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Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99)

Guidelines for Assigning Codes From This Chapter

Chapter 1 of ICD-10-CM includes a long list of infectious and parasitic diseases. Everything from cholera and bubonic plague to toxoplasmosis has a home here. But as you code, keep in mind that ICD-10-CM may list infections in the chapters for their specific anatomic area instead of in Chapter 1. Each time you code, search the index and then confirm your code choice in the tabular list.

List of Sections

- A00-A09: Intestinal infectious diseases
- A15-A19: Tuberculosis
- A20-A28: Certain zoonotic bacterial diseases
- A30-A49: Other bacterial diseases
- A50-A64: Infections with a predominantly sexual mode of transmission
- A65-A69: Other spirochetal diseases
- A70-A74: Other diseases caused by chlamydiae
- A75-A79: Rickettsioses
- A80-A89: Viral and prion infections of the central nervous system
- A90-A99: Arthropod-borne viral fevers and viral hemorrhagic fevers
- B00-B09: Viral infections characterized by skin and mucous membrane lesions
- B10: Other human herpesviruses
- B15-B19: Viral hepatitis
- B20: Human immunodeficiency virus [HIV] disease
- B25-B34: Other viral diseases
- B35-B49: Mycoses
- B50-B64: Protozoal diseases
- B65-B83: Helminthiases
- B85-B89: Pediculosis, acariasis and other infestations
- B90-B94: Sequelae of infectious and parasitic diseases
- B95-B97: Bacterial and viral infectious agents
- B99: Other infectious diseases

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The ICD-10-CM Official Guidelines for Coding and Reporting for Chapter 1 keep the focus on proper coding for HIV, infection agents as the cause of diseases classified to other chapters, infectious resistant to antibiotics, sepsis and shock, and methicillin-resistant *Staphylococcus aureus* (MRSA) conditions. It also includes information on coding for coronavirus. The information below covers the major points of Section I.C.1 of the Official Guidelines.

Guidelines Provide Crucial Answers for Coders Reporting HIV

The Official Guidelines give you practical coding guidance for a variety of HIV-related scenarios.

First, you must use B20 *Human immunodeficiency virus [HIV] disease* to report only confirmed cases of HIV. A diagnostic statement from the provider that the patient is positive for HIV or has an HIV-related illness counts as confirmation.

Sequencing: Whether you use B20 as the first-listed (or principal) diagnosis depends on the nature of the patient's visit.

Use B20 as the principal diagnosis for a patient admitted for an HIV-related condition (unless the patient is pregnant or recently gave birth, or if the patient was seen for hemolytic-uremic syndrome associated with HIV, as explained below). You also should report additional diagnoses for the HIV-related conditions documented for the patient.

On the other hand, if the provider admits the patient for a condition unrelated to HIV, you should choose your principal diagnosis based on the reason for admission. Next, report B20 and the codes for the patient's other HIV-related conditions.

The guidelines indicate the above sequencing rules apply regardless of whether the patient is newly diagnosed or has had previous encounters for HIV-related conditions.

B20 Isn't the Only Possibility for HIV Encounters

Asymptomatic: When documentation doesn't record any symptoms, but it does show the patient is HIV positive, you should use Z21 *Asymptomatic human immunodeficiency virus [HIV] infection status* rather than B20. However, if the provider documents AIDS or "HIV disease," treatment for an HIV-related illness, or one or more conditions caused by being HIV-positive, then you should use B20.

Inconclusive serology: When a patient with no definitive diagnosis or manifestations of HIV has an inconclusive HIV serology, you should not use B20. You should use R75 *Inconclusive laboratory evidence of human immunodeficiency virus [HIV]*.

Note that you should never use Z21 or R75 if the patient has ever been diagnosed with an HIV illness that falls under B20. You always should use B20 for patients who have had an HIV-related illness.

Pregnancy, puerperium: When a patient presents with an HIV-related illness during pregnancy, childbirth, or the puerperium, your first-listed (or principal) code must be from O98.7- *Human immunodeficiency [HIV] disease complicating pregnancy, childbirth, and the puerperium*. Then report B20 and the code or codes for the patient's HIV-related illnesses. Sequence codes from Chapter 15 first.

If the patient's status is asymptomatic HIV, report O98.7- and Z21.

Hemolytic-uremic Syndrome: When a patient presents with hemolytic-uremic syndrome associated with HIV, your first-listed (or principal) code must be D59.31 *Infection-associated hemolytic-uremic syndrome* followed by code B20.

HIV Test Codes Vary Based on Circumstances

The codes you report when a patient presents for determination of HIV status depends on the patient's specific case.

- You should use the screening code Z11.4 *Encounter for screening for human immunodeficiency virus [HIV]* as the primary code.
- For patients without symptoms who are in a high-risk group for HIV, you should use additional codes, if known and if applicable, for any associated high-risk behaviors.
- When a patient has an HIV test because of signs or symptoms, you should report the code(s) for the signs and symptoms. If the patient has counseling at the same session, report Z71.7 *Human immunodeficiency virus [HIV] counseling*, too.
  - ➢ Code Z71.7 is also the appropriate code to use when a patient returns for the test results and learns they are HIV negative. If the test shows the patient is HIV positive, report either Z21 for an asymptomatic patient or B20 *Human immunodeficiency virus [HIV] disease* for a symptomatic patient. For symptomatic patients, you also should add codes for the symptoms or confirmed HIV-related diagnoses.

Medically Managed HIV

If a patient with HIV disease, an HIV-related illness, or AIDS is currently being managed with antiretroviral medication, code B20 for the HIV disease along with Z79.899 *Other long term (current) drug therapy* to acknowledge the long term use of the antiretroviral medication.

HIV Prophylaxis Measures

Assign code Z29.81 *Encounter for HIV pre-exposure prophylaxis,* when a patient in the at-risk population receives Pre-exposure prophylaxis (PrEP) medication for the intention of preventing an HIV infection. You should also code any risk factors for acquiring HIV.

An Additional Code for an Organism May be Necessary

For patients with infections classified in chapters other than Chapter 1, but with no organism identified in the infection code, you should assign an additional code from Chapter 1, B95-B97 *Bacterial and viral infectious agents*, to identify the organism.

Look for the instructional note with the infection code advising you to assign an additional code for the organism.

Identify Infections Resistant to Antibiotics

You must always report a bacterial infection's resistance to antibiotics. If the infection code does not specify drug resistance, report both the infection code and a code from category Z16 *Resistance to antimicrobial drugs*.

Sort Through Sepsis, Severe Sepsis, and Shock

Sepsis is the body's overwhelming and life-threatening response to an infection which can lead to tissue damage, organ failure, and death. Septic shock refers to circulatory failure associated with severe sepsis and represents a type of acute organ dysfunction.

To report sepsis correctly, assign the code for the underlying systemic infection. Assign A41.9 *Sepsis, unspecified organism* when the causal organism isn't known.

Report a code from subcategory R65.2- *Severe sepsis* only when the provider documents severe sepsis or associated organ dysfunction. If the patient has multiple organ dysfunction (MOD), follow the instructions for reporting severe sepsis. If acute organ dysfunction is due to a condition other than sepsis, do not assign a code from R65.2-.

Caution: Query the provider when a patient with clinical signs of sepsis has negative or inconclusive blood cultures or if the term *urosepsis* is used. Urosepsis is not synonymous with sepsis and has no default code in the alphabetic index.

Remember Sequencing Rules for Severe Sepsis and Septic Shock

To report sepsis correctly, you should report a minimum of two codes, in this order:

- The systemic infection code
- A code from subcategory R65.2-; note that you may not assign R65.2- as a principal diagnosis
- A41.9 *Sepsis, unspecified organism*, if the causal organism is not documented
- Additional codes for acute organ dysfunction, if appropriate

If severe sepsis was not present on admission, the systemic infection code and a code from R65.2- should be associated as secondary diagnoses. Query the provider if the documentation isn't clear as to when severe sepsis developed.

When the documentation indicates septic shock, report codes in this order:

- The systemic infection code
- A septic shock code, either R65.21 *Severe sepsis with septic shock* or code T81.12- *Postprocedural septic shock*
- Additional codes for acute organ dysfunction

Note that septic shock cannot be assigned as a principal diagnosis.

Lock Down Proper Coding When Patient Has Localized Infection, Too

If the provider documents both sepsis or severe sepsis and a localized infection, such as pneumonia or cellulitis, as reasons for admission, assign codes in this order:

- The systemic infection code
- The appropriate code from R65.2-, if severe sepsis is present on admission
- The localized infection code

Caution: If severe sepsis develops after admission in a patient with a localized infection, assign the localized infection code first and then the appropriate sepsis or severe sepsis code.

Postprocedural Sepsis Coding Has Variations to Watch

When documentation reveals postprocedural sepsis, you should make sure the provider's documentation shows that the infection was in fact caused by a procedure, and you should report the code for the infection first, then the code for sepsis (T81.44-).

- Use an additional code to identify the infectious agent.
- If the patient has severe sepsis, add code, R65.2- *Severe sepsis* with an additional code(s) for any acute organ dysfunction.

If the sepsis occurred following an infusion, transfusion, therapeutic injection, or immunization, code first T80.2- *Infections following infusion, transfusion and therapeutic injection* or T88.0- *Infection following immunization*.

- Use an additional code to identify the infectious agent.
- If the patient has severe sepsis add code, R65.2- *Severe sepsis* plus an additional code(s) for any acute organ dysfunction.

If the sepsis occurs as the result of an obstetric surgical wound, code first the infection of the obstetric surgical wound, O86.00 to O86.03 *Infection of obstetric surgical wound*.

- Assign the additional code O86.04 *Sepsis following an obstetrical procedure*.
- Use an additional code to identify the infectious agent.
- If the patient has severe sepsis, assign the appropriate code from subcategory R65.2- *Severe sepsis* and an additional code(s) for any acute organ dysfunction.

Your coding will change a bit if the postprocedural infection leads to postprocedural septic shock. Code the infection as described above for coding sepsis due to a postprocedural infection and assign code T81.12- *Postprocedural septic shock* instead of R65.2- *Severe sepsis*. Assign an additional code for any organ dysfunction.

Don't Assume Infection Caused the Sepsis

When sepsis or severe sepsis result from something other than infection, use the following order for your codes:

- The code for the noninfectious condition, such as the appropriate burn or injury code, assuming this condition meets the definition of a principal diagnosis
- The code for the systemic infection
- A severe sepsis code from R65.2-, if present
- Codes for any associated organ dysfunction for severe sepsis

You won't assign a code from R65.1- *Systemic inflammatory response syndrome [SIRS] of noninfectious origin*.

Remember: If the sepsis meets the principal diagnosis requirements, you should report the systemic infection and sepsis/severe sepsis codes followed by the code for the noninfectious condition. You may report either the noninfectious condition or the sepsis as principal if both meet the definition of principal diagnosis.

Caution: When a patient has a noninfectious condition that results in an infection that then leads to severe sepsis, you should report a code from R65.2-. You should not also report a code from R65.1- *Systemic inflammatory response syndrome [SIRS] of noninfectious origin*.

Note: See the Official Guidelines Chapter 15 to report sepsis and septic shock related to abortion, pregnancy, childbirth, and the puerperium. See the Official Guidelines Chapter 16 to report bacterial sepsis involving a newborn.

Hemolytic-uremic Syndrome With Sepsis

When a patient is admitted with hemolytic-uremic syndrome associated with sepsis, your principal diagnosis must be D59.31 *Infection-associated hemolytic-uremic syndrome* followed by a code for the underlying systemic infection plus any additional conditions such as severe sepsis.

MRSA Conditions Often Feature Combination Codes

ICD-10-CM offers combination codes for certain methicillin resistant *Staphylococcus aureus* (MRSA) diagnoses. In those cases, you should report the combination code that describes the complete condition rather than reporting the individual elements.

Example 1: The patient has sepsis caused by MRSA. You should report A41.02 *Sepsis due to methicillin-resistant Staphylococcus aureus*.

Example 2: The patient has pneumonia due to MRSA. You should report J15.212 *Pneumonia due to methicillin-resistant Staphylococcus aureus*.

Do not report: When combination codes apply, you should not report B95.62 *Methicillin-resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere*. You also should not report Z16.11 *Resistance to penicillins*.

Double Up on the Codes When Necessary

You won't always have the option of using a combination code for a current MRSA infection. In those cases, you should report the condition as well as MRSA code B95.62. You shouldn't report Z16.11 as an additional code.

Distinguish Between Colonization and Infection

A person may have MRSA or methicillin-susceptible *Staphylococcus aureus* (MSSA) on or in the body without being sick. In these cases, you may see the documentation refer to colonization, carriage, carrier, MRSA screen positive, or MRSA nasal swab positive.

How to code: When documentation shows MSSA colonization, you should report Z22.321 *Carrier or suspected carrier of methicillin-susceptible Staphylococcus aureus*.

For MRSA colonization, use Z22.322 *Carrier or suspected carrier of methicillin-resistant Staphylococcus aureus*. When the patient has both MRSA colonization and MRSA infection documented, you may report codes for both.

Confirm Zika Before Coding It

You can only code confirmed cases of the Zika virus with code A92.5. Check your documentation closely. If the provider states "probable," "suspected," or "possible" Zika, use code Z20.821 *Contact with and (suspected) exposure to Zika virus*, instead.

Note: A confirmed diagnosis doesn't need to mention the type of test performed. A provider's statement that mentions "confirmed" is the only documentation needed to code A92.5.

Don't Mask the Facts When Coding Coronavirus

You can only code confirmed cases of COVID-19 in an outpatient setting. A patient needs a confirmed positive test result and physician documentation of such, in order to assign code U07.1 *COVID-19*. In an inpatient setting, positive tests results are not necessary to use code U07.1. Provider documentation stating that the patient has COVID-19 is sufficient.

For symptomatic (or asymptomatic) patients who were exposed or potentially exposed to COVID-19 and the infection was ruled out, (or the test results were inconclusive or unknown), assign code Z20.822 *Contact with and (suspected) exposure to COVID-19*.

If a patient is showing signs and symptoms of COVID-19, but the physician does not establish a definitive diagnosis, code each of the signs and symptoms as described.

Note: When a patient presents for screening for COVID-19, including preoperative testing, assign code Z11.52 *Encounter for screening for COVID-19*.

For patients with a personal history of COVID-19 (with no residual symptoms) that are presenting for a follow-up appointment, use codes Z09 *Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm* and Z86.16 *Personal History of COVID-19*.

Respiratory and Non-respiratory Manifestations of COVID-19

If a patient develops manifestations as a result of COVID-19, first code U07.1, followed by the code for the specific manifestation. Some common respiratory manifestations are pneumonia, acute bronchitis, lower respiratory infections, acute respiratory distress syndrome, and acute respiratory failure.

Coding For Conditions Present After COVID-19

If residual symptoms or sequela of a previous COVID-19 infection exist, first code the symptom or condition along with U09.9 *Post COVID-19 condition, unspecified*.

Note: Do not code U09.9 with a current COVID-19 infection.

Code U09.9 can be coded with U07.1 *COVID-19* only if the patient is being seen for a new active (current) COVID-19 infection. You can also code conditions from the previous infection along with manifestations of the new infection.

Note: For multisystem inflammatory syndrome coding, see Official Guidelines section I.C.1.g.1.l.

Finally, keep in mind that COVID-19 guidelines could potentially change as new information becomes available. Be sure to check with CMS before coding COVID-19.

Chapter 2: Neoplasms (C00-D49)

Guidelines for Assigning Codes From This Chapter

A neoplasm is a new, abnormal growth of tissue. Although you may often hear the term neoplasm in relation to cancerous tumors, which are malignant, not all neoplasms are malignant. ICD-10-CM includes codes in this chapter for all the following:

- Malignant neoplasms, which may be primary (at the point of origin) or secondary (the result of metastasis, or the location where the malignancy has spread)
- Benign neoplasms, which are cancer free
- Neuroendocrine tumors, which may be either malignant or benign, and form from hormone-releasing cells
- Carcinomas in situ, which are abnormal cells that stay in their original location but may later develop into invasive cancer
- Neoplasms of uncertain behavior, a specific histology type that the pathologist identifies when a neoplasm is transitioning from benign to malignant
- Behavior neoplasms for which the documentation doesn't specify the nature of the neoplasm

List of Sections

- C00-C14: Malignant neoplasms of lip, oral cavity and pharynx
- C15-C26: Malignant neoplasms of digestive organs
- C30-C39: Malignant neoplasms of respiratory and intrathoracic organs
- C40-C41: Malignant neoplasms of bone and articular cartilage
- C43-C44: Melanoma and other malignant neoplasms of skin
- C45-C49: Malignant neoplasms of mesothelial and soft tissue
- C50: Malignant neoplasms of breast
- C51-C58: Malignant neoplasms of female genital organs
- C60-C63: Malignant neoplasms of male genital organs
- C64-C68: Malignant neoplasms of urinary tract
- C69-C72: Malignant neoplasms of eye, brain and other parts of central nervous system
- C73-C75: Malignant neoplasms of thyroid and other endocrine glands
- C7A: Malignant neuroendocrine tumors
- C7B: Secondary neuroendocrine tumors
- C76-C80: Malignant neoplasms of ill-defined, other secondary and unspecified sites
- C81-C96: Malignant neoplasms of lymphoid, hematopoietic and related tissue
- D00-D09: In situ neoplasms
- D10-D36: Benign neoplasms, except benign neuroendocrine tumors
- D3A: Benign neuroendocrine tumors
- D37-D48: Neoplasms of uncertain behavior, polycythemia vera and myelodysplastic syndromes
- D49: Neoplasms of unspecified behavior

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The ICD-10-CM Official Guidelines for Coding and Reporting for Chapter 2 offer insights into proper coding for patients with neoplasms, particularly as it relates to sequencing the codes. The information below is from Section I.C.2 of the Official Guidelines.

General Information

The Official Guidelines explain that Chapter 2 includes the codes available for all malignant neoplasms and most benign neoplasms. In some cases, ICD-10-CM lists the codes for benign neoplasms in the chapters for their specific body systems instead of in Chapter 2.

To code a neoplasm, you must determine from the documentation if the neoplasm is benign, in situ, malignant, or of uncertain histologic behavior. For malignant neoplasms, take note of any secondary or metastatic sites.

Use .8 for overlapping sites: If a primary malignant neoplasm overlaps two or more adjacent (contiguous) sites, select the overlapping lesion code, .8, unless a specific combination code exists. If there are multiple neoplasms at the same site that are noncontiguous, such as tumors in different quadrants of the same breast, report individual codes for each site.

- ➢ A patient with more than one malignant tumor in the same organ may have either different primaries or metastatic disease. Query the provider as to the status of each tumor so you can assign the correct codes.

