ICD – 10 CM

CHAPTER SPECIFIC GUIDELINES
6,7,8,9,10,11

Chapter 6: Diseases of the Nervous System (G00-G99)

- **a. Dominant/nondominant side**
  - G81, Hemiplegia and hemiparesis
  - G83.1, Monoplegia of lower limb
  - G83.2, Monoplegia of upper limb
  - G83.3, Monoplegia, unspecified

IDENTIFY DOMINANT / NON DOMINANT SIDE IS AFFECTED

- **AFFECTED SIDE – not documented as dominant / non dominant**

➢ **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.**

- **b. Pain - Category G89**
- **General coding information:**
  - Acute / chronic
  - Post thoracotomy pain
  - Post procedural pain
  - Neoplasm related
  - Underlying definitive diagnosis known – do not code G89 (unless reason for encounter is for pain control /mgt)
  - Procedure aimed at treating the underlying condition
  - Eg : spinal fusion , kyphoplasty – code for condition (vertebral fracture /spinal stenosis) – do not code G89

PAIN – AS PRINCIPAL / FIRST LISTED DIAGNOSIS

- Pain control / pain management
  - e.g., a patient with displaced intervertebral disc, nerve impingement and severe back pain presents for injection of steroid into spinal canal – code from G89 + underlying cause of pain

- Insertion of Neuro stimulator – pain code as primary

- Treatment is for Underlying condition + insertion of neuro stimulator during same encounter – code for condition first + pain code

(b) Use of Category G89 Codes in Conjunction with Site Specific Pain Codes

- **(i) Assigning Category G89 and Site-Specific Pain Codes – eg:** if the code describes the site of the pain, but does not fully describe whether the pain is acute or chronic – assign both codes

- **(ii) Sequencing of Category G89 Codes with Site-Specific Pain Codes**

  – **Encounter for pain control / mgt – code G89 first + specific site of pain**

- **Encounter for any other reason except pain control / mgt** – relative definitive diagnosis not confirmed by provider – code for specific site of pain first + G89

- **Postoperative Pain**
  - **not associated with specific postoperative complication – code G89**
  - **associated with specific postoperative complication (painful wire sutures) –**
    - **code for complication first + G89** (G89.18 or G89.28) to identify acute / chronic pain

- **Neoplasm Related Pain**
  - Code G89.3
  - Encounter for pain mgt – code for pain first
  - Encounter for mgt of neoplasm – code for neoplasm first
- Central pain syndrome (G89.0)
- Chronic pain syndrome (G89.4) (different from chronic pain)

Chapter 7: Diseases of the Eye and Adnexa (H00-H59)

a. **Glaucoma**

1) Assigning Glaucoma Codes

- Type of glaucoma
- Affected eye
- Stage

2) Bilateral glaucoma with same type and stage

- Same type and same stage – code - type of glaucoma – bilateral – stage (7th character) - H40.1333
- Same type and same stage – but no classification code for bilateral – (H40.10 , H40.20)- report only one code with appropriate stage (7th character) - H40.10X4

3) Bilateral glaucoma stage with different types or stages

➢ **Bilateral glaucoma – each eye with diff types and stages – classification distinguishes laterality - code for each eye**

➢ **Bilateral glaucoma – each eye with different type– classification not distinguishes laterality – assign one code for each type with appropriate stage – H40.20X1, H40.10X1**

➢ **Same type but different stage – no laterality – assign the code for each eye with appropriate specified stage for each eye – H40.10X1, H40.10X2**

4) Patient admitted with glaucoma and stage evolves during the admission

– the stage progresses during the admission, assign the **code for highest stage** documented.

5) Indeterminate stage glaucoma

– Assignment of the **seventh character "4"** for **"indeterminate stage"** should be based on the clinical documentation.

b. Blindness/ low vision

- both eyes is documented - Visual impairment category is not documented - code H54.3, Unqualified visual loss, both eyes.

- one eye is documented but the visual impairment category is not documented - code from H54.6-, Unqualified visual loss, one eye.

- If "blindness" or "visual loss" is documented without any information about whether one or both eyes are affected - code H54.7, Unspecified visual loss.

