

## Objectives

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- Learn structure, organization & unique features of ICD-10-CM
- Understand basic coding guidelines
- Demonstrate ability to look up and code basic diagnosis
- Understand how coding guidelines to all types of care
- Relate coding guidelines to all types of care
- Know basic disease classification and how to use resource books
- Be able to determine primary diagnosis

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## Agenda

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## ICD-9 vs ICD-10

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- Introduction
- Objectives
- ICD-9 vs ICD-10
- Official Coding Guidelines
- Terms & Conventions
- Chapters of ICD-10-CM
- Q & A

- ICD-10 offers:
  - Increased precision with diagnoses
  - Full diagnostic titles for each code
  - More flexibility in incorporating advances in medicine & technology
  - Uses more current & up to date med terms
  - Laterality Added (left and right, both)
  - Room for expansion

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## Examples of Structure

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- S52 – Fx of Forearm
- S52.5 – Fx lower end of radius
- S52.52 – Torus Fx of lower end of radius
- S52.521 – Torus Fx of lower end of R radius
- S52.521D – Torus Fx of lower end of R radius, subsequent care

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## Official Coding Guidelines

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- Set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM coding manual itself

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**Conventions & General Guidelines**

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## Conventions

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- General rules for use of the classification independent of the guidelines
- Incorporated within the Alphabetic Index and Tabular List as instructional notes

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- In order for code to be correct we must ensure that every digit possible is recorded
  - For reimbursement
  - For statistical reporting
  - For clinical accuracy

- [] Brackets
  - Used in Alphabetic Index to identify manifestation codes
  - Used in Tabular List to enclose
    - Synonyms
    - Alternative wording
    - Explanatory phrases

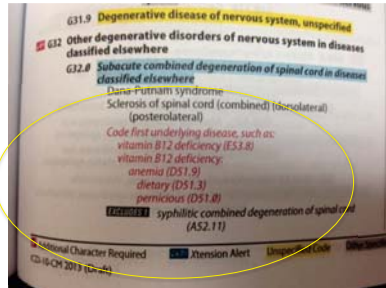
- "X" is used as a placeholder in certain codes to allow for future expansion
  - Example: T49.8X5D Adverse affect to a cosmetic
- Some categories have applicable 7<sup>th</sup> characters, use the "X" placeholder to ensure the 7<sup>th</sup> character is in the right place
  - Example: T75.4XXD Electrocutation

- () Parentheses
  - Used in both volumes 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
  - Referred to as nonessential modifiers
  - Example:
    - Hypertension, hypertensive (accelerated) (benign) (essential) (idiopathic) (malignant) (systemic)

## Punctuation

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- : Colons
  - Colons in the tabular list highlight an incomplete term



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## Other & Unspecified Codes

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- Other or Other Specified
  - Use when information in the medical record provides detail for which a specific code does not exist
- Unspecified
  - Use when the information in the medical record is insufficient to assign a more specific code

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## Abbreviations

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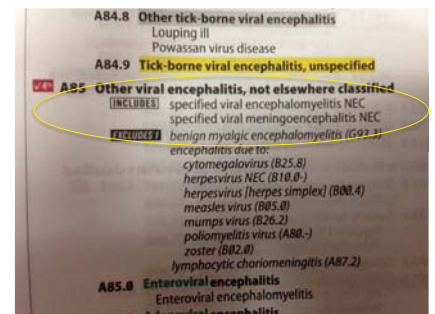
- NEC – Not elsewhere classifiable
  - Represents “other specified”
  - Used when a specific code is not available for a condition
- NOS – Not otherwise specified
  - Equivalent of unspecified

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## Includes Notes

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- A note that appears immediately under a three character code title to further define or give examples of the content of the category

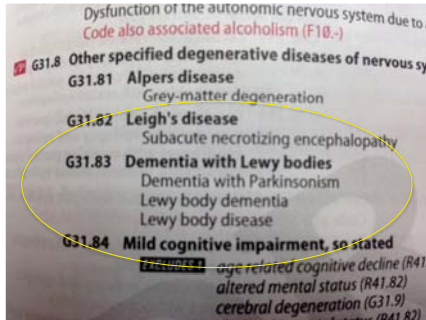


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## Inclusion Terms

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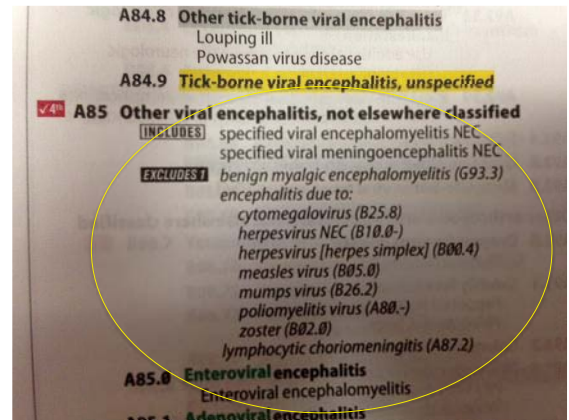
- List of terms included under some codes
- Conditions for which the code is to be used



