ICD-10 IMPLEMENTATION

WHY ICD-10?

- **Benefits of ICD-10**
  - ICD-10 provides more specific data (than ICD-9), and better reflects current medical practice
  - ICD-10 will
    - Improve operational processes across the health care industry by classifying detail within codes
    - Update the terminology and disease classifications to be consistent with current clinical practices, and medical/technological advances
    - Help clinical decision making
    - Improve tracking of disease
    - Allow for better outcomes
ICD–10 Implementation

- On **October 1, 2015** CMS will implement the ICD–10–CM (diagnosis) and ICD–10–PCS* (inpatient procedures), code sets
  - ICD–10–CM diagnosis codes will be used by all providers in **every health care setting**
  - *ICD–10–PCS will be used in the hospital inpatient setting only
  - Physicians will continue to use CPT codes to report procedures

ICD–10 Implementation

CMS–1500 Claim Form Changes

- **Claims cannot contain both ICD–9 and ICD–10 codes**
- See MLN Matters SE 1408

- Added to claim form: “ICD Ind.” to indicate ICD–9 (before 10/1/15) or ICD–10 (on and after 10/1/15)
- Allows you to report up to 12 diagnosis codes
- Changed labels of the diagnosis code lines to alpha characters (A – L)
- Removed the period within the diagnosis code lines

<table>
<thead>
<tr>
<th>21, DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, Relate to service line below (24E)</th>
<th>ICD Ind.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A, ___________</td>
<td>B, ___________</td>
</tr>
<tr>
<td>E, ___________</td>
<td>F, ___________</td>
</tr>
<tr>
<td>L, ___________</td>
<td>J, ___________</td>
</tr>
</tbody>
</table>
ICD–10 Implementation  
CMS Claims Processing Guidance

- MLN Matters Number: SE 1408
  - Included in your handout

- Claims that Span the ICD–10 Implementation Date

- Specific Guidance
  - Table A Institutional Providers
  - Table B Special Outpatient Claims Processing Guidance
  - Table C Professional Claims
    - Anesthesia Claims
  - Table D Supplier Claims
    - DME

- Allows for a one year “grace” period
- You must report ICD–10–CM codes
- But … will not deny due to lack of code specificity -- if in the correct “family”
- Agreement allows for partial advance payment to you, if Medicare is unable to process claims in a timely manner
- Medicare will have an Ombudsman in place for you as of October 1st; a communication center for problem claims
ICD–10 Implementation

ICD–10 LCDs

- All ICD–10 Local Coverage Determinations (LCDs) and associated ICD–10 Articles have been published on the Medicare Coverage Database (MCD)
  - Local Coverage Determinations include a list of diagnosis codes that will support the medical necessity of certain services/tests/procedures
  - They are available on Novitas’ website

- All ICD–10 LCDs and Articles will receive a new LCD Article ID number

ICD–10 Implementation

Transition Tool: GEMs

- General Equivalence Mappings (GEMs) were created to ensure that consistency in national data is maintained

- The GEMs are a tool to assist with converting ICD–9–CM databases ... to ICD–10–CM (and ICD–10–PCS)

- The GEMs are not a substitute for learning how to use the ICD–10 code sets
Compare ICD-9 : ICD-10-CM

<table>
<thead>
<tr>
<th>CHARACTERISTIC</th>
<th>ICD-9-CM (Vol. 1 – 2)</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Length</td>
<td>3–5 characters</td>
<td>3–7 characters</td>
</tr>
<tr>
<td>Available Codes</td>
<td>@ 13,000 codes</td>
<td>@ 72,000 codes</td>
</tr>
<tr>
<td>Code Composition</td>
<td>Digit 1 = alpha or numeric</td>
<td>Digit 1 = alpha</td>
</tr>
<tr>
<td></td>
<td>Digit 2–5 = numeric</td>
<td>Digit 2 = numeric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Digit 3–7 = alpha or numeric</td>
</tr>
<tr>
<td>Available space for new codes</td>
<td>Limited</td>
<td>Flexible</td>
</tr>
<tr>
<td>Overall detail embedded within codes</td>
<td>Ambiguous</td>
<td>Very specific (allows description of comorbidities, manifestations, etiology/causation, complications…)</td>
</tr>
<tr>
<td>Laterality</td>
<td>Does not identify right vs. left</td>
<td>Often identifies right vs. left</td>
</tr>
<tr>
<td>Example</td>
<td>813.15 Open fracture of head of radius</td>
<td>S52.123C  Displaced fracture of head of unspecified radius, initial encounter for open fracture type IIIA, IIIB, or IIIC</td>
</tr>
</tbody>
</table>

ICD-10 Transition Assessment: Documentation

- Evaluate patient charts to determine whether documentation supports the level of detail found in ICD-10
- Develop templates with ICD-10 documentation
- Implement documentation improvement strategies where needed
- Assess clinician’s documentation
- Nonspecific codes are still available
Documentation

- Acuity
  - Acute – Chronic – Recurrent
- Laterality
  - Right – Left – Bilateral
- Anatomic location specificity
- Timing
- Associated conditions
- Complication
- Etiology

- Let’s look at how specific these codes are ....

H66.01 – Notice the 5th Character

- H66.01 Acute suppurative otitis media with spontaneous rupture of ear drum
- H66.011 Acute suppurative otitis media with spontaneous rupture of ear drum, right ear
- H66.012 Acute suppurative otitis media with spontaneous rupture of ear drum, left ear
- H66.013 Acute suppurative otitis media with spontaneous rupture of ear drum, bilateral
- H66.014 Acute suppurative otitis media with spontaneous rupture of ear drum, recurrent, right ear
- H66.015 Acute suppurative otitis media with spontaneous rupture of ear drum, recurrent, left ear
- H66.016 Acute suppurative otitis media with spontaneous rupture of ear drum, recurrent, bilateral
- H66.017 Acute suppurative otitis media with spontaneous rupture of ear drum, recurrent, unspecified ear
- H66.019 Acute suppurative otitis media with spontaneous rupture of ear drum, unspecified ear
ICD-10-CM: Key Features

- Each ICD-10-CM code is 3 to 7 characters
- The first character is an alpha character
  - All letters except ‘U’ are used
- The second character is numeric
- Characters 3 – 7 are either alpha or numeric, with a decimal after the third character
- Alpha characters are not case sensitive
- Greater detail and specificity
- Codes are longer – Still in Categories / “Families”
ICD-10-CM: Structure & Format

**Category:**
- Alpha (Except U)

**Etiology, anatomic site, severity:**
- 2 - 7 Numeric or Alpha

**Additional Characters:**
- Added code extensions (7th character) for obstetrics, injuries, and external causes of injury

**3 – 7 Characters**

---

ICD-10-CM: Structure & Format

**Respiratory Chapter**

**With Acute Exacerbation**

**J 4 5**

**Asthma**

**Moderate Persistent Asthma**

**4 1**

**Moderate Persistent Asthma w/Exacerbation**
ICD-10-CM: Main Terms

- Failure
- Hypertension
- Fracture, traumatic
- Fracture, pathologic
- Pneumonia
- Cellulitis
- Complication
- Bronchitis
- Flutter

ICD-10-CM: Locating a Code

- To select a code in the classification that corresponds to a diagnosis or reason for visit documented in the patient’s chart …
  - First, locate the term in the Index
  - Then, verify the code in the Tabular List
  - Read and be guided by instructional notations that appear in both the Index and the Tabular List
ICD–10–CM: The Book
Alphabetic Index – Dash

- A dash (–) at the end of an index entry indicates that additional characters are required
  - Indicates more digits are needed to complete the code

- Specified site NEC L89.89–
- – stage 1 (healing) (pre-ulcer skin changes limited to persistent focal edema)
- – ankle L89.5–
- – back L89.1–
- – buttock L89.3–
- – coccyx L89.15–
- – contiguous site of back, buttock, hip L89.4–

ICD–10–CM: Character “X”

- Character “X” is used as a 5th character placeholder in certain 6 character codes to allow for future expansion …and to fill in other empty characters (e.g. character 5 and/or 6), when a code that is < 7 characters in length requires a 7th character

**For example:**

- **T46.1x5A**  Adverse effect of calcium-channel blockers, initial encounter
  - THE 'A' MUST BE IN THE 7TH CHARACTER POSITION

