ICD-10 and Emergency Care

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- ✓ This guide does not contain ANY legal advice.
- ✓ This guide shows what specific codes will change to when ICD-9-CM becomes ICD-10-CM.
- ✓ This guide does NOT discuss ICD-10-PCS.
- ✓ This guide does NOT replace ICD-10-CM coding manuals.
- ✓ This guide simply shows a practice what ICD-10-CM will look like within their specialty. The intent is to show that ICD-10 is not scary and it is not complicated.
- ✓ This guide is NOT the final answer to coding issues experienced in a medical practice.
- ✓ This guide does NOT replace proper coding training required by a medical coder and a medical practice. Images or graphics were obtained from free public domain internet websites and may hold copyright privileges by the owner.

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If the name of the original author, Steve Verno, has been replaced, it is possible that you have a thief on your hands.

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

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

There is a new rumor that ICD-10 will be bypassed with ICD-11. The problem with this new rumor is that there is nothing, in writing, about this rumor. The fact that ICD-10 will be effective as of October 1, 2014 is published by the Centers for Medicare and Medicaid Services and the World Health Organization. Anytime someone tells you something, GET IT IN WRITING! Rumors can ruin a practice and can cost a practice a lot of money because you trust the person who told you the rumor and you want to believe it, so you or you have your staff search the Internet for anything that provides provenance to the rumor. That is a huge waste of time and money and the person doing the searching may never find an answer.

In coding, there is a rule, "If it isn't documented, it doesn't exist". If an employee or a doctor told you something, make sure that they provide you with documentation to back it up. I am a speaker at conferences. Anything I present has laws, rules, or policies provided to show that what I'm saying is true, accurate, and correct. If someone says something, and you ask to see their proof, in writing, and they don't have it, case closed. You stop the rumor immediately and you save time and money in wasteful time researching.

Almost every day I see, "I need to find an answer to an office bet" and then the question comes up. "We have one employee that says… and another employee says… Who is right and please provide me with any and all references to back up your response, and, please, no jokes or funny responses please be serious." These questions are being discouraged and not answered.

In this guidebook, I reference guidelines and the official website where you can download it, for free. I personally attended a conference where I heard a speaker say something that didn't sound right. I wasn't the only one because many hands went up. The speaker had many respected certifications, yet failed to provide any proof to their

statement. When I asked the speaker for their documentation, he smiled and said "I'll send it to you." He walked away; never asking me for my address so that he could provide me with his answers and references. His walking away told me that he wasn't going to send it. It's been at least 10 years and nothing has come forth from this speaker. All this did was lower my respect for this person and I now question everything this person provides. I refuse to attend any conference where he still speaks.

Some people will spend hours on the internet trying to find out if what someone said is true. Coding and Billing are open to many rumors. For years, people have said, "I heard that ICD-9 is being replaced by ICD-10 this year, can someone tell me if this is true?" Or someone would say, "This year, ICD-10 replaces ICD-9." The problem is that these rumors weren't true, but, someone, tried to look important by saying it was happening. Right now a rumor going around is that ICD-10 won't take effect, and ICD-10 will be bypassed and we will go straight to ICD-11. That rumor has nothing to prove it is true. Nothing has been published by CMS, published in the Federal Register, documented at the Centers for Disease Control or World Health Organization. ICD-10 will become effective on October 1, 2014, it is true. Proof of ICD-10 being effective on October 1, 2014, can be found here at the CMS website and Federal Register:

http://www.cms.gov/Medicare/Coding/ICD10/Index.html

https://www.federalregister.gov/articles/2012/09/05/2012-21238/administrative-simplification-adoption-of-a-standard-for-a-unique-health-plan-identifier-addition-to

http://www.gpo.gov/fdsys/pkg/FR-2012-09-05/pdf/2012-21238.pdf

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

One huge change with ICD-10-CM is that there will be more codes to select from. ICD-9 has about 14,000 codes. ICD-10 starts with 68,000 codes and can go higher. ICD-9 did not have a code for a cranialrectal blockage, so you couldn't code that diagnosis or

you had to select an unspecified code, but now you can have a code for a cranialrectal blockage (YOU do know that cranialrectal blockage is not a real disease or injury).

ICD-10 is going to change the way YOU do business. Why? It is 100% dependent on medical record documentation. ICD-9 was forgiving to a doctor who is lax on their documentation. Steve could visit Dr. Smith with pain in his right ear. All Dr. Smith had to document was that Steve has OM which is short for otitis media and the coder could select a code for simple OM.

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

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

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

H66.9 **Otitis media**, unspecified

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

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

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

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

As you can see, under ICD-9-CM, you have one code you can select if the documentation is not specific. The patient may have been a child with ear pain in both ears, but all the doctor wrote is "OM" and nothing more.

Under ICD-10-CM, you have a possibility of five (5) codes and you do need more anatomical information to select the best possible code. Using a pure unspecified code such as H66.9 could cause your claim to be pended or placed under review, which could cause a significant revenue loss for the practice. A favorite doctor that I've known for many years is an expert witness where he is called to determine if a malpractice lawsuit should proceed to court or if the malpractice insurance company should issue a check. In most cases, after looking at the medical record, he recommends writing a check. He provides instruction to medical interns and residents

and he tells them: "Document the visit as if you had to appear in court to defend your actions. " I usually add, "Document the visit as if your paycheck and career is on the line."

I spend a lot of my time returning medical records for additional information because the documentation is insufficient to code the visit with 100% truth, accuracy and correctness. I code to protect the doctor, the patient, and MY paycheck. I only code what is documented. I never code a visit just to get paid. There will be an unofficial rule with coding and that rule will be: If it isn't documented, we don't code it. We do NOT code something just to get it paid.

With 30 years of clinical medicine in my personal background, I can say I know what should have been done during the visit, but I can't code based on that. I've seen doctors tell me, "I did this procedure." I say show me where it says you did this. There is no documentation to prove that the doctor said they did what they say and the doctor loses.

I also NEVER code based on what I am told on the Internet. I don't know if what I'm told is 100% true, accurate and complete. I don't know if the person asking the question works for a doctor or if they are a coding student and I NEVER help students. If I provide them with answers, they submit my work as their own and that is academic fraud. I NEVER support fraud, including academic fraud, in any form. If I do a coders work for them, they will never learn to become self-sufficient. If they go to work for a doctor, their lack of how to code could cost the doctor revenue or open doors to audits, inspections and refund demands. They could go so far as to Internet code. Internet coding is going to a website like ask yahoo or a coding and billing forum to ask what code should be used. Let's say you have an untrained coder who needs to code a cranialrectalectomy. They will go to the Internet and ask, "I forgot what the code is for a cranialrectalectomy. Can someone help me?" When they don't get a response, they become angry and then they will post, "Can't anyone here help me out? I thought I could get someone to help me here!" Thinking that posing a guilt trip will do the work, but it won't.

We have a generation that wants others to do their work for them and by putting a guilt trip on someone, they get instant gratification, but they don't know if what was provided is correct. Someone may come along with a name of ToddCPC and say we use code 99999. The name ToddCPC makes you believe that they are a certified coder because CPC stands for Certified Professional Coder. ToddCPC is NOT a coder.