Code the site of origin: For malignant neoplasms of ectopic tissue, which is tissue outside of its normal location, code the site of origin. For example, report C25.9 *Malignant neoplasm of pancreas, unspecified* for malignant pancreatic neoplasms involving the stomach.

The guidelines offer advice on how to start the search for the proper neoplasm code in the Index. Typically, you'll start by looking at the table located at the Index's neoplasm entry. But when the documentation includes the histology of the neoplasm (such as adenoma), you should look up that term in the Index and start your search there.

Begin With the Sequencing Basics

The Official Guidelines explain the proper code order when the patient presents for treatment of a malignancy.

- **Primary malignancy treated:** The guidelines start by saying that for an admission/encounter to treat of the primary malignancy, you should report the primary malignancy as the principal diagnosis.
  - ➢ But the guidelines quickly add an exception that if a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy, or external beam radiation therapy, assign the appropriate Z51.- code as the first-listed or principal diagnosis, and the diagnosis or problem for which the service is being performed as a secondary diagnosis.
    - ❒ You should remember this rule about using the encounter code before the neoplasm code as you read through the other rules and as you code for neoplasm treatment.
    - ❒ The guidelines also explain that if the encounter is to insert or implant radioactive elements, such as brachytherapy, assign the malignancy code first. Do not assign Z51.0 *Encounter for antineoplastic radiation therapy*.
  - ➢ Don't report symptoms, signs, and abnormal findings listed in Chapter 18 to replace the malignancy as the principal diagnosis, regardless of the number of admissions or encounters.
- **Secondary site treated:** When the purpose of an encounter is to treat only a secondary neoplasm, you should sequence the secondary neoplasm before the primary neoplasm.

Secondary Malignant Neoplasm of Lymphoid Tissue

When a primary malignancy of lymph tissue metastasizes beyond the lymph nodes, use codes from categories C81-C85 along with a final character of "9" to indicate an extranodal or solid organ site instead of coding the affected solid organ itself. For example, for metastases of B-cell lymphoma to the lung, brain, and left adrenal gland, assign code C83.39 *Diffuse large B-cell lymphoma, extranodal and solid organ sites.*

Understand How Variations Alter Code Order

Patients with neoplasms may present for multiple treatments or have multiple diagnoses that apply to the same encounter. The following guidelines help with coding those situations:

- **Chemotherapy/external beam radiation in addition to main reason:** When a single episode of care involves surgical neoplasm removal AND chemotherapy or external beam radiation treatment, you should assign the neoplasm code first. Similarly, if the reason the patient presents is a procedure like paracentesis or to determine the malignancy's extent, you should report the malignancy first even when the patient has chemotherapy or external beam radiation, too.
  - ➢ **Note:** If the sole reason for the encounter is chemotherapy or external beam radiation treatment, you should assign the appropriate Z code representing the chemotherapy or radiation as the first-listed code.
  - ➢ When the patient is being seen for the insertion or implantation of radioactive elements code Z51.0 *Encounter for antineoplastic radiation therapy* should not be assigned. Instead the appropriate code for the malignancy is reported as the principal or the first-listed diagnosis.
- **Complications develop:** When complications occur during a session for chemotherapy, immunotherapy, or external beam radiation therapy, you should report the appropriate Z51.- encounter code first with the complications as additional codes.
  - ➢ **Note:** When complications occur for a patient who is admitted for insertion or implantation of radioactive elements (e.g., brachytherapy), you should report the appropriate code for the malignancy as the principal or first-listed diagnosis, then report the code(s) for the complications.
- **Pregnancy:** If the patient is pregnant, assign first a code from subcategory O9A.1- *Malignant neoplasm complicating pregnancy, childbirth, and the puerperium*, followed by the malignancy code from Chapter 2.

Use C80 Unspecified Codes Sparingly

Code C80.0 *Disseminated malignant neoplasm, unspecified* only for cases of advanced metastatic disease with no known primary or secondary sites specified. You should never assign this code if either the primary site or any secondary sites are known.

Code C80.1 *Malignant [primary] neoplasm, unspecified* means a determination cannot be made as to the site of the primary malignancy and should rarely be used in an inpatient setting.

Base Anemia Code Choice on Cause

The general rule for coding complications is that if the encounter is aimed at treating the complication, you should report the complication before the neoplasm. Here's how the Official Guidelines apply that rule to anemia:

- **Anemia from malignancy:** When the patient presents for treatment of anemia due to malignancy, and only for the anemia, list the code for the malignancy as the primary diagnosis code followed by the appropriate code for the anemia. The typical anemia code in this situation is D63.0 *Anemia in neoplastic disease.*

  Note: This is an exception to the general practice of listing the code for the condition being treated as the primary diagnosis.
- **Anemia from therapy:** When the patient presents for treatment of only anemia due to chemotherapy, immunotherapy, or radiotherapy, you should report the appropriate anemia code first followed by the malignancy code and the adverse effect, such as T45.1X5- *Adverse effect of antineoplastic and immunosuppressive drugs* or Y84.2 *Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure*.

Follow the Rules for Dehydration, Surgical Complications, and Pathologic Fractures

Dehydration: In some cases, a patient with a malignancy may report for treatment only of dehydration. A typical example involves a patient who is suffering from nausea and vomiting as a result of chemotherapy at an earlier encounter. In those cases, you should report the dehydration first and then the malignancy.

Surgical complication: By now you know the sequencing rule: If the encounter is for treatment of a surgical complication, you should report the complication first.

Pathologic fractures: A neoplasm can result in a fracture. If the fracture is the primary reason for the treatment, assign a code from M84.5- *Pathological fracture in neoplastic disease* first, followed by the code for the neoplasm. If the neoplasm is the primary reason for the treatment, sequence the neoplasm code first, followed by the M84.5- code.

Master When to Switch to Personal History Z Code

A key element of coding for neoplasms is knowing when to swap from a neoplasm code to a code from category Z85 *Personal history of malignant neoplasm*.

The rule: You should use a personal history Z code only when documentation shows there is no evidence of any existing primary malignancy at that site.

In some cases, the patient will still have a secondary malignancy even after treatment eradicates the primary malignancy. You may report the secondary neoplasm first followed by the appropriate Z85 code for the personal history of the primary neoplasm.

Important: You should only assign subcategories Z85.0- through Z85.7- for the former site of a primary malignancy, not for the secondary malignancy, while you should assign codes from subcategory Z85.8- for the former site(s) of either a primary or a secondary malignancy.

Remission vs. personal history: Leukemia codes and category C90 *Multiple myeloma and malignant plasma cell neoplasms* indicate whether or not the patient is in remission. You can also utilize codes Z85.6 *Personal history of leukemia* and Z85.79 *Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues*. Query the provider if the documentation doesn't specify remission for these conditions.

Tackle Transplanted Organ Neoplasm Using Category T86

The Official Guidelines also offer instructions on how to code when a patient develops a malignant neoplasm of a transplanted organ. In that situation, report a complication code first, T86.- *Complications of transplanted organs and tissue* and then C80.2 *Malignant neoplasm associated with transplanted organ*. Use an additional code for the specific malignancy.

Note: See Chapter 6 of the Official Guidelines to report neoplasm pain control and management. For aftercare, follow-up care, and prophylactic organ removal for prevention of malignancy, see Chapter 21 of the Official Guidelines.

Chapter 3: Diseases of Blood/Blood-Forming Organs & Disorders Involving Immune Mechanism (D50-D89)

Guidelines for Assigning Codes From This Chapter

Chapter 3 includes conditions affecting the blood and related anatomic structures, such as the spleen and bone marrow. Some of the diagnoses you'll find in this chapter include anemias, coagulation defects, hemorrhagic conditions, white blood cell disorders, and spleen disorders. You'll also find immune disorders, including various immunodeficiency syndromes and graft-versus-host disease.

List of Sections

- D50-D53: Nutritional anemias
- D55-D59: Hemolytic anemias
- D60-D64: Aplastic and other anemias and other bone marrow failure syndromes
- D65-D69: Coagulation defects, purpura and other hemorrhagic conditions
- D70-D77: Other disorders of blood and blood-forming organs
- D78: Intraoperative and postprocedural complications of the spleen
- D80-D89: Certain disorders involving the immune mechanism

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The 2024 version of ICD-10-CM Official Guidelines for Coding and Reporting does not include specific guidelines for Chapter 3, stating that the section is reserved for future expansion.

Still, as with every ICD-10-CM chapter, you should be sure to review and apply the guidelines and instructions included in the code book with specific codes and code ranges. Below are some key areas to watch when coding for anemia.

CKD: When the patient has anemia due to chronic kidney disease (CKD), you must report a code from category N18 *Chronic kidney disease* in addition to D63.1 *Anemia in chronic kidney disease*. Codes from N18 indicate the stage of the illness.

➢ **Example:** Documentation shows the patient presented for treatment of stage 3 CKD. The provider also addresses the anemia caused by CKD during the encounter. You should report N18.3- *Chronic kidney disease, stage 3 [moderate]*, followed by D63.1 for the anemia.

Neoplastic disease: In cases where the patient has anemia due to a neoplasm, you should report the proper neoplasm code followed by D63.0 *Anemia in neoplastic disease*. However, if a patient has anemia caused by their chemotherapy, immunotherapy, or radiotherapy, and they present for treatment of the anemia only, your first-listed code should be the anemia code followed by the neoplasm and adverse effect codes.

➢ **Example:** The patient presents for treatment of anemia caused by treatment of colon cancer with overlapping neoplasms, C18.8 *Malignant neoplasm of contiguous or overlapping sites of colon* whose point of origin cannot be determined. You should report D63.0 followed by C18.8 and T45.1X5- *Adverse effect of antineoplastic and immunosuppressive drugs* or Y84.2 *Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure*.

Assign Additional Codes for Drug-induced Anemias

Autoimmune hemolytic anemia (AIHA) is caused by autoantibody-induced hemolysis (the premature destruction of circulating red blood cells). It is usually idiopathic but can be associated with infection, lymphoproliferative disorders, autoimmune diseases, and some drugs. Category D59 contains codes used to report the different types of hemolytic anemias. D59.0 *Drug-induced autoimmune hemolytic anemia* and D59.1- *Other autoimmune hemolytic anemias* codes require an additional code to identify the drug. Select a code from T36-T50 *Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances* with fifth or sixth character 5.

Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E00-E89)

Guidelines for Assigning Codes From This Chapter

List of Sections

- E00-E07: Disorders of thyroid gland
- E08-E13: Diabetes mellitus
- E15-E16: Other disorders of glucose regulation and pancreatic internal secretion
- E20-E35: Disorders of other endocrine glands
- E36: Intraoperative complications of endocrine system
- E40-E46: Malnutrition
- E50-E64: Other nutritional deficiencies
- E65-E68: Overweight, obesity and other hyperalimentation
- E70-E88: Metabolic disorders
- E89: Postprocedural endocrine and metabolic complications and disorders, not elsewhere classified

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

Chapter 4 of the ICD-10-CM Official Guidelines for Coding and Reporting is all about diabetes. The information below summarizes the key points from Section I.C.4 of the Official Guidelines.

Get to Know Combination Codes

Diabetes mellitus codes are combination codes that specify the type of diabetes mellitus, the body system affected, and the complications affecting that body system. You should report as many codes within a particular category as necessary to describe all complications of the disease. Sequence the codes based on the reason for the encounter. Assign as many codes from categories E08-E13 as needed to identify all associated conditions.

Begin by Establishing the Type of Diabetes

Diabetes mellitus has two main types. Type 1 involves the body not producing insulin and usually develops in children and young adults. Type 1 is often called juvenile diabetes and is the least common form. In type 2, the most common form of diabetes, the body does not produce adequate insulin or resists the effects of insulin it has produced, which results in high levels of glucose in the blood.

Age can be misleading. Don't let the patient's age determine your code selection as either type of diabetes can occur at almost any age.

Look to the documentation. If the type of diabetes mellitus is not documented, the default is E11.- *Type 2 diabetes mellitus*.

Insulin usage provides a clue. If the documentation in a medical record does not indicate the type of diabetes but indicates the patient uses insulin, assign code E11.- *Type 2 diabetes mellitus*.

Assign additional codes from category Z79 *Long term (current) drug therapy* to identify the long-term (current) use of insulin, oral hypoglycemic drugs, or injectable non-insulin antidiabetic medication as appropriate when a patient is treated with more than one type of antidiabetic medication.

If the provider treats the patient with *both* oral hypoglycemic medications **and** insulin, codes Z79.4 *Long-term (current) use of insulin* and Z79.84 *Long term (current) use of oral hypoglycemic drugs* should both be assigned.

Remember: Do not assign Z79.4 if the provider administers insulin to temporarily to bring a secondary diabetic patient's blood sugar under control during an encounter.

T85.6- is Your First Stop for Insulin Pump Malfunctions

Insulin pump malfunctions may result in underdosing or overdosing.

- **Underdosing:** Specify the type of malfunction with a code from subcategory T85.6- *Mechanical complication of other specified internal and external prosthetic devices, implants and grafts* as the principal or first-listed code, followed by code T38.3X6- *Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs*. You should then assign additional codes for the type of diabetes mellitus and any associated complications due to the underdosing.
- **Overdosing:** Look again to T85.6- when overdosing results from an insulin pump malfunction. Then assign T38.3X1- *Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental [unintentional]*.

Identify the Reason for Secondary Diabetes

When reporting secondary diabetes, codes under categories E08 *Diabetes mellitus due to underlying condition*, E09 *Drug or chemical induced diabetes mellitus*, and E13 *Other specified diabetes mellitus*, identify the underlying cause or complication causing the secondary diabetes mellitus. Remember, secondary diabetes always results from another condition, so you have to add the code for that condition to the mix.

Report routine use of insulin, oral hypoglycemic drugs, or injectable non-insulin antidiabetic drugs: For patients with primary or secondary diabetes mellitus who routinely use insulin, oral hypoglycemic drugs, or injectable non-insulin drugs, assign additional codes from category Z79 *Long term (current) drug therapy* to identify the routine long-term (current) use of these drugs.

Use of two drugs: For patients treated with either insulin or an oral hypoglycemic drug **and** an injectable non-insulin antidiabetic drug, assign codes for the insulin (Z79.4) or the oral hypoglycemic drug (Z79.84) **plus** code Z79.85 *Long-term (current) use of injectable non-insulin antidiabetic drugs*.

Important: Do not assign Z79.4 if the provider administers insulin temporarily to bring a secondary diabetic patient's blood sugar under control during an encounter.

Don't miss: For secondary diabetes due to removal of the pancreas or due to adverse effects from ingesting a substance, you should apply slightly different guidelines.

- For postpancreatectomy diabetes mellitus, you should report E89.1 *Postprocedural hypoinsulinemia*. You should also assign a code from category E13 *Other specified diabetes mellitus* and a code from subcategory Z90.41- *Acquired absence of pancreas* as additional codes.
- To determine proper coding for diabetes due to adverse effect of medication or poisoning, look to Chapter 19 and Chapter 20.

Note: See Chapter 15 for coding diabetes mellitus in pregnancy and gestational (pregnancy-induced) diabetes.

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

Guidelines for Assigning Codes From This Chapter

Chapter 5 includes codes for both organic psychotic conditions, such as senile dementia, and other psychotic conditions, such as schizophrenia. You'll also find codes for a variety of nonpsychotic disorders, such as anxiety disorders, psychosexual disorders, and drug abuse. Intellectual disabilities also land in this chapter.

List of Sections

- F01-F09: Mental disorders due to known physiological conditions
- F10-F19: Mental and behavioral disorders due to psychoactive substance use
- F20-F29: Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
- F30-F39: Mood [affective] disorders
- F40-F48: Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
- F50-F59: Behavioral syndromes associated with physiological disturbances and physical factors
- F60-F69: Disorders of adult personality and behavior
- F70-F79: Intellectual disabilities
- F80-F89: Pervasive and specific developmental disorders
- F90-F98: Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
- F99: Unspecified mental disorder

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The ICD-10-CM Official Guidelines for Coding and Reporting for Chapter 5 focus on pain disorders of psychological origin and mental and behavioral disorders due to psychoactive substance use.

Keep Pain Disorders Related to Psychological Factors Under Control

- When pain is exclusively related to psychological disorders, assign code F45.41 *Pain disorder exclusively related to psychological factors*. This type of pain disorder is also known as a persistent somatoform disorder.
- An Excludes1 note with category G89 *Pain, not elsewhere classified*, in Chapter 6, reminds you not to assign a G89 code with code F45.41.
- Do assign a code from category G89 with F45.42 *Pain disorders with related psychological factors* if the documentation demonstrates a psychological component with acute or chronic pain.

Watch for Psychoactive Substance Use Disorders in Remission

If a patient's physical, mental, or behavioral disorder due to psychoactive substance abuse disorders is in remission, you will choose a code from categories F10-F19 *Mental and behavioral disorders due to psychoactive substance use* with -.11, -.21, or -.91. Unless otherwise instructed by ICD-10-CM, rely on the provider's documentation to determine if an "in remission" code is appropriate.

If the patient has a mild substance use disorder that is in early or sustained remission, assign the appropriate code(s) for the substance abuse in remission. If the patient has a moderate or severe substance use disorder that is in early or sustained remission, assign a code for the substance dependence in remission.

Use a Single Code to Classify the Pattern of Use

When the documentation refers to use, abuse, and dependence of the same substance, such as alcohol or cannabis or opioid, assign only a single code to identify the pattern of use. Use these criteria to make your selection:

- If both use and abuse are documented, assign only the code for abuse.
- If both abuse and dependence are documented, assign only the code for dependence.
- If use, abuse, and dependence are all documented, assign only the code for dependence.
- If both use and dependence are documented, assign only the code for dependence.

Note: Report codes for psychoactive substance abuse disorders only when the psychoactive substance use disorder is associated with a physical, mental, or behavioral disorder and the provider documents this relationship.

Unspecified Psychoactive Substance Use No Longer Called a Disorder

You should only assign unspecified codes for psychoactive substance use (F10.9-, F11.9-, F12.9-, F13.9-, F14.9-, F15.9-, F16.9-, F18.9-, and F19.9-) when the use is related to a substance related disorder or medical condition. This disorder or condition must be documented by the provider. In 2019, the Official Guidelines removed the word "disorders" and added the word "unspecified" before psychoactive substance use. There is also an option allowing you to specify that the "unspecified substance use" is in remission.

Medical Conditions Caused by Psychoactive Substance Use, Abuse, and Dependence

If a patient develops a medical condition due to the use, abuse, or dependence of a psychoactive substance, this condition is not considered a substance-induced disorder. Code the medical condition along with a code for psychoactive substance use, abuse, or dependence.

