to malignancy:** D63.0 (Anemia in neoplastic disease) — ADDITIONAL code; the malignancy sequences first.
- **Anemia due to chemotherapy:** D64.81 — sequence with malignancy; may require adverse effect coding.

Rule 3 — Chemotherapy, Radiation, and Immunotherapy Encounters (THE EXCEPTION RULE)

This is one of the most frequently tested neoplasm sequencing rules on the CPC exam. When a patient presents specifically FOR chemotherapy, radiation, or immunotherapy administration:

- **Z51.11** — Encounter for antineoplastic chemotherapy → **PRINCIPAL DIAGNOSIS**
- **Z51.0** — Encounter for antineoplastic radiation therapy → **PRINCIPAL DIAGNOSIS**
- **Z51.12** — Encounter for antineoplastic immunotherapy → **PRINCIPAL DIAGNOSIS**
- The malignancy is then coded as an **ADDITIONAL diagnosis**.

> ★ **Coding Shot**
>
> **When in doubt about neoplasm sequencing, ask yourself: "Why was this patient admitted TODAY?"** That single question cuts through most neoplasm sequencing confusion. Is the patient here to receive chemo? Z51.11 leads. Is the patient here because the cancer itself is causing a problem? The cancer code leads. Is the patient here because the chemo caused anemia? The anemia leads. Let the reason for the visit drive the sequence.

Rule 4 — Personal and Family History of Cancer

- **Personal history of malignancy** (cancer no longer active, treatment completed) → **Z85.–** codes
- **Family history of malignancy** → **Z80.–** codes

Rule 5 — Current vs. History

- If cancer is **actively being treated OR the primary site is still present** → use malignancy code (C__.–)
- If cancer is **no longer present and treatment is complete** → use personal history code (Z85.–)

⚠️ **CAUTION!**

Sequencing primary vs. secondary neoplasm codes incorrectly can change the DRG assignment by thousands of dollars. Inpatient DRG grouping is sensitive to which malignancy code is listed first. In outpatient settings, incorrect neoplasm sequencing affects the primary diagnosis, which drives medical necessity for procedures, labs, and imaging. A pattern of incorrect neoplasm sequencing can trigger payer audits and trigger recoupment demands on both facility and professional claims.

◆ **CMS Rules**

Medicare Chemotherapy Claim Sequencing: Medicare's Outpatient Code Editor (OCE) edits will **reject claims** with incorrect malignancy sequencing for chemotherapy encounters. When Z51.11 is the principal diagnosis, the malignancy must appear as an additional code — not the other way around. Facilities that consistently sequence these claims incorrectly will receive edit rejections and delayed reimbursement. Medicare Advantage plans follow the same rules. Verify sequencing before submitting every chemotherapy claim.

Check This Out!

Cancer is the **second leading cause of death in the United States**, accounting for nearly 600,000 deaths annually. Coders who specialize in oncology coding are consistently among the **highest-paid medical coders** in the field, with COC (Certified Outpatient Coder) and oncology-specific credentials commanding premium salaries. If you master Chapter 2 of ICD-10-CM, you have a skill set that is always in demand.

Neoplasm Coding Quick Reference

Scenario	Principal Dx	Additional Code(s)
Admitted for treatment of primary breast cancer	C50.–	Any comorbidities
Admitted for treatment of liver metastases from colon cancer	C78.7	C18.– (primary)
Outpatient chemotherapy for lung cancer	Z51.11	C34.– (malignancy)
Radiation therapy for prostate cancer	Z51.0	C61
Anemia due to malignancy — admitted for transfusion	C__ .–	D63.0
Anemia due to chemotherapy	C__ .–	D64.81
Breast cancer, no evidence of disease — follow-up	Z08	Z85.3 (history)
Family history of colon cancer — screening colonoscopy	Z12.11	Z80.0 (family hx)
Carcinoma in situ of bladder — excision	D09.0	Procedure code
Benign meningioma — craniotomy	D32.0	Procedure code
Uncertain behavior of	D37.5	Per pathology only

Scenario	Principal Dx	Additional Code(s)
rectal polyp on path report		
Malignant neoplasm of unknown primary with lung mets	C80.1	C78.0–
Dehydration — patient also has active colon cancer	E86.0	C18.–
Nausea/vomiting due to chemotherapy	R11.2	C__ .–; Z79.899
Pain due to malignancy of bone	C__ .–	G89.3

✓ Quick Check 4.2

1. What is the FIRST step in coding any neoplasm in ICD-10-CM?

2. A patient is admitted specifically to receive chemotherapy. What code is sequenced as principal diagnosis?

3. True or False: If cancer is no longer active and treatment is complete, the malignancy code (C__.–) is still reported.

T **F**

4. What is the difference between a "primary" and a "secondary" malignant neoplasm?

5. A patient has colon cancer that has metastasized to the lungs and is admitted for treatment of the lung metastases. Which code is sequenced first?

EXERCISE 4-B

—

Neoplasms: Table Use, Sequencing, and Special Rules

Instructions: Use the ICD-10-CM Neoplasm Table and Tabular List. Assign all codes in correct sequence. Fill in ALL blanks.

1. Patient is seen for outpatient **chemotherapy for primary malignant neoplasm of the sigmoid colon**.

Code 1 (Principal): ___ ___ ___ . ___ ___

Code 2: ___ ___ ___ . ___ ___

2. Patient is admitted for **dehydration due to chemotherapy side effects**. Patient has primary malignant neoplasm of the left ovary.

Code 1 (Principal): ___ ___ ___ . ___

Code 2: ___ ___ ___ . ___ ___

3. Pathology report: **benign neoplasm of the thyroid gland**.

Code: ___ ___ ___ . ___

4. Patient with **primary malignant neoplasm of the prostate** — admitted for radiation therapy.

Code 1 (Principal): ___ ___ ___ . ___

Code 2: ___ ___

5. Patient has a **carcinoma in situ of the cervix uteri**, endocervix.

Code: ___ ___ ___ . ___

6. Patient previously treated for breast cancer — **no evidence of disease**, here for follow-up.

Code 1: ___ ___ ___

Code 2: ___ ___ ___ . ___ ___

7. Patient admitted with **anemia due to primary malignant neoplasm of the stomach**. Anemia is the reason for admission.

