Transition to ICD-10-CM
HMSA Primary Care

Presented by:
Essie White, CPC, CCCI, CPC-I, GCSS, CPMA
Healthcare Coding Consultants of Hawaii, LLC

July 29, 2015

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Course Objectives
• Explore and familiarize yourself with the ICD-10-CM codes
• Examine an overview of organizational changes to ICD-10
• Identify the areas of similarities and differences between ICD-9-CM and ICD-10-CM

ICD-10 Transition: Five Phases
1. Engage and Educate Physicians and Staff
2. Assess Current Readiness and Impact
3. Create a Timeline and Transition Plan
4. Implement your Transition Plan
5. Conduct Post Transition Analysis and Reporting

Most Physician Practices are still in Phase 1

Documentation & Transition
• Documentation is the cornerstone for ICD-10 transition success
• Accurate documentation is the primary responsibility physicians and other clinical providers have in the move to ICD-10
• Providers should focus on documentation elements and not the overwhelming number of new codes
• It’s important to engage your referral sources in providing accurate clinical information to support medical necessity

Documentation & Transition
• Labs and Radiologists depend on the referring physician for diagnostic information
• Physicians, coders and billers must understand the documentation and coding requirements for various third parties
**ICD-10: Benefits**

- Describing higher diagnostic complexity may support a higher complexity procedure or service payment
- Better data to justify payment, including pay-for-performance or diagnosis-based reimbursement (e.g., PCMH or ACO models)
- Increased information that can justify quality and outcomes assessment
- More specific diagnoses = reduced denials

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**ICD Background Information**

- Published by WHO in 1990
- U.S. last industrialized nation to implement ICD-10
- Two parts: ICD-10-CM and ICD-10-PCS
  - ICD-10-CM - Diagnosis
    - 3–7 alpha/numeric characters
  - ICD-10-PCS – Inpatient Procedure (only)
    - 7 alpha/numeric characters for -PCS

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**Official Guidelines**

Developed by the Cooperating Parties:
- American Hospital Association (AHA)
- American Health Information management Association (AHIMA)
- Centers for Medicare and Medicaid Services (CMS)
- National Center for Health Statistics (NCHS)

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**Overall Coding Process is the Same!**

1. Capture the required encounter documentation
2. Choose the correct code
   - Alphabetic Index
   - Tabular List
   - Read instructional notations

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**Alphabetic Index**

- Divided into two parts:
  - Diseases and Injuries
    - Neoplasm Table
    - Table of Drugs and Chemicals
  - External Causes
- Formatted like ICD-9-CM
  - Main terms in boldface
  - Subterms and essential modifiers are indented under main terms
### ICD-9-CM and ICD-10-CM Differences

<table>
<thead>
<tr>
<th>ICD-9-CM diagnosis codes</th>
<th>ICD-10-CM diagnosis codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 numeric digits in length</td>
<td>3-7 Alpha-Numeric characters in length</td>
</tr>
<tr>
<td>First digit may be alpha (E or V) or numeric</td>
<td>Character one is alpha</td>
</tr>
<tr>
<td>Digits 2-5 are numeric</td>
<td>Character two is numeric</td>
</tr>
<tr>
<td></td>
<td>Characters 3-7 are alpha or numeric</td>
</tr>
<tr>
<td>Lacks detail</td>
<td>Very specific</td>
</tr>
<tr>
<td>Lacks laterality</td>
<td>Has laterality</td>
</tr>
<tr>
<td>Approximately 14,000 codes</td>
<td>Approximately 69,000 available codes</td>
</tr>
</tbody>
</table>

### Tabular List Organizational Changes

- Divided into 21 chapters
  - Body or organ system
  - Etiology or Nature of Disease Process
- Disease of the Nervous System and Sense Organs is divided into 3 chapters
- External Causes (E-Codes) and Factors Influencing Health Status (V-Codes) are part of the core classification

### ICD-10 Format

- ICD-10 codes are alpha numeric
- All letters of the alphabet except U
- "V" codes are now in the Z section
- "E" codes are now VWXY codes
- Second through seventh characters are a combination of letters and numbers
- "O is not an 0....."
- "I is not a 1....."
**Code Structure**

- Most, but not all, categories are further subdivided into 4 or 5 or 6 character subcategories
- If a category is not further subdivided, it is considered to be a valid code

**Clinician Coding Workflow**

- Code Volume – 14,000 to 69,000+
- Some code descriptions are completely different
  - ICD-9 - Congenital bowing deformity
  - ICD-10 – Congenital bowing of long bones of leg
  - ICD-9 - Lymphoid leukemia
  - ICD-10 – Mature B-cell leukemia, Burkitt-type
- Description length increases an average of 25 to 45 characters
  - How will this affect your efficiency?....?

**Compare Codes**

- L03.313 Cellulitis of chest wall
- S42.311K Greenstick fracture of shaft of humerus, right arm, Subsequent encounter for fx with nonunion
- T45.2X5A Adverse effect of vitamins, Initial encounter
- 682.2 Cellulitis and abscess of trunk
- 733.82 Nonunion of Fracture
- E933.5 Vitamins, not elsewhere classified, causing adverse effects in therapeutic use

**Seventh Character**

- Used in Obstetrics, Musculoskeletal and Injury Sections
- Meanings vary
- Either alpha or numeric
- Placeholder X

**Use of Seventh Character**

- Episode of care for injuries and external cause
- OB complications – Represents fetus in multiple gestation affected by coded condition
- Combination codes for poisonings and external cause (accidental, intentional self-harm, assault, undetermined)

**7th Character**

**Injury and External Causes**

- Identifies Episode of Care
  - Initial - Receiving active treatment
  - Subsequent - Receiving routine care during healing or recovery (after active treatment)
  - Sequela - Complications or conditions arising as result of a condition
Episode of Care

M80.08XA Age related osteoporosis with current pathological fracture, vertebra(e), initial encounter
S61.421D Laceration with foreign body of right hand, subsequent encounter
T21.31XS Burn of third degree of chest, sequela

Placeholders

- ICD-10 utilizes a placeholder “X”
- The “X” is used as a fourth, fifth or sixth character placeholder to allow for future expansion
T88.8xxD Other specified complication of medical and surgical care, not elsewhere classified, subsequent encounter

Placeholder Character

- What is the use of the “X” placeholder in subcategory M48.40?
  - M48.40XA – placeholder before adding the 7th character for “A” initial encounter
- What is the use of the “X” placeholder(s) in category W11?
  - W11.XXXA – Fall from ladder, initial encounter – 3 placeholders

General Coding Guidelines

- Locating a code

**MOST CRITICAL RULE:**
Always begin search for the correct code assignment through the Alphabetic Index.
Never begin searching initially in the Tabular List as this will lead to coding errors.