Blood Alcohol Level

A patient's blood alcohol level does not need to be documented when coding from category Y90 *Evidence of alcohol involvement determined by blood alcohol level*. A code from category Y90 may be assigned when the provider documents a condition classifiable to category F10.

Get Your Facts Straight on Factitious Disorders

Code factitious disorder imposed on self (also known as Munchausen's syndrome) with a code from subcategory F68.1-. This disorder happens when a person causes their own symptoms or falsely reports them, which means that they fake their own illness. When you see documentation that states either factitious disorder by proxy or Munchausen's syndrome by proxy (MSBP), it means that a caregiver acts as the perpetrator, and injures a person they are caring for (the victim). The perpetrator may also falsely report that the victim suffered an injury. You should assign code F68.A to the perpetrator's chart and a suspected or confirmed abuse code, T74.- or T76.-, to the victim's chart.

Remember to Check Documentation When Coding Dementia

The severity of dementia (mild, moderate, severe, or unspecified) should be coded based on the provider's documentation. If the level of severity changes during inpatient care, code the highest level of severity documented during the stay. If documentation is insufficient to decide on the level of severity, use unspecified code options.

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

Guidelines for Assigning Codes From This Chapter

Chapter 6 features diseases of the nervous system, which includes a central nervous system and a peripheral nervous system. The central nervous system includes the brain and spinal cord, while the peripheral nervous system includes other nerve tissue responsible for tasks such as sending signals to muscles and sending sensory information to the central nervous system.

List of Sections

- G00-G09: Inflammatory diseases of the central nervous system
- G10-G14: Systemic atrophies primarily affecting the central nervous system
- G20-G26: Extrapyramidal and movement disorders
- G30-G32: Other degenerative diseases of the nervous system
- G35-G37: Demyelinating diseases of the central nervous system
- G40-G47: Episodic and paroxysmal disorders
- G50-G59: Nerve, nerve root and plexus disorders
- G60-G65: Polyneuropathies and other disorders of the peripheral nervous system
- G70-G73: Diseases of myoneural junction and muscle
- G80-G83: Cerebral palsy and other paralytic syndromes
- G89-G99: Other disorders of the nervous system

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The Official Guidelines for Chapter 6 offer a lot of information on pain. It also provides guidance on distinguishing between the dominant and nondominant side, a concept used in coding weakness and paralysis. The advice that follows is from the Official Guidelines.

Clear Up Confusion Over Dominant vs. Nondominant Side

Before you can assign codes from category G81 *Hemiplegia and hemiparesis* and subcategories G83.1- *Monoplegia of lower limb*, G83.2- *Monoplegia of upper limb*, and G83.3- *Monoplegia, unspecified*, you need to know if the affected side of the body is dominant or nondominant. The provider may document the affected side but not specify if the side is dominant or nondominant. Tabular notes may direct you to choose a particular dominance as the default choice for some codes, when the documentation does not specify one or the other. If a default choice isn't provided, use the following guidelines to make your selection:

- For ambidextrous patients, the default is dominant.
- If the left side is affected, the default is nondominant.
- If the right side is affected, the default is dominant.

Practice Proper Pain Coding Using These Guidelines

Among the various pain guidelines, you'll find help with sequencing. The general rule is that the code you report first should be the one that explains the reason for the encounter.

Pain control/management: You may sequence a code from category G89 *Pain, not elsewhere classified* first when the patient presents for pain control or management. Also report the underlying cause of the pain if the documentation includes the cause.

Underlying condition treatment: When a patient presents for treatment of the condition causing the pain, you should report the condition in the primary spot. You should not assign a pain code from G89.

Neurostimulator insertion: You should put the appropriate category G89 pain code first when the patient is admitted for insertion of a neurostimulator to control pain. But if the patient is admitted to treat the underlying condition and happens to also have a neurostimulator inserted, report the underlying condition first, followed by the appropriate G89 pain code.

With site-specific pain codes: If adding a code from G89 would add information (such as acute, chronic, etc.) to a site-specific pain code, you may report both codes. Again your sequencing depends on the reason for the encounter. For pain control or management, report the category G89 code followed by the site-specific code. For an encounter for any other reason, report the definitive diagnosis related to the visit. If there is no definitive diagnosis documented, report the site-specific pain code, followed by the G89 code.

Postoperative pain: You'll find options for postsurgical pain in G89.1- *Acute pain, not elsewhere classified* and G89.2- *Chronic pain, not elsewhere classified*. The guidelines make it clear that you should not use those codes for the typical levels of pain that occur right after an operation. You should default to acute pain when acute or chronic is not specified for postoperative pain.

Important: Use the provider's documentation plus Section III- Reporting Additional Diagnoses and Section IV- Diagnostic Coding and Reporting Guidelines for Outpatient Services, to code postoperative pain.

Note that when a specific complication causes the pain, you should report the appropriate complication code and can include G89.18 *Other acute postoperative pain* or G89.28 *Other chronic postprocedural pain*, if applicable. If the patient with the complication presents for control of the related pain, report the G89.- code first.

Chronic pain and chronic pain syndrome: The Official Guidelines do not define a time frame for when to classify pain as chronic, G89.2- *Chronic pain, not elsewhere classified*. Instead use the provider's documentation to make your choice. Similarly, only report G89.0 *Central pain syndrome* and G89.4 *Chronic pain syndrome* when the provider specifically documents the syndrome. See Chapter 5 for more information on pain disorders due to psychological factors.

Neoplasm-related pain: When coding for neoplasm-related pain, you should apply the same basic rules that are listed above. You should report G89.3 *Neoplasm related pain [acute] [chronic]* first when the patient presents for pain control or management. Then add the neoplasm code after that. But when the patient presents for neoplasm treatment, limit the pain code to being an additional diagnosis when documented.

See Chapter 2 for instructions on the sequencing of neoplasms for all other stated reasons for the admission/encounter (except for pain control/pain management). See Chapter 19 for pain due to medical devices.

Chapter 7: Diseases of the Eye and Adnexa (H00-H59)

Guidelines for Assigning Codes From This Chapter

Chapter 7 features diseases of the eye and adnexal structures. The adnexa refers to the adjoining, or accessory, portions of the eye, such as the ocular muscles and eyelids. The eye itself consists of the cornea, anterior chamber, iris, lens, vitreous body, retina, and the optic nerve. Also included in this section are the conjunctiva (which is the membrane that covers the eye and lines the eyelids), and the lacrimal system, or tear ducts.

List of Sections

- H00-H05: Disorders of eyelid, lacrimal system and orbit
- H10-H11: Disorders of conjunctiva
- H15-H22: Disorders of sclera, cornea, iris and ciliary body
- H25-H28: Disorders of lens
- H30-H36: Disorders of choroid and retina
- H40-H42: Glaucoma
- H43-H44: Disorders of vitreous body and globe
- H46-H47: Disorders of optic nerve and visual pathways
- H49-H52: Disorders of ocular muscles, binocular movement, accommodation and refraction
- H53-H54: Visual disturbances and blindness
- H55-H57: Other disorders of eye and adnexa
- H59: Intraoperative and postprocedural complications and disorders of eye and adnexa, not elsewhere classified

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The Official Guidelines for Chapter 7 help you with questions you may face when a patient has glaucoma in both eyes. You'll also find important tips for coding when the stage of the glaucoma changes during a patient's admission and how to tell the difference between the codes for indeterminate and unspecified stages. The information that follows is from the Official Guidelines.

Master Coding for Glaucoma Type and Stage

Glaucoma refers to a group of diseases that damage the optic nerve, leading to vision loss and blindness. You can assign as many codes from category H40 *Glaucoma* as you need to identify the type of glaucoma, the affected eye, and the stage of the disease.

Bilateral, same type/stage: When the patient has glaucoma in both eyes documented as the same type and stage, and there is a code for bilateral glaucoma, report only the one code for the type of glaucoma, bilateral, and select the 7th character for the stage. If the classification does not provide a code for bilateral glaucoma, such as H40.10- *Unspecified open-angle glaucoma*, H40.11- *Primary open-angle glaucoma*, or H40.20- *Unspecified primary angle-closure glaucoma*, report only one code for the type of glaucoma and choose the 7th character to represent the stage.

Bilateral, same type/different stages: When documentation shows the same type of glaucoma in each eye but with different stages, and the classification does not specify laterality, i.e., H40.10-, H40.11-, and H40.20-, you should report one code for the type of glaucoma for each eye with the 7th character for the specific glaucoma stage documented for each eye.

Bilateral, different types/stages: For a patient who has bilateral glaucoma with a different type and a different stage for each eye and the classification specifies laterality, you should report a code for each eye instead of the code for bilateral glaucoma. If the classification does not specify laterality, report one code for each type of glaucoma with the 7th character indicating the stage.

Evolving: If the patient's glaucoma gets worse during the patient's stay, report the code for the highest documented stage.

Indeterminate vs. unspecified: ICD-10-CM offers a 7th character of "4" for "indeterminate stage" and "0" for unspecified," which can be confusing. Use "0" only when the provider doesn't document the stage. Use "4" when the provider documents they can't determine the stage clinically.

Nail Down Visual Impairment Coding When Documentation is Incomplete

If your documentation indicates "blindness" or "low vision of both eyes," but the visual impairment category for the patient is not documented, assign code H54.3 *Unqualified visual loss, both eyes*. If the patient's "blindness" or "low vision" in one eye is documented, use a code from H54.6- *Unqualified visual loss, one eye* whenever the visual impairment category is not documented. If the provider documents "blindness" or "visual loss" but does not state if one or both eyes are affected, report code H54.7 *Unspecified visual loss*.

Chapter 8: Diseases of the Ear and Mastoid Process (H60-H95)

Guidelines for Assigning Codes From This Chapter

Chapter 8 covers the ear, the organ of hearing, and the mastoid process (the bony projection at the base of the temporal bone behind each ear), which serves as the site of attachment for the neck muscles. The ear consists of the external ear, the middle ear, and the inner ear. The tympanic membrane, or ear drum, divides the outer and middle ear. The inner ear is responsible for both hearing and balance.

List of Sections

- H60-H62: Diseases of external ear
- H65-H75: Diseases of middle ear and mastoid
- H80-H83: Diseases of inner ear
- H90-H94: Other disorders of ear
- H95: Intraoperative and postprocedural complications and disorders of ear and mastoid process, not elsewhere classified

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The 2024 version of the ICD-10-CM Official Guidelines for Coding and Reporting does not include specific guidelines for Chapter 8, stating that the section is reserved for future expansion.

As with every ICD-10-CM chapter, you should be sure to review and apply the guidelines and instructions included in the code book with the codes and code ranges. Below are some key areas to watch:

Learn the Ins and Outs of Otitis Media

Start with the basics: With more than 80 codes for otitis media, zeroing in the right code can be a challenge. For you to code appropriately, look for documentation that indicates the otitis media is:

- Nonsuppurative or suppurative
- Acute, acute recurrent, or chronic
- Tubotympanic or atticoantral, if appropriate
- Left, right, or bilateral

You'll typically choose between categories H65 *Nonsuppurative otitis media* and H66 *Suppurative and unspecified otitis media*. Watch for whether the case is serous, allergic, or another type and whether there is documentation of a spontaneous rupture of the ear drum to aid you in code selection.

Use additional codes: You'll use an additional code, if known, to identify tobacco use and exposure for codes in categories H65 and H66. If the patient has a perforated ear drum, use an additional code from category H72 *Perforation of tympanic membrane* for an associated perforated tympanic membrane.

In diseases classified elsewhere: You also should stay alert for times when you should use category H67 *Otitis media in diseases classified elsewhere*. As usual, you'll code the underlying disease first, but don't miss the Excludes1 note for influenza, measles, scarlet fever, and tuberculosis.

Helpful Hints for Hearing Loss

Conductive: Conductive hearing loss occurs because of a mechanical problem in the outer or middle ear. Sound does not carry or conduct efficiently from the outer ear canal to the eardrum and through the tiny bones (called ossicles) of the middle ear.

Sensorineural: Sensorineural hearing loss originates in the vestibulocochlear nerve, the inner ear, or the central processing centers of the brain. Sensorineural hearing loss can be mild, moderate, or severe, including total deafness.

Follow the documentation: To correctly report a code from category H90 *Conductive and sensorineural hearing loss*, the documentation must designate the hearing loss as conductive, sensorineural, or mixed and whether the hearing loss is in the right ear, left ear, or exists bilaterally.

Don't overlook: You can report unilateral hearing loss with unrestricted hearing in the opposite ear with a code from H90.4-*Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side*. Keep an eye on the Excludes1 notes for all of category H90 and for H90.5 *Unspecified sensorineural hearing loss*.

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

Guidelines for Assigning Codes From This Chapter

Chapter 9 is where you'll find codes related to diseases of the heart, blood vessels, and certain lymph conditions, too. ICD-10-CM includes codes from all over the body in this chapter, from cerebral artery occlusions to hemorrhoids to hypertension.

List of Sections

- I00-I02: Acute rheumatic fever
- I05-I09: Chronic rheumatic heart diseases
- I10-I1A: Hypertensive diseases
- I20-I25: Ischemic heart diseases
- I26-I28: Pulmonary heart disease and diseases of pulmonary circulation
- I30-I5A: Other forms of heart disease
- I60-I69: Cerebrovascular diseases
- I70-I79: Diseases of arteries, arterioles and capillaries
- I80-I89: Diseases of veins, lymphatic vessels and lymph nodes, not elsewhere classified
- I95-I99: Other and unspecified disorders of the circulatory system

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The part of the ICD-10-CM Official Guidelines for Coding and Reporting dedicated to Chapter 9 give you coding rules for hypertension (HTN), atherosclerotic coronary artery disease and angina, cerebrovascular accident (CVA), cerebrovascular disease, and acute myocardial infarction (AMI). The following material summarizes the major pointers for this chapter from the Official Guidelines.

Hang on to These Hypertension Coding Tips for Accurate Claims

To keep your coding compliant, apply these rules for coding hypertension diagnoses.

Hypertension and heart disease: Unless the documentation clearly indicates that a patient's hypertension and heart disease are *not* related, assume a causal relationship exists and assign codes accordingly. The terms hypertension and heart involvement are linked by the word "with" or "in" should be interpreted to mean "associated with" or "due to" in the Alphabetic Index or as an instructional note in the Tabular List. Documentation must link conditions not specifically associated with hypertension by words such as "with," "in," or "due to" in the classification in order to code them as related.

Assign a code from category I11 *Hypertensive heart disease* for hypertension with heart conditions classified to I50.- or I51.4-I51.7, I51.89, and I51.9. For patients with heart failure, assign an additional code for the type of heart failure from category I50.

If the heart condition is unrelated to hypertension, code the condition separately from I50.-, I51.4-I51.7, I51.89, or I51.9.

Assume HTN and CKD are connected. ICD-10-CM also presumes a causal relationship between HTN and chronic kidney disease (CKD).

So, if documentation shows a patient has HTN and a condition that falls under N18 *Chronic kidney disease*, then you should report a code from category I12 *Hypertensive chronic kidney disease*. If there is no indication that HTN and CKD caused one another, ICD-10-CM still makes the assumption that they are causal. It is only when a provider documents that the two are unrelated that you should assign two separate codes. You also should report the relevant N18 category code to indicate the CKD stage. See Chapter 14 of the Official Guidelines for more information on coding chronic kidney disease.

In addition to hypertensive CKD, be on the watch for acute renal failure in the documentation, too, because it merits an additional code when present.

Simplify coding for hypertensive heart and CKD. A single code from category I13 *Hypertensive heart and chronic kidney disease* indicates the patient has both hypertensive heart disease and hypertensive CKD. You again should assume a relationship between the HTN and CKD.

When the patient has hypertensive heart disease and CKD, you should choose a code from I13. You should not report codes from categories I11 *Hypertensive heart disease* and I12 *Hypertensive chronic kidney disease* together.

To fully describe the patient's medical status, pay attention to the ICD-10-CM instructions to report more than the I13.- code. If the patient has heart failure, you should assign an additional code from category I50 *Heart failure* to indicate the type.

You'll also need to add a code from category N18 *Chronic kidney disease* to show the CKD stage.

Note: It may sound obvious, but if a provider states that the CKD is not due to hypertension, you will not code the CDK as hypertensive.

Think two codes for head diagnoses. Not all hypertensive diseases have combination codes that instruct you to keep a separate HTN code off your claim.

When the patient is diagnosed with hypertensive cerebrovascular disease, you should report the appropriate code from I60-I69 *Cerebrovascular diseases* first, and then report the correct hypertension code.

Similarly, for hypertensive retinopathy, guidelines instruct you first to report a code from subcategory H35.0- *Background retinopathy and retinal vascular changes* and then the appropriate HTN code from I10-I15. Sequence the codes based on the reason for the encounter.

I15 applies when there's another cause. In some cases, an underlying condition can be the cause of the patient's HTN. When documentation reveals that situation, the HTN is known as secondary HTN.

To report this patient's diagnoses, you'll need one code to report the underlying condition (etiology) and a code from category I15 *Secondary hypertension* to report the HTN. Your sequencing will depend on the reason for the admission or encounter.

Understand the meaning of uncontrolled. Providers may document HTN using the terms controlled and uncontrolled. Controlled usually means the therapy being used is keeping the patient's HTN under control. Uncontrolled may mean either the HTN is untreated or that the current regimen isn't keeping the HTN under control.

In either case, you should choose the appropriate code from I10-I15 to provide the appropriate hypertension codes.

Resistant hypertension just won't quit. When anti-hypertensive medication does not lower blood pressure, a physician may document resistant hypertension. You will code this by assigning I1A.0 *Resistant hypertension* in addition to the code for the specific type of hypertension documented.

Elevated or transient doesn't equal HTN. If documentation shows only elevated blood pressure, you should not use a code from I10.

Code R03.0 *Elevated blood pressure reading without diagnosis of hypertension* is appropriate when documentation doesn't establish HTN definitively.

If the patient is pregnant, look instead to category O13 *Gestational [pregnancy-induced] hypertension without significant proteinuria* or O14 *Pre-eclampsia* for transient HTN of pregnancy.

Correctly Classify Pulmonary Hypertension. You should use category I27 *Other pulmonary heart diseases* to report pulmonary hypertension. When coding for secondary pulmonary hypertension, use I27.1, or I27.2-. You should also code any other associated conditions or adverse effects of drugs or toxins. Your sequencing will depend on the reason for the encounter except for adverse effects of drugs. See Official Guidelines for Chapter 19.

Get to Know Combination Codes for Atherosclerotic Coronary Artery Disease and Angina

ICD-10-CM offers combination codes for atherosclerotic heart disease with angina pectoris. You will find these combination code in subcategories I25.11- *Atherosclerotic heart disease of native coronary artery with angina pectoris* and I25.7- *Atherosclerosis of coronary artery bypass graft[s] and coronary artery of transplanted heart with angina pectoris*. Don't assign an additional code for angina pectoris when using one of these combination codes.