Code 1 (Principal): ___ ___ ___ . ___

Code 2: ___ ___ ___ . ___

8. True or False: A patient with personal history of colon cancer (treatment complete, no evidence of disease) should be assigned C18.9 at every visit.

T **F**

9. A colon cancer patient is admitted for **brain metastases**. Treatment this admission is focused on the brain.

Code 1 (Principal): ___ ___ ___ . ___ ___

Code 2: ___ ___ ___ . ___ ___

10. Patient's pathology report documents **uncertain behavior of a rectal neoplasm**.

Code: ___ ___ ___ . ___

11.

Which column of the Neoplasm Table is used when the pathologist documents that behavior cannot be determined? (circle one)

A. Column 2 B. Column 4 C. Column 5 D. Column 6

12. Patient is a **60-year-old female with a family history of breast cancer**. She presents for routine screening mammogram. Assign the primary code for this encounter.

Code: ___ ___ ___ . ___ ___ ___

☠️ **Toolbox — Section 4.2 Key Takeaways**

- Always **start with the Neoplasm Table** in the Alphabetic Index — never

go directly to the Tabular for neoplasm codes.

• The Neoplasm Table has **six columns**: primary, secondary, Ca in situ, benign, uncertain, and unspecified behavior.

• For chemotherapy, radiation, or immunotherapy encounters → **Z51.11, Z51.0, or Z51.12 is principal**; the malignancy is additional.

• Anemia due to malignancy = malignancy first + **D63.0**; anemia due to chemo = malignancy + **D64.81**.

• Cancer that is no longer active and treatment is complete → **Z85.– personal history code**, not a C-code.

SECTION 4.3 — ICD-10-CM Chapter 3: Diseases of the Blood and Blood-Forming Organs (D50–D89)

Overview of Chapter 3: D50–D89

Chapter 3 covers **anemias, coagulation defects, other blood disorders, and disorders involving the immune mechanism**. In the real coding world, the codes in this chapter are most frequently assigned as **additional diagnoses** — secondary to cancer, chronic kidney disease, nutritional deficiency, or medication effects. The most critical concept: many anemia codes require TWO codes — the anemia code AND the underlying cause.

4.3A — Anemias

Anemia is a condition in which the blood lacks enough healthy red blood cells or hemoglobin. ICD-10-CM classifies anemia by both **type** (what kind of anemia) and

cause (what is causing it). Both elements must be documented and coded accurately.

Types of Anemia and Key Codes

Iron Deficiency Anemia (D50.–) — the most common type of anemia worldwide:

- D50.0 — Iron deficiency anemia secondary to blood loss (chronic)
- D50.1 — Sideropenic dysphagia (Plummer-Vinson syndrome)
- D50.9 — Iron deficiency anemia, unspecified

Vitamin B12 Deficiency Anemia (D51.–):

- D51.0 — Vitamin B12 deficiency anemia due to intrinsic factor deficiency (**Pernicious anemia**)
- D51.9 — Vitamin B12 deficiency anemia, unspecified

Folate Deficiency Anemia (D52.–):

- D52.0 — Dietary folate deficiency anemia
- D52.9 — Folate deficiency anemia, unspecified

Aplastic Anemia (D60–D61): Bone marrow fails to produce sufficient blood cells. D61.9 = aplastic anemia, unspecified.

Anemia Due to Chronic Disease:

- D63.0 — Anemia in neoplastic disease (use additional code for the neoplasm; malignancy is coded first)
- D63.1 — Anemia in chronic kidney disease (CKD must be coded first per "Code First" instruction)

Sickle Cell Anemia (D57.–): Highly specific codes based on type and crisis status:

- D57.1 — Sickle-cell disease without crisis
- D57.00 — HbSS disease with acute chest syndrome
- D57.01 — HbSS disease with splenic sequestration

◆ **Official Guidelines for Coding and Reporting**

ICD-10-CM Official Guidelines, Section I.C.2.c.1 — Anemia Associated with Malignancy

"When the admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by the appropriate code for the anemia (such as code D63.0, Anemia in neoplastic disease)... When the admission/encounter is for management of anemia associated with an adverse effect of radiotherapy, the anemia code is sequenced first, followed by the appropriate codes for the neoplasm and the adverse effect."

Plain English: Anemia caused by the cancer itself → cancer code first, D63.0 additional. Anemia caused by chemotherapy → D64.81 first OR cancer first (check guidelines carefully for current direction). Anemia caused by radiation → anemia code leads, then malignancy, then adverse effect code. The cause of the anemia determines your sequencing.

Code	Type of Anemia	Key Notes	Common Additional Code Needed
D50.0	Iron deficiency anemia, secondary to blood loss	Must document chronic blood loss source	K92.1 (GI bleed) or other source
D50.9	Iron deficiency anemia, unspecified	Last resort — query for cause	None typically
D51.0	Pernicious anemia (B12 deficiency, intrinsic factor)	Autoimmune; requires B12 injections	None usually
D57.1	Sickle-cell disease without crisis	Confirm type (HbSS vs. HbSC)	Depends on complications
D63.0	Anemia in neoplastic disease	Always additional; cancer code first	Malignancy code (C__.–) coded first

Code	Type of Anemia	Key Notes	Common Additional Code Needed
D63.1	Anemia in chronic kidney disease	"Code First" note — CKD leads	N18.– (CKD stage) coded first
D64.81	Anemia due to antineoplastic chemotherapy	Chemo-induced; adverse effect sequencing	Malignancy + T45.1x5A (adverse effect)
D64.9	Anemia, unspecified	Last resort — do not default here without review	Depends on cause

★ Coding Shot

Anemia that is coded as "due to" or "associated with" another condition **almost always requires the underlying condition to be coded first**. Look for the "Code First" or "Use Additional Code" note at the anemia code in the Tabular. D63.0 and D63.1 both have explicit "Code First" notes — this means the neoplasm and the CKD code must come before D63.0 or D63.1 in the code set. These instructional notes are not suggestions. They are sequencing rules.

⚠ STOP!

Do NOT default to D64.9 (Anemia, unspecified) when a more specific type is documented or can be determined from lab results referenced in the chart. Review the laboratory findings, the clinical documentation, and the physician's description of the anemia before assigning an unspecified code. If the type is not clear from the record, query the physician. Unspecified codes signal to payers that documentation may be insufficient — and they are prime targets for medical record review requests.

