2020

Medical Billing Training: Certified Professional Biller (CPB™)

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Chapter 4

Introduction to ICD-10-CM

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) classifies patient morbidity and mortality information for statistical purposes. It also provides a basis for indexing health records by diseases and procedures for data storage and retrieval. The ICD-10-CM code(s) listed with a patient encounter explain why a patient had services (for example, a nebulizer treatment for *asthma*, a biopsy for a *skin lesion*, an X-ray for a *radial fracture*, etc.). ICD-10-CM codes are up to seven alpha and numeric characters in length. In 1988, the Medicare Catastrophic Coverage Act required appropriate diagnosis codes to be submitted with Medicare Part B claims. Although later repealed for the most part, diagnosis codes are still required for Medicare claims. ICD-10-CM is based on the official version of the World Health Organization's (WHO) 10th revision of the International Classification of Diseases (ICD-10). Prior to October 1, 2015, codes from ICD-9-CM, were used in the United States. Updates to ICD-10-CM are published in October of each year. The Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS) developed ICD-10-CM for use in the United States. CMS offers more information at https://www.cms.gov/medicare/coding/icd10/downloads/icd10_coops_sept_16.pdf

Correct coding facilitates the payment of services, tracks healthcare usage, predicts trends, aids patient care and advances research. The diagnosis codes should be reported to the highest level of specificity and reflect the information in the patient record. The entire record must be reviewed to determine the specific reasons for the encounter and conditions treated. ICD-10-CM codes and the medical record collectively provide the logic to support the medical necessity of procedures performed and services provided. Many payers have claim edits in their adjudication systems regarding "diagnosis to procedure codes" relationships. It is important for billers to have access to and be familiar with the specific policies of each payer.

One of the main payment denials that occur is due to lack of medical necessity. Any services that are sent to a payer must be justified by presenting the appropriate facts. Payers require that reimbursable services be reasonable and medically necessary. They also require that the following information be available to determine the need for care, if requested:

- Knowledge of the emergent nature or severity of the patient's complaint or condition
- All signs, symptoms, complaints, or background facts describing the reason for care
- The facts must be substantiated by the patient's medical record, and that record must be available to payers upon request

For example, a patient complains of left wrist pain and a provider takes a wrist X-ray, which is negative for fracture. When the claim is submitted, the payer needs to know why the X-ray was performed. The diagnosis (ICD-10-CM) code for wrist pain is reported with the wrist X-ray. Wrist pain supports medical necessity for the X-rays. Proper ICD-10-CM code selection will be discussed later in this chapter.

BILLING TIP

When submitting the primary diagnosis code, review other ICD-10-CM codes listed on the claim form and, if necessary, pertinent medical records. Other ICD-10-CM codes assigned to the encounter may provide additional information supporting treatment. For example, the primary reason for a visit may be headaches, but the patient also has urinary urgency which supports the medical necessity of a urinalysis. Headache is the primary diagnosis for the office visit and urinary urgency is the diagnosis attached to the urinalysis. Some insurance carriers will only review the first diagnosis attached to each procedure code.

This chapter is a high-level overview of the core elements of ICD-10-CM coding. It is expected that the medical biller has a basic understanding of diagnosis coding and how to use the ICD-10-CM code book. If more in-depth information is needed, refer to the curriculum available from AAPC at www.aapc.com.

Code Book Structure

The ICD-10-CM code book has two sections:

1. ICD-10-CM Alphabetic Index or Index to Diseases and Injuries: Diagnostic terms organized in alphabetic order and the corresponding code for the disease descriptions found in the Tabular List.
2. Tabular List: Diagnosis codes organized in alpha-numeric order and divided into chapters based on body system or condition.

Diagnosis codes are applicable to all healthcare settings unless otherwise noted.

ICD-10-PCS includes procedure codes, and typically is used by facilities only for inpatient services. This guide will focus

on the proper use of ICD-10-CM only. Coders use the two sections of ICD-10-CM to assign diagnosis codes for services rendered, and to establish medical necessity to support those services.

Tabular List of Diseases

The Tabular List of Diseases is a numerical listing that contains: 21 chapters to classify diseases and injuries by etiology (cause) or anatomical (body) site, and appendices. The topic areas for each are as follows:

Chapter	Descriptive Title	Code Range
1.	Certain Infectious and Parasitic Diseases	A00-B99
2.	Neoplasms	C00-D49
3.	Disease of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism	D50-D89
4.	Endocrine, Nutritional and Metabolic Diseases	E00-E89
5.	Mental, Behavioral and Neurodevelopmental Disorders	F01-F99
6.	Diseases of the Nervous System	G00-G99
7.	Diseases of the Eye and Adnexa	H00-H59
8.	Diseases of the Ear and Mastoid Process	H60-H95
9.	Diseases of the Circulatory System	I00-I99
10.	Diseases of the Respiratory System	J00-J99
11.	Diseases of the Digestive System	K00-K95
12.	Diseases of the Skin and Subcutaneous Tissue	L00-L99
13.	Diseases of the Musculoskeletal System and Connective Tissue	M00-M99
14.	Diseases of the Genitourinary System	N00-N99
15.	Pregnancy, Childbirth, and the Puerperium	O00-O9A
16.	Certain Conditions Originating in the Perinatal Period	P00-P96
17.	Congenital Malformations, Deformations, and Chromosomal Abnormalities	Q00-Q99
18.	Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified	R00-R99
19.	Injury, Poisoning and Certain Other Consequences of External Causes	S00-T88
20.	External Causes of Morbidity	V00-Y99
21.	Factors Influencing Health Status and Contact with Health Services	Z00-Z99

The Tabular List is broken down into three-character code categories (rubrics), with some code categories being complete codes. The code category is followed by a decimal point followed by up to four additional characters. The 4th, 5th, 6th, and 7th characters may be required.

Each character for all categories, subcategories, and codes may be either a letter or a number. Codes can be three, four, five, six, or seven characters. The first three characters represent the category. The 4th through the 6th characters represent etiology, anatomic site, severity, or other vital details. The 7th character is an extension which is primarily used for episode of care for injuries and other conditions with external causes.

The 1st character of a category is a letter. The 2nd through 7th characters may be either numbers or alpha characters. Subcategories are either four or five-character codes.

The 4th character in an ICD-10-CM code further defines the site, etiology, and manifestation or state of the disease or condition. The four-character subcategory includes the three-character category plus a decimal with an additional character to further identify the condition to the highest level of specificity.

The 5th or 6th character subclassifications represent the most accurate level of specificity regarding the patient's condition or diagnosis. Certain ICD-10-CM categories have applicable 7th characters. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct. The 7th character must always be in the 7th position. If a code is three, four, or five characters, but requires a 7th character extension, a placeholder X must be used to fill the empty characters.

EXAMPLE

Code J42 *Unspecified chronic bronchitis* does not break down any further. J44 Other chronic obstructive pulmonary disease is a category code and must have a 4th character to be a complete, including:

J44.0 Chronic obstructive pulmonary disease with (acute) lower respiratory infection

J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation

J44.9 Chronic obstructive pulmonary disease, unspecified

There are symbols throughout the Tabular List to identify when a code requires an additional character.

