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ICD 10 ORGANIZATIONAL AND STRUCTURAL CHANGES

May 2014

ORGANIZATIONAL & STRUCTURAL CHANGES IN ICD 10 CM

- ICD-10-CM consists of 21 chapters compared to 17 chapters in ICD-9-CM.
- ICD-9-CM's V and E codes are supplemental classifications; in ICD-10-CM, they are incorporated into the main classification.
- Diseases/conditions of the sense organs (eyes and ears) have been separated from the nervous system diseases/conditions and have their own chapters in ICD-10-CM.

ORGANIZATIONAL & STRUCTURAL CHANGES IN ICD 10 CM

- To reflect current medical knowledge, certain diseases have been reclassified (or reassigned) to a more appropriate chapter in ICD-10-CM.

- For example, gout has been reclassified from the endocrine chapter in ICD-9-CM to the musculoskeletal chapter in ICD-10-CM.

ORGANIZATIONAL & STRUCTURAL CHANGES IN ICD 10 CM

- In contrast to ICD-9-CM, which classifies injuries by type, ICD-10-CM groups injuries first by specific site (head, arm, leg, etc) and then by type of injury (fracture, open wound, etc).

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ORGANIZATIONAL & STRUCTURAL CHANGES IN ICD 10 CM

- Postoperative complications have been moved to procedure-specific body system chapters.

ORGANIZATIONAL & STRUCTURAL CHANGES IN ICD 10 CM

- ICD-10-CM codes are alphanumeric and can be up to seven characters in length; ICD-9-CM codes are only three to five characters in length.

NEW FEATURES IN ICD 10 CM

- The numerous new features in ICD-10-CM allow for a greater level of specificity and clinical detail
- Combination codes for conditions and common symptoms or manifestations
- Combination codes for poisonings and external causes
- Added laterality
- Added 7th characters for episode of care

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NEW FEATURES IN ICD 10 CM

- Expanded codes (injuries, DM, alcohol/substance abuse, postoperative complications)
- Inclusion of trimesters in OB codes

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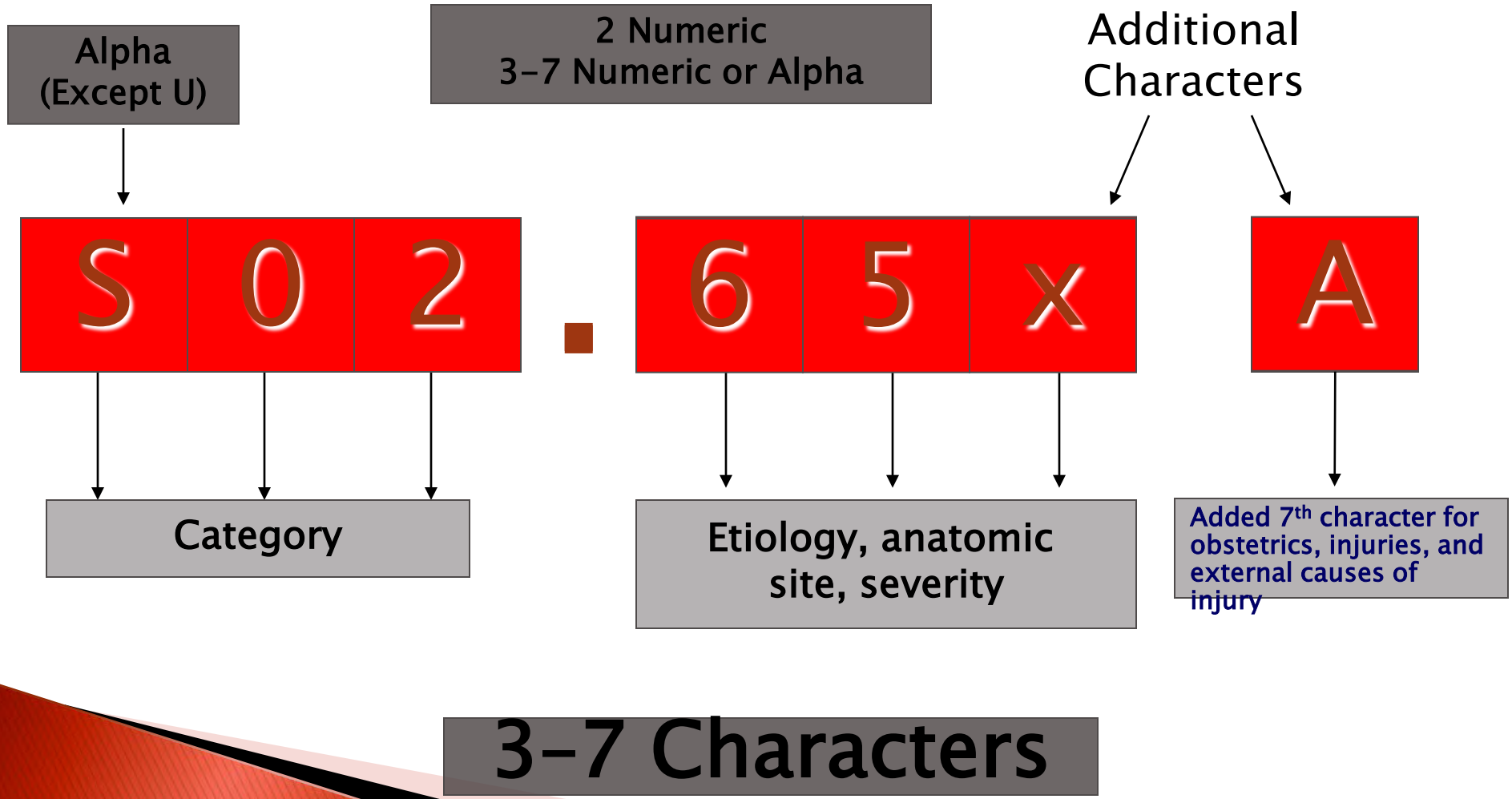
Coding and 7th Character S



3-7 Characters

Coding and Use of 7th Character

Aftercare Z codes are not used for aftercare for injuries

Combination codes for poisonings and external cause (accidental, intentional self-harm, assault, undetermined)

Chapter 15 – represents fetus in multiple gestation affected by condition being coded

GUIDELINE

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

GUIDELINE

- **Conditions that are an integral part of a disease process**
- Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification

GUIDELINE

- **Conditions that are not an integral part of a disease process**
- Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

GUIDELINE

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

GUIDELINE

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

GUIDELINE

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

GUIDELINE

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

GUIDELINE

- **Combination Code**
- A combination code is a single code used to classify: Two diagnoses, or A diagnosis with an associated secondary process (manifestation)
- A diagnosis with an associated complication

GUIDELINE

- **Sequela (Late Effects)**
- A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a sequela code can be used. The residual may be apparent early, such as in cerebral infarction or it may occur months or years later, such as that due to a previous injury.
- Coding of sequela generally requires two codes sequenced in the following order: The condition or nature of the
- Sequela is sequenced first. The sequela code is sequenced second.

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GUIDELINE

- **Laterality**
- Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign
- Separate codes for both the left and right side.
- If the side is not identified in the medical
- record, assign the code for the unspecified side.

GUIDELINE

Documentation for BMI Non-pressure ulcers and Pressure Ulcer Stages

For the Body Mass Index (BMI), depth of non-pressure chronic ulcers and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI and nurses often documents the Pressure ulcer stages). However, the associated diagnosis (such as overweight, obesity, or pressure ulcer) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.

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GUIDELINES CONTINUED ON BMI

- The BMI codes should only be reported as secondary diagnoses. As with all other secondary diagnosis codes, the BMI codes should only be assigned when they meet the definition of a reportable additional diagnosis

GUIDELINE

- **Syndromes**
- Follow the Alphabetic Index guidance when coding syndromes. In the absence of Alphabetic Index guidance, assign codes for the documented manifestations of the syndrome.
- Additional codes for manifestations that are not an integral part of the disease process may also be assigned when the condition does not have a unique code.

GUIDELINE

- **Documentation of Complications of Care**
- Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication. Query the provider for clarification, if the complication is not clearly documented.

GUIDELINE

- **Use of Sign/Symptom/Unspecified Codes**
- Sign/symptom and "unspecified" codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are Supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter.Each healthcare encounter should be coded to the level of certainty known for that encounter.

