ICD-10-CM
for Long Term Care

June 2015

Part II

Mental & Behavioral Disorders (F01 - F99)

- Note at beginning of chapter states includes psychological development
- Excludes2: symptoms, signs, and abnormal clinical laboratory findings, not elsewhere classified (R00 – R99)

- Need to be careful in this chapter as there are instructional notes throughout

Dementia

- Many of the dementia codes are also combined with another underlying problem.
- Before coding dementia, read all the notes at the beginning of the category and next to the main term.
- Read all of the includes and excludes notes

Dementias
Code first any neurological condition

Presenile dementia NOS	*F03.90*
Senile dementia NOS	*F03.90*

Dementia due to another condition

- The code F02.80 Dementia in other diseases classified elsewhere without behavioral disturbance or
- F02.81 Dementia in other diseases classified elsewhere with behavioral disturbance
  - requires the underlying condition to be coded first and requires the fifth character to identify whether there are behavioral disturbances
- Facilities should develop internal policy relating to behavior disturbance to ensure consistency

Dementia in other diseases classified elsewhere F02

Code first underlying physical condition:

Alzheimer's disease	*G30.-*
Picks	*G31.01*
Parkinson	*G20*
MS	*G35*
Epilepsy	*G40.-*

Excludes 1: Dementia with Parkinsonism (G31.83)

Altered mental state

- When a loss of consciousness or change in level of consciousness occurs without delirium, category R40.- should be considered.
  - somnolence (R40.0),
  - stupor (R40.1),
  - coma (R40.2-),
  - persistent vegetative state (R40.3),
  - transient alteration of awareness (R40.4).
- When the etiology or underlying cause is unknown, R41.82, Altered mental state, unspecified, is assigned.

Abuse and Dependence

- ICD-10 does not identify continuous or episodic use as was seen in ICD-9

CG C.5.b.2: When provide indicates abuse, dependence and/or use in same sentence, only one code is used

- If both use and abuse are documented, assign only the code for abuse
- If both abuse and dependence are documented, assign only the code for dependence
- If use, abuse, and dependence are all documented, assign only the code for dependence
- If both use and dependence are documented, assign only the code for dependence.

- When there is a history of drug dependence,
  - it is coded to "in remission."

Diseases of Nervous System

Dominant/Nondominant

- Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:
  - For ambidextrous patients, the default should be dominant.
  - If the left side is affected, the default is non-dominant.
  - If the right side is affected, the default is dominant

- categories G81, Hemiplegia and hemiparesis,
- Subcategories G83.1, Monoplegia of lower limb,
- Subcategories G83.2, Monoplegia of upper limb, Subcategories G83.3, Monoplegia, unspecified
- **Reference CG: C.6.1**

Dominant versus Non-dominant

	Hemiplegia on Left Side	**Hemiplegia on Right side**
Resident "eats" with left hand	Code as Left Dominant	Code as Right Non-Dominant
Resident "eats" with right hand	Code as Left Non-Dominant	Code as Right Dominant
Resident is identified as being "ambidexterous"	Code as Left Dominant	Code as Right Dominant
Documentation not available identifying which hand resident previously or currently eats with	Code as Left Non-Dominant	Code as Right Dominant

Epilepsy versus seizures

- A seizure occurring without an identified cause should be coded to R56.9, Unspecified Convulsion
- Note at beginning of category G40:

G40 Epilepsy and recurrent seizures
Note: the following terms are to be considered equivalent to intractable: pharmacoresistant (pharmacologically resistant), treatment resistant, refractory (medically) and poorly controlled

Glaucoma (H40.-)

- Assign as many codes as needed to fully identify resident's condition
- 7th character identifies stage
- Bilateral glaucoma, same type, same stage
  - Use bilateral glaucoma code if available
- Bilateral glaucoma, different type or stage
  - Use codes for appropriate eye, identifying stage and type for each

Example:
H40.2111 Acute angle closure glaucoma, right, mild stage
H40.2122 Acute angle closure glaucoma, left, moderate stage
H40.2131 Acute angle closure glaucoma, bilateral, mild stage

Bilateral Glaucoma	Classification Distinguishes Laterality	Classification Does Not Distinguish Laterality
Same type and stage	Assign one code for the type of glaucoma, bilateral, with the seventh character for the stage. *Example: Bilateral chronic angle-closure glaucoma, mild stage H40.2231*	Assign one code for the type of glaucoma with the seventh character for the stage. *Example: Bilateral open-angle glaucoma, mild stage H40.10x1*
Same type, but different stage	Assign codes for the type of glaucoma for each eye, with the seventh character for the specific stage rather than the code for bilateral glaucoma. *Example: Bilateral chronic angle-closure glaucoma, mild stage right eye, moderate stage left eye H40.2211 + H40.2222*	Assign codes for the type of glaucoma for each eye, with seventh character for the specific stage. *Example: Bilateral open-angle glaucoma, mild stage right eye, moderate stage left eye H40.10x1 + H40.10x2*
Different type, but same stage	Assign appropriate code for each eye rather than the code for bilateral glaucoma. *Example: Chronic-angle closure glaucoma, mild stage left eye, low tension open-angle glaucoma, mild stage right eye H40.2221 + H40.1211*	Assign codes for the specific type of glaucoma for each eye with the seventh character for the stage. *Example: Open-angle glaucoma, mild stage right eye, primary angle-closure glaucoma, mild stage left eye H40.10x1 + H40.20x1*

