

ICD-10-CM for Non-specific Specialty



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- ✓ This guide does not contain ANY legal advice.
- ✓ This guide shows what specific codes will change to when ICD-9-CM becomes ICD-10-CM.
- ✓ This guide does NOT discuss ICD-10-PCS.
- ✓ This guide does NOT replace ICD-10-CM coding manuals.
- ✓ This guide simply shows a practice what ICD-10-CM will look like within their specialty. The intent is to show that ICD-10 is not scary and it is not complicated.
- ✓ This guide is NOT the final answer to coding issues experienced in a medical practice.
- ✓ This guide does NOT replace proper coding training required by a medical coder and a medical practice.
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If the name of the original author, Steve Verno, has been replaced, it is possible that you have a thief on your hands.

For the past thirty-one (31) years, we have learned and used ICD-9-CM when diagnosis coding for our providers. ICD stands for International Classification of Diseases. We've been using the 9th Revision to code a documented medical condition. We will be replacing the 9th Revision with the 10th revision. As someone once said, just when we learned the answers, they changed the questions. Also, for years, there has been rumor that ICD-10 would be replacing ICD-9, and now this will soon be a reality.

ICD-10 will replace ICD-9-CM as of October 1, 2014.

There is a new rumor that ICD-10 will be bypassed with ICD-11. The problem with this new rumor is that there is nothing, in writing, about this rumor. The fact that ICD-10 will be effective as of October 1, 2014 is published by the Centers for Medicare and Medicaid Services and the World Health Organization. Anytime someone tells you something, GET IT IN WRITING! Rumors can ruin a practice and can cost a practice a lot of money because you trust the person who told you the rumor and you want to believe it, so you or you have your staff search the internet for anything that provides provenance to the rumor.

In coding, there is a saying, "If it isn't documented, it doesn't exist." If an employee or a doctor told you something, make sure that they provide you with documentation to back it up. How do I know this? My boss went to a conference and during a break, heard people talking about something. One of the speakers even said the same thing. When my boss came back, he had me stop my work and find out if what he heard was true. After a week of searching, I went back to my boss and told him that what he heard didn't exist. His reply was, "I don't believe you."

I speak at conferences and anything I present has laws, rules, or policies provided to show that what I'm saying is true, accurate, and correct. I personally attended a conference where I heard a speaker say something that didn't sound right. I wasn't the only one because many hands went up. The speaker had many respected certifications, yet the speaker failed to provide any proof to his statement. When I asked for his documentation, he smiled and said I'll send it to you. Guess what? It's been 10 years and nothing has come forth. All this did was lower my respect for this person and I now question everything this person provides. I refuse to attend any conference where he still speaks. My boss was correct with saying he didn't believe me, but he learned a hard lesson. He spent about \$1,000 in payroll to have me find anything that backed up what he heard at a conference. In the end, he dismissed what

he heard and from that point on, when we brought anything to him, we had to provide documented proof. That made me a better researcher.

To provide proof to ICD-10 being effective on October 1, 2014, can be found here:
<http://www.cms.gov/Medicare/Coding/ICD10/Index.html>

October 1, 2014 is on a Wednesday. What this means is, on Tuesday, September 30, 2014, you will use ICD-9-CM. At the end of the day, put your ICD-9 manuals in a safe place because you may need them later on and I will explain this. When you come in the next morning, you will open the brand new ICD-10-CM manuals and code the visit using them.

One huge change with ICD-10-CM is that there will be more codes to select from. ICD-9 has about 14,000 codes. ICD-10 starts with 68,000 codes and can go higher. ICD-9 did not have a code for a cranialrectal blockage, so you couldn't code that diagnosis or you had to select an unspecified code, but now you can have a code for a cranialrectal blockage (YOU do know that cranialrectal blockage is not a real disease or injury). ICD-10 is going to change the way YOU do business. Why? It is 100% dependent on medical record documentation. ICD-9 was forgiving to a doctor who is lax on their documentation. Steve could visit Dr Smith with pain in his right ear. All Dr Smith had to document was that Steve has OM which is short for otitis media and the coder could select a code for simple OM.

That code is **382.9** - Unspecified otitis media, Otitis media: NOS, acute NOS, chronic NOS

ICD-10 will require more work on the provider to document the exact type of diagnosis found with the patient. ICD-10 demands documentation of the anatomical area affected and allows for coding of chronic modalities.

Under ICD-10-CM, you have the following codes for Otitis Media:

H66.9 **Otitis media**, unspecified

H66.90 **Otitis media**, unspecified, unspecified ear

H66.91 **Otitis media**, unspecified. right ear

H66.92 **Otitis media**, unspecified, left ear

H66.93 **Otitis media**, unspecified, bilateral

As you can see, under ICD-9-CM, you have one code you can select if the documentation is not specific. The patient may have been a child with ear pain in both ears, but all the doctor wrote is "OM" and nothing more. Under ICD-10-CM, you have a possibility of five (5) codes and you do need more anatomical information to select the best possible code. Using a pure unspecified code such as H66.9 could cause your claim to be pended or placed under review, which could cause a significant revenue loss for the practice.

A favorite doctor I've known for many years is an expert witness where he is called to determine if a malpractice lawsuit should proceed to court or if the malpractice insurance company should issue a check. Many times after reviewing the medical record, he recommends writing a check. He provides instruction to medical interns and residents and he tells them: "Document the visit as if you had to appear in court to defend your actions." I usually add, "Document the visit as if your paycheck and career is on the line." I spend a lot of my time returning medical records for additional information because the documentation is insufficient to code the visit with 100% truth, accuracy and correctness. I code to protect the doctor, the patient, and MY paycheck.

I only code what is documented. I never code a visit just to get paid. There will be an unofficial rule with coding and that rule will be: If it isn't documented, we don't code it. We do NOT code something just to get it paid. With 30 years of clinical medicine in my personal background, I can say I know what should have been done during the visit, but I cannot code based on that. I've seen doctors tell me, "I did this procedure." I say show me where it says you did this. There is no documentation to prove that the doctor said they did what they say and the doctor loses. I also NEVER code based on what I am told on the internet. I don't know if what I'm told is 100% true, accurate and complete. I don't know if the person asking the question works for a doctor or if they are a coding student and I NEVER help students. If I provide them with answers, they submit my work as their own and I NEVER support fraud, including academic fraud, in any form. If I do a coders work for them, they will never learn to become self-sufficient.

Let's say you have an untrained coder who needs to code a cranialrectolectomy. They will go to the internet and ask, "I forgot what the code is for a cranialrectolectomy, can

someone help me?" When they don't get a response, they become angry and then they will post, "Can't anyone here help me out?" They do this hoping someone will feel guilty and give them what they want. Someone may come along with a name of ToddCPC and say we use code 99999. ToddCPC is NOT a coder. ToddCPC is a school kid in Omaha, Nebraska having fun punking the poster. So, now the coder enters 99999 as the code and sends the claim to the insurance company. The claim is denied payment. Claim after claim is denied payment because this coder is sending claims with bad codes. The doctor begins to notice the volume of denials and notices a huge drop in his practice revenue, so he contacts a consultant. In addition, the insurance company put a halt on all claims sent by the doctor. They send a letter demanding medical records and they're now going back 20 years. The information on the claim is wrong and it is not documented in the medical record. The next letter the doctor receives is a demand for the return of claim payments and they are demanding a 6 figure refund. The doctor cannot fight this because the claim was sent with wrong codes, codes that are not supported by the medical record documentation.

I recently went to a doctor who received a letter demanding the return of \$64,000. That would cause him to go out of business. I showed how his coder was sending claim with wrong codes and that the medical record documentation was so poor, that they didn't support any correct code that was submitted. Again, DOCUMENT THE MEDICAL RECORD AS IF YOU HAD TO GO TO COURT!

Coding Guidelines

Many of the guidelines under ICD-9-CM won't change under ICD-10-CM. You will see new guidelines because ICD-10 will offer new codes never seen before. As an example:

ICD-9 Guideline for Symptoms:

Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the physician. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0 -799.9) contain many, but not all codes for symptoms.

7. Conditions that are an integral part of a disease process

Signs and symptoms that are integral to the disease process should not be assigned as additional codes.

8. Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

ICD-10 Guideline for Symptoms:

Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all codes for symptoms.

5. Conditions that are an integral part of a disease process

Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

6. Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

As you can see, both guidelines are virtually identical, so the change to ICD-10 won't be a shock to a trained coder.

General Coding Guidelines

Level of Detail in Coding

Diagnosis codes are to be used and reported at their highest number of digits available. ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6 or 7 digits. Codes with three digits are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater detail.

A three-digit code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.

Code or codes from A00.0 through T88.9, Z00-Z99.8

The appropriate code or codes from A00.0 through T88.9, Z00-Z99.8 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.

4. Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all codes for symptoms.

5. Conditions that are an integral part of a disease process

Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

6. Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

7. Multiple coding for a single condition

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

For example, for bacterial infections that are not included in chapter 1, a secondary code from category B95, Streptococcus, Staphylococcus, and Enterococcus, as the cause of diseases classified elsewhere, or B96, Other bacterial agents as the cause of diseases classified elsewhere, may be required to identify the bacterial organism causing the infection. A "use additional code" note will normally be found at the infectious disease code, indicating a need for the organism code to be added as a secondary code.

"Code first" notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a "code first" note and an underlying condition is present, the underlying condition should be sequenced first. "Code, if applicable, any causal condition first", notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.

Multiple codes may be needed for late effects, complication codes and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

Acute and Chronic Conditions

If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

Combination Code

A combination code is a single code used to classify:

Two diagnoses, or A diagnosis with an associated secondary process (manifestation)

A diagnosis with an associated complication

Combination codes are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.

Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs. Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.

10. Late Effects (Sequela)

A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect 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 late effects generally requires two codes sequenced in the following order: The condition or nature of the late effect is sequenced first. The late effect code is sequenced second.

An exception to the above guidelines are those instances where the code for late effect is followed by a manifestation code identified in the Tabular List and title, or the late effect 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 late effect is never used with a code for the late effect.

See Section I.C.9. Sequelae of cerebrovascular disease

See Section I.C.15. Sequelae of complication of pregnancy, childbirth and the puerperium

See Section I.C.19. Code extensions

Impending or Threatened Condition

Code any condition described at the time of discharge as "impending" or "threatened" as follows:

If it did occur, code as confirmed diagnosis.

If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for “impending” or “threatened” and also reference main term entries for “Impending” and for “Threatened.”

If the subterms are listed, assign the given code.

If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

Reporting Same Diagnosis Code More than Once

Each unique ICD-10-CM diagnosis code may be reported only once for an encounter.

