Introduction

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes provisions for the standardization of health care information. These administrative simplification provisions include standards for electronic transmission of claims, provider identifiers, privacy, and code sets. A national committee of the Department of Health and Human Services has worked extensively over the past several years to develop recommendations that meet the HIPAA requirements. Committee discussion of code sets has been lengthy and controversial due to potential costs of the transition to new and revised code sets in terms of infrastructure (computer software), anticipated delays in billing at startup, and costs associated with training and education.

ICD-10-CM

The National Center for Health Statistics (NCHS) developed ICD-10-CM (*International Classification of Diseases, Tenth Revision, Clinical Modification*) in consultation with a technical advisory panel, physician groups, and clinical coders to assure clinical accuracy and utility. There are no codes for procedures in the ICD-10-CM and procedures are coded using the procedure classification appropriate for the encounter setting (e.g., Physicians’ Current Procedural Terminology or CPT, and ICD-10-PCS).

The NCHS notes that the tenth revision, clinical modifications represents a significant improvement over ICD-9-CM and ICD-10 mortality (cause of death) codes in terms of the increased number of codes in the current draft of ICD-10-CM as compared to ICD-10 and ICD-9-CM in addition to content and formatting improvements that include the addition of information relevant to ambulatory and managed care encounters, expanded injury codes, the creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition, the addition of up to a seven-digit alphanumeric subclassifications will increase the level of specificity, with the addition of laterally in code assignment.

The term clinical is used to emphasize the modification’s intent to serve as a useful tool in the area of classification of morbidity data for indexing of medical records, medical care review, ambulatory and other medical care programs, as well as for basic health statistics. To describe the clinical picture of the patient, the codes must be more precise than those needed for statistical groupings and trend analysis.

Final Rule for the Adoption of ICD-10-CM and ICD-10-PCS

On January 15, 2009, the Department of Health and Human Services released the final regulation to move from the current ICD-9-CM coding system to the ICD-10 coding system beginning October 1, 2013. This timeline will allow for time to plan and implement this regulatory change.

The final rule to update the current 4010 electronic transaction standard to the new 5010 electronic transaction format for electronic health care transactions was also published with an implementation of January 1, 2012. Version 5010 provides the framework needed to support ICD-10 diagnosis and procedure codes and is the prerequisite to implementing ICD-10.
On January 20, 2009, the White House released a memorandum placing a hold on all regulations which included the ICD-10 rule. In March 2009, a determination was made that the effective date would not be extended and the comment period would not be reopened for 5010 or ICD-10.

As discussed in other modules, ICD-10-CM is similar to ICD-9-CM in that some terminology, conventions, classifications, and other features are similar. This module will cover the ICD-10-CM basic information that every user will need in order to successfully use ICD-10-CM. There are multiple changes in store for coders such as:

- The addition of information relevant to ambulatory and managed care encounters
- Expanded injury codes in which ICD-10-CM groups injuries by site of the injury, as opposed to grouping in ICD-9-CM by type of injury or type of wound
- Creation of combination diagnosis/symptom codes, which reduces the number of codes needed to fully describe a condition
- The length of codes in ICD-10-CM being a maximum of seven characters, as opposed to five digits in ICD-9-CM
- Greater specificity in code assignment with the use of up to seven characters
- V and E codes being incorporated into the main classification in ICD-10-CM
- ICD-10-CM codes being alphanumeric and including all letters except U
- The length of codes in ICD-10-CM being a maximum of seven characters, as opposed to five digits in ICD-9-CM

**International Classification of Diseases (ICD)**

ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as in 1994. The classification is the latest in a series which has its origins in the 1850s. The first edition, known as the International List of Causes of Death, was adopted by the International Statistical Institute in 1893. WHO took over the responsibility for the ICD at its creation in 1948 when the Sixth Revision, which included causes of morbidity for the first time, was published. The World Health Assembly adopted in 1967 the WHO Nomenclature Regulations that stipulate use of ICD in its most current revision for mortality and morbidity statistics by all Member States.

The ICD is the international standard diagnostic classification for all general epidemiological, many health management purposes and clinical use. These include the analysis of the general health situation of population groups and monitoring of the incidence and prevalence of diseases and other health problems in relation to other variables such as the characteristics and circumstances of the individuals affected, reimbursement, resource allocation, quality and guidelines.

It is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and health records. In addition to enabling the storage and retrieval of diagnostic information for clinical, epidemiological and quality purposes, these records also provide the basis for the compilation of national mortality and morbidity statistics by WHO Member States.

ICD-10-CM far exceeds ICD-9-CM by the sheer number of codes and concepts provided. Disease classifications have been expanded to include health related conditions and to provide greater specificity at the sixth digit level and with a seventh digit extension. Use of the sixth and seventh digit extensions are not optional.
ICD-9-CM has 17 chapters, compared with 21 chapters in ICD-10-CM, which includes separate chapters for the eye and adnexa and the ear. The chapters are subdivided into blocks of three alphanumeric character categories. In addition, the classifications External Cause of Morbidity and Mortality and Factors Influencing Health Status and Contact with Health Services (V and E codes in ICD-9-CM) are not considered supplemental classifications in ICD-10-CM and have their own chapter classifications (Chapters 20 and 21).

**Characteristics of ICD-10-CM**

ICD-10-CM far exceeds its predecessors in the number of codes provided. The disease classification has been expanded to include health-related conditions and to provide greater specificity at the sixth digit level and with a seventh digit extension.

Guidance for the use of this classification can be found in the Official Coding and Reporting guidelines section of ICD-10-CM (www.cms.hhs.gov/icd10). The ICD-10 is copyrighted by the World Health Organization (WHO) and reproduced by permission for United States Government purposes.

**ICD-10-CM Format and Structure**

The ICD has been revised periodically to incorporate changes in the medical field. The Tenth Revision (ICD-10) differs from the Ninth Revision (ICD-9) in a number of respects although the overall content is similar:

1. ICD-10 is printed in a three-volume set compared with ICD-9 two-volume set
2. ICD-10 has alphanumeric categories rather than numeric categories
3. Some chapters have been rearranged
4. Some titles have changed
5. Conditions have been regrouped
6. ICD-10 has almost twice as many categories as ICD-9
7. Minor changes have been made in the coding rules for mortality

The ICD-10 consists of:

1. Tabular lists containing cause-of-death titles and codes (Volume 1)
2. Inclusion and exclusion terms for cause-of-death titles (Volume 1)
3. Alphabetical index to diseases and nature of injury
4. External causes of injury
5. Table of drugs and chemicals (Volume 3)
6. Description, guidelines, and coding rules (Volume 2)

**CODERS’ TIP**

ICD-10-CM is divided into the Alphabetic Index, which is an alphabetic list of terms and their corresponding codes, and the Tabular List, a numerical list of codes divided by chapter, according to condition or body system. Become familiar with chapter specific guidelines to know when the 7th character is needed.
The International Classification of Diseases (ICD) is designed to encourage international comparability in the collection and management of mortality statistics. Notable improvements in the contents and layout include:

- Addition of information relevant to ambulatory and managed care encounters
- Expanded injury codes
- Creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition
- Incorporation of common fourth and fifth digit subclassifications
- Laterality
- Greater specificity in code assignment

ICD-10-CM far exceeds its predecessors in the number of codes available. The disease classification has been expanded to include health-related conditions and to provide greater specificity at the sixth digit level and with a seventh digit extension. The sixth and seventh characters are not optional; they are intended for use in recording the information documented in the medical record. Table 1.1 below illustrates the chapter comparison between ICD-9-CM and ICD-10-CM. Notice that Diseases of the Eye and Adnexa and Diseases of the Ear and Mastoid Process will have its own chapter in ICD-10-CM.

CODERS’ TIP

Never code strictly from the alphabetical index, always confirm your code choice in the tabular list to insure the most appropriate code choice selection.

<table>
<thead>
<tr>
<th>Chapter</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Infectious and Parasitic Diseases</td>
<td>Certain Infectious and Parasitic Diseases</td>
</tr>
<tr>
<td>2</td>
<td>Neoplasms</td>
<td>Malignant Neoplasms</td>
</tr>
<tr>
<td>3</td>
<td>Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders</td>
<td>Disease of the Blood and Blood-Forming Organs and Certain Disorders involving Immune Mechanism</td>
</tr>
<tr>
<td>4</td>
<td>Diseases of the Blood and Blood-Forming Organs</td>
<td>Endocrine, Nutritional and Metabolic Diseases</td>
</tr>
<tr>
<td>5</td>
<td>Mental Disorders</td>
<td>Mental and Behavioral Disorders</td>
</tr>
<tr>
<td>6</td>
<td>Diseases of the Nervous System and Sense Organs</td>
<td>Diseases of the Nervous System</td>
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<tr>
<td>7</td>
<td>Diseases of the Circulatory System</td>
<td>Diseases of the Eye and Adnexa</td>
</tr>
<tr>
<td>8</td>
<td>Diseases of the Respiratory System</td>
<td>Diseases of the Ear and Mastoid Process</td>
</tr>
<tr>
<td>9</td>
<td>Diseases of the Digestive System</td>
<td>Diseases of the Circulatory System</td>
</tr>
<tr>
<td>10</td>
<td>Diseases of the Genitourinary System</td>
<td>Diseases of the Respiratory System</td>
</tr>
<tr>
<td>Chapter</td>
<td>ICD-9-CM</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>---------</td>
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<td>-----------------------------------------------</td>
</tr>
<tr>
<td>11</td>
<td>Complications of Pregnancy, Childbirth, and the Puerperium</td>
<td>Diseases of the Digestive System</td>
</tr>
<tr>
<td>12</td>
<td>Diseases of the Skin and Subcutaneous Tissue</td>
<td>Diseases of the Skin and Subcutaneous Tissue</td>
</tr>
<tr>
<td>13</td>
<td>Diseases of the Musculoskeletal System and Connective Tissue</td>
<td>Diseases of the Musculoskeletal System and Connective Tissue</td>
</tr>
<tr>
<td>14</td>
<td>Congenital Anomalies</td>
<td>Diseases of the Genitourinary System</td>
</tr>
<tr>
<td>15</td>
<td>Certain Conditions Originating in the Perinatal Period</td>
<td>Pregnancy, Childbirth and the Puerperium</td>
</tr>
<tr>
<td>16</td>
<td>Symptoms, Signs, and Ill-Defined Conditions</td>
<td>Certain Conditions Originating in the Newborn (Perinatal) Period</td>
</tr>
<tr>
<td>17</td>
<td>Injury and Poisoning</td>
<td>Congenital Malformations, Deformations and Chromosomal Abnormalities</td>
</tr>
<tr>
<td>18</td>
<td>N/A</td>
<td>Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified</td>
</tr>
<tr>
<td>19</td>
<td>N/A</td>
<td>Injury, Poisoning and Certain Other Consequences of External Causes</td>
</tr>
<tr>
<td>20</td>
<td>N/A</td>
<td>External Causes of Morbidity</td>
</tr>
<tr>
<td>21</td>
<td>N/A</td>
<td>Factors Influencing Health Status and Contact with Health Services</td>
</tr>
<tr>
<td>Supplementary Classification</td>
<td>Classification of Factors Influencing Health Status and Contact with Health Services (V codes)</td>
<td>N/A</td>
</tr>
<tr>
<td>Supplementary Classification</td>
<td>Classification of External Cause of Injury and Poisoning (E Codes)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Table 1.1**

**Alphabetic Index**

The Alphabetic Index is divided into three sections and is organized by main terms.

Section 1—Index to Diseases and Nature of Injury

Section 2—Index to External Causes

Section 3—Table of Drugs and Chemicals
The Alphabetic Index is organized in the same manner as ICD-9-CM. Codes are listed by “Main term” which describes the disease and/or condition. As with ICD-9-CM there are exceptions to the rule. Cross-references such as “see,” “see also” are also found in ICD-10-CM. Sub-terms and modifiers are located under the main terms following an indented format. Nonessential modifiers are found in parentheses after the main term. A nonessential modifier does not affect selection of the code and is used as guidance. In the section on external causes, the main term and modifiers identify the type of accident or occurrence, vehicles(s) involved, the place of occurrence, etc.

Notes appear in the Alphabetic Index to:

- Define terms
- Provide direction
- Provide coding instructions

**Combination Code**—The term represents a single code used to classify: two diagnoses, either a diagnosis with an associated sign or symptom or a diagnosis with an associated complication. Multiple codes should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis.

**Granularity**—As applied to ICD-10-CM, the term refers to the level of hierarchy and the amount of information the increased hierarchy provides to the diagnostic description.

**Laterality**—ICD-10-CM code descriptions include right or left designation. The right side is always character 1, and left side character 2. In those cases where a bilateral code is provided, the bilateral character is always 3. An unspecified side code is provided should the side not be identified in the medical record. The unspecified side is either a character 0 or 9, depending on whether it is a fifth or sixth character.

M12.15 Kaschin-Beck disease hip
M12.151 Kaschin-Beck disease, right hip
M12.152 Kaschin-Beck disease, left hip
M12.159 Kaschin-Beck disease, unspecified hip

**Morbidity**—The term refers to the disease rate or number of cases of a particular disease in a given age range, gender, occupation, or other relevant population based grouping.

**Mortality**—The term refers to the death rate reflected by the population in a given region, age range, or other relevant statistical grouping.

**Principal or First Listed Diagnosis**—The code sequenced first on a medical record defines the primary reason for the encounter as determined at the end of the encounter. In the inpatient setting, the first code listed on a medical record is referred to as the principal diagnosis. In all other health care settings, it is referred to as the first listed code. The Uniform Hospital Discharge Data Set (UHDDS) defines principal diagnosis as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.” The UHDDS definition also applies in selection of the first listed diagnosis code in other health care settings.

**Rubric**—The term refers to a group of similar conditions, which in ICD-10-CM denotes either a three character category or a four character subcategory.
Code Structure
The Tabular List contains categories, subcategories, and codes. Each character for all categories, subcategories, and codes may be either a letter or number. All categories are three characters. The first character of a category is a letter. The second and third characters are numbers. A three character category that has no further subdivision is equivalent to a code. Subcategories are either four or five characters. Subcategory characters may be either letters or numbers. Codes are four, five, or six characters and the final character in a code may be either a letter or number. Certain categories have seventh character extensions.

Three Character Categories
Following the “excludes” and “includes” notes, each chapter begins with a list of blocks—or subchapters—of three character categories, for example:

Three digit Categories

Chapter 1 Certain Infectious and Parasitic Diseases (A00–B99)
A00–A09 Intestinal infectious diseases
A15–A19 Tuberculosis
A20–A28 Certain zoonotic bacterial diseases
A30–A49 Other bacterial diseases
A50–A64 Infections with a predominantly sexual mode of transmission
A65–A69 Other spirochetal diseases
A70–A74 Other diseases caused by chlamydiae
A75–A79 Rickettsioses
A80–A89 Viral infections of the central nervous system
A90–A99 Arthropod-borne viral fevers and viral hemorrhagic fevers
B00–B09 Viral infections characterized by skin and mucous membrane lesions
B15–B19 Viral hepatitis
B20 Human immunodeficiency virus [HIV] disease
B25–B34 Other viral diseases
B35–B49 Mycoses
B50–B64 Protozoal diseases
B65–B83 Helminthiases
B85–B89 Pediculosis, acariasis and other infestations
B90–B94 Sequelae of infectious and parasitic diseases
B95–B97 Bacterial, viral and other infectious agents
B99 Other infectious diseases
Chapter 2  Neoplasms (C00–D49)
C00–C75  Malignant neoplasms, stated or presumed to be primary, of specified sites, except of lymphoid, hematopoietic and related tissue
C00–C14  Lip, oral cavity and pharynx
C15–C26  Digestive organs
C30–C39  Respiratory and intrathoracic organs
C40–C41  Bone and articular cartilage
C43–C44  Skin
C45–C49  Mesothelial and soft tissue
C50  Breast
C51–C58  Female genital organs
C60–C63  Male genital organs
C64–C68  Urinary tract
C69–C72  Eye, brain and other parts of central nervous system
C73–C75  Thyroid and other endocrine glands
C76–C80  Malignant neoplasms of ill-defined, secondary and unspecified sites
C81–C96  Malignant neoplasms, stated or presumed to be primary, of lymphoid, hematopoietic and related tissue
D00–D09  In situ neoplasms
D10–D36  Benign neoplasms
D37–D48  Neoplasms of uncertain behavior
D49  Neoplasms of unspecified behavior

Chapter 3  Diseases of the Blood and Blood-Forming Organs and certain Disorders Involving the Immune Mechanism (D50–D89)
D50–D53  Nutritional anemias
D55–D59  Hemolytic anemias
D60–D64  Aplastic and other anemias
D65–D69  Coagulation defects, purpura and other hemorrhagic conditions
D70–D78  Other diseases of blood and blood-forming organs
D80–D89  Certain disorders involving the immune mechanism

Chapter 4  Endocrine, Nutritional and Metabolic Diseases (E00–E90)
E00–E07  Disorders of thyroid gland
E08–E14  Diabetes mellitus
E15–E16  Other disorders of glucose regulation and pancreatic internal secretion
E20–E36 Disorders of other endocrine glands
E40–E46 Malnutrition
E50–E64 Other nutritional deficiencies
E65–E68 Obesity and other hyperalimentation
E70–E89 Metabolic disorders

Chapter 5 Mental and Behavioral Disorders (F01–F99)
F01–F09 Mental disorders due to known physiological conditions
F10–F19 Mental and behavioral disorders due to psychoactive substance use
F20–F29 Schizophrenia, schizotypal and delusional, and other non-mood psychotic disorders
F30–F39 Mood [affective] disorders
F40–F48 Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
F50–F59 Behavioral syndromes associated with physiological disturbances and physical factors
F60–F69 Disorders of adult personality and behavior
F70–F79 Mental retardation
F80–F89 Pervasive and specific developmental disorders
F90–F98 Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99 Unspecified mental disorder

Chapter 6 Diseases of the Nervous System (G00–G99)
G00–G09 Inflammatory diseases of the central nervous system
G10–G13 Systemic atrophies primarily affecting the central nervous system
G20–G26 Extrapyramidal and movement disorders
G30–G32 Other degenerative diseases of the nervous system
G35–G37 Demyelinating diseases of the central nervous system
G40–G47 Episodic and paroxysmal disorders
G50–G59 Nerve, nerve root and plexus disorders
G60–G64 Polyneuropathies and other disorders of the peripheral nervous system
G70–G73 Diseases of myoneural junction and muscle
G80–G83 Cerebral palsy and other paralytic syndromes
G90–G99 Other disorders of the nervous system
Chapter 7  Disorder of the Eye and Adnexa (H00–H59)
H00–H05  Disorders of eyelid, lacrimal system and orbit
H10–H13  Disorders of the conjunctiva
H15–H21  Disorders of sclera, cornea, iris and ciliary body
H25–H28  Disorders of lens
H30–H36  Disorders of choroid and retina
H40–H42  Glaucoma
H43–H45  Disorders of vitreous body and globe
H46–H47  Disorders of optic nerve and visual pathways
H49–H52  Disorders of ocular muscles, binocular movement, accommodation and refraction
H53–H54  Visual disturbances and blindness
H55–H59  Other disorders of eye and adnexa

Chapter 8  Diseases of the Ear and Mastoid Process (H60–H95)
H60–H62  Diseases of external ear
H65–H75  Diseases of middle ear and mastoid
H80–H83  Diseases of inner ear
H90–H95  Other disorders of ear