ToddCPC is a 15 year old school kid in Omaha, Nebraska or a 19 year old hacker in Russia, having fun pranking the poster.

So, now the coder enters 99999 as the code and sends the claim to the insurance company. The claim is denied payment. Claim after claim is denied payment because this coder is sending claims with bad codes. The doctor begins to notice the volume of denials and notices a huge drop in his practice revenue, so he contacts a consultant. In addition, the insurance company put a halt on all claims sent by the doctor. They send a letter demanding medical records and they're now going back 20 years. The information on the claim is wrong and it is not documented in the medical record. The next letter the doctor receives is a demand for the return of claim payments and they are demanding a 6 figure refund. The doctor can't fight this because the claim was sent with wrong codes, codes that are not supported by the medical record documentation.

I recently went to a doctor who received a letter demanding the return of $64,000. That would cause him to go out of business. I showed how his coder was sending claim with wrong codes and that the medical record documentation was so poor, that they didn't support any correct code that was submitted**.**

Again, DOCUMENT THE MEDICAL RECORD AS IF YOU HAD TO GO TO COURT!

Coding Guidelines

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

ICD-9 Guideline for Symptoms:

Signs and symptoms

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

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

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

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

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

ICD-10 Guideline for Symptoms:

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

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

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

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

Emergency Coding Guidelines

The guidelines listed below came from the ICD-10-CM Coding guidelines which came from the Centers for Disease Control website located at http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf

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

An exception to the above guidelines are those instances where the code for late effect is followed by a manifestation code identified in the Tabular List and title, or the late effect code has been expanded (at the fourth, fifth or sixth character levels) to include the manifestation(s). The code for the acute phase of an illness or injury that led to the late effect is never used with a code for the late effect.

Reporting Same Diagnosis Code More than Once
Each unique ICD-10-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions **when there are no distinct codes identifying laterality** or two different conditions classified to the same ICD-10-CM diagnosis code.

Sepsis
For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection. If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified.

A code from subcategory R65.2, Severe sepsis, should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.
(i) Negative or inconclusive blood cultures and sepsis

Negative or inconclusive blood cultures do not preclude a diagnosis of sepsis in patients with clinical evidence of the condition, however, the provider should be queried.

(ii) Urosepsis
The term urosepsis is a nonspecific term. It is not to be considered synonymous with sepsis. It has no default code in the Alphabetic Index. Should a provider use this term, he/she must be queried for clarification.

(iii) Sepsis with organ dysfunction
If a patient has sepsis and associated acute organ dysfunction or multiple organ dysfunction (MOD), follow the instructions for coding severe sepsis.

Septic shock
Septic shock is circulatory failure associated with severe sepsis, and therefore, it represents a type of acute organ dysfunction. For all cases of septic shock, the code for the underlying systemic infection should be sequenced first, followed by code R65.21, Severe sepsis with septic shock. Any additional codes for the other acute organ dysfunctions should also be assigned.

Septic shock indicates the presence of severe sepsis. Code R65.21, Severe sepsis with septic shock, must be assigned if septic shock is documented in the medical record, even if the term severe sepsis is not documented.

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

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

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

Diabetes mellitus and the use of insulin
If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11, Type 2 diabetes mellitus, should be assigned for type 2 patients who routinely use insulin, code Z79.4, Long-term (current) use of insulin, should also be assigned to indicate that the patient uses insulin. Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient's blood sugar under control during an encounter.

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

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

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

Secondary diabetes mellitus due to pancreatectomy

For postpancreatectomy diabetes mellitus (lack of insulin due to the surgical removal of all or part of the pancreas), assign code E89.1, Postsurgical hypoinsulinemia. Assign a code from category E08 and code Z79.4, Other acquired absence of organ, as additional codes.

Secondary diabetes due to drugs

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

Chapter 5: Mental and behavioral disorders (F01 – F99)

Pain disorders related to psychological factors

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

Pain - Category G89

General coding information

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

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

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

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

Category G89 Codes as Principal or First-Listed Diagnosis

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

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

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

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

Assigning Category G89 and Site-Specific Pain Codes

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

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

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

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

Postoperative Pain
The provider's documentation should be used to guide the coding of postoperative pain, as well as *Section III. Reporting Additional Diagnoses* and *Section IV. Diagnostic Coding and Reporting in the Outpatient Setting.*
The default for post-thoracotomy and other postoperative pain not specified as acute or chronic is the code for the acute form.
Routine or expected postoperative pain immediately after surgery should not be coded.

Postoperative pain not associated with specific postoperative complication
Postoperative pain not associated with a specific postoperative complication is assigned to the appropriate postoperative pain code in category G89.

Postoperative pain associated with specific postoperative complication
Postoperative pain associated with a specific postoperative complication (such as painful wire sutures) is assigned to the appropriate code(s) found in Chapter 19, Injury, poisoning, and certain other consequences of external causes. If appropriate, use additional code(s) from category G89 to identify acute or chronic pain (G89.18 or G89.28).

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.

Chronic pain syndrome
Central pain syndrome (G89.0) and chronic pain syndrome (G89.4) are different than the term "chronic pain," and therefore codes should only be used when the provider has specifically documented this condition.

Diseases of Eye and Adnexa (H00-H59)
Reserved for future guideline expansion

Chapter 8: Diseases of Ear and Mastoid Process (H60-H95)
Reserved for future guideline expansion

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/encounter.

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

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

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

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

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

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

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

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

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

Intraoperative and Postprocedural cerebrovascular accident
Medical record documentation should clearly specify the cause- and-effect relationship between the medical intervention and the cerebrovascular accident in order to assign a code for intraoperative or postprocedural cerebrovascular accident.

Proper code assignment depends on whether it was an infarction or hemorrhage and whether it occurred intraoperatively or postoperatively. If it was a cerebral hemorrhage, code assignment depends on the type of procedure performed.

Sequelae of Cerebrovascular Disease

Category I69, Sequelae of Cerebrovascular disease
Category I69 is used to indicate conditions classifiable to categories I60-I67 as the causes of late effects (neurologic deficits), themselves classified elsewhere. These “late effects” include neurologic deficits that persist after initial onset of conditions classifiable to categories I60-I67. The neurologic deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to categories I60-I67.

Codes from category I69 with codes from I60-I67
Codes from category I69 may be assigned on a health care record with codes from I60-I67, if the patient has a current cerebrovascular accident (CVA) and deficits from an old CVA.

Code Z86.73
Assign code Z86.73, Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits (and not a code from category I69) as an additional code for history of cerebrovascular disease when no neurologic deficits are present.

Acute myocardial infarction (AMI)

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

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

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

Acute Respiratory Failure

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

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

Sequencing of acute respiratory failure and another acute condition
When a patient is admitted with respiratory failure and another acute condition, (e.g., myocardial infarction, cerebrovascular accident, aspiration pneumonia), the principal diagnosis will not be the same in every situation. This applies whether the other acute condition is a respiratory or nonrespiratory condition. Selection of the principal diagnosis will be dependent on the circumstances of admission. If both the respiratory failure and the other acute condition

are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis *(Section II, C.)* may be applied in these situations.

