READY. SET. GO.
We’ll get you to ICD-10 in record time.

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Melinda Stegman, MBA, CCS

Unique Coding Guidance: Deciphering the Differences Between ICD-9-CM and ICD-10-CM Coding Guidelines
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Objectives

• Identify ICD-10-CM guidelines that contain significant revisions
• Learn how to apply the new guidelines to navigate through coding challenges
• Recognize where and how changes in the coding guidelines affect code assignment
International Classification of Diseases

• Same system
  – International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)
  – International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), 2013 pre-release draft

• Further evolution of the ICD system
  – Version 10.0 of ICD
    – Browse the Alpha draft of ICD-11 on the World Health Organization’s (WHO) website: http://apps.who.int/classifications/icd11/browse/f/en
    – Beta draft due by 2015

• Underlying basic structure, conventions and purpose remain the same

• Effective October 1, 2014
Distinctive ICD-10-CM Features

• Volume
  – Number of codes: *thousands* more in ICD-10-CM
    • ICD-9-CM: approximately 14,000
    • ICD-10-CM: approximately 69,000

• Format
  – Alphanumeric
  – Three to seven characters

• Specificity
  – Will present documentation challenges:
    • Anatomic site: further refinement
    • Severity (e.g., pressure ulcers, diabetes mellitus – 5 categories)
    • Laterality: paired organs or sites
    • Types of disease identified through advances in medical technologies (e.g., autoimmune diseases, genetic subtypes)
    • Encounter type embedded in code (initial vs subsequent visit)
ICD-10-CM Draft Official Guidelines for Coding and Reporting

• NCHS website: http://www.cdc.gov/nchs/icd/icd10cm.htm

• Same structure and presentation as ICD-9-CM
  – Section I: Conventions, General Coding 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
ICD-10-CM, Version 10.0

In general, the guideline content has been edited in accordance with the classification changes inherent in the ICD-10-CM system, including:

- Combination codes
  - Number of codes assigned

- Laterality and severity
  - Documentation requirements

- Seventh-character extensions
  - Aftercare
  - Sequelae (late effects)
  - Complications
### Sample Code Assignment

#### ICD-10-CM Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S72.21XA</td>
<td>Displaced subtrochanteric fracture of right femur, initial encounter</td>
</tr>
<tr>
<td>S43.Ø11A</td>
<td>Anterior subluxation of right humerus, initial encounter</td>
</tr>
<tr>
<td>SØØ.Ø3XA</td>
<td>Contusion of scalp, initial encounter</td>
</tr>
<tr>
<td>W01.19ØA</td>
<td>Fall on same level from slipping, tripping and stumbling with subsequent striking against furniture, initial encounter</td>
</tr>
<tr>
<td>Y92.Ø1Ø</td>
<td>Kitchen of single-family (private) house as the place of occurrence of the external cause</td>
</tr>
</tbody>
</table>
Structural Changes

• Excludes notes: two different types in ICD-10-CM
  – Excludes1
    • Basically means “not coded here”
    • Codes are mutually exclusive
      – Example: an anomaly that a patient is born with, and an acquired version of the same condition
  – Excludes2
    • Means “not included here”
    • Codes may be assigned together
      • The second condition is not included in the first, but both may be present and should be coded
  – See coding guideline I.A.12 for details on these instructions
Structural Changes

Complications of Care

Certain intraoperative and postprocedural complications are reclassified to specific body system chapters; yet others remain in chapter 19 (chapter 17, ICD-9-CM).

Sequence the complication code first followed by additional codes to specify the nature of the complication, when necessary:

*Examples*

Chapter 19:

**T86.43** Liver transplant infection

**B25.1** Cytomegaloviral hepatitis

Chapter 9:

**I97.41Ø** Intraoperative hemorrhage and hematoma of a circulatory system organ or structure complicating a cardiac catheterization
Structural Changes

• Complications of Care
  – Guideline I.B.16
    • Code assignment is based on the provider’s documentation of the relationship between the condition and the care or procedure.
    • Guideline extends to any complications of care, regardless of the chapter the code is located in.
    • Not all conditions that occur during or following medical care or surgery are classified as complications.
    • Must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication.
ICD-10-CM Characteristics