Chapter 9  Diseases of the Circulatory System (I00–I99)
I00–I02  Acute rheumatic fever
I05–I09  Chronic rheumatic heart diseases
I10–I15  Hypertensive diseases
I20–I25  Ischemic heart diseases
I26–I28  Pulmonary heart disease and diseases of pulmonary circulation
I30–I52  Other forms of heart disease
I60–I69  Cerebrovascular diseases
I70–I79  Diseases of arteries, arterioles and capillaries
I80–I89  Diseases of veins, lymphatic vessels and lymph nodes, not elsewhere classified
I95–I99  Other and unspecified disorders of the circulatory system
<table>
<thead>
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<th><strong>Diseases of the Respiratory System (J00–J99)</strong></th>
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<td>Acute upper respiratory infections</td>
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<td>J10–J18</td>
<td>Influenza and pneumonia</td>
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<td>J20–J22</td>
<td>Other acute lower respiratory infections</td>
</tr>
<tr>
<td>J30–J39</td>
<td>Other diseases of upper respiratory tract</td>
</tr>
<tr>
<td>J40–J47</td>
<td>Chronic lower respiratory diseases</td>
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<tr>
<td>J60–J70</td>
<td>Lung diseases due to external agents</td>
</tr>
<tr>
<td>J80–J84</td>
<td>Other respiratory diseases principally affecting the interstitium</td>
</tr>
<tr>
<td>J85–J86</td>
<td>Suppurative and necrotic conditions of the lower respiratory tract</td>
</tr>
<tr>
<td>J90–J94</td>
<td>Other diseases of the pleura</td>
</tr>
<tr>
<td>J95–J99</td>
<td>Other diseases of the respiratory system</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Chapter 11</strong></th>
<th><strong>Diseases of the Digestive System (K00–K94)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>K00–K14</td>
<td>Diseases of oral cavity and salivary glands</td>
</tr>
<tr>
<td>K20–K31</td>
<td>Diseases of esophagus, stomach and duodenum</td>
</tr>
<tr>
<td>K35–K38</td>
<td>Diseases of appendix</td>
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<tr>
<td>K40–K46</td>
<td>Hernia</td>
</tr>
<tr>
<td>K50–K52</td>
<td>Noninfective enteritis and colitis</td>
</tr>
<tr>
<td>K55–K63</td>
<td>Other diseases of intestines</td>
</tr>
<tr>
<td>K65–K68</td>
<td>Diseases of peritoneum and retroperitoneum</td>
</tr>
<tr>
<td>K70–K77</td>
<td>Diseases of liver</td>
</tr>
<tr>
<td>K80–K87</td>
<td>Disorders of gallbladder, biliary tract and pancreas</td>
</tr>
<tr>
<td>K90–K94</td>
<td>Other diseases of the digestive system</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th><strong>Diseases of the Skin and Subcutaneous Tissue (L00–L99)</strong></th>
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</thead>
<tbody>
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<td>L00–L08</td>
<td>Infections of the skin and subcutaneous tissue</td>
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<tr>
<td>L10–L14</td>
<td>Bullous disorders</td>
</tr>
<tr>
<td>L20–L30</td>
<td>Dermatitis and eczema</td>
</tr>
<tr>
<td>L40–L45</td>
<td>Papulosquamous disorders</td>
</tr>
<tr>
<td>L50–L54</td>
<td>Urticaria and erythema</td>
</tr>
<tr>
<td>L55–L59</td>
<td>Radiation-related disorders of the skin and subcutaneous tissue</td>
</tr>
<tr>
<td>L60–L75</td>
<td>Disorders of skin appendages</td>
</tr>
<tr>
<td>L76</td>
<td>Intraoperative and postprocedural complications of dermatologic procedures</td>
</tr>
<tr>
<td>L80–L99</td>
<td>Other disorders of the skin and subcutaneous tissue</td>
</tr>
</tbody>
</table>
### Chapter 13  Diseases of the Musculoskeletal System and Connective Tissue (M00–M99)

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
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<td>M00–M02</td>
<td>Infectious arthropathies</td>
</tr>
<tr>
<td>M05–M14</td>
<td>Inflammatory polyarthropathies</td>
</tr>
<tr>
<td>M15–M19</td>
<td>Osteoarthritis</td>
</tr>
<tr>
<td>M20–M25</td>
<td>Other joint disorders</td>
</tr>
<tr>
<td>M26–M27</td>
<td>Dentofacial anomalies [including malocclusion] and other disorders of jaw</td>
</tr>
<tr>
<td>M30–M36</td>
<td>Systemic connective tissue disorders</td>
</tr>
<tr>
<td>M40–M43</td>
<td>Deforming dorsopathies</td>
</tr>
<tr>
<td>M45–M49</td>
<td>Spondylopathies</td>
</tr>
<tr>
<td>M50–M54</td>
<td>Other dorsopathies</td>
</tr>
<tr>
<td>M60–M63</td>
<td>Disorders of muscles</td>
</tr>
<tr>
<td>M65–M67</td>
<td>Disorders of synovium and tendon</td>
</tr>
<tr>
<td>M70–M79</td>
<td>Other soft tissue disorders</td>
</tr>
<tr>
<td>M80–M85</td>
<td>Disorders of bone density and structure</td>
</tr>
<tr>
<td>M86–M90</td>
<td>Other osteopathies</td>
</tr>
<tr>
<td>M91–M94</td>
<td>Chondropathies</td>
</tr>
<tr>
<td>M95–M99</td>
<td>Other disorders of the musculoskeletal system and connective tissue</td>
</tr>
</tbody>
</table>

### Chapter 14  Diseases of the Genitourinary System (N00–N99)

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N00–N08</td>
<td>Glomerular diseases</td>
</tr>
<tr>
<td>N10–N16</td>
<td>Renal tubulo-interstitial diseases</td>
</tr>
<tr>
<td>N17–N19</td>
<td>Renal failure</td>
</tr>
<tr>
<td>N20–N23</td>
<td>Urolithiasis</td>
</tr>
<tr>
<td>N25–N29</td>
<td>Other disorders of kidney and ureter</td>
</tr>
<tr>
<td>N30–N39</td>
<td>Other diseases of the urinary system</td>
</tr>
<tr>
<td>N40–N51</td>
<td>Diseases of male genital organs</td>
</tr>
<tr>
<td>N60–N64</td>
<td>Disorders of breast</td>
</tr>
<tr>
<td>N70–N77</td>
<td>Inflammatory diseases of female pelvic organs</td>
</tr>
<tr>
<td>N80–N98</td>
<td>Noninflammatory disorders of female genital tract</td>
</tr>
<tr>
<td>N99</td>
<td>Other disorders of genitourinary system</td>
</tr>
</tbody>
</table>

### Chapter 15  Pregnancy, Childbirth and the Puerperium (O00–O99)

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O00–O08</td>
<td>Pregnancy with abortive outcome</td>
</tr>
<tr>
<td>O09</td>
<td>Supervision of high-risk pregnancy</td>
</tr>
<tr>
<td>O10–O16</td>
<td>Edema, proteinuria and hypertensive disorders in pregnancy, childbirth and the puerperium</td>
</tr>
</tbody>
</table>
O20–O29  Other maternal disorders predominantly related to pregnancy
O30–O48  Maternal care related to the fetus and amniotic cavity and possible delivery problems
O60–O77  Complications of labor and delivery
O80, O82  Encounter for delivery
O85–O92  Complications predominantly related to the puerperium
O93     Sequelae of complication of pregnancy, childbirth, and the puerperium
O94–O99  Other obstetric conditions, not elsewhere classified

Chapter 16  Certain Conditions Originating in the Perinatal Period (P00–P96)
P00–P04  Newborn affected by maternal factors and by complications of pregnancy, labor and delivery
P05–P08  Disorders related to length of gestation and fetal growth
P10–P15  Birth trauma
P19–P29  Respiratory and cardiovascular disorders specific to the perinatal period
P35–P39  Infections specific to the perinatal period
P50–P61  Hemorrhagic and hematological disorders of newborn
P70–P74  Transitory endocrine and metabolic disorders specific to newborn
P75–P78  Digestive system disorders of newborn
P80–P83  Conditions involving the integument and temperature regulation of newborn
P84     Other problems with newborn
P90–P96  Other disorders originating in the perinatal period

Chapter 17  Congenital Malformations, Deformations and Chromosomal Abnormalities (Q00–Q99)
Q00–Q07  Congenital malformations of the nervous system
Q10–Q18  Congenital malformations of the eye, ear, face and neck
Q20–Q28  Congenital malformations of the circulatory system
Q30–Q34  Congenital malformations of the respiratory system
Q35–Q37  Cleft lip and cleft palate
Q38–Q45  Other congenital malformations of the digestive system
Q50–Q56  Congenital malformations of genital organs
Q60–Q66  Congenital malformations of the urinary system
Q65–Q79  Congenital malformations and deformations of the musculoskeletal system
Q80–Q89  Other congenital malformations
Q90–Q99  Chromosomal abnormalities, not elsewhere classified
Chapter 18  Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00–R99)

R00–R09  Symptoms and signs involving the circulatory and respiratory systems
R10–R19  Symptoms and signs involving the digestive system and abdomen
R20–R23  Symptoms and signs involving the skin and subcutaneous tissue
R25–R29  Symptoms and signs involving the nervous and musculoskeletal systems
R30–R39  Symptoms and signs involving the urinary system
R40–R46  Symptoms and signs involving cognition, perception, emotional state and behavior
R47–R49  Symptoms and signs involving speech and voice
R50–R69  General symptoms and signs
R70–R79  Abnormal findings on examination of blood, without diagnosis
R80–R82  Abnormal findings on examination of urine, without diagnosis
R83–R89  Abnormal findings on examination of other body fluids, substance and tissues, without diagnosis
R90–R94  Abnormal findings on diagnostic imaging and in function studies, without diagnosis
R99     Ill-defined and unknown cause of mortality

Chapter 19  Injury, Poisoning and Certain Other Consequences of External Cause (S00–T88)

S00–S09  Injuries to the head
S10–S19  Injuries to the neck
S20–S29  Injuries to the thorax
S30–S39  Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals
S40–S49  Injuries to the shoulder and upper arm
S50–S59  Injuries to the elbow and forearm
S60–S69  Injuries to the wrist and hand
S70–S79  Injuries to the hip and thigh
S80–S89  Injuries to the knee and lower leg
S90–S99  Injuries to the ankle and foot
T07     Unspecified multiple injuries
T14     Injury of unspecified body region
T15–T19 Effects of foreign body entering through natural orifice
T20–T32 Burns and corrosions
T33–T34 Frostbite
T36–T50 Poisoning by adverse effect of and underdosing of drugs, medicaments and biological substances
Introduction to ICD-10-CM

T51–T65 Toxic effects of substances chiefly nonmedicinal as to source
T66–T78 Other and unspecified effects of external causes
T79 Certain early complications of trauma
T80–T88 Complications of surgical and medical care, not elsewhere classified

Chapter 20 External Causes of Morbidity (V01–Y98)
V00–X58 Accidents
V00–V99 Transport accidents
V00–V09 Pedestrian injured in transport accident
V10–V19 Pedal cyclist injured in transport accident
V20–V29 Motorcycle rider injured in transport accident
V30–V39 Occupant of three-wheeled motor vehicle injured in transport accident
V40–V49 Car occupant injured in transport accident
V50–V59 Occupant of pick-up truck or van injured in transport accident
V60–V69 Occupant of heavy transport vehicle injured in transport accident
V70–V79 Bus occupant injured in transport accident
V80–V89 Other land transport accidents
V90–V94 Water transport accidents
V95–V97 Air and space transport accidents
V98–V99 Other and unspecified transport accidents
W00–X58 Other external causes of accidental injury
W00–W19 Falls
W20–W49 Exposure to inanimate mechanical forces
W50–W64 Exposure to animate mechanical forces
W65–W74 Accidental drowning and submersion
W85–W99 Exposure to electric current, radiation and extreme ambient air temperature and pressure
X00–X09 Exposure to smoke, fire and flames
X10–X19 Contact with heat and hot substances
X30–X39 Exposure to forces of nature
X52, X58 Accidental exposure to other specified factors
X71–X83 Intentional self-harm
X92–Y08 Assault
Y21–Y33 Event of undetermined intent
Y35–Y38 Legal intervention, operations of war, military operations and terrorism
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Y62–Y84 Complications of medical and surgical care
Y62–Y69 Misadventures to patients during surgical and medical care
Y70–Y82 Medical devices associated with adverse incidents in diagnostic and therapeutic use
Y83–Y84 Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
Y90–Y98 Supplementary factors related to causes of morbidity classified elsewhere

Chapter 21 Factors Influencing Health Status and Contact with Health Services (Z00–Z99)

Z00–Z13 Persons encountering health services for examination and investigation
Z14–Z15 Genetic carrier and genetic susceptibility to disease
Z16 Infection with drug-resistant microorganisms
Z20–Z28 Persons with potential health hazards related to communicable diseases
Z30–Z39 Persons encountering health services in circumstances related to reproduction
Z40–Z53 Persons encountering health services for specific procedures and health care
Z55–Z65 Persons with potential health hazards related to socioeconomic and psychosocial circumstances
Z66 Do not resuscitate (DNR) status
Z67 Bloodtype
Z69–Z76 Persons encountering health services in other circumstances
Z79–Z99 Persons with potential health hazards related to family and personal history and certain conditions influencing health status

Four Character Categories

The four character categories further define the site, etiology, and manifestation or state of the disease or condition. The four-digit sub-category includes the three-digit category plus decimal with an additional digit to further identify the condition to the highest level of specificity.

The ICD-10-CM uses an indented format and each code includes the description of the code.

**EXAMPLE:**

- C15 Malignant Neoplasm of the Esophagus
- C15.3 Malignant neoplasm of upper third of esophagus
- C15.4 Malignant neoplasm of middle third of esophagus
- C15.5 Malignant neoplasm of lower third of esophagus
- C15.8 Malignant neoplasm of overlapping lesion of esophagus
- C15.9 Malignant neoplasm of esophagus, unspecified

**Dummy Placeholders**—Always the letter X is used to allow for future expansion.
Five-Six Character Subclassification
In ICD-9-CM, the fifth-digit identifies the most precise level of specificity. In ICD-10-CM, a 5th or 6th six character sub-classifications represents the most accurate level of specificity This addition may identify more specificity regarding the patient’s condition or diagnosis.

EXAMPLE:
- J10.8 Influenza due to other influenza virus with other manifestations
- J10.81 Influenzal gastroenteritis
- J10.89 Influenza with other manifestations
  - Influenzal encephalopathy
  - Influenzal myocarditis

EXAMPLE:
- S55.011 Laceration of ulnar artery at forearm level, right arm

Seventh Character Extension
Certain ICD-10-CM categories have applicable seven characters. The applicable seventh character is required for all codes within the category, or as the notes in the Tabular List instruct. The seventh character must always be the seventh character in the data field. If a code that requires a 7th character is not six characters, a placeholder X must be used to fill in the empty characters.

EXAMPLE:
- T50.B96A Underdosing of other viral vaccines, initial encounter
- T50.B96D Underdosing of other viral vaccines, subsequent encounter
- T50.B96S Underdosing of other viral vaccines, sequela

Dummy Placeholders
The ICD-10-CM utilizes a placeholder character “X.” The “X” is used as a fifth character placeholder at certain 6 character codes to allow for future expansion

EXAMPLE:
- O33.5xx0 Maternal care for disproportion due to unusually large fetus, not applicable or unspecified

Locating a Code in ICD-10-CM
To select a code in the classification that corresponds to a diagnosis or reason for visit documented in a medical record, first locate the term in the index, then verify the code in the Tabular List. Read and be guided by instructional notations that appear in both the index and the Tabular List. It is essential to use both the Index to Diseases and the Tabular List when locating and assigning a code.

The index does not always provide the full code. Selection of the full code, including laterality and any applicable extensions can only be done in the Tabular List. A dash (-) at the end of an index
entry indicates that additional characters are required. Even if a dash is not included at the index entry, it is necessary to refer to the Tabular List to verify that no extension is required.

ICD-10-CM Conventions

Code First/Use Additional Code Notes
Etiology/manifestation paired codes have a specific index entry structure. In the index both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second.

NEC
An index entry that states NEC directs the coder to an “other specified” code in the Tabular List (see inclusion terms under the Tabular Format subheading).

Punctuation
[ ] Brackets are used in the index and to identify manifestation codes.
( ) Parentheses are used in both the Index to Diseases and Tabular List to enclose supplemental words that do not affect the code number. The terms within the parentheses are referred to as nonessential modifiers.
: Colon is used after an incomplete term that needs one or more of the modifiers that follow to make it assignable to a given category
} The brace enclosed a series of terms each of which is modified by the statement appearing at the right of the brace.
, Comma-words following a comma are essential modifiers. The term in the inclusion note must be present in the diagnostic statement to qualify the code.

EXAMPLE:
A25.9 Rat bite fever, unspecified

Code Also
A “code also” note instructs that two codes may be required to fully describe a condition, but the sequencing of the two codes depends on the severity of the conditions and the reason for the encounter.

“See” and “See Also”
The “see” instruction following a main term in the Index indicates that another term should be referenced. It is necessary to go to the main term referenced with the “see” note to locate the correct code.

A “see also” instruction following a main term in the index instructs that there is another main term that may also be referenced that may provide additional index entries that may be useful. It is not necessary to follow the “see also” note when the original main term provides the necessary code.

EXAMPLE:
Amentia—see also Retardation, mental
—Meynert’s (nonalcoholic) F04
Annular—see also condition
Default codes
A code listed next to a main term in the ICD-10-CM Index is referred to as a default code. The default code represents that condition that is most commonly associated with the main term, or is the unspecified code for the condition. If a condition is documented in a medical record (for example, appendicitis) without any additional information, such as acute or chronic, the default code should be assigned.

EXAMPLE:
A simple statement of Appendicitis without further documentation would be coded K37 for unspecified appendicitis

Code First/Use Additional Code Notes
Codes that have both an underlying etiology and multiple body system manifestations due to the underlying etiology require sequencing the underlying condition first followed by the manifestation. Wherever such a combination exists there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

In most cases, the manifestation codes will have in the code title, “in diseases classified elsewhere.” Codes with this title are a component of the etiology/manifestation convention. The code title indicates that it is a manifestation code. “In diseases classified elsewhere” codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition.

In some circumstances, more than two codes may be required to fully describe a condition. In these cases a “use additional code” note will be present at a complication or manifestation code to indicate that more codes are needed. The additional codes used are secondary codes that are to be sequenced following any underlying cause and following the main manifestation (see same listing under Index Format subheading).

EXAMPLE:
H42 Glaucoma in diseases classified elsewhere
Code first underlying condition, such as:
- amyloidosis (E85.-)
- aniridia (Q13.1)
- Lowe's syndrome (E72.03)
- Reiger's anomaly (Q13.81)
- specified metabolic disorder (E70-E90)

Excludes Notes
Two types of “excludes” notes are found although each indicates that codes excluded from each other are independent of each other.

- Excludes1—Indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used for when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition. Conditions listed with Excludes1 are mutually exclusive.
EXAMPLE:
E11  Type 2 diabetes
    Excludes1:  gestational diabetes (O24.4-)
    Type 1 diabetes (E10.-)

EXAMPLE:
I10  Essential (primary) hypertension Includes:
    high blood pressure hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)
    Excludes1:  hypertensive disease complicating pregnancy, childbirth and the puerperium (O10-O11, O13-O16)

Note: Excludes1 instructs the user to go to another code for the excluded condition, so if the patient is pregnant code I10 is not assigned.

    Excludes2—Indicates that the condition excluded is not part of the condition represented by the code, but from a patient who may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together when both conditions exist.

