TIME WAITS FOR NO ONE: ICD-10-CM TRAINING PART ONE

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## Implementation Date:
**Oct. 1, 2014**

### Comparison

<table>
<thead>
<tr>
<th>ICD-9-CM diagnosis codes</th>
<th>ICD-10-CM diagnosis codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited space for adding new codes</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Lacks detail</td>
<td>Very specific</td>
</tr>
<tr>
<td>Lacks laterality</td>
<td>Has laterality</td>
</tr>
<tr>
<td>Difficult to analyze data due to non-specific codes</td>
<td>Specificity improves coding accuracy and richness of data for analysis</td>
</tr>
<tr>
<td>Codes do not adequately define diagnoses needed for medical research</td>
<td>Detail improves the accuracy of data used for medical research</td>
</tr>
<tr>
<td>Doesn’t support interoperability with other countries</td>
<td>Supports interoperability with other countries</td>
</tr>
</tbody>
</table>
Comparison

<table>
<thead>
<tr>
<th>ICD-9-CM diagnosis codes</th>
<th>ICD-10-CM diagnosis codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 characters in length</td>
<td>3-7 characters in length</td>
</tr>
<tr>
<td>First character is numeric or alpha (E or V)</td>
<td>First character is alpha (all letters except U)</td>
</tr>
<tr>
<td>Characters 2-5 are numeric</td>
<td>Character 2 is numeric Characters 3-7 are alpha or numeric</td>
</tr>
<tr>
<td>Use of decimal required after 3 characters</td>
<td>Use of decimal required after 3 characters</td>
</tr>
<tr>
<td>No placeholders</td>
<td>Use of dummy placeholder ‘X’</td>
</tr>
<tr>
<td>Alpha characters are case sensitive</td>
<td>Alpha characters are NOT case sensitive</td>
</tr>
<tr>
<td>Incomplete code titles</td>
<td>Complete code titles</td>
</tr>
<tr>
<td>14,315 diagnosis codes (Volumes 1,2)</td>
<td>69,099 diagnosis codes (Volumes 1,2)</td>
</tr>
<tr>
<td>3,838 procedure codes (Volume 3)</td>
<td>71,957 procedure codes (Volume 3)</td>
</tr>
</tbody>
</table>

Coding 3 to 7 Characters

- **Alpha (Except U)**
- **2 - 7 Numeric or Alpha**
- **Additional Characters**
- **Category**
- **Etiology, anatomic site, severity**
- **Added 7th character** for obstetrics, injuries, and external causes of injury

3 – 7 Characters
<table>
<thead>
<tr>
<th>Bill Type(s)</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>32X</td>
<td>Home Health (Inpatient Part B)</td>
<td>Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2014, but require those claims to be submitted using ICD-10 codes.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>3x2</td>
<td>Home Health – Request for Anticipated Payment (RAPs)*</td>
<td>* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2014.</td>
<td>*See Note</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bill Type(s)</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>81X</td>
<td>Hospice - Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>82X</td>
<td>Hospice – Non hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>83X</td>
<td>Hospice—Hospital Based</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

MLN Matters® Number: MM7492
ICD-10-CM

- What are we waiting on?
  - 5010 already implemented
  - OASIS C-1 changes proposed
  - Case mix diagnoses proposed
  - Grouper logic changes—July 1, 2014
  - For hospice—will there be a case mix system?
  - Testing and dual coding
- Schedule training

Proposed OASIS-C1

(R1011) List each inpatient diagnosis and ICD-10-CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 11 days (no V, W, X, Y, or Z codes or surgical codes).

<table>
<thead>
<tr>
<th>Inpatient Facility Diagnosis</th>
<th>ICD-10-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td></td>
</tr>
</tbody>
</table>

☐ N/A - Not applicable (patient was not discharged from an inpatient facility) [Omit N/A if option on SOC, SOC I]
Proposed OASIS-C1

(M1811) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's medical diagnoses and ICD-10-CM codes at the level of highest specialty for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y or Z codes or surgical codes):

<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Changed Medical Regimen Diagnosis</td>
</tr>
<tr>
<td>b</td>
<td>ICD-10-CM Code</td>
</tr>
<tr>
<td>c</td>
<td>d</td>
</tr>
<tr>
<td>e</td>
<td>f</td>
</tr>
</tbody>
</table>

[NA] = Not applicable (no medical or treatment regimen changes within the past 14 days)

(M1821) Primary Diagnosis (M1822) Other Diagnosis (M1825) Optional Diagnosis (OPTIONAL) (not used for payment)

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>ICD-10-CM Code</td>
<td>Description</td>
<td>Complete below the Optional Diagnosis for multiple coding situations (example: a manifestation code)</td>
</tr>
<tr>
<td>M1821 Primary Diagnosis</td>
<td>V, W, X, Y, Z codes NOT allowed</td>
<td>M1822 Other Diagnosis</td>
<td>V, W, X, Y, Z codes NOT allowed</td>
</tr>
<tr>
<td>a</td>
<td>b</td>
<td>c</td>
<td>d</td>
</tr>
<tr>
<td>(optional)</td>
<td>(optional)</td>
<td>(optional)</td>
<td>(optional)</td>
</tr>
</tbody>
</table>

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Proposed OASIS-C1

(M1021/1023/1025) Diagnoses, Symptom Control, and Optional Diagnoses: List each diagnosis for which the patient is receiving home care in Column 1, and enter its ICD-10-C M code at the level of highest specificity in Column 2 (diagnosis codes only - no surgical or procedure codes allowed). Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided. Rate the degree of symptom control for each condition in Column 2. ICD-10-C M sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a Z-code is reported in Column 2 in place of a diagnosis that is no longer active (a resolved condition), then optional item M1025 (Optional Diagnoses - Columns 3 and 4) may be completed as per instructions in Appendix D of the OASIS Guidance Manual – see discussion in Column 3 directions below. Diagnoses reported in M1025 will not impact payment but may be used to risk adjust quality measures.

Proposed OASIS-C1

Code each row according to the following directions for each column. Review Appendix D of the OASIS-C1 Guidance Manual for complete directions on correct completion of M1021, M1023 and M1025.

Column 1: Enter the description of the diagnosis. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 2: Enter the ICD-10-C M code for the condition described in Column 1 - no surgical or procedure codes allowed. Codes must be entered at the level of highest specificity and ICD-10-C M coding rules and sequencing requirements must be followed. Note that external cause codes (ICD-10-C M codes beginning with V, W, X, or Y) may not be reported in M1021 (Primary Diagnosis) but may be reported in M1023 (Secondary Diagnoses). Also note that when a Z-code is reported in Column 2, the code for the underlying condition can often be entered in Column 2, as long as it is an active on-going condition impacting home health care.
Proposed OASIS-C1

**Column 3:** (OPTIONAL) There is no requirement that HHAs enter a diagnosis code in M1025 (Columns 3 and 4). Diagnoses reported in M1025 will not impact payment but may be used to risk adjust quality measures. Agencies may choose to report an underlying condition in M1025 (Columns 3 and 4) when:
- a Z-code is reported in Column 2 AND
- the underlying condition for the Z-code in Column 2 is a resolved condition. An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.

**Column 4:** (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-C M coding guidelines, enter the diagnosis description and ICD-10-C M codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

**New Features**
Features

- 21 chapters including V, W, X, Y, and Z codes
- Injuries Grouped by Anatomical Site
- Excludes 1 and excludes 2 notes
- Postoperative complications moved to the specific chapter
- Full code titles
- Manifestation codes
  - Etiology [manifestation]

Combination Codes

- E10.21 Type 1 diabetes mellitus with diabetic nephropathy
- I25.110 AHD of native coronary artery with unstable angina
- K50.112 Crohn’s disease of Ile intestine with intestinal obstruction
Combination Codes for Poisonings and External Causes

- T36.0x1D Poisoning by penicillins, accidental, subsequent encounter

Other Features

- Added 7th Character for Episodes of Care
  - A—Initial encounter
  - D—Subsequent encounter
  - S—Sequela

- Changes in time frames
  - Acute myocardial infarction—time period changed from 8 to 4 weeks
Quiz

- V and E codes are supplemental classifications in ICD-10-CM. T or F
- What is the maximum number of characters in ICD-10-CM?
- How many chapters does ICD-10 contain?

