



ICD-10

ICD-10-CM

Day 1

2015



ICD-10-CM

ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES



Diabetes mellitus

- Combination codes
- No longer classified as controlled or uncontrolled
- Inadequately, out of control or poorly controlled coded by type with hyperglycemia





Case 1.25

- E11.321** **Diabetes, diabetic (mellitus) (sugar), type 2, with, retinopathy, nonproliferative, mild, with macular edema**
- E11.36** **Diabetes, diabetic (mellitus) (sugar), type 2, with, cataract**
- Z79.4** **Long-term (current) (prophylactic) drug therapy (use of), insulin**



Case 1.25 (continued):

Rationale: There is a combination code for the type 2 diabetes with nonproliferative diabetic retinopathy with macular edema. The diabetic cataract was documented and should be coded, but it requires a separate code. Since the patient has type 2 DM, and is on insulin, code Z79.4 should be assigned to indicate that as indicated by the note at category E11: Use additional code to identify any insulin use (Z79.4).



Case 1.26

E10.22 **Diabetes, diabetic (mellitus) (sugar) type 1, with, chronic kidney disease**

N18.3 **Disease, diseased, kidney (functional) (pelvis), chronic, stage 3 (moderate)**

K04.7 **Abscess, tooth, teeth (root)**

Rationale: The Tabular instructs the coder to use an additional code to identify the stage of the chronic kidney disease, N18.3. In this case, the hyperglycemia would not be coded since it was not documented by the physician as out of control in this limited documentation. A physician query might be warranted.



Case 1.27

- K85.0** **Pancreatitis (annular) (apoplectic) (calcareous) (edematous) (hemorrhagic) (malignant) (recurrent) (subacute) (suppurative), acute, idiopathic**
- E08.65** **Diabetes, diabetic (mellitus) (sugar), due to underlying condition, with, hyperglycemia**
- Z79.4** **Long-term (current) (prophylactic) drug therapy (use of), insulin**



Case 1.27 (continued):

Rationale: The notes in the Tabular show the sequencing in this case. Code first the underlying condition, and use additional code to identify any insulin use (Z79.4). Coding Guideline I.C.4.a.6.b. also gives direction for this case. For acute pancreatitis, assign code E85.0 for idiopathic pancreatitis, or that whose cause cannot be determined. Assign a code from category E08 and a code for long-term use of insulin.



Case 1.28

E66.01 **Obesity, morbid**

Z68.41 **Body, bodies, mass index (BMI), adult,
40.0 – 44.9**

Rationale: The Index indicates that morbid obesity is assigned code E66.01. When consulting the Tabular, the subcategory is Obesity due to excess calories. This is the correct code even though it is not documented that excess calories caused the obesity. This is the default code per the classification. The note at category E66 indicates that an additional code should be assigned for BMI when known (Z68.-).



Case 1.29

F50.2 **Bulimia (nervosa)**

E44.0 **Malnutrition, protein, calorie,
moderate**

Rationale: Protein-calorie malnutrition codes differentiate between mild and moderate levels.



Case 1.30

E86.0 Dehydration

A02.0 Gastroenteritis (acute) (chronic) (noninfectious), Salmonella or Infection, Salmonella, with (gastro)enteritis

Rationale: The dehydration would be the first listed code because it is the reason for the encounter and is the diagnosis that was treated. The gastroenteritis due to salmonella would be coded as an additional code. The symptoms (abdominal cramping, nausea, vomiting, diarrhea) are integral to the gastroenteritis and are not separately coded.

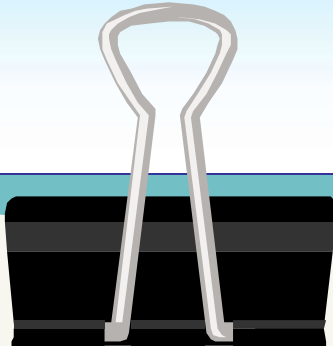


Case 1.31

E10.10 Diabetes, diabetic (mellitus) (sugar), type 1, with, ketoacidosis

E86.0 Dehydration

Rationale: The reason for the encounter is the diabetic ketoacidosis which would be sequenced first. The symptoms of nausea and vomiting, frequency of urination, and polydipsia would not be coded.

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Coding Note: A note appears in the Tabular under category E09 instructing to “Use additional code for adverse effect, if applicable, to identify drug (T36-T65 with fifth or sixth character 5).”
Use the Drugs and Chemical Table to locate this code. An additional note appears in the Tabular under category E09 instructing to “Use additional code to identify any insulin use (Z79.4).”



Case 1.32

E09.9

**Diabetes, diabetic, (mellitus)
(sugar) due to drug or chemical**

T38.0X5S

**Refer to Table of Drugs and
Chemicals, Corticosteroid,
adverse effect**

Z79.4

**Long-term (current)
(prophylactic) drug therapy
(use of), insulin**



Case 1.32 (continued):

Rationale: The reason for this encounter is the steroid-induced diabetes mellitus. E09.9 is sequenced first due to Coding Guideline I.C.19.e.5.a, which states that the nature of the adverse effect is assigned first followed by the appropriate code for the adverse effect (T36-T50). There is also a “use additional code” note under category E09 regarding the sequencing of adverse effect codes. The seventh character of S is assigned to code T38.0X5 as this is the sequela of the corticosteroid use. The seventh character D is used for encounters after the patient received active treatment and is receiving routine care.

Additionally, under category E09 there is another instructional note to “use additional code to identify any insulin use (Z79.4).”



Case 1.33

E05.20 **Hyperthyroidism (latent) (pre-adult)
(recurrent) with, goiter (diffuse),
nodular (multinodular)**

R00.2 **Palpitations (heart)**



Case 1.33 (continued):

Rationale: Although palpitations are integral to hyperthyroidism, the palpitations are coded as an additional (other) diagnosis in this case due to the fact that they were more pronounced, requiring additional clinical evaluation to be carried out. The UHDDS defines “other diagnoses” as those conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring.



Case 1.34

- E10.621** **Diabetes, diabetic (mellitus) (sugar), type 1, with foot ulcer**
- L97.521** **Ulcer, foot, *see* Ulcer, lower limb, lower limb, foot, left, with skin breakdown only**
- E10.51** **Diabetes, diabetic (mellitus) (sugar), type 1, with peripheral angiopathy**
- E10.22** **Diabetes, diabetic (mellitus) (sugar), type 1, with chronic kidney disease**
- N18.2** **Disease, diseased, kidney (functional) (pelvis), chronic, stage 2 (mild)**



Case 1.34 (continued):

Rationale: The diabetic ulcer is listed first because this appears to be the reason for treatment. The note under code E10.621 states to “Use additional code to identify site of ulcer (L97.4-, L97.5-)”. It is correct to list as many diabetic conditions as are present, and the stage 2 chronic kidney disease and the peripheral angiopathy are coded. An additional code, N18.2, is added to identify the stage 2 chronic kidney disease. It is not correct to assign Z79.4 because type 1 diabetics must use insulin to sustain life, and this is inherent in the Category E10 codes.



ICD-10-CM

MENTAL AND BEHAVIORAL DISORDERS



- Unique codes for alcohol and drug use, abuse, and dependence
- Continuous or episodic no longer classified
- History of drug or alcohol dependence coded as “in remission”
- Combination codes
- Blood alcohol level (Y90.-)



Case 1.35

F10.129 Abuse, alcohol (non-dependent), with, intoxication

Rationale: ICD-10-CM does not specify the severity of alcohol use as previously seen in ICD-9-CM. If alcohol dependence was documented, the coding would go to F10.2.



Case 1.36

F15.20 **Dependence (on) (syndrome),
amphetamine(s) (type), *see*
Dependence, drug, stimulant, NEC**

Rationale: ICD-10-CM classifies each drug by its type. If intoxication with the dependence is documented, an additional digit would be added.



