ICD-10 Coding

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General Guidelines

• Chapter conventions & instructions of the classification take precedence over general guidelines
• Where a placeholder “X” exists, it must used for the code to be valid
  Example: T45.2X4D
• S & S codes are generally not coded unless a definitive diagnosis is not known.
  Code only if directed to do so by the classification.

Sequela (late effects) – The residuals that remain after the acute phase of the injury or illness is over. 1 or 2 codes may be necessary. Code what you can see followed by the acute injury code.

  Example: Severe scarring of R elbow due to an old 3rd degree burn.
    L90.5 (adherent scar)
    T22.321D
• Provider documentation must be present to state that the condition (residual) is a direct result of the previous illness or injury.

Laterality codes available
- 1 = right
- 2 = left
• For bilateral sites the last character indicates laterality. When a condition exists on both sides and there is no available bilateral code, use the code for L & R.
• Update: Coders do not need to assign bilateral code for condition if a previous encounter resolved the condition on one side of the body and the present encounter is for the condition on the other side.
  Example: Patient had bilateral osteoarthritis of knees but R knee was previously replaced. Code osteoarthritis for L knee.

More Guidelines

• Combination codes for 2 codes where a relationship has been documented by the provider.
  Example: DM with retinopathy
• Expanded codes for injuries, complications and alcohol or substance abuse and manifestations
  Example: Nicotine dependence, cigarettes w/ withdrawal
  Update: Codes for psychoactive substance use, abuse or dependence should only be assigned based on the physician’s documentation and when they meet the definition of a reportable diagnosis.
• Acute & chronic guidelines unchanged
• Acute MI is considered until 4 weeks (28 days)
• HTN (I10) no longer has designation of benign, malignant or unspecified
• Fractures are coded using acute code with the appropriate 7th character for HH (no aftercare codes for fractures)
• No therapy only codes

7th Character A or D?
Clarifications made regarding the 2017 coding guidelines updates in October 2016

• 7th character “A”, initial encounter is used for each encounter where the patient is receiving active treatment for the condition.

Examples: Surgical treatment, evaluation and continuing treatment by the same or a different physician in the initial encounter but also in cases where active treatment is on-going.
  • Antibiotic therapy for a post-op infection in HH
  • Wound vac care in HH
• 7th character “D”, subsequent encounter is used for encounters after the patient has completed active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.

**Examples:** Follow-up visits, cast change or removal, aftercare in HH.
- Rehab therapy by PT or OT after fracture or injury
- Suture removal
- Dressing changes

**7th Character Examples**

1. Patient admitted to HH with an infected post-op wound and is still on antibiotics. This is still considered active treatment and a 7th character of “A” is used.
   - T81.4XXA

2. Patient was at home receiving routine aftercare for a wound and a Z48 code was used. Patient readmitted to hospital because wound dehisced and became infected. Treated in hospital and discharged home with antibiotics and orders for dressing changes. This is still active care and a 7th character of “A” is used.
   - T31.81XA & T81.4XXA

3. At recertification, wound is granulating, patient is no longer on antibiotics and routine care is being provided to wound. 7th character of “D” would be used.
   - T31.81XD

**Excludes 1 Notes**

**Excludes 1** – Not coded here! Any diagnoses listed here cannot be coded with the diagnosis you have selected. These two codes cannot be used together.

   **Example:** Type 2 DM (E11)
   **Excludes 1:** Diabetes due to underlying conditions (E08.-) Gestational diabetes (O24.4-)

**Update to Excludes 1:**
- Many confusing & ambiguous excludes notes in 2016 Manual
- Some of the Excludes 1 notes didn’t make sense. For example, Codes R40-R46 (signs & symptoms of emotional state and behavior) contained excludes notes for the entire group of Codes F01-F99 (All mental, behavioral & neuro development disorder codes) indicating that these two groups of codes could not be coded together.

   **Solution:** If the two conditions are not related to one another, it is permissible to report both codes together despite the Excludes 1 notation.

**Excludes 2 Notes**

**Excludes 2** – Not included here! Means that the condition included here is not part of the condition represented by the code you have chosen and you may use these together.

   **Example:** Acute sinusitis (J01.1-)
   **Excludes 2:** Chronic sinusitis (J32)

"With" Guidelines

- June 2016 Coding Clinic confirmed new guidelines for causal conditions
- The sub-term “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetical Index, or an instructional note in the Tabular Index.
- Any condition listed under a sub-term “with” in the index should be interpreted as linked to the main term when both conditions are present.
- “The classification presumes a causal relationship between the two conditions linked by these terms unless a provider has specifically documented an alternative etiology.
So What Does This Mean?

- If a physician documents another etiology for the condition the coder should not code to a complication or assume the link.
- The entire record should be reviewed to determine whether a relationship between the two conditions exists.
- The sub term "with" in the index should be interpreted as a link between diabetes and any of these conditions indented under the word "with".
- The physician documentation does not need to provide a link between (for example) the diagnoses of diabetes & CKD.
- This link can be assumed since the chronic kidney disease is listed under the sub term "with".
- These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated and due to some other underlying cause.

Specifically "With" Conventions

Reference Diabetes in the Alpha Index

- Diabetes with
  - Amyotrophy
  - Arthropathy
  - Autonomic (poly) neuropathy
  - Cataracts
- Convention not limited to Diabetes. This convention applies to all conditions.
  - See Dementia
  - See Hypertension

"With" Examples

- No previous assumption could be made with Diabetes & Osteomyelitis.
- Under new guideline, osteomyelitis is now listed under the sub-term "with" for Diabetes. Therefore, coders can assume that there is a causal relationship.
  - E11.69 – Diabetes, Type II with other specified manifestations
  - M86.- – Osteomyelitis

New OASIS Items

Two new OASIS items that has direct affect on ICD 10 Coding
1. M1028 – Active Diagnoses
2. M1060 – Height and Weight

M1028 – Active Diagnoses

(M1028) Active Diagnoses – Comorbidities & Co-existing Conditions – Check all that apply

See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

- 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
- 2 - Diabetes Mellitus (DM)

- Identifies physician or designee confirmed diagnoses that are active and associated with the current episode
- Active diagnoses are those that have a direct relationship to the patient’s current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at time of assessment.
- Do not include diagnoses that have been resolved or do not affect the patient’s current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at time of assessment.
Diagnoses Codes Appropriate for M1028

Codes that start with the first 4 characters of:
• I70.2 Atherosclerosis of native arteries of extremities
• I70.3 Atherosclerosis of bypass grafts of extremities
• I70.4 Atherosclerosis of autologous vein bypass
• I70.5 Atherosclerosis of nonautologous vein
• I70.6 Atherosclerosis of nonbiological bypass
• I70.7 Atherosclerosis of other type of bypass
• I70.91 Generalized atherosclerosis
• I70.92 Chronic total occlusion of artery of the extremities

Codes that start with 173.
• I73. Other peripheral vascular disease

Codes that start with the first 3 characters of:
• E08. Diabetes due to underlying condition
• E09. Drug or chemical induced diabetes mellitus
• E10. Type I diabetes mellitus
• E11. Type II diabetes mellitus
• E13. Other specific diabetes mellitus

What about combination codes for DM & PVD (E11.5-)?

M1060 – Height & Weight

(M1060) Height & Weight – While measuring, if the number is X.1 - X.4 round down; X.5 or greater, round up

- a. Height (in inches). Record most recent height measure since the most recent SOC/ROC
- b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)

• BMI code assignment may be based on medical record documentation from clinicians that are not the patient’s provider.
• However codes for obesity or overweight must be documented by patient’s provider.
• ICD-10 code for BMI can be calculated from height and weight in M1060
Chapter 1 – Infectious & Parasitic Diseases (A00-B99)

Chapter Guidelines

- Categories arranged in blocks
  - A01-A09 – intestinal infectious diseases
  - B15-B19 – viral hepatitis
- Some categories & subcategory titles have changed
  - ICD-9 – (008) Intestinal infections due to other organisms
  - ICD-10 – (A08) Viral & other specified intestinal infections
- Generally, the organism code (if known) follows the condition

Includes: Diseases generally recognized as communicable or transmissible

Excludes:
- Certain localized infections as they are coded to specific body-system chapters
- Excludes infectious or parasitic diseases in pregnancy (O98.-)
- Excludes influenza & other respiratory infections (J00-J22)
- Some codes will require an additional code to identify resistance to antimicrobial drugs (Z16.-)

Zika Virus Infections A92.5

- Code only confirmed cases as documented by the provider.
  Does not require documentation as to the type of test performed, only that there is a physician statement to support it.
- Assign A92.5 regardless of the stated mode of transmission.
- If provider documents “suspected”, “possible” or “probable” Zika, do not assign A92.5. Assign instead the reason for the encounter such as fever, rash or joint pain) or Z20.828, contact with & suspected exposure to other viral communicable diseases until an affirmative diagnosis is made.

Coding MRSA & MSSA

- MRSA and MSSA codes have stand alone codes (B95.-)
- When a diagnosis due to an infection caused by MRSA or MSSA use the combination code (A41.02 Sepsis due to MRSA).
- Assign the B95.- codes when there is documentation of an infection that does not have a combination code to includes the causal organism.
  (Ex: UTI due to MRSA, Wound infected w/ MRSA)

Coding HIV

- Code only confirmed cases
  - Depending on state regulations, B20 can be coded as primary diagnosis if patient is being seen for HIV related condition, followed by other codes for any complications (MS)
  - Example: Pneumocystic Pneumonia due to aids
    - HIV/AIDS B20
    - Pneumocystosis B59
  - Use Z21 for asymptomatic HIV (HIV + NOS)

Sepsis

- For diagnosed sepsis, code the underlying systemic infection (A40.- or A41.-).
  If the infection or cause is not specified, code (A41.9) Sepsis unspecified.
- For severe sepsis, at least two codes needed: 1st code for the underlying systemic infection (A40 or A41 code) followed by a code from category (R65.2-) severe sepsis. Add code for organ dysfunction if documented (i.e., renal or respiratory failure).
- If admission is for localized infection that developed into sepsis, code localized infection first.
**Sepsis Example**
- An 80 year patient admitted to homehealth with a diagnosis of Sepsis from a UTI that cultured streptococcus group A. Patient is on oral antibiotics at home.
  - N39.0 - UTI
  - A40.0 - Streptococcus A

**Septic Shock**
- Generally refers to organ failure due to severe sepsis
- Code first the systemic infection (A40.- or A41.- or T81.4) followed by (R65.21) severe sepsis with septic shock. Add additional codes for other acute organ dysfunction if applicable
- Septic shock cannot be coded as the primary diagnosis
**Example:** Septic shock with acute renal failure due to Streptococcus Pneumoniae
  - A40.3 (Sepsis due to Streptococcus Pneumoniae)
  - R65.21 (Severe sepsis with septic shock)
  - N17.9 (Renal failure)

**Sepsis Due to Post-Procedural Infection**
- Documentation must be present to make connection
- Post procedural code listed first followed by specific infection (T81.4) infection following a procedure
- If severe sepsis exists, add (R65.2-) with any additional codes for organ dysfunction
**Example:** Septic shock with acute renal failure due to Strep A from post-procedural infection
  - T81.4xxD (Sepsis due to post-procedural infection)
  - A40.0 (Sepsis due to Strep A)
  - R65.21 (Severe sepsis with septic shock)
  - N17.9 (Acute renal failure)
**Scenario 1**
- Admission to homecare following a CVA 2 months ago
- Cognitively & functionally impaired
- Has a stage 3 pressure ulcer with MRSA on R buttocks
- Has HTN with very labile BP readings
- Also has a foley cath in place
- Care will focus on pressure ulcer

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**Scenario 2**
- Patient admitted following acute renal failure due to septic shock from MSSA