Acute Myocardial Infarction (AMI)

I21 ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction

Includes: cardiac infarction
coronary (artery) embolism
coronary (artery) occlusion
coronary (artery) rupture
coronary (artery) thrombosis
infarction of heart, myocardium, or ventricle
myocardial infarction specified as acute or with a stated duration of 4 weeks (28 days) or less from onset

Use additional code, if applicable, to identify:
exposure to environmental tobacco smoke (Z77.22)
history of tobacco use (Z87.891)
occupational exposure to environmental tobacco smoke (Z57.31)
status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility (Z92.82)

tobacco dependence (F17.-)
tobacco use (Z72.0)

Use additional code, if known, to identify:
body mass index (BMI) (Z68.-)

Excludes2: old myocardial infarction (I25.2)
postmyocardial infarction syndrome (I24.1)
subsequent myocardial infarction (I22.-)

Acute Myocardial Infarction

- Acute myocardial infarction (AMI) with a duration of 4 weeks or less is classified to category I21:
  - ST elevation (STEMI); or
  - Non-ST elevation (NSTEMI).
  - 4th character indicates wall involved (e.g., anterolateral or inferior wall).
- Codes I21.0- through I21.2- provide a 5th character to describe the coronary artery involved (e.g., left main coronary artery).
- Codes I21.0-I21.3- identify transmural infarctions.
- Code I21.4- describes subendocardial infarction (not involving full-thickness of myocardium).

- Assign code I21.3, ST elevation (STEMI) myocardial infarction of unspecified site, if site or ST-elevation or non- ST-elevation is not documented.

Acute Myocardial Infarction, continued

- If a patient suffers a new AMI within 4 weeks of an initial AMI, assign category I22 with category I21
- Continue to use I21 codes from the onset of the AMI up to 4 weeks duration when the patient requires continued care:
  - Including patients who are transferred from the acute care setting to the post-acute setting within the 4 week timeframe.
- After the 4 weeks duration, assign an aftercare code to describe continued care.
- If MI is healed or old, assign history code I25.2 for old MI not requiring further care.

Other Acute and Subacute Ischemic Heart Disease

- Unstable angina (I20.0) includes:
  - Accelerated angina
  - Crescendo angina
  - De novo effort angina
  - Preinfarction angina
  - Intermediate coronary syndrome
  - Preinfarction angina, and
  - Worsening effort angina.
- Code I20.0 only when the underlying condition has not been identified and there is no surgical intervention.
- Use combination code I25.110 if the patient presents has CAD and unstable angina and previously had CABG

Chronic Ischemic Heart Disease and Atherosclerosis

- Category I25, Chronic heart disease, includes:
  - Coronary atherosclerosis,
  - Coronary dissection,
  - Chronic coronary insufficiency,
  - Myocardial ischemia,
  - Aneurysm of heart, and
  - Old MI.
- Code I25.1-, Atherosclerotic heart disease includes:
  - Arteriosclerotic cardiovascular heart disease,
  - Coronary artery atheroma,
  - Coronary artery disease, and
  - Coronary artery sclerosis,
- Subcategories I25.11 and I25.7- contain combination codes that describe atherosclerotic heart disease with angina pectoris.
  - Do not code angina pectoris separately
  - I25.1- is for native coronary arteries while I25.7- is for bypass grafts with 5th character describing type of graft

Heart Failure (I50.-)

- Two main categories of heart failure:
  - Systolic heart failure (I50.2-)
  - Diastolic heart failure (I50.3-)

I50 Heart failure
Code first: heart failure complicating abortion or ectopic or molar pregnancy (O00-O07, O08.8)
heart failure following surgery (I97.13-)
heart failure due to hypertension (I11.0)
heart failure due to hypertension with chronic kidney disease (I13.-)

Heart Failure (I50.-)

- Congestive heart failure is included in codes for systolic and diastolic heart failure.
- Code I50.9 is assigned for heart failure unspecified, including congestive heart failure NOS.

I50.2 Systolic (congestive) heart failure
Excludes1: combined systolic (congestive) and diastolic (congestive) heart failure (I50.4-)
I50.20 Unspecified systolic (congestive) heart failure
I50.21 Acute systolic (congestive) heart failure
I50.22 Chronic systolic (congestive) heart failure
I50.23 Acute on chronic systolic (congestive) heart failure
I50.3 Diastolic (congestive) heart failure
Excludes1: combined systolic (congestive) and diastolic (congestive) heart failure (I50.4-)
I50.30 Unspecified diastolic (congestive) heart failure
I50.31 Acute diastolic (congestive) heart failure
I50.32 Chronic diastolic (congestive) heart failure
I50.33 Acute on chronic diastolic (congestive) heart failure

Hypertensive Heart Failure c/ Congestive Failure & Chronic Kidney Disease

- Category I11 classifies hypertensive heart disease with/without heart failure:
  - Assign also a code from category I50 to describe the type of heart failure (if present).
- When chronic kidney disease (N18-) or contracted kidney (N26-) due to hypertension or arteriosclerosis of kidney is present, assign a code from category I12, Hypertensive chronic kidney disease:
  - Assign also code N18.1-N18.4, N18.5, N18.6, or N18.9 to describe stage of chronic kidney disease.