EXAMPLE:
J03  Acute tonsillitis
    Excludes2:  chronic tonsillitis (J35.0)

Excludes2—A Type 2 excludes note represents “Not included here.” An Excludes2 note indicates that the condition excluded is not part of the condition represented by the code, from but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together.

Excludes2 EXAMPLE:
I10  Essential (primary) Hypertension Includes:
    high blood pressure hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)
    Excludes2:  essential (primary) hypertension involving vessels of brain (I60-I69)
    essential (primary) hypertension involving vessels of eye (H35.0)

Excludes2 instructs the user that hypertension involving vessels of the eye has a different code than essential hypertension without further specification. If the patient has both systemic hypertension and primary hypertension of the eye, then it would be appropriate to assign a code for both conditions.

Inclusion Terms
Lists of terms are included under some codes. These terms are some of the conditions for which that code number is to be used. The terms may be synonyms of the code title, or in the case of “other
specified” codes, the terms are a list of some of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the index may also be assigned to a code.

ICD-10-CM expands upon both the excludes notes and inclusion terms at the beginning of each chapter.

**EXAMPLE:**

**Chapter 1  Certain Infectious and Parasitic Diseases**

Includes: diseases generally recognized as communicable or transmissible

Use additional code for any associated drug resistance (Z16)

Excludes: infectious and parasitic diseases specific to the perinatal period (P35–P39)

influenza and other acute respiratory infections (J00–J22)

**Other Specified and NEC**

Codes in the Tabular List with “Other…” or “Other specified…” are for use when the information in the medical record provides detail for which a specific code does not exist. The abbreviation NEC, “Not elsewhere classifiable” represents “other specified.” An index entry that states NEC directs the coder to an “other specified” code in the Tabular List.

**EXAMPLE:**

Abruptio placentae O45.9-

-with

afibrinogenemia O45.01

coagulation defect O45.00

specified NEC O45.09

disseminated intravascular coagulation O45.02

hypofibrinogenemia O45.01

specified NEC O45.8x-

**Unspecified and NOS**

Codes in the Tabular List with “Unspecified…” in the title are for use when the information in the medical record is insufficient to assign a more specific code. The abbreviation NOS, “Not otherwise specified,” in the Tabular List is the equivalent of unspecified.

**EXAMPLE:**

A04.9  Bacterial intestinal infection, unspecified

Bacterial enteritis NOS

**Use of “and”**

When the term “and” is used in a narrative statement, it represents and/or.
With/Without
When "with" and "without" are the two options for the final character of a set of codes, the default is always "without." For five character codes, a "0" as the fifth position character represents "without," and "1" represents "with." For six character codes, the sixth position character "1" represents "with" and "9" represents "without."

**EXAMPLE:**
- G40.501 Special epileptic syndromes, not intractable, with status epilepticus
- G40.519 Special epileptic syndromes, intractable, without status epilepticus

Default Codes
A code listed next to a main term in the ICD-10-CM Index is referred to as a default code. The default code represents that condition that is most commonly associated with the main term, or is the unspecified code for the condition. If a condition is documented in a medical record (for example, appendicitis) without any additional information, such as acute or chronic, the default code should be assigned.

Laterality
For bilateral sites, the final character of the codes in the ICD-10-CM indicates laterality. The right side is always character 1, the left side character 2. In those cases where a bilateral code is provided the bilateral character is always 3. An unspecified side code is also provided should the side not be identified in the medical record. The unspecified side is either a character 0 or 9 depending on whether it is a fifth or sixth character.

**EXAMPLE:**
- A patient is treated for an abscess of a bursa on the left wrist.
  - M71.03  Abscess of bursa, wrist
  - M71.031 Abscess of bursa, right wrist
  - M71.032 Abscess of bursa, left wrist
  - M71.039 Abscess of bursa, unspecified wrist

Correct code: M71.032 for this patient encounter

General Coding Guidelines
ICD-10-CM guidelines developed to assist both the physician and the coder in identifying diagnoses are similar to those ICD-9-CM, which should ease the transition. The guidelines are summarized in this section. Review the ICD-10-CM document for the complete general coding guidelines and guidelines specific to each chapter.

In addition to the general coding guidelines, there are guidelines for specific diagnoses and/or conditions in the ICD-10-CM by chapter that, unless otherwise indicated, apply to both inpatient and outpatient settings.
Locating a code in the ICD-10-CM

To select a code in the classification that corresponds to a diagnosis or reason for visit documented in a medical record, first locate the term in the Index, and then verify the code in the Tabular List. Read and be guided by instructional notations that appear in both the Index and the Tabular List.

It is essential to use both the Index and Tabular List when locating and assigning a code. The Index does not always provide the full code. Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular list. A dash (-) at the end of an Index entry indicates that additional characters are required. Even if a dash is not included at the Index entry, it is necessary to refer to the Tabular list to verify that no seventh character is required.

Level of Detail in Coding

Diagnosis codes are to be used and reported at their highest number of digits available.

ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6, or 7 digits. Codes with three digits are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater detail.

A three-digit code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the seventh character, if applicable.

Code or codes from A00.0 through T88.9, Z00–Z99.8

The appropriate code or codes from A00.0 through T88.9, Z00–Z99.8 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.

Signs and symptoms

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

EXAMPLE:
Abnormal Liver Function Test would be coded R94.5

As with ICD-9-CM coding signs and symptoms should not be reported with a confirmed diagnosis if the symptom is integral to the diagnosis. For example, if the patient is experiencing ear pain and the diagnosis is Otitis Media, the ear pain would be integral to the otitis media and not reported. A symptom code is used with a confirmed diagnosis only when the symptom is not associated with the confirmed diagnosis.

EXAMPLE:
A patient is diagnosed with epigastric pain. The physician referred the patient to a gastroenterologist to rule out ulcer.

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>789.06</th>
<th>Abdominal pain, epigastric</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10-CM</td>
<td>R10.13</td>
<td>Epigastric pain</td>
</tr>
</tbody>
</table>
Conditions that are an integral part of a disease process
Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

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

**EXAMPLE:**
A physician diagnosed a patient with rheumatoid arthritis of the right ankle and foot who also has rheumatoid polyneuropathy. The condition is coded in ICD-10-CM using the combination code. Currently in ICD-9-CM we do not have a combination code to fully describe the condition and must use two codes when reporting this diagnosis

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>714.0</td>
<td></td>
<td>Rheumatoid arthritis</td>
</tr>
<tr>
<td>357.1</td>
<td></td>
<td>Polyneuropathy in collagen vascular disease</td>
</tr>
</tbody>
</table>

With ICD-10-CM a combination code is available:

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M05.571</td>
<td></td>
<td>Rheumatoid polyneuropathy with rheumatoid arthritis of right ankle and foot</td>
</tr>
</tbody>
</table>

Multiple Coding for a Single Condition
In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code. “Use additional code” notes are found in the Tabular at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. The sequencing rule is the same as the etiology/manifestation pair, “use additional code” indicates that a secondary code should be added.

For example, for bacterial infections that are not included in chapter 1, a secondary code from category B95 *Streptococcus*, *Staphylococcus*, and *Enterococcus* as the cause of diseases classified elsewhere, or B96 *Other bacterial agents as the cause of diseases classified elsewhere* may be required to identify the bacterial organism causing the infection. A “use additional code” note will normally be found at the infectious disease code, indicating a need for the organism code to be added as a secondary code.

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

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

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

*A patient is treated by his primary care physician for Impetigo manifested by otitis externa of the right ear.*

The underlying condition is the impetigo and the manifestation in this example is the otitis externa.

The Impetigo is sequenced first followed by the Otitis externa.

- L01.00 Impetigo, unspecified
- H62.41 Otitis externa in other diseases classified elsewhere, right ear

This guideline is also based on the fact that the classification has the etiology/manifestation convention that requires that the underlying etiology take sequencing precedence over the acute manifestation.

Acute and Chronic Conditions

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

EXAMPLE:

*A patient was diagnosed with acute maxillary sinusitis that is chronic.*

In ICD-10-CM both codes for the acute and chronic condition are reported.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J01</td>
<td>Acute sinusitis</td>
</tr>
<tr>
<td></td>
<td>Includes: acute abscess of sinus acute empyema</td>
</tr>
<tr>
<td></td>
<td>of sinus acute infection of sinus acute inflammation</td>
</tr>
<tr>
<td></td>
<td>of sinus acute suppuration of sinus</td>
</tr>
<tr>
<td></td>
<td>Use additional code (B95-B97) to identify infectious agent.</td>
</tr>
<tr>
<td></td>
<td>Excludes1: sinusitis NOS (J32.9)</td>
</tr>
<tr>
<td></td>
<td>Excludes2: chronic sinusitis (J32.0-J32.8)</td>
</tr>
</tbody>
</table>

The correct diagnosis coding and reporting is:

- J01.00 Acute maxillary sinusitis, unspecified
- J32.0 Chronic maxillary sinusitis

Note: There is an Excludes2 note which indicates that conditions listed with Excludes2 are not considered inclusive to a code, but may be coexistent, and if present, should be coded as an additional code.

Combination Code

A combination code is a single code used to classify:

- Two diagnoses, or
- A diagnosis with an associated secondary process (manifestation)
- A diagnosis with an associated complication

Combination codes are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.
Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs. Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.

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

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

Impending or Threatened Condition
Code any condition described at the time of discharge as “impending” or “threatened” as follows:

- If it did occur, code as confirmed diagnosis.
- If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for “impending” or “threatened” and also reference main term entries for “Impending” and for “Threatened.”
- If the subterms are listed, assign the given code.
- If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

(43) Complications of Surgery and Other Medical Care
When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the first listed code.

EXAMPLE:
Dr. Smith performed a spinal puncture on Mr. Cartwright. The patient was doing well following surgery, but later in the evening, the patient was experiencing weakness and a loss of consciousness. The patient was rushed to the emergency room where Dr. Smith met the patient in the ER. The physician examined the patient and determined that cerebrospinal fluid (CFS) was leaking from the puncture site. The physician took the patient into a surgery suite and stopped the leak.

G97.0 Cerebrospinal fluid leak from spinal puncture

Reporting Same Diagnosis Code More than Once
Each unique ICD-10-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions or two different conditions classified to the same ICD-10-CM diagnosis code.
For bilateral sites, the final character of the codes in the ICD-10-CM indicates laterality. An unspecified side code is also provided should the side not be identified in the medical record. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side.

**CODERS’ TIP**

Looking in the medical record encounter may better enable you to choose the most appropriate code selection as ICD-10-CM includes much higher levels of specificity.

**Principal or First Listed Diagnosis**

Selection of principal diagnosis/first listed code is based first on the conventions in the classification that provide sequencing instructions. If no sequencing instructions apply, then sequencing is based on the condition that brought the patient into the hospital or physician office, and which condition was the primary focus of treatment. Conditions present on admission that receive treatment, but that do not meet the definition of principal diagnosis, should be coded as additional codes. Additional guidelines on the selection of the principal/first listed code include:

1. A sign or symptom code is not to be used as a principal diagnosis when a definitive diagnosis for the sign or symptom has been established.
2. A sign or symptom code is to be used as principal/first listed if no definitive diagnosis is established at the time of coding. If the diagnosis is confirmed (e.g., an X-ray confirms a fracture, pathology, or laboratory report confirms a diagnosis), prior to coding the encounter, the confirmed diagnosis code should be used.
3. If anticipated treatment is not carried out due to unforeseen circumstances, the principal diagnosis/first listed code remains the condition or diagnosis that the provider planned to treat.
4. When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis/first listed code.

Review the ICD-10-CM document for complete instructions on the selection of the principal diagnosis/first listed code.

**Selection of Secondary Diagnoses**

In most cases, more than one code is necessary to fully explain a health care encounter. Although a patient has an encounter for a principal/first listed diagnosis, the additional conditions or reasons for the encounter also need to be coded. These codes are referred to as secondary, additional, or “other” diagnoses.

“Other diagnoses” is an additional code that affects patient care in terms of requiring clinical evaluation or therapeutic treatment or diagnostic procedures or extended length of hospital stay or increased nursing care and/or monitoring. Diagnoses that relate to an earlier episode that have no bearing on the current hospital stay are to be excluded.

**Symptom Codes with Confirmed Diagnoses**

Two rules apply to use the symptom codes with confirmed diagnoses: (1) a symptom code should not be used with a confirmed diagnosis is the symptom is integral to the diagnosis; (2) a symptom
code should be used with a confirmed diagnosis if the symptom is not always associated with that diagnosis, such as the use various signs and symptoms associated with complex syndromes.

**CODERS’ TIP**
Looking in the medical record encounter may better enable you to choose the most appropriate code selection as ICD-10-CM includes much higher levels of specificity.

For bilateral sites, the final character of the codes in the ICD-10-CM indicates laterality. An unspecified side code is also provided should the side not be identified in the medical record. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side.

**Previous Conditions**
Some physicians include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous visits that have no bearing on the current treatment. Such conditions are not to be reported and are coded only if required by the hospital or physician office policy.

**For example** if the patient is being treated for hypertension and diabetes during the patient encounter and the patient had pneumonia which was resolved three months ago, and has no bearing on the services rendered at the visit, the pneumonia would not be reported.

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

If the abnormal test finding corresponds to a confirmed diagnosis it should not be coded in addition to the confirmed diagnosis. A sign or symptom code is to be used as principal/first listed if no definitive diagnosis is established at the time of coding. If the diagnosis is confirmed (e.g., an X-ray confirms a fracture, a pathology or laboratory report confirms a diagnosis) prior to coding the encounter, the confirmed diagnosis code should be used.

**Chapter-Specific Coding Guidelines**
In addition to general coding guidelines, there are guidelines for specific diagnoses and/or conditions in the classification. Unless otherwise indicated, these guidelines apply to all health care settings.

**Chapter 1: Certain Infectious and Parasitic Diseases (A00–B99)**

**Human Immunodeficiency Virus (HIV) Infections**
In ICD-10-CM there are several categories and codes to classify HIV. These categories are:

- B20-Human immunodeficiency virus (HIV) disease
- R75-Inconclusive laboratory evidence of human immunodeficiency virus (HIV)
- Z20.6-Contact with and exposure to human immunodeficiency virus [HIV]
- Z11.4-Encounter for screening for human immunodeficiency virus [HIV]
- Z71.7-Human immunodeficiency virus [HIV] counseling
- Z21-Asymptomatic human immunodeficiency virus (HIV) infection status
Code only Confirmed Cases

Code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline which can be found in Section II, H of the ICD-10-CM Official Guidelines.

In this context, “confirmation” does not require documentation of positive serology or culture for HIV; the provider’s diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

Code B20 is for use for symptomatic HIV patients. The patient has had any of the opportunistic infections associated with HIV virus. The code for HIV is synonymous with the term acquired immune deficiency syndrome (AIDS), and the AIDS replaced complex (ARC). Review the code example below:

**EXAMPLE:**

**B20 Human immunodeficiency virus [HIV] disease**
Includes: acquired immune deficiency syndrome [AIDS] AIDS-related complex [ARC] HIV infection, symptomatic

There is an instructional note to use an additional code to report any manifestation of AIDS.

Use additional code(s) to identify all manifestations of HIV infection.

Excludes1: asymptomatic human immunodeficiency virus [HIV] infection status (Z21) exposure to HIV virus (Z20.6) inconclusive serologic evidence of HIV (R75)

Currently in ICD-9-CM, the appropriate code for a symptomatic HIV patient is 042 (HIV) adding an additional diagnosis code to identify the manifestations of the disease.

**Note:** People with HIV can get many infections (called opportunistic infections, or OIs).

Selection and Sequencing of HIV Codes

Sequencing HIV codes in ICD-10-CM is similar to ICD-9-CM, Code B20 should be sequenced as the first listed diagnosis when the patient is treated for an HIV related or condition. Any non-related conditions may also be sequenced following the related conditions. When an HIV patient is treated for an unrelated condition, the diagnosis code for the unrelated condition is listed first, followed by the HIV related diagnosis code which is either B20 for a symptomatic patient, or Z21 for an asymptomatic patient.

If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (eg, the nature of injury code) should be the principal diagnosis. Other diagnoses would be B20 followed by additional diagnosis codes for all reported HIV-related conditions.

Whether the patient is newly diagnosed or has had previous admissions/encounters for HIV conditions is irrelevant to the sequencing decision.

Asymptomatic Human Immunodeficiency Virus

Z21, Asymptomatic human immunodeficiency virus [HIV] infection status, is to be applied when the patient without any documentation of symptoms is listed as being “HIV positive,” “known HIV,” “HIV test positive,” or similar terminology. Do not use this code if the term “AIDS” is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his or her HIV positive status; use B20 in these cases.
Code Z21 is used for reporting a patient diagnosed with HIV positive status but has never had any opportunistic infections. Once a patient has had a first opportunistic infection that patient is assigned code B20 thereafter. The draft guidelines state, “A patient should never be assigned a Z21 code, even if at a particular encounter no infection or HIV related condition is present. Codes B20 and Z21 should never appear on the same record.”

**EXAMPLE:**

Z20.6 Contact with and exposure to human immunodeficiency virus [HIV]
Excludes: asymptomatic human immunodeficiency virus [HIV] infection status (Z21)

The crosswalk from ICD-9-CM for HIV exposure V01.79 to ICD-10-CM is Z20.6.

Confirmation of HIV status does not require documentation of positive serology or culture for HIV. Reporting is based on the physician’s documentation that the patient has an HIV-related illness or is HIV positive.

**EXAMPLE:**

A patient tested by his internist tested positive for HIV without symptoms.

Z21 Asymptomatic human immunodeficiency virus [HIV] infection status
Includes: HIV positive NOS
Excludes: acquired immunodeficiency syndrome (B20) contact with or exposure to human immunodeficiency virus [HIV] (Z20.6) human immunodeficiency virus [HIV] disease (B20) inconclusive laboratory evidence of human immunodeficiency virus [HIV] (R75)

Code Z20.6 is reported only when a patient believes he or she has been exposed or has come into contact with the HIV virus.

**Note:** ICD-9-CM code V08-Asymptomatic human immunodeficiency virus (HIV) infection status is cross-walked to ICD-10-CM as Z21.

Patients with inconclusive HIV serology, but no definitive diagnosis or manifestations of the illness, may be assigned code R75 Inconclusive laboratory evidence of human immunodeficiency virus [HIV].

Code R75 is used when a patient has an inconclusive lab finding for HIV. This code is reported for newborns of HIV positive mothers whose HIV status has not been confirmed.

**EXAMPLE:**

R75 Inconclusive laboratory evidence of human immunodeficiency virus [HIV]
Includes: nonconclusive HIV-test finding in infants
Excludes: asymptomatic human immunodeficiency virus [HIV] infection status (Z21) human immunodeficiency virus [HIV] disease (B20)

The crosswalk from ICD-9-CM is 797.71-Inconclusive laboratory evidence of HIV to ICD-10-CM R75.
Patients with any known prior diagnosis of an HIV-related illness should be coded to B20. Once a patient has developed an HIV-related illness, the patient should always be assigned code B20 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (B20) should never be assigned to R75 or Z21 Asymptomatic human immunodeficiency virus [HIV] infection status.

During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of an HIV-related illness should receive a principal diagnosis code of O98.7-Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium followed by B20 and the code(s) for the HIV-related illness(es). Codes from Chapter 15 always take sequencing priority.

Patients with asymptomatic HIV infection status admitted (or presenting for a health care encounter) during pregnancy, childbirth, or the puerperium should receive codes of O98.7- and Z21.