General Coding Guidelines

- No change in guidelines from ICD-9
  - Code to highest level of specificity
  - Code signs and symptoms in the absence of a definitive diagnosis
  - Do not code signs and symptoms that are an integral part of a disease process
  - Code signs and symptoms that are not an integral part of a disease process

Combination codes for conditions and common symptoms or manifestations

- NEW
E10.21 Type I diabetes mellitus with diabetic nephropathy
I25.110 Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
K50.811 Crohn’s disease of both large and small intestine with rectal bleeding
Sequela (Late Effects)

• Residual effect after the acute phase of an illness or injury
• No time limit
• May occur months or years later
• Requires two codes
  – 1st - Condition or nature of sequela
  – 2nd - Sequela code

Laterality

<table>
<thead>
<tr>
<th>Right</th>
<th>Left</th>
<th>Bilateral</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

• If no bilateral code is provided, code both right and left
• If the side is not indicated in the documentation, code unspecified

Laterality

S20.001D Contusion of right breast, subsequent encounter
M79.662 Pain in lower leg, Left
M79.651 Pain in thigh, right
K40.00 Bilateral inguinal hernia, with obstruction, without gangrene, not specified as recurrent
H66.23 Chronic atticoantral suppurative otitis media, bilateral

Unspecified Codes

• Similar to ICD-9, ICD-10 does contain “unspecified” codes
• Coding guidelines advise use of “unspecified” in circumstances where the medical record does not contain sufficient information required to assign a more specific code

Unspecified Codes

• L02.629 Furuncle of unspecified foot
• R10.9 Unspecified abdominal pain
• K37 Unspecified appendicitis
• K81.9 Cholecystitis, unspecified
• R50.9 Fever, unspecified
• R53.82 Chronic fatigue, unspecified
• R07.9 Chest pain, unspecified
Combination Codes

E11.21  Type 2 diabetes mellitus with nephropathy complications
K81.2  Acute cholecystitis with chronic cholecystitis
K80.0  Calculus of gallbladder with acute cholecystitis without obstruction.
K50.112 Crohn’s disease of large intestine with intestinal obstruction

Coding Scenario

62-year-old male is seen for mild nonproliferative diabetic retinopathy with macular edema. He has type 2 DM and takes insulin on a daily basis. He also has diabetic cataract in his right eye. What diagnosis codes are assigned?

Answer

E11.321 Diabetes, diabetic (mellitus) (sugar), type 2, with, retinopathy, nonproliferative, mild, with macular edema
E11.36 Diabetes, diabetic (mellitus) (sugar), type 2, with, cataract
Z79.4 Long-term (current) (prophylactic) drug therapy (use of), insulin

Infections Resistant to Antibiotics

• Identify all infections documented as antibiotic resistant
• Assign code from category Z16

CHAPTER 1

Certain Infections and Parasitic Diseases (A00-B99)

Infections Resistant to Antibiotics

• Identify all infections documented as antibiotic resistant
• Assign code from category Z16

Sepsis

• Assign appropriate code for the underlying systemic infection
• If type or causal organism is not further specified assign code A41.9
• Negative or inconclusive blood cultures do not preclude a dx of sepsis
**Severe Sepsis**

- Requires acute organ dysfunction associated with sepsis
- Requires a minimum of 3 codes
  - Underlying systemic infection
  - Code from subcategory R65.2
    - If organism is not documented assign A41.9
  - Associated acute organ dysfunction

**Organization and Classification**

- Neoplasm table is no longer in the alphabetical listing; now a table at the end of the alpha index
- “Contiguous sites” is now called “overlapping sites”
- Codes with a dash – have a required 5th character for laterality

**Laterality**

- Neoplasm codes now include *laterality* as well as specific site
- If the side is *not indicated* in the documentation, code *unspecified*
- **Examples**: breast, ovary, cornea, lung, limb

**Examples**

- C44.21 - *Basal cell carcinoma* of skin and external auricular canal
- C50.11 - Malignant neoplasm of *central portion* of breast, *female*
- C50.12 - Malignant neoplasm of *central portion* of breast, *male*
- C69.8 - Malignant neoplasm of *overlapping sites* of eye and adnexa

**Malignant Neoplasms of Digestive Organs (C15-C26)**

- C15 - Malignant neoplasm esophagus
- C16 - Malignant neoplasm of stomach
- C17 - Malignant neoplasm small intestine
- C19 Malignant neoplasm rectosigmoid junction
- C20 Malignant neoplasm of rectum
- C21 - ...anus and anal canal
- C22 - ...Liver and intrahepatic bile ducts
Neoplasm of Small Intestines

- **C17.-** Malignant neoplasm of small intestine
  - C17.0...duodenum
  - C17.1...jejunum
  - C17.2...ileum
  - C17.3 Meckel's diverticulum, malignant
  - C17.8 Malignant neoplasm of overlapping sites of small intestine
  - C17.9 Malignant neoplasm of small intestine, unspecified

Neoplasm of Colon

- **C18.-** Malignant neoplasm of Colon
  - C18.0...cecum
  - C18.1...appendix
  - C18.2...ascending colon
  - C18.3...hepatic flexure
  - C18.4...transverse colon
  - C18.5...splenic flexure
  - C18.6...descending colon
  - C18.7...sigmoid colon
  - C18.8...overlapping sites of colon

Malignant Neoplasm of Brain and other parts of Central Nervous System

- **C70.-**...meninges
  - Cerebral
  - Spinal

- **C71.-**...brain
  - Cerebrum, except lobes and ventricles
  - Frontal
  - Temporal
  - Parietal
  - Occipital
  - Cerebral
  - Cerebellum
  - Brain stem
  - Overlapping sites

Neoplasm of Gallbladder

- **C23** Malignant neoplasm of gallbladder
- **C78.89** Secondary malignant neoplasm of other digestive organs
- **C22.1** Intrahepatic bile duct carcinoma
- **D13.5** Benign neoplasm of extrahepatic bile ducts

Other Examples

- **C90.00** Multiple myeloma not having achieved remission
- **C91.10** Chronic lymphocytic leukemia of B-cell type not having achieved remission
CHAPTER 3

Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism (D50-D89)

55

Nutritional anemias

Hemolytic anemias

Aplastic and other anemias and other bone marrow failure syndromes

Anemia, unspecified

Coagulation defects, purpura and other hemorrhagic conditions

Other disorders of blood and blood-forming organs

Intraoperative and postprocedural complications of the spleen

Certain disorders involving the immune mechanism

CHAPTER 4

Endocrine, Nutritional, and Metabolic Diseases (E00-E89)

Organization and Classification

- Diabetes and malnutrition have their own subchapters and code titles revised
- Diabetes now has five categories
  - (E08 – E13) There is NO E12.
- Controlled/uncontrolled is not a factor in code selection

Diabetes Mellitus

- Use as many codes as necessary to identify all of the associated conditions
- Type 2 DM is default if type is not documented
- Z79.4 Long term (current) use of insulin
  - Use only with Type 2 DM as appropriate
  - Do not use if insulin is given temporarily
Diabetes Mellitus

• **E11.321** Type 2 diabetes mellitus with **mild** nonproliferative diabetic retinopathy **WITH** macular edema
• **E11.349** Type 2 diabetes mellitus with **severe** nonproliferative diabetic retinopathy **WITHOUT** macular edema
• **E11.9** Type 2 diabetes mellitus **WITHOUT** complications.

**Coding Scenario**

62-year-old male is seen for mild nonproliferative diabetic retinopathy with macular edema. He has type 2 DM and takes insulin on a daily basis. He also has diabetic cataract in his right eye. What diagnosis codes are assigned?