Case 1.37

Z71.6 **Counseling (for), tobacco use**

F17.220 **Dependence, (on) (syndrome), nicotine,
see Dependence, drug, nicotine.
Dependence, drug, nicotine,
chewing tobacco**

Rationale: In ICD-10-CM, nicotine dependence is further specified by the type of product used.

There is a note at code Z71.6: Use additional code for nicotine dependence (F17.-).

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Coding Note:

The ICD-10-CM classification system does not provide separate "history" codes for alcohol and drug dependence. These conditions are identified as "in remission" in ICD-10-CM.



Case 1.38

F10.20 **Dependence, (on) (syndrome), alcohol (ethyl) (methyl) (without remission)**

K29.20 **Gastritis (simple), alcoholic**

F14.21 **History, personal (of), drug dependence – see Dependence, drug, by type, in remission. Dependence, (on) (syndrome), drug, cocaine, in remission**

Rationale: Gastritis would not be considered an alcohol-induced “disorder” for the code F10.288 as it is not a mental disorder. The cocaine dependence is coded as “in remission” because there is not a history code for drug dependence.




Case 1.39

F60.3 **Disorder, personality, borderline**

F10.21 **Alcohol, alcoholic, alcohol-induced,
addiction, with remission**

Z79.899 **Long-term (current) (prophylactic) drug
therapy (use of), drug, specified NEC**

Rationale: The additional information of “cluster B personality disorder” does not affect code assignment. Cluster B personality disorders include dramatic, erratic behaviors and include Histrionic, Narcissistic, Antisocial and Borderline Personality Disorders.

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Coding Note: ICD-10-CM provides a code to indicate blood alcohol level. Under the category F10, there is a "use additional code" note for blood alcohol level. Blood alcohol level can be indexed in the Index to External Causes.

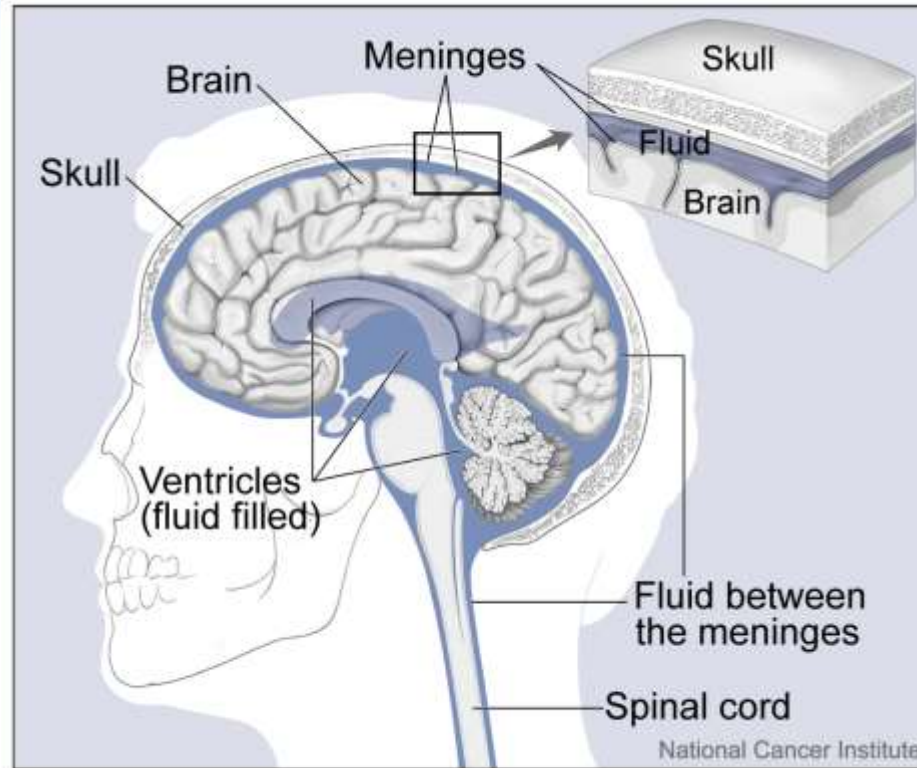


Case 1.40

F10.229 Intoxication, alcoholic (acute) (without dependence) –see Alcohol, intoxication. Alcohol, alcoholic, alcohol-induced, intoxication (acute) (without dependence), with, dependence

Y90.1 Index to External Causes, Blood alcohol level, 20–39mg/100ml

Rationale: A note under category F10, alcohol-related disorders, instructs the coder to “Use additional code for blood alcohol level, if applicable (Y90.-).” Continuous use of alcohol does not affect code assignment. The code F10.229 is assigned because there is no documentation that this is uncomplicated (F10.220). This might be an opportunity for a physician query for a more specific code.



Alan Hoofring

ICD-10-CM

DISEASES OF THE NERVOUS SYSTEM




- Category G81, G82, G83
 - Used only when listed conditions are reported without further specification or are stated to be old or longstanding, with unspecified cause
- Paralytic sequelae of infarct/stroke are in Chapter 9



- Epilepsy terminology updated
 - Localization-related idiopathic
 - Generalized idiopathic
 - Special epileptic syndromes
- Provides specificity for
 - Seizures of localized onset
 - Complex partial seizures
 - Intractable
 - Status epilepticus



Category G40 (Epilepsy and Recurrent Seizures) and G43 (Migraine)

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Note: The following terms are equivalent to intractable: pharmacoresistent (pharmacologically resistant), treatment resistant, refractory (medically), and poorly controlled.



Case 1.41

G30.0 **Alzheimer's disease or sclerosis, *see* Disease, Alzheimer's, early onset, with behavioral disturbance**

F02.81 **Dementia, in Alzheimer's disease, *see* Disease, Alzheimer's**

Z91.83 **Wandering, in diseases classified elsewhere**



Case 1.41 (continued):

Rationale: There is mandatory sequencing for these codes. The etiology (Alzheimer's disease) is sequenced first and the manifestation (dementia) is sequenced second. The Index provides the following documentation: Alzheimer's, early onset, with behavioral disturbance G30.0 [F02.81]. The use of the brackets in the Index indicates manifestation codes. Further, the note in the Tabular at the G30 category states to use an additional code to identify dementia with behavioral disturbance (F02.81). At the F02 category, the note states to code first the underlying physiological condition. The dementia is coded with behavioral disturbance because of the documentation of wandering off. At code F02.81, the note states to use additional code, if applicable, to identify wandering in dementia in conditions classified elsewhere (Z91.83). This code further specifies the behavioral disturbance as wandering off. Early onset Alzheimer's usually begins in middle age, before the age of 65.



Case 1.42

**G40.B19 Epilepsy, epileptic, epilepsia (attack)
(cerebral) (convulsion) (fit) (seizure), juvenile
myoclonic, intractable**

Rationale: The documentation indicates that the disorder is juvenile myoclonic epilepsy that is intractable. People with juvenile myoclonic epilepsy (JME) have myoclonic seizures which are identified as quick little jerks of the arms, shoulders, or occasionally the legs. The myoclonic jerks sometimes are followed by a tonic-clonic seizure. JME is one of the most common epilepsy syndromes, and makes up about 7 percent of all cases of epilepsy. JME may begin between late childhood and early adulthood, usually around the time of puberty.



Case 1.43

G81.94 Hemiplegia. Review Tabular for complete code assignment.

Rationale: Under the term Hemiplegia in the index, the only code option for this diagnosis is G81.9-. Review the Tabular under G81.9-, which offers five code choices. Coding Guideline I.C.6.a states, “Should the affected side be documented, but not specified as dominant or nondominant and the classification system does not indicate a default, code selection is as follows: If the left side is affected the default is nondominant.”



