Chapter Three

ICD-10-CM GENERAL CODING CONVENTIONS

ICD-10-CM (International Classification of Diseases, 10th version, Coding Modification) coding is used to report diagnoses, signs, symptoms and ill-defined conditions of a patient seeking medical treatment. In other words, the coding system reports what is wrong with the patient seeking treatment.

In order to ensure that the most specific and accurate diagnosis codes are reported, coders must be aware of the more specific notes and conventions contained within each individual volume of the ICD-10-CM book. The most important notes are described in the introductory section of all ICD-10-CM publications. These instructions are called "coding conventions".

The coding conventions include symbols as well as abbreviations and special notes that are contained throughout Volume I of the ICD-10 book. Volume II coding conventions include tables that provide additional reference for coders to accurately code for specific symptoms or established diagnoses.

Each ICD-10-CM publisher may have their own unique coding conventions; however, all ICD-10-CM publications, regardless of the publisher, include the standard coding conventions developed by the World Health Organization (WHO). These conventions make ICD-10-CM coding more accurate as well as more efficient.

In this chapter, coding conventions for both the alphabetic (Volume II) and numeric (Volume I) indexes are discussed in detail. Since Volume II is listed first in the ICD-10-CM manual, let's start with this volume.

ICD-10-CM Coding Conventions

There are a number of coding conventions that are used in both volumes of ICD-10. In this section, the focus will be coding conventions that are found in Volume I and Volume II of ICD-10-CM.

The coding conventions are used to provide more detailed guidance to coders when searching for code narratives and the equivalent numeric code associated with these narratives. Key coding conventions may be found in Volume I, Volume II or within both volumes. The following list provides standard coding conventions available throughout the ICD-10-CM coding system.

- ✓ **Format**, such as indenting
- ✓ **Abbreviations** such as NEC and NOS
- ✓ **Punctuation** such as colons and commas
- ✓ "**Includes**" and "**Excludes**" Notes and Inclusion Terms
- ✓ **Other** and **Unspecified** Codes
- ✓ **References** such as "See," and "See Also"
- ✓ **Phrases** such as Use Additional Code, and Code First
- ✓ **Brackets and Parentheses** [ ], *[ ]*, ( ),
- ✓ **"With" and "Without"** designation

ICD-10-CM Volume II Coding Convention Definitions

Volume II coding conventions can be found throughout the alphabetic index within ICD-10-CM. These coding conventions provide coders with additional guidance for choosing the correct Volume II narrative or phrase code lookup within a specific diagnosis category. Volume II may have one or more of the following symbols and/or additional instruction codes.

Symbols

[ ] ***Brackets:*** Utilized to identify manifestation codes of the diagnosis code being reported (i.e. Alzheimer's G30.9 [F02.80]).

▽ ***Subterms Yield:*** Sub-terms under the main category term may continue on next page or column.

√ ***Additional character required:*** Indicates code requires additional fourth, fifth, or sixth digit (the number is designated in the symbol).

( ) ***Parentheses:*** Parentheses enclose supplementary words that may be present or absent in the statement of a procedure or disease without affecting code assignment (i.e.: Conjunctivitis, (staphylococcal) (streptococcal)).

NEC: "Not Elsewhere Classifiable" identifies codes and terms that are to be used only when you lack the information necessary to code the diagnosis to a more specific category. This again is not justification for information not provided by a physician on an encounter form or when the diagnosis is not documented in the medical record. The NEC note indicates that the ICD-10-CM publication itself does not provide a more specific specification than the code being reported. The note may also indicate that the physician did not have enough information to be more specific, such as the need to wait for old records to substantiate the patient's recollection of their diagnosis (i.e.: Complication, mechanical, implant, stent NEC T85.698A)

Instructional Notes

Notes are listed throughout Volume II of ICD-10-CM. These notes are provided to assist the coder in further defining included terms that the code reference refers to, so that the coder isn't required to look up additional individual terms that would be included in the same numeric code assignment (i.e.: Capsulitis (joint), adhesive, (shoulder) M75.0).