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

Influenza due to *certain identified influenza* influenza *viruses*
Code only confirmed cases of avian influenza **(code J09.0-, Influenza due to identified avian influenza virus) or novel H1N1 or swine flu, code J09.1-**. This is an exception to the hospital inpatient guideline Section II, H. (Uncertain Diagnosis).

In this context, "confirmation" does not require documentation of positive laboratory testing specific for avian **or novel H1N1 (H1N1 or swine flu)** influenza. However, coding should be based on the provider's diagnostic statement that the patient has avian influenza.

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

Chapter 11: Diseases of Digestive System (K00-K94)
Reserved for future guideline expansion

Chapter 12: Diseases of Skin and Subcutaneous Tissue (L00-L99)

Pressure ulcer stage codes
Pressure ulcer stages
Codes from category L89, Pressure ulcer, are combination codes that identify the site of the pressure ulcer as well as the stage of the ulcer.
The ICD-10-CM classifies pressure ulcer stages based on severity, which is designated by stages 1-4, unspecified stage and unstageable.

Assign as many codes from category L89 as needed to identify all the pressure ulcers the patient has, if applicable.

Unstageable pressure ulcers
Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma. This code should not be confused with the codes for unspecified stage (L89.--9). When

there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.--9).

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

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

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

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

Patient admitted with pressure ulcer evolving into another stage during the admission
If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, assign the code for the highest stage reported for that site.

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

Acute traumatic versus chronic or recurrent musculoskeletal conditions

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

Coding of Pathologic Fractures
7th character A is for use as long as the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter,

evaluation and treatment by a new physician. 7th character, D is to be used for encounters after the patient has completed active treatment. The other 7th characters, listed under each subcategory in the Tabular List, are to be used for subsequent encounters for treatment of problems associated with the healing, such as malunions**,** nonunions, and sequelae.

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

Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00-*O9A*)

General Rules for Obstetric Cases
Codes from chapter 15 and 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.

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.

Final character for trimester
The majority of codes in Chapter 15 have a final character indicating the trimester of pregnancy. The timeframes for the trimesters are indicated at the beginning of the chapter. If trimester is not a component of a code it is because the condition always occurs in a specific trimester, or the concept of trimester of pregnancy is not applicable. Certain codes have characters for only certain trimesters because the condition does not occur in all trimesters, but it may occur in more than just one.

Assignment of the final character for trimester should be based on the trimester for the current admission/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. Whenever delivery occurs during the current admission, and there is an "in childbirth" option for the obstetric complication being coded, the "in childbirth" code should be assigned.

Selection of trimester for inpatient admissions *that encompass more than one trimesters*

In instances when a patient is admitted to a hospital for complications of pregnancy during one trimester and remains in the hospital into a subsequent trimester, the trimester character for the antepartum complication code should be assigned on the basis of the trimester when the

complication developed, not the trimester of the discharge. If the condition developed prior to the current admission/encounter or represents a pre-existing condition, the trimester character for the trimester at the time of the admission/encounter should be assigned.

Unspecified trimester
Each category that includes codes for trimester has a code for "unspecified trimester." The "unspecified trimester" code should rarely be used, such as when the documentation in the record is insufficient to determine the trimester and it is not possible to obtain clarification.

Selection of OB Principal or First-listed Diagnosis
Routine outpatient prenatal visits
For routine outpatient prenatal visits when no complications are present, a code from category Z34, Encounter for supervision of normal pregnancy, should be used as the first-listed diagnosis. These codes should not be used in conjunction with chapter 15 codes.

Prenatal outpatient visits for high-risk patients
For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category O09, Supervision of high-risk pregnancy, should be used as the first-listed diagnosis. Secondary chapter 15 codes may be used in conjunction with these codes if appropriate.

Episodes when no delivery occurs
In episodes when no delivery occurs, the principal diagnosis should correspond to the principal complication of the pregnancy which necessitated the encounter. Should more than one complication exist, all of which are treated or monitored, any of the complications codes may be sequenced first.

When a delivery occurs
When a delivery occurs, the principal diagnosis should correspond to the main circumstances or complication of the delivery. In cases of cesarean delivery, the selection of the principal diagnosis should be the condition established after study that was responsible for the patient's admission. If the patient was admitted with a condition that resulted in the performance of a cesarean procedure that condition should be selected as the principal diagnosis. If the reason for the admission/encounter was unrelated to the condition resulting in the cesarean delivery, the condition related to the reason for the admission/encounter should be selected as the principal diagnosis, even if a cesarean was performed.

Outcome of delivery
A code from category Z37, Outcome of delivery, should be included on every maternal record when a delivery has occurred. These codes are not to be used on subsequent records or on the newborn record.

Pre-existing conditions versus conditions due to the pregnancy
Certain categories in Chapter 15 distinguish between conditions of the mother that existed prior to pregnancy (pre-existing) and those that are a direct result of pregnancy. When assigning codes from Chapter 15, it is important to assess if a condition was pre-existing prior to pregnancy or developed during or due to the pregnancy in order to assign the correct code.

Categories that do not distinguish between pre-existing and pregnancy-related conditions may be used for either. It is acceptable to use codes specifically for the puerperium with codes complicating pregnancy and childbirth if a condition arises postpartum during the delivery encounter.

Pre-existing hypertension in pregnancy
Category O10, Pre-existing hypertension complicating pregnancy, childbirth and the puerperium, includes codes for hypertensive heart and hypertensive chronic kidney disease. When assigning one of the O10 codes that includes hypertensive heart disease or hypertensive chronic kidney disease, it is necessary to add a secondary code from the appropriate hypertension category to specify the type of heart failure or chronic kidney disease.

Fetal Conditions Affecting the Management of the Mother
Codes from categories O35 and O36
Codes from categories O35, Maternal care for known or suspected fetal abnormality and damage, and O36, Maternal care for other fetal problems, are assigned only when the fetal condition is actually responsible for modifying the management of the mother, i.e., by requiring diagnostic studies, additional observation, special care, or termination of pregnancy. The fact that the fetal condition exists does not justify assigning a code from this series to the mother's record.

Normal Delivery, Code O80
Encounter for full term uncomplicated delivery
Code O80 should be assigned when a woman is admitted for a full-term normal delivery and delivers a single, healthy infant without any complications antepartum, during the delivery, or postpartum during the delivery episode. Code O80 is always a principal diagnosis. It is not to be used if any other code from chapter 15 is needed to describe a current complication of the antenatal, delivery, or perinatal period. Additional codes from other chapters may be used with code O80 if they are not related to or are in any way complicating the pregnancy.

Uncomplicated delivery with resolved antepartum complication
Code O80 may be used if the patient had a complication at some point during the pregnancy, but the complication is not present at the time of the admission for delivery.

Outcome of delivery for O80
Z37.0, Single live birth, is the only outcome of delivery code appropriate for use with O80.

The Peripartum and Postpartum Periods
Peripartum and Postpartum periods
The postpartum period begins immediately after delivery and continues for six weeks following delivery. The peripartum period is defined as the last month of pregnancy to five months postpartum.

Peripartum and postpartum complication
A postpartum complication is any complication occurring within the six-week period.