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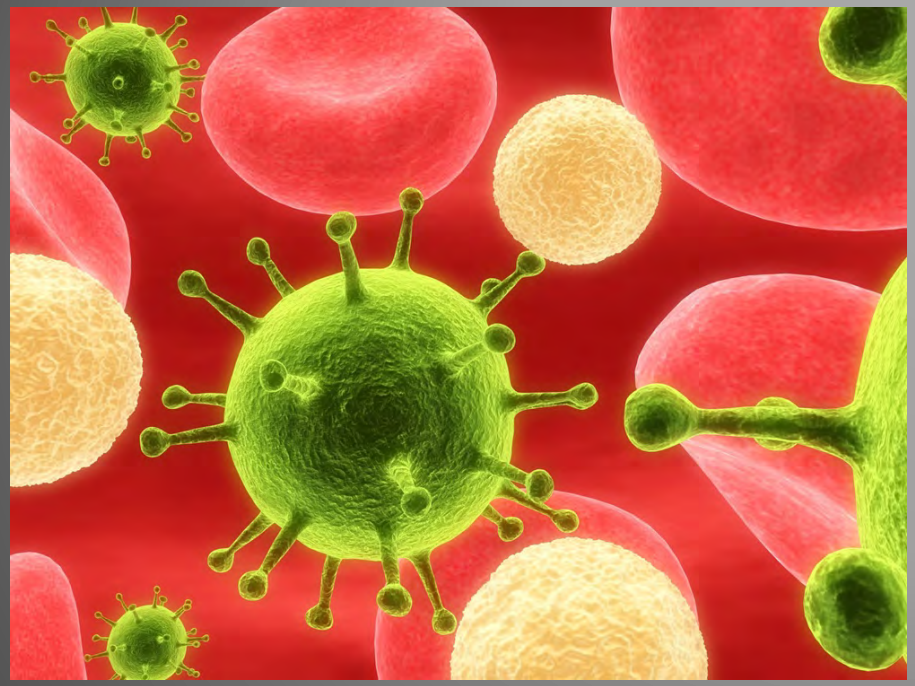


Certain Infectious and Parasitic Diseases

GUIDELINE

- **Code only confirmed cases**
- Code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline Section II, H.
- In this context, “confirmation” does not require documentation of positive serology or culture for HIV; the provider’s diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

GUIDELINE

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

GUIDELINE

- **Coding of Sepsis and Severe Sepsis**
- For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection.

GUIDELINE

- **Severe sepsis**
- The coding of severe sepsis requires a minimum of 2 codes: first a code for the underlying systemic infection, followed by a code from subcategory R65.2, Severe sepsis. If the causal organism is not documented, assign code A41.9, Sepsis, unspecified organism, for the infection. Additional code(s) for the associated acute organ dysfunction are also required.

GUIDELINE

- **Septic shock**
- Septic shock generally refers to circulatory failure associated with severe sepsis, and therefore, it represents a type of acute organ dysfunction.

GUIDELINE

- For cases of septic shock, the code for the systemic infection should be sequenced first, followed by code R65.21, Severe sepsis with septic shock or code T81.12, Postprocedural septic shock. Any additional codes for the other acute organ dysfunctions should also be assigned.
- As noted in the sequencing instructions in the Tabular List, the code for septic shock cannot be assigned as a principal diagnosis.

PARASITIC DISEASES

- Includes: diseases generally recognized as communicable or transmissible
- Use additional code to identify resistance to antimicrobial drugs (Z16)
- New section called infections with a predominantly sexual mode of transmission (A50-A64)

PARASITIC DISEASES

- When coding sepsis or AIDS, it is important to review the Coding Guidelines and the notes at the category level of ICD-10-CM

PARASITIC DISEASES

- Code first condition resulting from (sequela) the infectious or parasitic disease
- Bacterial and viral infectious agents (B95-B97) are provided for use as supplementary or additional codes to identify the infectious agent(s) in diseases classified elsewhere

Neoplasms

- ICD-10-CM

GUIDELINE

- To properly code a neoplasm it is necessary to determine from the record if the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior. If malignant, any secondary (metastatic) sites should also be determined.

GUIDELINE

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

GUIDELINE

- **Malignant neoplasm of ectopic tissue**
- Malignant neoplasms of ectopic tissue are to be coded to the site of origin mentioned, e.g., ectopic pancreatic malignant neoplasms involving the Stomach are coded to pancreas, unspecified

GUIDELINE

- The neoplasm table in the Alphabetic Index should be referenced first.
- However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate.

GUIDELINE

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

GUIDELINE

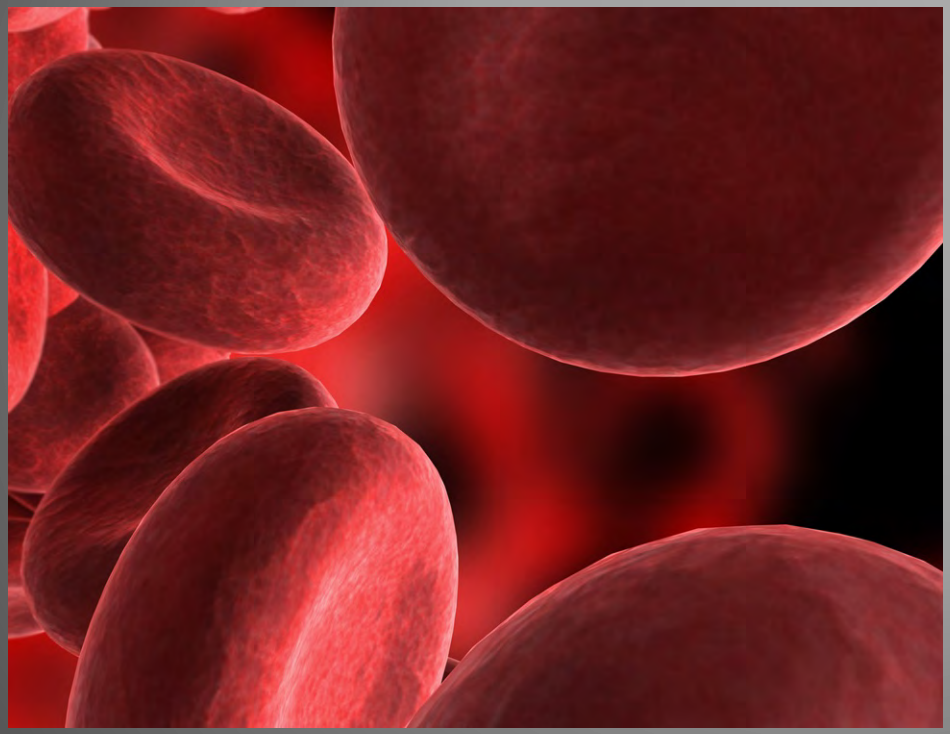
- **Encounter for treatment of secondary malignancy**
- When an encounter is for a primary malignancy with metastasis and treatment is directed toward the metastatic (secondary) site(s) only, the metastatic site(s) is designated as the principal/first-listed diagnosis. The primary malignancy is coded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

NEOPLASM

- The Neoplasm Table in the Alphabetic Index should be referenced first. However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate.

NEOPLASM

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



Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism

GUIDELINE

- There are no specific guidelines at this time.

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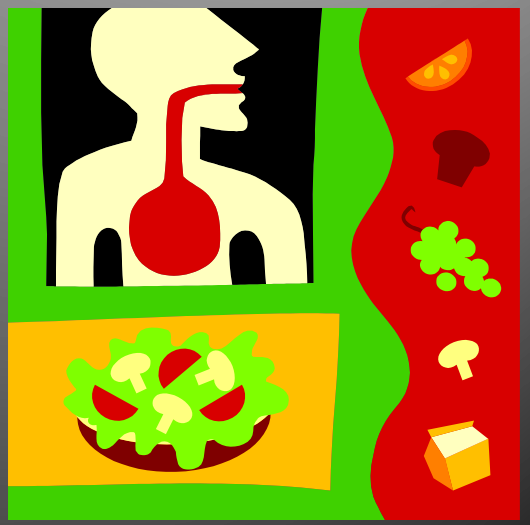
Endocrine, Nutritional and Metabolic Diseases

- ICD-10-CM



GUIDELINE

- **Diabetes mellitus**
- The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system. As many codes within a particular category as are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for a particular encounter.

GUIDELINE

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

DISEASES OF THE BLOOD

Diabetes mellitus

- Combination codes
- No longer classified as controlled or uncontrolled
- Inadequately, out of control or poorly controlled coded by type with hyperglycemia

Mental and Behavioral Disorders

- ICD-10-CM

GUIDELINE

- **Pain disorders related to psychological factors**
- Assign code F45.41, for pain that is exclusively related to psychological disorders. As indicated by the Excludes 1 note under category G89, a code from category G89 should not be assigned with code F45.41 Code F45.42, Pain disorders with related psychological factors, should be used with a code from category G89, Pain, not elsewhere classified, if there is documentation of a psychological component for a patient with acute or chronic pain.