This applies to bilateral conditions **when there are no distinct codes identifying laterality** or two different conditions classified to the same ICD-10-CM diagnosis code.

Laterality

For bilateral sites, the final character of the codes in the ICD-10-CM indicates laterality.

An unspecified side code is also provided should the side not be identified in the medical record. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side.

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 to identify the organism. An instructional note will be found at the infection code advising that an additional organism code is required.

Infections resistant to antibiotics

Many bacterial infections are resistant to current antibiotics. It is necessary to identify all infections documented as antibiotic resistant. Assign code Z16, Infection with drug resistant microorganisms, following the infection code for these cases.

Diabetes mellitus

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

Type of diabetes

The age of a patient is not the sole determining factor, though most type 1 diabetics develop the condition before reaching puberty. For this reason type 1 diabetes mellitus is also referred to as juvenile diabetes.

Type of diabetes mellitus not documented

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

Diabetes mellitus and the use of insulin

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 for type 2 patients who routinely use 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.

Diabetes mellitus in pregnancy and gestational diabetes

See Section I.C.15. Diabetes mellitus in pregnancy.

See Section I.C.15. Gestational (pregnancy induced) diabetes

Underdose of insulin due insulin pump failure

An underdose of insulin due to an insulin pump failure should be assigned to a code from subcategory T85.6, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, that specifies the type of pump malfunction, as the principal or first listed code, followed by code T38.3x6-, Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs. Additional codes for the type of diabetes mellitus and any associated complications due to the underdosing should also be assigned.

Overdose of insulin due to insulin pump failure

The principal or first listed code for an encounter due to an insulin pump malfunction resulting in an overdose of insulin, should also be T85.6-, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, followed by code T38.3x1-, Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional).

Secondary Diabetes Mellitus

Codes under category E08, Diabetes mellitus due to underlying condition, and E09, Drug or chemical induced diabetes mellitus, identify complications/manifestations associated with secondary diabetes mellitus. Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning).

Secondary diabetes mellitus and the use of insulin

For patients who routinely use insulin, code Z79.4, Long-term (current) use of insulin, should also be assigned. Code Z79.4 should not be assigned if insulin is given temporarily to bring a patient's blood sugar under control during an encounter.

Assigning and sequencing secondary diabetes codes and its causes

The sequencing of the secondary diabetes codes in relationship to codes for the cause of the diabetes is based on the tabular instructions for categories E08 and E09. For example, for category E08, Diabetes mellitus due to underlying condition, code first the underlying condition; for category E09, Drug or chemical induced diabetes mellitus, code first the drug or chemical (T36-T65).

(ii) Secondary diabetes due to drugs

Secondary diabetes may be caused by an adverse effect of correctly administered medications, poisoning or late effect of poisoning.

See section I.C.19.e for coding of adverse effects and poisoning, and section I.C.20 for external cause code reporting.

Pain disorders related to psychological factors

Assign code F45.41, for pain that is exclusively psychological. Code F45.41, Pain disorder with related psychological factors, should be used following the appropriate code from category G89, Pain, not elsewhere classified, if there is documentation of a psychological component for a patient with acute or chronic pain.

Dominant/nondominant side

Codes from category G81, Hemiplegia and hemiparesis, and subcategories, G83.1, Monoplegia of lower limb, G83.2, Monoplegia of upper limb, and G83.3, Monoplegia, unspecified, identify whether the dominant or nondominant side is affected. Should this information not be available in the record, **and the classification system does not indicate a default**, the default should be dominant. For ambidextrous patients, the default should also be dominant.

Pain - Category G89

General coding information

Codes in category G89, Pain, not elsewhere classified, may be used in conjunction with codes from other categories and chapters to provide more detail about acute or chronic pain and neoplasm-related pain, unless otherwise indicated below.

If the pain is not specified as acute or chronic, post-thoracotomy, postprocedural, or neoplasm-related, do not assign codes from category G89.

A code from category G89 should not be assigned if the underlying (definitive) diagnosis is known, unless the reason for the encounter is pain control/ management and not management of the underlying condition.

When an admission or encounter is for a procedure aimed at treating the underlying condition (e.g., spinal fusion, kyphoplasty), a code for the underlying condition (e.g., vertebral fracture, spinal stenosis) should be assigned as the principal diagnosis. No code from category G89 should be assigned.

Category G89 Codes as Principal or First-Listed Diagnosis

Category G89 codes are acceptable as principal diagnosis or the first-listed code:

When pain control or pain management is the reason for the admission/encounter (e.g., a patient with displaced intervertebral disc, nerve impingement and severe back pain presents for injection of steroid into the spinal canal). The underlying cause of the pain should be reported as an additional diagnosis, if known.

When a patient is admitted for the insertion of a neurostimulator for pain control, assign the appropriate pain code as the principal or first listed diagnosis. When an admission or encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is inserted for pain control during the same admission/encounter, a code for the underlying condition should be assigned as the principal diagnosis and the appropriate pain code should be assigned as a secondary diagnosis.

Use of Category G89 Codes in Conjunction with Site Specific Pain Codes

(i) Assigning Category G89 and Site-Specific Pain Codes

Codes from category G89 may be used in conjunction with codes that identify the site of pain (including codes from chapter 18) if the category G89 code provides additional information. For example, if the code describes the site of the pain, but does not fully describe whether the pain is acute or chronic, then both codes should be assigned.

(ii) Sequencing of Category G89 Codes with Site-Specific Pain Codes

The sequencing of category G89 codes with site-specific pain codes (including chapter 18 codes), is dependent on the circumstances of the encounter/admission as follows:

If the encounter is for pain control or pain management, assign the code from category G89 followed by the code identifying the specific site of pain (e.g., encounter for pain management for acute neck pain from trauma is assigned code G89.11, Acute pain due to trauma, followed by code M54.2, Cervicalgia, to identify the site of pain).

If the encounter is for any other reason except pain control or pain management, and a related definitive diagnosis has not been established (confirmed) by the provider, assign the code for the specific site of pain first, followed by the appropriate code from category G89.

Chronic pain

Chronic pain is classified to subcategory G89.2. There is no time frame defining when pain becomes chronic pain. The provider's documentation should be used to guide use of these codes.

Diseases of Eye and Adnexa (H00-H59)

Reserved for future guideline expansion

Diseases of Ear and Mastoid Process (H60-H95)

Reserved for future guideline expansion

Hypertension with Heart Disease

Heart conditions classified to I50.- or I51.4-I51.9, are assigned to, a code from category I11, Hypertensive heart disease, when a causal relationship is stated (due to hypertension) or implied (hypertensive). Use an additional code from category I50, Heart failure, to identify the type of heart failure in those patients with heart failure. The same heart conditions (I50.-, I51.4-I51.9) with hypertension, but without a stated causal relationship, are coded separately. Sequence according to the circumstances of the admission/encounter.

Hypertensive Chronic Kidney Disease

Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present. Unlike hypertension with heart disease, ICD-10-CM presumes a cause-and-effect relationship and classifies chronic kidney disease with hypertension as hypertensive chronic kidney disease.

The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease.

See Section I.C.14. Chronic kidney disease.

If a patient has hypertensive chronic kidney disease **and acute** renal failure, an additional code for the acute renal failure is required.

Hypertensive Heart and Chronic Kidney Disease

Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when both hypertensive kidney disease and hypertensive heart disease are

stated in the diagnosis. Assume a relationship between the hypertension and the chronic kidney disease, whether or not the condition is so designated. If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.

The appropriate code from category N18, Chronic kidney disease, should be used as a secondary code with a code from category I13 to identify the stage of chronic kidney disease.

See Section I.C.14. Chronic kidney disease.

The codes in category I13, Hypertensive heart and chronic kidney disease, are combination codes that include hypertension, heart disease and chronic kidney disease. The Includes note at I13 specifies that the conditions included at I11 and I12 are included together in I13. If a patient has hypertension, heart disease and chronic kidney disease then a code from I13 should be used, not individual codes for hypertension, heart disease and chronic kidney disease, or codes from I11 or I12. For patients with both acute renal failure and chronic kidney disease an additional code for acute renal failure is required.

Hypertensive Cerebrovascular Disease

For hypertensive cerebrovascular disease, first assign the appropriate code from categories I60-I69, followed by the appropriate hypertension code.

Hypertensive Retinopathy

Code H35.0, Hypertensive retinopathy, should be used with code I10, Essential (primary) hypertension, to include the systemic hypertension. The sequencing is based on the reason for the encounter.

Hypertension, Secondary

Secondary hypertension is due to an underlying condition. Two codes are required: one to identify the underlying etiology and one from category I15 to identify the hypertension. Sequencing of codes is determined by the reason for admission/encounter.

Hypertension, Transient

Assign code R03.0, Elevated blood pressure reading without diagnosis of hypertension, unless patient has an established diagnosis of hypertension. Assign code O13.-, Gestational [pregnancy-induced] hypertension without significant proteinuria, or O14.-, Gestational [pregnancy-induced] hypertension with significant proteinuria, for transient hypertension of pregnancy.

Hypertension, Controlled

This diagnostic statement usually refers to an existing state of hypertension under control by therapy. Assign code I10.

Hypertension, Uncontrolled

Uncontrolled hypertension may refer to untreated hypertension or hypertension not responding to current therapeutic regimen. In either case, assign code I10.

Atherosclerotic coronary artery disease and angina

ICD-10-CM has combination codes for atherosclerotic heart disease with angina pectoris. The subcategories for these codes are I25.11, Atherosclerotic heart disease of native coronary artery with angina pectoris and I25.7, Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris.

When using one of these combination codes it is not necessary to use an additional code for angina pectoris. A causal relationship can be assumed in a patient with both atherosclerosis and angina pectoris, unless the documentation indicates the angina is due to something other than the atherosclerosis.

If a patient with coronary artery disease is admitted due to an acute myocardial infarction (AMI), the AMI should be sequenced before the coronary artery disease.

Acute myocardial infarction (AMI)

ST elevation myocardial infarction (STEMI) and non ST elevation myocardial infarction (NSTEMI)

The ICD-10-CM codes for acute myocardial infarction (AMI) identify the site, such as anterolateral wall or true posterior wall. Subcategories I21.0-I21.2 and code I21.4 are used for ST elevation myocardial infarction (STEMI). Code I21.4, Non-ST elevation (NSTEMI) myocardial infarction, is used for non ST elevation myocardial infarction (NSTEMI) and nontransmural MIs.

