PROVIDER POCKET TOOL

Coding Tips

ICD-10-CM

fallonhealth

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ICD-10-CM AND CLINICAL DOCUMENTATION

Physician documentation is necessary to determine the appropriate medical treatment for the patient and is the basis for coding and billing determinations (U.S. Department of Health & Human Services).

Documentation concepts important for ICD-10-CM include: comorbidities, manifestations, etiology/causation, complications, detailed anatomical location, sequelae, degree of functional impairment, biological and chemical agents, phase/stage, lymph node involvement, lateralization and localization and procedure or implant related. Understanding the increased specificity is needed in the clinical documentation in order to capture the complete and accurate clinical picture of the patient.

Here are some helpful resources to learn more about ICD-10-CM:

- **Centers for Medicare & Medicaid Services:** www.roadto10.org
- **Massachusetts Health Data Consortium:** www.mahealthdata.org
- **Massachusetts Medical Society:** www.massmed.org/Physicians/Practice-Management/ICD-10-Resources/ICD-10-Resources/#.VO95G2w5Dcs
- **Fallon Health:** fallonhealth.org/ICD-10
- **World Health Organization:** http://apps.who.int/classifications/apps/icd/ICD10Training/

Medical Record Requirements

The Centers for Medicare & Medicaid Services (CMS) require that all medical record note entries include the following criteria:

- Two patient identifiers on each page (Patient name and DOB)
- Date of service on each page
- The medical record must be **complete** and **legible**
- Face-to-face encounter
- Provider signature with credential and signature date (signature stamps are not acceptable to CMS)

Whether on an EMR, hybrid or paper chart, all of the above criteria apply. **Legibility is key!**

Reporting Guidelines for Outpatient Services

ICD-10-CM Official Guidelines for Coding and Reporting require that within the medical record notes:

- Be as detailed and specific as possible when documenting conditions.
- Identify etiology, anatomic site and severity. Specify the encounter as initial, subsequent and/or sequelae to support the appropriate diagnosis code.
- Document all conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management.
- Do not document conditions that no longer exist. However, historical conditions or family history should be documented if it has an impact on current care or influences treatment.

- Chronic conditions and all comorbidities should be evaluated, managed, documented and coded within a visit note at least once each calendar year. **Avoid under-coding chronic conditions.**

Evaluation Requirements

- Use demonstrative statements to explain the current status of conditions/diagnosis, such as:
    - Rheumatoid arthritis-stable on meds
    - Congestive heart failure-condition worsening
    - Chronic Obstructive Asthma-inhaler; no issues
    - Diabetes Mellitus, Hemoglobin A1C ordered
    - Hyperlipidemia, ordered Lipid Panel
- Avoid blanket statements such as "all conditions stable, continue on meds." Each documented condition requires individual assessment/evaluation.
- Documented evidence of evaluation—do not list the diagnosis. Be sure to incorporate all test results within the body of the note.

EMR Helpful Hints

- **Update assessments** according to what was treated and/or evaluated at the time of visit.
- Documentation within the problem list is not a substitute for clear documentation within the body of the progress note and does not satisfy CMS medical record requirements.

MENTAL, BEHAVIORAL AND NEURODEVELOPMENTAL DISORDERS

Mental, behavioral and neurodevelopmental disorders (chapter 5)* in ICD-10-CM includes disorders of psychological development. Within this chapter in ICD-10-CM there are many blocks as identified below:

ICD-10-CM	Description
F01-F09	Mental disorders due to known physiological conditions
F10-F19	Mental and behavioral disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
F30-F39	Mood (affective) disorders
F40-F48	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
F50-F59	Behavioral syndromes associated with physiological disturbances and physical factors
F60-F69	Disorders of adult personality and behavior
F70-F79	Intellectual disabilities
F80-F89	Pervasive and specific developmental disorders
F90-F98	Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99	Unspecified mental disorder

** Refer to DSM V Manual*

Example of mental disorders due to known physiological conditions:

ICD-10-CM	Description
F01	**Vascular dementia** Vascular dementia as a result of infarction of the brain due to vascular disease, including hypertensive cerebrovascular disease. Includes: arteriosclerotic dementia. Code first the underlying physiological condition or sequelae of cerebrovascular disease. **F01.5 Vascular dementia** **F01.50** Vascular dementia **without behavioral disturbance** **F01.51** Vascular dementia **with behavioral disturbance** Vascular dementia **with aggressive behavior** Vascular dementia **with combative behavior** Vascular dementia **with violent behavior** Use additional code, if applicable, to identify wandering in vascular dementia **(Z91.83)**

ICD-10-CM	Description
F02	**Dementia in other diseases classified elsewhere** Code first the underlying physiological condition, such as: • Alzheimer's **(G30.-)** • Cerebral lipidosis **(E75.4)** • Creutzfeldt-Jakob disease **(A81.0-)** • Dementia with Lewy bodies **(G31.83)** • Epilepsy and recurrent seizure **(G40.-)** • Frontotemporal dementia **(G31.09)** • Hepatolenticular degeneration **(E83.0)** • Human immunodeficiency virus (HIV) disease **(B20)** • Hypercalcemia **(E83.52)** • Hypothyroidism, acquired **(E00-E03.-)** • Intoxications **(T36-T65)** • Jakob-Creutzfeldt disease **(A81.0-)** • Multiple sclerosis **(G35)** • Neurosyphilis **(A52.17)** • Niacin deficiency (pellagra) **(E52)** • Parkinson's disease **(G20)** • Pick's disease **(G31.01)** • Polyarteritis nodosa **(M30.0)** • Systemic lupus erythematosus **(M32.-)** • Trypanosomiasis **(B56.-, B57.-)** • Vitamin B deficiency **(E53.8)** **Excludes 1: dementia with Parkinsonism (G31.83)**