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MENTAL AND BEHAVIORAL HEALTH

- Unique codes for alcohol and drug use, abuse, and dependence
- Continuous or episodic no longer classified
- History of drug or alcohol dependence coded as “in remission”
- Combination codes
- Blood alcohol level (Y90.-)

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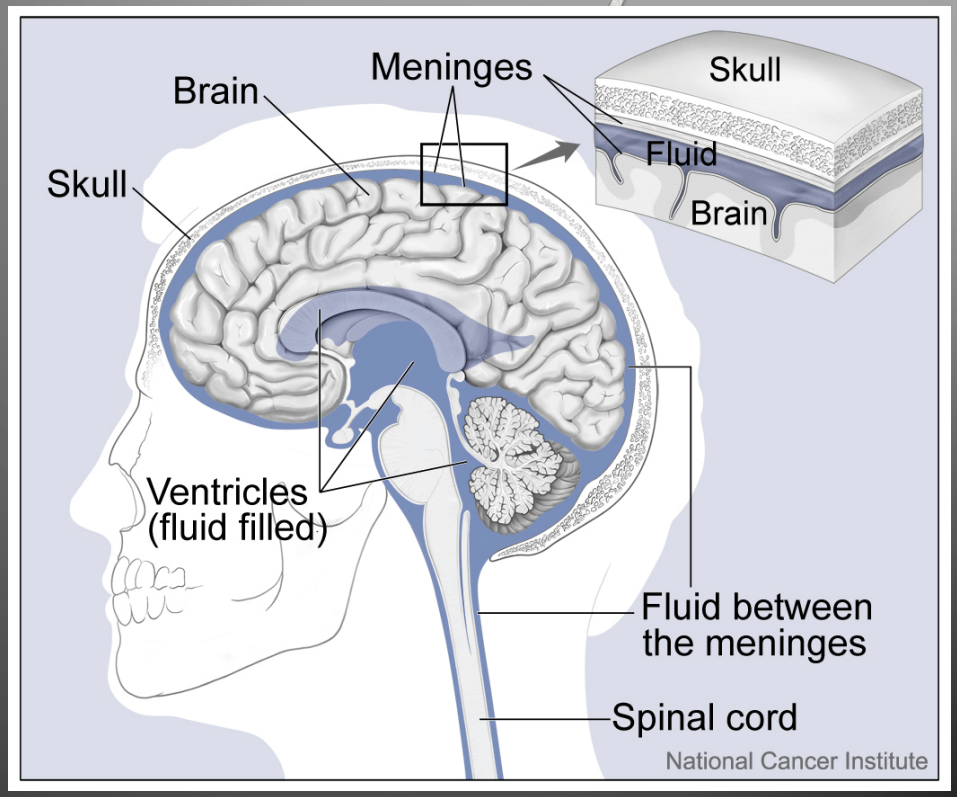
Coding Note:
The ICD-10-CM classification system does not provide separate "history" codes for alcohol and drug abuse. These conditions are identified as "in remission" in ICD-10-CM.

Diseases of the Nervous System

ICD-10-CM

Alan Hoofring



GUIDELINE

- Should the affected side be documented, but not specified as dominant or nondominant, and the ICD-10-CM Official Guidelines for Coding and Reporting classification system does not indicate a default, code selection is as follows:
- For ambidextrous patients, the default should be dominant.

  If the left side is affected, the default is non-dominant.
- If the right side is affected, the default is dominant.

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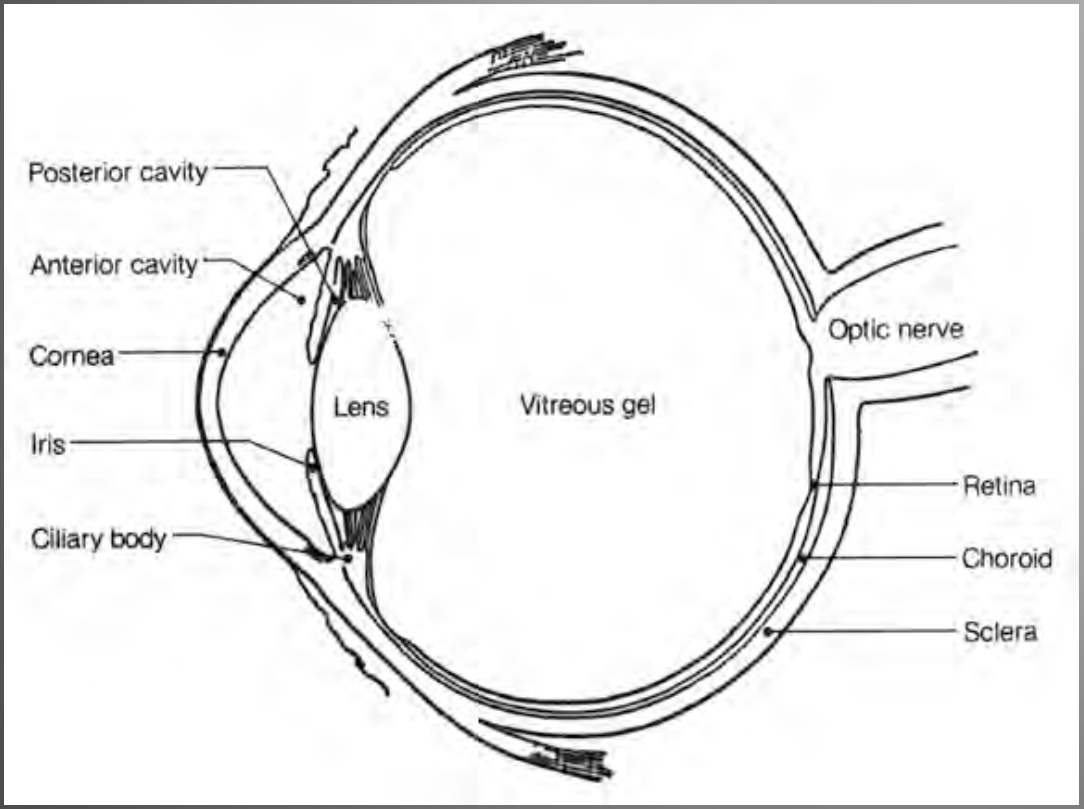
GUIDELINE

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

DISEASES OF THE NERVOUS SYSTEM

- Epilepsy terminology updated
  - Localization-related idiopathic
  - Generalized idiopathic
  - Special epileptic syndromes
- Provides specificity for
  - Seizures of localized onset
  - Complex partial seizures
  - Intractable
  - Status epilepticus



Diseases of the Eye and adnexa

GUIDELINE

- **Assigning Glaucoma Codes**
- Assign as many codes from category H40, Glaucoma, as needed to identify the type of glaucoma, the affected eye, and the glaucoma stage.

GUIDELINE

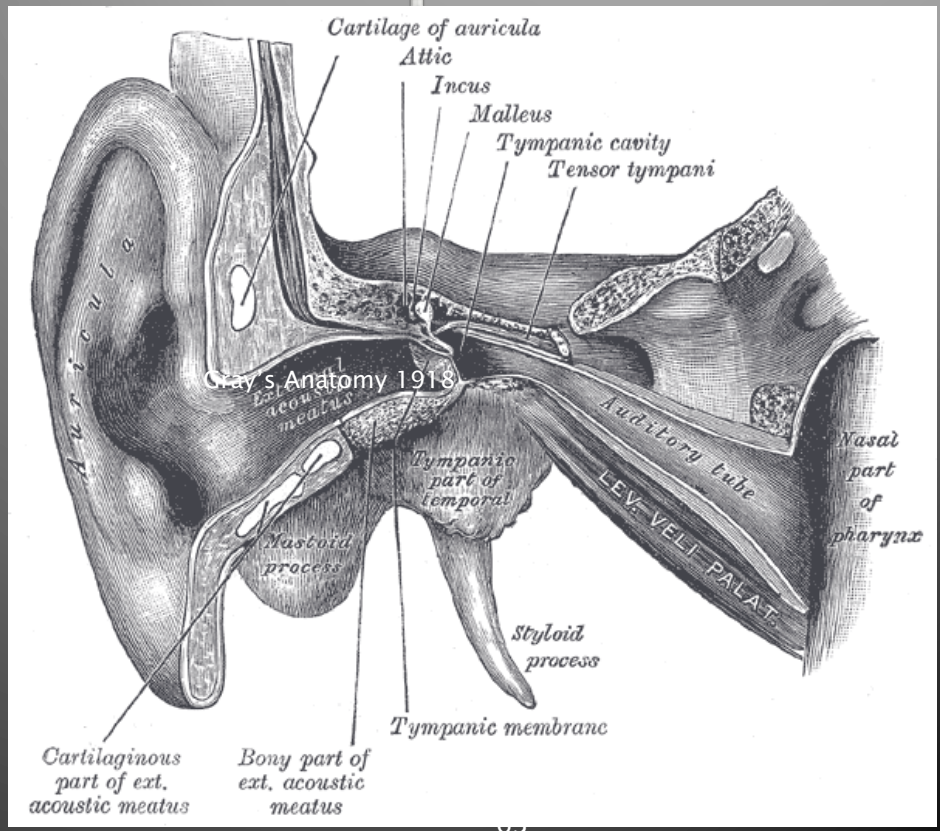
- **Bilateral glaucoma stage with different types or stages**
- When a patient has bilateral glaucoma and each eye is documented as having a different type or stage, and the classification distinguishes laterality, assign the appropriate code for each eye rather than the code for bilateral glaucoma.

