# Table of Contents

ICD-10-CM Coding Fundamental ........................................................................................................... 5
  Crosswalk............................................................................................................................................ 5
About Some Features and Convention/Guidelines in ICD-10-CM .............................................................. 6
Similarities to ICD-9CM ....................................................................................................................... 8
What is Medicare Risk Adjustment (MRA)? ......................................................................................... 8
ICD-10-CM and Risk Adjustment .......................................................................................................... 9
Physician data process and Risk Adjustment ....................................................................................... 9
Risk Adjustment Data Validation (RADV) ............................................................................................ 9
Documentation and MRA ....................................................................................................................... 10
ICD-10-CM: Impact on coding and documentation ............................................................................. 10
Provider signature requirements on the progress note ......................................................................... 10
Best Practices and Documentation ...................................................................................................... 11
Standards of Ethical Coder ................................................................................................................ 12
Steps to Correct Coding ..................................................................................................................... 13
Type of Codes ..................................................................................................................................... 13
Coding Diseases in ICD-10-CM .......................................................................................................... 14
Diabetes Mellitus .................................................................................................................................. 15
  Manifestations Grid ........................................................................................................................... 15
Morbid Obesity ..................................................................................................................................... 16
Low BMI .............................................................................................................................................. 16
Chronic Kidney Disease (N18) ............................................................................................................. 17
  Classification ..................................................................................................................................... 17
  CKD and Diabetes Mellitus ............................................................................................................... 18
  Anemia .............................................................................................................................................. 18
  CKD and Kidney Transplant ........................................................................................................... 18
  CKD and Hypertension .................................................................................................................... 18
  CKD Coding Examples ................................................................................................................... 19
Diseases of the Nervous System .......................................................................................................... 20
COPD and other Diseases of the Respiratory System .......................................................................... 21
  Bronchitis and Emphysema ............................................................................................................ 21
  Asthma ............................................................................................................................................ 22
  Other chronic respiratory diseases ............................................................................................... 23
  Reporting Tobacco Exposure ......................................................................................................... 23
Neoplasm in ICD-10-CM: Documenting and Coding ........................................................................... 24
  Classification ..................................................................................................................................... 25
    Malignant Neoplasm with two or more contiguous overlapping sites ............................................ 25
    Sequencing Neoplasm .................................................................................................................. 26
    Neoplasms and Metastasis/Metastatic ......................................................................................... 26
    Coding Complications associated with malignancies/therapy.................................................... 27
Some Remarks about HIV .................................................................................................................... 28
Diseases, Disorders and Injuries from the Musculoskeletal System ..................................................... 29
  Some facts about Rheumatoid Arthritis ......................................................................................... 29
  About Fractures ............................................................................................................................. 30
  Causes for Pathological Fractures ................................................................................................. 30
  The 7th Character Extension ......................................................................................................... 31
  Classification for Open Fracture .................................................................................................... 32
  Gustilo Classification ..................................................................................................................... 32
  Injuries ............................................................................................................................................ 32
ICD-10-CM Coding Fundamental

ICD-10 is the abbreviated term used to refer to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). The compliance date for implementation of the International Classification of Diseases, 10th Edition, Procedure Coding System/Clinical Modification (ICD-10-PCS/CM) was October 1, 2015 for all covered entities. The ICD-9-CM classification system, developed in the 1970s does not effectively represent 21st century medical concepts and technology and therefore cannot support the many ways that type of data is used today.

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), give guidelines for coding and reporting adopting the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). It is based on the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM:

- The American Hospital Association (AHA),
- the American Health Information Management Association (AHIMA),
- CMS, and
- NCHS and should be used as associate document to the official version of the ICD-10-CM as published on the NCHS website.

The specificity delivered by the used of ICD-10-CM, will provide better data for identifying diagnosis and its trends, public health needs, epidemic outbreaks, and bioterrorism events. It is intended also to provide potential benefits through improvement in benchmarking data, quality of patient care, public health reporting, as well as fewer rejected claims.

ICD-10-CM codes are are now required on all physician and outpatient claims with dates of service after October 1st 2015

Crosswalk

CMS has created General Equivalent Mapping (GEM) files that can be used to begin the development of a crosswalk. GEM files supply a list of probable matching options. So, if one ICD-9 code could map to 20 ICD-10 codes, then this file will supply all of these mapping options.

The mentioned tool contains references based on the GEMs files but it is not intended to be used as an ICD-10-CM conversion or mapping, nor as an ICD-9 to ICD-10 crosswalk. Take into account that while there are some codes in ICD-10-CM that map directly to codes in ICD-9, in some circumstances, a clinical scrutiny may be essential to define which code(s) should be chosen. There is no simple mapping; remember to always examine the code results before utilizing them.

The GEMS contain numerous occurrences of mappings where human involvement and judgment – based on examination of the clinical documentation – is essential to complete many of the links.

The ICD-10-CM implementation is a challenge. It is essential to realize that the migration to the new system it is more a clinical documentation issue than a coding problem. If the medical records are accurately documented by clinicians, the queries done by the coders to the Providers regarding incomplete diagnosis,
can be avoided or reduced. A joint effort between both is vital to achieve precise information, code assignment, and reporting of diagnoses and procedures. The importance of reliable documentation cannot be overstated.

**About some features and Convention/Guidelines in ICD-10-CM**

I. ICD-10-CM has the same hierarchical structure as ICD-9-CM. The ICD-10-CM Tabular List contains categories, subcategories and codes. All categories are 3 characters. Codes may be 3, 4, 5, 6 or 7 characters and the ones that have applicable 7th characters are still referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character.

   **Structure:**
   - Characters 1-3 – Category
   - Characters 4-6 – Etiology, anatomic site, severity, or other clinical detail
   - Character 7 – Extension

II. Character “X” is as placeholder to allow expansions in the future and to fill in other vacant characters. Where a placeholder exists, the X must be used in order for the code to be considered valid.

III. Insertion of clinical concepts not found in ICD-9-CM (Example: underdosing, blood type, blood alcohol level)

IV. The codes have been significantly expanded (e.g., injuries/fractures, diabetes, substance abuse, postoperative complications).

V. On the **code first** guideline the underlying or causal condition should be sequenced first followed by the manifested condition.

VI. A combination code is a single code used to clarify one of the following: two diagnoses; a diagnosis with an associated secondary process (manifestation) or a diagnosis with an associated complication. The combination code should be documented only if the code fully identifies the diagnostic conditions involved.

VII. Laterality is a new coding convention added to relevant ICD-10 codes to add specificity. Selected codes for conditions such as fractures, burns, ulcers, and certain neoplasms will require documentation of the side/region of the body where the condition occurs. In ICD-10, laterality codes include right, left, bilateral, or unspecified designations.

VIII. A seventh character extension is mostly used to document the episode of care for fractures, injuries, poisonings and other consequences of external causes. This character designates the episode of care as: A = Initial Encounter; D = Subsequent Encounter; S = Sequela. However, when documenting fractures, the assignment of the 7th character is more complicated because it includes extra information about the fracture (open or closed; healing as routine or has complications like delayed, non-union, malunion). Open fractures involving a high level of specificity, assume the Gustilo open Fracture Classification system.

IX. Certain ICD-10-CM categories have applicable 7th characters that are required for all codes within the category, or as the notes in the Tabular List instruct. The 7th character must always be the 7th character in the data field. If a code requires a 7th character, use a placeholder X to fill in the empty characters.

X. Subsequent episode of care: the initial time frame for acute myocardial infarction (AMI) treatment, in ICD-10-CM is within four weeks of onset.

XI. Drug underdosing is a new clinical terminology in ICD-10. It identifies circumstances in which a patient has taken less of a medication than suggested by their physician or less than instructed by the manufacturer, whether accidentally or on purpose. These codes require a 7th character extension to describe the encounter as: initial (A); subsequent (D); sequela (S).
XII. Clinical terminology changes in ICD-10-CM: These changes reflect standardization of the terms that are used today. Although not completely eliminated, commonly used terms such as “senile”, are no longer applicable for certain conditions. Ex: instead of Senile cataract with ICD 10 is Age-related cataract.

XIII. In ICD-10 there is a distinction between burns and corrosions. Burn codes are reported by body site, depth, extent, and a supplementary code to categorize the external cause when applicable (like in ICD-9), and have other concepts like reporting the agent or cause of the corrosion, laterality, etc.

XIV. ICD-10 incorporates two types of excludes notes: Excludes 1(pure excludes note). It means “Not coded here” and Excludes 2 represents “Not included here”. Each type of note has a different definition for use but they agree in indicating that codes excluded from each other are independent of each other.

XV. When documenting “borderline” diagnosis at the time of discharge, the diagnosis is coded as if it exists, except if the classification provides a specific entry (Ex: borderline diabetes has a code in the Alphabetic Index of R73.09 Other abnormal glucose). This guideline is used on inpatient or outpatient discharges. If the documentation is unclear on this regard, coders are encouraged to query for explanation.

XVI. Two new chapters added to ICD-10 include “Diseases of the Eye and Adnexa” (Chapter 7) and “Disorders of the Ear and Mastoid Process” (Chapter 8).

XVII. Codes start with a letter. It is vital not to confuse the letter “O” with a 0 (zero) and the letter “I” with a “1” (one). There is no letter U.

XVIII. There are nearly 70,000 diagnosis codes in ICD-10-CM.

XIX. In ICD-10-CM, pressure ulcer codes are combination codes that include: site; location and stage of the pressure ulcer. Example: L89.132 Pressure ulcer of right lower back, stage 2.

XX. Codes identified as V codes and E codes in ICD-9-CM, are now integrated into the main classification, rather than separated into additional groups.

XXI. Codes that describe signs & symptoms are acceptable to reporting purposes if a diagnosis has not yet been confirmed.

XXII. “Supplementary Classification of Factors Influencing Health Status and Contact with Health Services” was identified in ICD-9-CM with V codes. With ICD-10-CM, those services will be listed under a new set of codes: Z codes.

XXIII. There is one new punctuation mark in the Alphabetic Index, the dash. A dash(-) at the end of an Alphabetic Index entry indicates that additional characters are required to complete the code and that the Tabular List should be referenced in order to find the character needed.

XXIV. The conventions for the ICD-10-CM are the general rules for use of the classification separated of the guidelines. These conventions are integrated within the Alphabetic Index and Tabular List of the ICD-

ICD-10-CM guidelines are available at
Similarities between ICD-9-CM and ICD-10-CM

- Format: Tabular List and Alphabetic Index. They use the same hierarchical structure.
- Chapters in the Tabular are structured similarly to ICD-9-CM with some exceptions, such as: Sense organs (eye and ear) are now separated from Nervous System chapter in ICD-10-CM and relocated to their own chapters.
- The tabular list is presented chronologically as a list of codes divided into chapters based on body system or condition.
- Index is organized as in ICD-9-CM. Divided into 2 parts:
  ○ Alphabetic Index of Diseases and Injuries: it orders the main terms in an alphabetical manner with indented subterms under main terms.
  ○ Alphabetic Index of External Causes
  ○ Table of Neoplasm
  ○ Table of Drugs and Chemicals
- Codes are invalid if they are missing an applicable character.
- Codes are looked up the same way: find the terms in the Alphabetic Index; then verify code number in Tabular List.
- Several conventions have equivalent meaning (Abbreviations, punctuation, symbols, notes such as “code first” and “use additional code”).
- Nonspecific codes (“unspecified” or “not otherwise specified”) are accessible to use when detailed documentation to support more specific code is not available. Codes that describe symptoms and signs, as opposed to diagnoses, are appropriate for reporting purposes when a related conclusive diagnosis has not been confirmed by the provider.
- Observance of the official coding guidelines in all healthcare settings is required under the Health Insurance Portability and Accountability Act.
- If a condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and order the acute (subacute) code as the first one.
- Assign the combination code when that code fully identifies the diagnostic conditions included or when the Alphabetic Index it directs to do so.
- The code assignment for the Body Mass Index (BMI), depth of non-pressure chronic ulcers and pressure ulcer stage codes, may be taken from documentation given by clinicians who are not the patient’s provider considering that this information is normally documented by other personnel involved in the care of the patient (e.g., a dietitian and nurses). Nevertheless, the related diagnosis (such as obesity or pressure ulcer) must be reported by the patient’s provider.