Identify the Differences

- L03.313
- S42.311K
- T45.1X5D
- 682.2 Cellulitis and abscess of trunk
- 733.82--nonunion
- E933.1 Antineoplastics
Alphabetical Index

- Index to Diseases and Injuries
  - No hypertension table
- Neoplasm table is separate
- Table of Drugs and Chemicals
- Index to External Causes

Volume 2—Alphabetical Index

- Diagnoses in alphabetical order
- Term (non-essential modifier)
  - With
    - Term
    - Term
  - Subterm
  - Subterm
  - Subterm
    - Subterm
    - Subterm
    - Subterm

These subterms under the main terms are called 'essential modifiers.'

Essential modifiers change the code assignment.
Essential Modifiers

The indented terms are always read in conjunction with the main term.

- Diverticulosis K57.90
  - With bleeding K57.91
  - Large intestine K57.30
    - With
      - Bleeding K57.31
      - Small intestine K57.50
        - With bleeding K57.51
  - Small intestine K57.10
    - With
      - Bleeding K57.11
      - Large intestine K57.50
        - With bleeding K57.51

Looking up a term

- What's the noun?
- Not the body part
Aftercare involving Anemia deficiency Failure, failed heart Long term

A,B – Infectious and parasitic diseases
C – Neoplasms
D – Neoplasms & blood and blood forming organs
E – Endocrine, nutritional, and metabolic
F – Mental and behavioral disorders
G – Nervous system
H – Eye and adnexa, ear and mastoid process
I – Circulatory system
J – Respiratory system
K – Digestive system
### Tabular Chapters

<table>
<thead>
<tr>
<th>29</th>
<th>L – Skin and subcutaneous tissue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M – Musculoskeletal and connective tissue</td>
</tr>
<tr>
<td></td>
<td>N – Genitourinary system</td>
</tr>
<tr>
<td></td>
<td>O – Pregnancy, childbirth, and the puerperium</td>
</tr>
<tr>
<td></td>
<td>P – Perinatal period</td>
</tr>
<tr>
<td></td>
<td>Q – Congenital malformations, deformations and chromosomal abnormalities</td>
</tr>
<tr>
<td></td>
<td>R – Symptoms, signs and abnormal clinical and laboratory findings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>30</th>
<th>S,T – Injury, poisoning and certain other consequences of external causes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>U – Reserved by WHO for emergency codes</td>
</tr>
<tr>
<td></td>
<td>V,W,X,Y – External causes of morbidity</td>
</tr>
<tr>
<td></td>
<td>- How were they hurt *</td>
</tr>
<tr>
<td></td>
<td>- Where they were when they were hurt</td>
</tr>
<tr>
<td></td>
<td>- What activity were they doing</td>
</tr>
<tr>
<td></td>
<td>- External cause status</td>
</tr>
<tr>
<td></td>
<td>Z – Factors influencing health status and contact with health services</td>
</tr>
<tr>
<td></td>
<td>Note: * only encouraged external cause code in HH</td>
</tr>
</tbody>
</table>
Within a number of ICD-10-CM chapters, category restructuring and code reorganization have occurred resulting in the classification of certain diseases and disorders different than what is currently seen in ICD-9-CM.

Example: Gout
Example: Eyes and ears separated from the Nervous system chapter

- 4th character 8: other specified
- 4th character 9: unspecified
  - Have their own codes, unlike ICD-9-CM
  - Used to the highest level of specificity
  - May require placeholders so any 7th character will be placed in the 7th space, e.g., Fall down steps, stairs W10.8xxD
Quiz Time!

1. Gout is classified to the ____ chapter.
2. All of the following are structural differences except:
   a. Addition of a seventh character in some chapters
   b. Addition of placeholder
   c. Diseases and conditions of the eyes and ears are classified in the same chapter as diseases of the nervous system.
   d. Postop complications have been moved to procedure-specific body system chapters.

Quiz Time!

3. Which of the following statements is true?
   a. All codes include full code titles.
   b. All chapters require the addition of code extensions.
   c. All codes are 7 characters in length.
   d. All codes use the placeholder x.
4. Which of the following statements is true?
   a. No decimals are used.
   b. The first character is always an alpha
   c. Consist of 3-5 characters
   d. The second and third characters are always numeric.
Quiz Time!

5. The alpha for the genitourinary chapter is:
   a. P
   b. G
   c. N
   d. E

6. Which of the following is a valid ICD-10-CM code?
   a. 428.9
   b. L03.313
   c. T37.0xx1A
   d. M12x.58

Overview
Conventions & Official Guidelines
Example
Placeholder ‘X’

- Addition of dummy placeholder ‘X’ is used in certain codes to:
  - Allow for future expansion
  - T42.0x1D Poisoning by hydantoin derivatives, accidental, subsequent
- Fill out empty characters when a code contains fewer than 6 characters and a 7th character applies
  - W11.xxxD Fall from ladder, subsequent

Example
Addition of 7th Character

- Used in certain chapters to provide information about the characteristic of the encounter
- Must always be used in the 7th character position
- Can be a letter or a number
  - S02.110B
  - O65.0xx1
- If a code has an applicable 7th character, the code must be reported with an appropriate 7th character value in order to be valid
7th Character—Injuries

- A, initial encounter, is used while the patient is receiving active treatment for the injury.
- 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.
- S, sequel, is used for complications or conditions that arise as a direct result of an injury (ICD-10-CM coding guideline I.C.19.a).

Example 7th Character Fractures

- A = Initial encounter for closed fracture
- B = Initial encounter for open fracture
- D = Subsequent encounter for fracture with routine healing
- G = Subsequent encounter for fracture with delayed healing
- K = Subsequent encounter for fracture with nonunion
- P = Subsequent encounter for fracture with malunion
- S = Sequela
**Conventions--Parentheses**

- Parentheses are used in ICD-10-CM in both the Alphabetic Index and Tabular to enclose supplementary words that may be present or absent in the statement of a disease without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers.
  - Anemia (essential) (general) (primary)
  - Diabetes (mellitus) (sugar)
  - H44.611 Retained (old) magnetic foreign body in anterior chamber, right eye

**Conventions—Brackets**

- Square brackets in ICD-10-CM in the Tabular List are used to enclose synonyms, alternative wordings, abbreviations, and explanatory phrases.
  - J00 Acute nasopharyngitis [common cold]
- Brackets are used in the Index to identify manifestation codes.
  - Disease, Alzheimer’s
    - Alzheimer’s G30.9 [F02.80]
## Conventions

- Colons are used in the Tabular List after an incomplete term that needs one or more of the modifiers following the colon to make it assignable to a given category.
- **G73.7** Myopathy in diseases classified elsewhere
  - Excludes 1: myopathy in:
    - rheumatoid arthritis (M05.32)
    - sarcoidosis (D86.87)
    - scleroderma (M34.82)

## Conventions—Dashes

- ICD-9-CM 250.xx
- ICD-10-CM alpha index utilizes a dash at the end of the code number to indicate the code is incomplete
  - Fracture, pathologic ankle M84.47-
- A dash preceded by a decimal point
  - (.-) indicates an incomplete code in the tabular list. J44.-
Inclusion Notes

Inclusion notes contain terms that are the condition for which that code number is to be used. The terms may be synonyms of the code title, or in the case of “other specified” codes, the terms are a list of various conditions assigned to that code. The inclusion terms are not necessarily exhaustive (ICD-10-CM coding guideline I.A.11).

‘Includes’ appears at the category level and applies to the entire category.
Inclusion notes also appear at subcategory and code levels but ‘includes’ is not there

Excludes Notes

Excludes 1:
- An excludes 1 note is a pure excludes note. It means “NOT CODED HERE”
- Indicates the code excluded should never be used at the same time as the code above the Excludes 1 notes.
- Is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition

Excludes 2
- An excludes 2 note represents “not included here”.
- Indicates the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time
Excludes Note
Example

- J18.Ø Bronchopneumonia, unspecified organism
- **Excludes1:**
  - hypostatic bronchopneumonia (J18.2)
  - lipid pneumonia (J69.1)
- **Excludes2:**
  - acute bronchiolitis (J21.-)
  - chronic bronchiolitis (J44.9)

Other or Other Specified

Codes titled “other” or “other specified” are for use when the information in the medical record provides detail for which a specific code does not exist (ICD-10-CM coding guideline I.A.9.a).

NEC—Not elsewhere classified I25.89
Other forms of chronic ischemic heart disease

4th digit 8
**Unspecified**

This can be contrasted with “unspecified” codes when the information in the medical record is insufficient to assign a more specific code (ICD-10-CM coding guideline I.A.9.b).

