Speaking ICD-10-CM: Chronic Obstructive Pulmonary Disease (COPD)

ICD-9-CM

COPD documented with a more specific respiratory condition falls under multiple code categories:

- 491.20-491.22 Obstructive chronic bronchitis
- 493.20-493.22 Chronic obstructive asthma
- 496 Chronic obstructive pulmonary disease

ICD-10-CM

COPD documented with a more specific respiratory condition falls under one code category:

- J44.0-J44.9 Chronic obstructive pulmonary disease

Instructional Note: Code also type of asthma, if applicable (J45.-)

In ICD-9, code 496 (COPD) is not to be used with any code from categories 491 (chronic bronchitis), 492 (emphysema), or 493 (asthma).

In ICD-10, code category J44 encompasses asthma and bronchitis associated with COPD. Code category J44 includes other COPD, asthma with COPD, chronic asthmatic (obstructive) bronchitis, chronic bronchitis with airways obstruction, chronic bronchitis with emphysema, chronic emphysematous bronchitis, chronic obstructive asthma, chronic obstructive bronchitis and chronic obstructive tracheobronchitis.

Furthermore, in ICD-10, there is a note to use an additional code to identify exposure to environmental tobacco smoke (Z77.22)*, exposure to tobacco smoke in the perinatal period (P96.81)*, history of tobacco use (Z87.891), occupational exposure to environmental tobacco smoke (Z57.31)*, tobacco dependence (F17.-), and tobacco use (Z72.0)*.

*New specific tobacco related codes in ICD-10

ICD-10 Implementation Date: October 1, 2015

- Outpatient services are based on the Date of Service
- Inpatient services are based on the Date of Discharge


Y0114_15_25255_1_08/17/2015

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ICD-9-CM

Single diagnosis code:

427.31 – Atrial Fibrillation

ICD-10-CM

Multiple diagnosis codes:

I48.0 - Paroxysmal atrial fibrillation
I48.1 – Persistent atrial fibrillation
I48.2 – Chronic atrial fibrillation
I48.91 – Unspecified atrial fibrillation

ICD-10 code set provides multiple diagnosis codes that represent a progressive path (severity of illness) for atrial fibrillation:

- I48.0- Episodes come and go (attack) but resolve on their own
- I48.1- Episodes that require intervention (medication, cardioversion, ablation) to stop the atrial fibrillation and return heart to normal sinus rhythm (NSR)
- I48.2- Permanent atrial fibrillation, present all the time and cannot be returned to NSR with intervention
- I48.91- Not documented to specify as I48.0, I48.1, or I48.2

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ICD-10 Implementation Date: October 1, 2015

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Per EncoderPro, “Rheumatoid arthritis is a chronic, systemic inflammatory disease of unknown etiology, characterized by a variable but prolonged course with exacerbations and remissions of joint pains and swelling. In early stages, the disease attacks the joints of the hands and feet. As the disease progresses, more joints become involved.”

Notable differences in ICD-9 versus ICD-10 for Rheumatoid Arthritis with Polyneuropathy are:
- In ICD-9, diagnosis is reported with two separate codes
- In ICD-10, diagnosis is reported with a combination code including the specific site and laterality
  - Keep in mind that since a bilateral code is not provided, a separate code should be assigned for both left and right side when documented.

ICD-9-CM

714.0- Rheumatoid Arthritis
357.1- Polyneuropathy in collagen vascular disease

ICD-10-CM

M05.50- Rheumatoid polyneuropathy with rheumatoid arthritis, unsp. site
*M05.51_-of shoulder
*M05.52_- of elbow
*M05.53_- of wrist
*M05.54_- of hand
*M05.55_- of hip
*M05.56_- of knee
*M05.57_- of ankle and foot
M05.59- of multiple sites

*Sixth Digit: 1- Right, 2- Left, 9- Unsp.
Sepsis requires two codes to denote the more severe form of sepsis (severe defined as “with or without organ dysfunction/failure related to the sepsis”).