4.3B — Coagulation Defects and Other Blood Disorders

Code	Condition	Key Points
D66	Hemophilia A	Factor VIII deficiency; most common type of hemophilia
D67	Hemophilia B	Factor IX deficiency; also called Christmas disease
D68.0	Von Willebrand disease	Most common inherited bleeding disorder; affects platelet function
D69.–	Thrombocytopenia	Low platelet count; multiple causes; code to specificity (D69.3, D69.4, D69.6, etc.)
D75.1	Secondary polycythemia	Increased RBCs due to another condition (COPD, altitude, EPO use)
D89.9	Disorder involving the immune mechanism, unspecified	Used when immune disorder is documented but not further specified

✓ **Quick Check 4.3**

1. What is the correct code for **pernicious anemia**?

2. A patient has anemia associated with CKD Stage 3. Which code is listed FIRST in the code set?

3. True or False: D63.0 (Anemia in neoplastic disease) is sequenced BEFORE the malignancy code.

T **F**

4. What condition does code D66 represent?

5. A patient is documented to have iron deficiency anemia secondary to chronic GI blood loss. Which D50 code is most appropriate?

EXERCISE 4-C

—

Blood Disorders: Anemia Coding and Sequencing

Instructions: Assign the correct ICD-10-CM code(s) for each scenario. Determine correct sequencing. Fill in all blanks.

1. Patient has **anemia in chronic kidney disease, Stage 4**. Assign codes in correct sequence.

Code 1 (Principal): ___ ___ ___ . ___ ___

Code 2: ___ ___ ___ . ___

2. Patient has **pernicious anemia**.

Code: ___ ___ ___ . ___

3. Patient with **primary malignant neoplasm of the uterus** is admitted for **anemia due to the malignancy**.

Code 1 (Principal): ___ ___ ___ . ___ ___

Code 2: ___ ___ ___ . ___

4. Patient has **Hemophilia A**.

Code: ___ ___ ___

5. Patient has **sickle-cell disease (HbSS) without crisis**.

Code: ___ ___ ___ . ___

6. Patient has **iron deficiency anemia secondary to chronic blood loss**.

Code: ___ ___ ___ . ___

7. True or False: Von Willebrand disease is classified under the hemophilia codes in ICD-10-CM.

T F

8. The physician documents "anemia" with no further specification and the record has no lab values referenced. What is the correct code?

Code: ___ ___ ___ . ___

Note on the line: what action should you take BEFORE assigning this code?

9.

Which type of anemia is associated with

Factor IX deficiency

? (circle one)

A. Hemophilia A B. Von Willebrand Disease C. Hemophilia B D. Aplastic Anemia

10. True or False: Anemia in neoplastic disease (D63.0) can be sequenced as the principal diagnosis when the patient is admitted for the anemia treatment.

T F

☠️ **Toolbox — Section 4.3 Key Takeaways**

- Anemia "due to" or "associated with" another condition requires the

underlying condition coded first — check for "Code First" notes in the Tabular.

• **D63.0** (anemia in neoplastic disease) and **D63.1** (anemia in CKD) are both additional codes — never principal diagnoses standing alone.

• Pernicious anemia = **D51.0**; caused by lack of intrinsic factor; B12 injections required for life.

• Hemophilia A = **D66** (Factor VIII); Hemophilia B = **D67** (Factor IX). Know both for the CPC exam.

• Always code sickle-cell disease to the highest specificity — type AND crisis status are both captured in the D57 subcategories.

SECTION 4.4 — ICD-10-CM Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00–E89)

Overview of Chapter 4: E00–E89

Chapter 4 of ICD-10-CM covers an enormous range of conditions — from **thyroid disorders to diabetes to obesity to electrolyte imbalances**. Diabetes mellitus is by far the most tested condition in this chapter and one of the most tested on the CPC exam overall. Multiple codes are frequently required — always read instructional notes carefully before finalizing your code set.

4.4A — Diabetes Mellitus — HIGHEST YIELD ENDOCRINE TOPIC

Diabetes mellitus (DM) is a chronic metabolic disorder in which the body cannot properly regulate blood glucose. ICD-10-CM has five main categories for diabetes, and selecting the **correct category** is the first step — before you even think about complications.

Diabetes Categories at a Glance

Type	Code Category	Cause	Key Coding Note
Type 1 DM	E10.–	Autoimmune destruction of beta cells; no insulin production	Do NOT add Z79.4 — insulin is inherent to Type 1
Type 2 DM	E11.–	Insulin resistance; most common type; may use insulin or oral meds	Add Z79.4 if uses insulin; Z79.84 if oral hypoglycemics
DM due to underlying condition	E08.–	Pancreatic disease, endocrine disorder, other causes	Code the **underlying condition FIRST**
Drug/chemical-induced DM	E09.–	Medication-induced (steroids, tacrolimus, etc.)	Code the adverse effect of the drug first
Other specified DM	E13.–	Post-pancreatectomy, post-procedural, other specified	Use when another category does not apply

⚠️ **STOP!**

Do NOT assume Type 2 diabetes without documentation. Per ICD-10-CM Official Guidelines, if the type of diabetes is not documented, the **default is Type 2 (E11.–)**. However, this default applies ONLY when the physician has not specified the type. If ANY indication of the type exists in the record — insulin pump, history of DKA, childhood onset, physician notes — you should code accordingly and query if there is conflicting information. Never assume Type 1 without documentation, and never assign Type 2 when Type 1 is documented or

strongly indicated.

Diabetes Combination Codes — HIGH YIELD

One of the most powerful features of ICD-10-CM diabetes coding is the use of **combination codes** — a single code that captures both the diabetes type AND the complication. Check for a combination code before adding a separate complication code.

Code	Description	Notes
E11.21	Type 2 DM with diabetic nephropathy	Combination code — no separate nephropathy code needed
E11.22	Type 2 DM with diabetic chronic kidney disease	Add N18.– for the CKD stage ("Use Additional Code" note)
E11.311	Type 2 DM with unspecified diabetic retinopathy with macular edema	Add laterality code if applicable
E11.40	Type 2 DM with diabetic neuropathy, unspecified	Code to specific neuropathy type if documented
E11.51	Type 2 DM with diabetic peripheral angiopathy without gangrene	E11.52 if gangrene is present
E11.65	Type 2 DM with hyperglycemia	When hyperglycemia is the documented complication
E11.641	Type 2 DM with hypoglycemia with coma	E11.649 if without coma
E11.9	Type 2 DM without complications	Use when no complications are documented
E10.10	Type 1 DM with diabetic nephropathy, unspecified	Same combination code logic applies for E10 category

★ **Coding Shot**

The diabetes combination codes in ICD-10-CM **eliminate the need for multiple codes in most cases**. Before adding a separate complication code, always check: is there a combination code in the E10 or E11 subcategories that already captures both the diabetes AND the complication? For example, E11.21 already tells you it is Type 2 diabetes WITH nephropathy — you do not need a separate nephropathy code unless instructed to add one (like N18.– for CKD stage). Read the "Use Additional Code" notes carefully — they tell you exactly when you DO need that extra code.