NOS—Not Otherwise Specified

J12.9 Viral pneumonia, unspecified (contrast that with J12.89)

4th digit 9

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**Conventions—Relational Terms**

- And—interpreted to mean ‘and/or’ when it appears in a code title within the tabular list

- With—interpreted to mean ‘associated with’ or ‘due to’ when it appears in a code title, the alpha, or an instructional note in the tabular.
Laterality

For bilateral sites, the final character of the code indicates laterality.

If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side.

An unspecified code is also provided should the side not be identified in the medical record.

Laterality Example

Osteoarthritis

- M16.0 Bilateral primary osteoarthritis of hip
- M16.11 Unilateral primary osteoarthritis, right hip
- M16.12 Unilateral primary osteoarthritis, left hip
The Usual Basics

- Must use the alpha and the tabular.
- Read everything; it all means something.
- Code to the level of the highest specificity.
- Each unique ICD-10-CM diagnosis code may be reported only once for an encounter.

Sequela

- A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a sequela code can be used. The residual may be apparent early, such as in cerebral infarction, or it may occur months or years later, such as that due to a previous injury. Coding of sequela generally requires two codes sequenced in the following order: The condition or nature of the sequela is sequenced first. The sequela code is sequenced second.
- An exception to the above guidelines are those instances where the code for the sequela is followed by a manifestation code identified in the Tabular List and title, or the sequela code has been expanded (at the fourth, fifth or sixth character levels) to include the manifestation(s). The code for the acute phase of an illness or injury that led to the sequela is never used with a code for the late effect.
### Sequela

- **General Rule:** Code what you see first and the sequela (original injury with an S or original illness, e.g. polio) comes later.
  - G81.11 Spastic hemiplegia affecting right dominant side
  - S06.5x9S Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, sequela
- Code the sequela first when what you ‘see’ cannot go first (manifestation code).
- Sequela of cerebrovascular accidents

### Other

- For the Body Mass Index (BMI), **depth of non-pressure chronic ulcers** and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient.
Borderline Diagnoses

- If the provider documents a "borderline" diagnosis at the time of discharge, the diagnosis is coded as confirmed, unless the classification provides a specific entry (e.g., borderline diabetes). If a borderline condition has a specific index entry in ICD-10-CM, it should be coded as such. Since borderline conditions are not uncertain diagnoses, no distinction is made between the care setting (inpatient versus outpatient). Whenever the documentation is unclear regarding a borderline condition, coders are encouraged to query for clarification.

Sequencing
Sequencing

ICD-10-CM coding guideline I.A.17 states a “code also” note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction.

In contrast, the Code First/Use Additional Code notes provide sequencing order of the codes (underlying condition followed by the manifestation).

Etiology/Manifestation

- An example of the etiology/manifestation convention is dementia in Parkinson’s disease. In the Alphabetic Index, code G20 is listed first, followed by code F02.80 or F02.81 in brackets. Code G20 represents the underlying etiology, Parkinson’s disease, and must be sequenced first, whereas codes F02.80 and F02.81 represent the manifestation of dementia in diseases classified elsewhere, with or without behavioral disturbance.
Etiology/Manifestation

- Need to follow coding guidelines
- Buddy codes—have to be sequenced together with etiology preceding the manifestation
- Conventions
  - Alphabetical index two codes with second one within [italicized brackets] called manifestation
  - Tabular List: Code title in italics (a code in italics in the tabular may NEVER be coded without its cause preceding it).
  - Tabular List: Code first underlying condition at manifestation
  - Tabular List: Use additional code to identify manifestation (not always) at etiology
Multiple coding for a single condition

- In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code. “Use additional code” notes are found in the Tabular List at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. The sequencing rule is the same as the etiology/manifestation pair, “use additional code” indicates that a secondary code should be added.

Multiple coding for a single condition

- An “use additional code” note will normally be found at the infectious disease code, indicating a need for the organism code to be added as a secondary code.
- Find acute cystitis caused by E. coli
Sequencing

“Code first” notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a “code first” note and an underlying condition is present, the underlying condition should be sequenced first.

L89

Sequencing

“Code, if applicable, any associated condition first”, notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.

L97
Multiple codes may be needed for sequela, complication codes and obstetric codes to more fully describe a condition.

See the specific guidelines for these conditions for further instruction.
Review Questions

1. ICD-10-CM uses inclusion terms in the same way that ICD-9-CM does. T or F
What includes synonyms, alternative wording, or explanatory phrases in the Tabular List?
   a. Parentheses
   b. Brackets
   c. Dash
   d. Colon
The seventh character is always a letter. T or F?

Complications

- Code assignment is based on the provider’s documentation of the relationship between the condition and the care and procedure.
- Important to note that not all conditions that occur during or following medical care or surgery are classified as complications.
- There must be a cause and effect relationship between the care provided and the condition and indication in the documentation that it is a complication. If not clearly documented, query the provider for clarification.
2014 Guidelines

- Approved by the Cooperating Parties:
  - AHA (publishers of the Coding Clinic)
  - AHIMA
  - CMS
  - NCHS
- Section 1
  - Conventions
  - General Guidelines
  - Chapter specific guidelines
- Section 2—selection of primary diagnosis
- Section 3—selection of additional diagnoses

Chapter 1 Guidelines

A, B Infectious/Parasitic Diseases
What’s Included? What’s important?

- HIV- Code only confirmed cases.
- Principal diagnosis—B20 followed by related diagnoses
- If reason for admission not related to HIV, code HIV and related diagnoses as secondary.
- Z21 is code for asymptomatic HIV (no symptoms, no AIDS, no treatment for any condition for HIV-related illness).

Definitions

- **Sepsis**—Sepsis is a potentially life-threatening complication of an infection. Sepsis occurs when chemicals released into the bloodstream to fight the infection trigger inflammation throughout the body. This inflammation can trigger a cascade of changes that can damage multiple organ systems, causing them to fail. If sepsis progresses to septic shock, blood pressure drops dramatically, which may lead to death.

- **Localized infection**—An infection that is limited to a specific part of the body and has local symptoms.

- **Septicemia**—Septicemia is bacteria in the blood (bacteremia) that often occurs with severe infections.
A bacterial infection anywhere in the body may set off the response that leads to sepsis. Common places where an infection might start include:

- The bloodstream
- The bones (common in children)
- The bowel (usually seen with peritonitis)
- The kidneys (upper urinary tract infection or pyelonephritis)
- The lining of the brain (meningitis)
- The liver or gallbladder
- The lungs (bacterial pneumonia)
- The skin (cellulitis)

For patients in the hospital, common sites of infection include intravenous lines, surgical wounds, surgical drains, and sites of skin breakdown known as bedsores (decubitus ulcers).
What's Included? What’s important?

- ‘A’ codes for sepsis. Sequencing depends on circumstances. See the codes.
- A40 Streptococcal sepsis
- A41 Other sepsis
- R65.2 Severe sepsis with or without septic shock if acute organ dysfunction is documented.
- Septic shock generally refers to circulatory failure associated with sepsis (cannot be primary).

More Sepsis

- Sepsis with localized infection (pneumonia, UTI)
- If admitted with sepsis
  - Assign sepsis code first (A40-41)
  - Then localized infection
  - Severe? Add R65.2
- If admitted with localized and develops into sepsis
  - Code localized infection first
More Sepsis

- Postprocedural sepsis—must be documented by the physician—start with the specific postprocedural infection code (e.g., T81.4)
- Use appropriate A40-41 code next.

Infectious agents as the cause of diseases classified to other chapters

- Certain infections are classified in chapters other than Chapter 1 and no organism is identified as part of the infection code. In these instances, it is necessary to use an additional code from Chapter 1 to identify the organism. A code from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified to other chapters, B96, Other bacterial agents as the cause of diseases classified to other chapters, or B97, Viral agents as the cause of diseases classified to other chapters, is to be used as an additional code.
- Look up Infection, Staphylococcus aureus and compare the A codes to the B codes. Compare A41.0 to B95.61
  - A41.0 and B95.6-
A vs B Simplified

- A codes generally are coded first (sepsis)
- B codes 95, 96 and 97 are sequenced after what is infected. (These categories are provided for use as supplementary or additional codes to identify the infectious agent(s) in diseases classified elsewhere.)
- Post op wound with Staph aureus
  - T81.4xxD
  - B95.61

Infections resistant to antibiotics

- Many bacterial infections are resistant to current antibiotics. It is necessary to identify all infections documented as antibiotic resistant. Assign a code from category Z16, Resistance to antimicrobial drugs, following the infection code only if the infection code does not identify drug resistance.
- Except for MRSA
- Look up resistance, vancomycin
MRSA

- Combo codes
- Code these!
  - Sepsis due to MRSA __________
  - Pneumonia due to MRSA __________
  - Colonization by MRSA __________
- Do not assign Z16.11 Resistance to penicillins as an additional code.
- Colonization = MRSA screen positive or MRSA nasal swab positive but no active infection (can have active infection at same time)

Chapter 2 Guidelines C and D
Neoplasms and Blood Disorders
What is a Neoplasm?