Case 1.44

G00.1 **Meningitis, pneumococcal**

J13 **Pneumonia, pneumococcal, (broncho)
(lobar)**

Rationale: The patient had both meningitis and pneumonia, so both conditions should be coded. Both conditions were present at the time of admission; therefore, either the meningitis or pneumonia could be listed as the principal diagnosis. ICD-10-CM guidelines indicate that when there are two or more diagnoses equally meeting the criteria for principal diagnosis as determined by the circumstances of admission, any one of the diagnoses may be sequenced first.



Case 1.45

**G21.11 Parkinsonism (idiopathic) (primary),
secondary, due to drugs, neuroleptic**

**T43.4X5A Refer to Drug and Chemical Table,
Haloperidol, adverse effect**

F20.0 Schizophrenia, paranoid (type)

Rationale: The documentation implies that this is the initial encounter, so the seventh character A is assigned. There is no evidence that the drug was taken incorrectly, so adverse effect is selected. If there is any doubt, a query could be in order. The note at G21.11, Neuroleptic induced Parkinsonism, states to use additional code for adverse effect, if applicable, to identify drug (T43.3X5, T43.4X5, T43.505, T43.595). (T43.3-T43.5)



Case 1.45 (continued):

Haloperidol is an antipsychotic used in the treatment of schizophrenia and other conditions. The subcategory for T43.4 is Poisoning by, adverse effect of and underdosing of butyrophenone and thiothixene neuroleptics; neuroleptic is another word for antipsychotic. A common cause of secondary Parkinsonism is medications such as antipsychotics, metoclopramide, and Phenothiazine.



Case 1.46

G89.3 **Pain (*see also* Painful), acute, neoplasm related**

C50.911 **Refer to Neoplasm Table, by site, breast, malignant, primary site**

C78.7 **Refer to Neoplasm Table, by site, liver, malignant, secondary site**

Rationale: ICD-10-CM Coding Guideline I.C.6.b.5. states that code G89.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy or tumor. This code may be assigned as the principal or first-listed code when the stated reason for the encounter is pain control or pain management. The underlying neoplasm should be reported as an additional diagnosis.



Case 1.47

G45.9 **Attack, attacks, transient ischemic (TIA)**

E11.40 **Diabetes, diabetic (mellitus) (sugar), type 2, with, neuropathy**

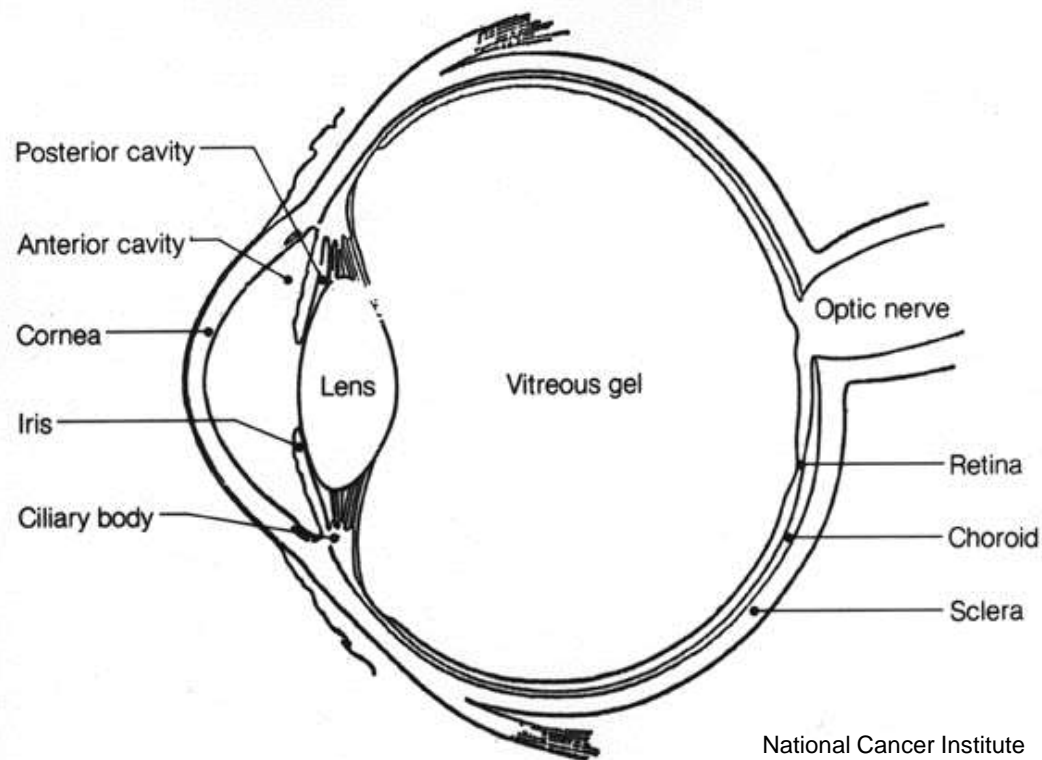
G43.119 **Migraine, classical – *see* Migraine, with aura**

Migraine, with aura, intractable



Case 1.47 (continued):

Rationale: The TIA is the first listed diagnosis as it was the reason for the encounter. The migraine is documented as classical. In ICD-10-CM, classical migraine is classified to with aura. An aura is a visual, motor, or cognitive phenomenon that prefaces the headache. An intractable migraine indicates that it is sustained and severe and not effectively terminated by standard outpatient interventions. ICD-10-CM also provides codes for with, without, or unspecified status migrainosus. Status migrainosus normally indicates a migraine attack lasting for more than 72 hours.



National Cancer Institute

ICD-10-CM

DISEASES OF THE EYE AND ADNEXA



- Concept of laterality
 - Right
 - Left
 - Bilateral
 - Unspecified

If bilateral is not available, assign code for right and left.





Case 1.48

H01.001 **Blepharitis (angularis) (ciliaris) (eyelid) (marginal) (nonulcerative), right, upper**

H01.004 **Blepharitis (angularis) (ciliaris) (eyelid) (marginal) (nonulcerative), left, upper**

Rationale: Blepharitis is an inflammation of the eyelash follicles along the edge of the eyelid.

In ICD-10-CM, blepharitis is subdivided between right and left eyes and also upper and lower eyelids.



Case 1.49

**H11.063 Pterygium (eye), recurrent. See
Tabular for correct code assignment.**

Rationale: Pterygium is a non-cancerous growth of the clear, thin tissue that lies over the conjunctiva. No treatment is required unless the pterygium begins to block vision. ICD-10-CM provides codes to identify pterygium of the left, right, or bilateral eyes.



Case 1.50

**H25.12 Cataract (cortical) (immature)
(incipient), age-related – *see* Cataract,
senile, nuclear (sclerosis)**

Rationale: With a diagnosis of age-related cataract, ICD-10-CM directs the coder to “senile cataract,” which is further specified by right, left, or bilateral.



Case 1.51

H40.11X2

**Glaucoma, open angle, primary.
See Tabular for complete code
assignment.**

Rationale: Review of the tabular at code H40.11 indicates the need for a seventh character to designate the stage of the glaucoma. Primary open-angle glaucoma is characterized by visual field abnormalities and intraocular pressure that is too high for the continued health of the eye. In this case, ICD-10-CM does not have separate codes to identify specific eyes.



Case 1.52

H59.012 Keratopathy, bullous (aphakic), following cataract surgery

Rationale: Bullous keratopathy, or corneal edema, is often a sequela of cataract extraction. In ICD-10-CM, codes for both keratopathy and keratopathy due to cataract surgery are provided. These codes are further subdivided by laterality.