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## Excludes 1 Notes

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## Excludes Notes

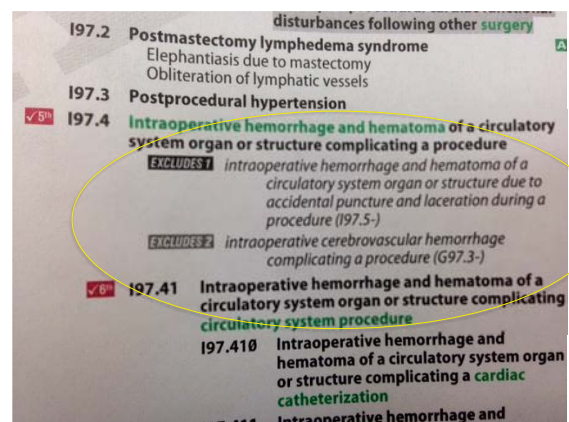
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- Excludes 1
  - Pure excludes note
  - **NOT CODED HERE!**
  - Indicates that the code excluded should never be used at the same time as the code above the note
- Excludes 2
  - Not included here
  - Indicates that the condition excluded is not a part of the condition represented by the code but a patient may have both conditions at the same time
  - Acceptable to use both the code and the excluded code together when appropriate

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## Excludes 2 Notes

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## “And”

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- Should be interpreted to mean either “and” or “or”
- **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

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## “See” and “See Also”

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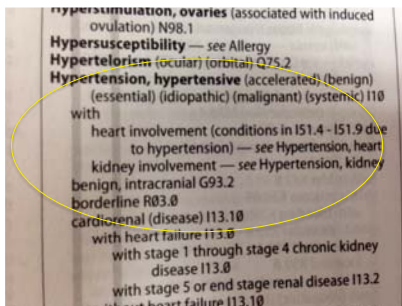
- See
  - Indicates another term should be referenced
  - Necessary to go to the main term referenced with the “see” note to locate the correct code
- See Also
  - Instructs that there is another main term that may also be referenced that may provide additional Alphabetic Index entries that may be useful

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## “With”

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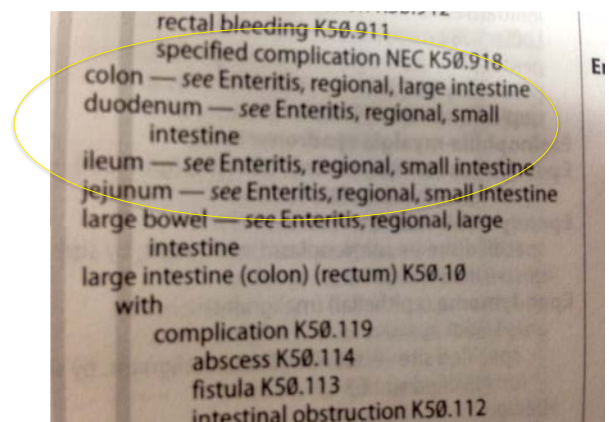
- Interpreted to mean “associated with” or “due to”
- Sequenced in Alphabetic Index right after main term



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## “See” and “See Also”

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## Signs & Symptoms

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- Are acceptable for reporting purposes when a related definitive diagnosis has not been established (or confirmed) by the provider
- Signs and symptoms that are an integral part of the disease process should *not* be assigned as additional codes unless otherwise instructed by the classification

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## Combination Code

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- A single code used to classify:
  - Two diagnoses **OR**
  - A diagnosis with an associated secondary process (manifestation)
  - A diagnosis with an associated complication
- Identified by referring to sub-term entries in the Alpha Index and by reading the inclusion and exclusion notes in the Tabular List
- Multiple coding should not be used when there is a combination code that clearly identifies all of the elements documented by the diagnosis

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## “Code Also” Note

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- Instructs that two codes may be required to fully describe a condition
- Note does not provide sequencing direction



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## Acute and Chronic Conditions

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

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## Sequela (Late Effects)

