Things to Know

Codes are entered into the OASIS

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
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<tbody>
<tr>
<td>ICD-10-CM</td>
<td>Diagnosis Code</td>
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<td>Description</td>
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<tr>
<td>[M1021] Primary Diagnosis</td>
<td>[M1023] Other Diagnosis</td>
<td>[M1025] Optional Diagnosis</td>
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<td>b</td>
<td>c</td>
<td>d</td>
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<td>[M1021]</td>
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<td>V, W, X, Y, Z codes NOT allowed</td>
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<tr>
<td>[M1025]</td>
<td>Optional Diagnosis</td>
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And the Plan of Care

And the codes have to match:

<table>
<thead>
<tr>
<th>OASIS</th>
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<tr>
<td>M1021</td>
<td>FL11</td>
<td>FL67</td>
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<td>M1023b</td>
<td>FL13</td>
<td>FL67A</td>
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<td>FL67G</td>
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<td>And so on…</td>
<td>And so on…</td>
<td>FL67H</td>
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</table>

Matching all the way down!!!

Know Eligibility and Coverage

Home Health

- Primary reason for home care
- All other diagnoses that impact care (any comorbid conditions having the potential to affect the patient’s responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself)

Hospice

- Terminal diagnosis
- Conditions related to the terminal diagnosis
- Even unrelated diagnoses now

And Payment

Home Health

- Episode
- Case mix system based at least partially on diagnoses used

Hospice

- Per diem basis
- Care for terminal diagnosis and related diagnoses (visits, medications, treatments, etc)
Scenario

- The patient has CHF, HTN, diabetes and unexplained melena. He was admitted to explore the reason for the melena. A polyp was removed from his colon. What condition(s) may be placed in M1011?
  a. All of the conditions
  b. Any condition that needed medication
  c. The melena and the polyp
  d. The polyp only because the melena is just a symptom.

Answer

c. Is the answer. The melena and the polyp were both actively treated. Melena is not a symptom.
M1017 Diagnoses Requiring Change

- Identifies if any change has occurred to the patient’s treatment regimen, health care services, or medications within the past 14 days.
  - Identify the patient’s recent history by identifying new diagnoses or diagnoses that have exacerbated over the past 2 weeks.
  - New onset of CHF 12 days ago, improved with treatment
- Mark "NA" if changes in the medical or treatment regimen were made because a diagnosis improved.
- UTI diagnosed 3 weeks ago, treated, improved and resolved

The intent of the item is not to identify diagnoses where all medical or treatment regimen changes in the last 14 days were related to improvement in a condition. If at any time in the last 14 days the patient requires a medical or treatment regimen change due to development of a new condition or lack of improvement or worsening of an existing condition, the diagnosis should be reported in M1017, even if the condition also showed improvement or stabilization during that time, or is improved at the time of SOC/ROC.
### Who Determines Diagnoses

- The assessing clinician is expected to complete the patient's comprehensive assessment and understand the patient's overall medical condition and care needs before selecting and assigning diagnoses.
- The determination of the patient's primary and secondary home health diagnoses must be made by the assessing clinician based on the findings of the assessment, information in the medical record, and input from the physician.
Diagnoses Change Based on Change in Patient Status

- Diagnoses may change during the course of the home health stay due to a change in the patient’s health status or a change in the focus of home health care.
- At each required OASIS time point, the clinician must assess the patient’s clinical status and determine the primary and secondary diagnoses based on patient status and treatment plan at the time of the assessment.

Symptom Control Not Used for Sequencing

- The order that secondary diagnoses are entered should be determined by the degree that they impact the patient’s health and need for home health care, rather than the degree of symptom control. For example, if a patient is receiving home health care for Type 2 diabetes that is “controlled with difficulty,” this diagnosis would be listed above a diagnosis of a fungal infection of a toenail that is receiving treatment, even if the fungal infection is “poorly controlled.”
- No symptom control rating on V, W, X, Y and Z codes

A Few Basics

Excludes Notes

- Excludes 1: An excludes 1 note is a pure "CODED HERE" note. Indicates the code excluded should ‘never’ be used at the same time as the code above the Excludes 1 notes. Exception is if the 2 conditions are unrelated.
- 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.
We have received several questions regarding the interpretation of Excludes1 notes in ICD-10-CM when the conditions are unrelated to one another.

Answer: If the two conditions are not related to one another, it is permissible to report both codes despite the presence of an Excludes1 note. For example, the Excludes1 note at code range R40-R46, states that symptoms and signs constituting part of a pattern of mental disorder (F01-F99) cannot be assigned with the R40-R46 codes. However, if dizziness (R42) is not a component of the mental health condition (e.g., dizziness is unrelated to bipolar disorder), then separate codes may be assigned for both dizziness and bipolar disorder. In another example, code range I60-I69 (Cerebrovascular Diseases) has an Excludes1 note for traumatic intracranial hemorrhage (S06.-). Codes in I60-I69 should not be used for a diagnosis of traumatic intracranial hemorrhage. However, if the patient has both a current traumatic intracranial hemorrhage and sequela from a previous stroke, then it would be appropriate to assign both a code from S06- and I69-.

 Scenario

- The patient fell from his bed and sustained a SDH with loss of consciousness of less than 10 minutes. Patient states that he was in a hurry to get to the restroom and thought he could make it without his quad cane. Patient was in observation status for 2 days and has been sent home with elderly mother. Patient history significant for hemiplegia of left nondominant side related to stroke 3 years ago. Care to include observation and assessment and teaching for any change in consciousness, therapy for fall prevention.
- S06.5x1D Traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less, subsequent. (Could argue A)
- I69.354 Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.
- Z91.81 History of falling

 Scenario

- Patient was drying off after her bath when she “felt funny” and her right arm stopped working. She called for help but then fell hitting her head on the bathtub, sustaining an epidural hemorrhage. Diagnoses include cerebral infarction with right dominant hemiplegia, malignant hypertension and epidural hemorrhage.
- I69.351 Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side+0.
- S06.4x0D Epidural hemorrhage without loss of consciousness.
Conventions—Relational Terms

- And—interpreted to mean ‘and/or’ when it appears in a code title within the tabular list (C34 Malignant neoplasm of bronchus and lung)
- 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. (Diverticulitis with bleeding)

Examples of ‘With’

- Reference diabetes in the index AS AN EXAMPLE
- Diabetes
  - with
    - amyotrophy
    - arthropathy NEC
    - autonomic (poly) neuropathy
    - cataract
    - Charcot’s joints
    - And so on…
- Not limited to diabetes…see dementia, with…
  - Dementia, with, Parkinson’s

With

The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.

For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.

Diabetic Manifestations

- It’s not the coder that assumes—the classification assumes a cause and effect relationship between diabetes and the listed manifestations
- The only time you do not code those manifestations specifically listed, as diabetic is if the physician has documented a different cause.
  - It is imperative that all documentation be reviewed for indications that there is another cause before assigning the manifestation to diabetes.
Examples

- The physician documents foot ulcer on a diabetic patient.
- The physician documents pressure ulcer on the right buttock on a diabetic patient.
- The patient has diabetes and also has polyneuropathy.
- The patient has diabetes and also has alcoholic polyneuropathy documented.
- The diabetic has a gangrenous pressure ulcer.

Examples

- The diabetic patient has PVD and arterial ulcers.
- The diabetic has an ulcer on his lower leg associated with stasis dermatitis with hemosiderin staining and a beefy wet appearance.
  - Know when you should really ask

CAUTION

- Arthropathy NEC
- Circulatory complication NEC
- Complication, specified NEC
- Kidney complications NEC
- Neurologic complication NEC
- Oral complication NEC
- Skin complication NEC
- For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.

CAUTION

- The patient has diabetes and OA. Do we code that as diabetic arthropathy?
- The patient has diabetes and CAD. Is that diabetic CAD?
  - (If diabetic CAD is documented: E11.59, I25.10)
- The Coding Clinic said that osteomyelitis CANNOT be assumed related to diabetes because it is not listed under ‘with.’
Questions Index Addenda

- Why is osteomyelitis indented under ‘with’ only under the generic code for diabetes?
- Coding Clinic used osteomyelitis as an example—because not listed, may not code as related without physician documentation

Diabetes, diabetic (mellitus) (sugar)
E11.9
with
- gastroparalysis E11.43
- osteomyelitis E11.69

Diabetes Categories

- **E08 DM due to underlying condition**
  - Code first underlying condition (e.g., pancreatitis, pancreatic cancer, injury to pancreas, cystic fibrosis, malnutrition, Cushing’s)
  - Use additional code for insulin (Z79.4) and/or oral antiglycemics (Z79.84)

- **E09 DM due to drug or chemical**
  - Sequencing depends on adverse effect or poisoning (Adverse Effect—e.g., steroids, pentamidine; E09.-, then T code for drug) (Poisoning—e.g., Dioxin, arsenic; T code for drug or chemical, then E09.-)
  - Use additional code for insulin (Z79.4) and/or oral antiglycemics (Z79.84)

- **E10 DM Type I**
  - Brittle, ketosis prone

- **E11 DM Type II**
  - Use additional code for insulin (Z79.4) and/or oral antiglycemics (Z79.84)
  - Includes unspecified diabetes

- **E13 Other specified DM**
  - Secondary diabetes NEC
  - Use additional code for insulin (Z79.4) and/or oral antiglycemics (Z79.84)
  - Special sequencing when caused by removal of pancreas (E89.1, E13.-, Z90.41-, Z79.4 and/or Z79.84)

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.”
Drug or chemical induced DM Adverse Effect

- 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.

Poisoning

- 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.

Examples

- The patient has steroid induced diabetes from taking corticosteroids for an upper respiratory infection last year.
  - E09.9 Drug or chemical induced diabetes
  - T38.0x5S Adverse effect of glucocorticoids, sequela

- The patient has diabetes from exposure to Agent Orange during the Vietnam conflict.
  - T53.7x1S Toxic effect of other halogen derivatives of aromatic hydrocarbons, accidental, sequela
  - E09.9 Drug or chemical induced diabetes

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.
  - Genetic susceptibility
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.

Genetic defects of beta cell function or insulin action
- Postpancreatectomy/post procedural DM
- Secondary DM, NEC

Specific guideline postpancreatectomy DM
- E89.1 Postprocedural hypoinsulinemia
- E13 code(s)
- Z90.41- Acquired absence of pancreas
- Z79.4 insulin and/or Z79.84 anti-glycemics

Diabetes Categories
- Diabetes
- Diabetes as an adverse effect of steroids with hyperglycemia
- Diabetes as a result of cystic fibrosis
- Diabetes after a pancreatectomy
- Ketosis prone diabetes
- Diabetes as a result of arsenic poisoning
- Type II DM with hyperglycemia due to taking steroids
The diabetes mellitus codes are combination codes that include:
- the type of diabetes mellitus (E08-E13),
- the body system affected, (4th character) and
- the complications affecting that body system (5th, 6th characters).

Diabetes codes should be sequenced based on the reason for a particular encounter.

Assign as many codes from the appropriate category (E08 –E13) as needed to identify all of the associated conditions that the patient has. (MANY Assumptions)

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. (Type 2 is the DEFAULT—do NOT code Type I just because the patient takes insulin)

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. (AND NOT on Type I)

Now code these...

- Secondary Diabetes
- Diabetes as an adverse effect of steroids with hyperglycemia
- Diabetes as a result of cystic fibrosis and CKD
- Diabetes after a pancreatectomy taking insulin
- Ketosis prone diabetes
- Diabetes as a result of arsenic poisoning years ago and chronic osteomyelitis of the 5th lumbar vertebrae
- Type II DM with hyperglycemia due to taking steroids

Now code these... answers

- Secondary Diabetes
  - E13.9
- Diabetes as an adverse effect of steroids with hyperglycemia
  - E09.65, T38.0x5D
- Diabetes as a result of cystic fibrosis and CKD
  - E84.8, E08.22, N18.9
- Diabetes after a pancreatectomy taking insulin
  - E89.1, E13.9, Z90.410, Z79.4
- Ketosis prone diabetes
  - E10.9
- Diabetes as a result of arsenic poisoning years ago and chronic osteomyelitis of the 5th lumbar vertebrae
  - T57.0x1S, E09.9, M46.26
- Type II DM with hyperglycemia due to taking steroids
  - E11.65, T38.0x5D
Diabetes 4th characters 0 and 1

- Diabetes with hyperosmolarity
  - Does not occur with Type 1 DM
    - No choice in Type 1 diabetics (no E10.0-)
- Diabetes with ketoacidosis
  - Occurs rarely with Type 2 diabetics
    - No choice in Type 2 diabetics (no E11.1-)
- Type II DM with ketoacidosis E13.10
- Do not code hyperglycemia with ketoacidosis.
- If the type of diabetes is unspecified but documented with ketoacidosis, do not code Type II. Query physician.

Example

- The patient is admitted to home care after a hospitalization for episode of diabetic ketosis with blood sugar of 857. The physician documents type 2 DM, neuropathy and CKD. The neuropathy required pain management and the CKD required dialysis for 2 days as a precaution. Codes for M1011 include:
  a. E10.10, E10.65, E10.42, N18.9
  b. E13.10, E11.65, E11.42, N18.9
  d. E11.10, E11.42, E11.22, N18.9

Explanation:

- E13.10 is the code to use for type 2 DM with ketoacidosis. It is more important to code the manifestation than the type.
- Do not code hyperglycemia with ketoacidosis.
- Neuropathy and CKD are assumed related to diabetes.

Remember that diabetes type is unspecified, then type II is coded?
- Diabetic ketoacidosis is not assumed to be type II because the type of diabetes is unspecified. Query the physician for type.
Diabetes (Other)

- 7—no 4th character 7
- 8—unspecified complications (do NOT use)
- 9—without complications (equivalent to 250.00)

NOT Diabetes
- Borderline diabetes
- Latent diabetes, and
- Prediabetes

R73.03 New

Diabetic Manifestations Effective NOW

- The subterm "with" in the Index should be interpreted as a link between diabetes and any of those conditions indented under the word "with."
- The physician documentation does not need to provide a link between the diagnoses of diabetes and chronic kidney disease to accurately assign code E11.22, Type 2 diabetes mellitus with diabetic chronic kidney disease. This link can be assumed since the chronic kidney disease is listed under the subterm "with."
- These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated and due to some other underlying cause besides diabetes.
- For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.”

Diabetic Manifestation Notables

- E11.22
  - Use additional code note (OK to code N18.9)
  - Patients with CKD may also suffer from other conditions, most commonly diabetes and hypertension. The sequencing of the CKD in relationship to codes for other contributing conditions is based on the coding conventions. FOLLOW THE TABULAR INSTRUCTIONS

- The classification assumes a relationship between CKD and HTN.
- The classification assumes a relationship between CKD and Diabetes.

- Diabetes, CKD and HTN
- E11.22, I12.9, N18.9 OR I12.9, E11.22, N18.9

N18-Chronic kidney disease

- Code first any associated:
  - Diabetic chronic kidney disease (DOES assume a cause-effect relationship)
  - Hypertensive chronic kidney disease (DOES assume a cause-effect relationship and if the patient has HTN and CKD documented, code as such)

- If the physician documents diabetic nephropathy (E11.21) and CKD (E11.22), code E11.22.
Diabetic Manifestation Notables

- E11.3- Macular edema includes the type of retinopathy (many changes ahead)
- E11.4- includes neuropathy unspecified, mononeuropathy, polyneuropathy, etc
  - E11.43 Includes gastroparesis/gastroparalysis
- E11.5 DM with gangrene includes the peripheral angiopathy (disease of the peripheral arteries)
- E11.610 Includes Charcot’s
  - Not M14.6
  - Neurogenic arthropathy

Examples

- Diabetic macular edema
- Diabetic neuralgia
- Diabetic gangrene
- Diabetic foot ulcer on toes (rt foot)
- Diabetic with high blood sugars
- Diabetic chronic osteomyelitis of right foot
- Borderline diabetes (2017)

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
Answers

- Diabetic with high blood sugars
  - E11.65
- Diabetic osteomyelitis (chronic) of the right midfoot
  - E11.69
- M86.671 Chronic osteomyelitis, right ankle and foot
- Borderline diabetes
  - R73.03

Sequencing Several Diabetic Complications/Manifestations

- Mrs. Wolfe has diabetic ulcers on three toes of her right foot (muscle necrosis on the worst), diabetic gangrene on a 4th toe and poorly controlled blood sugars.
- The ulceration and the blood sugars are the focus of care.

