



2024 coding  
guidelines  
included

Professional

# ICD-10-CM Professional for Physicians

**The complete official code set**

Codes valid from October 1, 2023  
through September 30, 2024

SAMPLE

2024

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## Optum Notations

### AHA Coding Clinic Citations

*Coding Clinics* are official American Hospital Association (AHA) publications that provide coding advice specific to ICD-10-CM and ICD-10-PCS.

*Coding Clinic* citations included in this manual are current up to the second quarter of 2022.

These citations identify the year, quarter, and page number of one or more *Coding Clinic* publications that may have coding advice relevant to a particular code or group of codes. With the most current citation listed first, these notations are preceded by the symbol **AHA:** and appear in purple type.

**I15.1 Hypertension secondary to other renal disorders**  
AHA: 2016, 3Q, 22

### Definitions

Definitions explain a specific term, condition, or disease process in layman's terms. These notations are preceded by the symbol **DEF:** and appear in purple type.

**M51.4 Schmorl's nodes**  
DEF: Irregular bone defect in the margin of the vertebral body that causes herniation into the end plate of the vertebral body.

### Coding Tips

The tips in the tabular list offer coding advice that is not readily available within the ICD-10-CM classification. It may relate official coding guidelines, indexing nuances, or advice from *AHA's Coding Clinic for ICD-10-CM/PCS*. These notations are preceded by the symbol **TIP:** and appear in brown type.

**B97.2 Coronavirus as the cause of diseases classified elsewhere**  
TIP: Do not report a code from this subcategory for COVID-19, refer to U07.1.

## Icons

**Note:** The following icons are placed to the left of the code.

Changes to ICD-10-CM codes, since the last published edition of this manual, are highlighted in two ways:

The following green icons identify new or revised codes effective April 1, 2022:

- **New Code – Midyear**
- ▲ **Revised Code – Midyear**

The following black icons identify new or revised codes effective October 1, 2022:

- **New Code**
- ▲ **Revised Code**
- ✓ **Additional Characters Required**

- ✓<sup>4th</sup> This symbol indicates that the code requires a 4th character.
- ✓<sup>5th</sup> This symbol indicates that the code requires a 5th character.
- ✓<sup>6th</sup> This symbol indicates that the code requires a 6th character.
- ✓<sup>7th</sup> This symbol indicates that the code requires a 7th character.

✓<sup>5th</sup> **H60.3 Other infective otitis externa**  
 ✓<sup>6th</sup> **H60.31 Diffuse otitis externa**  
**H60.311 Diffuse otitis externa, right ear**  
**H60.312 Diffuse otitis externa, left ear**  
**H60.313 Diffuse otitis externa, bilateral**  
**H60.319 Diffuse otitis externa, unspecified ear**

### Placeholder Alert

This symbol indicates that the code requires a 7th character following the placeholder "X". Codes with fewer than six characters that require a 7th character must contain placeholder "X" to fill in the empty character(s).

✓<sup>7th</sup> **T16.1 Foreign body in right ear**

This manual provides the most current information that was available at the time of publication. Except where otherwise noted, the icons and/or color bars reflect edits provided in the Integrated Outpatient Code Editor (IOCE) quarterly files utilized under the outpatient prospective payment system (OPPS). Because the October 2022 quarterly files were not available at the time this book was printed, the edits in this manual are based on the July 2022 quarterly files.

**Note:** In an effort to provide the most current edit information, Optum has provided a searchable data file that includes the final edit designations for all ICD-10-CM codes based on the IOCE October 2022 quarterly files. The edits included in the data file are as follows:

- Age
- Sex
- Manifestation
- Unacceptable principal diagnosis

This data file can be accessed at the following:

<https://www.optumcoding.com/ProductUpdates/>

Title: "2023 ICD-10-CM Outpatient Edits Data File"

Password: Provider23

**Note:** The following icons are placed at the end of the code description.

### Age Edits

#### **N** Newborn Age: 0

These diagnoses are intended for newborns and neonates and the patient's age must be 0 years.

**N47.0 Adherent prepuce, newborn**

#### **P** Pediatric Age: 0-17

These diagnoses are intended for children and the patient's age must be between 0 and 17 years.

**L21.1 Seborrheic infantile dermatitis**

#### **M** Maternity Age: 9-64

These diagnoses are intended for childbearing patients between the age of 9 and 64 years.

**O02.9 Abnormal product of conception, unspecified**

#### **A** Adult Age: 15-124

These diagnoses are intended for patients between the age of 15 and 124 years.

**R54 Age-related physical debility**

Fraility  
Old age  
Senescence  
Senile asthenia  
Senile debility  
**EXCLUDES1** age-related cognitive decline (R41.81)  
sarcopenia (M62.84)  
senile psychosis (F03)  
senility NOS (R41.81)

## Chapter-Level Notations

### Chapter-specific Guidelines with Coding Examples

Each chapter begins with the Official Guidelines for Coding and Reporting specific to that chapter, where provided. Coding examples specific to outpatient care settings have been provided to illustrate the coding and/or sequencing guidance in these guidelines.

### Muscle and Tendon Table

ICD-10-CM categorizes certain muscles and tendons in the upper and lower extremities by their action (e.g., extension or flexion) as well as their anatomical location. The Muscle/Tendon table is provided at the beginning of chapter 13 and chapter 19 to help users when code selection depends on the action of the muscle and/or tendon.