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Chapter 2 - Neoplasms

General Guidelines

- All malignant neoplasms coded here (active or not)
- Additional code from Chapter 4 (Endocrine) can be used to identify associated functional activity
- Not sure if the neoplasm has been excised or eradicated? Verify w/ provider or code the neoplasm.
- Use Z85 codes for personal history of neoplasm
- Use Z48.3 codes for routine aftercare following surgery for neoplasm

Behavior

- Uncertain – currently benign but its behavior cannot be determined further study is necessary
- Unspecified – not enough information to determine the type growth NOS, neoplasm NOS, new growth NOS, tumor NOS
- Mass – not to be considered a neoplasm unless documented

Other Terms

- In situ – an early form of carcinoma defined by non-invasion of surrounding area or tissue
- Malignant – invasion of healthy tissue or the spreading from the point of origin
- Primary malignancy – the site where the neoplasm originated
- Secondary malignancy – an area where the first listed neoplasm has metastasized.
- Contiguous sites – primary neoplasm with overlapping boundaries (point of origin cannot be determined)

More Guidelines

- Necessary to ascertain from documentation if neoplasm is malignant, benign, in situ, or of uncertain behavior
- If malignant, any metastatic secondary site should be coded also
- Reference alphabetical list first for histological term
- If treatment is directed at malignancy, designate malignancy as primary

Encounter for Primary Malignancy

Code first the primary neoplasm followed by any metastatic sites

Example: Left lower lobe lung neoplasm with metastasis to bone & pancreas

Code: C34.32 (malignant neoplasm of LLL or bronchus)  
C79.51 (2nd malignant neoplasm of bone NOS)  
C78.89 (2nd malignant neoplasm of pancreas NOS)

Treatment for Secondary Site

- When a primary neoplasm has metastasized to a secondary site and the focus is the secondary site, it is sequenced first followed by the primary malignancy
- Ex: R breast neoplasm with metastasis to brain (focus of care is brain mets)

Code: C79.31 (second malignant neoplasm of brain)  
C50.911 (malignant neoplasm of unspecified part of R breast)

Previously Excised Primary Malignancy

- If malignancy was excised and no further treatment is planned and no evidence of existing neoplasm, use Z85 code for personal history of neoplasm
- Ex: Breast cancer removed with no evidence of any remaining neoplasm

Code: Z85.3 (history of breast cancer)
• If after a primary site neoplasm is removed but a secondary site remains that metastasized or extended from the primary site, code secondary site as primary followed by the Z85 code.

• **Ex:** R lung removed due to neoplasm. No indications of neoplasm in lung and no further treatment directed at lung but neoplasm has metastasized to liver
  Code: C78.7 (secondary malignant neoplasm of liver)
  Z85.118 (personal hx of neoplasm of lung)

**Complications of Neoplasms**

• When encounter is specifically for a complication associated with the neoplasm, code the complication followed by the neoplasm code.

  **Exception** is anemia due to neoplasm

• **Example:** Anemia due to primary neoplasm of colon
  
  **Code:**
  C20 (primary rectal neoplasm)
  D63.0 (anemia in neoplasm disease)

**Anemia Due to Chemo or Immunotherapy**

When encounter is for anemia due to chemo or radiation, and anemia is the focus, code the anemia first followed by the neoplasm code followed by the T code for the adverse effect.

**Example:** anemia due to chemo for neoplasm of thyroid

**Code:**
D64.81 (anemia due to chemo or immunotherapy)
C73 (primary neoplasm of thyroid)
T45.1X5D (adverse effect of antineoplastic or immunosuppressive drugs)

**Dehydration Due to Neoplasm**

When encounter is for dehydration due to malignancy, sequence the dehydration code first followed by the neoplasm code.

**Example:** Focus of care is to maintain IV fluids via PICC line for a patient with colon (Sigmoid) cancer

**Code:**
E86.0 (dehydration)
C18.7 (malignant neoplasm of sigmoid colon)
Z45.2 (adjustment & management of vascular device)

**Aftercare**

When focus of care is for routine aftercare following surgery for neoplasm, code aftercare first followed by neoplasm code if still applicable or history code if no longer applicable

**Example:** Patient admitted for routine aftercare following surgery to remove a basal cell carcinoma on neck. Patient still receiving radiation

**Code:**
Z48.3 (aftercare following surgery for neoplasm)
C44.41 (basal cell carcinoma of skin on scalp & neck)

**Complication Resulting from a Surgical Procedure**

When a surgical procedure is performed to treat a neoplasm and a complication occurs, code complication first followed by the code for neoplasm. If the surgical procedure removed the neoplasm, code history of.

**Example:** Patient admitted for wound care following surgery to remove a basal cell carcinoma on neck. Wound is infected. Code infected post-op wound first followed by neoplasm or history code.

**Code:**
T81.4XXD (infection following a surgical procedure)
C44.41 (basal cell carcinoma of the neck)
**Scenario 1**
- Patient has malignant breast cancer that has metastasized to the bowels.
- Admitted post bowel resection of descending colon
- Will continue to require chemotherapy
- SN will be addressing wound, colostomy care and maintenance of PICC line

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**Scenario 2**
- Pt admitted for aftercare post bilateral radical mastectomy for neoplasm of R breast
- Also has neoplasm related anemia
- She will continue to be treated with Tamoxifen
- Pt also has controlled HTN

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Chapter Guidelines

- Use additional T36-T50 code for anemias due to an adverse effect
- For anemias due to CKD (N18.-) or neoplasms (C00-D49), etc., code the underlying condition first
- For congenital type anemias, code the underlying condition first

D50-D53 – Nutritional Anemias

Includes:
- Iron deficiency anemia secondary to chronic blood loss (D50.0)
- Iron deficiency anemia NOS (D50.9)
- B12 deficiency anemia (D51.-)
- Use the additional code (T36 – T50) to identify the drug that caused the anemia (D52.-)

Example: Folate deficiency anemia due to Metformin (D52.1)
Adverse Effect of Metformin (T38.3X5D)

Admission for B-12 Injections

- Diagnosis of B-12 anemia alone does not support medical necessity for B-12 injections.
- When a patient is admitted with the primary focus of B-12 injections, assure that there is an appropriate diagnosis for coverage in Medicare patients.
- Coverage is limited to specific types of anemias:
  - pernicious anemia (D51.0)
  - megaloblastic anemia (D51.1)
  - macrocytic anemia (D53.1)
  - anemia from fish tapeworm (D63.8)

D55-D59 – Hemolytic Anemias

Includes:
- Thalassemia (D56.-)
- Sickle Cell Disorders (D57.-).
  Use additional code for any associated fever (R50.81)
- Other hereditary hemolytic anemia (D58.-)
- Acquired hemolytic anemia (D59.-). Use additional code to identify the associated infection such as:
  - E. coli (B96.2-)
  - Pneumococcal pneumonia (J13)

D60-D64 – Aplastic & Other Anemias & Other Bone Marrow Failure Syndrome

- Use additional code if applicable to identify drug causing adverse effect (T36 – T50)
- For aplastic anemia due to an external substance, code first the toxic effect (T51 – T65)
- For anemia in CKD, code first the underlying disease (N18.- & D63.1)
- For anemia in other chronic diseases, code first underlying condition such as:
  - TB (A18.89)
  - Malaria (B50.0 – B54)
D70-D77 – Other Disorders of Blood & Blood-Forming Organs

- Code first any underlying neoplasms & use additional code for adverse effect to identify drug
  - Neoplasm (C00-C96)
  - Anemia due to antineoplastic chemo (D64.81)
  - Adverse effect of antineoplastic & immunosuppressive drug (T45.1X5D)

D78 – Intraoperative & Post-Procedural Complications of the Spleen

Includes:

- Intraoperative hemorrhage & hematoma of spleen complicating a procedure (D78.0-)
- Accidental puncture & laceration of spleen during a procedure (D78.1-)
- Post procedural hemorrhage & hematoma of spleen following a procedure (D78.2-)
- Other intraoperative and post-procedural complication of spleen (D78.8-).

Use additional code if needed to further specify the disorder

Code Break

1. Folate deficiency anemia ____________________
2. Anemia due to end-stage CKD ____________________
3. Spleen nicked during bowel surgery ____________________
4. Anemia due to chemotherapy for thyroid cancer ____________________
5. Hemophilia NOS ____________________

Scenario 1

- Patient admitted for newly diagnosed atrial fib on Coumadin.
- Also has B12 anemia.
- SN in for disease management, med teaching, PT/INR and to give monthly B12 injections

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Scenario 2

- Patient admitted with severe anemia due to chemo for neoplasm of the R kidney
- Had a R nephrectomy done several weeks ago

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Chapter 4 - Endocrine, Nutritional & Metabolic Diseases

Chapter Guidelines

- Codes no longer signify level of control
- Use as many codes as necessary from same type to indicate different manifestations
- Code will now indicate category of diabetes as well as the manifestation
- “Glycosuria, "glucosuria", "hyperglycemia or “polyuria” alone not to be considered diabetes
- If type is not documented, default code is E11.-
- If documentation does not indicate type of diabetes but patient is on insulin… default code is E11.- for Type II DM
- Age of patient not to be considered in determining type

Coding Insulin

- Use code Z79.4 for long-term current use of insulin
- New code for oral hypoglycemic Z79.84
- Long term use of oral or injectable meds can be used together
- Complications due to insulin pump malfunction:
  - Underdose of insulin due to insulin pump failure
    - mechanical complication of pump (T85.614)
    - underdosing of insulin (T38.3x6D)
  - Overdose of insulin due to insulin pump failure
    - mechanical complication of pump (T85.614)
    - poisoning by insulin (T38.3x1D)
- Code also appropriate diabetes code (E08 – E13)

Categories of Diabetes

- ICD-10 allows for 5 categories of DM
  - DM due to underlying condition (E08)
  - DM due to drugs or chemicals (E09)
  - DM type I (E10)
  - DM type II (E11)
  - Other Specified DM (E13)
  - Gestational Diabetes (O24.4-)

Fourth Digits

0 – Hyperosmolarity. Use in Type II. Not usually appropriate for HH.
1 – Ketoacidosis. Use in Type II. Not usually appropriate for HH.
2 – Renal Complications
  - Nephropathy
  - CKD

3 – Ophthalmic Complications
  - Retinopathy (includes macular edema) Note the list of new codes for retinopathy
  - Blindness
  - Cataracts

4 – Neurological Complications
  - Polyneuropathy
  - Autonomic Neuropathy
  - Gastroparesis (Add K31.84)

5 – Circulatory Complications
  - Peripheral angiopathy (includes gangrene)
6 – Other Specified Complications
   - Charcot's arthropathy
   - Osteomyelitis
   - Diabetic ulcers (use additional code for site of ulcer)
   - Hyperglycemia & hypoglycemia

8 – Unspecified Complications (don’t use in HH)

9 – No Complications

E08 Secondary Diabetes Due to Underlying Condition
   - Cystic Fibrosis, malignant neoplasm, pancreatectomy, pancreatitis, Cushing's Syndrome (code first the underlying disease)
   - Add Z79.4 (long-term use of insulin for patients who routinely use insulin)
   - Reference: Diabetes, due to, underlying condition

E09
   - Identifies secondary diabetes due to drugs or chemicals (steroid use)
   - Identifies also the manifestation or complication associated with the diabetes
   - Includes adverse effects of drugs (code first T36-T65 code for adverse effect)
   - Add Z79.4 (long-term use of insulin for patients who routinely use insulin) or Z79.84 (oral hypoglycemic)

E10 – DM Type I
   Includes: Juvenile onset diabetes & autoimmune process
   - Must be documented by physician
   - Age not a determining factor
   - Do not use long-term use of insulin code

E11 – DM Type II
   - Formally called Adult onset or NIDDM
   - Use as many as necessary to include all manifestations
   - 4th digit indicates complication
   - Use Z79.4 to indicate long-term use of insulin or Z79.84 for oral meds
   - Do not use Z79.4 code if insulin is given to a Type II patient temporarily
**E13 – Other Specified DM**

Includes: Diabetes due to genetic defects, post-procedural DM & secondary DM NEC
- Use additional Z79.4 for long-term use of insulin or Z79.84 for oral meds

**E13 Example**
- Patient admitted with diabetes developed after pancreatectomy due to neoplasm
- Is on insulin regularly
- Has developed diabetic polyneuropathy
- SN will address disease management & insulin

### New "With" Guidelines for Diabetes

- Became effective October 1, 2016
- Expanded list of conditions that can be automatically linked to Diabetes without specific provider documentation
- Some still require two codes for completion while others can be captured with one code.
- If documentation states that patient had diabetes and also has one of the conditions listed under the sub-term "with" in the alphabetical list, an assumption can be made as to cause & effect relationship if no other etiology has been stated

### Wounds & Circulatory Manifestations

- Is there documentation that the wound is caused by a circulatory issue?
- Is there documentation of PVD or other comorbidity?
- Diabetic Gangrene now linked with Diabetic PVD. Choices are now DM PVD w/ Gangrene or DM PVD w/o PVD. (E11.5-)
- Add separate code for Diabetic ulcer when applicable.

