



The Coding Institute

AVOID AUDITS • IMPROVE REIMBURSEMENT • REDUCE DENIALS • INCREASE REVENUE

ICD-10 Training Handbook 2014

Your guide to ICD-10 coding and documentation success.

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Introduction

No one can escape learning ICD-10.

If you are a provider, then you need to understand how ICD-10 requires specific documentation — documentation that differs from what was sufficient for ICD-9. If you don't meet the new documentation standards, then you won't be paid what you ethically deserve.

If you are a coder, you must know how to translate the clinical information from the operative report into the ICD-10 system. One incorrect character and your entire claim will be undermined.

Warning: If your practice has not begun training, dual coding, or reviewing of encounter forms, then you need to catch up. Did you know payers may start using the conversion to ICD-10 as another way to squeeze more money out of the reimbursements your practice should receive?

That's why you should use this **ICD-10 Training Handbook 2014** to learn about ICD-10 guidelines and GEMs, confront the training process and why knowing anatomy is so important, get to know some of the documentation changes you need to start implementing now, and check out ICD-10-PCS.

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Expert Breaks Down Your ICD-10 Transition Plan into 5 Phases

Don't forget to include productivity loss in your budget.

You need to make a plan for an ICD-10 transition — but do you know how to create one? Before you start panicking, check out this expert advice.

“Education and patience are key,” says **Dr. Ginger Boyle**, a practicing family physician who has developed a coding education program for her hospital and its family practice residency program during an Oct. 25th CMS National Provider Call entitled, “Preparing Physicians for ICD-10 Implementation.”

This presentation breaks down your ICD-10 transition into the following six phases:

- Planning.
- Communication and awareness.
- Assessment.
- Operational implementation.
- Testing.
- Transition.

In other words: To begin, you should establish the project structure, responsible parties, and highlight physician and coding champions who can be assets. You should also establish the budget. Be sure to include software upgrades, training needs, and productivity loss/gain.

Then, you talk to all those involved, which may include office admin, vendors, providers, clearinghouses, payors, and so on.

You need to monitor the impact on the following aspects:

- personnel: staff, providers
- claims
- reimbursement
- denials
- rejections

Bottom line: “Once you create a timeline, you need to stick to it,” Boyle says. When ICD-10-CM goes into effect, you should apply the code set and official guidelines in effect for the date of service reported.

For more information, you should go to the CMS ICD-10 page at URL: <https://www.cms.gov/Medicare/Coding/ICD10/>. ❖

Discover How to Navigate Your ICD-10-CM Manual — And What’s Different From Your ICD-9-CM Version

Your Injury/Poisoning codes and E codes completely transform.

Good news! You’ll find that your ICD-10-CM coding manual is similar to your ICD-9-CM one, which means you likely already know how to use it. However, don’t miss these subtle differences in your Alphabetic Index and Tabular List.

Check Out the Alphabetic Index

In the Alphabetic Index, you’ll have chapters divided up by letter with a list of terms and their corresponding code. This is where you’ll find the Index of Diseases and Injury, Index of External Causes of Injury, the Table of Neoplasms, and the Table of Drugs and Chemicals.

Here is an example of how hemiatrophy appears in the Alphabetic Index.

Hemiatrophy R68.89

- cerebellar G31.9
- face, facial, progressive (Romberg) G51.8
- tongue K14.8

ICD-10 differences: Here are a few changes to your Alphabetic index in ICD-10-CM:

- ❖ You won’t find morphology codes listed alongside descriptors and standard codes. Morphology codes no longer have a separate appendix either.
- ❖ The Table of Drugs and Chemicals contains an “under-dosing” column.

Don’t Miss This Big ICD-10 Alphabetic Index Change

One of the biggest changes to your ICD-10-CM Alphabetic Index includes what ICD-9-CM currently terms Injury/Poisoning codes and E codes.

In *Chapter 19: Injury, Poisoning And Certain Other Consequences of External Causes*, you'll find your injury codes are organized by body region, starting with the head and ending with the foot. For instance, you'll find the S75 category for "Injury of blood vessels at hip and thigh level" followed by S76 for "Injury of muscle, fascia and tendon at hip and thigh level."

In *Chapter 20: External Causes of Morbidity* contains what ICD-9-CM currently terms E codes (as well as some in Chapter 19). Chapter 20 codes specifically capture:

- ❖ what caused the injury or health condition,
- ❖ the intent behind it (such as unintentional or intentional),
- ❖ the place where an event occurred,
- ❖ what the patient was doing at the time, and
- ❖ the patient's status (such as civilian or military).

For instance, check out 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 playing as team or group: baseball*), and Y99.8 (*Other external cause status [recreation or sport not for income or while a student]*).

Now Check Out the Tabular List

In the Tabular List, you'll find 21 chapters, organized either by body/organ system (such as Diseases of the Circulatory System) or the etiology/nature of the disease process (such as Certain Infectious and Parasitic Diseases).

ICD-10 differences: Here are some differences to your chapters in ICD-10-CM:

- ❖ ICD-9-CM's chapter for the Diseases of the Nervous System and Sense Organs transforms into three separate chapters in ICD-10-CM.
- ❖ ICD-10-CM does not divide up the ICD-9-CM codes for E Codes (External Causes of Injury and Poisonings) and V Codes (Factors Influencing Health Status and Contact with Health Services).
- ❖ Some chapters are reordered.

These chapters are full of categories, subcategories, and codes. Remember, characters may be a letter or a number.

How to Decipher Code Categories

All categories are three characters. If a three character category doesn't have any subdivisions, then this is a complete code.

Subcategories can have either four or five characters. These subcategories have codes listed underneath them that can expand up to seven digits. Some of these codes require a seventh digit and are invalid without them.

Here's an example of how Mesothelioma appears in the Tabular Index.

[4th] Mesothelioma

C45.0 Mesothelioma of pleura

EXCLUDES 1 other malignant neoplasm of pleura (C38.4)

C45.1 Mesothelioma of peritoneum

Mesothelioma of cal-de-sac

Mesothelioma of mesentery

Mesothelioma of mesocolon

Mesothelioma of omentum

Mesothelioma of peritoneum (parietal) (pelvic)

EXCLUDES 1 other malignant neoplasm of tissue of peritoneum (C48-)

C45.2 Mesothelioma of pericardium

EXCLUDES 1 other malignant neoplasm of pericardium (C38.0)

C45.7 Mesothelioma of other sides

C45.9 Mesothelioma, unspecified

Let 4 FAQs Help Guide Your ICD-10 Focus

Don't limit your training to code selection alone.

The ICD-10 implementation deadline — October 1, 2015 — will be here before you know it, and if your practice isn't already preparing, now is the time to start. But where should you begin?

Take a look at these four questions recently sent in to *The Coding Institute* to learn some of the basics of ICD-10 and ensure your practice is set up for success.

Before you begin: Make sure you're learning the right code set. You'll see references to both ICD-10-CM and ICD-10-PCS. For diagnosis coding, you'll use ICD-10-CM. "ICD-10-PCS is a completely different coding system and designed for hospital inpatient procedures," points out **Kathy DeVault, RHIA, CCS, CCS-P**, director of HIM Solutions for AHIMA.

For the purposes of this article, we will be focusing on ICD-10-CM.

1. Can We Wait Until 2015 to Start Training?

Whatever you do, don't save your ICD-10 training until the last minute. If you're unsure of where to start, get an ICD-10 book and begin browsing the codes to get a feel for them and their format, DeVault suggests. You may be surprised at the similarities to ICD-9. "People often say the new code system wasn't as scary as they expected," she says.

Good idea: Take the ICD-10 coding guidelines and assign a chapter to each person on your team, DeVault suggests. Have them discuss and compare the differences from ICD-9. “Then you can start to narrow down what’s significant particular to your specialty,” she says.

Send at least one person from your office now for ICD-10 training and have him or her report back the impact of the transition, recommends **Joanne Byron, LPN, BSNH, CPC, PCS, CHA, ICDCT-CM, ICDCT-PCS**, a Certified ICD-10 Training Instructor with the American Institute of Healthcare Compliance (AIHC), based in Medina, OH. If you’re one of the practices or facilities around the country that does not use electronic health records, it’s even more important to get a head start on training, she notes.

2. Is Coding the Only Area We Need to Focus on For the ICD-10 Transition?

The coming transition to the ICD-10 code set isn’t just about coding. The changes will impact every kind of provider and all payer sources, as well as every aspect of your practice.

The first step you should take toward being prepared for the Oct. 1, 2015 transition deadline is to take a closer look at your current processes. Use the time between now and Jan. 1, 2015 to conduct a thorough assessment. Identify any operational challenges so you can develop and implement solutions before the deadline.

Then, talk to all those involved, which may include office administrators, vendors, providers, clearinghouses, payers, and other associates. You need to monitor the impact on the following aspects: personnel, claims, reimbursement, denials, and rejections.

3. What Are the Main ICD-9 vs. ICD-10 Differences?

Understanding the following six main differences should make it easier when your practice makes the transition from ICD-9 to ICD-10:

1. ICD-10 codes are alpha numeric and up to seven characters in length; ICD-9 codes are only three to five characters.
2. ICD-10 has 21 chapters; ICD-9 has 17.
3. ICD-9’s V and E codes are incorporated into the main classification in the ICD-10 code:
 - a. Placeholders (X) are required to hold places followed by additional characters.
 - b. Seventh characters are required for obstetrics, injuries, and external causes of injuries.
 - c. Post-operative complications will now be located specific to the procedure-specific body system.
4. ICD-10 will classify injuries first by specific site and then by type of injury. ICD-9 classified injuries by type.
5. ICD-10 includes full code titles for all codes, so it is not necessary to reference back to common fourth and fifth digit categories.

6. ICD-10 has combination codes for conditions and common symptoms or manifestations, for example E10.21 (*Type 1 diabetes mellitus with diabetic nephropathy*) and N30.01 (*Acute cystitis with hematuria*).

4. Does ‘x’ Mean the Same in ICD-10 as It Did in ICD-9?

No, the ‘x’ you’ll see in ICD-10 codes does not mean the same as it did in ICD-9 codes.

“We use an ‘x’ in ICD-9 to show that more digits are required, however an ‘x’ is a placeholder in ICD-10, so the dash has taken its place,” says **Lisa Selman-Holman**, consultant and principal of Selman-Holman & Associates and CoDR — Coding Done Right in Denton, Tex.

Seventh character: ICD-10 codes may have a seventh character that is a letter or number and provides more information about the condition being coded. For instance, check out T81.4xxD (*Infection following a procedure; subsequent encounter*).

Dummy placeholder: You don’t have a placeholder in ICD-9, but in ICD-10, it’s always the letter “x.” ICD-10 uses this dummy placeholder to:

- ❖ provide future expansion while keeping the six character structure (such as T65.0x2S), and
- ❖ meet the requirement of coding the highest level of specificity when a code has less than six characters and the code requires a seventh character (such as S17.0xxA).

Dash: When you see a dash at the end of a code, you should know that the code is incomplete. For instance, you might see M84.47- in the Tabular List, meaning you need to review the options to decide how to complete this code. ❖

6 Steps Show You How — and Why — You Must Be More Specific With Muscle and Connective Tissue Disorders

Hint: Pay attention to the site of involvement.

Practices seeing patients with orthopedic conditions may have the toughest challenges when it comes to ICD-10-CM. The reason is that when you’re coding for ligament disorders, palmar fascia contracture, foreign body granulomas, and muscle spasm, your ICD-10 code choices will expand substantially.

Follow these practical training steps to learn about how to handle — and when to not worry too much about — coding common connective tissue conditions.

Step 1: Get Clinical Staff Used to More Specifics

To prep doctors for this level of detail, start training now. “Before the ICD-10 implementation date, coders will need to educate their physicians on the need for a much higher degree of specificity in their diagnostic statements,” says **Heidi Stout, BA, CPC, COSC, PCS, CCS-P**, Coder on Call, Inc., Milltown, New Jersey and orthopedic coding division director, The Coding Network, LLC, Beverly Hills, CA.

Step 2: Identify Discrete Codes for Paraplegia, Fibromatoses

The ICD-9 codes for specific muscle disorders like 728.3 (*Other specific muscle disorders*) which includes disorders like athrogryposis and immobility syndrome (*paraplegic*) translate to two different codes in ICD-10. The ICD-10 code for immobility syndrome is M62.3 (*Immobility syndrome [paraplegic]*) and that for other specific disorders is M62.89 (*Other specified disorders of muscle*).

“Immobility syndrome has been awarded a specific code for ICD-10, while ‘other specified disorders of the muscle’ has been left undefined to capture the remainder of the unspecified muscle disorders,” says **Kristi Stumpf, MCS-P, CPC, COSC, ACS-OR**, owner, Precision Auditing and Coding, senior orthopedic coder & auditor, The Coding Network, Washington.

The ICD-9 code for fibrosis in muscle ligaments, 728.79 (*Other fibromatoses of muscle ligament and fascia*), extends to two ICD-10 codes as below:

- ❖ M72.1 (*Knuckle pads*)
- ❖ M72.4 (*Pseudosarcomatous fibromatosis*)

Step 3: Narrow Down To a Common Code for Ligament Disorders

The ligament disorder code in ICD-10 is more generalized to include a wider array of ligament disorders. Whereas the ICD-9 code 728.4 (*Laxity of ligament*) was solely descriptive of ligament laxity, the ICD-10 code category M24.2-- (*Disorder of ligament ...*) describes ‘disorder of ligament’. This implies that disorders other than a lax ligament can be reported with this code.

Remember: You need to identify the anatomic location where this condition occurs with fifth and sixth digits.

Step 4: Determine Scopes of ‘Other’ and ‘Unspecified’ Muscle Disorders

You’ll find a broader scope for M62.89 (*Other specified disorders of muscle*). The disorder can be in muscle tendons, fascia, ligament, or aponeurosis. The ICD-9 code 728.89 (*Other disorders of muscle ligament and fascia*), in contrast, is more specific for ligament and fascia.

For the unspecified disorders of the connective tissues, you have code 728.9 (*Unspecified disorder of muscle ligament and fascia*) in ICD-9. In ICD-10, you will opt for code M62.9 (*Disor-*

der of muscle, unspecified). “ICD-10 has listed a code specific to the muscle alone. There is also a specific code for disorder of ligament. The ligamentous disorder code is broken down by location, RT vs LT, with unspecified code for each body area when RT and LT are not listed. Coders can now be more specific as the actual tissue affected,” says Stumpf.

Step 5: Get More Specific for Various Other Conditions

The ICD-10 code for Dupuytren’s contracture in the palm is more specific and inclusive of the condition. The ICD-9 code 728.6 (*Contracture of palmar fascia*) includes Dupuytren’s contracture though the same does not appear in the descriptor. On the contrary, the ICD-10 code for the same is M72.0 (*Palmar fascial fibromatosis [Dupuytren]*) which aptly specifies the condition in the descriptor. “M72.0 is very specific to palmar fibromatosis, whereas ICD-9 code 728.6 can be utilized for any contracture of the palmar fascia. Although ICD-9 code 728.6 is used for Dupuytren’s contracture, it would also apply to any other pathology resulting in palmar contracture,” says Stumpf. “Dupuytren’s contracture is by far the most common cause of palmar fibromatosis,” adds **Bill Mallon, MD**, medical director, Triangle Orthopedic Associates, Durham, N.C.

The ICD-9 code 728.82 (*Foreign body granuloma of muscle*) for foreign body granuloma of muscle will become inclusive of foreign body granulomas in other soft tissues once ICD-10 rolls out. Code M60.20 (*Foreign body granuloma of soft tissue, not elsewhere classified, unspecified site*) includes foreign body granulomas in soft tissues other than the muscles. For example, you will report subcutaneous tissue foreign body granulomas using the code M60.20.

You will find a single code for muscle spasm in ICD-9. The code 728.85 (*Spasm of muscle*) includes spasm of any type, including that due to injury and stroke and due to conditions in which the brain or the spinal cord are destroyed, example cerebral palsy or multiple sclerosis. “In ICD-9, the default code for muscle contracture was 728.85, for lack of a more specific code choice,” says Stumpf.

However, going further in once ICD-10 implementation date hits, you will have an option of two codes for such conditions. These include M62.40 (*Contracture of muscle, unspecified site*) and M62.838 (*Other muscle spasm*).

The catch: You’ll need to know the potential reversibility of the muscle contraction. If the muscle has contracted, become shortened, and fixes the limb permanently in one position, you would use code M62.40. However, if it is a contraction that has some potential of reversibility, you report code M62.838.

“ICD-10 is supplying a very specific code for muscle contracture,” says Stumpf. “ICD-10 has supplied 24 codes from M62.40 through M62.49 to specify specific locations, RT vs LT, an unspecified code for each body location for use when RT/LT has not been clarified, and for ‘other site’ and ‘multiple sites’.”

Step 6: Don't Worry About Other Changes

Don't worry, however. You'll find other codes that do not reflect any change in descriptors in ICD-10. The descriptors for 728.5 (*Hypermobility syndrome*) in ICD-9 and M35.7 (*Hypermobility syndrome*) in ICD-10 are similar. The same is true of code 728.71 (*Plantar fascial fibromatosis*) in ICD-9 and code M72.2 (*Plantar fascial fibromatosis*) in ICD-10 for the fibrosis of the plantar fascia.

Another such example are the codes for necrotizing fasciitis in ICD-9, 728.86 (*Necrotizing fasciitis*) and M72.6 (*Necrotizing fasciitis*) in ICD-10 and for generalized muscle weakness in ICD-9, 728.87 (*Muscle weakness [generalized]*), and M62.81 (*Muscle weakness [generalized]*) in ICD-10. The codes for rhabdomyolysis in ICD-9 (728.88 [*Rhabdomyolysis*]) and ICD-10 (M62.82 [*Rhabdomyolysis*]) have common descriptors.

Another important condition that you may frequently report is the Ehlers-Danlos syndrome. "This commonly described condition may manifest as hypermobility and may present with ligamentous hyperlaxity," says Mallon. You report code 756.83 (*Ehlers-Danlos syndrome*) for this specific condition. Once the ICD-10 implementation date rolls around, you shall report Q79.6 (*Ehlers-Danlos syndrome*). ❖

Target These Areas to Fast Track Your ED Diagnosis Coding Transition

From extreme epistaxis to dolphin bites, specificity is all important with ICD-10.

If you're wondering how best to ensure your emergency department coding team is ready for ICD-10, help is here.

Read on for expert advice from certified ICD-10 instructor **Caral Edelberg, CPC, CPMA, CAC, CCS-P, CHC; AHIMA**, President, Edelberg Compliance Associates, Baton Rouge, LA, on how ICD-10 will affect ED coding and tips for a smooth transition.

Brush Up on Basic ICD-9, ICD-10 Differences

ICD-10-CM codes are the ones designated for use in documenting diagnoses. They are 3-7 characters in length and total 68,000, while ICD-9-CM diagnosis codes are 3-5 digits in length and number over 14,000. The ICD-10-PCS are the procedure codes and they are alphanumeric, 7 characters in length, and total approximately 87,000, while ICD-9-CM procedure codes are only 3-4 numbers in length and total approximately 4,000 codes.

Take a look at the following format diagrams that illustrate the differences in code structure between ICD-9 and ICD-10:

ICD-9-CM Code Format: Diagnosis Codes

9 9 9 •	9	9
Category	Subcategory	Additional Specificity

ICD-10-CM Structure: Diagnosis Codes

E 9 9 •	9 9 9	9
Category	Etiology, anatomic site, manifestation	Extension

The number of codes has increased significantly, and the reformatting of the number of characters per code and the demands for increased code specificity require significant planning, training, software/system upgrades/replacements. The move to ICD-10 impacts other coding and billing systems as well. As of January 1, 2012, the HIPAA transaction standards known as “5010” requires revision to accommodate ICD-10 codes, says Edelberg.

Get ED Physicians Ready for These Specifics

Although the major impact will be on IT systems and coding professionals, the dramatic change in ICD-10 code descriptions will mean your physicians will need to upgrade their documentation practices at all levels. Providers will be required to look differently at how differential diagnoses, final diagnoses, operative notes, diagnostic interpretations and more are documented, says Edelberg.

For a sneak peek at what’s coming ED coding, compare these common ED diagnosis statements and the associated codes in ICD-9 and ICD-10:

Condition	ICD-9-CM Codes	ICD-10-CM Codes
Dyspnea and shortness of breath with intercostal pain in left-sided rib cage	786.05, 786.09, 786.50	R06.02, R07.82
Emergency encounter for respiratory arrest in patient with myasthenia gravis	799.1, 358.01	R09.2, G70.01
Unstable angina in a former smoker who had a 10-year pack a day habit	411.1, V15.82	I20.0, Z87.891
Atypical chest pain	789.59	R07.89
Ischemic chest pain	413.9	I20.9
Extreme epistaxis requiring cauterization and packing	784.7	R04.0

Documentation pointer: Don't let the complexities of the new system throw you. Because so many conditions are combined into one ICD-10 code where they were previously identified individually, you will see complex statements like those below bundled into one specific code:

Condition	ICD-10 Code
Severe generalized abdominal pain with abdominal rigidity	R10.0
Initial encounter for electrocution	T75.4xxA
Acute bacterial food poisoning due to Salmonella with no current complications	A02.9
Coma Scale, eyes open, never, in the field (EMT or ambulance)	R40.2111

Anatomy rules: Providers will be required to provide a higher level of anatomical detail in notes and note conditions such as “stabbing”, “visible”, “extreme” and a more specific and exact location of problem.

Coma scale? Make sure you know it: Documentation of a Glasgow Coma Scale will be required for coding many neurologic complaints and will require that coders clearly understand how the Coma Score translates to conditions recognized for coding, (e.g. motor response, verbal response, eye opening). Expanding documentation “macros” and templates will be a significant component of the transition to ICD-10, says Edelberg.

Humor helps: Although preparation for ICD-10 is serious business, to provide some comic relief for what promises to be a bumpy road ahead, consider the following conditions that will be addressed by ICD-10 External Causes of Morbidity: ❖

Condition	ICD-10 Code
Skateboarded colliding with stationary object, initial encounter	V00.132A
Spacecraft collision injuring occupant, subsequent encounter	V95.43xD
Struck by turtle, initial encounter	W59.22xA
Bitten by dolphin, initial encounter	W56.01xA
Activity involving handheld interactive electronic device (texting?)	Y93.c2
Person on outside of car injured in collision with pedestrian or animal in non-traffic accident	V40.2xxD

Drill Down to Manifestations to Report Substance Use and Dependence Dx

Tip: Get clarity on abuse vs. dependence to get the correct code.

Get ready to change your mindset when choosing a diagnosis code for substance use, abuse, or dependence under ICD-10. Current ICD-9 codes focus on the patterns of use (episodic, continuous, or unspecified), but you'll need to define acute or chronic use to pinpoint the right code under ICD-10.

ICD-9: Sub-Par Documentation Could Trap You in 'Unspecified'

ICD-9 does not clearly define the terms "episodic" or "continuous" use, although you have fifth-digit subclassification choices for use that is unspecified, episodic, continuous, or in remission. Not having clearly defined parameters means providers might not adequately document the situation which relegates you to the "unspecified" fifth digit of 0.

Example: The physician diagnoses opioid dependence in the patient. Your code choices are:

- ❖ 304.00 — *Opioid type dependence; unspecified use*
- ❖ 304.01 — ... *continuous use*
- ❖ 304.02 — ... *episodic use*
- ❖ 304.09 — ... *in remission.*

ICD-10: Look for 'Abuse' vs 'Dependence' vs 'Unspecified'

ICD-10 has a clearer classification for the substance use and abuse codes. Begin by asking if the disorder (whether acute or chronic) results from longer-term use.

If the patient doesn't have a current, acute manifestation of the use or abuse, you'll code his condition as "uncomplicated." For example, you might choose F11.10 (*Opioid abuse, uncomplicated*) or F11.20 (*Opioid dependence, uncomplicated*) to describe opioid abuse or dependence.

Key: The clinician will document abuse or dependence according to clear parameters of clinical examination and medical history. If you don't have documentation of either abuse or dependence, you'll classify the condition as unspecified, with a code such as F11.90 (*Opioid use, unspecified, uncomplicated*).

If you look at the extended ICD-10 bridge for 304.00, you'll find more than 10 ICD-10 codes. Table 1 lists the ICD-10 codes that the current code 304.00 spans to.

Table 1: ICD-10 Codes Matching to 304.00 in ICD-9
Codes for opioid dependence with intoxication
<i>F11.220 Opioid dependence with intoxication, uncomplicated</i>
<i>F11.221 Opioid dependence with intoxication delirium</i>
<i>F11.222 Opioid dependence with intoxication with perceptual disturbance</i>
<i>F11.229 Opioid dependence with intoxication, unspecified</i>
Code for opioid dependence with withdrawal
<i>F11.23 Opioid dependence with withdrawal</i>
Code for opioid and mood disorder
<i>F11.24 Opioid dependence with opioid-induced mood disorder</i>
Codes for opioid use and psychotic disorders
<i>F11.250 Opioid dependence with opioid-induced psychotic disorder with delusions</i>
<i>F11.251 Opioid dependence with opioid-induced psychotic disorder with hallucinations</i>
<i>F11.259 Opioid dependence with opioid-induced psychotic disorder, unspecified</i>
Codes for opioid use and sexual or sleep disorders
<i>F11.281 Opioid dependence with opioid-induced sexual dysfunction</i>
<i>F11.282 Opioid dependence with opioid-induced sleep disorder</i>
Others
<i>F11.288 Opioid dependence with other opioid-induced disorder</i>
<i>F11.29 Opioid dependence with unspecified opioid-induced disorder</i>

Manifestations of intoxication and withdrawal: If the provider documents manifestations like delirium or withdrawal symptoms associated with abuse or dependence, you currently have separate codes choices under ICD-9. With ICD-10, however, you can report a single code to capture the conditions. Table 2 illustrates the intoxication and delirium options in ICD-10 and the corresponding existing codes in ICD-9.

Table 2: Codes for Manifestations Opioid Dependence	
ICD-9 Codes	ICD-10 Codes
<i>292.81 Drug-induced delirium</i>	<i>F11.221 Opioid dependence with intoxication delirium</i>
<i>304.00 Opioid type dependence unspecified use</i>	
<i>292.0 Drug withdrawal</i>	<i>F11.23 Opioid dependence with withdrawal</i>
<i>304.00 Opioid type dependence unspecified use</i>	

The same holds true for reporting of chronic problems due to substance use.

Example: If you need to report insomnia due to opioid dependence, you would report both 292.85 (*Drug induced sleep disorders*) and 304.00 as the secondary diagnosis code in ICD-9. In ICD-10, you'll turn to the single, more specific code F11.282 (*Opioid dependence with opioid-induced sleep disorder*).

For the DSM-IV definitions and criteria of abuse and dependence, please read more on <http://www.sis.indiana.edu/DSM-IV-Criteria.aspx> http://www.who.int/substance_abuse/terminology/abuse/en/index.html. ❖

Take This Migraine Signs and Symptoms ICD-10 Challenge

Try your hand at looking up these signs and symptom equivalents.

With ICD-10 on the horizon for late 2015, you need to start applying your otolaryngology diagnosis coding concepts to ICD-10. For instance, do you have a hard time telling the boundaries between migraine headache signs and symptoms? Pinpoint the appropriate migraine diagnosis using these pointers. *Then*, take the next step by converting these codes into ICD-10.

Remember, Symptoms Tell A Deeper Story

Even physicians do not have internationally accepted criteria for migraine-associated dizziness. When a patient who has migraine presents to the office with complaints of dizziness, usually, the otolaryngologist would diagnose it by looking at symptoms for a migraine headache (346.9x), which include:

- ❖ unilateral throbbing pain lasting from four to 72 hours, along with nausea/vomiting (787.01);
- ❖ photophobia (368.13); and/or
- ❖ abnormal auditory perception (388.40).

Challenge 1:

Your ICD-9 codes for the above-mentioned conditions are:

_____.

Your ICD-10 codes for the above-mentioned conditions are:

_____.



Additionally, vertigo (780.4) takes place often in patients who have had migraine episodes without aura (346.1x), but it can also occur in migraine with aura (346.0x).

The physician should also take a thorough history of the patient's migraine. For instance, he should determine if the dizziness had occurred during a headache-free interval, or if it came with symptoms such as spontaneous rotational vertigo, motion sickness (994.6), and visual motor sensitivity.

Challenge 2:

Your ICD-9 codes for the above-mentioned conditions are:

Your ICD-10 codes for the above-mentioned conditions are:

**Check Your Answers**

For **Challenge 1**, you should report migraine headache (346.9x); unilateral throbbing pain lasting from four to 72 hours, along with nausea/vomiting (787.01), photophobia (368.13); and abnormal auditory perception (388.40).

The ICD-10 equivalents are G43.-- (*Migraine*), R11.2 (*Nausea with vomiting, unspecified*),

H53.14- (*Visual discomfort*), and H93.2-- (*Other Abnormal auditory perceptions*).

For **Challenge 2**, you should report vertigo (780.4); migraine episodes without aura (346.1x); migraine with aura (346.0x); and motion sickness (994.6).

The ICD-10 equivalents are R42 (*Dizziness and giddiness*), G43.0- (*Migraine without aura*), G43.1- (*Migraine with aura*), and T75.3xxA (*Motion sickness, initial encounter*). ❖

Transform How You Report V Codes Into Z Codes

5 fill-in-the-blanks challenge your ob-gyn “encounter” diagnosis know-how.

The V codes are not only for providing supplemental information on your ob-gyn claims, and you could be facing denials or lower payments because you’re avoiding V codes. They are, in fact, key elements to correct coding practices. You don’t have to be wary of using your V codes.

Take this quiz and see how you score when it comes to V codes. Plus, find out what these codes will become in ICD-10.

Read These 5 Questions

Question 1: When the ob-gyn doesn’t get to the patient in time to deliver the baby (she delivers in the emergency department) but does deliver the placenta (59414, *Delivery of placenta [separate procedure]*), you should report _____ because the emergency-department doctor will report 650 (*Normal delivery*), assuming there are no other issues complicating the delivery.

Question 2: When you’re doing a hepatitis screening test for a non-pregnant ob-gyn patient, you should report _____ in the absence of any symptoms.

Question 3: A patient comes in for enteritis, but the ob-gyn doesn’t order an NST—instead he documents that the patient’s enteritis was not complicating the pregnancy. In that case, you should report 558.9 (*Other and unspecified noninfectious gastroenteritis and colitis*) and _____.

Question 4: If a pregnant patient has been exposed to Parvo but you don’t have the definitive test results back yet, you should use 648.9x (*Other current conditions classifiable elsewhere*) and _____ for the diagnoses codes.

Question 5: For a patient who has had a tubal ligation but has not made an attempt to have it reversed, the only diagnosis would be _____. Next, compare your responses to these answers.

Apply Actual Diagnosis Codes

Answer 1: V24.0 (*Postpartum care and examination; immediately after delivery*). Keep in mind that if the ob-gyn provides antepartum care for this patient, you can also report the antepartum visits according to the number of visits.

In ICD-10, you'll use Z39.0 (*Encounter for care and examination of mother immediately after delivery*).

Answer 2: V73.89 (*Special screening exam; other specified viral diseases*). Because the question states non-pregnant patient, this is the V code you would use. However, if the patient is pregnant, you would use V28.89 (*Other specified antenatal screening*) because this is part of the antenatal screening.

In ICD-10, you'll report Z11.59 (*Encounter for screening for other viral diseases*). The equivalent for V28.89 will be Z36 (*Encounter for antenatal screening of mother*). *Note:* In ICD-10, you will only have one code for antenatal screening — unlike the 11 code choices in ICD-9.

Answer 3: V22.2 (*Pregnant state, incidental*). This code indicates, by the way, the patient is also pregnant. If the enteritis is complicating the pregnancy, you should report 648.93 (*Other current conditions classifiable elsewhere, but complicating pregnancy; antepartum condition or complication*) along with 558.9. You wouldn't need a V code in this case.

In ICD-10, V22.2 will become Z33.1 (*Pregnancy state, incidental*). Code 648.93 will become O99.89 (*Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium*). You will have two options for 558.9, which are K52.89 (*Other specified noninfective gastroenteritis and colitis*) and K52.9 (*Noninfective gastroenteritis and colitis, unspecified*).

Answer 4: V23.89 (*Supervision of other high-risk pregnancy*) and V01.79 (*Contact with or exposure to other viral diseases*). This is because the ob-gyn only suspects the Parvo, but the possible presence of this condition would put the pregnancy at risk. If Parvo is not confirmed, the diagnosis code reverts to V22.0 or V22.1. If the ob-gyn confirms the Parvo, your diagnosis would change to 647.63 (*Other viral diseases in the mother classifiable elsewhere, but complicating pregnancy; antepartum condition or complication*). If the patient is not pregnant and the ob-gyn has not yet confirmed the Parvo, you would use only V01.79.

In ICD-10, V01.79 will become Z20.828 (*Contact with and [suspected] exposure to other viral communicable diseases*) in this case. Code 647.63 will become O98.51- (*Other viral diseases complicating pregnancy ...*) with a sixth digit based on trimester (1, 2, or 3).

Answer 5: V26.51 (*Tubal ligation status*). You can find this diagnosis code under procreative management in the V26.x category. Code V26.51 reflects the reason this patient is sterile. It excludes infertility not due to previous tubal ligation, which would direct you to the 628.0-628.9 diagnoses codes.

In ICD-10, V26.51 will become Z98.51 (*Tubal ligation status*). ❖

Diagnosis Spotlight: Get Specific With Pressure Ulcer Coding in ICD-10

Reporting multiple ulcers? Reduce confusion with separate codes for bilateral locations.

Coding for pressure ulcers in ICD-9 seems pretty straightforward, but don't relax your standards too much, as your coding will change when ICD-10 goes into effect Oct. 1, 2015. Take a closer look at how you'll report pressure ulcers.

ICD-9: Currently, under ICD-9, you'll first select a location code from the 707.00 to 707.09 range to describe where your patient has a pressure ulcer. Next, you'll list one of the six pressure ulcer stage codes in the 707.2x (*Pressure ulcer stages*) subcategory.

"The two-code method now makes so much sense — location then stage," says **Edie DiMuro, RN, BSN, COS-C, with Visiting Nurse Services of Connecticut** in Bridgeport.

On the other hand: In ICD-9, if a patient has bilateral pressure ulcers at the same location or several pressure ulcers in different locations but at the same stage, you cannot represent all the pressure ulcers with your coding, points out **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C, HCS-O**, consultant and principal of **Selman-Holman & Associates and CoDR — Coding Done Right** in Denton, Texas.

Welcome Simplicity, Laterality in ICD-10

You'll choose from 149 different pressure ulcer codes in the L89.000 to L89.95 range once ICD-10 goes into effect. But your pressure ulcer coding won't be any more complicated.

The fourth digit of each ICD-10 pressure ulcer code covers the general location of the pressure ulcer (such as "hip") and the fifth digit gives further location specifics, (such as "right hip" or "left hip"). Rather than listing an additional code to report the pressure ulcer stage, in ICD-10, the sixth digit describes the stage — Stages 1-4, or whether the ulcer is unstageable or of an unspecified stage.

Improvement: The ICD-10 pressure ulcer codes not only cut down on the number of codes you'll need to list, they also provide specificity that was frustratingly lacking in ICD-9.

