Comparison of the ICD-9-CM and ICD-10-CM Code sets

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In less than a year, the healthcare community will undergo another major change. With some preparation and training, ICD-10-CM will soon be in our rear view mirror, along with electronic transaction sets, HIPAA, Meaningful Use, and implementations of various Practice Management and Electronic Health Record Systems.

At first glance the differences between ICD-9-CM and ICD-10-CM seem as vast as the Grand Canyon. With some introductory training it becomes clear that while the code set is much larger, there are many similarities in how the code set is used. The introduction explain how to locate a code and the importance of the level of detail, and the chapter specific guidelines explain the nuances of coding diseases in the 21 Chapters (not all chapters have guidelines; some are reserved for the future). For trained coders, comparing the Chapter Guidelines side-by-side in both codes sets will reassure the coder that very little has changed with respect to the basic rules of coding using ICD-10-CM.

The major change is the expansion of the code set, to allow more specific codes to report laterality, episode of care, trimester, clinical details such as acute vs. chronic, and the expanded “cause codes”. The injury cause codes are very specific. For example, a physician need to document whether a patient was bitten or pecked, by a macaw or a parrot. What’s the difference? Macaws are a type of parrots while parrots are a very large group of attractive birds. Macaws are naturally distributed in the tropics and near tropics of North and South American continents, whereas parrots are found all over the world except Antarctica. Very specific, indeed!

In ICD-9-CM there are 17 Chapters, plus 2 supplementary chapters of V codes and E Codes. There are 21 Chapters in ICD-10-CM. The additional chapters are Eye and Adnexa and Ear and Mastoid Process have their own Chapters (eye and ear were combined in ICD-9-CM).

In ICD-10-CM, Chapters for External causes of morbidity and mortality (separate from injury and poisoning), and Codes for Special Purposes have replaced the supplementary chapters E and V in ICD-9-CM.

ICD-10-CM codes are all alphanumeric

Learning to navigate the larger code set can be mastered quickly by becoming familiar with the letter designations for each Chapter. “C” for Neoplasm (thinks Cancer) “E” for Endocrinology, “M” for Musculoskeletal and “O” for Obstetrics. The first character is always an alpha character designating the Chapter or Code Block within the Chapter. Subsequent characters may be alpha or numeric. (Example: I82.a11 Acute embolism and thrombosis of right axillary vein) The use of alphabetic characters within the codes is limited, and we see more alphabetic characters at the beginning and end of the codes. This makes it easier to distinguish between the number “1” and the letter “l”, as well as the number “0” and the letter “O”.
Codes may be 3, 4, 5, 6 or 7 characters in length. The ICD-10-CM tables provide guidance when a 4th, 5th, 6th or 7th character is required. Code Descriptions are listed in full, with the exception of the 7th character extension, which is found at the beginning of the code block, similar to the 5th digits in ICD-9.

The 7th place character is called the 7th character extension, and must always be reported in the 7th position, even when there is nothing required in the 4th, 5th or 6th character position. When this occurs, “X” is used as a placeholder. Example: T68.xxxA Hypothermia, initial encounter

**New Documentation Requirements by Chapter**

**Chapter 1 Certain Infections and Parasitic Diseases (A00-B99)**

The documentation requirements for HIV Exposure, Testing, HIV Positive Status, and AIDS in a patient who has had an opportunistic infection are outlined in the Chapter 1 Guidelines and are unchanged from ICD-9-CM. The most important rule to remember is to code only confirmed cases. The guidelines for coding and sequencing sepsis and severe sepsis are important to review as they have been expanded.

Sepsis is found in block A41 with an instruction to “code first noninfectious process or post procedural Sepsis. A41 codes are always sequenced second. Severe Sepsis is listed under R65.2 in Chapter 18, along with a code for organ dysfunction, found in the chapter for the affected organ.

Common viral infections, such as viral warts on the hands B07.9, are also listed in Chapter 1.

Infections that are more serious, such as Strep and Staphylococcus aureus and Methicillin Resistant Staph Aureus (MRSA) are found block B95-B97. These codes are provided for use as supplementary or additional codes to identify the infectious agent(s) in diseases reported in other chapters.

