ICD 10- What a Chiropractor Needs to Know

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Introduction

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD -10-CM) is the United States’ Clinical Modification to the World Health Organizations (WHO) International Classification of Disease, 10th Revision, adopted by WHO in 1990.

Australia was first with the Australian version in 1998. 2001 Canadians developed their version. The United States is the last industrialized nation that as not yet implemented ICD-10 (or a clinical modification) for morbidity, measuring diseases or causes of illnesses typically coded in a healthcare facility.

ICD 10

* 1990 –Endorsed by World Health Assembly (diagnosis only)
* 1994 –Release of full ICD-10 by WHO
* HIPAA Mandate- 1996
* 2002 (October) –ICD-10 published in 42 languages (including 6 official WHO languages)
* January 1, 1999 –U.S. implemented for mortality (death certificates)

ICD -10-CM – Who is in charge?

There are 4 organizations referred to as the Cooperating Parties that are in charge of ICD-10-CM for the United States. They are the National Center for Health Statistics (NCHS), the American Hospital Association (AHA), the American Health Information Management Association (AHIMA) and the Center for Medicare and Medicaid Services (CMS). The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

ICD 10-CM Code Structure

The first character of an ICD-9CM code is an alphabetic letter. All the letters of the alphabet are utilized with the exception of the letter U. which has been reserved by the WHO for the provisional assignment of new diseases of uncertain etiology (U00-U49) and for bacterial agents resistant to antibiotics (U80-U89). Some conditions in ICD-10-CM are not limited to the use of a single letter. For instance, neoplasm codes may begin with the letter C or D.

Characteristics of ICD-10-CM :

ICD-10-CM differs from ICD-9CM in its organization and structure, code composition and level of detail

ICD-10-CM

* Consists of three to seven characters
* First character is Alpha
* All letters used except U
* Character 2 always numeric
* Characters 3 through 7 can be alpha or numeric
* Always at least 3 digits (3-7 digits)
* Decimal placed after the first three characters
* Alpha characters are not case-sensitive

Code Structure of ICD-10-CM versus ICD-9-CM

ICD 10 CM codes may consist of up to seven characters with the seventh character representing visit encounter or sequelae for injuries and external causes.

ICD-10\_CM Codes may consist of up to seven characters, with the seventh character representing visit encounter or sequelae for injuries and external causes.



Organization and Structure of ICD-10-CM

The alphabetic index is divided into two parts – The Index to Diseases and Injuries and the Index to External Causes.

The Alphabetic Index in ICD-10-CM is formatted. Main terms are set in boldface and are listed in alphabetical order. Indented beneath the main term, any applicable subterm or essential modifier will be shown in their own alphabetic list.

The indented subterm is always read in combination with the main term. Nonessential modifiers appear in parentheses and do not affect the code number assigned. The “-“ at the end of an index entry indicates that additional characters are required.

Manifestation Codes

ICD-10-CM Alphabetic Index includes the suggestion of some manifestation codes in the same manner as ICD-9CM, by including the code as a second code, shown in brackets, directly after the underlying or etiology code (which should always be reported first).

Tabular List

The ICD-10-CM Tabular List is divided into 21 chapters. For some chapters, the body or organ system is the axis of the classification. Other chapters, such as Chapter 1: Certain infectious and parasitic diseases, group together conditions by etiology or nature of the disease process. ICD-9-CM has a single chapter for Diseases of the Nervous System and Sense Organs whereas ICD-10-CM places these conditions into three separate chapters. ICD-10-CM also does not separate out the ICD-9CM codes that explain the External Causes of Injury and Poisonings (E-Codes) and the Factors Influencing Health Status and Contact with Health Services (V codes) from the core classification.

The order of ICD-10-CM chapters is a bit different from the ICD-9-CM order. In ICD-10-CM, disorders of the immune mechanism are included with Diseases of the blood and blood-forming organs. In contrast, the immunity disorders are found in the ICD-9-CM chapter for Endocrine Nutritional and Metabolic Diseases. In addition, certain chapters are reordered. The ICD-10-CM codes for Diseases of skin and subcutaneous tissue (Chapter12) and Diseases of the musculoskeletal system and connective tissue (Chapter 13) follow the chapter for Diseases of the digestive system. Next are chapters for Diseases of the genitourinary system (Chapter 14), Pregnancy, childbirth, and puerperium (Chapter 16), and Congenital malformations, deformations and chromosomal abnormalities (Chapter 17). There are a number of ICD-10-CM chapters, category restructuring and code reorganization that have occurred resulting in the classification of certain diseases and disorders different than what is currently seen in ICD-9CM

Here are the 21 chapters of the ICD-10-CM classification system:

1. Certain infectious and parasitic diseases (A00-B99)
2. Neoplasms (C00-D40)
3. Diseases 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)

Chapters are further subdivided into subchapters (blocks) that contain three character categories and, similar to ICD-9-CM categories, form the foundation of the code. Each chapter in the Tabular List of ICD-10-CM begins with a summary of the blocks to provide an overview of the categories with the chapter. For example:

**Chapter 13**

Diseases of the musculoskeletal system and connective tissue (M00-M99)

|  |  |
| --- | --- |
| This chapter contains the following blocks: | |
| M00-M02 | Infectious arthropathies |
| M05-M14 | Inflammatory polyarthropathies |
| M15-M19 | Osteoarthritis |
| M20-M25 | Other joint disorders |
| M26-M27 | Dentofacial anomalies [including malocclusion] and other disorders of jaw |
| M30-M36 | Systemic connective tissue disorders |
| M40-M43 | Deforming dorsopathies |
| M45-M49 | Spondylopathies |
| M50-M54 | Other dorsopathies |
| M60-M63 | Disorders of muscles |
| M65-M67 | Disorders of synovium and tendon |
| M70-M79 | Other soft tissue disorders |
| M80-M85 | Disorders of bone density and structure |
| M86-M90 | Other osteopathies |
| M91-M94 | Chondropathies |
| M95 | Other disorders of the musculoskeletal system and connective tissue |
| M96 | Intraoperative and post procedural complications and disorders of musculoskeletal system, not elsewhere classified |
| M99 | Biomechanical lesions, not elsewhere classified |

Most but not all categories are further subdivided into four or five character subcategories. If a category is not further subdivided it is considered to be a valid code, such as P90, Convulsions of new born.