Cross References

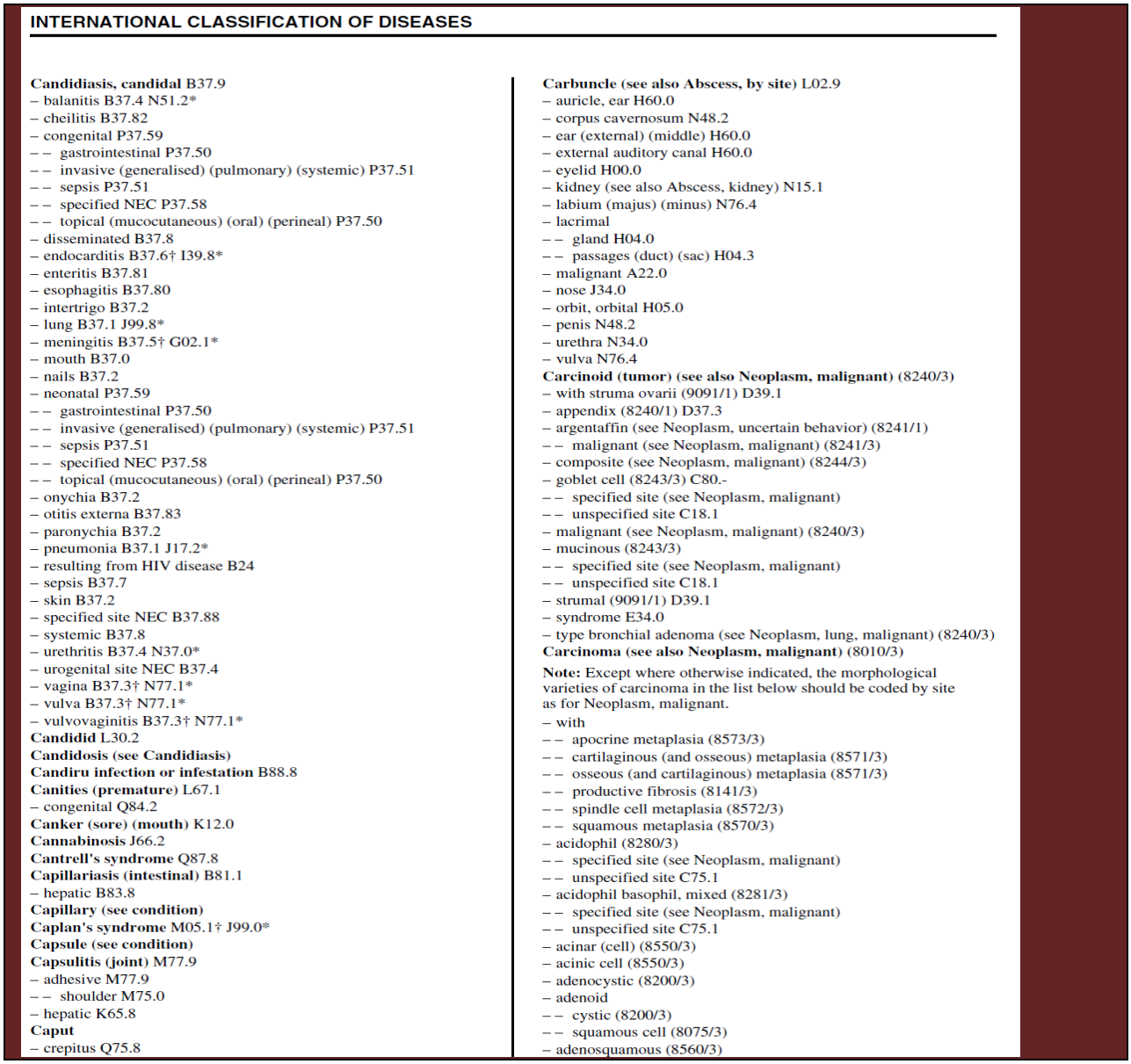
See: Directs you to a more specific term under which a correct or more specific code may be found (i.e.: Leaky Heart – *see* Endocarditis).

See Also: Indicates additional information is available that may provide an additional diagnostic code (i.e.: Median – *see also* condition).

Default Code: In the alphabetic index, the default code that the narrative points to should be used when there is no more descriptive code narrative to report the code.

An example would be an acute or chronic condition that is not documented as acute or chronic. Instead of the specific acute code or chronic code being reported, the default code would be used.

Volume II Alphabetic Index



INTERNATIONAL CLASSIFICATION OF DISEASES

Candidiasis, candidal B37.9
– balanitis B37.4 N51.2*
– cheilitis B37.82
– congenital P37.59
– – gastrointestinal P37.50
– – invasive (generalised) (pulmonary) (systemic) P37.51
– – sepsis P37.51
– – specified NEC P37.58
– – topical (mucocutaneous) (oral) (perineal) P37.50
– disseminated B37.8
– endocarditis B37.6† I39.8*
– enteritis B37.81
– esophagitis B37.80
– intertrigo B37.2
– lung B37.1 J99.8*
– meningitis B37.5† G02.1*
– mouth B37.0
– nails B37.2
– neonatal P37.59
– – gastrointestinal P37.50
– – invasive (generalised) (pulmonary) (systemic) P37.51
– – sepsis P37.51
– – specified NEC P37.58
– – topical (mucocutaneous) (oral) (perineal) P37.50
– onychia B37.2
– otitis externa B37.83
– paronychia B37.2
– pneumonia B37.1 J17.2*
– resulting from HIV disease B24
– sepsis B37.7
– skin B37.2
– specified site NEC B37.88
– systemic B37.8
– urethritis B37.4 N37.0*
– urogenital site NEC B37.4
– vagina B37.3† N77.1*
– vulva B37.3† N77.1*
– vulvovaginitis B37.3† N77.1*
Candidid L30.2
Candidosis (see Candidiasis)
Candiru infection or infestation B88.8
Canities (premature) L67.1
– congenital Q84.2
Canker (sore) (mouth) K12.0
Cannabinosis J66.2
Cantrell's syndrome Q87.8
Capillariasis (intestinal) B81.1
– hepatic B83.8
Capillary (see condition)
Caplan's syndrome M05.1† J99.0*
Capsule (see condition)
Capsulitis (joint) M77.9
– adhesive M77.9
– – shoulder M75.0
– hepatic K65.8
Caput
– crepitus Q75.8