Acute myocardial infarction, unspecified

Code I21.3, ST elevation (STEMI) myocardial infarction of unspecified site, is the default for the unspecified term acute myocardial infarction. If only STEMI or transmural MI without the site is documented, query the provider as to the site, or assign code I21.3.

AMI documented as nontransmural or subendocardial but site provided

If an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as a subendocardial AMI. If NSTEMI evolves to STEMI, assign the STEMI code.

If STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

See Section I.C.21.3 for information on coding status post administration of tPA in a different facility within the last 24 hours.

Subsequent acute myocardial infarction

A code from category I22, Subsequent ST elevation (STEMI) and non ST elevation (NSTEMI) myocardial infarction, is to be used when a patient who has suffered an AMI has a new AMI within the 4 week time frame of the initial AMI. A code from category I22 must be used in conjunction with a code from category I21.

The sequencing of the I22 and I21 codes depends on the circumstances of the encounter. Should a patient who is in the hospital due to an AMI have a subsequent AMI while still in the hospital code I21 would be sequenced first as the reason for admission, with code I22 sequenced as a secondary code. Should a patient have a subsequent AMI after discharge for care of an initial AMI, and the reason for admission is the subsequent AMI, the I22 code should be sequenced first followed by the I21. An I21 code must accompany an I22 code to identify the site of the initial AMI, and to indicate that the patient is still within the 4 week time frame of healing from the initial AMI.

The guidelines for assigning the correct I22 code are the same as for the initial AMI.

Chapter 10: Diseases of Respiratory System (J00-J99)

Chronic Obstructive Pulmonary Disease [COPD] and Asthma

Acute exacerbation of chronic obstructive bronchitis and asthma

The codes in categories J44 and J45 distinguish between uncomplicated cases and those in acute exacerbation. An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.

Acute Respiratory Failure

Acute respiratory failure as principal diagnosis

Code J96.0, Acute respiratory failure, or code J96.2, Acute and chronic respiratory failure, may be assigned as a principal diagnosis when it is the condition established after study to be chiefly responsible for occasioning the admission to the hospital, and the selection is supported by the Alphabetic Index and Tabular List. However, chapter-specific coding guidelines (such as obstetrics, poisoning, HIV, newborn) that provide sequencing direction take precedence.

Acute respiratory failure as secondary diagnosis

Respiratory failure may be listed as a secondary diagnosis if it occurs after admission, or if it is present on admission, but does not meet the definition of principal diagnosis.

Sequencing of acute respiratory failure and another acute condition

When a patient is admitted with respiratory failure and another acute condition, (e.g., myocardial infarction, cerebrovascular accident, aspiration pneumonia), the principal diagnosis will not be the same in every situation. This applies whether the other acute condition is a respiratory or nonrespiratory condition. Selection of the principal diagnosis will be dependent on the circumstances of admission. If both the respiratory failure and the other acute condition are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis (*Section II, C.*) may be applied in these situations.

If the documentation is not clear as to whether acute respiratory failure and another condition are equally responsible for occasioning the admission, query the provider for clarification.

Influenza due to *certain identified influenza influenza viruses*

Code only confirmed cases of avian influenza (**code J09.0-, Influenza due to identified avian influenza virus**) or novel H1N1 or swine flu, **code J09.1-**. This is an exception to the hospital inpatient guideline Section II, H. (Uncertain Diagnosis). In this context, "confirmation" does not require documentation of positive laboratory testing specific for avian **or novel H1N1 (H1N1 or swine flu)** influenza. However, coding should be based on the provider's diagnostic statement that the patient has avian influenza.

If the provider records "suspected or possible or probable avian influenza," the appropriate influenza code from category J10, Influenza due to other influenza virus, should be assigned. **A code from category J09, Influenza due to certain identified influenza viruses**, should not be assigned.

Diseases of Digestive System (K00-K94)

Reserved for future guideline expansion

Diseases of Skin and Subcutaneous Tissue (L00-L99)

Pressure ulcer stages

Codes from category L89, Pressure ulcer, are combination codes that identify the site of the pressure ulcer as well as the stage of the ulcer.

The ICD-10-CM classifies pressure ulcer stages based on severity, which is designated by stages 1-4, unspecified stage and unstageable . Assign as many codes from category L89 as needed to identify all the pressure ulcers the patient has, if applicable.

Unstageable pressure ulcers

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

Documented pressure ulcer stage

Assignment of the pressure ulcer stage code should be guided by clinical documentation of the stage or documentation of the terms found in the index. For clinical terms describing the stage that are not found in the index, and there is no documentation of the stage, the provider should be queried.

Patients admitted with pressure ulcers documented as healed

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

Patients admitted with pressure ulcers documented as healing

Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign the appropriate code for unspecified stage.

If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider.

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, assign the code for the highest stage reported for that site.

Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)

Site and laterality

Most of the codes within Chapter 13 have site and laterality designations. The site represents either the bone, joint or the muscle involved. For some conditions where more than one bone, joint or muscle is usually involved, such as osteoarthritis, there is a "multiple sites" code available. For categories where no multiple site code is provided and more than one bone, joint or muscle is involved, multiple codes should be used to indicate the different sites involved.

Bone versus joint

For certain conditions, the bone may be affected at the upper or lower end, (e.g., avascular necrosis of bone, M87, Osteoporosis, M80, M81). Though the portion of the bone affected may be at the joint, the site designation will be the bone, not the joint.

Acute traumatic versus chronic or recurrent musculoskeletal conditions

Many musculoskeletal conditions are a result of previous injury or trauma to a site, or are recurrent conditions. Bone, joint or muscle conditions that are the result of a healed injury are usually found in chapter 13. Recurrent bone, joint or muscle conditions are also usually found in chapter 13. Any current, acute injury should be coded to the appropriate injury code from chapter 19. Chronic or recurrent conditions should generally be coded with a code from chapter 13. If it is difficult to determine from the documentation in the record which code is best to describe a condition, query the provider.

Coding of Pathologic 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.

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

See Section I.C.19. Coding of traumatic fractures.

Osteoporosis

Osteoporosis is a systemic condition, meaning that all bones of the musculoskeletal system are affected. Therefore, site is not a component of the codes under category

M81, Osteoporosis without current pathological fracture. The site codes under category M80, Osteoporosis with current pathological fracture, identify the site of the fracture, not the osteoporosis.

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 Z87.31, Personal history of osteoporosis fracture, should follow the code from M81.

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.

Diseases of Genitourinary System (N00-N99)

Chronic kidney disease

Stages of chronic kidney disease (CKD)

The ICD-10-CM classifies CKD based on severity. The severity of CKD is designated by stages I-V. Stage II, code N18.2, equates to mild CKD; stage III, code N18.3, equates to moderate CKD; and stage IV, code N18.4, equates to severe CKD. Code N18.6, End stage renal disease (ESRD), is assigned when the provider has documented end-stage-renal disease (ESRD).

If both a stage of CKD and ESRD are documented, assign code N18.6 only.

Chronic kidney disease and kidney transplant status

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. Therefore, 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 a transplant complication such as failure or rejection **or other transplant complication** is documented, see section I.C.19.g for information on coding complications of a kidney transplant. If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.

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.

Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)

Chapter 18 includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditions regarding which no diagnosis classifiable elsewhere is recorded. Signs and symptoms that point to a **specific** diagnosis have been assigned to a category in other chapters of the classification.

Use of symptom codes

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

Use of a symptom code with a definitive diagnosis code

Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes. The definitive diagnosis code should be sequenced before the symptom code. Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

Combination codes that include symptoms

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.

Repeated 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.

Glasgow coma scale

The Glasgow coma scale codes (R40.2-) can be used in conjunction with traumatic brain injury codes or sequelae of cerebrovascular accident codes. These codes are

primarily for use by trauma registries, but they may be used in any setting where this information is collected. The coma scale codes should be sequenced after the diagnosis code(s).

These codes, one from each subcategory, are needed to complete the scale. The 7th character indicates when the scale was recorded. The 7th character should match for all three codes.

At a minimum, report the initial score documented on presentation at your facility. This may be a score from the emergency medicine technician (EMT) or in the emergency department. If desired, a facility may choose to capture multiple Glasgow coma scale scores.

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.

SIRS due to Non-Infectious Process

The systemic inflammatory response syndrome (SIRS) can develop as a result of certain non-infectious disease processes, such as trauma, malignant neoplasm, or pancreatitis. When SIRS is documented with a noninfectious condition, and no subsequent infection is documented, the code for the underlying condition, such as an injury, should be assigned, followed by code R65.10, Systemic inflammatory response syndrome (SIRS) of non-infectious origin without acute organ dysfunction, or code R65.11, Systemic inflammatory response syndrome (SIRS) of non-infectious origin with acute organ dysfunction. If an associated acute organ dysfunction is documented, the appropriate code(s) for the specific type of organ dysfunction(s) should be assigned in addition to code R65.11. If acute organ dysfunction is documented, but it cannot be determined if the acute organ dysfunction is associated with SIRS or due to another condition (e.g., directly due to the trauma), the provider should be queried.

Death NOS

Code R99, Ill-defined and unknown cause of mortality, is only for use in the very limited circumstance when a patient who has already died is brought into an emergency department or other healthcare facility and is pronounced dead upon arrival. It does not represent the discharge disposition of death.

Injury, poisoning, and certain other consequences of external causes (S00-T88)

Code Extensions

Most categories in chapter 19 have 7th character extensions that are required for each applicable code. Most categories in this chapter have three extensions (with the exception of fractures): A, initial encounter, D, subsequent encounter and S, sequela.

Extension "A", initial encounter is used while the patient is receiving active treatment for the injury. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

Extension "D" subsequent encounter is used for encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase. Examples of subsequent care are: cast change or removal, removal of external **or** internal fixation device, medication adjustment, other aftercare and follow up visits following injury treatment.

The aftercare Z codes should not be used for aftercare for injuries. For aftercare of an injury, assign the acute injury code with the 7th character "D" (subsequent encounter). Extension "S", sequela, is for use for complications or conditions that arise as a direct result of an injury, such as scar formation after a burn. The scars are sequelae of the burn. When using extension "S", it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The "S" is added only to the injury code, not the sequela code. The "S" extension identifies the injury responsible for the sequela. The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code.

Coding of Injuries

When coding injuries, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned. Multiple injury codes are provided in ICD-10-CM, but should not be assigned unless information for a more specific code is not available. These **traumatic injury** codes (S00-T14.9) are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.

The code for the most serious injury, as determined by the provider and the focus of treatment, is sequenced first.

Superficial injuries

Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.

Primary injury with damage to nerves/blood vessels

When a primary injury results in minor damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) for injuries to nerves and spinal cord (such as category S04), and/or injury to blood vessels (such as category S15). When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.