The fourth character 8, when placed after a decimal point (.8) is used to indicate some “other” specified category, and the fourth character 9 placed after a decimal point (.9) is usually reserved for an unspecified condition. This represents another classification modification with the separation of Not Elsewhere Classified (NEC) and Not Otherwise Specified (NOS) codes. ICD-9-CM sometimes combines these two into a single code. In ICD-10-CM the Other Specified and Unspecified each have their own code. Examples:

* M99.89 - Other biomechanical lesions of abdomen and other regions
* M99.9 - Biomechanical lesion, unspecified

Five and Six character codes provide even greater specificity or additional information about the condition being coded. Similar to ICD-9-CM, ICD-10-CM codes must be used to the highest number of characters available or to the highest level of specificity. When a category has been subdivided four, five, or six character codes, the code assigned must represent the highest level of specificity represented within ICD-10-CM.

Certain categories have an additional character. The seventh character must always be the seventh and final character of the code. When the code contains fewer than seven characters, placeholder X must be used to fill in the characters between the 4th character and the 7th character. Example:

* S13.4XXA Sprain of Cervical Spine Initial encounter

S13.4 Sprain of ligaments of cervical spine

* Sprain of anterior longitudinal (ligament), cervical
* Sprain of atlanto-axial (joints)
* Sprain of atlanto-occipital (joints)
* Whiplash injury of cervical spine

S13.4XXA Sprain of neck, initial visit

S13.4 XXB Sprain of neck, subsequent visit

Classification Chapters 5, 19 and 20.

ICD-10-CM Chapters 5 (Mental and behavioral disorders), 19 (Injury, poisoning and certain other consequences of external causes), and 20 (External Causes of Morbidity).

Chapter 5 in ICD-10-CM contains subchapters, categories and subcategories. Consequently, when comparing ICD-10-CM to ICD-9-CM some disorders are classified differently and greater clinical detail is obtainable.

Example: F17.213, Nicotine dependence, cigarettes, with withdrawal.

Chapter 19: Injury, poisoning and certain other consequences of external causes – A significant modification was made to the classification of injuries with the publication of ICD-10 and therefore ICD-10-CM. Specific types of injuries found in categories S00-S99 of Chapter 19 of ICD-10-CM were arranged by body region beginning with the head and concluding with the ankle and foot. However, effects of a foreign body, burns, and frostbite are not classified in the body region groups. This chapter also includes codes for poisoning, adverse effects, and other consequences of external causes.

Example: ICD-10-CM Chapter 19: Injury, poisoning and certain other consequences of external causes (S00-T88)

Examples: S13.8XXA Sprain of joints and ligaments of other parts of neck, initial encounter

S23.3XXD Sprain of ligaments of thoracic spine, subsequent encounter

T84.84XS Pain due to internal orthopedic prosthetic devices, implants and grafts, sequelae

Chapter 20: External causes of morbidity – Codes for external causes are no longer located in a separate classification in ICD-10-CM. Codes in Chapter 20 capture the cause of the injury or health condition, the intent (unintentional or accidental; or intentional such as assault or suicide), the place where the event occurred, the activity of the patient at the time of the event, and the person’s status (i.e. civilian, military).

Example: ICD-10-CM Chapter 20: External causes of morbidity (V00-Y99).

Examples: W21.03XA, Struck by baseball, initial encounter.

Y92.320, Baseball field as the place of occurrence of the external cause.

Y93.64, Activities involving other sports and athletics played as a team or group: baseball

Y99.8, Other external causes status (recreation or sport not for income or while a student)

ICD-10-CM Conventions and Coding Guidelines

Correct Assignment of ICD-10-CM diagnosis codes is dependent on the individual coding, understanding certain conventions used in the classification system. Similar to ICD-9-CM. Abbreviations, punctuation, symbols and notes are used as conventions and have special meanings that affect code assignment.

Instructional Notes:

Similar to ICD-9CM a variety of notes appear in both the Alphabetic Index and Tabular List of ICD-10-CM. The various types of notes are “includes” and “excludes” notes, “code first” notes, “use additional code” notes, and cross reference notes.

Includes:

The word 'Includes' appears immediately under certain categories to further define, or give examples of, the content of the category. A variety of notes appear in both the Alphabetic Index and Tabular List of ICD-10-CM. The various types of notes are “includes” and “excludes” notes, “code first” notes, “use additional code” notes, and cross reference notes.

Inclusion Notes – Includes notes are used as conventions in ICD-10-CM tabular List to clarify the conditions included with a particular chapter, section, category, subcategory, or code. It is important to remember that the list of inclusions terms is not exhaustive and may include diagnoses not listed in the inclusion note. Inclusion notes are introduced by the word “includes” when appearing at the beginning of a chapter, section or category.

At the code level, the word “includes” does not precede the list of terms included in this code.

Example:

M41 Scoliosis

Includes:kyphoscoliosis

Excludes Notes

The ICD-10-CM has two types of excludes notes. Each note has a different definition for use but they are both similar in that they indicate that codes excluded from each other are independent of each other.

Excludes1

A type 1 Excludes note is a pure excludes. It means 'NOT CODED HERE!' An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

Excludes2

A type 2 excludes note represents 'Not included here'. An excludes2 note indicates that the condition excluded is not part of the condition it is excluded from 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:

G44 Other headache syndromes

Excludes1:

headache NOS (R51)

Excludes2:

atypical facial pain (G50.1)

headache due to lumbar puncture (G97.1)

migraines (G43.-)

trigeminal neuralgia (G50.0)

Code First/Use Additional Code notes (etiology/manifestation paired codes)

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, followed by the manifestation. Wherever such a combination exists there are a 'use additional code' note at the etiology code, and a 'code first' note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes etiology followed by manifestation.