**Note:** This table is not all-inclusive, and proper code assignment should be based on the provider's documentation.

## Illustrations

This section includes illustrations of normal anatomy with ICD-10-CM-specific terminology.

SAMPLE



## Chapter 2. Neoplasms (C00-D49)

## NOTE

## Functional activity

All neoplasms are classified in this chapter, whether they are functionally active or not. An additional code from Chapter 4 may be used, to identify functional activity associated with any neoplasm.

## Morphology [Histology]

Chapter 2 classifies neoplasms primarily by site (topography), with broad groupings for behavior, malignant, in situ, benign, etc. The Table of Neoplasms should be used to identify the correct topography code. In a few cases, such as for malignant melanoma and certain neuroendocrine tumors, the morphology (histologic type) is included in the category and codes.

## Primary malignant neoplasms overlapping site boundaries

A primary malignant neoplasm that overlaps two or more contiguous (next to each other) sites should be classified to the subcategory/code .8 ("overlapping lesion"), unless the combination is specifically indexed elsewhere. For multiple neoplasms of the same site that are not contiguous, such as tumors in different quadrants of the same breast, codes for each site should be assigned.

## Malignant neoplasm of ectopic tissue

Malignant neoplasms of ectopic tissue are to be coded to the site mentioned, e.g., ectopic pancreatic malignant neoplasms are coded to pancreas, unspecified (C25.9).

AHA: 2017,4Q,103; 2017,1Q,4,5-6,8

This chapter contains the following blocks:

C00-C14	Malignant neoplasms of lip, oral cavity and pharynx
C15-C26	Malignant neoplasms of digestive organs
C30-C39	Malignant neoplasms of respiratory and intrathoracic organs
C40-C41	Malignant neoplasms of bone and articular cartilage
C43-C44	Melanoma and other malignant neoplasms of skin
C45-C49	Malignant neoplasms of mesothelial and soft tissue
C50	Malignant neoplasms of breast
C51-C58	Malignant neoplasms of female genital organs
C60-C63	Malignant neoplasms of male genital organs
C64-C68	Malignant neoplasms of urinary tract
C69-C72	Malignant neoplasms of eye, brain and other parts of central nervous system
C73-C75	Malignant neoplasms of thyroid and other endocrine glands
C7A	Malignant neuroendocrine tumors
C7B	Secondary neuroendocrine tumors
C76-C80	Malignant neoplasms of ill-defined, other secondary and unspecified sites
C81-C96	Malignant neoplasms of lymphoid, hematopoietic and related tissue
D00-D09	In situ neoplasms
D10-D36	Benign neoplasms, except benign neuroendocrine tumors
D3A	Benign neuroendocrine tumors
D37-D48	Neoplasms of uncertain behavior, polycythemia vera and myelodysplastic syndromes
D49	Neoplasms of unspecified behavior

## MALIGNANT NEOPLASMS (C00-C96)

Malignant neoplasms, stated or presumed to be primary (of specified sites), and certain specified histologies, except neuroendocrine, and of lymphoid, hematopoietic and related tissue (C00-C75)

AHA: 2022,1Q,16

TIP: Codes from this code block can be assigned for outpatient encounters based on the diagnosis listed in a pathology or cytology report when authenticated by a pathologist and available at the time of code assignment.

## Malignant neoplasms of lip, oral cavity and pharynx (C00-C14)

## ✓49 C00 Malignant neoplasm of lip

Use additional code to identify:

- alcohol abuse and dependence (F10.-)
- history of tobacco dependence (Z87.891)
- tobacco dependence (F17.-)
- tobacco use (Z72.0)

**EXCLUDES 1** malignant melanoma of lip (C43.0)  
Merkel cell carcinoma of lip (C4A.0)  
other and unspecified malignant neoplasm of skin of lip (C44.0-)

## C00.0 Malignant neoplasm of external upper lip

- Malignant neoplasm of lipstick area of upper lip
- Malignant neoplasm of upper lip NOS
- Malignant neoplasm of vermilion border of upper lip

## C00.1 Malignant neoplasm of external lower lip

- Malignant neoplasm of lower lip NOS
- Malignant neoplasm of lipstick area of lower lip
- Malignant neoplasm of vermilion border of lower lip

## C00.2 Malignant neoplasm of external lip, unspecified

- Malignant neoplasm of vermilion border of lip NOS

## C00.3 Malignant neoplasm of upper lip, inner aspect

- Malignant neoplasm of buccal aspect of upper lip
- Malignant neoplasm of frenulum of upper lip
- Malignant neoplasm of mucosa of upper lip
- Malignant neoplasm of oral aspect of upper lip

## C00.4 Malignant neoplasm of lower lip, inner aspect

- Malignant neoplasm of buccal aspect of lower lip
- Malignant neoplasm of frenulum of lower lip
- Malignant neoplasm of mucosa of lower lip
- Malignant neoplasm of oral aspect of lower lip

## C00.5 Malignant neoplasm of lip, unspecified, inner aspect

- Malignant neoplasm of buccal aspect of lip, unspecified
- Malignant neoplasm of frenulum of lip, unspecified
- Malignant neoplasm of mucosa of lip, unspecified
- Malignant neoplasm of oral aspect of lip, unspecified