- More severe - A41.9 and R65.20 (with septic shock R65.21)  
  Note: R65.20 (.21) MUST be reported with underlying systemic infection first - such as sepsis with or without organism A41.- (organisms have 4th or 5th digit specificity)

- Less severe - A41.9 Sepsis, unspecified organism  
  Note: Sepsis is not Bacteremia NOS (R78.8) and is not urosepsis/urinary tract infection (N39.0)
Speaking ICD-10-CM: Urosepsis

**ICD-9-CM**

Urosepsis, default code 599.0.

- **599.0** - meaning UTI (Urinary Tract Infection)
  - Use additional code to identify organism, such as *Escherichia coli* [E. coli] (041.41-041.49)
- **995.91** - meaning Sepsis
  - Code first underlying infection

**ICD-10-CM**

Urosepsis, code to condition. No default.

- **N39.0** - UTI
  - Use additional code (B95-B97), to identify infectious agent
- **A41.9** - Sepsis, unspecified organism

Differences in ICD-9 and ICD-10 Official Guidelines for Coding and Reporting, Section 1, Infectious and Parasitic Diseases:

ICD-9, “Note: The term urosepsis is a nonspecific term. If that is the only term documented then only code 599.0 should be assigned based on the default for the term in the ICD-9-CM index, in addition to the code for the causal organism if known.”

ICD-10, “The term urosepsis is a nonspecific term. It is not to be considered synonymous with sepsis. It has no default code in the Alphabetic Index. Should a provider use this term, he/she must be queried for clarification.”

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Countdown To ICD-10

Speaking ICD-10-CM:
Cerebral Artery Occlusion with Infarct

ICD-9-CM
434.91 - Cerebral artery occlusion, unspecified, with cerebral infarction

ICD-10-CM
I63.50 - Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral arteries

The main difference between ICD-9 and ICD-10, is that ICD-10 includes laterality and specificity that identifies the artery involved in the site of the infarction.

For example, I63.511 is right middle cerebral artery, I63.512 is left middle cerebral artery, or I63.519 is unspecified middle cerebral artery.

This same laterality pattern for sixth digit assignment follows for the anterior (I63.52-), posterior (I63.53-), and cerebellar arteries (I63.54-).

- Stroke is coded using I63.9 - Cerebral infarction, unspecified
- Transient Ischemic Attack (TIA) is coded using G45.9 - Transient cerebral ischemic attack, unspecified

ICD-10 Implementation Date:
October 1, 2015

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CMS ICD-10 Trainings:

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Speaking ICD-10-CM: Acute Myocardial Infarction (AMI)

There are two key changes related to AMI:

- **Encounter classification.** In ICD-9 a fifth digit, either 1 (initial episode of care) or 2 (subsequent episode of care) is added to the code to define the encounter. A subsequent MI is defined as further treatment of an MI that received initial treatment within 8 weeks of the initial MI. In ICD-10 an entirely new code I22 is used to identify a new MI occurring within 28 days of a prior MI. A code from I22 must be used in conjunction with a code from category I21.

- **ICD-10 categorizes by site of the STEMI specific to the coronary artery involved.** Coronary artery sites include: left main (I21.01), left anterior descending (I21.02), other coronary artery of anterior wall (I21.09), right coronary artery (I21.11), other of inferior wall (I21.19), left circumflex (I21.21), or other sites (I21.29).

ICD-9-CM

- **410.71** - Subendocardial infarction, initial episode care
- **410.31** - Acute myocardial infarction of inferoposterior wall, initial episode of care

ICD-10-CM

- **I21.4** - Non-ST elevation myocardial infarction (NSTEMI)
- **I21.11** - ST elevation myocardial infarction (STEMI) involving the right coronary artery
Speaking ICD-10-CM: Acute Respiratory Failure

ICD-9-CM

518.81 - Acute Respiratory Failure (including respiratory failure not otherwise specified)

ICD-10-CM

J96.00 - Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
J96.01 - with hypoxia
J96.02 - with hypercapnia
J96.90 - Respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia
J96.91 - with hypoxia
J96.92 - with hypercapnia

Respiratory failure refers to inadequate gas exchange by the respiratory system.

