ICD – 10 CM

CHAPTER 12 - 18

12. Chapter 12: Diseases of the Skin and Subcutaneous Tissue (L00-L99)

a. **Pressure ulcer stage codes**
   - **1) Pressure ulcer stages**
   - **L89 – SITE AND STAGE**
   - **STAGES – based on severity**
   - **Stages 1 – 4 ,deep tissue pressure injury , unspecified stage , unstageable.**
- **2) Unstageable pressure ulcers**
   - (L89.--0) – based on documentation
   - pressure ulcers whose stage cannot be clinically determined

- **3) Documented pressure ulcer stage**
  - For clinical terms describing the stage that are not found in the Alphabetic Index,
  - and there is no documentation of the stage, the provider should be queried
- **4) Patients admitted with pressure ulcers documented as healed**
  - healed **at the time of admission**.
  - NO code

- **5) Pressure ulcers documented as healing**
  - assigned based on the documentation in the medical record.
  - No information about the stage – Unspecified
  - unclear current / new ulcer / treated for a healing pressure ulcer – query the provider
  - Ulcer present on admission & healed at time of discharge – code site and stage present on admission

- **6) Patient admitted with pressure ulcer evolving into another stage during the admission**
  - admitted to an inpatient hospital with a pressure ulcer at one stage and it progresses to a higher stage
  - 2 separate codes
  - One code – site and stage on admission
  - Second code – same site and highest stage during stay

- **7) Pressure-induced deep tissue damage / deep tissue pressure injury**
  - **L89.--6**

b. Non-Pressure Chronic Ulcers

- **1) Patients admitted with non-pressure ulcers documented as healed – no code**
- **2) Non-pressure ulcers documented as healing – based on documentation / same as healing pressure ulcer**

- **3) Patient admitted with non-pressure ulcer that progresses to another severity level during the admission**
  - **2 codes**

Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)

a. Site and laterality

- **Site – bone , joint , muscle involved**
- **More than one bone / joint / muscle – assign multiple site code**
- **No multiple site code – code for different sites (multiple coding)**
- **Bone versus joint**
- the bone may be affected at the upper or lower end
- – site taken as bone

b. Acute traumatic versus chronic or recurrent musculoskeletal conditions

- Recurrent / chronic bone, joint or muscle conditions – chap 13
- Any current, acute injury – chapter 19 (injury)
- Unclear - query

c. Coding of Pathologic Fractures

- 7th character A – active treatment
- 7th character D - routine care - healing or recovery phase.
- malunions, nonunions, and sequelae
- **d. Osteoporosis**
- category M81 - without current pathological fracture
- category M80 - with current pathological fracture
- Identify site
- History of osteoporosis fractures, status code Z87.310 (Personal history of (healed) osteoporosis fracture)

14. Chapter 14: Diseases of Genitourinary System (N00-N99)

a. Chronic kidney disease

- 1) Stages of chronic kidney disease (CKD)
- based on severity.
- stages 1-5.
- End stage renal disease (ESRD) / stage 6

- **2) Chronic kidney disease and kidney transplant status**
- **Kidney transplant + but still having CKD**
- **N18 code** for the patient's stage of CKD
- code **Z94.0,** Kidney transplant status.

3) Chronic kidney disease with other conditions

- CKD + diabetes mellitus and hypertension.
- based on the conventions in the Tabular List.

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

a. General Rules for Obstetric Cases

- sequencing priority over codes from other chapters.
- pregnancy is incidental to the encounter, then code Z33.1, Pregnant state, incidental
- **Chapter 15 codes used only on the maternal record – never on newborn**
- Assignment of the final character for trimester – based on provider documentation

- **Selection of trimester for inpatient admissions that encompass more than one trimester –**
- Code trimester when the complication developed
- developed prior to the current admission – code trimester at time of admission
- **Unspecified trimester – rarely used**
- **7th character for Fetus Identification -** O31, O32, O33.3 - O33.6, O35, O36, O40, O41, O60.1, O60.2, O64, and O69

b. Selection of OB Principal or First-listed Diagnosis

- **1) Routine outpatient prenatal visits -**
- Z34, Encounter for supervision of normal pregnancy, should be used as the first-listed diagnosis
- **2) Supervision of High-Risk Pregnancy**
- routine prenatal outpatient visits with high risk - category O09, Supervision of high-risk pregnancy,

- **Outcome of delivery -** category Z37, Outcome of delivery
- **Pre-existing hypertension in pregnancy –**
- O10, Pre-existing hypertension complicating pregnancy
- add a secondary code – hypertension , heart failure, CKD

e. Fetal Conditions Affecting the Management of the Mother

- categories O35, Maternal care for known or suspected fetal abnormality and damage, and
- O36, Maternal care for other fetal problems,

2) In utero surgery -

- category O35
- Do not code from chap 16

f. HIV Infection in Pregnancy, Childbirth and the Puerperium -

- HIV related illness - subcategory O98.7-, B20
- Asymptomatic HIV - O98.7- and Z21

g. Diabetes mellitus in pregnancy

- category O24, Diabetes mellitus in pregnancy, childbirth, and the puerperium, first,
- followed by (E08- E13)

i. Gestational (pregnancy induced) diabetes

- Gestational (pregnancy induced) diabetes can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy
- Code O24.4, Gestational diabetes mellitus
- Do not code O24, Z79.4, Z79.84
- An abnormal glucose tolerance in pregnancy - O99.81

Puerperal sepsis

- Code O85, Puerperal sepsis
- B95-B96
- If severe sepsis documented – R65.2
- Organ dysfunction code

Poisoning, toxic effects, adverse effects and underdosing in a pregnant patient

- O9A.2 (first code)
- injury, poisoning, toxic effect, adverse effect or underdosing code
- Condition code

- **Normal Delivery, Code O80**
- **Encounter for full term uncomplicated delivery**
- always a principal diagnosis
- **Outcome of delivery for O80 -** Z37.0, Single live birth, is the only outcome of delivery code appropriate for use with O80.