## C00.6 Malignant neoplasm of commissure of lip, unspecified

## C00.8 Malignant neoplasm of overlapping sites of lip

## C00.9 Malignant neoplasm of lip, unspecified

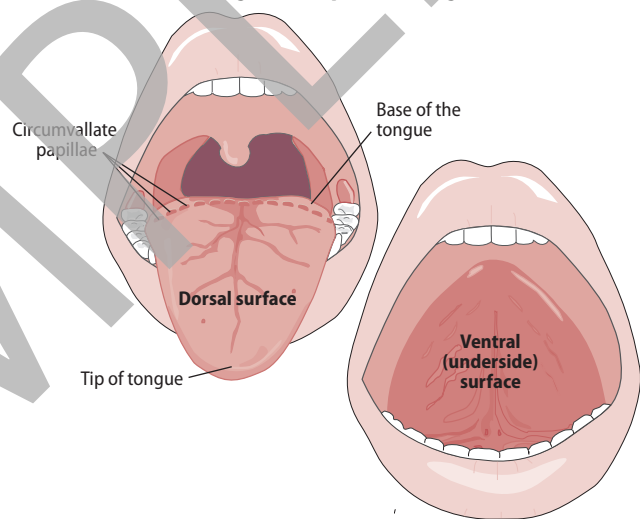
## C01 Malignant neoplasm of base of tongue

- Malignant neoplasm of dorsal surface of base of tongue
- Malignant neoplasm of fixed part of tongue NOS
- Malignant neoplasm of posterior third of tongue

Use additional code to identify:

- alcohol abuse and dependence (F10.-)
- history of tobacco dependence (Z87.891)
- tobacco dependence (F17.-)
- tobacco use (Z72.0)

## Malignant Neoplasm of Tongue



## ✓49 C02 Malignant neoplasm of other and unspecified parts of tongue

Use additional code to identify:

- alcohol abuse and dependence (F10.-)
- history of tobacco dependence (Z87.891)
- tobacco dependence (F17.-)
- tobacco use (Z72.0)

## C02.0 Malignant neoplasm of dorsal surface of tongue

- Malignant neoplasm of anterior two-thirds of tongue, dorsal surface

**EXCLUDES 2** malignant neoplasm of dorsal surface of base of tongue (C01)

## C02.1 Malignant neoplasm of border of tongue

- Malignant neoplasm of tip of tongue

## C02.2 Malignant neoplasm of ventral surface of tongue

- Malignant neoplasm of anterior two-thirds of tongue, ventral surface
- Malignant neoplasm of frenulum linguae

## C02.3 Malignant neoplasm of anterior two-thirds of tongue, part unspecified

- Malignant neoplasm of middle third of tongue NOS
- Malignant neoplasm of mobile part of tongue NOS

## Chapter 4. Endocrine, Nutritional, and Metabolic Diseases (E00–E89)

### Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

#### a. Diabetes mellitus

The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system. As many codes within a particular category as are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for a particular encounter. Assign as many codes from categories E08–E13 as needed to identify all of the associated conditions that the patient has.

Patient is seen for uncontrolled diabetes, type 2, with hyperglycemia diabetic nephropathy, and diabetic gastroparesis

**E11.65** Type 2 diabetes mellitus with hyperglycemia

**E11.21** Type 2 diabetes mellitus with diabetic nephropathy

**E11.43** Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy

**K31.84** Gastroparesis

*Explanation:* Use as many codes to describe the diabetic complications as needed. Many are combination codes that describe more than one condition. Code first the reason for the encounter. The term “uncontrolled” can refer to either hyperglycemia or hypoglycemia. In this case, “uncontrolled” is described as “with hyperglycemia.”

#### 1) Type of diabetes

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

A 45-year-old patient is diagnosed with type 1 diabetes

**E10.9** Type 1 diabetes mellitus without complications

*Explanation:* Although most type 1 diabetics are diagnosed in childhood or adolescence, it can also begin in adults.

#### 2) Type of diabetes mellitus not documented

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

Office visit lists diabetic retinopathy with macular edema and hypertension on patient problem list

**E11.311** Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema

**I10** Essential (primary) hypertension

*Explanation:* Since the type of diabetes was not documented, default to category E11.

#### 3) Diabetes mellitus and the use of insulin, oral hypoglycemics, and injectable non-insulin drugs

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. Additional code(s) should be assigned from category Z79 to identify the long-term (current) use of insulin, oral hypoglycemic drugs, or injectable non-insulin antidiabetic, as follows:

If the patient is treated with both oral **hypoglycemic drugs** and insulin, both code Z79.4, Long term (current) use of insulin, and code Z79.84, Long term (current) use of oral hypoglycemic drugs, should be assigned.

If the patient is treated with both insulin and an injectable non-insulin antidiabetic drug, assign codes Z79.4, Long term (current) use of insulin, and **Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs.**

If the patient is treated with both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes Z79.84, Long term (current) use of oral hypoglycemic drugs, and **Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs.**

Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient's blood sugar under control during an encounter.

Office visit lists chronic diabetes with daily insulin use on patient problem list

**E11.9** Type 2 diabetes mellitus without complications

**Z79.4** Long term (current) use of insulin

*Explanation:* Do not assume that a patient on insulin must have type 1 diabetes. The default for diabetes without further specification defaults to type 2. Add the code for long term use of insulin.