EXAMPLE

- 4th F01 Vascular Dementia
- 5th H21.4 Pupillary membranes
- 6th I87.00 Postthrombotic syndrome without complications
- 7th O32.0 Maternal care for unstable lie

ICD-10-CM Alphabetic Index (Index to Diseases and Injuries)

The ICD-10-CM Alphabetic Index is an alphabetic listing of diseases, conditions, and injuries along with their accompanying codes. It is used as a guide in finding the correct codes.

The ICD-10-CM Alphabetic Index has four distinct divisions:

1. Index to Diseases and Injuries
2. Table of Neoplasms
3. Table of Drugs and Chemicals (includes extensive list of drugs, industrial solvents, corrosive gases, noxious plants, pesticides, and other toxic agents to identify poisonings and external causes of adverse effects)
4. External Cause of Injuries Index (includes codes and terms that describe environmental circumstances such as accidents or acts of violence and other conditions which may be the cause of injury or other adverse effects)

Main terms in the ICD-10-CM Alphabetic Index usually reference the disease, condition, or symptom. Subterms modify the main term to describe differences in site, etiology, or clinical type. Subterms add specificity to the main term.

EXAMPLE

Lesion(s) (nontraumatic)

abducens nerve --see Strabismus, paralytic, sixth nerve

alveolar process K08.9

angiocentric immunoproliferative D47.Z9

anorectal K62.9

In this example, the indented subterms abducens nerve, alveolar process, angiocentric immunoproliferative, and anorectal further define the type of lesion.

In the process of finding a code in the ICD-10-CM Alphabetic Index it is important to figure out the main term. It is almost never a body part or an adjective. For example, if a patient has leg pain, the main term is pain, not leg. If the term leg is referenced first in the Alphabetic Index, it indicates:

Leg—*see* condition

When the term Pain is referenced in the ICD-10-CM Alphabetic Index, there are three columns of subterms, including:

Pain(s) (*see also* Painful) R52

abdominal R10.9

colic R10.83

generalized R10.84

with acute abdomen R10.0

lower R10.30

To find a code, use both the ICD-10-CM Alphabetic Index and the Tabular List. Locate the main term in the Alphabetic Index, review the subterms, and see what code(s) it lists. The Tabular List is referenced with the code listed in the Alphabetic Index. Any instructional notes in the category should be reviewed and followed. Do not code from the Alphabetic Index alone. It is imperative that the Tabular List is referenced for guidance on the use of additional characters, alternative codes, exclusions, additional codes, and/or sequencing instructions.

EXAMPLE

A patient is diagnosed with arteriosclerosis with chronic total occlusion of the coronary artery. The main term referenced in the ICD-10-CM Alphabetic Index is Arteriosclerosis. The subterm coronary (artery) sends the user to the code I25.10. In the Tabular List, category I25 are instructions to use additional code to identify chronic total occlusion of the coronary artery with code I25.82. If the Tabular List was not referenced, the additional code would not be coded.

Tables

The ICD-10-CM Alphabetic Index contains two tables with which the biller should be familiar: the Table of Neoplasms and the Table of Drugs and Chemicals.

The Table of Neoplasms identifies neoplasms by behavior (Malignant Primary, Malignant Secondary, Ca (carcinoma) in situ, Benign, Uncertain Behavior, or Unspecified Behavior) and by anatomical location.

The correct code selection is driven by the behavior of the neoplasm documented in the medical record. If malignant, it is important to determine whether it is a primary or secondary

(metastatic) site. In sequencing neoplasm codes, first determine which neoplasm was treated on the day of the encounter. If the treatment is directed at a metastasis, it is appropriate to report the secondary site as the principal diagnosis. Billers should refer to the Alphabetic Index for additional guidelines.

- Malignant is a severe form of neoplasm having the property for destructive growth and metastasis.
- Malignant Primary describes the site of the original cancer.
- Malignant Secondary describes a cancer that has metastasized.
- Carcinoma in situ (Ca in situ) describes a neoplasm that is contained within the original site or location.
- Benign describes a neoplasm that does not invade surrounding tissue or undergo metastasis.
- Uncertain Behavior indicates microscopy was unable to determine the pathology of the neoplasm.
- Unspecified Behavior indicates documentation has insufficient data to be able to categorize the neoplasm.

Radiation therapy or chemotherapy treatment encounters for neoplasms are reported using Z codes.

BILLING TIP

ICD-10-CM contains Z codes to indicate when the reason for admission is radiotherapy, chemotherapy, or immunotherapy. When the patient is seen solely for the administration of chemotherapy, immunotherapy, or radiation therapy, the appropriate Z code should be reported as the primary diagnosis, followed by the ICD-10-CM code for the malignancy being treated on the date of service.

EXAMPLE

Z51.0 Encounter for antineoplastic radiation therapy

C01 Malignant neoplasm of base of tongue

The Table of Drugs and Chemicals is a table that contains a classification of drugs and other chemical substances to identify poisoning states and external causes of adverse effects (includes extensive list of drugs, industrial solvents, corrosive gases, noxious plants, pesticides, and other toxic agents to identify poisonings and external causes of adverse effects). Poisonings can be any of the following:

- Accidental overdose of a drug
- Wrong substance taken or given
- Drug taken inadvertently
- Accident in usage of drug
- Suicide attempt
- Assault

An adverse effect is when a correct substance is properly administered in therapeutic or prophylactic dosage and the patient has a reaction.

Below is a portion of the Neoplasm Table:

	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified Behavior
lung	C34.9-	C78.0-	D02.2-	D14.3-	D38.1	D49.1
azygos lobe	C34.1-	C78.0-	D02.2-	D14.3-	D38.1	D49.1
carina	C34.0-	C78.0-	D02.2-	D14.3-	D38.1	D49.1
hilus	C34.0-	C78.0-	D02.2-	D14.3-	D38.1	D49.1
linqula	C34.1-	C78.0-	D02.2-	D14.3-	D38.1	D49.1
lobe NEC	C34.9-	C78.0-	D02.2-	D14.3-	D38.1	D49.1

When documentation indicates a personal history of malignancy (does not indicate current treatment), it is appropriate to code the encounter with a history code, such as Z85.9 *Personal history of malignant neoplasm, unspecified*.

Below is a portion of the Table of Drugs and Chemicals.

	External Cause (T-Code)					
Substance	**Poisoning, Accidental unintentional**	**Poisoning, Intentional self-harm**	**Poisoning, Assault**	**Poisoning, Undetermined**	**Adverse Effect**	**Under-dosing**
Amitriptyline	T43.011	T43.012	T43.013	T43.014	T43.015	T43.016
Amitriptylinoxide	T43.011	T43.012	T43.013	T43.014	T43.015	T43.016
Amlexanox	T48.6X1	T48.6X2	T48.6X3	T48.6X4	T48.6X5	T48.6X6
Ammonia (fumes)(gas)(vapor)	T59.891	T59.892	T59.893	T59.894	------	------
aromatic spirit	T48.991	T48.992	T48.993	T48.994	T48.995	T48.996
liquid (household)	T54.3X1	T54.3X2	T54.3X3	T54.3X4	------	------
Ammoniated mercury	T49.0X1	T49.0X2	T49.0X3	T49.0X4	T49.0X5	T49.0X6
Ammonium						
acid tartrate	T49.5X1	T49.5X2	T49.5X3	T49.5X4	T49.5X5	T49.5X6
bromide	T42.6X1	T42.6X2	T42.6X3	T42.6X4	T42.6X5	T42.6X6
carbonate	T54.3X1	T54.3X2	T54.3X3	T54.3X4	------	------

External Cause of Injuries Index

The External Cause of Injuries Index includes codes and terms that describe environmental circumstances such as accidents or acts of violence and other conditions which may be the cause of injury or other adverse effects. An external cause code can be used with any code within the range of A00.0-T88.9, Z00-Z99. Never use an external cause code as the first-listed or principal diagnosis.