Carbuncle (see also Abscess, by site) L02.9
– auricle, ear H60.0
– corpus cavernosum N48.2
– ear (external) (middle) H60.0
– external auditory canal H60.0
– eyelid H00.0
– kidney (see also Abscess, kidney) N15.1
– labium (majus) (minus) N76.4
– lacrimal
– – gland H04.0
– – passages (duct) (sac) H04.3
– malignant A22.0
– nose J34.0
– orbit, orbital H05.0
– penis N48.2
– urethra N34.0
– vulva N76.4
Carcinoid (tumor) (see also Neoplasm, malignant) (8240/3)
– with struma ovarii (9091/1) D39.1
– appendix (8240/1) D37.3
– argentaffin (see Neoplasm, uncertain behavior) (8241/1)
– – malignant (see Neoplasm, malignant) (8241/3)
– composite (see Neoplasm, malignant) (8244/3)
– goblet cell (8243/3) C80.-
– – specified site (see Neoplasm, malignant)
– – unspecified site C18.1
– malignant (see Neoplasm, malignant) (8240/3)
– mucinous (8243/3)
– – specified site (see Neoplasm, malignant)
– – unspecified site C18.1
– strumal (9091/1) D39.1
– syndrome E34.0
– type bronchial adenoma (see Neoplasm, lung, malignant) (8240/3)
Carcinoma (see also Neoplasm, malignant) (8010/3)
Note: Except where otherwise indicated, the morphological varieties of carcinoma in the list below should be coded by site as for Neoplasm, malignant.
– with
– – apocrine metaplasia (8573/3)
– – cartilaginous (and osseous) metaplasia (8571/3)
– – osseous (and cartilaginous) metaplasia (8571/3)
– – productive fibrosis (8141/3)
– – spindle cell metaplasia (8572/3)
– – squamous metaplasia (8570/3)
– acidophil (8280/3)
– – specified site (see Neoplasm, malignant)
– – unspecified site C75.1
– acidophil basophil, mixed (8281/3)
– – specified site (see Neoplasm, malignant)
– – unspecified site C75.1
– acinar (cell) (8550/3)
– acinic cell (8550/3)
– adenocystic (8200/3)
– adenoid
– – cystic (8200/3)
– – squamous cell (8075/3)
– adenosquamous (8560/3)

ICD-10-CM Volume I Coding Convention Definitions

Volume I coding conventions can be found within each section of three-digit category codes within ICD-10-CM. These coding conventions provide coders with additional guidance for choosing the correct Volume I numeric code within a specific diagnosis category. Coding conventions include specific symbols and instructional notes to aid the coder to code the diagnosis to the highest level of specificity allowed by the medical record documentation and narrative data available. Most of the ICD-10-CM coding instructions mirror those in ICD-

9-CM. Some have been expanded to accommodate the higher levels of detail in ICD-10-CM (i.e. excludes expanded to include excludes 1 and excludes 2).

ICD-10-CM structural format changes include the expansion from five digit codes to up to seven digits. The following list provides a breakdown of this and other format changes to the diagnosis coding system in Volume I.

- Valid codes may be 3-6 characters in length and are in **BOLD** typeface
- 4th character can be a letter or a number
- Codes longer than 3 characters have decimal point after first 3 characters (called a category code)
- Must code to highest level of detail, using the codes fourth, fifth, sixth or seventh digit where required
- Full code titles are used
- Coding conventions – excludes, code first and code also

Three digit category codes may have one or more of the following additional instruction codes.

Symbols

[ ] ***Brackets:*** Brackets enclose synonyms, alternate words, or explanatory phrases (i.e. Alzheimer's G30.9 [F02.80]).

: ***Colon:*** A colon is utilized after an incomplete term to provide more specific terms to make the code assignable to the given category

● ***New Code:*** Indicates new code for calendar year.

√ ***Additional character required:*** Indicates code requires additional fourth, fifth, or sixth digit (the number is designated in the symbol).

√x7th ***Extension Alert:*** Provided for codes that require a seventh digit extension code assignment for the numeric code.

N ***Newborn:*** Age range birth-28 days. Indicates that the diagnosis is for a newborn or neonate only and should not be used if patient age does not fall into one of these categories (i.e.: fetal distress, prenatal jaundice).

P ***Pediatric 0-17:*** Age range 0-17 years old. Indicates that the diagnosis is for a pediatric patient only and should only be used if patient is a pediatric patient (i.e.: Reyes Syndrome, child wellness exam).

M ***Maternity 12-55:*** Age range 12-55 years old. Indicates that the diagnosis is for a maternity patient to report conditions prevalent during and after pregnancy (i.e. diabetes during pregnancy).

A ***Adult:*** Age range 15-124 years old. Indicates that diagnosis is used to report condition for patient in adult age range with chronic or mental illness (i.e. senile delirium, mature cataract)

( ) ***Parentheses:*** While some parentheses enclose supplementary codes that do not affect code assignment reference to Volume I, there are other parentheses that **do** affect code assignment. Generally when code specificity is affected by the parentheses, there are one or two specific supplementary codes (in lieu of a larger list) that show the additional specificity.

Tip: *Since a coder does not code directly from Volume II, the coder does not need to be concerned about whether the supplemental codes listed in parentheses affect specificity or not. These instructions are separated for the purpose of showing all uses for parentheses in Volume II so that the coder understands what the parentheses are representing.*

▲***Revised Code Title:*** The code title has been revised for current year.

Revised Text: The code text description has been revised and should be reviewed in detail to ensure the code assignment is not affected.

Additional Instructional Notes

Excludes 1 - Under a three digit category code, an Excludes 1 designation means that the code is **NOT CODED HERE** and indicates that two codes are mutually exclusive and therefore cannot be coded as separate codes in same encounter (example E66).

***Coding Clinic Update- New 2017 ICD-10-CM guidelines state that two *unrelated* codes can be coded together even if an Excludes 1 note otherwise prohibits it.**

Example of Excludes 1 (related conditions)

B06 Rubella [German measles]
Excludes 1: congenital rubella (P35.0)

- Code being excluded is never used with this code
- The two conditions cannot occur together

Example of Excludes 1 (unrelated conditions)

G47.63 Sleep related bruxism (teeth grinding)
Excludes 1: other somatoform disorders (F45.8)

-Psychogenic dysmenorrheal is an inclusion term under F45.8, but can be coded with G47.63 because the two conditions are unrelated

Excludes 2 - Under a three digit category code, an Excludes 2 designation means that the code is **NOT INCLUDED HERE** and indicates that the two codes, the category under which the Excludes 2 code is listed and the Excludes 2 code listed, are distinctly separate and therefore can be coded together within the same encounter (example H21).