Coding of Traumatic Fractures

The principles of multiple coding of injuries should be followed in coding fractures. Fractures of specified sites are coded individually by site in accordance with both the provisions within categories S02, S12, S22, S32, S42, **S49**, S52, **S59**, S62, S72, **S79**, S82, **S89**, S92 and the level of detail furnished by medical record content. A fracture not indicated as open or closed should be coded to closed. A fracture not indicated whether displaced or not displaced should be coded to displaced. More specific guidelines are as follows:

Initial vs. Subsequent Encounter for Fractures

Traumatic fractures are coded using the appropriate 7th character extension for initial encounter (A, B, C) while the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

Fractures are coded using the appropriate 7th character extension for subsequent care for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase. Examples of fracture aftercare are: cast change or removal, removal of external or internal fixation device, medication adjustment, and follow-up visits following fracture treatment.

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

Care of complications of fractures, such as malunion and nonunion, should be reported with the appropriate 7th character extensions for subsequent care with nonunion (K, M, N,) or subsequent care with malunion (P, Q, R).

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.**

See Section I.C.13. Osteoporosis.

The aftercare Z codes should not be used for aftercare for injuries. For aftercare of an injury, assign the acute injury code with the 7th character "D" (subsequent encounter).

Multiple fractures sequencing

Multiple fractures are sequenced in accordance with the severity of the fracture. The provider should be asked to list the fracture diagnoses in the order of severity.

Coding of Burns and Corrosions

The ICD-10-CM distinguishes between burns and corrosions. The burn codes are for thermal burns, except sunburns, that come from a heat source, such as a fire or hot appliance. The burn codes are also for burns resulting from electricity and radiation. Corrosions are burns due to chemicals. The guidelines are the same for burns and corrosions.

Current burns (T20-T25) are classified by depth, extent and by agent (X code). Burns are classified by depth as 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.

Sequencing of burn and related condition codes

Sequence first the code that reflects the highest degree of burn when more than one burn is present.

- a. When the reason for the admission or encounter is for treatment of external multiple burns, sequence first the code that reflects the burn of the highest degree.
- b. When a patient has both internal and external burns, the circumstances of admission govern the selection of the principal diagnosis or first-listed diagnosis.
- c. When a patient is admitted for burn injuries and other related conditions such as smoke inhalation and/or respiratory failure, the circumstances of admission govern the selection of the principal or first-listed diagnosis.

2) Burns of the same local site

Classify burns of the same local site (three-digit category level, T20-T28) but of different degrees to the subcategory identifying the highest degree recorded in the diagnosis.

3) Non-healing burns

Non-healing burns are coded as acute burns.

Necrosis of burned skin should be coded as a non-healed burn.

4) Infected Burn

For any documented infected burn site, use an additional code for the infection.

5) Assign separate codes for each burn site

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.

6) Burns and Corrosions Classified According to Extent of Body Surface Involved

Assign codes from category T31, Burns classified according to extent of body surface involved, or T32, Corrosions classified according to extent of body surface involved, when the site of the burn is not specified or when there is a need for additional data. 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.

Categories T31 and T32 are based on the classic "rule of nines" in estimating body surface involved: head and neck are assigned nine percent, each arm nine percent, each leg 18 percent, the anterior trunk 18 percent, posterior trunk 18 percent, and genitalia one percent. Providers may change these percentage assignments where necessary to accommodate infants and children who have proportionately larger heads than adults, and patients who have large buttocks, thighs, or abdomen that involve burns.

7) Encounters for treatment of late effects 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" or sequela.

8) Sequelae with a late effect code and current burn

When appropriate, both a code for a current burn or corrosion with 7th character extension "A" or "D" and a burn or corrosion code with extension "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.

9) Use of an external cause code with burns and corrosions

An external cause code should be used with burns and corrosions to identify the source and intent of the burn, as well as the place where it occurred.

Adverse Effects, Poisoning , Underdosing and Toxic Effects

Codes in categories T36-T65 are combination codes that include the substances related to adverse effects, poisonings, toxic effects and underdosing, as well as the external cause. No additional external cause code is required for poisonings, toxic effects, adverse effects and underdosing codes.

A code from categories T36-T65 is sequenced first, followed by the code(s) that specify the nature of the adverse effect, poisoning, or toxic effect. **Note: This sequencing instruction does not apply to underdosing codes (fifth or sixth character "6", for example T36.0x6-).**

1) Do not code directly from the Table of Drugs

Do not code directly from the Table of Drugs and Chemicals. Always refer back to the Tabular List.

2) Use as many codes as necessary to describe

Use as many codes as necessary to describe completely all drugs, medicinal or biological substances.

3) If the same code would describe the causative agent

If the same code would describe the causative agent for more than one adverse reaction, poisoning, toxic effect or underdosing, assign the code only once.

4) If two or more drugs, medicinal or biological substances

If two or more drugs, medicinal or biological substances are reported, code each individually unless the combination code is listed in the Table of Drugs and Chemicals.

5) The occurrence of drug toxicity is classified in ICD-10-CM as follows:

Adverse Effect

Assign the appropriate code for adverse effect (for example, T36.0x5-) when the drug was correctly prescribed and properly administered. Use additional code(s) for all manifestations of adverse effects. Examples of manifestations are tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure.

Poisoning

When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration), assign the appropriate code from categories T36-T50. Poisoning codes have an

associated intent: accidental, intentional self-harm, assault and undetermined. Use additional code(s) for all manifestations of poisonings.

If there is also a diagnosis **of abuse or dependence on** the substance, the abuse or dependence is coded as an additional code.

Examples of poisoning include:

(i) Error was made in drug prescription

Errors made in drug prescription or in the administration of the drug by provider, nurse, patient, or other person.

(ii) Overdose of a drug intentionally taken

If an overdose of a drug was intentionally taken or administered and resulted in drug toxicity, it would be coded as a poisoning.

(iii) Nonprescribed drug taken with correctly prescribed and properly administered drug

If a nonprescribed drug or medicinal agent was taken in combination with a correctly prescribed and properly administered drug, any drug toxicity or other reaction resulting from the interaction of the two drugs would be classified as a poisoning.

(iv) Interaction of drug(s) and alcohol

When a reaction results from the interaction of a drug(s) and alcohol, this would be classified as poisoning.

See Section I.C.4. if poisoning is the result of insulin pump malfunctions.

Underdosing

Underdosing refers to taking less of a medication than is prescribed by a **provider** or a manufacturer's instruction. For underdosing, assign the code from categories T36-T50 (**fifth or sixth character "6"**).

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 (Z91.12-, Z91.13-) or complication of care (Y63.61, Y63.8-Y63.9) codes are to be used with an underdosing code to indicate intent, if known.

Toxic Effects

When a harmful substance is ingested or comes in contact with a person, this is classified as a toxic effect. The toxic effect codes are in categories T51-T65.

Toxic effect codes have an associated intent: accidental, intentional self-harm, assault and undetermined.

Adult and child abuse, neglect and other maltreatment

Sequence first the appropriate code from categories T74.- or T76.- for abuse, neglect and other maltreatment, followed by any accompanying mental health or injury code(s). If the documentation in the medical record states abuse or neglect it is coded as confirmed. It is coded as suspected if it is documented as suspected.

For cases of confirmed abuse or neglect an external cause code from the assault section (X92-Y08) should be added to identify the cause of any physical injuries. A perpetrator code (Y07) should be added when the perpetrator of the abuse is known. For suspected cases of abuse or neglect, do not report external cause or perpetrator code.

If a suspected case of abuse, neglect or mistreatment is ruled out during an encounter code Z04.71, Suspected adult physical and sexual abuse, ruled out, or code Z04.72, Suspected child physical and sexual abuse, ruled out, should be used, not a code from T76.

Complications of care

Documentation of complications of care

As with all procedural or postprocedural complications, code assignment is based on the provider's documentation of the relationship between the condition and the procedure.

Chapter 20: External Causes of Morbidity (V01- Y99)

Introduction: These guidelines are provided for the reporting of external causes of morbidity codes in order that there will be standardization in the process. These codes are secondary codes for use in any health care setting.

External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred the activity of the patient at the time of the event, **and the person's status (e.g., civilian, military).**

General External Cause Coding Guidelines

1) Used with any code in the range of A00.0-T88.9, Z00-Z99

An external cause code may be used with any code in the range of A00.0-T88.9, Z00-Z99, classification that is a health condition due to an external cause. Though they are most applicable to injuries, they are also valid for use with such things as infections or diseases due to an external source, and other health conditions, such as a heart attack that occurs during strenuous physical activity.

2) External cause code used for length of treatment

Assign the external cause code, with the appropriate 7th character (initial encounter, subsequent encounter or sequela) for each encounter for which the injury or condition is being treated.

3) Use the full range of external cause codes

Use the full range of external cause codes to completely describe the cause, the intent, the place of occurrence, **and if applicable**, the activity of the patient at the time of the event, **and the patient's status**, for all injuries, and other health conditions due to an external cause.

4) Assign as many external cause codes as necessary

Assign as many external cause codes as necessary to fully explain each cause. If only one external code can be recorded, assign the code most related to the principal diagnosis.

5) The selection of the appropriate external cause code

The selection of the appropriate external cause code is guided by the Index to External Causes, which is located after the Alphabetical Index to diseases and by Inclusion and Exclusion notes in the Tabular List.

6) External cause code can never be a principal diagnosis

An external cause code can never be a principal (first listed) diagnosis.

7) Combination external cause codes

Certain of the external cause codes are combination codes that identify sequential events that result in an injury, such as a fall which results in striking against an object. The injury may be due to either event or both. The combination external cause code used should correspond to the sequence of events regardless of which caused the most serious injury.

8) No external cause code needed in certain circumstances

No external cause code from Chapter 20 is needed if the external cause and intent are included in a code from another chapter (e.g. T360x1- Poisoning by penicillins, accidental (unintentional)).

b. Place of Occurrence Guideline

Codes from category Y92, Place of occurrence of the external cause, are secondary codes for use after other external cause codes to identify the location of the patient at the time of injury or other condition.

A place of occurrence code is used only once, at the initial encounter for treatment. No 7th characters are used for Y92. Only one code from Y92 should be recorded on a medical record. A place of occurrence code should be used in conjunction with an activity code, Y93.

Do not use place of occurrence code Y92.9 if the place is not stated or is not applicable.

A place of occurrence code is used only once, at the initial encounter for treatment. No 7th characters are used for Y92. Only one code from Y92 should be recorded on a medical record. A place of occurrence code should be used in conjunction with an activity code, Y93.

