Transition to ICD-10-CM
HMSA
Ophthalmology
August 24, 2015

PRESENTED BY:
ESSIE WHITE, CPC, COC, CGSC, CPC-I, CPMA

Disclaimer
• The information presented herein contains the views of the presenter and does not imply a formal endorsement or consultation engagement on the part of Healthcare Coding Consultants of Hawaii. Attendees are cautioned that information contained in this presentation is not a substitute for informed medical coding judgment.
• Healthcare Coding Consultants of Hawaii and the presenter disclaim all responsibility for any use made of such information.

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

ICD-10 Transition: Five Phases
1. Engage and Educate 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
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

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

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)
Overall Coding Process is the Same!

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

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>4-7 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>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>

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 V,W,X,Y codes
- Second through seventh characters are a combination of letters and numbers
- “O” is not an 0......
- “I” is not a 1......

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
Alphabetic Index, Cont.

- Alveolar (congenital) — see also Malposition, congenital
- Adrenal gland Q88.1
- Artery (peripheral) Q27.8
- Basilar NEC Q26.1
- Benign Q28.3
- Coronary Q42.5
- Blood vessel system Q27.8
- Bone Q16.8
- Brachial Q27.8
- Breast NEC Q28.1
- Broad Q27.8
- Breast NEC Q28.1
- Breast Q83.8

Tabular List
Organizational Changes

ICD – 9 – CM
- 17 Chapters
- V codes
- E codes

ICD – 10 – CM
- 21 Chapters
- Z codes
- V, W, X and Y codes

Abnormal, abnormality, abnormalities — see also Anomaly
- acid base balance mixed R97.2 Nonessential Modifier
- alpha fetoprotein R77.2
- alveolar ridge K03.9
- anatomical relationship Q89.9
- apertures, congenital, diphtheria Q79.1
- auditory perception H95.126
- dysphagia — see Dysphagia
- hyperacusis — see Hyperacusis
- menstruation — see Menstrual, auditory
- threshold shift — see Shift, auditory threshold

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
The order of the chapters differs

Injuries in ICD-10-CM are grouped first by specific site and then by type of injury

Post-op complications have been moved to procedure specific body system chapters

Includes full code titles on all codes

ICD-10-CM vs. ICD-9 Code Structure

Ex: Cataract, senile, subcapsular polar posterior, Bilateral

ICD-10 H25.043 ICD-9 366.14

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

Compare Codes

H00.033 Abscess of right eyelid

S05.61XA Penetrating wound without foreign body of eyeball, right

T49.5X5A Adverse effect ophthalmological drugs and preparation, initial encounter

317.13 Cellulitis eyelid

871.7 Penetrating injury to eyeball

E946.5 Adverse effects ophthalmological anti-infectives and other eye drugs in therapeutic use
Seventh Character

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

Use of Seventh Character

- Episode of care for injuries and external cause
- 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

- S05.01XA Injury of conjunctiva and corneal abrasion without foreign body, right eye, initial encounter
- S05.20XD Ocular laceration and rupture with prolapse or loss of intraocular tissue, left eye, subsequent encounter
- T15.81XS Foreign body in lacrimal duct, right sequela
Placeholder Character

**Exercise:**

- What is the use of the “X” placeholder in subcategory H40.11?

- What is the use of the “X” placeholder(s) in category X78?

**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.

- 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

**E10.311** Type 1 diabetes mellitus *with* unspecified diabetic retinopathy with macular edema

**E11.36** Type 2 diabetes mellitus *with* diabetic cataract

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

- **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

Laterality

- **H00.011** Hordeolum externum *right* upper eyelid
- **H00.022** Hordeolum internum *left* lower eyelid
- **S05.01XA** Injury of conjunctiva and corneal abrasion without foreign body, *right* eye, initial encounter
- **H54.11** Blindness, *right* eye, low vision *left* eye
- **H54.133** Sudden visual loss, *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 Code Examples

- **H00.013** Hordeolum externum right eye, unspecified eyelid
- **H00.019** Hordeolum externum unspecified eye, unspecified eyelid
- **H01.003** Unspecified blepharitis right eye, unspecified eyelid
- **H10.10** Acute atopic conjunctivitis, unspecified eye

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 2 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

- **Right**
- **Left**

- Neoplasm codes now include *laterality* as well as specific site
- If the side is *not indicated* in the documentation, code *unspecified*
- **Examples**: orbit, conjunctiva, retina, cornea, ciliary body, lacrimal gland and duct

Examples

- C43.1 - Malignant melanoma of the eyelid, including canthus
- C69.5 - Malignant neoplasm of lacrimal gland and duct
- C69.8 - Malignant neoplasm of *overlapping sites* of eye and adnexa

Organization and Classification

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

Combination codes include:

- Type of DM
- Body system affected
- Complications affecting that body system

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

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
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.-)

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

The ICD-10-CM classification system does not provide separate “history” codes for alcohol and drug abuse. These conditions are identified as “in remission” in ICD-10-CM.
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)
- 099.33 Smoking (tobacco) complicating pregnancy, childbirth, and the puerperium

