

THE CODE

The Official Medical Coding Newsletter of MiraMed, A Global Services Company

Vaccine and Prophylactic Immunotherapy Administration

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Someone asked me an interesting question that I had not thought about, hence the impetus to write this article. The question posed was “Why code immunization to Z23 in ICD-10-CM?”

So, I did some research and below is an excerpt from the **ICD-9-CM/ICD-10-CM/PCS Coordination and Maintenance Committee Meeting Summary of Diagnosis Presentations September 18-19, 2013.**

“Vaccine and Prophylactic Immunotherapy Administration”

Dr. James Nagel, Upper Chesapeake Medical Center, commented that he supports adding in more specificity for these vaccinations. He also suggested seeking input from the Advisory Committee on Immunization Practices regarding recommendations on certain vaccines and if others should be added. Specifically, he recommended considering codes for vaccines, rotavirus and meningococcal disease.

Darlene Hyman, of Upper Chesapeake Medical Center, indicated that she prefers to just have one code for the vaccine and then code the specific type of vaccine using a procedure code. She does agree with a code for an encounter for RhoGam injection.

Donna Picket indicated that there are philosophical issues here regarding how much detail a disease classification should have about what appears to be procedures. She invited participants to submit comments on these issues.

Sue Bowman, of the American Health Information Management Association, recommended changing the Excludes 1 notes at these codes so that one could code multiple encounters for vaccination codes together when needed (e.g., an MMR vaccine given at the same time as a separate tetanus vaccine).

(Continued on page 2)

TABLE of CONTENTS

Vaccine and Prophylactic Immunotherapy Administration ...	1
MedPAC Provides Some Hope for Hospital Short-Stay Policy Issues.....	4
We Will Miss You, Accelerated & Malignant Hypertension	6
Stars of MiraMed	6
MiraMed Acquires Plexus Management Group & Plexus Information Systems	7
Eye Prosthesis & Eye Implants: An Education.....	8
Brush Up On Medical Terminology.....	9
Are You a Good Auditor?.....	10
Coding Case Scenario.....	11

If you have an article or idea to share for *The Code*, please submit to:
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Vaccine and Prophylactic Immunotherapy Administration (Continued from page 1)

Nelly Leon-Chisen, of American Hospital Association, recommended further review of the Hemophilus influenzae Type B and whether that is too specific.

Becky Dolan, American Academy of Pediatrics, commented that their intent with this proposal was to retain one code for encounter for routine vaccines but to have separate codes for vaccines that are given in other types of settings or for non-routine reasons. Examples of these included giving a tetanus vaccine in an inpatient setting or a rabies vaccine (which is not routinely given to everyone). They did not intend to have all of the ICD-9-CM prophylactic vaccine codes carried over to ICD-10-CM and indicated that their members actually do prefer having one code for routine vaccines.”

http://www.cdc.gov/nchs/data/icd/icd_summary_sept_181913.pdf

In the 2015 ICD-10-CM draft we still encounter that Code Z23 applies to all vaccinations.

The following ICD-10-CM index entries contain back-references to ICD-10-CM Z23:

- Administration (for) – see also encounter (for)
prophylactic (measure)
vaccination Z23
- Immunization – see also vaccination
encounter for Z23
- Prophylactic
vaccination Z23
- Vaccination (prophylactic)
encounter for Z23

This code is used for the description synonyms below:

Bacterial disease vaccination given	Vaccination for diphtheria, tetanus, acellular pertussis, haemophilus influenzae type B and polio
Bacterial disease vaccination given (situation)	Vaccination for diphtheria, tetanus, pertussis and polio
Diphtheria and tetanus vaccination given	Vaccination for haemophilus influenzae type B
Diphtheria and tetanus vaccination given (situation)	Vaccination for herpes zoster
Diphtheria, tetanus and acellular pertussis vaccination given	Vaccination for HPV
Diphtheria, tetanus and acellular pertussis vaccination given (situation)	Vaccination for human papilloma virus (HPV)
Diphtheria, tetanus, acellular pertussis, haemophilus influenzae B and inactivated polio vaccinations given	Vaccination for influenza
Diphtheria, tetanus, acellular pertussis, haemophilus influenzae B and inactivated polio vaccinations given (situation)	Vaccination for measles, mumps and rubella
Diphtheria, tetanus, acellular pertussis, hepatitis B and inactivated polio vaccinations given	Vaccination for measles, mumps and rubella (MMR)
Diphtheria, tetanus, acellular pertussis, hepatitis B and inactivated polio vaccinations given (situation)	Vaccination for meningococcus
Diphtheria, tetanus, pertussis and polio vaccination given	Vaccination for strep pneumonia with pneumovax
Diphtheria, tetanus, pertussis and polio vaccination given (situation)	Vaccination for strep pneumonia with Prevna 13
Haemophilus influenzae type b vaccination	Vaccination for Streptococcus pneumoniae with pneumovax
Haemophilus influenzae type b vaccination (procedure)	Vaccination for Streptococcus pneumoniae with Prevna 13
Herpes zoster vaccination given	Vaccination for tetanus and diphtheria
Herpes zoster vaccination given (situation)	Vaccination for tetanus, diphtheria, acellular pertussis, hepatitis B and polio
Human papilloma virus vaccination given	Vaccination for varicella
Human papilloma virus vaccination given (situation)	Vaccination for varicella (chicken pox)
Influenza vaccination given	Vaccination for viral hepatitis
Influenza vaccination given (situation)	Vaccination for yellow fever
Measles, mumps and rubella vaccination given	Vaccination with combination vaccine
Measles, mumps and rubella vaccination given (situation)	Vaccination with combination vaccine
Meningococcal vaccination given	Vaccination with combination vaccine done

Vaccine and Prophylactic Immunotherapy Administration (Continued from page 2)

Meningococcal vaccination given (situation)	Vaccination with combination vaccine done (situation)
Pneumococcal 13-valent conjugate vaccination given	Varicella vaccination
Pneumococcal 13-valent conjugate vaccination given (situation)	Varicella vaccination (procedure)
Pneumococcal 23-valent polysaccharide vaccination given	Viral hepatitis vaccination given
Pneumococcal 23-valent polysaccharide vaccination given (situation)	Viral hepatitis vaccination given (situation)
Vaccination for bacterial disease	Yellow fever vaccination given
Vaccination for diphtheria, tetanus and acellular pertussis	Yellow fever vaccination given (situation)
Vaccination for diphtheria, tetanus and acellular pertussis (DTaP)	

Procedure codes are required to identify the types of immunization. Unlike CPT, the PCS procedure codes are not specific as to the type of toxoid or vaccine that is being administered.

<i>Section</i>	3 Administration
<i>Body System</i>	E Physiological Systems and Anatomical Regions
<i>Operation</i>	O Introduction: Putting in or on a therapeutic, diagnostic, nutritional, physiological or prophylactic substance except blood or blood products

<i>Body System/Region</i>	<i>Approach</i>	<i>Substance</i>	<i>Qualifier</i>
2 Muscle	3 Percutaneous	3 Anti-inflammatory 4 Serum, Toxoid and Vaccine 6 Nutritional Substance 7 Electrolytic and Water Balance Substance B Local Anesthetic H Radioactive Substance K Other Diagnostic Substance N Analgesics, Hypnotics, Sedatives T Destructive Agent	Z No Qualifier

In CPT DTaP administered to a six-year-old child would be coded as 90700 Diphtheria, tetanus toxoids and acellular pertussis vaccine (DTaP), when administered to younger than seven years, for intramuscular use, with the administration coded to 90471 Immunization administration (including percutaneous, subcutaneous, intramuscular, or jet injections); one vaccine (single or combination vaccine/toxoid). The PCS code for DTaP is 3E0234Z which does capture the body system/region 2 for intramuscular administration, but does not capture the specific drug.

Example: A 50-year-old patient presents for an office visit for ongoing monitoring and evaluation of her diabetes and, during the same visit, Fluvirin (influenza vaccine) is administered. The physician might report code 99213-25 with diagnosis code E11.9 Type II diabetes without complications.* In addition, she/he would also report Z23 encounter for immunization and the appropriate flu vaccine 90656 and administration 90471 codes.