Do not use place of occurrence code Y92.9 if the place is not stated or is not applicable.

c. Activity Code

Assign a code from category Y93, Activity code, to describe the activity of the patient at the time the injury **or other health condition occurred**.

An activity code is used only once, at the initial encounter for treatment. Only one code from Y93 should be recorded on a medical record. An activity code should be used in conjunction with a place of occurrence code, Y92.

If a patient is a student but is injured while performing an activity for income, use 7th character "2", work related activity.

A work related activity is any activity for which payment or income is received.
The activity codes are not applicable to poisonings, adverse effects, misadventures or late effects.

Do not assign Y93.9, Unspecified activity, if the activity is not stated.

d. Place of Occurrence, Activity, and Status Codes Used with other External Cause Code

When applicable, place of occurrence, activity, and external cause status codes are sequenced after the main external cause code(s). Regardless of the number of external cause codes assigned, there should be only one place of occurrence code, one activity code, and one external cause status code assigned to an encounter.

e. If the Reporting Format Limits the Number of External Cause Codes

If the reporting format limits the number of external cause codes that can be used in reporting clinical data, **report the code for the cause/intent** most related to the principal diagnosis. **If the format permits capture of additional external cause codes, the cause/intent, including medical misadventures, of the additional events should be reported rather than the codes for place, activity, or external status.**

Multiple External Cause Coding Guidelines

More than one external cause code is required to fully describe the external cause of an illness, injury or poisoning. The assignment of external cause codes should be sequenced in the following priority:

If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first listed external cause code will be selected in the following order:

External codes for child and adult abuse take priority over all other external cause codes.

See Section I.C.19., Child and Adult abuse guidelines.

External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.

External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse and terrorism.

External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, child and adult abuse and terrorism.

Activity and external cause status codes are assigned following all causal (intent) external cause codes.

The first-listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm, following the order of hierarchy listed above.

g. Child and Adult Abuse Guideline

Adult and child abuse, neglect and maltreatment are classified as assault. Any of the assault codes may be used to indicate the external cause of any injury resulting from the confirmed abuse.

For confirmed cases of abuse, neglect and maltreatment, when the perpetrator is known, a code from Y07, Perpetrator of maltreatment and neglect, should accompany any other assault codes.

See Section I.C.19. Adult and child abuse, neglect and other maltreatment

h. Unknown or Undetermined Intent Guideline

If the intent (accident, self-harm, assault) of the cause of an injury or other condition is unknown or unspecified, code the intent as accidental intent. All transport accident categories assume accidental intent.

Use of undetermined intent

External cause codes for events of undetermined intent are only for use if the documentation in the record specifies that the intent cannot be determined

Late Effects of External Cause Guidelines

1) Late effect external cause codes

Late effects are reported using the external cause code with the 7th character extension "S" for sequela. These codes should be used with any report of a late effect or sequela resulting from a previous injury.

2) Late effect external cause code with a related current injury

A late effect external cause code should never be used with a related current nature of injury code.

3) Use of late effect external cause codes for subsequent visits

Use a late effect external cause code for subsequent visits when a late effect of the initial injury is being treated. Do not use a late effect external cause code for subsequent visits for follow-up care (e.g., to assess healing, to receive rehabilitative therapy) of the injury or poisoning when no late effect of the injury has been documented.

Chapter 21: Factors influencing health status and contact with health services (Z00-Z99)

Note: The chapter specific guidelines provide additional information about the use of Z codes for specified encounters.

a. Use of Z codes in any healthcare setting

Z codes are for use in any healthcare setting. Z codes may be used as either a first listed (principal diagnosis code in the inpatient setting) or

secondary code, depending on the circumstances of the encounter. Certain **Z** codes may only be used as first listed or principal diagnosis.

b. Z Codes indicate a reason for an encounter

Z codes are not procedure codes. A corresponding procedure code must accompany a Z code to describe the procedure performed.

c. Categories of Z Codes

1) Contact/Exposure

Category Z20 indicates contact with, **and suspected** exposure to, communicable diseases. These codes are for patients who do not show any sign or symptom of a disease but **are suspected to** have been exposed to it by close personal contact with an infected individual or are in an area where a disease is epidemic.

Category Z77, indicates contact with and suspected exposures hazardous to health.

Contact/exposure codes may be used as a first listed code to explain an encounter for testing, or, more commonly, as a secondary code to identify a potential risk.

2) Inoculations and vaccinations

Code Z23 is for encounters for inoculations and vaccinations. It indicates that a patient is being seen to receive a prophylactic inoculation against a disease. Procedure codes are required to identify the actual administration of the injection and the type(s) of immunizations given. Code Z23 may be used as a secondary code if the inoculation is given as a routine part of preventive health care, such as a well-baby visit.

3) Status

Status codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition.

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. For example, code Z94.1, Heart transplant status, should not be used with a code from subcategory T86.2, Complications of heart transplant. The status code does not provide additional information. The complication code indicates that the patient is a heart transplant patient.

For encounters for weaning from a mechanical ventilator, assign code J96.1, Chronic respiratory failure, followed by code Z99.11, Dependence on respirator [ventilator] status.

The status Z codes/categories are:

Z14 Genetic carrier

Genetic carrier status indicates that a person carries a gene, associated with a particular disease, which may be passed to offspring who may develop that disease. The person does not have the disease and is not at risk of developing the disease.

Z15 Genetic susceptibility to disease

Genetic susceptibility indicates that a person has a gene that increases the risk of that person developing the disease.

Codes from category Z15 should not be used as principal or first-listed codes. If the patient has the condition to which he/she is susceptible, and that condition is the reason for the encounter, the code for the current condition should be sequenced first. If the patient is being seen for follow-up after completed treatment for this condition, and the condition no longer exists, a follow-up code should be sequenced first, followed by the appropriate personal history and genetic susceptibility codes. If the purpose of the encounter is genetic counseling associated with procreative management, code Z31.5, Encounter for genetic counseling, should be assigned as the first-listed code, followed by a code from category Z15. Additional codes should be assigned for any applicable family or personal history.

Z16 Infection with drug-resistant microorganisms

This code indicates that a patient has an infection that is resistant to drug treatment. Sequence the infection code first.

Z17 Estrogen receptor status

Z21 Asymptomatic HIV infection status

This code indicates that a patient has tested positive for HIV but has manifested no signs or symptoms of the disease.

Z22 Carrier of infectious disease

Carrier status indicates that a person harbors the specific organisms of a disease without manifest symptoms and is capable of transmitting the infection.

Z28.3 Underimmunization status

Z33.1 Pregnant state, incidental

This code is a secondary code only for use when the pregnancy is in no way complicating the reason for visit. Otherwise, a code from the obstetric chapter is required.

Z66 Do not resuscitate

Z67 Blood type

Z68 Body mass index (BMI)

Z74.01 Bed confinement status

Z76.82 Awaiting organ transplant status

Z78 Other specified health status

Z79 Long-term (current) drug therapy

Codes from this category indicate a patient's continuous use of a prescribed drug (including such things as aspirin therapy) for the long-term treatment of a condition or for prophylactic use. It is not for use for patients who have addictions to drugs. This subcategory is not for use of medications for detoxification or maintenance programs to prevent withdrawal symptoms in patients with drug dependence (e.g., methadone maintenance for opiate dependence). Assign the appropriate code for the drug dependence instead.

Assign a code from Z79 if the patient is receiving a medication for an extended period as a prophylactic measure (such as for the prevention of deep vein thrombosis) or as treatment of a chronic condition (such as arthritis) or a disease requiring a lengthy course of treatment (such as cancer). Do not assign a code from category Z79 for medication being administered for a brief period of time to treat an acute illness or injury (such as a course of antibiotics to treat acute bronchitis).

Z88 Allergy status to drugs, medicaments and biological substances

Except: Z88.9, Allergy status to unspecified drugs, medicaments and biological substances status

Z89 Acquired absence of limb

Z90 Acquired absence of organs, not elsewhere classified

Z91.0- Allergy status, other than to drugs and biological substances

Z92.82 Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to a current facility

Assign code Z92.82, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility, as a secondary diagnosis when a patient is received by transfer into a facility and documentation indicates they were administered tissue plasminogen activator (tPA) within the last 24 hours prior to admission to the current facility.

This guideline applies even if the patient is still receiving the tPA at the time they are received into the current facility.

The appropriate code for the condition for which the tPA was administered (such as cerebrovascular disease or myocardial infarction) should be assigned first.

Code Z92.82 is only applicable to the receiving facility record and not to the transferring facility record.

Z93 Artificial opening status

Z94 Transplanted organ and tissue status

Z95 Presence of cardiac and vascular implants and grafts

Z96 Presence of other functional implants

Z97 Presence of other devices

Z98 Other postprocedural states

Assign code Z98.85, Transplanted organ removal status, to indicate that a transplanted organ has been previously removed. This code should not be assigned for the encounter in which the transplanted organ is removed. The complication necessitating removal of the transplant organ should be assigned for that encounter.

See section I.C19.g.3. for information on the coding of organ transplant complications.

Z99 Dependence on enabling machines and devices, not elsewhere classified

Note: Categories Z89-Z90 and Z93-Z99 are for use only if there are no complications or malfunctions of the organ or tissue replaced, the amputation site or the equipment on which the patient is dependent.

4) History (of)

There are two types of history Z codes, personal and family. Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring.

Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.

Personal history codes may be used in conjunction with follow-up codes and family history codes may be used in conjunction with screening codes to explain the need for a test or procedure. History codes are also acceptable on any medical record regardless of the reason for visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

The history Z code categories are:

Z80 Family history of primary malignant neoplasm

Z81 Family history of mental and behavioral disorders

Z82 Family history of certain disabilities and chronic diseases (leading to disablement)

Z83 Family history of other specific disorders

Z84 Family history of other conditions

Z85 Personal history of malignant neoplasm

Z86 Personal history of certain other diseases

Z87 Personal history of other diseases and conditions

Z91.4- Personal history of psychological trauma, not elsewhere classified

Z91.5 Personal history of self-harm

Z91.8- Other specified personal risk factors, not elsewhere classified

Z92 Personal history of medical treatment

Except: Z92.0, Personal history of contraception

Except: Z92.82, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to a current facility

5) Screening

Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease (e.g., screening mammogram).

The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test.

A screening code may be a first listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done

during an office visit for other health problems. A screening code is not necessary if the screening is inherent to a routine examination, such as a pap smear done during a routine pelvic examination.

Should a condition be discovered during the screening then the code for the condition may be assigned as an additional diagnosis.