Case 1.53

H25.011 **Cataract (cortical) (immature) (incipient), age-related, *see* Cataract, senile, cortical**

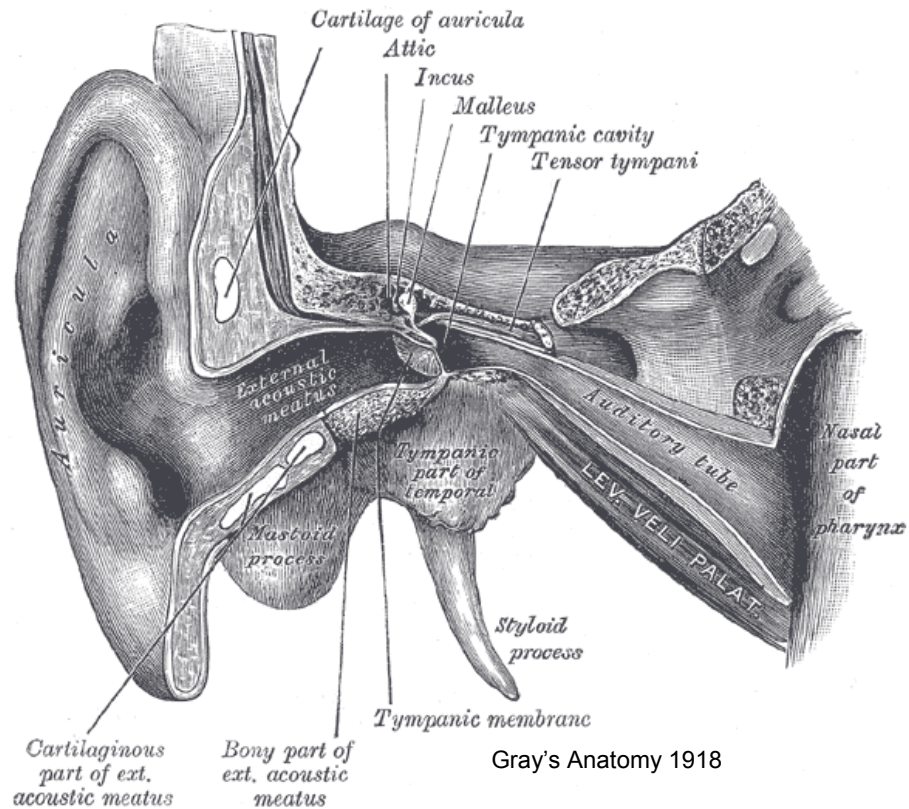
H59.311 **Hemorrhage, postoperative, *see* Complications, postprocedural, hemorrhage, by site
Complication(s) (from) (of), postprocedural, hemorrhage (hematoma) (of), eye and adnexa, following ophthalmic procedure**

Y92.530 **Index to External Causes, Place of occurrence, outpatient surgery center**



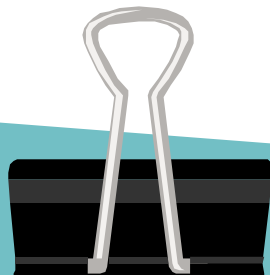
Case 1.53 (continued):

Rationale: Complication codes in ICD-10-CM are differentiated between intraoperative and postoperative. In this case, the primary diagnosis is the cataract and the postoperative complication is listed as a secondary diagnosis. A place of occurrence code may be added to indicate that this occurred in a day surgery center, but is not required. Coding Guideline I.C.20 states there is no national requirement for mandatory ICD-10-CM external cause code reporting. This code includes an outpatient surgery center connected with a hospital. Per Coding Guideline I.C.19.g.4, an external cause of injury code is not required as the complication code has the external cause included in the code.



ICD-10-CM

DISEASES OF THE EAR AND MASTOID PROCESS

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Note: Chapter note states to use an external cause code following the code for ear condition, if applicable to identify the cause of the ear condition.

- Otitis media
- Use additional code for any associated perforated tympanic membrane (H72.-)
- Use additional code to identify:
 - Exposure to environmental tobacco smoke (Z77.22)
 - Exposure to tobacco smoke in the perinatal period (P96.81)
 - History of tobacco use (Z87.891)
 - Occupational exposure to environmental tobacco smoke (Z57.31)
 - Tobacco dependence (F17.-)
 - Tobacco use (Z72.0)





Case 1.54

- H65.02** **Otitis (acute), media (hemorrhagic) (staphylococcal) (streptococcal) acute, subacute serous – *see* Otitis, media, nonsuppurative, acute, serous. Otitis media, nonsuppurative, acute or subacute, serous**
- H66.91** **Otitis (acute), media (hemorrhagic) (staphylococcal) (streptococcal), chronic**
- H72.821** **Perforation, perforated (nontraumatic) (of), tympanum, tympanic (membrane) (persistent post-traumatic) (postinflammatory), total**



Case 1.54 (continued):

Rationale: Otitis media has an expansion of codes in ICD-10-CM to classify these conditions. Laterality is also part of the classification in ICD-10-CM. In category H65, distinction is made between recurrent infections. A note is present stating that an additional code for any associated perforated tympanic membrane should be coded separately. It is then possible to show which tympanic membrane is perforated by assigning the correct code for right side associated with the chronic otitis media. Otitis media refers to inflammation of the middle ear (area between ear drum and inner ear including the eustachian tube). Serous otitis involves a collection of fluid that occurs in the middle ear space caused by altered eustachian tube function. This is also referred to as secretory or with effusion.



Case 1.55

H81.02 **Vertigo, Ménière's – *see* subcategory H81.0**

Rationale: The Index provides the category and the Tabular provides the specific laterality. Ménière's disease involves the inner ear and symptoms are vertigo, tinnitus, and a feeling of fullness or pressure in the ear.



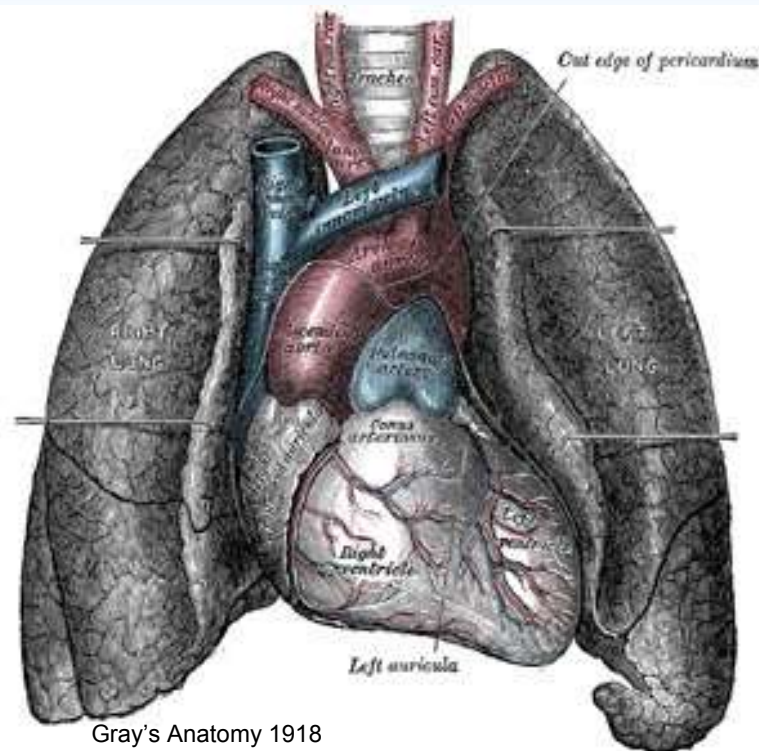
Case 1.56

- H80.03** **Otosclerosis (general) involving oval window, nonobliterative**
- H90.0** **Loss (of), hearing – *see* also Deafness. Deafness, conductive, bilateral**
- H95.31** **Complication(s), ear procedure, laceration – *see* Complications, intraoperative, puncture or laceration, ear. Complication(s) intraoperative, puncture or laceration (accidental) (unintentional) (of) ear, during procedure on ear and mastoid process**
- Y92.234** **Index to External Causes, Place of occurrence, hospital, operating room**



Case 1.56 (continued)

Rationale: The otosclerosis is listed first since it is the underlying condition causing the hearing loss, and absent any sequencing instruction in the classification system. Note that there are intraoperative and postprocedural complications available. Subcategory H95.3 provides codes for accidental puncture and laceration of the ear and mastoid process when a procedure on the ear and mastoid process was being performed (H95.31) and for accidental puncture and laceration of ear and mastoid process during other procedures. The cause of the complication is included in the complication code H95.31; therefore, an additional external cause code is not required. A place of occurrence code, however, can be assigned.