**Answer**

**E11.321** Diabetes, diabetic (mellitus) (sugar), type 2, with, retinopathy, nonproliferative, mild, with macular edema
**E11.36** Diabetes, diabetic (mellitus) (sugar), type 2, with, cataract
**Z79.4** Long-term (current) (prophylactic) drug therapy (use of), insulin

**Hyperlipidemia**

**Hypothyroid**
CHAPTER 5

Mental, Behavioral and Neurodevelopmental Disorders (F01-F99)

Organization and Classification
- Unique codes for alcohol and drug use, abuse, and dependence
- Continuous or episodic no longer classified
- Combination codes
- Blood alcohol level (Y90-)

Substance Abuse and Dependence
- F10 – F19: Unique codes for alcohol and drug use, abuse, and dependence
- Continuous or episodic no longer classified
- Combination codes describe dependence, with manifestations such as delirium, hallucinations, dementia
- Codes are similar to ICD-9 in that they identify abuse, dependence and use
- Alcohol and various drugs are listed by category
- Blood alcohol level is listed as an additional code, if known (Y90-)

Mental Disorders due to Physiologic Conditions
- F01. - Vascular Dementia
  - F01.50 without behavioral disturbance
  - F01.51 with behavioral disturbance
- F02. - Dementia in other diseases classified elsewhere
  - Code first the underlying physiologic condition, such as:
    - Alzheimers (G30-)
    - HIV disease (B20)
    - Neurosyphilis (A52.17)
- F06. - Mood disorders
  - Further classified as those with various features, such as depressive or manic
  *not an all-inclusive list

Mood (affective) Disorders
- F30.- represents the category for manic disorders
  - In order to accurately assign an ICD-10 code, additional documentation will be required:
    - with or without psychotic symptoms
    - severity of illness (mild, moderate, severe)
    - status of illness (partial or full remission)
- F31.- represents bipolar disorders
  - Additional documentation is required:
    - with or without psychotic features
    - severity of current episode (mild, moderate, severe)
    - status of episode (partial or full remission)
Mood Disorders – cont.

- Major depressive disorders F32.- and F33.-
  - Includes various types including endogenous, psychogenic, reactive, seasonal and others
  - Similar to ICD-9, depressive disorders are categorized based on
    - Episode (single or recurrent)
    - Severity (mild, moderate, severe)
    - With and without psychotic features
    - Status of illness (partial or full remission)
- Cyclothymic disorder F34.0
- Dysthymic disorder F34.1

Anxiety, Dissociative, Stress-related, Somatoform and Other Non-psychotic Disorders

- Phobic anxiety disorders F40.-
  - Additional documentation required for specific types of phobias, including animal type, natural environment, medical care, situational and 'other'
  - Agoraphobia is further categorized as with or without panic disorder
- Anxiety disorders are coded similarly to ICD-9, specific to
  - Generalized or mixed
- Post-traumatic stress disorder (PTSD) is subcategorized as
  - F43.10 Unspecified
  - F43.11 Acute
  - F43.12 Chronic

Pain Disorders

- F45.41 – Pain exclusively related to psychological disorders
- F45.42 – Pain disorders with related psychological factors + code from category G89

Behavioral and Emotional Disorders with Onset Usually Occurring in Childhood or Adolescence

- Attention deficit hyperactivity disorders are categorized as:
  - Predominantly inattentive type F90.0
  - Predominantly hyperactive type F90.1
  - Combined type F90.2
- Conduct disorders are categorized as
  - Confined to family context F91.0
  - Childhood onset type F91.1
  - Adolescent onset type F91.2
  - Oppositional defiant type F91.3

Remission

- Selection of codes for "in remission" for categories F10-F19 requires the provider's clinical judgment.
  - The appropriate codes for "in remission" are assigned only on the basis of provider documentation
  - ICD-10-CM does not provide separate "history" codes for alcohol and drug abuse. These conditions are identified as "in remission" in ICD-10

Use, Abuse, Dependence

When the provider documentation refers to use, abuse and dependence of the same substance, only one code should be assigned to identify the pattern of use based on the following:

- Hierarchy
  - Use
  - Abuse
  - Dependence
Nicotine Dependence

ICD-9-CM = 305.1
- Tobacco Use Disorder - Current smoker

ICD-10-CM = F17-
- Terminology change to Nicotine dependence
- Type of nicotine (cigarette, chewing tobacco, cigar, pipe, etc.)
- Remission/Withdrawal/Uncomplicated
- Use Z87.891 for History of nicotine dependence
- Use Z72.0 Tobacco Use (non-dependent)

Other Tobacco Use Codes

- Z87.891 History of Tobacco Use
- Z72.0 Tobacco Use (non-dependent)
- O99.33 Smoking (tobacco) complicating pregnancy, childbirth, and the puerperium

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Exposure to Tobacco Smoke

- Z77.22 Contact with and exposure to environmental tobacco smoke
- P96.81 Exposure to tobacco smoke in perinatal period
- Z57.31 Occupational exposure to environmental tobacco smoke

American Academy of Family Practice

- Advises their physicians on use of dependence codes versus tobacco use codes:
  - If you have not documented that a patient who uses tobacco is "dependent", then you would instead use the code for tobacco use (Z72.0), the difference is not well-defined, but the Centers for Disease Control and Prevention’s website states, "Tobacco use can lead to tobacco/nicotine dependence and serious health problems...Tobacco/nicotine dependence is a chronic condition that often requires repeated interventions.”

Coding Scenario

Joe, a 43-year-old male, is currently receiving treatment for alcohol dependence. As a result of Joe’s drinking, he is also on medication for chronic gastritis. He also has a history of cocaine dependence. What Codes are assigned?

Answer

- F10.20 Dependence, alcohol
- K29.20 Gastritis, alcoholic
- F14.21 History, personal, drug dependence, Cocaine

Rationale: The cocaine dependence is coded as "in remission" because there is not a hx code for drug dependence.
CHAPTER 6

Diseases of the Nervous System (G00 – G99)

Organization and Classification

- Sleep disorders have been moved from signs and symptoms (ICD-9) to nervous system
- Sleep apnea has its own subcategory (G47.3) with greater specificity to identify type
- Diseases of the sense organs are no longer contained in the same chapter as the nervous system

Dominant v. Non-Dominant

- Document - Dominant/Non-dominant in addition to Left or Right (Ex: G81.-)
- If dominant side is not documented use the following default guidelines:
  - 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.

Pain – Category G89

- May be used in conjunction with other codes to provide more detail
  - Acute or Chronic
  - Neoplasm-related
  - Post Procedural, Post-Thoracotomy or Post-Traumatic
- Do not use category G89 if pain is not specified as one of the above

Alzheimer’s disease – G30.-

- G30.0 Alzheimer’s disease with early onset
- G30.1 Alzheimer’s disease with late onset
- G30.8 Other Alzheimer’s disease
- G30.9 Alzheimer’s disease, unspecified
- Use add’l code to identify:
  - Delirium, if applicable (F05)
  - Dementia with behavioral disturbance (F02.81)
  - Dementia without behavioral disturbance (F02.80)

Category G40 (Epilepsy and Recurrent Seizures) and G43 (Migraine)

Note: The following terms are equivalent to intractable:
- pharmacoresistant
- treatment resistant,
- refractory (medically)
- poorly controlled.
CHAPTER 7

Disease of the Eye and Adnexa

(H00-H59)

Use an external cause code following the code for the eye condition, if applicable, to identify the cause of the eye condition.