However, this same patient in the inpatient setting admitted with exacerbation of asthma and history of diabetes given fluvirin would be coded as J45.901 unspecified asthma with (acute) exacerbation, E11.9 Type II diabetes without complications and Z23 encounter for immunization with the addition of the PCS code for the administration vaccine 3E0234Z introduction of vaccine, serum or toxoid into muscle. However, in the inpatient setting a reviewer/data analyst cannot determine from codes Z23 and 3E0234Z that the patient was given an influenza vaccine. In ICD-9-CM we would code the influenza vaccine to V04.81, Need for prophylactic vaccination and inoculation against influenza and 99.29, Injection or infusion of other therapeutic or prophylactic substance. If ICD-10-CM is designed to give greater code specificity would it not be warranted to either specify the type of immunization or the type of vaccine by expanding the qualifier (7th character)?

* If the type of diabetes mellitus is not documented in the medical record, the default is E11- Type 2 diabetes mellitus. ICD-10-CM 2015 Official Guidelines for Coding and Reporting Section I C. 4.a.2 (pg. 32).

http://www.cdc.gov/nchs/data/icd/ICD10cmguidelines_2015%209_26_2014.pdf

Medicare Payment Advisory Commission Provides Some Hope for Hospital Short-Stay Policy Issues

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On June 15, 2015, the Medicare Payment Advisory Commission (MedPAC) released its June 2015 Report to the Congress: [Medicare and the Health Care Delivery System](#). The MedPAC is an independent, nonpartisan Congressional agency that provides policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and health plans fairly, rewards efficiency and quality and spends tax dollars responsibly.

As part of its mandate from the Congress, each June MedPAC reports on issues affecting the Medicare program as well as broader changes in healthcare delivery and the market for healthcare services. While neither Congress nor the Health and Human Resources Centers for Medicare and Medicaid Services (CMS) must abide by or adopt MedPAC's recommendations, the recent report does bring some hope to the ongoing issue with hospital short-stays.

Short hospital inpatient stays have been scrutinized by Medicare's auditors because Medicare generally pays more for short inpatient stays than similar outpatient stays, these inpatient stays are highly profitable, and Medicare's guidelines for when to admit a patient are open to interpretation. As a result, hospitals have increased their use of outpatient observation stays, which can have implications for beneficiaries' financial liability. Per the June report, the MedPAC Commission has undertaken extensive work to understand these issues, including analyses of data on trends in inpatient and outpatient stays and conversations with a broad range of stakeholder groups. Through the course of this work, the Commission developed a set of recommendations that are designed to provide greater protections for beneficiaries and reduce administrative burden for hospitals, while ensuring that the program is not paying too much for hospital care.

- One-day inpatient hospital stays are relatively common in the Medicare program, accounting for over one million inpatient admissions (13 percent of the total) in 2012. Medicare generally pays more for short inpatient stays than similar outpatient observation stays and those inpatient stays are highly profitable.
- The Congress mandated that the Medicare Recovery Audit Contractor (RAC) Program be implemented in 2010 to identify and correct Medicare overpayments and underpayments. RACs have targeted short inpatient stays in their audit efforts, resulting in denials of these claims on the grounds that the patient should have been treated as an outpatient. Hospitals have appealed many claims denied by RACs and have expressed concern about the cost of pursuing appeals, large backlogs in the appeals process and limited options for rebilling denied inpatient claims as outpatient claims.
- Partly in reaction to the heightened scrutiny of short inpatient stays, hospitals have increased their use of outpatient observation status instead of admitting patients. Greater use of observation stays, in turn, has caused concern about beneficiaries' financial liability. While Medicare cost sharing for outpatient observation services is typically less than the inpatient deductible, for some beneficiaries the greater use of observation status has increased the likelihood that they will not qualify for Medicare coverage of post-acute skilled nursing facility services (which requires a preceding three-day hospital inpatient stay). Beneficiaries in observation status may also be liable for hospital charges related to prescription drugs received in the hospital and not covered under Medicare's outpatient payment system.