ICD-10-CM	Description
F02 *(continued)*	**F02.8 Dementia in other diseases classified elsewhere** **F02.80** Dementia in other diseases classified elsewhere **without behavioral disturbances** Dementia in other diseases classified elsewhere NOS **F02.81** Dementia in other diseases classified elsewhere **with behavioral disturbances** Dementia in other diseases classified elsewhere **with aggressive behavior** Dementia in other diseases classified elsewhere **with combative behavior** Dementia in other diseases classified elsewhere **with violent behavior** Use additional code, if applicable, to identify wandering in dementia in conditions classified elsewhere **(Z91.83)**

ICD-10-CM	Description
F03	**Unspecified dementia** • Presenile dementia NOS • Presenile psychosis NOS • Primary degenerative dementia NOS • Senile dementia NOS • Senile dementia depressed or paranoid type • Senile psychosis NOS **Excludes 1: senility NOS (R41.81)** **F03.9 Unspecified dementia** **F03.90** Unspecified dementia ***without*** **behavioral disturbances** (Dementia NOS) **F03.91** Unspecified dementia ***with*** **behavioral disturbance** Unspecified dementia ***with*** **aggressive behavior** Unspecified dementia ***with*** **combative behavior** Unspecified dementia ***with*** **violent behavior** Use additional code, if applicable, to identify wandering in unspecified dementia **(Z91.83)**

Examples of mental and behavioral disorders due to psychoactive substance use:

ICD-10-CM	Description
F10	**Alcohol related disorders** (use additional code for blood alcohol levels, if applicable **(Y90.-)** **F10.1 Alcohol Abuse** **Excludes 1:** • Alcohol dependence **(F10.2-)** • Alcohol use, unspecified **(F10.9-)** **F10.10** Alcohol abuse, **uncomplicated** **F10.12** Alcohol abuse **with intoxication** **F10.120** Alcohol abuse with intoxication, **uncomplicated** **F10.121** Alcohol abuse with intoxication, **delirium** **F10.129** Alcohol abuse with intoxication, **unspecified** **F10.14** Alcohol abuse with **alcohol-induced mood disorder**
F10.2	**Alcohol Dependence** **Excludes 1:** • Alcohol abuse **(F10.1-)** • Alcohol use, unspecified **(F10.9-)** **F10.20** Alcohol dependence, **uncomplicated** **F10.21** Alcohol dependence, **in remission**

ICD-10-CM	Description
F11	**Opioid related disorders** **F11.2 Opioid dependence** **Excludes 1:** • Opioid abuse **(F11.1-)** • Opioid use, unspecified **(F11.9-)** **F11.20** Opioid dependence, **uncomplicated** **F11.21** Opioid dependence, **in remission**

Examples of conditions from the schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders:

ICD-10-CM	Description
F20	**Schizophrenia** **Excludes 1:** • brief psychotic disorder **(F23)** • cyclic schizophrenia **(F25.0)** • mood (affective) disorders with psychotic symptoms **(F30.2, F31.2, F31.5, F31.64, F32.3, F 33.3)** • Schizoaffective disorder **(F25.-)** • Schizophrenic reaction NOS **(F23)** **F20.0** **Paranoid** schizophrenia • Paraphrenic schizophrenia **Excludes 1:** • Involutional paranoid state **(F22)** • Paranoia **(F22)**

ICD-10-CM	Description
F20 *(continued)*	**F20.1** **Disorganized** schizophrenia • Hebephrenic schizophrenia • Hebephrenia **F20.2** **Catatonic** schizophrenia • Schizophrenic catalepsy • Schizophrenic catatonia • Schizophrenic flexibilitas cerea **Excludes 1:** • catatonic stupor **(R40.1)** **F20.3** **Undifferentiated** schizophrenia • Atypical schizophrenia **Excludes 1:** • acute schizophrenia-like psychotic disorder **(F23)** **F20.5** **Residual** schizophrenia • Restzustand (schizophrenic) • Schizophrenic residual state **F20.8** **Other** schizophrenia **F20.81** **Schizophreniform disorder** • Schizophreniform psychosis NOS **F20.89** **Other schizophrenia** • Cenesthopathic schizophrenia • Simple schizophrenia
F20.9	**Schizophrenia, *unspecified***

Examples of conditions from the mood (affective) disorders:

ICD-10-CM	Description
F31	**Bipolar disorder** • Manic depressive illness • Manic depressive psychosis • Manic depressive reaction **Excludes 1:** • bipolar disorder, single manic episode **(F30.-)** • major depressive disorder, single episode **(F32.-)** • major depressive disorder, recurrent **(F33.-)** **F31.0** Bipolar disorder, current episode **hypomanic** **F31.1** Bipolar disorder, current episode **manic without psychotic features** **F31.10** Bipolar disorder, current episode manic without psychotic features, **unspecified** **F31.11** Bipolar disorder, current episode manic without psychotic features, **mild** **F31.12** Bipolar disorder, current episode manic without psychotic features, **moderate** **F31.13** Bipolar disorder, current episode manic without psychotic features, **severe**

ICD-10-CM	Description
F32	**Major depressive disorder, single episode** • Single episode of **agitated depression** • Single episode of **depressive reaction** • Single episode of **major depression** • Single episode of **psychogenic depression** • Single episode of **reactive depression** • Single episode of **vital depression** **Excludes 1:** • bipolar disorder **(F31.-)** • manic episode **(F30.-)** • recurrent depressive disorder **(F33.-)** **F32.0** Major depressive disorder, single episode, **mild** **F32.1** Major depressive disorder, single episode, **moderate** **F32.2** Major depressive disorder, single episode, **severe without psychotic features**

ICD-10-CM	Description	
F32 *(continued)*	**F32.3**	Major depressive disorder, single episode **severe with psychotic features** • Single episode of major depression with **mood-congruent psychotic symptoms** • Single episode of major depression with **mood-incongruent psychotic symptoms** • Single episode of major depression with **psychotic symptoms** • Single episode of **psychogenic depressive psychosis** • Single episode of **psychotic depression** • Single episode of **reactive depressive psychosis**
	F32.4	Major depressive disorder, single episode **in partial remission**
	F32.5	Major depressive disorder, single episode **in full remission**
	F32.8	Other depressive episodes • Atypical depression • Post-schizophrenic depression • Single episode of 'masked' depression NOS
	F32.9	Major depressive disorder, single episode, **unspecified** • Depression NOS • Depressive disorder NOS • Major depression NOS