In most cases the manifestation codes will have in the code title, 'in diseases classified elsewhere.' Codes with this title area component of the etiology follow manifestation convention. They are **never permitted to be used** as first listed or principal diagnosis codes. **They must be used** in conjunction with an underlying condition code and they **must be listed following** the underlying condition.

Cross Reference Notes – Cross reference notes are used in the ICD-10-CM Alphabetic Index to advise the coding professional to look elsewhere before assigning a code. The three cross reference notes are (see, see also, and see condition).

Code Also

A code also note instructs that 2 codes may be required to fully describe a condition but the sequencing of the two codes is discretionary, depending on the severity of the conditions and the reason for the encounter.

7th characters and placeholder X

For codes less than 6 characters that require a 7th character, a placeholder X should be assigned for all characters less than 6. The 7th character must always be the 7th character of a code.

As the 5th character for certain six character codes the X provides for future expansion without disturbing the 6th carrier character structure.

When a code has less than six characters, but requires a 7th character. The X is assigned for all characters less than six in order to meet the requirement of coding to the highest level of specificity.

Some ICD-10-CM categories require a seventh character to provide further specificity about the condition being coded. This seventh character may be a number or letter and must always be the seventh character.

Abbreviations:

**Not Elsewhere Classified (NEC)** – ICD-10-CM, like ICD-9-CM, contains codes to classify any and all conditions. A residual category, subdivision, or sub classification provides a location for “other” types of specified conditions that have not been classified anywhere else in the code set. These residual codes may also contain the term “NEC” as part of their descriptor. The Alphabetic Index uses NEC for a code description that will direct the coder to the Tabular list showing an “Other Specified” code description.

Not Otherwise Specified (NOS) – The unspecified or Not Otherwise Specified (NOS) codes are available for use when the documentation of the condition identified by the provider is insufficient to assign a more specific code.

Punctuation:

In ICD-10-CM, punctuation is used in both the Alphabetic index and the Tabular List. The types of punctuation included in ICD-10-CM are parentheses, brackets and colons.

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

**[ ] Brackets** – The Tabular List uses square brackets to enclose synonyms, alternative wordings or explanatory phrases. Brackets are used in the Alphabetic Index to identify manifestation codes.

**: Colons** – Colons are used in the Tabular List after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category. The colon is used with both “includes” and “excludes” notes, in which the words that precede the colon are not considered complete terms and therefore must be appended by one of the modifiers indented under the statement before the condition can be assigned the correct code.

Code First and Use Additional Code Notes – “Code first” and “use additional code” notes are important in ICD-10-CM. Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, ICD-10-CM has a coding convention that requires the underlying condition to be sequenced first followed by the manifestation. The “use additional code” note appears at the etiology code and a “code first” at the manifestation code.

Cross Reference Notes – Cross reference notes are used in the ICD-10-CM Alphabetic Index to advise the coding professional to look elsewhere before assigning a code. The three cross reference notes are (see, see also, and see condition).

Relational Terms

**And** – The term “and” is interpreted to mean “and/or” when it appears in a code title with the ICD-10-CM Tabular List.

**With** – The word “with” should be interpreted to mean: “associated with” or “due to” when it appears in a code title, the Alphabetic Index is sequenced immediately following the main term, not in alphabetic order.

ICD-10-CM Guidelines

The guidelines for ICD-10-CM are organized into four sections.

For ICD-10-CM Section I, this includes the structure and conventions of the classification and general guidelines that apply to the entire classification in addition to chapter specific guidelines that correspond to the chapters as they are arranged in the classification.

Section 1: The General coding Guidelines (Part B of Section 1) for ICD-10-CM are similar to their ICD-9-CM General Coding Guidelines counterparts with one additional guideline – Laterality. The Laterality Guideline states, “Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and the right side. If the side is not identified in the medical record, assign the code for the unspecified side.

Section II includes the structure and conventions of the classification and general guidelines that apply to the entire classification **in addition to** chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings.

Section III includes guidelines for reporting additional diagnoses in non-outpatient settings.

Section IV is for outpatient coding and reporting.

The complete 2014 version of the ICD-10-CM guidelines can be located on the NCHS website (<http://www.cdc.gov/nchs/icd/icd10cm.htm>).

The guidelines located on the above website are the official guidelines to be used for coding under ICD-10-CM. Go to (<http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf>)

The Alphabetic Index and Tabular List

1. The ICD-10-CM is divided into the Alphabetic Index, an alphabetical list of terms and their corresponding code, and the Tabular List, a structured list of codes divided into chapters based on body system or condition. The Alphabetic Index consists of the following parts: the Index of Diseases and Injury, the Index of External Causes of Injury, the Table of Neoplasms and the Table of Drugs and Chemicals.

2. Format and Structure:

The ICD-10-CM Tabular List contains categories, subcategories and codes. Characters for categories, subcategories and codes may be either a letter or a number. All categories are 3 characters. A three-character category that has no further subdivision is equivalent to a code. Subcategories are either 4 or 5 characters. Codes may be 3, 4, 5, 6 or 7 characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. Codes that have applicable 7th characters are still referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character. The ICD-10-CM uses an indented format for ease in reference.

3. Use of codes for reporting purposes

For reporting purposes only codes are permissible, not categories or subcategories, and any applicable 7th character is required.

4. Placeholder character

The ICD-10-CM utilizes a placeholder character “X”. The “X” is used as a placeholder for certain codes to allow for future expansion. An example of this is at the poisoning, adverse effect and underdosing codes, categories T36-T50. Where a placeholder exists, the X must be used in order for the code to be considered a valid code.

5. 7th Characters

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 the 7th character in the data field. If a code that requires a 7th character is not 6 characters, a placeholder X must be used to fill in the empty characters.

B. General Coding Guidelines

1. Locating a code in the ICD-10-CM

To select a code in the classification that corresponds to a diagnosis or reason for a visit documented in a medical record, first locate the term in the Alphabetic Index, and then verify the code in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.

It is essential to use both the Alphabetic Index **and** Tabular List when locating and assigning a code. The Alphabetic Index does not always provide the full code. 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 that additional characters are required. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required.