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
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.x)
- If dominant side is not documented use the following default guidelines:
  - For ambi-dextrous 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
Disease of the Eye and Adnexa (H00-H59)

CHAPTER 7

Disease of the Eye and Adnexa

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

Glaucoma

- Assign as many codes from category H40. - Glaucoma, as needed to identify the type of glaucoma, the affected eye, and the stage

Stages of Glaucoma

- Assign the 7th character to subcategories H40.10-, H40.11-, H40.12-, H40.13- and H40.14-, to designate the stage of glaucoma
  - 0  stage unspecified
  - 1  mild stage
  - 2  moderate stage
  - 3  severe stage
  - 4  indeterminate stage
Bilateral Glaucoma

• **Same type and Stage**
  – Report only the code for the type of glaucoma, bilateral, with the seventh character for the stage.
  • Example: **H40.1232** Pigmentary glaucoma, bilateral, Stage 2, moderate

Bilateral Glaucoma Different Types or Stages

• Assign the code for each eye rather than the bilateral glaucoma.
• If each eye is documented as having a different type, and the classification does not distinguish laterality, assign one code for each type of glaucoma with the seventh character for the stage.

Bilateral Glaucoma Same Type – Different Stage

• Patient has bilateral glaucoma and each eye is documented as having the **same type**, but **different stage**, and the classification does not distinguish laterality, assign a code for the type of glaucoma for each eye with the seventh character for the specific glaucoma stage documented for each eye.

Stage Evolves

• If a patient is admitted with glaucoma and the stage progresses during the admission, assign the code for the highest stage documented.
Indeterminate Stage

- Assignment of the seventh character "4" should be based on the clinical documentation. The "4" is used for glaucoma's whose stage cannot be clinically determined.
- Do not confuse the "4" with the "0", unspecified, which is used when there is NO documentation regarding the stage.

Glaucoma Suspect

- H40.00- Glaucoma suspect
  - Right
  - Left
  - Bilateral
  - Unspecified

Coding Scenario

Patient is diagnosed with single break retinal detachment of the right eye.

Answer

H33.011 – Retinal detachment with single break, right eye
Patient with pseudophakic, left eye is diagnosed with an uncontrolled primary severe open-angle glaucoma, left eye

- H40.11X3 – Uncontrolled primary severe open-angle glaucoma, left eye
- Z96.1 – Pseudophakia, left eye

Disorders of lens (Cataract)

H25.- Age-related cataract, Rt/Lt/Bilateral
  - Cortical
  - Anterior subcapsular polar
  - Posterior subcapsular polar
  - Other age-related incipient cataract (coronary, punctate, water clefts
  - Nuclear
  - Morgagnian type
  - Combined forms

H26.- Infantile and juvenile
  - Cortical, lamellar, or zonular
  - Nuclear
  - Anterior subcapsular polar
  - Posterior subcapsular polar
  - Combined forms
    - Right/Left/Bilateral
Disorders of lens (Cataract)

- **H26.1**- Traumatic
  - Localized
  - Partially resolved
  - Total

Disorders of lens (Cataract)

- **H26.2**- Complicated
  - Glaucmatous flecks (subcapsular)
  - Cataract with neovascularization
    - Code also associated condition, such as: chronic iridocyclitis (H20.1-)
  - Cataract secondary to ocular disorders
    - Code also associated ocular disorder

Disorders of lens (Cataract)

- **H26.3**- Drug-induced cataract Complicated
  - Rt/Lt/Bilateral
- **H26.4**- Secondary cataract
  - Rt/Lt/Bilateral
- **H28** Cataract in diseases classified elsewhere
  - Code first underlying disease, such as:
    - Hypoparathyroidism
    - Myotonia
    - Myxedema
    - Protein-calorie malnutrition

Other Examples:

- **H00**.- Hordeolum and chalazion
- **H01.0**.- Blepharitis
- **H01.1**- Noninfectious dermatoses of eyelid
- **H02.0**- Entropion and trichiasis of eyelid
- **H02.1**- Ectropion of eyelid
- **H02.2**- Lagophthalmos
- **H02.3**- Blepharochalasis
- **H02.6**- Xanthelasma of eyelid
Other Examples:

• **H02.8- Other specified disorders of eyelid**
  - Retained foreign body in eyelid
  - Cysts
  - Dermatochalasis
  - Edema
  - Elephantiasis
  - Hypertrichosis
  - Vascular anomalies

Other Examples:

• **H04.- Disorders of lacrimal system**
  - Dacryoadenitis
  - Acute
  - Chronic
  - Chronic enlargement

Other Examples:

• **H04.1- Other Disorders of lacrimal gland**
  - Dacryops
  - Dry eye syndrome
  - Lacrimal cyst
  - Primary atrophy
  - Secondary atrophy
  - Lacrimal gland Dislocation

Other Examples:

• **H04.2- Epiphora**
  - Epiphora due to excess lacrimation
  - Epiphora due to insufficient drainage
Other Examples:

- **H05.** Disorders of orbit
- **H10.** Conjunctivitis
- **H11.** Pterygium of eye
- **H15.** Disorders of sclera
- **H16.** Keratitis
- **H17.** Corneal scars and opacities
- **H20.** Iridocyclitis
- **H21.** Other disorders of iris and ciliary body