### Other Endocrine Disorders

- E15-E16 Other disorders of glucose regulation & pancreatic internal secretion
- E20-E35 Disorders of other endocrine glands
  - hypo or hyperparathyroidism
  - diabetes insipidus
  - ovarian or testicular dysfunction
- E36 Intraoperative complications of endocrine system
- E40-E46 Malnutrition
- E50-E64 Other nutritional deficiencies
- E65-E68 Overweight, obesity & other hyperalimentation
- E70-E88 Metabolic disorders
- E89 Postprocedural & metabolic complications & disorders, NEC
### Code Break

1. Diabetes w/ polyneuropathy due to steroid use ________________
2. Post-pancreatectomy diabetes w/ R mid-foot ulcer _________________
3. Type I diabetes with proliferative retinopathy of both eyes _________________
4. DM with gangrenous R great toe _________________
5. Hyperparathyroidism _________________

### Scenario 1

- Patient admitted for care of wound on R great toe and on R lower leg
- Has Type II DM with PVD and chronic venous insufficiency
- Recently started on insulin
- She also has HTN, severe depression

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Scenario 2
- Patient has diabetes secondary to long-term steroid use for emphysema
- Also has diabetic PVD
- SN to address disease management and insulin administration

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Scenario 3
- Patient with DM had a LAKA due to diabetic gangrene
- Also has diabetic retinopathy & mild CHF
- SN to address diseases management & dressing changes
- PT to address gait training

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Chapter 5 - Mental, Behavioral & Neurodevelopmental Disorders

Chapter Guidelines

Includes

- Diseases of psychological development
- Dementias, mood disorders and substance abuse
- All diseases due to an etiology of cerebral disease, brain injury or other insult leading to cerebral dysfunction
- If condition related to known CV disease, code a sequela first

Pain Disorders

- Pain disorders related to psychological factors
  - Assign F45.41 for pain specifically related to psych disorders.
  - Do not add code from G89 (Pain NEC)
  - Pain disorders with related psychological factors (F45.42-).
    Add code G89- (Pain acute or chronic)

F01-F09 - Mental Disorders Due to Known Physiological Conditions

- Vascular dementia (F01.5-)
  - Designate with or without behavioral disturbances
  - Code first any other physiological condition such as Alzheimer’s (G30.-)
  - Add additional code (Z91.83) for wandering if applicable

Example

Pt s/p CVA, diagnosed with R dominant side hemiparesis. Also has vascular dementia and cerebral atherosclerosis

- M1021 – I69.351 (hemiplegia following CVA, R dominant side)
- M1023b – I67.2 (cerebral atherosclerosis)
- M1023c – F01.50 (vascular dementia w/o behavioral disturbances)

More on Dementias

Dementia in other diseases classified elsewhere (F02.8)

- Code first the underlying physiological condition (Alzheimer’s, Parkinson’s, etc.) followed by one of these:
  - F02.80 (dementia in other diseases NOS w/o behavioral disturbances)
  - F02.81 (dementia in other diseases NOS w/ behavioral disturbances)
    *Use additional code, if applicable, to identify wandering in conditions classified elsewhere (Z91.83)

  **Alzheimer’s must be specifically documented by provider

- F03 – Unspecified Dementia (presenile dementia, dementia NOS, senile dementia) requires one of these:
  - F03.90 – Unspecified dementia w/o behavioral disturbances (Dementia NOS)
  - F03.91 – Unspecified dementia w/ behavioral disturbances (Dementia NOS)
    *Use additional code, if applicable, to identify wandering in conditions classified elsewhere (Z91.83)

Examples

- Dementia w/ Parkinsonism: G31.83, F02.80
- Dementia NOS w/o behavioral disturbances: F03.90
- Senile dementia w/ behavioral disturbances & wandering: F03.91 & Z91.83
- Alzheimer’s w/ dementia & wandering: G30.9- & F02.81 & Z91.83
F10 – F19
- Applies to alcohol, opioid, cannabis, sedatives, hypnotics, cocaine, etc.
- Includes mental behavior due to psychoactive substance use
  - “in remission” status must be documented by provider
  - code for substance use must be documented by provider
- Only one code need for substance & behavior
Example: F11.182 (opioid abuse with opioid-induced sleep disturbance)

Other Mental Disorders
- F04-F09 (mental & behavioral disorders due to known physiological conditions)
- Code the underlying physical condition first
Example:
Pt referred with diagnoses of frontal lob syndrome due to traumatic brain injury.
  - M1021a – S06.9X9D (concussion NOS)
  - M1023b – F07.0 (personality changes)

F20-F29 – Schizophrenia, Schizotypal, Delusional, & Other Non-Mood Psychotic Disorders
Includes:
- Schizophrenia (F20)
- Paranoia (F22)
Excludes:
- Brief psychotic disorders (F23)
- Mood affective disorders (F30.- thru F33.-)
- Schizophrenic reaction NOS (F23)

F30-F39 – Mood (affective) disorders
Includes:
- Bipolar disorders, single manic episode, manic episode & mixed affective episode
Examples: Major depressive disorder, single episode, mild (F32.0)
  Depression NOS & Major Depression NOS (F32.9)
**Scenario 1**

- Patient admitted with diagnosis of dementia with wandering.
- Currently taking Aricept as provider continues to do testing.
- PT will evaluate her for fall risk.

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**Scenario 2**

- Patient admitted with a long history of alcohol abuse. Now has periods of alcoholic delusions which has caused him to become combative.
- He also has chronic alcohol gastritis and edema of ankles which may be from liver failure.

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Chapter 6 - Diseases of the Nervous System

Chapter Guidelines

• For inflammatory diseases of the CNS, use an additional code to identify the causative organism if known.
• For inflammatory diseases caused by another disease process, code first the underlying disease

Example: Meningitis in diseases classified elsewhere
  - M1021a – A69.21 Meningitis due to Lyme disease
    - M1023b – G02 Meningitis in other infectious & parasitic disease

G20-G26 – Extrapyramidal & Movement Disorders
Includes: Parkinson’s Disease & drug induced dystonia
  • If dementia is present also, add F02.8- code
  • Use additional T code (to identify the drug) for the adverse effect if applicable

Example: Dyskinesia due to Haldol
  Drug induced dystonia (G24.01)
  Adverse effect of an antipsychotic (T43.4x5D)

G20 – Parkinson’s Disease
• Not to be confused with dementia w/ Parkinsonism (G31.83)
• Includes:
  - Hemiparkinsonism
  - Parkinson’s disease
  - Paralysis agitans
  - Parkinson’s NOS
• If dementia is present also, add F02.8- code

G30 – Alzheimer’s
• New Guideline: Early (before age 65) or late (after age 65) onset as documented by provider.
• Use additional code to identify delirium if applicable (F05)
• Also use an additional code to identify dementia (w/ or w/o behavioral disturbances) if applicable (F02.8-)
• Add an additional code to identify wandering if applicable (Z91.83)
• Not all patients with dementia have Alzheimer’s but all Alzheimer’s patients have dementia.

G31.83 Dementia w/ Lewy Bodies
• Includes:
  - Dementia with Parkinsonism
  - Lewy Body Dementia
  - Lewy Body Disease
• Use additional code for dementia w/ or w/o wandering. (F02.8-)
• Condition and dementia must be stated by provider.
• Not interchangeable with Parkinson’s Disease.

G32 – Other Degenerative Disorders of Nervous System in Diseases Classified Elsewhere
Includes:
• Sub-acute combined degeneration of spinal cord in diseases classified elsewhere
• Code first the underlying disease
Example: M1021a – E53.8 Vitamin B deficiency
M1023b – G32.0 Other degenerative disorders of nervous system in diseases classified elsewhere

G40-G47 – Episodic & Paroxysmal Disorders
Includes: Epilepsy & recurrent seizures
- Terms treatment resistant, refractory and poorly controlled are to be considered intractable for this code section
- Epilepsy (G40)
- Epileptic seizures due to ext causes (G40.5)
  - code also epilepsy & recurrent seizures
  - use additional code for drug if due to adverse effect

G60-G65
- Polyneuropathies & other disorders of the peripheral nervous system
- Nerve root neuropathies in diseases classified elsewhere (G55)
  - code first the underlying disease such as neoplasm (C00-D49)
- Polyneuropathies in diseases classified elsewhere (G63)
  - code first the underlying disease
  - does not include polyneuropathy in DM (E08-E13)

G80-G83 – Cerebral Palsy & Other Paralytic Syndrome
Includes: Cerebral palsy, hemiplegia, monoplegia, quadriplegia & other paralytic conditions
- To be used when paralysis is reported w/o further specification, stated to be old or longstanding or of unstated cause
- Do not use these codes for paralysis or hemiplegia from sequela of cerebrovascular accident or disease (I69.-)

G81-G83 – Hemiplegia & Hemiparesis
Includes:
- Hemiplegia & hemiparesis (G81)
- Paraplegia & quadriplegia (G82)
- Diplegia & monoplegia (G83)
- Paralytic syndrome NOS (G83.9)
- Specific codes identify whether dominant or non-dominant side is affected
- If side is documented but not specified as dominant or non-dominant, and there is not a default code, code as follows:
  - For ambidextrous patients, the default is dominant
  - If the left side is affected, the default is non-dominant
  - If the right side is affected, the default is dominant

G89-G99 – Other Disorders of the Nervous System
Includes: (both acute & chronic pain)
- Pain NEC (G89)
- Acute pain NEC (G89.1-)
- Chronic pain NEC (G89.2-)
- Neoplasm related pain (G89.3)
- Chronic pain syndrome (G89.4) (has limitations)
G89 Pain Codes

- Codes in this category may be used in conjunction with codes from other categories & chapters to provide more detail
- Physician documentation of acute, chronic, neoplasm related, etc., is necessary to use G89
- G89 codes are not necessary if definitive diagnosis is known unless encounter is specifically for pain control
- Routine or expected post-op pain should not be coded separately

Scenario

- Patient admitted to homecare after long hospitalization following a fall in his home
- He sustained a diffuse TBI and is left with residual hemiplegia of dominant R side, cognitive deficits and has a PEG tube and a foley in place
- Has chronic back pain since fall
- Wife does his feedings and SN will change foley monthly

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Chapter 9 – Diseases of the Circulatory System

