ICD-10-CM Official Coding Guidelines 2013 & 2014

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Resources

ICD-10-CM Guidelines posted at NCHS website

- 2014 Official Guidelines for Coding and Reporting http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf
- 2013 Official Guidelines for Coding and Reporting http://www.cdc.gov/nchs/data/icd/10cmguidelines_2013_final.pdf

ICD-10-CM and GEMS posted at CMS website:

- https://www.cms.gov/Medicare/Coding/ICD10/2014-ICD-10-CM-and-GEMs.html
- https://www.cms.gov/Medicare/Coding/ICD10/2013-ICD-10-CM-and-GEMs.html

AAPC ICD-9 to ICD-10 Reference Sheet

- http://static.aapc.com/ppdf/ICD9-ICD10-reference-sheet1.pdf

ICD-10-CM Official Guidelines for Coding and Reporting

- Section I. Conventions, general coding guidelines and chapter specific guidelines
- Section II. Selection of Principal Diagnosis
- Section III. Reporting Additional Diagnoses
- Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services
- Appendix I. Present on Admission Reporting Guidelines

Guideline Changes

- Narrative changes appear in **bold** text
- Items underlined have been moved within the guidelines since the 2012 version
- *Italics* are used to indicate revisions to heading changes

ICD-10-CM Conventions
Section I.A.13

- Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes)
  - There are manifestation codes that do not have "in diseases classified elsewhere" in the title. For such codes, **there is a "use additional code" note at the etiology code and a "code first" note at the manifestation code and the rules for sequencing apply**.

ICD-10-CM Conventions Section I.A.14

- "**And**"
  - The word "and" should be interpreted to mean either "and" or "or" when it appears in a title.
  - **For example, cases of "tuberculosis of bones", "tuberculosis of joints" and "tuberculosis of bones and joints" are classified to subcategory A18.0, Tuberculosis of bones and joints**.

General Coding Guidelines
Section I.B.13

Laterality

- **Some ICD-10-CM codes** indicate laterality, **specifying whether the condition occurs on the left, right or is bilateral**. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. **If the side is not identified in the medical record, assign the code for the unspecified side.**

Laterality Example

- A patient has bilateral carpal tunnel syndrome.
- The codes for carpal tunnel syndrome do not include a bilateral code.
- To report the bilateral condition, codes G56.01 *Carpal tunnel, right upper limb code G56.02 Carpal tunnel, left upper limb*, would need to be assigned.

Source: AAPC ICD-10 Tips & Resources, ICD-10 Guidelines

General Coding Guidelines
Section I.B.14

Documentation for BMI, Non-pressure ulcers and Pressure Ulcer Stages

- For the Body Mass Index (BMI), **depth of non-pressure chronic ulcers** and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider…

General Coding Guidelines
Section I.B.15

Syndromes

- Follow the Alphabetic Index guidance when coding syndromes. In the absence of Alphabetic Index guidance, assign codes for the documented manifestations of the syndrome. **Additional codes for manifestations that are not an integral part of the disease process may also be assigned when the condition does not have a unique code.**

General Coding Guidelines Section I.B.17.

Borderline Diagnosis

- **If the provider documents a "borderline" diagnosis at the time of discharge, the diagnosis is coded as confirmed, unless the classification provides a specific entry (e.g., borderline diabetes). If a borderline condition has a specific index entry in ICD-10-CM, it should be coded as such. Since borderline conditions are not uncertain diagnoses, no distinction is made between the care setting (inpatient versus outpatient). Whenever the documentation is unclear regarding a borderline condition, coders are encouraged to query for clarification.**