#### 4) Diabetes mellitus in pregnancy and gestational diabetes

See Section I.C.15. Diabetes mellitus in pregnancy.

See Section I.C.15. Gestational (pregnancy induced) diabetes

#### 5) Complications due to insulin pump malfunction

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

An underdose of insulin due to an insulin pump failure should be assigned to a code from subcategory T85.6, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, that specifies the type of pump malfunction, as the principal or first-listed code, followed by code T38.3X6-, Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs. Additional codes for the type of diabetes mellitus and any associated complications due to the underdosing should also be assigned.

A 24-year-old type 1 diabetic male treated in for hyperglycemia; insulin pump found to be malfunctioning and underdosing

**T85.614A** Breakdown (mechanical) of insulin pump, initial encounter

**T38.3X6A** Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs, initial encounter

**E10.65** Type 1 diabetes mellitus with hyperglycemia

*Explanation:* The complication code for the mechanical breakdown of the pump is sequenced first, followed by the underdosing code and type of diabetes with complication. Code all other diabetic complication codes necessary to describe the patient's condition.

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

The principal or first-listed code for an encounter due to an insulin pump malfunction resulting in an overdose of insulin, should also be T85.6-, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, followed by code T38.3X1-, Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional).

A 24-year-old type 1 diabetic male found down with diabetic coma, brought into ED and treated for hypoglycemia; insulin pump found to be malfunctioning and overdosing

**T85.614A** Breakdown (mechanical) of insulin pump, initial encounter

**T38.3X1A** Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional), initial encounter

**E10.641** Type 1 diabetes mellitus with hypoglycemia with coma

*Explanation:* The complication code for the mechanical breakdown of the pump is sequenced first, followed by the poisoning code and type of diabetes with complication. All the characters in the combination code must be used to form a valid code and to fully describe the type of diabetes, the hypoglycemia, and the coma.

#### 6) Secondary diabetes mellitus

Codes under categories E08, Diabetes mellitus due to underlying condition, E09, Drug or chemical induced diabetes mellitus, and E13, Other specified diabetes mellitus, identify complications/manifestations associated with secondary diabetes mellitus. Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis,



- F34.1 Dysthymic disorder** Rx Q
  - Depressive neurosis
  - Depressive personality disorder
  - Dysthymia
  - Neurotic depression
  - Persistent anxiety depression
  - Persistent depressive disorder
  - EXCLUDES 2** anxiety depression (mild or not persistent) (F41.8)
  - DEF:** Depression without psychosis. It is a less severe but persistent depression and is considered a mild to moderate chronic form of depression.
- 5th F34.8 Other persistent mood [affective] disorders**
  - AHA: 2016,4Q,14
- F34.81 Disruptive mood dysregulation disorder** HCC Rx ESR COM Q
- F34.89 Other specified persistent mood disorders** HCC Rx ESR Q
- F34.9 Persistent mood [affective] disorder, unspecified** HCC Rx ESR
- F39 Unspecified mood [affective] disorder** HCC Rx ESR
  - Affective psychosis NOS

**Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders (F40-F48)**

- 4th F40 Phobic anxiety disorders**
  - DEF:** Phobia: Broad-range anxiety with abnormally intense dread of certain objects or specific situations that would not normally have that effect.
- 5th F40.0 Agoraphobia**
  - DEF:** Profound anxiety or fear of leaving familiar settings like home, or being in unfamiliar locations or with strangers or crowds. Agoraphobia may or may not be preceded by recurrent panic attacks.
- F40.00 Agoraphobia, unspecified** Rx
- F40.01 Agoraphobia with panic disorder** Rx
  - Panic disorder with agoraphobia
  - EXCLUDES 1** panic disorder without agoraphobia (F41.0)
- F40.02 Agoraphobia without panic disorder** Rx
- 5th F40.1 Social phobias**
  - Anthropophobia
  - Social anxiety disorder
  - Social anxiety disorder of childhood
  - Social neurosis
- F40.10 Social phobia, unspecified** Rx
- F40.11 Social phobia, generalized** Rx
- 5th F40.2 Specific (isolated) phobias**
  - EXCLUDES 2** dysmorphophobia (nondelusional) (F45.22)
  - nosophobia (F45.22)
- 6th F40.21 Animal type phobia**
  - F40.210 Arachnophobia** Rx
    - Fear of spiders
  - F40.218 Other animal type phobia** Rx
- 6th F40.22 Natural environment type phobia**
  - F40.220 Fear of thunderstorms** Rx
  - F40.228 Other natural environment type phobia** Rx
- 6th F40.23 Blood, injection, injury type phobia**
  - F40.230 Fear of blood** Rx
  - F40.231 Fear of injections and transfusions** Rx
  - F40.232 Fear of other medical care** Rx
  - F40.233 Fear of injury** Rx
- 6th F40.24 Situational type phobia**
  - F40.240 Claustrophobia** Rx
  - F40.241 Acrophobia** Rx
  - F40.242 Fear of bridges** Rx
  - F40.243 Fear of flying** Rx
  - F40.248 Other situational type phobia** Rx
- 6th F40.29 Other specified phobia**
  - F40.290 Androphobia** Rx
    - Fear of men
  - F40.291 Gynephobia** Rx
    - Fear of women
  - F40.298 Other specified phobia** Rx