Example of Exclude 2

Example: J04.0 Acute laryngitis
Excludes 2: chronic laryngitis (J37.0)

- Excluded condition is not part of the condition represented by the code
- Acceptable to use both codes together if patient has both conditions

INCLUDES ***Includes:*** Appears under three digit codes to better define or give examples of contents of the specific category. The "includes" notes are not all inclusive notes; they are only lists of examples for more detail on the types of conditions that are included in the code category (i.e. F19).

Not Otherwise Specified (NOS): Designates a code as non-specific and is used to refer coder to continue looking for a more specific code(s). The NOS codes are used when the provider does not provide the details in the medical record documentation to assign a more specific code. If the provider does not provide specific documentation to support specificity, the coder must report the NOS code.

Not Elsewhere Classified (NEC): Used to direct the coder to an "other" or "other specified" code in the Tabular index. This designation is generally used when there is not a more specific diagnosis code that matches the medical record documentation.

Code First/Use Additional Code*:* Appears where additional codes are needed to give a more complete picture of the diagnosis or procedure (example G06). This designation also directs the coder to code the condition designated as "code first" before the additional supplemental codes. "Use additional code" is listed under the three digit category code in red letters.

Code First: Used to describe diagnoses that are not intended to be used as primary diagnoses. The code, its title, and instructions appear in italics. The note requires that the underlying disease be coded first and the condition that is being treated as the secondary. This is the only example of ICD-10 where the chief complaint or reason for visit is not the primary diagnosis and is not listed first (I79.8).

- Used when certain conditions have both an underlying etiology and multiple body system manifestations
- Requires the underlying condition be sequenced first followed by the manifestation
- Proper sequencing order of the codes: etiology followed by manifestation (same coding convention as ICD-9-CM)

Code Also Notes/Use Additional Code

- A "Code Also" note instructs that two codes may be required to fully describe a condition, but the sequencing of the two codes depends on the circumstances of the encounter.

- Additional manifestation code notes include "use additional codes"

In Diseases Classified Elsewhere

- An "In Diseases Classified Elsewhere" note instructs that the condition being treated (manifestation) is caused by another disease; therefore, two codes may be required

to fully describe the condition. Sequencing of the two codes depends on the circumstances of the encounter.

- Additional manifestation code notes include "in diseases classified elsewhere"

With/Without Designation: This note in the Tabular Index is provided as an instructional note to designate that the additional numeric code is "associated with" or "due to" another condition. The fifth and sixth character designation for "with" and "without" are defined below.

- ✓ **Fifth character code designation** – 0 represents "**without**" if in the 5th position
- ✓ **Fifth character code designation** – 1 represents "**with**" if in the 5th position
- ✓ **Sixth character code designation** – 1 represents "**with**" if in the 6th position
- ✓ **Sixth character code designation** – 9 represents "**without**" in the 6th position

Volume I Tabular Index

G93 Other disorders of brain

G93.0 Cerebral cysts
Arachnoid cyst
Porencephalic cyst, acquired

Excludes1: acquired periventricular cysts of newborn (P91.1)
congenital cerebral cysts (Q04.6)

G93.1 Anoxic brain damage, not elsewhere classified

Excludes1: cerebral anoxia due to anesthesia during labor and delivery (O74.3)
cerebral anoxia due to anesthesia during the puerperium (O89.2)
neonatal anoxia (P28.9)

G93.2 Benign intracranial hypertension

Excludes1: hypertensive encephalopathy (I67.4)

G93.3 Postviral fatigue syndrome
Benign myalgic encephalomyelitis

Excludes1: chronic fatigue syndrome NOS (R53.82)

G93.4 Other and unspecified encephalopathy

Excludes1: alcoholic encephalopathy (G31.2)
encephalopathy in diseases classified elsewhere (G94)
hypertensive encephalopathy (I67.4)
toxic (metabolic) encephalopathy (G92)

G93.40 Encephalopathy, unspecified

ICD-10-CM TABULAR LIST of DISEASES and INJURIES 2011

New ICD-10-CM Coding Conventions

While we can see that most of the coding conventions for the ICD-10-CM coding system mirror those found in ICD-9-CM, there are some new additions to ICD-10-CM that have been added in order to allow more specific codes to be assigned where documentation supports the specificity. These changes are included in Volume I and II. Therefore, we will discuss them together here. Where these changes affect specific code chapters in ICD-10-CM, they will be revisited in more detail within the specific specialty chapter provided in the manual.

Laterality character designation is defined by numeric digits 0, 1, 2, 3, or 9. These characters are defined below. Laterality has been added to some ICD-10-CM diagnosis code categories to show whether the diagnosis is affecting the left organ or anatomical site, right organ or anatomical site, bilateral organ or anatomical site, or if the organ or anatomical site is unspecified. Laterality is reported in the fifth or sixth digit space and is dependent on what code chapter and category is being reported.