Chapter Guidelines

- AMIs are considered acute for 4 weeks as opposed to 8 weeks in ICD-9 coding
- A causal relationship can be assumed between HTN & CKD without documentation
- A causal relationship can now be assumed between HTN and HF
- A causal relationship can be assumed between atherosclerosis & angina unless otherwise stated. (new combination code)
  - I25.11 atherosclerosis of native artery w/ angina
  - I25.7 atherosclerosis of graft w/ angina
- When AMI & CAD present, code AMI first

I10 – Essential Hypertension

Includes:

- Accelerated
- Arterial
- Benign
- Idiopathic
- No longer necessary to distinguish benign, malignant or unspecified
- Use additional code to identify: exposure to, history of use, dependence on, and/or use of tobacco

I11 – Hypertensive Heart Disease

- Heart conditions classified to I50.- or I51.4 to I51.9 (heart failure codes), are assigned to category I11, Hypertensive heart disease, under the new “with” guidelines.
  - With heart failure or without heart failure
  - Only one code required if heart failure not present
  - An additional code from category I50 is required to identify the type of heart failure if applicable

Scenario

- Patient referred with diagnoses of hypertensive heart disease with mild heart failure
- Had an MI 2 months ago
- Regularly take NTG for unstable angina

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I12 – Hypertensive Chronic Kidney Disease (CKD)

- Includes any condition in N18 & N26 due to HTN, arteriosclerosis of kidney, hypertensive nephropathy
- Use additional code to identify the stage of CKD (N18.1 – N18.9)

Scenario

- Patient admitted with diagnosis of HTN, CKD on dialysis
- Also has emphysema
- Patient was a 2 pack/day cigarette smoker for 30 years
- SN to see for disease management & medication teaching

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I13 – Hypertensive Heart & CKD

- Use additional code to identify stage of CKD (N18.1 – N18.9)
- Use additional code to identify associated heart failure (I50.-)

Scenario

- Patient admitted with diagnosis of hypertensive heart disease and heart failure with CKD on dialysis.

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<tr>
<th>(M1021) Primary Diagnosis &amp; (M1023) Other Diagnoses</th>
<th>(M1025) Optional Diagnoses (OPTIONAL)</th>
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### HTN, DM, HF & CKD

- Sequence depends on focus of care.
- When HTN and DM are documented along with CKD, assumption can be made with either the HTN or the DM linking them to CKD.
- Which condition (HTN or DM) is coded first, depends on the focus of care.
- Either can be first followed by the CKD (N18.-)
- In either scenario, add the I50 code for heart failure when applicable.

### I20 – Ischemic Heart Disease

**Includes:** Angina pectoris (I20)

- Use additional code to identify: exposure to (Z77.22), history of use (Z87.891), dependence on (F17.-), and/or use of tobacco (Z72.0)
- Use additional code for HTN (I10-I15)
- Unstable angina (I20.0)

### I21

**Includes:** Cardiac infarction, coronary rupture, MI of 4 weeks or less

- Codes for acute myocardial infarction (AMI), identify the site of the MI
- STEMI –“ST elevation MI” Damage extends thru wall muscle and coded to I21.0, I21.1 or I21.3 which is default code for transmural MI of unspecified site
- NSTEMI “Non ST elevation MI” Damage usually not extended thru wall and includes non-transmural MI is coded to I21.4

### Scenario

- Patient referred with diagnoses of atrial fib, CHF & HTN.
- Had a transmural MI 3 weeks ago.
- SN to focus on managing CHF & atrial fib

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<tr>
<th>(M1021 Primary Diagnosis &amp; (M1033) Other Diagnoses)</th>
<th>(M1026) Optional Diagnoses (OPTIONAL) (not used for payment)</th>
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### AMI

- An AMI documented as non-transmural or subendocardial with the site identified should be coded as a subendocardial AMI
- An MI is considered “acute” and is reported as acute for 4 weeks
- After 4 weeks code:
  - Old MI (and no further symptoms) (I25.2)
  - If MI is older than 4 weeks and patient is still symptomatic, query physician for reason such as:
    - Chronic ischemic heart disease (I25.9)
    - Unstable Angina (120.0)
    - Cardiomyopathy (I42.-)
Other AMIs
- Subsequent MI (I22)
  - when pt suffers a new AMI within 4 weeks of the initial AMI a code from category I22 (subsequent STEMI or NSTEMI) is used.
  - Sequence depends on circumstance
- Other current complications following an AMI within 4 weeks (I23)
  - a code from category I23 must be used in conjunction with a code from I21 or I22

AMI Scenario
- Patient referred to home health S/P transmural inferior wall MI 1 week ago
- Also had a transmural anterior wall MI 3 weeks ago
- Continues to take sublingual NTG for angina
- Patient also has DM & HTN well controlled with meds
- SN will address cardiac status & medication teaching

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I24 – Other Ischemic Heart Disease
Includes: I24.0 – Acute coronary thrombosis not resulting in an MI
Excludes 1: Atherosclerotic heart disease (I25.1-)
  - Dressler’s syndrome (I24.1)
  - Acute ischemic heart disease, unspecified (I24.9)
Excludes 1: I25.9 ischemic heart disease (chronic) NOS

I25 – Chronic Ischemic Heart Disease
- Use additional diagnosis to identify the presence of HTN (I10-I15)
- Use additional code to identify chronic total occlusion of coronary artery (I25.82)
- Old MI – healed & greater than 4 weeks with no symptoms (I25.2)
- Atherosclerosis of coronary artery bypass graft and coronary artery of transplanted heart with angina (I25.7)
- Chronic ischemic heart disease, unspecified (I25.9)
  - Ischemic heart disease (chronic) NOS

I26-I28 – Pulmonary Heart Disease & Diseases of Pulmonary Circulation
Includes:
- Pulmonary embolism (I26.-)
- Other pulmonary heart disease (I27.-)
- Other diseases of the pulmonary vessels (I28.-)
- Personal history of PE (Z87.711)
I30-I52 – Other Forms of Heart Disease
Includes:

- Pericarditis (use additional code for infectious agent (I30-)
- Other diseases of pericardium (I31.-)
- Acute & sub-acute endocarditis (I33.-)
- Endocarditis, valve unspecified (I38.-)
- Cardiomyopathy (I42.-)
- Cardiac arrhythmia NOS (I49.9)

I50 – Heart Failure
Includes:

- Left ventricular failure (I50.1)
- Systolic (heart) failure (I50.2-)
- Diastolic (heart) failure (I50.3-)
- Combined systolic & diastolic failure (I50.4-)
- Heart failure, unspecified (I50.9)

Update: Assign both I50.21 (acute systolic heart failure) and I50.32 (Chronic diastolic congestive heart failure) for a patient with acute systolic heart failure and chronic diastolic heart failure.

- The combination code I50.43 (acute on chronic HF) doesn’t fully capture the condition

Scenario

- Patient with a history of CAD admitted following a STEMI 6 weeks ago
- Continues to have SOB, chest pain & fatigue which physician attributes to angina
- Takes NTG for angina
- Also has HTN

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I60-I69 – Cerebrovascular diseases

- In general, most codes from category I60-I69 should not be used on home health claims.
- They are used to report acute cerebral vascular accidents or disease and are appropriate for inpatient coding or in M1011 or M1017 in home health.
- Codes in category I65 & I66 may be used in home health to indicate stenosis and/or occlusion of cerebral arteries when and infarct has not occurred.
- Any residuals that remain from an acute injury are considered sequelae and require an I69 code.

I69 – Sequelae (late-effects) of Cerebrovascular diseases

- Used to indicate conditions classifiable to I60-I67 as the cause of sequelae.
- Sequelae are considered conditions as a result of acute process and can occur at any time after the onset of causal condition or injury.
- Code first condition being addressed followed by appropriate I69 sequela code.
- Some codes in category will require additional code to identify exact residual.
- Hemiplegia & hemiparesis designated as dominant or non-dominant.
- Codes from category I69 that specify hemiplegia, hemiparesis and monoplegia identify whether the dominant or non-dominant side is affected.
- Should the affected side be documented, but not specified as dominant or non-dominant, and the classification system does not indicate a default, code selection as follows:
  - For ambidextrous patients, default is dominant.
  - If the left side is affected, default is non-dominant.
  - If the right side is affected, default is dominant.
- Codes from category I69 should not be assigned if patient does not have neurologic deficits.
- Personal history of TIA & cerebral infarction (Z86.73) are coded if no neurological deficits are present.
- Codes from category I69 may be assigned with codes from I60-I67, if patient has a current CV disease and deficits from an old CV disease.

I69 Example:

Patient suffered a CVA. Referred to home care for management of late effects of CVA - dysphasia, ataxia, and cognitive changes.

- I69.393 Late Effect CVA, ataxia
- I69.31 Late effect CVA, cognitive deficit
- I69.321 Late effect CVA, dysphasia

I70 – Atherosclerosis

Includes:

- Atherosclerosis of native arteries of the extremities (I70.20)
  - Use additional code if applicable to identify chronic total occlusion of artery of extremity (I70.92)
- Atherosclerosis of native artery of R leg with ulceration (I70.23)
  - Add additional code to identify severity of ulcer (L97.- with 5th character 1 to indicate R)
- Atherosclerosis of native artery of L leg with ulceration (I70.24)
  - Add additional code to identify severity of ulcer (L97.- with 5th character 2 to indicate L)
  - Laterality applies
- Atherosclerosis of native arteries of extremities with gangrene (I70.26)
  - Add additional code to identify severity of ulcer (L98.49-)
I74 – Arterial Embolism & Thrombosis
Includes: Embolism & thrombosis of abdominal aorta & extremities
- Verify with provider whether clot still exists. If not consider history code.

I80-I89 – Diseases of Veins, Lymphatic Vessels & Lymph Nodes Not Elsewhere Classified (NEC)
Includes:
- Phlebitis & thrombophlebitis
- I80.0 – of superficial vessels & lower extremities
- I80.1 – of femoral vein
- I80.2 – of other and unspecified deep vessels of lower extremities

I83 – Varicose Veins of Lower Extremities
Varicose veins of lower extremities with ulcer (I83.0-)
- Add additional code to identify severity of ulcer (L97.-)
- 5th character indicates L or R
- 6th character indicates site
- Relationship between varicosity & lower extremity wound must be documented
Examples:
- Varicose veins of L lower extremity with ulcer of calf (I83.022)
- Non-pressure ulcer of L calf limited to skin breakdown (L97.221)

I87 – Other Disorders of Veins
- Post-phlebetic syndrome with or without inflammation or ulceration (I87.0-)
- Venous Insufficiency (chronic) (peripheral) (I87.2)
  - Includes stasis dermatitis
  - Verify the extent if ulcer is present
- Chronic venous insufficiency (I87.3)
  - Includes stasis edema
  - May or may not involve inflammation and/or ulceration
- Add additional code for ulceration (L97.-)

I96 – Gangrene NEC
Includes: Gangrenous cellulitis
Excludes:
- Gangrene in atherosclerosis of native arteries (I70.26)
- Gangrene in DM (E08-E13)
- Gangrene in PVD (I73.-)

I97 – Intraoperative & Post-Procedural Complications & Disorders of Circulatory System NEC
Includes:
- Heart failure following surgery (I97.13-)
- Hypertension following surgery (I97.3)
- Hematoma or hemorrhage of circulatory system during procedure (I97.4-)
- Accidental puncture or laceration during procedure (I97.5-)
- Hematoma or hemorrhage of circulatory system after procedure (I97.6-)
Chapter 10 – Diseases of the Respiratory System

Chapter Guidelines

• When condition is described as occurring in more than one site and is not specifically indexed, it should be considered as being in lower respiratory site (tracheobronchitis indexed to bronchitis in J40)

• Some codes have been expanded to include notes indicating that an additional code should be assigned or an associated condition should be sequenced first.