The specificity of the subcategory is six digits beginning with the letter O. Diagnosis code(s) O98.71- is reported based on the trimester of pregnancy where as O98.72 is reported for HIV disease complicating childbirth and O98.72 is reported for complications of the puerperium.

**Note:** When a patient has HIV and is pregnant, codes from Chapter 15 of ICD-10-CM, Pregnancy, childbirth and the puerperium is always sequenced first. Code O98.7- should be sequenced second followed by the appropriate HIV code.

**EXAMPLE:**

O98.7  Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium

Use additional code to identify the type of HIV disease:
- Acquired immune deficiency syndrome (AIDS) (B20)
- Asymptomatic HIV status (Z21)
- HIV positive NOS (Z21)
- Symptomatic HIV disease (B20)

O98.71  Human immunodeficiency [HIV] disease complicating pregnancy

O98.711  Human immunodeficiency [HIV] disease complicating pregnancy, first trimester

O98.712  Human immunodeficiency [HIV] disease complicating pregnancy, second trimester

O98.713  Human immunodeficiency [HIV] disease complicating pregnancy, third trimester

O98.719  Human immunodeficiency [HIV] disease complicating pregnancy, unspecified trimester

O98.72  Human immunodeficiency [HIV] disease complicating childbirth

O98.73  Human immunodeficiency [HIV] disease complicating the puerperium
Encounters for Testing for HIV
If a patient is being seen to determine his or her HIV status, use code Z11.4, Encounter for screening for human immunodeficiency virus [HIV]. Use additional codes for any associated high risk behavior. If a patient with signs or symptoms is being seen for HIV testing, code the signs and symptoms. An additional counseling code Z71.7 Human immunodeficiency virus [HIV] counseling may be used if counseling is provided during the encounter for the test.

When a patient returns to be informed of his or her HIV test results and the test result is negative, use code Z71.7 Human immunodeficiency virus [HIV] counseling.

If the results are positive, see previous guidelines and assign codes as appropriate.

Infectious Agents as the Cause of Diseases Classified to Other Chapters
Certain infections are classified in chapters other than Chapter 1 and no organism is identified as part of the infection code. In these instances, it is necessary to use an additional code from Chapter 1 to identify the organism.

A code from category B95 Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified to other chapters, B96, Other bacterial agents as the cause of diseases classified to other chapters, or B97, Viral agents as the cause of diseases classified to other chapters, is to be used as an additional code to identify the organism. An instructional note will be found at the infection code advising that an additional organism code is required.

Infections Resistant to Antibiotics
Many bacterial infections are resistant to current antibiotics. It is necessary to identify all infections documented as antibiotic resistant. Assign code Z16 Infection with drug resistant microorganisms following the infection code for these cases.

Coding of Sepsis and Severe Sepsis

Sepsis, Severe Sepsis, and Septic Shock
Sepsis refers to an infection due to any organism that triggers a systemic inflammatory response, the systemic inflammatory response syndrome (SIRS). All codes with sepsis in the title include the concept of SIRS. For cases of sepsis that do not result in any associated organ dysfunction, a single code for the type of sepsis should be used.

For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection. If the type of infection or causal organism is not further specified, assign code A41.9 Sepsis, unspecified. A code from subcategory R65.2 Severe sepsis should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.

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

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

If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign a code from subcategory R65.2, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider.
Severe Sepsis
The coding of severe sepsis requires a minimum of two codes: first a code for the underlying systemic infection, followed by a code from subcategory R65.2 Severe sepsis.

If the causal organism is not documented, assign code A41.9 Sepsis, unspecified for the infection. Additional code(s) for the associated acute organ dysfunction are also required.

Due to the complex nature of severe sepsis, some cases may require querying the provider prior to assignment of the codes.

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

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

The terms bacteremia and septicemia NOS are coded to R78.81. If a patient with a serious infection is documented to have septicemia the physician should be asked if the patient has sepsis. If any organ dysfunction is documented the physician should be asked if the patient has severe sepsis. Negative or inconclusive blood cultures do not preclude a diagnosis of sepsis in patients with clinical evidence of the condition.

R78.8 Finding of other specified substances, not normally found in blood

EXAMPLE:

R78.81 Bacteremia
Septicemia NOS
Excludes1: sepsis-code to specified infection (A00-B99)

The term urosepsis is a non-specific term. If a physician uses the term in a medical record he/she should be asked for which specific condition is the term being used.

Sequencing of Severe Sepsis
If severe sepsis is present on admission, and meets the definition of principal diagnosis, the underlying systemic infection should be assigned as principal diagnosis followed by the appropriate code from subcategory R65.2 as required by the sequencing rules in the Tabular List. A code from subcategory R65.2 can never be assigned as a principal diagnosis.

When severe sepsis develops during an encounter (it was not present on admission) the underlying systemic infection and the appropriate code from subcategory R65.2 should be assigned as secondary diagnoses.

Severe sepsis may be present on admission but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear whether severe sepsis was present on admission, the provider should be queried.
Sepsis and Severe Sepsis with a Localized Infection
If the reason for admission is both sepsis or severe sepsis and a localized infection, such as pneumonia or cellulitis, a code(s) for the underlying systemic infection should be assigned first and the code for the localized infection should be assigned as a secondary diagnosis. If the patient has severe sepsis, a code from subcategory R65.2 should also be assigned as a secondary diagnosis. If the patient is admitted with a localized infection, such as pneumonia, and sepsis/severe sepsis doesn’t develop until after admission, the localized infection should be assigned first, followed by the appropriate sepsis/severe sepsis codes.

Sepsis Due to a Postprocedural Infection
Sepsis resulting from a postprocedural infection is a complication of medical care. For such cases, the postprocedural infection code, such as, T80.2 Infections following infusion, transfusion, and therapeutic injection, T81.4 Infection following a procedure, T88.0 Infection following immunization, or O86.0 Infection of obstetric surgical wound, should be coded first, followed by the code for the specific infection. If the patient has severe sepsis the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.

Sepsis and Severe Sepsis Associated with a Noninfectious Process (condition)
In some cases a noninfectious process (condition), such as trauma, may lead to an infection which can result in sepsis or severe sepsis. If sepsis or severe sepsis is documented as associated with a noninfectious condition, such as a burn or serious injury, and this condition meets the definition for principal diagnosis, the code for the noninfectious condition should be sequenced first, followed by the code for the resulting infection. If severe sepsis, is present a code from subcategory R65.2 should also be assigned with any associated organ dysfunction(s) codes. It is not necessary to assign a code from subcategory R65.1 Systemic inflammatory response syndrome (SIRS) of non-infectious origin, for these cases. If the infection meets the definition of principal diagnosis it should be sequenced before the noninfectious condition. When both the associated non-infectious condition and the infection meet the definition of principal diagnosis either may be assigned as principal diagnosis. Only one code from category R65, Symptoms and signs specifically associated with systemic inflammation and infection should be assigned. Therefore, when a non-infectious condition leads to an infection resulting in severe sepsis, assign the appropriate code from subcategory R65.2, Severe sepsis. Do not additionally assign a code from subcategory R65.1, Systemic inflammatory response syndrome (SIRS) of non-infectious origin. See Section I.C.18. SIRS due to non-infectious process.

Sepsis and SIRS
For other infections in which SIRS is present but sepsis is not in the code title, code R65.1, Systemic inflammatory response syndrome (SIRS), may also be assigned. For any infection, if associated organ dysfunction is present, a code from subcategory R65.2, Severe sepsis, should be used and the guidelines for coding of severe sepsis should be followed. Codes for sepsis and septic shock associated with abortion, ectopic pregnancy, and molar pregnancy are in Chapter 15. Code R65.1 and a code from R65.2 should not be used together on the same record.
**EXAMPLE:**

Review the ICD-10-CM example of SIRS and Sepsis

R65.1- Systemic inflammatory response syndrome (SIRS)
   Excludes1: sepsis-code to infection severe sepsis (R65.2)

R65.2- Severe sepsis Infection with organ dysfunction Code first underlying infection
   Use additional code to identify specific organ dysfunction, such as: acute renal failure
   (N17.-) acute renal failure
   (J96.0) acute respiratory failure
   (G72.81) critical illness myopathy
   (G93.41) encephalopathy (metabolic) (septic)
   (D65) disseminated intravascular coagulopathy [DIC]
   (G62.81) critical illness polyneuropathy
   hepatic failure (K72.0-)

**ICD-10-CM Chapter 2: Neoplasms (C00-D49)**

ICD-10-CM Chapter 2 contains codes for most benign and malignant neoplasms.

To properly code neoplasms, the documentation in the medical record must indicate the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior. If there is a malignancy, the secondary (metastatic) site should also be reported as it is currently with ICD-9-CM.

As in ICD-9-CM there is a separate Table of Neoplasms. The codes should be selected from the table. The guidelines in ICD-10-CM state; “If the histology (cell type) of the neoplasm is documented, that term should be referenced first, in the main section of the Index, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate.”

**EXAMPLE:**

A physician diagnosed a 54-year-old female patient with adenocarcinoma of the right breast, lower outer quadrant of the left side. The physician’s documentation indicated it as the primary site. The alphabetic index should be reviewed prior to referencing the Neoplasm Table.

The first step is to reference the Alphabetic Index:

*Adenocarcinoma* (M8140/3)—see also Neoplasm, malignant

The Alphabetic Index identifies adenocarcinoma as a malignancy reported by site. The coder then will reference the Neoplasm Table for selection of the correct code. Review an example from the Neoplasm Table for ICD-10-CM (Table 1.2).

The Neoplasm Table provides proper coding based on the histology of the neoplasm by site. The Tabular List should be referenced to verify that the correct code has been selected and a more specific code does not exist.
Comparison between ICD-9-CM and ICD-10-CM:

**ICD-9-CM**

174.5  Malignant neoplasm of lower-outer quadrant of female breast (Primary site)

**ICD-10-CM**

C50.512  Malignant neoplasm lower-outer quadrant left side (Primary site)

You will notice the correct diagnosis code for this example is C50.52 *Adenocarcinoma of the left side, lower outer quadrant, malignant, primary site*, which is found in the first column.

The Neoplasm Table provider proper coding based on the histology of the neoplasm by site. The Tabular list should be referenced to verify that the correct code has been selected and a more specific code does not exist.
Review the Tabular list example:

- C50.519  Malignant neoplasm of lower-outer quadrant of female breast, unspecified side
- C50.511  Malignant neoplasm of lower-outer quadrant of right female breast
- C50.512  Malignant neoplasm of lower-outer quadrant of left female breast

Chapter 2 of the ICD-10-CM contains the codes for most benign and all malignant neoplasms. Certain benign neoplasms, such as prostatic adenomas, may be found in the specific body system chapters. To properly code a neoplasm it is necessary to determine from the record if the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior. If malignant, any secondary (metastatic) sites should also be determined.

The neoplasm table in the Alphabetic Index should be referenced first. However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table to determine which column in the Neoplasm Table is appropriate. For example, if the documentation indicates “adenoma,” refer to the term in the alphabetic Index to review the entries under this term and the instructional note to “see also neoplasm, by site, benign.” The table provides the proper code based on the type of neoplasm and the site. It is important to select the proper column in the table that corresponds to the type of neoplasm. The Tabular should then be referenced to verify that the correct code has been selected from the table and that a more specific site code does not exist.

If the reason for the encounter is to diagnosis when malignancy may be present, assign a code(s) for sign(s)/symptom(s) unless confirmation of the diagnosis is made. Confirmation of a malignancy should be assigned when there is confirmation from an outpatient visit in the medical record or pathology report.

**EXAMPLE:**

During a routine examination, the physician found a suspicious breast mass in the left breast of a female patient who has a history of breast cancer of the right breast. The physician scheduled a biopsy in the outpatient surgery department at the hospital.

In ICD-10-CM two codes would be reported; 1 for the lump in the breast and the secondary diagnosis for the personal history:

- First listed diagnosis:  N 63 Unspecified lump in breast includes: nodule(s) NOS in breast
- Second listed diagnosis:  Z85.3 Personal history of primary malignant neoplasm of breast

See Section I.C.21. Factors influencing health status and contact with health services, Status, for information regarding Z15.0, Codes for genetic susceptibility to cancer.

If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis. The only exception to this guideline is if a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy, assign the appropriate Z51.0- code as the first-listed or principal diagnosis, and the diagnosis or problem for which the service is being performed as a secondary diagnosis.
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EXAMPLE:
A patient underwent removal of the upper lobe of the left lung due to lung cancer after a mass was discovered during CT scan.

The category to report is C34.1 Malignant neoplasm of upper lobe, bronchus or lung. The code is further divided by laterality right or left.

- C34.10 - Malignant neoplasm of upper lobe, bronchus or lung, unspecified side
- C34.11 - Malignant neoplasm of upper lobe, right bronchus or lung
- C34.12 - Malignant neoplasm of upper lobe, left bronchus or lung

The correct code to report is C34.12 "malignant neoplasm of upper lobe right lung.”

When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

EXAMPLE:
A patient was diagnosed with a malignant cancer of pancreatic duct with metastasis to liver. The patient is being treated for the liver cancer.

First listed diagnosis: C78.7 - Secondary malignant Neoplasm of liver
Second listed diagnosis: C25.3 - Malignant neoplasm of pancreatic duct

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

When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by code D63.0 "Anemia in neoplastic disease.”

EXAMPLE:
A patient was diagnosed with a malignancy of the frontal lobe. The patient was also suffering from anemia due to the tumor.

Code D63.0 - Anemia in neoplastic disease
Manifestation code (secondary)

Coding conventions require neoplasm code sequenced first and anemia, D63.0 sequenced second.

First listed diagnosis: C71.1 - Malignant neoplasm of frontal lobe
Second listed diagnosis: D63.0 - Anemia in neoplastic disease

When the admission/encounter is for management of an anemia associated with chemotherapy, immunotherapy or radiotherapy and the only treatment is for the anemia, the anemia is sequenced first followed by code T45.1x5 "Adverse effect of antineoplastic and immunosuppressive drugs.” The appropriate neoplasm code should be assigned as an additional code.
EXAMPLE:

A 48-year-old female patient was treated for anemia due to chemotherapy for a malignancy of the frontal lobe.

First listed diagnosis: D63.0—Anemia in neoplastic disease
Second listed diagnosis: T45.1x5—Adverse effect of antineoplastic and immunosuppressive drugs
Tertiary diagnosis: C71.1—Malignant neoplasm of frontal lobe

When the admission/encounter is for management of dehydration due to the malignancy or the therapy, or a combination of both, and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.

EXAMPLE:

A patient was admitted to the hospital for rehydration following chemotherapy for a malignancy of the ethmoidal sinus.

First listed diagnosis: E86.0—Dehydration
Second listed diagnosis: C31.1—Malignant neoplasm of ethmoidal sinus

When the admission/encounter is for treatment of a complication resulting from a surgical procedure, designate the complication as the principal or first-listed diagnosis if treatment is directed at resolving the complication.

EXAMPLE:

A patient was treated for sepsis following surgery for the removal of a malignant tumor of the lateral wall of the bladder.

First listed diagnosis: T81.4a Infection following a procedure, not elsewhere classified

Second listed diagnosis: C67.2 Malignant neoplasm of lateral wall of bladder

When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of primary and secondary malignant neoplasm, should be used to indicate the former site of the malignancy.

EXAMPLE:

A 56-year-old male was seen in follow-up following removal of the prostate three years ago for a malignancy.

First listed diagnosis: Z85.46 Personal history of primary malignant neoplasm of prostate
Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed with the Z85 code used as a secondary code.

**Episode of Care Involves Surgical Removal of Neoplasm**

When an episode of care involves the surgical removal of a neoplasm, primary or secondary site, followed by adjunct chemotherapy or radiation treatment during the same episode of care, the neoplasm code should be assigned as principal or first-listed diagnosis, using codes in the C00-D49 series or where appropriate in the C83-C90 series.

If a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy assign code Z51.0 *Encounter for antineoplastic radiation therapy*, or Z51.11 *Encounter for antineoplastic chemotherapy*, or Z51.12 *Encounter for antineoplastic immunotherapy* as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission more than one of these codes may be assigned, in any sequence.

**EXAMPLE:**

A patient underwent chemotherapy following a oophorectomy for removal of a malignant tumor of the left ovary.

First listed diagnosis: Z51.11 Chemotherapy session for neoplasm
Second listed diagnosis: C56.1 Malignant neoplasm of left ovary

The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis.

When a patient is admitted for the purpose of radiotherapy, immunotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is Z51.0 *Encounter for antineoplastic radiation therapy*, or Z51.11 *Encounter for antineoplastic chemotherapy*, or Z51.12 *Encounter for antineoplastic immunotherapy* followed by any codes for any complications.

**EXAMPLE:**

A patient was experiencing nausea and vomiting following radiation therapy for treatment of a malignant tumor or the parathyroid gland.

First listed diagnosis: Z51.0 Encounter for radiotherapy session
Second listed diagnosis: C75.0 Malignant neoplasm of parathyroid gland
Tertiary diagnosis: R11.0 Nausea with vomiting

When the reason for admission/encounter is to determine the extent of the malignancy, or for a procedure such as paracentesis or thoracentesis, the primary malignancy or appropriate metastatic site is designated as the principal or first-listed diagnosis, even though chemotherapy or radiotherapy is administered.
**EXAMPLE:**

A physician removed a malignant tumor from the descending colon in the outpatient surgery center. The physician recommended that the patient undergo chemotherapy the same day.

First listed diagnosis: C18.6 Malignant neoplasm of descending colon
Second listed diagnosis: Z51.11 Chemotherapy session for neoplasm

Symptoms, signs, and ill-defined conditions listed in Chapter 18 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal or first-listed diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm. Reference “Factors influencing health status and contact with health services,” encounter for prophylactic organ removal.

A patient may have more than one malignant tumor in the same organ. These tumors may represent different primaries or metastatic disease, depending on the site. Should the documentation be unclear, the provider should be queried as to the status of each tumor so that the correct codes can be assigned.

Code C80.0 *Disseminated malignant neoplasm, unspecified* is for use only in those cases where the patient has advanced metastatic disease and no known primary or secondary sites are specified. It should not be used in place of assigning codes for the primary site and all known secondary sites.

Code C80.1 *Malignant neoplasm, unspecified* equates to cancer, unspecified. This code should only be used when no determination can be made as to the primary site of a malignancy. This code should rarely be used in the inpatient setting.

**Sequencing of Neoplasm Codes**

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

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

Codes from Chapter 15, Pregnancy, childbirth, and the puerperium, are always sequenced first on a medical record. A code from subcategory O94.1-, Malignant neoplasm complicating pregnancy, childbirth, and the puerperium, should be used first, followed by the appropriate code from Chapter 2 to indicate the type of neoplasm.

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, followed by the appropriate code(s) for the neoplasm.

When an encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of 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.
When an encounter is for a pathological fracture due to a neoplasm, if 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. The “code also” note at M84.5 provides this sequencing instruction.

**EXAMPLE:**

A patient is treated for a pathologic fracture of the right tibia, due to a neoplasm of the right tibia

First listed diagnosis: M84.561a Pathologic fracture of bone in neoplastic disease, right tibia

Second listed diagnosis: C76.51 Malignant neoplasm of right lower limb

**Note:** The seventh character “a” identifies the initial patient encounter for the condition.

When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of primary and secondary malignant neoplasm, should be used to indicate the former site of the malignancy. See Section I.C.21. Factors influencing health status and contact with health services, History (of).

**EXAMPLE:**

A 56-year-old male was seen in follow-up following removal of the prostate three years ago for a malignancy.