Assume a causal relationship: When a patient has atherosclerosis and angina pectoris, you can assume the angina is due to the atherosclerosis unless the documentation indicates otherwise.

Sequencing tip: If a patient with coronary artery disease is admitted due to an acute myocardial infarction (AMI), report the AMI first, before the coronary artery disease.

Know the Facts About Intervention-related CVA Options

The Official Guidelines emphasize that documentation must clearly specify the cause-and-effect relationship between a medical procedure and a cerebrovascular accident (CVA) before you can assign a code for intraoperative or postprocedural CVA. To make a proper code assignment, you need to know if the CVA is due to infarction (obstruction of blood supply that leads to tissue death) or hemorrhage (profuse bleeding) and whether it occurred intraoperatively (during the procedure) or postoperatively (after the procedure).

For a patient who suffers a cerebral hemorrhage, code assignment depends on the type of procedure performed.

Master Coding for Sequelae of Cerebrovascular Disease

Codes from I69 *Sequelae of cerebrovascular disease* allow you to code for neurologic deficits that cerebrovascular diseases cause either at onset of the disease or at any time after. Keep in mind that you should use category I69 codes only for sequelae, or late effects, and not for deficits that are part of a current acute CVA.

However, if the patient has an acute CVA and also has late effects from a previous event, you may report the late effect (I69.-) and acute diagnoses (I60-I67) together.

In some cases, a patient may have an event and not suffer from late effects. Codes from I69 would not be appropriate for those patients. Instead use Z86.73 *Personal history of transient ischemic attack [TIA], and cerebral infarction*. See Section I.C.21.c.4 of the Official Guidelines, History (of), for use of personal history codes.

Dominant or nondominant side: Codes from category I69 that specify hemiplegia, hemiparesis, and monoplegia identify whether the dominant or nondominant side is affected. Tabular notes may direct you to choose a particular dominance as the default choice for some codes, when the documentation does not specify one or the other. If a default choice isn't provided, use the following guidelines to make your selection:

- For ambidextrous patients, the default is dominant.
- If the left side is affected, the default is nondominant.
- If the right side is affected, the default is dominant.

Keep the Focus on STEMI vs. NSTEMI for Acute Myocardial Infarction (AMI) Coding

The Official Guidelines for type 1 AMI coding stress that there are separate options for type 1 ST elevation myocardial infarction (STEMI) and type 1 non-STEMI (NSTEMI).

- It might help to explain that "ST" refers to a specific portion of an electrocardiogram (ECG). ST elevated away from the baseline suggests a heart attack is occurring (STEMI). But this elevation won't appear on ECGs for many patients experiencing an MI, so the provider will classify those as NSTEMI.

Use subcategories I21.0-I21.2 and I21.9 for type 1 STEMI. Turn to I21.4 for type 1 NSTEMI and nontransmural MIs.

- Nontransmural means not (non) through (trans) the wall (mural), indicating the heart muscle death due to restricted blood flow does not extend through the full thickness of the myocardial wall segment.

STEMI overrides NSTEMI: One thing you need to watch out for is that if type 1 NSTEMI evolves to STEMI, you should assign the STEMI code. What's more, you also should use a STEMI code when a type 1 STEMI converts to NSTEMI due to thrombolytic therapy. So in both cases, whether NSTEMI becomes STEMI, or STEMI becomes NSTEMI, you should use the appropriate STEMI code.

NSTEMI and site documented: Another area to watch is that you may see documentation of a nontransmural or subendocardial infarction along with a documented site. If an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as a subendocardial AMI. See Section I.C.21.c.3 of the Official Guidelines for information on coding status post administration of tPA in a different facility within the last 24 hours.

Unspecified MI: Assign I21.9 *Acute myocardial infarction, unspecified*, as the default code for an unspecified acute MI or unspecified type. If the provider doesn't specify the site but does document a type 1 STEMI or transmural MI, you should assign I21.3 *ST elevation (STEMI) myocardial infarction of unspecified site*.

Coding for a subsequent acute MI: Assign a code from category I22 *Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction*, for a patient who has suffered an initial type 1 or unspecified AMI and has a new AMI within four weeks. Also assign a code from category I21.

Remember: If the patient's subsequent MI is a different type from the initial MI, assign codes from category I21 to identify each type. Don't use a code from I22.

Hold off on aftercare coding for up to four weeks. You can continue to report from category I21 *ST elevation [STEMI] and non-ST elevation [NSTEMI] myocardial infarction* for all MI-related encounters up to four weeks old. If the patient is still receiving care related to the MI after four weeks, look to aftercare codes and not I21.- codes. For old or healed MIs not requiring further care, you may assign I25.2 *Old myocardial infarction*.

Be on the lookout for this MI distinction. Coronary microvascular dysfunction (CMD) is a condition that impacts the microvasculature of the heart by restricting microvascular flow and increasing microvascular resistance. Code I21.B *Myocardial infarction with coronary microvascular dysfunction,* if a physician documents that the patient has microvascular disease or dysfunction with their myocardial infarction.

The diagnosis may include myocardial infarction with non-obstructive coronary arteries (MINOCA) with microvascular disease as well.

Chapter 10: Diseases of the Respiratory System (J00-J99)
Guidelines for Assigning Codes From This Chapter

The respiratory system includes those organs that help you breathe, and those are the areas you'll find covered in Chapter 10. Many of the diagnoses relate to infections, but you'll also find other breathing-related conditions in this chapter, such as asthma and disorders caused by environmental toxins.

List of Sections

- J00-J06: Acute upper respiratory infections
- J09-J18: Influenza and pneumonia
- J20-J22: Other acute lower respiratory infections
- J30-J39: Other diseases of upper respiratory tract
- J40-J4A: Chronic lower respiratory diseases
- J60-J70: Lung diseases due to external agents
- J80-J84: Other respiratory diseases principally affecting the interstitium
- J85-J86: Suppurative and necrotic conditions of the lower respiratory tract
- J90-J94: Other diseases of the pleura
- J95: Intraoperative and postprocedural complications and disorders of respiratory system, not elsewhere classified
- J96-J99: Other diseases of the respiratory system

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The ICD-10-CM Official Guidelines for Coding and Reporting for Chapter 10 reveal proper coding solutions for four areas: chronic obstructive pulmonary disease (COPD) and asthma, acute respiratory failure, influenza due to certain viruses, and ventilator-associated pneumonia. Guidelines for vaping-related disorders are also included. The information that follows covers the major points from Section I.C.10 of the Official Guidelines.

Focus on the COPD and Asthma Coding Fundamentals

Proper code selection in categories J44 *Other chronic obstructive pulmonary diseases* and J45 *Asthma* requires you to distinguish between uncomplicated cases and those in acute exacerbation. An acute exacerbation is a worsening or a decompensation of a chronic condition. Although an exacerbation can be triggered by an infection, avoid assuming that a respiratory infection in a patient with chronic lung disease is equivalent to an acute exacerbation.

Determine Proper Place for Acute Respiratory Failure

Primary: The guidelines allow you to report codes J96.0- *Acute respiratory failure* or J96.2- *Acute and chronic respiratory failure* as a principal diagnosis, but they do stress the need to confirm it was the chief reason for the admission. Also, if other guidelines have related sequencing instructions, you should follow those before choosing acute respiratory failure as the principal diagnosis.

Secondary: Acute respiratory failure also can be a secondary diagnosis. You'd choose this sequencing when the diagnosis either wasn't present on admission or the diagnosis otherwise doesn't qualify as the principal diagnosis.

More sequencing rules: A patient may have more than one acute condition present on admission. To choose the principal diagnosis, you need to know which diagnosis is chiefly responsible for the admission and whether any ICD-10-CM sequencing rules affect those diagnoses. If multiple conditions share the same level of responsibility for admission, then inpatient facilities should follow the rules in Section II.C of the Official Guidelines, which state you may sequence any of the diagnoses first.

Inpatient Coders Need to Check This Influenza Rule

The guidelines for influenza hold an important exception for facility coders. The guidelines state that you should report only confirmed cases of influenza due to certain identified influenza virus from categories J09 *Influenza due to certain identified influenza viruses* and J10 *Influenza due to other identified influenza virus*. This is an exception to hospital inpatient guideline Section II.H *Uncertain Diagnosis*. Facilities should be sure to mark this exception with a reminder that even inpatient coders should report only confirmed cases using the specific influenza diagnoses listed above.

Note that "confirmed" simply means the provider must document that the patient has one of the listed types of influenza. You don't have to have a positive lab test to report the code.

What if it's not confirmed? For cases of these influenza diagnoses that are not confirmed, you should choose a code from J11 *Influenza due to unidentified virus*. Terms you may see related to unconfirmed diagnoses include suspected, possible, and probable.

Take the Guesswork out of Ventilator-associated Pneumonia

Ventilator-associated pneumonia, or VAP, is a life-threatening lung infection that affects patients who are already critically ill. As with all procedural or postprocedural complications, code assignment is based on the provider's documentation of the relationship between the condition and the procedure.

Let the provider connect the dots. Don't assume that a patient on a mechanical ventilator who develops pneumonia has ventilator-associated pneumonia. You should report J95.851 *Ventilator-associated pneumonia* only when the provider documents this specific condition. If the documentation is unclear as to whether the patient has a pneumonia that is a complication attributable to the mechanical ventilator, query the provider.

You won't need an additional code from categories J12-J18 to identify the type of pneumonia, but remember to report an additional code to identify the organism, e.g., B96.5 *Pseudomonas (aeruginosa) (mallei) (pseudomallei) as the cause of diseases classified elsewhere*.

VAP after admission: A patient with another type of pneumonia, such as J13 *Pneumonia due to Streptococcus pneumoniae*, may develop VAP after admission. You should assign the appropriate code from categories J12-J18 for the pneumonia diagnosed at the time of admission as the principal diagnosis. When VAP is documented, assign it as an additional diagnosis.

Hit This Code for Vaping-Related Disorders

When a patient has a condition(s) (including a lung injury) that is due to vaping, assign code U07.0 *Vaping-related disorder* as the principal diagnosis. Other manifestations such as acute respiratory failure can be coded as well.

Note: Respiratory signs and symptoms like coughing and/or shortness of breath should not be coded separately with a definitive diagnosis.

Chapter 11: Diseases of the Digestive System (K00-K95)

Guidelines for Assigning Codes From This Chapter

The first six sections of Chapter 11 codes cover mostly the digestive system from beginning to end, starting with the mouth and jaws and continuing to the intestines. The next section for digestive system diseases covers abdominal structures (peritoneum and retroperitoneum), the next two sections relate to diseases involving the organs, including many liver, gallbladder, biliary tract, and pancreas disorders. The final section identifies other diseases that do not fit into the first nine sections.

List of Sections

- K00-K14: Diseases of oral cavity and salivary glands
- K20-K31: Diseases of esophagus, stomach and duodenum
- K35-K38: Diseases of appendix
- K40-K46: Hernia
- K50-K52: Noninfective enteritis and colitis
- K55-K64: Other diseases of intestines
- K65-K68: Diseases of peritoneum and retroperitoneum
- K70-K77: Diseases of liver
- K80-K87: Disorders of gallbladder, biliary tract and pancreas
- K90-K95: Other diseases of the digestive system

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The 2024 version of the ICD-10-CM Official Guidelines for Coding and Reporting do not include specific guidelines for Chapter 11, stating that the section is reserved for future expansion.

Still, as with every ICD-10-CM chapter, you should be sure to review and apply the guidelines and instructions included in the code book with specific codes and code ranges. Below are some key areas to watch:

- **Ulcers:** When reporting esophageal (K22.1-), gastric (K25.-), duodenal (K26.-), and peptic (K27.-) ulcers, keep an eye out for an instruction specific to drug-induced ulcers. When the medical record shows a drug caused the ulcer, you should report a code from the T36-T50 range with fifth or sixth character of 5 to identify the drug. In addition, if the ulcer is caused by a corrosive substance, there is a code first note that instructs you to code for the chemical involved in a chemical-caused ulcer (T51-T65), if known.
- **Bariatric complications:** Two of the codes in category K95 *Complications of bariatric procedures* include an instruction to report an additional code to identify the specific infection if the complication is a result of infection. In other words, you should report more than just the existence of a complication. When reporting K95.01 *Infection due to gastric band procedure* and K95.81 *Infection due to other bariatric procedure*, you should check the documentation for the specific infective agent and report that code as well.
- **Diaphragmatic hernia:** The Excludes 1 note with category K44 *Diaphragmatic hernia* states that you should not use it for a congenital diaphragmatic hernia or a congenital hiatal hernia. Instead you should use Q79.0 *Congenital diaphragmatic hernia*. Similarly, although K44 includes hiatal hernias, you should use Q40.1 *Congenital hiatus hernia* for congenital hiatal hernias.
  - ➢ This Excludes 1 note serves as a reminder that ICD-10-CM often uses separate codes for acquired and congenital disorders. The definition of the acquired condition code may not specify "acquired," making it difficult to know whether the code only applies to an acquired condition. When coding a congenital condition, keep the likelihood of a distinct code in mind as you check the index and tabular list for the proper code.
- **Portal hypertension:** When documentation shows a complication related to portal hypertension, an instruction with K76.6 *Portal hypertension* states that you should report the complication as an additional diagnosis. The example ICD-10-CM gives is K31.89 *Other diseases of stomach and duodenum*, but this is not the only possibility. You should choose your codes based on the documentation for the specific case you're coding.

Chapter 12: Diseases of the Skin and Subcutaneous Tissue (L00-L99)

Guidelines for Assigning Codes From This Chapter

For a diagnosis involving the skin or the fatty subcutaneous tissue just under the skin, you'll likely find your code in Chapter 12. Cellulitis, dermatitis, psoriasis, corns, and hives are just some of the diagnoses you'll find here. You may be surprised to learn that this chapter also includes codes for diseases of the nails and hair.

But remember to always start your diagnosis code search in the Index. The codes for skin cancers such as melanoma and basal cell carcinoma are not in Chapter 12, and the Index will help you find the proper code.

List of Sections

- L00-L08: Infections of the skin and subcutaneous tissue
- L10-L14: Bullous disorders
- L20-L30: Dermatitis and eczema
- L40-L45: Papulosquamous disorders
- L49-L54: Urticaria and erythema
- L55-L59: Radiation-related disorders of the skin and subcutaneous tissue
- L60-L75: Disorders of skin appendages
- L76: Intraoperative and postprocedural complications of skin and subcutaneous tissue
- L80-L99: Other disorders of the skin and subcutaneous tissue

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The ICD-10-CM Official Guidelines for Coding and Reporting for Chapter 12 focus on coding for pressure ulcers (L89). The information below is from Section I.C.12 of the Official Guidelines.

Take note: ICD-10-CM codes for pressure ulcers are combination codes that specify both the site and the stage in a single code. If the patient has more than one pressure ulcer, you would assign as many codes as needed to identify all the involved sites.

Clinicians other than the patient's provider can document, too: You can utilize documentation from clinicians other than the patient's provider for the depth of non-pressure chronic ulcers and the depth of the pressure ulcer stage, but the provider must document any associated diagnosis.

Stages: There are four stages (1-4) used to identify the degree of severity of pressure ulcers. There are also codes for unstageable and unspecified. Choose the correct stage based on the clinical documentation. Go to "Ulcer, pressure" in the Alphabetic Index for key terms that you can look for in the documentation to determine the correct stage. If the ulcer stage has not been documented or the ulcer is not described well, query the provider. There is no code that can be assigned for a pressure ulcer documented as healed.

Pressure-induced deep tissue damage:

You now have the ability to code pressure-induced deep tissue damage and/or deep tissue pressure injuries. Use codes from the L89 category with a sixth character "6" to properly code these diagnoses (L89.--6).

See Section I.B.14 of the Official Guidelines, for pressure ulcer stage documentation by clinicians other than the patient's provider.

Separate Unstageable From Unspecified Stage

Do not confuse an unstageable pressure ulcer (L89.--0) with an unspecified stage pressure ulcer (L89.--9). Sometimes, a provider cannot determine the stage of a pressure ulcer because a skin or muscle graft has been applied over the ulcer, the ulcer is covered with eschar (scabbing), or the ulcer is documented as a deep tissue injury but without documentation of trauma. You must analyze the documentation to see if any of these situations apply before assigning L89.--0. Use unspecified (L89.--9) only when the documentation fails to identify the stage.

If during an encounter the provider performs debridement, and identifies the stage of the pressure ulcer, please assign the specific code for the stage identified subsequent to the debridement of the pressure ulcer.

Don't Confuse Healed With Healing

When the documentation for the patient's admission records a healed ulcer, you should not include a code for the ulcer. However, when the record mentions a healing ulcer, you should report the site and the ulcer stage documented. If the record fails to provide enough information to determine the stage of a healing pressure ulcer, report the code for an unspecified stage for that site. If the record does not make it clear whether the pressure ulcer is new or healing, you should ask the provider to clarify.

Report Two Codes for Progressing Ulcer

Finally, the guidelines offer instructions on what to do when a patient has a pressure ulcer that is one stage at admission (to an inpatient hospital), but evolves to a higher stage during the stay. You should report two separate codes. One for the site and stage of the ulcer upon admission and a second code for the same ulcer site and the highest stage reported during the patient's stay.

Handling Non-Pressure Chronic Ulcers

- **Healed NP ulcer:** You do not need to code a non-pressure ulcer for a patient that is admitted and the documentation indicates the ulcer is completely healed. But if a patient is admitted with non-pressure ulcers documented as *healing*, code that visit with the appropriate non-pressure ulcer code based on the documentation found in the medical record. If the documentation does not provide information about the severity of the healing non-pressure ulcer, assign the appropriate code for unspecified severity.
- **Unclear documentation:** Query the provider if the documentation you find is unclear, if the patient has a current (new) non-pressure ulcer, or if the patient is being treated for a healing non-pressure ulcer.
- **Healed by discharge:** If the ulcers were present on admission, but healed by the time the patient is discharged, assign the code for the site and severity of the non-pressure ulcer at the time of admission.
- **Progressing severity:** If a patient is admitted with a non-pressure ulcer that progresses to another higher severity level during the admission, you need to assign two separate codes. Assign a code for the site and severity level of the ulcer at admission and assign a second code for that same ulcer site for the highest severity level reported during the stay.

See Section I.B.14 of the Official Guidelines, for documentation of depth of non-pressure chronic ulcers by clinicians other than the patient's provider.

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

Guidelines for Assigning Codes From This Chapter

When you need to report a joint or spine disorder, a musculoskeletal deformity, or a pathologic fracture, you're likely to find your code in Chapter 13.