The Z code indicates that a screening exam is planned. A procedure code is required to confirm that the screening was performed.

The screening Z codes/categories:

Z11 Encounter for screening for infectious and parasitic diseases

Z12 Encounter for screening for malignant neoplasms

Z13 Encounter for screening for other diseases and disorders

Except: Z13.9, Encounter for screening, unspecified

Z36 Encounter for antenatal screening for mother

Selection of Principal Diagnosis

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc). In determining principal diagnosis the coding conventions in the ICD-10-CM, Volumes I and II take precedence over these official coding guidelines.

(See Section I.A., Conventions for the ICD-10-CM)

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task.

A. Codes for symptoms, signs, and ill-defined conditions

Codes for symptoms, signs, and ill-defined conditions from Chapter 18 are not to be used as principal diagnosis when a related definitive diagnosis has been established.

B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis.

When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

C. Two or more diagnoses that equally meet the definition for principal diagnosis

In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

D. Two or more comparative or contrasting conditions.

In those rare instances when two or more contrasting or comparative diagnoses are documented as "either/or" (or similar terminology), they are coded as if the diagnoses were confirmed and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

E. A symptom(s) followed by contrasting/comparative diagnoses

When a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be coded as additional diagnoses.

F. Original treatment plan not carried out

Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.

G. Complications of surgery and other medical care

When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the T80-T88 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned.

H. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out”, or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: *This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.*

I. Admission from Observation Unit Admission Following Medical Observation

When a patient is admitted to an observation unit for a medical condition, which either worsens or does not improve, and is subsequently admitted as an inpatient of the same hospital for this same medical condition, the principal diagnosis would be the medical condition which led to the hospital admission.

Admission Following Post-Operative Observation

When a patient is admitted to an observation unit to monitor a condition (or complication) that develops following outpatient surgery, and then is subsequently admitted as an inpatient of the same hospital, hospitals should apply the Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

J. Admission from Outpatient Surgery

When a patient receives surgery in the hospital's outpatient surgery department and is subsequently admitted for continuing inpatient care at the same hospital, the following guidelines should be followed in selecting the principal diagnosis for the inpatient admission:

If the reason for the inpatient admission is a complication, assign the complication as the principal diagnosis.

If no complication, or other condition, is documented as the reason for the inpatient admission, assign the reason for the outpatient surgery as the principal diagnosis.

If the reason for the inpatient admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis.

Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

For reporting purposes the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring.

The UHDDS item #11-b defines Other Diagnoses as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.” UHDDS definitions apply to inpatients in acute care, short-term, long term care and psychiatric hospital setting. The UHDDS definitions are used by acute care short-term hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc).

The following guidelines are to be applied in designating “other diagnoses” when neither the Alphabetic Index nor the Tabular List in ICD-10-CM provide direction. The listing of the diagnoses in the patient record is the responsibility of the attending provider.

A. Previous conditions

If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.

However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

B. Abnormal findings

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

Please note: This differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider.

C. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out” or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

Diagnostic Coding and Reporting Guidelines for Outpatient Services

These coding guidelines for outpatient diagnoses have been approved for use by hospitals/ providers in coding and reporting hospital-based outpatient services and provider-based office visits.

Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-10-CM Tabular List (code numbers and titles), can be found in Section IA of these guidelines, under “Conventions Used in the Tabular List.” Information about the correct sequence to use in finding a code is also described in Section I.

The terms encounter and visit are often used interchangeably in describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other.

Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that:

The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis applies only to inpatients in acute, short-term, long-term care and psychiatric hospitals. Coding guidelines for inconclusive diagnoses (probable,

suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

A. Selection of first-listed condition

In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis.

In determining the first-listed diagnosis the coding conventions of ICD-10-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines.

Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.

Outpatient Surgery

When a patient presents for outpatient surgery (same day surgery), code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.

Observation Stay

When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the first-listed diagnosis.

When a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses.

B. Codes from A00.0 through T88.9, Z00-Z99

The appropriate code(s) from A00.0 through T88.9, Z00-Z99 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

C. Accurate reporting of ICD-10-CM diagnosis codes

For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-10-CM codes to describe all of these.

D. Codes that describe symptoms and signs

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings Not Elsewhere Classified (codes R00-R99) contain many, but not all codes for symptoms.

E. Encounters for circumstances other than a disease or injury

ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services codes (Z00-99) is provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

See Section I.C.21. Factors influencing health status and contact with health services.

F. Level of Detail in Coding

ICD-10-CM codes with 3, 4, or 5 digits

ICD-10-CM is composed of codes with either 3, 4, 5, 6 or 7 digits. Codes with three digits are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth fifth digits, sixth or seventh digits which provide greater specificity.

Use of full number of digits required for a code

A three-digit code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character extension, if applicable.

G. ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit

List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

H. Uncertain diagnosis

Do not code diagnoses documented as "probable", "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

I. Chronic diseases

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

J. Code all documented conditions that coexist

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

K. Patients receiving diagnostic services only

For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign Z01.89, Encounter for other specified special examinations. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the V code and the code describing the reason for the non-routine test.

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Please note: This differs from the coding practice in the hospital inpatient setting regarding abnormal findings on test results.

L. Patients receiving therapeutic services only

For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy or radiation therapy, the appropriate Z code for

the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

M. Patients receiving preoperative evaluations only

For patients receiving preoperative evaluations only, sequence first a code from subcategory Z01.81, Encounter for pre-procedural examinations, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.

N. Ambulatory surgery

For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

O. Routine outpatient prenatal visits

See Section I.C.15. Routine outpatient prenatal visits.

P. Encounters for general medical examinations with abnormal findings

The subcategories for encounters for general medical examinations, Z00.0-, provide codes for with and without abnormal findings. Should a general medical examination result in an abnormal finding, the code for general medical examination with abnormal finding should be assigned as the first listed diagnosis. A secondary code for the abnormal finding should also be coded.

Q. Encounters for routine health screenings

See Section I.C.21. Factors influencing health status and contact with health services, Screening

NUMERICAL ORDER BY ICD-9-CM

ICD-9-CM

250.00 - Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled

ICD-10-CM

E11.9: Type 2 diabetes mellitus without complications

ICD-9-CM

272.0 - Pure hypercholesterolemia

ICD-10-CM

E78.0 - Pure hypercholesterolemia

ICD-9-CM

272.4 - Other and unspecified hyperlipidemia

ICD-10-CM

E78.5 - Hyperlipidemia, unspecified

ICD-9-CM

401.9 - Unspecified essential hypertension

ICD-10-CM

Too many codes to list. Provider needs to document more specificity to find the correct code.

ICD-9-CM

356.9 - Unspecified hereditary and idiopathic peripheral neuropathy

ICD-10-CM

G60.9 - Hereditary and idiopathic neuropathy, unspecified

ICD-9-CM

412 - Old myocardial infarction

ICD-10-CM

I25.2 - Old myocardial infarction

ICD-9-CM

530.81 - Esophageal reflux

ICD-10-CM

K21.0 - Gastro-esophageal reflux disease with esophagitis

K21.9 - Gastro-esophageal reflux disease without esophagitis

ICD-9-CM

600.01 - Hypertrophy (benign) of prostate with urinary obstruction and other lower urinary tract symptoms (LUTS)

ICD-10-CM

D29.1 - Benign neoplasm of prostate

ICD-9-CM

733.00 - Osteoporosis, unspecified

ICD-10-CM

Too many codes to list. Provider needs to document more specificity to find the correct code.

ICD-9-CM

V58.67 - Long-term (current) use of insulin

ICD-10-CM

Z79.4 - Long term (current) use of insulin

The process for coding ICD-10 is no different than that of ICD-9, but documentation will be the success or failure of ICD-10. Improper or lack of documentation will only delay claims processing and will decrease practice revenue. The coder reads the medical record. The coder reads that the doctor documented "Chest pain". The coder opens the ICD-10 manual, goes to the Index (words) and looks up the condition, which in this case is Pain.

Pain(s) (see also Painful) R52

- - chest (central) R07.4
- - - anterior wall R07.89
- - - atypical R07.89
- - - ischemic I20.9
- - - musculoskeletal R07.89
- - - non-cardiac R07.89
- - - on breathing R07.1
- - - pleurodynia R07.81
- - - precordial R07.2
- - - wall (anterior) R07.89

As you can see from the above ICD-10 index, you have chest pain listed as R07.4. Next you want to go to the tabular section to make sure that R07.4 is the correct code and to see if there are any coding conventions. Coding conventions provide us with additional information we need to ensure we have the correct code.

- R07 Pain in throat and chest
- Excludes.:dysphagia (R13) epidemic myalgia (B33.0) pain in:breast (N64.4)
- neck (M54.2)
- sore throat (acute) NOS (J02.9)
- R07.0 Pain in throat
- R07.1 Chest pain on breathing
- Incl.:Painful respiration
- R07.2 Precordial pain
- R07.3 Other chest pain
- Incl.:Anterior chest-wall pain NOS
- R07.4 Chest pain, unspecified

If you look at the above tabular section, you can see coding conventions identical to those from ICD-9-CM. You can see NOS which means Not Otherwise Specified, Incl which means Includes and excludes which means these medical conditions are not included in this code. Code R07.4 has no coding conventions or additional information, so, based on the medical record documentation of chest pain, we can select R07.4.

Again, if you can code ICD-9, you can code ICD-10. If you don't have the training in the process of coding, you will not be able to code under ICD-10.