DIABETES MELLITUS

Diabetes codes in ICD-10-CM are combination codes that include:

- Type of diabetes mellitus
- Body system affected
- The complication affecting the body system

There are five diabetes mellitus categories in the ICD-10-CM:

E08	Diabetes mellitus due to an underlying condition
E09	Drug or chemical induced diabetes mellitus
E10	Type 1 diabetes mellitus
E11	Type 2 diabetes mellitus
E13	Other specified diabetes mellitus

DIABETIC MANIFESTATIONS

When coding for diabetic manifestations in ICD-10-CM, if there is no "use an additional code" instruction, the combination code for type and manifestation is the only code reported. Providers need to document a cause and effect relationship in the documentation as coders can't assume a causal relationship (Coding Clinic, 2002, Q1).

Use additional code to identify any insulin use **(Z79.4).**

Examples of Diabetes Mellitus (DM) Type 2	
E11	**Type 2 diabetes mellitus** Includes: diabetes (mellitus) due to insulin secretory defect; diabetes NOS; insulin resistant diabetes (mellitus) Use additional code to identify any insulin use **(Z79.4)**

Examples of DM Type 2 with Kidney Complications	
E11.2	**Type 2 diabetes mellitus with kidney complications** **E11.21** Type 2 diabetes mellitus **with diabetic nephropathy** Type 2 diabetes mellitus **with intercapillary glomerulosclerosis** Type 2 diabetes mellitus **with intracapillary glomerulosclerosis** Type 2 diabetes mellitus **with Kimmelstiel-Wilson disease** **E11.22** Type 2 diabetes mellitus **with diabetic chronic kidney disease** Type 2 DM with **chronic kidney disease due to conditions classified to .21 and .22** Use additional code to identify stage of chronic kidney disease **(N18.1-N18.6)** **E11.29** Type 2 diabetes mellitus **with other diabetic kidney complication** • Type 2 diabetes mellitus with renal tubular degeneration

Examples of DM Type 2 with Ophthalmic Complications	
E11.3	**Type 2 diabetes mellitus with ophthalmic complications**
E11.31	**Type 2 diabetes mellitus with unspecified diabetic retinopathy** **E11.311** Type 2 diabetes mellitus **with unspecified diabetic retinopathy *with* macular edema** **E11.319** Type 2 diabetes mellitus **with unspecified diabetic retinopathy *without* macular edema**
E11.32	**Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy** • Type 2 diabetes with nonproliferative diabetic retinopathy NOS **E11.321** Type 2 diabetes mellitus **with mild nonproliferative diabetic retinopathy *with* macular edema** **E11.329** Type 2 diabetes mellitus **with unspecified diabetic retinopathy *without* macular edema**
E11.33	**Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy** **E11.331** Type 2 diabetes mellitus **moderate nonproliferative diabetic retinopathy *with* macular edema** **E11.339** Type 2 diabetes mellitus **moderate nonproliferative diabetic retinopathy *without* macular edema**

Examples of DM Type 2 with Ophthalmic Complications	
E11.34	**Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy** **E11.341** Type 2 diabetes mellitus **with severe nonproliferative diabetic retinopathy *with* macula edema** **E11.349** Type 2 diabetes mellitus **with severe nonproliferative diabetic retinopathy *without* macula edema**
E11.35	**Type 2 diabetes mellitus with proliferative diabetic retinopathy** **E11.351** Type 2 diabetes mellitus **with proliferative diabetic retinopathy *with* macular edema** **E11.359** Type 2 diabetes mellitus **with proliferative diabetic retinopathy *without* macular edema**
E11.36	**Type 2 diabetes mellitus with diabetic cataract**
E11.39	**Type 2 diabetes mellitus with other diabetic ophthalmic complication**

Examples of DM Type 2 with Neurological Complications	
E11.4	**Type 2 diabetes mellitus with neurological complications** **E11.40** Type 2 diabetes mellitus **with diabetic neuropathy, unspecified** **E11.41** Type 2 diabetes mellitus **with diabetic mononeuropathy** **E11.42** Type 2 diabetes mellitus **with diabetic polyneuropathy** Type 2 diabetes **with diabetic neuralgia** **E11.43** Type 2 diabetes mellitus **with diabetic autonomic (poly)neuropathy** Type 2 diabetes **with diabetic gastroparesis** **E11.44** Type 2 diabetes **with diabetic amyotrophy** **E11.49** Type 2 diabetes **with other diabetic neurological complication**

Examples of DM Type 2 Circulatory Complications	
E11.5	**Type 2 diabetes with circulatory complications** **E11.51** Type 2 diabetes **with diabetic peripheral angiopathy *without* gangrene** **E11.52** Type 2 diabetes **with diabetic peripheral angiopathy *with* gangrene** **E11.59** Type 2 diabetes mellitus **with other circulatory complications**
E11.6	**Type 2 diabetes mellitus with other specified complications**
E11.61	**Type 2 diabetes mellitus with diabetic arthropathy** **E11.610** Type 2 diabetes mellitus **with diabetic neuropathic arthropathy** Type 2 diabetes mellitus **with Charcot's joints** **E11.618** Type 2 diabetes mellitus **with other diabetic arthropathy**

Examples of DM Type 2 Circulatory Complications	
E11.62	**Type 2 diabetes with skin complications** **E11.620** Type 2 diabetes mellitus **with diabetic dermatitis** **E11.621** Type 2 diabetes mellitus **with foot ulcer** (Use additional code to identify site of ulcer **L97.4-, L97.5-**) **E11.622** Type 2 diabetes mellitus **with other skin ulcer** (Use additional code to identify site of ulcer **L97.1-L97.9, L98.41-L98.49**) **E11.628** Type 2 diabetes mellitus **with other skin complications**
E11.63	**Type 2 diabetes mellitus with oral complications** **E11.630** Type 2 diabetes mellitus **with periodontal disease** **E11.638** Type 2 diabetes mellitus **with other oral complications**