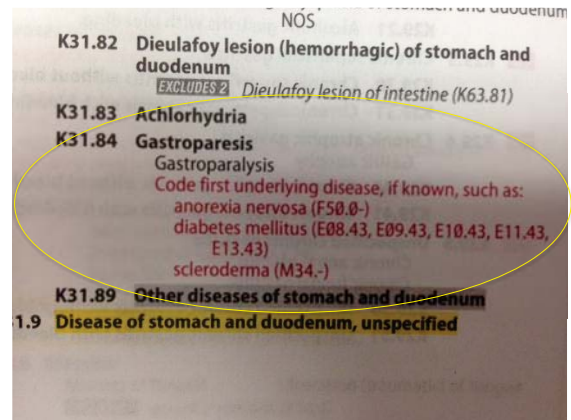
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- A residual effect after the acute phase of an illness or injury
- No time limit on when it can be used
- May require two codes
  - Chemical burn of cornea
  - Poisoning by cleaning chemical

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## Code First

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## Etiology/Manifestation

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- Code First
- Use additional code
- In diseases classified elsewhere
- Underlying condition first then manifestation
- Example:
  - Diabetes is underlying condition
  - Neuropathy is manifestation

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## Reporting Code More Than Once

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- Each unique ICD-10-CM diagnosis code may be reported only once for an encounter
- Applies to bilateral conditions when there are no distinct codes identifying laterality
- Applies when two different conditions are classified to the same code

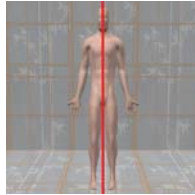
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## Laterality

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- If no bilateral code is provided and the condition is bilateral, assign separate codes for both left and right sides
- If side is not identified in medical record, assign the code for the unspecified side



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## Main Term

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- A term that must be used to locate a possible code in the tabular index
- Bold
- Left justified
- It's how you find the code!
- Represent conditions, diseases, nouns, adjectives, but not usually anatomical sites

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## BMI and Pressure Ulcer

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- BMI, depth of non-pressure chronic ulcers and pressure ulcer stage codes
  - Clinician can assign
  - Associated diagnosis (overweight, obesity, pressure ulcer) must be documented by patient's provider

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## Subterms

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- Indented from Main term
- Describe differences in condition, anatomical site, cause, clinical type

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1. Always locate the main term first in the Alphabetic Index
2. Then verify the code in the Tabular List
3. Read and be guided by the instructional notations that appear in both the Alphabetic Index and the Tabular List
4. Alpha Index does not always provide the full code
  - Laterality and 7<sup>th</sup> characters can only be assigned from the Tabular List
  - A dash at the end of an Alphabetic Index code may indicate additional characters are required

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- Includes diseases generally recognized as communicable or transmissible
- Use additional code to identify resistance to antimicrobial drugs (Z16.-)
  - Unless infection code specifically identifies drug resistance
- Pay close attention to Chapter 1 Guidelines and category notes for HIV and sepsis coding

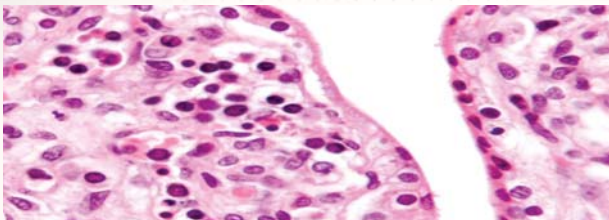
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## CHAPTER 1



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### Certain Infectious and Parasitic Diseases (A00-B99)



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## Sequela – Infections/Parasitic

- Codes B90-B94
  - used to indicate conditions in categories A00-B89 as the cause of sequela, which are themselves classified elsewhere
  - include residuals of diseases classifiable to the above categories if the disease itself is no longer present
  - Code first the condition (or “sequela”) resulting from the infectious or parasitic disease

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## 1.1 Sequela Case Study

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A patient is seen for right lower leg muscle atrophy that is the result of a previous bout of polio. What is the correct diagnosis code?

- M62.561 Atrophy, muscle, lower leg
- B91 Late effect(s) – See Sequelae, Sequelae (of), poliomyelitis (acute)

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## Sepsis

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- Requires one code from category A41 if no documentation of severe sepsis or an associated organ dysfunction
- Assign appropriate code for underlying systemic infection
- If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified organism.