What is Medicare Risk Adjustment (MRA)?

Regularly, payments to Medicare Advantage organizations were based merely on demographic information. This method did not guarantee accurate payment. Consequently risk adjustment was put into effect.

Its purpose is to pay Medicare Advantage organizations more correctly for the projected health care expenditures of enrollees by regulating payments looking at demographic and health status as well. Using the risk adjustment model from CMS-HCC, payments to Medicare Advantage organizations are higher for less healthy enrollees and lower for more healthy enrollees.
ICD-10-CM and Risk Adjustment

ICD-10-CM diagnosis codes have a pivotal role in the risk adjustment process.

The CMS-HCC model requires ICD-10-CM diagnosis codes to calculate risk adjustment payments. Those codes are also the origin of beneficiary health status information. CMS expects the submission of all CMS-HCC relevant diagnosis codes from physicians, hospital inpatient facilities, and hospital outpatient facilities. The model also demands the codes to be specific enough to admit accurate risk score calculation.

The guidelines must be followed at all times, and the ICD-10-CM code assigned to a diagnosis must meet the highest level of specificity according to the physician's documentation.

In general, the transition to ICD-10 have had a high influence on the structures involved in the Risk Adjustment Process and each system and interface must be tested to determine if the transition to ICD-10 is on the correct path.

Physician data process and Risk Adjustment

It is critical for physicians to comprehend that diagnostic data, in the form of ICD-10-CM codes, are the basis of risk adjustment payments. The CMS-HCC model depends on coding specificity with the emphasis on diagnosis coding rather than Current Procedural Terminology (CPT) coding.

Physicians must follow the next three steps to assured correct risk adjustment:
- Produce appropriate medical record documentation: According to the 1997 Documentation Guidelines for Evaluation and Management Services, medical record documentation must contain pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations/tests, treatments and outcome.
- Assign the codes following the ICD-10-CM Guidelines and they will be based on medical record documentation.
- Report the ICD-10-CM diagnostic data to the Health Plan.
- Reporting the ICD-10-CM diagnostic data to the Health Plan.

Risk Adjustment Data Validation (RADV)

Physicians and their office staff must be aware of Risk Adjustment Data Validation activities because they may be requested to provide medical record documentation to CMS.

Risk Adjustment Data Validation (RADV) occurs after the final risk adjustment data submission deadline for the Medicare Advantage contract calendar year. The purpose of RADV is to ensure risk adjusted payment integrity and to verify that all risk adjustment diagnosis codes submitted by Medicare Advantage organizations are supported by medical record documentation. CMS reviews medical records from hospital (inpatient and outpatient) and physician providers to validate enrollees CMS-HCCs that were assigned based on risk adjustment diagnoses submitted by Medicare Advantage organizations for payment.

The primary objectives of RADV are to:
- Verify enrollee CMS-HCCs used for payment.
- Identify risk adjustment discrepancies.
- Calculate enrollee-level payment error.
- Estimate national and contract-level payment errors.
- Implement contract-level payment adjustments.
Documentation and MRA

All Medicare Advantage organizations and specialty plans are required to attest the accuracy of the Risk Adjustment data submitted to CMS.

Providers must maintain precise medical records for every Medicare beneficiary, be aware of HIPAA guidelines and use standard Medicare coding rules and requirements.

It is vital for accurate Medicare Risk Adjustment that provider documentation is meticulous. **Coders can only code what is documented.** To code to the highest level of specificity, in compliance with ICD-10-CM guidelines, the documentation must be complete.

Detailed documentation impacts risk adjustment. Examples: Hepatitis C vs. Chronic Hepatitis C; ESRD vs. ESRD on Dialysis; DM vs. DMII w/ manifestations; Depression vs. Major Depression (degrees); Asthma vs. COPD; Bronchitis vs. Chronic Bronchitis.

The objective of thorough and accurate documentation in the progress notes is to help CMS evaluate the costs of taking care of the patient and pay Medicare Advantage plans appropriately.

**ICD-10-CM: Impact on Coding and Documentation**

- Increased specificity in a coding systems with a more logical structure and clinical accuracy, allow additional coding specificity.
- Enhancements in ICD-10-CM have eased the coding process (more complete and specific code titles, updated medical terminology, expanded and clearer instructional notes).
- Although careful medical record documentation would result in higher coding specificity and higher data quality, non-specific codes are still available when exhaustive documentation is unavailable. Sign/symptom and unspecified codes have acceptable uses, sometimes are even necessary. If a conclusive diagnosis has not been established by the end of the visit, it is correct to report codes for sign(s) and/or symptom(s) as a substitute of a definitive diagnosis. If the clinical information is not sufficient, unknown or unavailable when assigning a specific code for a disorder, it is acceptable to report the proper unspecified code. It is inappropriate to select a specific code that is not supported by the medical record documentation.

**Provider Signature Requirements on the Progress Note**

- All progress notes, dictated notes and consults must be signed by the provider rendering the services. Provider credentials must either be pre-printed on the progress note as a stationary or the provider must sign all progress notes with his/her name and credentials as part of their names and signature.
- Stamped signatures are no longer acceptable as January 1, 2009, as stated by the CMS.
- Progress Notes from Electronic Medical Records (EMR) must have the following wording as part of the signature line: ‘Electronically signed’, ‘Authenticated by’, ‘Signed by’, ‘Validated by’, ‘Approved by’, or ‘Sealed by’.
- The signed EMR record must be closed to all changes. Any additional information or updates can be added as an addendum within 30 days of the initial date of service (DOS).
Best Practices about Documentation

Medicare’s guidelines states: Code all documented conditions which coexist at the time of the visit that require or affect patient care or treatment. When documenting, take the following into consideration:

- Each medical record must contain:
  - Date of service
  - Patient’s complete name/and other identifier (DOB, chart #)
  - Provider name, signature and credentials
  - Handwriting that is legible (to someone else) if still not using EMR
  - Only industry standard abbreviations
  - Each medical condition on the assessment needs to have an evaluation statement.

- Always include a treatment plan using words such as continue, increase, decrease, add, name of medication, refer to, RTC or F/U, etc.

- At a minimum, include a brief statement that updates the status of each diagnosis. Medications may indicate a condition, but no disorder can be coded unless you write the words.

- Make sure that for every medication refilled, a diagnosis is listed and addressed on the Progress note at least once a year while specifying for which condition the medication is being prescribed.

- Use the word history to mean that the condition no longer exists, not that the medical history of the patient includes these conditions.

- Document at least twice a year:
  - Chronic conditions (CHF, COPD, DM).
  - Active status conditions (amputations, colostomy)
  - All conditions that require medication and treatment

- Be specific:
  - Major depression (degree), not depression.
  - Chronic bronchitis, not bronchitis.
  - Atrial Fibrillation, not cardiac dysrhythmia.
  - Malnutrition, not loss of weight.

- Words to use to describe the status of conditions and to show causal relationship:
  - Diabetic neuropathy or neuropathy due to DM or neuropathy caused by diabetes
  - Hypertensive heart disease
  - Describing words: acute, chronic, in remission, exacerbation, stable, compensated.

- Be careful about tense:
  - History of MI, not MI (after 4 weeks post)
  - Personal history of malignant neoplasm of thyroid, not thyroid cancer (after all treatment is done, use Z code for history of...)
  - Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits (Z86.73) or other sequelae of cerebral infarction (I69.-), not CVA (once the patient leaves the hospital do not use acute CVA (I63.-).

- Some conditions require 2 codes and both codes must be documented. Examples: CKD, stage IV due to diabetic nephropathy: Type 2 diabetes mellitus with diabetic nephropathy (E11.21) and Chronic kidney disease, stage 4 (severe) (N18.4)

- 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.

- Avoid contradicting information on the Progress Note, e.g., Between Physical examination and the Diagnosis’ assessment.

**Documenting contains 3 fundamental aspects:**

- Description of diagnosis as a current problem as opposed to an earlier condition.
- Selection of the appropriate ICD diagnosis code.
- Confirmation of the diagnosis with a complete documentation.
Standards of Ethical Coder

ICD-10-CM hasn’t change the way coding professionals face the challenges found in this era of payment, based on diagnostic and procedural coding. A reliable objective for coding and preserving a quality database is accurate clinical and statistical data.

The following standards of ethical coding, developed by AHIMA’s Coding Policy and Strategy Committee and approved by AHIMA’s Board of Directors, are offered to guide coding professionals in this process.

**Coding Professionals**

1. Are expected to support the importance of accurate, complete, and consistent coding practice for the production or quality healthcare data.

2. Should adhere, in all healthcare settings, to the ICD-10-CM (International Classification of Diseases, 10th revision, Clinical Modification) coding conventions; official coding guidelines approved by the Co-operating Parties; the CPT (Current Procedural Terminology) rules established by the American Medical Association and any other official coding rules and guidelines established for use with mandated standard code sets. Selection and sequencing of diagnoses and procedures must meet the definitions of required data sets for applicable healthcare settings.

3. Should use their skills, their knowledge of currently mandated coding and classification systems, and official resources to select the appropriate diagnostic and procedural codes.

4. Should only assign and report codes that are clearly and consistently supported by physician documentation in the health record.

5. Should consult physicians for clarification and additional documentation prior to code assignment when there is conflicting or ambiguous data in the health record.

6. Should not change codes or the narratives of codes on the billing abstract so that meanings are misrepresented. Diagnoses or procedures should not be inappropriately included or excluded because payment or insurance policy coverage requirements will be affected. When individual payer policies are in conflict with official coding rules and guidelines, these policies should be obtained in writing whenever possible. Reasonable efforts should be made to educate the payer on proper coding practices in order to influence a change in the payer’s policy.

7. As members of the healthcare team, should assist and educate physicians and other clinicians by advocating proper documentation practices, further specificity, and sequencing or inclusion of diagnoses or procedures when needed to more accurately reflect the acuity, severity, and the occurrence of events.

8. Should participate in the development of institutional coding policies and should ensure that coding policies complement, not conflict with, official coding rules and guidelines.

9. Should maintain and continually enhance their coding skills, as they have a professional responsibility to stay abreast of changes in codes, coding guidelines, and regulations.

10. Should strive for optimal payment to which the facility is legally entitled, remembering that it is unethical and illegal to maximize payment by means that contradict regulatory guidelines.
Steps to Correct Coding

1. Within the medical documentation, identify the diagnosis the provider assessed and confirmed as active.

2. Locate the condition in the alphabetic index and review the sub terms to find the most specific code available.

3. Once located, corroborate the suggested code selection in the tabular list and read the full code descriptor. This is an alphanumeric listing which organizes codes by disease and injury and that categorizes severity as well as complications.

4. Note if the Index suggest other indications for proper coding such as the need for extra characters. Diagnosis codes are to be used and reported at their maximum number of characters available.

5. If the Index leads you to a code that includes the terms other, unspecified, NOS or NEC, confirm that a more specific code isn’t available. Corroborate that the code complies with the philosophy of ethical coding and that is supported by the documentation.

6. The tabular index also contains information identifying the length of a code (from three to seven characters long) and includes additional information such as the “Excludes” notes. There are two types: “Excludes 1” (denote exact exclusions and it is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition) and “Excludes 2” (indicates that the disorder excluded is not part of the condition denoted by the code, but a patient may have both conditions at the same time).