Pregnancy-related complications after 6 week period
Chapter 15 codes may also be used to describe pregnancy-related complications after the peripartum or postpartum period if the provider document**s** that a condition is pregnancy related.

Chapter 18: Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)

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

Use of symptom codes

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

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

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

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

Repeated falls
Code R29.6, Repeated falls, is for use for encounters when a patient has recently fallen and the reason for the fall is being investigated.

Code Z91.81, History of falling, is for use when a patient has fallen in the past and is at risk for future falls. When appropriate, both codes R29.6 and Z91.81 may be assigned together.

Glasgow coma scale
The Glasgow coma scale codes (R40.2-) can be used in conjunction with traumatic brain injury codes or sequelae of cerebrovascular accident codes. These codes are primarily for use by trauma registries, but they may be used in any setting where this information is collected. The coma scale codes should be sequenced after the diagnosis code**(s)**.
These codes, one from each subcategory, are needed to complete the scale. The 7th character indicates when the scale was recorded. The 7th character should match for all three codes.

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

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

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

Death NOS
Code R99, Ill-defined and unknown cause of mortality, is only for use in the very limited circumstance when a patient who has already died is brought into an emergency department or

other healthcare facility and is pronounced dead upon arrival. It does not represent the discharge disposition of death.

Chapter 19: Injury, poisoning, and certain other consequences of external causes (S00-T88)

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

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

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

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

Extension "S", sequela, is for use for complications or conditions that arise as a direct result of an injury, such as scar formation after a burn. The scars are sequelae of the burn. When using extension "S", it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The "S" is added only to the injury code, not the sequela code. The "S" extension identifies the injury responsible for the sequela. The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code.

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

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

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

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

Coding of Traumatic Fractures
The principles of multiple coding of injuries should be followed in coding fractures. Fractures of specified sites are coded individually by site in accordance with both the provisions within categories S02, S12, S22, S32, S42, **S49,** S52, **S59,** S62, S72, **S79,** S82, **S89,** S92 and the level of detail furnished by medical record content.

A fracture not indicated as open or closed should be coded to closed. A fracture not indicated whether displaced or not displaced should be coded to displaced.

More specific guidelines are as follows:

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

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

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

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

A code from category M80, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, **even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.**

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

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

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

Current burns (T20-T25) are classified by depth, extent and by agent (X code). Burns are classified by depth as first degree (erythema), second degree (blistering), and third degree (full-thickness involvement). Burns of the eye and internal organs (T26-T28) are classified by site, but not by degree.

Sequencing of burn and related condition codes
Sequence first the code that reflects the highest degree of burn when more than one burn is present.

a. When the reason for the admission or encounter is for treatment of external multiple burns, sequence first the code that reflects the burn of the highest degree.

b. When a patient has both internal and external burns, the circumstances of admission govern the selection of the principal diagnosis or first-listed diagnosis.

c. When a patient is admitted for burn injuries and other related conditions such as smoke inhalation and/or respiratory failure, the circumstances of admission govern the selection of the principal or first-listed diagnosis.

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

Non-healing burns
Non-healing burns are coded as acute burns.
Necrosis of burned skin should be coded as a non-healed burn.

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

Assign separate codes for each burn site
When coding burns, assign separate codes for each burn site. Category T30, Burn and corrosion, body region unspecified is extremely vague and should rarely be used.

Burns and Corrosions Classified According to Extent of Body Surface Involved
Assign codes from category T31, Burns classified according to extent of body surface involved, or T32, Corrosions classified according to extent of body surface involved, when the site of the burn is not specified or when there is a need for additional data. It is advisable to use category T31 as additional coding when needed to provide data for evaluating burn mortality, such as that needed by burn units. It is also advisable to use category T31 as an additional code for reporting purposes when there is mention of a third-degree burn involving 20 percent or more of the body surface.

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

Encounters for treatment of late effects of burns
Encounters for the treatment of the late effects of burns or corrosions (i.e., scars or joint contractures) should be coded with a burn or corrosion code with the 7th character "S" or sequela.

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

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

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

A code from categories T36-T65 is sequenced first, followed by the code(s) that specify the nature of the adverse effect, poisoning, or toxic effect. Note: This sequencing instruction does not apply to

Underdosing codes (fifth or sixth character "6", for example T36.0x6-).

1) Do not code directly from the Table of Drugs

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

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

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

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

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

Adverse Effect

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

Poisoning

When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration), assign the appropriate code from categories T36-T50. Poisoning codes have an associated intent: accidental, intentional self-harm, assault and undetermined. Use additional code(s) for all manifestations of poisonings.
If there is also a diagnosis **of abuse or dependence on** the substance, the abuse or dependence is coded as an additional code.

Examples of poisoning include:
(i) Error was made in drug prescription

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

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

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

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

Underdosing

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

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

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

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

Adult and child abuse, neglect and other maltreatment
Sequence first the appropriate code from categories T74.- or T76.- for abuse, neglect and other maltreatment, followed by any accompanying mental health or injury code(s).

If the documentation in the medical record states abuse or neglect it is coded as confirmed. It is coded as suspected if it is documented as suspected.
For cases of confirmed abuse or neglect an external cause code from the assault section (X92-Y08) should be added to identify the cause of any physical injuries. A perpetrator code (Y07) should be added when the perpetrator of the abuse is known. For suspected cases of abuse or neglect, do not report external cause or perpetrator code.

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

Complications of care

1) **Complications of care**

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

External Causes of Morbidity (V01- Y99)
Introduction: These guidelines are provided for the reporting of external causes of morbidity codes in order that there will be standardization in the process. These codes are secondary codes for use in any health care setting.
External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred the activity of the patient at the time of the event**, and the person's status (e.g., civilian, military)**.

a. **General External Cause Coding Guidelines**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

g. Child and Adult Abuse Guideline

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

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

h. Unknown or Undetermined Intent Guideline

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

1) Use of undetermined intent

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

i. Late Effects of External Cause Guidelines

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

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

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

Terrorism Guidelines
1) Cause of injury identified by the Federal Government (FBI) as terrorism

When the cause of an injury is identified by the Federal Government (FBI) as terrorism, the first-listed external cause code should be a code from category Y38, Terrorism. The definition of terrorism employed by the FBI is found at the inclusion note at the beginning of category Y38. Use additional code for place of occurrence (Y92.-). More than one Y38 code may be assigned if the injury is the result of more than one mechanism of terrorism.

2) Cause of an injury is suspected to be the result of terrorism

When the cause of an injury is suspected to be the result of terrorism a code from category Y38 should not be assigned. Suspected cases should be classified as assault.

3) Code Y38.9, Terrorism, secondary effects

Assign code Y38.9, Terrorism, secondary effects, for conditions occurring subsequent to the terrorist event. This code should not be assigned for conditions that are due to the initial terrorist act.

It is acceptable to assign code Y38.9 with another code from Y38 if there is an injury due to the initial terrorist event and an injury that is a subsequent result of the terrorist event.

k. External cause status

A code from category Y99, External cause status, should be assigned whenever any other external cause code is assigned for an encounter, including an Activity code, except for the events noted below. Assign a code from category Y99,

External cause status, to indicate the work status of the person at the time the event occurred. The status code indicates whether the event occurred during military activity, whether a non-military person was at work, whether an individual including a student or volunteer was involved in a non-work activity at the time of the causal event.

