INTRO TO THE ICD-10-CM SYSTEM—TIME WAITS FOR NO ONE 2013

ICD-9-CM History

History ICD-9

- World Health Organization (WHO) developed ICD-9 for worldwide use
- U.S. developed clinical modification (ICD-9-CM)
- Implemented in U.S. in 1979
  - Expanded number of diagnosis codes
  - Developed procedure coding system
History ICD-9

ICD-9-CM is used to:

- Calculate payment
- Adjudicate coverage
- Compile statistics
- Assess quality
  - Risk adjustment
  - Outcomes

History ICD-9

- System is more than 30 years old
- Many categories are full
- Not descriptive enough
- Outdated medical terms
- New technologies are not included

ICD-10

- 1998 by WHO
- USA is the only industrialized nation that has not implemented ICD-10 or a clinical modification of ICD-10
- USA has been using ICD-10 for coding mortality since 1999.
- Clinical modification process began in 1994.

ICD-10 Final Rule

CMS-0013-F

- Published January 16, 2009
- October 1, 2014 - Compliance date for implementation of ICD-10 Clinical Modification (CM) and ICD-10-Procedure Coding System (PCS)
- Single implementation date for all users
- Date of service for all except inpatient settings
- Date of discharge for inpatient settings
- NO GRACE PERIOD
<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>

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

**ICD-10-CM**

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

MLN Matters® Number: MM7492
### Proposed OASIS-C1

(M1011) 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 14 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>

□ NA - Not applicable (patient was not discharged from an inpatient facility) [Omit NA option on SOC, R01]

(M1021) List Inpatient Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions treated during an inpatient stay within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):

<table>
<thead>
<tr>
<th>Diagnosis (Sequencing of diagnoses should reflect seriousness of each condition and should support the disciplines and services provided)</th>
<th>ICD-10-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Description</td>
<td></td>
</tr>
<tr>
<td>b. Description</td>
<td></td>
</tr>
<tr>
<td>c. Description</td>
<td></td>
</tr>
<tr>
<td>d. Description</td>
<td></td>
</tr>
<tr>
<td>e. Description</td>
<td></td>
</tr>
<tr>
<td>f. Description</td>
<td></td>
</tr>
</tbody>
</table>

(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-CM 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-CM 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 used.

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

□ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)
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-CM 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-CM coding rules and sequencing requirements must be followed. Note that external cause codes (ICD-10-CM 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.

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-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM 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-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

Code Freeze

- No new codes for ICD-9-CM
- No new codes for ICD-10-CM
- But does that mean no changes?
  - ICD-10-CM changes to the tabular and indices have been issued
  - ICD-10-CM guideline changes
  - There will be a few new changes in the tabular and index for October 1, 2014
- First REAL update will be October 1, 2015

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</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 place holder '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 and 7th Character Extensions

- Alpha (Except U)
- 2 - 7 Numeric or Alpha
- Additional Characters

3 – 7 Characters

Category
Etiology, anatomic site, severity
Added 7th character for obstetrics, injuries, and external causes of injury

New 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 Ig 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

Laterality Example

Osteoarthritis
- M16.Ø Bilateral primary osteoarthritis of hip
- M16.11 Unilateral primary osteoarthritis, right hip
- M16.12 Unilateral primary osteoarthritis, left hip
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
    - Subterm
    - Subterm
    - Subterm
    - Subterm
    - Subterm
- Essential modifiers change the code assignment
  - These subterms under the main terms are called 'essential modifiers.'
**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