- **T15.02xD**  Foreign body in cornea, left eye, subsequent encounter
  - THE 'D' MUST BE IN THE 7TH CHARACTER POSITION
ICD–10–CM: Conventions & Notes

- ICD–10 has same conventions as in ICD–9
  - Abbreviations
  - Cross reference
  - Punctuation marks
  - Relation term

- Instructional notes are also the same
  - Code first
  - Use additional code
  - Code also

ICD–10–CM: Similarities

- “And” means and/or
- “With” means associated with or due to
- NEC and NOS are used the same
  - Not elsewhere classified
  - Not otherwise specified

- Coding conventions for use of, “other” and “unspecified” codes are unchanged

- The code conventions for “includes notes” and “inclusion terms” are unchanged
ICD-10-CM: Excludes Notes

- ICD-10-CM has two types of Excludes Notes
- Each with a specific defined meaning
- Each type of note has a different definition for use, but they are similar in that they indicate that codes excluded from each other are independent of each other
- Each type is clearly marked so the meaning cannot be misinterpreted
  - Excludes 1
  - Excludes 2

ICD-10-CM: Excludes 1

- A Type 1 Excludes note is a pure excludes... It means "NOT CODED HERE!"
- An Excludes 1 note indicates that the code excluded should never be used at the same time as the code above the Excludes 1 note
- An Excludes 1 note means that the two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition
ICD–10–CM: **Excludes 1**

- The two conditions cannot occur together

*For example*

- **I06** Rheumatic aortic valve disorders has an Excludes1 of aortic valve disease not specified as rheumatic: I35.–

- Take a look at the Excludes 1 notes under E10 Type 1 Diabetes ....
ICD–10–CM: Excludes 2

- An Excludes 2 Note represents "Not included here"

- An Excludes2 note indicates that the condition excluded is not part of the condition it is excluded from ... but a patient may have both conditions at the same time

- When an Excludes2 note appears under a code it is acceptable to use both the code and the excluded code together

For Example ....

K85.2  Alcohol induced acute pancreatitis
       Excludes2: alcohol induced chronic pancreatitis (K86.0)

J44.1  Chronic obstructive pulmonary disease with (acute) exacerbation
       Decompensated COPD
       Decompensated COPD with (acute) exacerbation
       Excludes2: chronic obstructive pulmonary disease [COPD] with acute bronchitis (J44.0)
Code First

- Sequencing is directed under ‘Code First’ instruction
- Look at code I50 – Heart Failure

I50  Heart failure

- heart failure complicating abortion or ectopic or molar pregnancy (O00-O07, O08.8)
- heart failure due to hypertension (I11.0)
- heart failure due to hypertension with chronic kidney disease (I13.-)
- heart failure following surgery (I97.13-)
- obstetric surgery and procedures (O75.4)
- rheumatic heart failure (I09.81)

Examinations

- The Z codes allow for the description of encounters for routine examinations
  - General Check-Up / Physical Exam
  - Examinations for administrative purposes
  - Pre-employment physical
Examinations

- The codes are **not to be used** if the examination is for diagnosis of a suspected condition or for treatment purposes.

- In such cases, the code for the actual diagnosis is used.

- During a routine exam, should a diagnosis or condition be discovered, that diagnosis is to be coded as an additional code.

- Let’s look at some examination codes ....

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

- **Excludes1:** encounter for examination for administrative purposes (Z02-)
- **Excludes2:** encounter for pre-procedural examinations (Z01.81-)
  - special screening examinations (Z11-Z13)

**Z00.0** Encounter for general adult medical examination
- Encounter for adult periodic examination (annual) (physical) and any associated laboratory and radiologic examinations.
- **Excludes1:** encounter for examination of sign or symptom- code to sign or symptom general health check-up of infant or child (Z00.12-)

**Z00.00** Encounter for general adult medical examination without abnormal findings
- Encounter for adult health check-up NOS

**Z00.01** Encounter for general adult medical examination with abnormal findings
- Use additional code to identify abnormal findings
### Z01.8 Encounter for other specified special examinations

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| Z01.81 | Encounter for preprocedural examinations  
  | Z01.810 | Encounter for preprocedural cardiovascular examination  
  | Z01.811 | Encounter for preprocedural respiratory examination  
  | Z01.812 | Encounter for preprocedural laboratory examination  
  | Z01.818 | Encounter for other preprocedural examination  
    | Blood and urine tests prior to treatment or procedure  
    | Encounter for preprocedural examination NOS  
    | Encounter for examinations prior to antineoplastic chemotherapy |

### Outpatient Examples

- ✔ Encounter for prostate **Z12.5**
- ✔ Removal of Sutures **Z48.02**
- ✔ Observation Work Accident **Z04.2**
- ✔ Screening Colon Neoplasm **Z12.11**
Guideline: Use of Symptom Code with a Definitive Diagnosis Code

- Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes.

- The definitive diagnosis code should be sequenced before the symptom code.

Continued…

Guideline: Use of Symptom Code with a Definitive Diagnosis Code

- Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.
Guideline: Use of Symptom Code

- Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

*Example:* R10.0 Acute abdomen

Some Symptom Codes

- R04.0 Epistaxis
- R05 Cough
- R06.2 Wheezing
- R07.9 Chest pain
- R14.1 Gas Pain
- R19.36 Epigastric Pain
- R19.4 Change of bowel habits
- R50.9 FUO
Vaccinations: Z23

- All vaccinations will be assigned diagnosis: Z23
- The CPT code reported on your claim will show the specific vaccination
  - Influenza
  - Hepatitis B
  - Pneumonia

Z23 Encounter for immunization
  - Code first: any routine childhood examination
  - Note: procedure codes are required to identify the types of immunizations given.

ICD-10-CM

*Diagnosis Coding*
There are categories within each chapter of ICD-10
Each category ("family") starts with an alpha character
Each chapter is broken down into chapter blocks

ICD-10-CM
Diseases of the Circulatory System
(I00–I99)

For Example: Chapter 9 – Blocks

100–102  Acute rheumatic fever
105–109  Chronic rheumatic heart diseases
110–115  Hypertensive diseases
120–125  Ischemic heart diseases
126–128  Pulmonary heart disease and diseases of pulmonary circulation
130–152  Other forms of heart disease
160–169  Cerebrovascular diseases
170–179  Diseases of arteries, arterioles and capillaries
180–189  Diseases of veins, lymphatic vessels and lymph nodes, not elsewhere classified
195–199  Other and unspecified disorders of the circulatory system
**Hypertension: Codes & Categories**

- I10 Essential (primary) hypertension
- I11 Hypertensive heart disease
- I12 Hypertensive chronic kidney disease
- I13 Hypertensive heart and chronic kidney disease
- I15 Secondary hypertension

Do not need unspecified, benign, etc.

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**Hypertensive Heart Failure / Congestive Failure & Chronic Kidney Disease**

- Category I11 classifies hypertensive heart disease with/without heart failure: *There must be linkage—due to, HCVD, etc.*
  - Assign also a code from category I50 to describe the type of heart failure (if present)

- When chronic kidney disease (N18–) or contracted kidney (N26–) due to hypertension or arteriosclerosis of kidney is present, assign a code from category I12, Hypertensive chronic kidney disease:
  - Assign also code N18.1–N18.4, N18.5, N18.6, or N18.9 to describe stage of chronic kidney disease
Hypertension with Heart Disease

- I11.0 Hypertensive heart disease with heart failure
  Hypertensive heart failure
  Use additional code to identify type of heart failure (I50–)

- I11.9 Hypertensive heart disease without heart failure
  Hypertensive heart disease NOS

I50.2 Systolic (congestive) heart failure
  Excludes1: combined systolic (congestive) and diastolic (congestive) heart failure (I50.4–)
  I50.20 Unspecified systolic (congestive) heart failure
  I50.21 Acute systolic (congestive) heart failure
  I50.22 Chronic systolic (congestive) heart failure
  I50.23 Acute on chronic systolic (congestive) heart failure

I50.3 Diastolic (congestive) heart failure
  Excludes1: combined systolic (congestive) and diastolic (congestive) heart failure (I50.4–)
  I50.30 Unspecified diastolic (congestive) heart failure
  I50.31 Acute diastolic (congestive) heart failure
  I50.32 Chronic diastolic (congestive) heart failure
  I50.33 Acute on chronic diastolic (congestive) heart failure

I50.40 Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
I50.41 Acute combined systolic (congestive) and diastolic (congestive) heart failure
I50.42 Chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.43 Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
Guideline: Hypertensive Chronic Kidney Disease and Acute Renal Failure

- If a patient has hypertensive chronic kidney disease ESRD and acute renal failure, an additional code for the acute renal failure is required. Sequencing depends on the circumstances of the encounter.