7. Examine the chapter-specific coding guidelines found before the alphabetic index of the ICD-10-CM manual. Besides the notes inserted in precise sections or categories of codes, there also are notes incorporated at the beginning of each chapter of the tabular list.

8. Validate the code selection in the Tabular List. Make certain you have chosen the appropriate classification in accordance with the diagnosis and read all instructional material: “includes” and “excludes” notes; “And/With/See/See also” cross-references; “code also” notes; “default codes”; Etiology/manifestation codes (“code first”, “use additional code”, “code first underlying disease” and “in diseases classified elsewhere” notes); “Additional character required”; “Extension “X”” alert.

9. Examine definitions, relevant illustrations, color coding, age and sex symbols. Refer to the color/legend at the bottom of each page for symbols.

10. Finally, assign the code number you have determined to be correct.

Never code strictly from the alphabetical index

Type of Codes

- **Status code** – A current condition that may affect the course of treatment or its outcome (amputation status, artificial opening status, old MI).

- **History code** – The patient no longer has the condition. However it might go under periodic testing to make sure the condition does not reoccur.

- **Late effects, termed as sequel** – is a chronic or residual condition from a complication of an acute disorder that happens after the acute phase of a disease, illness or injury. There is no time limit on using the late effects code.

- **Rule out codes** — **Do not code it** until the condition has been confirmed.

- **Possible, probable or questionable** — **cannot** be coded. Use signs and symptoms until a definitive diagnosis is found.
Coding Diseases in ICD-10-CM

Diabetes Mellitus

Chapter IV: Endocrine, nutritional and metabolic diseases (E00-E89)

One of the major changes in the guidelines from ICD-9-CM to ICD-10-CM is coding for Diabetes mellitus. This is due to the creation of combination codes that are greatly used in coding for diabetic conditions. Those codes include the type of diabetes, body system affected and the specified complications involving the body system.

- ICD-10-CM provides coders with a much greater range of codes to choose from in the E08-E13 (Diabetes mellitus) series. As a result, providers must give additional information to describe complications of Diabetes. The creation of expanded combination codes permit for multiple conditions to be reported with fewer codes. The type of DM is mentioned first and the manifestation second, if required.
- Codes begin with an E (for Endocrine). Alpha characters are not case-sensitive.
- If the type is unclear or not documented, Diabetes mellitus, type II (E11.-) would be used as default.
- Diabetes codes can now up to 6 characters:
  - The first 3 characters represent the category.
  - The 4th character identifies the presence of manifestations or complications.
  - The 5th and 6th characters identify specific types of manifestation.
- Categories E08-E09 and E11-E13 related to DM, include a note regarding the usage of an additional code to identify any insulin use. Code Z79.4 Long-term current use of insulin will identify the use of insulin for diabetic management, routinely used. It is not correct to assign Z79.4 with the category E10 codes. For patients with type 1 diabetes, the use of insulin is required, therefore Z79.4 is redundant.
- New diabetic complications include: Diabetes with skin complications, with oral complications and with arthropathy. Ophthalmic conditions are expanded as well.
- The assumed cause-and-effect relationship in the classification of ICD-9 is not the same in ICD-10. ICD-10 does not presume a relationship between diabetes and osteomyelitis. However, the classification does presume a relationship between diabetes and certain diseases of the kidney, nerves, eyes, and circulatory system listed under the subterm “with” in the ICD-10 index.
- Despite applicable coding rules, diagnoses should be documented to the highest degree of specificity. If there is a causal relationship between any two conditions, it should be clearly identified as such in the medical record documentation with terms of linking verbiage such as “due to,” “associated with,” etc.
- The default for DKA (Diabetic Ketoacidosis) is Diabetes type 1. There is no Index entry to report this diagnosis in patients with type 2 diabetes.
- There is no current mechanism in ICD-10-CM to report Hyperosmolarity in a patient with DMI.
The terms control and uncontrolled are no longer part of the code set for Diabetes Mellitus.

DM described as poorly controlled, inadequately controlled or out of control will be coded to the diabetes, by type, with hyperglycemia (E11.65)
**Morbid Obesity**

Morbid obesity has to be explicitly stated by the provider in order to code as such (i.e., coders cannot make assumptions based on BMI). The World Health Organization (WHO) defines morbid obesity as ≥ BMI 40 while most bariatric surgery associations and programs consider BMI of ≥35 with comorbidities as morbid obesity. There are many factors in addition to BMI, such as muscle mass and age, that are used to determine a patient’s weight status. Ultimately, it is based on the provider’s clinical judgment as to whether a patient is underweight, normal weight, overweight, obese, extremely (severe, morbidly) obese, etc. When able, query the provider for clarification if there is a conflict in the medical record documentation.

AHA Coding Clinic, Q2, 2010 confirms that the BMI may be recorded by non-physician clinicians, but it cannot be reported unless also documented by the physician as associated with a related condition, such as morbid obesity. The BMI, even if it’s above 40, cannot be coded alone unless the provider assessed and confirmed the diagnosis.

For precise coding of overweight and obesity, the documentation should contain:

- Severity: Overweight, Obese, or Morbid obesity
- Causative factors: Excessive calories or Drug induced
- Association: e.g., Pregnancy
- Symptoms/Results/Manifestations: BMI or Alveolar hypoventilation

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbid (severe) obesity due to excess calories</td>
<td>E66.01</td>
</tr>
<tr>
<td>Morbid (severe) obesity with alveolar hypoventilation</td>
<td>E66.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BMI</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body mass index (BMI) 40.0-44.9, adult</td>
<td>Z68.41</td>
</tr>
<tr>
<td>Body mass index (BMI) 45.0-49.9, adult</td>
<td>Z68.42</td>
</tr>
<tr>
<td>Body mass index (BMI) 50-59.9 , adult</td>
<td>Z68.43</td>
</tr>
<tr>
<td>Body mass index (BMI) 60.0-69.9, adult</td>
<td>Z68.44</td>
</tr>
<tr>
<td>Body mass index (BMI) 70 or greater, adult</td>
<td>Z68.45</td>
</tr>
</tbody>
</table>

**Low BMI**

Diagnoses in connection with low BMI depend on the physician’s clinical judgment based on the findings in each individual case. No particular outcome is required or definitive.

If Malnutrition is determined, the degree must be specified:

- **Mild (E44.1)** with BMI 16-17.9 or loss of 21% to 30% of ideal weight
- **Moderate (E44.0)** with BMI <16 or loss of 30% or more of ideal body weight
- **Severe (E43)** very low weight for height (below -3z scores of the median WHO growth standards)
- **Cachexia (R64)** known also as wasting syndrome, refers to an alarming loss of body mass, including lean body mass and fat, in the setting of a serious disease state like cancer, AIDS, MS, celiac disease, etc.

*When assessing any type of disorder related with BMI, the documentation must support the diagnosis.*
Chronic Kidney Disease (N18) as part of Chapter XIV

- There are no big differences between ICD-9 and ICD-10 when it comes to coding CKD.
- When coding for patients with both acute renal failure and chronic kidney disease, an additional code for acute renal failure is required.
- Often these CKD stage codes are secondary codes, preceded on the record by a code for the underlying cause of CKD, usually a diabetes code or a hypertensive kidney disease code.
- The ICD-10-CM classifies CKD based on severity which is designated by stages 1–5, and ESRD based on GFR values and dialysis treatment.
- The best test to measure the level of kidney function and determine the stage of kidney disease is the Glomerular Filtration Rate (GFR). It can be calculated from blood creatinine, age, race, gender and other factors.
- Guidelines from the Kidney Foundation (KDOQI) established that the definition of CKD is centered on kidney damage for ≥ 3 months shown on pathological irregularities or markers of kidney damage (Ex: Persistent proteinuria or imaging tests with altered results) and on a GFR under 60 mL/min for at least 3 months between labs with/without kidney damage.

### Classification

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>GFR (mL/minute)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Kidney damage with normal or raised GFR</td>
<td>90-130</td>
</tr>
<tr>
<td>II</td>
<td>Kidney damage with mild reduced GFR</td>
<td>60-89</td>
</tr>
<tr>
<td>III</td>
<td>Moderate reduced GFR</td>
<td>30-59</td>
</tr>
<tr>
<td>IV</td>
<td>Severe reduced GFR</td>
<td>15-29</td>
</tr>
<tr>
<td>V</td>
<td>Kidney failure</td>
<td>&lt; 15 or dialysis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STAGE</th>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>N18.1</td>
<td>Slightly diminished function. Kidney damage w/normal or relative high GFR.</td>
</tr>
<tr>
<td>Stage 2</td>
<td>N18.2</td>
<td>Mild reduction in GFR w/kidney damage</td>
</tr>
<tr>
<td>Stage 3</td>
<td>N18.3</td>
<td>Moderate reduction in GFR.</td>
</tr>
<tr>
<td>Stage 4</td>
<td>N18.4</td>
<td>Severe reduction in GFR. Preparation for renal replacement therapy.</td>
</tr>
<tr>
<td>Stage 5</td>
<td>N18.5</td>
<td>Established kidney failure, or permanent renal replacement therapy (RRT). Excludes CKD stage 5 requiring dialysis.</td>
</tr>
<tr>
<td>ESRD (End stage renal disease)</td>
<td>N18.6</td>
<td>Patients with CKD requiring Dialysis.</td>
</tr>
<tr>
<td>For unspecified</td>
<td>N18.9</td>
<td>Severity is not specified</td>
</tr>
<tr>
<td>CKD and ESRD</td>
<td>N18.6 only</td>
<td></td>
</tr>
<tr>
<td>If Kidney Transplant</td>
<td>Z94.0</td>
<td></td>
</tr>
<tr>
<td>On Dialysis treatment</td>
<td>Z99.2</td>
<td></td>
</tr>
</tbody>
</table>

**Code assignment will be based on physician documentation of the specific stage and not the GFR result alone.**
Chronic Kidney Disease and Diabetes Mellitus

In ICD-10-CM, more than one code is required to diagnose diabetic CKD: one combination code that indicates the type of diabetes with chronic kidney disease and one that indicates the stage of CKD.

The following codes indicate CKD in diabetic patients in ICD-10-CM:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E08.22</td>
<td>Diabetes mellitus due to underlying condition with diabetic chronic kidney disease</td>
</tr>
<tr>
<td>E09.22</td>
<td>Drug or chemically induced diabetes mellitus with diabetic chronic kidney disease</td>
</tr>
<tr>
<td>E10.22</td>
<td>Type I diabetes mellitus with diabetic chronic kidney disease</td>
</tr>
<tr>
<td>E11.22</td>
<td>Type II diabetes mellitus with diabetic chronic kidney disease</td>
</tr>
<tr>
<td>E13.22</td>
<td>Other specified diabetes mellitus with diabetic chronic kidney disease</td>
</tr>
</tbody>
</table>

Anemia in CKD

When assigning code D63.1, Anemia in CKD, it is also necessary a code for CKD, category N18, to indicate the stage of CKD. These codes can be used as the principal/first listed code, and also as secondary codes. The sequence of the codes will depend on the reason for the encounter.

Example: If the treatment for the anemia is a component of an encounter but the primary reason for the encounter is the ESRD, codes should be sequenced as follows: N18.6, D63.1.

Anemia in chronic diseases, such as CKD or cancer, can be documented just as they were for ICD-9.

CKD and Kidney Transplant

Patients with kidney transplant may still suffer some type of CKD because the transplant may not completely reinstate kidney function. Consequently, having CKD alone does not mean there is a transplant complication.

Assign the code to establish the stage of CKD (N18 category) and code Z94.0, Kidney transplant status. The documentation must be clear as to whether the patient has a complication of the transplant.