ICD-10-CM characteristics affect:

• Which codes are assigned
  – Relevant timeframes
    • Obstetrics: ICD-9 episode of care vs. ICD-10 trimester
    • Acute myocardial infarction (AMI): ICD-9 subsequent episode of care vs. ICD-10 subsequent acute myocardial infarction

• How many codes are reported
  – Combination codes
  – Multiple codes

• How we report them
  – Seventh characters / alpha extensions
  – Placeholder “x”
  – Code sequence
Combination Codes

Combination Codes (I.B.9.)
A combination code is a single code used to classify:

• Two diagnoses:
  – A diagnosis with an associated secondary process (manifestation)
  – A diagnosis with an associated complication

• Provides *full identification* of diagnostic conditions

• Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis.
Combination Codes

Combination Codes (I.B.9)

Example: Diverticular disease of colon with complications

K57.2Ø Diverticulitis of large intestine with perforation and abscess without bleeding
K57.21 Diverticulitis of large intestine with perforation and abscess with bleeding
K57.3Ø Diverticulosis of large intestine without perforation or abscess without bleeding
K57.31 Diverticulosis of large intestine without perforation or abscess with bleeding
K57.32 Diverticulitis of large intestine without perforation or abscess without bleeding
K57.33 Diverticulitis of large intestine without perforation or abscess with bleeding
Combination Codes

Combination Codes (I.B.9)

Diagnosis: Coronary artery disease with unstable angina

ICD-9-CM
- 414.01 Coronary atherosclerosis of native coronary artery
- 411.1 Intermediate coronary syndrome

ICD-10-CM
- I25.11Ø Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
  Excludes 1: unstable angina without atherosclerotic heart disease (I2Ø. Ø)
Laterality

Laterality (I.B.12-13)

Anatomically paired organ or site designations may include:

- Right
- Left
- Bilateral: assign for conditions documented as affecting both sides
  – Separate right and left codes may be reported if no bilateral code is provided
- Unspecified: assign only if site is not specified in record
  – Documentation specificity required
Laterality

Laterality (I.B.12-13)
Example: Posterior scleritis

ICD-9-CM
379.07 Posterior scleritis

ICD-10-CM
H15.Ø3 Posterior scleritis
   H15.Ø31 Posterior scleritis, right eye
   H15.Ø32 Posterior scleritis, left eye
   H15.Ø33 Posterior scleritis, bilateral
   H15.Ø39 Posterior scleritis, unspecified eye
Seventh Characters

Seventh Characters (I.A.5)

• Required if applicable

• Must always be in the seventh-character field

• Placeholder “X” required to expand codes, when < six characters

• Code-specific to identify
  – Episode of care
  – Routine or delayed healing
  – Complications
  – Type or severity of injury (e.g., fracture type)
Borderline Diagnoses

• When documented, a “borderline” diagnosis should be coded as a confirmed and present diagnosis.
• If the condition has a specific indexed entry, it should be followed and coded accordingly.
• Borderline diagnoses are NOT the same as uncertain diagnoses, so there’s no difference in the guidelines between inpatient and outpatient cases.
• If the presence of a borderline diagnosis is questionable, the responsible provider should be queried.
• Refer to guideline I.B.17
Seventh-Character Extensions

Seventh Characters (I.C.19.a) in Chapter 19 Injury, Poisoning and Certain Other Consequences of External Causes (SØØ-T88)

• Aftercare (I.C.21.c.7) Z codes (ICD-9 V codes): Not for aftercare of injuries
  – Injury aftercare: assign the acute injury code with the seventh character “D” (subsequent encounter)

Example
S72.024D Nondisplaced fracture of epiphysis (separation) (upper) of right femur, subsequent encounter for closed fracture with routine healing

• The appropriate Z code may be reported as a secondary diagnosis, as appropriate (e.g., attention to surgical dressings)
Seventh-Character Extensions

Seventh-Character Extensions

• Sequelae (I.B.10, I.C.19.a) seventh character “S” is assigned for residual effects that present after the acute phase of the injury or condition has terminated; there is no time limit