**Chapter 2 Neoplasms (C00-D49)**

Neoplasms are coded by type (benign, malignant) and location. The location descriptions now include neoplasms overlapping site boundaries. A primary malignant neoplasm that overlaps two or more contiguous (next to each other) sites should be classified to the subcategory/code .8 “overlapping lesion” unless the combination is specifically indexed elsewhere. For multiple neoplasm of the same site that are not contiguous such as tumors in different quadrants of the same breast, codes for each site should be assigned. Breast neoplasm codes also indicate gender is some cases.

Secondary codes are also required (use additional code to identify…) for conditions related to the cancer, such as alcohol abuse and dependence, history of tobacco use, tobacco dependence and tobacco use.

**Chapter 3 Diseases of the Blood and Blood Forming Organs**

ICD-10-CM requires more specific documentation for many conditions related to hematology. For example, sepsis related to infectious organism. Nutritional anemias require more info as to the cause. For example, Vitamin B12 deficiency anemia (DS1) and more specific information should be documented.
on type of immune disorder. Anemia in neoplastic disease is listed as D63.0 and should follow the code for the neoplasm.

Certain Disorders of the Immune System are now in Chapter 3 with Diseases of Blood and Blood-Forming Organs

Chapter 4 Endocrine, Nutritional and Metabolic Disorders

In ICD-10-CM, Diabetes type 1 and 2 are no longer classified as ‘uncontrolled’ or ‘not stated as uncontrolled’. Codes for Secondary DM differentiate between underlying condition or drug-induced.

The diabetes mellitus (DM) codes are combination codes that include the type of DM, the body system affected, and the complications affecting that body system.

As many codes within a particular category as are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for a particular encounter. Assign as many codes from categories E08 – E13 as needed to identify all of the associated conditions that the patient has.

ICD-10 CM Codes under category E08, Diabetes mellitus due to underlying condition, and E09, Drug or chemical induced diabetes mellitus, identify complications/manifestations associated with secondary diabetes mellitus. Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning). Codes in E08 and E09 follow the primary code for the underlying condition or cause, and are never reported alone.

Long term use of Insulin Z79.4 is reported with Type I DM. If the type of DM is not documented, the default is E11 for Type II DM.

Obesity codes are also found in Chapter 4. There are classifications for overweight, obesity and other hyperalimentation (E65-E68). Codes for BMI are found under Z68 and are also reported.

Chapter 5 Mental, Behavioral and Neurodevelopmental disorders (F01-F99)

Pain that is exclusively related to psychological disorders should be assigned F45.41. A code from G89 should not be reported with F45.41. Pain disorders with related psychological factors should be used with a code from category G89, Pain, not elsewhere classified, if there is documentation of a psychological component for a patient with acute or chronic pain.

Psychoactive Substance Use, Abuse and Dependence (of the same substance) are reported with only one code at the highest level from 1) use 2) abuse and 3) dependence.

Smoking is reported with Z72.0 (tobacco use) as a Status Code and can be reported in addition to ICD-10 codes for conditions related to tobacco use. Treatment of tobacco use would be reported with codes in block F17 and are categorized by dependence uncomplicated, in remission or withdrawal. The codes also describe the product as cigarettes, chewing tobacco or other tobacco product.
Chapter 6 Diseases of the Nervous System

Category G40 contains the codes for epilepsy. The subcategories are broken down by syndrome, seizure type, intractable/not intractable, and with/without status epilepticus. Seizures are divided into two major categories- focal (partial) seizures and generalized seizures (G40.3-).

Focal seizures only occur in one part of the brain, while generalized seizures occur in both sides of the brain. Documentation should include Dominant/Nondominant side to describe hemiplegia, hemiparesis, Monoplegia to specify whether the dominant or Nondominant side is affected. Should be affected side be documented, but not specified as dominant or Nondominant, it is assumed the patient is right handed.

Pain- Category G89- Documentation must state if the pain is acute or chronic, post-thoracotomy, postprocedural, or neoplasm-related to use codes from category G89.

A code from G89 should not be assigned if the underlying (definitive) diagnosis is known, unless the reason for the encounter is pain control/management and not the management of the underlying condition.

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

Headache is found in Chapter 18 under R51. Migraine (G53) describes the common migraine without aura (G43.0-) and classic migraine with aura (G43.1-). Migraine codes are further defines as “with” or “without” status migrainosus. Status migrainosus refers to a rare and severe type of migraine that can last 72-hours or longer. The pain and nausea are so intense that people who have this type of headache often need to be hospitalized. Certain medications, or medication withdrawal, can cause this type migraine syndrome.