DISEASES OF THE ADNEXA AND EYE

- Concept of laterality
  - Right
  - Left
  - Bilateral
  - Unspecified

- Age-related instead of senile cataract

Diseases of the ear and mastoid process



Gray's Anatomy 1918

GUIDELINE

- There are no specific guidelines listed at this time.

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Note: Chapter note states to external cause code following the code for ear condition, if applicable to identify the cause of the ear condition.

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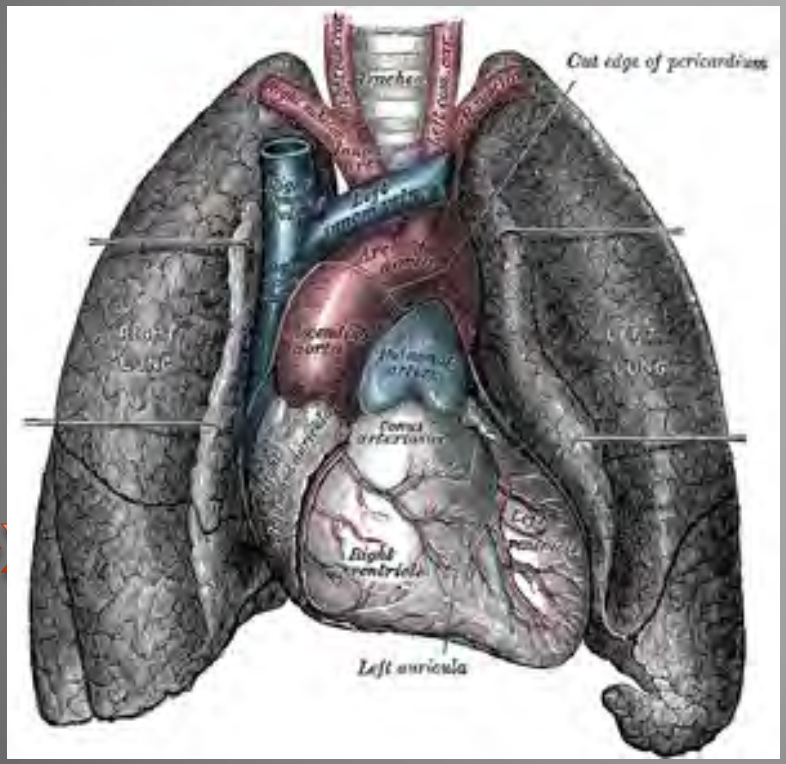
DISEASES OF THE EAR

- Otitis media
- Use additional code for any associated perforated tympanic membrane (H72.–)
- Use additional code to identify
  - Exposure to environmental tobacco smoke (Z77.22)
  - Exposure to tobacco smoke in the perinatal period (P96.81)
  - History of tobacco use (Z87.891)
  - Occupational exposure to environmental tobacco smoke (Z57.31)
  - Tobacco dependence (F17.–)
  - Tobacco use (Z72.0)



Gray's Anatomy 1918

Diseases of the Circulatory System

GUIDELINE

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

GUIDELINE

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

GUIDELINE

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

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GUIDELINE

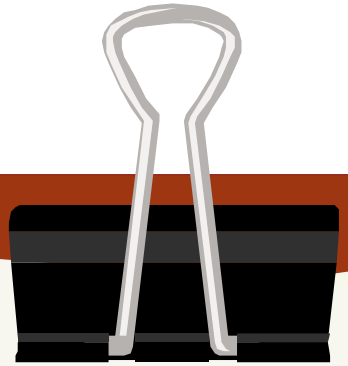
- For encounters occurring while the myocardial infarction is equal to, or less than, four weeks old, including transfers to another acute setting or a postacute setting, and the patient requires continued care for the myocardial infarction, codes from category I21 may continue to be reported. For encounters after the 4 week time frame and the patient is still receiving care related to the myocardial infarction, the appropriate aftercare code should be assigned, rather than a code from category I21.
- For old or healed myocardial infarctions not requiring further care, code I25.2, Old myocardial infarction, may be assigned.

DISEASES OF THE CIRCULATORY SYSTEM

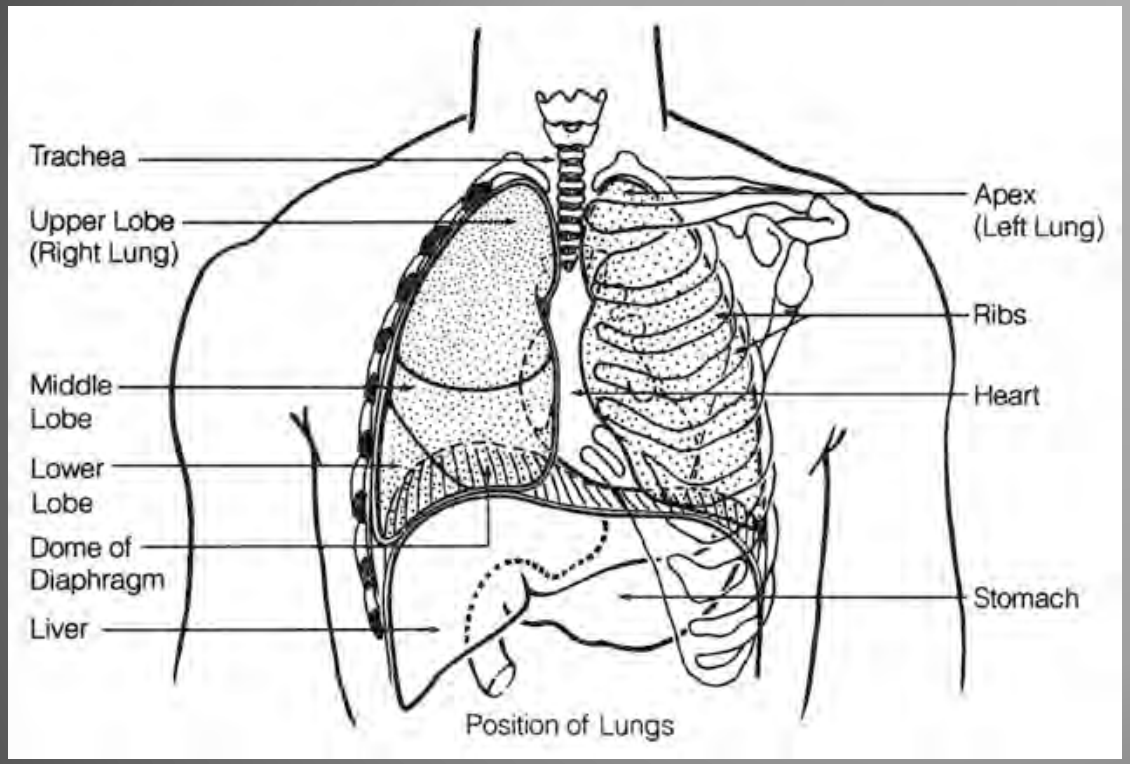
- Type of hypertension not used as an axis
- Acute MI codes changed from 8 weeks to 4 weeks or less

DISEASES OF THE CIRCULATORY SYSTEM

- I21 Initial AMIs
- I22 Subsequent AMIs



Coding Note: A code from category I23 must be used in conjunction with a code from category I22. The I23 code should be sequenced first, if it is the reason for encounter, or, it should be sequenced after the I21 or I22 code if the complication of the MI occurs during the encounter for the MI.



Diseases of the Respiratory System

National Cancer Institute

GUIDELINE

- **Chronic Obstructive Pulmonary Disease [COPD] and Asthma**
- Acute exacerbation of chronic obstructive bronchitis and asthma
- The codes in categories J44 and J45 distinguish between uncomplicated cases and those in acute exacerbation. An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.

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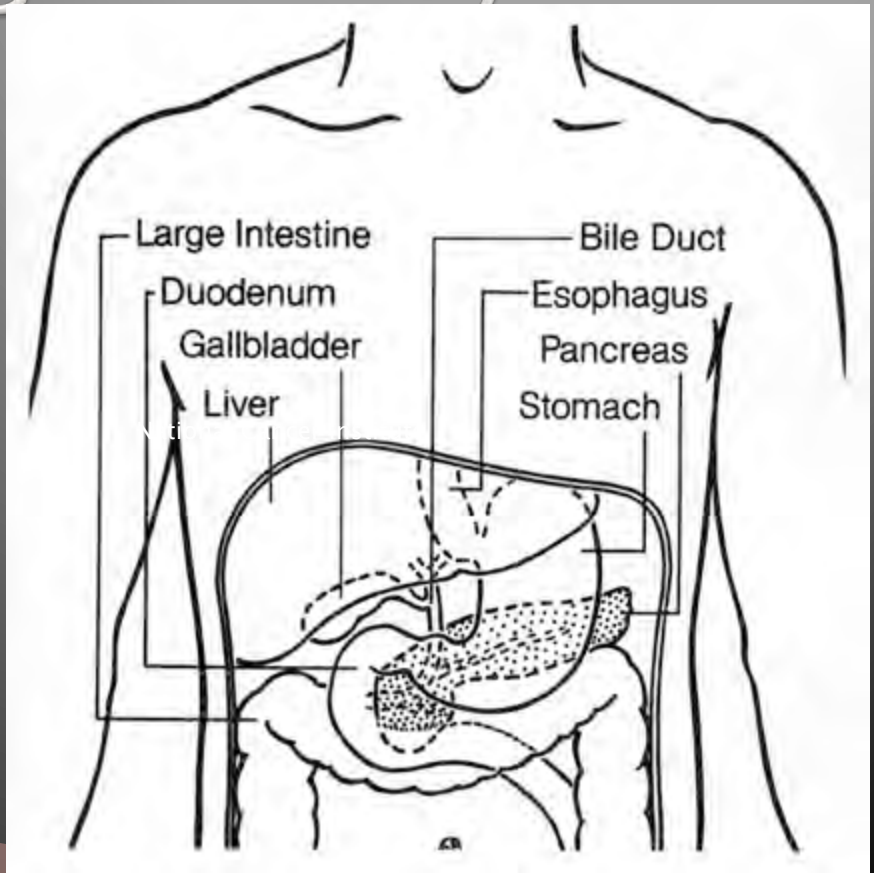
GUIDELINE

- **Influenza due to certain identified influenza viruses**
- Code only confirmed cases of influenza
- due to certain identified influenza viruses (category J09), and due to other identified influenza virus (category J10).