• Sequelae typically represent:
  – Complications
  – Late effects of injury
  – Other adverse conditions

• Two codes are usually required:
  – The specific sequela (late effect, residual condition) is sequenced first, followed by the injury code with the extension “S”

Example
Diagnosis: Right claw hand deformity due to old (healed) upper arm median nerve injury

M21.511 Acquired clawhand, right hand
S44.11XS Injury of median nerve at upper arm level, right arm
Sequelae

• Common sequelae:
  – I.C.9. – sequelae of cerebrovascular disease
    • Includes codes from category I69
    • For hemiplegia, hemiparesis & monoplegia, code the side affected:
      – 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
    • Codes from category I69 should not be assigned if the patient does not have neurologic deficits.
Sequelae

- Common sequelae:
  - I.C.15 – sequelae of complication of pregnancy, childbirth and the puerperium
  - Code first the actual sequela condition code
  - As a secondary code, assign:
    O94 Sequelae of complication of pregnancy, childbirth, and the puerperium
Diagnosis-Specific Guideline Topics

Certain guidelines require a change in coding practice, either due to ICD classification changes, system refinements or to provide other clinical information not available or possible with ICD-9-CM, such as:

- Anemia associated with malignancy (I.C.2.c.1)
- Diabetes mellitus (I.C.4.a)
- AMI (I.C.9.e)
- Documentation of depth of non-pressure chronic ulcers & stages of pressure ulcers (I.B.14)
- Substance abuse, use and dependence (I.C.5.c)
- Adverse effects, poisoning, underdosing and toxic effects (I.C.19.e)
Diagnosis-Specific Guideline Topics

Anemia Associated with Malignancy (I.C.2.c.1)

Encounter/admission for management of anemia associated with malignancy:

• Sequence malignancy first
  – Opposite of ICD-9-CM guideline (I.C.2.c.1); anemia sequenced first; malignancy second

• Code D63.Ø Anemia in neoplastic disease, or other specified form of anemia, is reported as additional diagnosis, as documented

• Instructional note at code D63.Ø:
  – Code first neoplasm (CØØ – D49)

• Ensure that documentation links the anemia directly to the malignancy
Diagnosis-Specific Guideline Topics

Anemia Associated with Malignancy (I.C.2.c.1)

Example
Patient with hepatocellular carcinoma is admitted for treatment of severe cancer-related anemia

C22.Ø Liver cell carcinoma
D63.Ø Anemia in neoplastic disease
Diagnosis-Specific Guideline Topics

Diabetes Mellitus (I.C.4.a)

- Separate code blocks/categories by cause or type:
  
  **EØ8** Diabetes mellitus due to underlying condition
  **EØ9** Drug or chemical induced diabetes mellitus
  **E1Ø** Type 1 diabetes mellitus
  **E11** Type 2 diabetes mellitus
  **E13** Other specified diabetes mellitus

- Combination codes for diabetes mellitus/manifestation

- No distinction between controlled and uncontrolled disease
Diagnosis-Specific Guideline Topics

Diabetes Mellitus (I.C.4.a)
The ICD-10-CM Index to Diseases and Injuries instruction regarding diabetes mellitus control:

Diabetes, diabetic
- inadequately controlled—code to Diabetes, by type, with hyperglycemia
- out of control—code to Diabetes, by type, with hyperglycemia
- poorly controlled—code to Diabetes, by type, with hyperglycemia

Codes include:
- E08.65 Diabetes mellitus due to underlying condition with hyperglycemia
- E09.65 Drug or chemical induced diabetes mellitus with hyperglycemia
- E10.65 Type 1 diabetes mellitus with hyperglycemia
- E11.65 Type 2 diabetes mellitus with hyperglycemia
- E12.65 Other specified diabetes mellitus with hyperglycemia
Diagnosis-Specific Guideline Topics

Diabetes Mellitus (I.C.4.a)

Example
Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy and macular edema

ICD-9-CM
250.50 Diabetes with ophthalmic manifestations
362.05 Moderate nonproliferative diabetic retinopathy
362.07 Diabetic macular edema

ICD-10-CM
E11.331 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
Diagnosis-Specific Guideline Topics

Acute Myocardial Infarction (AMI) (I.C.9.e)