G43.6 reports Persistent migraines and G43.7 reports chronic migraine. Chronic migraines are classified by the International Headache Society as a migraine that occurs greater than 15 days per month for at least 3 months. Persistent migraines are migraines that last more than three months and occur daily from within three days of onset.

Chapter 7 Eye and Adnexa (H00-H59)

New ICD-10-CM Documentation Elements for Laterality is the reason for the significant expansion of codes in this chapter. There are codes for right eye, left eye, bilateral eyes, and unspecified eye.

Eye diseases due to diabetes (e.g., retinal disorders, diabetic cataracts) are now in Chapter 4 – Endocrine, Nutritional and Metabolic Diseases- due to the introduction of combination codes for diabetes.
In ICD-9-CM Purulent endophthalmitis, was coded based on acute or chronic. In ICD-10-C the codes are require an additional code to identify the organism.

Cataracts are reported under Disorders of lens (H25-H28). The codes are based on type (age-related, infantile and juvenile, traumatic, complicated, drug induced and secondary cataract. The codes are all listed by laterality and have 4 entries for right eye, left eye, bilateral and unspecified.

Coding for Eye Injury is found in Chapter 19, Injury, Poisoning and Certain Other Consequences of External Injury. Codes in Block T26 are used to report Burns and Corrosion to the eye and adnexa. In ICD-9 burns were not distinguished by cause. In ICD-10 a burn is reported when the burn is caused by a heat source and corrosion is reported when the burn is from a chemical source. Additional external cause codes are reported to identify the source, place and intent of the burn (X00-X19, X75-X77, X96-X98, Y92)

Chapter 8 Ear and Mastoid

In ICD-10-CM, the codes for Diseases of the Ear and Mastoid Process are located in Chapter 8. Diseases of the external ear include codes for otitis externa, swimmers ear, and hematoma of the pinna. A common code for many primary care providers, as well as ENT specialists, in impaction of Cerumen H61.2- (the dash represents another character- 1 is right, 2 is left, 3 is bilateral).

The section for the middle ear includes the codes for otitis media, one of the most common diseases in childhood. The two main types of otitis media are acute otitis media (AOM) and otitis media with effusion (OME). Acute suppurative otitis media H66.001 with or without spontaneous rupture of ear drum is sudden, severe inflammation of middle ear, with pus. There are many codes in Block H65 and H66 to report otitis media based on cause (allergic, bacterial) clinical findings (mucoid, sanguinous, serous) location (right, left, bilateral) type (acute, chronic) and involvement (with or without ruptured ear drum and context (in diseases classified elsewhere). Chronic serous otitis media should be documented as occurring for at least 6 weeks.

Codes in H66 Suppurative and unspecified otitis media require an additional code for any associated perforated tympanic membrane (ear drum) using H73.-. H66.0- is listed “with” and “without” spontaneous rupture of the ear drum.

The section for the inner ear includes codes for otosclerosis, vestibular function disorders, and labyrinthitis. Documentation for auditory conditions should include the type of disorder and the ear, or ears, affected in order to assign the codes to the highest level of specificity available in ICD-10-CM.
Clinicians need to be aware of the heightened documentation requirements. Codes for diseases of the ear require laterality. Infective otitis externa codes require info for more specific causes (e.g., abscess, cellulitis). Conductive hearing loss is not differentiated by location of dysfunction. Meniere’s disease (H81.09) is coded by laterality, but there is no longer the component of active/inactive.

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

When coding hypertension with heart disease, use an additional code from category I50 when a causal relationship is stated. The same heart conditions with hypertension, but without a stated causal relationship, are coded separately. Hypertensive Chronic Kidney Disease is classifiable to category N18. ICD-10-CM presumes a cause-and-effect relationship and classifies chronic kidney disease with hypertension as hypertensive chronic kidney disease.

Acute Myocardial Infarction (I21) is specified as acute or with a stated duration of 4 weeks (28 days) or less from onset.

4 week time frame for a subsequent acute myocardial infarction
A code from category I22. Subsequent ST elevation (STEMI) and non ST elevation (NSTEMI) myocardial infarction is to be used when a patient who has suffered an AMI has a new AMI within the 4 week time frame of the initial AMI. A code from category I22 must be used in conjunction with a code from category I21.