(Continued on page 6)

MedPAC Provides Some Hope for Hospital Short-Stay Policy Issues *(Continued from page 5)*

As a result of their research, MedPAC has developed a set of recommendations that are designed to increase protections for beneficiaries and reduce the administrative burden for hospitals while ensuring that Medicare does not overpay for hospital care. The specific recommendations to short-stays are:

- The Secretary should:
 - direct RACs to focus reviews of short inpatient stays on hospitals with the highest rates of this type of stay,
 - modify each RAC's contingency fees to be based, in part, on its claim denial overturn rate,
 - ensure that the RAC look-back period is shorter than the Medicare rebilling period for short inpatient stays, and
 - withdraw the "two-midnight" rule.
- The Secretary should evaluate establishing a penalty for hospitals with excess rates of short inpatient stays to substitute, in whole or in part, for RAC review of short inpatient stays.
- The Congress should require acute-care hospitals to notify beneficiaries placed in outpatient observation status that their observation status may affect their financial liability for skilled nursing facility care. The notice should be provided to patients in observation status for more than 24 hours and who are expected to need skilled nursing services. This notice should allow patients to consult with their physicians and other health care professionals before discharge planning is complete.
- The Congress should package payment for self-administered drugs provided during outpatient observation on a budget-neutral basis within the hospital outpatient prospective payment system.
- The Congress should revise the skilled nursing facility three-inpatient-day hospital eligibility requirement to allow for up to two outpatient observation days to count toward meeting the criterion.

In light of the ongoing controversy with hospital short stays it is likely that Congress and CMS will seriously consider the MedPAC recommendations.

If you have a positive attitude and constantly strive to give your best effort, eventually you will overcome your immediate problems and find you are ready for greater challenges.

Pat Riley

We Will Miss You, Accelerated and Malignant Hypertension

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With the new coding in ICD-10-CM, both accelerated and malignant hypertension currently will be a remembrance of our past, when coding in ICD-9-CM. Both of these terms have been deleted. Does that mean it is not important anymore or that we cannot use other opportunities with physicians to query conditions?

NO! We still should note the condition in our thoughts and look to terminology and signs and symptoms to help us to code as accurately as possible. Terms such as hypertensive can be used to query physicians for hypertensive heart disease. Confusion/altered mental state with high elevations of blood pressure we should query for hypertensive encephalopathy. Also watch for other possible association that can be identified to have caused the hypertension (see secondary hypertension).

Yes getting queries answered by physicians will be tougher, and seemingly never-ending. Expectations are that ICD-10 queries will increase from five percent to eight percent up to a possible 18 percent to 20 percent in October, which will slowly decrease with physician education in the hospital facilities.

For now hypertension will be easy to remember. When coding in ICD-10-CM, I10 is the only code for unspecified type of hypertension. Look for the return of these terms in the future, but for now, say a fond farewell in October.

Stars of MiraMed

This month's Star of MiraMed is ...

Jonathan Landsman, CISA, MBA

Senior Director of Big Data Strategy

MiraMed Global Services

Jonathan Landsman started with MiraMed in 2014. As Senior Director of Big Data Strategy, Jonathan is focused on the strategy and initiatives for the processing and use of big data and data analytics for clients. Initiatives include dashboards for key performance indicators, revenue cycle and accounts receivable, as well as practice performance, quality measures, comparative benchmarking, operating room utilization and predictive analytics.

Mr. Landsman has nearly 15 years' experience in healthcare from both provider and payer perspectives. He has utilized both administrative and clinical data on Meaningful Use, ACO, HIEs and HIPAA initiatives. His quality initiatives experience includes work with eMeasures, HEDIS and CHIPRA reporting, as well as executive dashboards and comparative benchmark measures and analytics. These efforts have resulted in reduced costs, streamlined operations and processes, increased revenues and quality outcomes and greater provider adoption.



Jonathan Landsman, CISA, MBA

Landsman currently serves on the Board of Directors of the Oakland County Community Mental Health Authority. Most recently he was the Manager of EDI Data and Analytics for a Medicaid managed care organization. Previously, Landsman held positions with Thomson Reuters Healthcare as Director of Product Management their Clinical Management products and was Covisint/Compware's Chief HIPAA Compliance Officer and Healthcare Product Strategist for health information exchanges, as well as serving as Senior Audit Manager for Arthur Andersen. Jonathan earned his MBA from Wayne State University.