ICD-10-CM Conventions

The ICD-10-CM code book has established conventions for ease of reading, explanation, and use. Section I of the ICD-10-CM Official Guidelines for Coding and Reporting includes instructions for the conventions, general coding guidelines, and chapter specific guidelines. A biller needs to understand how to apply the conventions to ensure that the proper codes were reported on the claim in the proper order.

NEC = Not Elsewhere Classifiable

This abbreviation is used in both the ICD-10-CM Alphabetic Index and the Tabular List. It represents other specified code when the ICD-10-CM system does not provide a specific code for the patient's condition. Selecting a code with the NEC classification means that the provider documented more specific information regarding the patient's condition, but there is not a code to report the condition accurately.

EXAMPLE

The provider documents that a patient has a congenital cyst. When the main term Cyst is referenced in the ICD-10-CM Alphabetic Index with the subterm *congenital* NEC, it leads the coder to code Q89.8.

NOS = Not Otherwise Specified

This abbreviation is used in both the ICD-10-CM Alphabetic Index and the Tabular List. NOS is the equivalent of unspecified and is used only when the medical record lacks the information necessary to code to a more specific code.

EXAMPLE

The provider documents the patient has hypotension. When the main term Hypotension is referenced in the ICD-10-CM Alphabetic Index, it leads the coder to code I95.9.

BILLING TIP

With the advent of ICD-10-CM, some payers may refuse to pay unspecified codes. It may be necessary to review the documentation and/or query the provider if such a denial is received.

Punctuation

Brackets [ ] are used in the Tabular List to enclose synonyms, explanatory phrases, or alternate wording.

EXAMPLE

B20 Human immunodeficiency virus [HIV] disease

Brackets [ ] are used in the ICD-10-CM Alphabetic Index to identify manifestation codes.

EXAMPLE

Hepatitis

syphilitic (late) A52.74

congenital (early) A50.08 [K77]

late A50.59 [K77]

In this example, two codes are required to accurately report congenital syphilitic hepatitis: A50.08 *Early visceral congenital syphilis* and K77 *Liver disorders in diseases classified elsewhere.*

Parentheses ( ) are used in both the Alphabetic Index and Tabular list to enclose supplementary words that may be present or absent in the statement of a disease or procedure, without affecting the code number to which it is assigned. The terms in the parentheses are referred to as nonessential modifiers.

EXAMPLE

Cyst (colloid) (mucous) (simple) (retention)

In the Conventions section of the book, in the ICD-10-CM guidelines, there are important instructional notes listed that will help a biller ensure that the appropriate codes have been chosen.

Includes Notes: This note appears immediately under a three-character code title and provides further definition or gives examples.

Excludes Notes: There are two types of excludes notes. Each type of note has a different definition for use. They are similar in that they indicate that codes excluded from each other are independent of each other.

EXCLUDES1 A type 1 excludes note represents that the condition is NOT CODED HERE. This note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 note indicates when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition. Conditions listed with Excludes1 are mutually exclusive.

An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other. If it is not clear whether the two conditions involving an Excludes1 note are related or not, query the provider. For example, code F45.8 *Other somatoform disorders*, has an Excludes1 note for sleep related teeth grinding (G47.63), because teeth grinding is an inclusion term under F45.8. Only one of these two codes should be assigned for teeth grinding. However psychogenic dysmenorrhea is also an inclusion term under F45.8, and a patient could have both this condition and sleep related teeth grinding. In this case, the two conditions are clearly unrelated to each other, and so it would be appropriate to report F45.8 and G47.63 together.

EXCLUDES2 A type 2 excludes note represents that the condition is not included here. An Excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together.

EXAMPLE

N40 Benign prostatic hyperplasia

INCLUDES adenofibromatous hypertrophy of prostate
benign hypertrophy of the prostate
benign prostatic hyperplasia
benign prostatic hypertrophy
BPH
enlarged prostate
nodular prostate
polyp of prostate

EXCLUDES1 Benign neoplasms of prostate (adenoma, benign) (fibroadenoma) (fibroma) (myoma) (D29.1)

EXCLUDES2 Malignant neoplasm of prostate (C61)

In this example, the Includes note lists BPH as a diagnosis coded from category N40. The Excludes1 note states a diagnosis of a benign neoplasm of the prostate is coded to D29.1 and is not coded with codes from category N40. If the patient had both an enlarged prostate and a malignant neoplasm of the prostate, according to the Excludes2 note both are coded. If the patient only had a malignant neoplasm of the prostate, C61 is reported.

Sequencing instructions are also given in this section in the Etiology/Manifestation convention (code first, use additional code and in diseases classified elsewhere notes). Certain condi-

tions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. In these cases, ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation. Wherever such a combination exists, there is a "use additional code note at the etiology code, and a code first note at the manifestation code.

Code First

This notation is used in categories not intended to be the principal diagnosis. These codes are written in italics with a note. The note requires that the underlying disease (etiology) be recorded first, and the manifestation recorded second. The code first note will only appear in the Tabular List. This is why it is important to always verify codes in the Tabular List to assure proper code sequencing.

EXAMPLE

D63.0 *Anemia in neoplastic disease*

Code first neoplasm (C00-D49)

The Code First note indicates the code(s) listed should be sequenced first. If a female patient with right breast cancer has anemia due to the cancer, the proper codes and sequencing are C50.911, D63.0.

Use Additional Code

This notation is used to indicate that an additional code is needed to provide a more complete picture of the diagnosis, such as a manifestation. This notation indicates that the code(s) listed should be coded as additional (secondary) codes.

EXAMPLE

D70 Neutropenia

INCLUDES agranulocytosis
decreased absolute neurophile count (ANC)

Use additional code for any associated:

fever (R50.81)

mucositis (J34.81, K12.3-, K92.81, N76.81)

Examples of Additional Conventions used in the Tabular List are:

- Sex edits using symbols for male only and female only
- Age edits using letters A=Adult Age: 18–124; M=Maternity DX: 12–55; N=Newborn Age: 0 and P=Pediatric Age: 0–17
- Principal Diagnosis Flags are notated in blue highlighting for Manifestation code/not principal diagnosis and grey highlighting for Other Specified Code.

Examples of Additional Conventions used in the ICD-10-CM Alphabetic Index are:

- And - should be interpreted to mean either "and" or "or" when it appears in a title.
- With - should be interpreted to mean "associated with" or "due to" when it appears in a code title, the ICD-10-CM Alphabetic Index, or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. When the documentation specifically states the two conditions are unrelated, or when another guideline exists requiring documented linkage (for example, sepsis guidelines), the conditions are reported separately.