Use additional code:

• to identify infectious agent or virus
• to identify other conditions such as tobacco use (Z72.0) or dependence
• where applicable to identify exposure to tobacco smoke (Z77.22)

Code first:

• an associated lung disease
• underlying disease

J00-J06 – Acute Respiratory Infections

• Includes: Influenzas, sore throat, acute sinusitis & pneumonia
• For infections of upper respiratory tract, use additional code to identify the infectious agent (B95-B97)
• Note specific designations regarding etiology and/or manifestations related to influenza or pneumonia. Code also any other lung condition such as lung abscess

J09-J18 – Influenza & Pneumonia

• In influenza code also the type of pneumonia
• Code also the infectious organism if known
• In pneumonia due to influenza, code first the associated influenza code (J09.X1, J10.0-, J11.0-)

Example:

• Influenza due to novel influenza A virus with pneumonia (J09.x1)
• Parainfluenza viral pneumonia (J12.2)

J20-J22 – Other Acute Lower Respiratory Infections

Includes: Acute & chronic symptoms

Excludes:

• Chronic obstructive pulmonary disease with acute lower respiratory infection (J44.0)

J30-J39 – Other Diseases of Upper Respiratory Tract

• Includes: rhinitis, chronic sinusitis, nasal polyps, chronic laryngitis & tonsillitis
• Use additional code for infectious organism if known (B95-B97)
• J code includes any associated abscess

J40-J47 – Chronic Lower Respiratory Diseases

• Excludes bronchitis due to chemical agents (J68.0)
• Includes bronchitis not specified as acute or chronic and bronchitis NOS
• Add additional code for exposure to tobacco smoke (Z77.22)
• Chronic bronchitis NOS (J42)
**COPD**

- Emphysema NOS (J43.9)
- COPD with acute lower respiratory infection (use additional code to identify infection) includes COPD with acute bronchitis (J44.0)
- Chronic obstructive pulmonary disease with acute exacerbation (decompensated COPD) (J44.1)
- Chronic obstructive pulmonary disease NOS (COPD NOS) (J44.9)
- Chronic obstructive asthma & asthma with COPD now coded in (J44.9), COPD NOS
- Asthma (J45.-)
- For accuracy, always start in alphabetical index under “disease, lung, obstructive” which leads to J44.9 (COPD NOS). Coders should make every attempt to get more specific info.

**J43.9 Emphysema NOS**

Refer to Index:

- Emphysema. This includes COPD as indicated by nonessential modifiers (chronic, obstructive, pulmonary), (J43.9)
- Disease, lung, obstructive (chronic) there is a subterm with emphysema (J44.9)
- Use only when emphysema is the only info available
- Decompensated COPD is coded J44.1 (COPD w/ acute exacerbation)

Refer to Tabular:

- J44 Excludes 1 Note: emphysema without chronic obstructive bronchitis (J43.-)
- J43 Excludes 1 Note: emphysema with chronic obstructive bronchitis (J44.-)
- Follow the Tabular, not the Index when coding this scenario

**Code Break**

1. Patient has end stage COPD___________
2. Patient has emphysema_______________
3. Hx COPD unspecified _________________
4. Asthma NOS ________________________
5. Exacerbated COPD with pneumonia _______________

**J90-J94 – Other Diseases of the Pleura**

Includes:

- Pleural effusion NOS (J90)
- Chronic pneumothorax (J93.81)
- Acute pneumothorax (J93.83)

**J95 – Intraoperative & Post-Procedural Complications & Disorders of Respiratory System, NEC**

Includes:

- Tracheostomy complications (J95.0-)
- Intraoperative hemorrhage & hematoma complicating respiratory system (J95.6-)
- Accidental puncture or laceration complicating respiratory system during procedure (J95.7-)
- Post procedural respiratory failure (J95.82-)
- Post procedural hemorrhage or hematoma (J95.83-)
Chapter 11 – Diseases of the Digestive System

K00-K14 – Diseases of the Oral Cavity & Salivary glands

- Includes: Dental problems, gingivitis, oral ulcers & cysts
- Excludes: Oral neoplasms

K20-K31 – Diseases of Esophagus, Stomach & Duodenum

Includes:
- Esophagitis (K20.-)
- Gastro-esophageal reflux disease w/esophagitis (K21.0)
- Gastro-esophageal reflux disease w/o esophagitis (K21.9) Reflux NOS
- Gastric ulcers (K25.-) (4th character defines acute or chronic and w/ or w/o hemorrhage and perforation)
- Duodenal ulcers (K26.-) (4th character defines acute or chronic and w/ or w/o hemorrhage and perforation)
- Peptic ulcers (K27.-) (4th character defines acute or chronic and w/ or w/o hemorrhage & perforation)
- Acute gastritis (4th character indicates acute, chronic or alcoholic gastritis) (5th character indicates w/ or w/o bleeding) (K29.0-)
- Unspecified chronic gastritis (K29.5-)
- Other diseases of stomach & duodenum (K31.-)

Code Break
1. Acute gastric ulcer with hemorrhage ________________
2. Gastroparesis due to diabetes __________________
3. Patient with a long history of alcohol abuse that has led to alcohol gastritis with bleeding ________________

K40-K46 – Hernias

Excludes:
- Congenital, acquired (traumatic) hernia or recurrent hernia

Includes:
- Inguinal hernia (K40.-)
- Femoral hernia (K41.-)
- Umbilical hernia (K42.-)
- Ventral hernia (K43.-)
- Diaphragmatic hernia (K44.-)
- Hernia with gangrene & obstruction is classified to hernia with gangrene (indicated by 4th digit in each category)

Example: Patient with a recurrent right inguinal hernia with gangrene and obstruction – K40.41

K50-K52 – Non-Infective Enteritis & Colitis

Includes:
- Non-infective inflammatory bowel disease
  - Crohn’s disease (K50.0-)
  - Ulcerative colitis (K51.0-)
  - Ulcerative (chronic) proctitis (K51.2-)
- Non-infective gastroenteritis & colitis unspecified (Colitis & Enteritis NOS) (K52.9)
**K50 & K51**
- Both K50 & K51 require a 6th character code to fully describe the situation as follows:
  - 4th character describes location
  - 5th character describes without (0) or with (1) complications
  - 6th character defines the complication that is present (e.g., rectal bleeding, intestinal obstruction, fistula, abscess, other or unspecified complication)
  - Use additional code to identify manifestations

**K55-K64 – Other Diseases of Intestines**
Includes:
- Paralytic ileus & volvulus (K56.-)
- Fecal impaction (excludes constipation) (K56.41)
- Diverticulitis of small & large intestines (K57.-)
- Irritable bowel syndrome (K58.-)
- Constipation (K59.0)

**Code Break**
1. Crohn’s disease of small intestine with intestinal obstruction ______________
2. Neurogenic bowel ______________
3. Chronic ulcerative rectosigmoiditis with fistula ______________
4. Diverticulitis of the large intestine _______________

**K65-K68 – Diseases of Peritoneum & Retroperitoneums**
Includes:
- Peritonitis & peritoneal abscess (K65.-)
- Peritoneal abscess (intra & post-op) (K66.-)

**K70-K77 – Diseases of the Liver**
Excludes:
- Jaundice NOS (R17)
- Viral hepatitis (B15-B19)
Includes:
- Alcoholic liver disease, cirrhosis & failure (K70.-)
- Toxic liver disease (K71.-)
  - use additional code for adverse effect if applicable to identify drug (T36-T50)
  - code first any poisoning due to drug or toxin if applicable (T36-T50)

**K80-K87 – Disorders of Gallbladder, Biliary Tract & Pancreas**
Includes:
- Cholelithiasis (K80.-)
- Calculus of gallbladder w/ and w/o obstruction (K80.0)
- Cholecystitis (K81.-)
- Pancreatitis (K85.-)
- Alcohol-induced pancreatitis (K86.0)

**K90-K95 – Other Diseases of the Digestive System**
Includes:
- Intestinal malabsorption (celiac disease) (K90.-)
- Intraoperative & post-procedural complications & disorders of digestive system, NEC (K91.-)
K91 – Complications During or After Intestinal Surgery

Excludes:
- Complications of ostomies (K94.-)
  - complications due to radiation
  - ulcers

Includes:
- Vomiting following GI surgery (K91.0)
- Post-gastric surgery syndrome (K91.1)
- Intraoperative hemorrhage and hematoma of digestive system organ or structure complicating a procedure (K91.6-)
- Accidental puncture & laceration of a digestive system organ or structure during a digestive system procedure (K91.7-)
- Other intraoperative & post-op complications of a digestive system organ or structure during a digestive system procedure (K91.8-)

K92-K94 – Other Diseases of the Digestive System

Includes:
- GI hemorrhage, unspecified (K92.2)
- Complications of artificial openings of GI tract (K94.) (colostomy, enterostomy & enterostomy complications).
  - If complication is an infection, code first the infection code (A40.-, A41.-)
  - If complication is cellulitis of abdominal wall, code (L03.311)

K95 – Complications of bariatric procedures

- Use additional code to identify type of infection
- Add additional code for cellulitis or to further specify complication

Code Break

1. Alcoholic abuse cirrhosis _____________________
2. Drug induced pancreatitis ____________________
3. Peritoneal abscess following GI surgery ____________
Chapter 12 – Skin & Subcutaneous Tissue

Chapter Guidelines

• Certain conditions not found in Chapter 12 that relate to skin & subq tissue conditions have been moved to other chapters
  - certain infectious & parasitic diseases (A00-B99)
  - neoplasms (C00-D49)
  - systemic connective tissue disorders (M30-M36)

• Use additional code:
  - to identify infectious agent (L00-L08)
  - for adverse event to identify a drug (T36-T65)

• Code first:
  - any poisoning due to drug or toxin (T36-T65)
  - any underlying condition as the cause of skin condition (L97 as in non-pressure ulcers)
  - underlying condition in diseases classified elsewhere (L14 bullous disorders in diseases classified elsewhere)

L00-L08 – Infections of the Skin & Subq Tissue
Includes: Local infections, warts, zoster

• Use additional code (B95-B97) to indicate infectious agent
• Cutaneous abscess, furuncle & carbuncle (L02-)
• Cellulitis & acute lymphangitis (L03-)

Cellulitis & Abscess

• Abscesses & cellulitis are now classified in two separate codes
  - Cellulitis of neck (L03.221)
  - Cutaneous abscess of neck (L02.11)

• Use additional code to identify organism (B95-B96)
• I & D of an abscess remains an abscess
• If cellulitis or abscess is associated with a wound, code wound first followed by the cellulitis code

Example:
- L89.021 – PU of L elbow, stage I
- L03.114 – Cellulitis of L upper limb

Scenario
Pt admitted with several comorbidities and has a Stage III PU with cellulitis of L buttock. SN will address dressing changes and wound care with caregiver.