Remember, in ICD-9, you have no way to report bilateral ulcers of the same stage.

For example: Suppose your patient has a stage 3 pressure ulcer on his right buttock and a stage 3 pressure ulcer on his left buttock. You can only report one site and stage code pair to describe both ulcers: 707.05 (*Pressure ulcer; buttock*) and 707.23 (*Pressure ulcer, stage III*).

With ICD-10's improved laterality, you can report two codes to describe both pressure ulcers. For this patient, you would report L89.313 (*Pressure ulcer of right buttock, stage III*) as well as L89.323 (*Pressure ulcer of left buttock, stage III*) to better specify your patient's condition.

Stay the Course With Unstageable Pressure Ulcers

Just as you do in ICD-9, you'll have a code for reporting unstageable pressure ulcers in ICD-10. In ICD-9, it's 707.25 (*Pressure ulcer, unstageable*), while in ICD-10 it's L89.— 0 (*Pressure ulcer ... unstageable*). Remember, it's only appropriate to list an unstageable pressure ulcer code when the stage of your patient's pressure ulcer cannot be clinically determined.

For example, you should list an unstageable pressure ulcer code when the pressure ulcer is covered by eschar or when the patient has a documented deep tissue injury that is not due to trauma.

Just as in ICD-9, you'll list a different code when you have no documentation regarding the stage of the pressure ulcer. In ICD-9, look for 707.20 (*Pressure ulcer, unspecified stage*) while in ICD-10, you'll have to use L89.—9 (*Pressure ulcer ... unspecified stage*).

Try Your Hand at the Coding Scenario

Now that you know the basics of how pressure ulcer coding will change in ICD-10, why not test your skills with a scenario? If you don't already have an ICD-10 manual, you can find the latest version of the code set online at <http://cms.gov/Medicare/Coding/ICD10/2014-ICD-10-CM-and-GEMs.html>.

Coding scenario: Your patient has a stage 3 pressure ulcer on her right buttock and a stage 4 pressure ulcer on her right shoulder blade. She also has a DTI on her right heel. She has type 2 diabetes and failure to thrive. You will be providing dressing changes on the stage 3 and stage 4 pressure ulcers and pressure relief for her DTI with no dressings. Code for this patient with the following ICD-10 codes, says Selman-Holman.

- ❖ L89.114 (*Pressure ulcer of right upper back, stage 4*);
- ❖ L89.313 (*Pressure ulcer of right buttock, stage 3*);
- ❖ E11.9 (*Type 2 diabetes mellitus without complications*);
- ❖ R62.7 (*Adult failure to thrive*);
- ❖ L89.610 (*Pressure ulcer of right heel, unstageable*); and
- ❖ Z48.00 (*Encounter for change or removal of nonsurgical wound dressing*).

First, list your patient's pressure ulcers, since they are the focus of care. Sequence the stage 4 pressure ulcer first (L89.114) followed by the stage 3 (L89.313).

Next, list your patient's diabetes. Her pressure ulcers aren't a result of the diabetes, so there is no need to use manifestation coding here. Instead, list E11.9 to indicate your patient's type 2 diabetes.

Follow the diabetes code with R62.7 to indicate that your patient has adult failure to thrive. Then, list L89.610, the unstageable pressure ulcer code, to indicate that the patient also has a DTI.

Finally, report Z48.00 to indicate that you will be providing dressing changes. To find this code in the Alphabetic Index of your ICD-10 manual, look under “Aftercare, Involving, Removal of” or “Change, dressing (nonsurgical)” or “Admission, Removal of” or “Removal (of).” ❖

Start Memorizing This Pregnancy Code In Place of V22.2

Don’t overlook this Excludes1 notation.

When a patient reports to your practice and is pregnant, but the complaint she is being seen for is documented as “incidental” to the pregnancy, you will report this code along with a code outside of the obstetric complications chapter of ICD-10-CM that signifies the complaint.

ICD-9-CM Code: Right now, you should be reporting V22.2 (*Pregnant state, incidental*).

ICD-10-CM Code: In October, you will report Z33.1 (*Pregnant state, incidental*). Good news: You have a one-to-one correlation between these codes. Both descriptors match up. You’ll simply shift from V22.2 to Z33.1 when ICD-10 implementation date hits.

Documentation: The provider must document that pregnancy is incidental in the chart note at the time of the encounter in order for you to use this code.

Here is how you will locate this code in your Alphabetic Index:

Pregnancy (**childbirth**) (**labor**) (**puerperium**) —see also Delivery and Puerperal

- incidental finding Z33.1

State (**of**)

- pregnant, incidental Z33.1

Coding tips: You will see an Excludes1 note under Z33.1 stating you should not report this code with complications of pregnancy codes (O00-O9A). ❖

Tools: Pinpoint Your Rib ICD-10-CM Fracture Code Using This Chart

Don't overlook your "bilateral" option for a multiple rib fracture situation.

Fracture codes both explode and transform in ICD-10, which means you need to embrace any tool that can streamline your code selection.

Take a look at the following chart for rib fractures, and check out how you can easily "build" your seven digit diagnosis, based on your physician's documentation.

Follow These First Column Instructions

You should determine whether the fracture occurred in one rib or multiple ribs. If the injury was to one rib, you'll begin your code with "S22.3." If the rib was to multiple ribs, you'll use "S22.4" instead.

Tip: Once you have this code chosen, you'll follow the same row over to the next column.

Second Column Means Examining Location

In the second column, you'll choose your fifth and sixth characters based on anatomic location.

For instance, if the patient fractured a single rib on the right, you'll add "1X" onto your "S22.3" to make "S22.31X." You still have to add a seventh digit.

Heads up: Because these diagnoses describe rib fractures, you only have the option of displaced. Remember, displaced fractures mean the two ends of the bone are separated from one another. Not much can be done for fractured rib, which hasn't moved out of normal position or alignment.

Anatomic Location (Characters 1-4)	Side or Type (Characters 5-6)	Encounter (Character 7)
RIBS (SINGLE) (S22.3---)	1X = Displaced/Unspecified Right Side 2X = Displaced/Unspecified Left Side 9X = Displaced/Unspecified Side	A = initial encounter for closed fracture B = initial encounter for open fracture D = subsequent encounter for fracture with routine healing G = subsequent encounter for fracture with delayed healing K = subsequent encounter for fracture with nonunion S = sequela
RIBS (MULTIPLE) (S22.4---)	1X = Displaced/Unspecified Right Side 2X = Displaced/Unspecified Left Side 3X = Displaced/Bilateral 9X = Displaced/Unspecified	

Third Column Means Choosing Encounter

Finally, you need to add your last character, which means moving over to the last column. No matter what row in which you started, you will use the communal third row option, based on the patient's encounter. The initial visit depends on whether the rib fracture was open or closed.

So, if the patient with the single fracture to his right rib ("S22.31X") presents to your practice for a subsequent visit for routine healing, you will add "D" to complete your seven digit code. Therefore, the entire correct code will be S22.31XD.

Try Your Hand With This Example

Suppose a patient with bilateral displaced rib fractures presents for an initial visit for a closed fracture. What diagnosis code should you report?

Solution: S22.43XA.

Here's how you arrive at this diagnosis using the chart above. In the first column, you would choose the code for multiple ribs ("S22.4"). In the second column, you would choose the option for bilateral displaced, which is "3X." Finally, because this was the initial visit for a closed fracture, you would apply the "A" character from the third column. ❖

Debunk These 4 ICD-10 Myths and Mysteries

Aftercare codes won't be a thing of the past in ICD-10.

With the healthcare industry on edge and ready to jump into the ICD-10 transition, now is a critical time for coders to start the education process. Make certain your training is on-target, so you aren't caught up in any ICD-10 myths.

Myth #1: You don't need to purchase an ICD-10 coding manual.

"The truth is that coders planning to learn the ICD-10 code set must purchase an ICD-10 coding manual in order to properly complete training," says Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O, AHIMA Approved ICD-10 Trainer/Ambassador.

"Don't let someone fool you into thinking that the GEMs (General Equivalence Mappings) noted in the current ICD-9 Manual are an acceptable method for learning," says **Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O**, AHIMA Approved ICD-10 Trainer/Ambassador.

CMS states, "The GEMs are not a substitute for learning how to use ICD-10-CM and ICD-10-PCS. Providers' coding staff will assign codes describing the patients' encounters from the ICD-10-CM and ICD-10-PCS code books..."(CMS ICD-9-CM Notice, *General Equivalence Mappings*, April 2010, pg 1).

“Not only is trying to use the GEMs for learning likely to mislead your ICD-10 coding experience, but without the use of a current ICD-10-CM manual, you will not have access to coding guidance,” Whitemyer cautions.

Why? Just as is true in your current ICD-9 coding manual, the ICD-10 manual includes guidance such as when to use an additional code, and Excludes 1 and 2 notes, Whitemyer says. “These features are essential for the training process and any attempt to learn the ICD-10 code set without access to this information is incomplete.”

Myth #2: Everyone will use the same codes in ICD-10, so you can code the same regardless of the provider setting.

Wrong again, says Whitemyer. The implementation and use of the ICD-10-CM code set is tied to HIPAA regulation, so all providers will be required to make the transition and use the same code set beginning October 1, 2015. But coders will continue to utilize provider-specific guidance in assigning diagnoses codes, she says.

And the codes themselves cannot directly transfer for use from one provider setting to the next. For example, fracture codes will include a seventh character specifying the episode of care; such as in ICD-10 code S72.8X1D- (*Other fracture of right femur; subsequent encounter for fracture with routine healing*). The seventh character “D” in this code indicates subsequent episode, closed fracture, and routine healing, Whitemyer points out.

In ICD-10-CM, fracture codes such as S72.8X1D- include as many as sixteen possible seventh characters. And three of those seventh characters aren’t applicable to home health coding scenarios, for instance, because they indicate an initial encounter, Whitemyer says.

Myth #3: In ICD-10-CM, you can use the same code twice.

Absolutely not, Whitemyer says. Listing the exact same code twice in ICD-10-CM is no different than it is now — a mistake. It would be redundant and violate coding guidelines.

Yet some coders have leapt to this conclusion when reviewing the ICD-10 code set. “Coders, this is where you must be cautiously diligent to involve yourself in ICD-10 education and assure your complete understanding,” Whitemyer says.

Truth: The ICD-10-CM code set does provide specificity in codes to allow for laterality, Whitemyer says. Considering this, it might be appropriate to code, for example, a stage one decubitus ulcer of the right elbow (L89.011), followed by a stage 1 decubitus ulcer of the left elbow (L89.021), she says.

In a case such as the one described above, the coder is reporting a stage one decubitus ulcer of the elbow twice, because the patient has bilateral ulcers, Whitemyer says. But the coder isn’t reporting the same ulcer twice, she says.

On the other hand: If the ulcers were both located on one side, the coder would not duplicate the code, Whitemyer says. “One of the great benefits of the ICD-10-CM code set is its specificity. Coders need to keep in mind that specificity should not be confused with duplicity.”

Myth #4: Home health coders won’t have to use any aftercare codes in ICD-10.

This couldn’t be further from the truth, Whitemyer says. But there are definite changes in the use of aftercare codes within the ICD-10-CM code set, especially for home health coders, she says.

Most significantly for the home health coding community, this means no longer coding aftercare for fractures, but instead using the seventh character modifier to specify episode of care and healing status, Whitemyer says.

But home health coders will continue to use other aftercare codes such as Z47.1 (*Aftercare following joint replacement surgery*) when appropriate, Whitemyer says.

Tip: Aftercare codes in ICD-10-CM can be located in Chapter 21, “Factors influencing health status and contact with other health services” of the ICD-10-CM code set.

Have a Transition Plan

As you move from a code set of only 13,000 ICD-9-CM codes compared to ICD-10-CM’s 68,000, home health coders need to assure that they have a plan for a smooth and structured transition to the ICD-10 system, Whitemyer says.

Gold standard: Be sure that an AHIMA Approved ICD-10-CM Trainer provides any ICD-10 training, and verify any information that sounds suspect, Whitemyer advises. Coders need to keep in mind that just one course in ICD-10 won’t do, and that training and practice will be necessary to become comfortable working in the new code set prior to October 1st, 2015. ❖

Reader Questions

Look for Similarities with Catheter Infection Coding

Question: *Our patient has an implanted port with a localized Staphylococcus aureus infection that is resistant to penicillin and bacitracin. How should we code for her?*

Answer: Currently, you would list the following codes for this patient:

- ❖ 999.33 (*Local infection due to central venous catheter*);
- ❖ 041.12 (*Methicillin resistant Staphylococcus aureus*); and

- ❖ V09.81 (*Infection with microorganisms resistant to other specified drugs with resistance to multiple drugs*).

To find the right complication code for this patient, look under “Infection, “central-line associated” in the alphabetic index of your coding manual.

Follow up with 041.12 to describe the infection further and V09.81 to indicate that the infection is resistant to multiple drugs.

In ICD-10, you would report the following codes for this patient:

- ❖ T80.212- (*Local infection due to central venous catheter*);
- ❖ B95.62 (*Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere*); and
- ❖ Z16.24 (*Resistance to multiple antibiotics*). ❖

List 3 Codes for Post-Pancreatectomy Hypoinsulinemia

Question: *Our new patient had a Whipple procedure to treat pancreatic cancer located in the head of the pancreas. As a result of this partial pancreatectomy, the patient developed hypoinsulinemia and diabetes. There are plans for him to have chemotherapy and radiation. We are providing surgical aftercare. How should we code for him?*

Ohio Subscriber

Answer: A Whipple procedure treats pancreatic cancer by removing the head of the pancreas as well as parts of other nearby organs and tissues.

To code for this patient, in ICD-9, list the following codes:

- ❖ V58.42 (*Aftercare following surgery for neoplasm*);
- ❖ 157.0 (*Malignant neoplasm of head of pancreas*);
- ❖ 251.3 (*Postsurgical hypoinsulinemia*);
- ❖ 249.0 (*Secondary diabetes mellitus without mention of complication*); and
- ❖ V88.12 (*Acquired partial absence of pancreas*).

You'll need to list three codes to describe your patient's hypoinsulinemia following the Whipple procedure. If your patient had any diabetic manifestations, you would need to list them in addition to the correct 249.x code.

Tip: Pancreatic cancer often recurs even after surgical removal, and in your patient's case he will receive additional treatment directed at the neoplasm, so you should code for the neoplasm as current rather than using a V code to indicate a history of cancer.

In ICD-10, you would list the following codes for this patient:

- ❖ Z48.3 (*Aftercare following surgery for neoplasm*);
- ❖ C25.0 (*Malignant neoplasm of head of pancreas*);
- ❖ E89.1 (*Postprocedural hypoinsulinemia*);
- ❖ E13.9 (*Other specified diabetes mellitus without complications*); and
- ❖ Z90.41- (*Acquired absence of pancreas*).

You don't mention whether your patient is on insulin. If he is, in ICD-9 you should list V58.67 (Long-term [current] use of insulin) and in ICD-10, you'll report Z79.4 (Long-term [current] use of insulin). ❖

Check Out How DCIS Will Change

Question: Will DCIS still be one code in ICD-10? What about for the history code V13.8?

Tennessee Subscriber

Answer: You won't be lumping ductal carcinoma in situ (DCIS) with all in situ breast cancers once ICD-10 goes into effect Oct. 1, 2015. Unlike ICD-9, the new code set gives you several specific codes for DCIS, as well as one specific code for history of DCIS. That's something to keep in mind when your pathologist performs breast tissue exams and possibly immunohistochemistry staining using new/revised CPT® 2015 codes 88342 and +88343 (*Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear...*).

You currently report DCIS as 233.0 (*Carcinoma in situ of breast*). That's the same code you'd use for lobular carcinoma in situ or any other specified or unspecified in situ breast cancer.

ICD-9 code 233.0 crosswalks to 12 codes in ICD-10, three specifically for DCIS as follows:

- ❖ D05.10 — *Intraductal carcinoma in situ of unspecified breast*
- ❖ D05.11 — *Intraductal carcinoma in situ of right breast*
- ❖ D05.12 — *Intraductal carcinoma in situ of left breast*.

Notice: This is a great example to counteract the popular belief that you'll be expected to report a vast number of diagnosis codes on your claims once ICD-10 is implemented. On the contrary, "The ICD-10 codes are more precise. Therefore, one ICD-10-CM code may provide more detailed information than one ICD-9-CM code," explained CMS's **Pat Brooks** in a webinar earlier this year.

Find precise history code, too: If a patient had a previous DCIS lesion, your best bet under ICD-9 is V13.89 (Personal history of other specified diseases). That's because you shouldn't

report a history of breast cancer — V10.3 (Personal history of malignant neoplasm of breast) — for DCIS, which isn't a primary malignancy.

But you won't find an ICD-10 crosswalk for history of DCIS from V13.8 because it's such a generic code. As with DCIS itself, however, ICD-10 provides a much more specific code for history of DCIS: Z86.000 (Personal history of in-situ neoplasm of breast). ❖

Consider ICD-10 Options for CHF Patient

Question: Our patient has a principal diagnosis of congestive heart failure (CHF). She also has coronary artery disease (CAD), hypertension (HTN) and emphysema. She is using oxygen intermittently. How should we code for her?

Delaware Subscriber

Answer: List the following diagnoses for this patient:

- ❖ 428.0 (*Congestive heart failure, unspecified*);
- ❖ 492.8 (*Other emphysema*);
- ❖ 401.9 (*Unspecified Essential hypertension*);
- ❖ 414.00 (*Coronary atherosclerosis; of unspecified type of vessel, native or graft*); and
- ❖ V46.2 (*Dependence on supplemental oxygen*).

Your patient's principal diagnosis is CHF, you don't have additional details about this diagnosis, so 428.0 for CHF unspecified is your first-listed code.

You'll need to report the patient's other co-morbidities next. Sequencing for these conditions is discretionary, but make certain that the plan of care discusses the impact your patient's emphysema, hypertension, and CAD will have on her care.

Finally, list a status V code to indicate that the patient is receiving supplemental oxygen.

In ICD-10, you would list the following codes for this patient:

- ❖ I50.9 (*Heart failure, unspecified*);
- ❖ J43.9 (*Emphysema, unspecified*);
- ❖ I10 (*Essential [primary] hypertension*);
- ❖ I25.1 (*Atherosclerotic heart disease of native coronary artery*); and
- ❖ Z99.81 (*Dependence on supplemental oxygen*).

In ICD-10, at the emphysema code and the CAD code, you'll find a note to "Use additional code to identify" exposure to tobacco smoke or use. Be sure to include this information when appropriate. You can sequence these codes, such as Z72.0 (*Tobacco use*) further down in your list.

Just as in ICD-9, you can't assume the patient's heart problems are due to his hypertension, so you cannot list a hypertensive heart disease code for this patient.

To find the supplemental oxygen code in ICD-10, look under "dependence" in the alphabetic index. ❖

Use This "Z" Code for Gastrostomy Encounter

Question: *How should I report a gastrostomy encounter in ICD-10?*

Texas Subscriber

Answer: When your general surgeon sees a patient for removal or reinsertion of an existing gastrostomy (G) tube, you should currently report V55.1 (*Attention to gastrostomy*) as the reason for the encounter.

ICD difference: When ICD-9-CM shifts to ICD-10 on Oct. 1, 2015, you can't report V55.1 anymore. Instead, you should report ICD-10 code Z43.1 (*Encounter for attention to gastrostomy*). This will be a direct crosswalk between the two code sets with no significant changes in how you use the code.

Coder tips: Contrary to a popular misconception, you can use an aftercare code, such as Z43.1, as primary diagnosis. For instance, you would list the aftercare code first on your claim if the code describes the primary reason for the encounter, such as unplugging a G-tube.

Caveat: Suppose the surgeon closed a "gastrocutaneous fistula" at the site of an old G-tube that has been removed — should you report Z43.1? No. Because the G-tube has been removed, Z43.1 is no longer relevant. Instead, you should choose K31.6 (*Fistula of stomach and duodenum*).

Background: Patients typically have a G tube to provide nutrition or medication because the patient can't swallow liquids or food normally. If the tube becomes clogged or dislodged, your surgeon might need to modify the tube to get it functioning again. ❖

Code Thoroughly for Infected Vein Graft Site

Question: *Our patient has a diagnosis of internal dehiscence of an infected vein graft site that failed. We will be providing wound care. How should we code for her?*

Ohio Subscriber

Answer: Currently, you should list the following codes for this patient, says Tarboro, N.C.-based coding and billing specialist **Vonnie P. Blevins, HCS-D, HCS-O, COS-C, BCHH-C**:

- ❖ 998.31 (*Disruption of internal operation [surgical] wound*);
- ❖ 996.62 (*Infection due to other vascular device, implant, and graft*); and
- ❖ 996.1 (*Mechanical complication of other vascular device implant, and graft*).

Before coding for this patient, make certain that the complications have been verified with the physician, Blevins says. That done, look in the alphabetic index to find your codes. Start your search for the dehiscence with “disruption,” “wound,” “operation,” “internal.” Try “complications,” “vascular,” “device, implant, or graft,” “infection or inflammation” to find the infection code. And look under “complications,” “vascular,” “device, implant, or graft,” “mechanical” to indicate that the graft site failed. Next, verify your target codes in the tabular list.

Remember: You should only use 998.xx (*Other complications of procedures, not elsewhere classified*) codes when a more specific code is not available, Blevins says. For example, 996.62 is a better choice for describing your patient’s infection than 998.59 (Other postoperative infection) because 996.62 is more specific about what caused the infection.

Caution: It’s not appropriate to list a V code like V58.31 (*Encounter for change or removal of surgical wound dressing*) for wound care with this patient because his wound is complicated. As a general rule, V codes are not appropriate when treatment is directed at a current, acute disease or injury.

ICD-10: If you were coding for this patient under ICD-10, you would list the following codes, Blevins says:

- ❖ T81.32xD (*Disruption of internal operation [surgical] wound, not elsewhere classified; subsequent encounter*);
- ❖ T82.7xxD (*Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts; subsequent encounter*); and
- ❖ T82.318D (*Breakdown [mechanical] of other vascular grafts; subsequent encounter*).

Good news: To find T81.32xD, you’ll follow the same alphabetic index search terms as you did in ICD-9. Finding T82.7xxD takes a slightly different path than it did in ICD-9. Look under “infection,” “device, implant or graft,” “vascular.” And, to find T82.318D, look under complications, “vascular,” “graft,” “mechanical,” “breakdown,” “specified vessel NEC.”

Tip: You’ll see a note to list an additional code to identify the infection under T82.7xxD. If you know the organism that caused your patient’s infection, you can include another code to report those specifics. ❖

Here’s What You Can Do to Get Ready for ICD-10

Question: *What should we be doing now to prepare for the ICD-10 transition?*

Utah Subscriber

Answer: Your ICD-10 preparations should be focusing on both coding training and process changes at this point.

Don’t wait until the last minute to get started with training. If you’re unsure of where to start, get an ICD-10 book and begin browsing the codes to get a feel for them and their format.

You may be surprised at the similarities to ICD-9. Many coders are happy to find that the new code system isn't as scary as they feared.

Good idea: Take the ICD-10 coding guidelines and assign a chapter to each person on your team. Have them discuss and compare the differences from ICD-9. This will help you start to narrow down the codes that will have the biggest impact in your agency.

Send at least one person from your practice for ICD-10 training now. Then she can report back and share what she learns.

The coming transition to the ICD-10 code set isn't just about coding. The changes will impact every aspect of your agency processes.

To make certain you're ready for the Oct. 1, 2015 transition deadline, take a closer look at your current processes. Use the time between now and Jan. 1, 2015 to conduct a thorough assessment and identify any operational challenges your agency faces. This way, you can develop and implement solutions before the deadline.

As you begin to map out the steps in your transition, you'll need to establish the project structure, responsible parties, and highlight clinician and coding champions who can be assets. You should also create a budget. Be sure to include software upgrades, training needs, and productivity loss/gain.

Next, talk to all those involved to make sure they're up-to-speed with what's coming. And make certain to monitor the impact of the transition on personnel, claims, reimbursement, denials, and rejections. ❖

Decide Between Z51.11 and Z51.12

Question: *How do I choose between V58.11 and V58.12?*

Illinois Subscriber

Answer: Distinguishing chemotherapy from immunotherapy will help you decide whether V58.11 (*Encounter for antineoplastic chemotherapy*) or V58.12 (*Encounter for immunotherapy for neoplastic condition*) belongs on your claim.

Immunotherapy stimulates the body's ability to fight disease. Chemotherapy, on the other hand, attacks cancer cells. You should refer to individual payer guidelines for a complete list of drugs that qualify as immunotherapy. The American Cancer Society lists the cytokine IFN-alfa (*J9214, Injection, interferon, alfa-2b, recombinant, 1 million units*) and the monoclonal antibody rituximab (*J9310, Injection, rituximab, 100 mg*), among many others (www.cancer.org/docroot/ETO/eto_1_3_Immunotherapy.asp).

Remember: ICD-9 guidelines instruct you to report V58.1x codes as the primary code if the encounter is solely for chemotherapy or immunotherapy. If the patient receives both antineoplastic chemotherapy and antineoplastic immunotherapy at the same encounter, ICD-9 guidelines indicate that you may report both codes in any order.

Also, V58.11 and V58.12 are specific to antineoplastic encounters. That means that if your practice administers chemotherapy or immunotherapy for a nonneoplastic condition, these codes are not appropriate. Instead, ICD-9 guidelines instruct you to code the condition.

On the horizon: When you swap ICD-9 for ICD-10, these encounter V codes will change to the following codes:

- ❖ Z51.11 — *Encounter for antineoplastic chemotherapy*
- ❖ Z51.12 — *Encounter for antineoplastic immunotherapy.* ❖

Expand Your Jaw Pain Diagnosis

Question: *What diagnosis should I use for jaw pain due to temporomandibular joint (TMJ) disorder? I'd like to be more specific than "generalized pain."*

Georgia Subscriber

Answer: You're correct to try to steer clear of "catchall" diagnoses such as 780.96 (*Generalized pain*) whenever possible. The best diagnoses depend on your carrier guidelines and exactly what kind of pain the patient has.

Some coders recommend 524.60 (*Temporomandibular joint disorders, unspecified*) or 524.62 (*Arthralgia of temporomandibular joint*). Some insurance carriers, however, deny claims with TMJ as the primary diagnosis -- although they accept TMJ as a secondary diagnosis. Check the note because there is often also mention of a headache along with TMJ complaints. A headache (784.0) could be your primary diagnosis code with TMJ as a secondary diagnosis if it is documented in the chart.

Because of this, check which other diagnoses apply to the situation. You might be able to submit 526.9 (*Unspecified disease of the jaws*) or another pain-related symptom as the primary diagnosis and include the TMJ diagnosis as primary.

Collections note: Although you might be tempted to report one of these other diagnoses as the primary code because it increases your chances of reimbursement, remember to always code according to your surgeon's notes and the patient's condition. Dealing with a rejected claim because of a TMJ diagnosis is better than being accused of fraudulent coding.

ICD-10: When your diagnosis coding system changes, you will want to use these equivalents:

- ❖ Code 780.96 will become R52 (*Pain, unspecified*).
- ❖ Code 524.60 will become either M26.60 (*Temporomandibular joint disorder, unspecified*) or M26.69 (*Other specified disorders of temporomandibular joint*).
- ❖ Code 524.62 will become M26.62 (*Arthralgia of temporomandibular joint*).
- ❖ Code 784.0 will become either G44.1 (*Vascular headache, not elsewhere classified*) or R51 (*Headache*).
- ❖ Code 526.9 will become either M27.9 (*Disease of jaws, unspecified*) or M27.0 (*Developmental disorders of jaws*). ❖

Master Your MTHFR Codes

Question: What is MTHFR, and what codes should I report for it?

Kentucky Subscriber

Answer: MTHFR (Methylene-tetra-hydro-folate-reductase) is an enzyme that is needed to metabolize homocysteine, an amino acid found in protein foods.

When the mother carries a genetic mutation (MTHFR) that inhibits the production of this enzyme, this can affect either her or the fetus. When homocysteine levels are elevated (because MTHFR is lacking), she will have an increased risk of fetal neural tube defects and miscarriage. An elevated homocysteine level can also indicate an increased risk factor for blood clots, arteriosclerosis and strokes in the mother.

Because she is pregnant, you would have to either assign 648.93 (*Other current maternal conditions classifiable elsewhere, antepartum*) as the primary diagnosis or if she was showing signs of hypercoagulation problems, you should code 649.33 (*Coagulation defects complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication*).

She may also have a history of recurrent fetal loss, stillbirth, or neural tube defects. So reporting a V23 code is also an option if she is not currently showing signs of the condition herself. The non-ob code for this condition is 270.4 (*Disturbances of sulphur-bearing amino-acid metabolism*).

ICD-10: When ICD-9 becomes ICD-10 in 2015, you'll report the following equivalents:

- ❖ 648.93 = O99.89 (*Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium*)
- ❖ 649.33 = O99.11X (*Other diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism complicating pregnancy*) with a sixth digit of 1, 2 or 3 to indicate the trimester
- ❖ 270.4 = E72.12 (*Methylenetetrahydrofolatereductase deficiency*). ❖

Think All ICD-9 Codes Expand Into Multiple Options? Think Again.

Here's how you should report conditions both acute and chronic.

You may be operating under the assumption that ICD-9 codes will *always* multiply into more specific options, and that's why the ICD-10-CM manual is so big. However, that isn't always the case. Conditions requiring two or more ICD-9 codes right now will be simplified into a single ICD-10 option.

Best bet: To determine whether you should report multiple codes or a single ICD-10-CM code, you need to read your coding guidelines. Keep an eye out for phrases like “use additional code” or “code first.”

Capture Single Condition With Multiple Codes

True, you may find that a patient requires multiple ICD-10 codes to fully qualify the condition he or she has.

“Use additional code:” When you're searching the Tabular List, you'll find “use additional code” notes in situations where you should use a secondary code to fully describe a condition. For instance, you might tack on B95 (*Streptococcus, staphylococcus, and enterococcus*) as a secondary code to identify the bacteria causing the patient's infection.

“Code first:” You might come across “code first” notes in the Alphabetic Index. This means you should code the underlying condition first. For instance, under the B39 (*Histoplasmosis*) category, you'll see “code first associated AIDS (B20).”

“Code, if applicable, any causal condition first:” If you see “Code, if applicable, any causal condition first,” then you may use this code as a principal diagnosis when your physician hasn't specified the causal condition. If the physician has specified the causal condition, however, then you should code that as the principal diagnosis. For instance, under N13.8 (*Other obstructive and reflux uropathy*), you'll see “Code first, if applicable, any causal condition, such as enlarged prostate (N40.1).” That means if the provider diagnosed an enlarged prostate, then you would code N40.1 as your principal diagnosis.

Finally, you should be aware that you may need to report multiple codes for late effects, complication codes, and obstetric codes.

Bonus concept: Suppose a patient has a condition that is both acute (subacute) and chronic. How should you report this? According to the ICD-10-CM Official Guidelines for Coding and Reporting, you should code both acute (subacute) and chronic. List the acute (subacute) code first. For instance, a patient might have both acute thyroiditis (E06.0) as well as chronic thyroiditis with transient thyrotoxicosis (E06.2). You would report both codes with E06.0 listed first.

Report Multiple Conditions With Single Code

However, rather than code multiple diagnoses for a condition, you may find that ICD-10-CM already has a single code that reflects a combination.

Combination codes (which are a single, unique code) specify:

- ❖ Two diagnoses
- ❖ A diagnosis with an associated secondary process (manifestation)
- ❖ A diagnosis with an associated complication

Examples: You will find such combinations as I25.110 (*Arteriosclerotic heart disease of native coronary artery with unstable angina pectoris*), K50.013 (*Crohn's disease of small intestine with fistula*), and K71.51 (*Toxic liver disease with chronic active hepatitis with ascites*).

If you scan the Alphabetic Index, you will find combination codes listed as subterm entries, and you'll find them specified in the inclusion/exclusion notes in the Tabular List.

Rule: You can only assign a combination code when the physician fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs you.

Don't use multiple codes when a single combination code clearly identifies all the elements exists.

What should you do when a patient has a complication or manifestation that isn't listed in a single combination code? That's when you can use the secondary code(s).

Can You Report Same Diagnosis More Than Once?

You may be wondering if you can report the same diagnosis code more than once, and the answer is no.

In other words, if a patient has two different conditions that a single combination code describes, then you should only report that single combination code once.

Also, this rule applies to bilateral conditions when you don't have any distinct codes describing laterality. If the condition occurred on both the left and right side and your code states "bilateral," then you should report that bilateral diagnosis code only once. ❖

5 Tips Establish How You Should Report Late Effects (Sequela)

Here's the code you should sequence first.

You may know what late effects are in ICD-9, but how do you reflect them in ICD-10-CM? Actually, sequela is the new terminology in ICD-10 and using the sequela extension of “S” replaces the late effects categories (905–909) in ICD-9-CM.

Example: Current late effect code 905.1 (*Late effect of fracture of spine and trunk without mention of spinal cord lesion*) will become M48.43xS (*Fatigue fracture of vertebra, cervico-thoracic region, sequela of fracture*).

Follow these tips before you report a late effect code, so that your practice is never “late” collecting ethical reimbursement.

Tip 1: Review the Definition

“Sequela” is the new term used for late effects. Remember, a late effect is the residual effect that occurs after the acute phase of an illness or injury has terminated. For instance, you’ll report a sequela ICD-10 code for the scar formation after a burn.

Tip 2: Time for Sequela Varies

You won’t find any time limit specifying when you can start using a late effect code. Why not? Because late effects vary. The residual effect may be apparent early, such as in the case of a cerebral infarction, or it may occur months or years later, such as an effect due to a previous injury.

Tip 3: Generally, You Need 2 Codes — In This Order

When you code late effects, you’ll generally need two codes. You should sequence the condition or nature of the late effect first. You would code the late effect code second.

For instance, you might report M81.8 (*Other osteoporosis without current pathological fracture*) followed by E64.8 (*Sequelae of other nutritional deficiencies [calcium deficiency]*). The condition is osteoporosis, and the late effect is the calcium deficiency.

Exceptions: You may encounter instances when you will report the late effect followed by a manifestation code.

Another situation is when the late effect has been expanded (at the fourth, fifth, or sixth character) to reflect the manifestation. For instance, check out I69.191 (*Dysphagia following nontraumatic intracerebral hemorrhage*). The “following” means the definition includes the late effect.

You should never report the code for the acute phase of an illness or injury, even if that is what led to the late effect. Also, avoid the activity codes Y93.- or External Cause Status codes Y99.- with sequela(e) codes.

Tip 4: Here's How to Use Extension "S"

If you're looking at injury sequela(e) from ICD-10-CM's Chapter 19, you'll find most codes have a 7th character, which includes the code extension of "S." When using extension "S," you need to use both the injury code that precipitated the sequela and the code for the sequela itself. *Bottom line:* You'll add the "S" only to the injury code, not the sequela code.

The "S" extension identifies the injury responsible for the sequela. You'll sequence the specific type of sequela (e.g., scar) first, followed by the injury code.

Example: You would report M17.31 (*Unilateral post-traumatic osteoarthritis, right knee*) followed by S87.01xS (*Crushing injury of right knee, sequela*).