- Chapter 2 contains codes for most benign and all malignant neoplasms.
- Neoplasm is an abnormal mass of tissue as a result of neoplasia. Neoplasia is the abnormal proliferation of cells. The growth of the cells exceeds, and is uncoordinated with that of the normal tissues around it. The growth persists in the same excessive manner even after cessation of the stimuli. It usually causes a lump or tumor. Neoplasms may be benign, pre-malignant or malignant.
- In modern medicine, the term "tumor" is synonymous with a neoplasm that has formed a lump.

What is a Neoplasm?

- A neoplasm can be benign, potentially malignant (pre-cancer), or malignant (cancer).
- Benign neoplasms include uterine fibroids and melanocytic nevi (skin moles). They do not transform into cancer.
- Potentially malignant neoplasms include carcinoma in situ. They do not invade and destroy but, given enough time, will transform into a cancer.
- Malignant neoplasms are commonly called cancer. They invade and destroy the surrounding tissue, may form metastases and eventually kill the host.
Guidelines

- To properly code a neoplasm it is necessary to determine from the record if the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior. If malignant, any secondary (metastatic) sites should also be determined.
- Uncertain—neoplasms where histologic confirmation whether malignant or benign cannot be made.
- Unspecified—growth NOS, neoplasm NOS, new growth NOS, tumor NOS
- Mass—not a neoplasm

Neoplasm Table

- The neoplasm table in the Alphabetic Index should be referenced first. However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate.
  - Example: Adenoma
  - But what if the physician documents malignant adenoma?
Neoplasms Table

- Classifies by site (topography) with broad groupings for behavior (malignant, benign, etc)
- Laterality is important!!
- Primary—Cancer occurs after a single cell in a tissue is progressively genetically damaged to produce cells with uncontrolled proliferation. This uncontrolled proliferation, mitosis, produces a primary tumor. The cells which constitute the tumor eventually undergo metaplasia, followed by dysplasia then anaplasia, resulting in a malignant phenotype.

Malignancies

- Some cancer cells acquire the ability to penetrate the walls of lymphatic and/or blood vessels, after which they are able to circulate through the bloodstream (circulating tumor cells) to other sites and tissues in the body. This process is known (respectively) as lymphatic or hematogeneous spread.
Malignancies

- After the tumor cells come to rest at another site, they re-penetrate the vessel or walls and continue to multiply, eventually forming another clinically detectable tumor. This new tumor is known as a metastatic (or secondary) tumor. Metastasis is one of three hallmarks of malignancy. Most neoplasms can metastasize, although in varying degrees.

- If breast cancer metastasizes to the lungs, the secondary tumor is made up of abnormal breast cells, not of abnormal lung cells. The tumor in the lung is then called *metastatic breast cancer*, not *lung cancer*.

- May be sequenced in either order dependent on focus of care.
Mets to liver from pancreatic ca (metastatic pancreatic cancer)

If the reason for the encounter is for treatment of a primary malignancy, assign the malignancy as the principal/first-listed diagnosis. The primary site is to be sequenced first, followed by any metastatic sites.
Encounter for treatment of secondary malignancy

- When an encounter is for a primary malignancy with metastasis and treatment is directed toward the metastatic (secondary) site(s) only, the metastatic site(s) is designated as the principal/first-listed diagnosis. The primary malignancy is coded as an additional code.

Primary malignancy previously excised

- 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.
Example

- Grade 4 colon cancer excised and eradicated from ascending and transverse colon with metastasis to liver. Patient has colostomy but no further treatment to colon. Further chemo treatment directed to liver mets has been unsuccessful. Patient is seen for palliative care, pain management prn and therapy. Patient is independent with colostomy care.
- C78.7 Secondary malignant neoplasm of liver...
- Z85.038 Personal history of other malignant neoplasm of large intestine

Example to code

- 61 year old female admitted with small cell Ca of right lower lobe of lung with mets to intrathoracic lymph nodes, brain and right rib
Answer

61 year old female admitted with small cell Ca of right lower lobe of lung with mets to intrathoracic lymph nodes, brain and right rib

- C34.31
- C77.1
- C79.31
- C79.51

Primary malignant neoplasms overlapping site boundaries

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

- Code 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. It should not be used in place of assigning codes for the primary site and all known secondary sites.

Malignancy Site Unknown

- 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. This code should rarely be used in the inpatient setting.
- Cancer found at kidney but cell type means the cancer originated elsewhere (unknown primary)
Symptoms, Signs, and Ill-Defined Conditions

- Symptoms, signs, and ill-defined conditions listed in Chapter 18 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal or first-listed diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.

Pathologic fracture due to a neoplasm

- When an encounter is for a pathological fracture due to a neoplasm, and the focus of treatment is the fracture, a code from subcategory M84.5, Pathological fracture in neoplastic disease, should be sequenced first, followed by the code for the neoplasm.

- If the focus of treatment is the neoplasm with an associated pathological fracture, the neoplasm code should be sequenced first, followed by a code from M84.5 for the pathological fracture.
Neoplasm Example

- Patient with history of prostate cancer and mets to the right femur has pathological fx with routine healing to the right femur. He is admitted for therapy and nursing for O & A, strengthening, transfers and pain management. He is taking Morphine for pain.

Neoplasm Answers

- M1Ø21: M84.551D Pathological fracture in neoplastic disease, right femur, routine healing
- M1Ø23: C79.51 Secondary malignant neoplasm, bone
- M1Ø23: G89.3 Neoplasm related pain
- M1Ø23: Z85.46 History of prostate ca
- M1Ø23: Z79.891 Long term (current) use of opiate analgesic
Code these...

- Right female breast cancer with mets to R lung
- History of lung ca and pneumonectomy of left lung with continued smoking (some other primary reason for care)
- Mets to R kidney, unknown primary

Answers

- Right female breast cancer with mets to R lung
  - C50.911
  - C78.01
- History of lung ca and pneumonectomy of left lung with continued smoking
  - Z85.118
  - Z90.2
  - Z72.0
- Mets to R kidney, unknown primary
  - C79.01
  - C80.1
Anemia

Characterized by a deficiency of healthy red blood cells

- Anemia can be mild or it can be life threatening
- 4 Types
  - Nutritional Anemia
    - Chronic blood loss anemia
  - Hemolytic Anemia
  - Aplastic Anemia
  - Other Anemia

Nutritional Anemia

Nutritional Anemia is a lack of certain vitamins and minerals. Some examples are:

- Iron Deficiency anemia
- Vitamin B12 deficiency anemia
- Folate deficiency anemia
- Protein deficiency anemia
- The body either is not fed what it needs or the patient has a condition that does not allow for good absorption and the patient ends up suffering from malabsorption
Hemolytic Anemias

- Conditions that are caused from premature destruction (or rupture) of the red blood cells and the inability of the bone marrow to replace them.
- Hemolytic anemias are divided into two types:
  1. Those that are hereditary-Sickle cell anemia
  2. Those that are an acquired condition-Autoimmune anemia

Aplastic Anemia

Life threatening condition where the bone marrow does not have the ability to produce red blood cells. Although this is rare, there are contributing causes:

- High doses radiation and chemotherapy
- Exposure to toxic agents and chemicals
- Use of certain drugs
- Autoimmune disorder
- Viral infection
- Unknown or Idiopathic
The Roles of Insulin and Glucagon in Normal Blood Glucose Regulation

- A healthy person’s body keeps blood glucose levels in a normal range through several complex mechanisms. Insulin and glucagon, two hormones made in the pancreas, help regulate blood glucose levels:
  - Insulin, made by beta cells, lowers elevated blood glucose levels.
  - Glucagon, made by alpha cells, raises low blood glucose levels.
- When blood glucose levels rise after a meal, the pancreas releases insulin into the blood. Insulin helps muscle, fat, and liver cells absorb glucose from the bloodstream, lowering blood glucose levels.
The Roles of Insulin and Glucagon in Normal Blood Glucose Regulation