DISEASES OF THE RESPIRATORY SYSTEM

- **Asthma Severity**
- **Frequency of Daytime Symptoms**
- Intermittent
- Less than or equal to 2 times per week
- Mild Persistent
- More than 2 times per week
- Moderate Persistent
- Daily. May restrict physical activity
- Severe Persistent
- Throughout the day. Frequent severe attacks limiting ability to breathe.

Diseases of the Digestive System



GUIDELINE

- There are no specific guidelines at this time.

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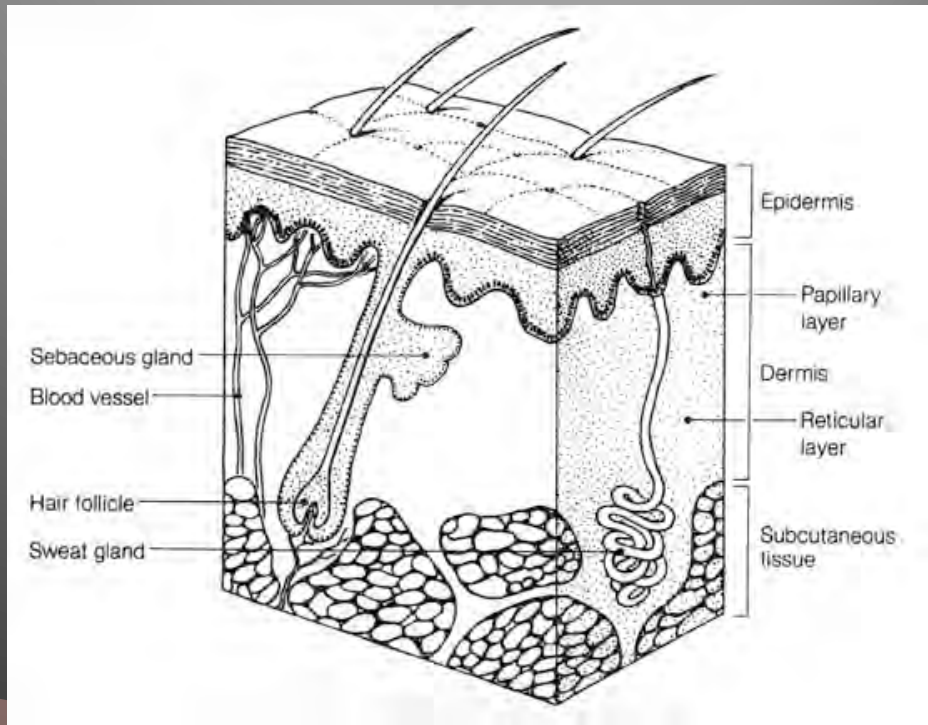
Diseases of the Skin and Subcutaneous Tissue

- ICD-10-CM



GUIDELINE

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

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GUIDELINE

- **Documented pressure ulcer stage**
- Assignment of the pressure ulcer stage code should be guided by clinical documentation of the stage

GUIDELINE

- **Patients admitted with pressure ulcers documented as healed**
- No code is assigned if the documentation states that the pressure ulcer is completely healed.

GUIDELINE

- **Patients admitted with pressure ulcers documented as healing**
- Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation
  does not provide information about the stage of the healing pressure ulcer, assign the appropriate code for unspecified stage.
- If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider.

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DISEASES OF THE SKIN

- Pressure ulcers
  - Site, laterality, and severity specified in single code
  - Severity identified as stage 1–4
- Non-pressure chronic ulcers
  - Site, laterality, and severity
  - Important note

- ICD-10-CM

Diseases of the Musculoskeletal System and Connective Tissue

GUIDELINE

- **Osteoporosis**
- Osteoporosis is a systemic condition, meaning that all bones of the musculoskeletal system are affected. Therefore, site is not a component of the codes under category M81, Osteoporosis without current pathological fracture. The site codes under category M80, Osteoporosis with current pathological fracture, identify the site of the fracture, not the osteoporosis.

Pathological or Stress Fracture Seventh Characters

A	• Initial encounter
D	• Subsequent – routine healing
G	• Subsequent – delayed healing
K	• Subsequent – nonunion
P	• Subsequent – malunion
S	• Sequela

DISEASES OF THE MUSKULOSKELETAL SYSTEM

- **Spontaneous rupture**
  - Occurs when normal force
    is applied to tissues that are inferred to have less than
    normal strength
- **Fragility fracture**
  - Sustained with trauma no more than a fall from a standing
    height or less occurring under circumstances that would not cause a fracture in a normal healthy bone

Coding **Note:**ICD-10-CM has three different categories for pathologic fractures – due to neoplastic disease, due to osteoporosis, and due to other specified disease.

The interpretation of Coding Guideline I.C.13.d.2 must be made by the physician. It is not appropriate for the coder to interpret if the patient had a minor fall or trauma that would not usually break a normal, healthy bone. The physician provides a connection between the fall and fracture due to osteoporosis.

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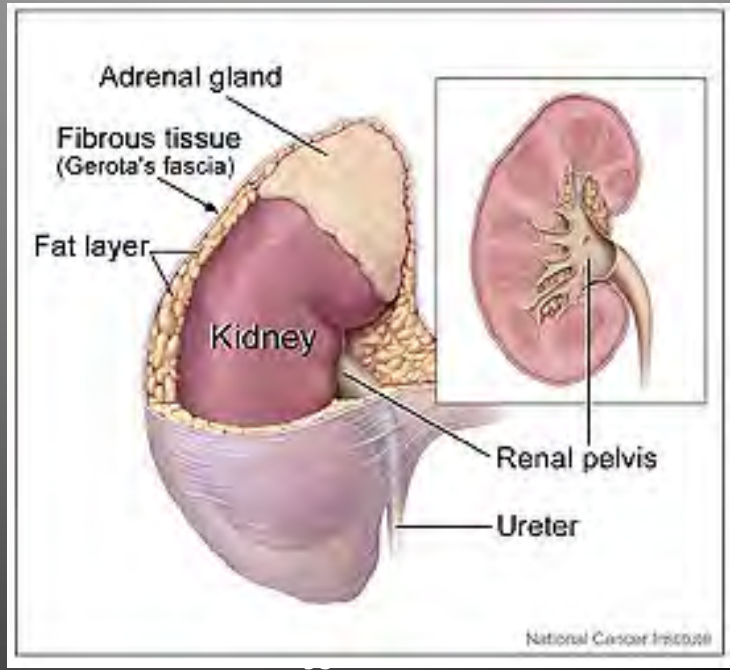
Diseases of the Genitourinary System

- ICD-10-CM



GUIDELINE

- **Chronic kidney disease**
- Stages of chronic kidney disease (CKD)
- The ICD-10-CM classifies CKD based on severity. The severity of CKD is designated by staGes 1-5. Stage 2, code N18.2, equates to mild CKD; stage 3, code N18.3, equates to moderate CKD; and stage 4, code N18.4, equates to severe CKD. Code N18.6, End stage renal disease (ESRD), is assigned when the provider has documented end -stage- renal disease (ESRD).