2. Level of Detail in Coding

Diagnosis codes are to be used and reported at their highest number of characters available.

ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth characters, which provide greater detail.

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

3. Code or codes from A00.0 through T88.9, Z00-Z99.8

The appropriate code or codes from A00.0 through T88.9, Z00-Z99.8 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.

4. Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all codes for symptoms.

See Section I.B.18 Use of Signs/Symptom/Unspecified Codes

5. Conditions that are an integral part of a disease process

Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

6. 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.

7. Multiple coding for a single condition

In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code. “Use additional code” notes are found in the Tabular List at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. The sequencing rule is the same as the etiology/manifestation pair, “use additional code” indicates that a secondary code should be added.

For example, for bacterial infections that are not included in chapter 1, a secondary code from category B95, Streptococcus, Staphylococcus, and Enterococcus, as the cause of diseases classified elsewhere, or B96, Other bacterial agents as the cause of diseases classified elsewhere, may be required to identify the bacterial organism causing the infection. A “use additional code” note will normally be found at the infectious disease code, indicating a need for the organism code to be added as a secondary code.

“Code first” notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a “code first” note and an underlying condition is present, the underlying condition should be sequenced first.

“Code, if applicable, any causal condition first”, notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.

Multiple codes may be needed for sequelae, complication codes and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

8. Acute and Chronic Conditions

If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

9. Combination Code

A combination code is a single code used to classify:

Two diagnoses, or

A diagnosis with an associated secondary process (manifestation)

A diagnosis with an associated complication

Combination codes are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.

Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs. Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.

10. Sequelae (Late Effects)

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

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

See Section I.C.9. Sequelae of cerebrovascular disease

See Section I.C.15. Sequelae of complication of pregnancy, childbirth and the puerperium

See Section I.C.19. Application of 7th characters for Chapter 19

11. Impending or Threatened Condition

Code any condition described at the time of discharge as “impending” or “threatened” as follows:

If it did occur, code as confirmed diagnosis.

If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for “impending” or “threatened” and also reference main term entries for “Impending” and for “Threatened.”

If the subterms are listed, assign the given code.

If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

12. Reporting Same Diagnosis Code More than Once

Each unique ICD-10-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions when there are no distinct codes identifying laterality or two different conditions classified to the same ICD-10-CM diagnosis code.

13. Laterality

Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.

16. Documentation of Complications of Care

Code assignment is based on the provider’s documentation of the relationship between the condition and the care or procedure. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. 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. Query the provider for clarification, if the complication is not clearly documented.

17. Borderline Diagnosis

If the provider documents a "borderline" diagnosis at the time of discharge, the diagnosis is coded as confirmed, unless the classification provides a specific entry (e.g., borderline diabetes). If a borderline condition has a specific index entry in ICD-10-CM, it should be coded as such. Since borderline conditions are not uncertain diagnoses, no distinction is made between the care setting (inpatient versus outpatient). Whenever the documentation is unclear regarding a borderline condition, coders are encouraged to query for clarification.

18. Use of Sign/Symptom/Unspecified Codes

Sign/symptom and “unspecified” codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflects what is known about the patient’s condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

C. Chapter-Specific

Guidelines

In addition to general coding guidelines, there are guidelines for specific diagnoses and/or conditions in the classification. Unless otherwise indicated, these guidelines apply to all health care settings. Please refer to Section II for guidelines on the selection of principal diagnosis.

*Note: this specific rendition is designed for use in coding chiropractic specific cases and not general medical cases. The following includes the chapters typically used by chiropractors for coding the specific conditions typically seen by chiropractors. If codes from other chapters than those listed are used, it would be wise to access the guidelines from the above identified website (page 5 or page 15).*

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

a. Dominant/Nondominant side

Codes from category G81, Hemiplegia and hemiparesis, and subcategories, G83.1, Monoplegia of lower limb, G83.2, Monoplegia of upper limb, and G83.3, Monoplegia, unspecified, identify whether the dominant or nondominant side is affected. Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:

• For ambidextrous patients, the default should be dominant.

• If the left side is affected, the default is non-dominant.

• If the right side is affected, the default is dominant.

b. Pain - Category G89

1) General coding information

Codes in category G89, Pain, not elsewhere classified, may be used in conjunction with codes from other categories and chapters to provide more detail about acute or chronic pain and neoplasm-related pain, unless otherwise indicated below.

If the pain is not specified as acute or chronic, post-thoracotomy, postprocedural, or neoplasm-related, do not assign codes from category G89 unless the reason for the encounter is pain control/ management and not management of the underlying condition.

When an admission or encounter is for a procedure aimed at treating the underlying condition (e.g., spinal fusion, kyphoplasty), a code for the underlying condition (e.g., vertebral fracture, spinal stenosis) should be assigned as the principal diagnosis. No code from category G89 should be assigned.

(a) Category G89 Codes as Principal or First-Listed Diagnosis

Category G89 codes are acceptable as principal diagnosis or the first-listed code:

• When pain control or pain management is the reason for the admission/encounter (e.g., a patient with displaced intervertebral disc, nerve impingement and severe back pain presents for injection of steroid into the spinal canal). The underlying cause of the pain should be reported as an additional diagnosis, if known.

• When a patient is admitted for the insertion of a neurostimulator for pain control, assign the appropriate pain code as the principal or first-listed diagnosis. When an admission or encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is inserted for pain control during the same admission/encounter, a code for the underlying condition should be assigned as the principal diagnosis and the appropriate pain code should be assigned as a secondary diagnosis.

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

(i) Assigning Category G89 and Site-Specific Pain Codes

Codes from category G89 may be used in conjunction with codes that identify the site of pain (including codes from chapter 18) if the category G89 code provides additional information. For example, if the code describes the site of the pain, but does not fully describe whether the pain is acute or chronic, then both codes should be assigned.

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

The sequencing of category G89 codes with site-specific pain codes (including chapter 18 codes), is dependent on the circumstances of the encounter/admission as follows:

• If the encounter is for pain control or pain management, assign the code from category G89 followed by the code identifying the specific site of pain (e.g., encounter for pain management for acute neck pain from trauma is assigned code G89.11, Acute pain due to trauma, followed by code M54.2, Cervicalgia, to identify the site of pain).