Example:
N17.9 Acute kidney failure, unspecified
I12.0 Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
N18.6 End Stage Renal Disease

- Let's look at the specificity of codes in Category N18...
CVA

- Due to Hemorrhage
  - Location or source of hemorrhage
- Subarachnoid
  - Specify artery, if known
- Intracerebral
  - Specify location, if known
- Intracranial
- Subdural
- Acute, Subacute, Chronic
- Extradural
- Laterality
- Document any associated diagnoses/conditions

CVA: Due to Causes other than Hemorrhage

- Cause
  - Thrombosis
  - Embolism
  - Other (specify)
- Unspecified Occlusion or stenosis
- Site
- Pre–cerebral Arteries
  - Specify artery, if known
- Cerebral Arteries
  - Specify artery, if known
- Laterality
**Some Code Examples: Cerebrovascular Diseases**

- **I60.11** Subarachnoid hemorrhage from right middle artery
- **I63.112** Cerebral infarction *due to* embolism of left vertebral artery
- **I63.312** Cerebral infarction *due to* thrombosis of left middle cerebral artery
- **I65.02** Occlusion and stenosis of left carotid artery

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**Codes: Intraoperative and Postprocedural Cerebrovascular Accident**

- **I97.81** Intraoperative cerebrovascular infarction
  - **I97.810** Intraoperative cerebrovascular infarction during cardiac surgery
  - **I97.811** Intraoperative cerebrovascular infarction during other surgery
- **I97.82** Postprocedural cerebrovascular infarction
  - **I97.820** Postprocedural cerebrovascular infarction during cardiac surgery
  - **I97.821** Postprocedural cerebrovascular infarction during other surgery
Guideline: Sequela of Cerebrovascular Disease

- Category I69 is used to indicate conditions classifiable to categories I60 – I67 as the causes of late effects (neurologic deficits), themselves classified elsewhere.

- These “late effects” include neurological deficits that persist after initial onset of conditions classifiable to categories I60 – I67.

- The neurological deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to categories I60 – I67.

Guideline: Sequela of Cerebrovascular Disease

- Codes from category I69 may be assigned on a record with codes from I60–I67, if the patient has a current cerebrovascular disease and deficits from an old cerebrovascular disease.

- Code Z86.73 is assigned when the patient has a history of cerebrovascular disease, such as TIA or CVA, but no neurological deficits.
Codes: Sequela of Cerebrovascular Disease

- **I69.05** – Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage
  - **I69.051** – Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side
  - **I60.059** – Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting unspecified side

Guidelines: MI–STEMI/NSTEMI

- Acute MI must be classified (documented) as **initial** or **subsequent**
- CHANGE from ICD–9…
- Acute MI is within 4 weeks/28 day period
Myocardial Infarction Encounters

- For encounters occurring while the MI is equal to, or less than, 4 weeks old, including transfers to another acute setting or post acute setting, **and** the patient requires continued care for the MI, codes from Category 121 may continue to be reported.

- For encounters **after the 4 week time frame** and the patient is still receiving care related to the MI, the appropriate **Aftercare Code** should be assigned (rather than a code from Category 121).

- For old or healed MIs not requiring further care, code 125.2, **old myocardial infarction**, is assigned.

Documentation – MI

- **Type**
  - STEMI vs NSTEMI
- **Acute less than 28 days**
- **Initial vs Subsequent**
- **Location wall**
- **Location Artery**
  - Right coronary artery
  - Left main coronary artery
- **Document any associated diagnoses/conditions**
Guideline: Subsequent Acute Myocardial Infarction

- A code from category I22, Subsequent ST elevation (STEMI) and non ST elevation (NSTEMI) myocardial infarction...

- Is to be used when a patient who has suffered an AMI has a new AMI within the 4 week time frame of the initial AMI – 28 DAYS

- Let’s look at the specificity of some of the codes from Category I21.1 and I22.1 ...

I21.1 ST elevation (STEMI) myocardial infarction of inferior wall
  I21.11 ST elevation (STEMI) myocardial infarction involving right coronary artery
  Inferoposterior transmural (Q wave) infarction (acute)

I21.19 ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall
  Acute transmural myocardial infarction of inferior wall
  Inferolateral transmural (Q wave) infarction (acute)
  Transmural (Q wave) infarction (acute) (of) diaphragmatic wall
  Transmural (Q wave) infarction (acute) (of) inferior (wall) NOS

  Excludes2: ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery
  (I21.21)

I22.1 Subsequent ST elevation (STEMI) myocardial infarction of inferior wall
  Subsequent acute transmural myocardial infarction of inferior wall
  Subsequent transmural (Q wave) infarction (acute) (of) diaphragmatic wall
  Subsequent transmural (Q wave) infarction (acute) (of) inferior (wall) NOS
  Subsequent inferolateral transmural (Q wave) infarction (acute)
  Subsequent inferoposterior transmural (Q wave) infarction (acute)

I22.2 Subsequent non-ST elevation (NSTEMI) myocardial infarction
  Subsequent acute subendocardial myocardial infarction
  Subsequent non-Q wave myocardial infarction NOS
  Subsequent nontransmural myocardial infarction NOS
Ischemia

- I25.10 ASHD
- I25.110 ASHD with unstable angina
- I25.2 Old MI
- I25.5 Ischemic cardiomyopathy
- I20.0 Unstable angina
- I20.9 Unspecified angina

- Some code examples ....

I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris
  Atherosclerotic heart disease NOS
I25.11 Atherosclerotic heart disease of native coronary artery with angina pectoris
  I25.110 Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
    Excludes1: unstable angina without atherosclerotic heart disease (I20.0)
  I25.111 Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm
    Excludes1: angina pectoris with documented spasm without atherosclerotic heart disease (I20.1)
  I25.118 Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris
    Excludes1: other forms of angina pectoris without atherosclerotic heart disease (I20.8)
  I25.119 Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris
    Atherosclerotic heart disease with angina NOS
    Atherosclerotic heart disease with ischemic chest pain
    Excludes1: unspecified angina pectoris without atherosclerotic heart disease (I20.9)
I25.2 Old myocardial infarction
  Healed myocardial infarction
  Past myocardial infarction diagnosed by ECG or other investigation, but currently presenting no symptoms
I25.3 Aneurysm of heart
  Mural aneurysm
  Ventricular aneurysm
Atrial Fibrillation and Flutter

- **Increased specificity**

  - I48.0 Paroxysmal atrial fibrillation
  - I48.1 Persistent atrial fibrillation
  - I48.2 Chronic atrial fibrillation
  - I48.3 Typical atrial flutter
  - I48.4 Atypical atrial flutter

  - I48.91 Unspecified atrial fibrillation
  - I48.92 Unspecified atrial flutter
Vascular

- Atherosclerosis of the extremity
  - Claudication
  - Rest pain
  - Ulcer
  - Gangrene

- Which leg?
  - Right
  - Left
  - Bilateral
  - Unspecified

Circulatory Extremity
Atherosclerosis

- Be sure to document …
  - Artery type
  - Complications
  - Extremity
  - Laterality
  - Ulcer

- Let’s look at the codes in Category I70.23…

I70.23  Atherosclerosis of native arteries of right leg with ulceration

  Includes: any condition classifiable to I70.211 and I70.221
  Use additional code to identify severity of ulcer (L97.~)

I70.231  Atherosclerosis of native arteries of right leg with ulceration of thigh
I70.232  Atherosclerosis of native arteries of right leg with ulceration of calf
I70.233  Atherosclerosis of native arteries of right leg with ulceration of ankle
I70.234  Atherosclerosis of native arteries of right leg with ulceration of heel and midfoot
  Atherosclerosis of native arteries of right leg with ulceration of plantar surface of midfoot
Ulcera

- The coding and documentation of non-pressure chronic ulcers has greatly expanded in ICD-10-CM

  - The codes are located in categories L97 and L98

- In order for the most appropriate code to be assigned at the highest level of specificity, documentation must include site, laterality, and severity

L97.21  Non-pressure chronic ulcer of right calf

- L97.211  Non-pressure chronic ulcer of right calf limited to breakdown of skin
- L97.212  Non-pressure chronic ulcer of right calf with fat layer exposed
- L97.213  Non-pressure chronic ulcer of right calf with necrosis of muscle
- L97.214  Non-pressure chronic ulcer of right calf with necrosis of bone
- L97.219  Non-pressure chronic ulcer of right calf with unspecified severity
Vascular

- I71.4 AAA
- I70.232 Atherosclerosis of native arteries of right leg with ulcer of calf
- I70.223 AS of native arteries of extremities with rest pain bilateral legs
- I70.262 AS of native arteries of extremities with gangrene, left leg

Status Post

- CABG Z95.1
- PTCA with Stent Z95.5
- PTCA Z98.61
- Prosthetic Valve Z95.2
- Xenogenic Valve Z95.3
- AICD Z96.810
Let’s Try One

A patient presents to the emergency department with 45 minutes of chest discomfort

ECG and cardiac biomarkers confirm non-ST elevation myocardial infarction

What code(s) would be assigned?