Nontraumatic subarachnoid hemorrhage (I60) is coded based on the location. The documentation should specify laterality as well as the specific artery. Nontraumatic intracerebral hemorrhage is coded to site.

Cerebral/precerebral infarctions/occlusion/stenosis all require the provider to document laterality, and the artery. Atherosclerosis of extremity codes are subdivided into legs/other extremities. Codes for Embolism/thrombophlebitis of veins are based on Laterality and Specific extremity vein

Varicose veins and Postphlebitic syndrome are coded based on Laterality.

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

There are new ICD-10-CM Documentation Elements Related to Respiratory Coding. Chronic Obstructive Pulmonary Disease (COPD) and Asthma (categories J44 and J45) distinguish between uncomplicated cases and those in acute exacerbation. Asthma is now mild persistent, moderate persistent and severe persistent. Mild asthma is coded as intermittent or persistent.

Sinusitis is reported with Block J01 for Acute Sinusitis or J32 Chronic Sinusitis. Each block contains specific listings based on location and type (acute or acute recurrent).

Influenza codes J09, J10, J11 report type of influenza virus as well as associated pneumonia or other manifestations (encephalopathy, myocarditis, otitis media or other manifestations).
Viral pneumonia (J12) Bacterial pneumonia (J15) is reported along with codes for associated influenza, or lung abscess. Pneumonia due to an identified infection is reported with a combination code such as J15.212 pneumonia due to methicillin resistant Staphylococcus aureus (MRSA) and it is not necessary to assign B95.62 to identify the MRSA.

Ventilator associated pneumonia should only be reported with J95.851 when the provided has documented the cause of the pneumonia. The fact that the patient is or was on a ventilator is not enough to assume the cause and effect relationship. Use an additional code to identify the organism, if known (B95.-, B96.-, B97.-) For ventilator lung in newborns, refer to the newborn codes in Chapter 16 (P27.8).

Chapter 11 Digestive System Coding Guidelines

New ICD-10-CM Documentation Elements Related to Digestive System Coding include Gastric ulcers with our without (w/or w/o) obstruction, Gastritis/duodenitis w/ or w/out obstruction, Crohn’s disease W/ or w/out complications and Diverticulosis/diverticulitis W/ or w/o perforation and W/ or w/o bleeding. Irritable Bowel Syndrome (IBS) is reported W/ or w/o diarrhea. Alcoholic liver diseases are reported W/ or w/o ascites. Anal Fissures are classified as acute or chronic. Toxic liver disease is listed with complications such as Presence or absence of Cholestasis or Hepatic necrosis.

Acute or chronic hepatitis is based on the type of chronic hepatitis is described as Persistent, Lobular or active, with ascites or coma. Acute pancreatitis is coded based on: Idiopathic, Biliary, Alcohol-induced, Drug-induced, Other and Unspecified.

Chapter 12 Diseases of the Skin and Subcutaneous Tissue

In ICD-10, the terms dermatitis and eczema are used synonymously and interchangeably. Contact dermatitis is described as Allergic or Irritant and substance cause.

Burns and Corrosions are identified by cause (e.g., heat, chemical). A seventh character for the episode of care is required.

Pressure ulcers are reported with combination codes. One code reports site and stage. This section has more specific bilateral codes. The level of detail in the integumentary chapter lists separate codes for abscesses and cellulitis as well as separate codes for furuncle (boil) and carbuncle. The codes are often based on laterality and exact location.

Non-pressure chronic ulcers of lower limb are listed in L97 and are reported second, after listing any associated conditions such as cardiovascular disease (atherosclerosis I70.2-) diabetic ulcers (E08.6-, E.09.6-, E10.6-, E11.6-). Skin infections are reported under L00-L08 unless classifiable to A00-B99.

Patients with multiple skin ulcers may require more than one code to report each ulcer treated.
Chapter 13 Diseases of the Musculoskeletal System and Connective Tissue

Diseases of the musculoskeletal system and connective tissue are coded under Chapter 15. While many fractures are listed under Chapter 19 as they are often due to injury, pathological fractures are found in Chapter 15. Most of the codes within chapter 13 have site and laterality designations. The site represents the bone, joint or the muscle involved. For some conditions where more than one bone, joint or muscle is usually involved, such as osteoarthritis. There is a "multiple sites" code available. For categories where no multiple site code is provided and more than one bone, joint or muscle is involved, multiple codes should be used to indicate the different sites involved.