• M1021a – L89.323 (PU of L buttock)
• M1023b – L03.317 (cellulitis of buttocks)

Cellulitis & Colostomies

• If problem is cellulitis of abdominal wall and not a complication of the colostomy, code (L03.311)
• Cellulitis associated with colostomies, gastrostomies, ileostomies is considered a complication of the opening and is coded from the GI chapter (K94.-)
• Cellulitis of urinary stomas is coded from Chapter 14 (N99.5-)
• Code also the infectious agent if applicable

L20-L30 – Dermatitis & Eczema

• These terms are used interchangeably
• L23 Allergic contact dermatitis
  - L23.3 due to drug (use additional code to identify the drug (T36-T50)
  - L23.4 due to irritant contact with skin (use additional code to identify drug (T36-T50)
L76 – Intraoperative & Post-Procedural Complications of Skin & Subq Tissue
- Includes hemorrhage & hematomas resulting from dermatological procedure
- Does not include hemorrhage, hematomas, seromas, dehiscence of a wound for surgery to specific body system

L80-L99 – Other Disorders of the Skin & Subq Tissue
Includes:
- Pressure ulcers (L89.0-)
- Vasculitis limited to skin, NEC (L95.-)
- Non-pressure ulcers of lower extremities (L97.-)
- Other disorders of skin & subq tissue NEC (L98.-)
- Other disorders of skin & subq tissue in disease classified elsewhere (L99)
  - code first underlying disease

L89- – Pressure Ulcers
Includes: Bedsores, decubitus, plaster ulcers, pressure sores
- Only one code necessary in ICD-10 to identify site and stage.
  6th character in code indicates the stage

Guidelines
- Depth of PU & non-pressure chronic ulcers may be based on medical record documentation from clinicians who are not the patient’s provider (physician or other practitioner qualified to make that diagnosis)
- But, the actual cause of ulcer must be documented by patient's provider. Check with physician if there is doubt. (pressure ulcer vs diabetic ulcer)
- Not coded once ulcer is completely healed (stage I & II) or completely closed (stage III & IV)
- Stages of pressure ulcers are never reversed
- Code healing pressure ulcer at the highest stage reported for that site
- Combination codes identify site and stage
- Code as many L89 codes as necessary
- Incorrect etiology or stage will negatively impact reimbursement

Pressure Ulcer Stages
- L89 category codes identify both the stage and the site (one code only)
- Codes are classified as stage I-IV, unspecified or unstageable
- Use as many codes from category to capture all pressure ulcers
- Unstageable pressure ulcers
  - pressure ulcer that can’t be staged because wound bed cannot be visualized (eschar, slough or skin or muscle graft)
  - deep tissue injury caused by pressure not trauma
- Unspecified pressure ulcer
  - no documentation as to the stage

Anatomy of a Pressure Ulcer Code
L89.012
- 1st 3 characters indicate category (pressure ulcer)
- 4th character indicates the site (elbow)
- 5th character indicates laterality (right)
- 6th character indicates stage (II)
Multiple Pressure Ulcers

- For bilateral pressure ulcers of the same site, list a code for each site with the specific laterality.
  **Example:** A bilateral stage 2 pressure ulcer of the left and right hip would be two separate codes: L89.222 & L89.212

- For pressure ulcers of multiple stages at the same lateral site, list a code for each stage by site.
  **Example:** A stage II and stage III pressure ulcer of right buttock: L89.313 & L89.312

Scenario

- Patient admitted to homecare for care of stage II PU of R heel & Stage III PU of sacrum
- Ulcer on sacrum is infected with MRSA and also has cellulitis.

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<tr>
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L97 – Non-Pressure Chronic Ulcers

Includes:

- Stasis ulcers & diabetic ulcers, ulcer of lower limb NOS
- Code first any associated conditions such as:
  - atherosclerosis (I70.-)
  - gangrene (I96)
  - chronic venous HTN (I87)
  - diabetes (E08-E13)
  - varicose veins (I83.-%)
- Coded by site and depth of wound
- Code also any infection or cellulitis

Coded by Depth

- 6th Character identifies the depth of non-pressure ulcer
  1 – Non-pressure chronic ulcer of left calf limited to breakdown of skin
  2 – Non-pressure chronic ulcer of left calf with fat layer exposed
  3 – Non-pressure chronic ulcer of left calf with necrosis of muscle
  4 – Non-pressure chronic ulcer of left calf with necrosis of bone
  9 – Non-pressure chronic ulcer of left calf with unspecified severity
Anatomy for Severity Identification

Arterial Ulcers

- Arterial Ulcer Codes (I70.23-, I70.24-, I70.33-, I70.34-, I70.43-, I70.44-, I70.53-, I70.54-, I70.63-, I70.64-, I70.73-, I70.74-)
  - Atherosclerosis of native arteries or bypass grafts
  - By site
  - With ulceration
  - With gangrene

Example: Arterial ulcer of left heel with skin breakdown
- I70.244 Atherosclerosis of native arteries of left leg with ulceration of heel and midfoot
- L97.421, Non pressure chronic ulcer of left heel & midfoot limited to breakdown of skin
- Note: Read instructions at I70.24- regarding use of 5th character of 2 in L97.-

Venous Ulcers

- Varicose veins (I83.0-, I83.2-)
  - Chronic venous hypertension (I87.31-, I87.33-)
  - Post phlebetic/ post thrombotic syndrome (I87.01-, I87.03)

Example: Varicose vein right calf with ulcer & inflammation, unspecified severity
- I83.212 Varicose vein of right LE with both ulcer & inflammation
- L97.219 Non pressure chronic ulcer of right calf with unspecified severity
- Note: Chronic venous insufficiency codes to I87.2
Scenario 1
- Patient admitted with DM, HTN & an ulcer on R calf due to chronic venous HTN
- Ulcer involves area to fat layer
- Cellulitis present

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Scenario 2
- Patient with a gangrenous diabetic ulcer on plantar surface of left foot
- Patient is on insulin

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Chapter 13 – Diseases of the MS & Connective Tissue

M00-M99
Includes:
• Result of previous injury or trauma to site, or recurrent conditions
• Bone, joint or muscle conditions as the result of a previous injury
• Chronic conditions
• Pathological fractures only. Acute fractures are in Chapter 19

Chapter Guidelines
• Most codes in chapter require designation of laterality
• Sites are divided into bone, joint, or muscle involved
• Some codes have “multiple sites” choices (arthritis, osteoarthritis)
• For categories where no “multiple site” code exists but the condition is present in more than one bone, joint or muscle, multiple codes are necessary

Acute or Chronic
• Current, acute injuries are generally coded from Chapter 19 (new fractures or open wounds)
• Recurrent conditions or injuries that are the result of an old healed injury are coded from Chapter 13 (contractures)
• Chronic conditions are coded here (osteoarthritis)

Pathological Fractures
• Spontaneous chronic or pathological fractures are reported using codes from this chapter (M84.4-)
  - stress fractures (M84.3-)
  - fatigue fractures of vertebrae (M48.4-)
  - collapsed fractures of vertebrae (M48.5-)
• No aftercare codes for pathological fractures
• A fracture in a patient with a known diagnosis of osteoporosis is considered a pathological fracture
• Pathological fracture codes are combination codes that include a 7th character to indicate subsequent care or sequela
  - “A” – initial episode while pt receiving active treatment
  - “D” – routine aftercare, subsequent episode
  - “S” – sequela
  - Other 7th characters (G, K, P) are for problems such as malunions, nonunions and delayed healing)
• Use additional code to identify any major osseous defect if present (M89.7-)
• Use Z87.311 for history of pathological fracture

M80 – Osteoporosis With Fracture
• Code from M80 should be used for any patient with known osteoporosis who suffers a fracture, even if patient had a minor fall or trauma, if it would not typically cause a healthy bone to fracture
• M80 codes identify the site of fracture

M81 – Osteoporosis Without Fracture
• Code first M81 for osteoporosis with history of prior healed pathological fracture
• Add Z87.310 for osteoporosis with a history of pathological fracture
Example:
- Patient with age-related osteoporosis admitted for routine aftercare following a fractured R humerus. Also had a fractured vertebrae 6 months ago.
- **M80.021D** (age-related osteoporosis w/ current pathological fx of R humerus)
- **Z87.310** (history of osteoporosis fracture)

**M86 – Osteomyelitis**
- Includes acute & chronic
- Use additional code to identify the infectious agent (**B95-B97**)
- Use additional code to identify major osseous defect (**M89.7**)

Examples:
- Acute osteomyelitis of R great toe due to MRSA
  - **M86.171** (other acute osteomyelitis of R ankle and foot)
  - **B95.62** (MRSA as the cause of diseases classified elsewhere)
- Chronic osteomyelitis of L BKA
  - **M1021a – M86.662** (Other chronic osteomyelitis of L tib/fib)
  - **M1023b – Z89.512** (acquired absence of L leg below knee)

**M00-M25 – Arthropathies**
Includes:
- **M00-M02** Infectious arthropathies (code also the infectious agent & code by site or generalized)
- **M05-M14** Rheumatoid arthritis with or w/o heart & other organ involvement

**Other M codes**
- Gout (**M10.-**)
- Charcot’s joint (**M14.671**)
  - Excludes Charcot’s joint in DM
  - Includes neuropathic arthropathy
- Arthropathies in other specified diseases - code first underlying disease such as:
  - Hyperparathyroidism (**E21.-**)
  - Sickle cell disorder (**D57.-**)
- Osteoarthritis (coded w/ laterality) (**M16.- & M17.-**)
- Generalized osteoarthritis coded (**M15.9**)
- Arthritis NOS coded (**M19.90**)

**Scenario**
- Patient admitted for PT due to Rheumatoid arthritis with polyneuropathy
- Also has osteoporosis and sustained a rib fracture 3 months ago

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Chapter 14 – Diseases of Genitourinary System

Chapter Guidelines

Stages of Chronic Kidney Disease (CKD)

- The ICD-10-CM classifies CKD based on severity. The severity of CKD is designated as stage 1-5.
  - Stage 1, code N18.1
  - Stage 2, code N18.2, equates to mild CKD;
  - Stage 3, code N18.3, equates to moderate CKD;
  - Stage 4, code N18.4, equates to severe CKD.
  - Stage 5, code N18.5
  - N18.6, End stage renal disease (ESRD), Use only w/ documented (ESRD).
    If both a stage of CKD & ESRD are documented, assign code N18.6 only.
  - N18.9 is used for CKD unspecified stage

Sequencing

Patients with CKD may also suffer from other serious conditions, most commonly DM & hypertension. The sequencing of the CKD code in relationship to codes for other contributing conditions is based on conventions in Tabular List.

Renal Failure

- Acute renal failure (N17.-)
  - Code also associated underlying condition such as severe sepsis (R65.2)
- Chronic renal failure (N18.-) (coded by stage)
- Unspecified renal failure (N19.-)

N30-N39 – Other Diseases of the Urinary System

Includes:

- Acute & chronic cystitis (N30.-)
- Neurogenic bladder (N31.9)
- UTI site not classified (N39.-)
- Stress incontinence (N39.3)
- Other specified incontinence (N39.4-)

N40-N53 – Diseases of the Male Genital Organs

Includes: BPH

Excludes: Neoplasms of bladder (D29 or C61)

N40-N41

- Enlarged prostate w/ or w/o UTI (N40.-)
- Inflammatory diseases of prostate (includes acute & chronic prostatitis) (N41.-)
  - Use additional code for infectious agent (B95-B97)

N60-N65 – Disorders of the Breast

Excludes:

- Disorders associated with pregnancy
- Neoplasms of breast

Includes:

- Post-procedural (acute) (chronic) kidney failure – use additional code to specify type of kidney disease (N99.0)
- Complications of urinary tract stomas (strictures, bleeding, malfunctions) (N99.5)
- Intraoperative hemorrhage & hematoma of GU system organ or structure complicating a procedure (N99.6-)
- Accidental puncture laceration of GU system organ or structure complicating a procedure (N99.7-)
- Complications of cystostomy (N99.51)
- Complications of other external stoma of urinary tract (N99.52)
  - 6th character attached to N99.52 as defined in N99.51 describes hemorrhage, infection, malfunction & other complication of other external stoma of urinary tract
  - N99.53 Complications of other stoma of urinary tract
  - 6th character attached to N99.53 as defined in N99.51 describes hemorrhage, infection, malfunction & other complication of other stoma of urinary tract

Scenario

- Patient admitted S/P surgery to remove bladder mass
- Bladder was accidently nicked during the procedure
- Has a foley cath in place with hematuria noted
- Patient has HTN & DM with polyneuropathy

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Chapter 18 – Symptoms, Signs & Abnormal Clinical & Lab Findings, NEC

R00-R99 – Symptoms, signs & abnormal clinical & lab findings, NEC

Includes:

- Abnormal vital signs
- Abnormal lab values
- Physical symptoms
- Ill-defined & unknown cause of mortality

Chapter Guidelines

- Signs & symptoms (S&S) that point definitely to a documented diagnosis has been assigned to the chapter they are associated with.
- When S&S of known diagnosis are present, code the appropriate diagnosis unless specifically directed to do otherwise.
- Most conditions in chapter are considered “not otherwise specified” (NOS), “unknown etiology” or “transient”.