  The word "with" in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.
- See and See Also - The "see" instruction following a main term in the ICD-10-CM Alphabetic Index indicates that another term should be referenced. The "see also" instruction following a main term in the ICD-10-CM Alphabetic Index instructs that there is another main term that may also be referenced to select the correct code.
- Code also note - instructs the coder that two codes may be required to fully describe a condition, but this note does not provide sequencing direction. Sequencing depends on the circumstances of the encounter.

Examinees taking the CPB® exam are expected to be familiar with all conventions noted in the code book to accurately identify correct use of the ICD-10-CM codes.

Steps to Look up a Diagnosis Code

Determine the main term of the diagnosis documented in the medical record. This information usually is found in the assessment and plan of care on operative reports, progress notes, encounter form, billing form, or procedure notes. A coder must have a solid foundation in medical terminology and anatomy to effectively review the medical record and determine the documented diseases/conditions that should be reported.

Look up the main term in the ICD-10-CM Alphabetic Index. The main term is the disease, illness, or condition of the patient.

EXAMPLES

Diagnosis: Acute maxillary sinusitis	Main term: sinusitis
Diagnosis: Left knee pain	Main term: pain
Diagnosis: Intrinsic asthma with acute exacerbation	Main term: asthma

There may be additional descriptive terms that affect code selection such as chronic or acute. All subterms should be reviewed to determine the most specific code. All *see* and *see also* notes should be reviewed.

The code referenced in the ICD-10-CM Alphabetic Index should be looked up in the Tabular List. All the Includes, Excludes1, Excludes2, code first and use additional code instructions should be reviewed to verify accuracy of the code. The notations and conventions in the ICD-10-CM code book provide direction to the coder when a more appropriate code should be reported.

Section Review 4.1

1. Which statement is TRUE regarding the ICD-10-CM code book?

   A. Every code requires seven characters.
   B. The External Cause of Injuries Index is the first index found in the ICD-10-CM code book.
   C. An ICD-10-CM code can be reported directly from the ICD-10-CM Alphabetic Index.
   D. The abbreviation that indicates a provider has documented a specific diagnosis but there is not a code for that specificity is NEC.

2. If a patient has acute diastolic heart failure, what is the main term that is used in the ICD-10-CM Alphabetic Index?

   A. Heart
   B. Acute
   C. Failure
   D. Diastolic

3. Which sections of ICD-10-CM does a biller use to code for a physician's office?

   A. ICD-10-CM Alphabetic Index and Tabular List
   B. Alphabetic Index only
   C. Tabular List only
   D. ICD-10-CM and ICD-10-PCS

4. In looking at the following listing in the ICD-10-CM Alphabetic Index, what can you tell about the codes for curvature of the spine due to Charcot-Marie-Tooth disease?

   Curvature
   spine (acquired) (angular) (idiopathic) (incorrect) (postural) --*see* Dorsopathy, deforming
   congenital Q67.5
   due to or associated with
   Charcot-Marie-Tooth disease (*see also subcategory M49.8*) G60.0

   A. Only one code is required G60.0
   B. Two codes are required with a code from subcategory M49.8 coded first
   C. Two codes are required, and it does not matter which one is coded first
   D. Two codes may be required; double check the Tabular List to be sure both codes are accurate and determine which to code first.

5. In looking at the notes with this code, which statement is TRUE?

K67 *Disorders of peritoneum in infectious diseases classified elsewhere*

Code first underlying disease, such as:

congenital syphilis (A50.0)

helminthiasis (B65.0-B83.9)

Excludes1: *peritonitis in chlamydia (A74.81)*
peritonitis in diphtheria (A36.89)
peritonitis in gonococcal (A54.85)
peritonitis in syphilis (late) (A52.74)
peritonitis in tuberculosis (A18.31)

A. Code K67 may be a first-listed code

B. Code K67 may be coded with code A74.81

C. Code K67 may never be coded with codes A74.81, A36.89, A54.85, A52.74 and A18.31

D. Code K67 is a secondary code with codes A74.81, A36.89 or A52.74 being coded first

ICD-10-CM Official Guidelines for Coding and Reporting

CMS and National Center for Health Statistics (NCHS) provide the ICD-10-CM Official Guidelines for Coding and Reporting. These guidelines are found in the ICD-10-CM code book. The ICD-10-CM guidelines provide instructions for proper code selection and code sequencing rules. Section I of the ICD-10-CM guidelines includes conventions, general coding guidelines, and chapter specific guidelines.

Subsection A. Conventions for the ICD-10-CM includes the conventions and punctuation discussed in the beginning of this chapter.

Subsection B. General Coding Guidelines includes locating a code, details about the level of coding, signs and symptoms, conditions that are an integral part of a disease process, conditions that are not an integral part of a disease process, multiple coding for a single condition, acute and chronic condition, combination code, sequela (Late Effects), impending or threatened condition, reporting same diagnosis more than once, laterality, documentation for BMI, non-pressure ulcers and pressure ulcer stages, syndromes, documentation of complications of care, borderline diagnosis, and use of sign/symptom/unspecified codes .

Subsection C. Chapter-Specific Coding Guidelines detail specific rules concerning each chapter. A biller should be familiar with the location of these and how to apply them.

Referencing the Guidelines

Documenting the guidelines is done by referencing the section, chapter, and section of the guidelines being referenced. To understand the reference to the guidelines, start by looking through the Table of Contents for the guidelines provided at the beginning of the ICD-10-CM code book. For example, a documented reference appears as Section I.C.2.b.

This indicates the guideline is found in:

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

Section I.C. Chapter-Specific Coding Guidelines

Section I.C.2. Chapter 2: Neoplasms (C00-D49)

Section I.C.2.b. Treatment of secondary site

I.C.2.b is referencing the following guideline on treatments of secondary sites:

When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

EXAMPLE

In the ICD-10-CM guidelines, you will see (we have emphasized the guideline reference by using a red font below).

Section I. Conventions, General Coding Guidelines and Chapter Specific Guidelines

C. Chapter-Specific Coding Guidelines

4. Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00-E89)

a. Diabetes mellitus

The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system. As many codes within a particular category as are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for a particular encounter. Assign as many codes from categories E08-E13 as needed to identify all associated conditions that the patient has.

1) Type of diabetes - The age of a patient is not the sole determining factor, though most type 1 diabetics develop the condition before reaching puberty. For this reason, type 1 diabetes mellitus is also referred to as juvenile diabetes.

2) Type of diabetes mellitus not documented

If the type of diabetes mellitus is not documented in the medical record the default is E11.-, Type 2 diabetes mellitus.

3) Diabetes mellitus and the use of insulin and oral hypoglycemics

Section I. B. General Coding Guidelines

Use Both Alphabetic Index and Tabular List

Always use both Tabular List and Index to Diseases and Injuries (Alphabetic Index). Verify the code number in the Tabular List. Never code directly from the Alphabetic Index because important instructions often appear in the Tabular List. Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular List. A dash (-) at the end of an Alphabetic Index entry indicates additional characters are required. Even if a dash is not included at the Alphabetic Index entry, refer to the Tabular List to verify that no 7th character is required or that no additional notes exist which can impact code selection. To locate an ICD-10-CM code, take the following steps:

1. Locate each term in the Alphabetic Index:

- Locate the main term in the Index to Diseases and Injuries (Alphabetic Index).
- Refer to any notes under the main term.
- Read any terms enclosed in parentheses following the main term.
- Refer to any modifiers of the main term.
- Do not skip subterms indented under the main term.
- Follow any cross-reference instructions, such as *see also*.
- Use of a medical dictionary can help you to identify main terms and understand the disease process to assist with accurate coding.