Acute Conjunctivitis

- **H10.1** - Acute
  - Right, Left, Bilateral
  - Mucopurulent
  - Acute atopic
  - Other acute
  - Pseudomembranous
  - Serous, except viral

Chronic Conjunctivitis

- **H10.4** - Chronic
  - Right, Left, Bilateral
    - Chronic giant papillary
    - Simple chronic
    - Chronic follicular
    - Vernal

Blepharoconjunctivitis

- **H10.5** -
  - Right, Left, Bilateral
    - Ligneous
    - Angular
    - Contact

- **H10.8** - Other
  - Pingueculitis

CHAPTER 8

Disease of the Ear and Mastoid Process (H60 – H95)
**Organization and Classification**
- New chapter in ICD-10-CM
- Diseases have been arranged into blocks for easier identification:
  - External ear
  - Middle ear and mastoid
  - Inner ear
  - Other disorders of the ear
  - Intraoperative and postprocedural complications

**Laterality**
- Right
- Left
- Bilateral
- If no bilateral code is provided, code both right and left
- If the side is not indicated in the documentation, code unspecified

**Otitis Media**
- Use additional code for any associated perforated tympanic membrane (H72.-)
- Use additional code to identify
  - Exposure to environmental tobacco smoke (Z77.22)
  - Exposure to tobacco smoke in the perinatal period (P96.81)
  - History of tobacco use (Z87.891)
  - Occupational exposure to environmental tobacco smoke (Z57.31)
  - Tobacco dependence (F17.-)
  - Tobacco use (Z72.0)

**Coding Scenario**
A five-year-old girl is seen for acute ear pain. Exam reveals left acute serous otitis media. Further exam revealed a total perforated tympanic membrane of the right ear due to chronic otitis media. What diagnoses codes are assigned?

**Answer**

H65.02  Otitis (acute), media, acute, serous, left

H66.91  Otitis (acute), media, chronic, right

H72.821  Perforation, perforated tympanum, total, right

**CHAPTER 9**
Diseases of the Circulatory System (I00 – I99)
ICD-10-CM vs. ICD-9 Code Structure

ICD-10-CM Code Format

ICD-9-CM Code Format

Ex: Coronary atherosclerosis of native coronary artery without angina pectoris

ICD-10  I25.10  ICD-9  414.01

Organization and Classification

• Terminology was revised to reflect more current medical practice

<table>
<thead>
<tr>
<th>Examplified ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>I10.1 Intermediate coronary syndromes</td>
<td>I00-I09 Unstable angina</td>
</tr>
<tr>
<td>I21.0 Acute myocardial infarction</td>
<td>I21.1 Acute coronary syndrome without myocardial infarction</td>
</tr>
<tr>
<td>I21.9 Acute coronary syndrome with myocardial infarction</td>
<td>I22.1 Acute coronary syndrome with myocardial infarction</td>
</tr>
</tbody>
</table>

• Hypertension is no longer classified as benign, malignant or unspecified

Compare Codes

- 148.0 Paroxysmal atrial fibrillation
- 105.0 Rheumatic mitral stenosis
- T82.390A Other mechanical complication of aortic (bifurcation) graft (replacement), Initial encounter
- 996.1 Mechanical complication of other vascular device, implant, and graft
- 427.31 Atrial fibrillation, paroxysmal
- 424.0 Mitral valve disorder

Hypertension

• More than just 110
• HTN “with” Heart Disease requires documentation causal relationship
  – Heart disease due to hypertension
  – Hypertensive heart disease
• HTN with CKD
  – Presumes cause-and-effect
• Read guidelines carefully

Hypertensive Disease (I10-I15)

• Use additional code to identify:
  – Exposure to environmental tobacco smoke (Z77.22)
  – History of tobacco use (Z87.891)
  – Occupational exposure to environmental tobacco smoke (Z57.31)
  – Tobacco dependence (F17.-)
  – Tobacco use (Z71.0)

Hypertensive Heart Disease

I11.0 Hypertensive heart disease with heart failure. (use add'l code to identify type of heart failure (I50.-)
I11.9 Hypertensive heart disease without heart failure

*Use add'l code for Tobacco
Hypertensive Heart and Chronic Kidney Disease

I13.0 Hypertensive heart and CKD with heart failure and stage 1 through stage 4 CKD, or unspecified CKD
- Use add’l code to identify type of heart failure (I50.-)
- Use add’l code to identify stage of chronic kidney disease (N18.1-N18.4, N18.9)
- Use add’l code for tobacco

I13.2 Hypertensive heart and CKD with heart failure and stage 5 CKD, or end stage renal disease.
- Use add’l code to identify type of heart failure (I50.-)
- Use add’l code to identify the stage of chronic kidney disease (N18.5, N18.6)
- Use add’l code for Tobacco
- If on dialysis, code Z99.2

Hypertensive Heart and CKD without Heart Failure

I13.10 Hypertensive heart and CKD without heart failure, with stage 1 through stage 4 CKD, or unspecified CKD
- Use add’l code to identify the stage of CKD (N18.1-N18.4, N18.9)

I13.11 Hypertensive heart and CKD without heart failure, with stage 5 CKD or end stage renal disease.
- Use add’l code to identify the stage of chronic kidney disease (N18.5, N18.6)

Secondary Hypertension

Code also underlying condition
- I15.0 Renovascular hypertension
- I15.1 Hypertension secondary to other renal disorders
- I15.2 Hypertension secondary to endocrine disorders
- I15.8 Other secondary hypertension
- I15.9 Secondary hypertension, unspecified
  - Use add’l code for Tobacco

Ischemic Heart Diseases (I20-I25)

- I20 Angina pectoris
  - Unstable (I20.0)
  - Angina pectoris with documented spasm (I20.2)
  - Other forms of angina pectoris (I10.8)
    - Use add’l code(s) for symptoms associated with angina equivalent

- Use add’l code to identify:
  - Exposure to environmental tobacco smoke
  - History of tobacco use
  - Occupational exposure to environmental tobacco smoke
  - Tobacco dependence
  - Tobacco use

Acute Myocardial Infarction

- Acute MI codes changed from 8 weeks to 4 weeks (28 days) or less
  - I21 Initial AMI – code used the entire 28 day period
  - I22 Subsequent AMI – code used when a subsequent AMI occurs during the 28 day period of the Initial AMI
  - I23 Complications following AMI must be used in conjunction with a code from I21- or I22-
  - Do not use AMI codes for encounters greater than 28 days.
Acute Myocardial Infarction

- STEMI (I21) is further categorized based on coronary artery involved
- Subsequent STEMI (I22) is used when a patient who has suffered an AMI has a new AMI with the 4 week timeframe of the original
  - Code from I21 is used with I22