- Insulin stimulates the liver and muscle tissue to store excess glucose. The stored form of glucose is called glycogen.
- Insulin also lowers blood glucose levels by reducing glucose production in the liver.
- When blood glucose levels drop overnight or due to a skipped meal or heavy exercise, the pancreas releases glucagon into the blood. Glucagon signals the liver and muscle tissue to break down glycogen into glucose, which enters the bloodstream and raises blood glucose levels.
- If the body needs more glucose, glucagon stimulates the liver to make glucose from amino acids.
Diabetes Categories

- E08 DM due to underlying condition
  - Code first underlying condition
  - Use additional code to identify insulin use
- E09 Drug or chemical induced DM
  - Notice difference between adverse effect and poisoning.
  - Use additional code to identify insulin use
- E10 Type 1 DM
- E11 Type 2 DM
  - Use additional code to identify insulin use
- E13 Other specified DM
  - Use additional code to identify insulin use

E08 DM due to underlying condition

- Any condition that impacts the pancreas function
- Cystic fibrosis- Cystic fibrosis produces abnormally thick mucus, which blocks the pancreas.
- Pancreatic cancer, Pancreatitis, and trauma can all harm the pancreatic beta cells or impair insulin production, thus causing diabetes.
- Malnutrition
- Cushing’s syndrome--induces insulin resistance. Cushing’s syndrome is marked by excessive production of cortisol—sometimes called the “stress hormone.”
E09 Drug or chemical induced DM

- Some medications, such as nicotinic acid and certain types of diuretics, anti-seizure drugs, psychiatric drugs, and drugs to treat HIV, can impair beta cells or disrupt insulin action. Pentamidine, a drug prescribed to treat a type of pneumonia, can increase the risk of pancreatitis, beta cell damage, and diabetes. Also, glucocorticoids—steroid hormones that are chemically similar to naturally produced cortisol—may impair insulin action. Glucocorticoids are used to treat inflammatory illnesses such as rheumatoid arthritis, asthma, lupus, and ulcerative colitis.

E09 Drug or chemical induced DM

- Many chemical toxins can damage or destroy beta cells in animals, but only a few have been linked to diabetes in humans. For example, dioxin—a contaminant of the herbicide Agent Orange, used during the Vietnam War—may be linked to the development of type 2 diabetes. In 2000, based on a report from the Institute of Medicine, the U.S. Department of Veterans Affairs (VA) added diabetes to the list of conditions for which Vietnam veterans are eligible for disability compensation. Also, a chemical in a rat poison no longer in use has been shown to cause diabetes if ingested. Some studies suggest a high intake of nitrogen-containing chemicals such as nitrates and nitrites might increase the risk of diabetes. Arsenic has also been studied for possible links to diabetes.
E10 Type 1 DM

- Type 1 diabetes is caused by a lack of insulin due to the destruction of insulin-producing beta cells in the pancreas. In type 1 diabetes—an autoimmune disease—the body’s immune system attacks and destroys the beta cells. Normally, the immune system protects the body from infection by identifying and destroying bacteria, viruses, and other potentially harmful foreign substances. But in autoimmune diseases, the immune system attacks the body’s own cells. In type 1 diabetes, beta cell destruction may take place over several years, but symptoms of the disease usually develop over a short period of time.

E10 Type 1 DM

- In type 1 diabetes, white blood cells called T cells attack and destroy beta cells. The process begins well before diabetes symptoms appear and continues after diagnosis. Often, type 1 diabetes is not diagnosed until most beta cells have already been destroyed.
- Genetic susceptibility
### E11 Type II DM

- Caused by a combination of factors, including insulin resistance, a condition in which the body's muscle, fat, and liver cells do not use insulin effectively. Type 2 diabetes develops when the body can no longer produce enough insulin to compensate for the impaired ability to use insulin.
- The role of genes is suggested by the high rate of type 2 diabetes in families and identical twins and wide variations in diabetes prevalence by ethnicity. Type 2 diabetes occurs more frequently in African Americans, Alaska Natives, American Indians, Hispanics/Latinos, and some Asian Americans, Native Hawaiians, and Pacific Islander Americans than it does in non-Hispanic whites.

### E13

- Genetic defects of beta cell function or insulin action
- Postpancreatectomy/post-procedural DM
- Secondary DM, NEC
- E89.1 Postprocedural hypoinsulinemia
- E13 code(s)
- Z90.41- Acquired absence of pancreas
Guidelines

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

Guidelines

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

  If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11, Type 2 diabetes mellitus, should be assigned.

  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.
Diabetes 4<sup>th</sup> Characters

- 2 as 4<sup>th</sup> character
  - R - Renal/Kidney complications

- 3 as 4<sup>th</sup> character
  - O - Ophthalmic

- 4 as 4<sup>th</sup> character
  - N - Neurological

- 5 as 4<sup>th</sup> character
  - C - Circulatory

- 6 as 4<sup>th</sup> character
  - O - Other — arthropathy, skin complications, oral complications, hypoglycemia, hyperglycemia and other

Examples

- Diabetic macular edema
- Diabetic neuralgia
- Diabetic gangrene
- Diabetic foot ulcer on toes (rt foot)
- Diabetic with high blood sugars
Answers

- Diabetic macular edema
  - E11.311
- Diabetic neuralgia
  - E11.42
- Diabetic gangrene
  - E11.52
- Diabetic foot ulcer on toes (rt foot)
  - E11.621
  - L97.519
- Diabetic with high blood sugars
  - E11.65

Chapter 5 Guidelines
F – Mental and Behavioral
Psychoactive Substance Use, Abuse And Dependence

- When the provider documentation refers to use, abuse and dependence of the same substance (e.g. alcohol, opioid, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:
  - If both use and abuse are documented, assign only the code for abuse
  - If both abuse and dependence are documented, assign only the code for dependence
  - If use, abuse and dependence are all documented, assign only the code for dependence
  - If both use and dependence are documented, assign only the code for dependence.

Alzheimer's Example

- Patient admitted for worsening dementia related to early onset Alzheimer's, including wandering episodes
Alzheimer's Answer

- M1021: G30.0 Alzheimer's disease early onset
- M1023: F02.81 Dementia in diseases classified elsewhere with behavioral disturbances
- M1023: Z91.83 Wandering in diseases classified elsewhere

Note: Alzheimer's is identified as early or late onset

Chapter 6 Guidelines
G - Nervous System
Dominant/Non-dominant side

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

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

Quiz

Patient has right sided hemiplegia. The coder should:

A. code it as unspecified hemiplegia because the dominant side is unknown
B. call the clinician and ask him/her to find out
C. call the doctor and ask
D. code it as dominant.
Hypertension with Heart Disease

Heart conditions classified to I50.- or I51.4-I51.9, are assigned to, a code from category I11, Hypertensive heart disease, when a causal relationship is stated (due to hypertension) or implied (hypertensive). Use an additional code from category I50, Heart failure, to identify the type of heart failure in those patients with heart failure.

The same heart conditions (I50.-, I51.4-I51.9) with hypertension, but without a stated causal relationship, are coded separately. Sequence according to the circumstances of the admission/encounter.
### Hypertensive Chronic Kidney Disease

- Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present. Unlike hypertension with heart disease, ICD-10-CM presumes a cause-and-effect relationship and classifies chronic kidney disease with hypertension as hypertensive chronic kidney disease.
- The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease.
- If a patient has hypertensive chronic kidney disease and acute renal failure, an additional code for the acute renal failure is required.

### Hypertensive Heart and Chronic Kidney Disease

- Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the chronic kidney disease, whether or not the condition is so designated. If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.
Hypertension

- I10 Essential hypertension
- I11 Hypertensive Heart Disease
  - (Hypertensive heart disease refers to heart problems that occur because of high blood pressure.)
  - Use additional code for heart failure (I50.-)
- I12 Hypertensive Chronic Kidney Disease
  - Use additional code for CKD (N18.-)
- I13 Hypertensive Heart and Chronic Kidney Disease
  - Use additional code for heart failure
  - Use additional code for CKD
- No malignant or benign
Heart Failure

- **Left-sided failure**--
  Common respiratory signs are tachypnea (increased rate of breathing) and increased work of breathing (non-specific signs of respiratory distress). Rales or crackles progressing to pulmonary edema.