• If the encounter is for any other reason except pain control or pain management, and a related definitive diagnosis has not been established (confirmed) by the provider, assign the code for the specific site of pain first, followed by the appropriate code from category G89.

2) Pain due to devices, implants and grafts

*See Section I.C.19. Pain due to medical devices*

3) Postoperative Pain

The provider’s documentation should be used to guide the coding of postoperative pain, as well as *Section III. Reporting Additional Diagnoses* and *Section IV. Diagnostic Coding and Reporting in the Outpatient Setting.*

The default for post-thoracotomy and other postoperative pain not specified as acute or chronic is the code for the acute form.

Routine or expected postoperative pain immediately after surgery should not be coded.

(a) Postoperative pain not associated with specific postoperative complication

Postoperative pain not associated with a specific postoperative complication is assigned to the appropriate postoperative pain code in category G89.

(b) Postoperative pain associated with specific postoperative complication

Postoperative pain associated with a specific postoperative complication (such as painful wire sutures) is assigned to the appropriate code(s) found in Chapter 19, Injury, poisoning, and certain other consequences of external causes. If appropriate, use additional code(s) from category G89 to identify acute or chronic pain (G89.18 or G89.28).

4) Chronic pain

Chronic pain is classified to subcategory G89.2. There is no time frame defining when pain becomes chronic pain. The provider’s documentation should be used to guide use of these codes.

5) Neoplasm Related Pain

Code G89.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic.

This code may be assigned as the principal or first-listed code when the stated reason for the admission/encounter is documented as pain control/pain management. The underlying neoplasm should be reported as an additional diagnosis.

When the reason for the admission/encounter is management of the neoplasm and the pain associated with the neoplasm is also documented, code G89.3 may be assigned as an additional diagnosis. It is not necessary to assign an additional code for the site of the pain.

*See Section I.C.2 for instructions on the sequencing of neoplasms for all other stated reasons for the admission/encounter (except for pain control/pain management).*

6) Chronic pain syndrome

Central pain syndrome (G89.0) and chronic pain syndrome (G89.4) are different than the term “chronic pain,” and therefore codes should only be used when the provider has specifically documented this condition.

*See Section I.C.5. Pain disorders related to psychological factors*

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

a. Site and laterality

Most of the codes within Chapter 13 have site and laterality designations. The site represents the bone, joint or the muscle involved. For some conditions where more than one bone, joint or muscle is usually involved, such as osteoarthritis, there is a “multiple sites” code available. For categories where no multiple site code is provided and more than one bone, joint or muscle is involved, multiple codes should be used to indicate the different sites involved.

1) Bone versus joint

For certain conditions, the bone may be affected at the upper or lower end, (e.g., avascular necrosis of bone, M87, Osteoporosis, M80, M81). Though the portion of the bone affected may be at the joint, the site designation will be the bone, not the joint.

b. Acute traumatic versus chronic or recurrent musculoskeletal conditions

Many musculoskeletal conditions are a result of previous injury or trauma to a site, or are recurrent conditions. Bone, joint or muscle conditions that are the result of a healed injury are usually found in chapter 13. Recurrent bone, joint or muscle conditions are also usually found in chapter 13. Any current, acute injury should be coded to the appropriate injury code from chapter 19. Chronic or recurrent conditions should generally be coded with a code from chapter 13. If it is difficult to determine from the documentation in the record which code is best to describe a condition, query the provider.

c. Coding of Pathologic Fractures

7th character A is for use as long as the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, evaluation and treatment by a new physician. 7th character, D is to be used for encounters after the patient has completed active treatment. The other 7th characters, listed under each subcategory in the Tabular List, are to be used for subsequent encounters for treatment of problems associated with the healing, such as malunions, nonunions, and sequelae.

Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.

*See Section I.C.19. Coding of traumatic fractures.*

d. Osteoporosis

Osteoporosis is a systemic condition, meaning that all bones of the musculoskeletal system are affected. Therefore, site is not a component of the codes under category M81, Osteoporosis without current pathological fracture. The site codes under category M80, Osteoporosis with current pathological fracture, identify the site of the fracture, not the osteoporosis.

1) Osteoporosis without pathological fracture

Category M81, Osteoporosis without current pathological fracture, is for use for patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis, even if they have had a fracture in the past. For patients with a history of osteoporosis fractures, status code Z87.310, Personal history of (healed) osteoporosis fracture, should follow the code from M81.

2) Osteoporosis with current pathological fracture

Category M80, Osteoporosis with current pathological fracture, is for patients who have a current pathologic fracture at the time of an encounter. The codes under M80 identify the site of the fracture. A code from category M80, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.

19. Chapter 19: Injury, poisoning, and certain other consequences of external causes (S00-T88)

a. Application of 7th Characters in Chapter 19

Most categories in chapter 19 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values (with the exception of fractures): A, initial encounter, D, subsequent encounter and S, sequela. Categories for traumatic fractures have additional 7th character values.

7th character “A”, initial encounter is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

7th character “D” subsequent encounter is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Examples of subsequent care are: cast change or removal, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.

The aftercare Z codes should not be used for aftercare for conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care. For example, for aftercare of an injury, assign the acute injury code with the 7th character “D” (subsequent encounter).

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

b. Coding of Injuries

When coding injuries, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned. Code T07, Unspecified multiple injuries should not be assigned in the inpatient setting unless information for a more specific code is not available. Traumatic injury codes (S00-T14.9) are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.

The code for the most serious injury, as determined by the provider and the focus of treatment, is sequenced first.

1) Superficial injuries

Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.