Where to look? Many musculoskeletal conditions are a result of previous injury or trauma to a site, or are recurrent conditions. Bone, joint, or muscle conditions that are the result of old healed injury are usually found in chapter 13. Recurrent bone, joint, or muscle conditions are also usually found in chapter 13. Any current, acute injury should be coded to the appropriate injury code from chapter 19

Arthritis and osteoarthritis have both site and laterality designations in ICD-10-CM. It also includes the type of arthritis such as primary, secondary or post-traumatic. Primary osteoarthritis is considered "wear and tear" osteoarthritis; this type of osteoarthritis is more commonly diagnosed, whereas secondary osteoarthritis is usually caused by an injury, heredity, obesity or something else. The treatment for both types is usually the same.

Arthritis and osteoarthritis are classified as “Primary” due to normal aging, and “Secondary” which has a defined cause such as trauma, heredity, or obesity.

Rheumatoid (RA) is a chronic systemic disease that affects the joints, connective tissues, muscle, tendons, and fibrous tissue, and is a chronic disabling condition often causing pain and deformity. Coding for rheumatoid arthritis in ICD-10-CM is broken down by site, laterality, complication, and with or without rheumatoid factor. Rheumatoid factor is an antibody in the blood that’s present in many, but not all, people with RA.

Osteoporosis is a systemic condition, meaning that all bones of the musculoskeletal system are affected. Site is not a component of the codes under category M81, Osteoporosis without current pathological fracture. The site codes under category M80, Osteoporosis with current pathological fracture, identify the site of the fracture, not the osteoporosis. Category M81, Osteoporosis without current pathological fracture, is for use for patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis, even if they have had a fracture in the past.
For patients with a history of osteoporosis fractures, status code Z87.31O Personal history of healed osteoporosis fracture should follow the code from M8l.

Category M8O, Osteoporosis with current pathological fracture, is for patients who have a current pathologic fracture at the time of an encounter. The codes under M8O identify the site of the fracture. A code from category M8O, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.

Chapter 14 New ICD-10-CM Documentation Elements Related to Genitourinary Coding

Chronic Kidney Disease is reported with Stages of Chronic Kidney Disease (CKD) listed under block N18. ICD-10-CM classifies-CKD based on severity. The severity of CKD is designated by stages 1-5. Stage 2, code N18.2, equates to mild CKD; stage 3, code N18.3, equates to moderate CKD; and stage 4, code N18.4, equates to severe CKD. Code N18.6 End stage renal disease (ESRD) is assigned when the provider has documented end-stage-renal disease (ESRD). If both a stage of CKD and ESRD are documented, assign code N18.6 only. When reporting N18.6 use an additional code to identify dialysis status (Z99.2).

Chronic Kidney Disease and Kidney Transplant Status requires documentation of restored function. Patients who have undergone kidney transplant may still have some form of CKD, because the kidney transplant may not fully restore kidney function. The presence of CKD alone does not constitute a transplant complication. Assign the appropriate N18 code for the patient's stage of CKD and code Z94.0 Kidney transplant status. If a transplant complication such as failure or rejection is documented, see section I.C.19.g for information on coding complications of a kidney transplant. If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.

Also found in this chapter of ICD-10-CM are disorders of the male and female genital organs. Male disorders listed in this chapter include diseases of the prostate, male Infertility, and erectile dysfunction.

Female disorder found in this chapter include pelvic inflammatory diseases, female infertility, and menopausal and perimenopausal disorders. Disorders of the breast (excluding those associated with childbirth) are also located in this chapter in blocks N60-N65.

Additional documentation will be required for laterality when reporting ICD-10 codes for the kidneys, ovaries and breasts.
Chapter 15 Pregnancy, Childbirth and the Puerperium

Diabetes mellitus is a condition characterized by high blood sugars, either because the person does not produce enough insulin, or because the cells do not respond to the insulin that is produced. There are three main types of diabetes mellitus (DM). Type I DM occurs when the body fails to produce enough insulin, and as a result, the person is required to take insulin. This form was previously referred to as "insulin-dependent diabetes mellitus" (IDDM) or "juvenile diabetes". Type 2 DM results from insulin resistance, a condition in which cells fail to use insulin properly. Type 2 was previously referred to as non-insulin-dependent diabetes mellitus (NIDDM) or "adult-onset diabetes". The third type is gestational diabetes and occurs when pregnant women without a previous diagnosis of diabetes develop high blood glucose levels.