Tip 5: Examine Pregnancy, Burns, and Coma Scale Scenarios

You have special situations in certain situations.

Burns: You can report both a current burn/corrosion code and a sequela(e) code at the same time. The reason is that burns/corrosions don't heal at the same rate. A patient's healing burn/corrosion may coincide with the sequela(e) of a healed burn or corrosion.

Pregnancy: Code O94 describes the sequela(e) of pregnancy, childbirth, and the puerperium. You'd sequence this second, with the complication first. For instance, you would report O90.81 (*Anemia of the puerperium*) followed by O94 (*Sequela[e] of pregnancy, childbirth, and puerperium*).

Coma Scale: If you check out R40.2-, you find codes for the Glasgow Coma Scale (GCS), which do not exist in ICD-9-CM. This is a way for physicians to assess the patient's conscious state, either initially or subsequently. You can use these codes with cerebrovascular disease sequela(e) codes I69. ❖

Good News: You Can Apply This Old ICD-9 Rule to ICD-10

If you understand these familiar phrases, then you know more than you think you do.

As you're preparing for the ICD-10 transition, you can get your feet wet with a few conventions, some of which are new, and some (such as 'NOS' and 'NEC') that are old hat.

To begin getting to know the ICD-10 code set, crack open your coding manual or access the codes online at www.cdc.gov/nchs/icd/icd10cm.htm#10update. Then, start to familiarize yourself with these key coding conventions as you look at the ICD-10 codes.

Seventh character: The seventh character may be a letter or number and provides more information about the condition being coded. For instance, check out T81.4xxD (*Infection following a procedure; subsequent encounter*).

Dummy placeholder: This is always the letter "x." ICD-10-CM uses this dummy placeholder to:

- a) provide future expansion while keeping the six character structure (such as T65.0x2S), and
- b) to meet the requirement of coding the highest level of specificity when a code has less than six characters and the code requires a seventh character (such as S17.0xxA).

Dash: When you see a dash at the end of a code, you should know that the code is incomplete. For instance, you might see M84.47- in the Tabular List, meaning you need to review the options to decide how to complete this code.

Note: We use an 'x' in ICD-9-CM to show that more digits are required, however an 'x' is a placeholder in ICD-10-CM so the dash has taken its place, says **Lisa Selman-Holman**, consultant and principal of Selman-Holman & Associates and CoDR — Coding Done Right in Denton, TX.

Abbreviations: You'll find two abbreviations in ICD-10: NEC (*Not Elsewhere Classifiable*) and NOS (*Not Otherwise Specified*).

NEC: Like ICD-9, this abbreviation contains codes for "other" types of specified conditions that haven't already been classified. An example is H26.8 (*Other specified cataract*).

NOS: When your physician doesn't clearly specify the condition, you can use a NOS code — although payers usually frown upon this process. An example is H40.9 (*Unspecified glaucoma*).

Punctuation: You'll find some familiar punctuation in ICD-10.

Parentheses: You'll find this punctuation in both the Alphabetic Index and the Tabular List. This may include words that the physician might have stated in his or her documentation. For instance, you'll find "Diabetes, diabetic (mellitus) (sugar)" in the Alphabetic Index. The parentheses indicate a non-essential modifier.

Brackets: This punctuation encloses synonyms, alternative wordings, and so on in the Tabular List. When you find brackets in the Alphabetic Index, this identifies manifestation codes. For instance, you'll find "Disease, Alzheimer's G30.9 [F02.80]" in the Alphabetic Index.

Phrases: You have a few familiar phrases in ICD-10, too. These include:

- ❖ "code first" notes,
- ❖ "use additional code" notes
- ❖ "see" cross references
- ❖ the term "and," meaning "and/or"
- ❖ the word "with," meaning "associated with" or "due to"

Take note: The phrase "code associated condition" means both conditions should be coded, but sequencing does not matter. ❖

Hone Your ICD-10 Hypertension Coding by Applying Familiar Guidelines

You'll still need physician documentation for hypertensive heart disease.

You'll be happy to know that hypertension coding in ICD-10 is pretty similar to what you're used to in ICD-9. Brush up on the basics for coding this condition and you'll be well on your way to mastering the steps in the new code set.

Primary/Essential Hypertension: 401.xx/I10

To code for primary hypertension in ICD-9, you'll first need to determine whether the hypertension is malignant, benign, or unspecified.

Most hypertension is considered primary or essential hypertension, and in ICD-9, it's coded with a 401.x (Essential hypertension) category code.

The fourth digit for 401.x codes indicates whether the hypertension is malignant, benign, or unspecified:

- ❖ 401.0 (*Essential hypertension, malignant*);
- ❖ 401.1 (*Essential hypertension, benign*); or
- ❖ 401.9 (*Essential hypertension, unspecified*).

In ICD-10, you no longer need to specify whether primary hypertension is malignant, benign, or unspecified, says coding expert **Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O, AHIMA Approved ICD-10 Trainer/Ambassador** in Weslaco, Texas. As a result, the hypertension table, found in the Alphabetic Index in ICD-9-CM isn't included in ICD-10. You'll report all primary hypertension with the same code: I10 (*Essential [primary] hypertension*).

Hypertension Coding by Organ Involvement

Primary hypertension can also be categorized according to end organ involvement. When hypertension causes heart disease, chronic kidney disease, or both heart and chronic kidney disease, both ICD-9 and ICD-10 refer you to separate code categories.

Hypertensive Heart Disease 402.xx/I11

When you are selecting a diagnosis code for a patient diagnosed with hypertensive heart disease in ICD-9, you look to the 402.xx (Hypertensive heart disease) category.

These codes are further specified with a fourth digit to indicate whether the hypertension is malignant, benign, or unspecified, and a fifth digit that indicates whether the patient also has a heart failure diagnosis.

In ICD-10, your code selection for patients with hypertensive heart disease is streamlined. You have two codes from which to choose:

- ❖ I11.0 (*Hypertensive heart disease with heart failure*) or
- ❖ I11.9 (*Hypertensive heart disease without heart failure*).

Additional code: For those patients who have a diagnosis that includes heart failure, ICD-9 and ICD-10 ask you to also list a code to specify the type of heart failure. In ICD-9, look to the 428.0-428.43 range. For ICD-10, you'll need to list a code from the I50.- category.

One thing that's a little confusing about the hypertensive heart disease ICD-10 codes is that "0" in the fifth digit on the ICD-9 code means that the patient does not have heart failure. But in ICD-10 the "0" on the end of the code means they do have heart failure, says **Lisa Selman-Holman, JD, BSN, RN, COS-C, HCS-D, HCS-O, AHIMA Approved ICD-10-CM Trainer/Ambassador of Selman-Holman & Associates, LLC, CoDR—Coding Done Right and Code Pro University** in Denton, Texas.

Caution: “Don’t get caught by habit and assume the other digits/characters are going to match up between ICD-9 and ICD-10 like they do with some codes,” Selman-Holman warns

Cause and effect: You must have documentation to support a causal relationship between the patient’s hypertension and his heart disease in order to list a 402.xx or I11.- code, White-myer says. If there is no documentation that the two conditions are linked, you must report them separately.

The relationship, documented by the physician, may be implied or stated, Selman-Holman says. An example of implied, is “hypertensive heart disease.” An example of stated is “heart failure due to hypertension.”

Hypertensive Chronic Kidney Disease 403.xx/ I12.-

When you are selecting a diagnosis code for a patient diagnosed with hypertensive chronic kidney disease in ICD-9, you look to the 403.xx (Hypertensive chronic kidney disease) category. These codes are further specified with a fourth digit to indicate whether the hypertension is malignant, benign, or unspecified, and a fifth digit that indicates the stage of chronic kidney disease.

Coding for hypertensive chronic kidney disease in ICD-10 is simplified, with two codes to choose from based on the stage of the chronic kidney disease:

- ❖ I12.0 (*Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease*) or
- ❖ I12.9 (*Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease*).

Additional code: When you report a code from the 403.xx or I12.- categories, you’ll need to list an additional code to indicate the stage of chronic kidney disease. For ICD-9, that’s a 585.x (Chronic kidney disease) code. In ICD-10, list a code from the N18.- (Chronic kidney disease) category.

Again, just keep in mind that “0” on the end of the code in ICD-10 means stage 5 or end stage renal disease is present, but in ICD-9 “0” on the end of the code means stage 1-4 or unspecified chronic kidney disease stage, Selman Holman says. And remember that the choice that includes unspecified ends with fourth digit “9.”

Cause and effect: Both ICD-9 and ICD-10 assume a causal relationship between hypertension and chronic kidney disease, Whitemyer says. So, when your patient has both diagnoses, it’s appropriate to code for them with a code from the 403.xx or I12.- category.

Hypertensive Heart and Chronic Kidney Disease 404.xx/ I13.-

When you are selecting a diagnosis code for a patient diagnosed with both chronic kidney disease and hypertensive heart disease in ICD-9, you'll look to the 404.xx (Hypertensive heart and renal disease) category. These codes are further specified with a fourth digit to indicate whether the hypertension is malignant, benign, or unspecified, and a fifth digit that indicates whether or not the patient has heart failure and the stage of chronic kidney disease.

You'll choose from four I13.- (Hypertensive heart and chronic kidney disease) codes to report hypertensive heart and chronic kidney disease in ICD-10.

Additional code: For those patients who have a diagnosis that includes heart failure, ICD-9 asks you to also list a code from the 428.0-428.43 range to specify the type of heart failure. You'll also need to list a code from the 585.x (Chronic kidney disease) category to indicate the stage of chronic kidney disease.

In ICD-10, you'll list a code from the I50.- category to identify the type of heart failure and the N18.- (Chronic kidney disease) category to indicate the stage of CKD. If your patient also has acute renal failure, you will also need to list the appropriate code from the N17.- (Acute kidney failure) category.

Cause and effect: Both ICD-9 and ICD-10 assume a causal relationship between hypertension and chronic kidney disease, but not between heart disease and hypertension. So, in order to list a hypertensive heart and chronic kidney disease code, you must have documentation that links the hypertension and the heart disease. ❖

Don't Have A Seizure Over Choosing Dx for Mental Disorder Presentations In The ED

Watch for specificity in documentation to select the most granular code listed for substance abuse related visits.

A big challenge in coding for mentally ill ED patients is assigning a diagnosis based on the ED presentation and the current mental status of the patient while that are in the ED setting. That diagnosis assignment can be even harder with the increased specificity ICD-10 will bring next year.

Read on for these insider tips on coding mental disorders from **Caral Edelberg, CPC, CPMA, CAC, CCS-P, CHC, AHIMA Certified ICD-10 Instructor** and President, Edelberg Compliance Associates so you're up to speed before the Oct. 1, 2015 deadline.

First, Identify The Source Of The Presenting Problem

Mental disorders seen in the emergency department, many relate to dementia, substance abuse, non-mood psychotic disorders, and anxiety disorders. These diagnosis categories appear in Chapter 5 - Mental and Behavioral Disorders (F01-F99) of the ICD-10 coding book.

This chapter of ICD-10 includes the following classifications to guide your code choice:

- ❖ Mental disorders due to psychological conditions
- ❖ Mental and behavioral disorders due to psychoactive substance use
- ❖ Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
- ❖ Mood affective disorders
- ❖ Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
- ❖ Behavioral syndromes associated with physiological disturbances and physical factors
- ❖ Disorders of adult personality and behavior
- ❖ Intellectual disabilities
- ❖ Pervasive and specific developmental disorders
- ❖ Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
- ❖ Unspecified mental disorders

Code the Underlying Condition First

Mental disorders due to a psychological condition include dementia, so you would code the underlying physiological condition first, such as Alzheimer's (G30.-); Parkinson's Disease (G20.-); and Intoxications (T36-T65). Unspecified dementia is differentiated between dementia with or without behavioral disturbance, Edelberg explains.

Alcohol and other substance abuse are differentiated from dependence and the physician must carefully document to support the appropriate coding of these abuse disorders. You may be struggling with caring for an intoxicated patient but for ICD-10 purposes, alcohol abuse is differentiated from alcohol dependence. Alcohol abuse is divided into a number of separate descriptive elements and that distinction will guide your code assignment, says Edelberg.

Options for ICD-10 include:

- ❖ abuse uncomplicated
- ❖ abuse w/intoxication uncomplicated
- ❖ w/intoxication delirium
- ❖ w/intoxication unspecified
- ❖ w/alcohol-induced mood disorder
- ❖ w/psychotic disorder (delusions, hallucinations, psychotic disorder, unspecified);
- ❖ with other alcohol induced disorders (anxiety disorder, sexual dysfunction, sleep disorder, other disorders NOS)

Is It Abuse or Dependence? Check the Documented History For the Answer

There are unique codes for alcohol and drug use (not specified as abuse or dependence), and abuse and dependence. And there are changes to drug and alcohol abuse and dependence as they no longer identify continuous or episodic use. A history of drug or alcohol dependence is coded as 'in remission.' There is a code for blood alcohol level (Y90.-) that can be assigned as an additional code when the documentation indicates its use, says Edelberg.

Pick the Right Category of the Substance Being Abused

ICD-10 includes the specific category of commonly abused substances. For example if college student is brought in by his roommate because he had been taking drugs that produced bizarre behavior and reported hallucination, you can identify the category of substance abuse with a diagnosis such as F16.951 (*Hallucinogenic use, unspecified with hallucinogen-induced psychotic disorder with hallucinations*).

Additional categories for substance abuse include:

- ❖ Opioid related disorders related to abuse, dependence or unspecified;
- ❖ Cannabis disorders related to abuse, dependence or unspecified,
- ❖ Sedative, hypnotic, or anxiolytic related disorders from abuse, dependence,
- ❖ Sedative, hypnotic or anxiolytic dependence with OTHER sedative, hypnotic or anxiolytic-induced disorders
- ❖ Sedative, hypnotic or anxiolytic-related drug use, unspecified
- ❖ Cocaine abuse, dependence, unspecified.
- ❖ Other stimulant related disorders
- ❖ Hallucinogen related disorders (abuse, dependence, unspecified)
- ❖ Hallucinogen use
- ❖ Nicotine dependence
- ❖ Inhalant related disorders (dependence, psychotic disorder, unspecified)
- ❖ Other psychoactive substance abuse disorders

Don't Let Coding For Depression Get You Down

Mood affective disorders such will require differentiation as to whether it is a single or recurrent episode and the severity of the episode is mild, moderate or severe. For example unspecified depression is coded as depression NOS, depressive disorder NOS and major depression, NOS. Depressive disorders are distinguished by single episode major depressive disorder, major depressive disorder recurrent, major recurrent in remission, persistent mood (affective) disorder and unspecified mood (affective) disorder. Detailed documentation of the patient's depressive condition will be required when known. For example is the major depressive single episode codes require a 4th digit to determine whether they are unspecified, mild moderate or severe, Edelberg adds.

Examples:

- ❖ 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*

Choosing the Right Pain Code Need Not Be a Huge Headache

The reasons many patients present to the ED is because of the pain caused by the actual medical condition involved. Chapter 6 - Diseases of the Nervous System (G00-G99) covers pain codes and other neurological diseases treated in the ED including:

Inflammatory diseases of the central nervous system

- ❖ *Systemic atrophies affecting the nervous system*
- ❖ *Extrapyramidal and movement disorders*
- ❖ *Degenerative diseases of the nervous system,*
- ❖ *Demyelinating diseases of the central nervous system*
- ❖ *Episodic and paroxysmal disorders,*
- ❖ *Nerve, nerve root and plexus disorders,*
- ❖ *Polyneuropathies and other disorders,*
- ❖ *Diseases of myoneural junction and muscle,*
- ❖ *Cerebral palsy and other paralytic syndromes*
- ❖ *Other disorders including pain*

Do You have A Dominant Side?

Consider a patient presenting with hemiplegia or hemiparesis, with ICD-10 you'll need to know whether the dominant or non-dominant side is affected. You'll also want to designate the limb or limbs affected using codes such as G83.1- (*Monoplegia of lower limb*) or G83.2- (*Monoplegia of upper limb*). If the affected side is noted but not whether that side is dominant, and the classification system does not indicate a default, select a code using the following rules, says Edelberg:

- ❖ If the right side is affected the default is dominant
- ❖ If the left side is affected, the default is non-dominant
- ❖ For ambidextrous patients, the default should be dominant

Take Two Aspirin and Apply This Advice for Reporting Pain

The codes identifying the site of the pain are found in Chapter 18, but Chapter 6 covers pain not elsewhere classified. If documented as acute or chronic, category G89 (Pain not elsewhere classified) is appropriate. However, if the encounter is for other than pain control or pain management without a definitive diagnosis, assign a code for the site of the pain first followed by a code from the G89 category. Chronic pain is reported with G89.2, but it requires specific documentation that the pain is, indeed, chronic. There is no time frame for classifying pain as chronic, Edelberg explains.

Seize These Tips for Epilepsy Diagnoses

ICD-10 updates the terminology for epilepsy, with terms to classify the disorder such as localization related idiopathic epilepsy, generalized idiopathic epilepsy and special epileptic syndromes.

Within those various categories, more specificity is possible, such as identifying seizures of localized onset, complex partial seizures, intractable and status epilepticus, says Edelberg. A note within category G40 (Epilepsy and recurrent seizures) provides the following terms to be considered equivalent to intractable:

- ❖ Pharmaco resistant (pharmacologically resistant)
- ❖ Treatment resistant
- ❖ Refractory (medically)
- ❖ Poorly controlled

Common ED Examples Are:

- ❖ G40.909 (*Epilepsy, unspecified, not intractable, without status epilepticus*)
- ❖ G45.9 (*Transient cerebral ischemic attack, unspecified*). ❖

Watch ICD-10 Dominant Side Guidelines With CVA Sequelae

Welcome a robust selection of combination codes.

Under ICD-10, coding for the sequelae (or late effects) of cerebrovascular accidents (CVAs) is easy and more specific. Category I69 (Sequelae of cerebrovascular disease) boasts a wide array of combination codes that will allow you to specify your patient's condition. But watch for "Use additional code" notes to alert you to situations where one code doesn't quite do the job.

New: When coding for hemiplegia, hemiparesis, and monoplegia, ICD-10 gives you the ability to report whether the condition impacts the dominant or nondominant side.

When the documentation indicates the affected side, but doesn't tell you whether it's the patient's dominant or nondominant side, base your choice on the following guidance:

- ❖ For ambidextrous patients, the default choice is dominant.
- ❖ If the left side is affected, the default choice is non-dominant.
- ❖ If the right side is affected, the default choice is dominant.

Coding scenario: Your patient was admitted to home care following a CVA. He has right-sided hemiplegia and dysphagia as a result of the CVA.

You would list the following codes for this patient:

- ❖ I69.351 (*Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side*);
- ❖ I69.391 (*Dysphagia following cerebral infarction*); and
- ❖ R13.10 (*Dysphagia, unspecified*).

You know the patient's right side is the one affected by his hemiplegia, but you don't know which side is dominant. Because his right side is affected, the default is to report this as affecting his dominant side.

When you locate I69.391 in the tabular list, you'll find a note asking you to "Use additional code to identify the type of dysphagia, if known (R13.1-)." You don't have any additional details about the phase of your patient's dysphagia, so R13.10 for "unspecified" is your code. ❖

Upgrade Your Patellar Open Fracture Reporting

First confirm type and then look to morphology and laterality.

When reporting ICD-10 codes for open fractures of the patella, you may feel lost in a plethora of codes. Here is how you can narrow down your choices to pick up the most accurate diagnosis codes.

Unlike ICD-9, ICD-10 offers a wide range of codes for open patellar fractures. The ICD-9 code for an open fracture of patella is 822.1 (*Open fracture of patella*).

When coding for open fractures of the patella in ICD-10, you will need to first check what was the type of fracture. Similar to the ICD-10 codes for closed fractures of patella, morphology and laterality are important, but only when you know what was the type of open fracture. You may lose payment if you miss this initial important step.

Confirm Type in Open Fracture

To select the appropriate codes, you'll need to determine whether the open fracture is type I, II, or III.

Check If Fracture Is Longitudinal Or Transverse

Once you have determined the type of open fracture of the patella, the next step is to confirm the morphology and displacement. Also, you will maintain focus for the right or the left side being involved. The simplest possible morphological variant in a fractured patella is the breaking of the bone into two pieces with the fracture line being either longitudinal or transverse.

For displaced longitudinal open fracture of right patella, you report S82.021B (*Displaced longitudinal fracture of right patella, initial encounter for open fracture type I or II*) or S82.021C (*Displaced longitudinal fracture of right patella, initial encounter for open fracture type IIIA, IIIB, or IIIC*). For the same on the left side, you report S82.022B (*Displaced longitudinal fracture of left patella, initial encounter for open fracture type I or II*) or S82.022C (*Displaced longitudinal fracture of left patella, initial encounter for open fracture type IIIA, IIIB, or IIIC*). However, when your radiologist does not specify the side of the displaced longitudinal open fracture in the patella, you report S82.023B (*Displaced longitudinal fracture of unspecified patella, initial encounter for open fracture type I or II*) or S82.023C (*Displaced longitudinal fracture of unspecified patella, initial encounter for open fracture type IIIA, IIIB, or IIIC*).

You follow the same set of rules for a nondisplaced longitudinal fracture of the patella. You can select the appropriate code from the following:

- ❖ S82.024B (*Nondisplaced longitudinal fracture of right patella, initial encounter for open fracture type I or II*)
- ❖ S82.024C (*Nondisplaced longitudinal fracture of right patella, initial encounter for open fracture type IIIA, IIIB, or IIIC*)
- ❖ S82.025B (*Nondisplaced longitudinal fracture of left patella, initial encounter for open fracture type I or II*)
- ❖ S82.025C (*Nondisplaced longitudinal fracture of left patella, initial encounter for open fracture type IIIA, IIIB, or IIIC*)
- ❖ S82.026B (*Nondisplaced longitudinal fracture of unspecified patella, initial encounter for open fracture type I or II*)
- ❖ S82.026C (*Nondisplaced longitudinal fracture of unspecified patella, initial encounter for open fracture type IIIA, IIIB, or IIIC*)

When your radiologist documents a transverse open fracture of the patella, you can adopt the same stepwise approach of determining the type, displacement, and side, to be able to navigate to the right code. You may choose from codes in the S82.031B (*Displaced transverse fracture of right patella, initial encounter for open fracture type I or II*) to S82.036C (*Nondisplaced transverse fracture of unspecified patella, initial encounter for open fracture type IIIA, IIIB, or IIIC*) range.

Several Fractured Pieces? Report Comminuted Fracture

Your radiologist may document a comminuted fracture of the patella when the X-ray shows that the bone is fragmented into three or more pieces.

For displaced comminuted fractures of type I or II, you report code S82.041B (*Displaced comminuted fracture of right patella, initial encounter for open fracture type I or II*) or S82.042B (*Displaced comminuted fracture of left patella, initial encounter for open fracture type I or II*) depending upon whether the right or the left patella was fractured.

Similarly, for type III fractures, you select from S82.041C (*Displaced comminuted fracture of right patella, initial encounter for open fracture type IIIA, IIIB, or IIIC*) or S82.042C (*Displaced comminuted fracture of left patella, initial encounter for open fracture type IIIA, IIIB, or IIIC*).

When your radiologist does not document the side of the displaced comminuted fracture, you report S82.043B (*Displaced comminuted fracture of unspecified patella, initial encounter for open fracture type I or II*) for type I or type II fractures and code S82.043C (*Displaced comminuted fracture of unspecified patella, initial encounter for open fracture type IIIA, IIIB, or IIIC*) for the type III fractures.

If however your radiologist documents a nondisplaced open comminuted fracture of the patella, you select from codes S82.044B (*Nondisplaced comminuted fracture of right patella, initial encounter for open fracture type I or II*), S82.044C (*Nondisplaced comminuted fracture of right patella, initial encounter for open fracture type IIIA, IIIB, or IIIC*), S82.045B (*Nondisplaced comminuted fracture of left patella, initial encounter for open fracture type I or II*), or S82.045C (*Nondisplaced comminuted fracture of left patella, initial encounter for open fracture type IIIA, IIIB, or IIIC*), depending upon the type and laterality of the fracture.

If you fail to confirm the laterality of the fracture in the clinical note, you can turn to S82.046B (*Nondisplaced comminuted fracture of unspecified patella, initial encounter for open fracture type I or II*) for fracture type I or II or S82.046C (*Nondisplaced comminuted fracture of unspecified patella, initial encounter for open fracture type IIIA, IIIB, or IIIC*) for fracture type III.

Remember: When ICD-10 goes into effect on Oct. 1, 2015, you should apply the code set and official guidelines in effect for the date of service reported. Learn more at www.cms.gov/ICD10/ and www.cdc.gov/nchs/icd/icd10cm.htm#10update. ❖

Navigate Your Way To The Right Neurofibromatosis Codes

Look for skin changes, hearing loss to ascertain the type of disease.

When reporting neurofibromatosis, you'll need to confirm the type of neurofibromatosis your physician is treating, which can range from an isolated growing tumorous mass on a nerve to a collection of signs that make up a syndrome.

Definition: Neurofibromatosis is a genetic disorder that mainly affects how nerve cells form and grow. It can cause tumors to grow on nerves. There is no cure for neurofibromatosis, so clinicians plan treatment (such as surgery to remove the tumors, radiation or chemotherapy) to control symptoms.

“The ICD-9 Tabular section lists the diagnosis codes for the various neurofibromatosis conditions in the Neoplasms chapter in contrast to ICD-10 which includes the neurofibromatosis diagnoses in the Congenital Malformations, Deformations and Chromosomal Abnormalities chapter,” says **Marvel Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO**, owner of MJH Consulting in Denver, Co.

Look at Definitive Skin Changes to Confirm Type 1

Neurofibromatosis type 1 (NF1 or von Recklinghausen’s disease) is one of the more common types of the disorder. This type causes skin changes and deformed bones, and usually begins at birth. Your provider should clearly document the findings in the patient record so a careful read-through will confirm that the clinical examination supports the diagnosis.

ICD-9: Currently, you report 237.71 (*Neurofibromatosis type 1 [von Recklinghausen’s disease]*) when your clinician definitively documents that the patient has von Recklinghausen’s disease.

When ICD-10 goes into effect, you’ll report Q85.01 (*Neurofibromatosis, type 1*). “Even though ICD-10 does not include “von Recklinghausen’s disease” in the actual ICD-10 Q85.01 code descriptor it is listed underneath as an alternative term. Additionally, the ICD-10 Alphabetic Index has a listing under the term “Von Recklinghausen” and directs coders to the Q85.01 code for the “disease” subterm,” says Hammer.

Hearing Loss Is Your Guide for Type 2

Neurofibromatosis type 2 is also called NF2 or central neurofibromatosis. This type of neurofibromatosis is characterized by bilateral acoustic neuromas, tumors of the vestibulocochlear nerve (8th Cranial nerve).

The main complaint you should specifically look for in the clinical records is hearing loss. Other symptoms can include tinnitus (ringing in the ears) or poor balance. Typically, you’ll notice that your clinician was treating a younger patient for hearing loss because signs of NF2 usually develop in the late teenage years or early 20s.

ICD-9: Under ICD-9, you report diagnosis 237.72 (*Neurofibromatosis, type 2 [acoustic neurofibromatosis]*) for neurofibromatosis type 2.

ICD-10: The corresponding ICD-10 code will be Q85.02 (*Neurofibromatosis, type 2*). Once again, you will notice that the actual descriptor of the ICD-10 code does not include the additional name, however as with the NF1 ICD-10 code, the alternate term “acoustic neurofibromatosis” is listed below the NF2 Q85.02 code. “Additionally, the Alphabetic Index of ICD-10 also has a listing for the sub term ‘acoustic’ under the term neurofibromatosis. It directs coders to review the Q85.02 code,” says Hammer.

Don't Miss the Rarest Forms

Schwannomatosis is a disorder characterized by multiple schwannomas, and is one of the rarest types of neurofibromatosis. Schwannomas are benign tumors involving the cells that produce the nerve sheath insulating the nerves. The schwannomas may be found everywhere in the body, including cranial, spinal, or peripheral nerves. “The only exception is on the vestibular branch of the 8th Cranial nerve. The primary symptom is pain, which develops as the schwannoma tumors enlarge or compress nerves / adjacent tissue. Some patients also may have numbness, tingling or weakness in the fingers and toes,” says Hammer.

On occasion, your clinician might document segmental schwannomatosis. This term refers to schwannomas that are localized to a part of the body such as an arm, leg or region of the spine. Also, your clinician might note the absence of any hearing loss.

When coding for schwannomatosis, report ICD-9 code 237.73 (*Schwannomatosis*). After ICD-10 implementation, you'll report Q85.03 (*Schwannomatosis*).

Other possibilities: Some other variants of the disorder also exist that you should be aware of, even if you don't code them very often. These might be known as type 3 or type 4 neurofibromatosis.

Example: Your clinician documents cutaneous neurofibromas in a patient who otherwise meets the requirement for a diagnosis of type 1 neurofibromatosis. Confirm that your clinician documents the diagnosis of neurofibromatosis type 4 and report ICD-9 code 237.79 (*Other neurofibromatosis*). Going further when ICD-10 is implemented, you will turn to code Q85.09 (*Other neurofibromatosis*).

Backup plan: When you aren't clear what type of neurofibromatosis the patient has and your clinician hasn't clearly documented the same, turn to code 237.70 (Neurofibromatosis unspecified). Under ICD-10 you'll report Q85.00 (*Neurofibromatosis, unspecified*).

“Some patients will only have a single sporadic neurofibroma, rather than one of the syndromes we have discussed so far. You will report this using the benign neoplasm of a nerve or connective tissue,” says **Gregory Przybylski, MD**, director of neurosurgery with New Jersey Neuroscience Institute of JFK Medical Center in Edison. ❖

Reader Questions

How to Interpret NEC and NOS in ICD-10

Question: *I was looking at the ICD-10-CM manual, and I noticed NEC and NOS. I know they stand for Not Elsewhere Classifiable (NEC) and Not Otherwise Specified (NOS), but how should I use them in ICD-10-CM?*

California Subscriber

Answer: Like ICD-9, the NEC (Not Elsewhere Classifiable) abbreviation contains codes for “other” types of specified conditions that haven’t already been classified. An example is H26.8 (*Other specified cataract*).

When your physician doesn’t clearly specify the condition, you can use a NOS (Not Otherwise Specified) code — although payers usually frown upon this process. An example is H40.9 (*Unspecified glaucoma*). ♦

ICD-10 Anemia Guidelines in the Spotlight

Question: *I read an article that said ICD-10 guidelines for anemia/neoplasm coding differ from ICD-9. Where can I access the ICD-10 guidelines?*

SuperCoder.com Subscriber

Answer: You can download the 2010 ICD-10 guidelines from CMS’s ICD-10 site: www.cms.gov/ICD10/12_2010_ICD_10_CM.asp. You also can download them from the CDC’s ICD-10-CM site: www.cdc.gov/nchs/icd/icd10cm.htm#10update.

Remember: When ICD-10 goes into effect on Oct. 1, 2015, you will apply the official ICD-10 coding guidelines in effect for the relevant date of service.

The anemia/neoplasm differences that you refer to most likely relate to coding anemia associated with a malignancy (when the encounter is for the anemia) and coding adverse effects.

Neoplasm/anemia scenario: Suppose a patient has anemia associated with a malignancy, and she presents for treatment of the anemia only.

ICD-9: ICD-9 guidelines state that your first-listed code should be for anemia, 285.22 (*Anemia in neoplastic disease*). Then, the guidelines instruct you to report the appropriate malignancy code(s) (ICD-9, Section I.C.2.c.1, www.cdc.gov/nchs/data/icd9/icdguide10.pdf).

ICD-10: ICD-10 guidelines, on the other hand, instruct you that in the above scenario, you must report the malignancy first and then the anemia code, D63.0 (*Anemia in neoplastic disease*) (ICD-10, Section I.C.2.c.1).

Treatment/anemia scenario: Suppose a patient has anemia caused by his chemotherapy, immunotherapy, or radiotherapy, and he presents for treatment of the anemia only.

ICD-9: You should sequence the anemia first (such as 285.3, *Antineoplastic chemotherapy induced anemia*), according to ICD-9 guidelines. Then report the appropriate neoplasm code (ICD-9, Section I.C.2.c.2). In addition, when the patient has an adverse reaction to a correctly prescribed and administered substance, ICD-9 instructs you to code the reaction followed by a code from E930-E949 (ICD-9, Section I.C.19.c). For example, you might report E933.1 (*Drugs, medicinal, and biological substances causing adverse effects in therapeutic use; antineoplastic and immunosuppressive drugs*).

ICD-10: Your first-listed code should be an adverse effect code, under ICD-10. Then report the anemia and neoplasm codes (ICD-10, Section I.C.2.c.2).

Bottom line: The ICD-10 change isn't just about new codes. Stay alert for changes to guidelines, as well. Get a head start by reading through the ICD-10 official guidelines that apply to the diagnoses you report most often. Consider highlighting differences in the logic and sequencing as you read through and compare for a more comprehensive understanding of important changes, especially for the codes you use most often for your specialty. ❖

Take a Peek at ICD-10 External Cause Coding

Question: *I'm wondering what external cause coding will look like in ICD-10. Could you provide an example?*

Massachusetts Subscriber

Answer: The **Cooperating Parties for ICD-10-CM/PCS and ICD-9-CM Coding** recently issued a clarification stating that external cause reporting guidelines won't change with the new code set. But your coding for these situations in ICD-10 will look entirely different from your ICD-9 coding.

Scenario: Suppose your patient had no hypertension diagnosis. But he continues to experience elevated blood pressure while taking blood pressure medication. While assessing the patient, the home health nurse discovers he was taking his medication once daily instead of twice daily because of the cost of the drug. To code for this patient in ICD-10, you would list:

- ❖ I10 (*Essential [primary] hypertension*);
- ❖ T46.5x6D (*Underdosing of other antihypertensive drugs, subsequent encounter*); and
- ❖ Z91.120 (*Patient's intentional underdosing of medication regimen due to financial hardship*). ❖

Go In-Depth With the Structure of the Human Bone

This ICD-10 example shows you why you should know these terms.

Bone comprises a rigid structure, which is based on dense connective tissue. A normal human bone is made up of the following essential macro and micro elements:

Periosteum: The periosteum is the dense fibrous membrane that is composed of irregular connective tissue and covers the bony surfaces. It comprises of an outer fibrous layer and inner cellular layer.

Medullary Membrane: Medullary membrane is a thin layer of highly vascular and areolar connective tissue lining cylindrical medullary cavity and harvesian canal. This membrane has osteogenic, hematopoietic and fracture healing properties.

Marrow: Marrow is a vascular substance found in the cylindrical cavities of the long bones and sternum, and facilitates the production of red blood cells, white blood cells, and platelets.

Blood Vessels and Nerves of Bone: The periosteum of the bones is extensively invaded by blood vessels and nerves. The vast distribution of blood vessels inside the bony canals constitutes the complex vasculature, which facilitates nutrition to the respective bones.

Haversian Canals (Canals of Havers): These can be explored through a transverse section of the bone. A Haversian canal typically comprises of a central hole within the bony region, which runs parallel to the long axis of bone. The canal is surrounded by numerous concentric rings or layers, which are also known as lamellae. The individual layers along with central canal constitute a haversian system (which is also known as osteon).