**Alphabetical Index Practice**

- Aftercare involving
- Anemia deficiency
- Failure, failed heart
- Long term

**Tabular Chapters**

- 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>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>Skin and subcutaneous tissue</td>
</tr>
<tr>
<td>M</td>
<td>Musculoskeletal and connective tissue</td>
</tr>
<tr>
<td>N</td>
<td>Genitourinary system</td>
</tr>
<tr>
<td>O</td>
<td>Pregnancy, childbirth, and the puerperium</td>
</tr>
<tr>
<td>P</td>
<td>Perinatal period</td>
</tr>
<tr>
<td>Q</td>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
</tr>
<tr>
<td>R</td>
<td>Symptoms, signs and abnormal clinical and laboratory findings</td>
</tr>
<tr>
<td>S,T</td>
<td>Injury, poisoning and certain other consequences of external causes</td>
</tr>
<tr>
<td>U</td>
<td>Reserved by WHO for emergency codes</td>
</tr>
<tr>
<td>V,W,X,Y</td>
<td>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>Z</td>
<td>Factors influencing health status and contact with health services</td>
</tr>
</tbody>
</table>

*Note: * only encouraged external cause code in HH

### Tabular List

- 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

### Characters

- 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
Activities—Find & Compare

- C40.21 [M90.661] and 170.7 [731.1]
- Note at the beginning of chapter 18 in ICD-10 and note at the beginning of chapter 16 in ICD-9
- Note for subchapter D37-D48 (ICD-10) and the note at 235-238 (ICD-9)

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
  - Diabetes
  - H44.611

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
K31.5

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, Other Specified, Unspecified

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
4th digit 8

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
4th digit 9

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.
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

   - G81.11 Spastic hemiplegia affecting right dominant side
   - S06.5x9S Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, sequela
2. Code the sequela first when what you see cannot go first (manifestation code).
3. 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

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.
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.

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

- “Code, if applicable, any causal 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
Sequencing

- 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?
2013 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

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 an indication in the documentation that it is a complication. If not clearly documented, query the provider for clarification.

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).

### 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

- M1021: I10 Essential (primary) hypertension
- M1023: T46.5x6D Underdosing of other antihypertensive drugs, subsequent encounter
- M1023: Z91.12Ø Patient's intentional underdosing of medication regimen due to financial hardship

- 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.
- Codes for underdosing should never be assigned as principal or first-listed codes (T36-T50 with fifth or sixth character 5).
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

Chapter Specific Guidelines

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.
  - A41.0 and B95.6-

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
Neoplasms

- 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
- If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis.

Sequencing Neoplasms with More than One Site

- When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

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.
Anemia associated with malignancy

- When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by the appropriate code for the anemia (such as code D63.0, Anemia in neoplastic disease).

Anemia Due To Neoplasm Example

- Patient admitted for management of anemia related to colon cancer. The focus of care is the anemia.

Anemia Due To Neoplasm Answer

- M1021: C18.9 Colon cancer unspecified
- M1023: D63.Ø Anemia in neoplastic disease

- Note: Different sequencing in ICD-9

Anemia associated with chemotherapy, immunotherapy and radiation therapy

- When the admission/encounter is for management of an anemia associated with chemotherapy or immunotherapy and the only treatment is for the anemia, the anemia code is sequenced first followed by the appropriate codes for the neoplasm and the adverse effect (T45.1X5, Adverse effect of antineoplastic and immunosuppressive drugs).
Antineoplastic Chemotherapy Anemia Example

- Patient admitted for management of anemia related to chemotherapy due to colon cancer. The focus of care is the anemia.

Antineoplastic Chemotherapy Anemia Answer

- M1Ø21: D64.81 Anemia due to antineoplastic chemotherapy
- M1Ø23: T45.1x5D Adverse effect of antineoplastic and immunosuppressive drugs subsequent
- M1Ø23: C18.9 Colon cancer unspecified

Other Guidelines for Neoplasms

- Dehydration
- Complication of surgery
- 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.

Code these...

- Right female breast cancer with mets to R lung
- History of lung ca and pneumonectomy of left lung with continued smoking
- Mets to R kidney, unknown primary
Code these...