Mrs. Wolfe:
- E11.621 DMII with foot ulcers
- L97.513 Ulcer other part of foot (toes), right, muscle necrosis
- E11.65 DMII with hyperglycemia
- E11.52 DMII with peripheral angiopathy with gangrene

Sequencing:

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<tr>
<th>(M1021 Primary Diagnosis &amp; (M1023) Other Diagnoses)</th>
<th>(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)</th>
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<tbody>
<tr>
<td>Column 1 (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)</td>
<td>Column 2 (ICD-10-CM and symptom control rating for each condition noted that the sequencing of these ratings may not match the sequencing of the diagnoses)</td>
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<td>Diabetes with foot ulcer</td>
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<td>Symptom control required on all.</td>
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<td>Description/ICD-10-CM</td>
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</table>
| E11 6 2 1 | }
Hyperglycemia

- With, Hyperglycemia
- Inadequately controlled – code to diabetes, by type with hyperglycemia
- Out of control – code to diabetes, by type with hyperglycemia
- Poorly controlled – code to diabetes, by type with hyperglycemia
- Uncontrolled - meaning hyperglycemia - see Diabetes, by type, with, hyperglycemia

Diabetes (except Type I)

- Use Additional
  - Revise from code to identify any insulin use (Z79.4)
  - Revise to code to identify control using:
    - insulin (Z79.4)
    - oral antidiabetic drugs (Z79.84)
    - oral hypoglycemic drugs (Z79.84)
  ...should also be assigned to indicate that the patient uses insulin or hypoglycemic drugs.

Z79

Z79.84 Long term (current) use of oral hypoglycemic drugs
- Long term (current) use of oral antidiabetic drugs
- Excludes2: long term (current) use of insulin (Z79.4)

Diabetes Ophthalmic Manifestations

One of the following 7th characters is to be assigned to codes in subcategory E--.32 to designate laterality of the disease:
- Add 1 right eye
- Add 2 left eye
- Add 3 bilateral
- Add 9 unspecified eye

(Also added more 7th characters to the ophthalmic codes in the H chapter)
Glaucoma

- **H42 Glaucoma in diseases classified elsewhere**
  - **Excludes1:**
    - Revise from glaucoma (in):
      - Revise to glaucoma (in) onchocerciasis (B73.02)
    - Delete onchocerciasis (B73.02)
    - Revise from syphilis (A52.71)
    - Revise to glaucoma (in) syphilis (A52.71)
    - Revise from tuberculosis (A18.59)
    - Revise to glaucoma (in) tuberculous (A18.59)
  - **Excludes2:** glaucoma (in) diabetes mellitus (E08.39, E09.39, E10.39, E11.39, E13.39)

E15-E16 Other disorders of glucose regulation and pancreatic internal secretion

- Drug induced hypoglycemia E16.0
- Hypoglycemia E16.2
  
  Consider that this hypoglycemia is not in a diabetic. (See E11.649)

Overweight, obesity and other hyperalimentation

- Overweight with BMI of 27
  - E66.3
  - Z68.27 BMI 27.0-27.9, adult
- The physician must document obesity, overweight before it can be coded. BMI can be coded based on clinician’s documentation.

Malnutrition Considerations

- Marasmus and kwashiorkor (E40-42) affect primarily children with profound low protein and calorie intake
- If the patient is dying of malnutrition, it isn’t mild (E44.1) or moderate (E44.0)
- What about T73.0 starvation noted in Excludes 2 note?
  - This is under injuries, “deprivation of food” infers by another person
Malnutrition Considerations

- What about E43 Unspecified severe protein-calorie malnutrition?
- What is starvation edema?
- What about cachexia?
- General physical wasting with loss of weight and muscle mass due to a disease
- R64 Cachexia
  - Wasting syndrome
  - Code first underlying condition, if known
  - Excludes 1: abnormal weight loss R63.4 nutritional marasmus E41

Cystic Fibrosis

- Cystic fibrosis patient with diabetes and Vitamin D deficiency.
  - E84.8 Cystic fibrosis with other manifestations
  - E08.9 DM due to underlying condition
  - E55.9 Vitamin D deficiency, unspecified

C,D--Neoplasms
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 (R codes)

Malignancies

- 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.
  - Coded as secondary malignant neoplasm of the lung
- Primary and secondary sites may be sequenced in either order depending on care.

Neoplasm Table

- Classifies by site (topography) with broad groupings for behavior (malignant, benign, etc)
- Some morphology types are included just in the alpha index—malignant melanomas and neuroendocrine tumors, for example.
- Laterality is important!!

Mets to liver from pancreatic ca (metastatic pancreatic cancer)

- Primary is origin of cancer
- Metastasis indicates other organs the cancer has gone to
  - Metastatic ca means the cancer has metastasized
  - First mentioned is usually primary
  - To/from
Neoplasm Table

- The neoplasm table in the Alphabetic Index should be referenced first.
  - Lung cancer in the right lung
- 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 of right lung
  - But what if the physician documents malignant adenoma?

Morphologic/Histologic Examples to Code

- Benign carcinoid of the rectum (*Tumor, carcinoid*)
- Subacute monocytic *leukemia* in remission (failed remission for hospice)
- 25 year old received treatment of malignant *melanoma* of skin at right breast and left arm

Answers

- Benign carcinoid of the rectum
  - D3A.026
- Subacute monocytic leukemia in remission
  - C93.91
- 25 year old received treatment of malignant melanoma of right breast and left arm
  - C43.52
  - C43.62

Remission

- Leukemia and Multiple myeloma and malignant plasma cell neoplasms, have codes indicating whether or not the leukemia has achieved remission.
- Z85.6, Personal history of leukemia, and Z85.79, Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues.
- If the documentation is unclear, as to whether the leukemia has achieved remission, the provider should be queried.
- C90-95, for example
  - 5th digit 0-not having achieved remission, failed remission
  - 5th digit 1-in remission
  - 5th digit 2-in relapse
Encounter for treatment of primary malignancy

- 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.

Malignancy vs History

- When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.
  - Default on the side of coding the cancer unless you know that the cancer is eradicated.

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
- And so on...

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') (overlapping sites of eye and adnexa), unless the combination is specifically indexed elsewhere (colon with rectum-C19).
- 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.
  - Cancer NOS
  - Malignancy NOS
- 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.
- Example weakness

Neoplasm Related Pain

- Code G89.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic.
- Malignant or benign
- May be primary (but not in hospice)

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.
- See the ‘code also’ note at M84.5

Neoplasm Example

- Patient with history of prostate cancer has mets to the right femur and severe pain as a result. Getting up from the chair, he heard a pop. He has a pathological fx related to the mets 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. (For hospice, add mets to lungs.)
Neoplasm Answers

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

Complications Associated with a Neoplasm

- When an encounter is for management of a complication associated with a neoplasm, such as dehydration, and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm.
- **Exception:** Anemia

Example

- Patient admitted for management of anemia due to cancer. Anemia is the focus of care.

  - Guideline: With anemia due to cancer, the cancer is coded first even if the anemia is the focus of care
    - Malignant neoplasm is coded first, then:
      - D63.0 Anemia in neoplastic disease

Example

- Patient has anemia due to chemotherapy.
- Treatment for the anemia? Or the cancer?
- **Guideline:** When the admission is for management of an anemia associated with an adverse effect of the administration of 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...
  - D64.81 Anemia due to antineoplastic therapy
  - T45.1x5D Adverse effect of antineoplastic drugs
  - Cancer
Complications Associated with a Neoplasm

- When an encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of the neoplasm, designate the complication as the principal/first-listed diagnosis.
  - Then code the neoplasm, if not resolved
  - History of neoplasm should be coded if resolved.

Code these...

- Squamous cell carcinoma of right ear
  - C44.222
- Patient with emphysema has history of lung ca and pneumonectomy of left lung in 2009 with continued smoking (cigarettes).
  - J43.9 Emphysema
  - Z85.118 History of lung ca
  - Z90.2 Acquired absence of lung
  - F17.210, Nicotine dependence, cigarettes, uncomplicated
- Mets to R kidney, unknown primary

Answers

- Squamous cell carcinoma of right ear
  - C44.222
- Patient with emphysema has history of lung ca and pneumonectomy of left lung with continued smoking
  - J43.9 Emphysema
  - Z85.118 History of lung ca
  - Z90.2 Acquired absence of lung
  - F17.210, Nicotine dependence, cigarettes, uncomplicated
- Mets to R kidney, unknown primary
  - C79.01
  - C80.1

Z Codes

- Z85.- for personal history
  - Also history, personal, benign neoplasm (Z86) and History, personal, in situ neoplasm (Z86)
- Z48.3 Aftercare, following surgery, neoplasm
  - Is the neoplasm resolved after the surgery?
    - If resolved, do not code the neoplasm as current diagnosis.
    - If not resolved or unknown at that time, continue to code the neoplasm.
  - Is aftercare the focus or the neoplasm the focus?
More Z Codes

- Surgical removal—Absence (partial, complete)
- Tobacco Use Z72.0 (only when the documentation specifies that the patient has an associated problem)
- Tobacco Dependence or smoker—Dependence, drug, nicotine (F17.21-)
  - ‘With other nicotine-induced disorder’ is used only if the physician links the condition to the smoking
- SERMs Z79.81-

Practice

- Patient with HF has a history of right breast cancer after a mastectomy and is taking Femara. She is on hold for reconstructive surgery until her HF symptoms have resolved.
- I50.9 Heart failure, unspecified
- Z79.811 Long term use of aromatase inhibitors
- Z85.3 Personal history of malignant neoplasm breast
- Z90.11 Acquired absence of right breast and nipple

Prophylactic Organ Removal

- For encounters specifically for prophylactic removal of an organ (such as prophylactic removal of breasts due to a genetic susceptibility to cancer or a family history of cancer), the principal or first-listed code should be a code from category Z40, Encounter for prophylactic surgery, followed by the appropriate codes to identify the associated risk factor (such as genetic susceptibility or family history).
- Query: Does this count as aftercare?

Prophylactic Organ Removal

- If the patient has a malignancy of one site and is having prophylactic removal at another site to prevent either a new primary malignancy or metastatic disease, a code for the malignancy should also be assigned in addition to a code from subcategory Z40.0, Encounter for prophylactic surgery for risk factors related to malignant neoplasms. A Z40.0 code should not be assigned if the patient is having organ removal for treatment of a malignancy, such as the removal of the testes for the treatment of prostate cancer.
Practice

- The patient was admitted to home care after mastectomy of right breast for cancer. The left breast was removed prophylactically because of genetic susceptibility. She will continue chemotherapy. Aftercare is the focus of care with dressing changes.

Malignant Neoplasm of Transplanted Organ

- A malignant neoplasm of a transplanted organ should be coded as a transplant complication. Assign first the appropriate code from category T86.-, Complications of transplanted organs and tissue, followed by code C80.2, Malignant neoplasm associated with transplanted organ. Use an additional code for the specific malignancy.

Answers

- The patient was admitted to home care after mastectomy of right breast for cancer. The left breast was removed prophylactically because of genetic susceptibility. She will continue chemotherapy and radiation. Aftercare is the focus of care with dressing changes.
- Z48.3 Aftercare following surgery for neoplasm
- C50.911 Malignant neoplasm right female breast
- Z40.01 Encounter for prophylactic removal of breast
- Z15.01 Susceptibility to malignant neoplasm of breast
- Z48.01 Surgical dressing changes

Chapter 1 Guidelines

A, B Infectious/Parasitic Diseases
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. (No separate code)

Example of Sepsis vs Septicemia

- Sepsis from Strep pneumoniae
  - A40.3 Sepsis due to Strep pneumoniae

- Septicemia from Strep pneumoniae
  - A40.3

  Index directs to A41.9 ( Septicemia NOS)

Sepsis

- Becoming more common in home care
- Sepsis
- Septicemia
- Severe sepsis
- Sepsis from a localized infection
- Postprocedural sepsis

Coding Sepsis

- ‘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).
Sepsis with localized infection

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

Severe Sepsis

- If a patient has sepsis and an acute organ dysfunction or multiple organ dysfunction, follow the instructions for coding severe sepsis.

- Minimum of two (three) codes
  - Underlying systemic infection
  - Code from subcategory R65.2-
  - Additional code for the associated organ dysfunction.

7th Character A

- 7th character “A”, initial encounter is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a different physician

  Additional examples of “initial” encounter (examples of active treatment)
  - Antibiotic therapy for postoperative infection
  - Wound vac treatment of wound dehiscence
  - Side note: NO Z code for wound vac!!!
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.

- Patient with postprocedural sepsis related to infected surgical wound caused by MRSA.
  - T81.4xxA Post-op infection
  - A41.02 MRSA sepsis

Postprocedural Sepsis

- Postprocedural infection is sequenced first instead of the sepsis code.
- Infection of central line with staph sepsis
  - T80.211A Bloodstream infection due to central venous catheter
  - A41.2 Sepsis due to unspecified Staph

Notice the different sequencing

HIV

- Code only confirmed cases.
- Principal diagnosis—B20 followed by related diagnoses (problem in Texas)
  - Use additional code(s) to identify all manifestations of HIV infection.
- If reason for admission not related to HIV, code HIV and related diagnoses as secondary.
- Patient with any known prior diagnosis of an HIV-related illness should be coded to B20 (even if the manifestation is resolved).

Examples

- Patient admitted for care for Kaposi’s sarcoma of the skin related to HIV.
  - B20 HIV
  - C46.0 Kaposi’s sarcoma of skin
- Patient admitted for CHF. Also has history of blurred vision (now resolved) related to HIV.
  - I50.9
  - B20
Asymptomatic HIV

Z21 is code for asymptomatic HIV (no symptoms, no AIDS, no treatment for any condition for HIV-related illness).

Sepsis

- The patient has a bloodstream infection related to a central line that has resulted in sepsis by Staph aureus (IV antibiotics). The correct coding is:
  a. A41.01, T80.219D
  b. T80.211A, A41.01
  c. T80.219A, A41.01
  d. A41.01, T80.211D

Code these...

- Chronic Pulmonary Histoplasmosis (capsulati) and associated AIDS
- Strep sepsis with acute kidney failure

Code these...

- Chronic Pulmonary Histoplasmosis and associated AIDS
  - B20 HIV
  - B39.1 chronic pulmonary histoplasmosis
- Strep sepsis with acute kidney failure
  - A40.9 Streptococcal sepsis, unspecified
  - R65.20 SIRS (severe) without septic shock
  - N17.9 Acute kidney failure, unspecified
**Another Scenario!**

- Patient admitted to hospice with a terminal diagnosis of sepsis with acute respiratory failure due to proteus mirabilis and pseudomonas aeruginosa. He also has diagnoses of aspiration pneumonia and COPD.

**Scenario Answer**

- A41.52 Sepsis due to pseudomonas
- A41.59 Other Gram-negative sepsis
- R65.20 Severe sepsis without septic shock
- J96.00 Acute respiratory failure
- J69.0 Aspiration pneumonia
- J44.9 COPD unspecified

**Coding Rationale**

- Sepsis with acute organ failure is coded as “severe” sepsis; sequence the A41.- code first, followed by R65.- to indicate severe sepsis, then the code to identify the associated organ failure.
- Pneumonia is an inflammation/swelling in lung tissue, can be caused by bacteria, virus or aspiration of foreign substance (like food/liquid). One of the complications of aspiration pneumonia is a secondary bacterial infection, so aspiration pneumonia itself isn’t always a lower respiratory infection – so don’t code with the J44.0 code for the COPD. Use J44.9 since not documented as exacerbated.