- F40.8 Other phobic anxiety disorders** Rx
  - Phobic anxiety disorder of childhood
- F40.9 Phobic anxiety disorder, unspecified** Rx
  - Phobia NOS
  - Phobic state NOS
- 4th F41 Other anxiety disorders**
  - EXCLUDES 2** anxiety in:
    - acute stress reaction (F43.0)
    - neurasthenia (F48.8)
    - psychophysiological disorders (F45.-)
    - transient adjustment reaction (F43.2)
    - separation anxiety (F93.0)
- F41.0 Panic disorder [episodic paroxysmal anxiety]** Rx
  - Panic attack
  - Panic state
  - EXCLUDES 1** panic disorder with agoraphobia (F40.01)
  - DEF:** Neurotic disorder characterized by recurrent panic or anxiety, apprehension, fear, or terror. Symptoms include shortness of breath, palpitations, dizziness, and shakiness; fear of dying may persist.
- F41.1 Generalized anxiety disorder** Rx
  - Anxiety neurosis
  - Anxiety reaction
  - Anxiety state
  - Overanxious disorder
  - EXCLUDES 2** neurasthenia (F48.8)
- F41.3 Other mixed anxiety disorders**
- F41.8 Other specified anxiety disorders**
  - Anxiety depression (mild or not persistent)
  - Anxiety hysteria
  - Mixed anxiety and depressive disorder
  - AHA: 2021,1Q,10
- F41.9 Anxiety disorder, unspecified**
  - Anxiety NOS
  - AHA: 2021,1Q,10
- 4th F42 Obsessive-compulsive disorder**
  - EXCLUDES 2** obsessive-compulsive personality (disorder) (F60.5)
  - obsessive-compulsive symptoms occurring in depression (F32-F33)
  - obsessive-compulsive symptoms occurring in schizophrenia (F20.-)
  - AHA: 2016,4Q,14-15
- F42.2 Mixed obsessional thoughts and acts** Rx
- F42.3 Hoarding disorder** Rx
- F42.4 Excoriation (skin-picking) disorder** Rx
  - EXCLUDES 1** factitial dermatitis (L98.1)
  - other specified behavioral and emotional disorders with onset usually occurring in early childhood and adolescence (F98.8)
- F42.8 Other obsessive-compulsive disorder** Rx
  - Anancastic neurosis
  - Obsessive-compulsive neurosis
- F42.9 Obsessive-compulsive disorder, unspecified** Rx
- 4th F43 Reaction to severe stress, and adjustment disorders**
  - F43.0 Acute stress reaction**
    - Acute crisis reaction
    - Acute reaction to stress
    - Combat and operational stress reaction
    - Combat fatigue
    - Crisis state
    - Psychic shock
  - 5th F43.1 Post-traumatic stress disorder (PTSD)**
    - Traumatic neurosis
    - DEF:** Preoccupation with traumatic events beyond normal experience (i.e., rape, personal assault, etc.) that may also include recurring flashbacks of the trauma. Symptoms include difficulty remembering, sleeping, or concentrating, and guilt feelings for surviving.
  - F43.10 Post-traumatic stress disorder, unspecified** Rx
  - F43.11 Post-traumatic stress disorder, acute** Rx
  - F43.12 Post-traumatic stress disorder, chronic** Rx

## Chapter 6. Diseases of the Nervous System (G00-G99)

### Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

#### a. Dominant/nondominant side

Codes from category G81, Hemiplegia and hemiparesis, and subcategories G83.1, Monoplegia of lower limb, G83.2, Monoplegia of upper limb, and G83.3, Monoplegia, unspecified, identify whether the dominant or nondominant side is affected. Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:

- For ambidextrous patients, the default should be dominant.
- If the left side is affected, the default is non-dominant.
- If the right side is affected, the default is dominant.

Hemiplegia affecting left side of ambidextrous patient

#### **G81.92 Hemiplegia, unspecified affecting left dominant side**

*Explanation:* Documentation states that the left side is affected and dominant is used for ambidextrous persons.

Right spastic hemiplegia, unknown whether patient is right- or left-handed

#### **G81.11 Spastic hemiplegia affecting right dominant side**

*Explanation:* Since it is unknown whether the patient is right- or left-handed, if the right side is affected, the default is dominant.

#### b. Pain—Category G89

##### 1) General coding information

Codes in category G89, Pain, not elsewhere classified, may be used in conjunction with codes from other categories and chapters to provide more detail about acute or chronic pain and neoplasm-related pain, unless otherwise indicated below.

If the pain is not specified as acute or chronic, post-thoracotomy, postprocedural, or neoplasm-related, do not assign codes from category G89.

A code from category G89 should not be assigned if the underlying (definitive) diagnosis is known, unless the reason for the encounter is pain control/management and not management of the underlying condition.

When an admission or encounter is for a procedure aimed at treating the underlying condition (e.g., spinal fusion, kyphoplasty), a code for the underlying condition (e.g., vertebral fracture, spinal stenosis) should be assigned as the principal diagnosis. No code from category G89 should be assigned.

Elderly patient with back pain is admitted for outpatient kyphoplasty for age-related osteopathic compression fracture at vertebra T3

#### **M80.08XA Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture**

*Explanation:* No code is assigned for the pain as it is inherent in the underlying condition being treated.