Aneurysm

- Aneurysms are classified according to location:
  - Aneurysm of coronary vessels (I25.41)
  - Dissecting aneurysm of abdominal aorta (I71.02)
  - Ruptured aneurysm of thoracic artery (I71.1)
  - Aneurysm of thoracic artery (I71.2)
  - Aneurysm of abdominal aorta with rupture (I71.3)
  - Thoracoabdominal aneurysm (I71.6)
  - Berry aneurysm (I67.1)
  - Syphilitic aneurysm of aorta (A52.01)
  - Traumatic aneurysm (S25.00-, S25.20-)

Cerebrovascular Disorders

- Acute organic (non-traumatic) conditions affecting the cerebral arteries:
  - Codes in categories I60-I68 classify *cerebral hemorrhage, occlusion, and thrombosis.*
- Category I63 describes cerebral infarction due to occlusion or stenosis of cerebral or precerebral arteries:
  - 6th characters identify the specific artery.
- Assign category I65 or I66 for occlusion or stenosis of cerebral or precerebral arteries without cerebral infarction:
  - 5th characters in subcategories I65.0, I65.2, I66.0, I66.1, and I66.2 indicate laterality (i.e., right, left or bilateral, or unspecified arteries).
- Z86.73 = history of TIA and cerebral infarction without residual deficits

- Screenshots from tabular list on next page…….

Cerebrovascular diseases (I60-I69)

Use additional code to identify presence of:
alcohol abuse and dependence (F10.-)
exposure to environmental tobacco smoke (Z77.22)
history of tobacco use (Z87.891)
hypertension (I10-I15)
occupational exposure to environmental tobacco smoke (Z57.31)
tobacco dependence (F17.-)
tobacco use (Z72.0)

Excludes1: transient cerebral ischemic attacks and related syndromes (G45.-)
traumatic intracranial hemorrhage (S06.-)

I63 Cerebral infarction

Includes: occlusion and stenosis of cerebral and precerebral arteries, resulting in cerebral infarction

Use additional code, if applicable, to identify status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility (Z92.82)

Excludes1: sequelae of cerebral infarction (I69.3-)

I63.0 Cerebral infarction due to thrombosis of precerebral arteries
- **I63.00 Cerebral infarction due to thrombosis of unspecified precerebral artery**
  - **I63.01 Cerebral infarction due to thrombosis of vertebral artery**
    - **I63.011 Cerebral infarction due to thrombosis of right vertebral artery**
    - **I63.012 Cerebral infarction due to thrombosis of left vertebral artery**
    - **I63.019 Cerebral infarction due to thrombosis of unspecified vertebral artery**
- **I63.02 Cerebral infarction due to thrombosis of basilar artery**
  - **I63.03 Cerebral infarction due to thrombosis of carotid artery**
    - **I63.031 Cerebral infarction due to thrombosis of right carotid artery**
    - **I63.032 Cerebral infarction due to thrombosis of left carotid artery**

I65 Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction

Includes: embolism of precerebral artery
narrowing of precerebral artery
obstruction (complete) (partial) of precerebral artery
thrombosis of precerebral artery

Excludes1: insufficiency, NOS, of precerebral artery (G45.-)
insufficiency of precerebral arteries causing cerebral infarction (I63.0-I63.2)

I65.0 Occlusion and stenosis of vertebral artery
- **I65.01 Occlusion and stenosis of right vertebral artery**
- **I65.02 Occlusion and stenosis of left vertebral artery**
- **I65.03 Occlusion and stenosis of bilateral vertebral arteries**
- **I65.09 Occlusion and stenosis of unspecified vertebral artery**

I65.1 Occlusion and stenosis of basilar artery

I65.2 Occlusion and stenosis of carotid artery
- **I65.21 Occlusion and stenosis of right carotid artery**
- **I65.22 Occlusion and stenosis of left carotid artery**
- **I65.23 Occlusion and stenosis of bilateral carotid arteries**
- **I65.29 Occlusion and stenosis of unspecified carotid artery**

I65.8 Occlusion and stenosis of other precerebral arteries

I65.9 Occlusion and stenosis of unspecified precerebral artery

Occlusion and stenosis of precerebral artery NOS

Sequelae of Cerebrovascular Disease

- Codes from category I69, Sequelae of cerebrovascular disease, allow for the specificity in coding residual effects of cerebrovascular disease.
  - ICD-10 removes the definitive time frame for a condition to be considered a late effect of a condition
- Category I69 provides instructional notes to assign additional codes to identify:
  - Type of paralytic syndrome;
  - Type of dysphagia; or
  - Other sequelae of cerebrovascular disease:
    - 4th characters indicate the causal condition.
- 5th characters provide information about neurological deficit. Neurological deficits such as hemiplegia and aphasia due to cerebrovascular accidents can be present at the onset:
  - Can be transient and resolve by discharge; If resolved by discharge, deficits are still coded.
  - Residual effects still present at discharge are not coded as late effects.