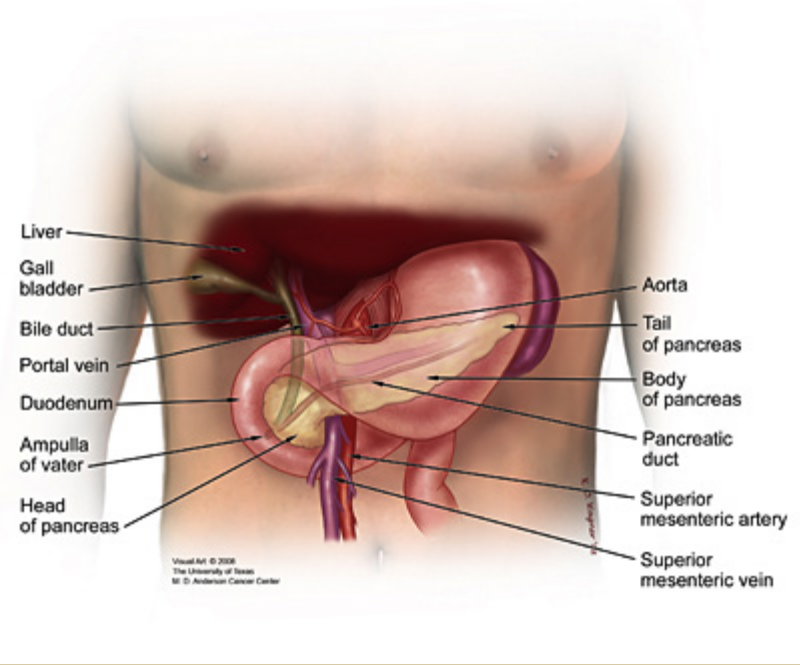
Borderline Diagnosis Example

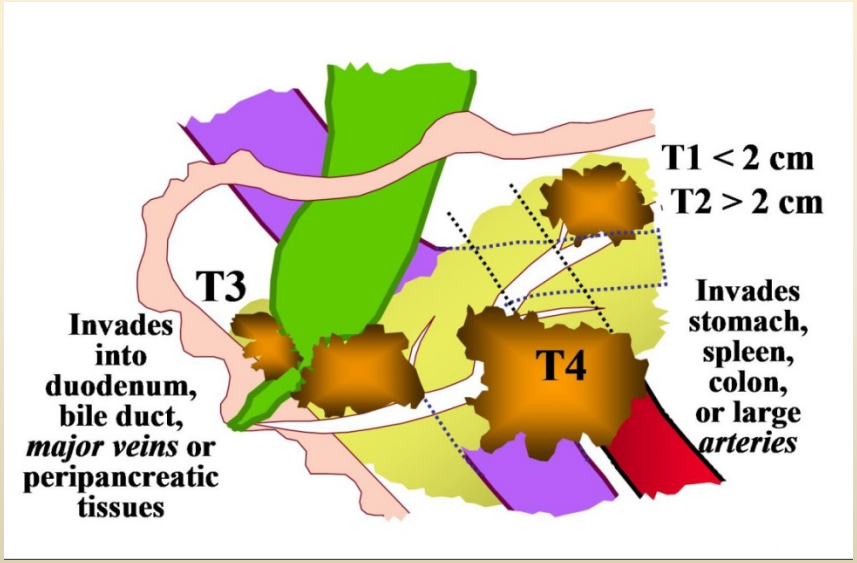
Borderline

diabetes mellitus	R73.09
hypertension	R03.0
osteopenia	M85.8-
pelvis, with obstruction	O65.1
during labor	
personality	F60.3

Chapter 2: Neoplasms (C00-D49) General Guidelines

- Malignant neoplasms of ectopic tissue are to be coded to the site **of origin** mentioned, e.g., ectopic pancreatic malignant neoplasms **involving the stomach** are coded to pancreas, unspecified (C25.9).





Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00-E89)
Section I.C.4.

Secondary diabetes mellitus

- Codes under categories E08, Diabetes mellitus due to underlying condition, E09, Drug or chemical induced diabetes mellitus, **and E13, Other specified diabetes mellitus**, identify complications/manifestations associated with secondary diabetes mellitus. Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning).

Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00-E89)

Section I.C.4.

Assigning and sequencing secondary diabetes codes and its causes

- The sequencing of the secondary diabetes codes in relationship to codes for the cause of the diabetes is based on the Tabular List instructions for categories E08, E09 **and E13**.

Chapter 9: Diseases of the Circulatory System (I00-I99), Section I.C.9.

Category I69, Sequelae of Cerebrovascular disease

- **Codes from category I69, Sequelae of cerebrovascular disease, that specify hemiplegia, hemiparesis and monoplegia identify whether the dominant or nondominant side is affected. Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:**
  - **For ambidextrous patients, the default should be dominant.**
  - **If the left side is affected, the default is non-dominant.**
  - **If the right side is affected, the default is dominant.**

Chapter 9: Diseases of the Circulatory System (I00-I99), Section I.C.9.

- **Codes from category I69 *and Personal history of transient ischemic attack (TIA) and cerebral infarction (Z86.73)***

  Codes from category I69 should not be assigned if the patient does not have neurologic deficits.

Chapter 10: Diseases of the Respiratory System (J00-J99), Section I.C.10.

Influenza due to certain identified influenza viruses

- Code only confirmed cases of influenza due to certain identified influenza viruses (category J09), **and due to other identified influenza virus (category J10).** This is an exception to the hospital inpatient guideline Section II, H. (Uncertain Diagnosis).

Chapter 10: Diseases of the Respiratory System (J00-J99)

- In this context, “confirmation” does not require documentation of positive laboratory testing specific for avian or other novel influenza A **or other identified influenza virus**. However, coding should be based on the provider’s diagnostic statement that the patient has avian influenza, or other novel influenza A, **for category J09, or has another particular identified strain of influenza, such as H1N1 or H3N2, but not identified as novel or variant, for category J10**.

Chapter 10: Diseases of the Respiratory System (J00-J99)

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

Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00-O9A)
Section I.C.15.

- **Abortion with Liveborn Fetus**
  - When an attempted termination of pregnancy results in a liveborn fetus, assign code **Z33.2. Encounter for elective termination of pregnancy** and a code from category Z37, Outcome of Delivery.

Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00-O9A)
Section I.C.15.

Complications leading to abortion

- **Codes from Chapter 15 may be used as additional codes to identify any documented complications of the pregnancy in conjunction with codes in categories in O07 and O08.**

Categories & Codes Exempt from Diagnosis Present on Admission Requirement

- **V00-V09 Pedestrian injured in transport accident**
  - **Except V00.81-, Accident with wheelchair (powered)**
    V00.83-, Accident with motorized mobility scooter
- **V10-V19 Pedal cycle rider injured in transport accident**
- **V20-V29 Motorcycle rider injured in transport accident**
- **V30-V39 Occupant of three-wheeled motor vehicle 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**
- **V98-V99 Other and unspecified transport accidents**

Categories & Codes
Exempt from Diagnosis POA Requirement

- **W14 Fall from tree**
- **W56 Contact with nonvenomous marine animal**
- **W58 Contact with crocodile or alligator**
- **W61 Contact with birds (domestic) (wild)**
- **W62 Contact with nonvenomous amphibians**

- **X71 Intentional self-harm by drowning and submersion**
  - **Except X71.0-, Intentional self-harm by drowning and submersion while in bath tub**
- **X72 Intentional self-harm by handgun discharge**
- **X73 Intentional self-harm by rifle, shotgun and larger firearm discharge**

Categories & Codes
Exempt from Diagnosis POA Requirement

- **X74 Intentional self-harm by other and unspecified firearm and gun discharge**
- **X75 Intentional self-harm by explosive material**
- **X76 Intentional self-harm by smoke, fire and flames**
- **X77 Intentional self-harm by steam, hot vapors and hot objects**
- **X81 Intentional self-harm by jumping or lying in front of moving object**
- **X82 Intentional self-harm by crashing of motor vehicle**
- **X83 Intentional self-harm by other specified means**

ICD-10-CM Coding Guidelines
2014

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Conventions for the ICD-10-CM Section I.A.7 **Punctuation**

( ) Parentheses are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers.

The nonessential modifiers in the Alphabetic Index to Diseases apply to subterms following a main term except when a nonessential modifier and a subentry are mutually exclusive, the subentry takes precedence. For example, in the ICD-10-CM Alphabetic Index under the main term Enteritis, "acute" is a nonessential modifier and "chronic" is a subentry. In this case, the nonessential modifier "acute" does not apply to the subentry "chronic".

General Coding Guidelines
Section I.B.18

Use of Sign/Symptom/Unspecified Codes

- **Sign/symptom and "unspecified" codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter**.

Use of Sign/Symptom/Unspecified Codes(continued)

- **If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflects what is known about the patient's condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.**

Chapter 20: External Causes of Morbidity (V00-Y99)

- **The external causes of morbidity codes should never be sequenced as the first-listed or principal diagnosis.**
- **There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20 is not required. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.**

Chapter 21: Factors Influencing health status and contact with health services (Z00-Z99)

- **Categories of Z codes**
- Encounters for Obstetrical and Reproductive Services
  - Codes in category Z3A, Weeks of gestation, may be assigned to provide additional information about the pregnancy. **The date of the admission should be used to determine weeks of gestation for inpatient admissions that encompass more than one gestational week.**

Section II. Selection of Principal Diagnosis

K. Admissions/Encounters for Rehabilitation

- **When the purpose for the admission/encounter is rehabilitation, sequence first the code for the condition for which the service is being performed. For example, for an admission/encounter for rehabilitation for right-sided dominant hemiplegia following a cerebrovascular infarction, report code I69.351, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, as the first-listed or principal diagnosis.**

K. Admissions/Encounters for Rehabilitation *continued*

- **If the condition for which the rehabilitation service is no longer present, report the appropriate aftercare code as the first-listed or principal diagnosis.**
- **For example, if a patient with severe degenerative osteoarthritis of the hip, underwent hip replacement and the current encounter/admission is for rehabilitation, report code Z47.1, Aftercare following joint replacement surgery, as the first-listed or principal diagnosis.**

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

- 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.” Section I. B. contains general guidelines that apply to the entire classification. **Section I.C. contains chapter-specific guidelines that correspond to the chapters as they are arranged in the classification**. Information about the correct sequence to use in finding a code is also described in Section I.

Categories & Codes Exempt from Diagnosis Present on Admission Requirement Appendix I

- **Y03 Assault by crashing of motor vehicle**
- **Y07 Perpetrator of assault, maltreatment and neglect**
- **Y08.8 Assault by strike by sports equipment**
- **Y32 Assault by crashing of motor vehicle, undetermined intent**

Present on Admission Exempt List

- 2014 Present on Admission Exempt List
- https://www.cms.gov/Medicare/Coding/ICD10/2014-ICD-10-CM-and-GEMs.html

Questions?

Please post in the Chat Box

Thank you!