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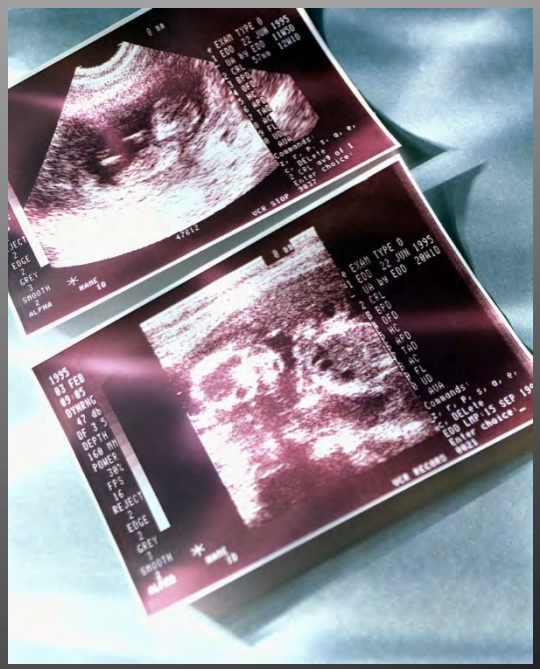
Additional Codes Required

N17	• Code also underlying condition
N18	• Code first etiology
N30	• Additional code infectious agent
N31	• Additional code urinary incontinence
N33	• Code first underlying disease
N40.1	• Additional code for associated symptoms

Pregnancy, Childbirth and the Puerperium

- ICD-10-CM



GUIDELINE

- **General Rules for Obstetric Cases**
- Codes from chapter 15and sequencing priority Obstetric cases require codes from chapter 15, codes in the range O00-O9A, Pregnancy, Childbirth, and the Puerperium. Chapter 15 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 15 codes to further specify conditions. Should the provider document that the pregnancy is incidental to the encounter, then code Z33.1, Pregnant state, Incidental, should be used in place of any chapter 15 codes. It is the provider's responsibility to state that the condition being treated is not affecting the pregnancy.

GUIDELINE

- Chapter 15 codes used only on the maternal record
- Chapter 15 codes are to be used only on the maternal record, never on the record of the newborn.

GUIDELINE

- Assignment of the final character for trimester should be based on the provider's documentation of the Trimester (or number of weeks) for the current admission or encounter. This applies to the assignment of trimester for pre-existing conditions as well as those that develop during or are due to the pregnancy.
- The provider's documentation of the number of weeks may be used to assign the appropriate code identifying the trimester

Trimesters	
1st	Less than 14 weeks 0 days
2nd	14 weeks 0 days to less than 28 weeks 0 days
3rd	28 weeks 0 days until delivery

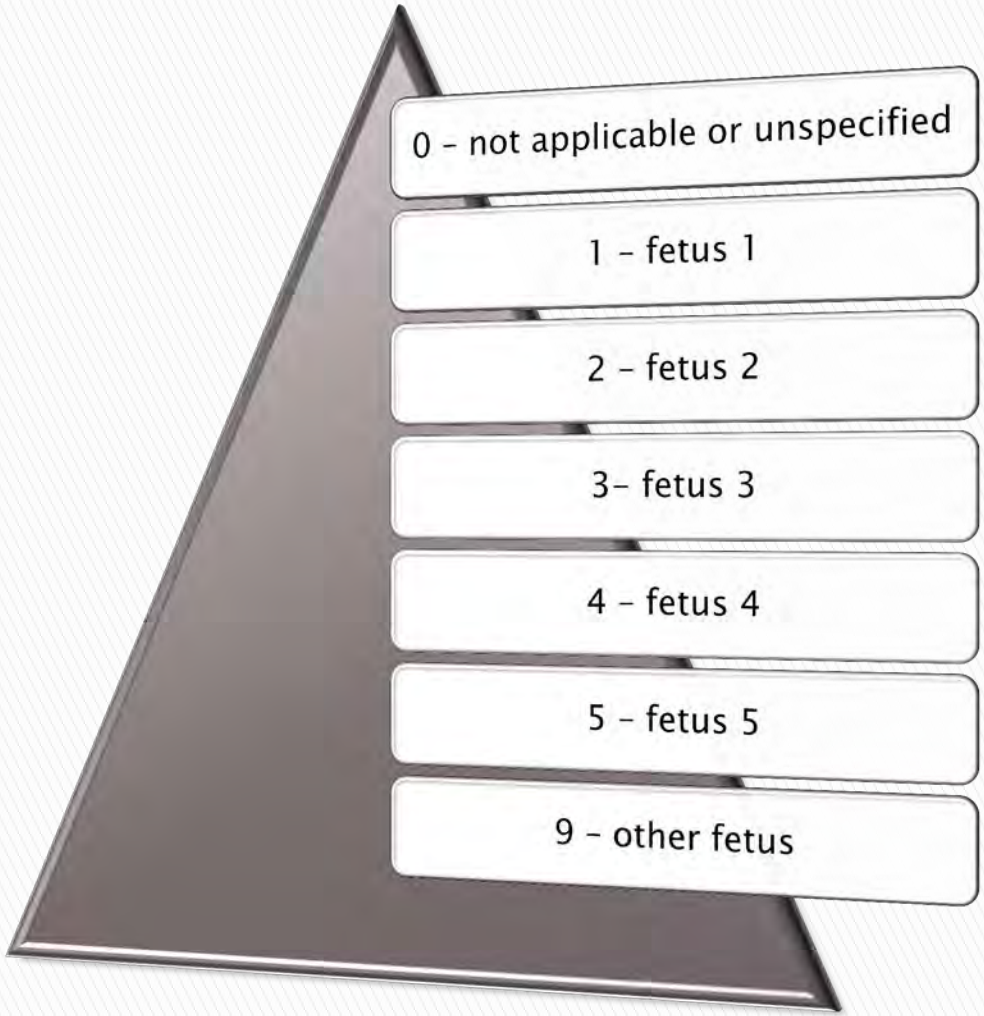
- Trimester axis of classification rather than episode of care
  - Not all conditions include codes for all three trimesters or is N/A
  - Counted from first day of last menstrual period

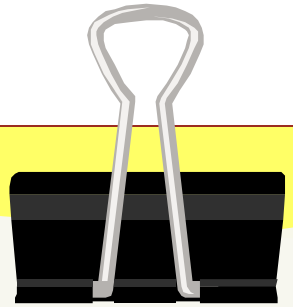
PREGNANCY, CHILDBIRTH AND THE PUERPERIUM

- Codes from this chapter are for use only on maternal records, never on newborn records
- Codes from this chapter are for use for conditions related to or aggravated by the pregnancy, childbirth, or by the puerperium (maternal causes or obstetric causes)
- Category Z3A – Weeks of Gestation, added to identify specific week of pregnancy

PREGNANCY

- **Abortion vs. fetal death**
  - 20 weeks instead of 22
- **Early vs. late vomiting**
  - 20 weeks instead of 22
- **Preterm labor**
  - 37 completed weeks of gestation


0 – not applicable or unspecified
1 – fetus 1
2 – fetus 2
3– fetus 3
4 – fetus 4
5 – fetus 5
9 – other fetus



Coding Note: ICD-10-CM provides a combination code for obstructed labor incorporating the obstructed labor with the reason for the obstruction into one code.

1st

- Less than 14 weeks 0 days

2nd

- 14 weeks 0 days to less than 28 weeks 0 days

3rd

- 28 weeks 0 days until delivery

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Certain conditions originating in the perinatal period

GUIDELINE

- **Chapter 16: Certain Conditions Originating in the Perinatal Period (P00-P96)**
- For coding and reporting purposes the perinatal period is defined as before birth through the 28th day following birth. The following guidelines are provided for reporting purposes