I69 Sequelae of cerebrovascular disease

Note: Category I69 is to be used to indicate conditions in I60-I67 as the cause of sequelae. The "sequelae" include conditions specified as such or as residuals which may occur at any time after the onset of the causal condition

Excludes1: personal history of cerebral infarction without residual deficit (Z86.73)
personal history of prolonged reversible ischemic neurologic deficit (PRIND) (Z86.73)
personal history of reversible ischemic neurologcial deficit (RIND) (Z86.73)
sequelae of traumatic intracranial injury (S06.-)
transient ischemic attack (TIA) (G45.9)

I69.0 Sequelae of nontraumatic subarachnoid hemorrhage
- **I69.00 Unspecified sequelae of nontraumatic subarachnoid hemorrhage**
- **I69.01 Cognitive deficits following nontraumatic subarachnoid hemorrhage**
- **I69.02 Speech and language deficits following nontraumatic subarachnoid hemorrhage**
  - **I69.020 Aphasia following nontraumatic subarachnoid hemorrhage**
  - **I69.021 Dysphasia following nontraumatic subarachnoid hemorrhage**
  - **I69.022 Dysarthria following nontraumatic subarachnoid hemorrhage**
  - **I69.023 Fluency disorder following nontraumatic subarachnoid hemorrhage**
    Stuttering following nontraumatic subarachnoid hemorrhage

Hypertension (I10)

- Hypertension described as accelerated, benign, essential, idiopathic, malignant, or systemic is assigned to code I10, Essential (primary) hypertension.
  - Whether hypertension is controlled or uncontrolled does not affect code assignment.
- Secondary hypertension (category I15) is caused by other primary disease and requires two codes.
  - Report the underlying cause first, followed by hypertension code.
- Transient hypertension is assigned code R03.0:
  - Unless the patient has an established diagnosis of hypertension.

Hypertensive Heart Disease

- Category I11 classifies hypertensive heart disease, including:
  - Cardiomegaly;
  - Cardiovascular disease;
  - Myocarditis; and
  - Degeneration of the myocardium.
- Causal relationship between hypertension and heart *disease must be documented.*
  - If no relationship is documented, assign separate codes.

Hypertension and Chronic Kidney Disease

- ICD-10-CM assumes a causal relationship between hypertension and chronic kidney disease.
- Category I12, Hypertensive chronic kidney disease:
  - 4th character indicates stage of chronic kidney disease.
- Assign the appropriate code from category I12 with a code from category N18 to identify the stage of chronic kidney disease.
- Category I12 does not include acute kidney failure.

I12 Hypertensive chronic kidney disease

Includes: any condition in N18.- due to hypertension
arteriosclerosis of kidney
arteriosclerotic nephritis (chronic) (interstitial)
hypertensive nephropathy
nephrosclerosis

Excludes1: hypertension due to kidney disease (I15.0, I15.1)
renovascular hypertension (I15.0)
secondary hypertension (I15.-)

Excludes2: acute kidney failure (N17.-)

I12.0 Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease

Use additional code to identify the stage of chronic kidney disease (N18.5, N18.6)

I12.9 Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease

Hypertensive chronic kidney disease NOS

Hypertensive renal disease NOS

Use additional code to identify the stage of chronic kidney disease (N18.1-N18.4, N18.9)

Hypertensive Heart and Chronic Kidney Disease

- Category I13 classifies hypertensive heart and chronic kidney disease:
  - Combination codes include hypertension, heart disease, and kidney disease.
  - Inclusion note at category I13 indicates conditions classified to categories I11-I12 included in category I13.
  - 4th and 5th characters indicate with/without heart failure, and stage of chronic kidney disease.
  - Also assign category I50 to describe type of heart failure.
  - Assign category N18- for stage of chronic kidney disease.
- If acute and chronic renal failure present, code both.

I13 Hypertensive heart and chronic kidney disease
Includes: any condition in I11.- with any condition in I12.-
cardiorenal disease
cardiovascular renal disease

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I13.0 Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
Use additional code to identify type of heart failure (I50.-)
Use additional code to identify stage of chronic kidney disease (N18.1-N18.4, N18.9)
I13.1 Hypertensive heart and chronic kidney disease without heart failure
I13.10 Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic

Hypertension with Other Conditions

- ICD-10-CM does not provide combination codes when hypertension is associated with other conditions that accelerate its development (e.g., cerebrovascular disease).

- Hypertensive cerebrovascular disease (I60-I69):
  - Assign first the appropriate code from categories I60-I69, followed by the appropriate hypertension code I10-I15.
- Hypertensive retinopathy:
  - Assign subcategory H35.0 with appropriate code from categories I10-I15.
  - Sequencing depends on the reason for the encounter.

Elevated Blood Pressure versus Hypertension

- Blood pressure readings can vary:
  - Diagnosis of hypertension is based on a series of readings, rather than a single reading.
- Assign code R03.0 for elevated blood pressure without hypertension.

Respiratory System

- When a respiratory condition is described as occurring in more than one site, and is not specifically indexed *(listed in the alphabetical index as a subterm)*, it should be classified to the lower anatomical site (eg: tracheobronchitis to bronchitis)
- Code also, where applicable:
  - Exposure to tobacco smoke
  - Exposure to tobacco smoke in perinatal period
  - History of tobacco use
  - Occupational exposure to environmental tobacco smoke
  - Tobacco dependence
  - Tobacco use

Asthma Coding Notes

- Wheezing alone is not considered asthma
- Never assume presence of status asthmaticus without a specific statement from the physician.
  - Status asthmaticus means no relieved or managed by treatments
- When there is documentation of both acute exacerbation and status asthmaticus, only the code with the final character of 2 should be assigned.
  - Example: Acute atopic asthma, status asthmaticus
- **Reference: C.10.a.1**

Coding Guidelines for Respiratory Failure

C.10.b.1: Acute Respiratory Failure as principal diagnosis

•A code from subcategory J96.0, Acute respiratory failure, or subcategory 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.