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## Bacterial/Viral B95-B97

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- Supplementary or additional codes to identify the infectious agent(s) in diseases classified elsewhere



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## Severe Sepsis

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- Requires a minimum of two codes:
  - first a code for the underlying systemic infection,
  - followed by a code from subcategory R65.2, Severe sepsis.
  - Additional code(s) for the associated organ dysfunction are also required (i.e., respiratory failure)

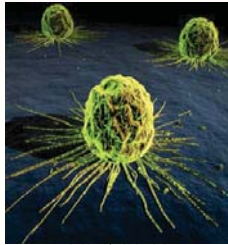
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## Neoplasms C00-D49



- Contains codes for most benign and all malignant neoplasms
  - First step is to determine from medical record if neoplasm is benign, in-situ, malignant or of uncertain histologic behavior
  - If malignant, any secondary (metastatic) sites should be determined
  - The Neoplasm Table in the Alphabetic Index should be referenced first
- **Example: Adenoma**

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## Neoplasm Table

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- Neoplasms grouped by behavior and then subgroups by site
- Neoplasm table found in the index
  - Identifies the behavior (columns) and site (rows)
- Important terms
  - Neoplasm
  - Tumor
  - Dysplasia
  - Mass
- A primary malignant neoplasm overlapping two or more contiguous (next to each other) sites should be classified to the subcategory/code .8 (overlapping lesion), unless the combination is specifically indexed elsewhere
- Multiple noncontiguous neoplasms of the same site, such as tumors in different quadrants of the same breast, codes for each site should be assigned

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- Z85-, Personal history of malignant neoplasm
  - History with no further treatment directed to the site and no evidence of existing primary malignancy
  - Any mention of extension, invasion or met to another site is coded as a secondary malignant neoplasm to that site

## Chapter 3



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**Diseases of the Blood  
and Blood-Forming Organs  
and Certain Disorders Involving the  
Immune Mechanism  
(D50-D89)**

## 2.1 Neoplasm Case Study

Small cell carcinoma of right lower lobe of lung with metastasis to the intrathoracic lymph nodes, brain and right rib

- C34.31 lung, malignant, primary, lower lobe
- C77.1 lymph gland, malignant, intrathoracic, secondary site
- C79.31 brain, malignant, secondary site
- C79.51 bone, malignant, rib, secondary site

- Same basic coding rules
- No specific Coding Guidelines at this time

## Congenital red cell aplastic anemia

- D61.01 Anemia (essential) (general) (hemoglobin deficiency) (infantile) (primary) (profound), aplastic, red cell (pure), congenital

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- Combination codes that include:
  - Type of DM
  - Body system affected
  - Complications affecting that body system
- Not classified as controlled or uncontrolled
  - Code by type with hyperglycemia



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## Endocrine, Nutritional and Metabolic Diseases (E00-E89)



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- Use as many codes as necessary to describe all complications
- If type of DM is not documented in the medical record, the default is E11.- Type 2 diabetes mellitus
- If the record does not indicate the type of DM, but does indicate the use of insulin, code also Z79.4 Long-term (current) use of insulin

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## 4.1 Diabetes Case Study

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62-year-old male with mild nonproliferative diabetic retinopathy with macular edema. He has type 2 DM and takes insulin on a daily basis. He also has a diabetic cataract in his right eye. What is the correct code assignment?

- combo code for Diabetic retinopathy with macular edema
- E11.321 Diabetes, diabetic (mellitus) (sugar), type 2, with, retinopathy, nonproliferative, mild, with macular edema
- E11.36 Diabetes, diabetic (mellitus) (sugar), type 2, with, cataract
- Z79.4 Long-term (current) (prophylactic) drug therapy (use of), insulin

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## Chapter 5



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## Mental and Behavioral Disorders (F01-F99)



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## Secondary Diabetes

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- DM due to underlying condition, drug or chemical induced or other specified
- Always caused by another condition or event
- Z79.4 should only be assigned for patients who routinely use insulin – not if only given to temporarily control blood sugar
- E09, Drug or chemical induced DM – use additional code from Drug and Chemical Table to identify drug causing adverse effect

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## In Remission

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- History of drug or alcohol dependence is coded "in remission"
- The appropriate codes for "in remission" are assigned only on the basis of provider documentation

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When the provider documentation refers to use, abuse and dependence of the same substance (e.g. alcohol, opioid, cannabis, etc.) only one code should be assigned to identify the pattern of use based on the following hierarchy:

1. Dependence
2. Abuse
3. Use



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## Diseases of the Nervous System (G00-G99)



A 52-year-old with dementia and forgetfulness has been wandering from home and getting lost. The diagnosis is dementia due to early-onset of Alzheimer’s disease.