If a complication resulting from the transplant as failure (T86.12), rejection (T86.11) or unspecified (T86.10) is documented, review guidelines for material on coding complications of a kidney transplant.

Chronic Kidney Disease and Hypertension

- **Hypertensive Chronic Kidney Disease:** The ICD-10 manual has no Hypertension Table in the index. One reason is because the “malignant” and “benign” hypertensive kidney disease codes are left out of ICD-10.

According to the ICD-10-CM Official Guidelines (C.9.a.2), because there is a presumed cause-and-effect relationship between CKD and hypertension, codes from category I12, Hypertensive CKD, should be assigned when both hypertension and a condition classifiable to category N18, CKD, are present. The physician would have to specifically document that CKD is not due to hypertension to negate the cause-and-effect relationship.

If the patient has hypertensive chronic kidney disease and acute renal failure, an additional code for the acute renal failure is required.
• **Hypertensive heart and chronic kidney disease:** As per ICD-10-CM Guideline, the codes in category I13, Hypertensive heart and CKD, are combination codes that include hypertension, heart disease and chronic kidney disease.
  
  ○ Codes from combination category I13 are assigned when both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis. If heart failure is present, an additional code from category I50 is given to identify the type of heart failure.
  
  ○ The proper code from category N18, CKD, should be used as a secondary code with a code from category I13 to categorize the stage of chronic kidney disease.
  
  ○ The includes note on I13, specifies that the conditions included at I11 and I12 are incorporated together in I13. If a patient has hypertensive heart disease and chronic kidney disease, then a code from I13 should be used, not individual codes for hypertension, heart disease and CKD.

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
<th>Additional codes are needed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I12.0</td>
<td>Hypertensive chronic kidney disease with CKD stage 5 or end stage renal disease</td>
<td>To identify stage of CKD (N18.5-N18.6)</td>
</tr>
<tr>
<td>I12.9</td>
<td>Hypertensive chronic kidney disease with CKD stage I through 4, or unspecified.</td>
<td>To identify stage of CKD (N18.1-N18.4, N18.9)</td>
</tr>
<tr>
<td>I13.0</td>
<td>Hypertensive heart and CKD with heart failure and stage I through 4 CKD, or unspecified CKD.</td>
<td>To identify heart failure (I50.-) and a code to identify stage of CKD (N18.1-N18.4, N18.9)</td>
</tr>
<tr>
<td>I13.10</td>
<td>Hypertensive heart and CKD without heart failure and stage I through 4 CKD, or unspecified.</td>
<td>To identify stage of CKD (N18.1-N18.4, N18.9)</td>
</tr>
</tbody>
</table>

**CKD Coding Examples**

1. Hyperkalemia due to CKD
   - **ICD-10-CM:** Hyperkalemia (E87.5), Chronic kidney disease, unspecified (**N18.9**)

2. A patient is seen for diabetic CKD, stage 3. The patient has type 2 diabetes and takes insulin on a daily basis.
   - **ICD-10-CM:** DM II with diabetic chronic kidney disease (E11.22), CKD, stage 3 (**N18.3**), Long term (current) use of insulin (**Z79.4**)

3. Patient has Hypertensive heart disease and ESRD. He also was diagnosed with heart failure
   - **ICD-10-CM:** Hypertensive heart and CKD w/heart failure and with stage 5 CKD, or ESRD (**I13.2**), End stage renal disease (**N18.6**), Heart failure, unspecified (**I50.9**).

4. A patient has systolic (congestive) heart failure due to hypertension with stage 5 CKD.
   - **ICD-10-CM:** Hypertensive heart and CKD with heart failure and with stage 5 CKD, or ESRD (**I13.2**), CKD, stage 5 (**N18.5**) and Chronic systolic (congestive) heart failure (**I50.22**).

5. Patient with hypertension and ESRD on dialysis 3 times a week.
   - **ICD-10-CM:** Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease (**I12.0**), ESRD (**N18.6** and Dependence on renal dialysis (**Z99.2**)

6. Patient is admitted for treatment of diabetes mellitus, type 2. Patient is on hemodialysis for ESRD.
   - **ICD-10-CM:** Type 2 diabetes mellitus without complications (E11.9), End stage renal disease (**N18.6**) and Dependence on renal dialysis (**Z99.2**). (Even though the patient has ESRD (**N18.6**) on dialysis (**Z99.2**) there is no documentation about if it's due to DM, therefore **E11.9** (Type 2 diabetes mellitus without complications) is coded.
Diseases of the Nervous System — Chapter VI (G00-G99)

1. A few conditions have been moved from Diseases of the circulatory System in ICD-9 to chapter VI in ICD-10-CM like:
   A. basilar and carotid artery syndromes;
   B. transient global amnesia and
   C. transient cerebral ischemic attack.

2. In ICD 9-CM all diseases of the nervous system, including eye/adenexa and ear/ mastoid process were in the same chapter. This distribution changed with ICD-10-CM. Diseases of the sense organs each have their own chapter: Chapter VII for diseases of the eye and adnexa (H00-H59), like Glaucoma (H40-H42) and Chapter VIII for Ear and mastoid process represented in blocks (H60-H95), like Diseases of the middle ear and mastoid (H65-H75).

3. Classification of sleep disorders have been improved, including them in Chapter VI, not in the signs and symptoms chapter.

4. Code expansions: Ex Alzheimer’s included early onset (G30.0) vs late onset (G30.1)

5. Medical terminology has been updated. For example: in the case of epilepsy and seizure disorder:
   A. Seizure disorders and recurrent seizures are coded to epilepsy.
      ○ Identify:
         • type (epilepsy, recurrent seizure)
         • if intractable (pharmacoresistant, poorly control, refractory (medically) and treatment resistant) or not intractable.
      ○ Document any associated diagnoses/conditions.
   B. Convulsions, new-onset and single, febrile or hysterical seizures are coded as non-epileptic.

6. About Monoplegia, Hemiplegia, Hemiparesis.— In each case, documentation should include the following:
   A. Identify laterality.
   B. Document any associated conditions/diagnoses.
   X. Specify dominant or nondominant.
      ○ If the affected side is documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, according to the guidelines the code selection is as follows:
         • For ambidextrous patients and when the right side is affected, the default is dominant.
         • If the left side is affected, the default is non-dominant.

Example 1: A patient goes to the Dr. after CVA that caused right hemiplegia.
Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side (I69.951)

Example 2: A patient with right hemiplegia is at the Provider’s office for a regular check up
Hemiplegia, unspec type, affecting dominant side (G81.91)

D. Coding Sequelae of Cerebrovascular Disease: References to Sequelae of cerebrovascular diseases (I69.-), are also found on page 39 dedicated to Cerebrovascular diseases.
COPD and other Diseases of the Respiratory System - Chapter X: j00-j99

- Codes for reporting diseases of the respiratory system feature relatively minor variations. Most of the changes involve understanding the anatomic terms, as well as the new general structure and rules of ICD-10-CM codes.
- The ICD-10-CM Official Guidelines give instructions for coding acute exacerbation of chronic obstructive bronchitis and asthma, acute respiratory failure and influenza due to avian virus as well as some extra instructions added for the diagnosis of Ventilator Assisted Pneumonia (VAP).
- Some codes have been expanded requiring the coder to:
  - **Use additional code to identify:** 1. the infectious agent
    2. the virus
    3. other conditions such as tobacco use or exposure
  - **Code first:** 1. any associated lung abscess
    2. the underlying disease
- The codes in categories J44 and J45 differentiate between uncomplicated cases and those in acute exacerbation. An acute exacerbation (deteriorating or decompensation of a chronic condition), is not equal to an infection superimposed on a chronic condition; however an exacerbation may be generated by an infection. (Guideline I.C.10.a.1. Acute Exacerbation of Chronic Obstructive Bronchitis & Asthma).
- At the beginning of Chapter X for diseases of the respiratory system, appears the instructional guideline: “when a respiratory condition is described as occurring in more than one site & is not specifically indexed, it should be classified to the lower anatomic site.” For example, tracheobronchitis is classified to bronchitis using code J40, bronchitis, not specified as acute or chronic.

<table>
<thead>
<tr>
<th>BRONCHITIS</th>
<th>Description - ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>J40</td>
<td>Bronchitis, not specified as acute or chronic</td>
</tr>
<tr>
<td></td>
<td>- Bronchitis: - NOS - Catarrhal - With tracheitis NOS</td>
</tr>
<tr>
<td></td>
<td>- Tracheobronchitis NOS</td>
</tr>
<tr>
<td>J41</td>
<td>Simple &amp; mucopurulent chronic bronchitis</td>
</tr>
<tr>
<td>J41.0</td>
<td>Simple chronic bronchitis</td>
</tr>
<tr>
<td>J41.1</td>
<td>Mucopurulent chronic bronchitis</td>
</tr>
<tr>
<td>J41.8</td>
<td>Mixed simple &amp; mucopurulent chronic bronchitis</td>
</tr>
<tr>
<td>J42</td>
<td>Unspecified chronic bronchitis:</td>
</tr>
<tr>
<td></td>
<td>- Chronic: - Bronchitis NOS - Tracheitis - Tracheobronchitis</td>
</tr>
<tr>
<td>EMPHYSEMA</td>
<td>Description - ICD-10-CM</td>
</tr>
<tr>
<td>J43</td>
<td>Emphysema</td>
</tr>
<tr>
<td>J43.0</td>
<td>Unilateral pulmonary emphysema [MacLeod’s syndrome]</td>
</tr>
<tr>
<td></td>
<td>- Swyer-James syndrome</td>
</tr>
<tr>
<td></td>
<td>- Unilateral emphysema</td>
</tr>
<tr>
<td></td>
<td>- Unilateral hyperlucent lung</td>
</tr>
<tr>
<td></td>
<td>- Unilateral pulmonary artery functional hypoplasia</td>
</tr>
<tr>
<td></td>
<td>- Unilateral transparency of lung</td>
</tr>
<tr>
<td>J43.1</td>
<td>Panlobular emphysema: - Panacinar emphysema</td>
</tr>
<tr>
<td>J43.2</td>
<td>Centrilobular emphysema</td>
</tr>
<tr>
<td>J43.8</td>
<td>Other emphysema</td>
</tr>
<tr>
<td>J43.9</td>
<td>Emphysema, unspecified</td>
</tr>
<tr>
<td></td>
<td>- Emphysema (lung) (pulmonary): - NOS</td>
</tr>
<tr>
<td></td>
<td>- Bullous</td>
</tr>
<tr>
<td></td>
<td>- Vesicular</td>
</tr>
<tr>
<td></td>
<td>- Emphysematous bleb</td>
</tr>
</tbody>
</table>
**Asthma**

1. In order to code asthma correctly, the physician must document the severity of the asthma and/or describe frequency. Terms used to define asthma have been enhanced to reflect the current clinical classification. These terms include:
   - **A. Intermittent asthma**, which is defined as less than or equal to two occurrences per week.
   - **B. Persistent asthma**, which includes 3 levels of severity:
     - **Mild**: more than two times per week
     - **Moderate**: daily and may restrict physical activity
     - **Severe**: throughout the day with recurrent severe attacks limiting the ability to breathe.

2. J44.- includes Asthma with COPD but the type of Asthma J45.- must be coded if applicable.

3. The 4th character indicates the severity & the 5th one identify whether status asthmaticus or exacerbation is present.