Using ICD-10-CM, women who are diabetic and become pregnant should be assigned a code from category O24 Diabetes mellitus in pregnancy, childbirth, and the puerperium first, followed by the appropriate diabetes code(s) (E08-E13) from Chapter 4. There is also a code for long-term use of insulin in ICD-10-CM, Z79.4 Long-term (current) use of insulin and it should be assigned if the diabetes mellitus is being treated with insulin.

Codes for gestational diabetes are found in subcategory O24.4 Gestational diabetes mellitus. The codes under subcategory O24.4 include diet controlled and insulin controlled. If a patient with gestational diabetes is treated with both diet and insulin, only the code for insulin-controlled is required. Code Z79.4 Long-term (current) use of insulin, should not be assigned with codes from subcategory O24.4.

There is a difference between gestational diabetes and abnormal glucose tolerance in pregnancy. Careful documentation will ensure accurate coding. Abnormal glucose is assigned a code from subcategory O99.81 Abnormal glucose complicating pregnancy, childbirth, and the puerperium in ICD-10-CM.

The majority of codes in Chapter 15 have a final character indicating the trimester of pregnancy. The timeframes for the trimesters are indicated at the beginning of the chapter. If trimester is not a component of a code it is because the condition always occurs in a specific trimester, or the concept of trimester of pregnancy is not applicable. Certain codes have characters for only certain trimesters because the condition does not occur in all trimesters, but it may occur in more than just one
Assignment of the final character for trimester should be based on the trimester for the current admission/encounter. This applies to the assignment of trimester for pre-existing conditions as well as those that develop during or are due to the pregnancy.

Codes from Chapter 21, Factors influencing Health status and contact with Health Services, should be reported with every routine antenatal visit by reporting Z34.0- to indicate the trimester of a normal pregnancy.

For antenatal care resulting from complications of pregnancy, report the Chapter 15 codes first, followed by Z3A.- to indicate weeks of gestation of pregnancy.

**Chapter 16- Certain Conditions Originating in the Perinatal Period**

Codes in this chapter are never for use on the maternal record. Codes from Chapter 15, the obstetric chapter, are never reported on the maternal record. Should a condition originate in the perinatal period, and continue throughout the life of the patient, the perinatal code should continue to be used regardless of the patient's age.

If a newborn has a condition that may be either due to the birth process or community acquired and the documentation does not indicate which it is, the default is due to the birth process and the code from chapter 16 should be used. If the condition is community-acquired, a code from chapter 16 should not be assigned.

**Prematurity and Fetal Growth Retardation**

Providers utilize different criteria in determining prematurity. A code for prematurity should not be assigned unless it is documented. Assignment of codes in categories P05, Disorders of newborn related to slow fetal growth and fetal malnutrition and P07, Disorders of newborn related to short gestation and low birth weight, not elsewhere classified, should be based on the recorded birth weight and estimated gestational age. Codes from category P05 should not be assigned with codes from category P07.

**Low Birth Weight and Immaturity Status**

Codes from subcategory P07, Disorders of newborn related to short gestation and low birth weight, are for use for a child or adult who was premature or had a low birth weight as a newborn and this is affecting the patient's current health status. When both birth weight and gestational age of the newborn are available, both should be coded with the birth weight (P07.0 or P07.1) sequenced before the gestational age (P07.2, P07.3).

**Chapter 17 Congenital Malformations, Deformations, and Chromosomal Abnormalities**

A congenital malformation is a defect that is present at birth. It may be genetic, result from exposure of the fetus to a malforming agent or of unknown causation. Examples include spina bifida, heart anomalies, cleft lip and/or palate and Down syndrome. Codes from chapter 17 may be used throughout the life of the patient. If a congenital malformation or deformity has been corrected, a personal history code should be used to identify the history of the malformation or deformity. Although present at birth, malformation/deformation/or chromosomal abnormality may not be identified until later in life.
When birth defects are noted at birth, the appropriate code from category Z38, Liveborn infants, according to place of birth and type of delivery, should be sequenced as the principal diagnosis, followed by any congenital anomaly codes, 00O-Q89.