G30.0 Alzheimer’s Disease, early onset with behaviors

F02.81 Dementia, in Alzheimer’s

Z91.83 Wandering in diseases classified elsewhere

- If affected side is documented but not specified as dominant or nondominant:
  - For ambidextrous patients, the default should be dominant
  - If the left side is affected the default is nondominant
  - If the right side is affected the default is dominant



- May be used with codes from other categories and chapters to provide more detail about pain
- Must be documented as:
  - Acute or chronic
  - Post thoracotomy, postprocedural or neoplasm-related
- Do not use if underlying diagnosis is known
- Chronic pain must be documented by the provider
- Central pain syndrome and chronic pain syndrome are different than the term “chronic pain”
  - Only used when specifically documented by provider

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- The following terms are considered to be equivalent to intractable
  - Pharmacoresistant (or pharmacologically resistant)
  - Treatment resistant
  - Refractory (medically)
  - Poorly controlled

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- Provider documentation guides coding
- Routine or expected postop pain should not be coded
- Postop pain associated with a specific complication is coded in Chapter 19 with an additional G89 code for acute or chronic

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- Left-sided hemiplegia
  - G81.94 Hemiplegia
- Seizure disorder
  - G40.909 Epilepsy, unspecified, not intractable, without status epilepticus
    - Includes Recurrent Seizures and Seizure Disorder NOS
    - (Seizure = R56.9 Unspecified convulsions)
- Parkinson’s Disease
  - G20

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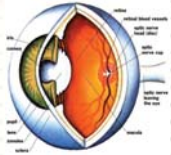


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## Diseases of the Eye and Adnexa (H00-H59)



### Coding Exercise 7.1

A patient with moderate primary open-angle glaucoma of the left eye.

What is the correct diagnosis code?

- H40.11X2 Glaucoma, open angle, primary.

### Glaucoma Guidelines

- Assign as many codes from category H40, Glaucoma, as needed to identify the type of glaucoma, the affected eye and the glaucoma stage
- Check for a bilateral code when both eyes are documented as same type and stage
- Code glaucoma to the highest stage documented

### CHAPTER 8

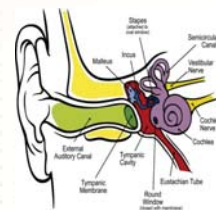


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## DISEASES OF THE EAR AND MASTOID PROCESS (H60-H95)



## Chapter Specific Note:

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- Use an external cause code, if applicable, following the code for the ear condition
  - Exposure to environmental tobacco smoke (Z77.22)
  - Exposure to tobacco smoke in the perinatal period (P96.81)
  - History of tobacco use (Z87.891)
  - Occupational exposure to environmental tobacco smoke (Z57.31)
  - Tobacco dependence (F17.-)
  - Tobacco use (Z72.0)

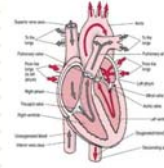
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## CHAPTER 9



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## DISEASES OF THE CIRCULATORY SYSTEM (I00-I99)



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## Ear Case Studies 8.2-8.4

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- Bilateral conductive hearing loss
  - H90.0
- Meniere's vertigo of left ear
  - H81.02
- Benign paroxysmal vertigo
  - H81.10

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## Hypertension with Heart Disease

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- You may not assume a causal relationship between hypertension and heart disease
- The documentation must state:
  - Hypertensive
  - Due to Hypertension

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## Hypertensive CKD

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- Assign codes from category I12, Hypertensive CKD when both hypertension and a condition classifiable to category N18, chronic kidney disease, are present
- You **may** assume a causal relationship between these two conditions
- Also code from category N18 to identify the stage of CKD

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## Combination Codes...

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- Hypertension and heart disease?
  - No – do not assume a causal relationship
- Hypertensive heart disease?
  - Yes – relationship must be stated to use the I11 code
- Chronic kidney disease and hypertension
  - Yes – you may assume a causal relationship- code to I12
- Chronic kidney disease and hypertensive heart disease
  - Yes – assume the relationship between the CKD and HTN – code to I13

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## HTN and Chronic Kidney Disease

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- Assume a causal relationship between the hypertension and the CKD whether or not the condition is so designated
- Assign additional codes for the stage of CKD and heart failure, if present

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## Transient HTN

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- Comes and goes, not permanent “white coat syndrome” just an elevated BP
- Transient HTN
  - Assign code R03.0, Elevated blood pressure reading without diagnosis of hypertension (unless pt. has established HTN diagnosis)

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## 9.1 HTN Case Study

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Stage 3 chronic kidney disease with congestive heart failure due to hypertension

- I13.0 Hypertension w/heart failure, with Stage 1-4 CKD
- I50.9 CHF
- N18.3 CKD Stage 3

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## Acute Myocardial Infarction