Lamellae: The bony osteon comprises of multiple layers that have the same focus, which overlap the central harvesian canal. These layers are termed as lamellae.

Lacunae: These appear as fusiform opaque spots between lamellar spaces and consist of the bone-corpuscle. Lacunae act as channels to provide nutrition to the Haversian system.

Canaliculi: These are very small canals connecting multiple lacunae together inside the harvesian system. Canaliculi extend from one specific lacuna and communicate to another series of lacunae within the harvesian canal.

Perichondrium: The non-vascularized layer of dense irregular connective tissue that covers the elastic and hyaline cartilage is termed as perichondrium. This layer primarily works as the growth layer of cartilage.

Osteoblasts: The inner surface of periosteum is invaded by the mononucleate formative cells that act to provide nutrition to the bony matrix during the early stages of bone development. These formative cells are termed as osteoblasts. However, osteoblasts descend in number as the age advances, thereby leading to the gradual degradation of the bony tissues.

Osteoclasts: The giant cells that remain involved in the absorption of the bone matrix are termed as osteoclasts or myeloplaxes. These are particularly located in red marrow, inside the Howship's foveolae (bony pits or cavities). Osteoclasts control the quantity of osteoblasts by enhancing the bone resorption process.

Medullary spaces: Medullary spaces are the cancellous tissue intervals that exist as a substitute of Haversian canals in the thin plates of bone, and remain confined between bone trabeculae.

Epiphysis: The articular end of a long bone, which is surrounded by cartilage, is defined as epiphysis. This portion of bone is further segregated into subchondral zone, including the epiphysial line.

Diaphysis: The shaft of a long bone (diaphysis) is constituted by a section of compact bone that contains bone marrow. Shaft indicates the mid section of the bone that contains components like medullary cavity, nutrient foramen, endosteum, periosteum and adipose tissue.

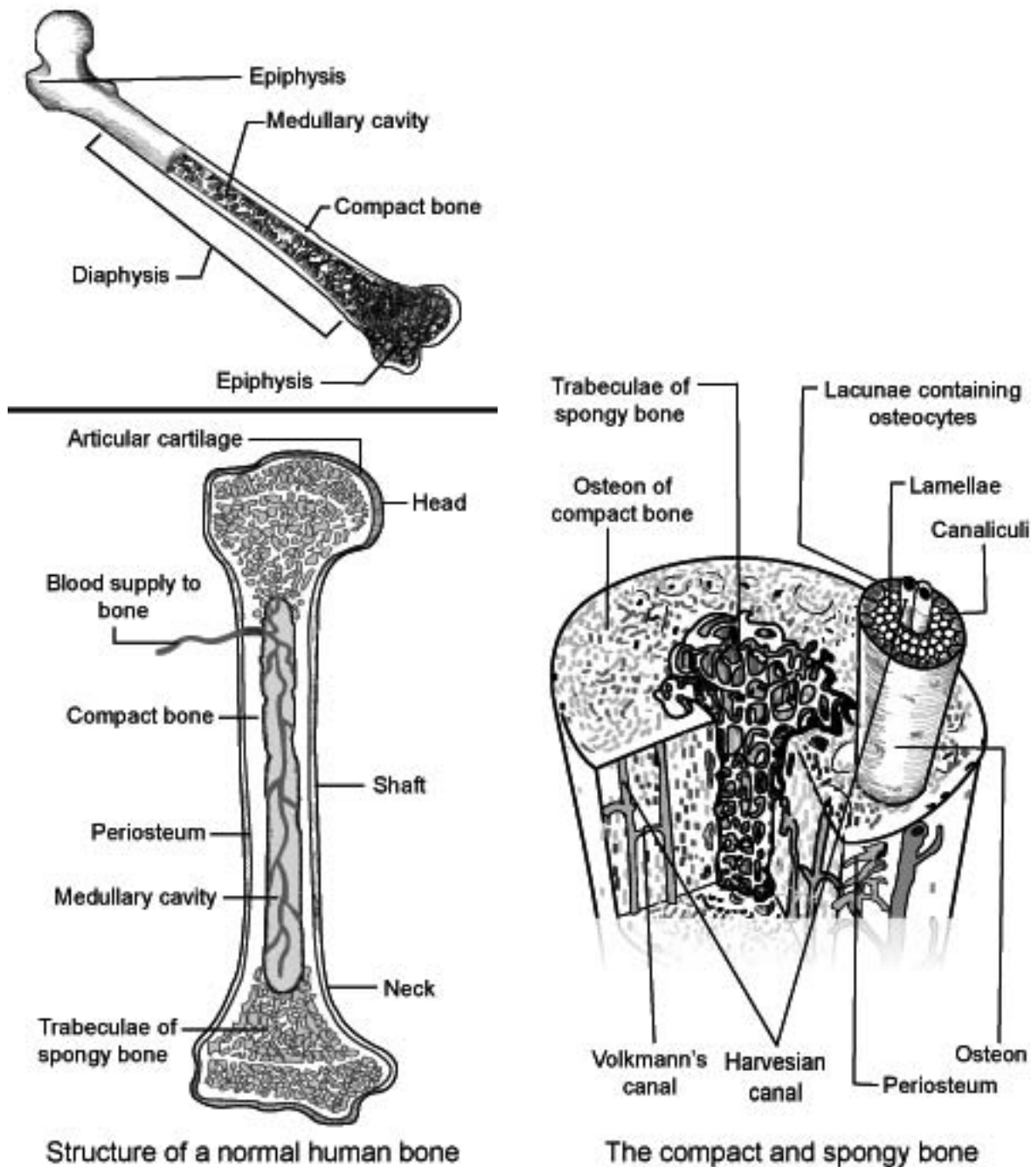
Metaphysis: The extended portion of the long bone (that lies adjacent to the epiphysis) is termed as metaphysis. Growth plates (or the epiphysial plates) are present as a part of the bony metaphysis, which particularly serves as the growth center of the long bone and facilitates the ossification process.

Now that you've learned the parts of the bone, let's apply this to your diagnosis coding.

Example: Suppose your physician documents that a patient has a nontraumatic acute slipped upper femoral epiphysis of the right hip. (*Note:* The epiphysis means the articular end of a long bone, which is surrounded by cartilage.) How should you report this?

You should report M93.013 (*Acute slipped upper femoral epiphysis [nontraumatic], right hip*).

Documentation note: Encourage your physician to specify the location of the affected hip to get a more detailed code. ❖



Take a Sneak Peak at Correct Coding for Cerebral Emboli

Anatomical site, laterality, infarctions guide you to correct code.

When ICD-10 hits, you will have to get more specific to report cerebral embolism diagnosis codes. In particular, you'll need to ensure your clinician clearly documents which territory in the central circulation was affected by the embolism.

Here's more on what's in store for embolism dx coding.

Look For Embolism Site When There Is No Infarction

In ICD-9, there is only one code that you can report for cerebral embolism without cerebral infarction. You report 434.10 (*Cerebral embolism without cerebral infarction*) for embolism in all territories of cerebral blood supply.

In ICD-10, your coding options expand to a choice of four codes: I66.09 (*Occlusion and stenosis of unspecified middle cerebral artery*), I66.19 (*Occlusion and stenosis of unspecified anterior cerebral artery*), I66.29 (*Occlusion and stenosis of unspecified posterior cerebral artery*), and I66.9 (*Occlusion and stenosis of unspecified cerebral artery*) depending upon the specific anatomical location of the embolism. The last code I66.9 applies when either your physician does not mention the site affected by the embolism or the same cannot be construed appropriately in the imaging and other diagnostic studies.

ICD-10 is further specific for laterality. For example, look at the codes below for occlusion or stenosis of the middle cerebral artery.

- ❖ I66.01 (*Occlusion and stenosis of right middle cerebral artery*)
- ❖ I66.02 (*Occlusion and stenosis of left middle cerebral artery*)
- ❖ I66.03 (*Occlusion and stenosis of bilateral middle cerebral arteries*)

The codes are specific for right, left, and bilateral involvement. "This is the true specificity provided by ICD-10 and providers may need guidance in improving their documentation to include these details so they can be accurately reported," says **Marvel Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO**, owner of MJH Consulting in Denver, Co.

These codes map to ICD-9 codes 434.00 (*Cerebral thrombosis without cerebral infarction*), 434.10 (*Cerebral embolism without cerebral infarction*), and 434.90 (*Cerebral artery occlusion unspecified without cerebral infarction*).

How to select a code: It will be helpful to know the anatomy of cerebral circulation to be able to spot the right code for cerebral embolism in ICD-10. Look at figure 1 to see the cerebral

circulation. The three main arteries on both sides, i.e. the anterior, middle, and posterior cerebral arteries, form a circle that gives off numerous other communicating branches to supply the brain.

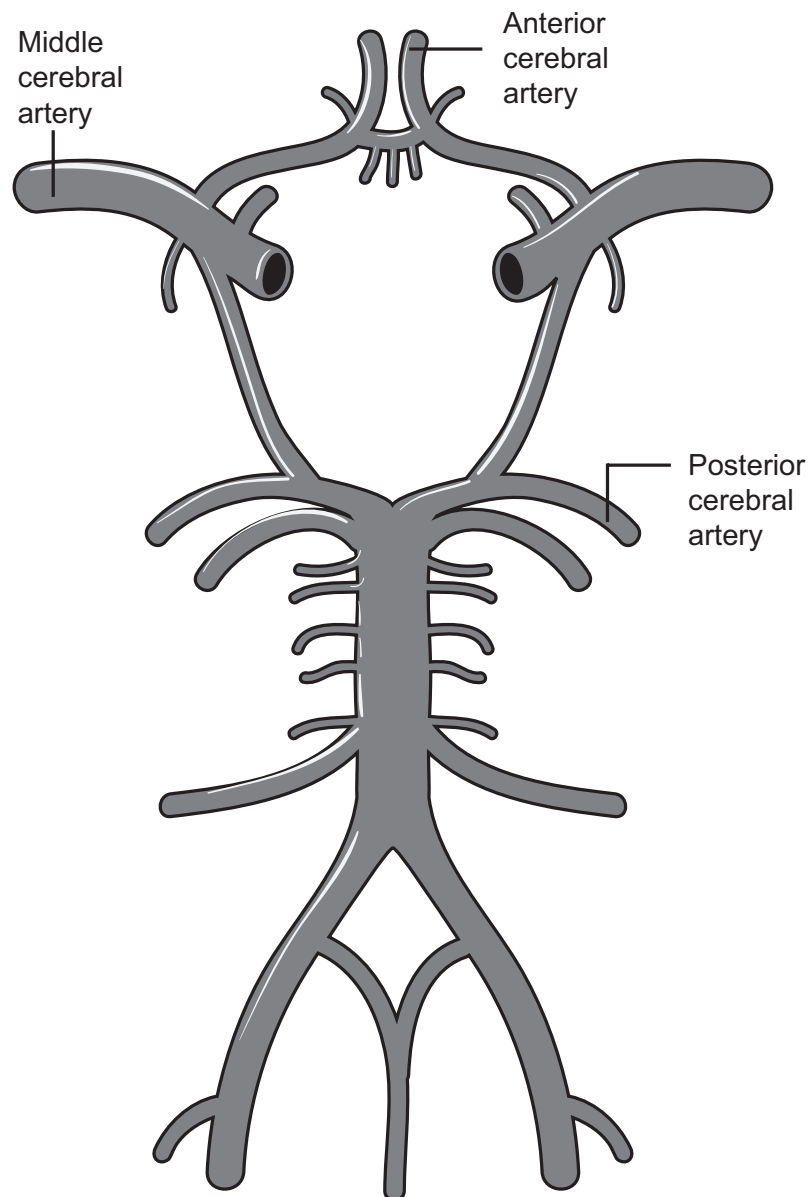


Figure 1: Cerebral circulation.

When reporting a cerebral embolism in any of these major arteries in the cerebral circulation, you will read through the suggestive symptoms that your clinician captures in the clinical notes and then look at the confirmatory imaging studies like CT or MRI he uses to come to a definitive diagnosis.

Learn from These Examples

Since regions in the brain control specific actions, your clinician can narrow down to the diagnosis of cerebral embolism and the potential site of obstruction and you confirm the

same as you read the symptoms and signs in the clinical records. The examples below provide cues for selecting the right coding, depending upon how your clinician approached the patient depending upon the presenting symptoms and signs in the patient.

Example 1: If your clinician documents that the patient presented with complaints of repeatedly bumping into objects, hitting obstacles on the roadside, or not being able to see half the printed page when reading, you confirm further down in the clinical notes that the site of occlusion is the posterior cerebral artery and report code I66.29. The symptoms and signs of posterior cerebral artery strokes are numerous and diverse, but may include acute loss of vision, confusion, posterior cranial headache, and dizziness.

Example 2: If your clinician documents that the patient presented with hemiplegia and fixation of the eyes and head turned to the opposite side, he will also investigate to confirm that the patient has had a middle cerebral artery occlusion. You report this condition with ICD-10 code I66.09.

Example 3: If your clinician documents that the patient had conditions like hemiparesis or hemiplegia of the lower limb, apraxia, anosmia, urinary incontinence, or grasp or suckling reflexes, you confirm him suspecting the involvement of the anterior cerebral artery and the reports of imaging and investigations will help him to confirm the diagnosis. In this case, you report ICD-10 code I66.19. ❖

617.2, 620.0, and More: Match the Code to the Female Reproductive Site

Give your coding a boost by tying code digits to actual structures.

When your radiologist interprets imaging of the female reproductive system, your ability to identify the body part involved will sharpen your coding.

Use the anatomic illustration below to locate the site described, and then match that site to the sampling of applicable ICD-9-CM and ICD-10-CM codes in the table. (The table shows only sample codes. You should choose a code for your particular case based on the documentation and the most specific code available in the manual.) ❖

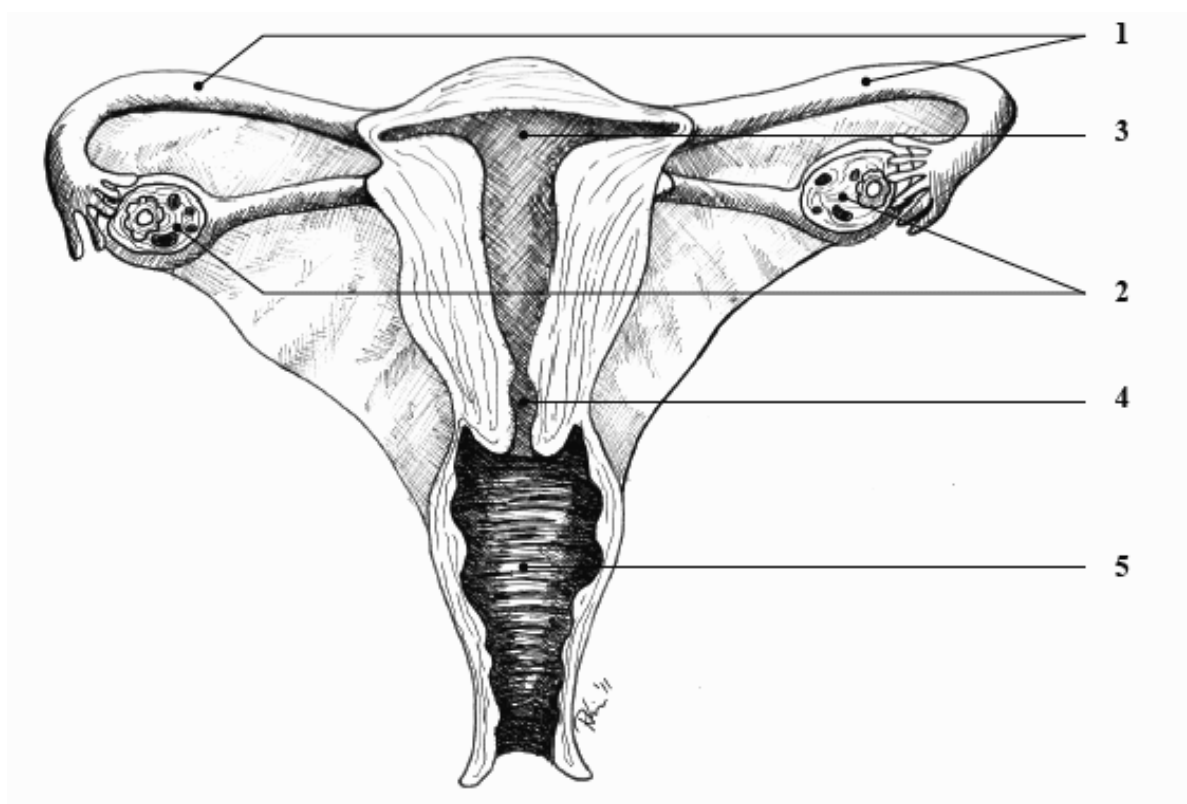


Illustration location	Anatomic site	Sample ICD-9 code	ICD-10 crosswalk	Code definition
1	Fallopian tubes	617.2	N80.2	Endometriosis of the fallopian tube
2	Ovaries	620.0	N83.0	Follicular cyst, ovary
3	Uterine cavity	752.32	Q51.811	Hypoplasia of uterus
4	Cervix	233.1	D06.-	Carcinoma in situ of cervix uteri
5	Vagina	184.0	C52	Malignant neoplasm of vagina

Can You Identify 7 Qualities of Good Documentation? Find Out

Expect denials when documentation doesn't support your code selection.

You may be able to choose diagnosis codes with the precision of a sharpshooter, but if the clinical record doesn't support the codes you report, you run the risk of down coding, focused medical review, and even fraud investigations. The documentation on which you base your coding is about to get even more scrutiny as the Oct. 1, 2015 ICD-10 transition date approaches. Make sure your clinicians' documentation techniques will pass muster with these expert tips.

Now's the time to assess clinicians' documentation skills, says **Arlene Maxim, RN founder of A.D. Maxim Consulting, A.D. Maxim Seminars**, and The National Coding Center, in Troy, Mich. Under ICD-10, clinicians will need to beef up their documentation, she says.

"Documentation will make or break this process," Maxim says ICD-10 will require a higher degree of specificity. Assessing documentation practices now allows your agency to begin improvement efforts before the added pressure of the ICD-10 deadline arrives.

Clinical documentation is the foundation of every health record, said **Dorothy D. Steed, CPC-H, CHCC, CPUM, CPUR, CPHM, ACS-OP, CCS-P, RCC, CPMA, RMC, CEMC, CPC-I, CFPC, PCS, FCS, CPAR, AHIMA Approved ICD-10 Trainer**, an independent healthcare consultant and educator in Atlanta, Ga. Clinicians may collect documentation only once, but others will use it many times so it's important to make every effort to prevent it from being misunderstood.

Clinicians need to think about how often others will use and access their documentation in the future, Steed said during the recent Eli-sponsored audioconference "Clinical Documentation Improvement." This critical information is needed for patient care.

Documentation and coding go hand-in-hand, Steed said. The "coder needs high quality documentation to determine coding quality and accuracy."

Steed outlined seven criteria for quality clinical documentation. Consider how your clinicians' documentation stacks up in each area and provide help in making the changes needed to better support coding choice.

1. **Legibility:** Documentation should be readable and easily deciphered. A lot of handwritten documentation isn't legible or decipherable, Steed cautioned. Rushed or careless documentation may cause other problems.

Legibility includes being able to read the name and title of the clinician completing the documentation, Maxim says.

This is an especially important aspect of good documentation, Steed said. Complete and legible entries provide protection for providers. But illegible entries in a medical record may cause:

- ❖ Misunderstanding of a patient's condition.
- ❖ Jeopardized reimbursement.
- ❖ Denied payment.
- ❖ Loss of legal appeals.
- ❖ Serious patient injury.

2. **Reliability:** Is the documentation trustworthy? Based on the diagnoses, is the documentation reliable? Does it support the rationale for the diagnoses and for medical necessity?

The reliability is not just related to the assessment (OASIS), but with every single visit note. Most denials and down coding occur when visit notes don't support the codes you report based on the original assessment, Maxim cautions.

3. **Precision:** Clinical documentation must be accurate, exact, and strictly defined. Increased detail generally means greater accuracy in documentation, Steed said.

The degree of specificity in documentation that will be necessary with ICD-10 will challenge even the most experienced home care clinician, Maxim says.

4. **Completeness:** Good documentation fully addresses all concerns in the record, and includes appropriate validation. Be absolutely sure every SOC assessment includes the beneficiary's prior level of function.

When records go under review by any contractor, the prior level of function will assist in supporting the need for home health care services, Maxim says.

5. **Consistency:** Documentation shouldn't be contradictory. Are there conflicting statements in the record? Are there conflicting opinions between providers that have not been clarified? Make sure any inconsistencies are addressed.

This is where the coordination of services comes into play, Maxim says. Many times a contradiction occurs when there is a lack of communication between the disciplines. "Get everyone on the same page."

6. **Clarity:** Documentation should be unambiguous. Vague documentation that does not totally describe a patient's condition won't support the services your agency provides.

7. **Timeliness:** Documentation must be up-to-date to help ensure optimal patient treatment.

Home health example: This includes the need for clinicians to document in the home, Maxim says. Clinicians should never be tempted to put off documentation until a more convenient time. Every hour away from the visit, a large percent of information is lost. "Our memory for specific information fades quickly. Agencies should begin enforcing requirements of in-home documentation."

You'll want to watch for under-documented OASIS areas such as Vision impairment (M1200). The clinical documentation must be consistent with any problems identified in this item. If your patient's vision scores as partially or severely impaired, you'll need to show evidence of it in the medical record. Good documentation includes details such as "provided large print reading materials," "made suggestions about improving the lighting for safety" or comments indicating that the clinician considered the patient's vision problems and their impact on medication management.

It is also important to include any diagnosis- or problem-related issue that causes vision impairment, Maxim says. Good documentation describes why the patient's vision is impaired and just how such impairment will impact the plan of care. ❖

Your Asthma Documentation Has to Get More Specific

Here's how to avoid that note in your report that says 'I need more information.'

Are you simply documenting "asthma?" That's not enough for ICD-10-CM. Find out how you need to brush up on your asthma lingo to maximize your coder's choice and increase your bottom line.

Danger: Remember, if you don't document asthma severity, then your coder has to choose J45.998 (*Other asthma*). Submitting this multiple times could red flag your practice for an audit.

Use These Key Terms for Asthma Severity

The ICD-10-CM codes will include the following terminology:

"Intermittent"

"Mild persistent"

“Moderate persistent”

“Severe persistent”

You can break down what these terms really mean by examining this chart:

	Intermittent	Mild Persistent	Moderate Persistent	Severe Persistent
Symptoms	2 or less days per week	More than 2 days per week	Daily	Throughout the day
Nighttime Awakenings	2 times per month or less	3-4 times per month	More than once per week but not nightly	Nightly
Rescue Inhaler Use	2 or less days per week	More than 2 days per week, but not daily	Daily	Several times per day
Interference with Normal Activity	None	Minor limitation	Some limitation	Extremely limited
Lung Function	FEV1 >80% predicted and normal between exacerbations	FEV1 >80% predicted	FEV1 60-80% predicted	FEV1 less than 60% predicted

(National Heart, Lung, and Blood Institute. Accessed: May 20, 2010. Expert Panel Report 3 (EPR3): Guidelines for the Diagnosis and Management of Asthma. URL: www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm)

Documentation advancement: You can state “the patient experiences asthma symptoms daily and uses his rescue inhaler daily,” which would direct the coder to moderate persistent asthma. Or you can make it easy on your coder by simply saying “the patient has moderate persistent asthma.”

Take action: Start increasing your documentation’s specificity by going in-depth with your patient’s asthma symptoms. Your goal is to avoid any unspecified codes, due to lack of documentation.

Here are your possible asthma variations:

- J45.20 — *Mild intermittent asthma, uncomplicated*
- J45.21 — *Mild intermittent asthma with (acute) exacerbation*
- J45.22 — *Mild intermittent asthma with status asthmaticus*
- J45.30 — *Mild persistent asthma, uncomplicated*
- J45.31 — *Mild persistent asthma with (acute) exacerbation*
- J45.32 — *Mild persistent asthma with status asthmaticus*
- J45.40 — *Moderate persistent asthma, uncomplicated*
- J45.41 — *Moderate persistent asthma with (acute) exacerbation*

J45.42 — *Moderate persistent asthma with status asthmaticus*
J45.50 — *Severe persistent asthma, uncomplicated*
J45.51 — *Severe persistent asthma with (acute) exacerbation*
J45.52 — *Severe persistent asthma with status asthmaticus*
J45.901 — *Unspecified asthma with (acute) exacerbation*
J45.902 — *Unspecified asthma with status asthmaticus*
J45.990 — *Exercise induced bronchospasm*
J45.991 — *Cough variant asthma*
J45.998 — *Other asthma.* ❖

Don't Let "Urosepsis" Infect Your ICD-10 Claim With Errors

If your MD doesn't want queries, then strike this term from future notes.

If you receive a physician note with the term "urosepsis," you may find yourself grappling with the question — is it a urinary tract infection (UTI) or a UTI with sepsis?

Currently: In ICD-9, you have coding conventions to follow, which is to use 599.0 (*Urinary tract infection, site not specified*) for "urosepsis." According to ICD-9 guidelines, "The term urosepsis is a nonspecific term. If that is the only term documented then only code 599.0 should be assigned based on the default for the term in the ICD-9-CM index, in addition to the code for the causal organism if known."

In the future: However, ICD-10 eliminates this term. The ICD-10-Manual includes a note to "code to condition," which means you must query the physician to determine the appropriate code assignment.

Specifically, ICD-10 guidelines state:

(ii) Urosepsis The term urosepsis is a nonspecific term. It is not to be considered synonymous with sepsis. It has no default code in the Alphabetic Index. Should a provider use this term, he/she must be queried for clarification.

Action item: Explain to your physicians and coders "urosepsis" does not exist in ICD-10. That means your physicians should not use that term, unless they want to be bothered with queries. More specific documentation about this condition is necessary. ❖

Got Gout? Here's What Documentation You Must Have for ICD-10-CM

Don't miss what these seventh characters mean.

A diagnosis of gout might seem simple enough to code, but a quick look at your ICD-9 choices shows more than 10 viable options. Ask your physician to provide details to help you pinpoint the correct code — and to help prepare for ICD-10, when you'll have even more choices to consider.

Is It Joint Pain, Arthritis, or Gout?

Part of accurate coding includes understanding the conditions you're reporting.

Gout is a form of arthritis of the joint that occurs due to high levels of uric acid in the blood. Elevated uric acid levels associated with gout attacks causes uric acid crystals to deposit in the synovial fluid of the joints and other soft tissues.

Joints are a primary target site for uric acid crystal deposition. When crystals form in the synovial fluid, it causes recurring attacks of joint inflammation, or arthritis. Chronic gout can lead to deposits of hard lumps of uric acid in the tissues, called a tophus or tophi, in and around the joints that can lead to joint destruction.

Diagnoses: Gout diagnoses fall under code family 274.xx (*Gout*) in ICD-9. For a patient's first experience with gout, 274.01 (*Acute gouty arthropathy*) might be your best choice, unless the physician doesn't specify a type of gout. In that instance, you should report 274.9 (*Gout, unspecified*).

Watch for Tophi and a Different Diagnosis

Some patients who have longstanding gout diagnoses might develop tophi. A tophus (the singular form of tophi) is a mass of uric acid crystals that often appear around joints. Less common locations for tophi can include the patient's cartilage, bone, synovium, skin, kidneys, or other organs. The deposits often signify chronic gout since they usually take about 10 years to develop after the onset of gout.

"Tophi are more common in men than women, but the incidence in women increases after they reach menopause," says **Ruby O'Brochta-Woodward, BSN, CPC, CCS-P, COSC, ACS-OR**, a compliance and research specialist with Twin Cities Orthopedics, P.A.

Choices: Once the physician ascertains chronic gout, ICD-9 offers two diagnoses. Check whether documentation mentions tophi to determine whether to report 274.02 (*Chronic gouty arthropathy without mention of tophus [tophi]*) or 274.03 (*Chronic gouty arthropathy with tophus [tophi]*).

Look Ahead to ICD-10 Options

When ICD-10 goes into effect, your diagnosis options for gout greatly expand.

Example: Whereas ICD-9 has a single code for chronic gout with tophi, ICD-10 will allow you to indicate chronic gout with tophi using any one of more than 100 codes. Under ICD-10, chronic gout is classified to a series of codes beginning with M1A. A fourth character further classifies the gout as follows:

- ❖ M1A.0 *Idiopathic*
- ❖ M1A.1 *Lead-induced*
- ❖ M1A.2 *Drug-induced*
- ❖ M1A.3 *Chronic gout due to renal impairment*
- ❖ M1A.40x1 *Other secondary chronic gout*
- ❖ M1A.9 *Chronic gout, unspecified*

Fifth and sixth characters can further specify location of the chronic gout. For example, M1A.011 indicates “Idiopathic chronic gout, right shoulder.” To indicate with tophus (or tophi), simply append the seventh character of “1.” A seventh character of “0” indicates “without tophus (tophi).” These seventh characters may be added to any code from category M1A. Thus, unspecified chronic gout with tophus (tophi) would be coded as M1A.9xx1.

Take note: Under ICD-10, information about the underlying cause and anatomic location are important to your coding. “For any of the ICD-10 codes for chronic gout with tophi, the presence of tophi would need to be supported by documentation, and the causative factor and location of gout would determine code selection,” say experts. ❖

Turn to ‘H61’ Series for Impacted Cerumen Coding Under ICD-10

Here’s how your documentation has to change.

Under ICD-9, you have one way to report impacted cerumen, but that will change when ICD-10 goes into effect. You will have to scan your physician’s notes to determine where this condition occurs.

Definition: Impacted cerumen, otherwise known as wax in the ear, can affect both children and adults. The condition occurs when layers of wax within the ear canal build up in the point of blocking the canal and putting pressure on the eardrum. Cerumen is most likely to become impacted when it is pushed against the eardrum by objects people put in their ears, or when

it is trapped against the eardrum by a hearing aid. Less common causes include overproduction of earwax or an abnormally narrow ear canal that tends to trap the wax.

Partial loss of hearing is the most important symptom of cerumen impaction. Other symptoms can be itching, tinnitus (noise or ringing in the ears), a sensation of fullness in the ear, and pain in the ear (otalgia). In children younger than one year, cerumen impaction is sometimes discovered during a routine check-up when the doctor finds that the earwax is blocking his or her view of the eardrum.

Check Out ICD-9 Versus ICD-10

Currently: ICD-9-CM provides a single diagnosis code for impacted cerumen: 380.4 (*Impacted cerumen*). The ICD-9 manual also directs you to report an additional external cause code, if applicable, to identify the cause of the ear condition.

ICD-10-CM: When your diagnosis coding system changes, you'll have to look to the H61.2- (*Impacted cerumen*) series of codes. The fourth digit will specify the affected ear:

H61.20, *Impacted cerumen, unspecified ear*

H61.21, *Impacted cerumen, right ear*

H61.22, *Impacted cerumen, left ear*

H61.23, *Impacted cerumen, bilateral*

Bulk Up Your Documentation

Physicians typically make a diagnosis of impacted cerumen by examining the patient's ear canal and eardrum with an otoscope. Irrigation is the most common method of removing impacted cerumen; the process involves washing out the ear canal with water from a commercial irrigator or a syringe with a catheter attached.

If irrigation is not an option or if it fails to remove the cerumen, the physician can remove the wax with a vacuum device or curette (a small, scoop-shaped instrument). The physician uses the curette to ease the impacted wax away from the sides of the ear canal. This ear wax removed by the physician using instrumentation and direct visualization is consistent with CPT® code 69210 (*Removal impacted cerumen [separate procedure], 1 or both ears*) for the procedure. This code cannot be used for irrigation only.

Physicians will need to be more detailed in their documentation of impacted cerumen by noting which ear is affected.

Coder tips: Check the chart documentation regarding the tactic used for wax removal and the provider who performed the procedure. Those factors won't change the diagnosis code you report, but will guide which CPT® procedure code you report.

On your superbill, list each of the available diagnosis options for impacted cerumen to prompt the physician to enter the necessary information. Let your practitioners know that they will need to include details regarding which ear has impacted cerumen so you don't have to report the 'unspecified' diagnosis.

Translate This To Your Superbill

Abbreviated options on your superbill could include:

XXXXXX, Imp cerumen, unspec

XXXXXX, Imp cerumen, R

XXXXXX, Imp cerumen, L

XXXXXX, Imp cerumen, bilat. ❖

Future Acute Bronchitis Coding: Etiology is Important

Single ICD-9 code transforms to ten codes in ICD-10.

You'll face big changes in reporting acute bronchitis when ICD-10 goes into effect, including needing to focus more on the condition's etiology. Read on for everything you'll need to know about successfully coding each patient's circumstances.

Prepare for Additional Options

Currently, ICD-9 lists only a single code for acute bronchitis: 466.0. You report 466.0 for any case of acute bronchitis with no concern for etiology, unless the patient has acute bronchitis with chronic obstructive pulmonary disease, in which case you report 491.22.

ICD-10 expansion: When ICD-9 shifts to ICD-10, you'll begin your code search with J20.- (*Acute bronchitis*). Then you'll drill down to a more specific code that describes the etiology. Your ten new choices will be:

- ❖ J20.0 (*Acute bronchitis due to Mycoplasma pneumoniae*)
- ❖ J20.1 (*Acute bronchitis due to Hemophilus influenzae*)
- ❖ J20.2 (*Acute bronchitis due to streptococcus*)
- ❖ J20.3 (*Acute bronchitis due to coxsackievirus*)
- ❖ J20.4 (*Acute bronchitis due to parainfluenza virus*)
- ❖ J20.5 (*Acute bronchitis due to respiratory syncytial virus*)
- ❖ J20.6 (*Acute bronchitis due to rhinovirus*)

- ❖ J20.7 (*Acute bronchitis due to echovirus*)
- ❖ J20.8 (*Acute bronchitis due to other specified organisms*)
- ❖ J20.9 (*Acute bronchitis, unspecified*)

Note: Code family J20.x will cover all cases of acute and subacute bronchitis along with acute tracheobronchitis. However, J20.x will not include allergic bronchitis (J45.909, *Unspecified asthma, uncomplicated*) and all types of chronic bronchitis (J42, *Unspecified chronic bronchitis*; J41.0, *Simple chronic bronchitis*; J44.0, *Chronic obstructive pulmonary disease with acute lower respiratory infection*; J41.1, *Mucopurulent chronic bronchitis*).

Age watch: Pay attention when your physician diagnoses bronchitis NOS (not otherwise specified). You'll still turn to J20.9 for patients below the age of 15. If the patient is above age 15, you'll report bronchitis NOS with J40 (*Bronchitis, not specified as acute or chronic*) instead.

Focus on Provider Documentation

Your physician usually will diagnose a case of acute bronchitis based on the signs and symptoms the patient is experiencing. ICD-10 codes for some of the common signs and symptoms that you'll find will include fever (R50.9, *Fever unspecified*), malaise (R53.81, *Other malaise*), nasal congestion (R09.81, *Nasal congestion*), wheezing (R06.2, *Wheezing*), and dry or suppurative, persistent cough (R05, *Cough*).

Since most of the cases of acute bronchitis are of viral origin and are self-limiting, the physician will treat the patient's current symptoms. If the patient has a significant amount of sputum formation, your physician might suspect a lower respiratory tract infection (such as pneumonia) and order further tests to rule out or confirm the condition.