- Right female breast cancer with mets to R lung
  - C50.911
  - C78.01
- Right female breast cancer with mets to R lung, treatment directed at lung
  - C78.01
  - C50.911
- 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

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

Diabetes

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

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.
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 Mellitus E11**
  - **E11: Type II Diabetes Mellitus**
  - Includes:
    - diabetes (mellitus) due to insulin secretory defect
    - diabetes NOS
    - insulin resistant diabetes (mellitus)
  - Use an additional code for insulin use (Z79.4)

- **Diabetes Mellitus E11 Example**
  - Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
  - M1Ø2Ø: E11.321 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
  - Note: Combination code includes all aspects of disease
### Diabetes Mellitus E11 Example

- Patient was admitted for diabetes type II with gangrene. Patient takes insulin

### Diabetes Mellitus E11 Answer

- M1Ø21: E11.52 Type II diabetes mellitus with diabetic peripheral angiopathy with gangrene
- M1Ø23: Z79.4 Long term use insulin

### Mental Behavioral/Nervous System

- Diabetic neuropathy, takes insulin but BS have been average 250. Focus of care is to get BS under control.
- E11.65 Type 2 DM with hyperglycemia
- E11.40 Type 2 DM with diabetic neuropathy, unspecified
- Z79.4 Long term use, insulin
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.

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

Code these!

- Severe Depression
- Bipolar disorder (manic)
- Borderline Schizophrenia
- Mild Memory Disturbance (Organic brain disease)
**Code these!**

- Severe Depression
  - F32.2 Major depressive disorder, single episode without psychotic features
- Bipolar disorder (manic)
  - F31.10 Bipolar disorder, current episode manic without psychotic features, unspecified
- Borderline Schizophrenia
  - F21 Schizotypal Disorder
- Mild Memory Disturbance (Organic brain disease)
  - G93.9
  - F06.8

**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 non-dominant side is affected. 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 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.

**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
  - 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

Examples to code

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

Category I69, Sequelae of Cerebrovascular disease

- Category I69 is used to indicate conditions classifiable to categories I60-I67 as the causes of sequel (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)

CVA Example

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

CVA Example

- M1021: 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
Notes

- Angina is considered integral to CAD 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.

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

- M1021: I25.10 Atherosclerotic heart disease of native coronary artery without angina
- M1023: I25.2 Old healed MI
- Note: ICD-10 definition acute MI = 4 weeks
  ICD-9 definition acute MI = 8 weeks

Myocardial Infarction Example

- Patient was treated for an inferior wall MI in last 3 weeks 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 CAD 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

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.
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 Ulcer Example

- 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.

Pressure Ulcer Answer

- 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

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.Ø8xD Age related osteoporosis with current pathological fracture, vertebra
- 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.

Use of symptom codes

- Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified

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.

- 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.
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.

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

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

Injuries

- 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

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

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 these...

- 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)
- Quadriplegia after a spinal cord injury at C6 one year ago when the auto he was driving ran into a tree. H&P mentions complete lesion.
  - G82.53 Quadriplegia
  - S14.116S Complete lesion C6
  - V47.52xS Driver of other car collision with fixed or stationary object (optional)

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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Aftercare & Post-surgical Complications

Answers

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

<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
- Patient status post CABG
  - Z48.812
  - Z95.1
- Patient with infected surgical wound
  - T81.4xxD
Take Away Points

• CMS expects the Home Health industry to have an overall transition cost from ICD-9 to ICD-10 of 16.58 million dollars
• Preparation is the key
• Communication is vital
• Establish a team to implement the conversion
• Coding Clinic guidance will be retired so ‘unlearning’ rules will be as important as learning the new code set
• Clinicians must document in detail

Take Away Points

• Improved documentation is being driven by initiatives such as quality measures, value based purchasing, and patient safety
• Coders must have increased knowledge not just in the new coding system itself, but medical terminology, anatomy and physiology in general
• Payment in part, will be linked to precise coding
• Accurate coding depends on thorough documentation
• Both are critical to your agency’s success in an ICD-10 environment
• There will be a productivity drop and there will be a slowdown in claims processing—what is your plan?

Questions?? Send to brandi@selmanholman.com
Sign up for my blog at www.selmanholmanblog.com

Like us on Facebook
Selman-Holman & Associates, LLC
You’re invited to join the groups: Homecare Coders ICD-10-CM For Coders