Insulin Use Z Code Rules

- **Type 2 patient using insulin:** Add **Z79.4** (Long-term current use of insulin) as an additional code to the E11.– code.
- **Type 2 patient using oral hypoglycemic agents:** Add **Z79.84** (Long-term current use of oral hypoglycemic drugs) as additional.
- **Type 1 patient using insulin:** Do **NOT** add Z79.4 — insulin use is inherent to Type 1 diabetes. Adding Z79.4 to a Type 1 code is incorrect.

⚠ **CAUTION!**

Adding Z79.4 to a Type 1 diabetes claim (E10.–) is incorrect and may trigger a **payer audit**. Payers' claims editing systems flag E10.– + Z79.4 as a contradiction because Type 1 diabetes by definition requires insulin — the Z code is redundant and signals a potential coding error. This combination is a known compliance risk. Never add Z79.4 to any E10 code. Reserve Z79.4 exclusively for Type 2 diabetics and other types (E08, E09, E13) who require insulin.

◆ **Official Guidelines for Coding and Reporting**

ICD-10-CM Official Guidelines, Section I.C.4.a — Diabetes Mellitus

"If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11-, Type 2 diabetes mellitus, should be assigned... An individual who uses insulin is not necessarily a Type 1 diabetic... Assign as many codes from categories E08–E13 as needed to identify all of the associated conditions that the patient has."

Plain English: Insulin use does NOT automatically mean Type 1 diabetes. Type 2 diabetics can and do use insulin. When the type is not documented, default to Type 2. Assign as many diabetes codes as needed to capture all documented complications — but always check for combination codes first, since one code may already cover multiple elements.

► Worked Example 4.4.1 — Type 2 DM with CKD on Insulin

Clinical Documentation:

Patient with Type 2 diabetes with diabetic chronic kidney disease Stage 3, on insulin.

Step 1 — Identify the diabetes type: Type 2 → E11 category.

Step 2 — Identify the complication: Diabetic chronic kidney disease → Look for combination code → **E11.22** (Type 2 DM with diabetic chronic kidney disease).

Step 3 — Check instructional notes for E11.22: "Use Additional Code to identify stage of CKD (N18.1–N18.6)" → Stage 3 = **N18.3**.

Step 4 — Document insulin use: Type 2 on insulin → Add **Z79.4** (Long-term

current use of insulin).

Final Code Set (correct sequence):

Position

Code

Description

Reason

1st

E11.22

Type 2 DM with diabetic chronic kidney disease

Principal — the diabetes with its complication

2nd

N18.3

Chronic kidney disease, stage 3

Required by "Use Additional Code" note at E11.22

3rd

Z79.4

Long-term current use of insulin

Required for Type 2 patients using insulin

★ From the Trenches

"I spent my first two years coding in an endocrinology practice, and I can honestly say that diabetes coding alone took me at least six months to feel truly comfortable with. The combination codes changed everything when ICD-10-CM

rolled out — but you still have to know which code captures what, when to add the CKD stage, when to add the Z codes, and when one code really is enough. My advice: build a cheat sheet of your most-used diabetes codes with their 'use additional code' reminders right next to them. You'll use it every single day."

— Priya S., CPC, CPMA | Senior Coding Specialist, Endocrinology | Academic Faculty Practice, Nashville, TN

◆ CMS Rules

Medicare Chronic Condition Data Warehouse and Diabetes Quality Reporting: CMS tracks diabetes codes submitted on Medicare claims through the **Chronic Condition Data Warehouse (CCW)**. Incorrect diabetes type coding — such as assigning Type 2 when the patient actually has Type 1 — directly affects the accuracy of CMS quality metrics, hospital star ratings, and ACO performance scorecards. Risk-adjusted payment models (including Medicare Advantage capitation) rely on accurate diabetes coding. Incorrect diabetes codes can cause your facility to receive underpayments or trigger risk adjustment audits. Get the type right — every time.

● Check This Out!

Diabetes mellitus affects more than 37 million Americans — approximately 11% of the U.S. population — and costs the U.S. healthcare system over **$327 billion annually** in direct medical costs and lost productivity. An additional 96 million Americans have prediabetes. Because diabetes is so prevalent and so costly, diabetes coding accuracy is critically important to public health tracking, quality measure reporting, and appropriate risk-adjusted reimbursement across every care setting.

4.4B — Thyroid Disorders

Code	Condition	Key Points
E03.9	Hypothyroidism, unspecified	Most common thyroid disorder; underactive thyroid; treated with levothyroxine
E03.0	Congenital hypothyroidism with diffuse goiter	Present at birth; newborn screening detects this
E04.9	Nontoxic goiter, unspecified	Enlarged thyroid without hyperthyroidism
E05.00	Thyrotoxicosis with diffuse goiter, without thyrotoxic crisis	Graves disease — autoimmune hyperthyroidism
E05.01	Thyrotoxicosis with diffuse goiter, with thyrotoxic crisis or storm	Life-threatening emergency; critical coding distinction
E06.3	Autoimmune thyroiditis	Hashimoto's thyroiditis — most common cause of hypothyroidism
C73	Malignant neoplasm of thyroid gland	Coded from Chapter 2 (C-codes), NOT from Chapter 4 (E-codes)

4.4C — Obesity and BMI Coding

Obesity is coded from the E66 category. BMI (Body Mass Index) codes from category Z68 are reported as **additional codes only** — never as the principal diagnosis on their own. BMI codes are assigned based on the physician's documentation of obesity or overweight; a coder cannot assign a BMI code based solely on height and weight measurements in the chart.