**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 Staphylococcus aureus and compare the A codes to the B codes. Compare A41.01 to B95.61
  - DO NOT USE A49 codes!
## B Simplified

- 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 Post-op infection
  - B95.61 S. aureus (as organism causing localized infection)

## Examples

- Staphylococcal boil on the right cheek
  - L02.02 Furuncle of face
  - B95.8 Staph unspecified
- Acute cystitis with E. coli
  - N30.00 Acute cystitis
  - B96.20 E. coli, unspecified

## Combination Codes

- West Nile Virus (virus)
  - A92.30
- Viral meningitis (meningitis)
  - A87.9
- Postmeasles pneumonia (pneumonia)
  - B05.2
- CMV hepatitis (hepatitis)
  - B25.1

## Infections resistant to antibiotics

- Many bacterial infections are resistant to current antibiotics. It is necessary to identify all infections documented as antibiotic resistant.
- The convention 'Use additional code to identify resistance to antimicrobial drugs (Z16.-)' is located at the beginning of the chapter and applies to the entire chapter. The only exception is MRSA.
MRSA—combination codes that indicate the bacteria (SA) and the resistance (and even sometimes the actual condition, e.g., pneumonia, sepsis.

- Assign a code from category Z16, Resistance to antimicrobial drugs, following the infection code only if the infection code does not identify drug resistance.
  - Example: MRSA doesn’t use a Z16 code
- Look up resistance, vancomycin

When a patient is diagnosed with an infection that is due to methicillin resistant Staph aureus and that infection has a combo code that includes the causal organism, assign the appropriate combo code for the condition.

- If a combo code is appropriate, do not use B95.62 (identifies organism in local infection).
- Do not assign a code from Z16.11 (Resistance to penicillins) to MRSA.

MRSA

- Code these!
  - Sepsis due to MRSA __________
  - Pneumonia due to MRSA __________
  - Colonization by MRSA __________
- Colonization = MRSA screen positive or MRSA nasal swab positive but no active infection (can have active infection at same time)

Answers!

- Sepsis due to MRSA A41.02
- Pneumonia due to MRSA J15.212
- Colonization by MRSA Z22.322
MRSA

Not all are combination codes—use the B code.
- Pt admitted with MRSA UTI.
  - N39.0 UTI, unspecified
  - B95.62 MRSA

Multiple Resistance

Patient admitted with infected surgical wound cultured Staph aureus resistant to penicillins and cephalosporins.
- T81.4xxA infected surgical wound
- B95.62 MRSA
- Z16.19 Resistance to specified beta lactam antibiotics

F--Mental, Behavioral and Neurodevelopmental Disorders

Dementia

DSM V – Replaced “dementia” with Major Neurocognitive Disorder
- Major neurocognitive disorder without behavioral disturbance (inclusion note)
- Major neurocognitive disorder with behavioral disturbance (inclusion note)
F01-F09-Mental Disorders due to known physiological reasons

- Disorders that have an etiology in cerebral dysfunction (cerebral disease or injury)
- Can be primary or secondary
  - If there is a ‘code first’ note then these conditions must be coded secondary.

Vascular dementia (F01.5-)

- Being rejected as a primary diagnosis in HH and hospice.
- Occurs as a result of infarction of the brain due to vascular disease, including hypertensive vascular disease.
- Autoregulation may be lost in individuals with severe hypertensive arteriosclerotic vascular disease, abrupt lowering of blood pressure may lead to infarct.

Let’s look at the conventions.
- Code first the underlying physiological condition or sequelae of cerebrovascular disease. (ICD-10)

Vascular Dementia

Sudden post-stroke changes in thinking and perception may include:
- Confusion
- Disorientation
- Trouble speaking or understanding speech
- Vision loss
- Changes in a “ladder” fashion

Dementia, unspecified F03.9-

- Senile and presenile dementia are classified as dementia, unspecified in ICD-10-CM (F03.90)
- Senile—65 and older
- Presenile—Under the age of 65
- Sometimes documented as ‘senile dementia of the Alzheimers type’
F03.9- Unspecified Dementia

- Includes:
  - Presenile dementia, NOS
  - Presenile psychosis, NOS
  - Primary degenerative dementia, NOS
  - Senile dementia, NOS
  - Senile dementia depressed or paranoid type
  - Senile psychosis, NOS

Senile Dementia

Senile dementia is actually a group of several different diseases.
- Alzheimer's disease,
- Vascular dementia,
- Parkinson's disease, and
- Lewy body disease.

F02.8-Dementia in other diseases classified Elsewhere

- Code first the underlying physiological condition
- **F02.80 Without behavioral disturbances**
- **F02.81- with behavioral disturbances**

- This code is a manifestation code and REQUIRES an etiology code

Fixes and Additions at F02

- **Code first**
  - dementia with Parkinsonism (G31.83)
  - Huntington's disease (G10)
  - prion disease (A81.9)
  - traumatic brain injury (S06.-)

- Delete **Excludes1:**
  - dementia with Parkinsonism (G31.83)

This is gone.

By the way
Alzheimers G30.-/F02.8-
- Commonest form of dementia.
- Brain atrophies and abnormal proteins, called amyloid, accumulate in the brain substance, in the form of senile plaques.
- Abnormal filaments appear in the brain cells called neurofibrillary tangles.
- Gradual deterioration

Parkinson’s Dementia G20/F02.8-
- Brain changes begin in a region that plays a key role in movement.
- As brain changes gradually spread, they often begin to affect mental functions, including memory and the ability to pay attention, make sound judgments and plan the steps needed to complete a task.
- Abnormal microscopic deposits called “Lewy bodies” composed chiefly of alpha-synuclein, a protein that’s found widely in the brain but whose normal function isn't yet known.

Lewy Body Dementia G31.83 / F02.8-
- Also called Parkinsonism dementia or Dementia with Lewy bodies
- Third most common cause of dementia after Alzheimers disease and vascular dementia, accounting for 10 to 25 percent of cases.

Huntington’s Disease G10 / F02.8-
- Progressive brain disorder caused by a single defective gene on chromosome 4
- Defective huntingtin protein leads to brain changes that cause abnormal involuntary movements, a severe decline in thinking and reasoning skills, and irritability, depression and other mood changes.
- Anxiety, and uncharacteristic anger and irritability.
- Another common symptom is obsessive-compulsive behavior, leading a person to repeat the same question or activity over and over.
So what’s the key???

- Cannot accept “dementia” as a terminal diagnosis.
- Cannot accept senile dementia or vascular dementia as a primary diagnosis. What caused the condition?
- Remember that Alzheimer’s is the most common. Should you ask?
- Parkinson’s vs Parkinsonism

Code these Diagnostic Statements

- Early onset Alzheimer’s dementia with wandering.
- Dementia post CVA and uncontrolled hypertension

Diagnostic Statements

- Early onset Alzheimer’s dementia with wandering
- G30.0 Alzheimer’s disease early onset,
- F02.81 Dementia, with behaviors
- Z91.83 Wandering, in diseases classified elsewhere

Diagnostic Statements

- Dementia post CVA
- I69.31 Cognitive deficits following cerebral infarction
- F01.50 vascular dementia
- I10 Hypertension
Psychoactive Substance Use

- 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.
- EXCEPTION: Smoker!!! Alcoholic, alcoholism

Other New Terms

- Mild neurocognitive disorder describes a level of cognitive decline that requires compensatory strategies and accommodations to help maintain independence and perform activities of daily living. To be diagnosed with this disorder, there must be changes that impact cognitive functioning.
- In the later stages of dementia, a person gets details mixed up and sometimes fabricates things from fragmented memories. In the field of Psychiatry there is a name for this mental process called "confabulation", which is defined as: Filling in memory gaps with a falsification that a person believes to be true.
- Amnestic disorders cause discreet memory impairment without any symptoms of other cognitive disorders. The exact causes of these disorders are not known, but much has been learned over the years about treatment for them. Symptoms include memory problems - both old memories and the ability to form new memories.

Alcohol (Inclusion Notes)

- F10.10 Alcohol abuse, uncomplicated
  - Alcohol use disorder, mild
- F10.14 Alcohol abuse with alcohol-induced mood disorder
  - Alcohol use disorder, mild, with alcohol-induced bipolar or related disorder
  - Alcohol use disorder, mild, with alcohol-induced depressive disorder
- F10.20 Alcohol dependence, uncomplicated
  - Alcohol use disorder, (moderate)
  - Alcohol use disorder, severe
- F10.26 Alcohol dependence with alcohol-induced persisting amnestic disorder
  - Alcohol use disorder, moderate, with alcohol-induced major neurocognitive disorder, amnestic-confabulatory type
  - Alcohol use disorder, severe, with alcohol-induced major neurocognitive disorder, amnestic-confabulatory type
- F10.27 Alcohol dependence with alcohol-induced persisting dementia
  - Alcohol use disorder, moderate, with alcohol-induced major neurocognitive disorder, nonamnestic-confabulatory type
  - Alcohol use disorder, severe, with alcohol-induced major neurocognitive disorder, nonamnestic-confabulatory type
Use Disorder—Mild, Moderate, Severe

- Will see the same changes with
  - F11 Opiate use disorder
  - F12 Cannabis
  - F13 Sedatives
  - F14 Cocaine
  - F15 Other stimulants
  - F16 Hallucinogen
  - F17 Tobacco
  - F18 Inhalant
  - F19 Other Psychoactive Substance

Mild Use = Abuse
Moderate or Severe Use = Dependence
(Guideline did not change.)

Diagnostic statements

- Patient with emphysema related to 3ppd x 30 years.
  - J43.9 emphysema
  - F17.218 Nicotine dependence with induced disorder

- Exacerbation of persistent moderate asthma due to parents smoking e-cigarettes.
  - J45.41 Moderate persistent asthma with acute exacerbation
  - Z77.29, Contact with and (suspected) exposure to other hazardous substances

Diagnostic Statements

- Chronic alcohol abuse with dependence
  - F10.20 Alcohol dependence, uncomplicated

- Mild cannabis use with cannabis-induced anxiety disorder.
  - F12.180

Code the Following Diagnostic Statements

- Bipolar disorder, moderate manic episode

- Mild recurrent major depressive disorder
Answers

- Bipolar disorder, moderate manic episode
  F31.12
- Mild recurrent major depressive disorder
  F33.0

Pseudobulbar affect-F48.2

- An example of convention vs guideline
- Code first underlying cause, if known, such as
  □ ALS (G12.21)
  □ MS (G35)
  □ Sequelae of cerebrovascular disease (I69.-)
  □ Sequelae of traumatic intracranial injury (S06.-)

Neurological disorder characterized by involuntary crying or uncontrollable episodes of crying and/or laughing or other emotional displays.

Sequela: The Guideline

A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. (THE ORIGINAL INJURY HAS HEALED OR ORIGINAL ILLNESS IS RESOLVED BUT SOMETHING IS LEFT OVER.)

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.

Sequela Paraphrased

- General Rule: Code what you see first (condition or nature of the sequela) and the sequela code (original injury with an S or original illness sequela code, e.g. polio B91) comes later.
  □ G81.11 Spastic hemiplegia affecting right dominant side
  □ S06.5x9S Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, sequela

- What do you see when you reference sequela, injury?
**The Guideline**

- 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.
- Code the sequela code first when what you ‘see’ cannot go first (manifestation code).
  - E64.3 Sequela of rickets
  - M49.82 Spondylopathy in diseases classified elsewhere

**Examples**

- Patient has muscle atrophy of the right lower leg from polio he had as a child in the 1950s.
  - What goes first?
  - How is the sequela of polio found in the index?
  - Read the code first note and the other informational note.
  - Code it:

**The Guidelines**

- 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.
- Sequelae of cerebrovascular accidents
  - I69.351 Hemiplegia/hemiparesis right dominant side…

**Examples**

- Facial weakness after a cerebral infarction
  - Sequela, infarction, cerebral, facial weakness
  - How many codes are required?
Example Exception

- The manifestation examples are not common, but...
- Coma as a result of a subdural hemorrhage. (Injury, intracranial)
- General Rule: *What do you see? And then the sequela comes later.*
- *Except that: What appears at R40.2?*

Answers

- M62.561 Muscle wasting and atrophy, NEC, right lower leg
- B91 Sequela of poliomyelitis
- I69.392 Facial weakness following cerebral infarction
- S06.5x9S Traumatic subdural hemorrhage NOS, sequela
- R40.20 unspecified coma

General Guidelines

- Hemiplegia/hemiparesis/Monoplegia/Monoparesis
  - When right or left is specified but dominant side is not specified
    - Default to dominant for the ambidextrous patient
    - Left side defaults to non-dominant
    - Right side defaults to dominant
Scenario

Mr. Johnson is admitted to home health for IV antibiotics to treat an extradural intraspinal abscess due to MRSA. He is ordered 6 weeks of bid IV antibiotics.

- G06.1 Intraspinal Abscess
- B95.62 MRSA
- Z45.2 Encounter for adjustment and management of vascular access device
- Z79.2 Long Term (current) use of antibiotics

Scenario continued

- Mr. Johnson is an incomplete quadriplegic due to the intraspinal abscess (now resolved) at C5-6. He is receiving therapy and requires care to his suprapubic catheter with cellulitis with MRSA.

Scenario answered

- Mr. Johnson is an incomplete quadriplegic due to the intraspinal abscess (now resolved) at C5-6. He is receiving therapy and requires care to his suprapubic catheter with cellulitis with MRSA.
- G82.54 Quadriplegia C5-C7 Incomplete
- G09 Sequelae of inflammatory diseases of CNS
- N99.511 Cystostomy infection
- L03.311 Cellulitis of abdominal wall
- B95.62 MRSA

Multiple Sclerosis-G35

Mr. Parker is referred to home health due to increased weakness in his legs related to MS. He is no longer able to transfer to toilet or bath without assistance. Nursing must provide catheterization for neurogenic bladder.

- G35 Multiple Sclerosis
- N31.9 Neurogenic Bladder
- Z46.6 Encounter for fitting/adjustment of urinary device
Mr. Jones has new onset seizures and is admitted to home health for instruction, assessment and monitoring of anticonvulsants. His H&P states that he has idiopathic general epilepsy. His medication is still being monitored and adjusted because he continues to have seizures. ‘Pharmacoresistant’ is documented.

G40.319 Generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus

What does intractable mean?

G60-65- Polyneuropathies and other disorders of the PNS

• Includes neuropathies, polyneuropathies and other disorders.
• Causes of neuropathic conditions must be determined
  ▪ Hereditary
  ▪ Idiopathic
  ▪ Drug induced
  ▪ Inflammatory
• Do not code these when caused by diabetes! See G63

Mr. Squire is admitted to home health for PT/OT related to flaccid hemiplegia of his left side. The coder has reviewed his record and no documentation reports the side of dominance or the cause of the hemiplegia. He is wheelchair bound.