ICD-10-CM

DISEASES OF THE CIRCULATORY SYSTEM



What's New?



- Type of **hypertension** not used as an axis
- **Acute MI** codes changed from 8 weeks to **4 weeks** or less



AMI

- **I21** – Initial AMIs
- **I22** – Subsequent AMIs
 - A code from category **I22** must be **used in conjunction** with a code from category **I21**.
 - Category **I22** is **never used alone**.
 - The **sequencing** of the **I22** and **I21** codes depends on the circumstances of the encounter.

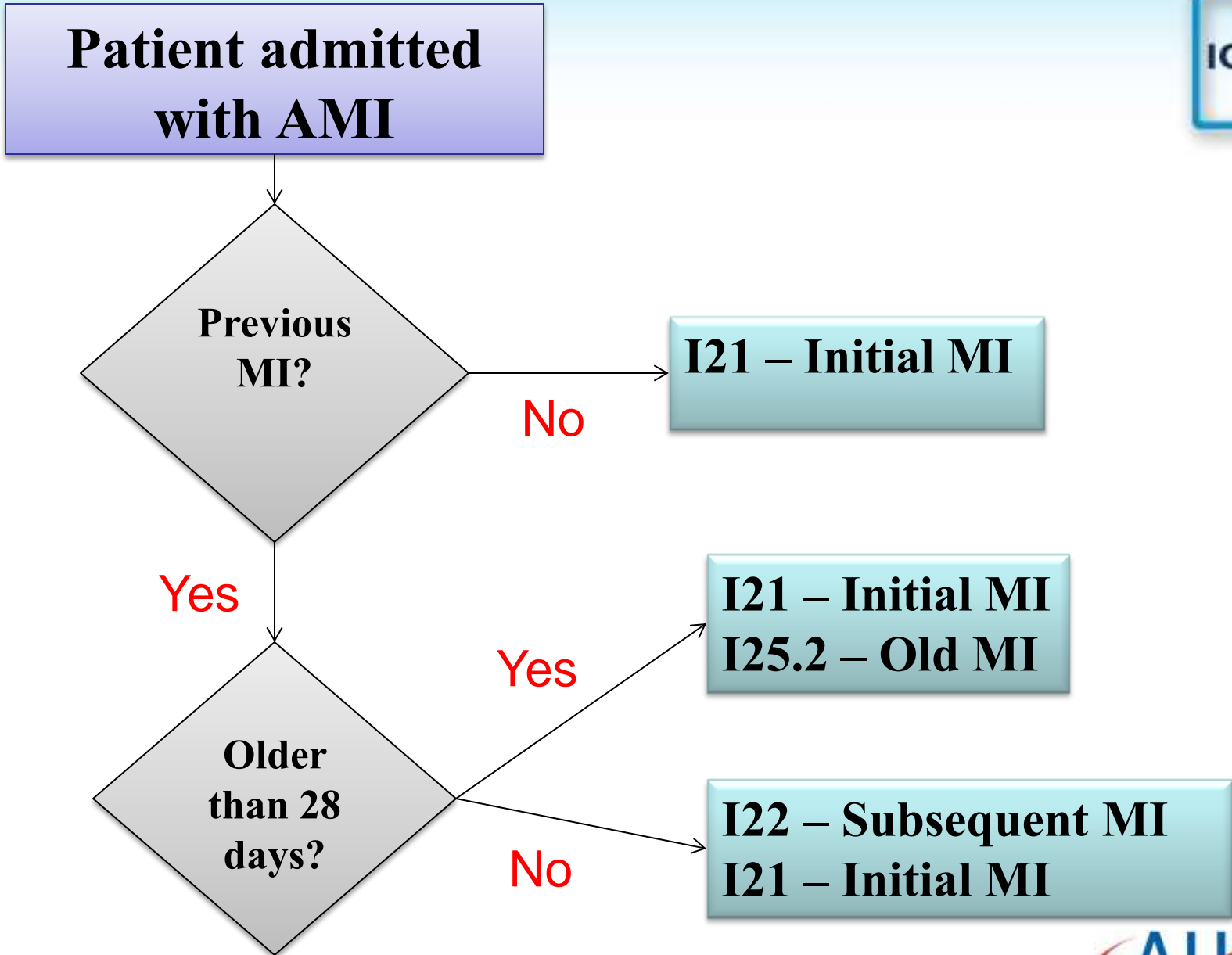
Category I22



- A code from category I22 must be used in conjunction with a code from category I21.
- Category I22 is never used alone.
- The sequencing of the I22 and I21 codes depends on the circumstances of the encounter.



PREPARATION IS THE KEY TO SUCCESS



Note: Sequencing depends on circumstances of admission





Case 1.57

**I10 Hypertension, hypertensive,
(accelerated) (benign) (essential)
(idiopathic) (malignant) (systemic)**

Rationale: ICD-10-CM does not differentiate between benign and malignant hypertension.



Case 1.58

I13.0 **Hypertension, hypertensive, (accelerated) (benign) (essential) (idiopathic) (malignant) (systemic), cardiorenal (disease), with heart failure, with stage 1 through stage 4 chronic kidney disease**

I50.9 **Failure, failed, heart (acute) (senile) (sudden), congestive (compensated) (decompensated)**

N18.3 **Disease, diseased, kidney (functional) (pelvis), chronic, stage 3 (moderate)**



Case 1.58 (continued):

Rationale: In ICD-10-CM, a combination code is used to identify those diagnoses that include hypertensive heart and kidney disease. Under I13.0 there is a “use additional code” note to identify both the type of heart failure and the stage of chronic kidney disease. The cross-reference under Disease, diseased – *see also* syndrome did not reveal any additional information. The term Kidney is represented under Disease, diseased.



Case 1.59

I21.4 Infarct, Infarction, myocardium, myocardial (acute) (with stated duration of 4 weeks or less), non-ST elevation (NSTEMI)

I48.0 Fibrillation, atrial or auricular (established)



Case 1.59 (continued):

Rationale: Per the Official Coding Guidelines, “If an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as a subendocardial AMI.” The STEMI and NSTEMI are treated differently. Generally, the STEMI is caused by complete obstruction of the coronary artery, and causes damage that involved the full thickness of the heart muscle, while the NSTEMI is caused by a partial obstruction and the damage does not involve the full thickness of the heart wall.



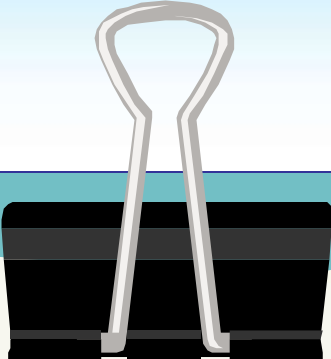
Case 1.60

- I22.1** **Infarct, Infarction, myocardium, myocardial (acute) (with stated duration of 4 weeks or less), subsequent (recurrent) (reinfarction), inferior (diaphragmatic) (inferolateral) (inferoposterior) (wall)**
- I21.4** **Infarct, Infarction, myocardium, myocardial (acute) (with stated duration of 4 weeks or less), non-ST elevation (NSTEMI)**
- I48.0** **Fibrillation, atrial or auricular (established)**



Case 1.60 (continued):

Rationale: The Official Coding Guidelines specifically address the sequencing of I22 and I21 and this is stated as: “The sequencing of the I22 and I21 codes depends on the circumstances of the encounter.”

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Coding Note: A code from category I23 must be used in conjunction with a code from category I22. The I23 code should be sequenced first, if it is the reason for encounter, or, it should be sequenced after the I21 or I22 code if the complication of the MI occurs during the encounter for the MI.