EXAMPLE

COPD: This acronym is not found in the ICD-10-CM Alphabetic Index. A medical dictionary can tell you that COPD is an abbreviation for chronic obstructive pulmonary disease (a condition of the lungs). With this information, the coder will be able to identify the main term in the Alphabetic Index. In the Alphabetic Index, COPD can be found under Obstruction, obstructed, obstructive/lung/disease, chronic. The correct code is J44.9 *Chronic obstructive pulmonary disease, unspecified.*

Obstruction, obstructed, obstructive

lung J98.4

disease, chronic J44.9

There can be more than one way to find the correct code. For example, to find the code for COPD you could also locate it under Disease, diseased/pulmonary/chronic obstructive or Disease, diseased/lung/obstructive (chronic).

In searching the Alphabetic Index, if you start with the wrong main term, you may be directed to the correct term. For example, if you looked under the main term Pulmonary, there is a note informing you to *see* condition. This notation instructs you to look under the condition, not the anatomic site.

PRACTICAL CODING NOTE

When trying to determine the main term, it is sometimes helpful to read the diagnosis right to left. For example, Chronic Obstructive Pulmonary Disease (COPD) can be found by looking in the ICD-10-CM Alphabetic Index under Disease/pulmonary/chronic obstructive.

2. Verify the code in the Tabular List:

- Find the code in the Tabular List
- Review any category notes (located under the three-character category)
- Review notes for the code including Includes notes, Excludes1 and Excludes2 notes, code first notes, code additional notes, etc.

Level of Detail in Coding

Code to the highest degree of specificity. A three-character code may be used only when the category is not subdivided further. When a three-character code has subdivisions, the appropriate subdivision must be coded. The three-character category may be further subdivided by the use of 4th, 5th, and 6th characters, which provide greater detail. Codes may also require a 7th character extender. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.

Signs and Symptoms

Signs, symptoms, and ill-defined conditions may be coded in the medical record in the absence of a definitive diagnosis. Codes from Chapter 18 are considered general signs and symptoms. The use of codes from this section (R00-R99) may be appropriate to use when a more specific diagnosis cannot be made even after additional review of the patient's condition has been conducted. Possible, probable, suspected, questionable or rule out diagnoses should never be coded or reported in the outpatient setting. The condition should be coded that most accurately describes the encounters such as signs, symptoms, abnormal test results, or other reason(s) for the encounter. Do not code from this section when the symptom is considered an integral part of the disease process.

EXAMPLE

A physician documents "Cough, fever—Rule out pneumonia" on a patient in the office. In this instance, cough and fever are reported as the diagnoses because the physician has not confirmed the patient has pneumonia.

R05 *Cough*

R50.9 *Fever, unspecified*

In the inpatient setting for facility diagnosis coding, it is appropriate to report suspected or rule out diagnoses as if the condition does exist. This is only true for facility reporting for inpatient services, for all diagnoses *except* HIV. HIV is the only condition that must be confirmed if it is to be reported in the inpatient setting.

Conditions That Are an Integral Part of a Disease Process

Codes for symptoms, signs, and ill-defined conditions are not to be reported as diagnoses when a related definitive diagnosis has been established, unless otherwise instructed by the classification. If you are unsure if a symptom is part of a disease process, query the physician should be queried.

EXAMPLE

A patient presents with severe abdominal pain, nausea, and vomiting. The provider diagnoses the patient with acute appendicitis. In this case, only a code for the appendicitis is reported because the abdominal pain, nausea, and vomiting are symptoms of appendicitis. To locate the code, look for Appendicitis in the ICD-10-CM Alphabetic Index. Then, look for the subterm acute. No additional subterms apply in this example. The code referred to in the Alphabetic Index is K35.80, which must be confirmed by reviewing the code in the Tabular List.

Conditions That Are Not an Integral Part of a Disease Process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

EXAMPLE

A patient presents with nasal congestion and facial pain. The provider diagnoses the patient with acute frontal sinusitis. The patient also complains of constipation. A code is selected for the acute sinusitis and the constipation. The nasal congestion and facial pain are symptoms of the acute sinusitis (J01.10) and are not reported. Constipation (K59.00) is not related to the sinusitis and is reported separately.

J01.10 Acute frontal sinusitis, unspecified

K59.00 Constipation, unspecified

To locate the codes, look in the ICD-10-CM Alphabetic Index for the main term sinusitis, the subterm acute, and then the subterm frontal. You are directed to J01.10. Then, look for Constipation and you are directed to K59.00. Verify the code selection in the Tabular List.

Multiple Coding for a Single Condition

Multiple coding of diagnoses is required for certain conditions not subject to the rules for combination codes. Etiology/manifestation codes were discussed earlier with use additional code and code first notations. There are other single conditions that also require more than one code. Use additional code notes are found in the Tabular List on codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition.

a. ICD-10-CM Alphabetic Index: Codes for both etiology and manifestation of a disease appear following the subentry term, with the second code in brackets. Assign both codes in the same sequence in which they appear in the Alphabetic Index.

b. Tabular List: Instructional notes that indicate when to use more than one code:
   - Code first
   - Code, if applicable, any causal condition first
   - Code also
   - Use additional code

EXAMPLE

A patient is diagnosed with amyloid heart disease. In the ICD-10-CM Alphabetic Index, look for Disease, diseased/heart (organic)/amyloid. Two codes are listed on the same line — E85.4 [I43]. This indicates both codes are required to describe this diagnosis. In the Tabular List, verify the codes. Notice under the code I43 the instructional note "Code first underlying disease, such as: amyloidosis (E85.-)." This statement indicates that E85.4 *Organ-limited amyloidosis* should be listed first, followed by I43.

The correct diagnosis codes and sequencing are:

E85.4 Organ-limited amyloidosis

I43 Cardiomyopathy in diseases classified elsewhere

Combination Code

A combination code is used to fully identify an instance in which two diagnoses, or a diagnosis with an associated secondary process (manifestation) or complication, are included in the description of a single code number. Assign a combination code only when that code fully identifies the diagnostic conditions involved, or when instructed in the Alphabetic Index.

EXAMPLE

A patient has acute and chronic systolic heart failure. Instead of reporting code I50.21 *Acute systolic (congestive) heart failure* and I50.22 *Chronic systolic (congestive) heart failure*, report the combination code I50.23 *Acute on chronic systolic (congestive) heart failure*.

Look in the ICD-10-CM Alphabetic Index for Failure, failed/heart/systolic/acute/and (on) chronic (congestive) I50.23. Verify the code selection in the Tabular List.