<table>
<thead>
<tr>
<th>ASHMA</th>
<th>Description - ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>J45</td>
<td>Asthma</td>
</tr>
<tr>
<td>J45.2</td>
<td>Mild intermittent asthma</td>
</tr>
<tr>
<td>J45.20</td>
<td>Uncomplicated</td>
</tr>
<tr>
<td>J45.21</td>
<td>With (acute) exacerbation</td>
</tr>
<tr>
<td>J45.22</td>
<td>With status asthmaticus</td>
</tr>
<tr>
<td>J45.3</td>
<td>Mild persistent asthma</td>
</tr>
<tr>
<td>J45.30</td>
<td>Uncomplicated</td>
</tr>
<tr>
<td>J45.31</td>
<td>With (acute) exacerbation</td>
</tr>
<tr>
<td>J45.32</td>
<td>With status asthmaticus</td>
</tr>
<tr>
<td>J45.4</td>
<td>Moderate persistent</td>
</tr>
<tr>
<td>J45.40</td>
<td>Uncomplicated</td>
</tr>
<tr>
<td>J45.41</td>
<td>With (acute) exacerbation</td>
</tr>
<tr>
<td>J45.42</td>
<td>With status asthmaticus</td>
</tr>
<tr>
<td>J45.5</td>
<td>Severe persistent</td>
</tr>
<tr>
<td>J45.50</td>
<td>Uncomplicated</td>
</tr>
<tr>
<td>J45.51</td>
<td>With (acute) exacerbation</td>
</tr>
<tr>
<td>J45.52</td>
<td>With status asthmaticus</td>
</tr>
<tr>
<td>J45.9</td>
<td>Other and unspecified asthma</td>
</tr>
<tr>
<td>J45.90</td>
<td>Unspecified:</td>
</tr>
<tr>
<td></td>
<td>· Asthmatic bronchitis NOS</td>
</tr>
<tr>
<td></td>
<td>· Childhood asthma NOS</td>
</tr>
<tr>
<td></td>
<td>· Late onset asthma</td>
</tr>
<tr>
<td>J45.901</td>
<td>Unspecified asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.902</td>
<td>Unspecified asthma with status asthmaticus</td>
</tr>
<tr>
<td>J45.909</td>
<td>Unspecified asthma, uncomplicated</td>
</tr>
</tbody>
</table>
### OTHER CHRONIC RESPIRATORY DISEASES

<table>
<thead>
<tr>
<th>OTHER CHRONIC RESPIRATORY DISEASES</th>
<th>Description - ICD-10-CM</th>
</tr>
</thead>
</table>
| J44                                | Other chronic obstructive pulmonary diseases  
  • Asthma with COPD. Code also type of Asthma (J45.-) when applicable  
  • Chronic bronchitis:  
    - Asthmatic (obstructive)/emphysematous w/airway(s) obstruction, emphysema  
    - Chronic obstructive:  
      - Asthma/bronchitis/tracheobronchitis |
| J44.0                              | COPD w/acute lower respiratory infection (such as acute bronchitis or pneumonia). Use additional code to identify the infection. |
| J44.1                              | COPD w/acute exacerbation, unspecified.  
  Excludes2: COPD w/acute bronchitis (J44.0) |
| J44.9                              | COPD, unspecified  
  • Chronic obstructive  
    - Airway disease NOS  
    - Lung disease NOS |
| J47                                | Bronchiectasis  
  • Bronchiectasis with (acute) exacerbation  
  • Bronchiectasis with acute lower respiratory infection  
  • Bronchiectasis, uncomplicated |

The **INCLUDES** note for J44 contains Chronic bronchitis with Emphysema when found on the same scenario. The **EXCLUDES** note clarifies not to code Emphysema if Chronic bronchitis is no present. In that case use Emphysema (J43.-).

### Reporting Tobacco Exposure

1. The documentation must be precise in order to find evidence of whether the patient had exposure to second-hand smoke, a history of tobacco use, current use or dependence.
2. Several "use additional code" notes are included related to tobacco exposure and use:

<table>
<thead>
<tr>
<th>TOBACCO EXPOSURE AND USE</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z77.22</td>
<td>Exposure to environmental tobacco smoke</td>
</tr>
<tr>
<td>P96.81</td>
<td>Exposure to tobacco smoke in the perinatal period</td>
</tr>
<tr>
<td>Z87.891</td>
<td>Personal history of nicotine dependence</td>
</tr>
<tr>
<td>Z57.31</td>
<td>Occupational exposure to environmental tobacco smoke</td>
</tr>
<tr>
<td>(F17.-)</td>
<td>Tobacco dependence</td>
</tr>
<tr>
<td>Z72.0</td>
<td>Tobacco use</td>
</tr>
</tbody>
</table>

Use and dependence are further explained on pages 35-36.

### Coding Examples

- Patient has mild asthma that recurs once or twice a week, but does not impede physical activity.  
  **ICD-10-CM**: Mild intermittent asthma, uncomplicated (J45.20).
- Patient with chronic laryngitis. This patient is a long-time, dependent tobacco user who smokes cigarettes.  
  **ICD-10-CM**: Chronic laryngitis (J37.0) and Nicotine dependence, cigarettes, uncomplicated (F17.210).
- Patient visits the Doctor with acute bronchitis and COPD.  
  **ICD-10-CM**: COPD with acute bronchitis (J44.0) and Acute bronchitis, unsp. (J20.9) as it is part of the Excludes2 note, meaning it is not included in the code J44.0. It is appropriate to code for both.
Neoplasm in ICD-10-CM: Documenting and Coding (Chapter II and III)

A. Codes begin with a “C” or a “D”.

B. In the neoplasm table, a dash and/or and check mark at the end of a code indicates an additional character is needed (e.g., laterality). The tabular list must be reviewed for the complete code.

C. Categories C00-C75 organize primary malignant neoplasms according to their point of origin.

D. Categories C76-C80 contain malignant neoplasms for ill-defined, other secondary and unspecified sites.

E. For correct code assignment, the gender, site, and laterality should be identified as site and laterality are needed for both male and female breast cancer codes to be properly assigned.

F. Morphology codes have six digits to identify:
   • the first 4 digits, the histological type;
   • the 5th digit, the behavior (malignant primary, malignant secondary (metastatic), in situ, benign, uncertain whether malignant or benign) and
   • the 6th digit is a sorting code (differentiation) for solid tumors, also used as a distinctive code for lymphomas and leukemia.

G. Lymphomas and Leukemia do not metastasize to secondary sites. They circulate within the lymphatic or hematopoietic circulation and may occur in other sites within these tissues. Assign to morphology rather than to site.

H. Malignant neoplasms of ectopic tissue are to be coded to the site mentioned. Ex: ectopic pancreatic malignant neoplasms are coded to pancreas, unspecified (C25.9).

I. The entries under the main term polycythemia in the ICD-10-CM Index to Diseases and Injuries are different than the entries in the ICD-9-CM Index to Diseases. In ICD-9-CM, vera is a nonessential modifier to polycythemia. That is not the case in ICD-10-CM, where Polycythemia Vera is coded differently than polycythemia. Polycythemia in ICD-10-CM without further specificity is coded as a disease of the blood and blood-forming organ while in ICD9 it is coded with a neoplasm code.

In ICD-10-CM both polycythemia and secondary polycythemia are reported with code D75.1 from chapter 3, "Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism". If the physician documents Polycythemia Vera, then ICD-10-CM code D45 from the neoplasms chapter is reported.

J. Classification: the two main items of information for classification are:
   • the place where the tumor is (anatomical location; site; topography) and
   • the morphology (histology, cytology). For example the form of the tumor when scrutinized under the microscope as this indicates its behavior (malignant, benign, in situ, and uncertain behavior). If the term or descriptor is not documented, consult the index under Neoplasm, then by site.

All neoplasms are classified, whether they are functionally active or not. An additional code from Chapter IV (Endocrine, nutritional and metabolic diseases) may be used, if desired, to identify functional activity associated with any neoplasm.

When coding neoplasms, the category reorganization has “In Situ” neoplasms listed before the “Benign” neoplasms.

*If only the terms “mass” or “lesion” are mentioned, it is not correct to select a code from category D49, Neoplasms of unspecified behavior. The term Neoplasm is not to be used except when the growth is neoplastic in nature.*
## Neoplasm's Classification

### SOLID ORGAN/TISSUE NEOPLASMS:

<table>
<thead>
<tr>
<th>1. Site</th>
<th>2. Histologic behavior</th>
<th>3. Histologic type for some organs/tissues</th>
</tr>
</thead>
<tbody>
<tr>
<td>In situ</td>
<td>Benign</td>
<td>Liver &amp; intrahepatic bile ducts (Ex: Hepatoblastoma)</td>
</tr>
<tr>
<td></td>
<td>Malignant</td>
<td>Skin (Ex: Basal cell carcinoma, unsp.)</td>
</tr>
<tr>
<td></td>
<td>Uncertain behavior</td>
<td>Mesothelial and soft tissue (Ex: Mesothelioma, Kaposi's sarcoma)</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>Neuroendocrine tumors (Ex: Malignant carcinoid tumor)</td>
</tr>
<tr>
<td></td>
<td>Malignant neoplasms</td>
<td>Neoplasms In situ</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Skin (Ex: Melanoma in situ and Carcinoma in situ)</td>
</tr>
<tr>
<td></td>
<td>Benign neoplasms</td>
<td>Skin (Ex: Melanocytic nevi)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uterus (Ex: Leiomyoma)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neuroendocrine (Ex: Benign carcinoid tumor)</td>
</tr>
<tr>
<td>4. Laterality, for paired organs or extremities</td>
<td>5. Sex, for neoplasms of the breast</td>
<td></td>
</tr>
</tbody>
</table>

### Malignant neoplasm with two or more contiguous overlapping sites

- Malignancies of 2 or more adjacent sites should not be coded as one or the other without asking the physician.
- According to the 2012 ICD-10-CM Official Guidelines for Coding and Reporting (C.2) for a primary malignant neoplasm with two or more contiguous overlapping sites, coders should classify the sites to the subcategory/code with .8 (overlapping sites), unless the combination is specifically indexed elsewhere. Examples:
  
  A. *Carcinoma of esophagus and stomach* is specifically indexed to C16.0, while carcinoma of the tip and ventral surface of the tongue should be assigned to C02.8.
  
  B. *Patient with a primary malignant tumor in the splenic flexure and transverse colon.*

  **ICD-10-CM:** Malignant neoplasm of overlapping site of colon (C18.8).

  **Rationale:** Tumor, malignant in the Alphabetic Index, it directs the user to “see Neoplasm, malignant, by site” (the Neoplasm Table).

Intestine, splenic flexure, malignant, primary, and Intestine, transverse, malignant, primary in the Neoplasm Table, it directs the user to **C18.5 Malignant neoplasm of splenic flexure** and **C18.4 Malignant neoplasm of transverse colon**.

The patient has a malignancy that has invaded the splenic flexure and transverse colon, which are contiguous sites. Instead of coding both **C18.5** and **C18.4**, the user would code C18.8, Malignant neoplasm of overlapping site of colon.

*For multiple neoplasms of the same site that are not contiguous such as tumors in different quadrants of the same breast, codes for each site should be assigned.*
Sequencing Neoplasm

The 2012 ICD-10-CM Official Guidelines for Coding and Reporting ratify that:

- If the treatment is directed at the malignancy, the malignancy should be listed as the principal/first-listed diagnosis. The only exception is when the patient presents exclusively for administration of chemotherapy, immunotherapy, or radiation therapy. Coders should sequence first the primary site, followed by any metastatic sites.

- If the encounter is strictly for chemo, immunotherapy or radiation, those codes are coded as principle diagnosis and the malignancy is secondary. Then, the proper Z51 category code should be assigned as the principal/first-listed diagnosis, with the malignancy as a secondary diagnosis while the service is being performed.

Examples:

1. Patient diagnosed with a carcinoma of small intestines resected 3 months, localized in the area where duodenum and jejunum join. He has been receiving chemotherapy since then and came today for treatment.