CODING CHAPTERS

Under ICD-9-CM, you have the following:

- Chapter 1: Infectious and Parasitic Diseases (001-139)
- Chapter 2: Neoplasms (140-239)
- Chapter 3: Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
- Chapter 4: Diseases of Blood and Blood Forming Organs (280-289)
- Chapter 5: Mental Disorders (290-319)
- Chapter 6: Diseases of Nervous System and Sense Organs (320-389)
- Chapter 7: Diseases of Circulatory System (390-459)
- Chapter 8: Diseases of Respiratory System (460-519)
- Chapter 9: Diseases of Digestive System (520-57)
- Chapter 10: Diseases of Genitourinary System (580-629)
- Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium (630-677)
- Chapter 12: Diseases Skin and Subcutaneous Tissue (680-709)
- Chapter 13: Diseases of Musculoskeletal and Connective Tissue (710-739)
- Chapter 14: Congenital Anomalies (740-759)
- Chapter 15: Newborn (Perinatal) Guidelines (760-779)
- Chapter 16: Signs, Symptoms and Ill-Defined Conditions (780-799)
- Chapter 17: Injury and Poisoning (800-999)
- Chapter 18: Classification of Factors Influencing Health Status and Contact with Health Service (Supplemental V01-V84) and Supplemental Classification of External Causes of Injury and Poisoning (E-codes, E800-E999)

Under ICD-10, you have the following:

- Chapter 1: Certain infectious and parasitic diseases (A00-B99)
- Chapter 2: Neoplasms (C00-D48)
- Chapter 3: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)
- Chapter 4: Endocrine, nutritional and metabolic diseases (E00-E90)
- Chapter 5: Mental and behavioral disorders (F01-F99)
- Chapter 6: Diseases of the nervous system (G00-G99)
- Chapter 7: Diseases of the eye and adnexa (H00-H59)
- Chapter 8: Diseases of the ear and mastoid process (H60-H95)
- Chapter 9: Diseases of the circulatory system (I00-I99)

Chapter 10: Acute upper respiratory infections (J00-J06)
Chapter 11: Diseases of oral cavity and salivary glands (K00-K14)
Chapter 12: Diseases of the skin and subcutaneous tissue (L00-L99)
Chapter 13: Diseases of the musculoskeletal system and connective tissue (M00-M99)
Chapter 14: Diseases of the genitourinary system (N00-N99)
Chapter 15: Pregnancy, childbirth and the puerperium (O00-O99)
Chapter 16: Certain conditions originating in the perinatal period (P00-P96)
Chapter 17: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
Chapter 18: Symptoms and signs involving the circulatory and respiratory systems (R00-R09)
Chapter 19: Injury, poisoning and certain other consequences of external causes (S00-T98)
Chapter 20: External causes of morbidity (V01-Y98)
Factors influencing health status and contact with health services (Z00-Z99)

E Codes will become V-Y Codes
V Codes will become Z Codes.

The Table of Drugs and Biologicals that were 900 series codes and E Codes are now T Codes.

There were 18 Chapters in ICD-9-CM and we have 20 chapters under ICD-10-CM.

The proposed effective date for ICD-10 is October 1, 2014.

So, what do we have to do?

PREPARING FOR ICD-10

Training

If your current coder has NO training, you need to send them to be trained how to code. If they cannot code under ICD-9, they will not be able to code under ICD-10. As I stated the process of coding is the same. Being the spouse of the doctor, a receptionist or an accountant is NOT a coder.

A coder MUST read the medical record, go to the coding manual and find the code in the Index, then go to the tabular and read the actual code. The coder must read any coding conventions to determine the exact code that is documented in the medical record. Coding is NOT getting a test study guide and taking that test to be awarded initials. What happens is that the person comes along and asks for codes using the

internet. It's sad when you see someone with reputable coding initials asking basic questions, "Can someone give me a code for chest pain?" or what code can I use with a cranialrectalectomy? The code being provided may be fake and the person asking will have no clue on this because they don't know how to code and they won't open the manual. Forums will stop providing codes to those who ask.

Right now, some are telling the person asking for a code that the forum is not the proper place to ask for codes. The student who cheats by asking a forum to provide them with the coding answers to their homework or their test will find themselves expelled and if hired, will become unemployed. At one time, I was teaching a coding class. I gave my students a homework assignment. One of my students asked every question, hoping to get someone to do her work. Someone gave her all incorrect answers. When she turned in her homework, the class was given a pop quiz. The pop quiz was the homework assignment. She made a copy of her homework and tried to hide the pages in her coding manual. Instead of looking up the codes, she was copying the answers from her homework. She was very surprised that she failed every test answer. What was also interesting is that a couple of my other students did the same thing by going on the internet to get someone to answer their homework assignment. It was interesting that the student had every homework question correct, yet, they failed the same identical question when tested on those questions.

Years ago, I was taught RTFM! When I asked a fellow coder a question, his reply was RTFM! Over and over I was told RTFM! What's RTFM? READ THE FREAKING MANUAL, only freaking is a nice way of saying the "F" word. They were right. I must have read thousands of medical records during my training and my coding book was so worn out. I learned: Read the medical record, look up the condition in the index, look up the code in the tabular, pay attention to coding conventions. I spent 6 months on a probationary status before being allowed to code an actual visit for claim submission. My teacher made sure I was 100% accurate, 100% of the time.

In a company where I worked, we had a coder with a mile of initials come to me, asking, Steve, "What code can I use with this?" I smiled and gave her wrong codes because I had no clue how to code at the time. The boss called her to ask her where she got her information. She said Steve gave them to me. When I was asked, I said, "I'm not a coder and yes, I gave them to her, but it's her job to code, not mine." She was terminated. My punishment was to undergo coding training and my teacher could make a seasoned Marine Corps drill sergeant cry.

Today, many practices now give a coding employee candidate a pre-employment test. These tests don't come with a study guide. You are given the test cold, without advance notice and you better pass. Having initials after your name won't allow you any special privileges. I recently spoke to one doctor. She told me if you walk in with initials after your name, turn around and leave. You won't be hired. When I asked

why, she told me that these people are supposed to know how to code, but they cannot do it, they don't know what they're doing, so she makes her job easy. Initials don't get hired automatically. If you fail her coding test, she contacted your coding association with the recommendation that your initials be revoked and she will tell that association that under no circumstances will any of their coders be hired by her or her associates, simply because she doesn't trust the certification that the organization issues. To repeat myself, if you know how to code using ICD-9, you should have no problem coding using ICD-10. If not, take this time to undergo training. A doctor's spouse, a receptionist, medical biller and accountant is NOT a coder. A biller is trained in the basics of coding to understand the codes to be placed on the claim and a medical biller uses their basic knowledge of coding to appeal a claim denial when coding is involved, but a medical biller is not a coder.

Staff coders with training and certification need to undergo ICD-10 familiarization training to show coding using ICD-10 codes are not going to be difficult. If you can code under ICD-9, you shouldn't have any problems coding under ICD-10. American Academy of Professional Coders (AAPC) will need to take a proficiency assessment for certification. Professional Association of Healthcare Coding Specialists (PAHCS) certified coders do not. So, if your coder is certified by the AAPC, ensure that they take the AAPC ICD-10 proficiency assessment so that they can undergo recertification.

Documentation:

If your documentation is currently insufficient or poor, now is the time to improve your documentation. Include anatomy if the condition affects an anatomical area. If there is right or left or both, document left or right or both. Take your ego down a step and look at how important your documentation affects many. If affects YOU as a doctor, it affects your staff who depend on the claims payment to be paid themselves. It affects your patient. Your lack or insufficient documentation could result in improper or insufficient treatment, causing you to undergo a malpractice lawsuit. Sadly many malpractice lawsuits are settled out of court due to poor documentation and many more are lost in court. Your documentation or lack thereof will determine if you will win or lose the lawsuit. As a patient, I've looked at the records of my visits. The doctor who doesn't document properly loses me as their patient. The doctor that cannot document my visit properly, places my health in jeopardy. So when I'm asked by friends or family members who they should see for their healthcare, the doctor who poorly documents will not get my recommendation. You have 10 months to improve your documentation. Again, if it isn't documented, it doesn't exist and you don't code it.

Look at the following documentation and ask yourself, can you code from it and is it complete?

S: Pt here for follow up
O: Pt improving since last visit.
A: Doing much better
P: RTC in 2 weeks.

OK, what do we have? Nothing! Pt here for follow up, follow up for what? When was the patient seen last and why? What medical condition is being treated for, during this visit? Doing much better is not a diagnosis. I'm sure you can agree that the documentation above is very poor, but, you would be amazed at how often this happens. Someone will go on the internet and ask, my doctor treated a patient, "Can someone give me a code so I can get the visit paid?" Ok, what code would YOU select? I'd take this back to the doctor and have a heart to heart with him/her.

Here is another:

S: Pt here with c/o vision problems in both eyes.
O: Snellen test: 20/15. PERL
A: Deep Cataracts in both eyes.
P: Referral to Dr X, ophthalmologist.

Really? Cataracts with pupils equal and reactive to light? 20/15 vision with cataracts? This doctor charged a 99215 office visit. There is nothing within this documentation that supports a 99215 established patient office visit. The doctor contacted me because he was wondering why the insurance company requested many of his patient's medical records and now they wanted \$64,000 returned to them.

OK, here is one more:

S: Pt here C/O pain in large right toe after stubbing toe on coffee table.
O: Large (R) toe red & painful to touch. All systems are reviewed and are negative.
A: (1) AIDS, (2) Sprain toe, (3) Strain Toe, (4) Fx Toe, (5) Lumbago
P: Referral to Dr. Y (Orthopedist)

Again, really? This was a 99214 visit. AIDS? Where is the lab test and why is there a diagnosis of AIDS with a toe pain complaint? How can there be a diagnosis of a fracture with no x-rays. It looks like someone is trying to cover all bases. There is nothing documented to show us that this patient is a returning patient. There is NO x-ray, NO lab, so, again, where did the doctor use to determine AIDS and a fracture? Not only that, the patient has a sprain, strain AND a fracture of the same body part? This whole thing screams badly! Where did the back pain come from? Why were all body

systems examined and if there is back pain, what is causing it? The patient stubbed their toe. If all systems are negative how is it there is back pain in addition to the toe problem? Is this a fishing expedition to justify a high level office visit? When asked, the doctor said he was told to do this by the insurance company. Naturally they denied the doctor's accusation. The insurance company is the entity auditing the doctor and demanding the return of past payments.

Now, how does the following look:

S: 57 Y/O obese male C/O chest pain x 20 minutes. Chest pain began while pt was sitting in a chair on a cruise ship that was headed to shore. Pain suddenly and without warning radiated across center of chest and down the left arm to the fingers. Pain felt like heartburn. Pt denies sweating and breathing difficulties. Pt took baby aspirin to alleviate the pain. Pain was a 5 on a scale of 10 and then started disappearing approximately a few moments after taking baby aspirin. When the ship docked, pt debarked and drove self to emergency room with no increase in chest pain during the drive. There was no LOC, dizziness or any other symptoms. Pt has no known personal history of cardiac problems. Has never suffered from high blood pressure or any other cardiac problems. Grandfather suffered heart attack at age 67. Grandfather passed away due to heart attack. Father passed away at age 57 from prostate cancer. Mother is also deceased. She passed away in 2010 at age 77 from lung cancer. Both parents were heavy smokers. Father was also an alcoholic. Pt has no known allergies and is taking no other medications. This is pt's first chest pain episode. Pt decided to go on a no carbohydrate diet about 3 months ago to lose weight. This was not physician recommended or supervised. Pt only ate meats, eggs, and cheeses for all three meals. Pt doesn't drink alcohol or smoke. Pt does not exercise at all. Pt is 355 lbs and appears morbidly obese.