Acute vs. Chronic

Codes often differentiate between acute and chronic manifestations of diseases. Acute refers to conditions that have sudden onset, relatively short duration and expected recovery or improvement. Chronic refers to conditions that are of longer duration and usually do not resolve completely over time. Chronic diseases are often punctuated by acute exacerbations or episodes of sudden worsening of the chronic condition that resolve with intervention leaving the patient at their baseline level.

When a code exists for acute exacerbation of a chronic condition, the combination code is reported. For example, J45.901 is used for asthma with (acute) exacerbation. There are instances when a patient will have both the acute form and the chronic form of a condition and there is not a combination code to report both. In this case, the acute code is sequenced first followed by the code for the chronic condition. For example, when a patient has both acute and chronic tonsillitis, it is reported as J03.90 *Acute tonsillitis* followed by J35.01 *Chronic tonsillitis*.

Sequela (Late Effects)

A sequela (late effect) is the residual effect or condition produced after the acute phase of an injury or illness has terminated. Key phrases such as "due to an old injury" or "due to previous illness" are indicators that the problem or condition may be a sequela. If these phrases are not present in the diagnostic statement, the injury or condition may be considered a sequela if sufficient time has elapsed between the original condition and sequela. There is no time limit on when a sequela code can be used. The residual effect may be apparent early after an acute phase of an illness, as in a cerebrovascular accident, or it may occur much later (one year or more), as with a previous injury or illness for example, following an auto accident.

When a patient is being treated for a condition that is a "late effect" of an earlier injury or disease, reference the main term sequela from the ICD-10-CM Alphabetic Index. Sequela should be coded according to the nature of the residual condition of the late effect. Two codes usually are required when coding sequela. The residual condition is coded first, and the code(s) for the cause of the sequela are coded as secondary. It may be necessary for the biller to go to the External Cause of Injuries Index to identify and reference the appropriate late effect of an external cause. The documentation in the medical record should support the manifestation or residual effect, as well as the cause.

The code for the cause of the sequelae may be used as a principal diagnosis when no residual diagnosis is identified. The code for the acute phase of an illness or injury that led to the late effect is never used with a sequela code.

The following examples are sequela and their cause:

- Limp due to old fracture of the right femur
- Traumatic arthritis following fracture of the right hand
- Facial droop following a stroke
- Scar contracture of the left elbow due to third degree burns

EXAMPLE

A patient is diagnosed with reflex sympathetic dystrophy in his right hand due to an old traumatic fracture of the hand. The reflex sympathetic dystrophy is the first-listed code, with the fracture of the hand being the secondary diagnosis. The codes reported and the sequencing they are reported in are:

G90.511 Complex regional pain syndrome I of right upper limb

S62.91XS Unspecified fracture of right wrist and hand, sequela

Impending or Threatened Condition

When a patient is discharged with a condition described as impending or threatened, review the ICD-10-CM Alphabetic Index for the subterm impending or threatened under the main term of the condition. Also reference impending or threatened as the main term. If a suitable code does not exist, report the signs and symptoms that led the provider to suspect an impending or threatened condition.

EXAMPLE

A pregnant patient is complaining of bloody discharge. She is admitted with a diagnosis of threatened abortion. When the main term *Threatened* with the sub-term *Abortion* is referenced in the ICD-10-CM Alphabetic Index, it sends the user to code O20.0 *Threatened abortion*. Since a code is listed, the sign/symptom of bloody discharge is not coded.

Reporting Same Diagnosis Code More than Once

Do not report the same diagnosis code more than once for an encounter. This applies to bilateral conditions when there is no distinct code(s) identifying laterality or two different conditions classified to the same ICD-10-CM diagnosis code.

Laterality

ICD-10-CM allows for the reporting of laterality (right, left, bilateral). For bilateral sites, the final character of the code indicates laterality. An unspecified side code is also provided when the side is not identified in the medical record. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side.

When a patient has a bilateral condition and each side is treated during separate encounters, assign the "bilateral" code (as the condition still exists on both sides), including for the encounter to treat the first side. For the second encounter for treatment after one side has previously been treated and the condition no longer exists on that side, assign the appropriate unilateral code for the side where the condition still exists (eg, cataract surgery performed on each eye in separate encounters). The bilateral code would not be assigned for the subsequent encounter, as the patient no longer has the condition in the previously treated site. If the treatment on the first side did not completely resolve the condition, then the bilateral code would still be appropriate.

EXAMPLE

When a patient complains of pain in his right and left leg, there are codes to distinguish between the right and left leg. Code M79.604 *Pain in right leg* and M79.605 *Pain in left leg* are both reported.

Documentation of BMI, Depth of Non-Pressure Ulcers, Pressure Ulcer Stages, Coma Scale, and NIH Stroke Scale

Codes for Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes can be reported based on documentation from any clinician involved in the patient's care.

For example, a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale. However, the associated diagnosis such as overweight, obesity, acute stroke, 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.

The BMI, coma scale, and NIHSS codes should be reported as secondary diagnoses.

EXAMPLE

A patient with a BMI of 39.8 has a stage 3 pressure ulcer on her right buttock. The correct codes are L89.313 *Pressure ulcer of right buttock, stage 3* and Z68.39 *Body mass index (BMI) 39.0-39.9, adult.*

Syndromes

When coding syndromes, if the syndrome is not located in the ICD-10-CM Alphabetic Index, code the patient's documented manifestations of the syndrome. For example, a patient is diagnosed with Alstrom syndrome (a rare genetic disease). From the Alphabetic Index, look for Syndrome/Alstrom. There is not a listing for syndrome or Alstrom. The coder must review the documentation to report the patient's signs and symptoms. 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.

General Coding Practices

The ICD-10-CM code book contains numerous general and specific practices for successful coding. Medical billers preparing and reviewing claims must be familiar with appropriate practices to bill accurately on behalf of a physician's office or other medical entity. The following are a few examples of coding practices that should be utilized and reflected on claims submitted to payers.

Documentation of Complications of Care

Not all conditions that occur during or following surgery or other medical care are classified as complications of care. To code a complication of care, there 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. Coders should query the provider for clarification, if the complication is not clearly documented.

Borderline Diagnosis

Borderline diagnoses are not the same as uncertain diagnoses. Borderline diagnoses are coded as confirmed diagnoses unless there is an index entry of borderline for that classification.

Use of Sign/Symptom/Unspecified Codes

Signs and symptoms are reported unless a definitive diagnosis has been established. Once the definitive diagnosis has been established, the definitive diagnosis is reported. When sufficient clinical information isn't known or is unavailable about a particular health condition to assign a more specific code, report the appropriate unspecified code.

Section I.C. Chapter-Specific Coding Guidelines

Chapter 20: External Causes of Morbidity (V00-Y99)

External cause codes are secondary to the diagnosis codes in Chapters 1–19 of ICD-10-CM. They are never a principal (first-listed) diagnosis. The external cause codes provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred, the activity of the patient at the time of the event and the person's status for example, civilian or military). Report all external cause codes needed to explain the injury or health condition.

Place of occurrence codes are reported to identify where an injury occurred such as in the patient's home or at a baseball field. Generally, a place of occurrence code is assigned only once, at the initial encounter for treatment. Do not use place of occurrence code Y92.9 *Unspecified place or not applicable* if the place is not stated or is not applicable.