Laterality Character Designation by Digit

- ✓ **Right side** is character 1
- ✓ **Left side** is character 2
- ✓ **Bilateral** is character 3
- ✓ **Unspecified side** is either a character 0 or 9, depending on whether it is a fifth or sixth character

Example of laterality code in ICD-10-CM

H80.0 Otosclerosis involving oval window, nonobliterative

H80.0**0** Otosclerosis involving oval window, nonobliterative, unspecified ear

H80.0**1** Otosclerosis involving oval window, nonobliterative, right ear

H80.0**2** Otosclerosis involving oval window, nonobliterative, left ear

H80.0**3** Otosclerosis involving oval window, nonobliterative, bilateral

Seventh character designation is utilized in ICD-10-CM to provide additional information about the encounter. The seventh character is only used in certain chapters of ICD-10-CM.

The seventh digit is used in some chapters to define whether the encounter is the initial encounter, subsequent encounter or a sequela (late effect) encounter.

Seventh Character Designation for Type of Encounter

"A" - **initial encounter** is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

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

"S", sequela encounter is used for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. The scars are a sequela, or a late effect, of the burn. When using 7th character "S", it is necessary to report both the injury code that precipitated the sequela and the code for the sequela or late effect. The "S" is added only to the injury code, not the sequela code. The 7th character "S" identifies the injury responsible for the sequela. When coding for a sequela, the sequela (e.g. scar) is sequenced first, followed by the injury code.

Placeholder X is used for codes that are only 3-5 digits long to ensure that the code that requires a seventh digit is able to be reported to the highest level of specificity. The X is added to the 4th, 5th, and or 6th digit space so that the seventh digit code can be added to the code assignment.

Placeholder X may be used for any of the following scenarios:

- Used as placeholder to allow for further expansion of certain code series.
- "X" is used as placeholder to validate code use
- Poisoning, adverse effect and under dosing codes are examples of code sections that utilize the "X" placeholder

Example of X placeholder

Code category T36 Poisoning by adverse effect requires a 7th character to determine if visit is the initial (A), subsequent (D) or sequela (late effect) (S) visit, however there is no 6th digit character defined for this code.

T36.96XA (the X is the placeholder so that the required 7th digit may be reported)

Specific Chapter Coding Guidelines for ICD-10-CM

Coding for Diabetes

Diabetes mellitus is a chronic condition that causes high blood sugar levels over prolonged periods. There are three main categories or types of diabetes: type I, type II and gestational diabetes. Code descriptions for type I and type II diabetes describe the type of diabetes that the patient has and whether the diabetes is controlled or uncontrolled. The provider must document that the diabetes is uncontrolled in order to code the uncontrolled diabetes codes.

There are six categories of diabetes codes in ICD-10-CM.

- ✓ E08 Diabetes mellitus due to an underlying condition
- ✓ E09 Drug or chemical induced diabetes mellitus
- ✓ E10 Type I diabetes mellitus (juvenile)
- ✓ E11 Type II diabetes mellitus
- ✓ E13 Other specified diabetes mellitus

Diabetes codes are defined by the type of diabetes (Type I and Type II), manifestation categories caused by diabetes, and causes of diabetes. Manifestation codes are combined with diabetes codes to provide a more specific diabetes code.

Type I diabetes, also known as juvenile diabetes, is diabetes that is usually detected in patients under the age of 20 and is usually diagnosed when the person is a child or young adult. Diabetes Type I is reported using code category E10.

Type II diabetes is generally diagnosed in older adult and overweight patients. Diabetes Type II is reported using code category E11. If the diabetes is not specified as Type I or Type II, the unspecified code would be reported in the E11 category as well.

Diabetics with **Type I diabetes with no complications** or manifestations of the disease are reported using code E10.9.

Type I diabetes with manifestations present due to the diabetes are reported using code series E10.1x-E10.8x depending on what manifestation is present as a result of the diabetes. In order to use these codes, the provider must document the manifestation that is caused by the diabetes. The specific manifestation symptom (i.e. peripheral vascular disease) is not required to code the diabetes manifestation codes.

If the manifestation code is documented, the diabetes code and the manifestation code should both be reported. The chart below provides coders with a guide to appropriate assignment of codes based on the provider documentation for Type I diabetes.

DOCUMENTATION GUIDE FOR DIABETES CODING
Diabetes Mellitus with no complication, E10.9 – Use when documentation states: "DM", "Diabetes Mellitus," "NIDDM", "IDDM", "Diabetes w/o complications"
Diabetes with renal manifestations, E10.2x – Use when documentation states: "DM w/ renal manifestations", "Diabetic nephropathy" "Diabetes with CKD"
Diabetes with ophthalmic manifestations E10.3x – Use when documentation states: "DM w/ ophthalmic manifestations", "Diabetic retinopathy", "Diabetes with macular edema"
Diabetes with neurological manifestations E10.4x – Use when documentation states: "DM w/ ", "Diabetic mononeuropathy or polyneuropathy", "Diabetes with neuropathy"
Diabetes with circulatory manifestations E10.5x – Use when documentation states: "DM w/ peripheral angiopathy", "Diabetic with vascular disease", "Diabetes with PVD"
Diabetes with other manifestations E10.6x – Use when documentation states: "DM w/ other manifestations" and the manifestation is documented "Diabetic bone changes", "Diabetes with ulcers"

***Coding Clinic Update- New 2017 Coding Clinic guidelines state that the word "with" in the Alphabetic or Tabular Index indicates an assumed causal relationship and one code is used for both conditions (if applicable), unless documentation states otherwise. The provider no longer has to specifically document a causal relationship between conditions if they are linked by the word "with" in either index.**

Diabetics with **Type II diabetes with no complications** or manifestations of the disease are reported using code E11.9

Type II or unspecified diabetes with manifestations present due to the diabetes are reported using code series E11.2x-E11.6x depending on what manifestation is present as a result of the diabetes. In order to use these codes, the provider must document the manifestation that is caused by the diabetes. The specific manifestation symptom (i.e. peripheral vascular disease) is not required to code the diabetes manifestation codes.