List of Sections

- M00-M02: Infectious arthropathies
- M04: Autoinflammatory syndromes
- M05-M14: Inflammatory polyarthropathies
- M15-M19: Osteoarthritis
- M20-M25: Other joint disorders
- M26-M27: Dentofacial anomalies [including malocclusion] and other disorders of jaw
- M30-M36: Systemic connective tissue disorders
- M40-M43: Deforming dorsopathies
- M45-M49: Spondylopathies
- M50-M54: Other dorsopathies
- M60-M63: Disorders of muscles
- M65-M67: Disorders of synovium and tendon
- M70-M79: Other soft tissue disorders
- M80-M85: Disorders of bone density and structure
- M86-M90: Other osteopathies
- M91-M94: Chondropathies
- M95: Other disorders of the musculoskeletal system and connective tissue
- M96: Intraoperative and postprocedural complications and disorders of musculoskeletal system, not elsewhere classified
- M97: Periprosthetic fracture around internal prosthetic joint
- M99: Biomechanical lesions, not elsewhere classified

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

For Chapter 13, the ICD-10-CM Official Guidelines for Coding and Reporting concentrate on proper coding of site and laterality, acute traumatic versus chronic or recurrent musculoskeletal conditions, coding of pathologic fractures, and osteoporosis. The information below is from Section I.C.13 of the Official Guidelines.

Specificity is Key

- Select the code that designates the specific bone, joint or muscle involved and the side of the body.
- Use the "multiple sites" code, if one is available, instead of coding each site separately.
- Code the bone, not the joint, if a condition such as avascular necrosis or osteoporosis affects the end of the bone and includes the joint.

Acute Traumatic vs. Chronic or Recurrent

Before choosing between acute traumatic and chronic or recurrent codes, remember that a condition can be the result of previous injury or trauma or a recurrent condition. You'll find bone, joint, or muscle conditions that are the result of a healed injury in Chapter 13, as well as recurrent conditions. Remember to code acute injuries from Chapter 19.

Use the 7th Character for Pathologic Fractures

A pathologic fracture is a break in a weakened bone caused by disease, such as a tumor, rather than trauma or stress. Coding varies based on the stage of the treatment.

Active treatment: To report a pathologic fracture receiving active treatment, you use a code from Chapter 13 range M84.4- to M84.6- *Pathological fracture…* ending in 7th character A. Examples of active treatment are surgical treatment, emergency department encounter, evaluation, and continuing treatment by the same or a different physician. Remember that it doesn't matter whether or not the provider is seeing the patient for the first time.

Aftercare: Select a code with 7th character D for encounters after the patient has completed active treatment for the fracture and is receiving routine care for the fracture during the healing or recovery phase. You'll find other 7th character options listed under each subcategory in the Tabular List to identify subsequent encounters for treatment of problems associated with healing, such as malunions, nonunions, and sequelae.

If complications arise after surgical treatment, use the appropriate complication codes.

Note: See Chapter 19 for coding of traumatic fractures.

Bone up on Osteoporosis Coding

Osteoporosis is a systemic condition, affecting the whole body, so you won't find site codes in category M81 *Osteoporosis without current pathological fracture*. If an osteoporosis patient sustains a fracture, choose a code from M80 *Osteoporosis with current pathological fracture* to identify the site of the fracture, not the osteoporosis.

Without current fracture: Use category M81 for patients without a current fracture, even if they have had a fracture due to osteoporosis in the past. For those patients, assign status code Z87.310 *Personal history of [healed] osteoporosis fracture* after category M81.

With current fracture: Select a code from category M80 based on fracture site. Never use a traumatic fracture code for a patient with known osteoporosis.

Multisystem Inflammatory Syndrome

The Official Guidelines mention multisystem inflammatory syndrome, and COVID-19 infections. See section I.C.1.g.1.l for further information.

Chapter 14: Diseases of the Genitourinary System (N00-N99)

Guidelines for Assigning Codes From This Chapter

The genitourinary system, which Chapter 14 covers, includes both the reproductive organs and the urinary organs. You'll find codes related to the kidneys and urinary tract; the male genital organs, including the prostate and infertility issues; the breasts; female pelvic organs; and the female genital tract, including diagnoses such as endometriosis and menopause.

List of Sections

- N00-N08: Glomerular diseases
- N10-N16: Renal tubulo-interstitial diseases
- N17-N19: Acute kidney failure and chronic kidney disease
- N20-N23: Urolithiasis
- N25-N29: Other disorders of kidney and ureter
- N30-N39: Other diseases of the urinary system
- N40-N53: Diseases of male genital organs
- N60-N65: Disorders of breast
- N70-N77: Inflammatory diseases of female pelvic organs
- N80-N98: Noninflammatory disorders of female genital tract
- N99: Intraoperative and postprocedural complications and disorders of genitourinary system, not elsewhere classified

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

Although there are a variety of diagnoses in Chapter 14, the ICD-10-CM Official Guidelines for Coding and Reporting focus on proper coding of chronic kidney disease. The information below is from Section I.C.14 of the Official Guidelines.

Capture All the Information for Chronic Kidney Disease Coding

An important element of coding chronic kidney disease (CKD) is reporting the stage, from 1-5. For instance, you report stage 1 using N18.1 *Chronic kidney disease, stage 1* and stage 2 using N18.2 *Chronic kidney disease, stage 2 [mild]*. Stage 3 (N18.3-) is considered moderate and stage 4 (N18.4) severe.

There's also a distinct code for end stage renal disease (ESRD), N18.6 *End stage renal disease*. When documentation shows both a stage and ESRD, you should report only ESRD code N18.6 and not the code for the stage.

Transplant: When a patient who has had a kidney transplant has CKD, you should report the appropriate code for the CKD stage and Z94.0 *Kidney transplant status*. Note that CKD following kidney transplant does not qualify as a complication, so you should not code it as such. When the documentation isn't clear about whether or not the CKD is a complication, ask the provider for clarification. See Section I.C.19.g.3 of the Official Guidelines for codes for transplant failure or rejection.

Other conditions: When the patient has another condition in addition to CKD, such as diabetes mellitus (Chapter 4) or hypertension (Chapter 9), be sure to review each condition's code for rules on proper sequencing and reporting.

Check Chapter 1 for Urosepsis Rule

You won't find every relevant guideline for Chapter 14 in the Chapter 14 section of the Official Guidelines. You'll find one important example in the Chapter 1 guidelines for Infectious and Parasitic Diseases.

In Section I.C.1.d, you'll find a note explaining that the term urosepsis has no clinical meaning, and it has no default code in the Alphabetic Index. If a provider documents urosepsis, you must ask for clarification. If they identify a urinary tract infection, you would select the code based on the location of the infection. You should also report a code for the infecting organism if known.

Chapter 15: Pregnancy, Childbirth and the Puerperium (O00-O9A)

Guidelines for Assigning Codes From This Chapter

As Chapter 15's name indicates, you'll find codes here for diagnoses related to pregnancy, childbirth, and the puerperium (the weeks immediately after the birth). This chapter primarily includes codes for complications, but it also includes codes for normal delivery.

List of Sections

- O00-O08: Pregnancy with abortive outcome
- O09: Supervision of high risk pregnancy
- O10-O16: Edema, proteinuria and hypertensive disorders in pregnancy, childbirth and the puerperium
- O20-O29: Other maternal disorders predominantly related to pregnancy
- O30-O48: Maternal care related to the fetus and amniotic cavity and possible delivery problems
- O60-O77: Complications of labor and delivery
- O80-O82: Encounter for delivery
- O85-O92: Complications predominantly related to the puerperium
- O94-O9A: Other obstetric conditions, not elsewhere classified

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The Official Guidelines for Chapter 15 cover a variety of topics, including when to look outside the chapter for the proper codes. One important rule for this chapter is that generally these codes trump codes in sequencing priority from other chapters. Also important is that these codes belong on claims for the mother, not for the newborn. You can read the complete guidelines for this chapter in Section I.C.15 of the Official Guidelines. Guidelines are also included that address COVID-19 in pregnancy, childbirth, and the puerperium.

Keep in Mind That Z Codes May Apply Instead

Note that when a patient presents for an encounter and the pregnancy is incidental, meaning that the reason for the encounter is not the pregnancy, you should report Z33.1 *Pregnant state, incidental*, instead of a code from Chapter 15. The provider's documentation should clearly state that the reason for the visit is not the pregnancy.

Also, if a patient presents for routine prenatal visits and no codes from Chapter 15 apply because there are no pregnancy complications, you should assign Z codes such as, Z34.0- *Encounter for supervision of normal first pregnancy*, Z34.8- *Encounter for supervision of other normal pregnancy*, or Z34.9- *Encounter for supervision of normal pregnancy, unspecified* as the diagnosis. To clarify, do not use these codes with codes from Chapter 15.

Code High-Risk Supervision as Primary Diagnosis

Assign a code from category O09 *Supervision of high-risk pregnancy* as the first-listed diagnosis. Other Chapter 15 codes may also be reported when appropriate.

Identify the Trimester With a Final Character

Most of the codes in Chapter 15 require a final character to indicate which trimester the complication occurs in. Here are the time frames for each trimester:

- First trimester: less than 14 weeks, 0 days
- Second trimester: 14 weeks, 0 days through 27 weeks and 6 days
- Third trimester: 28 weeks through delivery

Certain conditions always occurs in a specific trimester, and sometimes, the trimester of pregnancy is simply not applicable to the condition. Some conditions may occur in more than one trimester but not in every trimester. You must check the documentation and the index to determine whether a final character is needed for certain codes. The final character is based on the trimester at the time of admission or encounter, whether the condition is pre-existing or occurred during the pregnancy.

In childbirth option: Whenever you have a code with an "in childbirth" option, use that code if a complication occurs during delivery. If the classification does not specify a code with the "in childbirth" option, you may assign a code identifying the current trimester.

Unspecified trimester: Although a final character exists for an unspecified trimester, you should not assign that code unless the record fails to document the trimester and it is impossible to get the record clarified.

Overlapping trimesters: Assign the final character based on which trimester the patient was in at the time of admission/encounter for the complication, even if the complication developed prior to admission or is a pre-existing condition. Do not assign the character for the trimester at the time of discharge.

Which Week to Code?

A pregnant patient must complete a full week of gestation in order for it to be coded as such. For example, if a provider documents 15 weeks and 6 days of gestation, code 15 weeks. In other words, this patient is in their 16th week of pregnancy, but it must be documented as 15 weeks since they have not completed the full 16th week as of yet.

Identify Fetus with 7th Character in Multiple Gestation Complications

Certain categories of complication diagnoses codes (O31-, O32-, O33.3-O33.6, O35-, O36-, O40-, O41-, O60.1-, O60.2-, O64-, and O69-) require that you assign a 7th character to identify the fetus affected. Use a 0 as the 7th character for:

- Single gestations.
- Insufficient documentation to determine the affected fetus and clarification is not possible.
- When the affected fetus cannot be clinically determined.

If the pregnancy is a multiple-gestation pregnancy, fetuses one through five are identified with corresponding 7th characters of 1-5. A 7th character of 9 identifies "other."

Delivery May Affect Complication Coding

No delivery: For an encounter where delivery doesn't happen, choose the complication that led to the encounter as the principal diagnosis. If there's more than one complication, you may report any one of them first.

Delivery: When reporting the delivery encounter, your principal diagnosis needs to represent the "main circumstances or complication of the delivery" if the delivery is complicated. If the patient has a cesarean section (C-section), choose the code responsible for admission as the principal code, even if it's unrelated to the condition that led to the C-section. Also be sure to include a code for outcome of the delivery (Z37.-) in the maternal record.

Focus on Maternal Impact of Fetal Conditions

Heed the code descriptors before you use codes from categories O35 *Maternal care for known or suspected fetal abnormality and damage* or O36 *Maternal care for other fetal problems*. As the definitions specify, those codes are appropriate only when the condition is one "affecting the management of the mother," such as a condition that leads to additional tests or performing in utero surgery. The mere existence of the fetal condition is insufficient reason to assign one of these codes if it doesn't affect the mother's care.

In utero surgery. In utero surgery on a fetus should be reported as an obstetric encounter. A diagnosis code from category O35 to identify the fetal condition is appropriate along with the appropriate procedure code. Keep in mind that you should never use the codes in Chapter 16 on the mother's record.

Remember Sequencing for Pregnant Patients With HIV or Diabetes

HIV: Choose O98.7- *Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium* as the principal diagnosis for a patient who is admitted because of an HIV-related illness and who is pregnant or recently gave birth. Then, depending on the patient's HIV status, add B20 *Human immunodeficiency virus [HIV] disease* — which includes AIDS, AIDS-related complex, and symptomatic HIV infection — or Z21 *Asymptomatic human immunodeficiency virus [HIV] infection status*, which includes HIV positive, NOS.

Diabetes: Code first one of the codes from the category O24 *Diabetes mellitus in pregnancy, childbirth, and the puerperium*, if known. Then, add an appropriate diabetes code from Chapter 4 code(s) (E08-E13).

For pre-existing diabetes mellitus in pregnancy, you have two codes to choose from O24.01- (type 1) and O24.11- (type 2). Add an additional character 1-3 for the first through third trimesters and 9 for unspecified trimester. You have other codes in this same category for diabetes mellitus in childbirth and puerperium.

For gestational diabetes in pregnancy, choose from the subcategory O24.41-, adding additional characters for diet controlled (0), insulin controlled (4), and unspecified control (9). This category does not specify the trimester. Do not use any other code from category O24 when you report this code. Since gestational diabetes is a temporary condition, insulin use is built into these codes and Z79.4 should not be coded with them.

If the patient is receiving medication to control the pre-existing diabetes, you should also add Z79.4 *Long-term [current] use of insulin*, Z79.84 *Long-term [current] use of oral hypoglycemic drugs*, and/or Z79.85 *Long-term [current] use of injectable non-insulin antidiabetic drugs* as documented by the provider.

If the patient is diagnosed with abnormal glucose tolerance but not diabetes mellitus, you should assign a code from subcategory O99.81- *Abnormal glucose complicating pregnancy, childbirth, and the puerperium*.

Don't Overlook Other Complications

Sepsis and septic shock: If you assign a code from Chapter 15 for a complication of sepsis during pregnancy, delivery, abortion, or the puerperium, assign an additional code to identify the specific type of infective agent, if known. In addition, look to the subcategory R65.2- *Severe sepsis* if severe sepsis is present, with additional code(s) to identify affected organs, if appropriate.

For example, if you assign code O85 *Puerperal sepsis* caused by a bacteria, you would add a code from categories B95-B96 *Bacterial infections in conditions classified elsewhere* to identify the cause of the infection. Do not use codes from category A40 *Streptococcal sepsis* or A41 *Other sepsis* when you assign O85 for puerperal sepsis.

If applicable, add code R65.2- *Severe sepsis* and add a code for any associated acute organ dysfunction.

Note: Do not code O85 for sepsis following an obstetrical procedure. See the ICD-10-CM Official Guidelines section I.C.1.d.5.b.

Alcohol: Assign a code from subcategory O99.31- *Alcohol use complicating pregnancy, childbirth, and the puerperium* when a pregnant patient uses alcohol during the pregnancy or postpartum period. Classify manifestations of alcohol use with an additional code from category F10 *Alcohol-related disorders*.

Tobacco: When a pregnant patient uses any tobacco product during pregnancy or the postpartum period, report it with codes in subcategory O99.33- *Tobacco use disorder complicating pregnancy, childbirth, and the puerperium* along with a code from category F17 *Nicotine dependence* to identify the type of nicotine dependence.

Drugs: You should assign codes from subcategory O99.32-, *Drug use complicating pregnancy, childbirth, and the puerperium*, when a patient uses drugs during the pregnancy or postpartum. These codes cover illegal drug use, or the inappropriate use or abuse of prescription drugs. Assign secondary code(s) from categories F11-F16 and F18-F19 to identify manifestations of the drug use.

Other adverse events and effects: If a pregnant patient suffers a complication due to poisoning, toxicity from a drug or other substance, underdosing of a drug, or other adverse effect, choose a code from subcategory O9A.2- *Injury, poisoning and certain other consequences of external causes complicating pregnancy, childbirth, and the puerperium* as a primary diagnosis. Follow it with additional code(s) that specify the cause of the complication. See Chapter 19, Adverse effects, poisoning, underdosing, and toxic effects.

COVID-19 and pregnancy: If during pregnancy, childbirth, or the puerperium a patients presents with COVID-19 as the reason for the encounter, assign code O98.5- *Other viral diseases complicating pregnancy, childbirth and the puerperium* as the principal diagnosis and then add U07.1 *COVID-19* and any COVID-related manifestations as secondary codes.

If a COVID-19 infection is discovered when the patient is present for an unrelated admission/encounter, code the reason for visit along with codes O98.5- and U07.1.

Factor Complication's Time Frame Into Coding Choice

Resolved before delivery: Although you shouldn't report O80 *Normal delivery* when a complication code from Chapter 15 applies, you may report O80 if the patient had a previous complication that resolved by the time of the delivery admission. You can report diagnosis codes from other chapters if they are not complicating the pregnancy or delivery.

Remember to assign Z37.0 *Single live birth* for the outcome of delivery with O80; no other outcome of delivery code is acceptable with O80.

Complications after delivery: The Official Guidelines define postpartum as the 6 weeks after delivery. But you may report Chapter 15 codes even after this time if the provider documents the condition is pregnancy-related. Peripartum is the last month of pregnancy and five months after delivery. Chapter 15 codes can even be assigned after the peripartum period provided the documentation supports a pregnancy-related complication, such as pregnancy-associated cardiomyopathy.

Pregnancy-associated cardiomyopathy: When a patient who does not have pre-existing heart disease develops cardiomyopathy as a result of their pregnancy, assign code O90.3 *Peripartum cardiomyopathy*. Although it may be diagnosed in the third trimester, pregnancy-related cardiomyopathy can continue for months after delivery — therefore, the diagnosis *peripartum cardiomyopathy*. You can only use this code, however, for a pregnant patient without pre-existing heart disease.

Sequelae of pregnancy-related complications: If a patient develops a condition resulting from a complication (a sequela) and requires

care or treatment after the complication has resolved, code the condition (sequela) first and then code O94 *Sequelae of complication of pregnancy, childbirth, and the puerperium*.

Note: This code can be used any time after the initial six-week postpartum period.

Don't Get Thrown by Delivery Outside Hospital

When a patient presents for routine care after delivering outside of the hospital, report Z39.0 *Encounter for care and examination of mother immediately after delivery*. If the patient presents with complications after delivering outside the hospital, choose codes based on those complications. You can use this code any time after the postpartum period.