The activity code is assigned from category Y93 to describe the activity of the patient at the time the injury or other health condition occurred. Do not assign Y93.9 *Activity, unspecified* if the activity is not stated.

If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:

- External codes for child and adult abuse take priority over all other external cause codes.
- External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
- External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse and terrorism.
- External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, child and adult abuse and terrorism.
- Activity and external cause status codes are assigned following all causal (intent) external cause codes.

The first-listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm, following the order of hierarchy listed above.

Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

Not all patient encounters are for a problem or condition. Chapter 21 of ICD-10-CM includes codes reported to identify the reason why the patient is receiving services when a disease or disorder is not the reason. Codes in this chapter are referred to as Z codes. There are many reasons that a person seeks health services, such as:

1) Contact/exposure - Category Z20 indicates contact with, and (suspected) exposure to, communicable diseases

2) Inoculations and vaccinations - Code Z23 *Encounter for immunization*.

3) Status - The patient is a carrier of a disease or has the sequela or residual of a past disease or condition.

4) History (of) - There are two types of history Z codes, personal and family.

5) Screening - The provider tests for a disease or disease precursors for early detection and treatment.

6) Observation - These codes are to be used as principal diagnosis only. The only exception to this is when the principal diagnosis is required to be a code from category Z38, *Liveborn infants according to place of birth and type of delivery*. Then a code from category Z05 *Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out*, is sequenced after the Z38 code. Additional codes may be added if they are unrelated to the suspected condition being observed.

7) Aftercare - Aftercare visit codes cover situations when the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease.

8) Follow up - The follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists. They should not be confused with aftercare codes, or injury codes with a 7th character for subsequent encounter, that explain ongoing care of a healing condition or its sequela. Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first, followed by the history code.

9) Donor - Codes in category Z52 *Donors of organs and tissues* are used for living individuals who are donating blood or other body tissue. These codes are only for individuals donating for others, not for self-donations. They are not used to identify cadaveric donations.

10) Counseling - Counseling Z codes are used when a patient or family member receives assistance in the aftermath of an illness or injury, or when support is required in coping with family or social problems. They are not used in conjunction with a diagnosis code when the counseling component of care is considered integral to standard treatment.

11) Encounters for Obstetrical and Reproductive Services - Z codes for pregnancy are for use in those circumstances when none of the problems or complications included in the codes from the Obstetrics chapter exist (a routine prenatal visit or postpartum care). Codes in category Z34 *Encounter for supervision of normal pregnancy* are always first-listed and are not to be used with any other code from the OB chapter. Codes in category Z3A, *Weeks of gestation*, may be assigned to provide additional information about the pregnancy. Category Z3A codes should not be assigned for pregnancies with abortive outcomes (categories O00-O08), elective termination of pregnancy Z codes, nor for postpartum conditions. The date of the admission should be used to determine weeks of gestation for inpatient admissions that encompass more than one gestational week. The outcome of delivery, category Z37, should be included on all maternal delivery records. It is always a secondary code. Codes in category Z37 should not be used on the newborn record. Z codes for family planning (contraceptive) or procreative management and counseling should be included on an obstetric record either during the pregnancy or the postpartum stage, if applicable.

12) Newborns and Infants -Newborn Z codes/categories: Z76.1 *Encounter for health supervision and care of foundling*, Z00.1 *Encounter for routine child health examination*, Z38 *Liveborn infants according to place of birth and type of delivery*

13) Routine and administrative examinations - The Z codes allow for the description of encounters for routine examinations, such as, a general check-up or examinations for administrative purposes, such as, a pre-employment physical. The codes are not to be used if the examination is for diagnosis of a suspected condition or for treatment purposes. In such cases the diagnosis code is used. During a routine exam, should a diagnosis or condition be discovered, it should be coded as an additional code. Pre-existing and chronic conditions and history codes may also be included as additional codes as long as the examination is for administrative purposes and not focused on any particular condition.

Z codes can be used in any healthcare setting. They can be sequenced as primary or secondary codes. There is a list of all the Z codes that can only be reported as the first listed diagnosis. The complete list can be found in Section I.C.21.c.16.

Section Review 4.2

1. What is/are the correct code(s) for a patient with type 1 diabetic neuropathy?

   A. E11.40
   B. E90.40
   C. E10.9, G62.9
   D. E10.40

2. How many chapters does ICD-10-CM contain?

   A. 17
   B. 19
   C. 21
   D. 20

3. What general guideline is addressed in I.C.1.a.2.c?

   A. Documentation unclear as to whether sepsis or severe sepsis is present on admission
   B. Other codes for MRSA
   C. Whether the patient is newly diagnosed
   D. Code only confirmed cases

4. What are the correct codes for benign hypertensive heart disease and stage 3 chronic kidney disease?

   A. I10, I11.9, I12.9, N18.3
   B. I13.10, N18.3
   C. N18.3, I13.10
   D. I13.0, N18.3

5. What is/are the correct code(s) for a patient with acute on chronic maxillary sinusitis?

   A. J01.00, J32.0
   B. J01.00
   C. J32.0, J01.00
   D. J01.01

Diagnosis Coding Guidelines for Outpatient Reporting

Diagnostic Coding and Reporting Guidelines for Outpatient Services is described in Section IV of the ICD-10-CM guidelines. These coding guidelines for outpatient diagnoses have been approved for use by hospitals/providers in coding and reporting hospital-based outpatient services and provider-based office visits. Review the following guideline sections for coding and reporting outpatient services. Locate Section IV in your ICD-10-CM code book to visualize where these guidelines are located.

Selection of First-Listed Condition

- In the outpatient setting, the term first-listed diagnosis 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 ICD-10-CM Alphabetic Index. Never begin searching initially in the Tabular List because this will lead to coding errors.

EXAMPLE

A middle-aged male presents with a complaint of constant facial pain. The physician ordered diagnostic tests to determine the source of the pain. The initial patient visit is completed with the diagnosis of facial pain (R51) because a definitive diagnosis had not yet been determined.

When a patient presents for outpatient surgery, the reason for the surgery is the first-listed diagnosis even if the surgery is not performed due to complications. When the patient presents for outpatient surgery and develops complications requiring admission to observation, the reason for the surgery is the first-listed diagnosis followed by the codes for the complication(s).

Codes from A00.00 through T88.9, Z00-Z99

The appropriate code(s) from A00.00 through T88.9 and Z00-Z99 must be used to identify diagnoses, signs, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

Accurate Reporting of ICD-10-CM Diagnosis Codes

For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient's condition using terminology that includes specific diagnoses, as well as symptoms, problems, or reasons for the encounter. There are ICD-10-CM codes to describe all of these situations.

EXAMPLE

The physician's documentation indicates that the patient has stable, benign hypertension (I10), with a new onset of nausea (R11.0) and blurred vision (H53.8).

Codes that Describe Symptoms and Signs

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a physician has not established (confirmed) the diagnosis. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00-R99) contains many, but not all, codes for symptoms.

EXAMPLE

Patient presents to the outpatient clinic complaining of abdominal cramps. The physician performed a complete history and physical examination and could not determine the cause of the cramps. The diagnosis code reported for this encounter is based on the symptom, which is the abdominal cramps (R10.9).