Answer Diagram:
Non-ST elevation (NSTEMI) myocardial infarction

Circulatory Chapter

Non-ST elevation

1 2 1

ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction, initial

4
Let’s Try One

What code is assigned for the diagnosis “Non-ST elevation (NSTEMI) myocardial infarction, occurred 5 weeks ago”?

Answer Diagram: Old Myocardial Infarction

Circulatory Chapter

1 2 5

Old Myocardial Infarction

Chronic Ischemic Heart Disease

2
Let’s Look at Chapter 10

**ICD-10-CM**

Diseases of the Respiratory System
Chapter Blocks – J00-J99

Chapter Blocks

- J00-J06  Acute upper respiratory infections
- J09-J18  Influenza and pneumonia
- J20-J22  Other acute lower respiratory infections
- J30-J39  Other diseases of upper respiratory tract
- J40-J47  Chronic lower respiratory diseases
- J60-J70  Lung diseases due to external agents
- J80-J84  Other respiratory diseases principally affecting the interstitium
- J85-J86  Suppurative and necrotic conditions of the lower respiratory tract
- J90-J94  Other diseases of the pleura
- J95      Intraoperative and postprocedural complications
- J96-J99  Other diseases of the respiratory system
Chapter 10 – Instruction Note

- Use additional code, where applicable, 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)

Upper Respiratory Infection

- J02.8 Acute pharyngitis due to other specified organisms
- J02.9 Acute pharyngitis, unspecified
- J30.0 Vasomotor rhinitis
- J30.9 Allergic rhinitis, unspecified
- J01.90 Acute sinusitis, unspecified
- J01.91 Acute recurrent sinusitis, unspecified
- J01.80 Other acute sinusitis
- J01.81 Other acute recurrent sinusitis
- J06.9 Acute upper respiratory infection, unspecified
Acute Bronchitis

- **J20.0** Acute bronchitis *due to* Mycoplasma pneumonia
- **J20.1** Acute bronchitis *due to* Hemophilus influenza
- **J20.2** Acute bronchitis *due to* streptococcus
- **J20.5** Acute bronchitis *due to* respiratory syncytial virus
- **J20.6** Acute bronchitis *due to* rhinovirus
- **J20.7** Acute bronchitis *due to* echovirus
- **J20.8** Acute bronchitis *due to* other specified organisms
- **J20.9** Acute bronchitis, *unspecified*

Bronchiolitis

- **J21** Acute bronchiolitis
  - Includes: acute bronchiolitis with bronchospasm
  - Excludes2: respiratory bronchiolitis interstitial lung disease (J84.115)
  - **J21.0** Acute bronchiolitis *due to* respiratory syncytial virus
  - **J21.1** Acute bronchiolitis *due to* human metapneumovirus
  - **J21.8** Acute bronchiolitis *due to* other specified organisms
  - **J21.9** Acute bronchiolitis, unspecified
    - Bronchiolitis (acute)
      - Excludes1: chronic bronchiolitis (J44.-)
  - **J22** Unspecified acute lower respiratory infection
    - Acute (lower) respiratory (tract) infection NOS
    - Excludes1: upper respiratory infection (acute) (J06.9)
Guideline: COPD and Asthma

- The codes in categories J44 and J45 distinguish between uncomplicated cases and those in acute exacerbation.

- An acute exacerbation is a worsening or a decompensation of a chronic condition.

- An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.

Asthma: Terminology Changes

Documentation needed for asthma diagnoses

Is the asthma

Intermittent ?
Persistent ?

How severe is the asthma?

Mild ?
Moderate ?
Severe ?
### Severity of Asthma Classification

#### Presentation of Asthma before (without) Treatment

<table>
<thead>
<tr>
<th>Type of Asthma</th>
<th>Symptoms</th>
<th>Nighttime Symptoms</th>
<th>Lung Function</th>
</tr>
</thead>
</table>
| Severe persistent | <ul><li>Continual symptoms</li><li>Limited physical activity</li><li>Frequent exacerbations</li></ul> | Frequent           | • FEV₁ or PEF ≤ 60% predicted  
• PEF variability > 30% |
| Moderate persistent | <ul><li>Daily symptoms</li><li>Daily use of inhaled short-acting beta₂-agonist</li><li>Exacerbation of affect activity</li><li>Exacerbation > 2 times/week ≥ 1 day(s)</li></ul> | > 1 time/week      | • FEV₁ or PEF 60-80% predicted  
• PEF variability ≤ 30% |
| Mild persistent | <ul><li>Symptoms > 2 times/week but < 1 time/day</li><li>Exacerbation may affect activity</li></ul> | > 2 times/month   | • FEV₁ or PEF ≥ 80% predicted  
• PEF variability 20-30% |
| Mild intermittent | <ul><li>Symptoms ≤ 2 times/week</li><li>Asymptomatic and normal PEF between exacerbations</li><li>Exacerbations of varying intensity are brief (a few hours to a few days)</li></ul> | ≥ 2 times/month  | • FEV₁ or PEF ≥ 80% predicted  
• PEF variability < 20% |

FEV₁ = The maximal amount of air a person can forcefully exhale over one second accounting for the variables of height, weight, and race used to denote the degree of obstruction with asthma

PEF = Peak Expiratory Flow is the maximum flow of expelled air during expiration following full inspiration (big breath in and then big breath out)


### Mild Intermittent Asthma

- **J45.2** Mild Intermittent asthma
  - **J45.20** Mild intermittent asthma, uncomplicated
    - Mild Intermittent asthma NOS
  - **J45.21** Mild Intermittent asthma with (acute) exacerbation
  - **J45.22** Mild intermittent asthma with status asthmaticus
Mild Persistent and Moderate Persistent

- J45.3 Mild persistent asthma
  - J45.30 Mild persistent asthma, uncomplicated
    Mild persistent asthma NOS
  - J45.31 Mild persistent asthma with (acute) exacerbation
  - J45.32 Mild persistent asthma with status asthmaticus

- J45.4 Moderate persistent asthma
  - J45.40 Moderate persistent, uncomplicated
    Moderate persistent asthma NOS
  - J45.41 Moderate persistent with (acute) exacerbation
  - J45.42 Moderate persistent with status asthmaticus

Severe Persistent Asthma

- J45.5 Severe persistent Asthma
  - J45.50 Severe persistent, uncomplicated
    Severe persistent asthma NOS
  - J45.51 Severe persistent with (acute) exacerbation
  - J45.52 Severe persistent with status asthmaticus
Code Examples: Asthma J45

- J45.901 Unspecified asthma with (acute) exacerbation
- J45.902 Unspecified asthma with status asthmaticus
- J45.909 Unspecified Asthma
- J45.990 Exercise induced bronchospasm
- J45.991 Cough variant asthma
- J45.998 Other asthma

Chronic Obstructive Pulmonary Disease

- J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection
  - Use additional code to identify the infection
- J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation
  - Decompensated COPD
  - Decompensated COPD with (acute) exacerbation
  - Excludes2: chronic obstructive pulmonary disease [COPD] with acute bronchitis (J44.0)
- J44.9 Chronic obstructive pulmonary disease, unspecified
  - Chronic obstructive airway disease NOS
  - Chronic obstructive lung disease NOS
Sinusitis

- Code examples from Category J01 and J32
- Notice guidance ....
- Includes
- Use additional code
- Excludes 1 and Excludes 2 Notes
Influenza