Watch Definitions and Circumstances for Accurate Abortion Coding

Definitions: Abortion simply means premature termination of pregnancy. You may be familiar with the term miscarriage, which in medical language is a spontaneous abortion. An induced abortion is an elective termination of pregnancy, regardless of the reason. You may see the words *incomplete abortion* referring to retained products of conception (fetus and/or placenta), following either a spontaneous or elective abortion.

Fetus liveborn: When the fetus is liveborn during an attempted pregnancy termination, you should report Z33.2 *Encounter for elective termination of pregnancy* and a code from category Z37 *Outcome of delivery*.

Post-abortion retained products of conception: If a patient retains tissue from the placenta or fetus after an elective termination of pregnancy, you would assign a O07.4 *Failed attempted termination of pregnancy without complication* and Z33.2 *Encounter for elective termination of pregnancy*. If the retained products followed a spontaneous abortion without complications, assign code O03.4 *Incomplete spontaneous, abortion without complication*. These codes can be appropriate even when the patient had a discharge diagnosis of complete abortion. However, if in addition to retained products of conception, the patient has a specific complication associated with the spontaneous abortion or elective termination of pregnancy, you will assign the appropriate complication code (i.e., O03.-, O04.-, O07.-) instead of code O03.4 *Incomplete spontaneous abortion without complication* or O07.4 *Failed attempted termination of pregnancy without complication*.

Complications: Other codes from Chapter 15 that identify documented complications of the pregnancy can be used in combination with codes from categories O04- *Complications following (induced) termination of pregnancy*, O07- *Failed attempted termination of pregnancy*, and O08- *Complications following ectopic and molar pregnancy*.

Hemorrhage: If hemorrhaging occurs after an elective abortion, do not code this as a postpartum hemorrhage, instead use code O04.6 *Delayed or excessive hemorrhage following [induced] termination of pregnancy.* Since this is a post event do not include the code Z33.2 *Encounter for elective termination of pregnancy*. Do not be misled into coding O72.1 *Other immediate postpartum hemorrhage*, as this code is not meant for post abortion conditions.

Don't Overlook Codes for Abuse in a Pregnant Patient

Sequence codes for suspected or confirmed abuse first before assigning appropriate codes to report the specific injury or sexual abuse, or codes to identify the abuser. Subcategories to report abuse include:

- O9A.3- *Physical abuse complicating pregnancy, childbirth, and the puerperium*
- O9A.4- *Sexual abuse complicating pregnancy, childbirth, and the puerperium*
- O9A.5- *Psychological abuse complicating pregnancy, childbirth, and the puerperium*

See Chapter 19, Adult and child abuse, neglect and other maltreatment, for additional codes.

Note: For COVID-19 infections in newborns, see Chapter 16.

Chapter 16: Certain Conditions Originating in the Perinatal Period (P00-P96)

Guidelines for Assigning Codes From This Chapter

Chapter 16's title refers to the perinatal period, which includes the period before birth as well as 28 days after birth. But the key to properly applying these codes is understanding that you never use them on the maternal record. Use these codes for the specific patient (whether an infant or older) who has a condition with origins just before the patient was born or within the first four weeks of life.

List of Sections

- P00-P04: Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery
- P05-P08: Disorders of newborn related to length of gestation and fetal growth
- P09: Abnormal findings on neonatal screening
- P10-P15: Birth trauma
- P19-P29: Respiratory and cardiovascular disorders specific to the perinatal period
- P35-P39: Infections specific to the perinatal period
- P50-P61: Hemorrhagic and hematological disorders of newborn
- P70-P74: Transitory endocrine and metabolic disorders specific to newborn
- P76-P78: Digestive system disorders of newborn
- P80-P83: Conditions involving the integument and temperature regulation of newborn
- P84: Other problems with newborn
- P90-P96: Other disorders originating in the perinatal period

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The Chapter 16 ICD-10-CM Official Guidelines for Coding and Reporting help you with assigning codes for conditions arising before birth and in the 28 days after. Guidelines are also included that cover COVID-19 infections in newborns. The information below is from Section I.C.16 of the Official Guidelines.

Factor In These 6 General Rules

The guidelines start with general rules for Chapter 16 coding:

1. You should never use Chapter 16 codes or codes from category Z38 *Liveborn infants according to place of birth and type of delivery* on the maternal record nor should you use Chapter 15 codes on a newborn record.
2. Code P95 *Stillbirth* is used only in facilities that record stillbirths separately. Do not use any other code with P95, and do not include it on the mother's record.
3. If a condition present at birth continues throughout the patient's life, Chapter 16 codes still apply.
4. On a newborn record, the delivering hospital reports the appropriate liveborn code from category Z38 *Liveborn infants according to place of birth and type of delivery*. Then the hospital reports the appropriate Chapter 16 code followed by any relevant codes from other chapters that provide more details. Should the baby be transferred to another hospital, the receiving hospital should not assign Z38 codes.
5. Chapter 16 includes codes for conditions caused by the birth process, not for community-acquired conditions. But if a condition could be either and the record doesn't specify, you should use a Chapter 16 code.
6. The Chapter 16 guidelines instruct you to report all clinically significant conditions noted on the routine newborn exam. In relation to the newborn exam, a condition is clinically significant if it requires any of the following:
   - ➢ Clinical evaluation
   - ➢ Therapy
   - ➢ Diagnostic services
   - ➢ An extended hospital stay
   - ➢ Higher than normal nursing care and/or monitoring
   - ➢ Watching because of the implications on the patient's future health

Keep in mind that this last bullet in particular applies to coding the newborn exam, and you shouldn't assume it applies to coding in other areas.

Suspected Conditions Not Found

Assign a code from category Z05 *Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out*, to identify those instances when a healthy newborn is evaluated for suspected diseases and conditions that are determined, after study, not to be present. Use this code on the birth record as a secondary code after a Z38 code. On any chart other than the birth record, Z05.- can be assigned as the principal or first-listed code. When the provider suspects a problem and documents the signs and symptoms, use codes for those signs and symptoms instead of using a code from category Z05.

Use Caution When Assigning Premature, Slow Fetal Growth, Malnutrition, and Low Birth Weight Codes

Note that the guidelines indicate that because providers have different definitions of prematurity, you should assign a prematurity code only when the provider documents prematurity.

Carefully check the documentation before you assign codes from 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*. Go by the documented birth weight and estimated gestational age. Keep these points in mind:

- Do not assign codes from the P05 category in combination with codes from P07.
- Code birth weight before gestational age, if both are documented, with appropriate codes from the P07 category.
- Codes from category P07 can be used for adults if their current health is impacted by those conditions.

See also Chapter 21 for more codes for other factors influencing health status.

Start With This Chapter for Newborn Sepsis

For newborn sepsis, you should report a code from category P36 *Bacterial sepsis of newborn*, includes congenital sepsis, rather than codes from Chapter 1, Certain Infectious and Parasitic Diseases. If the documentation doesn't indicate whether the sepsis is congenital or community-acquired, the default is congenital, and you should

assign a code from the P36 category. Most of the P36 code descriptors include the causative organism. However, if you have to use a code that does not identify the organism, you should add a code from category B95 *Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified elsewhere* or B96 *Other bacterial agents as the cause of diseases classified elsewhere*. If appropriate, you can use additional codes, if known, from R65.2- *Severe sepsis* to report severe sepsis and associated organ dysfunction.

Chapter 17: Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00-Q99)

Guidelines for Assigning Codes From This Chapter

To report a condition present from birth, you should use a code from Chapter 17. Examples of conditions you'll find here include spina bifida, ventricular septal defect, patent ductus arteriosus, and congenital hip deformities.

List of Sections

- Q00-Q07: Congenital malformations of the nervous system
- Q10-Q18: Congenital malformations of eye, ear, face and neck
- Q20-Q28: Congenital malformations of the circulatory system
- Q30-Q34: Congenital malformations of the respiratory system
- Q35-Q37: Cleft lip and cleft palate
- Q38-Q45: Other congenital malformations of the digestive system
- Q50-Q56: Congenital malformations of genital organs
- Q60-Q64: Congenital malformations of the urinary system
- Q65-Q79: Congenital malformations and deformations of the musculoskeletal system
- Q80-Q89: Other congenital malformations
- Q90-Q99: Chromosomal abnormalities, not elsewhere classified

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The ICD-10-CM Official Guidelines for Coding and Reporting for Chapter 17 supply helpful information for reporting congenital anomalies, which you may report as either primary or secondary diagnoses. The information below is from Section I.C.17 of the Official Guidelines.

Keep Your Manifestation Coding in Line With the Rules

In some cases, an anomaly may not have a unique code, but you may report codes for manifestations of the anomaly.

When there is a unique code for the anomaly, you shouldn't report codes for typical manifestations of that anomaly.

Don't Limit Code Use Based on Age

Although the word congenital means present from birth, it doesn't put an age restriction on the patients these codes can apply to. You may report a congenital anomaly code for a patient of any age. In fact, providers may not identify some types of congenital anomalies until years after the patient's birth.

When the provider identifies the anomaly at birth, the guidelines offer specific rules for coding the birth. You should report the appropriate liveborn infant code from category Z38 *Liveborn infants according to place of birth and type of delivery*, followed by the code for the anomaly.

Caution: If the congenital anomaly is documented as corrected, you should report a personal history code for that anomaly.

Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99)

Guidelines for Assigning Codes From This Chapter

Chapter 18 is your go-to chapter for codes when the documentation doesn't include a definitive diagnosis, but documentation does include the signs or symptoms that triggered the visit. You'll also find the codes you'll use when the results of a test, such as an electrocardiogram or urinalysis, are abnormal.

Caution: You may find codes for signs and symptoms associated with specific diagnoses in other chapters, as well.

List of Sections

- R00-R09: Symptoms and signs involving the circulatory and respiratory systems
- R10-R19: Symptoms and signs involving the digestive system and abdomen
- R20-R23: Symptoms and signs involving the skin and subcutaneous tissue
- R25-R29: Symptoms and signs involving the nervous and musculoskeletal systems
- R30-R39: Symptoms and signs involving the genitourinary system
- R40-R46: Symptoms and signs involving cognition, perception, emotional state and behavior
- R47-R49: Symptoms and signs involving speech and voice
- R50-R69: General symptoms and signs
- R70-R79: Abnormal findings on examination of blood, without diagnosis
- R80-R82: Abnormal findings on examination of urine, without diagnosis
- R83-R89: Abnormal findings on examination of other body fluids, substances and tissues, without diagnosis
- R90-R94: Abnormal findings on diagnostic imaging and in function studies, without diagnosis
- R97: Abnormal tumor markers
- R99: Ill-defined and unknown cause of mortality

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The Chapter 18 ICD-10-CM Official Guidelines for Coding and Reporting help you with assigning codes when a diagnosis has not yet been determined or when a patient has symptoms or manifestations unrelated to the diagnosis. The information below is from Section I.C.18 of the Official Guidelines.

Apply These General Guidelines From Chapter 18

The chapter guidelines include these instructions:

- You may use the signs and symptoms codes when the provider hasn't confirmed a definitive diagnosis.
- You should not report signs and symptoms if they're a usual part of the disease process for the confirmed diagnosis you're reporting or if the diagnosis code is a combination code that includes the symptoms in the descriptor.
- You may report signs and symptoms not usually associated with the confirmed diagnosis you're reporting, but code the primary diagnosis first.

Heed the Rules for These Specific Circumstances

Repeated falls: When a patient presents for a workup to investigate the reason for recent falls, use code R29.6 *Repeated falls*. When a patient presents for a different problem but is at risk for repeated falls due to a history of falling, assign code Z91.81 *History of falling*. Sometimes, you can use both codes for the same encounter, for example, if the patient had fallen in the past followed by an interval without falls and then starts having repeated falls again.

Coma: You may use R40.20 *Unspecified coma* when the underlying cause of the coma is not known, or the cause is a traumatic brain injury and the coma scale is not documented in the medical record. When a patient presents with loss of consciousness or reduced alertness after a traumatic brain injury or cerebrovascular accident (stroke), the provider generally performs a neurological examination to determine the patient's level of consciousness. The provider will follow specific guidelines that have associated scores, which are added up to determine the coma score. EMTs may report coma scores when the patient presents initially, but some facilities may capture a coma score at intervals throughout the patient's stay. Regardless of who assigns the score, the initial score documented in the medical record should always be assigned a code. See Section I.B.14 of the Official Guidelines, for coma scale documentation by clinicians other than the patient's provider.

When assigning coma scale codes (R40.21- to R40.24-), remember they cannot be used with code R40.2A *Nontraumatic coma due to underlying condition*.

The following guidelines will help you correctly apply the coma scale codes:

1. Sequence the coma scale codes after the diagnosis code(s).
2. Choose one code from each subcategory: R40.21- *Coma scale, eyes open*, R40.22- . . . *best verbal response*, R40.23- . . . *best motor response* to get a complete scale.
3. Add a 7th character to indicate when the scale took place; you should use the same 7th character for all three codes.
4. If only the total score is documented, choose code R40.24- *Glasgow coma scale, total score*.
5. Do not report codes for unspecified coma, individual, or total Glasgow coma scale scores if your patient is sedated or in a medically induced coma.

Remember: Although these codes are used principally by trauma registries, R40.2- codes for coma may also be employed in any facility where this information is collected.

Clinicians can document too. You can utilize documentation from clinicians other than the patient's provider to assign codes for ratings on the coma scale.

Tackle multiple coma scores: If coma scores are monitored and documented multiple times within the first 24 hours of admission, you need to assign the code for the coma score at the time of admission only. Guidelines do not lay much significance on coma scores reported after admission, but within 24 hours of it.

Functional quadriplegia: GUIDELINE HAS BEEN DELETED EFFECTIVE OCTOBER 1, 2017.

SIRS due to noninfectious process: Patients can develop systemic inflammatory response syndrome (SIRS) as a result of trauma, pancreatitis, malignant neoplasm, or other noninfectious processes. When the medical record documents such a condition in conjunction

with SIRS and no infection is documented, you should code first the primary diagnosis. Then, code R65.10 *Systemic inflammatory response syndrome [SIRS] of noninfectious origin without acute organ dysfunction*, or R65.11 . . . *with acute organ dysfunction* if acute organ dysfunction resulting from the SIRS is documented. In the latter case, report a separate code for the specific type of organ dysfunction(s). If the record documents acute organ dysfunction but does not connect it to the primary diagnosis or SIRS, query the provider.

Death NOS: Use code R99 *Ill-defined and unknown cause of mortality* only when a patient is pronounced dead upon arrival. Do not use this code for the discharge disposition of death.

NIHSS Stroke Scale: To identify the patient's neurological status and the severity of the stroke, use the NIH stroke scale (NIHSS) codes (R29.7-) as secondary codes to the acute stroke codes (I60-I63).

Remember: Always report the initial documented score.

You can utilize documentation from clinicians other than the patient's provider to assign codes for ratings on the NIHSS stroke scale. See Section I.B.14 of the Official Guidelines for more information.

Remember These Additional Rules From the General Guidelines

Check Chapter 1 rule for HIV test. The guidelines for Chapter 1, Infectious and Parasitic Diseases, will help keep you on track when reporting an encounter for HIV testing. You should report an HIV code only for confirmed cases of HIV, so when a patient with signs and symptoms presents for HIV testing, you should report the signs and symptoms rather than HIV. See Section I.C.1.a.2.h of the Official Guidelines for more information.

Remember different rules for 'probable' diagnoses. Section IV.H, which relates to coding outpatient encounters, includes a rule every coder should know: "Do not code diagnoses documented as 'probable,' 'suspected,' 'questionable,' 'rule out,' or 'working diagnosis' or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit."

Caution: As Section IV.H also explains, the above rule "differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals." Section II.H explains that those inpatient hospitals may report uncertain diagnoses as established diagnoses.

Chapter 19: Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T88)

Guidelines for Assigning Codes From This Chapter

Chapter 19 covers a wide variety of injuries, complications, and types of toxin exposure. Burns, contusions, fractures, and poisonings are just a few of the conditions you'll find in this chapter. You'll also use codes in this chapter to report late effects of injuries, poisonings, and other similar conditions. Be sure to read the instructions ICD-10-CM includes for this chapter in the code book. You may be surprised to learn that when a code title includes more than one injury site, the use of "and" means "either or both sites." "With" is the term that shows the code requires both sites.

Note: Injury codes from Chapter 19 should not be assigned for injuries that occur due to medical intervention. In such cases, you should assign the appropriate complication code(s).

List of Sections

- S00-S09: Injuries to the head
- S10-S19: Injuries to the neck
- S20-S29: Injuries to the thorax
- S30-S39: Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals
- S40-S49: Injuries to the shoulder and upper arm
- S50-S59: Injuries to the elbow and forearm
- S60-S69: Injuries to the wrist, hand and fingers
- S70-S79: Injuries to the hip and thigh
- S80-S89: Injuries to the knee and lower leg
- S90-S99: Injuries to the ankle and foot
- T07: Injuries involving multiple body regions
- T14: Injury of unspecified body region
- T15-T19: Effects of foreign body entering through natural orifice
- T20-T25: Burns and corrosions of external body surface, specified by site
- T26-T28: Burns and corrosions confined to eye and internal organs
- T30-T32: Burns and corrosions of multiple and unspecified body regions
- T33-T34: Frostbite
- T36-T50: Poisoning by, adverse effect of and underdosing of drugs, medicaments and biological substances
- T51-T65: Toxic effects of substances chiefly nonmedicinal as to source
- T66-T78: Other and unspecified effects of external causes
- T79: Certain early complications of trauma
- T80-T88: Complications of surgical and medical care, not elsewhere classified

  Note: The chapter uses the S-section for coding different types of injuries related to single body regions and the T-section to cover injuries to unspecified body regions as well as poisoning and certain other consequences of external causes.

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The ICD-10-CM Official Guidelines for Coding and Reporting for Chapter 19 supply important guidance on everything from the application of 7th characters to coding the complications of care. The information below is from Section I.C.19 of the Official Guidelines.

Get to Know 7th Character Options

You'll find 7th characters throughout Chapter 19. Except for fractures, choose A for an *initial encounter*, D for a *subsequent encounter*, and S for *sequela* (late effect). Here are some tips to help you choose:

- The initial encounter (A) means active treatment — not the first time the provider sees the patient. Examples include surgery, emergency department visit, and evaluation and continuing treatment by the same or a different physician.
- Active treatment for complication codes must be treatment for the condition described by the code.
- Choose subsequent encounter (D) for routine care after the initial encounter. Examples include cast change or removal, an X-ray to check healing status of a fracture, removal of an external or internal fixation device, medication adjustment, and other follow-up visits.
- When a 7th character is available to identify subsequent care, don't use aftercare Z codes.
- Code both the injury and a late effect, or sequela, but remember to append the S to the injury code — not the sequela code.