Peripartum - last month of pregnancy to five months postpartum.

postpartum period - after delivery and continues for six weeks following delivery

- **Routine postpartum care -**
- code Z39.0, Encounter for care and examination of mother immediately after delivery, should be assigned as the principal diagnosis.
- **Pregnancy associated cardiomyopathy – O93.0**
- **Sequelae of complication of pregnancy, childbirth, and the puerperium - O94**

- TOP- Termination of pregnancy
- **Abortion with Liveborn Fetus**
- assign code Z33.2, Encounter for elective termination of pregnancy and
- a code from category Z37, Outcome of Delivery.
- **Retained Products of Conception following an abortion –** O03.4 /O07.4

Abuse in a pregnant patient

- O9A.3, Physical abuse complicating pregnancy, childbirth, and the puerperium,
- O9A.4, Sexual abuse
- O9A.5, Psychological abuse , should be sequenced first
- Code for associated current injury

16. Chapter 16: Certain Conditions Originating in the Perinatal Period (P00-P96)

The perinatal period is defined as before birth through the 28th day following birth

a. General Perinatal Rules

- **Chapter 16 Codes -** never for use on the maternal record.
- **Principal Diagnosis for Birth Record -** Z38, Liveborn infants according to place of birth and type of delivery, as the principal diagnosis (initial birth record only)

- Perinatal condition, the code from chapter 16 should be sequenced first.
- a condition originate in the perinatal period, and continue throughout the life of the patient – code perinatal code regardless of age
- **Birth process or community acquired conditions – default is birth process (if not documented)**
  - **Community acquired – do not assign chap 16 codes**
- All clinically significant conditions noted on routine newborn examination should be coded.

Prematurity and Fetal Growth Retardation

- P05, Disorders of newborn related to slow fetal growth and fetal malnutrition,
- P07, Disorders of newborn related to short gestation and low birth weight, not elsewhere classified (based on birth weight and estimated gestational age)
- birth weight and gestational age documented – 2 codes – code for birth weight first and followed by gest age
- **Low birth weight and immaturity – P07**

Bacterial Sepsis of Newborn

- **P36 -** Bacterial sepsis of newborn, includes congenital sepsis (principal diag)
- Congenital / acquired – not documented – default is congenital
- If P36 includes causal organism – do not code from B95 / B96
- If not included – code B95/B96 with P36
- If severe sepsis – use additional code R65.2 and organ failure code

Chapter 17: Congenital malformations, deformations, and chromosomal abnormalities (Q00-Q99)

- Q00-Q99, Congenital malformations, deformations, and chromosomal abnormalities
- abnormality does not have a unique code assignment – additional code for manifestations
- Manifestations are inherent – do not assign separate codes for manifestations
- Chapter 17 may be used throughout the life of the patient
- deformity has been corrected – personal history code
- For birth admission – Z38 (first) + Q00- Q99

Exercise

- Unstageable pressure ulcer of LT hip
- Healing pressure ulcer of RT buttock , stage 3
- Osteomalacia
- Pathological fracture at right ulna and radius
- Pregnant pt at 17^{th} week present for check up. She is HIV positive symptomatic.
- Sepsis due to streptococcus of NB

Chapter 18: Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)

- **a. Use of symptom codes –** no related definitive diagnosis
- **b. Use of a symptom code with a definitive diagnosis code -** not routinely associated with that diagnosis
- Definitive diagnosis as principal code
- associated routinely - no separate code for S/S
- **c. Combination codes that include symptoms – do not assign additional code for S/S**

- **d. Repeated falls**
- Code R29.6, Repeated falls (reason for fall being investigated)
- Code Z91.81, History of falling (past and risk for furure falls)
- R29.6 and Z91.81 may be assigned together (when appropriate)

- **e. Coma scale -**
- The coma scale codes (R40.2-)
- used in conjunction with traumatic brain injury codes**,** acute cerebrovascular disease or sequelae of cerebrovascular disease codes.
- Used in trauma registries
- assess the status of the central nervous system for other non-trauma conditions (ICU)
- should be sequenced after the diagnosis code(s).
- Assign code R40.24, Glasgow coma scale, when total score is documented
- Do not code medically induced coma or a sedated patient

- **g. SIRS due to Non-Infectious Process**
- such as trauma, malignant neoplasm, or pancreatitis.
- code for the underlying condition, such as an injury
- code R65.10, Systemic inflammatory response syndrome (SIRS) of non-infectious origin without acute organ dysfunction
- code R65.11, Systemic inflammatory response syndrome (SIRS) of non-infectious origin with acute organ dysfunction + organ dysfunction code
- Unclear - query

- **h. Death NOS – R99**
- **i. NIHSS Stroke Scale**
- The NIH stroke scale (NIHSS) codes (R29.7- -) can be used in conjunction with acute stroke codes (I63) to identify the patient's neurological status and the severity of the stroke.
- The stroke scale codes should be sequenced after the acute stroke diagnosis code(s).