G81.04 Flaccid hemiplegia of the left nondominant side

Z99.3 Dependence on wheelchair
<table>
<thead>
<tr>
<th>Importance of Assessment and Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Which side is dominant?</td>
</tr>
<tr>
<td>- If the patient is right sided dominant and</td>
</tr>
</tbody>
</table>
  the hemiplegia has affected his right side |
  then that is more significant than if he |
  was left sided dominant.                    |
| - Document the side affected and dominance  |
| - Hemiparesis = one-sided weakness          |
| - Flaccid or spastic hemiplegia?            |

<table>
<thead>
<tr>
<th>Paraplegia G82.2-</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Could be congenital…Q</td>
</tr>
<tr>
<td>- Could be injury, tumor, etc</td>
</tr>
<tr>
<td>- Issues</td>
</tr>
<tr>
<td>- Choices</td>
</tr>
<tr>
<td>- Unspecified (Being rejected by some payors)</td>
</tr>
<tr>
<td>- Complete</td>
</tr>
<tr>
<td>- Incomplete</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quadriplegia G82.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Unspecified  G82.50 (being rejected by some payors)</td>
</tr>
<tr>
<td>- C1-4 Complete</td>
</tr>
<tr>
<td>- C1-4 Incomplete</td>
</tr>
<tr>
<td>- C5-7 Complete</td>
</tr>
<tr>
<td>- C5-7 Incomplete</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Paraplegia and Quadriplegia</th>
</tr>
</thead>
<tbody>
<tr>
<td>- If the paralysis, paresis is the result of a spinal cord injury, it should be coded as a sequela of that injury</td>
</tr>
<tr>
<td>- For example</td>
</tr>
<tr>
<td>- G82.52 C1-4 incomplete</td>
</tr>
<tr>
<td>- S14.154(\circ) incomplete lesion C4 level, sequela</td>
</tr>
<tr>
<td>- (Add the fracture if applicable)</td>
</tr>
</tbody>
</table>
Pain Codes G89
General Guidelines

- Provide more specific info on pain in a patient when the POC is addressing pain management
  - Should be specified as Acute, Chronic, Post-Thoracotomy, Post-Procedural, or Neoplasm-related
- DO NOT assign when an underlying cause of the pain is known (i.e., a more specific, definitive dx like osteoarthritis)
- Assign when nature of pain is not part of the definitive diagnosis, i.e., acute, chronic.

Example

Mr. Smith is admitted to the agency for therapy (PT & OT) to treat a decline in mobility related to primary osteoarthritis of the bilateral knees. He has pain daily that ranges from 2-7 in the joints.
  - Code only the osteoarthritis M17.0
  - The pain is related to the osteoarthritis condition—will not code the pain separately

More Pain Coding Specifics

- Pain codes (G89) may be used as primary when the focus of care
- Pain codes (G89) may be used in conjunction with site specific codes when the pain code provides greater detail
- Sequencing is dependent on focus of care
  - If Pain control is focus of care then G89 code is assigned first

Example

- Mrs. Smith fell off the porch and hurt her neck. PT and OT will treat her decreased mobility and SN will manage pain.
  - M54.2 pain in the neck
  - G89.11 Acute pain due to trauma
  - The pain code adds information regarding the nature and cause of the pain.
More Pain Coding Specifics

- Coding Chronic Pain (subcategory G89.2)
  - Time frame not defined, but physician must specify as “Chronic”
  - Chronic Pain Syndrome (G89.4) and Central Pain Syndrome (G89.0) require that the physician specify the syndrome.

- Coding Neoplasm-Related Pain

- Coding Postoperative Pain
  - Unusual postoperative pain
  - Default is acute when not specified
  - Used alone when NOT associated with a post-operative complication
  - If pain associated with a complication, assign the complication and the pain code, as appropriate, to identify acute or chronic pain.

Scenario

- Mrs. Williams has had a bilateral knee replacement performed 6 weeks ago. She is admitted to home health for therapy and pain management. Despite orders for Percocet, she reports ongoing pain in the joints replaced of 8-10 at all times, which impairs mobility. Physician documents pain due to the prosthesis.
  - T84.84xD (or A) Pain due to internal orthopedic prosthetic devices…
  - G89.18 Other acute post-procedural pain
  - Z96.653 Presence of Artificial Knee joint, bilateral
  - Use additional code to identify the specified condition resulting from the complication (found at the beginning of the complication codes above T80).

When Pain is a Complication

- T code is used first to report the complication
- Pain is post procedural and G code is used to provide additional information
  - Default to acute
- Must use a Z code to define the presence of joint replaced
  - With complication of joint replaced, Z code may still be used if complication code doesn’t identify the joint
Scenario

Christopher Columbus is referred to hospice with a terminal diagnosis of anoxic brain damage following an extended submersion when his sailboat overturned. He is in a persistent vegetative state and expected to live less than 1 month.

- G93.1 Anoxic brain damage
- R40.3 Persistent vegetative state
- V90.04xS Drowning and submersion due to sailboat overturning, sequelae

I--Diseases of the Circulatory System

Hypertension

- I10 Essential hypertension
- I11 Hypertensive heart disease
  - I11.0 with heart failure
  - I11.9 without heart failure
- I12 Hypertensive chronic kidney disease
  - I12.0 with stage 5 or ESRD
  - I12.9 with stage 1-4 or unspecified
- I13 Hypertensive heart and chronic kidney disease
  - I13.0-I13.2 Variety with or without heart failure and stage of CKD

Hypertension “with”

“With” is already in effect. Change in guideline just cemented the change.
How about this one? Hypertension

- The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term “with” in the Alphabetic Index.
- These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.
- For hypertension and conditions not specifically linked by relational terms such as “with,” “associated with” or “due to” in the classification, provider documentation must link the conditions in order to code them as related.

And this...

- The same heart conditions (I50.-, I51.4-I51.9) with hypertension are coded separately if the provider has specifically documented a different cause.
- 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. CKD should not be coded as hypertensive if the physician has specifically documented a different cause.
- Example: CKD due to PKD

Compare

The Guideline forever before
- 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).

2017 Guideline (Oct 1 2016)
- The classification presumes a causal relationship between hypertension and heart involvement …, as the two conditions are linked by the term “with” in the Alphabetic Index.

Still there in the guidelines

Chronic kidney disease with other conditions
- Patients with CKD may also suffer from other serious conditions, most commonly diabetes mellitus and hypertension. The sequencing of the CKD code in relationship to codes for other contributing conditions is based on the conventions in the Tabular List.
Examples

- The patient has diabetes, HTN and CKD
  - I11.22, I12.9, N18.9 OR
  - I12.9, E11.22, N18.9
- The patient has diabetes, HTN, heart failure and CKD
  - I11.22, I13.0, I50.9, N18.9 OR
  - I13.0, E11.22, I50.9, N18.9 OR maybe
  - I13.0, I50.9, E11.22, N18.9

I16 Hypertensive Crisis

- Code also any identified hypertensive disease (I10-I15)
- I16.0 Hypertensive urgency - A systolic blood pressure greater than 180 or a diastolic pressure greater than 110, without associated progressive organ dysfunction. There may be associated severe headache, shortness of breath, nosebleeds, or severe anxiety.
- I16.1 Hypertensive emergency occurs when blood pressure reaches levels that lead to impending or progressive organ damage. This usually involves blood pressure levels exceeding 180 systolic or 120 diastolic, but it can occur at even lower levels in patients whose blood pressure had not been previously high. Some potential consequences of uncontrolled blood pressure in this range include stroke, loss of consciousness, memory loss, acute myocardial infarction or angina, aortic dissection, damage to the eyes and kidneys, and pulmonary edema.
- I16.9 Hypertensive crisis, unspecified

Hypertensive Crisis Guideline

- Assign a code from category I16, Hypertensive crisis, for documented hypertensive urgency, hypertensive emergency or unspecified hypertensive crisis. Code also any identified hypertensive disease (I10-I15). The sequencing is based on the reason for the encounter.

General Guidelines Hypertensive Heart Disease

- Heart conditions classified to I50.- or I51.4-I51.9 are assigned to a code from I11 when a causal relationship is STATED or IMPLIED
  - Physician MUST state or imply relationship
  - I51.4-I51.9 are included however use an additional code for heart failure, if present.
  - Specific sequencing required
- For patients who do NOT have a stated or implied relationship between the same heart conditions (I50-, I51.4-I51.9) and hypertension, the conditions are coded separately (no specific sequencing required with hypertension and the heart disease)
  - I10 Essential Hypertension OR
  - I12.- Hypertensive Chronic Kidney Disease (if CKD present)
**General Guidelines**

**Hypertensive Chronic Kidney Disease**

- May assume a relationship between hypertension and chronic kidney disease
- Code to I12.-
  - Stage 5 or ESRD with hypertension I12.0
  - Stage 1-4 or unspecified CKD with hypertension I12.9
  - Specific sequencing required with CKD

**General Guidelines**

**Hypertensive Heart and CKD**

- I13—combination code when hypertensive heart disease is verified when the patient has I50.- or I51.4 – I51.9 (I11) and the patient also has CKD (I12).
  - Use additional code for heart failure when present.
  - Use additional code for CKD.

**Name that category**

- Hypertension and ESRD I10
- Hypertension and CHF I11
- Systolic heart failure due to hypertension I12
- Malignant hypertension I12
- Patient has CKD and hypertensive cardiomegaly I13

**Name that category**

- Hypertension and ESRD I10
- Hypertension and CHF I11
- Systolic heart failure due to hypertension I12
- Malignant hypertension I12
- Patient has CKD and hypertensive cardiomegaly I13
### Answers

- Hypertension and ESRD I12.0, N18.6
- Hypertension and CHF I11.0, I50.9
- Systolic heart failure due to hypertension I11.0, I50.20
- Malignant hypertension I10
- Patient has CKD and hypertensive cardiomegaly I13.10, N18.9

### I20-25: Ischemic heart disease

- I20 Angina (by itself)
- I21 – I22 MI
- Post infarction angina (I23) is considered a complication (specifically documented)
  - I23.7 and I25.118 if CAD is also documented (CC 2nd q 2015)
- I25 Chronic ischemic heart disease
  - ASHD/CAD

### Angina

- In the presence of CAD, code to I25.--; alone code to I20
- Mr. Parker is referred to home health due to increased recurrent chest pain related to angina and increased use of nitroglycerine tablets. He has a comorbid diagnosis of hypertension.
  - I20.9 Angina pectoris, unspecified
  - I10 Hypertension

### Angina

Mr. Kinsey has new onset chest pain with pre-existing diagnosed CAD and hypertension.

I25.119 Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris

I10 Hypertension
MI I21 vs. I22

- Initial MI coded to I21 for 4 weeks
- Any subsequent MI within the same 4 weeks is coded to I22
  - Sequencing
  - Site is more important than STEMI/non-STEMI
  - Care setting does not change code
- Old MIs not requiring further care— I25.2

Questions and Notables

- I21.3 is default for initial MI when location is not provided
- Only one code for NSTEMI but if location is known, code to location.
- I22.9 is default for subsequent MI when location is not provided.
- What to do after 4 weeks??? Referred to EAB.
  - I25.5 has been suggested if CAD is not documented.

STEMI vs non-STEMI

- NSTEMI account for about 30% and STEMI about 70% of all myocardial infarction.
- NSTEMI occurs by developing a complete occlusion of a minor coronary artery or a partial occlusion of a major coronary artery previously affected by atherosclerosis. This causes a partial thickness myocardial infarction (partial thickness damage of heart muscle).
- STEMI occurs by developing a complete occlusion of a major coronary artery previously affected by atherosclerosis. This causes a transmural myocardial infarction (full thickness damage of heart muscle).

STEMI vs non-STEMI

- NSTEMI does not show ST segment elevation in ECG (due to partial thickness damage of heart muscle) and later does not progress to a Q-wave. For this reason, it is also called a non–Q-wave myocardial infarction (NQMI). On the other hand, STEMI shows ST segment elevation in ECG (due to full thickness damage of heart muscle) and later progress to a Q-wave myocardial infarction (QWMI).
- Cardiac markers including CK-MB (creatine kinase myocardial band), troponin I and troponin T, all elevate both in cases. But the elevation of these markers is often mild in NSTEMI compared with STEMI.
**I25 CAD / ASHD**

- No unspecified choice for coronary arteries
- Assume the native coronary arteries are involved unless the physician documents something extra
  - Do NOT use I25.7- just because there has been a CABG in the past.

**Scenario**

- Mrs. Haveaheart is referred to home care after a STEMI involving the LAD coronary artery and subsequent CABG. CAD is documented. She also has atrial fibrillation and hypertension.

**Scenario coded**

- Z48.812 Aftercare following surgery on the circulatory system
- I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris
- I21.02 STEMI involving left anterior descending coronary artery
- I10 Hypertension
- I48.91 Unspecified atrial fibrillation
- Z95.1 aortocoronary bypass status

**Scenario**

- Mrs Sepulveda is admitted to home health for nursing and therapy following a Non-ST elevation Myocardial Infarction (NSTEMI) occurring 3 weeks prior to admission. The patient has a longstanding history of coronary atherosclerosis and angina but no coronary bypass surgery. She had angioplasty with stent.

- MIs are sequenced prior to ASHD when admitted for the MI.
Mrs Sepulveda is admitted to home health for nursing and therapy following a Non-ST elevation Myocardial Infarction (NSTEMI) occurring 3 weeks prior to admission. The patient has a longstanding history of coronary atherosclerosis and angina but no coronary bypass surgery. She had angioplasty with stent in day surgery yesterday.

Z48.812 Aftercare surgery circulatory
I25.119 Atherosclerosis with Angina
I21.4 NSTEMI
Z95.5 Presence of coronary angioplasty implant and graft

- Includes Cardiomyopathy, acute pericarditis, acute endocarditis, Atrial fibrillation and flutter, and Heart Failures.
- Heart Failure should be coded to greatest specificity. Include all reported types of heart failure

Note ‘code first’ notes

Pleural effusion is coded in addition to heart failure when it requires separate treatment (2d Q 2015)

- HFrEF, heart failure with low ejection fraction, or heart failure with reduced systolic function = systolic heart failure

- HFpEF, heart failure with preserved systolic function = diastolic heart failure

Mrs. Portland is admitted for acute on chronic combined heart failure. She has recurrent pleural effusions, had 1.2 liters of fluid removed in a pleural tap, refuses to have any further taps or chest tubes. Other dx of a STEMI of the LADA 5 weeks ago, chronic respiratory failure with hypoxia, and CAD with unstable angina. She is on O2.
### Cardiovascular Answer

- I50.43 Acute on chronic combined HF
- J91.8 Pleural effusion in conditions classified elsewhere
- J96.11 Chronic respiratory failure with hypoxia
- I25.110 CAD with unstable angina
- Z99.81 Dependence on oxygen
- What about I25.2?

### I60-69: Cerebral Vascular Diseases

- 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.

### I60-69: Cerebral Vascular Diseases

- Hemiplegia/hemiparesis/Monoplegia/Monoparesis
  - When left or right is documented but dominant side is not specified
    - Default to dominant for the ambidextrous patient
    - Left side defaults to non-dominant
    - Right side defaults to dominant

### I60-69: Cerebral Vascular Diseases

- Codes from category I69 may be assigned on a health care record with codes from I60-I67, if the patient has a current cerebrovascular disease and deficits from an old cerebrovascular disease.
- Do not mix I69 codes with codes I60-I67 on the claim.
I60-69: Cerebral Vascular Diseases

- Codes from category I69 should not be assigned if the patient does not have neurologic deficits.
- Use Z86.73 for history without deficits

Scenario

- Mr. Jacques is referred for Hospice with a new diagnosis of occlusion (no infarct) of bilateral carotid arteries and vascular dementia which has resulted in functional decline and lack of oral intake (what does that mean?). Terminal diagnosis is listed as vascular dementia.
- I65.23 Occlusion and stenosis of bilateral carotid arteries
- F01.50 Vascular Dementia
- R63.3 Feeding difficulties
- R63.0 Anorexia (lack of appetite)

Sequela of CVAs

NON-traumatic bleeds

- If CVA is from a subarachnoid hemorrhage (I60.- as inpatient, will be I69.0- in home health or hospice)
- If CVA is from a intracerebral hemorrhage (I61.- as inpatient, will be I69.1- in home health or hospice)
- If CVA is from an intracranial hemorrhage I62.- as inpatient, will be I69.2- in home health or hospice
- If NOT a bleed (most strokes are caused by a clot (I63.-), then:
- If just documented as a ‘stroke’—I69.3-

Just say no...