In addition, the physician might order a sputum culture (89220, *Sputum, obtaining specimen, aerosol induced technique [separate procedure]*) to learn the etiology of the condition. This will often be essential if he suspects a bacterial origin that will require antibiotics.

Example: A 20-year-old male patient arrives at your physician's office with complaints of severe persistent cough for a period of about ten days with moderate amounts of sputum production. He also complains of fever with chills, nasal congestion, and generalized body and muscle aches.

Upon examination, the physician arrives at an initial diagnosis of acute bronchitis. Under ICD-10 you will report a preliminary diagnosis as J20.9 since the etiology is not confirmed. The physician suspects a bacterial origin, so he sends a sputum sample for culture. When the pathology result arrives, it confirms an infection due to streptococcus. The etiology is now confirmed, so you'll report the condition using J20.2.

Don't Be Afraid of J20.9

Once you begin coding under ICD-10, you'll need to check the encounter notes for more details about what caused the acute bronchitis. If the documentation does not identify the etiology of the condition, then you'll resort to J20.9.

An "unspecified" diagnosis is never a coder's favorite choice, but it might be your most accurate option.

"Be sure not to assign a definitive cause unless the physician confirms and documents the causal organism," says **Carol Pohlig, BSN, RN, CPC, ACS**, senior coding and education specialist at the University of Pennsylvania Department of Medicine in Philadelphia. "Just as in ICD-9, do not assign a diagnosis if the physician references a causal organism as 'suspected,' 'probable,' or 'possible.'"

If that's as detailed as the documentation gets, J20.9 is the correct choice. ❖

Zero in on Documentation Specifics For Neck of Femur Fracture 6th, 7th Digits

Confirm side for closed fractures, side and type for open fractures.

ICD-9 gives you options of one code each for closed and open fractures of the unspecified part of the neck of femur. With ICD-10 implementation, you will need your surgeon to be specific about the side of body, the fracture occurred. In addition, for open fractures, your surgeon will also need to confirm the type of the fracture.

Use this ICD-10 walkthrough to assist you in assigning the correct femoral neck code, prior to the Oct. 2015 implementation deadline.

Check Out What 6th Digit Means

You will turn to category S72.00 for an unspecified fracture of the femoral neck. In this category of codes, there are 6th and 7th digits further which help you to select a code based on laterality and stage of encounter. "A 6th digit is required to specify whether it is a fracture of the right (1) or left (2) femur or if unspecified (9). If bilateral, the code would be reported twice. And lastly a 7th digit is required to specify the stage of the encounter — initial, subsequent with routine healing vs. delayed healing vs. nonunion vs. malunion, and sequelae," says **Ruby O'Brochta-Woodward, BSN, CPC, CCS-P, COSC, ACS-OR**, compliance and research specialist, Twin Cities Orthopedics, P.A.

“If both femurs are fractured, you would not be reporting the same code twice; you would be reporting two different codes. The 6th digit would be ‘1’ for an unspecified fracture of the neck of the right femur while for the left femur it would be ‘2’,” says **Heidi Stout, BA, CPC, COSC, PCS, CCS-P**, Coder on Call, Inc., Milltown, New Jersey and orthopedic coding division director, The Coding Network, LLC, Beverly Hills, CA.

7th Digit Classification Has an Impact

This 7th digit classification transforms the reporting of femur fractures in ICD-10. “The 7th digit classification will remove the follow up V codes, the 900 series late effect codes, the 733.81 (*Malunion of fracture*) and 733.82 (*Nonunion of fracture*) for nonunion and malunion and will give you the ability to code for a delayed union,” says Woodward. “In ICD-9, there are options for follow up visits, nonunion, malunion, and sequelae but these are more generic codes and are not directly tied to the specific fracture type. There is currently no coding option for a delayed healing.”

Confirm Side for Closed Fractures

When you report for a femoral neck fracture where your surgeon does not specify which part of the femoral neck was fractured, you report code 820.8 (*Fracture of unspecified part of neck of femur closed*) in ICD-9.

With the implementation of ICD-10 in 2015, you will need to specifically report if the fracture was on the right or the left side.

Make sure your surgeon documents the side for a closed fracture of the unspecified part of neck of femur. Depending upon whether it was a right or left sided fracture, you report code S72.001A (*Fracture of unspecified part of neck of right femur, initial encounter for closed fracture*) or S72.002A (*Fracture of unspecified part of neck of left femur, initial encounter for closed fracture*). ICD-10 calls for extensive documentation. “The differences between fracture diagnosis reporting in ICD-9 and ICD-10 demand comprehensive physician education as few documents support the level of detail demanded for fracture code assignment in ICD-10,” says Stout.

If however, your surgeon fails to document the side for the fracture of the unspecified part of the neck of femur, you will report code S72.009A (*Fracture of unspecified part of neck of unspecified femur, initial encounter for closed fracture*). “This is not to be a recommended option, and you should train your surgeons to specify the side, as this will be a possible method for insurance denials,” says **Bill Mallon, MD**, former medical director, Triangle Orthopedic Associates, Durham, N.C.

Look at Side and Type for Open Fractures

When reporting an open fracture of an unspecified part of the femoral neck, you report code 820.9 (*Fracture of unspecified part of neck of femur open*). When ICD-10 goes effective, you will select the right code depending upon not only the side but also the type of fracture (Table 1). “The ICD-10 scenario for an unspecified open fracture of the femoral neck will be

very similar to that for the closed fracture,” says Woodward. “The 6th digit option will be the same for the open as the closed fracture, specifying laterality. The 7th digit will include the same options as those for the closed fracture however the classification of the open fracture using the Gustillo classification will also be required for each stage of the encounter except the sequelae. In ICD-9, the coder has only one code option, 820.9.”

“Reporting codes such as 820.9 that include the word ‘unspecified’ as part of their definition are starting to draw denials as payers seek greater specificity in physician reporting before they will pay a claim,” says Stout.

If however, your surgeon fails to document the side of the open fracture of unspecified part of neck of femur, you will report code S72.009B (*Fracture of unspecified part of neck of unspecified femur, initial encounter for open fracture type I or II*) for type I and II fractures and code S72.009C (*Fracture of unspecified part of neck of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC*) for type III fractures.

Make sure you have complete documentation. “It will be imperative for the provider to document laterality, whether the visit is an initial or follow up visit, and if there are any complications related to the fracture,” says Woodward. “If the current problem is a result of a previous fracture (i.e. sequelae of the fracture), it will be imperative for the provider to document that as well as the specifics of the fracture type. Additionally, they will need to document the open classification of the fracture and not merely document that it is an open fracture.” ❖

Table 1: ICD-10 Codes for open fracture of unspecified part of neck of femur.

S72.001B	Fracture of unspecified part of neck of right femur, initial encounter for open fracture type I or II
S72.001C	Fracture of unspecified part of neck of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC
S72.002B	Fracture of unspecified part of neck of left femur, initial encounter for open fracture type I or II
S72.002C	Fracture of unspecified part of neck of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC

Differentiate Between Tenderness and Rebound Tenderness for ICD-10 Clarity

You'll still focus on type of pain and location to choose a code.

When your physician sees a patient who presents with right upper quadrant abdominal pain, but he is unable to document a more definitive diagnosis, your only choice is to code the signs and symptoms discerned. Presently, with ICD-9, you have detailed rules to follow when selecting the most appropriate diagnosis code, however, and guidelines will get even more specific under ICD-10.

Check Type of Pain Under ICD-9

Currently, you have two diagnosis choices for pain or tenderness in the upper right abdominal quadrant:

- ❖ 789.01, *Abdominal pain, right upper quadrant*
- ❖ 789.61, *Abdominal tenderness, right upper quadrant.*

Without a specific clinical diagnosis for the pain or tenderness you will decide which code to report based on whether the physician documents the primary symptom as pain (789.01) or tenderness (789.61).

Further Describe Tenderness With ICD-10

When ICD-10 goes into effect, you'll have an additional code option. The diagnoses will be:

- ❖ R10.11, *Pain localized to upper abdomen; right upper quadrant pain*
- ❖ R10.811, *Right upper quadrant abdominal tenderness*
- ❖ R10.821, *Right upper quadrant rebound abdominal tenderness.*

ICD-10 changes: Pain code 789.01 corresponds directly to R10.11. However, ICD-10 offers two possible matches to the current tenderness code 789.61. The choices distinguish between tenderness and rebound tenderness (pain or tenderness that is more pronounced after a sudden release of pressure, such as when the physician presses on the abdomen and then rapidly removes his hand).

Documentation: Therefore, physicians and other providers will need to distinguish whether the patient is experiencing pain, tenderness, or rebound tenderness. They also will need to document the abdominal site of pain. Your ICD-10 options mirror your ICD-9 options:

- ❖ Right upper quadrant
- ❖ Left upper quadrant
- ❖ Right lower quadrant

- ❖ Left lower quadrant
- ❖ Periumbilic (in the area of the navel [umbilicus])
- ❖ Epigastric (midline above the navel [umbilicus])
- ❖ Generalized
- ❖ Unspecified site.

Check point: One option provided by ICD-9 that is not immediately apparent under ICD-10 is the option of “other specified site,” which includes multiple sites (fifth digit of “9” under ICD-9). If the patient has pain or tenderness in multiple sites in the abdomen, you will apparently need to report multiple ICD-10 codes, one for each site. ❖

Justify Your Choice of Jones Fracture Code in ICD-10

Confirm side of foot and displacement of fracture.

ICD-9 offers only a single code for closed fracture of metatarsal bone(s) - 825.25 (*Fracture of metatarsal bone[s] closed*). Note that is the only code for the closed fracture of one or more metatarsal bones and is not specific for a particular metatarsal bone. You can report the same code for fracture in any metatarsal bone, first to fifth.

Adopt This 3-Step Approach for ICD-10 Codes

When reporting Jones fracture in ICD-10, the following steps will help to guide you to the most accurate code:

- ❖ Determine if the fracture is displaced or nondisplaced.
- ❖ Determine if the fracture is in the right or the left foot.
- ❖ Determine if the fracture is open or closed.

“Because of the significant differences in fracture coding between ICD-10 and ICD-9, it is imperative that coders begin educating their physicians well in advance of the ICD10 implementation date,” says **Heidi Stout, BA, CPC, COSC, PCS, CCS-P**, Coder on Call, Inc., Milltown, New Jersey and orthopedic coding division director, The Coding Network, LLC, Beverly Hills, CA.

“Key areas to cover are the expansion from 4 or 5 digit codes to 7 digit codes that require the physician to document location of fracture, including laterality, whether the fracture is open or closed, and whether the fracture is displaced or nondisplaced at the time of the initial encounter, says Stout. “For the follow-up encounter, the physician must indicate whether the fracture is healing in a routine manner, delayed manner, or if a malunion or nonunion has developed.”

ICD-10: The future code set offers more specific options for this fracture than ICD-9 does.

- ❖ S92.351 — *Displaced fracture of fifth metatarsal bone, right foot*
- ❖ S92.352 — *Displaced fracture of fifth metatarsal bone, left foot*
- ❖ S92.353 — *Displaced fracture of fifth metatarsal bone, unspecified foot*
- ❖ S92.354 — *Nondisplaced fracture of fifth metatarsal bone, right foot*
- ❖ S92.355 — *Nondisplaced fracture of fifth metatarsal bone, left foot*
- ❖ S92.356 — *Nondisplaced fracture of fifth metatarsal bone, unspecified foot.*

Tip: You need to pay attention to the sixth digit to pick up the right code. “The 6th digit will refer to laterality and displacement,” says **Ruby O’Brochta-Woodward, BSN, CPC, CCS-P, COSC, ACS-OR**, compliance and research specialist, Twin Cities Orthopedics, P.A.

The seventh character is chosen based on the encounter:

- ❖ "A" indicating initial encounter for closed fracture
- ❖ "B" indicating initial encounter for open fracture
- ❖ "D" indicating subsequent encounter for routine healing
- ❖ "G" indicating subsequent encounter for delayed healing
- ❖ "K" indicating subsequent encounter for non-union
- ❖ "P" indicating subsequent encounter for malunion
- ❖ "S" indicating sequela (pathological fracture for a fracture caused by a disease process or a late effect)

“The 7th character extenders are used for fracture code assignment in ICD-10-CM to indicate the encounter,” says **Josie Dunn, CPC**, Department of Orthopedics, University of Maryland Faculty Practices, Maryland. “The 7th digit will refer to episode of care: initial closed fracture, initial open fracture, subsequent, sequelae, delayed union, nonunion, and malunion,” says Woodward.

How is ICD-10 Different?

When your surgeon does not document if the fracture was open or closed, you report the fracture as closed. This is also applicable for ICD-9 currently. “ICD-10-CM guidelines state that a fracture not indicated as open or closed should be coded to closed,” says Dunn. However, unlike ICD-9, ICD-10 indicates that you may report a fracture as displaced when your surgeon does not document the displacement. “ICD-10-CM guidelines also state that a fracture not indicated, whether displaced or nondisplaced, should be coded to displaced,” says Dunn.

Higher stakes: “ICD-10 codes are far more specific and require greater specificity on the part of the providers to ensure correct ICD-10 code selection for the type of fracture (open vs closed, late effect or sequela), the state of the healing process (routine, delayed, malunion, or nonunion), the type of encounter (initial or subsequent), and the side (right vs left),” says **Kristi Stumpf, MCS-P, CPC, COSC, ACS-OR**, owner, Precision Auditing and Coding, senior orthopedic coder & auditor, The Coding Network, Washington.

Stress fracture: In ICD-9, you report stress fracture of 5th metatarsal with code 733.94 (*Stress fracture of the metatarsals*). This maps to M84.376A (*Stress fracture, unspecified foot, initial encounter for fracture*) and M84.379A (*Stress fracture, unspecified toe[s], initial encounter for fracture*) in ICD-10. “In ICD-10 stress fractures will be defined as foot and toe. There will be no separate designation for metatarsal,” says Woodward. “Nonunion/delayed union/malunion will be the same base code as the original fracture and defined by the 7th digit.” ❖

S82.84- Demands Multiple Details for Bimalleolar Ankle Fractures

Follow the guidelines if documentation doesn't indicate displaced or nondisplaced.

You may be accustomed to documenting closed or open fractures under ICD-9, but you'll need to include additional details so that coders can choose the most specific fracture code under ICD-10. A quick review of coding for a closed bimalleolar fracture is a helpful introduction to what's in store when ICD-10 becomes effective in October of next year.

Diagnosis: A bimalleolar fracture indicates the patient fractured two malleoli. “Bi-” means two, and malleoli are the bony protuberances on the sides of the ankle. So if documentation shows the patient fractured the lateral and medial malleoli, the patient has a bimalleolar fracture. A closed fracture means the fracture did not break through the skin.

ICD-9-CM:

- ❖ 824.4, *Bimalleolar fracture closed*

ICD-10-CM:

- ❖ S82.841A, *Displaced bimalleolar fracture of right lower leg, initial encounter for closed fracture*
- ❖ S82.842A, *Displaced bimalleolar fracture of left lower leg, initial encounter for closed fracture*
- ❖ S82.843A, *Displaced bimalleolar fracture of unspecified lower leg, initial encounter for closed fracture*
- ❖ S82.844A, *Nondisplaced bimalleolar fracture of right lower leg, initial encounter for closed fracture*
- ❖ S82.845A, *Nondisplaced bimalleolar fracture of left lower leg, initial encounter for closed fracture*

- ❖ S82.846A, *Nondisplaced bimalleolar fracture of unspecified lower leg, initial encounter for closed fracture*

ICD-9 coding rules: ICD-9 includes a single bimalleolar closed fracture code, 824.4, in the 824.x range (*Fracture of ankle*). Dupuytren's fracture is also coded to 824.4.

ICD-10 changes: ICD-10 divides bimalleolar closed fracture coding into multiple S82.84- options. Note that ICD-10 indexes Dupuytren's fracture to the S82.6- range (*Fracture of lateral malleolus*).

Documentation: To help you choose among the more specific ICD-10 codes for a bimalleolar closed fracture, be sure to let the physician know you'll need documentation of whether the fracture is displaced or nondisplaced and which leg is involved. You also may have noticed the code definitions include the phrase "initial encounter." The "A" used as the seventh character in the codes represents "initial encounter." For a closed fracture in the S82.- range, you'll choose from these options:

- ❖ A, initial encounter for closed fracture
- ❖ D, subsequent encounter for closed fracture with routine healing
- ❖ G, subsequent encounter for closed fracture with delayed healing
- ❖ K, subsequent encounter for closed fracture with nonunion
- ❖ P, subsequent encounter for closed fracture with malunion
- ❖ S, sequela.

Coder tips: You may not always have all the information you need, so be sure to apply these coding guidelines listed for the S82.- range:

- ❖ A fracture not indicated as displaced or nondisplaced should be coded to displaced
- ❖ A fracture not indicated as open or closed should be coded to closed.

Remember: CMS has finalized the ICD-10 compliance date of Oct. 1, 2015. When ICD-10 goes into effect, you should apply the code set and official guidelines in effect for the date of service reported. Learn more at www.cms.gov/ICD10/ and at www.cdc.gov/nchs/icd/icd10cm.htm#10update. ❖

Segregate Your Diabetes Mellitus Codes Based on Type

Hint: Use fourth and fifth digit expansion to specify complications.

When your physician diagnoses diabetes mellitus or any manifestation of diabetes, you'll have to scour through patient documentation to check diabetes type (type 1 or type 2) and look specifically for the type of complications and organ systems involved to arrive at the appropriate diagnosis code to report the condition using ICD-10 codes.

ICD-9: When a patient presents with diabetes, you must determine the fourth digit for 250.xx (*Diabetes mellitus*) according to the type of diabetic complication the patient has, if any. If the patient presents with diabetes without any complications, your first four digits will be 250.0 (*Diabetes mellitus without mention of complication*).

Regardless of whether the patient has Type 1 diabetes or Type 2 diabetes, you'll report the diagnosis with the same parent code, 250 (*Diabetes mellitus*). Under ICD-9, the fifth digit provides the final two pieces of information on the patient's diabetic condition: the diabetes type (I or II) and whether it is controlled. Under ICD-9, the fifth digit options are:

- 0 – type II or unspecified type, not stated as uncontrolled
- 1 – type I (juvenile type), not stated as uncontrolled
- 2 – type II or unspecified type, uncontrolled
- 3 – type I (juvenile type), uncontrolled

Caveat: Although you have different codes to report diabetes with complications, those codes are limited in their ability to specify the complications. For example, if a patient presents with Type 2 uncontrolled diabetes with the complication of proliferative diabetic retinopathy with macular edema, you'll report the primary condition with 250.52 (*Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled*). As you can see in this example, from that code you can only make out that there is an ophthalmic complication without actually knowing what the manifestation is. To identify the particular manifestation, you will need to use one or more additional codes. Thus, in this example, you would also report 362.02 (*Proliferative diabetic retinopathy*) and 362.07 (*Diabetic macular edema*).

Delve Deeper into Documentation to Check Complication Specifics

ICD-10 change: When your diagnosis coding system changes, you'll no longer flip to the same code section for both Type 1 and Type 2 diabetes. Although you are currently accustomed to starting off with "250" for all diabetes patients, your coding options will expand

dramatically under ICD-10. Under ICD-10, you'll have to report Type 1 diabetes with E10.xxx and Type 2 diabetes with E11.xxx. The fourth digit specifies the organ systems that show some manifestation, for example, ophthalmic/neurologic/renal, and the fifth (and, sometimes, sixth) digit elaborates the type of complication.

Type 1: You'll code all Type 1 patients by starting out with the E10 series (*Type 1 diabetes mellitus*), and then you'll move on from there after reviewing the patient's chart to determine whether any further manifestations exist.

Example: Your physician sees a patient that presents with Type 1 diabetes with foot ulcer. In this case, you'll look to E10 as your first three characters to reflect the Type 1 diagnosis, followed by the additional digits "621" to reflect that the patient has a foot ulcer complicating the diabetes condition that he is facing. Therefore, the full code will be E10.621 (*Type 1 diabetes mellitus with foot ulcer*).

Type 2: You'll code all Type 2 patients by starting out with the E11 series (*Type 2 diabetes mellitus*), then moving on from there after reviewing the patient's chart to determine whether any further manifestations exist.

Example: Your physician reviews a 55-year-old patient with Type 2 diabetes and kidney complications. Your physician arrives at a diagnosis of diabetic nephropathy due to diabetes mellitus. In this instance, you'll go straight to E11.x and scroll down to E11.21 (*Type 2 diabetes mellitus with diabetic nephropathy*).

Documentation: Just because Type I diabetes is often described as "juvenile type" or "juvenile onset," don't assume that all pediatric patients have Type I diabetes. It is becoming increasingly common for practitioners to diagnose and treat Type II diabetes developed in childhood or adolescence. Also, there are many instances wherein your FP might treat type 2 diabetes with insulin. So don't automatically consider a patient who is being treated with insulin to be suffering from Type 1 diabetes.

Helpful in determining whether a patient has Type I or Type II diabetes is the results of a C-peptide assay, which measures insulin production and can indicate which type of diabetes is present. These test results may be important as you select your fifth digit under ICD-9, so check the documentation for those results.

Coder tips: When you prepare for ICD-10, adjust your superbills and electronic coding systems to offer the physicians the choice of Type 1 or Type 2 when they choose a diabetes diagnosis. Then leave a blank line marked "complication(s)" so that your FP can fill in any applicable complication, allowing you to select the most accurate code from among the many options available under ICD-10. ❖

Confront Your Cardiac and Respiratory Presentations Documentation

Hypertension codes have less specificity except when reported with chronic kidney disease

ICD-10 Chapter 9 contains conditions from a wide range of cardiovascular diseases such as acute rheumatic fever, chronic rheumatic and other forms of heart diseases, diseases of arteries, arterioles and capillaries, diseases of veins, lymphatic vessels and lymph nodes and several other and unspecified disorders of the circulatory system. You will want to brush up on these since they account for nearly 20 percent of level 5 ED visits.

Don't Worry About Hypertension Type When Assigning Your ICD-10 Diagnosis Codes

Unlike most translations where there is much more specificity than in ICD-9, the type of hypertension (benign, malignant, and unspecified) is not used in ICD 10 CM; there is only one code for essential hypertension (I10). Additional diagnosis codes may be required to identify additional conditions such as heart failure/heart conditions, type of heart failure and heart conditions with hypertension that do not have a causal relationship, says **Caral Edelberg, CPC, CPMA, CAC, CCS-P, CHC, AHIMA Certified ICD-10 Instructor and President, Edelberg Compliance Associates**.

For example: Report hypertensive kidney disease with the following conditions:

- ❖ Assumes a cause-and-effect relationship between hypertension and kidney disease
- ❖ If chronic kidney disease is present, hypertensive chronic kidney disease is coded with category I12
- ❖ Stage I, II, III, IV, or end stage should be identified from N18
- ❖ If acute renal failure is present, code it as an additional diagnosis

If hypertensive heart and chronic kidney disease are both diagnosed, code combined from the I13 family. Chronic kidney disease is identified as a secondary diagnosis. Hypertension and chronic kidney disease are not reported separately, because you should assume a relationship between these conditions, even if not explicitly stated in the chart documentation. However, if acute renal failure is documented along with the chronic kidney disease, it should be coded separately, Edelberg explains.

You Can't Have TMI When Coding For AMI

You will want to remember these tips for reporting cardiovascular emergencies. Myocardial Infarction is divided into three distinct levels; acute, unspecified and subsequent acute. The

default code for unspecified term acute MI is I21.3 (ST elevation STEMI myocardial infarction of unspecified site) is. If it is a subsequent MI, which is defined as within 4

weeks of initial AMI, then two codes are required; one from I22 (subsequent STEMI and non-ST elevation [NSTEMI]); and a second, I21 for the current MI. Sequencing is dependent on documentation of the circumstance of the encounter.

What to document: Work with providers to remind them of the importance of documenting prior MI's, particularly those that have occurred within four weeks prior to the patient's ED visit, warns Edelberg.

Don't Let Choosing An Angina Diagnosis Cause You Chest Pain

ICD-10 has combination codes for atherosclerotic heart disease with angina pectoris. When using one of these combination codes, you won't need an additional code for angina pectoris. A causal relationship can be assumed in a patient with both atherosclerosis and angina pectoris, unless the documentation indicates the angina is due to something other than the atherosclerosis.

Documentation tip: ED physicians need to use the term "angina" instead of chest pain or to specify the chest pain as 'ischemic' chest pain, which is an inclusion term for angina pectoris, unspecified, Edelberg advises.

Breathe Easy With These ICD-10 Respiratory Coding Tips

Chapter 10, Diseases of the Respiratory System, also includes many common ED presentations such as pharyngitis, bronchitis, pneumonia, asthma, and emphysema. As with diseases of the circulatory system in Chapter 9, additional codes are required to identify exposure, history, dependence and use of tobacco/tobacco smoke.

Coders will want to review the ICD-10 Z codes that describe factors influencing health status and contact with health services for relevance to ED respiratory related presentations. For example, the additional codes related to tobacco use include Z87.891 (*Personal history of nicotine dependence*), Z77.22 (*Contact with and [suspected] exposure to environmental tobacco smoke [acute][chronic]*), Z57.31 (*Occupational exposure to environmental tobacco smoke*), and Z72.0 (*Tobacco use*). Most of the respiratory conditions require assigning these additional codes. Also in this category of respiratory diagnoses is status post administration of TPA in a different facility within the past 24 hours prior to admission to the current facility), another condition that requires provider documentation on a consistent basis, says Edelberg.

Look for Specific Documentation Of The Location Of Upper Respiratory Infections

ICD-10 is specific about the anatomical location of the infection. Upper respiratory infections including nasopharyngitis, sinusitis, pharyngitis, tonsillitis, laryngitis and tracheitis, obstruc-

tive laryngitis and epiglottitis, and upper respiratory infections, when acute with no underlying conditions are all separate headings in Chapter 10.

Watch For Underlying Conditions With Pharyngitis Diagnoses

How you code that “sore throat” can make the difference in whether it supports a level 2 or a level 4 ED visit. Acute pharyngitis is coded only when the underlying condition cannot be identified in the documentation. Higher specificity supports testing and the medical decision making which, in turn, supports medical necessity for claims. Acute pharyngitis includes acute sore throat, streptococcal pharyngitis, acute pharyngitis due to other, unidentified organisms, and unspecified pharyngitis which includes the following acute conditions: gangrenous pharyngitis, infective pharyngitis, pharyngitis NOS, sore throat NOS, suppurative pharyngitis and ulcerative pharyngitis, says Edelberg.

Don't Forget To Recognize The Influence Of Influenza

This category requires coding of the associated influenza if applicable. Pneumonia with unspecified organism includes Bronchopneumonia w/unspecified organism; lobar pneumonia w/unspecified organism; Hypostatic pneumonia, with unspecified organism, other pneumonia, with unspecified organism and pneumonia w/unspecified organism, she adds. ❖

Preterm Labor Codes 644.00 And 644.03 Transition to New O60.0-Options

Don't overlook these 'Includes' notes.

Preterm labor is labor that begins more than three weeks before the patient expects to deliver her baby but after the 20th week of pregnancy. Contractions may cause the cervix to open earlier than normal. Notice that there is no ICD-9-CM code for preterm labor with delivery. You would code that situation with 644.2x.

Currently, you should report preterm labor with:

- ❖ 644.00, *Threatened premature labor unspecified as to episode of care*
- ❖ 644.03, *Threatened premature labor antepartum*

ICD-10-CM: When your diagnosis system changes after October 1, 2015, you have three new options:

- ❖ O60.00, *Preterm labor without delivery, unspecified trimester*
- ❖ O60.02, *Preterm labor without delivery, second trimester*
- ❖ O60.03, *Preterm labor without delivery, third trimester*

Change: These three choices specify second trimester (O60.02) or third trimester (O60.03). If your provider does not specify which trimester, you would use O60.00, but this should be a rare occurrence if the documentation includes information about the weeks of gestation, which can be converted into trimester information using the ICD-10 definitions for trimesters. When the premature labor results in premature delivery, you should select a different set of codes.

Documentation: In order to report these preterm labor codes, the provider must document that the preterm labor occurred without delivery and the pregnancy's trimester.

Here is how you'll find these codes in the Alphabetic Index:

Pregnancy (childbirth) (labor) (puerperium) —see also Delivery and Puerperal

- complicated by (care of) (management affected by)
- - preterm labor
- - - without delivery O60.00
- - - - second trimester O60.02
- - - - third trimester O60.03
- - - second trimester
- - - - with preterm delivery O60.10
- - - - without delivery O60.02
- - - third trimester
- - - - without delivery O60.03

Coders tips: You will see an Includes notes under the preterm labor category (O60) that says that these codes include onset (spontaneous) of labor before 37 completed weeks of gestation. But remember, spontaneous labor may also mean spontaneous abortion if it takes place prior to 20 weeks gestation, so you should clarify this information before reporting.

You will also see an Excludes1 note that forbids you from reporting these codes with false labor (O47.0-) or threatened labor NOS (O47.0-). ❖

Shift V45.01 and V45.02 To New Z Codes

Don't expect to see pacemaker and AICD codes grouped the same in ICD-9 and ICD-10.

When you need to indicate the presence of a pacemaker or automatic implantable cardiac defibrillator (AICD), without need for care, you'll have to get used to turning to Z codes when ICD-10 is implemented. Here are the options you'll use.

ICD-9-CM codes

- ❖ V45.01, *Cardiac device in situ; cardiac pacemaker*
- ❖ V45.02, *Cardiac device in situ; automatic implantable cardiac defibrillator*

ICD-10-CM codes

- ❖ Z95.0, *Presence of cardiac pacemaker*
- ❖ Z95.810, *Presence of automatic (implantable) cardiac defibrillator*

ICD-9 coding rules: You use V45.01 and V45.02 to indicate the presence of the named devices. If the patient has an AICD with synchronous cardiac pacemaker, you should report V45.02. If the patient has a malfunction or other complication, you should instead code that condition. And if the patient presents for fitting or adjustment, you should use V53.3x (*Fitting and adjustment of cardiac device*).

ICD-10 changes: ICD-10 offers a one-to-one code correspondence to your ICD-9 options. You'll use the AICD code when the patient has an AICD with synchronous cardiac pacemaker. As with ICD-9, you should use a different code range for complications: T82.- (*Complications of cardiac and vascular prosthetic devices, implants and grafts*). And for adjustment or management, you'll turn to Z45.0- (*Encounter for adjustment and management of cardiac device*).

Documentation: Your providers' documentation should not need to change for you to choose the appropriate ICD-10 code.

Coder tips: Although these codes have a one-to-one match between ICD-9 and ICD-10, they are not organized the same way. In other words, if you look at a list of ICD-9 codes, V45.01 is followed immediately by V45.02. In ICD-10, there are a handful of codes between Z95.0 and Z95.810, the latter of which requires two more digits than Z95.0. If you use the index and then verify your code in the tabular list, these structural changes shouldn't put a hitch in your coding.

Remember: CMS has finalized the ICD-10 compliance date of Oct. 1, 2015. When ICD-10 is implemented, you should apply the code set and official guidelines in effect for the date of service reported. Learn more at www.cms.gov/ICD10/ and [www.cdc.gov/nchs/icd/icd10cm.htm#10 update](http://www.cdc.gov/nchs/icd/icd10cm.htm#10_update). ❖

Tackle ADHD Type to Accurately Report F90 Code

Combined type can now be separately reported from predominantly hyperactive types.

If your physician diagnoses attention deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD), you'll have to look more keenly at the type of ADHD/ ADD to arrive at the correct ICD-10 diagnosis to report.

ICD-9: Under the ICD-9 coding system, you have two general codes for these conditions:

- ❖ 314.00 – *Hyperkinetic syndrome of childhood; Attention deficit disorder without mention of hyperactivity (includes a diagnosis of predominantly inattentive type)*
- ❖ 314.01 – *Hyperkinetic syndrome of childhood; Attention deficit disorder with hyperactivity (includes a diagnosis of ADHD of predominantly hyperactive/impulsive type, combined type, and overactivity NOS; also includes simple disturbance of attention with overactivity).*

Although these two coding options mention “childhood,” the same diagnosis codes are used even when the condition is found in adults. If the hyperkinesis is a symptom of an underlying disorder, then you should code the underlying disorder instead.

Look to Type for ICD-10 Assignment

With ICD-10, you'll find that your diagnosis coding options are expanded and require more specificity. Your new coding options will be:

- ❖ F90.0 — *Attention-deficit hyperactivity disorder, predominantly inattentive type*
- ❖ F90.1 — *Attention-deficit hyperactivity disorder, predominantly hyperactive type*
- ❖ F90.2 — *Attention-deficit hyperactivity disorder, combined type*
- ❖ F90.8 — *Attention-deficit hyperactivity disorder, other type*
- ❖ F90.9 — *Attention-deficit hyperactivity disorder, unspecified type*

Key term: “Under ICD-9, the key to choosing the correct code is whether or not there is a mention of hyperactivity,” states **Kent Moore, Senior Strategist** for Physician Payment at the American Academy of Family Physicians. “Under ICD-10, typology becomes much more important. You need to know if the condition is predominantly inattentive, hyperactive, a combination, or of some other type. Otherwise, you will be left to code the unspecified type on a routine basis, which may be problematic,” Moore adds.

Documentation: With ICD-10, you have a specific code to tell the insurer that the patient has both ADD and ADHD (F90.2, combined type). Therefore, the documentation should

clearly reflect the specific condition that your physician diagnoses, whether it's ADD, ADHD, combined type, or another type.

Practice tips: For unspecified ADHD diagnoses, you'll have to report F90.9, but this code will most likely only apply if you do not document enough information to allow you to report a more specific code. If you find that you're reporting F90.9 frequently, get to know the specifics of the new ADD and ADHD codes, so you can ensure that your claims are as specific as possible. Also, if your physician is not specifically mentioning the type of ADHD in the documentation, you can go back and check with him to see which type the patient's condition falls into so that you can avoid F90.9 and report a more specific diagnosis code based on the type.

Example: Your family practitioner assesses an 11-year-old boy brought in by his parents with complaints of restlessness and hyperactivity. The patient is new to the physician. The parents explain that he was having problems with discipline in school, was often disruptive during his classes, and was not able to keep up with the rest of the children in his studies. He was often rebellious at home, too, and was a source of tension and friction for the parents.

The parents first noticed this behavior of hyperactivity and restlessness when it was brought to their attention by the school authorities when he was about 10 years old, and his behavior was becoming more erratic and difficult by the day, which finally made the parents try and seek help.

Your physician conducts a thorough physical examination and a complete mental status examination, a complete psychiatric and medical history of the patient and family, and a thorough review of systems. Your physician also assesses the patient for anxiety and other learning disabilities.

Your physician also conducts interviews with the child's parents and sends out standard evaluation forms to be filled in by his teachers at school.

Based on the signs and symptoms, observations of the child, assessment of the interviews conducted, and the assessment of the evaluation forms completed by his teachers, your physician arrives at a diagnosis of ADHD of predominantly hyperactive type.