A code from Y99, External cause status, should be assigned, when applicable, with other external cause codes, such as transport accidents and falls. The external cause status codes 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 the status is not stated.

History (of)

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

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

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

The history Z code categories are:

Z80 Family history of primary malignant neoplasm
Z81 Family history of mental and behavioral disorders
Z82 Family history of certain disabilities and chronic diseases (leading to disablement)
Z83 Family history of other specific disorders
Z84 Family history of other conditions
Z85 Personal history of malignant neoplasm

Z86 Personal history of certain other diseases
Z87 Personal history of other diseases and conditions
Z91.4- Personal history of psychological trauma, not elsewhere classified
Z91.5 Personal history of self-harm
Z91.8- Other specified personal risk factors, not elsewhere classified
Z92 Personal history of medical treatment

Except: Z92.0, Personal history of contraception

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

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

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

A screening code may be a first listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done during an office visit for other health problems. A screening code is not necessary if the screening is inherent to a routine examination, such as a pap smear done during a routine pelvic examination.

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

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

The screening Z codes/categories:
Z11 Encounter for screening for infectious and parasitic diseases
Z12 Encounter for screening for malignant neoplasms
Z13 Encounter for screening for other diseases and disorders
Except: Z13.9, Encounter for screening, unspecified
Z36 Encounter for antenatal screening for mother

Observation
There are two observation Z code categories. They are for use in very limited circumstances when a person is being observed for a suspected condition that is ruled out. The observation codes are not for use if an injury or illness or any signs or symptoms related to the suspected

condition are present. In such cases the diagnosis/symptom code is used with the corresponding external cause code.

The observation codes are to be used as principal diagnosis only. Additional codes may be used in addition to the observation code but only if they are unrelated to the suspected condition being observed.

Codes from subcategory Z03.7 Encounter for suspected maternal and fetal conditions ruled out, may either be used as a first listed or as an additional code assignment depending on the case. They are for use in very limited circumstances on a maternal record when an encounter is for a suspected maternal or fetal condition that is ruled out during that encounter (for example, a maternal or fetal condition may be suspected due to an abnormal test result). These codes should not be used when the condition is confirmed. In those cases, the confirmed condition should be coded. In addition, these codes are not for use if an illness or any signs or symptoms related to the suspected condition or problem are present. In such cases the diagnosis/symptom code is used.

Additional codes may be used in addition to the code from subcategory Z03.7, but only if they are unrelated to the suspected condition being evaluated.

Codes from subcategory Z03.7 may not be used for encounters for antenatal screening of mother.

For encounters for suspected fetal condition that are inconclusive following testing and evaluation, assign the appropriate code from category O35, O36, O40 or O41**.**

The observation Z code categories:

Z03 Encounter for medical observation for suspected diseases and conditions ruled out

Z04 Encounter for examination and observation for other reasons

Except: Z04.9, Encounter for examination and observation for unspecified reason

Aftercare

Aftercare visit codes cover situations when the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare Z code should not be used if treatment is directed at a current, acute disease. The diagnosis code is to be used in these cases.

Exceptions to this rule are codes Z51.0, Encounter for antineoplastic radiation therapy, and codes from subcategory Z51.1, Encounter for antineoplastic chemotherapy and immunotherapy. These codes are to be first listed, followed by the diagnosis code when a

patient's encounter is solely to receive radiation therapy, chemotherapy, or immunotherapy for the treatment of a neoplasm. If the reason for the encounter is more than one type of antineoplastic therapy, code Z51.0 and a code from subcategory Z51.1 may be assigned together, in which case one of these codes would be reported as a secondary diagnosis**.**

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

The aftercare codes are generally first listed to explain the specific reason for the encounter. An aftercare code may be used as an additional code when some type of aftercare is provided in addition to the reason for admission and no diagnosis code is applicable. An example of this would be the closure of a colostomy during an encounter for treatment of another condition.

Aftercare codes should be used in conjunction with other aftercare codes or diagnosis codes to provide better detail on the specifics of an aftercare encounter visit, unless otherwise directed by the classification. Should a patient receive multiple types of antineoplastic therapy during the same encounter, code Z51.0, Encounter for antineoplastic radiation therapy, and codes from subcategory Z51.1, Encounter for antineoplastic chemotherapy and immunotherapy, may be used together on a record. The sequencing of multiple aftercare codes **depends on the circumstances of the encounter.**

Certain aftercare Z code categories need a secondary diagnosis code to describe the resolving condition or sequelae**. F**or others, the condition is **included** in the code title.

Additional Z code aftercare category terms include fitting and adjustment, and attention to artificial openings.

Status Z codes may be used with aftercare Z codes to indicate the nature of the aftercare. For example code Z95.1, Presence of aortocoronary bypass graft, may be used with code Z48.812, Encounter for surgical aftercare following surgery on the circulatory system, to indicate the surgery for which the aftercare is being performed. A status code should not be used when the aftercare code indicates the type of status, such as using Z43.0, Encounter for attention to tracheostomy, with Z93.0, Tracheostomy status.

The aftercare Z category/codes:

Z42 Encounter for plastic and reconstructive surgery following medical procedure or healed injury

Z43 Encounter for attention to artificial openings

Z44 Encounter for fitting and adjustment of external prosthetic device

Z45 Encounter for adjustment and management of implanted device

Z46 Encounter for fitting and adjustment of other devices

Z47 Orthopedic aftercare

Z48 Encounter for other postprocedural aftercare
Z49 Encounter for care involving renal dialysis
Z51 Encounter for other aftercare

Follow-up
The follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists. They should not be confused with aftercare codes, or injury codes with 7th character "D," that explain ongoing care of a healing condition or its sequelae. Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first, followed by the history code.

A follow-up code may be used to explain **multiple** visits. Should a condition be found to have recurred on the follow-up visit, then the code for the condition should be assigned as an additional diagnosis.

The follow-up Z code categories:
Z08 Encounter for follow-up examination after completed treatment for malignant neoplasm
Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
Z39 Encounter for maternal postpartum care and examination

Counseling
Counseling Z codes are used when a patient or family member receives assistance in the aftermath of an illness or injury, or when support is required in coping with family or social problems. They are not use**d** in conjunction with a diagnosis code when the counseling component of care is considered integral to standard treatment.

The counseling Z codes/categories:
Z30.0- Encounter for general counseling and advice on contraception
Z31.5 Encounter for genetic counseling
Z31.6- Encounter for general counseling and advice on procreation
Z32.2 Encounter for childbirth instruction
Z32.3 Encounter for childcare instruction
Z69 Encounter for mental health services for victim and perpetrator of abuse
Z70 Counseling related to sexual attitude, behavior and orientation
Z71 Persons encountering health services for other counseling and medical advice, not elsewhere classified
Z76.81 Expectant mother prebirth pediatrician visit

Newborns and Infants

Newborn Z codes/categories:

Z76.1 Encounter for health supervision and care of foundling

Z00.1- Encounter for routine child health examination

Z38 Liveborn infants according to place of birth and type of delivery

Routine and administrative examinations

The Z codes allow for the description of encounters for routine examinations, such as, a general check-up, or, examinations for administrative purposes, such as, a pre-employment physical. The codes are not to be used if the examination is for diagnosis of a suspected condition or for treatment purposes. In such cases the diagnosis code is used. During a routine exam, should a diagnosis or condition be discovered, it should be coded as an additional code. Pre-existing and chronic conditions and history codes may also be included as additional codes as long as the examination is for administrative purposes and not focused on any particular condition.