Code	Description	BMI Threshold / Notes
E66.01	Morbid (severe) obesity due to excess calories	BMI ≥ 40; most commonly coded obesity type in inpatient settings
E66.09	Other obesity due to excess calories	BMI 30.0–39.9
E66.1	Drug-induced obesity	Code the adverse effect of the drug first
E66.9	Obesity, unspecified	Last resort; query if BMI/type not documented
Z68.–	Body mass index (BMI) codes	Always ADDITIONAL codes; never principal; adults only (21+)
Z68.5–	Pediatric BMI codes	For patients age 2–19; different coding than adult BMI

4.4D — Fluid and Electrolyte Disorders

Fluid and electrolyte disorders are frequently coded as **additional diagnoses** associated with another primary condition (dehydration following surgery, hypokalemia due to diuretic therapy, hyponatremia in heart failure, etc.). Always check for sequencing instructions — many of these codes have "code first underlying condition" instructions.

Code	Condition	Clinical Significance
E86.0	Dehydration	Most common fluid disorder coded; frequently secondary to vomiting, diarrhea, or poor intake
E86.1	Hypovolemia	Decreased blood volume; distinguish from simple dehydration
E87.0	Hyperosmolality and hypernatremia	High sodium; associated with dehydration and altered mental status

Code	Condition	Clinical Significance
E87.1	Hyponatremia	Low sodium; common in heart failure, cirrhosis, SIADH
E87.5	Hyperkalemia	High potassium; associated with CKD, ACE inhibitors; cardiac risk
E87.6	Hypokalemia	Low potassium; common with diuretic use, vomiting, diarrhea
E87.8	Other disorders of electrolyte and fluid balance NEC	When specific electrolyte disorder does not fit above categories

✓ Quick Check 4.4

1. A patient with Type 2 diabetes uses both insulin and metformin. What two Z codes, if any, should be added to the diabetes code(s)?

2. True or False: A BMI code (Z68.–) can be assigned as the principal diagnosis on a claim.

T **F**

3. A Type 1 diabetic patient is on an insulin pump. Should Z79.4 be added to the claim? Explain.

4. What is the code for Hashimoto's thyroiditis?

5. A patient presents with low potassium documented as hypokalemia. What is the correct ICD-10-CM code?

EXERCISE 4-D

—

Endocrine, Obesity, and Metabolic Coding

Instructions: Assign all correct ICD-10-CM codes in the correct sequence. Fill in every blank. Use your code book.

1. Patient has **Type 2 diabetes with diabetic nephropathy**, not on insulin.

Code 1: ___ ___ ___ . ___ ___

2. Patient has **Type 2 diabetes with unspecified diabetic retinopathy with macular edema**, on insulin.

Code 1: ___ ___ ___ . ___ ___ ___

Code 2: ___ ___ ___ . ___

3. Patient has **Type 1 diabetes with hyperglycemia**.

Code 1: ___ ___ ___ . ___ ___

Is Z79.4 required here? (circle) YES NO

4. Patient has **morbid obesity with BMI of 43.2**.

Code 1: ___ ___ ___ . ___ ___

Code 2 (BMI): ___ ___ ___ . ___ ___

5. Patient is diagnosed with **hypothyroidism, unspecified**.

Code: ___ ___ ___ . ___

6. Patient has **Type 2 diabetes with diabetic chronic kidney disease, Stage 4, on oral hypoglycemics only**.

Code 1: ___ ___ ___ . ___ ___

Code 2: ___ ___ ___ . ___

Code 3: ___ ___ ___ . ___ ___

7. Patient has **autoimmune thyroiditis** (Hashimoto's).

Code: ___ ___ ___ . ___

8. Patient presents with **dehydration and hyponatremia**. Both are documented. Assign codes.

Code 1: ___ ___ ___ . ___

Code 2: ___ ___ ___ . ___

9. True or False: A coder can assign a BMI code based solely on documented height and weight measurements, even if the physician does not document obesity or overweight.

T F

10.

Patient with drug-induced diabetes (steroid-induced) on oral hypoglycemics. What is the correct

diabetes code category

? (circle one)

A. E10.– B. E08.– C. E09.– D. E11.–

11. Patient has **hyperkalemia**. Assign the correct code.

Code: ___ ___ ___ . ___

12. Patient has **Graves disease (thyrotoxicosis with diffuse goiter, no thyrotoxic storm)**.

Code: ___ ___ ___ . ___ ___

☠️ **Toolbox — Section 4.4 Key Takeaways**

- Diabetes has five ICD-10-CM categories (E08–E13) — always identify the

correct type and cause before selecting a code.

• Combination codes capture diabetes + complication in one code — **always check for a combination code first**.

• Add **Z79.4** for Type 2 on insulin; **Z79.84** for Type 2 on oral hypoglycemics; **never add Z79.4** to Type 1.

• BMI codes (Z68.–) are **always additional** — never principal — and require provider documentation of overweight/obesity.

• Electrolyte disorders are frequently secondary conditions — always check for "code first" notes and sequence accordingly.

SECTION 4.5 — Putting It All Together: Coding from Real Documentation

Now it is time to take everything you have learned in Sections 4.1 through 4.4 and apply it to complete, real-world clinical scenarios. This is exactly what you will do on the CPC exam — and every day at work. For each scenario below, walk through the coding process step by step before writing your codes. Identify how many codes are needed, what they are, and why they are sequenced in that order.

► Scenario 4.5.1 — Sepsis with Diabetes, CKD, and Hypokalemia

Clinical Documentation:

Patient admitted with sepsis due to E. coli. Patient also has Type 2 diabetes on insulin and Stage 3 CKD. Labs show hypokalemia.

Step 1 — Identify the principal diagnosis: Sepsis due to E. coli → **A41.51** (Sepsis due to Escherichia coli). This is the principal diagnosis — sepsis always leads the code set.

Step 2 — Code the diabetes with CKD: Type 2 DM with diabetic CKD → **E11.22**. CKD Stage 3 → add **N18.3** per "use additional code" note at E11.22.

Step 3 — Insulin use: Type 2 on insulin → add **Z79.4**.

Step 4 — Electrolyte disorder: Hypokalemia → **E87.6**.