Case 1.61

I23.7 Angina (attack) (cardiac) (chest) (heart) (pectoris) (syndrome) (vasomotor), post-infarctional

I21.09 Infarct, infarction, myocardium, myocardial (acute) (with stated duration of 4 weeks or less), ST elevation (STEMI), anterior (anteroapical) (anterolateral) (anteroseptal) (Q wave) (wall)

Rationale: ICD-10-CM provides a category (I23) to identify current complications following STEMI and NSTEMI. A code from category I23 must be used in conjunction with a code from category I21 or category I22. The I23 code should be sequenced first if it is the reason for encounter. A note appears in the Tabular under category I23 regarding the use of this code category.



Case 1.62

I25.119 **Disease, diseased, coronary (artery) – see Disease, heart, ischemic, atherosclerotic (of), with angina pectoris – see Arteriosclerosis, coronary (artery), native vessel, with angina pectoris**

Rationale: ICD-10-CM has combination codes for atherosclerotic heart disease with angina pectoris. There are subcategories for disease of the native artery, coronary artery bypass graft(s), and coronary artery of transplanted heart. It is not necessary to use an additional code for angina pectoris when using these combination codes.



Case 1.63

- I25.110** **Angina (attack) (cardiac) (chest) (heart) (pectoris) (syndrome) (vasomotor), with atherosclerotic heart disease – see Arteriosclerosis, coronary (artery), native vessel with angina pectoris, unstable**
- I69.351** **Hemiparesis – see Hemiplegia, following, cerebrovascular disease, cerebral infarction**
- Z95.1** **Status (post), aortocoronary bypass**



Case 1.63 (continued):

Rationale: The coronary artery disease of the native vessel is coded because the previous cardiac catheterization showed that the bypass grafts are patent. Also, per the Official Coding Guidelines, “ICD-10-CM has combination codes for atherosclerotic heart disease with angina pectoris. When using one of these combination codes it is not necessary to use 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 atherosclerosis.”



Case 1.64

I50.33 Failure, failed, heart (acute) (senile) (sudden), diastolic (congestive), acute (congestive), and (on) chronic (congestive)

Rationale: An additional code for congestive heart failure is not required, as “congestive” is already identified in the above code.



Case 1.65

I63.322 **Infarct, infarction, cerebral – (*see also* Occlusion, artery, cerebral or precerebral, with infarction). Occlusion, artery, cerebral, anterior, with infarction, due to, thrombosis OR Infarct, infarction, cerebral, due to thrombosis, cerebral artery. Review the Tabular for correct code assignment.**

G81.91 **Hemiplegia. Review the Tabular for correct code assignment.**



Case 1.65 (continued):

Rationale: It is necessary to review the Tabular for complete code assignment for both the cerebral infarction and the hemiplegia. If the record and the classification system does not indicate a default, the default should be dominant for hemiplegia. Coding Guideline I.C.6.a. states, “Should this information not be available in the record, and the classification system does not indicate a default, the default should be dominant.”



Case 1.66

I69.354 Hemiparesis – *see* Hemiplegia, following, cerebrovascular disease, stroke

I69.320 Aphasia, following cerebrovascular disease, cerebral infarction

Rationale: Category I69 is used to indicate neurological deficits that persist after initial onset of conditions classifiable to categories I60-I67. The left is specified as the side of the hemiparesis. After reviewing the Index, it is necessary to select the correct code for subcategory I69.35 from the Tabular.



Case 1.67

I25.110 Angina (attack) (cardiac) (chest) (heart) (pectoris) (syndrome) (vasomotor), with atherosclerotic heart disease – see Arteriosclerosis, coronary (artery), native vessel with angina pectoris, unstable

I25.2 Infarct, infarction, myocardium, myocardial, healed or old

Rationale: Crescendo angina is included in unstable angina, *see* the Index, Angina, crescendo – *see* Angina, unstable.



Case 1.68

I25.720 **Atherosclerosis - *see also* Arteriosclerosis, coronary artery, with angina pectoris, - *see* Arteriosclerosis, coronary (artery), bypass graft, autologous artery, with, angina pectoris, unstable**

I11.0 **Failure, failed, heart (acute) (senile) (sudden), hypertensive – *see* Hypertension, heart (disease) (conditions in I51.4-I51.9 due to hypertension), with, heart failure (congestive)**

I50.9 **Failure, failed, heart (acute) (senile) (sudden) congestive (compensated)**



Case 1.68 (continued):

Rationale: ICD-10-CM differentiates between the different types of bypassed coronary arteries, including native arteries, autologous vein, autologous artery, and nonautologous graft material. Hypertensive congestive heart failure requires two diagnosis codes to correctly identify the condition. The note at code I11.0 states “Use additional code to identify type of heart failure (I50.-).”



Case 1.69

I21.19 Infarct, infarction, myocardium, myocardial (acute) (with stated duration of 4 weeks or less), ST elevation (STEMI), inferior (diaphragmatic) (inferolateral) (inferoposterior) (wall), NEC

I23.0 Hemopericardium, following acute myocardial infarction (current complication)



Case 1.69 (continued):

Rationale: The ICD-10-CM codes for acute myocardial infarction identify the site.

Subcategory I21.1 is used for ST elevation myocardial infarction of the inferior wall. A code from category I23 must be used in conjunction with a code from category I21 or category I22. The I23 code should be sequenced after the I21 or I22 code if the complication of the MI occurs during the encounter for the MI.



Case 1.70

I63.442 **Infarct, infarction, cerebellar – *see* Infarct, cerebral. (*See also* Occlusion, artery, cerebral, or precerebral, with infarction). Occlusion, occluded artery, cerebellar (anterior inferior) (posterior inferior) (superior) with infarction, due to, embolism. Review the Tabular for complete and correct code assignment.**

R13.10 **Dysphagia**

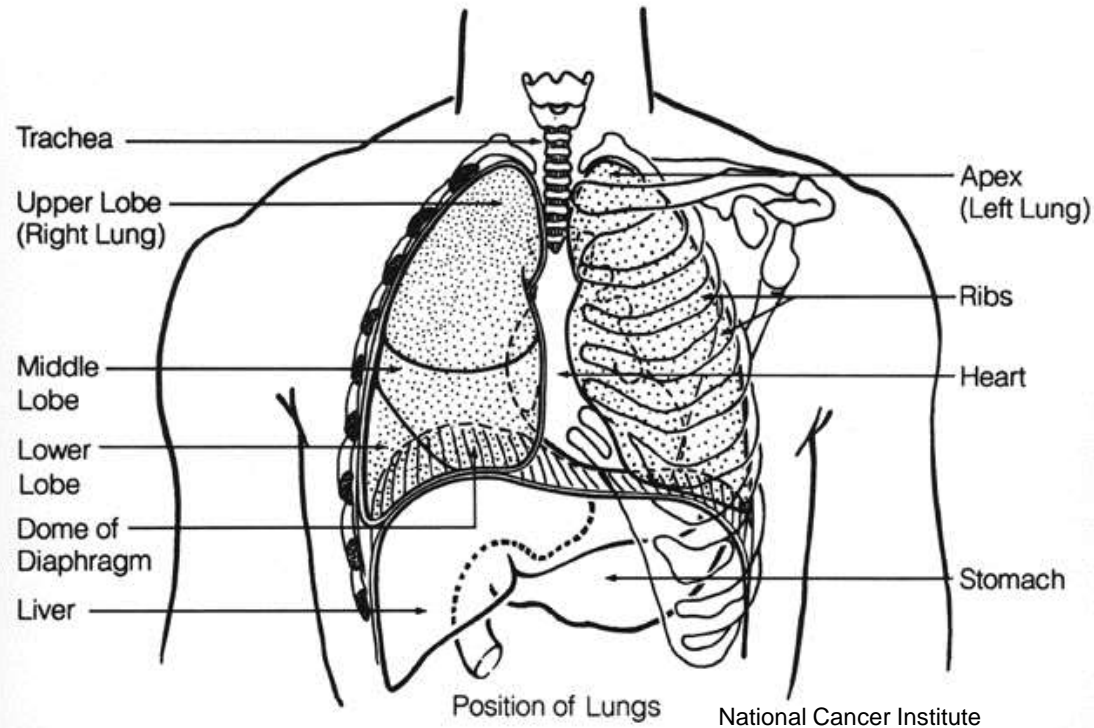
G81.91 **Hemiplegia. Review Tabular for complete code assignment.**



Case 1.70 (continued):

Rationale: ICD-10-CM provides specific codes to identify the involved artery in a cerebrovascular infarction. There is a note under code I69.391 to “use additional code” to identify type of dysphagia, if known (R13.1-). Right dominant side (G81.91) was selected based on Coding Guideline I.C.6.a which states “should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows: if the right side is affected the default is dominant.” Codes from category I69 are not used in this scenario, as the Dysphagia and hemiplegia are acute deficits from the current CVA.