Examples of DM Type 2 Circulatory Complications	
E11.64	**Type 2 diabetes with hypoglycemia** **E11.641** Type 2 diabetes mellitus **with hypoglycemia *with* coma** **E11.649** Type 2 diabetes mellitus **with hypoglycemia *without* coma**
E11.65	**Type 2 diabetes mellitus with hyperglycemia**
E11.69	**Type 2 diabetes mellitus with other specified complication** (Use additional code to identify complication)
E11.8	**Type 2 diabetes mellitus *with* unspecified complications**
E11.9	**Type 2 diabetes mellitus *without* complications**

Examples of DM Type 2 Circulatory Complications	
E13	**Other specified diabetes mellitus: (E13.0 - E13.9)** **Includes:** • Diabetes due to genetic defects of beta-cell function • Diabetes mellitus due to genetic defects in insulin action • Postpancreatectomy diabetes mellitus • Secondary diabetes mellitus NEC Use additional code to identify any insulin use **(Z79.4)** **Excludes 1:** • Diabetes mellitus due to autoimmune process **(E10.-)** • Diabetes mellitus due to immune mediated pancreatic islet beta-cell destruction **(E10.-)** • Diabetes mellitus due to underlying condition **(E08.-)** • Drug or chemical induced diabetes mellitus **(E09.1-)** • Gestational diabetes **(024.4-)** • Neonatal diabetes mellitus **(P70.2)** • Type 2 diabetes mellitus **(E11.-)**

CHRONIC KIDNEY DISEASE

What to remember

CMS medical documentation guidelines require that the medical record substantiates what stage a member is in, as well as clearly document the condition with the terminology of "chronic kidney disease" (CKD).

ICD-10-CM	Description	GFR Kidney Function
N18.1	Chronic kidney disease: **Stage 1**	> or equal to 90
N18.2	Chronic kidney disease: **Stage 2 (mild)**	60-89
N18.3	Chronic kidney disease: **Stage 3 (mod)**	30-59
N18.4	Chronic kidney disease: **Stage 4 (severe)**	15-29
N18.5	Chronic kidney disease: **Stage 5** **Excludes 1:** CKD, Stage 5 requiring dialysis **(N18.6)**	< 15

ICD-10-CM	Description	GFR Kidney Function
N18.6	**End Stage renal disease** • CKD requiring chronic dialysis • Use additional code to identify dialysis status **(Z99.2)**	< 15
N18.9	**Chronic kidney disease, unspecified** • Chronic renal disease • Chronic renal failure NOS • Chronic renal insufficiency • Chronic uremia • Renal disease NOS	
N19	**Unspecified kidney failure** • Uremia NOS **Excludes 1:** • Acute kidney failure **(N17.-)** • Chronic kidney disease **(N18.-)** • Chronic uremia **(N18.9)** • Extrarenal uremia **(R39.2)** • Prerenal uremia **(R39.2)** • Renal insufficiency (acute) **(N28.9)** • Uremia of newborn **(P96.0)**	

Clearly document within the visit note if the patient is on dialysis.

PERIPHERAL VASCULAR DISEASE

Atherosclerosis of Extremities

Atherosclerosis of the extremities requires very specific documentation to capture the correct code, for example: type of artery, type of bypass graft(s), location, laterality, symptomology, and complications as indicated.

Examples of atherosclerosis of extremities include:

ICD-10-CM	Description
I70.21	Atherosclerosis of *native arteries of extremities* **with intermittent claudication**
I70.211	Atherosclerosis of *native arteries of extremities* **with intermittent claudication, *right* leg**
I70.212	Atherosclerosis of *native arteries of extremities* **with intermittent claudication, *left* leg**
I70.213	Atherosclerosis of *native arteries of extremities* **with intermittent claudication, *bilateral* legs**
I70.22	Atherosclerosis of *native arteries of extremities* **with rest pain**
170.221	Atherosclerosis of *native arteries of extremities* **with rest pain, *right* leg**
I70.222	Atherosclerosis of *native arteries of extremities* **with rest pain, *left* leg**

ICD-10-CM	Description
I70.223	Atherosclerosis of *native arteries of extremities* **with rest pain, *bilateral* legs**
I70.23	Atherosclerosis of *native arteries of right leg* **with ulceration** (Includes any condition classifiable to **170.211** and **170.221**) Use additional code to identify severity of ulcer (**L97.-** with fifth character 1)
I70.231	Atherosclerosis of *native arteries of right leg* **with ulceration of thigh**
I70.232	Atherosclerosis of *native arteries of right leg* **with ulceration of calf**
I70.233	Atherosclerosis of *native arteries of right leg* **with ulceration of ankle**
I70.234	Atherosclerosis of *native arteries of right leg* **with ulceration of heel and midfoot**
I70.26	Atherosclerosis of *native arteries of extremities* **with gangrene** (Includes any condition classifiable to **I70.21-, I70.22-, I70.23-, I70.24-, I70.25-)** Use additional code to identify the severity of any ulcer **(L98.49-),** if applicable
I70.261	Atherosclerosis of *native arteries of extremities* **with gangrene, right leg**
I70.262	Atherosclerosis of *native arteries of extremities* **with gangrene, left leg**
I70.263	Atherosclerosis of *native arteries of extremities* **with gangrene, bilateral legs**

CEREBROVASCULAR DISEASE

Coding for an active CVA is only used when the event is occurring and up to the discharge from the hospital for an acute CVA. Once a patient is discharged from the hospital the condition is no longer considered active but should be coded as a "history of" CVA.

Documentation of cerebrovascular diseases requires specific information such as location, type of artery involved, cause (due to), disease versus hemorrhage.

It is important to document the deficits (late effects, sequelae) resulting from a CVA. The sequelae include conditions specified as such or as residuals which may occur at any time after the onset of the causal condition.