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- Code category I21 for initial MI less than or equal to 4 weeks old
- Code category I22 for subsequent MI
  - Use when a patient who has suffered an AMI has a new AMI within the 4 week time frame of the initial AMI
  - Must be used in conjunction with a code from category I21-never alone

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## CAD and ANGINA

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- Combo codes
- Additional code is not necessary to capture angina pectoris
- Causal relationship is assumed when patient has both atherosclerosis and angina unless documentation indicates otherwise

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## Acute Myocardial Infarction

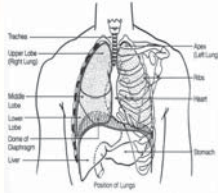
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- I21.3, ST elevation (STEMI) myocardial infarction of unspecified site is default for “unspecified MI”
- If an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as a subendocardial AMI
- Old or healed MI not requiring further care is I25.2

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## DISEASES OF THE RESPIRATORY SYSTEM (J00-J99)



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## Acute Exacerbation

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- COPD and Asthma
  - acute exacerbation
    - Worsening or decompensation of a chronic condition
    - Not equivalent to an infection superimposed on a chronic condition
    - May be triggered by an infection

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## Chapter Notes

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- Respiratory condition described as occurring in more than one site that is not specifically indexed, classify to the lower anatomic site (e.g. tracheobronchitis to bronchitis in J40)
- Additional codes required for some categories:
  - To identify infectious agent or virus
  - Associated lung abscess
  - Underlying disease
  - Tobacco use or exposure

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## Influenza

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- Code only confirmed cases due to certain identified viruses (J09 and J10)
- Suspected, possible or probable should be coded to J11, Influenza due to unidentified influenza virus

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## Ventilator Associated Pneumonia

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- Only code based on provider documentation
- Additional code required to identify organism
- Do not use an additional code from categories J12-J18 to identify type of pneumonia
  - UNLESS: Patient was admitted to hospital with one type of pneumonia and subsequently developed VAP (which would become a secondary diagnosis)

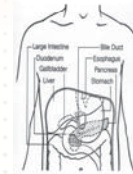
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## CHAPTER 11



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## DISEASES OF THE DIGESTIVE SYSTEM (K00-K95)



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## 10.1 COPD Case Study

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COPD with emphysema

J43.9 Emphysema (remember that emphysema IS COPD) read the notes in the book – more specific – COPD is a generic code

\*Pay attention to includes and excludes notes

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## 11.1 Hernia Case Study

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Patient with recurrent right inguinal hernia with gangrene and obstruction

K40.41 Hernia, inguinal, with gangrene (and obstruction) recurrent

- Category note:
  - Hernia with both gangrene and obstruction is classified to hernia with gangrene

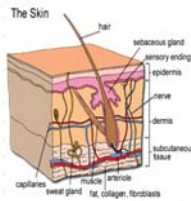
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## CHAPTER 12



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### Diseases of the Skin and Subcutaneous Tissue (L00-L95)



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## 12.1 Pressure Ulcer Case Study

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Patient with gangrenous pressure ulcer of right hip with cellulitis and pressure ulcer of sacrum documented by physician. Nursing assessment indicated stage 2 sacral ulcer and stage 3 decubitus ulcer of right hip

- I96 – Ulcer, gangrenous, gangrene
- L89.213 – Ulcer, pressure, Stage 3, hip
- L89.152 – Ulcer, Stage 2, sacral
- L03.115 – Cellulitis, lower limb

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## Pressure Ulcer Stage Codes

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- Combination codes that identify site and stage
- Severity designated by stages 1-4, unstageable and unspecified based on clinical documentation
- Any associated gangrene should be sequenced first
- Unspecified vs. unstageable
- No code is assigned for healed pressure ulcer

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## CHAPTER 13



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ICD-10 IQ

### Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)



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## Musculoskeletal System

Insight | Expertise | Knowledge

## Aftercare

Insight | Expertise | Knowledge

- Most codes have site and laterality designations
- Site represents bone, joint or muscle involved
- “Multiple sites” codes

- Aftercare for broken bones will now be coded to *fracture* with 7<sup>th</sup> character *D*
- Pathological and stress fractures are found in this chapter

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## Seventh Characters

Insight | Expertise | Knowledge

## Osteoporosis

Insight | Expertise | Knowledge

- A – initial encounter
- D – subsequent encounter
- G – subsequent encounter – delayed healing
- K – subsequent encounter – nonunion
- P – subsequent encounter – malunion
- S – sequela

- Use category M81, Osteoporosis without pathologic fx, for patients with osteoporosis who do not current have a pathologic fracture due to osteoporosis.
  - patients with a history of osteoporosis fractures, status code Z87.310, Personal history of (healed) osteoporosis fracture, should follow code M81

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## Pathological Fracture

Insight | Expertise | Knowledge

- Use category M80, Osteoporosis with current pathological fracture, for patients who have a current pathological fracture at the time of an encounter.
  - DO NOT USE traumatic fracture code here
  - this **must** be determined and documented by the physician.