Encounters for Circumstances Other than a Disease or Injury

The Classification of Factors Influencing Health Status and Contact with Health Services (Z00-Z99) are provided to record healthcare encounters for circumstances other than a disease or injury.

EXAMPLE

Patient presents for follow-up visit after completing treatment for a malignant neoplasm. To locate the diagnosis code, look in the ICD-10-CM Alphabetic Index for Examination/follow-up (routine) (following)/malignant neoplasm to locate Z08.

Level of Detail in Coding

ICD-10-CM is composed of codes with three, four, five, six, or seven characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be subdivided further with use of additional characters, which

provide greater specificity. A three-character code is to be used only if it is not further subdivided.

Where further specificity is provided, additional characters must be assigned. A code is invalid if it has not been coded to the full number of characters (highest level of specificity) required for that code. See also Official ICD-10-CM Guidelines for Coding and Reporting, section I.B.2.

ICD-10-CM Code for the Diagnosis, Condition, Problem or Other Reason for the Encounter

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 responsible primarily for the services provided. List additional codes that describe any co-existing conditions.

EXAMPLE

The patient presents for evaluation of generalized osteoarthrosis, multiple sites. During the patient encounter, the physician also evaluates the patient's constipation and recommends a change in diet. Diagnosis codes for this encounter are M15.9 *Polyosteosteoarthritis, unspecified* and K59.00 *Constipation, unspecified.*

Uncertain Diagnosis

Do not code diagnoses documented as possible, probable, suspected, questionable, rule out, or working diagnosis. 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.

EXAMPLE

The patient presents to the emergency department with low back pain and hematuria. The physician dictates, "rule out kidney stone." Diagnosis codes for this encounter are M54.5 *Low back pain* and R31.9 *Hematuria, unspecified.* The rule out condition cannot be assigned a diagnosis code for outpatient services.

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(s).

EXAMPLE

A patient receives treatment every three months for chronic pancreatitis. A diagnosis code K86.1 *Other chronic pancreatitis* is assigned for each medical encounter.

Code All Documented Conditions that Coexist

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

EXAMPLE

The patient presents with chest pain. The patient's father has a prior diagnosis of ischemic heart disease. Diagnosis codes for this encounter include R07.9 *Chest pain,* unspecified and Z82.49 *Family history of ischemic heart disease and other diseases of the circulatory system.*

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 (for example, chronic conditions) may be sequenced as additional diagnoses.

For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign Z01.89 *Encounter for other specified special examinations.*

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). See also ICD-10-CM Official Guidelines for Coding and Reporting, section IV.K). This differs from coding practice in the hospital inpatient setting regarding abnormal findings on test results.

EXAMPLE

A patient presents for an MRI of the brain with the complaint of dizziness. This patient has been diagnosed with a malignant neoplasm of the bladder and is currently receiving chemotherapy treatment. The diagnosis code R42 *Dizziness and giddiness* is sequenced first because it is the primary reason for the

outpatient diagnostic service. Diagnosis code C67.9 *Malignant neoplasm of bladder, unspecified* may be sequenced as the secondary diagnosis code.

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 (for example, chronic conditions) may be sequenced as additional diagnoses.

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

EXAMPLE

A patient presents to the outpatient department for chemotherapy to treat cancer of the rectosigmoid junction. Diagnosis codes are sequenced as Z51.11 *Encounter for antineoplastic chemotherapy and C19 Malignant neoplasm of rectosigmoid junction.*

Patients Receiving Preoperative Evaluations Only

For patients receiving pre-operative evaluations only, sequence a code from subcategory Z01.81 *Encounter for pre-procedural examinations* to describe the pre-operative consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-operative evaluation.

EXAMPLE

A patient presents for a pre-operative screening chest X-ray prior to surgery for a unilateral inguinal hernia. The X-ray detects an undefined abnormality in the right lower lobe, and the radiologist recommends additional imaging studies. Diagnosis sequencing for this encounter includes:

Z01.818 Encounter for other preprocedural examination

K40.90 Unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent

R91.8 Other nonspecific abnormal finding of lung field

PRACTICAL CODING NOTE

Pre-operative screening exams are found in the ICD-10-CM Alphabetic Index by looking for Examination/pre-procedural (pre-operative).

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 because it is the most definitive.

Routine Outpatient Prenatal Visits

For routine outpatient prenatal visits when no complications are present, a code from category Z34 *Encounter for supervision of normal pregnancy* should be used as a principal diagnosis. These codes should not be used with chapter 15 codes. It would be inappropriate to code Z34.80 *Encounter for supervision of other normal pregnancy, unspecified trimester* if the patient is diagnosed with a condition that complicates the pregnancy.

For example, if a patient has gestational diabetes, the proper code is O24.419 *Gestational diabetes mellitus in pregnancy, unspecified control*. The 6th character is selected based on how the diabetes is controlled (diet, insulin, etc.).

Encounters for General Medical Examinations with Abnormal Findings

Patient's often see their medical provider for annual general medical examinations. During the examination, the provider may identify an abnormal finding. When this occurs, a code from subcategory Z00.0, for general adult medical examinations with the code for abnormal findings, is reported as the primary code. The abnormal findings are reported as additional codes. According to the ICD-10-CM guidelines, "An examination with abnormal findings refers to a condition/diagnosis that is newly identified or a change in severity of a chronic condition (such as uncontrolled hypertension, or an acute exacerbation of chronic obstructive pulmonary disease) during a routine physician examination."

Glossary

Acute—A condition with a rapid and short course.

Anatomical—Body site.

And—Can mean either "and" or "or" when it is in the code description.

Brackets [ ]—Symbol to enclose synonyms, alternate wording, or explanatory phrases.

Chronic—A condition that develops slowly and lasts a long time.

Combination Code—Single code used to classify two diagnoses.

External Codes—Codes reported to identify how an injury occurred and the location of where it occurred.

Etiology—Cause of the disease.

Eponym—Disease or syndrome named after a person.

Essential Modifiers—Subterms that are listed below the main term in alphabetical order and are indented.

Excludes1—Note to indicate the terms listed are to be reported with a code from another category.

Excludes2—Note indicates that the condition excluded is not part of the condition represented by the code. A patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together.

Includes—Note under a three-character category title to define further or to give an example of the contents of the category.

NEC—Not elsewhere classifiable.

Nonessential Modifiers—Subterms that follow the main term and are enclosed in parentheses. They can clarify the diagnosis but are not required.

NOS—Not otherwise specified.

Parentheses ( )—Symbol to enclose supplementary words that may be present or absent in the statement of a disease or procedure, without affecting the code number to which it is assigned.

See Also—Note that indicates additional information is available that may provide an additional diagnostic code.

See—Note that directs you to a more specific term under which the correct code can be found.

Sequela—A residual effect or condition produced after the acute portion of an injury or illness has passed.

Tabular List—Diagnosis codes organized in numerical order.

Unspecified—Codes are used when the information in the medical record is not available for coding more specifically.

Use Additional Code—Note instructing you report a second code, if the information is available, to provide a more complete picture of the diagnosis.

With—Means "associated with" or "due to" in a code title in the ICD-10-CM Alphabetic Index or an instructional note in the Tabular List.

Z Codes—Codes used to describe circumstances or conditions that could influence patient care.