MiraMed Global Services Acquires Plexus Management Group and Plexus Information Systems

MiraMed Global Services, LLC (MMGS) is pleased to announce the acquisition of Plexus Management Group, Inc. (Plexus MG) and Plexus Information Systems, Inc. (Plexus IS). Plexus is the latest addition to join the family of MiraMed Global Services.

Plexus MG is a consulting service and practice management organization that identifies and solves the technical, operational, and strategic challenges that face hospitals and physician groups. The services offered focus on billing and collection issues, financial management, physician practice standards, JCAHO preparation, OR management consulting, human resources, scheduling, credentialing and information systems management.

Plexus IS, a leading anesthesia information management systems provider, developed Anesthesia Touch™, a comprehensive Anesthesia Information Management System (AIMS) that works on an iPad and workstation, for use by hospitals, surgery centers and individual providers. Anesthesia providers can document their preoperative evaluation, intraoperative anesthesia care and post anesthesia discharge on one simple interface. Quality data capture, clinical decision support and staff resource management are some of many additional features.

MMGS, a full-service healthcare business process outsourcing provider, believes the acquisition of Plexus IS and Plexus MG will position MiraMed as an undisputed leader in the healthcare industry, from first point of care to claim adjudication. MiraMed strives to provide a broad portfolio of customizable solutions. Our family of companies has been crafted strategically to provide end-to-end support, to improve productivity and ultimately increase value for our clients in the healthcare industry. To learn more about the acquisition, please visit: <http://www.miramedgs.com/news/press-releases/291-miramed-acquires-plexus-management-group-and-plexus-information-systems>.

PLEASE TAKE A MOMENT ...

It is our mission to grow and improve this newsletter with each issue. In order to accomplish this goal we need your help! Your input is extremely valuable. Please take a moment to answer the following:

- Tell us what you would like to see in future publications.
- What types of articles would be most beneficial?
- Has this newsletter been of value to you?
- Would you be interested in submitting an article for publication?

You may send your responses via e-mail to kim.capello@miramedgs.com.

Eye Prosthesis and Eye Implants: An Education

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The History of Artificial Eyes:

They say that the eyes are the windows to the soul. Truly they are! During ancient times, the eye was a symbol of life particularly in Egypt, where bronze and precious stone eyes were placed on the deceased.

Ambrose Pare, a famous French surgeon, was the first to describe the use of artificial eyes to fit an eye socket. These earliest versions were crafter from gold and silver, and two types were commonly used: eklephara and hypoblephara, intended to be worn in front of and under the eyelids, respectively.

- An eklephara consists of a leather-covered metal base with a painted eye, lid and lashes that was worn over the eyelid.
- A hypoblephara is a metal accessory inserted under the eyelid intended for used in an atrophic eye since enucleation was not performed until the mid-1800s.

Indications of Eye Prosthesis in the Field of Medical Coding:

Today, Coders need to be acquainted with the operations performed on the eye that would require eye prosthesis:

Evisceration: This is the removal of the contents of the eye but leaving the outer layer of the eyeball, or sclera, intact.

Enucleation: This involves the removal of the eye, including the globe, but leaving the rest of the orbital (eye socket) contents in place. Examples of the orbital contents are the bones of the orbit, extra ocular muscles, fat and conjunctiva.

Orbital Exenteration: This is the removal of all eye socket contents, including muscles, the lacrimal gland system, and the optic nerve, as well as varying parts of the bone of the orbit.



Brush Up On Medical Terminology: Blood, Blood-Forming Organs, and the Immune Mechanism

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Term	Word Origin	Definition
Bandemia	band/o bands -emia blood condition	An increase in the amount of band cells (immature white blood cells).
Erythrocytosis	erythr/o red -cytosis condition of abnormal increase amount of cells	An excessive amount of red blood cells in the blood.
Hemophilia	hem/o blood -philia condition of attraction	A type of bleeding disorder in which the blood does not clot normally due to insufficient clotting factors.
Homeostasis	home/o same -stasis controlling, stopping	Ability to maintain balance internally.
Polycythemia vera	poly- many, much cyt/o cell -(h)emia blood condition vera true	A disorder of the bone marrow which results in excessive production of red blood cells produced.
Sarcoidosis	sarc/o flesh -oid like -osis abnormal condition	A disease with no known cause which usually involves abnormal collections of granulomas which could affect one or more organs of the body.
Septicemia	septic/o infection -emia blood condition	A life threatening condition due to presence of bacteria in the blood which results in systemic infection that is spread elsewhere in the body.
Thrombocytopenia	thromb/o clot cyt/o cell -penia deficiency	A condition where platelet count is abnormally low.