Other Forms of Heart Disease

- 130.- Acute pericarditis
- 131.- Other diseases of pericardium
- 132.- Pericarditis in diseases classified elsewhere (Code first underlying disease.)
- 133.- Acute and subacute endocarditis
- 134.- Nonrheumatic mitral valve disorders
- 135.- Nonrheumatic aortic valve disorders
- 136.- Nonrheumatic tricuspid valve disorders
- 137.- Nonrheumatic pulmonary valve disorders

Other forms of Heart Disease

- I40.- Acute myocarditis
- I41.- Myocarditis in disease classified elsewhere. (Code first underlying disease, such as: typhus (A75.-)

Other Forms of Heart Disease

- 142.- Cardiomyopathy
  - Dilated
  - Obstructive hypertrophic
  - Other hypertrophic
  - Endocardial fibroelastosis
  - Other restrictive
  - Alcoholic
  - Cardiomyopathy due to drug and external agent
  - Other
  - Unspecified

Other forms of Heart Disease

- I44.- Atrioventricular and left bundle branch block
- I45.- Other conduction disorders
  - Right fascicular block
  - Other and unspecified right BBB
  - Bifascicular block
  - Trifascicular block
  - Nonspecific intraventricular block
  - Other specified heart block
  - Pre-excitation syndrome
  - Other specified conduction disorders

Other Forms of Heart Disease

- 144.- Cardiac arrest
  - Cardiac arrest due to underlying cardiac condition
  - Cardiac arrest due to other underlying condition
  - Cardiac arrest, cause unspecified
Other forms of Heart Disease

• I50.- Heart Failure
  • Left ventricular
  • Systolic
  • Diastolic
  • Combined
  – Code first:
    • Heart failure complicating pregnancy
    • Heart failure following surgery
    • HF due to hypertension with CKD
    • Obstetric surgery and procedures
    • Rheumatic heart failure

Laterality

I21.01 ST elevation (STEMI) myocardial infarction involving left main coronary artery

S25.322A Major laceration of left innominate or subclavian vein, initial

S21.121D Laceration with foreign body of right front wall of thorax without penetration into thoracic cavity, subsequent

S27.332S Laceration of lung, bilateral, sequela

Coding Scenario

• Acute ST elevation (STEMI) myocardial infarction involving the left anterior descending coronary artery
Answer:
I21.02 Anterior wall STEMI involving LAD coronary artery

Coding Scenario

• Acute ST elevation (STEMI) myocardial infarction involving the left circumflex coronary artery. Patient has a history of tobacco use.
Answer:
I21.21 ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery
Z87.891 History of Tobacco use

Organization and Classification

• Organized similarly to ICD-9-CM; however, diseases have been rearranged.
• Terminology changes
  – Example: Asthma classified as intermittent, mild persistent, moderate persistent, and severe persistent
• Classification changes that provide greater specificity
  – Manifestations are reflected in the code
Chapter 10 - Guidelines

- When assigning any code from this chapter, use an additional code to identify any tobacco dependence, use, or exposure.
- J10 Influenza contains a note to use an additional code to identify the virus.
- J44 and J45 distinguish between uncomplicated cases vs. acute exacerbation.

Asthma Severity

<table>
<thead>
<tr>
<th>Frequency of Daytime Symptoms</th>
<th>Frequency of Daytime Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intermittent</strong></td>
<td>Less than or equal to 2 times per week</td>
</tr>
<tr>
<td><strong>Mild Persistent</strong></td>
<td>More than 2 times per week</td>
</tr>
<tr>
<td><strong>Moderate Persistent</strong></td>
<td>Daily. May restrict physical activity</td>
</tr>
<tr>
<td><strong>Severe Persistent</strong></td>
<td>Throughout the day. Frequent severe attacks limiting ability to breathe.</td>
</tr>
</tbody>
</table>

Coding Scenario

- The patient has increasing shortness of breath, weakness, and ineffective cough. Treatment included oxygen therapy and prescription meds. Diagnoses listed as acute respiratory insufficiency due to acute exacerbation of COPD and tobacco dependence. What diagnosis codes are assigned?
- Answer:
  - J44.1 Disease, diseased, pulmonary, chronic obstructive, with exacerbation (acute)
  - F17.208 Dependence tobacco, unspecified with other nicotine-induced disorders
CHAPTER 11

Diseases of the Digestive System (K00-K94)

Hernia

- Documentation elements
- Bilateral, unilateral, with or without obstruction, with or without gangrene
  - Inguinal - K40-
  - Femoral - K41-
  - Umbilical - K42-
  - Ventral - K43-
  - Diaphragmatic hernia - K44-
  - Other abdominal hernia - K45-
  - Unspecified abdominal hernia - K46-

Irritable Bowel Syndrome

- K58.0 Irritable bowel syndrome WITH diarrhea
- K58.9 Irritable bowel syndrome WITHOUT diarrhea
  - Irritable bowel syndrome NOS

Disorders of Gallbladder

- Cholelithiasis K80-K80.8
- Documentation elements
  - With acute cholecystitis
  - With or without obstruction
  - With cholangitis – Bile duct
  - With or without obstruction

Other Disease of Intestine/Colon

- Abscess - K63.0
- Perforation – K63.1
- Fistula – K63.2
- Ulcer – K63.3
- Enteroptosis – K63.4
- Polyp, Colon – K63.5
  - Adenomatous polyp Cecum D12.0
  - " Appendix D12.1
  - " Ascending colon D12.2
Other Diseases of GI Tract

- K92.0 Hematemesis
- K92.1 Melena
- K92.3 Gastrointestinal hemorrhage, unspecified (gastric, intestinal NOS)
- K92.81 Gastrointestinal mucositis (ulcerative) Code also type of associated therapy, antineoplastic and immunosuppressive drugs (T45.1X)

Diseases of the Skin and Subcutaneous Tissue (L00-L99)

CHAPTER 12

Organization and Classification

- Complete restructuring
  - Brings together groups of diseases that are related
  - Greater specificity has been added
  - Title changes to reflect current terminology

Note: Dermatitis and eczema are used synonymously and interchangeably

Compare Codes

- L02.01 Cutaneous abscess of face
- L90.5 Scar condition and fibrosis of skin
- T63.414A Toxic effect of venom of centipedes and venomous millipedes, undetermined, initial encounter
- 682.0 Cellulitis and Abscess face
- 709.2 Scar condition and fibrosis of skin
- 989.5 Toxic effect of other substance, venom

Laterality

- Abscess and cellulitis codes are now separate categories (L02 & L03)
- Abscess and cellulitis codes include laterality as well as specific site
- If the side is not indicated in the documentation, code unspecified
Laterality

- **C4A.71** Merkel Cell carcinoma of right lower limb, including hip
- **D23.22** Other benign neoplasm of skin of left ear and external auricular canal
- **H65.06** Acute serous otitis media, recurrent, **bilateral**

Pressure Ulcers

- Pressure ulcer codes (**L89**) are combination codes that identify site, laterality and stage of the ulcer
- Assignment of pressure ulcer stage is guided by clinical documentation and includes laterality and specific sites

Non-Pressure Ulcers

- Non-Pressure ulcer codes (**L97**) are limited to lower limbs and combine laterality and specific locations
- Assignment of additional codes such as atherosclerosis of limbs or diabetic ulcers is required

Coding Scenario

Five-year-old is brought to her physician by her mom. She has broken out with hives. Diagnosis made of Allergic urticaria.