2) Primary injury with damage to nerves/blood vessels

When a primary injury results in minor damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) for injuries to nerves and spinal cord (such as category S04), and/or injury to blood vessels (such as category S15). When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.

g. Complications of care

1) General guidelines for complications of care

(a) Documentation of complications of care

*See Section I.B.16. for information on documentation of complications of care.*

2) Pain due to medical devices

Pain associated with devices, implants or grafts left in a surgical site (for example painful hip prosthesis) is assigned to the appropriate code(s) found in Chapter 19, Injury, poisoning, and certain other consequences of external causes. Specific codes for pain due to medical devices are found in the T code section of the ICD-10-CM. Use additional code(s) from category G89 to identify acute or chronic pain due to presence of the device, implant or graft (G89.18 or G89.28).

4) Complication codes that include the external cause

As with certain other T codes, some of the complications of care codes have the external cause included in the code. The code includes the nature of the complication as well as the type of procedure that caused the complication. No external cause code indicating the type of procedure is necessary for these codes.

5) Complications of care codes within the body system chapters

Intraoperative and postprocedural complication codes are found within the body system chapters with codes specific to the organs and structures of that body system. These codes should be sequenced first, followed by a code(s) for the specific complication, if applicable.

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

The external causes of morbidity codes should never be sequenced as the first-listed or principal diagnosis.

External cause codes are intended to 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 (e.g., civilian, military).

There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

a. General External Cause Coding Guidelines

1) Used with any code in the range of A00.0-T88.9, Z00-Z99

An external cause code may be used with any code in the range of A00.0-T88.9, Z00-Z99, classification that is a health condition due to an external cause. Though they are most applicable to injuries, they are also valid for use with such things as infections or diseases due to an external source, and other health conditions, such as a heart attack that occurs during strenuous physical activity.

2) External cause code used for length of treatment

Assign the external cause code, with the appropriate 7th character (initial encounter, subsequent encounter or sequela) for each encounter for which the injury or condition is being treated.

3) Use the full range of external cause codes

Use the full range of external cause codes to completely describe the cause, the intent, the place of occurrence, and if applicable, the activity of the patient at the time of the event, and the patient’s status, for all injuries, and other health conditions due to an external cause.

4) Assign as many external cause codes as necessary

Assign as many external cause codes as necessary to fully explain each cause. If only one external code can be recorded, assign the code most related to the principal diagnosis.

5) The selection of the appropriate external cause code

The selection of the appropriate external cause code is guided by the Alphabetic Index of External Causes and by Inclusion and Exclusion notes in the Tabular List.

6) External cause code can never be a principal diagnosis

An external cause code can never be a principal (first-listed) diagnosis.

7) Combination external cause codes

Certain of the external cause codes are combination codes that identify sequential events that result in an injury, such as a fall which results in striking against an object. The injury may be due to either event or both. The combination external cause code used should correspond to the sequence of events regardless of which caused the most serious injury.

8) No external cause code needed in certain circumstances

No external cause code from Chapter 20 is needed if the external cause and intent are included in a code from another chapter (e.g. T36.0X1- Poisoning by penicillins, accidental (unintentional).

b. Place of Occurrence Guideline

Codes from category Y92, Place of occurrence of the external cause, are secondary codes for use after other external cause codes to identify the location of the patient at the time of injury or other condition.

A place of occurrence code is used only once, at the initial encounter for treatment. No 7th characters are used for Y92. Only one code from Y92 should be recorded on a medical record.

Do not use place of occurrence code Y92.9 if the place is not stated or is not applicable.

c. Activity Code

Assign a code from category Y93, Activity code, to describe the activity of the patient at the time the injury or other health condition occurred.

An activity code is used only once, at the initial encounter for treatment. Only one code from Y93 should be recorded on a medical record.

The activity codes are not applicable to poisonings, adverse effects, misadventures or sequela

Do not assign Y93.9, Unspecified activity, if the activity is not stated.

A code from category Y93 is appropriate for use with external cause and intent codes if identifying the activity provides additional information about the event.

d. Place of Occurrence***,*** Activity***,*** and Status Code***s*** Used with other External Cause Code

When applicable, place of occurrence, activity, and external cause status codes are sequenced after the main external cause code(s). Regardless of the number of external cause codes assigned, there should be only one place of occurrence code, one activity code, and one external cause status code assigned to an encounter.

e. If the Reporting Format Limits the Number of External Cause Codes

If the reporting format limits the number of external cause codes that can be used in reporting clinical data, report the code for the cause/intent most related to the principal diagnosis. If the format permits capture of additional external cause codes, the cause/intent, including medical misadventures, of the additional events should be reported rather than the codes for place, activity, or external status.

f. Multiple External Cause Coding Guidelines

More than one external cause code is required to fully describe the external cause of an illness or injury. The assignment of external cause codes should be sequenced in the following priority:

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*.*

*See Section I.C.19., Child and Adult abuse guidelines.*

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.

g. Child and Adult Abuse Guideline

Adult and child abuse, neglect and maltreatment are classified as assault. Any of the assault codes may be used to indicate the external cause of any injury resulting from the confirmed abuse.

For confirmed cases of abuse, neglect and maltreatment, when the perpetrator is known, a code from Y07, Perpetrator of maltreatment and neglect, should accompany any other assault codes.

*See Section I.C.19. Adult and child abuse, neglect and other maltreatment*

h. Unknown or Undetermined Intent Guideline

If the intent (accident, self-harm, assault) of the cause of an injury or other condition is unknown or unspecified, code the intent as accidental intent. All transport accident categories assume accidental intent.

1) Use of undetermined intent

External cause codes for events of undetermined intent are only for use if the documentation in the record specifies that the intent cannot be determined.

i. Sequelae (Late Effects) of External Cause Guidelines

1) Sequelae external cause codes

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

2) Sequelae external cause code with a related current injury

A sequelae external cause code should never be used with a related current nature of injury code.

3) Use of sequelae external cause codes for subsequent visits

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

j. Terrorism Guidelines

1) Cause of injury identified by the Federal Government (FBI) as terrorism

When the cause of an injury is identified by the Federal Government (FBI) as terrorism, the first-listed external cause code should be a code from category Y38, Terrorism. The definition of terrorism employed by the FBI is found at the inclusion note at the beginning of category Y38. Use additional code for place of occurrence (Y92.-). More than one Y38 code may be assigned if the injury is the result of more than one mechanism of terrorism.