First listed diagnosis: Z85.46 Personal history of primary malignant neoplasm of prostate

The categories for leukemia, and category C90, Multiple myeloma, have codes for in remission. There are also codes Z85.6 Personal history of leukemia and Z85.79 Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues. If the documentation is unclear, as to whether the patient is in remission, the provider should be queried.

**Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00–E90)**

**Diabetes mellitus**

Within this category are the following blocks:

- E00-E07 Disorders of the thyroid gland
- E08-E14 Diabetes Mellitus
- E15-E16 Other disorders of glucose regulation and pancreatic internal secretion

The biggest change in the guidelines from ICD-9-CM to ICD-10-CM is coding for Diabetes Mellitus.
Diabetes Mellitus codes in ICD-10-CM are combination codes that include:

- Type of diabetes mellitus
- Body system affected, and;
- The complications affecting that body system

There are six (6) Diabetes Mellitus categories in the ICD-10-CM. They are:

- E08 Diabetes Mellitus due to an underlying condition
- E09 Drug or chemical induced diabetes mellitus
- E10 Type 1 diabetes mellitus
- E11 Type 2 diabetes mellitus
- E13 Other specified diabetes mellitus
- E14 Unspecified diabetes mellitus

All the categories above with the exception of E10 include a note directing users to use an additional code to identify any insulin use, which is Z79.4. The concept of insulin and non-insulin requiring are not a component of the DM (diabetes mellitus) categories in ICD-10-CM. Code Z79.7 Long-term current use of insulin is added to identify the use of insulin for diabetic management even if the patient is not insulin dependent in code categories E08-E09 and E11-E14.

The fourth character under these categories refer to underlying conditions with specified complications, whereas, the fifth character defines the specific manifestation such as neuropathy, angiopathy, etc.

**EXAMPLE:**

A 45-year-old NIDDM patient returns to his physician’s office for a 3 month follow-up visit. The patient has no complaints. After an expanded problem-focused history and physical examination, the physician documents in the medical record, “NIDDM well controlled with Diabinese, diet, and exercise. Patient will continue with same medication dosage, monitor glucose levels with home monitoring system, and return in 3 months for recheck.”

First listed diagnosis: E11.9—Type 2 diabetes mellitus without complications

Definitions for the types of Diabetes Mellitus are included in the “Includes notes” under each DM category. Sequencing of diabetes codes from categories E08–E09 have a “Code first” note indicating that diabetes is to be sequenced after the underlying condition, drug or chemical that is responsible for the diabetes. Codes from categories E10–E14 (Diabetes mellitus) are sequenced first, followed by codes for any additional complications outside of these categories if applicable.

The diabetes mellitus codes are combination codes that include the type of DM, the body system affected, and the complications affecting that body system. As many codes within a particular category as are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for a particular encounter. Assign as many codes from categories E08–E13 as needed to identify all of the associated conditions that the patient has.
EXAMPLE:
A Type 1 diabetic patient with Kimmelstiel-Wilson disease visited his endocrinologist in follow-up.

E10.21 Type 1 diabetes mellitus with diabetic nephropathy
Type 1 diabetes mellitus with Kimmelstiel-Wilson disease

EXAMPLE:
A patient with Type 1 diabetes has developed moderate nonproliferative diabetic retinopathy.

First listed diagnosis: E10.339 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema

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

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

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

EXAMPLE:
A 45-year-old Type 2 patient returns to his physician’s office for a 3-month follow-up visit. The patient has been on insulin for the past eight months since the diabetes was not well controlled. After an expanded problem-focused history and physical examination, the physician documents in the medical record, “Type 2 diabetes mellitus currently maintaining good control with insulin, diet, and exercise. Patient will continue with same medication dosage, monitor glucose levels with home monitoring system, and return in 3 months for recheck. We may consider discontinuing insulin if patient remains in good control.

First listed diagnosis: E11.9 Type 2 diabetes mellitus without complications
Second listed diagnosis: Z79.4 Long-term (current) use of insulin

Diabetes Mellitus in Pregnant Patient
Codes for pregnancy, childbirth and the puerperium, which are located in Chapter 15 of ICD-10-CM, are always sequenced first on the medical record. A patient who has a pre-existing DM who becomes pregnant should be assigned a code from category O24 Diabetes Mellitus in Pregnancy, Childbirth, and the Puerperium followed by the diabetes code from Chapter 4 of ICD-10-CM.
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These codes have been expanded in ICD-10-CM. The fourth character subcategory codes identify the type of diabetes as pre-existing Type 1 or Type 2, unspecified, or gestational.

The fifth character indicates whether the diabetes is treated during pregnancy, childbirth, or the puerperium. The sixth character indicates the trimester during which treatment is sought. With gestational diabetes the sixth character identifies whether the gestational diabetes is diet-controlled, insulin controlled or unspecified control.

**EXAMPLE:**

A 25-year-old patient with diabetes mellitus Type 1 in her second trimester visited her OB/GYN for her routine follow-up visit. The patient’s blood sugar was well controlled and the patient indicated she was doing well with her diet and exercise regimen. The physician scheduled the patient for follow-up for one month.

First listed diagnosis: O24.012 Pre-existing diabetes mellitus, Type 1, in pregnancy, second trimester

Second listed diagnosis: E10.69 Type 1 diabetes mellitus with other specified complication

**EXAMPLE:**

A 27-year-old patient developed gestational diabetes in her third trimester. The patient’s condition is controlled with diet and exercise.

O24.41 Gestational diabetes mellitus in pregnancy

O24.410 Gestational diabetes mellitus in pregnancy, diet-controlled

**Note:** See Section I.C.15, Diabetes mellitus in pregnancy, and section I.C.15. Gestational (pregnancy induced) diabetes.

**Complications Due to Insulin Pump Malfunction**

An undosage of insulin due to an insulin pump failure should be assigned to a code from subcategory T85.6, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, that specifies the type of pump malfunction, as the principal or first listed code, followed by code T38.3x6- Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs. Additional codes for the type of diabetes mellitus and any associated complications due to the undosage should also be assigned.

The principal or first listed code for an encounter due to an insulin pump malfunction resulting in an overdose of insulin, should also be T85.6- Mechanical complication of other specified internal and external prosthetic devices, implants and grafts followed by code T38.3x1- Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional).

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

**Pain disorders related to psychological factors**

Assign code F45.41 for pain that is exclusively psychological. There is also, generally, a psychological component of any type of acute or chronic pain. Code F45.41 Pain disorder with related psychological factors should be used following the appropriate code from category G89 Pain, not elsewhere classified if there is documentation of a psychological component for a patient with acute or chronic pain. See Section I.C.6. Pain
EXAMPLE:
A patient is treated by her psychiatrist for chronic pain syndrome that is psychological.

First listed diagnosis: F45.42 Pain disorder with related psychological factors

Code also associated acute or chronic pain (G89-)

Second listed diagnosis: G89.4 Chronic pain syndrome

Chapter 6: Diseases of Nervous System (G00–G99)

Dominant/nondominant Side
Codes from category G81, Hemiplegia and hemiparesis, and subcategories, G83.1 Monoplegia of lower limb, G83.2 Monoplegia of upper limb, and G83.3 Monoplegia, unspecified identify whether the dominant or nondominant side is affected. Should this information not be available in the record, the default should be dominant. For ambidextrous patients, the default should also be dominant.

Pain—Category G89

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

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

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

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

Category G89 Codes as Principal or First-Listed Diagnosis
Category G89 codes are acceptable as principal diagnosis or the first-listed code:

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

- When a patient is admitted for the insertion of a neurostimulator for pain control, assign the appropriate pain code as the principal or first listed diagnosis. When an admission or encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is inserted for pain control during the same admission/encounter, a code for the underlying condition should be assigned as the principal diagnosis and the appropriate pain code should be assigned as a secondary diagnosis.
Use of Category G89 Codes in Conjunction with Site Specific Pain Code

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

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

- If the encounter is for pain control or pain management, assign the code from category G89 followed by the code identifying the specific site of pain (eg, encounter for pain management for acute neck pain from trauma is assigned code G89.11 Acute pain due to trauma followed by code M54.2 Cervicalgia to identify the site of pain).
- If the encounter is for any other reason except pain control or pain management, and a related definitive diagnosis has not been established (confirmed) by the provider, assign the code for the specific site of pain first, followed by the appropriate code from category G89.

See Section I.C.19. Pain due to medical devices

Postoperative Pain
The provider’s documentation should be used to guide the coding of postoperative pain, as well as Section III. Reporting Additional Diagnoses and Section IV. Diagnostic Coding and Reporting in the Outpatient Setting.

The default for post-thoracotomy and other postoperative pain not specified as acute or chronic is the code for the acute form. Routine or expected postoperative pain immediately after surgery should not be coded.

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

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

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

Neoplasm Related Pain
Code G89.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic.
This code may be assigned as the principal or first-listed code when the stated reason for the admission/encounter is documented as pain control/pain management. The underlying neoplasm should be reported as an additional diagnosis.

When the reason for the admission/encounter is management of the neoplasm and the pain associated with the neoplasm is also documented, code G89.3 may be assigned as an additional diagnosis. It is not necessary to assign an additional code for the site of the pain.

See Code G89.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic. Section I.C.2 for instructions on the sequencing of neoplasms for all other stated reasons for the admission/encounter (except for pain control/pain management).

**Chronic Pain Syndrome**

Central pain syndrome (G89.0) and chronic pain syndrome (G89.4) are different than the term “chronic pain,” and therefore codes should only be used when the provider has specifically documented this condition. See Section I.C.5. Pain disorders related to psychological factors

**Chapter 7: Diseases of Eye and Adnexa (H00–H59)**

Reserved for future guideline expansion

**Chapter 8: Diseases of Ear and Mastoid Process (H60–H59)**

Reserved for future guideline expansion

**Chapter 9: Diseases of Circulatory System (I00–I99)**

**Hypertension**

**Hypertension with Heart Disease**

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

**EXAMPLE:**

A patient visits his cardiologist for his 3 month follow-up visit. He is being treated by the cardiologist for hypertensive heart disease with benign hypertension.

First listed diagnosis: I11.9 Hypertensive heart disease without heart failure

**Hypertensive Chronic Kidney Disease**

Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present. Unlike hypertension with heart disease, ICD-10-CM presumes a cause-and-effect relationship and classifies chronic kidney disease with hypertension as hypertensive chronic kidney disease.

The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease. See Section I.C.14. Chronic kidney
disease. If a patient has hypertensive chronic kidney disease and acute renal failure, an additional code for the acute renal failure is required.

**EXAMPLE:**
A patient with malignant hypertension and stage 5 chronic renal disease is admitted to the critical care unit. The patient is now in acute renal failure with acute cortical necrosis.

First listed diagnosis: I12.0 Hypertensive chronic kidney disease with stage V chronic kidney disease or end stage renal disease

Second listed diagnosis: N18.5 Chronic kidney disease, stage V

**Hypertensive Heart and Chronic Kidney Disease**
Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the chronic kidney disease, whether the condition is so designated. If heart failure is present, assign an additional code from category I50 to identify the type of heart failure. The appropriate code from category N18, Chronic kidney disease, should be used as a secondary code with a code from category I13 to identify the stage of chronic kidney disease. See Section I.C.14. Chronic kidney disease.

The codes in category I13, Hypertensive heart and chronic kidney disease, are combination codes that include hypertension, heart disease and chronic kidney disease. The Includes note at I13 specifies that the conditions included at I11 and I12 are included together in I13. If a patient has hypertension, heart disease and chronic kidney disease then a code from I13 should be used, not individual codes for hypertension, heart disease and chronic kidney disease, or codes from I11 or I12. For patients with both acute renal failure and chronic kidney disease, an additional code for acute renal failure is required.

**EXAMPLE:**
A patient is admitted to the hospital with acute diastolic heart failure due to hypertension with end stage renal disease.

Three codes are required in this example:

First listed diagnosis: I13.2 Hypertensive heart and renal disease with both heart failure and chronic renal failure

Second listed diagnosis: I50.31 Acute diastolic (congestive) heart failure

Tertiary diagnosis: N18.6 End-stage renal disease

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

**Hypertensive Retinopathy**
Code H35.0 *Hypertensive retinopathy* should be used with code I10, Essential (primary) hypertension, to include the systemic hypertension. The sequencing is based on the reason for the encounter.
Hypertension, Secondary
Secondary hypertension is due to an underlying condition. Two codes are required: one to identify the underlying etiology and one from category I15 to identify the hypertension. Sequencing of codes is determined by the reason for admission/encounter.

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

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

EXAMPLE:
A patient visits his internist for his 3 month follow-up visit. He has been treated for hypertension for more than three years. The patient’s current blood pressure is 165/110 mm Hg. The patient is a current smoker, but is not dependent. The physician adjusts the patient’s medication, reviews previous blood pressure readings, counsels the patient regarding smoking cessation, and asks the patient to follow-up in 2 months. The documentation indicates benign hypertension without good control.

First listed diagnosis: I10 Essential (primary) hypertension
Second listed diagnosis: Z72.0 Tobacco use

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

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

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

If a patient with coronary artery disease is admitted due to an acute myocardial infarction (AMI), the AMI should be sequenced before the coronary artery disease. See Section I.C.9. Acute myocardial infarction (AMI).

EXAMPLE:
A patient with unstable angina with atherosclerosis of the coronary artery was admitted to the hospital for treatment.

First listed diagnosis: I25.110 Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
Intraoperative and Postprocedural cerebrovascular accident
Proper code assignment depends on whether it was an infarction or hemorrhage and whether it occurred intraoperatively or postoperatively. If it was a cerebral hemorrhage, code assignment depends on the type of procedure performed. Medical record documentation should clearly specify the cause- and-effect relationship between the medical intervention and the cerebrovascular accident in order to assign this code.

Sequelae of Cerebrovascular Disease

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

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

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

Acute Myocardial Infarction (AMI)

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

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

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

4. Subsequent acute myocardial infarction
A code from category I22, Subsequent ST elevation (STEMI) and non ST elevation (NSTEMI) myocardial infarction, is to be used when a patient who has suffered an AMI has a new AMI within the 4 week time frame of the initial AMI. A code from category I22 must be used in conjunction with a code from category I21.

The sequencing of the I22 and I21 codes depends on the circumstances of the encounter. Should a patient who is in the hospital due to an AMI have a subsequent AMI while still in the hospital code...
I21 would be sequenced first as the reason for admission, with code I22 sequenced as a secondary code. Should a patient have a subsequent AMI after discharge for care of an initial AMI, and the reason for admission is the subsequent AMI, the I22 code should be sequenced first followed by the I21. An I21 code must accompany an I22 code to identify the site of the initial AMI, and to indicate that the patient is still within the 4 week time frame of healing from the initial AMI. The guidelines for assigning the correct I22 code are the same as for the initial AMI.

**EXAMPLE:**

A patient was admitted to the hospital suffering from an acute myocardial infarction of the inferior wall. The patient was released three weeks ago after suffering an acute MI of the left anterior descending coronary artery.

First listed diagnosis: I22.1 Subsequent ST elevation (STEMI) myocardial infarction of inferior wall

Second listed diagnosis: I21.02 ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery

**Chapter 10: Diseases of Respiratory System (J00–J99)**

Chapter 10 of ICD-10-CM includes the following blocks:

- J00–J06 Acute upper respiratory infections
- J10–J18 Influenza and pneumonia
- J20–J22 Other acute lower respiratory infections
- J30–J39 Other diseases of upper respiratory tract
- J40–J47 Chronic lower respiratory diseases
- J60–J70 Lung diseases due to external agents
- J80–J84 Other respiratory diseases principally affecting the interstitium
- J85–J86 Suppurative and necrotic conditions of the lower respiratory tract
- J90–J94 Other diseases of the pleura
- J95–J99 Other diseases of the respiratory system

**Chronic Obstructive Pulmonary Disease [COPD] and Asthma**

Conditions included in this category include:

- Asthma with chronic obstructive pulmonary disease
- Chronic asthmatic (obstructive) bronchitis
- Chronic bronchitis with airways obstruction
- Chronic bronchitis with emphysema
- Chronic emphysematous bronchitis
- Chronic obstructive asthma
- Chronic obstructive bronchitis
- Chronic obstructive tracheobronchitis
EXAMPLE:

A patient with COPD was admitted by her internist with a diagnosis of COPD with
respiratory syncytial virus pneumonia.

First listed diagnosis: J44.0 Chronic obstructive pulmonary disease with acute
lower respiratory infection
Secondary diagnosis: J12.1 Respiratory syncytial virus pneumonia

Acute Exacerbation of Chronic Obstructive Bronchitis and Asthma
The codes in categories J44 and J45 distinguish between uncomplicated cases and those in acute
exacerbation. An acute exacerbation is a worsening or a decompensation of a chronic condition. An
acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though
an exacerbation may be triggered by an infection.

Acute Respiratory Failure

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

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

Sequencing of Acute Respiratory Failure and Another Acute Condition
When a patient is admitted with respiratory failure and another acute condition, (eg, myocardial
infarction, cerebrovascular accident, aspiration pneumonia), the principal diagnosis will not be the
same in every situation. This applies whether the other acute condition is a respiratory or nonrespi-
ratory condition. Selection of the principal diagnosis will be dependent on the circumstances of
admission. If both the respiratory failure and the other acute condition are equally responsible for
occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the
guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis
(Section II, C.) may be applied in these situations.

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

Influenza Due to Avian Influenza Virus (Avian Influenza)
Code only confirmed cases of avian influenza. This is an exception to the hospital inpatient guide-
line Section II, H. (Uncertain Diagnosis).

In this context, “confirmation” does not require documentation of positive laboratory testing
specific for avian influenza or novel H1N1 (H1N1 or swine flu). However, coding should be based
on the provider’s diagnostic statement that the patient has avian influenza.
If the provider records “suspected or possible or probable avian influenza,” the appropriate influenza code from category J10, Influenza due to other influenza virus, should be assigned. Code J09 Influenza due to avian influenza virus should not be assigned.

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

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

Pressure Ulcers
Pressuring ulcer stages. Codes from category L89, Pressure ulcer, are combination codes that identify the site of the pressure ulcer as well as the stage of the ulcer.

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

Unstageable pressure ulcers
Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (eg, the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma. This code should not be confused with the codes for unspecified stage (L89.--9). When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.--9).

EXAMPLE:
A patient is treated for a pressure ulcer of the ankle
Code assignment: L89.509 Pressure ulcer of unspecified ankle, unspecified stage

EXAMPLE:
A patient is treated for a pressure ulcer of the left buttock
Code assignment: L89.329 Pressure ulcer of left buttock, unspecified stage

Documented pressure ulcer stage
Assignment of the pressure ulcer stage code should be guided by clinical documentation of the stage or documentation of the terms found in the index. For clinical terms describing the stage that are not found in the index, and there is no documentation of the stage, the provider should be queried. A code from this category is not assigned if the documentation states the pressure ulcer is completely healed.

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

If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider.
**Patient admitted with pressure ulcer evolving into another stage during the admission**

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

**Documentation for BMI and Pressure Ulcer Stages**

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

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

**Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)**

**Site and Laterality**

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

**EXAMPLE:**

A patient is treated by an orthopedic surgeon for osteoarthritis of the right knee. The patient complains of chronic knee pain that worsens at night. The physician prescribed an anti-inflammatory drug to relieve the pain.