Answer:
**L50.0** Urticaria, allergic

Examples

- **L90.5** Scar
- **L08.9** Inflammation skin
- **L24.3** Irritant contact dermatitis **due to** cosmetics

CHAPTER 13

Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)
Organization and Classification

- Almost every code in Chapter 13 of ICD-10-CM has been expanded
  - Greater specificity of sites
  - Laterality
- Many codes moved from various chapter in ICD-9-CM to Chapter 13 in ICD-10-CM
  - Gout moved from Endocrine
  - Osteomalacia moved from Endocrine

Site and Laterality

- Bone
- Joint
- Muscle
- Multiple
- If no “multiple” code exists, assign a code for each site

- Right
- Left
- Bilateral
- If no “bilateral” code exists, assign a code for each side

Pathological or Stress Fracture

Seventh Characters

A • Initial encounter
D • Subsequent – routine healing
G • Subsequent – delayed healing
K • Subsequent – nonunion
P • Subsequent – malunion
S • Sequela

Osteoarthritis

ICD-9 Category 715
- Osteoarthritis
  - Primary
  - Secondary
  - Generalized
  - Localized

ICD-10 Category M16
- Primary – wear/tear
  - Secondary
    - Post-traumatic
    - Resulting from hip dysplasia
    - Other – usually injury, heredity, obesity or something else.
- Laterality
  - Right
  - Left
  - Bilateral

Rheumatoid Arthritis

Rheumatoid Arthritis is broken down by site, laterality, complication, and with or without rheumatoid factor. Rheumatoid factor is an antibody in the blood that’s present in many, but not all, people with RA.
**RA Examples**

1. Rheumatoid lung disease with rheumatoid arthritis of right hand  
   - M05.141
2. Rheumatoid arthritis without rheumatoid factor, left elbow  
   - M06.022
3. Juvenile rheumatoid arthritis with systemic onset, right knee  
   - M08.261

**Osteoporosis without Pathological Fracture**

Category **M81**, Osteoporosis without current pathological fracture, is for use for patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis, even if they have had a fracture in the past. History of osteoporosis fractures, status code **Z87.310** should follow the code from **M81**.

**Coding Scenario**

Patient returns for her three month follow up having been diagnosed with postmenopausal osteoporosis. The patient had a pathologic fracture one year ago. The patient is treated with medication.  
**M81.0** Age related osteoporosis without current pathological fracture.  
**Z87.310** Personal history of osteoporosis fracture (healed)

**Osteoporosis with Current Pathological Fracture**

Category **M80**, Osteoporosis with current pathological fracture, is for patients who have a current fracture at the time of the encounter. The codes under M80 identify the site of the fracture. A code from M80-, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.

**Gout**

ICD-9 Category 274
- Acute
- Chronic
- Complication

ICD-10 Categories M1a-M10-
- Acute/Chronic
- Primary/Secondary
- Site/joint
- Laterality
- With/without tophus (7th digit required)

Additional documentation required

**Chronic Gout**

Chronic Gout:

Use additional codes to identify:
- autonomic neuropathy in diseases classified elsewhere (G99.0)
- calculus of urinary tract in disease classified elsewhere (N22)
- cardiomyopathy in diseases classified elsewhere (I43)
- disorders of external ear in diseases classified elsewhere (H61.1, H62.8-)
- etc.
Chronic Gout Terminology

- Idiopathic
- Lead-induced
- Drug-induced
- Gout due to renal impairment
- Other secondary

Derangement of Knee

ICD-9 Category 717
- Derangement vs. Tear
- Location
  - Medial/lateral meniscus
    - Bucket handle
    - Anterior horn
    - Posterior horn
  - Other derangement
- Additional documentation required

ICD-10 Category M23-
- Derangement (chronic)
- Spontaneous disruption
  - Location/site
    - Meniscus; bucket handle, anterior horn, posterior horn
    - Anterior cruciate ligament
    - Posterior cruciate ligament
    - Medial collateral ligament
    - Lateral collateral ligament
    - Capsular ligament
- Laterality
  - Acute Tear/Sprain see Category S83

Joint Disorders

- Update in Terminology
  - Specifies joint vs. body area
- Laterality
- Greater specificity
  - Fistula
  - Flail joint
  - Instability
  - Osteophyte
  - Hemarthrosis
  - Effusion
  - Pain
  - Stiffness
Sciatica
ICD-9 Category 724.3
• No specific documentation elements
  Additional documentation required
ICD-10 Category M54-
• Laterality
• With Lumbago

Muscle Spasm/Contracture
ICD-9 Category 728.85
• No specific documentation elements
  Additional documentation required
ICD-10 Category M62.4-
• Laterality
• Location/site
  - Shoulder
  - Upper Arm
  - Forearm
  - Hand
  - Thigh
  - Lower leg
  - Ankle and foot
  - Other site
  - Multiple sites

Trigger Finger
ICD-9 Category 727.03
• No specific documentation elements
  Additional documentation required
ICD-10 Category M65.3-
• Laterality
• Specify finger
  - Thumb
  - Index finger
  - Middle finger
  - Ring finger
  - Little finger

Stress Fracture
ICD-9 Category 733-
• Site
  - Femur (neck, Shaft)
  - Fibula
  - Metatarsal
  - Pelvis
  - Tibia
  - Other bone
  Additional documentation required
ICD-10 Category M80-
• Laterality
• Episode of Care
• Site
  - Ulna
  - Radius
  - Shoulder
  - Humerus
  - Foot
  - Hand
  - Fingers
  - Ankle
  - Tibia
  - Toes
  Additional documentation required

Diseases of the Genitourinary System (N00-N99)

CHAPTER 14
Organization and Classification

- Disorders of the breast now in the GU chapter
- Codes for enlarged prostate have been expanded to include **enlarged** and **nodular**
- Pelvic disorders may include **mild or moderate, complete, incomplete**, other descriptors

Chapter 14 - Guidelines

- No changes in CKD guidelines from ICD-9 to ICD-10
- Instructions added to menopausal and other perimenopausal disorders to clarify "due to naturally occurring (age-related) menopause and perimenopause" are classified to category **N95**

Additional Codes Required

- N17.- Code also underlying condition
- N18.- Code first etiology
- N30.- Additional code infectious agent
- N31.- Additional code urinary incontinence
- N33 Code first underlying disease
- N40.1 Additional code for associated symptoms

Disorders of the Breast Laterality Required

- Fibroadenosis
- Fibrosclerosis
- Hypertrophy of breast
- Unspecified lump in breast
- Fissure and fistula of nipple
- Fat necrosis of breast (Code first breast necrosis due to breast graft (T85.89)
- Atrophy of breast
- Galactorrhea not associated with childbirth
- Mastodynia

Disorders of the Breast

- N61 Inflammatory disorders
- N62 Hypertrophy of breast
- N63 Unspecified lump in breast
- N64.0 Fissure and fistula of nipple
- N64.1 Fat necrosis of breast – Code first breast necrosis due to breast graft (T85.89)
- N64.2 Atrophy of breast
- N64.3 Galactorrhea not associated with childbirth
- N64.4 Mastodynia