##### (a) Category G89 codes as principal or first-listed diagnosis

Category G89 codes are acceptable as principal diagnosis or the first-listed code:

- When pain control or pain management is the reason for the admission/encounter (e.g., a patient with displaced intervertebral disc, nerve impingement and severe back pain presents for injection of steroid into the spinal canal). The underlying cause of the pain should be reported as an additional diagnosis, if known.

Patient presents for steroid injection in the right elbow due to chronic pain associated with primary degenerative joint disease.

#### **G89.29 Other chronic pain**

#### **M19.021 Primary osteoarthritis, right elbow**

*Explanation:* Since the encounter is for control of pain, not treating the underlying condition, the pain code is sequenced first followed by the underlying condition. The M25 pain code is not necessary as the underlying condition code represents the specific site.

- When a patient is admitted for the insertion of a neurostimulator for pain control, assign the appropriate pain code as the principal or first-listed diagnosis. When an admission or encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is inserted for pain control during the same admission/encounter, a code for the underlying condition should be assigned as the principal diagnosis and the appropriate pain code should be assigned as a secondary diagnosis.

##### (b) Use of category G89 codes in conjunction with site specific pain codes

###### (i) Assigning category G89 and site-specific pain codes

Codes from category G89 may be used in conjunction with codes that identify the site of pain (including codes from chapter 18) if the category G89 code provides additional information. For example, if the code describes the site of the pain, but does not fully describe whether the pain is acute or chronic, then both codes should be assigned.

Patient is seen to evaluate chronic right knee pain

#### **M25.561 Pain in right knee**

#### **G89.29 Other chronic pain**

*Explanation:* No underlying condition has been determined yet so the pain would be the reason for the visit. The M25 pain code in this instance does not fully describe the condition as it does not represent that the pain is chronic. The G89 chronic pain code is assigned to provide specificity.

###### (ii) Sequencing of category G89 codes with site-specific pain codes

The sequencing of category G89 codes with site-specific pain codes (including chapter 18 codes), is dependent on the circumstances of the encounter/admission as follows:

- If the encounter is for pain control or pain management, assign the code from category G89 followed by the code identifying the specific site of pain (e.g., encounter for pain management for acute neck pain from trauma is assigned code G89.11, Acute pain due to trauma, followed by code M54.2, Cervicalgia, to identify the site of pain).

Management of acute, traumatic left shoulder pain

#### **G89.11 Acute pain due to trauma**

#### **M25.512 Pain in left shoulder**

*Explanation:* The reason for the encounter is to manage or control the pain, not to treat or evaluate an underlying condition. The G89 pain code is assigned as the first-listed diagnosis but in this instance does not fully describe the condition as it does not include the site and laterality. The M25 pain code is added to provide this information.

- If the encounter is for any other reason except pain control or pain management, and a related definitive diagnosis has not been established (confirmed) by the provider, assign the code for the specific site of pain first, followed by the appropriate code from category G89.