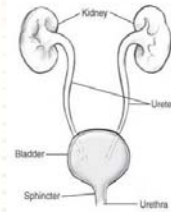
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## CHAPTER 14



Raise Your  
ICD-10 IQ

## Diseases of the Genitourinary System (N00-N99)



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## 13.1 Path Fracture Case Study

Insight | Expertise | Knowledge

An 80-year-old female with senile osteoporosis complaining of severe back pain with no history of trauma. Provider documentation reveals pathological compression fractures of several lumbar vertebrae.

-M80.08XD

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## Stages of Chronic Kidney Disease

Insight | Expertise | Knowledge

- CKD classification based on severity designated by stages 1-5
- End stage renal disease (ESRD) is assigned when it has been documented by the provider (Stage 5 requiring chronic dialysis)
- If both a stage of CKD and ESRD have been documented, assign the code for ESRD only

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## 14.1 Kidney Failure Case Study

Insight | Expertise | Knowledge

An 83-year-old man with complaints of lower abdominal pain and the inability to urinate over the past 24 hours, diagnosed as acute kidney failure due to acute tubular necrosis, caused by a urinary obstruction. The urinary obstruction was a result of the patient's benign prostatic hypertrophy.

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## CHAPTER 17



Raise Your  
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### Congenital Malformations, Deformations and Chromosomal Abnormalities (Q00-Q99)



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## Kidney Failure Answer

Insight | Expertise | Knowledge

N17.0 – Failure, kidney, acute w/tubular necrosis

N40.1 – Hypertrophy, prostate – see enlargement, prostate with luts

N13.8 – Obstruction, urinary

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## Congenital Malformations

Insight | Expertise | Knowledge

- Assigned any time in a patient's life if being diagnosed or treated
- May be present at birth but not diagnosed until later in life
- If previously treated and resolved, code personal history code

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## Manifestations

Insight | Expertise | Knowledge

- DO NOT code manifestations if they are inherent to the malformation/deformation/abnormality
- DO code manifestations that are not inherent
- EX: Down Syndrome – Use F70-79 to further identify the intellectual disability

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## CHAPTER 18



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## Symptoms, Signs and Abnormal Clinical and Laboratory Findings (R00-R99)



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## 17.1 Down Syndrome Case Study

Insight | Expertise | Knowledge

### Down Syndrome -Q90.9

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## Signs & Symptoms

Insight | Expertise | Knowledge

- Symptoms, signs, abnormal results and ill-defined conditions without a classifiable diagnosis
- Only use if definitive diagnosis has not been established
- May be used in addition to a definitive diagnosis as long as the sign or symptom is not routinely associated with that diagnosis

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## Signs & Symptoms

Insight | Expertise | Knowledge

- R29.6, Repeated falls
  - when patient has recently fallen and the reason is being investigated
- Z91.81, History of falling
  - when a patient has fallen in the past and is at risk for future falls
- May be assigned together

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## CHAPTER 19



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### Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T88)



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## 18.1 Fever Case Study

Insight | Expertise | Knowledge

Patient with fever of 101 degrees with chills. Lab tests and urinalysis are within normal limits. Physician gives final diagnosis as fever with chills, possible viral syndrome.

- R50.9 Fever (infection) (of unknown origin) (persistent)(with chills) (with rigor)

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## 7<sup>TH</sup> CHARACTERS

Insight | Expertise | Knowledge

- A – initial encounter
  - Active treatment (surgical treatment, ED encounter, eval & tx by new physician)
- D – subsequent encounter
  - Routine care during healing or recovery phase
  - Aftercare Z codes are not used for aftercare for injuries or poisonings where 7<sup>th</sup> characters are provided to identify subsequent care
- S – sequelae
  - Complications or conditions arising as direct result of condition

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## Injuries

Insight | Expertise | Knowledge

- Assign separate codes for each injury unless a combo code is provided
- Superficial injuries are not coded when associated with more severe injuries of same site
- Do not assign traumatic injury codes for normal, healing surgical wounds or complications of these

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## Traumatic Fractures

Insight | Expertise | Knowledge

- A fracture not indicated as open or closed should be coded to closed
- A fracture not designated as displaced or non-displaced should be coded to displaced
- 7<sup>th</sup> characters
  - Some fractures have expanded 7<sup>th</sup> characters to identify open fractures
- Compound fracture = open fracture