Disorders of the Urinary System

- UTI’s are categorized in N30.- (cystitis), N34.- (urethritis), N39.0 (UTI site not specified)
- Urinary incontinence codes are found in N39.4.
- Recurrent and persistent hematuria, found in N02.- and distinguished by extent of glomerular involvement
CHAPTER 15

Trimesters

- Episode of care (delivered, antepartum, postpartum) is no longer applicable
- Most codes have a final character identifying the trimester of pregnancy in which the condition occurred
- Some conditions or complications occur during certain trimesters, thus not all conditions include codes for all three trimesters
- Weeks of gestation code also appended

OB/ Weeks of Gestation

Example:
- O23 = category for infections of GU tract in pregnancy
- O23.12, infections of bladder in pregnancy, 2nd trimester
- Z3A.16 16 weeks of gestation pregnancy

Although it seems redundant, both codes are required

CHAPTER 17

Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00-Q99)

Organization and Classification

- Arrangement of categories have been grouped into subchapters making it easier to identify types of conditions
- Terminology changes
- Greater specificity
- Codes may be used throughout life of patient

Category Q00-Q99

- For birth admission, the appropriate code from category Z38-, Live-born infants, according to place of birth and type of delivery, should be sequenced as the principal diagnosis, followed by any congenital anomaly codes.
- If congenital malformation has been corrected, a personal history code used.
- Although present at birth, an abnormality may not be identified until later in life, and if diagnosed by physician.
Malformation/Abnormality

• Code may be principal or first listed diagnosis or secondary diagnosis
• When no unique code is available, assign additional code(s) for any manifestations
• When the code assignment specifically identifies the malformation, deformation, or chromosomal abnormality, manifestations that are an inherent component of the anomaly should not be coded separately
• Additional codes should be assigned for manifestations that are not an inherent component

Organization and Classification

• General signs and symptoms follow those related specifically to a body system or other relevant grouping
• Some codes have been moved to a chapter more specific to the symptom
• Hematuria now includes various types

Organization and Classification

• General signs and symptoms follow those related specifically to a body system or other relevant grouping
• Some codes have been moved to a chapter more specific to the symptom
  – Hematuria, idiopathic N02.9
    • Hematuria, unspecified R31.9
  – Dyspepsia, functional K30
    • Epigastric pain (Dyspepsia) R10.13

Organization and Classification

• Other symptom sections are basically unchanged from ICD-9 other than expansion due to specificity
  – Example: seizures now include simple or complex and post-traumatic
  – Example: localized swelling may include laterality
  – Example: dysphagia includes different phases (oral, pharyngeal, etc)

Category R00 – R99

• No more specific diagnosis can be made even after all facts have been investigated
• Signs or symptoms existing at time of initial encounter - transient and causes not determined
• Provisional diagnosis in patient failing to return
Category R00 – R99 cont.

• Referred elsewhere before diagnosis made
• More precise diagnosis not available
• Certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right

Signs and Symptoms

R10. - Abdominal and pelvis pain
  – Acute
  – Localized to upper abdomen
    • Rt, Lt, Epigastric
  – Pelvic and perineal
    – Localized to other parts of lower abdomen
    – Rt, Lt, Periumbilical
    – Abdominal tenderness
      • Rt, Lt, Lt lower, Lt lower, Periumbilic, Epigastric, Generalized
      – Rebound
        • Rt upper, Lt upper, Rt lower, Left lower, Periumbilic, Epigastric, Generalized

Signs and Symptoms

• R19.3 - Abdominal rigidity
  – Rt upper quadrant
  – Lt upper quadrant
  – Rt lower quadrant
  – Lt lower quadrant
  – Periumbilic
  – Epigastric
  – Generalized

Signs and Symptoms

R11. - Nausea and vomiting
  – R11.2 Nausea with vomiting, unspecified
  – R11.0 Nausea
  – R11.1 - Vomiting
    • Vomiting without nausea
    • Projectile
    • Vomiting of fecal matter
    • Bilious vomiting

Repeated Falls

• R29.6 - Use if encounter is regarding a current fall
• Z91.81 – History of falling

Category R65 - SIRS

• Codes identify SIRS of non-infectious origin with and without acute organ dysfunction and severe sepsis with and without septic shock
• Instructional note indicates underlying condition or infection should be coded first
• Sepsis not classified to R65 - coded to infection. e.g., A41.9 assigned for sepsis, unspecified
Examples

• R55 Syncope and collapse
• R63.4 Abnormal weight loss
• R94.31 Abnormal EKG?
• R05 Cough
• R53.82 Chronic fatigue syndrome?
• R74.0 Nonspecific elevation of levels of transaminase and lactic acid LDH

Abnormal blood chemistry

Elevated BP
Coding Scenario

Patient is seen complaining of RUQ abdominal pain. In addition, the patient is having nausea and vomited several times. Patient also has elevated blood pressure readings but a diagnosis of HTN was not made at this visit. Patient was given an order for an outpatient sonogram.

Answer

R16.11 Pain(s) (see also Painful), abdominal, upper, right quadrant
R11.2 Nausea, with vomiting
R03.0 Elevated, blood pressure, reading (incidental) (isolated) (nonspecific), no diagnosis of hypertension

Rationale: No conclusive diagnosis was documented, therefore the symptoms are coded.

Organization and Classification

Encompasses 2 alpha characters

S = Injuries related to body region
T = Injuries to unspecified region, Poisonings, external causes

• Note that codes within T section that include the external cause do not require an additional external cause code

Use secondary code(s) from Chapter 20 to indicate cause of injury

Injuries now Grouped by:

Injury Type
• Superficial Injury
• Open wound
• Fracture
• Dislocation/Sprain
• Nerve injury
• Blood vessel injury
• Muscle injury
• Traumatic amputation

Site (examples)
• Ankle and Foot
• Ankle
• Foot
• Toes

Organization and Classification

Injuries grouped by body part rather than category of injury

• Head (S00-S09)
• Neck (S10-S19)
• Thorax (S20-S29)
• Abdomen, Low back, pelvis (S30-S39)
• Etc.
Definitions

- **Initial encounter** - the patient is receiving active treatment for the condition
  - Surgical treatment
  - Emergency department encounter
  - Evaluation and treatment by a new physician

- **Subsequent encounter** - after patient received active treatment for the condition and receiving routine care during healing or recovery phase
  - Cast change or removal
  - Removal of external or internal fixation device
  - Medication adjustment
  - Other aftercare and follow-up visits following injury treatment

- **Sequela** - Complications or conditions that arise as a direct result of a condition. Such as: a Scar formation after burn
  - Use both the injury code that precipitated sequela and code for sequela
  - “S” added only to injury code, not sequela code
  - “S” identifies injury responsible for sequela
  - Specific type of sequela (like scar) sequenced first, followed by injury code

Combination codes for poisonings and external causes

- **T36.0X1A** Poisoning by penicillin, accidental (unintentional), initial encounter

Fractures

- **Greater specificity**
  - Type of fracture
  - Specific anatomical site
  - Displaced vs nondisplaced
  - Laterality
  - Routine vs delayed healing
  - Nonunion
  - Malunion

Fractures Cont.