Example of Late affect Conditions

Hemiplegia, hemiparesis, and monoplegia following cerebrovascular disease **(ICD10 category I69.9-)**

When documenting a hemiplegia and hemiparesis in a patient medical record, the provider needs to state the side of the body that is affected (ex: dominant, non-dominant, right or left side).

PRESSURE ULCERS

Documentation for pressure ulcers should include the term "pressure ulcer" or other such terms inclusive under this term in ICD-10-CM including: Bed sore, Decubitus ulcer, Plaster ulcer, Pressure area, and Pressure sore along with location, stage, and laterality as appropriate.

0	=	Unstageable
1	=	Stage I
2	=	Stage II
3	=	Stage III
4	=	Stage IV
9	=	Unspecified Stage

Examples of Pressure Ulcer Codes:

ICD-10-CM	Description
L89.00-	**Pressure ulcer of *unspecified* elbow** **L89.000** Pressure ulcer of unspecified elbow, **unstageable** **L89.001** Pressure ulcer of unspecified elbow, **stage 1** **L89.002** Pressure ulcer of unspecified elbow, **stage 2** **L89.003** Pressure ulcer of unspecified elbow, **stage 3** **L89.004** Pressure ulcer of unspecified elbow, **stage 4** **L89.009** Pressure ulcer of unspecified elbow, **unspecified stage**
L89.01-	**Pressure ulcer of *right* elbow** **L89.010** Pressure ulcer right elbow, **unstageable** **L89.011** Pressure ulcer of right elbow, **stage 1** **L89.012** Pressure ulcer of right elbow, **stage 2** **L89.013** Pressure ulcer of right elbow, **stage 3** **L89.014** Pressure ulcer of right elbow, **stage 4** **L89.019** Pressure ulcer of right elbow, **unspecified stage**

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

It is important to document whether COPD is related to another diagnosis, for example, emphysema, asthma or bronchitis.

COPD Code Examples:

ICD-10-CM	Description
J40	**Bronchitis, not specified as acute or chronic** • Bronchitis, NOS • Bronchitis with tracheitis NOS • Catarrhal bronchitis • Tracheobronchitis NOS
J41.-	**Simple and mucopurlent chronic bronchitis** **J41.0** **Simple** chronic bronchitis **J41.1** **Mucopurulent** chronic bronchitis **J41.8** **Mixed** simple and mucopurulent chronic bronchitis

ICD-10-CM	Description
J42	**Unspecified chronic bronchitis** • Chronic bronchitis NOS • Chronic tracheitis • Chronic tracheobronchitis
J43.-	**Emphysema**
J44.-	**Other chronic obstructive pulmonary disease** • Asthma with COPD • Chronic asthmatic (obstructive) bronchitis • Chronic bronchitis airways obstruction • Chronic bronchitis with emphysema • Chronic emphysematous bronchitis • Chronic obstructive asthma • Chronic obstructive bronchitis • Chronic obstructive tracheobronchitis • Chronic obstructive with (acute) exacerbation Code also type of asthma, if applicable **(J45.-)**

ASTHMA

Documentation and appropriate coding for Asthma needs to be described in the documentation using terms such as: mild intermittent, mild persistent, moderate persistent, severe persistent, or unspecified. Within each of these descriptors are choices for uncomplicated, exacerbated, or with status asthmaticus. **Reminder:** For COPD with asthma, a second code from category **J45.-** is needed to identify the type of asthma.

Asthma Code Examples:

ICD-10-CM	Description	
J45.2-	**Mild intermittent asthma**	
	J45.20	**Mild intermittent** asthma, **uncomplicated**
		Mild intermittent asthma, **NOS**
	J45.21	**Mild intermittent** asthma with (acute) **exacerbation**
	J45.22	**Mild intermittent** asthma with **status asthmaticus**

ICD-10-CM	Description
J45.3-	**Mild persistent asthma** **J45.30** **Mild persistent** asthma, **uncomplicated** **Mild persistent** asthma, **NOS** **J45.31** **Mild persistent** asthma with (acute) **exacerbation** **J45.32** **Mild persistent** asthma with **status asthmaticus**
J45.4-	**Moderate persistent asthma** **J45.40** **Moderate persistent** asthma, **uncomplicated** **Moderate persistent** asthma, **NOS** **J45.41** **Moderate persistent** asthma, with (acute) **exacerbation** **J45.42** **Moderate persistent** asthma, with **status asthmaticus**
J45.5-	**Severe persistent asthma** **J45.50** **Severe persistent** asthma, **uncomplicated** **Severe persistent** asthma, **NOS** **J45.51** **Severe persistent** asthma with (acute) **exacerbation** **J45.52** **Severe persistent** asthma with **status asthmaticus**

ICD-10-CM	Description
J45.9-	**Other and unspecified asthma** **J45.90** **Unspecified** asthma Asthmatic bronchitis NOS Childhood asthma NOS Late onset asthma **J45.901** **Unspecified** asthma with (acute) **exacerbation** **J45.902** **Unspecified** asthma with **status asthmaticus** **J45.909** **Unspecified** asthma, **uncomplicated** Asthma NOS
J45.99	**Other asthma** **J45.990** Exercise induced bronchospasm **J45.991** **Cough variant** asthma **J45.998** Other asthma

CORONARY ARTERY DISEASE

The appropriate code assignments will depend on the specificity of the documentation. For example, if a patient has CAD and there is no past history of bypass surgery and no angina, then it is appropriate to assign code **I25.10** to identify Atherosclerotic heart disease of **native coronary without angina pectoris.**

Some examples of the combination codes for angina associated with atherosclerotic heart disease include:

ICD-10-CM	Description
I23	Certain current complications following ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction (within the 28 day period) A code from category **I23** must be used in conjunction with a code from category **I21** (STEMI) or category **I22** (NONSTEMI). The **I23.-** code should be sequenced first, if it is the reason for the encounter, or, it should be sequenced after the **I21** or **I22** code if the complication of the MI occurs during the encounter for the MI. **I23.7** Post infarction angina