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## Aftercare

Insight | Expertise | Knowledge

- Aftercare for broken bones will now be coded to *Fracture* with 7<sup>th</sup> character *D*
- Traumatic fractures are found in this chapter

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## Fracture Specificity

Insight | Expertise | Knowledge

- Greater specificity for fractures
  - Type
  - Specific site
  - Displaced vs non-displaced
  - Routine vs delayed healing
  - Mal-union
  - Type of encounter

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## 19.1 Elbow FX Case Study

Insight | Expertise | Knowledge

A patient admitted for aftercare following traumatic lateral epicondyle fracture of the right elbow, which is healing normally.

- S42.431D Fracture, traumatic (abduction) (adduction) (separation), humerus, lower end, epicondyle, lateral (displaced)

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## 19.3 Digoxin Case Study

Insight | Expertise | Knowledge

A patient taking Digoxin is experiencing nausea, vomiting and profound fatigue. The patient indicates that she has been taking the drug as prescribed. Evaluation and treatment focused on adjustment of medication only.

- R11.2 Nausea, with vomiting
- R53.83 Fatigue
- T46.0X5D Table of Drugs and Chemicals, Digoxin, adverse effect

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## Adverse Effects

Insight | Expertise | Knowledge

- Drug correctly prescribed and properly administered
- Code nature of adverse effect followed by the code for the cause in the Table of Drugs and Chemicals
  - Tachycardia, delirium, vomiting, renal failure, etc.
- DO NOT code directly from the Table!

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## Poisoning

Insight | Expertise | Knowledge

- Error made in drug prescription
- Overdose of drug intentionally taken
- Non-prescribed drug taken with correctly prescribed and properly administered drug
- Interaction of drugs and alcohol
- 5<sup>th</sup> or 6<sup>th</sup> character shows intent
- Use additional code for manifestations of poisoning

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## Under-dosing

Insight | Expertise | Knowledge

- Taking less than is prescribed by provider or manufacturers instruction inadvertently or deliberately
- Noncompliance (Z91.12-, Z91.13-) or complication of care (Y63.61, Y63.8-Y63.9) codes are to be used in addition to indicate intent, if known

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## External Causes Morbidity (V00-Y99)



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## Toxic Effects

Insight | Expertise | Knowledge

- Harmful substance is ingested or comes in contact with a person
- Associated intent:
  - Accidental
  - Intentional self-harm
  - Assault
  - Undetermined

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## External Causes of Morbidity

Insight | Expertise | Knowledge

- Not used in LTC
- Never sequenced as first listed diagnosis
- Example: Fall from stairs, car accident
- These were "E Codes" in ICD-9

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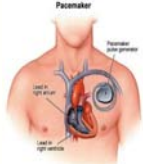
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**Raise Your ICD-10 IQ**

**Factors Influencing Health Status and contact with health services (Z00-Z99)**



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## Coding Examples

Insight | Expertise | Knowledge

- Resistance to penicillin, Z16.11
- Body mass index, adult, (33.0), Z68.33
- Long term (current) use of antibiotics, Z79.2
- Personal history of malignant neoplasm, bladder Z85.51
- Presence of automatic implantable cardiac defibrillator Z95.810

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## Z CODES

Insight | Expertise | Knowledge

- Previously V Codes
- For use in any health care setting
- Aftercare (except for fractures & rehab)
- personal history codes
- noncompliance
- acquired absence of limb
- devices

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## 21.1 Aftercare Case Study

Insight | Expertise | Knowledge

A 75-year-old woman was admitted for occupational therapy (OT) following cardiac bypass surgery. She continues to have significant acute post-thoracotomy pain. Assign the correct diagnostic code(s).

- Z48.812 Aftercare, following surgery (for)(on), circulatory system
- Z95.1 Status (post), aortocoronary bypass
- G89.12 Pain(s) (see also Painful), acute, post-thoracotomy

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- This 81-year-old female is a resident of the nursing facility due to *CHF* and *atrial fibrillation*. She fell from the bed at the nursing facility and was transferred to the hospital. She was readmitted to the nursing facility to resume care and to add physical therapy following *open reduction and pinning of left comminuted subcapital femoral neck fracture*.



- I50.9 Failure, heart, congestive
- I48.91 Fibrillation, atrial or auricular (established)
- S72.012D Fracture, traumatic, femoral neck, see Fracture, femur, upper end, subcapital (displaced)
- R29.6 Falls (repeated)

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