Heart Failure

When the right side of the heart starts to fail, fluid collects in the feet and lower legs. As the heart failure becomes worse, the upper legs swell and eventually the abdomen collects fluid (ascites). Weight gain accompanies the fluid retention and is an excellent measure of how much fluid is being retained. Puffy swelling (edema) is a sign of right heart failure, especially if the edema is pitting edema. With pitting edema, a finger pressed on the swollen leg leaves a finger imprint. Non-pitting edema is not caused by heart failure.
Systolic Heart Failure

The pumping action of the heart is reduced or weakened. A common clinical measurement is the ejection fraction (EF). The ejection fraction is a calculation of how much blood is ejected out of the left ventricle (stroke volume), divided by the maximum volume remaining in the left ventricle at the end of diastole or relaxation phase. A normal ejection fraction is greater than 50%. Systolic heart failure has a decreased ejection fraction of less than 50%.

Diastolic Heart Failure

The heart can contract normally but is stiff, or less compliant, when it is relaxing and filling with blood. This impedes blood filling into the heart and produces backup into the lungs and CHF symptoms. Diastolic heart failure is more common in patients older than 75 years, especially in women with high blood pressure. In diastolic heart failure, the ejection fraction is normal.
Examples to code

- Hypertensive chronic diastolic heart failure
- Malignant Hypertension
- Hypertension and ESRD on dialysis
- Left ventricular failure

Examples to code

- Hypertensive chronic diastolic heart failure
  - I11.0 Hypertensive heart disease with heart failure
  - I50.32 Chronic diastolic (congestive) heart failure
- Malignant Hypertension
  - I10 Hypertension
- Hypertension and ESRD on dialysis
  - I12.0 Hypertensive CKD with Stage 5 or ESRD
  - N18.6 ESRD
  - Z99.2 dialysis status
- Left ventricular failure—I50.1
Category I69, Sequelae of Cerebrovascular disease

- Category I69 is used to indicate conditions classifiable to categories I60-I67 as the causes of sequela (neurologic deficits), themselves classified elsewhere. These “late effects” include neurologic deficits that persist after initial onset of conditions classifiable to categories I60-I67. The neurologic 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.
- Personal history of transient ischemic attack (TIA) and cerebral infarction (Z86.73)

Sequelae of I60-67

- Non-traumatic subarachnoid hemorrhage requires identification of laterality (right and left) and the specific artery for acute CVAs. (I69.0)
  - If known, the Sequela code can be more specific.
- Nontraumatic intracerebral hemorrhage requires identification of the site to assist in choosing a more specific sequela code (I69.1):
  - Subcortical hemisphere
  - Cortical hemisphere
  - Brain stem, Cerebellum, Ventricle, Multiple or specified locations
Sequelae of I60-67

- Cerebral and precerebral infarctions, occlusion, and stenosis require identification of cause (thrombosis, embolism, unspecified), laterality (right and left) and specific artery (If bleed, I69.2, otherwise I69.3)
- Do NOT choose I69.9 for sequela of CVAs!!!
- Sequela require documentation of the residual deficits

CVA Example

- Patient admitted for right sided hemiparesis and dysphagia due to CVA
CVA

Example

- M1Ø21: I69.351 Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
- M1023: I69.391 Dysphagia following cerebral infarction
- M1023: R13.10 Dysphagia, unspecified

Note: Should the affected side be documented, but not specified as dominant or non-dominant and the classification system does not indicate a default, code selection as follows:

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

Cardiovascular system
Guidelines

- Angina is considered integral to ASHD unless otherwise noted by the physician.
- A MI is coded as I21.- in the first 4 weeks.
- If the patient has a second MI in the first 4 weeks, it is coded with I22.-
- The sequencing of the I21 and I22 codes depends on the circumstances of the encounter.
- I21.3 is the default if only AMI is documented.

Myocardial Infarction Example

- Patient admitted to home health with new diagnosis of CAD after acute MI 5 weeks ago. Patient is no longer having symptoms
Myocardial Infarction
Answer

- M1Ø21: I25.1Ø Atherosclerotic heart disease of native coronary artery without angina
- M1Ø23: I25.2 Old healed MI

Note: ICD-1Ø definition acute MI = 4 weeks
ICD-9 definition acute MI = 8 weeks

Myocardial Infarction Example

- Patient was treated for an inferior wall MI in the last 14 days and then was readmitted to hospital for anterior wall MI. He is being admitted to home care for O and A of unstable angina and his ASHD and teaching on his multiple new cardiac meds.
Myocardial Infarction Answers

- M1Ø21: I25.11Ø AHD with unstable angina
- M1Ø23: I21.19 MI other coronary artery inferior wall
- M1Ø23: I22.Ø MI of anterior wall
- M1Ø23: Z79.899 Other long term (current) drug therapy

- It is most important to code location.
**Respiratory system**

- A little flap of cartilage called the epiglottis (attached to the root of the tongue) prevents choking or aspiration of food. During the swallowing process, the epiglottis closes over the larynx.
- Air passes through the larynx on its way to the lungs by a tube called the trachea (windpipe).

The trachea is kept open by 16-20 cartilaginous C-shaped rings that stiffen the outside of the tube. The trachea divides into two distinct structures called bronchial tubes or bronchi (singular = bronchus) and each leads to a separate lung and continues to divide into smaller and smaller structures until it reaches the bronchioles.
Bronchitis

- Bronchitis is an inflammation of the bronchial tubes, the airways that carry air to your lungs. It causes a cough that often brings up mucus, as well as shortness of breath, wheezing, and chest tightness. There are two main types of bronchitis: acute and chronic.

- Chronic bronchitis is one type of COPD (chronic obstructive pulmonary disease). The inflamed bronchi produce a lot of mucus. This leads to cough and difficulty getting air in and out of the lungs.

Respiratory system

- Each terminal bronchiole continues to narrow until reaching the smallest structure known as the alveolar ducts which end in tiny air sacks called the alveoli.

- These little sacks allow for the exchange of oxygen between the alveolus and the capillary surrounding it. At the same time the capillary deposits the carbon dioxide into the alveolus.
Emphysema

Emphysema is a type of chronic obstructive lung disease (COPD) involving hyperinflation of air sacs with destruction of alveolar walls

- Patients typically have symptoms of both chronic bronchitis and emphysema, but the classic triad also includes asthma.

Asthma

- Not all people with COPD have asthma, but many do have an asthmatic component to either emphysema or chronic bronchitis, or even a mix of all three, while most asthma patients do not have COPD.

There remains the debate among medical professionals whether chronic asthma belongs under the umbrella term COPD because, unlike emphysema and chronic bronchitis, asthma can be reversed and responds well to various medications.
Respiratory system

- The lungs are covered by a protective covering called the pleura with an outer layer known as the parietal pleura and an inner layer known as the visceral pleura.
- A serous (thin watery liquid) allows the lungs to stay moist and facilitates movement of the lungs inside the chest.

Respiratory system

- The right side of the lung is separated into 3 distinct lobes.
- The left side of the lung is divided into only 2 lobes (because the heart takes up some of the space that would otherwise be occupied by another lobe).
- Each lung has an upper portion known as the apex and the lower portion known as the base. There is an additional area of the lung along the midline region where blood vessels, nerves, lymphatic tissue and bronchial tubes enter and exit known as the hilum.
Acute exacerbation of chronic obstructive bronchitis and asthma

- 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.
- See difference between J44 and J45.

Key Documentation Elements

- COPD—(chronic bronchitis, emphysema or both) “flare-ups” (exacerbations) are episodes of new or increasing symptoms that last at least three days. These symptoms may include: cough, mucus, wheezing, shortness of breath, or tightness in the chest. A COPD flare-up may require treatment beyond normal medications and, in some cases, exacerbations may require hospitalization. Does the physician include exacerbation or flare-up in the documentation?
COPD

- J43.- Emphysema
  - J43.9 Emphysema, NOS
- J44.9 Emphysema with chronic (obstructive) bronchitis
- J44 Other chronic obstructive pulmonary disease
  - Asthma with COPD
  - Chronic asthmatic (obstructive) bronchitis
  - Chronic bronchitis with airways obstruction
  - Chronic emphysematous bronchitis
  - Chronic obstructive asthma
  - Chronic obstructive bronchitis
  - Chronic obstructive tracheobronchitis

J44 Other chronic obstructive pulmonary disease

- J44.0 COPD with acute lower respiratory infection
  - Use additional code to identify the infection
- J44.1 COPD with (acute) exacerbation
  - Decompensated COPD
  - Decompensated COPD w/acute exacerbation
- J44.9 COPD, NOS
### Layers of Skin