If the manifestation code is documented, the diabetes code and the manifestation code should both be reported. The chart below provides coders with a guide to appropriate assignment of codes based on the provider documentation for Type II diabetes.

DOCUMENTATION GUIDE FOR DIABETES CODING
Diabetes Mellitus with no complication, E11.9 – Use when documentation states: "DM", "Diabetes Mellitus," "NIDDM", "IDDM", "Diabetes w/o complications"
Diabetes with renal manifestations, E11.2x – Use when documentation states: "DM w/ renal manifestations", "Diabetic nephropathy" "Diabetes with CKD"
Diabetes with ophthalmic manifestations E11.3x – Use when documentation states: "DM w/ ophthalmic manifestations", "Diabetic retinopathy", "Diabetes with macular edema"
Diabetes with neurological manifestations E11.4x – Use when documentation states: "DM w/ neurological manifestations", "Diabetic neuropathy", "Diabetes with peripheral neuropathy"
Diabetes with peripheral manifestations E11.5x – Use when documentation states: "DM w/ peripheral manifestations", "Diabetic vascular disease", "Diabetes with PVD"
Diabetes with other specified complications E11.6x – Use when documentation states: "DM w/ other manifestations" and the manifestation is documented "Diabetic bone changes", "Diabetes with ulcers"

When documentation supports more than one diabetic manifestation code (i.e. diabetic retinopathy and diabetic neurology) on the same date of service, each individual diabetes code and each specific manifestation should be coded separately. Do not report diabetes with no complications (E11.9) if diabetes with manifestation is documented on the same date of service.

Example of Multiple Diabetic Manifestations for Same Date

Type II Diabetic Retinopathy (Background) code E11.319 and H35.00 and
Type II Diabetic Peripheral Neuropathy code E11.40 and G62.9

Chronic diabetes can be controlled by diet or medication. The code for insulin use is reported using code Z79.4 Long term (current) use of insulin. This code is used to report insulin dependent diabetes mellitus regardless of how long the patient has been using insulin (one day or 10 years). Insulin medications that would support use of the Z79.4 include: Humalog, Humulin R, Novolin R, Lantus, Novolog, Aprida, and Levemir. The code for hypoglycemic drug use is reported using code Z79.84 Long term (current) use of oral hypoglycemic drugs. **This is a new code in 2017 and is used to report routine use of hypoglycemic drugs to treat type II diabetes.**

Gestational diabetes is diabetes that is diagnosed during the second trimester of pregnancy and goes away after the pregnancy is over. Gestational diabetes is reported in code category O24. Gestational diabetes of a mother that affects the newborn is reported utilizing coded P70.0.

Coding for Burns

Burns are coded by site, severity, type (burn or corrosion), degree of burn, and TBSA (total body surface area) of the burn. The code category for burns in ICD-10-CM is T20-T32.

Multiple burns should be coded separately when coding in different areas (list the codes from highest to lowest severity). However, when the burns are from the same general area but with different degrees of severity, code the highest severity only.
Sunburns are not classified in the burn code series T20-T32. Sunburns would be coded from category L55 based on the degree of the burn (L55.0 for sunburn, first degree; L55.9 for sunburn, unspecified).

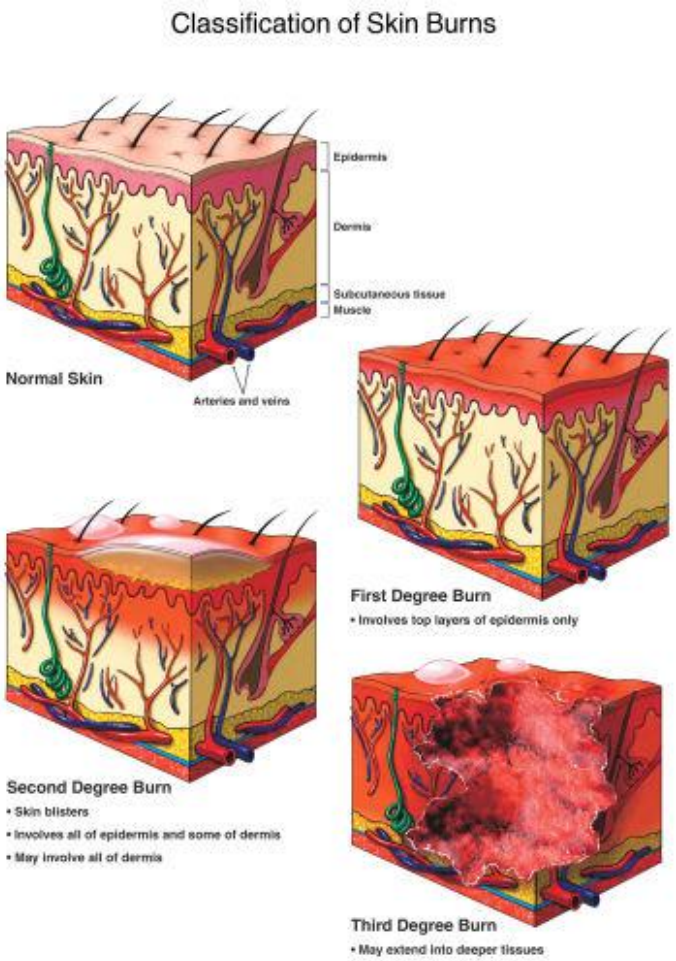
The fourth digit classification indicates the severity of the burn (i.e.: 1st degree) and the fifth digit classification provides more detail regarding the anatomical sight. There are three degrees of burns. The degrees of a burn are defined as follows.