Final Code Set:

#

Code

Description

Rationale

1

A41.51

Sepsis due to E. coli

Principal — underlying systemic infection

2

E11.22

Type 2 DM with diabetic CKD

Combination code for DM + CKD

3

N18.3

CKD, Stage 3

"Use Additional Code" instruction at E11.22

4

Z79.4

Long-term current use of insulin

Type 2 patient on insulin

5

E87.6

Hypokalemia

Lab-documented electrolyte disorder

► Scenario 4.5.2 — Chemotherapy Encounter with Breast Cancer, Metastases, and Anemia

Clinical Documentation:

Patient presents to outpatient oncology clinic for chemotherapy for primary malignant neoplasm of left breast with metastases to the liver. Patient also has iron deficiency anemia due to the malignancy.

Step 1 — Reason for encounter: Chemotherapy encounter → **Z51.11** is

principal (exception rule for chemo encounters).

Step 2 — The primary malignancy: Left breast cancer → use Neoplasm Table → primary malignant → verify site and laterality → **C50.912** (or appropriate breast subsite code for left breast).

Step 3 — Metastatic site: Liver metastases → Column 2 of Neoplasm Table → **C78.7** (Secondary malignant neoplasm of liver).

Step 4 — Anemia due to malignancy: Malignancy is already coded → add **D63.0** (Anemia in neoplastic disease).

Final Code Set:

#

Code

Description

Rationale

1

Z51.11

Encounter for antineoplastic chemotherapy

Principal — reason for the outpatient visit

2

C50.912

Malignant neoplasm of breast, left (verify subsite)

Primary malignancy — additional after Z51.11

3

C78.7

Secondary malignant neoplasm of liver

Metastatic site — additional

4

D63.0

Anemia in neoplastic disease

Additional — anemia due to cancer

► Scenario 4.5.3 — AIDS with PCP Pneumonia and Severe Sepsis

Clinical Documentation:

Patient with AIDS presents with Pneumocystis pneumonia and severe sepsis with septic shock.

Step 1 — AIDS: Symptomatic HIV disease → **B20**. AIDS is the principal diagnosis here since the severe sepsis and pneumonia are manifestations of the AIDS.

Step 2 — Pneumocystis pneumonia: PCP (Pneumocystis jirovecii) is an AIDS-defining opportunistic infection → **B59** (Pneumocystosis).

Step 3 — Severe sepsis with septic shock: Sepsis is present with septic shock → **R65.21** (Severe sepsis with septic shock).

Step 4 — Identify the sepsis source: The underlying infection driving the sepsis is the Pneumocystis pneumonia — consider whether an additional sepsis organism code applies per documentation. If physician documents sepsis due to the HIV/AIDS immune compromise, the coding follows the sepsis guidelines with B20 leading.

Final Code Set:

#

Code

Description

Rationale

1

B20

HIV disease (AIDS)

Principal — underlying disease driving all manifestations

2

B59

Pneumocystosis (PCP pneumonia)

AIDS-defining opportunistic infection — manifestation

3

R65.21

Severe sepsis with septic shock

Severity indicator — severe sepsis with shock

► Scenario 4.5.4 — Type 1 DM with Hyperglycemia, Morbid Obesity, Hypothyroidism

Clinical Documentation:

Patient with Type 1 diabetes with hyperglycemia, morbid obesity (BMI 43.2), and hypothyroidism.

Step 1 — Type 1 DM with hyperglycemia: Combination code → **E10.65** (Type 1 DM with hyperglycemia). Do NOT add Z79.4 — Type 1.

Step 2 — Morbid obesity: BMI ≥ 40 → **E66.01** (Morbid obesity due to excess calories).

Step 3 — BMI code: BMI 43.2 → **Z68.43** (BMI 43.0–43.9 — verify exact Z68 code for 43.2).

Step 4 — Hypothyroidism: If unspecified → **E03.9**.

Final Code Set:

#

Code

Description

Rationale

1

E10.65

Type 1 DM with hyperglycemia

Principal — primary reason for encounter

2

E66.01

Morbid (severe) obesity due to excess calories

Additional comorbidity

3

Z68.43

BMI 43.0–43.9

Additional — always accompanies obesity documentation

4

E03.9

Hypothyroidism, unspecified

Additional comorbidity

Note: Z79.4 is NOT added because this is a Type 1 patient. Insulin use is inherent to Type 1 diabetes.

► Scenario 4.5.5 — Carcinoma In Situ, Treatment Discussion

Clinical Documentation:

Pathology report confirms carcinoma in situ of the cervix uteri. Patient is here for discussion of treatment options.

Step 1 — Identify the neoplasm behavior: Carcinoma in situ → Column 3 of the Neoplasm Table. Site = Cervix uteri.

Step 2 — Look up in Neoplasm Table: "Neoplasm, cervix uteri" → Ca in Situ column → **D06.9** (Carcinoma in situ of cervix uteri, unspecified) or D06.0/D06.1 if endocervix or exocervix is specified.

Step 3 — The encounter: This is a discussion of treatment options — no chemotherapy administered today, no surgical procedure today. Code the

primary reason for the encounter: the carcinoma in situ.

Final Code Set:

#

Code

Description

Rationale

1

D06.9

Carcinoma in situ of cervix uteri, unspecified

Principal — the confirmed diagnosis driving the encounter

Note: This is NOT a malignant neoplasm code (C-code). Carcinoma in situ is a D-code. The distinction is critical.

✓ Quick Check 4.5

1. In Scenario 4.5.1, why is A41.51 listed as the principal diagnosis rather than E11.22?

2. In Scenario 4.5.2, why is Z51.11 listed as the principal diagnosis rather than the breast cancer code?

3. True or False: In Scenario 4.5.4, Z79.4 should be added because the patient with Type 1 diabetes is using insulin.

T **F**

4. In Scenario 4.5.5, why is a D-code assigned rather than a C-code for the cervical finding?

5. A patient with AIDS and severe sepsis with septic shock is admitted. Which condition is typically sequenced first in the code set?

EXERCISE 4-E

—

Multi-System Coding Scenarios (Independent Practice)

Instructions: For each scenario, assign ALL ICD-10-CM codes in the correct sequence. Use your code book. Write each code on a separate line. No answers are provided — this exercise is for independent skill-building.

1. Patient admitted with **severe sepsis due to MRSA, septic shock, acute respiratory failure**. Patient has Type 2 diabetes on oral hypoglycemics.

Code 1: ___ ___ ___ . ___ ___

Code 2: ___ ___ ___ . ___ ___

Code 3: ___ ___ ___ . ___ ___

Code 4: ___ ___ ___ . ___

Code 5: ___ ___ ___ . ___ ___

2. Outpatient encounter: **immunotherapy for primary malignant neoplasm of the sigmoid colon with retroperitoneal lymph node metastases**. Patient has iron deficiency anemia, unspecified.