C.10.b.2: 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.

Coding Guidelines for Respiratory Failure

C.10.b.3: 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 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

C.10.c: Influenza due to certain identified influenza viruses

•Code only confirmed cases of influenza due to certain identified influenza viruses (category J09), and due to other identified influenza virus (category J10). 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 other novel influenza A or other identified influenza virus. However, coding should be based on the provider's diagnostic statement that the patient has avian influenza, or other novel influenza A, for category J09, or has another particular identified strain of influenza, such as H1N1 or H3N2, but not identified as novel or variant, for category J10.

•If the provider records "suspected" or "possible" or "probable" avian influenza, or novel influenza, or other identified influenza, then the appropriate influenza code from category J11, Influenza due to unidentified influenza virus, should be assigned. A code from category J09, Influenza due to certain identified influenza viruses, should not be assigned nor should a code from category J10, Influenza due to other identified influenza virus.

Influenza in non-Inpatient setting

- J11.- (influenza due to unidentified influenza virus) should not be used in an outpatient or long term care setting
- If culture is ordered, do **not** code suspected or probable influenza
  - Code the presenting symptoms as the reason for the test

Tracheostomy Complications—Subcategory J95.0

- Classified to subcategory J95.0 in chapter 10 of ICD-10-CM.
- Infection of a tracheostomy is classified to code J95.02, with an additional code to identify the type of infection and/or a code from category B95-B97 to identify the organism, or sepsis, A40.-, A41.-.
- Mechanical complications are coded to J95.03.
- Other complications, such as:
  - Hemorrhage of tracheostomy, which is coded to J95.01.
  - Trachea-esophageal fistula following tracheostomy, which is coded to J95.04.

- Alphabetical index: Complications, tracheostomy

Caution Notes for Respiratory System:

- Do not assume a respiratory infection or condition from a laboratory or radiology report without physician concurrence.
- However, infection may be assigned without laboratory evidence when supported by clinical documentation.

- Ventilator-associated pneumonia must have correlation documented by physician. **Cannot** code just because patient has pneumonia and is on a ventilator.
  - Note there are specific coding guidelines for Ventilator-associated pneumonia **(ref: C. 10.d.1)**
- Code J98.11, Atelectasis, should not be assigned on the basis of an x-ray finding alone; it should be coded only when the physician identifies it as a clinical condition that meets the criteria for a reportable diagnosis.

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Part III

Skin & Subcutaneous Disorders (L00-L99)

- Need to look for instructional notes, Excludes1 and Excludes2
- Many notes stating to code also infectious agent (B95-B97)

Coding Guidelines: Pressure Ulcer Stage Codes

C.12.a.1) 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

C.12.a.2) 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).

C.12.a.3) 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 Alphabetic Index. For clinical terms describing the stage that are not found in the Alphabetic Index, and there is no documentation of the stage, the provider should be queried.

C.12.a.4) Patients admitted with pressure ulcers documented as healed
No code is assigned if the documentation states that the pressure ulcer is completely healed.

C.12.a.5) 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.

C.12.a.6) 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.

Make sure your codes represent the fact you do know your residents!

dermis, unspecified hip

L89.203 Pressure ulcer of unspecified hip, stage III
Healing pressure ulcer of unspecified hip, stage III
Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue, unspecified hip

L89.204 Pressure ulcer of unspecified hip, stage IV
Healing pressure ulcer of unspecified hip, stage IV
Pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon, or bone, unspecified hip

L89.209 Pressure ulcer of unspecified hip, unspecified stage
Healing pressure ulcer of unspecified hip NOS
Healing pressure ulcer of unspecified hip, unspecified stage

L89.21 Pressure ulcer of right hip

L89.210 Pressure ulcer of right hip, unstageable

L89.211 Pressure ulcer of right hip, stage I
Healing pressure ulcer of right hip back, stage I
Pressure pre-ulcer skin changes limited to persistent focal edema, right hip

L89.212 Pressure ulcer of right hip, stage II
Healing pressure ulcer of right hip, stage II
Pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis, right hip

L89.213 Pressure ulcer of right hip, stage III
Healing pressure ulcer of right hip, stage III
Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue, right hip

L89.214 Pressure ulcer of right hip, stage IV

focal edema, left hip

L89.222 Pressure ulcer of left hip, stage II
Healing pressure ulcer of left hip, stage II
Pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis, left hip

L89.223 Pressure ulcer of left hip, stage III
Healing pressure ulcer of left hip, stage III
Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue, left hip

L89.224 Pressure ulcer of left hip, stage IV
Healing pressure ulcer of left hip, stage IV
Pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon, or bone, left hip

L89.229 Pressure ulcer of left hip, unspecified stage
Healing pressure ulcer of left hip NOS
Healing pressure ulcer of left hip, unspecified stage

L89.3 Pressure ulcer of buttock

L89.30 Pressure ulcer of unspecified buttock

L89.300 Pressure ulcer of unspecified buttock, unstageable

L89.301 Pressure ulcer of unspecified buttock, stage I
Healing pressure ulcer of unspecified buttock, stage I
Pressure pre-ulcer skin changes limited to persistent focal edema, unspecified buttock

L89.302 Pressure ulcer of unspecified buttock, stage II
Healing pressure ulcer of unspecified buttock, stage II