- Do NOT use I69.9-
- Reference ‘Sequela’ in the index
Scenario

- Mr. Jarvis was referred to home care after a stroke for right sided hemiplegia, dysphasia and cognitive changes.
- I69.351 Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
- I69.321 Dysphasia following cerebral infarction
- I69.31 Cognitive deficits following cerebral infarction

Changes to I69.31

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I69310</td>
<td>Add Attention and concentration deficit following cerebral infarction</td>
</tr>
<tr>
<td>I69311</td>
<td>Add Memory deficit following cerebral infarction</td>
</tr>
<tr>
<td>I69312</td>
<td>Add Visuospatial deficit and spatial neglect following cerebral infarction</td>
</tr>
<tr>
<td>I69313</td>
<td>Add Psychomotor deficit following cerebral infarction</td>
</tr>
<tr>
<td>I69314</td>
<td>Add Frontal lobe and executive function deficit following cerebral infarction</td>
</tr>
<tr>
<td>I69315</td>
<td>Add Cognitive social or emotional deficit following cerebral infarction</td>
</tr>
<tr>
<td>I69318</td>
<td>Add Other symptoms and signs involving cognitive functions following cerebral infarction</td>
</tr>
<tr>
<td>I69319</td>
<td>Add Unspecified symptoms and signs involving cognitive functions following cerebral infarction</td>
</tr>
</tbody>
</table>

Sequela of Strokes

- I69.3-
  - Which ones require more info?
  - Other paralytic syndrome
  - Dysphagia
  - Other sequelae
    - Seizures
    - Muscle weakness
    - Foot drop

I70-I79 Arterial

- PVD, PAD are arterial conditions
- Diabetic and also has PVD??
- Atherosclerosis of lower extremities
  - I70.2- for native arteries of lower extremities
### I80-I89 Veins, lymphatic vessels

- Conditions are acute unless physician specifies chronic
  - Acute embolism and thrombus (I82.4-) = DVT, NOS
  - Stasis ulcer
    - I87.2, L97.-
  - Esophageal varices
    - I85.0-, I85.1-

### Scenario

Mr. Lee is admitted to the home care for wound care due to atherosclerosis of the legs with multiple resulting ulcers of the bilateral lower legs on the bilateral ankles and lower calves. The referral from the wound center reports exposure of adipose tissue in all 4 ulcers. Nursing assessment confirms this.

### Scenario Coded

**Requires 8 Codes!!**

- I70.232 Atherosclerosis of the native arteries of the right calf with ulceration
- I70.233 Atherosclerosis of the native arteries of the right ankle with ulceration
- I70.242 Atherosclerosis of the native arteries of the left calf with ulceration
- I70.243 Atherosclerosis of the native arteries of the left ankle with ulceration

- L97.312 Non-pressure chronic ulcer of right ankle with fat layer exposed
- L97.322 Non-pressure chronic ulcer of left ankle with fat layer exposed
- L97.212 Non-pressure chronic ulcer of right calf with fat layer exposed
- L97.222 Non-pressure chronic ulcer of left calf with fat layer exposed
Sequencing these codes

- I70.232 Atherosclerosis of the native arteries of the right calf with ulceration
- L97.212 Non-pressure chronic ulcer of right calf with fat layer exposed
- I70.233 Atherosclerosis of the native arteries of the right ankle with ulceration
- L97.312 Non-pressure chronic ulcer of right ankle with fat layer exposed

Sequencing these codes

- I70.242 Atherosclerosis of the native arteries of the left calf with ulceration
- L97.222 Non-pressure chronic ulcer of left calf with fat layer exposed
- I70.243 Atherosclerosis of the native arteries of the left ankle with ulceration
- L97.322 Non-pressure chronic ulcer of left ankle with fat layer exposed

Venous stasis

- Patient has venous stasis disease.
  - I87.2 Venous insufficiency (chronic) (peripheral) stasis dermatitis moved here
- Patient has chronic venous hypertension with ulceration at right ankle (fatty tissue).
  - I87.311 Chronic venous HTN with ulcer of RLE
  - L97.312 Non-pressure chronic ulcer of right ankle with fat layer exposed

Venous stasis ulcers

- Occur due to improper functioning of venous valves, usually of the legs
- Major cause of chronic wounds, occurring in 70-90% of leg ulcer cases
- Medial distal leg, are usually “wet” wounds, and can be painful
- May have hemosiderin staining
Arterial Ulcers

- Also known as ischemic ulcers
- Mostly located on the lateral surface of the ankle or the distal digits
- Caused by lack of blood flow to the capillary beds of the lower extremities
- Characteristic deep, punched out look, often extending down to the tendons
- Very painful

S,T – Injuries (Fractures) and Poisoning

Things to Remember

- 7th character is not used in all ICD-10-CM chapters – Used in Musculoskeletal, Obstetrics, Injuries, External Causes chapters
  - Glaucoma, Gout and Coma
- Different meaning depending on section where it is being used (Go up to the box)
- Must always be used in the 7th character position
- When 7th character applies, codes missing 7th character are invalid

This chapter consists of:

- NO aftercare codes. There are NO aftercare codes for trauma injuries of any kind!!!!! Do not add z codes for dressing changes or suture removal, etc.
- Continue to code the injury until healed. 7th character will be determined by the type of care needed.
Application of 7th Characters in Chapter 19

- Most, BUT NOT ALL, categories in chapter 19 have a 7th character requirement for each applicable code.
- A = Initial encounter
- D = Subsequent encounter
- S = Sequela

Different 7th characters for fractures

Chapter 19 Guideline A vs D

- While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.
- Whether or not the patient is still receiving active treatment is key
- A = Initial encounter

7th Character A

- 7th character “A”, initial encounter is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a different physician.

Additional examples of “initial” encounter (examples of active treatment)
- Antibiotic therapy for postoperative infection
- Wound vac treatment of wound dehiscence
  - Side note: NO Z code for wound vac!!!
7th Character D

- 7th character “D” subsequent encounter is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.
- Examples of subsequent care are: cast change or removal, an x-ray to check healing status of fracture, removal of external or internal fixation device, medication adjustment, other aftercare and follow-up visits following treatment of the injury or condition.
- Home health is typically “aftercare”

7th Character D Examples

- Rehabilitative therapy encounters (e.g., physical therapy, occupational therapy)
- Suture removal
- Follow-up visits to assess healing status (regardless of whether the follow-up is with the same or a different provider)
- Dressing changes and other aftercare

7th Character S Examples

- Sequela (Late Effect): Residual effect (condition produced) arising as a direct result of an acute condition
- Scar formation after a burn
- Traumatic arthritis following previous gunshot wound
- Quadriplegia due to spinal cord injury
- Skin contractures due to previous burns
- Auricular chondritis due to previous burns
- Chronic respiratory failure following drug overdose

Complications of Injury Treatment

- Care for complications of surgical treatment of injuries during the healing or recovery phase should be coded with the appropriate complication codes.
- Instead of aftercare because the complication has been “fixed” code the complication with 7th character D
Each encounter (episode) stands alone

- Documentation for current encounter
  - Diagnoses current and relevant
  - Key to code selection is based on active treatment
- Documentation from previous encounter – May NOT be used to determine 7th character
  - Just because the previous episode was coded with an A in 7th character, does not necessarily mean the same 7th character will be used this time
- Key to code selection is based on active treatment

Home Health Care Examples

- Home health care services for continuation of IV antibiotics Use 7th character A
- Home care for routine dressing changes and care of healing wound
  - Postoperative wound infection previously treated in acute care hospitalization
  - No longer receiving antibiotics – T81.4XXD Infection following a procedure, subsequent encounter
  - No longer receiving active treatment
  - Now receiving routine care during healing and recovery phase

More examples from the Coding Clinic

Question
- A patient was diagnosed with a right traumatic anterior cruciate ligament (ACL) tear and presents for physical therapy treatment. The physician’s prescription documents, right ACL tear, right knee pain and difficulty walking. What diagnosis codes should be reported?

Answer
- S83.511D, Sprain of anterior cruciate ligament of right knee, subsequent encounter. This is not active treatment of the ACL tear and therefore 7th character “D” subsequent encounter is assigned.
- Do not assign codes for difficulty walking or knee pain since these signs and symptoms are routinely associated with ACL tear.
- According to Section 1.B.5 of the guidelines, “Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.”
More examples from the Coding Clinic

Question
- A patient sustained a Colles’ fracture of her left upper extremity after slipping and falling on an icy sidewalk four months ago. At that time, she was admitted and the fracture treated by open reduction and internal fixation. After discharge, a routine follow-up x-ray demonstrated a healing fracture. Because the patient was complaining of weakness and achiness in her hand and wrist, the orthopedist referred her for outpatient physical therapy. The therapist performed functional training, static stretches and strengthening exercises. What is the appropriate 7th character for the encounter for physical therapy?

Answer
- S52.532D, Colles’ fracture of left radius, subsequent encounter, for closed fracture with routine healing, as the reason for the encounter.
- W00.0XXD, Fall on same level due to ice and snow, subsequent encounter, to describe the external cause of the injury.
- The patient is receiving physical therapy during the healing phase of the fracture.

And a note regarding M1011/M1017
- If the injury or complication was initially treated (actively treated) in the hospital, then the 7th character is A.
- If not an inpatient hospital, look closely at what treatment was provided to get the correct 7th character for M1011/M1017.
- Rehab is D!!

And since we’re talking about injuries...
- 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.
- V, W, X, and Y codes are not required unless there is a special instruction or a payor requires.
**Burns and Corrosions**

- Electrical heating appliances
- Electricity
- Flame
- Friction
- Hot air or hot gases
- Hot objects
- Lightning
- Radiation (but not radiation-related disorders of the skin)
- Scalds
- Chemical burns (corrosions)

- Excludes sunburns!
- The guidelines are the same for burns and corrosions.

**Burns**

- First degree (erythema), second degree (blistering), and third degree (full-thickness involvement). Burns of the eye and internal organs (T26-T28) are classified by site, but not by degree.
- Do NOT use T30!! When coding burns, assign separate codes for each burn site. Category T30, Burn and corrosion, body region unspecified is extremely vague and should rarely be used.
- Non-healing burns are coded as acute burns.
- Necrosis of burned skin should be coded as a non-healed burn.

**Burns--Guidelines**

- No aftercare codes for burns
  - 7th character
    - A for active is an option
    - D—subsequent care (healing/recovering)
    - S—sequela
  - Code location of burn with severity of burn
    - Code worst burn first
    - Classify burns of the same local site (three-character category level, T20-T28) but of different degrees to the subcategory identifying the highest degree recorded in the diagnosis.

**Burns Guidelines**

- It is advisable to use category T31 as additional coding when needed to provide data for evaluating burn mortality, such as that needed by burn units. It is also advisable to use category T31 as an additional code for reporting purposes when there is mention of a third-degree burn involving 20 percent or more of the body surface. Use Rule of Nines
- For any documented infected burn site, use an additional code for the infection.
Non-Healing Burn

- Code a non-healing burn as an acute burn
- Your patient has an ulcer on his left lower leg where he left a heating pad (which the therapist told him to apply) and burned his leg. Because of his atherosclerosis (with claudication) the second degree burn has never healed. The focus of the care is the care of the ulcer/burn.
- T24.232D Burn of second degree left lower leg
- I70.212 Atherosclerosis of native arteries extremities w/intermittent claudication, left leg
- Y63.5 Inappropriate temp in local application (optional)

3rd Degree Burn

Codes T23.361A or D, T23.371A or D

Sequela of burns

- Encounters for the treatment of the late effects of burns or corrosions (i.e., scars or joint contractures) should be coded with a burn or corrosion code with the 7th character “S” for sequela.
- The burn has healed but the patient has a skin contracture at the wrist. PT/OT are ordered.
- L90.5 Scar conditions and fibrosis of skin
- T23.371S Burn of 3rd degree of R wrist, sequela
Sequela Reminder

- General Rule: Code what you see first and the sequela code (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 code first when what you 'see' cannot go first (manifestation code).
  - E64.3 Sequela of rickets
  - M49.82 Spondylopathy in diseases classified elsewhere

- Sequela of cerebrovascular accidents
  - I69.351

Acute burn and sequela of burn

- When appropriate, both a code for a current burn or corrosion with 7th character “A” or “D” and a burn or corrosion code with 7th character “S” may be assigned on the same record (when both a current burn and sequelae of an old burn exist). Burns and corrosions do not heal at the same rate and a current healing wound may still exist with sequela of a healed burn or corrosion.

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Example

- Burn on back of hand hasn’t healed, but progressing nicely. Burn on wrist has healed but there is a skin contracture. Nursing will provide wound care to burn and OT will work on contracture.
- T23.361D Burn of 3rd degree of R dorsum of hand
- L90.5 Scar conditions and fibrosis of skin
- T23.371S Burn of 3rd degree of R wrist, sequela
Guidelines

- Traumatic injury codes (S00-T14.9) are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.
- Alphabetic index—Wound, open
  - Amputation
  - Bite
  - Laceration--A jagged wound or cut.
  - Puncture

From Wikipedia

- Incisions or incised wounds, caused by a clean, sharp-edged object such as a knife, razor, or glass splinter.
- Lacerations, irregular tear-like wounds caused by some blunt trauma. Lacerations and incisions may appear linear (regular) or stellate (irregular). The term laceration is commonly misused in reference to incisions.
- Abrasions (grazes), superficial wounds in which the topmost layer of the skin (the epidermis) is scraped off. Abrasions are often caused by a sliding fall onto a rough surface.

From Wikipedia

- Puncture wounds, caused by an object puncturing the skin, such as a nail or needle.
- Penetration wounds, caused by an object such as a knife entering and coming out from the skin.
- Gunshot wounds, caused by a bullet or similar projectile driving into or through the body. There may be two wounds, one at the site of entry and one at the site of exit, generally referred to as a "through-and-through."

Trauma Wound Example

- Patient admitted for wound care to lacerated left calf due to falling from moving motorized mobility scooter.
Trauma Wound Answer

- S81.812D Laceration without foreign body of left lower leg
- V00.831D Fall from moving motorized mobility scooter

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

Complications and Injuries

- Patient had a traumatic rupture of the palmar ligament of the right middle finger at the metacarpophalangeal and interphalangeal joint which was repaired. Home care will continue with routine dressing changes and remove sutures when ready.
- S63.422A was coded in the hospital.
- What do we code?

Complications and Injuries

- Teenager Randy was sneaking out of his upstairs window, fell and pierced his right elbow on the rebar his mom had buried in the garden to keep the dogs from lying on her flowers.
- Rebar was removed however the wound is infected with Staph aureus. He is home on antibiotics and dressing changes.

Rebar Randy

- S51.041A Puncture wound with foreign body of right elbow
- B95.61 Staph aureus

- If healing well, S51.041D
Superficial Injuries

- Injury, superficial = abrasion
- Skin Tears do not ordinarily require the skills of a nurse (no skilled care = no code)
- Skin tears should be documented as Partial Thickness Wounds (PTW)
- Use Payne Martin or Staar classification
- If complicated—infected, diabetic and atherosclerosis—then trauma wound

Trauma fractures

Increase in ICD-10 Codes

- Codes related to musculoskeletal care make up > 50% of ICD-10 codes.
- Approximately one-third of ICD-10 codes are related to fractures
- 25,000 due to laterality

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
Fractures

Classifications of fractures:
- Open or closed
  - Default is closed
  - Gustilo grade, if open
- Displaced or non-displaced
  - Default is displaced

Traumatic or pathological
- Traumatic: bone breaks due to fall or injury
- Pathological: bone breaks due to a disease of the bone, a tumor or infection

Types of Fractures

7th Character Open Fractures

Look at 7th character for S72
- Type I
- Type II
- Type IIIA
- Type IIIB
- Type IIIC

Appropriate to assign the 7th character for open fracture Type I or II (7th characters E, H, M or Q) as a default when a patient presents for a subsequent visit and the original Gustilo-Anderson classification is not known. (1st Q 2016)

Now part of the coding guidelines
<table>
<thead>
<tr>
<th>Gustilo Grade</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Open fracture, clean wound, wound &lt;1 cm in length</td>
</tr>
<tr>
<td></td>
<td>Open fracture, wound &gt; 1 cm in length without extensive soft-tissue damage, flaps, avulsions</td>
</tr>
<tr>
<td>II</td>
<td>Open fracture with extensive soft-tissue laceration, damage, or loss or an open segmental fracture. This type also includes open fractures caused by farm injuries, fractures requiring vascular repair, or fractures that have been open for 8 hr prior to treatment</td>
</tr>
<tr>
<td>III</td>
<td>Type III fracture with adequate periosteal coverage of the fracture bone despite the extensive soft-tissue laceration or damage</td>
</tr>
<tr>
<td>IIIA</td>
<td>Type III fracture with extensive soft-tissue loss and periosteal stripping and bone damage. Usually associated with massive contamination. Will often need further soft-tissue coverage procedure (i.e. free or rotational flap)</td>
</tr>
<tr>
<td>IIIB</td>
<td>Type III fracture associated with an arterial injury requiring repair, irrespective of degree of soft-tissue injury.</td>
</tr>
</tbody>
</table>

### 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
- **S72.001D Subsequent encounter for closed fracture of unspecified part of neck of right femur with routine healing**
- **W05.0xxD Fall from wheelchair (optional)**
- **Note:** A fracture not indicated as opened or closed should be coded to closed
- **Note:** A fracture not indicated as displaced or non-displaced is coded to displaced

### Scenario
- **Patient was pulled down by her large dog while walking and has an open oblique fracture of the shaft of the right radius. ORIF and coming home for therapy and wound care.**
- **S52.331E Displaced oblique fracture of shaft of right radius, subsequent encounter for open fracture, type I or type II with routine healing**
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.