Conjunctivitis

- **H10.0** Mucopurulent
- **H10.1** Acute atopic
- **H10.2** Other acute conjunctivitis
- **H10.3** Unspecified acute
- **H10.4** Chronic conjunctivitis
  - Chronic giant papillary
  - Simple chronic
  - Chronic follicular
  - Vernal
  - Other chronic allergic conjunctivitis

Viral Conjunctivitis

- **B30.0** Keratoconjunctivitis due to adenovirus
- **B30.1** Conjunctivitis due to adenovirus
- **B30.2** Viral pharyngoconjunctivitis
- **B30.3** Acute epidemic hemorrhagic conjunctivitis (enteroviral)
- **B30.8** Other viral conjunctivitis
Pterygium of eye

- H11.0-
  - Unspecified
  - Amyloid
  - Central
  - Double
  - Peripheral
  - Peripheral, progressive
  - Recurrent

Keratoconjunctivitis

- H16.2-
  - Unspecified
  - Exposure
  - Sicca, not specified as Sjogren’s
  - Neurotrophic
  - Ophthalmia nodosa
  - Phlyctenular
  - Vernal

Conjunctival Hemorrhage

- H11.3-
  - Unspecified
  - Right
  - Left
  - Bilateral

Opacity

- H17.- Cornea
  - Central
  - Congenital Q13.3
  - Degenerative – see Degeneration, cornea
  - Hereditary – see Dystrophy, cornea
  - Inflammatory – see Keratitis
  - Minor
  - Peripheral
  - Sequelae of trachoma (healed) B94.0
  - Specified
Vitreous Floater

- Floater - see Opacity, vitreous
- **H43.39** - Vitreous (humor)
  - Congenital **Q14.0**
  - Membranes and strands **H43.31**

Age-related Macula Degeneration

- **H35.30** - Unspecified macular degeneration
- **H35.31** - Nonexudative age-related macular degeneration
- **H35.32** - Exudative age-related macular degeneration
- **H35.33** - Angioid streaks of macula

Macula Puckering

- **H35.37** - Puckering of macula
  - H35.371 Puckering of macula, right eye
  - H35.372 Puckering of macula, left eye
  - H35.373 Puckering of macula, bilateral
  - H35.379 Puckering of macula, unspecified
Organization and Classification

- Terminology was revised to reflect more current medical practice
- Hypertension is no longer classified as benign, malignant or unspecified

Hypertension

- More than just I10
- 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

Example

- **H40.05** - Ocular Hypertension
  - H40.051 Right
  - H40.052 Left
  - H40.053 Bilateral
  - H40.059 Unspecified eye

CHAPTER 12

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

Laterality

Right  Left

- 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

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
**Organization and Classification**

- *Recurrent* and conditions related to a *healed injury* are usually found in Chapter 13
- *Current, acute*, new injuries are found in Chapter 19

**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

---

**Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, NEC (R00-R99)**

**CHAPTER 18**

**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
**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

**Coding Scenarios**

1. **G512.0** - Bell’s palsy,  
   - **P11.3** Bell’s palsy infant or newborn
2. **H53.8** Blurred vision -
3. **R29.810** Fascial weakness, (droop)

**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

**Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T88)**

**CHAPTER 19**
Injuries grouped by body part rather than category of injury
• Head (S00-S09)
• Neck (S10-S19)
• Thorax (S20-S29)

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

---

**Definitions**

**Initial encounter** - the patient is receiving active treatment for the condition
• Surgical treatment
• Emergency department encounter
• Evaluation and treatment by the same or different 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
• Xray to check healing of fracture
Definitions

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

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

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 seen in the ED and diagnosed with ocular laceration and rupture with prolapse, right eye. He was taken to the OR for repair.

Answer

- **S05.21XA** Ocular laceration and rupture with prolapse or loss of intraocular tissue, right eye, initial encounter

- External cause is not stated, therefore, not coded.

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

External Causes of Morbidity (V00-Y99)

CHAPTER 20
Organization and Classification

- 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

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 or road (Y92.4-)
  - Use of cellular telephone at time of transport accident (Y93.C-)

Category Y99-

- Assign Y99, External cause status, to indicate work status
  - Military activity
  - Non-military person was at work
  - An individual including a student or volunteer was involved in a non-work activity

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

CHAPTER 21
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

• Z01.00 Encounter for examination of eyes and vision **without** abnormal findings
• Z01.01 Encounter for examination of eyes and vision **with** abnormal findings (use additional codes for 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

• Z01.818 Encounter for pre-procedural examination
• Z79.891 Long term (current) use of opiate analgesic
• Z80.8 Family history of malignant neoplasm of other organs or systems. (conditions classifiable to C69-)
• Z02.4 Encounter for examination for driving license
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
- **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 Translation

**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
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)
ICD-10 Code Set Websites

NCHS
- http://www.cdc.gov/nchs/icd/icd10cm.htm#icd2014

CMS

37 Days

Thank You!

808-947-2633
www.hcchawaii.com

Questions, Comments or Feedback?
Please call or email