- Outside to the inside consist of three distinct layers
- Epidermis - thin cellular membrane layer; containing keratin which is a hard protein which is constantly renewed every 3-4 weeks
- Dermis - dense, fibrous, connective tissue layer containing collagen the fibrous protein material found in bone and cartilage
- Subcutaneous layer - thick, fat containing area and serves as insulation to the deeper layers of tissue
## Accessory Organs of the Skin

- **Hair** - growth is about ½ inch per month
- **Nails** - growth is about 1mm per month
- **Sebaceous glands** - secrete sebum which lubricates the skin and minimizes water loss
- **Sweat Glands** - tiny openings known as pores
- **Apocrine glands**
  - Large dermal exocrine glands located in the axilla (underarms) and the genital area. When sweat is secreted and meets with bacteria = human body odor
  - Another apocrine gland is the mammary gland that secretes milk after the birth of a child

## Types of Cells

- **Keratinocytes** - produce keratin
  - Keratin is a scleroprotein & is the main constituent of hair, skin and nails
  - Keratinization allows the skin to be waterproof and prevent dehydration of the deeper layers from fluid loss
- **Melanocytes** - are found in the bottom layer of the skin and produce melanin which is the pigment that gives hair and skin its color
  - Melanocytes are responsible for the freckles and moles that are found on skin as well as the response from suntanning
Types of Cells

- Langerhans Cells - are found in the stratum spinosum layer of the epidermis and migrate from the bone marrow
  - They initiate the immune response and defend against environmental antigens
  - These cells are similar to macrophages as they ingest and digest other cells, cellular disease, bacteria and necrotic tissue
- Merkel Cells - are not completely understood as they have associations with sensory nerve cells and touch receptors in the skin
  - They are highly sensitive to touch and light touch and help with discrimination of shapes and textures

Types of Cells

- Dermal Cells - Dermis (second layer of skin) has three different types of cells
  - Fibroblasts - help determine physical properties of connective tissue. Produce collagen, reticular and elastic fibers and glycoproteins found in the matrix and give the dermis structure
  - Mast cells - serve as hypersensitivity reactors to intruders to the skin
  - Macrophages - ingest cellular debris and pathogens and play a key role in immunity
Pressure Ulcers

Assign as many codes from category L89 as needed to identify all the pressure ulcers the patient has, if applicable.

Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma. This code should not be confused with the codes for unspecified stage (L89.--9). When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.--9).

Pressure Ulcers

No code is assigned if the documentation states that the pressure ulcer is completely healed.

- Stage 1s and 2s heal
- Stage 3s and 4s do not heal.

If documented as healing, the appropriate stage code should be assigned.
Patient admitted with a stage III pressure ulcer to left heel. A stage II pressure ulcer to right heel. The stage III wound is gangrenous.

M1Ø21: I96 Gangrenous cellulitis
M1Ø23: L89.623 Pressure ulcer of left heel, stage 3
M1Ø23: L89.612 Pressure ulcer of right heel, stage 2

Note: Code first any associated gangrene (I96)
Arterial Ulcer Example

- Patient admitted with arterial skin ulcer of left calf due to atherosclerosis

Arterial Ulcer Answer

- M1021: I70.242 Atherosclerosis of native arteries of left leg with ulceration of calf, skin
- M1023: L97.221 Non pressure ulcer of left calf limited to skin

Note: Reason for ulcer, if known, should be sequenced first

Note: Codes available for severity of ulcer
## Ulcer Severity

L97.22- Non-pressure chronic ulcer of left calf

- 1 Non-pressure chronic ulcer of left calf limited to breakdown of skin
- 2 Non-pressure chronic ulcer of left calf with fat layer exposed
- 3 Non-pressure chronic ulcer of left calf with necrosis of muscle
- 4 Non-pressure chronic ulcer of left calf with necrosis of bone
- 9 Non-pressure chronic ulcer of left calf with unspecified severity

## Chapter 13 Guidelines

M – Musculoskeletal
Musculoskeletal

- Result of previous injury or trauma to a site, or are recurrent conditions.
- Bone, joint or muscle conditions that are the result of a healed injury
- Recurrent bone, joint or muscle conditions
- Chronic or recurrent conditions
- Any current, acute injury should be coded to the appropriate injury code from chapter 19.

7th Characters for Pathological Fractures

- 7th character A is for use as long as the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, evaluation and treatment by a new physician.
- 7th character, D is to be used for encounters after the patient has completed active treatment.
- The other 7th characters, listed under each subcategory in the Tabular List, are to be used for subsequent encounters for treatment of problems associated with the healing, such as malunions, nonunions, and sequelae.
Osteoporosis With Fracture Example

- Patient admitted for aftercare of pathological fractured vertebra due to age related osteoporosis. Documentation indicates patient had previous healed pathological fracture of humerus due to osteoporosis.

Osteoporosis With Fracture Answer

- M1Ø21: M8Ø.Ø8xØD Age related osteoporosis with current pathological fracture, vertebra subsequent encounter
- M1Ø23: Z87.31Ø Personal history of healed osteoporosis fracture

Note: Age related osteoporosis is separate category from other osteoporosis

Note: Pathological fracture is separate category from osteoporosis fracture
Osteoporosis with current pathological fracture

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

Osteoporosis without pathological fracture

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

- CKD stages—see N18
- Presence of CKD alone does not represent a transplant complication.
- Z90.4 kidney transplant status
- Patients with CKD may also suffer from other serious conditions most commonly diabetes and HTN. The sequencing of the CKD code in relationship to codes for other contributing conditions is based on the conventions in the Tabular list.
Chronic Kidney Disease

- Chronic kidney disease, or CKD, is a condition that affects the function of the kidneys, and that may progress over time to kidney failure (end stage).
- When the kidneys fail, dialysis or a kidney transplant is needed to support life and people can live for decades with dialysis and/or kidney transplants. Many diseases can cause CKD. The most common are diabetes and high blood pressure.

Kidney Disease Risk Factors

- Diabetes
  - Almost 40% of new dialysis patients have diabetes, making it the fastest growing risk factor for kidney disease.
  - Type 2 diabetes is the number one cause of kidney failure, responsible for more than one out of every three new cases.
Kidney Disease Symptoms

Kidneys make urine, so when the kidneys are failing, the urine may change. How?

- Have to get up at night to urinate—nocturia
- Urine may be foamy or bubbly—sign of proteinuria
- Urinate more often, or in greater amounts than usual, with pale urine—polyuria
- Urinate less often, or in smaller amounts than usual, with dark colored urine—oliguria
- Urine may contain blood—hematuria
- Feel pressure or have difficulty urinating—dysuria

Chronic Kidney Disease & Fatigue

- Healthy kidneys make a hormone called erythropoietin (a-rithÔ-ro-poÔ-uh-tin) that tells your body to make oxygen-carrying red blood cells.
- As the kidneys fail, they make less erythropoietin. With fewer red blood cells to carry oxygen, your muscles and brain become tired very quickly.
- This condition is called anemia. What kind? Code it!
| 199 | Chapter 17 Guidelines  
| Q – Congenital Malformations |

Guidelines

- When a code does not describe the condition entirely, use additional codes to identify the manifestations.
- These codes may be used throughout the life of the patient.
- If it has been corrected, a personal history code should be used.
Use of symptom codes

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

- 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.
Use of symptom codes

- Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.
- ICD-10-CM contains a number of combination codes that identify both the definitive diagnosis and common symptoms of that diagnosis. When using one of these combination codes, an additional code should not be assigned for the symptom.

New Guideline

- Sign/symptom and “unspecified” codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.
- If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis.
New Guideline

When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflects what is known about the patient’s condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

Falls

- Code R29.6, Repeated falls, is for use for encounters when a patient has recently fallen and the reason for the fall is being investigated.
- Code Z91.81, History of falling, is for use when a patient has fallen in the past and is at risk for future falls. When appropriate, both codes R29.6 and Z91.81 may be assigned together.
Chapter 19 Guidelines
S,T – Injury and Poisoning

Application of 7th Characters in Chapter 19

Most categories in chapter 19 have a 7th character requirement for each applicable code.

No aftercare code for injuries

- A = Initial encounter
- D = Subsequent encounter
- S = Sequela  (p.55)

- Encouraged to add the external cause code for how the injury happened for home care
External Cause Codes

- In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

Traumatic Hip Fracture Example

- Patient admitted for aftercare of traumatic right hip (neck of femur) fracture after falling out of wheelchair
Traumatic Hip Fracture

Answer

- M1Ø21: S72.ØØ1D Subsequent encounter for closed fracture of unspecified part of neck of right femur with routine healing
- M1Ø23: WØ5.ØxxD Fall from wheelchair (optional)

Note: A fracture not indicated as opened or closed should be coded to closed

Trauma vs Fragility Fracture

- A code from M80, not a trauma fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma if that fall or trauma would not usually break a normal, healthy bone.
Open Wound Example

- Patient admitted for wound care to lacerated right forearm due to falling from moving motorized mobility scooter.