ICD-10-CM	Description
I25.11	Atherosclerotic heart disease of **native coronary artery with angina pectoris** **I25.110** Atherosclerotic heart disease of **native coronary artery with unstable angina pectoris** **I25.111** Atherosclerotic heart disease of **native coronary artery with angina pectoris with documented spasm**
I25.70	Atherosclerosis of coronary artery **bypass graft(s) unspecified, with angina pectoris** **I25.700** Atherosclerosis of coronary artery **bypass graft(s) unspecified, with unstable angina pectoris** **I25.701** Atherosclerosis of coronary artery **bypass graft(s) unspecified, with angina pectoris with documented spasm**
I25.75	Atherosclerosis of native coronary artery of transplanted heart, **with angina pectoris** **I25.750** Atherosclerosis of native coronary artery of transplanted heart **with unstable angina.** **I25.751** Atherosclerosis of native coronary artery of transplanted heart with angina pectoris **with documented spasm**

LIVER DISEASE

Hepatitis

Documentation of hepatitis should state whether it is acute, chronic or viral. The tables below are examples of some common types of hepatitis.

ICD-10-CM	Description
K73	**Chronic hepatitis, not elsewhere classified** **Excludes:** • Alcoholic hepatitis (chronic **K70.1-**) • Drug-induced hepatitis (chronic) (**K71.-**) • Granulomatous hepatitis (chronic) NEC (**K75.3**) • Reactive non-specific hepatitis (chronic) (**K75.2**) • Viral hepatitis (chronic) (**B15-B19**) **K73.0** Chronic **persistent** hepatitis, not elsewhere classified **K73.1** Chronic **lobular** hepatitis, not elsewhere classified **K73.2** Chronic **active** hepatitis, not elsewhere classified **K73.8** **Other chronic hepatitis, not elsewhere classified** **K73.9** **Chronic hepatitis, unspecified**

Examples of acute viral hepatitis:

ICD-10-CM	Description
B15	**Acute Hepatitis A**
	B15.0 Hepatitis A ***with*** **hepatic coma**
	B15.9 Hepatitis A ***without*** **hepatic coma** Hepatitis A (Acute) (viral) NOS
B16	**Acute Hepatitis B**
	B16.0 Acute Hepatitis B **with delta agent *with* hepatic coma**
	B16.1 Acute Hepatitis B **with delta agent *without* hepatic coma**
	B16.2 Acute Hepatitis B **without delta agent *with* hepatic coma**
	B16.9 Acute Hepatitis B **without delta agent *without* hepatic coma** Hepatitis B (Acute) (Viral) NOS

Examples of chronic viral hepatitis:

ICD-10-CM	Description
B18	**Chronic viral hepatitis**
	B18.0 Chronic viral hepatitis B ***with*** **delta-agent**
	B18.1 Chronic viral hepatitis B ***without*** **delta-agent** Chronic (viral) hepatitis B
	B18.2 Chronic viral **hepatitis C**
	B18.8 Other chronic viral hepatitis
	B18.9 Chronic viral hepatitis, unspecified

Alcoholic liver disease is in the **K70** code category within this group. Use additional code to identify alcohol abuse and dependence **(F10.-). Alcoholic fatty liver** is assigned to code **K70.0,** the most common liver problem experienced by people who are alcohol dependent.

Examples of the alcoholic liver diseases:

ICD-10-CM	Description
K70.1	**Alcoholic Hepatitis** **K70.10** Alcoholic hepatitis ***without*** **ascites** **K70.11** Alcoholic hepatitis ***with*** **ascites**
K70.2	Alcoholic **fibrosis and sclerosis** of liver
K70.3	**Alcoholic cirrhosis of liver** **Alcoholic cirrhosis NOS** **K70.30** Alcoholic cirrhosis of liver ***without*** **ascites** **K70.31** Alcoholic cirrhosis of liver ***with*** **ascites**

Examples of other diseases of the liver:

ICD-10-CM	Description
K76.0	**Fatty (change of) liver, not elsewhere classified** Nonalcoholic fatty liver disease (NAFLD) **Excludes 1:** nonalcoholic steatohepatitis (NASH) (K75.81)
K76.6	**Portal hypertension** (Use additional code for any associated complications, such as: portal hypertensive gastropathy **(K31.89)**
K76.89	**Other specified diseases of the liver** • Cyst (simple) of liver • Focal nodular hyperplasia of liver • Hepatoptosis

Cirrhosis

ICD-10-CM includes codes for fibrosis and cirrhosis of the liver (**K74** code category). Documentation should describe the patient's condition fully to support the appropriate level of code.

Examples of fibrosis and cirrhosis of the liver:

ICD-10-CM	Description
K74	**Fibrosis and cirrhosis of the liver** Code also, if applicable, viral hepatitis, (acute) (chronic) **B15-B19** **Excludes 1:** • Alcoholic cirrhosis of liver **(K70.3)** • Alcoholic fibrosis of liver **(K70.2)** • Cardiac sclerosis of liver **(K76.1)** • Cirrhosis of liver with toxic liver disease **(K71.7)** • Congenital cirrhosis of liver **(P78.81)** • Pigmentary cirrhosis of liver **(E83.110)** **K74.0** Hepatic **fibrosis** **K74.1** Hepatic **sclerosis** **K74.2** Hepatic **fibrosis with hepatic sclerosis** **K74.3** **Primary** biliary cirrhosis Chronic nonsuppurative destructive cholangitis **K74.4** **Secondary** biliary cirrhosis **K74.5** **Biliary cirrhosis, unspecified**

ICD-10-CM	Description
K74.6	**Other and unspecified cirrhosis of liver**
	K74.60 Unspecified cirrhosis of liver Cirrhosis of liver NOS
	K74.69 Other cirrhosis of liver Crypotogenic cirrhosis of liver Macronodular cirrhosis of liver Micronodular cirrhosis of liver Mixed type cirrhosis of liver Portal cirrhosis of liver Post necrotic cirrhosis of liver

HIV/AIDS

In ICD-10-CM there are different code selections dependent upon whether the patient is HIV positive as opposed to HIV positive and has any type of related illness. In ICD-10-CM there is a specific code for exposure to the HIV virus.