Hypoxia refers to abnormally low oxygen content in any tissue or organ, or the body as a whole.
  • Etiologies include: cardiogenic or noncardiogenic pulmonary edema, pneumonia and pulmonary hemorrhage.

Hypercapnia is a rise in arterial carbon dioxide. There is inadequate alveolar ventilation; both oxygen and carbon dioxide are affected with carbon dioxide buildup that cannot be eliminated.
  • Etiologies include: drug overdose, neuromuscular disease and severe airway disorders like asthma or chronic obstructive pulmonary disease (COPD).

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ICD-9-CM

438.89 - Other late effects of cerebrovascular disease
728.87 - Muscle weakness (generalized)

ICD-10-CM

I69.35 - Hemiplegia and hemiparesis following cerebral infarction

Sixth digit:
- 1 - affecting right dominant side
- 2 - affecting left dominant side
- 3 - affecting right non-dominant side
- 4 - affecting left non-dominant side
- 6 - affecting unspecified side

Differences in AHA Coding Clinic Advice for ICD-9 and ICD-10:

ICD-9: 2005, Q1, Weakness Secondary to Late Effect of Cerebrovascular Accident (CVA), “Assign code 438.89, Other late effects of cerebrovascular disease and code 728.87, Muscle weakness, for residual muscle weakness secondary to late effect of cerebrovascular accident.”

ICD-10: 2015, Q1, Residual Right-Sided Weakness Due to Previous Cerebral Infarction, “Assign code I69.351, Hemiplegia and hemiparesis following cerebral infarction, affecting right dominant side, for the residual right-sided weakness due to cerebral infarction. When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with hemiparesis/hemiplegia. Unilateral weakness outside of this clear association cannot be assumed as hemiparesis/hemiplegia, unless it is associated with some other brain disorder or injury.” This advice is only applicable to ICD-10 code assignment.

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**ICD-9-CM**

- **311** - Depression NOS
- **296.2** - MDD, single episode*
- **296.3** - MDD, recurrent episode*

* Fifth Digit Subclassification:
  - **___.0** - Unspecified
  - **___.1** - Mild
  - **___.2** - Moderate
  - **___.3** - Severe, w/o psych. behavior
  - **___.4** - Severe, specified with psych. behavior
  - **___.5** - In partial or unspecified remission
  - **___.6** - In full remission

**ICD-10-CM**

<table>
<thead>
<tr>
<th>F32._-</th>
<th>MDD, single</th>
<th>F33._-</th>
<th>MDD, recurrent</th>
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<td>___.0-</td>
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</tr>
<tr>
<td>___.1-</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>___.2-</td>
<td>Severe w/o psych feature</td>
<td></td>
<td></td>
</tr>
<tr>
<td>___.3-</td>
<td>Severe specified with psych. symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>___.4-</td>
<td>In partial rem.</td>
<td>___.40-</td>
<td>in rem., unsp.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>___.41- in partial rem.</td>
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<td>___.42- in full rem.</td>
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<tr>
<td>___.5-</td>
<td>In full rem.</td>
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</tr>
<tr>
<td>___.8-</td>
<td>Other</td>
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</tr>
<tr>
<td>___.9-</td>
<td>Unspecified</td>
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</tr>
</tbody>
</table>

* In ICD-9, Depression NOS leads to code 311 (depressive disorder, not elsewhere classifiable) listed under Other Nonpsychotic Mental Disorders.

* In ICD-10, Depression NOS leads to code F32.9 (major depressive disorder, single episode, unspecified) listed under Mood [Affective] Disorders.