Code 1: ___ ___ ___ . ___ ___

Code 2: ___ ___ ___ . ___ ___

Code 3: ___ ___ ___ . ___ ___

Code 4: ___ ___ ___ . ___

3. Patient with AIDS admitted for treatment of oral candidiasis and dehydration.

Code 1: ___ ___ ___

Code 2: ___ ___ ___ . ___ ___

Code 3: ___ ___ ___ . ___

4. Patient has **Type 2 diabetes with diabetic peripheral angiopathy without gangrene, morbid obesity (BMI 41.0), on insulin**.

Code 1: ___ ___ ___ . ___ ___

Code 2: ___ ___ ___ . ___ ___

Code 3: ___ ___ ___ . ___ ___

Code 4: ___ ___ ___ . ___

5. Patient has **anemia in CKD Stage 5, hypothyroidism, and hyponatremia**.

Code 1: ___ ___ ___ . ___

Code 2: ___ ___ ___ . ___

Code 3: ___ ___ ___ . ___

Code 4: ___ ___ ___ . ___

6. Patient is admitted with **pernicious anemia and hyperkalemia**. Physician documents dehydration as well.

Code 1: ___ ___ ___ . ___

Code 2: ___ ___ ___ . ___

Code 3: ___ ___ ___ . ___

7. Patient presents for **radiation therapy for carcinoma in situ of the bladder**.

Code 1: ___ ___ ___ . ___

Code 2: ___ ___ ___ . ___

8. Patient has **drug-induced diabetes (steroid-induced), Type not**

otherwise specified, with hyperglycemia, on insulin.

Code 1: ___ ___ ___ . ___ ___

Code 2 (adverse effect): ___ ___ ___ . ___ ___ ___ ___

Code 3: ___ ___ ___ . ___

9. Patient with **known HIV-positive status (asymptomatic) admitted for appendicitis with peritonitis**.

Code 1: ___ ___ ___ . ___ ___

Code 2: ___ ___ ___

10. Patient has **Graves disease (thyrotoxicosis with diffuse goiter) with thyrotoxic crisis, Type 2 diabetes without complications, on oral hypoglycemic agents**.

Code 1: ___ ___ ___ . ___ ___

Code 2: ___ ___ ___ . ___

Code 3: ___ ___ ___ . ___ ___

☠️ **Toolbox — Section 4.5 Key Takeaways**

- Multi-system coding requires asking: **what is the principal reason for this admission/encounter?** That drives sequencing.
- The **sepsis code always leads** the code set when sepsis is present — even when the patient has multiple comorbidities like diabetes or CKD.
- Chemotherapy and radiation therapy encounters are **exceptions** — Z51.11 or Z51.0 leads, and the malignancy is additional.
- Carcinoma in situ = **D-codes**, not C-codes. Don't confuse them on the exam.
- When multiple conditions are present, assign codes for ALL documented conditions that receive treatment or affect management — and sequence

them thoughtfully.

◆ Chapter 4 Summary

1. **Sepsis sequencing:** The underlying systemic infection is always coded first (A40.–/A41.–). Severe sepsis adds R65.20 or R65.21, plus codes for organ dysfunction. Septic shock (R65.21) is never the principal diagnosis.

2. **HIV and AIDS coding rules:** HIV-positive asymptomatic = Z21; symptomatic AIDS = B20. Once B20 is assigned, it is reported at every future encounter. "Urosepsis" and B20 are two of the most commonly tested coding traps — know them cold.

3. **Neoplasm Table is mandatory:** All neoplasm coding begins with the Neoplasm Table in the Alphabetic Index — never with the Tabular. Site first, then behavior, then column selection.

4. **Primary vs. secondary neoplasm sequencing:** The reason for the visit determines which malignancy code leads. Chemotherapy/radiation encounters are the exception — Z51.11 or Z51.0 leads regardless.

5. **Anemia with underlying condition:** Anemia associated with CKD (D63.1) or malignancy (D63.0) always requires the underlying condition coded first per "Code First" notes in the Tabular. These are additional codes — not principal diagnoses.

6. **Diabetes combination codes:** ICD-10-CM provides extensive combination codes that capture diabetes type AND complication in a single code. Always check for a combination code before adding a separate complication code.

7. **Insulin Z code rules:** Add Z79.4 for Type 2 diabetics on insulin; add

Z79.84 for oral hypoglycemics. Never add Z79.4 to a Type 1 diabetes code — insulin use is inherent to Type 1.

8. **BMI coding:** BMI codes (Z68.–) are always additional codes, never principal. They require the provider to document obesity or overweight — a coder cannot assign them based solely on recorded height and weight measurements.

9. **Electrolyte disorders:** Hyponatremia (E87.1), hypokalemia (E87.6), hyperkalemia (E87.5), and dehydration (E86.0) are frequently coded as additional diagnoses. Always look for "code first" instructions and sequence with the underlying cause.

10. **Outpatient vs. inpatient uncertain diagnoses:** In outpatient settings, do NOT code "uncertain" or "probable" diagnoses — code to the highest degree of certainty (signs, symptoms, findings). In inpatient settings, uncertain diagnoses documented at discharge may be coded as if confirmed.

◆

Chapter 4 Review — 30 Questions

Complete all questions. Use your ICD-10-CM code book where applicable. This review covers the full content of Chapter 4.

SECTION A — MULTIPLE CHOICE (QUESTIONS 1–10)

Circle the letter of the best answer for each question.

1.

A patient is admitted with severe sepsis due to Staphylococcus aureus (MRSA) with acute respiratory failure and septic shock. Which code is sequenced as the

principal diagnosis

?

A. R65.21 — Severe sepsis with septic shock
B. A41.02 — Sepsis due to MRSA
C. J96.00 — Acute respiratory failure
D. A41.9 — Sepsis, unspecified

2.

A patient with confirmed AIDS is admitted for repair of a hip fracture sustained in a fall. There are no active HIV-related conditions documented this encounter. Which is the correct approach to HIV coding?

A. Code Z21 only — the patient has no active HIV illness
B. Do not code any HIV-related code — not relevant to the encounter
C. Code B20 — AIDS is always reported once established, regardless of reason for encounter
D. Code R75 — inconclusive laboratory evidence

3.