First Degree – includes burn of epidermis, dermis, subcutaneous and muscle.

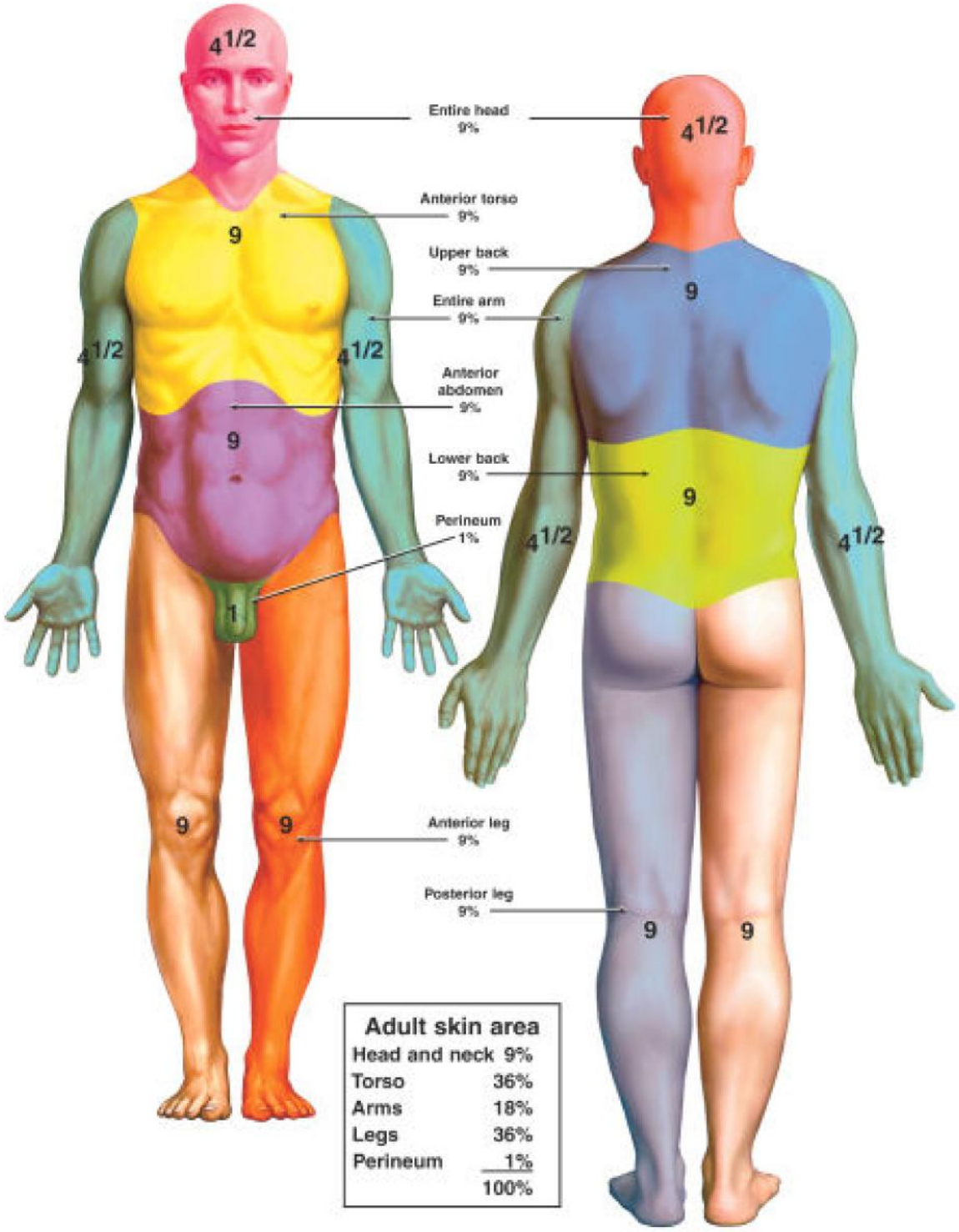
Second Degree – includes partial thickness burns. Partial thickness burns describe burns affecting the top two layers of skin (epidermis and hypodermis). Partial thickness burns can turn into third degree burns over time.

Third Degree – includes full thickness burns. Full thickness burns describe burns that destroy both the epidermis and dermis layers of skin. Full thickness burns may also affect deeper underlying structures as well.

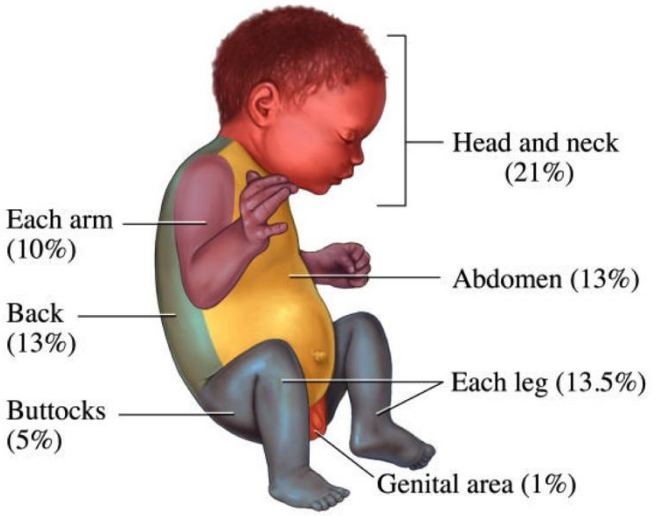
The degree of the burn is based on how many layers of the skin are burned. The levels of skin are documented below and provide coders with a means to match the narratives within the provider documentation to the terminology illustrated below to ensure that the appropriate degree is reported.