Coding Caution Notes – Pressure Ulcers

- Assign code I96.- if gangrene is present with ulceration.
- The code assignment for the pressure ulcer stage may be based on nursing documentation **once** the physician has documented the presence of the pressure ulcer of the site.
- Recommend facility-specific internal coding policy confirming use of nursing documentation and specific form

Coding Caution Notes - Dermatitis

- Dermatitis and ecxzema are used synonymously and interchangeably

- For many skin conditions, it is important to determine if it is due to an adverse effect of a medication or due to a poisoning.
- If dermatitis is a poisoning (due to incorrect use of the drug):
  - Assign the category T36-T65 code first.
    - T36.0x1A + L27.0, Initial encounter for dermatitis due to accidental ingestion of mother's penicillin tablets
- If dermatitis is an adverse effect (due to proper administration of a drug):
  - Assign category T36-T65 as an additional code.
    - L27.0 + T36.0x5A, Initial encounter for dermatitis due to penicillin tablets taken as prescribed

Musculoskeletal disorders

CG C.13.a: Site and laterality

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

I.C.13.a.(1) 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

I.C.13.b

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 and 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.

Musculoskeletal conditions

- Placeholders in use!
- Laterality codes in use!
- Several codes contain letters in the category code
  - M1a. – Idiopathic gouty arthritis

Pathological Fractures

- Pathological fractures due to osteoporosis are coded to **M80.-**, while traumatic fracture are coded in Chapter 19 under injuries, by site.
- Care must be used to ensure you are in the appropriate section.
  - I often suggest to my students to highlight the terms Pathological and Traumatic in their Alphabetical Index to make sure they code from the correct term.
- A seventh character is required when coding pathological or stress-related fractures
- Never code traumatic fracture with a pathological fracture of the same bone.

Osteoporosis

I.C.13.d

Osteoporosis is a systemic condition, meaning all bones of the musculoskeletal system are affected. Therefore, site is not a component of the codes under category M81, Osteoporosis without current pathological fracture.

The site codes under category M80, Osteoporosis with current pathological fracture, identify the site of the fracture, not the osteoporosis

Osteoporosis without pathological fracture

I.C.13.d.(1)

Category M81, Osteoporosis without current pathological fracture, is for use for patients with osteoporosis who do not currently have a pathological fracture due to the osteoporosis, even if they have had a fracture in the past.

For patients with a history of osteoporosis fractures, status code Z87.310, Personal history of (healed) osteoporosis fracture should follow the code from M81.

Pathological Fractures

I.C.13.c.

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 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 code.

Arthritis (M19.-)

- In ICD-10, arthritis and osteoarthritis are the same code
- Need to review all subterms under arthritis to ensure appropriate coding
- Primary axis
  - Site—whether it involves multiple sites (M15.-, Osteoarthritis) or single joints.
- Verification of the arthritis code in the Tabular Listing is necessary for correct fifth and sixth character assignment.

Gait Abnormality (R26.-)

- Has been expanded to include:
  - Ataxia R26.0
  - Falling R29.6
  - Paralytic R26.1
  - Spastic R26.1
  - Staggering R26.0
  - Unsteadiness R26.81
  - Walking Difficulty R26.2

Congenital Anomalies

- Codes from Chapter 17 can be used throughout the life of the patient and may need continued care after admission to a long-term care facility.
- If a congenital malformation or deformity has been corrected, a personal history code should be used to identify the history of the malformation or deformity.
- Whenever the condition is diagnosed by the physician, it is appropriate to assign a code from codes Q00- Q99.

Coding Injuries

- Two axes for coding injuries:
  - Anatomical site
  - Type of injury
- Important to review instructional notes:
  - Instructional notes (i.e., inclusion and exclusion notes) are used extensively in chapter 19.
  - These notes assist in correct code assignment.
  - Many sections also contain Excludes 1 and Excludes 2 notes

- 7th Character value
  - If a seventh character is required, and the code is not six characters:
    - a placeholder "x" must be used to fill in empty spaces.
  - Most categories in this chapter have three 7th character values (with the exception of fractures): A, initial encounter, D, subsequent encounter and S, sequela

C.19.a Application of 7th Characters in Chapter 19

•7th character "A", initial encounter is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

•7th character "D" subsequent encounter is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Examples of subsequent care are: cast change or removal, removal of external or internal fixation device, medication adjustment, **other aftercare and follow up visits following treatment of the injury or condition.**

C.19.a Application of 7th Characters in Chapter 19

•The aftercare Z codes should not be used for aftercare for conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care.

- •For example, for aftercare of an injury, assign the acute injury code with the 7th character "D" (subsequent encounter).

•7th character "S", sequela, is for use for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. The scars are sequelae of the burn. When using 7th character "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 7th character "S" identifies the injury responsible for the sequela.
- •The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code.

C.19.b.**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. Code T07, Unspecified multiple injuries should not be assigned in the inpatient setting unless information for a more specific code is not available.

•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.

C.19.c 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 ICD-10-CM Official Guidelines for Coding and Reporting **2015** Page 67 of 115

•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.

C.19.c.1 Initial vs. Subsequent Encounter for Fractures

•Traumatic fractures are coded using the appropriate 7th character 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. The appropriate 7th character for initial encounter should also be assigned for a patient who delayed seeking treatment for the fracture or nonunion.