2) Cause of an injury is suspected to be the result of terrorism

When the cause of an injury is suspected to be the result of terrorism a code from category Y38 should not be assigned. Suspected cases should be classified as assault.

3) Code Y38.9, Terrorism, secondary effects

Assign code Y38.9, Terrorism, secondary effects, for conditions occurring subsequent to the terrorist event. This code should not be assigned for conditions that are due to the initial terrorist act.

It is acceptable to assign code Y38.9 with another code from Y38 if there is an injury due to the initial terrorist event and an injury that is a subsequent result of the terrorist event.

k. External cause status

A code from category Y99, External cause status, should be assigned whenever any other external cause code is assigned for an encounter, including an Activity code, except for the events noted below. Assign a code from category Y99, External cause status, to indicate the work status of the person at the time the event occurred. The status code indicates whether the event occurred during military activity, whether a non-military person was at work, whether an individual including a student or volunteer was involved in a non-work activity at the time of the causal event.

A code from Y99, External cause status, should be assigned, when applicable, with other external cause codes, such as transport accidents and falls. The external cause status codes are not applicable to poisonings, adverse effects, misadventures or late effects.

Do not assign a code from category Y99 if no other external cause codes (cause, activity) are applicable for the encounter.

An external cause status code is used only once, at the initial encounter for treatment. Only one code from Y99 should be recorded on a medical record.

Do not assign code Y99.9, Unspecified external cause status, if the status is not stated.

21. Chapter 21: Factors influencing health status and contact with health services (Z00-Z99)

Note: The chapter specific guidelines provide additional information about the use of Z codes for specified encounters.

a. Use of Z codes in any healthcare setting

Z codes are for use in any healthcare setting. Z codes may be used as either a first-listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter. Certain Z codes may only be used as first-listed or principal diagnosis.

b. Z Codes indicate a reason for an encounter

Z codes are not procedure codes. A corresponding procedure code must accompany a Z code to describe any procedure performed.

c. Categories of Z Codes

1) Contact/Exposure

Category Z20 indicates contact with, and suspected exposure to, communicable diseases. These codes are for patients who do not show any sign or symptom of a disease but are suspected to have been exposed to it by close personal contact with an infected individual or are in an area where a disease is epidemic.

Category Z77, indicates contact with and suspected exposures hazardous to health.

Contact/exposure codes may be used as a first-listed code to explain an encounter for testing, or, more commonly, as a secondary code to identify a potential risk.

2) Inoculations and vaccinations

Code Z23 is for encounters for inoculations and vaccinations. It indicates that a patient is being seen to receive a prophylactic inoculation against a disease. Procedure codes are required to identify the actual administration of the injection and the type(s) of immunizations given. Code Z23 may be used as a secondary code if the inoculation is given as a routine part of preventive health care, such as a well-baby visit.

3) Status

Status codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition.

A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code. For example, code Z94.1, Heart transplant status, should not be used with a code from subcategory T86.2, Complications of heart transplant. The status code does not provide additional information. The complication code indicates that the patient is a heart transplant patient.

4) History (of)

There are two types of history Z codes, personal and family. Personal history codes explain a patient’s past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring.

Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.

Personal history codes may be used in conjunction with follow-up codes and family history codes may be used in conjunction with screening codes to explain the need for a test or procedure. History codes are also acceptable on any medical record regardless of the reason for visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

**The history Z code categories are:**

Z80 Family history of primary malignant neoplasm

Z81 Family history of mental and behavioral disorders

Z82 Family history of certain disabilities and chronic diseases (leading to disablement)

Z83 Family history of other specific disorders

Z84 Family history of other conditions

Z85 Personal history of malignant neoplasm

Z86 Personal history of certain other diseases

Z87 Personal history of other diseases and conditions

Z91.4- Personal history of psychological trauma, not elsewhere classified

Z91.5 Personal history of self-harm

Z91.8- Other specified personal risk factors, not elsewhere classified

Exception:

Z91.83, Wandering in diseases classified elsewhere

5) Screening

Screening is the testing for disease or disease precursors in seemingly well Individuals so that early detection and treatment can be provided for those who test positive for the disease (e.g., screening mammogram).

The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test.

A screening code may be a first-listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done during an office visit for other health problems. A screening code is not necessary if the screening is inherent to a routine examination, such as a pap smear done during a routine pelvic examination.

Should a condition be discovered during the screening then the code for the condition may be assigned as an additional diagnosis.

The Z code indicates that a screening exam is planned. A procedure code is required to confirm that the screening was performed.

The screening Z codes/categories:

Z11 Encounter for screening for infectious and parasitic diseases

Z12 Encounter for screening for malignant neoplasms

Z13 Encounter for screening for other diseases and disorders

Except: Z13.9, Encounter for screening, unspecified

Z36 Encounter for antenatal screening for mother

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. The aftercare Z code should not be used if treatment is directed at a current, acute disease. The diagnosis code is to be used in these cases.

The aftercare Z codes should also not be used for aftercare for injuries. For aftercare of an injury, assign the acute injury code with the appropriate 7th character (for subsequent encounter).

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.

Some of the codes for routine health examinations distinguish between “with” and “without” abnormal findings. Code assignment depends on the information that is known at the time the encounter is being coded. For example, if no abnormal findings were found during the examination, but the encounter is being coded before test results are back, it is acceptable to assign the code for “without abnormal findings.” When assigning a code for “with abnormal findings,” additional code(s) should be assigned to identify the specific abnormal finding(s).

Pre-operative examination and pre-procedural laboratory examination Z codes are for use only in those situations when a patient is being cleared for a procedure or surgery and no treatment is given.

The Z codes/categories for routine and administrative examinations:

Z00 Encounter for general examination without complaint, suspected or reported diagnosis

Z01 Encounter for other special examination without complaint, suspected or reported diagnosis

Z02 Encounter for administrative examination

Except: Z02.9, Encounter for administrative examinations, unspecified

Z32.0- Encounter for pregnancy test

14) Miscellaneous Z codes

The miscellaneous Z codes capture a number of other health care encounters that do not fall into one of the other categories. Certain of these codes identify the reason for the encounter; others are for use as additional codes that provide useful information on circumstances that may affect a patient’s care and treatment.