What to report: You report the evaluation of the patient with an appropriate new patient E/M code such as 99203 (*Office or other outpatient visit for the evaluation and management of a new patient...*). You report the diagnosis using 314.01 if you're using ICD-9 and F90.1 if you are using ICD-10-CM. ❖

Ace Reporting Angiodysplasia of the Colon

Confirm the presence of hemorrhage to get to the right code.

Your oncologist will often see patients for bleeding in the stools. When reporting the right diagnosis codes for angiodysplasia of the colon, your choice is guided by the presence or absence of hemorrhage.

ICD-9-CM: Depending on presence or absence of hemorrhage, angiodysplasia can be reported using the following two codes in ICD-9-CM:

- ❖ 569.84 — *Angiodysplasia of intestine (without mention of hemorrhage)*
- ❖ 569.85 — *Angiodysplasia of intestine with hemorrhage*

Reminder: The ICD-9-CM codes 569.84 and 569.85 are specific to reporting angiodysplasia of the intestine. If your oncologist diagnoses angiodysplasia of the stomach or the duodenum, you cannot use these two codes. Instead, depending on the presence or absence of hemorrhage, you will have to report the diagnosis with 537.82 (Angiodysplasia of stomach and duodenum [without mention of hemorrhage]) or 537.83 (Angiodysplasia of stomach and duodenum with hemorrhage) if the location of the vascular deformity is in the stomach or duodenum.

Observe Minor Descriptor Changes in ICD-10-CM

When you begin using ICD-10-CM codes, a diagnosis of angiodysplasia of the colon will again rely on the presence or absence of hemorrhage, as it does in ICD-9-CM.

Under ICD-10-CM, you will have two codes to report angiodysplasia of the colon:

- ❖ K55.20 — *Angiodysplasia of colon without hemorrhage*
- ❖ K55.21 — *Angiodysplasia of colon with hemorrhage*

As in ICD-9-CM codes, you cannot report angiodysplasia of the stomach and duodenum with K55.20 or K55.21. Instead, taking note of hemorrhage, you will report a diagnosis of angiodysplasia of the stomach or duodenum using K31.811 (*Angiodysplasia of stomach and duodenum with bleeding*) or K31.819 (*Angiodysplasia of stomach and duodenum without bleeding*).

Note: Although a dieulafoy lesion of the intestine is a hemorrhagic lesion, you should not report this condition using K55.21 if you are using ICD-10-CM codes or 569.85 in the ICD-9-CM system. You have a separate code in ICD-9-CM and in ICD-10-CM to report this condition. You will report 569.86 (Dieulafoy lesion [hemorrhagic] of intestine) while using ICD-9-CM and K63.81 (Dieulafoy lesion of intestine) if you are using ICD-10-CM codes. Note, K63.81

does not include the 'hemorrhagic' descriptor in ICD-10-CM, says **Kelly C. Loya, CPC-I, CHC, CPHT, CRMA**, Director of Reimbursement and Advisory Services, Altegra Health, Inc.

Review These Basics Briefly

Documentation spotlight: When your oncologist arrives at a diagnosis of angiodysplasia of the colon, some of the signs and symptoms that you are most likely to see in the documentation of the patient will include episodes of blood in stools (hematochezia or melena). The bleeding can be noted as minimal or in some cases, significant bleeding may be noted in the patient documentation. In some cases, the bleeding may be noted to have occurred in the past and resolved on its own. On the other hand, your oncologist might report angiodysplasia of the colon in an asymptomatic patient in whom the lesion was identified at the time of a screening colonoscopy.

Upon examination, your oncologist might note the presence of tachycardia and signs of hypotension if the bleeding was recent and massive. If your oncologist suspects a diagnosis of angiodysplasia based on history alone, he may perform tests such as a complete blood count, hemoglobin count, and guaiac stool labs. Usually in a patient with angiodysplasia of the colon, you will note that the patient also suffers from iron deficiency anemia and guaiac stool is positive when there is bleeding.

Your oncologist may use colonoscopy to arrive at the diagnosis of angiodysplasia. He will also perform selective mesenteric angiography to aid in the diagnosis. Your physician will look to perform selective mesenteric angiography if an angiodysplasia is suspected but not clearly identified during a colonoscopy, says **Michael Weinstein, MD**, gastroenterologist at Capital Digestive Care in Washington, D.C., and former representative of the AMA's CPT® Advisory Panel.

Example: Your oncologist reviews a 68-year-old male patient for complaints of passing fresh blood in the stools. He says that he has had these symptoms before although the bleeding was much less and had resolved by itself spontaneously. He also complains of feeling tired, irritable, having a reduced appetite, and suffering from headaches that are causing him to feel dizzy.

The oncologist performs a thorough physical examination and notes the presence of tachycardia, inflamed tongue and cold extremities. He withdraws a blood sample and sends it to the lab for analysis. He also performs a digital rectal examination, withdraws a stool sample and performs a guaiac stool test.

The lab tests results reveal the presence of a microcytic hypochromic anemia (iron deficiency anemia) and guaiac stool tests are positive for occult blood.

Your oncologist performs colonoscopy that reveals multiple vascular lesions in the proximal ascending colon. He identifies a lesion that has active bleeding and uses a Nd:YAG laser to obliterate the bleeding. Based on these observations, your oncologist arrives at a diagnosis of angiodysplasia.

What to report: If you are reporting the guaiac stool test, use 82272 (Blood, occult, by peroxidase activity [e.g., guaiac], qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening). For the colonoscopy, report 45382 (Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding [e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator]).

Use K55.21 once ICD-10-CM is effective and 569.85 for the ICD-9-CM coding system. If, during the course of the evaluation, your oncologist ordered a mesenteric angiography, then the radiologist will use 75726 (Angiography, visceral, selective or supraselective [with or without flush aortogram], radiological supervision and interpretation) to report the service. ❖

Pulmonology: Distinguish Byssinosis Diagnosis Distinctly With J66.0

Hint: Look for other expansions to J66 for pneumopathy due to inhalation of other dusts.

When your pulmonologist diagnoses byssinosis, a condition caused by inhalation of cotton dust, you'll be pleased to know that you have a very specific code to report this condition with ICD-10 codes, a choice that you did not have while using ICD-9.

ICD-9: When reporting a diagnosis of byssinosis in ICD-9, you'll have to report it with 504 (*Pneumonopathy due to inhalation of other dust*). You'll have to report the same diagnosis code for inhalation of other dust particles like cannabis (cannabinosis) or unprocessed flax (flax dressers' disease).

Caveat: You cannot use 504 for a diagnosis of allergic alveolitis (495.0-495.9); bagassosis (495.1); asbestosis (501); and farmer's lung (495.0) as these have other specific ICD-9 codes that you can report when your clinician diagnoses these conditions.

ICD-10: When you begin using ICD-10 codes, 504 that you use to report a diagnosis of pneumopathy due to inhalation of other dusts crosswalks to category J66 (*Airway disease due to specific organic dust*). As in ICD-9, the list of exclusions is similar and comprises allergic alveolitis (J67.-); asbestosis (J61); bagassosis (J67.1); farmer's lung (J67.0); hypersensitivity pneumonitis due to organic dusts (J67.-) and reactive airways dysfunction syndrome (J68.3).

However, unlike in ICD-9 where you have a more general code that includes byssinosis, cannabinosis and flax-dressers' disease, in ICD-10, you have more specific codes to report

these diagnoses separately. J66 expands into the following four codes so that you can report these diagnoses appropriately based on the type of dust that is inhaled:

- ❖ J66.0 (*Byssinosis*)
- ❖ J66.1 (*Flax-dressers' disease*)
- ❖ J66.2 (*Cannabinosis*)
- ❖ J66.8 (*Airway disease due to other specific organic dusts*)

So, when your pulmonologist arrives at a diagnosis of byssinosis, you can report this diagnosis with J66.0. By looking at the ICD-10 code, you can ascertain what type of dust has caused the pneumopathy while this cannot be done when you report 504 using ICD-9 codes.

Focus on These Basics Briefly

Documentation spotlight: Your pulmonologist will arrive at a diagnosis of byssinosis based on a thorough history, medical examination, signs and symptoms and based on the findings of blood tests and diagnostic tests such as pulmonary function tests, CT scans and chest x-rays.

The history of working with cotton dust will make your pulmonologist suspect a diagnosis of byssinosis. Some of the signs and symptoms that your pulmonologist might note in a patient suffering from byssinosis might include symptoms similar to that seen in asthma. So, the patient is more likely to present symptoms such as wheezing, coughing, difficulties with breathing and tightness of the chest area.

Tests: Based on history, signs and symptoms and physical findings, if your pulmonologist suspects a diagnosis of byssinosis your clinician will order for imaging tests such as a chest x-ray or a CT scan to ascertain the diagnosis. He might also opt to obtain an arterial blood sample to check for arterial blood gases to see if there is any reduction in oxygen saturation.

Your pulmonologist might also depend on pulmonary function tests such as spirometry (94010, *Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement[s], with or without maximal voluntary ventilation*), determination of lung volumes (94727, *Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes*) and respiratory flow volume (94375, *Respiratory flow volume loop*) to support the diagnosis of byssinosis.

Example: A 47-year-old male patient arrives at your pulmonologist's office with complaints of breathing difficulties and tightness of the chest area. He complains that he has been having these symptoms for quite sometime now and of late the symptoms have increased and has been affecting his work and day-to-day life. He also mentions that he seems to be having these symptoms more during the start of the week and then it seems to stabilize for some days and he feels better during the rest of the week.

Upon questioning, your pulmonologist notes that the patient has been working as a handler of raw cotton for more than 15 years now. Based on this history of working in the cotton industry and the signs and symptoms, your pulmonologist suspects a diagnosis of byssinosis.

On examination, your pulmonologist notes wheezing and reduced lung expansion during breathing. Your pulmonologist withdraws an arterial blood sample and sends it to the lab to check for arterial blood gases. Your clinician also orders for a chest x-ray.

He performs pulmonary function tests like spirometry, respiratory flow volume and determination of lung volumes.

Based on history, signs and symptoms, results of lab tests, imaging tests and pulmonary function tests, your clinician is able to confirm a diagnosis of byssinosis.

What to report: You report the evaluation of the patient with 99203 (*Office or other outpatient visit for the evaluation and management of a new patient...*). You report the pulmonary function tests with 94010 and 94727. According to Correct Coding Initiative (CCI) edits, the CPT® code 94375 is bundled into 94010 with the modifier indicator '0,' which means that you cannot report these two codes for the same session together. For this reason, you will only report 94010 and 94727 for the PFTs and not report 94375.

You report the diagnosis of byssinosis with J66.0 if you are using ICD-10 codes or report 504 if you are using the ICD-9 coding system. ❖

Underlying Condition Will Be Key to Choosing Pathological Fracture Diagnosis

This common diagnosis supporting vertebroplasty will become more inclusive.

When your pain management specialist performs vertebroplasty, you have three possible CPT® procedure codes to consider, based on the spinal area and number of vertebral bodies treated:

- ❖ 22523 – *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); thoracic*
- ❖ 22524 – *... lumbar*

- ❖ +22525 – ... *each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure).*

You also have a range of associated diagnoses that payers might accept for vertebroplasty. One of the most common is 733.13 (*Pathological fracture of vertebrae*), which will expand into multiple options based on the type of encounter and how the fracture is healing once ICD-10 becomes effective.

ICD-10 Diagnosis Starts With Underlying Reason

The new diagnosis choices for pathological fracture of vertebrae are found in the “M” category of ICD-10 that represents “Diseases of the musculoskeletal system and connective tissue” (Chapter XIII). A closer look shows that they fall into two separate code families:

- ❖ M80 – *Osteoporosis with current pathological fracture (under Disorders of bone density and structure)*
- ❖ M84 – *Disorder of continuity of bone (part of Osteopathies and Chondropathies).*

Coding tip 1: Your providers will need to ascertain and document the underlying cause of the patient’s vertebral fracture and need for vertebroplasty. That knowledge will point you to the correct category of M80 or M84.

Note: The M48 (*Other spondylopathies*) codes of ICD-10 deal with collapsed vertebrae rather than pathological fractures. Some of these codes such as M48.5xxX could potentially support medical necessity for vertebroplasty, but coverage typically is for pathologic fractures.

Obtain Encounter Status Details

Once you turn to the correct “M” coding family, you’ll have several options to eliminate before reaching the most accurate diagnosis. The seventh digit for the M80 and M84 codes include the following options:

- ❖ 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 (sequel).

Coding tip 2: Stress the importance of documenting whether the vertebroplasty your pain management specialist performs is initial or subsequent treatment. Notes regarding the fracture status will also help you correctly identify the code’s seventh digit and thus help you choose the most accurate diagnosis. ❖

Drill Down for Functional Dyspepsia Specifics With K30

Hint: You cannot report K30 for psychogenic dyspepsia.

When reporting a diagnosis of functional dyspepsia, you'll have a very specific code in ICD-10 for this condition, whereas, in ICD-9, you're limited to a more generic code that covers all functional disorders of the stomach.

ICD-9: You report a diagnosis of functional dyspepsia using the ICD-9 code 536.8 (*Dyspepsia and other specified disorders of function of stomach*). You'll use the same diagnosis code for other diagnoses such as achylia gastrica; hourglass contraction of stomach; hyperacidity; hyperchlorhydria; hypochlorhydria; indigestion; or tachygastric. However, you cannot use 536.8 if the diagnosis is achlorhydria (536.0); heartburn (787.1) or for functional disorders of the stomach specified as psychogenic (306.4).

ICD-10: When you begin using ICD-10 codes, a diagnosis of functional dyspepsia has to be reported with K30 (*Functional dyspepsia*). Unlike in ICD-9, you have a very specific code in ICD-10 to report functional dyspepsia and you do not use the same diagnosis code for other conditions as you do with 536.8 in ICD-9.

Red flag: However, you cannot use K30 when your clinician is assessing symptoms of dyspepsia caused due to another condition. In such a case, you report this with R10.13. You also cannot use K30 when the symptom is of heartburn (R12). In addition, the other diagnoses that your clinician makes for which you cannot report K30 includes nervous dyspepsia; neurotic dyspepsia or psychogenic dyspepsia. You report all these conditions using F45.8 (Other somatoform disorders).

Check These Basics Briefly

Documentation spotlight: Some symptoms that you are most likely to encounter in the documentation of a patient suffering from functional dyspepsia might include upper abdominal pain; bloating; heartburn; belching; feeling of fullness; and nausea. Your clinician will record a complete history including history of any medications that the patient is currently taking and check for other symptoms such as vomiting, signs of bleeding (dark stools) or other GI symptoms to look for any other cause for the dyspepsia. Upon examination, your clinician might note signs of tenderness on palpating the upper abdominal area.

Tests: Since the signs and symptoms of functional dyspepsia will mimic other conditions such as an ulcer, gastroesophageal reflux disease (GERD); dyspepsia caused as a result of medications and other serious conditions such as cancer, your gastroenterologist will want to rule out these conditions prior to arriving at a diagnosis of functional dyspepsia.

Your clinician will undertake an upper GI endoscopy to see if there is a cause for the dyspepsia and to rule out any serious complications such as an ulcer that is bleeding or has caused a perforation. As H. pylori infections are also thought of to be a cause for causing the symptoms of functional dyspepsia, your clinician might also order for tests to check for H. pylori infections.

Based on the history, symptoms, and tests to rule out other causes of the symptoms of dyspepsia, your clinician will arrive at the diagnosis of functional dyspepsia.

Example: Your gastroenterologist recently reviewed a 55-year-old established male patient with complaints of heartburn and severe upper abdominal pain. He says that he has had these symptoms for sometime now and the trouble has been gradually on the rise. He says that intake of food has not much influence on reducing his symptoms although it sometimes helps.

Your gastroenterologist recorded a complete history of the patient including a review of allergies and past, family, and social history. The patient's current medication list was updated. He also has no history of any vomiting or blood in the stools. Upon examination, the patient experienced tenderness on palpation of the upper abdominal area.

Your gastroenterologist also ordered for a C-13 breath test to check for H. pylori infection. The test returned negative for presence of H. pylori infection.

Your gastroenterologist subsequently performed an upper abdominal endoscopy to see if the patient has any problems such as an ulcer, strictures, signs of reflux, and to check for any other lesions or masses that could be causing the problem. He notes that he found no such signs of significance.

Based on history, signs and symptoms, and results of tests, your gastroenterologist confirmed a diagnosis of functional dyspepsia.

What to report: You report the evaluation of the patient using 99213 (*Office or other outpatient visit for the evaluation and management of an established patient...*); the EGD procedure with 43235 (*Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen[s] by brushing or washing [separate procedure]*).

You report the C-13 breath test using 83013 (*Helicobacter pylori; breath test analysis for urease activity, non-radioactive isotope [e.g., C-13]*) for the analysis that your gastroenterologist provides and use 83014 (*Helicobacter pylori; drug administration*) for the administration of the non-radioactive isotope.

You report the diagnosis with K30 if you're using ICD-10 codes or use 536.8 if you are using ICD-9 coding system. ❖

Effortlessly Transition to Mild Pre-Eclampsia Diagnoses

Your ob-gyn needs to start documenting the pre-eclampsia severity.

Pre-eclampsia is a condition where hypertension occurs during a patient's pregnancy along with significant amounts of protein in the urine. This is the most common dangerous pregnancy complication, and it may affect both the mother and the unborn child.

Currently, you should report this condition with these ICD-9-CM codes:

- ❖ 642.40, *Mild or unspecified pre-eclampsia as to episode of care*
- ❖ 642.41, *Mild or unspecified pre-eclampsia with delivery*
- ❖ 642.42, *Mild or unspecified pre-eclampsia with delivery with postpartum complication*
- ❖ 642.43, *Mild or unspecified pre-eclampsia antepartum*
- ❖ 642.44, *Mild or unspecified pre-eclampsia postpartum*

ICD-10 Change: When your diagnosis system changes as of October 1, 2015, you should have these diagnoses on hand:

- ❖ O14.00, *Mild to moderate pre-eclampsia, unspecified trimester*
- ❖ O14.02, *Mild to moderate pre-eclampsia, second trimester*
- ❖ O14.03, *Mild to moderate pre-eclampsia, third trimester*
- ❖ O14.90, *Unspecified pre-eclampsia, unspecified trimester*
- ❖ O14.92, *Unspecified pre-eclampsia, second trimester*
- ❖ O14.93, *Unspecified pre-eclampsia, third trimester*

Right now, you would report mild pre-eclampsia with four codes (642.41-642.44), but in ICD-10-CM,

you will have three diagnoses based on the patient's trimester (O14.00-O14.03). The first code (O14.00) has an unspecified trimester, but the other two describe the second and third trimesters.

Documentation: Your provider will most likely already document the patient's trimester, but he or she should specify the pre-eclampsia as mild and not severe pre-eclampsia or HELLP syndrome.

Here's how you can find these codes in the Alphabetic Index:

Delivery (childbirth) (labor)

- cesarean (for)
- - pre-eclampsia O14.9-
- - - mild O14.0-
- - - moderate O14.0-
- complicating
- - pregnancy O16-
- - - gestational (pregnancy induced) (transient) (without proteinuria) O13-
- - - - with proteinuria O14.9-
- - - - - mild pre-eclampsia O14.0-
- - - - - moderate pre-eclampsia O14.0-

Pre-eclampsia O14.9-

- - mild O14.0-
- - moderate O14.0-

Coder tips: If your provider does not specify the severity of the pre-eclampsia, you can report O14.92-O14.93 (Unspecified pre-eclampsia ...) based on trimester.

Under the O14 category (Pre-eclampsia), you will see an Excludes1 note that forbids you from reporting these codes with pre-existing hypertension with pre-eclampsia (O11). ❖

R07.89 Lets You Report Chest Pressure and More as of Oct. 1

Following inclusion notes will keep your coding on track.

Once ICD-10-CM is implemented on Oct. 1, 2015, you'll need to know the meaning of "intercostal" if you want to choose the appropriate chest pain code. Here's how the new codeset options break down.

ICD-9-CM

- ❖ 786.59, *Other chest pain*

ICD-10-CM

- ❖ R07.82, *Intercostal pain*
- ❖ R07.89, *Other chest pain*

Chest pain can refer to a number of descriptions related to discomfort in the patient's chest. Note that this is not the same as breast pain, which is coded elsewhere.

ICD-9 coding rules: ICD-9 includes discomfort, pressure, and tightness in the chest under 786.59.

ICD-10 changes: ICD-10 divides your chest pain coding options among multiple codes. R07.82 is specific to pain designated as intercostal (between the ribs). The ICD-10 index, like ICD-9, points you to the code for "other chest pain" (R07.89) for discomfort, pressure, and tightness in chest.

Documentation: Your provider's documentation should not need to change for you to choose the proper ICD-10 code if it allows you to distinguish between intercostal pain and the terms classified under "other" chest pain. Keep in mind, you'll have separate codes for painful respiration (*R07.1, Chest pain on breathing*), *precordial pain (R07.2, Precordial pain; R07.81, Pleurodynia)*, and *unspecified chest pain (R07.9, Chest pain, unspecified)*.

Coder tips: Remember to read your inclusion notes. ICD-9 places "anterior chest wall" pain under 786.52 (*Painful respiration*). ICD-10 lists "Anterior chest-wall pain NOS [not otherwise specified]" under R07.89 (*Other chest pain*). ❖

Look to F50 Series for Eating Disorder Diagnoses

Hint: Distinguish from binge eating or purging type to nail the ICD-10 diagnosis.

When the pediatrician diagnoses an eating disorder, you're currently quite familiar with the 307.xx series of ICD-9 codes, but your options won't change too dramatically under ICD-10, which will offer a fairly easy transition to your coding strategy.

Capture This Bulimia Change

ICD-9: You currently use 307.51 (*Bulimia nervosa*) to report a diagnosis of bulimia nervosa. You use the same diagnosis code if the pediatrician mentions the diagnosis as overeating of nonorganic origin. However, you cannot report 307.51 if the diagnosis is anorexia nervosa (307.1), anorexia of unspecified cause (783.0), overeating of unspecified cause (783.6), vomiting NOS (787.03), cyclical vomiting (536.2), cyclical vomiting associated with migraine (346.2x) or psychogenic cyclical vomiting (306.4).

ICD-10: When you begin using ICD-10 codes, a bulimia nervosa diagnosis will crosswalk from 307.51 to F50.2 (Bulimia nervosa). You will also report F50.2 if you make a diagnosis of bulimia NOS or hyperorexia nervosa.

However, you cannot report F50.2 if you make a diagnosis of anorexia nervosa of binge eating or purging type.

Focus on These Basics Briefly

Documentation spotlight: The pediatrician will arrive at a diagnosis of bulimia nervosa based on a complete history and an evaluation of the person's signs and symptoms; the encounter will include a complete mental status examination, a complete psychiatric and medical history of the patient and family, and a review of systems, along with ordering and interpreting diagnostic tests.

Some of the symptoms that the clinician might note in the documentation will include light-headedness, dizziness, palpitations, soreness of throat (due to purging), abdominal pain, bloating, dysphagia, flatulence, constipation, and amenorrhea.

Upon examination of the patient, the pediatrician might note dry skin, nail damage, hair loss, edema, obesity, enlargement of parotids, hypotension, bradycardia, or tachycardia. Some of the lab tests that the clinician is likely to order if he suspects bulimia nervosa will include a CBC, amylase levels, blood chemistry to check for metabolic disturbances, and urinalysis to check hydration and to look for substance abuse.

If the pediatrician suspects bulimia nervosa, he might also ask for an ECG to rule out cardiovascular complications. The pediatrician will also assess the patient for other co-morbidities such as anxiety, depression, impulse disorders, and ADHD.

The pediatrician may also ask the patient to fill out assessment questionnaires, such as the SCOFF mnemonic questionnaire, eating disorder for primary care (ESP) questionnaire, and the eating attitude test (EAT) to help arrive at a diagnosis of bulimia nervosa.

Follow These Changes to Anorexia Nervosa

Reporting anorexia nervosa under ICD-10 requires you to look for specifics on whether the disease type is restricting or purging. Rely on the advice below to guide you to the right codes when ICD-10 comes into effect.

Pinpoint Weight Loss Reason in ICD-9

If you are using ICD-9-CM codes to report a diagnosis of anorexia nervosa, you will have to report it with 307.1 (*Anorexia nervosa*). But it is essential to note that this code cannot be used to report loss of appetite (783.0, *Anorexia*), weight loss due to feeding problems (783.3, *Feeding difficulties and mismanagement*) or any other unspecified eating disorder (307.50,

Eating disorder, unspecified). In ICD-9-CM, you have to report anorexia nervosa with 307.1, irrespective of the type of the condition that the person is suffering from.

Look for Anorexia Type in ICD-10

When ICD-10 comes into effect, you will have to report anorexia nervosa using one of three codes under F50.0 (*Anorexia nervosa*). But as in ICD-9, you cannot report conditions like loss of appetite (*R63.0, Anorexia*) and a psychogenic loss of appetite (*F50.8, Other eating disorders*) using this code. F50.0 expands to three other codes depending on the type of anorexia nervosa using a fifth digit expansion.

So if the patient is suffering from a restricting type of anorexia nervosa, you report the condition with F50.01 (*Anorexia nervosa, restricting type*), and you report F50.02 (*Anorexia nervosa, binge eating/purging type*) if the person is suffering from a purging type of anorexia nervosa. However, if the type of anorexia is not specified, you will turn to F50.00 (*Anorexia nervosa, unspecified*).

The most common signs and symptoms of anorexia nervosa that you will see include appearance of severe malnutrition and weight loss. You might see details such as the person being excessively conscious about calorie intake, undertaking strict diets despite being underweight and thin, constant thoughts about food and cooking although he/she resorts to eating in very limited quantities (much less than normal) and the feeling of being overweight although the person is severely underweight.

The pediatrician will usually ask for tests such as complete blood count (CBC) to assess malnutrition, glucose tolerance test to assess other conditions such as diabetes, liver function and blood urea nitrogen tests to assess for malnutrition, urinalysis to check for substance abuse, etc. These tests are conducted to rule out other conditions that might be causing the problem or to ascertain the reasons for the condition. These tests will also help the pediatrician in assessing how the condition is affecting other major organ systems that might need treatment during management of the patient.

Coder Tips: Before ICD-10 approaches, be sure and replace the instances of 307.x with the F50 series to streamline your coding conversion. ❖

Get Specifics About Pacemaker Adjustments for ICD-10 Success

Hint: Z45 family will draw lines between battery and other parts.

When your anesthesia provider is called into a case involving pacemaker adjustments, you currently have three diagnosis choices based on the device involved. You'll need to gather more details from the cardiologist for ICD-10 coding, however, to ensure you submit the correct diagnosis.

ICD-9 includes the following choices for cases when the physician fits, adjusts, removes, replaces, or reprograms a cardiac device:

- ❖ V53.31 – *Fitting and adjustment of cardiac pacemaker*
- ❖ V53.32 – *Fitting and adjustment of automatic implantable cardiac defibrillator*
- ❖ V53.39 – *Fitting and adjustment of other cardiac device.*

ICD-9 coding rules: The V53.3x codes apply to removal and replacement of devices, as well as reprogramming, but they are not appropriate if you are indicating only status without need for care (in that case, use ICD-9 code V45.0x, Cardiac device in situ). You should not use V53.31 to indicate mechanical complication; instead use 996.01 (Mechanical complication due to cardiac pacemaker [electrode]).

If the patient has an AICD with synchronous cardiac pacemaker, you should look to V53.32 rather than V53.31 for fitting and adjustment encounters.

ICD-10 change: You'll still only have four code choices when ICD-10 becomes effective in October 2015, but they encompass more than the current options:

- ❖ Z45.010 – *Encounter for checking and testing of cardiac pacemaker pulse generator (battery)*
- ❖ Z45.018 – *Encounter for adjustment and management of other part of cardiac pacemaker*
- ❖ Z45.02 – *Encounter for adjustment and management of automatic implantable cardiac defibrillator*
- ❖ Z45.09 – *Encounter for adjustment and management of other cardiac device.*

ICD-10 guidelines: Under ICD-10, you'll have to choose between two codes for pacemaker services: Z45.010 for the pulse generator and Z45.018 for any other part. You'll still have one code for AICD services (Z45.02) and one related to other devices (Z45.09).

The includes and excludes notes accompanying the ICD-10 codes are similar to those for the ICD-9 codes. A note with Z45.010 tells you it is appropriate for replacing a pacemaker pulse

generator. A note with Z45.02 explains you should use that code when the patient has an encounter for adjustment and management of an AICD with synchronous cardiac pacemaker.

Notes for the entire Z45.- range indicate the codes apply to removal or replacement of an implanted device. However, you should look elsewhere to code malfunction or other complications of a device (see T82.1-, *Mechanical complication of cardiac electronic device*) or the simple presence of a device (see Z95.-, *Presence of cardiac and vascular implants and grafts*).

Documentation: Your provider's documentation shouldn't need to change for you to find the proper code under ICD-10, as long as he is clear about which device and which part of a pacemaker is being serviced. For more efficient coding, make distinguishing between services related to pacemaker batteries and services related to other pacemaker parts easy on yourself. For example, you could list both codes on the superbill, or list Z45.01- and have the provider mark or circle "pulse gen" or "other." ❖

Know the Rhinitis Cause to Report This Dx Under ICD-10

You'll be checking the 'J30.x' section to find the right rhinitis code next year.

Rhinitis can be a common diagnosis for otolaryngologists throughout the year, which means you'll need to know how to report it when ICD-10 takes effect. Once again, careful and complete physician documentation will determine which diagnosis code you can report.

Definition: Rhinitis is inflammation of the nasal membranes characterized by a combination of the sneezing, nasal congestion, nasal itching, and rhinorrhea. The patient's eyes, ears, sinuses, and throat can also be involved. Allergic rhinitis – a collection of symptoms that occur when you breathe in something you are allergic to – is the most common cause of rhinitis. The causes of allergic rhinitis may differ depending on whether the symptoms are seasonal, perennial, or sporadic/episodic.

Under ICD-9: ICD-9-CM guidelines direct you to report 477.9 (*Allergic rhinitis, cause unspecified*) when the physician does not document a specific cause for the patient's allergic rhinitis. Report a more specific diagnosis (such as 477.0, *Allergic rhinitis due to pollen*) when possible. Include an additional code on the claim to identify the infectious organism.

ICD-10 changes: When ICD-10 goes into effect in October 2015 which is less than a year away, you'll have two condition-specific codes to choose between: J30.0 (*Vasomotor rhinitis*)

and J30.9 (*Allergic rhinitis, unspecified*). You'll find both codes in Chapter 10, Diseases of the Respiratory System; under the subsection Other Diseases of Upper Respiratory Tract (J30-J39).

Documentation: Obtaining a detailed history is important in the evaluation of allergic rhinitis. A thorough history (*including factors such as family history of allergic diseases and environmental or occupational exposures*) may help identify specific triggers for the condition.

You might test the patient for reaction to specific allergens in order to confirm the diagnosis of allergic rhinitis and determine specific allergic triggers. Skin testing is the most common method of allergy testing, but physicians might also obtain a nasal smear to establish the diagnosis.

Coder tips: ICD-10 will include several diagnoses for specific causes of allergic rhinitis (which you might find documented in your physician's chart as hay fever or nasal allergies). Study all your choices in the diagnosis J30 family (Vasomotor and allergic rhinitis) before assigning a code:

- ❖ J30.0 – *Vasomotor rhinitis*
- ❖ J30.1 – *Allergic rhinitis due to pollen (includes allergy NOS due to pollen, hay fever, and pollinosis)*
- ❖ J30.2 – *Other seasonal allergic rhinitis*
- ❖ J30.5 – *Allergic rhinitis due to food*
- ❖ J30.8 – *Other allergic rhinitis*
- ❖ J30.81 – *Allergic rhinitis due to animal (cat) (dog) hair and dander*
- ❖ J30.89 – *Other allergic rhinitis (includes perennial allergic rhinitis)*
- ❖ J30.9 – *Allergic rhinitis, unspecified.*

Coding guidelines note that J30.9 will include spasmodic rhinorrhea. You'll submit different codes, however, for allergic rhinitis with asthma (bronchial) (J45.909) or rhinitis NOS (J31.0).

Your physician will need to specify the cause of allergic rhinitis so you can code more accurately. Once a patient is diagnosed with allergic rhinitis and receives ongoing treatments, you can continue to include the code on your claims.

Example: A patient is undergoing a treatment plan of allergy injections for allergic rhinitis. When the patient returns to your office for additional treatments, add the appropriate allergic rhinitis diagnosis to the claim because that's the reason for the patient's office visit. ❖

T82.- Codes for Cardiac Device Complications Demand A Lot of Details

Check for the specific problem before using these 996.71-996.72 replacements.

If you have a patient present with a pacemaker complication after ICD-10 is implemented, you'll have to sift through eight different codes to find the best match for his case. Be sure your practice has a plan to capture the complication and encounter details the new codes will require.

The diagnosis: The codes below apply to non-mechanical complications of heart valve prostheses or other cardiac devices, implants, or grafts, such as a pacemaker, implantable defibrillator, or bypass graft. Complications may include embolism, fibrosis, hemorrhage, pain, stenosis, or thrombosis due to the device's presence.

ICD-9-CM Codes:

- ❖ 996.71, Other complications due to heart valve prosthesis
- ❖ 996.72, Other complications due to other cardiac device, implant, and graft

ICD-10-CM Codes:

- ❖ T82.817-, *Embolism of cardiac prosthetic devices, implants and grafts*
- ❖ T82.827-, *Fibrosis of cardiac prosthetic devices, implants and grafts*
- ❖ T82.837-, *Hemorrhage of cardiac prosthetic devices, implants and grafts*
- ❖ T82.847-, *Pain from cardiac prosthetic devices, implants and grafts*
- ❖ T82.857-, *Stenosis of cardiac prosthetic devices, implants and grafts*
- ❖ T82.867-, *Thrombosis of cardiac prosthetic devices, implants and grafts*
- ❖ T82.897-, *Other specified complication of cardiac prosthetic devices, implants and grafts*
- ❖ T82.9XX-, *Unspecified complication of cardiac and vascular prosthetic device, implant and graft.*

The appropriate 7th character is to be added to each code from category T82:

- ❖ A, initial encounter
- ❖ D, subsequent encounter
- ❖ S, sequela
- ❖ ICD-9 coding rules:

ICD-9 coding rules: ICD-9 offers two coding options. One (996.71) is specific to heart valve prosthesis complications. The other (996.72) applies to other cardiac devices, implants, and

grafts specified in the documentation. The various non-mechanical complications that occur all fall under those broad codes. One important exception is coronary graft occlusion due to atherosclerosis, which you should instead code from the 414.0x range (Coronary atherosclerosis).

ICD-10 changes: ICD-10 makes use of seven characters to add specificity to each code. The new codeset will divide your options based on the specific type of complication. You also will need to add a seventh character specifying the encounter type (initial, subsequent, sequela). Like ICD-9, ICD-10 codes coronary graft atherosclerosis under separate ranges, which differ based on documentation of angina: I25.7- (*Atherosclerosis of coronary artery bypass graft[s] and coronary artery of transplanted heart with angina pectoris*) and I25.81- (*Atherosclerosis of other coronary vessels without angina pectoris*).