Cleft lip and cleft palate are congenital malformations. A cleft lip is a physical separation of the two sides of the upper lip, which often extends beyond the base of the nose and includes the bones of the upper jaw and/or upper gum. A cleft palate is a split in the roof of the mouth. It can involve the hard palate and/or the soft palate. The condition may occur on one or both sides of the mouth. The lip and palate develop separately, so it is possible to have a cleft palate alone, or both conditions together.

In ICD-10-CM, codes for cleft lip /cleft palate are broken down by laterality, portion of the palate, and if the conditions occur separately or together.

Chapter 18- Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified

Chapter 18 includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditions regarding which no diagnosis classifiable elsewhere is recorded. Signs and symptoms that point rather definitely to a given diagnosis have been assigned to a category in other chapters of the classification.

Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

Never use a definitive diagnosis code when the documentation includes phrases such as “Rule out, Question of, Suspected or Probable”. Code the signs and symptoms unless there is a definite diagnosis.

Chapter 19 – Injury, Poisoning and Certain other Consequences of External Causes

With the implementation of ICD-10-CM, coding for fractures will require an in-depth knowledge of the patient's course of treatment. ICD-10-CM will require more precise location choices, laterality, episode of care, and indication as to the healing process of the fracture. ICD-10-CM indicates that a fracture not indicated as open or closed should be coded to closed (which is the same as ICD-9-CM currently reads). ICD-10-CM also indicates that a fracture not indicated whether displaced or non-displaced should be coded to displaced (ICD-9-CM does not specifically state this).

7th character extenders are utilized for fracture code assignment in ICD-10-CM to indicate the encounter. The encounter denotes where the patient is in the treatment cycle: initial, subsequent, or sequel (late effect). In some cases there are 16 choices for the 7th character extenders for a fracture. When you look at the choices in detail, you can see that it is a major improvement to the process of coding the patient's diagnosis. For instance, when coding for traumatic fractures, the initial visit by the provider will require the “initial encounter” 7th character extender to indicate the patient is receiving active medical treatment for their condition:

ENOS Medical Coding
A - initial encounter for closed fracture  
B - initial encounter for open fracture type I or II initial encounter for open fracture NOS  
C - initial encounter for open fracture type IIIA, IIIB, or IIIC

Initial encounters include first visits, evaluation by a new provider, and surgical intervention.

When the patient returns for subsequent visits, it will be necessary to indicate his or her healing process with the appropriate 7th character, including:  
D - subsequent encounter for closed fracture with routine healing  
F - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing  
H - subsequent encounter for open fracture type I or II with delayed healing  
K - subsequent encounter for closed fracture with nonunion  
R - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion

These 7th character extenders are used to indicate the patient has completed active medical treatment and is receiving routine care during the healing or recovery phase. The 7th character extender S is used to indicate a sequela, or late effect has occurred.

While code assignment for fractures may take a little longer with ICD-10-CM, more precise, detailed code assignment will lead to faster claim adjudication and fewer record requests.

**Coding of Traumatic Fractures**  
The principles of multiple coding of injuries should be followed in coding fractures. Fractures of specified sites are coded individually by site in accordance with both the provisions within categories S02, S12, S22, S32, S42, S52, S62, S72, S82, S92 and the level of detail furnished by medical record content.

A fracture not indicated as an open or closed should be coded to closed. A fracture not indicated whether displaced or not displaced should be coded to displaced.

In ICD-10-CM fractures have both site and laterality designations. Fractures are very specific to type and location for coding purposes.

Some fracture types are:
- Greenstick fracture: an incomplete fracture in which the bone is bent. This type occurs most often in children.  
- Transverse fracture: a fracture at a right angle to the bone's axis.  
- Oblique fracture: a fracture in which the break has a curved or sloped pattern.  
- Comminuted fracture: a fracture in which the bone fragments into several pieces.  
- An impacted fracture is one whose ends are driven into each other. This is commonly seen in arm fractures in children and is sometimes known as a buckle fracture. Other types of fracture are
pathologic fracture, caused by a disease that weakens the bones, and stress fracture, a hairline crack.

**Fractures and the cause of injury (Place of Occurrence code and Activity Code)**

Injuries should always be reported with an external cause code in addition to the diagnosis of the injury, especially on the first claim. If the activity and location where the injury occurred are documented, report an external cause code from Y92 (place of occurrence) and Y93 (activity code).

**EXAMPLE:**
While playing tennis in a tournament at the Country Club, a male player sprained his left wrist and was treated in a hospital emergency department close to the courts.