* In order to code to the highest degree of specificity, documentation needs to specify whether Major Depressive Disorder is mild, moderate, severe with or without psychological features, or in partial or full remission.

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ICD-10 Implementation Date: October 1, 2015

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CMS ICD-10 Trainings:

Y0114_15_25398_1_08/17/2015

Speaking ICD-10-CM:
Human Immunodeficiency Virus (HIV)

ICD-9-CM

V08- Asymptomatic human immunodeficiency virus (HIV) infection status

042- Human immunodeficiency virus [HIV]

079.53- Human immunodeficiency virus, type 2 (HIV 2), in conditions classified elsewhere and of unspecified site

ICD-10-CM

Z21- Asymptomatic human immunodeficiency virus [HIV] infection status

B20- Human immunodeficiency virus [HIV] disease

B97.35- Human immunodeficiency virus, type 2 [HIV 2] as the cause of diseases classified elsewhere

Only confirmed cases of HIV are to be coded (this is an exception to hospital inpatient guidelines). Code assignment is based on the provider’s diagnostic statement that the patient is HIV positive or has an HIV-related illness; confirmation does not need to be documented with positive serology or culture of HIV. Asymptomatic HIV status is used for reporting a patient diagnosed with HIV status without having had an opportunistic infection. Once a patient has had an HIV-related illness or condition, it is to be coded as HIV disease thereafter. The code for HIV disease is synonymous with the terms acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), and symptomatic HIV infection. There is a note to use additional code(s) to identify all manifestations of HIV and/or HIV-2 infection for HIV disease.

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ICD-9-CM
Example: Alcohol use and abuse with current intoxication delirium
• 291.0 - Alcoholic delirium

Example: Heroin dependence, in remission
• 304.03 - Opioid (heroin) type dependence, in remission

Example: Episodic marijuana abuse
• 305.22 - Cannabis (marijuana) abuse, episodic

ICD-10-CM
Example: Alcohol use and abuse with current intoxication delirium
• F10.121 - Alcoholic abuse with intoxication delirium

Example: Heroin dependence, in remission
• F11.21 - Opioid dependence, in remission

Example: Episodic marijuana abuse
• F12.10 - Cannabis (marijuana) abuse, episodic

Per Coding Guidelines, appropriate code assignment relies on the provider’s clinical judgment for mental and behavioral disorders due to psychoactive substance use; such a relationship has to be documented. Additionally, the diagnosis for “in remission” is only assigned based on documentation in the medical record as coders are not allowed to assume.

There is a coding hierarchy in place when documentation refers to use, abuse, and/or dependence of the same substance (e.g., alcohol, opioid, cannabis, etc.). Only one code should be assigned to identify the pattern of use:

• When both use and abuse are documented, only abuse is coded
• When both abuse and dependence are documented, only dependence is coded
• When use, abuse and dependence are all documented, only dependence is coded
• When use and dependence are documented, only dependence is coded

ICD-10 Implementation Date: October 1, 2015

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Speaking ICD-10-CM: Status of Below Knee Amputation

ICD-9-CM

V49.75- Lower limb amputation status, below knee

ICD-10-CM

Z89.51- Acquired absence of leg below knee
• __.____1- Right leg below knee
• __.____2- Left leg below knee
• __.____9- Unspecified leg below knee

Each unique diagnosis code may only be reported once for an encounter.

• ICD-10-CM: This applies to bilateral conditions when there are no distinct codes identifying laterality or two different conditions classified to the same ICD-10-CM diagnosis code. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side.

• ICD-9-CM: This applies to bilateral conditions or two different conditions classified to the same ICD-9-CM diagnosis code.
  • In ICD-9, there is no way to differentiate whether status of amputation below the knee is of the right, left, or even both legs.

Note: Traumatic amputation codes fall under Injury and Poisoning chapter.

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CMS ICD-10 Trainings:

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