Documentation: To choose the most appropriate ICD-10 code, you'll need documentation that the complication is due to a cardiac prosthetic device, implant, or graft. You'll need to know whether the complication is an embolism, fibrosis, hemorrhage, pain, stenosis, thrombosis, or something else. Your physician should be documenting this information already, so you'll just want to be sure the information is easily accessible so you may code efficiently. Take extra care to be sure you can easily distinguish whether the encounter is initial, subsequent, or sequela.

Coder tips: Unspecified complication code T82.9XX- includes "XX" as placeholders in spaces five and six to allow you to apply the seventh character as instructed.

ICD-10 Official Guidelines explain proper use of the seventh characters which specify the encounter:

- ❖ Use A, initial encounter, while the patient is receiving active treatment for the injury. "Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician."
- ❖ Use D, subsequent encounter, "for encounters after the patient has received active treatment of the injury and is receiving routine care for the injury 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 injury treatment."
- ❖ Use S, sequela, "for complications or conditions that arise as a direct result of an injury, such as scar formation after a burn. The scars are sequelae of the burn." When you use S, "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 'S' extension identifies the injury responsible for the sequela. The specific type of sequela (e.g., scar) is sequenced first, followed by the injury code."

ICD-10-CM guidelines are available at www.cdc.gov/nchs/icd/icd10cm.htm. ❖

Use Broader Reporting Options For Anorectal Abscess

Hint: Use separate code when you clinician diagnoses anal and rectal abscesses.

When your family physician diagnoses an abscess in the anorectal area, you'll need to delve deeper into documentation to check the location of the abscess to report it accurately using ICD-10 codes.

When your family physician arrives at a diagnosis of an abscess in the anal and/or rectal area, you will have to report it with 566 (Abscess of anal and rectal regions) when using ICD-9 codes. Remember that the same code is used, regardless of the location.

Select From 5 Codes Depending on Abscess Type

When you begin using ICD-10 codes, 566 in ICD-9 will crosswalk to the K61 (Abscess of anal and rectal regions) family of codes in ICD-10. Be aware that K61 further expands into five more codes that are based on the location of the abscess in the anal and/or rectal area:

- ❖ K61.0 – *Anal abscess –This includes perianal abscess, but don't code abscess of the anal sphincter using this code (see K61.4 below).*
- ❖ K 61.1 –*Rectal abscess – This includes perirectal abscess, but don't code abscess of the ischiorectal fossa using this code (see K61.3 below).*
- ❖ K61.2 –*Anorectal abscess*
- ❖ K61.3 –*Ischiorectal abscess*
- ❖ K61.4 –*Intrasphincteric abscess*

Check Symptoms and Diagnostic Details in Documentation

Your family physician will arrive at a diagnosis of anorectal abscess based on findings of history, signs and symptoms, examination, observational findings, imaging studies, and laboratory findings. In certain cases, he might resort to other laboratory tests, such as blood tests or a urinalysis. Your clinician might also want imaging studies such as an MRI, CT scan, or an ultrasound, especially when the abscess is in the deeper areas of the rectum, to arrive at a diagnosis of a rectal abscess.

Some of the symptoms that you are more likely to see in a patient suffering from an anorectal abscess will include pain in the anorectal area, fever (*R50.9, Fever, unspecified*), pus discharge, swelling in the anorectal area that could possibly be felt like a lump, pain in the lower abdominal area (*R10.30, Lower abdominal pain, unspecified*), constipation, and pain during bowel movements.

Example: Your physician assesses a patient suffering from severe anal pain with pus discharge. He complains of lower abdominal discomfort and severe pain during bowel movements. Upon examination, your family physician notes a sizeable lump in the anal area with discharge of pus. He orders a blood test and urinalysis to confirm a diagnosis of abscess in the anal region. You report the evaluation the patient with 99203 (*Office or other outpatient visit for the evaluation and management of a new patient...Typically, 30 minutes are spent face-to-face with the patient and/or family*) and the diagnosis of the abscess with 566 if you are using ICD-9 and K61.0 if you are using ICD-10 codes. ❖

Z45.0- Will Help You Report Cardiac Device Encounters

Prepare to distinguish between pacemaker battery and other parts.

ICD-10 will require you to be a little more specific about coding pacemaker adjustment encounters, but you should have an easier transition to coding automatic implantable cardiac defibrillator (AICD) encounters.

ICD-9-CM Codes:

- ❖ V53.31, *Fitting and adjustment of cardiac pacemaker*
- ❖ V53.32, *Fitting and adjustment of automatic implantable cardiac defibrillator*
- ❖ V53.39, *Fitting and adjustment of other cardiac device*

ICD-10-CM Codes:

- ❖ Z45.010, *Encounter for checking and testing of cardiac pacemaker pulse generator (battery)*
- ❖ Z45.018, *Encounter for adjustment and management of other part of cardiac pacemaker*
- ❖ Z45.02, *Encounter for adjustment and management of automatic implantable cardiac defibrillator*
- ❖ Z45.09, *Encounter for adjustment and management of other cardiac device*

The codes above apply to encounters where the physician fits, adjusts, removes, replaces, or reprograms a cardiac device.

ICD-9 coding rules: The V53.3x codes apply to removal and replacement of devices, as well as reprogramming, but they are not appropriate if you are indicating only status without need

for care (in that case, use ICD-9 code V45.0x, *Cardiac device in situ*). You should not use V53.31 to indicate mechanical complication; instead use 996.01 (*Mechanical complication due to cardiac pacemaker [electrode]*).

Remember that if the patient has an AICD with synchronous cardiac pacemaker, you should look to V53.32 rather than V53.31 for fitting and adjustment encounters.

ICD-10 changes: Under ICD-10, you'll have to choose between two codes for pacemaker services: Z45.010 for the pulse generator and Z45.018 for any other part. You'll still have one code for AICD services (Z45.02) and one related to other devices (Z45.09).

The includes and excludes notes accompanying the ICD-10 codes are similar to those for the ICD-9 codes. A note with Z45.010 tells you it is appropriate for replacing a pacemaker pulse generator. A note with Z45.02 explains you should use that code when the patient has an encounter for adjustment and management of an AICD with synchronous cardiac pacemaker.

Notes for the entire Z45.- range indicate the codes apply to removal or replacement of an implanted device. However, you should look elsewhere to code malfunction or other complications of a device (see T82.1-, *Mechanical complication of cardiac electronic device*) or the simple presence of a device (see Z95.-, *Presence of cardiac and vascular implants and grafts*).

Documentation: Your provider's documentation should not need to change for you to find the proper code under ICD-10, as long as he is clear about which device and which part of a pacemaker is being serviced. For more efficient coding, make distinguishing between services related to pacemaker batteries and services related to other pacemaker parts easy on yourself. For example, you could list both codes on the super bill, or list Z45.01- and have the provider mark or circle "pulse gen" or "other."

Coder tips: You may have noticed the ICD-10 codes started with the letter Z. ICD-10's Z codes essentially replace ICD-9's V codes, according to **Lynn M. Anderanin, CPC, CPC-I, COSC**, in her "ICD-10-CM 101" presentation for AudioEducator.com.

Remember: CMS has finalized the ICD-10 compliance date of Oct. 1, 2015. When ICD-10 is implemented, you should apply the code set and official guidelines in effect for the date of service reported. Learn more at www.cms.gov/ICD10/ and www.cdc.gov/nchs/icd/icd10cm.htm#10update. ❖

Crack This Chronic Neck Pain Code Equivalent in ICD-10

ICD-9 and ICD-10 codes share a common descriptor.

Chronic pain the neck is a common diagnosis you may be reporting. The good news is that ICD-10 transition will offer no additional challenges for reporting neck pain. You'll have a simple one-to-one match in ICD-10.

When your surgeon makes a diagnosis of chronic neck pain, you report 723.1 (*Cervicalgia*) in ICD-10. Your choice will remain simple in ICD-10, when you'll make an easy switch to M54.2 (*Cervicalgia*).

Diagnosis M54.2 falls under the category "Other Dorsopathies; Dorsalgia." Note that M54.2 does not apply to cervicalgia due to intervertebral cervical disc disorder. For those situations, ICD-10 directs you to the M50 (*Cervical disc disorders*) code family.

Coding tip: Don't fall into the trap of reporting neck pain (or pain in any of the spinal regions) with one of the joint pain codes from ICD-9. Coding options in that group pinpoint joint pain in the shoulder region (719.41), upper arm (719.42), pelvic region and thigh (719.45), and other anatomic regions. A "pain in joint" choice, however, isn't as accurate for neck pain as 723.1.

Document it: The biggest factor in correctly coding neck pain is knowing the anatomic site. Ensure that your providers always specify the site, so you can report a detailed code whenever possible. ❖

Untangle Umbilical Hernia Diagnosis Knots With Simple Transition to K42

Hint: Presence or absence of gangrene is still the deciding factor to arrive at the right code.

When your gastroenterologist diagnoses umbilical hernia, you'll continue to use the presence or absence of obstruction or gangrene as the basis for reporting the condition with ICD-10 codes.

ICD-9: While reporting a diagnosis of umbilical hernia, you have three code choices to choose from depending on if your gastroenterologist identifies the presence or absence of

any obstruction or gangrene. So, you will have to report the condition using one of the following three code choices:

- ❖ 551.1 (*Umbilical hernia with gangrene*)
- ❖ 552.1 (*Umbilical hernia with obstruction*)
- ❖ 553.1 (*Umbilical hernia without obstruction or gangrene*)

Note More Specificity to Umbilical Hernia With Obstruction in ICD-10

When you begin using ICD-10 codes after Oct.1, 2015, you'll have to report a diagnosis of umbilical hernia with K42 (Umbilical hernia). Again, depending on the presence or absence of obstruction or gangrene, you have three code choices to more accurately report the condition. You can report a diagnosis of umbilical hernia with these three codes in ICD-10:

- ❖ K42.0 (*Umbilical hernia with obstruction, without gangrene*)
- ❖ K42.1 (*Umbilical hernia with gangrene*)
- ❖ K42.9 (*Umbilical hernia without obstruction or gangrene*)

If you look at the descriptor to K42.0, you'll notice that this descriptor has been made more specific than its ICD-9 predecessor, namely 552.1 as it is specific for umbilical hernia with obstruction and specifically mentions that there is no gangrene.

Caveats: You'll have to use K42.0 if your gastroenterologist makes a diagnosis of incarcerated umbilical hernia, irreducible umbilical hernia or strangulated umbilical hernia when no gangrene is mentioned in the documentation. Use K42.9 when the diagnosis is umbilical hernia NOS.

Focus on These Basics Briefly

Documentation: When your gastroenterologist diagnoses umbilical hernia, some of the signs and symptoms that you are more likely to see in patient documentation will include pain, tenderness in the area around the umbilicus, vomiting and redness of the affected area. In young infants, the umbilical hernia will be seen as a protrusion when the child cries or coughs. Sometimes, there might be no evident signs and symptoms and your gastroenterologist might notice the presence of the umbilical hernia during a physical examination.

An umbilical hernia will be identified by your gastroenterologist during a physical examination. Your gastroenterologist will decide if any surgical repair is necessary based on the fascial defect rather than the amount of protrusion. Also, repair is not indicated in very young children below the age of five as in most cases, the condition will resolve on its own without any intervention.

When your gastroenterologist diagnoses an umbilical hernia, he might ask for imaging studies such as an x-ray or an ultrasound to see if there are any complicating factors such as strangulation, obstructions or the presence of gangrene.

Example: Your gastroenterologist reviews a 53-year-old female patient of African American origin for complaints of severe pain that has developed around her umbilical area over the past few weeks. The patient told that she had a bulge over her umbilical area right since childhood and it had never troubled her in the past although the size of the protrusion had increased significantly following the birth of her third child about 15 years ago.

Upon examination, your gastroenterologist notes significant protrusion of tissue in the umbilical area and observes signs of strangulation of the protruded tissue and notices signs of gangrene. He makes a diagnosis of umbilical hernia and orders for an abdominal ultrasound and x-ray.

Based on the observations during physical examination and from the results of the imaging studies, your gastroenterologist makes a diagnosis of umbilical hernia with gangrene. You'll report this diagnosis with K42.1 if you're using ICD-10 codes or report 551.1 with ICD-9 codes. ❖

I49.3 Gives Ventricular Premature Beats Their Own Code

Term swap: ICD-10 uses 'depolarization' instead of 'beats.'

Many Part B practices see patients with premature heartbeat disorders, so you may have those diagnosis codes at the top of your mind. But in your preparations for ICD-10, pay attention to two key premature beat coding changes to ensure clear sailing for your claims.

ICD-9-CM Codes:

- ❖ 427.60, *Premature beats unspecified*
- ❖ 427.61, *Supraventricular premature beats*
- ❖ 427.69, *Other premature beats*

ICD-10-CM Codes:

- ❖ I49.1, *Atrial premature depolarization*
- ❖ I49.3, *Ventricular premature depolarization*
- ❖ I49.40, *Unspecified premature depolarization*
- ❖ I49.49, *Other premature depolarization*

Diagnosis: A premature heartbeat is an extra beat that comes earlier than a regular heartbeat. The patient may say it feels like her heart skipped a beat. A premature atrial contraction

arises from the heart's upper chambers, the atria. Premature ventricular contractions arise from the heart's lower chambers, the ventricles.

ICD-9 coding rules: ICD-9 includes one code for unspecified premature beats (427.60). It applies to ectopic beats, extrasystoles, extrasystolic arrhythmia, and premature contractions or systoles that are not otherwise specified. You use a different code, 427.61, for supraventricular premature beats, including premature beats, contractions, or systoles documented as atrial. Finally you have 427.69 for all other premature beats, including ventricular premature beats, contractions, or systoles.

ICD-10 changes: The first thing you may notice about the ICD-10 codes is that they refer to “depolarization” rather than “beats.” Depolarization relates to electrical stimulation causing contraction of the heart muscle. The second thing you may notice is that ICD-10 divides your code choices based on atrial (I49.1), ventricular (I49.3), unspecified (I49.40), and other (I49.49). So unlike ICD-9, ICD-10 doesn't lump “ventricular” in with “other.”

Documentation: Be sure ICD-10 tools allow the physician to easily mark atrial, ventricular, or other types. If your physician knows whether the patient has ventricular or atrial premature beats, he should be documenting that already. But if your charge tickets or other tools are based on coding, the staff may be trained to look only for atrial premature beats because ICD-9 includes ventricular under the “other” code. This won't work for ICD-10's more specific codes.

Also watch the documentation for ectopic beats, extrasystoles, extrasystolic arrhythmias, and premature contractions, which ICD-10 places under “other” code I49.49. And don't miss that “Premature beats NOS” falls under unspecified code I49.40.

Coder tips: If you look in the I49.- range, you'll see another depolarization code: I49.2 (*Junctional premature depolarization*). Medicare General Equivalency Mappings (GEMs) cross this to 427.0 (*Paroxysmal supraventricular tachycardia*) rather than to an ICD-9 “premature beat” code.

Also be sure to review the rules that apply to the I49.- range as a whole. You should “code first” cardiac arrhythmia complicating abortion or ectopic or molar pregnancy (O00-O07, O08.8-) or obstetric surgery and procedures (O75.4). The I49.- range excludes neonatal dysrhythmia (P29.1-) and a number of bradycardia diagnoses assigned to unspecified bradycardia code R00.1 (NOS, sinoatrial, sinus, and vagal). ❖

Making This “True Crosswalk” Assumption Could Cost You Time and Money

Follow this guide to find out what each flag really means.

You have seen plenty of ICD-9 to ICD-10 bridges online, but beware: these bridges are based on GEMs, which are only about 50-percent accurate. If you rely solely on this mapping tool, you are likely to miss important coding subtleties, which could land your claim in limbo-land.

Follow this step-by-step explanation to master GEMs and what each digit really means.

Basics: GEMs stand for General Equivalent Mappings. Note: The important term to remember is “general.”

The GEMs are the raw material from which providers, health information vendors and payers can derive specific applied mappings to meet their needs. You can use GEMs to study the differences between ICD-9-CM and ICD-10-CM/PCS.

The GEM file is a “flat file,” meaning this is a record with no structural relationships. (You can download it here: http://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp#TopOfPage)

Are GEMs a True Crosswalk?

The word “crosswalk” is often used to refer to code mappings (as in, data element mappings between two distinct data models: ICD-9 and ICD-10), but be advised: GEMs are **not** true crosswalks. They are reference mappings, to help the user navigate the complexity of translating meaning from one code set to the other. They are tools to help you understand, analyze, and make distinctions that manage the complexity, and to derive their own applied mappings (if that’s your goal).

The GEMs are more complex than a simple one-to-one crosswalk, and some statistics say they’re only about 50-percent accurate. What GEMs are effective at is reflecting the relative complexity of the code sets clearly. The relationship between them is not simple. GEMs effectively demonstrate this, rather than making the transition from the old to the new code system in an oversimplified way.

What are GEMs Relationships Like?

You can have a variety of different code relationships in the GEMs file. Here are a few:

Some codes have a one-to-one correlation. Code 003.21 (*Salmonella meningitis*) in ICD-9 matches up to A02.21 (*Salmonella meningitis*) in ICD-10-CM.

Some codes won't match because of specificity. For instance, 649.53 (*Spotting complicating pregnancy*) does not, for instance, exactly equal O26.851 (*Spotting complicating pregnancy, first trimester*). To arrive at the correct code in ICD-10-CM, you have to know the trimester.

Also, ICD-10-CM codes may combine multiple diagnoses or concepts, such as:

- ❖ a chronic condition with acute manifestation (G40.911, *Epilepsy, unspecified, intractable, with status epilepticus*);
- ❖ two concurrent acute conditions (R65.21, *Severe sepsis with septic shock*);
- ❖ acute condition with external cause (T39.012A, *Poisoning by aspirin, intentional self-harm, initial encounter*).

On the other hand, ICD-10-CM code Z72.3 (*Lack of physical exercise*) doesn't have a ICD-9 target at all.

So given you can have varied code relationships between the old system and the new, that's why you can't count the GEMs file as being cut-and-dried.

What Key Terms Should You Know?

"Target system" means the destination code set. In other words, this is the set the GEM is mapping 'to.'

"Source system" means the original code set. In other words, this is the set the GEM is mapping 'from.'

When you see your ICD-9-CM code targeting an ICD-10-CM code, then that is called "forward mapping."

On the other hand, when you see an ICD-10-CM code targeting an ICD-9-CM code, then that is called "backward mapping."

"Reverse lookup" means that you're using a GEM by looking at a target system code and examining the codes that translate to it.

What is an Example of a GEM?

Let's look at the file itself. Here's an example of what your GEM file looks like.

62130 N8500 00000

In GEM terms, 62130 is your source (which is code 621.30 with your decimal applied); N8500 is your target; and 00000 represents your flags.

Translation: This means 621.30 (*Endometrial hyperplasia, unspecified*) maps directly to N8500 (*Endometrial hyperplasia, unspecified*).

How do you know this? Let's focus on the flags, the '00000' number.

What Do the Flags Mean?

Each digit of the '00000' number represents five different flags.

Key: The 0 means off. The 1 means on.

These flags are:

1st digit: Approximate Flag

2nd digit: No Map Flag

3rd digit: Combination Flag

4th digit: Scenario Flag

5th digit: Choice Flag

Examine the Approximate Flag

"Approximate" is Flag 1, which is in column 1 of the flags. The majority of alternatives are considered an approximate match. "0" means the translation is an identical match. This is rare in the procedure GEMs but more common in the diagnosis GEMs.

Remember this example?

62130 N8500 00000

The first flag is a "0," meaning you already know that 621.30 has an identical match in N8500.

On the other hand, check out this example:

K3189 5363 10000

K3189 5375 10000

K3189 53789 10000

The first flag is a "1," means that the complete meaning of the source code differs from the complete meaning of the target system code. In other words, K31.89 (*Other diseases of stomach and duodenum*) includes the meanings of all three codes: 536.3 (*Gastroparesis*), 537.5 (*Gastroptosis*), and 537.89 (*Other specified disorders of stomach and duodenum*). This isn't a direct match. All of these meanings are approximate.

Find Out What ‘No Map’ Flag Means

“No Map” is Flag 2, which is in column 2 of the flags. A “1” means there is no plausible translation for the source system code. A “0” means there is at least one plausible translation for the source code.

Let’s refer back to our familiar example:

62130 N8500 00000

This means you have at least one plausible translation for the source code. Code 621.30 has a plausible translation in N8500.

However, look at this example:

T500x6A NODX 11000

Because you see a “1” as Flag 2, you can see that T500x6A (*Underdosing of mineralocorticoids and their antagonists, initial encounter*) has no plausible translation. The “NODX” means no description found.

Conquer the Combination Flag

“Combination” is Flag 3, the scenario and choice list flags. When you see a 0 in this position, as in our example, this means the code maps to a single code.

62130 N8500 00000

In other words, 621.30 only maps to N8500.

On the other hand, when you see a 1 in this position, this means the code maps to more than 1 code. Look at this example:

I25111 41401 10111

I25111 4139 10112

See the “1” in the third digit? This means that I25.111 (*Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm*) maps to 414.01 (*Coronary atherosclerosis of native coronary artery*) with 413.9 (*Other and unspecified angina pectoris*).

Remember: The term “with,” means “associated with” or “due to.”

Figure Out the Scenario Flag

Now that you have identified Flags 1 through 3, let’s examine Flags 4 and 5 (or the fourth and fifth digits).

Flags 4 and 5 clarify combination entries.

For the Scenario Flag (4th digit), you'll see 0 meaning Off, or digits 1-9 meaning, "In a combo entry, this is a collection of codes from the target system containing the necessary codes that combined as directed will satisfy the equivalent meaning of a code in the source system."

Source: General Equivalence Mappings: Documentation for Technical Users (download at <http://www.cdc.gov/nchs/icd/icd10cm.htm>)

Here's our previous example:

62130 N8500 0000

The "0" turns the Scenario column off, so you know that you don't need to worry about this. But this won't always be the case:

T422X1A 9662 1011

T422X1A E8558 1012

T422X1A 9660 10121

T422X1A E8558 10122

Notice how you have "1" and "2" in the fourth digit column. This breaks down these codes into two scenarios, as follows:

Scenario 1: Code (T42.2x1A, *Poisoning by succinimides and oxazolidinediones, accidental [unintentional], initial encounter*) maps to 966.2 (*Poisoning by succinimides*) with E855.8 (*Accidental poisoning by other specified drugs acting on central and autonomic nervous systems*).

Scenario 2: Code T42.2x1A (*Poisoning by succinimides and oxazolidinediones, accidental [unintentional], initial encounter*) maps to 966.0 (*Poisoning by oxazolidine derivatives*) with E85.58 (*Accidental poisoning by other specified drugs acting on central and autonomic nervous systems*).

Choice Flag Can Be a Challenge

Finally, in the Choice column or 5th digit, you'll see 0 meaning off or digits 1-9 meaning, "In a combination entry, this is a list of one or more codes in the target system from which one code must be chosen to satisfy the equivalent meaning of a code in the source system."

Source: General Equivalence Mappings: Documentation for Technical Users (download at <http://www.cdc.gov/nchs/icd/icd10cm.htm>)

Here's our previous example:

62130 N8500 00000

Because the last digit is a “0,” this means the choice column is off.

On the other hand, look at this backwards mapping example:

R6521 99592 10111

R6521 78552 10112

The last digits here are 1 and 2. This means that ICD-10-CM code R65.21 (*Severe sepsis with septic shock*) matches to both 995.92 (*Severe sepsis*) and 785.52 (*Septic shock*). The ICD-10-CM code combines them both.

What Should You Do With This GEMs Knowledge?

You might be reading through the GEMs flags and thinking, this is a very cumbersome process. Software folks are doing it, so you may think you don’t have to learn about GEMs. But you may have to verify your software for accuracy and find inconsistencies.

Action step: Start with the top 25. Pull the most common diagnoses you use in your office, and look into your system to see if they map correctly from ICD-9-CM to ICD-10-CM. Then you can get your vendor to correct them.

Remember, inaccurate coding will result in increased denials and delayed payments.

This was a broad overview of GEMs. If you want to learn more, download this PDF: “General Equivalence Mappings: Documentation for Technical Users” at <http://www.cdc.gov/nchs/icd/icd10cm.htm>. ❖

Test Yourself By Matching GEMs Terms to These Statements

Did you catch what forward/backward mapping means?

Occasionally, you’ll find an activity or game to help you digest your ICD-10 coding knowledge. Try your hand at this filling-in-the-blank challenge.

1. GEMs stand for _____.
2. You need to know about GEMs because you may have to _____ and _____.
3. You might classify R65.21 as a _____.
4. _____ means the destination code set. In other words, this is the set the GEM is mapping ‘to.’

5. When you look up ICD-10-CM code Z72.3's equivalent, you will find _____.
6. Because the GEMs are a record with no structural relationships, you would classify it as a _____.
7. GEMs are **NOT** a _____.
8. You could classify the correlation between 003.21 and A02.21 as _____.
9. _____ means the original code set. In other words, this is the set the GEM is mapping 'from.'
10. _____ means on.
11. _____ means that you're using a GEM by looking at a target system code and examining the codes that translate to it.
12. When you see an ICD-10-CM code targeting an ICD-9-CM code, then that is called _____.
13. _____ means off.
14. When you see your ICD-9-CM code targeting an ICD-10-CM code, then that is called _____.
15. _____ will result in increased denials and delayed payments.

- A. General Equivalence Mappings
- B. True crosswalk
- C. Flat File
- D. One-to-one
- E. No match
- F. Combination code
- G. Target system
- H. Source system
- I. Forward mapping
- J. Reverse lookup
- K. 1
- L. 0
- M. Verify your software for accuracy
- N. Find inconsistencies
- O. Inaccurate coding
- P. Backward mapping ❖

These the answers to the previous article

Answers: 1A, 2MN, 3F, 4G, 5E, 6C, 7B, 8D, 9H, 10K, 11J, 12P, 13L, 14I, 15O ❖

Examine How PCS Organizes Root Operations

Key: Boil down what physician performed to match root operation definitions.

If you want a complete picture of ICD-10 going into effect in 2015, you should not overlook ICD-10-PCS. Take a minute to examine root operations.

When reporting ICD-10-PCS, you have to really break down what the physician performed into one of 31 root operations.

You can find them grouped together like this:

- Root operations that take out some/all of a body part
- Root operations that take out solids/fluids/gasses from a body part
- Root operations involving cutting or separation only
- Root operations that put in/put back or move some/all of a body part
- Root operations that alter the diameter/route of a tubular body part
- Root operations that always involve a device
- Root operations involving examination only
- Root operations that include other repairs
- Root operations that include other objectives

Underneath these nine categories, you'll find the 31 root operations.

Example: Suppose your physician performs an open cholecystectomy. This means that the physician surgically removes the gallbladder. You would thus categorize this as a "root operation that takes out some/all of a body part."

Underneath that section, you'll find five of the root operations grouped here:

- Excision
- Resection
- Detachment
- Destruction
- Extraction

Because the root operation of "resection" is defined as "cutting off, without replacement, all of a body part," you would classify the cholecystectomy as a resection. Therefore, you would use "T" as your root operation, which represents resection.

You would report 0FT40ZZ, which means:

0 - Medical/Surgical (section)

F - Hepatobiliary system and pancreas (body system)

T - Resection (root operation)

4 - Gallbladder (body part)

0 - Open (approach)

Z - None (device)

Z - None (qualifier).

Challenge: What if your physician performed multiple procedures with distinct objectives (such as a procedure that removes some/all of a body part as well as a procedure that involved a device)? Then you should report multiple codes. ❖

Step 1 to Coding Section “0” ICD-10-PCS? Identify the Body System

Familiarize yourself with the 28 possible numbers and letters.

The “Medical and Surgical” or “0” section of the ICD-10-PCS manual is the largest section. When you choose the appropriate PCS code from this section, you have to look for the *body system* to get to your code’s second digit.

Definition: The “body system,” according to the ICD-10-PCS guidelines, is a “general physiological system or anatomical region involved. Body systems are a collection or grouping of organs or contiguous body parts, shared (adjacent) body parts.” You will find 28 body systems and 3 general anatomical regions. They are:

Body Systems:

0 — Central Nervous System

1 — Peripheral Nervous System

2 — Heart and Great Vessels

3 — Upper Arteries

4 — Lower Arteries

5 — Upper Veins

- 6 — Lower Veins
- 7 — Lymphatic and Hemic Systems
- 8 — Eye
- 9 — Ear, Nose, Sinus
- B — Respiratory System
- C — Mouth and Throat
- D — Gastrointestinal System
- F — Hepatobiliary System and Pancreas
- G — Endocrine System
- H — Skin and Breast
- J — Subcutaneous Tissue and Fascia
- K — Muscles
- L — Tendons
- M — Bursae and Ligaments
- N — Head and Facial Bones
- P — Upper Bones
- Q — Lower Bones
- R — Upper Joints
- S — Lower Joints
- T — Urinary System
- U — Female Reproductive System
- V — Male Reproductive System

General Anatomical Regions:

- W — Anatomical Regions, General
- X — Anatomical Regions, Upper Extremities
- Y — Anatomical Regions, Lower Extremities

Example 1: Suppose your surgeon performs a lysis of adhesions of the large intestine. You know that this code will come from the “0” section of your PCS manual. Your next step is to identify the second digit.

Solution 1: Because the procedure took place in the large intestine, you should look at “D,” the gastrointestinal system. Your full code is 0DNE0ZZ.

Example 2: On the other hand, suppose your surgeon performs a change of a sinus drainage tube. Again, this procedure will come from the “0” section of your PCS manual, but what should you report for the second digit?

Solution 2: Because this procedure occurred in the sinuses, you should look at “9,” which is for the ear, nose, and sinus. Your full code will be 092YX0Z. ❖

To Build Your ICD-10-PCS Code, You Must Identify the Root Operation

Hint: If your doc performs two root operations, report two PCS codes.

When you build a PCS code from the “0” section (the largest one), you must first identify the body system — but your second step is to choose the root operation. This will be the third character of your PCS code, but be aware: your selection can be tricky, because you need to distinguish between similar root operation attributes.

Remember: A PCS code consists of seven characters — and will always include seven characters, unlike ICD-10-CM. Here is a break down of what each character means:

1	2	3	4	5	6	7
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier

Take a Broad Overview of 3rd Character

You will find 31 root operations in the medical and surgical section, and they are arranged into the following groupings:

- ❖ Root operations that take out some/all of a body part
- ❖ Root operations that take out solids/fluids/gasses from a body part
- ❖ Root operations involving cutting or separation only
- ❖ Root operations that put in/put back or move some/all of a body part
- ❖ Root operations that alter the diameter/route of a tubular body part
- ❖ Root operations that always involve a device
- ❖ Root operations involving examination only
- ❖ Root operations that include other repairs
- ❖ Root operations that include other objectives

Note: If your physician performs multiple root operations with distinct objectives, you should submit multiple PCS codes.

Your root operations are (in alphabetic order):

- ❖ Alteration
- ❖ Bypass

- ❖ Change
- ❖ Control
- ❖ Creation
- ❖ Destruction
- ❖ Detachment
- ❖ Dilation
- ❖ Division
- ❖ Drainage
- ❖ Excision
- ❖ Extirpation
- ❖ Extraction
- ❖ Fragmentation
- ❖ Fusion
- ❖ Insertion
- ❖ Inspection
- ❖ Map
- ❖ Occlusion
- ❖ Reattachment
- ❖ Release
- ❖ Removal
- ❖ Repair
- ❖ Replacement
- ❖ Reposition
- ❖ Resection
- ❖ Restriction
- ❖ Revision
- ❖ Supplement
- ❖ Transfer
- ❖ Transplantation

Watch out: Some of these root operations are similar. For instance, “resection” has a subtle distinction from “excision.”

An “excision” means the physician used a sharp instrument to cut out or off a portion of body part without replacement. Examples of “excision” procedures are a breast lumpectomy or liver biopsy.

On the other hand, a “resection” means the physician cut out or off, without replacement, all of a body system. Examples of “resection” procedures are a total mastectomy or a cholecystectomy.

Difference: “Excision” refers to the removal of a portion of a body part, whereas “resection” refers to the removal of all of a body system.

Examine This Example PCS Chart

Suppose your physician performs an insertion of an infusion pump into the patient's chest. Using a percutaneous approach, he inserts the pump underneath the subcutaneous tissue.

Step 1: First of all, you know this is part of the Medical and Surgical section of the PCS manual. Then, you should identify the body system. This would be the subcutaneous tissue and fascia.

Step 2: The physician inserted the infusion pump. Because this is an insertion, you would use root operation "H" (meaning insertion) as your third character.

Here is what your chart looks like:

Section: 0 Medical and Surgical			
Body System: J Subcutaneous Tissue and Fascia			
Operations: H Insertion putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part.			
Body Part	Approach	Device	Qualifier
S Subcutaneous Tissue and Fascia, Head and Neck	0 Open	1 Radioactive Element	Z No Qualifier
V Subcutaneous Tissue and Fascia, Upper Extremity	3 Percutaneous	3 Infusion Device	
W Subcutaneous Tissue and Fascia, Lower Extremity			
T Subcutaneous Tissue and Fascia, Trunk	0 Open	1 Radioactive Element	Z No Qualifier
	3 Percutaneous	3 Infusion Device	
		V Infusion Pump	

Result: Your final code selection is 0JHT3VZ. ❖

Define Your Physician's Approach Using PCS Code's 5th Character

You have seven potential options.

Every ICD-10-PCS code has seven characters, each character defining one aspect of the procedure performed. Together, they give a complete picture. You should choose your fifth character based on the physician's approach.

Definition: "Approach" refers to the technique a physician uses to reach the site of the procedure.

ICD-10-PCS offers the following options for identifying the approach:

Approach	Fifth Character
Open	0
Percutaneous	3
Percutaneous endoscopic	4
Via natural or artificial opening	7
Via natural or artificial opening endoscopic	8
Via natural or artificial opening with percutaneous endoscopic assistance	F
External	X

Here is how you should define each of these approaches:

- ❖ **Open:** The physician cuts through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure.
- ❖ **Percutaneous:** The physician gains entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to reach the site of the procedure.
- ❖ **Percutaneous endoscopic:** The physician gains entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to reach and visualize the site of the procedure.
- ❖ **Via natural or artificial opening:** The physician will use a natural or artificial opening to access the site of the procedure.
- ❖ **Via natural or artificial opening endoscopic:** Instrumentation enters through a natural or artificial external opening to reach and visualize the site of the procedure.
- ❖ **Via Natural or Artificial Opening with Percutaneous Endoscopic Assistance:** Like above, this involves instrumentation entering through a natural or artificial external opening, but it also involves puncture or minor incisions through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure.
- ❖ **External:** The physician will perform a procedure directly on the skin or mucous membrane or indirectly by application of external force through the skin or mucous membrane.

Example 1: Suppose your physician performs liposuction on the patient's left upper arm. This procedure involves a small tube-like instrument called a cannula is inserted through tiny incisions to surgically remove fat cells. Therefore, the approach is percutaneous. You should use a fifth character of "3." (The full code is 0JDF3ZZ.)

Example 2: On the other hand, suppose your physician performs a dilation and curettage (D&C). During a D&C, the physician will dilate the cervix by inserting instrumentation via the vagina (natural opening). The instrumentation is then used to remove uterine tissue. Because the approach is via a natural opening and does not involve any endoscopic or percutaneous endoscopic assistance, you will apply a fifth character of "7." (The full ICD-10-PCS code is 0UDB7ZZ.) ❖

How to Determine the Device Value For Your PCS Code's Character 6

Bonus: Tackle this combination of materials special case.