Keep These Fundamentals in Mind for Trauma Cases

- Report each injury separately unless ICD-10-CM offers a combination code for the specific injuries.
- Sequence first the injury the provider states is most serious.
- Codes from category T07 *Unspecified multiple injuries* should not be assigned in the inpatient setting unless information for a more specific code is not available.
- Traumatic injury codes, S00-T14.9 are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.
- Don't report abrasions and contusions associated with a more serious injury, but you should report minor injuries to peripheral nerves and blood vessels as secondary codes after reporting the larger associated injury.

Watch for Expanded 7th Character Options for Traumatic Fractures

In addition to initial encounter, subsequent encounter, and sequela codes, you'll choose a 7th character to describe aspects of the fracture.

- **Nonunion vs. malunion.** For subsequent care, choose K, M, or N for nonunion and P, Q, or R for malunion.
- **Open vs. closed.** Code as closed if the provider doesn't specify open or closed.
- **Displaced or nondisplaced.** Code as displaced if the provider doesn't specify.

For aftercare, assign an acute fracture code with the appropriate 7th character — not a Z code.

Don't choose a traumatic fracture code when a fracture is due to osteoporosis. Look to category M80 in Chapter 13. See Section I.C.13.d of the Official Guidelines for more information on osteoporosis.

Sequencing: When a patient has more than one fracture, your first code should be the most severe fracture.

Physeal fractures: When coding a physeal fracture, only code the type of fracture. It is not necessary to use a separate code to identify the bone that is fractured.

Watch These Areas When Reporting Burns and Corrosion

ICD-10-CM distinguishes between thermal burns (from a heat source) and corrosion (a chemical burn). Classify current burns (T20-T25) by depth, extent, and by agent (X code) as first degree (erythema), second degree (blistering), and third degree (full-thickness involvement). Classify burns of the eye and internal organs (T26-T28) by site, not by degree.

Classify burns of the same local site (three-character category level, T20-T28) but of different degrees to the subcategory identifying the highest degree recorded in the diagnosis.

Sequencing: When a patient has more than one burn, your first code should be for the highest degree of burn. If those burns of different degrees are at the same anatomical site and on the same side, report only the code for the highest degree.

A patient may have both internal and external burns, or the patient may have burns as well as related conditions. In those cases, your first code should reflect the reason for admission.

Nonhealing burns: Use an acute burn code for nonhealing burns.

Infection: For infected burn sites, use an additional code for the infection.

Separate sites: Assign a separate code for each burn site. Avoid using unspecified category T30.

Only assign codes for burns of multiple sites (multiple burns NOS), when the medical record documentation does not specify the individual sites.

Extent of body surface area: In case of acute burns or corrosions, when the site of burn or corrosion is not mentioned, or when there is need for additional documentation, you may use codes from categories T31 *Burns classified according to extent of body surface involved* or T32 *Corrosions classified according to extent of body surface involved*. You may additionally use a T31.- code for submitting data related to burn mortality.

Rule of nines: Proper use of codes in categories T31 (burns) and T32 (corrosion) depends on understanding the "rule of nines":

- Head and neck: 9 percent
- Each arm: 9 percent
- Each leg: 18 percent
- Anterior trunk: 18 percent
- Posterior trunk: 18 percent
- Genitalia: 1 percent

The above list shows the basic body surface estimate, but providers may vary from this list for children whose heads are proportionately larger than adults', and for patients who have large buttocks, thighs, or abdomens with burns.

Sequelae: When the patient presents for treatment of late effects of a burn or corrosion, such as scars or joint contracture, report the burn or corrosion code with 7th character S. Do not use codes belonging to categories T31 and T32 to code for the sequelae of burns or corrosions.

Keep in mind that burns and corrosions don't heal at the same rate, and you can report sequela codes alongside current burn codes. See Section I.B.10 of the Official Guidelines for more on sequelae, (late effects).

External cause: Don't forget to assign a code to identify the source of a burn, its intent, and the place where it occurred.

Check Additional Code Requirements for Adverse Effects, Poisonings, and Toxic Effects

Codes in categories T36-T65 are combination codes that combine the substance taken and the intent. Don't report an external cause code. Here are the basics:

- Don't code from the Table of Drugs and Chemicals. Always code from the tabular.
- Use as many codes as necessary to describe all ingested substances.
- Assign a code only once if the same code describes the causative agent for more than one adverse reaction.
- Code each substance individually unless a combination code is available.
- Select a code from subcategory T50.91- to capture the ingestion of multiple unspecified drugs, medicinal, or biological substances.

Adverse effect: When the patient presents with an adverse effect from a correctly prescribed and administered drug, first report the effect and then report a code from T36-T50, Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances.

Poisoning: Poisoning codes (T36-T50) apply in cases of:

- Error in drug prescription or administration
- Intentional overdose
- Interaction of a nonprescribed agent with a properly prescribed and administered agent
- Interaction of alcohol and a drug

You should report the poisoning code first, if known, followed by a code for the manifestation. You may report a drug abuse or dependence code as well when appropriate. See Section I.C.4.a.5 of the Official Guidelines if poisoning is the result of insulin pump malfunctions. For sequela (late effects) see Section I.B.10 of the Official Guidelines.

Underdosing: When the patient takes less medication than prescribed, assign a code from categories T36-T50, with a fifth or sixth character of "6." Never assign an underdosing code as the principal or first listed code. If underdosing causes a relapse or exacerbation of a medical condition, code the condition. Code the intent, if known, with a noncompliance or complication of care code. Choose from noncompliance codes (Z91.12-, Z91.13-, Z91.14- and Z91.A4-) or complication of care codes (Y63.6-Y63.9). A provider does not need to document a change in condition in order for you to code underdosing. A documented statement simply noting that the patient has been taking less medication than prescribed is sufficient documentation for an underdosing code.

Remember: You also consider it underdosing when a patient discontinues the use of a prescribed medication by their own initiative – meaning, the patient was not directed by their medical provider to stop taking the medication.

Toxic effect: When reporting a toxic effect (T51-T65), use the appropriate Z code to indicate whether the intent was accidental, intentional self-harm, assault, or undetermined. Be sure to also code all the associated manifestations of the toxic effect.

Report Abuse, Neglect, and Other Maltreatment First

When reporting abuse, neglect, and maltreatment, sequence first the code from categories T74 or T76 for abuse, neglect, and other maltreatment, followed by any accompanying mental health or injury code(s).

If the documentation in the medical record states abuse or neglect is suspected, code from category T76. Report a code from category T74 only if the document specifies abuse or neglect is confirmed.

If there are physical injuries, choose an external cause code from the assault section (X92-Y09). If the perpetrator is known, use a code from category Y07 unless the documentation says abuse is only "suspected."

If a suspected case of abuse, neglect, mistreatment, alleged rape, or sexual abuse is ruled out during an encounter, code Z04.71, Z04.41, or Z04.42, not a code from T76.

If a suspected case of forced sexual exploitation or forced labor exploitation is ruled out during an encounter, assign code Z04.81 or code Z04.82, not a code from T76.

Apply Special Rules for Medical Device and Transplant Complications

Basics: After reporting a code from T80-T88, Complications of Surgical and Medical Care, Not Elsewhere Classified, you have to decide whether to report an additional code to identify the complication. Only report an additional code if it adds specificity to the code you've reported.

Pain due to medical devices: You'll find specific codes for pain due to medical devices in the T code section of the ICD-10-CM code book. Use additional code(s), if known, from category G89 to identify acute or chronic pain due to presence of the device, implant, or graft (G89.18 or G89.28).

Non-kidney transplant: Before reporting a code from category T86 *Complications of transplanted organs and tissue* for a complication related to a nonkidney organ transplant, remember that you shouldn't assign the code unless the complication affects the function of the organ. See I.C.21. of the Official Guidelines for transplant organ removal status and I.C.2. for malignant neoplasms associated with a transplanted organ. See Section I.C.1.d.4. of the Official Guidelines for sequencing of sepsis due to infection in transplanted organ.

Kidney transplant: Chronic kidney disease (CKD) following a kidney transplant does not qualify as a complication, so you should not code it as such. Use T86.1- *Complications of kidney transplant*, for complications such as failure or rejection. Use an additional code to report the specific complication. See Chapter 14 to report CKD.

Complication of care codes: Some of the complications of care codes include the nature of the complication as well as the type of procedure that caused the complication. You won't report an additional external cause code for the procedure.

Note: You will want to assign intraoperative and postprocedural complication codes from specific body system chapters unless the complication is specifically indexed to a T code in Chapter 19.

Sequence intraoperative and postprocedural complication codes found in body system chapters first. Then code any specific complications.

Finally, the documentation behind complication of care codes should explain how the complication was clinically significant. The word "complication" need not be stated, but the condition altering the treatment must be clearly expressed in the chart.

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

Guidelines for Assigning Codes From This Chapter

Chapter 20's title refers to the cause of an injury or health condition, whether the intent behind the cause was intentional or unintentional/accidental (e.g., whether an injury was due to suicide or assault), the patient's location or activity at the time of the event, and whether the patient was a civilian or in the military.

The key to properly applying these codes is understanding that the purpose of these codes is for research — to provide data on the causes of injuries and other health conditions so that the government and healthcare agencies can come up with strategies to prevent them. There is no mandatory national requirement for reporting external causes of morbidity, but a state or individual payer may have such requirements. However, it is hoped that providers will voluntarily report these codes for the valuable data they provide, as noted above.

List of Sections

- V00-X58: Accidents
- V00-V99: Transport accidents
- V00-V09: Pedestrian injured in transport accident
- V10-V19: Pedal cycle rider injured in transport accident
- V20-V29: Motorcycle rider injured in transport accident
- V30-V39: Occupant of three-wheeled motor vehicle injured in transport accident
- V40-V49: Car occupant injured in transport accident
- V50-V59: Occupant of pick-up truck or van injured in transport accident
- V60-V69: Occupant of heavy transport vehicle injured in transport accident
- V70-V79: Bus occupant injured in transport accident
- V80-V89: Other land transport accidents
- V90-V94: Water transport accidents
- V95-V97: Air and space transport accidents
- V98-V99: Other and unspecified transport accidents
- W00-X58: Other external causes of accidental injury
- W00-W19: Slipping, tripping, stumbling and falls
- W20-W49: Exposure to inanimate mechanical forces
- W50-W64: Exposure to animate mechanical forces
- W65-W74: Accidental non-transport drowning and submersion
- W85-W99: Exposure to electric current, radiation and extreme ambient air temperature and pressure
- X00-X08: Exposure to smoke, fire and flames
- X10-X19: Contact with heat and hot substances
- X30-X39: Exposure to forces of nature
- X50: Overexertion and strenuous or repetitive movements
- X52-X58: Accidental exposure to other specified factors
- X71-X83: Intentional self-harm
- X92-Y09: Assault
- Y21-Y33: Event of undetermined intent
- Y35-Y38: Legal intervention, operations of war, military operations, and terrorism
- Y62-Y84: Complications of medical and surgical care
- Y62-Y69: Misadventures to patients during surgical and medical care
- Y70-Y82 Medical devices associated with adverse incidents in diagnostic and therapeutic use
- Y83-Y84 Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
- Y90-Y99 Supplementary factors related to causes of morbidity classified elsewhere

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The ICD-10-CM Official Guidelines for Coding and Reporting for Chapter 20 supply important guidance on everything from the application of 7th characters to sequencing codes in the correct order. The information below is from the Official Guidelines.

Know When to Apply an External Cause of Morbidity Code

The primary application for these codes is injuries. However, these codes may also apply to diseases, infections, and other health conditions that can be attributed to an external cause and that can be reported with a code in the range of A00.0-T88.9 or Z00-Z99. For example, if a stroke occurs during a boxing match or a player has a heart attack during a football game, it would be appropriate to apply an external cause code. Never use a code from Chapter 20 as the principal or primary (first-listed) diagnosis code.

Add a 7th Character for Each Encounter

Most of the codes in Chapter 20 require a 7th character (A, initial encounter; D, subsequent encounter; or S, sequela) for each encounter while the patient is under treatment for an injury or condition. When the patient is seen by a new or different provider, match the 7th character to the encounter. That is, if a patient is seen in the emergency room for an injury, that's the initial encounter. If the patient is referred to a surgeon to repair a fracture, the encounter is still an initial encounter, because the patient is undergoing active treatment for the injury. Once the fracture has been repaired and is healing, follow-up visits would be coded as subsequent encounters. Sequela, of course, is used when the patient suffers a "late effect" or condition resulting from the trauma after the fracture has healed.

Note: Category Y92 is a notable exception to the 7th character code requirement.

Assign all external cause codes that apply. You may need multiple codes to fully explain the circumstances surrounding an injury or other condition. When not limited by the number you can record, add as many of these external cause codes as apply:

- Code cause of the injury or condition.
- Code the intent — was it assault, self-inflicted, accidental, unknown?
- Code the location where the injury occurred.
- Code the activity the patient was involved in, if applicable.
- Code the patient's status — driver, passenger, pedestrian; civilian or military; other.

Get the Sequencing Right Every Time

Use the Alphabetic Index of External Causes to find the appropriate codes and watch for Inclusion and Exclusion notes in the Tabular List to be sure you're applying the appropriate code(s). When you are applying external cause codes, keep these guidelines in mind:

1. External cause codes should be applied in the following order:
   - Child and adult abuse
   - Terrorism events
   - Cataclysmic events
   - Transport accidents
2. If you can record only one external cause code, use the one describing the cause most closely related to the primary diagnosis.
3. Separate injuries caused by separate events should be assigned a separate code for each cause.
4. If you can add more codes, cause, and intent, including complications of surgery and medical care, always take precedence over codes for place, activity, or status.
5. Activity and status codes follow cause codes, if applicable, and if there is room on the form.

External cause codes aren't always necessary. Do not add an external cause code if the primary diagnosis code includes the cause, for example, many of the T (poisoning) codes in Chapter 19.

Sequence of events. When you choose a combination code that describes a sequence of events, the order of events should follow the same order in which the event happened. Try to choose a code that sequences the cause of the most serious injury first.

Place of occurrence, activity, and status. In general, categories Y92 *Place of occurrence of the external cause* codes, Y93 *Activity* codes, and Y99 *External cause status* codes are assigned only for the initial encounter for treatment.

Rarely, a new injury, such as might occur during hospitalization, would require the addition of a Y92 code to subsequent encounters. 7th characters are not used with Y92 codes. The guidelines state, "Do not use place of occurrence code Y92.9- *Unspecified place or not applicable* if the place is not stated or is not applicable." Since this statement appears to present a conflict, confirm the use of this code with your payer.

Add Y93 codes only if the activity is relevant to the diagnosis. Y93 codes do not apply to adverse effects, poisonings, or complications of surgery or medical care. The guidelines state, "Do not assign Y93.9 *Activity, unspecified* if the activity is not stated." This statement also appears to present a conflict, so confirm the use of this code with your payer.

Assign Y99 codes to indicate the work status of the person at the time of the causal event, whether military, nonmilitary, or student/volunteer in a nonwork activity. If there is no external cause code assigned, do not assign a Y99 code. Y99 codes are applicable to other external cause codes, such as transport accidents and falls but not to poisonings, adverse effects, injuries during surgery or medical care, or sequela. The guidelines also state, "Do not assign code Y99.9 *Unspecified external cause status* if the status is not stated." Again, confirm the use of this code with your payer to eliminate the conflict.

Look to X92-Y08 (Assault) for Child and Adult Abuse

Any of the assault codes may be applied to record the external cause of an injury due to confirmed abuse. When the person who inflicted the abuse or is responsible for neglect or maltreatment is known, add a code from category Y07 *Perpetrator of assault, maltreatment and neglect* to the assault code. See Section I.C.19.f. of the Official Guidelines, Adult and child abuse, neglect and other maltreatment.

Know When to Use Undetermined Intent Category

Use an accidental intent code if the cause is not known or not specified. Use undetermined intent external cause codes only if the medical record specifies that the intent cannot be determined. All transport accident categories are assumed to be accidental.

Capture Sequelae (Late Effects) With External Cause Codes

Use the external cause codes with an "S" in the 7th character to report a late effect or sequela resulting from a previous injury. In the situation of a related current injury you are instructed to never use these codes with a related current nature of injury code.

See Section I.B.10. of the Official Guidelines, for more information on sequela (late effects).

Guidelines further advise you not to use a late effect external cause code for subsequent follow-up care such as, visits to assess healing or rehabilitative therapy, unless the provider documents the treatment is for a late effect of the initial injury.

No Need for Assault Code When Terrorism Code Applies

ICD-10-CM includes a specific definition for terrorism in an inclusion note with the category Y38 *Terrorism*. When the cause of the patient's injury meets that terrorism definition, choose a code from the Y38 category. If there is more than one mechanism of injury, you can use an additional Y38 code to identify it. You should not report a separate assault code. Add an additional code from the Y92 category for place of occurrence.

Don't use this category when the cause is "suspected" terrorism. Classify suspected cases of terrorism as assault.

Assign code Y38.9- *Terrorism, secondary effects* for injuries or conditions that occurred as a result of the terrorist event. Do not assign Y38.9- to injuries resulting from the initial terrorist act. You can report code Y38.9- with another Y38 code when an injury is sustained in both the initial terrorist event and as a result of subsequent related events.

Don't Get Swept Away by Cataclysmic Events

When an injury occurs during a cataclysmic event, you need to determine if the injury was a direct result of the event itself or if it occurred for another reason.

If an injury occurs because of a hurricane or flood, code the injury first and then assign the external cause of morbidity code X37.0- for hurricane or X38 for flood. External cause codes for cataclysmic events take priority over other external cause codes except in the case of child and adult abuse or terrorism.

Note: If the injury results from the collapse of a man-made structure that was destroyed because of a cataclysmic event, you shouldn't assign X36.0- *Collapse of dam or man-made structure*; instead, just code the cataclysmic event.

If the injury occurred during a cataclysmic event, but not because of it, you need to assign a different external cause code.

Example: For a traffic accident that happens during an evacuation for a hurricane or flood, you would assign the code for injury first, then the external cause code for a transport accident as long as the flood did not cause the accident. If the flood caused the accident, sequence the external cause of the flood after the principal diagnosis.

Note: You can assign additional external cause codes along with the code for the cataclysmic event (e.g., bitten by a dog, or exposure to excessive natural heat or cold).

Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

Guidelines for Assigning Codes From This Chapter

Z codes are key to correct coding practices as both primary and secondary codes, giving information both about the nature of the encounter and the patient's circumstances.