Exercise - Eye

1. Jim suffers from paralysis of his upper right arm.

2. Primary open angle glaucoma, not yet staged

3. Senile cortical cataract – RT eye

4. Pigmentary glaucoma bilaterally, moderate stage on RT, mild stage on LT

Chapter 9: Diseases of the Circulatory System (I00-I99)

a. Hypertension

- The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the **term "with" in the Alphabetic Index.**

- These conditions should be coded as related even in the **absence of provider documentation**

- unless the documentation clearly states the conditions are unrelated

1) **Hypertension with Heart Disease / HF**

- code from category I11 (primary)
- Check for HTN with heart disease (I11.9) /
- HTN with heart failure – I11.0, I50.-
- Use additional code(s) from category I50, Heart failure, to identify the type(s) of heart failure in those patients with heart failure.
- if the provider has documented heart conditions are unrelated to the hypertension- sequence according to circumstances of encounter

2) Hypertensive Chronic Kidney Disease

- Hypertensive chronic kidney disease – assign code from category I12 (primary)

- Assign CKD – N18 (secondary)

- No relation documented – do not assign I12

- Hypertensive chronic kidney disease + acute renal failure – additional code for ARF assigned

3) Hypertensive Heart and Chronic Kidney Disease

- Hypertensive heart and chronic kidney disease – I13 (primary)
- Heart failure – I50 (type)
- CKD – N18 (stage)
- Do not assign individual codes
- CKD + ARF – add code for ARF

4) Hypertensive Cerebrovascular Disease

- Assign code from categories I60-I69,
- Followed by hypertension code

5) Hypertensive Retinopathy

- Subcategory H35.0 (Background retinopathy and retinal vascular changes)
- category I10 – I15 (Hypertensive disease to include the systemic hypertension)
- Sequencing based on reason for encounter

6) Hypertension, Secondary

- **Two codes – Etiology + I15 (for hypertension)**
- **Sequencing based on encounter**

7) Hypertension, Transient

- R03.0, Elevated blood pressure reading without diagnosis of hypertension

- Assign code O13.-, Gestational [pregnancy-induced] hypertension without significant proteinuria,

- O14.-, Pre-eclampsia, for transient hypertension of pregnancy.

8) Hypertension, Controlled

– I10-I15, Hypertensive diseases.

9) Hypertension, Uncontrolled (not responding to current treatment)

I10-I15, Hypertensive diseases

10) Hypertensive Crisis

- **category I16 - Hypertensive crisis**
- documented hypertensive urgency, hypertensive emergency or unspecified hypertensive crisis
- Code also any identified hypertensive disease (I10-I15).
- Sequencing based on encounter

11) Pulmonary Hypertension

- category I27 – other pulmonary heart diseases
- For secondary pulmonary hypertension (I27.1, I27.2-),
- code also any associated conditions or adverse effects of drugs or toxins
- The sequencing is based on the reason for the encounter, except for adverse effects of drugs

b. Atherosclerotic Coronary Artery Disease and Angina

- combination codes
- I25.11 (Atherosclerotic heart disease of native coronary artery with angina pectoris)
- I25.7 (Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris)
- CAD with admission for AMI – code for AMI first

c. Intraoperative and Postprocedural Cerebrovascular Accident

- Medical record documentation

- an infarction or hemorrhage

- intraoperatively or postoperatively.

- cerebral hemorrhage - code assignment depends on the type of procedure performed

d. Sequelae of Cerebrovascular Disease

- **1) Category I69, Sequelae of Cerebrovascular disease -** hemiplegia, hemiparesis and monoplegia

- 2) Codes from category I69 with codes from I60-I67 – both coded when there is a current CVA and deficits from old CVA

- 3) Codes from category I69 and Personal history of transient ischemic attack (TIA) and cerebral infarction (Z86.73) – do not code I69 if no neurologic deficits

e. Acute myocardial infarction (AMI)

1) **Type 1 ST elevation myocardial infarction (STEMI) and non-ST elevation myocardial infarction (NSTEMI)**

- type 1 acute myocardial infarction - identify the site, such as anterolateral wall or true posterior wall

- Subcategories I21.0-I21.2 and code I21.3 are used for type 1 STEMI

- Code I21.4, Non-ST elevation (NSTEMI) myocardial infarction, is used for type 1 NSTEMI and nontransmural MIs.