Total Body Surface Area (Rule of Nines) – Adults (TBSA Code Category T31)



Total Body Surface Area (Rule of Nines) – Infants



Example

A patient presents to the ER with first and second degree burns of the thigh (T24.219A) and right foot (T25.221A). The patient also suffers first and second degree burns of the right knee (T24.221A). Only the second degree burns of the body areas would be coded (highest severity).

Category T31 describes the TBSA involved. The fourth digit describes the percentage of TBSA and the fifth digit describes the TBSA with third degree burns only.

Example

A patient suffering from second degree burns on the trunk of the body and third degree burns on both legs.

T21.20XA Second degree burn trunk, unspecified site
T31.33 36% TBSA (2 legs)
T24.309A Burn of third degree of unspecified site of unspecified lower limb, except ankle and foot, initial encounter

Note: When the site of a burn is unspecified, code category T31 would be listed as primary code. If the site of the burn is specified, the code series T20-T25 would be assigned (by location) and coded as primary code, and the T31 code category as the supplemental or secondary code.

Coding Sequela (Late Effects) for Injuries

When coding for conditions classified as late effects of a previous condition, the proper code for the symptom for which the patient presents should be coded in addition to the initial cause of the condition.

Example: Patient presents to the physician with severe hip pain. She was in a car accident one-year prior and had fractured the same hip. After evaluating the patient and doing an x-ray of the hip, the physician diagnosed the patient with osteoarthritis that had set in the bone when the fracture healed.

M16.50 Unilateral post-traumatic osteoarthritis, unspecified hip
S72.90XS Unspecified fracture of unspecified femur, sequela

Factors Influencing Health Status and Contact with Health Services

Codes designated as "V" codes in ICD-9-CM are reported as "Z" codes in ICD-10-CM. "Z" codes describe encounters for patients who are exhibiting no signs or symptoms, but have complaints that may affect their health status. Immunizations, preventative medicine, and counseling are all examples of services for which the "Z" codes would be reported. Though generally used as supplementary codes, "Z" codes may also be utilized as primary diagnoses.

"Z" codes are used in the following three instances:

- Services provided to a patient who is asymptomatic (exhibits no signs or symptoms) but comes in for health services
  (i.e. annual preventative exam, immunizations, etc)

- When a patient requires specific treatment such as chemotherapy for a malignant neoplasm or for removal of pins used to set a bone (orthopedic aftercare)

- When a patient presents in the absence of signs and symptoms but suspects they may have a certain condition (not current illness but may affect health in the future)

The following main terms are common when directing coders to utilize "Z" codes:

Exposure to	Problem (with)
Aftercare	Suspected condition
Observation	Admission
Attention (to)	Supervision
Examination	Status (post)
History of	Screening

Looking up family and personal histories is made much easier in ICD-10-CM. When coding a "history of" condition or treatment, ICD-10-CM lists the family history first with family history conditions from A-Z listed under "family" and the personal history is listed after with personal history conditions from A-Z listed under "personal".

"Z" codes are listed alphabetically in the same section as all other ICD-10-CM codes in Volume II (section 1). In the Volume I Tabular Index, "Z" codes are found in Chapter 21.

For neoplasms that no longer exist or are no longer being treated, code the appropriate "Z" code for the services provided or that are being performed for follow-up visits to ensure that the neoplasm has not returned or metastasized (those listed as "no recurrence"). Neoplasms that are no longer active or no longer being treated should be reported as "history of" codes.

Example of Personal History of Neoplasm

Patient is being seen for follow-up mammogram to monitor breast cancer. Patient was diagnosed in 2005 with breast cancer and subsequently underwent surgery to remove the cancer. Last mammogram performed in 2013 showed no recurrence of the cancer. An order is written for patient to obtain a mammogram and patient has been instructed to make sure the mammogram is done before her next appointment.

Z85.3 Personal history of breast cancer

Category code Z04 describes observation and evaluation for suspected conditions not found and is the appropriate code series to use in these cases. Where signs and symptoms exist, code these as primary codes instead of the observation code.

External Cause Codes

External cause codes have been expanded in ICD-10-CM. The external cause codes (E codes in ICD-9-CM) now begin with the letters W, X, and Y. External cause codes are codes used for supplementary purposes only. Never use W, X, and Y codes as primary diagnoses. You may use more than one external cause code to describe how a specific incident occurred. External cause codes are basically descriptive codes and are utilized to try to explain how a specific incident occurred and where it occurred. Reporting the external cause (how) and location (where) of a code also helps payers determine that an accident or injury is covered by the appropriate payer (i.e. homeowners, workman's compensation, auto accident or commercial payer).

The External Cause Alphabetic Index is located independent of the Alphabetic Index for diagnosis signs, symptoms and/or ill defined conditions. The External Cause Alphabetic list is found after the Table of Drugs and Chemicals. In the Tabular Index external cause codes are listed in Chapter 20.

Example of External Cause Code Usage:

A child falls from the monkey bars and injures himself on the playground at the Peter Pan Daycare. The child is rushed to the physician's office where the physician evaluates the child's ankle and performs an x-ray of the ankle to make sure there is no fracture. The x-ray reveals no fracture and the patient's ankle is wrapped and the child is sent home.

M79.609 Pain in limb, unspecified
W09.8XXA Fall on or from other playground equipment, initial encounter

 **More information on** ICD-10 General Coding Conventions can be found online in your supporting materials folder at **www.xacthealthcaresolutions.com** as well as in the introductory portion of your ICD-10-CM manual.