• Changes:
  – Structure
  – Parameters

• Same:
  – Underlying concepts
  – Sequencing

• Code also tissue plasminogen activator (tPA) antigen use, tobacco dependence, use or exposure
Diagnosis-Specific Guideline Topics

AMI Changes (I.C.9.e)

Time parameters (and definition of “subsequent”) changed:

• Eight weeks or less in ICD-9-CM
  410 Acute myocardial infarction
  Includes: myocardial infarction specified as acute or with a stated duration of 8 weeks or less

• In ICD-9-CM, “subsequent” refers to the episode of care (initial, subsequent); Episode of care concept has been eliminated in ICD-10-CM.

• Four weeks or less in ICD-10-CM
  I21 ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction
  Includes: myocardial infarction specified as acute or with a stated duration of 4 weeks (28 days) or less from onset

• In ICD-10-CM, “subsequent” refers to an additional AMI: within four weeks (28 days) of a previous AMI, regardless of site

• Ensure that physicians are clear in their documentation and understand the new meaning for “subsequent”
Diagnosis-Specific Guideline Topics

AMI Changes (I.C.9.e)

ICD-10-CM classifies AMI into two categories:

• Initial AMI:
  – Report I21 for four weeks (28 days) regardless of setting.
    
      Example
      I21  ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction

• Subsequent AMI:
  – Report when patient with an AMI suffers a new AMI within four weeks of onset of the initial MI.
    
      Example
      I22  Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction

• Sequencing depends on the circumstances of the encounter
  – Second MI must occur within the 4 week period after the first MI to use I22 codes
  – May sequence I22 codes first if reason for encounter/admission
  – I22 Subsequent MI and I21 Initial AMI can occur in separate or same admissions/encounters
Diagnosis-Specific Guideline Topics

AMI Changes (I.C.9.e)

Example:
A patient suffered an acute MI of the left anterior descending coronary artery, was treated and discharged. He is now readmitted three weeks later with a new inferior wall MI.

I22.1 Subsequent ST elevation (STEMI) myocardial infarction of inferior wall
I21.02 ST elevation (STEMI) myocardial infarction involving the left anterior descending coronary artery

The I22 code is sequenced first as the reason for the encounter. Code I21.02 is listed secondarily and is reported as an AMI, since it is within the 4-week timeframe from the initial MI.
Diagnosis-Specific Guideline Topics

- Documentation of **depth** of non-pressure chronic ulcers & **stages** of pressure ulcers

  - Code assignment may be based on medical record documentation from clinicians who are not the patient’s provider.

  - Information is typically documented by other clinicians involved in the care of the patient.

  - The associated diagnosis (such as chronic non-pressure 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.
Diagnosis-Specific Guideline Topics

Substance Abuse, Use and Dependence (I.C.5.b)

Example 1
Chronic alcohol abuse with dependence
F10.20 Alcohol dependence, uncomplicated

Example 2
Cannabis use with anxiety disorder due to cannabis abuse
F12.180 Cannabis abuse with cannabis-induced anxiety disorder
Diagnosis-Specific Guideline Topics

Substance Abuse, Use and Dependence (I.C.5.b)

• No chapter 5 official guidelines in ICD-9-CM

• ICD-10-CM, chapter 5 guidelines:
  – Pain disorders related to psychological factors (I.C.5.a)
  – Mental and behavioral disorders due to psychoactive substance use (I.C.5.b)
Diagnosis-Specific Guideline Topics

Substance Abuse, Use and Dependence (I.C.5.b)

Guidelines unique to ICD-10-CM include:

- “Continuous” or “episodic use” designations are obsolete

- Combination codes include associated conditions (e.g., withdrawal, sleep disorders and psychosis)

- Unique subcategories represent status: use, abuse, and dependence

- History of drug or alcohol dependence is classified as “in remission”

- An additional code is necessary to report blood alcohol level (Y90.-), when documented
Diagnosis-Specific Guideline Topics

Substance Abuse, Use and Dependence (I.C.5.b)

- If more than one (use, abuse, dependence) is documented, assign only one code:
- If both use and abuse are documented, assign only the code for abuse

- If both abuse and dependence are documented, assign only the code for dependence

- If use, abuse and dependence are all documented, assign only the code for dependence

- If both use and dependence are documented, assign only the code for dependence
Diagnosis-Specific Guideline Topics

Adverse Effects, Poisoning, Underdosing and Toxic Effects

(I.C.19.e) Codes T36–T65 classify adverse effects, poisonings, toxic effects and underdosing

- No additional external cause code required

- Sequence T36–T65 code first when reporting a poisoning. Intent is included in the 5th or 6th character.