Some of the codes for routine health examinations distinguish between "with" and "without" abnormal findings. Code assignment depends on the information that is known at the time the encounter is being coded. For example, if no abnormal findings were found during the examination, but the encounter is being coded before test results are back, it is acceptable to assign the code for "without abnormal findings." When assigning a code for "with abnormal findings," additional code(s) should be assigned to identify the specific abnormal finding(s).

Pre-operative examination **and pre-procedural laboratory examination** Z codes are for use only in those situations when a patient is being cleared for **a procedure or** surgery and no treatment is given.

The Z codes/categories for routine and administrative examinations:

Z00 Encounter for general examination without complaint, suspected or reported diagnosis

Z01 Encounter for other special examination without complaint, suspected or reported diagnosis

Z02 Encounter for administrative examination

Except: Z02.9, Encounter for administrative examinations, unspecified

Z32.0- Encounter for pregnancy test

Miscellaneous Z codes

The miscellaneous Z codes capture a number of other health care encounters that do not fall into one of the other categories. Certain of these codes identify the reason for the encounter; others are for use as additional codes that provide useful information on circumstances that may affect a patient's care and treatment.

Nonspecific Z codes

Certain Z codes are so non-specific, or potentially redundant with other codes in the classification, that there can be little justification for their use in the inpatient setting. Their use in the outpatient setting should be limited to those instances when there is no further

documentation to permit more precise coding. Otherwise, any sign or symptom or any other reason for visit that is captured in another code should be used.

Nonspecific Z codes/categories:

Z02.9 Encounter for administrative examinations, unspecified

Z04.9 Encounter for examination and observation for unspecified reason

Z13.9 Encounter for screening, unspecified

Z41.9 Encounter for procedure for purposes other than remedying health state, unspecified

Z52.9 Donor of unspecified organ or tissue

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

Z92.0 Personal history of contraception

Z Codes That May Only be Principal/First-Listed Diagnosis

The following Z codes/categories may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined:

Z00 Encounter for general examination without complaint, suspected or reported diagnosis

Z01 Encounter for other special examination without complaint, suspected or reported diagnosis

Z02 Encounter for administrative examination

Z03 Encounter for medical observation for suspected diseases and conditions ruled out

Z33.2 Encounter for elective termination of pregnancy

Z31.81 Encounter for male factor infertility in female patient

Z31.82 Encounter for Rh incompatibility status

Z31.83 Encounter for assisted reproductive fertility procedure cycle

Z31.84 Encounter for fertility preservation procedure

Z34 Encounter for supervision of normal pregnancy

Z39 Encounter for maternal postpartum care and examination

Z38 Liveborn infants according to place of birth and type of delivery

Z42 Encounter for plastic and reconstructive surgery following medical procedure or healed injury

Z51.0 Encounter for antineoplastic radiation therapy

Z51.1- Encounter for antineoplastic chemotherapy and immunotherapy

Z52 Donors of organs and tissues

Except: Z52.9, Donor of unspecified organ or tissue

Z76.1 Encounter for health supervision and care of foundling

Z76.2 Encounter for health supervision and care of other healthy infant and child

Z99.12 Encounter for respirator [ventilator] dependence during power failure

Selection of Principal Diagnosis

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

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

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

In determining principal diagnosis the coding conventions in the ICD-10-CM, Volumes I and II take precedence over these official coding guidelines.

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

Codes for symptoms, signs, and ill-defined conditions

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

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

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

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

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

Two or more comparative or contrasting conditions.

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

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

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

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

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

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

Admission from Observation Unit

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

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

Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

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

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

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

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

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

Previous conditions

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

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

Abnormal findings

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

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

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

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

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

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

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

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

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

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

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

Uncertain diagnosis
Do not code diagnoses documented as “probable”, “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s)

to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

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

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

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

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

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

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

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

ICD9 to ICD-10

The following are a small example of some of the most used codes in the emergency department.

Codes Indexed Numerically by ICD-9-CM Code

ICD-9-CM
401.9 (Essential hypertension, UNSPECIFIED)

ICD-10-CM
I10 - Essential (primary) hypertension
O10.019 - Pre-existing essential hypertension complicating pregnancy, unspecified trimester

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ICD-9-CM
079.99 **Unspecified viral infection**

ICD-10-CM
B34.9 Viral infection, unspecified

ICD-9-CM
465.9 (Acute upper respiratory infections of multiple or unspecified sites

ICD-10-CM
J06 Acute upper respiratory infections of multiple and unspecified sites

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ICD-9-CM
599. Urinary tract infection, site not specified

ICD-10-CM
N39.0 Urinary tract infection, site not specified
Use additional code (B95-B97), to identify infectious agent.

ICD-9-CM
780.6 Fever

ICD-10-CM
R50.9 Fever, unspecified
Note, you have more than 288 different fever codes

ICD-9-CM
786.50 Chest Pain, Unspecified

ICD-10-CM
R07.9 or R07.4 Chest pain, unspecified

ICD-9-CM
E812.0 Other motor vehicle traffic accident involving collision with motor vehicle

ICD-10-CM
X82.0 Intentional collision of motor vehicle with other motor vehicle
Y32 Crashing of motor vehicle, undetermined intent

ICD-9-CM
E885.9 (Fall from other slipping, tripping, or tumbling

ICD-10-CM
W01 Fall on same level from slipping, tripping and stumbling

ICD-9-CM
E888 Other and unspecified fall

ICD-10-CM
W18.30XA Fall on same level, unspecified, initial encounter
W18.30XD Fall on same level, unspecified, subsequent encounter
W18.30XS Fall on same level, unspecified, sequela

ICD-9-CM
E917.9 (Other striking against with or without subsequent fall)

ICD-10
W18.49 (Other slipping, tripping and stumbling without falling)

ICD-9-CM
E920.8 (Other specified cutting and piercing instruments or objects)

ICD-10
injury caused by cutting or piercing instruments (W25-W27)
W25 Contact with sharp glass
W26 Contact with knife, sword or dagger
W26.0 Contact with knife
Excludes1: contact with electric knife (W29.1)
W26.1 Contact with sword or dagger

ICD-9-CM
V22.2 Pregnant state, incidental

ICD-10-CM
Z33.1 Pregnant state, incidental

ICD-9-CM
V58.3Attention to dressings and sutures

ICD-10-CM
Z48.0 Encounter for attention to dressings, sutures and drains

Indexed by Disease, Alphabetically

Acute upper respiratory infections of multiple or unspecified sites
465.9 (ICD-9-CM)
J06 (ICD-10-CM)

Attention to dressings and sutures
V58.3 (ICD-9-CM)
Z48.0 (ICD-10-CM)