“fall from standing height or less”

Ms. Yappie tripped over a crack in the sidewalk when walking her Pomeranian and has a fracture of the left patella and left elbow (olecranon process). She has a ORIF of both and is coming home for therapy and wound care. The therapist documents abnormality of gait and decreased range of motion in the elbow. Other diagnoses include osteoporosis.

Ms. Yappie

M80.062D Age-related osteoporosis with current pathological fracture, left lower leg, subsequent encounter
M80.032D Age-related osteoporosis with current pathological fracture, left forearm, subsequent encounter

Symptoms routinely associated with the definitive diagnosis are not coded separately.

Fall from standing height or less

Mr. Yuppie was walking his Mastiff when the dog saw a cat sitting on a fence and took off, pulling Mr. Yuppie off of his feet and slamming him on the sidewalk. He has fractures of the left patella (comminuted) and left elbow (olecranon process). He has a ORIF of both and is coming home for therapy and wound care. The therapist documents abnormality of gait and decreased range of motion in the elbow. Other diagnoses include osteoporosis.

These are not osteoporosis fractures, although osteoporosis will impact healing and rehab.

S82.042D Displaced comminuted fracture of left patella, subsequent, routine healing
S52.022D Displaced fracture of olecranon process without intraarticular extension of left ulna, subsequent, routine healing

M81.0 Age related osteoporosis without current pathological fracture
Mr. Yuppie in the hospital

- S82.042A Displaced comminuted fracture of left patella, initial encounter
- S52.022A Displaced fracture of olecranon process without intraarticular extension of left ulna, initial encounter

Mr. Yuppie in rehab

- S82.042D Displaced comminuted fracture of left patella, subsequent encounter
- S52.022D Displaced fracture of olecranon process without intraarticular extension of left ulna, subsequent encounter

Complications

- Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.
- Meaning...continue to code the complication code with a D during the healing or recovery phase.
- Stop coding it only when it is healed.
- Example: ORIF for fracture and surgical site gets infected. No longer infected...T81.4xxD

Fracture

- Mrs. Kuhlmann is a cool Mimi and broke her right humerus at mid shaft (comminuted) in a go cart accident when riding with her grandson who was demonstrating how he could 'drift' when it turned over. She has an ORIF.
- S42.351D Displaced comminuted fracture of shaft of humerus, right arm, subsequent encounter for routine healing
- V86.69xD Passenger of other special all-terrain or other off road motor vehicle injured in nontraffic accident
Complication of Internal Fixation Device

- Same patient...She has an ORIF and the fixation device has come loose resulting in a nonunion of the fracture. At home until surgical intervention to replace fixation device can be scheduled. Stabilization until surgery
- Should you code the nonunion or the complication first??
- Use additional code to identify the specified condition resulting from the complication.
- Loosening of internal fixation devices cannot be assumed a complication. A little loosening is expected, especially in those that are expected to come out.

Complication of Internal Fixation Device

- T84.120A Displacement of internal fixation device of right humerus
- S42.351K Displaced comminuted fracture of shaft of humerus, right arm, nonunion
- V86.69xA Passenger of other special all-terrain or other off road motor vehicle injured in nontraffic accident

Now, it's been fixed...providing surgical aftercare in addition to the care for the fracture
- T84.120D Displacement of internal fixation device of right humerus, subsequent
- S42.351D Displaced comminuted fracture of shaft of humerus, right arm, subsequent

Fracture of the Hip

- Patient fell off the bed when his foot got caught in the covers and he has a fracture of the right greater trochanter.

Fracture of the Hip

- Patient fell off the bed when his foot got caught in the covers and he has a fracture of the right greater trochanter.
- S72.111D Fracture of greater trochanter of right femur, subsequent encounter for closed fracture with routine healing
- W06.xxxD Fall from bed, subsequent encounter
Fracture of the Hip

- The patient with the broken hip refused a joint replacement. His fracture has healed but his right leg is significantly shorter than his left.
- M21.751 Unequal limb length (acquired), right femur
- S72.111S Fracture of greater trochanter of right femur, sequela
- W06.xxxS Fall from bed, sequela

Fracture with Spinal Cord Injury

- Patient had an unstable burst fracture of the 1st lumbar vertebra resulting in a complete lesion at L1. He is paraplegic as a result. He is being discharged home after rehab.
- G82.21 Complete paraplegia
- S34.111S Complete lesion of L1 level of lumbar spinal cord
- S32.012S Unstable burst fracture of 1st lumbar vertebra
- Code first any associated spinal cord and spinal nerve injury (S34.-)

Joint Replacements???

- Aftercare following joint replacements for fractures
  - Z47 has excludes 1 note for fractures
  - No aftercare codes for injuries
  - Do not use aftercare codes when 7th characters are available to indicate aftercare
  - Code the fracture with 7th character D
  - Bundling demonstration project
  - Do NOT code abnormality of gait
  - This issue did NOT make it into the September CC so stay tuned
- No question on joint replacements for OA
  - It is appropriate

Laterality

- When a patient has a bilateral condition and each side is treated during separate encounters, assign the "bilateral" code (as the condition still exists on both sides), including for the encounter to treat the first side.
- For the second encounter for treatment after one side has previously been treated and the condition no longer exists on that side, assign the appropriate unilateral code for the side where the condition still exists (e.g., cataract surgery performed on each eye in separate encounters). The bilateral code would not be assigned for the subsequent encounter, as the patient no longer has the condition in the previously-treated site. If the treatment on the first side did not completely resolve the condition, then the bilateral code would still be appropriate.
The Usual Question

- My patient had a left knee replacement 3 years ago and now has had a right knee replacement. Do I code each knee separately? It seems ‘not right’ if I use bilateral because he just had the one done.
- Code bilateral: Z96.653 Presence of artificial hip joint, bilateral

Intracranial injuries

Things to Remember...

- Difference between a traumatic intracranial bleed and a CVA type bleed
  - External vs internal
- Coding the acute injury (usually D) vs the sequel of an injury (S)
- What is the Plan of Care?
  - Seizures, coma and not woken up?
  - Stable?
  - Neurological deficits only?

Example

- Patient fell out of bed and received a subdural hemorrhage. The doctor documented that the wife states that the patient was out for less than 5 minutes. He was admitted for observation and now comes home for further observation.
  - Injury, intracranial
  - S06.5x1D Traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less
  - W06.xxxD Fall out of bed
Example

- Patient fell off the steps at the WWII Memorial when he was visiting. He sustained a subdural hemorrhage. He was comatose for 28 days. He has left dominant spastic hemiplegia and speech problems and is coming home after 2 months in rehab.
- G81.12 spastic hemiplegia affecting left dominant side
- R47.02 Dysphasia
- S06.5x5S traumatic subdural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
- W10.8xxS Fall from steps

Example

- Patient was hit by a car while riding his scooter down the road sustaining a subdural hemorrhage. He was resuscitated at the scene. He is comatose and his family wants him home to die. The nurse documents eyes open to pain, best verbal response none and best motor response extension. He has a tracheostomy and a G tube feeding that the family will care for.

Answers

- S06.5x6S Subdural hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level
- R40.2124 Coma scale, eyes open, to pain
- R40.2214 Coma scale, best verbal response none
- R40.2324 Coma scale, best motor response extension
- Z93.0 Status tracheostomy
- Z93.1 Status gastrostomy

Rationale

- R40.2 indicates to code the intracranial injury first.
- The coma is a sequela of the head injury, so S is used on the injury.
- Glasgow coma scale scores may be coded based on clinician documentation.
- Status codes for artificial openings
Miscellaneous S T Changes

Deleted codes like this:

- S06.0X5 Concussion with loss of consciousness greater than 24 hours with return to pre-existing conscious level
- Deleted S06.0x2 – S06.0x8
- Loss of consciousness (LOC) of more than 30 minutes should not be classified as a concussion or mild traumatic brain injury.

Complications

- Code assignment is based on the provider’s documentation of the relationship between the condition and the care or procedure, unless otherwise instructed by the classification.
- 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.

The Usual Complications

- Complications of surgical and medical care, NEC
  - T81 Complications of procedures, NEC
  - T84 Complications of internal orthopedic prosthetic devices, implants and grafts
  - T86 Complications of transplanted organs and tissue
  - T87 Complications peculiar to reattachment and amputation
Surgical Complications NEC

- T81 Complications of procedures are NEC codes
- Find the codes for infected post-op wound and dehiscence
- Notice 7th character

Non healing Surgical Wound

- ICD-10-CM does not provide a specific code to describe nonhealing surgical wound. Assign code T81.89X-, Other complications of procedures, not elsewhere classified, for an unspecified nonhealing surgical wound.
- If a postsurgical wound does not heal due to infection, assign code T81.4XX-, Infection following a procedure.
- If the wound was closed at one time and is no longer closed, it is coded as disruption. In that case, code T81.3-, Disruption of wound, not elsewhere classified, should be assigned.

‘Planned’ vs Traumatic Amputations

- Amputations are coded with aftercare codes when routine care is being provided for a planned amputation
  - Z47.81 Aftercare following amputation
  - Use additional code to specify the level of amputation and laterality.
- If traumatic amputation…NO AFTERCARE

Amputations

**‘Planned’**

- Patient’s right great toe is amputated because of a diabetic ulcer that won’t heal. He also has diabetic PVD.
  - Z47.81 Aftercare following amputation
  - E11.51 Diabetes with peripheral angiopathy
  - Z89.411 Acquired absence of right great toe

**Traumatic**

- Patient’s right great toe was cut off when mowing the lawn (powered lawnmower).
  - S98.111D Traumatic amputation of right great toe
  - W28.xxxD Contact with powered lawn mower
  - (Status code for absence is not used because the traumatic amputation code provides the information)
Infected R BKA (surgical)

Code ______________
Infected R BKA (surgical): T87.43

Dehiscence of amputation stump

Code ______________
Dehiscence of amputation stump T87.81

Previous Toe amputation-Non healing with eschar

Code ______________
Previous Toe amputation-Non healing with eschar T87.54

Infected and Dehisced (external) Surgical Wound

Codes ____________, ____________
Infected and Dehisced (external) Surgical Wound T81.31xD, T81.4xxD (or A)
**Mechanical Complication**

- The patient has a muscle flap on a stage IV pressure ulcer. The flap is not healing and is breaking down. How should this be coded?
  - Complication, graft, muscle, breakdown
  - T84.410A (active?)

**Complication**

- The patient’s peritoneal dialysis catheter is infected with MRSA and has been abandoned. Home health is ordered to change dressings to the infected site. The patient has a new AV fistula and a central line (triple lumen). Home health will teach the patient/caregiver how to administer IV antibiotics through new central line.
  - Infection, due to…, device, catheter, dialysis, intraperitoneal
  - MRSA, infection, as the cause of diseases classified elsewhere
  - Admission, adjustment, device, specified NEC, vascular access
  - T85.71x A infection and inflammatory reaction due to peritoneal dialysis catheter
  - B95.62 MRSA
  - Z45.2 Fitting and adjustment of IV

**Same patient…**

- Now the central line has a localized infection with cellulitis and MRSA. The doctor wants the HHA to continue with dressing changes to both sites and administer the IV antibiotic.
  - T80.212A Local infection due to CVC
  - L03.313 Cellulitis chest wall
  - T85.71x A Infection and inflammatory reaction due to peritoneal dialysis catheter
  - B95.62 MRSA

**Complication Transplant**

- The patient has a rejection of his bone marrow transplant due to graft-versus-host disease.
  - Complication, transplant, bone marrow
  - T86.01 Bone marrow transplant rejection
  - D89.813 Graft-versus-host disease, unspecified
Complication of Joint Prosthesis

- The patient’s new right hip prosthesis is infected with Staph aureus.

- *Complication, joint prosthesis, infection, hip*

- T84.51xA Infection and inflammatory reaction due to internal right hip prosthesis

- B95.61 Staph aureus

Periprosthetic Fractures

Deleted from the T84 category

- **M97 Periprosthetic fracture around internal prosthetic joint**
  - Excludes2: fracture of bone following insertion of orthopedic implant, joint prosthesis or bone plate (M96.6-)
  - breakage (fracture) of prosthetic joint (T84.01-)

Category M97 has 7th characters for: A initial encounter; D subsequent encounter; S sequela

- M97.0 Periprosthetic fracture around internal prosthetic hip joint
- M97.01 Periprosthetic fracture around internal prosthetic right hip joint
- M97.02 Periprosthetic fracture around internal prosthetic left hip joint
- M97.1 Periprosthetic fracture around internal prosthetic knee joint
- M97.11 Periprosthetic fracture around internal prosthetic right knee joint
- M97.12 Periprosthetic fracture around internal prosthetic left knee joint

And so on...

Rationale: Fractures around a prosthesis are not complications of the prosthesis, but the result of the same conditions as other fractures, that is, trauma or pathological conditions.

ICD10--Table of Drugs and Chemicals

Combination codes—no need for external cause code

- Poisening, accidental (default when poisioning)
- Poisening intentional self-harm
- Poisening assault
- Poisening undetermined
- Adverse effect (therapeutic use in ICD-9)
- Underdosing

- A - Initial encounter
- D - Subsequent encounter
- S - Sequela
**Table of Drugs and Chemicals**

- 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

**Poisoning**

- 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.
- T—code for poisoning, accidental (unless the physician has documented something specific)
- E—Effect(s) of the poisoning

**Poisoning Example**

- Patient misunderstood the instructions for his Coumadin and has been taking twice the amount prescribed. He has a GI bleed.

  T—T45.511D poisoning by Coumadin
  E—K92.2 Gastrointestinal hemorrhage, unspecified

**Adverse Effect Example**

- Patient has been taking the prescribed amount of Coumadin, however he has a GI bleed. SN for observation and assessment, teaching and venipuncture for monitoring levels.