- Code only confirmed cases of influenza due to certain identified influenza viruses
  - Category J09

- In this context, “confirmation” does not require documentation of positive laboratory testing specific for avian or other novel Influenza A

- Coding should be based on provider’s diagnostic statement that the patient has avian influenza, or other novel Influenza A
Pneumonia Documentation

- Document causative organism (if known)
- Document mechanism:
  - Aspiration
  - Ventilator–associated
  - Radiation–induced
  - Other (specify)
- Document any associated illness:
  - Respiratory failure
  - Sepsis
  - Underlying lung disease
  - Other (specify)
- Document history of tobacco use – past/present
Chapter 10 – Code Category J95

J95.61 Intraoperative hemorrhage and hematoma of a respiratory system organ or structure complicating a respiratory system procedure

J95.62 Intraoperative hemorrhage and hematoma of a respiratory system organ or structure complicating other procedure

Let’s Try One

Assign the code for acute recurrent maxillary sinusitis
**Answer Diagram:**

Acute recurrent maxillary sinusitis

Let's Try One

Patient is seen for pneumonia

Assign the code
Answer Diagram: Pneumonia

- Respiratory Chapter
- J18.9
- Pneumonia
- Unspecified

Diabetes

- Documentation Requirements
- Changes from ICD-9
Types of Diabetes

- Distinction between Type I, Type II, and Secondary Diabetes
  - No longer based on insulin dependent versus non-insulin dependent
  - Type I often referred to as juvenile diabetes
- If the type is not specified, must assume Type II
- If type is not specified and patient uses insulin, must assume Type II
- Code Z79.4, Long-term (current) use of insulin, should also be assigned to indicate that the patient uses insulin
  - Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient’s blood sugar under control during an encounter

Reference: Coding Guideline C.4.a.1 – C.4.a.3
Diabetes

Coding Guideline C.4.a states "as many codes within a particular category to describe ALL complications may be used"

When coding multiple manifestations, a diabetic code is assigned with each manifestation from a different category.

**Example:** Diabetic neuropathy and diabetic angiopathy have two codes.
- E11.42 Diabetes with polyneuropathy
- E11.51 Diabetes with peripheral angiopathy without gangrene or
- E11.52 ...with gangrene

---

Diabetes – Changes

- 5 Categories of Codes for Diabetes Mellitus in ICD–10–CM vs 2 Categories in ICD–9–CM

**E08** Diabetes Mellitus Due to Underlying Condition
**E09** Drug or Chemical Induced Diabetes Mellitus

**E10** Type 1 Diabetes Mellitus
**E11** Type 2 Diabetes Mellitus

**E13** Other Specified Diabetes Mellitus
Diabetes – Documentation

- Type
  - Type 1
  - Type 2
- Drug/chemical induced
- Due to underlying condition
- Other specified type
- Control
  - Inadequate control
  - Out of control
  - Poorly Controlled
- Hypoglycemia
- Hyperglycemia

Diabetes – Documentation

- Insulin use
- Manifestation/Complication *(document link to diabetes)*
  - Circulatory complications
  - Hyperosmolarity
  - With or without coma
  - Hypoglycemia
  - Ketoacidosis
  - With or without coma
  - Kidney complications
  - Neurological complications

Let’s look at some diabetes codes ....
E10 Type 1 diabetes mellitus
   Includes: brittle diabetes (mellitus)  
   diabetes (mellitus) due to autoimmune process  
   diabetes (mellitus) due to immune mediated pancreatic islet beta-cell destruction  
   idiopathic diabetes (mellitus)  
   juvenile onset diabetes (mellitus)  
   ketosis-prone diabetes (mellitus)  
   Excludes1: diabetes mellitus due to underlying condition (E08.-)  
   drug or chemical induced diabetes mellitus (E09.-)  
   gestational diabetes (O24.4-)  
   hyperglycemia NOS (R73.9)  
   neonatal diabetes mellitus (P70.2)  
   postpancreatectomy diabetes mellitus (E13.-)  
   postprocedural diabetes mellitus (E13.-)  
   secondary diabetes mellitus NEC (E13.-)  
   type 2 diabetes mellitus (E11.-)  
E10.1 Type 1 diabetes mellitus with ketoacidosis  
E10.10 Type 1 diabetes mellitus with ketoacidosis without coma  
E10.11 Type 1 diabetes mellitus with ketoacidosis with coma  
E10.2 Type 1 diabetes mellitus with kidney complications  
E10.21 Type 1 diabetes mellitus with diabetic nephropathy  
   Type 1 diabetes mellitus with intercapillary glomerulosclerosis  
   Type 1 diabetes mellitus with intracapillary glomerulonephrosis  
   Type 1 diabetes mellitus with Kimmelstiel-Wilson disease  
E10.22 Type 1 diabetes mellitus with diabetic chronic kidney disease  

E11.5 Type 2 diabetes mellitus with circulatory complications  
E11.51 Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene  
E11.52 Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene  
   Type 2 diabetes mellitus with diabetic gangrene  
E11.59 Type 2 diabetes mellitus with other circulatory complications  
E11.6 Type 2 diabetes mellitus with other specified complications  
E11.61 Type 2 diabetes mellitus with diabetic arthropathy  
   E11.610 Type 2 diabetes mellitus with diabetic neuropathic arthropathy  
   Type 2 diabetes mellitus with Charcot's joints  
   E11.618 Type 2 diabetes mellitus with other diabetic arthropathy  
E11.62 Type 2 diabetes mellitus with skin complications  
E11.620 Type 2 diabetes mellitus with diabetic dermatitis  
   Type 2 diabetes mellitus with diabetic necrobiosis lipoidica  
E11.621 Type 2 diabetes mellitus with foot ulcer  
   Use additional code to identify site of ulcer (L97.4-, L97.5-)  
E11.622 Type 2 diabetes mellitus with other skin ulcer  
   Use additional code to identify site of ulcer (L97.1-L97.9, L98.41-L98.49)  
E11.628 Type 2 diabetes mellitus with other skin complications
Diabetes: Use additional code

- Uncontrolled diabetes is coded to diabetes, by type, with hyperglycemia
  - E10.65, Type I diabetes with hyperglycemia
  - E11.65, Type II diabetes with hyperglycemia
- Develop a policy regarding use of code Z79.4, Long-term (current) use of insulin to ensure consistency
  - Note under E11 to use additional code to identify insulin use

E11 Type 2 diabetes mellitus
- Includes: diabetes (mellitus) due to insulin secretion defect
- Diabetes NOS
- Insulin resistant diabetes (mellitus)
- Use additional code to identify any insulin use (Z79.4)
- Excludes: diabetes mellitus due to underlying condition (E08-)

Neoplasms

- To appropriately code a neoplasm, you must know the morphology (histology): malignant, benign, in situ, uncertain behavior
  - Malignant codes include primary and secondary sites
- The table of neoplasm should be used to correctly identify the topography code; it is located after Z in the alphabetical index
  - The table lists neoplasms by anatomical site, and the columns are utilized to select one of the six types and the associated code
- Sequencing of codes is dependent on reason for admission or encounter

Reference: Coding Guideline C.2.a and CG C.2.b
### Neoplasm Table

<table>
<thead>
<tr>
<th>Neoplasm, neoplastic</th>
<th>Malignant Primary</th>
<th>Malignant Secondary</th>
<th>Carcinoma in situ</th>
<th>Benign</th>
<th>Uncertain Behavior</th>
<th>Unspecified Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>abdomen, abdominal</td>
<td>C70.2</td>
<td>C79.8</td>
<td>C99.8</td>
<td>D86.7</td>
<td>D48.7</td>
<td>D49.8</td>
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<td>- cavity</td>
<td>C79.2</td>
<td>C79.8</td>
<td>D86.7</td>
<td>D48.7</td>
<td>D49.8</td>
<td></td>
</tr>
<tr>
<td>- organ</td>
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<td>C79.8</td>
<td>D86.7</td>
<td>D48.7</td>
<td>D49.8</td>
<td></td>
</tr>
<tr>
<td>- viscera</td>
<td>C70.2</td>
<td>C79.8</td>
<td>D86.7</td>
<td>D48.7</td>
<td>D49.8</td>
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<tr>
<td>- wall</td>
<td>C44.5</td>
<td>C79.2</td>
<td>D04.5</td>
<td>D23.5</td>
<td>D48.5</td>
<td>D49.2</td>
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<td>- connective tissue</td>
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<td>C79.8</td>
<td>-</td>
<td>D21.4</td>
<td>D49.1</td>
<td>D49.2</td>
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<td>abdominal pelvic</td>
<td>C70.8</td>
<td>C79.8</td>
<td>-</td>
<td>D86.7</td>
<td>D48.7</td>
<td>D49.8</td>
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<td>accessory sinus-see</td>
<td>Neoplasm, sinus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Let’s Try One!