List of Sections

- Z00-Z13: Persons encountering health services for examinations
- Z14-Z15: Genetic carrier and genetic susceptibility to disease
- Z16: Resistance to antimicrobial drugs
- Z17: Estrogen receptor status
- Z18: Retained foreign body fragments
- Z19: Hormone sensitivity malignancy status
- Z20-Z29: Persons with potential health hazards related to communicable diseases
- Z30-Z39: Persons encountering health services in circumstances related to reproduction
- Z40-Z53: Encounters for other specific health care
- Z55-Z65: Persons with potential health hazards related to socioeconomic and psychosocial circumstances
- Z66: Do not resuscitate status
- Z67: Blood type
- Z68: Body mass index [BMI]
- Z69-Z76: Persons encountering health services in other circumstances
- Z77-Z99: Persons with potential health hazards related to family and personal history and certain conditions influencing health status

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The ICD-10-CM Official Guidelines for Coding and Reporting cover a variety of rules to keep your Z code reporting on track. The information below summarizes the key points from Section I.C.21 of the Official Guidelines.

4 Factors Trigger Z Code Use

The guidelines delineate the four main reasons you'll use Z codes:

- A healthy patient presenting for a specific encounter, such as organ donation, vaccination, or screenings
- Aftercare of an injury or disease
- Circumstances influencing health status or potential hazards to community health
- Birth status

Other basic rules include that you may report Z codes in any healthcare setting, and that it's possible for Z codes to be primary or secondary codes, depending on the code and the circumstances.

Important: If a patient's history is limited, you can use any documentation necessary to assign Z codes that help describe the patient and reason(s) for the encounter. Moreover, the Z codes can be used to give additional data about the encounter.

Note: Z codes cannot be substituted for procedure codes; a procedure code must be used in conjunction with a Z code to report the procedure performed.

Clinicians Can Document, Too

You can utilize documentation from clinicians other than the patient's provider to assign codes for BMI. You can also use clinician's documentation to code social determinants to heath categorized as codes Z55-Z65 *Persons with potential health hazards related to socioeconomic and psychosocial circumstances*. These include problems related to education and literacy, employment/unemployment, and problems stemming from personal relationships or upbringing. You can report BMI and codes from Z55-Z65 as secondary diagnoses.

Below are some of the main guidelines related to Z code categories.

Contact/Exposure Means No Signs/Symptoms

Use codes from category Z20 *Contact with and [suspected] exposure to communicable diseases* and category Z77 *Other contact with and [suspected] exposures hazardous to health* for patients who have been exposed to the disease but who have no signs or symptoms of the disease. You can use them as primary codes for testing encounters or as secondary codes to supply information about risk.

Remember Z Codes for Inoculations and Vaccinations

Code Z23 represents inoculation and vaccination encounters. You may use code Z23 as a secondary code when the patient has the inoculation as part of a preventive healthcare visit. Use procedure codes to report the actual administration/injection and type of immunization.

Status Codes Add Information That May Affect Treatment

A status code offers information about the patient that may affect treatment, such as presence of a prosthetic. Don't confuse status codes with history codes, which you use when the patient doesn't have the condition anymore.

When you report a code from one of the body system chapters that includes the same information that's in the status code, don't report the status code. For example, do not report code Z94.1 *Heart transplant status* with a code from subcategory T86.2- *Complications of heart transplant*. Z94.1 does not provide any additional information. But for encounters for weaning from a mechanical ventilator, you would assign a code from subcategory J96.1- *Chronic respiratory failure* followed by code Z99.11 *Dependence on respirator [ventilator] status*, because the status code supplies more information about the patient's situation.

For a full list of status codes/categories, see the Official Guidelines section I.C.21.c.3 in your ICD-10-CM code book.

BMI: You should only assign BMI codes with a valid associated reported diagnosis (such as overweight or obesity). Do not assign BMI codes during pregnancy.

tPA status: In addition to the instructions ICD-10-CM includes with Z92.82 *Status post administration of tPA [rtPA] in a different facility within the last 24 hours prior to admission to current facility*, you should know that only the receiving facility should report Z92.82 and the code applies even when the patient is still on tPA upon arrival at the receiving facility.

Drug use: Do not use codes from category Z79 *Long-term [current] drug therapy* for patients addicted to drugs or in detoxification/maintenance programs. Use drug dependence codes instead.

Genetic susceptibility: Assign codes from category Z15 *Genetic susceptibility to disease* only as a secondary code and if the patient has a gene that increases the patient's risk for that disease.

Underimmunization: Three codes exist to indicate whether a patient is underimmunized. Assign Z28.310 *Unvaccinated for COVID-19*, Z28.311 *Partially vaccinated for COVID-19*, or Z28.39 *Other underimmunized status* when the provider or clinician documents this in a patient's chart.

Apply History (of) Codes for Eradicated Conditions

The Z code section includes codes for both personal history and family history.

Personal history codes typically apply to conditions the patient used to have that have the potential to occur again. Family history codes represent conditions found in the patient's family, suggesting the patient may be at higher risk for the disease.

While applying these codes, remember to assign the codes for reason of encounter first, such as screening or counselling. Next, you may assign the personal and/or family history codes as additional diagnoses.

For a list of personal and family history codes and categories, see the Official Guidelines section I.C.21.c.4 in your ICD-10-CM code book.

Hold Screening Codes for Patients With No Symptoms

Use the screening Z codes for tests on patients with no signs or symptoms of the disease being tested for. If a patient has a sign or symptom, then the test is diagnostic and a screening code is not appropriate. Use the sign or symptom code for the test encounter instead.

You may use screening codes as either primary or secondary codes depending on the reason for the encounter. Note that when the screening is a usual part of an exam, such as a Pap smear during a routine pelvic exam, you do not need to report the screening code.

Screening Z code categories include the following:

- Z11 — *Encounter for screening for infectious and parasitic diseases*
- Z12 — *Encounter for screening for malignant neoplasms*
- Z13 — *Encounter for screening for other diseases and disorders shift to lie below encounter Except: Z13.9, Encounter for screening, unspecified*
- Z36 — *Encounter for antenatal screening for mother*

Think Twice Before Using These Observation Codes

You'll rarely use the observation Z codes because they apply only when the provider keeps a patient without signs or symptoms under observation for a suspected condition that the provider then rules out. Use observation codes primarily as the principal/first-listed diagnosis code; other codes may be added only if they are unrelated to the reason for observation.

An observation code can be used as a secondary diagnosis code only when a patient is being observed for an additional unrelated condition or injury that eventually gets ruled out. An example would include seeking treatment for a fracture and then being observed for a suspected COVID-19 infection that is ultimately ruled out.

When a pregnant patient is seen for a suspected maternal or fetal condition that is ruled out during the encounter, you can assign a code from subcategory Z03.7- *Encounter for suspected maternal and fetal conditions ruled out*. Do not use these conditions if the condition is confirmed.

Do not use if an illness or any signs or symptoms related to the suspected condition or problem are present. Use the appropriate diagnoses codes or signs or symptoms codes. It is acceptable to use additional codes, if known, with Z03.7- for conditions unrelated to the suspected condition.

Do not use codes from subcategory Z03.7- for antenatal screening encounters. See Section I.C.21.c.5 of the Official Guidelines, Screening.

Assign the appropriate code from categories O35, O36, O40, or O41 for encounters for suspected fetal condition that are inconclusive following testing and evaluation.

You'll find observation Z codes under the following categories:

- Z03 — *Encounter for medical observation for suspected diseases and conditions ruled out*
- Z04 — *Encounter for examination and observation for other reasons. Except: Z04.9 — Encounter for examination and observation for unspecified reason*
- Z05 — *Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out*

Capture Z05 Codes for Observation and Evaluation of Newborns for Suspected Conditions

Assign a code from category Z05 *Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out*, when a healthy newborn is evaluated for a suspected condition, but it is determined that the condition is not present. Do not assign a code from category Z05 however, when the patient has identified *signs or symptoms* of a suspected problem; in this case, code the sign or symptom found in the patient's record.

Z05 on the birth record: Report a code from category Z05 as a secondary code after the code from category Z38 *Liveborn infants according to place of birth and type of delivery*.

Z05 on other than the birth record: You may assign a category Z05 code as a principal or first-listed code for readmissions or encounters when the code from category Z38 no longer applies.

Remember: Codes from category Z05 are for use only for healthy newborns and infants for which after study no disease or condition is found to be present.

Aftercare Generally Applies to Recovering Patients

The guidelines categorize a variety of encounters as aftercare that you may not immediately think of as applying to patients in the healing or recovery phase after initial treatment is complete. The guidelines acknowledge this, pointing out that Z51.0 E*ncounter for antineoplastic radiation therapy* and Z51.1- *Encounter for antineoplastic chemotherapy and immunotherapy* are exceptions to the definition of aftercare.

You typically use aftercare codes as the first-listed code, but these can also be additional codes in cases where the patient presents for treatment of another condition and aftercare also takes place. You may report other codes in addition to aftercare codes to provide additional information, such as status Z codes.

For a list of aftercare codes and categories, see the Official Guidelines section I.C.21.c.7 in your ICD-10-CM code book.

Assign a Follow-Up for Encounters Related to Past Conditions

When the provider sees a patient to check on a condition that no longer exists following treatment, use a follow-up code. Note how these codes differ from aftercare, which typically refers to treatment for a healing condition or the consequences of that condition. You also would not use a follow-up code for injuries for which there are subsequent encounter codes with a 7th character.

To more fully explain the follow-up, you may report a history Z code as an additional code.

When a condition recurs, report the code for the condition rather than the follow-up code.

You'll find follow-up Z codes in these categories:

- Z08 — *Encounter for follow-up examination after completed treatment for malignant neoplasm*

- Z09 — *Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm*
- Z39 — *Encounter for maternal postpartum care and examination*

Note: Treatments mentioned in follow-up codes Z08 and Z09 may be medical or surgical in nature.

Use Donor Codes for Healthy Donors

Report a code from category Z52 *Donors of organs and tissues* to identify an individual donating blood or body tissue for the benefit of others, as well as for self donation-such as autografts. However, these codes do not apply to cadaveric donations.

Keep an Eye on Reason for Counseling

Use the counseling Z codes to identify encounters for counseling patients and/or families for specific conditions and circumstances. You don't need to report a counseling code with another diagnosis code when counseling is part of standard care.

Use code Z71.84 *Encounter for health counseling related to travel* only if a patient is counseled for future travel purposes.

If the provider specifically counsels a patient or caregiver regarding the safety of a vaccine, assign the code Z71.85 *Encounter for immunization safety counseling*. However, remember that this code does not apply during the encounter for routine administration of vaccines, where the provider may explain about risks and potential side effects of the vaccine.

If the sole reason for an encounter is for pediatric-to-adult transition counseling, assign code Z71.87 *Encounter for pediatric-to-adult transition counseling*. This code can also be used if this type of counseling is provided in addition to other services during a visit. Sequencing of the medical condition treated or this counseling code will depend upon the specific circumstances of the encounter.

For a list of counseling codes and categories, see the Official Guidelines section I.C.21.c.10 in your ICD-10-CM code book.

Obstetrics and Related Conditions Have Strict Coding Rules

ICD-10-CM includes Z codes for pregnancy that you should use only when no code from the obstetrics chapter applies, for example, category Z34 *Encounter for supervision of normal pregnancy*.

You may assign codes from category Z3A *Weeks of gestation* to provide additional information about the pregnancy. When an admission extends beyond a single gestational week, use the date of the admission to determine weeks of gestation.

Be sure to include a code from Z37 *Outcome of delivery* on each maternity delivery record, but only as a secondary code.

For a list of obstetric-related codes and categories, see the Official Guidelines section I.C.21.c.11 in your ICD-10-CM code book.

For further instruction on the use of these codes, see the Official Guidelines section I.C.15 Pregnancy, Childbirth, and the Puerperium.

Track Down Newborn Guidelines in Other Sections

The Chapter 21 guidelines direct you to see the Chapter 16 guidelines, as well as the observation code guidelines discussed above, for help with reporting newborn codes.

Some codes and categories to review include:

- Z76.1 — Encounter for health supervision and care of foundling
- Z00.1- — Encounter for routine child health examination
- Z38 — Liveborn infants according to place of birth and type of delivery

Routine and Administrative Exams Don't Involve Suspected Diagnoses

These codes for routine and administrative exams are not appropriate for exams related to diagnosing a suspected condition or for treatment. You'd use the related diagnosis code for those exams.

Note, however, that if the provider makes a diagnosis during a routine exam, you may report the routine exam followed by the confirmed diagnosis. Similarly, you may report additional codes for chronic or other conditions the patient already has.

You'll use these Z codes and categories for routine and administrative exams:

- Z00 — *Encounter for general examination without complaint, suspected or reported diagnosis*
- Z01 — *Encounter for other special examination without complaint, suspected or reported diagnosis*
- Z02 — *Encounter for administrative examination Except: Z02.9, Encounter for administrative examinations, unspecified*
- Z32.0- — *Encounter for pregnancy test*

Miscellaneous Z Codes Include Prophylactic Organ Removal

If a Z code doesn't fit into any of the other categories, you'll find it here. Examples include palliative care, elective surgery, problems related to lifestyle and life management, and economic circumstances. Be sure to only use these codes when the documentation specifies that the patient has an associated problem.

For a list of miscellaneous Z codes and categories, see the Official Guidelines section I.C.21.c.14 in your ICD-10-CM code book.

Prophylactic organ removal: The guidelines give specific instructions for coding removal of organs to prevent disease. When a patient presents for removal of breasts, ovaries, or other organs because the patient has a genetic susceptibility to, or a family history of, a specific cancer, you should report a code from category Z40 *Encounter for prophylactic surgery*. Then report another code for the genetic susceptibility or family history.

When a patient has cancer at one site and undergoes organ removal at another site to prevent cancer forming there, report the malignancy code in addition to a code from subcategory Z40.0- *Encounter for prophylactic surgery for risk factors related to malignant neoplasms*. But be sure to distinguish prophylactic removal from removal to treat a malignancy, "such as the removal of the testes for the treatment of prostate cancer," the guidelines warn. See Section I.B.14 of the Official Guidelines, for Z55-Z65 Persons with potential health hazards related to socioeconomic and psychosocial circumstances, documentation by clinicians other than the patient's provider.

Keep Nonspecific Z Codes as a Last Resort

ICD-10-CM offers nonspecific Z codes with the warning that their use should be very limited, particularly in the inpatient setting. One example of a nonspecific code is Z04.9 *Encounter for examination and observation for unspecified reason*. Always try to find a more specific code describing the sign, symptom, or other reason for the encounter before choosing a nonspecific code.

For a list of nonspecific Z codes and categories, see the Official Guidelines section I.C.21.c.15 in your ICD-10-CM code book.

Mark These Z Codes as Principal/First Listed Only

ICD-10-CM designates certain Z codes as reportable only as principal/first-listed diagnoses. The exception is that when more than one Z code meets the definition for principal/first-listed diagnosis, you may report these codes somewhere other than the primary spot.

For a list of Z codes you should report only as principal/first-listed codes, see the Official Guidelines section I.C.21.c.16 in your ICD-10-CM code book.

Mainstream the Social Determinants of Health

You may code social information for a person that bears a significant contribution to their health condition by using codes from categories Z55-Z65 *Persons with potential health hazards related to socioeconomic and psychosocial circumstances*. This information needs to be documented in the official medical record. Documentation by clinicians other than the patient's doctor, such as a social worker, case manager, nurse, or community health worker qualifies for these codes.

Assign as many social determinants of health codes as necessary, but make sure the codes are only reported if the patient experiences problems as a result of the potential health hazards these codes represent. These codes should also only be used as secondary codes.

In case the patient reports the information, it should be included in the medical record by the clinicians.

Note: Even though the patient is living alone, you should not assign the code Z60.2 *Problems related to living alone* unless there is clear documentation of a potential risk or need for assistance at home.

Assign code Z59.41 *Food insecurity* if there is a documentation supporting patient's concern about availability of food.

Similarly, Z59.0- *Homelessness* may be assigned if there is a valid documentation indicating that the patient is homeless. Homelessness might impact when the patient is discharged.

For a list of social determinants of health codes, see the Official Guidelines section I.C.21.c.17 in your ICD-10-CM code book.

Also, refer to section I.B.14. of the Official Guidelines for documentation by clinicians other than the patient's provider.

Chapter 22: Codes for Special Purposes (U00-U85)
Guidelines for Assigning Codes From This Chapter

This relatively recent chapter was created in 2021 in the wake of the COVID-19 pandemic to provide codes for emerging pathologies, and for emergency use.

List of Sections

U00-U49 Provisional assignment of new diseases of uncertain etiology or emergency use

Highlights From the ICD-10-CM 2024 Official Guidelines for Coding and Reporting

The ICD-10-CM Official Guidelines for Coding and Reporting direct readers to section I.C.10.e for guidelines regarding vaping disorders and section I.C.1.g.1 for COVID-19 diagnosis.

Note: U codes were added to the ICD-10-CM 2021 code set to address immediate critical conditions and special purposes.

Don't Mask the Facts When Coding Coronavirus

You can only code confirmed cases of COVID-19 in an outpatient setting. A patient needs a confirmed positive test result and physician documentation of such, in order to assign code U07.1 *COVID-19*. In an inpatient setting, positive tests results are not necessary to use code U07.1. Provider documentation stating that the patient has COVID-19 is sufficient.

For symptomatic or asymptomatic patients who were exposed, or potentially exposed to COVID-19, assign code Z20.828 *Contact with and (suspected) exposure to other viral communicable diseases*.

If a patient is showing signs and symptoms of COVID-19, but the physician does not establish a definitive diagnosis, code each of the signs and symptoms as described.

Note: When a patient presents for screening for COVID-19, including preoperative testing, assign code Z11.52 *Encounter for screening for COVID-19*.

For patients with a personal history of COVID-19 with no residual symptoms that are presenting for a follow-up appointment use codes Z09 *Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm*, and Z86.16 *Personal History of COVID-19*.

Coding For Conditions Present After COVID-19

If residual symptoms or sequela of previous COVID-19 infections exist, first code the symptom or condition along with U09.9 *Post COVID-19 condition, unspecified*.

Note: Do not code U09.9 with a current COVID-19 infection.

Code U09.9 can be coded with U07.1 *COVID-19* only if the patient is being seen for a new active (current) COVID-19 infection. You can also code conditions from the previous infection along with manifestations of the new infection.

Finally, keep in mind that COVID-19 guidelines could potentially change as new information becomes available. Be sure to check with CMS before coding COVID-19.

Multisystem Inflammatory Syndrome

See section I.C.1.g.1.l in the Official Guidelines for further information on how to code multisystem inflammatory syndrome with current, past, or suspected COVID-19.

Boost Your Knowledge of Underimmunization

When a provider or clinician documents that a patient is underimmunized for COVID-19, you can now report that documentation with codes Z28.310 *Unvaccinated for COVID-19* or Z28.311 *Partially vaccinated for COVID-19*.