S63.501A Unspecified sprain of right wrist, initial encounter
Y93.73 Activity, racquet and hand sports
Y92.312 Tennis court as the place of occurrence as the external cause

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

This chapter has expanded and requires multiple codes to identify How an injury occurred, Where the injury occurred (Place of Occurrence Y92), What the person was doing (Activity codes Y93) and the Status of the person at the time the event occurred (External cause status Y99) to distinguish between civilian, military and volunteer activities.

This is a chapter that has been the source of discussion. The degree of granularity of ICD-10-CM is evident when reviewing the difference between W61.0 and W61.1 (Contact with a Parrot or Macaw) and the type of contact: bitten, stuck, or other exposure. W61.3 contact with chicken requires a 5th character to identify the type of contact: struck by chicken (W61.32) or peck by chicken (W61.33) and both codes require a 7th character for the episode of care, as well as a place of occurrence (Y92.72 Farm).

What is the difference between a crocodile and an alligator? It’s all in their smile. A crocodile has a V shaped snout and an alligator has a U shaped snout. But in ICD-10, it’s W58.0 for alligator contact and W58.1 for crocodile contact. Don’t stop there, you will need to choose between bitten, stuck or crushed, and don’t forget to add the 7th character for the episode of care.

**Chapter 21 Factors Influencing Health Status and Contact with Health Services**

Z codes are for use in any health care setting. Z codes may be used as either a first-listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter. Certain Z codes may only be used as first-listed or principal diagnosis.
Z Codes Indicate a Reason for an Encounter. Z codes are not procedure codes. A corresponding procedure code must accompany a Z code to describe the procedure performed. For example, Z23 Encounter for immunization requires a procedure code to identify the type of immunizations given.

Z00 Encounter for a general adult medical examination requires a 5\textsuperscript{th} digit, to report “with” or “without” abnormal findings. In ICD-9-CM, V70 was used to report a general medical examination without further information.

Z codes are also reported in addition to codes for diseases and conditions when there is a problem related to lifestyle such as Tobacco use (Z72.0), Lack of physical exercise (Z72.3) or inappropriate diet and eating habits (Z72.4)

Codes for Personal History and Family History are also found in Chapter 21 and are similar to the same codes in the V code supplementary section of ICD-9.

Get Ready! Become familiar with the new details ICD-10-CM will require of your patient encounter notes. Review crosswalks of your practice’s most frequently used ICD-10-CM codes and focus on the fact there there is a “one-to-many” crosswalk that cannot depend on a simple one page paper reference sheet. Many denials and delays in reimbursement can be avoided with good training and documentation.

Nancy M. Enos, FACMPE, CPC-I, CPMA, CEMC, CPC

AAPC Approved ICD-10 Instructor

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Detailed Program Goal:

The 2 modules provide a general overview of ICD-10 concepts and a comprehensive study of the codes in the Chapter. The goal is to give coders and clinicians in the specialty training on ICD-10-CM. The practical application provides a list of the top 25 codes from the Chapter in ICD-9-CM and crosswalks them to the codes in ICD-10-C M for review, and find in the ICD-10 manual, and learn the key differences. There is an interactive quiz that will provide reinforcement of these concepts.

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Chapter 9 Diseases of the Circulatory System |
| **Gastroenterology**                          | Includes Introduction and Overview and  
Chapter 11 Diseases of the Digestive System |
| **Urology**                                   | Includes Introduction and Overview and  
Chapter 14 Diseases of the Genitourinary System |
| **Endocrinology**                             | Includes Introduction and Overview and  
Chapter 4 Endocrine, Nutritional and Metabolic Diseases |
| **Hematology/Oncology**                       | Includes Introduction and Overview and  
Chapter 2 Neoplasms  
Chapter 3 Diseases of the Blood and Blood Forming Organs |
| **Ophthalmology**                             | Includes Introduction and Overview  
Chapter 7 Diseases of the Eye and Adnexa |
| ICD-10 Specialty Training- 4 modules          | $399 per specialty |
| **OB Gyn**                                    | Includes Introduction and Overview  
Chapter 14 Diseases of the GU System  
Chapter 15 Pregnancy, Childbirth and the Puerperium  
Chapter 21 Factors Influencing Health Status |
| **Pulmonary/Allergy**                         | Includes Introduction and Overview  
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