To complete your seven character ICD-10-PCS code, you're sixth character relies on the device. Not only do you have to decide if the physician had to use a device, but you have to know the *type* of device. That sometimes involves untangling tricky terminology.

Follow through these steps to understanding what device character you should apply.

Step 1: Break Down Device Types and Values

When you choose your device digit or letter (the sixth character), you may have to decipher whether the procedure involved four types of devices:

- ❖ Grafts or prostheses
- ❖ Implants
- ❖ Simple or mechanical appliances
- ❖ Electronic appliances

The general types of devices are:

- ❖ Biological or synthetic material that takes the place of all or a portion of a body part (i.e., skin graft, joint prosthesis)
- ❖ Biological or synthetic material that assists or prevents a physiological function (i.e., IUD)
- ❖ Therapeutic material that is not absorbed by, eliminated by, or incorporated into a body part (i.e., radioactive implant)
- ❖ Mechanical or electronic appliances used to assist, monitor, take the place of or prevent a physiological function (i.e., cardiac pacemaker, orthopedic pin).

If the procedure does not involve a device, then you will use the no device character value of "Z."

Also, the devices must remain after the procedure. Materials that incidental to the procedure, such as clips and sutures, are not considered devices.

Step 2: Make the Extraluminal, Transluminal Distinction

To understand "extraluminal" versus "intraluminal," you need to know what lumen means. The lumen is the inside space of a tubular structure, such as an artery or intestine.

Extraluminal: This device works on the outside of the lumen, such as the clipping of a cerebral aneurysm.

Intraluminal: An intraluminal device means that the device is within the lumen, such as within a blood vessel.

Here is an example of an extraluminal or intraluminal procedure. Examine the “Device” column:

Section	0 Medical and Surgical		
Body System	3 Upper Arteries		
Operation	V Restriction: Partially closing an orifice or the lumen of a tubular body part		
Body Part	Approach	Device	Qualifier
0 Internal Mammary Artery, Right 1 Internal Mammary Artery, Left 2 Innominate Artery 3 Subclavian Artery, Right 4 Subclavian Artery, Left 5 Axillary Artery, Right 6 Axillary Artery, Left 7 Brachial Artery, Right 8 Brachial Artery, Left 9 Ulnar Artery, Right A Ulnar Artery, Left B Radial Artery, Right C Radial Artery, Left D Hand Artery, Right F Hand Artery, Left R Face Artery S Temporal Artery, Right T Temporal Artery, Left U Thyroid Artery, Right V Thyroid Artery, Left Y Upper Artery	0 Open 3 Percutaneous 4 Percutaneous Endoscopic	C Extraluminal Device D Intraluminal Device Z No Device	Z No Qualifier

Step 3: Define Autologous, Nonautologous

“Autologous” means that the cell source comes from the patient. For instance, a patient scheduled for a non-emergency surgery may donate blood for herself that will be stored for the surgery. In that way, she is both the donor and the recipient. Another example is that the patient may have an autologous skin graft, which means the skin is taken from the patient’s body and used as the graft. You would use the ICD-10-PCS value of “7.”

On the other hand, “nonautologous” means the cell source is not from the patient. The donor and the recipient are not the same person. For instance, if the patient has an emergency surgery and requires a blood from a blood bank, then this blood is “nonautologous.” You would use the ICD-10-PCS value of “K.”

Check out the following example of a PCS chart featuring autologous and nonautologous devices. In particular, examine the “Device” column for your sixth character:

Section	0 Medical and Surgical		
Body System	R Upper Joints		
Operation	G Fusion: Joining together portions of an articular body part rendering the articular body part immobile		
Body Part	Approach	Device	Qualifier
0 Occipital-cervical Joint 1 Cervical Vertebral Joint 2 Cervical Vertebral Joints, 2 or more 4 Cervicothoracic Vertebral Joint 6 Thoracic Vertebral Joint 7 Thoracic Vertebral Joints, 2 to 7 8 Thoracic Vertebral Joints, 8 or more A Thoracolumbar Vertebral Joint	0 Open 3 Percutaneous 4 Percutaneous Endoscopic	7 Autologous Tissue Substitute A Interbody Fusion Device J Synthetic Substitute K Nonautologous Tissue Substitute Z No Device	0 Anterior Approach, Anterior Column 1 Posterior Approach, Posterior Column J Posterior Approach, Anterior Column

Step 4: Tackle This Combination Scenario

Physicians sometimes use combinations of devices and materials on a vertebral joint to render the joint immobile. When the physician uses combinations of devices on the same vertebral joint, you would code the device value as follows:

- ❖ If the physician uses an interbody fusion device to render the joint immobile (alone or containing other material like bone graft), you would code the procedure with the device value “Interbody Fusion Device” (A).
- ❖ If the physician uses the bone graft as the *only* device to render the joint immobile, you should code the procedure with the device value “Nonautologous Tissue Substitute” (K) or “Autologous Tissue Substitute” (7).
- ❖ If the physician uses a mixture of autologous and nonautologous bone graft (with or without biological or synthetic extenders or binders) to render the joint immobile, you should code the procedure with the device value “Autologous Tissue Substitute” (7).

Examples: Suppose a physician performs a fusion of a vertebral joint using a cage style interbody fusion device containing morsellized bone graft. You would select the “Interbody Fusion Device” character (A). On the other hand, suppose the physician performs a fusion of a vertebral joint using a bone dowel interbody fusion device made of cadaver bone and packed with a mixture of local morsellized bone and demineralized bone matrix. In this circumstance, you would still select the “Interbody Fusion Device” character (A).

Editor’s note: Refer to *ICD-10-PCS 2012 Code Book Appendix D* (pages 509–516). Appendix D provides a Device Key and Aggregation Table.❖

Clarify How PCS Works By Observing the Obstetrics Section 1

Here’s why you should start memorizing 10E0XZZ.

If you’re looking for a succinct ICD-10-PCS section to examine, then check out the Obstetrics Section 1. Because this section includes only procedures performed on a pregnant female, it’s small — and therefore perfect for using as an example for the rest of ICD-10-PCS.

Highlight These 2 Guidelines for Obstetrics

In this section, you’ll find two guidelines: a single guideline related to products of conception and a single guideline related to procedures following delivery or abortion. They state:

“C.1.Products of Conception

Procedures performed on the products of conception are coded to the Obstetrics section. Procedures performed on the pregnant female other than the products of conception are coded to the appropriate root operation in the Medical and Surgical section.

Example: Amniocentesis is coded to the products of conception body part in the Obstetrics section. Repair of obstetric urethral laceration is coded to the urethra body part in the Medical and Surgical section.

C.2 Procedures following delivery or abortion

Procedures performed following a delivery or abortion for curettage of the endometrium or evacuation of retained products of conception are all coded in the Obstetrics section, to the root operation Extraction and the body part Products of Conception, Retained. Diagnostic or therapeutic dilation and curettage performed during times other than the postpartum or post-abortion period are all coded in the Medical and Surgical section, to the root operation Extraction and the body part Endometrium.”

Source: Printed verbatim from the *ICD-10-PSC Official Guidelines for Coding and Reporting*.

The Root Operations Limit PCS Tables

This section contains a single body system value — pregnancy (0)— along with 12 root operation values and three body part values: Products of Conception (0), Products of Conception, Retained (1), and Products of Conception, Ectopic (2). Because you only have one body system and 12 root operations, you will find only 12 tables available in the Obstetrics section from which to construct procedure codes.

The root operations are as follows:

- ❖ **Abortion**
- ❖ Change
- ❖ **Delivery**
- ❖ Drainage
- ❖ Extraction
- ❖ Insertion
- ❖ Inspection
- ❖ Removal
- ❖ Repair
- ❖ Reposition
- ❖ Resection
- ❖ Transplantation

Benefit: “While there are two root operations that apply only to Obstetrics, the other 10 root operations also are used in the Medical and Surgical section. Learning the definitions of those

10 root operations common to both sections and learning how these definitions are applied in the Obstetrics section will help coders understand how they are used and applied in the Medical and Surgical section as well,” says **Lauri Gray, RHIT, CPC**, Clinical/Technical Editor at Contexo Media in Salt Lake City.

“In the process of learning ICD-10-PCS Obstetrics coding, coders also will become familiar with the format of the tables and will be able to learn how to easily use these tables to construct a code,” Gray says.

Underline Abortions, Deliveries, and Extractions

The “abortion” and “delivery” root operations are specific to this section.

The root operation **Abortion (A)** applies only to artificially terminated pregnancies. It is “subdivided according to whether an additional device such as a laminaria or abortifacient is used, or whether the abortion was performed by mechanical means.”

If either a laminaria or abortifacient is used, then the approach is “Via Natural or Artificial Opening.” All other abortion procedures are those done by mechanical means (the products of conception are physically removed using instrumentation), and the device value is “Z, No Device.”

Caution: You should not report the root operation Abortion for “manually assisted spontaneous abortion. Manually assisted spontaneous abortion is reported with the root operation Delivery (E).”

Additionally, “do not report the root operation Abortion for missed or incomplete abortion requiring suction and/or curettage of products of conception. Suction/curettage of nonviable products of conception is reported with the root operation Extraction (D).”

If you’re reporting a **Delivery (E)**, you need to check out these highlights:

- ❖ “The root operation Delivery applies only to manually assisted vaginal delivery of the products of conception.
- ❖ The products of conception may be a full-term viable fetus or nonviable products of the conception.
- ❖ There is a single code that can be constructed from Table 10E, 10E0XZZ Delivery of Products of Conception, External Approach.”

Reporting an **Extraction (D)**? Check out these must-know tips:

- ❖ “The root operation Extraction applies to Cesarean deliveries and to vaginal deliveries requiring the use of forceps, vacuum or internal version.
- ❖ Cesarean deliveries always are reported with the approach value 0 for open approach and require a qualifier to more specifically identify the approach as Classical (0), Low Cervical (1) or Extraperitoneal (2).

- ❖ Vaginal extractions always are reported with the approach value 7, Via Natural or Artificial Opening, and require a qualifier to specifically identify the type of assisted vaginal delivery as Low Forceps (3), Mid Forceps (4), High Forceps (5), Vacuum (6), Internal Version (7) or Other (8)."

Source: Printed verbatim from the *ICD-10-PCS Official Guidelines for Coding and Reporting*.

Try Your Hand at These Examples

Example 1: Suppose your physician performs a transvaginal abortion using vacuum aspiration technique. How should you report this in ICD-10-PCS?

Solution 1: You should go to the Obstetrics Section 1, highlight "0" for the single body system of pregnancy, and then decide what root operation this is — which is an abortion, "A." This means your first three characters are "10A."

The physician is removing "products of conception" (0) "via natural/artificial opening" (7). He did not use a device, because the physician manually removed this using instrumentation, so you should say "no device"(Z). Finally, the last character qualifier is "vacuum" (6).

Your complete code is therefore 10A07Z6.

Example 2: Suppose your physician performed a manually assisted delivery. How should you report this with ICD-10-PCS?

Solution 2: Again, you should go to the Obstetrics Section 1, highlight "0" for the single body system of pregnancy, and then decide what root operation this is — which is "delivery" (E). This means your first three characters are "10E."

The physician is removing "products of conception" (0) via an "external" (X) approach. He did not use a device, so you should say "no device"(Z). Finally, the last character qualifier is "no qualifier" (Z).

Therefore, your complete code is 10E0XZZ. You'll eventually memorize this code, because you will be reporting this often. ❖

Procedure Examples

Discover Why Writing “Right Carotid Endarterectomy” Won’t Be Enough

Hint: Even if the physician doesn’t use a device, you need to know that.

If the physician documents a “right carotid endarterectomy,” you can easily report your ICD-9 procedure code — but your potential selections become a little more complicated in ICD-10-PCS.

If you want to avoid having to scramble to educate physicians in 2015, start improving your documentation *now*.

The Simplicity of ICD-9 Will Be Gone in 2015

Suppose you have a patient claim on your desk with documentation that describes a “right carotid endarterectomy for a critical right internal carotid artery stenosis.”

Right now, you can report the right carotid endarterectomy procedure with 38.12 (*Endarterectomy of other vessels of head and neck*).

However, when you look at your ICD-10-PCS equivalents, you have to have more specific documentation.

Here’s What You Need in the Documentation

ICD-10-PCS requires specific information in terms of the type of procedure, the anatomic location/body part, the approach, and the device.

Type of procedure: You need to know whether the right carotid endarterectomy was a “dilation” or “extirpation.” A “dilation” means that the procedure expanded an orifice or lumen of a tubular body part. On the other hand, an “extirpation” means that the procedure took or cut out solid matter from a body part.

Anatomic location/body part: Through the “critical right internal carotid artery stenosis” notation, you know that this procedure took place on the right internal carotid artery. That is one area of documentation you don’t need to update.

Approach: You do need to know what approach the physician used. Was this open, percutaneous, or percutaneous endoscopic?

Device: Similarly, you need to know what sort of device the physician used—or if she didn't use a device at all. Your options are:

- ❖ Intraluminal Device, Drug-eluting
- ❖ Intraluminal Device
- ❖ No Device

Taking these extra steps in documentation will mean fewer headaches in the future.

Check Out Your ICD-10-PCS Possibilities

According to these limits of available documentation in the patient's medical record, you have the following "Extirpation" or "Dilation" ICD-10-PSC options:

Extirpation	
ICD-10	Description
03CK0ZZ	Extirpation of Matter from Right Internal Carotid Artery, Open Approach
03CK3ZZ	Extirpation of Matter from Right Internal Carotid Artery, Percutaneous Approach
03CK4ZZ	Extirpation of Matter from Right Internal Carotid Artery, Percutaneous Endoscopic Approach
Dilatation	
ICD-10	Description
037K04Z	Dilation of Right Internal Carotid Artery with Drug-eluting Intraluminal Device, Open Approach
037K0DZ	Dilation of Right Internal Carotid Artery with Intraluminal Device, Open Approach
037K0ZZ	Dilation of Right Internal Carotid Artery, Open Approach
037K34Z	Dilation of Right Internal Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
037K3DZ	Dilation of Right Internal Carotid Artery with Intraluminal Device, Percutaneous Approach
037K3ZZ	Dilation of Right Internal Carotid Artery, Percutaneous Approach
037K44Z	Dilation of Right Internal Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
037K4DZ	Dilation of Right Internal Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
037K4ZZ	Dilation of Right Internal Carotid Artery, Percutaneous Endoscopic Approach

Therefore, without increased specificity in the documentation, you will be unable to choose the appropriate code. ❖

Add the Type of Neurogenic Bladder Condition to Report

Without key information, you will have too many potential codes.

Drastic changes are coming for inpatient coders, and the way providers currently document procedures will become incomplete in 2015. Check out this carotid bypass scenario and find out what you need to know for accurate ICD-10-PCS claims.

Scenario: The physician's operative notes indicate right common carotid to internal carotid bypass. This was to treat a critical right internal carotid artery stenosis. Currently, you can code this procedure with 39.29 (*Other [peripheral] vascular shunt or bypass*).

However, you cannot report this procedure — as stated — in ICD-PCS.

What's missing? In order to correctly bill this procedure in ICD-10-PCS, you have to have the following information:

- ❖ Type of procedure
- ❖ Anatomic location/body part
- ❖ Approach
- ❖ Device

You don't know the approach (open, percutaneous, or percutaneous endoscopic) and device (drug-eluting intraluminal device, intraluminal device, or no device).

Here are the potential codes you can use:

Bypass	
ICD-10	Description
031H0JJ	Bypass Right Common Carotid Artery to Right Extracranial Artery with Synthetic Substitute, Open Approach
031H09J	Bypass Right Common Carotid Artery to Right Extracranial Artery with Autologous Venous Tissue, Open Approach
031H0AG	Bypass Right Common Carotid Artery to Intracranial Artery with Autologous Arterial Tissue, Open Approach
031H0AJ	Bypass Right Common Carotid Artery to Right Extracranial Artery with Autologous Arterial Tissue, Open Approach
031H0JG	Bypass Right Common Carotid Artery to Intracranial Artery with Synthetic Substitute, Open Approach
031H09G	Bypass Right Common Carotid Artery to Intracranial Artery with Autologous Venous Tissue, Open Approach
031H0KG	Bypass Right Common Carotid Artery to Intracranial Artery with Nonautologous Tissue Substitute, Open Approach
031H0KJ	Bypass Right Common Carotid Artery to Right Extracranial Artery with Nonautologous Tissue Substitute, Open Approach
031H0ZG	Bypass Right Common Carotid Artery to Intracranial Artery, Open Approach
031H0ZJ	Bypass Right Common Carotid Artery to Right Extracranial Artery, Open Approach



Your Provider's Transfusion Notes Must Specify Body Part, Approach, Substance, and Qualifier

Check out how many PCS options you have without detailed information.

Notes describing the simple transfusion of red blood cells might direct you to an ICD-9 procedure code right now, but without details, you'll have dozens of ICD-10-PCS potential codes in 2015.

Here's what your provider's documentation needs.

Scenario: The physician notes "Transfusion of Red Blood Cells, Leukocyte Reduced."

The medical record indicates the patient has received treatment for myelodysplastic syndrome pancytopenia secondary to anemia. The discharge summary and progress notes document the transfusion of blood.

First, Examine ICD-9 Procedure Codes

The ICD-9 Code system provides codes for Transfusion of Blood and Blood Components (99.0 Series) with respect to type of transfusion (e.g. transfusion of packed cells, platelets, coagulation factors, other serum etc.).

Therefore, the existing clinical documentation supports both the transfusion and clinical indicator as red blood cells, which leads to accurate code in ICD-9 as:

❖ 99.04 — *Transfusion of packed cells*

Here's What Information You Do Have

Unfortunately, you cannot properly assign the ICD-10-PCS code. Given the documentation you have, you have enough for the following three

Section (relates to type of procedure): Administration

Body System (refers to general body system): Circulatory

Root Operation (specifies objective of procedure): Transfusion: Putting in blood or blood products

Pick Apart What's Missing For ICD-10-PCS Coding

However, you don't have enough to continue on with your ICD-10-PCS code. Here's where your code gets muddled:

Body Part/Region (refers to specific part of body system on which procedure is being performed):

- ❖ Peripheral
- ❖ Central Vein
- ❖ Peripheral
- ❖ Central artery

Approach (is the technique the provider uses to reach the site of the procedure):

- ❖ Open
- ❖ Percutaneous

Substance:

- ❖ Red Blood Cells
- ❖ Frozen Red Blood Cells

Qualifier (provides additional information about procedure):

- ❖ Autologous
- ❖ Non-Autologous

Check out the potential codes you can use:

Peripheral Vein
30230N Red Blood Cells >
30230N0 Transfusion of Autologous Red Blood Cells into Peripheral Vein, Open Approach
30230N1 Transfusion of Nonautologous Red Blood Cells into Peripheral Vein, Open Approach
30230P Frozen Red Cells >
30230P0 Transfusion of Autologous Frozen Red Cells into Peripheral Vein, Open Approach
30230P1 Transfusion of Nonautologous Frozen Red Cells into Peripheral Vein, Open Approach
33N Red Blood Cells >
30233N0 Transfusion of Autologous Red Blood Cells into Peripheral Vein, Percutaneous Approach
30233N1 Transfusion of Nonautologous Red Blood Cells into Peripheral Vein, Percutaneous Approach

Peripheral Vein
30233P Frozen Red Cells >
30233P0 Transfusion of Autologous Frozen Red Cells into Peripheral Vein, Percutaneous Approach
30233P1 Transfusion of Nonautologous Frozen Red Cells into Peripheral Vein, Percutaneous Approach
Central Vein
30240N Red Blood Cells >
30240N0 Transfusion of Autologous Red Blood Cells into Central Vein, Open Approach
30240N1 Transfusion of Nonautologous Red Blood Cells into Central Vein, Open Approach
30240P Frozen Red Cells >
30240P0 Transfusion of Autologous Frozen Red Cells into Central Vein, Open Approach
30240P1 Transfusion of Nonautologous Frozen Red Cells into Central Vein, Open Approach
30243N Red Blood Cells >
30243N0 Transfusion of Autologous Red Blood Cells into Central Vein, Percutaneous Approach
30243N1 Transfusion of Nonautologous Red Blood Cells into Central Vein, Percutaneous Approach
30243P Frozen Red Cells >
30243P0 Transfusion of Autologous Frozen Red Cells into Central Vein, Percutaneous Approach
30243P1 Transfusion of Nonautologous Frozen Red Cells into Central Vein, Percutaneous Approach
Peripheral Artery
30250N Red Blood Cells >
30250N0 Transfusion of Autologous Red Blood Cells into Peripheral Artery, Open Approach
30250N1 Transfusion of Nonautologous Red Blood Cells into Peripheral Artery, Open Approach
30250P Frozen Red Cells >
30250P0 Transfusion of Autologous Frozen Red Cells into Peripheral Artery, Open Approach
30250P1 Transfusion of Nonautologous Frozen Red Cells into Peripheral Artery, Open Approach
30253N Red Blood Cells >
30253N0 Transfusion of Autologous Red Blood Cells into Peripheral Artery, Percutaneous Approach
30253N1 Transfusion of Nonautologous Red Blood Cells into Peripheral Artery, Percutaneous Approach
30253P Frozen Red Cells >
30253P0 Transfusion of Autologous Frozen Red Cells into Peripheral Artery, Percutaneous Approach
30253P1 Transfusion of Nonautologous Frozen Red Cells into Peripheral Artery, Percutaneous

Central Artery
30260N Red Blood Cells >
30260N0 Transfusion of Autologous Red Blood Cells into Central Artery, Open Approach
30260N1 Transfusion of Nonautologous Red Blood Cells into Central Artery, Open Approach
30260P Frozen Red Cells >
30260P0 Transfusion of Autologous Frozen Red Cells into Central Artery, Open Approach
30260P1 Transfusion of Nonautologous Frozen Red Cells into Central Artery, Open Approach
30263N Red Blood Cells
30263N0 Transfusion of Autologous Red Blood Cells into Central Artery, Percutaneous Approach
30263N1 Transfusion of Nonautologous Red Blood Cells into Central Artery, Percutaneous Approach
30263P Frozen Red Cells
30263P0 Transfusion of Autologous Frozen Red Cells into Central Artery, Percutaneous Approach
30263P1 Transfusion of Nonautologous Frozen Red Cells into Central Artery, Percutaneous Approach

Therefore, for you to provide the correct ICD-10-PCS code, the provider needs to provide detailed and specific information on the following indicators:

- ❖ Body Part/Region
- ❖ Approach
- ❖ Substance
- ❖ Qualifier. ❖

Research How to Report Radiation Oncology Procedures in ICD-10-PCS

Highlight this character for the radioactive isotope.

When you prepare to report a radiology oncology procedure, you need to pay particular attention to characters 3-6, as these specify the radiation, treatment type, modality, and radioactive isotope.

Review Your Seven Digit PCS Structure

When reporting any ICD-10-PCS code, you have seven characters. You can break them down as follows:

Character 1	Section
Character 2	Body System
Character 3	Root Type
Character 4	Treatment Site
Character 5	Modality Qualifier
Character 6	Isotope
Character 7	Qualifier

For radiation oncology services, you can focus on the first character of “D,” because “D” stands for “radiation oncology.”

Specifically, the main focus of your character selection should be the following:

Character 3 (Root Type) — This specifies the basic modality (beam radiation, brachytherapy, stereotactic radiosurgery, and other radiation).

Character 4 (Treatment Site) — This specifies the treatment site that is the radiation therapy’s target location.

Character 5 (Modality Qualify) — This character further specifies the treatment modality, which includes photons, electrons, heavy particles, and contact radiation.

Character 6 (Isotope) — This describes the radioactive isotope administered in the oncology treatment.

Try Your Hand at This Example

Suppose you receive a claim that describes brachytherapy of the prostate with high dose rate (HDR) using Cesium 137. How should you report this?

Answer: DV1097Z.

Break it down: First of all, because this is a radiology oncology procedure, you should refer to the radiology oncology section (D).

Then, you’re looking at the prostate as the site, which leads you to the second character of “V” (Male reproductive system). So your code is “DV” so far.

Next, you have to decide the type of radiation. The claim described brachytherapy, so you should choose the third character of “1” (Brachytherapy). Your code is therefore “DV1.” That brings you to this PSC table:

Section	D	Radiation Oncology	
Body System	V	Male Reproductive System	
Modality	1	Brachytherapy	
Treatment Site	Modality Qualifier	Isotope	Qualifier
0 Prostate 1 Testis	9 High Dose Rate (HDR) B Low Dose Rate (LDR)	7 Cesium 137 (Cs-137) 8 Iridium 192 (Ir-192) 9 Iodine 125 (I-125) B Palladium 103 (Pd-103) C Californium 252 (Cf-252) Y Other Isotope	Z None

Based on this table, you’ll choose “0” (Prostate) for the fourth digit. This is the target site of the radiation therapy. Your code is “DV10.”

The physician is delivering a High Dose Rate (HDR), so your next character is “9” (HDR). Your code is “DV109.”

The isotope is Cesium 137, so your next character is “7” (Cs-137). Your code is now “DV1097.”

Finally, you have no qualifier, so your complete code is “DV1097Z.” ❖

Select the Appropriate Cesarean Procedure and Diagnosis Codes With This Advice

For a cesarean, ICD-10-CM guidelines say to use this code as your primary dx.

Although the terminology seems cold, ICD-10-PCS says you should treat cesareans as “extractions of products of conception.” Check out this procedure note and go the extra step of applying both ICD-10-CM codes to your single procedure code.

Read Through This Inpatient Note

Inpatient admission: The patient, gravida II, para 1, was admitted at approximately 33 weeks gestation. She has mild contractions and was contracting every 7-8 minutes. An ultrasound shows twins, approximately four pounds each. I gave the patient magnesium sulfate to stop the contractions, but she continued contracting through the drug. After developing

a fever with suspected chorioamnionitis, I performed a low cervical cesarean section. The umbilical cord was found to be wrapped tightly around the neck of twin 1.

Discharge diagnoses: Cesarean of liveborn twins prematurely at 33 weeks gestation. Chorioamnionitis. Umbilical cord compression.

Break Down Your ICD-10-CM Diagnoses

Here's how you should report your diagnoses.

Important: Because the patient is at 33 weeks, she is in the third trimester, which is defined by 28 weeks through delivery.

Therefore, you should report the following obstetric codes:

- ❖ O60.14x0 — *Preterm labor third trimester with preterm delivery third trimester; not applicable or unspecified*
- ❖ O30.003 — *Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester*
- ❖ O41.1230 — *Chorioamnionitis, third trimester; not applicable or unspecified*
- ❖ O69.1xx1 — *Labor and delivery complicated by cord around neck, with compression; fetus 1*

You would also report outcome code Z37.2 (*Outcome of delivery, twins, both liveborn*).

Primary diagnosis: These are numerous ICD-10-CM codes, several of which could qualify as the primary diagnosis. Refer to **ICD-10-CM Guideline I.15.b.4 Selection of OB Principal Diagnosis When a Delivery Occurs**. This section states:

When a delivery occurs, the principal diagnosis should correspond to the main circumstances or complication of the delivery. In cases of cesarean delivery, the selection of the principal diagnosis should be the condition established after study that was responsible for the patient's admission. If the patient was admitted with a condition that resulted in the performance of a cesarean procedure that condition should be selected as the principal diagnosis. If the reason for the admission/encounter was unrelated to the condition resulting in the cesarean delivery, the condition related to the reason for the admission/encounter should be selected as the principal diagnosis, even if a cesarean was performed.

Therefore, you should report O60.14x0 as your primary diagnosis.

Check Your ICD-10-PCS Procedure Code

Remember, every ICD-10-PCS code has seven characters. Here's how to break down your ICD-10-PCS selection.

Character 1: The physician performed a cesarean, so you know that you need to refer to the ob section of your ICD-10-PCS manual. That's "Chapter 1 Obstetrics."

Characters 2-3: According to ICD-10-PCS, a cesarean is an "extraction." Therefore, you should look at the table for "Pregnancy, Extraction" which is the table for 10D.

Section	1	Obstetrics															
Body System	0	Pregnancy															
Operation	D	Extraction: Pulling or stripping out or off all or a portion of a body part by the use of force															
	Body Part	Approach	Device	Qualifier													
0	Products of Conception	0	Open	Z	No Device	0	Classical	1	Low Cervical	2	Extraperitoneal						
0	Products of Conception	7	Via Natural or Artificial Opening	Z	No Device	3	Low Forceps	4	Mid Forceps	5	High Forceps	6	Vacuum	7	Internal Version	8	Other
1	Products of Conception, Retained	7	Via Natural or Artificial Opening	Z	No Device	Z	No Qualifier										
2	Products of Conception, Ectopic	8	Via Natural or Artificial Opening Endoscopic	Z	No Device	Z	No Qualifier										

Character 4: Your next digit should be "0" for "Products of Conception."

Character 5: Your next code is "0" for "Open." This specifies the cesarean section.

Character 6: Then, you should report "Z," because the physician did not use a device.

Character 7: Finally, your last selection is "1" for "Low cervical." The physician specified a low cervical cesarean section in the documentation.

Put all these codes together, and you'll have 10D00Z1. ❖

3 Steps Transform How to Report Transplant Procedures

Define allogeneic, syngeneic, and zooplasmic for an accurate 7th character.

If your physician performs transplant services, then you need to pay attention to the seventh character qualifier. Remember, one misrepresented character could mean the difference between a denial and the reimbursement your physician ethically deserves.

Heads up: Even if your physician does not perform transplants, check out how a single incorrect character in your seven-character code can change the service's definition entirely.

Step 1: Define Transplantation or 3rd Character of "Y"

According to PCS guidelines, a transplantation procedure means "putting in or on all or a portion of a living body part taken from another individual or animal to physically take the place and/or function of all or a portion of a similar body part." For example, you might encounter a heart or kidney transplant.

Note: Before you start checking to see if you can report multiple procedures, you need to take into account this part of the definition: "During transplantation, the native body part may or may not be taken out. The organ transplanted may or may not take all the function of the native organ." That means you shouldn't consider reporting the removal of the failing kidney in addition to the transplantation of the new one.

Important: You should report the transplantation code according to the organ you are transplanting.

Pitfall: If you have a bone marrow transplantation claim, you should not look at transplantation codes. Instead, you should turn to a "transfusion" service, which you will find in the section administration — not a "transplantation" procedure from the medical and surgical section.

Step 2: Identify the Genetic Compatibility in Your 7th Character

One of the biggest challenges of a transplant PCS code is to identify your seventh character, which will depend on whether the body part is allogeneic, syngeneic, or zooplasmic. Here's what each of these terms mean:

- ❖ **Allogeneic** — If your physician is using a graft of tissue that comes from a donor that is genetically different from (but the same species as) the recipient. That means this comes from one person's body and is grafted to another person. You'll see this term also identified as an "allogeneic graft," "allogeneic homograft," "homograft," "homologous graft," or "homoplastic" graft.
- ❖ **Syngeneic** — This type of graft comes from a donor who is genetically identical to the recipient. In other words, this might involve identical twins or between animals of a single highly inbred strain. You'll see this term also identified as an "isogeneic graft," "isogeneic homograft," "isograft," "isologous graft," "isoplastic graft," "syngeneic graft," and "syngeneic homograft." You might also see "syngraft isograft."

- ❖ **Zooplastic** — If you see the “zoo” part of this term and think it must have to do with animals, then you would be correct. This is a graft in which the tissue comes from an animal. The physician transfers this tissue to a human. For instance, surgeons sometimes transfer a heart valve from a pig to replace a damaged heart valve in a human.

Step 3: Try Your Hand at These Examples

To reiterate how you report these transplantation services, you should try your hand at coding these examples using PCS tables.

Tip: Break down your code by each character.

Example 1: A brother donates his heart to his twin. How would you report this procedure?

Hint: Because this involved a twin, you would choose a syngeneic seventh character.

Character 1 Section	Character 2 Body System	Character 3 Root Operation	Character 4 Body Part	Character 5 Approach	Character 6 Device	Character 7 Qualifier
Medical and Surgical	Heart and Great Vessels	Transplant	Heart	Approach	No Device	Syngeneic
0	2	Y	A	0	Z	1

Solution: Your code is 02YA0Z1.

Example 2: Your physician documents “a right renal transplantation, allograft.” How should you report this procedure?

Hint: You should alter where you look for your PCS code in a different table because this involves a kidney. Therefore, your second character is “T” for the Urinary System.

Character 1 Section	Character 2 Body System	Character 3 Root Operation	Character 4 Body Part	Character 5 Approach	Character 6 Device	Character 7 Qualifier
Medical and Surgical	Urinary System	Transplant	Kidney, Right	Open	No Device	Allogeneic
0	T	Y	0	0	Z	0

Solution: Your full code is 0TY00Z0.

Example 3: Your physician documents an “allogeneic transplant of heart.” How should you report this procedure?

Character 1 Section	Character 2 Body System	Character 3 Root Operation	Character 4 Body Part	Character 5 Approach	Character 6 Device	Character 7 Qualifier
Medical and Surgical	Heart and Great Vessels	Transplant	Heart	Open	No Device	Allogeneic
0	2	Y	A	0	Z	0

Solution: The code you should report is 02YA0Z0. ❖

Reader Question

“X” Won’t Just Mark a Spot in ICD-10-PCS

Question: *I’ve read articles or heard instructors who use “x” as a way to show that codes need an additional digit. A co-worker says the “x” will have a different meaning in ICD-10-PCS. Can you explain?*

Georgia Subscriber

Answer: Your co-worker is right: “x” can be a placeholder under ICD-10 but won’t have that role under ICD-10-PCS. The ICD-10-PCS codes are so detailed that the concept of placeholders doesn’t exist. Because of that, an “X” in an ICD-10-PCS code carries particular meaning instead of simply filling a spot.

Explanation: Each ICD-10-PCS code is a seven-digit combination of letters and numbers, with each digit (or character) telling you something about the procedure (body system, root operation, body part, surgical approach, etc.).

You’ll use categories and cross-reference charts to determine the appropriate letter or number for each digit in the code. An “X” can be one of those characters, and its meaning will depend on its position in the code and section involved.

For example, “X” can represent anatomical regions/upper extremities when placed as the second character in the code. But “X” can also represent an external approach when listed as the code’s fifth character, or a diagnostic test when listed as the seventh character. It all depends on knowing what each character in the code signifies.

For example, look at 0G9G4ZX. The “X” in this case shows that the fine-needle aspiration biopsy of the left lobe of the thyroid was done for diagnostic purposes. ❖

Device Key Simplifies Choosing PCS Character 6

Question: *My physician inserted a “sirolimus-eluting coronary stent.” How should I classify this device in ICD-10-PCS?*

California Subscriber

Answer: You should characterize this device as an intraluminal device, drug-eluting in heart and great vessels.

Remember: To understand “extraluminal” versus “intraluminal,” you need to know what lumen means. The lumen is the inside space of a tubular structure, such as an artery or intestine. An extraluminal device works on the outside of the lumen, such as the clipping of a cerebral aneurysm. An intraluminal device means that the device is within the lumen, such as within a blood vessel.

If you’re confused about classifying your device, you can always check the “Device Key,” which is an appendix in ICD-10-PCS. ❖

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