First listed diagnosis: M17.11 Unilateral primary osteoarthritis, right knee

**Bone Versus Joint**

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

**Acute Traumatic Versus Chronic or Recurrent Musculoskeletal Conditions**

Many musculoskeletal conditions are a result of previous injury or trauma to a site, or are recurrent conditions. Bone, joint or muscle conditions that are the result of a healed injury are usually found in Chapter 13. Recurrent bone, joint or muscle conditions are also usually found in Chapter 13. Any current, acute injury should be coded to the appropriate injury code from Chapter 19. Chronic or recurrent conditions should generally be coded with a code from Chapter 13. If it is difficult to determine from the documentation in the record which code is best to describe a condition, query the provider.
Coding of Pathologic Fractures
Seventh character A is for use as long as the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, evaluation and treatment by a new physician. Seventh character, D is to be used for encounters after the patient has completed active treatment. The other seventh characters, listed under each subcategory in the Tabular List, are to be used for subsequent encounters for treatment of problems associated with the healing, such as malunions and nonunions, and sequelae. Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.


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

Osteoporosis without Pathological Fracture
Category M81, Osteoporosis without current pathological fracture, is for use for patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis, even if they have had a fracture in the past. For patients with a history of osteoporosis fractures, status code Z87.310 Personal history of osteoporosis fracture should follow the code from M81.-.

EXAMPLE:
A patient is treated with medication for postmenopausal osteoporosis. The patient had a pathologic fracture one year ago and the physician is following her condition every three months.

First Listed Diagnosis: M81.0 Age-related osteoporosis without current pathological fracture
Secondary Diagnosis: Z87.310 Personal history of (healed) osteoporosis fracture

Osteoporosis with Current Pathological Fracture
Category M80, Osteoporosis with current pathological fracture, is for patients who have a current pathologic fracture at the time of an encounter. The codes under M80 identify the site of the fracture. A code from category M80, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.

Chapter 14: Diseases of Genitourinary System (N00–N99)

Chronic kidney disease

Stages of Chronic Kidney Disease (CKD)
The ICD-10-CM classifies CKD based on severity. The severity of CKD is designated by stages I-V. Stage II, code N18.2, equates to mild CKD; stage III, code N18.3, equates to moderate CKD; and stage IV, code N18.4, equates to severe CKD. Code N18.6, End stage renal disease (ESRD), is assigned when the provider has documented end-stage-renal disease (ESRD). If both a stage of CKD and ESRD are documented, assign code N18.6 only.
Chronic Kidney Disease and Kidney Transplant Status
Patients who have undergone kidney transplant may still have some form of CKD, because the kidney transplant may not fully restore kidney function. Therefore, the presence of CKD alone does not constitute a transplant complication. Assign the appropriate N18 code for the patient’s stage of CKD and code Z94.0 Kidney transplant status. If a transplant complication such as failure or rejection is documented, see section I.C.19.g for information on coding complications of a kidney transplant. If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.

Chronic Kidney Disease with Other Conditions
Patients with CKD may also suffer from other serious conditions, most commonly diabetes mellitus and hypertension. The sequencing of the CKD code in relationship to codes for other contributing conditions is based on the conventions in the Tabular List.


EXAMPLE:
A patient in end stage renal disease is admitted to undergo dialysis. The patient is prepared and fitted for a peritoneal dialysis catheter and dialysis is performed in the outpatient hospital dialysis center.

First listed diagnosis: Z49.02 Encounter for fitting and adjustment of peritoneal dialysis catheter
Second listed diagnosis: N18.6 End stage renal disease Chronic kidney disease requiring chronic dialysis

Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00–O99)

General Rules for Obstetric Cases
Trimesters are defined as follows:
- 1st trimester—less than 14 weeks 0 days
- 2nd trimester—14 weeks 0 days to less than 28 weeks 0 days
- 3rd trimester—28 weeks 0 days until delivery

Codes for unspecified trimester should never be reported unless it is impossible to determine the trimester from the medical record documentation in the medical record.

Codes from Chapter 15 and Sequencing Priority
Obstetric cases require codes from Chapter 15, codes in the range O00–O99, Pregnancy, Childbirth, and the Puerperium. Chapter 15 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with Chapter 15 codes to further specify conditions. Should the provider document that the pregnancy is incidental to the encounter, then code Z33.1 Pregnant state, incidental should be used in place of any Chapter 15 codes. It is the provider’s responsibility to state that the condition being treated is not affecting the pregnancy.

Chapter 15 Codes Used Only on the Maternal Record
Chapter 15 codes are to be used only on the maternal record, never on the record of the newborn.
Final Character for Trimester
The majority of codes in Chapter 15 have a final character indicating the trimester of pregnancy. The timeframes for the trimesters are indicated at the beginning of the chapter. If trimester is not a component of a code it is because the condition always occurs in a specific trimester, or the concept of trimester of pregnancy is not applicable. Certain codes have characters for only certain trimesters because the condition does not occur in all trimesters, but it may occur in more than just one.

Selection of Trimester for Extended Inpatient Admissions
In instances when a patient is admitted to a hospital for complications of pregnancy and remains in the hospital for an extended period of time, it is possible for complications to develop during different trimesters. The antepartum complication code should be assigned on the basis of the trimester when the complication developed.

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

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

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

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

When a Delivery Occurs
When a delivery occurs, the principal diagnosis should correspond to the main circumstances or complication of the delivery. In cases of cesarean delivery, the selection of the principal diagnosis should correspond to the reason the cesarean delivery was performed unless the reason for admission/encounter was unrelated to the condition resulting in the cesarean delivery.

Outcome of Delivery
A code from category Z37, Outcome of delivery, should be included on every maternal record when a delivery has occurred. These codes are not to be used on subsequent records or on the newborn record.
Pre-existing Conditions Versus Conditions Due to the Pregnancy
Certain categories in Chapter 15 distinguish between conditions of the mother that existed prior to pregnancy (pre-existing) and those that are a direct result of pregnancy. When assigning codes from Chapter 15, it is important to assess if a condition was pre-existing prior to pregnancy or developed during or due to the pregnancy in order to assign the correct code.

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

Pre-existing Hypertension in Pregnancy
Category O10, Pre-existing hypertension complicating pregnancy, childbirth and the puerperium, includes codes for hypertensive heart and hypertensive chronic kidney disease. When assigning one of the O10 codes that includes hypertensive heart disease or hypertensive chronic kidney disease, it is necessary to add a secondary code from the appropriate hypertension category to specify the type of heart failure or chronic kidney disease. See Section I.C.9. Hypertension.

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

In Utero Surgery
In cases when surgery is performed on the fetus, a diagnosis code from category O35, Maternal care for known or suspected fetal abnormality and damage, should be assigned identifying the fetal condition. Assign the appropriate procedure code for the procedure performed.

No code from Chapter 16, the perinatal codes, should be used on the mother’s record to identify fetal conditions. Surgery performed in utero on a fetus is still to be coded as an obstetric encounter.

HIV Infection in Pregnancy, Childbirth and the Puerperium
During pregnancy, childbirth or the puerperium, a patient admitted because of an HIV-related illness should receive a principal diagnosis from subcategory O98.7-, Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium, followed by the code(s) for the HIV-related illness(es).

Patients with asymptomatic HIV infection status admitted during pregnancy, childbirth, or the puerperium should receive codes of O98.7- and Z21 Asymptomatic human immunodeficiency virus [HIV] infection status.

EXAMPLE:
A patient who is HIV positive is in her second trimester of pregnancy. Her pregnancy is progressing well without complications.

First Listed Diagnosis:  O98.712 Human immunodeficiency [HIV] disease complicating pregnancy, second trimester
Secondary Diagnosis:  Z21 HIV positive NOS
Diabetes Mellitus in Pregnancy
Diabetes mellitus is a significant complicating factor in pregnancy. Pregnant women who are diabetic should be assigned code O24 Diabetes mellitus in pregnancy, childbirth, and the puerperium first, followed by the appropriate diabetes code(s) (E08–E13) from Chapter 4.

EXAMPLE:
A patient with gestational diabetes is seen by the OB/Gyn for her routine visit during her seventh month of pregnancy. The patient is doing well and her gestational diabetes is well controlled with diet.

First listed diagnosis: 024.410 gestational diabetes mellitus in pregnancy, diet-controlled.

Long-Term Use of Insulin
Code Z79.4 Long-term (current) use of insulin should also be assigned if the diabetes mellitus is being treated with insulin.

Gestational (Pregnancy Induced) Diabetes
Gestational (pregnancy induced) diabetes can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy. Gestational diabetes can cause complications in the pregnancy similar to those of pre-existing diabetes mellitus. It also puts the woman at greater risk of developing diabetes after the pregnancy. Codes for gestational diabetes are in subcategory O24.4, Gestational diabetes mellitus. No other code from category O24, Diabetes mellitus in pregnancy, childbirth, and the puerperium, should be used with a code from O24.4.
The codes under subcategory O24.4 include diet controlled and insulin controlled. If a patient with gestational diabetes is treated with both diet and insulin, only the code for insulin-controlled is required.

Code Z79.4 Long-term (current) use of insulin should also be assigned if the gestational diabetes is being treated with insulin. An abnormal glucose tolerance in pregnancy is assigned a code from subcategory O99.81 Abnormal glucose complicating pregnancy, childbirth, and the puerperium.

Sepsis and Septic Shock Complicating Abortion, Pregnancy, Childbirth, and the Puerperium
When assigning a Chapter 15 code for sepsis complicating abortion, pregnancy, childbirth, and the puerperium, a code for the specific type of infection should be assigned as an additional diagnosis. If severe sepsis is present, a code from subcategory R65.2, Severe sepsis, and code(s) for associated organ dysfunction(s) should also be assigned as additional diagnoses.

Alcohol and Tobacco Use During Pregnancy, Childbirth, and the Puerperium
Alcohol use During Pregnancy, Childbirth, and the Puerperium
Codes under subcategory O99.31, Alcohol use complicating pregnancy, childbirth, and the puerperium, should be assigned for any pregnancy case when a mother uses alcohol during the pregnancy or postpartum. A secondary code from category F10, Alcohol related disorders, should also be assigned.

Tobacco use During Pregnancy, Childbirth, and the Puerperium
Codes under subcategory O99.33, Smoking (tobacco) complicating pregnancy, childbirth, and the puerperium, should be assigned for any pregnancy case when a mother uses any type of tobacco.
product during the pregnancy or postpartum. A secondary code from category F17, Nicotine dependence, or code Z72.0 Tobacco use should also be assigned.

Poisoning, Toxic Effects, Adverse Effects, and Underdosing in a Pregnant Patient
A code from subcategory O9A.2-, Injury, poisoning and certain other consequences of external causes complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by the appropriate poisoning, toxic effect, adverse effect or underdosing code, and then the additional code(s) that specifies the condition caused by the poisoning, toxic effect, adverse effect or underdosing.

See Section I.C.19. Adverse effects, poisoning, underdosing, and toxic effects.

Normal Delivery, Code O80

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

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

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

Peripartum and Postpartum Periods
The postpartum period begins immediately after delivery and continues for six weeks following delivery. The peripartum period is defined as the last month of pregnancy to five months postpartum. A postpartum complication is any complication occurring within the six-week period.

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

Admission for Routine Postpartum Care Following Delivery Outside Hospital
When the mother delivers outside the hospital prior to admission and is admitted for routine postpartum care and no complications are noted, code Z39.0 Encounter for care and examination of mother immediately after delivery should be assigned as the principal diagnosis.

Pregnancy Associated Cardiomyopathy
Pregnancy associated cardiomyopathy, code O90.3, is unique in that it may be diagnosed in the third trimester of pregnancy but may continue to progress months after delivery. For this reason, it is referred to as peripartum cardiomyopathy. Code O90.3 is only for use when the cardiomyopathy develops as a result of pregnancy in a woman who did not have pre-existing heart disease.
Sequelae of Complication of Pregnancy, Childbirth, and the Puerperium

Code O94 Sequelae of complication of pregnancy, childbirth, and the puerperium is for use in those cases when an initial complication of a pregnancy develops sequelae requiring care or treatment at a future date. This code may be used at any time after the initial postpartum period. Like all late effect codes, is to be sequenced following the code describing the sequelae of the complication.

Abortions

Abortion with Liveborn Fetus

When an attempted termination of pregnancy results in a liveborn fetus assign a code from subcategory O60.1, Preterm labor with preterm delivery, category Z37, Outcome of Delivery. The procedure code for the attempted termination of pregnancy should also be assigned.

Retained Products of Conception Following an Abortion

Subsequent encounters for retained products of conception following a spontaneous abortion or elective termination of pregnancy are assigned the appropriate code from category O03, Spontaneous abortion, or code Z33.2. Encounter for elective termination of pregnancy. This advice is appropriate even when the patient was discharged previously with a discharge diagnosis of complete abortion.

Chapter 16: Newborn (Perinatal) Guidelines (P00–P96)

For coding and reporting purposes the perinatal period is defined as before birth through the 28th day following birth. The following guidelines are provided for reporting purposes.

General Perinatal Rules

Use of Chapter 16 Code

Codes in this chapter are never for use on the maternal record. Codes from Chapter 15, the obstetric chapter, are never permitted on the newborn record. Chapter 16 code may be used throughout the life of the patient if the condition is still present.

Principal Diagnosis for Birth Record

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

Use of Codes from other Chapters with Codes from Chapter 16

Codes from other chapters may be used with codes from chapter 16 if the codes from the other chapters provide more specific detail. Codes for signs and symptoms may be assigned when a definitive diagnosis has not been established. If the reason for the encounter is a perinatal condition, the code from chapter 16 should be sequenced first.

Use of Chapter 16 Codes after the Perinatal Period

Should a condition originate in the perinatal period, and continue throughout the life of the patient, the perinatal code should continue to be used regardless of the patient’s age.
Birth Process or Community Acquired Conditions

If a newborn has a condition that may be either due to the birth process or community acquired and the documentation does not indicate which it is, the default is due to the birth process and the code from Chapter 16 should be used. If the condition is community-acquired, a code from Chapter 16 should not be assigned.

Code All Clinically Significant Conditions

All clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring; or
- has implications for future health care needs.

Note: The perinatal guidelines listed above are the same as the general coding guidelines for “additional diagnoses,” except for the final point regarding implications for future health care needs. Codes should be assigned for conditions that have been specified by the provider as having implications for future health care needs.

Observation and Evaluation of Newborns for Suspected Conditions Not Found

Assign a code from categories P00-P04 to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present. Do not use a code from categories P00-P04 when the patient has identified signs or symptoms of a suspected problem; in such cases, code the sign or symptom.

EXAMPLE:

A two-day-old baby is suspected to be in withdrawal. The neonate’s mother was an active cocaine user up until delivery.

First listed diagnosis: P04.41 Newborn (suspected to be) affected by maternal use of cocaine

Coding Additional Perinatal Diagnoses

Assigning Codes for Conditions that Require Treatment

Assign codes for conditions that require treatment or further investigation, prolong the length of stay, or require resource utilization.

Codes for Conditions Specified as Having Implications for Future Health Care Needs

Assign codes for conditions that have been specified by the provider as having implications for future health care needs.

Note: This guideline should not be used for adult patients.
Prematurity and Fetal Growth Retardation
Providers utilize different criteria in determining prematurity. A code for prematurity should not be assigned unless it is documented. Assignment of codes in categories P05, Disorders of newborn related to slow fetal growth and fetal malnutrition, and P07, Disorders of newborn related to short gestation and low birth weight, not elsewhere classified, should be based on the recorded birth weight and estimated gestational age. Codes from category P05 should not be assigned with codes from category P07.

When both birth weight and gestational age are available, two codes from category P07 should be assigned, with the code for birth weight sequenced before the code for gestational age.

Low Birth Weight and Immaturity Status
Codes from subcategory Z91.7, Low birth weight and immaturity status, are for use as personal status codes for a child or adult who was premature or had a low birth weight as a newborn and this is affecting the patient’s current health status. See Section I.C.21. Factors influencing health status and contact with health services, Status.

Bacterial Sepsis of Newborn
Category P36, Bacterial sepsis of newborn, includes congenital sepsis. If a perinate is documented as having sepsis without documentation of congenital or community acquired, the default is congenital and a code from category P36 should be assigned. If the P36 code includes the causal organism, an additional code from category B95 Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified elsewhere, or B96, Other bacterial agents as the cause of diseases classified elsewhere, should not be assigned. If the P36 code does not include the causal organism, assign an additional code from category B96. If applicable, use additional codes to identify severe sepsis (R65.2-) and any associated acute organ dysfunction.

Stillbirth
Code P95 Stillbirth is only for use in institutions that maintain separate records for stillbirths. No other code should be used with P95. Code P95 should not be used on the mother’s record.

Chapter 17: Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00–Q99)
Assign an appropriate code(s) from categories Q00–Q99, Congenital malformations, deformations, and chromosomal abnormalities when a malformation/deformation/or chromosomal abnormality is documented. A malformation/deformation/or chromosomal abnormality may be the principal/first listed diagnosis on a record or a secondary diagnosis.

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

When the code assignment specifically identifies the malformation/deformation/or chromosomal abnormality, manifestations that are an inherent component of the anomaly should not be coded separately. Additional codes should be assigned for manifestations that are not an inherent component.

Codes from Chapter 17 may be used throughout the life of the patient. If a congenital malformation or deformity has been corrected, a personal history code should be used to identify the history of the malformation or deformity. Although present at birth, malformation/deformation/or chromosomal abnormality may not be identified until later in life. Whenever the condition is diagnosed by the physician, it is appropriate to assign a code from codes Q00–Q99.
For the birth admission, the appropriate code from category Z38, Liveborn infants, according to place of birth and type of delivery, should be sequenced as the principal diagnosis, followed by any congenital anomaly codes, Q00–Q89.

Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00–R99)

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

Use of Symptom Codes

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

**EXAMPLE:**

A patient visited his family physician with symptoms of nausea and vomiting. The symptoms began two days ago. The patient has no other symptoms. The physician examines the patient and prescribes medication to help with the condition.

First listed diagnosis: R11.0 Nausea with vomiting

Use of a Symptom Code with a Definitive Diagnosis Code

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

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

**EXAMPLE:**

A patient is seen by a cardiologist with chest pain and shortness of breath on exertion. The physician documents a diagnosis of bradycardia.

First listed diagnosis: R00.1 Bradycardia, unspecified

In this example the sign/symptoms are related to the condition and would not require an additional diagnosis.

Combination Codes that Include Symptoms

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

Repeated Falls

Code R29.6 *Repeated falls* is for use for encounters when a patient has recently fallen and the reason for the fall is being investigated. Code Z91.81 *History of falling* is for use when a patient has fallen in the past and is at risk for future falls. When appropriate, both codes R29.6 and Z91.81 may be assigned together.
Glasgow Coma Scale
The Glasgow coma scale codes (R40.2-) can be used in conjunction with traumatic brain injury codes or sequelae of cerebrovascular accident codes. These codes are primarily for use by trauma registries, but they may be used in any setting where this information is collected. The coma scale codes should be sequenced after the diagnosis code.

Three codes, one from each subcategory, are needed to complete the scale. The seventh character indicates when the scale was recorded. The seventh character should match for all three codes.

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

SIRS Due to Non-Infectious Process
The systemic inflammatory response syndrome (SIRS) can develop as a result of certain non-infectious disease processes, such as trauma, malignant neoplasm, or pancreatitis. When SIRS is documented with a noninfectious condition, and no subsequent infection is documented, the code for the underlying condition, such as an injury, should be assigned, followed by code R65.10, Systemic inflammatory response syndrome (SIRS) of non-infectious origin without acute organ dysfunction or code R65.11 Systemic inflammatory response syndrome (SIRS) of non-infectious origin with acute organ dysfunction.