  K92.2 GI hemorrhage, unspecified
  D68.32 Hemorrhagic disorder due to extrinsic circulating anticoagulants
  T45.515D adverse effect coumadin
  Z51.81 Encounter for monitoring
  Z79.01 Long term (current) use of anticoagulants
**Underdosing**

- 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.
- Noncompliance or complications of care codes are to be used with an underdosing code to indicate intent, if known.
  - C—Condition
  - T—T code for underdosing of the drug
  - Z—Z code for Underdosing reason

**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.**

- I10 Essential (primary) hypertension
- T46.5x6D Underdosing of other antihypertensive drugs, subsequent encounter
- Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship

**COPD**

- Chronic inflammation of the respiratory passages
- Includes lung tissue, bronchioles, alveoli
- Generally related to exposure to inhaled irritants
- Reduced expansion and inflammatory processes prohibit full oxygenation or release of byproducts
  - Carbon Dioxide build up
- ICD-10 requires coder to include (code also) any applicable/known tobacco exposure
### Conventions at J44

- **Includes**
  - asthma with chronic obstructive pulmonary disease
  - chronic asthmatic (obstructive) bronchitis
  - chronic bronchitis with airways obstruction
  - chronic bronchitis with emphysema
  - chronic emphysematous bronchitis
  - chronic obstructive asthma
  - chronic obstructive bronchitis
  - chronic obstructive tracheobronchitis

### J44—Conventions

- Although asthma is included, if information is provided on type of asthma, code also the specific J45 code
  - Check out the index
- Use additional code to report tobacco use, history of use, or exposure
  - Smoker equals...
- May add additional code for oxygen dependence when known.
- Chronic respiratory failure should be added when documented.
- Chronic respiratory insufficiency should NOT be added (integral).

### J44-confusion

- J44.- note to code also J45 (already included)
- Emphysema at J43 vs J44
- Code both J44 and J45 only if you know type of asthma.
- Do not code J43 and J44 together.

### Scenario

Mrs. Winston is admitted for IV antibiotic and PICC line care to treat pneumonia due to MRSA. She also has a history of COPD with chronic obstructive bronchitis, and is oxygen dependent.

Even though the pneumonia is the focus of care, what is coded first?
Scenario Coded

- J44.0 COPD with lower respiratory infection
- J15.212 MRSA pneumonia
- Z99.81 Oxygen dependence
- Z45.2 Fitting and adjustment of vascular catheter
- Z79.2 Long term current use of antibiotic medication

- J44.0 indicates presence of lower respiratory infection
  - Note sequencing instruction.

Scenario

- Mrs. Green is admitted following diagnosis of a pseudomonas lung abscess. She is on 30 days of oral antibiotic therapy and will receive skilled nursing and therapy. She has also been a smoker for 30 years.

Scenario Coded

- J85.2 Abscess of the lung without pneumonia
- B96.5 Pseudomonas
- F17.210 Nicotine dependence, cigarettes, uncomplicated
- Z79.2 Long Term use of antibiotic

- B96.5 additional code is used for pseudomonas
- Additional code for tobacco dependence as the patient is a smoker
- Excessive length of antibiotic therapy so use of antibiotic also coded

Other Notes

- A patient with COPD who also has a lower respiratory infection is *not* assumed exacerbated. If Mrs. Winston is also documented as exacerbated, then:
  - J44.0 COPD with lower respiratory infection
  - J15.212 MRSA pneumonia
  - J44.1 Exacerbation of COPD (can be primary)
    - See Excludes 2 note
Scenario

Mr. James is referred to home health for skilled nursing care following hospitalization for acute respiratory failure with hypoxia. He has just been started on oxygen. He has additional diagnoses of chronic respiratory failure and COPD which is noted as exacerbated in the clinical record.

Scenario Coded

J96.21 Acute and Chronic Respiratory Failure with Hypoxia
J44.1 COPD exacerbated
Z99.81 Dependence on Supplemental Oxygen
- Acute condition is superimposed on chronic.
- Physician has specified both the acute and chronic respiratory failure
- Physician has specified “with hypoxia”
- COPD is reported as exacerbated so J44.1 code is used

Abscess, Furuncle, Carbuncle

- How is it documented?
  - Abscess of the skin—see L02.-
  - Abscess of the breast—see N61
  - Abscess of bone—osteomyelitis and so on
  - Post-surgical abscess—that’s a complication T81.4xx- (T81.43-?)
- Which ones are coded as abscesses?
  - Furuncle aka boil
  - Carbuncles—deeper and in groups
Cellulitis

- The patient has cellulitis on the lower legs and weeping blisters from heart failure. Heart failure and the cellulitis with dressings is the focus of care. The patient is on 7 days of oral antibiotics.
- The doctor has to diagnose cellulitis. It is not just red, swollen areas.
- I50.9 Heart failure, unspecified
- L03.115 Cellulitis of right lower limb
- L03.116 Cellulitis of left lower limb
- R23.8 Other skin changes

L05.- Pilonidal cyst and sinus with abscess

- Cyst or abscess near or on the natal cleft of the buttocks that often contains hair and skin debris. A sinus tract, or small channel, may originate from the source of infection and open to the surface of the skin.

Diagnostic Statement

- Staphylococcal boil, left groin
  L02.224-Furuncle of groin
  B95.8-Unspecified staphylococcus as the cause diseases classified
- Pilonidal fistula with abscess
  L05.02—Pilonidal sinus with abscess
These are not ulcers!

- Mrs. Droop has lost 150 pounds after being on “The Biggest Loser” and has sagging skin. She now has sores between the folds of her skin on her abdomen.
- L30.4 Intertriginous dermatitis
- L98.7 Excessive and redundant skin and subcutaneous tissue

Dermatitis and eczema

- The two terms are used synonymously and interchangeably.
- Patient had an allergic reaction to cephalosporin causing a rash over most of his body. Steroid pack prescribed for intense itching.
- L27.0 Generalized skin eruption due to drugs and medicaments taken internally
- T36.1x5A Adverse reaction to cephalosporin
- Z79.52 Long term use of steroids

Mr Greenjeans

- Mr. Greenjeans has a long-standing history of sun exposure and presents for treatment of skin lesions of the ears, scalp, and face. The skin biopsy obtained on the previous encounter is consistent with solar keratosis.
  - L57.0 Actinic keratosis
  - X32.xxxD Exposure to sunlight, subsequent encounter (that excludes 1 note is going to be fixed)

This is an example of what???

Gangrene and Similar Sounding Conditions

- Pyoderma Gangrenosum L88
  By I, Monopol, CC BY-SA 3.0, https://commons.wikimedia.org/w/index.php?curid=2302371

- Gas gangrene A48.0
  Medical emergency
Gangrene and Similar Sounding Conditions

- Gangrene I96 OR
- Diabetic gangrene E11.52
  - Gangrene
    - With
      - Diabetes
      - OR
  - Atherosclerosis with gangrene I70.261
- Also known as dry gangrene

Gangrenous pressure ulcer

- NOT related to diabetes
- I96 gets coded first!!
- Issues with case mix system

Pressure Ulcer Guidelines

- Pressure ulcers (L89.-)
  - Combination codes that indicate location (laterality) and staging of ulcer. They do not require a second code to describe the stage. The 6th character of the code indicates the stage.
  - ICD-10-CM classifies pressure ulcers from stages 1-4, unspecified, and unstageable.
  - Assign as many codes in L89.- category that are needed to identify all the pressure ulcers the patient has.
  - If documentation indicates that pressure ulcer is completely healed (not closed), then do not code the pressure ulcer.

Do not code HEALED pressure ulcers

- Stage I and II PUs heal—do not code once healed.
- Stage III and IV PUs do not heal, they close and are never considered healed.
- New guidance—if the pressure ulcer is reportable, or is part of the POC it should be coded.
Pressure Ulcer Guidelines

- Pressure ulcers, on admission, described as “healing” should be assigned the appropriate pressure ulcer stage based on the documentation in the clinical record. If the documentation is unclear as to whether the patient has a new pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider.
- Interpretation: Do not reverse stage. May have to ask what stage pressure ulcer was at its worst.
- OASIS allows you to assume that it is at least stage III.

- If a patient is admitted with a pressure ulcer at one stage, and it progresses to a higher stage, assign the code for the highest stage reported for that site.
  - Code it at its worst stage.
  - Change in guideline
- Also a new category of pressure ulcers of contiguous sites (back, buttock and hip) are included in the (L89.4-) pressure ulcer category.
  - Are you still counting it as 3 ulcers on OASIS?

- Assignment of stages of pressure ulcers can be based on:
  - Documentation from the provider
  - Documentation from the agency clinician.
- Diagnosis must come from physician

- Unstageable pressure ulcers (L89.- -0)
  - Ulcers should be coded as unstageable when the stage cannot be clinically determined because of:
    - Eschar
    - Skin or muscle graft
    - Deep tissue injury (not due to trauma)
  - Do not confuse this with unspecified stage (L89.- -9)
    - When there is no specific documentation regarding stage.
    - THIS SHOULD NOT BE USED SINCE YOU CAN CODE STAGE BASED ON DOCUMENTATION FROM AGENCY CLINICIANS!
Pressure Ulcers Guidelines

- Applies to the inpatient setting with limited use in home health/hospice
- For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and stage of the pressure ulcer at the time of admission.
- Patient admitted with pressure ulcer evolving into another stage during the admission
- If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, two separate codes should be assigned: one code for the site and stage of the ulcer on admission and a second code for the same ulcer site and the highest stage reported during the stay.

Our Biggest Issue on the Horizon

<table>
<thead>
<tr>
<th>OASIS C1</th>
<th>OASIS C2</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Pressure ulcer with a skin graft is a pressure ulcer.</td>
<td>- Pressure ulcer with a skin graft is NOT a pressure ulcer.</td>
</tr>
<tr>
<td>- Stage 3 and 4 closed ulcers are still counted.</td>
<td>- Stage 3 and 4 closed ulcers are NOT counted.</td>
</tr>
</tbody>
</table>

Scenario

- The physician indicates as part of the diagnosis list a pressure ulcer on the right buttock. The nurse says there is also a pressure ulcer on the right hip and one on the right ankle. The nurse is not sure whether to mark all these pressure ulcers on the OASIS. What should you tell him?

Potential Responses

- a. Mark all the pressure ulcers on the OASIS. That is one diagnosis we do not need confirmation from the physician.
- b. Mark all the pressure ulcers on the OASIS. We'll need to confirm the diagnoses when we call the physician for wound care orders.
- c. Verify all the diagnoses with the physician prior to marking the pressure ulcer items on the OASIS.
Mark all the pressure ulcers on the OASIS. We'll need to confirm the diagnoses when we call the physician for wound care orders.

OASIS guidance indicates that the pressure ulcer items may be marked by the clinician prior to verification with the physician (based on WOCN and NPUAP guidance) but the physician must verify the diagnoses before coding.

**Non Pressure ulcers (L97.-)**

- Laterality
- Based on depth of wound, defined by anatomical depth including skin only, subcutaneous tissue layer (fat layer exposed), muscle tissue layer necrosis, and bone necrosis.
  - Which is based on clinician documentation

**OASIS vs Coding**

- May mark a wound as a pressure ulcer on the OASIS without physician verification
- Assessing clinician may stage
- Must then get orders for care/prevention and the diagnosis is verified at that time
- May code a pressure ulcer only with physician verification of the diagnosis
- May code stage based on assessing clinician’s documentation

**Methods of diagnosis of bone necrosis**

- The only definitive way to diagnosis necrosis of the bone is through imaging. It is generally thought of as being an irreversible process. If the necrosis occurs next to a joint surface, it is generally considered to cause joint deformity. However, no one really knows if this is true, and such conclusions are, to some extent, artifacts of our current diagnostic methods for bone necrosis. With the advent of MRI, we finally have a tool which can show abnormalities within about 2 weeks of the original insult.
**L97 Non-pressure chronic ulcer of the lower limb, not elsewhere classified**

- Code first any associated conditions such as:
  - Any associated gangrene
  - Atherosclerosis of the lower extremities
  - Chronic venous hypertension
  - Diabetic ulcers
  - Postphlebitic syndrome
  - Postthrombotic syndrome
  - Varicose ulcer

**Scenario**

- The patient has a documented gangrenous stage 3 pressure ulcer to the left medial ankle and also has diabetes.

**Answer**

- NOT a diabetic ulcer (the physician has documented a different cause for the ulcer)
- Not diabetic gangrene
- L96 gangrene
- L89.523 Pressure ulcer of left ankle, stage 3
- E11.9 Diabetes without manifestations

**L98.- Other disorders of skin and subcutaneous tissue, NEC**

- L98.4- Non pressure chronic ulcer of skin, NEC
  - Further divided into severity of damage
  - Not lateral specific
- L98.41- Non pressure chronic ulcer of buttock
- L98.42- Non pressure chronic ulcer of back
- L98.49- Non pressure chronic ulcer of skin of other sites
Injuries are coded in the S, T chapter, unless they are old.

37 yo male fell from ladder straining his rotator cuff on right shoulder:
- S46.011D Strain of muscle and tendon of rotator cuff R shoulder, subsequent encounter

73 yo male with progressively worsening pain in R shoulder diagnosed with incomplete rotator cuff tear:
- M75.111 Incomplete rotator cuff tear of R shoulder, not specified as traumatic

No aftercare following surgery for trauma:
- S46.011D
  - D = routine care for the condition during the healing or recovery phase

No aftercare code that specifically indicates “aftercare following surgery for musculoskeletal conditions”:
- See Z47.89 Encounter for other orthopedic aftercare
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.

Fractures in the M Chapter

- Osteoporosis fractures M80.0-
- Stress fractures M84.3-
- Pathological fractures, NEC M84.4-
- Neoplastic fractures M84.5-
- New codes for atypical femoral fracture (M84.75-)

- All have 7th characters
- Default of D (subsequent encounter for fracture with routine healing)

Complications

- Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.

Osteoporosis

- Systemic condition, therefore site is not a component
- Characterized by a decrease in bone mass and density
- Primary type 1 or postmenopausal osteoporosis—women after menopause postmenopausal—M81.0/M80.0- (DEFAULT)
- Primary type 2 osteoporosis or senile osteoporosis occurs after age 75 and is seen in both females and males at a ratio of 2:1. (age related M81.0/M80.0-)
- Secondary osteoporosis may arise at any age and affect men and women equally. Chronic predisposing medical problems or disease, or prolonged use of medications such as glucocorticoids (corticoid-induced osteoporosis). (specified type NEC M81.8/M80.8)
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.

Osteoporosis With Fracture Example

- Mrs. Boniva admitted for pathological fractured vertebra due to osteoporosis. Documentation indicates patient had previous healed pathological fracture of humerus due to osteoporosis.

- What if the physician just says osteoporosis??

Osteoporosis With Fracture Answer

- M80.08xD Age related osteoporosis with current pathological fracture, vertebra subsequent encounter.
- Z87.310 Personal history of healed osteoporosis fracture

*Note: Age related osteoporosis is separate category from other osteoporosis. Age related osteoporosis is the default.*

*Note: Pathological fracture is separate category from osteoporosis fracture*
The patient tripped over the leg of her walker and broke her hip. You should consider this a pathological fracture because she fell from a standing height or less. True or False

False. You should consider the fracture pathological if there is known osteoporosis.

Direct infection--invasion by infective organisms (organisms invade the synovial tissue)
Indirect infection-Microbial infection of the body is established however organisms can not be identified or is inconsistent in the joints.
What kind of codes are included in M01? M02?
Septic joint coded here

Gout—M10.-
Code chronic gout with tophi M1A.9xx1
Charcot’s joint, R foot M14.671
Check out the Excludes 1
Joint derangements and ligament issues are due to OLD injuries or are spontaneous, i.e. without injury
Arthritis

- Arthritis defaults to Osteoarthritis
- OA is divided into primary OA and secondary OA (that due to hip dysplasia, old trauma, obesity, etc)
- Information as to primary or secondary for most arthritis
- Should get information as to joints involved and laterality

Arthritis Defaults

- Check the index.
  - Ankle, hand, foot and hip default to primary
  - Conflicts with inclusion note in tabular
- Knee does *not* default to primary

Osteoarthritis

- Most common DJD (Arthritis defaults)
- Breaks down the cartilage causing pain, swelling, and reduced motion in the joints.
- Many differences between ICD-9 and ICD-10
- Types
  - Polyosteoarthritis (generalized)
  - M16.-OA of hip
  - M17.-OA of knee
  - And so on...

