September 2012

ICD-10-CM 2013 Draft Official Coding Guidelines

On September 5, 2012, the National Center for Health Statistics (NCHS), the federal agency responsible for use of the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10), in the United States, released the 2013 draft version of the official coding guidelines. The four organizations that make up the Cooperating Parties for the ICD-10-CM—the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS—approved the guideline revisions. The ICD-10-CM Official Guidelines for Coding and Reporting (2013) should be used as a companion document to the official 2013 draft version of the ICD-10-CM.

Several revisions were made to clarify existing guidance. Excerpts from the official guidelines where revisions occurred are presented with a brief discussion.

Narrative changes appear in bold text

*Italics* are used to indicate revisions to heading changes

Section I. Conventions, general coding guidelines and chapter specific guidelines

A. Conventions for ICD-10-CM

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.

Discussion: Language was added to clarify that there are two types of etiology/manifestation codes. First, the codes that fall under the ICD-10-CM etiology/manifestation convention represent conditions that have both an underlying etiology and multiple body system manifestations due to the underlying etiology. The code titles of manifestation codes mention “in diseases classified elsewhere.” 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. This coding convention is a carry over from the WHO ICD-10 classification system in which the underlying condition is noted as a “dagger code” and the manifestation is an “asterisk code.”

Example:

- E35 Disorders of endocrine glands in diseases classified elsewhere
  - Code first underlying disease, such as:
    - late congenital syphilis of thymus gland [Dubois disease] (A50.5)
    - tuberculous calcification of adrenal gland (B90.8)

The second type of code is a manifestation code whose title does not include “in diseases classified elsewhere.” The revised guideline now states that “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.”

Example:

- J84.03 Idiopathic pulmonary hemosiderosis
  - Code first underlying disease, such as:
    - disorders of iron metabolism (E83.1-)
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.

Discussion: The example was added just to demonstrate the various combinations of conditions that the “and” term allows to be classified to that code.

B. General Coding Guidelines

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.

Discussion: The language was added not only to define laterality, but also to instruct the coder to use the “unspecified” option when laterality is not documented.

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 (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 (e.g., a dietitian often documents the BMI and nurses often documents the pressure ulcer stages).

Discussion: The depth of a nonpressure ulcer (i.e., skin, fat layer, muscle, or bone) will be used to determine correct code assignment. The inclusion of the depth of nonpressure chronic ulcers to the guideline used for pressure ulcer staging clarifies which clinician’s documentation can support the code assignment for nonpressure chronic ulcers.

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.

Discussion: Guideline revisions direct that, in the absence of Alphabetic Index guidance, additional codes should be assigned, as appropriate, to report all manifestations of a syndrome that may be present, including those not integral to the disease process.

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.

©2012 OptumInsight, Inc.
Discussion: This new guideline clarifies that borderline diagnoses should not be confused with uncertain diagnoses documented as “probable,” “suspected,” “likely,” “questionable,” “possible,” or “still to be ruled out,” or other similar terms indicating uncertainty. An uncertain diagnosis is coded as if the condition existed or was established for inpatient admissions, or is coded to the highest degree of certainty for outpatient encounters. Unlike an uncertain diagnosis, a borderline diagnosis should be coded as confirmed regardless of the care setting.

2. 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).

Discussion: Neoplasms of ectopic tissues are neoplasms of normal tissues arising in abnormal locations. A heterotopic pancreas, also known as ectopic pancreas, refers to a developmental anomaly in which primitive pancreatic cells migrate and are included in the intestinal wall or in other abdominal organs, including the stomach, and lack anatomic or vascular connection with the pancreas. In the example provided in the guidelines the ectopic pancreatic neoplasm involves malignancy of the ectopic pancreas of the stomach. Since the malignancy is actually of pancreatic cells, although in an abnormal location, the code assignment is still malignant pancreatic neoplasm.

4. Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00-E89)
   a. Diabetes mellitus
      6) 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).

Discussion: The addition of the E13 category under this guideline was a correction of an omission to the previous version of the guidelines.

4. Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00-E89)
   a. Diabetes mellitus
      (b) 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. For example, for category E08, Diabetes mellitus due to underlying condition, code first the underlying condition; for category E09, Drug or chemical induced diabetes mellitus, code first the drug or chemical (T36-T65).

Discussion: The addition of the E13 category under this guideline was a correction of an omission to the previous version of the guidelines. The example for sequencing E08 or E09 was deleted in the guidelines.

9. Chapter 9: Diseases of the Circulatory System (I00-I99)
   d. Sequelae of Cerebrovascular Disease
      1) Category I69, Sequelae of Cerebrovascular disease
Category I69 is used to indicate conditions classifiable to categories I60-I67 as the causes of sequela (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, 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.

3) 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. See Section I.C.21.4. History (of) for use of personal history codes.

Discussion: The addition of instruction to assign a default code for dominance according to the side affected or whether the patient is ambidextrous provides needed guidance since neither the index nor the tabular previously provided that guidance. While the guideline [Section I.C.21.4] specifically stated that ‘History of ‘codes should be assigned for conditions that “no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring”, there was no specific guideline under the sequelae of cerebrovascular disease guideline. The addition of this specific guidance is to reinforce the ‘History of’ guideline. The guideline now mirrors guideline Sec I.C.6. a. concerning coding dominant or nondominant sides for hemiplegia and monoplegia codes classified in chapter 6 “Diseases of the Nervous System.”

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

   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.

   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.
Discussion: With the realignment of the influenza categories J09-J11 in the 2012 draft version of ICD-10-CM, it was necessary to make the appropriate changes to this version of the guideline.

15. Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00-O9A)
   q. Termination of Pregnancy and Spontaneous Abortions
      1) 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.
      3) 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.

Discussion: The previous guidance was to “assign a code from subcategory O60.1, Preterm labor with preterm delivery, and a code from category Z37, Outcome of Delivery. The procedure code for the attempted termination of pregnancy should also be assigned.” The guideline now focuses on the reason for the encounter and the instruction to assign a procedure code was deleted. The ICD-10-CM coding guidelines cannot include instruction for assigning procedure codes since the procedure codes are not part of the ICD-10-CM classification system.

16. Chapter 16: Certain Conditions Originating in the Perinatal Period (P00-P96)
   b. 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.
      Reserved for future expansion

Discussion: The ICD10-CM guideline concerning observation and evaluation of newborns for suspected conditions not found is being reevaluated at this time.

Appendix I: Present on Admission Reporting Guidelines
Categories and 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
   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

©2012 OptumInsight, Inc.
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
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

Discussion: Several codes were added to the list of code exempt from the Present on Admission reporting requirement.