GUIDELINE

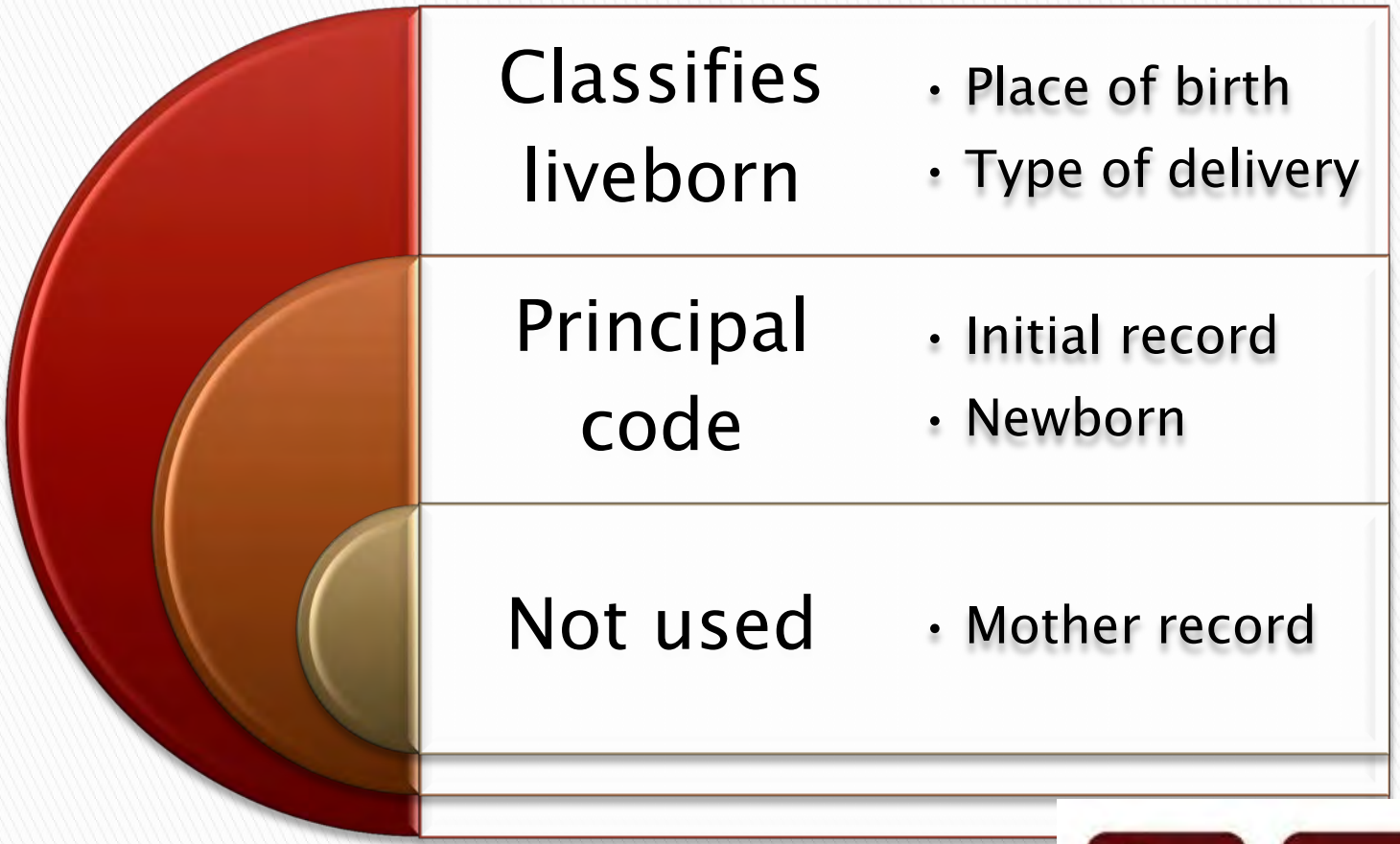
- **Principal Diagnosis for Birth Record**
- When coding the birth episode in a newborn record, assign a code from category Z38, Liveborn infants according to place of birth and type of delivery, as the principal diagnosis. A code from category Z38 is assigned only once, to a newborn at the time of birth.
- If a newborn is transferred to another institution, a code from category Z38 should not be used at the receiving hospital.
- A code from category Z38 is used only on the newborn record, not on the mother's record.

CONDITIONS IN PERINATAL PERIOD

- Codes from this chapter are for use on newborn records only, never on maternal records and include conditions that have their origin in the fetal or perinatal period (before birth through the first 28 days after birth) even if morbidity occurs later.

CONDITIONS IN PERINATAL PERIOD

- When both birth weight and gestational age of the newborn are available, both should be coded with birth weight sequenced before gestational age.



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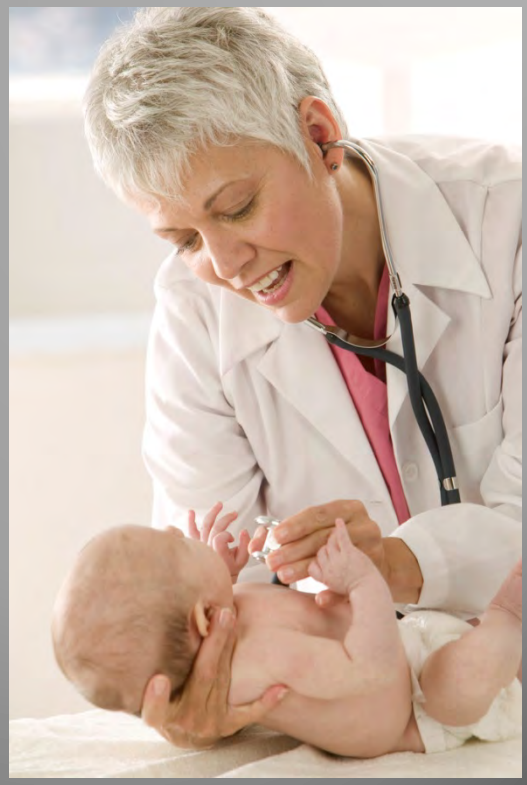
- ICD-10-CM



Congenital Malformations, deformations and chromosomal abnormalities

GUIDELINE

- **Congenital malformations, deformations, and chromosomal abnormalities (Q00-Q99)**
- Assign an appropriate code(s) from categories Q00-Q99, Congenital malformations, deformations, and chromosomal abnormalities when a malformation, deformation or chromosomal abnormality is documented. A malformation/deformation/or chromosomal abnormality may be the principal/first-listed diagnosis on a record or a secondary diagnosis.

GUIDELINE

- When a malformation/deformation/or chromosomal abnormality does not have a unique code assignment, assign additional code(s) for any manifestations that may be present.

CONGENITAL MALFORMATIONS, ETC

- When no unique code is available, assign additional code(s) for any manifestations
- When the code assignment specifically identifies the malformation, deformation, or chromosomal abnormality, manifestations that are an inherent component of the anomaly should not be coded separately
- Additional codes should be assigned for manifestations that are not an inherent component

CONGENITAL MALFORMATIONS, ETC

- If congenital malformation has been corrected, a personal history code used
- Although present at birth, abnormality may not be identified until later in life, and if diagnosed by physician, assign a code from codes Q00-Q99
- For birth admission, the appropriate code from category Z38, Liveborn infants, according to place of birth and type of delivery, should be sequenced as the principal diagnosis, followed by any congenital anomaly codes, Q00-Q89.

Symptoms, Signs and Abnormal Clinical and Laboratory Findings

GUIDELINE

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

GUIDELINE

- **Use of a symptom code with a definitive diagnosis code**
- Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes. The definitive diagnosis code should be sequenced before the symptom code.

GUIDELINE

- **Combination codes that include symptoms**
- ICD-10-CM contains a number of combination codes that identify both the definitive diagnosis and common symptoms of that diagnosis.
- When using one of these combination codes, an additional code should not be assigned for the symptom.

a
- No more specific diagnosis can be made even after all facts have been investigated

b
- Signs or symptoms existing at time of initial encounter – transient and causes not determined

c
- Provisional diagnosis in patient failing to return

d
- Referred elsewhere before diagnosis made

e
- More precise diagnosis not available

f
- Certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right

Used with traumatic brain injury or sequelae of cerebro-vascular disease codes

Coma Scale

- Primarily for use by trauma registries and research use, but may be used in any setting
- Sequenced after the diagnosis code(s)
- One from each subcategory (R40.21, R40.22, R40.23) needed
- Seventh character indicates when recorded – should match

0	Unspecified time
1	In field (EMT or ambulance)
2	At arrival to ER
3	At hospital admission
4	24 hours after admission

SYMPTOMS, SIGNS AND ABNORMALITIES

- Codes identify SIRS of non-infectious origin with and without acute organ dysfunction and severe sepsis with and without septic shock.
- Instructional note indicates underlying condition or infection should be coded first.
- Sepsis not classified to R65-coded to infection. e.g., A41.9 assigned for sepsis, unspecified.

Injury, Poisoning, and Certain Other Consequences of External Causes

GUIDELINE

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

GUIDELINE

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

GUIDELINES

- **If the same code would describe the causative agent**
- If the same code would describe the causative agent for more than one adverse reaction, poisoning, toxic effect or underdosing, assign the code only once.
- If two or more drugs, medicinal or biological substances are reported, code each individually unless a combination code is listed in the Table of Drugs and Chemicals.

GUIDELINE

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

GUIDELINE

- **Examples of poisoning include:**
- (i) Error was made in drug prescription Errors made in drug prescription or in the administration of the drug by provider, nurse, patient, or other person.
- (ii) Overdose of a drug intentionally taken If an overdose of a drug was intentionally taken or administered and resulted in drug toxicity, it would be coded as a poisoning.
- (iii) Nonprescribed drug taken with correctly prescribed and properly administered drug If a nonprescribed drug or medicinal agent was taken in combination with a correctly prescribed and properly administered drug, any drug toxicity or other reaction resulting from the interaction of the two drugs would be classified as a poisoning.
- (iv) Interaction of drug(s) and alcohol when a reaction results from the interaction of a drug(s) and alcohol, this would be classified as poisoning.

GUIDELINE

- Toxic Effects
- When a harmful substance is ingested or comes in contact with a person, this is classified as a toxic effect.
- The toxic effect codes are in categories T51-T65.
- Toxic effect codes have an associated intent:accidental, intentional self-harm, assault and undetermined.