•Fractures are coded using the appropriate 7th character 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.

C.19.c.1 Initial vs. Subsequent Encounter for Fractures , continued

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

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

•*See Section I.C.13. Osteoporosis.*

•The aftercare Z codes should not be used for aftercare for traumatic fractures. For aftercare of a traumatic fracture, assign the acute fracture code with the appropriate 7th character.

Fracture Coding Notes

- Multiple fractures of the same bone(s) classified with *different* fourth- or fifth-character subdivisions (bone part) within the same three-digit category are coded individually by site.

Example: Comminuted fracture of the shaft of the right humerus with nondisplaced closed fracture-dislocation of right shoulder involving the greater tuberosity is coded as

- S42.301A, Unspecified fracture of shaft of humerus, right arm, initial encounter for closed fracture, and
- S42.254A, Nondisplaced fracture of greater tuberosity of right humerus, initial encounter for closed fracture.

Aftercare for Fractures

- Aftercare for traumatic fractures is coded to the acute fracture with the appropriate seventh-character value for subsequent care.
- The aftercare Z codes should not be used for aftercare of injuries.
- Instead, the acute injury code is assigned with the appropriate seventh-character value for subsequent encounter.

Skull Fractures and Intracranial Injuries

- Any associated intracranial injury is coded separately from category S06.
- If intracranial injury involves open wound of head (S01-) or fracture of skull (S02-), they are coded separately. Intracranial injuries require additional characters describing:
  - Loss of consciousness
  - Duration of unconscious state
  - Return to preexisting level of consciousness
  - Loss of consciousness with death, regardless of duration
- Review the medical record (e.g., emergency department record and/or admitting note) to obtain this information.

Orthopedic Aftercare

- Report Z codes for admissions or encounters for other (non-fracture related) orthopedic aftercare:
  - Z47.1 Aftercare following joint replacement surgery
  - Z47.2 Encounter for removal of internal fixation device
  - Z47.81 Encounter for orthopedic aftercare following surgical amputation
  - Z47.82 Encounter for orthopedic aftercare following scoliosis surgery
  - Z47.89 Encounter for other orthopedic aftercare

External Cause of Morbidity

- External cause of morbidity codes (categories V01-Y99) are reported with injury codes.
- External cause codes capture:
  - Cause (how an injury occurred)
  - Intent (accidental or intentional, e.g., suicide or assault)
  - Person's status (e.g., civilian, military, etc.)
  - Place where the injury occurred
- Activity codes (category Y93) describe the activity of a person seeking care for injuries and health conditions:
  - When the injury or other health condition resulted from the activity; or
  - When the activity contributed to the injury or health condition.
- Codes for poisoning, adverse effect, and underdosing (categories T36-T50) and for toxic effects of substances chiefly nonmedicinal as to source (categories T51-T65) include information on the cause and intent.
  - No external cause code from chapter 20 is needed for these codes.

External Cause of Injury

- Reporting of External cause is *optional* unless mandated by state or insurance carrier regulation.
  - Recommend facility-specific internal coding policy to ensure consistency in use
- Selection of External cause codes is guided by the Index to External Causes of Injury.
- Coding Guidelines contain a hierarchal reporting structure
- If number of External cause codes is limited by reporting format:
  - Report the code for the cause/intent most related to the principal diagnosis.
- If format permits capture of additional External cause codes:
  - Report the cause/intent of the additional events rather than the codes for place, activity, or external status.
- If two or more events cause separate injuries:
  - Assign an External cause code for each injury.

Burns

- Assign categories T20-T32 for current burns:
- Code non-healing burns and necrosis of burned skin as acute current burns.
  - T20-T28 (seventh character A for initial encounter or D for subsequent encounter)
- Code sequelae of burns (e.g., scarring or contracture) as sequela.
  - T20-T28 (seventh character S for sequela)
- When coding burns, assign separate codes for each burn site.

Sequencing of Burns

- Burns of the ***same*** site at the third-character category level (T20-T28), but of different degrees (depth), are classified according to the highest degree.
  - Third-degree burn takes precedence over a second-degree burn.
  - Second-degree burn takes precedence over a first-degree burn.
    - Example: First-degree and second-degree burns of the leg are coded to T24.209-, Burn of second degree of unspecified site of unspecified lower limb, except ankle and foot. Do not assign a code for the first-degree burn.
  - Report fifth character 0 for less than 10 percent body surface or no body surface involved in the third-degree burn.
- When coding multiple burns from different catetories (sites), code first the highest-degree burn (most severe).
- Burns use “rule of nine” for assigning extent

Poisoning and Adverse Effects

- Conditions due to drugs and medicinal and biological substances are classified to T36-T50.
- There are combination codes that specify both the responsible substance and whether it is a poisoning (including the intent, e.g., accidental), an adverse effect, or an underdosing, with the fifth or sixth character used to specify the following:
  - 1 Poisoning, accidental (unintentional)
  - 2 Poisoning, intentional self-harm
  - 3 Poisoning, assault
  - 4 Poisoning, undetermined
  - 5 Adverse effect
  - 6 Underdosing

Poisoning and Adverse Effects, con't

- Important to understand the distinctions between the different definitions:
- Adverse effect of correct substance properly administered
  - Code the nature of the adverse effect first
- Poisoning
  - Prescribed incorrectly
  - Overdose of substance (includes larger dose than prescribed)
  - Wrong substance given or taken in error/incorrectly
  - Synergistic effect with non-prescription and prescription medication
  - Interaction with alcohol
- Underdosing by (inadvertently) (deliberately) taking less substance than prescribed or instructed