Miscellaneous Z codes/categories:

Z41 Encounter for procedures for purposes other than remedying health state

Except: Z41.9, Encounter for procedure for purposes other than remedying health state, unspecified

Z53 Persons encountering health services for specific procedures and treatment, not carried out

Z56 Problems related to employment and unemployment

Z57 Occupational exposure to risk factors

Z58 Problems related to physical environment

Z59 Problems related to housing and economic circumstances

Z60 Problems related to social environment

Z62 Problems related to upbringing

Z63 Other problems related to primary support group, including family circumstances

Z64 Problems related to certain psychosocial circumstances

Z65 Problems related to other psychosocial circumstances

Z72 Problems related to lifestyle

Z73 Problems related to life management difficulty

Z74 Problems related to care provider dependency

Except: Z74.01, Bed confinement status

Z75 Problems related to medical facilities and other health care

Z91.1- Patient’s noncompliance with medical treatment and regimen

Z91.83 Wandering in diseases classified elsewhere

Z91.89 Other specified personal risk factors, not elsewhere classified

15) Nonspecific Z codes

Certain Z codes are so non-specific, or potentially redundant with other codes in the classification, that there can be little justification for their use in the inpatient setting. Their use in the outpatient setting should be limited to those instances when there is no further documentation to permit more precise coding. Otherwise, any sign or symptom or any other reason for visit that is captured in another code should be used.

Nonspecific Z codes/categories:

Z02.9 Encounter for administrative examinations, unspecified

Z04.9 Encounter for examination and observation for unspecified reason

Z13.9 Encounter for screening, unspecified

Z41.9 Encounter for procedure for purposes other than remedying health state, unspecified

Z52.9 Donor of unspecified organ or tissue

Z86.59 Personal history of other mental and behavioral disorders

Z88.9 Allergy status to unspecified drugs, medicaments and biological substances status

Z92.0 Personal history of contraception

16) Z Codes That May Only be Principal/First-Listed Diagnosis

The following Z codes/categories may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined:

Z00 Encounter for general examination without complaint, suspected or reported diagnosis

Z01 Encounter for other special examination without complaint, suspected or reported diagnosis

Z02 Encounter for administrative examination

Z03 Encounter for medical observation for suspected diseases and conditions ruled out

Z04 Encounter for examination and observation for other reasons

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

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.

Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-10-CM Tabular List (code numbers and titles), can be found in Section IA of these guidelines, under “Conventions Used in the Tabular List.” Section I.B. contains general guidelines that apply to the entire classification. Section I.C. contains chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Information about the correct sequence to use in finding a code is also described in Section I.

The terms encounter and visit are often used interchangeably in describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other.

Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that:

The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis applies only to inpatients in acute, short-term, long-term care and psychiatric hospitals.

Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

A. 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 Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.

B. Codes from A00.0 through T88.9, Z00-Z99

The appropriate code(s) from A00.0 through T88.9, Z00-Z99 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

C. 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 which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-10-CM codes to describe all of these.

D. Codes that describe symptoms and signs

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

E. Encounters for circumstances other than a disease or injury

ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services codes (Z00-Z99) are provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems*.*

*See Section I.C.21. Factors influencing health status and contact with health services.*

F. Level of Detail in Coding

1. ICD-10-CM codes with 3, 4, 5, 6 or 7 characters

ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of

codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity.

2. Use of full number of ***characters*** required for a code

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

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

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

H. Uncertain diagnosis

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

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

I. Chronic diseases

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

J. Code all documented conditions that coexist

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

K. Patients receiving diagnostic services only

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

For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign Z01.89, Encounter for other specified abnormal finding should be assigned as the first-listed diagnosis. A secondary code for the abnormal finding should also be coded.

Q. Encounters for routine health screenings

*See Section I.C.21. Factors influencing health status and contact with health services, Screening*

Coding Exercises

The following sheets will be used for coding exercises using the principals covered above. The official references for this section are as follows:

ICD-10-CM Guidelines

<http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf>

ICD-10-CM Codes and Descriptionshttp://www.cdc.gov/nchs/icd/icd10cm.htm#icd2014

**Work Sheet Problems:**

1. The 24-year-old male patient presents with neck pain. He woke up with the pain. There is no radiation of pain down the arms. The pain is localized to the neck. Range of motion is diminished in flexion, extension and left lateral flexion. What is the diagnosis?

**What Major Category would be appropriate?**

**What Subcategory code is appropriate?**

2. The 46 year old female patient presents with low back pain with pain radiating down the right leg. This has been going on for 2 weeks and seems to be worsening. Straight Leg Raise Test is positive on the right at 40 degrees with pain going down the back of the right leg to the ankle. Deep Tendon Reflexes are +2 bilateral, Toe Walk and Heel Walk are normal. What is the diagnosis?

**What is the Major Category?**

**What Sub Category Code is Appropriate?**

3. The 42-year-old male patient was the seat belted driver of a 2012 Honda Accord. He was struck from rear by a 2014 Dodge Durango. At the time of the impact he was sitting at a stoplight looking straight ahead. He was not aware of the impending impact. At the time of impact he was thrown back into his seat, where he hit his head against the headrest and then he was thrown forward hard. He hit his right knee on the dash. The seatbelt stopped him hard. Immediately he had a headache in the back of his head and his knee was painful and throbbing. He got out of the car, and was walking with a limp. What is the diagnosis?

**What is the Major Category?**

**What Sub Category Code is Appropriate?**

**Are their other Categories available?**

4. The 15 year old female soccer player was injured while blocking a kick. She landed on the ground injuring her left hip, knee and ankle. The joints are stable. There is no evidence of fracture. She reports pain in the left knee in the inferior medial portion, the left ankle below the medial malleolus and along the left IT Band. What is the diagnosis?

**What is the Major Category?**

**What Sub Category Code is Appropriate?**

**Are their other Categories available?**