When using the Neoplasm Table in the Alphabetic Index, which column is used for a cancer that has spread FROM the colon TO the liver?

A. Column 1 — Malignant Primary
B. Column 3 — Ca in Situ
C. Column 2 — Malignant Secondary
D. Column 5 — Uncertain Behavior

4.

A patient presents to the outpatient oncology clinic specifically to receive chemotherapy for Stage III lung cancer. What is the correct principal diagnosis?

A. C34.30 — Malignant neoplasm of lower lobe, unspecified
B. Z51.11 — Encounter for antineoplastic chemotherapy
C. Z51.0 — Encounter for antineoplastic radiation therapy
D. Z79.899 — Other long-term drug therapy

5.

Which ICD-10-CM code represents

pernicious anemia

?

A. D50.9
B. D64.9
C. D51.0
D. D63.0

6.

A patient has Type 2 diabetes with diabetic chronic kidney disease, Stage 3. She takes metformin daily and does NOT use insulin. What is the correct complete code set?

A. E11.22, N18.3, Z79.4
B. E11.9, N18.3, Z79.84
C. E11.22, N18.3, Z79.84
D. E11.65, Z79.84

7.

When should Z79.4 (Long-term current use of insulin) be added to a diabetes coding set?

A. Whenever any patient uses insulin, regardless of diabetes type
B. Only for Type 1 diabetic patients
C. For Type 2 and other specified diabetes types (E08, E09, E13) when insulin is used — not for Type 1
D. Z79.4 is never required; insulin use is always implied by the diabetes code

8.

A patient is admitted for anemia. The patient also has Stage 4 CKD. Which statement about coding this scenario is correct?

A. Code D63.1 first, then N18.4
B. Code N18.4 first, then D63.1
C. Code only D63.1 — the CKD is implied
D. Code only N18.4 — anemia is not separately coded with CKD

9.

Which ICD-10-CM code represents

morbid obesity due to excess calories

(BMI ≥ 40)?

A. E66.9
B. E66.1
C. E66.09
D. E66.01

10.

What does code category

Z85.–

represent in neoplasm coding?

A. Current active malignancy

B. Family history of malignant neoplasm

C. Personal history of malignant neoplasm (no longer present, treatment complete)

D. Encounter for cancer screening

SECTION B — TRUE / FALSE (QUESTIONS 11–20)

Write T for True or F for False on the line provided.

11. "Urosepsis" is a valid ICD-10-CM code and should be assigned when a physician documents that term in the record.

T **F** Answer:

12. Code Z21 (Asymptomatic HIV infection status) is the correct code for a patient who has been diagnosed with AIDS and currently has no active HIV-related illness.

T **F** Answer:

13. When a patient is admitted for treatment of a secondary (metastatic) malignant site, the secondary site code is sequenced first.

T **F** Answer:

14. Adding Z79.4 to a Type 1 diabetes code (E10.–) is a correct coding practice when the patient's chart confirms daily insulin use.

T **F** Answer:

15. The code D63.0 (Anemia in neoplastic disease) can be sequenced as the principal diagnosis when the primary reason for admission is treatment of the anemia.

T **F** Answer:

16. A coder may assign a BMI code (Z68.–) based solely on documented height and weight measurements, even if the provider has not documented obesity.

T **F** Answer:

17. Septic shock (R65.21) may be sequenced as the principal diagnosis when it is the most severe condition documented at admission.

T **F** Answer:

18. Carcinoma in situ is classified using D-codes (D00–D09) in ICD-10-CM, not C-codes.

T **F** Answer:

19. When an Excludes1 note appears in ICD-10-CM Chapter 1, the excluded condition is NEVER coded together with the code where the Excludes1 note appears.

T **F** Answer:

20. Per ICD-10-CM guidelines, when the type of diabetes mellitus is not documented in the medical record, the default code category is Type 1 (E10.–).

T **F** Answer:

SECTION C — FILL-IN-THE-BLANK (QUESTIONS 21–25)

Write the correct term, code, or concept on the line.

21. Per ICD-10-CM Official Guidelines, **sepsis** is defined as:

22. Carcinoma in situ means cancer cells are present but:

23. When a patient is admitted specifically for chemotherapy administration, the principal diagnosis should be code , not the malignancy code.

24. The ICD-10-CM code for **pernicious anemia** (Vitamin B12 deficiency due to intrinsic factor deficiency) is:

25. Morbid (severe) obesity due to excess calories is defined in ICD-10-CM as obesity with a BMI of or greater.

SECTION D — CODING SCENARIOS (QUESTIONS 26–30)

For each scenario, assign ALL ICD-10-CM codes in the correct sequence. Write each code on a separate line. On the last line, briefly state your sequencing rationale.

26.

Patient is admitted with severe sepsis due to Streptococcus pneumoniae, with acute kidney injury and septic shock. Patient also has Type 2 diabetes, controlled, on oral hypoglycemics.

Code 1:	
Code 2:	
Code 3:	
Code 4:	
Code 5:	

Sequencing rationale:

27.

Patient with AIDS is admitted with Pneumocystis jirovecii pneumonia (PCP) and severe dehydration. No sepsis documented.

Code 1:	
Code 2:	
Code 3:	

Sequencing rationale:

28.

Patient is admitted for radiation therapy for primary malignant neoplasm of the prostate. Patient also has benign prostatic hyperplasia and Type 2 diabetes without complications, not on insulin or oral medications.

Code 1:	
Code 2:	
Code 3:	
Code 4:	

Sequencing rationale:

29.

Patient has Type 1 diabetes with diabetic peripheral neuropathy (unspecified) and morbid obesity (BMI 42.5). Patient also has hypothyroidism, unspecified.

Code 1:	
Code 2:	
Code 3:	
Code 4:	
Code 5:	

Sequencing rationale:

30.

Patient presents to outpatient clinic for chemotherapy for primary malignant neoplasm of the right ovary, with peritoneal metastases. Patient has anemia due to the malignancy and hypernatremia documented in today's lab results.

Code 1:	
Code 2:	
Code 3:	
Code 4:	
Code 5:	

Sequencing rationale:

for Coding and Reporting. Always reference the current year's Official Guidelines and your current code book. Codes and guidelines are updated annually by CMS and NCHS — verify currency before applying in practice.

Proceed to Chapter 5 — ICD-10-CM: Mental, Behavioral, and Nervous System Disorders (F01–G99)