Circulatory Status Z Codes

- Circulatory status Z codes indicate circulatory-related health status as follows:
  - Heart valve transplant (Z94.1)
  - Presence of cardiac pacemaker (Z95.0)
  - Aortocoronary bypass status (Z95.1)
  - Presence of prosthetic heart valve (Z95.2)
  - Presence of xenogenic heart valve (Z95.3)
  - Presence of other heart-valve replacement (Z95.4)
  - Presence of coronary angioplasty implant and graft (Z95.5)
  - Presence of other cardiac and vascular implants and grafts (Z95.8)
  - Presence of automatic (implantable) cardiac defibrillator (Z95.810)
  - Presence of other cardiac and vascular implants and grafts (Z95.811)
  - Presence of fully implantable artificial heart (Z95.812)
  - Presence of other cardiac implants and grafts (Z95.818)
  - Peripheral vascular angioplasty status with implants and grafts (Z95.820)
  - Presence of other vascular implants and grafts (Z95.828)
- Report these codes when status affects patient care:
  - Status Z codes assigned as an additional code only.

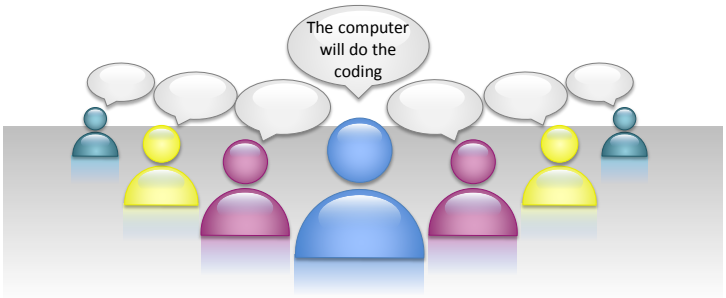
Miscellaneous Z-Codes

- Recommend facility-specific coding policies to indicate when and if the following codes will be used:
  - Do not resuscitate status (Z66)
  - Carrier of infectious diseases (Z22.-)
  - Personal history of neoplasm (Z85.-)
  - Long-term (current) drug use (Z79.-)
  - Acquired absence of limb (Z89.-)
  - Acquired absence of organ (Z90.-)
  - History of falling (Z79.81)
  - Artificial opening status (Z93.-)

Miscellaneous Z-Codes (cont.)

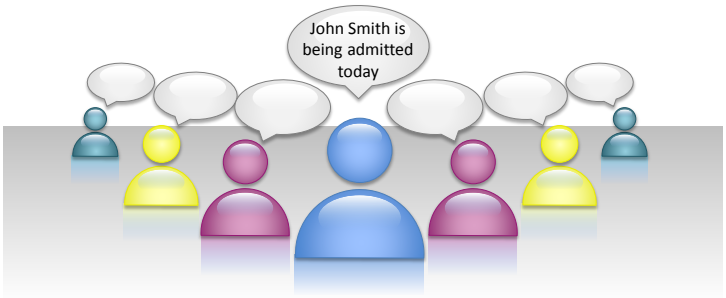
- Recommend facility-specific coding policies to indicate when and if the following codes will be used:
  - Transplanted organ and tissue status (Z94.-)
  - Presence of cardiac and vascular implants (Z95.-)
  - Presence of other functional implants (Z96.-)
  - Presence of other devices (Z97.-)

Who has heard this before?



- *"We do not need to train our coders"*
- *"Our software vendor says the system will do it automatically"*

Who has heard this before?



- **"We do not need to train our coders"**
- **"The hospital has already coded the record, we can use those codes"**

What do we say then?

- ***This has been seen before…. Many times…..***
- *The additional number of codes, fields and characters used by ICD-10 coding schemes allow for significantly more granularity and a wider variety of codes.*
- ***•ICD-9-CM Total codes = 24,000***
- ***•ICD-10-CM/PCS codes = 155,000***
  - ICD-10-CM: **68,000 unique codes**
  - ICD-10-PCS: **87,000 unique codes**

GEMS Coding

- Care needs to be used when utilizing ICD-9 to ICD-10 crosswalks.
- GEMS was developed to build correlation between codes; NOT to facilitate coding
- The GEMS attempts to identify a cross-reference by linking one code to many possible alternative codes
- Need to understand the difference in the codes to be able to reconcile the differences

Example: Hemiplegia

- In ICD-10, Dominance and side affected are key to code assignment
- ICD-9-CM: 342.91: Hemiplegia, unspecified, affecting dominant side
  - G81.90: Hemiplegia, unspecified affecting unspecified side
  - G81.91: Hemiplegia, unspecified affecting right dominant side
  - G81.92: Hemiplegia, unspecified affecting left dominant side
  - G81.93: Hemiplegia, unspecified affecting right nondominant side
  - G81.94: Hemiplegia, unspecified affecting left nondominant side

Documentation Challenges

- Does current documentation contain enough information to correctly and fully code condition?
  - Acute Myocardial Infarction – date identified to determine if within 4 months?
  - CVA – infarction, hemorrhage, thrombosis?
  - Infections – identify organism?

Questions?

References

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http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html

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http://www.roadto10.org
http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html