   **ICD-10-CM:** Encounter for antineoplastic chemotherapy (Z51.11); Malignant neoplasms of overlapping sites of small intestine (C17.8) and Acquired absence of other specified parts of digestive tract (Z90.49).

   **Rationale:** Chemotherapy, is the first listed diagnosis (reason for the encounter). The patient is still receiving chemotherapy, then the neoplasm is still coded as current using the overlapping sites code (the cancer is in both duodenum and jejunum). Acquired absence of the small intestine’s code is used because the category includes the resected organ/part, complete/partial.

2. A female patient presents with two malignant neoplasms of the left breast; one in the upper-out inner quadrant and one in the lower-inner quadrant.

   **ICD-10-CM:** Malignant neoplasm of lower-inner quadrant of left female breast (C50.312), and Malignant neoplasm of upper-inner quadrant of the left female breast (C50.412).

   **Rationale:** On Breast in the Neoplasm Table, specific sites are listed. Breast, lower-inner quadrant, malignant, primary, it directs to C50.3; Breast, upper-inner quadrant, it directs them to (C50.4). Codes (C50.3-) and (C50.4-) in the Tabular Index show that additional characters are necessary to indicate laterality and the gender of the patient. In the example, the female patient has 2 malignancies of the left breast that are not contiguous. The 2 codes that would correspond to the example are needed.

Neoplasms and Metastasis/Metastatic

The terms "metastatic" and "metastasis" are frequently used vaguely in describing neoplastic disease, sometimes meaning that the site named is primary and others that it is secondary. When two or more sites are described as "metastatic" in the diagnostic statement, each of the stated sites should be coded as secondary or metastatic.

A. **METASTATIC TO:** shows that the site cited is secondary. Example: Metastatic carcinoma to the lung is coded as secondary malignant neoplasm of the lung (C78.0).

B. **METASTATIC FROM:** specifies that the site point out is the primary site. Example: Metastatic carcinoma from the breast shows that the breast is the primary site (C50.9). A code for the metastatic site should also be assigned.

C. **SINGLE METASTATIC SITE:** When only one site is defined as metastatic without more conclusive information, refer first to the morphology type in the Alphabetic Index and code to the primary condition of that site.
Example: Metastatic renal cell carcinoma of the lung.

**ICD-10-CM:** Malignant neoplasm of kidney, except renal pelvis, unspecified side (C64.9) and Secondary malignant neoplasm of lung, unspecified side (C78.00).

D. No site stated:
- Code C80.0, Disseminated malignant neoplasm, unspecified, should be applied when the patient has advanced metastatic disease and no known primary or secondary sites are stated.
- Code C80.1, Malignant (primary) neoplasm, unspecified, parallels to Cancer, unspecified and should only be used when no conclusion can be reach as to the primary site of a malignancy.
  - When no site is identified for the secondary neoplasm, Code C79.9, Secondary malignant neoplasm of unspecified site, is assigned.
  - When no site is indicated in the diagnostic but the morphology type is qualified as metastatic, the code provided for that morphological type is given for the primary diagnosis with a code for secondary neoplasm of unspecified site as well.
  - Example: Metastatic apocrine adenocarcinoma with no site specified, is coded as a primary malignant neoplasm of the skin, site unspecified (C44.99). An additional code of C79.9 is as signed for the secondary neoplasm.
  - When a patient is admitted because of a primary neoplasm with metastasis and the treatment is directed toward the secondary site only, the secondary neoplasm is the principal diagnosis even though the primary malignancy is still present.

Example: A patient has a primary malignancy in the right renal pelvis that metastasizes to the right ureter and presents for treatment of the ureter.

**ICD-10-CM:** Secondary malignant neoplasm of other urinary organs (C79.19) (reason of the encounter). Then, Malignant neoplasm of right renal pelvis (C65.1).

**Coding and sequencing of complications associated with the malignancies or with the therapy thereof are subject to the following guidelines:**

1. Anemia associated with malignancy, the malignancy first and anemia second.
   - Example: Patient admitted for treatment of malignancy-associated anemia. The patient has malignant neoplasm of the fundus of the stomach. The only treatment given is for the anemia.

   **ICD-10-CM:** Malignant neoplasm of fundus of stomach (C16.1); Anemia in neoplastic disease (D63.0)

   **Rationale:** In this scenario, although the patient is being treated only for the anemia, coders must report the malignancy first. D63.0 has an instructional note underneath it that states to code first neoplasm (C00-D49).
   
   **A. Anemia associated with chemo /immunotherapy:** the adverse event coded first, the anemia second, and then the malignancy.
   
   **B. Anemia associated with radiation:** anemia first, malignancy second and third is radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure (Y84.2).

2. Dehydration due to the malignancy: When an encounter is for management of a complication associated with a neoplasm, such as dehydration, and the treatment is only for the complication, the complication is coded first.

3. When a primary malignancy has been excised but further treatment is directed to that site, such as an additional surgery for the malignancy, radiation therapy or chemotherapy, the primary malignancy code should be used until treatment is completed.
4. Pathological fracture due to a neoplasm: If a encounter is for pathological fracture due to neoplasm, and the focus of treatment is the fracture, a code from subcategory M84.5, Pathological fracture in neoplastic disease, is sequenced first followed by the code for the neoplasm.

If the focus of treatment is the neoplasm with an associated pathological fracture, the neoplasm code should be sequenced first, followed by a code from M84.5 for the fracture.

5. Treatment of a complication resulting from a surgical procedure: For a complication resulting from a surgical procedure performed to treat the neoplasm, designate the complication as the principal/first-listed diagnosis. See guideline regarding the coding of a current malignancy versus personal history to determine if the code for the neoplasm should also be assigned.

6. Remission: The categories for leukemia, and category C90, Multiple myeloma and malignant plasma cell neoplasms, have codes indicating whether or not the leukemia has achieved remission. There are also codes, Personal history of leukemia (Z85.6) and Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues (Z85.79). If the documentation is vague the provider should be asked, as to whether the leukemia has reached remission.

Personal History
• If the Primary malignancy is still being treated, code malignancy.
• When a primary malignancy has been excised or removed from its site, there is no additional treatment directed to that site, and there is no indication of any prevailing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used.

Some Remarks about HIV
• Code only confirmed cases of HIV infection: This is an exception to the hospital inpatient. HIV to be established there, does not require a positive serology or culture. The provider’s diagnosis stating that the patient is HIV positive or has an HIV-related condition is acceptable and enough. If the disorder is listed as “probable”, “rule out” or “possible” would not be given ICD-10 code B20.

• Selection and sequencing of HIV Codes: When a patient is treated for HIV-related condition (s) the main diagnosis should be B20, Human immunodeficiency virus (HIV) disease, followed by an additional diagnosis code for each reported HIV-related condition.

• When a person living with HIV gets certain infections (called opportunistic or OUs) and if the type of blood cell that fights infection (CD4 cells) falls below a certain level in persons with HIV, he/she will be diagnosed with AIDS.

• Once a patient is diagnosed as having the symptomatic HIV category B20, the HIV care will always be reported with B20, even if the patient’s condition improves as much as to appear asymptomatic. Physician’s documentation should be consistent from one encounter to the next one.

<table>
<thead>
<tr>
<th>TESTING</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for HIV (without S &amp; S) - Z11.4</td>
<td>Human immunodeficiency virus (HIV) counseling - Z71.7</td>
</tr>
<tr>
<td>Contact with and (suspected) exposure to HIV (without S &amp; S) - Z20.6</td>
<td>HIV testing due to S &amp; S, regardless of whether he/she knowingly has been exposed to the virus - Code specific S &amp; S</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TESTING RESULTS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative: HIV counselling (code for services rendered during an encounter) - Z71.7</td>
<td>(HIV) disease complicating pregnancy, childbirth and the puerperium - (O98.7)</td>
</tr>
<tr>
<td>Inconclusive: no definitive diagnosis or laboratory evidence of (HIV) - R75</td>
<td>Positive without Symptoms: Asymptomatic HIV Infection status. Positive results but no signs or symptoms - Z21</td>
</tr>
<tr>
<td>Positive with Symptoms: Human immunodeficiency virus [HIV] disease - B20</td>
<td></td>
</tr>
</tbody>
</table>
Diseases, Disorders and Injuries from the Musculoskeletal System

Diseases, disorders and injuries from the musculoskeletal system are coded in ICD-10-CM in Chapter XIII: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99), and Chapter XIX: Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88).

These chapters refer to both the muscles and bones (including diseases, fractures, and injuries) within this body system.

A. **Additional documentation required two designations:** The majority of codes in Chapter XIII of ICD-10-CM have been expanded in some way. This is primarily due to the additional documentation that is required in regards to site and laterality.
   1. **Site:** The site represents either the bone, muscle, or joint involved.
      - There is an option for multiple sites when a diagnosis concerns more than one bone, muscle, or joint. For example, other juvenile arthritis, multiple sites (M08.89).
      - When more than one bone, joint, or muscle is involved and there is not a multiple site option or code, multiple codes must be used to indicate the sites involved. For example: Osteomyelitis of cervical and lumbosacral vertebra would be coded as Osteomyelitis of vertebra, cervical region (M46.22) and Osteomyelitis of vertebra, lumbosacral region (M46.27).

2. **Laterality:** All codes that have laterality requirements need to have identified whether the disease, injury, or diagnosis is located on the right or left region.
   - Example: Patient has a diagnosis of an abscess of bursa of the right shoulder.
   - **ICD-10-CM:** Abscess of bursa, right shoulder (M71.011).

B. **Reorganization of codes:** Several codes from various chapters in ICD-9-CM were moved to chapter XIII in ICD-10-CM because they were principally focused on the musculoskeletal system. Example: Gout, disease that primarily involves joints, it was rearrange and moved from Chapter III to Chapter XIII.

C. **Combination codes for some conditions & associated symptoms:** There are some codes that comprise 2 diagnoses, or a diagnosis with an associated secondary process & a diagnosis with an associated complication. Example: Endocarditis in systemic lupus erythematosus (M32.11).

D. **Expansion:** Due to the necessity of greater detail, the musculoskeletal code system reflects an expansion to capture with accuracy the patient's health.
   - Example: Rheumatoid arthritis and Bursitis ICD-9-CM codes are mapped to “several” ICD-10-CM codes. This system offer more elements identifying laterality and body sites.

Some facts about Rheumatoid arthritis (RA)

- Do not assess Rheumatoid arthritis, unspec (M06.9) (or any disorder) as an established condition if it is only suspected and not categorically confirmed. Instead, document the signs and symptoms.
- A positive rheumatoid factor test is useful but not crucial to confirm the Rheumatoid arthritis. Clinical evaluation and further tests are needed.
- It is important to identify the site(s) affected and the laterality as well as to determine if with or without rheumatoid factor among other specifications.
- When documenting Rheumatoid arthritis, besides the Physical examination, always include the treatment plan (Like Methotrexate, DMARDs, Physical therapy targeting the relief of the symptoms, etc.).
About Fractures

1. Fractures in ICD-10-CM have gone through a substantial amount of changes that require:
   A. The type of fracture as displaced or nondisplaced, if not indicated, fractures are coded as displaced.
   B. Site of the fracture.
   C. Support for laterality.
   D. Identification of episode of care.
   E. Identification of Open or Closed: According to ICD-10-CM Official Coding Guidelines section I.C.19.c, a fracture not identified as open or closed is coded as closed. In ICD-10-CM, fracture codes require a seventh character for the episode of care, some of which are based on whether the fracture is closed or open.
   F. Use the Gustilo classification system for further classification of open fractures.