If an associated acute organ dysfunction is documented, the appropriate code(s) for the specific type of organ dysfunction(s) should be assigned in addition to code R65.11. If acute organ dysfunction is documented, but it cannot be determined if the acute organ dysfunction is associated with SIRS or due to another condition (eg, directly due to the trauma), the provider should be queried.

Death NOS
Code R99 Ill-defined and unknown cause of mortality is only for use in the very limited circumstance when a patient who has already died is brought into an emergency department or other health care facility and is pronounced dead upon arrival. It does not represent the discharge disposition of death.

Chapter 19: Injury, poisoning, and certain other consequences of external causes (S00–T88)
Code Extensions
Most categories in chapter 19 have seventh character extensions that are required for each applicable code. Most categories in this chapter have three extensions (with the exception of fractures): A, initial encounter, D, subsequent encounter and S, sequela.

Extension “A,” initial encounter is used while the patient is receiving active treatment for the injury. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.
example:
While playing tennis in a tournament at the Clay Court Country Club, a male player sprained his right wrist and was treated in a hospital emergency department close to the courts.

First Listed Diagnosis: S63.501 Unspecified sprain of right wrist, initial encounter
Secondary Diagnosis: Y93.73 Tennis (external cause, activity)
Tertiary Diagnosis: Y92.312 Tennis court as the place of occurrence as the external cause

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

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

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

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

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

example:
A patient not wearing a seatbelt was involved in an automobile accident, hit the windshield was treated in the emergency room for a laceration to the scalp.

First listed diagnosis: S01.01A Laceration without foreign body of scalp

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

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

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

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

Initial vs. Subsequent Encounter for Fractures

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

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

Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes. Care of complications of fractures, such as malunion and nonunion, should be reported with the appropriate seventh character extensions for subsequent care with nonunion (K, M, N,) or subsequent care with malunion (P, Q, R). A code from category M80, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture. See Section I.C.13. Osteoporosis.

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

EXAMPLE:

A patient underwent surgery for an open burst fracture of the lumbar vertebra which became unstable.

First listed diagnosis:  S32.012B

Note: The seventh character “B” identifies the initial encounter for the open fracture.

Multiple Fractures Sequencing

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

Coding of Burns and Corrosions

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

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

**Sequencing of Burn and Related Condition Codes**

Sequence first the code that reflects the highest degree of burn when more than one burn is present.

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

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

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

**Burns of the Same Local Site**

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

**Non-healing Burns**

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

**Infected Burn**

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

**Assign Separate Codes for Each Burn Site**

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

**Burns and Corrosions Classified According to Extent of Body Surface Involved**

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

Categories T31 and T32 are based on the classic “rule of nines” in estimating body surface involved: head and neck are assigned nine percent, each arm nine percent, each leg 18 percent, the anterior trunk 18 percent, posterior trunk 18 percent, and genitalia one percent. Providers may change these percentage assignments where necessary to accommodate infants and children who have proportionately larger heads than adults, and patients who have large buttocks, thighs, or abdomen that involve burns.
EXAMPLE:
A fireman suffered a third degree burn of the scalp with a 10 percent, total body surface area (TBSA) a second degree burn of the neck and a third degree burn of the right forearm involving four percent TBSA battling a house fire. He was in the house containing the fire when the burns occurred. He was taken to the hospital emergency department for treatment.

First listed diagnosis: T20.35A Burn of third degree of scalp; (any part), initial encounter
Second listed diagnosis: T22.311A Burn of third degree of right forearm, initial encounter
Tertiary diagnosis: T20.27A Burn of second degree of neck, initial encounter
Additional diagnosis T31.11A Burns involving 10–19 percent of body surface with 10–19 percent third degree burns
Additional diagnosis: X00.0xxA Exposure to flames in uncontrolled fire in building or structure, initial encounter
Additional diagnosis: Y92.019 Unspecified place in single family residence (private) house as the place of occurrence as the external cause

Encounters for Treatment of Late Effects of Burns
Encounters for the treatment of the late effects of burns or corrosions (i.e., scars or joint contrac-
tures) should be coded with a burn or corrosion code with the seventh character “S” or sequela.

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

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

Adverse Effects, Poisoning, Underdosing and Toxic Effects
Codes in categories T36–T65 are combination codes that include the substances related to adverse effects, poisonings, toxic effects and underdosing, as well as the external cause. No additional external cause code is required for poisonings, toxic effects, adverse effects and underdosing codes. A code from categories T36–T65 is sequenced first, followed by the code(s) that specify the nature of the adverse effect, poisoning, or toxic effect.

Do Not Code Directly from the Table of Drugs
Do not code directly from the Table of Drugs and Chemicals. Always refer back to the Tabular List.
Use as Many Codes as Necessary to Describe
Use as many codes as necessary to describe completely all drugs, medicinal or biological substances. If the same code would describe the causative agent for more than one adverse reaction, poisoning, toxic effect or underdosing, assign the code only once.

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

The Occurrence of Drug Toxicity is Classified in ICD-10-CM as Follows:

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

EXAMPLE:
A patient took an overdose of penicillin that was prescribed correctly resulting in projectile vomiting.

First listed diagnosis: T36.0x5A Adverse effect of penicillins, initial encounter
Second listed diagnosis: R11.12 Projectile vomiting

Poisoning
When coding a poisoning or reaction to the improper use of a medication (eg, overdose, wrong substance given or taken in error, wrong route of administration), assign the appropriate code from categories T36–T50. Poisoning codes have an associated intent: accidental, intentional self-harm, assault and undetermined. Use additional code(s) for all manifestations of poisonings.

If there is also a diagnosis of drug abuse or dependence to the substance, the abuse or dependence is coded as an additional code.

Examples of poisoning include:

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

2. Overdose of a drug intentionally taken if an overdose of a drug was intentionally taken or administered and resulted in drug toxicity, it would be coded as a poisoning.

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

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

Note: See Section I.C.4. if poisoning is the result of insulin pump malfunctions.
EXAMPLE:
A patient was prescribed penicillin by her physician for an infection. The patient decided instead of taking the drug as prescribed (500 mg twice per day) she would take 1000 mg twice per day so it would work faster and she would feel better sooner. The patient became very ill after taking 2000 mg the first day which resulted in projectile vomiting.

First listed diagnosis: T36.0x1A Poisoning by penicillins accidental (unintentional), initial encounter
Second listed diagnosis: R11.12 Projectile vomiting

Underdosing
Underdosing refers to taking less of a medication than is prescribed by a physician or a manufacturer’s instruction. For underdosing, assign the code from categories T36-T50. Codes for underdosing should never be assigned as the principal or first-listed diagnosis. If a patient has an exacerbation of the medical condition for which the drug is prescribed because of reduction in dose, then the medical condition itself should be coded.

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

Toxic Effects
When a harmful substance is ingested or comes in contact with a person, this is classified as a toxic effect. The toxic effect codes are in categories T51-T65.

Toxic effect codes have an associated intent: accidental, intentional self-harm, assault, and undetermined.

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

If the documentation in the medical record states abuse or neglect it is coded as confirmed. It is coded as suspected if it is documented as suspected.

For cases of confirmed abuse or neglect an external cause code from the assault section (X92-Y08) should be added to identify the cause of any physical injuries. A perpetrator code (Y07) should be added when the perpetrator of the abuse is known. For suspected cases of abuse or neglect, do not report external cause or perpetrator code.

If a suspected case of abuse, neglect or mistreatment is ruled out during an encounter code Z04.71 Suspected adult physical and sexual abuse, ruled out or code Z04.72 Suspected child physical and sexual abuse, ruled out should be used, not a code from T76.
EXAMPLE:
A six-year-old child spilled her milk at the kitchen table during breakfast and her father poured a hot cup of coffee on her right hand as punishment causing a 2nd degree burn on the child’s hand, which needed treatment. The patient was taken to the emergency room of the local hospital by her mother and social services were contacted by a concerned physician.

First listed diagnosis: T23.201A  Burn of second degree of right hand, unspecified site, initial encounter
Second listed diagnosis: Y08.89A  Assault by other specified means, initial encounter
Tertiary diagnosis: Y92.010  Kitchen of single-family (private) house as the place of occurrence as the external cause
Additional diagnosis: Y07.11  Biological father as perpetrator of maltreatment and neglect

Complications of care

Documentation of Complications of Care
As with all procedural or postprocedural complications, code assignment is based on the provider’s documentation of the relationship between the condition and the procedure.

Pain Due to Medical Devices
Pain associated with devices, implants or grafts left in a surgical site (for example painful hip prosthesis) is assigned to the appropriate code(s) found in Chapter 19, Injury, poisoning, and certain other consequences of external causes. Specific codes for pain due to medical devices are found in the T code section of the ICD-10-CM. Use additional code(s) from category G89 to identify acute or chronic pain due to presence of the device, implant or graft (G89.18 or G89.28).

Transplant Complications Other than Kidney
Codes under category T86, Complications of transplanted organs and tissues, are for use for both complications and rejection of transplanted organs. A transplant complication code is only assigned if the complication affects the function of the transplanted organ. Two codes are required to fully describe a transplant complication, the appropriate code from category T86 and a secondary code that identifies the complication.

Pre-existing conditions or conditions that develop after the transplant are not coded as complications unless they affect the function of the transplanted organs.

Chronic Kidney Disease and Kidney Transplant Complications
Patients who have undergone kidney transplant may still have some form of chronic kidney disease (CKD) because the kidney transplant may not fully restore kidney function. Code T86.1- should be assigned for documented complications of a kidney transplant, such as transplant failure or rejection or other transplant complication. Code T86.1- should not be assigned for post kidney transplant patients who have chronic kidney (CKD) unless a transplant complication such as transplant failure or rejection is documented. If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.
For patients with CKD following a kidney transplant, but who do not have a complication such as failure or rejection, see section I.C.14. Chronic kidney disease and kidney transplant status.

**Complication Codes that Include the External Cause**

As with certain other T codes, some of the complications of care codes have the external cause included in the code. The code includes the nature of the complication as well as the type of procedure that caused the complication. No external cause code indicating the type of procedure is necessary for these codes.

**Complications of Care Codes within the Body System Chapters**

Intraoperative and postprocedural complication codes are found within the body system chapters with codes specific to the organs and structures of that body system. These codes should be sequenced first, followed by a code(s) for the specific complication, if applicable.

**Chapter 20: External Causes of Morbidity (V01–Y99)**

Introduction: These guidelines are provided for the reporting of external causes of morbidity codes in order that there will be standardization in the process. These codes are secondary codes for use in any health care setting. External cause codes are not required for reporting to some third-party payers.

External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred and the activity of the patient at the time of the event.

**General External Cause Coding Guidelines**

**Used with Any Code in the Range of A00.0–T88.9, Z00–Z99**

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

**External Cause Code Used for Length of Treatment**

Assign the external cause code, with the appropriate seventh character (initial encounter, subsequent encounter or sequela) for each encounter for which the injury or condition is being treated.

**Use the Full Range of External Cause Codes**

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

**Assign as Many External Cause Codes as Necessary**

Assign as many external cause codes as necessary to fully explain each cause. If only one external code can be recorded, assign the code most related to the principal diagnosis.
The Selection of the Appropriate External Cause Code
The selection of the appropriate external cause code is guided by the Index to External Causes, which is located after the Alphabetical Index to diseases and by Inclusion and Exclusion notes in the Tabular List.

External Cause Code Can Never Be a Principal Diagnosis
An external cause code can never be a principal (first listed) diagnosis.

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

No External Cause Code Needed in Certain Circumstances
No external cause code from Chapter 20 is needed if the external cause and intent are included in a code from another chapter (eg, T36.0x1- Poisoning by penicillins, accidental (unintentional)).

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

A place of occurrence code is used only once, at the initial encounter for treatment. No seventh characters are used for Y92. Only one code from Y92 should be recorded on a medical record. A place of occurrence code should be used in conjunction with an activity code, Y93. Use place of occurrence code Y92.9 if the place is not stated or is not applicable.

EXAMPLE:
While alpine skiing in Colorado, the patient fell and suffered a stress fracture of the right femur.

First listed diagnosis M84.351A Stress fracture, right femur, initial encounter
Second listed diagnosis: V00.32 Snow-ski accident
Tertiary diagnosis Y92.39A Other specified sports and athletic area as the place of occurrence of the external cause
Additional diagnosis: Y93.23 Other individual sport (Activity)

Activity Code
Codes from category Y93, Activity code, are secondary codes for use with other external cause codes to identify the activity of the patient at the time of the injury.

An activity code is used only once, at the initial encounter for treatment. Only one code from Y93 should be recorded on a medical record. An activity code should be used in conjunction with a place of occurrence code, Y92.

If a patient is a student but is injured while performing an activity for income, use seventh character “2,” work related activity. A work related activity is any activity for which payment or income is received. Use activity code Y93.9 if the activity of the patient is not stated or is not applicable.
EXAMPLE:
A seven-year-old female who went swimming at local public pool was attempting to dive into the pool, but tripped on the concrete and fell into the water hitting her head on the wall of the pool resulting into a contusion of the head. The child’s mother took the child to the emergency room for care.

- First listed diagnosis: S00.93 Contusion of unspecified part of head
- Second listed diagnosis: W16.032 Fall into swimming pool striking wall causing other injury (external cause)
- Tertiary diagnosis: Y92.34 Swimming pool (public) as the place of occurrence as the external cause
- Additional diagnosis Y93.01 Swimming (activity)

Note: The seventh character “1” is used for non-work related activity

Place of Occurrence and Activity Code Used with Other External Cause Code
When applicable, a place of occurrence and an activity code are sequenced after the main external cause code(s). Regardless of the number of external cause codes assigned there should be only one place of occurrence code and one activity code assigned to an encounter.

If the Reporting Format Limits the Number of External Cause Codes
If the reporting format limits the number of external cause codes that can be used in reporting clinical data, code the one most related to the principal diagnosis.

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

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

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

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

For confirmed cases of abuse, neglect and maltreatment, when the perpetrator is known, a code from Y07, Perpetrator of maltreatment and neglect, should accompany any other assault codes. See Section I.C.19. Adult and child abuse, neglect and other maltreatment
Unknown or Undetermined Intent Guideline
If the intent (accident, self-harm, assault) of the cause of an injury or other condition is unknown or unspecified, code the intent as accidental intent. All transport accident categories assume accidental intent.

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

Late Effects of External Cause Guidelines
Late effects are reported using the external cause code with the seventh character extension “S” for sequela. These codes should be used with any report of a late effect or sequela resulting from a previous injury.

Late Effect External Cause Code with a Related Current Injury
A late effect external cause code should never be used with a related current nature of injury code.

Use of Late Effect External Cause Codes for Subsequent Visits
Use a late effect external cause code for subsequent visits when a late effect of the initial injury is being treated. Do not use a late effect external cause code for subsequent visits for follow-up care (eg, to assess healing, to receive rehabilitative therapy) of the injury or poisoning when no late effect of the injury has been documented.

Terrorism Guidelines

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

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

Code Y38.9, Terrorism, Secondary Effects
Assign code Y38.9 Terrorism, secondary effects for conditions occurring subsequent to the terrorist event. This code should not be assigned for conditions that are due to the initial terrorist act. It is acceptable to assign code Y38.9 with another code from Y38 if there is an injury due to the initial terrorist event and an injury that is a subsequent result of the terrorist event.

External Cause Status
A code from category Y99 should be assigned whenever any other external cause code is assigned for an encounter including an Activity code. Assign a code from category Y99 (external cause status) to indicate the work status of the person at the time the even occurred.
Do not assign a code from category Y99 for:
- Poisonings
- Adverse effects
- Misadventures
- Late effects

Do not assign code Y99.9 (unspecified external cause status) if the status is not stated in the medical record.

Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00–Z99)

Note: The chapter specific guidelines provide additional information about the use of Z codes for specified encounters.

Use of Z Codes in Any Health Care Setting

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

Z Codes Indicate a Reason for an Encounter

Z codes are not procedure codes. A corresponding procedure code must accompany a Z code to describe the procedure performed.

Categories of Z Codes

Contact/Exposure

Category Z20 indicates contact with, or exposure to, communicable diseases. These codes are for patients who do not show any sign or symptom of a disease but have been exposed to it by close personal contact with an infected individual or are in an area where a disease is epidemic. These codes may be used as a first listed code to explain an encounter for testing, or, more commonly, as a secondary code to identify a potential risk.

Inoculations and Vaccinations

Code Z23 is for encounters for inoculations and vaccinations. It indicates that a patient is being seen to receive a prophylactic inoculation against a disease. Procedure codes are required to identify the actual administration of the injection and the type(s) of immunizations given. Code Z23 may be used as a secondary code if the inoculation is given as a routine part of preventive health care, such as a well-baby visit.

EXAMPLE:

A six-month-old child came for her routine check up. The patient is a very active healthy child. During the encounter the physician determined the patient needed the suggested vaccinations.

First listed diagnosis: Z00.12 Encounter for routine child health examination without abnormal findings

Second listed diagnosis: Z23 Encounter for immunizations
Status
Status codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition.

A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code. For example, code Z94.1 Heart transplant status should not be used with a code from subcategory T86.2, Complications of heart transplant. The status code does not provide additional information. The complication code indicates that the patient is a heart transplant patient.

For encounters for weaning from a mechanical ventilator, assign code J96.1 Chronic respiratory failure followed by code Z99.11 Dependence on respirator [ventilator] status.

The status Z codes/categories are:

- **Z14** Genetic carrier—Genetic carrier status indicates that a person carries a gene, associated with a particular disease, which may be passed to offspring who may develop that disease. The person does not have the disease and is not at risk of developing the disease.
- **Z15** Genetic susceptibility to disease—Genetic susceptibility indicates that a person has a gene that increases the risk of that person developing the disease.

Codes from category Z15 should not be used as principal or first-listed codes. If the patient has the condition to which he/she is susceptible, and that condition is the reason for the encounter, the code for the current condition should be sequenced first. If the patient is being seen for follow-up after completed treatment for this condition, and the condition no longer exists, a follow-up code should be sequenced first, followed by the appropriate personal history and genetic susceptibility codes.

If the purpose of the encounter is genetic counseling associated with procreative management, code Z31.5 Encounter for genetic counseling should be assigned as the first-listed code, followed by a code from category Z15. Additional codes should be assigned for any applicable family or personal history.

- **Z16** Infection with drug-resistant microorganisms—This code indicates that a patient has an infection that is resistant to drug treatment. Sequence the infection code first.
- **Z17** Estrogen receptor status
- **Z21** Asymptomatic HIV infection status—This code indicates that a patient has tested positive for HIV but has manifested no signs or symptoms of the disease.
- **Z22** Carrier of infectious disease—Carrier status indicates that a person harbors the specific organisms of a disease without manifest symptoms and is capable of transmitting the infection.
- **Z28.3** Underimmunization
- **Z33.1** Pregnant state, incidental—This code is a secondary code only for use when the pregnancy is in no way complicating the reason for visit. Otherwise, a code from the obstetric chapter is required.
- **Z66** Do not resuscitate
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- **Z67** Blood type
- **Z68** Body mass index (BMI)
- **Z74.01** Bed confinement status
- **Z76.82** Awaiting organ transplant status
- **Z78.-** Other specified health status

#### EXAMPLE:

A healthy 33-year-old male patient was examined by his family physician during a routine preventive exam. The patient has no specific problems but is HIV positive without any other symptoms.

First listed diagnosis: **Z00.00** Encounter for general adult medical examination without abnormal findings

Second listed diagnosis: **Z21** Asymptomatic human immunodeficiency virus [HIV] infection status

Codes from this category indicate a patient’s continuous use of a prescribed drug (including such things as aspirin therapy) for the long-term treatment of a condition or for prophylactic use. It is not for use for patients who have addictions to drugs. This subcategory is not for use of medications for detoxification or maintenance programs to prevent withdrawal symptoms in patients with drug dependence (e.g., methadone maintenance for opiate dependence). Assign the appropriate code for the drug dependence instead.