- Glioblastoma multiforme of the frontal lobe
### Index

**Glioblastoma (multiforme)**
- with sarcomatous component
- - specified site — see Neoplasm, malignant, by site
- - unspecified site C71.9
- giant cell
- - specified site — see Neoplasm, malignant, by site
- - unspecified site C71.9
- specified site — see Neoplasm, malignant, by site
- - unspecified site C71.9

#### Table

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Malignant Primary</th>
<th>Malignant Secondary</th>
<th>Ca in situ</th>
<th>Benign</th>
<th>Uncertain Behavior</th>
<th>Unspecified Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- - xiphoid process</td>
<td>C41.3</td>
<td>C79.51</td>
<td>-</td>
<td>D16.7</td>
<td>D49.0</td>
<td>D49.2</td>
</tr>
<tr>
<td>- - zygomatic</td>
<td>C41.0</td>
<td>C79.51</td>
<td>-</td>
<td>D16.4+</td>
<td>D49.0</td>
<td>D49.2</td>
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<td>- - buccal/mouth</td>
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<td>C79.89</td>
<td>D00.00</td>
<td>D10.39</td>
<td>D37.00</td>
<td>D49.0</td>
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<td>- - bowel — see Neoplasm, intestine</td>
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<td>- - buccal/pleura</td>
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<td>C78.86</td>
<td>-</td>
<td>D38.12</td>
<td>D49.2</td>
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<td>C79.31</td>
<td>-</td>
<td>D33.2</td>
<td>D43.2</td>
<td>D49.6</td>
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<tr>
<td>- - basal ganglia</td>
<td>C71.0</td>
<td>C79.31</td>
<td>-</td>
<td>D33.0</td>
<td>D43.0</td>
<td>D49.6</td>
</tr>
<tr>
<td>- - cerebellar/pontine angle</td>
<td>C71.6</td>
<td>C79.31</td>
<td>-</td>
<td>D33.1</td>
<td>D43.1</td>
<td>D49.6</td>
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<tr>
<td>- - cerebellum NOS</td>
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<td>C79.31</td>
<td>-</td>
<td>D33.1</td>
<td>D43.1</td>
<td>D49.6</td>
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<tr>
<td>- - cerebrum</td>
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<td>C79.31</td>
<td>-</td>
<td>D33.0</td>
<td>D43.0</td>
<td>D49.6</td>
</tr>
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<td>- - choroid plexus</td>
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<td>C79.31</td>
<td>-</td>
<td>D33.1</td>
<td>D43.1</td>
<td>D49.6</td>
</tr>
<tr>
<td>- - corpus callosum</td>
<td>C71.8</td>
<td>C79.31</td>
<td>-</td>
<td>D33.2</td>
<td>D43.2</td>
<td>D49.6</td>
</tr>
<tr>
<td>- - corpus striatum</td>
<td>C71.5</td>
<td>C79.31</td>
<td>-</td>
<td>D33.0</td>
<td>D43.0</td>
<td>D49.6</td>
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<tr>
<td>- - cortic (cerebral)</td>
<td>C71.0</td>
<td>C79.31</td>
<td>-</td>
<td>D33.0</td>
<td>D43.0</td>
<td>D49.6</td>
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<tr>
<td>- - frontal lobe</td>
<td>C71.1</td>
<td>C79.31</td>
<td>-</td>
<td>D33.0</td>
<td>D43.0</td>
<td>D49.6</td>
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<tr>
<td>- - globus pallidus</td>
<td>C71.0</td>
<td>C79.31</td>
<td>-</td>
<td>D33.0</td>
<td>D43.0</td>
<td>D49.6</td>
</tr>
</tbody>
</table>
Sequencing is influenced by condition AND the treatment rendered

Anemia due to malignancy
- Malignancy sequenced first, followed by anemia

Anemia due to chemotherapy, or immunotherapy
- Anemia sequenced first, followed by malignancy and code for adverse reaction of chemotherapy/immunotherapy

Dehydration due to malignancy
- Dehydration sequenced first, followed by malignancy

Reference: Coding Guideline C.3
Neoplasms, continued

- Malignancy in two or more contiguous sites
  - Most anatomical sites allow use of subcategory .8 for overlapping lesions
- Malignancy in two or more non-contiguous sites
  - Coders: Recommend querying physician
- Disseminated malignancy
  - C80.0, Disseminated malignant neoplasm, unspecified, is for use only in those cases where the patient has advanced metastatic disease and no known primary or secondary sites are specified.
- Malignant neoplasm, site unspecified
  - Code C80.1, Malignant (primary) neoplasm, unspecified, equates to Cancer, unspecified. This code should only be used when no determination can be made as to the primary site of a malignancy.

History of Malignant Neoplasm

Coding Guideline C.2.d: When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.

Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site.

The secondary site may be the principal or first-listed with the Z85 code used as a secondary code.

Let’s look at these codes....
Z85.3 Personal history of malignant neoplasm of breast
   Conditions classifiable to C50.-

Z85.4 Personal history of malignant neoplasm of genital organs
   Conditions classifiable to C51-C63
   Z85.40 Personal history of malignant neoplasm of unspecified female genital organ
   Z85.41 Personal history of malignant neoplasm of cervix uteri
   Z85.42 Personal history of malignant neoplasm of other parts of uterus
   Z85.43 Personal history of malignant neoplasm of ovary
   Z85.44 Personal history of malignant neoplasm of other female genital organs
   Z85.45 Personal history of malignant neoplasm of unspecified male genital organ
   Z85.46 Personal history of malignant neoplasm of prostate

Screening for Malignant Neoplasm

Z12.3 Encounter for screening for malignant neoplasm of breast
   Z12.31 Encounter for screening mammogram for malignant neoplasm of breast
      Excludes1: inconclusive mammogram (R92.2)
   Z12.39 Encounter for other screening for malignant neoplasm of breast

Z12.4 Encounter for screening for malignant neoplasm of cervix
   Encounter for screening pap smear for malignant neoplasm of cervix
   Excludes1: encounter for screening for human papillomavirus (Z11.51) when screening is part of general gynecological examination (Z01.4-)

Z12.5 Encounter for screening for malignant neoplasm of prostate

Z12.6 Encounter for screening for malignant neoplasm of bladder

Z12.7 Encounter for screening for malignant neoplasm of other genitourinary organs
   Z12.71 Encounter for screening for malignant neoplasm of testis
   Z12.72 Encounter for screening for malignant neoplasm of vagina
      Vaginal pap smear status-post hysterectomy for non-malignant condition
Neoplasm – Documentation Tips

- Behavior:
  - Malignant (primary, secondary, in-situ)
- Document any secondary sites
- Laterality (specify right/left)
- Anatomical site Other condition(s) associated with malignancy (dehydration, anemia, etc.)
- Complication(s) associated with neoplasm
- Carcinoid
- History of
- Has the malignancy been excised or eradicated?
- Is there still treatment being provided for the primary and/or metastatic site?

Let’s Look At Chapter 15

ICD-10-CM
Pregnancy, Childbirth, and the Puerperium
Chapter Blocks O00–O9a
Documentation of Time

- Documentation of conditions/complications of pregnancy will need to specify the trimester in which that condition occurred.
- Some codes, but not all, specify trimester.
- ICD-9-CM documentation required “episode of care” (delivered, antepartum, post-partum) instead of trimester, childbirth, puerperium.