- **Greater specificity**
  - Type of encounter
    - Initial
    - Subsequent
    - Sequela
Fractures Seventh Character

- A – Initial closed
- B – Initial open
- D – Subsequent routine
- G – Subsequent delayed
- K – Subsequent nonunion
- P – Subsequent
- S – Sequela
- And others….Check out S52.6, S52.9

Be careful which “pink block” you use

Fractures

- Some fracture categories provide for seventh characters to designate the specific type of open fracture based on the Gustilo open fracture classification
- A fracture not indicated as displaced or nondisplaced should be coded to displaced
- A fracture not designated as open or closed should be coded to closed

Guidelines - Burns

- Code burns of the same site but of different degrees to the highest degree
- Code non-healing burns as acute
- Use additional code for infection
- Assign additional code from category T31 or T32 to identify extent of body surface involved

Poisoning, Adverse Effect, Underdose

- Poisoning
  - Overdose of substances
  - Wrong substance given
  - Taken in error
- Adverse effect - “Hypersensitivity,” “Reaction,” of correct substance properly administered
- Underdosing - Taking less of medication than is prescribed or instructed by manufacturer either inadvertently or deliberately

Poisoning, Adverse Effect, Underdose

- Combination codes for poisonings/ external cause (accidental, intentional self-harm, assault, undetermined)
- Table of Drugs and Chemicals groups all poisoning columns together
  - Followed by adverse effect and underdosing
- When no intent of poisoning is indicated, code to accidental
  - Undetermined intent is only for use when there is specific documentation in record that intent cannot be determined

Alcohol and Nicotine

- Alcohol and tobacco use or exposure is required to be coded with many other conditions, including but not limited to:
  - Malignant neoplasms
  - Cardiovascular conditions
  - Respiratory conditions
Note: History of anything (nicotine dependence, neoplasm, alcoholism, etc.) should always mean in the past
Complications of Care

• Use additional code from category G89 to identify acute or chronic pain due to presence of device, implant or graft
• Combination codes that include external cause do not require additional code
• Complications of care codes within the body system chapters should be sequenced first

Coding Scenario

Patient presents to the urgent care clinic with a 2 cm laceration of the left heel with foreign body. (external cause not given) FB removed, wound was sutured.

S91.322A Laceration, heel – see laceration, foot (except toes(s) alone), left, with foreign body. Review the Tabular for correct seventh character.

Organization and Classification

• No longer a supplemental classification
• No one-to-one relationship exists for ICD-9-CM E-Codes to ICD-10-CM – “E-codes” have been disseminated to Chapters 19 (combination codes) – 20
• Most applicable to injuries, also valid for other use – i.e., infections or heart attack occurring during strenuous physical activity
• External cause code may be used with any code in range A00.0-T88.9, Z00-Z99, that is health condition due to external cause
Organization and Classification

- Encompasses alpha characters V, W, X, and Y
- Assign external cause code, with appropriate seventh character for each encounter for which injury or condition is being treated
  - Initial encounter
  - Subsequent encounter
  - Sequela

External Cause Guidelines

- Assign as many codes as necessary
- Never a principal (first listed) diagnosis
- Assign combination external cause codes identify sequential events corresponding to the sequence of events
- No external cause code needed for combination codes from another chapter that include cause and intent

Category Y92 – Place of Occurrence

- Use with activity code
- Only on initial encounter
- Only one Y92 code on record
- Do not use Y92.9 if place not stated

Category Y93 – Activity

- Use with Y92 and Y99
- Only on initial encounter
- Only one Y93 code on record
- Do not use Y93.9 if activity not stated
- Not applicable to poisonings, adverse effects, misadventures, or late effects

Transport Note

- Use additional code to identify
  - Airbag injury (W22.1)
  - Type of street, road, Hwy (Y92.4-)
  - Use of cellular telephone at time of transport accident (Y93.C2)

Category Y99-

- Assign Y99, External cause status, to indicate work status
  - Civilian activity done for income or pay
  - Military activity
  - An individual including a student or volunteer was involved in a non-work activity
CHAPTER 21

Factors Influencing Health Status and Contact with Health Services (Z00-299)

Organization and Classification

- Some categories have rephrased titles
- Some conditions no longer have the specificity they did in ICD-9-CM

Example: In ICD-10, Code Z23, Encounter for immunization is not further classified. In ICD-9, category codes V03 through V06 are used to identify the types of immunizations.

Examples

- Z00.00 Encounter for general adult medical exam without abnormal findings
- Z00.01 Encounter for general adult medical exam with abnormal findings (use additional codes for findings)
- Z01.411 Encounter for gyn exam with abnormal findings (use additional screening codes and also codes for abnormal findings)

Use of Z Codes

- Can be used in any healthcare setting
- May be used as either primary or secondary code, depending on the circumstances
- Certain Z codes may only be used as primary
- Corresponding procedure code must accompany the Z code

Examples

- Z00.00 Encounter for general adult medical exam without abnormal findings
- Z00.01 Encounter for general adult medical exam with abnormal findings (use additional codes for findings)
- Z01.411 Encounter for gyn exam with abnormal findings (use additional screening codes and also codes for abnormal findings)

Examples

- Z01.818 Encounter for pre-procedural examination
- Z79.891 Long term (current) use of opiate analgesic
- Z80.0 Family history of malignant neoplasm of digestive organs
- Z90.710 Acquired absence of uterus with cervix

Examples

- Z02.4 Encounter for examination for driving license
- Z79.5 Long term (current) use of steroids
  - Z79.51 Inhaled steroids
  - Z79.52 Systemic steroids
- Z80.8 Family history of malignant neoplasm of other organs or systems. (conditions classifiable to C69.9)
- Z96.1 Presence of intraocular lens (pseudophakia)
- Z97.0 Presence of artificial eye
- Z97.3 Presence of spectacles and contact lenses
Tools for Success

GEMs—General Equivalence Mapping:
- A mapping tool that attempts to include all valid relationships between the codes in ICD-9-CM and ICD-10-CM
- An excellent training tool to be used to familiarize differences between ICD 9 and ICD-10 and may also be used to select the correct ICD-10 code.
- The mapping identifies one-to-one and one-to-many code relationships
- Only 5% of ICD-9 to ICD-10 are a direct match

Selecting an ICD-10 GEMs Transition Software
- Should allow search by code and description
- Should be bi-directional: ICD-9 to ICD-10 and vice versa
- Look for the ability to perform code searches and store frequently used codes ("Cheat Sheet")
- Have a print function to enable creation of training tools
- May be a stand alone or integrated product

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ICD 10: Next (or first) Steps

Evaluate internal processes:
- Conduct a practice impact assessment (internal as well as business partners)
- Update ICD 10 coding resources (manual, encoder or online lookups)
- Perform a chart review to identify areas for CDI
- Provide documentation feedback for physicians (immediate and ongoing)
63 Days

Thank You!

Questions, Comments or Feedback?
Please call or email

808-947-2633
www.hcchawaii.com