2. Fracture has two separate main entries in the ICD-10-CM alphabetic index:

3. Acute/traumatic vs chronic/recurrent: Many musculoskeletal conditions are a result of previous injury or trauma to a site, or are recurrent conditions.
   - If recurrent, they are usually found in chapter XIII.
   - Any current acute injury should be coded to the appropriate injury code from chapter XIX.

4. If treatment is directed at the current injury, coders should not use the Z series of codes (aftercare). The injury code should be reported with a 7th-character extension to identify the episode of care. Assigning a extension allows to track the continuity of care and the type of injury.

   Example: A patient is at the office for a follow up of his a nonunion distal right humerus fracture.

   ICD-10-CM: Unspecified fracture of lower end of right humerus, subsequent encounter for fracture with nonunion (S42.401K). This code includes the site and laterality.

Causes for Pathological Fractures

ICD-10-CM identifies 3 different causes for pathologic fractures:

1. Neoplastic disease: When an encounter is for a pathological fracture due to a neoplasm, and the focus of treatment is the fracture, a code from subcategory (M84.5-), Pathological fracture in neoplastic disease, should be sequenced first, followed by the code for the neoplasm. If the focus of treatment is the neoplasm with an associated pathological fracture, the neoplasm code should be sequenced first, followed by a code from (M84.5-)for the pathological fracture.

2. Other specified disease: including among others there are osteomyelitis, Paget’s disease, disuse atrophy, hyperparathyroidism, and nutritional or congenital disorders.
3. Osteoporosis: Osteoporosis is a systemic condition, signifying that all bones of the musculoskeletal system are affected. It is the most common type of bone disease. Regarding pathological fractures, Osteoporosis has 2 categories:

- Osteoporosis without pathological fracture: Category **M81**, is for use on patients with osteoporosis who do not have at this time a pathologic fracture due to the osteoporosis, even if they have had one before. Site is not a component of the codes under category M81. For patients with a history of osteoporosis fractures, status code **Z87.310**, Personal history of (healed) osteoporosis fracture, should be added following the code from M81.

- Osteoporosis with current pathological fracture: Category **M80**, is for patients who have a current pathologic fracture at the time of the encounter. The codes under M80 identify the site of the fracture, not the osteoporosis. 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 as the result of a trauma that would not usually break a healthy bone. This category involves a 7th character to describe the type of encounter.

The 7th Character Extension

In certain circumstances is a necessity to assign a 7th character to code particular diagnoses. The 7th character always occupies the 7th space data field even for codes that are less than 6 characters. That character refers to the episode of care and includes: Initial & Subsequent encounter and Sequela.

The episode of care for fractures is more complex than for other injuries, because it demands supplementary information about the fracture: open or closed, healing phase, routine or with complications, nonunion or malunion.

<table>
<thead>
<tr>
<th>EXTENSION</th>
<th>TYPE OF ENCOUNTER</th>
<th>TO BE USED</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Initial encounter for closed fracture</td>
<td>When the patient is receiving active treatment for the injury, (e.g., surgical treatment or emergency department encounter)</td>
</tr>
<tr>
<td>B</td>
<td>Initial encounter for open fracture</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Subsequent encounter for fracture with routine healing</td>
<td>For encounters that occur after the patient has received and completed active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase, (e.g., cast change or removal, medication adjustment, removal of external or internal fixation device or other aftercare and follow-up visits)</td>
</tr>
<tr>
<td>G</td>
<td>Subsequent encounter for fracture with delayed healing</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>Subsequent encounter for fracture with nonunion</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Subsequent encounter for fracture with malunion</td>
<td></td>
</tr>
<tr>
<td>S</td>
<td>Sequela</td>
<td>For complications or conditions that arise as a direct result of an injury (e.g., scar formation after a burn). When using extension S, code both the injury that caused the sequela and the sequela itself. Code the condition or problem first, and the sequela code second.</td>
</tr>
</tbody>
</table>
Classification for Open Fractures

There are multiple classification systems for fractures including the Gustilo classification, the Tscherne, the Mangled Extremity Severity Scale, the Hanover scale, and the AO fracture scale.

ICD-10-CM codes for certain types of open fractures require a 7th character that categorizes open fractures using the **Gustilo classification**. This is the most widely used structure and is generally accepted as the primary classification system for open fractures.

This classification is not for all bones or all types of fractures. Therefore, in addition to stating the site of the fracture, the medical record must provide the necessary specificity in the documentation to allow the coder to assign the correct 7th character extension as this character is not optional.

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**Gustilo Classification**

- **TYPE I**
  - low-energy/velocity
  - clean wound
  - wound < 1 cm in length
  - intramedullary nailing, average time to union 21-28 weeks
  - soft tissue injury and fracture comminution is minimal

- **TYPE II**
  - contamination and soft tissue damage (flaps, avulsion) is moderate
  - wound > 1 cm in length
  - intramedullary nailing, average time to union 26-28 weeks
  - minimal fracture comminution

- **TYPE III**
  - high-energy/velocity or crushing (i.e., injuries due to farm accidents, gunshot, war, tornado, high-speed vehicle)
  - massive/highly contaminated wound
  - wound > 1 cm in length
  - extensive soft tissue damage/loss (flaps, avulsion, crush) requires vascular repair or has been open for 8 hours prior to treatment
  - segmental or severely comminuted fracture w/ displacement, bone loss, traumatic amputation

**Grade III A:**
- wound < than 10 cm w/ crushed tissue & contamination
- intramedullary nailing, average time to union is 30-35 weeks
- soft tissue coverage of bone is usually possible

**Grade III B:**
- wound > than 10 cm w/ crushed tissue & contamination
- intramedullary nailing, average time to union is 30-35 weeks
- soft tissue is inadequate & requires regional or free flap

**Grade III C:**
- fracture w/ a major vascular injury requiring repair for limb salvage
- in some cases, it will be necessary to consider BKA following tibial fracture

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**Injuries**

Codes are organized by the general site of the injury and then by type, beginning with the more superficial injuries and ending with injuries involved in deeper body structures.

In addition, when coding for a traumatic injury, ICD-10 also requires the use of secondary codes to identify the external cause of injury. Examples:

- **By anatomic location**: Displaced fracture of medial phalanx of right index finger, initial encounter for closed fracture (S62.620A)
- **By Type (like contusion, foreign body, wound)**: Puncture wound with foreign body, left foot, initial encounter (S91.342A)
- **Sequela - complication or condition that arises as a direct result of the injury**: Displaced subtrochanteric fracture of right femur, sequela (S72.21XS)
Mental Behavioral & Neurodevelopmental disorders—Chapter V:(F01-F99)

1. Specificity, detail and expansion of some codes: Classification improvements with more codes more subchapters, categories, subcategories, and codes that provide greater clinical detail. For example, Other Isolated or Specific Phobias and Alcohol and substance abuse.

2. The codes in this chapter are to be assigned with provider documentation of a mental or behavioral disorder based in its clinical judgment not just founded upon symptoms, signs & abnormal clinical laboratory findings.

3. Combination Codes for Mental and Behavioral Health: Combination codes have been generated for drug and alcohol use and associated conditions, such as withdrawal, sleep disorders, or psychosis. A code for blood alcohol level, (Y90.-) can be assigned as a supplementary code when documentation supports its use. Some Ex: Sedative, hypnotic or anxiolytic dependence with intoxication delirium (F13.221); Hallucinogen dependence with intoxication and delirium (F16.221).

4. Code titles are more ample.

5. Certain diseases have been reclassified to reflect up-to-date medical knowledge: changes in names and definitions of disorders have been made to reflect more current clinical terminology and to regulate the terms used to diagnosed mental, behavioral and substance use disorders.

6. Pain disorders linked to psychological factors (F45.4): The ICD-10-CM guidelines have been expanded to include information related to: code F45.41 indicates only psychological pain that is not supported by any medical condition and code F45.42 which designates a genuine medical pain with a psychological factor. When using this last code, the provider should report the related acute or chronic pain (G89.-) as well. Note that pain NOS is reported with R52.

7. Sequencing of the intellectual disability codes (F70–F79): When coding in ICD-10-CM, the connected physical or developmental disorder should be coded first and then the intellectual disability code.

8. Category of “mood disorders,” code range F30–F39, includes conditions such as manic episode, bipolar disorder, major depressive disorder, and persistent mood disorders.

9. If insomnia is due to a mental health illness/behavioral condition, code F51.05 should be assigned, followed by a code reporting the exact mental disorder.

10. Updates to medical terminology: Bipolar I disorder, single manic episode will change to Manic episode; Undersocialized conduct disorders, aggressive will become Conduct disorder childhood-onset type (F91.1).

11. When hearing loss is causing a delay in a patient’s development of the speech and language, the type of hearing loss should be identified with a secondary code.

12. If delirium is due to an identified physiological condition, the underlying condition should be coded first, followed by Delirium due to known physiological condition (F05).

Term ‘in remission’: The appropriate codes for in remission are assigned only on the basis of provider documentation (as defined in the Official Guidelines for Coding and Reporting I.C.5.b.1). It can be classified as in partial or full remission and, according to the stage, may still have depressive symptoms or not. The patient will be receiving treatment to reduce the risk of further episodes or will be very closely monitored by the Physician. e.g., Major depressive disorder, single episode, in full remission (F32.5); Major depressive disorder, recurrent, in partial remission (F33.41).
A. **Major Depressive Disorder:** Within ICD-10-CM, the documentation of a Major Depressive Disorder should specify or include the following information, if known:

![Diagram of Major Depressive Disorder]

*Depressive disorder NEC (311) in ICD-9-CM will code to Major depressive disorder, single episode, unspecified (F32.9) in ICD-10-CM. Specificity is key when documenting.*

B. **Persistent Mood Disorder:** Includes Cyclothymic (F34.0) and Dysthymic disorder (F34.1)

C. **Certain anxiety and stress-related disorders:** Includes Social Phobia (F40.1); Specified (isolated) phobias (Example: Animal type phobia (F40.21); Panic disorder (F41.0))

D. **Schizophrenia:** Codes are in category F20 and are broken down by subtype:
- Paranoid schizophrenia (F20.0)
- Catatonic schizophrenia (F20.2)
- Residual schizophrenia (F20.5)
- Disorganized schizophrenia (F20.1)
- Undifferentiated schizophrenia (F20.3)
- Schizophreniform disorder (F20.81)

Example: Patient with paranoid schizophrenia comes in for a check-up. He is doing well with Aripiprazole and psychotherapy, but has started to gain weight. Labs were ordered to check his cholesterol level due to possible side effects of the medication and weight control is discussed.

**ICD-10-CM: Paranoid schizophrenia (F20.0)**

E. **Other Conditions**
- **Vascular dementia:** Two common types:
  - Vascular dementia w/o behavioral disturbance (F01.50)
  - Vascular dementia with behavioral disturbance (F01.51).
- **Eating Disorders:** Like Anorexia nervosa, restricting type (F50.01); Anorexia nervosa, binge eating/purging type (F50.02); Bulimia nervosa (F50.2).
- **Pervasive Developmental Disorders (PDDs):** Like Autism (F84.0) and Asperger’s syndrome (F84.5)

F. **Bipolar Disorder:** Patient suffers dramatic mood swings from mania to depression. In ICD 10 is classified by the following parameters:
- **Type:** type I or type II
- **Current episode:** Hypomanic, manic, depressed, mixed
- **Severity:** Mild, moderate, severe
  - With or without psychotic features
- **Remission status:** Partial or Full
Substance Use, Abuse, and Dependence

In ICD-10 for the classification of substance use, abuse and dependence, the terms are not interchangeable. They are separate conditions. Per Coding Guideline I.C.5.c.2. Hierarchy Rules for Coding Psychoactive Substance Use, Abuse and Dependence, when the provider documentation refers to use, abuse and dependence of the same substance (e.g., alcohol, opiod, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:

<table>
<thead>
<tr>
<th>Code only:</th>
<th>When documented:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse</td>
<td>Use and Abuse</td>
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<tr>
<td>Dependence</td>
<td>Dependence and Abuse</td>
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<td>Use and Dependence</td>
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<td>Use, Abuse and Dependence</td>
</tr>
</tbody>
</table>

Alcohol Use, Abuse and Dependence

Alcohol abuse and dependence codes no longer identify continuous or episodic use.