Trimester Definitions

- **1st Trimester:** < 14 weeks 0 days
- **2nd Trimester:** 14 weeks to < 28 weeks 0 days
- **3rd Trimester:** > 28.0 weeks to delivery
Pre-eclampsia

- **O14.10** Severe pre-eclampsia, unspecified trimester
- **O14.12** Severe pre-eclampsia, second trimester
- **O14.13** Severe pre-eclampsia, third trimester

Some codes will show the trimester the complication occurred in

---

Documentation of Time

- Early vs late
- Missed Abortion vs Fetal Demise
- 20 weeks

**O21.1** Hyperemesis gravidarum with metabolic disturbance
Hyperemesis gravidarum, starting before the end of the 20th week of gestation, with metabolic disturbance such as carbohydrate depletion
Hyperemesis gravidarum, starting before the end of the 20th week of gestation, with metabolic disturbance such as dehydration
Hyperemesis gravidarum, starting before the end of the 20th week of gestation, with metabolic disturbance such as electrolyte imbalance

**O21.2** Late vomiting of pregnancy
Excessive vomiting starting after 20 completed weeks of gestation
Weeks of Gestation

- The chapter starts with a note that states:
- Use additional code from category Z3A, Weeks of Gestation, to identify the specific week of pregnancy
- *For Example:*
- Z3A.24 –24 weeks Gestation of Pregnancy

Hypertension in Pregnancy

- **O10.01** Pre-existing hypertension complicating pregnancy first trimester
- **O11.1** Pre-existing hypertension with pre-eclampsia, first trimester
- **O12.00** Gestational edema, first trimester
- **O14.00** Mild-moderate pre-eclampsia trimester unspecified
Diabetes Mellitus is a significant complicating factor in pregnancy

Pregnant women who are diabetic should be assigned a code from Category O24, Diabetes Mellitus in Pregnancy, Childbirth, and the Puerperium, **first**

followed by the appropriate diabetes code(s) (E08–E13) from Chapter 4

---

O24.1 Pre-existing diabetes mellitus, type 2, in pregnancy, childbirth and the puerperium

insulin-resistant diabetes mellitus in pregnancy, childbirth and the puerperium

Use additional code (for):

- from category E11 to further identify any manifestations
- long-term (current) use of insulin (Z79.4)

O24.11 Pre-existing diabetes mellitus, type 2, in pregnancy

- O24.111 Pre-existing diabetes mellitus, type 2, in pregnancy, first trimester
- O24.112 Pre-existing diabetes mellitus, type 2, in pregnancy, second trimester
- O24.113 Pre-existing diabetes mellitus, type 2, in pregnancy, third trimester
- O24.119 Pre-existing diabetes mellitus, type 2, in pregnancy, unspecified trimester

O24.12 Pre-existing diabetes mellitus, type 2, in childbirth

O24.13 Pre-existing diabetes mellitus, type 2, in the puerperium
Gestational Diabetes

- Gestational (pregnancy induced) diabetes can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy.

- Gestational diabetes can cause complications in the pregnancy similar to those of pre-existing diabetes mellitus. It also puts the woman at greater risk of developing diabetes after the pregnancy.

- Codes for gestational diabetes are in subcategory O24.4, Gestational Diabetes Mellitus.
- No other code from category O24.

See How the Index Looks

- Diabetes, gestational (in pregnancy) O24.419
  - affecting newborn P70.0
  - diet controlled O24.410
  - in childbirth O24.429
  - diet controlled O24.420
  - insulin (and diet) controlled O24.424
  - puerperal O24.439
  - diet controlled O24.430
  - insulin (and diet) controlled O24.434
A 32-year-old female patient with type 1 diabetes is G2, P1, 26 weeks and is seen to evaluate her diabetes in pregnancy

- **O24.012** Pre-existing diabetes mellitus, type 1, in pregnancy, second trimester
- **Z3A.26** 26 weeks gestation of pregnancy
O28 Abnormal findings on antenatal screening of mother
   Excludes 1: diagnostic findings classified elsewhere - see Alphabetic Index
   O28.0 Abnormal hematological finding on antenatal screening of mother
   O28.1 Abnormal biochemical finding on antenatal screening of mother
   O28.2 Abnormal cytological finding on antenatal screening of mother
   O28.3 Abnormal ultrasonic finding on antenatal screening of mother
   O28.4 Abnormal radiological finding on antenatal screening of mother
   O28.5 Abnormal chromosomal and genetic finding on antenatal screening of mother
   O28.8 Other abnormal findings on antenatal screening of mother
   O28.9 Unspecified abnormal findings on antenatal screening of mother

Documentation of Time

› O75.81 Maternal exhaustion complicating labor and delivery

› O86.0 Infection of obstetric surgical wound

› O86.12 Endometritis following delivery

› O86.21 Infection of kidney following delivery

› O23.03 Infection of kidney third trimester
Location

- O23.01 Infections of kidney in pregnancy, first trimester
- O23.11 Infections of bladder in pregnancy, first trimester
- O23.31 Infections of other parts of urinary tract in pregnancy, first trimester

Pyelonephritis: Example

- The patient has acute pyelonephritis
  - O23.01 Infections of kidney in pregnancy, first trimester
  - N10 Acute Pyelonephritis
Other O99

- O99: Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium

- Use additional code to identify specific condition

- Hypothyroid
  - O99.281 + E03.9

Let's look at some codes in Category O99:

- O99.33 Smoking (tobacco) complicating pregnancy, childbirth, and the puerperium
  - Use additional code from F17 to identify type of tobacco
  - O99.330 Smoking (tobacco) complicating pregnancy, unspecified trimester
  - O99.331 Smoking (tobacco) complicating pregnancy, first trimester
  - O99.332 Smoking (tobacco) complicating pregnancy, second trimester
  - O99.333 Smoking (tobacco) complicating pregnancy, third trimester
  - O99.334 Smoking (tobacco) complicating childbirth
  - O99.335 Smoking (tobacco) complicating the puerperium
### Change: New Category O9A

- **O9A** Maternal malignant neoplasms, traumatic injuries and abuse classifiable elsewhere but complicating pregnancy, childbirth and the puerperium

- Let’s look at codes in Category O9A …
O9A.1 Malignant neoplasm complicating pregnancy, childbirth and the puerperium
Conditions in C00-C96
Use additional code to identify neoplasm
Excludes2: maternal care for benign tumor of corpus uteri (O34.1-)
matrial care for benign tumor of cervix (O34.4-)
O9A.11 Malignant neoplasm complicating pregnancy
O9A.111 Malignant neoplasm complicating pregnancy, first trimester
O9A.112 Malignant neoplasm complicating pregnancy, second trimester
O9A.113 Malignant neoplasm complicating pregnancy, third trimester
O9A.119 Malignant neoplasm complicating pregnancy, unspecified trimester
O9A.12 Malignant neoplasm complicating childbirth
O9A.13 Malignant neoplasm complicating the puerperium

O9A.2 Injury, poisoning and certain other consequences of external causes complicating pregnancy,
childbirth and the puerperium
Conditions in S00-T88, except T74 and T76
Use additional code(s) to identify the injury or poisoning
Excludes2: physical, sexual and psychological abuse complicating pregnancy, childbirth and the puerperium
(O9A.3-, O9A.4-, O9A.5-)
O9A.21 Injury, poisoning and certain other consequences of external causes complicating pregnancy
O9A.211 Injury, poisoning and certain other consequences of external causes complicating pregnancy, first trimester
O9A.212 Injury, poisoning and certain other consequences of external causes complicating pregnancy, second trimester
O9A.213 Injury, poisoning and certain other consequences of external causes complicating pregnancy, third trimester
O9A.219 Injury, poisoning and certain other consequences of external causes complicating pregnancy, unspecified trimester
O9A.22 Injury, poisoning and certain other consequences of external causes complicating childbirth
O9A.23 Injury, poisoning and certain other consequences of external causes complicating the puerperium
Supervision of Pregnancy

- Z34.00  Encounter for supervision of normal first pregnancy; Unspecified trimester
- Z34.01  First trimester
- Z34.02  Second trimester
- Z34.03  Third trimester
- Z35.80  Encounter for supervision of normal pregnancy; Unspecified trimester

Encounters Not Related to Pregnancy

- Z01.4  Encounter for routine GYN exam
- Z30    Encounter for contraceptive management
- Z31    Encounter for procreative management
- Z32    Encounter for pregnancy test and childbirth and childcare instruction
- Z33    Pregnant state
Let’s Look at Chapter 16

ICD-10-CM
Certain Condition Originating in the Perinatal Period
Chapter Blocks:P00–P96

Guideline: Perinatal Conditions After the Perinatal Period

- Use of Chapter 16 Codes after the Perinatal Period
  “Should a condition originate in the perinatal period, and continue throughout the life of the patient, the perinatal code should continue to be used regardless of the patient’s age.”
Suspected to be – Category P00