Injuries grouped by body part rather than category of injury

- Encompasses 2 alpha characters
  - S
    - Injuries related to body region
  - T
    - Injuries to unspecified region
    - Poisonings, external causes
- Note: Use secondary code(s) from Chapter 20 to indicate cause of injury
- Codes within T section that include the external cause do not require an additional external cause code

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- Greater specificity
  - Type of fracture
  - Specific anatomical site
  - Displaced vs nondisplaced
  - Laterality
  - Routine vs delayed healing
  - Nonunion
  - Malunion
  - Type of encounter
    - Initial
    - Subsequent
    - Sequela

Fracture 7th character

- A – Initial closed
- B – Initial open
- D – Subsequent routine
- G – Subsequent delayed
- K – Subsequent nonunion
- P – Subsequent malunion
- S – Sequela

FRACTURES

- Some fracture categories provide for seventh characters to designate the specific type of open fracture based on the Gustilo open fracture classification
- A fracture not indicated as displaced or nondisplaced should be coded to displaced
- A fracture not designated as open or closed should be coded to closed

FRACTURES

- Initial encounter
  - The patient is receiving active treatment for the condition
    - Surgical treatment
    - Emergency department encounter
    - Evaluation and treatment by a new physician

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FRACTURES

- Subsequent encounter
  - After patient received active treatment for the condition and receiving routine care during healing or recovery phase
    - Cast change or removal
    - Removal of external or internal fixation device
    - Medication adjustment
    - Other aftercare and follow-up visits following injury treatment

SEQUELA

- Complications or conditions that arise as a direct result of a condition
  - Scar formation after burn
- Use both the injury code that precipitated sequela and code for sequela
- S added only to injury code, not sequela code
- S identifies injury responsible for sequela
- Specific type of sequela (like scar) sequenced first, followed by injury code

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Poisoning, Adverse Effect, Underdose

Poisoning	Overdose of substances Wrong substance given or taken in error
Adverse effect	"Hypersensitivity," "reaction," or correct substance properly administered
Underdosing	Taking less of medication than is prescribed or instructed by manufacturer either inadvertently or deliberately

POISONING

- Use additional code(s) for manifestations of poisoning
- Assign code for the nature of the adverse effect followed by code for the drug
- Use additional code for intent of underdosing:
  - Failure in dosage during medical and surgical care (Y63.61, Y63.8–Y63.9)
  - Patient's underdosing of medication regime (Z91.12–, Z91.13–)

POISONING

- Combination codes for poisonings/ external cause (accidental, intentional self-harm, assault, undetermined)
- Table of Drugs and Chemicals groups all poisoning columns together
  - Followed by adverse effect and underdosing
- When no intent of poisoning is indicated, code to accidental
  - Undetermined intent is only for use when there is specific documentation in record that intent cannot be determined

Coding Note: ICD-10-CM categories S52, Fracture of forearm; S72, Fracture of femur; and S82, Fracture of lower leg, including ankle, have additional seventh characters (B, C, E, F, H, J, M, N, Q, R) to identify open fractures with the Gustilo classification.

Gustilo Classification

I	• Low energy, Wound less than 1 cm
II	• Greater than 1 cm with moderate soft tissue damage
III	• High energy wound greater than 1 cm with extensive soft tissue damage
IIIA	• Adequate soft tissue cover
IIIB	• Inadequate soft tissue cover
IIIC	• Associated with arterial injury

External causes of morbidity

- ICD-10-CM

GUIDELINE

- The external causes of morbidity codes should never be sequenced as the first-listed or principal diagnosis.
- External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred the activity of the patient at the time of the event, and the person's status (e.g., civilian, military).

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GUIDELINE

- There is no national requirement for mandatory ICD -10-CM external cause code reporting.
- Unless a provider is subject to a state -based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required.
- In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

GUIDELINE

- **Multiple External Cause Coding Guidelines**
- More than one external cause code is required to fully describe the external cause of an illness or injury. The assignment of external cause codes should be sequenced in the following priority: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:

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GUIDELINE

- External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, child and adult abuse and terrorism.
- Activity and external cause status codes are assigned following all causal (intent) external cause codes.
- The first-listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm, following the order of hierarchy listed above.

GUIDELINE

- External codes for child and adult abuse take priority over all other external cause codes.
- See Section I.C.19., Child and Adult abuse guidelines.
- External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
- External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse and terrorism.

GUIDELINE

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

Transport Accidents

- A transport accident is one in which vehicle must be moving or running or in use for transport purposes at the time of the accident
- Definitions of transport vehicles provided in classification

Transport Note

Use additional code to identify
Airbag injury (W22.1)
Type of street or road (Y92.4-)
Use of cellular telephone at time of transport accident (Y93.C-)

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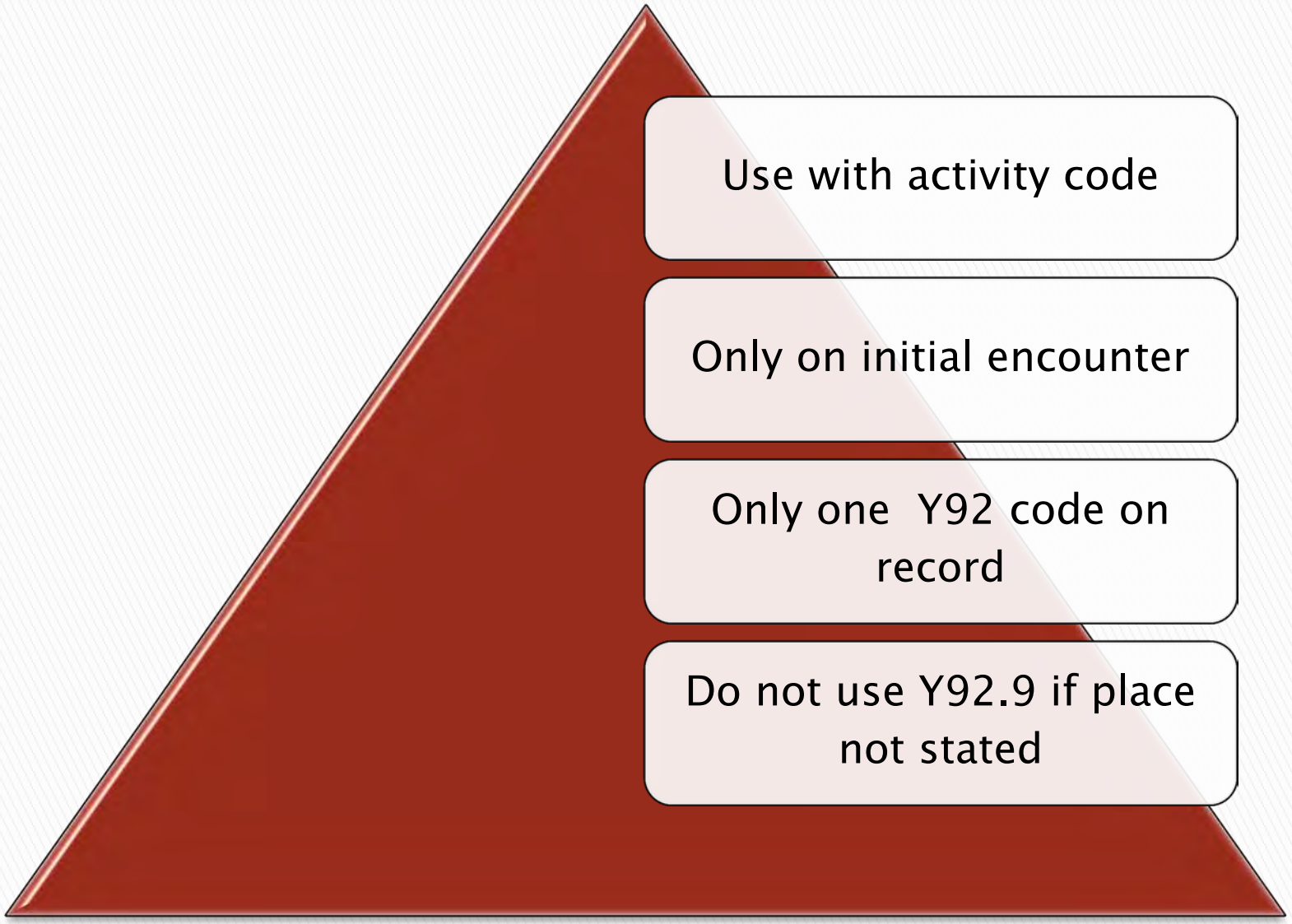
Use with activity code
Only on initial encounter
Only one Y92 code on record
Do not use Y92.9 if place not stated

Category Y99

- Assign with other external cause codes, such as transport accidents and falls
- Are not applicable to poisonings, adverse effects, misadventures, or late effects
- Do not assign a code from category Y99 if no other external cause codes (cause, activity) are applicable for the encounter
- Do not assign code Y99.9, Unspecified external cause status, if status is not stated

Factors Influencing Health Status and contact with health services

- ICD-10-CM

GUIDELINE

- Use of Z codes in any healthcare setting Z codes are for use in any healthcare setting. Z codes may be used as either a first-listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter.
- Certain Z codes may only be used as first-listed or principal diagnosis.

GUIDELINE

- **ICD-10-CM Official Guidelines for Coding and Reporting**
- Z Codes indicate a reason for an encounter
- Z codes are not procedure codes. A corresponding procedure code must accompany a Z code to describe any procedure performed.

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