Are You a Good Auditor?

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Direction: All Medical Coding staffs are encouraged to send their correct codes based from the case provided. They must present their codes along with Coding clinics, coding guidelines or any coding references applicable for any codes that are to be **Added, Deleted** or **Revised**. Answers to this scenario will be published in our next issue.

A 70-year-old female admitted to MiraMed Medical Center for surgical treatment of her Stage IV pressure ulcer of the coccyx. The patient was taken to surgery and the physician performed debridement of the coccyx wound with sharp excision down to the fascia and the bone. While the patient was in the hospital, she continued to receive treatment for her chronic diastolic heart failure, coronary artery (native vessel) disease with known total chronic occlusion in at least two coronary vessels. The procedure went well and the patient was discharged home.

	ICD-9-CM	ICD-10-CM
Principal Diagnosis	707.03	L89.154
Secondary Diagnosis	428.32	I50.32
Secondary Diagnosis	414.00	I25.10
Secondary Diagnosis	414.2	I50.9
Secondary Diagnosis		L25.82
	ICD-9-CM	ICD-10-PCS
Principal Procedure	77.69	0QBC0ZZ

Correct Answer From Previous Case Scenario:

	ICD-9-CM	Audit Remark	ICD-10-CM	Audit Remark
Principal Diagnosis	099.54	Revised 099.54 to 099.53, patient was treated for nongonococcal urethritis.	A56.09	No change.
Secondary Diagnosis	616.0	No change.	N72	Delete N72, there is coding convention to code for additional condition.

Coding Case Scenario



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Direction: Code for ICD-9-CM Diagnosis and Procedure and its corresponding ICD-10-CM and PCS. Answers to this scenario will be published in our next issue.

A six-year-old boy was brought to the emergency department by his mother because of a suspected allergic reaction. The patient was experiencing wheezing, urticarial and tingling on his lips and in his mouth. The patient was at school and ate food that contained small bits of peanuts, unknown to him at the time. The mother states he has a known allergy to peanuts and has had reactions in the past when exposed to peanuts, even without eating them. The physician documented that the patient has relatively mild anaphylactic reaction to food (peanuts) and the patient received a treatment. He was observed in the emergency room for another three hours and had a complete resolution of his symptoms.

Correct Answer from Previous Case Scenario:

	ICD-9-CM	ICD-10-CM	Remark
Principal Diagnosis	285.22	C34.32	<p>ICD-9-CM: Assign 285.22 as PDX as patient was admitted for treatment of anemia and no treatment is done for the cancer. Assign 162.5 as SDX for the primary left lower lobe lung cancer. Cancer is still coded as present because it still has undergoing treatment. This is consistent with Coding Clinic, Fourth Quarter 2009, Page 156, Effective with Discharges, October 1, 2009.</p> <p>Anemia Associated with Malignancy: When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate anemia code (such as code 285.22, Anemia in neoplastic disease) is designated as the principal diagnosis and is followed by the appropriate code(s) for the malignancy.</p> <p>Code 285.22 may also be used as a secondary code if the patient suffers from anemia and is being treated for the malignancy.</p> <p>ICD-10-CM: Assign C34.32, malignant neoplasm of lower lobe, left bronchus or lung, as PDX based on ICD-10-CM chapter specific coding guidelines chapter 2, Neoplasms.</p> <p>Anemia Associated with Malignancy: When admission/encounter is for management of an anemia associated with 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 and the adverse effect (T45.1x5, adverse effect of antineoplastic and immunosuppressive drugs).</p> <p>Assign D63.0 as SDX for the anemia in neoplastic disease.</p> <p>*Sequencing of Anemia of malignancy is different in ICD-10-CM.</p>
Principal Procedure	99.04	30233N1	Nonautologous packed red blood cells transfusion.