Open Wound Answer

- M1Ø21: S51.811D Laceration without foreign body of right forearm
- M1Ø23: VØØ.831D Fall from moving motorized mobility scooter (optional)

Note: Fall from non moving motorized mobility scooter WØ5.2xxD
Guidelines--Burns

- Burns=Thermal Burns, except sunburns (see includes note for T20-T32)
- Corrosions=chemical
- Degrees do not include loss of body part
- Highest degree first
- Classify burns of the same local site but of different degrees to the subcategory identifying the highest degree recorded
- If infected, add the ‘B’ code.

Guidelines—Burns

- Do not use T30. Assign a code for each location.
- Extent of body surface involved (T31/T32) when 3rd degree burns involving 20% or more using the Rule of Nines.
- May code a sequela of a burn and a current burn at the same time
- The external cause code should be used with burns and corrosions.
Acute Burn
Example

☐ Patient admitted for wound care due to second degree burn of left foot due to hot bath water

Acute Burn
Answer

☐ M1Ø21: T25.222D Burn of second degree of left foot
☐ M1Ø23: X11.ØxxD Contact with hot bath water (optional)

Note: 5th and 6th character ‘x’ required
Note: 7th character required
Sequela

7th character “S”, sequela, is for use for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. The scars are sequelae of the burn. When using 7th character “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 7th character “S” identifies the injury responsible for the sequela. The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code.

Sequela (Late Effect) Burn Example

Patient admitted for PT and OT due to joint contracture after the healing of a third degree burn to the right foot when the hot oil from a fry kettle poured on his foot at the restaurant at which he worked.

- Sequela are coded with a S 7th character.
- What do you see? Code it first
- Next code the injury with an S
- Next code how the original injury occurred with an S (optional).
Sequela (Late Effect) Burn Answer

- M1Ø21: M24.574 Joint contracture right foot
- M1Ø23: T25.321S Sequela of burn of third degree of right foot
- M1Ø23: X1Ø.2xxS Contact with hot oil, sequela (optional)

The condition or nature of the sequela is sequenced first. The sequela code is sequenced second.

Note: 5th and 6th character ‘x’ required
Note: 7th character required

Code this one...

- Spastic hemiplegia of the left side after CHI and subdural hemorrhage in 1988 after he fell off a ladder.

- G81.14
- S06.5x9S
- W11.xxxS (optional)
<table>
<thead>
<tr>
<th>Chapter 21 Guidelines</th>
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</thead>
<tbody>
<tr>
<td>Z –Factors Influencing…</td>
</tr>
</tbody>
</table>

Guidelines

- May be first listed or secondary depending on circumstances.
- Status—either a carrier or has the sequelae or residual of a past disease or condition
  - Informative—may affect the course of treatment/outcome
  - Should not be used if diagnosis code includes the info (status transplant with transplant complication)
Guidelines

- History—past medical condition that no longer exists and is not receiving any treatment, but that has a potential for recurrence and therefore may require continued monitoring.
  - History may alter treatment/outcome.

Guidelines

- Aftercare—initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for long term consequences of disease.
- Aftercare code should not be used if treatment is directed at a current, acute disease.
- Not to be used for injuries.
Guidelines

- Aftercare codes should be used in conjunction with other aftercare codes (read Z codes) or diagnosis codes to provide better detail on the specifics of an aftercare encounter visit… The sequencing of multiple aftercare codes depends on the circumstances of the encounter.

Example

- Patient had left BKA for diabetic gangrene. Providing aftercare, observation and assessment and dressing changes.

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Description</th>
<th>M1025</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>
## Answers

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Description</th>
<th>M1025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z47.81</td>
<td>Aftercare amputation</td>
<td></td>
</tr>
<tr>
<td>E11.51</td>
<td>DM w/peripheral angiopathy wo gangrene</td>
<td></td>
</tr>
<tr>
<td>Z89.512</td>
<td>Acquired absence of left leg below knee</td>
<td></td>
</tr>
<tr>
<td>Z48.01</td>
<td>Encounter for surgical dressing changes</td>
<td></td>
</tr>
</tbody>
</table>

## Same patient, but....

- The amputation site is infected (MRSA) and necrosed. Orders are to continue to provide care to the surgical wound and dressing changes.
Same patient, but....

- The amputation site is infected (MRSA) and necrosed. Orders are to continue to provide care to the surgical wound and dressing changes.

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T87.54</td>
<td>Necrosis of amp stump, LLE</td>
</tr>
<tr>
<td>T87.44</td>
<td>Infection of amp stump, LLE</td>
</tr>
<tr>
<td>B95.62</td>
<td>MRSA (cause of diseases classified elsewhere)</td>
</tr>
<tr>
<td>E11.51</td>
<td>DM with periph angiopathy wo gangrene</td>
</tr>
</tbody>
</table>

More surgical patients...

- Patient is receiving aftercare for an appendectomy.
- Patient status post CABG
- Patient with infected surgical wound
More surgical patients...

- Patient is receiving aftercare for an appendectomy.
  - Z48.815 Appendicitis
- Patient status post CABG
  - Z48.812
  - Z95.1
- Patient with infected surgical wound
  - T81.4xxD

Poisonings, Adverse Effects and Underdosing
**Table of Drugs and Chemicals**

- Poisoning, accidental
- Poisoning intentional self-harm
- Poisoning assault
- Poisoning undetermined
- Adverse effect (therapeutic use in ICD-9)
- Underdosing

- A - Initial encounter
- D - Subsequent encounter
- S - Sequela

---

**Table of Drugs and Chemicals**

- **Includes:**
  - Poisoning is defined as:
    - overdose of substances
    - wrong substance given or taken in error
  - Adverse effect is defined as:
    - 'hypersensitivity', 'reaction', etc. of correct substance properly administered
  - Underdosing is defined as:
    - taking less of a medication than is prescribed or instructed by the manufacturer, whether inadvertently or deliberately
Table of Drugs and Chemicals

- Codes from categories T36-T65 are combo codes that include the substance that was taken as well as the intent.
  - Guideline: When coding a poisoning or improper use of a medication first assign the appropriate code from categories T36-T50. Use additional code(s) for manifestations of poisonings.
  - Guideline: When coding an adverse effect of a drug that has been correctly prescribed and properly administered, assign the appropriate code for the nature of the adverse effect followed by the appropriate code for the adverse effect of the drug (T36-T50 with a 5th or 6th character of 5).

Table of Drugs and Chemicals

- Guideline: Codes for underdosing should never be assigned as principal or first-listed codes. If a patient has a relapse or exacerbation of the medical condition for which the drug is prescribed because of the reduction in dose, then the medical condition itself should be coded.
  - Also add Z code for underdosing.
Underdosing Example

- Patient with diagnosis of Hypertension continued to experience elevated blood pressure while taking blood pressure meds. Upon patient interview, it was found the patient was taking medication once daily instead of twice daily because of the cost of the drug.

Underdosing Answer

- M1Ø21: I1Ø Essential (primary) hypertension
- M1Ø23: T46.5x6D Underdosing of other antihypertensive drugs, subsequent encounter
- M1Ø23: Z91.12Ø Patient's intentional underdosing of medication regimen due to financial hardship
Poisoning Example

- Patient has taken his Lasix 40mg every morning and night. The prescription bottle reads 40mg daily. Patient is dehydrated and hypokalemic.
Poisoning Answer

- M1Ø21: T5Ø.1x1D poisoning by diuretics
- M1Ø23: E86.Ø dehydration
- M1Ø23: E87.6 hypokalemia

Adverse Effect Example

- Patient has been taking the prescribed amount of Lanoxin, however his pulse rate is now 42 and he is toxic according to lab values. SN for observation and assessment, teaching and venipuncture for monitoring levels.
### Adverse Effect

**Answer**

- M1Ø21: R00.1 Bradycardia
- M1Ø23: T46.Øx5D cardiotonic glycosides
- M1Ø23: Z51.81 Encounter for monitoring
- M1Ø23: Z79.899 Long term (current) use of other high risk medication

### Sources

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- [http://en.wikipedia.org/wiki/Metastasis](http://en.wikipedia.org/wiki/Metastasis)
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