- √4th 070 Perineal laceration during delivery** COM M ♀
- INCLUDES** episiotomy extended by laceration
- EXCLUDES 1** *obstetric high vaginal laceration alone (O71.4)*
- AHA:** 2016,2Q,34; 2016,1Q,3-4,5
- 070.0 First degree perineal laceration during delivery** COM M ♀
- Perineal laceration, rupture or tear involving fourchette during delivery
- Perineal laceration, rupture or tear involving labia during delivery
- Perineal laceration, rupture or tear involving skin during delivery
- Perineal laceration, rupture or tear involving vagina during delivery
- Perineal laceration, rupture or tear involving vulva during delivery
- Slight perineal laceration, rupture or tear during delivery
- 070.1 Second degree perineal laceration during delivery** COM M ♀
- Perineal laceration, rupture or tear during delivery as in 070.0, also involving pelvic floor
- Perineal laceration, rupture or tear during delivery as in 070.0, also involving perineal muscles
- Perineal laceration, rupture or tear during delivery as in 070.0, also involving vaginal muscles
- EXCLUDES 1** *perineal laceration involving anal sphincter (O70.2)*
- √5th 070.2 Third degree perineal laceration during delivery** COM M ♀
- Perineal laceration, rupture or tear during delivery as in 070.1, also involving anal sphincter
- Perineal laceration, rupture or tear during delivery as in 070.1, also involving rectovaginal septum
- Perineal laceration, rupture or tear during delivery as in 070.1, also involving sphincter NOS
- EXCLUDES 1** *anal sphincter tear during delivery without third degree perineal laceration (O70.4)*  
*perineal laceration involving anal or rectal mucosa (O70.3)*
- AHA:** 2016,4Q,53-54
- 070.20 Third degree perineal laceration during delivery, unspecified** COM M ♀
- 070.21 Third degree perineal laceration during delivery, IIIa** COM M ♀
- Third degree perineal laceration during delivery with less than 50% of external anal sphincter (EAS) thickness torn
- 070.22 Third degree perineal laceration during delivery, IIIb** COM M ♀
- Third degree perineal laceration during delivery with more than 50% external anal sphincter (EAS) thickness torn
- 070.23 Third degree perineal laceration during delivery, IIIc** COM M ♀
- Third degree perineal laceration during delivery with both external anal sphincter (EAS) and internal anal sphincter (IAS) torn
- 070.3 Fourth degree perineal laceration during delivery** COM M ♀
- Perineal laceration, rupture or tear during delivery as in 070.2, also involving anal mucosa
- Perineal laceration, rupture or tear during delivery as in 070.2, also involving rectal mucosa
- 070.4 Anal sphincter tear complicating delivery, not associated with third degree laceration** COM M ♀
- EXCLUDES 1** *anal sphincter tear with third degree perineal laceration (O70.2)*
- 070.9 Perineal laceration during delivery, unspecified** COM M ♀
- √4th 071 Other obstetric trauma** COM M ♀
- INCLUDES** obstetric damage from instruments
- √5th 071.0 Rupture of uterus (spontaneous) before onset of labor** COM M ♀
- EXCLUDES 1** *disruption of (current) cesarean delivery wound (O90.0)*  
*laceration of uterus, NEC (O71.81)*
- 071.00 Rupture of uterus before onset of labor, unspecified trimester** COM M ♀
- 071.02 Rupture of uterus before onset of labor, second trimester** COM M ♀
- 071.03 Rupture of uterus before onset of labor, third trimester** COM M ♀
- 071.1 Rupture of uterus during labor** COM M ♀
- Rupture of uterus not stated as occurring before onset of labor
- EXCLUDES 1** *disruption of cesarean delivery wound (O90.0)*  
*laceration of uterus, NEC (O71.81)*
- 071.2 Postpartum inversion of uterus** COM M ♀
- 071.3 Obstetric laceration of cervix** COM M ♀
- Annular detachment of cervix
- 071.4 Obstetric high vaginal laceration alone** COM M ♀
- Laceration of vaginal wall without perineal laceration
- EXCLUDES 1** *obstetric high vaginal laceration with perineal laceration (O70.-)*
- AHA:** 2016,1Q,5
- 071.5 Other obstetric injury to pelvic organs** COM M ♀
- Obstetric injury to bladder
- Obstetric injury to urethra
- EXCLUDES 2** *obstetric periurethral trauma (O71.82)*
- AHA:** 2014,4Q,18
- 071.6 Obstetric damage to pelvic joints and ligaments** COM M ♀
- Obstetric avulsion of inner symphyseal cartilage
- Obstetric damage to coccyx
- Obstetric traumatic separation of symphysis (pubis)
- 071.7 Obstetric hematoma of pelvis** COM M ♀
- Obstetric hematoma of perineum
- Obstetric hematoma of vagina
- Obstetric hematoma of vulva
- √5th 071.8 Other specified obstetric trauma** COM M ♀
- 071.81 Laceration of uterus, not elsewhere classified** COM M ♀
- 071.82 Other specified trauma to perineum and vulva** COM M ♀
- Obstetric periurethral trauma
- AHA:** 2016,1Q,4; 2014,4Q,18
- 071.89 Other specified obstetric trauma** COM M ♀
- 071.9 Obstetric trauma, unspecified** COM M ♀
- √4th 072 Postpartum hemorrhage** COM M ♀
- INCLUDES** hemorrhage after delivery of fetus or infant
- 072.0 Third-stage hemorrhage** COM M ♀
- Hemorrhage associated with retained, trapped or adherent placenta
- Retained placenta NOS
- Code also type of adherent placenta (O43.2-)**
- AHA:** 2019,3Q,11
- 072.1 Other immediate postpartum hemorrhage** COM M ♀
- Hemorrhage following delivery of placenta
- Postpartum hemorrhage (atonic) NOS
- Uterine atony with hemorrhage
- EXCLUDES 1** *uterine atony NOS (O62.2)*  
*uterine atony without hemorrhage (O62.2)*  
*postpartum atony of uterus without hemorrhage (O75.89)*
- AHA:** 2016,1Q,4
- DEF:** Uterine atony: Failure of the uterine muscles to contract after the fetus and placenta are delivered.
- 072.2 Delayed and secondary postpartum hemorrhage** COM M ♀
- Hemorrhage associated with retained portions of placenta or membranes after the first 24 hours following delivery of placenta
- Retained products of conception NOS, following delivery
- 072.3 Postpartum coagulation defects** COM M ♀
- Postpartum afibrinogenemia
- Postpartum fibrinolysis
- √4th 073 Retained placenta and membranes, without hemorrhage** COM M ♀
- EXCLUDES 1** *placenta accreta (O43.21-)*  
*placenta increta (O43.22-)*  
*placenta percreta (O43.23-)*
- DEF:** Postpartum condition resulting from failure to expel placental membrane tissues due to failed contractions of the uterine wall.
- 073.0 Retained placenta without hemorrhage** COM M ♀
- Adherent placenta, without hemorrhage
- Trapped placenta without hemorrhage
- 073.1 Retained portions of placenta and membranes, without hemorrhage** COM M ♀
- Retained products of conception following delivery, without hemorrhage

## Chapter 21. Factors Influencing Health Status and Contact With Health Services (Z00-Z99)

### NOTE

Z codes represent reasons for encounters. A corresponding procedure code must accompany a Z code if a procedure is performed. Categories Z00-Z99 are provided for occasions when circumstances other than a disease, injury or external cause classifiable to categories A00-Y89 are recorded as "diagnoses" or "problems." This can arise in two main ways:

(a) When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem which is in itself not a disease or injury.

(b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.