Chest Pain, Unspecified
786.50 (ICD-9-CM)
R07.9 or R-7.4 (ICD-10-CM)

Essential hypertension, UNSPECIFIED
401.9 (ICD-9-CM)
(ICD-10-CM)
I10 - Essential (primary) hypertension

Fever
780.6 (ICD-9-CM)
R50.9 (ICD-10-CM

Other and unspecified fall
E888 (ICD-9-CM)
W18.30, Fall on same level unspecified (ICD-10-CM
W18.31, Fall on same level due to stepping on an object (ICD-10-CM)
W18.39 Other fall on same level (ICD-10-CM)

Other motor vehicle traffic accident involving collision with motor vehicle
E812.0 (ICD-9-CM)
X82.0 (ICD-10-CM)
Y32 (ICD-10-CM)

Other specified cutting and piercing instruments or objects
E920.8 (ICD-9-CM)
W25 (ICD-10-CM)
W26 (ICD-10-CM)
W26.0 (ICD-10-CM)
Excludes (W29.1)
W26.1 (ICD-10-CM)

Other striking against with or without subsequent fall
E917.9 (ICD-9-CM)
W18.49 (ICD-10-CM)

Pregnant state, incidental
V22.2 (ICD-9-CM)
Z33.1 (ICD-10-CM)

Unspecified viral infection
079.99 (ICD-9-CM
B34.9 (ICD-10-CM)

Urinary tract infection, site not specified
599 (ICD-9-CM)
N39.0 (ICD-10-CM)
Use additional code (B95-B97), to identify infectious agent.

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

ICD-10-CM Index

Pain(s) (see also Painful) R52
- - chest (central) R07.4
- - - anterior wall R07.89
- - - atypical R07.89
- - - ischemic I20.9
- - - musculoskeletal R07.89
- - - non-cardiac R07.89
- - - on breathing R07.1
- - - pleurodynia R07.81
- - - precordial R07.2
- - - wall (anterior) R07.89

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

ICD-10 Tabular

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

If you look at the above tabular section, you can see coding conventions identical to those from ICD-9-CM. You can see NOS which means Not Otherwise Specified, Incl which means Includes and excludes which means these medical conditions are not included in this code. Code R07.4 has no coding conventions or additional information, so, based on the medical record documentation of chest pain, we can select R07.4. Again, if you can code ICD-9, you can code ICD-10. If you don't have the training in the process of coding, you won't be able to code under ICD-10.

CODING CHAPTERS

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

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

Under ICD-10, you have the following:

Chapter 1: Certain infectious and parasitic diseases (A00-B99)
Chapter 2: Neoplasms (C00-D48)
Chapter 3: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)
Chapter 4: Endocrine, nutritional and metabolic diseases (E00-E90)

Chapter 5: Mental and behavioral disorders (F01-F99)
Chapter 6: Diseases of the nervous system (G00-G99)
Chapter 7: Diseases of the eye and adnexa (H00-H59)
Chapter 8: Diseases of the ear and mastoid process (H60-H95)
Chapter 9: Diseases of the circulatory system (I00-I99)
Chapter 10: Acute upper respiratory infections (J00-J06)
Chapter 11: Diseases of oral cavity and salivary glands (K00-K14)
Chapter 12: Diseases of the skin and subcutaneous tissue (L00-L99)
Chapter 13: Diseases of the musculoskeletal system and connective tissue (M00-M99)
Chapter 14: Diseases of the genitourinary system (N00-N99)
Chapter 15: Pregnancy, childbirth and the puerperium (O00-O99)
Chapter 16: Certain conditions originating in the perinatal period (P00-P96)
Chapter 17 Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
Chapter 18: Symptoms and signs involving the circulatory and respiratory systems (R00-R09)
Chapter 19: Injury, poisoning and certain other consequences of external causes (S00-T98)
Chapter 20: External causes of morbidity (V01-Y98)
Factors influencing health status and contact with health services (Z00-Z99)

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

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

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

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

So, what do we have to do?

PREPARING FOR ICD-10

Training

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

A coder MUST read the medical record, go to the coding manual and find the code in the Index, then go to the tabular and read the actual code. The coder must read any coding conventions to determine the exact code that is documented in the medical record. Coding is NOT getting a test study guide and taking that test to be awarded initials. What happens then is that that same person comes along and asks for codes using the Internet. It's sad when you see someone with reputable coding initials asking basic questions, "Can someone give me a code for chest pain?" or "What code can I use with a cranialrectalectomy?" The code being provided may be fake and the person asking will have no clue o this because they don't know how to code and they won't open the manual. Forums will stop providing codes to those who ask.

Right now, some are telling the person asking for a code that the forum is not the proper place to ask for codes. The student who cheats by asking a forum to provide them with the coding answers to their homework or their test will find themselves expelled and if hired, will become unemployed.

At one time, I was teaching a coding class. I gave my students a homework assignment. One of my students asked every question, hoping to get someone to do her work. Someone gave her all incorrect answers. When she turned in her homework, the class was given a pop quiz. The pop quiz was the homework assignment. She made a copy of her homework and tried to hide the pages in her coding manual. Instead of looking up the codes, she was copying the answers from her homework. She was very surprised that she failed every test answer. What was also interesting is that a couple of my other students did the same thing by going on the internet to get someone to answer their homework assignment. It was interesting that the student had every homework question correct, yet, they failed the same identical question when tested on those questions.

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

My teacher made sure I was 100% accurate, 100% of the time. In a company where I worked, we had a coder with a mile of initials come to me, asking, "Steve, what code can I use with this?" I smiled and gave her wrong codes because I had no clue how to code at the time. The boss called her to ask her where she got her information. She said Steve gave them to me. When I was asked, I said, "I'm not a coder and yes, I gave them to her, but it's her job to code, not mine." She was terminated. My punishment was to undergo coding training and my teacher could make a seasoned Marine Corps drill sergeant cry.

Today, many practices now give a coding employee candidate a pre-employment test. These tests don't come with a study guide. You are given the test cold, without advance notice and you better pass. Having initials after your name won't allow you any special privileges. I recently spoke to one doctor. He told me if you walk in with initials after your name, turn around and leave. You won't be hired. When I ask why, she told me, Steve, these people are supposed to know how to code, but they can't do it, they don't know what they're doing, so she makes her job easy. Initials don't get hired automatically. If you fail her coding test, she contacted your coding association with the recommendation that your initials be revoked and she will tell that association that under no circumstances will any of their coders be hired by her or her associates, simply because she doesn't trust the certification that the organization issues.

To repeat myself, if you know how to code using ICD-9, you should have no problem coding using ICD-10. If not, take this time to undergo training. A doctor's spouse, a receptionist, medical biller and accountant is NOT a coder. A biller is trained in the basics of coding to understand the codes to be placed on the claim and a medical biller uses their basic knowledge of coding to appeal a claim denial when coding is involved, but a medical biller is not a coder.