Quiz

- Physicians document polyosteoarthritis all the time. True or False
- Primary osteoarthritis is:
  - A. the origin of the OA
  - B. the first joint affected by the inflammation
  - C. related to the age of the patient
  - D. the first diagnosis listed
- Must ask primary or secondary to get specific code.
Question

- An elderly patient with end-stage Alzheimer’s disease, dementia and functional quadriplegia, who is completely immobile due to bilateral joint contractures of the hip and knees, receives home health care and daily physical therapy consisting of passive range-of-motion exercises. What codes should the physical therapist report?

Answer

- Assign any of the applicable contracture codes (i.e., M24.551, Contracture, right hip, M24.552, Contracture, left hip, M24.561, Contracture, right knee, M24.562, Contracture, left knee), as the first-listed diagnosis.
- R53.2, Functional quadriplegia,
- G30.9, Alzheimer’s disease, unspecified, and
- F02.80, Dementia in other diseases classified elsewhere without behavioral disturbance, should be assigned as additional diagnoses.

Symptoms, Signs and Ill Defined Conditions

<table>
<thead>
<tr>
<th>Code the Symptoms</th>
<th>Do not code the symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>When that’s all we have</td>
<td></td>
</tr>
<tr>
<td>When the patient has a symptom not routinely associated with the condition</td>
<td>Hemoptysis with pneumonia</td>
</tr>
<tr>
<td>When there is an instruction to code the symptoms (N40.1-)</td>
<td>Dyspnea with pneumonia</td>
</tr>
</tbody>
</table>

Code the Symptoms

- 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 (not integral). The definitive diagnosis code should be sequenced before the symptom code.
- Remember the proximate diagnosis vs underlying condition “rule”?
Do not code the symptoms

- Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes (integral), 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.

Physical Therapists and Symptoms

- The guidelines in Section I, Conventions, General Coding Guidelines and Chapter Specific Guidelines, apply to all providers, including physical therapists. If the symptom is integral to the diagnosis it would not be separately coded.

More examples from the Coding Clinic

Question
- A patient with a known diagnosis of Parkinson’s disease with frequent falls and lack of coordination is referred by the physician for physical therapy for fall prevention. What diagnosis codes should be reported for the physical therapy visit?

Answer
- G20, Parkinson’s disease, as the first-listed diagnosis.
- R29.6, Repeated falls, should be assigned as an additional diagnosis since falls are not integral to Parkinson’s disease.

More examples from the Coding Clinic

Question
- A patient with low back pain and sciatica with left lower extremity pain radiating to the knee and difficulty walking was seen by an orthopedist and referred to physical therapy (PT). The primary reason that PT is involved is to resolve the pain and improve mobility. What diagnosis codes should be reported for the physical therapy visit?

Answer
- M54.42, Lumbago with sciatica, left side, for the low back pain and sciatica.
- R26.2, Difficulty in walking, not elsewhere classified, as an additional diagnosis, since it is not integral to sciatica or lumbago.
 Syndromes

- Follow the Alphabetic Index guidance when coding syndromes. In the absence of Alphabetic Index guidance, assign codes for the documented manifestations of the syndrome. Additional codes for manifestations that are not an integral part of the disease process may also be assigned when the condition does not have a unique code.
- No code for the syndrome? Code all the symptoms/parts separately.

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.

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 reflect 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.
Functional quadriplegia

- Functional quadriplegia (code R53.2) is the lack of ability to use one’s limbs or to ambulate due to extreme debility. It is not associated with neurologic deficit or injury, and code R53.2 should not be used for cases of neurologic quadriplegia. It should only be assigned if functional quadriplegia is specifically documented in the medical record.

Gathering More Information

- Referring physicians
- Indications of other illnesses:
  - Medications
  - Treatments
  - Interview of patient/caregiver
  - And verifying those findings with the physician and/or medical director

Now Our “Favorite” Symptom Codes

- R26 Abnormalities of Gait and Mobility
  - Excludes 1 (for example, ataxia R27.0)
  - R26.0 Ataxic gait
  - R26.1 Paralytic gait
  - R26.2 Difficulty in walking, NEC
  - R26.8 Other abnormalities of gait and mobility
    - R26.81 Unsteadiness on feet
    - R26.89 Other abnormalities of gait and mobility
  - R26.9 unspecified abnormalities of gait and mobility

- Code what the physician says, but first consider whether the symptom is appropriate to code.
Z—Factors Influencing Health Status...

Z—Assignment of Last Resort

General Guidelines

- These codes represent reasons for encounters. A corresponding procedure code must accompany a Z code if a procedure is performed.
- Doesn’t apply.

How to Find Z Codes

- Admission
- Aftercare
- Attention
- Encounter
- Examination
- Exposure
- History
- Management
- Observation
- Presence
- Problem
- Resistance
- Status

Common categories used in Home Health

- Aftercare
  - Surgical
  - Attention to….
  - Fitting and adjustment….

- Status

- History
Initial treatment of the disease has been performed and the patient requires continued care during the healing or recovery phase, or for long term consequences of the disease. Do not use if treatment is directed at a current, acute disease.

No aftercare codes for surgery following an injury—assign injury code with 7th character for subsequent care (D).

Certain aftercare (Z) code categories need a secondary diagnosis code to describe the resolving condition or sequelae:
- **Z48.3-Aftercare following surgery for the neoplasm**
  - Use additional code to identify the neoplasm
- For other Z codes, the condition is included in the code title.
  - **Z43.3-Encounter for attention to colostomy**

Attention Z Codes explain a patient's medical condition that currently exists, is receiving treatment, and is affecting the plan of care.

- **Feeding/Cleansing/Teaching**
- Must be doing something to or about the condition or sequelae.
- Is the agency providing treatment/attention to the ostomy site?
  - Yes  Z43
  - No   Z93
- Is the ostomy complicated?
  - Yes—Do not code the Z code, see complication, ____ostomy

Is the condition still present?
- Code it next after Z code

Is the condition resolved by surgery?
- Optional use of M1025
- No payment involved in M1025
### Attention to vs Status

<table>
<thead>
<tr>
<th>Attention to</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Z43.0 trach</td>
<td>□ Z93.0 trach</td>
</tr>
<tr>
<td>□ Z43.1 gastrostomy</td>
<td>□ Z93.1 gastrostomy</td>
</tr>
<tr>
<td>□ Z43.2 ileostomy</td>
<td>□ Z93.2 ileostomy</td>
</tr>
<tr>
<td>□ Z43.3 colostomy</td>
<td>□ Z93.3 colostomy</td>
</tr>
<tr>
<td>□ Z43.4 other digestive tract</td>
<td>□ Z93.4 other digestive tract</td>
</tr>
<tr>
<td>□ Z43.5 cystostomy</td>
<td>□ Z93.5- cystostomy</td>
</tr>
<tr>
<td>□ Z43.6 other urinary</td>
<td>□ Z93.6 other urinary</td>
</tr>
</tbody>
</table>

### Z43-Encounter for attention to artificial openings

- **Includes:**
  - Closure of artificial openings
  - Passage of sounds or bougies through artificial openings
  - Reforming artificial openings
  - Removal of catheter from artificial openings
  - Toilet or cleansing of artificial openings.

### Z45 vs Z95

- **Cardiac pacemaker**
  - □ Z45.0- Agency is reprogramming the device either manually or via computer
  - □ Z95.0 Status or presence--stating as a fact the patient has the device, not doing anything with it

### More Examples

- □ Z46.6 Encounter for fitting and adjustment of urinary device
- □ Z46.82 Encounter for fitting and adjustment of non-vascular catheter
  - Pleurex catheters?
- □ Z95.2 Presence of prosthetic heart valve
- □ Z95.5 Presence of coronary angioplasty implant and graft
Orthopedic aftercare

- Z47.1- Aftercare following joint replacement surgery
  Use additional code (Z96.6-)
- Z47.3- Aftercare following explantation of joint prosthesis
  5th character designates location
- Z47.81- Encounter for orthopedic aftercare following surgical amputation
  Use additional code to identify the limb amputated (Z89.-)

Joint Replacement

Patient returns home after joint replacement to the right hip for bilateral primary OA. Needs therapy for gait abnormality.

- Z47.1 Aftercare following joint replacement surgery
- M16.12 Unilateral primary OA, left hip
- R26.89 Other abnormalities of gait and mobility (optional)
- Z96.641 Presence of right artificial hip joint

Scenario

Patient had mastoiditis which resulted in an intracranial abscess. The intracranial abscess was evacuated and drained. Another surgeon did a partial mastoidectomy. The patient continues on long term antibiotics via IV. The surgical wounds are progressing nicely with dressing changes by SN.
Code

- Z48.811 Aftercare following surgery on the nervous system
- Z48.810 Aftercare following surgery on the sense organs
- Z45.2 Encounter for adjustment and management of vascular access device
- Z48.01 Encounter for change or removal of surgical wound dressing

Status Codes

- Status Z Codes explain a patient’s medical condition that currently exists and is not receiving any treatment, but has the potential to affect the plan of care and therefore may require continued monitoring.

- Indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition

Status Codes

- A status code is informative, because the status may affect the course of treatment and its outcome.

- A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code.

Z79

- Continuous use of a prescribed drug for the long term treatment of a condition or for prophylactic use (extended period for the prevention of DVT) or as treatment of a chronic condition or a disease requiring a lengthy course of treatment (cancer).

- Not for brief period to treat acute illness or injury.
Status Codes

3 main terms to find
- Status
- Absence
- Presence

Example: Z95.810 presence of automatic implantable cardiac defibrillator
  - Not listed under status; but listed under ‘presence’

Non compliance codes greatly expanded
- Z91.11 Patient’s noncompliance with dietary regimen
- Z91.12 Patient’s intentional underdosing of medication regimen
  - Z91.120 Patient’s unintentional underdosing of medication regimen due to financial hardship.

History codes are acceptable on any medical record regardless of the reason for the visit.

A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

Explain a patient’s past medical condition that no longer exists and is not receiving any treatment, but has the potential for recurrence and therefore may require continued monitoring.
Z74.- Problems related to care provider dependency

- Z74.01- Bed confinement status
- Z74.09- Other reduced mobility
  - Chair ridden
- Z74.1 Need for assistance with personal care
- Z74.2 Need for assistance at home and no other household member able to render care
- Z74.3 Need for continuous supervision

Z72.- Problems related to lifestyle

- Z72.0 Tobacco Use
- Z72.3 Lack of physical exercise
- Z72.4 Inappropriate diet and eating habits

Note: These codes should be assigned only when the documentation specifies that the patient has an associated problem.

The Nephron

N-Diseases of the Genitourinary System
N-Naughty Parts

The Nephron


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Acute kidney failure is the rapid loss of the kidneys' ability to remove waste and help balance fluids and electrolytes in the body. In this case, rapid means less than 2 days. Many causes may include, decreased blood flow due to hypotension, infections that directly injure the kidney, urinary tract blockage, among other reasons.

- If documentation of acute and chronic kidney failure, code both.
- Code also associated underlying condition

Patients who have undergone kidney transplant may still have some form of chronic kidney disease (CKD) because the kidney transplant may not fully restore kidney function.

- The presence of CKD alone does not constitute a transplant complication.
  - Assign the appropriate N18.- code for the patient’s stage of CKD and code Z94.0 Kidney transplant status.
  - If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.

Patients with CKD may also suffer from other conditions, most commonly diabetes and hypertension. The sequencing of the CKD in relationship to codes for other contributing conditions is based on the coding conventions. FOLLOW THE TABULAR INSTRUCTIONS

- The classification assumes a relationship between CKD and HTN.
- The classification assumes a relationship between CKD and Diabetes.

Diabetes, CKD and HTN
E11.22, I12.9, N18.9 OR I12.9, E11.22, N18.9
**N18-Chronic Kidney Disease**

- Use additional code to identify kidney transplant status, if applicable (Z94.0)
- If ESRD is documented, then use N18.6 (regardless whether receiving dialysis).
- If stage V is documented, use N18.5 unless undergoing dialysis, then use N18.6. (Use additional code to identify dialysis status-Z99.2)

**N99-Intraoperative and postprocedural complications and disorders of genitourinary system, NEC**

- N99.0 Postprocedural (acute) (Chronic) kidney failure
  - Use additional code to type of kidney disease
- N99.1- Postprocedural urethral stricture
- N99.2 Postprocedural adhesions of the vagina
- N99.3 Prolapse of the vaginal vault following hysterectomy
- N99.4 Postprocedural pelvic peritoneal adhesions

- N99.5 Complications of stoma of urinary tract
  - N99.51- Complication of Cystostomy
    - 6th character identifies the type of complication
  - N99.52- Complication of other external stoma of urinary tract
    - 6th character identifies the type of complication
  - M99.53- Complication of other stoma of urinary tract
    - 6th character identifies the type of complication
- N99.6- Intraoperative hemorrhage and hematoma of a genitourinary system organ or structure complicating a procedure
- N99.7- Accidental puncture or laceration of a genitourinary system organ or structure during a procedure
- N99.8- Other intraoperative and postprocedural complications and disorders of genitourinary system
Scenario

- H&P indicates that the patient had a hemorrhage into the bladder during the hysterectomy. Orders are to monitor urinary output and report increased bloody urine or inability to urinate.
  a. N99.61
  b. N99.62
  c. N99.820
  d. N99.821

Diseases of the Liver
K70-K77

- K70.- Alcoholic liver disease with specific complications
- K71.- Toxic liver disease
  - Code 1st poisoning due to drug/toxin, if applicable
  - Use additional code for adverse effect, if applicable, to identify drug
- K72.- Hepatic failure, NEC
  - Includes hepatitis, NEC with hepatic failure
  - Hepatic encephalopathy, NOS
  - Yellow liver atrophy or dystrophy

K—Digestive System

Diseases of the Liver
K70-K77

- K73.- Chronic hepatitis, NEC
- K74.- Fibrosis and cirrhosis of the liver
  Code also, if applicable, viral hepatitis
- K75.- Other inflammatory liver diseases
  - Abscess
  - Phlebitis
  - Autoimmune
  - NASH
  - Hepatitis, NOS
Complications of artificial openings of the digestive system K94.-

- K94.0- Colostomy complications
- K94.1- Enterostomy complications
- K94.2- Gastrostomy complications
- K94.3- Esophagostomy complications

Quiz

- Infectious colitis caused by E. coli
- Chronic bleeding duodenal ulcer
- Hepatic encephalopathy with coma, chronic hepatic failure

Quiz

- Infectious colitis caused by E. coli
- A04.4 Infectious E coli enteritis
- Chronic bleeding duodenal ulcer
- K26.4 chronic or unspecified duodenal ulcer with hemorrhage
- Hepatic encephalopathy with coma, chronic hepatic failure
- K72.11 Chronic hepatic failure with coma

Q—Congenital malformation...
**Conventions and Guidelines**

- May be the principle/first listed diagnosis or secondary diagnosis
- When a malformation/deformation/or chromosomal activity does not have a unique code assignment, assign additional code(s) for any manifestations that may be present.
- Components of the anomaly that are inherent should not be separately coded.

**Q00-Q07-Congenital malformation of the Nervous System**

- Q05.-Spina Bifida
  - Further defined by location
  - Further defined with or without hydrocephalus
  - Use additional code for any associated paraplegia (paraparesis) (G82.2-)

**Spina Bifida**

- Developmental congenital disorder caused by the incomplete closing of the embryonic neural tube. Some vertebrae overlying the spinal cord are not fully formed and remain unfused and open. If the opening is large enough, this allows a portion of the spinal cord to protrude through the opening in the bones. Most common sites are lumbar and sacral areas.
- Falls into 3 categories:
  - Spina bifida occulta
  - Spina bifida cystica with meningocele
  - Spina bifida cystica with myelomeningocele
Q35-37-Cleft Lip and Palate

- Use additional code to identify associated malformation of the nose (Q30.2)

Down Syndrome

- Use additional code to identify any associated physical conditions and degree of intellectual disability
- Down’s syndrome, also known as Trisomy 21 is a genetic disorder caused by the presence of all or part of a third copy of Trisomy 21. It is the most common chromosome abnormality in humans.
- (Intellectual disability is coded with F70-79)

What questions do you have?

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