ICD-10-CM	Description
Z20.6	**Contact with and (suspected) exposure to human immunodeficiency virus (HIV)** **Exclude 1:** • Asymptomatic HIV; infection status (Z21)
Z21	**Asymptomatic human immunodeficiency virus (HIV) infection status** • HIV positive NOS • Code first HIV disease complicating pregnancy, childbirth and the puerperium, if applicable **(098.7-)** **Excludes 1:** • Acquired immune deficiency syndrome **(B20)** • Contact with HIV **(Z20.6)** and exposure to HIV **(Z20.6)** • HIV disease **(B20)** • Inconclusive laboratory evidence of HIV **(R75)**

ICD-10-CM	Description
B20	**Human immunodeficiency virus (HIV) disease** • Acquired immune deficiency syndrome (AIDS) • AIDS-related complex (ARC) • HIV infection, symptomatic Code first HIV disease complicating pregnancy, childbirth and the puerperium, if applicable **(098.7-)** Use additional code(s) to identify all manifestations of HIV infection **Excludes 1:** • Asymptomatic HIV infection status **(Z21)** • Exposure to HIV virus **(Z20.6)** • Inconclusive serologic evidence of HIV **(R75)**

CANCER-NEOPLASMS, LEUKEMIA AND MYELOMA

To properly code neoplasms, the documentation in the medical record must indicate if the neoplasm is benign, in situ, malignant, or uncertain histologic behavior. If there is a malignancy, the secondary (metastatic) site should also be reported.

Malignancies are only coded until the patient has completed definitive treatment. Definitive treatment means surgery, chemotherapy, and/or radiation therapy aimed at eradicating the malignancy.

- Patients who do not receive definitive treatment for their malignancies continue to be coded with the malignancy diagnosis.

ICD-10-CM calls for more specific documentation for neoplasms based on the site of the neoplasm as well as its laterality (right, left, bilateral).

Active cancer

Increase specificity in documentation and include whether the patient's condition is diagnosed as: nothaving achieved remission, in remission or in relapse.

- Malignant neoplasm of the prostate – primary site still on radiation therapy; code to **C61.**
- Malignant neoplasm lower-outer quadrant of female breast left side primary site - repeat mammogram in 3 months, continuing on Tamoxifen; codes to **C50.512**

History of cancer

Patients who have completed therapy are coded with a "personal history of cancer" diagnosis code (Z-code), even if they are undergoing surveillance for re-occurrence of the malignancy.

Personal history of malignant neoplasm of prostate; codes to **Z85.46**

Personal history of malignant neoplasm of breast; codes to **Z85.3**

RHEUMATOID ARTHRITIS

Documentation for rheumatoid arthritis includes site, laterality, complication and with or without rheumatoid factor.

Examples of Rheumatoid arthritis:

ICD-10-CM	Description
M05.142	Rheumatoid lung disease with rheumatoid arthritis of left hand
M06.021	Rheumatoid arthritis without rheumatoid factor, right elbow
M08.262	Juvenile rheumatoid arthritis with systemic onset, left knee

FRACTURES

Fracture diagnoses require more detailed documentation and greater code specificity that includes:

- Type of fracture: closed, open displaced, non-displaced
- Specific anatomical site
- Laterality
- Routine vs. delayed healing
- Nonunion
- Malunion
- Type of encounter: initial, subsequent, sequela

Examples of osteoporosis without current pathological fractures:

ICD-10-CM	Description
M81	**Osteoporosis without current pathological fracture** Use additional code to identify: • Major osseous defect, if applicable **(M89.7-)** • Personal history of (healed) osteoporosis fracture if applicable **(Z87.31)** **Excludes 1:** • Osteoporosis with current pathological fracture **(M80.-)** • Sudeck's atrophy **(M89.0)**

ICD-10-CM	Description
M81 *(continued)*	**M81.0** **(Age related osteoporosis without current pathological fracture)** Involutional osteoporosis **without current pathological fracture** Osteoporosis NOS Postmenopausal osteoporosis **without current pathological fracture** Senile osteoporosis **without current pathological fracture** **M81.6** **Localized osteoporosis (Lequesne)** **Excludes 1:** • Sudeck's atrophy **(M89.0)** **M81.8** **Other osteoporosis without current pathological fracture** Drug induced osteoporosis **without current pathological fracture** Idiopathic osteoporosis **without current pathological fracture** Osteoporosis of disuse **without current pathological fracture** Postoophorectomy osteoporosis **without current pathological fracture** Post surgical malabsorbtion osteoporosis **without current pathological fracture** Post-traumatic osteoporosis **without current pathological fracture** Use additional code for adverse effect, if applicable to identify drug (**T36-T50** with fifth or sixth character 5.

Examples of osteoporosis with current pathological fractures:

ICD-10-CM	Description
M80	**Osteoporosis with current pathological fracture** • Osteoporosis with current fragility fracture Use additional code to identify major osseous defect, if applicable **(M89.7-)** **Excludes 1:** • Collapsed vertebra NOS **(M48.5)** • Pathological fracture NOS **(M84.4)** • Wedging of vertebra NOS **(M48.5)** The appropriate seventh character is to be added to each code from category **M80.** **A.** initial encounter for fracture **D.** subsequent encounter for fracture with routine healing **G.** subsequent encounter for fracture with delayed healing **K.** subsequent encounter for fracture with nonunion **P.** subsequent encounter for fracture with malunion **S.** sequela

ICD-10-CM	Description	
M80 *(continued)*	**M80.0**	**Age-related osteoporosis with current pathological fracture** Involutional osteoporosis **with current pathological fracture** Osteoporosis NOS **with current pathological fracture** Postmenopausal osteoporosis **with current pathological fracture** Senile osteoporosis **with current pathological fracture**
	M80.00	Age-related osteoporosis **with current pathological fracture, *unspecified site.***
	M80.01	Age-related osteoporosis **with current pathological fracture, *shoulder***
	M80.011	Age-related osteoporosis **with current pathological fracture, *right shoulder***
	M80.012	Age-related osteoporosis **with current pathological fracture, *left shoulder***
	M80.019	Age-related osteoporosis **with current pathological fracture, *unspecified shoulder***