Includes:

- Cases for which no specific diagnosis can be made
- S&S existing at time of an initial encounter, is considered transient and cause could not be determined
- Provisional diagnosis in a patient failed to follow-up for definitive diagnosis
- Cases referred elsewhere for further investigation or treatment
- Cases in which a more precise diagnosis was not available
- Certain symptoms, for which supplementary information is provided
- Some S&S may be found in other chapters
  - Breast mass or lump (N63) Chapter 14
  - Itch (L29.9) Chapter 12
  - Pain in the eye (H57.1) Chapter 7

R00-R09 – S&S Involving Circulatory & Respiratory Systems

Includes:

- Abnormal vital signs (R00.-)
- Hemorrhage from respiratory passages (hemoptyis, pulmonary hemorrhage NOS) (R04.-)
- Cough (R05.-)
- Abnormal breathing (wheezing, dyspnea, tachypnea) (R06.-)
- Shortness of Breath (R06.02) can be used with a dx of pneumonia that no exists but SOB is a residual. Add code for hx of pneumonia (Z87.01)

R10-R19 – S&S Involving Digestive System & Abdomen

Includes:

- Abdominal & pelvic pain (R10.-)
- Nausea & vomiting (R11.1-)
- Aphagia & dysphagia (R13.-)
- Fecal Incontinence (R15.-)

R20-R23 – S&S Involving Skin & Subq Tissue

Includes:

- Rashes (R21)
- Localized swelling, mass & lump (does not include neoplasms) (R22.-)
- Other skin changes (cyanosis, pallor) (R23.-)
R25-R29 – S&S Involving Nervous & MS Systems
Includes:
- Abnormal involuntary movements (cramps, spasms) (R25.-)
- Abnormal gait & mobility (ataxia, difficulty walking) (R26.-)
  - use the correct code for cause of gait issues
  - considered integral in hemiplegia, low back pain, or joint replacement of lower extremities.
  - try to ascertain a more specific description of gait issue
- Use Difficulty in Walking (R26.2) for chronic conditions of the bone or joint
- Repeated falls (falling, tendency to fall) used when a pt has fallen and reason for falling is being investigated. May be used in conjunction with Z91.81 (history of falling) (R29.6)

R30-R39 – S&S Involving GU System
Includes:
- Dysuria (R30.3)
- Hematuria (R31.-)
- Urine retention (code causal condition first, such as enlarged prostate)

R40-R44 – S&S Involving Cognitive, Perception, Emotional State & Behavior
Excludes: S&S constituting part of a pattern of mental disorder (F01-F99)
Includes: Coma - includes coma NOS (R40.2-) (7th character required)

R47-R49 – S&S Involving Speech & Voice
Excludes: Stuttering (F80.81)
Includes: Dysphasia & aphasia (R47.- ); Slurred speech (R47.81)

R50-R60 – General S&S
Includes:
- Fever presenting w/ conditions classified elsewhere (code first the underlying condition) (R50.81)
- Post-procedural fever (R50.82)
- Fever unspecified (R50.9)
- Pain unspecified (R52)
- Malaise & fatigue (neoplasm related fatigue, weakness NOS, debility, frailty, etc.) (R53.-)
- Functional Quadriplegia (R53.2)
- Syncope & collapse (R55)
- Edema (R60.-)

R65 – Severe Sepsis
Includes:
- Infection with associated acute organ dysfunction
- Sepsis with acute organ dysfunction
- Code first the underlying infection such as:
  - infection following a procedure (T81.4)
  - sepsis NOS (A41.9)
- Use additional code to identify specific acute organ failure:
  - acute renal failure (N17.-)
  - acute respiratory failure (J96.0-)
  - hepatic failure (K72.0-)
- Severe sepsis without septic shock (R65.20)
- Severe sepsis with septic shock (R65.21)
**Scenario**
- Patient admitted to home health after recent hospital stay for small bowel obstruction
- Developed severe sepsis with renal failure in hospital following surgery for small bowel obstruction
- Has severe malaise & fatigue & abdominal pain.
- SN in for disease management & colostomy care education

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### Chapter 19 – Injury, Poisoning & Certain Other Consequences of External Causes

#### Chapter Guidelines
- Injury, poisoning & certain other consequences of external causes
- **S** codes are used to code different types of injuries related to single body regions
- **T** codes are for injuries to unspecified body regions as well as poisoning and certain other consequences of external causes
- Use of additional codes from Chapter 20 (external causes of injuries) to indicate cause of injury is not mandatory but encouraged for more clarification and data collection
- Use additional code to identify any retained foreign body if applicable
- Fractures in a patient with known osteoporosis are coded as pathological fractures (*new guideline*)

#### S Codes
- No aftercare codes here
- Injuries are grouped by anatomical site rather than injury type with exception of burns

*Includes:*
- Dislocation & sprains  
- Crushing Injuries
- Traumatic hemorrhages  
- Open wounds
- Traumatic amputations  
- Fractures
- Superficial injuries/contusions  
- Blast injuries

#### Application of 7th Character
- Most (not all) codes in chapter will require one of three 7th characters:
  - **A** initial encounter
  - **D** subsequent encounter
  - **S** sequela

#### Fracture - 7th Character
Fractures in this chapter have additional choices for 7th characters:
- **G** subsequent encounter for fracture with delayed healing
- **K** subsequent encounter for fracture with nonunion
- **P** subsequent encounter for fracture with malunion

##### 7th Character "A"
- Initial encounter
- Used while patient is still receiving active care (ER, surgery, new physician evaluation) or when patient is still receiving active care at home.

*Example: Dehisced wound*
- Generally won't be appropriate for homecare

*Example: Pt presents to ER with a fractured right radius*
- **S52.91XA** unspecified fractured R radius
- 6th character "X" is a filler
- 7th character "A" indicates initial encounter

##### 7th Character "D"
- Subsequent encounter
- Used when patient is receiving routine aftercare after patient has received active treatment during the healing or recovery phase
- Cast removal or change, medication adjustment, other aftercare and follow-up visits following treatment of the injury or condition
• Home health will no longer use aftercare codes for injuries where 7th character is available to identify subsequent aftercare

Example: Patient with fractured radius is at home, now receiving aftercare.
•  S52.91XD unspecified fracture R radius
•  6th character “X” is a filler
•  7th character “D” indicates subsequent encounter

7th Character “S”
•  Sequela (late effect)
•  Used when the acute phase and aftercare are over and pt is receiving care for a complication or a condition that arise as a direct result of a condition
•  Chronic pain, scarring, contracture
•  The specific condition (residual) is coded first followed by appropriate sequela code

Example: Chronic pain (G89.21) following healed radius fracture R arm (S52.91XS)
•  6th character “X” is a filler
•  7th character “S” indicates residual (chronic pain)

Wounds
•  May be open (lacerations, punctures, bites, tears, abrasions, avulsions) or open/internal (intracranial hematoma, ruptures, fractures)
•  May be described as with or without an opening into a cavity
•  May be complicated (delayed healing, FB present, infected) or without mention of complication
•  All “open wounds” are not trauma wounds
•  Surgical amputations for medical reasons not coded here

Fractures
•  Coded by site with categories S02, S12, S22, S32, S42, S49, S52, S62, S79, S82, S89, S92 and the appropriate 7th character for episode of care
•  Includes: anatomical site, laterality, type of fracture, healing status and part of the bone when applicable
•  A fracture not indicated as open or closed should be considered closed.
•  Default is non-displaced if not stated otherwise
•  Never use 7th characters A, B or C in HH or hospice
•  Complications of surgical treatment for fractures are coded with the appropriate complication code

Code Break
1.  Fracture of coronoid process of R ulna ______________________
2.  Displaced segmental fracture of shaft of L humerus ___________________
3.  Non-union of Torus fracture of upper end of R tibia _____________________
4.  Comminuted fracture of patella and sprain of lateral collateral ligament of R knee_______________________________

S00-S09 – Injuries to head (face, scalp, teeth)
•  Use additional code to specify any infection
•  Use appropriate 7th character to indicate type of encounter
  - "A" Initial encounter
  - "D" Subsequent encounter
  - "S" Sequela

Example: S01.01xD laceration of scalp w/o foreign body
S02 – Fracture of Skull & Facial Bones
- Code also any associated intracranial injury (S06.‐)
- A fracture not indicated as open or closed should be coded as closed

S03-S05 – Injuries to the Eye & Facial Nerves
- Code first any intracranial injuries
- Code also any associated open wounds
- Code also any skull fractures
- Use additional code to identify any visual field defect or blindness (H53.4‐, H54)
- Laterality is an option
- Use appropriate 7th character to identify encounter (A, D, S)

S06 – Intracranial Injury
- Includes traumatic brain injury
- Code also any open wound of head (S01.‐) or skull fracture (S02.‐)
- Does not include head injury NOS (S09.90)
- Use appropriate 7th character to identify encounter (A, D, S)

S08.0‐, S09.‐
- Avulsion of scalp (S08.‐)
- Includes amputation of ear & ruptured eardrum
- Code any associated open wound (S01.‐)
- Unspecified injury of the face & head (S09.‐)

S10-S19 – Injuries to the Neck
- Includes open wounds, contusions, abrasions, blisters, puncture wounds and insect bites of neck
- Use associated cervical spine injury (S14.0, S14.1‐)
- Use 7th character to indicate encounter, sequela or complication
- S12 Fracture of cervical vertebrae and other parts of neck
  - "A" Initial encounter for closed fracture
  - "B" Initial encounter for open fracture
  - "D" Subsequent encounter for fracture w/ routine healing
  - "G" Subsequent encounter for fracture w/ delayed healing
  - "K" Subsequent encounter for fracture w/ non-union
  - "S" Sequela

S20-S29 – Injuries to the Thorax
- Includes contusions, open wounds, bites, lacerations, puncture wounds
- Open wound of thorax (S21.‐)
  - code also any associated injury
  - heart (S26.‐)
  - intrathoracic organs (S27.‐)
  - traumatic hemothorax (S27.1‐)

S22
- Fracture of rib(s), sternum & thoracic spine (S22.‐)
  Code first any associated injury:
  - of thoracic spine (S27.‐)
  - of spinal cord (S24.0‐, S24.1‐)
  - Add appropriate 7th character for encounter

S23 – Subluxation, Dislocation & Sprains of T spine
• Code also any:
  - fractures (S22.0-)  
  - open wounds (S21.0-)  
  - transient paralysis (R29.5)

• Use appropriate 7th character for encounter

S30-S39 – Injuries to Abdomen, Lower Back, Lumbar Spine, Pelvis & External Genitals
- Use appropriate 7th character for encounter
- S30 includes superficial injuries, contusions, abrasions
- S31 includes open wounds, lacerations and puncture wounds
- S32 includes fractures of lumbar spine & pelvis (use appropriate 7th character)

S33
- Includes subluxation, dislocation & sprains of L spine
- Code also any open wounds or spinal cord injury
- Use appropriate 7th character for encounter

S40-S49 – Shoulder & Upper Arm
- Includes superficial injuries, contusions (S40.0-)
- Open wound of shoulder & upper arm (S41.0-)
- Fracture of clavicle & humerus (S42.0-) (use appropriate 7th character)
- Dislocation & sprain of shoulder joints & ligaments (S43.0-) (use appropriate 7th character)

S50-S59 – Injuries to Elbow & Forearm
- Includes: Superficial injuries, bites, puncture wounds, lacerations & fractures of forearm
- Code also any infections or cellulitis
- Add appropriate 7th character to indicate encounter, sequela or complication

S60-S69 – Injuries to Wrist, Hand & Fingers
- Includes: Superficial injuries, bites, puncture wounds, lacerations & fractures of forearm
- Code also any infections or cellulitis
- Use appropriate 7th character to indicate encounter, sequela or complication

S70-S79 – Injuries to Hip & Thigh
- Includes: Superficial injuries, contusions, open wounds, fractures
- Code any associated infections or cellulitis
- Use appropriate 7th character to identify encounter, sequela or complication

S80-S89 – Injuries to Knee & Lower Leg
- Includes: Superficial injuries, contusions, open wounds, fractures
- Code any associated infections or cellulitis
- Use appropriate 7th character to identify encounter, sequela or complication

S90-S99 – Injuries to Ankle & Foot
- Includes: Superficial injuries, contusions, open wounds, fractures
- Code any associated infections or cellulitis
- Use appropriate 7th character to identify encounter, sequela or complication

T80-T88 – Complications
• Complication must be documented by provider. Not all conditions that occur after surgery or a procedure are to be considered a complication.
• A cause and effect relationship between care provided and the condition must be stated as a complication.