AHA: 2018,4Q,60-61

This chapter contains the following blocks:

Z00-Z13	Persons encountering health services for examinations
Z14-Z15	Genetic carrier and genetic susceptibility to disease
Z16	Resistance to antimicrobial drugs
Z17	Estrogen receptor status
Z18	Retained foreign body fragments
Z19	Hormone sensitivity malignancy status
Z20-Z29	Persons with potential health hazards related to communicable diseases
Z30-Z39	Persons encountering health services in circumstances related to reproduction
Z40-Z53	Encounters for other specific health care
Z55-Z65	Persons with potential health hazards related to socioeconomic and psychosocial circumstances
Z66	Do not resuscitate status
Z67	Blood type
Z68	Body mass index (BMI)
Z69-Z76	Persons encountering health services in other circumstances
Z77-Z99	Persons with potential health hazards related to family and personal history and certain conditions influencing health status

### Persons encountering health services for examinations (Z00-Z13)

### NOTE

Nonspecific abnormal findings disclosed at the time of these examinations are classified to categories R70-R94.

**EXCLUDES 1** examinations related to pregnancy and reproduction (Z30-Z36, Z39-)

**4th** **Z00** Encounter for general examination without complaint, suspected or reported diagnosis

**EXCLUDES 1** encounter for examination for administrative purposes (Z02-)

**EXCLUDES 2** encounter for pre-procedural examinations (Z01.81-) special screening examinations (Z11-Z13)

AHA: 2017,4Q,95

**5th** **Z00.0** Encounter for general adult medical examination

Encounter for adult periodic examination (annual) (physical) and any associated laboratory and radiologic examinations

**EXCLUDES 1** encounter for examination of sign or symptom - code to sign or symptom

general health check-up of infant or child (Z00.12-)

**Z00.00** Encounter for general adult medical examination without abnormal findings **PDX** **A**

Encounter for adult health check-up NOS

AHA: 2016,1Q,36

**Z00.01** Encounter for general adult medical examination with abnormal findings **PDX** **A**

Use additional code to identify abnormal findings

AHA: 2016,1Q,35-36

**5th** **Z00.1** Encounter for newborn, infant and child health examinations

**6th** **Z00.11** Newborn health examination

Health check for child under 29 days old

Use additional code to identify any abnormal findings

**EXCLUDES 1** health check for child over 28 days old (Z00.12-)

**Z00.110** Health examination for newborn under 8 days old **PDX** **N**

Health check for newborn under 8 days old

**Z00.111** Health examination for newborn 8 to 28 days old **PDX** **N**

Health check for newborn 8 to 28 days old  
Newborn weight check

**6th** **Z00.12** Encounter for routine child health examination

Health check (routine) for child over 28 days old

Immunizations appropriate for age

Routine developmental screening of infant or child

Routine vision and hearing testing

**EXCLUDES 1** health check for child under 29 days old (Z00.11-)

health supervision of foundling or other

healthy infant or child (Z76.1-Z76.2)

newborn health examination (Z00.11-)

AHA: 2018,4Q,36

**Z00.121** Encounter for routine child health examination with abnormal findings **PDX** **A**

Use additional code to identify abnormal findings

AHA: 2016,1Q,34-35

**Z00.129** Encounter for routine child health examination without abnormal findings **PDX** **A**

Encounter for routine child health examination NOS

AHA: 2016,1Q,34

**Z00.2** Encounter for examination for period of rapid growth in childhood **PDX** **A**

**Z00.3** Encounter for examination for adolescent development state **PDX** **A**

Encounter for puberty development state

**Z00.5** Encounter for examination of potential donor of organ and tissue **PDX**

**Z00.6** Encounter for examination for normal comparison and control in clinical research program

Examination of participant or control in clinical research program

**5th** **Z00.7** Encounter for examination for period of delayed growth in childhood

**Z00.70** Encounter for examination for period of delayed growth in childhood without abnormal findings **PDX** **A**

**Z00.71** Encounter for examination for period of delayed growth in childhood with abnormal findings **PDX** **A**

Use additional code to identify abnormal findings

**Z00.8** Encounter for other general examination **PDX**

Encounter for health examination in population surveys

**4th** **Z01** Encounter for other special examination without complaint, suspected or reported diagnosis

**INCLUDES** routine examination of specific system

**NOTE** Codes from category Z01 represent the reason for the encounter. A separate procedure code is required to identify any examinations or procedures performed

**EXCLUDES 1** encounter for examination for administrative purposes (Z02-)  
encounter for examination for suspected conditions, proven not to exist (Z03-)

encounter for laboratory and radiologic examinations as a component of general medical examinations (Z00.0-)

encounter for laboratory, radiologic and imaging examinations for sign(s) and symptom(s) - code to the sign(s) or symptom(s)

**EXCLUDES 2** screening examinations (Z11-Z13)

**5th** **Z01.0** Encounter for examination of eyes and vision

**EXCLUDES 1** examination for driving license (Z02.4)

**Z01.00** Encounter for examination of eyes and vision without abnormal findings **PDX**

Encounter for examination of eyes and vision NOS

**Z01.01** Encounter for examination of eyes and vision with abnormal findings **PDX**

Use additional code to identify abnormal findings

AHA: 2016,4Q,21

# Chapter 10. Diseases of the Respiratory System (J00–J99)

Respiratory System