OSTOMY STATUS

The key to documenting an Ostomy Status is to clearly explain if it's **present** or **reversed.**

Examples of common ostomy "status" codes:

ICD-10-CM	Description
Z93.0	Tracheostomy status
Z93.1	Gastrostomy status
Z93.2	Ileostomy status
Z93.3	Colostomy status
Z93.4	Other artificial opening of GI tract status
Z93.50	Unspecified cystostomy status
Z93.51	Cutaneous-vesicostomy status
Z93.52	Appendico-vesicostomy status
Z93.59	Other cystostomy status
Z93.6	Other artificial opening of urinary tract status (Nephrostomy, Ureterostomy, Urethrostomy)
Z93.8	Other artificial opening status
Z93.9	Artificial opening status, unspecified

Attention to Artificial Openings

Artificial openings that require attention or management should be captured from documentation that supports that care ("attention to") was provided to the opening during the encounter.

Examples of common "attention to" ostomy codes:

ICD-10-CM	Description
Z43.0	Encounter for attention to tracheostomy
Z43.1	Encounter for attention to gastrostomy
Z43.2	Encounter for attention to ileostomy
Z43.3	Encounter for attention to colostomy
Z43.4	Encounter for attention to other artificial openings of digestive tract
Z43.5	Encounter for attention to cystostomy
Z43.6	Encounter for attention to other artificial openings of urinary tract (nephrostomy, ureterostomy, urethrostomy)
Z43.7	Encounter for attention to artificial vagina
Z43.8	Encounter for attention to other artificial openings
Z43.9	Encounter for attention to unspecified artificial opening

Note: There may also be other diagnosis codes to report related to complications, malfunctioning or adjustments or change(s) made to the artificial opening.

STATUS OF AMPUTATION(S)

Code category **Z89** includes acquired absence of limb (amputation status). Providers should document specific anatomical location and laterality of the amputation site.

Below is a selected list of amputation status code examples:

ICD-10-CM	Description
Upper limb-above wrist amputation status	
Z89.201	Right upper limb, unspecified level
Z89.202	Left upper limb, unspecified level
Z89.209	Unspecified upper limb, unspecified level
Upper limb-below elbow amputation status	
Z89.211	Right upper limb, below elbow
Z89.212	Left upper limb, below elbow
Z89.219	Unspecified upper limb, below elbow
Upper limb-above elbow amputation status	
Z89.221	Right upper limb, above elbow
Z89.222	Left upper limb, above elbow
Z89.229	Unspecified upper limb, above elbow

ICD-10-CM	Description
Toes, foot, and ankle amputation status	
Z89.411	Right great toe
Z89.412	Left great toe
Z89.419	Unspecified great toe
Z89.421	Other right toe(s)
Z89.422	Other left toe(s)
Z89.429	Other toe(s) unspecified side
Z89.431	Right foot
Z89.432	Left foot
Z89.439	Unspecified foot
Z89.441	Right ankle
Z89.442	Left ankle
Z89.449	Unspecified ankle
Below knee amputation status	
Z89.511	Right leg, below knee
Z89.512	Left leg, below knee
Z89.519	Unspecified leg, below knee
Above knee amputation status	
Z89.611	Right leg, above knee
Z89.612	Left leg, above knee
Z89.619	Unspecified leg, above knee

BMI AND OBESITY

BMI documentation can be from clinicians who are not the patient's provider; however an associated diagnosis (such as morbid obesity) must be documented in the patient's record by a provider to assign the morbid obesity code. If the patient is morbidly obese the provider must state this in the document to correlate with the noted BMI of 40 and higher.

BMI Code Examples:

ICD-10-CM	Description
Z68.1	BMI 19 or less, adult
Z68.20	BMI 20.0-20.9, adult
Z68.21	BMI 21.0-21.9, adult
Z68.22	BMI 22.0-22.9, adult
Z68.23	BMI 23.0-23.9, adult
Z68.24	BMI 24.0-24.9, adult
Z68.25	BMI 25.0-25.9, adult
Z68.26	BMI 26.0-26.9, adult
Z68.27	BMI 27.0-27.9, adult
Z68.28	BMI 28.0-28.9, adult
Z68.29	BMI 29.0 – 29.9, adult
Z68.30	BMI 30.0 - 30.9, adult
Z68.31	BMI 31.0 – 31.9, adult
Z68.32	BMI 32.0 - 32.9, adult
Z68.33	BMI 33.0 – 33.9, adult

ICD-10-CM	Description
Z68.34	BMI 34.0 – 34.9, adult
Z68.35	BMI 35.0 - 35.9, adult
Z68.36	BMI 36.0 – 36.9, adult
Z68.37	BMI 37.0 – 37.9, adult
Z68.38	BMI 38.0 – 38.9, adult
Z68.39	BMI 39.0 – 39.9, adult
Z68.41	BMI 40.0 – 44.9, adult
Z68.42	BMI 45.0 – 49.9, adult
Z68.43	BMI 50.0 – 59.9, adult
Z68.44	BMI 60.0 – 69.9, adult
Z68.45	BMI 70 or greater, adult
Z68.51	BMI, pediatric, less than 5th percentile for age
Z68.52	BMI, pediatric, 5th percentile to less than 85th percentile for age
Z68.53	BMI, pediatric,85th percentile to less than 95th percentile for age
Z68.54	BMI, pediatric, greater than or equal to 95th percentile for age

Obesity Code Examples:

ICD-10-CM	Description
E66.3	Overweight
E66.9	Obesity unspecified, NOS
E66.01	Morbid (severe) obesity

NOTES

These informational tips are based on the ICD-10-CM Official Guidelines and do not represent the full details in ICD-10-CM but rather a sample of excerpts.

For complete rules and regulations, refer to the ICD-10-CM Official Guidelines.

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