**Example:** Patient has surgery to repair a traumatic injury & part of incision is intentionally left open to facilitate healing (not a complication)

• Use additional code to indicate an adverse effect if applicable (T36-T50) with the 5th or 6th character of 5 to indicate the drug.
• Use additional code(s) to identify specified condition resulting from complication
• Use additional code to identify devices involved and details of circumstances (Y62-Y82) misadventures during surgical or medical care

**Complication Examples**
• Disruption of external operation wound, NEC (T81.31)
• Breakdown of internal fixation device of vertebrae (T84.216)
• Liver transplant rejection (T86.41)
• Infection of amputation stump, LLL (T87.44)

**Code Break**
1. Disruption of abdominal surgical wound _____________________
2. Superficial infection of PICC __________________
3. Periprosthetic fracture of R knee joint _____________________
4. Kidney transplant rejection ________________________________

**Amputations**
• Planned amputations are coded as aftercare (Z47.81) Use additional code to identify level of amputation & laterality (Z89.412) amp of L great toe
• Traumatic amputations are coded
  - traumatic amputation of R great toe (S98.11-)
• Amputation stump complications are coded from T87 not T81
• Coded by laterality – no 7th character needed
  - neuroma of amputation stump, RLE (T87.33)

**Examples:**
Patient admitted for care of a L BKA. Amputation done due to DM wound.
• M1021a – Z47.81 Aftercare following amputation
• M1023b – E11.9 DM II w/o complications
• M1023c – Z89.512 Acquired absence of LLL

Same patient….wound now infected with MRSA.
• M1021a – T87.44 Complication of amputation
• M1023b – A49.02 MRSA
• M1023c - E11.9 DM II w/o complications
• M1023d – Z89.512 Acquired absence of LLL

**Burns**
• Electrical heating device
• Lightning
• Electricity
• Radiation
• Flame
• Chemical burns or corrosions
• Hot air or gasses  • Scalds
• Hot objects

• **T20-T25** are coded as acute by degree & site
• Use additional external cause code to identify, source, place and intent of burn (X code)
• For corrosive burns use an additional code to identify chemical & intent (T51-T65)
• **Do not** use category **T30** (burn of unspecified site)
• Non healing burns are coded as acute burns (7th character needed for encounter)
• Code worst burn first
• If more than one degree of burn exists on the same site, code highest degree burn first
• Use additional code for infection if applicable
• Sequela (late effect) of a burn is coded with the acute burn code using 7th character “S”
  - 2nd degree burn of chest – sub encounter (**T21.21XD**)
  - 2nd degree burn of chest – sequela (**T21.21XS**)
• It is sometimes appropriate to code an acute burn and a sequela of a burn on the same claim.

**Example:**
• Pt sustained 3rd degree burns of both forearms. R arm healing is delayed. Left arm has healed but contracture is present. Code both:
  - 3rd degree burn of R forearm (**T22.311D**)
  - 3rd degree burn of L forearm sequela 9 (add code for scarring L90.5)

**Scenario**
• Patient fell at home and broke proximal end of tibia & shaft of fibula of R leg
• PT will address ambulation, safety & transferring
• Patient has Type II DM (on insulin), emphysema
Poisoning, Adverse Effects, Underdosing as Toxic Effects

- Codes T36-T65 are combination codes that include the substance taken and the effect
- No additional external cause needed.
- Use table of drugs and chemicals but always refer to tabular list to confirm code
- Use as many codes as necessary

Table of Drugs & Chemicals

Poisoning is defined as:
- Overdose of substances
- Wrong substance given or taken in error

Adverse effect is defined as:
- 'Hypersensitivity', 'Reaction', etc., of correct substance properly administered

Underdosing is defined as:
- Taking less of a medication than is prescribed or instructed by the manufacturer, whether inadvertently or deliberately

Poisoning
- When poisoning is the result of overdose, wrong medication or wrong dosage, code first appropriate code from T36-T50 followed by manifestation of poisoning

Example: Patient knowingly took more of her Ambien than what was ordered in order to get sleep. She is now very confused
- T42.6X1D Unintentional poisoning of sedative
- R41.0 Confusion NOS

Adverse Effect
- When coding an adverse effect from a medication that was correctly prescribed and administered, code first the code for the effect of the drug followed by the appropriate code from T36-T50 to identify the drug and the intent.

Example: Patient takes Coumadin as ordered but is now Coumadin toxic and has hematuria as a result
- R31.9 Hematuria
- T45.511 Coumadin, unintentional
Underdosing

- New concept in ICD-10
- Used to indicate the taking of less of a medication that has been prescribed
- If underdosing results in recurrence or exacerbation of the condition it was meant to treat, code the condition first followed by the underdosing code

Example: Patient only takes her BP meds when she “needs” it because it’s “too expensive”. BP is very labile
- I10 Essential HTN
- T46.5X6D Underdosing of antihypertensive
- Z91.120 Intentional underdosing of meds due to cost
Chapters 20 & 21 – External Causes of Morbidity

V00-Y99 External Cause Codes
- Codes from this chapter are used as secondary codes to indicate cause of injury, and other adverse effects. Use only for initial encounter
- Most often the injury or adverse effect will originate in Chapter 19 (S00-T88 injuries & poisonings) but may be used with codes from other chapters to indicate cause of condition
- Most codes in this chapter will require a 7th character
- Not applicable in cases of poisonings & adverse effects of drugs

Z00-Z99
- Factors influencing health status and contact with health services
- Some Z codes can be primary while others can only be secondary
- Z codes represent reasons for encounters with circumstances other than a disease. Injury or external cause classifiable to the other chapters (A00-Y89) are recorded as “diagnosis” or “problems”.
- Significant changes from ICD-9 with expansions of history codes and elimination of therapy only codes and aftercare codes for fractures and injuries (V57.x & V54.x)

Categories (Keywords)
- Admission
- Aftercare* • Observation
- Attention • Presence
- Examination** • Problem
- Exposure • Resistance
- History • Status
- Inoculations & vaccines

*Includes surgical aftercare, attention to & fitting and adjustment
**Not generally used in HH

Aftercare
- For situations where the initial acute phase is over but patient continues to require follow-up care or attention during the recovery phase
- Do NOT use if patient is still receiving active treatment for a condition (i.e., care after surgery for a neoplasm that is still being treated, surgery did not eliminate neoplasm)
- Never use for complex complications or care – routine aftercare only
- Generally are listed as primary to explain the reason for the encounter
- May be used as an additional code when aftercare is being provided secondary to the reason for admission (i.e. attention to PICC during an admission for pneumonia)
- Use of multiple aftercare codes is permitted to fully identify and provide detail of encounter
- Sequencing depends on circumstances of encounter
- Aftercare following fractures are coded from Chapter 19 (acute fracture code) with the appropriate 7th character to identify encounter, sequela or complication
- Surgical aftercare following injury and trauma not coded here. Use acute injury or trauma code with the appropriate 7th character to identify encounter, sequela or complication
Attention to
• Used to explain treatment or care a pt is receiving due to a current condition
• Cleansing/Changing/Feeding/Teaching/Removal
• Must be actively providing a skill (not used to indicate presence of)

Examples:
• Encounter for attention to cystostomy (Z43.5)
• Encounter for fitting & adjustment of urinary device (Z46.6)
• Encounter for surgical aftercare (Z48.81-)

Status Codes
• Used to indicate that a condition currently exists and may have an impact on POC but in itself is not actively receiving care or treatment from clinician
• Can be used to indicate that a pt is either a carrier of a disease or has a sequela or a disease that is not currently being treated
• The status can have a direct impact on POC

Examples:
• Personal hx of malignant neoplasm - larynx (Z85.21)
• Acquired absence of L leg above knee (Z89.612)
• Note the expansion of non-compliance codes:
  • Reasons are more specific & includes:
    - Noncompliance with diet (Z91.11)
    - Intentional under-dosing of medications (Z91.12)
    - Intentional under-dosing of medication regimen due to financial problems (Z91.120)
    - Unintentional under-dosing of medications due to age related debility (Z91.130)
    - Noncompliance with renal dialysis (Z91.15)

History of
• Used to explain patient’s past medical condition that no longer exists but has potential for recurrence and therefore warrants monitoring
• Two types:
  1. Personal
  2. Family
• Other personal risk factors that have a direct impact on current POC
  - Hx of falling (Z91.81)
  - Hx of wandering (Z91.83) (code first underlying disorder)

Code Break
• Encounter for non-surgical wound care __________________________
• Encounter for IV antibiotics thru PICC __________________________
• A/C for LLL amputation due to gangrene __________________________
• Encounter for monthly catheter changes __________________________

Joint Replacements
• Aftercare following joint replacement (Z47.1)
• Not a combination code. Use additional code to identify joint replaced (Z96.6-)
• Laterality codes available
**Joint Explantation**

- Use for aftercare following the removal of joint after implantation or for care after insertion of a new joint following prior explantation of a joint (Z47.3-)
- Add additional code for “acquired absence of joint” with or w/o presence of antibiotic spacers (Z89.521)

**Joint Explantation Scenario**

- Patient S/P bilateral knee replacement
- R knee incision & joint space infected
- Joint removed, antibiotic spacers inserted & long-leg cast applied while infection is addressed

**Special Instructions**

Acquired absence codes (Z89-Z90) and artificial opening codes (Z93-Z99) codes can only be used when there are no complications or malfunctions.

**Long-Term Use**

- Use for long-term (current) drug therapy (Z79)
- Use for long-term prophylactic purposes
- Code also any therapeutic drug level monitoring (Z51.81)
- Assign when patient is receiving medication for an extended period of time for prophylaxis or treatment

**Artificial Opening Codes**

- Use when encounter is for management of the artificial opening (Z43.-)
- Status code to indicate presence of artificial opening (Z93)
- Complications of external stomas (J95.-, K94.-, N99.5)

**Code Break**

1. Acquired absence of R breast & nipple
2. Patient noncompliance with medication regimen
3. Presence of L artificial hip joint
4. Personal history of neoplasm of small bowel

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### Table: Primary Diagnosis & Other Diagnoses

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Thanks for Attending!
Feel free to contact us with any questions.
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