- **Z79.-** Long-term (current) drug therapy

Assign a code from Z79 if the patient is receiving a medication for an extended period as a prophylactic measure (such as for the prevention of deep vein thrombosis) or as treatment of a chronic condition (such as arthritis) or a disease requiring a lengthy course of treatment (such as cancer).

Do not assign a code from category Z79 for medication being administered for a brief period of time to treat an acute illness or injury (such as a course of antibiotics to treat acute bronchitis).

#### EXAMPLE:

A patient who has Type 2 diabetes mellitus is seen by his endocrinologist in follow-up. The patient is doing well with diet and has been on insulin for five months. The physician decided to keep the patient on insulin for a couple more months to make sure his blood sugar remains stable.

First listed diagnosis: **E11.9** Type 2 diabetes without complications

Second listed diagnosis: **Z79.4** Long term use of insulin

Categories Z89–Z90 and Z93–Z99 are for use only if there are no complications or malfunctions of the organ or tissue replaced, the amputation site or the equipment on which the patient is dependent.

- **Z88** Allergy status to drugs, medicaments and biological substances
- **Except**: **Z88.9**, Allergy status to unspecified drugs, medicaments and biological substances status
- **Z89** Acquired absence of limb
- **Z90** Acquired absence of organs, not elsewhere classified
- Z91.0- Allergy status, other than to drugs and biological substances
- Z91.7- Low birth weight and immaturity status
- Z91.82 Status post administration of tPA(rtPA) in a different facility within the last 24 hours prior to admission to a current facility
- Z93 Artificial opening status
- Z94 Transplanted organ and tissue status
- Z95 Presence of cardiac and vascular implants and grafts
- Z96 Presence of other functional implants
- Z97 Presence of other devices
- Z98 Other postprocedural states
- Z98.85 Transplanted organ removal status
- Z99 Dependence on enabling machines and devices, not elsewhere classified

**History of**

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

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

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

The history Z code categories are:

- Z80 Family history of primary malignant neoplasm
- Z81 Family history of mental and behavioral disorders
- Z82 Family history of certain disabilities and chronic diseases (leading to disablement)
- Z83 Family history of other specific disorders
- Z84 Family history of other conditions
- Z85 Personal history of primary and secondary malignant neoplasm
- Z86 Personal history of certain other diseases
- Z87 Personal history of other diseases and conditions
- Z91.4- Personal history of psychological trauma, not elsewhere classified
- Z91.5 Personal history of self-harm
- Z91.6- Personal history of other physical trauma
- Z91.8- Other specified personal risk factors, not elsewhere classified
- Z92 Personal history of medical treatment
- Except: Z92.0, Personal history of contraception
- Z92.82 Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility
**Example:**

A patient with a history of breast cancer who is currently using Tamoxifen as a preventive measure visits her oncologist one year after a mastectomy of her left breast due to a malignant tumor which was primary. She is doing well with no sign of recurrence. The physician decided to continue the Tamoxifen therapy and will see her back in follow-up in six months.

**First listed diagnosis:** Z85.3 Personal history of primary malignant neoplasm of the breast

**Note:** The malignant neoplasm would not be coded since there is no active treatment currently for cancer. A history code is reported even if the patient is using medication for prevention of recurrence.

**Screening**

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

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

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

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

The screening Z codes/categories:

- **Z11** Encounter for screening for infectious and parasitic diseases
- **Z12** Encounter for screening for malignant neoplasms
- **Z13** Encounter for screening for other diseases and disorders
- **Except:** Z13.9 Encounter for screening, unspecified
- **Z36** Encounter for antenatal screening for mother

**Example:**

A patient with a family history of ovarian cancer undergoes her annual pap and pelvic examination along with routine blood work which came back negative.

**First listed diagnosis:** Z12.73 Screening for malignant neoplasm of ovary

**Observation**

There are two observation Z code categories. They are for use in very limited circumstances when a person is being observed for a suspected condition that is ruled out. The observation codes are not
for use if an injury or illness or any signs or symptoms related to the suspected condition are present. In such cases the diagnosis/symptom code is used with the corresponding external cause code.

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

The observation Z code categories:

- Z03 Encounter for medical observation for suspected diseases and conditions ruled out
- Z04 Encounter for examination and observation for other reasons (Except: Z04.9, Encounter for examination and observation for unspecified reason)

**EXAMPLE:**

A ten-year-old female was transported by ambulance to the emergency department following a car accident. The mother was driving on icy roads and the minivan she was driving flipped on its top. After examination, without any significant injuries identified, the physician decided to observe the child for a few hours before releasing the child from the emergency room.

First listed diagnosis: Z04.1 Encounter for examination and observation following transport accident

**Aftercare**

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

The aftercare Z codes should also not be used for aftercare for injuries. For aftercare of an injury, assign the acute injury code with the seventh character “D” (subsequent encounter). Exceptions to this rule are codes Z51.0 Encounter for antineoplastic radiation therapy and codes from subcategory Z51.1 Encounter for antineoplastic chemotherapy and immunotherapy. These codes are to be first listed, followed by the diagnosis code when a patient’s encounter is solely to receive radiation therapy or chemotherapy for the treatment of a neoplasm. If the reason for the encounter is more than one type of antineoplastic therapy, code Z51.0 and a code from subcategory Z51.1 may be assigned together, in which case one of these codes would be reported as a secondary diagnosis.

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

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

Certain aftercare Z code categories need a secondary diagnosis code to describe the resolving condition or sequelae, for others, the condition is inherent in the code title.
Additional Z code aftercare category terms include fitting and adjustment, and attention to artificial openings.

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

The aftercare Z category/codes:

- Z42 Encounter for plastic and reconstructive surgery following medical procedure or healed injury
- Z43 Encounter for attention to artificial openings
- Z44 Encounter for fitting and adjustment of external prosthetic device
- Z45 Encounter for adjustment and management of implanted device
- Z46 Encounter for fitting and adjustment of other devices
- Z47 Orthopedic aftercare
- Z48 Encounter for other postprocedural aftercare
- Z49 Encounter for care involving renal dialysis
- Z51 Encounter for other aftercare

**Follow-up**

The follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists. They should not be confused with aftercare codes, or injury codes with seventh character “D,” that explain ongoing care of a healing condition or its sequelae. Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first, followed by the history code. A follow-up code may be used to explain repeated visits. Should a condition be found to have recurred on the follow-up visit, then the code for the condition should be assigned as an additional diagnosis.

The follow-up Z code categories:

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

**EXAMPLE:**

A 25-year-old female who six weeks ago delivered a healthy seven pound baby girl is seen by her OB physician in routine follow-up. The patient is doing fine and is released from care and will begin seeing her family physician for any further treatment.

First listed diagnosis: Z39.2 Encounter for routine postpartum follow-up
**Donor**
Codes in category Z52, Donors of organs and tissues, are used for living individuals who are donating blood or other body tissue. These codes are only for individuals donating for others, not for self donations. They are not for use to identify cadaveric donations.

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

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

**EXAMPLE:**
A patient who is in her third trimester of pregnancy visits a pediatrician to discuss the upcoming delivery and care of her child after delivery.

First listed diagnosis: Z76.81 Expectant mother prebirth pediatrician visit

**Encounters for Obstetrical and Reproductive Services**
See Section I.C.15. Pregnancy, Childbirth, and the Puerperium, for further instruction on the use of these codes.

Z codes for pregnancy are for use in those circumstances when none of the problems or complications included in the codes from the Obstetrics chapter exist (a routine prenatal visit or postpartum care). Codes in category Z34, Encounter for supervision of normal pregnancy, are always first listed and are not to be used with any other code from the OB chapter.

The outcome of delivery, category Z37, should be included on all maternal delivery records. It is always a secondary code. Codes in category Z37 should not be used on the newborn record.

Z codes for family planning (contraceptive) or procreative management and counseling should be included on an obstetric record either during the pregnancy or the postpartum stage, if applicable.

Z codes/categories for obstetrical and reproductive services:
- Z30 Encounter for contraceptive management
- Z31 Encounter for procreative management
- Z32.2 Encounter for childbirth instruction
Z32.3  Encounter for childcare instruction
Z33  Pregnant state
Z34  Encounter for supervision of normal pregnancy
Z36  Encounter for antenatal screening of mother
Z37  Outcome of delivery
Z39  Encounter for maternal postpartum care and examination
Z76.81  Expectant mother prebirth pediatrician visit

**EXAMPLE:**
A patient delivered a set of healthy twins in the hospital via cesarean. Mother and babies are doing fine and will be released in two days.

First listed diagnosis:  Z37.2  Twins, both liveborn
Second listed diagnosis:  Z38.31  Twins, liveborn infant, delivered by cesarean born in hospital

### Newborns and Infants

See Section I.C.16. Newborn (Perinatal) Guidelines, for further instruction on the use of these codes.

Newborn Z codes/categories:

- Z76.1  Encounter for health supervision and care of foundling
- Z00.1-  Encounter for routine child health examination
- Z38  Liveborn infants according to place of birth and type of delivery

**EXAMPLE:**
A three-year-old male visited his pediatrician with complaints of ear pain with a temperature during his routine annual examination. The patient is otherwise has no complaints. Mom states the patient has been complaining of ear pain for two days and his temperature comes and goes. The physician completed the preventive examination, decided to defer his vaccinations until his acute otitis media externa of both ears resolves. The patient was prescribed a prescription and was asked to return in five days.

First listed diagnosis:  H60.93 Unspecified otitis externa, bilateral
Second listed diagnosis:  Z00.11  Encounter for routine child health examination with abnormal findings

### Routine and Administrative Examinations

The Z codes allow for the description of encounters for routine examinations, such as a general check-up or examinations for administrative purposes such as a pre-employment physical. The codes are not to be used if the examination is for diagnosis of a suspected condition or for treatment purposes. In such cases the diagnosis code is used. During a routine exam, should a diagnosis or condition be discovered, it should be coded as an additional code. Pre-existing and chronic conditions and history codes may also be included as additional codes as long as the examination is for administrative purposes and not focused on any particular condition.
Some of the codes for routine health examinations distinguish between “with” and “without” abnormal findings. Code assignment depends on the information that is known at the time the encounter is being coded. For example, if no abnormal findings were found during the examination, but the encounter is being coded before test results are back, it is acceptable to assign the code for “without abnormal findings.” When assigning a code for “with abnormal findings,” additional code(s) should be assigned to identify the specific abnormal finding(s).

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

The Z codes/categories for routine and administrative examinations:

- **Z00** Encounter for general examination without complaint, suspected or reported diagnosis
- **Z01** Encounter for other special examination without complaint, suspected or reported diagnosis
- **Z02** Encounter for administrative examination (Except: Z02.9, Encounter for administrative examinations, unspecified)
- **Z32.0-** Encounter for pregnancy test

**EXAMPLE:**

A 35-year-old healthy female went to her internist for an annual physical exam. The patient had no complaints. The physician counseled the patient on diet and exercise and diagnosed the patient as a healthy female with no significant findings.

First listed diagnosis: Z00.00 Encounter for general adult medical examination without abnormal findings

**Miscellaneous Z codes**

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

**Prophylactic Organ Removal**

For encounters specifically for prophylactic removal of an organ (such as prophylactic removal of breasts due to a genetic susceptibility to cancer or a family history of cancer), the principal or first listed code should be a code from category Z40, Encounter for prophylactic surgery, followed by the appropriate codes to identify the associated risk factor (such as genetic susceptibility or family history).

If the patient has a malignancy of one site and is having prophylactic removal at another site to prevent either a new primary malignancy or metastatic disease, a code for the malignancy should also be assigned in addition to a code from subcategory Z40.0, Encounter for prophylactic surgery for risk factors related to malignant neoplasms. A Z40.0 code should not be assigned if the patient is having organ removal for treatment of a malignancy, such as the removal of the testes for the treatment of prostate cancer.
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Miscellaneous Z codes/categories:

- **Z28**  Immunization not carried out
- **Z28.3**  Underimmunization status
- **Z40**  Encounter for prophylactic surgery
- **Z41**  Encounter for procedures for purposes other than remedying health state
  (Except: Z41.9, Encounter for procedure for purposes other than remedying health state, unspecified)
- **Z53**  Persons encountering health services for specific procedures and treatment, not carried out
- **Z55**  Problems related to education and literacy
- **Z56**  Problems related to employment and unemployment
- **Z57**  Occupational exposure to risk factors
- **Z58**  Problems related to physical environment
- **Z59**  Problems related to housing and economic circumstances
- **Z60**  Problems related to social environment
- **Z61**  Problems related to negative life events in childhood
  (Except: Z61.81-, Personal history of abuse in childhood)
- **Z62**  Other problems related to upbringing
- **Z63**  Other problems related to primary support group, including family circumstances
- **Z64**  Problems related to certain psychosocial circumstances
- **Z65**  Problems related to other psychosocial circumstances
- **Z72**  Problems related to lifestyle
- **Z73**  Problems related to life management difficulty
- **Z74**  Problems related to care provider dependency
  (Except: Z74.01, Bed confinement status)
- **Z75**  Problems related to medical facilities and other health care
- **Z76.0**  Encounter for issue of repeat prescription
- **Z76.3**  Healthy person accompanying sick person
- **Z76.4**  Other boarder to health care facility
- **Z76.5**  Malingerer [conscious simulation]
- **Z76.89**  Persons encountering health services in other specified circumstances
- **Z91.1-**  Patient’s noncompliance with medical treatment and regimen
- **Z91.89**  Other specified personal risk factors, not elsewhere classified
EXAMPLE:
A patient who has been diagnosed recently with mixed bipolar disorder which is moderate is counseled by his psychiatrist for non compliance. He takes his medication occasionally and is not compliant with his treatment plan.

First listed diagnosis: F31.62  Bipolar disorder, current episode mixed, moderate
Tertiary diagnosis: Z91.12  Patient's intentional underdosing of medication regimen

There is also a note under Z91.1 to reported a code from T36-T50 with the final character 6 (Table of Drugs and Chemicals). Since in this example we do not know what drug the patient is taking, the physician would need to be queried.

Nonspecific Z Codes
Certain Z codes are so non-specific, or potentially redundant with other codes in the classification, that there can be little justification for their use in the inpatient setting. Their use in the outpatient setting should be limited to those instances when there is no further documentation to permit more precise coding. Otherwise, any sign or symptom or any other reason for visit that is captured in another code should be used.

Nonspecific Z codes/categories:
- Z02.9  Encounter for administrative examinations, unspecified
- Z04.9  Encounter for examination and observation for unspecified reason
- Z13.9  Encounter for screening, unspecified
- Z41.9  Encounter for procedure for purposes other than remedying health state, unspecified
- Z52.9  Donor of unspecified organ or tissue
- Z88.9  Allergy status to unspecified drugs, medicaments and biological substances status
- Z92.0  Personal history of contraception

Z Codes that May Only be Principal/First-Listed Diagnosis
The following Z codes/categories may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined:
- Z00  Encounter for general examination without complaint, suspected or reported diagnosis
- Z01  Encounter for other special examination without complaint, suspected or reported diagnosis
- Z02  Encounter for administrative examination
- Z03  Encounter for medical observation for suspected diseases and conditions ruled out
- Z33.2  Encounter for elective termination of pregnancy
- Z31.81  Encounter for male factor infertility in female patient
Section II. Selection of Principal Diagnosis

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

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

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

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

(See Section I.A., Conventions for the ICD-10-CM)

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

A. Codes for Symptoms, Signs, and Ill-Defined Conditions

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

B. Two or More Interrelated Conditions, Each Potentially Meeting the Definition for Principal Diagnosis.

When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.
C. Two or More Diagnoses that Equally Meet the Definition for Principal Diagnosis
In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

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

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

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

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

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

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

I. Admission from Observation Unit

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

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

When a patient receives surgery in the hospital’s outpatient surgery department and is subsequently admitted for continuing inpatient care at the same hospital, the following guidelines should be followed in selecting the principal diagnosis for the inpatient admission:

- If the reason for the inpatient admission is a complication, assign the complication as the principal diagnosis.
- If no complication, or other condition, is documented as the reason for the inpatient admission, assign the reason for the outpatient surgery as the principal diagnosis.
- If the reason for the inpatient admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis.

Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

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

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

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

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

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

A. Previous Conditions

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

However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
B. Abnormal Findings
Abnormal findings (laboratory, X-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

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

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

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

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services
These coding guidelines for outpatient diagnoses have been approved for use by hospitals/providers in coding and reporting hospital-based outpatient services and provider-based office visits.

Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-10-CM Tabular List (code numbers and titles), can be found in Section IA of these guidelines, under "Conventions Used in the Tabular List." Information about the correct sequence to use in finding a code is also described in Section I.

The terms encounter and visit are often used interchangeably in describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other.

Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that:

The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis applies only to inpatients in acute, short-term, long-term care and psychiatric hospitals.

Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

A. Selection of First-listed Condition
In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis. In determining the first-listed diagnosis the coding conventions of ICD-10-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines.

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

The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.
**Outpatient Surgery**
When a patient presents for outpatient surgery (same day surgery), code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.

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

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

**B. Codes from A00.0 through T88.9, Z00-Z99**
The appropriate code(s) from A00.0 through T88.9, Z00-Z99 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

**C. Accurate Reporting of ICD-10-CM Diagnosis Codes**
For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient’s condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-10-CM codes to describe all of these.

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

**E. Encounters for Circumstances Other than a Disease or Injury**
ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services codes (Z00-99) is provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems. See Section I.C.21. Factors influencing health status and contact with health services.

**F. Level of Detail in Coding**

**ICD-10-CM Codes with 3, 4, or 5 Digits**
ICD-10-CM is composed of codes with either 3, 4, 5, 6 or 7 digits. Codes with three digits are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth fifth digits, sixth or seventh digits which provide greater specificity.

**Use of full Number of Digits Required for a Code**
A three-digit code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the seventh character extension, if applicable.
G. ICD-10-CM Code for the Diagnosis, Condition, Problem, or Other Reason for Encounter/visit
List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

H. Uncertain Diagnosis
Do not code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

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

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

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

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

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

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

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

L. Patients Receiving Therapeutic Services Only
For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.
The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy or radiation therapy, the appropriate Z code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

M. Patients Receiving Preoperative Evaluations Only
For patients receiving preoperative evaluations only, sequence first a code from subcategory Z01.81, Encounter for pre-procedural examinations, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.

N. Ambulatory Surgery
For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

O. Routine Outpatient Prenatal Visits
See Section I.C.15. Routine outpatient prenatal visits.

P. Encounters for General Medical Examinations with Abnormal Findings
The subcategories for encounters for general medical examinations, Z00.0-, provide codes for with and without abnormal findings. Should a general medical examination result in an abnormal finding, the code for general medical examination with abnormal finding should be assigned as the first listed diagnosis. A secondary code for the abnormal finding should also be coded.

Q. Encounters for Routine Health Screenings
See Section I.C.21. Factors influencing health status and contact with health services, Screening.

Note: Some vacant, three-character categories in ICD-10-CM to allow for revisions/future expansion.

References
1. Physician ICD-10-CM 2010, Ingenix
3. AHA Coding Clinic, American Hospital Association, multiple editions referenced.
6. American Hospital Association; NCVHS Committee recommendation for I-10; www.ahacentraloffice.org/ahacentraloffice/html/icd10resources.html
7. ICD-10-CM Volume 1 and 2, Ingenix 2010