ICD-10-CM



DISEASES OF THE RESPIRATORY SYSTEM



- New terminology for asthma
- Respiratory condition in more than 1 site (not specifically indexed) classified to lower anatomic site
- Additional code notes



Case 1.71:

**J14 Pneumonia (acute) (double)
(migratory) (purulent) (septic)
(unresolved), Hemophilus influenza
(broncho) (lobar)**

Rationale: The H. influenza pneumonia is coded to J14. The symptoms are not coded because they are inherent in the pneumonia code.



Case 1.72

- J44.1** **Disease, diseased, pulmonary, chronic obstructive, with exacerbation (acute)**
- F17.200** **Dependence (on) (syndrome), tobacco – *see* dependence, drug, nicotine**
- Z71.6** **Counseling (for), substance abuse, tobacco**

Rationale: The acute respiratory insufficiency is a symptom that is an integral part of the COPD and is not coded.



Case 1.73

J45.51 Asthma, asthmatic (bronchial) (catarrh) (spasmodic), persistent, severe, with exacerbation (acute)

Rationale: There are categories of the three degrees of persistent asthma, with the ability to identify with or without exacerbation and status asthmaticus.

PREPARATION IS THE KEY TO SUCCESS



Asthma Severity	Frequency of Daytime Symptoms
Intermittent	Less than or equal to 2 times per week
Mild Persistent	More than 2 times per week
Moderate Persistent	Daily. May restrict physical activity
Severe Persistent	Throughout the day. Frequent severe attacks limiting ability to breathe.



Case 1.74

J96.00

Failure, respiration, respiratory, acute

J44.0

Bronchitis (diffuse) (fibrinous) (hypostatic) (infective) (membranous) (with tracheitis), acute or subacute, with chronic obstructive pulmonary disease

J20.9

Bronchitis (diffuse) (fibrinous) (hypostatic) (infective) (membranous), acute or subacute

J44.1

Disease, diseased, pulmonary, chronic obstructive, with, exacerbation (acute)



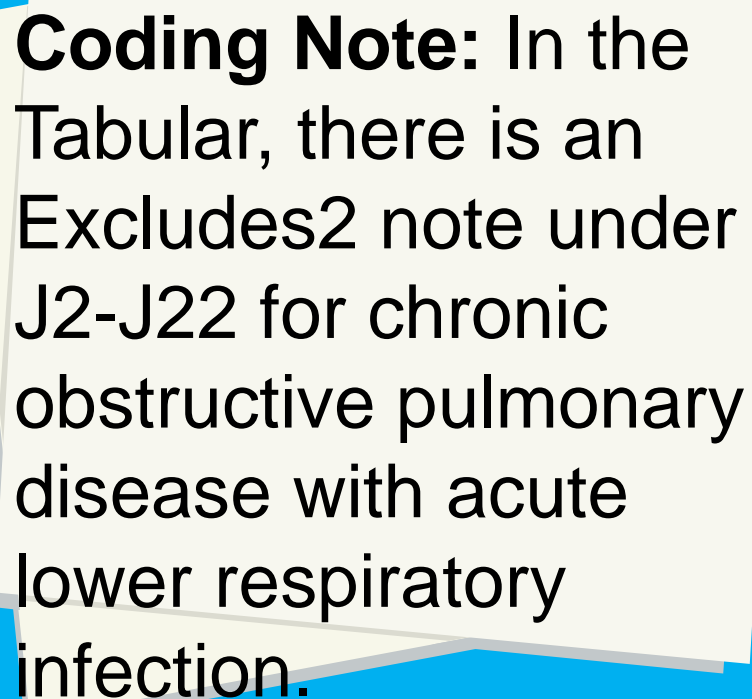
Case 1.74 (continued):

Rationale: Review Coding Guidelines I.C.10.b.1-3 regarding sequencing of respiratory failure. Code J96.00 may be assigned as the principal diagnosis when it is the condition established after study to be chiefly responsible for occasioning the admission to the hospital, and the selection is supported by the Index and Tabular. In this case, no other guidelines conflict, such as obstetrics, poisoning, HIV, and such. The patient was started on mechanical ventilation in the ER. The documentation is limited in this brief scenario, however, so if there was any doubt about the correct sequencing, the physician should be queried. Code J20.9 is added to identify the infection (acute bronchitis). Under J44.0, there is a note: “Use additional code to identify the infection.”



Case 1.74 (continued):

There is an *Excludes2* in the tabular under (J20-J22) for chronic obstructive pulmonary disease with acute lower respiratory infection.— *Excludes2*: COPD with acute lower respiratory infection (J44.0). Both codes J44.0 and J20.9 are necessary to correctly code the acute bronchitis with COPD. Code J44.1 is added as an additional code to identify the COPD exacerbation. There is an *Excludes2* note under J44.1, but both codes can be assigned when both acute bronchitis and an acute exacerbation are documented. The Index entries also show COPD with acute bronchitis and acute exacerbation at the same indentation level, meaning that one doesn't include the other.

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Coding Note: In the Tabular, there is an Excludes2 note under J2-J22 for chronic obstructive pulmonary disease with acute lower respiratory infection.



Case 1.75

J69.0 **Pneumonia, aspiration, due to food
(regurgitated)**

K21.9 **Reflux, gastroesophageal**

Rationale: The chest rales, dyspnea, cyanosis, and hypotension are all symptoms of aspiration pneumonia and are not assigned codes. The gastroesophageal reflux contributed to the condition and should be coded.

Case 1.76



J09.X2 Influenza (bronchial) (epidemic) (respiratory) (upper) (unidentified influenza virus), due to identified novel influenza A virus, with, respiratory manifestations, NE

Rationale: Coding Guideline I.C.10.c. states that only confirmed cases of influenza due to certain identified viruses (category J09) are coded. This is an exception to the hospital inpatient guideline Section II, H. In this context, “confirmation” does not require documentation of positive laboratory testing specific for avian or other novel influenza A. However, coding should be based on the provider’s diagnostic statement. In this case, there is no documentation that a laboratory test confirmed the novel influenza A virus, but the statement was documented as a confirmed diagnosis, not “possible,” “probable,” or other such terms. ICD-10-CM provides some combination codes for associated manifestations (respiratory, gastroenteritis, other).