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

Documentation:

If your documentation is currently insufficient or poor, now is the time to improve your documentation. Include anatomy if the condition affects an anatomical area. If there is right or left or both, document left or right or both. Take your ego down a step and look at how important your documentation affects many. If affects YOU as a doctor, it affects your staff who depend on the claims payment to be paid themselves. It affects

your patient. Your lack or insufficient documentation could result in improper or insufficient treatment, causing you to undergo a malpractice lawsuit. Sadly many malpractice lawsuits are settled out of court due to poor documentation and many more are lost in court. Your documentation or lack thereof will determine if you will win or lose the lawsuit.

As a patient, I've looked at the records of my visits. The doctor who doesn't document properly loses me as their patient. The doctor that cannot document my visit properly, places my health in jeopardy. When I'm asked by friends or family members who they should be seen for their healthcare, the doctor who poorly documents will not have my recommendation. You have 10 months to improve your documentation.

Again, if it isn't documented, it doesn't exist and you don't code it.

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

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

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

Here is another:

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

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

OK, here is one more:

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

Again, really? This was a 99214 visit. AIDS? Where is the lab test and why is there a diagnosis of AIDS with a toe pain complaint? How can there be a diagnosis of a fracture with no x-rays. It looks like someone is trying to cover all bases. There is nothing documented to show us that this patient is a returning patient. There is NO x-ray, NO lab, so, again, where did the doctor use to determine Aids and a fracture? Not only that, the patient has a sprain, strain AND a fracture of the same body part? This whole thing screams badly! Where did the back pain come from? Why were all body systems examined and if there is back pain, what is causing it? The patient stubbed their toe. If all systems are negative how is it that there is back pain in addition to the toe problem? Is this a fishing expedition to justify a high level office visit? When asked, the doctor said he was told to do this by the insurance company. Naturally they denied the doctor's accusation. The insurance company is the entity auditing the doctor and demanding the return of past payments.

Now, how does the following look:

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

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

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

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

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

Manuals

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

be denied because the codes you selected were not effective. Now, could this happen? Very possibly because I've seen it happen many times.

In 2004, I worked for a doctor. He retired in 2004, closing his practice. In 2010, we received a court order to send a claim to a patient's insurance company. We originally sent a claim and it was denied, causing us to bill the patient. The patient took his health plan to court. The fact that the insurance company was ordered to pay the claim it didn't stop them from trying to avoid doing so. As an attempt to not comply with a court order, they demanded a replacement claim citing the reason that due to the timeframe, all claims from 2004 were purged from their computer system and they didn't have the original claim anymore to process it. Their thinking was that if the provider couldn't send a replacement claim, there was nothing to process and then no need to pay it. They could inform the judge that they couldn't process and pay what they didn't have, but that didn't work. What they didn't realize is that when the doctor retired, we exported all of his software files and placed them on a storage drive we kept in a bank safe deposit box, so recreating the claim wasn't too hard, but we had to ensure that the 2004 codes were on the resubmitted claim. I extracted the original claim data, verified the accuracy and manually produced a claim form which was sent to the insurance company, the patient's lawyer and the judge.

We also ensured we had a signed authorization from the patient allowing us to send the claim to his lawyer and judge so that we stayed within HIPAA privacy requirements. The insurance company received the claim and decided to see if they could continue to throw up roadblocks to keep from complying with the court order. Now they demanded the medical record with the thinking that there was no way that the medical record would be available after all these years, but they were wrong. Again, all medical records were scanned and stored electronically on the storage drive. The record was found, reprinted and sent to the insurance company. With no more roadblocks, they had the claim and the medical record, so they complied with the court order and paid the claim. So, don't throw those ICD-9 books away, put them in a safe place in the event you need them. A 1 terabyte hard drive costs around $89 and you would be amazed at how much data it can hold. I go back to 1999 with the doctor's data and we have claims, EOBs, checks, correspondence, checks, and medical records with room to spare. We used a simple $49 all in one printer, scanner, fax machine, so saving data is not expensive these days.

Updated Software

Medical Billing software needs to be updated to include both ICD-9-CM and ICD-10. This is because with an October 1, 2013 proposed effective date, Claims for September 30th and before September 30th dates of service will still use ICD-9 Codes. Your software will need to be able to handle both code sets. If not, then you will need to replace all ICD-9 codes with ICD-10 codes. You will also need to add additional ICD-10 codes for the medical conditions that could not be coded under ICD-9. As you saw

above, some medical conditions may have ONE ICD-9 code but could have many under ICD-10, especially those codes that rely on anatomical areas. You want someone trusted to make your software changes to ICD-10 codes and you want to verify that their work is 100% true, accurate, and correct.

Updated Carrier Policies and Procedures

Providers who are contracted and have agreed to carrier coding policies should be reviewing these policies and to make sure the contracted carrier is ready to accept the new codes. You should find out if there are going to be any claims payment delays due to the changeover to ICD-10 as this may affect contract payment timeframes. While YOU may be ready, are they? Will your claims be bogged down by claims from doctors who are not ready? ABC Insurance Company may have a policy for a cardiac stress test. In that policy, there are diagnosis codes that support medical necessity. If Steve comes in for his annual cardiac stress test and the code under ABC's policy is R07.4 (chest pain), you want to ensure that Steve's medical record documents R07.4 so that you can comply with the coding requirement for the cardiac stress test. If you have code L21.0, you can bet the claim will be denied for medical necessity. Why? I don't think a diagnosis of dandruff supports a cardiac stress test, do you? Again, if you agreed to comply with an insurance policy, you want to make sure you have a copy of the updated policy to ensure compliance with that policy. Go to your local Medicare MAC and download their LCDs for the services you render. Go to your local Medicaid carrier to also download those policies that affect the medical care you provide. You don't want to find yourself behind the "8 ball" when the changeover takes place. Staying on top of these things will keep your practice revenue ongoing.

Updated Compliance Plans

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

Updated Coding Denial Appeals

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

Updated Superbills

If the practice is using a superbill that contains ICD-9 codes, these should be replaced with the appropriate ICD-10 code(s). Many superbills I've looked at have the correct

diagnosis identified by name, but the ICD-9 code is incorrect or outdated from the current ICD-9 code. On one, the diagnosis is identified as HIV. The code shown on the superbill is 042.59. HIV is 042 only. Under ICD-10, HIV is B20. It may take a few weeks to convert all your ICD-9 codes on a superbill then send it to your printing company for publishing. If you do this now, you won't be pressured into trying to get it done in a few days just to have it available on October 1, 2014.

FINANCE:

There are practices that are in excellent financial shape.

There are practices that can barely make it from day to day.

You have 10 months to work on a financial plan that can allow you to survive this change. While you may send a claim on October 1, it doesn't mean that the claim will be paid quickly. There may be delays. Insurance company's process billions of claims every day, so you can imagine what happens when millions of unprepared doctors are sending claims at the same time and those claims are slowing down the insurance company's processing time. While YOU may be ready, they might not. Their system may have a hiccup causing your claims to be pended while they request medical records from you.

Make sure you are financially secure until the system is in full force where you are getting payment within reasonable timeframes. You worked hard to make your practice successful, keep working to keeping it going. Not only do you depend on your claim revenue, so does your entire staff. Bills will continue to come in and they will still demand payment regardless if your claims are paid or not.

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

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

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

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

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

I can be reached at steve_verno@yahoo.com

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