O: Skin is warm and dry to touch. No evidence of cyanosis on lips or fingers. There is no pain upon abduction and adduction of both arms. Pt shows equal strength in both hands and is able to walk heel to toe with no pain or problems. Will order cardiac enzyme tests and an EKG. Reviewed medical records and there are no entries suggesting that pt has had this medical condition in the past. Blood Pressure: 160/110 Pulse 120 Respirations 32. Pt does not appear to be in distress, is aware of time and place. PERL. EKG shows tachycardia and nothing else. Cardiac enzymes are elevated suggesting cardiac event. Contacted pt's primary care physician. Last visit with PCP was 2 years ago for flu like complaints. No flu like complaints at this time. No medications prescribed. No complaints similar to current complaints made to PCP during any past visit. Contacted Dr. Hart, staff cardiologist who recommends admission, tests for possible heart blockage, Rx of blood thinners, and MRI of heart. Chest pain, Hypertension, Tachycardia, CHF and morbid obesity.

A: Chest pain, Hypertension, Tachycardia, CHF and morbid obesity.

P: Heparin, 80 units/kg IV bolus, Referral to Dr. Hart in Cardiology, Admission to coronary intensive care unit.

A little better? This was billed as a 99285 emergency care visit and it is clearly supported by the excellent documentation. Again, put aside all egos and make sure you are improving your documentation. How would you want your visit documented if you were the patient? Document as if you had to go to court! As a coder, I can tell you that I've won many appeals just because the doctor documented the visit in an outstanding manner. The documentation was key when being reviewed by a regulatory agency. Documentation can make the difference between getting a claim paid, a denial overturned with a payment in the hundreds of dollars versus writing a refund check for thousands of dollars.

Manuals

ICD-10 Manuals will need to be obtained and used. Don't get rid of your ICD-9 manuals. Why? Let's say, Steve comes to see you on Tuesday, September 30, 2014. Steve's visit is under ICD-9-CM coding. Due to some unknown reason, Steve is shown as uninsured or self-pay even though Steve provided his insurance coverage when he was seen. You send Steve multiple statements instead of sending a claim. Steve thinks that this is nothing more than an administrative error on your part and you will fix this and send a claim to his health plan, but the problem isn't fixed. Steve's account is eventually sent to a debt collection agency. After this happens, you are contacted by regulatory agencies, Steve's insurance and Steve's lawyer. It might be possible that a claim can still be sent to Steve's health plan so that it is not denied as timely filing. It could now be 2015 and the codes used in 2015 are ICD-10 codes, but Steve's visit is supposed to be coded using ICD-9, simply because ICD-10 wasn't effective on the day Steve was seen. If you send the claim using ICD-10, the claim will be denied because the codes you selected were not effective. Now, could this happen? Very possibly because I've seen it happen many times.

In 2004, I worked for a doctor. He retired in 2004, closing his practice. In 2010, we received a court order to send a claim to a patient's insurance company. We originally sent a claim and it was denied, causing us to bill the patient. The patient took his health plan to court. The fact that the insurance company was ordered to pay the claim, didn't stop them from trying to avoid doing so. As an attempt to not comply with a court order, they demanded a replacement claim citing the reason that due to the timeframe, all claims from 2004 were purged from their computer system and they didn't have the original claim anymore to process it. Their thinking was that if the provider couldn't send a replacement claim, there was nothing to process and then no need to pay it. They could inform the judge that they couldn't process and pay what they didn't have, but that didn't work.

What they didn't realize is that when the doctor retired, we exported all of his software files and placed them on a storage drive we kept in a bank safe deposit box, so recreating the claim wasn't too hard, but we had to ensure that the 2004 codes were on the resubmitted claim. I extracted the original claim data, verified the accuracy and manually produced a claim form which was sent to the insurance company, the patient's lawyer and the judge. We also ensured we had a signed authorization from the patient allowing us to send the claim to his lawyer and judge so that we stayed within HIPAA privacy requirements. The insurance company received the claim and decided to see if they could continue to throw up roadblocks to keep from complying with the court order. Now they demanded the medical record with the thinking that there was no way that the medical record would be available after all these years, but they were wrong. Again, all medical records were scanned and stored electronically on the storage drive. The record was found, reprinted and sent to the insurance company. With no more roadblocks, they had the claim and the medical record, so they complied with the court order and paid the claim.

So, don't throw those ICD-9 books away, put them in a safe place in the event you need them. A 1 terabyte hard drive costs around \$89 and you would be amazed at how much data it can hold. I go back to 1999 with the doctor's data and we have claims, EOBs, checks, correspondence, checks, and medical records with room to spare. We used a simple \$49 all in one printer, scanner, fax machine, so saving data is not expensive these days.

Updated Software

Medical Billing software needs to be updated to include both ICD-9-CM and ICD-10. This is because with an October 1, 2013 proposed effective date, Claims for September 30th and before September 30th dates of service will still use ICD-9 Codes. Your software will need to be able to handle both code sets. If not, then you will need to replace all ICD-9 codes with ICD-10 codes. You will also need to add additional ICD-10 codes for the medical conditions that could not be coded under ICD-9. As you saw above, some medical conditions may have ONE ICD-9 code but could have many under ICD-10, especially those codes that rely on anatomical areas. You want someone trusted to make your software changes to ICD-10 codes and you want to verify that their work is 100% true, accurate, and correct.

Updated Carrier Policies and Procedures

Providers who are contracted and have agreed to carrier coding policies should be reviewing these policies and to make sure the contracted carrier is ready to accept the new codes. You should find out if there are going to be any claims payment delays due to the changeover to ICD-10 as this may affect contract payment timeframes. While YOU may be ready, are they? Will your claims be bogged down by claims from doctors who are not ready? ABC Insurance Company may have a policy for a cardiac stress

test. In that policy, there are diagnosis codes that support medical necessity. If Steve comes in for his annual cardiac stress test and the code under ABC's policy is R07.4 (chest pain), you want to ensure that Steve's medical record documents R07.4 so that you can comply with the coding requirement for the cardiac stress test. If you have code L21.0, you can bet the claim will be denied for medical necessity. Why? I don't think a diagnosis of dandruff supports a cardiac stress test, do you? Again, if you agreed to comply with an insurance policy, you want to make sure you have a copy of the updated policy to ensure compliance with that policy. Go to your local Medicare MAC and download their LCDs for the services you render. Go to your local Medicaid carrier to also download those policies that affect the medical care you provide. You don't want to find yourself behind the 8 ball when the changeover takes place. Staying on top of these things will keep your practice revenue ongoing.

Updated Compliance Plans

Practices and Billing Companies should update their compliance plans regarding ICD-10 coding. Extra attention should be directed to performing internal audits of charts and claims. You want to catch any problems early so that they don't become worse, which could cause carrier or investigative agency audits which may come with fines, penalties, loss of licensure, sanctions and closure. When you do what is right, you have no fear of audits or inspections. You welcome them.

Updated Coding Denial Appeals

If you are using a cookie cutter appeal, then the appeals should be reviewed and updated to conform to ICD-10 standards. If you are appealing a denial of an EKG, you cannot have ICD-9 code 786.50 as the code for chest pain, if the documentation has chest pain, you have to change the code to R07.9 or R07.4 (the final code hasn't been published yet and depending on the source, you could find either code listed)

Updated Superbills

If the practice is using a superbill that contains ICD-9 codes, these should be replaced with the appropriate ICD-10 code(s). Many superbills I've looked at have the correct diagnosis identified by name, but the ICD-9 code is incorrect or outdated from the current ICD-9 code. On one, the diagnosis is identified as HIV. The code shown on the superbill is 042.59. HIV is 042 only. Under ICD-10, HIV is B20. It may take a few weeks to convert all your ICD-9 codes on a superbill, and then send it to your printing company for publishing. If you do this now, you won't be pressured into trying to get it done in a few days just to have it available on October 1, 2014.

FINANCE:

There are practices that are in excellent financial shape. There are practices that can barely make it from day to day. You have 10 months to work on a financial plan that can allow you to survive this change. While you may send a claim on October 1, it doesn't mean that the claim will be paid quickly. There may be delays. Insurance

company's process billions of claims every day, so you can imagine what happens when millions of unprepared doctors are sending claims at the same time and those claims are slowing down the insurance company's processing time. While YOU may be ready, they might not. Their system may have a hiccup causing your claims to be pended while they request medical records from you. Make sure you are financially secure until the system is in full force where you are getting payment within reasonable timeframes. You worked hard to make your practice successful, keep working to keeping it going. Not only do you depend on your claim revenue, so does your entire staff. Bills will continue to come in and they will still demand payment regardless if your claims are paid or not.

Continue to fight fraud, abuse and any up/downcoding issues.

As with any changes there is always the fear that using something new is better resolved by downcoding a claim to remain under the "radar". You are NEVER under the radar. Insurance companies already know what codes you bill and what codes you should be billing. Finding more codes available could lead to temptation to upcode or to submit a false claim to increase practice revenue.

If we use the time we have been given for preparation, the transition from ICD-9 to ICD-10 can be very seamless. Procrastination may work for filing an IRS tax return. This doesn't work in our profession. You need to be prepared well enough in advance so that you are ready to go when you come in to treat patients on Wednesday morning of October 1st. I've said it so many times - ICD-10 is not scary to a trained coder. I've been looking at it for many years. If I can code ICD-10, so can you and I'm 61 years old!

Be very careful because any time something is new, someone will want to make money on it. You may receive phone calls, faxes and letters telling you that a seminar on ICD-10 is available. Some calls may be pressure calls which sounds like, "Hello, this is (garbled) with (garbled). We're offering training on ICD-10. If you don't attend this seminar, your claims won't be paid." They are very good at making you believe that you need to attend their seminar and when you show up you are under several hours of expert sales tactics to buy books that they are selling. I know I've been to them. I would recommend that if you wish to attend a seminar, you do so through a trusted organization such as the Medical Association of Billers, the Professional Association of Healthcare Coding Specialists (PAHCS), the American Academy of Professional Coders (AAPC) or an organization that you trust completely, however, we live in the land of the free, and you have the freedom of choice to attend any seminar you wish and I won't try to dissuade you from doing so. There is an old saying which goes, Caveat Emptor.

The key to the successful use and transition to ICD-10 is going to ensure our Providers are aware of their responsibility towards better documentation of the patient's medical condition(s).

Use the following formula: PPD = Lawsuits and LOR (Loss of Revenue). (PPD stands for PISS Poor Documentation = Lawsuits and LOR.

I can be reached at steve_verno@yahoo.com

I wish all much success and
Never Give Up, Never Surrender!