Case 1.77

- J43.9** **Emphysema (atrophic) (bullous) (chronic) (interlobular) (lung) (obstructive) (pulmonary) (senile) (vesicular)**
- I50.9** **Failure, failed, heart (acute) (senile) (sudden), congestive (compensated) (decompensated)**
- I10** **Hypertension, hypertensive (accelerated) (benign) (essential) (idiopathic) (malignant) (systemic)**
- I48.0** **Fibrillation, atrial or auricular (established)**



Case 1.77 (continued):

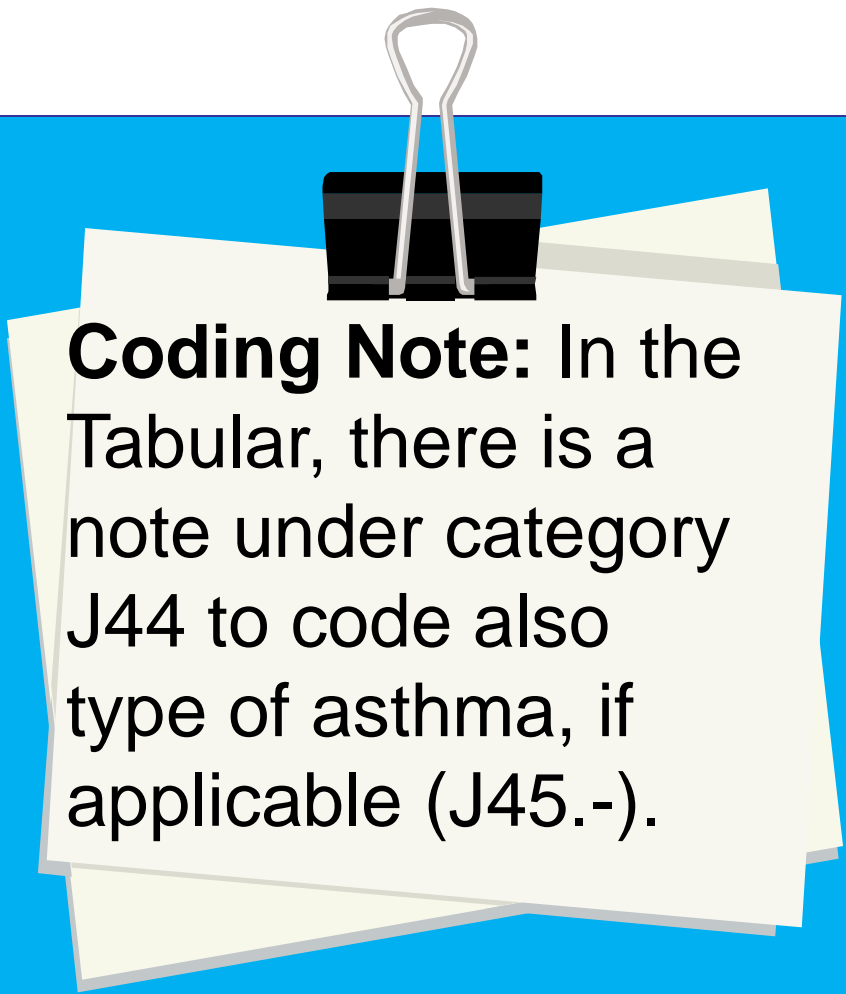
Rationale: Code J43.9 includes the COPD as indicated by the nonessential modifiers. Additionally, there is an Excludes1 note under J44 (COPD) for emphysema (J43.-). Follow Index and Tabular carefully. When indexing COPD via Disease, lung, obstructive (chronic) there is a subterm with emphysema (J44.9). When verifying J44.9 in the Tabular there is an *Excludes1* note: J44 *Excludes1*: emphysema without chronic bronchitis (J43.X). The emphysema in category J44 would be emphysema **with** chronic bronchitis.



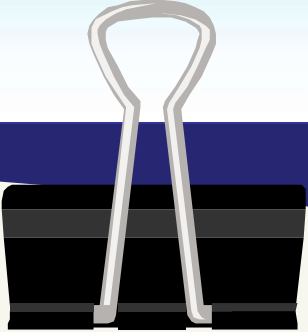
Case 1.77 (continued):

When verifying J43.9 in the Tabular there is an *Excludes 1* note: emphysema with chronic (obstructive) bronchitis (J44.x). To differentiate these two categories with emphysema, chronic bronchitis is key and must be documented. In this case, follow the Tabular, not the Index.

The CHF and hypertension are coded with two codes since there is no stated causal relationship. ICD-10-CM Coding Guidelines state that if heart conditions (I50.-, I51.4 – I51.9) with hypertension do not have a documented causal relationship, the conditions are coded separately.

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Coding Note: In the Tabular, there is a note under category J44 to code also type of asthma, if applicable (J45.-).

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Coding Note: In the Tabular there is an *Excludes2* note under category J45 for asthma with chronic obstructive pulmonary disease. By definition, when an *Excludes2* note appears under a code, it is acceptable to use both the code and the excluded code together if the patient has both conditions at the same time.



Case 1.78

J45.42

Asthma, asthmatic, moderate persistent, with, status asthmaticus

J44.1

Disease, lung, obstructive (chronic), with, acute, exacerbation NEC



Case 1.78 (continued):

Rationale: An instructional note under category J44 provides instructions to “code also type of asthma, if applicable (J45.42).” An *Excludes2* note appears under J45 for “asthma with chronic obstructive pulmonary disease.” A type 2 “excludes note” represents “not included here.” An *Excludes2* note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an *Excludes2* note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate. The “code also” note does not provide sequencing direction.



Case 1.79

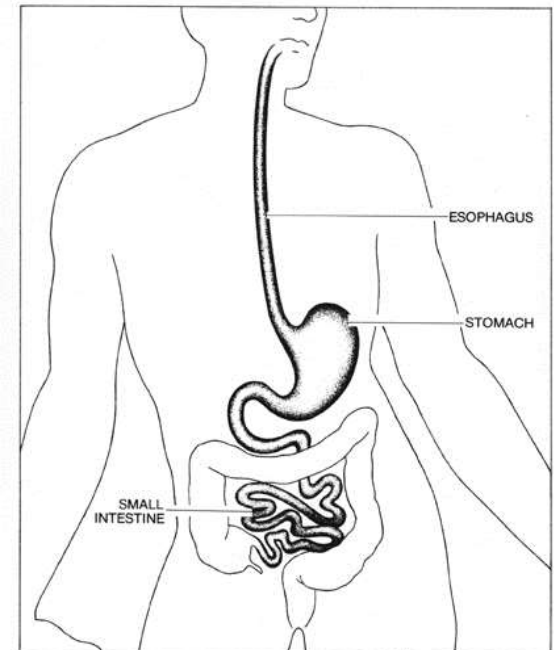
E86.0 Dehydration

**J43.9 Emphysema (atrophic) (bullous)
(chronic) (interlobular) (lung)
(obstructive) (pulmonary) (senile)
(vesicular)**

Z99.11 Dependence, on, ventilator

Rationale: The dehydration is the reason for admission and therefore should be listed as the principal diagnosis.

Coding Note: A note appears in the Tabular under code I69.391 to use an additional code to identify the type of dysphagia, if known (R13.1-).



National Cancer Institute



Case 1.80

- J69.0** **Pneumonia, aspiration, due to food (regurgitated)**
- I69.391** **Dysphagia, following, cerebrovascular disease, cerebral infarction**
- R13.19** **Dysphagia, neurogenic**
- L89.211** **Ulcer, decubitus – *see* Ulcer, pressure by site
Ulcer, pressure, stage 1 (healing) (pre-ulcer skin changes limited to persistent focal edema), hip, right**
- L89.221** **Ulcer, pressure, Ulcer, pressure, stage 1 (healing) (pre-ulcer skin changes limited to persistent focal edema), hip, left**



Case 1.80 (continued):

Rationale: The documentation substantiates the assignment of aspiration pneumonia as the first listed diagnosis. The neurogenic dysphagia is due to an old cerebral infarction and should be coded. R13.19 is coded in addition to I69.391 due to an instructional note under I69.391 stating “Use additional code to identify the type of dysphagia, if known (R13.1-).” Two decubitus ulcer codes are required since the patient has ulcers of both the right and left hip. L89.211 is pressure ulcer of the right hip, stage 1 and L89.221 is pressure ulcer of the left hip, stage, 1.