ICD-10-CM — Guidelines for the Physician Coder

Nannette Orme, CPC, CCS-P, CPMA, CEMC
Clinical Technical Editor, Optum360
ICD-10-CM — Guidelines for the Physician Coder

• Outpatient Services Guidelines
  – First listed diagnosis
  – Sequencing
  – Sequela

• NOTE: All information cited is from the *ICD-10-CM Official Guidelines for Coding and Reporting 2014*
Outpatient services guidelines

- IV. Diagnostic coding and reporting guidelines for outpatient services

  - IV.A. Selection of first-listed condition

  - In the outpatient setting, the first-listed diagnosis term is used in lieu of principal diagnosis.

  - In determining the first-listed diagnosis, the coding conventions of ICD-10-CM, as well as the general and disease specific guidelines, take precedence over the outpatient guidelines.

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

  - The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.
Outpatient services guidelines continued

• IV.A.1. Outpatient surgery

When a patient presents for outpatient surgery (same day surgery), code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.

• IV.A.2. Observation stay

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

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

• IV.G. ICD-10-CM code for the diagnosis, condition, problem or other reason for encounter/visit

List first the ICD-10-CM code for the diagnosis, condition, problem or other reason for encounter/visit *shown in the medical record to be chiefly responsible for the services provided*. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

• This is an exception to the first-listed guideline.

• Usually in the office setting, the provider will document the primary diagnosis as the first-listed.

• Usually in the outpatient surgical setting, the first, listed diagnosis will be the primary reason for the procedure.
Outpatient services guidelines, continued

• IV.H. Uncertain diagnosis

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

Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.
Outpatient Services Guidelines continued

• IV.I. Chronic diseases

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

• IV.J. Code all documented conditions that coexist

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

• IV.K. Patients receiving diagnostic services only

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

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

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

• IV.L. Patients receiving therapeutic services only

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

The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy or radiation therapy, the appropriate Z code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.
Outpatient services guidelines, continued

• IV.M. Patients receiving preoperative evaluations only

For patients receiving preoperative evaluations only, first sequence a code from subcategory Z01.81, “Encounter for pre-procedural examinations,” to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Also code any findings related to the pre-op evaluation.

• IV.N. Ambulatory surgery

For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.
• IV.P. Encounters for general medical examinations with abnormal findings

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

• I.B.10. Sequelae (late effects)

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

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

• I.C.9.d.1. Category I69, sequelae of cerebrovascular disease

Category I69 is used to indicate conditions classifiable to categories I10-I67 as the causes of sequelae (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 nondominant.
– If the right side is affected, the default is dominant.
Sequela continued

• I.C.15.p.Code O94, Sequelae of complication of pregnancy, childbirth, and puerperium

  Code O94, “Sequelae of complication of pregnancy, childbirth, and the puerperium,” is for use in those cases when an initial complication of a pregnancy develops a sequela requiring care or treatment at a future date.

• I.C.15.p.2. After the initial postpartum period
  This code may be used at any time after the initial postpartum period.

• I.C.15.p.3. Sequencing of Code O94
  This code, like all sequelae codes, is to be sequenced following the code describing the sequelae of the complication.
Sequelae, continued

• I.C.19.a. Application of 7th characters in chapter 19

7th character “S” sequela is for use for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. The scars are sequelae of the burn. When using 7th character “S” it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The “S” is added only to the injury code, not the sequela code. The 7th character “S” identifies the injury responsible for the sequela. The specific type of sequela (e.g., scar) is sequenced first, followed by the injury code.
Sequelae, continued

- **I.C.20.i. Sequelae (late effects) of external cause guidelines**

- **I.C.20.i.1. Sequelae external cause codes**
  
  Sequelae are reported using the external cause code with the 7th character “S” for sequela. These codes should be used with any report of a late effect or sequela resulting from a previous injury.

- **I.C.20.i.2. Sequelae external cause code with a related current injury**
  
  A sequela external cause code should never be used with a related current nature of injury code.

- **I.C.20.i.3. Use of sequelae external cause codes for subsequent visits**
  
  Use a late-effect external cause code for subsequent visits when a late effect of the initial injury is being treated. Do not use a late-effect external cause code for subsequent visits for follow-up care (e.g., to assess healing, to receive rehabilitative therapy) of the injury when no late effect of the injury has been documented.
Thank you.

Contact information:
Nannette Orme, CPC, CCS-P, CPMA, CEMC
1-801-982-3260
nannette.orne@optum.com