- If a type 1 NSTEMI evolves to STEMI – **code STEMI**
- If a type 1 STEMI converts to NSTEMI due to thrombolytic therapy **– still coded as STEMI**
- Encounter when MI - equal to, or less than, four weeks old – continue to report code from I21
- after the 4 week time frame (still receiving care) – after care codes assigned
- For **old or healed myocardial infarctions** not requiring further care, **code I25.2, Old myocardial infarction**

2) Acute myocardial infarction, unspecified

- **Code I21.9**, Acute myocardial infarction, unspecified

- If only type 1 STEMI or transmural MI without the site is documented, **assign code I21.3**

3) AMI documented as nontransmural or subendocardial but site provided

- still coded as a subendocardial AMI.

4) Subsequent acute myocardial infarction

- I22, Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction (has a new AMI within the 4 week time frame of the initial AMI – type 1 / unspecified)

- I22 and I21 used together – based on encounter

- Do not assign code I22 for subsequent myocardial infarctions other than type 1 or unspecified.

- For subsequent type 2 AMI - assign only code I21.A1

- For subsequent type 4 or type 5 AMI - assign only code I21.A9.

- If a subsequent myocardial infarction of one type occurs within 4 weeks of a myocardial infarction of a different type - assign category I21 to identify each type.

- Do not assign a code from I22.

- Codes from **category I22 should only be assigned if both the initial and subsequent myocardial infarctions are type 1 or unspecified.**

5) Other Types of Myocardial Infarction

- Type 1 myocardial infarctions are assigned to codes I21.0-I21.4.

- Type 2 myocardial infarction (myocardial infarction due to demand ischemia or secondary to ischemic **im**balance) is assigned to code I21.A1 – underlying cause coded first

- **If** a type 2 AMI is described as NSTEMI or STEMI, only assign code I21.A1

- Codes I21.01-I21.- only for type 1 AMIs.

- Acute myocardial infarctions type 3, 4a, 4b, 4c and 5 are assigned to code I21.A9 (other MI)

- "Code also" and "Code first – follow for complications and for coding post procedural MI

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

a. Chronic Obstructive Pulmonary Disease [COPD] and Asthma

- **1) Acute exacerbation of chronic obstructive bronchitis and asthma - J44 and J45**

b. Acute Respiratory Failure

- **as principal diagnosis -**
    - J96.0, Acute respiratory failure
    - J96.2, Acute and chronic respiratory failure – coded first as a reason for admission
    - Exception – obstetrics, poisoning, HIV , newborn)

- **As secondary diagnosis**

– respiratory failure after admission/ if does not meet the principal diag

3) Sequencing of acute respiratory failure and another acute condition

- respiratory failure and another acute condition, (e.g., myocardial infarction, cerebrovascular accident, aspiration pneumonia) -

- the principal diagnosis depends on circumstances

- If unclear – query the provider

c. Influenza due to certain identified influenza viruses

- Code only confirmed cases – provider documentation

- J09 - certain identified viruses

- J10 - other identified viruses

- "suspected" or "possible" or "probable" - J11 – unidentified virus

d. Ventilator associated Pneumonia (VAP)

1) Documentation of Ventilator associated Pneumonia

- Code J95.851, Ventilator associated pneumonia – provider documentation must.

- additional code to identify the organism (e.g., Pseudomonas aeruginosa - code B96.5

- Do not code J95.851 for pt has pneumonia and on mechanical ventilator

2) Ventilator associated Pneumonia Develops after Admission

- A patient may be admitted with one type of pneumonia and develop VAP.

- **Principal diagnosis- Pneumonia due to organism – J12 –J18**

- Add code for VAP – J95.851 if documented VAP

e. Vaping-related disorders

- For patients presenting with condition(s) related to vaping, assign code U07.0, Vaping-related disorder, as the principal diagnosis. For lung injury due to vaping, assign only code U07.0.

- Assign additional codes for other manifestations, such as acute respiratory failure (subcategory J96.0-) or pneumonitis (code J68.0).

- Associated respiratory signs and symptoms due to vaping, such as cough, shortness of breath, etc., are not coded separately, when a definitive diagnosis has been established.

- However, it would be appropriate to code separately any gastrointestinal symptoms, such as diarrhea and abdominal pain.

Exercise

1. AMI – anterolateral wall

2. Hemiplegia due to late effects of CVA

3. Hypertensive heart and CKD with ESRD

4. Hypertensive heart disease with systolic failure

5. Pneumococcal sepsis due to pneumococcal pneumonia with SIRS and renal failure