- Adverse effects of drugs correctly prescribed and administered are reported with the nature of the effect (diagnosis) followed by the appropriate code for the adverse effect of the drug (T36-T5Ø). Intent is included in the 5th or 6th character.

- Inclusion of “underdosing” as a new concept to the classification
  - Taking less of a prescribed medication resulting in relapse or exacerbation of medical condition due to a reduction in dosage.

- Code also noncompliance (Z91.12-,Z91.13-) or complication of care codes (Y63.61,Y63.8-Y63.9) to report intent, if known.
Diagnosis-Specific Guideline Topics

Adverse Effects, Poisoning, Underdosing and Toxic Effects (I.C.19.e)

Examples

Underdosing

A stressed, sleep-deprived patient with partial generalized, idiopathic epilepsy forgets to take Dilantin, resulting in subtherapeutic levels with resultant exacerbation and epileptic seizure

G40.509 Epileptic seizures related to external causes, not intractable, without status epilepticus

G40.309 Generalized idiopathic epilepsy and epileptic syndromes, non-intractable, without status epilepticus

T42.0X6A Underdosing of hydantoin derivatives, initial encounter

Z91.138 Patient’s unintentional underdosing of medication regimen for other reason
Diagnosis-Specific Guideline Topics

Adverse Effects, Poisoning, Underdosing and Toxic Effects (I.C.19.e)

Examples

Adverse Effect (drug-induced condition, properly prescribed and administered)

A 15-year old patient presents with hives, attributed to an allergy to erythromycin prescribed for right otitis media.

L5Ø.Ø  Allergic urticaria
T36.3X5A  Adverse effects of macrolides, initial encounter
H66.91  Otitis media, unspecified, right ear
Diagnosis-Specific Guideline Topics

Adverse Effects, Poisoning, Underdosing and Toxic Effects (I.C.19.e)

Examples

Poisoning (Overdose - “see Poisoning” in Index )
Patient is admitted with acute toxic hepatitis and convulsions due to suicide attempt by overdose of acetaminophen

T39.1x2A Poisoning by 4-Aminophenol derivatives, intentional self-harm, initial encounter
K71.2 Toxic liver disease with acute hepatitis
R56.9 Unspecified convulsions
POA Considerations

• For those of you working in the acute care (hospital) setting
  – Guidelines for combination codes
    • Assign “N” if any part of the combination code was not present on admission
      – COPD with acute exacerbation and the exacerbation was not present on admission;
      – Gastric ulcer that does not start bleeding until after admission;
      – Asthma patient develops status asthmaticus after admission
    • Assign “Y” if all parts of the combination code were present on admission
      – Patient with acute prostatitis admitted with hematuria

• If the final diagnosis includes comparative or contrasting diagnoses, and both were present, or suspected, at the time of admission, assign “Y.”
• For infection codes that include the causal organism, assign “Y” if the infection (or signs of the infection) was present on admission, even though the culture results may not be known until after admission.
National Center for Healthcare Statistics (NCHS)

ICD-10-CM Draft Official Guidelines for Coding and Reporting

• Guidelines updated regularly

• Posted on NCHS website:
  http://www.cdc.gov/nchs/icd/icd10cm.htm
Additional Official Coding Advice

What about the American Hospital Association’s Coding Clinic?

• *AHA Coding Clinic for ICD-10-CM*

• No conversion of past advice from ICD-9 to ICD-10

• AHA Central Office has announced it will accept ICD-10-CM/PCS coding questions.
Thank You!

Contact information
Melinda Stegman, MBA, CCS    Clinical Technical Editor
703 780-3607
melinda.stegman@optum.com