Those codes are further broken down into the following:

- Uncomplicated
- With: intoxication; withdrawal; alcohol-induced psychotic disorder and persisting amnestic disorder; alcohol-induced persisting dementia; other alcohol-induced disorder; unspec. alcohol induced disorder

The ICD-10-CM classification system does not provide separate “history” codes for alcohol and drug abuse. A patient with a history of drug or alcohol dependence is coded as “in remission”.

### Nicotine Use and Dependence

- Cigarettes (F17.210)
- Other Tobacco product (F17.29-)
- Chewing tobacco (F17.22-)

### Complication

- Uncomplicated
- In remission
- With withdrawal
  - With other nicotine-induced disorder
  - With unspecified nicotine-induced disorder
Other Drug Use, Abuse and Dependence

These categories are further broken down:

- with intoxication (uncomplicated, delirium, perceptual disturbances, unsp.)
- with induced psychotic disorder (delusions, hallucinations, other)
- with other induced disorder (anxiety disorder, sexual dysfunction, sleep disorder, other disorder, unsp.)
- Example: Patient presents to the office with uncomplicated alcohol dependence and cocaine abuse with cocaine-induced anxiety disorder

ICD-10-CM: Alcohol dependence, uncomplicated (F10.20) & Cocaine abuse w/cocaine-induced anxiety disorder (F14.180)

Caffeine Dependence

Caffeine is recognized as the most widely used stimulant in the world. Though reasonable consumption has occasionally been considered to be harmless and beneficial, the use of caffeine has been also associated with numerous medical issues including hypertension, heart complications, anxiety disorders, and insomnia, among others.

In ICD-10-CM Category F15-, mental and behavioral disorders due to use of other stimulants, includes caffeine in code F15.20, other stimulant dependence, uncomplicated. This HCC code should be reported if the documentation supports the diagnosis.

Circulatory System - Chapter IX: (I00-I99)

Ischemic Heart Disease: I10-I25

A. Coronary artery disease and angina

ICD-10-CM establish the code selection by type of vessel or graft:

1. CAD of a native artery appears in category (I25.1-). The additional characters in this code denote the presence or absence of angina pectoris, making it a combination code. By creating a combination code, it is eliminated the argument about which diagnosis should be considered the principal diagnosis.
   - The default code is I25.10 for a native artery without angina pectoris. I25.11 correspond to Atherosclerotic heart disease of native coronary artery with angina pectoris

2. Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris. (I25.7-).
   - When using one of these combination codes it is not required to use an additional code for angina pectoris. A causal relationship can be implicit in a patient with both atherosclerosis and angina pectoris, except the documentation specifies the angina is due to something other than the atherosclerosis.
   - If a patient with coronary artery disease is admitted due to an AMI, the AMI should be sequenced before the coronary artery disease.

3. Angina Pectoris:
   - Unstable (I20.0)
   - With documented spasm (I20.1)
   - Other forms (I20.8)

Example: A patient is diagnosed with CAD and Angina with no previous history of a CABG.

B. **Chronic ischemic heart disease, unspecified**: (I25.9) Symptoms for more than 4 weeks. Locate it in the Alphabetic Index by looking for the terms disease, heart, ischemia, myocardium, and then chronic.

C. **Myocardial infarctions: Acute MI is coded by:**
   - Site (anterolateral wall or posterior wall)
   - Type (STEMI or NSTEMI)
   - Temporal Parameter (Initial, subsequent and old)

In ICD-10-CM, MIs appear in the following code categories:
- **(I21.-) ST elevation (STEMI and non-ST elevation (NSTEMI)) MIs.** Denotes the specific wall and the coronary artery involved in the MI. Code (I21.-) has an includes note that states acute MIs are defined as having a duration of four weeks (28 days) or less from onset.
- **Code I21.3, STEMI 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.
- **(I22.-) Subsequent ST elevation (STEMI and non-ST elevation (NSTEMI)) MIs.** There is a separate code specifically for subsequent MIs, and the term “subsequent” denotes an additional AMI within a 4 week time frame of an initial MI.
- **Code category (I22.-) also distinguishes between STEMI vs. NSTEMI and denotes the specific wall involved in the MI.**
  - Code (I22.-) has an includes note that states the subsequent MI occurs within four weeks (28 days) of a previous MI, regardless of site. Coders must report a code from the (I22.-) category in conjunction with a code from the (I21.-) category. The sequencing of the I22 and I21 codes depends on the circumstances of the encounter.
  - Category I22 must be used affiliated with a code from category I21.
- **(I23.-) Complications following MI within the 28 day period.**
- **I25.2 - Old MI.** Patient has a history of an MI.
- **If a STEMI converts to NSTEMI due to thrombolytic therapy (use of drugs to break up or dissolve blood clots) it is still coded as a STEMI.**

Examples:

1. A patient is being treated for an Acute Non-ST Anterior Wall MI which she suffered 5 days ago. The patient also has Atrial Fibrillation.
   **ICD-10-CM:** Non-ST Elevation (NSTEMI) Myocardial Infarction (I21.4) and Unspecified Atrial Fibrillation (I48.91).

2. Patient suffered an acute MI of the right coronary artery 3 weeks ago. He is presenting for his 2 week hospital follow-up. He is getting better.
   **ICD-10-CM:** ST elevation (STEMI) myocardial infarction involving right coronary artery (I21.11) (Less than 28 days).

3. Patient presents for a check-up. She suffered an MI of the left main coronary artery. She is asymptomatic and requires no continued care for the MI. Due to her history, is being followed.
   **ICD-10-CM:** Old myocardial infarction (I25.2).
Diseases of Arteries, Arterioles and Capillaries: I70-I79

- Include atherosclerosis, aneurysm, thrombus, embolism, PVD, and other strictures and dissections of these vessels.
- Examples: Arteriosclerosis of legs with intermittent claudication (I70.213); Abdominal aortic aneurysm (I71.4); CABG status post (Z95.1)
- As required by the specificity needed in ICD-10, is important to:
  o State laterality and acuity, when applicable
  o Identify any chronic total occlusion of an artery
  o Detail the diseased vessel (e.g., atherosclerosis of popliteal artery Gore-Tex graft)
  o Clarify atherosclerosis versus PVD
  o Differentiate a bypass graft in-stent versus end-stent stenosis
- Include various forms of pericarditis, cardiomyopathy, heart block, arrhythmias, valve disorders, pericardial effusion, and heart failure.

A. Heart Failure (I50.-): The subcategories indicate the type: left ventricular; systolic; diastolic and combined systolic and diastolic.

  “Congestive” is an nonessential modifier in the heart failure codes. It is broken down by time parameters as acute, chronic and acute on chronic.

  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.

  Examples:
  1. Patient comes for a check-up of his chronic diastolic heart failure. Reports he’s sleeping and feeling better on meds. He will return in 3 months.
     
     **ICD-10-CM:** Chronic diastolic (congestive) heart failure (I50.32).
  2. 78 years old female who return for recheck. She has acute on chronic systolic heart failure due to hypertension.
     
     **ICD-10-CM:** Hypertensive heart disease with heart failure (I11.0) and Acute on chronic systolic heart failure (I50.23).
  3. Patient with diagnosis of systolic congestive heart failure due to hypertensive heart disease and stage 5 chronic kidney failure. The patient has been prescribed Lasix previously but admits he forgets to take his medication every day due to his advanced age.
     
     **ICD-10-CM:** Hypertensive heart and CKD with heart failure and with stage 5 CKD or ESRD (I13.2); Systolic (congestive) heart failure (I50.20) and CKD 5 (N18.5).

B. Atrial Fibrillation can now be identified as:
- Paroxysmal (I48.0)
- Persistent (I48.1)
- Chronic (I48.2)
- Unspecified (I48.91)

C. Atrial Flutter
- Typical (I48.3)  
  Unspecified (I48.92)
- Atypical (I48.4)

D. Sick sinus syndrome (I49.5): ICD-10 gives its own code to “Sick Sinus Syndrome” (I49.5). The code is also appropriate for tachycardia-bradycardia syndrome.

  If the documentation shows: Sinoatrial bradycardia, Sinus bradycardia, Slow heartbeat, or Vagal bradycardia, you'll use the code R00.1 instead (Bradycardia, unspecified).
Cerebrovascular Diseases (I60-I69)

To evaluate cerebrovascular diseases:

- List conditions that exist because of a cerebrovascular event.
- Describe the residual condition fully (e.g., cognitive deficits, aphasia, dysarthria, hemiplegia, etc.).
- Specify the anatomic site (e.g., upper limb, lower limb).
- State the laterality when applicable (i.e., right or left).
- Identify the affected side as dominant or non-dominant.
- Provide the underlying cause (e.g., homonymous hemianopia secondary to history of a ruptured aneurysm).

- **Types:**
  - **Nontraumatic hemorrhagic CVAs** (I60.- to I62.-): Important to provide the location or source of the hemorrhage (if known); Right or left artery (if applicable). If the documentation states bilateral hemorrhage sites, assign codes for each side, since there is no bilateral option for this series.
    
    Example: A patient with nontraumatic subarachnoid hemorrhage of bilateral vertebral arteries.
    
    ICD-10-CM: Nontraumatic subarachnoid hemorrhage from right vertebral artery (I60.51) and Nontraumatic subarachnoid hemorrhage from left vertebral artery (I60.52).
  - **Oclusive CVAs** (I63.- to I68.-): Must determine if it is Thrombosis, embolism, or unspecified; Infarction or not resulting in infarction and the Location of occlusion.
    
    If the patient has an infarction due to bilateral thromboses in the right and left carotid arteries, both codes would need to be assigned.
  - Cerebral infarction due to thrombosis of unspecified carotid artery (I63.039). Excludes sequelae of cerebral infarction (I69.3).

Sequelae

- Sequelae of cerebrovascular disease (i.e., synonymous with late effect) appears in ICD-10-CM code (I69.-) and it specifies whether the sequelae is a result of a hemorrhagic or occlusive CVA, as well as the residual condition. The combination codes make it easier to identify all specific information in one code.
- Report code Z86.73 (Personal history of CVA/TIA without residual deficits) as an additional code for history of cerebrovascular disease when no neurologic deficits are present.
- Codes from category (I69.-), Sequelae of cerebrovascular disease, that specify hemiplegia, hemiparesis and monoplegia, identify whether the dominant or nondominant side is affected.

*Note: See page 20 for Hemiplegia and Hemiparesis.*

Screening, Routine Examination– Chapter XXI: (Z00-Z99)

- The ICD-10-CM Tabular List categorizes codes to represent reasons for encounters as Z codes. The codes have 3 to 7 characters, but Z-code categories Z00-Z99 consist of 3 to 6 characters.
- Screening visits provide asymptomatic individuals with early detection testing for diseases such as a screening mammogram for early detection of breast cancer in women. Screening codes can be used as either a first-listed or additional code depending on the reason for the encounter.

**Common screening codes:**

- Cardiovascular disorders (Z13.6)
- Encounter for screening for other disorder (Z13.89). Includes Depression, Nephropathy, etc
- Screening for diabetes mellitus (Z13.1)
- Screening for malignant neoplasm of respiratory organs (Z12.2)
Reminder:

This tool is just an overview about some chronic disorders commonly found in the medical records. Always remember to examine the coding guidelines to determine the final assignment of a code.