P00 Neonatal (suspected to be) affected by maternal conditions that may be unrelated to present pregnancy

Code first any current condition in newborn

Excludes: newborn (suspected to be) affected by maternal complications of pregnancy (P01.-)
  newborn affected by maternal endocrine and metabolic disorders (P70-P74)
  newborn affected by noxious substances transmitted via placenta or breast milk (P04.-)

P00.0 Neonatal (suspected to be) affected by maternal hypertensive disorders
Newborn (suspected to be) affected by maternal conditions classifiable to O10-O11, O13-O16

P00.1 Neonatal (suspected to be) affected by maternal renal and urinary tract diseases
Newborn (suspected to be) affected by maternal conditions classifiable to N00-N39

P00.2 Neonatal (suspected to be) affected by maternal infectious and parasitic diseases
Newborn (suspected to be) affected by maternal infectious disease classifiable to A00-B99, J09 and J10

Excludes: infections specific to the perinatal period (P35-P39)
  maternal genital tract or other localized infections (P00.8)

Jaundice

- P59.0 Neonatal jaundice due to premature delivery
- P59.9 NOS
- P55.1 ABO Isoimmunization of newborn
- P58.1 Neonatal jaundice due to bleeding
Encounters with Pediatrician

- **Z00.1** Encounter for newborn, infant and child health examinations
- **Z23** Encounter for immunization
  Code first any routine exam
- **Z76.2** Encounter for health supervision and care of other healthy infant and child

### Z00.11 Newborn health examination
- Health check for child under 29 days old
- Use additional code to identify any abnormal findings
- Excludes1: health check for child over 28 days old (Z00.12-)

- **Z00.110** Health examination for newborn under 8 days old
  Health check for newborn under 8 days old

- **Z00.111** Health examination for newborn 8 to 28 days old
  Health check for newborn 8 to 28 days old
  Newborn weight check
Encounters with Pediatrician

- Z00.121 Encounter for routine child health examination with abnormal findings
- Z00.129 Encounter for routine child health examination without abnormal findings

*Excludes 1:
- health check for child under 29 days old (Z00.11–)
- health supervision of foundling or other healthy infant or child (Z76.1–Z76.2)
- newborn health examination (Z00.11–)

Infections

- A08.0 Rotaviral enteritis
- A08.4 Viral enteritis
- B37.0 Oral thrush
Injuries

- Arranged by body region starting with the head and ending with the foot
  - Superficial injury
  - Open wound
  - Fracture
  - Dislocation and sprain
  - Injury of nerves
  - Injury of blood vessels
  - Injury of muscle and tendon
  - Crushing injury
  - Traumatic amputation
  - Other and unspecified injuries

Fractures – Documentation

Assign codes based on

- Site (bone)
- Side (laterality, if applicable)
- Type (open, closed, physeal/Salter Harris)
- Displaced / Nondisplaced
- Stage of healing
- **Episode of Care 7th character required**
- Open fractures will be coded based on the Gustilo open fracture classification
- **Look at Category S42.3....**
S42.31 Greenstick fracture of shaft of humerus
   The appropriate 7th character is to be added to all codes in subcategory S42.31
   A - initial encounter for closed fracture
   D - subsequent encounter for fracture with routine healing
   G - subsequent encounter for fracture with delayed healing
   K - subsequent encounter for fracture with nonunion
   S - sequela
S42.311 Greenstick fracture of shaft of humerus, right arm
S42.312 Greenstick fracture of shaft of humerus, left arm
S42.319 Greenstick fracture of shaft of humerus, unspecified arm

S42.32 Transverse fracture of shaft of humerus
S42.321 Displaced transverse fracture of shaft of humerus, right arm
S42.322 Displaced transverse fracture of shaft of humerus, left arm
S42.323 Displaced transverse fracture of shaft of humerus, unspecified arm
S42.324 Nondisplaced transverse fracture of shaft of humerus, right arm
S42.325 Nondisplaced transverse fracture of shaft of humerus, left arm
S42.326 Nondisplaced transverse fracture of shaft of humerus, unspecified arm

S42.33 Oblique fracture of shaft of humerus
S42.331 Displaced oblique fracture of shaft of humerus, right arm
S42.332 Displaced oblique fracture of shaft of humerus, left arm
S42.333 Displaced oblique fracture of shaft of humerus, unspecified arm

Additional Fracture Codes: S52

- S52.302 Unspecified fracture of shaft of left radius
- S52.311 Greenstick fracture of shaft of radius, right arm
- S52.322 Displaced transverse fracture of shaft of left radius
- S52.332 Displaced oblique fracture of shaft of left radius
- S72.22x Displaced sub trochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing
Documentation to Include

- Traumatic
- Stress
- Pathologic
- Location:
  - Which bone?
  - Which part of the bone?
- Laterality:
  - Right,
  - Left,
  - Bilateral
- Non-displaced
- Displaced
- Open/Closed (Greenstick, spiral)
- Encounter:
  - Initial
  - Subsequent
- For routine healing
- For non-union
- For malunion

Let’s Try One

- Patient presents with a displaced transverse fracture of the right humeral shaft
- Fracture was reduced and cast placed
Answer

- S42.321A
- Displaced transverse fracture of shaft of humerus, right arm, initial encounter for closed fracture

Let’s Look at Chapter 19

ICD–10–CM
Injury, poisoning and certain other consequences of external causes

Chapter Blocks: S00–T98
Chapter 19 – Blocks – **S Codes**

- S00–S09: Injuries to the head
- S10–S19: Injuries to the neck
- S20–S29: Injuries to the thorax
- S30–S39: Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals
- S40–S49: Injuries to the shoulder and upper arm
- S50–S59: Injuries to the elbow and forearm
- S60–S69: Injuries to the wrist and hand
- S70–S79: Injuries to the hip and thigh
- S80–S89: Injuries to the knee and lower leg
- S90–S99: Injuries to the ankle and foot

Continued….

Chapter 19: Blocks – **T Codes**

- T07: Unspecified multiple injuries
- T14: Injury of unspecified body region
- T15–T19: Effects of foreign body entering through natural orifice
- T20–T32: Burns and corrosions
- T33–T34: Frostbite
- T36–T50: Poisoning by, adverse effect of and underdosing of drugs, medicaments and biological substances
- T51–T65: Toxic effects of substances chiefly nonmedicinal as to source
- T66–T78: Other and unspecified effects of external causes
- T79: Certain early complications of trauma
- T80–T88: Complications of surgical and medical care, not elsewhere classified
Codes Sections S00–S99 and T07–T88

- This chapter uses the S range of codes for coding different types of injuries related to single body regions

- ... and the T range of codes to cover injuries to unspecified body regions as well as poisoning and certain other consequences of external causes

Guideline: Application of 7th Character

7th Characters

- A Initial encounter
- D Subsequent encounter
- S Sequela
7th Character “A”

- 7th Character “A”, initial encounter is used while the patient is receiving active treatment for the injury

Examples of active treatment are:

- Surgical treatment
- Emergency department encounter
- Evaluation and treatment by a new physician

7th Character “D”

- 7th Character “D”, subsequent encounter is used for encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase

Examples of subsequent care are:

- Cast change or removal
- Removal of external or internal fixation device
- Medication adjustment
- Other aftercare and follow up visits following injury treatment
7th Character “S”

- 7th Character “S”, **sequelea**, is for use for complications or conditions that arise as a direct result of an injury, such as scar formation after a burn
  - The scars are sequelae of the burn
- When using extension “S”, it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself
  - The “S” is added only to the injury code, not the sequela code
  - The “S” extension identifies the injury responsible for the sequela
- The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code

Coding Example: Sequela

Scenario: Patient suffered a third degree burn of the left hand after accidentally touching a hot stove in his kitchen. He has a painful scar as a result of the burn

L90.5  Scar conditions and fibrosis of skin

T23.302S  Burn of third degree of left hand, unspecified site, sequela

X15.XXXS  Contact with hot stove (kitchen)
READY. SET. CODE!
Gearing Up for ICD–10
Resources on the Web

ICD–10 News & Information
https://www.cms.gov/ICD10

2016 ICD–10–CM General Equivalency Mappings (GEMs)
and–GEMs.html

2016 Guidelines

ICD–10 Provider Resources
http://www.roadto10.org

Questions?
Thank – You!

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